The No Outcome–No Income Tsunami is Here: Are You a Surfer, Swimmer, or Sinker?

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A perfect storm is developing as this decade closes. Hospital investment revenue is in a free fall, self-pay revenue streams are at risk, and capital acquisition is challenging against a backdrop of a global financial collapse.

However, just when it could not get any worse, a tsunami that has been quietly building off-shore for years in a climate of stakeholder unrest now threatens all but the best prepared. New cresting workforce issues, transparency pressure, strained hospital-physician relations, and now Pay-for-Performance demands have been hammering our health care leaders in ever more powerful waves. They have now coalesced into an enormous force that is bearing down on our hospitals.

We contend that the drama that will play out on the health care stage will star what Malcolm Gladwell would call the "outliers"[1] from his book of the same name. They will be the leaders and organizations that exhibit true greatness in a new arena of quality performance.

NO OUTCOME–NO INCOME TSUNAMI

In 2004, Pay-for-Performance was just appearing on the horizon. Our article, "The No Outcome No Income Tsunami," was intended as an early-warning signal to health care leaders.[2] Now, almost 4 years later, we revisit the subject.

From "No Margin–No Mission"

To "No Outcome–No Income"

At that time, we were finding ourselves at the end of an era of blind health care purchasing. We believed that the mantra espoused by many health care leaders to encourage cost control of "No Margin–No Mission" would be replaced by the "No Outcome–No Income" call of many stakeholders led by purchasers.

Many hospitals have survived "playing defense" in the arena of quality. For some, every play of their game is to keep the revenue ball. Fixated on the "margin scoreboard," many have not worried about making quality touchdowns as long as the cash flowed and they contained cost.

In 2004, we felt that the broad cost containment methods that served administrators well in the past were not sustainable. We felt that limiting investments in patient safety, infection control, education, and workforce development would be the very strategies that would pull hospitals under in the future. The future is here.

CRITICAL QUESTIONS

A number of questions need to be answered to clarify the current crisis situation. They include the following:

(1) In light of the global financial woes, will hospital performance be a national priority?
(2) Is there really a hospital quality crisis, or has this been overblown?
(3) Who are the forces behind the tsunami, and will they be sustained?
(4) What will define hospital "greatness" in the new no outcome–no income era?
(5) What can organizations do to survive and even succeed with the tsunami?

SURFERS, SWIMMERS, AND SINKERS

We stated, in our early warning article, that there would be "surfers who will make things happen, swimmers who will watch what happened, and sinkers who will wonder what happened."

Surfers: Make Things Happen

The surfers will be the organizations who will leverage the power of the wave and blow by competitors who will be caught behind the curve.[2]

They will have read the horizon, aligned their teams on a common platform, developed their talent, ignited their passion, and put the strokes of hard work into action. They will catch the wave and almost magically accelerate away from the ranks. The science and art of improving-at-improving will demand a new-found respect of all administrators…especially those who become the "new losers" in this new era of performance.

Swimmers: Watch What Happens

The swimmers will likely feel as though they have been thrown overboard as they watch their competition rapidly pull away.

They will thrash around to address self-induced wounds in their quality systems. Those who have neglected or cut patient safety programs will end up increasingly reacting to events… playing defense. For instance, now that serious reportable events have to be reported to state agencies, such as in California, both Centers for Medicare & Medicaid Services (CMS) surveyors and the press show up (this occurred with 18 Southern California hospitals only months after the state policy became law).[3]

Once surveyors start following the threads of performance shortfalls, they can camp out at organizations inspecting ever more and finding more. This happened in California. This scrutiny generates a huge tax on already short-staffed departments, putting them even further behind on preventing events. Failure can become a self-fulfilling prophecy.

Swimmers will tread water to survive. Many will be out of the competition in quality and patient safety, and will be the prey of aggressive value-based purchasers.

Some will have time to get reorganized to compete and become surfers. However, they will need to act now.

Sinkers Wonder: What Happened?

The sinkers will be those organizations with a terminal case of "mural dyslexia." This condition is when one cannot read the writing on the wall. They will not survive the forces of the new health care economy. The snail's pace of health care change that has been a friend to the status quo will no longer be around. The organizations with poor patient safety performance will become poster children of shame.

DEFYING BUSINESS LAWS OF GRAVITY

Quality, cost, value, speed, and trust are intrinsically interlocked and tightly coupled. We can only defy the business laws of gravity for a time. In health care, time is measured in glacial minutes. However, like a ball being thrown in the air…what goes up, must come down.

The spending of the Medicare endowment payment program has been turbocharged by our free market economy and propelled our industry straight up, suspending the business laws of gravity…temporarily. For years, hospital revenue has been a "given," and the quality of services to the recipient of the services was in no way linked to payment.

Further, the microtransaction payment system of payment for activities rewarded those driving volume with no check and balance of quality. If hospitals and physicians had the patient volume and billed lots of reimbursable activities, their sustainability and success were assured. Hospital administrators were lulled into driving revenue and managing cost, and only cost.

Volume-Centered Care is in Clear and Present Danger

The gravitational pull of economic dynamics has now canceled this meteoric rise. Welcome to the business laws of gravity. Our reimbursement ball is coming down.

A NATIONAL PRIORITY

President-elect Obama, as recent as December 27, 2008, reiterated on national television that health care would be number 3 on his agenda of priorities after financial stabilization, and energy strategies, which put it above tax reform and education—clearly all important issues. (Oral Communication, Wolf Blitzer News. Dec. 27, 2008. 11AM ET CNN)

During 2008, the National Quality Forum (NQF) convened the largest and broadest quality coalition ever created, called The National Priority Partnership. It includes stakeholders from all sectors to establish National Priorities to bring about safer, more affordable patient-centered health care. Patient safety, including infections and care coordination (2 of their 6 priorities), specifically addresses safety in hospital performance and synchronizes with the NQF Safe Practices addressed in a later section.[4] These other 4 priorities include family and patient engagement, population health, palliative and end-of-life care, and overuse.

In addition, in the third quarter of 2008, the Chasing Zero Conference[5] was held, which addressed Healthcare-Associated Infections (HAIs), where the leaders of the Institute for Healthcare Improvement (IHI), NQF, The Joint Commission, The Leapfrog Group, CMS, and the Agency for Healthcare Research and Quality (AHRQ) declared that prevention of such infections was an issue that requires national priority status, thus complimenting such focus by the National Priority Partnership described above. These leaders were asked very specific and tactical questions, such as: "Will success in eliminating HAIs require that the typical hospital infection control department structure and function be scrapped and rebuilt?" Originally developed to detect infection outbreaks, most are not equipped to do more than auditing. Their answer on the record was: "Yes, absolutely." Infection control leaders and departments need to have the authority, accountability, and ability to drive performance improvement action.

So at that conference, these leaders of the most important quality, certifying, and purchasing organizations told hospital leaders what they need to do. They declared infection prevention a national priority.

When a senior CMS leader of the value-based purchasing initiative was recently asked whether the financial conditions or a change in the presidential administration would change or minimize the impact of implementation of the payment polices tied to hospital-acquired conditions (HACs), he stated that they would not and that the program is tied to statute.[6]

On December 19, 2008, the office of inspector general (OIG) briefed Congress about treatment in U.S. hospitals that caused prolonged hospital stay, permanent harm, life-sustaining intervention, or death to patients.[7] Hospitalized Medicare beneficiaries were surveyed by physician reviewers, who recorded outcomes based on definitions from both the NQF list of Serious Reportable Events and CMS's list of HACs. The level of harm was recorded based on an established harm scale.

The OIG revealed that 15% of the patients experienced 1 or more serious adverse events, according to the criteria of NQF's

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list of serious reportable events or CMS list of HACs. In addition to the serious harm reported, some of the patients experienced 1 or more temporary harmful events, such as a drug reaction that caused discomfort but did not result in serious harm.

Although these results are not nationally representative, the extent of adverse events and temporary harm found in this case study substantiates concerns about the incidence of adverse events in U.S. hospitals, and the importance of safety initiatives to reduce occurrences.

Just the fact that the OIG thinks harm is important enough to address and provide a formal briefing to the US Congress should speak volumes to hospital leaders. Again, new "writing on the wall."

Our first question was: In light of the global financial woes, will hospital performance be a national priority? The answer is a very clear "yes."

THE TSUNAMI FORCES

The growing energy layers of the tsunami, consisting of the quality experts, Congress, employers, certifiers, the media, consumers, standards organizations, and government payer forces, continue to build. New requirements and transparency demands are exploding in breadth and depth of impact.

Under a sea of complexity, long-ignored fault lines in the tectonic plate of health care finally snapped into a major fracture with unprecedented force. The early shock waves under the water line were first felt by quality leaders more than a decade ago, triggering a slow-motion chain reaction through Congress, then employers, the Joint Commission, the media, consumers, national standards organizations, and finally by government and third party payers. Each layer added to a rapidly growing and ever-surging tidal wave.

Quality Leaders, the Institute of Medicine, and Congress

Early testimonies of quality leaders such as Lucian Leape, often thought of as the father of patient safety, and Don Berwick, the North Star of quality and President and CEO of the IHI, 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) reporting to the U.S. Congress. The resulting report, *To Err Is Human: Building a Safer Health Care System*, catalyzed tremendous national attention and accelerated the momentum. The series of IOM reports that have followed this original work have underscored and detailed the opportunities for improvement.[8–12]

The incidence of preventable harm is clearly much greater now than was originally estimated during these early watershed events. Over the years we have seen the great success of the IHI's 100,000 Lives Campaign, which has saved more than 120,000 lives, the IHI's 5 Million Lives Campaign, affecting the safety of even more patients, and the recent recognition by the CDC that health care-associated infections cause almost 100,000 deaths per year alone.

At the 2008 IHI National Forum on Quality, it was reported from an analysis of the entire CMS database of beneficiaries that two-thirds of seniors over 65 who are admitted to the hospital with a medical diagnosis will either be readmitted or dead within 1 year. This is a very sobering finding soon to be published in detail.[13]

So the answer to our second question—is there really a quality crisis, or has the issue been overblown?—is clearly yes, we are in a major crisis, and no, it has not been overblown.

In fact, the rate of improvement in U.S. hospitals is arithmetic, while the rate and risk of systems failures is log-arithmic. Most safety leaders would agree that most hospitals are unsafe and that current quality improvement programs are falling further and further behind over time—what we thought was safe in the past will be unsafe in the future. See Figure 1 for a graphic presentation of performance trajectories in institutions that are "unsafe" versus those that give great care.

Leapfrog: A Pay for Performance Pioneer

Appalled with the preventable cost, loss of life, and suffering of their employees, U.S. employers became active and formed The Leapfrog Group in 1999. Now composed of more than 185 Fortune 500 companies and other large private and public sector health care purchasers, together, they wield more than $69 billion in annual purchasing power and represent more than 34 million covered lives.[14] The Leapfrog Group has clearly kept 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." (Arnie Milstein, MD, MPH. Oral Communication, November 22, 2008) He goes on to provide a message to such CEOs.

"If You Bet Your Job on High-Yield Performance Improvement, the Market Will Reward You"

Naysayers who argue that The Leapfrog Group has not moved market share need only look at the fine print of their current payer contracts. Many have adopted the Leapfrog measures.[15]

The Joint Commission

The Joint Commission has embraced the patient safety movement through its ever more important and growing safety standards and has joined The Leapfrog Group as an implementation partner and a harmonization partner of the NQF Safe Practices for Better Healthcare updates. Despite intense attention on the topics, the Joint Commission has found that patient safety compliance remains low and harm continues. All experiences confirm that the numbers often cited in the IOM reports are low estimates of a much larger problem. Dr. Peter Angood, Chief Safety Officer for The Joint Commission, believes that "hospital leaders need to synchronize their internal performance
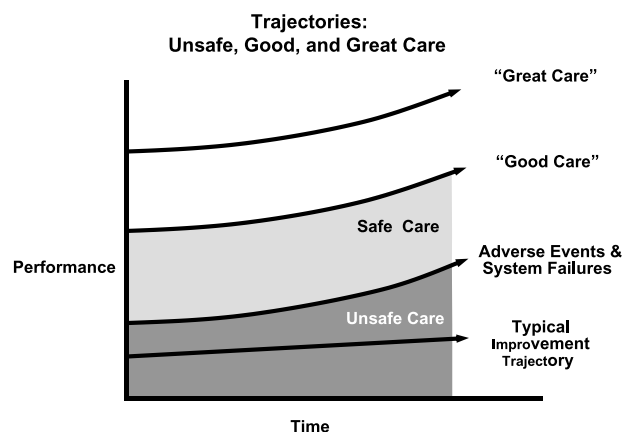

FIGURE 1. Trajectories: unsafe, good, and great care.

measures and incentives with the external measures now being required by external certifying, quality, and purchasing organizations in order to succeed in the future." (Oral Communication, Dec. 31, 2008).[16]

Media

The media have capitalized on the safety issue driving ratings since the 1999 IOM report. Unfortunately, some of them have followed some of the less edifying maxims of "If it bleeds, it leads" and "Never let the facts get between you and a good story." Other great contributors to the quality movement, like Laura Landro of the *Wall Street Journal*, have provided fair and balanced articles addressing critical issues.[17,18] Such constructive attention has helped drive the movement and saved lives.

Consumer Awareness

A sleeping giant that has just started to awaken is consumer awareness. Consumers are becoming increasingly informed and empowered and are now voting with their feet, especially now that costs are hitting their pocket book. Personal health care costs are a leading cause of bankruptcy…even for those with medical insurance![19]

National Quality Forum

Founded on the basis of the recommendation of the IOM, the NQF has become the major quality standard-setting organization in the U.S.[10] The serious reportable events mentioned earlier originated with the NQF. The NQF, with organizations such as AHRQ, IHI, The Joint Commission, The Leapfrog Group, and CMS, with support of organizations such as the Texas Medical Institute of Technology, have led the way in harmonizing national standards, such as the NQF Safe Practices for Better Healthcare, described in a later section, that are now being directly used for performance payment and safety compliance.

CMS and Government Forces

The Centers for Medicare & Medicaid (CMS) took the first step toward aligning Medicare payment with better quality through a Pay-for-Reporting initiative by launching the "Reporting Hospital Quality Data for Annual Payment Update" in an effort to get hospitals to voluntarily report quality measure performance.[20]

The recent implementation of the "no-pay" policy of CMS for preventable HACs has demonstrated that the tide is really turning and is clearly "pay for performance."[21,22]

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*From Pay-for-Reporting to
Pay-for-Performance to Pay-for-Improving*

CMS is clearly having discussions with major organizations about the concept of "Pay-for-Improving," so that hospitals generate credit toward financial incentives for improving over the prior year's performance. This is a sure sign to hospital leaders that being above average or the "cream of the crap"[23] will no longer keep them competitive in the future.

CMS has both "bait" and "stick" functions. Thomas Hamilton, Director of the Survey and Certification Group at CMS, the leader in charge of the army of surveyors which assesses health care organizations after bad events, represents the "stick" group. He recently said, "We know that hospitals dance in the spotlight, yet we know other things are going on in the dark." (Oral communication, June 30, 2008)[22]

The Pay-for-Performance quality bonuses and penalties being implemented by government, and now being embraced by private payers, signal an irreversible trend.[24] Federal and private payers are permanently resetting the market thermostat of tomorrow.[22]

Our third question was: Who are the forces behind the tsunami, and will they be sustained?

Clearly, there is more and more energy behind the wave, especially with the government payer forces at play. In an environment of financial bailouts, health care reform may not look as expensive as it once did.[25]

HOW WILL GREATNESS BE DEFINED?

There are consistent themes in the thinking and writings of some of our most gifted contributors to the national body of knowledge on leadership and organizational performance. That is the concept of "greatness."

Values Genetics

A universal finding is that great organizations have great leaders and that great leaders inspire and design organizations to behave consistently with a set of core values. The greatest organizations seem to unleash the talent within their people to aspire far beyond the norm for callings that are more social than financial.

Ann Rhoades, the people systems leader of Southwest Airlines and jetBlue, now in health care, tells us that leaders drive values, values drive behaviors, and behaviors drive performance. The collective behaviors define an organization's culture.

We recently established a "values genetics" model which describes the values-behaviors connection, where core values are like genes that are expressed in behaviors like traits. Behavior traits are mediated by conscious and unconscious choice and are predictable. The culture of an organization can intensify or suppress the expression of the values, not unlike the "nature versus nurture" dynamic we see in biologic systems.

In the article "Values Genetics: Who are the Smartest Guys in the Room," we reported on interviews of health care gurus about characteristics of the next generation of great health care leaders. Their responses were surprising. None of the gurus cited intelligence, skills, or knowledge. Incredibly, all of them cited human values like humility, courage, compassion, and integrity.

Recognizing in this article that values are the most important characteristic of great leaders, we depict measurable dimensions of Idealized Future Leaders in a radar chart.[26] See Figure 2.

They include personal core values; intelligence quotient; emotional intelligence quotient, a key ingredient for good collaborators; what we defined as performance intelligence quotient (a measure of competence or ability to administrate performance improvement methods); education; and credentials for the position; and finally knowledge and skills along the clinical, operations, and finance dimensions.[26]

Although there are certain common personal characteristics of great leaders, Bill George, a truly great leader in the health care device industry, author of *True North* and numerous articles, has taught us about authentic leadership and that there is no cookie cutter approach to leadership.[27] He and his colleagues state that "authentic leaders demonstrate a passion for their
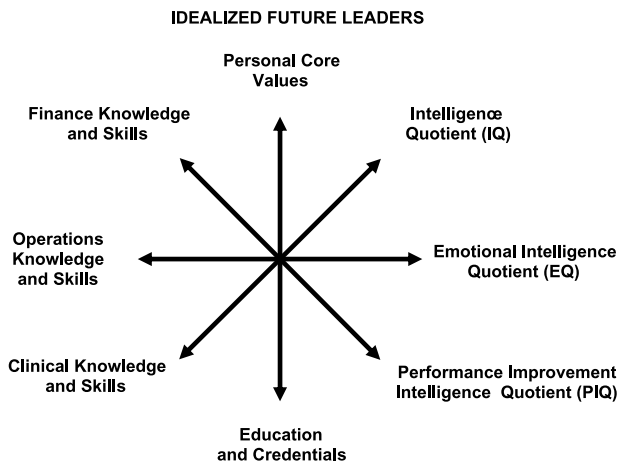
IDEALIZED FUTURE LEADERS

FIGURE 2. Idealized future leaders.

purpose, and practice their values consistently with their hearts as well as their heads" in their own unique way.[28]

Talent, Passion, and Hard Work (10,000 Hours of it)

In the book *Outliers*,[1] Malcolm Gladwell has identified characteristics of those who have attained greatness. They have talent and passion, and exhibit hard work. He proposes that the relationship between talent and success is a matter of attaining a certain threshold level, and that once that threshold is met, there is not a direct linear relationship between talent and success. He states that one must have passion, but that the characteristic of "super"—after reaching a certain threshold of talent—is attained after a lot of plain old hard work. The common denominator of those who have attained greatness across many diverse fields is

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TABLE 1. Seven Dimensions of Culture

Communication: high-performing organizations have very clear communication channels within their structures and systems, as well as excellent linkages with outside organizations. A great deal of consistent effort is placed on clear, simple communication throughout team structures and up and down the command chain.

Underlying Values: the real underlying values (which may not be those on the wall) drive everything about the organization. High performers mirror their values at every level. Leaders drive the values, values drive behaviors, and behaviors drive performance.

Leadership: the success of high performing organizations revolves completely around leaders at every level and around the structures and systems that they put into place that enable expression of the values through everything.

Teamwork: if teamwork is the gears of how we work collectively, then communication is the lubricant that allows this to be manifested. Great organizations have invested in the knowledge and skill development to build great teams. This does not happen unintentionally.

Unity and Trust: unity around a constancy of purpose cannot happen without trust. Trust is faith in the future performance and behaviors of others that is not yet seen.

Reliability: high-performance organizations are those that have either formally or informally adopted the characteristics of high-reliability organizations, as described by Weick et al.[26]

Energy state: cultures that are transforming or constantly improving have a capacity for extra effort over and above that needed to deliver basic care. Those with a fatigued and short-handed workforce are greatly handicapped in this area.

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that they have put in 10,000 hours of practice in their field. Furthermore, he states that great players have "accumulative benefits" over time that may not be solely due to talent, but more to opportunities which they create through their work and by virtue of circumstances out of their direct control. Gladwell's concepts spell good news for many of us who are not gifted in the extreme—we can win if we put in the effort.

Execution—The Make or Break

In other industries, CEOs are not fired for their strategies. They are fired for the failure to execute.

Don Berwick and leaders of IHI tell us that "ideas, will, and execution" are critical to the success of leaders.[29]

Bob Whitman and Bill Bennett of Franklin Covey, who have studied leadership and high performance organizations, state that "failure is due to inconsistencies in execution." They have defined 4 disciplines of execution: focus on wildly important goals, act on lead measures, create a cadence of accountability, and keep a compelling scorecard. They have found leadership must unleash the talent in an organization. [Oral communication, Dec. 19, 2008]

The Bus and Flywheel

Jim Collins, author of *Level 5 Leadership*, *Built to Last*, and *Good to Great*, has inspired us with business forensic analysis of great performance. Believing that leadership was often used as a "plug factor," he reluctantly came to the conclusion that leadership was the special ingredient of great organizations, and that such leadership was critical to an inflection point transformation from good to great.[30–32]

He told us that great organizations "get the right people on the bus," and they overcome the flywheel of inertia through disciplined people, disciplined thought, and disciplined action.

CULTURE—Corporate DNA

Through our research of 3,100 hospitals adopting the NQF Safe Practices, we have studied 7 elements of what we have coined "corporate DNA of High Performers." These include communication, underlying values, leadership, teamwork, unity, reliability, and energy state. See Table 1 for a more complete description of these elements.[26]

Graphically depicted in Figure 3, our CULTUREScan measure, the dimension of 1 clear vision (1 Vision, Care Leaders Corp. Austin, TX) has been added to the DNA set. We are finding, through study of hospital organizations, that those that
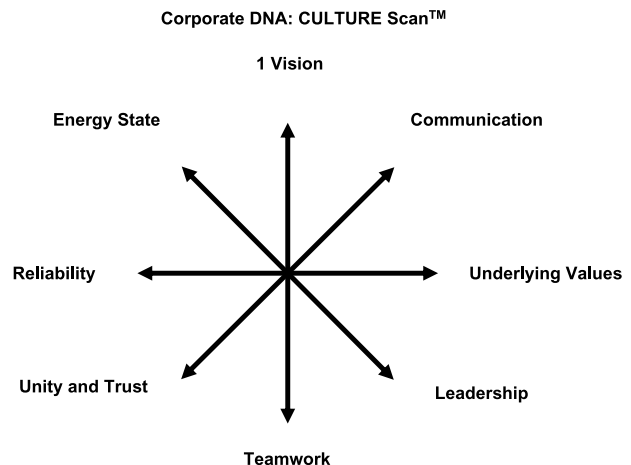
Corporate DNA: CULTURE Scan™

FIGURE 3. Corporate DNA: CULTUREScan.

recognize these dimensions and aspire to improve on them will have a higher likelihood to deliver great and safe care.

In the final analysis, hospitals are social organizations. If less than 25% of what we do clinically and technically is in the medical literature; if over 70% of what we do is implemented by people; and if national performance leaders are not all the big brand hospital systems or academic centers with great wealth; then even those typically skeptical of the "soft stuff" of human performance and great leadership need to take heed. Too often, we allow the skeptics and pessimists to trip up those who reach for the stars. Even Albert Einstein has reminded us that "great spirits have always encountered violent opposition from mediocre minds."[33]

SURFERS

The tsunami and surfing are merely metaphors to capture our attention and illustrate basic principles. We know that there will be a series of P4P waves. Like politics, all health care is dictated by local forces that vary. However, to most of us who have been paddling around our local ponds for years, these first waves will really seem like a tsunami.

To play out the surfing metaphor, let us look at the basic fundamentals of surfing and apply the principles of greatness to hospital leadership and performance.

Surfing basics require the following:
- understanding of the direction, force, and shape of the wave;
- a steerable solid platform that will provide lift and forward direction;
- skills to smoothly propel the platform forward to match the speed and direction of the wave; and
- ability to stand and balance the platform while controlling its trajectory.

Great hospitals that have prioritized quality created a unified safety platform like a surfboard and have real lift out of the chaos of public reporting. They clearly have an understanding of the wave or waves coming and are well positioned to take advantage of the new forces. Most importantly, they have been practicing and improving at improving. Like the seasoned surfer, they have put in the thousands of hours and made many thousands of attempts at riding waves. Thus, they have been building reliable skills at propelling themselves forward and balancing the forces of gravity and the waves.

Anyone who has tried the sport realizes that a great athlete cannot just jump on a board and surf. The many failures at catching waves are more instructive about the fundamentals than is the great ride.

As Gladwell would say, a threshold of talent, real passion, and most importantly many hours of practice make for greatness.

There may not be any organizations that have attained true greatness across their entire enterprise, however there are many that are aspiring to be great and have established greatness in some service lines. They include Geisinger Health System in Danville, PA, Virginia Mason in Seattle, WA, and the Brigham and Women's Hospital in Boston, MA, to name a few.

Geisinger Health System has integrated 40 critical steps that anyone undergoing coronary bypass surgery should have performed. However, they assure in their ProvenCare model that these steps are taken for every patient every time. They have been able to turn the tables on health care payers and have guaranteed their outcome and pay for their own complications. Recognized in the medical literature and lay innovation press, they are clearly surfing in cardiac care.[34,35] Although quality and safety was their vision, financial success was an outcome. They have driven margin up over 100% while reducing readmissions by 45%. The unschooled finance leaders may jump to the conclusion that they are losing margin from readmissions; however, readmissions are loss leaders—15% of hospital beds are occupied by readmissions and they consume 60% of hospital resources.[36]

Virginia Mason Hospital has trained more than 300 people in Japan in the Toyota performance improvement methods and has been able to dramatically improve services that are being recognized by the international community.[37] This is another hospital which is surfing the quality waves in specialty care. Their governance board set the tone for the direction and was a winner of a special Leapfrog Group Governance award.

The radiology department of the Brigham and Women's Hospital is setting a whole new bar in performance improvement. A top-tier Leapfrog hospital, it is pioneering new developments in health information technology that reduce inappropriateness of imaging studies while guiding referring physicians to the right studies. Their work is so extraordinary that it has been embraced by some health care purchasers who now require their software be used for approval of studies. The hospital wins, patients win, and payers win with the cost coming out of waste. The energy of Dr. Ramin Khorasani, coupled with the radiology leadership of Dr. Steven Selzer and support of their CEO, Dr. Gary Gottleib, is a winning combination. (Oral Communication, Dec. 2, 2008, RSNA Meeting)

Greatness is an addiction, and to quote a lyric from the Beach Boys, there is nothing like it. ("Catch a Wave")

"Catch a Wave and
You are Sitting on Top of the World"

Finally, a factor that re-enforces the concept of accumulative advantage and helps explain why winners keep winning is confidence. Rosabeth Moss Kanter, the famous business guru, in her book *Confidence: How Winning Streaks and Losing Streaks Begin and End*, addresses winning streaks and losing streaks.[38] She observes that what confidence makes more likely is that people and teams will analyze problems, face them head-on, communicate, and cooperate with those whose support they need. They take the initiative to make adjustments or try innovations. She says that "people with confidence can count on themselves, count on other people, and count on shaping events."

Before we address the swimmers, we will provide a framework and a step-by-step approach below that all can use to help make their organizations better surfers.

NQF SAFE PRACTICES: A HOSPITAL SURFER'S GUIDE

The NQF Safe Practices for Better Healthcare—2009 update is the most harmonized set of national standards ever developed. Consisting of 34 practices to be released in the first quarter of 2009, it provides a clear guide for U.S. hospitals and health care organizations.[39]

Consistent with the surfing metaphor, this set of Safe Practices provides a clear platform design for forward motion. It lays out the job for leaders to balance resource needs with performance, and it defines key actions that hospital teams must execute to align with the direction and pace of the new waves of quality demands.

Why are the NQF Practices so Important?

These Safe Practices clarify the roles of leadership in health care organizations, and most importantly they will be used by payers, certifiers, and quality organizations to drive compensation and transparency. We have detailed them in another recent publication.[40]

"Not Just the Right Thing to Do…
The Right Thing to Do to Get Paid"

They are harmonized across the measures, standards, and practices of the original harmonization partners of NQF, The Joint Commission, The Leapfrog Group, the AHRQ, and the CMS HACs.

These practices have also been synchronized with new guidelines developed by organizations focused on HAIs. They include the Infectious Disease Society of America, the Society for Healthcare Epidemiologists of America, the Association for Professionals in Infection Control and Epidemiology, the American Hospital Association, and the Centers for Disease Control and Prevention.[41]

How can Leaders Systematically Apply
"Greatness Principles" to Improve?

By using the surfing metaphor and applying the greatness principles described earlier, we can explore a step-by-step adoption of the NQF practices.

Step 1: Determine Your "Is State"

There are no shortcuts. Winning involves courage, investment, and plain old hard work.

The CEO, the C-Suite, and the governance team need to have a cold, hard reality check. If you are not already pursuing safety as your number 1 strategic focus, you are likely unsafe and need to make a change. Look at the dimensions of your
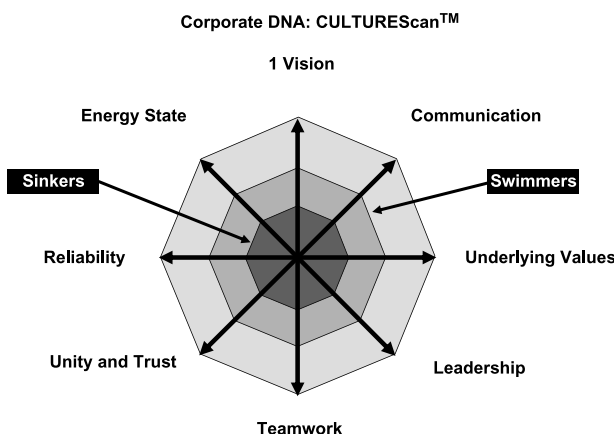

FIGURE 4. Corporate DNA: CULTUREScan.

corporate DNA (Fig. 4) and think about the dimensions of idealized leaders we have provided. See Figures 2 and 4.

If you are not in the top deciles of quality and safety measures, or a leader in national collaboratives, such as those run by the IHI, then this "Is State" approach may explain why.

An established improvement formula that is built into the activities for leaders in the NQF Safe Practices, and used in Leapfrog pay-for-performance safe practices surveys, is the 4A Model of Adoption. They include "Awareness, Accountability, Ability, and Action."[42]

- Hospitals must be fully aware of the performance gaps—both the national numbers and their own numbers.
- Leaders must be personally accountable for closing 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.

Compare yourself to the top safety leaders, not to the average. Average hospitals are in for a world of hurt both for their patients and their leaders in the next decade if they do not transform.

Step 2: Disciplined People

Taking our direction from Jim Collins, we need to get the right people on the bus—ideally with what he describes as Level 5 Leaders at the helm.[30] Ann Rhoades tells us how to build everything on and through the declared core values of the organization. Bill George tells senior leaders to be authentic and to live their values.

- Core values: leaders need to reconfirm them, define expected behaviors of everyone for each of them, and select or remove players from the team who do not have them. The NQF Safe Practice 1, Leadership Structures and Systems, defines activities for governance board members that include verifying that the organization is behaving consistently with the values…in writing.
- Some may need to go: in the words of the dying Professor Randy Pausch, author of *The Last Lecture*, "If there is an elephant in the room—introduce him," when he discussed the seriousness of his disease. If ANYONE on the governance or administrative leadership team is not prepared to make every decision on the basis of adherence to the core values, he must be dealt with fairly. Graciously and thoughtfully, he must be invited to serve elsewhere. If an organization is not prepared to do that, the pursuit of excellence is fruitless and the exercise of this approach will be a charade.
- Patient safety officer with accountability and authority: safe Practice 1 also requires that a Patient Safety Officer be appointed. Is your safety officer someone who "drew the black bean" and had this duty already added to an overwhelming list of duties, or do you have someone on the bus who will have the full knowledge and skill set required to serve you? We have defined such requirements in prior articles. Does this person have both accountability and authority to make changes?[43]
- New information flow: the practices also define new roles for leaders of nursing, pharmacy, and medical staff to have access to governance and administrative leaders to provide the information and feedback necessary to ensure safety. A simple examination of meeting schedules and information reporting systems against the safe practices will find most hospitals reconfiguring structures and systems.

Step 3: Disciplined Thought

Collins tells us that we have to have the courage to look in the mirror and face the brutal facts. He says we must then focus on our "Hedge Hog," or the intersection of what we can be the best at, where we have the greatest passion, and what drives our economic model.

• Safe practice 4, identification and mitigation of risks and hazards: this practice defines the real meat of tying resources to risk and performance improvement. Least implemented, it is likely that this area will be of greatest focus in the next decade. It defines the integration of risk management and performance improvement.

• Systems redesign: the surfers have taken a careful look at their major service lines and silos of service and have come to the conclusion that they have to re-frame their work around their strengths, protect against their weaknesses, and optimize performance against financial issues. Clearly, this must be undertaken in a manner that requires much more detail than can be addressed here. The function-specific NQF practices provide a perfect mechanism to redefine performance requirements.

Step 4: Disciplined Action

Collins provides us with the concept of disciplined action, and Gladwell provides the evidence that no one achieves greatness without practice. The leaders of Franklin Covey address the make-or-break issue of execution.

With the sea change ahead, there will be a C-Suite change in the roles of great organizations. As Henry Adams, the American historian and the grandson and great-grandson of presidents said, the president or leader "resembles the commander of a ship at sea. He must have a helm to grasp, a course to steer, a port to seek."[44,45]

Governance Teams

We use the word "team" here because in great organizations that is what they are—and they provide the vital *leadership* and precious *resources* and ensure that there is a *system* of accountability to succeed. Dr. David Hunt, a gifted surgeon who represented CMS on the NQF Safe Practices team, reminds us through the story of adoption of modern sterile technique that these 3 elements are critical, and that without them we fail. The principles of sterile technique were developed by Dr. Joseph Lister in the UK, yet he faced challenges driving adoption. Dr. Theodor Billroth in the 19th century was able to successfully adopt the principles because he had the advantage of leadership engagement, resources, and a system or systematic approach to implementation. (Oral communication, December 9, 2006).[22] Your governance team will give you what you need to build and steer your safety platform to surf the waves ahead.[46]

• CEOs, COOs, and CFOs: our top administrative leaders with the most power must make the organization's vision vivid and real—we need to be able to visualize that port we seek. Success is never a straight line journey. Leaders must keep us on course. They must have their hands on the controls that leverage immediate feedback and adjustment to the performance systems that affect their ships. If they are not living the behaviors that paint the values in all they do, they are sending a message.

• Chief nursing officers: our CNOs at great organizations will have more authority and accountability. They will assume the role of talent development and people systems performance, instead of merely managing nursing policy issues. Safe Practice 9 (Implement critical components of a well-designed nursing workforce which mutually reinforce patient safe-

guards) reinforces the requirement for their input and role in safety, defined in the first Safe Practice addressing leadership. It is the actions of nurses at the bedside that drive most NQF Safe Practices!

• Chief quality and safety officers: in great organizations they will be less in the "audit business" and more in the "action business" than they are today. They will have more authority and accountability for performance. They will be, in some cases, "the Chief Revenue Preservation Officer."[22] They will be your lookout for new waves to come and will help redesign systems for infection control, integrate risk management and performance improvement.

• Chief information officers: Our CIOs often think of their role as I.T. - information technology. They agree that their role is 90% T and 10% I—that is to say, their primary job is to get the technologies implemented and running. In the next 5 years, we believe that they will be 10% T and 90% I. The technologies will be stabilized, and clinical and nonclinical leaders will depend on them for actionable information to reduce risk and optimize performance. To them, we say, "get ready."

Risk Officers and Managers

There is and will be an ever-changing role for those in risk management. They will be less in the claims management and financial asset protection business, and more in the anticipatory risk identification and mitigation business. They will work very closely with the quality teams and help with early recognition and warning initiatives that prevent high impact, low frequency events. See the existing Safe Practice 4 (Risk Identification and Mitigation), which defines an entirely new collaborative role between risk and performance improvement groups. National leaders in disclosure and care of the caregiver after adverse events, such as Dr. Tim McDonald of the University of Illinois, who is known for the expression "stop the bleeding and start the healing" (oral communication, December 8, 2008) and Rick Boothman of the University of Michigan, who has pioneered a principled approach to adverse events, should be the mentors of everyone in risk management. Their session at the 20th IHI National Forum, entitled "Extreme Honesty: A Healthier Response to the Malpractice Threat," presented December 8, 2008, addressed risk issues.

Everyone must work to develop a culture of quality entrepreneurship, systems optimization, and most importantly, measurable high-reliability execution. Otherwise, failure is
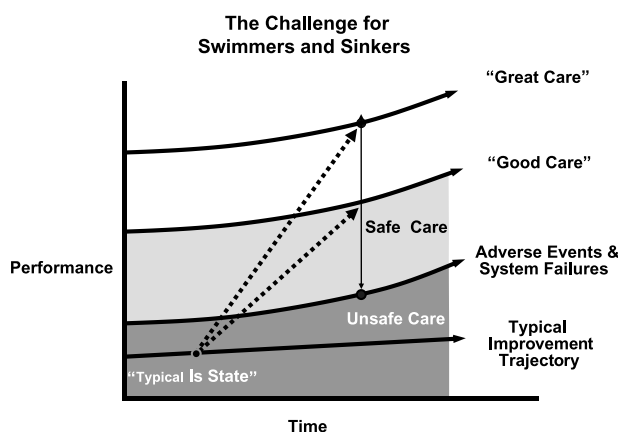

FIGURE 5. The challenge for swimmers and sinkers.

inevitable. In short, as is often quoted by many, culture eats everything for lunch.

SWIMMERS

There will be hospitals that do not catch the first wave. That does not mean that they would not surf. It does mean that they will likely have a tougher time, like the surfer who tries to regain the composure necessary to coordinate an offensive attack on a wave set while being pummeled by the last set. See Figures 4 and 5.

Star organizations of the present and past, like some cited in publications such as *US News and World Report*, have terrific "silo strengths" and great national brands. Some will find enterprise systems performance and continuity of care failures to be a crushing blow.

Some will do what Collins says great leaders do: look in the mirror and face the brutal facts. Others will act like a once-great athlete, trying to glide on past glories. It is only too easy to start to believe one's own press releases.

Many who are at risk for becoming swimmers will have leveraged success by simultaneously ramping up silo revenue while clamping down on silo cost control, thus ignoring enterprise systems performance. Patients flow across silos, with adverse events commonly occurring along their path at silo interfaces.

In the case of the swimmers, their Patient Safety Officers will be a lifeline for their patients and a life jacket for their CEOs.[43] How well they will survive depends on how fast they can strap together their silos and become patient-centered. Pride goeth before the fall, and humility is a rare commodity in the C-Suite of former industry leaders who ignored the sea change.

For some of the swimmers suffering from more mercenary profit-driven cultures, we will have to rehabilitate their leaders who may have been deluded by the Wall Street and business school religion of "What's in it for me?" and adopted an "end justifies the means" behavior model. Such organizations may have compromised patient safety and rationalized harming patients through situational ethics and moral relativism—"I need to make more money to serve, and harm is a cost of doing business."

Some swimmers will be the former stars of the finance-centered game who are suffering what Jim Collins intimates about the stages of the fall from greatness. In national speeches, such as the 2006 AHA Meeting held in San Diego, he has told us that studies of great organizations that have fallen show sequential stages of demise. First is arrogance; followed by becoming insular, then—as performance slips—there is a stage of denial. This is followed by a stage of grasping at other business models or expansion. They are then plagued by broad, inconsistent performance that leads to capitulation. Rarely is the fall related to technology or product failure, and is always due to leadership failure. Again, that plaguing issue of leadership is at the heart of performance.

SINKERS

Sadly, there will always be the laggards. Everett Rogers, the author of *Diffusion of Innovations* who is best known for the theory by the same name, defined the very last adopters of a new innovation as "laggards." They were defined as individuals who are critical to new ideas and become adopters when something has become mainstream or even tradition.[47]

In light of the rapidity with which the tsunami-like changes will occur, seemingly out of nowhere, laggard organizations are likely to have certain risk for sustainability, unless

their environment is so shielded that they are the only game in town.

Laggard individuals are increasingly easy to pick out in an organization. They debate the business case for doing the right thing for patients.

They are often the same people who argue that resources should not be given to patient safety unless hospitals are paid extra for such programs.

It is time to remind them that they are no longer defying the business laws of gravity and that principles of other businesses now apply.

It is Not About ROI—It is About SIB: Stay in Business!

Debating the business case for patient safety is as foolish as a restaurant debating the business case for refrigeration. It is not about ROI. It is about SIB: Stay In Business. Restaurants cannot charge a new price point for safe food any more than we can wait for new payment to deliver safe care. Market forces will not allow it.

Still others will argue that it is not at the time of financial crisis that we should invest in safety and quality issues that affect tomorrow's payment.

Fortunes are Not Made in Boom Times … That is Merely the Collection Period

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Perhaps we can take some solace in the words presented by Bob Whitman, CEO of Franklin Covey, as a quote from George Wood Bacon, "Fortunes are not made in boom times… That is merely the collection period. Fortunes are made in depressions or lean times when the wise man overhauls his mind, his methods, his resources, and gets in training for the race to come." (Oral communication, December 8, 2008)

A DEFINING MOMENT

Hospital leaders have little time left to decide who they and what their organizations are going to be.

This is a defining moment…it will define you or you will define it. Will your organization be a surfer, swimmer, or sinker?

It will take the conscious choice of leaders to build your board, learn the waves, develop the work strokes to gain speed, and gain the balance to takeover your destiny. To quote Dr. Bill Scharff of OSF Healthcare "failure is the path of least resistance." (Oral Communication December 8, 2008)

Clearly, great organizations continuously "face the brutal facts" to become great; however, we share a final quote from Theodore Roosevelt for those who less constructively find fault with those who seek greatness. We provide it for the recreational critics who pride themselves on being skeptics, many who pretend they have some special intelligence and critical thinking skills, when in reality they may be deluded, afraid, bluffing, or jealous and "playing defense" for the status quo.

The No Outcome–No Income Tsunami

It is not the critic who counts: not the man who points out how the strong man stumbles or where the doer of deeds could have done better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood, who strives valiantly, who errs and comes up short again and again, because there is no effort without error or shortcoming, but who knows the great enthusiasms, the great devotions, who spends himself for a worthy cause; who, at the best, knows, in the end, the triumph of high achievement, and who, at the worst, if he fails, at least he fails while daring greatly, so that his place shall never be with those cold and timid souls who knew neither victory nor defeat.

(Speech at the Sorbonne, Paris, April 23, 1910, "Citizenship in a Republic.")

REFERENCES

1. Gladwell M. *Outliers: The Story of Success*. Boston (MA): Little, Brown and Company; 2008.

2. Denham CR. The no-outcome no-income tsunami: surviving "pay-for-performance." Focus on Patient Safety. *The National Patient Safety Foundation*. 2004;7(1):1–3. Available at http://npsf.org/paf/npsfp/fo/pdf/Focus2004Vol7No1.pdf. Last accessed January 5, 2009.

3. Clark C. *4 Hospitals Penalized for Serious Mistakes. Facilities Fined $25,000; Death, Patient Harm Cited*. The San Diego Union Tribune. 2008:A–1.

4. National Quality Forum. National Priority Partnership. Available at http://www.qualityforum.org/about/NPP. Last accessed January 3, 2009.

5. Chasing Zero Summit. Hospital-Acquired Infections. Available at http://www.cardinalhealth.com/chasingzero/HAI/FAQs/. Last accessed January 2, 2009.

6. Valuck TB. CMS Listening Session for Public Comment on Hospital-Acquired Conditions. TMIT recorded communication, presented December 8, 2008, to a national audience. Available at http://www.safetyleaders.org/pages/idPage.jsp?ID = 4917. Last accessed January 2, 2009.

7. Levinson DR. Department of Health and Human Services. Office of Inspector General. Adverse events in hospitals: case study of incidence among Medicare beneficiaries in two selected counties. OEI-06-08-00220. Available at http://oig.hhs.gov/oei/reports/oei-06-08-00220.pdf. Last accessed January 5, 2009.

8. Kohn LT, Corrigan JM, Donaldson MS, eds. *Committee on Quality of Health Care in America, Institute of Medicine. To Err is Human: Building a Safer Health System*. Washington, DC: The National Academies Press; 2000. Available at http://www.nap.edu/catalog.php?record_id = 9728. Last accessed January 5, 2009.

9. Hurtado MP, Swift EK, Corrigan JM, eds. *Committee on the National Quality Report on Health Care Delivery, Board on Health Care Services. Envisioning the National Health Care Quality Report*.

Washington, DC: The National Academies Press; 2001. Available at http://www.nap.edu/catalog.php?record_id = 10073. Last accessed January 5, 2009.

10. Committee on Health Care in America, Institute of Medicine (IOM). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: The National Academies Press; 2001. Available at http://www.nap.edu/catalog.php?record_id = 10027. Last accessed January 5, 2009.

11. Adams K, Corrigan JM, eds. *Committee on Identifying Priority Areas for Quality Improvement. Priority Areas for National Action: Transforming Health Care Quality*. Washington, DC: The National Academies Press; 2003. Available at http://www.nap.edu/catalog.php?record_id = 10593. Last accessed January 5, 2009.

12. Page A, ed. *Committee on the Work Environment for Nurses and Patient Safety. Keeping Patients Safe: Transforming the Work Environment of Nurses*. Washington, DC: The National Academies Press; 2004. Available at http://www.nap.edu/catalog.php?record_id = 10851. Last accessed January 5, 2009.

13. Boutwell A, Jencks S, Nielsen G, et al. Reducing Re-hospitalizations in a State or Region. Minicourse M1. Presented at the Institute for Healthcare Improvement's 20th Annual National Forum on Quality Improvement in Health Care; November 19, 2008; Nashville, TN. Available at http://www.ihi.org/ihi/files/Forum/2008/Handouts/M1_ReducReHosp_Boutwell.pdf. Last accessed January 5, 2009.

14. The Leapfrog Group Website. Available at http://www.leapfroggroup.org./. Last accessed January 2, 2009.

15. Landro L. Doctors and hospitals find they can't stay offline any longer. Reprinted with permission by Healthcare Information and Management Systems Society (HIMSS). Available at http://www.himss.org/ASP/ContentRedirector.asp?ContentId = 17320. Last accessed January 5, 2009.

16. The Joint Commission. The Joint Commission: Mission-Related Commitments. N.D. Available at http://www.jointcommission.org/AboutUs/mission_commitments.htm. Last accessed January 5, 2009.

17. Landro L. Curbing antibiotic use in war on 'superbugs.' Wall Street Journal. September 3, 2008. Available at http://online.wsj.com/article/SB122039916170892933.html. Last accessed January 5, 2009.

18. Landro L. Health care industry agrees on set of rules for patient safety. Wall Street Journal. November 1, 2008. Available at http://online.wsj.com/article/SB116234626074809703.html. Last accessed January 5, 2009.

19. Himmelstein DU, Warren E, Thorne D, et al. MarketWatch: illness and injury as contributors to bankruptcy. Health Affairs Web Exclusive. February 2, 2005. Available at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.63v1. Last accessed January 5, 2009.

20. QualityNet. Available at http://www.qualitynet.org/dcs/ContentServer?cid = 1120143435363&pagename = QnetPublic%2FPage%2FQnetHomepage&c = Page. Last accessed January 5, 2009.

21. Centers for Medicare & Medicaid Services. Hospital-Acquired Conditions and Present on Admission Indicators. Reporting Listening Session Leader: Tom Valuck. December 17, 2007, 10:00 am ET. Transcripts from the listening session available at http://www.cms.hhs.gov/HospitalAcqCond/07_EducationalResources.asp#TopOfPage. Last accessed January 5, 2009.

22. Denham CR. CEOs: meet your new revenue preservation officer…your PSO! *J Patient Saf*. 2008;4(3):201–211.

23. Bell J. Definition for Cream of the Crap: A company, product, or service whose only notoriety is derived from the fact that it is of the lowest possible quality. In: Peckham A [compiler]. *The Urban Dictionary*. Kansas City (MO): Andrews McMeel Publishing LLC; 2005.

24. Agency for Healthcare Research and Quality (AHRQ). Pay for Performance: A Decision Guide for Purchasers. Phase 2. Design. Question 7: Should we use carrots or sticks - bonuses or penalties - or a

combination? Available at http://www.ahrq.gov/qual/
p4pguide2.htm#q7. Last accessed January 5, 2009.

25. 2008 National Policy Conference: Quality at the Crossroads. 9th Annual
Meeting. Arlington (VA) National Quality Forum: October 15–17, 2008.
Available at http://www.qualityforum.org/2008_npc/agenda.asp. Last
accessed January 5, 2009.

26. Denham CR. Values genetics: who are the real smartest guys in the
room? *J Patient Saf*. 2007;3(4):214–226.

27. George B. *True North: Discover Your Authentic Leadership*. San
Francisco (CA): Jossey-Bass; 2007.

28. George WW, Sims P, McLean AN, et al. *Discovering Your Authentic
Leadership*. Cambridge (MA): Harvard Business Review; 2007 Feb.
Available at http://harvardbusinessonline.hbsp.harvard.
edu/hbsp/hbr/articles/article.jsp;jsessionid = GM4IP0JP3DZ
PYAKRGWDSELQBKE0YIISW?ml_action = get-article&articleID =
R0702H&ml_page = 1&ml_subscriber = true. Last accessed
January 5, 2009.

29. Reinertsen JL, Bisognano M, Pugh MD. *Seven Leadership Leverage
Points for Organization-Level Improvement in Health Care. IHI
Innovation Series White Paper* (2nd Ed). Cambridge (MA): Institute for
Healthcare Improvement; 2008. Available at http://www.ihi.org/IHI/
Results/WhitePapers/SevenLeadershipLeveragePointsWhitePaper.htm.
Last accessed January 5, 2009.

30. Collins J. Level 5 Leadership: The Triumph of Humility and Fierce
Resolve. *Harv Bus Rev*. 2001;79(1):66–76, 175.

31. Collins J. *Good to Great: Why Some Companies Make the Leap… and
Others Don't*. New York (NY): HarperCollins; 2001.

32. Collins J, Porras JI. *Built to Last: Successful Habits of Visionary
Companies*. New York (NY): HarperCollins; 1994.

33. Einstein A. ThinkExist.com Available at http://en.thinkexist.com/
quotation/great_spirits_have_always_encountered_violent/
145937.html. Last accessed January 5, 2009.

34. Carbonara P. Geisinger Health System's Plan to Fix America's Health
Care. Fast Company 2008 Oct:129. Available at http://www.
fastcompany.com/magazine/129/the-cure.html. Last accessed
January 5, 2009.

35. Darves B. Physician pay-for-performance programs taking hold. New
England Journal of Medicine. NEJM Career Center. Career Resources
for Physicians. 2007 Dec. Available at http://www.nejmjobs.org/
career-resources/pay-for-performance.aspx. Last accessed
January 5, 2009.

36. Denham CR, Dingman J, Foley ME, et al. Are you listening…are you
really listening? *J Patient Saf*. 2008;4(3):148–161.

37. The Leapfrog Group Announces the Winners of Two New Health
Care Quality Awards [press release]. Washington, DC: The Leapfrog
Group; January 24, 2007. Available at: http://www.leapfroggroup.org/
media/file/Release_-_Quality_awards_winners.doc. Last accessed
January 5, 2009.

38. Kanter RM. *Confidence: How Winning Streaks and Losing Streaks
Begin and End*. New York (NY): Crown Business; 2004.

39. National Quality Forum Safe Practices - 2009 Update. Available at
http://www.qualityforum.org/projects/ongoing/safe-practices/. Last
accessed January 5, 2009.

40. Denham CR. A growing national chorus: the 2009 Safe Practices for
Better Healthcare. *J Patient Saf*. 2008;4(4):253–260.

41. Yokoe DS, Mermel LA, Anderson DJ, et al. A compendium of strategies
to prevent healthcare-associated infections in acute care hospitals.
Infect Control Hosp Epidemiol. 2008;29Suppl 1:S12–21. Available at
http://www.journals.uchicago.edu/doi/pdf/10.1086/591060. Last
accessed January 5, 2009.

42. Denham CR. Patient safety practices: leaders can turn barriers into
accelerators. *J Patient Saf*. 2005;1(1):41–55.

43. Denham CR. The new patient safety officer: a lifeline for patients, a life
jacket for CEOs. *J Patient Saf*. 2007;3(1):43–54.

44. PBS. American Experience. The Presidents. Available at http://
www.pbs.org/wgbh/amex/presidents/. Last accessed January 5, 2009.

45. Denham CR. Leaders need dashboards, dashboards need leaders.
J Patient Saf. 2006;2(1):45–53.

46. Anderson KM, Schulke K. *Linking Public Accountability to
Quality Improvement. Hospitals & Health Networks (H&HN)*. Chicago
(IL): Health Forum Inc.; 2008 Nov. Available at http://www.hhnmag.
com/hhnmag_app/jsp/articledisplay.jsp?dcrpath = HHNMAG/Article/
data/11NOV2008/0811HHN_FEA_QualityUpdate&domain =
HHNMAG. Last accessed January 5, 2009.

47. Rogers EM. *Diffusion of Innovations*. 5th ed. New York (NY): Free
Press; 2003.

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