

What Are You Doing About Health Care Quality in Your Practice?

Part I

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Ms Satinsky

“Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge”

In May 2005, Paul Miles, MD, vice president and director of Quality Improvement of the American Board of Pediatrics, addressed the annual meeting of the Alice Aycock Poe Center for Health Education (Miles, 2005). Dr Miles talked about six core competencies for physicians in the 21st century: provision of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning, and system-based practice. He contrasted these core competencies with the traditional idea of: “I’m a physician; trust me.” Dr Miles suggested that every practicing physician ask him or herself two important questions: (1) How do I know that what I’m doing works? and (2) How can I improve what I do? He was talking about the quality of health care and the imperative of each and every physician to improve it. Physicians in the future must be able to respond to their patients and society saying: “Yes, we trust you, but show us the data” (Brennan, 2002).

Focusing on Improving the Quality of Care

From my perspective as a practice management consultant, physicians frequently express concerns to me about inadequate reimbursement, problems with cash flow and human resources, compliance issues, marketing, and making good investments in new information technology to support their practices. However, they rarely mention how they are measuring the quality of health care they are providing or how they are planning to improve it.

My personal observations about physician concern for the quality of health care and quality improvement were confirmed by the recently reported findings of a 2003 Commonwealth Fund Survey of Quality of Care covering more than 1,800 physicians (Audet, et al, 2005). The study’s authors found that physicians’ adoption of measures, tools, and quality is moving slowly and is not where it should be to achieve a high performance. One of the major obstacles to making quality improvement routine was lack of information about their own practices. The study also noted that physicians are not comfortable sharing physician-specific performance data with the general public, with their own patients, or with medical leadership. Finally, the study noted that practice size affects the likelihood that physicians receive

and use data on quality of care. Those in practices with 50 or more physicians were more likely to be involved in quality improvement activities than those in smaller practices.

Physicians need to become more proactive in measuring and improving the quality of care they are providing. Not only will they improve patient care, but they will be more capable of responding to payer/purchaser incentive programs. Quality and quality improvement (QI) in health care are complex subjects. My goal in this article is to raise your awareness. I hope that my comments will be informative and provocative so that when you finish reading you will want to learn more and do more in the setting where you provide care. I’ll begin with definitions of quality and quality improvement. I’ll describe some of the quality and quality improvement initiatives that already exist and with which you may already be familiar. I’ll talk about the importance of measurement for comparing the current status with post-improvement status. Most important, I’ll offer guidance to those of you who want to make quality of care and quality improvement a priority for your practices.

There are seven appendices at the end of Part II of this article: glossary of terms related to quality (Appendix 1); national and state public and private agencies, organizations, and associations that are focusing on health care quality and improvement (Appendices 2 and 3 respectively); recommended books and articles (Appendix 4); continuing education on quality and quality improvement (Appendix 5); on-line information related to the promotion of quality in health care (Appendix 6); and Programs in the Centers for Medicare & Medicaid Services (CMS) Physician Focused Quality Initiative (Appendix 7). Part II will appear in the next number of the *Forum*.

What Are Quality and Quality Improvement in Health Care?

The Institute of Medicine (IOM) defines quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Lohr, 1990). The IOM’s important 1991 report, *Crossing the Quality Chasm. A New Health System for the 21st Century* (Institute of Medicine, 2001), extends this concept a step further and comments: “Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge.” Quality is the difference between the care that is given now and the care that could be delivered, given what we already know. As the IOM report docu-

ments thoroughly, Americans don't have that guarantee, and the difference between what exists now and the ideal is a chasm, not merely a gap.

The quality chasm in health care isn't large because health care professionals don't know enough or try hard enough. We all know the problem with health care financing mechanisms in the United States – they pay for services, not quality of care. But misaligned financial incentives aren't the primary problem. Outmoded systems of work are the major barrier that prevents all Americans from receiving state-of-the-art health care. In laying out an agenda to address this system malfunction, the IOM calls for health care that is safe, effective, patient-centered, timely, efficient, and equitable.

The evaluation of quality of care should focus on structure, process, and outcomes (Donabedian, 1980). Structural quality refers to the health system capabilities of both large integrated and small systems. Process quality looks at clinician/patient interactions. Outcomes evaluation refers to changes in health status. Although it is possible to measure quality of structure, process, and outcome, most quality of care information is about appropriateness and professional standards (Institute of Medicine, 2001).

Just where does quality improvement fit in? Quality improvement is the method by which we close the gap between the current state(s) and the desirable state(s), using measurement before, during, and after to track changes and results. Improvement science is a formal body of knowledge that applies the scientific method to improving complex systems. The principles of improvement science involve: (1) understanding healthcare as a system, (2) using a balanced set of process and outcome measures tracked over time to determine if change results in improvement, (3) using an explicit evidence base to determine which changes should be implemented and tested, (4) focusing on multidisciplinary teams to make change, and (5) avoiding a focus only on poor performers (Speroff and O'Connor, 2004).

The IOM recommends six steps for bringing both the American health care system as a whole and its many components toward a place that will give every individual the care that he or she now lacks. Here is the list of recommendations and my related questions that can help you relate their application to your own practice setting.

1. **Redesign processes of care to more effectively meet the needs of the chronically ill.** Whatever your specialty, you take care of both individuals and groups of patients with chronic conditions. These patients consume more time and resources than your other patients, so you want to be sure that you, your care team, and your patients themselves are managing their care as efficiently as possible. Can you identify patients with chronic conditions? Does your practice have special protocols for providing care and for educating these patients and their families?
2. **Make efficient use of information technology to automate clinical information and make access to that information easier for both patients and the care team.** If you routinely collect demographic information about your patients and document the care that you provide, you have a head start in addressing quality of care. The important question is, how well can you access the information that you have and use it along with information that is available from other sources to help you provide quality care? Do you spend a lot of time looking for medical records that are piled on someone's desk? Do you have a Web site, and if the answer is yes, do you use it interactively to allow patients to communicate with your practice? If you have already purchased electronic health records (EHR) or are thinking about introducing this application into your practice, are you focusing on ways in which the technology can help you better meet the needs of your patients and your care team or are you fretting about the price? Do interfaces between your practice management system, your Web site, and your EHR allow you to access information from all three sources when you need it? Are you aware of the National Voluntary Consensus Standards for Ambulatory Care that have been endorsed by the National Quality Forum? Can you readily measure the quality of the care that you and your practice deliver for both individual patients and for your practice as a whole?
3. **Manage your own and your workforce's knowledge base and skills.** Your medical school and subsequent training gave you a good knowledge base, but it didn't teach you enough to sustain you for the rest of your medical career. The base of knowledge continuously expands, so even the smartest physician can benefit from the availability of new information on diagnoses and treatment. In the future, maintaining board certification and state licensure will require a commitment to lifelong learning and periodic self-assessment. The same high level of competency holds true for your clinical and administrative staff. Can each one of you access information on new findings, new treatments, new medications, new administrative requirements, new administrative solutions, and, most importantly, on your patients themselves?
4. **Coordination of care across patient conditions, services, settings, and time?** If you are a primary care physician or medical specialist, the office visit is the way in which you interact most frequently with patients. If you are a surgeon, your main interaction with your patients may be in a hospital or ambulatory surgery center setting, with briefer interactions in your office. Are you able to coordinate care for your patients across settings, regardless of the time of day or night that the patients or your medical colleagues contact you? Problems with handoffs and the management of transitions from one provider to another are major sources of medical error.
5. **Enhancing the effectiveness of teams.** Although the physician/patient interaction is of the utmost importance, your patients interact with other people in your office and/or at the hospital. Do all those who interact with patients work as a team, or do they work as individuals with little coordination of efforts? Communication skills are critical, and there is a growing awareness of the need to understand cultural, language, and literacy issues in relating to patients.
6. **Improving performance by incorporating care pro-**

“Quality improvement is the method by which we close the gap between the current state(s) and the desirable state(s)”

cesses and outcomes measurement into your daily work. You need to work smarter, not harder and longer. If you are part of a large health care system or belong to an IPA or physician association, process redesign may already be part of a larger organizational agenda into which your practice fits. Do you understand, analyze, and improve the processes that affect patient care? Do you measure the impact of what you do, set goals, and take steps to improve? Does your practice have an ongoing plan to systematically improve care?

Appendix 1 contains a glossary of terms that are commonly used in talking about quality and quality improvement.

Examples of Health Care Quality and Quality Improvement Programs

Quality of health care and quality improvement are not new subjects. You may be familiar with and/or participate in some of the programs that already exist. Many of the current initiatives are external to medical practices and feature financial incentives for quality improvement. Although each initiative that I describe here has contributed in some way toward better understanding of quality problems and ways to address them, many of the externally-driven programs don't affect your structure and processes for delivering care. Only you can do that.

My list of quality and quality improvement initiatives is by no means exhaustive. It includes: disease management, centers of excellence, evidence-based medicine, practice guidelines, National Committee for Quality Assurance (NCQA) HEDIS standards, Bridges to Excellence, the Leapfrog Group, and Pay-for-Performance.

Disease management: a systematic and comprehensive approach to improving the management of a condition (Institute of Medicine 2001). The goal is to coordinate care and control costs by integrating components across the entire delivery system and by applying tools that are appropriate for the target population. One limitation of most disease management programs is that they focus on cost reduction and target the most severely ill patients. Patients do not always have a say in whether or not they can participate. Another shortcoming with disease management is that the primary care physician is sometimes excluded from the process unless his/her involvement is deliberately made part of the program. Although most disease management programs are not usually categorized as quality or quality improvement programs, there have been some successful efforts to improve the quality of care for chronic diseases using the Wagner Chronic Care Model and quality improvement (<http://www.aamc.org/newsroom/pressrel/2005/050428.htm>).

Centers of excellence: the underlying premise is that there is a high correlation between volume and positive outcomes. Both the Centers for Medicare and Medicaid Services and many of the managed care plans have established standards for centers of excellence. These centers receive a single bundled fee for all services related to specific complex procedures. As with disease management, the major focus is on cost reduction, and patients do not always have input on whether or not they will seek care from a center of excellence. Again, these programs are not usually labeled as quality or QI programs,

although some of them have achieved good results.

Evidence-based medicine (EBM): the concept of using research evidence to make decisions about the care of individual patients has existed since the 1950s and 1960s. Since that time, the standards for evidence have become more rigorous, and the tools for assembling evidence have become more powerful and widely available (Davidoff, 1999). Historically, one concern in using evidence-based medicine to improve the quality of care has been practicality. When information is widely scattered, busy independent physicians who are not researchers are unlikely to take the time to frame a research question, review available evidence, and select the best evidence as a guide in patient care. In order to address this issue, both the United Kingdom and the United States have made progress in synthesizing available evidence. The Cochrane Collaboration in England and the Agency for Healthcare Research and Quality's Evidence-Based Practice Centers (including Duke Medical Center in North Carolina) have facilitated the organization of evidence-based medicine so that the results are easier to use. Another concern with EBM is that for a large part of medical care, there is not yet solid evidence.

Practice guidelines: the IOM defines clinical practice guidelines as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances (Institute of Medicine, 1992). The guidelines take the evidence and move a step ahead; they build conclusions or recommendations about appropriate and necessary care for specific types of patients (Lohr et al, 1998). A problem with guidelines is that they are based on evidence. When there is variability in the reliability of evidence, there is variability in the guidelines. A partnership of the Agency for Healthcare Research and Quality, the American Medical Association, and the American Association of Health Plans has created a National Guideline Clearinghouse that offers on-line access to a large and growing resource. But guidelines alone don't produce quality, particularly if there is no opportunity for physician judgment and patient feedback in their application. The real issue is that physicians do not know how to improve in a systematic and measurable way. Dissemination of evidence-based guidelines alone has not significantly changed practice performance.

National Committee for Quality Assurance (NCQA): this organization sets standards for health plans and makes available comparative quality data. Its Health Plan Employer Data and Information Set (HEDIS) indicators focus primarily on the occurrence of desired or undesired events in specific population groups. Some HEDIS measures, such as rates of childhood immunization and mammography, deal with illness prevention. Other measures, such as the percentage of diabetics who have had an annual eye exam, focus on caring for people who have been diagnosed with a chronic illness. Similar to practice guidelines, quality measures or indicators alone do not have a major impact unless physicians know how to improve in a systematic and measurable way.

The Leapfrog Group (www.leapfroggroup.org/): this purchasing group was established in 2000 in order to drive "leaps" in quality and safety in hospitals by leveraging performance transparency at the provider level, consumer incentives, and provider rewards (Galvin, 2004). The Group includes 150 public and private purchasers and represents more than 34 million lives. Hospital participation is voluntary, and almost half of the 3,000 eligible institutions have chosen to be included. Leapfrog sponsors 15 initiatives throughout the country, and its Web site contains the results. In a recent editorial,

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Dr Robert S. Galvin, director of Global Health for General Electric and one of the founders of the Leapfrog Group, acknowledged that the initiative has not had the desired effect of significantly improving hospital safety (Galvin, Delbanco, Milstein, and Belden, 2005).

Pay-for-Performance (P4P): pay-for-performance programs offer financial incentives to physicians for achieving specific, measurable patient safety, quality, satisfaction, or efficiency objectives. These programs generally base a portion of physician payment on quantitative measures that may include patient care process measures, outcomes measures, or patient satisfaction scores (MGMA, 2005). Although pay-for-performance programs are relatively new, the programs in California and in Boston have already paid out financial rewards to physicians. Both the Medical Group Management Association (MGMA) and the American Medical Association (AMA) have developed specific standards to be met by any such programs (MGMA 2005 and AMA 2005). In July 2005, Senator Chuck Grassley (R-Iowa) introduced the Medicare Value Purchasing Act of 2005 (S. 1356) into the U.S. Senate. The bill would give the Secretary of DHHS broad statutory authority to develop and implement Medicare P4P programs.

Bridges to Excellence (BTE) (www.bridgestoexcellence.org/): spearheaded by General Electric and six other large employers, and physician leaders, Bridges to Excellence (BTE) is a pay-for-performance program that rewards physicians for delivering high quality care to patients with diabetes (Diabetes Care Link), and coronary disease (Cardiac Care Link). There is also a financial reward for the use of office-based EMR (Physician Office Link). In the diabetes and cardiac care programs, both of which are administered by the National Committee on Quality Assurance (NCQA), physicians can receive certification by meeting process and outcome goals developed by the American Diabetes Association and the American Heart Association. Because BTE uses process and outcome measures, it avoids the problem of small sample size that can penalize practices. The number of patients required for certification in each of these three programs is 35. Right now, a major shortcoming of BTE is that it is available only to physicians who provide care to the patients of participating employers. BTE is considering licensing the product so that large health plans can use it (Galvin, et al, 2005).

Importance of Measurement in the Quality of Medicine

If measurement is the key to understanding your current status and the improvements that you make, what do you measure? The Centers for Medicare & Medicaid Services (CMS) has been working with the American Medical Association's Physician Consortium for Performance Improvement and the National Committee for Quality Assurance to measure the improvement of care for such clinical conditions as coronary artery disease and heart failure, diabetes, high blood pressure, osteoarthritis, asthma, behavioral health, prenatal care, and preventive care. In January 2005, the Performance Measurement Workgroup proposed a starter set of measures based on their ability to meet five criteria: (1) clinical importance and scientific validity, (2) feasibility, (3) relevance to physician performance, (4) consumer relevance, and (5) purchaser relevance.

After an expedited review process, the National

Quality Forum endorsed National Voluntary Consensus Standards for Ambulatory Care. These standards represent the consensus of more than 260 health care providers, consumer groups, professional associations, purchasers, federal agencies, and research and quality improvement organizations. They are a standardized set of measures for gauging and publicly reporting the quality of ambulatory care. Go to the Web site www.qualityforum.org for the approved measures.

Public and Private Initiatives in Quality of Care and Quality Improvement

The quality of health care as a national concern and priority is fairly recent. Following the occurrence and publicity around numerous errors and devastating consequences, the IOM published its 1999 report, *To Err is Human: Building a Safer Health System* (Institute of Medicine, 2000). That report was a wake-up call to the entire health care industry, and quality of care and quality improvement are now both high priorities at the national and state levels. Appendices 2 and 3 list many national and state public and private agencies, organizations, and associations that are concerned with both quality and quality improvement in health care.

Suggestions for Moving Ahead

Quality is a huge topic, and it is tempting to set it aside for another day. My advice is to learn more about national and state quality improvement initiatives. Use your research to gain a broad perspective so you can designate someone within your practice to organize your efforts, but remember that quality is everyone's responsibility. Then objectively assess your current situation, organize your findings, and decide what actions to take. Last but not least, document your quality efforts.

In my opinion, it is essential to distinguish quality improvement efforts that originate within your practice from activities that you undertake in order to satisfy external standards. Both are important. Standards that are imposed by outside agencies and organizations are likely to impact your bottom line more than the way in which you deliver patient care. But if you only strive to meet standards set outside your practice without critically examining the way in which you deliver care, you won't change the structures and processes that affect your clinical results.

Learn More About Quality and Quality Improvement

So much information on quality and quality improvement is available that the challenge is in knowing where to start. I recommend reading the IOM's *Crossing the Quality Chasm* (Institute of Medicine, 2001). Although the book is long and detailed, it will give you an excellent framework, providing insights into what is wrong and how to fix it. The observations and recommendations are well documented, and you'll have the confidence of knowing that the material comes from a

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reliable source.

Other good places to begin your quality journey are the Dartmouth Microsystems Web site (www.clinical-microsystem.org) and *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*, by Langley, et al (Langley, et al, 1996). I also recommend the American Health Quality Association Web site (www.ahqa.org) for both information and links to other organizations and projects. AHQA's bimonthly Quality Update summarizes the many quality activities and events going on throughout the country, and its Web site has good information on patient safety. The Institute for Healthcare Improvement Web site (www.ihp.org) also has excellent information.

Quality and quality improvement are becoming an important component of the training, continuing education, and credentialing for health care professionals. Both the American Board of Medical Specialties and state licensing boards require physicians to become competent in quality improvement and be able to demonstrate with data that they can measure and improve the quality of care. Look at the American Board of Internal Medicine's new charter on professionalism (www.abim.org) to see how that organization describes the quality imperative. The American Academy of Pediatrics (www.aap.org), the American Academy of Family Physicians (www.aafp.org), and the American College of Physicians (www.acponline.org) have been extremely proactive about quality, and their respective Web sites contain information that you might want to use in your practice. For example, the American Academy of Pediatrics EQIPP tool offers physicians assistance in managing patients with ADHD, asthma, and other conditions. The American Academy of Family Physicians Quality Initiative includes criteria for performance measures and a practice enhancement program.

The American College of Surgeons (www.facs.org) offers four programs directed toward quality improvement. These are the National Surgical Quality Improvement Program (ACS NSQIP) and accreditation of bariatric surgery, trauma, and cancer centers (Petty, 2005).

If you would like to participate in training or continuing education that focuses on quality and quality improvement, I recommend the programs offered by the American College of Physician Executives (www.acpe.org) and by the Institute for Health Care Improvement (www.ihp.org). Both of these organizations have trained thousands of physicians, and their curricula are a good combination of theory and practice. Your own specialty society may also offer training.

Many of the organizations and associations that I have listed in this article hold regular meetings for which you can get CME credit. I highly recommend attending a meeting that is not limited to your specialty. You'll gain broad exposure to quality efforts throughout the country and/or state and have the opportunity to network with a wide variety of colleagues. For example, here in North Carolina the Quality Council of North Carolina

holds an annual spring symposium that brings together health care professionals in medicine, nursing, research, management, and administration. The Carolinas Center for Medical Excellence (formerly Medical Review of North Carolina), our state's Quality Improvement Organization (QIO), sponsors the annual Ralph E. Snyder Conference each fall. The North Carolina Healthcare and Communications Alliance, Inc, (NCHICA) annual meeting is in the fall.

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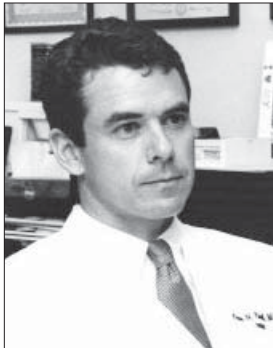
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Lessons of Katrina

Personal Experience with SMAT Team II, Waveland, Mississippi, September 2-10, 2005

Peter N. Purcell, MD



Dr Purcell

The following is an account of my experience "on the ground" in the Katrina disaster area, and how a similar storm may affect us, the local medical community.

On September 11, 2005, I returned from a nine-day deployment to Waveland, Mississippi, as a trauma surgeon with SMAT-II, the North Carolina State Medical Assistance Team. SMAT was originally created as a medical unit to deal with disasters occurring in North Carolina, but due to the unprecedented magnitude of the Katrina disaster, the governor of Mississippi asked Governor Easley for emergency medical assistance and SMAT was activated. Following are my impressions of the unit, our mission, and the relief effort as I experienced it. I should emphasize that these impressions are mine and not necessarily anybody else's from SMAT, FEMA, or any other organization. I did not function as any type of administrator—just as a "foot soldier"—a doctor on the ground delivering medical care. My impressions were formed from my experiences during this time and may not represent other parts of the relief effort.

SMAT

SMAT consists of approximately 200 medical per-

sonnel, including 10 physicians (four emergency physicians, three trauma surgeons, one orthoped, and two anesthesiologists). Equipment to set up a 122-bed, totally self-contained hospital (two operating rooms, four ICU beds, eight step-down beds, and 110 ward beds) is included with SMAT and was deployed on this mission. I'm proud to say that on this initial deployment three of the 10 physicians were members of the medical staff of New Hanover Health Network—Dr John Tseng from the ED, Dr Mike Hahn from anesthesiology, and myself from surgery.

We left Wilmington at 0500 Friday morning, joined with the other SMAT teams from around the state in Charlotte, and left Charlotte Friday night in a convoy of 30 vehicles and many tons of medical equipment. After almost 48 hours of travel (with delays caused by fuel shortages, vehicle breakdowns, and administrative delays from Washington) we arrived at our location, the parking lot of a destroyed shopping center.

We spent the next 10 hours preparing the site and setting up the hospital. As there was absolutely no remaining infrastructure left in the area (power, water, food, many roads, and most homes simply gone) we operated as a completely self-contained unit. We cleared our new home of glass and other debris (vital to prevent injuries from helicopter landings) and set up a large facility consisting of an OR/ICU/step-down unit, patient tents, triage tent, acute care tent, pharmacy, decontamination unit, command and control unit, helipad, and many storage units for equipment. All power came from gen-

"I did not function as any type of administrator—just as a foot soldier"