

Interfacility Transfer Toolkit

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IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

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February 27, 2019

Greetings Esteemed Colleagues:

The Idaho Emergency Medical Services Physician Commission (EMSPC) and Emergency Medical Services Advisory Committee (EMSAC) are directing significant time and resources into the issue of interfacility transports and critical care transports. To that end, a stakeholder committee was formed, and we are working with organizations, such as the Bureau of Rural Health & Primary Care, Idaho Hospital Association, Idaho Board of Medicine, Idaho Board of Nursing, Emergency Nurses Association, EMS ground and air medical services, and others, to better define, streamline, and encourage the correct level and mode of patient transport.

In March 2018, a survey of Idaho Critical Access Hospitals (CAHs) and transport-licensed EMS agencies was conducted to help define interfacility transport issues. The survey results were enlightening and confirmed some of the realities of interfacility patient transports. The committee discussed opportunities to facilitate collaboration and communication between CAHs and EMS agencies, sending/receiving hospitals, and practitioners, to enhance patient care delivery.

The committee developed a toolkit for CAHs and EMS agencies to help facilitate and enhance the interfacility transfer process. The toolkit includes resources to support informed decision-making and customizable templates to meet your specific interfacility transfer needs. We encourage you to review the toolkit, adopt and adapt the templates, as needed, and implement these best-practice strategies.

Thank you for your commitment to supporting the delivery of safe, timely, and effective patient transfers.

Sincerely,

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Chair, EMSPC

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Interfacility Scope Matrix

Check all that apply:	Intervention	BLS / ILS	RN/ABC	ALS	CCT/Specialty Teams
Patient Type:					
	Transport with Air Medical crew where responsibility for patient care lies solely on the Air Medical crew.	X			
	Stable patient. Requires no special care. May have NG tube, Foley Catheter, gastrostomy tube, or patient controlled device that requires no intervention from transporting personnel.	X			
	Stable patient. Requires cardiac monitoring or may need paramedic level intervention. No reasonable expectation that the patient condition will deteriorate.		X	X	
	Stable patient requiring care outside the EMT scope of practice.		X	X	X
	Patient who is stable but whose condition has a reasonable expectation of deteriorating.				X
	Unstable patient				X
Airway/Breathing Interventions:					
	Oxygen by mask or cannula	X			
	Basic vent management (refer to Ventilator Standards)		X*	X	
	Enhanced vent management				X
IV Access/Medication Administration:					
	Saline lock without additives and not requiring access or flush en route	X			
	Saline Lock without additives. Peripheral IV without additives (D10W, Normal Saline, or Lactated Ringers acceptable).	OM/X			
	Peripheral IV drug infusion with any drug approved by Agency Medical Director - administered without an IV pump		X	X	
	Any Medical Director approved formulary medication that requires an IV pump.		X	OM	X
	IV infusion of any drug outside Medical Director approved ALS formulary.		X		X
	Blood products maintenance		X	X	
	Blood products initiation		X		X
	Central venous access device (capped)	X			
	Central venous access device with fluids infusing		X	X	
	Arterial access device				X
	Pulmonary artery line in place				X
Other Devices:					
	Temporary venous pacemaker		X		X
	Chest tube management		X	X	

RN - Completion of ABC course and credentialed as ABC by medical director

This matrix was adopted from the Idaho EMSPC Standards Manual, this does not replace the Standards Manual. This document was meant for agency and hospital guidance and as a resource.

Transfer Checklist

Date: _____

Patient Name: _____

Reason for Transfer: _____

Medications needed during transport: _____

Special equipment or other needs: _____

Transfer Checklist:

Appropriate crew

BLS / ILS

RN/ABC

ALS

CC/Specialty Team

In addition to
standard crew
configuration

Appropriate equipment and medications

Ventilator

Medication Pump

Ordered Medications

Other: _____

Orders included for RN

Sample Transfer Orders for Ambulance Based Clinicians

1. Code status

- Full Code
- DNR/DNI
- DNR
- Other:

2. Diet

- NPO
- Sips OR ice chips okay
- Other:

3. Telemetry

- Cardiac
- O2 saturation
- Waveform ETCO2
- Ambulance unit
- Hospital unit
- Other:

4. Immobilization

- C-spine motion restriction
- Thoracolumbar motion restriction
- Fractures:
- Other:

5. IV infusion

- NS / LR / D51/2NS _____ at _____ ml/h
- Blood products: _____
- Heparin: _____
- Norepinephrine: _____
- Nitroglycerin: _____
- Other: _____

6. Medications

- Ondansetron: _____
- Morphine: _____
- Norepinephrine: _____
- Nitroglycerin: _____

7. Other:

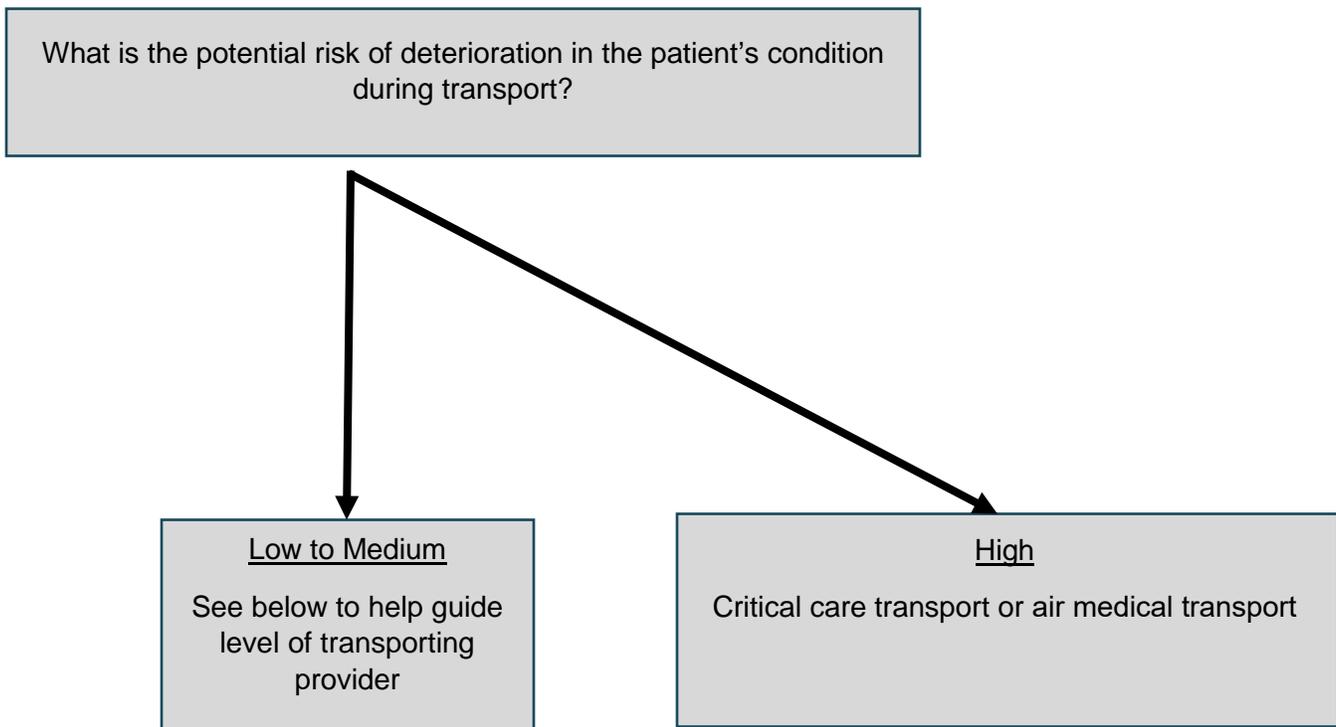
- Other: _____
- _____
- _____
- _____

Hospital Numbers:

Call sending ER physician for medical control

MD signature: _____

Interfacility Transport Decision Tree Sample



When arranging for EMS interfacility transfers, ensure that all relevant patient information has been relayed and there is a clear understanding of the patient's stability and needs.

Conduct provider-to-provider handoff. The following information should be relayed between the sending and receiving physician:

1. Patient age/gender
2. Chief complaint
3. Working diagnosis
4. Current vital signs
5. Current treatments (IV, oxygen, medications and monitors)
6. Potential transport orders (pain management, IV fluids, etc.)
7. Destination facility
8. Precautions needed
9. Special considerations
10. Time frame for transport

Ground Risk Matrix Sample

Ground Transport Risk Assessment	0	1	2	3	4	SCORE
WEATHER	Day	Visiblity > 1 mile		Visiblity < 1 mile but > 1/4 mile	Visiblity < 1/4 mile	
	Night		Visiblity < 1 mile		Visiblity < 1 mile but > 1/4 mile	
ROAD TYPE	4-Lane interstate or City	2-lane Good conditions or mix of 4-lane	Curvy or Narrow 2-lane	Mountainous, Curvy & Narrow		
ROAD CONDITIONS	Clear and Dry	Wet	Light snow/mixed precipitation	Heavy Snow/ Precipitation	Ice/ Heavy drifting snow	
FATIGUE		Last 4 hrs. of shift (< 3 transports prior)	Last 4 hrs. of shift (> 3 transports prior)	Trip extending past 12 hr. shift (< 3 trips this shift)	Trip extending past 12 hr. shift (> 3 trips this shift)	
Additional for out of county calls and weather changes:						
FAMILIARITY	Familiar with Location/ Facility		Limited Familiarityw/ Facility and Location		Not Familiar w/ Facility or Location	
Total Score						

- | | | |
|--|---------------------------|--|
| | 0-4 Low Risk | Normal Operations |
| | 5-7 Medium Risk | Increased Awareness |
| | 8-11 Moderate Risk | <i>(Extreme Caution)</i> ALL Crew members on tranport will meet and discuss ways to reduce/mitigate risk level |
| | 12-17 High Risk | <i>(Consider delaying or turning down transport until risks can be reduced)</i> |
| | 18 + STOP | All Crew members on tranport will meet and discuss ways to reduce/mitigate risk level too include notification of Administrator On Call before accepting transport. |

Code and Rule Regarding EMS Interfacility Transports

1. RNs conducting interfacility transfers in an ambulance as the only ALS provider must be certified as Ambulance Based Clinicians (ABC).

305.AMBULANCE-BASED CLINICIANS -- PERSONNEL REQUIREMENTS.

01. Ambulance-Based Clinician Certified by Department. An EMS agency that advertises or provides out-of-hospital patient care by affiliating and utilizing a currently licensed registered nurse, advanced practice registered nurse, or physician assistant, as defined in IDAPA 16.01.02, "Emergency Medical Services (EMS) - Rule Definitions," must ensure that those individuals maintain a current ambulance-based clinician certificate issued by the Department. See Section 306 of these rules for exceptions to this requirement. (7-1-14) **02.**

Based on the rules above, a Respiratory Therapist does not meet the requirements of a primary provider during transport on an ambulance.

2. What is an ABC?

Obtaining an Ambulance-Based Clinician Certificate. An agency, on behalf of an individual who desires an ambulance-based clinician certificate, must provide the following information on the Department's application for a certificate: (7-1-14) **a.** Documentation that the individual holds a current, unrestricted license to practice issued by the Board of Medicine or Board of Nursing; and (7-1-14) **b.** Documentation that the individual has successfully completed an ambulance-based clinician course; or (7-1-14) **c.** Documentation that the individual has successfully completed an EMT course. (7-1-14)

3. RNs acting as ABCs must be affiliated with the EMS agency that is transporting the patients.

16.01.07.101.AFFILIATION REQUIRED TO PRACTICE.

Licensed EMS personnel must be affiliated with an EMS agency, and only practice under the supervision of the agency medical director as required in IDAPA 16.02.02, "Rules of the Idaho EMS Physician Commission." (3-29-12)

4. RN / ABC is limited to the ILS-level scope of practice for 911 calls, ALS-level for interfacility transfers. If ILS-level agency is utilizing RN's for

ALS-level calls, the agency will need to obtain an ALS Transfer License. Refer to the scope-of-practice matrix in the Physician’s Commission Standards Manual 2018-1 for allowed skills at each level.

16.01.03.305.05. Licensed Personnel Requirements and Ambulance-Based Clinicians. An EMR/BLS, EMT/ BLS, or AEMT/ILS agency may use ambulance-based clinicians to meet the licensed personnel requirements for agency licensure. An ALS agency, licensed with an ALS transfer declaration described in Section 204.04 of these rules, may use ambulance-based clinicians to meet the licensed personnel requirements for the transfer declaration. (7-1-16)

5. The current IDAPA rules do not permit RN / ABC personnel to practice critical care skills on ambulance transports unless they are conducting the transport as an affiliated member of a licensed Critical Care agency that is conducting the transport.

16.01.07.077.01. STANDARDS OF PROFESSIONAL CONDUCT FOR EMS PERSONNEL.

01. Method of Treatment. EMS personnel must practice medically acceptable methods of treatment and must not endeavor to extend their practice beyond their competence and the authority vested in them by the medical director. EMS personnel must not perform any medical procedure or provide medication that deviated from or exceeds the scope of practice for the corresponding level of licensure established under IDAPA 16.02.02, “Rules of the Idaho Emergency Medical Services (EMS) Physician Commission.” (7-1-16)

6. Using the same rules above, it is a violation for an EMS agency to transport a patient whose required care is above the level of their EMS agency license.

IDAPA 16.01.03.200

EMS AGENCY-- LICENSING MODEL.

01. Licensing an EMS Agency. An eligible EMS agency in Idaho is licensed using a descriptive model that bases the agency licensure on the declarations made in the most recent approved initial or renewal application. An EMS agency must provide only those EMS services described in the most recent application on which the agency was issued a license by the Department.

7. An EMS agency that does not have a “Transfer” license declaration is not allowed to conduct interfacility transports. EMS agencies conducting interfacility transfers of patients are required to have a “Transfer”

declaration on their agency license. This can be at the BLS, ILS, ALS, or Critical Care level as specified in the license declaration.

16.01.03.204.04 Transfer. The transfer operational declaration is available to an ambulance agency that provides EMS personnel and equipment for the transportation of patients from one (1) medical care facility in their designated geographic coverage area to another. An agency with this operational declaration must declare which sending facilities it routinely responds to if requested. (7-1-14).

8. What steps do we need to take to be able to legally do interfacility transport of patients using our local EMS agency when the patient requires RN or mid-level on board during transport?

1. Select the RNs or Mid-level personnel who will be transporting the patients and have them officially affiliate with the local ambulance service
2. Have these selected RNs or Mid-levels obtain an ABC certification
3. Have the local EMS agency apply for an ALS Transfer license declaration
4. Transport Medical protocols will need to be created for interfacility transports

EMTALA Decision Tree and Sample Documents



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Avoiding EMTALA Penalties

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In the aftermath of the Affordable Care Act, providers should not forget the original means for extending care to the uninsured: the Emergency Medical Treatment and Active Labor Act ("EMTALA"). Under EMTALA, if a patient comes to a hospital or hospital-owned urgent care center, the hospital and its on-call physicians must provide an appropriate screening exam and, if the patient has an emergency medical condition, provide stabilizing treatment or an appropriate transfer regardless of the patient's ability to pay. 42 U.S.C. § 1395dd; 42 C.F.R § 489.24. Participating hospitals with specialized capabilities cannot refuse to accept the transfer of an unstabilized person. 42 C.F.R § 489.24(f). Physicians—including on-call physicians—who violate EMTALA may be subject to a \$50,000 civil penalty. Hospitals that violate EMTALA are subject to civil penalties of \$25,000 to \$50,000 per violation, lawsuits for damages, and/or exclusion from Medicare. 42 U.S.C. § 1395dd(d).

The following are a few "best practices" to avoid EMTALA liability based on my years of defending EMTALA cases:

1. **Always do what is best for the patient.** In the end, EMTALA is about the patients. So long as you do what is best for the patient, you will not face significant EMTALA liability even if there is an EMTALA violation.
2. **Document, document, document!** In the majority of the actions I have defended, the providers rendered appropriate care consistent with EMTALA, but they failed to adequately document their actions or the bases for their actions. "If it's not in the chart, it didn't happen." Make sure you document your actions and the reasons for your actions. If you discover deficient documentation, correct the record through appropriately designated late entries, supplements, or amendments.
3. **Maintain written policies.** Written policies enable your staff to comply and establish the basis for correction when staff fails to comply. Appropriate policies also help protect you: regulators are less likely to impose penalties against you if a rogue employee violates written policies. Regulators are less sympathetic when you have no written policies. Periodically check your policies against 42 C.F.R. §§ 489.20(r), 489.24, and CMS's corresponding Interpretive Guidelines to ensure the policies track regulatory requirements.
4. **Train and re-train personnel.** The policies matter little unless you periodically train staff and document the training. The training may work: staff may actually comply. Even if they fail to comply, documented training will help insulate you from the actions of a rogue employee who knowingly or negligently violates your policies

after being properly trained.

5. **Post the required EMTALA signs.** The signs must be posted in "dedicated emergency departments" as defined in 42 C.F.R. § 489.24(b) and associated waiting areas. The signs should be posted in English as well as other languages required by HHS's Limited English Proficiency guidance. Ensure your personnel are familiar with the rights guaranteed in the signs.

6. **Know to whom, when, and where EMTALA applies.** EMTALA's screening requirements apply to all Medicare-participating hospitals with dedicated emergency departments. EMTALA's obligation to receive transfers applies to all participating hospitals with specialized capabilities whether or not they have dedicated emergency departments. EMTALA is generally triggered if a potential emergency patient is on hospital property, including hospital-owned facilities within 250 yards of the main campus. It applies to persons in hospital-owned or in-bound ambulances. It generally applies to a hospital's off-campus urgent care, labor and delivery, mental health, and similar centers where persons typically come for emergency-type services without an appointment. EMTALA does not apply to on- or off-campus facilities that are not operated under the hospital's provider number, e.g., private physician offices or rural health centers. EMTALA does not apply to off-campus centers that do not typically provide urgent care or emergency-type services even if owned by a hospital. EMTALA does not apply to requests for preventive care, e.g., immunizations or flu shots. EMTALA does not apply to patients who come for scheduled diagnostic, therapeutic, or outpatient appointments even if an emergency arises after they begin treatment. EMTALA does not apply to police requests to gather evidence unless the situation suggests the patient may have an emergency condition. EMTALA does not apply after a patient is admitted as an inpatient. Of course, malpractice standards and Medicare conditions of participation may still apply even if EMTALA does not.

7. **Maintain and review the emergency department log.** Hospitals are required to maintain a central log of persons who come to the hospital for emergency care, whether the person received treatment, and whether the patient was stabilized, admitted, transferred, or discharged. This is the first document the surveyors will review when they investigate your facility; be sure that it is accurate. Periodically review the log to ensure it contains appropriate information and identify potential EMTALA problems. If there are deficiencies, correct the log or the underlying medical records as appropriate.

8. **Conduct and document an appropriate medical screening exam.** If a person comes to the hospital seeking potential emergency care, provide an appropriate screening exam to determine whether an emergency medical condition exists. The appropriateness of the exam depends on the patient's presenting symptoms and the hospital's capabilities. In some cases, a brief

exam or questioning may be sufficient to rule out an emergency medical condition; other cases may require diagnostic tests and on-call specialists. Triage is not an exam. Depending on the symptoms, an appropriate exam typically includes obtaining vital signs, relevant history, physical exam of the involved area or system, ancillary tests or specialty consults as indicated, and continued monitoring, all of which should be documented in the record. If the exam rules out an emergency medical condition, the hospital's EMTALA obligation ends; the hospital should document the absence of an emergency condition. If the exam identifies an emergency medical condition, then the hospital must provide the stabilizing treatment or appropriate transfer described below. If the patient needs exams or tests beyond the hospital's capability to determine whether an emergency condition exists, the hospital should transfer the patient to an appropriate facility to complete the exam consistent with the transfer requirements described below.

9. **Use qualified medical personnel.** The screening exam must be conducted by qualified medical personnel ("QMP"). QMP may be physicians, midlevels, or even nurses so long as they have the necessary competence and privileges to conduct the exam, the exam is within their scope of practice, and the hospital's governing body has authorized that category of practitioner to perform the exam through its bylaws or policies. Some clinicians may be a QMP for certain exams but not others, e.g., an L&D nurse may be a QMP for labor-related issues, but not other conditions. Check the hospital's bylaws or policies to ensure that the board has appropriately identified and privileged those who may perform screening exams, and that the exams are performed accordingly.
10. **Document a timely response.** Do not delay care. Unduly delayed care is inadequate care. Impatient persons may leave the emergency room due to delays which raise EMTALA suspicions. Triage patients. If you cannot examine them relatively promptly, communicate with the patient. If a person leaves before receiving the exam or stabilizing treatment, document any justifiable delay and your reasonable efforts to convince them to remain.
11. **Do not delay the exam while obtaining payment info.** The key here is "delay". You may start the registration process before the exam so long as you do not condition or delay the exam or treatment based on payment. For example, you may ask the patient about his or her means of payment, but ensure the patient understands that you will provide emergency care regardless of the patient's ability to pay. Do not seek preauthorization from payors before examining the patient or initiating stabilizing treatment. Do not discourage the patient from receiving the required emergency care.
12. **Perform and document stabilizing treatment.** If the screening exam reveals an emergency medical condition, the hospital must provide stabilizing treatment within its capabilities and/or an appropriate transfer. EMTALA ends once a patient is stabilized, i.e.,

the emergency condition has resolved even though the underlying medical condition may persist. A patient is stable for transfer if no material deterioration in the patient's condition is likely to result from or occur during the transfer. A patient is stable for discharge if the patient has reached a point where his or her continued care could be reasonably performed as an outpatient or later as an inpatient, provided the individual is given appropriate discharge instructions. A woman in labor is stable when she has delivered the child and the placenta, and there are no other emergency conditions. A psychiatric patient is stable if the patient is protected and prevented from harming themselves or others. If the patient is stable, you may discharge or transfer the patient without complying with the remaining EMTALA obligations; however, ensure that your documentation confirms that the patient is stable. Regulators will review the records to determine compliance and hindsight is always 20/20. If the patient is not stable, you must continue to provide stabilizing treatment or conduct an appropriate transfer as described below.

13. **For transfers, document patient consent and/or physician certification.** Movement within the hospital or between the hospital's own facilities generally does not constitute a "transfer" for purposes of EMTALA or trigger EMTALA's transfer requirements; nevertheless, the hospital should ensure that patients who are moved between hospital facilities are accompanied by appropriate personnel. If the patient is not stabilized, transfers or discharges outside the hospital must comply with EMTALA. An unstabilized patient may request transfer or discharge, in which case the hospital should obtain a written request from the patient that documents the reasons for the request, associated risks and benefits, and the patient's EMTALA rights. Absent such a request, a physician must certify in writing that the benefits of the transfer or discharge outweigh the risks. Transfer forms may help document physician certification, but beware forms that simply allow a physician to check a box. The form and/or medical records should document the relevant risks and benefits and demonstrate the physician's considered decision. Only physicians may certify patient transfers. If the physician is not present, a QMP may certify the transfer after consulting with the physician. The physician must countersign the certification. Although physician certification is only required for the transfer of unstable patients, hospitals should consider following the certification and EMTALA transfer process for all patients who are transferred or discharged from the emergency department—even those who are considered stable—for several reasons: (i) physician certification helps confirm EMTALA compliance if the regulators dispute that the patient was stable; (ii) a uniform process helps avoid compliance lapses; and (iii) physician certification helps protect against malpractice in addition to EMTALA claims.
14. **Use appropriate means for transfer.** If an unstable patient is to be transferred, the hospital must contact the receiving facility to

confirm that the receiving facility has the capability and agrees to receive the patient. The transferring hospital should document the contact, including the name and title of the person at the receiving facility who agreed to the transfer. The transferring hospital must do what it can to minimize the risks of transfer, including providing appropriate treatment, personnel and means of transportation. Transfer by private vehicle may be appropriate in some cases, but it will raise suspicions. If a patient is to be transferred by private vehicle, consider and document (i) the patient's request to transfer by private vehicle; (ii) your offer to transfer by ambulance or other means; (iii) factors indicating that transfer by private vehicle is appropriate, or the patient's informed refusal to transfer by other means; (iv) the patient is accompanied by competent person(s); and (v) any instructions appropriate for the transfer, e.g., to proceed directly to the other facility. Finally, the transferring hospital must send relevant records to the receiving facility, either at the time of the transfer or as soon as such records become available. If the transfer resulted from an on-call physician's failure to respond, the transferring hospital must forward the name of the on-call physician to the receiving facility.

15. **Receive appropriate transfers.** Hospitals that participate in Medicare and have specialized capabilities (e.g., specialty hospitals) must accept the transfer of unstabilized patients even if they do not have an emergency department and, therefore, would not otherwise be obligated to provide a screening exam or stabilizing treatment if the patient had come directly to the receiving hospital. The receiving hospital cannot place conditions on their acceptance, or require a certain method of transfer. The receiving hospital must receive the transfer even though there are other hospitals with specialized capabilities closer to the sending hospital. Hospitals are not, however, required to accept transfers if they provide the same level of service as the transferring hospital and, therefore, have no specialized capabilities. Also, the receiving hospital is not required to accept the transfer of inpatients or patients who have been stabilized since EMTALA no longer applies to such patients. If a hospital with specialized capabilities refuses to accept a transfer, document the circumstances of such refusal and warn them of their EMTALA obligations. If you represent a hospital that refuses to accept a transfer, ensure that the refusal is justified and document the basis of the refusal, including any circumstances that confirm the absence of specialized capabilities.
16. **On-call physicians beware.** The hospital is obligated to maintain and utilize a list of physicians who are on call to respond to emergency cases. The list should identify the particular physician(s) by name; assigning physician groups is insufficient. Failure to timely respond in person at the hospital may subject the on-call physician to a \$50,000 penalty. CMS advises hospitals to establish and enforce a set response time in minutes (e.g., within 30 minutes); hospitals that fail to enforce call requirements may be subject to EMTALA penalties along with the delinquent physician.

Physicians may use mid-levels to respond in their place if clinically appropriate; however, the physician must respond in person if requested by the emergency department. Unless there is a compelling patient care need, the physician must report to the hospital where the patient is located; the physician cannot direct that the patient be sent to the physician's office or another hospital merely for the physician's convenience. Hospitals must have written policies in place to cover situations when an on-call physician cannot respond, e.g., backups if the hospital allows on-call physicians to schedule elective surgery while on-call or to provide on-call duties simultaneously at other facilities. Although there is no specific rule, CMS wants hospitals to "strive" to provide call coverage for specialty services offered at the hospital; with that said, CMS acknowledges that circumstances may prevent 24/7 call coverage for all specialties. Hospitals may enter community call plans that allocate call for certain specialties among hospitals if certain conditions are met.

17. **Watch out for in-bound ambulances.** EMTALA is triggered if a patient is in a hospital-owned or in-bound ambulance; hospitals generally cannot divert an in-bound ambulance unless the hospital is on diversion status. If you are on diversion status, document your status, including the time and reason for diversion. If you are not on diversion status, you can still discuss treatment recommendations with the ambulance crew. For example, if you are not on diversion status but the patient needs services you cannot provide, explain that to the ambulance; just make sure they understand that you are not diverting them, and that you document that fact. If the ambulance disregards your advice and comes to your hospital, perform an appropriate screening exam, provide stabilizing treatment, and/or document an appropriate transfer before sending them on.
18. **Document the patient's refusal of treatment or transfer.** Competent patients have the right to consent to or refuse treatment. If a patient refuses the exam, treatment or transfer otherwise required by EMTALA, the hospital should take reasonable steps to obtain the patient's written refusal. The written refusal or medical records should describe the exam or treatment that was offered, the associated risks and benefits, the patient's reasons for refusing the offered care, and the patient's EMTALA rights. If the patient refuses to sign a written refusal, the hospital should document its attempt to obtain the patient's written refusal.
19. **Respond promptly to complaints and investigations.** If you discover a possible EMTALA violation, immediately collect and review the relevant records and confirm the relevant facts. Interview those involved. As appropriate, supplement or correct the record while memories are still relatively fresh and the information is available. The additional information may confirm that no EMTALA violation occurred, or may otherwise justify the actions taken. If there was a violation, take appropriate corrective action, which may include modifying policies, conducting additional

training, and disciplining those involved. Prompt remedial action may mitigate exposure to sanctions.

20. **Reporting violations.** Hospitals that receive improper transfers must report the violation within 72 hours to CMS or the state surveyors, but there is no obligation to self-report your own violation. If you believe you have received an improper transfer, contact the sending facility to confirm the facts before reporting. If you believe you violated EMTALA and that the receiving facility intends to report you, consider self-reporting to obtain whatever credibility you can with the regulators.
21. **Responding to investigations.** If you are investigated, be cooperative. CMS will give you an opportunity to explain and submit a corrective action plan. Use your opportunity to present your reasonable position, e.g., by providing additional facts or statements that may not appear in the record; explain why there was no EMTALA violation; and/or state remedial steps you have taken to avoid any problems in the future. An experienced healthcare attorney who understands EMTALA may help you respond. In most cases, CMS will accept the plan of correction without further action. In some cases, CMS may refer the matter to the Department of Justice to prosecute EMTALA violations. Even in those cases, regulations require that the government consider several factors before imposing penalties. Complying with the foregoing steps should help you avoid the penalties.

For questions regarding this update, please contact

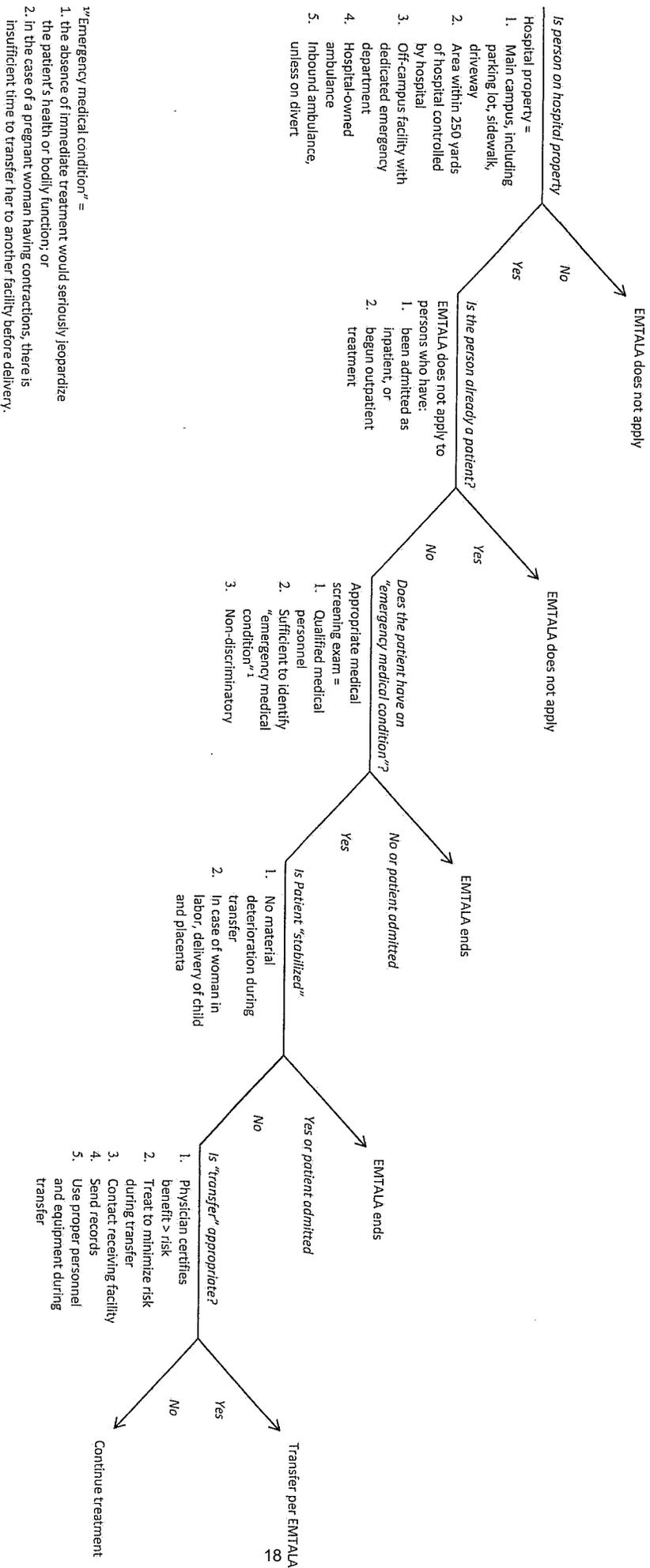
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DECISION TREE



¹"Emergency medical condition" =

1. the absence of immediate treatment would seriously jeopardize the patient's health or bodily function; or
2. in the case of a pregnant woman having contractions, there is insufficient time to transfer her to another facility before delivery.

SAMPLE EMTALA POLICY

[NOTE: This is a sample policy based on EMTALA regulations and Interpretive Guidelines. Specific application of the policy may depend on the hospital's capacity, capabilities, personnel, policies governing the provision of emergency care, and EMS protocols in the hospital's community. Hospitals should review their circumstances and modify the policy accordingly].

PURPOSE

To ensure that Hospital complies with the requirements of the Emergency Medical Treatment and Active Labor Act ("EMTALA") and associated regulations. (42 U.S.C. § 1395dd and 42 C.F.R. §§ 489.20, -.24). Additional information is available in the CMS Interpretive Guidelines available at <http://www.cms.hhs.gov/surveycertificationgeninfo/downloads/SCLetter08-15.pdf>

APPLICATION

- 1. Location.** This Policy applies to the Hospital's main campus, including (1) any department on the Hospital's main campus; (2) Hospital property within 250 yards of the main buildings (e.g., parking lots, driveways and sidewalks); and (3) any Hospital-owned air or ground ambulance. This Policy does not apply to (1) off-campus facilities unless such facilities have a dedicated emergency department; or (2) facilities that are not controlled by the Hospital (e.g., physician offices on Hospital property).
- 2. Persons.** This Policy applies to persons who come to the Hospital seeking emergency care. It does not apply to (1) persons who have been admitted to the Hospital as patients (inpatients); or (2) persons who develop a potential emergency medical condition after they have begun receiving treatment as an outpatient (outpatients). Care for inpatients and outpatients shall be governed by separate policies and the applicable standard of care.

POLICY

The Hospital shall comply with the emergency care obligations imposed by EMTALA. These obligations include the following:

- 1. Medical Screening Examination.** If a person comes to the Hospital and a request is made for their emergency care or, if the person is unable to communicate, a reasonable person would believe that the person is in need of emergency care, then *qualified medical personnel* will, within the Hospital's capability and capacity, conduct and document an *appropriate medical screening examination* reasonably calculated to identify an *emergency medical condition*.

An appropriate medical screening examination should address the presenting symptoms and comply with current policies and procedures for assessment of those presenting symptoms, including but not limited to a history of the presenting problem; a documented physical examination of the involved area or system; and the use of on-call physicians and ancillary tests or services routinely available to the Hospital if needed to determine whether an *emergency medical condition* exists. The chart should document continued monitoring until the patient is stabilized or transferred.

Emergency medical condition is a condition manifesting itself by acute and severe symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the health of the individual (including the health of an unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; or (2) with respect to a pregnant woman who is having contractions, that there is insufficient time to safely transfer the woman to another hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or the unborn child. A woman having contractions is presumed to be in labor unless *qualified medical personnel* certify, after a reasonable time of observation, that the woman is in false labor.

Qualified medical personnel. Hospital's governing body hereby designates the following as medical personnel qualified to perform a medical screening examination on emergency department patients as required by EMTALA: (1) physicians, (2) midlevel providers (e.g., PAs, NPs, and other advance practice nurses) acting within the scope of their licensure; and (3) registered nurses (RNs), if and only to the extent that the nature of the patient's request for examination and treatment is within the scope of practice of the RN (e.g., a request for a blood pressure check and that check reveals that the patient's blood pressure is within normal range). In the case of RNs, if the nature of the patient's request for examination and treatment involves independent medical diagnosis or treatment outside the RN's scope of permissible practice, the RN shall contact the physician or midlevel to complete the examination and/or arrange for an appropriate transfer of the patient to another facility consistent with EMTALA requirements and this policy.

2. Stabilizing Treatment. If the *medical screening examination* indicates that the person has an *emergency medical condition*, the Hospital will provide: (1) treatment within the capabilities of the staff and facilities routinely available at the Hospital (including on-call physicians and ancillary services routinely available) as required to *stabilize* the person before the person is discharged or transferred to another facility; or (2) an *appropriate discharge or transfer* as described below.

3. Appropriate Discharge or Transfer.

A. Stabilized person. If the person is *stabilized*, the Hospital may discharge or transfer the person as appropriate. The person's *stabilized* condition should be documented in the medical records. A person is deemed *stabilized* under the following circumstances:

(1) **For discharge:** if the person does not need continued care, or no material deterioration is likely to result if the patient receives continued care as an outpatient or later as an inpatient and the patient is given a plan for appropriate follow-up care.

(2) **For transfer to another facility:** if the person's emergency medical condition is resolved, although the underlying medical condition may remain, and/or no material deterioration of the person's condition is likely to result from or occur during the transfer.

(3) **For a pregnant woman having contractions:** if the woman has delivered the child and the placenta, or has been determined by *qualified medical personnel* to be in false labor after a reasonable period of observation.

(4) **For psychiatric conditions:** if the person is not in danger of harming themselves or others, or they are protected from harming themselves or others.

B. Unstabilized person. If the individual is not *stabilized*, the Hospital will not discharge or transfer the person unless the following conditions are met:

(1) **Patient's consent or physician certification.** The Hospital may transfer or discharge an unstabilized patient if: (1) the person requests in writing a discharge or transfer to another facility after being informed of the Hospital's EMTALA obligations and the risks of discharge or transfer (*see Patient Treatment Consent/Request/Refusal Form*); (2) a physician certifies in writing that the benefits of discharge or transfer outweigh the risks (*see Patient Transfer or Discharge Form*); or (3) if a physician is not physically present, a *qualified medical person* consults with a physician and certifies in writing that the benefits of discharge or transfer outweigh the risks. The physician must subsequently countersign the certification. (*See Patient Transfer or Discharge Form*).

(2) **Appropriate transfer.** If an individual is to be transferred to another medical facility, the Hospital will: (1) provide medical treatment within its capacity that minimizes the risk to the individual's health or the health of the unborn child during transfer; (2) contact the receiving hospital to confirm that the receiving hospital has the space and personnel to receive the transfer and that the receiving hospital agrees to receive the transfer; (3) send copies of all medical records related to the

emergency condition for which the person presented; and (4) arrange for transfer by qualified personnel and appropriate equipment.

4. Persons Presenting Away from the Emergency or Labor and Delivery Departments. If a person presents at a Hospital department other than the Emergency or Labor and Delivery Departments, and a request is made for examination or treatment for a potential emergency medical condition or, if the person is unable to communicate, a reasonable person would believe that the person needs emergency care, then Hospital personnel should do the following: (1) provide such emergency care as the circumstances, experience, and training of the Hospital personnel would allow; and (2) immediately call the Emergency Department for direction and appropriate disposition. The Emergency Department may dispatch *qualified medical personnel*, transport the individual to the Emergency Department, and/or take such other action that is in the person's best interests.

5. Acceptance of Patient Transfers. Requests for patient transfers to the Hospital should be received and addressed by **[IDENTIFY POSITION]**. The Hospital will not refuse to accept the transfer of an individual to the Hospital for emergency care if: (1) the individual requires the Hospital's specialized capabilities or facilities (including but not limited to **[IDENTIFY ANY SPECIALIZED CAPABILITIES]**) unless the Hospital lacks the capacity to treat the individual, or (2) the individual is in an ambulance *en route* to the Hospital unless the Hospital is on diversionary status.

6. Air or Ground Ambulance.

A. Ambulance owned by the Hospital. The foregoing provisions apply to persons who are in an ambulance owned or operated by the Hospital for purposes of receiving emergency care in the Hospital's dedicated emergency department. If the ambulance is *en route* to the Hospital, the ambulance will not be diverted to another facility unless: (1) the diversion is in the person's best interests and the Hospital complies with the requirements for *an appropriate transfer* identified above; or (2) the transfer is appropriate pursuant to a community-wide EMS protocols.

B. Ambulance not owned by the Hospital. An ambulance that is not owned by the Hospital but that is *en route* to the Hospital will not be diverted to another facility unless the Hospital is on diversionary status.

7. Patient's Refusal to Consent. The person has the right to refuse examination, treatment, or an appropriate transfer. In such cases, the Hospital will: (1) offer the individual the examination, treatment, or transfer required by EMTALA and document in the medical records the examination, treatment or transfer that was refused; (2) explain to the individual the risks and benefits of the examination, treatment, or transfer, and document that such risks and benefits were explained; (3) take reasonable steps to obtain the individual's written informed refusal (*see Patient Treatment Consent/Request/Refusal Form*); and (4) if the individual refuses to sign a written informed refusal, the Hospital will document the foregoing, including the steps it took to obtain the individual's written informed refusal.

8. No Delay in Examination or Treatment. The Hospital will not delay the emergency care described above in order to inquire about the individual's method of payment or insurance status. Reasonable registration processes may be followed (including asking for insurance information) if they do not delay or discourage the person from receiving the emergency care described above. Preauthorization will not be sought from insurers or primary care physicians before providing the examination and, where necessary, initiating stabilizing treatment as described above.

9. No Discrimination in Examination or Treatment. The Hospital will provide the emergency care described above without regard to an individual's age, sex, race, color, national origin, handicap, diagnosis, or financial status, except to the extent that a circumstance is medically significant to the provision of appropriate medical care.

10. On-call physicians.

A. On-call list. The Hospital will maintain a list of on-call physicians who are available to assist the Hospital in providing emergency care as described above. If a *medical*

screening examination indicates that a person has an *emergency medical condition* requiring the services of an on-call physician, the Hospital shall contact the on-call physician to provide necessary consultation. The on-call physician shall respond in within [____] minutes unless circumstances prevent an earlier response. The physician may respond by telecommunication, provided that the physician shall present at the Hospital if requested by the emergency room physician or *qualified medical personnel*.

B. On-call physician's failure to respond. If an on-call physician fails or is unable to respond in a timely fashion, the Hospital will: (1) contact an alternative or back-up physician from the on-call list, if any; (2) if no alternative or backup physicians are available and the person needs emergency care that is not available at the Hospital, arrange for an *appropriate transfer* to another hospital or medical facility as described above; (3) send the name and address of the on-call physician who refused or failed to respond within a reasonable time to the receiving hospital or medical facility; and (4) notify **[IDENTIFY ENTITY]** of the physician's failure to timely respond so that appropriate action may be taken depending on the circumstances, which action may include corrective action against the physician or the physician's privileges.

11. Reporting Suspected Violations.

A. Violation by Hospital. If any person associated with the Hospital has reason to believe that the Hospital has violated this policy or EMTALA, they should immediately report the facts and circumstances to **[IDENTIFY PERSON]**.

B. Violation by a different facility. If any person associated with the Hospital has reason to believe that an individual has been transferred to the Hospital by another facility in violation of EMTALA, they shall promptly report the incident to **[IDENTIFY RECIPIENT OF INFORMATION]**. If, after an appropriate investigation, it is determined that a violation has occurred, the **[IDENTIFY RECIPIENT]** shall report the suspected violation to CMS or the Idaho Bureau of Facility Standards.

12. No Retaliation. The Hospital will not take adverse action against a physician or other *qualified medical personnel* because they refuse to authorize the transfer of an individual with an emergency medical condition that has not been stabilized, or against any hospital employee because the employee reports an EMTALA violation.

13. Signs and Records. The Hospital will maintain the following signs and records:

A. EMTALA signs. The Hospital will post conspicuously signs explaining individuals' EMTALA rights in the Emergency Department, Labor and Delivery Department, and other areas where individuals are likely to wait for examination or treatment.

B. Medicaid signs. The Hospital will post conspicuously information indicating whether the Hospital participates in Medicaid.

C. Transfer records. The Hospital will maintain for five (5) years medical and other records related to individuals transferred or discharged to or from the Hospital.

D. Central log. The Hospital will maintain a central log on each individual who comes to the Hospital seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred or discharged. The Hospital will also maintain in the log information for those individuals who come to an off-campus dedicated emergency department seeking examination or treatment of an emergency medical condition.

APPROVED BY: _____ DATE: _____

Governing Body

SAMPLE HOSPITAL DIVERSION POLICY

[NOTE: This is a sample diversion policy based on EMTALA regulations and Interpretive Guidelines. Specific application of the policy may depend on the hospital's capacity, capabilities, personnel, policies governing the provision of emergency care, and EMS protocols in the hospital's community. Hospitals should review their circumstances and modify the policy accordingly].

PURPOSE: On occasion, HOSPITAL may be temporarily overwhelmed by the volume of emergency patients or its lack of capacity to care for patients, thereby necessitating the diversion of in-bound ambulances to other facilities. This policy establishes standards and processes for ensuring that such diversions are handled properly so that persons may receive appropriate emergency care without undue delay consistent with applicable law.

POLICY: HOSPITAL will divert in-bound ambulances to other facilities when HOSPITAL lacks the capacity and capability to properly care for the patient at HOSPITAL. If a person arrives at HOSPITAL despite the diversion, HOSPITAL will provide appropriate emergency treatment and/or effect a proper transfer to another facility consistent with the requirements of the Emergency Medical Treatment and Active Labor Act ("EMTALA").

PROCEDURE

1. **LIMITS ON DIVERSION.** Hospital will not divert potential patients except as follows:

a. In-Bound Ambulance. HOSPITAL will not divert an in-bound ground or air ambulance unless HOSPITAL is on Diversion Status as described below. If HOSPITAL is not on Diversion Status but HOSPITAL personnel believe that the patient needs care that HOSPITAL cannot provide as effectively as another facility, HOSPITAL personnel shall discuss their concerns with the ambulance and recommend that the ambulance take the patient to the other facility; however, HOSPITAL should not divert the ambulance or suggest that HOSPITAL will refuse to treat the patient if brought to HOSPITAL. The HOSPITAL personnel who communicated with the ambulance should document such communications in the Emergency Department Log *[or other appropriate record]*.

b. HOSPITAL-Owned Ambulance. HOSPITAL will not transfer or divert a HOSPITAL-owned ambulance to another facility unless: (1) the patient or their legally authorized surrogate requests the diversion; (2) the ambulance is operated under community-wide emergency medical service ("EMS") protocols that direct the ambulance to another facility; (3) the ambulance is operated under the direction of a physician who is not employed by or otherwise affiliated with HOSPITAL; or (4) a HOSPITAL physician certifies that the benefits of the diversion outweigh the risks to the patient, and the HOSPITAL otherwise effects an appropriate transfer as required by EMTALA. (See Policy No. ____, Emergency Treatment). The ambulance personnel and, if applicable, the HOSPITAL physician shall document the circumstances of the diversion or transfer in the ambulance log and the Emergency Department Log *[or other appropriate record]*.

c. Transfer From Another Facility. If another facility asks to transfer an unstabilized patient to HOSPITAL, HOSPITAL shall accept the transfer if (1) HOSPITAL has specialized capabilities that the other facility lacks, such as *[specify any specialized capabilities of HOSPITAL, e.g., mental health, neurosurgery, NICU, burn unit, obstetrics, etc.]*; and (2) HOSPITAL has the capacity to treat the patient. HOSPITAL may decline the transfer if (1) HOSPITAL lacks capacity to treat the patient (e.g., HOSPITAL is on Diversion Status as described below); or (2) the transferring facility has the same capacity and capabilities as HOSPITAL. All requests to accept transfers shall be directed to *[JOB TITLE]*. *[JOB TITLE]* shall consult with relevant health care providers, including specialists, and confirm HOSPITAL's capability and capacity before agreeing to accept or declining the transfer on behalf of

HOSPITAL. [JOB TITLE] shall document the communications and circumstances of the transfer in the Emergency Department Log [or other appropriate record], and shall notify the Emergency Department or other relevant department of the anticipated transfer.

d. Other Persons. Prior to the person's arrival at HOSPITAL, HOSPITAL may divert a person who is not in an in-bound ambulance or at another facility. For example, if the person is at home or in an in-bound private car, HOSPITAL may instruct the person to go to another facility. In doing so, HOSPITAL shall consider the person's best interest, and should not divert the person due to financial concerns or illegal discrimination. (See Policy No. ____, Acceptance of Patients). The HOSPITAL personnel who communicated with the person shall document such communications in the Emergency Department Log [or other appropriate record].

e. Persons Who Arrive at HOSPITAL Despite Diversion Status. If a person arrives at HOSPITAL seeking emergency care, HOSPITAL will provide an appropriate screening examination, stabilizing treatment and/or an appropriate transfer consistent with EMTALA. (See Policy No. ____, Emergency Treatment). HOSPITAL will provide such care whether or not HOSPITAL is on Diversion Status, and whether or not the person or ambulance disregarded HOSPITAL's attempt to divert the person. HOSPITAL may transfer an unstabilized patient if either (1) the patient or their surrogate consent to the transfer, or (2) a physician certifies that the benefits of transfer outweigh the risks, and the hospital otherwise effects an appropriate transfer consistent with EMTALA requirements. (See Policy No. ____, Emergency Treatment). Another hospital with specialized capabilities (including those capabilities which HOSPITAL lacks) is obligated to accept the transfer.

2. DIVERSION STATUS. HOSPITAL may divert an in-bound ambulance or decline to accept a transfer from another facility if HOSPITAL is on Diversion Status with regard to the services relevant to the patient's condition.

a. Standard for Diversion. HOSPITAL may initiate Diversion Status if HOSPITAL lacks the capacity or capability to care for additional emergency patients after considering:

- The overall best interests of patients and persons who need emergency services.
- The number and availability of qualified staff, beds and equipment reasonably necessary to care for additional emergency patients. In determining available resources, HOSPITAL should include resources that would otherwise be reserved for potential inpatient emergencies or anticipated elective admissions. All unassigned beds that are appropriate for emergency care shall be deemed available.
- HOSPITAL's past practices of accommodating additional patients, including utilizing resources that are appropriate for but not normally assigned for emergency care, calling back staff, expedited discharges, *etc.* if HOSPITAL utilized such methods in the past to provide overflow emergency services.

Hospital shall not divert an in-bound ambulance due to financial considerations.

b. Efforts to Avoid Diversion. HOSPITAL will initiate Diversion Status only after HOSPITAL has exhausted all internal resources to meet the current patient load, including reasonable attempts to call back staff; expedite appropriate discharges; open additional available beds appropriate for emergency patient care; etc.

c. Types of Diversion. HOSPITAL may initiate varying levels of Diversion Status depending on the circumstances, including the following:

- Emergency Department Diversion:** HOSPITAL's emergency department is unable to safely accept any in-bound ambulance traffic. Ambulances should be diverted to other facilities.

□ **Specialty Diversion:** HOSPITAL is unable to care for patients requiring certain types of specialty services (e.g., neurology, trauma, mental health, obstetrics, etc.) that would normally be within HOSPITAL's capability. Emergency patients requiring such specialty services should be diverted to other appropriate facilities.

□ **Critical Care Diversion:** HOSPITAL has no monitored beds available. Emergency patients requiring monitored beds should be diverted to other appropriate facilities.

□ **Disaster Diversion:** HOSPITAL is currently responding to a mass casualty incident and has instituted a disaster plan. All in-bound ambulances not involved in the incident should be diverted to other facilities.

3. INITIATING DIVERSION STATUS. Diversion Status shall be initiated as follows:

□ **Authorized Personnel.** Diversion Status may only be initiated by *[JOB TITLE, e.g., EMERGENCY DEPARTMENT SUPERVISOR, CHARGE NURSE, AND/OR ADMINISTRATOR ON DUTY]* after consulting with the emergency department physician. Emergency department physicians or other health care providers who believe that Diversion Status should be initiated should immediately contact *[JOB TITLE]*.

□ **Notice.** Upon initiating Diversion Status, the *[JOB TITLE]* shall immediately notify the following entities that HOSPITAL is on Diversion Status for the specified services.

□ The statewide EMS dispatch service and any local 911 dispatch services;

□ Local EMS providers, including ground and air ambulance services, fire departments, and police and sheriff departments;

□ Area hospitals that may receive diverted ambulances; and

□ Other emergency responders or health care entities that may be affected by HOSPITAL's Diversion Status.

□ **Documentation.** Upon initiating Diversion Status, the *[JOB TITLE]* shall immediately document in the Emergency Department Log *[or other appropriate record]*:

□ The date and time that Diversion Status was initiated;

□ the person initiating Diversion Status;

□ The circumstances that justified Diversion Status, including steps taken to avoid or mitigate Diversion Status; and

□ The notice given to EMS providers.

□ **Monitoring.** The *[JOB TITLE]* shall continually monitor the conditions that necessitated Diversion Status. Diversion Status is intended to be temporary, and HOSPITAL should take appropriate action to modify or terminate Diversion Status as quickly as possible, including reasonable attempts to call back staff; expedite appropriate discharges; open additional available beds appropriate for patient care; etc.

4. RENEWING DIVERSION STATUS. Diversion Status will automatically terminate after four (4) hours unless the [JOB TITLE] renews the Diversion Status.

Documentation. Upon renewal, the [JOB TITLE] shall document in the Emergency Department Log [or other appropriate record]:

- The date and time that Diversion Status was renewed;
- The person renewing Diversion Status;
- The circumstances that justified renewal of the Diversion Status; and
- The notice given to EMS providers.

5. TERMINATING DIVERSION STATUS. Diversion Status will automatically terminate after four (4) hours unless renewed by [JOB TITLE]. In addition, Diversion Status may be terminated at anytime by the following:

Authorized Personnel. Diversion Status may be terminated by [JOB TITLE] after consulting with the emergency department physician. Emergency department physicians or other health care providers who believe that Diversion Status should be terminated should contact [JOB TITLE].

Notice. Upon terminating Diversion Status, [JOB TITLE] shall immediately notify the entities who were notified of the Diversion Status.

Documentation. Upon terminating Diversion Status, the [JOB TITLE] shall immediately document in the Emergency Department Log [or other appropriate record]:

- The date and time that Diversion Status was terminated;
- The name of the person terminating Diversion Status;
- The circumstances that justified termination of Diversion Status; and
- The notice given to EMS providers.

6. COMMUNITY CALL PLAN. [NOTE: In 2008, CMS proposed allowing hospitals in a community to establish a community call plan whereby the hospitals may divide responsibility for providing call coverage for the community. Under the proposal, hospitals might divide the responsibility by specific service (e.g., hospital X provides call coverage for neurology, while hospital Y provides call coverage for NICU); or, alternatively, by time period (e.g., hospital x provides neurology call during days 1-15, while hospital Y provides neurology call during days 15-31). These rules have not been finalized, but hospitals in the same community may consider entering a community call plan if and when the proposals are finalized. The proposal sets forth specific elements that should be included in the community call plan. The community call plan may affect the hospital's capacity or capability, and may be relevant to the hospital's diversion policy. (See CMS-1390-P)]

RELATED POLICIES

- Policy No. ____, Emergency Treatment (EMTALA)
- Policy No. ____, Acceptance of Patients

REFERENCES

- 42 U.S.C. § 1395dd
- 42 C.F.R. § 489.24
- EMTALA Interpretive Guidelines, CMS State Operations Manual, Appendix V
- *Arrington v. Wong*, 237 F.3d 1066 (9th Cir. 2001) (holding that a hospital may not divert an in-bound ambulance unless the hospital is on diversion).

**SAMPLE EMERGENCY DEPARTMENT
PATIENT TRANSFER OR DISCHARGE FORM**

Patient Name: _____

Number: _____

PHYSICIAN CERTIFICATION [To be completed by physician if patient transferred or discharged from ED].

- No emergency medical condition.** The patient has received a medical screening exam, but the patient does not have an emergency medical condition.
- Stable.** The patient has an emergency medical condition, but the condition is stable. No material deterioration is likely to result from (1) a transfer to another facility or (2) discharge with instructions for appropriate follow-up care.
- Transfer is in patient's best interests.** The patient has an unstable emergency medical condition, but the benefits of discharging or transferring the patient outweigh the risks to the patient as described below:
 1. Benefits of transfer:
 - Specialized equipment or services at the receiving facility [describe]: _____
 - Other [describe]: _____
 2. Risks of transfer:
 - Deterioration of medical condition during transfer.
 - Delay in treatment due to transfer.
 - Other [describe]: _____

_____ Physician	_____ Date and time
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TRANSFER CHECKLIST [To be completed by ED nurse when the patient is transferred to another facility].

1. **Patient Consent or Request for Transfer.** The patient has been informed of their EMTALA rights and the risks and benefits of transfer. After being informed, the patient or their representative:
 - Consents to the transfer recommended by the physician. [Complete Patient Transfer Consent form].
 - Requests the transfer against the advice of the physician. [Complete Patient Transfer Consent form].
 - The Hospital is or was unable to obtain written consent from the patient or their representative because: _____
2. **Accepting Facility:** _____
 - The facility was contacted; has the capability and capacity to provide appropriate treatment; and has agreed to accept the transfer and provide appropriate treatment to the patient.
 Name of person at facility who agreed to accept transfer: _____
 Name of person at this Hospital who contacted accepting facility: _____
 Date/time of contact: _____
3. **Method of Transportation.**
 - Private vehicle.
 - Ambulance with appropriate equipment and practitioners.
 - Aircraft with appropriate equipment and practitioners.
 - Other [describe]: _____
 Name of transporting entity: _____
 The patient was offered but refused the recommended method of transport. [Complete Patient Transfer Consent form].
4. **Records.** Copies of the following records have been sent to the accepting facility:
 - History, physical, consultations and progress notes.
 - Nursing observations.
 - Laboratory and other test results.
 - Patient consent for transfer or physician certification.
 - Name and address of any on-call physicians who failed to respond.
 - Other records relevant to the emergency care.
 - Additional records will be sent when available.

_____ Nurse or other appropriate person.	_____ Date
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**SAMPLE EMERGENCY DEPARTMENT
PATIENT TREATMENT OR TRANSFER
CONSENT / REQUEST / REFUSAL**

YOUR RIGHTS CONCERNING EMERGENCY CARE.

- You have the right receive an appropriate medical screening examination within the capability of the Hospital to determine whether you have an emergency medical condition.
- If it is determined that an emergency medical condition exists, you have the right to receive treatment within the capability of the Hospital to stabilize the emergency medical condition or to receive an appropriate transfer to another medical facility to receive such treatment.
- You have the right to such emergency care even if you do not have insurance and cannot pay.

Complete the box that applies.

CONSENT TO TRANSFER. *[To be completed if the patient consents to a transfer recommended by a physician].*

I have been examined by a physician and/or by other qualified medical personnel. They have explained my condition to me, and have recommended that I be transferred to _____.
The risks and benefits of the proposed transfer have been explained to me, and I understand that I have the right to emergency care as explained above. By signing below, I consent to the recommended transfer.

REQUEST FOR TRANSFER. *[To be completed if the patient requests a transfer that is not recommended by a physician].*

I have been examined by a physician and/or by other qualified medical personnel. They have explained my condition to me and have recommended that I not be discharged or transferred to another medical facility. They have explained the risks and benefits of the discharge or transfer. I am aware of the risks of discharge or transfer, and I understand that I have the right to emergency care as explained above. Nevertheless, by signing below, I request a transfer or discharge for the following reasons:

1. Medical facility to which the patient requests a transfer: _____
2. Patient's reason for requesting discharge or transfer: _____

REFUSAL TO CONSENT TO TREATMENT OR TRANSFER. *[To be completed if the patient refuses examination, treatment or transfer that is recommended by a physician].*

A physician and/or other qualified medical personnel have recommended that I receive the examination, treatment or transfer described below. The risks and benefits of the proposed treatment or transfer and the failure to receive the treatment or transfer have been explained to me. I understand that I have the right to emergency care as explained above. Nevertheless, by signing below, I refuse the proposed treatment or transfer for the following reasons:

1. Examination, treatment, or transfer that was offered but refused: _____
2. Patient's reason for refusing the examination, treatment or transfer: _____

Patient or authorized representative

Date and time

Relationship/authority of representative

Hospital witness

Date and time

Note: if the patient or their representative refuses to sign the consent or refusal, complete the reverse side

PATIENT REFUSED TO SIGN CONSENT OR REFUSAL. [*To be completed by hospital if the patient refuses to sign a written consent or refusal*].

The Hospital has taken all reasonable steps to obtain the patient's written informed consent or refusal for the examination, treatment or transfer described on the reverse side and/or in the medical records. The Hospital has explained to the patient or their representative the risks and benefits of the examination, treatment, or transfer, or the failure to obtain the examination, treatment or transfer. Despite the Hospital's efforts, the patient or their representative has refused to provide the written informed consent or refusal.

Explain the reason the patient refused to sign the consent or refusal, if known: _____

Hospital representative

Date

To be completed by EMS personnel:

- The Patient is age 18 or over and comprehends the need for, the nature of and the significant risks associated with their proposed healthcare.
- The Patient is under age 18 or is otherwise incompetent to make their own healthcare decisions, but their Personal Representative has executed this form.
- The following were explained to the Patient or their Personal Representative prior to or at the time of their decision to transport the Patient to another facility:
 - The risks and benefits of transporting the Patient to their preferred facility instead of [HOSPITAL NAME].
 - The patient's right to receive further examination and treatment at [HOSPITAL NAME] regardless of their ability to pay consistent with EMTALA
- If the Patient or Personal Representative failed or refused to sign this form, explain the reason: _____

EMS Personnel

Date

Time am/pm

SAMPLE REQUEST FOR TRANSFER BY PRIVATE VEHICLE

Patient Name: _____ Birthdate: _____

To be completed by Patient or their Personal Representative:

1. I am the Patient or the Personal Representative with authority to make healthcare decisions for the Patient.
2. I understand that _____ (“Hospital”) has recommended that the Patient be transferred to _____ for further healthcare services.
3. Hospital has recommended that the Patient be transferred by the following means instead of by private vehicle:
 Air or ground ambulance.
 Law enforcement.
 Other: _____
4. Despite the foregoing, I request that the Patient be transferred by private vehicle for the following reasons: _____
5. I have been informed and understand that transferring the Patient by private vehicle may result in additional risks to the Patient, including but not limited to the following:
 - Decline in the Patient’s condition during the transfer that may require immediate medical intervention by qualified personnel.
 - Lack of cooperation by the Patient that may interfere with the transfer.
 - Unforeseen circumstances that may interfere with the transfer, e.g., car troubles or accidents, road closures, detours, driver error, etc.
 - Delay in the receipt of needed medical care resulting in adverse consequences to the Patient.
 - Other: _____

6. I will ensure that the following is done during the transfer to minimize the risk to the Patient:
(initial each):
_____ The vehicle is in good working condition and is expected to arrive safely at the facility.
_____ The vehicle will be driven by a person other than the Patient who is competent and qualified to drive the vehicle.
_____ The Patient will at all times be accompanied by one or more persons who are able to protect and assist the Patient during the transfer.
_____ The Patient will be driven directly to the other facility without undue delay.
_____ If any problems arise during the transfer, we will call the Hospital at (208) _____, or other appropriate agency that may render assistance.
_____ Other: _____

7. The risks of transfer by private vehicle have been fully explained to me, and I my questions have been answered to my satisfaction.

Quality Assurance / Quality Measures

It is important that high risk, infrequent events be monitored for quality and safety. Interfacility transfers of patients are clearly shown to be high risk procedures, and in scenarios where non-EMS personnel are used, the risk is increased. While it is tempting to review only those which have an adverse outcome ensuring that certain basic conditions are met routinely are extremely important as well. Some suggested markers:

- Was a safety matrix utilized before the transfer?
- If an ambulance based clinician used were appropriate orders in place?
- Did the crew level meet state standards for patient condition?
- Written hand off information for transfer given at time of transfer?
- Hypotension or hypoxia during transport?
- Debrief after transport?
- Other operational/clinical concerns?

Documentation Template

On the next page is a sample documentation template to be used by interfacility transport providers. All ABCs should have a login to their EMS agency's patient care reporting system. The documentation template may be left for the receiving facility or to assist with charting after a transfer.

SERVICE NAME: _____ (PLEASE PRINT)					Date of Transfer:						
Pt Complaint:				Reason for transfer:							
PATIENT INFORMATION					TIMES (MILITARY)						
(Last Name) (MI)			(First)		Unit Notified:			Arrived at Sending Facility:			
(Street Address) #)				(Apt. #)	Patient Contact			En Route with Patient:			
(City)		(State)		(Zip Code)			Arrived at Receiving Facility:		Transfer of Care:		
(Phone)		(Date of Birth)			(Age)			Back in Service:		Back at Quarters:	
(Gender)	(SSN#)		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Other		Race: <input type="checkbox"/> Other <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Undetermined <input type="checkbox"/> White <input type="checkbox"/> American Indian, Eskimo or Aleut						
Chief Complaint:					Injury/Illness Narrative:						
Past Medical History:					Pertinent Findings on Physical Exam:						
Allergies:					Patient Medications						
Emergency Medical Care Given:					Patient Response to Emergency Medical Care:						
Provider Impression – Select all that apply <input type="checkbox"/> Abdominal Pain/Problems <input type="checkbox"/> Diabetic Symptoms <input type="checkbox"/> Other <input type="checkbox"/> Stings/Venomous Bites <input type="checkbox"/> Airway Obstruction <input type="checkbox"/> Electrocutation <input type="checkbox"/> Poisoning/Drug Ingestion <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Alleged Sexual Assault <input type="checkbox"/> Hyperthermia <input type="checkbox"/> Pregnancy/OB Delivery <input type="checkbox"/> Syncope/Fainting <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Hypothermia <input type="checkbox"/> Psychiatric Disorder <input type="checkbox"/> Traumatic Hypovolemia <input type="checkbox"/> Altered Level of Consciousness <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Respiratory Arrest <input type="checkbox"/> Traumatic Injury <input type="checkbox"/> Behavioral Disorder <input type="checkbox"/> Hypovolemia <input type="checkbox"/> Respiratory Distress <input type="checkbox"/> Vaginal Hemorrhage <input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> Inhalation Injury <input type="checkbox"/> Seizure <input type="checkbox"/> Unknown <input type="checkbox"/> Cardiac Rhythm Disturbance <input type="checkbox"/> Not Applicable <input type="checkbox"/> Shock <input type="checkbox"/> Chest Pain/Discomfort <input type="checkbox"/> Obvious Death <input type="checkbox"/> Smoke Inhalation											
Destination:				Receiving Physician:							
CLINICAL INFORMATION											
TIME	B/P	PULSE	RESP	TEMP	Pulse O2	Glascow Coma Score Eye Verbal Motor Total				Respiratory Effort: <input type="checkbox"/> Normal <input type="checkbox"/> Shallow/labored <input type="checkbox"/> Deep/Labored <input type="checkbox"/> Deep/Non-Labored <input type="checkbox"/> Absent <input type="checkbox"/> Labored/Fatigued <input type="checkbox"/> Not Assessed <input type="checkbox"/> Unknown	Resp. Sounds: L R <input type="checkbox"/> Clear <input type="checkbox"/> <input type="checkbox"/> Ronchi <input type="checkbox"/> <input type="checkbox"/> Rales <input type="checkbox"/> <input type="checkbox"/> Wheezes <input type="checkbox"/>
										Skin Perfusion: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Not Assessed	Pupils: L R <input type="checkbox"/> Normal <input type="checkbox"/> <input type="checkbox"/> Constricted <input type="checkbox"/> <input type="checkbox"/> Dilated <input type="checkbox"/> <input type="checkbox"/> No react. <input type="checkbox"/>
Date:			Signature:								

Credentialing Form Sample

Provider _____ Agency _____

State EMS Licensure # _____ Exp _____

RN Licensure # _____ Exp _____

.....
CPR _____ Exp _____

ACLS _____ Exp _____

PALS _____ Exp _____

(Please provide copies of above certification cards)

BIAD Education & Skill Checkoff Date _____

Ambulance Operations Check Date _____

Signature of Preceptor and Date

Agency Orientation _____ Date _____

Skills Verification _____ Date _____

Field Training Program _____ Date _____

The above provider has successfully completed all requirements for credentialing for the _____ EMS Agency and is fully credentialed at the level of _____.

Provider understands and agrees to adhere to all requirements for continuous credentialing within the system. Failure to do so will result in loss of credentials and need for recompletion of the process.

Provider Signature Date Medical Director Signature Date

Escalation Pathway.

This is a term for the situation in which either weather or crew availability precludes immediate safe transport of a patient. While from the sending providers viewpoint the obvious goal is to “get the patient out of here” sometimes that actually involves more risk than sheltering the patient until conditions change. Several procedures can help minimize the impact and stress of this.

First, recognize that this will happen. Weather happens, and usually when you have critical patients arrive. Plan for it.

A conference call with dispatch, sending and receiving providers, and often the involved transport crew is extremely helpful. This allows clarity on current and evolving weather conditions, allows for a plan for weather/window checks with an established timeline for updates.

Have an agreement with your usual accepting facility to provide assistance with the management of the patient who is being sheltered. This should involve all the specialties with whom you deal – OB, pediatrics, adult intensive care, etc. There is probably a point person at your usual accepting hospitals who could help facilitate this. With current technology it is often possible to have very ill patients managed well at a CAH for a period of time using telemedicine.

Anticipate unusual situations, for example a critical pediatric patient who must be sheltered. Where is the best place to hold the patient, who is the best staff to care for them, what team could you create to deal with the patient? Doing this ahead of time makes this a planned event rather than a crisis.

And lastly, part of an escalation pathway should include considering whether the patient really needs to be moved. Some of the more risky transports involve patients who are clearly not survivable – massive head bleeds, post codes patients who will clearly not survive – you all know your own examples. Having an intensivist who can consult and definitively weigh in on this can often relieve a lot of anxiety and completely remove our EMS personnel from undue risk.

Just Culture Resources

Emergency Medical Services (EMS) Specific:

- <http://www.centerforpatientsafety.org/just-culture-in-ems/>
- <https://www.jems.com/articles/2013/06/creating-ems-culture-safety.html>
- <https://www.ems1.com/paramedic-chief/articles/374186048-Just-Culture-basics-for-EMS/>
- http://www.naemt.org/docs/default-source/advocacy-documents/positions/Just_Culture_in_EMS.pdf?sfvrsn=8b905568_0
- http://www.rccp.us/uploads/2/9/4/5/2945795/20-just_culture_overview_slides.pdf
- <https://www.itrauma.org/wp-content/uploads/2014/04/Thackery-BuildingaCultureofSafetyinEMS.pdf>
- <https://www.ems.gov/pdf/Strategy-for-a-National-EMS-Culture-of-Safety-10-03-13.pdf>
- <http://naemt.org/initiatives/ems-safety/safety-resources>
- http://www.centrelearn.com/trainingtrends/just_culture_ems.html
- <https://www.ems.gov/pdf/nemsac/aug2012/Culture%20of%20Safety%20Update%20-%20ACEP%20-%2008292012.pdf>
- http://www.rccp.us/uploads/2/9/4/5/2945795/20-just_culture_overview_slides.pdf

Hospital or EMS:

- https://partnershipforpatients.cms.gov/p4p_resources/tsp-culturechange/toolculturechange.html
- <https://psnet.ahrq.gov/perspectives/perspective/50/making-just-culture-a-reality-one-organizations-approach>
- <http://www.safetyleaders.org/pages/workshopsWebinars.jsp?step=2>
- https://www.powershow.com/view/deb39-OGZjM/The_Just_Culture_Initiative_powerpoint_ppt_presentation
- <https://www.unmc.edu/patient-safety/documents/patient-safety-and-the-just-culture.pdf>
- <https://www.fsbpt.org/Licensees/EthicalConduct/BasicConceptsofaJustCulture.aspx>
- <https://www.outcome-eng.com/>