

THE RAPID PULSE

February 2006

Faces & Places

WELCOME

Houston, TX:
Andrea Campbell

Tacoma, WA:
Carla Green
Kenneth Simmett

FAREWELL

El Centro, CA:
LCDR Brenda Mitchell

Florence, AZ:
CDR Fernando Farfan
LT Tanya Toussaint

San Diego, CA:
LT Rebecca McTall

THE DIRECTOR'S PERSPECTIVE

By Dr. Gene Migliaccio

Welcome to another installment of *The Rapid Pulse!* In this issue, I want to re-enforce some of the topics discussed during the last all-hands conference call.

One of the main areas of focus from the conference call, was the issue of personal responsibility. The Commissioned Corps is now being looked to as a Ready Force. All officers have the responsibility for ensuring that they are basic qualified. In that vein, if any DIHS officer is not basic qualified, they will not be afforded the opportunity to participate in CME. Also, we will not initiate and/or approve awards for those officers not basic qualified. We will be providing supervisors with a list of their officers who are not basic qualified, with the hope of seeing much improvement in the number of DIHS officers who have obtained basic qualification.

Also, it is imperative to ensure that you work any issues you may have, through the appropriate chain of command, and always at the lowest level when possible. On our official website, we have provided a Functional Directory which details the Points of Contact for various administrative services and functions within DIHS. The Directory is located at: http://www.inshealth.org/documents/M&B_Unit_Functional_Assignments.doc

We have also placed a DIHS Directory at <http://www.inshealth.org/documents/>

DIHS HQ Functional Phone Directory_8 Feb 06.xls.

I also want to thank CDR Mary Bowling for the wonderful presentation on root cause analysis that she conducted during the all-hands conference call, and for stressing the importance and value of root cause analysis after a sentinel event. The insight and expertise that she provided, will continue to serve our organization (and most importantly our detained population) well.

I want to thank everyone for their continued hard work. Our organization has made a very strong start into 2006.

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DEPLOYING WITH THE COAST GUARD

By LCDR Elizabeth Escalera

At five o'clock in the morning, the intercom announcement was loud and clear, "Lieutenant Commander Escalera, lay to the flight deck." I was being summoned to the flight deck again. I rolled out of bed and headed towards the flight deck wondering what awaited me. Was it another fake illness or a self-inflicted injury?

As a PHS officer assigned to DIHS, this was my second year participating in the Alien Migrant Interdiction Operation (AMIO) with the U.S. Coast Guard (USCG) in Key West, Florida. I would be serving aboard USCG boats, known as "cutters," for four weeks.



Last year I was out here for three weeks and other than literally running from hurricanes, my assignment had been uneventful. This year, however, would be much more challenging. The challenge was not the patients' illnesses; the challenge was working with unreliable information, limited resources, and less than desirable conditions.

The mission of the AMIO is to interdict and repatriate migrants. Due to the "wet foot/dry foot" law which allows Cubans to remain in the US if they touch US soil, many Cubans take desperate measures to reach the US, including risking their lives in unseaworthy vessels. If caught, many fake life threatening illness or harm themselves in hopes of a medical evacuation to the US. My mission was, "To provide medical assistance to the US Coast Guard, by assessing and treating Cuban migrants

to prevent medical evacuation to U.S. soil for non-life threatening medical conditions."

The "emergency" that had pulled me out of bed was a head injury. Apparently the migrant had fallen down the ladder and landed on his buttocks. Once on the ground, he appeared to have a "seizure" and hit his head, causing it to bleed. After cleaning and dressing the superficial wound it became evident that the patient was non-responsive by choice.



His vital signs were stable and by the effort he was displaying to keep his eyes tightly shut, it was clear that he was not unconscious. I informed him, in Spanish, that his injury was minor and he would not be medically evacuated. Within minutes, he was fully alert and informed us that he was "fine." After a thorough neurological exam the assessment was confirmed: the migrant had faked the "convulsion" after the fall. This was the fourth "emergency" (fake illness) I had this year. By the end of my assignment, I would serve on seven different cutters, see over 280 patients, identify fake illness, treat self-inflicted injuries, and care for chronic and acute medical conditions.

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Although this was indeed a challenging assignment, it was also very rewarding. The migrants appeared appreciative of the care they received. The Coast Guard crew, especially the commanding and executive officers, expressed their gratitude for our PHS officers' assistance. Subsequently a position for a permanent PHS officer in Key West has been approved.



Perhaps this most recent “adventure” with the Coast Guard will be my last one, perhaps not! I am grateful that I was provided the opportunity to serve outside of my comfort zone and feel honored to have had the opportunity to work with such professionalism as exhibited by the members of the Coast Guard.

Literature Review: *Working With Emotional Intelligence*, Daniel Goleman

(Submitted by LCDR Jean Pierre DeBarros)

Working with Emotional Intelligence is a great read for anyone in a management position, or looking to be in a management position. For that matter, even if you're not in a management position, you will certainly find a lot of value in what the author has to say on IQ vs. EQ (Emotional Quotient).

This book is actually a follow-up to the author's prior successful publication, *Emotional Intelligence: Why It Can Matter More Than IQ*.

The success of this book led to corporate America inquiring how the EQ applied to management and leadership within the work setting. Ian Cook of Fulcrum Associates Inc. put together a good review of the book.

REVIEW:

What are the ingredients that make up superior performers in our organizations? Must they be intelligent? Know their stuff? Have unyielding drive? Be likeable? Recent research indicates grey matter and technical/job knowledge are but threshold competencies. What differentiates the "stars" are the personal qualities, the so-called "soft skills." It appears that Antoine de St.-Exupéry perhaps got it right in *The Little Prince* when he said, "That which is essential is invisible to the eye."

The top two reasons managers are "derailed" in their careers, according to the Center for Creative Leadership, are

- Inability/unwillingness to adapt
- Failure to establish and maintain collaborative working relationships.

Now Dan Goleman has followed his 1995 ground-breaking book, *Emotional Intelligence*, with a cutting edge application of his research to the world of work. If you are at all concerned about human performance and development in your organization, read this book!

Goleman's thesis is that somewhere between 75% to 90% of effective performance, particularly in the case of managers and leaders, is attributable to "emotional intelligence" (EI).

What is EI? He defines it as, "the capacity for

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recognizing our own feelings and those of others, for motivating ourselves, and for managing emotions well in ourselves and in our relationships." He devotes two-thirds of the book to laying out in detail 25 competencies, grouped into five domains, the first three reflecting how we manage ourselves and the last two how we handle our relationships with others. These domains are:

Self-Awareness:

An ability to notice what you are feeling in the moment and to tap into your intuitive self as you deal with the daily decisions and challenges of organizational life. It includes exercising a self-confident, candid openness to feedback about your strengths, your blind spots and where you need to grow.

Self-Regulation:

Managing your deeper emotions and impulses appropriately, rather than self-indulgently (know anyone who allows himself/herself to "fly off the handle" and lash out at others?). It includes positioning these feelings against the wider perspective of your longer-term goals and the interests of others and the organization at-large.

"Stress-hardy" individuals are those who have mastered the ability to stay focused and constructively energized in times of stress. This domain is also about choosing to be trustworthy ("walking your talk") and allowing space in your world for ambiguity and for the (often different) ideas of others.

Motivation:

A combination of an internally generated drive to achieve, an emotional commitment (often called passion) to goals (both your own and the organization's), a willingness to mobilize yourself and others to action, all the while placing an optimistic "spin" on challenges and setbacks you face.

Empathy:

This is an absolute key to establishing working rela-

tionships. It builds on the first two domains. You can't tune in to others if you are preoccupied by your own disrupting feelings. Empathy means having a genuine interest in, and sensitivity to, the perspectives, concerns and needs of others. In companies, it includes a service orientation to the customer as well as a healthy attunement to the prevailing organizational politics.

Social Skills:

Influencing others is a prerequisite to your success. To influence, you deal with the emotional state of others. With individuals, you build rapport, communicate, resolve disagreement, and inspire them towards your vision and ideas. With groups and teams, you network (it's a verb now), collaborate, create a sense of the team's identity, and foster the synergy from the pursuit of collective goals.

Goleman believes all of the emotional competencies can be developed. This is done, he says, by replacing old, ingrained habits of thought, feeling and behavior with new habits. You do it by practicing the new habits, over time engaging new neural pathways in your brain as you install your new, more appropriate default responses. He outlines a 14-point process for doing this to bolster your organization's "immune system" that keeps it healthy, resilient and able to take advantage of opportunities that emerge.

The author makes a strong case for the high leverage gained by focusing on the soft skills which underpin and drive "hard" business and organizational results. He draws our attention to the importance of what he calls the "invisible interpersonal economy" that exists in organizations. Your high performing leaders and individual contributors are those who

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understand and work effectively with the "currency" of this parallel economy the emotions that are attached to the needs, hopes and fears of all who work in your organization.

So, what does this book mean for managers? I believe Daniel Goleman has tapped into some fundamental truths about human performance in organizations. He has laid out the roadmap. We need to focus the investment of our people development dollars in these emotional competencies that so often receive only lip service in business today.

This requires faith: the return on investment takes time. Why? Because many of our old habits are well entrenched, often since childhood. Many of these competencies are rooted deep in our personality. Yet, we know they hold the key to individual performance and effectiveness. What Daniel Goleman has done is move us one step closer to that question we must eventually answer in management training: Can we, in fact, develop strong performers without addressing the human psyche itself? Worth a read!

Ian Cook, presenter and consultant, is an expert in assisting managers and supervisors build strong teams and get more from their employees through modern leadership approaches. He can be reached toll free at: (888) FULCRUM (385-2786) or ian@888fulcrum.com.

ABSTRACT:

Daniel Goleman's phenomenal New York Times bestseller, *Emotional Intelligence*, added a new phrase to our daily vocabulary and fundamentally changed the way we perceive personal excellence. Now, in a book sure to revolutionize how we approach our careers - and how businesses understand their crucial priorities - Goleman redefines the yardstick for success at work.

Drawing on his unparalleled access to business leaders around the world, as well as on studies conducted in more than 500 organizations, Goleman

reveals the skills that distinguish the star performers in every field. From entry-level jobs to top executive positions, the single most important factor is not IQ, advanced degrees, or technical expertise. It is emotional intelligence.

Self-awareness, self-confidence, and self-control; commitment and integrity; the ability to communicate and influence, to initiate and accept change. Goleman demonstrates that these competencies are at a premium in today's job market. The higher up the leadership ladder you go, the more vital all aspects of emotional intelligence become, often determining who is hired and who is fired, who is passed over and who promoted.

Star performers stand out not only by personal achievement but by their capacity to work well on teams and with people. Those who are isolated or explosive - unable to manage change or conflict - can be toxic to the entire organization.

The good news is, as the latest research into human behavior and brain science proves, we all possess the potential to improve our emotional intelligence - at any stage in our career. Goleman provides specific, scientifically grounded guidelines for cultivating these invaluable capabilities - and also explains why so much conventional corporate training is a waste of time.

Working with Emotional Intelligence is a book sure to change the shape of business organizations - and the attitudes of those who lead them - for decades to come.

ADMINISTRIVIA

The following is a guide on the process for article/briefing/poster submission.

1. First line supervisor reviews the document and applies edits for grammatical and context review.

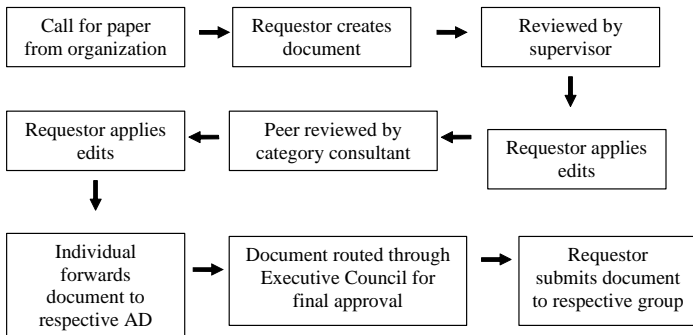
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2. Based on the category, document is routed to the appropriate consultant for “peer” review and edits (i.e. Mental Health, CDR Cadavid, Nursing, CDR Belsito).
3. Document is forwarded to the respective Branch Associate Director who will review and route through the Executive Council for final approval.

A cover memo should be attached to detail the specifics of the requesting authority

- Name of meeting/publication
- Anticipated audience
- Deadline for submissions (we will make all efforts to expedite the process, given that some organizations have very short deadlines)
- Any other pertinent information



NOTE: Prior to committing DIHS, you should always check with your chain of command.

Should you have any questions, please contact LCDR Jean Pierre DeBarros at 202.732.0011 or jeanpierre.debarros@dhs.gov .

**Executive Committee
Discussion of CaseTrakker**

(submitted by LCDR Elizabeth Osborne)

The Executive Committee met to discuss the issues that have been raised concerning the performance of the CaseTrakker system. This article summarizes the

discussion and decisions made.

CaseTrakker Performance Testing

Although performance at most sites has never been good, it has seriously degraded since the beginning of December, when both Krome and San Diego started using the system. Both sites were brought into replication in December. This increased the amount of data sharing that was being performed.

The IT Group executed a performance test of the eMR system using Pearsall and Houston as the models. These sites were chosen because Houston does not experience performance issues and Pearsall continually experiences performance problems. The only difference in the sites is the fact that Pearsall is a part of replication and Houston is not.

During the performance testing, all equipment at Pearsall was shut down. The servers were brought back on line and software was used to monitor the performance of the servers and network.

Then CaseTrakker was started on one system and the monitoring continued. What we saw was that once CaseTrakker was started, the performance of the SANS, where the database is stored, degraded and SQL Server (the database system) started performing 300 data reads and writes per second.

This heavy SQL activity continued for 10 minutes after CaseTrakker was started. No actions were being taken on CaseTrakker with the exception of the login.

Discussions with Microsoft and SQL experts explained that when a database is replicating, it is constantly preparing for the next moment when it will share data. We took this

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information and looked closely at how Houston performs when multiple users are actively using CaseTrakker versus Pearsall when there is no activity.

What we discovered was that 65% of the data in a CaseTrakker database at a replicating site was non-eMR data. It is data that SQL maintains in order to perform replication when replication is turned on. Writing and managing this data puts a strain on the SQL Server and SANS, resulting in poor performance of the eMR, even when replication is shut down. Shutting down replication would improve performance of the eMR. However, there is a need for a centralized database for data analysis and archival purposes.

CaseTrakker Upgrades

Upgrading CaseTrakker requires that actions be performed on 16 servers (2 in HQ and 14 field sites). The process takes at least 8 hours and is usually scheduled for a weekend to reduce the impact on operations and improve the chances of the upgrade going smoothly.

Whenever we upgrade the CaseTrakker system, the eMR becomes unstable for 2 weeks: users can't log in, some screens are missing data, and some reports stop working. In our discussions with Microsoft and SQL experts, we discovered that SQL replication will delay some activities if it is busy.

When we upgrade CaseTrakker with a new configuration, we first delete the old configuration and then add the new one. SQL Replication may delay some of the deletes or adds to be performed at some point later. It appears that SQL does finally complete the activity within 2 weeks, because on the 3 occasions that we have sent out a new version, the system became stable after 2 weeks.

The latest upgrades to CaseTrakker will require that we upgrade the CaseTrakker system to version 3.5 as well as push out the new configuration of changes that we have made.

Both of these changes will cause problems because

they are handled by replication. It is feared that these changes will generate more issues than the IT Staff can handle given the current level of support requests due to poor performance of the system. The result will be an unstable eMR system and outages at the sites.

CaseTrakker Alternatives

A Request for Information (RFI) was released 2 years ago to obtain information about eMR and Managed Care products that were commercially available. We received over twenty responses, but some were unable to meet all of our requirements. When the Request for Proposal (RFP) was released, only 5 vendors responded. Two vendors could only support the Managed Care portion, one vendor proposed custom development of the system, and two proposed using their systems and customizing them to meet DIHS needs.

One of the latter solutions would not allow us to make future modifications and was 5 times more expensive than CaseTrakker. Custom development is costly and difficult to maintain, so that option was discounted. The result was the selection of the CaseTrakker system.

If we performed a similar RFI/RFP process today, it is anticipated that the results would be the same. If we changed some of our requirements, we would probably identify other eMR options. In addition, we have not explored the use of the VA VISTA system. This system is free to government entities and would allow us to make any required changes.

IT Support

The original contract for IT Support included only 12 sites and 150 users. DIHS has

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grown to 14 sites and approximately 400 users. In addition, the eMR application was added, which also required more computer equipment and more user support. Although many IT Support functions have been automated, we have not been able to improve the support provided to users and have seen some increase in system outages. The system outages are mainly due to the lack of proactive maintenance of the systems. The IT Staff is consumed with handling problems and does not have the time to perform proactive maintenance or monitoring of the systems to prevent outages.

The options for improving IT Support are to increase IT staffing or decrease IT responsibilities. The existing IT contract does not allow for expansion. In addition, the IT budget to support additional staffing would strain DIHS funding.

Therefore, the remaining option is to decrease IT responsibilities. This can be done by centralizing all of the services so that systems can be shared. This would reduce the number of systems that IT would have to support.

Centralization

Centralization allows distributed systems to be brought together to provide services from a central location. There have been several case studies on this and Microsoft centralized their support operations recently. When Microsoft closed over 200 sites and centralized at 6 regional facilities, they decreased their systems by 75%. Decreasing the systems that have to be maintained will allow DIHS to reduce the strain on IT support staff.

To centralize our operations, all applications would be run from HQ with a disaster recovery site in Houston. All email would be centralized, reducing the need for an email server at each site. CaseTrakker would be accessed remotely using CITRIX, the same software used to access DACS and CORE. That would eliminate the need for the eMR and database servers at the

field sites. In addition, there would be no need for the SANS at all sites. The extra equipment would be pulled to HQ and a backup data center in Houston. The servers would be clustered so that several servers could serve the same purpose. With clustering, users are connected to the server that is least busy so that the user receives the best performance available. In addition, centralizing the eMR would give all sites access to all data at all times, without using replication. The data in HQ and Houston would be kept in synch using hardware-based synchronization software. This would not generate the additional data or read/write operations that are created by SQL.

With clustering, the 71 servers currently owned by DIHS would not all be needed. DIHS could reduce the number of servers used and maintained by the IT Staff. In addition, when one server is taken off-line for maintenance, the other servers take its place. Therefore, users would not be aware of a server being taken down.

Centralizing operations would reduce the amount of equipment required and maintained by the IT Staff, would provide better performance for users, and would reduce the number of

Decisions

The EC made the following decisions:

1. Replication would be terminated immediately.
2. A plan would be developed for moving to a centralized solution.
3. We would have a vendor come in to demonstrate the VA system as a possible alternative to CaseTrakker.
4. Once replication is shut down, the modifications to the CaseTrakker system will be deployed. A plan will be distributed to identify the changes made and the schedule for the upgrades. In addition, several training sessions will be presented on how to use the new CIPS and Infectious Disease capabilities.

AFFILIATION AND ACCREDITATION

By LCDR Jean Pierre DeBarros

Board Certification is an important aspect of professional proficiency in your specific category.

As it relates to health care administration, board certification is vital in demonstrating proficiency in the area of health care management. It is an expectation of HSAs, AHSAs and any other health services officer with a degree in health services administration.

By the same token, any officer aspiring to attain and retain a position as a health services administrator is expected to demonstrate proficiency in the field of health care administration. One of the avenues to maintain proficiency is through a professional affiliation and becoming board certified.

Affiliation is as simple as completing a membership form. Through affiliation, you gain entry to a network of health care administrators, either at the national or local level. Accreditation generally involves proving proficiency in the field of health care administration via a multiple choice test and answering a few essay questions. Successfully completing the exam earns you the title of 'accredited' for the next 3 years, at which point you need to renew your accreditation, committee memberships, literature reviews, presenting a session, etc.) in the field of health care administration within that 3-year period. In addition, accreditation entitles you the use of a suffix (i.e. CAAMA, CACHE, etc.) following your name.

The top four associations are the American Academy of Medical Administrators (AAMA), the American College of Health Care Executives (ACHE), the Medical Group Management Association (MGMA) and the Healthcare Information and Management System Society (HIMSS). I have been a member of AAMA since 1999 and have been accredited with them since 2002. I have attended conferences for AAMA and MGMA.

All these associations have their one respective merits. AAMA and ACHE prove beneficial to those interested in more of the macro-operation of health care administration while MGMA brings its teachings and guidance closer to operations at the middle-management level. MGMA offers great lessons-learned and best practices within their annual program. HIMSS is strictly focused on the facet of technology within the health care industry.

Affiliation/accreditation demonstrates your serious intent of becoming and maintaining your status as a health care administrator. This weighs heavily during the decision process for selection to HSA positions. Once promoted to the position of HSA/AHSA it is beneficial to you and DIHS that the officer pursue affiliation/accreditation.

Many of us within DIHS are ready to discuss with you any of these organizations so that you can weight your options.

Professional Board Certification and National Certification Examinations:

American Academy of Medical Administrators (AAMA)

<http://aameda.org/>

<http://aameda.org/ProfAdvancement/professionaladv.html>

American College of Healthcare Executives (ACHE)

<http://www.ache.org/aboutache.cfm>

<http://www.ache.org/membership/AdvtoDiplomate/advtodiplomate.cfm>

Medical Group Management Association (MGMA)

<http://www.mgma.com/>

<http://www.mgma.com/membership/ushome.cfm>

Healthcare Information and Management Systems Society (HIMSS)

<http://www.himss.org/ASP/index.asp>

<http://www.himss.org/ASP/CertificationHome.asp>

The individuals identified on the following table have been selected to serve as the primary responsible individual for addressing the topics or areas raised at the 2006 Houston Leadership conference. A designation as lead or POC is not meant to imply these individuals must complete this task in isolation; we are encouraging everyone in the Division to review the topics and contact the POC to offer assistance on any topic you have an interest or expertise in. Almost every attendee from the conference expressed a willingness to assist in resolving/addressing these issues – so please step up and contact the POCs! **The overarching goal is to have ALL topics/issues resolved within 6 months (July 28, 2006).**

Topic	Prioritization (High, Med, Low)	Timeline (30 days, 3 months, 6 months)	Lead Individual / POC
Travel	H	Prior to Feb 28	Bramante
Communication - including Streamlining Policy/procedures	H	3 months	Downs
Several topics combined due to inter-relationships: <u>Staffing model</u> , vacancies, medical escorts/TDY, CCRF (all resource allocation and utilization focused)	H	3 months	Jarres
Nurse Manager Role	H	3 months	Belsito
Short Stay Units (SSU)	H	3 months	Shack
Emergency COOP	H	30 days	Hochberg/Falzini
Strategic Management System /Plan	H	3 months	DeBarros
Mental Health	Med-H	3 months	Cadavid
Best Practices	Med-H	6 months	D. Warner
Space – Infectious Detainees	Med-H	30 days	Belsito
EMR/Casetrakker	Med-H	3 months	Magtibay
Website	Medium	3 months	DeBarros
Areas of Responsibility	Medium	30 days	Downs, Shack, Jarres, Osborne
Accreditation	Medium	30 days	Bowling
Analysis unit	Med-Low	30 days	Wulu
Recognition / Awards	Med-Low	3 months	K. Brown
Standardize tours of facilities	Low	3 months	OD

30 days: March 10, 2006
3 months (or less): May 5, 2006
6 months (or less); July 28, 2006