In This Issue of JAMA

February 9, 2016
Volume 315, Number 6
Pages 529-626

Research

Interventions to Reduce Inappropriate Antibiotic Prescribing 562

Meeker and colleagues report results of a 47-site cluster randomized trial examining 3 behavioral interventions to reduce inappropriate antibiotic prescribing for acute respiratory tract infections. The interventions were electronic order sets suggesting nonantibiotic treatments; accountable justification, prompting clinicians to provide justification for prescribing antibiotics in patients' health records; and emailed peer comparisons of antibiotic prescribing rates. The authors found that use of accountable justification and peer comparison resulted in lower rates of inappropriate antibiotic prescribing. In an Editorial, Gerber discusses strategies to improve antimicrobial stewardship in the outpatient setting.

Editorial 558
Continuing Medical Education jamanetworkcme.com

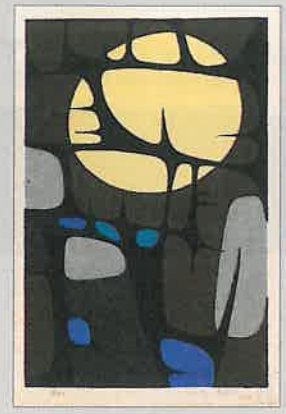
Task-Oriented Upper Extremity Rehabilitation After Stroke 571

In a multicenter randomized trial involving 361 individuals with moderate upper extremity motor impairment after stroke, Winstein and colleagues compared the efficacy of a 30-session structured and task-oriented outpatient rehabilitation program with either an equivalent dose or a lower and unspecified dose of unstructured upper extremity occupational therapy—both based on usual and customary practice. The authors report that the task-oriented rehabilitation program did not significantly improve motor function or recovery beyond that achieved with usual and customary upper extremity rehabilitation.

Mortality and Readmission Rates in VA vs Non-VA Hospitals 582

To assess the comparative performance of Veterans Affairs (VA) and non-VA hospitals, Nuti and colleagues analyzed cross-sectional data from male Medicare beneficiaries aged 65 years and older who were hospitalized for acute myocardial infarction (AMI), heart failure (HF), or pneumonia at 104 VA hospitals and 1513 non-VA hospitals between 2010 and 2013. The authors report that hospitalization at VA hospitals for AMI and HF was associated with lower risk-standardized 30-day all-cause mortality rates and higher risk-standardized all-cause readmission rates for all 3 conditions—both nationally and within similar geographic areas. In an Editorial, Jha discusses achievements and challenges in the VA health care system.

Editorial 560



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Editor in Chief
Howard Bauchner, MD

132 YEARS
OF CONTINUOUS
PUBLICATION

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Clinical Review & Education

Antibiotic Therapy, Mortality in Community-Acquired Pneumonia 593

Community-acquired pneumonia accounts for approximately 600 000 hospital admissions in the United States each year. Initial empirical antibiotic therapy often covers both typical and atypical bacterial pathogens; however, questions remain regarding antibiotic selection and timing and conversion from intravenous to oral antibiotic administration. Lee and colleagues addressed these questions in a systematic review and analysis of data from 17 observational studies and 3 randomized trials of hospital treatment of community-acquired pneumonia. Among the authors' findings—predominantly derived from observational studies of low quality—was that antibiotic therapy initiated within 4 to 8 hours of hospital arrival and consisting of β-lactam-macrolide combination therapy or fluoroquinolone monotherapy was associated with lower short-term mortality.

Author Audio Interview jama.com Continuing Medical Education jamanetworkcme.com

Working While Sick: Changing the Culture 603

Working while sick is not uncommon among physicians. An article in *JAMA Pediatrics* reported results of a survey of physicians and advanced practice clinicians, which found that—despite recognizing their behavior put patients at risk—83% worked while sick at least once in the prior year. In this From The JAMA Network article, Tanksley and colleagues discuss reasons clinicians work while sick and suggest changes in the professional culture and in organizational policies to ensure physicians are healthy when engaged in direct patient care.

HbA_{1c} in the Evaluation of Diabetes Mellitus 605

This JAMA Diagnostic Test Interpretation article by O'Keeffe and colleagues presents a 76-year-old man who requests help to manage his type 2 diabetes. The patient was diagnosed 18 months ago, when a fasting blood glucose level was 200 mg/dL. Treatment with metformin was initiated but discontinued after 1 year when his HbA_{1c} was 6.4%. Comorbid diagnoses include hereditary spherocytosis. The patient reports polyuria and polydipsia. Home glucometer recordings are consistently greater than 350 mg/dL. How would you interpret the laboratory results?

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Editor's Audio Summary
Howard Bauchner, MD, summarizes and comments on this week's issue.

The JAMA Forum
Insightful commentary on the political aspects of health care from leading health economists, health policy experts, and legal scholars

Author Interview
AUDIO Interview with Michael J. Fine, MD, MSc, author of "Antibiotic Therapy for Adults Hospitalized With Community-Acquired Pneumonia: A Systematic Review"

Instructions for Authors
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