

---

**INTERFACILITY TRANSFER GUIDELINES (# 5600)**

---

1. **AUTHORITY** - All interfacility patient transfers (including those to a trauma center) are to be performed according to the patient transfer provisions contained in the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Emergency Medical Treatment and Labor Act (EMTALA) of 1986, the Omnibus Budget Reconciliation Acts (OBRA) amended in 1987 and 1989, California Code of Regulations Title 22, and JCAHO.

2. **POLICY STATEMENT:**

The purpose of this policy is to define the appropriate use of EMS personnel utilized during an interfacility transfer and information on how to arrange for transport vehicles. It is not intended to be a substitute for internal hospital policies specific to COBRA/OBRA regulations.

This policy addresses the appropriate transfer of a patient by ambulance with an emergency medical condition, who has been stabilized by the transferring facility, accepted by the receiving facility and transported with appropriately qualified personnel. Prior to initiating any transfer, the transferring physician has the responsibility to perform a medical screening exam to determine if the patient has an emergency medical condition, stabilize (if possible) and prepare the patient for the transfer.

3. **DEFINITIONS:**

- 3.1 **Transfer** - the movement of a patient outside a hospital's facilities at the direction of any person employed by or affiliated with a hospital. This includes transfers to another facility for diagnostic tests. A transfer does not include the movement of a patient who has been declared dead or leaves the facility against medical advice (AMA) or without the knowledge of the facility (elopement).
- 3.2 **Emergency Medical Condition** - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in, 1) placing the health of the individual (or in a pregnant woman, the health of her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or, 3) serious dysfunction of any bodily organ or part.
- 3.3 **To Stabilize** - to provide medical treatment of the condition as may be necessary to assure, within reasonable probability, that no material deterioration of the condition is likely to result from or during the transfer. With respect to the pregnant woman having contractions, to stabilize includes delivery of the infant and placenta.

**If the patient has not been stabilized, the patient may not be transferred unless:**

- The patient (or legal representative), who is capable of making rational decisions regarding their medical care and after being informed of the risks, requests in writing, transfer to another facility; or,
- The transferring physician signs a certificate that based upon the information available at the time that the medical benefits provided at another facility outweigh the increased risk of the transfer. The receiving hospital physician must approve the transfer, and the patient must agree to the transfer.

---

**INTERFACILITY TRANSFER GUIDELINES (# 5600)**

---

- 3.4 **Appropriate transfer** - A transfer where the transferring physician has:
- 3.4.1 provided a medical screening examination and medical treatment within its capacity that minimizes the risks to the patient's health;
  - 3.4.2 confirmed that the receiving facility has an accepting physician, available space and qualified personnel to treat the patient. There should be physician-to-physician communication between the sending and receiving physicians to confirm the acceptance of the patient;
  - 3.4.3 made available all medical records to the receiving facility regarding the diagnosis and care of the patient;
  - 3.4.4 arranged for qualified personnel to accompany the patient in an appropriate transport vehicle (BLS/ALS/CCT/helicopter) with essential equipment and medications required for the transfer.
  - 3.4.5 determined that the patient has no emergency medical condition or a stabilized emergency medical condition. *The receiving hospital still must consent to the transfer.*
- 3.5 **Inappropriate transfer** - a "lateral" transfer of an unstabilized patient between essentially comparable facilities (those with equal capabilities where the benefits of the transfer do not outweigh the risks) or those based solely on financial considerations are not an appropriate reason for transfer. Exceptions: Mechanical failure of essential testing equipment, lack of intensive care bed space or at the request of the patient.
- 3.6 **Qualified personnel**
- 3.6.1 The transferring physician is responsible for:
    - Determining the level of personnel necessary to accompany the patient;
    - Maintaining the continuity of care initiated at the transferring facility.
  - 3.6.2 The healthcare practitioner attending the patient must be able to recognize and treat any changes in the patient's condition, taking into consideration the patient's current medical condition and all reasonably foreseeable complications that may occur during transfer.
  - 3.6.3 The decision regarding the level of transport personnel required (ALS vs. BLS) should be made by the transferring physician, based on the level of care required, scope of practice, equipment needs and the ETA vs. the urgency of the transport. A minimum of one paramedic must accompany the patient for the transfer to be considered an ALS transport.
  - 3.6.4 An **EMT-I** may only transfer a patient:
    - without an emergency medical condition; or,
    - with an emergency medical condition that has been stabilized and has no potential (within reasonable probability) to deteriorate enroute.

---

**INTERFACILITY TRANSFER GUIDELINES (# 5600)**

---

- 3.6.5 A **paramedic** may only transport a patient who has not been stabilized to a facility that provides a **higher level of care**.

*The transferring physician must determine if the care that may be required during transport is within the scope of practice of a paramedic. If not, appropriate hospital staff and/or equipment should be sent with the patient. A "Physicians Certificate"\*\*\* must be completed documenting that the benefits of the transfer outweigh the risks. (\*\*example may be found in the California Health Care Association consent manual)*

### 3.7 Medical control

- 3.7.1 All patient care rendered by prehospital care personnel must be within the defined scope of practice according to Title 22, and Alameda County EMS protocols.

- 3.7.2 A paramedic may only take orders from a base hospital physician. There are no provisions for an EMT to take orders from a physician.

#### 3.7.3 Base Contact by paramedics (excluding CCT-P)

- **Base Contact is required prior to transport** if the transferring physician has ordered any ALS treatment and/or the patient has not been stabilized.
- *Paramedics may follow transferring physician's written orders ONLY when: 1) the transferring physician speaks to the base physician, and they mutually agree on the course of treatment; 2) the proposed treatment plan is within the paramedic's scope of practice.*
- When there is a request to transfer a patient to a higher level of care facility that is not the "closest" higher level of care facility, base contact shall be made. If the facility requesting the transfer is a base hospital the paramedics shall contact an alternate base hospital.
- If the patient being transferred is a **trauma patient** then **Highland Trauma Base** shall be contacted.
- **Base contact is not required** if the patient is stable and no ALS treatment has been ordered by the transferring physician. If the patient's condition changes during transport, Base Contact should be made for orders if required in policy.
- Base Contact may be made anytime a paramedic has a question regarding patient condition, destination and/or the appropriateness of the transfer.

## 4. INITIATING A TRANSFER

### 4.1 Trauma Center transfers

- 4.1.1 Call the hospital operator and ask to speak to:
- Highland: Senior Trauma Chief Resident/Trauma Surgeon on call
  - Eden: Trauma Surgeon on duty
  - Children's: Call PICU (800 ICU KIDS) and ask to speak to intensivist on duty

---

**INTERFACILITY TRANSFER GUIDELINES (# 5600)**

---

- 4.1.2 All transfers to Trauma Centers will be designated **Code 3**.
- 4.1.3 Trauma Centers with patients who are members of PPOs or HMOs must call the appropriate plan hospital to advise them of the patients' status at Trauma Center upon admission.
- 4.2 **Arranging ambulance transport** (excluding CCT-P transfers. See specific hospital agreement for arranging transport by CCT-P)
  - 4.2.1 **Non-emergent transfers** - Each hospital should initiate, in advance, transfer agreements with an ambulance company able to provide the appropriate level of staffing and equipment required.
  - 4.2.2 **Emergent transfers** - the transferring hospital should contact **ALCO-CMED** for response of a code 3 ambulance. If the patient is not in the Emergency Department, specific information regarding the location of the patient should be provided.