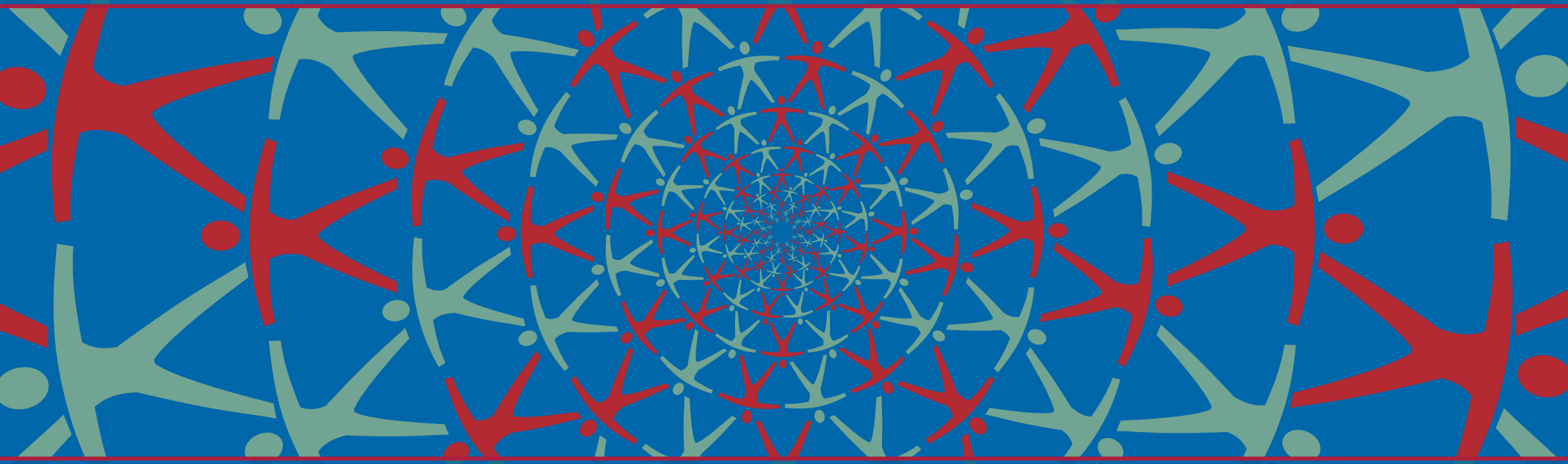
1st Edition, Winter 2013

Patient Surge in Disasters:
A Hospital Toolkit for Expanding Resources in Emergencies



Rapid Discharge Tool
(RDT)

NYC Health

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Rapid Discharge Tool
Guidance Document

PURPOSE:

The Rapid Discharge Tool (RDT) is designed to assist hospital administrators and emergency managers in preparing for and responding to unexpected increases in patient volume by providing them with adaptable plans for rapid discharge based on promising bed surge capacity practices.

AUDIENCE:

Because a mass casualty incident can occur at any time, the *Rapid Discharge Tool* offers a wide range of effective actions to increase bed capacity and may be especially useful to hospital staff members in the following areas:

- Incident Command Center
- Hospital Administration
- Admitting/Patient Access Services
- Nursing Administration
- Off-hours Administrator
- Emergency Management

GUIDELINES FOR USE:

The *Rapid Discharge Tool* is formatted as a quick-reference guide for healthcare professionals. Each section of the tool is divided into columns which are defined as follows:

Action

An action is a set of planning or response activities that leads to a greater number of additional, available staffed beds.

Phase

A phase is the period of time during which emergency preparedness or response activities occur. *There are two hospital-specific **phases** in this tool:*

- *Planning*: the preparatory time prior to an emergency incident.
- *Response*: the time directly after the occurrence of a mass casualty incident when a hospital must immediately meet accelerated patient demand; and, the period directly following when patient demand continues to exceed a hospital's supply of beds.

Step(s)

Activities outlined within an ***Action*** that are intended to achieve one or more outcome(s).

Outcome(s)

The result(s) of a team's conducting an Action's steps and activities. The outcomes' benefits are summarized in comments in the ***Outcome(s)*** column. We recommend reading these comments before undertaking the action to determine what shape these benefits may take in your hospital.

Possible Team Members

Many of the tool's actions contain activities that may require the consent and cooperation of management in the departments represented in this column. Please note that team composition will vary from one hospital to another.

Estimated Time Required

The *Estimated Time Required* column provides the approximate time for completing an Action's steps and activities.

Bed Yield Potential *(not in Planning Document)*

The *Bed Yield Potential* is an experience-based estimate of how many additional, available beds will result from taking an action. A simple "high-medium-low" scale is used to quickly convey each action's potential in yielding beds:

- HIGH: increase in bed surge capacity up to 30% of current bed inventory (i.e., total number of additional, available beds)
- MED: increase in bed surge capacity up to 20% of current bed inventory
- LOW: increase in bed surge capacity up to 10% of current bed inventory

Notes:

- *Percentages will vary greatly from one hospital to another depending on such variables as census, patient case mix, available and/or obtainable resources, implementation timeline, and process owner cooperation.*
- *For many actions, substantial initial gains are often realized when response initiatives are first engaged. The yield potential of these actions is likely to decline in extended response.*

ABBREVIATIONS:

See *Patient Surge in Disasters: A Hospital Toolkit for Expanding Resources in Emergencies – Introduction and References* for keyword and abbreviation explanations.

SUMMARY DOCUMENTS:

Summary Documents are provided on Pages 8 and 15 to preview the planning and response sections (respectively) of the Rapid Discharge Tool.

APPENDICES:

To help bed surge capacity planners incorporate the planning and response components of the Rapid Discharge Tool into their emergency plans, the following appendices are attached:

AUTHORSHIP:

An early version of the *Rapid Discharge Tool* grid was submitted to the New York City Department of Health (NYC DOHMH) by Continuum Health Partners, Inc.,[1] a Center for Bioterrorism Preparedness Planning (CBPP).

Substantive editing of this work was performed by William Lang MS, an Administrative Consultant with an extensive background in hospital operations and emergency management.

[1] Surge Capacity Advisory Group, *Promising Practices and Recommendations for Hospitals for Bed and Personnel Surge,* Continuum Health Partner's CBPP/Medisys CBPP, August 2005

Rapid Discharge Tool (RDT)
Summary Document - Planning

INTRODUCTION & OVERVIEW:

In a mass casualty incident, there will most likely be an immediate demand for additional, available beds. This demand is known as surge, and a hospital's ability to accommodate such an increase in patient volume is often referred to as surge capacity. The New York City Department of Health and Mental Hygiene (NYC DOHMH) has determined that the two most effective methods for quickly increasing bed capacity are **rapid discharge** and **capacity expansion**. The former is the subject of this document.

Four activities[2] that contribute to the majority of patient discharges have been identified and incorporated into the RDT planning and response documentation. The Planning Document (pages 9-14) provides guidance on how to organize teams in order to accomplish these critical activities most effectively; the Response Document (pages 16-20) offers a selection of steps that will accomplish desired capacity expansion outcomes. In both instances, all activity either derives from or reports to the Bed Management Committee (BMC) - a team of healthcare professionals who are expert in emergency management and knowledgeable about patient discharging.

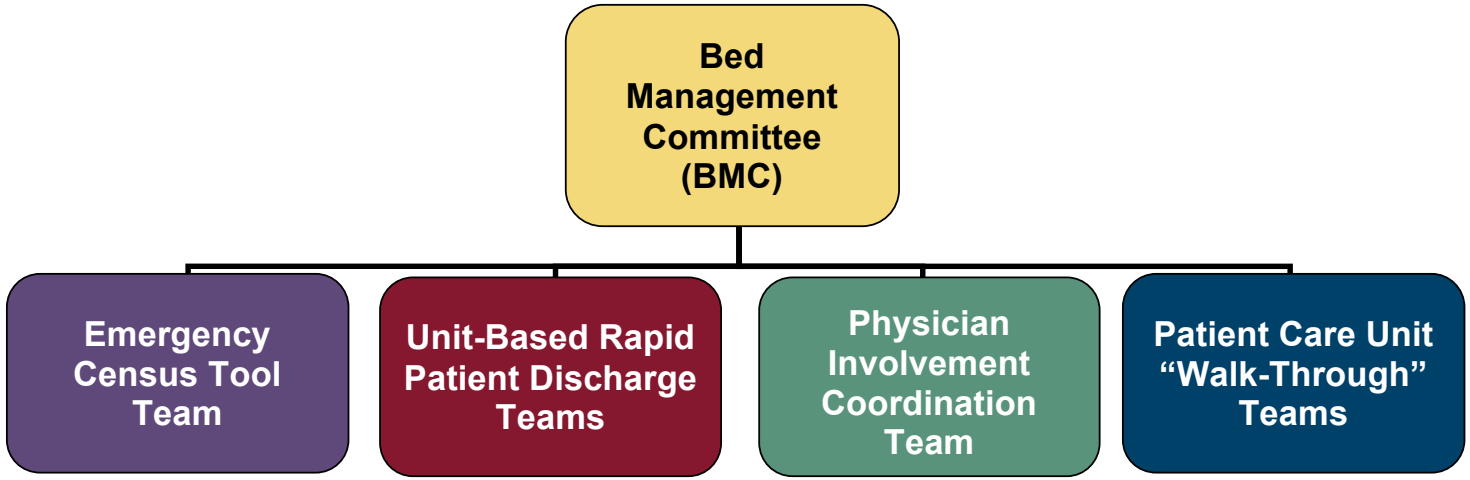
The following pages will introduce the Planning functions of the Rapid Discharge Tool.

[2] See *Summary Document/Response*, Page 15

Rapid Discharge Tool
Summary Document - Planning

ORGANIZATION STRUCTURE:

The RDT's work is overseen by the Bed Management Committee (BMC). The BMC's first task is to organize effective working teams to accomplish actions. The four 'Action' teams are shown in the diagram below. Each team is tasked with producing a key element of the RDT.



See *Rapid Discharge Tool – Guidance Document* for column definitions

Action	Phase	Step(s)	Outcome(s)	Possible Team Members	Estimated Time Required
⇨ Organize a **Bed Management Committee (BMC)**. **Bed Management Committee:** A core group of clinical and administrative bed management experts. The BMC is charged with organizing and directing activities related to inpatient admissions, discharges and transfers in accordance with hospital policies and procedures. Membership expands according to emergent need, and includes Hospital Incident Command System (HICS) representatives. BMC leadership is provided by Nursing or Admitting, or both. **Bed Management Committee (BMC)**	**Planning**	1. Create and convene a BMC. Note: hospitals may find their existing "Bed Boards" - or similar type of daily bed management meetings - ideally suited to assume responsibility for BMC planning and response actions. (see Appendix A, page 21) 2. Include membership from staff and management in all key patient activity areas (as outlined in the *Possible Team Members* column). 3. Develop, organize and coordinate activities as outlined in this Rapid Discharge Tool. 4. Identify a "permanent" BMC meeting location during emergencies.	✧ BMC provides a means to determine ongoing discharge potential by frequently monitoring all key patient activity areas. ✧ Open reporting encourages full disclosure of beds status ✧ Discharges are reported timely. ✧ Discharge numbers will significantly increase as a result of more closely coordinated efforts among team members. ✧ Coordinated BMC oversight of rapid discharge activities will yield maximum number of additional, available beds. ✧ All meetings will take place on schedule in the same location.	▪ Admitting ▪ Nursing ▪ Emergency Dept ▪ Emergency Management ▪ Administration ▪ Environmental ▪ Medicine ▪ Surgery (see Appendix A, page 21 for listing of additional team members)	3-4 Weeks

See *Rapid Discharge Tool – Guidance Document* for column definitions

Action	Phase	Step(s)	Outcome(s)	Possible Team Members	Estimated Time Required
⇨ Create an **Emergency Census Tool Team**. **Emergency Census Tool Team:** A team of bed management professionals who are assigned the task of developing a hospital-specific census-capture tool that will be used by BMC during emergencies. The Emergency Census Tool will profile vacant beds and discharge potential on all patient care units; it may also include Additional Beds in Non-Traditional Clinical Space, Isolation Capacity, and Rollover Capacity. The Emergency Census Tool Team may be assigned "ownership" of the census tool and be responsible for keeping it up-to-date. **Emergency Census Tool Team**	**Planning**	1. Create and convene an *Emergency Census Tool Team*. 2. Using the hospital census, *Emergency Census Tool Team* develops an *Emergency Census Tool* that includes the following: ▫ Patient Care Units ▫ Intensive Care Units ▫ Unit Names ▫ Unit Capacities ▫ Vacant Beds ▫ Patient Discharge Status ▫ Emergency Dept Holds (see Appendices B & C, pages 25 & 26) 3. Include *Date & Time*, and *Person Completing the Tool*. Other hospital-specific information, such as *Rollover Capacity* and *Additional Beds* can be added. 4. Emergency Census Tool Team presents completed tool to BMC.	✧ Rapid identification of patients who are at or near discharge. ✧ Allows BMC to quickly assess bed capacity. ✧ Census captured with this form will be used to update HERDS. ✧ Current census will provide guidance for staffing and coverage decisions. ✧ Time-stamping each census will allow managers to measure impact of surge over a period of hours/days. ✧ Census Tool Team maintains ownership of tool.	▪ Admitting ▪ Nursing ▪ Emergency Department	2-4 Weeks

See *Rapid Discharge Tool – Guidance Document* for column definitions

Action	Phase	Step(s)	Outcome(s)	Possible Team Members	Estimated Time Required
⇨ Organize **Unit-Based Rapid Patient Discharge Teams (UBRPDT)**. **Unit-Based Rapid Patient Discharge Team:** A unit-based team of clinical professionals whose primary goal is to assure that discharge policies and procedures are applied to all patients timely, preferably using a discharge planning tool such as an *Intend to Discharge Form*. **Unit-Based Rapid Patient Discharge Teams**	**Planning**	1. Create *Unit-Based Rapid Patient Discharge Teams* that are empowered to overcome barriers to timely patient discharging. (see Appendix D, page 27) Note: Hospitals may find their existing *Length of Stay* or *Discharge* teams ideally suited to assume responsibility for unit-based planning and response discharge activities. 2. Create or utilize an existing discharge planning tool, such as an *Intend to Discharge* form. (refer to your own Discharge tool or Referral form) 3. Communicate rapid discharge planning and response activities with Attending Physicians. 4. Instruct teams to report results to BMC.	✧ Provide clear picture of patient throughput delays and in-efficiencies. ✧ Determine discharge potential of all inpatient areas. ✧ Assure appropriate interventions with medical staff and support services to facilitate timely patient discharging for the duration of emergency. ✧ Use of discharge tool will keep activities organized and expedite discharges. ✧ Attending involvement will facilitate and expedite patient discharging. ✧ Timely delivery of information will result in faster bed turnaround (staffed beds).	▪ Attending Physician ▪ Nursing (Nurse Manager, Case Manager) ▪ Social Work	3-4 Weeks

See *Rapid Discharge Tool – Guidance Document* for column definitions

Action	Phase	Step(s)	Outcome(s)	Possible Team Members	Estimated Time Required
⇨ Coordinate **Physician Involvement Coordination Team (PICT).** **Hospital Physicians At-A-Glance:** *Hospitalists* are doctors employed by the hospital; they may have the ability to discharge, depending on arrangement with private attendings. *Housestaff* are doctors (residents and chief residents) who are in a residency program; generally, they are able to discharge only with orders from a private attending. *Attendings* are doctors with admitting privileges; their patients cannot generally be discharged without their approval. **Physician Involvement Coordination Team**	**Planning**	1. Create and convene a *Physician Involvement Coordination Team*. (see Appendix E, page 29) 2. Team considers (and then documents) how to engage Medicine/ Surgery Leadership to work closely with unit management in order to expedite discharges. 3. Team considers (and then documents) how hospitalists, housestaff, and/or private attendings will assist in rapid discharging. Possible physician roles include: ○ evaluating telemetry patients ○ preventing un-necessary internal transfers ○ approving patient transfers to off-service beds. ○ rapid discharging by hospitalists. 4. Teams report findings to BMC.	✧ Physician support will significantly bolster timely, safe discharging efforts and increase number of available beds. ✧ Brainstorming exercise in Appendix E, page 29, will generate hospital-specific ideas for increasing physician support of and involvement in rapid discharging.	▪ Medicine ▪ Surgery ▪ Nursing ▪ Admitting	4-5 Weeks

See *Rapid Discharge Tool – Guidance Document* for column definitions

Action	Phase	Step(s)	Outcome(s)	Possible Team Members	Estimated Time Required
⇨ Organize **Patient Care Unit "Walk-Through" Teams**. **Walk-Through Teams:** Patient status changes occurring in between BMC meetings may go unreported. Small teams of Admitting representatives walk through patient care units noting empty beds and confirming patient discharge status. **Patient Care Unit "Walk-Through" Teams**	**Planning**	1. Create Patient Care Unit "Walk-Through" Teams comprised of Admitting manager and/or clerk. (see Appendix F on page 33) 2. Plan for teams to "walk" the patient care units at least once during each shift. 3. For optimum benefit, these walk-throughs occur in between BMC meetings, though they can take place at any time. 4. Report findings to BMC.	✧ Enables a manual reconciliation of identified potential versus actual patient discharges. ✧ Increased monitoring of beds creates awareness of need for timely discharge reporting. ✧ Even one additional discharge will help to decompress the Emergency Department.	▪ Admitting ▪ Nursing	1-2 Weeks

Rapid Discharge Tool (RDT)
Summary Document - Response

INTRODUCTION & OVERVIEW:

Whereas the Planning section of the RDT is concerned primarily with setting up an organizational structure around which teams can prepare and recommend key rapid discharging activities, the Response section deals with the actual implementation of those actions. This difference is reflected by the addition of a *Bed Yield Potential* column in the Response section. Please see the Guidance Document on page 6 for more detail.

The connection between the Planning and the Response Tools is illustrated in the Response section where options to select activities in the *Steps* column will be guided by how well the Planning section actions were executed. An example of this can be found on page 13, where physician involvement implementation choices will depend largely on ideas evaluated, developed and selected during the planning phase.

The following pages will introduce surge capacity planners to the Response functions of the Rapid Discharge Tool.

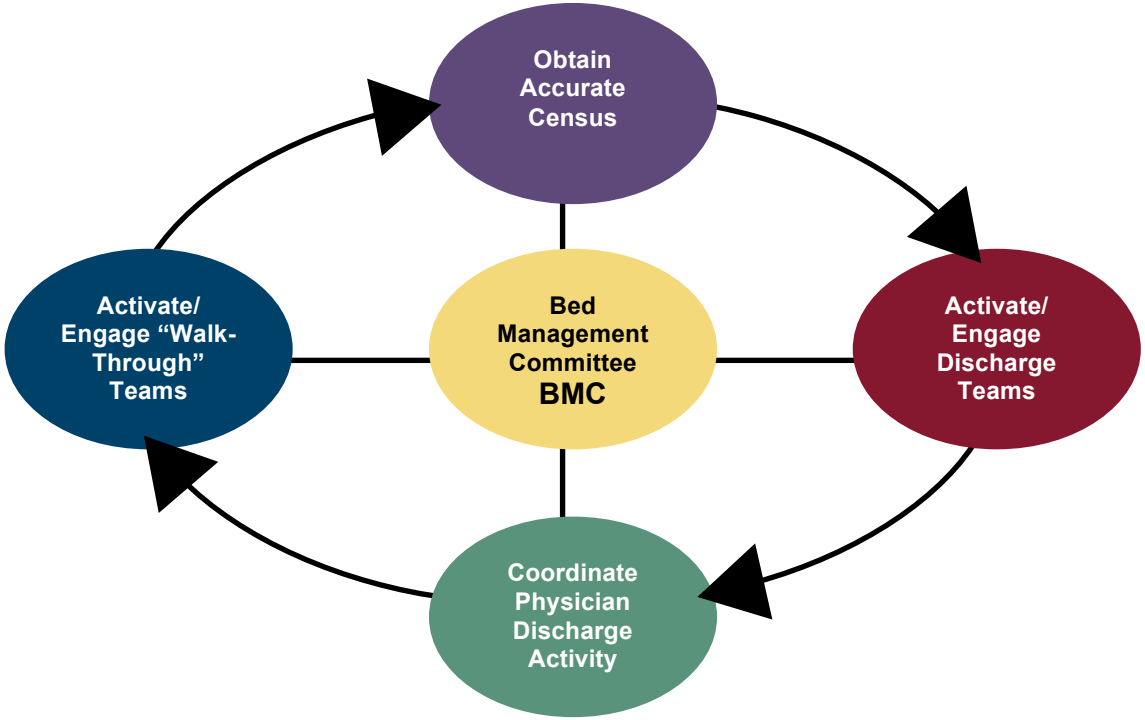
Note: The use of N/A in the *Bed Yield Potential* column indicates an administrative activity that does not measurably affect bed surge capacity in the response phase.

See *Rapid Discharge Tool – Guidance Document* for column definitions

Rapid Discharge Tool
Summary Document – Response

IMPLEMENTATION STRUCTURE:

To provide surge capacity planners with an overview of the RDT's key response activities.



See *Rapid Discharge Tool – Guidance Document* for column definitions

Action	Phase	Step(s)	Outcome(s)	Possible Team Members	Estimated Time Required	Bed Yield Potential
☐ **Convene** Bed Management Committee (BMC). **Bed Management Committee BMC**	**Response**	☐ Convene Bed Management Committee (BMC) immediately and then again at beginning of each shift ongoing during incident – more often, if necessary. ☐ Include representa-tives from all PCUs, ICUs, Operating Room, Emergency Dept, and Environmental Services. (see Appendix A, page 21)	✧ BMC will initiate and monitor all rapid discharge activity.	▪ Admitting ▪ Nursing ▪ Emergency Dept ▪ Emergency Management ▪ Administration ▪ Environmental ▪ Medicine ▪ Surgery (See Appendix A, page 21) for listing of additional, possible team members.	1-2 Hours x3 times/ day	HIGH N/A
☐ **Obtain** Accurate Census of all Patient Care Units (PCUs) and identify patients for discharge. **Obtain Accurate Census**	**Response**	☐ Capture data at BMC meetings using *Emergency Census Tool (or equivalent).* Ongoing, maintain and update tool with changes affecting bed capacity. (see Appendices B & C, pages 25 & 26)	✧ Provides snapshot of current census. ✧ Details impending admission, discharge and transfer (ADT) activity. ✧ Allows management to quickly convey information/ instructions to PCU representatives. ✧ Provides data for HERDS submission.	▪ Admitting ▪ Nursing ▪ Emergency Department	1-2 Hours x3 times/ day	HIGH

See *Rapid Discharge Tool – Guidance Document* for column definitions

Action	Phase	Step(s)	Outcome(s)	Possible Team Members	Estimated Time Required	Bed Yield Potential
			✧ Up-to-date tool will assure that data can be compiled quickly and accurately.			
		☐ Continually update electronic or manual *Bed Tracking System*.	✧ Updates data reported to BMC. ✧ Captures information not reported at BMC meetings. ✧ Expedites bed turnover by alerting Environmental Services to discharge beds.	▪ Admitting ▪ Environmental Services	1-2 Hours x3 times/ day	MED TO HIGH
☐ **Activate** Unit-Based Rapid Patient Discharge Teams. **Activate/ Engage Discharge Teams**	**Response**	☐ Unit-based teams assess patients and make appropriate, safe discharge referrals, preferably using a standardized discharge planning tool, such as an *Intend to Discharge* form.	✧ Form will communicate progress in discharge process to all team members.	▪ Medicine ▪ Surgery ▪ Social Work ▪ Clinical Leadership (Unit) ▪ Case Managers	(up to) 1 Hour	HIGH
		☐ Teams identify and resolve barriers to discharging (see *Appendix G, page 35*).	✧ Once barriers are identified, team will take actions to remove them.		1 Hour +	HIGH
		☐ Teams communicate with physicians to expedite discharges.	✧ Timely physician cooperation will greatly assist discharging.		1 Hour +	HIGH

See *Rapid Discharge Tool – Guidance Document* for column definitions

Action	Phase	Step(s)	Outcome(s)	Possible Team Members	Estimated Time Required	Bed Yield Potential
		☐ Teams report results to the BMC.	✧ Information will be used to assign beds to incoming patients.		½ Hour	N/A
☐ **Engage** physicians in the rapid discharge process. **Coordinate Physician Discharge Activity**	**Response**	☐ Increase physician support of and involvement in rapid discharging as follows: (see Planning Section, and approved ideas from work on Appendix E, page 29) ☐ Access housestaff through Medicine/ Surgery Leadership. ☐ Access hospitalists through Department of Medicine. ☐ Access/utilize attending physicians through Medicine/Surgery Leadership.	✧ Physician involvement will help to eliminate barriers to patient discharge, and result in a more timely delivery of available, staffed beds.	▪ Senior Administration ▪ Nursing ▪ Clinical Leadership ▪ Admitting	1-2 Hours ½ Hour ½ Hour 1 Hour +	MED TO HIGH MED TO HIGH MED HIGH

See *Rapid Discharge Tool – Guidance Document* for column definitions

Action	Phase	Step(s)	Outcome(s)	Possible Team Members	Estimated Time Required	Bed Yield Potential
☐ **Activate** small "Walk-Through" teams to capture unreported discharges and vacant beds on all patient care units. **Activate/ Engage "Walk-Through" Teams**	**Response**	☐ BMC assigns small teams comprised of admitting managers/ staff to walk through PCUs in-between BMC sessions and conduct patient-by-patient bed status reviews (see Planning).	▪ Capture unreported discharges. ▪ Reconciliation of unit bed census against *Emergency Census Tool*.	▪ Admitting ▪ Nursing	(up to) 1 Hour	LOW TO MED
		☐ Repeat walk-throughs at least once during each shift, preferably in-between BMC meetings.	✧ Capture unreported discharges. ✧ Increased monitoring yields better overall discharging results.		(up to) 1 Hour	LOW TO MED
		☐ Teams report results to the BMC.			½ Hour	N/A

Bed Management Committee (BMC)

Rapid Discharge Tool

Appendix A

Bed Management Committee (BMC) Guidance Document

PURPOSE:

This guidance document is intended to guide surge capacity planners in forming a multidisciplinary **Bed Management Committee (BMC)**. Using material presented in the NYC DOHMH *Rapid Discharge* and *Capacity Expansion* tools, the BMC will have primary responsibility for planning and implementing those activities that will yield the greatest number of additional, available inpatient beds.

TEAM COMPOSITION:

Because much of the planning and response activity relating to rapid discharge and capacity expansion will need to be directed by individuals who are expert in these areas, it is suggested that the Bed Management Committee be comprised of a **core group of mid-to-senior level individuals** from the following departments:

- Administration
- Admitting
- Bed Tracking Manager (HICS)
- Emergency Management
- Emergency Medicine
- Environmental Services
- Medicine
- Nursing
- Patient Tracking Manager (HICS)
- Social Work
- Surgery

Other departments can be called upon as necessary; these may include, but are not limited to:

- Dietary / Food Services
- Facilities / Engineering
- Infection Control
- Information Services
- Laboratory
- Materials Management
- Mental Health
- Patient Accounts / Finance
- Patient Transport
- Pediatrics
- Pharmacy
- Radiology
- Respiratory Care
- Safety
- Telecommunications
- Union

LEADERSHIP:

Leadership of the Bed Management Committee should be assigned to one or more of the core team members, preferably the most senior Admitting and/or Nursing representative(s).

REPORTING:

In a mass casualty incident, hospitals will likely mobilize their Hospital Incident Command System (HICS), and reporting of patient census and beds data will be routed to the Command Center by appropriate HICS representatives. It is therefore strongly suggested these latter positions be filled by core members of the BMC, thereby eliminating unnecessary, go-between reporting steps.

INSTRUCTIONS:

Use the Bed Management Committee Form on the next page to list the **core members** of the BMC. Be certain to list HICS roles (where applicable), and to consider (and document) how the actions outlined in the Rapid Discharge Tool will be coordinated/engaged by off-hours (evening, night, weekend) BMC and/or HICS contacts. It is recommended that a separate form be used for each of these shifts. The BMC form will need to be kept up-to-date, with copies routinely placed in the Incident Command Center and other key locations.

Working spreadsheets of all RPD tools are downloadable at:
http://www.nyc.gov/html/doh//html/em/emergency-surge.shtml

Hospital Name: **Date:**

Bed Management Committee Membership Roster				
Name	**Title/Department**	**HICS Title** (if applicable)	**Shift**	**Phone # and Email Address**

Emergency Census Tool Team

Rapid Discharge Tool
Appendices B & C

SAMPLE Emergency Census Tool Worksheets Guidance Document

PURPOSE:

Because data accuracy is critical in managing bed surge capacity, an appropriate emergency census tool must be developed and maintained.

TEAM COMPOSITION:

It is suggested that individuals with considerable bed management experience be invited to join this team. Admitting/Patient Access management should certainly be involved in the construction of an Emergency Census Management Tool as presented in Appendix B, page 25; Nursing Management should also participate in the development of a census tool based on patient acuity, as presented in Appendix C, page 26.

LEADERSHIP:

Leadership of the Emergency Census Tool Team should be assigned to the most senior Admitting or Nursing representative – or both.

REPORTING:

In a mass casualty incident, the Emergency Census Tool will be the most up-to-date and accurate measurement of patient census compiled by the BMC.

INSTRUCTIONS:

Using your daily census as a starting point, create an Emergency Census Tool that will serve the internal and external census data reporting needs of your hospital during a disaster. Refer to the sample worksheets in Appendices B & C, as required.

Emergency Census Tool Team

Rapid Discharge Tool
Appendix B

SAMPLE Emergency Census Tool Worksheet

Date:_____ **Time**:_____ **Manager/Representative**:_____

UNIT (Medicine)	Cap	Vac	P/D	D/C	Trans	
					In	Out
Total						

UNIT (Surgery)	Cap	Vac	P/D	D/C	Trans	
					In	Out
Total						

UNIT (ICU)	Cap	Vac	P/D	D/C	Trans	
					In	Out
CCU						
SICU						
MICU						
PACU						
PICU						
Total						

Notes

Rollover Capacity	
Source/Area	**# Beds**
Total	

Additional Beds	
Source	**# Beds**
Short Stay	
Blood Bank	

ED Holds	
Acute	**#**
Med	
Surg	
ICU	
Card	
Iso	
Peds	

Key: **Cap** – Capacity; **Vac** – Vacant; **P/D** – Potential Discharge; **D/C** – Discharge; **Trans** – Transfers

Emergency Census Tool Team

Rapid Discharge Tool
Appendix C

SAMPLE Emergency Census Tool Worksheet (for Hospitals using Patient Categorization)

Date:_____ **Time**:_____ **Manager/Representative**:_____

UNIT (Medicine)	Cap	Vac	1	2	3	4
Total						

UNIT (Surgery)	Cap	Vac	1	2	3	4
Total						

UNIT (ICU)	Cap	Vac	1	2	3	4
CCU						
SICU						
MICU						
PACU						
PICU						
Total						

Notes

Rollover Capacity	
Source/Area	**# Beds**
Total	

Additional Beds	
Source	**# Beds**
Short Stay	
Blood Bank	

ED Holds	
Acute	**#**
Med	
Surg	
ICU	
Card	
Iso	
Peds	

Key: Cap - Capacity; Vac - Vacant; **1** - Patients ready for discharge; **2** - Patients who do not require oxygen or cardiac monitoring; **3** - Patients who require oxygen and/or cardiac monitoring; **4** - Patients who require isolation. (Note: **1** and **2** rankings are those patients who have been evaluated as being closest to discharge)

Unit-Based Rapid Patient Discharge Teams

Rapid Discharge Tool
Appendix D

Unit-Based Rapid Patient Discharge Teams (UBRPDT) Guidance Document

PURPOSE:

Teams of clinicians are formed on every medicine and surgery unit to specifically assess patients and coordinate discharge readiness decisions, preferably using a standardized discharge planning tool such as an *Intend to Discharge* form. These teams actively identify and resolve barriers to discharging (see *Appendix G, page 35)*, and communicate with physicians to expedite discharges.

TEAM COMPOSITION:

Because staffing and position descriptions may vary widely from one hospital to another, so too does the membership profile of the UBRPDTs. In virtually all hospitals, however, the following individuals will comprise these teams' core group: Physician with authority to discharge, Nurse Manager, Case Manager, and Social Worker. Adding to this group (e.g., a pharmacy representative) is at the discretion of each hospital and, more particularly, dependent upon the specific needs and resources of each unit.

LEADERSHIP:

Leadership of the UBRPDT should be assigned to one of the core team members, preferably the Nurse Manager.

REPORTING:

Unit-Based Rapid Patient Discharge Team (UBRPDT) consistently and in a timely reports their results to the BMC.

INSTRUCTIONS:

For every patient care unit, use a UBRPDT Membership Roster to list the core team members. Be certain to consider (and document) how each team will be coordinated/engaged off-hours (evening, night, weekend). It is recommended that a separate form be used for each of these shifts. The UBRPDT Membership Roster(s) will need to be kept up-to-date, with copies routinely given to the BMC. Unit staff should also have ready access to this information.

Hospital Name: **Patient Care Unit:** **Shift:** **Date:**

Unit-Based Rapid Patient Discharge Team Membership Roster				
Name	**Title/Department**	**HICS Title**	**Shift**	**Phone # and Email Address**

Physician Involvement Coordination Team

Rapid Discharge Tool
Appendix E

Physician Involvement Coordination Team (PICT) Guidance Document

BACKGROUND:

Physician support is a key aspect of increasing bed surge capacity. Timely and safe discharge efforts can increase the number of additional, available beds in the immediate and extended phases of a hospital's surge response. The *Physician Involvement Coordination Team* is a planning committee that looks at physicians' current roles in the hospital's patient discharge systems and then develops ideas on how hospitalists, housestaff and private/service attending physicians can assist in rapid discharge.

The following Brainstorming/Planning Activity is designed to help surge capacity planners organize efforts for increasing physician involvement and support in timely and safe rapid discharge:

Brainstorming Planning Activity

PURPOSE:

Brainstorming is a technique where every team member's relevant response is acceptable. The goal is to gather the widest variety of answers as possible, first without evaluating any of them. Brainstorming is especially effective for exploring sensitive or controversial issues; engaging people who are hesitant to contribute; and, generating a lot of ideas quickly.

TEAM COMPOSITION:

PICT team membership will vary from one hospital to another, but it is suggested that clinical and non-clinical professionals who have a solid understanding of bed management are invited to join this group. Suitable candidates might include senior representatives from Hospital Administration, Medicine, Surgery, Nursing, and Admitting/Patient Access. Serving members on the BMC would also be excellent choices as the PICT will cease to exist after it has developed three (3) implementation plans (see below). It will be important for the BMC to keep a copy of the completed PICT Membership Roster for possible future reference.

LEADERSHIP:

Leadership of the Physician Involvement Coordination Team should be assigned to a senior-level physician.

Hospital Name: **Date:**

Physician Involvement Coordination Team Membership Roster		
Name	**Title/Department**	**Phone # and Email Address**

Physician's Involvement Coordination Team Brainstorming Activity

PROCEDURE:

Each PICT member introduces ideas about possible ways of increasing physician support of and involvement in rapid discharge without evaluating them.

MATERIALS:

In working as a group you may want to record each idea on a computer, blackboard or a piece of paper.

TIME:

(Group) 40 minutes to 90 minutes; (Individuals) 30 minutes each

NEXT STEPS:

Develop an implementation plan for **three (3)** of the evaluated ideas.

The following topics and questions are areas the group might discuss. They are not exhaustive and in no way reflect what each PICT will generate. After a short time, give members the chance to reflect on, evaluate and prioritize the list. You may choose to do this activity as a group, or each team member can generate their ideas and circulate them among the team.

POSSIBLE TOPICS:

- Role of the discharge team
- Roles of the discharge team members
- Telemetry patient evaluation
- Preventing unnecessary internal transfers
- Transfers to off-service beds
- Private attendings turn over discharging to chief residents or hospitalists

EVALUATION QUESTIONS:

- What are the differences between discharging, timely discharging, and rapid discharging?
- What are the similarities?
- What are the barriers to physician involvement in rapid patient discharging?
- Why are attending physician discharge orders mandatory in most hospitals?
- How can physicians coordinate with other teams to increase the number of patient discharges?
- Does the organizational structure “work” for or against patient discharging?
- If against, what remedial action(s) can be engaged to change the structure?
- Does the hospital culture place importance on timely patient discharging?
- If not, what can be done to improve or educate the culture to the importance of timely discharging?
- What can individual physicians do to improve timely discharging?

- What can different physician groups (e.g., hospitalists) do to improve timely discharging?
- List some traditional ways in which physicians can assist more with discharging.
- List some non-traditional ways in which physicians can assist with discharging.
- How do physician extenders (i.e., Physician Assistants) assist with discharging?
- Can physician extenders (i.e., Physician Assistants) do more to assist physicians with discharging? How?
- How can the department chairs (e.g., Medicine, Surgery) contribute more to rapid discharging?
- What steps can be taken to discharge patients if attending physician is not available?
- What experience do you have with physicians engaging in rapid patient discharging?
- What lessons were learned?
- What would happen if physicians did not discharge patients during an emergency?
- Is there anything physicians could be offered that might improve discharging?
- How about the opposite?

INSTRUCTIONS:

Following above activity, the PICT will choose their three (3) most promising ideas for increasing physician support of and involvement in rapid patient discharging. An implementation plan should accompany each idea. Create more space in the chart, as required.

Hospital Name: **Date:**

Physician Involvement Coordination Team Promising Ideas for Physician Involvement in Rapid Patient Discharging	
Evaluated Idea (Opportunity)	**Implementation Plan**
1.	
2.	
3.	

Patient Care Unit "Walk-Through" Teams

Rapid Discharge Tool
Appendix F

Patient Care Unit "Walk-Through" Teams Guidance Document

BACKGROUND:

Patient Care Unit "Walk-Through" Teams are an effective way to capture bed vacancies and discharges that may have gone unreported at the most recent BMC meeting. This activity is something many admitting/patient access managers routinely do when beds are in short supply.

PURPOSE:

Many patient status changes occurring in between BMC meetings may go unreported. There are numerous reasons why this occurs, from simple oversight to change-in-shift staff dynamics. Small teams comprised of admitting/patient access managers and/or representatives can walk through patient care units noting empty beds and confirming patient discharge status. The optimal time to "walk the floors" is in between BMC meetings, though this activity can take place at any time. In a tight bedding situation, the importance of capturing even one additional, available bed cannot be overestimated.

TEAM COMPOSITION:

Staffing permitted, admitting/patient access managers and representatives are best suited for this activity. Representatives from nursing who are knowledgeable about bed management could equally be considered for team inclusion.

LEADERSHIP:

Leadership of the "Walk-Through" Teams should be assigned to members from admitting/patient access.

REPORTING:

Patient Care Unit "Walk-Through" Teams report their results to the BMC.

INSTRUCTIONS:

Use a separate Patient *Care Unit "Walk-Through" Teams Membership Roster* to list the members of the team. Be certain to consider (and document) how each team will be coordinated/engaged off-hours (evening, night, weekend). It is recommended that a separate form be used for each of these shifts. The Patient *Care Unit "Walk-Through" Teams Membership Roster* will need to be kept up-to-date, with copies routinely given to the BMC. Admitting/Patient Access management and staff should also have ready access to this information.

Hospital Name: **Shift:** **Date:**

Patient Care Unit "Walk-Through" Teams Membership Roster				
Name	**Title/Department**	**HICS Title (if applicable)**	**Shift**	**Phone # and Email Address**

Rapid Discharge Tool
Appendix G

Barriers to Timely Discharging Self-Assessment Tool Guidance Document

PURPOSE:

In completing this tool, the Bed Management Committee (BMC) will be able to identify primary and secondary causes for discharge delays. In a mass casualty incident, a full understanding of the problems associated with timely discharging will help the BMC to accomplish the following:

- ⇨ Unit-Based Rapid Discharge Teams will anticipate discharge barriers and issue appropriate instructions/orders to avoid them. These teams will also effectively problem resolve barriers they encounter with pre-designed solutions.
- ⇨ Physician Involvement will be more productive, as doctors gain a greater understanding of their role in both creating and eliminating barriers to timely discharging.
- ⇨ Patient Care Unit "Walk-Through" Teams will quickly identify how and where barriers are causing discharge delays and communicate this information back to the BMC.

INSTRUCTIONS:

Rank each Clinical and Non-Clinical Barrier by placing a check mark (✓) in the appropriate column, then complete questions 3 & 4. Create and use extra lines/spaces as needed.

Barriers to Timely Discharging
Self-Assessment Survey

Hospital Name: **Date:**

	Not a Problem	Minor Problem	Major Problem	Not Sure
1. Clinical Barriers				
■ Waiting for lab results				
■ Waiting for prescriptions				
■ Weekdays: MD not available to write Discharge Order				
■ Weekends / Holidays / Off-Hours: MD not available to write Discharge Order				
■ Unit activity delays discharge (e.g., codes)				
■ Discharge practices vary widely from unit to unit				
■ Waiting for consulting physicians				
■ Inconsistent discharge team composition				
■ Lack of discharge planning tool in patient charts (i.e., *Intend to Discharge Form*)				
■ Hospital policy requires attending physician to "sign-off" on discharges				
■ Doctors do not usually estimate (and document) date of discharge				
■ Private physicians round late due to their office hour's conflict with discharge rounds/activity.				
■ Residency education activities (i.e., conflicting with morning discharge activity)				
2. Non-Clinical Barriers				
■ Late notification (to patient) of discharge decision				
■ Patient awaiting transportation or escort home				
■ Patient/family refusing to leave early (or at all)				
■ No assigned waiting area for discharged patients				
■ Inclement weather prevents patient pick-up				
■ Staffing shortage				

	Not a Problem	Minor Problem	Major Problem	Not Sure
■ Patient referral notifications taking a long time				
■ Change of shift issues				
■ Patient awaiting bed assignment at sub-acute care facility				

3. **Please list any additional clinical and non-clinical barriers that represent a major problem for timely discharging in your hospital:**

_____

_____

_____

4. **Please rank your top 5 clinical and non-clinical barriers to timely discharging. In the "Solution" column, briefly describe how you plan to address each of the barriers:**

BARRIER	SOLUTION
Clinical	
1.	
2.	
3.	
4.	
5.	
Non-Clinical	
1.	
2.	
3.	
4.	
5.	

Rapid Discharge Tool
Appendix H

Off-Hours Management of Rapid Discharge Guidance Document

BACKGROUND:

Appendices A through G are designed to assist hospitals in preparing for and responding to unexpected increases in patient volume during the immediate phase of a disaster by providing them with clearly defined activities organized around a Bed Management Committee (BMC). These activities include:

- Forming a BMC (or equivalent)
- Developing an Emergency Census Monitoring Tool
- Organizing Unit-Based Rapid Patient Discharge Teams (or equivalent)
- Evaluating Ideas to Increase Physician Support and Involvement in Rapid Discharging
- Assembling Patient Care Unit Walk-Through Teams (or equivalent)
- Considering Barriers to Patient Discharge

Both the Physician Involvement Coordination Team (Appendix E) and the Barriers to Timely Discharging Self-Assessment Tool (Appendix G) add a problem-identification and problem-solving dimension that further challenges hospitals to look for ways to improve their operations in order to maximize the benefits of the Rapid Discharge Tool's (RDT) activities. By combining RDT activities with physician involvement and patient flow solutions, hospitals will be able to improve the following key rapid discharge processes:

- **Acquiring accurate census data**
- **Organizing rapid discharging**
- **Monitoring patient discharge**

At a day-long NYC DOHMH-sponsored Surge Clinics, understanding these processes became the learning objective for one of the workgroup sessions – a Micro Tabletop Exercise. This exercise presented participants with an "off-hours" disaster scenario, thereby providing hospitals with an opportunity to explore response solutions to problems associated with this timeframe.

OBJECTIVE:

The Objective of Appendix H is to assist hospitals in preparing for and responding to unexpected increases in patient volume during the immediate phase of a disaster *occurring outside of normal business hours*.

PURPOSE:

Hospitals will complete their immediate phase, rapid discharge plans by successfully engaging Appendix H work requirements, which include: ***convening their BMCs***, ***profiling capacity differences between "normal" and "off hours" shifts***, ***filling out a questionnaire***, ***conducting a tabletop exercise, completing a brief tabletop exercise "hot wash"***, and ***drafting hospital-specific plans for their "off-hours" management of rapid discharge***. Once this work is done, and assuming Appendix A through G requirements have been completed, hospital plans for rapid discharge can be considered "final".

INSTRUCTIONS:

Separate instructions accompany each of the above Appendix H components (italicized in bold). Prior to engaging these activities, it is strongly recommended that all Appendix H documents first be read thoroughly in the order in which they are presented.

Upon initial review of this documentation, the hospital emergency manager should select or assign a Moderator for the Micro Tabletop Exercise. In order that the Moderator has time to prepare, s/he needs to be given the Rapid Discharge Tool (RDT) and Appendix H at least two weeks in advance of the exercise. See page 51 for more detail.

Work Overview & Submission Requirements

Work Overview:

Activities that are color-coded in **bold green** (see below) signify work that is either required and/or must be submitted to the DOHMH. These activities have been placed in text boxes underneath section headings throughout the document for easier identification.

1. **Convene BMC to complete Appendix H activities with core group of senior members – Page 41**
2. **BMC members complete Sign-In Sheet – Page 41**
3. **BMC members complete a Hospital Capacity Profile form – Page 42**
4. **BMC members complete Pre Micro Tabletop Exercise Questionnaire (submission not required) – Page 45**
5. **BMC members conduct Micro Tabletop Exercise – Page 50**
6. **BMC members complete Micro Tabletop Exercise Hot Wash – Page 69**
7. **BMC members complete Hospital-Specific Plan – Page 71**

Submission Requirements (see Guidelines document for more detail):

Hospital Emergency Manager submits the following, completed documents to DOHMH:

- Bed Management Committee (BMC) Sign-In Sheet (page 41)
- Hospital Capacity Profile form (page 42)
- Micro Tabletop Exercise Hot Wash form (page 69)
- Hospital-Specific Plan (page 71)

Off-Hours Management of Rapid Discharge
Bed Management Committee Sign-In Sheet

Convene BMC to complete Appendix H activities with core group of senior members

PURPOSE:

The purpose of convening BMC is to involve core group of senior members in completing all Appendix H activities.

INSTRUCTIONS:

1. Schedule a meeting with core group of senior BMC members.
2. Use BMC sign-in sheet (below).

HELPFUL HINT

⇨ See Rapid Discharge Tool, Appendix A, page 21, for list of senior BMC representatives.

Hospital: **Date:**

Bed Management Committee (BMC) Sign-In Sheet			
Name	**Title/Department**	**Shift**	**Phone # and Email Address**

Off-Hours Management of Rapid Discharge
Hospital Capacity Profile

BMC members complete a Hospital Capacity Profile form

OBJECTIVE:

In completing the *Hospital Capacity Profile* (HCP), Emergency Planners will be made aware of their hospital-specific patient discharge-related staffing constraints during the off-hours shifts. Knowing these constraints could become barriers to engaging the key rapid discharge processes, emergency managers (and others) will be challenged to problem-resolve the issues while conducting the Appendix H "Saturday afternoon" tabletop exercise (page 64) and completing the Hospital-Specific Plan (page 71).

PURPOSE:

The purpose of the *Hospital Capacity Profile* is to provide emergency managers with a reference they can use to make decisions regarding possible decreased capacity during certain off-hours shifts.

HELPFUL HINT

⇨ Use last full month's data for census questions, unless otherwise indicated.

INSTRUCTIONS:

1. Choose Y or N, or answer as appropriate, making certain all columns are filled in.
2. Enter "N/A" if hospital does not have resource/operation, or question does not apply.

Hospital Capacity Profile				
Hospital Resources & Operations	Normal Hours M-F Days	Evenings	Nights	Weekends (incl Holidays) Days
Census				
Number of inpatient beds ***in operation*** (excluding nursery)				
What % of inpatient beds in operation is Isolation?				
What % of inpatient beds in operation is Pediatric?				
What % of inpatient beds in operation is Rehabilitation?				
What % of inpatient beds in operation is Psychiatry?				
What % of inpatient beds in operation is Drug/Detox?				
Average ***daily*** census - weekdays & weekends - based on total capacity of inpatient beds in operation. Use data from last full month (excluding nursery)	%			%
Emergency Department				
# of ED beds/bays				
Average # of staffed ED beds/bays?				
# of ED Registration staff?				
Are ED Registrars able to assign beds to patients?	Y / N	Y / N	Y / N	Y / N
Does ED offer “Fast Track” or “Urgent Care” Program?	Y / N	Y / N	Y / N	Y / N
Hospital Operations				
Discharge Rounds routinely conducted?	Y / N	Y / N		Y / N
Title of most senior on-site Nursing Administrator?				
Admitting/Patient Access Manager on-site?	Y / N	Y / N	Y / N	Y / N
# of Admitting/Patient Access staff on-site?				
# of Social Workers on-site?				
Inpatient Transportation Manager on-site?	Y / N	Y / N	Y / N	Y / N
# of Inpatient Transporters on-site?				
Housekeeping/Environmental Services Manager on-site?	Y / N	Y / N	Y / N	Y / N
# of Housekeepers/Environmental Services staff on-site?				
“Stat Labs” turnaround in less than 1 hour?	Y / N	Y / N	Y / N	Y / N
Operating Rooms In Use for Elective Procedures?	Y / N	Y / N	Y / N	Y / N

Hospital Capacity Profile				
Hospital Resources & Operations	Normal Hours M-F Days	Evenings	Nights	Weekends (incl Holidays) Days
Health Care Providers				
% of care provided by Private Attending Physicians	%	%	%	%
% of care provided by Hospitalists	%	%	%	%
Does your hospital have a residency program?	Y / N	Y / N	Y / N	Y / N
How many Phys. Assistants are involved in patient care?				
How many Nurse Practitioners are involved in patient care?				
Does your hospital routinely assess MD Length of Stay?	Y / N			
Systems				
Does your ED use an electronic patient management system?	Y / N			
If Yes to above, what is system name?				
Does your ED registration system use virtual beds?	Y / N			
Which of the following does your hospital employ to keep track of inpatient bed activity (admissions, transfers and discharges)? a. Manual Bed Board b. Electronic Bed Board c. Patient Tracking System d. Other (describe) (*Enter appropriate letter(s) for each column*)				
Do your inpatient bed management and/or registration system(s) use virtual beds on your med/surg units?	Y / N			
Is your inpatient bed management and/or registration system(s) capable of creating “phantom units” (i.e., patient care units comprised of virtual beds)?	Y / N			

END OF HOSPITAL CAPACITY PROFILE – PROCEED TO PRE-MICRO TABLETOP QUESTIONNAIRE ON PAGE 45

Off-Hours Management of Rapid Discharge
Pre Micro Tabletop Exercise Questionnaire

BMC Members complete *Pre Micro Tabletop Exercise Questionnaire*

OBJECTIVE:

DOHMH recognizes that hospitals may confront unique challenges during an "off-hours" disaster (*"off-hours" shifts include Evenings, Nights, Weekends and Holidays)*. The objective of the *Pre Micro Tabletop Exercise Questionnaire* is, therefore, to help hospital BMCs organize the information they will need to both successfully conduct the Micro Tabletop Exercise and write a hospital-specific plan for rapid discharging during off-hours shifts.

PURPOSE:

Because reduced staffing and other resource shortfalls can become rapid discharge barriers during "off-hours" disasters, this questionnaire has been designed to encourage BMCs to anticipate these and other problems and solutions that may arise during this timeframe. As such, it is a planning tool that hospitals can use to generate discussion about how to organize their key rapid discharge activities during an off-hours emergency.

KEY POINTS

- ⇨ Questions pertain to normal "off-hours" operations (unless otherwise indicated).
- ⇨ If certain questions are perceived as difficult, this may indicate a need for more in-depth review of subject matter.
- ⇨ Answers should be carefully considered – they may be used in your hospital's final plan.
- ⇨ The Rapid Discharge Tool (RDT) is a good reference tool for many of the Pre Micro Tabletop Exercise Questionnaire questions.
- ⇨ Reduced staffing in "off-hours" shifts is assumed – even where the BMC may consist of only one or a few individuals.
- ⇨ To help guide discussion during the tabletop exercise and to aid development of the hospital-specific plan, at least one or two individuals should become subject matter expert(s) in the material covered in the questionnaire.
- ⇨ Completed *Pre Micro Tabletop Exercise Questionnaire* ***does not have to be submitted*** to DOHMH, but it is suggested hospitals use it as a reference in completing other Appendix H components.

INSTRUCTIONS:

1. As a group, BMC members complete this questionnaire prior to conducting the Micro Tabletop Exercise.
2. Expand the table to use as much space as you require.

Pre Micro Tabletop Exercise Questionnaire	
QUESTION	**RESPONSE**
Acquiring accurate census data	
1. Name/title, brief job description, and responsibilities of most senior on-site off-hours administrator?	
2. Name/title, brief job description, and responsibilities of individual who assigns beds to ED patients?	
3. Provide a brief job description, and responsibilities of your on-site or on-call expert Bed Coordinator (aka "Bed Czar").	
4. If hospital does not have an on-site or on-call expert Bed Coordinator, define what steps are taken to provide on-site or on-call bed management expertise, and when. (e.g., "effective immediately, Admitting Director/Manager will be on call/recall 24/7").	
5. Describe actions your senior on-site administrator takes to rapidly capture accurate census at your hospital? (e.g., convene BMC, direct a walk-through)	
6. Names/titles, brief job descriptions, and responsibilities of core and ancillary members attending emergency BMC meetings.	
7. Identify a pre-designated meeting space used in a disaster. Include directions and accessibility solutions (e.g., call Security to unlock door).	
8. Name/title, brief job description, and responsibilities of individual who keeps hospital Emergency Census Tool updated throughout a disaster.	

Pre Micro Tabletop Exercise Questionnaire	
QUESTION	**RESPONSE**
9. List other necessary census-capture tools to quickly gather patient census and discharge information (e.g., bed-by-bed discharge status form, intend to discharge form).	
10. If hospital does not have other necessary census-capture tools, define what steps will be taken to develop them, and when (e.g., "plan to finalize a unit-based bed-by-bed census status tool by September 20xx").	
11. Name/title, brief job description, and responsibilities of individual(s) who are assigned to initially walk-through the patient care units to identify and verify actual and potential discharges.	
Organizing rapid discharging	
12. Detail list of actions your senior on-site administrator and/or BMC take to activate the Unit-Based Rapid Patient Discharge Teams (UBRPDTs) (e.g., Nursing Supervisor pages Medicine, etc.).	
13. Describe how the UBRPDT activation decision is communicated to your Patient Care Units (e.g., Nursing Supervisor calls Charge Nurses).	
14. Name(s)/title(s), brief job descriptions, and responsibilities of individual(s) who comprise the UBRPDTs during "off-hours" disasters?	
15. List tools that are used to assist UBRPDTs in identifying patients who are either "at" or "near" discharge (e.g., "intend to discharge" form, or "unit-based, bed-by-bed patient discharge status" form).	
16. If hospital does not use patient discharge status identification tools, define what steps will be taken to develop them, and when.	
17. How often do UBRPDTs round their units to update/monitor patient discharges? (e.g., twice during each shift).	

Pre Micro Tabletop Exercise Questionnaire	
QUESTION	**RESPONSE**
18. How are UBRPDT patient discharge updates communicated to the BMC and when? (e.g., by Charge Nurse at BMC).	
19. Titles of other Health Care Practitioners (HCPs) who are able to assess patients to discharge during a disaster if their Private Attending(s) cannot be reached? (e.g., Physician Assistants).	
20. Is patient care unit staff aware of approved discharge practices that involve HCPs other than Private Attendings? Circle Yes or No.	Yes / No
21. If staff is not aware of approved discharge practices that involve HCPs other than Private Attendings, what steps will hospital take to assure staff is properly trained, and when?	
22. If other HCPs are not allowed to assess Private Attendings' patients to discharge during a disaster, is hospital exploring options to allow them to do so? If yes, explain. If no, explain why not.	
Monitoring patient discharge	
23. Detail list of actions your senior on-site administrator and/or BMC take to activate hospital Walk-Through Team (e.g., directs Admitting Representative to survey units using census-capture tools, assigns walk-through frequency, and considers continuity between shifts).	
24. Name/title, brief job description, and responsibilities of individual(s) who comprise the "off-hours" Walk-Through Team during a disaster?	
25. List tools that are used to assist Walk-Through Team in its continued monitoring of patients who are either "at" or "near" discharge. (e.g., bed-by-bed patient discharge status form).	

Pre Micro Tabletop Exercise Questionnaire	
QUESTION	**RESPONSE**
26. If hospital does not use patient discharge status identification tools for the continued monitoring of patients who are “at” or “near” discharge, define what steps will be taken to develop them, and when.	
27. How often during each shift does the BMC instruct the Walk-Through Team to survey the units? (e.g. at least once during each shift)	
28. How and when does Walk-Through Team communicate its findings to the BMC? (e.g., Team immediately phones admitting on identifying a vacant bed or patient discharge and documents this on a bed-by-bed patient discharge status form to present at BMC).	

END OF QUESTIONNAIRE - PROCEED TO MICRO TABLETOP EXERCISE ON PAGE 50

Off-Hours Management of Rapid Discharge
Micro Tabletop Exercise
Guidance Document

BMC members conduct Micro Tabletop Exercise

OBJECTIVE:

The objective of this exercise is for participants to evaluate and improve their emergency response preparedness to "off-hours" rapid discharging so that they will be able to construct their hospital rapid discharge plan for this timeframe.

PURPOSE:

In the wake of a mass casualty incident, hospitals have been asked to plan to increase their bed capacity by up to 20% within 8 hours of notification. The purpose of running this Saturday afternoon, change-of-shift tabletop scenario is to form a surge capacity team that will assess, plan and increase their facility's bed capacity through rapid discharging - during an off hours shift in the immediate phase of a disaster.

MICRO TABLETOP EXERCISE DIRECTORY

INSTRUCTIONS:

1. First, make certain that Moderator customizes the tabletop scenario to your hospital (see page 64) by inserting hospital-specific information in the bracketed areas (***bold red*** print).
2. Print sufficient quantities of each section of the Micro Tabletop Exercise.
3. Follow instructions carefully, as outlined in Steps 1 through 9 in the Moderator's Guide.

Off-Hours Management of Rapid Discharge
Micro Tabletop Exercise – MODERATOR'S GUIDE

OVERVIEW:

The Moderator's Guide provides step-by-step instructions to the individual who will be moderating (or "facilitating") the Micro Tabletop Exercise. It is divided into two sections, Parts I & II, which directly corresponds to the tabletop scenario.

Steps 1 through 6 in Part I instruct the Moderator to set up the room and table, provide an orientation of the tabletop exercise process, review the participants guide and answer questions, distribute the event description and event discussion questions, and conduct an outcome session.

Steps 7 through 9 in Part II instruct the Moderator to distribute the event description and event discussion questions, and conduct an outcome session.

Following the conclusion of Step 9, the Moderator will conduct a 10 minute summary debriefing using the two questions in the *Micro Tabletop Exercise Hot Wash* grid on page 69. Participants responses need to be recorded as this document will be submitted to DOHMH.

Finally, a *Managing the Group* section is provided on page 59. Many useful suggestions regarding tabletop management (participants and processes) can be found here. Also, a listing of possible BMC core and ancillary members is offered as a reference.

PURPOSE:

The purpose of this guide is twofold:

- to help assure the Moderator keeps the discussion on track by focusing on the stated objective of the Micro Tabletop Exercise (page 50); and,
- to help the Moderator maintain his/her full attention to the tabletop process.

INSTRUCTIONS:

1. Follow the Steps beginning on page 53.
2. At conclusion of Part II's Outcome Session, continue to Hot Wash on page 69.

MODERATOR'S GUIDE

PART I

STEP 1: Room and Table Set-Up

- Reserve room for at least 2 hours.
- Seat 5-10 participants at one table (preferably a round table).
  See Participants Guide on page 62 for guidance in selecting tabletop team members.
- Place flipchart with markers next to the table.
- Write topics on flipchart (see *Overview of the Process* below)
- Place a copy of the Rapid Discharge Tool (RDT) on the table.
- Place a copy of the Participants Guide for each participant on the table.

STEP 2: 10 Minutes - Orientation Overview of the Tabletop Process

Welcome and Moderator's Introduction:

⇨ Moderator to state his/her name and title/department.

⇨ Select key statements from the Participants Guide that explain the **Moderator's Role**.

Brief Introductions of the Participants:

⇨ Name, title/department and length of time in role. Most participants will likely know one another so comments should be kept brief – about **30 seconds** each.

Quick overview of the purpose of the tabletop session:

- ⇨ Suggested introduction to tabletop purpose: "Most everyone in the room is capable of handling the kind of disaster scenario described in this exercise. But what happens if this should occur when you are not there? Participants are being asked to step out of their shoes for the next hour and put themselves in the place of their weekend staff."
- ⇨ Suggested advice to participants: "Exact answers to discussion topics are not required; rather, a demonstration of identifying and working through challenges and arriving at solutions is more important than actual numbers (such as trying to match admitted patients to available beds)."

Overview of the Process:

- ⇨ Length of session: 65 minutes (including Hot Wash)
- ⇨ The Tabletop Exercise focuses on **3 topics**:
  1. Acquiring census data
  2. Organizing rapid discharge
  3. Instituting ongoing discharge status monitoring
- ⇨ Process Guidelines (refer to Participants Guide, page 62)

Moderator should:

- o Make sure that each participant has a ***Participants Guide***.
- o Make sure that group has a flipchart with the **three major discussion topics** (above) on one page.
- o Spend time at the table ensuring everyone has an opportunity to participate and that the discussion topics are being addressed.
- o Remind group of time and to be prepared to summarize their work at the end of each session.
- o Record summary of effective practices on flipchart.

STEP 3: 5 Minutes - Review Participants Guide & Answer Questions

- ⇨ Moderator reads following sections from the Participant's Guide:
  - o Introduction
  - o Objectives
  - o Overview
- ⇨ Moderator will manage time and process to work through all the topics and questions.
- ⇨ Moderator prompts group to select:
  - ***Person in Charge*** to identify other roles and to encourage participants to focus on critical issues raised in each module.
  - ***Recorder*** to post notes of key strategies (per above topic areas) to flipchart, represent the table, and summarize group's discussion.

STEP 4: 5 Minutes - Distribute Event Description and Chronology Part I

- ⇨ Moderator asks a participant to read the scenario.

STEP 5: 15 Minutes - Distribute Discussion Questions (Player Handout)

- ⇨ Moderator asks group to respond to the Discussion Questions (see Reference below).
- ⇨ Moderator ask group to create 3 charts (see above Topics), and Unsolvables chart (i.e., to acknowledge irresolvable issues so that the group can move on to more productive activity).

STEP 6: 5 Minutes - Outcome Session

- ⇨ Moderator asks group to present their responses in a session facilitated by the Moderator, before proceeding to the second module.
- ⇨ Moderator creates Summary Chart of Effective Practices (& Unsolvables Chart)

FOR REFERENCE ONLY

Discussion Questions for Part I are:

- What are the next steps?
- Who will you contact?
- How will you determine how many patients you can make room for?

ASK IF THERE IS ANYTHING ELSE TO DISCUSS BEFORE GOING ON TO PART II ON PAGE 57

PART II

STEP 7: 5 Minutes - Distribute Event Description and Chronology Part II

- ⇨ Moderator asks a participant to read the scenario.

STEP 8: 15 Minutes - Distribute Discussion Questions (Player Handout)

- ⇨ Moderator asks group to respond to the Discussion Questions.
- ⇨ Moderator asks group to create 3 charts (see above Topics), and Unsolvables chart.

STEP 9: 5 Minutes - Outcome Session

- ⇨ Moderator asks group to present their responses in a session facilitated by the Moderator, before proceeding to the Hot Wash (see page 69).
- ⇨ Moderator creates Summary Chart of Effective Practices (& Unsolvables Chart)
- ⇨ Closing Comments and “Thank you for your participation in this workshop”

FOR REFERENCE ONLY

Discussion Questions for Part II are:

- What are the next steps?
- What can be done to enhance rapid discharge?
- How can census be continuously updated (collected, compiled, verified, recorded, and used)?

Prompting Questions for Part II are:

- How is discharge status determined?
- How is this information reported? Updated?
- How can the unreachable Private Attending's 4 patients (who have been awaiting discharge orders) be discharged?

END OF TABLETOP EXERCISE – PROCEED TO HOT WASH DOCUMENT ON PAGE 69

MANAGING THE GROUP

Moderator Tasks

- Guide and moderate the discussion using a conversational approach.
- Regulate time and work to ensure opportunity for full participation by all members of the group.
- Visit with group to help organize thoughts and work, and move discussion along, referencing the Rapid Discharge Tool.
- Help group to frame challenges in ways that lead to solutions (use SMART problem identification - Specific, Measurable, Achievable, Relevant, and Time-framed).
- Encourage out-of-the-box thinking.
- Provide expert-informed guidance on identifying challenges and solutions.
- To guide process only; will not be part of substantive conversation, nor contribute to its content – but will keep groups focused on learning objectives (see Participants Guide).
- To summarize group work by learning objectives during outcome sessions.

Participants

- Participants in the workgroup will include middle to senior level individuals from the following hospital areas of operations: Administration, Emergency Management, Medicine, Nursing, and Admitting/Patient Access.

Moderator Activity

- Prompt participants to discuss the sequence of events – notification of key personnel (who?)⇨ scheduling of meetings (who, when, where?)⇨ monitoring bed usage (who, how?)⇨ data collection and aggregation activities⇨ open/close bed decisions⇨ updating/monitoring data.

- Moderator will work with the group toward a goal of balanced and full participation by holding off on "immediate or second" follow-up comments, until others have had a first opportunity to contribute.
- Given time constraints, individual participants will need to balance providing full and important feedback with being as succinct as possible. Facilitator may periodically remind participants of this need.
- Help group conceptualize challenges. Have the group "diagnose" the greatest challenges in terms of:
  - ⇨ **who** is involved;
  - ⇨ **what** are the key/most common features of the challenge;
  - ⇨ **when** in the process is the challenge most likely to be manifest;
  - ⇨ **where** does the challenge reside (or emanate from) in the process/system;
  - ⇨ **how** does the challenge most commonly present itself.

Table Discussion

- Participants discuss their next steps based on the given information. During the groups' discussions, the moderators listen in to the conversations and, where appropriate, help the group to focus on the discussion topics:
  - ▫ Acquiring accurate census data of all available staffed beds. (Verifying availability)
  - ▫ Organizing rapid discharge of patients identified as dischargeable.
  - ▫ Implementing ongoing bed census and discharge status monitoring.

Role List – for Bed Management Committee (BMC)

Suggested Members:

Bed Management Committee (BMC)	
Core	**Ancillary**
• Administration • Admitting • Bed Tracking Manager (HICS) • Emergency Management • Emergency Medicine • Environmental Services • Medicine • Nursing • Patient Tracking Manager (HICS) • Social Work • Surgery	• Dietary / Food Services • Facilities / Engineering • Infection Control • Information Services • Laboratory • Materials Management • Mental Health • Patient Accounts / Finance • Patient Transport • Pediatrics • Pharmacy • Radiology • Respiratory Care • Safety • Telecommunications • Union

Off-Hours Management of Rapid Discharge
Micro Tabletop Exercise – PARTICIPANTS GUIDE

Introduction

This "micro" version of a tabletop exercise emphasizes the importance of using a multidisciplinary team approach. Tabletop exercises generally organize participants into teams that correspond to functional areas within an institution. In this case, the ***Person in Charge*** will identify roles and encourage participants to focus on the critical issues raised in each module. This Micro Tabletop Exercise has been designed to encourage free and open exchange of ideas. Enjoy!

Objectives

At the end of the Micro Tabletop Workgroup Session, participants will be able to:

1. Describe what steps are necessary to obtain accurate and reliable bed-census data, including approximately how many patient discharges are necessary to accommodate anticipated admissions.
2. Identify strategies for rapid discharging for a hospital involved in a large-scale local disaster.
3. Discuss considerations for the continual updating of census data.

Overview of the Process

- Length of session: 65 minutes
- The exercise focuses on 3 topics:
  - ⇨ Acquiring census data
  - ⇨ Organizing rapid discharge
  - ⇨ Instituting ongoing discharge status monitoring
- After the moderator introduces each module, team will be asked to respond to a series of questions.

Next Steps

- Your **Tabletop Team** should select a:
  - ⇨ **Person in Charge** to identify other roles and to encourage participants to focus on the critical issues being raised.
  - ⇨ **Recorder** to post notes of key strategies (per above topic area) to flipchart and to represent the table and summarize group's discussion.
- At the end of the ***first module***, team Reporter will be asked to present the team's responses in a session facilitated by the moderator, before proceeding to the second module.
- At the end of the ***second module***, team Reporter will be asked to present the team's responses in a session facilitated by the moderator.
- After the second module, a short **"hot wash" debriefing** will be facilitated by the Moderator.

Moderators will

- Guide and moderate the discussion.
- Regulate time and work to ensure opportunity for full participation by all members of the group.
- Visit with group to help organize thoughts and work.
- Help group to frame challenges in ways that lead to solutions.
- Encourage out-of-the-box thinking.
- Provide expert-informed guidance on identifying challenges and solutions.

Off-Hours Management of Rapid Discharge
Micro Tabletop Exercise – Event Description & Chronology

Part I

Saturday, 1:46pm — You are the [**enter** title] in-charge at [**enter** your Hospital] located at [**enter** hospital location]. [**enter** Hospital name] is a [**describe** hospital: full-service/specialty, teaching/non-teaching, for profit/non-profit/city owned, # ED beds].

It is 70 ° and sunny on a Saturday afternoon in May. After a long string of cold and rainy weeks it's finally a beautiful day and the City is brimming with people. It has been a pretty normal day so far at [**enter** hospital name]. More staff than usual were late this morning but for now, just before 2:00pm, you have nearly 100% staff in attendance. Everyone is talking about the beautiful day and how they cannot wait to get outdoors. [**enter** hospital name] "midnight census" was 93% full, and as usual the emergency department is running heavy at roughly 120% of its capacity due to "lack of appropriate, available beds". The ED is on ambulance diversion because of the back-up.

2:04pm — On your return from the cafeteria, you meet a hospital employee coming into [**enter** hospital name]. She tells you that she had to get off of her train two stops before her usual station and walk to work because of stalled trains. She heard that there had been some kind of an accident. As you are walking past a security station, you overhear one of the guards telling his supervisor that 1010 WINS is reporting a large [**enter** borough name] subway fire. Outside, you notice that you've been hearing wave after wave of sirens racing by.

2:17pm — [**enter** Hospital name]'s ED Physician-In-Charge is notified by the citywide desk at FDNY-EMS to prepare to receive an unknown number of causalities from a major explosion in the [**enter** local subway line] at the [**enter** nearby subway station]. The information at this time does not indicate how many injured there are, but the ED is informed to expect at least 30 patients, adult and pediatric, in the first wave. You page the Administrator On Call.

2:21pm The ED Physician-In-Charge calls you to see if you can talk to admitting to quickly make room for the 20 patients now waiting in the ED for admission. You calmly tell the ED physician that you will get back to him.

2:24pm Admitting reports there are no immediately available inpatient beds and to check back later for an update on discharges. The Administrator On Call has not responded to your page and Senior Management is away on retreat and unreachable.

Table Discussion - 1st Round

Table Discussion:

Each table discusses their next steps based on the information given.

Discussion Questions:

Considering the presented scenario:

- What are the next steps?
- Who will you contact?
- How will you determine how many patients you can make room for?

Bed Management Committee (BMC):

The BMC is charged with organizing and directing activities related to inpatient admissions, discharges and transfers in accordance with hospital policies and procedures. Membership expands according to emergent need but may include representatives from such areas as Administration, Admitting, Emergency Management, Emergency Medicine, Environmental Services, Medicine, Nursing, Social Work, and Surgery.

Part II

Explosion at the [enter nearby subway station]

Saturday, 2:56pm — Around 2:30pm it became known that at least two subway trains were involved in the explosion. In addition to the explosions themselves, there are now reports of smoke-filled tunnels and trains all along the east side subway lines, power shut-offs, and thousands of panicked people trying to escape the catastrophe.

At 2:56, fearing the possibility of further explosions, the Mayor orders a full closure of all New York City subways and commuter rail lines. Traffic has become congested throughout the city, with many streets gridlocked and there is a constant wail of sirens. CNN reports that Homeland Security cannot rule out a terrorist event.

3:06pm — Staff for the next shift is having difficulty arriving to work. And senior level approval is normally necessary to mandate key staff to stay on an extra shift.

3:45pm — The ED physician-in-charge is upset that only 4 of the admitted ED patients have moved to the floor, and he has begun sending patients up to the floors on stretchers.

3:55pm — 90 ambulatory and EMS-delivered injured persons have begun to arrive at [enter hospital name]. It is likely that 18 patients will need to be admitted (4 ICUs, 5 ORs, 9 Med/Surg), and 72 will need to be treated with probable discharge. The ER staff state they are "beyond" capacity.

Some of the patient care units report they are unable to reach Private Attendings who have dischargeable patients – one such doctor has 4 surgical patients awaiting discharge orders.

Table Discussion – 2nd Round

Table Discussion:

Each table discusses their next steps based on the information given.

Discussion Questions:

Considering the presented scenario:

- What are the next steps?
- What can be done to enhance rapid discharge?
- How can census be continuously updated (collected, compiled, verified, recorded, and used)?

Conclusion / Closing Remarks

Off-Hours Management of Rapid Discharge
Micro Tabletop Exercise – *Hot Wash*

BMC members complete Micro Tabletop Exercise Hot Wash

OVERVIEW:

A "hot wash" debriefing is a learning opportunity for participants to state their observations while they remain fresh in their minds. It is led by the Micro Tabletop Exercise Moderator, who asks the participants to give a recap of what they observed and to document the major issues and gaps.

INSTRUCTIONS:

1. *Review and answer questions in the Micro Tabletop Exercise Summary grid.*
2. *Expand the grid to accommodate responses.*
3. *Devote 5 minutes to each question.*

Micro Tabletop Exercise Hot Wash	
Question	***Response***
1. Outline the ***major issues and gaps*** identified by the exercise in the following areas: o Acquiring accurate census data o Rapid patient discharging o Monitoring patient discharge	

Micro Tabletop Exercise Hot Wash	
Question	***Response***
2. Identify ***potential next steps*** (with expected implementation dates) to address major issues and gaps in the following areas: ○ Acquiring accurate census data ○ Organizing rapid patient discharging ○ Monitoring patient discharge	

END OF MICRO TABLETOP HOT WASH – PROCEED TO HOSPITAL-SPECIFIC PLAN ON PAGE 71

Off-Hours Management of Rapid Discharge
Hospital-Specific Plan

BMC members complete Hospital-Specific Plan

OBJECTIVE:

To prepare hospitals to organize their rapid discharge activities in the "off-hours" shifts.

PURPOSE:

In drafting this plan, hospitals will be laying a foundation for rapidly discharging patients in their off-hours shifts during an emergency. By adapting key Rapid Discharge Tool (RDT) activities to this timeframe, the purpose of this plan is to assist hospital administrators in preparing for unexpected increases in patient volume at a time when resources may already be challenged.

HELPFUL HINTS

- ⇨ Base your answers on weekend-day shifts; provide more specific information for other "off-hours" shifts, if required.
- ⇨ Assume most senior on-site administrator will be *Person in Charge* until ICS is mobilized.
- ⇨ Use provided references (*Refer to*…) as a possible source for answers to questions.
- ⇨ Consider and include other steps that may be applicable to your hospital.
- ⇨ Provide primary and secondary phone numbers where *contact information* is requested.

INSTRUCTIONS:

1. Use form below and expand as required (or develop separately as a Word document).

Hospital: **Date:**

Off Hours Management of Rapid Discharge HOSPITAL-SPECIFIC PLAN

I Organize a Bed Management Committee

A. **BMC Members**.
Refer to Rapid Discharge Tool (RDT), page 21, "Bed Management Committee (BMC) Guidance Document"

i. List name/title, brief job description, responsibilities, and contact information of most senior on-site off-hours administrator.

ii. List names/titles, brief job descriptions, responsibilities, and contact information of core and ancillary BMC members who are on-site during off-hours shifts.

iii. List names/titles, brief job descriptions, responsibilities, and contact information of available (on-call) core and ancillary BMC members. Be certain to include expert Bed Coordinator (e.g., "Bed Czar" or Admitting Director), as applicable.

B. **Pre-designated Meeting Location**. (Alternatively, in lieu of a meeting location, describe method of communication among BMC on-site members)
Refer to Appendix H, page 46, question 7

i. Describe exact location where BMC meetings are held during an off-hours disaster.

ii. Provide directions and access information to meeting location (e.g., call Security to open door), as applicable.

iii. List meeting-location telephone number, if applicable.

Off Hours Management of Rapid Discharge
HOSPITAL-SPECIFIC PLAN

C. **Emergency Census Tool Updating**.
Refer to Appendix H, page 46, question 8

i. List name/title, brief job description, responsibilities, and contact information of off-hours individual (e.g., Admitting Supervisor) who is assigned to update the hospital Emergency Census Tool.

ii. Describe all data sources used to update Emergency Census Tool (e.g., patient tracking system, data collection forms, patient care unit "walk-throughs").

iii. State frequency of Emergency Census Tool updates (e.g., at beginning and middle of each shift).

iv. List individuals who receive Emergency Census Tool updates and how they receive them (e.g., ED Charge Nurse, hand-delivery).

II Organize Unit-Based Rapid Patient Discharge Teams (UBRPDTs)

A. Unit-Based Rapid Patient Discharge Team (UBRPDT) Members.
Refer to Appendix H, page 47, question 14

i. For each patient care unit, list names/titles, brief job descriptions, responsibilities, and contact information of individuals who comprise off-hours Unit-Based Rapid Patient Discharge Teams. Be certain to include physician roles (i.e., Attending, Resident).

B. UBRPDT Activation Decision.
Refer to Appendix H, page 47, question 13

i. Name(s)/title(s), brief job descriptions, responsibilities, and contact information of individuals who are authorized to activate Unit-Based Rapid Patient Discharge Teams.

ii. Define criteria for activating your UBRPDTs (e.g., ED census, disaster declared).

iii. Use a diagram (or action steps) to describe how the UBRPDT activation decision is implemented. Be certain to include "de-activation" steps.

Off Hours Management of Rapid Discharge
HOSPITAL-SPECIFIC PLAN

C. UBRPDT Activities.
Refer to RDT, page 27, "Organize Unit-Based Rapid Patient Discharge Teams"

i. State how often UBRPDTs will "round" their units each shift to update/monitor patient discharges.

ii. Describe all tools (e.g., electronic medical records, discharge status forms, bulletin board posting of patient discharge status updates) that are used by the UBRPDTs to update/monitor patient discharges.

iii. Explain how updated patient discharge status information is communicated timely to the BMC (e.g., unit clerk phones/faxes information to admitting).

D. Health Care Provider (HCP) Involvement and Support of UBRPDTs.
Refer to Appendix H, page 48, questions 19-22,

i. Describe hospital/medical board policy regarding patient discharge in the event a Private Attending Physician is not reachable.

ii. List names/title(s), brief job descriptions, responsibilities, and contact information of HCPs who are authorized to discharge patients in the event a Private Attending Physician is not reachable.

iii. If HCPs are not authorized to discharge patients during a disaster, explain if hospital is considering options to allow them to do so. If not, explain.

Off Hours Management of Rapid Discharge
HOSPITAL-SPECIFIC PLAN

III Organize Ongoing Discharge Status Monitoring

A. Patient Care Unit "Walk-Through" Team Member Qualifications.
Refer to Appendix H, page 48, question 24

i. Provide *Job Action Sheet* for "Walk-Through" Team Member. Be certain to include following requirements: understanding of the discharge process, experience with bed management, and knowledge of patient flow barriers.

B. Patient Care Unit "Walk-Through" Team Members.
Refer to Appendix H, page 48, question 24

i. Name(s)/title(s), brief job descriptions, responsibilities, and contact information of individual(s) who are assigned to walk-through the patient care units to identify and verify actual and potential discharges - ongoing.

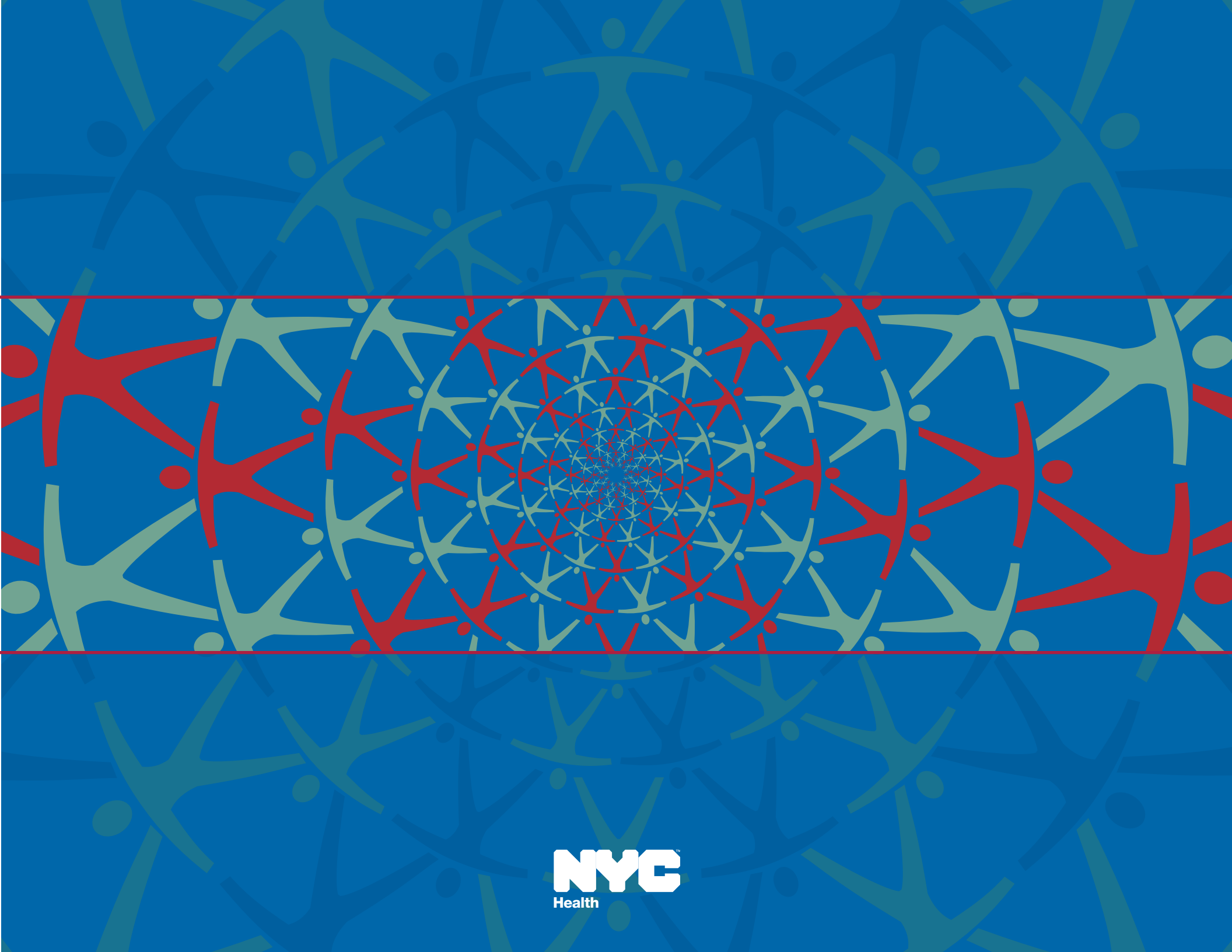
C. Patient Care Unit "Walk-Through" Team Activities.
Refer to RDT, page 33, "Organize Patient Care Unit *Walk-Through* Teams"

i. State how often (during each shift) BMC will direct "Walk-Through" Teams to survey all patient care units.

ii. Describe tools (e.g., systems, forms) that are used by the "Walk-Through" Teams to update/monitor patient discharges.

iii. Explain how updated patient discharge status information is communicated timely to the BMC (e.g., phone, fax).

END OF HOSPITAL-SPECIFIC PLAN: SUBMIT APPENDIX H WORK TO DOHMH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