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Joan Hutton, a certified personnel consultant through the National Association of Personnel Services, has a background of more than 25 years in national search and placement for healthcare management and consulting. She has developed a reputation for providing the highest caliber of services through the Hutton Group, Inc., which has consultants in northern Florida, Virginia, Massachusetts, and Illinois.

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Generalizability in the Design, Reporting, and Application of Quality Improvement

Linda Harrington, Jacqueline Fowler Byers

Researchers use the term *generalizability* to describe the extent to which research findings from a study can be extrapolated to other people, places, and times (Polit & Beck, 2004). Generalizability is a test of rigor that is used when the research project is designed, in order to ensure the inclusion of elements that will facilitate the transfer of the research findings to other environments with similar populations. Generalizability is also used by research readers to determine the appropriateness of applying study findings to their own patient population, practice setting, and time.

With patients, resources, and results at risk, quality improvement professionals need to consider whether generalizability and other similar tests of rigor should be applied in quality improvement (QI) initiatives. The answer to this question holds value for healthcare leaders who deal with issues of quality, attempt to develop evidence-based practices, and respond to continuous requirements for change from licensure, regulatory and accrediting bodies, consumers, and payers. This article explores whether generalizability should be a consideration in QI.

Why Is Generalizability Important in QI?

During discussions about whether generalizability fits within the framework of QI, the differences between research and QI are less important than the similarities and the differences in how those similarities are approached (Byers & Beaudin, 2002). The question is whether generalizability is important in QI.

The term *external validity* was first used by Campbell and Stanley in 1963 to denote the basis for generalizing quantitative research findings to other populations, settings, and times (Campbell & Stanley, 1963). The terms *generalizability*, *generalization*, and *external validity* are often used interchangeably. Bellin and Dubler (2001) posited that research derives much of its legitimacy from its generalizability. Ferguson (2004) asserted that

Abstract: *Generalizability* refers to the appropriateness of transferring findings from one context to another context. The term, typically thought to be a property of research and often a distinguishing factor between research and quality improvement, is being scrutinized as the research and quality improvement continuum narrows. This article explores the origins and requirements of generalizability and the question of using generalizability in quality improvement initiatives.

generalizability is the effective link between knowledge generation and knowledge utilization. Still others question the application of generalizability in research.

Kerlinger and Lee (2000) doubted whether research was generalizable, asserting that samples are rarely representative of the population. According to Hegyvary (2002), few research studies are sufficiently comprehensive to justify generalization and policy recommendations. Despite the detractors, external validity has remained an accepted principle of rigor in quantitative research for more than 40 years.

Because qualitative research (like QI efforts) has been criticized for lacking scientific rigor, the growing body of qualitative research has more recently been giving attention to the issue of generalizability. Tobin and Begley (2004) argued that although the transference of validity from quantitative research to qualitative research may seem inappropriate, failure to do so is tantamount to a rejection of rigor and thereby a threat to the acceptance of qualitative research findings.

Morse (1999) argued that if qualitative research is not generalizable, then it is of little use. Morse compared quantitative and qualitative research methods, including differences in generalizability, and concluded that quantitative research can be generalized statistically because the study sample is matched by demographics to the study population, and, if comparable, the findings are considered generalizable. However, participants in

Key Words

external validity
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research

qualitative research are selected for their ability to provide information about the topic being examined, which makes the research generalizable to similar situations.

Healthcare quality professionals endeavor to define the elements of rigor in their investigatory processes, just as quantitative researchers and (more recently) qualitative researchers do. Byers and Aragon (2003) acknowledged that although generalizability is not the primary goal of QI initiatives, findings are frequently applied to other settings and situations. One benefit of examining generalizability in QI is that resources and time can be more efficiently used if researchers understand—in advance—when and how to replicate QI findings.

According to Casarett, Kalash, and Sugarman (2000), most QI interventions are generalizable to some degree. They stated that it is not clear how an initiative that produces generalizable knowledge should be evaluated if the initiative lacks formal recruitment of subjects and is within the accepted standard of care. They assumed that certain risks or burdens are imposed to make results generalizable and that such efforts could result in a loss of privacy or confidentiality. For example, when researchers collect additional data in order to better characterize the study population, they may inadvertently compromise the subjects' privacy or confidentiality.

In 2001, Bottrell (as cited in Lynn, 2004) asked 24 healthcare quality professionals to differentiate between research and QI. Respondents typically stated that QI provides rapid feedback of data, which allows for ongoing development of the intervention. When differentiating generalizability in QI from generalizability in research, the participants responded that although generalizability exists in QI, QI is not defined by it; research, however, *is* defined by generalizability.

Generalizability in the QI Content

Although generalizability may not be widely recognized in QI, readers may apply findings from reported and published QI activities to their own populations or settings (Byers & Aragon, 2003), and thus the findings deserve further examination. Healthcare quality professionals need to improve their reporting of the factors that could affect the generalizability of their findings when they publish their

research. For example, researchers examining measures of external validity in published mental health studies from 1981 to 1996 reported that generalizability of treatments and outcomes, whether experimental or observational, was low and poorly documented (Braslow et al., 2005). Variables used to assess the generalizability of studies included setting (inpatient, outpatient, mixed, government, and academic affiliation), patient characteristics (race, gender, age, and comorbidities), sampling methods (random, systematic, quota, and convenience), study design, random treatment allocation, and funding sources.

Braslow et al. (2005) acknowledged that negative scores on generalizability indexes might reflect poor reporting, not actual omission, and did not necessarily mean that a study's findings lacked generalizability. In some cases, treatment effects were independent of the setting, patient, and, characteristics of treatment implementation; however, assuming so may be unsound. Thus, poor documentation of generalizability limits the usefulness of the findings and the publication (Braslow et al.).

According to Yore (2003), generalizability is just as problematic in experimental research as it is in nonexperimental research. Yore proposed three strategies to improve generalizability: sample-to-population approaches, analytic generalization, and case-to-case transfer. When researchers are generalizing from samples to populations, Yore recommended that as a reporting minimum, researchers should describe sampling procedures and size to alert readers to possible problems in application. With analytic generalization, authors should generalize findings to a theory or model and not to a population. Multiple case studies that use common questions, procedures, data sources, and principles of analyses support generalizability by verifying the interpretation of data from earlier cases.

Braslow et al. (2005) suggested four ways to improve generalizability and its documentation. First, investigators should adequately document and report factors relevant to external validity (e.g., sampling methods, patient and provider characteristics, and study site characteristics), and journal editors should promote the reporting of these factors. Second, an expert panel should create a checklist of items critical to the evaluation and documentation of external validity and then use it as

the publication standard. Third, researchers should attempt to study patients and contexts to which findings could be extrapolated. Fourth, the researchers recommended that studies be designed to mirror the way the interventions will be used in actual clinical practice (Braslow et al.).

Several guidelines for reporting research that address generalizability may provide guidance for QI. The rationale for using these guidelines is to prevent the omission of important information in published reports. **Figure 1** lists the more popular guidelines. These guidelines are specific to different types of research but have many of the same factors. Both the Consolidated Standards of Reporting Clinical Trials (CONSORT) and STrengthening the Reporting of OBServational studies in Epidemiology (STROBE) guidelines recommend inclusion of a diagram that illustrates the flow of participants through each stage and notes any deviations.

Information from the reporting guidelines for research can help healthcare quality professionals generate guidelines for QI that are already under way. In 1999, the editorial team of *Quality in Health Care* proposed the use of reporting guidelines to reflect QI work (Moss & Thompson, 1999). The eight criteria concerned context, problem, key measures, process of gathering information, analysis and interpretation, strategy for change, effect of change, and next steps.

Speroff, James, Nelson, Headrick, and Brommels (2004) identified factors in Plan-Do-Study-Act (PDSA) quality improvements that should be reported to enable readers and users to determine whether findings are generalizable: Are the findings exportable? What elements are required? What is the influence of contextual and organizational factors on generalization? How were the subjects selected? What consideration is given to a different population? The parallel between the criteria for excellence in research and those for excellence in PDSA improvements could be explained, they thought, because both have the same foundation—the scientific method. They asserted that systemic and sustained quality of care depends on transferable knowledge of the key aspects of QI processes. The context of QI matters and should be communicated.

Davidoff and Batalden (2005) asserted that the lack of scholarly accounting in QI publications is

a serious problem; it limits the availability of evidence on efficacy and slows the distribution of recognized improvements. The authors also recommended more detailed reporting of QI studies and provided criteria for settings relevant to generalizability. The criteria included geographic location, local organization, staffing, structures, processes, and patterns, as well as habits and traditions in the setting. The authors discussed the context of the setting, suggesting that findings be examined in light of similarities to and differences from other settings.

An increasing number of QI professionals want to raise the level of science, rigor, safety, and impact of QI studies. Designing generalizability into the structure of studies and using QI initiatives may be the answer. Regardless of whether healthcare quality professionals intend for their findings to be generalized, the findings *are* being generalized. Readers of published reports on QI studies and projects are adopting and implementing recommendations, often without consideration of differences in populations, settings, and times.

Figure 2 presents questions that can help healthcare quality professionals determine whether their study is generalizable. Users of reported QI activities should consider how differences between their populations, settings, and times may affect the applicability of findings before implementing any changes.

The questions posed in **Figure 2** have implications for QI publications and presentations. It is important that all disseminated QI recommendations include reporting on issues of persons, place, and time. Authors and presenters have a responsibility to acknowledge and disclose the weaknesses of their recommendations. It is equally important that healthcare quality professionals make recommendations justified by the findings; failure to do so could compromise scientific integrity and the success of later interventions.

Conclusion

Determining whether findings from a QI study are generalizable is ultimately the responsibility of the reader and the user of reported QI (Yore, 2003). Because of increasing pressure for evidence-based practice, safety, and improved outcomes, the time has come to elevate the science of QI. Healthcare quality professionals can design and report QI projects according to sound principles that support the

Figure 1. Guidelines for Reporting Generalizability Variables in Research

Guideline	Web Site	Persons (Participants)	Place	Time
Consolidated Standards of Reporting Clinical Trials (CONSORT)	www.consort-statement.org	Eligibility criteria; sample size determinants; randomization, blinding; baseline demographics and clinical characteristics; numbers randomly assigned, receiving intended treatment, completing the study, and analyzed; participant flow	Settings and location where data were collected	Dates defining periods of recruitment and follow-up
Standards for Reporting of Diagnostic Accuracy (STARD)	www.consort-statement.org/stardstatement.htm	Inclusion and exclusion criteria; recruitment; sampling; beginning and ending dates of recruitment; clinical and demographic characteristics (age, gender, presenting symptoms, current treatments, recruitment center); number who satisfied inclusion criteria but did not participate	Settings and locations where data were collected	
Strengthening the Reporting of Observational Studies in Epidemiology (STROBE)	www.strobe-statement.org	Inclusion and exclusion criteria, sources and methods of selection; sample size and rationale; report on numbers of individuals at each stage of the study (e.g., numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analyzed); reasons for non-participation at each stage; characteristics (e.g., demographic, clinical, social) and information on exposures and potential confounders	Settings and locations where data were collected	Dates defining periods of data collection
Transparent Reporting of Evaluations with Nonrandomized Designs (TREND)	www.trend-statement.org/asp/documents/statements/AJPH_Mar2004_Trendstatement.pdf	Eligibility criteria, including criteria at different levels in recruitment and sampling plan (e.g., cities, clinics, subjects); method of recruitment (e.g., referral, self-selection), including the sampling method if a systematic sampling plan was implemented; sample size determination, and, when applicable, explanation of any interim analyses and stopping rules; number included in or excluded from the main analysis, by study condition	Settings and locations where data were collected	

Figure 2. Proposed Criteria for Designing, Reporting On, and Applying Quality Improvement (QI) Projects to Address Generalizability

Area	Reconciliation
Person	<p>What population is described in the QI recommendation?</p> <ul style="list-style-type: none"> • What were the inclusion criteria? • What were the exclusion criteria? • What were the demographics? <p>What is your population?</p> <p>What are the differences between your population and the inclusion and exclusion criteria and demographic variables?</p> <p>Are these differences significant?</p> <ul style="list-style-type: none"> • Would the differences have an impact on patient safety? • Would the differences have an impact on needed resources? • Would the differences have an impact on results? <p>Can you justify using the recommendation in your population?</p>
Place	<p>Where was the QI project done (e.g., large or small hospital, academic or community hospital, acute care or nonacute care facility)?</p> <p>Where do you plan to implement the QI solution?</p> <p>What are the differences between the two settings?</p> <p>Are these differences significant?</p> <p>Can you justify using the recommendation in your setting?</p>
Time	<p>What is the time described in the QI recommendation?</p> <p>Is the time adequately described?</p> <p>What is the time in which you wish to implement the QI recommendations?</p> <p>Is it appropriate for the time described in the report?</p>
Replicated reports	<p>Is there more than one report on this topic?</p> <p>Are the reports from different authors and different locations?</p> <p>Can you justify any inconsistencies in findings or recommendations?</p>

generalizability of their findings. The appropriate step is to evaluate principles appropriate for QI and to systematically implement and evaluate their application in QI. Healthcare continues to change rapidly, and these changes affect time, energy, resources, and patients. Healthcare quality professionals can optimize resources and outcomes if they focus on efforts that have undergone rigorous development and evaluation.

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q&a: Joan Hutton on Career Planning for Healthcare Quality Professionals

Joann Genovitch-Richards, Interviewer



q From your perspective as a recruiter for organizations in a wide range of healthcare settings, what are the trends in the recruitment of healthcare quality leaders? What skills and capabilities are currently being required by organizations, and how are these trends different from the trends seen 10 years ago?

a Healthcare quality leaders are being asked to assume far more responsibility than they were 10 years ago. The simpler functions of overseeing just a quality department disappeared with the advent of outcomes management, disease management, and integrated compliance programs. Positions today require a much deeper and broader set of skills and management abilities. Employers now expect a “guru” who not only understands all of these programs but has a proven track record in implementing change across a hospital and healthcare system and can motivate management, physicians, nurses, and other personnel to buy into these changes. This expectation also applies to consultants: regulatory agencies and major consulting firms that have a clinical focus are increasingly looking for consultants who have a cross-functional background.

q Traditionally, nurses were hired and trained within one institution, and their education was supplemented by conferences from accreditation bodies and professional meetings. This process often led nurses to careers in healthcare quality. What are the current career trajectories and educational requirements for people coming into the healthcare quality field?

a The old fashioned way of learning quality—on the job training—simply is not enough for workers who hope to

Joan Hutton has a background of more than 25 years in national search and placement for healthcare management and consulting. She has developed a reputation for providing the highest caliber of services from her Florida office and through her consultants in northern Florida, Virginia, Massachusetts, and Illinois. Clients and candidates confirm that the reputation of the Hutton Group, Inc., is built on professionalism and integrity. Hutton and all of her consultants are former healthcare executives. “By Professionals for Professionals” is their motto, and quality is their mission. A registered nurse with a Bachelor of Arts in psychology from Marygrove College, Detroit, MI, Hutton has a diploma in nursing education from the University of Windsor, Ontario, Canada, and she is a certified personnel consultant through the National Association of Personnel Services. This latter certification is an employment-law designation and is held by only a few hundred consultants nationwide. Hutton had 15 years of experience as a nursing administrator and an educator before becoming a chief operating officer. She taught in and managed major medical centers, hospitals, and community hospitals. She is involved in the National Association for Healthcare Quality (she chaired its marketing task force in 1990–1991), the American Health Information Management Association, and the Health Care Financial Management Association, and she is the former president of the Florida Association for Healthcare Quality. Her community activities include participating in the Chamber of Commerce and volunteering with the Youth Guidance Program of Indian River County, FL. Hutton is a nationally recognized speaker on career development, revitalization of corporate careers, and future trends in quality and information management and has published articles on related subjects in several healthcare journals. An adjunct faculty at Indian River Community College, she conducts workshops for professional groups and teaches senior seminars for college and university healthcare programs.

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succeed in today's market. In order to thrive in a cross-functional environment the professional must commit to ongoing learning, certification programs, and an advanced degree program that offers study in industry as well as in healthcare quality processes. Although physicians still have the mindset that it takes a nurse to understand quality, the focus on benchmarking, statistics, and data analysis is changing administrative perspectives and hiring practices. People with backgrounds in medical technology, health information management, and quality and management engineering are bringing new perspectives to the field.

q **What career planning advice would you give a person who has just entered a new healthcare quality role? Are there specific time frames for staying in various roles or in organizations that offer a leadership career track in healthcare quality?**

a Professionals need to find a seasoned mentor who really knows the field and offer to do anything necessary to be his or her assistant. They need to get an advanced degree and continue taking as much continuing education as is available through local and state meetings in addition to any Internet courses to qualify for the Certified Professional in Healthcare Quality examination and other related certifications such as Six Sigma and Lean Thinking.

The best type of organization for offering a career track is one with an extensive regional or national network of facilities and regional offices. These multiple settings offer potential for ascending a ladder of successive, more complex positions within the organization.

I would point to a few cardinal rules regarding job changes and time frames to remain in any position. At the beginning of a career in any field, an individual needs to stay in a position for at least 2 years in order to show that he or she has experience in the basics of that field. After the first position, he or she needs to stay a minimum of 4 years and preferably not much longer than 6 years in successive positions. The rationale for this time frame is to show that the person has "staying power" but is not afraid of new challenges and will not stay long enough to get stuck in a rut.

q **You have the opportunity to meet with the administrative leaders of many organizations as you begin a recruitment process. What are the trends of the organizational structures for quality and performance improvement, data analysis and statistical capabilities, patient safety, risk management, case management, and the medical staff peer review functions? Is the pendulum swinging toward consolidation of such areas under one leader in certain types of organizations or toward specialization within these various content areas? Are allocations of full time equivalents (FTEs) changing?**

a As hospitals merge into regional and national healthcare systems, administrators are seeking leaders with vision, cross-functional skills, and the ability to adjust to change and assist all levels of management in being prepared to handle these changes. Departments concerned with compliance, risk, case management, outcomes, and quality management are definitely being consolidated under one vice president or director in hospitals or healthcare systems. Each area is subsequently headed up by a manager, not a director. As health systems grow, the role of the leader will become more complex. Individual areas now have fewer FTEs, and this trend will continue because of revenue restrictions. Very soon everyone will have to be able to manage cross-functional responsibilities.

q **How has the recent introduction of the role of physician chief quality officer (often in addition to the roles of chief medical officer, vice president for medical affairs, or—in the next generation—employed physician leader) changed organizational structures, particularly in hospitals, and the opportunities for nonphysician healthcare quality professionals to take on leadership roles? What advice would you give a quality leader who will now be reporting to a physician leader?**

a My advice to the person now reporting to a physician quality officer is to be patient. Although the current trend is to have a physician serve as the chief quality officer, this trend is beginning to change. Administrators are recognizing that physicians may not have the management skills

necessary to lead their organizations into the future. This trend will create a wide variety of opportunities for other healthcare professionals to fill the gap. But physicians will eventually catch up with management education and training and close the gap again.

q What final career planning advice would you give our healthcare quality professional readership?

a Quality, in its broadest sense, offers the most challenging of all possible roles in today's healthcare market. The need for educated, trained professionals is steadily increasing. The potential opportunities are endless. This is the future, and it is here now!

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Lecia A. Albright, Media Editor

Strategic Management of the Health Care Supply Chain

Eugene S. Schmeller, Larry R. Smeltzer, Lawton Robert Burns, Jossey-Bass, www.josseybass.com/WileyCDA, 2006, \$60, 328 pages, ISBN 0-787980-39-0

Audience: administrators, governing board members, material management workers, and procurement managers

Key Words: cost containment and management, process improvement, redesign and reengineering, resource utilization

Strategic Management of the Health Care Supply Chain is based on 3 years of healthcare-based research that evaluated supply chain management; the research was carried out by faculty from the W. P. Carey School of Business at Arizona State University, Tempe, AZ. The authors' goal was to provide healthcare organizations with information that they can use to assess the significance of supply chain management and its role in managing costs and improving organizational performance. Other industries, such as manufacturing, have already accepted and applied this concept, but it has just recently attracted the attention of healthcare quality professionals.

Chapter 3, "Internal Customer Relationship and Performance Management," addresses the major constituents involved in the supply chain process—the physician and clinician end users. The discussion presents numerous factors that contribute to challenges from this group. In the section on personalities and social styles the authors explain why individuals respond to situations in a particular way. They also discuss what many healthcare quality professionals deal with daily—the need to modify behavior and attitudes for the good of the patient and the organization.

The book presents a logical argument for those who have not adopted this concept of managing the healthcare supply chain. It would serve as a good reference both for those in healthcare management and for those who want to learn about supply chain management.

The usefulness to healthcare quality professionals is the authors' demonstration of a way to redesign their processes that could help organizations better manage costs and improve efficiencies in managing supplies.

Reviewed by Steven Chinn, DPM MS CHE CPHRM, chief of quality management at VA Palo Alto Health Care System, Palo Alto, CA

Remaking American Medicine

CrosskeysMedia, PBS Home Video, www.pbs.org, 2006, \$29.98, 4 episodes, ASIN B000ILYZOM

Audience: healthcare professionals, patient advocates, patient safety officers, quality managers

Key Words: case/care management, community health services, consumer/advocacy, health education, medical errors, patient safety

As many as 98,000 Americans die each year because of preventable medical errors, according to the Institute of Medicine's 1999 report *To Err Is Human: Building a Safer Health System*. *Remaking American Medicine* is a four-part video series that was first broadcast on PBS. The series not only highlights some of the scenarios in which medical errors occur but also focuses on unique programs throughout the United States that address other aspects of healthcare management. Each episode offers an insider's glimpse into the workings of the U.S. healthcare system. Individual patient stories are shared, along with stories about healthcare programs and institutions that have created innovative approaches to solving key system problems.

The first episode, "Silent Killer," addresses medical errors in healthcare and highlights the patient safety movement. Emotional stories told by families and patients who were the victims of medical errors provide a compelling introduction to the topic of patient safety. Key healthcare leaders such as Donald Berwick, chief executive officer of the Institute for Healthcare Improvement, are interviewed; they describe the cost of medical errors to the

healthcare system and ways to prevent such errors. This episode would be an effective tool for an organization to use in staff education when creating a patient safety awareness campaign.

“First Do No Harm” is a natural follow-up to “Silent Killer.” It addresses hospital-acquired infections and the devastating impact that they can have on patient care outcomes. This episode also uses individual patient and family interviews to tell the story of what can go wrong if an infection occurs in an otherwise routine patient care stay or procedure. The episode shows another aspect of how medical errors affect patients and the healthcare system overall.

“The Stealth Epidemic” focuses on community health, using a number of community healthcare programs as illustrations. One compelling statement made during this episode is that the current U.S. healthcare system does not pay for prevention. The stories demonstrate the impact that outreach programs run by nurses and clinical care specialists can have on the maintenance of health status in patient populations with chronic disease. They show how healthcare costs can be dramatically reduced while patients’ quality of life is being improved.

The last episode, “Hand in Hand,” presents a family-centered care approach to improving the healthcare programs and organizations in which patients and families participate. It illustrates the positive outcomes that can come from asking for patient and family input when creating new programs and services. A hospital that incorporated parent input into the design of its new facility and a program in which pediatric patients meet monthly to discuss problems and provide insight into improvements to the hospital are highlighted. This episode sends a powerful message about the importance of including patients in the “inner sanctum” of decision making, which in most organizations continues to be the purview of administrators and physician leaders.

Each episode is 60 minutes. Whether viewed individually or as a series, these videos offer a timely review of some key healthcare issues in the United States today.

Reviewed by Lecia A. Albright, BS CPHQ, principal and owner of LARA Consulting, LLC, Spotsylvania, VA, and JHQ’s media editor

The Truth About Health Care: Why Reform Is Not Working in America

David Mechanic, Rutgers University Press, <http://rutgerspress.rutgers.edu>, 2006, \$26.95, 229 pages, ISBN 0-8135-3887-4

Audience: academicians, administrators, healthcare professionals, policy makers

Key Words: healthcare delivery, healthcare quality, healthcare reform, medical policy

Despite spending \$1.9 trillion on healthcare each year, Americans have a healthcare system that is broken, fragmented, and uncoordinated. Forty-six million people are without health insurance. The author of *The Truth About Health Care* finds this fact “unacceptable and shameful” (p. ix), given that the United States is the richest country in the world. Mechanic describes the evolution of the current healthcare system in ways that favor an assortment of stakeholders instead of the true needs of patients. The purpose of the book is “to explore broadly the influences that make achieving consensus and implementing significant change so very difficult” (p. 1). The book has three parts: “Our Health Dilemma,” “The Struggle for Solutions,” and “The Fork in the Road.”

Mechanic contends that “through no planned design or evil intent, our health care system has evolved in ways that better serve a myriad of economic, professional, and political interests than those of patients and families, and the larger public” (p. ix). Amid the abysmal state of healthcare in the United States, Congress proposes to reduce Medicaid spending by \$10 billion over the next 5 years, which would further endanger the already fragile healthcare safety net.

In his introduction, Mechanic describes the healthcare landscape: the problems of the uninsured, the challenges of chronic disease, the scope of medical error, the pharmaceutical revolution, and the uncertain future. Another issue he addresses in part 1 is healthcare leaders’ inability to focus on population health versus individualized care. He asks whether the healthcare leadership in the United States can “use our rich resources, inventiveness, and many other assets to develop a system that better serves the entire population and that produces higher quality care and better outcomes” (p. 20).

The United States has made many efforts during the past century to introduce more organized, system-based programs. The healthcare plan of former U.S. president William J. Clinton was met with skepticism and ridicule when it was introduced in the early 1990s. Managed care was introduced broadly as a new cost-containment measure. Within these constraints, efforts were made to manage care. Mechanic pleads with the reader not to forget “that small population of seriously impaired individuals who have traditionally been a public responsibility and who should receive first priority in our thinking and planning” (p. 83).

Chapter 7, “Quest for Quality,” is an exceptional brief on the status of quality in healthcare and the current focus on this aspect of medicine. Standardization (not a new concept) and shared vision can promote more effective care.

Society’s trust in healthcare and doctors is discussed in chapter 9, “Restoring Trust in the

Health System.” According to Mechanic, trust has eroded over the years, partly because of the increasingly competitive marketplace. The chapter includes examples of efforts to rebuild trust with consumers, both locally and nationally.

Mechanic is optimistic that the broken U.S. healthcare system can be fixed. He believes that the cost of extending health insurance to the 46 million uninsured is affordable and would be money well spent. He believes that will and commitment are needed to fix the broken system. He concludes, “At some point, we as a nation will have to decide whether we wish to design our health care system primarily to satisfy those who profit from it or protect the health and welfare of all Americans” (p. 188).

Reviewed by Luc R. Pelletier, MSN APRN BC CPHQ FNAHQ FAAN, editor in chief of JHQ and administrative liaison with Sharp Mesa Vista Hospital, San Diego, CA

Quality NETWORK

Robert J. Rosati and Daniel van Leeuwen, 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 future reviews. To read previous reviews that have appeared in the journal, visit www.nahqplus.org, the exclusive Web site for NAHQ members.

Knowledge Is Infectious

www.knowledgeisinfectious.org/

Key Words: infection control, quality of care

Knowledge Is Infectious was created by and receives ongoing support from Cook Medical, part of Cook Group Incorporated, a medical manufacturing company. The Web site is an open forum for the exchange of ideas and information among professionals about healthcare-associated infections. The site’s home page readily loads, but there are several areas of the Web site with different software platforms. For example, to access the files in the “Look” section, users will need a copy of Adobe Acrobat Reader. There are also streaming videos, podcasts, and a blog. Although the Web site was created to help build open discussions, the “Share” section is gated and requires a password, which is free upon request. The rationale provided on the site is that the password and registration requirements allow open communication but also prevent users from feeling monitored by those outside the community. The value of the site stems from the variety of resources on infection control, including a calendar of infection control conferences and links to evidence-based guidelines (in English, Spanish, German, Italian, French, and Portuguese). Links to several other infection control Web sites are also provided. Added value is derived from the ability to dialogue with other professionals on infection control issues. No costs are associated with membership, access, or downloads. I bookmarked the Web site.

Reviewed by Linda Harrington, PhD RN CNS CPHQ, associate professor at Texas Christian University, Fort Worth, TX, and nurse researcher at Presbyterian Hospital, Plano, TX. She is also a member of JHQ’s review panel.

U.S. Department of Health and Human Services: Consumer Assessment of Health Providers and Systems

www.cms.hhs.gov/CAHPS/

Key Words: consumer, Medicaid, Medicare, surveys

The Consumer Assessment of Health Providers and Systems (CAHPS), formerly known as Consumer Assessment of Health Plans Study, has expanded its scope beyond health plans. CAHPS is a family of surveys that ask consumers and patients to evaluate the interpersonal aspects of healthcare. These surveys allow researchers, providers, and partners of the Centers for Medicare & Medicaid Services (CMS) to explore consumers’ experiences with healthcare plans and providers. CAHPS surveys are organized into several sections, including Fee for Service, Hospital, In Center Hemodialysis, Medicare Advantage, and Nursing Home.

Click on “CAHPS Reports” and then click on “Social Marketing” to find detailed information describing CMS’s consumer research “to help the agency, its partners, and health care professionals to better understand the informational needs and wants of people enrolled in various CMS programs.” For example, by using marketing principles that create behavior change, healthcare professionals can transform scientific “recommendations into communication materials that are understandable to various consumers served by CMS.” On the home page, click on “CAHPS Survey Users Network” to be directed to the Agency for Healthcare Research and Quality Web site (<https://cahps.ahrq.gov>). This site provides a wealth of knowledge regarding the National

QUALITY NETWORK

CAHPS Benchmarking Database, survey products, user resources, and quality links that are helpful for healthcare quality professionals.

The Web site is easy to navigate and free of charge. A feedback form is available for comments and suggestions. I placed this Web site on my favorites list.

Reviewed by Sandra E. Ward, MA MS RN CPUR CPHQ, risk management coordinator, HIP Health Plan of New York, New York City, NY.

Center for Aging Services Technologies

www.agingtech.org

Key Words: computers and computerization, consumer/advocacy, e-health, geriatrics, health information management, patient health information

The Center for Aging Services Technologies (CAST) Web site is easy to navigate and provides the healthcare quality professional with a glimpse into the future of how aging in America can improve with technology. The public can access the site, but there is a membership fee to join CAST. Click on "Resources" to access links to various healthcare Web sites, for example, the Administration on Aging (U.S. Department of Health and Human Services), the Alzheimer's Association, a case study on electronic health records in postacute and long-term care, Caregiving Blog by Philips Lifeline, and Aging Boomers: Technology to the Rescue (a great video).

CAST is leading the national charge to develop and deploy technologies that can improve the aging experience in America. CAST has

four focus areas: (1) driving a national vision of how technologies can improve the quality of life for seniors while reducing healthcare costs, (2) accelerating technology research and development pilots with seniors to fulfill this vision, (3) advocating to remove barriers to the rapid commercialization of proven solutions, and (4) promoting national dialogue about standards to ensure interoperability and widespread access to aging services technologies. CAST was established in 2003 and is now a national coalition of more than 400 technology companies, aging services organizations, research universities, and government representatives. I added this Web site to my bookmarks.

Reviewed by Margaret P. Chu, MPA BSN RNC CCM CPHQ, president of MPC and Associates, East Williston, NY, and a member of JHQ's review panel

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 e-mail questions, sites for review, or, better yet, sites with reviews, to Quality NETwork editor Daniel van Leeuwen at dvanleeu@nycap.rr.com.

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 City, NY.

Daniel van Leeuwen, MPH RN CPHQ, is a manager in information technology at St. Peter's Hospital, Albany, NY.

Quality Products and Resources

Luc R. Pelletier

This *JHQ* feature provides members with interesting up-to-the-minute resources that will help them navigate through 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

Automated Healthcare Technology Increases Safety in Hospitals

Technology that is typically used in retail stores might help hospitals organize their healthcare system with the integration of automated dispensing cabinets, bedside bar code verification systems, and smart infusion pumps. Cardinal Health Systems in Dublin, OH, devised a plan to offer clients a variety of automated systems that will make it easier for healthcare professionals to provide care. This new technology includes Care Fusion® bedside verification application, Pyxis MedStation® units, and Alaris® System IV pumps. These products will increase safety and help hospitals solve the more difficult problems related to patient care.

For more information, visit www.cardinalhealth.com.

New Program to Prevent Drug Interactions

Doctors will have an easy resource to help prevent harmful drug interactions. The RxSafety Alerts™, developed by Resolution Health, Inc., will give doctors and nurses electronic alerts when a drug interaction could possibly harm a patient. RxSafety Alerts analyze nightly prescription drug claim feeds along with historical medical services, prescription drug claims, and laboratory test results. When a potentially dangerous drug interaction exists, an electronic alert is sent to the particular pharmacist or nurse, who will then contact the prescribing physician. These alerts

first became available in January 2007. The RxSafety Alerts program is offered to large companies and healthcare plans.

For more information, contact Daniel Heneghan at dheneghan@resolutionhealth.com.

JAX Software to Help Implement Joint Commission Standards

A new software platform can help healthcare organizations maintain an ongoing Joint Commission compliance program. JAX is a hybrid software program that combines Joint Commission consultation with a software platform. This program provides healthcare organizations with summaries, plans of improvement, assessment, and implementation of compliance efforts in accordance with Joint Commission standards. Xpediate, the software development company for JAX, inputs survey results and reports into J Assessment, another software program that works with JAX to help maintain compliance programs. Workgroups are then trained to automatically generate plans of action using J Assessment. By using a combination of these programs, healthcare organizations can maintain compliance with the changing standards required by the Joint Commission.

For more information, call 415/945-9738 or visit www.xpd8llc.com/software/jax.htm.

Resources

Improved Quality of Care for Mental Health Services

Mental Health, United States, 2004 is a report containing the latest information available on mental health services. Published every 2 years since 1983, this report was released in March 2007 by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services. This report offers detailed information about coordinating primary, mental health, and substance abuse care; implementing quality improvement tools; assessing various

populations; and analyzing national mental health services statistics.

For the first time, this edition includes chapters on quality improvement and its application to the mental health field. Specialized topic areas include a national overview of mental health consumer organizations in the United States and the role of information technology as a force that promotes transformation and improved quality of care.

Specific issues, population assessments, and national service statistics in this compendium include the following:

- mental healthcare in primary care settings
- parental reports of emotional or behavioral difficulties and mental health service use among school-age children
- mood disorder prevalence among young men and women
- national and state trends of organized mental health services
- data on the number of mental health practitioners and trainees.

Mental Health, United States, 2004 is available free online at <http://mentalhealth.samhsa.gov/publications/allpubs/SMA06-4195/default.asp>. Print copies are available free of charge from SAMHSA's National Mental Health Information Center at 877/SAMHSA-7 (877/726-4727). Request inventory number SMA-06-4195.

For related publications and more information, visit www.samhsa.gov/.

Disruptive Innovation: Can Healthcare Learn from Other Industries?

As we attempt to deal with rising healthcare costs, is technology the problem or the solution? Both, says Clayton Christensen, a Harvard Business School professor and one of America's most influential business thinkers.

In an interview in the March 2007 journal *Health Affairs*, Christensen talks with California HealthCare Foundation president and CEO Mark Smith about spiraling healthcare costs and the deployment of technology. According to Christensen, technology can be deployed in healthcare in two ways. The first, which increases costs, is to help experts do more sophisticated things that historically were not possible. Examples include total body scanning and using titanium joints. The second method lowers costs through "disruptive innovation,"

a phenomenon Christensen has written about extensively across many industries. Citing the personal computer as an example, he explains that disruptive innovation is a technology that brings a more affordable and accessible product or service into the market, which allows a new population of consumers to buy and use this product or service. Christensen cites retail-based clinics, which are designed to treat a limited set of conditions, as one such example in healthcare.

He also explains that, in the same way that Intel turned the art of computer design into a "rules-based activity," the medical profession is now turning the diagnoses of increasing numbers of diseases, possibly even cancer, into rule-based activities, a shift that allows lower-cost providers to take over the treatment of these diseases.

For more information and to access the complete article free of charge, visit the Health Affairs Web site at www.chcf.org/topics/healthinsurance/index.cfm?itemID=131599.

Understanding State Variation in Healthcare Performance

In the recent update of its annual *National Healthcare Quality Report* (NHQR), the Agency for Healthcare Research and Quality finds that improvements in the quality of care, while impressive in certain areas, are not occurring with many of the 42 core measures of quality examined by the report. Moreover, improvements are highly variable across the United States.

A data brief prepared by the Commonwealth Fund's Commission on a High Performance Health System—*The Agency for Healthcare Research and Quality's National Healthcare Quality Report, 2006*—analyzes some of the state variation in performance described in the NHQR and provides insight into possible causes. The report discusses some of the changes that are needed to realize consistent, broad improvements in performance, including a well-organized healthcare system, expanded access to care, and achievable targets for quality.

The authors believe that progress in healthcare performance in the United States will not be substantial until national standards and performance benchmarks are in place.

For more information and to access the brief free of charge, visit www.cmwf.org/usr_doc/1006_Schoenbaum_AHRQ_nat_hltcare_quality_report_2006_data_brief.pdf.

Substance Abuse Training Manual Teaches Motivational Strategies

The training manual *Enhancing Motivation for Change Inservice Training*, which gives new substance abuse counselors the basics for motivating clients, is now available from the Substance Abuse and Mental Health Services Administration (SAMHSA). This training focuses on strategies to motivate clients to alter their substance use and to begin and stick to a change in behavior. Clinicians have found the approaches in this training useful with populations characterized by denial and resistance, such as court-mandated offenders.

The new manual is based on SAMHSA's Treatment Improvement Protocol 35 (enhancing motivation for change in substance abuse treatment) and is written in a way that substance abuse counselors can understand without having extensive training backgrounds. The training approach includes presentation, discussion, group or partnered practice exercises, and between-session assignments to help counselors practice new skills and integrate learning into their practices.

Counselors will learn about change theory and motivational strategies, assess clients' readiness for change, and develop skills for enhancing client motivation. This training manual would be particularly helpful for new counselors or clinicians who are unfamiliar with motivational enhancement. The 11 modules include presentation instructions, Microsoft PowerPoint slides, homework assignments, and handouts.

Enhancing Motivation for Change Inservice Training is available online at <http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17504>. Print copies are available free of charge from SAMHSA's Health Information Network at 877/SAMHSA-7 (877/726-4727). Request inventory number PHD1135.

For related publications and more information, visit www.samhsa.gov/.

Action Plan for Behavioral Health Workforce Development

The Annapolis Coalition on the Behavioral Health Workforce has released *An Action Plan for Behavioral Health Workforce Development*. This report is the culmination of a 2-year effort to create a national strategic plan to strengthen the mental health and addictions workforce. More than 5,000 individuals were engaged in the planning process. In addition to the full plan, an executive summary is also available.

A national workforce crisis has been widely recognized. It is characterized, in part, by problems of recruitment and retention, minimal workforce diversity, inadequate access to training, the questionable relevance and effectiveness of many educational programs, and a lack of cultural competence among those providing care. Until now, no single planning resource has encompassed workforce development for prevention, treatment, and recovery across the mental health and addiction sectors of this field. This report is designed to bridge those sectors and the traditional professional disciplines. It also addresses preparation and support of a workforce to meet the needs of patients across the lifespan. The report places major emphasis on expanded roles for health-care providers working with people in recovery, children, family members, and community coalitions in caring for themselves and in educating the traditional workforce.

The Annapolis Coalition is a not-for-profit organization committed to promoting the development of the behavioral health workforce. The coalition provides consultation and technical assistance to organizations and governments and can assist those seeking to implement the plan's recommendations. The plan is available for download free of charge at the Annapolis Coalition's Web site at www.annapoliscoalition.org/.

More information about the Annapolis Coalition and its capabilities is available at www.annapoliscoalition.org.

Luc R. Pelletier is JHQ's editor in chief. He is an administrative liaison at Sharp Mesa Vista Hospital in San Diego, CA, and also has a healthcare consulting practice.