



Message from the Chair

As incoming chair of the ASQ Healthcare Division, I want to thank our outgoing chair, Douglas Dotan, for his hard work and dedication to making the ASQ HCD a meaningful and relevant part of the United States healthcare provider landscape. Last year, much was accomplished, but much work remains. Members of our committed leadership team are **David Eitel, MD**, Chair Elect, Audit Chair, and Program Co-Chair; **Bill Dunwoody, MBA**, Secretary; **John Harrison, RN**, Treasurer; **Dan Reid**, Standards Chair; **Joe Fortuna, MD**, Membership Chair; **Elizabeth Smith, PhD**, Education Chair; **Mickey Christensen**, Previous Chair; **Martin Merry, MD**, Program Co-Chair; **Matthew Mireles, PhD**, Newsletter Editor; **Laura Kinney**, Quality Management Planning Chair; **David Birnbaum, PhD**, Special Interest Group Liaison; and many regional counselors. I am a practicing cardiothoracic surgeon in Cedar Rapids, Iowa, and serve as Chief Medical Officer of Physicians' Clinic of Iowa, a 50-physician multi-specialty group certified to the ISO 9001 QMS in 2003.

In recent discussions with my colleagues, it is clear that a number of major trends are developing within the U.S. healthcare marketplace. Estimated cost of healthcare is expected to approach \$2.4 trillion and double within 10 years. With 47 million uninsured, interest in universal coverage will increase. Healthcare is the top domestic issue in the 2008 presidential campaign. Consumers will become more engaged as hospi-

tals and physicians provide pricing and quality metrics through information transparency. Shifting more costs from employers to employees results in higher premiums, deductibles, and/or copays. Payers who recognize the importance of chronic disease management will sponsor more care management programs and medical home projects. Since health outcomes in the U.S. are lower than in most other industrialized countries, more focus will be placed on incentive-based programs for providers with emphasis on delivering evidence-based care. Pay-for-performance programs and other quality initiatives will expand. Use of electronic health record systems will increase as data standards and privacy and security safeguards are developed. Although initially expensive to deploy, EHRs will connect and integrate healthcare information to reduce waste and save money in future years.

These complex issues affect virtually all sectors of the economy. Even short-term solutions will require hard work, dedication, and rigorous systems thinking. Long-term answers will need a new paradigm, a different system of care, and may involve major changes in our payment mechanisms. We believe the ASQ HCD is in a strong position to contribute towards these efforts. Following a very successful Quality Institute for Healthcare in May this year, plans are underway for our QIHC 2009 meeting. Co-chairs Martin Merry and David Eitel have announced that the theme for QIHC 2009 is

Building a Better Delivery System. The focus is on discovering and presenting new models for healthcare delivery that can be adopted by other care delivery systems. These new models may have been applied at micro (departmental/business unit) or macro (organization-wide/community/population) levels. Our program committee wants to achieve an international presence at the 2009 conference and encourages applications from countries outside the U.S.

The completed HCD 2008-2009 Business Plan shows membership increased by 10%, a 3-year strategic plan for the HCD was developed, the HCD mission and vision was reviewed and updated, the HCD education programs and the Nightingale Scholarship promoted. We developed relationships with other healthcare organizations, partnered with other ASQ sections and divisions to increase brand recognition and provided speakers at section meetings, developed webinars, enhanced marketing and branding strategies, improved website content and value, and may develop an ASQ healthcare certificate as a possible addendum to a current certification such as CMQ/OE.

We face numerous challenges, but I am confident that we have a great team in place to address some of the important issues outlined above. We welcome your support and participation in the next 12 months.

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EDITOR'S NOTES: A PARADIGM IN HEALTHCARE ON THE HORIZON

Excitement and anticipation are all around! A new paradigm in healthcare is materializing as you are reading my notes. The Patient Safety and Quality Improvement Act of 2005 is finally being implemented and the final rule of this Act will spell out the common format and qualifications for the Patient Safety Organizations (PSOs). Now, hospitals and health providers can report incidents under federal protection through PSOs. More details about PSOs will be discussed in coming issues! Talk about timing in an election year, Congress is seriously considering an alternate

accreditation process for healthcare organizations. Many of you have been asking about this development, and we are happy to oblige with an informative interview by one of the leading experts, Yehuda Dror of DNV Healthcare, Inc. His interview is our featured column. So, buckle your seatbelt. Real changes are happening!

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DNV APPROACHES ITS GOAL OF BECOMING A NATIONAL ACCREDITATION ORGANIZATION FOR U.S. HOSPITALS

AN INTERVIEW WITH YEHUDA DROR, PRESIDENT OF DNV HEALTHCARE, INC.

By Mickey Christensen, Past Chair, ASQ Healthcare Division

MC: Could you give us a brief history of DNV Healthcare?

YD: DNV Healthcare Inc. is a division of DNV, a 140-year-old independent foundation whose organizational purpose is to safeguard life, property and the environment. After many years, DNV is now on the verge of becoming the first new hospital accreditation service in more than 40 years.

MC: Could you explain why you are entering the competitive healthcare market?

YD: Our goal is to establish a new standard for hospital accreditation using our innovative NIAHOSM program. To do that, we must obtain “deeming authority” from the U.S. Centers for Medicare and Medicaid Services (CMS) to accredit hospitals.

Recently, new milestones were achieved, including an on-site observation by CMS of a DNV hospital accreditation survey. This follows acceptance of DNV’s extensive written documentation earlier in the year. The 210-day review process will be concluded in early October, when a final decision on DNV’s application will be published in the U.S. Federal Register.

MC: What is your personal feeling about this accreditation process?

YD: We are extremely pleased with the progress towards approval and recognition as a national accreditation organization for hospitals. There’s a lot of buzz in the field about DNV among hospitals and accreditation experts, and our application is generating a lot of excitement. All of our surveyors are trained in both ISO 9001 and the Medicare standards. The result is a more streamlined accreditation process that captures “best practices” and spreads them across the organization. This process leads to continual, sustainable improvement.

MC: How does DNV demonstrate its full capabilities?

YD: To be in position to win national deeming authority for U.S. hospitals required the ability to define a new accreditation process and establish the “credentials” necessary to assure CMS that DNV can deploy its services efficiently to hospitals of disparate size, patient population and geographic location. DNV needed to demonstrate nationwide accreditation capabilities as a prerequisite to even being considered for deeming authority. We had to invite numerous U.S. hospitals to participate in the NIAHOSM accreditation program even while these hospitals were maintaining their CMS-approved accreditation with another accrediting body such as the Joint Commission, AOA or a state-survey). NIAHOSM, which stands for National Integrated Accreditation for Healthcare Organizations, is dramatically different from current accreditation services because it integrates ISO 9001 quality management with Medicare’s Conditions of Participation for Hospitals into a single survey process.

A positive side-effect of this “prove yourself” process is that hospitals that are also potential customers were able to experience NIAHOSM on a trial basis and could compare the advantages of NIAHOSM to their current accreditation program.

MC: What are the major advantages of a DNV accreditation?

YD: One fundamental difference is that the core structure of the NIAHOSM accreditation program helps to immediately clarify its advantages as a catalyst for business efficiency and quality. Hospitals appreciate its annual survey cycle rather than having a survey once every three years.

MC: How do you feel about “fault finding” rather than looking for “what is right”?

YD: So many hospitals are frustrated that traditional accreditation is focused on

finding faults for which they penalized, versus triggering innovation which will prevent problems from occurring in the first place. NIAHOSM not only allows but, in fact, encourages change. We believe that is the best way to facilitate innovative, lasting improvements in patient safety and quality.

MC: Has hospital accreditation reached the tipping point?

YD: DNV isn’t the only group to believe the accreditation market is overdue for some healthy competition. The recent passage of new healthcare legislation in the U.S., specifically H.R. 6331, which strips “statutory authority” from The Joint Commission, is a prime example. This legislation was effective July 15, 2008, and provides for a two-year transition.

There has been a kind of virtual monopoly in hospital accreditation, and that’s finally giving way to new ideas from the private sector. By losing statutory authority, the Joint Commission, which owns about 85% of the U.S. market, must now have its accreditation services renewed and approved by CMS, just like us. Until this new law was passed, they hadn’t been accountable to anyone since they started in the 1960s. Hard to believe, but true.

MC: Will H.R. 6331 have any international implications?

YD: This same U.S. law may provide a significant overseas opportunity for DNV to export NIAHOSM to countries seeking accreditation of their hospitals to U.S. standards. Under H.R. 6331, hospitals in any country will be able to use NIAHOSM accreditation as a way to receive Medicare reimbursement for care provided to eligible U.S. citizens. DNV has more than the law on its side and a very experienced, dedicated global organization with presence in 100 countries and a workforce of over 8,000 employees. We are absolutely in the right place at the right time to help foster a transformation in the efficacy of hospital services around the world.