



On the Radar

Issue 425
15 July 2019

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On the Radar

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Reports

What a difference a place makes: the growing impact of health and wellbeing boards

Local Government Association

London: Local Government Association; 2019. p. 40.

URL	https://www.local.gov.uk/what-difference-place-makes-growing-impact-health-and-wellbeing-boards
Notes	This report from the UK's Local Government Association highlights how health and wellbeing boards (HWBs) are making a difference through a wide range of initiatives, including reducing hospital admissions and time spent in hospital, reducing demand for GP appointments, helping thousands of smokers to quit, imposing restrictions on fast food outlets near schools, and reducing unemployment, poverty and poor housing. These boards are in some way a reflection of the role local government in the UK plays in (public) health.

The role of the GP in caring for gender-questioning and transgender patients

RCGP Position Statement

Royal College of General Practitioners

London: Royal College of General Practitioners; 2019. p. 12.

URL	https://www.rcgp.org.uk/policy/rcgp-policy-areas/transgender-care.aspx
Notes	<p>The UK's Royal College of General Practitioners has released this position statement on the provision of care for people who are questioning their gender and those who are transgender. The College believes that education and training for healthcare professionals, IT systems, and access to gender identity services must all be addressed in order to improve the care trans patients receive.</p> <p>GPs are most often the first point of contact with the health care system for individuals questioning their gender. In some cases, GPs can be the first people they confide in about their gender identity or uncertainties about their gender identity. General practice plays a vital role in ensuring these patients receive the care they need. GPs are expected to approach the holistic care of gender-questioning and transgender patients as they do with every patient – openly, respectfully, sensitively and without bias.</p> <p>The Royal College of GPs recognises that GPs are not experienced in treating and managing patients with gender dysphoria and trans health issues. Gender dysphoria and gender identity issues are not part of the GP curriculum or GP Specialty Training, and GPs are currently required to refer patients experiencing gender dysphoria to gender identity specialists for further assessment and treatment advice. GPs face difficulties in accessing gender identity specialists in a timely way which often has severe implications for the mental and physical health of their patients. As such, GPs are under increasing pressure to provide services which are usually provided in specialist clinics, as they lie outside the remit of a GPs generalist expertise, with limited access to specialist support.</p> <p>There is an urgent need to increase the capacity of gender identity specialists and clinics and expand the understanding of gender variance issues across the entire health system, including more definitive knowledge about the causes of rapidly increasing referrals and the outcomes of interventions or 'wait and see' policies. The gaps in education, guidance and training for GPs around treating gender dysphoria for both adults and children, and managing broader trans health issues, also needs to be urgently addressed.</p>

Promoting an overdue digital transformation in healthcare

Jones GL, Peter Z, Rutter K-AR, Somauroo A

McKinsey & Company; 2019.

URL	https://www.mckinsey.com/~media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/Promoting%20an%20overdue%20digital%20transformation%20in%20healthcare/Promoting-an-overdue-digital-transformation-in-healthcare.ashx
Notes	<p>This briefing paper from McKinsey and Company may (to some) seem to be stating the obvious, but it is a succinct summary of current state of technology in healthcare across 30 countries. The authors note that many of 'the barriers to a digital transformation in healthcare are often decidedly nontechnological' and cite work that 'found that the three barriers to digital most mentioned by leaders in the pharmaceutical and medical-technology industry were culture and mind-set, organizational structure, and governance.' The authors proceed to give 'a set of six conditions that can smooth the path toward a successful systemwide digital transformation in healthcare'. The six conditions are:</p>

	<ol style="list-style-type: none"> 1. Governments have a role to play in instigating digital transformation in healthcare systems 2. Payers and standards bodies can accelerate and sustain technological advancement by adapting reimbursement guidelines 3. Healthcare organizations that promote open innovation will help spur digital transformation 4. Healthcare providers can improve adoption and expedite benefits by focusing on tangible value to consumers 5. Stakeholders who invest in the right mix of skills can help accelerate and sustain long-term digital transformation 6. Payers and providers can start with near-term initiatives—but still need long-term investment.
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Journal articles

Unwarranted clinical variation in health care: Definitions and proposal of an analytic framework

Sutherland K, Levesque J-F

Journal of Evaluation in Clinical Practice. 2019 [epub].

DOI	https://doi.org/10.1111/jep.13181
Notes	<p>After describing a conceptual framework for levers of change in health care in an article in BMJ in 2017, Sutherland and Levesque have now proposed an analytic framework for unwarranted clinical variation. They argue that given the considerable interest in unwarranted variation, both within Australia and internationally, there is a need for a strong conceptual framework to delineate warranted and unwarranted variation.</p> <p>Sutherland and Levesque examined 190 studies on unwarranted variation and grouped the factors associated with variation into three themes:</p> <ol style="list-style-type: none"> 1. Patients' and clinicians' agency and motivation 2. Evidence and judgement 3. Personal and organisational capacity <p>This forms the basis of the analytic framework – variation can be considered within these themes to determine if it is warranted or unwarranted. The paper urges careful consideration of the complexity of measuring unwarranted variation and acknowledges that the framework does not provide guidance about which of these categories should be investigated.</p> <p>The Commission examines variation in the <i>Australian Atlas of Healthcare Variation</i> series (https://www.safetyandquality.gov.au/publications-and-resources/australian-atlas-healthcare-variation-series). The Commission's approach to addressing unwarranted variation harnesses the principles in the clinical governance standard in the National Safety and Quality Health Service Standards.</p> <p><i>National Safety and Quality Health Service Standards User Guide for the Review of Clinical Variation in Health Care</i></p> <p>The Commission will be releasing a consultation draft of the <i>User Guide for the Review of Clinical Variation in Health Care</i> to support health service organisations implement a new action in the NSQHS standards, second edition. The new Action (1.28) is part of the Governance Standard, and includes monitoring and investigating data on clinical variation to improve clinical practice. The Guide includes practical advice and case studies to show some of the different ways health service organisations can implement Action 1.28.</p>

DOI	https://doi.org/10.1071/PY19041								
Notes	<p>In this Australian paper, the authors review the value of having continuity of care (COC) and some of the barriers to achieving it, before presenting a series of recommendations for improving continuity of care in the primary care setting. The authors note that 'Continuity of care' is accompanied by a range of patient benefits, including reduced all-cause mortality; lower rates of hospital presentation and preventable admission; and improved patient satisfaction.</p> <p>The authors note that continuity of care is not simply 'the longitudinal relationship between a single healthcare provider and a patient that extends beyond discrete episodes of care'. As they write, 'There is also continuity of a health team, continuity of a health service, continuity of a specific service (such as mental health) and continuity of information within a health service. In primary care, continuity can be provided by any HCP [health care professional]; including doctors, Indigenous health workers, nurses, midwives and allied health professionals.'</p> <p>Recommendations for improving continuity of care</p> <table> <tr> <td>Practice procedures</td><td> Booking procedures to optimise COC Reminder systems to support regular contact Better use of mobile phone, SMS and email for follow up Photo business cards of regular HCP as appointment cards Daily staff handover of key patients and issues Regular staff meetings and training focussed on COC Regular patient surveys and audits of COC and feedback to staff Develop practice policies based on survey and audit results Target patients with multimorbidity or complexity Telehealth in remote settings Flexible clinic hours </td></tr> <tr> <td>Small teams</td><td> Small multidisciplinary teams Regular contact with target patients Provide patients with telephone, SMS and email access to their team Hospital visits, home visits and coordination of care Professional support, especially for HCPs in rural and remote settings </td></tr> <tr> <td>Staff retention</td><td> Robust recruitment process Reward staff retention Flexible rostering, fractional appointments, job share arrangements Professional development opportunities Adequate recreational leave Suitable accommodation Partner employment Child care arrangements Financial incentives </td></tr> <tr> <td>Research and advocacy</td><td> A universal COC definition that acknowledges the patient experience An accepted and validated tool to measure COC Measurement of community-determined endpoints and outcomes Prospective studies to strengthen the evidence base Keep COC 'on the radar' of practice managers and policymakers </td></tr> </table>	Practice procedures	Booking procedures to optimise COC Reminder systems to support regular contact Better use of mobile phone, SMS and email for follow up Photo business cards of regular HCP as appointment cards Daily staff handover of key patients and issues Regular staff meetings and training focussed on COC Regular patient surveys and audits of COC and feedback to staff Develop practice policies based on survey and audit results Target patients with multimorbidity or complexity Telehealth in remote settings Flexible clinic hours	Small teams	Small multidisciplinary teams Regular contact with target patients Provide patients with telephone, SMS and email access to their team Hospital visits, home visits and coordination of care Professional support, especially for HCPs in rural and remote settings	Staff retention	Robust recruitment process Reward staff retention Flexible rostering, fractional appointments, job share arrangements Professional development opportunities Adequate recreational leave Suitable accommodation Partner employment Child care arrangements Financial incentives	Research and advocacy	A universal COC definition that acknowledges the patient experience An accepted and validated tool to measure COC Measurement of community-determined endpoints and outcomes Prospective studies to strengthen the evidence base Keep COC 'on the radar' of practice managers and policymakers
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Hunter and New England Diabetes Alliance: innovative and integrated diabetes care delivery in general practice
 Acharya S, Philcox AN, Parsons M, Suthers B, Luu J, Lynch M, et al
 Australian Journal of Primary Health. 2019;25(3):219-43.

DOI	https://doi.org/10.1071/PY18179
Notes	Paper reporting on a quality improvement program in diabetes health care across a large health district that included rural and remote geography and a limited specialist workforce. An integrated diabetes care model was implemented, linking specialist teams with primary care teams through capacity enhancing case-conferencing in general practice supported by comprehensive performance feedback with regular educational sessions. The paper reports on both the initial pilot project and a larger scale implementation across the region. Scaling projects often brings new challenges, just as sustaining change can be challenging. The authors argue that ‘An integrated care model where specialist teams are engaged collaboratively with primary care teams in providing education, capacity-enhancing case-conferences and performance monitoring may achieve improved health outcomes for people with diabetes.’ Benefits were not limited to improved patient outcomes but ‘included partnership and trust building between specialist and primary care’. Further, the authors suggest that this experience may be a model in building capacity across primary care for many chronic conditions.

Leadership development and primary care
 Swanwick T, Varnam R
 BMJ Leader. 2019;3(2):59-61.

DOI	http://dx.doi.org/10.1136/leader-2019-000145
Notes	Commentary piece arguing that given the role that primary care could play in delivering an effective and sustainable health system, there is a need to develop the leadership by and for primary care . The authors call for a ‘future where leadership and management is welcomed and embraced by the primary care community as an essential part of their professional responsibilities’ and this will contribute to primary care taking ‘its place in leading the profound system changes required in health and care to respond to the future needs of patients, local communities and wider populations’.

Reducing door-to-needle times in stroke thrombolysis to 13 min through protocol revision and simulation training: a quality improvement project in a Norwegian stroke centre
 Ajmi SC, Advani R, Fjetland L, Kurz KD, Lindner T, Qvindesland SA, et al
 BMJ Quality & Safety. 2019 [epub].

DOI	https://doi.org/10.1136/bmjqs-2018-009117
Notes	Door-to-needle time is recognised as being of vital importance for those suffering acute ischaemic stroke. This quality improvement report describes how a Norwegian stroke centre that had achieved and sustained a median door-to-needle time of under 30 minutes sought to further reduce the door-to-needle times in stroke thrombolysis. Engaging the entire acute stroke treatment team and refining their treatment protocol saw their median door to needle times were reduced from 27 to 13 minutes and remained consistent after 13 months. The authors report that ‘Risk-adjusted cumulative sum charts indicate a reduced proportion of patients deceased or bedridden after 90 days. There was no significant change in balancing measures (stroke mimics, fatal intracranial haemorrhage and prehospital times).’

Serious misdiagnosis-related harms in malpractice claims: The “Big Three” – vascular events, infections, and cancers
 Newman-Toker David E, Schaffer Adam C, Yu-Moe CW, Nassery N, Saber Tehrani Ali S, Clemens Gwendolyn D, et al
 Diagnosis. 2019 [epub].

DOI	https://doi.org/10.1515/dx-2019-0019
Notes	<p>Issues around diagnosis, whether that be misdiagnosis, diagnostic error or over-diagnosis, have come to the fore in recent years. The scale of each or any of these is not always clear. This paper reports on an attempt to the estimate the burden of serious misdiagnosis-related harms in the USA. The study sought to identify diseases accounting for the majority of serious misdiagnosis-related harms (morbidity/mortality). The study used malpractice claims data and analysed vascular events, infections, and cancers, including frequency, severity, and settings. The authors report that from 55,377 closed malpractice claims, they found 11,592 diagnostic error cases [median age 49, interquartile range (IQR) 36–60; 51.7% female] including 7379 with high-severity harms (53.0% death). They report that the ‘Big Three diseases accounted for 74.1% of high-severity cases (vascular events 22.8%, infections 13.5%, and cancers 37.8%). In aggregate, the top five from each category (n = 15 diseases) accounted for 47.1% of high-severity cases. The most frequent disease in each category, respectively, was stroke, sepsis, and lung cancer. Causes were disproportionately clinical judgment factors (85.7%) across categories (range 82.0–88.8%).’</p> <p>They conclude that ‘The Big Three diseases account for about three-fourths of serious misdiagnosis-related harms. Initial efforts to improve diagnosis should focus on vascular events, infections, and cancers.’</p>

In Hospitals With More Nurses Who Have Baccalaureate Degrees, Better Outcomes For Patients After Cardiac Arrest
 Harrison JM, Aiken LH, Sloane DM, Brooks Carthon JM, Merchant RM, Berg RA, et al
 Health Affairs. 2019;38(7):1087-94.

DOI	https://doi.org/10.1377/hlthaff.2018.05064
Notes	<p>There is existing literature on nursing staffing and safety and quality to which this paper adds. This paper reports finding support for a more educated nursing staff having a beneficial effect. Using data from four US states, they report a 10-percentage-point increase in the share of hospital nursing staff with a bachelor’s degree corresponds with a 24 percent increase in a patient’s odds of surviving an in-hospital cardiac arrest with limited cerebral damage. The authors observe that ‘These findings contribute to the growing body of evidence that supports policies to increase access to baccalaureate-level education and improve hospital nurse staffing.’</p>

Australian Journal of Primary Health
 Volume 25 Number 3 2019

URL	https://www.publish.csiro.au/py/issue/9441
Notes	<p>A new issue of the <i>Australian Journal of Primary Health</i> has been published. Articles in this issue of the <i>Australian Journal of Primary Health</i> include:</p> <ul style="list-style-type: none"> • Challenges in primary care policy (Stephen Duckett) • Reducing alcohol-related harm in people recently treated for hepatitis C (Sasha Hermosa, Stelliana Goutzamanis, Joseph Doyle and Peter Higgs) • Effectiveness of chronic obstructive pulmonary disease self-management interventions in primary care settings: a systematic review (Hassan Hosseinzadeh and Mahmoud Shnaigat)

	<ul style="list-style-type: none"> • How can healthcare professionals address poor health service utilisation among refugees after resettlement in Australia? A narrative systematic review of recent evidence (Jamuna Parajuli and Dell Horey) • Continuity of care: why it matters and what we can do (Alexandra Hofer and Malcolm McDonald) • Hunter and New England Diabetes Alliance: innovative and integrated diabetes care delivery in general practice (Shamasunder Acharya, Annalise N. Philcox, Martha Parsons, B Suthers, J Luu, M Lynch, M Jones and J Attia) • Behavioural change in primary care professionals undertaking online education in dementia care in general practice (Michael W Bentley, Rohan Kerr, Margaret Ginger and Jacob Karagoz) • Evaluation of health promotion capacity gains in a state-wide rural food literacy intervention (Claire Palermo, Louise van Herwerden, Isabella Maugeri, Fiona McKenzie-Lewis and Roger Hughes) • Expanded normal weight obesity and blood pressure in Chinese adults: a community-based cross-sectional study (Huijing He, Li Pan, Feng Liu, Jingang Ma, Zhiping Hu, Li Wang, Yajun Li and Guangliang Shan) • A qualitative investigation of barriers, support-seeking and coping among South Sudanese people with chronic hepatitis B in Australia (William Mude, Christopher Fisher, Jacqui Richmond, Jack Wallace and R Le Gautier) • Has a national policy guideline influenced the practice of raising the topic of alcohol and breastfeeding by maternal healthcare practitioners? (Roslyn Carmel Giglia and Tracy Reibel) • The Enhanced Maternal and Child Health nursing program in Victoria: a cross-sectional study of clinical practice (Catina Adams, Leesa Hooker and Angela Taft)
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Healthcare Papers

Volume 18, Number 1, 2019

URL	https://www.longwoods.com/publications/healthcarepapers/25865/1/vol.-18-no.-1-2018-reflecting-on-choosing-wisely-canada-at-five-years
Notes	<p>A new issue of <i>Healthcare Papers</i> has been published with the theme 'Reflecting on Choosing Wisely Canada at Five Year'. Articles in this issue of <i>Healthcare Papers</i> include:</p> <ul style="list-style-type: none"> • Introduction: Choosing Wisely Canada Now in the Big Leagues (R Bell) • Invited Essay: Reflecting on Choosing Wisely Canada at Five Years: Accomplishments, Challenges and Opportunities for Reducing Overuse and Improving Quality (Karen Born, Tai Huynh and Wendy Levinson) • Commentary: Choosing Wisely in the Northwest Territories: A Case for Thinking Beyond the Test in Rural and Remote Northern Communities (Pooja Chugh and Suraiya Naidoo) • Commentary: Choosing Wisely in the Context of Corporate Influence (Quinn Grundy) • Commentary: Choosing Wisely Canada Needs to Start Helping Doctors to Understand How Commercial Influences Affect Their Prescribing (Joel Lexchin) • Commentary: Choosing Wisely: An Important Step in the Right Direction to Addressing Overuse of Health Services (Moriah E Ellen and M G Wilson) • Commentary: De-implementation of Low-Value Care: Audit and Feedback Wisely (Noah M. Ivers and Laura Desveaux)

	<ul style="list-style-type: none"> • Commentary: Choosing Wisely Canada Must Do More Than Recommend Wise Choices (Alan J Forster and Ashley Ryer) • Commentary: Choosing Digital Technologies Wisely: Six Dimensions to DECIDE (Kendall Ho) • The Authors Respond: Overuse in Canada: A Complex Problem in a Complex Healthcare System (Karen Born, Wendy Levinson and Tai Huynh)
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Health Affairs

Volume 38, Number 7 (July 2019)

URL	https://www.healthaffairs.org/toc/hlthaff/38/7
Notes	<p>A new issue of <i>Health Affairs</i> has been published with the themes ‘Physicians, Nurses, Disparities, And More’. Articles in this issue of <i>Health Affairs</i> include:</p> <ul style="list-style-type: none"> • To Improve Outcomes, Health Systems Invest In Affordable Housing (David Tuller) • Physicians’ Well-Being Linked To In-Basket Messages Generated By Algorithms In Electronic Health Records (Ming Tai-Seale, Ellis C Dillon, Yan Yang, Robert Nordgren, Ruth L Steinberg, Teresa Nauenberg, Tim C Lee, Amy Meehan, Jinnan Li, Albert Solomon Chan, and Dominick L Frosch) • Accuracy Of The Relative Value Scale Update Committee’s Time Estimates And Physician Fee Schedule For Joint Replacement (John W Urwin, Emily Gudbranson, Danielle Graham, Dawei Xie, Eric Hume, and E J Emanuel) • In Hospitals With More Nurses Who Have Baccalaureate Degrees, Better Outcomes For Patients After Cardiac Arrest (Jordan M Harrison, Linda H Aiken, Douglas M Sloane, J Margo Brooks Carthon, Raina M Merchant, Robert A Berg, and Matthew D McHugh) • Daily Nursing Home Staffing Levels Highly Variable, Often Below CMS Expectations (Fangli Geng, David G Stevenson, and David C Grabowski) • The Role Of Social Risk Factors In Dialysis Facility Ratings And Penalties Under A Medicare Quality Incentive Program (Andrew C Qi, Anne M Butler, and Karen E Joynt Maddox) • A National Examination Of Long-Term Care Setting, Outcomes, And Disparities Among Elderly Dual Eligibles (Rebecca J Gorges, Prachi Sanghavi, and R Tamara Konetzka) • Racial And Ethnic Disparities In Care Following The New York State Sepsis Initiative (Keith Corl, Mitchell Levy, Gary Phillips, Kathleen Terry, Marcus Friedrich, and Amal N Trivedi) • Fewer Bonuses, More Penalties At Skilled Nursing Facilities Serving Vulnerable Populations (Jennifer Gaudet Hefe, Xiao “Joyce” Wang, and Emily Lim) • Growth Of Public Coverage Among Working Families In The Private Sector (Douglas Strane, Genevieve P Kanter, Meredith Matone, Ahaviah Glaser, and David M Rubin) • Blue-Collar Workers Had Greatest Insurance Gains After ACA Implementation (Sumit D Agarwal, Anna L Goldman, and B D Sommers) • Low-Income Childless Adults’ Access To Antidiabetic Drugs In Wisconsin Medicaid After Coverage Expansion (Nam Hyo Kim, Kevin A Look, and Marguerite E Burns) • Association Of State Policies With Medicaid Disenrollment Among Low-Income Medicare Beneficiaries (Eric T Roberts, Jacqueline Hayley Welsh, Julie M Donohue, and Lindsay M Sabik)

	<ul style="list-style-type: none"> • Twenty Years Of Antiretroviral Therapy For People Living With HIV: Global Costs, Health Achievements, Economic Benefits (Steven S Forsythe, William McGreevey, Alan Whiteside, Maunank Shah, Joshua Cohen, Robert Hecht, Lori A Bollinger, and Anthony Kinghorn) • Epidemiological And Health Systems Implications Of Evolving HIV And Hypertension In South Africa And Kenya (Brianna Osetinsky, Jan A C Hontelez, Mark N Lurie, Stephen T McGarvey, Gerald S Bloomfield, Sonak D Pastakia, Richard Wamai, Till Bärnighausen, Sake J de Vlas, and O Galárraga) • The Impact Of Price Regulation On The Availability Of New Drugs In Germany (Ariel D Stern, Felicitas Pietrulla, Annika Herr, Aaron S Kesselheim, and Ameet Sarpatwari) • Sending The Wrong Price Signal: Why Do Some Brand-Name Drugs Cost Medicare Beneficiaries Less Than Generics? (Stacie B Dusetzina, Shelley Jazowski, Ashley Cole, and Joehl Nguyen) • Air Ambulances With Sky-High Charges (Ge Bai, Arjun Chanmugam, Valerie Y. Suslow, and Gerard F Anderson) • ACO Contracts With Downside Financial Risk Growing, But Still In The Minority (Kristen A Peck, Benjamin Usadi, Alexander J Mainor, Elliott S Fisher, and Carrie H. Colla) • Impact Of Medicare Readmissions Penalties On Targeted Surgical Conditions (Karan R Chhabra, Andrew M Ibrahim, Jyothi R Thumma, Andrew M Ryan, and Justin B Dimick) • Nonopioid Overdose Death Rates Rose Almost As Fast As Those Involving Opioids, 1999–2016 (Christopher J Ruhm) • Dying To Access Methadone (Jessica L Gregg)
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BMJ Quality and Safety online first articles

URL	https://qualitysafety.bmj.com/content/early/recent
Notes	<p><i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • Managing risk in hazardous conditions: improvisation is not enough (Rene Amalberti, Charles Vincent)

International Journal for Quality in Health Care online first articles

URL	https://academic.oup.com/intqhc/advance-articles
Notes	<p><i>International Journal for Quality in Health Care</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • Quality health care in extreme adversity—an action framework (Sheila Leatherman; Linda Tawfik; Dilshad Jaff; Grace Jaworski; Matthew Neilson; Shamsuzzoha Babar Syed; Mondher Letaief) • Economic evaluation of guideline implementation in primary care: a systematic review (Eva Kovacs; Xiaoting Wang; Ralf Strobl; Eva Grill)

Online resources

[UK] NICE Guidelines and Quality Standards

<https://www.nice.org.uk/guidance>

The UK's National Institute for Health and Care Excellence (NICE) has published new (or updated) guidelines and quality standards. The latest reviews or updates are:

- Quality Standard QS185 *Hearing loss in adults* <https://www.nice.org.uk/guidance/qs185>
- Quality Standard QS186 *Lyme disease* <https://www.nice.org.uk/guidance/qs186>

[USA] Patient Safety Primers

<https://psnet.ahrq.gov/primers/>

The Patient Safety Primers from the (US) Agency for Healthcare Research and Quality (AHRQ) discuss key concepts in patient safety. Each primer defines a topic, offers background information on its epidemiology and context, and provides links to relevant materials.

- **Maternal safety** Pregnancy, childbirth, and the postpartum year present a complex set of patient safety challenges. This primer reviews trends in US maternal morbidity and mortality and offers recommendations and resources for improving maternal safety and addressing contributing factors at policy, system, facility, and clinician levels.
<https://psnet.ahrq.gov/primers/primer/50/Maternal-Safety>

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