

Oregon Pediatric Interfacility Interfacility Transfer Transfer Guideline Toolkit



2014



Oregon Emergency
Medical Services
for Children



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Emergency Medical Services for Children



In 1984 the national Emergency Medical Services for Children (EMSC) program was established to ensure quality of and access to pediatric emergency care in the hospital and pre-hospital setting. Federal grants fund EMSC programs in all 50 states. In compliance with the Government Performance Results Act, ten national Performance Measures assess and address inequities in pediatric emergency care at provider, facility, and statutory levels.

Thank you to Legacy Mt. Hood, Oregon Health and Science University, Samaritan North Lincoln, Sky Lakes, and Good Shepard Hospital for providing copies of their policies, and to the North Carolina, Florida, Maryland, Minnesota, California, National, and Washington EMSC programs for creating publically available resources.

BACKGROUND

Children are the *largest subspecialty* group in the US healthcare system.

27% of ED patients are under 18 years old.

Only **1 in 12** children presents to a Children's Hospital¹



The remainder are seen at the 79% of departments that see <20 pediatric patients a day

In Oregon, 80% of EDs see a low to medium volume of pediatric patients (<1800-4999 patients annually).

All these factors contribute to a need for stream-lined, efficient transfers of pediatric patients.

17.4 million children in the nation live over 60 minutes from trauma care¹

Six eastern Oregon counties have fewer than 6 residents/square mile⁴



78% of Oregon hospitals are designated as rural³

INTERFACILITY TRANSFER GUIDELINES

The national EMSC program recommends that by 2017, 90% of Emergency Departments adopt written **interfacility transfer guidelines** with eight pediatric-specific components^{6,7}.

In 2013, only 44% of Oregon ED's met this goal:

TARGET: 90% of hospitals in the State have written inter-facility transfer guidelines that cover pediatric patients and that include the following components of transfer:

- Defined process for **initiation of transfer**, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communication)
- Process for **selecting the appropriate care facility**
- Process for selecting the **appropriately staffed transport service** to match the patient's acuity level (level of care required by patient, equipment needed in transport, etc.)
- Process for **patient transfer** (including obtaining informed consent)
- Plan for transfer of patient **medical record**
- Plan for transfer of copy of **signed transport consent**
- Plan for transfer of **personal belongings** of the patient
- Plan for provision of **directions and referral institution** information to family⁶



BENEFITS OF GUIDELINE IMPLEMENTATION

Inter-facility transfer guidelines streamline *“timely transfer to a facility with specialized pediatric services”* ⁹



Well-documented processes ensure smooth transitions, increase safety during transfer, and streamline decisions to enable healthcare providers to focus on patient medical and family needs. Consistent procedures enable rapid triage and transfer of critically ill pediatric patients, reducing mortality and morbidity. Written transfer guidelines assist both receiving and referring facilities in daily operation as well as mass casualty or disaster incidents⁸.

According to the *Guide for Interfacility Patient Transfer* by the National Highway Traffic Safety Administration¹⁰, guideline implementation “provides

- Reference for providers based on best practice and evidence-based research
- Direct correlation to improved health outcomes
- Reduced risk of morbidity and mortality
- Easily measured benchmarks for QI
- Improved patient safety
- Comparison and consistency with facilities also using guidelines
- Clear understanding of the capabilities of transfer providers and practices on the part of the physician and public
- Clearly defined expectations and responsibilities”

Transfer guidelines and agreements are not intended to be binding statutes, rather pre-documented best practices suited to your facility, your patients’ needs, and national evidence-based research.

DEFINITIONS AND DATA

Guideline:

Preferred and written suggestion, without force of a standard. Providers and facilities are not held legally responsible for acting at this level. According to the Institute of Medicine, guidelines are **“systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.”**



Inter-facility Transfer Guidelines:

Hospital-specific outlines for procedural and administrative policies related to transfer of critically ill patients to facilities that provide specialized or otherwise unavailable pediatric care⁶.

2013 Pediatric Readiness Project

In 2013, the National EMSC Data Analysis Resource Center assessed 4,146 Emergency Departments across the nation on readiness for pediatric patients, calculating a score out of 100 points. In Oregon, 88% of EDs responded, creating robust data describing Oregon pediatric emergency care. The data displayed herein was self-reported by 50 responding hospitals.

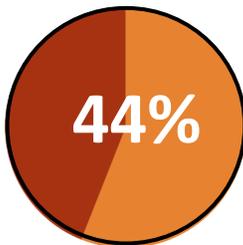
The [Pediatric Readiness Project](#) measures are based on recommendations of the *Joint Policy Statement: Guidelines for the Care of Children in the Emergency Department*⁹.



Oregon facilities with complete transfer guidelines scored 16 points higher than those missing one or more aspects, indicating the correlation between quality pediatric care and robust transfer guidelines.

COMPONENT 1: ROLES

“Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center for requesting transfer and communication”



of Oregon hospitals (22 facilities) do NOT specify this process in written plans



RESOURCE

- ◆ [Maryland EMSC Interhospital Transfer Resource Manual](#), page 15
- ◆ [Minnesota EMSC Pediatric Inter-facility Transfer Guidelines Template](#), page 4

NOTE: TRANSFER AGREEMENTS

The National [IFTG toolkit](#) provides additional information on non-exclusive Transfer Agreements. These agreements do not need to be binding, as explained in the following example clause:

“Nothing in this Agreement shall be construed as limiting the right of either to affiliate or contract with any hospital or nursing home on either a limited or general basis while this agreement is in effect.”



DOWNLOAD [Generic Patient Transfer Agreement](#)

RESOURCE

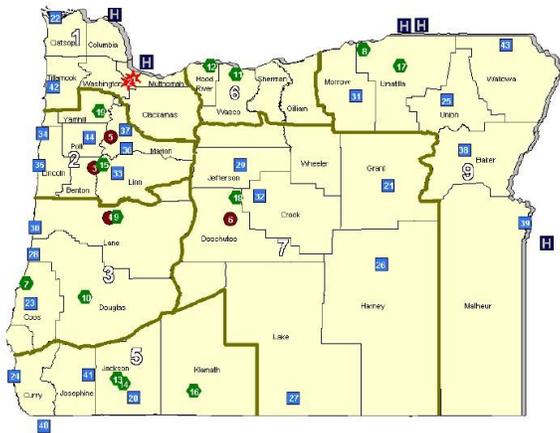
[California Model Pediatric Interfacility Transfer Agreement](#), page 3

COMPONENT 2: FACILITY SELECTION

“Process for selecting the appropriate care facility”

46%

of Oregon hospitals (23 facilities) do NOT specify this process in writing



RESOURCE

[Oregon Trauma Hospital Contact Information](#)

[Oregon Burn Center Transfer Sheet](#)



RESOURCE

- ◆ [Maryland's Interfacility Transfer Resource Manual](#) Trauma: page 53
- ◆ [Washington State Department of Health](#): trauma, critical illness, and burn patients
- ◆ [Minnesota EMSC Guidelines Template](#): physiologic, anatomic, and other criteria requiring advanced non-trauma, trauma, and burns care

Note: EMTATLA

The Emergency Medicine Treatment and Active Labor Act (EMTALA) only applies until the patient is admitted and stabilized, meaning that this performance measure is not automatically met with EMTALA compliance¹⁰. For more information, access the resource [Understanding EMTALA](#).

COMPONENT 3: STAFF AND EQUIPMENT

“Process for selecting the appropriately staffed transport service to match the patient’s acuity level (level of care required by patient, equipment needed in transport, etc.)”

RESOURCE

- ◆ [Montana Guidelines](#), page 5-7
- ◆ [Maryland EMSC Interhospital Transfer Resource Manual](#), page 15
- ◆ [Utah Resources and Guidelines](#), page 11



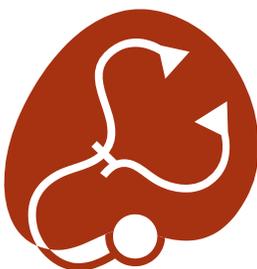
According to the National Highway Traffic Safety Administration¹⁰, evaluation of the patient determines the following provider qualifications:

Stable with no risk of deterioration: Basic Life Support (BLS)

Stable with low risk of deterioration: Intermediate or Advanced Life Support (ALS)

Stable with medium risk of deterioration: ALS or Pediatric Transport Team

Stable with high risk of deterioration or Unstable: ALS and Pediatric Transport Team



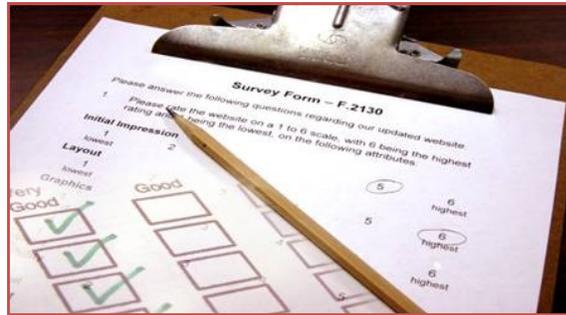
RESOURCE

[Joint Policy Statement on Equipment on Ground Ambulances](#)

The [Guidelines for Pediatric Interfacility Transport Programs](#) authored by the California EMS Authority and [Guidelines for Air and Ground Transportation of Pediatric Patients](#) by the American Academy of Pediatrics Committee on Hospital Care outline necessary equipment for safe transport of pediatric patients.

COMPONENT 4: PROCESS

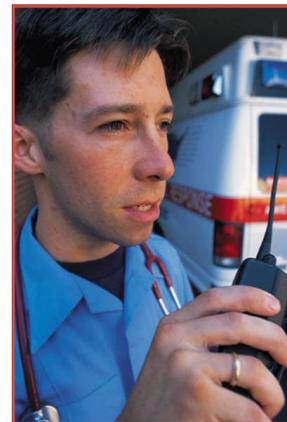
“Process for patient transfer including obtaining informed consent”



Transfer Checklists provide consistent and quality guidance to providers regarding the transfer process itself and the details such as those expressed in Components 5-8.

Transfer Checklist Models:

- Washington [Template for an Inter-facility Transfer Checklist](#), page 7
- Florida [Interfacility Transfer Form](#) , pages 3-4
- [National Toolkit Form](#)



42%

of Oregon hospitals do not have a specified process for transfer in writing

Pediatric Patient Consent Forms

RESOURCE

[Florida EMSC Transfer Consent example](#), pages 5-6

[Maryland Resource Manual](#), page 73

COMPONENTS 5-7: RECORDS, CONSENT, BELONGINGS

“Plan for transfer of patient medical record, copy of signed transport consent, and personal belongings of the patient”



These transfer details are essential to excellent care and can be streamlined through a consistent plan and written checklist.



The Minnesota EMSC Transfer Guideline Template states:

“Documentation shall include at least the following:

- ◆ Identification of the patient
- ◆ Diagnosis
- ◆ Copies of the relevant portions of the patient’s medical, nursing, dietary, laboratory, X-ray, and medication records
- ◆ Relevant transport forms
- ◆ Copy of signed consent for transport of a minor”

RESOURCE

[National Authorization for Transfer Template](#)

Accompanying Documentation (Check Appropriate Items):

<input type="checkbox"/> Emergency Department Record	<input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Lab Tests
<input type="checkbox"/> Medication Record	<input type="checkbox"/> History and Physical	<input type="checkbox"/> EKG
<input type="checkbox"/> X-Ray/Diagnostic Films	<input type="checkbox"/> Copy of Transfer Form	<input type="checkbox"/> Other: _____

Family Considerations

<input type="checkbox"/> Patient belongings given to family	<input type="checkbox"/> Family given directions to accepting facility	<input type="checkbox"/> Patient belongings transferred with patient
<input type="checkbox"/> Name of accepting physician and facility information given to family		

COMPONENT 8: DIRECTIONS

“Plan for provision of directions and referral institution information to family”

The family should be provided with written directions and phone numbers of the receiving unit or ED and accepting physician. This item should be included in the transfer checklist, as in the examples listed in Components 4-7.



RESOURCES

[North Carolina EMSC Inter-facility Transfer Checklist form](#) page 11

Thank you for taking the time to investigate these eight components. While not exhaustive, they represent a common ground of practices and benchmarks that all Oregon hospitals can develop and utilize.

These processes may be common practice at your facility, but we encourage you to develop written documentation for reference, clarity, and consistency. Together we can improve and strengthen Oregon’s capability to care for pediatric patients!



NEXT STEPS

Please contact us at Oregon Emergency Medical Services for Children to continue or begin a conversation about how we can support in the development of Pediatric Interfacility Transfer Guidelines specific to your facility.

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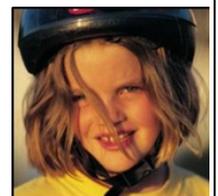
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The National Emergency Medical Services for Children program provides a comprehensive toolkit complete with downloadable samples of Transfer Agreements and Guidelines. This toolkit was developed by a team of ten representatives from the Emergency Nurses Association and the Society of Trauma Nurses and the EMSC National Resource Center.



DOWNLOAD [National EMSC Toolkit](#)



RESOURCES AND REFERENCES

- ¹[Transfer Processes—An Opportunity for Improving Pediatric Emergency Care](#). Dr. Elizabeth Edgerton. 12 Sept 2013, webinar.
- ²[Pediatric Preparedness of United States Emergency Departments: a 2003 survey](#). Gausche-Hill M, Schmitz C, Lewis RJ. *Pediatrics*, 2007.
- ³[Oregon Trauma System Map](#). Oregon Health Authority, EMS and Trauma Systems. 1 Feb 2012.
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- ⁵[Emergency Medical Services for Children](#). Health Resources and Services Administration: Maternal and Child Health.
- ⁶[EMSC Performance Measure Implementation Manual](#). The EMSC National Resource Center, 2009.
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- ⁸[Interfacility Transfer Toolkit for the Pediatric Patient](#). Emergency Medical Services for Children, Emergency Nurse Association Pediatric Committee, Pediatric Special Interest Group of the Society of Trauma Nurses. 2013.
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- ¹¹[Understanding EMTALA](#). Ethics Resource Center, American Medical Association. Powerpoint.
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- ¹³[Maryland Interhospital Transfer Resource Manual](#). Maryland Emergency Medical Services. Nov 2009.
- ¹⁴[EMSC Pediatric Inter-facility Transfer Guidelines Template](#). Minnesota EMSC. November 2012.
- ¹⁵[Pediatric Consultation and Transfer Guidelines](#). Washington State Department of Health, Northwest MedStar Critical Care Transport Service. Feb 2010.
- ¹⁶[State of Pediatric Interfacility Transport](#). Second National Pediatric and Neonatal Interfacility Transport Medicine Leadership Conference. *Pediatric Emergency Care*, Feb 2002.
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- ¹⁹[Joint Policy Statement: Equipment for Ground Ambulances](#). American Academy of Pediatrics, American College of Emergency Physicians, American College of Surgeons Committee on Trauma, EMSC, Emergency Nurses Association, National Association of EMS Physicians, National Association of State EMS Officials. December 2013.
- ²⁰[Transfer of the Pediatric Patient](#): Recommendations of the North Carolina EMSC Advisory Committee Office of Emergency Medical Services. November 2009.

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