

## 2008 Subject Index

### 5 Million Lives Campaign

- Case Study: Getting Boards on Board at Allen Memorial Hospital, Iowa Health System (Slessor S.R., Crandall J.B., Nielsen G.A.). Apr., 221–227.
- Getting Boards on Board: Engaging Governing Boards in Quality and Safety (Conway J.). Apr., 214–220.
- Improved Care for Patients with Congestive Heart Failure (Jacobsen D., Sevin C.). Jan., 13–19.
- Case Study: Enhancing Effective and Efficient Congestive Heart Failure Management at Columbus Regional Hospital (Dunscob J., Hull B.). Jan., 20–26.

### The 2008 American Hospital Association–McKesson Quest for Quality Prize®

- Munson Medical Center: Embedding a Culture of Safety and Quality Improvement into the Organization (Haslinger T.). Nov., 665–670.
- University of Michigan: Quality and Safety in an Academic Medical Center (Strong D.L., et al.). Nov., 671–677.

### The 2008 John M. Eisenberg Patient Safety and Quality Awards

#### Individual Achievement

- An Interview with Michael Cohen (Bates D.W.). Dec., 693–696.
- Innovation in Patient Safety and Quality at the Local Level*
- Transparency as a Pillar of Quality and Safety Culture: The Experience of the New York City Health and Hospitals Corporation (Audet A-M.J., et al.). Dec., 707–712.
- Innovation in Patient Safety and Quality at the National Level*
- The National Coordinating Council for Medication Error Reporting and Prevention: Promoting Patient Safety and Quality Through Innovation and Leadership (Cousins D.D., Heath W.M.). Dec., 700–702.
- Aligning Hospital and Physician Performance Incentives: A Shared Success Model (Gilbert L., et al.). Dec., 703–706.

#### Research

- An Interview with Neil Wenger (Semla T.). Dec., 699–699.

## A

### Accreditation

- Quality of Care in Accredited and Nonaccredited Ambulatory Surgical Centers (Menachemi N., et al.). Sep., 546–551.

### Adverse Events

- How Often are Potential Patient Safety Events Present on Admission? (Houchens R.L., Elixhauser A., Romano P.S.). Mar., 154–163.
- Addressing Postdischarge Adverse Events: A Neglected Area (Tslimingras D., Bates D.W.). Feb., 85–97.
- Adverse Events During Hospitalization: Results of a Patient Survey (Fowler E.J., et al.). Oct., 583–590.

## C

### Case Study in Brief

- Reducing Accidental Extubation in Neonates (Loughead J.L., et al.). Mar., 164–170.

### Clinical Microsystems Series

- Clinical Microsystems, Part 1. The Building Blocks of Health Systems (Nelson E.C., et al.). Jul., 367–378.
- Clinical Microsystems, Part 2. Learning from Micro Practices about Providing Patients the Care They Want and Need (Wasson J.H., et al.). Aug., 445–452.
- Clinical Microsystems, Part 3. Transformation of Two Hospitals Using Microsystem, Mesosystem, and Macrosystem Strategies (Godfrey M.M., et al.). Oct., 591–603.
- Clinical Microsystems, Part 4. Building Innovative Population-Specific Mesosystems (McKinley K.E., et al.). Nov., 655–663.

### Conference Reports

- Transparency in Health Care: Leading the Way (Malcolm E.F., Mastanduno M.P., Abdu W.A.). Jul., 428–431.

### Continuity of Care

- Deficits in Discharge Documentation in Patients Transferred to Rehabilitation Facilities on Anticoagulation: Results of a Systemwide Evaluation (Gandara E., et al.). Aug., 460–463.
- Handoffs Causing Patient Harm: A Survey of Medical and Surgical House Staff (Kitch B.T., et al.). Oct., 563–570.

## E

### Ernest A. Codman Awards

#### Behavioral Health Care

- Improving Treatment Engagement in Opioid-Dependent Outpatients with a Motivated Stepped-Care Adaptive Treatment Model (King V.L., Brooner R.K.). Apr., 209–215.

#### Hospital

- Improving Care of the Sepsis Patient (Zubrow M.T., et al.). Apr., 187–191.
- Improving Outcomes in Pediatric Procedural Sedation (Lubisch N., Roskos R., Sattler S.). Apr., 192–195.
- Reducing Anticoagulant Medication Adverse Events and Avoidable Patient Harm (Jennings H.R., et al.). Apr., 196–200.

#### Long Term Care

- Enhanced Toileting Program Decreases Incontinence in Long Term Care (Morgan C., et al.). Apr., 206–208.

#### Multiple Organization

- The Road to Zero Preventable Birth Injuries (Mazza F., et al.). Apr., 201–205.

### Evidence-Based Medicine

- Patient-Directed Intervention Versus Clinical Reminders Alone to Improve Aspirin Use in Diabetes: A Cluster Randomized Trial (Persell S.D., et al.). Feb., 98–105.

## F

### Forum

- Controversy and Quality Improvement: Lingering Questions About Ethics, Oversight, and Patient Safety Research (Kass N., et al.). Jun., 349–354.
- Development of the SQUIRE Publication Guidelines: Evolution of the

SQUIRE Project (Davidoff F, et al.). Nov., 681–688.  
Medicare's Decision to Withhold Payment for Hospital Errors: The Devil Is in the Details (Wachter R.M., Foster N.E., Dudley R.A.). Feb., 116–123.

## **H** Health Professions Education

Teaching Residents About Practice-Based Learning and Improvement (Morrison L.J., Headrick L.A.). Aug., 453–459.

## **I** Information Technology

Implementing Computerized Physician Order Management at a Community Hospital (Kraus S., et al.). Feb., 74–84.

Implementing Online Medication Reconciliation at a Large Academic Center (Bails D., et al.). Sep., 499–508.

## **L** Leadership

The Impact of Disruptive Behaviors and Communication Defects on Patient Safety (Rosenstein A.H., O'Daniel M.). Aug., 464–471.

Patient Safety Rounds in a Pediatric Tertiary Care Center (Rinke M.L., et al.). Jan., 5–12.

## **M** Medication Safety

Reducing Medication Prescribing Errors in a Teaching Hospital (Garbutt J., et al.). Sep., 528–536.

## **Methods, Tools, and Strategies**

Expanding the Pediatrician's Black Bag: A Psychosocial Care Improvement Model to Address the "New Morbidities" (Abatemarco D.J., et al.). Feb., 106–115.

## **N** National Patient Safety Goals

Inpatient Suicide and Suicide Attempts in Veterans Affairs Hospitals (Mills P.D., et al.). Aug., 482–488.

Pressure Ulcer Monitoring: A Process of Evidence-Based Practice, Quality, and Research (Harrison M.B., Mackey M., Friedberg E.). Jun., 355–359.

Suicide in Inpatient Settings: Are Our Hospitals Safe Enough? (Cullen S.W., Marcus S.C.). Aug., 472–473.

Suicide in the Medical Setting (Ballard E.D., et al.). Aug., 474–481.

## **O** Organizational Change and Learning

Growing Organizational Capacity Through a Systems Approach: One Health Network's Experience (MacKenzie R., et al.). Feb., 63–73.

Paying the Piper: Investing in Infrastructure for Patient Safety (Pronovost P.J., et al.). Jun., 342–348.

## **P** Patient and Family Involvement

Can Patient Safety Be Measured by Surveys of Patient Experience? (Solberg L.I., et al.). May, 266–274.

Reconceptualizing the Informed Consent Process at Eight Innovative Hospitals (Matiasek J., Wynia M.K.). Mar., 127–137.

HIPAA Costs and Patient Perceptions of Privacy Safeguards at Mayo Clinic (Williams A.R., et al.). Jan., 27–35.

## **Performance Improvement**

The CLABs Collaborative: A Regionwide Effort to Improve the Quality of Care in Hospitals (Koll B.S., et al.). Dec., 713–723.

The Cost Consequences of Improving Diabetes Care: The Community Health Center Experience (Huang E.S., et al.). Mar., 138–146.

Does Reducing Length of Stay Make a Business Case? (Weeks W.B., Resar R.). Nov., 627–628.

The Effect of Health Care System Administrator Pay-for-Performance on Quality of Care (Herrin J., Nicewander D., Ballard D.J.). Nov., 646–654.

Financial Impact and Costs Associated with Ventilator-Associated Pneumonia in Pediatric ICU Patients (Brilli R.J., et al.). Nov., 629–638.

Focusing Measures for Performance-Based Privileging of Physicians on Improvement (Myers S., et al.). Dec., 724–733.

An ICU QI Collaborative in Nine VA Hospitals: Reducing Ventilator-Associated Pneumonia and Catheter-Related Bloodstream Infection Rates (Bonello R.S., et al.). Nov., 639–645.

Improving the Documentation of Vital Signs: A Business Reengineering Efficiency Study (Szpunar S., et al.). Mar., 171–178.

Improving Reassessment and Documentation of Pain Management (Gordon D.B., et al.). Sep., 509–517.

Improving the Translation of Research into Primary Care Practice: Results of a National Quality Improvement Demonstration Project (Ornstein S., et al.). Jul., 379–390.

Inducing Sustainable Improvement in Depression Care in Primary Care Practices (Nease D.E., et al.). May, 247–255.

The National Health Plan Collaborative To Reduce Disparities and Improve Quality (Lurie N., et al.). May, 256–265.

A Practical, Robust Implementation and Sustainability Model (PRISM) for Integrating Research Findings into Practice (Feldstein A.C., Glasgow R.E.). Apr., 228–243.

Strategies for Success: A PDSA Analysis of Three QI Initiatives in Critical Care (Lipshutz A.K.M., et al.). Aug., 435–444.

## **Performance Measures**

Does the Leapfrog Program Help Identify High-Quality Hospitals? (Jha A.K., et al.). Jun., 318–325.

The Era of Big Performance Measurement: Here at Last? (Lindenauer P.K., Shojania K.G.). Jun., 307–308.

How Useful Are Voluntary Medication Error Reports? The Case of Warfarin-Related Medication Errors (Zhan C., et al.). Jan., 36–45.

Identifying Top-Performing Hospitals by Algorithm: Results from a Demonstration Project (Allison J.J., et al.). Jun., 309–317.

Outcomes of an Initial Set of Standardized Performance Measures for Inpatient Mental Health (Williams T., et al.). Jul., 399–406.

Positive Predictive Value of ICD-9-CM Codes to Detect Acute Exacerbation of COPD in the Emergency Department (Ginde A.A., et al.). Nov., 678–680.

Variation in Quality of Care Within Health Systems (Hines S., Joshi M.S.). Jun., 326–332.

When Is Antipsychotic Polypharmacy Supported by Research Evidence? Implications for QI (Gören J.L., et al.). Oct., 571–582.

## **R**

### **Rapid Response Systems: The Stories**

- A Controlled Trial of a Rapid Response System in an Academic Medical Center (Rothschild J.M., et al.). Jul., 417–427.
- The Growth of Rapid Response Systems (Steel A.C., Reynolds S.F.). Aug., 489–495.
- Implementing an MET-Based Rapid Response System at Toronto General Hospital (Warner M.B., Reynolds S.F.). Jan., 57–59.
- Improving Sepsis Care Through Systems Change: The Impact of a Medical Emergency Team (Sarani B., et al.). Mar., 179–183.
- Using an Advanced Practice Nursing Model for a Rapid Response Team (Benson L., et al.). Dec., 743–747.

### **Rapid Response Teams: The Stories**

- Using a Medical Emergency Team to Manage Anaphylactic Shock (Burns B., et al.). Jun., 360–363.

### **Reporting Systems**

- Does Error and Adverse Event Reporting by Physicians and Nurses Differ? (Rowin E.J., et al.). Sep., 537–545.

### **Research Methods**

- Hospital Selection Bias in Safety Climate Studies (Rosen A.K., et al.). May, 275–284.
- Measuring Practice Systems for Chronic Illness Care: Accuracy of Self-Reports from Clinical Personnel (Scholle S.H., et al.). Jul., 407–416.

### **Root Cause Analysis**

- The Effectiveness of Root Cause Analysis: What Does the Literature Tell Us? (Percarpio K.B., Watts B.V., Weeks W.B.). Jul., 391–398.

## **T**

### **Teamwork and Communication**

- Communicating, Coordinating, and Cooperating When Lives Depend on It: Tips for Teamwork (Salas E., et al.). Jun., 333–341.
- Debriefing Medical Teams: 12 Evidence-Based Best Practices and Tips (Salas E., et al.). Sep., 518–527.

### **Timeliness and Efficiency**

- Using Patient Traffic Control to Reduce Treatment Delays for High-Risk Patients at a VA Hospital (Schmitt B.P., et al.). Mar., 147–153.

### **Tool Tutorial**

- Developing Process-Support Tools for Patient Safety: Finding the Balance Between Validity and Feasibility (Marsteller J.A., et al.). Oct., 604–607.
- The Daily Goals Communication Sheet: A Simple and Novel Tool for Improved Communication and Care (Schwartz J.M., et al.). Oct., 608–613.
- The Team Checkup Tool: Evaluating QI Team Activities and Giving Feedback to Senior Leaders (Lubomski L.H., et al.). Oct., 619–623.
- Using Work Flow Analysis and Technology Assessment to Improve Performance on Quality Measures (Tavakoli F.). May, 297–303.
- View the World Through a Different Lens: Shadowing Another Provider (Thompson D.A., et al.). Oct., 614–618.

## **U**

### **USP Medication Safety Forum**

- Enteral Feeding Misconnections: A Consortium Position Statement (Guenter P., et al.). May, 285–292.
- Error-Avoidance Recommendations for Tubing Misconnections When Using Luer-Tip Connectors: A Statement by the USP Safe Medication Use Expert Committee (Simmons D., et al.). May, 293–296.
- Medication Errors in the Ambulatory Treatment of Pediatric ADHD (Bundy D.G., et al.). Sep., 552–559.
- Medication Errors Associated with Code Situations in U.S. Hospitals: Direct and Collateral Damage (Lipshutz A.K.M., et al.). Jan., 46–56.
- Medication Errors Involving Patient-Controlled Analgesia (Hicks R.W., et al.). Dec., 734–742.