Maryland Association for Healthcare Quality

April - May - June 2009, Issue 32

In This Issue

PRESIDENT'S MESSAGE

Dear MAHQ Members,

Spring is finally here!

MAHQ hosted an informational table at the Maryland Patient Safety Center 5th Annual Patient Safety Conference. MAHQ Board members staffed the table, where the following information was available:

- CPHQ Review Course Interest Survey
- Organizational Membership Survey
- Sample copies of past newsletter issues
- Spring Educational Conference Brochure
- Spring Educational Conference Save the Date Flyer
- What is MAHQ? Brochure
- Why Become a CPHQ? Flyer

The Board plans to conduct a survey via Survey Monkey regarding interest in organizational membership, CPHQ review courses, and Meet and Greet events to facilitate networking, as well as PayPal usage, especially barriers/challenges.

The Spring Educational Conference entitled, "**Aligning Accreditation and Quality: The DNV Perspective**," will be held on Friday, May 22, 2009 at the Maritime Institute and has been approved for 5.5 CEUs. The conference brochure is available on the MAHQ web site at: http://www.mdahq.org. Additional conference information can be found later in the newsletter. Please share this information with your colleagues, especially those involved in accreditation and regulatory activities. The registration deadline is **May 11, 2009**.

The Board recently completed the annual By-laws' update. Members will be receiving a copy via email. Please review and send any comments/suggestions to me at: cwilso42@jhmi.edu. The By-laws will be voted upon during the President's Welcome at

the conference.
Subscription to the MAHQ Google Group is a membership benefit. Members are encouraged to use the Group as a resource. Per the MAHQ Job Posting Policy, MAHQ members can post job positions from their places of employment to the Group as well as to the web site for 60 days. I will be personally emailing all Google Group members, who have not yet renewed for 2009, before unsubscribing anyone from the Group.

The MAHQ Board meets on the 4th Thursday from 6:00 p.m.-8:00 p.m. at a rotating site. Board meetings are open to MAHQ members. Please contact a Board member, if you would like to attend.

Lastly, I and the Board welcome your input in our effort to make MAHQ the premier state healthcare quality association. Please do not hesitate to contact me if you have any questions or concerns.

Sincerely,

Cheri Wilson, MA, MHS candidate, CPHQ
President, Maryland Association for Healthcare Quality (MAHQ)

Congratulations

Congratulations to Mimi Rigney at Holy Cross Hospital for winning the $50 Visa Gift Card at the information table hosted by MAHQ at the Maryland Patient Safety Center 5th Annual Patient Safety Conference.

Upcoming Events

May 19, 2009 – Maryland Association of Health Care Executives (MAHCE), Executive Roundtable, Four Points by Sheraton at BWI Airport, Baltimore, MD
http://mahce.ache.org/x16.xml

May 20-22, 2009 - National Patient Safety Foundation (NPSF) Annual Patient Safety Congress, Gaylord National, Washington, DC area
http://www.npsf.org/npsfac/

May 22, 2009 - MAHQ Spring Educational Conference, "Aligning Accreditation and Quality: The DNV Perspective," Maritime Center, Linthicum, MD

June 18, 2009 - Maryland Society for Healthcare Risk Management (MDSHRM) Annual Dinner Meeting and Educational Session on the Disclosure Process, Tentative Location Turf Valley Country Club, Time TBD

September 13-16, 2009 - 34th NAHQ Annual Educational Conference, Gaylord Texan Resort Hotel & Convention Center, Grapevine, TX
http://www.nahq.org/conference/

October 18-24, 2009 - Healthcare Quality Week
http://www.nahq.org/hqw/

Aligning Accreditation and Quality: The DNV Perspective

DNV Healthcare Inc. (DNVHC) is an operating company of Det Norske Veritas (DNV).

DNVHC has corporate offices in Houston, Texas and Cincinnati, Ohio. DNV is an international, independent, self-supported, tax-paying foundation that has more than 300 offices in over 100 countries and more than 9,000 employees. Established in 1864 in Oslo, Norway DNV has been operating in the United States since 1898. With a corporate purpose of safeguarding life, property, and the environment, DNV has a worldwide reputation for quality and integrity in certification, standards development and risk management in a wide range of industries, including extensive international healthcare experience. On September 26, 2008 the US Centers for Medicare and Medicaid (CMS) approved DNVHC by granting it deeming authority for hospitals. Any hospital accredited by DNVHC after that date is deemed to be in compliance with the Medicare Conditions of Participation (CoP).

DNV Healthcare Inc. accreditation is called NIAHO℠. NIAHO℠ is the acronym for the National Integrated Accreditation for Healthcare Organizations. NIAHO℠ is the name of DNVHC's hospital accreditation program. The NIAHO℠ standards integrate requirements based on the CMS Conditions of Participation (CoPs) with the internationally recognized ISO 9001 Standards for the formation and implementation of the Quality Management System. ISO 9001 is the infrastructure of quality that infiltrates every aspect of your organization – it enables an organization to reach maximum effectiveness and efficiency in its processes that leads to improved outcomes, both clinically and financially. These two sets of standards form the basis of DNVHC's revolutionary Integrated Accreditation concept in NIAHO℠.

The intent of this program will provide an overview of the NIAHO℠ Accreditation Process and the ISO 9001:2000 Quality Management System requirements.

ISO 9001:2000 Quality Management System Requirements

Compliance with ISO 9001:2000 demonstrates that your healthcare organization takes quality assurance seriously. In fact, many government departments and companies now require their suppliers to show proof of a certified Quality Management System (QMS). The following describe some of the benefits derived from ISO 9001:

- Increased profits driven by streamlined processes
- Decreased operating costs due to fewer errors and reduced rework
- Breakdown of silos as staff from different departments and levels work together
- Increased productivity as the correct staff, equipment, data, and documentation are integrated into the complete process
- Increased staff responsiveness to patients and other customers needs
- Increased confidence among staff as quality improves
- Increased physician satisfaction with the quality system and improved patient outcomes
- Improved organizational outcome through alignment of quality management systems and your business strategy

The challenge for hospitals is not only to meet a set of standards at one point in time, but also to have the quality management infrastructure in place to maintain a constant level of readiness and continual improvement of processes.

The process for ISO 9001 gives hospitals the tools to put in place a continual quality process. In order to meet the requirements of ISO 9001 Quality Management System the hospital must make the requirements an integral part of the Standard Operating Procedures for the hospital. ISO 9001 is a standard recognized internationally in and out

of the healthcare field, and as such, is value added for hospitals.

ISO 9001 can help the healthcare industry to move beyond its traditional approaches to quality, performance improvement, and create a healthcare delivery system that is integrated and synchronized for patient safety, enhancing profitability and improving patient outcomes.

The ISO 9001 and NIAHO[SM] accreditation process is a vehicle to improve the quality of patient care, increase efficiency and reduce costs. It is the logical next step on your journey of continual improvement.

Learning Objectives

Learn how to apply the elements of a strong quality management infrastructure with the ISO 9001:2000 requirements and developing processes to improve the performance of an organization at all levels

Describe the rationale for the need of a new accreditation alternative

Distinguish between the characteristics of a healthcare delivery system that uses traditional approaches to quality and those that are truly integrated and synchronized for performance improvement

Summarize the DNV Healthcare NIAHO[SM] Accreditation process and survey activities for hospital accreditation.

Program Agenda

7:30a – 8:00a	Registration and Continental Breakfast
8:00a – 8:15a	MAHQ President's Welcome
8:15a – 8:45a	Overview of DNV Healthcare Inc
8:45a – 10:00a	Introduction to ISO 9001:2000 Guidelines Relate the ISO 9001:2000 requirements in the context of NIAHO[S]
10:00a – 10:15a	Morning Break
10:15a – 12:15p	Relating the ISO 9001:2000 Quality Requirements in the Context of the Accreditation Process
12:15p – 1:00p	Lunch
1:00p – 2:15p	A Culture of Readiness or a Culture of Quality: Achieving Optimal Outcomes
2:15p – 2:30p	Morning Break
2:30p – 3:00p	Measuring Alignment and Embedding the Process
3:00p – 3:30p	Questions & Answers
3:30p – 3:45p	Wrap-up, Evaluations

Bios for Speakers

Rebecca J. Wise, MHA has an undergraduate degree in Training and Development and a Master Degree in Hospital and Health Administration from Xavier University. She has over twenty years of operational experience at the executive level in healthcare organizations and was an administrator surveyor in the hospital and integrated survey programs and also on the faculty in the Department of Education at the Joint Commission for six years. She has taught many, many seminars across the country related to JCAHO compliance and staff competency for JCAHO, state hospital associations, and individual healthcare organizations and has successfully completed a RAB QMS Lead Auditor Program She has been instrumental in the development of a software product to measure and aggregate staff competence as well as software to manage the quality profiles of physicians. Rebecca is COO of DNV Healthcare Inc., a national accreditation company headquartered in Cincinnati.

Patrick Horine, MHA has an undergraduate degree in Training and Development and Master Degree in Hospital and Health Administration from Xavier University. He has many years of experience in healthcare including Chief Quality Officer, Director of Business Development, and as Chief Executive Officer of an urban hospital in Cleveland. Patrick is an expert in Performance Improvement, Patient Safety, data inventory development and analysis, and Sentinel Events and Root Cause Analysis and has presented many seminars as well as worked on-site with healthcare organizations on these issues. He has successfully completed a RAB QMS Lead Auditor Program. Patrick is Executive Vice President, Accreditation of DNV Healthcare Inc., a national accreditation company headquartered in Cincinnati.

Legislative Update

Camille Dobson, MPA, CPHQ
Legislative Chair

Federal Perspective
As you might have heard, health care issues have moved from individual states' agendas to the Federal government's agenda with the election of Barack Obama in November. They have really been the "laboratories of reform" in terms of coverage and access over the past 5 years. Unfortunately, at this time, states are particularly ill-equipped to deal with the rising tide of uninsured Americans given the budget deficits they are facing.

However, President Obama has made health care reform one of his keystone initiatives. His new Director of the Office of Management and Budget, Peter Orzsag stated in his last presentation before leaving the Congressional Budget Office that:

"Addressing health care issues will be crucial to closing the nation's looming fiscal gap—which is caused to a great extent by rising health care costs. Spending on health care has consumed an ever-increasing share of gross domestic product (GDP) over the past 45 years, and its share will continue to rise unless changes occur to slow the trajectory…. Concerns about the rising cost of health care would be less pressing if there was unambiguous evidence that greater spending meant better health outcomes or a higher quality of care. The evidence, however, suggests that the nation's increasing spending on health care may not be improving the quality of that care or health outcomes. In addition, the fact that clears geographic variations in health care spending lead to no corresponding differences in measured health outcomes suggests that the potential exists to reduce health care spending without affecting the quality of health

care."

Budget Options, Volume I, Congressional Budget Office. December 2008.

It is clear that managing rising health care costs will not be the only challenge tackled, but how to get better health outcomes – better quality – from that spending. Two new laws, enacted in February, 2009 have implications for every sector of the health care industry, but single out health care investments and improvements in quality for special attention.

The American Recovery and Reinvestment Act (ARRA or "stimulus bill") enacted on February 19, 2009, included a number of initiatives (accompanied by funding) to promote health care quality.

The largest is a new Federal investment in health information technology (HIT) - $19 billion over 27 months. One of the stated goals of this investment is to improve health care quality, reduce medical errors, reduce health disparities, and advance the delivery of patient centered care. The HIT provisions of this bill will set national standards for interoperable technologies, develop patient privacy safeguards, create and/or increase payment incentives for providers to become "meaningful adopters" of HIT and provide grant funding to a variety of stakeholders. Other provisions include a Prevention and Wellness Fund ($1B) to develop evidence-based clinical and community-based prevention and wellness strategies that deliver specific, measurable health outcomes that address chronic disease rates, and Primary Health Care Workforce grants ($500m) to train nurses and primary care physicians and dentists; National Health Service Corps; and Patient Navigator Program.

Likewise, Title IV (Strengthening Quality Of Care Health Outcomes) of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), signed on February 13, 2009, addresses a number of health care quality issues related to children.

These include:

- Establishment by HHS of a set of pediatric quality measures that improves the initial core measures, expands the existing measures, and increases the portfolio of evidence based pediatric quality measures available. $20 million in grant funds are provided for development and testing of these measures; and
- $25 million in grant funding for models to reduce childhood obesity conducted by cities, counties, FQHCs, universities, health care providers, and community based organizations.

This bill also extends the enrollee protections now provided to Medicaid managed care enrollees to children enrolled in CHIP health plans, and requires mental health parity for CHIP programs.

I'll look forward to providing an assessment in this space next year of the progress the country has made in focusing on getting better outcomes for our health care investments and ensuring that all Americans have access to adequate and affordable health care.

In the General Assembly

There were a few bills of interest to our members who work in hospitals or managed care organizations enacted in the Session that ended on April 13, 2009. Two are based on the recommendations of the Task Force on Health Care Access and Reimbursement, which issued its final report in December 2008, and one is intended to complement the HIT provisions of ARRA.

HB 526/SB 646 - Credentialing of Health Care Providers by Managed Care Organizations, Insurance Carriers, and Hospitals
This bill requires each hospital to use one of two uniform credentialing forms for credentialing physicians and adds managed care organizations to the list of carriers subject to uniform credentialing requirements.

The task force found that data gathering for credentialing is time consuming and expensive for hospitals and health plans. Providers must respond to redundant data requests, delay providing care, and suffer a loss in revenue because of delays in review of documentation. Centralizing credentialing enables health plans and hospitals to obtain information from several common trusted sources and enables providers to submit most information just once.

While the Department of Health and Mental Hygiene's Office of Health Care Quality (OHCQ) and MIA have common standard credentialing forms, MIA's form is aligned with the Council for Affordable Quality Healthcare (CAQH) universal provider data source, while the OHCQ form is not. The task force concluded that MIA and OHCQ should align their standards using CAQH resources to improve efficiency by eliminating duplicate hospital and health plan data collection. In the long term, hospitals and health plans may see savings due to reduced staffing for credentialing and privileging functions.

HB 585/SB 661 - Health Insurance - Use of Physician Rating Systems by Carriers

This bill establishes requirements for the Maryland Health Care Commission (MHCC) to approve "ratings examiners" to review "physician rating systems." The bill prohibits carriers from using a physician rating system unless the system is approved by a ratings examiner.

On this topic, the task force found that meaningful efforts to measure and publicly report the comparative quality of physician practices are needed to help consumers make informed choices of where and from whom to seek care. Physician performance measurement is relatively new, complex, and rapidly evolving. The need for transparency, accuracy, and oversight in the process is significant, and scrutiny, disclosure, and oversight by appropriate authorities if physicians, consumers, and purchasers are to have confidence in rating systems.

The task force recommended that the General Assembly pass legislation requiring health plans licensed by MIA to fully disclose to consumers and physicians important aspects of their ranking system, and specifically recommended that any legislation reflect the November 2007 consent agreement between the Office of the Attorney General of the State of New York and United HealthCare, which prescribes United's physician performance measurement system. This bill is largely based on that consent agreement.

In Maryland, physician rating systems are used at least in part as the basis for pay-for-performance (P4P) initiatives administered by CareFirst (Quality Rewards program) and Aetna (Bridges to Excellence P4P program).

Currently, the National Committee for Quality Assurance (NCQA) is the only organization to have nationally recognized standards for physician performance measurement. On August 13, 2008, the Consumer-Purchaser Disclosure Project, a consortium of leading consumer, employer, and labor organizations funded by the Robert Wood Johnson Foundation, named NCQA as an independent reviewer to certify that health insurers assess and report on the quality of physicians in an effective and fair manner. The bill establishes that any physician rating system approved by NCQA would be deemed to be approved under Maryland law.

HB 706 - Electronic Health Records - Regulation and Reimbursement

This bill requires the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) to designate a State health information exchange (HIE) by October 1, 2009. Additionally, beginning the later of January 1, 2015, or the date established for the imposition of penalties under ARRA, each provider using an electronic health record (EHR) that seeks payment from a State-regulated payor must use EHRs that are certified by a national certification organization designated by MHCC and capable of connecting to and exchanging data with the State HIE. State-regulated payors may reduce payments to health care providers for noncompliance with these requirements.

As mentioned above, ARRA provides $19 billion in funding which in part will pay for monetary incentives to Medicaid and Medicare providers to encourage adoption of EHR. Medicare incentives are targeted at physicians and hospitals that demonstrate "meaningful use" of EHR, and are phased out over a six-year period followed by penalties imposed on nonadopters. Medicaid incentives provide 100% federal funding to certain providers that serve a high volume of Medicaid patients and to federally qualified health centers and rural health clinics that treat low-income patients. As with the Medicare incentives, the Medicaid incentives are provided on a phased-down basis.

Maryland is one of four states selected for a five-year CMS demonstration project to help primary care physicians adopt EHR. Beginning June 2009, CMS will provide a modest initial payment and future incentives based on clinical performance for up to 200 physician practices. A solo practice can earn up to $58,000 and a larger practice approximately $290,000 over the five-year period.

MHCC's Center for Health Information Technology is planning a "citizen-centric" statewide health information exchange. Two multi-stakeholder planning groups – Chesapeake Regional Information Systems for Our Patients (CRISP) and the Montgomery County Health Information Exchange Collaborative – reported to MHCC on February 20, 2009 regarding governance, privacy and security policies, access issues, and strategies to assure appropriate patient engagement and control. A request for applications for the exchange is anticipated in April. Development of the exchange should begin in fiscal 2010 and take three to four years before full implementation. To date, these efforts have been funded using money from the hospital all-payor system. Funding for the implementation phase will include $10.0 million from hospital rate adjustments.

NAHQ 33rd Annual Educational Conference
Session 201: "Partnering with Our Patients to Improve Quality"

Deborah A. Bonin, RHIA, CPHQ
Aurora Health Care, Milwaukee, WI

By Cheri C. Wilson, MA, MHS candidate, CPHQ

Aurora Health Care (http://www.aurorahealthcare.org/) is an integrated not for profit health care delivery system in Wisconsin comprised of 13 hospitals, 100 clinics, 130 retail pharmacies, and a home health care agency. The system employs 3,400 physicians, including 700 employed physicians, as well as 26,000 employees.

Patient-centered care is defined as "a collaborative relationship between patient and provider, with effective communication and empowered consumers taking an active role in their care" (Gerteis,

1993; IOM, 2006). The seven dimensions of patient-centered care include:

- Respect for patient's values, preferences
- Coordination and integration of care
- Information, communication, education
- Physical comfort
- Emotional support, alleviation of fear
- Involvement of family and friends
- Transition and continuity

Patient-centered care at Aurora Health Care involved a long-term strategy. The phrase, "We are all caregivers," was applied to all employees whether involved in direct patient care. In addition, Aurora Health Care followed Planetree (http://www.planetree.org/), which advocates a patient-centered, holistic approach to health care promoting mental, emotional, spiritual, social and physical healing. The ten Planetree components are:

- Importance of family, friends and social support
- Importance of nutritional and nurturing aspects of food
- Complementary/integrated therapies to expand a patient's choice
- Importance of human touch
- Spirituality and the importance of inner resources
- Healing arts as nutrition for the soul
- Empowering patients through information and education
- Human interaction
- Architectural design conducive to health and healing
- Healthy communities - expanding the boundaries of health care

Ms. Bonin described a quality improvement project that involved patients, the Walworth County Patient Safety Advisory Council. Walworth County, WI is located in southeastern, WI, and is a rural community >93,000 with (18,000 adults 55+). Aurora Health Care operates five clinics, four retail pharmacies, and one hospital. There are 8,500 Aurora patients 55+ with over 26,000 clinic visits per year. The project goal was to establish a patient safety advisory council that would develop interventions to improve medication safety. The objectives were to:

- develop and implement medication safety strategies that could be used by patients, the providers, and the community
- measure medication list accuracy in the clinic record
- measure the impact of the project on the engagement of patients, providers, and the community

The project, which was to be conducted for two years, received $500,000 in funding from AHRQ and Aurora Health Care. In addition, the project partnered with Consumers Advancing Patient Safety (CAPS, http://www.patientsafety.org/) and Midwest Airlines, which is known for its leather seats and chocolate chip cookies.

The first step was to recruit patients with the key characteristics--good communication skills, ability to collaborate with diverse individuals in a group setting, representation of the consumer base for the project, and firsthand knowledge of the topic. The patients' roles and responsibilities were to focus on the specific project goals and objectives, committed to improving care, ability to maintain confidentiality, and a willingness to share information with family, friends, and the community. Recruiting individual patients was perhaps the most challenging step. Aurora Health Care obtained referrals from healthcare providers. The healthcare provider (physician, nurse, or pharmacist) initiated the contact with the patient. This direct contact demonstrated to the patient that his/her participation and opinion was valued. A project coordinator conducted for follow-up. Patients were recruited from volunteers, parents, spouses, and retired employees. Community

representatives were also recruited from the Rotary Club, churches, social service agencies, and public libraries in order to broaden the scope of perspectives beyond the traditional one-on-one health care relationship between patient and physician and to recognize the role of the community in health care issues. Candidates completed an application form outlining the Council's duties and responsibilities. Once accepted, the Council members completed a confidentiality statement modeled on the hospital volunteer confidentiality statement, which was HIPAA compliant.

The Walworth County Patient Safety Council consisted of eleven patients/caregivers, who were 55 years of age or older, twelve healthcare providers (doctors, nurses, pharmacist, and social workers), and representatives from the community, such as the Office of Aging and Medicaid. Although the patients received a $50 stipend per meeting attended, some patients declined. Food was served at every meeting. Personal recognition was also a key component. Patients shared personal stories, were project champions, and participated in local, state, and national presentations. For example, in 1997, the Council received the Institute for Safe Medication Practices Cheers Award. One of the patients accompanied the Council chairperson to Las Vegas to accept the award.

All Council members participated in a 1 1/2 day long overnight orientation at a resort conducted by national speakers from CAPS and Midwest Airline. The orientation's goals were to create a new model of patient-provider collaboration, build rapport and trust among team members, share personal experiences related to the project goal, and develop/review the Council's vision and mission. The Council's vision was "A safe, compassionate, innovative health care community that listens, learns, and responds collaboratively with patients. The Council's mission was "The patient safety council will implement a community partnership model for the purpose of developing innovative methods to improve medication safety."

The Council defined ground rules that were reviewed at every meeting--speaking in nonmedical terminology, addressing all members in the same manner (by their first names with titles left at the door), setting meeting times that were convenient, and selecting a meeting location that was centrally located and neutral. For example, meetings were not held at the healthcare facility, but at the county health and human services office instead.

The Council developed two tools--a medication list and medication bags. Patients created a list of all the medications they were taking along with their healthcare providers. Since the list targeted the senior population, it was printed in a larger font. The medication bag initially had five prototypes and ended up being designed like a lunch bag. The Council received 500 evaluations. Patients especially did not want "My Medications" printed on the bag because it might be stolen. Both the medication list and bags were tested in the community. The project lasted over two years. During that period, 16,000 medication lists and 7,300 medication bags were distributed with 80+ educational programs with 2,300 participants. The patient, who went to Las Vegas, distributed the second highest number of medications as well as was involved in the educational programs. Throughout the project, patients were a key component to the implementation.

The Council's metrics for improvements in medication safety were:

- Accuracy of the clinic medication list (prescription medications only, not over-the counters and herbals)
    - Improved from 55% to 72% from 2005 to 2007
- Healthcare providers' perspective: The medication list/medication bag helped facilitate communication between you and your patients.
    - Medication list - 96% of healthcare providers agree/strongly agree
    - Medication bag - 60% of healthcare providers agree/strongly agree

- Patients' perspective: Did you bring your medication list or your medicines/medication bag to your last clinic appointment?

- Medication list - 72%, Medication bag - 23%

The Council wanted to identify the barriers associated with patients bringing the medication bags to appointments, especially in light of the cost difference. The medication lists cost $.15 per card vs. $3.00 per medication bag.

Since the two-year project period has ended, the Council no longer meets. However, the patients are involved in other projects. Ms. Bonin suggested other ways to include patients, such as have patients "trial" an intervention, obtain their feedback, and incorporate their suggestions into the final product. In addition, use real patient stories of adverse events as videos for staff education, create disease-specific advisory groups, e.g. heart failure and diabetes, site-specific advisory groups, and as members of patient safety and quality teams.

References

Agency for Healthcare Research and Quality, Aurora Health Care. *Guide for developing a community-based patient safety advisory council.* http://www.ahrq.gov/qual/advisorycouncil/

Committee on Identifying and Preventing Medication Errors, Aspden, Philip, Wolcott, Julie, Bootman, J. Lyle, Cronenwett, Linda R. (eds.). *Preventing Medication Errors: Quality Chasm Series*. Washington, DC: Institute of Medicine, 2006.

Consumers Advancing Patient Safety, Aurora Health Care. *Toolkit - How to create an accurate medication list in the outpatient setting through a patient-centered approach.* http://patientsafety.org/page/109587/

Gerteis, Margaret, Edgman-Levitan, Susan, Daley, Jennifer, and Delbanco, Thomas L. (eds.). *Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care*. San Francisco: Jossey-Bass, 1993.

From the NAHQ E-News

Joint Commission Q&A

Question: Can the survey notification time occur earlier than 7:30 am on the first day of a survey?

Joint Commission: The Joint Commission is evaluating whether or not we will provide earlier notification, but at this time, we cannot commit to a notification time earlier than 7:30 am. Unannounced surveys are important because they help healthcare organizations focus on providing safe, high-quality care at all times, not just when they are preparing for a survey. In addition, unannounced surveys

- affirm the expectation of continuous compliance with standards—both the Joint Commission's expectations of its accredited organizations and those organizations' expectations of themselves
- enhance the credibility of the accreditation process by ensuring that surveyors observe organization performance under normal circumstances
- reduce the unnecessary costs that healthcare organizations incur to prepare for surveys
- address public concerns that the Joint Commission receives an accurate reflection of the quality and safety of care.

The following surveys are *not* conducted unannounced:

- first surveys for organizations that choose the Early Survey Policy option

- Periodic Performance Review Option 2 and Option 3 surveys
- initial surveys (for organizations undergoing their first Joint Commission survey).

However, all surveys of hospitals, critical access hospitals, and other programs with federal deeming authority are unannounced. A 7-day notice is given for some surveys, including those for Department of Defense and the Bureau of Prison facilities. Short prior notice is given for certain smaller organizations in the ambulatory, behavioral healthcare, home care, and laboratory accreditation programs and for the Health Care Staffing Services Certification program. Short prior notice is given for all disease-specific care certification program reviews. For more about the unannounced survey process, visit www.jointcommission.org/AccreditationPrograms/unannounced.htm

NQF Releases 2009 Safe Practices for Better Healthcare

To guide healthcare systems in providing care that is free from error and harm, the National Quality Forum (NQF) has released its *2009 Safe Practices for Better Healthcare*. To accelerate the pace of adoption of NQF's Safe Practices nationwide, a yearlong Webinar series providing implementation strategies and commentary from experts in the field will begin April 23.

The report offers "clear tools for those who provide, purchase, and use healthcare to ensure that harm is reduced and care is safe. While improvements have been made in patient safety, they must spread farther and faster," said Janet Corrigan, NQF president and CEO. "We cannot afford—in lives or dollars—to provide care that is unsafe. Every patient deserves safe, high-quality healthcare every time they receive care."

The *Safe Practices* report is "intended to provide a road map for hospitals and health systems to improve safety. By focusing on an evidence-based systems approach, we hope to provide guidance to clinical leadership to make wise decisions about implementing programs and policies to measurably improve safety," said Gregg Meyer, senior vice president of the Center for Quality and Safety at Massachusetts General Hospital and cochair of NQF's 2009 safe practices steering committee.

Each Webinar will address specific practices from the report to guide the healthcare industry in more rapid adoption of safety practices. For example, one of the Webinars will address measurement and public reporting for improvement—an area that NQF advocates as part of any reform strategy. Additional information about the *Safe Practices* report and the Webinar series is available at www.qualityforum.org/safe_practices/

You and Your Career: Managing Through Tough Times

Barbara A. Fuchs, MS BSN RN CCMEP CPHQ FNAHQ

Quality professionals have been directly and indirectly affected by the financial crisis. The financial crisis has caused organizations to close, merge, or reduce their current workforce. If your organization has not been affected yet, rumors are probably swirling around the organization, making it difficult to work in an environment where people are unsure, frightened, and insecure. Managing these uncertain times is not easy. Many employees feel that they are their jobs, so when they lose their position, they may experience a loss of identity or self-worth and an inability to manage their personal lives. Employees who remain with their organizations feel a sense of loss, survivor's guilt, and insecurity that may affect their ability to manage day to day.

Keep in mind that both groups will go through the five stages of loss: denial, anger,

bargaining, depression, and acceptance. The length of time a person experiences each phase varies, but similar questions arise during progress through the stages: Why me? How could upper management do this to me? Why am I so angry at my colleagues—or at myself? What can I do to make things as they were? Why don't I have energy for career or personal life? Why do I want to retreat from my friends and family? Why am I sad all of the time? How do I create a new path for myself? What lessons have I learned about myself, my profession, my higher purpose?

No matter where you are on this continuum, you must remember and recognize that

- you are more than your title and position
- many good and talented people are losing their positions in this environment
- you have a right to feel how you feel
- it is not a sign of weakness to seek professional help
- some friends, including colleagues and acquaintances, will seem to be abandoning you at this time. It may be that they are simply too frightened and insecure about their own careers. True friends will reach out and do all they can to support you during this time.

If you are unemployed, about to be unemployed, or worried about being unemployed, follow the following steps:

1. Assess your financial situation calmly and without panic. Rein in spending and develop a budget. Consider all resources, including healthcare benefits and education assistance. How long can you and your family survive with your current savings or severance pay?
2. Carefully perform a self-assessment that includes your skills, talents, and desires. For many, the current circumstances present an opportunity to pursue a dream or life calling.
3. Activate your support system. Discuss certain topics with your family and other topics with a friend, mentor, or trusted colleague.
4. Although finding a new position is a full-time job, don't let it consume you. Make time for yourself and take periodic breaks to clear your head and restore your energy and sense of balance.
5. Thank those who assist or support you in any way.
6. If you feel secure in your current position, you should keep your résumé current, always look for new skills to develop, network consistently, and create a development plan and assess it on a quarterly basis.

One final thought: Believe in yourself, explore all of the possibilities, and celebrate your next success!

Barbara Fuchs is president of EPiQ Services, LLC, in Collegeville, PA. She can be reached at bfuchs.epiqsvc@comcast.net.

Product Feature: How to Powerfully View Data When "Yucky" Events Are Rare!

Featuring Sandra K. Murray, MS RD
When dealing with rare events—falls, needle sticks, infections—standard run charts or control charts are not always accurate. Using two newer control charts, T and G, to track time or counts between rare events is more appropriate for healthcare quality. How to Powerfully View Data When "Yucky" Events Are Rare! explains the rationale for understanding and using appropriate data. Purchasers of the presentation will receive an e-mail containing the download link and will have access to the presentation, formatted as a downloadable voice-over Microsoft PowerPoint file, for 45 days. To purchase, go to www.nahq.org. The cost is $99.95 for members and $129.95 for nonmembers. (Those completing the presentation and evaluation will receive 1.25 CPHQ CE hours.)

NAHQ To Initiate Market Research

At the NAHQ board meeting in February, board members discussed initiating new market research this year. This initiative is a follow-up to market research conducted in 2005–2006. Current plans call for developing a request for proposals to select a research company. The focus will be on globalization issues, a changing membership and customer base, ways to add value to NAHQ, and the changing face of the healthcare industry. Researchers will question who makes up a quality team, how composition is related to practice setting, and how quality is spread across the continuum. This research is slated to be completed before NAHQ's 2009 annual educational conference.

DID YOU KNOW……

……We encourage you to submit an article, which may be about an interesting session or seminar that you have attended, your recent experience with JCAHO, project results, study or research results, or anything that would be of interest to quality professionals. If your article is accepted for publication, you will receive a complimentary conference attendance. Please email your submission to the Newsletter Committee Chair Laura Schwartze at **laura.schwartze@hughes.net**

BOARD MEETINGS OPEN TO MEMBERS

Board of Director's meetings is held monthly, ten months of the year. Meetings are usually held on the fourth Thursday evening of the month in rotating locations, for the convenience of the Board members. Some meetings are now conducted via teleconference. We welcome the attendance and input of the general membership, at all meetings. Contact any Board Member by email for information and directions. Verify the location and time on the morning of the meeting.

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