

Share and Learn Conference Call

Date: January 12, 2009
 Time: 2:00p.m. to 3:30p.m. EST
 Topic: Performance Measure PM 66d and e
 Interfacility Transfer Guidelines and Agreements
 Facilitator: Theresa Morrison-Quinata, EMSC NRC Outreach Team Leader

Invited Speakers:

Dan Manz, Vermont; Eric Hicken, New Jersey; and Scott Hogan, Washington

Participating Grantees:

Alaska, Raj Maskay	Maryland, Renee (MIEMSS)
Connecticut, Wendy Wheeler	Minnesota, Kristi Berg
Delaware, Marie Renzi	Montana, Bobbi Perkins
Delaware, DuPont Hospital, Diana Hochstuhl	Nebraska, Debbie Kuhn
District of Columbia, Cynthiana Lightfoot	New Hampshire, Janet Houston
Florida, Patricia Kenyon	New Jersey, Eric Hicken
Idaho, Rachael Alter	New York, Martha Gohlke
Illinois, Evelyn Lyons	North Dakota, Kelli Rice
Illinois, Kathy Janies	Ohio, Joe Stack
Iowa, Katrina Altenhofen	Oklahoma, Stacey Morton
Kansas, Sarah House	Pennsylvania, Steve Mrozowski
Kentucky, Tom Taylor	Rhode Island, David Parker
Louisiana, Debbie Huffman	Tennessee, Rhonda Phillippi
Maine, Jan Brinkman	Texas, Beverly Willis
Maryland, Cyndy Wright-Johnson	Vermont, Dan Manz
Maryland, Chuck	Vermont, Peter Otten
	Washington, Scott Hogan

NEDARC Attendees:

Colleen Cummins, Craig Hemingway, Kent Paige, Andrea Genovesi, and Patricia Schmuhl, and Mike Ely

NRC Attendees:

Theresa Morrison-Quinata, Jocelyn Hulbert, Gayathri Jayawardena and Tasmeen Weik

Vermont's Interfacility Transfer Guidelines & Agreements Best Practice

Dan Manz, Vermont EMS Director, shared information regarding their master combined interfacility transfer agreement and guideline.

The Vermont State Hospital Association created the master inter facility patient transfer agreement and guidelines followed by all Vermont hospitals in March 1999. At that time, all hospitals in the State agreed to accepting transferred patients from one another as well as to utilize the guidelines outlined in the master agreement. This agreement was reflected by signatures of all 17 hospital administrators indicating both their support and commitment to the process.

When the Federal EMSC Program announced the EMSC Performance Measures, the Vermont EMSC Program and EMS Director investigated state processes to assure timely and safe inter-facility transfer of patients. The following was learned:

- the master agreement and guideline had not been updated since its development;
- signatories were not necessarily still with many of the hospitals;
- the master agreement and guidelines did not specifically identify pediatric patients;
- and though hospital leaders were not aware that the master agreement and guidelines existed, all were in agreement that the standard procedures as outlined in the master document should be utilized, kept and be updated.

Developing a collaborative partnership with the Hospital Preparedness Program staff proved to be a critical partnership in assuring steps to update the master document with the integration of pediatric considerations. The Health Department had previously identified interfacility transfer to be a vital process during mass casualties and pandemic flu outbreaks.

Other partners who have championed updating this master document include:

- Vermont's State Office of Rural Health
- Vermont Hospital Association

To learn more about Vermont's efforts to update their interfacility transfer guidelines and agreements and progress thus far, contact Dan Manz at dmanz@vdh.state.vt.us.

New Jersey's Interfacility Transfer Guidelines & Agreements Best Practice

Eric Hicken, EMSC Program Manager for the State of New Jersey, shared the State's process for assessing facility preparedness for swiftly transferring pediatric patients to higher levels of care.

The NJ EMSC Program, in partnership with the Burlington County College, is conducting "Emergency Department Evaluations through Simulation" at NJ hospitals. The goal of the simulation project is to evaluate and improve pediatric readiness and responsiveness. The evaluation includes observation of treatment(s) provided by staff as well as transfer processes that would be followed for pediatric patients when appropriate resources are unavailable.

The use of clinical scenarios and the simulation mannequins, allows EMSC Advisory Board members, Burlington County College faculty and state EMSC staff opportunities to:

For more information contact Diana Fendya at dfendya@cnmc.org
www.childrensnational.org/emsc

- observe policies and procedures essential to care of the pediatric patient;
- identify quality improvement opportunities;
- ensure pediatric equipment availability;
- identify potential staff training needs; and
- evaluate pediatric EMS registry documentation processes.

During the planning and implementation of the project, the NJ EMSC Team experienced the following challenges:

- associated costs of simulators and medical personnel to conduct the training (\$100,000 estimate);
- securing an operator for the simulator (simulation mannequins require the expertise of a trained operator) ;
- determining simulation evaluation times that allowed sufficient staff to participate in the evaluation while ensuring ongoing emergency care of patients;
- misunderstanding of hospital staff concerned over possible retaliation if inadequate performance during the simulation; and
- facilities volunteering to participate in the simulation training each month.

Important lessons learned in planning and implementing this project included the following:

- Work closely with key partners to avoid miscommunication and misunderstanding.
- Address concerns immediately and provide assurance and clarity to those who are concerned, especially during the planning phase of the project. (Hospital administrators initially feared associated fines or penalties if the stimulated patient scenarios identified negative actions potentially leading to adverse patient outcomes. NJ EMSC had to befriend administrators, through the NJ Hospital Association, and assure them that only recommendations would come out of the stimulation, no fines nor penalties.)
- Assure permission has been granted by all key agencies/institutions to conduct the simulations; and coordinate the best time to conduct the evaluation with the facilities to allow participation while ensuring patient care is not interrupted.
- Advance planning and coordination is important to assure key personnel are available to operate the simulators and others to record staff responses.

Many positive outcomes resulted from the simulation project including:

- The development of an evaluation tool that accurately assessed current transfer processes and treatments and facilitated improvement conversations with staff.
- Sharing evaluation findings during the debriefing period also encouraged staff to assist in identifying potential gaps in the emergent transfer of the pretend patients.
- With the gaps identified, an opportunity then emerged for evaluators and EMSC leadership to work with staff on strategies to improve the quality of care rendered during transfer.

To learn more about New Jersey's simulation project and how it has helped them to identify their system's strengths and weaknesses to improve the quality of care for children, contact Eric Hicken at.

Eric.Hicken@doh.state.nj.us.

Washington's Interfacility Transfer Guidelines & Agreements Best Practice

Scott Hogan, EMSC Program Manager for the State of Washington, shared his strategies as he worked with key partners in the State to develop pediatric interfacility transfer guidelines.

In 2006, Washington State's EMSC Program conducted a survey to determine the number of hospitals with pediatric interfacility transfer agreements and guidelines. Survey results supported a need to develop state-wide transfer guidelines. Draft Pediatric Interfacility Transfer Guidelines were developed by the EMSC manager with guidance and feedback from the EMSC Advisory Committee, the State Trauma Nurse Coordinators and the EMSC NRC.

The first draft of the Guidelines incorporated key concepts, but did not have all the required guideline components as stipulated in performance measure 66d. All of the components were integrated into a next draft. Each version of the Guidelines were distributed to various groups for review; and then finally presented to the EMSC Advisory Committee for approval.

There were many miscommunications and misunderstandings about the Guidelines during the early stages of their development:

- There was concern that the Guidelines might limit a hospital's ability to treat children, even if they had the means and capability to do so.
- Hospitals were also concerned that procedures that had worked in the past would now need to be changed.

To assure a clear understanding, it became essential for the EMSC manager to participate in numerous statewide meetings and explain the need for the Guidelines. The proposed Guidelines were introduced as a template that individual hospitals could adapt to accommodate specific situations that may already exist. The Washington State EMSC Program does not have the authority to require hospitals to have pediatric transfer guidelines. The template was a tool to assist the hospital in voluntary development of institution-specific pediatric transfer guidelines.

Another strategy utilized to gather support for interfacility transfer agreements and guidelines was to invite several of the State's EMSC Advisory Committee to watch the EMSC NRC webcast on Performance Measures 66 d and e. The webcast provided additional education and enhanced understanding of the performance measures. Prior to the webcast there was resistance from Committee members to the integration of the all of the recommended guideline components. Two weeks post webcast, the EMSC Advisory Committee agreed to advocate for interfacility transfer guidelines and agreements.

Additional support for the initiative also occurred when site reviewers for state trauma center verification also began checking and verifying the existence and use of interfacility transfer guidelines and agreements.

To learn more about Washington's strategies to achieve PM66d, contact Scott Hogan at scott.hogan@doh.wa.gov.

Participant's Questions and Comments

Question 1:

Who were the key individuals in the hospital who helped advocate for the acceptance of the pediatric guidelines in Washington?

Many representatives on the EMSC Advisory Committee and the Governor's Steering Committee agreed with the need to have pediatric interfacility guidelines. They were both supportive and helpful during the development of the guidelines. In addition, the Vice-President of the State Hospital Association, a member of the EMSC Advisory Committee, also provided support for the project..

Question 2:

Has the New Jersey EMSC program thought about publishing their findings and lessons learned from the Simulation Project?

Yes we have. In March, the NJ EMSC Team will be presenting its findings at the Human Patient Simulation Network (HPSN) Conference which will be held in Florida.

Question 3:

Prior to arriving at the facility to conduct the Emergency Department simulation training did you give notice?

Yes, we worked in collaboration with the Emergency Nurses Association and other key partners to assure there was buy-in and support of the project.

Question 4:

Is everyone involved in the NJ Simulation Project evaluated?

Yes, all involved in the process of receiving and transferring the patient are evaluated to improve the hospitals readiness and capabilities.

Question 5:

How long is each scenario?

Each scenario is about 3 hours long and time is also built-in for evaluation (20-30 minutes) and debriefing (30 minutes).

Question 6:

Was there any resistance to revising and updating the master interfacility transfer agreement and guidelines from the hospitals in Vermont? *No, hospital personnel agreed that the standard procedures were developed in 1999 and dated. The Critical Access Hospitals are also in support of the update.*

Comment 1:

I took a look at Washington's guidelines on their website and found them to be extremely helpful. I would therefore recommend sharing the website address with all EMSC program managers.

Marie Renzi, Delaware

Washington State Guidelines may be found at: www.doh.wa.gov/hsqa/emstrauma

The next section of: *Best Practices For EMSC State Partnership Grantees* - PM 66d and 66e may be found at: [Best Practices PM66d and 66e](#)

**Next Share and Learn Conference Call
February 23, 2009 @ 2:00PM eastern
PM 67– Pediatric Education Requirements For Recertification of BLS and ALS Providers**