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American Heart Month Issue!

WomanHeart, American Heart Association, STEMI Care & Heart Healthy Recipes

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Mission

The mission of the California Association for Healthcare Quality is to develop and promote the healthcare quality professional through:

- Education and Resources
- Networking
- Leadership in the Industry

Vision

We will be recognized as a leader in healthcare quality and patient safety. As a leader, we will:

- Identify and advance best practices
- Promote professional development
- Influence industry trends

Values

- Excellence
- Integrity
- Diversity
- Collaboration
- Professional Growth
- Continuous Improvement

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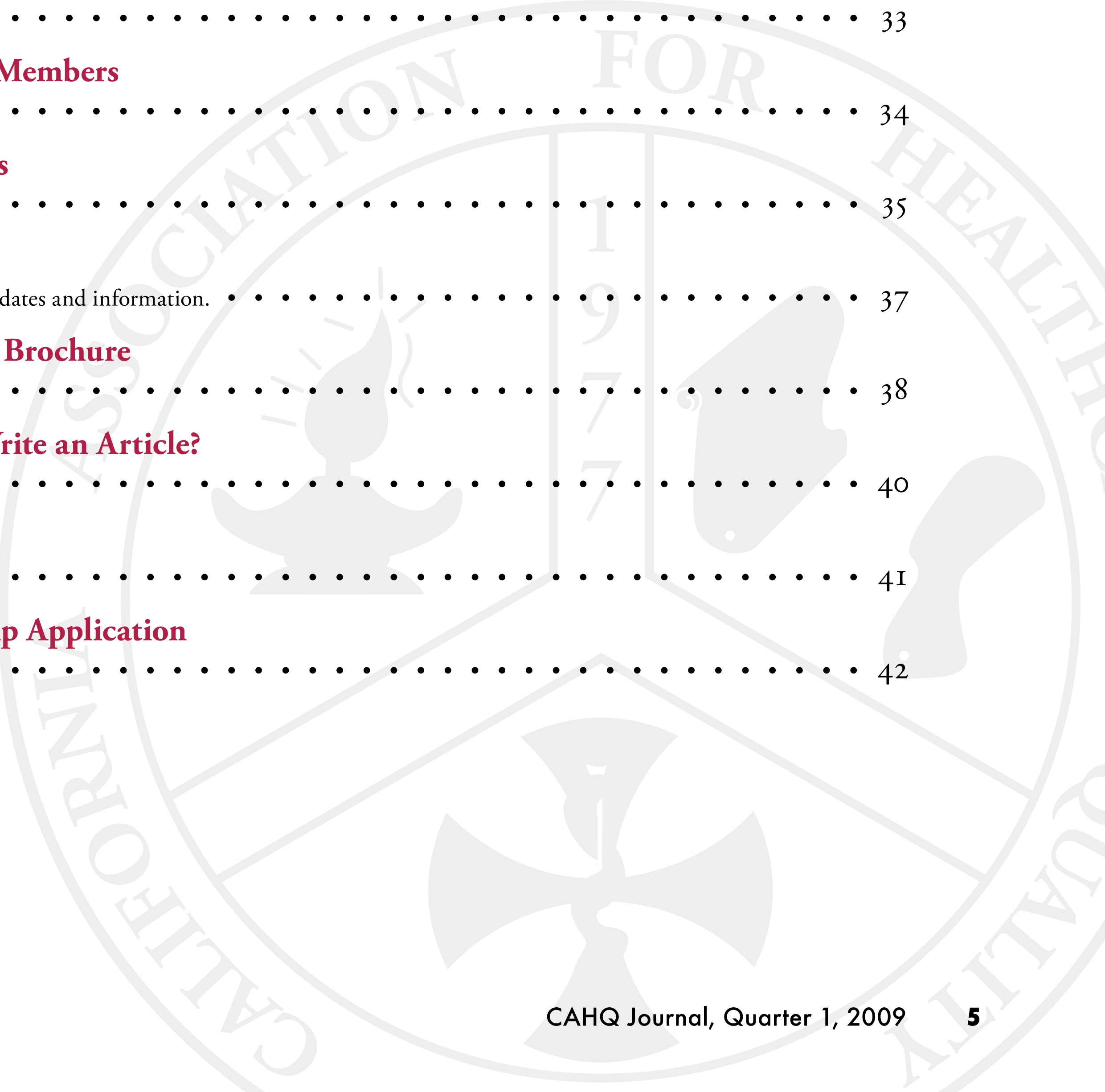

A Message from the President

Tricia Kassab, RN, MS, CPHQ

CAHQ President Tricia Kassab

At a recent Southern California Patient Safety Collaborative offered by the Hospital Association of Southern California, Dr. Della Lim provided the keynote topic "Seven Habits of Highly Safe People and Organizations". It was a thought provoking session and emphasized that Patient Safety should be Job # 1. Patient Safety is not a priority; it is a way of life.

1. Accept Vulnerability

The first "habit" to embrace is that we are vulnerable and not perfect. We must engage our patients and key stakeholders to truly understand care from their perspectives. In order to improve safety we must identify the system wastes and overuse of tests and simplify the way we do our work.

2. Learning to Learn

Children do not have preconceived notions of the way the world should look. As adults, we could learn from children and look at things from outside our paradigm. We need to understand evidence based care, learn how it impacts patient care, and be open minded to implement care that may not be how we were taught years ago.

3. Be aware of Assumptions

How often do we "assume" care is being provided in an evidenced based way? Hand hygiene is a perfect example. Our patients trust that caregivers will provide care safely and "assume" we will wash our hands every time to mitigate the chance of infections. Do you assume care elements are being provided every time in your specific area? How do you know?

4. Situational Awareness and Communication

There are a team of professional experts that provide care to patients. Who is taking care of the patient? Do we have a shared mental model that we are providing care the same way every time? IHI has recently published the "Surgical Safety Checklist" which is a step by step process to assure all caregivers are providing standard work. Do all of your teams feel safe to speak up with concerns? When teams debrief

and a patient outcome was good, ask yourself "What was our lucky break?"

5. Checking the Production-Protection Balance

Does production trump safety? We struggle with the balance in surgical services between efficiency, including turnover times and slowing down to make sure counts are done effectively, and full team briefings and debriefings are implemented consistently. When we do things quickly, we may miss critical steps that could affect our patient outcomes. We need to keep the balance forefront in our minds, and continue to provide education to all leaders.

6. Develop Trust and Transparency

In order to promote trust, we must be honest with ourselves and our patients and families. When an adverse event occurs, are we truthful? Patients expect medical disclosure, an expression of apology and want to know what is being done to prevent this from happening again. How do we invite patients to be at our side? Some organizations have included families and patients on task forces (e.g. pressure ulcers, infection, medication reconciliation, etc) which can help provide a sense of urgency for change.

7. Establish appropriate Roles and Policies

Do you have too many policies? How can staff be expected to understand them, never mind practice? We need to keep it simple! The notion of "Just Culture" helps to mitigate a culture of inconsistency and treats everyone uniformly. It is accountability through behavioral choices. We need to establish simple realistic policies, and hold staff accountable for following. If one intentionally chooses not to follow the policy, they are reckless. If one drifted for a moment and did a work around, would we handle both situations the same? Just Culture provides a roadmap/algorithm that helps us understand healthy norms.

In order for patient safety to be a way of life, everyone in healthcare has a part. We all need to be part of the work, and hold each other accountable to assure our patients and families are receiving evidenced-based care every time and everywhere. The power of one (you) is all it takes!

A Message from the Co-Editor

Kathy Chai, MSN, PhD, CPHQ, FNAHQ

Kathleen Chai

Happy 2009! Can you believe it? I am challenged to add that 9 at the end of the year but it gets easier the more checks I write. Later in this issue Pat writes about her experience with snow and since I first read it, we have had nothing but wind and heat here in Southern California. It's not really what a person is prepared for in January.

Speaking of being prepared, I am concerned about the next few months and years as it relates to healthcare. With the political climate changing, and the economy diving into the tank, I do not know what will happen to our health services. I am now a full time State employee. If any of you have not been listening to the State related news, we face the possibility of receiving IOUs instead of paychecks in February. While that may not be pleasant for me, there are many others who will feel the loss greater than I will. I am beginning to hear from new RN grads that they cannot get a job. However, I have been able to ascertain that they have not been able to get the exact job they wanted, in the organization they wanted, on the shift they wanted. Many of us remember those times but many of these new grads are second career graduates who were told a few short years ago that there would always be work for nurses. I think we need to be more clear about what that means, especially to those currently joining the profession.

How about the quality process? Yes, we are still collecting the "required" elements of data and for some of us, that data is somewhat automated. How about those who manually screen charts to collect the data? How much longer will we have the resources to do so? How much will automating our data systems cost if that becomes federally mandated? At what cost will that be to the organization?

Before you think I am plunging into a negative abyss, I need to tell you, it's just the opposite. I think we are still able to mold and form the way quality is done, but we need to be heard. Many of us have had the experience that makes us confident we know the right way to do things. How are we using that experience? Are we marching into the C-Suite and sharing our expertise? Are we letting our lawmakers know what works and what doesn't? Are we educating the staff in our organization to prepare them for what may be coming? We can do all of these things. The National Association for Healthcare Quality has strategic positions on the Joint Commission Hospital PTAC (Professional and Technical Advisory Committee). Diane Brown from California is the Co-Chair. The organization is also involved with the National Quality Forum. Barbara Corn from NAHQ was previously elected chair of the NQF Quality Measurement, Research and Improvement Council. What impact can we as an organization and as individuals have?

Maybe it's the political moment, but I feel we are nearing the point when the opportunity to become an active part in the change that needs to take place is now. Let me know how you plan to take part or actively prepare yourself for the changes that will happen in the next few years. I look forward to hearing from you.

Kathleen Chai

A Message from the Co-Editor: Collaboration

Pat Lucken, RN, MSN, FNP-C, CPHQ

Pat Lucken

In honor of heart month, this issue of CAHQ is dedicated to cardiology topics. Two of this issues author's are new acquaintances of mine. While researching the Internet recently for STEMI Center articles one name kept surfacing over and over.

That name is Dr Ivan Rokos, MD, FACEP, FACC. Since San Bernardino County just implemented a regional STEMI program, I decided to contact Dr Rokos.

I sent an E-mail one Sunday and was surprised when I heard back from him just a couple of hours later. He was away at a conference back east and promised to contact me later that week. As promised, Dr Rokos e-mailed me later that week. I explained that San Bernardino County had recently regionalized STEMI care. Since Dr Rokos works with a Southern California STEMI Summit he invited San Bernardino County to participate in the third annual STEMI Summit in Palm Springs in June of 09.

Dr Rokos is a busy ED Physician and also is on faculty at UCLA. He also works with AHA, ACC and IHI. He recognized me from a recent IHI call he helped to host on AMI care. I realized that I attended his second annual STEMI Summit the year prior. Dr Rokos connected me to Mr., Tue Nguyen. Tue is the AHA Mission Lifeline Director for Southern California. Mission Lifeline is AHA's most recent campaign to improve care of STEMI patients.

Tue immediately attended our San Bernardino County Inland Empire Emergency Medical Agencies (ICEMA) North End Quality Committee. During the roundtable Tue, said he felt like he was at home and vowed to join our group as a permanent member. Tue drives all the way from LA to the high desert to attend the quality group composed of EMS personnel and local healthcare facilities.

I often marvel at how small the healthcare community truly is, how one small e-mail to a complete stranger opened a new world of opportunity. Thank-you Dr Rokos and Mr. Nguyen for your leadership in pursuit of cardiac excellence and your contributions to this issue of CAHQ.

I welcome our new partnership as we welcome in the New Year.

Collaboration really is the Heart of Healthcare Improvement!

Pat

WomanHeart

Dori Marino, RN

On December 13, 2006 I found out after cardiac catheterization that I needed open heart surgery. My left main coronary artery was 80% blocked. I was told that the only treatment for left main disease was a coronary artery bypass graft which I had on December 14, 2006. That is how my heart story begins but how it continues is up to me and how it ends is up to God.

Briefly, I will tell you how my heart disease started long before I knew I had heart disease. At age 44 I had a cholesterol reading at a Health Fair. My total cholesterol was over 250. I went on a low fat diet and increased my exercise routine. By age 51 I was placed on statins to lower my cholesterol and by 55 I was also diagnosed with hypertension and placed on medications. I had various heart examinations the ten years before my surgery such as stress tests, echocardiograms, nuclear medicine stress tests etc. but never a cardiac catheterization which would have revealed the disease in my coronary arteries. As a nurse I was well aware of the risk factors that were slowly building up but I denied them because I felt great. It wasn't until the a six or eight months before my surgery that I began to feel tired and short of breath with strenuous activity but still I blamed it on getting old. I was 59 when I started noticing my decrease in energy and pain in my back. I never had chest pain or chest tightness typical symptoms associated with heart attacks. Later I learned that women may not present with the same cardiac symptoms that men have. Heart research is mostly done on men.

After my surgery, I had many unanswered questions. I went on the Internet and found a web site called WomenHeart. On this site I connected with other women with heart disease and joined the WomenHeart organization. In July 2007, after completing a questionnaire, I was chosen to attend a WomenHeart Symposium in Rochester, Minnesota to learn more about the WomenHeart campaign to educate women on heart disease. At this symposium I connected with other women with heart disease, learned more about heart disease in women and learned how to take better care of myself through diet, exercise and stress relieving techniques. Before going to the WomenHeart Symposium at the Mayo clinic I agreed to do 25 hours of community service after I became a WomenHeart Champion. I have completed my 25 hours by speaking at health fairs, cardiac rehab programs, libraries, women's groups and clubs.

In September of 2008 I filled out a questionnaire, sent to me by WomenHeart, regarding cholesterol as a contributing factor of my heart disease. I got a call from General Mills informing me that I had been chosen to be on the Cheerios box for the heart awareness campaign in February 2009. I went with the Cheerios Circle of Helping Hearts Campaign to various Southern California locations to do cholesterol screenings, blood pressure checks and blood sugar readings. In February 2009 I will be on over a million boxes of Cheerios boxes and for every code sent back to General Mills via mail or e-mail WomenHeart will get $1.00 to continue to promote education to women on heart disease.

I feel very fortunate that I had early detection, accurate diagnosis, and proper treatment for my occluded coronaries arteries. Not all women are as fortunate as I am; many will die of heart disease or become disabled by heart disease. The biggest threat to American women is heart disease. Heart disease kills more women in America today than any other disease and that includes breast cancer. By getting heart education out to women I feel I can help reduce the incidence of heart disease in women.

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Dr. Ivan Rokos

Regional STEMI Receiving Center Networks: The Evolution of a Major Paradigm Shift in 2009

Ivan Rokos, MD, FACEP, FACC

Primary Percutaneous Coronary Intervention (PPCI) for ST-elevation myocardial infarction (STEMI) is the most complex, multi-disciplinary, and time-sensitive therapeutic intervention in the world of medicine today: the process is measured in minutes, the outcomes in terms of short-term mortality, and teamwork and smooth transitions are increasingly recognized as essential for success.

In 2009, there are 10 large and powerful "tectonic plates" re-shaping acute STEMI heart attack care systems, both in California and across the nation. Their convergence makes the creation of regional STEMI Receiving Center networks essentially inevitable.

The Trauma Center Model (1970): Regional trauma centers have existed for almost 4 decades, have reduced morbidity/mortality, and serve as a model for STEMI network formation.

New Technology (last decade): Sophisticated computer algorithms have automated both the diagnosis of STEMI by pre-hospital 12-lead ECG machines (PH-ECG) and provided additional safety during transport with Automatic External Defibrillators (AED). For Emergency Medical Services (EMS), these technological advances allow for rapid and broad implementation of pre-hospital cardiac triage protocols.

NRMI Registry (1990-2006): across the nation, "slow" was the status quo for emergency balloon angioplasty and stenting (ie, PPCI) of STEMI heart attacks. Recent efforts are finally showing improvement. (Editor's note (ktc): the NRMI Registry no longer exists. There are a number of indicators collected related to MIs but one identified by the National Quality Measures Clearinghouse is related timeliness and is "Emergency medicine: percentage of patients (regardless of age) with an emergency department diagnosis of STEMI or new LBBB on 12-lead ECG who received primary PCI who

had documentation that the emergency physician initiated communication with the cardiology intervention service within 10 minutes of the diagnostic 12-lead ECG." Further information can be found at http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?doc_id=10324&string=stemi

The Feds and Core Measures (2003): Mandated transparency with public reporting of hospital Door-to-Balloon (D2B) times. (Editor's note (ktc): Both Joint Commission and the Centers for Medicare and Medicaid submitted measures for AMI. Some are being reported by one organization and some of them are part of both organization's reporting data. AMI inpatient mortality as an example is only being reported by the Joint Commission. For an inclusive list of national reported AMI measures, go to http://www.qualitymeasures.ahrq.gov/search/searchresults.aspx?Type=3&txtSearch=AMI+Core+measures&num=20

Institute of Medicine Report (2006): Documented the dangerous epidemic of Emergency Department (ED) and hospital over-crowding. Also, proposed that EMS needs to be more regionalized, coordinated, and accountable. For more information, a report brief from The Future of Emergency Care in the United States Health System can be located at http://www.iom.edu/Object.File/Master/35/014/Emergency%20Care.pdf

ACC/AHA STEMI Guidelines (2004): Set D2B ≤90 minutes as the national benchmark for quality angioplasty and stenting in STEMI.

ACC D2B Alliance (2006): Largest quality-improvement initiative ever undertaken by the American College of Cardiology. The campaign promoted 7 evidence based strategies to help hospitals achieve a goal of >75% rate of D2B ≤90 minutes.

"Grassroots" Initiative (2006): "Rationale for Establishing Regional STEMI Receiving Center (SRC) Networks" published by our group (http://www.emcreg.org/pdf/Rokos06.pdf). Data presented at ACC.08 meeting showed an 85% rate of D2B ≤90 minutes and 67% rate of EMS-to-Balloon (E2B) ≤90 minutes when patients are identified by a pre-hospital ECG (PH-ECG) and transported directly to a designated SRC hospital. A follow-up manuscript is in press in JACC Cardiovascular Interventions.

ACTION-GWTG Registry (http://www.cardiosource.com/clinicalcollections/clinicalcollections.asp?CCID=25) (2008): Efforts are currently underway to have a universally available national database infrastructure that can standardize and analyze all SRC network parameters.

AHA Mission: Lifeline (2007): A very large initiative from the American Heart Association focused upon improving the overall quality of STEMI heart attack care. The program is a national community-based STEMI initiative that seeks to improve healthcare system readiness and responsiveness. Mission: Lifeline spans patient recognition of symptoms and early access via 9-1-1, acute care by a coordinated team (EMS, ED, cardiac cath lab), and long term secondary prevention. The #1 Goal is patient-centered care that is timely and high quality.

In addition to the information identified above, Dr. Rokos has provided the link to the UCLA EKG Challenge online site where you can test your EKG interpretation accuracy. The link is http://www.emergencymedicine.ucla.edu/ecgchallenge/

Please let us know if you find this information useful. Kathy

The State of STEMI Care & Next Steps

Venkat Devineni, MD, FACC
Pat Lucken, RN, MS, BC-NP, CPHQ

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American College of Cardiology (ACC)

A handful of states are early adopters for the regionalization of ST Elevation Myocardial Infarction (STEMI) Centers. STEMI Receiving Centers (SRC's) work within geographic regions partnering with local emergency medical services (EMS), pre-hospital transport agencies and transferring facilities. The common goal is to expedite care and facilitate PCI times < 90 minutes. A positive pre-hospital EKG and possibly a manual read or transmitted EKG gets the patient en-route to the nearest SRC if the estimated time of arrival is less than 30 minutes.

Some 400,000 persons in the US experience a STEMI each year. Of those, some 30% fail to receive any reperfusion strategy. For every fifteen minutes beyond the 90 minute window there is an increase in mortality. Only half of the US hospitals have cardiac catheterization laboratories. Of those with cath labs only half are equipped to perform PCI.

SRC's are patterned after the Golden Hour of trauma. Deaths from MI are three times more common then death from motor vehicle accidents. The aim is to get the patient in route to the SRC or destination hospital, the one equipped to handle STEMI's on a 24/7/365 basis. The main hypothesis in favor is the more procedures a facility performs the better the outcomes.

The American College of Cardiology (ACC) and the American Heart Association (AHA) are leaders in promoting PCI times of less than 90 minutes. The ACC's Door to Balloon Alliance (D2B) began in November of 2006 and has over one thousand hospitals participating. The D2B Alliance for Quality is a Guidelines Applied to Practice project (GAP). Many tools are available at their website http://www.d2balliance.org to achieve this goal.

The American Heart Association (AHA) began Mission Lifeline in May of 2007. AHA's Mission Lifeline's Campaign is to decrease deaths from STEMI. A full access article titled, "Mission: Lifeline-a new plan to decrease deaths from major heart blockages," is available at their website http://www.americanheart.org by typing in the search box. Many other AMI tools are available as well.

Other strategic partners are the National Heart Lung and Blood Institute (NHLBI) as well as The Institute for Healthcare Improvement (IHI). IHI and the ACC's D2B recently provided a Webinar free of charge to participating facilities. Dr Ivan Rokos MD, FACEP was on the call and provided valuable information.

Dr Rokos has lectured extensively on the subject of emergency cardiac care. One very useful PowerPoint http://www.naemsp.org/documents/Rokos-NAEMSP.08.v5.pdf proposes to raise the bar further by focusing on E2B. E2B time is the first positive pre-hospital EKG that is time-stamped and sets the clock in motion. The goal of E2B is to attain a positive pre-hospital EKG to balloon time of less than 90 minutes.

Barriers for E2B include potential false positive reads. These barriers may be addressed by ongoing educational

efforts for pre-hospital personnel in interpretation, access (proper lead placement) and not over triaging the use of pre-hospital EKG. Next to perfect is the F2B, or first dispatch to balloon time. This is the time the call originates and the clock begins in motion until the balloon inflation. Finally there is S2B, as you may have guessed that is the first symptom onset to balloon time. This is a measure of how well the community is educated to access emergency cardiac care. This time includes first symptom onset to balloon time.

St Mary Medical Center in Apple Valley, Ca, recently finished their site visit for STEMI destination facility and became an official STEMI Center on January 1st, 2009. The site visit included an assessment of the last 20 STEMI patient's medical records. Three fourths of the patients arrived by EMS. There was good documentation on two of the patients why a pre-hospital EKG was not done; one had excessive diaphoresis the other intractable coughing. The remaining patients all had positive pre-hospital EKG's that confirmed AMI on the computer print-out as well as paramedic notation of ST elevation. All of these also correlated later to the coronary anatomy & culprit lesion. There was only one outlier that was greater than 90 minutes.

Moving forward having perfected our D2B program 92% of the time for 2008, we plan to focus on E2B with our EMS partners. Following that we would move on to the F2B then the S2B. SMMC would love to hear from you. SMMC was recently appointed a mentor hospital for AMI care by IHI. AMI mentor hospitals can be reached at http://www.ihi.org/IHI/Programs/Campaign/mentor_registry_ami.htm

The cath lab team at SMMC won highest hospital patient satisfaction scores for the past two of three years

Next Generation Improvement for Healthcare Systems:

A Comprehensive Structure-Process-Outcome Patient-Centered Medical Home Model for Redesigning Medical Practices

Lumetra

Linda M. Sawyer, PhD, RN
Fabio Sabogal, PhD
Joseph E. Scherger, MD, MPH

The new Obama Administration and Congress have given every indication that healthcare reform is a priority area for legislative and regulatory action.[1, 2] This coupled with the very real prospect that an important portion of the forthcoming economic stimulus package will designate significant resources for health information technology indicates that the healthcare industry is on the verge of another period of transition. Whether this is a positive transformation that results in improved access to care along with increased quality, safety, and efficiency depends much more on whether we have incorporated important lessons from our recent past than increased spending. A recently released study by the McKinsey Global Institute found American's spent more than $477 billion more on healthcare than we should have when compared to other peer countries.[3] In addition, the U.S. healthcare system produces poorer clinical outcomes with greater costs compared to other industrialized countries.[4, 5]

More money is not and should not be our default solution for what ails healthcare today. A thoughtful and lasting approach to improving the quality and safety of care in combination with an effective health information technology infrastructure is the treatment we believe our nation's healthcare system desperately needs.

Throughout Lumetra's 25 years of working with providers, payers, health plans, consumers, and government to improve the healthcare systems, we have seen what works and, quite frankly what has not worked. From this vantage point we learned that in order

for outcomes to improve and for change to take root, we must move beyond a singular focus on process improvement and process quality. As suggested by Donabedian, a pioneer in defining healthcare quality improvement, contemporary quality should be evaluated and emphasized equally on three levels: structure, process and outcomes:[6]

Structure Quality - Looks at healthcare system characteristics (e.g. health information technology and facility design) and capacities, as well as availability of resources to deliver healthcare (e.g. provider certification and training).

Process Quality - Assesses the delivery of healthcare services, and the extent to which appropriate procedures and treatments for a given condition are delivered, or professional standards are adhered to.

Outcomes Quality - Examines the effects of treatment by changes in patients' health status, including improvement in condition or reduction of harmful effects.

Recently we are encouraged to observe Donabedian's multi-dimensional concept of healthcare quality slowly be incorporated into physician office practices. Adopting and encouraging policies and incentives that accelerate the emergence of the Patient-Centered Medical Home Model could go a along way towards reducing the overpayment found in McKinsey not to mention patient safety vulnerabilities highlighted by the Institute of Medicine.[7-9]

Poorly designed healthcare systems are unacceptably common. Bad systems produce bad outcomes, compromise care quality and patient safety, and increase healthcare costs.[7, 8] The vast majority of physician offices are organized around the outdated acute care model consisting of episodic visits, an abundance of paperwork, and rising costs, which restrict practitioners' ability to provide the care patients and their caregivers need.[10-14] This model's shortcomings include:

- Overburdened physicians with insufficient time to provide best-quality care
- Low patient and provider satisfaction in part due to limited quality communication
- Poor model for preventive care and chronic illness management
- Insufficient time for the longer visits that complex patients need
- Inability to educate and activate patients providing good answers to patients' questions
- Low patient awareness, suboptimal treatment and poor control of chronic illnesses
- Common mistakes in prescribing, missed diagnoses, wrong treatment

This ineffective model produces overuse, underuse, disparities, misuse, and errors in quality of services and treatment.[15] Here are some examples:

- ***Underuse***. Effective and appropriate care is often not delivered to patients. Underuse has been documented for preventive, acute and chronic care. About 50 percent of people received recommended preventive care. In fact, "the care delivered in the United States often does not meet professional standards."[18]
- ***Overuse***. Unnecessary care is often delivered resulting in waste of resources and time, as well as patient harm, and sometimes death. Overuse of antibiotics is expensive and exposes patients to unnecessary risk.[16, 17] About 51% of patients diagnosed as having colds, 52% of patients diagnosed as having upper respiratory tract infections, and 66% of patients diagnosed as having bronchitis were treated with antibiotics, despite the fact that antibiotics offer little or no benefit for these conditions.
- ***Disparities***. Racial or ethnic disparities in healthcare are persistent across a range of illnesses and

Modernize the System to Lower Costs and Improve Quality

"America spends almost twice as much as other industrialized countries on health care spending per capita with poorer health outcomes. And yet, health care spending is expected to double within the next decade. A growing body of research points to substantial opportunities to improve quality of care while reducing costs. Some researchers estimate that as much as 30% of health care spending does not contribute materially to patient outcomes. We must dramatically redesign our health system to reduce inefficiency and waste and bring down costs for families and individuals."

— Barack Obama. Affordable Health Care for All Americans.
The Obama-Biden Plan, JAMA, October 22/29, 2008(30),16, 1927-1928.

healthcare services. These disparities remain even after adjustment for socioeconomic differences and other healthcare access-related factors."[9] For example, racial differences in invasive cardiac procedures persist despite severity of disease. African Americans receive disproportionately fewer treatments (catheterizations, percutaneous transluminal coronary angiography (PTCAs), and coronary artery bypass grafting (CABGs)) than white patients. Disparities are also observed for Hispanics and whites, although these were less consistent.[19]

- *Misuse and Error.* Errors in treatment are widespread, and misuse is characterized as the failure to execute procedures and plans correctly.[20] In fact, 44,000 to 98,000 people die each year because of preventable medical errors, making hospital-based errors the eighth leading cause of death in U.S. costing the healthcare system between $17 to $29 billion annually.[7] In a survey of primary care experiences in five countries, authors find "Across dimensions of care, the United States stands out for its relatively poor performance. With the exception of preventive measures the US primary care system ranked either last or significantly lower than the leaders on almost all dimensions of patient-centered care: access, coordination, and physician-patient experiences. These findings stand in stark contrast to U.S. spending rates that outstrip those of the rest of the world."[21]
- *Public Perceptions of Healthcare Quality.* Consumers are dissatisfied with the healthcare system. In a national survey, 55 percent of respondents said that they are currently dissatisfied with the quality of healthcare in this country. About 40 percent believe that the quality of healthcare has "gotten worse" in the past five years, where as only 17 percent think it is better. Half are worried about the safety of their care.[22]

Redesigning Physician Office Practices: The Patient-Centered Medical Home (PCMH)

A patient-centered medical home is an innovative model for primary care more effectively structured to provide superior quality of care in physician practices by delivering comprehensive, ongoing and coordinated care for people of all ages and all clinical conditions.[5, 23, 24] Within this framework, every patient has a medical home, a personal physician who leads a team of qualified professionals at the practice level who are in charge of providing ongoing, comprehensive care at all stages of life including preventive, acute care, chronic care and end of life care.[23]

Transformation to a PCMH Model enables practices to replace the brief visit model with a new vision of office practice that reduces costs, improves quality and enhances service. The cornerstones of this system are patients' continuous access to care, proactive care and activated patients.[5, 23]

This promising care model focuses in enhancing access and providing high quality of healthcare services through open-access scheduling, online appointments, enhanced hours, improved physician-team-patient-caregiver communication, group visits, e-mail communication, coordinated chronic disease management, web-based health information, better clinical decision support systems, use of electronic health record systems and outcome analyses.[13, 14, 25]

Patient-Centered Medical Home Improves Healthcare Quality, Communication, Coordination and Equality

The PCMH model focuses on quality, communication and coordination. Quality and patient safety are at the core of this model because outcomes are defined in partnership between the care team and the patient and caregivers, and continuously monitored by population management tools that provide real-time feedback to the care team.[5, 25] In addition, the provision of clinical decision support systems such as up-to-day evidence-based clinical guidelines at the point-of-care, improves healthcare quality and reduce medical errors.[26] Equally important is the establishing of quality standards and related metrics to monitor, report and improve medical healthcare outcomes.[26]

Communication is enhanced via face-to-face, group visits and online communications between and among healthcare professionals, patients and

caregivers. Better care coordination is attained by sharing information across clinical settings and by supporting clinicians with up-to-date medical information using electronic medical record systems and other health information technology tools.

The PCMH model focuses on patient activation. The care team works in very close partnership with the patient and their families. Patients have a central role in managing their chronic illness using effective self-management and problem-solving strategies.[27] They are empowered to ask questions and to learn about how to navigate the complex healthcare system. Also, the care team supports patient-self-management strategies by helping patients to set realistic goals and specific action plans to reach these goals. In addition, the care team provides emotional support, condition-specific information and disease management strategies, and ensures adequate follow-up increasing patient satisfaction and better medical outcomes.[27]

Patient-centered medical homes promote equity in healthcare.[28] When adults have a medical home – healthcare settings that provides timely, well-organized and enhanced access to healthcare providers - and health insurance coverage, racial and ethnic disparities are reduced or eliminated.[28] A national study among 2,830 adults found that linking patients to medical homes increase access, preventive screenings and management of chronic conditions.[28] The survey found that cholesterol rates and breast cancer and prostate screening tests were higher among adults who received patient reminders.[28] When adults from different minority groups have medical homes, they are as likely to receive these reminders.[28]

Other important outcomes of the Patient-Centered Medical Home are:

- Technology-enabled communications and ability to interact with more patients per day
- Fewer appointments per day, saved for patients who need more of his/her time
- Improved quality of care, fewer prescribing errors and missed diagnoses
- Enhanced convenience for physicians and patients through continuous communication access, decreased waiting time, and automated prescription refill
- Increase overall savings to the healthcare system through reduced hospitalizations and complications of chronic illness

A Medicaid PCMH program, the Community Care of North Carolina, that focused on superior quality and cost outcome using disease management, evidence-based clinical guidelines, and a physician-led team approach, showed a saving of $195 to $215 million in 2003 and between $230 and $260 millions saved the state in 2004.[28] A report on financing the new model of family medicine estimated that if every American used a primary care physician as their usual source of care, there would be a 5.6% reduction in healthcare costs and a national saving of $67 billion dollars per year.[25]

A New Vision of Office Practice

The redesign of physician offices requires fundamental changes related to:

- Continuous management and monitoring of a patient population prioritizing conditions
- Patient-centered care home managing needs and demands in a new web-based platform of services
- Planned and proactive care
- Best evidence-based clinical knowledge at the point-of-care
- Continuous access to face-to-face and electronic multimodal communication
- Taking the time to be effective (time to heal)
- Fewer time intensive visits
- Culturally appropriate patient education tools to activate patients/caregivers
- Teamwork approach that provide comprehensive primary care across the lifecycle for children youth and adults and interpersonal skills
- Focus on comprehensive and personal care

Recognizing Physician Practices as Medical Homes

The National Committee for Quality Assurance (NCQA) released standards for Physician Practice Connections – Patient Centered Medical Homes (PPC-PCMH).[23] This program recognizes primary care practices that provide superior quality of care using evidence-based standards of care. Some of the dimensions of care measured in the program are:

- Access and communication

- Patient Tracking and Registry Functions
- Patient Self-Management
- Electronic Prescribing
- Test Tracking
- Referral Tracking
- Performance Reporting and Improvement
- Advanced Electronic Communications

For PPC-PCMH recognition, practices must pass at least five dimensions of quality care. NCQA broadly publicizes those physician practices that are recognized as a patient-centered medical home.[23] Quality and professional medical organizations such as the American Academy of Family Physicians (AAFP), the American Osteopathic Association (AOA), the American College of Physicians (ACP) and the Institute for Healthcare Improvement (IHI) support the Patient-Centered Medical Home. These organizations and many payers are looking for more efficient and safer structure-processes-outcomes at the physician practices level that use the Patient Centered Medical Homes model to produce better quality healthcare at reduced costs.

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Notes from NAHQ

Kathleen Tornow Chai

NAHQ has published the second edition of Q-Solutions. The entire references is :

Pelletier,L.R. & Beaudin, C.L. (Eds). (2008). Q Solutions: Essential Resources for the Healthcare Quality Professional, Second Edition. Glenview, IL: National Association for Healthcare Quality.

The book can be accessed through the online order information at http://www.association-office.com/NAHQ/etools/products/products.cfm

Plan ahead! NAHQ's 34th Annual Educational Conference; Dates: Sunday September 13th, 2009 through Wednesday September 16th, 2009. Gaylord Texan Resort Hotel & Convention Center, Grapevine, TX

Special Interest Groups (SIGs) Starting in early February, six new Special Interest Groups (SIGs) will be available as a NAHQ members-only benefit—in the areas of acute care, behavioral health, critical access/rural healthcare, home care, long-term care, and managed care. SIGs connect individuals with similar interests and allow them to share knowledge, promote specialties, identify professional challenges, and advance the profession. Watch for an e-mail in early February with instructions for joining the SIG of your choice and signing up for an individual Listserv. If you checked a specific organization or facility type on your NAHQ membership application, you will be automatically added to the appropriate SIG Listserv. If you did not identify an organization or facility type, you will need to sign up through the Members-Only section of the NAHQ Web site. You may join as many SIGs as you like. For more information, go to www.nahq.org.

NAHQ e-news Readership Survey Results: NAHQ says thanks to the nearly 300 NAHQ e-news readers who recently responded to the online readership survey. Ninety-two percent of readers said the newsletter is meeting their needs, and 60% said they share it with others, including personnel from infection control, risk management, patient safety, and nursing. Survey respondents also provided feedback on issues they'd like to see covered this year. Among the most requested topics were Centers for Medicare and Medicaid Services regulations and core measures, Joint Commission standards and changes, and SIG-related issues. Other suggestions were technology and the electronic health record; pay for performance; infection control and National Patient Safety Goals; public reporting and transparency; insurance, risk management and national health insurance; Lean/Six Sigma; and issues related to the election and the economy. NAHQ appreciates your input and promise to address your concerns!

Helping Patients Make Healthy Lifestyle Changes

April Popejoy, MS, RD, CDE, BC-ADM

Good nutrition is a fundamental ingredient for a healthy lifestyle. There is a Chinese proverb that states, "He who takes medicine and neglects to diet wastes the skill of his doctors." Simply put, all the medicines in the world cannot replace a nutritious diet. The food we eat provides fuel for our mind and bodies. Selecting foods that contain high amounts of vitamins, minerals, and fiber with limited amounts of unhealthy fats, sodium, and excess sugars can provide our body with necessary fuels without adverse health effects.

Even though most of us understand the importance of healthy nutrition, many individuals find it difficult to make necessary dietary changes. The reason for this difficulty is multi-faceted. Many people have been making poor diet choices for several years. It can be very difficult for some to change old habits. We currently live in an "obesiogenic" environment where unhealthy foods are cheap and easily accessible. It now takes extra effort to eat nourishing foods and to exercise daily.

Another factor for poor diet choices is the enormous amount of misinformation that barrage us from books, news, Internet, and magazines. Fad diets, outrageous weight loss claims, foods promoted to cure disease, and a list of other health scams can be found everywhere. It can be confusing and discouraging for individuals searching for information on healthy eating to discover contradicting and dangerous advice.

Another reason for our patient's resistance to make healthy eating changes is

the public's mistrust of diet recommendations. As we learn more about nutrition, health organizations are required to change dietary guidelines. This can sometimes leave the impression that health guidelines are too variable and untrustworthy. For example, guidelines on eggs and cholesterol have changed considerably in the last few years. Egg yolks are known to be high in cholesterol and Americans were encouraged for many years to limit their egg yolk consumption to no more than 2-3 per week. Scientists have more recently found that saturated and trans fat intakes likely affect serum cholesterol levels more than dietary cholesterol intake. We have now changed the recommendation to allow 4-5 egg yolks per week. Eggs are now being promoted as a good source of protein, choline, and antioxidants that protect the eyes such as lutein and zeaxanthin. A few studies have even found regular egg consumption may improve lipid profiles. The change in egg recommendations seems logical when considering the recent findings on eggs and overall health. However, to the public it can seem that what we claim to be detrimental one week we promote as healthy the next.

So how can we as health professionals help patients make better food choices? The first step would be for us to be sure we are making good choices ourselves. As nurses, physicians, therapists, and dietitians we should be eating mostly whole, fresh foods and less fried, processed, and convenience foods. Eating healthy in our busy lives can be done but it requires planning. Be sure to have plenty of healthy, easy foods on hand for quick meals. If we incorporate healthy eating into our own routines, we will be better equipped to encourage our patients to make similar changes.

Another way we can help our patients is to guide them toward sources of sound nutrition advice. We must strive to teach our communities how to avoid diet scams and how to analyze unrealistic health claims. We should encourage them to gather information from reputable sources such as the American Dietetic Association, American Heart Association, mypyramid.gov, and other government publications. We can teach them that websites ending in .gov, .edu, or .org typically provide more reliable information than .com or .net. We should encourage our patients to avoid "diets" found in fashion magazines and supplement advertisements.

Dietitians have been specifically trained to teach people how to make better food choices. However, many other health professionals can be equipped with the skills to provide basic nutrition guidance. It is important that we all provide accurate health messages that follow evidence-based guidelines. Remember that simple and direct health messages have been found to be the most effective. If we can provide our patients with consistent, easy to follow messages that are tailored to their culture and lifestyle, we will find their receptiveness to the information greatly improved.

Easy tips for consumers to choose healthier foods:

- Eat plenty (at least five servings daily) of brightly colored fruits and vegetables
- Select whole grain breads, crackers, and cereals. Look for "whole wheat flour" as the first ingredient.
- Have plenty of healthy foods on hand. If healthy foods are easily accessible we will be more likely to eat them.
- Plan weekly meals based on grocery store sale items. This is the best way to eat healthy on a budget.
- Limit fast food to only one visit per week (or less).
- Limit fried food to no more than one serving per week.
- Eat breakfast daily.
- Select mostly foods that can be found in nature such as fruits, vegetables, lean meats, beans, and other plant foods.
- Limit high-sugar, high-calorie beverages such as soda pop, juice, sweet teas, and other sugar-sweetened drinks. These are empty calories that add up fast!

The following recipe is a great example of an easy, healthy meal loaded with good nutrition.

Recipe on following page

Baked Salmon and Roasted Vegetables

(Serves 4)

Roasted Vegetables

1 Sweet Potato
1 Onion
1 Green Pepper
1 Red Pepper
3 Large Carrots
Handful Cherry Tomatoes
1 Medium Tomato
Vegetable Marinade
1 tsp Paprika
Pinch Dried Basil
Pinch Dried Thyme
Large Pinch Dried Chives
Few Drops Lemon Juice
5 Tbsp Olive Oil

Baked Salmon

4 Fresh or Frozen Salmon Filets (thaw if frozen)
2 Tbsp Balsamic Vinegar
2 Tbsp Olive Oil
Dash Dried Dill
Dash Dried Oregano
Dash Paprika
(You may also use other spices as desired.)

Preheat oven to 350 degrees F. Place vegetables on a large baking tray. Mix marinade ingredients together. Pour marinade over vegetables and cover with tin foil. Bake vegetables for 20 minutes covered. Remove foil and bake for additional 10 minutes or until vegetables are soft.

While vegetables are baking, place salmon filets in middle of tin foil squares. Mix together vinegar, oil, and spices. Pour mixture over filets. Fold the tin foil to create a sealed package. Bake at 350 F for 8-10 minutes. Fish should be flakey when fully cooked.

Serve with brown rice.

American Heart Association Rapid Access Journal Report

Mission: Lifeline–A New Plan to Decrease Deaths from Major Heart Blockages

Tue Nguyen, Director LA Mission Lifeleine, American Heart Association

Mission Lifeline is the community partnership of The American Heart Association (AHA) and Emergency Medical Services and acute care facilities to expedite the care of heart attack patients suffering from ST elevated myocardial infarction.

"The goal of Mission Lifeline is to develop community-based systems across the country so patients can get appropriate care more quickly. Ultimately our goal is to improve outcomes and save lives."

This press release is published with permission of AHA

DALLAS, May 30 – The American Heart Association today launched Mission: Lifeline, a community-based initiative aimed at quickly activating the appropriate chain of events critical to opening a blocked artery to the heart that is causing a heart attack.

"Mission: Lifeline is our newest tool in fighting disability and death caused by heart attack and stroke," said Raymond J. Gibbons, M.D., American Heart Association president.

"To improve their outcomes from a heart attack, patients need to recognize heart attack symptoms and immediately call 911 for emergency assistance. From that starting point, this critical chain of events must move quickly and appropriately so that we can open the blocked artery to their heart and restore blood flow to the heart muscle. This initiative will seek to improve quality and speed in many steps of this sequence of care for heart attack patients."

Gibbons said the association is uniquely able to activate national, state and local resources to implement the systems of care that improve patient outcomes. "With our network of thousands of volunteers and health professionals we can insure patients get the care they need, where they need it

and when they need it," he said. "We have great therapy for heart attacks. We must deliver it to everyone, and quickly, to save more lives – the context is that simple."

Mission: Lifeline is based on the findings of a group of key experts and stakeholders the association convened last year to develop a plan for improving care for ST-elevation myocardial infarction (STEMI), a type of heart attack caused by the sudden, total blockage of a coronary artery. The findings and recommendations of this workgroup will appear online today in Circulation: Journal of the American Heart Association.

While most of the 865,000 heart attacks that occur each year are non-ST elevation heart attacks that are not easy to recognize early, ST elevation heart attacks can be quickly recognized and treated to reduce heart damage. A STEMI heart attack carries a substantial risk of death and disability and calls for a quick response on many fronts. Although Mission: Lifeline is focusing on improving the system of care for the nearly 400,000 people who suffer from a STEMI heart attack, improving that system will ultimately improve care for all heart attack patients.

"Despite the proven benefits of quickly restoring blood flow to the heart muscle during a heart attack, 30 percent of STEMI patients do not receive the treatments available," said Alice Jacobs, M.D., past president of the American Heart Association and leader of the workgroup proposing the recommendations. "Regrettably, public awareness campaigns and community-based interventions have not yet been effective in reducing the time from symptom onset to first medical contact or in increasing the number of patients who use emergency medical services to get to hospitals where they can receive the appropriate care. We must have a system in place that will do this."

"Addressing the systems of care for STEMI is a complex issue," she said. "As part of this initiative, STEMI treatment has been assessed from all points of view: doctor, nurse, patient, payer, hospitals, emergency medical services and policy-maker. It is the local community that can save a life and we are committed to empowering our communities to do just that. Because each community will have unique needs – based on geographical size and location, as well as varying resources among other factors – one system of care won't meet the needs of everyone. Through Mission: Lifeline we are working with local stakeholders to find the local solutions that will work for their communities."

Jacobs, professor of medicine at Boston University School of Medicine and director of the cardiac catheterization lab at Boston Medical Center, said there are two ways to open the heart artery for STEMI patients: either with clot-busting drug therapy or with the artery-opening procedure known as angioplasty. Among patients who receive either therapy in the United States, less than half are treated within the recommended timeframes after arriving at the hospital (30 minutes for clot-busting drugs; 90 minutes for angioplasty).

Angioplasty, which is also called percutaneous coronary intervention (PCI), is a procedure in which a tiny wire is inserted into the blocked area of a person's artery and a balloon is inflated to re-open the artery and restore blood flow to the heart. In many cases, a wire mesh tube, called a stent, is put in place to prop the artery open and prevent re-blockage. When performed as an emergency, the procedure is called "primary" PCI.

"Research suggests that primary PCI, when performed in a timely fashion by health care providers in experienced medical centers, is superior to clot-busting therapy in reducing the rates of death and complications after a STEMI heart attack – even when patients need to be transported from a hospital that can't perform PCI to one that can," Jacobs said. "However, clot-busting therapy is the mainstay of treatment because it is more widely available."

Of the nearly 5,000 acute care hospitals in the United States, about 2,200 have heart catheterization laboratories and only 1,200 of those are capable of performing PCI, according to the summary of last year's conference proceedings. Jacobs said that jeopardizes timely delivery of primary PCI to the majority of STEMI patients.

"Saving time saves lives. Getting STEMI patients the timely care they need involves a series of events that must flow seamlessly to be most effective," Jacobs said. "The goal of Mission: Lifeline is to develop community-based systems across the country so patients

can get appropriate care more quickly. Ultimately our goal is to improve outcomes and save lives."

This process starts with patient education to make the public more aware of the signs of a heart attack (which can be more subtle than most people realize) and the importance of calling 911 for emergency medical services (EMS) for transport to the hospital. Unfortunately, over half of STEMI patients either drive themselves to the hospital or are driven by family and friends resulting in a delay in life-saving diagnosis and treatment that trained EMS personnel could provide, Jacobs said.

Improving the diagnosis of STEMI heart attacks by EMS personnel before hospital arrival will be a crucial part of Mission: Lifeline. Currently, the diagnosis of STEMI or non-STEMI patients is typically not made until a patient arrives at the emergency room. However, if EMS systems have the personnel, training and appropriate resources, they can acquire, interpret and transmit 12-lead electrocardiograms (ECGs) that can show the patient is having a STEMI heart attack.

In the ideal scenario, the catheterization laboratory would be activated by EMS from the field, or by emergency physicians at the hospital after receiving transmitted ECGs from the EMS staff treating the patient. Patients transported to a non-PCI-capable hospital by EMS would remain on the stretcher with EMS personnel in attendance until the decision is made about whether to transport to a PCI-capable hospital. For patients who transport themselves to a non-PCI-capable hospital and require primary PCI, their transfer would occur with the same urgency as a 911 call.

"Since the majority of STEMI patients go to hospitals without onsite primary PCI capabilities, these medical facilities will play a pivotal role in increasing the number of patients with timely access to angioplasty," Jacobs said.

These hospitals would be referred to as STEMI referral hospitals and would treat patients according to standard triage and transfer protocols recommended by the American College of Cardiology/American Heart Association guidelines, with incentives to rapidly transfer appropriate patients to a PCI-capable hospital for primary PCI. The system of care would also incorporate rapid data transfer to the PCI-capable hospital.

Other integral steps in the process will be working with payers and policy makers to ensure that mechanisms are in place for appropriate reimbursement and accountability protocols. A final component will be the development of a STEMI Center Certification Program with criteria for both STEMI referral and receiving hospitals.

Existing regional STEMI systems of care in Minnesota, North Carolina and Boston have served as models for the development of Mission: Lifeline. The American Heart Association-led initiative is being piloted in California, Texas and Florida, where state-level task forces of key stakeholders have already convened. Other states are considering holding similar meetings over the next year.

"The American Heart Association is proud to be a leader on national and local fronts in developing systems that deliver evidenced-based quality health care to patients," Gibbons said. "Our guidelines for emergency cardiovascular care, our stroke center certification program and our Get With The Guidelines hospital quality improvement initiative have already saved many lives, but there is more we can do. Mission: Lifeline will help save more lives."

THE BOTTOM LINE

Blessings of the Season

Pat Lucken, RN, MSN, FNP-C, CPHQ

In Mid-December we experienced a rare sight in the Mojave Desert, one of beauty & awe. Nearly a foot of snow was dumped in the high desert over a short period of time.

We learned later that motorists were stranded for hours on the Interstate 15. The Medical Director of our ED, Dr Bolivar had to abandon his vehicle on the I-15 & thumbed a ride to work from a kind stranger with a truck on steroids.

I really waited too long to leave work and somehow managed the 15 mile trek home sliding all the way. I made it to the end of our very long street only to become hopelessly stuck in deep snow. A neighbor tried to help me get unstuck but to no avail. Another neighbor gave me her umbrella to cover myself for the long hike home. She would have driven me but she was frightened of driving in these conditions. None of my family answered their cell phones as they were out playing in the snow. I made it home soaking wet. You could not tell where the curb ended and the street began.

My family insisted that I not leave my car at the end of the street fearing some disastrous ending. I told them that is why we have insurance to cover such matters. They hiked down anyway to rescue my disabled sports car. After quite some time my youngest son Tim discovered a hidden compartment and a hook that inserts into the front of the car. A neighbor with one of those trucks on steroids rescued my car & it got parked safely in our garage.

A co-worker who lives nearby was not so lucky. She made it all the way to her driveway only for her husband to help her pull the vehicle in closer

by gunning it thus crashing into another of their vehicles in the process. Luckily I am not aware of any serious injuries or deaths due to motor vehicle accidents related to the snowfall.

I think that is mainly because the following day everyone in the high desert had a snow day. SMMC went on internal disaster the first evening and stranded workers either stayed at the hospital or at friend's nearby. Some of my co-workers worked on policies and procedures opting to stay at the hospital. I wondered why I got an e-mail from one of them at 1:30 am. I asked if she had insomnia also and found out she was at work still working! I felt guilty that I was home with my family & some were still hard at work.

A week later on Christmas day my parents headed up to see us. It is normally a one hour drive. They encountered a Sigalert and also it started to rain. It was also very cold and it would not take much more of a temperature drop to start snowing. I began to worry about their decision to drive up anyway. Determined to make it for the holiday they forged on. Just as they came up the Cajon Pass the clouds parted and they saw a double rainbow. My mother has since shared the story over and over with her friends and viewed it from a Biblical sense.

I was so surprised when I heard a knock on the door and it was them arriving safely and also on time. The turkey was roasted to perfection. My family was re-united safe and sound.

All we have now are the memories of the snow and our family holiday and we have plenty of photo's to prove it. A beautiful ending to 2008 as we welcome in 2009.

Happy New Year,
Pat Lucken

Pats husband John with horses Bucket and Smoky

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2008 Author/Article Index

CAHQ expresses gratitude for those whom have contributed articles, press releases, reflections, book, conference and movie reviews over the past year.

A special thanks to our graphic designer Colin MacGregor!

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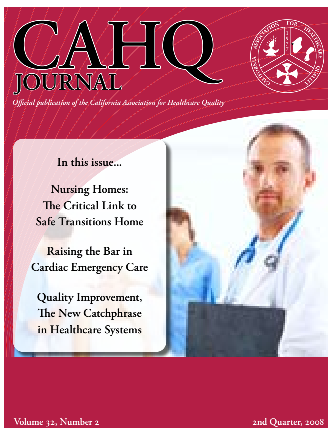

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Kathleen Tornow Chai, PhD, MSN, CPHQ, FNAHQ

http://www.qualitymeasures.ahrq.gov

Do you ever find yourself searching for a particular indicator or measure? Do you wonder how others measure the same thing? How about something concrete like falls? A review of the literature available on the National Quality Measures Clearinghouse identified 45 different references for falls. Each of the references included a brief summary, information about the measure validity, a description of the measure with rationale for its usage, numerator, denominator and data source information, the organization collecting the data, the developer of the measure, and the availability of the measure. It's a treasure trove of information!

The website is easy to navigate and information is clear and intuitive. Information is displayed in a way that directs the eye to important points and the pages are not busy with extra documentation. The pathways to access the measures are direct and there is enough information to pique your interest to continue searching. Sometimes the topics that appear in the search do not appear to be related to the search term used, but once the additional information is accessed, the link becomes clear.

Going back to the topic of falls, the following information was linked to measures:

- NCQA measures related to a history of falls in the geriatric outpatient.
- Falls related to risk assessments and plans of care for falls, in ambulatory patients.
- Percentages of patients who fall in ambulatory surgical centers.
- Elderly patients taking antipsychotics, tricyclic antidepressants, anticholinergic medications or sleep agents who fall (Medication Management).
- Medicare patients with chronic renal failure on NSAIDS who fall.
- Osteoporosis (any age) and falls.
- Problem drinking and falls.
- Post operative hip fractures (not related to preoperative diagnosis).

The vast amount of information on each topic is impressive. There are linkages to find the actual measure and information on which to base a search for benchmarks. This is the best case scenario for not reinventing the wheel.

The website also has other features. Every week a list of updated or new measures and the organization that developed them is published. This is found under the tab What's New? Under the tab named About, the organization describes itself this way:

The National Quality Measures Clearinghouse™ (NQMC), sponsored by the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services, is a database and Web site for information on specific evidence-based health care quality measures and measure sets. NQMC is sponsored by AHRQ to promote widespread access to quality measures by the health care community and other interested individuals.

"The NQMC mission is to provide practitioners, health care providers, health plans, integrated delivery systems, purchasers and others an accessible mechanism for obtaining detailed information on quality measures, and to further their dissemination, implementation, and use in order to inform health care decisions. NQMC builds on AHRQ's previous initiatives in quality measurement, including the Computerized Needs-Oriented Quality Measurement Evaluation System (CONQUEST), the Expansion of Quality of Care Measures (Q-SPAN) project, the Quality Measurement Network (QMNet) project, and the Performance Measures Inventory (PMI)."

The website can be searched by the following topics:

- Disease/Condition
- Treatment/Intervention

- Domain
- Organization
- Measure Archive
- Measure Index
- Measure Initiatives
- Measures Most Viewed
- Measures In Progress
- NQF-Endorsed Measures
- Related NGC Guidelines

There is even a mechanism where one can compare two or more measures against each other. For some of our members, this may be one stop shopping. This piece was written after Catherine Martin identified the clearinghouse as a useful website. Would you like to see more articles like this? I would be happy to review and critique online sources for members of the organization and publish my findings. Comments are appreciated.

Welcome California's New 2008 Certificants for CPHQ

Jose Alfredo Acosta
Amy E. Ando
Kathy R. Baroody
Margaret R. Blaszcak
Cynthia Caldwell
Jodi A Dailey
Hazel E. DeLeon
Laura Ann Finn
Angela Flack
Donna Garro
Carroll Geary
Mary Cheri Graham-Clark
Robert J Habell
Maria Charo Jumaoas
Sheila E. Kaneshiro
Kimberly M. Karrle
Sarna Ivy Kolvan
Marianne Marchetti
Lisa Massarweh
Ellenn M. Matiasevich
Robert Eugene McFarland
Elizabeth J McIntosh
Jeremy Mehelchick
Leslie A. Mulhern
Mary Josephine Mullen
Charles Clint Patterson
Bayley A. Raiz
Karie Rego
Maria Robinson
JoAnne M. Seitz
Paramjit Singh
Julia Katherine Slininger
Pamela P. Smith
Mohammed A. Tohemer
Catherine E. Toneck
Heather Marie Vanhousen
Barbara Ann Waggoner
Gay Waland
Michael L. Walsh
Shelly Whalon
Philip D White
Lynda Wills
Susan Wisniewski
Donna D Young

Welcome, to all of the new CAHQ members! 7/15/08–1/10/09

Joyce Boddie
Linda Bomersbach
Kapinea Brown
Marti Carter
Kathy Cawthon
Theresa A. Cesiro
Madelaine A. Cope
Jacqueline Curtom
Johnetta Davis
Hazel De Leon
Kathleen A. Dion
Mary Eichhorn
Stephanie Farrell
Glorivic S. Fazon-Ruiz
Mary Fitzgerald
Emerald Foster
Donna Garro
Carol George
Gloria Gomez
Kimberly Guy-Wright
Rhoda Harris
Tambra Hayes
Diane Newell Healey
Norri Hernandez Ay-Ad
Stephanie Hewitt
Sherri L. Horowitz
Bonnie Howell
Angela Hughes
Jana Johnston
Sharon Kingsberry

Sue LaPisto
Elke Lienhop
Elizabeth Ann London
Glena Loyola
Dov Marocco
Lisa Massarweh
Mary Mendelsohn
Shaunette Miller
Trish Molloy
Nancy A. Morales
Kate O'Brien
KJ Page
Lucy Pantoskey
Martin F. Peavey
Alberta Pedroja
Schlene Peet
Jacqueline Phillips
Anthony S. Pineda
David Pringle
Corley Roberts
Diana Rouse
Diane Scharf
Barbara Stimek
Sonja Thaler
Shannon Truesdell
Matthew Whaley
Chance White
Phyllis M. Winston
Terri Woolf
Xochitl Ybarra

Author Bios

Pat Lucken, MSN, BC-NP, CPHQ
Pat received her MSN/FNP from Azusa Pacific University in Azusa Ca. She is currently Director of Cardiac Service Line at St Mary Medical Center, in Apple Valley, Ca (part of the St Joseph Healthsystem of Orange, Ca). Pat serves on the Board of The California Association for Healthcare Quality (CAHQ) as Journal Co-editor from 07 to present. She also serves on the Board of Inland Counties Emergency Medical Agency (ICEMA) as Secretary for the North End Quality Committee from 07 to present. pat.lucken@stjoe.org

Fabio Sabogal, PhD
Fabio Sabogal, PhD, is a Senior Healthcare Information Consultant for the Scientific Analysis Department at Lumetra, responsible for synthesizing evidence-based information for the diverse quality improvement projects. He has more than 20 years of experience as a university professor and healthcare outcome researcher, and has written more than 50 peer-reviewed journal articles. Dr. Sabogal has extensive expertise in cultural competency, health communications, ethnic social marketing, public-participation campaigns and community mobilization interventions. As a member of a project team, he provides qualitative and quantitative research methodology expertise in the design, implementation and evaluation of quality improvement interventions across clinical settings. fsabogal@lumetra.com

Joseph E. Scherger, MD, MPH
Joseph is the Consulting Medical Director – Quality and Informatics at Lumetra and former Medical Director of the Doctor's Office Quality - Information Technology (DOQ-IT) project. Dr. Scherger is a Clinical Professor of Family & Preventive Medicine at the University of California, San Diego. His main focus is the redesign of medical office practice using the tools of Health Information Technology and the methods of Quality Improvement. Dr. Scherger is a member of the Institute of Medicine and served on the IOM Quality Committee that wrote To Err is Human (2000) and Crossing the Quality Chasm (2001). jscerger@ucsd.edu

Linda M., Sawyer, PhD, RN
Linda M. Sawyer, PhD, RN is the Chief Executive Officer at Lumetra. She has held program leadership and contract management responsibility for the organization's private and public sector contracts. Dr. Sawyer has more than 15 years of progressive management experience and 30 years of clinical practice experience as a registered nurse. Before joining Lumetra, she was an assistant clinical professor at the University of California, San Francisco School of Nursing and still maintains a faculty appointment at UCSF in the Community Health Systems department. She has an extensive background in quality improvement, home health, managed care, cross-cultural issues in healthcare, and ethics. She is an active member of the Chief Operating Officer Business Forum and the American College of Healthcare Executives. lsawyer@lumetra.com

Dori Marino, RN
Dori is a registered nurse with over three decades of healthcare experience. She is an Administrative Coordinator at St Mary Medical Center in Apple Valley, Ca.

She is a Womanheart spokesperson & volunteer's time to her community educating woman on heart heath. She is a spokes-person for Cheerios. Her heart story will soon grace over one million cereal boxes of Cheerios. Dori can be reached at dorimarino@verizon.net

April Popejoy, MS, RD, CDE, BC-ADM
April is a Master's prepared Registered Dietician who is also a Certified Diabetes Educator. She is also certified in Advanced Diabetes Management.

She works with both inpatient and outpatient client's at St Mary Medical Center, in Apple Valley, Ca. She helps to lead an outpatient support group for Diabetes at SMMC and is also often a featured guest at the Cardiac Support Group. She volunteers time in the community addressing issues of diabetes, childhood obesity, cardiac risk reduction, heart healthy choices and enjoys working with diverse populations.

Tue Nguyen
Tue Nguyen graduated from the University of Oklahoma with a B.S. in Chemistry and Biochemistry in 2000. Tue establishes local initiatives to raise

awareness of treatment deficiencies and provide education to EMS workers, physicians, and other healthcare professionals through the American Heart Association's Mission: Lifeline Campaign. As Campaign Director, he works closely with policy makers to increase awareness and obtain funding for additional programs. Presently, his responsibility spans across Southern California, targeting emergency medical services (EMS) programs.

Kathleen Tornow Chai, PhD, MSN, CPHQ, FNAHQ

Kathleen is an energetic proponent for healthcare quality. In the past three years she was the Director of Education and Quality at Kaiser West Los Angeles. In this role she oversaw quality, risk management, medical staff office, staff and physician education. Currently Kathy is the BSN Coordinator at California State University, Dominguez Hills where she is on faculty. Prior to that Kathy worked full time for her own consulting firm, KTC Consulting, and traveled nationally providing assistance to organizations needing advice in quality, accreditation and licensure and nursing areas.

An energetic learner, Kathy completed her Ph.D. in Education at Claremont Graduate School. Her dissertation focused on the impact of learning style and computer and information literacy on learning by nurses pursuing post RN degrees. Her commitment to the professional development of others frequently extends beyond her formal professional roles.

Kathy believes that one of the strongest tools used by a quality professional is networking and has held a number of positions both locally with the California Association for Healthcare Quality and nationally with the National Association for Healthcare Quality, including Board positions. It keeps her head filled with new ideas from the people she meets and constantly searching for new ways to meet the challenges in today's healthcare environment.

Ivan Rokos MD, FACEP, FACC

Ivan is a graduate of the Harvard-MIT Health Sciences and Technology program, where he earned his MD in 1992. He completed an internship at the New England Deaconess Hospital and residency at the Los Angeles County/USC Emergency Medicine Program in 1997. He gains his current clinical perspective from working in three different worlds: the academics of UCLA, the county hospital environment at Olive View-UCLA, and in a busy community Emergency Department/Trauma Center at Northridge Hospital.

Dr Rokos has served as a principal site investigator at both Northridge and Olive View-UCLA on multiple clinical trials involving both STEMI and NSTEMI patients since 2000. These multi-center trials were coordinated by either the Boston TIMI group, DCRI at Duke, and CRF in New York. This has provided an excellent opportunity to interface with a diverse group of cardiology thought-leaders.

Most recently, Dr. Rokos has been very involved with planning regional STEMI care in LA County and co-authored the paper explaining the rationale behind these efforts in the October 2006 issue of the American Heart Journal. His involvement in these regional efforts lead to his appointment as ACEP liaison to the American College of Cardiology D2B Alliance steering committee. He is also a member of the American Heart Association Mission: Lifeline ECC and Model Evaluation committees. Finally, Dr. Rokos received an honorary FACC designation in September, 2008.

Dr Rokos was born and raised in Portland, Oregon. His parents emigrated from the Czech Republic in 1965. Ivan's wife, Ann Mohrbacher, also earned her MD from Harvard (1987) and now specializes in hematology-oncology at USC. They have two school-age kids, and the whole family enjoys a wide range of sports and outdoor activities.

Save These Dates!

Healthcare Quality Overview and Workshops

Janet A. Brown, BA, BSN, RN, CPHQ, FNAHQ

Janet Brown is well known in the field of healthcare quality as a consultant and educator. She is the author of The Healthcare Quality Handbook: A Professional Resource and Study Guide, in its 22nd annual edition (July 2007), and has taught more than 95 Workshops nationally for healthcare quality professionals preparing for the CPHQ Certification Examination. She is also co-author of Managing Managed Care II: A Handbook for Mental Health Professionals, in its second edition, and a complementary Casebook. Janet is owner of JB Quality Solutions, Inc., and has been actively involved with healthcare organizations making strategic system changes for quality improvement, resource and risk management, and managed care. She has served on the CAHQ Board, was the first Chair of the National Healthcare Quality Foundation, received the National Association for Healthcare Quality's National Distinguished Member Award, and is a Past President and current Fellow of NAHQ.

2009 Workshops
Thursdays & Fridays

1/29/09 – 1/30/09

7/16/09 – 7/17/09

10/15/09 – 10/16/09

Also don't forget the CAHQ Spring Conference on March 30, 2009

Who should attend?	Professionals responsible for quality management and/or organizational improvement in all areas of health care delivery including: Compliance/Safety Officers, Nurse Leaders, Risk Managers, Healthcare Administrators, Consultants, QI/UR Professionals, Legal Nurse Consultants, Managed Health Care Professionals, PI Professionals, Case Managers, Infection Preventionists, and Medical Staff Leaders.
Continuing education	This program is approved by the California Board of Registered Nursing, provider number 03370, for 7.5 contact hours. This activity will be submitted to the National Association for Healthcare Quality for 7.5 CPHQ CE credits.
Registration	Due to limited space, all registrations must be postmarked by February 8, 2009. *First 30 people registered will receive a copy of "Sorry Works!" by Doug Wojcieszak.* You may pay by credit card or by check, payable to CAHQ. Email confirmation will be sent to each participant – be certain to provide us with your email address. Registration will only be guaranteed with receipt of payment. On-site registrations will be accepted with full payment on a first-come, first-served basis.
Cancellation policy	**ALL CANCELLATIONS MUST BE MADE IN WRITING** by mail or fax (see above for contact information). A $75 processing fee will be charged for cancellations and/or registration transfer. No refunds will be provided for cancellations received after March 14, 2009. Registrants who are unable to attend may send an alternate, provided they notify CAHQ in writing prior to March 23, 2009. In lieu of canceling for a refund, you may transfer your credit to any other CAHQ educational function until December 1, 2009. A transfer fee of $75.00 will apply.
Tuition	CAHQ Members • *(early registration by 2/8/09)* $199.00 CAHQ Members • *(late registration after 2/8/09)* $249.00 Register & Join • *(early registration by 2/8/09)* $279.00 Register & Join • *(late registration after 2/8/09)* $329.00 Non CAHQ Members • $379.00
Accommodations	The Costa Mesa Hilton is holding a Limited Number of rooms at $139 plus tax per night. For reservations please call the hotel EARLY to book. A group discount will be available. All reservations are on a space available basis. Make reservations prior to March 20th to ensure you receive the discounted rate. Self parking is $5.00 per day. **Costa Mesa Hilton** **3050 Bristol Street** **Costa Mesa, CA** **PHONE (714) 540-7000**

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Costa Mesa, CA

March 30, 2009
7 AM to 5 PM

Q U A L I T Y

First 30 people registered will receive a copy of "Sorry Works!" by Doug Wojcieszak

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Objectives

- State three ways in which *"Just Culture"* enhances patient safety
- List ways in which apologies after a sentinel event benefits the facility and decreases risks
- Identify the reporting factors for the Never 28 events
- Outline the benefits to creating a learning culture
- Discuss the changes in infection control and how they impact healthcare facilities

Seminar Schedule

Time	Session	Presenter
7:00 AM – 8:00 AM	Registration & Continental Breakfast	
8:00 AM – 8:15 AM	Welcome	TriciaKassab, RN, CPHQ / CAHQ President 2008-09
8:15 AM – 9:45 AM	Just Culture	David Marx, JD
9: 45 AM – 10:45 AM	CHOC's Approach to Performance	Beth Rowett, MA, MHA, CPHQ Angie Chang
10:45 AM – 11:30 AM	Break & Vendors Move between the Quality Circles; On-line demo of CHOC's performance; Team Stepps	Beth Rowett, MA, MHA, CPHQ Angie Chang
11: 30 AM – 12:30PM	CDPH: Updates related to Infection Control	Jennifer Hoke, MSN, RN, Nurse Consultant, CDPH
12: 30 PM – 1: 30 PM	ANNUAL MEETING & LUNCH *(provided)*	Tricia Kassab & CAHQ Board
1:30 PM – 2:30 PM	Update: Never 28 Reportable Events, CMS; Present on Admission; SB 541	Mark Kadzielski, Esquire
2:30 PM – 3:30 PM	*Sorry Works!* Crucial Conversations in Risk Managment Dealing with Families After a Sentinel Event	Doug Wojcieszak
3:30 PM – 3:50 PM	Break & Vendors	
3:50 PM – 4:40 PM	Quality Answers for Never Questions	PANEL: Doug Wojcieszak; Mark Kadzielski; David Marx, JD; Jennifer Hoke, MSN, RN; Tricia West, RN, BSN, MBA/HCM, CHN, PHN, LNC. *Moderator:* Tricia West
4:40 PM – 5:00 PM	Closing & Announcements	Judy Pugach, RN, MPH, CPHQ, CAHQ President 2009-10

Presenter Biographies

Angie Chang is the Director of Performance Measurement and Analysis. Her primary focus is overseeing the Strategic Balanced Scorecard, known affectionately as CHOCO Tracks for CHOC Children's Hospital at Orange *(2007 CAPE Bronze Award Recipient)* and for CHOC Children's at Mission Hospital and is is responsible for the operational performance of this application.

Jennifer Hoke, MSN, RN is a Nurse Consultant in infection control for the California Department of Public Health, Center for Healthcare Quality, Licensing & Certification program. She has worked in a variety of healthcare settings, including LTC, ICU, L&D, and School Nursing. Her experiences also include a state surveyor, a trainer for new surveyors and a QA Specialist for CDPH.

Mark Kadzielski, Esquire is in health law practice in Los Angeles. His practice focuses on the representation of healthcare providers, medical staff and managed care enterprises in a broad spectrum of matters, including regulatory investigations, contracting issues, credentialing, peer review, licensing and by-laws.

David Marx, JD is a safety engineer with a juris doctor in law who is the father of "Just Culture", helping organizations along their journey by bringing safety science and law together to help safety/risk managers, huyman resource managers, and line managers work together to improve operational safety and performance.

Beth Rowett, MA, MHA, CPHQ is Vice President at Children's Hospital of Orange County (CHOC) in Orange, California. Included in her areas of responsibility are Quality, Performance Improvement, Risk, Patient Safety, Accreditation & Licensure, and Customer Service. She is leading the Strategic Balanced Scorecard Initiative at CHOC, having previously instituted a Balanced Scorecard at another medical center

Julia Slininger, RN, BS, CPHQ, is a Healthcare Consultant with Lumetra. Her more than 25 years experience in healthcare quality improvement has included leading statewide collaboratives and facilitating the collaborative exchange between hospital teams.

Tricia West, RN, BSN, MBA/HCM, CHN, LNC, founder and CEO of P.J. West and Associates, Inc., a medical legal consulting firm. Ms. West is a Past President of CAHQ, past Editor of the CAHQ Journal and the current Education Chair.

Doug Wojcieszak is a public relations consultant who has had several personal and professional experiences with tort reform and medical malpractice issues. He teaches healthcare, insurance and legal professionals what patients and families want most after adverse events and bad outcomes.

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E-mail__________________________________

Master Card /Visa Number _______________________

Exp. Date________________

ADA Requirements____________________________

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Registration__________________Total $____________

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Q U A L I T Y

Do you want to write an article for the CAHQ Journal?

Article Submission Criteria

We at CAHQ are extremely interested in anyone who would be willing to write and share their articles with us for inclusion in the Journal. Please submit your articles to the Co-Editors Kathy Chai at ktc1@cox.net or Pat Lucken at pat.lucken@stjoe.org by the deadline dates of Oct 1, Jan 1, April 1, and July 1.

Article Length: Article submissions should be between 2,500 and 3,500 words.

Software: Submit articles as MicrosoftWord or CorelWordPerfect documents.

Margins: Set all margins at one inch, header and footer at 0.5 inches.

Font: Use Times New Roman or Ariel, 12 pt throughout (including title, headlines, subheadlines, etc.)

Titles: Make titles flush left and bold, in sentence format. The first word is capitalized, the rest lowercase, unless one of the words is a proper noun.

Headlines: Make headines as short as possible and avoid punctuation. The first word is capitalized, the rest lowercase, unless one of the words is a proper noun.

Author: Include the author(s) name underneath the headline with all of the titles correlating to the author

Spacing: Set spacing for single space between lines of text; **do not double space between paragraphs**.

Alignment: Set for flush left throughout.

Paragraphs: Indent the first line of each paragraph one half inch using <Tab> instead of indent formatting or multiple spaces. Indented quotation margins are one half inch on the left with the first line tabbed at one inch.

Bold, Italic and Underline: Do not underline anything. Make titles and first level headings bold, sentence format, no periods. Make second level headings italic, sentence format. Avoid third level headings if possible. Use italic for emphasis within the body of the article.

Bullet Points: If applicable, use round dark bullet points, **flush left alignment**.

Footnotes/Endnotes: In Microsoft Word (Windows) go to Insert > Reference > Footnote. In Microsoft Word (Mac) go to Insert > Footnote. In Word Perfect go to Insert > Footnote/Endnote.

Graphics: If graphics are included in the article document for plaement, also submit the graphic file separately. Avoid using graphics obtained from the internet as they are usually very poor quality. Any photographs and raster images should be desired dimensions at 72 ppi. Accepted file formats include: JPEG, TIFF, BMP, Adobe Photoshop (PSD), PDF and PNG. Illustrations and vector graphics (including tables and graphs) should be in one of the following formats: Adobe Illustrator (AI), EPS, PDF or SVG.

Biography: Include a brief author's biography of **no more than 50 words** at the end of the article (article authors only).

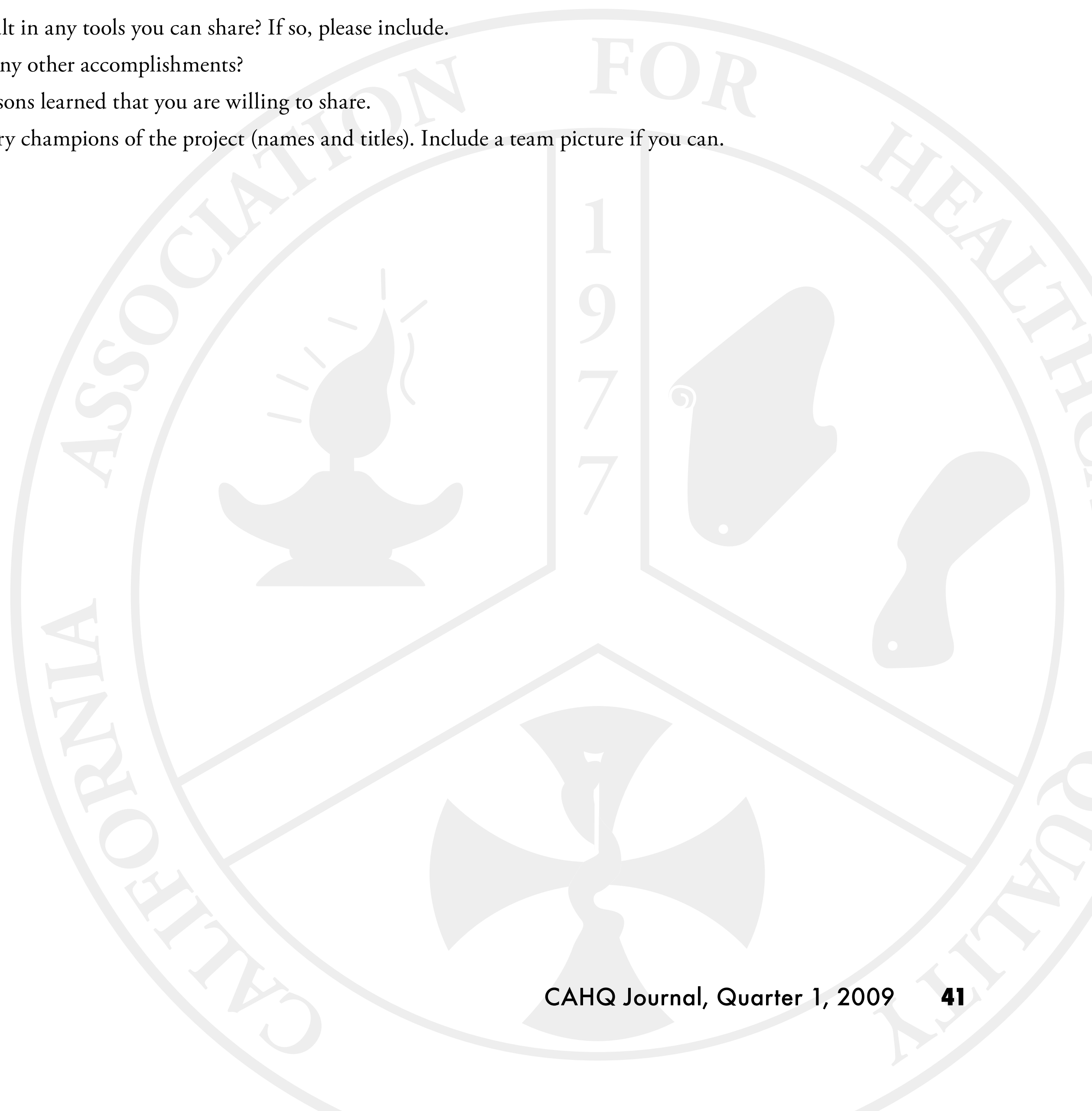
Article Summary: Include a **25-40 word summary** description of your article for use on the Table of Contents.

Guidelines for Articles on Hospital Quality Projects

Style and Information Sheet

The questions below can act as a guide in helping you write your article.

1) When did you start working on the project?
2) What was the purpose of the project? What were your goals?
3) What clinical measures did you work on improving?
4) Where is your hospital located?
5) What is the size of your hospital?
6) What is the size of the hospital staff? Quality improvement team staff (if applicable)?
7) What is the average patient to nurse ratio?
8) Did you or your team attend any training? Please describe.
9) Did you provide any training? To whom? Please describe.
10) What improvements did you experience and when? (Please be as specific as possible and use data, percentage points, etc.) Provide graphs if possible.
11) Did your project result in any tools you can share? If so, please include.
12) Did you experience any other accomplishments?
13) Did you have any lessons learned that you are willing to share.
14) Who were the primary champions of the project (names and titles). Include a team picture if you can.



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☐ Omit my name from lists CAHQ shares with non-affiliated organizations. (You will still receive all CAHQ mailings.)
☐ I hold active status as a ***Certified Professional in Healthcare Quality (CPHQ)***.
☐ I am a current member of the **National Association for Healthcare Quality (NAHQ)**, a CAHQ affiliate.
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☐ MD/DO license #________________
☐ Cert. Med. Staff Coord. (CMSC) #___________
☐ Certified Risk Manager
Type_______________________ #________________
☐ Registered Health Information Administrator (RHIA)_____________
☐ Registered Health Information Technician (RHIT) ________________
☐ Cert. Prof. Cred. Specialist (CPCS) #____________________
☐ Other professional license/certification/accreditation.
Type______________________ #________________

In which type of organization/facility do you currently work? (Select the 1 most appropriate description)

☐ Acute care hospital or medical center
☐ Behavioral health facility
☐ Long term care facility
☐ Government agency (non-hospital)
☐ Insurance company/PPO
☐ Private review organization
☐ Outpatient clinical facility
☐ Specialty healthcare facility (e.g., chemical dependency or rehab.)
☐ Corporate or network/system headquarters
☐ Licensure or accreditation body
☐ Managed care organization
☐ Health maintenance organization
☐ Home health/hospice
☐ Consultant
☐ None of these apply

What is/are your area(s) of expertise? (Check all that apply)

☐ Quality management/improvement
☐ Medical staff services
☐ Information management
☐ Ambulatory/rehabilitative care
☐ Home care
☐ Risk management
☐ Managed care
☐ Patient safety
☐ Infection Control
☐ Behavioral health
☐ Care/case/utilization management
☐ Administration
☐ Corporate compliance
☐ Long term care
☐ Nursing

Which best describes your current position? ☐ Senior management ☐ Supervisory ☐ Middle Management ☐ Consultant ☐ Staff

How many years of experience do you have in the healthcare quality field? ________________

Have you been a CAHQ member before? ☐ Yes ☐ No If yes, when? __________(year)