WAHQ
WISCONSIN ASSOCIATION FOR HEALTHCARE QUALITY

News & Views

President's Corner

WAHQ President

Linda Buel, RN, CPHQ

I hope that you enjoyed the summer months. The 2006 Annual Conference was a splendid success and our newsletter includes summaries of the speakers, as well as the evaluation results. We are grateful to all 2006 conference attendees for their comprehensive, thoughtful, feedback nd recommendations for future topics. The Board is preparing the 2007 conference schedule, which will include national and regional experts of timely topics relevant to healthcare quality professionals across the continuum.

In March, 2006, NAHQ Board of Directors approved the following Principles of NAHQ Leadership and I find they are valuable reminders to us in whatever quality capacity we function.

- It is our responsibility to our patients, families, organizations, and colleagues to strive to be exceptional leaders.

Principles of NAHQ Leadership

- ***Constructive Relationships.*** *An exceptional leader develops constructive relationships with others and recognizes the interdependence between the board, teams, and individual members. Effective leaders exhibit trust in others and communicate with candor, respect,* and honesty.

Mission Driven. *An exceptional leader views the concepts of mission, vision,* and core values as crucial forces that drive daily decisions not as word products that are periodically revised. The leader works with others to stretch beyond the mundane to craft a compelling vision that builds synergy and passion, and which guides each decision that is made.

Strategic Thinking. Exceptional leaders challenge themselves and others to think strategically. They push for the alignment of agendas and goals with strategic priorities that will advance the association's journey towards greatness.

Passion and Vigor. Exceptional leaders serve as ambassadors for the association and the quality profession. They enthusiastically support the association's mission and vision, work with others to implement the strategic plan, and welcome diversity in membership and thought. Exceptional leaders balance personal and professional activities so that they remain professionally challenged as well as physically and emotionally fit.

Culture of Inquiry. Exceptional leaders value a culture of inquiry. They evaluate information with a critical eye, ask questions, and challenge any conclusions that are not based on sound analysis. They also ask for and value qualitative as well as quantitative information.

Association- Mindedness. Exceptional leaders are constantly aware of their own potential conflicts-of-interest and keep the interests of the association above anything else. They do not allow themselves to be unduly influenced by stirrings of loyalty to people, products, orprogrammatic functions.

Ethos of Transparency. Exceptional leaders advocate that members, teams, and other stakeholders have access to appropriate and accurate information regarding finances, operations, and results. They ensure that all decision-makers have the information needed to make sound decisions.

Integrity. Exceptional leaders promote strong ethical values and hold themselves and others accountable for acting with integrity. They understand the importance of meeting deadlines and responsibilities. They establish and/or support mechanisms for oversight to assure optimal accountability for and control over the association's resources. (cont'd pg. 2)

Data Analysis To Action

Register now!

WAHQ Annual Conference

FRIDAY, March 9, 2007

at the Crowne Plaza

4402 E. Washington, Madison,WI

1-800-404-7630

WHAT'S INSIDE

SUMMER . FALL 2006

On-Line Continuing Education Credits (CEC)

National Association for Healthcare Quality (NAHQ)

You can link to the NAHQ page to view CE articles:
http://www.nahq.org/db/ce/

This is the page to search CEC by topic, and then the searcher is guided to the articles with the current CE tests. The tests are those that are the **most current** and **still available for credit** from the **past 2 years**. Expiration date is noted with the article information. A score of 80% is required to pass the test

Examples of Current Topics Include:

- **Compliance**
- **Documentation**
- **Education Training & Communication**
- **Evidenced Based Medicine**
- **Government Regulations**
- **Hedis-Managed Care Focus**
- **HIPAA**
- **Information Management**
- **Informed Consent**
- **OASIS-Home Healthcare Program**

The online tests are $15 for members and $25 for nonmembers. Participants take the tests, pay with a credit card, and receive a certificate online if they've passed the test.

Address Changes and Email Addresses

We value your membership and would like to make sure we are sending materials to all of our members. If your address changes or you would like to add an email address to our database, please contact Virginia Wyss at (608) 752-3911 or by email at VWyss@ameritech.net.

Visit our WAHQ Website

Looking for the latest WAHQ news? You can visit our Web site at www.wahq.org for the latest information on healthcare activities at home and around the country.

We are fortunate to have the expertise of MetaStar to guide us in the development of our Web page. This avenue of networking would not be possible without Metastar's technical and financial support. Special thanks to Rich Peacock, webmaster, Metastar Inc.

Other Quality Websites

WI Bureau of Quality Assurance	http://dhfs.wisconsin.gov
New CMS Internet site	www.cms.hhs.gov
Wisconsin Collaborative	*www.wiqualitycollaborative.org*
Wisconsin Price Point	*www.wipricepoint.org*
Health Grades	*www.healthgrades.com*
Center for Disease Control	*www.cdc.gov*
Healthy People 2010	*www.healthypeople.gov*
Minnesota Adverse Health Reports	*www.health.state.mn.us/patientsafety/*

President's Corner (continued from page 1)

Exceptional leaders request, value, and appropriately respond to audits, surveys, and other critical appraisals of operational integrity.

Sustaining Resources. Exceptional leaders prioritize resources (human and financial) in keeping with the association's mission, vision, and strategic plan. They use proven means as well as innovative solutions, partnerships, and other approaches to overcome potential resource limitations and gaps.

Results-Oriented. Exceptional leaders are results-oriented. They collaborate with others to develop performance measures that adequately evaluate the progress of teams, projects, and the association as a whole. They assess efficiency, effectiveness, impact, and quality. When available, they use benchmark and/or historical data as an aid to evaluate performance. They support changes in organizational direction when results indicate that a fresh approach is in order.

Continuous Learning. Exceptional leaders evaluate their own performance and contributions to the association and profession. They stay abreast of current developments in the field, seek ongoing education, and actively contribute to the profession's body of knowledge. They listen intently to and learn from the ideas of others. As appropriate, they work with others to set meeting agendas so that learning opportunities are embedded into associational governance and team-oriented activities.

Forward Thinking. Exceptional leaders are forward thinking. They understand that organizations are living entities that must continuously adapt and change in order to remain viable over time. Exceptional leaders embrace positive change, mentor others, encourage future leaders to take advantage of leadership development opportunities, and respect the good-faith decisions made by other leaders.

Approved by the NAHQ Board of Directors, March 2006

Excerpted from *The Source: Twelve Principles of Governance That Power Exceptional Boards*. Washington, D.C.: BoardSource 2005, www.boardsource.org

2007 - WAHQ Annual Conference At a Glance

Data

Analysis

To

Action

Featured Speaker:
Susan Mellott, PhD, RN, CPHQ, FNAHQ

Dr. Mellott has over ten years of experience which has been focused on healthcare quality in multiple settings including hospitals, long term care centers, home health settings, clinics, and networks.

She has experience with decreasing costs, improving patient/customer satisfaction and quality, while involving teams from the facility, including physicians and administrative staff using data to develop action plans.

She also has extensive experience with the survey process, especially with the Joint Commission on Accreditation of Hospitals (JCAHO) standards and surveys.

WAHQ Conference Agenda (CEU-approximately six hours)

7:30 -8:00 a.m.	**Registration & Continental Breakfast**
8:00 -8:15 a.m.	**Welcome**
8:15 -10:15 a.m.	**Susan Mellott- Transforming Data into Valuable Information**
9:45 -10:15 a.m.	**Break/Exhibits & Posters**
10:15-11:15 a.m.	Susan Mellott Transforming Data cont'd
11:15-11:45 a.m.	**Annual Meeting**
11:45-12:30 p.m.	**Lunch/Exhibits & Posters**
12:30- 1:45 p.m.	Using Data for Public Reporting Mark Kirschbaum, Vice President Quality, University of Wisconsin (UW)
1:45-2:15 p.m.	Break
2:45-3:30 p.m.	Using Chronic Disease Management Data to Redesign Outpatient Delivery Systems - Panel Presentation Gale Garvey, Project Management - UW Mary Conti, RN Froedtert Hospital

2007 Conference Sponsor

The Risk Management and Patient Safety Institute (RMPSI) was established to meet the needs of health care leaders through the promotion of patient safety and clinical risk reduction. The institute provides cutting-edge products and services that assist health care providers in reducing loss, enhancing patient safety, and improving quality of care. WAHQ would like to thank the RMPSI for their support.

New WAHQ Members

Submitted by Virginia Wyss,

2006 Conference Evaluation Summary
by Gloria Field

The reviews are in and it was a "great" conference according to the returned evaluations. Presentations received very impressive ratings and comments which included requests for return of topics. Other comments identified "practical tools", good references and examples, excellent content and handouts, something we strive for in "take home" information from any conference. Attendees indicated that the conference gave them very "up-to-date", "current" information.

Attendees, in general, continue to like the location with the easy on, easy off access, and most importantly, "absolutely the best coffee"….someone with my own priorities…how about that!

As we were repeatedly told, the quality of the presentations was excellent and very relevant for QI people with the vast majority indicating they would definitely recommend this program.

(Continued on page 6)

Understanding the Public Reporting of Patient Satisfaction

Submitted by: Tom Schlesinger, Ph.D.
Senior Consultant for Strategic Initiatives
Gundersen Lutheran Health System

The Rise of Consumerism.

Most experts nowadays acknowledge that managed care was a failure as a solution to the cost problem in health care. While we saw some one-time savings, health care costs continued to grow quickly, and both health care providers and patients disliked the restrictions imposed by managed care. At about the same time as the decline of managed care as a cost control strategy, another change was occurring - conservatives were gaining power in national politics.

The conservative mindset tends to dislike the idea of regulation, and instead puts greater faith in the free market. That is, they have a basic belief that the free market does the best job in allocating goods and services. So, given that managed care (which attempted to regulate the supply of health care) was not a solution, conservatives in Washington championed a market-based solution called Consumerism.

Advocates of Consumerism believe that health care problems in cost and quality today, result because consumers lack information on quality, and are not 'sensitive' to the cost of it. Consumerism wants to make some fundamental changes to the process of purchasing

In the health care to make it operate more along the lines of a free market. In the traditional model of healthcare in the U.S., the insurer is responsible for most of the cost of the care, and the provider is largely responsible for ensuring quality. Consumerism would change that by providing good information on the quality of healthcare from a given provider, and asking the consumer to bear more of the cost - that is, have more 'skin' in the game.

So what is health care quality? Based on the Institute of Medicine's six dimensions of health care(Crossing the Quality Chasm, 2001),
bar for those of us in the health care industry. The results of the survey should patient-centered care is one aspect of health care quality. We typically measure patient-centered care through patient satisfaction reporting. For many years now, hospitals have been making use of patient satisfaction reports to improve service to patients but according to the American Consumer Satisfaction Index (http://www.theacsi.org/), almost no progress has been made in the past ten years. An alternative to this 'internally driven' model of improvement would be a market-based model such as Consumerism. That is, make information on the quality of service publicly available, and let consumers decide where to go for their care. This is the premise behind the public reporting of patient satisfaction.

The H-CAHPS Survey. However, in order to publicly report patient satisfaction, a standard survey must be administered in a standard manner, and it must be used by a great majority of hospitals. H-CAHPS differs from most patient satisfaction surveys in that it attempts to be more objective by asking how often a particular behavior occurred rather than asking the patient to rate their satisfaction with service. (e.g. How often doctors communicated well with them). The response categories are: Never, Sometimes, Usually, and Always. Interestingly, CMS plans to report the data based on what's called 'top box'. That is, what percent of your patients say the particular behavior *Always* occurs. That is setting a pretty high follow consumers to make objective comparisons of health care providers. These are the goals of a project named H-CAHPS being driven the Center or Medicare and Medicaid Services (CMS). Currently major vendors such as Press Ganey, NRC/Picker, PRC, etc dominate the patient satisfaction 'industry'. Most of these vendors strongly opposed the HCAHPS initiative

(continued on page 5)

Call for Storyboards 2007 WAHQ Conference

Submitted By Sheri Krueger-Dix

- Another WAHQ opportunity to network and share your successes and lessons learned with your professional peers.
- If you are interested in presenting a **Storyboard that demonstrates a progressive topic that would highlight Healthcare Quality**

Storyboard presenters will receive a 1-yr. transferable **WAHQ membership per organization.**

Please submit a brief description (80 words or less)
to Sheri Krueger Dix.
Due by January 8th, 2007
The **WAHQ BOD will review** all submissions and confirm presentors with **guidelines by February 16th 2007.**
email: sdix@fmlh.edu or
Phone: 262-257-3495 or 414-850-8488

Storyboard presenters will receive a 1-yr. transferable **WAHQ membership per organization.**

Understanding Public Reporting … (continued from pg. 4)

because their thought it would be disruptive to current improvement efforts, and probably, because it was seen as a threat to their business. The H-CAHPS project has been in the works for four years now and currently national implementation of the new survey is set to begin in October 2006 with the first public reporting in late 2007. So what will this mean to us? We must be prepared for the public reporting of our patient satisfaction results. These results of the survey will be posted on the CMS website (www.hospitalcompare.hhs.gov). When they are first published, local media are likely to also publicize it as well. And indeed, if the premise around consumerism is correct, increased cost sharing and publicly available information on quality may also begin to affect our bottom lines.

Most of us with hospitals are faced with the question as to how to best integrate this new survey into existing patient satisfaction processes. I see three possible options, each with its own advantages and disadvantages.

Option 1- use both your existing survey and the H-CAHPS survey. That is, send out sufficient H-CAHPS surveys to satisfy CMS requirements for participation, but rely on your existing survey to drive internal quality improvement work. While this minimizes the disruption to your current process, it involves the expense of having two survey processes, and may either result in 'over-surveying' your patients or taking the risk of running out of patients to whom to send surveys. Perhaps more importantly, you would NOT be using the publicly reported data to drive your quality improvement work. Thus, your HCAHPS scores may or may not increase based on your efforts.

Option 1A- Press Ganey dominates the patient satisfaction industry. At this time, Press Ganey
recommends a variation of this approach - integrate the current survey with H-CAHPS, to you. In addition, CMS will not trend the data, publicly reported data to drive quality improvement.
break it out by individual unit, or provide percentile rank information.
and send out the minimal number of surveys to satisfy the CMS requirement, but then revert to the standard Press Ganey survey to drive your internal quality improvement efforts (trend and break out by unit). This approach also fails to use the publicly reported data to drive quality improvement.

Option 2 – replace your existing survey with H-CAHPS. While this is more cost-effective, H-CAHPS is a fairly short survey and doesn't touch on several areas that may be of interest to you. In addition, CMS will not trend the data, break it out by individual unit, or provide percentile rank information.

Option 3 – Integrate your existing survey into the H-CAHPS tool and send out sufficient numbers of these surveys so you can use the data for internal quality improvement (breaking out the data by unit, trending it over time), *and* for public reporting. This option may allow you to keep particularly important survey questions (for trending purposes) while minimizing the cost of using the H-CAHPS survey. You will need to work with your vendor (or your internal departments) to ensure the data can be trended over time and broken out by unit. It avoids the risk of over-surveying patients, and importantly allows you to use the H-CAHPS data to drive quality improvement work. If you like this approach, you may wish to contact your vendor to see if they will be supporting an integrated survey such as that suggested here.

Whether or not you agree with the fundamental principles of Consumerism, it is hard to argue with the idea of increased transparency for health care information. The public reporting of hospital patient satisfaction data is a step in the right direction.

Wisconsin Association for Healthcare Quality (WAHQ) 2006-2007 Membership Application

online conference registration: http://www.wahq.org/conf/conference_20070309_reg.asp

Name_____Credentials_____(CPHQ, RN, LPN, RRA, ART, Other)

Title_____ Business Phone ( ) _____-_____Home Phone ( )____-_____

Organization _____FAX ( ) ____-_____ Email _____

Business Address _____ City _____State ____ Zip _____

Are you a member of NAHQ? ___Yes ___ No (Please check) Send more information regarding _____NAHQ

Annual Membership Fee □ $45 Member Conference Fee □$175 Non-member w/membership□ $260

Make check payable to **WAHQ** **Mail or bring to conference, 2007:**

Virginia Wyss
2202 Tradition Lane
Janesville, WI 53545

Email VWyss@ameritech.net Phone: (608) 752-3911

Affiliation with the National Association for Healthcare Quality (NAHQ) to join logon to:

NAHQ Membership http://www.association-office.com/nahq/etools/memberships/membership.cfm **annual membership $115**

2006 Conference Reports

"Making Sense with SENSEMAKING"

presented by Mary Brueggeman, MS, RN, C.

Submitted by Gloria Field

"Sensemaking" is used as a tool and can be applied to our daily work in our endeavors toward quality and safe patient care.

These learnings were experienced in a National Patient Safety Pilot in which six hospitals in the nation joined with the Center for Medicare and Medicaid Services (CMS) and Quality Improvement Organizations (QIO's). The pilot was based on learning from near-miss or "good catch" events within a microsystem related to a specific focus of care.

Mary explained how it "incorporated error detection and containment and promoted the development of a learning environment that has the potential for sustaining the essential ingredient for safety, learning from failure."

Ultimately, the goal is for process improvement to be sustainable with the capability of "spread".

Sense-making is an effort to harness all the available information about an event and build a "common knowledge" or "shared understanding" about what happened along the way to discovery of an event or near-miss.

What is gained is a clear statement of the situation, a common perspective regarding the discovery of the event and, in the case of the near-miss, an identified recovery point in the process. It also includes understanding of the points along the way where actions impact the event, and identification of points where improvements can be tested that will add safeguards to the process.

The safety pilot included the use of causal trees as the foundation of sensemaking anevent. The causal tree outlines the consequent event, recovery actions and travels through the antecedents based on the experience each person brings to the conversation. It brings staff that are involved "together" to make "sense" of what happened.

There are still questions about how "Sensemaking" differs from "Root Cause Analysis (RCA)". In my mind, it is a usable facilitated conversation at the local micro-system level for bringing staff together, at the point of care. This can impact changes that result in rapid cycle process improvement based on near-miss discovery that may not reach our perceived level in which we use RCA.

A classification system (Eindhoven Classification System) was utilized to analyze near-misses that promoted Just Culture methods of studying latent and active errors that lead to establishing safer processes. Again, an understanding was gained in using causal trees and developing rapid cycle changes through the learnings in sensemaking.

As we come to embrace a culture of safety and reach for "high reliability" in which "preoccupation with failure" is one of the essential components, sensemaking can make a significant difference within microsystems in changing the safety culture and improving processes that frontline staff can implement and support.

2006 Conference Evaluations

(continued from pg. 3)

Recommendations from participants:

1. Nice variety of storyboards with excellent content and topics but more are needed and more aisle space is needed in front of posters to allow people to circulate.
2. Power Point information needs to be larger print but there was a "thanks" for providing enlarged, hard to read slides in the handouts-
3. "All presenters should provide handouts."
4. Provide brief breakouts by region—come up with common goals or share solutions to common issues.
5. Recommendation that we don't need the added cost for credit card registration, but still some interest with "raise rates to cover cost"Have a monitor around the room with mike for audience questions, can't hear them Recommendations for Newsletter:
   Stories from individual settings, board sponsored regional activities, and legislative activity.
6. Explain ribbon color code
7. Continued preference for location with easy access off the interstate.
8. Place monthly updates on the web-site
9. Continue to use agenda wisely, it was efficiently run

The topics receiving the highest rankings were:

- Information Systems Specific to Quality Professionals;
- Quality Measurement Methods;
- Outcomes across the Continuum of Care.

Representatives from the Board will be seeking feedback from membership on what focus to take and specifics of interest within the preferences.
Other recommendations included Pay 4 Performance, Cultural Needs in Healthcare, more Human Factors engineering topics.

2006 Conference Reports

"The ThedaCare Improvement System: Creating a Lean Culture in Healthcare"

Submitted by Ray Riska

Session 4 of the WAHQ Annual State Conference was "The ThedaCare Improvement System: Creating a Lean Culture in Healthcare". Dr. Gerard, a dynamic speaker, gave is some background on ThedaCare and took us through the time line in creating a Lean culture there. He spoke of tools used in Lean being fundamental to the quality improvement process i.e. value stream mapping, run charts, algorithms, etc. and gave examples of their use at ThedaCare.

Dr. Gerard's **first goal** in creating a Lean culture was the **development of a structure for change.** Specifically, he spoke of the commitment of senior management. He did not want their support of the process but wanted them to drive the process. He and others had weekly meeting with senior management (including the CEO) to keep them involved and driving the process.
Prior to the start of the program he and senior management were involve in two working retreats to facilitate communication and knowledge of the process. He stated it was imperative that senior management understood the process and owned the process

The **second goal** in creating the culture was **gaining the support of the front line staff.** One of the key factors in gaining this support was a pledge to the front line staff to not fire staff as a result of increases efficiency created through the process.

Persons who were displaced by the process would be offered jobs in other areas with similar responsibilities and the same pay scale. He added in the beginning there were dissenters who were given the choice of coming on board or going elsewhere and some of these people did go elsewhere.

Presented by Roger Gerard PhD

The **ultimate goal** at ThedaCare is to **supply a defect free customer experience**. To do this you need to know what the customer wants and to recognize the difference between a buyer of a service and a broker of a service.

Dr Gerard talked about Rapid Improvement Events and gave us a summary of the lessons learn over the last 3 years in the development of a culture of Lean. He provided some cost savings data for the time period of January 2005- October 2005 during which ThedaCare saved approximately 9 million will incurring Lean expenses of app. 3.5 million, for a return on investment of 2.7-1 million dollars.

Of note the *largest grouping of cost savings came from salaries and revenue*, accounting for approximately 8 million of the total savings.

2005-2007 WAHQ Goals

Submitted by Linda Buel, President

Goal 1 – Education – this includes our annual conference newsletters, and Metastar's CPHQ study session. Will be emailing the newsletter to members with email and mailing to those that do not have access to Email.

Goal 2 – Networking – Improved communications with our members through an enhanced website, and continued liaison with other state organizations.

Goal 3 – State presence – CPHQ recognition and acknowledgement of member awards through the newsletter. Just a reminder, if you pass your CPHQ exam, please send evidence of your success and membership to our treasurer for $75.00 reimbursement.

Goal 4 – Strengthen relationship with NAHQ – maintain NAHQ affiliation through strong membership and participate in the NAHQ Leadership Council.

We continue to meet the minimum 25% dual membership for WAHQ and NAHQ. We have three members who participate on the NAHQ Leadership Council.

Goal 5 – Fiscal Responsibility –The board is continually looking for ways to increase member benefits and maintain budget conscious activities.

Treasurer's Report

Submitted by Matt Wahoske, Treasurer

ACCOUNT BALANCES

• Checking	$8406.92
• Savings	$8512.97
• Annuity	$4946.47
Total	$21,866.36

Note: The 2005 NAHQ conference in New Orleans was cancelled due to a hurricane.

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WAHQ Board of Directors

Board Members Left to Right:Sheryl Krueger Dix; Linda Buel; Carol Ferguson; Sally Rosemeyer; Ray Riska; Mary Conti; Virginia Wyss; Mary Firkus; Gloria Fields; Ann Radtke ;Judy Stysma; Matt Wahoske