

Assessing the Competencies

Emphasizing the "other" competencies

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Designated Institutional Official



LEADING MEDICINE

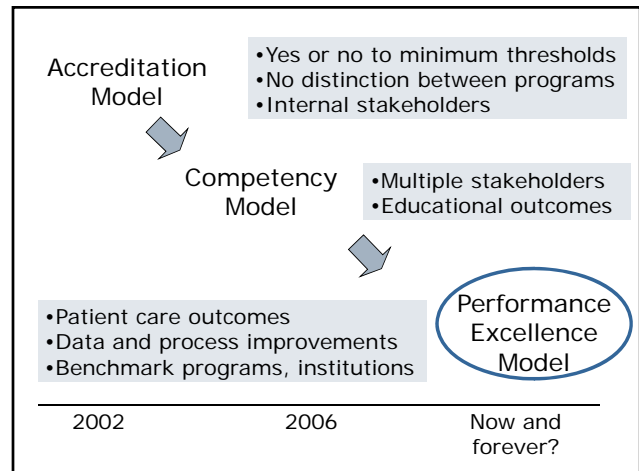
Agenda

- Describe competence
- Describe goals of assessment
- Identify opportunities for assessment
- Identify best practices for instruction and assessment

What is competence?

- | | |
|---|--|
| <ul style="list-style-type: none"> □ Traditional view <ul style="list-style-type: none"> ■ "Good 'ole boy networks" ■ Accountable to internal stakeholders ■ Licensure and specialty tests and certification | <ul style="list-style-type: none"> □ Expanded view <ul style="list-style-type: none"> ■ Different makeup of RRC and visitors ■ Accountable to diverse stakeholders ■ Changing view of "recertification" ■ USMLE Step 2CS |
|---|--|

The quality of being capable of performing an allotted function



ACGME Outcome Project: General Competencies

- Patient care
- Medical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

Dreyfus Model

Novice	Rule-driven <i>Mentoring, conformance to rules</i>
Advanced Beginner	Situational application of rule <i>Experience with more situations</i>
Competent	Ready for practice (ACGME) <i>Considerable experience coping with real situations</i>
Proficient	Recognizes when normal outcomes are not going to occur; able to perceive and react to subtleties
Expert	
Master	

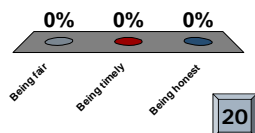
Purposes of assessment

- | | |
|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Feedback | <input type="checkbox"/> Evaluation |
| <input type="checkbox"/> Formative | <input type="checkbox"/> Summative |
| <input type="checkbox"/> Coaching | <input type="checkbox"/> Appraisal |

	Feedback	Evaluation
Purpose	Corrective/ Learning	Certification/ Contract Renewal
Scope	Narrow/Specific Patients	Broad/ Competencies
Delivery Method	Verbal	Written
Scoring	Qualitative	Qualitative and Quantitative
Affective Response	Low Anxiety	High Anxiety
Target Audience	Learner	Society

What is the most important concern in most evaluators' minds?

- ✓ 1. Being fair
2. Being timely
3. Being honest



Fair Clinical Evaluations

- Reliable
 - Regardless of evaluator
 - Regardless of occasion of evaluation
- Valid
 - Describe current performance
 - Predict future performance

ACGME requires that . . .

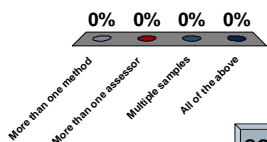
Assessment use methods that produce an *accurate* assessment of residents' competence in the six areas and include evaluation by faculty, patients, peers, self, and other professional staff

ACGME also requires "aggregated assessment"

- Assemble multiple methods of assessment for
 - An individual learner to make decisions about the learner
 - A group of learners to make decisions about a program
 - Patient outcomes to make decisions about the effectiveness of a program

What are minimum requirements for assessment?

1. More than one method
2. More than one assessor
3. Multiple samples
- ✓ 4. All of the above



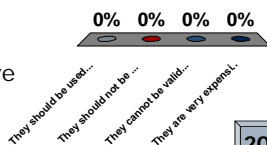
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Good "assessment" forms

- Seen as credible by users (face validity)
- Low cost – in time, money, morale
- Results easily interpreted by faculty and learners
- Do not unnecessarily "rattle" observer or learner
- Reliably and accurately reflect the learner's skill

Which statements are true about global performance ratings by competency?

- ✓ 1. They should be used as part of residents' assessment.
2. They should not be used as part of assessment.
3. They cannot be validated.
4. They are very expensive to design.



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What used to be "new" is now expected

- "Other" raters, multiple raters
- Practice-based learning and improvement
 - EBM Journal Clubs
 - EBM on rounds
 - M&M with focus on QI

The toolbox

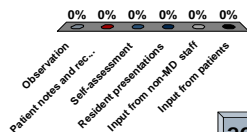
- Chart-stimulated recall
- Checklist evaluation
- 360° global rating form
- OSCE
- Portfolio
- Record review

Opportunities for assessment?

- Observation
- Questioning
- Demonstration
- Patient notes and records
- Self-assessment
- Presentations
- Input from staff or patients or both
- Patient logs
- Learner projects

Which are most useful to your program?

1. Observation
2. Patient notes and records
3. Self-assessment
4. Resident presentations
5. Input from non-MD staff
6. Input from patients



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A closer look

- Professionalism
- Interpersonal and communication skills
- Practice-based learning and improvement
- Systems-based practice

Professionalism

- Conflicts of interest management
- Impairment
- Ethics
- Leadership (leading, directing, and mentoring)
- Personal well-being
- Professional development and life-long learning

Patient Survey of Resident Physician
Evaluator: _____ **Subject:** _____
Rotation: _____
Employer: _____

After reading each statement, please circle one response. The resident physician will not know that you have evaluated him. Your responses will be combined with those of other patients. Thank you for helping us improve our residents' education and your patient care.

1) The resident physician does whatever it takes to get me all the care I need.	Never	Rarely	Sometimes	Often	Most of the time	Almost always	Always	N/A
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) The resident physician's medical skills are not as good as they should be.	Never	Rarely	Sometimes	Often	Most of the time	Almost always	Always	N/A
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) Sometimes the resident physician cares more about what is convenient for him or her than about my medical needs.	Never	Rarely	Sometimes	Often	Most of the time	Almost always	Always	N/A
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4) The resident physician is extremely thorough and careful.	Never	Rarely	Sometimes	Often	Most of the time	Almost always	Always	N/A
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5) I completely trust the resident physician's decisions about which medical treatments are best for me.	Never	Rarely	Sometimes	Often	Most of the time	Almost always	Always	N/A
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6) The resident physician is totally honest in telling me about all of the different treatment options available for my condition.	Never	Rarely	Sometimes	Often	Most of the time	Almost always	Always	N/A
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7) The resident physician only thinks about what is best for me.	Never	Rarely	Sometimes	Often	Most of the time	Almost always	Always	N/A
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8) Sometimes the resident physician does not pay full attention to what I am trying to tell him or her.	Never	Rarely	Sometimes	Often	Most of the time	Almost always	Always	N/A
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9) I have no worries about putting my life in the resident physician's hands.	Never	Rarely	Sometimes	Often	Most of the time	Almost always	Always	N/A
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10) All in all, I have complete trust in the resident physician.	Never	Rarely	Sometimes	Often	Most of the time	Almost always	Always	N/A
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[Return to Questionnaire](#)

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Resident to complete self-assessment before 6-month formal evaluation session with Program Director.

Self-Assessment of Professionalism

Please circle the rating that represents your self-assessment of your professionalism.

1. I work to maintain my medical knowledge and clinical and team skills in order to provide the highest quality of care to patients.	Never	2	3	4	5	6	7	8	9	Always
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I make sure that my patients are completely and honestly informed before and after consent to a treatment.	Never	2	3	4	5	6	7	8	9	Always
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I make sure that my patients are completely and honestly informed when a medical error has occurred that may injure the patient.	Never	2	3	4	5	6	7	8	9	Always
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I safeguard confidential information about patients and protect their medical records.	Never	2	3	4	5	6	7	8	9	Always
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I am sensitive to patients' illnesses, beliefs, personal circumstances, and surroundings.	Never	2	3	4	5	6	7	8	9	Always
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I work to reduce barriers to equitable health care to avoid discrimination based on education, finances, geography, age, culture, and gender.	Never	2	3	4	5	6	7	8	9	Always
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I work with other physicians, hospitals, and payers to avoid superfluous tests and procedures.	Never	2	3	4	5	6	7	8	9	Always
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I recognize any potential conflicts of interest in providing patient care and disclose any conflicts of interest that arise during the course of my professional duties and activities.	Never	2	3	4	5	6	7	8	9	Always
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I collaborate with other physicians to improve the quality of patient care.	Never	2	3	4	5	6	7	8	9	Always
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I show respect toward other physicians and health care professionals.	Never	2	3	4	5	6	7	8	9	Always
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I regularly review and accept external scrutiny of my professional performance.	Never	2	3	4	5	6	7	8	9	Always
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I would like to improve in the following aspect of professionalism:	_____									

Interpersonal and Communication Skills

Written

- Clinical documentation
- Manuscripts
- Abstracts
- Posters
- Consult letters

Verbal

- Informal (patients, care providers, etc.)
 - Phone call consults
- Formal
 - Case presentations
 - Professional presentations

Presentation assessment

The resident identified and explained key points.

Yes No N/A

The resident summarized key points briefly.

Yes No N/A

Evidence-Based Medicine

The resident gathered essential and accurate data for the presentation.

Strongly Agree Agree Undecided Disagree Strongly Disagree N/A

The resident effectively searched the literature for the best evidence related to the presentation's content.

Strongly Agree Agree Undecided Disagree Strongly Disagree N/A

The resident applied knowledge of study designs and statistical methods to the appraisal of clinical studies and other information regarding diagnostic and therapeutic effectiveness.

Strongly Agree Agree Undecided Disagree Strongly Disagree N/A

The resident critically evaluated scientific studies and determined their applicability to patient care.

Strongly Agree Agree Undecided Disagree Strongly Disagree N/A

The resident applied evidence-based knowledge in making recommendations for clinical practices.

Strongly Agree Agree Undecided Disagree Strongly Disagree N/A

The resident responded effectively to questions about the "best evidence" available on the presentation's content.

Strongly Agree Agree Undecided Disagree Strongly Disagree N/A

The resident facilitated the learning of others, including students, residents, or health care professionals.

Strongly Agree Agree Undecided Disagree Strongly Disagree N/A

Overall, the resident demonstrated competence in using the best evidence to investigate, evaluate, and improve patient care practices.

Strongly Agree Agree Undecided Disagree Strongly Disagree

Comments

Remaining Characters: 5000

Resident receiving a phone call from patient or referring physician

- Introduced self and representative attending, service or organization (e.g., "Hello, emergency medicine service, how may I help you?")
- Time and date of call
- Name of patient and unique identifier (e.g., hospital number, date of birth)
- Appropriate triage of call (e.g., emergent, urgent, routine)
- Determined if patient chart needed for call (e.g., routine appointment scheduling vs. medical query)
- Documentation of content of call (medical necessity, urgency, disposition)
- Provided information in a timely (e.g., returned call) and courteous manner
- Disclosed information in an appropriate and sensitive manner
- If intended receiver of call is not available or receiver is unable to assist the caller at that particular time then informed patient/referring physician in an appropriate manner of disposition (e.g., "I can't answer question that but I will find out myself or find someone who can help and I will call you back")
- Recorded call back information appropriately including caller name, identifier, nature of call, urgency of call, return number (including area code or extension), name and spelling (phonetic pronunciation if also necessary) of caller, organization of caller if applicable, best time to return call if needed
- Treated caller with respect (e.g., did not argue or raise voice to caller)
- Did not place caller on hold unnecessarily
- Did not place caller on hold without informing them (not "Hello, please hold")
- Did not place caller on hold for longer than 30 seconds without returning to phone to explain and apologize for delay
- Thanked caller
- Documented phone encounter appropriately in chart (e.g., signature, time, date)

Resident calling a patient or referring physician

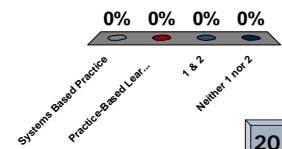
- Introduced self and identified representative attending or organization
- Asked for appropriate individual call recipient by name
- Informed call recipient of nature of call (e.g., "I am calling because...")
- If intended call recipient is not available then resident left an appropriate message (including name, organization, general nature of call, return phone number, and best time to call)
- If intended call recipient is available, then provided appropriate information in a professional (e.g., "sir, madam") and courteous manner (e.g., used "please," "thank you," "you are welcome").
- Disclosed information in an appropriate venue (e.g., setting to protect privacy, away from public earshot) and to appropriate call recipient only
- Did not disclose inappropriate information (e.g., medically, legally, or ethically sensitive data)
- Documented phone record (e.g., patient name, date, time, content of call, signature, placed hard copy in chart)

Other communication issues

- Complaint management
- Conflict resolution
- Interdepartmental and medical staff relations
- Team building
- Teaching
- Communicating bad news

Which ACGME competencies do patient safety and quality involve?

1. Systems Based Practice
2. Practice-Based Learning & Improvement
- ✓ 3. 1 & 2
4. Neither 1 nor 2



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Practice-based Learning and Improvement

- On call consultation evaluation
- Chart review

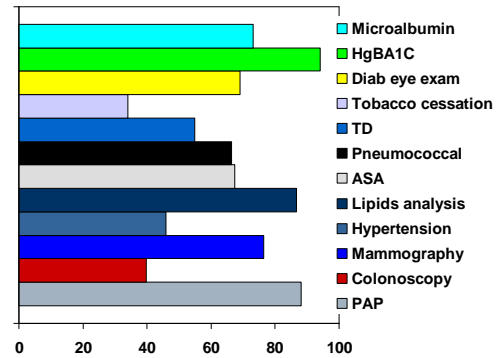
Resident On-Call Consultation Evaluation Tool (OCAT)

Medical Record #	Date of Service	Resident	Score	Comments
			1 2 3	Appropriate History Documented 1. Unsatisfactory: History poorly documented, omitting key elements 2. Borderline: Key points documented, minor points omitted 3. Satisfactory: All pertinent points in the history clearly documented
			1 2 3	Appropriate Examination Documented 1. Unsatisfactory: Each key finding is not documented 2. Borderline: Key examination findings are documented, minor findings are not 3. Satisfactory: Complete ophthalmic examination clearly documented
			1 2 3	Assessment & Plan: Problem list 1. Unsatisfactory: Omission of any exam finding in the problem list 2. Borderline: Each identified exam finding listed, not in order of importance 3. Satisfactory: Each identified exam finding, clearly listed, in order of importance
			1 2 3	Assessment & Plan: Differential Diagnosis 1. Unsatisfactory: Major omissions from differential diagnosis 2. Borderline: Minor omissions from differential diagnosis 3. Satisfactory: Differential diagnosis listed for each item on problem list
			1 2 3	Assessment & Plan: Treatment Plan 1. Unsatisfactory: Plan lacks points that will compromise patient care 2. Borderline: Plan lacks minor points 3. Satisfactory: Plan is appropriate for differential diagnosis
			1 2 3	Consultation Promptness 1. Unsatisfactory: The resident evaluates patient after 60 minutes 2. Borderline: The resident evaluates patient between 30-60 minutes 3. Satisfactory: The resident evaluates patient within 30 minutes
			1 2 3	Agreement with Resident's perceived urgency rating* 1) Minor (e.g. conjunctivitis, symptoms, corneal abrasion, conjunctivitis, astigmatism) 2) Significant (e.g. hyphema, orbital cellulitis, lid laceration, corneal ulcer, retinal nerve palsy) 3) Severe (e.g. open globe, pupillary block, angle closure glaucoma, lens subluxation)
				Urgency Rating: 1. Unsatisfactory: Resident's rating is 2 levels different from evaluator's. 2. Borderline: Resident's rating is 1 level different from evaluator's. 3. Satisfactory: Resident's rating is the same as the evaluator's.

Chart reviews may improve systems of care

- Identify system barriers to patient care
- Flowchart care of patients
- Learn a method to evaluate patient care critically
- Identify problem areas and possible solutions

Compliance with Prevention Strategies

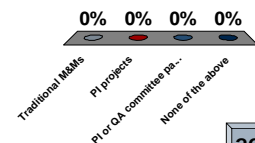


The program specific PIF requires

- Experiential learning
 - Identifying system errors
 - Implementing improvement
- How residents achieve competence in
 - Advocating for quality patient care and optimal patient care systems
 - Working in interprofessional teams to enhance patient safety and care quality

Which activities may not qualify as "experiential learning" for residents?

1. Traditional M&Ms
2. PI projects
3. PI or QA committee participation
4. None of the above



Systems-based Practice

- [Simulation based curriculum](#)
- Web-based education
- [Independent study projects](#)
- [CLARION—interprofessional](#)
- Outcomes card
- [Health Care Matrix](#)

Clinical Health Economics System Simulation (CHESS)

- Computerized team-based simulation
- Three teams
 - Three different reimbursement models
 - Each team selects 2-3 medically justifiable treatment options
- CHESS displays
 - Physician reimbursement, patient and societal costs, and income extrapolated across physician's panel of patients

Voss JD, Nadkarni MM, Schectman JM. Acad Med. 2005;80:129-34.

Health Systems Independent Study Project (HSISP)

- Seminar-based curriculum lacked opportunity for application
- Implemented
 - Self-directed assessment of health care system or delivery issue
 - 3rd year HMO Rotation at Kaiser Permanente

Allen E, Zerzan J, Choo C et al. Acad Med. 2005;80:125-8. Oregon Health & Science University, Portland, Oregon.

To work, mentors must

- Devote 1-5 hours per mentee for an 8 week block
- Have knowledge of HSISP goals, basic research, and IRB and HIPAA
- Protect residents' time
 - 6 to 8 half-days during rotation

Samples of completed projects

- Quality Improvement
 - Improvement of adult immunization rates
- Patient safety/medical errors
 - Identifying systems for blame free reporting of medical errors
- Physician profiling
 - Monitoring physician performance and patient satisfaction

Incorporating PBLI projects into residency curriculum

- Ambulatory setting (month rotations)
- Residents work on PBLI project, discussed first day on rotation
- Other residents continue project on successive rotations
- Chief residents coordinate

Department of Medicine, Lenox Hill Hospital, New York, NY

CLARION

- **C**linician/**A**dministrator **R**elationship **I**mprovement **O**rganization
- Student run organization
 - University of Minnesota since 2001
 - Medicine, nursing, pharmacy, public health
- Extracurricular and interprofessional
 - Interprofessional Case Competition (root cause analysis of a fictional sentinel event)
 - Interprofessional teams (1 member from each school)

CLARION activities

- [Friday Night at the ER®](#) Simulation
- Crossing the Quality Chasm discussion (users manual)
- [Interprofessional patient safety seminar—First Do No Harm®](#)
- Interprofessional Case Competition
 - Root cause analysis of a fictional sentinel event
 - Interprofessional teams (1 member from each of the 4 schools)



First Do No Harm®

- ❑ Video series and manuals
 - A Case Study of Systems Failure
 - ❑ Expert commentaries
 - ❑ Apology and disclosure
 - Taking the Lead (community hospital response to sentinel event)
 - Healing Lives, Changing Culture

www.p4PS.org Partnership for Patient Safety

The Health Care Matrix provides

- ❑ Diagnostic tools for healthcare systems (IOM Aims)
- ❑ Diagnostic tools for the education system (ACGME Competencies)
- ❑ Information about opportunities for improvement (hot cells)

Bingham JW, Quinn DC, et al. Jt Comm J Qual Patient Saf. 2005;31:98-105.

		Clinical Case or Diagnosis					
		Safe	Timely	Effective	Efficient	Equitable	Patient-centered
ACGME							
	Assessment of Care						
	Patient Care Yes/No						
	Medical Knowledge						
	Interpersonal & Communication Skills						
Professionalism							
Systems-Based Practice							
Improvement							
Practice-based Learning And Improvement							

Care of Patients with Respiratory Distress						
IOM Aims ACGME Competencies	Safe	Timely	Effective	Efficient	Equitable	Patient-Centered
Assessment of Care						
Patient Care (Overall Assessment) Yes/No						
Medical Knowledge & Skills (What must we know?)	The cells are completed down and across.					
Interpersonal & Communication Skills (What must we say?)						
Professionalism (How must we behave?)						
Systems-Based Practice (On whom do we depend and who depends on us?)						
Improvement						
Practice-Based Learning & Improvement (What have we learned? What will we improve?)	Last cells to be completed; identify an improvement project					
Information Technology						
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Care of Patients with respiratory distress						
IOM Aims ACGME Competencies	Safe	Timely	Effective	Efficient	Equitable	Patient-Centered
Assessment of Care						
Patient Care (Overall Assessment) Yes/No	No	No	No	No	No	?
Medical Knowledge & Skills (What must we know?)	Intubation requires the skills and can tend only to be performed by those with frequent and good at least 10-year experience	Always obtain	Only due to oral attempts would fail in	Approach to tracheotomy care and always emergencies differ depending on experience, training, and hospital ward		Patients may receive different levels of tracheotomy care depending on nursing staff, hospital ward, and managing service
Interpersonal & Communication Skills (What must we say?)	Better way to communicate likelihood of obstruction and difficult airway			lights at time		Contacted family after death - both MICU and ENT present for discussion
Professionalism (How must we behave?)	MICU/Anesthesia ignore otolaryngologic advice about secure airway					
Systems-Based Practice (On whom do we depend and who depends on us?)	MICU/Anesthesia ignore otolaryngologic advice about secure airway					Trach care may vary depending on patient floor
Improvement						
Practice-Based Learning & Improvement (What have we learned? What will we improve?)	Need variety of suction catheters available Determine the essential equipment for tracheotomy care. Practice ENT communication with other departments	Patients with tracheotomy can still perform normal and difficult intubation airway Know where tracheostomies are for each unit	patient can be orally intubated to respiratory airway Define clear roles for tracheotomy	Create order set to specify supplies, necessary as well as initial steps if airway lost.		
Information Technology						
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Equitable: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status

"Have standard order set available for all ICU's and floors. Make order set easy to use so different services may implement."

What are your next steps??

- Invent new assessments and opportunities?
- Take advantage of existing opportunities to create meaningful opportunities?
- Some of both?

Questions?