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*Deborah Flores, Joann Genovich-Richards*

Peter J. Pronovost, MD PhD, is a practicing anesthesiologist and critical care physician, lecturer, patient-safety researcher, and leader. The director of the quality and safety research group and the medical director for the Center for Innovations in Quality Patient Care at Johns Hopkins, he has developed valid, feasible tools to improve quality of care and patient safety that are being used by thousands of hospitals nationwide.

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# q&a: Peter J. Pronovost on Intensive Care Unit Safety at Johns Hopkins

Deborah Flores and Joann Genovich-Richards



**q** What was the genesis of the eight-step unit-based safety program in the ICU at Johns Hopkins?

**a** The program was designed to create enough structure to implement a safety culture change throughout our institution and to be flexible enough to defer to the wisdom of local workers. It evolved through trial and error and has since been simplified. Now it is limited to six steps, beginning and ending with measuring the culture of safety. When we started this, we measured culture as part of the program. At Johns Hopkins we

1. perform an annual health system-wide culture-of-safety assessment as an institution
2. educate staff about the sciences of safety
3. identify defects by incident reporting (which many hospitals have), by morbidity and mortality conferences, and, more important, by asking staff, "How do you think we are going to harm the next patient, and how can we prevent it?"
4. develop our executive partnership. The executive personnel are part of the safety team of their unit. They meet monthly, review defects, and make sure they have the resources to fix them.
5. ask staff to learn from one defect a month. We found that in our old model staff were great at discovering defects or discussing them but infrequently learned from them. They often failed to close the loop and improve the system. But we all know that safety is a journey—the work is never done. So we now ask local work areas to learn from one defect a month. Johns Hopkins uses a tool called "How to investigate a defect." It asks staff what happened, why it happened, and what might be done to reduce the probability that it will recur. One team tool (obtaining goals, holding morning briefings or operating room briefings, shadowing) is considered each month.
6. remeasure culture.

Peter J. Pronovost, MD PhD, is a practicing anesthesiologist and critical care physician, lecturer, patient-safety researcher, and leader. He is an associate professor in the departments of anesthesiology and critical care medicine and surgery in the School of Medicine, the department of nursing in the School of Nursing, and the department of health policy and management in the Bloomberg School of Public Health at Johns Hopkins University. Dr. Pronovost is the director of the quality and safety research group and the medical director for the Center for Innovations in Quality Patient Care at Johns Hopkins. He holds a doctorate in clinical investigation from the Johns Hopkins Bloomberg School of Public Health.

Dr. Pronovost has written more than 100 articles and chapters in the fields of patient safety, intensive care unit (ICU) care, quality healthcare, and evidence-based medicine. Nationally, he is chair of the ICU Advisory Panel for Quality Measures with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), chair of the ICU Physician Staffing Committee for the Leapfrog Group, and member of the National Quality Forum Quality Measures Work Group. He has won several national awards for his research, including the 2004 John Eisenberg Patient Safety Research Award. Dr. Pronovost is currently leading several large safety projects funded by the U.S. Agency for Healthcare Research and Quality. He has developed valid, feasible tools to improve quality of care and patient safety that are being used by thousands of hospitals nationwide.

**q** You have mentioned the results from some of your preliminary work at Johns Hopkins and the impact the program is having. Do data from other organizations demonstrate that these strategies work in different settings?

**a** The results have been amazing. We just finished our third culture survey. The ICU has moved from the bottom 10th percentile in culture to the 90th. We started with 55% of staff members saying it is difficult to speak up if they perceive a problem; we are down to

## Keywords

anesthesiologist  
intensive care unit  
quality of care

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16% and still trying to reduce that further. Many improvements have been made in the areas of medication safety and adverse outcomes related to infection, but we also coupled this program with focused intervention to improve those things. It's difficult to determine how they contributed to these other focal outcomes. Our motto is that you need both the culture change and focused improvement. Coupling culture change and focused improvement creates the potential to reorganize work, which allows it to be sustained and continuous.

**q** How did you achieve the buy-in of clinical staff and medical staff for the safety initiatives such as reducing ventilator-associated pneumonia, and how did you decide where to focus your greatest efforts? What will need to change if you are to achieve widespread use of initiatives to improve care in ICUs?

**a** The buy-in is really quite interesting. This is the only improvement that has been the result of a pull from staff rather than a push from central administration. Typically we would go into units and study infections and medication errors. This program has such high face validity, and I think it is because we don't go in saying, "We know what the units' problems are." Rather, we go in saying, "I know you are committed to safety, so please help us discover what the defects are, and let's work together to solve them." We don't have the answers; we just give enough structure to help guide the process. And we now have more units demanding this than we have executives to partner and coaches to support them. We now serve 34 different patient care areas where this process has been implemented. We have measured culture safety in the whole hospital, and the units in which less than 60% of staff report positive safety and teamwork climate will be the targets this year. We are measuring using a safety attitude questionnaire. Our goal is high safety and teamwork climate. We want 80% of staff reporting positive safety and teamwork climate.

**q** Are you embracing the Surviving Sepsis campaign, and, if so, what actions are you taking?

**a** A week before the guidelines were published, we were working with a project funded by the VHA Foundation to develop measures for the use of evidence-based interventions in severe sepsis and septic shock. What we found is that guidelines are great for summarizing the evidence, but they are not very effective at changing practice. Guidelines are often 80–200 pages long and are not used by caregivers at the point of care. Our approach has always been to convert guidelines into quality measures, which we call a *reliability model*. It suggests that we pick a patient population outcome, find out what the evidence says we should do (or what our evidence-based process is), and then develop performance measures to see whether we are doing these things. We ensure that we are doing them and then see whether outcomes improve. We have taken these sepsis guidelines and developed quality measures for them. We have implemented these process measures through systematically collecting data from 19 ICUs in the VHA. We are doing it now in 60. We went from timing antibiotics and giving appropriate antibiotics about 40% to 50% of the time to having over 90% of patients get appropriate antibiotics at the appropriate time. What we've seen with pneumonias is that we don't know how good we can be because nobody has ever been reliably able to ensure that patients get all the interventions that have proven outcomes.

**q** The idea of senior management adopting a unit and working with it for improvement sounds innovative. Tell us more about how this is going.

**a** We found that we need to connect a decision maker with the frontline needs, and we use the term *executive partnership*. Communication mistakes are a common cause of errors, but they don't occur only among the care team. These communication defects go up and down our organization, and often senior leaders aren't aware of the population's real clinical needs. We needed to create a system for this communication. We found that having a senior leader partner with the departmental manager works amazingly well and really helps improve culture. Over 6 months the departmental manager takes over the role for the senior leader and

demonstrates to the staff that they can help solve their own clinical needs.

**q** What are you doing to improve communication throughout the ICUs and as patients transfer to other units or departments?

**a** We've packaged seven tools to improve communication. Our staff very quickly said, "We don't want to hear a theory. We want practical tools that we can use." So we came up with these tools:

1. daily goals
2. shadowing and offering comments after walking in someone else's shoes
3. rounds observations (one person for one patient each week)
4. morning briefings where the attending answers three simple questions: What happened overnight that we need to know? Who's coming and going for the day? What am I worried about during the day?

What we've been doing is allowing the team to pick one of these tools every month, analyze the results, and identify improvement opportunities.

**q** Do you have any other suggestions or thoughts for readers?

**a** It is important that organizations have strategic plans for how they will improve cultures and move beyond putting out fires or simply completing a project. They need to take a step back and reflect on the question "How do we know we are safer?" and develop a plan to answer that. Culture can be one of those measures, along with how often we learn from defects, how often we use evidence-based interventions, and how often we harm patients. The program at Johns Hopkins has been demonstrated to improve culture and enable staff to learn from defects. It can put you on the journey to be able to answer the question "How do you know you are safer?"

*Deborah Flores, EdD MBA RN, is associate administrator at the South Texas Health System, McAllen, TX, and is JHQ's q&a editor.*

*Joann Genovich-Richards, PhD MBA MSN RN, is the president of Sharendipity Enterprises, Inc., a healthcare consulting firm in Sterling Heights, MI, and is JHQ's q&a editor.*

# Media Reviews

Lecia A. Albright, Media Editor

## Electronic Health Records: A Practical Guide for Professionals and Organizations

Margaret K. Amatayakul, MBA RHIA CHPS FHIMSS  
American Health Information Management Association,  
[www.ahima.org](http://www.ahima.org), 2004, \$69.95, 418 pages, ISBN 1-58426-133-1

**Audience:** hospital boards, medical directors, practice managers, physicians, informatics consultants

**Key Word:** electronic health records, information technology

This book is an excellent resource for physicians considering implementation of an electronic health record (EHR), as well as a primer for hospital board members considering the organizational challenges of implementing an EHR. The logical and concise coverage of a timely topic is neither too technical nor sophomore and demonstrates the author's working knowledge of the issues for consideration in EHR adoption.

The book is not a "how to," but rather an overview of the steps in the process of adopting an EHR. This overview provides the novice with a good understanding of what to expect in preparing an organization as well as how to glean enough knowledge to be conversant with prospective vendors and contractors. Emphasis is placed on identifying the expectations of the organization or institution and leadership buy-in as essential for success.

The book is well written, and the appendixes include HL 7 Draft Standards that provide an example of high-level functional user requirements similar to what an organization will define in the process of implementing an EHR. The American Health Information Management Association's Data Quality Management Model is also included, supporting the importance of considering data application, collection, warehousing, and analysis with the EHR in advance of implementation.

I recommend this book for general reading in health administration and most definitely

for professionals and organizations considering EHR adoption.

*Reviewed by Mary S. Savitsky, MPA MHA RN CPHQ*

## The Healthcare Quality Book: Vision, Strategy, and Tools

Scott B. Ransom, Maulik S. Joshi, David B. Nash, Eds.

Health Administration Press, [www.ache.org/pubs/ransom.cfm](http://www.ache.org/pubs/ransom.cfm), 2004, \$79.00, 494 pages, ISBN 1-56793-224-X

**Audience:** healthcare administrators, healthcare quality professionals, nurses

**Key Words:** dashboards, data collection, PDSA, quality infrastructure, quality report cards

The editors have organized the book into three sections: Knowledge and Science Foundation, Organization and Microsystem, and Environment. Most of the articles are written according to a common format, regardless of the section in which they appear. First, the author introduces the subject of the chapter with a theoretical discussion. Then a case study, a conclusion, study questions, and references are presented. A few chapters do not include case studies, though as a rule examples are cited.

Part 1 covers the basics, discussing efficiency versus effectiveness, variation, the Plan-Do-Study-Act cycle, and other quality management fundamentals that are sometimes misused and misunderstood by quality professionals. The final chapter in this part presents an overview of systems, theories, and tools in current vogue.

Part 2 emphasizes data, data collection, and analysis. The chapters review indicators, statistical tools, physician profiling, and newer concepts such as dashboards and scorecards. The most interesting chapters in this section address the infrastructure of organizational quality and quality strategies. In the opinion of this reviewer, chapters 13-16 should have been presented first, given the import of

their collective message: To quote A. Al-Asaf, "There are not enough words to describe how important management commitment is to the success of quality." Some may disagree, however, with Al-Asaf's contention that the chief quality officer (CQO) must have a "clinical background." There are trained professionals other than registered nurses who are eminently prepared by education and experience to be CQOs.

Part 3 is briefer, describing the effect of accreditation and payers on quality improvement.

I plan to use this textbook in the quality management courses I teach.

*Reviewed by Suzanne Belanger, MBA CPHQ*

### Measurement in Nursing and Health Research, 3rd Edition

*Carolyn Feher Waltz, Ora Lea Strickland, Elizabeth R. Lenz*

*Springer Publishing Company, Inc., www.springerpub.com/books/nursing, 2004, \$83.95, 448 pages, ISBN 0-8261-2635-9*

**Audience:** nurses, healthcare quality professionals, healthcare students, marketing professionals

**Key Words:** data collection, qualitative studies, quantitative studies, research, scale development, statistical analysis, study design

This book provides a thorough resource for healthcare professionals seeking to expand their knowledge of research practices. Processes related to designing, testing, and selecting instruments and methods and procedures for the measurement of variables are covered in detail.

The 24 chapters move the reader along the learning curve at a nice pace. Even if you aren't a statistical expert, you will find interesting resource information. The reference list at the end of each chapter is especially helpful.

Two appendixes complete the text. The first contains a compilation of measurement resources, print and Internet, for nursing and other disciplines. The list of proprietary and public domain software packages is timely and extensive. The second appendix breaks out data sources into clinical and epidemiological, administrative, and sociodemographic categories.

This talented group of authors, along with eight additional contributors, guides readers through complex theories, formulas, and methods in a

way that is accessible and accommodating. If one is interested in a text that will help with personal research or in understanding published research articles, then this book would be a nice addition to one's learning library.

*Reviewed by Carole S. Guinane, MBA RN*

### Surviving Healthcare

*Pamela Armstrong, MPH MBA*

*Chestnut Ridge Books, www.survivinghealthcare.com/, 2004, \$19.95, 300 pages, ISBN 0-9754560-5-9*

**Audience:** healthcare consumers, healthcare quality professionals, nurses, physicians

**Key Words:** disease-specific programs, evidence-based medicine, health insurance, health plans, healthcare outcomes

As the title implies, the target audience for this book is an important segment of the healthcare quality team: consumers! Those who (1) accept that they have responsibility in the process of maintaining personal health, (2) are willing to invest effort in assessing and modifying behaviors that decrease their risk of preventable illness, (3) have access to health insurance, and (4) are willing to use the book's advice to make the best healthcare decisions possible will benefit most from this book. Clear descriptions of different types of health plans guide selection among options readers may have. Armstrong describes contemporary concepts of quality in healthcare that consumers can use to make decisions as they interact with a U.S. healthcare system that is frighteningly complex and fragmented. Emphasis is given to maintaining one's own set of medical records, asking questions at any point of service, and learning to use preventive care guidelines. Appendix A provides online and print sources of information about specific diseases or conditions, including current evidence-based guidelines for care. Appendix B leads consumers to the current leading sources of quality comparison data. One reference (p. 178) directs readers to the Agency for Healthcare Research and Quality in Appendix B, which is not listed (perhaps National Committee for Quality Assurance was intended).

Supported by credible references, the author attacks several commonly held myths including "It's All the Insurance Companies' Fault,"

“Higher Cost Means Higher Quality,” and “Doctor Welby Medicine Is Best.”

Topics are addressed in a consumer-friendly style; cartoons and anecdotes help explain issues. The author warns readers against using anecdotes as tools for making sound decisions when scientifically validated data are available.

Those willing to invest the effort, even healthcare-industry insiders, will find this book a useful guide to respected online sources of information on medical issues and quality comparison data.

*Reviewed by Jane Miller, MSN RN CPHQ*

*JHQ* welcomes the opportunity to review various media potentially of benefit to healthcare quality professionals and the people they serve. Reviews are published in every issue of *JHQ*.

To have your product reviewed by a healthcare quality expert, please send a nonreturnable copy to

Media Editor

Media Reviews

*Journal for Healthcare Quality*

4700 W. Lake Avenue

Glenview, IL 60025-1485

*Lecia A. Albright, CPHQ, is the principal and owner of LARA Consulting, LLC, located in Fredericksburg, VA. Her e-mail address is laraconsulting@adelphia.net.*

# Quality NETWORK

Daniel van Leeuwen and Robert J. Rosati, Quality NETWORK Editors

“Quality NETWORK” offers reviews of selected Web sites relevant to healthcare quality professionals. The editors welcome comments and feedback on the column as well as suggestions for further reviews. To read previous reviews that have appeared in the journal, visit [www.NAHQPlus.org](http://www.NAHQPlus.org), the Web site exclusively for NAHQ members.

## The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP)

[www.nccmerp.org/](http://www.nccmerp.org/)

**Key Words:** IOM priorities, medication errors, NCC MERP, patient safety

NCC MERP, an independent body addressing the interdisciplinary causes and prevention of errors, serves a nationwide audience of colleges, schools, and state associations of medicine, pharmacy, and nursing; national professional associations; managed care organizations; and third-party payers. The site contains a listing of recommendations (e.g., improving accuracy of prescription writing, promoting and standardizing bar coding, and reducing packaging errors). The accuracy in prescription writing contains the unapproved abbreviations now adopted by the Joint Commission on Accreditation of Healthcare Organizations. Although most of the recommendations were adopted between 1996 and 2003, NCC MERP began reviewing and revising some of the older recommendations in 2005. The site provides a link for consumers to report medication errors to the United States Pharmacopeia or the Food and Drug Administration. This site should be bookmarked by anyone who requires succinct summaries of medication safety recommendations.

## Substance Abuse and Mental Health Services Administration State Data

[www.nationaloutcomemeasures.samhsa.gov](http://www.nationaloutcomemeasures.samhsa.gov)

**Key Words:** behavioral healthcare, databases, outcomes, substance abuse

The Substance Abuse and Mental Health Services Administration recently launched a new service on its Web site. The goal of the National Outcome Measures is “to achieve a performance environment with true accountability. We are looking at the data we are collecting and asking why we are collecting it. And, we asked how we are using it to manage and measure performance. If we are not using the data collected, we are taking steps to stop collecting it. Our emphasis on a limited number of national outcomes and related national outcome measures is built on a history of extensive dialogue with our colleagues in state mental health and substance abuse service agencies and, most importantly, the people we serve.”

The data focuses on 10 domains, including abstinence from drug use and alcohol abuse or decreased symptoms of mental illness with improved functioning. Four domains focus on resilience and sustaining recovery (e.g., getting and keeping a job or enrolling and staying in school; decreased involvement with the criminal justice system; securing a safe, decent, and stable place to live; and social connectedness to and support from others in the community such as family, friends, co-workers, and classmates). Two domains examine the treatment process itself, looking at available services and services provided. One measure is increased access to services for both mental health and substance abuse. Another measure is increased retention in services for substance abuse or decreased inpatient hospitalizations for mental health treatment. The final three domains examine the quality of services provided. These include client perception of care, cost-effectiveness, and use of evidenced-based practices in treatment.

QUALITY NETWORK

The site is still in development. For example, the mental health and substance abuse data section contains only data from Texas about at-risk populations and the shortage of mental health professionals. The section on data sources provides links to National Survey of Substance Abuse Treatment Services, National Survey on Drug Use and Health, Treatment Episode Data Set, Substance Abuse, Prevention, and Treatment Block Grant, Health Professional Shortage Areas, and the Center for Mental Health Statistics Uniform Reporting System.

Track this site over time to monitor the development of national measures and national benchmarks. We will.

### The United States Pharmacopeial Convention, Inc.

[www.usp.org/](http://www.usp.org/)

**Key Words:** IOM priorities, medication errors, medication therapy, patient safety

The United States Pharmacopeia (USP) is the official public standards-setting authority for all prescription and over-the-counter medicines, dietary supplements, and other healthcare products manufactured and sold in the United States. USP sets standards for the quality of these products and works with healthcare providers to help them reach the standards. An independent, science-based public health organization, USP operates two programs to promote safer care of patients who take medications and stay in hospitals. The Medication Errors Reporting Program allows healthcare professionals to report medication errors directly to USP. MEDMARX, an Internet-based medication error and adverse drug reaction reporting program, is designed for use in hospitals and health systems. The *United States Pharmacopeia–National Formulary* (USP–NF) is a book of public pharmacopeial standards. It contains standards for medicines, dosage forms, drug substances, medical devices, and dietary supplements. USP–NF is available in English in print, online, and CD formats. The site contains a downloadable pdf catalogue of standards and instructions for reading the standards. The site is fairly dry, but medication safety aficionados will find it informative.

### Virtual Toolbox for Quality Pharmacy Practice

[pharmacytoolbox.org/main.cfm](http://pharmacytoolbox.org/main.cfm)

**Key Words:** medication therapy, QI toolbox

This site enables pharmacy operators to view and create their own quality practice programs based on actual programs currently in use in community pharmacy. The site requires registration and password for entry. The step-by-step course begins with Quality Program Principles: three simple, concise pages on continuous quality improvement readable in a few minutes. The Sample Program section links to 10 different downloadable, Microsoft Word-format quality improvement program descriptions from a variety of pharmacy types (huge chain, small stand-alone, one with robotics). The Build Your Own Program section provides a quick demonstration of their building process and then the very detailed walk-through and flow-charting of all dispensing and management processes. This site is highly recommended not just to pharmacists but to anyone interested in modeling an exciting, user-friendly, meaningful course to build a quality clinical program.

*Reviewed by Daniel van Leeuwen, MPH RN CPHQ CHE*

### Help Identify and Review Sites

The JHQ team invites you to help identify and review Web sites. A review consists of the name of the site or sponsoring organization, a URL reference, key words, the intent of the site, and comments about ease of navigation, value, pertinence to the healthcare quality professional, timeliness, and cost, if any.

Please forward—via e-mail—questions, sites for review, or, better yet, sites with reviews, to Quality NETWORK co-editor Robert Rosati at [robert.rosati@vnsny.org](mailto:robert.rosati@vnsny.org).

*Robert J. Rosati, PhD, is director of outcomes analysis and research at the Center for Home Care Policy and Research, Visiting Nurse Service of New York, New York, NY. His e-mail address is [robert.rosati@vnsny.org](mailto:robert.rosati@vnsny.org).*

*Daniel van Leeuwen, MPH RN CPHQ CHE, is director of professional and community standards at St. Peter's Addiction Recovery Center in Guilderland, NY.*

# Quality Products and Resources

Compiled by Sandra E. Ward

This *JHQ* feature provides members with up-to-the-minute, interesting resources that will help them navigate the constant flood of healthcare quality information. Brief descriptions of recently released media are provided, as well as ordering and Internet access information. New product announcements and company contact information are also provided.

## Products

### New Funding Bolsters Efforts to Certify Electronic Health Record Products

The Certification Commission for Healthcare Information Technology (CCHIT), an independent, private-sector initiative to certify health information technology (HIT) products, has received a \$219,000 grant from the California HealthCare Foundation (CHCF) to support the national certification process for electronic health records (EHRs). The grant will help support the development of a test methodology and testing procedures, selection of test entities, and coordination of a certification pilot.

“EHR products hold great potential to improve the quality and efficiency of care in the physician office, consumers’ main point of contact with the healthcare system,” said Sam Karp, chief program officer at the California HealthCare Foundation. “Certifying that EHR products meet specified standards for functionality, security and interoperability is an important step in encouraging investment in these products, especially for physicians in solo and small practices,” said Karp.

The support from CHCF augments more than \$100,000 in recent unrestricted funding to CCHIT from healthcare industry stakeholders, including physician associations, providers, payers, and vendors. That funding will allow CCHIT to continue its work as an independent, private-sector initiative to certify HIT products. Seed funding for CCHIT came from the American Health Information Management Association (AHIMA), the Health Information and Management Systems Society

(HIMSS), and the National Alliance for Health Information Technology (NAHIT).

CCHIT was formed in July 2004 by three leading industry associations in healthcare information management and technology—AHIMA, HIMSS, and NAHIT. The mission of CCHIT is to accelerate the adoption of robust, interoperable healthcare information technology throughout the United States by creating an efficient, credible, and sustainable mechanism for the certification of healthcare IT products.

CHCF, based in Oakland, is an independent philanthropy committed to improving California’s healthcare delivery and financing systems. Formed in 1996, its goal is to ensure that all Californians have access to affordable, quality healthcare.

For more information, visit [www.cchit.org](http://www.cchit.org) and [www.chcf.org](http://www.chcf.org).

### Knowledge Factor, Inc., Launches Revolutionary Competency Assessment

After more than 15 years of research, testing, and market validation, Knowledge Factor, Inc., released its Confidence-Based Assessment™ (CBA), a tool that measures competency based not only on what a person knows but also on the person’s confidence in that knowledge. Knowledge Factor’s patented process substantially reduces, and can even eliminate, guessing that skews the results of most other assessments and puts organizations at risk of not knowing the competency level of employees.

“Research has proven that confidence is the best predictor of performance—that people only act upon information they confidently understand,” said Pat Engstrom, CEO of Knowledge Factor. “By measuring both confidence and knowledge with the CBA, organizations can know with a high degree of certainty how competent their employees are, and can be better positioned to reduce risks and maximize productivity and revenues.”

Traditional assessments measure only how many questions someone answers correctly, making it impossible to distinguish between a person guessing correctly and one who answers

correctly with confidence. CBA differentiates between

- correct answers that are answered with confidence, indicating competency
- correct answers that are answered with doubt
- correct answers that are total guesses, equivalent to no knowledge
- incorrect answers that are answered with confidence, indicating misinformation.

The CBA can capture and validate knowledge confidence because of the unique structure of its multiple-choice questions and detailed analysis. Upon completion of an assessment, the user and his or her management can view a summary of the user's competency profile, providing immediate identification of confidently held misinformation, unknowns, doubts, and knowledge competency.

Utilizing the CBA as the centerpiece for all of its products and services, Knowledge Factor offers

- a competency audit that identifies areas of risk where training needs to be intensified within an enterprise
- the CBA as a stand-alone competence assessment and certification tool
- the CBA and Learning Suite, which identifies the knowledge gaps using the CBA and also remediates those gaps rapidly and effectively.

"Companies spend millions of dollars each year on the best training and technology available, yet they have no way of knowing how effective that investment is," said Engstrom. "For the first time, with the CBA, we can measure the competency of employees. We can validate the effectiveness of a company's existing training, determine how to fill critical knowledge gaps to improve productivity and compliance, increase employee safety or reduce the risk of costly litigation."

Founded in 2000, Denver-based Knowledge Factor is a leader in competency assessment and remediation. In 2003 the company became the owner of a patented and effective methodology, or CBA, that has become the foundation for its unique offerings. The Company's CBA and Learning Suite of products measures competency, certifies learning, and provides a rapid and targeted learning solution to organizations and individuals.

*For more information, visit [www.knowledgefactor.com](http://www.knowledgefactor.com).*

## InteGreat's IC-Chart EMR System Selected by Internists PC

InteGreat, a leading provider of electronic medical record (EMR) systems for medium to large group practices, announced the addition of Internists PC, a 16-physician medical group, to its client roster. This agreement demonstrates InteGreat's ability to deliver on its goal to enable midsize group practices to benefit from the same sophisticated technology available to large practices.

Internists PC will implement InteGreat's IC-Chart EMR system practice-wide on Tablet PCs to document patient encounters, automate prescribing, and increase office efficiency through an easy-to-use Web browser interface. InteGreat's IC-Chart will integrate with Internists PC's Misys practice management system. Implementation is expected to take 8 months.

"We evaluated several vendors but InteGreat's flexible template system most closely matched our practice needs," states Internists PC clinic administrator, Margaret A. Jaszcz, MBA. "Our goal is to operate in a paperless environment and we believe InteGreat's IC-Chart will take us there."

According to Dr. Beckett, the physician leader of the project, "The browser-based system will allow our doctors to have access to the EMR from the hospitals, our outreach clinics and from home. The great use of the Internet really sold us."

InteGreat's IC-Chart boasts the highest adoption rate in the industry and the industry's shortest implementation time. According to Jay Anders, MD, chief medical officer at InteGreat, "We are pleased to be recognized by Internists PC as the EMR vendor of choice. We look forward to a rapid implementation at Internists PC to help the practice improve its patient information management, enhance patient care and optimize healthcare delivery costs."

Based in Cedar Rapids, IA, Internists PC is an adult multispecialty internal medicine practice.

InteGreat, based in Scottsdale, AZ, is an industry-leading provider of EMR software that enables physician group practices to enhance patient care while increasing productivity, eliminating paperwork, and gaining a rapid return on investment. InteGreat's user-friendly, Web-based, modular products provide management of clinical data, including

transcription records, lab results, and radiology reports, and capture critical patient health summary data and medications.

*For more information, visit [www.internistspc.com](http://www.internistspc.com) and [www.igreat.com](http://www.igreat.com) or call 800/676-1360.*

### Medical Verification Solutions

Medical Verification Solutions (MVS), a member of the Medical Reliance Group, provides a primary source of credential verification service for credentialing physicians and other medical care providers for health plans and hospitals. MVS is certified by the National Committee for Quality Assurance and accredited by the Utilization Review Accreditation Commission (URAC), and accredited and compliant with the Joint Commission on Accreditation of Healthcare Organizations. Benefits include easy request submission, instant access to status information, 100% paperless digital processing, and online access to all completed credentialing files.

*For more information, visit [www.mvshome.com](http://www.mvshome.com) or call 877/330-5076.*

## Resources

### New AHRQ Resource Guide in Diabetes Care Offers Help to States

The Agency for Healthcare Research and Quality (AHRQ), in partnership with the Council of State Governments, developed *Diabetes Care Quality Improvement: A Resource Guide for State Action* and a comparison workbook, *Diabetes Care Quality Improvement: A Workbook for State Action*. Both are designed to help states assess the quality of diabetes care and develop quality improvement strategies.

*Both the resource guide and the workbook can be found online at [www.ahrq.gov/qual/diabqualoc.htm](http://www.ahrq.gov/qual/diabqualoc.htm). Printed copies may be ordered by calling 800/358-9295 or by e-mailing [ahrqpubs@ahrq.gov](mailto:ahrqpubs@ahrq.gov).*

### *Pocket Guide to Good Health for Adults and Pocket Guide to Good Health for Children*

The guides were developed by the Agency for Healthcare Research and Quality (AHRQ), part of the U.S. Department of Health and Human Services. The U.S. Preventive Services Task Force (USPSTF), an independent panel of experts in primary care and prevention convened by AHRQ, reviews the evidence of effectiveness of clinical preventive services

and makes recommendations for their use in primary care. The guides are based on USPSTF recommendations. Put Prevention into Practice, a national program sponsored by AHRQ, develops resources for clinicians, patients, and office systems to increase the delivery of USPSTF-recommended preventive services in the primary care setting.

*Both pocket guides can be obtained free of charge by calling AHRQ Publications Clearinghouse at 800/358-9295 or by e-mailing [ahrqpubs@ahrq.gov](mailto:ahrqpubs@ahrq.gov).*

### Diabetes-Cardiovascular Disease Tool Kit

This is a comprehensive kit of patient education materials on topics related to diabetic cardiovascular disease (CVD). Development of the comprehensive tool kit with patient education materials on topics related to diabetic CVD is the result of an educational partnership with the American Diabetes Association, American College of Cardiology, and Preventive Cardiovascular Nurses Association. Topic areas include Type 2 diabetes, nutrition and exercise, risk factor management, coronary heart disease, and vascular diseases. The purpose of these materials is to highlight the link between diabetes and CVD.

*For more information, call 800/Diabetes (342-2383). The tool kit can be obtained in hard copy or CD-ROM.*

### Americans Lack Understanding of Social Security

In a collaborative effort, the Harris Poll and the International Longevity Center (ILC-USA) have released the findings of a recent poll that revealed that most Americans lacked basic understanding of Social Security (SS), private pension plans, and other private retirement plans. Only half of those surveyed knew that SS guaranteed payment for life; only a quarter knew that SS guaranteed protection from inflation; about half knew that SS provides life disability coverage for spouses or children of workers who die or are disabled; only one in six adults knew that SS has lower administrative costs than the other two plans; and almost half did not know that SS has never failed to pay benefits.

Harris Interactive Inc. ([www.harrisinteractive.com](http://www.harrisinteractive.com)), located in Rochester, NY, is the 15th largest and fastest-growing market research firm in the world. Known for the Harris Poll and for pioneering Internet-based research methods,

Harris Interactive conducts proprietary and public research to help its clients achieve clear, material, and enduring results. To become a member of the Harris Poll Online, visit [www.harrispollonline.com](http://www.harrispollonline.com). The ILC-USA is a not-for-profit, nonpartisan research, policy, and education organization whose mission is to help societies constructively address the issues of population aging and longevity. It is also an independent affiliate of Mount Sinai School of Medicine.

*For more information contact Michael Curran, communications coordinator, at [michaelc@ilcusa.org](mailto:michaelc@ilcusa.org) or 212/606-3380. To view the poll, please visit [www.ilcusa.org/news/news.htm](http://www.ilcusa.org/news/news.htm).*

### **JCAHO Announces 2006 National Patient Safety Goals for Ambulatory Care and Office-Based Surgery Organizations**

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) released

new guidelines regarding the 2006 National Patient Safety Goals and related requirements applicable to accredited ambulatory care facilities and offices in which surgery is performed. The goals are to improve the accuracy of patient identification, to improve the effectiveness of communication among caregivers, to improve the safety of using medications, to reduce the risk of health-care-associated infections, to accurately and completely reconcile medications across the continuum of care, and to reduce the risk of surgical fires.

*For more information, visit [www.jcaho.org/accredited+organizations/patient+safety/npsg.htm](http://www.jcaho.org/accredited+organizations/patient+safety/npsg.htm).*

*Sandra Ward, MS MA RN CPHQ CPUR, is risk management coordinator for HIP Health Plan of New York and a member of JHQ's editorial board.*