President's Corner

By Diane Schallert, RN, MSM, CPHQ

My message to all our readers is to say quality and quality improvement efforts are "alive and well" in Wisconsin. The fall issue, 2000 of the WAHQ newsletter featured an article from JAMA, describing the nationwide rankings for the performance on 24 quality of care indicators related to six medical conditions common in the Medicare population. Wisconsin ranked 11th in the nation at that time. Greg Simmons, CEO and President of MetaStar, commented that healthcare
providers in hospitals, ambulatory care settings and other service areas continue to improve the already high level of care delivered in Wisconsin. The many readers of this newsletter play a major role in the efforts to increase compliance rates for the indicators relative to the care and management of certain diseases, including AMI, CHF, Pneumonia, TIA/Stroke, Breast Cancer, Diabetes and adult immunizations.

My professional work, as a clinical quality specialist, takes me to many hospitals and ambulatory care settings, meeting teams of professionals and support staff, that are eager to discuss their QI plans, barriers and strategies to continually seek methods to make improvements with key processes and/or system changes. The energy, enthusiasm and dedication to making positive changes or maintain the gains they achieve, is very noticeable in the very small to the larger healthcare settings.

The hospital teams have developed pathways, protocols or revised assessment and discharge tools; introduced care management models or other continuum of care initiatives, such as CHF centers. MetaStar has conducted user group sessions throughout the state for hospital ambulatory teams to share successes, pathways, documentation tools, storyboard presentations, survey preparation plans and effective methods for use of data.

The ambulatory care settings and the managed care systems have initiated or enhanced diabetes flow sheets, preventive care flow sheets, reminder
systems, patient and staff education materials, established diabetes registry, diabetes and immunization clinic days. One method to measure effectiveness of all the strategies is the use of data. This, too, has been effective in the efforts and application of the plan, do, study, act cycles that are continuous. Hospitals, clinics and public health agencies have created community-based coalitions for immunization, smoking cessation and breast cancer screening programs. The examples have proven to be cost effective, integrating human resources and expertise to meet the needs of the community. Yes, there are many visible ongoing efforts to maintain and improve the quality of healthcare for people of Wisconsin. The role of the healthcare quality professional continues to play a major role in this endeavor. I am confident that Wisconsin can rank number one in future nationwide surveys.

A final note in this message from me is to share briefly my thoughts that surround the 26th Annual NAHQ conference held in September in Reno. WAHQ representatives on the Leadership council included Kathy Noe, Gloria Field, and myself. As always, the conference contained many vital and current healthcare issues, some of what is summarized in this newsletter.

What made this 2001 conference different was the horrible events of Tuesday, September 11, that unfolded as those of us were pulling our luggage into the large ballroom for the final keynote speaker, knowing we were headed home at noon. Needless to say, that any inconvenience many faced trying to get home was nothing compared to the tragedy encountered by so many directly then and even now as stories continue to be unveiled.

In spite of all the shock, fear, anger, and confusion that occurred that morning, it was remarkable to see and feel the comforting words and support from so many in the NAHQ Leadership and membership, the Reno community, and from our families, friends, and co-workers at home. There were many stories to tell then and now.

Many NAHQ members from Wisconsin met to see what we could do together for travel, to share our thoughts, watch TV for updates, and reach out to new friends who were directly affected. We felt stronger and less anxious by sharing.

We will remember this conference always.

What's Inside

Annual WAHQ Conference March 1, 2002

"Promoting Quality through Coordination of Care"

Featured Topics/Speakers

Safety & Medical Error Prevention
Dr. Matthew Scanlon, Assistant Professor, Medical College of Wisconsin

Congestive Heart Failure Across the Continuum
Karl Raaum Director Cardiovascular Center & Laurie Lawson, RN Case Manager

Long Term Care
Speaker to be announced

Annual WAHQ Report

Chronic Care: How to Achieve Continuity Across the Continuum
Donna Warzynski RN, WNA President, Director Oncology & Chronic Care Services, St Michael's Hospital, Stevens Point

Location:
Crowne Plaza - East Towne,
4402 East Washington Avenue
Madison, WI 53704
Tele 1-800-404-7630
FAX 1-608-244-4759

Cost :
(Networking Lunch Included.)
Members: $150.00
Joining or renewal: $185.00
Nonmembers: $225.00

Summary of the WAHQ Board Meeting

May, August, November 2001

By Diane Schallert, RN, MSM, CPHQ

1. The Board members defined criteria statements for the selection of the Leadership Council representatives at NAHQ. The three selected are Diane Schallert, President; Kathy Noe, President-elect; and Gloria Field, WAHQ Secretary.
2. Each regional representative provided some strategies for recruitment and retention in their region. The use of e-mails, luncheon meetings and conference calls were mentioned. Please contact your regional rep to offer suggestions for increasing participation in your areas.
3. The annual WAHQ educational conference will be held March 1, 2002, at the Crowne Plaza, Madison. The board members reviewed the 2001 conference evaluations for topic areas. A major focus will be centered on "best practices and cost effectiveness in the continuum of care". We will call on the volunteer members to assist with the conference plans and implementation processes. Plans and speakers were finalized.
4. A measure to assist the WAHQ Financial Plan is to decrease the costs for Board meetings, therefore we have eliminated one meeting and a board member will host one of the scheduled meetings.
5. Members reviewed the WAHQ By-laws for any needs to update or make changes. None were identified. Additionally, a review of the strategic goals was begun, to maintain progress.
6. Potential vacant Board positions for 2002 were identified and discussed. Ballots will be prepared and WAHQ members will have the opportunity to vote.
7. Methods to enhance the WAHQ website will be investigated for future needs and costs.

The members of the WAHQ Board continue to volunteer their time, dedication and expertise for the membership and for representation to the NAHQ mission and goals. I personally appreciate all the efforts that are necessary to make this happen.

NAHQ NEWS

(Summary comments from the spring, summer, and fall 2001 editions)

By Diane Schallert, RN, MSM, CPHQ

1. NAHQ's annual education conference was held Sept 8-11, 2001, in Reno, Nevada. Keynote speakers discussed issues and innovations in managed care, clinical ethics and highlights from the author of "Creativity, Innovations and Quality". (See highlights in this newsletter)
2. NAHQ was represented at a National meeting in November 2000, sponsored by the Quality Interagency Coordination Task Force (QuIC). Purpose was to refine a research agenda pertaining to various domains, including epidemiology of error, error prevention in non-hospital settings and more. Further information about QuIC and the nation's agenda on medical errors can be obtained from website: http://www.quic.gov/about/quicfact.htm
3. Refer to an excellent article on HIPAA in the summer issue of NAHQ news. There are numerous HIPAA resources on the web. HIPAA online – this is an interactive tool that discusses subscriber rights – http://www.hcfa.gov/medicaid/hipaa/online/default.asp . HIPAA related legislation – http://www.hcfa.gov/medicaid/hipaa/content/sreeg.asp#mpha .
4. CPHQ - The 2001 review and study sessions, sponsored by NAHQ were held in Reno, NV, on September 6-7; in Rosemont, IL, on September 21-22; and Washington, DC, on October 12-13. The examination for the certification was conducted in over 40 sites, in the United States and some International cities, in November 2001. Visit the www.nahq.org website for additional CPHQ information.

Best wishes and success to the Wisconsin candidates. A web-based self-study product is being developed as a review for the exam. Additionally the exam will be offered in a computer-based format, in an ongoing test cycle beginning September 1, 2002. 2002 will be the last year that NAHQ offers the course in its traditional format, in three locations. Watch for the changes on the NAHQ website.

5. NAHQ's member e-mail discussion group (ListServ) is a valuable communication tool for the membership to share issues of importance in daily woks life. Examples for discussion included staffing issues; job descriptions for quality healthcare professionals; patient falls and sentinel events; policies/programs; PI models. If a WAHQ member is interested to join NAHQ and to become a member on the ListServ, please visit the NAHQ website. The ListServ is an excellent method for national networking.
6. NAHQ – State President conference calls.

a. NAHQ Board met to discuss strategic goals. Goal #2 is the development of products and services. There is intent to diversify aim at other healthcare settings educational needs – such as managed care.

b. Membership Campaign project. The goal was to award those affiliated states with the most increase in membership. The three top winners were District of Columbia, Utah, and Connecticut.

c. Input was gathered for promotion to the State Association Excellence Award.

d. Recent calls and e-mails discuss the state challenges for membership and education.

7. New on-line search capabilities for the NAHQ membership directory will begin in January 2002. Beginning in 2002, the NAHQ Board will implement the use of Balanced Scorecard to measure overall effectiveness of the association.
8. Planning is underway for the 27th Annual Conference, to be held September 22-25, 2002 in Nashville, TN. Refer to the NAHQ website.

26th Annual Educational Conference Report

By Diane Schallert, RN, MSM, CPHQ

September 8-11, 2001 - Reno, NV

Keynote Speakers – General Sessions

"Resuscitating Managed Care: Getting off Life Support and Recovering Credibility"

by Barry S. Scheur, JD

The presentation centered on a managed care plan, unique in its philosophy, standards, and methods to turn around the negativity surrounding the definition of managed care. The "Oath's Story" describes a methodology for restoring credibility; new form of medical management; defining and communicating the meaning of quality.

"The Ethic and Spirit of Caring"

by Diann Uustal, EdD, MS, RN.

Dr Uustal is a nationally recognized nurse ethicist, educator, and author known for her thought provoking presentations and care based ethical reasoning. As she walked among the attendees in a very large ballroom, you were immersed in her real life experiences that explored the values and ethics that enhance qualitative caring and form therapeutic relationships. The examples had a theme of "dying with dignity"

"Little Hope: How Common Sense Thinking can lead to a Mess"

by Paul Plsek, MS.

Mr. Plsek is a senior fellow with IHI.

He believes we need a new common sense in health care today and to build a better understanding of how complex systems actually work. As an example, current common sense says, "we must overcome resistance to change. It's a battle out there." The new common sense thinking says "instead of battling resistance, with natural energy in the system, understand natural attraction to change." He has authored many publications on QI tools: Creativity, Innovation and Quality.

Please note: The featured speaker presentations and others are available on audiotape and can be purchased from the NAHQ website.

www.nahq.org

Jackson County Community Health Network Project

By Wanda Plache, WAHQ Southwest Representative

In May 2000, the Jackson County Community Health Network, Inc. (JCCHN) received a one-year network-planning grant from the Federal Office of Rural Health Policy. With this grant, they developed a community-based network to improve and expand existing services, avoid duplication of services, and provide better access to the community.

Working with the Wisconsin Office of Rural Health (WORH), the JCCHN completed a community needs assessment. Using the Hometown Health planning model as recommended by the WORH, the Jackson County Community Health Network sought to answer three basic questions: 1) Where is the community now, 2) Where does it want to be, and 3) How will we get there?

Local leadership was involved through all aspects of this assessment which included interviews with 41 informed opinion holders, prioritizing the community's health needs, identifying five task forces, and developing implementation plans to address needs.

An interview tool using key informants was selected as the primary data gathering tool. Key informant interviews are a useful way to quickly gather data about how community members view community-level issues and problems. Key informants were first asked to rate the quality of health care in Jackson County. Overall, these key informants viewed the quality of health care in Jackson County positively. Key informants were then asked to identify the most compelling health issues for Jackson County. These were identified as

- Lack of health insurance/high cost of health care and medication,
- Need for more services for the elderly and the poor elderly,
- No hospice care
- Limited home-based services (not enough home health workers),
- High risk teen behavior, and
- Need for quality medical care

After review of the interview data, five task forces were created to develop implementation plans to address these issues.

These implementation plans will direct the JCCHN's work over the next few years. A plan to prioritize these implementation plans is currently being developed to allow different issues to be addressed in phases.

(This article was condensed from information compiled by the Wisconsin Office of Rural Health and Jackson County Community Health Network, Inc. For more information about conducting community needs assessments or writing grants, contact the Wisconsin Office of Rural Health, 608-265-3608.)

Visit our 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.

There are links to other healthcare quality resources from our Web page as well as the latest newsletter from WAHQ and our quality conference brochure listing our educational offerings.

We are fortunate to have the expertise of MetaStar to guide us in the development of our Web page. This avenue of networking through the Internet would not be possible without their technical and financial support; we are forever grateful.

So, visit our site and let us know if you find it beneficial. Our e-mail can be accessed through the Web page too. Any suggestions or ideas from our members on the Web page is always welcome.

How will NAHQ Impact Healthcare Quality?

By Kathryn Noe, RN, CPHQ,
WAHQ President Elect, Leadership Council Representative

Leadership Report from Reno, Nevada September 8, 2001

The National Association for Healthcare Quality Leadership Council's Mission is to improve the quality of healthcare and to support the development of professionals in healthcare quality.

The Vision statement includes NAHQ as a global leader and a premier source of expertise in healthcare quality. The Vision and Mission were adopted in August of 1998. One of the strategies used to accomplish the Vision and Mission is the Certified Professional Healthcare Quality (CPHQ) Certification test.

There are currently 7,040 active CPHQ members. The November 2000 Certified Professional Healthcare Quality Certification test had a 69% passing rate. The survey feedback provided by the exam candidates and current CPHQ members reflects excellent satisfaction with exams and the recertification process.

Another major focus included in the Mission and Vision of the National Association of Quality is to provide on-going communication to the State Leadership and the Membership.

Two major Quality Improvement projects were initiated during 2001: 1) Completing the transition to computerized year round testing by the fourth quarter of 2002 and 2) Web site development and expansion at http://www.cphq.org

Strategic Planning is underway to achieve the Vision and Mission. The National Leadership has identified the following goals and objectives which will measure the effectiveness of the vision and mission. The targeted 2002 initiatives are identified in Italics.

1. NAHQ will be a member-focused organization. General liability insurance will be added as a benefit for the States. NAHQ will continue quarterly President conference calls.

a. The NAHQ Board will continuously seek input front members on their exceptions-b.

The Board will enhance communication with affiliated state associations

2. NAHQ will provide products and services that increase the value of membership. The Board will implement a new CPHQ preparation product for target release in summer 2002.

The Research team is focusing on critical appraisal tools.

a. The Board will provide continuos strategic decision-making frame work for implementation of future products and services.

3. NAHQ will strengthen the practice of Healthcare quality and the role of the Healthcare quality professional. HQCB will develop a model for internal expansion of CPHQ. The target markets were identified and a marketing plan established.

a. NAHQ will monitor National healthcare issues with strong implementation for healthcare quality and as appropriate, provide input and/ or develop position statement papers on these issues.

b. NAHQ will continue to develop strategic partnerships to influence the practice of healthcare quality, such as the National Quality Forum.

Progress towards these goals and objectives will be communicated via the Leadership Council. Members will receive updates through the National Journal: "Journal for Healthcare Quality" and the WAHQ newsletter.

Call for March 1st Continuum of Care Poster Abstracts

To increase the opportunity for members to share examples of successes for Continuum of Care, we are planning to include up to 10 poster presentations at the March 1st 2002 WAHQ Conference. Any Continuum of Care initiative may be submitted for consideration. It may be a Disease Specific or System Improvement effort. The Abstract should include the following information:

- Title of the presentation
- Contact person, name and title
- Goal or objective of the initiative
- Description of the initiative (250 words or less)
- Results of the initiative
- Planned Handouts

If selected the presenter will receive a $50 reduced conference fee. Please send your abstract by January 31st 2002 to:

Diane Schallert,
WAHQ President, RN, MS, CPHQ
Via email: DSCHALLE@metastar.com
Phone: (608) 274-1940

US House, Senate Pass Nursing Shortage Bills

WASHINGTON (Reuters Health)

Both the US House and Senate Thursday passed bills aimed at addressing the nation's nursing shortage, but the measures differ enough that they will have to be reconciled after Congress returns from its winter break in late January.

The House bill, passed by voice vote, is a scaled-back version of a broader bill introduced earlier this year by Rep. Lois Capps (D-CA), a former nurse.

In an effort to attract more people to the nursing workforce, the bill would order the Department of Health and Human Services (news - web sites) to develop a series of public service announcements over the next 6 years to educate the public about the nursing profession, including where to go for more information about becoming a nurse.

One of the major problems we face is the misperception that nursing is an unappealing career and woman's work," said Capps.

"These public service announcements will help us counter that impression and explain the value and benefits of a career in nursing."

The bill would also expand the existing federal program that helps nurses pay off their student loans if they agree to serve in areas with nursing shortages. For the first time, scholarships could be offered to attract applicants at the front end of the training process.

Finally, the bill calls for a study by the General Accounting Office (news - web sites) to determine whether there is a shortage of nursing faculty, and, if it finds such a shortage exists, to recommend ways to alleviate that shortage. The study is due by September 30, 2002.

The Senate bill, sponsored by Barbara Mikulski (D-MD), Tim Hutchinson (R-AR), Jim Jeffords (I-VT) and John Kerry (D-MA), includes provisions similar to those in the House bill, along with several others.

The Senate bill would also, for example, create "career ladder" programs to encourage individuals to advance in the nursing profession, and provide for scholarships, loans and grants to encourage nurses to pursue advanced degrees that would lead them to become nurse educators.

The Senate bill would also create a National Commission on the Recruitment and Retention of Nurses.

"In Maryland alone, 15% of the nursing jobs are vacant," said Mikulski in a statement. "If we don't effectively address the crisis in nursing, those hospitals, nursing homes and health centers will soon be on life support."

MEDICATION SAFETY

By Gloria Field

Summary of Presentation by Kenneth G. Herman, MHA PharmD FACHE
Joint Commission

Since the publication of the 1st IOM Report with the pronouncement of 44,000 - 98,000 patient deaths annually due to error, the goal has become a 50% reduction in errors over the next five years. Medication errors are a "subset of errors in healthcare". The objectives outlined in this presentation include: 1) the discussion of the concept of processes, risk points in processes and
steps to minimize those risk points; 2) examination of typical errors in the medication use process; and 3) discussion of strategies for patient safety and risk reduction. Mr. Herman described the delivery of healthcare as a concept involving many "interrelated" processes with the outcome being the result of the "success" of all of the interrelated steps based on Joint Commission's definition of "process".
Joint Commission has categorized sub-processes of medication use as vulnerable steps
in the medication use process.

Those recognized vulnerable steps in Medication Use are:

1. Ordering or Prescribing
2. Dispensing
3. Administration
4. Monitoring

Getting medications into the formulary is also considered a "sub-process" that is essential step in medication use.
Mr. Herman went on to discuss the following risk points and strategies related to each of the steps as will as risk points specific to the disciplines involved in the process.
The following is a breakdown of that discussion:

Risk Points - Ordering/Prescribing Process:

1. Lack of available information with the lack of multidisciplinary approach including nutritional, polypharmacy/concommittal illnesses, etc.
2. Information about best practices not available
3. Legibility of orders-RN/Pharmacist reluctance to question MD
4. Unclear clinical practice guidelines
5. Hierarchy issues

Risk Points - Dispensing of Medications

1. Legibility of orders and the reluctance to question MD
2. Drug information constantly changing
3. Look alike/sound alike drugs (Colors-generic & brand, similar use-sound same)
4. Distraction
5. Environmental issues
6. Off shift preparation by RN's
7. "Stock" medications
8. Storage issues
   • Proper refrigeration
   • In pharmacy
   • On units (expired medications, storage of infrequently used meds

Risk Points - Administering Medications

1. Multiple persons giving meds
2. New drug-new device
3. Volume of drugs
4. Polypharmacy
5. Staffing
6. Distraction
7. Competency
8. Information Availability

Physicians:

1. Unfamiliarity with immediate drug affects
2. Unfamiliarity with administration instructions
3. Unfamiliar with incompatibilities
4. Culture discourages looking up unknown information
5. Administration during emergency or when other practitioner refuses

Pharmacists:

1. Infrequent administration
2. Lack of complete patient history
3. Administration during emergency or high risk procedures
4. Access to double-check mechanisms not usually available
5. Unfamiliar with monitoring after administration-outside scope of practice

Nursing Personnel:

1. "Five Rights" often only error training
2. Error reported discouraged by culture
3. Staffing
4. Distraction
5. Competency
6. Access to training opportunities
7. Hierarchy issues

Risk Points - Monitoring

1. Concommittal disease
2. Workload/staffing
3. Unfamiliarity with drug effects/need for monitoring
4. Lack of clear communication with patient

Strategies for Prescribing Errors:

1. Information Availability
   • History and Physical
   • Drug Dosing Information (automated computer enhancements, readily available, complete, quick
2. Incompatibilities/contraindications/interactions
3. Clinical pharmacist on units
4. Assessment and treatment
   • Multidisciplinary approach
   • Information easily available
   • Clinical pharmacist review of cases for risks, physiologic impact, polypharmacy
   • Decrease number of drugs available from one class
5. Prescribing/Ordering
   • Availability of pharmacist
   • Information availability
   • Direct computer entry vs written
   • Legibility
   • Polypharmacy/concommittal illnesses
   • Preprinted orders/clear clinical practice guidelines

Strategies needing to be addressed for Dispensing Errors:

1. Errors in transcription to pharmacy profile/MAR - direct computer order entry
   • Preparation of orders from label without original order
2. Error in calculation - standardized methods
3. Preparing more than one drug at a time - reviewing
   the batching and checking process
4. Distractions - including lack of double checks
5. Making instead of buying
6. Automated drug systems control of medications, not their dispensing
   • No guarantee of correct use
   • Loses important double check of pharmacist
   • Still possible to divert drugs
   • Limit access between units ("stealing from ICU")
   • Require education as to inherent med errors

Strategies needing to be addressed for Administration:

1. Make allergy, height, weight information readily available (computerized)
2. Include drug histories-Have you ever taken MAO's, anesthesia, narcotics?
3. Use bar coding if available
4. Make reporting of errors and risk points easy
5. Communicate high risk-problem prone drugs or administration areas
6. Use protocols for high risk drugs (epidural, hazardous drugs)
7. Use quick reference guides for new devices
8. Take serious look at staffing and distraction
9. Partner with patient and family
10. Simplify - standard drug administration times
11. Limit access to medication rooms
12. Strict control after hours (special training for staff access)
13. Take double checks serious
14. Remove "pharmacy only" meds from units
15. Use color codes allergy bracelets
16. Post generic/brand name charts
17. Post drug/drug, drug/food interaction charts
18. Use automated dispensers wisely
19. Partnering with Patients

• Instruct patients on clues to medication "changes"
• Teach patients about medications
• Teach patients actual names/doses
• List medications and schedules at bedside for patient/family
• Teach patients the aid "five rights" rule

Strategies for Monitoring:

1. Continually monitoring of patient's response to medications
2. Educate patient on when to notify staff
3. Awareness of antagonists/reversal agents
4. Emergency procedure awareness
5. Continued competency on high risk drugs

Proximate Causes:

1. Variable input
2. Complex
3. Non-standardized
4. Tightly coupled
5. Heavily dependent on human intervention
6. Hierarchical vs team
7. Tight time constraints
8. Loose time constraints

Public Fears:

Getting the wrong medication 61%
Drug Interaction 58%
Cost of Treatment 58%
Procedural Complications 56%
Having enough Information about meds 53%
Getting an Infections 50%
Suffering from Pain 49%
Cost of Prescriptions 41%
ASHP Oct 1999

Mr. Herman stressed the overall risk reduction strategies in safety process design address goals to prevent error, to protect the patient from error, and to mitigate the effect of error. Simplification, standardization, and fail safe designs that are not tightly coupled and include redundancy were basically the recommended actions in safety design.

These identified risk points in conjunction with the ISMP Medication Safety self-assessment survey results can be useful in focusing process changes and implementing recognized improvement strategies.

Revised Diabetes Guidelines

By Pat Zapp, Director
WI Diabetes Control Program

The Wisconsin Essential Diabetes Mellitus Care Guidelines, Revised 2001, are now available. They were recently revised to incorporate the latest scientific evidence regarding good diabetes care. They are the products of a collaborative effort of the Wisconsin Diabetes Advisory Group, a committee of over 55 key stakeholders in diabetes care. The target audience for the guidelines includes primary care providers and health systems (e.g., managed care organizations, other insurers, clinics, purchasers, etc.) Based on clinical trials, accepted science and expert opinion, the guidelines provide a concise, general framework for the prevention of diabetic complications. The Guidelines can be downloaded from the Diabetes Control Program (DCP) web site http://www.dhfs.state.wi.us/heath/diabetes/DBMCGuidelns.htm

To order a printed version of the Guidelines, please contact Judy Wing, 608-261-6855.

HIPAA Tools for Success

By Kathryn Noe, RN, CPHQ,
WAHQ President Elect, Leadership Council Representative

NAHQ Fall Conference

Bill Bysinger, a consultant for Superior Consultant Holdings Corporation, out of Alpharetta, Georgia presented common sense tips to assist with Health Insurance Portability & Accountability Acts, (HIPAA) Compliance.

He recommended the following steps:

First, a user friendly and free web site, (www.wedi.org/snip) with information on how to understand the rules and implications.

Second, to form a multidisciplinary team, including vendors, payors and patients in the community.

Thirdly, during project implementation to use tools that meet your ongoing needs and are affordable.

Flowsheets in Outpatient Records Works!

By Carol Fergusan, Metastar

MetaStar's diabetes project encourages providers to use a flowsheet for their diabetes patients to serve as a reminder of when certain periodic tests should be done. Data aggregated over many clinics and systems shows how much of a help this is.

In 1096 medical records abstracted, over one-fifth contained a flowsheet that was being used to document dates of tests.

99.7% of patients with a flowsheet had had at least one HgbA1c test within the past year compared with 94.1% without a flowsheet ($p<.0001$).

52.1% of patients with a flowsheet had documentation of a dilated eye exam within the past two years compared with 30.7% without ($p<.0001$).

80.9% of patients with a flowsheet had had a lipid panel within the past two years compared with 69.6% of patients without ($p<.001$).

If you have diabetes, what would you like your clinic to do?

Address Changes and E-Mail 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 e-mail address to our database, please e-mail at mccarth@hughes.technet contact
Anna McCarthy at (608) 758-9028.

Regional E-Mail Group?

As WAHQ regional members. Would you like to participate ire your regional e-mail group? We know there are a lot of interested WAHQ members in participating regional groups. Short of creating a true list serve, we would like to create e-mail groups for each region. This will provide your regional representative with a quick method to communicate information for all interested members. Each region should determine how they would like to utilize the e-mail groups. Please e-mail your representative with your ideas. You can do this by accessing the WAHQ website and selecting the Beard Member Information bullet Find your representative and e-mail away
You may e-mail Sheri at sdix@fmlh.edu with your name, region and e-mail address to be added
to your regional e-mail group list.

Call for Articles

We are always on the lookout for articles to share with our membership. If you can assist us with our goal to produce newsletters with useful information, please submit any articles, storyboards, quality successes, or newsworthy features to:
Newsletter Editor
Mary Conti
6134 S. 15th Ct.
Milwaukee, WI 53221
Phone: (414) 764-4487
Fax: (414)805-4265
E-mail: mconti@fmlh.edu

Congratulations New CPHQ's!

Congratulations to all the New CPHQ's and to those CPHQ's that recertified in December, 2001.
We wish you continued success in your career as healthcare quality professionals.
WAHQ continues to support your continuing educational activities through the WAHQ annual educational conference held in March. Additionally, we will list other educational opportunities in the newsletter or on the WAHQ web, with links to the NAHQ website.
One of the special benefits with a WAHQ membership is the $75.00 re-imbursement monies
available for the CPHQ candidate successfully completing the original exam for that year. For those who are current members and were WAHQ members prior to November, 2001, please contact
the WAHQ treasurer, Linda Buel., about the process for re-imbursement.

Treasurer's Report

By Linda Buel
As of 9/28/2001
Assets
Checking $4,811.79
Savings $484.88
Deferred Annuity $4,281.68
Liabilities $0
Total Assets $9,578.35

WAHQ MEMBERSHIP APPLICATION

Name: _____ Credentials:_____ (CPHQ, RN, LPN, RRA, ART, Other)
Title: _____ Business Phone: ( )_____ Home Phone: ( )_____
Organization: _____Fax: ( )_____ Business E-mail: _____
Business Address: _____ City:_____ State:____ Zip:_____
Business Address: _____ City:_____ State:____ Zip:_____
Are you a member of NAHQ? ___Yes ___No (Please check)
Send more information on: ____ NAHQ Membership ____ CPHQ Program
Signature:_____ (Please include dues of $35/one year)
Mail to: Anna McCarthy, 2229 Pioneer Rd, Janesville, WI 53546; (608) 758-9028
or e-mail Anna McCarthy at mccarth@hughes.technet

2001-2002 WAHQ BOARD OF DIRECTORS

Officers

President
Diane Schallert, RN, MSM, CPHQ
(608) 274-1940
dschalle@metastar.com

President-Elect
Kathryn Noe
(608) 847-6161 ext. 248
knoe@milebluff.com

Secretary
Gloria Field
(608) 346-5257
mri.gf@smhosp.org

Treasurer
Linda Buel
(715) 356-7574
buelin@hyhc.com

Liaisons

Membership Coordinator
Anna McCarthy, CPHQ
(608) 758-9028
mccarthy@co.rock.wi.us

Newsletter Editor
Mary Conti
(414) 805-4426
mconti@fmlh.edu

Regional Representatives

Northcentral
Deb Napowocki
(715) 346-5644
mri.dnapiwocki@smhosp.org

Northeast
Karen Oskey, UR Chief
(920) 498-4235
koskey@stmgb.org

WAHQ
Board Position Openings and Election for 2002

The WAHQ Board is looking for WAHQ members who would like to run for a Board position. Positions to be elected in the upcoming ballots are as follows:

***Secretary**
***Southwest Representative**
***North Central Representative**
***Southeast Representative**

Northwest
Donna Jensen
(715) 468-7833 ext. 310
djensen@lycosmail.com

Southcentral
Kathy Swanson
(608) 831-8208 ext. 1924
kswanson@picwisconsin.com

Southeast
Mary Conti
(414) 805-4426
mconti@fmlh.edu
Sheryl Krueger Dix
(414) 259-4865
sdix@fmlh.edu

Southwest
Wanda Plachecki
(608) 284-5396
wplach@aol.com