

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

The No-Outcome, No-Income Tsunami: Surviving “Pay 4 Performance”

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It is coming. Falling reimbursements, rising malpractice woes, cresting work force issues, and strained hospital-physician relations are hammering healthcare leaders in ever more powerful waves.

Just when it couldn’t get any worse, the biggest threat is looming just over the horizon. Quietly building offshore in a climate of stakeholder unrest is a tsunami that threatens all but the best prepared. The question is how to survive when the Pay-4-Performance tsunami strikes.

The current no-margin, no-mission era in health care is coming to an end. It is giving way to a new no-outcome, no-income era. Revenue will no longer be automatic; it will increasingly be linked to verifiable performance.

For years, hospital revenue has been a given. If hospitals had the patient volume, they were safe. Hospital administrators have been lulled into managing cost, and only cost. Now the threat to revenue is a clear and present danger.

Danger looms just over the horizon

Under a sea of complexity, long-ignored fault lines in the tectonic plate of health care have finally snapped into a major fracture with unprecedented force. The early shock waves under the water line were first felt by quality leaders, triggering a slow-motion chain reaction through Congress, then employers, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the media, consumers, and finally payers. With each, a layer is forming—a rapidly growing and ever-surging tidal wave.

Testimonies of quality leaders such as NPSF Distinguished Advisors Lucian Leape, MD, and Donald Berwick, MD, have revealed major safety problems in American health care. Such input led to a comprehensive evaluation of medical error and patient safety by the Institute of Medicine (IOM). The resulting report, *To Err Is Human: Building a Safer Health Care System*,¹ catalyzed tremendous national attention and accelerated the momentum.

Appalled with the preventable cost, loss of life, and suffering of their employees, US employers became activated and formed The Leapfrog Group. Leapfrog is composed of more than 150 Fortune 500 companies and other large private- and public-sector healthcare purchasers; together, they wield more than \$59 billion in annual purchasing power and represent more than 33 million covered lives.

“The current no-margin, no-mission era in health care is ... giving way to a new no-outcome, no-income era. Revenue will no longer be automatic; it will increasingly be linked to verifiable performance.”

JCAHO has embraced the patient safety movement through its new safety standards and has joined The Leapfrog Group as an implementation partner.

The Leapfrog Group has clearly caught the attention of hospitals and caregivers. In the words of Leapfrog Co-founder Arnie Milstein, MD, MPH, “Hospital CEOs have a tremendous opportunity. America’s Fortune 500 companies have given you a road map to market success. My message to you is that if you bet your job on high-yield performance improvement, the market will reward you.”²

Naysayers who argue that The Leapfrog Group has not moved market share need only look at current payer contract tiers. Leapfrog’s standards have been picked up by more than 70 programs across the US, even if they lack the Leapfrog logo.

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Surviving “Pay 4 Performance”

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This article was adapted from a video and forthcoming book by Dr. Denham.

On May 5, 2004 at the NPSF Patient Safety Congress, Dr. Denham will present a plenary session titled “Breaking News from the Pay-4-Performance Movement: Purchasers Provide a Road Map for Market Success.” His co-presenters will include: Arnie Milstein, MD, MPH, Medical Director, Pacific Business Group on Health, San Francisco, Calif; and Richard “Rick” Norling, President and CEO, Premier, Inc., San Diego, Calif.

The media are capturing more than a crisis of confidence in Wall Street. We are experiencing the same phenomenon in health care. It doesn't really matter whether the blame is placed on the “gotcha” press or on a few bad apples. The media seized the opportunity to leverage consumer fear into higher ratings by employing the golden rule of journalism: If it bleeds, it leads. Hold on to your hat, the worst is yet to come.

Consumer awareness is a sleeping giant that is just starting to awaken. Consumers are becoming increasingly informed, empowered, and are starting to vote with their feet.

The new Pay-4-Performance quality bonuses and penalties being implemented by payers signal the beginning of the end of blind healthcare purchasing. Private and federal payers are resetting the market thermostat of tomorrow.

Much has happened in the last 18 months. The Centers for Medicare and Medicaid Services (CMS) announced 10 voluntary quality measures “likely to be tied to future payment.”³ In May 2003, the 30 National Quality Forum (NQF) Safe Practices were jointly approved by CMS, JCAHO, and the American Hospital Association (AHA).⁴

In 2004, the NQF Safe Practices will be tied to Leapfrog hospital rankings. CMS has announced a Pay-4-Performance pilot program with a major hospital alliance.⁵ Finally, when President Bush signed the recent Medicare bill, the 10 voluntary measures became coupled with Medicare payment.⁶

Surviving the tsunami

How, then, do hospitals survive this no-outcome, no-income tsunami? They certainly can't work harder. They're just going to have to work smarter. Interestingly, those who have had the courage to take the bet on quality have been dramatically surprised.

The many hospitals involved in Institute for Healthcare Improvement's collaboratives, those pursuing Baldrige targets, and hospitals like Heartland Healthcare in St. Joseph, Mo, have hit a surprising and unforeseen “tipping point.” Quality and safety initiatives actually drive enterprise-wide system performance and the bottom line.

This is explained by the same “a-ha!” experienced in technology solution development. Clinical, operational, and financial performance are intrinsically linked and tightly coupled. Hospital silo and department activity-based accounting and budgeting perspectives defy the measurement of innovation's impact on system-wide performance.

How important is the business case for patient safety?

Debating the case for patient safety as an industry is as foolish as the restaurant industry debating the case for kitchen cleanliness or refrigeration. It is not about return on investment (ROI), it is about SIB—Stay in Business. Drilling down on the business case for specific initiatives, technologies, products, and services is terrifically important. How else will hospitals make the right investment choices with precious resources in such short supply?

“Debating the case for patient safety as an industry is as foolish as the restaurant industry debating the case for kitchen cleanliness or refrigeration. It is not about ROI, it is about SIB—Stay in Business.”

There are no shortcuts. Winning involves courage, investment, and plain old hard work. An established improvement formula used to accelerate adoption of high-impact technologies is now being applied through the latest Leapfrog Pay-4-Performance safe practices survey. It consists of “the four As—Awareness, Accountability, Ability, and Action.”^{7,8}

- Hospitals must be fully **aware** of the performance gaps—both the national numbers and their own numbers.
- Leaders must be personally **accountable** to close quality gaps through performance reviews and/or compensation.
- **Ability** is critical. Hospitals can be aware and accountable; however, if hospital staff do not have the ability to act (the education, skills, compensated time, and dark green dollars to invest), they risk producing nothing more than empty programs. Worse, they discourage the troops.
- Hospitals need to take **action**. The biggest job of all is to overcome the inertia of the current healthcare culture, which is crippling quality entrepreneurship. From front-line research with over 250 CEOs and senior leaders (TMIT, unpublished data, 3rd Q 2004), it is clear that efforts must be made to rehabilitate leaders who have been deluded by the Wall Street and business school religion of “What's in it for me?” and “The end justifies the means.” These leaders rationalize resistance to patient safety through situational ethics. The job of healthcare

leaders is to energize the rank and file out of the comfort zone of inaction and a “not invented here” mentality. Leaders and administrators need to discard the knee-jerk no-margin, no-mission mantra that routinely kills quality and safety initiatives. Everyone must work to develop a culture of quality entrepreneurship, high reliability focus, and systems thinking. Otherwise, failure is inevitable. In short, culture eats everything for lunch.

Surfers, swimmers, and sinkers

When the full brunt of the Pay-4-Performance tsunami comes—and it will—there will be 3 types of organizations: the surfers who “make things happen” and race ahead, leveraging the power of the wave; the swimmers who “watch what happens” and barely ride it out; and the sinkers who “wonder what happened” and drown.

Hospital leaders have to decide whether they are going to be surfers, swimmers, or sinkers. It is time to act because the no-outcome, no-income tsunami is on its way. **NPSF**

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What Is a Tsunami?

Webster's Encyclopedic Unabridged Dictionary

defines a tsunami as “an unusually large sea wave produced by a seaquake or undersea volcanic eruption.” Tsunamis are generated by a sudden displacement of the sea floor. Unlike hurricanes, they occur suddenly and strike without warning. Thus they are extremely dangerous to all in their path.

Stand Up for Patient Safety!

NPSF invites your hospital to show its leadership and commitment to patient safety by becoming a Stand Up for Patient Safety™ member. This nationwide initiative is aimed at providing the information, education, and tools that fuel measurable patient safety improvement in hospitals.

The NPSF-sponsored Stand Up for Patient Safety™ program provides a meaningful way for hospitals and health systems to participate in the patient safety movement and demonstrate their commitment to this important issue.

The Stand Up for Patient Safety™ program provides practical tools to enhance existing patient safety and quality improvement initiatives, including an extensive Member Resources Guide designed for use by specific audiences at your institution—administration, trustees, clinical staff, patients and families, and public relations and marketing personnel.

More than 160 hospital and health system members already serve as national leaders in this program. NPSF invites your organization to join the leadership ranks in patient safety.

For more information, visit www.npsf.org or contact Stephanie Hench at shench@npsf.org or (703) 506-3280.

NPSF thanks Stand Up's founding hospitals and health systems

Ascension Health, St. Louis, Mo
Baptist Health South Florida, Coral Gables, Fla
Children's Hospitals and Clinics, Minneapolis/St. Paul, Minn
Exempla Healthcare, Denver, Colo
Fairview Health Services, Minneapolis, Minn
Martin Memorial Health Systems, Stuart, Fla
Memorial Hermann Healthcare System, Houston, Tex
Mission St. Joseph's Health System, Asheville, NC
North Shore-Long Island Jewish Health System, Great Neck, NY
Partners HealthCare, Massachusetts General Hospital, and Brigham and Women's Hospital, Boston, Mass
Scott & White, Temple, Tex
Sisters of St. Francis Health Services, Inc., Mishawaka, Ind
St. Joseph Regional Health Center, Bryan, Tex
Trinity Health, Novi, Mich
Vanderbilt University Medical Center, Nashville, Tenn
Virginia Mason Medical Center, Seattle, Wash

Can a National Primary Care Error-Reporting System Make a Difference in Medical Practice?

BY NANCY C. ELDER, MD, MSPH; DEBORAH GRAHAM, MSPH; AND JOHN HICKNER, MD, MS

Primary care practices provide the majority of medical care in America,¹ yet the errors that occur in these practices and interventions to decrease them have rarely been rigorously and systematically studied.² To address this issue, in 2001 the American Academy of Family Physicians (AAFP) established the AAFP Center for Evaluation and Research in Patient Safety in Primary Care.

In 2002, building on AAFP research in error reporting by family physicians,³ a Web-based medical error-reporting system was developed as the central element for patient safety research and quality improvement program development.

Many healthcare providers are now asked to report errors through hospitals, health plans, and increasingly, legislation. The rationales for reporting errors are many, including the ability to systematically track and understand where and how errors occur. Anecdotal evidence shows that physicians who reported errors in earlier studies are making changes in their practices simply from participating in the error-reporting system. AAFP decided to investigate this possibility further.

AAFP's current error-reporting study was designed to find out more about a common task performed in primary care—laboratory and imaging test processing. In 2003, AAFP asked physicians and staff of 8 family practice offices to report errors related to test processing, an area where many errors occur, partly because there are many transitions in the process as shown in the table below.

More than 700 errors were reported in a 6-month period. To find out if the act of reporting errors led to improvement

and change from the reporters themselves, the researchers visited all 8 practices and held 18 focus groups to assess the effect of participating in the error-reporting study. The 139 focus group participants ranged from physicians, physician assistants, nurse practitioners, nurses, and medical assistants to front-office staff, billing and medical record clerks, and office managers.

Focus group members reported that participating in the error-reporting study led to changes in awareness and culture, as well as changes on an individual and practice level. While participants wanted major changes like electronic health records, more staff, and improved space to decrease their test-processing errors, error reporting alone led them to make some smaller but beneficial changes.

Awareness and culture changes

- Being more aware of errors—how easily and frequently errors can occur, the fact that they can occur anywhere, that serious errors are relatively rare, and that errors are made by individuals as well as by the system;
- Being increasingly aware of others' jobs and roles;
- Recognizing a lack of functioning systems in current practice; and
- Being willing to offer advice and suggestions to improve something.

Increased awareness of errors was the most commonly mentioned change among the practice participants. One participant commented, "I think it's opened my eyes more to what really goes on as far as things that shouldn't go on and

Testing process step	Transitions within the practice	Transitions between practice and outside lab or facility	Transitions between practice and patient
Ordering and implementation	Doctor to staff	Staff to lab or facility	Doctor/staff to patient
Tracking and receiving results	Staff to doctor	Lab or facility to staff	
Notifying the patient	Doctor to staff		Doctor/staff to patient
Follow-up with patient	Doctor to staff Staff to doctor	Staff to lab or facility Lab or facility to staff	Doctor/staff to patient Patient to doctor/staff

things that they don't mean, mistakes they don't mean to happen but they do happen."

Many participants became more aware that they had multiple ways to do many of the necessary steps in test processing—and that tended to lead to more errors. "I think the study has made me painfully aware of the fact that we don't have a system and secondly, how difficult it is to set up a system," said one focus group member.

Individual changes resulting from error reporting

- Double checking one's own work and being more attentive;
- Making specific, individual changes for a problem area, such as paying more attention to results, tracking the follow-up log more frequently, notifying more patients of test results, and tracking labs ordered on one's patients individually;
- When a patient, being diligent about calling for your own results; and
- Doing more research on patient safety issues.

A common response given by participants was that error reporting made them more diligent about their own work. "Double check, double check, double check everything," remarked one attendee.

Others found some work methods that seemed to work better for them and were less likely to lead to errors. "I've made some minor adjustments in my daily orders, a way of finding things that haven't come through," one participant commented. "I've just done something that makes it easier to find them."

Practice changes resulting from error reporting

- Making specific changes in a problem area, such as categorizing charts for nursing response, sorting radiology reports, and changing communication methods;
- Writing or updating policies and memos;
- Instituting a practice-wide tracking system with a lab log; and
- Adding a practice-wide referral and diagnostic surveillance program.

Even little changes can make a difference

These practice changes were not done frequently and weren't always easy, but were seen as important. "We switched from writing everything down on little pieces of paper and sticking them in the charts to e-mailing back and forth on lab results," said one project participant. "That needed to be done. It's been a very positive change, but it took a lot of investment."

Sometimes simple changes, like sending memos and making lists more public, made a noticeable difference. "We now have a list in the front office and one in the hallway that the doctors can refer to for insurance information—such as the paperwork needed to send a particular patient's test to the lab," said another participant.

"Sometimes simple changes, like sending memos and making lists more public, made a noticeable difference."

The researchers were pleased to see that taking part in an error-reporting study has led to changes in primary care practices. In less than a year, the increased awareness of test-processing errors and the cultural changes that errors exist and must be addressed led to individuals and the practices as a group instituting changes to improve care.

Reporting errors alone is clearly not enough to institute the major changes needed to improve test-processing systems in complex, busy primary care practices. But as one focus group member noted, "If we can make the error known and get it corrected, it frees up a lot of time for all the other tasks we have to do." NPSF

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On May 4, 2004 at the NPSF Patient Safety Congress, authors Elder, Graham, and Hickner will present a session titled "A National Error-Reporting Program to Improve Safety in Family Physicians' Offices."

Nursing Homes: An Important, But Often Overlooked Setting in Patient Safety

BY DAVID R. GIFFORD, MD, MPH

In 1997, there were approximately 1.6 million Americans residing in some 16,000 nursing homes (or long-term care facilities) at an annual cost of \$53 billion.¹ Nearly half of Medicare beneficiaries discharged from a hospital today are admitted to a skilled nursing facility. However, the nursing home population is often ignored in clinical trials and by most efforts to improve patient safety, which tend to focus on the acute care setting or physician offices.

“A study of 18 nursing homes found that medication-prescribing errors are common ... with 51% determined to be preventable—including most of those associated with life-threatening events.”

Older patients are more prone to the effects of medical errors
Nursing home residents represent an extremely frail and vulnerable population, putting them at high risk for the adverse effects of medical errors. They are increasingly older, sicker, and more functionally dependent than the general population.

The mean age of nursing home residents is 84 years; 46% are over age 85. Almost two-thirds are cognitively impaired. More than 90% need assistance with at least one activity of daily living (ADL) and nearly half have either bowel or bladder incontinence.

The average nursing home resident receives 6 to 7 medications per day. Residents suffer from a wide range of chronic medical conditions such as heart failure and diabetes, and many suffer from multiple ailments.²

Recent research suggests that medical errors contribute to the poor quality of care in nursing homes. A study of 18 nursing homes found that medication-prescribing errors are common (1.89 per 100 resident months) with 51% determined to be preventable—including most of those

associated with life-threatening events.³ Another study found that approximately 40% of hospital admissions from nursing homes were inappropriate, due in large part to errors of omission.⁴

CMS spearheads Nursing Home Quality Initiative

To address the issue of elder care, in November 2002 the Centers for Medicare and Medicaid Services (CMS) launched the Nursing Home Quality Initiative (NHQI). This national program has two components: public reporting of quality measures for every Medicare- and Medicaid-certified facility, and quality-improvement assistance to nursing homes. Most of the quality measures focus on adverse outcomes, many of which are preventable, such as pressure ulcers, pain, decline in ADLs, and delirium.

As part of NHQI, quality-improvement organizations (QIOs) in each state have been working more closely with approximately 15% of their state nursing homes to improve the quality measures. QIOs provide support material and clinical tools in conjunction with training seminars; many QIOs have created collaboratives of nursing homes that follow the Institute for Healthcare Improvement model. Lessons learned from these efforts provide valuable insights into efforts to improve patient safety in nursing homes.⁵

As found in the 1999 Institute of Medicine report, *To Err Is Human: Building a Safer Health Care System*,⁶ many adverse outcomes are the result of system problems rather than individual errors. However, a frequent response from nursing home leaders is, “If the staff just did what they were supposed to do [ie, follow our policy and protocol], we would not have any problems.”

As a result, nursing homes tend to address these problems at the individual healthcare worker level through more intensive educational efforts rather than examining and changing the system that has allowed the worker to make an error.

Staff turnover: A roadblock to safety improvement

The high staff turnover at all levels in nursing homes has hampered efforts to change the system as well as limiting the effectiveness of educational efforts.⁷ The mean length of service for an administrator is 6 months and 50% of certified nurse assistants turn over twice a year.

Leaders must change organizational culture

Rather than focusing on changes to specific clinical practices, QIOs are beginning to discuss the need to focus on the role of leadership in changing the organizational infrastructure and culture to address staff retention. Leadership support and involvement are some of the strongest predictors of high-performing healthcare facilities.⁸ Approaches to increasing staffs' sense of involvement may result in a greater impact on patient safety than efforts focusing on specific clinical conditions and protocols.

“Lessons learned from QIO programs working with nursing homes can inform national patient safety efforts.”

NHQI points the way for nursing home improvement

Despite the challenges, there have been some significant improvements and successes in NHQI. For example, the proportion of nursing home residents with daily pain who report their pain as moderate or severe has decreased by 32% nationally. The prevalence of pain is a primary clinical focus for all QIOs. Bringing nursing homes together in collaboratives to learn from each other also has been a very successful strategy, leading to active sharing of protocols and clinical tools.

Lessons learned from QIO programs working with nursing homes can inform national patient safety efforts. Efforts to improve patient safety will require approaches that providers can use to improve care systems, as well as lessons learned on how to implement these approaches and strategies. Similarly, the QIO program and nursing homes would benefit from input and lessons learned from patient safety efforts in other settings, particularly with health information technology (HIT).

For example, despite the high number of medications being prescribed in nursing homes, computer practitioner order entry has essentially been limited to the hospital or

physician office setting. Lessons learned on integrating HIT into the daily work flow will be extremely important to the successful implementation of HIT in nursing homes. Efforts to improve patient safety should not ignore this very frail and vulnerable population. **NPSF**

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On May 5, 2004 at the NPSF Patient Safety Congress, Dr. Gifford will lead a session titled "Quality Improvement Organizations to Target Patient Safety Issues in Long-Term Care."

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Plan to Attend “Let’s Get On With It!” May 3-7 at the Hynes Convention Center in Boston

There’s still time to register for NPSF’s sixth
annual Patient Safety Congress, “Let’s Get On
With It! Improving the Safety of Patients” May
3-7 at the Hynes Convention Center in Boston.

This year’s theme reflects the urgency of
creating safe, supportive organizational
cultures for patients and staff. The 5-day
Congress offers a powerful blend of knowledge
and experience:

- Stimulating plenary sessions with leading
national and international faculty;
- Solutions-oriented breakout sessions to help
you transform culture for every setting in
the healthcare system;
- Exhibitors showcasing the latest resources
available to help you reduce medical errors;

- Poster sessions on culture change, safety
solutions, and research activities; and
- Breakfast roundtable sessions designed to
connect you with experts and other NPSF
Congress participants so you can pursue
answers to your questions.

Meet *Focus* authors

The authors of this issue of *Focus* will lead
sessions at this year’s Congress. Don’t miss the
opportunity to meet and learn from them.

Register now!

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