BAYSTATE HEALTH
How centralization is helping one dynamic health system maximize resources.

COMMAND CENTER LEADERSHIP
Kettering Health Network's unique journey to optimized patient care.

RURAL + URBAN CHALLENGES
Carilion Clinic's Command Center provides care excellence across its communities.

DISASTER READINESS
Stories of responsiveness and resilience.

PATIENT FLOW *quarterly*™

SPECIAL ISSUE VOL.ONE

PEOPLE, PROCESS, & PLATFORM

Meeting health systems where they are in the centralization process to provide real-time data and enterprise transparency

Centralized Care & Command Center Excellence

TeleTracking

WHERE TO BEGIN?

Getting started on the journey to better care.

For more than three decades, TeleTracking has operated with one distinct mission—to ensure that no one waits for the care that they need—and we have the people, process, and platform to help efficiently manage every step of the patient care continuum. Our decades of clinical and operational experience mean we are incredibly knowledgeable about the patient flow challenges that healthcare systems of every size and demographic face.

The COVID-19 pandemic has shined a light on the fact that every system needs real-time, enterprise-wide transparency, with actionable and meaningful data, to drive decision-making. A health system command center, for example, centralizes care, provides operational alignment and shared situational analysis. And whether it's an integrated delivery network or a system of community hospitals, we have the insight and expertise to design a solution to meet you where you are—and show you how we can do better together.

The following pages highlight the exceptional work being done by health systems at various points in their journey to increased transparency and visibility through a centralized approach to care. We hope you find the stories interesting and inspiring—and can start to envision how a health system command center can work for you.

LEARN HOW TO GET STARTED TODAY AT TELETRACKING.COM


MORE PATIENTS.
BETTER CARE.

BAYSTATE HEALTH MAXIMIZES RESOURCES THROUGH CENTRALIZATION

Care delivery at any health system is complex. It's a delicate balancing act of managing capacity between a system's main, tertiary facility and its community hospitals. When you add on simultaneously making sure every patient receives the care they need, when they need it, the complexity mounts. This is what Baystate Health, a not-for-profit, integrated healthcare system serving over 800,000 people throughout western New England was facing—while trying to manage an increase in volume with a patient management system that was being phased out and a manual transfer center.

THE VOLUME IS SIGNIFICANT. WITH A WORKFORCE OF NEARLY 12,000, AND MORE THAN 980 BEDS ACROSS OUR FIVE HOSPITALS, THE ANNUAL IMPACT INCLUDES:

* Over 1.8 million outpatient visits, providing comprehensive sick and preventive care
* Over 197,000 emergency and urgent care visits
* More than 36,600 surgeries performed
* More than 4,000 babies born at Baystate Health hospitals

"We knew we needed to do something to maximize our resources and provide the best care possible to the greatest number of patients. That is why we decided to embark on a journey to centralize care and use all of our beds—not just those at our tertiary facility. And while we had worked on several process improvement initiatives, we were still lacking a system that could give us that one simple snapshot of volume and available beds across Baystate Health," said Alicia Meacham RN, BSN, Program Director for Transfer Center. "That's when we discovered TeleTracking and what it could do to help us move from a tedious, labor-intensive system (Microsoft® Excel to manage our transfer center, and a patient flow system that forced us to toggle between 25 units) to a streamlined system that lets us see in a couple seconds the beds we have open and available, while also giving us the ability to effectively manage our discharge process."

VISIBILITY AND WORKING AS A SYSTEM

The visibility provided by a centralized approach to care marked a turning point between the Baystate hospitals working as individual facilities to Baystate working as a comprehensive system. The evolution started with Baystate Medical Center (BMC)—the largest tertiary care center—being the first facility to implement TeleTracking in September 2017 and a new facility going live every six months after that.

"This was a significant change for our community hospitals in particular. For example, they weren't used to getting transfers. They were used to taking patients from providers, offices, but they had never really taken patients from another community hospital into their community hospital. The action was to always call the next biggest tertiary care center. We certainly experienced that at BMC, where we were consistently overburdened by volume—and yet we knew there were patients who could receive the care they needed at one of our community hospitals," explained Meacham. "Visibility allowed us to start effectively load-balancing patient volume between our facilities."

The ability to do this type of load-balancing begins with a three-way phone call between patient placement, the accepting physician and an emergency department physician. Nurses in patient placement start gathering information to make the correct placement, and by being able to determine the patient's status, the provider is able to start placing orders. This call ensures that patients are booked appropriately, at the right status, 24 hours a day.

SYSTEM AND PATIENT GOALS

"Our system-wide goal is to keep patients local and provide their care as close to home as possible," continued Meacham. "BMC is our tertiary center and a Level I trauma center for when a patient truly needs to come here. However, if a service can be provided elsewhere within one of our community hospitals, we want to place the patient there. This is where we engage our community hospitals to take patients more readily instead of automatically thinking they'll send them directly to Baystate Medical Center."

This approach also impacts patient satisfaction because it's always easier for a patient and their family to be closer to home. In 2020, one of the team's main goals was to continue to optimize community hospitals and place patients there whenever possible.

LOCATION, LOCATION, LOCATION

A centralized approach is a commitment and the right location is critical to success. Baystate's Command Center is in a large room within Baystate Medical Center, which includes both patient placement and transfer center functions. It is comprised of clinical staff, nursing staff and nonclinical staff, such as patient placement techs, environmental services managers, transport dispatch, admitting and external ambulance. Cohorting in one location has made it easier for everyone to be on the same page and work to effectively progress patients on their care journeys.

RELATIONSHIPS ARE KEY TO CHANGE

"The biggest challenge we faced with implementing our centralized approach to care was culture change," said Meacham. "And the biggest part of that was encouraging our community hospitals to give up control and not feel like something was being taken away from them. It was important to help them understand that by centralizing all of patient placement, they could focus on being a nurse versus assigning beds."

"Relationship-building is an important part of cultural change and that's why I encourage my staff to participate in different committees across the health system to see people, engage in conversation, and help break down barriers," added Meacham.

One specific way Meacham works to engage the hospitals and nursing staffs is through a morning bed huddle, Monday through Friday. She also works closely with the floor staff, ensuring that their 24-hour work process is in TeleTracking and that they are consistently entering projected discharges.

Meacham also spearheads the operations committee—where leaders of the different service lines and community hospitals discuss opportunities, changes and challenges. The committee pulls people together in order to think differently about what they can do to make things better for both staff and patients.

"One example that came out of the committee is our work to predict discharges and send them as close to 24 hours out as possible," shared Meacham. "We want to predict the right patients and make sure that we put that information into TeleTracking so that we have the data to continuously improve. That information gives us the ability to run reports, look at each floor, and home in on what they're doing well or what they may need to work on."

The team also recently launched an innovative approach to huddles with the implementation of a night huddle at 1:30 a.m. This new tactic makes it possible to predict discharges further in advance, and has discharges entered on the weekends as well—giving them a seven-day-a week process instead of a five-day-a-week process. By encouraging people to make sure that they're updating TeleTracking predicted discharges before 1:00 a.m., everyone has a better understanding of who's leaving for the day and if there are any barriers that need to be addressed.

SUCCESSFUL RESULTS LEAD TO RECOGNITION

Baystate's centralized approach to care is generating results. From 2017 through the first part of 2019, patient transfer volume increased from 327 to 540 transfer requests a month. And in September 2019 alone, the team took on ED calls, and with their community work, the number of patient transfers jumped from 540 to 829. And they continue to grow.

"TeleTracking is so much more than just an application—it is a complete program because of the way it has been incorporated here at Baystate Health," said Meacham.

CARE TRAFFIC CONTROL CERTIFIED™

The success of Baystate Health is being recognized as one of TeleTracking's inaugural Care Traffic Control Certified health systems—which was announced at TeleCon19.

For close to three decades, TeleTracking has recognized the benefits of a centralized approach to care—and how much effort goes into centralizing operations and integrating people, process and technology. That work is now being honored with the opportunity to become Care Traffic Control Certified™ (CTCC). In addition to creating a standard set of criteria to measure centralization success, the program is also designed to foster collaboration, innovation and continuous performance improvement between centers.

"We've worked hard to create our program, are proud of what we're achieving and are excited to help others achieve the same level of success as a Care Traffic Control Certified health system," concluded Meacham.

Baystate Health is a not-for-profit integrated health system headquartered in Springfield, Massachusetts, serving Western Massachusetts and the Knowledge Corridor Region of Massachusetts and Connecticut. The system has four hospitals, over 80 medical practices, and 25 reference laboratories.

Kettering Health Network Operational Command Center

A CENTRALIZED VISION

HOW A NEXT-GENERATION OPERATIONAL COMMAND CENTER IS IMPROVING PATIENT CARE.

Kettering Health Network in Dayton, Ohio is a faith-based, nonprofit health system operating with the mission to improve the quality of life of the people in the communities they serve through health care and education.

It is that type of commitment that has resulted in Kettering becoming one of the most recent health systems to launch an operational command center—cutting the ribbon January 21, 2019 on a brand new, nearly 17,000-square-foot center. The first of its kind in southwest Ohio, the NASA-like command center will serve all facilities within the Kettering Health Network, which together comprises eight hospitals, 11 emergency departments, and 120 outpatient facilities.

To help other leaders who are ready to embark on this type of journey, we had the opportunity to sit down with project lead, John Weimer, Vice President, Network Emergency, Trauma and Operations Command Center. John brings more than 20 years of both administrative and clinical healthcare experience to the project.

As we chronicle Kettering's journey in upcoming issues of *Patient Flow Quarterly*, this first interview focuses on what led Kettering down this path.

Q. What operational challenges were you trying to solve, and what were you looking for in a solution?

A. Like most systems, the focus is on growth and new, easily accessible points of entry for the communities that we serve. One growth tactic was the elevation of our community hospitals—because historically, large, inner-city hospitals have handled high-acuity patients. Over the last six to seven years, Kettering has focused on creating a strong presence in what we call "bedroom communities"—by providing services locally so that patients don't have to commute. Because as populations age, and with seniors often having no one else to rely on, driving an hour or two just really isn't feasible.

That strategy alone led to us really growing as a system. We opened five new sites in three years and started to see a whole new influx of patients and needed to figure out how to effectively manage them.

We started researching operational options, learned about TeleTracking, attended an event and brought the information back to our leadership teams. The information aligned well, especially with our IT folks—their whole creed is people, process, and technology. They understand the importance of the patients and the clinicians, the processes in the work they do, and if that can be combined with technology it leads to less of a cognitive load for them.

Q. In the midst of those changes, one of your competing hospitals was planning to close its doors. What impact has that had on Kettering, and did that expedite your timeline to launch your center?

A. Good Samaritan Hospital in Dayton operated the second largest emergency department in the community with 70,000 ED visits annually—along with everything else you would expect from a full-service hospital. Before they announced their closure, we thought we had about a 12-month timeline to implement our command center. In order to serve the needs of the community, we knew we had to accelerate the process. In addition, we were also experiencing enormous growth in our own organization—we had more than doubled the emergency patients coming through our door over the past five years and were already on target to see more than 320,000 ED patients this year. With Good Samaritan's closure, we knew those numbers were only going to increase. In addition to these market changes and the consequent increased volume, we were in the process of opening two additional facilities.

Q. What was your executive team's reaction to the command center concept and centralized approach to patient care when they realized this could solve challenges related to capacity and visibility across the network?

A. The interest level was very high, and our teams were engaged and ready to collaborate—which led to truthful and trusting conversations with small groups of our most senior leaders, as well as with some of our community partners. And the result was a clear directive to execute their vision as quickly as possible, with my responsibility tied to getting all the folks at our campuses on board and up to speed with this new approach.

Q. What is your vision for the NOCC (Network Operational Command Center)? What are the phases that you plan to go through?

A. We realize we're novices with the command center approach and that's why one of the truly great parts of working with TeleTracking are the partnerships—both with your teams of experts and the other clients that you're able to connect us with.

The result of these different perspectives has been fascinating—and has helped us make sure we have the right people in the room as we've been working through the planning process and that they're all communicating effectively from an operational standpoint. And that means that six months ago, the answer to the question of our approach and vision would have been very different from what it is today because we're continuing to learn as we implement. The one thing that hasn't changed is our end goal of making things seamless for both our clinicians and our patients.

That being said though, phase one is focused on bed placement and access—moving folks in and out of our system, including coordinating our internal transports so our lateral moves go smoothly. We are also working with our utilization management and social services teams to make sure we're doing what's best for the patient and using our resources most effectively by using system attributes to help properly prioritize the work. Right now, that information is on paper and white boards, with people walking around with patient lists in their pockets. We're excited about being able to bring this online and connect that information to all of our teams.

We have been taking a highly strategic approach to the overall planning process, knowing that things will be different in year one than it will be in year two. And our construction is allowing for that type of evolution and increased volume. We have our footprint today, plus we've saved space for the future, and can look at other areas in the building if we need to.

Q. What have been some lessons learned along the way since the project kicked off in July 2018?

A. Educating key stakeholders in our organization about TeleTracking has been critical. I think that the biggest lesson learned was the initial sell. "This is an operational decision. It has implications to our EMR, it has implications to our clinical folks, it has implications to our finance cycle, but most importantly it has implications to our patients if we chose to do nothing."

JOHN WEIMER

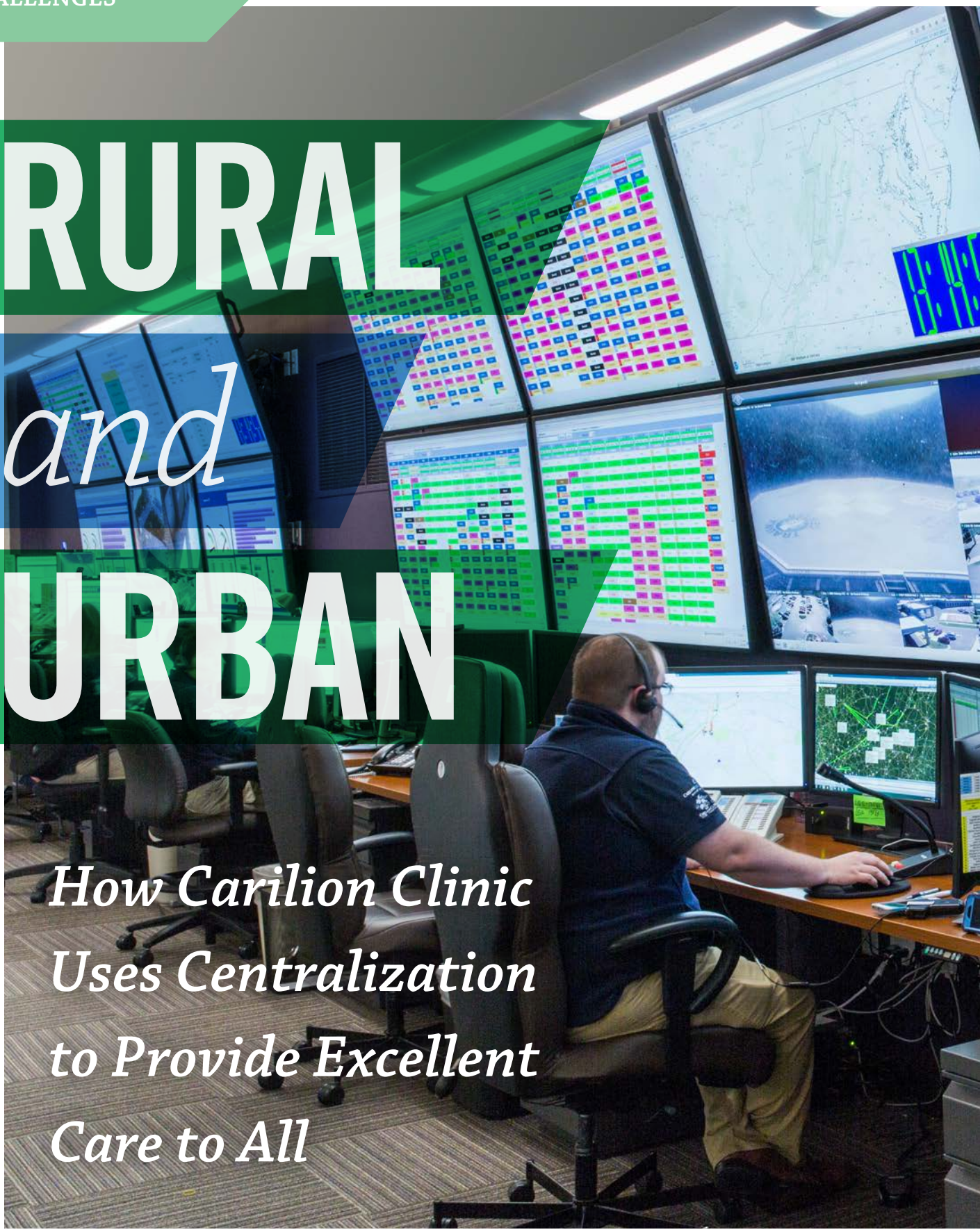
MS, RN, AEMT, CEN, NEA-BC, FACHE, Vice President, Network Emergency, Trauma and Operations Command Center, Kettering Health Network

John has oversight of Kettering's TeleTracking Call Center and Prehospital Emergency Services. He is also supervising the development of operations for a new hospital scheduled to open in the summer of 2019 and is leading the Network Operations Command Center project.

Prior to joining Kettering Health Network, John worked in healthcare organizations in southwest Ohio and Los Angeles in various leadership and clinical positions.

John is a graduate of Wright State University with a Bachelor of Science degree in Nursing and a Master of Science degree in Nursing Administration and Healthcare Systems. He holds a master's certificate in Leadership and Executive Development from the University of Dayton.

RURAL *and* URBAN



How Carilion Clinic Uses Centralization to Provide Excellent Care to All


CARE TRAFFIC CONTROL
CERTIFIED
BLS
BLS
CLOSED
CLOSED
VAMC
CATH
EMS
INS
VENT
24
7

Collaborating to serve the community; a commitment to doing what's right for patients; unwavering in providing exceptional quality and service; showing compassion for patients every day; and fostering creativity and innovation in the pursuit of excellence. Simple, powerful words that represent the values of Carilion Clinic, a six-hospital system in Roanoke, VA—and why the team there decided to adopt a centralized approach to care, with a health system command center, in order to provide the best possible care.

A TRUE PIONEER

The benefits of a centralized approach to care, driven by a health system command center, are clear—operational alignment, improved efficiency, enhanced patient safety and satisfaction, and growth and sustainability. And Carilion is a true pioneer in this space having been an early adopter of this model in 2004—first by centralizing patient placement and eventually integrating their transfer center functions.

Carilion initially adopted this centralized model to solve the challenges associated with patient access and throughput because they simply had more patients than beds. As part of this initiative, they were also digging into patient length of stay and determining what services could be administered on an outpatient versus an inpatient basis. In addition, they were running at 95-98% capacity—which could be problematic for patients with time-sensitive medical issues. When the team centralized and simplified—and sent the right patient to the right facility—the result was a 40% increase in patient transfers to secondary campuses. As the center continued to grow and evolve over the last 16 years, the team has relocated to a new space—in fact they've implemented four centers since then, learning more each time.

"We've been doing bed placement and patient transfers out of our command center, known as the Carilion Transfer and Communications Center or CTaC, for two of our campuses since 2004. The CTaC also houses a communications center that provides dispatchers for the ambulance fleet, as well as three helicopters; environmental services; oversight for clinical transport operations; tight integration with utilization management nurses, and soon-to-expand operations into a satellite room for remote telemetry as well as remote TeleSitters," says Paul Davenport, RN, MBA, NREMTP-RET., CMTE Vice President-Emergency Services & Care Management. "We're proud that we've recently expanded our bed placement capabilities to include five locations, including three rural hospitals."

THE HISTORY OF TAKING COMMAND OF CARE—ON-SITE AND OFF-SITE

Carilion's first center was located in their flagship Roanoke hospital, simply because there was space available and it was given to the team. And while that first onsite location was convenient, the current center, which opened in October 2017, is offsite and built on the principles of high reliability organizations [organizations with systems in place that make them exceptionally consistent in accomplishing their goals and avoiding potentially catastrophic errors, which is absolutely essential at a health system] and the importance of shared situational awareness.

"Centralizing once siloed functions and opening a health system command center is definitely a learning process. Each time we've moved we found we needed a bigger footprint to operate from because once you realize the advantages of co-locating the different areas that impact hospitals throughput, you realize the benefits and synergies of having them in the same workspace," Davenport said. "We have nurses working in our transfer center and we have EMTs and paramedics working in our communications center. So, if someone says, 'I have a helicopter landing in 10 minutes and need an ICU

bed.' the team can make the necessary moves so the bed is ready when the patient arrives."

RURAL OUTREACH

While Carilion Clinic's flagship hospital is in metropolitan Roanoke, the service area is much broader with about 280 miles between the farthermost practices, so CTaC helps Carilion serve the more than 1 million residents who live in mostly rural western and southwest Virginia. The challenges patients and providers face are very different in rural areas. Patients typically have less access to doctors, hospitals and specialty care; they often must travel great distances, which means being away from support networks and incurring transportation costs; and they're often uninsured. Being able to effectively manage these patients and ensure they receive the best care in the most efficient manner is critical to delivering beneficial clinical services.

Carilion knows this firsthand and that's why they have been focused on making a positive impact in their communities. For example, the decision was made to fully maximize the capacity of the network and "light up" additional hospitals. As a result, CTaC now has a complete view of the status and availability of beds at these sites, as well as the status of admitted patients, upcoming discharges, rooms that are being cleaned, and more. This makes it possible to effectively load-balance across the system, have more insight into patient wait and hold-times, keep patients close to home as long as they don't need a higher level of care at the flagship hospital, and improve satisfaction and overall patient flow efficiency. "It requires a sophisticated, coordinated effort between Carilion's fleet of air and ground transport vehicles, our patient placement teams and each of the hospitals," said Davenport.

COLLABORATORS, COLLEAGUES—AND THE FIRST TELETRACKING CARE TRAFFIC CONTROL CERTIFIED™ SYSTEM

Carilion and TeleTracking have been long-time partners and collaborators. In fact, Carilion has been serving as a reference and a role model to other health systems that are beginning their command center journey. Recently the success at Carilion was recognized as one of the inaugural Care Traffic Control Certified health systems—which was announced at TeleTracking's Annual Client Conference last October.

For close to three decades, TeleTracking has recognized the benefits of a centralized approach to care—and how much effort goes into centralizing operations and integrating people, process and technology. That work is now being honored with the opportunity to become Care Traffic Control Certified™. In addition to creating a standard set of criteria to measure centralization success, the program is also designed to foster collaboration, innovation and continuous performance improvement between centers.

"We are proud of the impact we're having in our community, are pleased our accomplishments are being recognized and are excited to help others achieve the same level of success as a Care Traffic Control Certified health system," concludes Davenport.

PAUL DAVENPORT, RN, MBA, NREMTP-RET., CMTE
Vice President-Emergency Services & Care Management

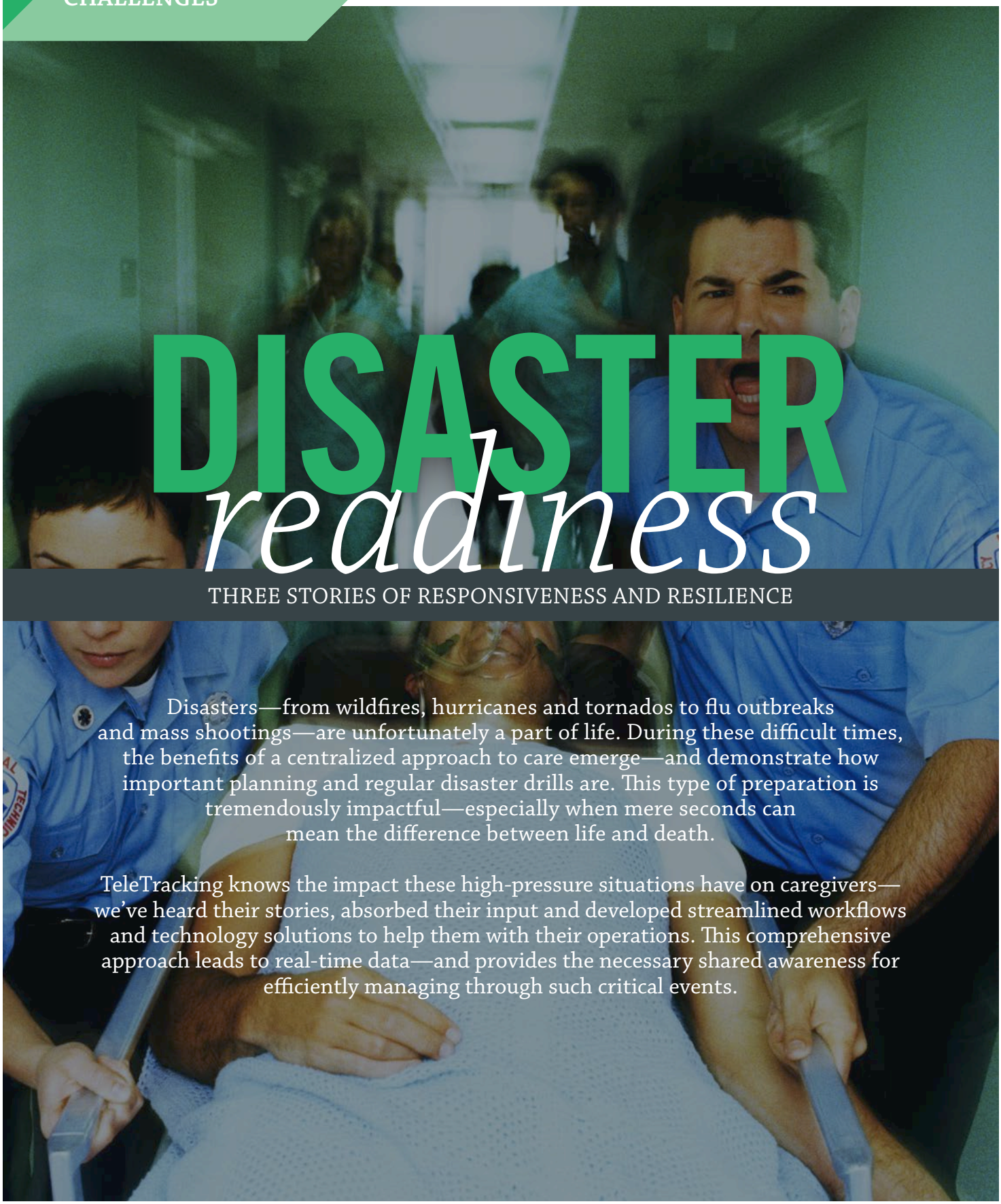
Mr. Davenport serves as the administrative leader for: Emergency Medicine (all Carilion sites), Emergency Residency Program, Carilion Roanoke Memorial Hospital's Emergency Department, Carilion Clinic Patient Transportation (CCPT), and Carilion Clinic's Operation Center (transfer, bed placement, and CCPT communications). In 2014, Davenport took on additional responsibility for Care Management and serves as the Interim Chief Nursing Officer for Carilion Medical Center.

Prior to his role as Vice President, Mr. Davenport was the Senior Program Director for Carilion Clinic Patient Transportation (CCPT) and Carilion Clinic LifeGuard. The program's services include 44 ambulances, three response vehicles, critical care ground transport, neopeds, rotorwing operations, communications center, area disaster coordination, mass gathering, contract 911 services, and injury prevention grant administration. Total volume for the service is over 50,000 transports a year. During this time, Davenport was recognized in 2006 as The Association of Air Medical Services (AAMS's) Program Director of the Year.

Davenport is a third generation EMS provider, and began his career as a volunteer firefighter in Chesterfield County, Virginia.

Mr. Davenport has a B.S.N. from Radford University and a Masters of Business Administration from Averett University.

In addition to his role at Carilion, Davenport is a private consultant, specializing in helping healthcare systems and transport agencies in improving teamwork, patient flow, integration, operations, and contracting.



DISASTER *readiness*

THREE STORIES OF RESPONSIVENESS AND RESILIENCE

Disasters—from wildfires, hurricanes and tornados to flu outbreaks and mass shootings—are unfortunately a part of life. During these difficult times, the benefits of a centralized approach to care emerge—and demonstrate how important planning and regular disaster drills are. This type of preparation is tremendously impactful—especially when mere seconds can mean the difference between life and death.

TeleTracking knows the impact these high-pressure situations have on caregivers—we've heard their stories, absorbed their input and developed streamlined workflows and technology solutions to help them with their operations. This comprehensive approach leads to real-time data—and provides the necessary shared awareness for efficiently managing through such critical events.

Three health systems recently had to put what they had done during drills into practice— Kettering Health Network in Dayton, OH; Broward Health in Ft. Lauderdale, FL; and University Medical Center in El Paso, TX. John Weimer, Vice President of Emergency and Trauma Services at Kettering Health Network; Justin Willis, Nurse Manager, Centralized Patient Logistics Center at Broward Health; and Jesus Reverol, Industrial Engineer at University Medical Center of El Paso share their experiences.

PFQ: Explain the recent disaster that your hospital/system responded to?

Weimer: We were impacted by the mass shooting in Dayton's Oregon District on August 4, 2019. The shooter was neutralized by the Dayton police department within 30 seconds, however, there were 40 casualties including nine fatalities, as well as the deceased shooter.

Willis: We were in the forecast cone for Hurricane Dorian, the Category 5 hurricane that stalled over the northern Bahamas in early September.

Reverol: Mid-morning on Saturday, August 3, 2019, University Medical Center (UMC) received a surge of trauma patients from a mass casualty shooting event, approximately five miles from our campus. An active shooter with an assault rifle opened fire in a Walmart, killing and injuring customers.

Q: How many patients were transferred into /out of your facility because of this event?

Weimer: Three of our hospitals received casualties—a total of 14 patients.

Willis: We received several patients from the Bahamas, however, it did not impact daily operations.

Reverol: We received a total of 15 patients as a result of the shooting. One of the 15 patients was transferred to UMC from Del Sol Medical Center to receive more advanced surgical care. Two of the 15 patients were children with minor injuries that were later transferred to El Paso Children's Hospital where they were subsequently treated and released 24 hours after they arrived.

Q: How prepared were you for the disaster?

Reverol: UMC is very fortunate to have strong executive leaders that support our Emergency Preparedness Committee. This committee is chaired by UMC's Safety Officer and Director of Safety Operations. The chairs of this committee facilitate training exercises annually.

UMC did training in was March 2019, with an active shooter exercise. Participating members included the El Paso Children's Hospital (EPCH), local law enforcement officers and the Texas Tech University Health Sciences Center. The objectives were to evaluate our hospital policies and procedures for the active threat; demonstrate timely activation and use of the Hospital Incident Command Center (HICS) and our emergency management system; identify the resources needed and those available within the hospital during the active threat; identify department training needs; identify emergency management needs at the hospital and provide senior leadership with input on active threat training/planning needs.

Q: Were you able to operate 'normally' despite the disaster?

Weimer: By activating our emergency operation plan and standing up the Emergency Operations Center with hospital incident command, we were able to handle the surge of patients without compromising normal operations. It is worth noting that the time of the incident was very early morning, no elective procedures were scheduled during this time making access to surgical suites a non-issue.

Reverol: Our emergency department triaged patients and did not divert any patients to other hospitals. Nor did we divert EMS/ambulance traffic to other hospitals. Our hospital was able to operate "normally" despite the disaster. This demonstrates teamwork and the ability to prioritize the needs of the patients with required resources.

Various department team members came in without having to be called. As soon as some heard the news, they immediately came to the hospital to offer their assistance. And our departments really pulled together because everyone's job, at every level, became crucial. Environmental Services shined the brightest as their assistance was essential to ensuring rooms were turned over promptly for the next patient. The phlebotomists who came in to assist the blood bank team members were another shining example—emphasizing our ability to keep up with the massive blood transfusions that some of the severely injury patients required.

The technology aspect was also extremely vital. Keeping track of the patients that came through our doors, and their disposition, was not only important to our operations—it was also important to law enforcement and family members who needed to know who was receiving treatment at our trauma center. Patient name reconciliation was done electronically and shared through our web-based Emergency Operations Command Center Network.

We are very fortunate to have strong executive leaders that support our Emergency Preparedness Committee.

– UMC EL PASO

Q: Do you regularly drill for disasters?

Willis: Yes, we do semi-annual drills to prepare for hurricanes and mass casualty events. We did not sustain a direct hit from Hurricane Dorian, so it was an opportunity for us to do refresher training with the Patient Logistics Center and hospital staff to ensure everyone had proper access and knew what their responsibilities were.

Q: Did you co-locate your incident command system in your operational command center?

Willis: We did not co-locate our incident command system with our operational command center, however census data and bed availability from TeleTracking was available. As our center evolves, we are considering integrating them in the future.

Reverol: Initially they were co-located, then we made the decision to separate them due to space constraints, the number of responders and campus safety concerns. The two were rejoined during a second debriefing and at the closing debriefing sessions. While they were co-located, both the Hospital Incident Command and the command center worked in tandem, feeding information to each other regarding bed availability and status, pending and confirmed discharges, and dispatched EVS and transportation through TeleTracking as needed.

Q: Did you rely on paper or technology during the disaster?

Willis: We relied on technology. We used real-time census data to report directly to the State of Florida regarding our bed availability. We also trained hospital staff to pre-triage patients in case we needed to prioritize evacuations using the trauma triage tagging system (green, yellow, red, black). We also had the ability to track staff, visitors and non-patient boarders through TeleTracking.

Q: Please share three lessons you learned that your peers should consider as they prepare for the next event?

Weimer:

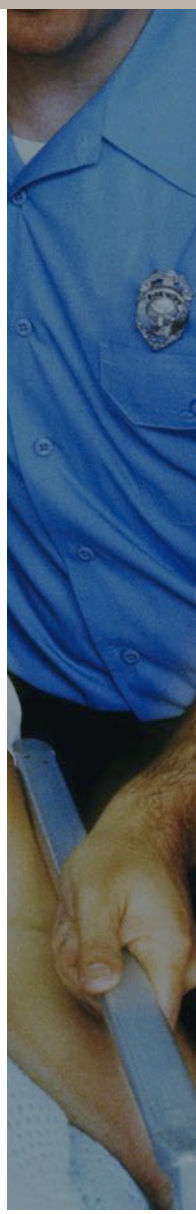
(1) Drill with the community, including the agencies you will be working with during a large event. Relying on established relationships proved to be invaluable during our response.
(2) Have a plan for media. Our public information officer was inundated with requests almost immediately, including international media outlets. A crisis communications plan is essential.
(3) Utilizing an after-action process to evaluate and formally document a response is also essential. It is important to get feedback from all levels of the organization to ensure continued quality improvement and planning for future events.

Willis:

(1) Pre-train both nursing leadership and the patient access staff on how to register patients in TeleTracking, without involving the ADT system.
(2) Have a defined evacuation triage system in place.
(3) Pre-determine the physical locations of where your disaster locations will be.

Reverol:

(1) Participate in as many exercises/drills available at the regional level. Each drill should have pre-assigned objectives and participants should take a good hard look at any exposed weaknesses and rectify them before an actual event occurs.
(2) Establish solid communications with multiple agencies, from law enforcement to behavioral health agencies.
(3) Practice like you play by involving all the departments that would be impacted by such an event because the ability to work as a team is essential.



OUR MISSION:

To ensure that no one will ever have to wait for the care that they need.

WHERE TO BEGIN?

Our team is experienced in working with hospitals and health systems at every stage in the journey to centralized care.

Let's talk today about where we can start together to ensure you're set up for success today and for all that tomorrow may bring.

TeleTracking®

Pittsburgh | Nashville | Raleigh | London

info@teletracking.com | 800-331-3603