Resources and Guidelines for the Triage and Transfer of Trauma Patients

Utah Department of Health
Bureau of Emergency Medical Services

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Field Triage Decision Scheme

Measure vital signs and level of consciousness

Step One

Glasgow Coma Score	<12 or
Systolic blood pressure, mm Hg	<90 or signs and symptoms of shock in pediatric patients; or
Respiratory rate, /min	<10 or >29 (<20 in infant less that 1 yr)

Yes

Transport to Level I or II Trauma Center. If < 15 years, transport to pediatric-designated Level I or II trauma center. Steps 1 and 2 attempt to identify the most seriously injured patients in the field. These patients should be transported to the highest level of care readily available. If that level of care is a Trauma Center, transport immediately. If a trauma center is not readily available, transport to the closest facility for resuscitation, stabilization and transfer to an appropriate trauma center.

No

Assess Anatomy of Injury

Step Two

- All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee
- Flail chest
- Two or more proximal long-bone fractures
- Crush, de-gloved, or mangled extremity
- Amputation proximal to wrist and ankle
- Pelvis fractures
- Open or depressed skull fracture
- Paralysis

Yes

Transport to Level I or II Trauma Center If < 15 years, transport to pediatric- designated Level I or II trauma center. Steps 1 and 2 attempt to identify the most seriously injured patients in the field. These patients should be transported to the highest level of care readily available. If that level of care is a Trauma Center, transport immediately. If a trauma center is not readily available, transport to the closest facility for resuscitation, stabilization and transfer to an appropriate trauma center.

No

Assess Mechanism of Injury

Step Three

- Falls Mechanism plus physiologic criteria present
  - Adults >20 ft (1 story= 10 ft) or falls down stairs
  - Children > 10 ft or 2-3 times the height of the child
- High Risk Auto Crash plus physiologic criteria present
  - Significant intrusion: > 12 in, occupant site; > 18 in, any site
  - Ejection (partial or complete) from automobile
  - Death in same passenger compartment
  - Vehicle telemetry data consistent with significant injury, i.e., rollover
- Auto vs pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact
- Motorcycle crash >20 mph with physiologic criteria present

Yes

- Transport to closest appropriate trauma center or specific resource hospital. Contact Medical Control per agency protocol & **EMS provider judgment**

No

Assess special patient or system

Step Four

- Age
  - Older adults: Risk of injury/death increases after age 55
  - Children <15 yrs: Should be triaged preferentially to pediatric designated trauma centers
- Anticoagulant and bleeding disorders
- Burns- > 10% second or third degree
- Time-sensitive extremity injury
- End-state renal disease requiring dialysis
- Pregnancy>20 weeks
- **EMS provider judgment**

Yes

Contact Medical Control and consider transport to trauma center or a specific resource hospital.

No

Transport according to protocol

Utah Bureau of Emergency Medical Services
Designated Trauma Centers

Level I Trauma Centers

University of Utah
50 North Medical Drive
Salt Lake City, Utah 84132
801-587-8980
Trauma Program Manager, Janet Cortez, RN
801-581-2622

Intermountain Medical Center (Provisional)
5121 South Cottonwood Drive
Murray, Utah 84157-7000
801-507-6600
Trauma Program Manager, Sue Day, RN
801-507-6689

Primary Children's Medical Center
100 North Medical Drive
Salt Lake City, Utah 84113
801-588-2293
Trauma Program Manager, Kris Hansen, RN
801-588-2238

Level II Trauma Centers

Ogden Regional Medical Center
5475 S. 500 E.
Ogden, Utah 84405
801-479-2376 888-372-6762
Trauma Program Manager, Deanna Wolfe, RN
801-479-2318

McKay Dee Hospital and Medical Center
3939 Harrison Blvd
Ogden, Utah 84403
801-387-7000
Trauma Program Manager- Kathy Calton, RN
801-387-2054

Utah Valley Regional Medical Center

1034 North 500 West
Provo, Utah 84604
Trauma Program Manager, Jean Lundquist, RN
801-357-7555

Level III Trauma Centers

Logan Regional Hospital

1400 North 500 East
Logan, Utah 84342
435-716-1000
Trauma Coordinator, Roxanne Kondradt, RN
435-716-5617

Dixie Regional Medical Center

1380 East Medical Center Drive
St. George, Utah 84790
435-251-1020
Trauma Coordinator, Jan Call, RN
435-251-1084

Level IV Trauma Centers

Allen Memorial Hospital

719 West 400 North
Moab, Utah 84444
Trauma Coordinator Nancy Chartier, RN
435-259-7191

Bear River Valley Hospital

440 West 600 North
Tremonton, Utah 84337
435-257-7441
Trauma Coordinator, Curtis Hughes, RN
435-257-4335

Uintah Basin Medical Center

250 West 300 North
Roosevelt, Utah 84066
435-722-4691
Trauma Coordinator, Roger Burton, RN
435-722-4691 x1486

Hospitals submitting Letter of Intent for Trauma Center Designation
(in process but not designated)

Level III

Timpanogos Regional Hospital
750 West 800 North
Orem, Utah 84057
(801) 714-6000

Mountain View Hospital
1000 East 100 North
Payson, Utah 84651
(801) 465-7000

Level V

Delta Community Medical Center
126 South White Sage Avenue
Delta, Utah 84624
(435) 864-5591

Fillmore Community Medical Center
674 South Highway 99
Fillmore, Utah 84631
(435) 734-5591

Utah Department of Health
Bureau of Emergency Medical Services
Trauma Resource Directory

Hospital	Designated Trauma Center	ER Physician Staffed 24/7	Neuro-surgery Available 24/7	Pediatric ICU 24/7	Trauma Orthopedics 24/7	Intensive Care Unit 24/7	Radiology Available 24/7	CT 24/7	Lab Available 24/7
Designated Trauma Centers									
University of Utah	Level I	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Intermountain Medical Center	Level I	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Primary Children's	Level I	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
McKay Dee	Level II	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Ogden Regional	Level II	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Utah Valley Regional	Level II	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Dixie Regional Medical Center	Level III	Yes	No	No	Yes	Yes	Yes	Yes	Yes
Logan Regional	Level III	Yes	No	No	Yes	Yes	Yes	Yes	Yes
Allen Memorial	Level IV	Yes	No	No	On Call	No	Yes	Yes	Yes
Bear River Valley	Level IV	20 Min	No	No	No	No	On Call	On Call	On Call
Uintah Basin Medical Center	Level IV	Yes	No	No	Yes	No	On Call	On Call	On Call
Resource Hospitals									
Alta View	No	Yes	No	No	No	Yes	Yes	Yes	Yes
American Fork	No	Yes	No	No	No	Yes	Yes	Yes	Yes
Ashley Valley	No	No	No	No	No	Yes	On call	On call	On call
Beaver Valley Hospital	No	On Call	No	No	No	No	On call	On call	On call
Brigham City Community	No	Yes	No	No	No	No	Yes	Yes	Yes
Central Valley	No	On Call	No	No	No	No	Yes	On Call	Yes
Cottonwood	No	Yes	No	No	No	Yes	Yes	Yes	Yes
Cache Valley Specialty	No	Yes	No	No	No	No	Yes	Yes	Yes
Castleview	No	Yes	No	No	No	Yes	Yes	Yes	Yes
Davis Hospital	No	Yes	No	No	No	Yes	Yes	Yes	Yes
Delta Community	No	On Call	No	No	No	No	On Call	On Call	On Call
Dixie Regional	No	Yes	No	No	No	Yes	Yes	Yes	Yes
Fillmore Community	No	On Call	No	No	No	No	On Call	On Call	On Call
Garfield County	No	On Call	No	No	No	No	Yes	On Call	On Call
Gunnison Valley	No	On Call	No	No	No	No	Yes	Yes	On Call
Heber Valley	No	On Call	No	No	No	No	Yes	On Call	On Call
Jordan Valley	No	On Call	No	No	No	Yes	Yes	Yes	Yes
Kane County	No	On Call	No	No	No	No	Yes	Yes	Yes
Lakeview	No	Yes	No	No	No	Yes	Yes	Yes	Yes
LDS Hospital	No	Yes	No	No	No	Yes	Yes	Yes	Yes
Milford Valley	No	No	No	No	No	No	No	No	No
Mountain West	No	Yes	No	No	No	Yes	Yes	Yes	Yes
Mountain View	No	Yes	No	No	No	Yes	Yes	Yes	Yes
Orem Community	No	Yes	No	No	No	No	Yes	Yes	Yes
Pioneer Valley	No	Yes	No	No	No	Yes	Yes	Yes	Yes
St. Marks	No	Yes	No	No	No	Yes	Yes	Yes	Yes
Salt Lake Regional	No	Yes	No	No	No	Yes	Yes	Yes	Yes
San Juan Hospital	No	On Call	No	No	No	No	Yes	Yes	Yes
Sanpete Valley	No	Yes	No	No	No	No	On Call	On Call	On Call
Sevier Valley	No	On Call	No	No	No	No	Yes	Yes	Yes
Timpanogos Regional	No	Yes	No	No	No	Yes	Yes	Yes	Yes
Valley View Medical Ctr	No	Yes	No	No	No	Yes	Yes	Yes	Yes
VA Medical Center	No	Yes	No	No	No	Yes	Yes	Yes	Yes

How to Initiate a Referral and Transport

A transfer should be initiated any time the trauma patient requires care beyond the capacity of the referring facility.

1. The referring physician should contact the receiving referral center, and the receiving physician must confirm that the admission is accepted.
2. Once acceptance of the patient is confirmed, mode of transport is considered by the referring and receiving physicians based on:
    a) Patient's medical needs during transport; and
    b) Need to minimize out-of-hospital transport time.
3. If a helicopter is the indicated mode of transport:
    a) The sending facility will arrange air transportation (preferably in consultation with referral center). The sending facility is deemed ultimately responsible for decisions regarding the mode of transfer.
    b) The following patient information should be provided:
        - Approximate weight and age
        - Mechanism of injury
        - Suspected major injuries or medical condition
        - Status of other family members that may be injured and location if known.
        - Level of consciousness and airway status
        - History, including medications
        - Most recent vital signs
        - Ongoing therapies
        - Specialized equipment, e.g. isolette, ventilator, etc.
        - Call back number
        - Referring facility and physician

4. If an ambulance is the indicated mode of transport:
    a) The referring hospital will contact an appropriately licensed ambulance service of its choice that is capable of providing the level of care required.
    b) If the patient requires a level of care during transport outside the scope of practice of the ambulance staff, the hospital should provide for a supplemental provider capable of providing the care required.
5. A copy of all medical records must be sent with the patient and include the following:
    - Physician notes
    - Nursing notes
    - Medication and fluid records
    - Copies of X-rays
    - Laboratory results

PROMPT TRANSPORT

Do not delay transport while awaiting laboratory or radiology results. Results can be communicated by phone/fax as they become available. Where available, tele-health communication is encouraged.

GUIDELINES FOR TRANSFER OF THE ADULT TRAUMA PATIENT

Patients with severe multiple system injury from any location in the state are candidates for referral to a Level I or Level II Trauma Center. Transfer patients to the closest appropriate level trauma center based on specialty medical care needs and resources required for patients' injuries.

INDICATIONS FOR TRANSFER
Adults with one or more of the following:

A. Severe multiple injuries (2 or more systems), severe single system injury, or CNS injury or head trauma.

B. Cardiac or major vessel injuries

C. Injuries with complications (e.g., shock, sepsis, respiratory failure, cardiac failure)

D. Severe facial injuries

E. Severe orthopedic injuries, i.e., unstable pelvic ring disruption, Open long-bone fractures, or fractures with loss of distal pulse.

F. Co-morbid factors (e.g., Age>55 years, cardiac or respiratory disease, insulin-dependent diabetes, morbid obesity)

G. Injuries beyond the treatment capacity of the community hospital.

H. Second or Third degree burns covering more that 10% of TBSA.

GUIDELINES FOR TRANSFER OF THE PEDIATRIC PATIENT

REASONS FOR TRANSFER TO A PEDIATRIC TRAUMA CENTER

1. Trauma - any of the following:
    - a. Multiple-system injury (two or more systems)
    - b. Penetrating wounds
        - (1) Head
        - (2) Chest
        - (3) Abdomen
    - c. Cardiac or major vessel injury
    - d. Massive maxillofacial trauma
    - e. Spinal injury with or without deficit
    - f.. Severe head injury
        - (1) Glasgow Coma Scale score (GCS) less than or equal to 12 (patient does not open eyes or talk)
        - (2) Deteriorating GCS regardless of score
        - (3) Penetrating wound
        - (4) Depressed skull fracture or open head injury
        - (5) CSF leak–otorrhea or rhinorrhea
        - (6) Focal or lateralizing signs, i.e. posturing
        - (7) Intracranial hemorrhage
    - g. Single-system injury that cannot be managed by the community hospital
2. Burns: **(Contact Burn Center for possible direct admit)**
    - a. Second- and third-degree burns greater than 10% total body surface area
    - b. Burns involving face, hands, feet, or perineum
    - c. Electrical burns
    - d. Chemical burns
    - e. Suspected inhalation injury
    - f. Circumferential burns
3. Evidence of shock
    - a. Hypotension
    - b. Mottled, cold, pale extremities
    - c. Tachycardia
    - d. Thready pulse
    - e. Tachypnea
    - f. Decreased level of consciousness
    - g. Urine production less than 0.5 ml/kg/hr
    - h. Metabolic acidosis (pH less than 7.2)

4. Any seriously ill child who cannot be managed in the community hospital

- Patients with carbon monoxide toxicity and no major burns should be considered for hyperbaric oxygen treatment.

TREATMENT GUIDELINES FOR TRANSPORT OF THE PEDIATRIC PATIENT

NOTES: These steps are guidelines in the assessment and stabilization of a pediatric trauma patient. Not all of these steps need to be accomplished prior to transfer of a patient to a trauma center. Call the pediatric trauma center for consultation/transfer as early as possible after considering that a patient may need care in a trauma center.

Newborns may require modification of these guidelines.

1. Children should receive 100% oxygen during transport.
2. Children transported with an ETT will have a gastric tube to suction.
3. Children should be transported with a patent IV/IO.
4. Children receiving aminophylline or other continuous-drip medications must have the IV rate regulated by an infusion pump.
5. In general, children under 5 kg will be transported in an isolette to prevent hypothermia. Dependent on the particular patient, involvement of the neonatal transport nurse may be requested.
6. It is especially important to maintain body temperature in children. Patients should be kept warm with blankets and heat.
7. The transport service must be notified of the transport of any child with a potentially infectious disease.

EYE TRAUMA

INTRODUCTION

The main objective of the system is to provide optimal clinical management of severe ocular injuries.

INDICATIONS FOR TRANSFER

1. Serious eye injury, including but not limited to:
    - A. Open globe (penetrating or rupture)
    - B. Chemical burns of the eye
    - C. Peri-orbital trauma
    - D. Intraocular foreign bodies (foreign material inside the eye, not on the surface)
2. Individualized consultations are available for any other eye injuries.
3. Patients with isolated eye injuries, who are medically stable.

NOTE: Patients with other significant trauma should be transported to the appropriate facility for stabilization before transfer to an eye center.

STABILIZATION PROCEDURES/PREPARATION FOR TRANSPORT

1. Protect eye with an eye shield ONLY.
2. DO NOT remove impaled objects. Stabilize in place.
3. Chemical injuries should receive continuous irrigation (if strong alkaline or acid, attempt to determine initial pH of the eye):
    - A. Water, sterile water, or normal saline
    - B. Send specimen of chemical with patient.
4. Keep patient NPO.

TRANSPORT PATIENT with:

1. Copy of medical record
    - A. Treatment rendered (including medications).
    - B. Laboratory and x-ray results available.

    Send copies of X-rays and CT scans if obtained prior to transport.

    DO NOT delay transport awaiting results.

2. Eye shield
3. Specimens of chemical agent, if indicated

HAND/UPPER EXTREMITY TRAUMA

INTRODUCTION

The following guidelines are intended to aid in decision-making, with the understanding that appropriate consultation should be obtained if there is a question as to referral.

INDICATIONS FOR TRANSFER

1. Primary considerations
    A. Presence of isolated injury to the upper extremity
    B. Complex hand injury
    C. Stability of the patient
2. Major upper extremity trauma
    A. Complex hand injury involving bones, tendons, nerves
    B. Complete or incomplete upper extremity amputation
    C. De-gloving, crushing, de-vascularization injuries
3. Major lower extremity trauma. (Toe injuries are NOT candidates for microsurgery or referral.)
    A. De-gloving, crushing injury without suspicion of major long-bone fracture
    B. Clean-cut amputation of a foot of a child. (There are very few indications for re-implantation of any portion of a lower extremity because of the risks to the patient compared with the potential benefit. Children with foot amputations are candidates for referral.)
    C. Clean-cut amputation at the ankle (child or adult)
    D. Patients with amputation above the ankle. (There is an occasional situation in which the part can be re-implanted or converted from an above-knee to a below-knee amputation in order to preserve knee function.)

STABILIZATION PROCEDURES/PREPARATION FOR TRANSPORT

1. Total patient assessment
    A. Assess for evidence of other trauma. If the patient is stable, follow emergency care instructions below while consultation and preparation for transport are accomplished.
2. Emergency care
    A. DO NOT wash, rinse, scrub, or apply antiseptic to extremity. Apply dry sterile dressing, wrap in Kling or Kerlix, apply pressure, elevate, and cool.
    B. DO NOT wash, rinse, scrub, or apply antiseptic solution to the severed part.
        1) Wrap in dry sterile gauze or toweling (depending on size). Package amputated extremity in sealed plastic bag and place ON TOP OF coolant bags or sealed bag of ice in a container (Styrofoam).

THE AMPUTATED PART MUST NOT BE SUBMERGED IN ICE WATER. If the ice melts, replace it with another bag of ice.

C. For partial amputation:

1) Place severed part(s) in a functional position.
2) Apply dry sterile dressing.
3) Splint.
4) Elevate extremity.
5) Apply coolant bags or ice bag to the outside of the dressing.

D. If possible, control bleeding with pressure. If tourniquet is necessary, place it close to the amputation site.

E. Consider appropriate pain medication.

TRANSPORT PATIENT with:

1. Copy of medical record including:
   A. X-ray and laboratory results.

DO NOT delay transport while awaiting results.

   B. Documentation of medications given:

1) Tetanus prophylaxis
2) Antibiotics
3) Pain medications

2. Extremity and/or part:
   A. Elevated and cooled.
   B. Splints, as necessary.

NEUROTRAUMA TRANSFER GUIDELINES
HEAD INJURIES SPINE INJURIES

This section provides guidelines for the stabilization and transport of patients with head and spinal cord injuries. Its purpose is to expedite the transfer of appropriate patients to the closest **Level I or Level II Trauma Center**, which is the specialty referral center for these injuries. Patients who are under 15 years of age should be transported to a pediatric trauma center.

INDICATIONS FOR HEAD INJURY TRANSFER
Presence of any one symptom below:

1. Patients with deterioration in level of consciousness
2. Severely head-injured patients (Glasgow Coma Scale score <12)
3. Patients with focal or lateralizing signs, such as hemiparesis or posturing
4. Patients with penetrating cranial injury, including gunshot wounds or depressed skull fractures
5. Patients with cerebrospinal fluid leak: rhinorrhea or otorrhea
6. Seizures within 48 hours of trauma
7. Inability to perform immediate rapid neurosurgical pre-operative studies, intracranial monitoring, or neurosurgical operation that is or is likely to be necessary in management of the patient
8. Moderate head injury patients who may require other procedures or prolonged anesthesia (Glasgow Coma Scale scores of 12 or less)

INDICATIONS FOR SPINE INJURY TRANSFER

Presence of any one symptom below:
1. Adult spinal cord injuries
2. Patients with suspected spinal injury, whose level of consciousness is deteriorating
3. Patients with possible spinal fractures or dislocations that are unstable or need stability evaluation
4. Patients with neurological deficits
5. Patients with penetrating spinal injury, including gunshot or stab wounds
6. Patients with documented stable or unstable spinal column injuries with or without neurologic deficit
7. Inability to rapidly reduce fractures compressing the spinal cord by closed and/or surgical techniques

EMTALA

The Emergency Medical Treatment and Active Labor Act (EMTALA) became effective in 1986 as a federal law as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). It applies to hospitals receiving federal funding from Medicare and offering emergency care and physicians providing services in such hospitals. The purpose of EMTALA is to insure that patients with an emergency medical condition are assessed and treated at any hospital providing emergency services without consideration of ability to pay. It is sometimes referred to as the "anti-dumping" law.

EMTALA places certain conditions and affixes certain responsibilities in connection with inter-hospital patient transfers under certain circumstances. At the outset, it is important to remember that duties imposed by EMTALA are in addition to traditional state law requirements that patients be transferred in accordance with the standard of medical care applicable in a given situation. A patient must always be transferred under the conditions that a reasonably prudent physician of like skill and training would require.

The general principles of EMTALA, as of January 2001, are briefly outlined below. The contours of EMTALA continue to evolve in the courts, and legal counsel should be consulted and the full statutory and regulatory materials reviewed to understand how EMTALA might impact a particular situation at any given time. Under current applicable Centers for Medicare and Medical Services (CMS) guidelines, a hospital offering emergency care is required to comply with EMTALA, regardless of whether it operates an emergency room as such.

Additionally, federal courts have held that the transfer requirements of EMTALA apply to any patient who comes to a hospital and who has an emergency condition even if the patient did not present at the emergency room. Thus if a patient were admitted for an elective procedure and developed an emergency condition, under this interpretation, EMTALA would apply to an inter-hospital transfer of the patient. Regulations effective January 10, 2001 expand the geographic area in which a hospital becomes responsible for EMTALA compliance. Under the new regulations a patient is on hospital property when the patient is on the main hospital campus which is defined as the physical area immediately adjacent to the main buildings as well as other areas within 250 yards of the main buildings and any other areas determined on an individual case basis by the CMS regional office.

Under the regulations, hospital property also includes the hospital’s parking lots, sidewalks, and driveways plus certain facilities located off campus. A patient is on hospital property when in an ambulance owned and operated by the hospital or when in any ambulance when it is on the hospital campus. A recent case from the United States Court of Appeals for the Ninth Circuit has interpreted the EMTALA regulations to mean that a patient has come to a hospital for purposes of EMTALA once an ambulance carrying the patient radios a hospital that it is en route to the hospital. Under the ruling in that case, a hospital is not able to redirect a patient who is en route unless the hospital is on "diversionary status" (lacks the staff or facilities to accept any additional emergency patients). Receiving hospitals are required to report violations of the EMTALA transfer.

Rendezvous between an EMS and helicopter on the hospital helipad does not constitute EMTALA violation unless hospital medical personnel are requested to assist in patient care and refuse to assist.

SCREENING EXAMINATION

EMTALA requires that a hospital offering emergency care provide a screening examination to any individual who comes to hospital property (including ambulances owned and operated by the hospital) requesting examination or treatment of a medical condition. The examination must be

within the hospital's capabilities and conducted by individuals determined qualified in the hospital's by-laws or rules and regulations and who meet the emergency services requirements of hospitals participating in Medicare.

ABILITY TO PAY MUST NOT INTERFERE

At no time should any effort be made to determine the patient's ability to pay for or cover by insurance the costs of the EMTALA requirements. The most current notice from CMS and Office of Inspector General proposes to require that the hospital employ properly trained staff members to respond to patient inquiries about costs in an effort to make certain the patient realizes the extent to which EMTALA procedures are available without cost.

EMTALA STABILIZATION REQUIREMENT

If it is determined that an emergency medical condition exists, either by means of a screening examination or otherwise, the hospital must either provide treatment within the capabilities of the staff and facilities available at the hospital to stabilize the condition or transfer the patient to another medical facility which can and has agreed to provide appropriate care.

If a patient refuses treatment or transfer, EMTALA provides specific requirements for documenting the circumstances of a refusal and the fact that the patient was properly informed of the risks and benefits. Samples of such documentation are attached. Before any forms are implemented, the proposed procedure for using such forms should be reviewed with counsel to insure appropriateness in a given situation.

EMTALA REQUIREMENTS BEFORE A PATIENT CAN BE TRANSFERRED

In general, if a hospital is aware that a patient is experiencing an emergency condition, the patient can only be transferred if:

A. The emergency medical condition has been stabilized as required under EMTALA; or

B. The following conditions are met:

1. The transfer is requested in writing by the patient or a legally responsible person acting on the patient's behalf after being informed of the hospital's obligations under EMTALA. The request must state the reasons for the request and indicate that the person making the request is aware of the risks and benefits of the transfer;
2. A physician has signed a certification that based upon the information available at the time of the transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or
3. If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its by-laws or rules and regulations) has signed the certification referred to in paragraph 2 above after consultation with a physician who agrees with the certification and countersigns the certification which contains a summary of the risks and benefits upon which it is based.

EMTALA REQUIREMENTS FOR A PATIENT TRANSFER

EMTALA requires that a transfer meet certain requirements. Under EMTALA, the responsibility for meeting these requirements rests with the transferring physician:

A. The transferring hospital must provide medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child.

B. The receiving facility must have available space and qualified personnel for the treatment of the individual and must have agreed to accept transfer of the individual and to provide appropriate medical treatment.

C. The transferring hospital must send to the receiving facility all medical records (or copies) related to the emergency condition available at the time of transfer including:

1. Available history;
2. Records related to the individual's emergency condition;
3. Observations of signs or symptoms;
4. Preliminary diagnosis;
5. Results of any tests;
6. The informed written consent or certification (or a copy) required for transfer;
7. Name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.

D. Records not readily available from the transferring hospital's files must be sent as soon as practicable after the transfer.

E. The transfer must be effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

1. Under EMTALA, Emergency Medical Services providers may not always be qualified to provide the level of care for certain patients being transferred.
2. A patient's condition may make the presence of a physician or some other specialist mandatory.
3. **Under current CMS guidelines, the physician at the sending hospital is responsible for determining:**

    (i) The appropriate mode of transfer (i.e.) ground ambulance, helicopter
    (a) Critical Care ambulance;
    (b) Neonatal Care ambulance;
    (c) Advanced Life Support or Basic Life Support ambulance;

A participating hospital that has specialized capabilities or facilities (including burn units, shock-trauma units, neonatal intensive care units) may not refuse to accept from a transferring hospital an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual. EMTALA is enforced by CMS and by the Department of Health and Human Services' Office of the Inspector General. Investigations are based on complaints, and the limitations period is 2 years for any violation.

Possible penalties for violations are:

- Termination of a hospital's Medicare provider agreement.
- A hospital civil money penalty between $25,000 (for a hospital with less than 100 beds) to $50,000 per violation.

- A physician (including on-call physicians) civil money penalty up to $50,000 per violation.
- The exclusion of a physician from Medicare and Medicaid programs.
- Civil suit by a patient for damages.
- A suit by a receiving facility which suffered loss because of another hospital’s violation of EMTALA.

Sample Form. Review with counsel before using.

Refusal of Examination, Treatment, or Transfer

I understand that the hospital must provide me a medical screening examination to determine whether I have an emergency medical condition, and if I do, to either stabilize the condition or transfer me in an appropriate manner to another facility.

I further understand that the medical screening and stabilization or transfer in connection with an emergency condition must be performed by the hospital without regard for whether I am able to pay or whether I have insurance which will pay part or all of the costs of the examination, treatment, or transfer.

The hospital proposes to perform the following examination, treatment, or transfer:
The hospital has informed me of the following risks and benefits of this proposed examination, treatment, or transfer:

I refuse the examination, treatment, or transfer set forth above for the following reasons:
I understand my refusal is against medical advice and that my refusal may result in serious harm to me including death.

Date: __________

Patient Signature: ____

Patient Name: ____

Date of birth: ____________________

Address: ______________________________________

____

Witness: ____

Sample Form. Review with counsel before using.

Patient Request for Transfer

I understand that the hospital must provide me a medical screening examination to determine whether I have an emergency medical condition, and if I do, to either stabilize the condition or transfer me in an appropriate manner to another facility.

I further understand that the medical screening and stabilization or transfer in connection with an emergency condition must be performed by the hospital without regard for whether am able to pay or whether I have insurance which will pay part or all of the costs of the examination, treatment, and/or transfer.

I understand these obligations of the hospital, and I request a transfer to:

The reasons for my request for a transfer are:

The hospital has informed me that the transfer which I request exposes me to the following risks:

Date: ___________________________

Patient Signature: _____________________________________

Patient Name: _______________________________________

Date of birth: ___________________________

Address: ____________________________

____

Witness: ____

Sample Form. Review with counsel before using.

Certification of Transfer

Patient Name: ____

It is hereby certified that, based upon the information available at the time of transfer, the medical benefits to this patient reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual, and, in the case of labor, to the unborn child, from being transferred.

This certification is based on the following risks and benefits.

Risks:

Benefits:

Name of Certifying Physician: *____

Signature of Certifying Physician: ____

Date: _________________

*If a physician is not physically present in the emergency department at the time of transfer, a qualified medical person (as determined by the hospital in its by-laws or rules and regulations) must consult with a physician and sign the certification below. The physician must subsequently countersign above:

Name of qualified medical person ____

Signature of qualified medical person ____

Name of physician consulted ____

At (time)___________________ on (Date)___________________

Sample Form. Review with counsel before using.

INTERHOSPITAL TRANSFER CHECKLIST

The reason for transfer: ___ higher level of care ___ for specialty care ___ patient request ___ directed by payor

Attending physician written order for transfer on chart ____yes ____no

Reason for transfer has been discussed with patient and/or family ____yes ____no

Consent for transfer has been signed by patient and/or responsible family member ____yes ____no

Medical screening exam provided by: ____

Attending physician has contacted receiving physician ____yes ____no

Name of accepting physician ____

Contact phone numbers: ____

Name of receiving hospital ____

Mode of transport: ____ ambulance ____helicopter _____ private car

Level of care needed during transport ____BLS ___ ALS ___ RN ___ Respiratory

____

Equipment needed for support of patient during transport is available on transport unit. ____yes ____no

Medications and IV fluids needed during transport are with patient. ____yes ____no

Patient's airway and ventilation is being controlled with ____________________________

The following copies of the medical records related to the patient's emergency condition are being provided to the receiving hospital at the time of the patient's arrival:

____ 1. Prehospital care record
____ 2. ED record of care
____ 3. Medical history, if available
____ 4. Results of laboratory studies
____ 5. Copies of radiographs
____ 6. Nursing care records, including I & O documentation and vital signs
____ 7. Doctor's orders for care during transfer
____ 8. Transfer consent form

PROMPT TRANSPORT

Do not delay transport while awaiting laboratory or radiology results. These can be communicated by phone as they become available. Tele-health resources, when available may be used.

Appendix

TRANSFER AGREEMENT

This Agreement is made and entered into by and between **IHC Health Services, Inc., a Utah non-profit corporation, d.b.a. Primary Children's Medical Center (PCMC)** and **<<<Name of Hospital>>>, a <<<Hospital location>>> non-profit corporation.**

WITNESSETH:

WHEREAS, the parties desire to promote more efficient and effective patient care through routine transfers of appropriate patients between their institutions; and

WHEREAS, the parties desire to fulfill their obligations under state and federal law with regard to transfer of patients between facilities; and

WHEREAS, the parties wish to establish a coordinated and cooperative program for the use of skills, resources, and physical plant of both parties to provide improved and continuous pediatric patient care, and

WHEREAS, the parties desire to state fully their agreement in connection with the transfer of patients between facilities;

NOW, THEREFORE, in consideration of the mutual covenants set forth herein, the parties agree as follows:

1. Effective Date: This Agreement shall commence upon **<<<Effective Date>>>,** and continue in effect until terminated as provided in paragraph seven (16) below.

2. Decision to Transfer: A patient in the Transferring Facility may be transferred to PCMC upon the decision of the attending/transferring physician that transfer is appropriate, provided that the patient is accepted for transfer by the receiving facility. Both facilities will exercise their best efforts to facilitate transfers between their institutions. A patient will be accepted for transfer from the transferring facility provided that a physician on the receiving facility's medical staff has agreed to take the patient and there is a bed available and there is/are qualified personnel to treat the pediatric patient

3. Transfer Protocols: In arranging a transfer, each facility will adhere to the written procedure/protocols adopted from time to time by the receiving facility and disclosed to the transferring facility. Each facility agrees to comply with applicable state and federal statutes and regulations in transferring patients. The transferring facility will not transport a patient without prior approval of the receiving facility.

4. Consent to Transfer: The transferring facility will be responsible to obtain the patient's guardian consent to the transfer to PCMC prior to the transfer if the patient's guardian is available. When obtaining consent, the Transferring Facility will explain the risks and benefits of transfer and transportation to the patient's guardian. If the patient's guardian is not available, transfer must be deemed medically necessary as determined by the Transferring facility.

5. Compliance with EMTALA: Transferring Facility will transfer each patient in compliance with the Emergency Medical Treatment and Active Labor Act of 1985 (42 UCS § 1395dd). In addition the Transferring Facility will designate a receiving physician at PCMC.

6. Transportation of Patient: The transferring facility shall be responsible for securing transportation for patient transfer, including the necessary equipment and personnel to match patient's acuity level during the transport. The transport personnel will provide appropriate medical care as determined by the patient's acuity level. In the absence of a state guideline, responsibility for the pediatric patient rests with the Transferring Facility and transferring physician up to arrival at PCMC.

7. Discrimination: Conditions appropriate for transfer are to be applied uniformly by the referring facility and PCMC without discrimination by reason of patient's race, religion, age, national origin, sexual orientation, handicap or medical diagnosis, or financial status.

8. Patient's Medical Records: Transferring Facility will send with each patient at the time of transfer an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption; including a discharge summary together with essential identifying and administrative information. The information accompanying the patient will include:

    a. Copy of signed consent to transfer
    b. Initial diagnostic impression, diagnosis
    c. Patient name, address, age, weight
    d. Name, address and phone number of next of kin
    e. History of injury/illness
    f. Condition at admission
    g. Vital signs, including Glasgow Coma Scale scores – pre-hospital, during stay in emergency department, and at time of transfer
    h. Laboratory and x-ray findings, appropriate laboratory specimens, and copies of all x-ray films
    i. Fluids, given by type, volume and time
    j. Name, address and phone number of physician referring the patient
    k. Name of physician at PCMC who has been contacted about the patient
    l. Name, address and phone number of patient's designee who is patient's attorney-in-fact under patient's healthcare power of attorney or a copy of the patient's healthcare power of attorney, living will or patient's healthcare directive
    m. Personal belongings of the patients

    Information not available at the time of transfer shall be provided to PCMC in a timely manner.

9. Family Centered Care: Whenever possible, the Transferring Facility should provide the guardians of the pediatric patient with the following:
    a. The name, address, and phone number of PCMC
    b. The name, address and phone number for the receiving physician.

10. Transfer Reciprocity: Patients transferred to PCMC may be referred back to Transferring Facility for continued medical care when medically appropriate. The referring physician and institution agree to accept the patient for the required care.

11. Feedback: A mechanism exists to encourage PCMC as appropriate to deliver feedback to the Transferring Facility and transporting agency about individual patient care and outcomes, as necessary for performance improvement.

12. Billing: All bills incurred with respect to any services performed by either facility shall be billed and collected by the facility providing such services. The cost of transporting the patient, including any equipment or personnel required, shall be borne by the transferring facility.

13. Confidentiality: Both parties agree that confidentiality of the patient's medical records and related inter-hospital documents regarding patient care, results of peer review of patient's care by PCMC, including care provided prior to patient's arrival at PCMC, must be maintained. Federal Law prohibits the release of any patient information to anyone outside the organization unless required for purposes of treatment, payment, or health care operations, and discussion of Protected Health Information (PHI) within the organization should be limited. Acceptable uses of PHI within the organization should be limited. Both facilities understand that PHI may include written, oral, electronic, or photographic information. If either or both Facilities, at any time, avertedly or not breach the patient confidentiality policies and procedure, they agree to notify the respective Privacy Officer.

14. Patient Belongings: The Transferring Facility will retain accountability for the security of the patient's personal effects that remain in the Transferring Facility at the time of transfer. Likewise, PCMC will assume responsibility for personal effects transferred with the pediatric patient.

15. Advertising: Neither party shall use the name of the other in any promotion or advertising or any form of marketing unless review and approval of the intended use is obtained in writing from the other party.

16. Term of Agreement: This Agreement will continue in full force and effect until terminated by either party. Either party may terminate this Agreement with or without cause upon sixty (60) days prior written notice to the other party or if the other party ceases to be duly licensed by the State of Utah.

17. Liability: Each of the parties hereto shall be responsible only for its own acts and omissions with respect to transfer or receipt of patients pursuant to this Agreement.

18. Amendments: Any amendments to this Agreement shall be in writing and duly executed by both parties.

19. Governing Law: This Agreement is governed by and construed in accordance with the laws of the State of Utah.

20. Entire Agreement, Binding Effect: This Agreement contains the entire agreement of the parties with respect to the subject matter covered by this Agreement. No other agreement, statement, or promise made by one of the party's employee, officer, or agent, which is not contained in this Agreement will be binding or valid.

21. Severability: If any provisions of this Agreement will, for any reason, be held in violation of any applicable law, governmental rule or regulation, the invalidity of the specific provisions herein shall not be held to invalidate the remaining provisions of this Agreement. Such other provisions and the entirety of this Agreement will remain in full force and effect unless the removal of the invalid provision destroys the legitimate purposes of this Agreement, in which event this Agreement will be null and void.

22. Assignment: This Agreement shall not be assigned by either party without the prior written consent of the other part

23. Any and all notices required or permitted to be given, pursuant to this Agreement, shall be in writing and be considered as properly given if mailed by certified, return receipt mail.

Executed by the parties through their duly authorized representatives on this _____ day of ________________.

IHC HEALTH SERICES INC., DBA
PRIMARY CHILDREN'S MEDICAL CENTER
100 North Medical Drive
Salt Lake City, Utah, 84113

By:____________________________________

Title: CEO, Hospital Administrator

Date:____________________________________

Hospital Name:
Address

By:____________________________________
Name

Title:____________________________________

Date:____________________________________

Criteria for Consideration of Transfer*

American College of Surgeons/COT 2006

A. Critical Injuries to Level I or highest regional trauma center
1. Carotid or vertebral arterial injury 2. Torn thoracic aorta or great vessel 3. Cardiac rupture 4. Bilateral pulmonary contusion with PaO_2 to FIO_2 ratio less than 200 5. Major abdominal vascular injury 6. Grade IV or V liver injuries requiring > 6 U RBC transfusion in 6 hours 7. Unstable pelvic fracture requiring >6 U RBC transfusion in 6 hours 8. Fracture or dislocation with loss of distal pulses
B. Life-threatening injuries to Level I or II trauma center
1. Penetrating injury or open fracture of the skull 2. Glasgow Coma Scale score <14 or lateralizing neurologic signs 3. Spinal fracture or spinal cord deficit 4. >2 unilateral rib fractures or bilateral rib fractures with pulmonary contusion 5. Open long bone fracture 6. Significant torso injury with advanced co-morbid disease(such as coronary artery disease, chronic obstructive pulmonary disease, type 1 diabetes mellitus, or immuno-suppression)

RBC indicates red blood cells

Note: It may be appropriate for an injured patient to undergo operative control of ongoing hemorrhage before transfer if a qualified surgeon and operating room resources are promptly available at the referring hospital.

* Resources for Optimal Care of the Injured Patient 2006, Committee on Trauma, American College of Surgeons p. 28

Skills Level Approved by Bureau of EMS

- **EMT-Basic**
  - Vital signs
  - Initial assessment
  - Spinal immobilization
  - CPR
  - Control bleeding
  - Stabilize/immobilize fractures
  - Emergency childbirth
  - Semi-automatic defibrillation
  - Oral suctioning
  - Pocket mask artificial ventilation
  - Bag valve mask ventilation
  - Stoma patient ventilation
  - Oropharyngeal airway insertion
  - Nasopharyngeal airway insertion
  - Oxygen administration, nasal cannula, masks
  - Flow restricted oxygen powered ventilation device
  - Metered dose inhalers -- Patient's Own Medication
  - Aspirin -- Patient's Own Medication
  - Nitroglycerin -- Patient's Own Medication
  - Epinephrine by auto-injector -- Patient's Own Medication
  - Oral glucose*
  - Activated Charcoal*

- **EMT-I** All EMT-Basic plus the following:
  - Focused physical exams
  - Cannulation of peripheral veins
  - Intraosseous needle placement and infusion
  - Drawing blood samples
  - Pulse-oximetry
  - End-tidal CO2 detection
  - Administer medications orally, intramuscularly, subcutaneously, endotracheal
  - Orotracheal intubation
  - Intraosseous infusions in infants and children
  - Interpretation of basic cardiac dysrythmias
  - Defibrillation
  - Extubation
  - Newborn resuscitation
  - Measuring blood sugar levels
  - Aspirin
  - Albuterol Sulfate (Nebulized)
  - Dextrose 50%
  - Epinephrine 1:1000
  - Epinephrine 1:10,000
  - Lidocaine
  - Morphine Sulfate
  - Naloxone

- Nitroglycerine (tablets or spray)
- Lidocaine IV drip
- Isotonic Solution (NS or LR)

- **EMT-IA** All EMT-I plus the following:
  - Administer medications orally, rectally*, intramuscularly, subcutaneously, endotracheal
  - Placement of NG and OG tubes*
  - Foreign body removal in obstructed airways
  - Intraosseous infusions in infants and children*
  - Interpretation of basic cardiac dysrythmias
  - Intraosseous needle placement and infusion
  - Drawing blood samples
  - Oral Intubation (with ET tube and dual lumen airways)*
  - Replace trach tube through stomas*
  - Adenosine *
  - Atropine Sulfate *
  - Diazepam *
  - Furosemide

- **EMT-Paramedic** All EMT-IA plus:
  - Needle jet insuflation
  - Needle Chest Decompression
  - Cricothyrotomy
  - Nasal intubations
  - Cannulation of external jugular veins
  - Subclavian IV access
  - Diphenhydramine *
  - Dopamine *
  - Meperidine *
  - Oxytocin *
  - Promethazine *
  - Sodium Bicarbonate *
  - Ammonia Capsules