NOR-CAL EMS	4104	Interfacility Transfer
Nor-Cal EMS Policy & Procedure Manual		Hospitals
Effective Date: 01/01/2025		Next Revision: 01/01/2028
Approval: Jeffrey Kepple MD – MEDICAL DIRECTOR		SIGNATURE ON FILE

Authority

California Code of Regulations, Title 22, Sections 100063, 1000145, 1000147, 1000172, 1000175, and 1000266. California Health and Safety Code, Division 2.5, Sections 1797.204, 1997.206, 1797.222, 1798.170, and 1797.172.

Purpose

1. To clarify and define the scope of practice for various EMS providers performing IFTs (Interfacility Transfers) by ambulances.
2. Establish procedures to arrange, facilitate, and track interfacility transfers.
3. Further to establish a process for the Base Hospital to help balance the responsibility of maintaining the 911 system (public safety) with getting patients to definitive care.
4. This policy is directed at the local EMS systems where the 911 Ambulances respond to both public safety responses (911 Requests) and IFTs from the local hospital(s).
5. This policy does not apply to ambulance services that strictly perform IFTs.
6. Identify appropriate level of care and method of transport within the Nor-Cal EMS Region.

Policy

1. Hospitals shall comply with all applicable Federal, State, and Local laws, regulations, and policies governing the access, treatment, and transfer of patients.
2. Hospitals shall develop written policies governing transfers ensuring compliance with all applicable laws, regulations, and policies.
3. Hospitals shall develop written transfer agreements with facilities offering resources, specialty services not available internally.
4. No transfer will take place without the transferring physician ensuring that:
   A. The patient received an appropriate medical screening examination and medical treatment within the transferring facility's capacity that minimizes the risks to the patient's health.
   B. There is an accepting physician.
   C. The accepting facility has the capacity to care for the patient and has consented to accept the patient.
   D. All available medical records regarding the patient's diagnosis and care have been made available to the accepting facility.
   E. The patient has no emergency medical condition or has been stabilized to the facility's ability.
   F. There will be attendance by appropriately licensed or certified personnel with the essential equipment and medications needed to ensure appropriate treatment during transport. This may require specialty teams to be utilized such as neonatal transport.
   G. When determining the necessary qualifications, consideration must be given to the length of time the patient is expected to be in the care of the transporting personnel, the patient's condition at the time of transfer, and the likelihood of the patient's condition deteriorating during the transfer.
5. The transferring physician remains responsible for the patient until such time as the patient arrives at and is accepted by the intended receiving facility and the receiving physician.
6. The providers transporting the patient shall consult with the physician before leaving the facility.

Procedure

7. The sending hospital, under the direction of the transferring physician shall arrange for appropriate transfer and method of transportation. This will occur in coordination with the transport agency and dispatch.
8. Transfer of care includes a verbal report to the transport personnel and provide all documentation needed to continue care of the patient at the receiving facility.
   A. Transfer of care includes a verbal report to the transporting personnel from the transferring physician or nurse caring for the patient at the time of transport.

SCOPE OF PRACTICE FOR VARIOUS PREHOSPITAL PROVIDERS FOR IFTs

EMT (Basic Life Support)

1. Oxygen by mask or nasal cannula.
2. Monitor Pulse Oximetry.
3. Monitor Foley catheters.

4. Monitor Intravenous catheters at set rates, for specifics see spreadsheet.
5. Use suction.
6. Monitor and Adjust CPAP.
7. Monitor nasogastric tubes.
8. Monitor gastric tubes.
9. Patient controlled device that requires no intervention from the transporting personnel.
10. Cannot monitor arterial lines.
11. Can monitor central venous lines that are capped.
12. D10 as a substitute for TPN.
13. Peripheral IV, or saline/heparin lock without additives.

Paramedic (Advanced Life Support)

1. Monitor and adjust heparin infusions of 100 units/ ml concentration, the maximum infusion may not exceed 1600 units/hour.
2. Monitor and adjust nitroglycerin infusions. Can adjust upwards to a maximum rate of 50mcg/minute. The rate of increase may not exceed 5 mcg/minute every 5 to 10 minutes.
3. Peripheral IV with any drug listed in paramedic scope of practice being administered to a stable patient, infused with and without an IV pump.
4. The usual dose of potassium is 10-20 mEq added to (one) 1 liter of IV solution and administered at a mechanically (pump) controlled rate not to exceed 10 mEq/hour (restrictions in scope of practice limits dose to 40 mEq/L).
5. Cannot monitor arterial lines.
6. Monitor and adjust transport ventilators.
7. Monitor Chest Tube without suction.

CCT-RN (Critical Care Nurse) (NOT MICN)

Wide scope of practice because of Standard Operating Protocols (SOPs). Some of the following can be monitored by a paramedic who is CCT-P or FP-C (or equivalent as approved by Nor-Cal EMS). This is covered under the Unified Scope of Practice for paramedics. Needs to have nurse partner and CAMTS accredited.

1. IV infusion of any drug requiring an IV pump outside basic paramedic scope of practice.
2. Monitor arterial line.
3. Intra-Aortic Balloon Pump.
4. Intravenous temporary pacemaker.
5. Chest tube with suction.
6. Pulmonary artery line.
7. Intracranial pressure line in-place.

DEFINITIONS OF THE CLINICAL STATUS FOR PATIENTS AND RESPECTIVE IFT TIME FRAMES

The following are guidelines for the severity of the patients' clinical condition. These are guidelines and the patient category can and should be adjusted as the patient condition changes.

1. **Critical Patients**: Transport services need an immediate response, preferentially utilizing Air Medical Resources (Helicopter), Critical Care Transport (CCT) and if appropriate 911 ALS ground ambulance. These patients are hemodynamically unstable, on vasoactive infusions, and usually ventilated. Examples of these patients would include the following but not limited to: STEMI patients, TBI patients who are ventilated, Stroke patients receiving thrombolytics, trauma patients that are hemodynamically unstable that are being resuscitated, and septic patients that are on vasoactive infusions after being fluid resuscitated and receiving antibiotics. Orthopedic injuries that exhibit neurovascular compromise can fall into this category.
2. **Semi-Urgent**: Transport services need to respond rapidly. The response time to the sending facility for transport services, optimally less than 90 minutes. These patients have the potential to deteriorate. The expected response time needs to be balanced with the status of the entire 911 system. It is the responsibility (California Health and Safety Code) of the Base Hospital and Base Hospital Physician to help manage the 911 system in coordination with the EMS supervisors, dispatch, and PSAPs. Examples of these patients would include the following but not limited to: Non-STEMI patients that are hemodynamically stable and do not require immediate cardiac intervention, septic patients that have been adequately resuscitated with antibiotics being administered, and severe COPD patients that are on continuous beta-agonist therapy.
3. **Non-Urgent**: Transport units will be sent as the system allows. The expectation being up to and including 180 minutes. However, if the system is down units there can be delays up to 4 hours. Examples of patients that meet these criteria are orthopedic injuries that are hemodynamically stable and without neurovascular compromise such as stable hip fractures, forearm fractures and humerus fractures where patients are not expected to go to surgery immediately.

THE FOLLOWING ARE GUIDELINES FOR PATIENTS BEING TRANSFERRED FROM INPATIENT UNITS TO OTHER FACILITIES WITH GREATER RESOURCES

1. Labor and Delivery: patients from the Labor and Delivery unit will be treated with the urgency as critical and/or emergent patients (as defined above). These patients' clinical condition can and does change rapidly and require contact with the sending physician.
2. Critical Care Units: patients from Critical Care Units will be treated with urgency as the critical patient time frames defined above. Again, consultation with the physician is required.
3. Post-Operative Patients: patients being transferred after surgery will again be treated with the same urgency as the critical patient time frame defined above. Consultation with the sending physician is required.
4. General Medical/Surgical Patients: Patients from Medical/Surgical units will be evaluated and every effort will be made to expedite these transfers. This category is treated as a ~~Urgent to~~ Non-Urgent time frame. These patients will be responded to between 60 and 240 minutes depending on the clinical status. The urgency can be upgraded after the attending physician has been consulted.

Transport method decision guidelines:

The decision of which transport method is chosen is up to the sending facility primary care provider to decide what category and transport method (air medical, CCT or ALS/BLS ground transport) the patient meets and decide. Then dispatch with the local EMS supervisors will consider weather and other transportation conditions and work with the sending facility to determine the most advantageous mode of transport. The sending facility needs to alert dispatch and EMS supervisors if there will be multiple transfers. Ideally this process is a collegial and collaborative process.

ROLES, EXPECTATIONS, AND DUTIES THAT BASE AND ALTERATIVE BASE HOSPITALS AND PHYSICIANS HAVE IN THE MANAGEMENT OF LOCAL 911 EMS SYSTEM

The following are citations from California Health and Safety regarding the roles, expectations, and duties that Base/Alternative Base Hospitals and Physicians have in the management of the local 911 EMS system. It is the duty of the Base/Alternative Base Hospital to help maintain the integrity of the local EMS system. There needs to be a balance between the duty to respond to 911 requests (public safety) and taking resources out of the local EMS system for IFTs (Interfacility Transports to definitive care). Nowhere is this more difficult than in the Rural and Frontier regions.

1797.58. (Base Hospital)

"Base hospital" means one of a limited number of hospitals which, upon designation by the local EMS agency and upon the completion of a written contractual agreement with the local EMS agency, is responsible for directing the advanced life support system or limited advanced life support system and prehospital care system assigned to it by the local EMS agency. (Amended by Stats. 1984, Ch. 1391, Sec. 6.)

1797.59. (Base Hospital Physician)

"Base hospital physician" or "BHP" means a physician and surgeon who is currently licensed in California, who is assigned to the emergency department of a base hospital, and who has been trained to issue advice and instructions to prehospital emergency medical care personnel consistent with statewide guidelines established by the authority. Nothing in this section shall be deemed to abridge or restrict the duties or functions of a physician and surgeon as otherwise provided by law. (Added by Stats. 1984, Ch. 1391, Sec. 7.)

1797.90. (Medical Control)

"Medical control" means the medical management of the emergency medical services system pursuant to the provisions of Chapter 5 (commencing with Section 1798). (Added by Stats. 1980, Ch. 1260.)
1797.67. (Designated Facility)

"Designated facility" means a hospital which has been designated by a local EMS agency to perform specified emergency medical services systems functions pursuant to guidelines established by the authority. (Added by Stats. 1983, Ch. 1246, Sec. 12.)

1798.2. (Base Hospital Direction of Prehospital Personnel)

1. The base hospital shall implement the policies and procedures established by the local EMS agency and approved by the medical director of the local EMS agency for medical direction of prehospital emergency medical care personnel. (Amended by Stats. 1988, Ch. 1390, Sec. 7.)
2. Medical control is maintained in accordance with policies and procedures established by the local EMS agency, with the approval of the medical director of the local EMS agency.

3. Any responsibilities of a base station hospital, including review of run reports or provision of continuing education, which are not assigned to the alternative base station, are assigned to either the local EMS agency, a base hospital for another area of the local EMS system, or a receiving hospital which has been approved by the medical director to, and has agreed to, assume the responsibilities. (Added by Stats. 1988, Ch. 1390, Sec. 12.)
4. The medical direction is provided by either of the following:
   A. A physician and surgeon who is trained and qualified to issue advice and instructions to prehospital emergency medical care personnel.
   B. A mobile intensive care nurse who has been authorized by the medical director of the local EMS agency, pursuant to Section 1797.56, as qualified to issue instructions to prehospital emergency medical care personnel. (Added by Stats. 1988, Ch. 1390, Sec. 8.)

The above are meant as guidelines and sound clinical judgment needs to be exercised. It is expected that there is mutual respect between all health care providers. Further, nothing in this document means that a transport agency must transport a patient beyond their capabilities.