

# NAHQRS

Nebraska Association for Healthcare  
Quality, Risk, & Safety



Nebraska Association for Healthcare  
Quality, Risk and Safety

<http://www.nahqrs.org/>

Volume 2  
Issue 3



**Kathi Kelly, RN, BSN, CPHQ**  
**President, NAHQRS**  
**Director of Quality Programs, Risk Manager,**  
**Privacy Officer**  
**Memorial Health Care Systems**  
**Seward, Nebraska**

It is hard to believe that summer is almost here. Hardly a time we thought we would be worrying about such things as influenza.

I know many of us wear a variety of hats, one of which may be Infection Prevention and Control. The Swine Influenza is producing a high level of attention. APIC and your local Health Department are wonderful resources in addition to our expert members. This is a time when we need to rely on our networks for assistance. Nebraska is fortunate to have numerous resources for all our healthcare related questions and needs.

Our teams are making great progress towards completing our 2009 goals.

We have finalized our Mission Statement – ***Develop and empower healthcare Quality, Risk and Safety professionals to advocate for and improve patient care in Nebraska.*** Thank you for all of your work to complete this project.

Bill has completed the Rules of Order for TWIV and established the permanent TWIV sites. Each meeting will be evaluated for need of additional sites.

Have you had a chance to visit our website, <http://nahqrs.org/>?

The plan is to put our presenters' documents in the "Member Only" section. We are also moving towards on-line registration for our general meetings.

Plan to hear more about this at our next meeting, June 5, 2009 at St. Francis Medical Center in Grand Island.

At the national level, NAHQ implemented the Special Interest Groups, SIGs.

Charlie White is the CAH/Rural Health SIG Team Leader. This is the first year and I feel that SIGs will be very beneficial.

Visit the NAHQ website to check out which SIG interests you (<http://www.nahq.org/>).

It is an excellent opportunity to get connected at the national level.

I want to take this opportunity to thank Kari Clark for all her work and leadership with the Vendor Show which takes place in conjunction with the CIMRO Quality Forum on May 4, 2009.

Kari has been a wonderful leader for our organization. Her commitment and hard work will be missed!

Thank you to everyone who assisted Kari with this project.

Delinda Lampe, Event Coordinator, stepped forward to serve as the vendor host – thank you!

I hope I will see most of you at the June meeting.

Until then, be safe, happy and healthy!

*“The quality of expectations determines the quality of our actions.” AG*

**Kathi**

## Historian Report

### *Another cause to celebrate . . .*

Healthcare Risk Management week is June 15-19, 2009. The theme for this year is “Thinking Safety, Earning Trust.” How appropriate that this is the theme as our organization seeks to promote safe and trusted care to our patients and communities.

The ASHRM website has information, logo items and ideas to help you promote awareness of your job as risk manager and what you do to ensure your organization is a safe place to work as well as a safe place to receive care.

I will be arranging for a proclamation signing with the governor for June 10.

I will forward more information when I receive confirmation of the date.

I hope you can join us in Lincoln as we, as an organization, proclaim what we promote in each of our work places every day.

In Legislative news, the Medical Home Act (LB 396) was signed into law on April 22 to become effective September 5, 2009.

This program is designed to provide Medicaid recipients better access to care while also providing better coordination of care.

I will be watching to see how this unfolds.

*Donna Jorgensen*  
*Historian*

## **Reminder:**

**Please send me your application and dues (\$50) for 2009 if you have not already done so.**

**Thank you!**

**Cathy Broz, RN, BSN  
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## **NAHQRS Member Bio**

No Member Bio's this Newsletter



NHA Update  
Monica Seeland, RHIA  
Vice President Quality Initiatives

## **Education for Quality Improvement Professionals (EQulP)**

All Critical Access Hospitals and CAH Network hospitals should have recently received the next video in the Education for Quality Improvement Professionals (EQulP) series. This project was recommended by the members of the Rural QI Steering Committee and is funded by the FLEX grant, administered by the Nebraska Department of Health & Human Services.

This DVD focuses on the quality improvement process and includes six videos, each approximately 30 – 50 minutes in length.

The first video, *The Quality Movement in Health Care*, focuses on the need for service quality, how to identify projects to work on, and how to set up a governance body to sponsor projects to completion.

The second video, *The Voice of Your Customer*, helps you understand who your customer is and how to translate the voice of the customer into the issues that are critical to quality.

Video #3; *How Bad Is It, Really*, shares some tools you can use to determine how significant your problem is, and to determine which issue to work on.

Video #4; *Making the Change Happen*, discusses tools and techniques to help you identify the best solution to your problem and to implement the solution.

Video #5; *Asking People to Change*, is designed to help you understand how people react to change and provide you with some tips to help you successfully implement change. Finally,

Video #6; *Making the Changes Last*, provides you with tips to assure that the changes you have implemented will continue to give you the results you desire.

If you have any questions or suggestions for future topics, please contact Monica Seeland at 402-742-8152 or [mseeland@nhanet.org](mailto:mseeland@nhanet.org).

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**"Many people would rather die than think; in fact, most do so."**

**Bertrand Russell**

**"Thinking is the hardest work there is, which is the probable reason so few engage in it."**

**Henry Ford**



Resources for better healthcare

## **Stroke Quality Measure Reporting Coming Soon**

- Submitted by Jackie Trojan, RN, BSN, CIMRO of Nebraska Quality Improvement Advisor

The Joint Commission (TJC) has already announced that not only will Primary Stroke Centers be required to collect all ten of the Stroke Consensus Measures, but also beginning in October 2009 all Joint Commission accredited hospitals will have to submit the eight National Quality Forum-endorsed stroke consensus measures.

It is anticipated that CMS will add these measures as a requirement of the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) initiative, but we do not know when. The FY2011 Federal Register draft is expected to be released soon. After it is released, providers can submit questions and comments prior to the deadline.

The measures below are from the Specifications Manual Version 3.0, located at: <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228695698425>.

### **Venous Thromboembolism (VTE) Prophylaxis**

**Description:** Ischemic and hemorrhagic stroke patients who received venous thromboembolism (VTE) prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission.

**Rationale:** Stroke patients are at increased risk of developing VTE. One study noted proximal deep vein thrombosis in more than a third of patients with moderately severe stroke. Reported rates of occurrence vary depending on the type of screening used. Prevention of VTE, through the use of prophylactic therapies, in at-risk patients is a noted recommendation in numerous clinical practice guidelines. For acutely ill stroke patients who are confined to bed, thromboprophylaxis with low-molecular-weight heparin (LMWH), low-dose unfractionated heparin (LDUH), or fondaparinux is recommended if there are no contraindications. Aspirin alone is not recommended as an agent to prevent VTE.

### **Discharged on Antithrombotic Therapy**

**Description:** Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge.

**Rationale:** The effectiveness of antithrombotic agents in reducing stroke mortality, stroke-related morbidity and recurrence rates has been studied in several large clinical trials. While the use of these agents for patients with acute ischemic stroke and transient ischemic attacks continues to be the subject of study, substantial evidence is available from completed studies. Data at this time suggest that antithrombotic therapy should be prescribed at discharge following acute ischemic stroke to reduce stroke mortality and morbidity as long as no contraindications exist. For patients with a stroke due to a

cardioembolic source (e.g., atrial fibrillation, mechanical heart valve), warfarin is recommended unless contraindicated. Warfarin is not generally recommended for secondary stroke prevention in patients presumed to have a non-cardioembolic stroke.

Anticoagulants at doses to prevent VTE are insufficient antithrombotic therapy to prevent recurrent ischemic stroke or transient ischemic attack (TIA).

### **Anticoagulation Therapy for Atrial Fibrillation/Flutter**

**Description:** Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.

**Rationale:** Nonvalvular atrial fibrillation (NVAf) is a common arrhythmia and an important risk factor for stroke. It is one of several conditions and lifestyle factors that have been identified as risk factors for stroke. It has been estimated that over two million adults in the United States have NVAf. While the median age of patients with atrial fibrillation is 75 years, the incidence increases with advancing age. For example, The Framingham Heart Study noted a dramatic increase in stroke risk associated with atrial fibrillation with advancing age, from 1.5 percent for those 50 to 59 years of age to 23.5 percent for those 80 to 89 years of age. Furthermore, a prior stroke or TIA are among a limited number of predictors of high stroke risk within the population of patients with atrial fibrillation. Therefore, much emphasis has been placed on identifying methods for preventing recurrent ischemic stroke, as well as preventing first stroke. Prevention strategies focus on the modifiable risk factors such as hypertension, smoking, and atrial fibrillation. Analysis of five placebo-controlled clinical trials investigating the efficacy of warfarin in the primary prevention of thromboembolic stroke, found the relative risk of thromboembolic stroke was reduced by 68% for atrial fibrillation patients treated with warfarin. The administration of anticoagulation therapy, unless there are contraindications, is an established effective strategy in preventing recurrent stroke in high stroke risk-atrial fibrillation patients with TIA or prior stroke.

### **Thrombolytic Therapy**

**Description:** Acute ischemic stroke patients who arrive at this hospital within 2 hours of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours of time last known well.

**Rationale:** The administration of thrombolytic agents to carefully screened, eligible patients with acute ischemic stroke has been shown to be beneficial in several clinical trials. These included two positive randomized controlled trials in the United States; The National Institute of Neurological Disorders and Stroke (NINDS) - Studies Part I and Part II. Based on the results of these studies, the Food and Drug Administration approved the use of intravenous recombinant tissue plasminogen activator (IV r-TPA or t-PA) for the treatment of acute ischemic stroke when given within three hours of stroke symptom onset. A large meta-analysis controlling for factors associated with stroke outcome confirmed the benefit of IV t-PA in patients treated within three hours of symptom onset. While controversy still exists among some specialists, the major society practice guidelines developed in the United

States all recommend the use of IV t-PA for eligible patients. Physicians with experience and skill in stroke management and the interpretation of CT scans should supervise treatment.

### **Antithrombotic Therapy By End of Hospital Day 2**

**Description:** Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2.

**Rationale:** The effectiveness of antithrombotic agents in reducing stroke mortality, stroke related morbidity and recurrence rates have been studied in several large clinical trials. While the use of these agents for patients with acute ischemic stroke and transient ischemic attacks continues to be the subject of study, substantial evidence is available from completed studies. Data at this time suggest that antithrombotic therapy should be administered within two days of symptom onset in acute ischemic stroke patients to reduce stroke mortality and morbidity as long as no contraindications exist.

Anticoagulants at doses to prevent venous thromboembolism are insufficient antithrombotic therapy to prevent recurrent ischemic stroke or TIA.

### **Discharged on Statin Medication**

**Description:** Ischemic stroke patients with LDL > 100 mg/dL, or LDL not measured, or, who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.

**Rationale:** An elevated serum lipid level has been a well-documented risk factor for coronary artery disease (CAD) and reflects an organ-specific manifestation of atherosclerosis, which is a disease process that can affect the heart and the major and minor branches of the arterial tree. The reduction of LDL cholesterol, through lifestyle modification and drug therapy when appropriate, is recommended for the prevention of myocardial infarction and other major vascular events for patients with CAD (or coronary risk equivalent conditions) - according to the National Cholesterol Education Program's Adult Treatment Panel III (NCEP ATP III) Guidelines. Recently, there has been an increased focus on the detection of patients with these risk factors when they present with other manifestations of atherosclerosis and assuring that these patients are treated with lipid lowering medication if they meet NCEP ATP III guidelines. While symptomatic carotid artery disease is one of the recognized coronary disease risk equivalents that qualify patients for treatment under ATP III, there was little data until recently about the role of lipid lowering to prevent recurrent stroke or major vascular events in patients who presented with atherosclerotic stroke but did not otherwise qualify for treatment under ATP III. The Stroke Prevention by Aggressive Reduction in Cholesterol Levels (SPARCL) study examined the effects of statins to lower LDL cholesterol in patients with stroke or TIA of atherosclerotic origin who had no other reason for taking lipid lowering therapy (i.e., they were without prior CAD or risk equivalent conditions), and had a fasting LDL > 100 mg/dL. The trial convincingly demonstrated that intensive lipid lowering therapy using statin medication was associated with a dramatic reduction in the rate of recurrent ischemic stroke and major

coronary events. The treatment was well tolerated and cost effective. As a result, intensive lipid lowering therapy through use of a statin medication is now recommended for all patients with stroke or TIA of atherosclerotic origin who have an LDL > 100 mg/dl (or with LDL < 100 mg/dl due to being on lipid lowering therapy prior to admission).

Based on these guidelines, all patients with ischemic stroke or TIA should have lipid profile measurement performed within 48 hours of admission unless results are available from within the past 30 days. A large body of evidence suggests that non-fasting lipid levels drawn in the first 48 hours after a major vascular event are reliable predictors of baseline lipid profiles, but after that time they may become unreliable. It is recommended that all patients with ischemic stroke or TIA with coronary heart disease or symptomatic atherosclerotic disease who have an LDL  $\geq$  100 mg/dl (or with LDL < 100 mg/dl due to being on lipid lowering therapy prior to admission) should be treated with a statin. The target goal for cholesterol lowering is an LDL-c level of <100 mg/dL. An LDL-c <70 mg/dL is recommended for very high-risk persons with multiple risk factors. For patients with stroke of atherosclerotic origin, intensive lipid lowering therapy with statins should be initiated in those who have an LDL  $\geq$  100 mg/dl (or with LDL < 100 mg/dl due to being on lipid lowering therapy prior to admission).

### **Stroke Education**

**Description:** Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.

**Rationale:** There are many examples of how patient education programs for specific chronic conditions have increased healthful behaviors, improved health status and/or decreased healthcare costs of their participants. Clinical practice guidelines include recommendations for patient and family education during hospitalization as well as information about resources for social support services. Some clinical trials have shown measurable benefits in patient and caregiver outcomes with the application of education and support strategies. The type of stroke experienced and the resulting outcomes will play a large role in determining not only the course of treatment, but also what education will be required. Patient education should include information about the event (e.g., cause, treatment, and risk factors), the role of various medications or strategies, as well as desirable lifestyle modifications to reduce risk or improve outcomes. Family/caregivers will also need guidance in planning effective and realistic care strategies appropriate to the patient's prognosis and potential for rehabilitation

### **Assessed for Rehabilitation**

**Description:** Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.

**Rationale:** Each year about 700,000 people experience a new or recurrent stroke, which is the nation's third leading cause of death. Approximately two thirds of these individuals survive and require rehabilitation. Stroke is a leading cause of serious, long-term disability in

the United States, with about 4.4 million stroke survivors alive today. Forty percent of stroke patients are left with moderate functional impairment and 15 to 30 percent with severe disability. More than 60 percent of those who have experienced stroke, serious injury or a disabling disease have never received rehabilitation. Stroke rehabilitation should begin as soon as the diagnosis of stroke is established and life-threatening problems are under control. Among the high priorities for stroke are to mobilize the patient and encourage resumption of self-care activities as soon as possible. A considerable body of evidence indicates better clinical outcomes when patients with stroke are treated in a setting that provides coordinated, multidisciplinary stroke-related evaluation and services. Effective rehabilitation interventions initiated early following stroke can enhance the recovery process and minimize functional disability. The primary goal of rehabilitation is to prevent complications, minimize impairments, and maximize function.

### **Suggestions to prepare for stroke measure reporting:**

- Complete a retrospective chart review to assess current processes of care specific to stroke patients
- Review all standing orders and/or protocols to see if they are consistent with the new measures
- Convene a Stroke Care Team to address opportunities for improvement
- Begin to educate physicians and clinical staff on the new measures
- Set up a mechanism to monitor measure performance on a concurrent basis

CIMRO of Nebraska will continue to keep hospitals updated on changes to the CMS measures reporting as information becomes available. For questions regarding hospital data collection and reporting, contact Jackie Trojan, RN, BSN at [jtrojan@neqio.sdps.org](mailto:jtrojan@neqio.sdps.org) or 800/458-4262.

This material was prepared by CIMRO of Nebraska, the Quality Improvement Organization for the state of Nebraska, under a contract with the Centers for Medicare & Medicaid Services (CMS), a federal agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 9SOW-NE-PS-61/0409

**Have a new Job?**

**Get a new phone number?**

**Change your email address?**

**Forgot to tell your best friends?**

**If you have changes that we should know about – just click on the link below to forward those changes to the people who really care.**

**Cathy Broz**

[dchqi@bwtelcom.net](mailto:dchqi@bwtelcom.net)



To view the **SONAR** website, Calendar of Events, Member Hospitals, & Resource Links visit:

<http://www.chmccook.org/sonar.htm>

**SONAR Mission Statement: To assist health care facilities in education, networking, and resources to meet regulatory compliance.**

**SONAR** is a group of healthcare professionals (Safety Officers, Risk Managers, Infection Control, Environmental Service, and Maintenance Directors, Quality Improvement, etc.) started in 1998 in southwest Nebraska. Members represent large and small licensed facilities, sharing a common goal, **Safety**. Membership is as far west as Chadron and has been as far east as Columbus.

**SONAR** meets bi-monthly, typically the last Friday of the month, with meetings held in North Platte. (If a holiday falls on the last Friday we will schedule another meeting date).

Annual membership fees are \$100.00 per facility. Members are encouraged to bring others from their facility to the meetings when the subject matter pertains to their area of interest.

## **Safety Healthcare Conference**

This conference is held annually in North Platte. Every hospital, a large number of medical clinics and nursing homes in the state is invited to attend. We cover topics that our attendees have identified and bring in a variety of vendors for attendees to visit with, see new products, and discuss need to know issues.

## **Resources**

We have received assistance from many organizations and businesses.

A few of those include, but are not limited to:

**Central Community College**

**Nebraska Safety Council**

**Nebraska Environmental Training Center**

**Nebraska Department of Environmental Quality**

**Center for Biopreparedness**

**Nebraska Workforce Development**

**State Fire Marshall**

With the assistance of the resources listed and others, we strive to meet the regulations set by OSHA, EPA, and Joint Commission, federal, state and local regulations.

If you are interested in learning more about this or in networking, sharing ideas, policies and procedures, checklists, and brainstorming with other healthcare professionals; contact us today. We truly believe that Working Together Just Makes Sense!

If you would like to join **SONAR** or have additional questions or comments please contact:

Dari Olson, **SONAR** Chairman  
Safety Director, McCook Community Hospital  
Phone 308-344-8362  
Email: [dolson@chmccook.org](mailto:dolson@chmccook.org)

## Quality – Risk Management – Patient Safety

The following is submitted by Stacy Cerio MSN, RN  
Regional Services Consultant - BryanLGH  
[stacy.cerio@bryanlgh.org](mailto:stacy.cerio@bryanlgh.org)

### **Heartland Health Alliance hospitals participate in Spring Quality workshops.**

Eighty healthcare workers representing 18 facilities participated in a three-day workshop presented by Darlene Bainbridge. Darlene is nationally known for her dedication and work with quality programs in healthcare.

Having served as CEO of a critical access hospital and hospital surveyor, Darlene was able to share her life's experiences and knowledge with the group and provide specific meaningful quality information.

Below is a brief summary of each workshops focus.

We had a very diverse healthcare group and Darlene was able to present insights at every level.

### **Health Quality and Performance for Today's Dynamic Healthcare Environment**

This session was important in laying the groundwork for the identification of weaknesses in existing quality programs and programmatic changes that will serve the hospital better going forward.

**Those in attendance:** CEO's, Nursing Leaders, Quality Improvement, OB supervisors, Or Supervisor

### **Building effective Systems and Tools to Support Value-Adding Quality Efforts**

This session was important in identifying more effective approaches to quality and performance improvement that promote efficiency, effectiveness and user-friendliness as we work to build stronger patient care and service delivery systems.

**Those in attendance Audience:** CEO's, Nursing Leaders, Quality Improvement, OB Supervisors, OR Supervisors

### **The Role of the Quality Committee and Reporting Quality Up to the Board**

This session was important in identifying more effective reporting, oversight and information management approaches as we work to build stronger patient care and service delivery systems.

**Those in attendance:** CEO's, Nursing Leaders, Quality Improvement, OB Supervisors, OR Supervisors, Risk Managers, CFO

# Job Postings

# SRA

Search Research Associates, Inc.

400 West Cummings Park, Suite 6900  
Woburn, MA 01801  
[harry@search-research.com](mailto:harry@search-research.com)

Phone 877-938-0990 X210 Cell 781-296-7096  
Contact: Harry Anderson  
VP Healthcare Services

## **Chief Quality Officer - SC**

The Chief Quality Officer is responsible for planning, administration, and monitoring of consistent readiness of all quality management, regulatory requirements, and quality improvement processes. The Chief Quality Officer will oversee and coordinate all hospital efforts to monitor and maintain compliance with all regulatory, State, Federal government, and Joint Commission on Accreditation of Healthcare Organization standards. The position reports directly to the CEO.

### Position Requirements

Minimum of three years in an acute care facility and demonstrates a clear working knowledge of general hospital operations, JCAHO, OSHA, Medicare COP, and state requirements. Minimum of two years experience in Quality Management required. Must have coordinated JCAHO preparation and participated in State and CMS surveys within past three years. RN, BSN (MSN Preferred)

## **HOT Director of Quality Management and Regulatory Compliance - LA**

The Director of Quality Management and Regulatory Compliance (QMRC) for a 160 bed hospital is responsible for planning, administration, and monitoring of consistent readiness of all quality management, regulatory requirements, and quality improvement processes. The Director of QMRC will oversee and coordinate all hospital efforts to monitor and maintain compliance with all regulatory, State, Federal government, and Joint Commission on Accreditation of Healthcare Organization standards. The position reports directly to the CEO.

### Position Requirements

A Nursing or other clinical healthcare license/degree with minimum of two years experience in Quality Management required. Must have coordinated JCAHO preparation and participate in State and CMS surveys within past three years.

## **Director Quality/Performance Improvement - TX**

Direct the development and implementation of hospital PI programs. Assess the effectiveness of PI department structure and goal work, providing consultation and mentoring to staff and serve as a resource for Performance Improvement. Provide system leadership and support for accreditation and regulatory programs. Serve as member of management team instituting Lean Program Development. Build, implement and manage new programs and coordinate program components and activities. Serve as resource and mentor to Hospital entity DQM's and others as needed to support and enhance program success effectively managing staffing growth and development of staff resources.

Also I am searching for:

**Regional Dir Compliance – TX**  
**Chief Quality Officer – TN**

**Chief Quality Officer – TX**  
**Director of Quality – DC**

**HOT VP Quality Services – OK**

### **Harry Anderson**

**VP Healthcare Services**

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Case and Risk Management

Quality/Performance Improvement

**TELL ME WHAT YOUR NEEDS ARE, WE CAN HELP!**

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# Next Meeting June 5, 2009 Saint Francis Medical Center, Grand Island

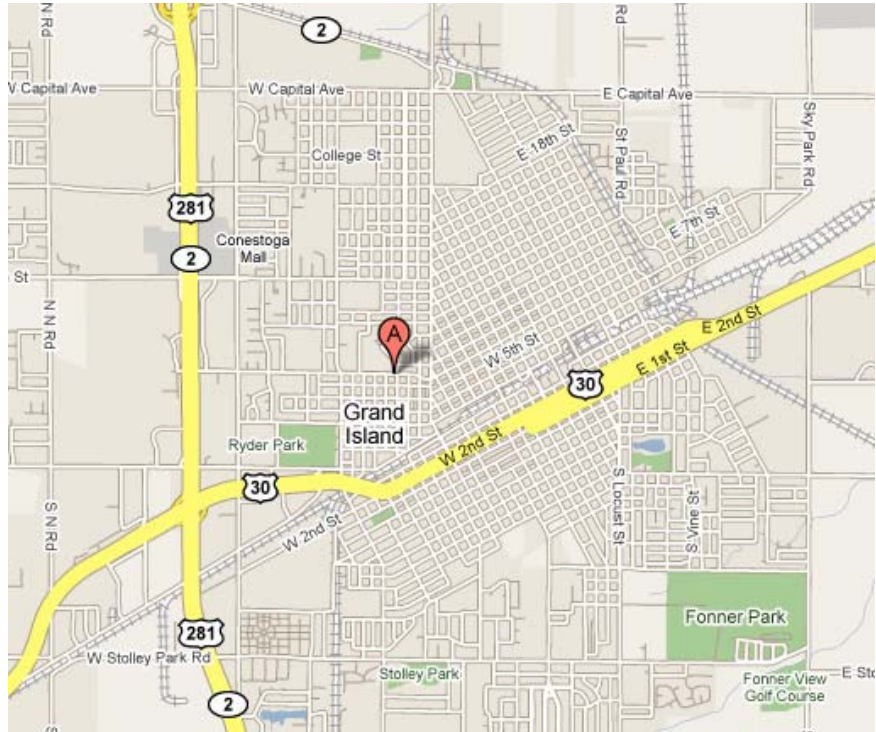
## Saint Francis Medical Center

2116 West Faidley Ave  
Grand Island, NE 68802

Website: <http://www.saintfrancisgi.org/index1.php>

Click on the link  
below to bring  
up web map:

[http://maps.google.com/maps?hl=en&q=grand+island+ne+oncology&oe=UTF-8&um=1&ie=UTF-8&sa=N&tab=wl&ei=jRoESqadC9qgmAfYw6HYBA&oi=property\\_suggestions&resnum=0&ct=property-revision&cd=1](http://maps.google.com/maps?hl=en&q=grand+island+ne+oncology&oe=UTF-8&um=1&ie=UTF-8&sa=N&tab=wl&ei=jRoESqadC9qgmAfYw6HYBA&oi=property_suggestions&resnum=0&ct=property-revision&cd=1)



## Future NAHQRS Meetings

August 7, 2009 North Platte  
Lincoln December 6, 2009 York  
2010 TBD

October TBD, 2009  
February 5,

April 2, 2010 TBD

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Next publish date is July 7, 2009

Comments on this newsletter, or future articles for submission or information, or other tidbits for publication can be sent to Bill Redinger at: [wredinger@sfmtc-gi.org](mailto:wredinger@sfmtc-gi.org)

### Future Newsletter publish dates:

- July 7, 2009
- September 2, 2009
- November 6, 2009

- January 5, 2010
- March 2, 2010