

# **Hospital Patient Movement Support Guide**

**NC Office of Emergency Medical Services  
Healthcare Preparedness Program**

# Background

- **As defined in the State Emergency Operations Plan, NCOEMS has the responsibility to coordinate “Emergency Mass Patient Movement” during a disaster**
- **Process includes participation from the Statewide Patient Coordination Team – comprised of representatives from the transfer centers at the large health systems**

# Guidelines

- **Patient movement process NOT designed for time sensitive needs**
  - STEMI, Stroke, Trauma, EMTALA
- **Patients must be informed and consent**

# Guidelines

**Criteria that do meet potential statewide patient movement coordination:**

- **Hospital has started a derisking or evacuation process with their primary plan and has run short of resources or is having difficulty placing all their patients.**
- **Potential or real impact to multiple hospitals requiring assistance.**

# Guidelines

**Criteria that do meet potential statewide patient movement coordination:**

- **Emergent situation resulting in need for patients to be moved rapidly with statewide support.**
- **Other needs on a case-by-case basis.**

# Types of Patient Movement

- **Decompression:** the identification and movement of admitted patients that are appropriate for discharge, downgrade, or lateral movement to another unit, to increase capacity to receive incoming patients.
- **De-risking:** the process by which a healthcare facility proactively relocates admitted patients in anticipation of an incident that could trigger an emergent evacuation.
- **Healthcare Facility Evacuation:** the emergent movement of admitted patients to an alternate internal or external location in response to a mass-effect event as a result of patient safety concerns. Allows for option of ED Closure

# General Process

- **Notify**
- **Planning Form**
- **Activation Decision**
- **Patient Placement**
- **Patient Transportation**



# Notification

- Requestor notifies local Emergency Management
  - Local EM to Regional EM to State EM to NCOEMS/ESF-8
- Requestor notifies local Healthcare Coalition
  - HCC to Local EM and NCOEMS/ESF-8

# Planning Forms

- **Basic information about number/anticipated number of patients to guide decision making process**
  - **Name of Facility/County**
  - **Primary Contact Information**
  - **Estimated Number of Patients**
    - **Breakdown of patient type requested for Healthcare Facilities (ICU, Med Surge, Etc.)**
  - **Potential Transportation Needs**
    - **(Specialty Care Transport, ALS/BLS, Wheelchair Van, etc.)**

# Planning Forms



## TEMPLATE - Hospital Patient Movement Planning Form

Instructions: This form should be completed in it's entirety for EACH facility requesting support

### Facility Details

Please provide all facility details below to ensure rapid contact can be made to support placement of patient movement request:

Associated Healthcare Preparedness Coalition

County of Facility

Name of Healthcare Facility (no abbreviations):

Name of Person Making Request

Title of Person Making Request

Primary Phone Number

Alternative Phone Number

Email

Full Name of 24-hour POC (e.g. EOC / Emergency Mgr)

24-hour Phone Number

Alternate Phone Number

Email

# Planning Forms

## Patient Transportation Request Details:

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### GROUND TRANSPORTATION REQUESTS:

**Number of stretcher patients needing ALS transport:**

Provide numerical value to indicate # of patients

**Number of stretcher patients needing BLS transport:**

Provide numerical value to indicate # of patients

**Number of non-ambulatory patients that may need a wheelchair but do not require stretcher**

Provide numerical value to indicate # of patients

### AIR AMBULANCE TRANSPORTATION REQUESTS:

**Number of ADULT patients requiring transportation by Air:**

Provide numerical value to indicate # of patients

**Number of PEDIATRIC patients requiring AIR transportation:**

Provide numerical value to indicate # of patients

**Number of NEONATE patients requiring AIR transportation:**

Provide numerical value to indicate # of patients

# Planning Forms

## Patient Placement Bed Types Needed:

**ADULT:**

Med/Surgical

OB/LND

Psychiatric

Critical: ICU

Critical: CCU

**PEDIATRIC:**

Ped Med/Surgical

PICU

NICU

**OTHER:**

Other, please specify below:

Please specify details for other:



# Planning Form Submission - Error

- After Clicking “Submit”
  - No Confirmation Received/Error – Scroll Up and Look For Red Missing Required Fields, Then Re-Submit

The screenshot shows a form with several fields. The 'Name of Person Making Request' section has 'First' and 'Last' name fields, both with red error icons and the message 'This field is required.' The 'Title of Person Making Request' field is empty. The 'Primary Phone Number' field has a red error icon and the message 'This field is required.' The 'Alternative Phone Number' field is filled with '+1 555-555-5555'. The 'Email' field is empty with a red error icon and the message 'This field is required.'

**Name of Person Making Request**

First ⓘ Last ⓘ

This field is required.

**Title of Person Making Request**

**Primary Phone Number**

+1 555-555-5555 ⓘ

This field is required.

**Alternative Phone Number**

+1 555-555-5555

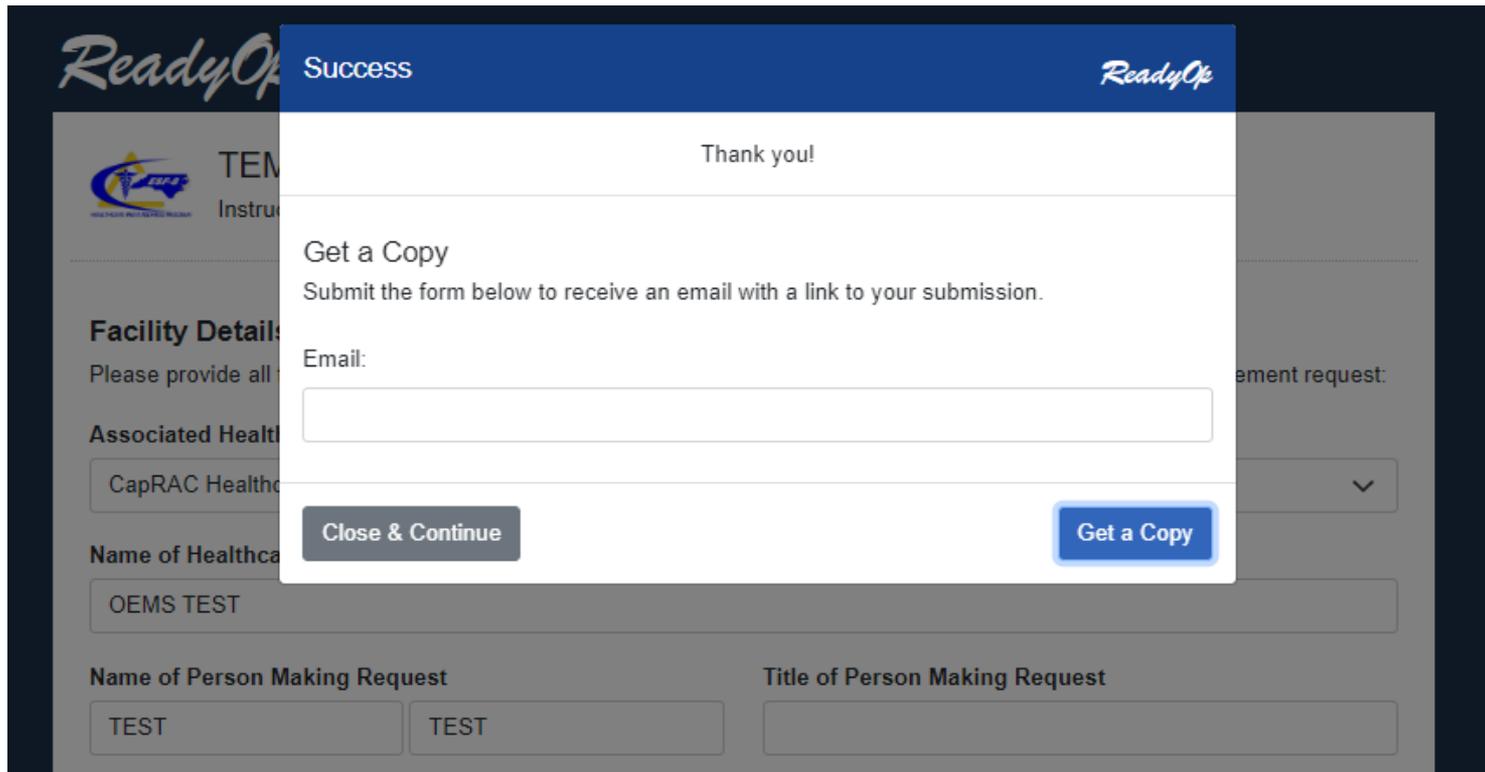
**Email**

ⓘ

This field is required.

# Planning Form Submission - Successful

- After Clicking “Submit”
  - Confirmation Received – Successful Entry



The image shows a screenshot of a web application interface. A modal dialog box is centered on the screen, indicating a successful submission. The dialog has a blue header with the text "Success" and the "ReadyOp" logo. Below the header, it says "Thank you!". The main content of the dialog is titled "Get a Copy" and contains the text "Submit the form below to receive an email with a link to your submission." followed by an "Email:" label and an empty text input field. At the bottom of the dialog, there are two buttons: "Close & Continue" on the left and "Get a Copy" on the right. The background of the page is dimmed and shows a form with the "ReadyOp" logo and the text "TEM Instru". The form has several sections: "Facility Details" with a sub-section "Please provide all", "Associated Health" with a dropdown menu showing "CapRAC Health", "Name of Healthca" with a text input field containing "OEMS TEST", and "Name of Person Making Request" and "Title of Person Making Request" with text input fields containing "TEST".

# Activation Decision

- **SERT/ESF-8 work together to determine appropriate level of activation to meet needs of the situation**
- **Statewide Patient Coordination Team consults to help determine needs for healthcare facility movement**

# Patient Placement

- **Individual Patient Information Submission**
  - Patient Demographics
  - Patient Location
  - COVID Status
  - Specialized Equipment/Needs
  - Transportation Details
- **Bulk Upload Process Available**
  - Excel Template

# Individual Patient Entry

*ReadyOp*



## TEMPLATE - Hospital Individual Patient Transfer Request Form

Provide detailed information on patients needing transfer to/from healthcare facilities

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### **Transferring Facility Information**

This form is NOT meant for critical time sensitive needs (STEMI, Stroke, Trauma, EMTALA etc.) please follow normal processes for time sensitive patients.

Please provide as much information as possible about the patient. This information will help the Patient Coordination Team ensure proper placement.

After submission of this form please enter your email to receive the link to this form. This link will allow you to view your entry, see the assigned Patient ID number after our team processes the form, and monitor for any updates.

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# Individual Patient Entry

**FOR INTERNAL USE ONLY! TO BE COMPLETED BY NC DHHS STAFF**

DO NOT ENTER ANYTHING IN THIS SECTION!!

PROCEED TO THE NEXT SECTION TO ENTER FACILITY INFORMATION

**DHHS Patient ID Number (DO NOT ENTER ANYTHING HERE!)**

**Patient Placement Status**

- Received by NCOEMS Staff
- Waitlisted
- Consult Pending
- Resolved by Consult
- Removed from List (Reason in Notes Below)
- Accepted (Placed at a Facility)

**Date Patient Placement**



**Time Pt Placed**

hrs



**Name of Accepting/Consulting Facility**

**If "Other" Selected, Please Enter Name Here:**

# Individual Patient Entry

## TRANSFERRING FACILITY INFORMATION

Name of Facility

If Other, Please Enter Facility Name Here:

County

First Name of Person Completing Form:

Last Name of Person Completing Form:

Title of Person Completing Form:

Phone Number XXX-XXX-XXXX:

Email

# Individual Patient Entry

## PATIENT INFORMATION

First Name of Patient:

Last Name of Patient:

Patient's Date of Birth  
(MM/DD/YYYY)



Patient Weight (kgs):

Unit / Floor Name:

Room Number:

Unit Phone # XXX-XXX-XXXX:

Primary Diagnosis:

COVID Status:

# Individual Patient Entry

## Specialty Patient Type:

Behavioral Health:

Dialysis:

ECMO:

ICU:

Infection Control Precautions:

OB Patient:

  
Yes  
No

Pediatric:

Trauma Patient:

Please list any "other" specialty patient type:

All Yes/No Questions

# Individual Patient Entry

## Specialty Patient Equipment:

Arterial BP:

Balloon Pump:

Central Line:

Chest Tube(s):

Drain(s):

IV Access:

IV Drip(s):

Neuro Monitor:

Oxygen Dependency:

Pacer:

PICC:

Swan Cath:

Traction:

Umbilical Line:

Ventilator:

Ventricular Assist Device:

Please list any "other" specialty equipment:

All Yes/No Questions

# Individual Patient Entry

Describe the overall situation for the patient, including a brief background, pertinent labs/test results, and any other information that might be useful to assist with trying to find placement for the patient.

Use this space to enter a brief narrative explaining the patient, the background, and any pertinent information that might help find proper placement for the patient.

Medication List

Choose File No file chosen

Additional Attachment

Choose File No file chosen

---

# Individual Patient Entry

## TRANSPORTATION DETAILS

Healthcare facilities should make every effort to provide transportation to and from the receiving facility. State transportation assets are extremely limited, which could result in a significantly delayed evacuation.

Do you need transportation for this patient?

Yes

No

Type of Transport Needed

If "Other" selected above, please describe below:

Additional Notes/Concerns for Transportation:

# Individual Patient Entry

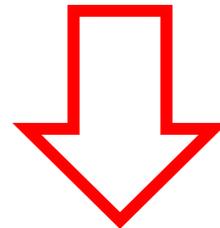
## END OF REQUEST FORM, SCROLL DOWN AND CLICK "SUBMIT" BELOW

If you hit submit and nothing happens, please scroll back up and look for any fields highlighted in red that are required. It should say "This field cannot be left blank", then try to submit again. Successful submission will take you to a page that confirms your submission and offers a link for your records.

Do NOT enter below this line - for OEMS staff only

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Scroll Down To Bottom of  
Page



Click Submit Button

Submit

# Individual Patient Entry – Internal Use

Do NOT enter below this line - for OEMS staff only

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INTERNAL USE ONLY! PLEASE DO NOT CLICK BELOW

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## Transportation Status

Transportation Method:

- Sending Facility
  - Receiving Facility
  - State Coordinated Transport Needed
-

# Individual Patient Entry – Internal Use

## State Coordinated Transportation Tracking Information

Transport Needed

Pending Transport (identified asset for transport)

Agency and Asset Number of Resource Transporting Patient

Transport Resources RO Form Number

Time



Date



Transferring (patients are en route to new placement)

Time



Date



Received (patients have completed entire process)

Time

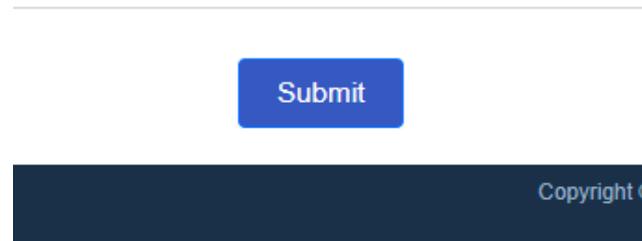


Date



Transport/Tracking Notes:

# Individual Patient Entry



- **Should receive confirmation message upon successful completion and submission, same as with planning form.**
- **If no confirmation pops up, scroll back up and look for highlighted red required fields, then re-submit.**

# Form Submission - Error

- No Confirmation/Error – Scroll Up and Look For Red Missing Required Fields, Then Re-Submit

## PATIENT INFORMATION

First Name of Patient:

Patient First Name



This field is required.

Last Name of Patient:

Patient Last Name



This field is required.

Patient's Date of Birth  
(MM/DD/YYYY)



This field is required.

Patient Weight (kgs):



This field is required.

Unit / Floor Name:



This field is required.

# Form Submission – Successful

**ReadyOp** Success **ReadyOp**

Your submission has been received. Please enter your email below to receive a link to view your entry, see the assigned Patient ID number for this submission, and monitor for any new updates.

If you have any questions, please feel free to reach out to us at [OEMSPatientMovement@dhhs.nc.gov](mailto:OEMSPatientMovement@dhhs.nc.gov)

Stay safe!

**Get a Copy**  
Submit the form below to receive an email with a link to your submission.

Email:

**Close & Continue** **Get a Copy**

Background text on the left: **Transferring F**  
This form is NOT n  
for time sensitive p  
After submission o  
see the assigned F  
DHHS Patient ID I  
Internal DHHS P  
**TRANSFERRI**  
Name of Facility

Background text on the right: mal processes  
w your entry,

# “Get a copy” Email

[External] Your recent submission



13 - Emergency Operations Plans <notifications@nc.readyop.com>

To Ezzell, David

Reply

If there are problems with how this message is displayed, click here to view it in a web browser.

**CAUTION:** External email. Do not click links or open attachments unless you verify. Send all suspicious email as an attachment to [Report Spam](#).

Thank you for your recent submission, a copy of your submitted record can be found at the following link: <https://nc.readyop.com/fe/QEigdD0>

You're receiving this e-mail because you requested to receive a copy of your submitted data. If you did not perform this request, please disregard this e-mail.

# Copy of Entry via Email Link

*ReadyOp*

 **TEMPLATE - Hospital Individual Patient Transfer Request Form**  
Provide detailed information on patients needing transfer to/from healthcare facilities

---

**Transferring Facility Information**

This form is NOT meant for critical time sensitive needs (STEMI, Stroke, Trauma, EMTALA etc.) please follow normal processes for time sensitive patients.

Please provide as much information as possible about the patient. This information will help the Patient Coordination Team ensure proper placement.

After submission of this form please enter your email to receive the link to this form. This link will allow you to view your entry, see the assigned Patient ID number after our team processes the form, and monitor for any updates.

---

**FOR INTERNAL USE ONLY! TO BE COMPLETED BY NC DHHS STAFF**

DO NOT ENTER ANYTHING IN THIS SECTION!!  
PROCEED TO THE NEXT SECTION TO ENTER FACILITY INFORMATION

DHHS Patient ID Number (DO NOT ENTER ANYTHING HERE!)

**Patient Placement Status**

- Received by NCOEMS Staff
- Waitlisted
- Consult Pending
- Resolved by Consult
- Removed from List (Reason in Notes Below)
- Accepted (Placed at a Facility)

Date Patient Placement      Time Pt Placed      Name of Accepting/Consulting Facility

      hrs

# Copy of Entry via Email Link

**FOR INTERNAL USE ONLY! TO BE COMPLETED BY NC DHHS STAFF**

DO NOT ENTER ANYTHING IN THIS SECTION!!  
PROCEED TO THE NEXT SECTION TO ENTER FACILITY INFORMATION

DHHS Patient ID Number (DO NOT ENTER ANYTHING HERE!)

Patient Placement Status

Received by NCOEMS Staff

Waitlisted

Consult Pending

Resolved by Consult

Removed from List (Reason in Notes Below)

Accepted (Placed at a Facility)

Date Patient Placement  Time Pt Placed  hrs Name of Accepting/Consulting Facility

Once reviewed by NCOEMS we will assign a Patient ID number. This number will be referenced to avoid HIPAA concerns.

# Patient Placement Status

The status will be updated as patients work their way through the system.

## Placement Status

### Patient Placement Status

 Received by NCOEMS Staff Waitlisted Consult Pending Resolved by Consult Removed from List (Reason in Notes Below) Accepted (Placed at a Facility)

Date Patient Placement

Time Pt Placed

hrs

Name of Accepting Facility

# Patient Placement Status

## Placement Status

### Patient Placement Status

- Received by NCOEMS Staff
- Waitlisted
- Consult Pending
- Resolved by Consult
- Removed from List (Reason in Notes Below)
- Accepted (Placed at a Facility)

Date Patient Placement

Time Pt Placed

Name of Accepting Facility

# Patient Placement Status

## Placement Status

### Patient Placement Status

- Received by NCOEMS Staff
- Waitlisted
- Consult Pending
- Resolved by Consult
- Removed from List (Reason in Notes Below)
- Accepted (Placed at a Facility)

Date Patient Placement

09/08/2022

Time Pt Placed

1738

hrs

Name of Accepting Facility

Duke University Hospital

# Patient Placement Status

- **Received by NCOEMS**
  - Entry has been reviewed by NCOEMS Staff and sent to Transfer Centers
- **Waitlisted**
  - Under review by Transfer Centers and holding until placement is available
- **Consult Pending**
  - Transfer Center agrees to reach out to find out more about the patient and potential accept or find alternative option

# Patient Placement Status

- **Resolved by Consult**
  - Transfer center was able to resolve by consult, no physical transfer necessary
- **Removed From List**
  - Patient expired, improved, transferred outside this process, or no longer needs/wants/qualifies for transfer
- **Accepted (Placed at a facility)**
  - A bed has been secured via transfer center

# Bulk Patient Upload

- **Same information as the Individual Placement Form, but in an Excel template that can be filled out**
- **Excel template is uploaded into ReadyOp for secure bulk transmission of sensitive information**
- **Requires precise formatting so that NCOEMS Staff can import form into the ReadyOp System**
- **Could be automated export by EMR Vendor**

# Bulk Patient Upload

AutoSave  Hospital Patient Movement Bulk Upload Template • Saved

File Home Insert Draw Page Layout Formulas Data Review View Help ACROBAT

Clipboard: Paste, Cut, Copy, Format Painter  
Font: Calibri, 12, Bold, Italic, Underline, Paragraph, Font Color  
Alignment: Text, Center, Right, Justify, Merge & Center  
Number: General, Currency, Percentage, Decimals  
Conditional Formatting, Table Tools

	A	B	C	D	
1	Name of Facility	If Other, Please Enter Facility Name Here:	County	First Name of Person Completing Form:	La
2					
3					
4					

# Bulk Patient Upload

- **Yellow Header:** Required field with required format
- **Blue Header:** Optional field with required format
- **Note:** Some fields have required format. Excel contains drop down menu to help select appropriate answer/format.

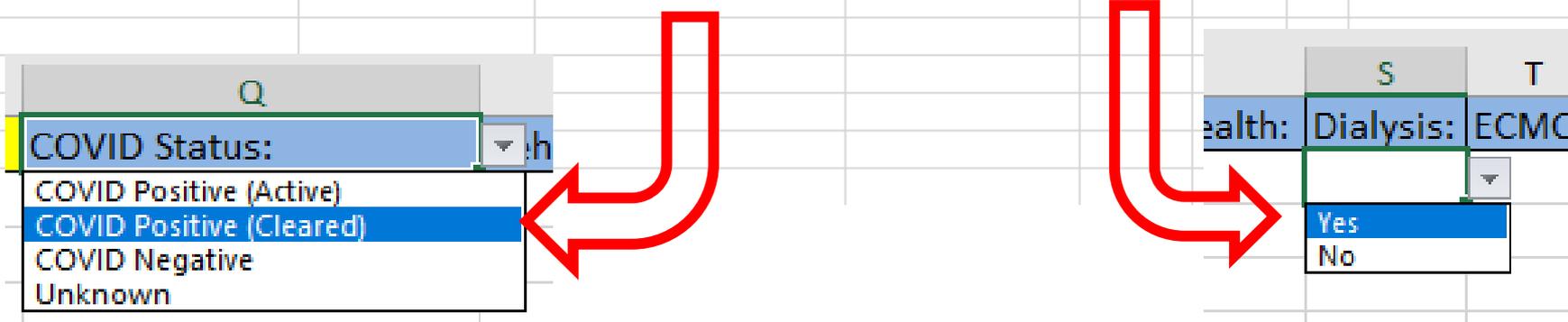
O	P	Q	R	S	T	U	V
Unit Phone # XXX-XXX-XXXX:	Primary Diagnosis:	COVID Status:	Behavioral Health:	Dialysis:	ECMO:	ICU:	Infection Control Pre

Q
COVID Status:
COVID Positive (Active)
COVID Positive (Cleared)
COVID Negative
Unknown

S	T
Dialysis:	ECMO:
Yes	No



# Bulk Patient Upload

ReadyOp



## TEMPLATE - Hospital Bulk Patient Movement Form

This form is for bulk upload of patients that need to be transported and have not been uploaded individually on the Single Patient Movement Form. Please use the Excel template that was shared upon activation and do not change any of the columns, as this will delay processing. This submission is secure and allows for HIPAA Compliance.

Questions regarding this form should be sent to [OEMSPatientMovement@dhhs.nc.gov](mailto:OEMSPatientMovement@dhhs.nc.gov)

County Name:

Associated Healthcare Preparedness Coalition

Name of Facility:

If "Other", Please Enter Name Here

Name of Person Making Request

Title of Person Making Request

Primary Phone Number

Alternate Phone Number

Email

Full Name of 24-hour POC (e.g. EOC / Emergency Mgr)

24-hour Phone Number

Please Attach Bulk Excel Upload Here

Choose File

No file chosen

# Patient Transportation

- **Responsibility for transportation lies with the sending facility**
- **Receiving facility may be able to provide transportation if sending facility is unable**
- **Options include: Contract entities, Specialty Care Transport Companies, Local/Regional Resources**
- **State Coordinated Transportation EXTREMELY LIMITED, could lead to delays**

# Questions?

- **Contacts**

- Kimberly Clement, HPP Program Manager

- [kimberly.clement@dhhs.nc.gov](mailto:kimberly.clement@dhhs.nc.gov)

- David Ezzell, Operations Manager

- [david.ezzell@dhhs.nc.gov](mailto:david.ezzell@dhhs.nc.gov)