Conflict Management in Times of Competing Resources and Priorities

Stephen Weber, MD, ScM
Associate Professor – Infectious Diseases & Global Health
Chief Medical Officer & Vice President for Clinical Effectiveness
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Learning Objectives

Upon completion, participants should be able to:

› Identify the stakeholders involved in epidemic preparedness and the relationship to infection prevention and healthcare epidemiology leaders

› Identify areas of limited resources and demonstrate the importance of advanced and systematic planning to avoid conflict

› Establish a framework for decision making when dealing with limited resources in the setting of an epidemic
Introduction
The University of Chicago Medicine

- **Capacity**
  - 805 licensed adult and pediatric beds
  - 9,000 employees
  - 842 faculty physicians
  - 1,100 residents and fellows
  - Level 1 trauma (2018)

- **Staffing**
  - 760,000 outpatient visits
  - 91,000 emergency visits
  - 29,000 admissions
  - 21,000 surgeries

- **Discovery**
  - $128 million NIH funding
The University of Chicago Medicine Infection Prevention Program

- **Leadership and staffing**
  - Full time RN Director (30 years’ experience)
  - 1.8 physician FTEs (adult and pediatric)
  - 8 ICP FTE and support staff

- **Key activities**
  - Surveillance
  - Performance improvement (PI)
  - Outbreak investigation
  - Laboratory support

- **Organization**
  - Reports to Chief Quality Officer
  - Under Clinical Effectiveness Office (CMO)
  - Close integration with other PI and operational units
Experience: Disclosures and Revelations

Community-Acquired Methicillin-Resistant Staphylococcus aureus in Children With No Identified Predisposing Risk

Betsy C. Herold, MD; Lilly C. Immengrick, MD; Melinda C. Maranan, MD; Diane S. Lauderdale, PhD; Ryan E. Gaskin; Susan Boyle-Valva, PhD; Cindy D. Leitch; Robert S. Daum, MD

Context.—Community-acquired methicillin-resistant Staphylococcus aureus (MRSA) infections in children have occurred primarily in individuals with recognized predisposing risks. Community-acquired MRSA infections in the absence of identified risk factors have been reported infrequently.

Objectives.—To determine whether community-acquired MRSA infections in children with no identified predisposing risks are increasing and to define the spectrum of disease associated with MRSA isolation.

Design.—Retrospective review of medical records.


Setting.—The University of Chicago Children’s Hospital.

Main Outcome Measures.—Prevalence of community-acquired MRSA over time, infecting vs colonizing isolates, and risk factors for disease.

Who: Perils in Partnership
Form Follows Function: Structural Features Should Position Infection Prevention for Routine Operations As Well As Emergencies

- Authority
  - Statutory authority
  - Ties to operating plan/strategic plan
  - Vertical positioning (level-setting)

- Visibility and accessibility
  - Integration in quality infrastructure
  - Organizational “all-access pass”
  - Chain of command (short and strong)

- Collaboration and partnerships
  - Performance improvement (Quality, Lean, etc.)
  - Business continuity/emergency planning
  - Operating teams
Successful Internal Relationships Are a Driver to Success: Organizational and Interpersonal Considerations
External Relationships and Positioning Can Be Equally Critical and Such Relationships Need to Be Cultivated
Personal Positioning: Understanding How Infection Prevention Professionals and Healthcare Epidemiologists Ensure Effectiveness

- **Credibility**
  - Do I have and demonstrate expertise?
  - Is my information and knowledge up to date?
- **Reliability**
  - Am I present?
  - Am I consistent, in or out of crisis?
- **Approachability**
  - Am I open to new ideas and concerns?
  - Can I be flexible when necessary?

*What is the brand of your program within the organization?*
What: Anticipating Needs in the Time of Crisis
Dwight D. Eisenhower

“Plans are useless.
It is the planning that is indispensable.”
Risk Assessment: The Cornerstone to Preparedness Planning at Any Level in Any Organization

Timely, routine, and thoughtful risk assessment allows for:

- Identification of needs and sensible allocation of resources and expertise
- Engagement of key stakeholders
- Surfacing of new and emerging threats
Emergency Preparedness as an Element of Routine Infection Prevention Risk Assessment

- Annual infection control risk assessment is not just a good idea, it’s “the law”
- Embedding preparedness into annual risk assessment ensures focus and attention
- Semi-quantitative methods are suitable for consideration of even rare or unlikely emerging threats

### Sample Hospital Infection Control Risk Assessment

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<th>Likelihood</th>
<th>No. Affected</th>
<th>Severity</th>
<th>Vulnerability</th>
<th>Total Risk</th>
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Simulation: Risk Assessment in Action

- Tabletops, live drills, and regional/national collaborative exercises all play a role in infection prevention preparedness.
- Focus scenarios based on specific results of risk assessment but with an aim to developing generalizable skills and systems for preparedness.

Ebola Training and Simulation (2014)

Tabletop Simulation: Booth School

Cumulative Reported Smallpox Cases December 22
Total = 16,000
Operation Dark Winter (June, 2001)
Key Resource: Equipment (Ventilators)

- **Stockpiling**
  - For most organizations, it is not prudent or economical to stockpile critical equipment for emergencies when there are existing capital pressures.

- **Flexibility**
  - Be flexible in purchasing to ensure that devices are suitable for use in an emerging-pathogen event to allow for safe and sensible repurposing.
  - Focus on durability, decontamination, and disinfection.

- **Collaboration**
  - Designation of “Centers of Excellence” (COE) allows for concentration and even redistribution and consolidation of equipment resources to specific centers.
Key Resource: Supplies (PPE, Medications)

- **Stockpiling**
  - For most organizations, it is not prudent or economical to stockpile critical supplies for emergencies when there are existing pressures for routine use.
  - However, the temptation is great, and consideration can be given to maintaining a par level to support operations for a defined period of time.

- **Flexibility**
  - Given supply chain vulnerability, especially in the case of a large event, consider maintaining redundant supply chains to support operations.
  - Ensure that policies and training support this adaptability.

- **Collaboration**
  - Coordination between centers and providers allows for standardization of best-practice principles even while allowing for variation in specific supplies.
  - Be realistic about outside support in case of event.
Key Resource: Space (Care and Treatment Areas)

- **Stockpiling: dedicated space**
  - Dedicated space (mothballed outside of an event) is an option only when aligned with strategic plan and overall organization priorities (eg, COE designation)
  - Dedicated spaces must be available for training and education

- **Flexibility**
  - Repurposing a care area outfitted with necessary features is a sensible middle ground
  - Need to accept the disruption to services
  - “Pop-up units” may be an option for organizations lacking the space or resources for dedicated units and facilities

- **Collaboration**
  - Dedicated centers are ideal, but every organization needs an option for caring for affected patients
  - Consider sharing movable resources (equipment, supplies, expertise)
Key Resource: People and Expertise

- Roles and expectations
  - Confront challenging human-resource issues in advance to avoid coercion and controversy (labor relations, trainees, premium/hazard pay)
  - Prepare job action sheets relevant to the anticipated event in accordance with standards (and sometimes independent of usual or routine responsibilities)

- Staffing
  - Ensure that all providers and staff are performing to the highest extent of their abilities and licensure (especially infection prevention professionals)
  - Clinical assignments may be determined more by technical skills than content expertise (intensivists vs ID for Ebola)

- Resilience
  - Advanced planning requires redundancy and sensitivity to account for the enormous strain and pressure associated (particularly) with a prolonged event
How: Making Decisions Under Stress
Absent of a Clear Understanding of the Key Stakeholders and Roles, Competition Will Emerge and Confusion Will Ensue
Form Follows Function II: Hospital Incident Command

- HICS is an approach that can be applied by any healthcare organization to manage threats, planned events, or emergency incidents.

- HICS does not just provide an organizational structure for incident management; it is designed to guide the planning, building, and adapting of that structure.

- Using HICS for every incident or planned event helps develop and sustain skills needed for large-scale incidents.

- HICS is a flexible, scalable, and adaptable system that can be used by all hospitals regardless of size, location, patient acuity, patient volume, or hazard type.

California Emergency Medical Services Authority. Hospital Incident Command System Guidebook, 5e. 2014.
HICS: Fundamental Elements of Design and Execution

1. Predictable chain of command with a suggested span of control
2. Accountability of position and team function, including prioritized action checklists
3. Common language for promoting interagency communication
4. A flexible and scalable incident management system addressing planning and response needs of any size hospital with universal applicability
5. Modular design and adaptability allowing planning and management of non-emergent incidents or events
6. Guidance requirements from the NIMS and accreditation agencies regarding hospital use of incident command system principles in unity of effort with community response partners
7. MBO in which the problem encountered is evaluated, a plan to remedy the problem is identified and implemented, and the necessary resources are assigned

California Emergency Medical Services Authority. Hospital Incident Command System Guidebook, 5e. 2014.
HICS Incident Management Team

Operations Section Chief
- Staging Manager
  - Personnel Staging Team Leader
  - Vehicle Staging Team Leader
  - Equipment/Supply Staging Team Leader
  - Medication Staging Team Leader
- Medical Care Branch Director
  - Inpatient Unit Leader
  - Outpatient Unit Leader
  - Casualty Care Unit Leader
  - Behavioral Health Unit Leader
  - Clinical Support Unit Leader
  - Patient Registration Unit Leader
- Infrastructure Branch Director
  - Power/Lighting Unit Leader
  - Water/Sewer Unit Leader
  - HVAC Unit Leader
  - Building/Grounds Unit Leader
  - Medical Gases Unit Leader
- Security Branch Director
  - Access Control Unit Leader
  - Crowd Control Unit Leader
  - Traffic Control Unit Leader
  - Search Unit Leader
  - Law Enforcement Interface Unit Leader
- HazMat Branch Director
  - Detection & Monitoring Unit Leader
  - Spill Response Unit Leader
  - Victim Decontamination Unit Leader
  - Facility/Equipment Decontamination Unit Leader

Planning Section Chief
- Resources Unit Leader
- Situation Unit Leader
- Documentation Unit Leader
- Demobilization Unit Leader

Incident Commander

Logistics Section Chief
- Service Branch Director
  - Communications Unit Leader
  - IT/IS Equipment Unit Leader
  - Food Services Unit Leader
- Support Branch Director
  - Employee Health & Well-Being Unit Leader
  - Supply Unit Leader
  - Transportation Unit Leader
  - Labor Pool & Credentialing Unit Leader
  - Employee Family Care Unit Leader

Medical-Technical Specialists
- Biodefense
- Chemical
- Radiological
- Medical Affairs
- Risk Management
- Medical/Child
- Pediatric Care
- Medical Librarian

Finance/Administration Section Chief
- Time Unit Leader
- Procurement Unit Leader
- Compensation/Claims Unit Leader
- Cost Unit Leader

Public Information Officer
- Liaison Officer
- Safety Officer

California Emergency Medical Services Authority. Hospital Incident Command System Guidebook, 5e. 2014.
At the Table: Infection Prevention, Healthcare Epidemiology, and HICS

- **Primary bio- or infectious incident or event**
  - IC/HE serves as MTS
  - MTS “has the ear” of the incident commander and participates in all report outs and is expected to provide active contribution and commentary
  - No major decisions are made without the input and endorsement of MTS
  - MTS is available to and advises section chiefs (including operations)

- **Noninfectious incident or event**
  - IC/HE reports to Medical Care Branch Director
  - IC/HE is available to advise and support Medical Branch of Operations Section
  - IC/HE relies on HICS relationships and reporting to understand and act on relevant items or issues
Making HICS Work: Discipline and Alignment in Incident Command

- Rigorous application of structure
  - Authority granted to leadership and participants
  - Scope of event and authority is well defined
  - No last-minute substitutions
- Disciplined execution at meetings
  - Timely and focused reporting
  - Clear expectations for all participants
  - Respect for authority but clear and direct communication
- Adaptability
  - Depth at position (“B team” simulation)
The First Decision: How Will This Event Affect Our Routine Business and Operations (and Bottom Line)?

- The scale and scope of the event or threat will often dictate the scale and scope of the response required; however, under many circumstances, the organization will need to make an active decision about the effect on routine operations:
  - Elective surgical cases
  - Ambulatory visits
  - Time off/holidays
  - Overtime and other premium pay
  - Allocation of resources (space, time, budget)

- This decision must be made by (rapid) consensus and with clear sign off at the highest executive levels

- *Especially in the case of epidemics or infectious events, the IC/HE team must provide credible and timely information to inform the decision*
Formal Decision Analysis

- Decision analysis methods allow for rigorous and quantitative assessment of possible courses
  - A decision needs to be made (even no decision)
  - Probability assessments can be used to assess sensitivity of various decision points
  - Weighting of outcomes compels decision makers to articulate values
  - Requires discipline and clear communications

- Analysis paralysis?
  - *Don’t just do something, stand there!*

![Decision Tree Diagram]

- Decision
- Uncertainty (external event)
Much Less Formal Decision Analysis for Times of Uncertainty

- **Rational**: Is this decision sensible with the information available at this time?
- **Practical**: Can we realistically expect to execute on this decision and plan?
- **Equitable**: Does this decision and plan taken into account the needs and expectations of those that we serve?
Culture, Decision Making, and Execution

- The decisions that will ultimately lead to success or failure in effectively managing an event will not be made by senior leaders or executives in the command center.
- Execution in the moment by professional and non-professional staff on the front lines is the product of communication, culture, and trust.

“In the absence of supervision or clear policy or practice guidance, will your team member make the right decision?”
Conclusions:
Crisis Management
The Bigger Picture: Lessons Learned From Outbreaks, Pandemics, and Emerging Pathogens

Why do we seem to manage better in the setting of crises?
- Alignment
- Singularity of purpose
- Alignment of mission
- Respect for expertise of others
- Disciplined decision making
- Clear and effective communication
- Uncertainty breeds collaboration in the right environment

EBOLA MANAGEMENT
How to Avoid the Traps and Execute Brilliantly