

Workshops Focus on Management and Leadership

From quality improvement to coordination of the care of pregnant patients, many of the conference's concurrent workshops stressed tools for health professionals to better administer and guide their work. Highlights of four of the workshops are outlined below.

Leadership Development and Team Building

Learning to ride a bicycle requires different skills from those needed to drive a truck, and that transition can best be accomplished through a process dubbed "experiential learning," or learning by doing. This example served to introduce this breakout session, during which some 40 attendees were assigned an experiential learning exercise of their own.

Divided into groups of seven or eight, participants were given a measured length of rope and told to form a circle on the floor, representing a "boat". The groups had 15 minutes to plan how to fit every person into the "boat" and hold their position for 30 seconds while singing a stanza of any member's national anthem.

Following the exercise, participants reported on the skills they used to execute their plans. Discussion centered around how groups choose a leader, how to define success and what type of communication and negotiation skills are needed to complete a team task. Group dynamics varied: some teams chose a leader immediately, while others shared decision making equally. Some teams asked questions to establish boundaries for the task, and others did not ask questions because they did not want boundaries given to them. One US participant said the exercise would be useful in a hospital setting to demonstrate the pros and cons of collaboration versus competition.

Quality Improvement in Health Care

As both CEE and American health practitioners strive to do more with less, many use the principles of quality improvement to guide their work. J.B. Collins, director of continuous improvement at Carolina Medicorp, Inc. in Winston-Salem, North Carolina gave a whirlwind introduction to quality improvement.

"It's not just let's have some teams, do flow charts and that's quality. That's only a tiny part. You have to have an environment that fosters positive change in which everyone is working together toward a common end," he said.

According to Collins, the aims of improvement are threefold: to eliminate problems that arise because of failure to meet patients' expectations, to achieve significant cost reduction while maintaining or improving quality, and to change the expectations of customers through new or high-value products and services.

For example, the pharmacy at Children's Hospital for Pulmonary Diseases in Zagreb, Croatia, reconfigured the way it distributed drugs in the hospital. By issuing drugs under each patient's name on a daily basis rather than sending an approximate quantity of each drug for departments to distribute, expenditures for medications decreased by 32 percent and drug interactions can now be more closely monitored for each patient.

"There is no lack of enthusiasm for this new system," said Sanda Erlich-Lipej, MSPhar, a pharmacist at the hospital. "Doctors and nurses are extremely interested in cooperating so we have the feeling that we are contributing to the advancement of our crafts."

Managing Care Across the Continuum

"Despite the fact that the vast majority of us entered health care professions because we wish to provide respectful, compassionate care of our fellow man, many of our patients, especially our

complicated patients, interact with our health care system without having some of their most basic expectations met," Barbara Bogomolov, RN, manager of community health for Barnes-Jewish Hospital in St. Louis, Missouri, said during a session focused on connecting the scattered pieces of patient care.

"Are we, who work in hospitals or physician practices, or home care organizations, or in the ambulatory care clinics doing something terribly wrong? Or are we just not doing something critical right? No matter how much energy we put into our particular health care activity, if that energy is not channeled, coordinated and patient centered, to steal a phrase from you surgeons out there, we may operate successfully and still lose the patient," she continued.

One coordinator for care, from the spectrum of outpatient to hospice, must be chosen to manage how a patient moves through and interacts with the health care system, said Francis Hutchinson, BSN, director of Forsyth Memorial Care in Winston-Salem, North Carolina. This case manager is often the family practitioner.

Practitioners need to put aside egos and competition to ensure that patient care is organized and that the best setting for that care is provided, said Ahti Virkus, MD with the Keila Family Practice Center in Keila, Estonia.

"In the CEE, where we are just starting to create the pieces in this continuum, this may be easier than for those of you who are trying to fit the pieces together," she said.

In particular, hospice care is a new concept for some CEE countries, which have traditionally been reticent in acknowledging the status of terminally ill patients, said Arkadijs Gandzs, MD, director of Bikur Holim Hospital in Riga, Latvia.

Management of the Pregnant Patient

Establishing a regional system of perinatal care that prioritizes at-risk patients will help save money and ensure that pregnant patients who need the most care will have advanced treatment available, said Penelope Shackelford, MD, director of pediatric infectious diseases at the Washington University School of Medicine in St. Louis, Missouri.

In this system, some hospitals would handle normal births, while others would be equipped with more technology and expertise to help mothers and babies who are at risk for complications. However, competitive pressures in marketing and finance can lead hospitals to battle over which will provide the highest level of care, Shackelford said.

At the same time, more attention must be paid to preventive care, said David Gagnon, MPH, executive director of the National Perinatal Information Center in Providence, Rhode Island.

"Infant and perinatal mortality rates in the United States have decreased primarily because of technology, but not in many instances because of an improvement in preventive care," he said. "The US is 24th in the world in terms of infant mortality. We're now on a plateau, and that's not something to be proud of."

Gagnon advocates improved education for both doctors and pregnant women, cheaper birth control, reduction of exposure to toxic substances, reduction of substance abuse and improvement in infection control. Obstetrical staff both in the US and CEE need to expand laboratory evaluations, such as glucose monitoring, in pregnant patients; increase monitoring of fetal heart rate; and prescribe folic acid supplements for pregnant women to reduce neural tube defects in developing fetuses, he said.

Developing a multi-disciplinary team, from obstetricians and gynecologists to emergency medical personnel, was an essential part of coordinating care for pregnant patients in Estonia, said Anita Jain, MD, with the George Washington University Medical Center in Washington, DC. The partnership with hospitals in Tallinn, Estonia, has developed a course in women's health and provides fellowships for advanced training in women's health care in the US to Tallinn physicians and nurse-midwives.

In Romania, development of neonatology as a specialty was a priority, said Mary Ann Micka, MD, MPH, formerly a USAID health officer there and now chief of health and population for AID's Europe and New Independent States Bureau. However, obstetricians were slow to trust a new specialty they saw encroaching on their territory. But after developing an intensive training course, obstetricians are now eager to learn more about neonatology, she said.

"Now two years later, obstetricians and neonatologists are talking to each other about common problems," she said. "This kind of exchange, teaching your peers, will eventually help spread these ideas. This is how the word is spreading in Romania, and this is what's going to work."