

THE RAPID PULSE

July 2006

Faces & Places

WELCOME

Florence, AZ:

Ms. Cindy Walton-Sparks

FAREWELL

Batavia, NY:

Ms. Debra Pope

Florence, AZ:

Ms. Marisol Binguochea
Mr. Bill Stahlberg

El Centro, CA:

CDR Walter Moore
(retired after 30 years
with PHS!)

Houston, TX:

Ms. Samara Johnson

THE DIRECTOR'S PERSPECTIVE

By Dr. Gene Migliaccio

Welcome to another installment of *The Rapid Pulse*.

As I'm sure you all gathered during our most recent conference call, this is a very exciting time for DIHS, as we continue to expand our services and operations.

DIHS will have a critical role to play in President Bush's Secure Border Initiative (SBI).

The SBI is a comprehensive approach to immigration enforcement, focusing primarily on two major enforcement themes: 1) controlling the border and 2) immigration enforcement within our country.

One of the goals of the SBI is to end the "catch and release" of non-Mexican illegal aliens. Because DHS does not have enough facilities to hold all of the aliens that are caught illegally entering our country, some aliens must be released on bond and introduced to society.

One of the remedies to this problem is for DHS to expand the capacity of its detention system by bringing more "beds" online, along with the appropriate staff, in order to detain

aliens until their removal. This is where DIHS will play a vital role.

By October 1 of this year, there will be six or more new detention facilities, along with an additional 7,000 beds.

DIHS is preparing to staff these new facilities promptly with dedicated administrators and medical providers. We want to ensure we have the right staff mix to meet the complex and unique needs of the detained population.

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LENGTH OF SERVICE SPOTLIGHT: CAPT DON BROWN

By CAPT Don Brown

I view my change in 1992 from retail pharmacy to the Commissioned Corps of the Public Health Service as the most fortunate change in my career. After graduating from the University of Oklahoma, I worked as a retail pharmacist for several years. A few years into my career, most of this country's healthcare made a major shift towards third party reimbursement.

Because I wanted to use my professional knowledge for patient care instead of spending more and more time doing clerical duties related to third party reimbursement, I began searching for options to leave retail pharmacy. I was accidentally introduced to the existence of the Commissioned Corps of the United States Public Health Service by a pharmacy extern from Bangladesh. The rest, as they say, is history.

I went to work as a Civil Service staff pharmacist with the Federal Bureau of Prisons at the Federal Correctional Institute in El Reno, OK while waiting for acceptance into the Commissioned Corps. In January 1992 I put on the Commissioned Corps uniform and have never looked back.

As a newly commissioned LCDR, I worked as a staff pharmacist and later as a senior pharmacist in the El Reno facility. The facility operated a federal correctional institute, a federal prison camp, and a transfer center. Approximately 60,000 federal inmates were processed through El Reno each year.

Opportunity knocked again when I was selected as chief pharmacist at the INS Service Processing Center in El Centro, CA. I served there until the chief pharmacist position in Florence, AZ opened.

A year and a half after transferring to Florence, the HSA transferred from there, and I applied for the HSA position. I served as Florence HSA for over two years until taking on DIHS consultant responsibilities in January 2000.

Since that time I have held a variety of temporary and permanent titles. I am one of a relatively small number of Division employees that has traveled to every DIHS facility to fulfill my duties. Currently, I am both the Division's national pharmacy consultant and the national telehealth project manager.

As the telehealth project manager, I have guided the growth of the teleradiology program from four to ten facilities, with a ten fold increase in X-ray volume. I am currently coordinating movement of teleradiology systems to new locations at our facilities in Krome, Port Isabel, and LA Staging-Santa Ana.

My latest project in telehealth is initiating telepsychiatry. A pilot project was instituted which allowed the DIHS psychiatry consultant, Dr. Cadavid, to treat patients at the Florence, AZ facility while he remained at the Krome, FL facility via live videoconferencing. A variety of improvements have been made in this initial system and the Division is currently beginning its rollout of high quality videoconferencing with systems in Krome, El Centro, San Diego, and Washington, D.C. This system will be expanded to other sites and will be available for selected usage in addition to treatment of mental health issues.

In 2001, I was selected as DIHS pharmacy consultant. My varied duties include chairing the DIHS National Pharmacy and Therapeutics Committee, reviewing national policy and SOPs, revising the DIHS Pharmacy Talking Paper, maintaining pharmacy statistics for the Division, and assuring that new pharmacists receive proper training and orientation.

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I have made several presentations at annual meetings of the Commissioned Officers Association and the American Telemedicine Association. My most recent presentation was “Teleradiology- Securing our Border from a Deadly Killer” at the April 2005 American Telemedicine Association annual meeting.

I have had the opportunity to deploy both within and outside of the United States during my time with DIHS. In 2001, I deployed as a pharmacist to Washington, D.C. in response to the anthrax bioterrorist attack. In 1999 I deployed in both pharmacy and managerial roles to the Commonwealth of the Northern Mariana Islands for several weeks in support of medical care for detained Chinese migrants.

During my career with DIHS I have had the opportunity to fill many roles for varying periods of time (days to years), in addition to my regular duties. These include acting DIHS chief of staff, acting DIHS chief HSA, DIHS Emergency Medical Response Team member, DIHS Strategic Planning Team member, DIHS Balanced Scorecard Workgroup member, DIHS National Performance Improvement Committee member, DIHS Jail Management Services Audit Team member, OMB Circular A-76 Performance Work Statement Team leader, OMB Circular A-76 Source Selection Evaluation Board team member, HRSA PharmPAC alternate member, grant reviewer for the Office for the Advancement of Telehealth, DHHS Antimicrobial Resistance Task Force member, Operation Thunder Road (to assist federal law enforcement initiative in southern Florida), South Florida Mass Immigration Exercise, Southern Arizona Mass Immigration Exercise, and Florence INS Tactical Intervention and Control Team member.

I actively participated in developing the standardized DIHS clinic design and the listing of furniture, fixtures and equipment for this standardized design, and was actively involved in the preparation and opening of every new DIHS facility that has opened in the last four years.

In my personal life, I enjoy outdoor activities and emergency radio communications. Until my son earned the rank of Eagle Scout last year, I was actively involved as a Boy Scout leader and have backpacked over much of Arizona. I am also known as KD7RQK and am an active member of the Pinal County Emergency Communications Group. I am licensed to operate on both HAM radio and General Mobile Radio Service frequencies.

Editor’s Note: In our “Length of Service Spotlight,” we will profile DIHS staff (Commissioned Corps and civil service) with five or more years of service to the Division! So, if you have been with DIHS more than five years and want to write about your experience, or you want to shine the spotlight on someone else with five or more years of service to DIHS, please feel free to submit an article to The Rapid Pulse!

Literature Review: “Evidence-Based Management”

By Dr. Timothy Shack

For those who attended the DIHS 2006 Senior Leadership Symposium in Houston, you may remember my excitement over an article entitled “Evidence-Based Management” (Jeffrey Pfeffer and Robert I. Sutton, *Harvard Business Review*, vol. 84, No. 1, p 65-74, Jan. 06). I referenced this article as the first time that I can remember that a medical practice model was cited as inspiration for a business practice model. In the best of health care environments, decisions regarding patient care are made using information from research that is soundly conducted and clinically relevant. “Evidence-Based Management” argues for leaders and managers to adopt a similar decision-making process for business decisions.

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Evidence-based medicine (EBM) is a prime example of total quality management applied to health care, where the medical decision-making process is examined as a system for improvement. The process includes: (1) clearly defining the question to be answered (to include the outcome to be achieved); (2) compiling and evaluating the available evidence; (3) deciding what evidence best relates to the case at hand; (4) assigning greater weight to evidence from well-designed studies; (3) evaluating the results of the decision by measuring the outcome of the decision against the pre-decision expected outcome.

The goal of EBM is for the healthcare professional to make “conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients,” according to the Centre for Evidence-Based Medicine (www.cebm.net). An example of EBM in practice is the Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents, dated May 4, 2006. The guidelines grade the quality of medical evidence available for each recommendation. In addition, a rating is given as to the strength of each recommendation. The use of this type of rating scheme following the evaluation of medical evidence has greatly simplified the decision making process for providers who care for patients with HIV. The availability of these guidelines on-line to the public has also greatly enhanced the dissemination of this important information. (The guidelines are available at <http://AIDSinfo.nih.gov>).

Evidence can also simplify decisions by removing unfounded or unproven logic from the decision-making process. Too often, closely-held beliefs and traditions are used as the basis for a decision, when evidence would provide a better answer. In *Blink* by Malcolm Gladwell, the story of Dr. Lee Goldman illustrates how decisions based on the meticulous, scientific study of a problem can lead to a simpler and better process. The “Goldman criteria”

use only three variables to evaluate patients with chest pain to determine which patients are at the highest risk for myocardial infarction, challenging the long established practice of taking a detailed history, performing a physical examination, and consulting with a cardiologist. Although years of knowledge and experience can not be replaced by a simple algorithm, by clearly defining the question at hand and the desired outcome, and then rigorously seeking the evidence for the decisions, Goldman improved the timeliness and accuracy of clinical decisions.

Medical evidence is somewhat easier to measure (qualify and quantify) than management evidence, primarily due to the basis of medicine in science. Management systems contain more intangible elements than medical systems, or at least are less well studied and defined. A good attempt at creating evidence for business management is the book *Good to Great*, where Jim Collins attempts to apply scientific principles to answer the question of how a business can go from good to great performance. Collins first frames a specific question to be answered, then applies rigorous research to find and rate the evidence (see Appendix 1.D of *Good to Great*). In the process, he debunks several unfounded beliefs. For example, Collins expected to find a correlation between the executive compensation system and making the leap from good to great. Instead, he found that, “The evidence simply does not support the idea that the specific structure of executive compensation acts as a key lever in taking a company from good to great.”

The article “Evidence-based Management” offers some examples of evidence for management decisions. To follow onto the above example from *Good to Great*, Pfeffer and Sutton state that, “There is, in fact, little evidence that equity incentives of any kind, including stock

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options, enhance organizational performance.” They then cite a study from Dan R. Dalton and colleagues from Indiana University which reviewed more than 220 studies and concluded that equity ownership had no consistent effect on financial performance. Another example of evidence for management practice comes from a study done at the University of Missouri which compared decision-making groups that stood up during ten- to 20-minute meetings with groups that sat down. Those that stood up took 34% less time to make decisions, and the quality was just as good. Although we were not aware of this study at the time, the Director and the Associate Directors meet each workday morning at 08:30 AM for a fifteen minute stand up meeting to review significant issues. The evidence has confirmed what we assumed to be a good management practice.

Practitioners of evidence-based management must be aware of some pitfalls. First, for both medicine and management, lack of evidence and lack of benefit are not the same. Even without evidence, decision-makers must use their experience and skill to good effect. Second, as more data are pooled and aggregated, it becomes more difficult to compare the questions answered in the research to the questions needed to be answered by the decision-maker at a particular moment. Finally, although I see this last point as an opportunity rather than a pitfall, Pfeffer and Sutton state that, “Leaders who are committed to practicing evidence-based management also need to brace themselves for a nasty side effect: When it is done right, it will undermine their power and prestige, which may prove unsettling to those who enjoy wielding influence.” They go on to state, “Facts and evidence are great levelers of hierarchy. Evidence-based practice changes power dynamics, replacing formal authority, reputation, and intuition with data.”

Despite these pitfalls and the paucity of science behind most business decisions, leaders who practice evidence-based management will make better deci-

sions. These leaders will ask for evidence of efficacy when a change is proposed. They will take the time to discuss the logic behind a decision. They will become, and demand others to become, more disciplined in thinking about problems and decisions. They will reward experimentation and the learning that results from the experiment, even if the experiment fails. They will keep learning while acting on the best knowledge. “An emphasis on evidence-based decision making in a culture that reinforces speaking the truth about how things are going is certainly another crucial component [to success].”

A Day in The Life of a DIHS Clinical Director

By CAPT Abelardo Montalvo, M.D.

Editor’s Note: Have you ever wondered what it would feel like to step into the role of a clinical director (CD) in DIHS? Ever wondered what a “typical” day was for one of our CDs? Well tune in...as we take a look at a day in the life of Clinical Director CAPT Abelardo Montalvo, M.D...

0745-0800

Arrive to work, sign for keys, report to the triage area, check which staff members who are assigned to the shift, review special appointments for new arrivals with chronic medical conditions.

0800

Begin the Short Stay Unit morning report. All admitted cases are reviewed. Any pertinent changes in the treatment plan are discussed. Afterwards, I also perform my daily rounds and examine and discuss the treatment and possible discharge plans with the patients.

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0830

I return to my office, review my emails, and take care of those requiring immediate attention. Then, I review the “charts review pending review” in the EMR and organize my appointments for the day. I review any other documents needing my signature and I may meet with the HSA, as needed, to discuss clinic, patients, and operational issues.

0900

About this time I usually begin patient evaluations. The first 3-4 hours of the clinic are dedicated to direct patient care and to discuss with the staff any questions they may have. I select the most complicated cases as soon as possible after their admission to Krome. I alternate new patients with patients already known in my clinics. We also see all new arrivals with chronic conditions early so they can receive their medications before COB.

An example would be a 30 year old newly diagnosed HIV patient meeting all the criteria to initiate antiretroviral treatment, scheduled to return to his country in two weeks. After obtaining a medical history I complete the physical examination, explain all laboratory results, and counsel him about therapeutic options, drugs side effects, and continuity of care. After weighing benefits vs. risk, we agreed to hold any treatment until he returns to his country. Once there he will evaluate the resources available and will coordinate with his physician on a realistic treatment plan.

1100 hours

The nurse performing sick-call approaches me to request that I evaluate an eight year old male patient, in the Processing Area, who appears sick and has a 102° F fever. I walk to Processing and find that there are between 20 and 30 new arrivals held in two large cells. All ICE officers were busy. I request to see the child and I am escorted to a room behind the counter. There are two scared adolescents on a bench with a middle age female and a child lying on the other bench, covered with a white

blanket. All appear scared and distrustful. I introduce myself and talk to them in Spanish. They appear to lose their fear and begin to ask questions about my uniform and equipment. After completing their evaluations I resolved the child’s problem with OTC’s from our pharmacy. The family was transferred to the Hotel a short while later.

1200 hrs

After a light lunch, I take care of the remaining emails and complete several administrative tasks. At this time of the day, the patients are having lunch in the kitchen facility

1300 to 1600

The last hours of the day are dedicated to complete all patient evaluations and appointments of patients with chronic care conditions, routine physical examinations, and remaining sick call cases. At 1500 hours the change of shift takes place and all available staff participates.

After the change of shift, as I am about to go home, I am approached by an OIG investigator. He had received authorization to review a medical case of a patient with a complaint about the medical services. After consulting with the HSA, we proceed to evaluate the case. It was a 40 year old male wanting surgery to repair a hernia. He had been evaluated in the clinic on multiple occasions and there was documentation of prior orientation. I addressed the services covered under the Benefits Package.

I was finally able to leave the facility around 1800 hours. In the parking lot I receive a call on my cell phone. The nurse on duty notifies me of a new arrival whose chest x-ray was abnormal with suspected active tuberculosis. The patient was placed in respiratory isolation to initiate the appropriate medical interventions.

I hope this provides the readers with a snapshot of a typical day in the life of a clinical director.

Procurement Quiz Answers

By LT Jimmy N. Lee

1. The IMPAC card should be used whenever possible for any services and supplies needed in the day-to-day operation of DIHS.

- a. True
- b. False**

The IMPAC card is subject to small purchase provisions established in the Federal Acquisition Regulations (FAR), HHS and HRSA regulations. The IMPAC card should only be used for mission essential services and supplies. All IMPAC cardholders must obtain written authorization from the DIHS Approving Official prior to each transaction.

2. Micropurchase means an acquisition of supplies or services that do not exceed \$2000.

- a. True
- b. False**

Micropurchase refers to acquisitions that do not exceed \$2500. Purchases that fall within this threshold may be paid with the IMPAC card. Purchase orders or calls against blanket purchase agreements are needed when the request for supplies and services exceed the \$2500 micropurchase threshold.

3. The act of approving an unauthorized commitment by an official who has the authority to do so is called:

- a. Modification
- b. Ratification**
- c. Amendment
- d. Constructive change

Ratification is the process of approving an unauthorized commitment. An “unauthorized commitment” means an agreement that is not binding solely because the Government representative who made it lacked the authority to enter

into that agreement on behalf of the Government.

4. _____ are authorized to enter into an agreement of behalf of the Government.

- a. Health Services Administrators
- b. IMPAC cardholders
- c. Program managers
- d. None of the above**

The Contracting Officer (CO) is the only official authorized to enter into, administer, and terminate contract agreements.

5. The individual responsible for an unauthorized procurement may be legally and financially liable and subject to disciplinary action.

- a. True**
- b. False

All procurements must comply with the FAR guidelines and criminal penalties may be imposed for certain serious violations. Cardholders are responsible for the security of their IMPAC card and should not give out their card number except when placing oral / telephone orders since this could lead to misuse and personal liability.

6. Formal contracts are not needed for recurring requirements for services such as recurring maintenance services, interpreting services, and parking services.

- a. True
- b. False**

Recurring service refers to a requirement that is needed on a month to month or quarterly basis. No matter how small the dollar amount is for the requested service, a formal contract is needed with the preferred vendor. The IMPAC card should not

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be used to pay for any type of recurring service. However, the IMPAC card may be used to replenish medical and office supplies that are needed on a recurring basis.

- 7. The official document that identifies specific goods and services is called a _____
 - a. Standard Form 1034
 - b. HHS 393**
 - c. OF 612
 - d. DD 214
 - e. 1040 EZ

The HHS 393 is the official document used to identify specific goods and services. It initiates the preparation of the solicitation and sets the acquisition process in motion.

- 8. Purchase requirements under \$100,000 are called _____
 - a. Negotiated acquisitions
 - b. Simplified acquisitions**
 - c. General acquisitions
 - d. Equity acquisitions

“Simplified acquisition” refers to the purchase of supplies and services between \$2500 - \$100,000 dollars. It is very important to be clear with your requirements since all purchases under \$100,000 must be made as firm fixed price-purchase orders. This means that the price agreed to in the purchase order “IS” the price. If the offeror spends more money than agreed to, they will not get reimbursed. If the offeror spends less, the Government does not get reimbursed.

- 9. An agreement used for filling anticipated repetitive needs for supplies and services is called a
 - a. Interagency agreement
 - b. Fixed price agreement
 - c. Competitive agreement

d. Blanket purchase agreement
Blanket Purchase Agreement (BPA) is a simplified ordering tool to satisfy recurring requirements. BPAs are set up by many government agencies in order to streamline ordering procedures and to establish buying power through quantity discounts and volume purchasing.

- 10. What information must be submitted to DIHS HQ to be considered adequate for processing a requisition above the micro-purchase dollar threshold?
 - a. Specifications
 - b. Three vendors
 - c. Price quote from government representative
 - d. Point of contact information
 - e. All of the above**

In order to avoid delays in the procurement process, “all of the above” should be provided to DIHS HQ. In addition, any requisition for supplies or services over \$2500 must be submitted and approved as a line item on the DIHS and HRSA Procurement Plans.

Director– From Front Page

DIHS is preparing to staff facilities in Texas, Arizona, Ft. Stewart, Georgia and Denver, Colorado. In all, DIHS plans to hire an estimated additional 115 commissioned officers and 120 contract staff over the next few months.

Because of the magnitude of this challenge, we will TDY some staff to assist with facility start-ups. We will ask others to accept a Permanent Change of Station (PCS). I have no doubt that we are prepared for the challenges ahead. It will be an exciting time for the Division.

YEAR-END CLOSE-OUT

By LCDR Jean Pierre DeBarros

Greetings from our nation's capital. We find ourselves in that critical period of our operational fiscal year: the 4th quarter.

As in football, this the one everyone is watching... every engagement beyond this point is being closely monitored while everyone is looking to get in the game for a piece of what's left.

Well, our pie all of sudden just got a whole lot smaller. As the Director stated in this issue's opening article, we have a daunting task ahead of us with the opening of eight new sites.



For a finance officer, I am well aware that I have now become everyone's best friend while everyone tries to dodge any reprogramming of funds. The truth is that with a well versed execution plan, the doldrums should be seamless.

The key is communication, and the Management and Budget Branch is making a strong effort to ensure you are aware of all facets of the year-end close-out.

First and foremost is the salaries and benefits object class. This account is preloaded with enough money to get us through the year as this is the livelihood of our most important asset and is never touched, modified or reprogrammed unless we actually call for more funding.

The other object class of significant importance is the object class which ensures that our contract partners get funding so as to provide for the welfare of their staff and families.

This year, the 4th quarter travel budget will have to

be considerably modified. The three previous quarters have been challenging in respect to travel support for Hurricanes Katrina and Wilma.

This object class will experience a fourth quarter like it never has before. We plan to travel 44 staff members (38 to Harlingen, TX and six to Taylor, TX) over a period of 72 days at an exasperating estimated cost of \$1.7 million, in support of the aforementioned initiatives.

The equipment and supplies object class is faring well, though we have not expensed nearly as much as we actually budgeted for. For the coming fiscal year, HQ and the cost center managers will focus on many of these topics.

My goal for the coming fiscal year is to establish a decentralized mechanism whereas cost center managers will be assigned to each facility. This individual will be responsible for keeping the pulse of their local entity's fiscal soundness to include all services within that service processing center.

One of the immediate initiative is the implementation of an equipment review board to ensure that all requests for equipment are filtered through the review of a board that will determine the prioritization of equipment purchases based on the needs of the mission at that point in time.

Another initiative soon to be launched is the implementation of a mechanism for sharing "best practices." More to follow on this soon.

The Management & Budget Branch financial and travel teams stand ready to serve you and the critical mission you tackle everyday.