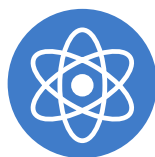


# PATIENT EVACUATION TOOLKIT



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# INTRODUCTION

In 2011 and 2012, Hurricane Irene and Superstorm Sandy, respectively, severely impacted the Greater New York region. Both storms caused extensive flooding that required a large number of hospitals and nursing homes to evacuate patients to other facilities. While hospital patients and nursing home residents were successfully transported during both storms, the events revealed areas for improvement in the coordination of large-scale patient evacuations.

Greater New York Hospital Association (GNYHA) and the New York City Department of Health and Mental Hygiene (DOHMH) convened the Patient Movement Workgroup (PMW) in February 2015 to collaboratively develop solutions to challenges identified during those previous large-scale patient evacuations. The workgroup included emergency managers, transfer center leaders, and health information technology staff from hospitals and health systems, along with personnel from medical transport agencies, and State and local government agencies involved in emergency response.

The workgroup met monthly, moving through a process of defining key concerns, discussing potential approaches or solutions, developing and testing resources and processes, and then sharing information with defined stakeholder groups. The workgroup ultimately identified four priority areas for improvement in the patient evacuation coordination process:

1. [Defining standardized bed types to facilitate bed matching](#)
2. [Sharing critical medical and demographic information during the transport process](#)
3. [Improving medical record access after patient transfer](#)
4. [Recommending best practices for disaster credentialing of health care personnel](#)

This toolkit contains resources developed by the workgroup that address the first three items above. A separate toolkit related to disaster credentialing is under development. For each of the first three priority areas, details are provided on the workgroup's key concern and the approaches that followed. Descriptions of each resulting product, plus links to the products available on the GNYHA website, are also included.



# PART 1: DEFINING STANDARDIZED BED TYPES TO FACILITATE BED MATCHING

## CONCERN

Hurricane Irene caused nearly 10,000 hospital patients and long-term care residents to be evacuated. A little more than a year later, Hurricane Sandy forced the evacuation of more than 6,000 patients and residents. As health care institution staffs searched for beds for evacuating patients, their ability to identify appropriate beds and resources for specific patients was hindered by varying interpretations of commonly used bed-type terms. Staff members at different hospitals believed they were talking about the same resources when using terms such as Intensive Care Unit (ICU) or Medical/Surgical beds. That was not the case, however, as they discovered with the arrival of incoming patients.

## APPROACH

Faced with this issue, workgroup members sought to create standardized bed definitions to be used as a common vocabulary regionally or statewide to facilitate appropriate bed matching during large-scale patient evacuations. With this approach in mind, the workgroup examined existing bed-type classifications, including:

- New York State Department of Health (DOH) licensed bed types (total of 36)
- DOH Healthcare Facility Evacuation Center (HEC)\* bed types (total of 18)
- Hospital Available Beds for Emergencies and Disasters (HAvBED) Bed Categories (total of 7)



[See graphic containing existing bed-type classifications on page 4.](#)

Collectively, workgroup members focused on the DOH HEC bed categories, and then worked to reduce the categories to the smallest possible number that still allowed for specificity. Ultimately, the group developed five categories: Critical Care, Medical/Surgical, Perinatal, Psychiatric, and Rehabilitation.

\*The HEC is an operation activated by DOH during emergency events to assist with bed matching and patient transport.

## Existing Bed-Type Clasifications

### NYS Licensed Bed Types:

AIDS	Neonatal Intensive Care
AIDS-SNF	Neonatal Intermediate Care
Alcohol Detoxification	Pediatric
Behavioral Intervention	Pediatric ICU
Behavioral Intervention Step Down	Physical Medicine and Rehabilitation
Bone Marrow Transplant	Prisoner
Burns Care	Psychiatric
Chemical Dependence – Detoxification	Respiratory
Chemical Dependence – Rehabilitation	RHCF
Coma Recovery	RHCF – Coma Recovery
Coronary Care	RHCF – Traumatic Brain Injury
Drug Rehabilitation	SNF – Head Injury
Inpatient Certified	Rehabilitation
Intensive Care	Special Use
Maternity	Transitional Care
Medical/Surgical	Traumatic Brain Injury
Medical/Surgical (TB)	Ventilator Dependent
Neonatal Continuing Care	Ventilator Dependent Pediatric

### NYS Healthcare Evacuation Center Categories:

Adult Acute Rehab	Labor and Delivery
Adult ICU	NICU
Adult Medical/Surgical	Pediatric Acute Rehab
Adult Psychiatric	Pediatric ICU
AllR Room	Pediatric Medical/Surgical
Bariatric	Pediatric Psychiatric
Coma Recovery	Post Delivery
Healthy Newborn Isolettes	TBI Acute Care
Infant Cribs	Ventilator

### HA<sub>v</sub>BED Categories:

Adult ICU	Medical/Surgical
Airborne Infection/Isolation	Pediatric
Burn	Pediatric ICU
	Psychiatric

## Bed Definitions

The definitions developed by the group focused on the minimum level of services required by patients in each category, including personnel, equipment, and facilities. For each category, the workgroup developed a standard bed definition into which a large majority of patients would fit, as well as an augmented services definition that listed additional resources that a small number of patients could potentially require.

# STANDARDIZED BED DEFINITIONS

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### GROUP A: CRITICAL CARE – Standard bed definition

Critical care patients require sophisticated intervention to restore or maintain life processes.

This requires:

- Providing immediate and continuous attention (usually reflected in low nurse to patient staffing ratios);
- Monitoring (telemetry must be available to provide continuous monitoring; rapid POC testing should be available);
- Specialized facilities (such as an ICU, PACU, or other critical care setting);
- Specialized equipment (such as ventilators, dialysis equipment, and readily available imaging);
- Specialized personnel (such as critical care specialists, respiratory therapists).

### GROUP A: CRITICAL CARE – Augmented services for this bed type

Patients in this category require additional services beyond those included in the standard definition.

Examples of augmented services include:

- CVVH
- ECMO
- Airborne isolation
- Enhanced equipment (i.e., bariatric)
- Enhanced personnel (i.e., unusual subspecialty)

*Postpartum mothers in ICU with baby elsewhere in hospital should be noted in augmented services to ensure transport to same hospital.*

### GROUP B: MEDICAL/SURGERY – Medical/surgical patients have medical illnesses or disorders, as well as diseases or conditions normally treated by surgery, who do not require critical care support.

Medical/surgical patients can be cared for with:

- 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.*

### GROUP B: MEDICAL/SURGERY – Augmented services for this bed type

Patients in this category require additional services beyond those included in the standard definition.

Examples of augmented services include:

- Dialysis
- Airborne isolation
- Enhanced equipment (i.e., bariatric)
- Enhanced personnel or treatments (i.e., unusual subspecialty, specialized wound care)

*Postpartum mothers in Med/Surg with baby elsewhere in hospital should be noted in augmented services to ensure transport to same hospital.*



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.



Download the *Standardized Bed Definitions* document at [www.gnyha.org](http://www.gnyha.org)

Once the definitions were finalized, the focus shifted to how the bed definitions could be operationalized by hospitals. The workgroup developed separate Excel-based spreadsheet documents for hospitals evacuating patients and hospitals receiving patients. Each document contains a section to facilitate pre-planning and a section to support patient evacuation during an incident. Both documents also incorporate Transportation Assistance Levels (TAL). The TAL framework, developed by DOH, is designed to facilitate transportation asset allocation during large-scale patient evacuation. There are three TALs corresponding to Stretcher (Level 1), Wheelchair (Level 2), and Ambulatory (Level 3). Assets for the stretcher category consist of Advanced Life Support (ALS) and Basic Life Support (BLS) ambulances.

Once drafted, three pilot tests were conducted to assess and refine the tools developed by the workgroup. The pilots were designed to test the utility of the tools and validate the standardized definitions. Each pilot focused on one or two bed definition groups. Patient units that corresponded to those definitions were selected, with unit staff completing the relevant worksheets for current patients. A brief “hot wash” was then conducted with staff to elicit their feedback. Additionally, for the first two pilots, a post-pilot quality assurance process was conducted to ensure that patients were placed into the appropriate bed category.

After each test, the workgroup made substantial revisions to the form design and definitions. Several complementary tools were also developed and are described below.

## PRE-EVENT HOSPITAL UNIT CROSSWALK

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### PURPOSE OF THIS CROSSWALK

The five bed categories listed below were developed by the DOHMH-GNYHA Patient Movement Workgroup, and are designed to facilitate bed matching across hospitals during emergency incidents that necessitate large-scale patient evacuation. All hospitals in New York State are asked to crosswalk the existing units within their facility to these five standardized bed categories.

### INSTRUCTIONS

The left side of the table below contains definitions of the five standardized bed categories. In the table on the right list all units within your facility for which the majority of patients would fit into this standardized bed category. If there are units where patients may be split between two categories, such as Critical Care and Medical/Surgical list the unit under both categories. In the last section please list any units that are extremely difficult to crosswalk ahead of time; these units should be prioritized for attention at the beginning of any event that may require evacuation.

After completing this exercise, a copy of the crosswalk table should be maintained in the Hospital Command Center, the Bed Management office and in any other relevant location in your facility. It is recommended that the crosswalk be reviewed and updated annually.

#### GROUP A: CRITICAL CARE – Standard bed definition

Critical care patients require sophisticated intervention to restore or maintain life processes.

##### This requires:

- Providing immediate and continuous attention (usually reflected in low nurse to patient staffing ratios);
- Monitoring (telemetry must be available to provide continuous monitoring; rapid POC testing should be available);
- Specialized facilities (such as an ICU, PACU, or other critical care setting);
- Specialized equipment (such as ventilators, dialysis equipment, and readily available imaging);
- Specialized personnel (such as critical care specialists, respiratory therapists).

#### Hospital units whose patients would meet the CRITICAL CARE definition:

1.
2.
3.
4.
5.
6.



Download the *Pre-Event Hospital Unit Crosswalk* at [www.gnyha.org](http://www.gnyha.org)



## Pre-Event Hospital Unit Crosswalk

This document is designed to assist hospital staff pre-event by familiarizing them with the standardized bed definitions and facilitating decisions about which units within the hospital will likely correspond to which standardized bed definition. It is suggested that hospitals review and revise this document annually, and that it be kept in the Hospital Admitting Office, the Hospital Command Center, and other relevant bed management activity locations.

## Evacuating Hospital Workbook

The *Evacuating Hospital Workbook* is designed for use at the Hospital Command Center by staff serving in the Patient Tracking Unit within the Hospital Incident Command System (HICS), or performing a similar function. The Workbook contains six tabs.

The screenshot shows the Microsoft Excel interface for the 'EvacuatingHospital\_Workbook.xlsx' file. The ribbon includes Home, Layout, Tables, Charts, SmartArt, Formulas, Data, and Review. The active cell is F108. The spreadsheet content is as follows:

**27**

**28** PART 1: HIGHLY SPECIALIZED PATIENTS

**29** Note about highly specialized patients -- for hospitals that treat patients requiring highly specialized services or equipment such as transplant patients, traumatic brain

**30** injury, coma recovery, prison or forensic patients, high risk obstetrical patients, or other patients that may require services that are not routinely provided at all

**31** hospitals, pre-arrangements should be made with receiving facilities that can offer a comparable level of care. Clinical conversations will then take place at the time of

**32** an emergency event between the sending and receiving facility to manage each patient's transfer and ongoing care.

**33**

**34**

**35** Please detail pre-arrangements you already have with other institutions to receive your specialized patients that do not fall into the five categories above.

**36**

**37** Receiving Hospital: \_\_\_\_\_

**38**

**39** Patient Type(s): \_\_\_\_\_

**40**

**41** Patient Type(s): \_\_\_\_\_

**42**

**43** Patient Type(s): \_\_\_\_\_

**44**

**45** Receiving Hospital: \_\_\_\_\_

**46**

**47** Patient Type(s): \_\_\_\_\_

**48**

**49** Patient Type(s): \_\_\_\_\_

**50**

**51** Patient Type(s): \_\_\_\_\_

**52**

**53**

**54**

**55** Please list other highly specialized patients for which you need assistance with making pre-arrangements:

**56**

**57** Patient Type(s): \_\_\_\_\_

**58**

**59** Patient Type(s): \_\_\_\_\_

**60**

**61** Patient Type(s): \_\_\_\_\_

**62**

**63**

**64** PART 2: SUMMARY OF INFORMATION FROM TABS 2-6

# Meeting standard definition	Patient Category	# Needing augmented services
0	Adult ICU (Patient aged 18 and older):	0

**65**

**66** 1. Evacuating Cover Sheet 2. Group A Critical Care 3. Group B Med Surg 4. Group C Perinatal 5. Group D Psychia

- Tab 1 includes three sections. The first section, to be completed in advance of an event, details pre-arrangements made with other hospitals to care for highly specialized patients, such as those who have had a transplant or are in coma recovery. The second section aggregates information provided in Tabs 2-6, which correspond to the five standardized bed types. For each bed type, the cell on the left totals the number of evacuating patients in that bed type who meet the standard definition. The cell on the right totals the number needing augmented services. The third section totals patients by TAL.
- Data displayed in Tabs 2-6 aggregates information provided at the unit level for all hospital units that contribute patients to that particular bed definition. Each tab totals the number of evacuating patients within that bed type, separated into those meeting the standard definition and those needing augmented services. Patient totals are also organized by TAL. Lastly, the tab contains space to document additional information for patients requiring augmented services, including name, medical ID number, and a brief description of the additional services required. Please note that the *Unit Level Form Workbook* described below is designed for use on individual patient units.

It is important to note that the *Evacuating Hospital Workbook* is designed to help staff serving in the HICS structure or Hospital Command Center to begin conversations with staff in other hospitals and/or with government response partners about broad bed matching and transportation asset needs. It does not replace the need for clinician-to-clinician conversations about individual patients, or final decisions regarding allocation of potentially scarce transportation assets. It is designed to efficiently collect information on the hospital's overall evacuation needs, and through the use of the augmented services category, help the Hospital Command Center focus on patients who may require more effort to place in an appropriate receiving hospital.

Depending on the amount of time that elapses before evacuation is complete, Hospital Command Center staff may request updated documentation from patient units to ensure that numbers are as current as possible. This is important given that patient conditions can change, especially during stressful events.

### **Evacuating Hospital – Unit Level Form Workbook**

The *Unit Level Form Workbook* contains a separate tab for each patient subcategory within the standardized bed definitions (total of 15). Each worksheet is designed to capture information for all patients requiring evacuation on a single patient unit. Staff in the Hospital Command Center, using the *Pre-event Hospital Unit Crosswalk Document* as a guide, would deliver the appropriate worksheet or worksheets to each unit with instructions to complete it for a specific point in time. Each worksheet captures basic information about

every patient on the unit, including name, medical ID number, whether the patient meets the standard or augmented definition for the corresponding bed type, and the recommended TAL. Depending on the amount of time that elapses before evacuation is complete, Hospital Command Center staff may request that unit staff verify and update previously completed worksheets at regular intervals.

**UNIT LEVEL FORM: CRITICAL CARE -- ADULT**

**FORM INSTRUCTIONS:**

Unit managers should complete this form ensuring all patients on the unit requiring evacuation are included.

Fill in the Unit Name, Unit Location, and Name and Title of person or persons completing this form.

For each patient on the unit fill in the medical identification number or, as an alternative, place one patient unit sticker in the identification field. For institutions that use a state or jurisdictional patient tracking system (i.e. e-INDS in New York State), the patient ID number or sticker that corresponds to that system can be placed here.

Each patient should have one box checked in the "Needed Services" section indicating whether this patient requires standard critical care or requires augmented services (see definitions below). For patients requiring augmented services, please briefly describe his/her needs in the area provided. If the patient has downgraded care needs and can be cared for safely in a standard medical or surgical unit please check the "Recommended for lower acuity care (Med/surg Care)" box and leave the critical care boxes unchecked.

For each patient check one Transportation Assistance Level (TAL), recommending the level of transportation needed to safely move the patient to the receiving facility. If you need assistance determining whether an individual patient needs an Advanced vs. Basic Life Support ambulance, please refer to the Patient Evacuation TAL 1 Job Aid.

**UNIT LEVEL PATIENT EVACUATION FORM -- CRITICAL CARE (ADULT, 18+)**

**Standard bed definition** – Critical care patients require sophisticated intervention to restore or maintain life processes. This requires:

- Providing immediate and continuous attention (usually reflected in low nurse to patient staffing ratios);
- Monitoring (telemetry must be available to provide continuous monitoring; rapid POC testing should be available);
- Specialized facilities (such as an ICU, PACU, or other critical care setting);
- Specialized equipment (such as ventilators, dialysis equipment, and readily available imaging);
- Specialized personnel (such as critical care specialists, respiratory therapists).

**Augmented services for this bed type:** Patients in this category require additional services beyond those included in the standard definition. Examples of augmented services include:

- CVVI
- ECMO
- Airborne isolation
- Enhanced equipment (ie, bariatric)
- Enhanced personnel (ie, unusual subspecialty)

Unit Name: \_\_\_\_\_

Unit Location: \_\_\_\_\_

Name, title of person completing form: \_\_\_\_\_ Ctrl/Pager #: \_\_\_\_\_

Patient 1	Needed Services:	Transportation Assistance Level:
Medical ID # _____	<input type="checkbox"/> Critical Care - Standard Definition	<input type="checkbox"/> TAL Level-1 ALS (Stretcher)
[Place Patient ID sticker here]	<input type="checkbox"/> Critical Care -- Augmented Services	<input type="checkbox"/> TAL Level-1 ALS (Bariatric Stretcher)
	<input type="checkbox"/> Recommend lower acuity care (Med/Surg Care)	<input type="checkbox"/> TAL Level-1 BLS (Stretcher)
		<input type="checkbox"/> TAL Level-1 BLS (Bariatric Stretcher)

Instructions Sheet | **Critical Care Adult** | Critical Care Pediatric | Med-Surg Adult | Med-Surg Pediatric | Geriatric Psych | Adult Psych | Pediatric Psych | Addictive

 Download the *Unit Level Form Workbook* at [www.gnyha.org](http://www.gnyha.org)

### Patient Evacuation TAL 1 Job Aid

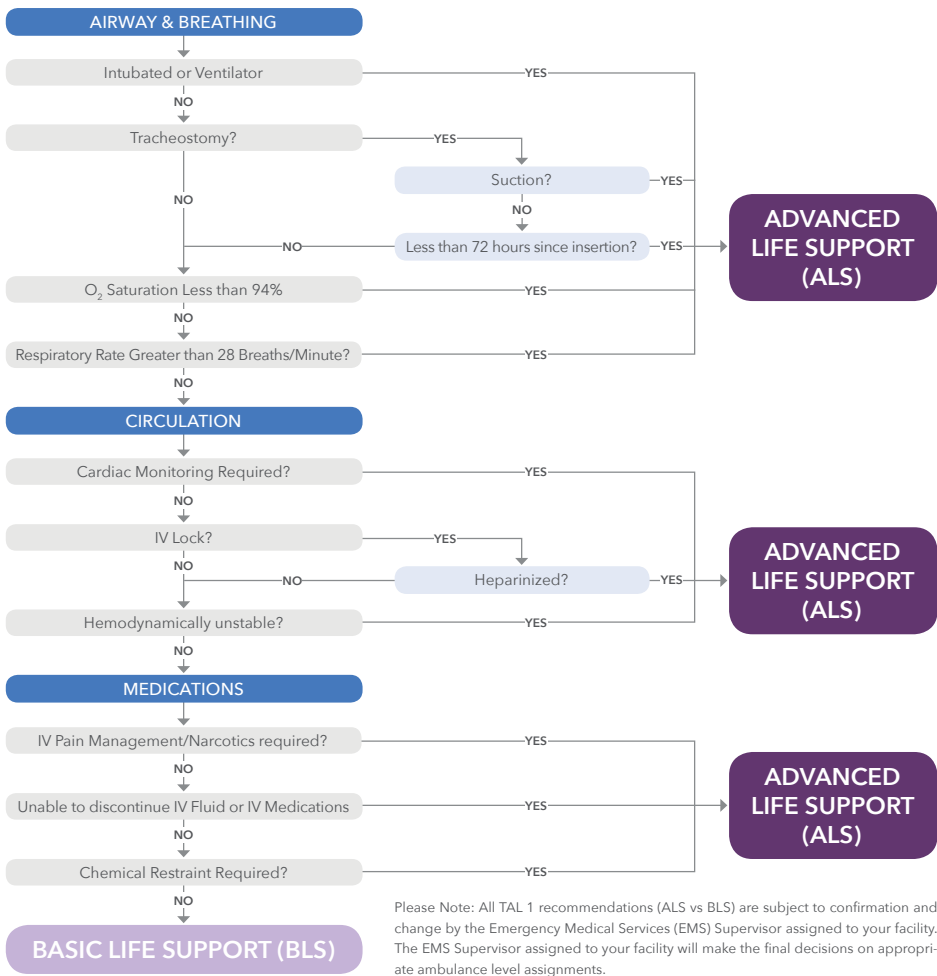
The *Patient Evacuation TAL 1 Job Aid* is designed to support clinicians caring for critical care or medical/surgical patients in making transportation asset recommendations. Given the need to preserve ALS ambulance units for the most critical patients, this tool walks the user through a series of questions to determine whether a patient requires a BLS unit or an ALS unit for transport. This document serves as a reference for clinicians completing the *Unit Level Form Workbook*.

# PATIENT EVACUATION TAL 1 JOB AID

Selecting an Advanced Life Support (ALS) vs. Basic Life Support (BLS) Ambulance

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*This decision tree does not apply to Transportation Assistance Level (TAL) 2 (Wheelchair) and TAL 3 (Ambulatory) patients.* This is designed to help determine if a patient can be transported in a BLS ambulance or if a patient requires an ALS ambulance. Please review the patient's records and attempt to safely discontinue or modify treatment so that your patient can fit in the BLS category solely for the duration of transport.



 Download the *Patient Evacuation TAL 1 Job Aid* at [www.gnyha.org](http://www.gnyha.org)

## Receiving Hospital Worksheet

The *Receiving Hospital Worksheet* is designed to help Hospital Command Center staff determine available resources to receive different types of patients. Similar to the *Evacuating Hospital Workbook*, it has planning and response portions, with most of the work completed pre-event.

Ahead of time, receiving facilities are asked to:

- Indicate any pre-arrangements the hospital has made to accept highly specialized patients
- Indicate the quantities of certain equipment and services
- For each standardized bed definition and sub-category, indicate whether the hospital can receive this type of patient, any exclusions that apply to receiving such patients, and the total number of available, staffed beds of that type

At the time of an event necessitating a patient surge, Hospital Command Center staff would indicate in the response portion of the document current bed availability within each standardized bed category.

The *Receiving Hospital Worksheet* has utility from a system and jurisdictional perspective. For large health systems with multiple hospitals, health care coalitions, and geographic jurisdictions, completion of the planning portions of the worksheet can inform evacuation planning efforts.

**PATIENT EVACUATION PLANNING AND RESPONSE FORM FOR RECEIVING HOSPITALS**

**Instructions:**  
This form can be used to plan for and respond to hospital evacuations.

**During the PLANNING phase:**  
- Document your receiving relationships for highly specialized patients  
- Indicate the types of beds available in your institution, using the drop down lists below (Yes/No), and indicate any exclusions that your facility CANNOT generally accept.

**During the RESPONSE phase:**  
- After discharging patients in anticipation of receiving surge patients from evacuating facilities, indicate the number of available beds for each type in the column on the right.

**SPECIALIZED PATIENTS**

Note about specialized patients -- for hospitals that treat patients which require highly specialized services or equipment such as transplant patients, traumatic brain injury, coma recovery, prison or forensic patients or high risk obstetrical patients, sending facilities should make pre-arrangements with receiving facilities that offer a comparable level of care. Clinical conversations will then take place at the time of an emergency event between the evacuating and receiving facility to manage each patient's transfer and ongoing care.

Please detail pre-arrangements you have with other institutions to accept specialized patients that do not fall into the categories below. If known, include the unit that the specific patient type would be admitted to within your institution.

Sending Institution:	Patient Type:	Receiving Unit:
Sending Institution:	Patient Type:	Receiving Unit:
Sending Institution:	Patient Type:	Receiving Unit:

Please list other types of highly specialized patients your institution would be prepared to accept:

Patient Type:	Patient Type:
Patient Type:	Patient Type:

**General Equipment/Services:**  
In this section, list the number (or a range) of each item available. At the time of an event, this section can be updated with the current number of items available.

Item	Number
Bariatric beds	
Ventilators	
Airborne isolation room	
Neonatal isolettes	
Infant cribs	



## PART 2: SHARING CRITICAL MEDICAL AND DEMOGRAPHIC INFORMATION DURING THE TRANSPORT PROCESS

### 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, transporting patients, and 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 information needed to care for patients during this transition period.

### APPROACH

While some jurisdictions have developed a standalone 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 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 the purpose such forms would have during a patient evacuation scenario.

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, and initial care at a receiving facility during an evacuation scenario. This process resulted in the development of a list of recommended data elements organized into four domains—demographic information, patient information, transport-related information, and clinical information—for inter-facility transfer forms and patient face sheets.

### Suggested Implementation Process

With workgroup input, GNYHA created the document below. It was sent January 2016 to Chief Executive Officers and other key staff at GNYHA member hospitals.



Hospitals were encouraged to compare the lists of suggested data elements to their current inter-facility transfer forms and patient face sheets, determine which elements were already present, and which should be considered for inclusion. Understanding the complexities involved in making form changes within hospitals, the document included an *Internal Process Change Workflow*, outlining key steps to consider in undertaking this 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



Download the *Suggested Data Elements* document at [www.gnyha.org](http://www.gnyha.org)

## Role Of Health Information Technology (HIT)

Given the role that HIT can play in auto-populating variables of interest, hospitals were urged to work with their facility's HIT staff to create standard electronic medical record (EMR) reports aligned with the suggested data elements, either in parallel with or at the conclusion of the paper form revision process. The creation of such reports has the potential to increase speed and accuracy during an emergency event, as well as during routine inter-facility transfers.



# PART 3: IMPROVING MEDICAL RECORD ACCESS AFTER PATIENT TRANSFER

## CONCERN

Despite advances in health information exchange and EMR remote access capabilities, during previous evacuations, clinicians at receiving hospitals often had difficulty accessing key portions of a patient's medical record from the evacuating hospital.

## APPROACH

The workgroup took a practical approach to this issue, developing a worksheet designed to facilitate planning discussions between likely send-receive partners to help them develop record-sharing strategies in advance of an emergency event.

## IMPROVING MEDICAL RECORD ACCESS DURING LARGE-SCALE PATIENT EVACUATION

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### PURPOSE OF THIS WORKSHEET

In advance of the 2016 Coastal Storm Season, emergency managers in collaboration with colleagues in hospitals across the New York City region are encouraged to complete this worksheet to:

- Better understand methods that a hospital could use to share patient medical records with other institutions
- Have planning conversations with other hospitals to which the hospital is likely to send patients, or from which it is likely to receive patients

By completing this worksheet it is hoped that hospitals can identify actions that could be taken before an event to increase the likelihood that critical medical information can be accessed by providers at a receiving facility during an emergency event.

### HOW TO USE THIS WORKSHEET

In collaboration with health information technology (HIT) leadership, clinical leadership, and transfer center staff, the hospital ("home institution") should complete Part A below. *Target completion date: June 15, 2016.*

After completing Part A, each institution should choose up to three other hospitals to which the hospital is likely to send patients, or from which it is likely to receive patients. For hospitals that are part of a network, please consider choosing at least one in-network partner. For all hospitals, please consider choosing one hospital in close proximity to the institution, and another institution to which the hospital's most specialized patients would likely be sent.

After choosing these three hospitals, meet with emergency management, clinical leadership, and HIT counterparts at each of the identified institutions. The first part of the meeting should consist of presenting and discussing information outlined in Part A. Together each pair of institutions should then complete Parts B, C, and D to identify strategies that can be carried out in the next one to two months to increase access to patient medical records between institutions. *Target completion date: July 15, 2016.*



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.



Download the *Improving Medical Record Access Worksheet* at [www.gnyha.org](http://www.gnyha.org)

## Improving Medical Record Access During Large-Scale Patient Evacuations

The *Improving Medical Record Access Worksheet* is divided into two parts. Part A is designed to help a facility understand its own data exchange capabilities through a series of questions related to:

- Existing clinical documentation
- Non-EMR-sharing strategies that have been used previously or considered
- EMR platform capabilities
- Current electronic data sharing carried out by the institution

Informed by the knowledge attained in Part A, hospitals are then encouraged to use Parts B through D to facilitate planning conversations with three likely send-recipient partner institutions. The worksheet asks users to describe how each pair of institutions would share medical record information if an event were to occur today, and to also explore two short-term strategies that could be pursued in the next one-to-two months to improve medical record sharing between the institutions.

## PRIVACY LAW AND THE SHARING OF MEDICAL INFORMATION DURING EMERGENCIES

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Questions often arise about the sharing of patient information and the applicability of Health Insurance Portability and Accountability Act (HIPAA) regulations during emergencies. HIPAA applies to covered entities such as hospitals, nursing homes, physician practices, and managed care companies. In general, HIPAA safeguards protected health information (PHI) from disclosure. *Hospitals and other covered entities are permitted to share PHI for the purposes of treatment, notification, and in the interest of public safety, within certain bounds, which are discussed below.* Sharing of PHI is regulated by the U.S. Department of Health and Human Services (HHS). To the extent that New York State laws also govern such sharing, the New York State Department of Health (DOH), Office of Mental Health, and Office of Alcohol and Substance Abuse Services also may exercise regulatory oversight.

This document details what PHI can be shared and with whom during specific types of emergency incidents, including:

- Mass casualty events
- Patient evacuation
- Disease outbreaks

This document draws upon guidance produced by the HHS Office for Civil Rights (OCR) in the wake of Hurricane Katrina (**September 2005 OCR Bulletin**) and other storms, and updated guidance released during the 2014 West Africa Ebola Outbreak (**November 2014 OCR Bulletin**). While the document does not specifically address state laws, there is significant alignment between HIPAA and New York State law on the sharing of PHI in the above scenarios. For questions about how HIPAA interacts with state law, hospital attorneys should be consulted.



Download the *Privacy Law* document at [www.gnyha.org](http://www.gnyha.org)

## Privacy Law and Sharing Medical Information During Emergencies

During workgroup discussions related to medical record sharing, concerns were often voiced about privacy law and the sharing of medical information during emergency situations. Given the frequency of these concerns, the workgroup decided to develop an overview document that details the application of the Health Insurance Portability and Accountability Act (HIPAA) under three emergency scenarios: mass casualty incidents, patient evacuation, and communicable disease outbreaks.



## CONCLUSION

Over the past year, hospitals have started using the tools developed by the Patient Movement Workgroup. Several have updated their inter-facility transfer forms and patient face sheets, often working with their HIT staff to maximize auto-generation of variables from EMR systems. These hospitals have not only enhanced their patient evacuation processes, but have improved their day-to-day transfer processes. GNYHA and DOHMH have engaged DOH to explore integration of the resources and processes developed by this workgroup into DOH-developed facility and patient evacuation systems and applications. While every jurisdiction is distinct, many of the challenges that impede large-scale patient evacuation are similar. Hospitals are encouraged to adapt the tools and resources in this toolkit to the specific needs of their jurisdiction.

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## QUESTIONS

For questions about this toolkit, please contact Jenna Mandel-Ricci, GNYHA at [jmandel-ricci@gnyha.org](mailto:jmandel-ricci@gnyha.org) or (212) 258-5314.



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