Preparing for the Worst

A national clinical outsourcing company prepares for pandemic flu and recognizes that clinicians have responsibilities at home, too.

Photos Courtesy of Natalie Clark

Public health organizations estimate that the 1918 pandemic influenza killed as many as 50 million people worldwide in only 18 months, and that likely doesn't account for the unreported long-term morbidity suffered by a large number of survivors of the "Spanish Flu." It also only takes into account the statistics from developed nations. According to the World Health Organization, the world faces three pandemics each century, and by that standard such an event is well overdue. In the face of these frightening facts, disaster planning is critical.

In the summer of 2006, TEAMHealth, the country's largest hospital-based clinical outsourcing company, initiated a program to dramatically improve disaster preparedness among its affiliated physicians, employees, and associated caregivers. Within the scope of all-hazards planning, TEAMHealth elected to initially focus on building a toolkit to assist in preparation for pandemic influenza.

Two of the key architects of the program are Dr. Gar LaSalle, chief medical officer, and Theresa Tavernero, associate director of patient safety.

Gar LaSalle, MD

LaSalle, MD, assumed the position of chief medical officer for TEAMHealth in 2001. His responsibilities include developing and promoting best administrative and clinical practices throughout the organization, directing risk management and risk education initiatives, and promoting effective communication with and training of medical directors and affiliated staff physicians to incorporate improvement strategies.

Prior to his tenure at TEAMHealth, Dr. LaSalle completed his emergency medicine residency training at UCLA where he later served as faculty. He is assistant professor of emergency medicine at the University of Washington and at the University of South Florida. He also holds a master's degree in fine arts in film and video from California Institute of the Arts. His credits include affiliate faculty for the State of Washington American Heart Association, past chairman of the Washington State Emergency Life Support Task Force, national president of the Emergency Medicine Residents' Association, and public relations advisor of the American College of Emergency Physicians. His films have won many awards, and his award winning documentary work, the first to ever depict emergency medicine as practiced in the United States, has aired on PBS.

Theresa Tavernero is the associate director for patient safety program for TEAMHealth. She works in the Patient Safety Office of the Risk Management Department and also serves as a faculty member and instructor for TEAMHealth Institute, the education arm of TEAMHealth, providing instruction and consultation on her areas of expertise, which include teamwork, communication, nursing, risk management, and clinical simulation to medical directors and affiliated clinicians.

Theresa Tavernero, RN

Tavernero earned her nursing degree from the University of Washington and her master's degree in health and business administration from Chapman University in Orange, California. She is currently completing her doctorate degree in health administration from Kennedy Western University in Thousand Oaks, California.

Tavernero is certified in emergency nursing and holds certification in trauma nurse and emergency nurse pediatrics. She taught the Combat Medic Proficiency Course for the U.S. Army and has directed numerous emergency departments. Tavernero most recently served in the role of regional director for the emergency and trauma services and emergency preparedness for the Franciscan Health System. She is an active member of the Emergency Nurses Association.

Q: In terms of all-hazards planning, and more specifically preparing for pandemic influenza, do medical professionals have their heads in the sand?

GL: The fact is…we are all human, and it's just human nature for us to be in denial about potential disasters. There has been a lot of publicity about avian flu, for instance, and because it has not materialized thus far, perhaps some caregivers feel the media has been "crying wolf." But pandemic flu is a very real threat; it's not so much a matter of if, but when it will happen. Disaster experiences have routinely identified major gaps and oversights in planning and management, and because hectic schedules and dealing with day-to-day operations often take precedence over planning for the future, the medical community is generally unprepared for a full-scale disaster situation.

TT: The scope of disaster planning and the level of preparedness in hospitals varies widely. Historically, communities have looked to hospitals to have the capacity and means to handle disasters, assuming that the physicians and nursing staff will be present and available to care for patients. Hospital disaster drills focus largely on establishing a command center and mobilizing and communicating with staff who are in-house to fill the key positions within an incident command system structure. When it comes to having all the physician providers engaged and participating in disaster drills, many hospitals quietly excuse them from having to participate, due to actual patient care that must take precedence. Because it can be difficult and uncomfortable to ask providers not in the hospital to disrupt their personal lives or medical business, they are not routinely called to respond to the drills. In the many years I have been involved in leading hospital disaster activities, I have learned that although physicians understand that they are to report to the hospital in cases of disasters, they lack the procedural understanding of whether or not to respond, where exactly they are to report, and how their specific duties might change.

Hospitals rely on contractual obligations of organizations such as TEAMHealth to staff the emergency departments as needed, including during disasters. Hospitals may assume that physicians will be available and present, but in the case of a pandemic what happens if providers fall ill or die? We felt it was important to have a dialogue in our organization surrounding this scary question, and we contend it is a real issue for all healthcare organizations.

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Q: What is TEAMHealth doing to better equip affiliated physicians and other hospital caregivers to prepare for a pandemic?

GL: As the nation's largest hospital-based clinical outsourcing company, we are in a unique position to help improve disaster planning throughout the medical community. With a well-structured and well-communicated effort, we can affect hundreds of facilities across the country.

TT: Because a major part of our business is providing hospitals with physicians to staff their emergency departments and hospitalists to work throughout hospitals, our affiliated providers are likely to be on the front lines of service in a disaster situation.

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With an overwhelming amount of information about the pandemic available, we wanted to provide our affiliated providers with the most essential, pertinent, and updated information possible. We have selected information from the most recognized agencies around the country with which to build our educational toolkit. It provides affiliated physicians, TEAMHealth employees, and our nursing partners in hospitals three broad categories of information: general information about the pandemic, information focusing on preparing the individual and family members, and information on a range of topics dealing with clinical and administrative aspects of managing the pandemic as well as other disasters.

Q: Why did you focus on pandemic influenza?

GL: The world experiences an average of three pandemics per century. By that measure, we are overdue, so it is not a matter of whether or not a pandemic flu is coming, but when it will arrive. Pandemic flu is a real disaster that would severely compromise the medical community's ability to care for the American public, especially considering the current state of preparedness. Every community's infrastructure will be impacted and that will compromise the ability of even a prepared and willing medical community to respond quickly and adequately. While it is true that events such as hurricanes, tornadoes, and earthquakes occur more frequently, the magnitude, reach, and urgency of pandemic flu influenced our decision. In my opinion, if we prepare for pandemic flu, we will be prepared for a great number of other events as a result.

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Q: How have you approached planning?

TT: We developed a system-based, multi-affiliate, and multi-disciplinary approach, using the theories of diffusion of innovation. It started at the top with Dr. LaSalle as the executive sponsor and leader of the project. He assigned three project leaders—Mark Harris, MD; Kim Moore, MD; and me—who secured support from our Medical Advisory Board. We then created a national task force including key people from across our organization in various disciplines including human resources, legal, marketing communications, IT, TEAMHealth Institute, risk management, and operations. All participated in the dialogue from which we developed our toolkit, training, and operational plans.

GL: We have a variety of methods to communicate about the toolkit. Our ED medical directors work closely with hospital-employed nursing directors. Networking through our medical director training program, the medical directors' very active listserv and a new web-based mechanism called Nurse 411, we are facilitating the best communication possible between these key players. In addition, TEAMHealth's organizational structure includes redundant communication vehicles, regional operating centers throughout the country, a well established interactive medical director network, a strong Patient Safety Office, and TEAMHealth Institute, the educational arm of our company, allows for distribution of information much more quickly than would otherwise be possible.

Q: Did anything come up in initial conversations that you didn't expect? Any surprises?

TT: The further we got into the discussions around the history of pandemics, the more people realized that pandemic flu is not only a real possibility but a likely probability. The dialogue with the task force revealed a range of emotional responses, from fear and hopelessness to skepticism and denial. But as we kept challenging them on the "what-ifs," it was clear that people kept returning to their primary concern, which was centered on the safety of themselves and their families. We realized that to plan for the disaster, we had to first address the healthcare providers' primary concerns—how to keep themselves and their families safe.

We assume emergency department physicians and nurses are hero types that will respond to any and all emergencies. The fact is that these caregivers are people. They have houses and families. Sometimes they get sick. If providers are not personally prepared for an event like this, they may be unable or unwilling to respond. Then to whom will the public turn?

Although TEAMHealth is a physician staffing organization and not a hospital, we recognize the importance of organizations such as ours to have a plan to continue operations so we can continue to support the hospitals. While we all want to believe that physicians, contracted physicians, and employees will all show up, we should recognize that in disasters such as the pandemic, providers and other employees may be truant from work because they are ill or caring for their families. We need to face these realities and be proactive about developing contingency plans.

Q: Describe the planning/toolkit? What are the components?

GL: The toolkit is primarily a web-based application but we provide the

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information in several different ways: online, paper copy, CD, and as a stuffer in payroll material. The toolkit is comprised of three components.

The first component is general information about pandemic influenza. This includes information on what it does to the human body, how to recognize it, how it is spread, and a biomedical description of the influenza virus. This information was compiled from the best possible public sources including the Centers for Disease Control and the World Health Organization. The second component discusses individual and family preparation. Again, we did not anticipate including this type of information until the multidisciplinary, multi-affiliate conversations. When we witnessed the emotional response of team members, we realized we had to think about our caregivers not only as professionals, but also as individuals who worry about their loved ones and who could become distracted from their work.

The third component provides clinical and administrative information. It includes pertinent articles from trusted sources as well as presentations and speaking points for medical directors so they can relay information to the hospital staff with little effort. The clinical information is different for each type of provider: doctors, nurses, or medical directors. It includes up-to-date information on effective vaccination, medication, and lab testing. Rather than provide them with a variety of approaches to treating pandemic influenza, we have sifted through voluminous amounts of relevant information and provided one concise, clinically proven solution.

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TT: Part of the toolkit focuses on continuity of operations. In our case, we must continue to staff the hospitals and support our affiliated providers and employees so they can continue to support our organization's mission. From previous disasters we have learned there is frequently a breakdown in communications and a turf war over who is in charge. The information contained in our administrative toolkit includes various resources based on the nationally recognized and adopted model of incident command. We include sample disaster policies and procedures as well as disaster emergency credentialing tools—both preemptive and expedited—so qualified providers can assist where they are needed as opposed to just where they have gone through the regional certification process. As a national organization we understand the nuances of each state's certification process, and our broad reach means we can send our people through preemptive certification in areas that may be more widely-affected by a disaster.

Q: What did you learn from the process of this planning?

GL: The medical community, as a whole, is not prepared for a disaster. More than that, some members of the community do not recognize disaster planning as a necessity because everyone assumes that heroics will save the day. The planning process may seem overwhelming, but we have to start somewhere. We must select leaders who are committed and diligent about planning. We have to seek input across discipline lines and earn the buy-in from all necessary parties. We must also be sensitive to timing, account for regional differences, and be open to diverse opinions.

Q: What are your next steps?

TT: Having completed the Educational Toolkit, we have initiated Phase II—the development of an Operational Toolkit. Using the National Incident Command System, it will include templates that help identify critical roles (with successors) and functions within each affiliate. It also includes various tools to aid in pre-establishing disaster staffing and credentialing functions. We intend to pilot the program in two locations to provide a baseline for other affiliates to build their plans and tailor them to individual needs.

GL: A major portion of the operational phase will be to conduct table-top disaster drills in which we get decision-makers around a table and verbally play out a fictitious disaster. These exercises will undoubtedly identify gaps in the system and will be a valuable educational experience. They accomplish both the rare feat of getting key people in the same room at the same time and allowing everyone to think about the disaster plan in context. A successful table-top almost always leads to vast improvements in a plan.

Q: How might local authorities play a role in this preparation process?

GL: The key components of the operational toolkit will be available to TEAMHealth medical directors to incorporate into their hospital plans. They will also have the opportunity to incorporate the information into the community disaster plan. TEAMHealth medical directors and affiliated providers will be primarily engaged with the local authorities, and they will have the strength of affiliate and national TEAMHealth resources.

Q: What advice can you offer hospitals and caregivers when it comes to planning for disasters?

GL: Take an honest look at your current disaster plan. Does it integrate local authorities? Is everyone in your community on the same page? Talk with the fire marshal and the chief of police. Talk with public utility officials to determine

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whether community infrastructure will be there when you need it. Inside the hospital, make sure your team is mentally, psychologically, and physically prepared. Insist they have a plan at home so that their families are prepared and safe. Keep them up-to-date on their vaccines. Teach them protocol and explain the chain of command—from the janitor to the governor. It may be hard to find the time—healthcare is a busy place—but it's critical to the welfare of our communities and our nation.

TT: Ensure repetitive and redundant efforts to communicate with your audience. Find people in the organization who will help get out the word and get people's buy-in. Keep in mind that some people may prefer to receive information via email while others may want information verbally or in print. Information from the top down is important, and getting input from the front line is imperative.

Anyone planning for disasters has to take in consideration the very real and fundamental human element—fear. If healthcare providers have family members who are ill, they may not be able to show up. We are all just human, and we need to start by talking about this openly no matter how uncomfortable or overwhelming it may seem. PSQH