

AT RISK REGISTRY



At Risk Registry

August 2015

Introductory User Guide

The At Risk Registry is a service provided by mumms© Software for the management of hospital patients requiring assistance during an emergency. This user guide is intended for the primary users in hospitals, regional coordinators, and state ESF8 support.

At Risk Registry

APPLICATION PURPOSE

The evacuation of hospital patients is a critical function of ESF 8 during an event. Due to geographic considerations, types of assets needed, and the large number of organizations involved, this operation is extremely complex and lasts long after the event is over. The need to repatriate patients from evacuation sites back home or back to the evacuating hospital can last over a month after normal response activities have finished. This complexity can easily lead to confusion when the decision-makers and those embedded in the actual operation do not have accurate and timely information. The purpose of this project is to improve the quality of the information generated in the process and in doing so, to improve the process itself.

The current Medical Institution Evacuation Plan (MIEP) operation is characterized as a “14 step” process. It is actually a 37-step process that involves approximately 10 different versions of the same basic information – a list of patients. Two other major characteristics of the process include:

1. The use of email as the primary means of communication between stakeholders. In addition, the process relies on a non-secure, public email service to transfer and store patient information.
2. The use of spreadsheets as the primary “container” for information. Because this is not a single database, the result is the proliferation of spreadsheets at every point in the process; all having different information. Manipulation of the data is highly susceptible to errors due to the lack of data integrity.

As with all complex processes, improvement is always possible, and the revision of this process is not done lightly. The complexity of the current process is dependent on large numbers of people understanding and agreeing to the way things are done. An argument could be made that any changes to the way information is handled has the danger of introducing major disruptions. The answer to the argument is that improvement in the way information is managed will decrease the probability of failure at every point in the process.

This project is intended to deploy a method and a system for managing patient information related to the MIEP. The effort involves the use of a technology platform developed for the Louisiana/Mississippi Hospice and Palliative Care Association (LMHPCA) to manage hospice organization patients during an emergency. The application was developed by Secure Computing (SC) in New Orleans. In order to meet the needs of the MIEP process, SC has significantly enhanced the structure and functionality of the system.

The characteristics of the system include the following:

1. It is a secure, web-based application.
2. Hospitals can upload (or enter) patient lists before an event and maintain data about patient status and evacuation needs.
3. Depending upon login identity, the user has customized views of the data based on his/her role in the process. There are three different categories of intended users – Hospital user, Designated Regional Coordinator (DRC) user, and State ESF8 support user.
4. The application can quickly and easily generate the spreadsheets required by TPMRC to manifest patients for evacuation (TPMRC can use this application if desired; eliminating several steps in the process).
5. Patients can be tracked at every step of the process.

6. Secure Computing can automatically and securely transmit database extracts to the DHH Data Warehouse to facilitate more robust reporting and providing real-time situational awareness.

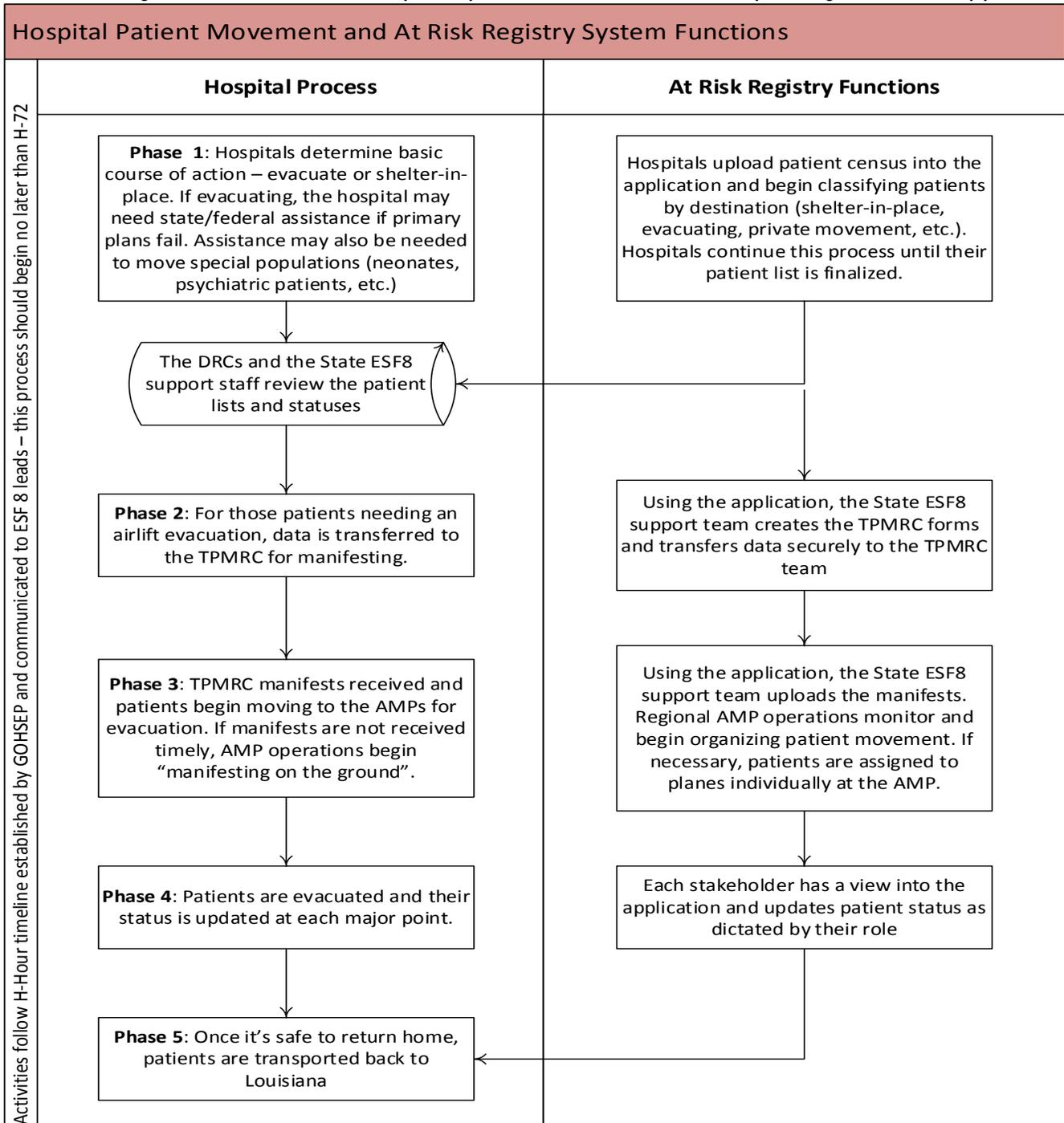
In summary, Secure Computing has provided a platform on which the MIEP process can be streamlined and improved, enabling all stakeholders to have a unique view into the evacuation and repatriation process. Because of the advantages of the new database platform and structure, the hospice and home health functionality will soon be migrated over to this platform. This brings a new level of true process and information management to local and state ESF 8 stakeholders.

OVERALL PROCESS

From a hospital's perspective, the overall use of the At Risk application is very simple:

1. Upload or enter patient information;
2. Update patient evacuation statuses; and
3. Monitor the process through repatriation.

The following chart summarizes the major hospital functions and the corresponding uses of the application.



USER ASSUMPTIONS

The first step in the process is the establishment of an “event.” This will be done by Secure Computing staff, and it essentially creates a “container” for all of the patient and other data associated with the event. Secure Computing will establish the event in the application in consultation with the State ESF 8 incident command structure.

Once the event has been created in the database, State ESF8 Support staff, will notify the DRC network and hospitals throughout the state of the creation of the event. This can trigger several actions:

1. Hospitals can begin to prepare patient lists for potential uploading into the application. This preparation can happen in several ways:
 - a. The hospital can use its EHR system to generate a compliant file that can be uploaded to the application.
 - b. The hospital can create a compliant file through several means; or
 - c. The hospital can enter patients directly into the application.

Hospitals that upload patient lists will be notified of any errors that are encountered in the process. This eliminates an “all or nothing” approach. Correct data will be uploaded giving hospitals the opportunity to correct mistakes through direct data entry or re-uploading of correct data.

2. The application will be accessed through several means giving the user the opportunity to securely login to the site:



Secure Computing will work with State ESF8 Support staff to ensure that login assistance is available during the initial part of the event timeline.

3. Once logged in, the hospital can manage its patient population throughout the process. No further uploads, downloads, or file transfers are required.

MAIN SCREEN

The screenshot shows the 'AtRisk Registry' interface for 'Patients'. At the top left is the logo and 'Patients' title. At the top right, user information is displayed: 'Username: chhos (Hospital Staff)', 'Region: Region 1', 'Organization: Children's Hospital', and 'Event: 2015 Hurricane Gulfstorm-Ultimate Caduceus Exercise'. Below this are links for 'Faq', 'Support', and 'Logout'. The main header area contains a 'Patients' dropdown menu, a selected event '2015 Hurricane Gulfstorm-Ultimate Caduceus Exercise', and a '-- Choose Report --' dropdown. Below the header are buttons for 'Add New Record', 'Progress Note', and 'Bulk Edit'. A table of patient records is displayed, with columns for 'Last Name', 'First Name', 'Gender', and 'PMR Remarks'. Each row includes a checkbox and 'Edit Delete' links. At the bottom, there is a 'note' field, 'User' and 'Entered On' dropdowns, and a 'Submit Note' button. Annotations A, B, C, and D point to the event selection, the main content area, the top right navigation, and the 'Bulk Edit' button, respectively.

	Last Name	First Name	Gender	PMR Remarks	
<input type="checkbox"/>	CHNOLA	TEVIN	Male	50	Edit Delete
<input type="checkbox"/>	CHNOLA	LANIE	Female	20.7	Edit Delete
<input type="checkbox"/>	CHNOLA	JOHN	Male	3.89	Edit Delete
<input type="checkbox"/>	CHNOLA	KAY	Female	55.8	Edit Delete
<input type="checkbox"/>	CHNOLA	JAYYON	Male	3.84 ,Cardiac Monitor	Edit Delete
<input type="checkbox"/>	CHNOLA	CAILYNN	Female	54.1	Edit Delete
<input type="checkbox"/>	CHNOLA	TERROL	Male	45.9	Edit Delete
<input type="checkbox"/>	CHNOLA	SECILY	Female	11.7	Edit Delete
<input type="checkbox"/>	CHNOLA	OWEN	Male	21.8	Edit Delete
<input type="checkbox"/>	CHNOLA	VICTORIA	Female	69.2	Edit Delete
<input type="checkbox"/>	CHNOLA	JUSTIN	Male	14.86	Edit Delete
<input type="checkbox"/>	CHNOLA	SAMARION	Male	4.725 ,ventilator Dependent,Cardiac Monitor	Edit Delete
<input type="checkbox"/>	CHNOLA	MICHAEL	Male	11.7	Edit Delete
<input type="checkbox"/>	CHNOLA	JULIAN	Male	51	Edit Delete
<input type="checkbox"/>	CHNOLA	JAMMIE	Male	1.61	Edit Delete

Action Options

- A. Displays the event name as well as the drop down selection for events. Note: the system is designed to default to the most current event.
- B. Displays the editable screens to input data as well as report views that provide an organized format of information as output.
 - a. Choose Actions
 - b. Download/Upload Templates
 - c. Edit Screens
- C. Options for converting the data on the screen into a preferred format.
- D. Selections for making changes and additions to the initial list of patients and data uploaded or inputted.

USER ACTIONS

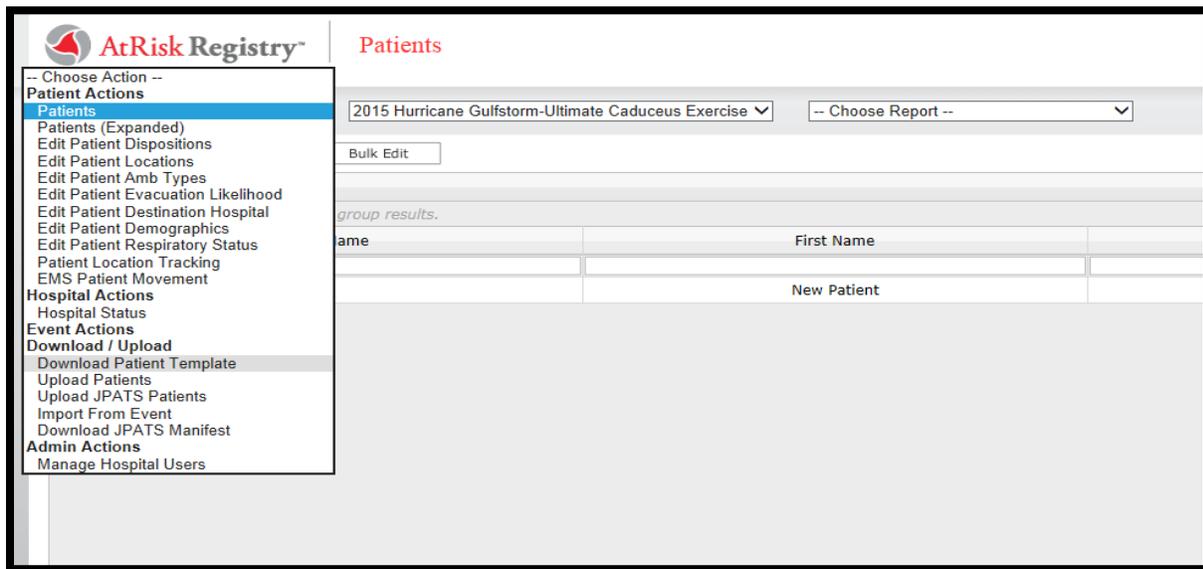
A. Hospital verifies Event

The Hospital should be sure they are inputting data and making updates to information in the most current event. The event name can be displayed in two places on every screen. The center drop-down menu allows hospitals to select the event in case the system does not automatically default to the most current event.



B. Screen selections to input data, edit information, and run reports

a. Hospital Chooses an Action



b. **Download** the Patient Template form, complete the patient information using the current census of patients. Some Hospitals have the capability to extract the necessary information for the template from their electronic medical records database into an excel spreadsheet that they can upload back into the system OR copy and paste into the downloaded template.

Upload the completed Patient Template into the system. **NOTE:** Hospitals should plan to work from this initial list once DRC and State review activities have begun (usually after H-72)

Patient Upload Screen

- “Update Current Patients” - If DRC and State reviews have not begun, hospitals may continue to use their internal medical records system to assist with updating the initial list daily until DRC/State review begins
 - “Replace Current Patients” – use for initial uploads and if discrepancies are observed with the initial template uploaded (i.e. information was partially uploaded or partial patient list exists from manually inserted data – using *Add New Record*)
- c. Use the **“Edit” screens** to update patient information. The bulk of the information a hospital will need to update will pertain to patient evacuation status, evacuation location, and dispositions. Patient clinical data may need to be modified if the condition of the patient is noted by a physician as changed. For example: a patient whose condition has deteriorated and becomes critical will need additional clinical information added into the system if the hospital is evacuating.

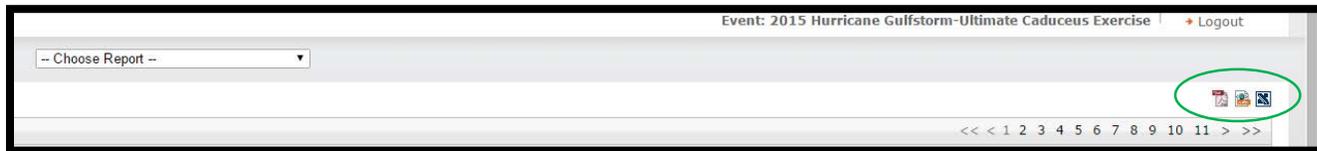
Attachment C provides a list of the columns/field categories included in each screen view. **Note:** Any edits to a field will be changed on each screen in which that field/column exists.

C. Data formatting conversion tools

The hospital can utilize the icons if it needs to transfer the data on screens into an excel spreadsheet.

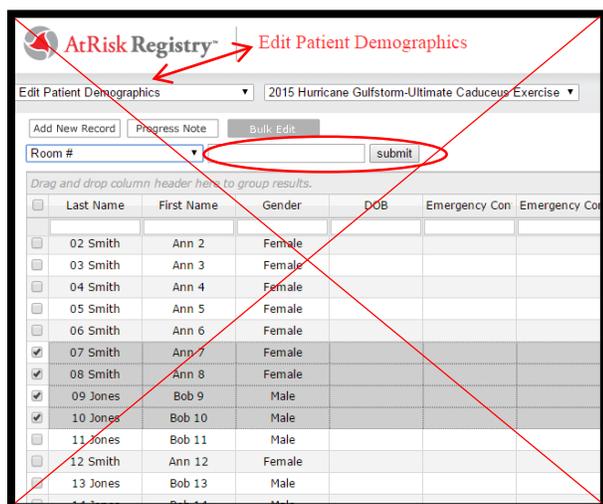
Reasons why these tools are helpful:

- Hard Documentation for after action reporting
- Collecting information from multiple departments/locations/persons simultaneously for transfer into the database at a later time
- Information tracking during a power failure or loss of internet connectivity

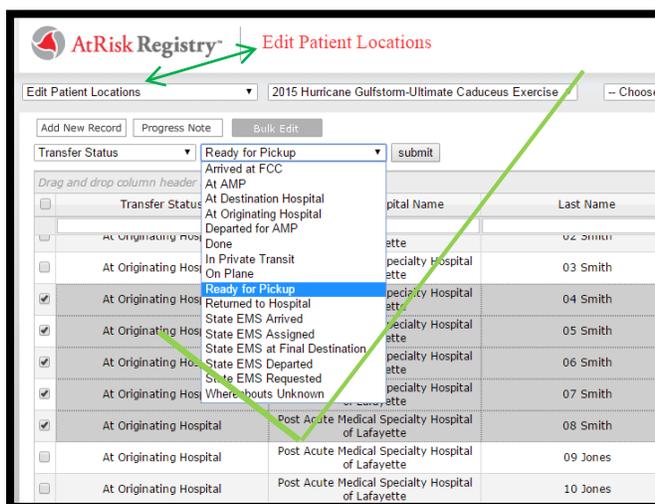


D. Maintaining patient lists

- **“Add New Record”** allows hospital user to add patients individually. Once added, the name will be searchable and will appear on each screen for additional details to be completed.
- **“Progress Note”** allows the hospital to include additional data with one patient. Because some of the open-ended text fields may have character limits, the progress notes feature can allow a hospital more room to add clinical data as well as a feature for internal staff to document patient interactions. **Note:** while the system will allow for multiple patient rows selected, a progress note must be entered for each line selected.
- **“Bulk Edit”** allows the hospital to change information for groups of patients on a single screen. The user will select the individuals to change, will determine the information to bulk edit from that screen, and select submit. **Note:** while the system will allow the user to select a field which has open-ended text, the bulk edit function is best used for the *drop down fields* in which all selected individuals are to receive identical edits. For example, selecting “bulk edit” for editing patient demographics gives the user mostly open-ended text boxes --- ultimately persons will not have identical room #'s and DOBs (Date of birth).



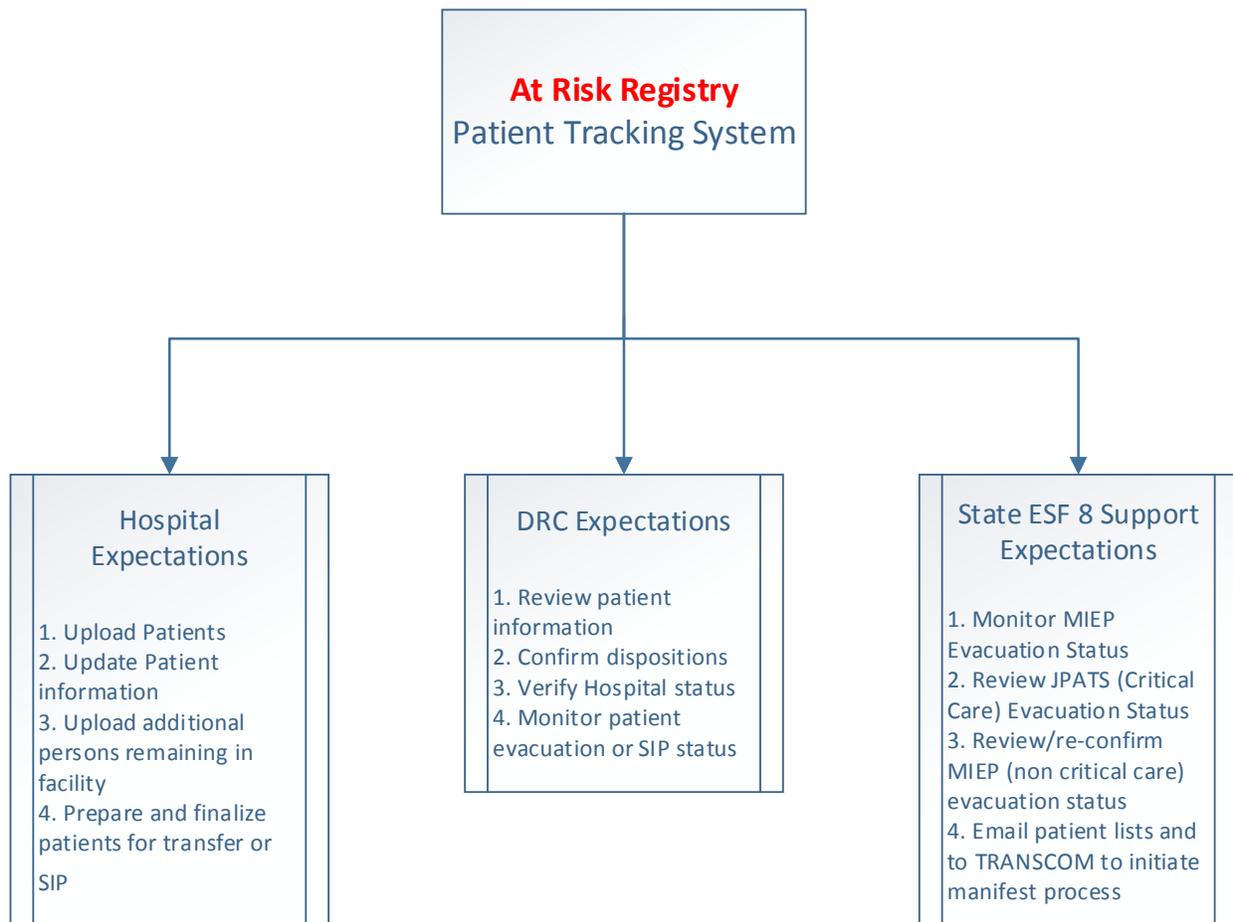
Not ideal use of Bulk Edit function



Ideal use of Bulk Edit function

SUMMARY

The remaining steps associated with the use of the At Risk Registry are highly dependent upon the role of the person using the system and their intentions for patient tracking. Below are the resources available to assist the different users of the program.



REFERENCES

User Guides

The following documents were created to assist hospital, DRC, and state level users with utilizing the At Risk Registry application. These guides are intended to provide an understanding of the processes and expectations of the system and the ESF-8 network role. Each document should be applicable to any region in the state however some regions may choose to conduct further training to imbed their internal methods for information flow into the system.

Hospital Expectations Guide – Walks hospitals through the steps and expectations of inputting patients and maintaining the information for the duration of an event

DRC Expectations Guide – Walks the Designated Regional Coordinator through the steps to guide hospitals, review and verify data in the system prior to movement of patients

State ESF8 Support Expectations Guide – Walks ESF8 Support staff through the steps to review and verify information for quality and completeness prior to sending patient lists for manifestation