

### Introduction

The purpose of this section is to reconcile the unique aspects of interfacility transfers with current NH EMS law, licensure, and acute care protocols. It is intended to provide flexibility, when possible, for individual agencies, institutions, and communities to meet their unique needs.

### Interfacility Transfer

An interfacility transfer is defined as any EMS ambulance transport from one healthcare facility to another. Examples include hospital-to-hospital, hospital-to-rehabilitation, and hospital-to-long-term care. (Guide for interfacility patient Transfer, NHTSA, April 2006.)

### Transferring Institution

Responsibility for patient transfer lies with the transferring physician/provider and must take into account the risks versus the benefits to the patient. Providing appropriate equipment, medications, and qualified staffing during transport is paramount to patient safety. These parameters should be based on the requirements of the patient at the time of transfer, and in reasonable anticipation of foreseeable complications, deterioration, and medical needs that might arise during transport.

Initiation of a transfer should be a carefully coordinated effort by the transferring and receiving physicians/providers, the transferring and receiving facilities, and the transferring unit and personnel. Time or advanced notification may be needed for the transferring EMS unit to reconfigure in order to meet the needs outlined here. The following provides guidelines for the selection of appropriate NH EMS personnel to provide interfacility transport of patients consistent with their current scope of licensure, protocols, and training. Staffing, Medical Control, documentation, medications, transfer protocols, and procedures are addressed.

### Training Levels

Standard paramedic curriculum does not specifically address the care of the critically ill patient during an extended transport. NH requires specific training for paramedics to provide extended transport of critically ill or injured patients.

New Hampshire has multiple levels of interfacility transfer capabilities including: Paramedic Interfacility Transport (PIFT) and Critical Care Teams (CCT) as defined in the PIFT Administrative Manual. All paramedics who will be staffing an interfacility transfer must be credentialed at a minimum of PIFT level training. The PIFT level of training is intended to address the majority of interfacility transfer situations. However, some patients will have a level of acuity and/or complexity that requires a CCT level transport—either air or ground. The CCT level of credentialing requires greater training, medical oversight, and service support, and is intended for the more limited number of acute and complex interfacility transfers that occur; therefore, a limited number of paramedics will be credentialed to function at the CCT level. If that level of resource is not readily available it is an acceptable practice to supplement the PIFT crew with hospital staff that is qualified to provide the level of care the patient requires.

Interfacility transfers that are appropriate for EMT or AEMT level of care do not require additional levels of credentialing beyond training requirements defined in the NH EMS protocols and by [Saf-C 5900](#).

Policy Continues 

Protocol Continues

NH EMS protocols enable PIFT paramedics to continue medications that are not within their routine scope of practice during an interfacility transport, including continuous infusions, repeat boluses, or blood products, providing that, prior to transporting the patient:

- Medication is started prior to leaving the transferring facility.
- The paramedic proactively obtains working knowledge and education of any such medications or products by reviewing current medication monographs (hardcopy or electronic), consulting with sending clinicians, medical directors, or clinical pharmacists, reviewing established practice policies (such as for blood products), or other standard clinical research means.

EMS providers must refuse to transport patients that have a level of acuity and/or medication regimen that they are not comfortable with, and work with the sending facility to acquire optimal staffing (such as sending nursing staff or requesting a CCT transport).

### Minimum Staffing

The transferring physician/provider is responsible for determining the level of EMS provider and resources that are appropriate to meet the patient's current and anticipated condition and needs. The following are examples only and do not comprise a comprehensive list.

### Stable patient with no risk for deterioration

1 EMT provider and second licensed provider (minimum) driver.

- No IV infusions.
- Oxygen for stable patients permitted.
- Previously inserted Foley catheter, suprapubic tube, established feeding tube (NG, PEG, J-tube not connected to infusion or suction).
- Saline lock permitted.

### Stable patients with low risk of deterioration

1 AEMT provider and second licensed provider driver.

- Any crystalloid infusion.
- IV infusion pump for non-pharmacologic agents.
- Patient-controlled analgesic (PCA) pump.
- Medications within the AEMT scope of practice.

### Stable patients with medium risk of deterioration

PIFT credential required. This protocol is only to be used by paramedics and EMS units who have been trained and credentialed to perform PIFT-level transfers by the NH Bureau of EMS and the EMS Medical Control Board.

1 PIFT paramedic provider and second licensed provider (as driver or second provider).

- Transcutaneous pacing.
- BiPap
- Stable long-term ventilated patient to or from a medical facility, long term care facility, and/or home, provided the patient is stable and the transport is not of an acute nature, current ventilator settings may be maintained during transport.
- Acutely Intubated/mechanically ventilated patients on assist control or SIMV with non-complex settings. All intubated patients must have second provider in patient compartment. All intubated patients must be on a mechanical ventilator.
- Medical monitoring devices, procedures, and medication administration consistent with scope of practice and/or PIFT training.

Policy Continues

Protocol Continues

- Advanced airway management.
- Chest tube.
- Infusion of previously initiated blood products.
- Maintenance of previously initiated medications.
- Epidural catheter if secured, capped, and labeled.

### **Unstable or stable patients with high risk of deterioration**

**CCT required.** Option 1 of this policy is only to be used by paramedics and EMS units who have been trained and credentialed to perform CCT-level transfers by the NH Bureau of EMS and the EMS Medical Control Board.

**Option 1:** CCT air or ground ambulance, **OR**

**Option 2:** 1 PIFT paramedic provider, 1 EMT driver and, at a minimum, 1 additional, (sending) **hospital-based**, qualified advanced health care provider (e.g., a critical care or emergency registered nurse, physician assistant, nurse practitioner, physician, CCT paramedic).

Examples:

- Multiple vasoactive medication drips.
- Uncorrected shock.
- Invasive monitoring.
- Balloon pump.
- Transvenous pacing.
- Intubated/ventilated patients with complex vent settings **only** (Pressure control and/or PEEP > 10 mmHg) require a respiratory care practitioner in the patient compartment with PIFT paramedic. This does not apply to long term vented patients as stated in "Stable patients with medium risk of deterioration".
- Intubated/ventilated patients with complex vent settings (pressure control and/or PEEP > 10 mmHg) and another condition causing a high risk of deterioration also require a respiratory care practitioner in the patient compartment in addition to the above required hospital based provider.

The MCB strongly encourages the use of paramedics specially trained for the type of patient/condition being transported but recognizes that a CCT crew may not always be available.

As a measure of last resort, in cases where CCT providers are unavailable **AND** delay in transfer would have a significant negative impact on patient outcome, other transport arrangements may be initiated provided that:

1. The sending facility makes an exhaustive effort to send additional personnel.
2. The NH Bureau of EMS and Unit EMS Medical Director are notified within 48 hours and appropriate TEMSIS and IFT documentation is completed by the EMS Unit and the sending physician/institution.
3. All interventions are within the scope of practice of the transporting provider and vehicle.
4. EMS providers must refuse to transport patients that have a level of acuity and/or medication regimen that they are not comfortable with, and work with the sending facility to acquire optimal staffing.

Policy Continues

Policy Continued**Definitions**

- **Unstable Patient:** A patient who cannot be stabilized at the transporting facility, who is deteriorating or likely to deteriorate. (From “Guide for Interfacility Patient Transfer,” NHTSA.)
- **Stable Patient:** Hemodynamically stable patient with a secure airway and who is **NOT** in acute distress.

**Medical Control Responsibilities**

According to EMTALA, patient care during transport until arrival at the receiving facility is the responsibility of the transferring physician/provider unless other arrangements are made.

Sometimes, as in certain air medical transport services or ground critical care units, the transport unit is functioning as an extension of a tertiary care center. It operates under that facility’s protocols, medical directorship, and on-line medical control.

In the prehospital environment the EMS system operates under protocols. In the interfacility transfer environment written transfer orders that are within the scope of the provider’s protocols and licensure are also required to be authored by the transferring physician/provider. The combination of protocols and transfer orders provide off-line medical control.

Transfer orders must be specific, appropriate to the patient being transferred, and reasonably anticipate potential complications en route. Transfer orders may reference the use of NH EMS protocols where they are applicable. If patients develop new signs and/or symptoms during transport, beyond their initial transfer diagnosis, providers may treat the new signs and/or symptoms according to protocols. Where transfer orders and NH EMS protocols are in conflict, transfer orders take precedence.

The transferring physician/provider should be immediately available to review transport orders and provide medical control communication via radio telephone during the transport. If the physician/provider is unavailable they must make other arrangements for review of the transfer orders with the transport crew.

**PIFT and CCT Prerequisites and Oversight**

It is the responsibility of the NH Bureau of EMS to monitor the quality of care delivered under this system and to set the standards for credentialing providers and units. PIFT and CCT transports shall only be conducted by those providers who have completed and maintain the approved training and who are credentialed by a unit that is approved by the NH Bureau of EMS.

The field of critical care interfacility transport is fluid and there are often questions related to scope of practice. There is a subcommittee established by the NH EMS Medical Control Board (MCB) to consider questions and make interim rulings on those questions until such a time as the MCB has the opportunity to consider and modify or adopt such rulings. These responses will be posted on the NHBEMS website.