Jackson Hole Fire/EMS Operations Manual

Approved by:	Will Smith, Medical Director	Title:	**Interfacility/Home Transfers**
		Division:	17
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PURPOSE

To define provider skill levels for Interfacility Transfers (IFT) and to assure that patients requiring a medical transfer are accompanied by personnel capable and authorized to provide the appropriate level of care. This document shall also provide guidelines to ensure that transfers are executed in a safe and timely manner based on patient needs and crew safety.

SECTION I – DEFINITIONS

Definition: Any transfer, after initial assessment and stabilization, from and to a healthcare facility or other location.

Examples include:

1. Hospital to hospital
2. Hospital to specialty care facility
3. Hospital to rehabilitation facility
4. Hospital to long-term care facility
5. Hospital to airport for air medical transfer
6. Hospital to home
7. Rehabilitation/Transitional care facility to home

Requests for ambulance service from all other facilities, e.g., physician's offices, urgent care centers, clinics, nursing homes, assisted living centers or other facilities not equipped or licensed to provide acute inpatient care are considered either "emergency" or "routine transport" calls rather than IFT. The emergency (911) or non-emergency dispatch system should be activated by these other (non-acute care) facilities for patients requiring emergency transport and care.

SECTION II – RESPONSIBILITY FOR PATIENT CARE

The overriding principle for all aspects of IFT is matching patient needs with adequate provider knowledge and skills, equipment and an infrastructure that provides seamless patient flow during transport. Any judgment should err on the side of caution in providing care at the level likely to be needed or potentially needed during IFT.

Transferring physician's responsibilities:

- The transferring physician shall be responsible for determining the medical need for transfer and for ordering the transfer.
- The patient shall not be transferred to another facility until the receiving hospital or other location consent to accept the patient.
- The transferring physician retains responsibility for the patient until care is successfully transferred to the receiving hospital.

SECTION III – LEVELS OF PATIENT ACUITY AND STAFFING

In order to provide safe and effective care, provider capabilities must match the patient's current and potential needs. In coordination with the transferring facility and physician, the Shift Officer and Duty Officer will determine staffing levels based on information received at the time of request. The Jackson Hole Fire/EMS Medical Director or designee may be consulted as needed to help facilitate the appropriate provider skill level and/or equipment for the IFT. If a patient acutely deteriorates and the transferring EMS crew requires additional resources, they will activate the appropriate EMS system in the area they may be traveling. This may include ground and/or air resources, if available. Contact with online medical control may also provide additional benefit with ongoing medical care during the transfer.

Levels of Patient Acuity and Scope of Practice Matrix
(NHTSA Guide for Interfacility Patient Transfer, April 2006)

Stable with no anticipated risk for deterioration - EMT

- Requiring only observation, oxygen, monitoring of vital signs, saline lock, and basic emergency medical care.

Stable with low risk of deterioration – EMT-Intermediate

- Continuous IV fluids, some IV medications including pain medications and anti-emetics, increased need for assessment and interpretation skills (advanced care).

Stable with medium to high risk of deterioration or Unstable - Paramedic

- EKG monitoring, limited cardiac medications, (e.g.- amiodarone, heparin or nitroglycerine).
- Patients requiring advanced airway management, (e.g.- intubated, on ventilator), patients on multiple vasoactive medication drips.
- Patients whose condition has been initially stabilized, but has likelihood of deterioration.
- Any patient who cannot be stabilized at the transferring facility, who is deteriorating or likely to deteriorate, such as patients who are post-resuscitation, or have sustained multiple trauma.

Requiring a level of service beyond the scope of the Paramedic- Specialty Care Transport

- Patient's condition requires ongoing care that must be furnished by health professionals in an appropriate specialty area, for example, emergency or critical care nursing, respiratory care, cardiovascular care, or a paramedic with additional training.
- A physician, RN or other appropriate health care provider will be accompanied by an EMT-Intermediate or Paramedic.
- If a registered nurse accompanies the patient, appropriate orders for care during the transfer shall be given by the transferring physician.

SECTION IV- REGIONAL INTERFACILITY TRANSFERS (<150 miles one-way, e.g. Idaho Falls, ID – Eastern Idaho Regional Medical Center)

1. Transfers of an acute nature may be requested at any time with short notice.
2. Non-urgent transfer requests should be scheduled with adequate notice in order to ensure that staffing for primary 911 response is maintained.
3. Prior to a transfer, the crew will review road conditions for travel advisories or road construction. Alternate routes may need to be considered. If conditions are deemed unsafe, the transfer may be delayed until travel conditions improve. These decisions will be determined and coordinated with the Transfer crew, Shift Captain and Duty Officer.
4. Crews will obtain a department credit card for refueling ambulance and meals as needed. Credit card can be obtained from Administration or Duty Officer and returned on completion of the transfer or the following day.
5. Crews may charge meals on the department credit card based on the U.S. General Services Administration travel reimbursement rates as posted at www.gsa.gov/perdiem.
6. All charges need itemized receipts which must be submitted to Administration on return.
7. Crews should minimize dining to <30 minutes whenever possible to ensure a timely return to service area.

SECTION V- LONG DISTANCE INTERFACILITY TRANSFERS (>150 miles one-way, e.g. Salt Lake City, UT Facilities, Casper, WY Facilities)

1. Requests must be received no later than 11:00 am on the day of the transfer.
2. Transportation must be initiated by 12:00 pm, except in rare cases requiring an emergent long-distance transfer.
3. Prior to a transfer, the crew will review road conditions for travel advisories or road construction. Alternate routes may need to be considered. If conditions are deemed unsafe, the transfer may be delayed until travel conditions improve. These decisions will be determined and coordinated with the Transfer crew, Shift Officer and Duty Officer.
4. Crews will obtain a department credit card for refueling ambulance, meals and lodging as needed. Credit card can be obtained from Administration or Duty Officer and returned on completion of the transfer or the following day.
5. For unscheduled late night transfers, the crew may opt to stay at a hotel for rest as deemed necessary for safe return travel.
6. Crews may charge meals and lodging on the department credit card based on the U.S. General Services Administration travel reimbursement rates as posted at www.gsa.gov/perdiem.
7. All charges need itemized receipts which must be submitted to Administration on return.
8. Crews should minimize dining to <30 minutes whenever possible to ensure a timely return to service area.
9. Crews should consider sharing driving time on the return trip to limit tired driving.

SECTION VI- CREW RESPONSIBILITIES

1. Ensure that all appropriate paperwork and personal items accompany the patient to the receiving facility.
2. Obtain a complete Medical Necessity form (Physician Certification Statement) and Demographics sheet from the transferring facility.
3. Provide the receiving facility with a thorough patient report upon arrival.

4. Rehabilitate the ambulance prior to placing it back in service; including fueling, cleaning, and resupplying as needed.
5. Complete a Patient Care Report upon returning to home base.

SECTION VII- LOGISTICAL CONSIDERATIONS

1. Are multiple ambulances out of service or engaged in calls for service?
2. Will the transfer(s) significantly deplete emergency resources? If so, are there other appropriate IFT options (air ambulance, other ground agencies)?
3. Is the transfer crew adequately rested?
4. What is the appropriate medic unit based on the distance, weather, and equipment requirements?