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After years of waiting, health care finally has a Baldrige winner!

'Quality journey' at SSM Health Care has taken years, hard work

Until this year, no health care organization has captured the coveted Malcolm Baldrige National Quality Award (MBNQA), the top honor a U.S. company can receive for quality management and quality achievement.

Now, however, all that has changed. SSM Health Care (SSMHC), a St. Louis-based not-for-profit health system, has become the first health care organization in the country to be named an MBNQA winner.

The award is presented each year to as many as three organizations by the U.S. Department of Commerce, and is administered by the Baldrige National Quality Program, National Institute of Standards and Technology in Gaithersburg, MD.

"The reality is that this is probably the most gratifying experience of my life, and that has become more and more clear with the tremendous response we have had [for being the first health care winner]," says **Sr. Mary Jean Ryan**, FSM, president/CEO of SSM. "The expectations for us as an organization have been raised, and the task for us now is to live up to that."

Baldrige award winners are considered role models, she notes, "and in my weaker moments that has scary dimensions to it."

"Certainly, the judges have been cognizant of the fact that the

Key Points

- SSM Health Care was not an "overnight success;" quality journey has taken many years.
- Health care faced unique challenges in competing with industry.
- Baldrige standards helped SSM crystallize mission, goals.

education and health care sectors have been eligible, and that last year we selected three education recipients," notes **Joe Muzikowski**, chair of the Baldrige panel of judges and a judge for the past three years.

"A judge has to balance his objectivity along with this kind of hope of eventually getting a [health care] winner, but you can't go into the process rooting for one," he says.

Why not sooner?

Why has it taken so long for a health care organization to emerge as a Baldrige winner?

"This is the fourth year for eligibility," notes Muzikowski. "In the late 1980s, when Baldrige was first implemented, it took a few years for service firms to get a winner, while manufacturing's primary driver was losing competitiveness to foreign manufacturers." (The first winners were manufacturers.)

"I think there's a parallel here. Just as it took until 1990 to get the first service winner, it has taken longer for health care to understand the need to develop these standards. Manufacturing, which was in a crisis, saw the need. During the last few years, a lot of external light has been put on health care processes and improving outcomes," he points out.

"We've talked about [there being no health care winners] a lot as an organization, and I think there are several reasons," Ryan adds. "First, we do not have the luxury of making widgets. So, when we talk about processes, how many processes can we possibly have in health care?"

Also, she adds, health care has an unusual element no other profession has: physicians.

"This is a group with whom we work very closely, and with whom we want to continue to work closely, but they have no financial responsibility for our organization," Ryan observes. "I can't articulate all the reasons for that, but it's like having an outside group work with you that brings you customers, makes demands on you, but has no financial responsibility."

Add to that the realities of health care financing today, she says, and "those complexities cannot be mirrored in any other industry."

The long quality journey

SSM's journey to the Baldrige Award began in 1990, when it first began pursuing continuous quality improvement. "About 18 months later, the [Institute for Healthcare Improvement] asked me to be a keynoter at their '91 forum," Ryan recalls.

"From that point on, we have given probably hundreds of presentations around QI, and people have come in to talk with us about the things we do. We put ourselves out there and have always wanted to share what we learned — even if it was not complimentary," she adds.

SSM began to formally pursue the Baldrige four years ago, and was the first health care organization to receive a site visit. Ryan says SSM has used the Baldrige model over the past seven years to help achieve its mission.

"First of all, we looked at the criteria you had to

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SSM Health Care shares its best practices

As part of St. Louis-based SSM Health Care's (SSMHC) "Clinical Collaborative" process, physicians work with other caregivers, administrators, and staff to make rapid improvements in clinical outcomes.

Selection of clinical collaboratives occurs in alignment with system goals, such as improving patient outcomes and satisfaction and improving patient safety. SSMHC has undertaken six collaboratives involving 85 teams in 2002, up from 14 teams in 1999. The results for SSMHC's clinical collaboratives for patients with congestive heart failure and ischemic heart disease demonstrate levels that approach or exceed national benchmarks.

In addition, CARE PATHWAYS, protocols, and standing orders are used to outline a standardized plan of care for SSMHC's patients. These tools are designed with patient input and are intended to create partnerships with physicians to improve patient care.

SSMHC collaborative hospitals have maintained a high level of Coumadin treatment for patients who have congestive heart failure and atrial fibrillation to prevent blood clots.

More than 80% of SSMHC patients are on Coumadin treatment compared to the benchmark of 60%. Also, SSMHC has attained national benchmark levels of patients receiving lipid-lowering agents to decrease morbidity and mortality in patients who have suffered a heart attack.

AA Credit Rating

For the fourth consecutive year, SSMHC has maintained an investment grade rating in the "AA Credit Rating" category (published by the two national rating agencies — Standard & Poor's and Fitch). This rating is attained by less than 1% of U.S. hospitals.

The SSMHC systemwide "Healthy Communities" initiative was launched in 1995 to leverage the system's resources with those of the communities it serves.

SSMHC requires each of its entities to actively engage in one or more community projects such as free dental clinics and campaigns to reduce smoking and drinking among teens. It encourages and supports employees at all levels of the organization to participate on teams involved in identifying opportunities for community outreach.

In addition, SSMHC provides a significant amount of charity care to improve the health of the communities it serves.

Since 1999, SSMHC has exceeded its charity care goal of contributing a minimum of 25% of its operating margin from the prior year.

Currently, SSMHC is providing in excess of 29% of the previous year's operating margin to provide care to communities that are economically, physically, and socially disadvantaged.

SSMHC's Strategic, Financial, and Human Resource Planning Process (SFPP) is comprehensive and begins with the board of director's review of vision and mission statements and corporate planning's survey of the key participants from the previous year.

The process extends over a 12-month cycle and involves all of the organization's networks, entities, and departments. Three-year (long-term) and annual (short-term) planning horizons are used. System management sets and communicates systemwide goals to each entity and provides standardized forms and definitions to ensure a consistent format and alignment of plans with the system's overall goals.

Department goals are further cascaded to the employees, with individual "passports" reflecting individual goals that support the department goals.

Every three years during the SFPP, environmental scanning is used to identify and plan for potential customers, customers of competitors, and future markets. The scan includes market research, analysis of market share by product line, population trends, and an inventory of competitors, which includes their market share trends and competitive positions.

In addition, data from annual medical staff surveys, patient satisfaction surveys, physician contacts, literature searches, telephone surveys, and focus groups of competitors' customers are used.

SSMHC's share of the market in the St. Louis area increased over each of the past three years to 18%, while three of its five competitors have lost market share.

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SSMHC has established formal and informal listening and learning tools for former and current patients and their families; surveys are customized for each of the key segments.

Tools include:

- satisfaction surveys;
- market research;
- comment cards;
- complaint management system;
- patient follow-up calls;
- Internet response system.

In addition, SSMHC assesses potential patients and future markets through a variety of tools.

SSMHC uses an automated system to make clinical, financial, operational, customer, and market performance information available to all of its sites. For example, SSMHC makes data available to physician partners from any location via multiple devices, including personal computers, personal digital assistants, pagers, and fax machines. Connected physicians have increased steadily from 3,200 in 1999 to 7,288 in 2002.

SSMHC uses a continuous quality improvement (CQI) process design model to design its key health care, support, and business processes.

A CQI process improvement model is used to make improvements to existing processes. For example, employee satisfaction data, internal customer feedback, and outcome and in-process measures are used to facilitate rapid identification and correction of potential problems.

SSMHC tailors employee benefits to provide flexibility and respond to women employees who make up 82% of its work force.

The health system also offers:

- flexible work hours;
- work-at-home options;
- long-term care insurance;
- insurance coverage for legally domiciled adults;
- retreats;
- wellness programs.

Tuition assistance and student loan repayment programs are highly regarded as significant benefits differentiating SSMHC from its competitors. SSMHC's turnover rate for all employees has improved from 21% in 1999 to 13% as of August 2002.

SSMHC has maintained a continuous focus on increasing the number of minorities in professional and managerial positions. Minorities in professional and managerial positions increased from almost 8% in 1997 to 9.2% in 2001, considerably better than the health care industry benchmark of 2%. ■

meet before you could apply," she recalls. "We had a pilot program we used as a self-assessment. One of the things we did early on was to put teams around categories, in areas where we thought there were major gaps."

One of the things the teams discovered was that the system didn't have a single mission statement. "So, it came to us in one of those very defining moments that we needed a single mission statement," Ryan recalls. "We spent a year and a half with 3,000 employees working on it."

The end result was the following: "Through our exceptional health care services, we reveal the healing presence of God."

"We were very proud of it," she says. "But Baldrige replied, 'OK, how do you define *exceptional*? Your comparative data are about averages; you have to compare yourself to the *best*.' In other words, we had to find data to demonstrate exceptional clinical outcomes; exceptional patient, physician, and employee satisfaction; exceptional financial results."

To this day, she looks back on that challenge as one of the defining moments in SSM's history. "If you don't have a place to start, you never know how far you'll be able to go," she asserts.

A rigorous process

To actually win the award, SSM had to go through a rigorous process. First, all applicants had to submit a 50-page application.

"The lead judge and most of the panel go through this in excruciating detail," Muzikowski says. "You have a phone call with the team leader to clarify any issues."

He says four major questions are asked:

- What is different about this organization in person than what we saw on paper?
- What are the significant strengths that would be role model practices?
- What were the key vulnerabilities?
- What were the key strengths in results, or areas for improvement?

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"Results are critical, as they count for 45% of the total points," Muzikowski says. "We look at *systems* and the demonstration of synergy. That's the difference between a very good company and a winner."

He adds, however, that the process is about more than just naming winners; it's about sharing best practices as well.

"Last year, one comment I heard was from a manufacturing professional who said, 'Yes, we can learn from health care and vice versa.' Now that there's a health care winner, I hope we see the same thing now, with health care looking to share best practices," Muzikowski says. **(For a summary of SSM's best practices, see box, pp. 3-4.)** ■

Quality focus shining on corporate ethics

2003 questions from Baldrige reveal focus

With the recent spate of Wall Street scandals, perhaps it's not all that surprising that the Baldrige National Quality Programs 2003 Criteria for Performance Excellence will include new questions to reinforce the focus on corporate ethics. The questions are:

- How do you address the following key factors in your governance system?
  - — management accountability for the organization's actions;
  - — independence in internal and external audits;
  - — protection of stockholder and stakeholder interests, as appropriate.
- How do you evaluate the performance of your senior leaders, including the chief executive and members of the board of directors, as appropriate?
- What are your results for key measures or indicators of ethical behavior and of stakeholder trust in the governance of your organization?

In addition, health care applicants will be asked specifically if their performance results are made public. So, just what implications does this new focus have for health care professionals in general and, more specifically, for quality managers?

"Most health care professionals will see this as a compliance issue," says **Patrice L. Spath**, of Forest Grove, OR-based Brown-Spath & Associates.

"A lot of them have compliance plans, and part of those plans is business ethics. While there's been an uproar over [corporate accounting issues], health care professionals for the most part would be inclined to say that we had to deal with this several years ago in terms of Medicare fraud and abuse," she says.

These people would be taking too narrow a view of the issue, insists **Mary C. Bostwick**, with the Baldrige National Quality Program National Institute of Standards and Technology in Gaithersburg, MD.

"We think of it as a broader issue than, say, financial fraud," she asserts. "There are patient care ethics, such as what kind of information you have, how accurate it is, and how you safeguard confidentiality; there are community ethics — what do you give back to the community in terms of community health?"

David J. Nygren, PhD, leader of the corporate governance group for Mercer Delta Consulting Company in New York City, agrees. "Ethics involves not only compliance, but the principles that guide that behavior," he explains. "For example, you can't *just* be enforcing HIPAA [the Health Insurance Portability and Accountability Act]; that's not really the framework of ethics we are looking for."

Why should health care professionals be

Key Points

- Compliance just scratches the surface of a comprehensive ethics policy.
- Being true to your mission is a critical component of governance responsibilities.
- Quality managers play an important role in feedback, implementation.

concerned with ethics and governance issues?

"If you start with the assumption that all individuals at some point need health care, and given the vulnerability that people experience in treatment, you need to assure that beyond compliance you measure your performance against some standard of excellence that should be a fundamental governance concern," Nygren says.

"The role of any board is fidelity to the mission. If you are in health care, leadership must ensure there are procedures in place to guarantee integrity," he adds. "If you promise health and healing, and that patients will be well cared for, that has an ethical component — what you say should be what you do."

That's true as well in terms of fiscal responsibility, Nygren adds. "If you do anything that exposes the hospital to further risk, you could be exposing the hospital to [financial] liability," he says. "There has to be congruence between what you say and do — how you define ethics, and whether you are faithful to that definition."

Nygren consults to CEOs and boards of Fortune 500 companies around enterprisewide change and has been involved with health care for 25 years. From that perspective, he says, it is the board's responsibility to set policy, but it is the quality professional's responsibility to see that processes are in place that really ensure there is fidelity to those policies.

"Take, for example, increased risk factors," Nygren says. "From a quality standpoint, one thing you would try to do in ethics is minimize risk — around disclosure, insurability, and so on. Ethics policies that frame the proper policy response are essential for the quality manager to attend to.

"At the quality manager level is where you try to write policies and procedures that will be approved by the board, whether they deal with patient safety or with confidentiality," he explains. "These all are ethics issues that address building patient confidence, so that they feel safe and not at risk."

"We really believe that ethics starts at the top," Bostwick adds. "The role of the middle manager is not so much a leadership role as an awareness role, as well as one of information transfer. The quality manager is in an ideal position to be more instructive and to share information with a wider audience."

Spath agrees. "The ethics of an organization are usually driven by the attitude of its leaders. A lot of dilemmas health care professionals get into involve not agreeing with the ethics of senior leaders. For example, the leader might say we don't need additional nursing staff, but the nurses may think it affects quality of care. This becomes an ethical issue, as to whether the institution values quality," she notes.

If a quality manager believes there is an ethical problem, at the very least, he or she should know to whom to take that problem, Spath says.

Creating a policy

So, what are the practical steps involved in creating an ethics/governance policy? Experts say it usually begins with a task force or a committee.

"Most hospitals I'm familiar with have an ethics committee as part of their board," Nygren says.

"It's important that you have some group that deals with ethics," Spath adds. "It should include the risk manager, the compliance officer if you have one, ideally a member of the governing board, and obviously senior leaders to make sure decisions match their vision for the organization."

The quality manager should sit on such a task force and have a role in policy-making, Bostwick says. "But it all comes back to leadership needing to take the initiative," she points out. "The quality manager should try to get literature in front of the leaders and increase their awareness of these issues. Also, they can share changes that have worked in other organizations."

Just what should the policy address? First of all, Nygren says, it should include a code of conduct and ethics. This breaks down into several key areas:

- **Business integrity.**

  The board should be interested in transparency of information from management — full disclosure and accountability, he says. "This includes keeping stakeholders fully apprised of your operations, which is particularly important in health care."
- **Conflict of interest.**

  Members of the board, in particular, should not have any financial benefit accrue to them by virtue of sitting on any other board of an organization that may have dealings with the hospital. Any breach of ethics should be disclosed immediately.
- **Full disclosure of community benefit.**

  This consistently should be measured against the institution's mission.
- **An ombudsman function.**

This is to ensure that "whistle-blowing," or internal violations reports, have a clear line of sight to an audit committee that oversees risk and ethics. "This is *very* important for health care," Nygren notes.

- **Privacy of communications.**

This privacy should revolve not only around the patient, but around physician practices as well.

Measuring your performance

Beyond establishing an ethics policy, it's critical that you evaluate your performance. "You have to have measures to define if you are in compliance [with your policy]," Nygren says. "The board has responsibility for annual reviews, and this ought to be in a report that is given to the board."

An even bigger challenge, he adds, is to make sure your measures are accurate and quantifiable, and that they get tracked. "Many ethics violations are simply not tracked," he asserts.

What are some measures that might be adopted? "This can vary with the institution, but the principles that guide the ethical conduct of an institution should derive fundamentally from its mission," Nygren says, noting that nonprofits have slightly different missions than for-profit facilities, because they are dealing with stakeholders as opposed to shareholders.

Bostwick adds that measures might include such things as the percent of independent board members, relationships with your community constituencies, results of ethics reviews, and — for a less mature organization — the number of people who have been trained in the ethics policy.

What cannot be overlooked, as is made clear in the new Baldrige questions, is that the people at the top must be evaluated as well.

"In business and industry, it's the board that does this," Bostwick notes. "They have an executive compensation committee that reviews performance — and this should include an ethics review. For a hospital, it's the trustees."

"The board is supposed to represent the public interest," Nygren notes, "And it delegates that responsibility to the CEO. How leaders are evaluated and to what extent ethical considerations impact that evaluation is a quality issue."

In a nonprofit facility, he says, this includes looking for mission integrity; overall organizational performance (of which ethics is a key driver); qualitative indicators of how much the leader represents alignment with future strategy and the health needs of the community; and to what extent he or she stands out as a person who represents the board's interests to the community. "You should also evaluate strategic leadership," he says. "To what extent does this individual look toward the future?" ■

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Successful practices benchmarked at CHA

Members encouraged to learn from each other

[Editor's note: This is the third in a three-part series on the Catholic Health Association of the United States' (CHA) performance improvement program, "Living Our Promises, Acting on Faith." The previous article described how the baseline data derived from a comparative date process informed the selection of a specific area targeted for performance improvement. In this final installment, we see how CHA empowered its members to benchmark successful practices implemented at other member facilities and systems.]

Using its 12 collaborative partners as the focal point, the CHA wanted to ensure that these partners would share what they learned with the members, the Catholic Health Ministry, explains **Julie Jones**, MA, director of resource development.

"At the national level, our goal was to empower

Key Points

- The goal was empowerment of members to move on to more successful practices.
- Employee involvement in decision making was a key area of focus.
- Several facilities model identified best practices successfully.

members with information so they could move to successful practices," she notes.

In June 2001, at the CHA's annual assembly of members, the Performance Improvement Collaborative Report "Employee Satisfaction with Involvement in Decision Making," was released. "We promoted it there through story boards and at a session during the assembly for all members interested in learning," says Jones, who facilitated the session.

The speakers included Robert G. Gift, MS, president of Omaha, NE-based Systems Management Associates Inc., and a consultant to the CHA on the initiative; one of the CHA's ethicists; and CEOs from the two facilities profiled in the report — St. Joseph Regional Medical Center in Ponca City, OK, and Providence Hospital in Washington, DC.

Outlining successful practices

The session outlined successful practices through interviews with high performers (external to the CHA) and through sharing what the collaborative benchmarking initiative had learned, as well as through the profiles of the facilities.

The program at Providence Hospital entailed the initiation of Employee Planning Days, which had begun in 1991. Each year, at the beginning of the hospital's planning cycle, four sessions are conducted to generate employee input that will shape the strategic plan. The four-hour sessions involve about 400 nonmanagement employees, from all levels and all departments.

The planning days, which also involve dividing into smaller discussion groups, are organized around three themes:

1. Mission.
2. Organizational performance.
3. Quality, defined at Providence as "meeting or exceeding expectations that represent value to patients / customers."

According to Providence president and CEO **Sr. Carol Keehan**, DC, "Approximately 80% of the facility's innovations — from the need for a new nursing home to ways to reward employees who don't use up their sick time — come from the planning days."

St. Joseph was recognized for a number of different practices that resulted in a high level of satisfaction among its 550 employees. It was rated a "high performer" on the measure "percent of employees indicating satisfaction with their involvement in decision making."

This was attributed to a number of integrated strategies, including:

- **A strong emphasis on performance improvement.**

This cultural expectation is impressed on all new employees, and performance appraisal includes involvement in organizational improvement activities.

- **Manager and supervisor training.**

In their first year on the job, manager / supervisors will received about 50 hours of management training.

- **The Quality of Work Life initiative.**

A 12-member employee task force initiated a work / life survey and then recommended further development in six areas:

1. education;
2. staffing;
3. benefits / compensation / performance evaluation;
4. management / supervision;
5. employee / physician relations;
6. communication.

To date, the following results have been achieved:

1. increased nurse education resources;
2. improved hospital security staffing;
3. improved employee communication methods;
4. nursing wage adjustment;
5. enhanced benefit plan with paid time off;
6. more consistent supervisory practices.

Spreading the message

After the assembly, the CHA released the report to the entire ministry, to both individual facilities and systems. "Our goal was to leverage our information and turn it into performance improvement for the ministry," Jones says. "We know that some facilities have followed up on the report."

For example, she observes, Providence Portland

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(OR) Medical Center, one of the members of the original collaborative group, implemented employee planning days in February 2002.

"They took the information they learned, and they applied it; it went very well," Jones says.

"They are in the process of implementing the recommendations that came out of those sessions, which focus around employee retention, employee safety, and patient safety," she explains. They are publishing a newsletter to close the loop of communication with employees and have a site on their intranet.

As the CHA initiative continued, a report was released in spring 2002 on data and trends from acute care facilities. It provides follow-up data collected in 2001 and, where possible, includes comparisons to baseline data collected in 1999 and 2000. It is divided into these major sections:

- organizational culture;
- holistic care;
- care for poor and vulnerable people;
- care for the dying;
- relationship to the church.

"Each section offers examples and provides resources," Jones explains. For example, an Iowa-based team of several CHA-member organizations is cited for developing a manual, *Recognizing Pain as the 5th Vital Sign: A Guide to Developing and Implementing an Effective Pain Management Program.*

Jones says she is "absolutely pleased with the results to date. We have had success on a number of fronts, some of them planned and some not."

The CHA expected that when it started measuring performance and giving members comparative data, it would begin performance improvement, "and that has been achieved," Jones asserts.

"We also wanted the process to be educational from the beginning — and it has been," she continues. "We met recently with several executives who noted a major breakthrough in addition to the data; we have helped employees understand in a much deeper way our mission and their role in it." ■

U.S. end-of-life care gets a (barely) passing grade

Survey shows there is much more work to be done

America received a grade of "mediocre" on its care for the dying in a new report from the Washington, DC-based organization Last Acts, *Means to a Better End.* The report, funded by the Robert Wood Johnson Foundation in Princeton, NJ, provides a state-by-state report card on end-of-life (EOL) care.

Among the key findings in the survey of 1,000 individuals are:

Nationally, only 25% of deaths occur at home, although more than 70% of Americans say that this is where they would prefer to die.

About half of all deaths occur in hospitals, but less than 60% of the hospitals in any given state offer specialized EOL services.

Nationally, an average of 14% offer palliative care, 23% offer hospice care, and 42% offer pain management services. Although these programs are becoming more available, reimbursement issues still are a challenge. Funding for such programs often depends on inconsistent sources, such as donations and private grants.

The percentage of deaths that include a hospice stay varies by state, from about 5% to 42%. Most states have only fair hospice use, with about 12% to 25% of deaths including a hospice stay.

Experts agree that patients need at least 60 days of hospice care to maximize its benefits, but the report found that hospice stays range from 14 to 43 days per state.

In any given state, at least one in four nursing-home residents experiences pain for at least two months without appropriate pain management.

On average, the percentage of U.S. physicians certified in palliative care is 0.33% (33 physicians for every 10,000 people); the average percentage of nurses certified in hospice and palliative care is

Key Points

- The vast majority of Americans would prefer to die at home.
- A minority of hospitals offer hospice or palliative care services.
- Report card enables state-to-state comparisons, benchmarking.

0.41% (41 nurses for every 10,000). This lags far behind the needs of the U.S. population.

Twenty states recommend that people draw up a single, comprehensive advance directive (a living will and/or a medical power of attorney), which reduces confusion. Thirty-five states do not require that mandatory forms or language be used for advance directives, which allow people to state their wishes in their own way.

Between 16% and 37% of deaths among Medicare recipients in any given state include hospitalization in an intensive care unit (ICU) during the last six months of life. ICU care often is uncomfortable and unwanted: A study of cancer patients in the ICU found that 55% to 75% had moderate to severe pain, discomfort, anxiety, sleep disturbance, or unsatisfied hunger or thirst.

Twenty-four states have pain management policies that explicitly address the needs of the terminally ill, and 18 policies express concern about the undertreatment of pain in this group. Experts agree that up to 95% of serious pain can be treated effectively, but half of all dying people still experience severe pain.

Hospital not the best place?

One of the more interesting findings is the fact that the vast majority of patients prefer to die at home. "One poll shows that figure as high as 86%," notes **Judith R. Peres,** LCSW-C, deputy director of Last Acts. "They want to be comforted at home, surrounded by loved ones."

What health care institutions must realize, she notes, is that in the dying process most people prefer privacy.

"A semiprivate room does not lend itself to 24-hour visiting," she observes. "Also, with appropriate palliative care, almost any case can be managed at home."

In essence, she says, it often can be a better "quality" move to let patients go home, rather than to keep them in the hospital; "although a good institution can set the stage properly."

This raises the issues of what constitutes good palliative care. To Peres, it is a holistic concept encompassing biological, psychological, social, and spiritual needs. "Comprehensive, holistic care treats the whole person," she explains.

"Providing comfort involves seeking to eliminate *all* suffering — physical, emotional — attending to the family system and to spiritual needs." In fact, she notes, there is an entire movement that argues palliative care should not be just for EOL care, but rather should be moved "upstream," to the point at which the diagnosis is made.

Pain management, an important subset of palliative care, is one of the areas in which health care currently falls short, Peres says. As the report notes, 95% of all pain can be treated effectively.

"There are peer-reviewed studies cited in the report," she notes. "However, a well-meaning primary care physician won't alleviate pain in the same way a pain management-trained physician would." (To see the report, go to: www.lastacts.org.)

Interestingly, people will rate pain management highly as a critical component of care but also say they want to be awake and conscious, says Peres. "However, when they are asked to make a choice, they choose pain management," she asserts.

Using the report card

How can the report card be used to improve care? "For the general public, we hope they can see that the use of advance directives is very important in making their wishes known," Peres says.

Policy-makers, she notes, can compare their states' laws to those in other states. "They can certainly do something that will make physicians less fearful [of providing the most appropriate palliative care], and these are not budget-busters," she declares.

In addition, the American Hospital Association and other health groups through the Circle of Life awards (also supported by the Robert Wood Johnson Foundation) are working to recognize new approaches to EOL care that can provide models others can adapt to fit their community's needs and resources.

"Quality managers can take ideas presented in the report; sprinkled throughout are award winners," Peres notes. "They can contact their fellow hospital leaders and see how they put their programs in place." ■

Need More Information?

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Med school teaches bioterror response

AAMC cites program as a model

Key Points

- Subtle, natural course changes are seen as most effective.
- Students are trained to respond to "all events," not just specific attacks.
- Efforts are under way to enable benchmarking by other institutions.

The bioterrorism training program at the University of Pittsburgh School of Medicine, among the first of its kind in the nation, has been described as a model by the Washington, DC-based Association of American Medical Colleges (AAMC) during its recent annual meeting.

The program integrates level-appropriate content throughout the four-year medical school curriculum, placing the appropriate content into existing courses and evaluations. Students are taught how to identify, triage, and treat patients exposed to biological, chemical, and radiological terrorism, emerging infectious diseases, and environmental pollution. They also are taught about food and water source safety, the impact of pharmaceutical treatments, terrorist hoaxes, and technologic threats to the continuity of public and health services.

Officials from the school currently are working to help foster benchmarking in other medical teaching facilities in an effort to better prepare health care professionals to deal with potential future biodisasters.

"This type of content has always been included in med school curricula," notes **John D. Mahoney**, MD, assistant dean for medical education. "But when I learned about it in the '80s, it was as *history* — anthrax was about sheep handlers, and the military worried about chemical weapons. Military medical school had hundreds of hours of classes, while we had snippets."

But when Mahoney developed the current curriculum, he brought to the process his background as an emergency physician and toxicologist.

"Disaster response is about getting out there and getting your hands dirty. I was used to thinking about all of the bad things that *could* happen — and helping our hospital plan for them. As we headed toward Y2K, as the rest of the country was increasingly worried about threats of chemical weapons, I felt we should cover them in our curriculum," he explains.

Mahoney's first steps were deliberately gradual. The first move involved one hour in the classroom and a couple hours of independent work, blended into the usual curriculum. "We brought it into the clerkship in internal medicine in 2000, just like any other subject," Mahoney notes. "We did it quietly — on purpose. We wanted to quietly introduce the subject as an ordinary topic of 21st century medicine. As such, the students accepted it as a reasonable thing to learn about."

The first course began in July 2000. "More than a year later, the anthrax attacks occurred, and students were saying, 'It's a good thing I learned this,'" Mahoney observes.

In August 2002, the school rolled out an "all-threats" approach. "If a hospital has a disaster plan, and it is specialized for anthrax — well, we may never see another anthrax attack; the next time it may be plague," Mahoney explains. "It's even far more likely a bus will crash or we'll have several cases of West Nile happen — or there'll be a GI outbreak on cruise ships."

Accordingly, two key principles are employed to bring out the curriculum:

- **Prepare for all things.**
- **Make preparedness part of the normal fabric of studying medicine, and reinforce that message again and again.**

"It's the same approach as, say, the one used when a nurse in triage hears a cough," Mahoney says. "They will think TB. They won't panic, but they'll *think* of it."

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Level-appropriate content is inserted into courses in the context in which it makes the most sense. "For example, if there's not enough vaccine to go around, who should get it? *That* sounds like an ethics course," Mahoney points out.

"We're not going to have daylong seminars or even hour-long seminars," he continues. "We will infiltrate the introductory courses with a small bit of content. Naturally, the infectious disease course will get a fair bit, but every course will get something. In the applied clinical pharmacology course, which is an advanced course, we might teach about the mechanism of action of chemical agents and antidotes, and so on."

Another consideration would be the public health aspect: How does a community cope with an outbreak? "Part of what we're teaching doctors is to get them to know their role in a disaster," Mahoney explains.

"Doctors are used to thinking they are in charge, but in a disaster, it may be the mayor or a soldier. Also, they are used to treating a patient. We need to teach a community perspective," he points out. As part of the introductory course, students go into a community and learn to understand its needs.

The key premise of the new approach, says Mahoney, is that every physician has the potential to be the first one to encounter a given situation, but not every physician is a specialist in infectious disease.

"Accordingly, we need to make every one sufficiently knowledgeable so that they can be the proverbial canary in the coal mine," he observes. "They need to be able to recognize that there's something odd going on, and to know what to do — for example, call the infectious disease department. If all we achieve is getting first responders up to that level, we will have done a lot." Now, Mahoney is helping to spread the approach to other institutions.

"We were approached by the AAMC, who wanted to know how we 'anticipated' the bioterror problem, and how others can learn the same things," he recalls. "I was invited to help develop a plan on how to bring curricula like this to other medical schools." There have been several meetings, and interestingly enough, what Mahoney and his colleagues have proposed is right in keeping with the thinking of the Centers for Disease Control and Prevention.

"Our goal is to have all medical personnel brought up to a certain basic level of competence to approaching these events — knowing the first steps, and then beyond that knowing how to work with a team of experts," Mahoney concludes. ■