Happy New Year to everyone at CTAHQ. I hope that you have had an opportunity to enjoy friends and family during the holiday season.

We have two new members to the CTAHQ board. Denise Myrick, CTAHQ treasurer, has moved to Oregon. We wish her well and good luck in her new position. Barbara Kaplowe has agreed to fill in temporarily as Treasurer. Marilyn Folick has stepped down as CTAHQ secretary and Janice Watkins has agreed to finish out Marilyn’s term. We thank both Barbara and Janice for helping out CTAHQ in our hour of need.

Kathy Adamo, a long time CTAHQ member passed away. Kathy was a well respected and admired health care and quality professional among her colleagues. She will be missed but not forgotten. Kathy’s friendship and memories will stay with us, and her family and friends forever. We send our heart felt condolences to the Adamo family and all that knew her.

CTAHQ has the opportunity to apply for a 1,500 dollar educational grant through HQF. Please visit the www.nahq.org for more detailed information. Lavern Jenkins, Education team leader, will be coordinating this effort for CTAHQ. If you are interested in becoming involved, this is an excellent opportunity to meet other CTAHQ members and have a better understanding of what your organization has to offer. Please consider this opportunity and the positive impact it can have for our organization. Lavern Jenkins’ contact information is laverne.jenkins@ynhh.org.

Don’t forget to visit the CTAHQ website www.ctahq.org. We are continually updating the site to make it one that you will refer to often for local and national health care quality information.

The next education conference is titled “Immunizations across the Continuum”. It will be held on January 26, 2005 from 5-9 PM at the Four Points Sheraton Hotel in Meriden. Improving immunization rates for our patients and community is an important and complex process. Join us to share your ideas. Please mark your calendars and make every effort to attend. The registration brochure with more detailed information about speakers and topic discussions is included in this newsletter.
Membership Team
By Lois Benis, Team Leader

Our 2006 membership drive was very successful!
Thanks to everyone who renewed and welcome to our new members:

Beth Barrientos                Kate Betancourt
Kathleen Davis               Nancy Evans
Kathryn Fitzgerald          Judith Gherlone
Joseph Hughes              Susan Jacobsen
Stanly Konieczny            Tunde Kovacs
Janine LaRochelle           Hilary Littles
Kathy Mazerkolle            Maureen McQueeney
Cheryl O’Dea                Theresa Rankin-Carle
Cheryl Ringo                Adele Santangelo
Sahel Shwayhat            Mary Staskiewicz
Joetta Thiel                   Jean Van Arnam

Congratulations to Terri Savino who recruited the most new members! Terri will receive a $25.00 gift certificate to be used toward a CTAHQ educational program in 2006.

Congratulations also to Sue Wrubel, Claire Davis, Leona Mariani, and Sherry Strammiello! Each recruited 2 new members and will receive a $10.00 gift certificate to be used toward a CTAHQ educational program in 2006.

- Current membership is 88
- # of renewals – 65 (74%)
- # of new members – 23 (26%)
- # of members who are also CPHQs – 38 (43%)
- # of members who also belong to NAHQ – 40 (45%)

Membership benefits include:
- Quarterly educational programs with CEUs (for CPHQs)
- Recognition of Certified Professionals in Healthcare Quality (CPHQs)
- Networking opportunities
- Quarterly Newsletter (for Connecticut and National news and information)
- Member Directory (for contact information)
- Affiliation with the National Association for Healthcare Quality (NAHQ)

Fundraising Team
By Donita Semple, Team Leader

The goal of this team is to raise enough funding to underwrite the organizational annual contribution to HQF and to fund one member’s registration to the NAHQ conference. This fundraising is done through raffles at our educational meetings. At our October meeting, we raffled a fall wreath and raised $67.17.

This year the fundraising committee has begun discussions on a more aggressive fundraising initiative. We are exploring the sponsorship of a Connecticut River Boat Mystery Cruise for our membership and their guests. Stay tuned to hear more.

Denise Myrick’s enthusiasm will be sadly missed by this team but we strongly encourage our members to participate in this planning.
Going for the Gold 2006

in sharing your stories of celebrating
Healthcare Quality at your Hospitals.

Please E-mail to terri_savino@midhosp.org

This information is needed to
submit electronically for
NAHQ State Excellence Award

Editor’s note:
“Networking With” is a new addition to CTAHQ News, which will showcase different organizations that promote quality improvement methods. Our first piece was written by Gary Rosentreter Ed.D, Executive Director of the Connecticut Quality Council, located in Hartford.

A major function of The Connecticut Quality Council (CQC) is to facilitate the sharing of quality and continuous improvement related information and experiences among its members. The CQC promotes and enhances quality and continuous improvement in the local region. We accomplish this by offering a forum for exchange of information, networking, providing education and training opportunities, being a resource for information, and disseminating best practices. Our scope includes Six Sigma, Lean and many other improvement processes designed to enhance organizational performance.

The CQC:
- Is a private, non-profit coalition consisting of businesses, government, healthcare and education that is membership driven.
- Has over 100 members who share experiences, expertise, and resources.
- Is one of two non-degree entities of Rensselaer at Hartford
- Is a respected and valued resource since 1990 for education and training with over 30,000 participants attending training via public and contracted workshops
- Is a professional and established networking and information sharing organization for all organizations that are pursuing continuous improvement

Upcoming Events in 2006

- A Site Visit will be held Hartford Hospital to understand how their “Simulated Training Center” is being used to improve the quality of care and foster many continuous improvements in the operational units. Date to be soon announced will be in late March. CTAHQ members are invited to attend.

(Continued on page 7)
Job Opportunities

Hospital Quality Measurement Coordinator
Yale New Haven Health System
New Haven, CT

Position located in New Haven, CT. Working closely with our member hospitals – Yale-New Haven Hospital, Bridgeport Hospital and Greenwich Hospital – you will collect, document and report relevant patient safety and health outcomes data as a part of public reporting and pay-for-performance programs.

We’re seeking dynamic candidates with a Bachelor’s Degree (Master’s preferred) and nursing certification, as well as 5+ years’ clinical experience and 3+ years’ experience with chart abstraction, health outcomes data collection and analysis.

We offer generous compensation, excellent benefits, and a truly challenging and rewarding career opportunity. Please visit our website to apply on-line at www.yalenewhavenhealth.org. Resumes can also be sent to rebecca.wolfe@ynhh.org.

Statewide, private non-profit care management agency serving the elderly and disabled in need of home and community-based long-term care is now hiring:

Director, Care Management Associates (CMA)
Care Management Associates, a division of CCCI, currently has an opening for Director. Results oriented, high-energy candidates must possess a Bachelor’s degree, Masters preferred, in business or healthcare administration or a related field with at least four years health and/or human services business experience with a minimum of two years in a supervisory capacity. Demonstrated success in launching a new business, policy development, planning, contracting and budgeting as well as proficiency in oral and written communications and the ability to work independently and creatively in a challenging, entrepreneurial environment. Proven positive track record managing revenue growth.

Full-Time, Part-Time and Per Diem positions available in the Hartford, Waterbury, and Norwich areas for: Nurse Care Manager
Successful candidates must possess a BSN with 1-year clinical experience or RN diploma with 2 years clinical experience and a current CT RN license. Computer skills desirable.

Social Service Care Manager
Successful candidates must possess a BA or BS in social work, gerontology or a related human services field and 2 years clinical experience. MSW preferred. Computer skills desirable

Please submit resume with salary history to: Human Resources Department, CONNECTICUT COMMUNITY CARE, INC., 43 Enterprise Drive, Bristol, CT 06010-7472 or FAX: 860-585-0858. E-mail: hr@ctcommunitycare.org. Website: www.ctcommunitycare.org Affirmative Action-Equal Opportunity Employer M/F/D/V

Assistant Vice President of Risk Management and Quality Management
Griffin Hospital, Derby, CT

Reporting directly to President & CEO, the Assistant Vice President of Quality Control and Risk Management plans, implements and manages quality management and risk management programs designed to enhance the quality of patient care, reduce injuries and prevent patient claims. The Assistant Vice President facilitates the integration of continuous quality improvement methods across organization initiatives to evaluate and improve processes that lead to efficient delivery of quality care.

Successful candidates will possess a master’s degree in health care administration, business and/or other related degree. J.D. preferred. RN or medical clinician or equivalent with a minimum of five years experience in Quality Management Improvement in an acute care environment, plus two years experience in a legal role such as a lawyer or paralegal is required.

Must be self-motivated and be able to work cooperatively with hospital staff at all levels of the organization, members of the medical staff and outside individuals involved in the hospital’s claims and risk management activities. Ability to maintain strictest confidence regarding quality assurance and risk management information. Excellent verbal, presentation, organizational and written skills with an interest in staff education; knowledge of JCAHO requirements; knowledge of current concepts in quality assessment and improvement, including statistical and/or data analysis.

We offer an excellent salary and benefits. Contact us and see why we have been voted “100 Best Companies to Work For” for six consecutive years! Please email your resume to pgrele@griffinhealth.org or fax to Pat Grele, Human Resources at 203-732-7156. We invite you to visit our website at: www.griffinhealth.org
Healthcare quality and safety means doing the right thing, the right way, at the right time, the first time. To be a model of excellence, healthcare professionals must commit to delivering services of the highest quality by emphasizing continuous improvement of processes, communication, teamwork, and measurable results.

This goal is complex and requires new ways of thinking and new skills. All physicians and staff members need to be vigilant to ensure they are providing the best possible care for patients.

There are three keys elements necessary for improving the quality of healthcare services: An understanding of how to minimize the “human” factors that impact the quality and safety of care systems; applications of methods to measure and analyze performance; and continuous improvement of services by acting on performance information.

MINIMIZE THE HUMAN FACTORS

Actions to improve both the individual and systematic aspects of healthcare services must take into consideration the human factors associated with performance. These factors strongly influence two performance aspects: work environment and actions needed to improve performance.

For the work environment to support performance excellence, there must be trust between management and staff members and a shared commitment to quality. This trust can be fostered by a credible, nonpunitive attitude towards errors that encourages people to share information about quality problems and participate in actions to prevent recurrence. Part of the trust also includes the belief that management will make every effort to deal with the conditions that negatively impact individual and system performance. Management must also make it clear that data defining the nature and frequency of errors and system problems is important to the department. Without data, process improvement strategies only represent “best guesses” as to what actions are needed.

Often, healthcare professionals still believe humans are “perfectible” and that the “blame-and-train” tactic is the optimal route to improvements. When faced with human error, the traditional response is to blame the human and institute new training. But when the vast majority of quality problems or medical accidents are attributed to human error, it indicates that something is wrong with the system, not the people.

Consider this: How would you approach a problem caused by a noisy environment over which you have no control? You wouldn’t blame the noise. Instead, you would design a process that could function effectively regardless of the noise. This is exactly the approach that should be taken in response to human error – redesign the process to fit the people who must use it.

Once the notion that human mistakes are inevitable is accepted, it becomes clear that improvement actions focused solely on changing individual performance will not result in sustainable quality gains. Performance improvement requires systemwide strategies and process changes. Individual assessment is needed to target training opportunities; however, the quality of patient care services will only be advanced by designing systems that forgive human errors. A “forgiving system” is resistant to errors and process failures or can easily recover if a problem occurs.

One solution is to force people to stop and think twice before proceeding to the next step in the process. An example of this is the “time out” expected of the operative team prior to the start of a surgical procedure. This process change is intended to reduce the likelihood of a wrong site, wrong procedure, or wrong person surgery. Creating a pause in the process is one way of making it more forgiving of errors. Computerized technologies rely on alert message, alarms, and “undo” commands to help people avoid incorrect actions and recover from mistakes. Nonautomated processes would benefit from similar tactics.
The new CPHQ Recertification policy became effective for those CPHQ’s due to recertify 12/31/2005. The new policy reads as follows:

**Revocation of Credential**

If the CPHQ does not recertify by January 31 following the year ending each recertification cycle, their certification will be revoked for failure to comply with recertification requirements. Individuals who have failed to comply will receive “Revocation Notice”. This revocation will become effective as of the date this letter which will be mailed to the CPHQ’s last known address. Individuals whose credentials have been revoked may not use the credential designation of CPHQ in representing themselves and will be required to sit for the examination if they wish to become certified as a CPHQ in the future.

A recertification form can be obtained by visiting the following link:

If you have any questions regarding the CPHQ certification you may contact them via email at info@chpq.org or via phone at 800/346-4722.

Also, please remember to report any address or email changes directly to CPHQ. The CPHQ database is separate from the NAHQ membership database.

**CTAHQ News**
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Email: jricho@srhs.org

CTAHQ encourages you to market your skills and increase your visibility by displaying your CPHQ status. You can do this by wearing your CPHQ pin or using camera ready artwork available from CPHQ on your business cards and stationery.
HQF New Quality Professional Grant
The HQF New Quality Professional Grant is for a NAHQ member who has been in the healthcare quality field less than 2 years and is not yet a Certified Professional in Healthcare Quality (CPHQ). The grant will be for $1,000, which can be used for travel and registration expenses for attendance at either a NAHQ CPHQ Review Course or the annual conference. One grant will be chosen annually.
Use the following web address to obtain the application. http://www.nahq.org/awards/newprofgrant.doc

HQF Career Development Grant
The HQF Career Development Grant is aimed at a NAHQ member who has been in the healthcare quality field at least 5 years and is a CPHQ. The grant will be for $1,000, which can be used for travel and registration expenses for attendance at either a NAHQ CPHQ Review Course or the annual conference. One grant will be chosen annually.
Use the following web address to obtain the application http://www.nahq.org/awards/careerdevgrant.doc

HQF Certification Grant
The HQF Certification Grant awards financial assistance to healthcare quality professionals who have not yet attained the CPHQ credential by sponsoring their fee to take the exam. The total number of awards and amount of award will be determined annually by the HQF Board of Trustees.
Use the following web address to obtain the application http://www.nahq.org/awards/Certgrantapp.doc

NAHQ Dates to Remember
February
17 Winter NAHQ News mailed
March
1 NAHQ Ballot is available online
April
7 Fellowship applications are due
14 Mail Conference Brochure
21 Nominations due for Claire Glover & Distinguished Member Awards
28 Deadline for HQF grants applications

News!
(Continued from page 3)

CQC
- Concepts and Applications Half Day Workshops and Networking will be held on March 8th, April 12th and May 17th from 8:30 am to 12:30. Recognized content experts from academia and businesses will jointly facilitate a discussion on “Quality Management Topics” that are being implemented in organizations today. These experts will share their work and research on the topics below followed by a guided discussion with the participants. Participants are encouraged to bring real issues from their organizations for analysis with other group members and content experts. Specific Topics are:
  - A Practical Guide To Implementation Of Sustainable Change
  - Building Quality Into Your Organization
  - Integration Of Six Sigma and LEAN in Organizations
- New 2006 Connecticut Quality Council Catalog of public workshops is out with some new programs regarding the “Human Factors” in continuous improvement. See our Web Page www.ctqualitycouncil.org
- We are conducting many Private contracted programs in 2006 such as a new “Cross Functional Collaboration” and “Team Effectiveness” Workshops within organizations
- The Quality Manager Certificate Program for 2006 Starts March 14 and runs through May 24 this year. This Five Module Certificate Program is a joint effort through the Lally School of Management and Technology and CQC.

Contact Information
If you would like additional information, please visit our website at www.ctqualitycouncil.org or Email: cqc-info@rh.edu
Or you may contact:
Gary Rosentreter Ed.D.
Rensselaer at Hartford Campus
Connecticut Quality Council
Executive Director
Phone: 860-548-7861
The first step in performance improvement is to acknowledge that error is inevitable. Such acknowledgement is paramount to creating a work environment supportive of excellence. Without a supportive culture, quality problems are likely to remain hidden rather than brought into the open and analyzed.

The inescapable conclusion is that human errors cannot be avoided. Rather, error needs to be managed through culture changes, systemwide strategies, and better process design. Departments can use the self-assessment questionnaire in Figure 1 to determine how well they are doing in minimizing the human factors associated with performance. The more statements employees can strongly agree to, the more likely it is that your department will be successful at achieving lasting performance improvements.

**MEASURE PERFORMANCE**

Effective performance improvement depends on the collection, analysis, and dissemination of relevant information. In the cycle of neverending improvement, performance measures play an important role in:

- Tracking progress against departmental goals;
- Identifying opportunities for improvement;
- Comparing performance against both internal and external standards;
- Formulating the direction of strategic activities; and
- Achieving quality and productivity improvements.

Making constructive use of measurement data is critical if departmental performance is to improve. First, the right measures must be selected. If not, people will focus their efforts on activities that do not move the department toward desired performance goals. A combination of structure, process and outcomes measures can be used.

For efficiency's sake, it is best to concentrate on a few vital, meaningful measures. If there are too many measures, people may become too intent on measurement and lose focus on improving results. A guiding principle is to measure what matters most. Although each department is unique, there are certain questions that should be kept in mind when selecting performance measures:

- Are the department's services contributing to the organization's overall success by assisting in the achievement of strategic goals? How can the department's contribution be measured?
- What performance does the department want to improve? What critical activities and outcomes should be measure?
- What are the vital requirements of the department's customers? What is the most important to patients and other internal customers? How can these customer expectations be measured?
- What is important to accreditation and regulatory agencies? What are the national or local topics of interest that affect patient care services, and how can these issues be measured?

Once the essential measures of the department's services are defined, the next step is to establish performance expectations or targets for each measure. Performance targets are quantifiable estimates or results expected for a given period of time. Targets can be broken down into goals for discrete short-term intervals (e.g. the next two quarters). Medium- or long-term performance targets can also be established.

Performance targets should promote a high-quality and safe environment but also represent realistic expectations. The real art of setting performance targets is to create a challenging but achievable target, the best of which stretch the capabilities of staff members and the departments but are, nonetheless, possible. Stretch targets not only result in genuine improvement but also help build staff pride and confidence. On the other hand, impossible performance targets demotivate and stifle innovation.

Whenever possible, performance targets should be derived from baseline data representing past performance or derived from comparison data from similar organizations.

**ANALYZE PERFORMANCE RESULTS**

If properly constructed, performance measures will result in data that are meaningful to decision makers in terms of improving performance. The data generated should be timely, relevant, and concise. Assessment results should provide information on how well current performance compares to intended goals and on the effectiveness of departmental activities and operations in terms of their specific contribution to performance goals. Numerous factors need to be considered when analyzing performance results:
- Are the right measures being used to evaluate performance?
- Do the measures provide a better understanding of the cause-and-effect relationship between processes and outcomes?
- Do the measures reflect organizational or departmental priorities?
- Do the data indicate any understandable performance trend over time?
- Do the data suggest improvement opportunities in areas other than one(s) being assessed?
- If performance targets are not met, what inhibited successful performance?
- If performance targets are significantly exceeded, are there additional benefits to be gained in terms of reducing costs or improving quality or safety?

The manager or staff members responsible for departmental quality improvement can conduct the analysis of performance data. However, ultimately everyone in the department should be apprised of the results. Reports or briefings that summarize and track results should be shared at staff meetings or through other communications. It is best to use simple, eye-catching tables or graphics such as run charts to summarize performance data. Don’t make people “hunt for the needle in the haystack.” Use color or other techniques to highlight improvement opportunities. Use the same report format for all measures because it is easier for people to quickly comprehend the results.

The payback from performance measurement comes from using the data to improve performance. If the results are not used, employees will not take performance measurement seriously nor will they trust the management is really committed to dealing with problems. When the hard work of data collection yields nothing more than periodic reports of performance, staff can quickly lose trust in management’s commitment to excellence. The information must be used to make positive changes that contribute to achieving departmental goals and objectives.

**IMPROVING PERFORMANCE**

Most healthcare professionals are deeply committed to the highest-quality work. In support of this commitment, improvement actions should be initiated whenever there is a gap between what is actually happening and what is desired. These opportunities may be discovered in various ways:

- Incident reporting
- Analysis of performance measurement data;
- Findings from regulatory and accreditation survey;
- Patient/client feedback; and
- Physicians and/or staff member concerns.

Systematic analysis of the data generated through these activities may identify problems or opportunities for improvement in processes or systems. The essential next step is to use the information to improve the quality and safety of care and services provided.

JCAHO standards require that leaders define criteria by which improvement priorities are selected, with activities significantly affecting patient outcomes being most important. Because improvement projects are resource intensive, when several opportunities for improvement are identified, choices may need to be made. The following criteria can be used as a guide for choosing improvement projects:

1. **The problem is important.** It has been a problem for some time and is widespread. The benefit of solving the problem is obvious.
2. **Support for change exists.** People recognize the need for change either because of personal experiences or because performance measurement data has persuaded them that a change is necessary.
3. **The project has emotional appeal/visibility.** People are motivated to work on solving the problem.
4. **The status quo has some risks.** There are hazards associated with not addressing the problem. If something is not done, it may create other problems – e.g. patient care may suffer, staff morale may drop, and/or physicians may no longer admit patients.

Performance improvement has many names that are often used interchangeably. You may have heard of total quality management, continuous quality improvement, plan-do-check-act, or clinical practice improvement. The organization’s performance improvement plan should identify the name of the improve-
ment model to be used in all departments. Regardless of the title given to the improvement model or the steps involved, the important components should:
- Bring together a team of people with knowledge of the process;
- Start with a common understanding of the improvement goal;
- Use data, not intuition or anecdotal references, to determine what changes need to be made;
- Assign people who “own” the process to be responsible for putting the changes into action; and
- Use data to determine the effectiveness of actions after implementation.

There are several approaches to investigating the cause of problems and taking actions. Regardless of the improvement model used within an organization, all approaches include five basic process improvement steps: plan, diagnose the problem, intervene, study impact, and sustain gains. Quality improvement tools and techniques are used throughout the steps of an improvement project. Whatever the project’s goal, systematic improvement in quality requires recognition of the systems and processes of the service being provided.

1. Plan

At the onset, it is essential to decide on the process to be improved, and there should be data available supporting the assumption that there is a problem. Problems may be given to a team to examine (such as sentinel event investigation), or the manager or staff may choose the problem to be studied. Once the nature of the project has been decided, the next important step is to gather the appropriate people to work on solving it. The project team should be composed of people who meet the following criteria:
- They must have a fundamental knowledge of the process and, therefore, should be people who work with or have a particular interest in the process.
- They must represent all parts of the process and, as appropriate, the various levels in the organization. It is easy to unintentionally omit those who are considered to be external to a process, such as representatives of the HIM, pathology, or x-ray departments, mainte-
- At least one team member should be skilled in process improvement methodologies or root cause analysis. Ideally, the team leader should have training in team facilitation.

The ideal team has five to nine members. If it becomes too large, this may indicate that the project’s scope is too ambitious. Improvement takes time and, in a stressed work environment, physicians and staff members may find it difficult to participate as active team members. For this reason, meetings should be well structured to ensure that members are able to contribute their fundamental knowledge of a given process in the most time-effective manner.

Once the team is assembled, a clear statement of what is to be accomplished by the project is developed. The project will not result in improvements without a clear and firm intention to do so. The goal/aim should be expressed in specific terms – e.g. 30% improvement in appropriate antibiotic timing of preoperative antibiotic administration within six months. Agreement on the goal is crucial – as is allocation of the people and resources necessary to accomplish the goal.

2. Diagnostic Phase

During this phase, the team establishes the full extent of the problem, determines what changes can be made that will result in the improvement, and selects measures to evaluate the success of the changes.

The process of care to be improved must be thoroughly examined so an accurate “diagnosis” of the problem cause can be made. This part of the project requires a fair degree of planning. No one person should be expected to undertake all aspects of the review. Data collection and analysis may take some time, but the importance of gathering this information cannot be understated.

During this process, many different proactive risk assessment techniques and process improvement tools may be used: process flow chart, customer focus group, brainstorming, checklist, cause-and-effect diagram, run chart or statistical process control chart, pareto chart, events and causal factors charts, failure mode and effects analysis, etc. A person trained in improvement techniques can help the team select the best tools to identify and analyze the process. Once
all the information about the problem is gathered and examined, the team will need to agree on the principal causes. Based on the evidence presented, the team selects the interventions that will be trialed to bring about the improvement.

All improvement requires making a change – but not all changes result in improvement. Since changes in the system can be disruptive, it is important to identify the most promising changes. Many sources can contribute good ideas for changes through critical thinking about the current system, creative thinking, watching the process, getting insight from a completely different situation, learning from other organizations, and more. In addition, recommendations published by other professional groups and relevant literature sources may provide some ideas on how to change the process.

It is helpful to know the types of errors people are making. This information can guide the team in determining what actions can best be taken to reduce mistakes. For example, procedural errors may indicate poor workload management, teamwork problems, and/or ineffective procedures while communication errors may reflect inadequate team training or complacency. Decision errors point to the need for more training in expert decision making or critical thinking. Finally, violations of current policies or procedures may be an indication of poor procedures, weak leadership, or a culture of noncompliance.

3. Intervention

In this phase, the changes identified in the diagnostic phase are implemented. Changes must be tested prior to full implementation to ensure everything goes as planned. People are far more willing to test a change if they know changes can and will be amended as needed. Often, project teams are involved in testing more than one change as a time, all aimed at achieving the same ultimate goal.

Continuous performance improvement is basically a trial-and-learning approach. Process changes are tired, the consequences observed, and people learn from those consequences. The completion of one project can lead directly into the first phase of another project. Performance excellence requires a departmentwide commitment to constantly testing better ways of doing things as part of the daily routine. Such a commitment is not easy, but the alternative can be worse – accept an inadequate status quo or take blind stabs at improvement without a clear understanding of the consequences.

4. Study Impact

All improvement projects include a follow-up phase; that is, data are gathered to determine the effectiveness of action plans. In some instances, already-existing performance measures can be used to evaluate results. In other situations, special studies may be necessary. Healthcare organizations must be able to demonstrate to themselves and others that improvement activities have resulted in better performance.

The accreditation standards of most groups, including JCAHO and the Accreditation Association for Ambulatory Health Care, require that the effectiveness of improvement interventions be measured. The accreditation decisions made by these groups will be based, in part, on demonstrated effectiveness of an organization’s improvement projects.

After the changes are fully implemented, the effect is measured and recorded. If desired results are not realized, the team returns to the diagnostic phase to reevaluate the problem and select alternative solutions. If the preliminary analysis of the changes show that actions have been successful as defined by the project’s goals, then the changes are made on a permanent basis. This may require rewriting of procedures, educating and training physicians and/or staff, formal communications or other ventures for the actions to be incorporated into people’s way of doing things.

5. Sustain the Gains

This step involves ongoing monitoring of important process and outcomes to ensure desired improvements have been achieved and the improvements are lasting. During this phase, the team determines how the process will be periodically monitored to determine whether the process changes continue to achieve desired results. Relevant measures of performance are incorporated into the department’s routine monitoring activities.

SUMMARY

Research has established that the provision of
healthcare services is not error free. The question facing the healthcare industry is how to minimize the human factors that affect quality and safety. Achieving performance excellence starts with a supportive work culture. The human issues of teamwork, communication and leadership are vital to achieving performance excellence. Next, healthcare professionals must accept that all people make mistakes so systems and processes can be designed to be more forgiving of errors. Last, a planned and systematic approach must be used to measure, analyze, and improve performance.

Successful implementation of performance improvement calls for strong partnerships between physicians, managers, and staff members. Performance excellence requires that everyone work together to ensure that healthcare is safe, effective, appropriate, customer focused, and efficient.

- Patricie L. Spath, BA, RHIT is a healthcare quality specialist, author of 101 Tools for Improving Healthcare Performance, a partner in Brown-Spath & Associates (www.brownspath.com), and an assistant professor in the department of health services administration at the University of Alabama in Birmingham.

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Are You Minimizing the Human Factors?

Place a check (x) in the Low, Medium, or High box to indicate how strongly you agree with each of these statements as they relate to your department.

<table>
<thead>
<tr>
<th>People in this department......</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
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<tbody>
<tr>
<td>1. Believe even competent, well-trained professionals can make mistakes</td>
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<td>2. Cooperate with one another to resolve problems.</td>
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<td>3. Feel comfortable reporting quality problems or unsafe conditions to their supervisor.</td>
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<td>4. Regularly report all patient incidents and near misses.</td>
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<td>5. Believe there are process changes that can be made to reduce the likelihood of a medical mishap.</td>
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<td>6. Are willing to change some of their old habits to improve quality and patient safety.</td>
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<td>7. Believe the department's leaders are committed to continually improving performance.</td>
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<td>8. Take time to discuss and act on the department's performance results.</td>
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SAVE THE DATE !!!
NEW ENGLAND REGIONAL HEALTHCARE RISK MANAGEMENT CONFERENCE
MAY 7, 8, AND 9th, 2006
MOHEGAN SUN RESORT
Uncasville, Connecticut

Conference topics include disclosure of adverse events to patients and families, ethics, obstetrics, emergency department issues, and documentation mock trial to name a few.

MAKE YOUR RESERVATIONS NOW!
Conference room rate: $149.00
Call 1-888-777-7922
Ask for conference code: CSHRM1
Immunizations Across the Continuum of Care

Panel Discussion Leader: Leona Mariani, RN, MBA, CPHQ, ABQAURP Vice President of Quality, Eastern CT Health Network (ECHN)

Ms. Mariani has 15 years of clinical and managerial experience in the inpatient area, with 13 years of quality experience in acute, long term and homecare. She currently serves as VP of Quality for the ECHN and will moderate the panel. She is also past president of CTAKHQ.

About the Speakers:

Visiting Nurse Association: Ms. Donna Girard RN, MSN, who has 20 years of acute care experience and 15 years of homecare, assisted living and case management experience is currently the Community Health Director for Midstate VNA & Hospice. She will describe the process and barriers that a VNA experiences as they attempt to improve vaccination rates.

Long Term Care: Ms. Leona Mariani RN, MBA, CPHQ, ABQAURP has experience in maintaining JCAHO accreditation for Woodlake at Tolland Eldercare Service for over 10 years. She has worked with Liz Oswald MSN, Director of Nursing at Woodlake, to develop this educational portion of our session.

Acute Care Hospital: Ms. Theresa Schmidt RN, BSN, CPHQ, who has 20 years experience in the acute care setting including 10 years of experience in quality, is the Nursing QI Coordinator for Manchester and Rockville Hospitals in the ECHN System. She was instrumental in making significant improvements to the vaccination process using the paper and computerized medical record.

Managed Care: Ms. Diane Aresco RN, BSN, has previously worked with Kaiser Permanente and has 15 years experience with ConnectiCare currently as the Manager of QI & Preventative Health Dept. She has focused on Flu immunization with the goal of increasing ConnectiCare’s high risk members who receive the flu shot. In 2002 the flu program won a CT Quality Improvement Award and Innovative Quality Improvement Award from the American Association of Health Plans.

FOUR POINTS SHERATON
275 Research Parkway
Meriden, Connecticut 06492
Telephone: (203)238-2380
At the end of this presentation, the participant will be able to:

1. Identify strategies used to improve immunization status in patients/residents/clients receiving immunizations in various healthcare settings.

2. Examine current methods used to communicate immunization status for patients moving from one healthcare setting to another.

3. Discuss payment within the context of barriers and underuse of providing immunizations to patients/residents/clients.

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AGENDA

5:00-5:30 pm Registration/Networking

5:30-6:00 pm Dinner

6:00 Presentation with Panel Discussion

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CONTINUING EDUCATION CREDITS

This activity will be submitted to the National Association for Healthcare Quality for 2 Continuing Education hours.

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From Hartford (I-91 South): Take I-91 South to exit 17 (East Main Street). At the end of the exit, take a left onto East Main Street. At the second stop light, take a right onto Pomeroy Avenue (Texaco on the corner). The Four Points Sheraton Hotel will be ½ mile on the right.

From Hartford (Rt 15 South): Take Route 15 South (Merritt Parkway) to exit 67 W. At the end of the exit, take a left onto East Main Street. At the second stop light, take a right onto Pomeroy Avenue (Texaco on the corner). The Four Points Sheraton Hotel will be ½ mile on the right.

From New Haven (I-91 North): Take I-91 North to exit 16. At the end of the exit, take a right onto East Main Street. At the first light take a right onto Pomeroy Avenue (Texaco on the corner). The Four Points Sheraton Hotel will be ½ mile on the right.

From New Haven (Rt 15 North): Take Route 15 North (Merritt Parkway) to exit 67. At the end of the exit, take a left onto East Main Street. At the second stop light, take a right onto Pomeroy Avenue (Texaco on the corner). The Four Points Sheraton Hotel will be ½ mile on the right.

From Waterbury: Take I-84 East to exit 27 onto I-691 East. Follow I-691 to exit 10 (I-91/Rt 15 South exit). Stay in right hand lane and get off first exit, 67W (East Main Street exit). At the end of the exit, take a left onto East Main Street. At the second stop light take a right onto Pomeroy Avenue (Texaco on the corner). The Four Points Sheraton Hotel will be ½ mile on the right.

From Middletown: Take Route 66 to exit 13 (East Main Street). Follow straight through to second light. Take a left onto Research Highway. Follow to stop sign. Go straight. The Four Points Sheraton Hotel on the right hand side.
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CTAHQ
Jacqueline Richo
c/o Hospital of Saint Raphael
QI Department
1450 Chapel Street
New Haven, CT 06511