

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

8th Annual NPSF Patient Safety Congress Draws 1,400

BY LARRY STEPNIK, SEVERYN GROUP, INC., AND ALLISON FISSEL, MA, NPSF

IN THIS ISSUE

8th Annual NPSF Patient Safety Congress Draws 1,400

Lessons Learned at the Edge of Culture Change

Using a Patient-Partnership Model to Improve Medication Safety

NPSF Presents 4 New Awards at San Francisco Patient Safety Congress

More than 1,400 patient safety participants from around the world gathered at the San Francisco Marriott on May 10-12, 2006 for the NPSF's 8th Annual Patient Safety Congress. The Congress included 68 sessions led by 138 national and international patient safety experts, healthcare providers, researchers, and patient and family representatives.

A pre-conference Leadership Day, plenary sessions, and workshops highlighted policies and programs that have resulted in cultural change and sustained improvement. The Congress, entitled "Leadership for Safety: The Time Is NOW," emphasized NPSF's sense of urgency and commitment to:

- Developing leadership skills among senior executives and middle managers to promote patient safety;
- Creating a culture that focuses on creating a remarkable, safe experience for staff, patients, and family members;
- Fostering a culture that values transparency, disclosure, and apology for errors; and
- Helping nurse leaders and front-line nurses become more active in promoting patient safety in their organizations.

In conjunction with the NPSF Congress, The Pan American Health Organization/World Health Organization (PAHO/WHO) held its first workshop on Patients for Patient Safety. This program is one of 6 of the World Alliance for Patient Safety, established by WHO in 2004 to advance patient safety practices and policies around the world.

Leadership Day focuses on the importance of frameworks

The pre-Congress Leadership Day was broadened this year to incorporate the findings from a series of regional meetings sponsored by NPSF and AIG which focused on the leadership challenges in the middle of organizations. The data presented showed a significant gap between executive and mid-level managers' perceptions of patient safety and informed the discussions that took place throughout the day.

NPSF found that senior executives are consistently much more optimistic than middle managers about the degree to which patient safety has become a priority in their

organization. This work led to augmenting the Leadership Day by offering an executive track as well as a management track, thus providing for a better understanding of the leadership challenges throughout organizations. The Leadership Day sessions uncovered roadblocks to advancing patient safety, with middle managers and executives offering recommendations to overcome these barriers.

"The Congress included 68 sessions led by 138 national and international patient safety experts, healthcare providers, researchers, and patient and family representatives."

Discussions focus on leverage points for leaders

The Harvard Business School case study approach was used to provide practical advice on achieving safety improvements through levers. The Leadership Day was hosted by David M. Lawrence, MD, retired chairman and CEO of Kaiser Foundation Health Plan and Hospitals and an NPSF Distinguished Advisor.

James B. Conway, MAM, CHE, senior fellow at the Institute for Healthcare Improvement (IHI), senior consultant to the Dana-Farber Cancer Institute, and NPSF Distinguished Advisor, set the stage by reviewing what patients and families expect from the healthcare system 100% of the time.

Richard Bohmer, MD, associate professor at the Harvard Business School, led a discussion of a case study from Seattle's Virginia Mason Medical Center (VMMC), which has been successful in transforming itself from a money-losing

CONTINUED ON PAGE 2

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institution plagued by low staff morale into an organization that consistently provides high-quality, efficient, and safe care that meets the expectations of patients and family members.

Gary S. Kaplan, MD, FACMPE, chairman and CEO of VMMC, and Sarah Patterson, MHA, FACMPE, VMMC's executive vice president and hospital administrator, joined Dr. Bohmer in presenting and discussing the case.

“The emotional wounds of both patients and caregivers need to be treated, and the best treatment for both parties is honesty, openness, and apology if an error has occurred.”

—Lucian L. Leape, MD

The Leadership Day included presentations on 4 key levers that healthcare organization leaders can use in their efforts to improve the safety of care:

1. Patients and families;
2. Physicians;
3. The board of directors; and
4. The Malcolm Baldrige framework.

Patricia Sodomka, FACHE, senior vice president of patient- and family-centered care at the MCG Health System of the Medical College of Georgia, led a discussion on engaging patients and families. Jack Silversin, DMD, DrPH, president of Amicus, an organization devoted to physician culture and change in physician organizations, spoke about involving physicians.

William F. Jessee, MD, FACMPE, vice chair of the board of directors at Exempla Healthcare in Denver, president and CEO of the Medical Group Management Association, and an NPSF board member, discussed engaging the board of directors. Randall L. Linton, MD, president and CEO of Luther Midelfort, a 4-hospital, 1-clinic system of Mayo Health System, addressed using the Baldrige Framework to promote safety.

Creating a remarkable experience for customers

Ann Rhoades, president of People Ink, former executive vice president of people for JetBlue Airways and former vice

president of the people department at Southwest Airlines, concluded the Leadership Day and served as the keynote speaker at the opening plenary of the Patient Safety Congress. Rhoades shared her expertise—garnered mostly from the travel industry—about how to meet or exceed expectations by Creating A Remarkable Experience (CARE) for customers on a consistent basis. She reviewed 5 elements that Southwest, JetBlue, and other high-performing organizations have found critical to their success:

1. Living and breathing a set of values;
2. Hiring “A” players who mirror those values;
3. Continually exceeding your people's expectations;
4. Being excessive about your customers/patients; and
5. Creating a disciplined culture of excellence.

Doctors and patients discuss disclosure and apology

This plenary session included stories from physicians and patients about disclosure and apology after a medical error. Georges Peter, MD, professor of pediatrics emeritus at Brown Medical School, shared his story as a patient who was the victim of a serious burn caused by a heating pad.

Jo Shapiro, MD, chief of otolaryngology, head and neck surgery at Brigham and Women's Hospital in Boston, discussed the issue of disclosure and apology from the physician's perspective. Two personal experiences with medical errors have given Dr. Shapiro insights into why physicians often find it difficult to admit and take responsibility for mistakes, and to apologize to patients.

Lucian Leape, MD, adjunct professor of health policy at the Harvard School of Public Health and NPSF Distinguished Advisor, built on the patient and physician perspective by making the case for disclosure and apology. “The emotional wounds of both patients and caregivers need to be treated,” said Leape, “and the best treatment for both parties is honesty, openness, and apology if an error has occurred.”

NPSF Distinguished Advisors lead 3rd town hall meeting

NPSF's Distinguished Advisors—a group of national experts and leaders in patient safety—engaged in a discussion with Congress attendees. Panelists included: Carolyn Clancy, MD, director of the Agency for Healthcare Research and Quality; James B. Conway, MAM, CHE; David M. Lawrence, MD, Lucian Leape, MD, and Julie Morath, RN, MS, chief operating officer for Children's Hospitals and Clinics of Minnesota. The discussion was moderated by Margaret O'Kane, MHA, president of the National Committee for Quality Assurance.

Lessons Learned at the Edge of Culture Change

BY HANK GRINVALSKY, MD, AND COLLEAGUES, CINCINNATI VETERANS AFFAIRS MEDICAL CENTER

All of us in health care are participants in a hierarchical culture that has historically relied on the competence, skill, and judgment of the individual practitioner to manage quality and safety. That culture has served the medical field well—and is responsible for remarkable achievements. However, treating patients in a modern acute-care hospital setting safely, effectively, and efficiently involves a very complex set of processes requiring the simultaneous, coordinated contributions of many disciplines.

The traditional relationships and patterns of communication, and the command/control architecture they imply (data up, orders down), do not support the improved quality of care that healthcare professionals sincerely want to provide. But changing the established culture is proving especially challenging.

Using teamwork to change culture

In early 2002, the staff at the Cincinnati VA Medical Center was trying to understand and learn from their latest failure

in communication, decision-making, and teamwork. Their search for answers sparked an interest in the practices of high-reliability organizations that, despite “celebrated” failures, had learned to reduce the risk of these failures through team concepts and behaviors:

- Structured communication and feedback;
- Identification, open discussion, and reduction of error;
- An extended concept of team;
- Leadership and facilitation;
- Trust and conflict resolution;
- Rehearsal; and
- Monitoring.

These team concepts and skills are not part of traditional healthcare education or training. Teaching these concepts to healthcare staff is one thing; once the skills are taught, creating a work environment in which they are successfully applied is an altogether different and formidable challenge.

CONTINUED ON PAGE 4

Neurologist Hank Grinvalsky, MD, is a founding member of Aviso, an organizational development consulting firm. He served as chief of staff at the Cincinnati VA Medical Center from 1990 until his retirement in 2002, and taught at the University of Cincinnati College of Medicine for 22 years. Contact him at: henry.grinvalsky@med.va.gov.

See page 5 for a full listing of the Cincinnati VA Medical Center's pilot program team led by Dr. Grinvalsky.

NPSF Patient Safety Congress Draws 1,400

CONTINUED FROM PAGE 2

Nurses focus on their role in patient safety

The closing plenary session, titled “Our Time, Our Watch, Our Work: Nurse Leaders in Action,” featured nurse leaders discussing their role and that of the nursing profession in promoting patient safety.

Panelists included: Kathleen Bartholomew, RN, RC, MN, clinical nurse manager for orthopedics at Swedish Medical Center in Seattle; Caryl Lee, MSN, nurse director of the Patient Safety Learning Center in Ann Arbor, Mich; Nellie Robinson, RN, MS, vice president and chief nursing officer at Children's National Medical Center in Washington, DC;

and Karlene Kerfoot, PhD, RN, CNAA, FAAN, a principal with Kerfoot & Associates in Indianapolis.

The nurse leaders held a broad discussion of their views and recommendations for promoting patient safety. Their focus: recognizing the unique position and opportunities nurses and nurse leaders have in influencing cultural change throughout their organizations.

Full Congress proceedings will be made available in the next *Journal of Patient Safety* and at www.npsf.org. **NPSF**

Lessons Learned at the Edge of Culture Change

CONTINUED FROM PAGE 3

How does a healthcare organization change a “successful,” well-defended, hierarchical professional and organizational culture to not only permit, but require, teamwork?

Concord Collaborative Care Model leads the way

In fall 2002, the groundbreaking accomplishments of a team at Concord Hospital in New Hampshire were recognized with the John M. Eisenberg Patient Safety Award for System Innovation.¹ Paul Uhlig, MD, and Jeff Brown led that extraordinary group to develop the Concord Collaborative Care Model (CCCM), an elegantly simple application of human-factors science and high-reliability organization theory to the bedside care of cardiac surgery patients.

“How does a healthcare organization change a ‘successful,’ well-defended, hierarchical professional and organizational culture to not only permit, but require, teamwork?”

CCCM’s collaborative approach brings a high-functioning team and structured communication to the patient bedside.²

- All disciplines are present and collaboratively develop a 24-hour care plan.
- Patients and their families are active participants and team members.
- All information is directed to the patient.
- Ordinary language is used (or immediate translation occurs).
- Error is openly and honestly discussed and addressed.

This non-traditional approach provides a vital context that expects and encourages team behaviors and skills.

Cincinnati develops CCCM-based pilot program

With assistance from experts in organizational development and adult learning, staff at Cincinnati developed a pilot that:

- Appropriated CCCM and adapted it for use at Cincinnati, a complex teaching environment;
- Formed an interdisciplinary design team and targeted a “manageable” specialty service—general surgery—with strongly supportive clinical leadership;
- Identified key skills and concepts, focusing on assertive statements and active listening;
- Developed and presented a worksite “curriculum” to front-line and supervisory staff on every shift, in 5 participative 10-20 minute segments, with follow-up shadowing and feedback; and
- Developed supporting pocket-reference tools.

Collaborative rounds in general surgery began in February 2005. Despite careful preparation and staggering advantages, physician participation waned during an unexpected transition in local surgery service leadership. The commitment and enthusiasm of non-physician team members remains high, but regrettably, Cincinnati is now considering options that require less physician involvement.

What lessons were learned?

The list on the next page offers 16 lessons learned through attempts to change the established culture. These lessons, which both amuse and encourage, tell the tale of fragile gains. **NPSF**

References

- 1 Uhlig PN, Brown J, Nason AK, Camelio A, Kendall E. John M. Eisenberg Patient Safety Awards. System innovation: Concord Hospital. *Jt Comm J Qual Improv.* 2002;28:666-672.
- 2 Uhlig PN, et al. Reconfiguring clinical teamwork for safety and effectiveness. *Focus on Patient Safety.* 2002;5(3):1-2.

For further reading

Helmreich RL and Merritt AC: *Culture at Work in Aviation and Medicine—National, Organizational and Professional Influences*, Ashgate Publishing Limited, England, 1998.

Cultural Change: 16 Lessons Learned

1. Ownership is important. Find a way to let it be *their* idea or *their* project. (It can't be my idea or my project.)
2. Aggressively recruit support for the project. Be willing to talk to anyone, anywhere, under any circumstances.
3. Recruit your champions carefully. When appeals to reason and emotion fail, you may need someone with the power to unambiguously dictate "Make it so" or "Just do it!"
4. Be inclusive from the start. Don't forget Respiratory Therapy.
5. Respect an individual's time as a scarce resource. It is often the currency of the realm.
6. Start with a few basic principles and remain true to them—then trust the group process. None of us is as good as all of us.
7. Practice what you preach. Presentations and meetings of the design team should model the skills and behaviors you are trying to promote.
8. Teaching a concept or skill is often futile unless there is an opportunity—and the expectation—to immediately apply it.
9. Constantly solicit feedback from every imaginable source. Respond to it quickly and visibly; be grateful for the help.
10. Constantly provide feedback—privately when it is sensitive (with empathy, encouragement, and support), publicly when it is good.
11. Practice, practice, practice. Work out the bugs, become effective and efficient before you "go live."
12. Be very flexible. Be prepared to make changes—lots of changes—"on the fly."
13. When pushed, the dominant culture pushes back. Even when prepared to "outwit, outplay, outlast," you may lose.
14. Every organization's culture is different. What works for one, works for one.
15. Always carry a spare.
16. Decide what you are willing to settle for—a "best alternative to full implementation" or BATFI—and create it as you go:
 - Create an awareness of new possibilities to replace traditional approaches and results.
 - Influence discussions and decisions about models of care.
 - Distribute new tools.
 - Develop specific skills (assertive statements, active listening) and concepts (collaboration, structured communication, high-performance teamwork, crew resource management) with broad applicability, among front-line staff.
 - Develop a permanent clinical pharmacy presence on daily surgical rounds.
 - Change the relationships and conversations between surgeons and the interdisciplinary front-line staff in ways that invite knowledge, communication, and a different type of participation in patient care processes.
 - Encourage the patient's active participation in care processes as well as error identification and reduction.
 - Promptly apologize for mistakes.
 - Move the organization closer to a culture of safety.

The Cincinnati VA Medical Center's pilot program team included: Mark Adams, psychology intern; John Bendele, nurse anesthetist; Jennifer Blanchard, clinical pharmacist; Robert Bower, surgeon-leader; Raymond Cook, chaplain; Helene Dreibelbis, social worker; Sue Dyrenforth, clinical psychologist; Amanda Eisenlohr, project leader; James Hall, psychologist; Stephen Hanson, clinical pharmacist; Alice Holder, physical therapist; Belinda Huff, respiratory therapist; Amy Katz, social psychologist; Monica Kong, clinical dietitian; Kasaundra Kruer, psychologist; Molly Lyons, patient safety coordinator; Mark Molloy, surgeon; Terri Ohlinger, nurse; Jody Orther, nurse manager; Marta Render, physician-leader; Kathleen Sandlin, nurse manager; John Scheper, social worker; Elizabeth Smith, nurse; Jeffrey Sussman, surgeon; Christopher Ward, psychologist; Jackie Westerfield, risk manager; Nance Widdowson, nurse manager; Arthur Williams, surgeon; and Scott Wuest, nurse manager.

Using a Patient-Partnership Model To Improve Medication Safety

BY KATHY LEONHARDT, MD, MPH, PATIENT SAFETY OFFICER, AURORA HEALTH CARE, MILWAUKEE

Kathy Leonhardt, MD, MPH, is the patient safety officer at Aurora Health Care in Milwaukee, a Stand Up for Patient Safety Hospital. Contact Leonhardt at kathryn.leonhardt@aurora.org.

Kathy Leonhardt, MD, MPH, patient safety officer at Aurora Health Care in Milwaukee, participated as a Fellow in the 2005–2006 Patient Safety Leadership Fellowship (PSLF) offered by NPSF, Health Forum, and the Health Research and Educational Trust. Leonhardt has since used the learnings from the Fellowship to implement a patient-partnership model to improve outpatient safety.

Involving patients and families as partners with their health-care providers has been promoted by the patient safety movement and endorsed by many healthcare entities and by patients themselves. Research shows that patient-centered care can enhance care outcomes, patient adherence to treatment recommendations, chronic disease outcomes, and patient satisfaction.¹⁻³

“[R]esearch has shown that adverse drug events may occur at a rate of 27 per 100 [out]patients—4 times as high as the rate reported in inpatient studies.”

A culture of safety—and an environment that endorses partnering with patients—are new concepts for healthcare providers, requiring a change in organizational culture.⁴⁻⁵ Little research has been conducted in the outpatient setting on using patient-provider partnership councils to foster patient-centered principles, or how this concept might relate to patient safety.⁶

Needed: Programs to reduce outpatient medication errors

The medication process has been recognized as an element of health care with significant safety risks.⁴ Yet much of the research on medication safety has been conducted in the inpatient setting. The limited outpatient medication safety research has shown that adverse drug events may occur at a rate of 27 per 100 patients—4 times as high as the rate reported in inpatient studies.⁷ Medication errors can be attributed to the differences between what patients do and what physicians expect them to do.²

Patients' non-adherence to their prescribed medications is correlated with increased risk of hospitalization, poor outcomes, and death.⁸ Older Americans taking multiple prescription drugs from more than one provider are particularly susceptible to medication errors. Various strategies to improve adherence have been identified. However, no reported interventions have been generated from the consumer perspective and implemented in a partnership model that includes patients, clinicians, and retail pharmacies.

Developing a patient-partnership model to improve outpatient safety

As a PSLF Fellow, Leonhardt adapted evidence-based strategies from the patient-centered care literature to create a Patient Safety Council enabling patients and providers to collaborate on strategies to improve medication safety. Aurora Health Care, a large integrated healthcare system based in Milwaukee, serves 1 million patients each year throughout eastern Wisconsin via its 14 hospitals, 120 clinics, 136 community pharmacies, and other facilities. Walworth County was selected as the site of the project due to Aurora's strong community presence through its 5 health care clinics and Aurora retail pharmacies.

Two project partners provided additional expertise: Consumers Advancing Patient Safety (CAPS), a national consumer-led organization experienced in developing safety advisory boards, and Midwest Airlines, which offered airline industry expertise on organizational culture of safety and consumer service.

The Walworth County Patient Safety Council was established in November 2005 with the support of a 2-year grant from the Agency for Healthcare Research and Quality. This council, consisting of 11 patients and 12 healthcare providers—all residents of Walworth County—brings patients and providers together to develop strategies for improving medication safety in their community. Their work targets adults age 55 and older. During their monthly meetings, patients, nurses, physicians, and pharmacists work together to identify strategies to improve medication safety.

Council focuses on communication

The council zeroed in on communication as a critical barrier between patients and their providers regarding medication use. This translated to a need for effective strategies to empower patients to become active partners in their

care and facilitate communication between patients and providers.

The council created 2 interventions to improve medication safety: a bag for carrying medications to healthcare appointments, and a personal medication list for the patient to complete. Council members selected prototype examples of medication bags and lists and had them evaluated by more than 300 community members through presentations at community clubs, informal social gatherings, professional meetings, and home visits.

In the next few months, thousands of medication bags and personal medication lists will be prepared and distributed throughout Walworth County as part of the campaign to improve medication safety. This grassroots public health approach will provide education and tools for effective communication about medications throughout the community.

Involving healthcare providers

The council is also considering medication safety strategies directed at healthcare providers. Clinic chart forms, electronic medical record systems, and retail pharmacy computer programs are being evaluated for their role in assuring accurate medication documentation. An Internet-based personal health record, which would allow patients to access their own pharmacy-based medication history, is being developed to facilitate the exchange of medication information between patient and pharmacy. Clinic staff members are receiving education and training on communication, patient partnering, and medication safety.

The project's impact is being evaluated by:

- Measuring the medication-list accuracy in clinic-based patient medical records (comparing the patient's medications to those recorded in the clinic chart); and
- Gauging the satisfaction and engagement of patients, providers, and council members through a variety of survey indicators identifying community penetration.

Medication toolkits target seniors

The new medication bags, lists, and selected strategies for effective communication will be packaged into toolkits to improve medication safety for individuals 55 years and older. These kits will be disseminated in Walworth County as well as the other Aurora Health Care clinics throughout

Wisconsin. In collaboration with AHRQ, the toolkits may also be disseminated nationally. A second toolkit will present methods for implementing a community-based Patient Safety Council.

Working together to advance patient safety

This project has already demonstrated the power of bringing patients, providers, and their community together to address patient safety. Universal familiarity with the problem of safely managing medications for older individuals generates enthusiasm from patients and providers alike. The power of sharing these stories with patients and providers at one table, and recognizing that no one person has the answer, invigorates the group to find innovative solutions.

The experience of partnering with patients on this project has transformed the approach used in other Aurora projects: patients are being asked to participate in a variety of programs. Changing behaviors and practices—of patients and providers—is not a simple task. The Walworth County Patient Safety Council is an innovative approach to partnering with patients and the community to improve medication safety.

PSLF provides project guidance

The Patient Safety Leadership Fellowship provided support and guidance for this project's implementation. The Fellowship includes education and training on a variety of models including complexity science, appreciative inquiry, and systems thinking. Leadership training, teamwork, and communication are studied, discussed and practiced throughout the Fellowship. Specifically, the role of the patient as an active partner on the healthcare team is evaluated from multiple perspectives. The Walworth County Patient Safety Council's innovative approach is based on the premise that the patient must be an integral part of the team, contributing as an equal partner in the development of safety programs.

PSLF's nationally recognized patient safety experts—faculty, guest lecturers, and Fellows—provided practical advice learned from dealing with similar issues at their own organizations and helped translate the intellectual learnings from the Fellowship into real-life applications. **NPSF**

References

- 1 Greenfield S, Kaplan S, Ware JE Jr. Expanding patient involvement in care: effects on patient outcomes. *Ann Intern Med.* 1985;102:520-528.
- 2 Hammons T, Piland NF, Small SD, Hatlie MJ, Burstn H. Ambulatory patient safety: what we know and need to know. *J Ambulatory Care Manage.* 2003;26:63-82.
- 3 Holman H, Lorig K. Patients as partners in managing chronic disease. *Partnership is a prerequisite for effective and efficient health care.* *BMJ.* 2000;320:526-527.
- 4 Kohn LT, Corrigan JM, Donaldson MS, eds. To Err is Human: Building a Safer Health System. Washington, DC: Committee on Quality of Health Care in America, Institute of Medicine. National Academy Press; 2000. Available at: <http://books.nap.edu/catalog/9728.html>. Accessed on: January 3, 2005.
- 5 Crossing the Quality Chasm: A New Health System for the 21st Century. Institute of Medicine, Committee on Quality of Health Care in America. Washington, DC: National Academy Press, 2001. Available at: <http://books.nap.edu/catalog/10027.html>. Accessed on: January 3, 2005.
- 6 Gurwitz JH, Field TS, Harrold LR, et al. Incidence and preventability of adverse drug events among older persons in the ambulatory setting. *JAMA.* 2003;289:1107-1116.
- 7 Gandhi TK, Weingart SN, Borus J, et al. Adverse drug events in ambulatory care. *N Engl J Med.* 2003;348:1556-64.
- 8 National Quality Forum. Improving Use of Prescription Medications: A National Action Plan. Workshop Proceedings. Washington, DC. 2005.

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NPSF Presents 4 New Awards at San Francisco Patient Safety Congress

NPSF congratulates the winners of 4 new awards presented
at the 8th Annual NPSF Patient Safety Congress, May 10-12, in
San Francisco.

The Socius Award was presented to Linda Kenney, founder
and president of Medically Induced Trauma Support Services
(MITSS). This award, whose name is derived from the Latin
word for partner, is presented to an individual or organiza-
tion for work that exhibits positive and effective partner-
ship between patients, families, and providers in pursuit of
improved patient safety.

The Chairman's Medal was presented to Doug Bonacum,
MBA, and Suzanne Graham, RN, PhD, of Kaiser Permanente.
This award recognizes and encourages emerging leadership
in patient safety. The Chairman's Medal honors an organiza-
tion or individual whose demonstrated leadership has resulted
in measurable positive change and improvements in patient
safety while creating a culture that supports respect, trans-
parency, learning, and cooperation.

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The Stand Up for Patient Safety Management Award was
presented to North Shore Long Island Jewish Health System
for its initiative, "Managers Target Hospital-Associated
Infection by Standardizing Practices." This NPSF award is
sponsored by the AIG Healthcare Division of Lexington
Insurance Company, a member company of American
International Group, which partners with NPSF to bring the
Stand Up program to its insureds. The award is given to a
Stand Up for Patient Safety member organization that has
successfully implemented an outstanding patient safety
initiative led by or created by mid-level management.

The People's Choice Award for Solutions Poster was pre-
sented to University of Miami Medical Group for a poster on
its Physician-Patient Advocacy Program at the University of
Miami's Miller School of Medicine. The award winner was
chosen by Congress attendees from 55 posters that show-
cased successful solutions in patient safety. [NPSF](#)

