

The Quality Choir: From Warm-up to Harmony

Charles R. Denham, MD

INTRODUCTION

Hospitals feel under siege, CEOs and senior leaders are extremely frustrated, trustees are anxious, and quality teams are overwhelmed. For most, stress and confusion is the rule, not the exception. There appears to be no end in sight.

The certifying, purchasing, and quality organizations appear to be challenging them from all directions. They seem to be asking for entirely different data and information simultaneously. Like an orchestra warming up, it is very hard to decode any message or harmony from this incoherent and chaotic noise.

The demands for transparency are accelerating in scope and volume. Change in our industry has historically occurred at a glacial pace; however, the clock speed of the quality movement is amazing even the greatest skeptics. This is clearly driven by Pay-For-Performance.¹

BACKGROUND

One can trace the beginnings of this phenomenon to national awareness created by the first I.O.M. Report "To Err Is Human."² The second report, "Crossing The Quality Chasm," established the 6 aims and 3 design principles to cross the quality chasm.³ The aims of patient safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity were defined. The design principles to generate these aims were defined as patient-centeredness, evidence-based medicine, and systems performance improvement. Interestingly, the only element cited as both an aim and design principle is the often misunderstood concept of patient-centeredness.

Outcomes, process, structural, and patient measures have been evolving at an accelerating pace. Outcome measures are the Holy Grail; however, they require the most time and investment. Process measures are used as proxies for outcomes measures. Structure and patient-centered measures are earliest in development and are driven more by payers such as The Leapfrog Group than by academic innovation.⁴

Music has been described as the harmonization of opposites, the unification of disparate things, and the conciliation of warring elements.⁵ In information technology, harmonization can be described as the coordination process used by standards development organizations to make standards work together. Processes to achieve harmonization include convergence, modeling, mapping, translation, and other techniques.⁶

The bad news is that we are in a time of chaos; however, the good news is that help is on the way. This article seeks to provide a forward view of the harmonization of measures, standards, and practices by certifying, purchasing, and quality organizations. The intent is to encourage leaders to make the investments now that will advantage them in the future. Our cottage industry is about to transition into a performance-driven market where good old American competition will occur on a national scale.

From the Texas Medical Institute of Technology, Austin, Texas.

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Clearly the instruments of certification, performance improvement, and value-based purchasing need more than a tuning; however, they are being pressed into service with few identifiable barriers.⁷

The earliest example of the harmonization of quality measures, standards, and practices was the process of updating the safe practices described in the “Safe Practices for Better Healthcare” originally published by the National Quality Forum.⁸ The adoption of these practices is what The Leapfrog Group is measuring to reward performance.

Skeptics fear that harmonization is a pipe dream; however, highly motivated leaders of the major stakeholder organizations including the Agency for Healthcare Research and Quality (AHRQ), National Quality Forum (NQF), Joint Commission for Accreditation of Healthcare Organizations (JCAHO), The Leapfrog Group, Institute for Healthcare Improvement (IHI), and Centers for Medicare and Medicaid (CMS) have agreed to work together in an unprecedented way.

Even skeptics cannot ignore the drumbeat of P-4-P... P-4-P...P-4-P coming from disgruntled employers and purchasers who are setting a new tempo out of sheer desperation to cut exploding costs.

In reality the cacophony of quality noise currently engulfing hospitals might just be the orchestra warming up. The voices of leaders captured in the following interviews may not yet be a choir; however, their resonance is clear.

QUALITY LEADER INTERVIEWS

Carolyn M. Clancy, MD, Director of the Agency for Healthcare Research and Quality (AHRQ)

Dr. Denham: Our TMIT team and subject matter experts are honored to be working with AHRQ, NQF, the Joint Commission, The Leapfrog Group, the Institute for Healthcare Improvement, and CMS to develop quality targets in a common language for the hospitals. Can you give us your view on the convergence of the stakeholders’ quality objectives and this harmonization effort?

Dr. Clancy: Certainly. First of all, I think the overarching message is that, although there are a number of different acronyms associated with specific processes to promote patient safety or outcomes to see that we’re on track, they are converging. These are not separate roads, we’re not all going in different directions, and I think that’s a very, very important message. Any time a tragedy happens at an institution, there’s an instant urge to do something about it. Not just at that institution, but at other institutions like it, because it’s the completely normal reaction to say, “I don’t want that to happen here. We could’ve avoided this.” And that’s fabulous. That’s what makes health care so exciting; it’s that kind of response that’s generated right away. On the other hand, if we’re not making sure that what we do is evidence-based, we actually run the risk of making the problem worse by diverting resources into a well-intentioned intervention intended to solve a problem that may actually be creating other problems inadvertently.

Dr. Denham: The original work that led to the NQF Safe Practices was funded by AHRQ, was it not?

Dr. Clancy: A big focus of our research is evaluating the evidence underlying best practices in patient safety. We supported a systematic review several years ago, which was the foundation for the initial set of Safe Practices from the National Quality Forum, and I’m thrilled that you are Co-Chairing the effort to update that because, like evidence in any other part of health care, it’s dynamic; it needs to be updated so that it always reflects the best in current science. We will definitely be working closely with the Joint Commission and the National Quality Forum, IHI, and folks in The Leapfrog Group to try to make sure that we can communicate more effectively, that there is this continued convergence and harmonization across these efforts, because I think that’s incredibly important.

Kenneth W. Kizer, MD, MPH, President and CEO, National Quality Forum (NQF)

Dr. Denham: Yes, there is plenty of evidence underlying the performance measures that are coming out of the consensus process. That doesn’t mean that we have all the answers or the evidence-base is perfect. However, it is good enough for now. The evidence we have is sufficient to move forward. The evidence-base will build and get better over time; the measures will get better over time.

Dr. Kizer: Yes, there is plenty of evidence underlying the performance measures that are coming out of the consensus process. That doesn’t mean that we have all the answers or the evidence-base is perfect. However, it is good enough for now. The evidence we have is sufficient to move forward. The evidence-base will build and get better over time; the measures will get better over time.

Dr. Denham: Do you think that Pay-For-Performance will have an impact on the business case for patient safety and quality in the next 12 to 24 months?

Dr. Kizer: There is no question in my mind that Pay-For-Performance means that quality improvement should be your essential business strategy. It is no longer simply the right thing to do morally, ethically and philosophically, but it must also become your essential business strategy.

Dennis O’Leary, MD, President, Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Dr. O’Leary: A steadfast champion for patient safety.

Dr. Denham: You have been a tremendous supporter of the harmonization of the patient safety measures, standards, and practices. Can you share your perspective?

Dr. O’Leary: I think the obligation of the measurers is to create as much commonality as possible across the measures that are being used. That started with the contract that the Joint Commission signed with CMS in September 2004, to create not comparability, but identity between their corresponding measures, and not at the measure level but the data element level and to maintain that identity going forward over time.^{9,10} We also have a commitment that all of those measures will go through the National Quality Forum consensus development process. I think that starts to build a strong case that only the measures that have gone through the National Quality Forum should be used for measurement, for whatever purposes it is

being used. I think that is a major step forward and as you see initiatives like the IHI's 100 Thousand Lives Campaign,¹¹ the measurement activities being undertaken there, involve an upfront commitment that where there are common measures between the six planks in the IHI initiative, the Joint Commission, and CMS measures—those are the measures that are going to be used.

Dr. Denham: So it is reasonable to state that there is a light at the end of the tunnel—that all of these organizations are really dedicated to making things easier, to show some cohesion and alignment of their measures and objectives?

Dr. O'Leary: I think there is definitely a major effort to create alignment of measures among the major players. I also think it's fair to say that the bar is being raised in terms of public and purchaser expectations about measurement capability and that those expectations are pushing, if not outstripping the capabilities of hospitals to deliver. As we move into the world of Pay-For-Performance, not only are the expectations around the quality and integrity of measures high, the expectation of a broader scope of measures is there and I think it begins to really force the issue of the fundamental need for electronic health records.

Suzanne DelBanco, PhD, COO, The Leapfrog Group

Dr. Denham: The Leapfrog Group has vigorously supported the work in harmonization of the quality measures, standards, and practices. Why?

Dr. DelBanco: Healthcare purchasers want national measures and standards set for the safety and quality of health care. It is only with harmonization and standardization that purchasers, employees, retirees, and dependents for whom they buy health care, will be able to compare their choices and make informed health care decisions.

Dr. Denham: Are you pleased with the national response to The Leapfrog Group Survey in 2004? We understand that the 2005 response is even more vigorous.¹²

Dr. DelBanco: We are, 5 years after the IOM released its "To Err is Human" report, hospitals that are in a flurry of activity to reduce preventable mistakes and improve quality.² Through our voluntary survey, we are finding increasing uptake and implementation of the 30 practices for safer health care endorsed by the members of the National Quality Forum, though we still have a long way to go.¹²

Donald Berwick, MD, MPP, President, CEO, Institute for Health Care Improvement (IHI) and Visionary who Conceived and Launched the 100,000 Lives Campaign

Dr. Denham: As of the time of this interview, more than 2300 hospitals have responded to the 100,000 Lives Campaign and growing every day.¹¹ Are you surprised?

Dr. Berwick: I have always suspected that the energy for improvement latent in the workforce is great. The Campaign seems somehow to have unleashed that energy to a level I have not seen before. What does surprise me is that so many hospitals are willing to take the courageous step of admitting that we do have something this big to fix. That combination—facing reality plus the commitment to improvement—is a

wonderful foundation for progress. Now must come the hard work—to actually make changes. Implementation is the essential next step.

Dr. Denham: The campaign has significant overlap with other performance improvement initiatives. Was this intentional?

Dr. Berwick: The 100,000 Lives Campaign is consciously designed to overlap with and provide synergy with existing important national-scale leadership efforts, such as the NQF Safe Practices initiative, CMS areas of focus, and the Surgical Care Improvement Project (SCIP), to name but a few.

Mark McClellan, MD, PhD, Administrator for the Centers for Medicare and Medicaid Services (CMS)

Dr. Denham: What is your personal vision for patient safety and how important it is to America?

Dr. McClellan: I think it is extremely important. We can't afford to not move forward on patients' safety initiatives today. Medical errors are responsible for thousands of deaths, millions of hospitalizations, and many billions of dollars in added healthcare costs. In an era when we're concerned more than ever about rising healthcare costs, we simply can't afford not to do anything about it. The good news is that there are more proven methods out there, where evidence is available on steps that can be taken, by hospitals, by doctors' offices, and by other healthcare organizations to reduce patients' safety problems, to improve quality of health care, improve outcomes, and avoid the added cost of complications. So we need to get after it now and I intend to do that.

Dr. Denham: As you know, when the IOM's report came out and quoted 98,000 deaths in America,² there was a lot of resistance. However, now many experts believe that the numbers are greater. Do you have any comment?

Dr. McClellan: While the numbers may be greater, the bottom line is that there are a lot of preventable deaths that ought to be prevented and there are a lot of avoidable costs that need to be avoided. We have better opportunities than ever in the Medicare and Medicaid programs to address these problems. The new Medicare legislation gave us some new authorities and new funding and new opportunities to create incentives for healthcare organizations to take steps to improve safety and improved quality, so it's time for us to get after it.¹¹ It's time for us to take steps right now that improve safety and get the savings that can result.

Dr. Denham: What message do you have for those that are sitting on the fence regarding patient safety and quality? Do I jump in and really get engaged? Do I hang back? Is the Pay-For-Performance phenomenon really going to happen?

Dr. McClellan: I see more evidence than ever before that Pay-For-Performance approaches can work. We have more validated measures of quality. But they're starting to implement payment adjustments that depend on the production of quality measures and there's a lot of momentum for expanding the universe of those measures, and expanding the magnitude of these payment system adjustments so that the payment systems might be even more related to quality and performance; this is not just happening in Medicare, it's happening among other healthcare purchasers around the country.¹³

DISCUSSION

The Center for Medicare and Medicaid Services Quality Improvement Roadmap released in July of 2005 reinforces Dr. McClellan's passion and commitment to patient safety.¹⁰ Further, it emphasizes the importance of patient-centered care that is "the right care for every person, every time." The opening words of the document addressed the six IOM aims for improving US health care: patient safety, effectiveness, patient-centeredness, timeliness, and equity.

Throughout the CMS roadmap, the strategies of partnerships, development and utilization of quality measures, Pay-For-Performance, assistance in use of technologies, and access to better treatments are emphasized. All reinforce the importance of quality and harmony.¹⁰

Clearly all of the stakeholders are aligning. Most importantly, payment is clearly going to be more and more closely tied to the quality measures, standards, and practices as they evolve.

The NQF Safe Practices Maintenance Committee, Co-Chaired by this author and Dr. Gregg Meyer, formerly a visionary leader at AHRQ and now leader of the Massachusetts General Hospital Physician's Organization, is responsible for updating the 30 safe practices. Certain practices will be considered for removal from the endorsed list, some will be added, and a number will be considered for modification. The evidentiary base will be updated as will the practices to mirror their evolution since the original report.

The Four C Harmony

A major goal of the committee is to harmonize the practices across the key stakeholders including AHRQ, NQF, the JCAHO, The Leapfrog Group, the IHI 100,000 Lives Campaign, and CMS. The committee will "Crosswalk" the practices to each of the corresponding initiatives or standards of each organization. It will then seek to "Cross-language" the practices to more closely correspond with the initiatives, such that hospitals have the most clear and actionable path. The committee will identify opportunities for the organizations to "Cross-credit" activities by hospitals, so that they do not need to undertake duplicative efforts for full credit for initiatives that clearly overlap. Because all of the organizations mentioned above are all participating in the process as representatives on the committee, they have committed to "Cross-communicate" the ultimate harmonization. They will communicate how what they request of hospitals overlaps with the practices, standards, and measures. This will help drive home the synchronous approach hospitals can take to achieve top performance recognition across the board.¹⁴

From Pay-For-Perception to Pay-For-Performance

For decades, hospitals have been paid for perception. They have been rewarded by patronage of consumers and healthcare plans based on their brand and reputation, the credentials of doctors, and for winning their local medical arms race in technologies. For instance, in the 2005 US News & World Report's Annual "America's Best Hospitals" ranking, reputation is the only criteria for five specialties, based on a sampling of 200 board-certified physicians in the field.^{15,16}

For many specialties, current rankings depend partially on hard data from the field, such as mortality ratio, number and types of services, and care-related factors; however, perception and reputation are still major measures for ranking.

Dr. David Shore, in his recently released book, "The Trust Prescription in Healthcare: Building Your Reputation With Consumers," implies that "Healthcare is in the middle of a trust famine—a continuing, long-term decline in trust sustained by isolated acts of criminality, inhumanity, and medical error."¹⁷ These are biting words to providers, yet the data supports this decline.

The critics of Pay-For-Performance make the legitimate claim that, in the early reward programs, what we really have is Pay-For-Process. However, process measures, used as surrogates for outcomes, may not correlate as well with the patient's objectives of their care or outcomes as intended. In fact, preliminary examination of data from findings, based on a statewide evaluation of all Pennsylvania hospitals, has shown a disconnect between hospital outcomes (such as in-hospital mortality) and the quality measures (often referred to as "process measures") reported in "Hospital Compare (personal communication, Wolf August 2005)." Many Pennsylvania hospitals are ranked very high in process performance and yet, in the face of these excellent rankings, Pennsylvania recently became the first state to publicly report the toll that hospital-acquired infections take on patients—11,668 hospitalized patients suffered infections last year—with 1510 deaths and \$2 billion in hospital charges as a result.¹⁸ Clearly, we are but at the beginning of having the tools we need for tying our processes to real outcomes. In a perfect world, it would be best to have perfect measurement tools before Pay-For-Performance programs were developed; however, this will not occur as a practical reality.

The indications are that the payment for individual process measures is only a transitory period until outcomes and composite measures do evolve. The major market forces are aligning to drive real consensus in measures, standards, and practices.

True Pay-For-Performance is on the horizon. As mentioned earlier, change in healthcare time is admittedly excruciatingly slow. However, the eventual movement to true "patient-centered care" as carefully defined by the IOM is only a matter of time. The incentives are falling into place.

From Production-Centered Care to Patient-Centered Care

Blind purchasing by the federal purchaser, CMS, healthcare plans, and insurance companies, based on units of care with no check and balance for quality, has led to production-centered care. Driven by volume and revenue-generating provider behaviors, leading to batch-care where one size fits nobody, health care has become entirely fragmented to each patient.

The concept of patient-centered care, which is both an IOM aim and a design principle is defined as "healthcare that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and solicit patients' input on the education and support they need to make

decisions and participate in their own care.”¹⁹ The true meaning of Patient-Centered care is the least well understood and sometimes referred to by physicians who have not read the fine print above as “Kum-ba-ya care.”

Dimensions of patient-centered-care were referenced to Gertis et al. (1993)²⁰ within the landmark IOM (2001) report “Crossing the Quality Chasm” as: (1) respect for patients’ values, preferences, and expressed needs; (2) coordination and integration of care; (3) information, communication, and education; (4) physical comfort; (5) emotional support—relieving fear and anxiety; and (6) involvement of family and friends.

More recently, as technology and the concepts about patient-centered care have advanced, the definition for essential dimensions of patient-centered care has been refined by AHRQ to include but are not limited to: (1) accessible and customized information, communication, and education; (2) continuous collaboration, coordination, and integration of care among providers, across conditions and settings; (3) shared decision-making of clinicians with patients and their families; (4) self-efficacy and self-management skills for patients; (5) patients’ experience of care; (6) provider-patient partnership; and, (7) enhanced cultural competence of healthcare providers.²¹

A careful review of the 30 NQF Safe Practices,⁶ and those that are being emphasized by the certifying, purchasing, and quality organizations, reveals that many of these practices directly target gaps in patient-centered care defined above. They do so because most of the practices are information-centric.

These performance gaps have grown through revenue and profit-motivated production-centered care or have developed as a result of the increasing complexity of medicine required to treat older and older patients faster and faster.

In the future, there will be a check and balance; transparency will provide the check and Pay-For-Performance will provide the balance.

Leaders Must Ask: If Not—Why Not?

Harmonization is all well and good; however, the key question trustees, CEOs, senior leaders, and those in charge of quality at their hospitals must answer is; what action should they take?

In the words of Dr. Kenneth Kizer, the leader of the NQF, when he announced the release of the 30 safe practices report in May of 2003,⁹ “Providers can no longer suffer from ‘mural dyslexia’...where they can’t read the writing on the wall.” Leaders must not miss the changing tone of the quality chorus—their financial future depends on it.

Leaders must ask the “if not—why not” questions. Trustees must ask their CEOs whether their hospitals are submitters to “The Leapfrog Group” voluntary survey, pursuing the Baldrige Award, whether they are using AHRQ indicators for safety, whether they have committed to the IHI 100,000 Lives Campaign, and whether they are aggressively pursuing the JCAHO safety goals and standards. For each and every such initiative, they must ask the tough “if not—why not?” question. The answers will give them a clear place to roll up their sleeves. Quality leaders in hospitals must look themselves in the mirror and ask the same question.

The Quality Choir and the Conductor

Some things we do not know about the future and some things we do know. For instance, we do not know which voice of the quality choir will be the loudest, which purchasers will be most effective in leveraging the quality metrics, and how fast Pay-For-Performance will evolve.

We do know that the measures, standards, and practices are converging. We know that Pay-For-Performance will be a reality and that such reward programs will be coupled to the quality metrics.

We know that harmonization will occur and that in the end it will be the consumers who will be the ultimate conductor of the quality choir. They will demand patient-centered care and they will get it because they will be paying for it.

As time goes on, hospital leaders....like it or not....will join the chorus—or have to face the music alone.

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