CMQ is pleased and honored to announce that Arnold Milstein, MD, MPH will join attendees at Medical Quality 2009 in Los Angeles in February to accept the 2009 Founders’ Award. Dr. Milstein is the medical director of the Pacific Business Group on Health, the largest employer health care purchasing coalition in the U.S., as well as the chief physician at Mercer Health & Benefits and national thought leader at Mercer Human Resource Consulting.

“Arnie Milstein is one of our most innovative national quality leaders,” said Lou Diamond, president of ACMQ. “He has been a driving force behind improving the efficiency of the delivery system and his work has certainly impacted the national initiative to bridge the quality gap.”

Milstein’s work focuses on health care purchasing strategy, the psychology of clinical performance improvement, and clinical innovations that reduce total health care spending.

Among his many accomplishments in the quality field have been co-founding both the Leapfrog Group and the Consumer-Purchaser Disclosure Project. He heads performance measurement activities for both initiatives and is a Congressional MedPAC Commissioner.

The New England Journal of Medicine’s series on employer-sponsored health insurance described him as a “pioneer” in national efforts to advance quality of care. He was selected for the highest annual award of the National Business Group on Health for distinguished innovation in health care cost reduction and quality gains. He was elected to the Institute of Medicine of the National Academy of Sciences and is a faculty member at UCSF’s Institute for Health Policy Studies.

**Prestigious Awards**

Joining Dr. Milstein as recipients of ACMQ’s awards will be RAND Health, accepting the 2009 Institutional Leadership in Quality Award; Prathibha Varkey, MD, MPH, 2009 Service Award; and Mark Granoff, MD, PhD, MPH and James Cross, MD, special President’s Awards.
Our Vital Need for Cost Containment
Measuring and Analyzing for Cost Effectiveness

As we focus national attention on cost containment, quality improvement and ensuring access to care, those interested in quality will have to re-engage in the cost containment debate and deal with multiple financial dimensions. Cost containment is not simply an economic dimension, but has significant quality and clinical implications. What are some of the financial dimensions we ought to engage in?

First, we have to understand what are the costs of healthcare delivery and what are the cost drivers. In 2006, the US spent $2.1 trillion dollars on healthcare, or 16% of GDP, with rates of increase recently that exceed the rates of quality improvement (see the most recently published AHRQ National Healthcare Quality Report at www.ahrq.gov/qual/qdr07.htm). Rates of increase in costs are similar to those in many other western industrial countries, the latter from a lower base rate as a % of GDP.

The list of drivers of healthcare costs is a long one, including the way healthcare is financed, the collapse of managed care, waste, new technology (see CBO Report 2764, Jan. 2008 at www.cbo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf) and the provision of “unnecessary” services with benefits that are, at best, marginal. The system is in part supply and demand driven. We have no credible and sustainable cost controls in place. Many of these cost drivers are caused by our inability to routinely apply evidence-based medicine to public policy decisions, including but not limited to benefit design and both health professional and patient decision-making. The system is failing to apply evidence-based management principles, as describe by Shortel, and to implement care delivery systems based on models such as the one described by Ed Wagner, the so-called Wagner Chronic Disease Model. Some have suggested that building out the health information technology (HIT) infrastructure will improve quality and patient outcomes and reduce costs.

Clearly adoption of HIT is desirable; after all, healthcare delivery is essentially an information exchange exercise. But the cost implications and specifically the cost savings still need to be documented, with a number of reports raising doubts about cost savings from HIT adoption. (CBO report 2976, May 2008 at www.cbo.gov/ftpdocs/91xx/doc9168/05-20-HealthIT.pdf).

Second, we do need to understand the costs of delivering the quality improvement and cost containment initiatives. The goal ought to be to strive for a high value system – low costs with high quality.
Recognizing Our Wonderful Volunteers

This column is an appreciative shout-out to all ACMQ members who give their time so generously in the midst of the extraordinarily busy schedules most of you juggle.

Executive Committee and Board of Trustees: Members of ACMQ’s governing body, aside from their responsibilities for governance and oversight, work to recruit members, solicit grants and sponsorships, write for publications, and generally donate their time, money and expertise. Just this month (October) more than three quarters of our board members traveled to Washington, DC for an all day board and strategic planning meeting. On a weekend. At their own expense.

MQM Authors: Eighteen members of ACMQ took on the important, time-consuming and challenging task of researching, writing and revising chapters for the book Medical Quality Management: Theory and Practice. Editor Prathibha Varkey, who will be the 2009 Service Award recipient at Medical Quality 2009 in Los Angeles, contributed a huge amount of time to pull the book together.

MQM Reviewers: Sixteen members volunteered to take on the vital task of reviewing one or more chapters of the book and make suggestions on improving content.

Policy Reviewers: The twelve members of the Ethics and Professional Policy Committee review and make recommendations for updates to current policies, suggest and research topics for new policies, and write policy drafts.

Student/Resident Section: The four elected leaders of the SR Section meet by conference call at least every two weeks and put their high levels of energy into increasing SR membership, promoting the Quality Scholarships and spreading the word about quality in medical schools and residency programs.

Editors: The two editors of this newsletter alternate as editor, performing such editorial duties as writing and editing columns, suggesting, soliciting and editing original articles from members, and proof-reading final drafts. The editor of the American Journal of Medical Quality, David Nash, is a tireless promoter of the AJMQ in addition to his role as editor-in-chief, editorial writer and content decision-maker.

Conference Planning and Moderating: This year boasts our largest committee ever; twenty-one people volunteered to help plan our 2009 conference, meeting by conference call every two weeks to discuss and select topics and speakers, taking on moderator duties, and judging abstract submissions.

Grants Solicitation: The sixteen members of the Grants and Sponsorships Committee work at the all-important task of approaching potential supporters of ACMQ’s educational programs and soliciting unrestricted educational grants.

Membership Recruitment: Our twelve-member Membership Committee oversees individual and corporate recruitment campaigns and works on a personal level to promote membership.

Bylaws Review: Our eight-member Bylaws Committee undertakes an annual review of the bylaws, makes recommendations for improvements, and drafts amendments as directed by the board.

AMA Delegates: Our two elected delegates represent ACMQ at the two annual HOD meetings, traveling to Chicago and other cities at their own expense, and keep the board informed of relevant decisions and other issues.

Publications Oversight: The ten members of the Publications Committee have oversight over the nitty-gritty administration and contractual obligations of journal, newsletter and book publication.

All this hard work is so impressive and we are most grateful and appreciative. ACMQ members truly follow the encouraging words of President Theodore Roosevelt, speaking to the U.S. Chamber of Commerce in 1906: “Every man owes part of his time and money to the business or industry to which he is engaged. No man has a moral right to withhold his support from an organization that is striving to improve conditions within his sphere.”

bridget.brodie@acmq.org
Value Driven Outcomes – Where Are We?

Neil R. West, MD

The quest for value in healthcare is undergoing some exciting changes. I have written in past columns about the reporting processes in various states such as Minnesota, Wisconsin and California. One of the beauties of the Wisconsin Collaborative on Healthcare Quality is the historical graphics that illustrate a medical group’s improvement year over year! (www.wchq.org) AHRQ recently listed that Michael Leavitt, Secretary of HHS, has endorsed 11 Value driven collaboratives.

Most interesting to this writer is the ongoing work in Geisinger Health Systems (www.geisinger.org/quality/) under the direction of CEO Glenn Steele Jr., MD. Geisinger is a mixed model integrated system which has been on a decade long adoption of Electronic Health Records (EHR) located in Danville, Pa. Recently, they have debuted providing a ‘guarantee’ of valued outcomes for their services. This is a fairly radical approach to customer satisfaction but one worthy of study, emulation and perhaps broader adoption. Medicine needs to look and ask how these practices are organized to deliver these ‘values’! Make a phone call or take a trip to Danville to learn from these ‘value’ practice changers.

The role of electronic health records is a foundation to launch the necessary systematic change to enable the automation of many repetitive processes in our health care delivery systems. Making sure that our healthcare consumers have access to the performance of the delivery system is important. These electronic backbones can be used within a healthcare entity, then move to a community, then regional and finally nationally.

Systematic data for patients within a given healthcare entity like Mayo Clinic, Kaiser Permanente, Lahey Clinic, Group Health to name a few are successful in addressing patients who appear to be under-served. Measurement of composite scores for management of diabetes or cancer screening give a more accurate picture on the health care systems ability to manage all of their patients, not just one metric.

The Minnesota Community metrics have added the diabetic composite score which looks at HbA1c level, LDL level, blood pressure control, renal screen, eye screen and cessation of smoking. The most recent composite diabetic score data reveals the average for all clinics in Minnesota is around 17%! The best are at 38%. You might say that is awful. It is important to benchmark where your system is performing and then work to implement improved processes. Gail Amundson, MD commented, “What is the best batting average in the American League?” She feels that we need to change the questions we ask of our delivery systems. Amundson is CEO for Quality Quest for Health with Caterpillar in Peoria, Illinois.

There have recently been a number of ‘accepted’ practices in medicine such as arthroscopic intervention for arthritis of the knee that should reduce the number of procedures for this disorder. It is estimated that there are over 1,000,000 knee arthroscopies done annually in the U. S. with an aggregate cost of $7 billion dollars! However, the outcomes are not appreciably different from physical therapy and conservative management. What is the value of the $7 billion dollars expended on a treatment that yields no difference in functional outcomes? Evidence based medicine is a constantly evolving science. Short term radiation for certain breast cancer cases are just as effective as long term radiation courses. These insights need to be share widely with the health networks in our country.

Pay for Performance (P4P) is being pushed as a quality improvement method for medical groups. Certainly, the experiences of many in the P4P arena can document improved throughput with the programs. However, these initiatives tend to be regional or based only on commercial patients or sponsored by a health care plan. What practices would desire is a collation of all their patients regardless of payer source. That is where a Regional Health Information Organization (RHIO) has a role. Many states and regions are moving along this track, for example, Delaware, California, Indianapolis, and Asheville, N.C. Some countries such as Sweden and the Netherlands have excellent registries to track outcomes.

The Integrated Healthcare Association (IHA) in California is a P4P program built on a fairly long record of common metrics across all commercial payers. Over the past several years, IHA distributed some $210 million dollars to medical groups, according to Tom Williams, Executive Director of IHA. These funds have enabled medical groups to build many of the electronic infrastructures needed to measure throughput. The challenge is to now build a culture that covers all patients and reports on a composite score level not just for commercial purposes but for the whole region.

The February 12-14, 2009 meeting of ACMQ in Los Angeles will feature tracks on skill building for informatics structure, current results and outcomes of pay for performance, and building quality into medical delivery organizations. So, where are we? Come and learn at the ACMQ 2009 spring meeting. Be a part of defining value and building systems of care which positively differentiate your system or regional performance from the median!

nrwest@comcast.net
Engaging Physicians to Improve Quality: A Case-Based Approach

Kenneth Cohn, M.D., MBA, FACS

The distinction between what physicians and nurses principally do (care for patients) and what administrators principally do (finance, operations, marketing) is blurring. Recent decisions at the Center for Medicare and Medicaid Services (CMS) not to reimburse hospitals for complications, such as catheter acquired urinary tract infections, decubitis, and falls that occur in the hospital, compel us to put aside significant differences in background, training, and outlook and place patients and families at the center of our joint universe. A significant question going forward is how do we engage people to improve quality who do not want to be engaged? In this brief essay, I will focus on building on success, using healthy competition, and being creative.

Definition of Quality

One of the reasons for skirmishes over quality may be that different groups have different definitions. I have chosen to use the one espoused by Buttell, Hendler, and Daley in their chapter, “Quality in Healthcare: Concepts and Practice”: Quality is the degree to which health services increase the likelihood of desired health outcomes, are consistent with current practitioner knowledge, and meet the expectations of healthcare users. Quality depends on five principles (Buttell, Hendler, and Daley 2007):

- Leadership: the ability to influence behavior to improve outcomes
- Measurement of outcomes and care processes
- Reliability: including shared goals, mitigation of risk, rewards for achieving goals, and actions to correct suboptimal performance
- Practitioner skills: to avoid overuse, underuse, and misuse of patient services
- The marketplace: the perception of quality drives word-of-mouth feedback about organizations and practitioners and decision-making about where to go for diagnosis and treatment

Building on Success

A group of physicians at a New England teaching hospital where I facilitated a physician-led clinical priority setting project tried to deal with the conflicts of improving quality and decreasing variability without being criticized for imposing “cookie-cutter care” on their colleagues. They united physicians by focusing on how to make better use of their limited time. The first project they undertook was a hospital-based anticoagulation clinic, which saved practitioners 1-2 phone calls per day per patient. Next, they focused on a clinical pathway that would allow Post Anesthesia Care Unit (PACU) nurses to wean patients off of ventilators without an attending surgeon needing to be physically present. This measure decreased the number of patients staying overnight in the PACU by one third. By starting small and building on success, now they have implemented computerized physician order entry (CPOE) and an electronic medical record (EMR) successfully, which have abolished errors due to handwriting recognition and significantly decreased medication errors and adverse drug reactions.

Healthy Competition

People quip that organizing physicians is like herding cats. However, one can reframe this perspective by building on the competitive instincts of physicians to improve care. For example, a cardiac catheterization laboratory in Connecticut in which six cardiologists worked, was experiencing such a proliferation of supplies that it considered closing down a procedure room to add storage space. The director turned to his cardiology colleagues and asked them for their input. He showed bar graphs showing dissimilar supply use and procedure time among cardiologists labeled by number, so that only he knew which name corresponded with each number. Clinical outcomes, such as myocardial infarction and death by American Heart Association (AHA) category and elective versus emergent status also varied significantly.

The director encouraged the cardiologists to think about how they might limit variation, improve outcomes, and cut supply costs, telling them that they would analyze the data in another four months. If they did not make progress within six months, he would post names of the cardiologists rather than numbers on a bulletin board in the catheterization laboratory to obtain the input of the entire catheterization laboratory staff.

Within four months, procedure times and outcomes for the entire group were within one standard deviation, and the physicians had decreased their vendors to two, cutting costs substantially while improving clinical outcomes. As one of the cardiologists explained, “None of us wanted to be an outlier, except on the positive side.” (Cohn, 2005).

Creativity

Sometimes desperate situations cry out for unconventional approaches. Leon Bender, president of the medical staff at Cedars Sinai Medical Center, increased hand-washing compliance from 80% to nearly 100% for several years by culturing the hands of physician colleagues, photographing the bacteria on the Petri dishes, and using the photograph as a screen saver on every computer in the hospital that physicians used to obtain clinical information. Dr. Bender (See APPROACH, page 6)
Memo From: Robert L. Barchi, MD, PhD, President, Thomas Jefferson University

I am delighted to announce that Thomas Jefferson University has established the Jefferson School of Health Policy and Population Health (JSHPPH). This new school, which will begin enrolling students in September 2009, builds on Jefferson’s strengths in health policy and population health and reaffirms our position as a leading, innovative academic medical center.

JSHPPH will provide graduate academic programming, continuing education courses and conferences, and sustained research and consulting in areas of health policy, healthcare quality and safety and chronic care management. Jefferson will be the only university in the nation to offer a Master’s Degree in Chronic Care Management. Students will also be able to pursue a Master’s in Health Policy and in Healthcare Quality and Safety, as well as doctorates in Health Policy (PhD or DrHP) and Population Health Sciences (PhD).

I am also pleased to announce that David B. Nash, MD, MBA, has been named the School’s Founding Dean and will report to me. Many of you already know Dr. Nash, the Dr. Raymond C. and Doris N. Grandon Professor of Health Policy. He is internationally recognized for his work in outcomes management, medical staff development and quality-of-care improvement. A board certified internist, Dr. Nash has been with Jefferson since 1990, when he founded the original Office of Health Policy. Most recently he served as Chair of the Department of Health Policy at Jefferson Medical College. From 1996 to 2003, he was the first Associate Dean for Health Policy at Jefferson Medical College and was named Co-director of the Masters Program in Public Health at Jefferson in 2004. Dr. Nash received his BA in economics from Vassar College, his MD from the University of Rochester School of Medicine and Dentistry, and his MBA in Health Administration from the Wharton School of the University of Pennsylvania.

Dr. Nash’s tenure at Jefferson mirrors the growing recognition that providers must be educated with a global view of healthcare in order to improve the health of populations in the U.S. Focused on policy and population health, with an interdisciplinary curriculum that allows medical, nursing and allied health students to take classes together, the JSHPPH fills a critical need in public health education.

Please join me in congratulating Dr. Nash as he launches this important new academic initiative.

ACMQ congratulates Dr. Nash and looks forward to exploring ways of working with him to support the new academic program.
Quality Across the Spectrum of Care
(Focus on the National Quality Forum's National Priorities)

American College of Medical Quality
Annual National Conference
February 12-14, 2009
Hyatt Regency Century Plaza, Los Angeles, CA
(Call 1-800-223-1234, group G-ACMQ)

INCLUDES
- The Half-Day Healthcare Quality Improvement Institute
  "Introduction to Biomedical and Health Informatics: What Every Physician Should Know"
- 2009 Awards Luncheon Founders' Award Address: Arnold Milstein, MD, MPH
- Joint conference with the American College of Preventive Medicine

SPEAKERS
- Janet M. Corrigan, PhD, MBA
- Jack Lewin, MD
- Robert Brook, MD
- Kenneth W. Kizer, MD, MPH
- Elaine Batchlor, MD, MPH
- Neil Wenger, MD, MPH
- Frederick E. Turton, MD, MBA
- Bruce Bagley, MD
- Full list at www.acmq.org/natconf/index.cfm

TOPICS
- The "advanced medical home" concept
- P4P: The consequences for the quality agenda
- Key transition points in healthcare delivery
- Medical ethics
- The economics of quality: Does Wall St. care?
- The essential tools of biomedical informatics
- The critical impact of clinical quality databases

Program updates and registration at www.acmq.org
MEDICAL QUALITY 2009 HOTEL AND TRAVEL INFORMATION

Hyatt Regency Century Plaza: The 4-diamond hotel features 726 newly renovated deluxe rooms with private balconies, 32" LCD flat panel TV with Internet capability. All guest rooms have high-speed wireless Internet access. The Hyatt is located in West Los Angeles, within walking distance of Beverly Hills and just 10 miles from LA International Airport.

Room Rate: Special ACMQ conference discount rate is $199 per night, for reservations made on or before January 16, 2009. Please call 1-800-223-1234 or 310-228-1234 and identify the group as G-ACMQ to make your reservations.

REGISTRATION FORM

Name ___________________________________ First name or nickname for badge ________________________

Organization/Employer ___________________________________ Title ______________________________________

Address _________________________________________________ __________________________________________

City ___________________ State ___________ Zip __________

Phone __________________ Fax ___________________ E-mail (required) ______________________

Check to request a vegetarian diet (Awards Luncheon) _________

Check if you have special accessibility needs _______ Identify needs ______________________________________

Registration Options

A. _____ Medical Quality 2009: Thursday-Saturday, February 12-14, 2009
   Early: through 12/31/08 ACMQ member $495 Non-member $625 $__________
   After 12/31/08 ACMQ member $595 Non-member $725

B. _____ Single day only (check one) _______ Thursday _______ Friday _______ Saturday
   Early: through 12/31/08 ACMQ member $215 Non-member $235 $__________
   After 12/31/08 ACMQ member $235 Non-member $255

C. _____ JOIN ACMQ NOW: Special conference rate of $95 ($70 for affiliates)
   (Membership application documents will be sent to you on receipt of your registration) $__________

D. _____ ACPM Opening Reception and Poster Session on Thursday at $40 $__________

TOTAL PAYMENT $__________

Go to www.preventivemedicine2009.org for details of the American College of Preventive Medicine schedule. All ACPM sessions are open to everyone who registers for Medical Quality 2009.

Method of Payment:

____ Check Enclosed  ____ Visa/Mastercard Card # ________________ Exp. date ____________

Signature ___________________________________ Name on card _____________________________

Fees for the 2008 National Conference include meeting book, certificate of credit, cocktail reception, continental breakfasts, coffee breaks, Awards Luncheon on Saturday, buffet lunch on Friday and Saturday.

ACMQ is a 501(c)(3) non-profit organization and is federally tax-exempt. Tax ID# is 23-7318735.

Organizational/Corporate Member Registration

Special rates are available for organizational/corporate members. Please call 1-800-924-2149 or send a message to acmq@acmq.org for details.

Please fax this form to 301-913-9142 or mail to ACMQ, 4334 Montgomery Ave., 2nd Fl., Bethesda, MD 20814
ACMQ 2009 Student & Resident Scholarship Program

The scholarship program depends entirely on the generosity and commitment of ACMQ members. The goal of the program, launched last year, is to reward students who have demonstrated exceptional accomplishments in health care quality measurement and improvement.

The following individual and organizational members of ACMQ have committed to contributing to the 2009 scholarship program.

- Aetna*
- Kathleen Butler*
- Atlantic Health System
- (Donald Casey)*
- James Cross*
- Angelo Giardino*
- Paul Gitman
- Mark Granoff*
- Joel Grossman
- Alan Krumholz
- The Lorber Center (Howard Kerpen)*
- Mark Lyles
- Donald Harper Mills
- Michael Shannon
- Rahul Shah
- SBS Solutions (Jacque Sokolov)*
- Texas Children's Hospital
- (Angelo Giardino)*
- Ann Wadstrom
- Josie Williams

* Sponsors of full scholarships

To donate to the program please complete the form below and send with your donation. Or wait for your membership dues notice (individual members only) and add your donation to your dues payment.

**ACMQ Student & Resident Section Scholarship Fund**

**DONOR FORM**

1. I am pleased to support the ACMQ Student & Resident Section by donating the following amount to the Student & Resident Scholarship Fund:

   $50 _____  $100 _____  $200 _____  $500 _____  $1,500 _____  (entitles donor to a scholarship in the name of the donor, e.g. John Doe Quality Scholarship or ABC Medical Center Quality Scholarship)

2. I understand that my donation will be applied to the Student & Resident Scholarship Program only.

3. I understand and agree that my donation will be recognized in the ACMQ newsletter:

   _____ YES  _____ NO

4. _____ My donation is enclosed
   _____ Please send me an invoice

Signature ___________________________________________ Date ______________

Name (print) ___________________________________________ Membership # (if known) ____________

Phone number __________________________  E-mail address __________________________________________

Your donation is tax deductible. ACMQ's tax ID# is 23-7318735. Please fax this page to 301-913-9142.

THANK YOU!
Health Information Technology: More Than the Money

A new issue brief from the Alliance for Health Reform

One of the advantages of working in Washington, DC and its environs is access to the many briefings on Capitol Hill. The Alliance for Health Reform holds regular lunch briefings on current issues in health care and all their presentations, resource materials, transcripts and so on can be found on their website at www.allhealth.org.

The Alliance's most recent issue brief on HIT can be downloaded from the home page. This brief aims to answer the question: Does HIT save money, improve quality, or both? Adoption, challenges and policy implications are also covered.

Below is an excerpt from the paper, published in October 2008, which draws from information presented at a June 2008 briefing:

Some health policy analysts believe that the main importance of health information technology lies in its potential for improving health care quality and reducing disparities – whether it saves money or not. This issue brief explores the quality improvement aspects of health IT, and some barriers to its wider adoption.

Fast Facts

- Health information technology (HIT) can help lessen some patient deaths, medication errors and failure to deliver recommended treatments.
- HIT tools now available include electronic prescribing, electronic health records (EHR) linked to patient history and practice guidelines, and electronic support for physician diagnosis and treatment options.
- E-prescribing and decision support have the potential to reduce medication error rates by 50-90 percent.
- Only 4 percent of physicians have a fully functional EHR system.
- More than half of U.S. residents think HIT should be a top priority for the next president.
- Potential government roles could include setting standards and privacy policies, providing consumer protection, and offering financial incentives for HIT adoption.

The conclusion drawn from the issue brief is that public support is strong for information technology as a tool to improve care quality. With this support, plus the attention being paid by presidential candidates, the interest by policymakers on both sides of the aisle, and the many research studies and reports indicating the potential benefits of health IT, the question is not whether health information in the U.S. will fully enter the technological age, but when.

HIT Information Websites

- Alliance for Health Reform www.allhealth.org
- Certification Commission for Health Information Technology www.cchit.org/index.asp
- Congressional Budget Office www.cbo.gov
- The eHealth Initiative www.ehealthinitiative.org
- HHS Office of the National Coordinator for Health IT www.hhs.gov/healthit
- Institute of Medicine www.iom.edu
- Markle Foundation www.markle.org
- National Alliance for Health Information Technology www.nahit.org
- National Committee for Quality Health Care www.ncqhc.org
- National Quality Forum www.qualityforum.org
- The RAND Corporation www.rand.org/health

The Mission of the Alliance for Health Reform

...In the heat of debate, opinion leaders need an unbiased source of information so they can understand the roots of the nation’s health care problems and the trade-offs posed by competing proposals for change. The Alliance...offers a full array of resources and viewpoints, in a number of formats, to elected officials and their staffs, journalists, policy analysts and advocates.

A nonpartisan, nonprofit group, the Alliance believes that all in the U.S. should have health coverage at a reasonable cost. But we do not lobby for any particular blueprint, nor do we take positions on legislation. Senator Jay Rockefeller of West Virginia is our founder and honorary chairman and Senator Susan M. Collins of Maine serves as honorary co-chairman. The diverse board includes distinguished leaders from the fields of health care, business, labor and consumer advocacy...

Since 1991, the Alliance has organized more than 200 forums in Washington and around the nation, each presenting a balance of expert views... We brief reporters, editorial writers and producers in newsrooms across the country on health policy debates in Washington and how they affect local citizens.

In addition, we produce issue briefs regularly on current topics... The Alliance's media resource service assists journalists nationwide to develop articles and broadcasts on health care issues...
CALL FOR NOMINATIONS FOR OFFICERS 2009-2010

Elections of ACMQ officers for 2009-2010 will be held at the annual business meeting on Saturday, February 14, 2009 in conjunction with Medical Quality 2009 in Los Angeles, California.

The ACMQ Nominating Committee is accepting nominations for the following key positions:

- President Elect
- Vice President
- Secretary
- Treasurer
- AMA Delegate
- Alternate AMA Delegate

All these elected positions are for one-year terms. Elected officers, with the exceptions of the AMA delegates, may serve in any position for a maximum of two consecutive terms. To ensure continuity, AMA delegates may serve an indefinite number of terms.

Members of the Nominating Committee are past presidents of ACMQ: Mark Granoff, MD, PhD, MPH, (Chair), Robert Pendrak, MD, Paul Gitman, MD, George Martin, MD, Edward Middleman, MD, MPH, Arthur Pelberg, MD, MPA, Alex Rodriguez, MD, David Jones, MD, MPH, Donald Hugie, MD, Ann Wadstrom, MD.

Please return this completed form by e-mail or by fax to 301-913-9142 and include in brief the reasons for each nomination. **Self-nominations are welcomed.** Your nominations must be received by November 15, 2008.

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Your name: _____________________________ Date: ________________
**Director of Patient Safety & Organizational Excellence**

*Champlain Valley Physicians Hospital (CVPH) Medical Center*

**www.cvph.org**

_Northeastern NY – Live Where Others Vacation!

CVPH seeks a Director of Patient Safety & Organizational Excellence, a position that supports the hospital’s implementation of its Patient Centered Care Vision, reporting to the AVP of Quality Resources. Position works with all department heads to strengthen systems and processes to assure the delivery of safe patient centered care, is responsible for keeping CVPH current with all regulatory/accreditation standards (including state/federal), and provides direction/oversight for patient safety and customer service initiatives organization-wide.

CVPH: non-profit, JCAHO accredited, regional center with over 2,100 employees providing care to 170,000 residents in Northeast NY. Average daily census of 200 inpatients, plus 64 residents in nursing home unit, and a Medical Staff of over 150 physicians. 2007 stats: 12,287 admissions, 101,130 patient days, 1,048 births, 50,002 emergency department visits and 18,136 surgical procedures.

On Lake Champlain, at the edge of the Adirondack Mountains, Plattsburgh is 1 hour from Olympic-Lake Placid region and Montreal, Quebec. CVPH offers a wonderful combination of high technology and small town charm, ease of living and friendliness.

Required: Bachelors in healthcare related field and experience with JCAHO, DOH, federal and state regulations. Preferred: RN; 2 years management experience; Patient Safety; IHI and Change Management experience.

Zaidee Laughlin, HR, CVPH Medical Center, 75 Beekman Street
Plattsburgh, NY 12901, 800-562-7301, Lzaidee@cvph.org