OVERVIEW OF THE PATIENT MOVEMENT WORKGROUP & WORKGROUP PRODUCTS

October 2016

GREATER NEW YORK HOSPITAL ASSOCIATION
Over 100 years of helping hospitals deliver the finest patient care in the most cost-effective way.

Greater New York Hospital Association (GNYHA): Who We Are

- Founded in 1904, Greater New York Hospital Association (GNYHA) is a trade association comprising nearly 250 hospitals and continuing care facilities, both voluntary and public, in the metropolitan New York area and throughout the State, as well as New Jersey, Connecticut, and Rhode Island.
- Key areas of work:
  - Advocacy
  - Quality & Patient Safety
  - Finance, Insurance, and Graduate Medical Education
  - **Emergency Preparedness**
  - Diversity & Community Health
  - Provider Operations & Compliance

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Patient Movement Workgroup

- Co-led by NYC Department of Health and Mental Hygiene and GNYHA
  - Includes broad range of SMEs (emergency managers, transfer center staff, clinical leadership, medical staff specialists, and staff of transport agencies)
  - Representatives from NYC Health + Hospitals, Northwell, Mount Sinai, New York Presbyterian, SUNY Downstate, Montefiore, NYU Langone, NYSDOH, DOHMH, NYCEM, REMSCO, FDNY
- Meeting monthly since February 2015 to tackle issues that **hampered patient evacuation** during Hurricanes Irene & Sandy
  1. Standardized bed definitions to facilitate bed matching immediately before patient evacuations
  2. Facilitating sharing of critical medical information during transport
  3. Increasing post-transfer PHI exchange between sending and receiving facilities
  4. Best practices related to emergency credentialing of healthcare personnel

Standardized Bed Definitions to Facilitate Bed Matching Immediately **Before Patient Evacuations**

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#1: Standardized Bed Definitions to Facilitate Bed Matching: **Concern and Goal**

- Concern: During Hurricanes Sandy and Irene, different understandings of commonly used bed type terms compromised the ability of involved staff to identify appropriate beds/resources for patient that needed to be evacuated. *Put another way, an ICU bed is not an ICU bed is not an ICU bed across different types of institutions.*

- Goal: Create standardized bed definitions that can be used as a common vocabulary regionally or statewide to facilitate appropriate bed matching.

#1: Standardized Bed Definitions to Facilitate Bed Matching: **Approach**

- Examined several bed categorizations frameworks including: NYSDOH bed types (36), NYSDOH Healthcare Evacuation Center (HEC) categories (18), VA/DoD (7)
  - Honed in on **HEC categories**
- Group worked to reduce these categories into the smallest possible number that still allowed for specificity
- Began to develop definitions for 5 broad categories:
  1. Critical Care
  2. Med/Surg
  3. Perinatal
  4. Psychiatric
  5. Rehab

Focus on staff and equipment that would be needed for patients in each category.

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#1: Standardized Bed Definitions to Facilitate Bed Matching During Evacuations: **Approach continued**

- Developed definitions for these 5 categories – standard *(appropriate for large majority of patients within a category)* and augmented
  1. Critical Care (adult, pediatric)
  2. Med/Surg (adult, pediatric)
  3. Perinatal (antepartum, labor and delivery, postpartum, healthy newborn)
  4. Psychiatric (geriatric, adult, child, adult addiction treatment – medically managed, adult addiction treatment – medically supervised)
  5. Rehab (adult, pediatric)

  **Define pediatrics as <18 years of age*

Please refer to definition handout provided.

Development of Sending Hospital and Receiving Hospital Forms

- Once we developed the definitions, we needed to operationalize their use during an evacuation scenario
- We designed forms to facilitate evacuation planning whether facility is handling evacuation on its own, via its healthcare system, or using HEC resources
  - Portion of the form to be done in advance of an event (planning); other portion completed during event (response)
  - Separate forms for sending hospitals and receiving hospitals; designed to collect aggregate numbers at unit level
  - Also incorporates NYS DOH Transportation Assistance Levels (TALs)

Testing of Definitions and Forms

- Have verified standard and augmented definitions with specialists in each area
- Have conducted two pilot tests:
  - NYP Lower Manhattan – sending form only; focus on critical care, med/surg and perinatal
  - Mt. Sinai Hospital and Mt. Sinai St. Lukes – sending and receiving forms; focus on rehab and pysch categories
  - Planning additional pilot with NYU Langone; will focus on perinatal category

***After each pilot have made significant revisions to the forms*

Group B: Medical/Surgery -- Medical/surgery patients have medical illnesses or disorders, as well as diseases or injuries normally treated by surgery, who do not require critical care support

Directions:
- Indicate with numbers the total number of patients your facility needs to evacuate to another facility for each group below, and then the total number within each sub-group.
- For each sub-group, please divide the number as indicated -- those that need a standard bed within that sub-category and then those that require augmented services, describing those services in the box provided. Please carefully read the definitions provided for each patient type and ensure that patients listed in the totals meet the definitions. Be especially careful when evaluating patients in "step down" or intermediate care settings, to ensure that receiving facilities with the appropriate resources and care level can be identified.

Standard bed definition for all bed types in this group:	**Augmented services for all bed types in this group:**	**Guidelines for completing TALS:**
• General medical staff (including major medical and surgical subspecialists, and general medical/surgical floor nurses) • General medical equipment, such as a standard hospital bed, medical air/oxygen, IV and medication administration supplies are sufficient for care. ** *Patients in this category should not require telemetry during transport. If this is required, consider putting these patients into the Critical Care category.*	Patients who need additional services beyond those included in the standard definition should be counted in the "augmented services" column. Examples of augmented services include: • dialysis • airborne isolation • enhanced equipment (ie, bariatric) • enhanced personnel or treatments (ie, unusual subspecialty, specialized would care)	For patients in each bed type, please count the number of patients requiring each transportation assistance level (TAL). For patients requiring stretcher, indicate whether ALS or BLS level support is required. Patients with continuous IV medications, intubated, or on ventilator require ALS. If patients weigh greater than 300 pounds, count as bariatric. If infants require isolette, count as

Category	# Meeting Standard Definition	# Augmented Services	Total Adult Med/Surg
Adult Med/Surg (Patient aged 18 and older):			0

List to the right all units within hospital which contributed patients to this category:

For each patient in the augmented services column, briefly describe augmented services required (dialysis, airborne isolation, bariatric equipment, etc.) and name of current unit (i.e., Med/Surg 3West):

TALs: For total # of patients listed above, indicate how many require each level.

	Name	Needs	Current unit	TAL level	Number
Patient 1				Level 1 stretcher ALS	
Patient 2				Level 1 stretcher BLS	
Patient 3				Level 1 bariatric ALS	
Patient 4				Level 1 bariatric BLS	
Patient 5				Level 2 wheelchair	
Patient 6				Level 3 ambulatory	
Patient 7				Neonatal transport	
				Total	0

Med/Surg Form Page – Adult Med/Surg Category

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Next Steps & Questions for You

- Between October-December presenting at all DOH regional/sub-regional meetings to elicit feedback
  - DOH is considering integration of these definitions into the HEC application and other statewide systems.

Questions for YOU:

- Do these definitions make sense for your facility?
- Would you be able to integrate these definitions and/or forms into your internal processes? Evacuation plans?

Future Opportunities

- It is technically possible to build logic into EMR systems to automatically and continuously assign patients to a Standardized bed category and a Transportation Assistance Level
  - Stanford Children's Hospital, using Epic, has developed and implemented a transportation resource algorithm
  - Mt. Sinai Health System beginning work in this area

- Such approaches have the potential to improve both day-to-day transfers and large-scale patient evacuations

Facilitating Sharing of Critical Medical Information **During the Transport Process**

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#2. Facilitating Sharing of Critical Medical Information During Transport Process: **Concern and Goal**

- Concern: During Hurricanes Sandy and Irene, basic clinical and demographic information was not always available to the clinicians and staff responsible for staging at the sending hospital, facilitating transport, and triage, as well as those providing initial care at the receiving hospital – a process that can take several hours.

- Goal: Facilitate process by which all patients have critical clinical and demographic information with them throughout the transport process.

Facilitating Sharing of Critical Medical Information During Transport Process: **Approach**

- While some jurisdictions have developed a stand-alone patient evacuation form, workgroup members concluded that using day-to-day systems and documents would result in higher adherence during an emergency incident.
- Workgroup considered serval sources of clinical and demographic information.
- Decided use of inter-facility transfer forms and patient face sheets was most sensible.
  - Generally used at hospitals across the NY Region, and day-to-day purpose mimics the intended purpose during an emergency evacuation.
- Workgroup examined nearly a dozen examples of such forms, assessing the frequency with which various elements were used, and weighing the importance of these elements during a large-scale patient evacuation.

Facilitating Sharing of Critical Medical Information During Transport Process: **Suggested Data Elements**

Workgroup members collaboratively developed a list of suggested data elements for inter-facility transfer forms and patient face sheets, with four information domains:

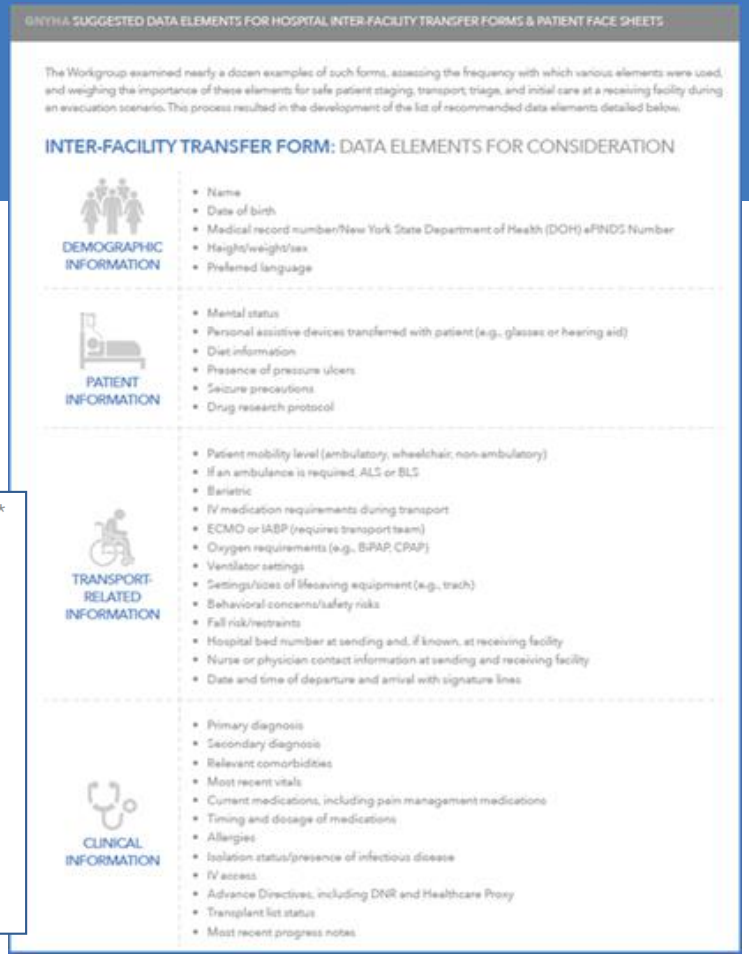
- Demographic
- Patient
- Transport-related
- Clinical

PATIENT FACE SHEET: DATA ELEMENTS FOR CONSIDERATION*

PATIENT FACE SHEET

- Name
- Medical record number/DOH eFINDS Number
- Social Security number
- Sex
- Date of birth
- Address
- Emergency contact information/next of kin
- Primary Care Physician name and phone number
- Parent/guardian information for minors
- Advance Directives, including DNR and Healthcare Proxy
- Insurance information
- Guarantor information
- Activities of Daily Living
- Room and bed number
- Primary diagnosis

Some elements appear on both this list and the inter-facility transfer form list



GNYHA SUGGESTED DATA ELEMENTS FOR HOSPITAL INTER-FACILITY TRANSFER FORMS & PATIENT FACE SHEETS

The Workgroup examined nearly a dozen examples of such forms, assessing the frequency with which various elements were used, and weighing the importance of these elements for safe patient staging, transport, triage, and initial care at a receiving facility during an evacuation scenario. This process resulted in the development of the list of recommended data elements detailed below.

INTER-FACILITY TRANSFER FORM: DATA ELEMENTS FOR CONSIDERATION

DEMOGRAPHIC INFORMATION

- Name
- Date of birth
- Medical record number/New York State Department of Health (DOH) eFINDS Number
- Height/weight/sex
- Preferred language

PATIENT INFORMATION

- Mental status
- Personal assistive devices transferred with patient (e.g., glasses or hearing aid)
- Diet information
- Presence of pressure ulcers
- Seizure precautions
- Drug research protocol

TRANSPORT-RELATED INFORMATION

- Patient mobility level (ambulatory, wheelchair, non-ambulatory)
- If an ambulance is required, ALS or BLS
- Bariatric
- IV medication requirements during transport
- ECMO or IABP (requires transport team)
- Oxygen requirements (e.g., BiPAP, CPAP)
- Ventilator settings
- Settings/sizes of lifesaving equipment (e.g., trach)
- Behavioral concerns/safety risks
- Fall risk/restraints
- Hospital bed number at sending and, if known, at receiving facility
- Nurse or physician contact information at sending and receiving facility
- Date and time of departure and arrival with signature lines

CLINICAL INFORMATION

- Primary diagnosis
- Secondary diagnosis
- Relevant comorbidities
- Most recent vitals
- Current medications, including pain management medications
- Timing and dosage of medications
- Allergies
- Isolation status/presence of infectious disease
- IV access
- Advance Directives, including DNR and Healthcare Proxy
- Transplant list status
- Most recent progress notes

Launch of Transfer Form Initiative

SUGGESTED DATA ELEMENTS

FOR HOSPITAL INTER-FACILITY TRANSFER FORMS & PATIENT FACE SHEETS

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This document provides data elements that member hospitals, particularly in the New York City (NYC) Region–the five boroughs, Long Island, and the Greater Hudson Valley–are encouraged to include on their existing inter-facility transfer forms and patient face sheets. The document was developed by GNYHA's Patient Movement Workgroup in response to challenges faced in evacuating patients during Hurricanes Irene and Sandy. Including these elements has the potential to improve day-to-day patient transfers, and most important, can contribute to the availability of clinical and demographic information to aid in patient staging at a sending facility, patient transport, and patient triage, as well as initial care at a receiving facility during emergency incidents that necessitate large-scale patient evacuation.

PATIENT MOVEMENT WORKGROUP

Launched in February 2015, the Workgroup is jointly led by the New York City Department of Health and Mental Hygiene (DOHMH) and GNYHA. The Workgroup convenes clinicians, emergency managers, health information technology specialists, transfer center leadership, and others from a number of area hospitals and health systems, as well as government agencies and medical transport organizations. The Workgroup has worked to address several related challenges experienced during Hurricanes Irene and Sandy that complicated patient evacuation.

FOCUS AREA

During Hurricanes Sandy and Irene, basic clinical and demographic information was not always available to the clinicians and staff responsible for staging at the sending hospital, facilitating transport, and triage, as well as to those providing initial care at the receiving hospital. Regardless of clinical conversations that may occur between providers at both hospitals, it is important that staff involved with patient care throughout the evacuation and transport process (which can take several hours) possess certain information needed to care for the patient during this transition period. Furthermore, having a set of data elements used across institutions can help ensure that, regardless of the origin or destination of a patient, clinicians across the region know what information they might expect when transporting or receiving a patient.

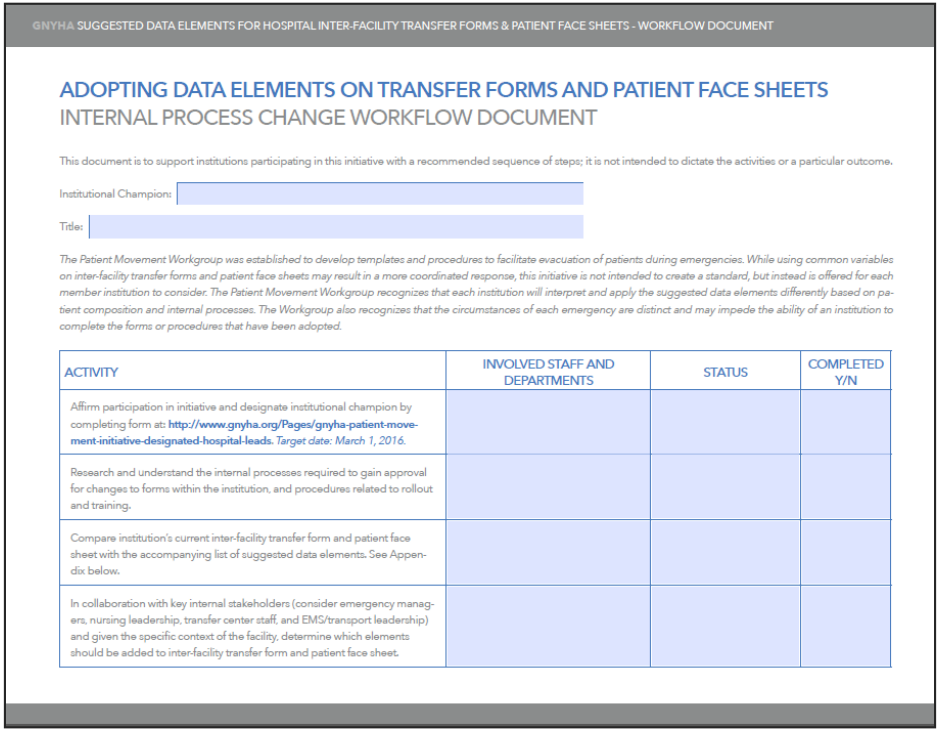
PROPOSED SOLUTION

While some jurisdictions have developed a stand-alone patient evacuation form, Workgroup members concluded that using day-to-day systems and documents would result in higher adherence during an emergency incident. The Workgroup considered several existing sources of clinical and demographic information for this purpose, ultimately deciding that using inter-facility transfer forms and patient face sheets held the greatest promise. These two documents are generally used at hospitals across the region, and in the case of inter-facility transfer forms, their day-to-day purpose mimics in certain respects the purpose such forms would have during a patient evacuation scenario.

The Patient Movement Workgroup was established to develop templates and procedures to facilitate evacuation of patients during emergencies. While using common variables on inter-facility transfer forms and patient face sheets may result in a more coordinated response, this initiative is not intended to create a standard, but instead is offered for consideration by each member institution. The Workgroup recognizes that each institution will interpret and apply the suggested data elements differently based on patient composition and internal processes. The Workgroup also recognizes that the circumstances of each emergency are distinct and may impede the ability of an institution to complete the forms or procedures that have been adopted.

GNYHA is a dynamic, constantly evolving center for health care advocacy and expertise, but our core mission—helping hospitals deliver the finest patient care in the most cost-effective way—never changes.

Package sent to CEOs of all member hospitals January 15th.



GNYHA SUGGESTED DATA ELEMENTS FOR HOSPITAL INTER-FACILITY TRANSFER FORMS & PATIENT FACE SHEETS - WORKFLOW DOCUMENT

ADOPTING DATA ELEMENTS ON TRANSFER FORMS AND PATIENT FACE SHEETS

INTERNAL PROCESS CHANGE WORKFLOW DOCUMENT

This document is to support institutions participating in this initiative with a recommended sequence of steps; it is not intended to dictate the activities or a particular outcome.

Institutional Champion:

Title:

The Patient Movement Workgroup was established to develop templates and procedures to facilitate evacuation of patients during emergencies. While using common variables on inter-facility transfer forms and patient face sheets may result in a more coordinated response, this initiative is not intended to create a standard, but instead is offered for each member institution to consider. The Patient Movement Workgroup recognizes that each institution will interpret and apply the suggested data elements differently based on patient composition and internal processes. The Workgroup also recognizes that the circumstances of each emergency are distinct and may impede the ability of an institution to complete the forms or procedures that have been adopted.

ACTIVITY	INVOLVED STAFF AND DEPARTMENTS	STATUS	COMPLETED Y/N
Affirm participation in initiative and designate institutional champion by completing form at: **http://www.gnyha.org/Pages/gnyha-patient-movement-initiative-designated-hospital-leads.** *Target date: March 1, 2016.*			
Research and understand the internal processes required to gain approval for changes to forms within the institution, and procedures related to rollout and training.			
Compare institution's current inter-facility transfer form and patient face sheet with the accompanying list of suggested data elements. See Appendix below.			
In collaboration with key internal stakeholders (consider emergency managers, nursing leadership, transfer center staff, and EMS/transport leadership) and given the specific context of the facility, determine which elements should be added to inter-facility transfer form and patient face sheet.			

Suggested Internal Process

ACTIVITY
Affirm participation in initiative and designate institutional champion by completing form at: **http://www.gnyha.org/Pages/gnyha-patient-movement-initiative-designated-hospital-leads**. *Target date: March 1, 2016.*
Research and understand the internal processes required to gain approval for changes to forms within the institution, and procedures related to rollout and training.
Compare institution's current inter-facility transfer form and patient face sheet with the accompanying list of suggested data elements. See Appendix below.
In collaboration with key internal stakeholders (consider emergency managers, nursing leadership, transfer center staff, and EMS/transport leadership) and given the specific context of the facility, determine which elements should be added to inter-facility transfer form and patient face sheet.
Participate in calls GNYHA holds for designated hospitals leads for this initiative. Calls will take place in the spring of 2016 to support this work within member institutions.
Work through the form revision process within the institution as determined by internal protocols and procedures.
Via a survey provided by GNYHA, provide information about which data elements the institution added to its inter-facility transfer form and patient face sheet. *Target date: September 1, 2016.*
Engage Health Information Technology staff within the institution to develop a complementary EMR transfer report that can automatically populate the required variables on the transfer form. Gain an understanding of the process and timeline for creating such an EMR report and provide support and input as needed.
Once revisions to the paper form have been achieved, provide needed support to ensure that revised forms are appropriately rolled out and training occurs.
Once the EMR transfer report has been built, ensure that it is appropriately tested and piloted. Encourage use of the EMR transfer report with routine inter-facility transfers.
In collaboration with the group of internal stakeholders identified earlier, use complementary communication and training opportunities with key departments to underscore the rationale for and importance of these form changes and use of the complimentary EMR transfer report.

Implementation Efforts

- GNYHA has held 2 implementation support calls (April, June); planning 3rd for later in year
- Also planning survey to understand reach/impact of initiatives
- What GNYHA has observed thus far:
  - For health systems, effort to approach this initiative centrally
  - In institutions that are the furthest along, efforts are led by a multi-disciplinary team
  - Institutions are working to maximize the amount of information that can be auto-generated from their EMRs
  - Many institutions indicate that this initiative is improving their day-to-day transfer workflows and documentation

Complementary Work

- Trying to engage EMR vendors to develop back-end template forms containing the list of suggested data elements; would reduce development burden on individual hospitals
- Recent conversation with downstate RHIOs; plan to launch pilot to test pushing and pulling of static transfer forms between institutions for day-to-day transfers
- Also interested in integration with eFinds system

Increasing **Post-Transfer** PHI Exchange between Sending and Receiving Facilities

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#3 Increasing Post-patient Transfer Data Exchange between Sending and Receiving Facilities: **Concern and Goal**

- Concern: Despite advances in HIE and EMR remote access capabilities, clinicians at receiving hospitals often have difficulty accessing key portions of the medical record post-patient transfer.

- Goal: Facilitate planning discussions between likely send-receive partners to develop record sharing strategies in advance.

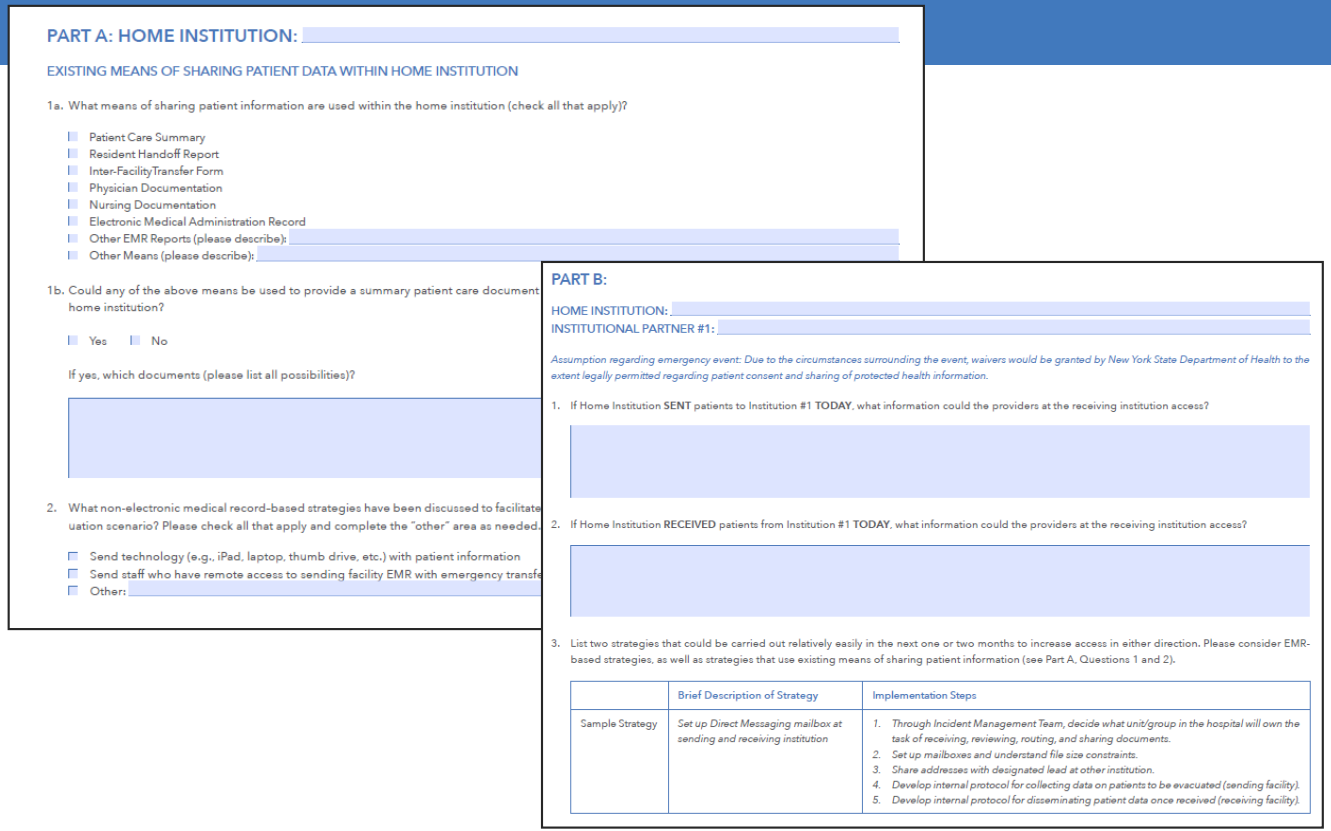
#3 Increasing Post-patient Transfer Data Exchange between Sending and Receiving Facilities: **Approach**

- No judgement – any method of data exchange/data sharing is acceptable; emphasis is on pre-planning
- Help facilities understand current capabilities related to data exchange:
  - Summary forms, reports, and documentation used day-to-day by clinicians
  - EMR platform remote access capabilities
  - RHIO utilization – mode used and type of data shared
- Encourage planning conversations with likely send-receive partner institutions:
  - Decide in advance HOW data can be most easily shared
  - Work through needed system modifications and permissions NOW to facilitate exchange at the time of an event

Worksheet Developed and Disseminated

Part A designed to help hospitals better understand their own medical record sharing capabilities

Parts B through D (all identical) designed to facilitate planning conversations between a home institution and 3 partner institutions



PART A: HOME INSTITUTION:

EXISTING MEANS OF SHARING PATIENT DATA WITHIN HOME INSTITUTION

1a. What means of sharing patient information are used within the home institution (check all that apply)?

- Patient Care Summary
- Resident Handoff Report
- Inter-FacilityTransfer Form
- Physician Documentation
- Nursing Documentation
- Electronic Medical Administration Record
- Other EMR Reports (please describe):
- Other Means (please describe):

1b. Could any of the above means be used to provide a summary patient care document
home institution?

Yes No

If yes, which documents (please list all possibilities)?

2. What non-electronic medical record-based strategies have been discussed to facilitate
uation scenario? Please check all that apply and complete the "other" area as needed.

- Send technology (e.g., iPad, laptop, thumb drive, etc.) with patient information
- Send staff who have remote access to sending facility EMR with emergency transfe
- Other:

PART B:

HOME INSTITUTION:

INSTITUTIONAL PARTNER #1:

Assumption regarding emergency event: Due to the circumstances surrounding the event, waivers would be granted by New York State Department of Health to the extent legally permitted regarding patient consent and sharing of protected health information.

1. If Home Institution **SENT** patients to Institution #1 **TODAY**, what information could the providers at the receiving institution access?

2. If Home Institution **RECEIVED** patients from Institution #1 **TODAY**, what information could the providers at the receiving institution access?

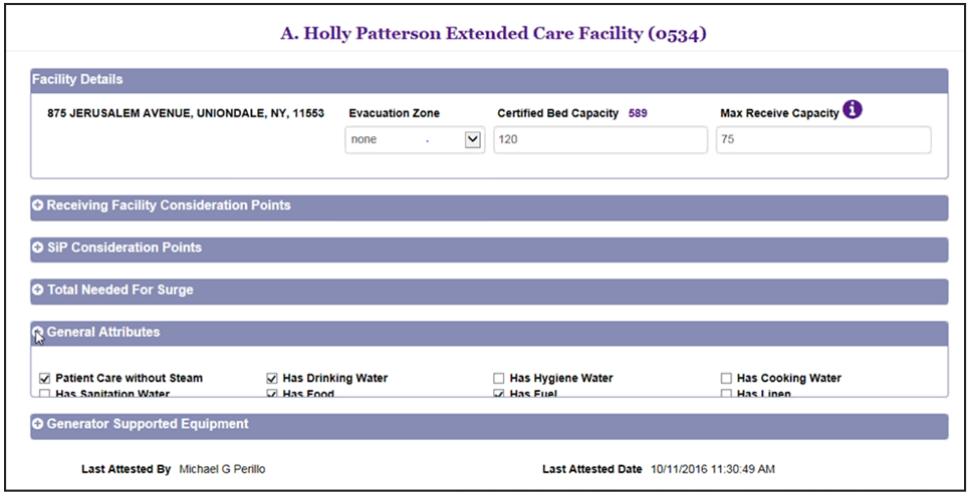
3. List two strategies that could be carried out relatively easily in the next one or two months to increase access in either direction. Please consider EMR-based strategies, as well as strategies that use existing means of sharing patient information (see Part A, Questions 1 and 2).

	Brief Description of Strategy	Implementation Steps
Sample Strategy	*Set up Direct Messaging mailbox at sending and receiving institution*	1. *Through Incident Management Team, decide what unit/group in the hospital will own the task of receiving, reviewing, routing, and sharing documents.* 2. *Set up mailboxes and understand file size constraints.* 3. *Share addresses with designated lead at other institution.* 4. *Develop internal protocol for collecting data on patients to be evacuated (sending facility).* 5. *Develop internal protocol for disseminating patient data once received (receiving facility).*

Further Steps

- Have reached out to Epic – would like to understand how Epic hospitals can best configure EMR platforms to facilitate data sharing during an evacuation scenarios

- Exploring with SDOH how information about data sharing capabilities can be integrated into the Facility Profile Application



Best Practices Related to Emergency Credentialing of Healthcare Personnel

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#4 Best Practices Related to Credentialing of Healthcare Personnel: **Concern and Goal**

- Concern: In the aftermath of Hurricane Sandy many healthcare personnel worked at other institutions for prolonged periods of time. Involved sending and receiving institutions developed innovative strategies for managing the privileging and credentialing processes.

- Goal: Develop a guidance document and complementary toolkit that reviews credentialing and privileging requirements and standards, and provides information about promising strategies in the preparedness, response and recovery phases of an incident.

#4 Best Practices Related to Credentialing of Healthcare Personnel: **Approach**

- Contacted Medical Staff Specialist leadership at institutions most affected by clinician movement during Hurricane Sandy including NYU, Northwell and Mt. Sinai.
- Through conversations elicited information about practices developed during the response to Sandy or since then.
- Also reviewed regulations and standards related to privileging and credentialing .

Guidance Document and Toolkit Under Development

- Several versions of the document/toolkit have been shared with the workgroup with feedback informing revisions and additions
- Guidance document structure:
  - Expectations related to granting of disaster privileges
  - Role of institutional bylaws and policies
  - Emerging practices – preparedness, response and recover phases
  - Review of State, Interstate and National Initiatives that may impact disaster credentialing in the future

  **Document discusses medical providers and advanced practice providers separately from nursing and allied health professionals*
- Toolkit includes sample policies, templates and forms

Guidance Document and Toolkit: Next Steps

- Make additional revisions based on workgroup feedback
- Share with SDOH and state and regional healthcare associations to elicit feedback
- Based on input, finalize and disseminate document

Thank you!

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