

From Harmony to Healing: Join the Quality Choir

Charles R. Denham, MD

The music score has now been written. The audience is filling the national auditorium. You are on the stage, and the chaos of warm up is about to end. The question is...are you ready to perform with the quality choir?

Transparency means that you have no option. Your performance will be visible to all...this could be a dream come true or your worst nightmare.

Those who have embraced evidence-based safe practices and public reporting through the Leapfrog Group statewide performance improvement collaborative programs and initiatives, such as the Institute for Healthcare Improvement (IHI) 100,000 Lives Campaign, Healthcare Quality Alliance, or Surgical Care Improvement Group will be at an advantage. They will have played instruments of leadership and performance improvement. Others will have a hard time finding their instruments, much less their seats on stage.

We will no longer be respected for just winning the medical arms race with the best technologies. Bond ratings will reflect sustainability and embrace the dimensions of quality and safety. Adoption of safe practices will not just be the right thing to do, but they will be the right thing to do to get paid.

Hospitals will no longer be paid for playing their own tune, the public is much more savvy. The era of blind trust in care providers is over. Consumers have read our reviews. They are coming to our health care concert with far greater awareness of our challenges than ever before. They will consciously avoid harm and aggressively seek healing.

HARMONIZING SAFE PRACTICES FOR BETTER HEALTH CARE

Feedback from the front line reveals that at least 2 critical needs must be met for transformational hospital performance improvement: harmonization of the measures, standards, and practices required by certifying, purchasing, and quality organizations; and leadership engagement and development (Don Berwick, personal communication, March 14, 2006).

The most successful example of harmonization that this author has witnessed is the process of updating of the National Quality Forum (NQF) Safe Practices for Better Healthcare¹ through the Safe Practices Consensus Standards Methods Maintenance Committee which we have addressed in a prior article.²

The NQF consensus process has been completed by a world-class committee. However, it would have been a mission impossible without the commitment, dedication, and vision of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Centers for Medicare and Medicaid Services (CMS), IHI, the Leapfrog Group, and Agency for Healthcare Research and Quality (AHRQ), which we coined the *Quality Choir* in a prior publication.³ Representation of multiple stakeholders on the committee included extraordinary quality leader support from provider organizations through Doug Bonacum of Kaiser, Jennifer Daley of Tenet, and Dr Peter Pronovost of Johns Hopkins. Dr David Hunt of CMS and Jim Battles of AHRQ provided enormous input as representatives from federal agencies. Mike Cohen of the Institute for Safe Medication Practices, Maulik Joshi of Delmarva Foundation, Mary McDonald of AFT Healthcare, and Maura McAuliff provided vital subject matter support from frontline quality and

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member organizations. Dr Rick Croteau of JCAHO provided invaluable expertise and detailed support. Dr Jim Heathcox of Cardinal provided critical input on medication systems as a supplier representative. This author's co-chairperson, Dr Gregg Meyer, quoted later, provided exemplary leadership.

The process we used to harmonize the practices can be described as the 4 Cs, which included the concepts of cross walk, cross language, cross credit, and cross communication of the practices. A major goal of the committee was to harmonize the practices across the key stakeholders, including AHRQ, JCAHO, the Leapfrog Group, the IHI 100,000 Lives Campaign,⁴ and CMS. The committee cross walked the practices to each of the corresponding initiatives or standards of each organization. It then sought to cross language the practices to synchronize the literal translation of overlapping initiatives, such that hospitals would have the most clear and actionable path. The committee then identified opportunities for the organizations to cross credit activities by hospitals, so that they would not need to undertake duplicative efforts for full credit for initiatives that clearly overlap. Because all of the organizations mentioned previously were participating in the process as representatives on the committee, they committed to cross communicate the ultimate harmonization when the practices were confirmed as national standards.

Completed in the first quarter of 2006 and reviewed by the market in the second quarter, the process retired 3 practices and produced 3 new practices, which maintained the original total number of 30 practices. Material changes were recommended for 23 practices of the 2003 endorsed list. Four from the 2003 endorsed list had no material change other than updated references. The 3 new practices included those addressing disclosure, direct caregivers, and medication reconciliation. Reviews of these practices will be provided in future publications.

Responding to the request of the provider community, the practices have more specificity and clarity regarding what will be required for compliance. Where there was not sufficient evidence, certain information was provided in "Implementation Approaches" sections for each of the practices. Specific attention was paid to the individual needs or characteristics of children's hospitals, rural hospitals, and specialty hospitals. Input was provided from more than 250 subject matter experts, leading academic institutions, and from many frontline hospitals.

A wide range of subject matter experts was consulted, and a careful evidence-based review of the practices was undertaken, including input from The Medical Institute of Technology's (TMIT) 260 experts and the TMIT Research Test Bed Collaborative of more than 3100 hospitals. The practices were harmonized across the JCAHO, CMS, AHRQ, the Leapfrog Group, and the IHI, with the hope of providing a common roadmap for health care institutions.

Task forces with each of these organizations carefully cross walked, looked for cross-language and cross-credit opportunities, and have committed to cross communicate the practices when they become standards.

A major focus of the committee was to develop and refine a practice entitled "Creating and Sustaining a Culture of Patient Safety." It recognized the continued need for emphasis on leadership and comprises 4 elements:

- Leadership structures and systems
- Culture measurement, feedback, and interventions
- Teamwork and team-based interventions
- Identification and mitigation of risks and hazards

Workforce-related practices included those addressing nursing, direct caregivers who are not nurses, and intensive care unit care.

A set of practices organized in a chapter entitled "Information Management and Continuity of Care" addresses critical care information, discharge systems, safe adoption of integrated clinical systems, such as CPOE, and abbreviations.

Medication management practices include the pharmacists' roles in medication reconciliation, high-alert medications, standardized medication labeling and packaging, and unit dose medications.

Health care-associated infections-related practices address aspiration and ventilator-associated pneumonia, hand hygiene, influenza prevention, central venous line bloodstream infection prevention, and surgical site infection prevention.

A number of condition-specific practices include those related to evidence-based referrals for high-risk procedures, anticoagulation therapy and deep vein thrombosis/venous thromboembolism prevention, wrong site, wrong procedure, and wrong surgery prevention, perioperative myocardial infarct/ischemia prevention, and contrast media-induced renal failure prevention.

INTERVIEWS WITH FRONTLINE LEADERS

Interview: Donald Berwick, MD, MPP, President, Chief Executive Officer of the IHI

Dr Denham: We understand that harmonization of measures and standards at the front line is important. What have you learned through the 100,000 Lives Campaign?

Dr Berwick: Harmonization with alignment of agendas is the most common request we're getting from the front line. Hundreds, thousands of hospitals involved come back to us often with the request, "Get it lined up. We can't dance to so many different tunes at the same time. Can you all please come together?" We've made a lot of progress now, and I think one of the reasons behind the success of the 100,000 Lives Campaign is that the requests that we're making of hospitals and leaders have become much more harmonized now, and the more we do that, the better it'll be.

Dr Denham: Are you surprised that CMS, the Joint Commission, IHI, the Leapfrog Group, and AHRQ have harmonized a common set of practices with complete agreement?

Dr Berwick: Health care comes from a background of fragmentation. We've built so many silos—hospitals, clinics, doctors, agencies, associations. It's easy to go in different directions. But I have a lot of respect for the leaders of the forces that, together, can call health care to become what it should be. This has created a platform for people to really talk to each other about what we want to get done. I'm not surprised at all that they have come to agreement. At bottom, the mission is the same (electronic communication [video], March 14, 2006).

Interview: Carolyn M. Clancy, MD, Director of the AHRQ

Dr Denham: Now that the harmonization process has been undertaken using a very careful evidence-based manner, do you think that health care leaders will embrace it?

Dr Clancy: My first thought is that it's incredibly exciting that these 6 organizations came together to make sure that hospitals and other health care facilities can have 1 set of rules for the road. Now that the hard work has been done, reviewing everything that's known, updating, harmonizing, and pulling everything together in a very coherent way, I'm confident that health care professionals and health care leaders across the country will take this very seriously.

Dr Denham: Please give us your perspective regarding the importance of engaged leadership regarding adoption of safe and best practices.

Dr Clancy: Since the Institute of Medicine's report was published, there's been a huge growth in awareness of all the problems related to the critical need to make health care safer. Leadership has clearly emerged as a theme that gets broad recognition by many in health care. Having said that, I think many leaders don't know what that means beyond feeling that it's very important. What's going to be very exciting is when they have a very clear road map for what they need to do, how to work with their boards, and so forth.

Dr Denham: Do you have a message for trustees and governance boards?

Dr Clancy: The message for board members is that this issue is a critical part of your job. Overseeing what goes on in a hospital or health care institution involves asking tough questions and regularly seeing what's happening in terms of improving quality and safety in health care. That's just as important as the bottom line (electronic communication [video], May 11, 2006).

Interview: Dennis S. O'Leary, MD, President of the JCAHO

Dr Denham: The entire market is starting to recognize that incremental improvement is not enough and that we are being completely overwhelmed by systems failures. Do you have a message regarding leadership engagement of the board and the C suite in transformational change?

Dr O'Leary: Transformational change is all about leadership. It involves making patient safety the priority. It means moving toward systems improvement. You are not serious about systems improvement unless you are implementing Toyota lean methods, 6 sigma, a formal improvement methodology, or you have a systems engineer on your staff. Otherwise, you are not there. Our leadership and our organizations across the country have to move to that new plateau.

Dr Denham: We often quote your powerful statement that "trustees don't need to know all the answers—they just need to know the right questions." Can you elucidate?

Dr O'Leary: Trustees need to be engaged in patient safety. They need to care about what's going on inside the organization. That means being able to ask questions. They don't need to know all the answers, but they need to know

where the money is in the system, and to hold the leadership of the organization—the executive management, the medical leadership, the nursing leadership—accountable for answering those questions and producing the kind of data that they need to answer those questions (electronic communication [video], May 11, 2006).

Interview: Janet M. Corrigan, PhD, MD, President and Chief Executive Officer of the NQF

Dr Denham: You have taken the helm of the NQF as we are bringing the NQF Safe Practices updating process to a close. Are you pleased with the consensus process and the work produced by the committee and the many contributing organizations?

Dr Corrigan: I think there's a lot to be proud of and excited about. For the first time, the recent work on patient safety practices brought the major stakeholders and organizations together to harmonize their expectations and requirements. So, this is a big accomplishment (electronic communication [video], August 18, 2006).

Interview: Suzanne Delbanco, PhD, MPH, Chief Executive Officer of The Leapfrog Group

Dr Denham: Can you provide us with the perspective of the payers and consumers regarding the value of the harmonized set of safe practices?

Dr Delbanco: Well, it's been a long road, and we're thrilled that we're now at this point where we've achieved harmonization in patient safety. We can now take an approach to measurement and determine whether or not patient safety practices are in place. It's a very important day for purchasers and consumers. Now, what we need to do is communicate about what it is that we've harmonized. Our job will be to work with employers and consumers to get the word out. Then we will use that communication as a means to both motivate improvement in the care provided, as well as to promote the transparency of information for those who use and pay for health care in order for them to understand more about what's taking place within the walls of hospitals.

Dr Denham: Do you believe that the NQF consensus process is a mode for national standards development?

Dr Delbanco: The Leapfrog Group really believes in the consensus process. We're active members of the National Quality Forum, and we believe it provides a great venue for making sense out of many different approaches to measuring patient safety. And this particular process provides an opportunity to bring in line the different approaches that various organizations were taking. It allows us to assess the practices that were taking place in hospitals and make sure that we're all speaking the same language when we talk about what should be done and how to measure them (electronic communication [video], May 11, 2006).

Interview: Maureen Bisognano, Executive Vice President and Chief Operating Officer of the IHI

Dr Denham: As a pioneer of quality and patient safety and leader of the steering committee of the original NQF safe

practices, what is your reaction to the updated set now that we have harmonization across these organizations?

Maureen Bisognano: It is an amazing thing. As the co-chair of the original committee, it was a very difficult task to get people on the same page, requiring a lot of time and energy. This new effort that has put everybody on the same page is making a world of difference.

Dr Denham: Where do you think we will see the most impact of harmonization?

Maureen Bisognano: It will be most important to the CEOs of the world. What they're telling us is that they need a relatively short list of targets that are evidence based where everyone is on the same page. Then when I ask, "Would you implement these?" Their reaction is, "Why wouldn't I?" (electronic communication [video], March 14, 2006).

Interview: David Knowlton, Chair, President, Chief Executive Officer, New Jersey Healthcare Quality Institute

Dr Denham: How important is the harmonization process?

David Knowlton: There are so many different variables coming at hospital CEOs today. They often talk to me about the measure du jour. Harmonization is critically important, especially if the practices and measures are harmonized, and the major groups are politically aligned. This is essential if you want to get movement.

Dr Denham: As a board member of the Leapfrog Group, do you think public reporting really is translating into quality right at the pump?

David Knowlton: Absolutely. For instance, in our state of New Jersey, we started public reporting very early. We started in 1990. It is not only the consumer who reads this information, but CEOs review these data as well. Doctors and CEOs don't like to be outliers so they're the first ones that act on that data. Before we started reporting quality data on heart surgery in New Jersey, we had low scores. Then we reported the data, and the scores went way up, driven by the fact that people care. We saw improvement in quality over 2 to 3 years (personal communication, July 14, 2006).

Interview: Sue Sheridan, MBA, cofounder and Vice President, Consumers Advancing Patient Safety; Founder of Parents, Infants, and Children with Kernicterus

Dr Denham: As a patient advocate, what do you think of the concept of harmonizing the NQF Safe Practices?

Sue Sheridan: I personally have not been involved in the harmonization of these practices. However, I am very familiar with them as a person working within the system trying to make improvements. I am very familiar with all the separate lists of goals facing hospitals—daunting and overwhelming. Harmonization is brilliant! Because it's going to help everybody focus on 1 list, and it will give impetus to people working together in better ways.

Dr Denham: Will this help focus the consumer movement?

Sue Sheridan: It will not allow any excuses in the future...to not get things right. So I think harmonization is

going to keep us safer, but it is also going to put more pressure on the health care system which we need to keep us safe. Now, we can bring focus on them from the consumer point of view. If these errors continue, there is absolutely no excuse (electronic communication [video], September 11, 2006).

Interview: Roger Resar, MD, Senior IHI Fellow, Associate Professor Mayo Health System

Dr Denham: You have a rare view as a thought leader in patient safety and as an internal adviser of the Mayo Clinic. Can you comment on the value of harmonization of measures standards and practices as they relate to your work?

Dr Roger Resar: Our work in reliability has been tremendously enlightening. Now that we have a standardized set of safe practices, we can really engage strategies and tactics that employ reliability principles and generate real impact on very common safety issues.

Dr Denham: Your organization took a very deliberate, systematic, and thoughtful evaluation of the NQF Safe Practices. This input was very valuable to the consensus process. Was it valuable to your organization?

Dr Roger Resar: We did undertake a very thoughtful and careful evaluation with teams represented by the key clinical subject matter experts. It was a very valuable process to us, and it was a terrific opportunity to make a real contribution to the national standards. Any time such a process is undertaken by your best people, they always identify new opportunities for excellence (personal communication, September 27, 2006).

Interview: David Hunt, MD, Medical Officer at the CMS

Dr Denham: Please react to the experience of the harmonization of the practices.

Dr Hunt: Out in the hospital community, the response has been tremendous. One thing that we found out is that harmonization means so much more than 2 measures that sound very similar. The benefit is that the very stressed, typically understaffed quality improvement departments in the hospitals don't have to try to herd cats. They have a shorter list of initiatives that they have to work on. Everybody gets the benefit of 1 set of work that can be distributed to all of the groups requesting information—the payer groups, the regulatory bodies, and the accreditation agencies.

Dr Denham: Was all of the energy we put into the cross-walk and cross-language activities worth the effort?

Dr Hunt: The benefit is definitely worth the effort. I never ever want to try to indicate that this is something that was easy to do, or a very short put on our end, the stakeholders' end. It's not an easy thing to do because so many times, the business models of CMS, the Medicare system, and the Joint Commission line up very frequently and very closely. However, the alignment may not be exactly the same. So, many times the measures were borne out of a realization that we needed to have this business requirement met, and it is very difficult to align the elements at a highly granular specification level. It's tough. It's tough work. But when you look at the work that the hospitals are going to have to do, in the long run, it definitely is well worth it. It's been a challenge, but

it also has been very gratifying to work together with the stakeholders.

Dr Denham: Please react to the collaborative experience of the harmonization of the practices. Do you think that there will be further interest in collaboration on harmonization?

Dr Hunt: It was definitely a great experience. The groups worked well together, primarily because we found out how much we do have in common. Moving forward, there is already that commitment from the leadership to move forward in synchrony. So, we have a good understanding that before we've made a move 1 way or the other, we shouldn't act unilaterally (electronic communication [video], December 14, 2005).

Interview: Jennifer Daley, MD, Chief Medical Officer and Senior Vice President, Office of Clinical Quality, Tenant Health Care

Dr Denham: As a frontline quality leader for a major multistate organization which is putting a major emphasis on quality, what are the important issues to harmonization?

Dr Daley: Coming from the front line, one of the most frustrating things is that many of the patient safety organizations seem to have different or inconsistent or absolutely unaligned messages. One of the exciting things about the work that we've done with the committee is we've had JCAHO, CMS, AHRQ, Leapfrog, and NQF all at the table. We've worked incredibly hard to make sure that the messages are all consistent across all those organizations. I'm very excited and hopeful that work will really clarify the practical issues for people like me who work on the front line trying to make care safer for patients.

Dr Denham: The first element of the practice of creating and sustaining a culture for safety is to establish a structure to create and support that culture. What are your thoughts?

Dr Daley: When the safe practices were first put together, this notion of a culture of safety was a little fuzzy. Now, with these revisions, we have so much more experience in knowing what we're talking about when we talk about a culture of safety. So, originally, we talked about creating and supporting a culture of safety. Now, we talk about creating and sustaining the culture of safety. The critical piece of sustaining the culture of safety is around leadership. That is the important piece that's really been incorporated into these new safe practices. In such leadership, we talked about being transparent, communicating and supporting the goals by living those goals and being accountable for them (electronic communication [video], December 14, 2005).

Interview: David Classen, MD, MS, Associate Professor of Medicine, University of Utah

Dr Denham: As a major subject matter expert in the area of medication management and adverse drug events, what will the value be of harmonization and emphasis on pharmacy leadership engagement?

Dr Classen: Medication management is a complex, yet mission-critical, process. As recent events (death of babies in

Indiana) have shown, it remains a very risky process. Much effort has been focused on regulation and automation of the medication use process. Given the volume of best practices in this area and the number of technology solutions that are being thrown at it, organizations are often perplexed about where to focus or even where to begin. Harmonizing regulation, best practices, and automated solutions in the area of medication management would provide enormous value to the many organizations who are still struggling to create a highly reliable medication management process.

Dr Denham: Do you believe that the emphasis of the practices on readiness and focus on investing and preparing the social infrastructure for technology adoption in the case of the CPOE practice was a valuable enhancement?

Dr Classen: Yes I do. CPOE represents one of the largest clinical change initiatives that hospitals have ever undertaken. If you look at organizations that have been successful, more than 80% of that success is due to focusing on the cultural, social, change management, and clinician engagement issues, not the technology issues. Uncovering these issues with some form of organizational readiness assessment is an essential part of any approach to broad adoption of CPOE within the hospitals (personal communication, September 28, 2006).

Interview: Ginny Ueberroth, Trustee, Hoag Hospital, Newport Beach, California

Dr Denham: As a trustee of a hospital that is seeking to become a national high performer, what does harmonizing the national standards mean to you regarding creating a common or clear road map for quality?

Ginny Ueberroth: It gives us the right questions to ask and allows us to provide direct support and guidance to our administrative teams. It also allows us to allocate resources more thoughtfully and responsibly, thereby living up to our commitment to the community.

Dr Denham: Is the specificity of the practices that defines explicit activities to be undertaken by trustees helpful and will the fact that knowledge transfer to trustees be required a positive feature?

Ginny Ueberroth: These features provide us with real tactical support and provide guidance in an ever more complex world with many competing priorities. It is clearly important that we spend more of our time on quality and safety issues (personal communication, September 24, 2006).

Interview: Lillee Gelinas, RN, MSN, Vice President and Chief Nursing Officer, Victorian Healthcare Association, Inc

Dr Denham: As a very valuable contributor to the nursing and workforce practices, you emphasized the importance of harmonization to implementation. Why?

Lillee Gelinas: The first step in the process was to gain consensus—we needed to make sure we were on target. That's very important to launching improvement. However, at the end of the day, having a clear practical understanding of the harmonized practices, supported by national consensus, will help generate advocates for implementation. This is critical.

Dr Denham: What message would you have for hospital and health care organization leaders? Do we have enough evidence to act?

Lillee Gelinas: One of the things we learned in the process is that we don't have a failure of evidence. We have a failure of execution. So, as we move forward with leaders, we must communicate that we have the evidence. We've taken that off the table. Let's get about rolling our sleeves up and getting the job done (electronic communication [video], August 18, 2006).

Interview: Carol Haraden, PhD, Vice President at the IHI; Quality of Care Outcomes Researcher, Educator, and Change Leader

Dr Denham: What lessons have you learned about adoption of innovations that we can apply to adoption of the safe practices?

Dr Haraden: It is a commonly held notion that most people believe their way into acting, when in fact most people act their way into believing. We have 2 choices; we can wait and try to build people's belief systems by continually telling them why and how they should do something or we can help them act and gain the belief that the innovation or practice works by putting them into action. Learning through action can drive improvement. There is real power there.

Dr Denham: What advice do you have for those leaders and organizations that are on the sidelines, still analyzing where to start?

Dr Haraden: Enough with ready and aim. Let's fire. We're never going to be completely ready. We know the problems. We know where to aim our solutions right now. Many are waiting until the stars align to get ready, and they're never going to align. You're never going to have everything perfect...exactly the right workforce, the perfect electronic medical record, the best computerized prescription order entry. Right now, our employees are waiting for us to call them to action. They are waiting for us to set our aspirations and aims. It is time to say of practices or processes "they aren't perfect; they don't have to be perfect; we can do this now. We can begin to figure this out together as we build better systems." You know, in the end, our systems will be better for it...and so will we (electronic communication [video], September 24, 2006).

Interview: Julie Ann Morath, RN, MS, Chief Operating Officer, Children's Hospital and Clinics of Minnesota

Dr Denham: As a Chief Operating Officer and national patient safety expert, what insights can you provide us from the operations perspective? What message do you have for leaders of operations?

Julie Morath: Well, there's a Churchillian quote, "This is the end of the beginning." At our organization, we have been working on this for 6 years. The more we work on safety and the deeper our knowledge, the more we see there is to do. What we've been able to do is to orient the whole organization and its operations around the platform of patient safety. That is job number 1 for leaders. From that, everything

else follows—it must be hardwired. Patient safety must be hardwired into expectations of all our job descriptions, in our incentives, in our credentialing, our continuing education, our orientation. It's number 1 on agendas in our meetings. We should be in continual pursuit of best practices. There's never a time when we can be complacent with the status quo. We must always be driving to get better at what we're doing.

Dr Denham: What is the future for high-performing organizations?

Julie Morath: Every day, we have new research, and there are new tools becoming available, and so we're testing those and continuing to learn from them. Our future is to really move into a status of high reliability, similar to other high-risk organizations. We've been on that pathway, and new and better information is becoming available about the applications in health care itself, such as the safe practices. And so we must test those, be a laboratory for them, and find new and better ways to deliver safer and better care (electronic communication [video], March 26, 2006).

GREGG S. MEYER, MD, MSC, MEDICAL DIRECTOR, MASSACHUSETTS GENERAL HOSPITAL PHYSICIANS ORGANIZATION; CO-CHAIRMAN NQF SAFE PRACTICES PROGRAM

Dr Denham: It's exciting to see how far we have come with the harmonization; however, this is just the beginning. What are your thoughts regarding the next steps?

Dr Meyer: We've come a long way, and I think some incredibly hard work has been done by a superb committee. With that said, we've really only just begun. We've done the work that it takes to harmonize all these practices, to send a very strong and clear and obtainable message. But now, we have to do the hard work to get that implemented. So, we can't stop; we have to keep pushing forward, and I think this next step of the process is going to be a very exciting one.

Dr Denham: What is your message to medical leaders of our health care organizations?

Dr Meyer: Now I think the message to us is *Let's really get to work*. Pulling together the practices and harmonizing them has sent a clear message. Now, we have to make sure the receptive sites are ready for it. They need to become ready to take this mantle and move forward with it. We need to be there to help support them. We've gathered a very strong evidentiary base for the way that we want to move forward. We've given a clear pathway to do it. Now, all we need is to support all the organizations across the country to move along this pathway. Because the committee concluded that if we make progress across the board on these, American health care will be changed. It will be changed because we'll all be able to look in the mirror and say, "We helped make it safer" (electronic communication [video], March 17, 2006).

Interview: Donald Berwick, MD, MPP, President, Chief Executive Officer of the IHI

Dr Denham: What learnings can we apply from the lessons of the 100,000 Lives Campaign to the adoption of the NQF Safe Practices?

Dr Berwick: I think the 100,000 Lives Campaign has created an opportunity that may only come once in my lifetime. We have almost the whole of the American health care industry, at least the American hospital industry, trying to do something together, and I think it creates an opportunity for them to do even more together. And if we're smart enough to take advantage of that opportunity, we can begin to create what we haven't had in America, a great health care system.

Dr Denham: Do you have a message for our health care leaders regarding adoption of the practices going forward?

Dr Berwick: Let's get everybody onboard, do it all, then let's figure out agendas that are compelling and fresh so that we can keep up the momentum. We can build excellence the country's never seen before (electronic communication [video], March 14, 2006).

FROM HARM TO HEALING

To become real healing organizations, we have a long way to improve from our current fragmented care model, which is fraught with systems failures, discontinuities, and broken information loops.

The framework depicted in Figure 1 presents a continuum of quality that embraces the science of reliability.

At the lowest end is production-centered care, or some might say profit-centered care, that is driven by perverse financial incentives.

At an intermediate level is patient-centered care that is consistent with the Institute of Medicine definition: "Essential dimensions of patient-centered care include, but are not limited to, customized information, communication, and education; coordination and integration of care across conditions and settings, and over time; shared decision making of clinicians with patients and families; self-efficacy and self-management skills for patients; patient's experience of care; effective provider-patient partnership; and enhanced cultural competence of health care providers."^{5,6} The highest level addresses whole person or integrative care, including mind, body, and spirit.

Such reconciling frameworks are simplistic and imperfect and can help us separate the signal from the noise as we pursue our quest for quality. They provide just 1 more

view of a very complex set of systems. The TMIT is using this framework and more comprehensive derivations to research safe practices adoption and development in our research test bed collaborative.

Imbedded in this framework design is the concept that safety must be the first requirement or intrinsic property for progression in performance improvement. That is not to say that we cannot deliver elements of patient-centered care or complementary care without delivering safe care. However, as we look at a situation of infinite demand for care and finite financial resources, it is important that we embed prioritization in our models for improvement—*first do no harm*.

Conventional care has developed around financial incentives, procedural compensation, and the development of medications and treatments with devices that can be patented, branded, and that drive commerce. Without such commerce, we would be lacking many of our great breakthroughs. However, this is not enough.

Certain elements of alternative and complementary care, which may have developed in a parallel track outside our conventional care models, now have real traction as well, in that there is increasing evidence that treatment of mind, body, and spirit have real impact as a force multiplier. Actions taken by payers to cover certain complementary care treatments argue their place in the system, even to the most vigorous skeptics.

As we examine the NQF Safe Practices for their value, we must recognize what they are and what they are not. They are a set of evidence-based practices that are evolving. The requirements are bare minimums, and they do not address all areas of safety. They address only a portion of the lower end of the quality continuum depicted in Figure 1.

In the body of the documentation of the NQF Safe Practices, we address outcomes, process, structure, and patient-centered measures. The last of these are in their infancy; however, these are very important to patients and their families. It is important to realize that they address some of the most important elements to healing.

As we seek to drive adoption of the practices, we must create awareness of the performance gaps, the practices target, lay personal accountability at the feet of those who have to leverage change in their organizations, invest in the

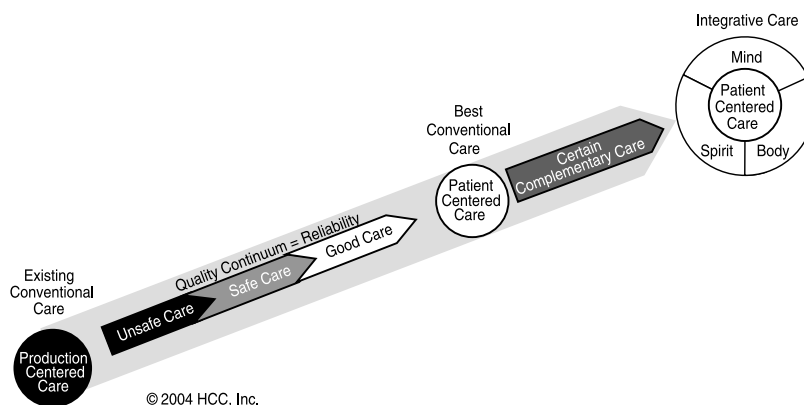


FIGURE 1. The quality continuum.

ability for change, and finally prompt action for adoption. However, this is not enough.

Key questions regarding the path from harm to healing include those of the *who*, *what*, *when*, and *how*. Pay-for-performance and its Siamese twin, transparency, provide growing pressures to explain the *why* if the moral imperative were not enough for the financially motivated.

The *who* is becoming more and more clear—servant leadership at every level is the magic ingredient. We must engage and develop leaders from governance boards, the C suite of administrative leadership, formal and informal medical leaders, pharmacy directors, radiology leaders, nursing leaders, and virtually everyone in the organization, not just to adopt the practices, but to get back to treating patients as we would want to be treated. This means emphasizing elements of the upper end of the quality continuum.

We have addressed the *what* in the harmonized practices. In the words of Dr Haraden, quoted previously, it is time to “act our way into believing.” When we see the impact on patient care through adoption of the practices, it will not take good caregivers long to connect the dots.

Now that the practices are harmonized across the major certifying, purchasing, and quality organizations, the *when* should be clear. More than 1260 hospitals are submitting to the Leapfrog Group survey, measuring adoption of the practices. More than 500 hospitals are collaborating with TMIT in statewide collaboratives, preparing for full transparency. More than 3000 hospitals have joined the IHI 100,000 Lives Campaign, which includes practices harmonized with this NQF set of practices.

Interestingly, when we address the *how*, it brings us back to the *who*. We now understand that success rides less on the shoulders of the tactics and more on the leaders we engage and develop to lead the charge. Those leaders will have an intrinsic tuning fork of values that will resonate with creating a safe, reliable, and healing organization. They will keep our organizations on pitch when the sheet music is missing.

IT IS A ROUGH ROAD TO THE STARS

The road from harm to healing will not be an easy one—there will be many casualties of all kinds along the way. The mantra of no margin-no mission, the *financial ends justify the clinical means* mentality, and cost-cutting quality to make the numbers strategies will find themselves on the

ash heap of health care history. Many old guard health care leaders resisting change will likely opt out of this future.

We are reminded of a plaque found on the launch pad of Apollo 1 when 3 astronauts died the preventable death of systems failures. The inscription reads *Ad Astra Per Aspera*, which means *It is a rough road to the stars*. Innovation and leadership means taking risks. It means energizing all of the players in the vessel of your organizations. It means playing on the simple harmonics of their values and their desire to serve others, and it means weeding out those that do not have those values.

The ushers are sounding the bell. The house lights are coming down, and the spotlights are now on you. Are you going to bolt for the nearest exit and take early retirement, or have the courage to pick up your instrument and face the audience?

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