

State of Wisconsin

**Department of Health and Family Services
Division of Public Health**

Bureau of Local Health Support and Emergency Medical Services

2006

Interfacility Transport Guidelines

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January 15, 1996 Development

The State of Wisconsin wishes to acknowledge the talents and efforts of the previous team of healthcare professionals who gave their valuable time and expertise to develop the first draft of the Scope of Practice for Interfacility Transfers on which this version is based.

PREFACE

This version of Interfacility Transport Guidelines builds on the previous version implemented on January 15, 1996. This version also clarifies changes to the scope of practice based on updated Administrative Rules.

In a departure from the January 15, 1996 document, these guidelines are intended for use by hospitals and physicians as well as ambulance service providers to clarify who can provide interfacility transportation, to delineate qualifications of staff who provide interfacility transports, and to act as an assessment tool to aid in the determination of how to meet the resource needs for a given interfacility transport. With better definitions and prudent interpretation of Emergency Medical Treatment and Active Labor Act (EMTALA), these guidelines will be an indispensable educational tool and reference to assure safe and appropriate transfer of patients. As such, this document, when used by hospitals, physicians, and EMS personnel, shall assist in maintaining compliance with currently recognized federal guidelines.

This document is meant to define the minimum scope of practice for EMS professionals involved in interfacility transport, not for hospital-employed and/or hospital-based professionals who function under the scope of practice defined by that institution. The scope of practice in these guidelines is within state and national parameters for the given EMS providers, but as individual EMS services' medical directors have the ability to tailor the scope of practice in developing an operational plan for their services, a local provider's scope of practice may be quite different. The table located within outlines the scope of practice ceiling for the EMT, EMT-Basic IV Technician, and EMT-Intermediate. Many of these providers are not locally authorized to perform all of the listed skills. In contrast, the table defines a starting point for the EMT-Paramedic level provider. With additional training and dedicated medical direction, paramedics can perform many added skills if approved in their local operational plan. As such, the Bureau suggests, with assistance from the local transport service medical director, this guideline be amended to reflect the local resource's scope of practice. Regardless of this document, the scope of practice for a local provider must be clearly defined in their state approved operational plan.

Transfer agreements between healthcare facilities and the transferring EMS service should be established. This document does not supplant or substitute in any way for those mutually determined agreements.

This document recognizes that interfacility transport is different from 911 transports.

INTENT: To provide guidelines for ambulance transport of patients between acute care hospitals.

AUTHORITY: ss. 146.50 Wisconsin Statute
Chapter HFS 110 Wisconsin Administrative Rule
Chapter HFS 111 Wisconsin Administrative Rule
Chapter HFS 112 Wisconsin Administrative Rule
Chapter HFS 118 Wisconsin Administrative Rule

POLICY: 1. It is the responsibility of the transferring physician, in consultation with the receiving physician, to determine the appropriateness of transfer, the appropriate level of care required by the patient's condition, the appropriate mode of transportation and the appropriate personnel (EMT-Basic, EMT-Basic IV Technician, EMT-Intermediate, EMT-Paramedic, Registered Nurse, Physician, Specialized Critical Care Transport Service, etc.) to provide care during transport.

2. Medically and legally, the responsibility for safe interfacility transfers rests with the transferring hospital and not the local EMS system. There is no legal mandate for an EMS system to provide for interfacility transfers.
3. On-line Medical Control shall be identified and agreed upon prior to patient transport. The referring physician or accepting physician may provide the medical direction and if so, must be readily available via voice contact within a reasonable time. The transport service's medical director will be the default provider of medical control, and has final authority if there is any dispute regarding the care and services requested.
4. Patients requiring clinical skills (Scope of Practice) and/or equipment beyond those of an EMT, EMT-IV Tech, EMT-I or EMT-P should only be transported via a critical care transport service and accompanied by appropriately trained and equipped clinical personnel who can safely and appropriately manage that patient's condition. It is the responsibility of the referring physician and health care institution to insure this level of care is provided.
5. Ambulance services providing interfacility transport of patients shall:
 - a. Be a Wisconsin licensed provider.
 - b. Maintain on file, as required under Wisconsin Administrative Rule, an approved Interfacility Operational Plan.
 - c. Maintain a program for continuous quality improvement.
 - d. Advertise and offer only services that are within the scope of practice and license level of provider and personnel.
 - e. Assure the ambulance is staffed with a minimum of two licensed crewmembers and additional crewmembers in the patient compartment to meet the anticipated needs of the patient. One person can be a registered nurse, physician assistant, or physician provided by the referring facility who is trained in the skills the service is authorized to provide.
6. Such transports shall not significantly compromise the local 911/EMS resources of the community. It is the responsibility of the transport service provider to determine whether adequate resources are available to maintain appropriate coverage to the community before committing to the requested transport.
7. At no time shall a licensed provider be ordered to operate outside of their State approved scope of practice.
8. Interfacility transport services must ensure that the medical personnel providing interfacility transport retain qualifications and competency in performing the procedures and administering medications necessary to meet the specific needs of the patient during the interfacility transport.

To insure safe and appropriate care for all patients and medico-legal protection for EMS providers and health care personnel, it is highly recommended that all transporting services and referring facilities develop interfacility transfer agreements that address the above 8 points.

Definitions

“Ambulance” has the meaning specified in s. 146.50 (1)(a), Stats., namely, an emergency vehicle, including any motor vehicle, boat or aircraft, whether privately or publicly owned, which is designed, constructed or equipped to transport sick, disabled or injured individuals.

“Ambulance service” has the meaning specified in s.146.55 (1) (a), Stats., namely, the business of transporting sick, disabled or injured individuals by ambulance to or from facilities or institutions providing health services.

“Ambulance service provider,” “ambulance provider” or “provider” has the meaning specified in s. 146.50 (1) (c), Stats., namely, a person engaged in the business of transporting sick, disabled or injured individuals by ambulance to or from facilities or institutions providing health services.

“Basic life support” or “BLS” means emergency medical care that is rendered to a sick, disabled or injured individual, based on signs, symptoms or complaints, prior to the individual’s hospitalization or while transporting the individual between health care facilities and that is limited to use of the knowledge, skills and techniques received from training under s. 146.50, Stats., and ch. HFS 110 as a condition for being issued an EMT–basic license.

“Critical care and specialty care transport” means use of licensed health care personnel (RN, NP, MD, DO, EMT-P, PA, RRT, etc.) with hospital-defined and approved critical care skills and a scope of practice that is more comprehensive than that of an ALS ambulance service provider thereby allowing for the highest level of care available for emergent and/or specialty (e.g. obstetric, neonatal, pediatric, extracorporeal technology, etc.) interfacility transport of patients with a high degree of clinical acuity and potential for deterioration.

“Advanced life support” or “ALS” means use, by appropriately trained and licensed personnel, in prehospital and interfacility emergency care and transport of patients, of the medical knowledge, skills and techniques included in the department–approved training required for licensure of emergency medical technicians–intermediate under ch. HFS 111 or emergency medical technicians–paramedic under ch. HFS 112 and which are not included in basic life support.

“Interfacility transport” means scheduled or prearranged transportation of emergent or non-emergent patients between health care facilities.

“Medical control” means direction, through verbal orders or a department–approved protocol, supervision and quality control by the medical director or by a physician designated by the medical director, of the activities of an EMT performing skills in the pre–hospital setting or during interfacility transport of a patient.

“Operational Plan” means a document submitted for review and approval by DHFS that represents an ambulance service provider’s plan for the delivery of emergency care and transportation of patients.

“EMTALA” - The Emergency Medical Treatment and Active Labor Act enacted in 1986.

“Transfer Agreement” means a written understanding between a facility and an interfacility transport service with regards to the service’s specific scope of practice as defined in their DHFS approved operational plan, the level of care available and the responsibility for medical control.

I. Introduction/Intent

The transfer of patients between facilities is a fundamental component of the health care system. It allows access to various levels of care (emergent, critical, and specialty) for individuals and communities that may not otherwise receive such care. It also facilitates the existence of regional and integrated health care systems, such as occurs in a managed care environment. Transfers occur with the expectation that the reasonably-anticipated risks and complications en route shall be non-existent to minimal, but may be adequately handled by transport team personnel.

As health care reform progresses, the demand to regionalize resources and move patients to those resources will increase. The objective of this guideline statement is to promote safe and appropriate patient transfer. As such, it provides the referring physician and institution with a tool to assist in decision-making regarding staffing requirements and qualifications for the care of the transferred patient.

II. Authority

The regulations governing out-of-hospital emergency medical care rest with the Department of Health and Family Services. Through Administrative Rule, specific scopes of practice are established for all levels of EMS licensure.

ss. 146.50 Wisconsin Statute
Chapter HFS 110 Wisconsin Administrative Rule
Chapter HFS 111 Wisconsin Administrative Rule
Chapter HFS 112 Wisconsin Administrative Rule
Chapter HFS 118 Wisconsin Administrative Rule

In 1986, with amendments in 1990 and 1994, Congress enacted the "federal anti-dumping legislation" (COBRA, the Consolidated Omnibus Budget Reconciliation Act, PL 99-272, and subsequently EMTALA, Emergency Treatment and Active Labor Act), which was designed to prevent the transfer of patients from one facility to another based solely upon their ability to pay. This legislation outlined specific steps that the transferring physician and transferring facility must perform prior to initiating or implementing the transfer. Fundamentally, EMTALA seeks to ensure that the patient is clinically stable, has consented to the transfer, and may benefit from care available at the receiving hospital that is not available at the referring hospital.

III. Policy

Responsibility of Transferring Physician/Facility

Patient Care

According to EMTALA, the transferring physician is responsible for identifying the receiving physician, identifying the receiving hospital, and writing transfer orders in consultation with the receiving physician. The transferring physician is also responsible for determining the method of transport (i.e. ground or air), the necessary and most appropriate personnel to accompany the patient, the necessary and appropriate life support equipment to accompany the patient, and the medical treatment and medication orders for the duration of the transfer to cover any reasonably foreseeable complications during transfer. This mandate requires knowledge of Wisconsin EMS statute and rule and EMTALA. These Interfacility Transport Guidelines are designed to clarify for the transferring physician at a glance those procedures and medications within the scope of practice for any individual licensed EMS provider.

The decision to transfer a patient must be preceded by an analysis of the potential benefits of the transfer measured against the potential risks, considering not only the patient but the transport personnel as well. The risk/benefit analysis should include a determination of the patient's current medical problems and the most suitable facility for management. In addition, the patient's likelihood for deterioration without transfer, the urgency of definitive management, and the availability of tertiary resources must be factored into the decision to transfer.

There is significant risk of deterioration during the transfer of critically ill patients. Prior to initiation of a transfer, the patient should be adequately assessed and stabilized as much as possible. The extent to which this can be accomplished depends on the resources available at the transferring institution, the illness or injury, and the age of the patient. In some cases, such as seriously ill pediatric and neonatal patients, a specialty transport team may best accomplish adequate stabilization and provide the necessary equipment prior to transfer. Some patients may require assessments and interventions unavailable at the referring facility. The transferring physician is responsible for stabilizing patients to the best of his or her ability and, in the case of a critically ill infant or child, may benefit from early communication with the receiving hospital's specialty transport service. Although some patients will require transfer without definitive stabilization, there is no evidence to support the "scoop and run" approach to the interfacility transport of critically ill patients and a growing science supporting

early, goal-directed therapy. In addition, current literature demonstrates an improved outcome and decreased incidence of adverse events when neonatal and pediatric patients are transported by specialized neonatal and pediatric transport teams.

Obstetric patients and women in labor present special problems and considerations. To avoid the potential complications of a delivery during transfer, patients with imminent delivery should generally be delivered prior to transfer, even in the case of high-risk pregnancy. Resources to care for mother and child at the referring facility are far superior to that available in any transporting unit. Once delivered, mother and child can be more safely transferred if necessary and by the appropriate level of care team required.

Methods and Level of Transfer

It is the responsibility of the transferring physician to choose the most appropriate mode of transport and level of care. Important considerations include patient acuity, time to transfer, and distance to receiving facility. For the unstable critical patient, rapid interfacility transport to a more comprehensive facility may be required. In contrast, non-emergent interfacility transfer may not require speed or sophisticated transfer services. Prior knowledge of local and regional transport capabilities is essential. Important to note is that there is not a State statutory mandate for EMS systems to provide for interfacility transfers.

Personnel and Equipment

It is essential that appropriate personnel and equipment accompany the patient during interfacility transport. The personnel must have the qualifications and competency in performing the procedures and administering medications necessary to meet the specific needs of the patient during the interfacility transport. Personnel needed to provide an appropriate level of care during the transport are often not available at, or cannot be spared from the sending facility. Specialty care transport teams can be used to supplement appropriate personnel and provide necessary equipment for a transfer. These teams usually have personnel who are specially trained and, more importantly, have significant experience in the management of critical care transports. The level of training required for interfacility transport depends on the severity of illness. The Wisconsin EMS Scope of Practice will provide guidance when selecting the most appropriate staffing configuration for EMS interfacility transfers.

The DHFS' Bureau of Local Health Support and Emergency Services has authority and control over the scope of practice for out-of-hospital providers (First Responders, EMTs, and Paramedics). The Bureau does not directly control the practice of nurses, physician assistants, or physicians. In general, their licenses do not limit their scope, but rather their scope of practice is defined by their individual training, experience, and

credentialing. For example, while both are licensed nurses, it is unlikely an obstetrics nurse would be qualified to manage a balloon pump or a critically injured pediatric patient. Likewise, a cardiac nurse may not be qualified to care for a complicated pregnancy or a neonate. As such, the scope of practice for these providers needs to be clarified and confirmed by the providing agency prior to their use as transporting personnel. The establishment of a transfer agreement will facilitate the understanding of these non-EMS health care providers' credentials.

If provided by the transporting service, these personnel's scope of practice will be defined in the service's operational plan and these personnel's credentials and capabilities are the responsibility of the medical director of the transporting service. If provided by the transferring facility, these personnel's credentials and capabilities are the responsibility of the transferring physician and/or facility. If provided by the receiving facility, these personnel's credentials and capabilities are the responsibility of the receiving physician and/or facility. It is incumbent on the transferring facility to match the skill of any of these providers to the given need of the patient.

Medical Control/Direction

The responsibility of on-line medical direction during transport should be established prior to the transport based on a mutual agreement between the transferring physician, the transport service medical director, and the receiving physician. Having an interfacility transfer agreement in place prior to transfer facilitates this process.

The options for on-line medical control during transfer include: (1) the transferring physician assumes medical control, (2) the receiving physician assumes medical control, or (3) the medical director or his/her surrogate (a medical control physician) of the transporting service assumes medical control. The actions of the transport service personnel are ultimately the responsibility of the service medical director by *respondent superior*. Medical direction serves a critical quality control function over every aspect of patient care and system operation, including the appropriateness of clinical protocols, adequacy of provider education, selection of equipment, and prevention of medical errors. It is essential that the physician providing medical control is readily available via voice (within a reasonable time) to the transport personnel and be medically qualified to direct care for the patient. Several factors determine the most appropriate individual to exercise on-line medical control responsibility but patient care considerations must be paramount. In some situations, the selection may be primarily based on communication capabilities. If only one physician can maintain direct communication with the transport vehicle during transfer, medical responsibility should be with that physician. Appropriate specialty back up needs to be available as needed for appropriate patient care (e.g. obstetric, neonatal or

pediatric). Regardless of the identified physician providing medical control, *once the EMS or specialty transport team assumes care of the patient, the medical director of the transport service or his/her surrogate has final authority for the care of the patient and protection of the transport team.* **The determination of on-line medical responsibility must be made in advance and this determination must be documented.**

Responsibility of Interfacility Transport Service

State Approved Operational Plan/Licensure

The interfacility transfer service and its medical director are responsible for maintaining ambulance service provider and individual provider licensures, defining the scope of practice of the personnel in conjunction with current rule (off-line medical direction), and submitting for approval to DHFS an interfacility operational plan. To submit a plan, the service must be a Wisconsin licensed provider. The plan shall include the following essential components: level of service to be provided (scope of practice), provision for medical direction (on-line and off-line), written protocols including standing orders, and a continuous quality improvement (CQI) program. Some of these items and their requirements are presented in detail below.

On-Line Medical Direction

On-line medical direction for interfacility transport carries the same importance as on-line medical direction for EMS systems involved primarily in pre-hospital emergency medical care. On-line medical direction allows the physician to give direct orders to manage those conditions not addressed by standing orders or protocols as approved in the operational plan. To be effective, there must be a system available to allow voice communication from the transport team to an appropriate physician. On-line medical direction capability is essential for medical personnel functioning outside the hospital. Continuous communication capabilities should be ensured, but if continuous communication is not available during transport, written transfer orders must include sufficient instructions to allow the personnel attending the patient to respond appropriately to medical crises and changing patient status. Standing orders or protocols may be developed off-line to meet these needs. The medical director must have access to and involve other specialists for consultation in development of specialty transport protocols (i.e. obstetric, neonatal or pediatric patients).

The referring, receiving and on-line physicians must consider that the existing pre-hospital protocols found in EMS systems are not automatically transferable to the environment of the interfacility transfer. Separate interfacility transport protocols are essential and require DHFS approval prior to implementation as part of an EMS service's interfacility operational plan. The service medical director will act as the default on-line medical director in the event the transferring or receiving physician is not capable of providing such service.

This document also recognizes that even with anticipation of patient needs during transport, situations will arise that cannot be foreseen. In this event, transport personnel are to initiate care based upon protocols of a 911 provider while seeking consultation with on-line medical control and/or requesting an appropriate level intercept or diverting to an appropriate facility.

Finally, such transports shall not compromise the local 911/EMS resources of the community. It is the responsibility of the transport service provider to determine whether adequate resources are available to maintain appropriate coverage to their community before committing to the requested transport.

Off-line Medical Direction

Off-line medical direction represents the foundation of physician responsibility and involvement with interfacility transfer, much as it does with traditional EMS systems. The off-line medical director assumes responsibility for the overall quality of health care delivered by an interfacility transport service. The medical director must have authority commensurate with that responsibility, including ultimate authority in medical matters. This includes, but is not limited to, the establishment of standing orders and protocols for treatment of patients during transfer. Additionally, the medical director must have the authority to approve transfer team composition, to credential, define and approve competency levels for team members and to set standards for training requirements. The ideal off-line medical director is a trained emergency physician who is active in the practice of emergency medicine and has a particular interest and expertise in EMS systems and interfacility patient transfer. This medical director must have access to and involve other specialists for consultation in development of specialty transport protocols (i.e. obstetric, neonatal or pediatric patients) if the EMS service chooses to engage in those types of transfers and be compliant with national consensus guidelines (i.e. NHTSA, NAEMSP, etc.).

Treatment protocols are an essential component of off-line medical direction. They are documents that provide the basis for a uniform quality of care throughout for a service and define the procedures and interventions for personnel during patient transfer. Treatment protocols become the basis for the initial training and continuing

education for personnel. Additionally, they form the basis for ongoing monitoring of the service through quality improvement. Accordingly, these protocols are the responsibility of the service medical director. These protocols should be incorporated in an interfacility transfer agreement to help demonstrate the scope of practice and provide transferring facilities and physicians with information regarding the skill and knowledge of the transport service.

Further, this document assumes the ambulance service provider and ambulance service provider medical director maintain written evidence of education, initial and on-going proficiency and authorization of all procedures and medications performed by any licensed person, and must make these records available to DHFS authorized persons upon request.

Documentation

As with all other areas of medical care, documentation, data collection and reporting to appropriate agencies is critical to ensuring proper medical care and medico-legal protection. The format for documentation of interfacility transfer information should be established by the service with its medical director's input and should focus on physiologic monitoring, patient care interventions, and general changes in patient condition during transfer. Administrative Rule requires DHFS approval of forms.

Special Populations

It is well recognized that ill and injured pediatric patients have unique clinical requirements. It is recommended that hospitals in the State have written interfacility transfer agreements that specify alternate care sites (i.e. children's hospitals) that have the capabilities to meet the clinical needs of critically ill and injured pediatric patients. In additions, inter-facility guidelines should be in place that specify transportation of patients, staff, and equipment to and from the alternate care site; that provides for individual tracking to and from the alternate care site; and that ensures inter-facility communication between the referring hospital, transporting service and the alternate care site.

IV. Summary

It is clear that hospitals and physicians arranging for interfacility transfer of patients do so with the expectation that a mechanism is in place for safe and appropriate patient care during that transport. This expectation is based on experience with the day-to-day functioning of organizations within EMS systems. EMS system providers must render their customary scope of practice to transferred patients, as defined by policies and protocols. This scope of practice must be defined for referring hospitals and physicians so that safe and appropriate care can be provided for each individual patient as defined by their unique care requirements. The establishment of interfacility agreements, off-line treatment protocols, and pre-established on-line medical control will help ensure safe and appropriate provision of care during interfacility transport.

The transferring physician/facility is responsible for:

1. Stabilizing the patient within the capacity of the facility.
2. Performing a risk/benefit analysis of transfer.
3. Determining the mode of transfer based on patient acuity, distance and weather conditions in consultation with the receiving facility physician.
4. Determining the medical needs of the patient during transfer and the medical qualifications of the personnel required to meet that need.
5. Recognizing and respecting the limitations of the providers' scope of practice, which means:
 - a. Not requiring a higher level of care from these personnel than is defined by their scope
 - b. Recognizing the need for specialty transport services that may not be available from EMS-based transport services and promptly contacting these services
6. Determining the credentials and capabilities of any personnel provided by the facility for the transport.
7. Insuring on-line medical control is readily available by voice contact within 3 minutes.

The transport agency is responsible for:

1. Having an approved interfacility transport operational plan on file with the State of Wisconsin.
2. Complying with said approved plan.
3. Insuring providers have current licensure and training as needed to meet their approved scope of practice.
4. Insuring that the transport will not compromise the local 911/EMS resources.
5. Insuring provision of care remains within the provider's scope of practice.
6. Insuring on-line medical control is readily available.

Wisconsin Scope of Practice

Interfacility Transport Guidelines

This document is intended to be dynamic in nature and changes should be anticipated as scope of practice changes occur. Medications and procedures not found in this document must have the approval of the Department of Health and Family Services prior to use.

The scope of practice for individual providers is rule-based and provided on the following table. Some skills listed on the table are optional and may not be part of the scope of practice for a given service, thus when requesting an ambulance for interfacility transfer, any limits placed by the transporting service must be recognized and respected. **The individual service's medical director determines the actual scope of practice for its providers as defined in the approved operational plan.** Paramedics may potentially have an unlimited scope of practice. They can perform skills and provide treatments as their medical director chooses but the paramedics must be trained appropriately and deemed competent by their medical director. They must maintain necessary credentials and documentation of competency. Of great importance, this “expanded scope” must be approved by DHFS as part of the service's operational plan. For example, a service may have paramedics that are trained and approved to monitor chest tubes: chest tube monitoring *can* be within the scope of practice for a paramedic; *however*, it does not follow that every paramedic can be expected to do this.

While the DHFS Bureau of Local Health Support and Emergency Services has authority and control over the scope of practice for out-of-hospital providers (first responders, EMTs, and paramedics) it does not have control over the practice of nurses, physician assistants, or physicians. Therefore, this document will not address the scope of practice for these professionals. However, for nurses that are employed by a non-hospital based transport service, their scope of practice must be reflected in the operational plan submitted to DHFS for approval.