7.x Interfacility Transfers

INTRODUCTION
The purpose of this section is to ensure interfacility transfers (IFT) comply with current VT law, licensure, and EMS protocols. It is intended to promote efficiency in IFT while maintaining patient safety.

INTERFACILITY TRANSFER
An IFT is defined as any EMS ambulance transport from one healthcare facility to another facility, including emergency departments (ED). In general, transports from a non-hospital healthcare facility and 911 calls to a hospital ED by EMS should not be regarded as interfacility transfers.

- EMS personnel should follow their standard scope of practice, unless specific restrictions are included in the transferring facility provider's written orders for transport.
- If at any time during transport a patient develops new signs/symptoms or has a change in status, EMS personnel shall refer to the appropriate VT EMS Protocol.
- If there is a conflict between VT EMS Protocols and the transferring facility provider's written orders for transport, EMS should follow the written orders, as long as they are within the EMS practitioner's scope of practice.

Transferring Facility Responsibilities
- Certify benefits of transfer outweigh all expected risks
- Ensure that patient has an accepting provider and bed assignment at destination facility
- Transferring provider must ensure ongoing care will be sufficient and appropriate, and provide resources as necessary
- Transferring provider remains responsible and available to serve as medical direction for transporting agency during transfer
- Provide complete set of patient care orders for the transporting agency
- In any case where the number of patients requiring transport exceeds the number of available EMS resources, the transferring institution shall decide the order in which patients are transported

Transporting Agency Responsibilities
- Assign personnel and resources that are most appropriate (consider training/experience, environmental factors, equipment needs)
- Decline transports when proper resources cannot or will not be provided and/or their level of training/experience is not compatible with patients acuity
- Consult medical direction as necessary during transport
- Seek education or information about therapies, transport equipment, or medications outside of normal formulary as necessary

Shared Responsibilities
- Assign the appropriate transport agency level for patient transport including sending hospital staff, if necessary (see following pages)
- Receive and relay a complete patient care report
- Ensure every effort has been made to mitigate risk, including environmental factors.

Medical Direction Responsibilities
According to EMTALA, patient care during transport until arrival at the receiving facility is the responsibility of the transferring provider unless other arrangements are made with appropriate medical direction.

In certain Air Medical Transport services or ground critical care units, the transport unit may function as an extension of a tertiary care center and operate under that facility's medical direction and on-line medical direction.

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Medical Direction Responsibilities (continued)
In the prehospital setting, EMS operates under VT EMS protocols. During IFT, written transfer orders that are within the scope of the EMS practitioner's or other healthcare provider's level of licensure are also required to be authored by the transferring provider. The combination of protocols and transfer orders provide off-line medical direction.

Transfer orders must be specific, appropriate to the patient being transferred, and reasonably anticipate potential complications enroute. Transfer orders may reference the use of VT EMS protocols where they are applicable. If patients develop new signs and/or symptoms during transport, beyond their initial transfer diagnosis, EMS personnel may treat the new signs and/or symptoms according to VT EMS protocols. If transfer orders and VT EMS protocols are in conflict, transfer orders take precedence assuming they are within the scope of the EMS practitioner's or other healthcare provider's level of licensure. The transferring provider should be available to review transport orders and provide medical direction during the transport.

Transport Agency Levels

- EMT
- AEMT
- Paramedic
- Critical Care Paramedic (CCP)
- Critical Care Transport Team (CCT)

At a minimum, 2 licensed EMS practitioners in the vehicle, of which 1 may be the driver, **OR** 1 licensed EMS practitioner providing patient care and a VT-certified VEFR driver.

Interfacility transfers that are appropriate for EMT, AEMT, or Paramedic levels of care do not require additional levels of credentialing beyond training requirements defined in the VT EMS protocols.

National Scope of Practice allows regular Paramedics to provide IFT for appropriately selected patients. However, there are still several important procedures and medications vital to the safe interfacility transfer of critically ill or injured patients that are beyond the scope of practice for a Paramedic for which advanced critical care knowledge and skills will be required.

The Vermont CCP endorsement provides an expanded scope of practice for numerous procedures and medications vital to the safe transport of the critically ill or injured patient. The CCP endorsement is outlined in the Appendix 5. Procedures or medications in Appendix 5 labeled as "W" require an additional waiver from VT EMS.

Some critically-ill patients will have a level of acuity and/or complexity that requires a more advanced Critical Care Transport team (CCT)—either by air or ground. If that level of resource is not readily available, it is an acceptable practice to supplement the EMS crew with hospital staff that is qualified to provide the level of care the patient requires. EMS practitioners must decline to transport patients that have a level of acuity and/or medication regimen outside of their scope of practice, and work with the sending facility to acquire optimal staffing (such as sending nursing staff or other provider).

The transferring physician/provider is responsible for determining the level of EMS practitioner and resources that are appropriate to meet the patient's current and anticipated condition and needs. In the interfacility transfer environment, all patient care delivered must be within the scope of the EMS practitioner's or other healthcare provider's protocols and licensure. (EMS practitioners may need to educate sending/receiving facility staff about their respective scopes of practice and any limitations contained therein.)

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INTERFACILITY TRANSPORT TEAM SCOPES OF PRACTICE

EMT

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- Care and treatment of stable patients.
- Therapies within the EMT scope of practice (Appendix 4).
- Medications within EMT scope of practice (Appendix 1).
- Non-invasive monitoring (BP, HR, RR, SpO_2, temperature).
- Previously inserted Foley catheter, suprapubic tube, established feeding tube (NG, PEG, J-tube not connected to infusion or suction).
- Saline lock permitted (no infusion).
- Maintenance of stable, long term ventilated patients with any mode of ventilation so long as the patient is familiar and capable of operating the equipment OR patient is accompanied by a care provider who is capable of the same.

ADVANCED EMT

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- Care and treatment of stable patients.
- Therapies within the AEMT scope of practice (Appendix 4).
- Medications within AEMT scope of practice (Appendix 1).
  - May be administered orally (PO) per patient care transfer orders.
- Any isotonic or balanced crystalloid IV infusion (no pump).
- Cardiac monitoring for cardiac arrest arrhythmias only and correlated with physical assessment findings (no palpable pulses). If cardiac monitoring is indicated due to suspected or anticipated non-cardiac arrest arrythmias, the patient is not appropriate for transport by an AEMT.
  - Monitor all of the following vital signs:
    - Heart rate, respirations, non-invasive blood pressure, SpO_2, $ETCO_2$.
    - 4 lead ECG as a vital sign ONLY, non-interpretive.
    - Alarm when rates are above or below limits set by the operator.
      - ❑ The AEMT should be familiar with and configure visual and audible cardiac monitor alarm settings for each patient transport.
  - Semiautomatic mode for defibrillation of patients in cardiac arrest.
  - 12-lead analysis and transmission (computer interpretation).
- CPAP.

PARAMEDIC

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- Care and treatment of potentially unstable patients.
- Therapies within the Paramedic scope of practice (Appendix 4).
- Medications within Paramedic scope of practice (Appendix 1).
  - Any medication on the EMS formulary that was started as an infusion prior to departure may be continued.
  - Initiation of previously ordered antibiotic infusion.
  - May be administered orally (PO) per patient care transfer orders.
- Maximum 1 vasopressor infusion.
- Cardiac monitoring of 4 lead ECG with anticipated need for ACLS intervention.
- Chest tube maintenance.
- Invasive monitoring equipment if capped/locked and labeled for transport.
- Epidural catheter if secured, capped, and labeled.

The following require a *SECOND* provider in the patient compartment:

- Active transcutaneous pacing at time of transfer.
- Anticipated cardioversion.
- Anticipated deep suctioning.
- Automated Transport Ventilator - ATV (Stable intubated patient). May only adjust rate, tidal volume, and adult vs. child settings, if applicable.
- RSI/DSI. (Agency & providers must be credentialed.)

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CRITICAL CARE PARAMEDIC, including but not limited to:

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- Care and treatment of unstable patients.
- Greater than one vasopressor infusions.
- Initiation of additional blood products.
- Managing uncorrected shock.
- Initiation of additional antibiotics or antivirals.
- Initiation of insulin infusion.
- Continuation of invasive monitoring.
- Continuation of balloon pump/impella pump. (Requires CCP waiver.)
- Transvenous pacing.
- NPPV (BiPAP) which may require complex adjustments or conversion back to PPV mode.
- Rapid sequence or delayed sequence induction. (Requires RSI credentialing.)
- Intubated/ventilated patients. (Complex vent settings may require additional team members.)

Critical Care Transport Team Configuration

It is preferred that complex patients be managed by a Critical Care Transport (CCT) team. If a CCT is not available, consider the following alternatives. (Exercising any of the following alternative crew configurations does not expand the scope of practice of the assigned crew.)

Preference: Critical Care Transport (CCT) Team.

Alternative 1: Critical Care Paramedic (CCP) and one of the following:

- CFRN/CTRN/CCRN/CEN (with appropriate adjunctive certifications e.g., ACLS, NRP etc.)
- FP-C, CCP-C (CCP)
- Respiratory Therapist
- Physician Assistant
- Nurse Practitioner
- Physician

Alternative 2: Paramedic and one of the following:

- CFRN/CTRN/CCRN/CEN (with appropriate adjunctive certifications e.g., ACLS, NRP etc.)
- FP-C, CCP-C (CCP)
- Respiratory Therapist
- Physician Assistant
- Nurse Practitioner
- Physician

Alternative 3: As a measure of last resort, in cases where CCT providers are unavailable AND delay in transfer would have a significant negative impact on patient outcome, crew configurations not listed above may be utilized provided that:

- The sending facility makes reasonable effort to send appropriate personnel.
- An occurrence report is sent via email Vermont EMS and to the local District Medical Advisor (DMA) within 24 hours.
- All interventions are within the scope of practice of the assembled crew.
- Nothing shall preclude the transferring facility or transporting agency from sending additional providers not listed above if they feel it is appropriate for continuing patient care.

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Definitions

Unstable Patient: A critically ill or injured patient who cannot be stabilized at the transporting facility, who is deteriorating or likely to deteriorate during transport. (From "Guide for Interfacility Patient Transfer," NHTSA.)

Potentially Unstable: A critically ill or injured patient who is currently stable (as defined below) but whose disease process will likely lead to instability or an acute change in condition enroute.

Stable Patient: Hemodynamically stable patient with a secure airway and who is **NOT** in acute distress or likely to deteriorate during transport

Resources: Could refer to personnel, equipment, medications or therapies.

Sufficient & Appropriate: Transferring facilities are responsible for the coordination of ongoing care during transfer until the patient arrives at the destination facility. In certain Air Medical Transport services or ground critical care units, the transport unit may function as an extension of a tertiary care center and operate under that facility's medical direction and on-line medical direction. Patient must continue receiving care that is commensurate with their condition and potential for deterioration throughout transfer within the limits of the system. This may mean providing additional transferring facility or transporting agency personnel, up to and including physicians if necessary.

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Prerequisite Protocol 7.x

Transport Levels

EMT Stable	AEMT Stable	Paramedic Potentially Unstable	Critical Care Paramedic Unstable
❑ EMT therapies ❑ EMT medications ❑ Vital signs ❑ Temperature monitoring ❑ Foley catheter ❑ Suprapubic catheter ❑ Feeding tube with no need to access or adjust ❑ Saline lock ❑ Maintenance of stable, long term ventilated patients with any mode of ventilation so long as the patient is familiar and capable of operating the equipment OR patient is accompanied by a care provider who is capable of the same	❑ AEMT therapies ❑ AEMT Medications ❑ Any crystalloid infusion ❑ Patient-controlled analgesic (PCA) pump that is locked ❑ Cardiac monitoring for cardiac arrest arrythmias only (See AEMT section of this protocol.) ❑ CPAP ❑ $ETCO_2$	❑ Paramedic therapies ❑ Paramedic medications ❑ Any infusion started prior to departure ❑ Any medication on the EMS formulary that was started as an infusion prior to departure may be continued, including antibiotics and insulin ❑ Max 1 vasopressor ❑ Continuation of blood or blood products ❑ Cardiac monitoring of 4 lead ECG with anticipated need for ACLS intervention ❑ Serial 12 leads ❑ Chest tube maintenance ❑ Invasive monitoring equipment which has been capped/locked and labeled for transport ❑ Epidural catheter if secured, capped, and labeled **The following require a SECOND provider in the patient compartment:** ❑ Active transcutaneous pacing ❑ Cardioversion ❑ Deep suctioning ❑ Automated Transport Ventilator - ATV (Stable intubated patient) May only adjust rate, tidal volume, and adult vs. child settings, if applicable ❑ RSI/DSI (requires credentialing)	Including but not limited to: ❑ Multiple vasoactive medications/pressors ❑ Initiation of additional blood products ❑ Initiation of additional antibiotics or antivirals ❑ Initiation of insulin infusion ❑ Managing uncorrected shock. ❑ Continuation of invasive monitoring. ❑ Continuation of balloon pump/impella pump (requires waiver) ❑ Transvenous pacing. ❑ NPPV (BiPAP) ❑ Intubated/ventilated patients ❑ Complex patients may require additional staffing resources (see below) Critical Care Transport Team Options: • CCT (Air/Ground) • CCP & at least one of the following: ○ 1 CFRN/CTRN **or** ○ 1 CCRN/CEN **or** ○ 1 NP/PA **or** ○ 1 FP-C/CCP-C **or** ○ 1 Respiratory Therapist **or** ○ 1 Physician • Paramedic & at least one of the following: ○ 1 CFRN/CTRN **or** ○ 1 CCRN/CEN **or** ○ 1 NP/PA **or** ○ 1 FP-C/CCP-C **or** ○ 1 Respiratory Therapist **or** ○ 1 Physician • Last resort ○ Any other appropriate crew