

Performance Strategies



Automate Medication Safety from the Dockside to the Bedside

Vol. 2, Issue 3, 2008

Baptist Health Enhances Safety Using Medication Management Automation



*By Eric McVey, MD
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Baptist Health Systems, Jackson, Miss.*



Eliminating Medication Errors

Patient safety goes by many different names, including quality assurance and performance improvement. Regardless of the name, it has been the mission of [Baptist Health Systems](#) for many years. And now that numerous government and watchdog organizations have assigned a “body count” to problems such as medication errors, patient safety has become a hot-button issue.

This spotlight provides added impetus for healthcare providers to focus on improving medication management. Our goal at Baptist? Provide safe patient care, from start to finish. To stay on track, we proactively identify where things can go wrong and then determine how to prevent the potential problems. Using this root cause analysis approach, we have identified gaps in our armor and are improving them through policy changes, workflow modifications and implementation of information technology solutions.

Automating Medication Management

Instead of simply “fixing” problems using technology solutions, we decided we would only invest in technologies that support the most effective workflow. A multidisciplinary task force identified as many as a dozen potential missteps in our process. We found vulnerabilities because of our practice to manually route medication orders from physicians to pharmacists to nurses to patients.

More than 40 nurses and pharmacists participated in this medication administration review of more than 4,000 orders. Around 80 staff members took part in 150 hours of process redesign workshops. These efforts resulted in the resolution of more than 230 process issues and the creation of 34 workflow redesigns. Not only did we improve the overall process, but in some cases, we eliminated entire processes.

Such extensive analysis made it possible for us to invest in technologies that met the needs of an optimal workflow. For example, instead of stocking unit-based cabinets with medications for all patients, we began using multiple medication carts on each floor. Now nurses don’t have to wait in line at the dispensing cabinet. This single change has resulted in the elimination of 14,000 hours of idle time for nurses each year.

Most importantly, the solutions, which include computerized provider order entry (CPOE), pharmacy automation, bar-coded medication administration and robotic dispensing technologies, work in concert to prevent errors. The solutions ensure the “five rights” of medication management — right drug, right patient, right dose, right time, and right route of administration. The redesign reduced the manual hand-offs where errors could occur and streamlined the medication delivery process at the same time.

As Baptist has rolled out the systems, nursing units have administered more than 90% of medications electronically. As a result, more than 70% of our nurses and pharmacists report that the technology has helped them avert potentially dangerous mistakes.

Moving Patient Safety to New Heights

To truly affect patient safety, however, we realize how important it is to implement integrated information systems that support our over-arching quality goals — not merely employ stand-alone technologies.

CONTINUED ON PAGE 2

Baptist Health Enhances Safety Using Medication Management Automation (Cont.)

To that end, in addition to medication management automation, we rely on an electronic health records (EHR) system and a physician portal to enhance overall patient safety. With the EHR, clinicians gain immediate access to patient-specific information, while the portal adds value by enabling doctors to access patient data including radiology images, laboratory results and transcriptions anytime, anywhere.

To move the patient safety needle even more, we plan to enhance clinical decision support tools in the future. We want to be sure physicians have all the relevant clinical research at their fingertips so they can make evidence-based decisions on the care decision at hand.

The Continuous Quest to Improve Quality

Through the automation of our medication management process, we have drastically reduced errors — but we know that the quest to provide safe patient care is never ending. As we move forward, we will continue to assess care, identify potential areas for improvements and implement technologies to support the optimal patient care experience. Our clinicians and patients deserve nothing less.

Eric A. McVey, III, MD, currently serves as Vice President and Chief Medical Officer of Mississippi Baptist Health Systems. Dr. McVey is certified by the American Board of Internal Medicine in the specialty of internal medicine and the subspecialty of infectious diseases. He maintains a clinical appointment at the University of Mississippi School of Medicine as Assistant Clinical Professor. He has served as Chairman of the Council on Medical Education of the Mississippi State Medical Association, President of the Central Medical Society, and Chairman of the Board of Directors of the Mississippi Foundation for Medical Care, the peer review organization for the state of Mississippi.

Results Scorecard

Item Measured	Handwritten Orders	Electronic Orders (through 04/30/2008)
Average time medication order written to verified in Pharmacy	1 hour 53 minutes	8.7 minutes
Average time order written to received in performing department	1 hour	0 minutes
Percent of orders requiring call for legibility clarification	2 %	0 %
Percent of orders not time/date stamped	54 %	0 %

At Baptist Health, 34 residents and staff physicians have used CPOE to place 25,510 orders (as of 4/30/08). The organization measured results for handwritten versus electronic orders. For example, the average time a medication order went from written to verified in the Pharmacy was 1 hr. 53 min. for a handwritten order to 8.7 minutes for an electronic order.

Learn More

[NPS Foundation Proposes Universal Patient Compact](#)

[AHA Quality Center](#)

[AnMed Health Fully Integrates Medication Management](#)

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Medication Safety Gains — Moving Forward in Steps



By Mary A. Dallas, MD
Medical Information Officer
Presbyterian Healthcare Services



[Presbyterian Healthcare Services](#) (PHS), which serves more than 650,000 citizens throughout New Mexico, has a strong commitment to improving the quality of care we deliver. We regularly measure how we are doing and use the results to make positive changes. We stand behind our efforts by publishing a performance scorecard on our Web site that compares our performance with other healthcare delivery systems and national benchmarks.

Improving Medication Safety: Evaluating Processes and Workflows

When the Institute of Medicine published *To Err is Human* in 1999, PHS was already evaluating its medication processes in an effort to improve patient safety. The report encouraged us to speed up our automation efforts.

We created a multidisciplinary task force to study our workflows and medication use processes. Our task force recommended a bar-code-driven, centralized robotic drug distribution system, aided by unit-based medication cabinets on patient floors.

First Steps in Implementing Automation

Believing that automating the pharmacy would provide an early medication safety win, we installed McKesson's pharmacy robot in 2001. The robot achieved an accuracy level of 99.9% in stocking bar-coded, unit-dose inpatient medications... and freed up valuable time for pharmacists to spend on more direct patient care activities. We also began preparing for point-of-care bar-code scanning by using a contracted service to bar code patient-specific doses and bulk items. This was made easier by an FDA ruling in 2006 that all drug makers must bar code patient-level drug doses.

Metric Check: Dramatic Impact from Automating the Pharmacy

To determine the effects of automation on overall patient safety, we hired consultants to evaluate the system redesign. They measured medication errors before and after the pharmacy automation. The findings were dramatic: overall, medication administration errors were reduced by 77.9%.

To gain further safety results, we added McKesson's bar-code administration system, which ensures the "five rights" of administration and creates an electronic medication administration record (eMAR). We also added its physician portal, which enables physicians to quickly see doses due and administration times in real-time.

Next Step: Reduce Variances by Targeting Manual Workflows

Next, we added computerized provider order entry (CPOE) with clinical decision support. Using a toolkit, we designed CPOE "iForms" and outlines to reduce the steps required to enter orders, as well as to help drive best practices through decision support. These outlines and iForms enable us to present orders as groups, often with embedded rules and simple calculations to speed up the process of placing orders. Our physicians feel that use of these tools is critical to integrating CPOE into hospital care. Our pharmacists appreciate the order details, which sometimes were missing from paper orders. Most important is the end result — the patient receives the right care in a safer, more efficient way.

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Medication Safety Gains — Moving Forward in Steps (Cont.)

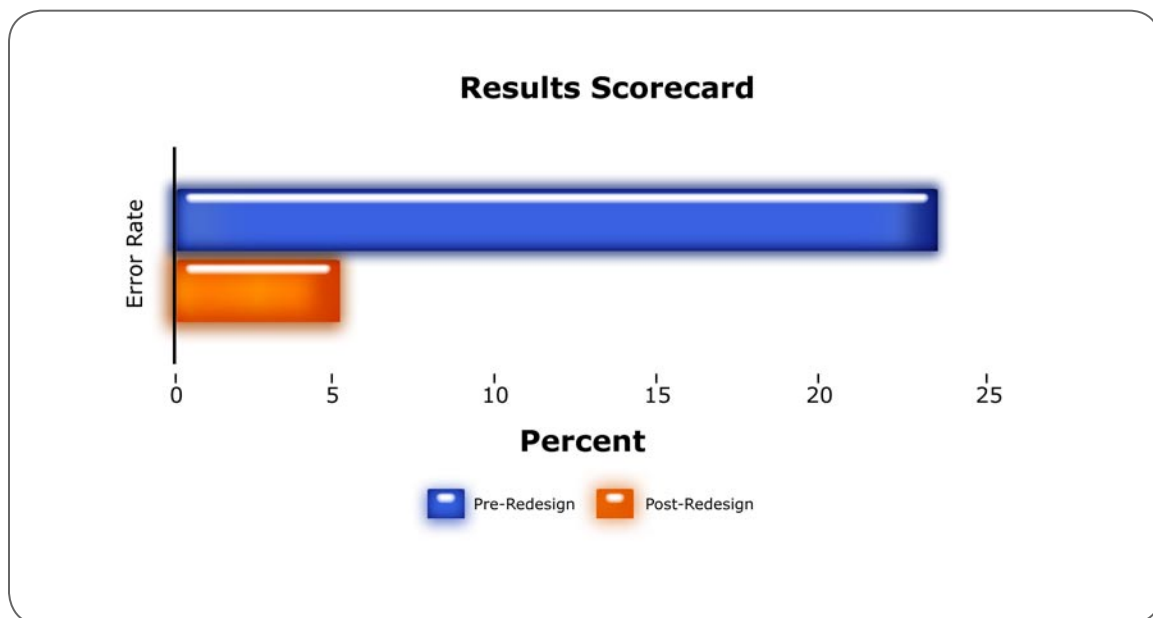
Nurses have adapted relatively easily to the pharmacy component of medication automation, but have been less comfortable using an automated solution to manage documentation related to patient orders and task lists. The ease of adoption for each hospital unit has varied — a big factor is pre-existing paper-based processes. One of our Six Sigma teams is working on a Lean design process to redesign the nursing workflow for greater efficiency and to better leverage automated solutions.

Organizational and Patient Care Benefits

Automating an organization is hard work — it changes everyone's workflow and daily tasks. But it drives a degree of standardization that facilitates best practices across the organization, while still enabling some flexibility. If your organization perseveres, there's no doubt you'll see gains in medication safety and in the efficiency of patient care.

Measuring and reporting metrics related to efforts like medication automation are necessary to gauge the progress your organization is making overall. Clinician and patient stories help validate those metrics and bring home the message on a daily basis. For example, one of our orthopedists responded to a patient with postoperative respiratory distress. After seeing the patient, he sat down at the computer, entered his orders, and within minutes watched an EKG tech, an X-ray tech, and a lab tech show up on the unit. We never saw that kind of response from our paper-based system. These kinds of stories make us say, 'Wow. This works really, really well.'

Mary A. Dallas, MD, started at Presbyterian Medical Group in 1996 as an Internist, and since 2000 she has worked with the group as an Adult Hospitalist Physician. From 2001 to 2006, she was the Medical Director of the Adult Hospitalist Group, managing the Adult Hospitalist Program at Presbyterian and Kaseman Hospitals. Since October 2005, Dr. Dallas has served as the Medical Information Officer of Presbyterian Hospital, with responsibility for strategic planning, development and implementation of clinical information systems. She has completed courses in Medical Informatics, Six Sigma, and project management, and is currently studying for a Masters in Medical Informatics at Northwestern University.



Presbyterian Healthcare Services reduced the Total Errors from 23.5% of medication orders to 5.2% after implementing a pharmacy robot and bar-code point-of-care technologies. An error was defined as a deviation from the physician's medication order as written in the patient's chart. Categories included those defined by the American Society of Health System Pharmacists standards, such as improper dose, wrong dosage form, wrong time and wrong route. When Wrong Time was removed from the calculation, the errors were reduced to 1.9%

Learn More

[NPSF: What Consumers Can do to Make Health Care Safer](#)

[The Pharmacy-to-Bedside Hybrid Medication Distribution System](#)

[St. Dominic-Jackson uses “Bed-side Back” Strategy for Patient Safety](#)

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St. Joseph's Sees Safety Gains with Limited Resources



*By Charles Fennell, CIO
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A HIGHER LEVEL OF CARE

Improving Medication Safety

[St. Joseph's Hospital Health Center](#) is a David-like organization grappling with a Goliath-like challenge. Like other healthcare providers, we are trying to eradicate medication errors — an industry-pervasive problem that often results in serious adverse events including death. Because we are a community-based organization, we have to work smart. We need to strategically address medication management by reinforcing a culture of safety and by implementing supporting technologies that will quickly provide us with both clinical and financial returns.

Working Strategically to Combat Errors

Like most community hospitals, we have to make the most of our limited human and financial resources. We quickly realized that we could not just wage a battle on medication errors using information technology, but instead had to engage physicians, nurses, pharmacists and other staff members in the quest to improve patient safety.

To stress that culture is the shoulder behind the IT wheel, I spent time with our professionals to explain there is no intrinsic value in information technology — the value is in how we use it. After staff members internalized this message, the project quickly went from being perceived as an IT-based venture to a collaborative – and successful – organization-wide initiative. In other words, physicians, nurses, pharmacists and other staff members did not sit back and wait for IT to make things happen, but instead, brought their expertise to the project — and became equally accountable for its success.

Making the Most of Limited Resources

Rallying the troops was just the start. We also needed to make the most of limited financial resources. Our plan is to ultimately automate the entire medication management process from dockside to bedside, but we began by incrementally implementing technologies that would be financially manageable while still reaping immediate results.

For example, we implemented medication administration technologies immediately, looking to a computerized provider order entry system as a later phase. Why? Almost 98% of the errors committed during the medication administration phase are at the bedside and can't be reversed once administered. When there is an error in a physician order, it is more likely to be flagged because orders are reviewed by nurses and pharmacists.

In addition to identifying technologies that provide out-of-the-gate benefits, we have made the most of existing systems. For example, adjustments to the nursing documentation system and the addition of a lab interface to the pharmacy system are enhancing medication management without requiring a significant capital investment. In essence, we identified these as the "low hanging fruit," the improvements we could make that would have an immediate impact on patient safety but would not drain our financial or human resources.

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St. Joseph's Sees Safety Gains with Limited Resources (Cont.)

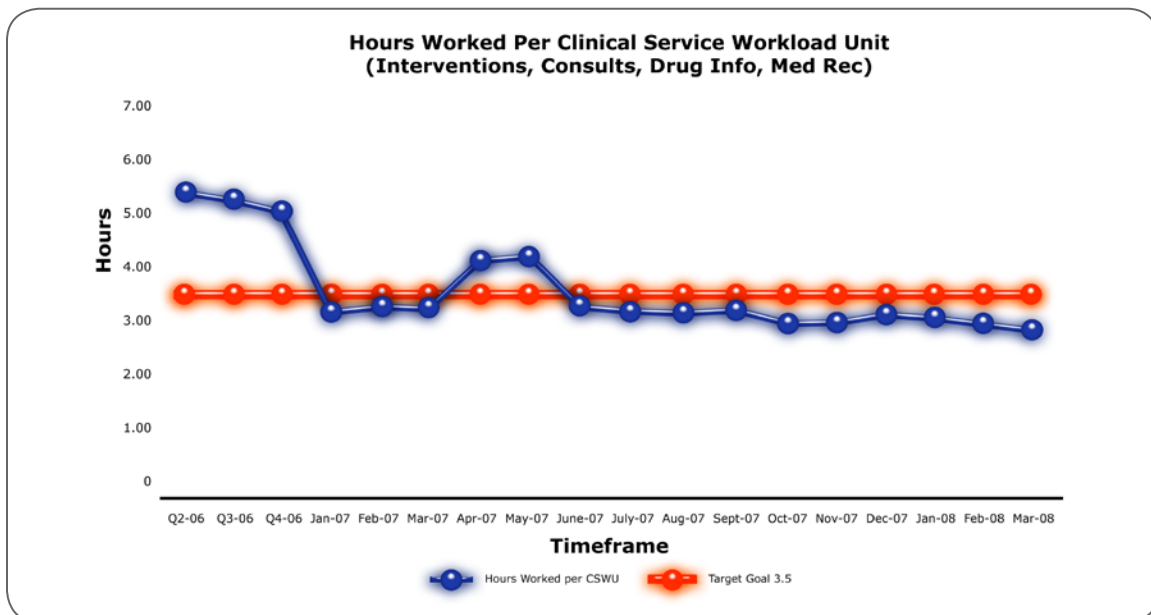
Realizing a Quick Return

The implementation of technology has resulted in a variety of benefits. For example, the robotic distribution of medications in the pharmacy has enabled us to cut the amount of time that staff members spend pulling medications, making it possible to use pharmacists for more important clinical activities. In addition, nurses now feel that they have the tools needed to enhance patient safety, and they also report improved workflow and increased job satisfaction.

Perhaps most important, the medication safety technologies have helped clinicians identify and prevent errors in 13% of the medications being administered to patients.

By adopting a phased approach to the automation of medication management, St. Joseph's has quickly reaped important patient safety and organizational efficiency gains. These accomplishments, in turn, will help keep the momentum alive as our organization moves toward complete automation, from dockside to bedside.

Charles Fennell has more than 20 years experience in information technology serving the healthcare community. He joined St. Joseph's Hospital Health Center in 2001 as vice president and CIO. Mr. Fennell has led strategic IT initiatives that have enabled St. Joseph's to strengthen its operational performance, improve clinical outcomes and patient safety as well as enhance physician satisfaction. St. Joseph's is a non-profit, 431-bed hospital and healthcare network serving Central New York.



After implementing automated dispensing cabinets and Horizon Meds Manager™, St. Joseph's increased the number of clinical workload units (interventions, consults, calls to the pharmacy to answer in-depth questions and the obtaining of medication histories) and decreased total hours worked. The organization has shown a significant improvement in productivity as measured by their benchmark of hours worked per clinical service workload unit.

Learn More

[AHRQ Hospital Survey on Patient Safety Culture](#)

[2009 National Patient Safety Goals](#)

[Mary Lanning Memorial Creates Culture of Safety](#)

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ISMP: It's Easier than You Think – Prevent Medication Errors by Automating



By Michael R. Cohen, RPh, MS, ScD
President
Institute for Safe Medication Practices



Reducing medication errors is obviously a vital part of improving patient care, and that should always be the primary concern of every healthcare organization. Yet, causing harm to patients has substantial financial costs as well. Errors raise per-patient costs by an estimated \$5,857. Even this figure – which is considered very conservative – costs the healthcare system \$3.5 billion annually.

In addition, the government and insurance companies are using their clout to push hospitals toward reducing errors. Earlier this year, WellPoint joined a growing list of payors that no longer reimburse for costs stemming from preventable medical errors. Aetna now includes stipulations in some provider contracts that prohibit payment (or billing patients) for care arising from the National Quality Forum's list of 27 "never events," which include medication errors.

Analyzing Reported Medication Errors

Each day the causes of medication errors are collected and analyzed by the [Medication Errors Reporting Program \(MERP\)](#). Operated by the [U.S. Pharmacopeia \(USP\)](#) in cooperation with the [Institute for Safe Medication Practices \(ISMP\)](#), the MERP program finds that the number of errors – which range from giving the wrong drug to the wrong dosage of the right drug – is staggering. One study estimated the number of hospital medication errors at more than 450,000. In almost all cases, one fact is clear: most easily could be prevented if hospitals employed technologies such as electronic order entry, bar-code scanning of medications and smart pumps.

Just consider how these events happen.

Look Alike, Sound Alike Drugs: Many drugs have similar names, but different uses. Recently a hospital pharmacist mistakenly placed sumatriptan, a prescription medication for migraine headaches, into a dispensing bin reserved for the diabetes drug sitiglipitan. The two drugs sound alike and look alike, and in the rush of a busy hospital it was an honest mistake.

Yet, if bar-codes had been in use, it's unlikely this drug would have ended up in the wrong bin or delivered to patients who didn't need it. The migraine medication would have been scanned when it arrived at the hospital pharmacy, and scanned again when it was placed in the dispensing machine. The software would have alerted the pharmacy that something was wrong.

Cryptic Writing of Drug Orders: Use of a computerized provider order entry (CPOE) system eliminates the danger of handwritten orders being misinterpreted. When the order becomes part of an electronic medical record, it will be acted upon much faster than a note in a paper chart. And when coupled with the power of clinical decision support, electronic order entry guides physicians and other clinicians to best practices and evidence-based care.

These systems drive greater efficiency at all levels. How many hours are lost when nurses or pharmacists have to double-check medication orders or call back physicians to verify unclear or inappropriate medication orders?

Administration Errors at Bedside: The final chance to eliminate a medication error is at the bedside. Bar-code scanning of the drug, the patient and the caregiver's ID badge not only electronically documents the administration, but helps ensure that the right drug goes to the right patient at the right time in the right dose and via the right method. Smart infusion pumps can detect IV drug overdoses by recognizing pump programming errors.

CONTINUED ON PAGE 9

ISMP: It's Easier than You Think – Prevent Medication Errors by Automating (Cont.)

Changing the Culture

Automation is a powerful tool for making care safer, but it is not a cure-all. Hardwiring safety into your culture requires commitment from every member of the hospital staff — from administrators and IT professionals to physicians, nurses and other caregivers.

The hospital must invest both the time and resources to create buy-in for the new systems. Doctors and nurses must endorse the switch from the familiar way of practice to new and sometimes challenging technology deployment.

The entire organization must also take a larger view of medication safety by looking beyond its own experiences. Some errors with severe side effects may occur so infrequently that a particular institution may see them only every few years. Yet they must also be part of the monitoring process.

Instituting an automated safety program is not easy, and the resources required – both upfront and ongoing – are considerable. Yet, the rewards for the patient and the organization are more than worth the time, effort and cost.

Michael Cohen is president of The Institute for Safe Medication Practices, a non-profit healthcare organization that specializes in understanding the causes of medication errors and providing error-reduction strategies to the healthcare community, policy makers, and the public. He is editor of the textbook, [Medication Errors](#) (2007 American Pharmaceutical Association) and serves as co-editor of the ISMP Medication Safety Alert! publications, which reach over 2 million health professionals and consumers. Dr. Cohen is a member of the Sentinel Event Advisory Group for the Joint Commission and served recently as a member of the Committee on Identifying and Preventing Medication Errors, Institute of Medicine. Over the past five years, Cohen has consistently been recognized by Modern Healthcare magazine as one of the top "100 Most Powerful People in Healthcare."

Supporting Safe Prescribing for Patients with Special Dosing Requirements

Recent news stories have elevated medication dosing errors to the national spotlight. In May, well-known actor Dennis Quaid testified before Congress about the hardship he and his family endured when an incorrect dosage of Heparin was given to his newborn twins — 1,000 times the recommended strength. High-risk, complex patients require special care when it comes to medication dosing.

For the very young, the very old and the very sick in particular, physicians must consider a myriad of complex factors when calculating dosing requirements for their patients. Studies have shown that in pediatrics, the most common type of medication error is a dosing error at the ordering stage. A study published in April 2008 in the journal *Pediatrics* found that there are about 11 adverse drug events for every 100 hospitalized children.

"We are constantly evaluating strategies that will help to eliminate medication errors, particularly in patients with complex dosing requirements," said Jeff Ferranti, M.D., M.S., director of Pediatric Informatics and Computerized Patient Safety Initiatives at Duke University Hospital. Use of information technology, says Dr. Ferranti, "has the potential to be of particular relevance in pediatric and neonatal units where specialized approaches to weight and age-based dosing are required and small miscalculations can cause significant problems."

[Information technology can support the dosing process](#) by providing patient-specific recommendations coupled with sophisticated dose calculators and rounding algorithms tightly tailored to the indication for the medication, including criteria such as the patient's age, dosing weight, body surface area, renal function and diagnosis. Including these capabilities in the electronic order entry process can help increase the accuracy and safety of medication prescribing.

Events

**Nurse Advise-ERR
Newsletter Offers Tactics
to Prevent Errors
*Free to Nurses in 2008***

During 2008, McKesson is helping underwrite free subscriptions to nurses for ISMP's medication safety newsletter. The newsletter provides accounts of reported errors, checklists of error reduction strategies, and quick tips for safe practices.

[Subscribe to the newsletter.](#)

Recorded Webinars:

Series on
**[Automating Your
Pharmacy](#)**

Series for Nurse Leaders
**[Designing Frameworks
for Patient Safety](#)**

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Vol. 2, Issue 3, 2008

It's Time: Making Patient Safety Automatic



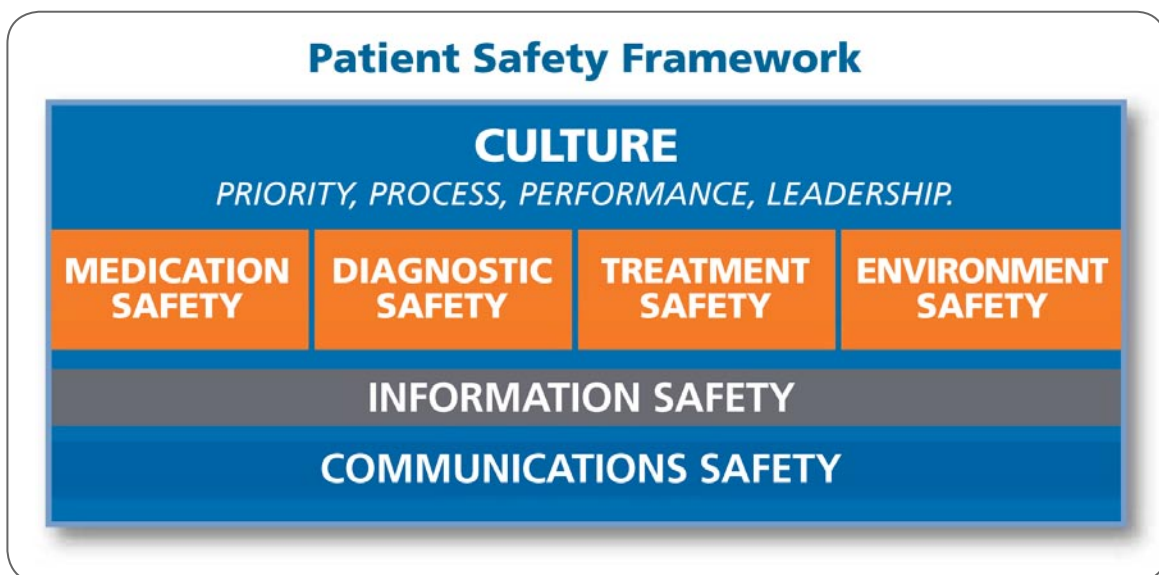
By Mary Beth Navarra-Sirio, RN, MBA
Patient Safety Officer
McKesson Provider Technologies

The 1999 landmark Institute of Medicine report, *To Err is Human*, called attention to the nearly 100,000 people who die from medical errors every year. It also pointed to an obvious starting place for improvement: medication management. Hospitals quickly saw the power of technologies like bar-code scanning, pharmacy automation and CPOE in helping to prevent medication errors at each stage where they can occur.

Now there is a sense of urgency to eliminate preventable errors like never before — reinforced by every headline on a preventable mistake and each time another payor joins CMS in ceasing to reimburse for “never events.” The time has come to take a more holistic view of patient safety because we won’t stop all the errors until we change our approach. Safety is much more than compliance — it’s hardwiring safety into every process by using the power of technology and reinventing the culture of care.

Patient Safety — The Big Picture

What is the definition of patient safety? At McKesson, we believe it is: “The sustained, proactive process of identifying, avoiding and rapidly resolving errors, omissions and miscommunications that could affect patient health or safety, at any point, in any care setting.” We also look at patient safety as a framework that spans the entire healthcare continuum.



CONTINUED ON PAGE 12

It's Time: Making Patient Safety Automatic (Cont.)

- **Medication safety** covers the entire medication use process, from the loading dock to the patient's bedside, including the prescribing, transcribing, dispensing, administering and monitoring of medications.
- **Diagnostic safety** includes the gathering and interpretation of data that supports accurate and timely diagnosis. Strategies to promote evidence-based diagnosis are essential.
- **Treatment safety** ensures the accurate capture, recording, executing and sharing of data related to care delivery. Evidence-based guidelines, treatment plans and clinical decision support are essential, as is electronic capture of data as part of the permanent patient record for all the care team to see.
- **Environmental safety** ensures that the patient's surroundings are safe, including the proper level and mix of staffing, taking steps to avoid infection, following appropriate protocols, and having needed supplies on hand.
- **Information safety** refers to the availability of secure, up-to-date, complete medical records for every patient. Cross-setting records must be permanent, portable and trustworthy, with longitudinal data on allergies, medication history and so on.
- **Communications safety** includes the sharing of relevant, real-time information to all authorized, interested parties, with particular focus on the need to improve hand-off communications. According to the Joint Commission, breakdowns in communication remain by far the root cause of most sentinel events.

Cracking the Patient Safety Code

Healthcare has complex processes with many moving parts that affect and support patient safety. Making improvements means taking an incremental approach, making a change in one area and ensuring it is sustained before moving on. Some strategies include:

- **Gain buy-in from hospital leadership** — To succeed, there needs to be a mandate and a change in culture from the board of directors down. Everyone's job is to make safety the first priority.
- **Start with areas of quick impact** — Medication management is a great place to start safety improvements. Automate the medication process to prevent errors. After that, environmental safety presents fertile ground for improvement.
- **View the big picture** — Examine all of your processes, from the dockside to the bedside. Are your medications bar-coded? Do you have automated dispensing? Do your physicians use CPOE with clinical decision support? Do you have a longitudinal, cross-setting EHR?
- **Measure, adjust and reinforce** — There is an old axiom — "What gets measured gets done." Create dashboards that provide information from the executive level to front-line caregivers. Technology can empower you to check progress against patient safety goals each day — from minute to minute or shift to shift. Immediate feedback enables everyone to make immediate adjustments.

Taking Care Safely Forward

As McKesson celebrates its 175th anniversary this year, it gives us reason to reflect on how healthcare has changed since we were founded in 1833. Our founders first delivered vital medications by covered wagon. We've created many innovations over the years, including the pioneering use of bar-code scanning of medications at the patient's bedside in 1988. Now millions of clinicians prevent millions of errors each year by simply scanning a bar code before administering a medication. We are committed to partnering with our customers to help them in their efforts to continue "taking care forward" and creating a culture of care that helps ensure safety for every patient.

Mary Beth Navarra-Sirio, RN, MBA, is McKesson's patient safety officer and develops patient safety strategies for McKesson products, lectures around the country and works with McKesson's Public Affairs department to educate policy makers on the importance of technology in improving patient safety.

Quest for Quality Award Honors Leadership and Innovation in Patient Safety

The American Hospital Association-McKesson Quest for Quality Prize was founded to honor and reward organization-wide commitment to quality, patient-centered care. The award uses the Institute of Medicine's (IOM) six quality aims as the foundation for the award: safety, patient-centeredness, effectiveness, efficiency, timeliness, and equity. Applicants demonstrate a systematic approach to achieving the IOM aims, documenting progress, and providing replicable models and systems for others to follow.

The award winner receives \$75,000, and two finalists receive \$12,500 each. Other hospitals may be recognized with Citations of Merit. All U.S. hospitals are eligible. You can nominate your own or another organization by completing a [nomination form](#). An application packet will be e-mailed after receipt of the nomination. The 2008 awards will be announced in July. The deadline for submitting an application for 2009 is October 12, 2008. View the [criteria for the award](#).

Quest for Quality is an American Hospital Association Award supported by grants from McKesson Corporation and the McKesson Foundation.

Related Solutions

[Patient and Medication Safety](#)

[Medication Safety Advantage](#)

[Patient Care Advantage](#)

[McKesson Continuum of Care](#)

[Bar-Code Medication Packaging Solutions](#)