



ADMINISTRATIVE POLICY MANUAL

Subject: EMTALA

Effective Date: October 2, 1996
Approved by: Executive Vice President/COO/CNO
Responsible Parties: Director, Risk Management
Revised Date: 7/01; 1/02; 9/6/10; 4/14/16; 11/30/18; 4/5/19
Reviewed Date: 7/97; 8/98; 5/04
Keywords:

The following policy is in compliance with the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 USC Section 1395dd and 42 CFR Section 489.24.

PURPOSE:

To establish guidelines for completion on an appropriate Medical Screening exam (MSE) and for either accepting an appropriate transfer from another facility or providing an appropriate transfer to another facility of an individual with an emergency medical condition ("EMC"), who requests or requires a transfer for further medical care and follow-up to a receiving facility as required by EMTALA, 42 U.S.C. Section 1395dd, and all Federal requirements and interpretive guidelines promulgated thereunder.

A. RIGHT OF INDIVIDUALS UNDER EMTALA:

Under EMTALA, an individual will receive, regardless of the patient's ability to pay, within the capabilities of the Hospital's staff and facilities:

- 1.** An appropriate medical screening examination by qualified medical personnel, including ancillary service routinely available to the Hospital to determine whether or not an **emergency medical condition** exists;
- 2.** Necessary stabilizing treatment for **emergency medical condition** (including treatment for an unborn child); and
- 3.** If necessary, an **appropriate transfer** to another facility.

B. PATIENT REFUSAL UNDER EMTALA:

The Hospital will take reasonable steps to secure the written consent of the patient or the legally qualified individual acting on behalf of the patient ("the patient's representative"), in the following situations:

1. If the patient or the patient's representative is offered further medical examination and treatment and, after being advised of the risks and benefits of such examination and treatment, the patient or the patient's representative refuses to consent to the examination and treatment; or
2. If the patient's medical condition is such or circumstances are such, that further medical examination and treatment cannot be provided by the Hospital, and after being advised of the risks and benefits of an appropriate transfer, the patient or the patient's representative refuses to consent to the appropriate transfer.

The Hospital will take all reasonable steps to secure the patient's written informed consent to a refusal as defined above.

DEFINITIONS:

- A. Capacity** means the Hospital's ability to accommodate the patient's or transferring facility's request for examination, treatment, or transfer.
- B. Capability** means availability of providers, services or facilities able to deliver specialized care, including, but not limited to, trauma, behavioral health, stroke, cardiac intervention and regional referral centers.

SPECIAL CONSIDERATIONS:

- A patient in a non-hospital owned ambulance/helicopter who has arrived on hospital property is considered to have **come to the Emergency Department**. If a member of the ambulance staff contacts the Hospital's Emergency Department by telephone or telemetry communications prior to arrival onto the Hospital property and informs the Hospital's Emergency Department that it has a patient to transport the Emergency Department for examination and treatment, Hospital may divert the ambulance/helicopter prior to arrival as set forth in the Admission Restriction/Diversionary/Fly-By status; that is, it does not have the capacity or capability to accept any additional patients at that time. If the ambulance staff disregards the Hospital's instructions and transports the patient to the Hospital's property, the patient is considered to have come to the Emergency Department.
- 250 Yard Rule – If an individual who is not a hospital patient comes elsewhere on **hospital property** (that is, the individual comes to the Hospital but not to the dedicated Emergency Department), an EMTALA obligation on the part of the Hospital may be triggered if either the individual request examination or treatment for an **emergency** medical condition or if a prudent layperson observation would believe that the individual is suffering from an **emergency** medical condition. The terms "Hospital property" means the entire main Hospital campus, including the parking lot, sidewalk and driveway or Hospital departments, **including any buildings owned by the Hospital that are within 250 yards of the Hospital**
- Hospital Diversion
 - A. Diversion by the Hospital shall mean expressed inability of the Hospital's Emergency Department or specialty services to accept ambulance/helicopter traffic prior to the arrival on the Hospital premises due to lack of capacity or capability. If the ambulance/helicopter disregards the Hospital's instruction to divert, and transports the patient onto the Hospital's premises, the patient may

not be diverted, but must be provided an appropriate medical screening examination for purposes of identifying an emergency medical condition and appropriate transfer in compliance with EMTALA.

- **Notification of Reduced Capacity or Capability**

It is the responsibility of a relevant ancillary or specialty service related to patient care to notify the Nursing Service Supervisor when services are unavailable, including the estimated time when such services shall become available. The Nursing Services Supervisor will then notify the Emergency Department Charge Nurse and other Hospital staff as necessary based on services impacted. Pre-Hospital and specialist notification numbers are as follows:

1. SYSCOM (1-800-648-3001)
2. Delaware Trooper 2 (1-302-856-6306)
3. The Hospital's On-Call Trauma Surgeon
4. The Administrator On-Call; and
5. Other area ambulance services and Hospitals as appropriate

C. An emergency medical condition (EMC) is defined by federal statute as follows:

1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in:
 - a. placing the health of the individual (or, with respect to a pregnant woman the health of the woman or her unborn child) in serious jeopardy;
 - b. serious impairment of bodily functions; or
 - c. serious dysfunction of any bodily organ or part; or
2. In case of a pregnant woman who is having contractions:
 - a. that there is inadequate time to effect a safe transfer to another hospital before delivery; or
 - b. that the transfer may pose a threat to the health or safety of the woman or the unborn child.

D. Medical Screening Examination (MSE) means the process required to reach with reasonable clinical confidence, the point at which it can be determined whether an **emergency medical condition** as defined herein does or does not exist. The **medical screening** process shall be conducted in a nondiscriminatory manner.

With regard to a medical screening examination of a **minor** who is not accompanied to the Hospital by his/her parent or legal guardian a **medical screening examination** must be completed on any minor who requests examination or treatment of a medical condition. Hospital should attempt to contact the minor child's parents or legal guardian but should never delay the **medical screening examination** to obtain parental consent. If the **medical screening** reveals no **emergency medical condition**, then attempts should be made to obtain the appropriate consent before proceeding with further evaluation and treatment. If an **emergency medical condition** is found to exist, the condition should be treated and stabilized without delay.

E. Qualified Medical Personnel (QMP) means those individuals who are designated to perform the **medical screening examination** by the Hospital's Board of Trustees through the Medical Staff By-Laws.

F. Patient Evaluation and Treatment

When an individual comes to the Emergency Department seeking medical treatment, the Hospital will provide a **medical screening examination** to determine whether the individual has an **emergency medical condition**. Hospital shall not delay providing the **medical screening examination** or **stabilizing** treatment to inquire about the patient's method of payment or insurance status. The Hospital **will not send away** any patient from the Emergency Department without a **medical screening examination** and/or further **stabilization** which may be required under EMTALA. Should the patient refuse such treatment, the Hospital will make every effort to obtain the patient's signature on a Refusal of Medical Treatment form. The event will be documented in an appropriate medical record.

1. A **qualified medical personnel (QMP)** that has been designated as a **QMP** in accordance with the Hospital's Medical Staff By-Laws will perform the **medical screening examination**.
2. If the **QMP** determines that the patient does not have an **emergency medical condition**, this policy ceases to apply.
3. If the **QMP** determines that the patient has an **emergency medical condition**, the Hospital must provide either:
 - a. Such additional medical treatment that is within the capabilities of the available staff and facilities, and that is necessary to stabilize the medical condition, or
 - b. Appropriate transfer of the individual to another medical facility.
4. If the **emergency medical condition** is stabilized, the organization has met the obligations of the EMTALA law.

G. Patient Log

The Hospital's Electronic Medical Record System will serve as the Log of individuals who seek care, the refusal or acceptance of treatment, course of treatment, disposition and destination if transferred are captured.

H. Signage

Appropriate EMTALA signs will be posted conspicuously throughout the Hospital. These signs will specify the rights of individuals with EMCs and women in labor. Signage will be in compliance with EMTALA requirements for legibility and content.

I. Transfers

Any transfer of an individual with an EMC must be initiated either by a written request for transfer from the individual or the legally responsible person acting on the individual's behalf or by a physician order with the appropriate physician certification required under EMTALA. EMTALA obligations regarding the appropriate transfer of an individual determined to have an EMC apply to any Emergency Department ("ED") or Dedicated Emergency Department (DED) of a Hospital

whether located on or off the Hospital campus and all other departments of the Hospital located on Hospital property.

A Hospital with specialized capabilities or facilities (including, but not limited to burn units, shock-trauma units, neonatal intensive care units, dedicated behavioral health units, or regional referral centers in rural areas) shall accept from a transferring Hospital an appropriate individual with an EMC who requires specialized capabilities if the receiving Hospital has the capacity to treat the individual. The transferring Hospital must be within the boundaries of the United States.

The transfer of an individual shall not consider the age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state or local law, except to the extent that pre-existing medical condition or physical or mental handicap is significant to the provision of appropriate medical care to the individual

J. Transfer of Individuals Who Have Not Been Stabilized

1. If an individual who has come to the Emergency Department has an EMC that has not been stabilized, the Hospital may transfer the individual only if the transfer is an appropriate transfer and meets the following conditions:
 - a. The individual or a legally responsible person acting on the individual's behalf requests the transfer, after being informed of the Hospital's obligation under EMTALA and of the risks and benefits of such transfer. The request must be in writing and indicate the reasons for the request as well as indicate that the individual is aware of the risks and benefits of transfer; or
 - b. A physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of the woman in labor, to the woman or the unborn child, from being transferred. The certificate must contain a written summary of the risks and benefits upon which it is based; or
 - c. If a physician is not physically present in the transferring DED at the time the individual is transferred, a qualified medical person ("QMP") has signed a certification after a physician in consultation with the QMP, agrees with the certification and subsequently countersigns the certification. The certification must contain a written summary of the risks and benefits upon which it is based.
NOTE: The date and time of the physician or QMP certification should match the date and time of the transfer.
2. A transfer will be an appropriate transfer if:
 - a. The transferring Hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

- b. The receiving facility has capacity and capability for the treatment of the individual and has agreed to accept the transfer and to provide appropriate medical treatment;
- c. The transferring Hospital sends the receiving Hospital copies of all medical records related to the EMC for which the individual presented that are available at the time of transfer. The name and contact information of any on-call physician who has refused or failed to appear within the transferring Hospitals on-call guidelines/policies to provide necessary stabilizing treatment should be communicated in writing to the CMD or designee
- d. The transfer is effected through qualified personnel and transportation equipment as required including the use of necessary and medically appropriate life support measures during the transport.

Hospitals that request transfers must recognize that the appropriate transfer of individuals with unstabilized EMCs that require specialized services should not routinely be made over great distances bypassing closer Hospitals with the necessary capacity and capability to care for the unstabilized EMC. (See Appendix A)

3. Higher Level of Care. A higher level of care should be the more likely reason to transfer an individual with an EMC that has not been stabilized. The following are examples of a higher level of care:

- a. A receiving Hospital with **specialized capabilities or facilities** that are not available at the transferring Hospital (including, but not limited to burn units, shock-trauma units neonatal intensive care units, dedicated behavioral health units, or regional referral centers in rural areas) must accept an appropriate transfer of an individual with an EMC who requires specialized capabilities or facilities if the Hospital has the capacity and capability to treat the individual. See Additional Reference: MIEMMS Inter-Facility Transfer Guide.
- b. Peninsula Regional Medical Center will consider all State of Maryland and Joint Commission specialty center designations when receiving requests from transferring Hospitals.
- c. All Medical Staff providers will direct transfer requests from receiving hospitals/providers to the Access Center.

K. Additional Transfer-Related Situations

1. Diagnostic Facility. If an individual is moved to a diagnostic facility located at another Hospital for diagnostic procedures not available at the transferring Hospital and the Hospitals arrange to return the individual to the transferring Hospital, the transfer requirements must still be met by the sending Hospital. The receiving Hospital is not obligated to meet the EMTALA transfer requirements when implementing an appropriate transfer back to the transferring Hospital. The recipient Hospital will send or communicate the results of the tests performed to the transferring Hospital.

2. Off-Campus Hospital-Based Facilities to Nonaffiliated Hospital. A transfer from a Hospital-based facility located off-campus to a nonaffiliated Hospital must still comply with the requirements of an appropriate transfer as defined by EMTALA. A Memorandum of Transfer must be used in such situations,

NOTE: Off-Campus Provider Based EDs or DED. A movement of a patient from an off-campus provider-based ED or DED to the main Hospital ED is a movement and not a transfer.

3. Pre-Existing Transfer Agreements. Appropriate transfer agreements should be in place and in writing between the Hospital, including any outpatient or other off-campus departments where care is provided and other Hospitals in the area where the outpatient or off-campus departments are located. Even if there are pre-existing transfer agreements between transferring and receiving Hospitals, a physician certificate is required for any medically indicated transfer.
4. Transfers For High Risk Deliveries. If the Hospital is not capable of handling the delivery of a high-risk woman in labor, they must provide an MSE and any necessary stabilizing treatment as well as meet the requirements of an appropriate transfer even if a transfer agreement is in place. In addition, a physician certification that the benefits of transfer outweigh the risks of transfer of the woman in labor.
5. Women in Labor. For a woman in labor, a transfer may be made only if the woman in labor or her representative requests the transfer, and if a physician signs a **certification** that the benefits reasonably expected from the provision of appropriate medical treatment at another facility outweigh the increased risks to the individual or the unborn child. A Hospital cannot cite State law or practice as the basis for transfer. **A woman in labor who requests transfer to another facility may not be discharged against medical advice to go to the other facility.** The risks associated with such a disposition must be thoroughly explained to the patient and documented. If the patient still insists on leaving to go to another facility, the facility should take all reasonable steps to obtain the patient's request in writing and take all reasonable steps to have the patient transported using qualified personnel and transportation equipment. **Transporting a woman in labor by privately-owned vehicle is not an appropriate form of transportation.**
6. Exceeded Capacity. If the transferring Hospital has the capability but lacks the capacity to treat the individual, then the individual would likely benefit from the transfer and it would be permissible if all other conditions of an appropriate transfer are met and must include an accepting provider at the receiving facility.
7. Lateral Transfers. Transfers between hospitals of comparable resources and capabilities are not permitted unless the receiving facility would offer enhanced care benefits to the patient that would outweigh the risks of the transfer. Examples of such situations include a mechanical failure of equipment or no ICU beds available.
8. Observation Status. An individual who has been placed in observation status is not an inpatient, even if the individual occupies a bed overnight. Therefore, an individual placed in an observation status who came to the Hospital's DED for example, does not terminate the EMTALA obligation of that hospital or a recipient

Hospital toward an individual who remains in unstable condition at the time of transfer. The EMTALA obligation does not end until the patient has been stabilized, appropriately transferred, discharged or admitted as an inpatient. Therefore, any transfer of a patient in observation status who initially presented **to a DED must meet all the requirements of an EMTALA transfer.**

L. Authority to Conduct a Transfer

The transferring physician is responsible for determining the appropriate mode of transportation, equipment and attendants for the transfer in such a manner as to be able to effectively manage any reasonably foreseeable complication of the individual's condition that could arise during the transfer. Only qualified personnel, transportation and equipment, including those life support measures that may be required during transfer shall be employed in the transfer of an individual with an unstabilized EMC. If the individual refused the appropriate form of transportation determined by the transferring physician and decides to be transported by another method, the transferring physician is to document that the individual was informed of the risks associated with this type of transport and the individual should sign a form indicating the risks have been explained and the individual acknowledges and accepts the risks. All additional requirements of an appropriate transfer are to be followed by the transferring Hospital.

M. Access Center/Bed Management

Access Centers do not: (1) diagnose or determine treatment for medical conditions; (2) make independent decisions regarding the feasibility of transfer; (3) make independent decisions as to where the individual will be transferred; or (4) determine how a transfer shall be effected. At the transferring Physician's request, the Access Center must facilitate a discussion between the transferring Physician and the on-call Physician of the receiving facility. **The on-call Physician does not have the authority to refuse an appropriate transfer on behalf of the facility.**

The Access Center may, at the request of the transferring facility, provide information on the availability of EMS or transport options for transfer of an individual. However, the Access Center does not select the level of care provided by the transferring facility. The transfer acceptance cannot be predicated upon the transferring facility using a mode of transportation chosen by the receiving facility or an Access Center.

N. Document the Request. The Access Center must document its communication with the transferring facility, or in the case of Peninsula Regional Medical Center being the transferring facility, the receiving Hospital, including the request date and time and the name of the person accepting the transfer. The Access Center may provide or receive a face sheet to facilitate the transfer but they may not provide any information to, or respond to questions from PRMC or receiving facility from the Face Sheet regarding whether or not the patient has insurance or the type of insurance, or other information regarding the patient's ability to pay for services prior to acceptance of the patient.

O. Transfers That Are Requested by the Individual But Not Medically Indicated

If a medically unstable individual, or the legally responsible person, requests a transfer to another Hospital that is not medically indicated, the individual or the

legally responsible person must first be fully informed of the risks of the transfer; the alternatives (if any) to the transfer; and the Hospital's obligation to provide further examination and treatment sufficient to stabilize the individual's EMC.

A transfer will be an appropriate transfer only when the request meets all of the following requirements:

- is in writing and indicates the reasons for the request;
- contains a statement of the Hospital's obligations under EMTALA and the benefits and risks that were outlined to the person signing the request;
- indicates that the individual is aware of the risks and benefits of the transfer;
- is made part of the individual's medical record, and a copy of the request should be sent to the receiving facility when the individual is transferred; and
- is not made through coercion or by misrepresenting the Hospital's obligation to provide an MSE and treatment for an EMC or labor.

P. Refusal to Consent to Transfer

If an individual, or the legally responsible person acting on the individual's behalf, refuses to consent to the Hospital's offer to transfer the individual to another facility for services the Hospital does not provide and informs the individual, or the legally responsible person, of the risks and benefits to the individual of the transfer, all reasonable steps must be taken to secure a written refusal from the individual or the person acting on the individual's behalf. The individual's medical record must contain a description of the proposed transfer that was refused by the individual or the person acting on the patient's behalf, a statement that the individual was informed of the risks and benefits and the reason for the individual's refusal to consent to the transfer.

Q. Transfer of Individuals Who Are Medically Stable

EMTALA does not apply to an individual who has been medically stabilized. The Hospital has no further EMTALA obligation to an individual who has been determined not to have an EMC or whose EMC has been stabilized or who has been admitted as an inpatient.

- a. **Document Stable Condition.** The stability of the individual is determined by the treating ED physician or physician managing the observation status of the patient or QMP in consultant with the physician. After it is determined that the individual is medically stable, the physician or physician managing the observation status of the patient or QMP must accurately and thoroughly document the parameters of such stability.
 - i. A woman who is in labor is considered to be stabilized only after she has been delivered of the child and the placenta.
 - ii. An individual presenting with psychiatric symptoms is considered to be stabilized when he/she is protected and prevented from harming self or others.
 - iii. If there is a disagreement between the treating physician and an off-site physician or specialist (e.g., a physician at the receiving facility or the individual's primary care physician if not physically present at the first facility) about whether the individual is stable for transfer, **the medical judgment of the physician who is treating the**

individual at the transferring facility DED takes precedence over that of the off-site physician.

R. Recipient Hospital Responsibilities (PRMC's Responsibilities)

- a. As a participating Hospital that has specialized capabilities or facilities (including, but not limited to burn units, shock-trauma units, neonatal intensive care units, dedicated behavioral health units, or regional referral centers in rural areas) may not refuse to accept an appropriate transfer from a transferring Hospital within the boundaries of the United States, of an individual who requires such specialized capabilities or facilities if the receiving Hospital has the capacity to treat the individual.
- b. PRMC's or the recipient Hospital's EMTALA obligation do not extend to individuals who are inpatients at another Hospital.
- c. If an individual arrives through the DED as a transfer from another Hospital or health care facility, the Hospital has a duty to have a physician or QMP, not a triage nurse, perform an appropriate MSE. The MSE must be documented in the medical record.
- d. PRMC or other recipient Hospital with specialized capabilities that delays the treatment of an individual with an EMC who arrives as a transfer from another facility could be in violation of EMTALA, depending on the circumstances of the delay.
- e. EMTALA regulations apply as soon as an individual arrives on the facility's campus regardless of arrival mode.
- f. Pursuant to the MIEMSS and Joint Commission designations for STEMI and Stroke, the EMS service may take the patient directly to the Interventional Radiology Suite or the Cardiac Catheterization Lab if the Endovascular or Cath Lab team, including the appropriately credentialed physician, is present upon arrival of the patient. This will occur only upon verification with the accepting specialist. The awaiting physician in the Unit would perform the additional evaluation and treatment and document such findings in the medical record. The Interventional Radiology Suite or Cardiac Cath Lab would be responsible for ensuring the registration as an emergency patient thus ensuring the patient appears on the Central/EMTALA log.
- g. In situations when the PRMC's Access Center receives a request from a transferring Hospital and no specialty bed is available, but the DED has capacity and capability to further treat and stabilize the individual and an on-call physician is available, PRMC should accept the transfer as an ED to ED transfer.
- h. PRMC Medical Staff members are responsible for coordinating all transfer requests through the Access Center.

S. Reporting Potential EMTALA Violations

Any Access Center employee, ED provider, specialty physician or administrator who has reason to believe that a potential violation of the law has resulted in an inappropriate transfer must notify the Risk Management Office and Chief Medical Officer immediately.

Cindy Lunsford, Executive Vice President/COO/CNO

ADMINISTRATIVE POLICY MANUAL

Subject: EMTALA – Appendix A

Effective Date: October 2, 1996
Approved by: Executive Vice President/COO/CNO
Responsible Parties: Director, Risk Management
Revised Date: 7/01; 1/02; 9/6/10; 4/14/16; 11/30/18
Reviewed Date: 7/97; 8/98; 5/04
Keywords: EMTALA

LEVELS OF TRANSPORTATION

In Maryland, patient transfers fall into two levels, BSL, ALS, and SCT. For most up to date Maryland Medical Protocols for EMS providers go to www.miemss.org documents tab. There is an additional Maryland Inter-Hospital Transfer Resource Manual for any questions on level of care in the State of Maryland or on how to arrange transportation or to contact a facility.

BLS (BASIC LIFE SUPPORT)

A licensed commercial ambulance is staffed at a minimum with a driver and an EMT-B attendant. BLS may transport patients within the scope of practice of an EMT-B that includes patients who are stable with maintenance IVs. BLS licensed ambulances may not add a nurse or other health care provider to staff the ambulance for the purpose of caring for a patient who requires care outside the scope of practice of the EMT-B. These patients must be transported by an ALS (Advanced Life Support) licensed ambulance.

ALS (ADVANCED LIFE SUPPORT)

A licensed ALS commercial ambulance is staffed at a minimum with an EMT-B driver and a CRT or EMT-P attendant. The ALS provider may start IVs, as well as administer certain medications and perform certain procedures that are listed in the Maryland Medical Protocols for EMS Providers, which defines the scope of practice for all Maryland EMS pre-hospital providers. Patients requiring care outside the scope of practice of the ALS provider must be accompanied by a healthcare provider authorized by law to provide the level of care required and in accordance with EMTALA.

SCT (SPECIALTY CARE TRANSPORT)

A licensed SCT commercial ambulance is staffed at a minimum with an EMT-B driver and two additional providers. The scope of practice of the SCT paramedic requires additional training, includes additional medications and procedures and is defined in the Maryland Medical Protocols for EMS Providers. If the patient's care is outside the scope of practice of an SCT paramedic, the first of the two additional providers must be either a nurse or physician with critical care expertise. The second provider may be either an SCT paramedic or a paramedic who has been oriented to specialty care transports. If the

patient's care is within the scope of practice of the SCT paramedic, the first provider may be either a nurse with critical care expertise or the specially prepared SCT paramedic. The second provider may be either a CRT licensed after July 1, 2011, or a paramedic who has been oriented to specialty care transports.

NEONATAL

Licensed neonatal commercial ambulances are specialized ambulances that are staffed and equipped to transport critically ill newborns from their Hospital of birth to a tertiary care facility. Transport of critically ill newborns may be carried out only in a licensed neonatal ambulance.

INTERHOSPITAL TRANSFERS VIA HELICOPTER OR FIXED-WING AIRCRAFT

Interhospital transfers via aircraft are only rarely appropriate. Aircraft transfers expose the patient and the community to additional risk, delay and expense. Peninsula Regional Medical Center has a Preferred Provider Agreement with Life Net which has an aircraft based in Georgetown, Delaware. This PPA provides the service that if they are not available they will search for the next closest appropriate aircraft. The Maryland Referral Network is available through SYSCOM and can assist with providing/locating an aircraft suitable for transport of these patients deemed appropriate.

Air Medical Transport should be considered for interfacility transfer of patients for whom time is critical and time-critical interventions are required, or when it is important to minimize time out of the Hospital setting.



ADMINISTRATIVE POLICY MANUAL

Subject: Addendum to EMTALA Policy –
Peninsula Regional Medical Center (PRMC)
Patient Access/Transfer Center Guidelines

The PRMC Access/Transfer Center is a 24/7 accessible service that allows referring providers to access admissions and transfer services for their patients throughout the PRMC service area as well as outlying service areas that are not supported by community or hospital based subspecialty services. The PRMC Access/Transfer Center is staffed by Registered Nurses who facilitate admissions/transfer = ranging from same-day emergent transfers and acceptances to more routine needs such as infusion therapies or non-emergent service needs.

PRMC Access/Transfer Center will executive the transfer/admission requests via a three way recorded communication for physician-to-physician discussion and agreed upon disposition.

I. General Information

The Access/Transfer Center has the ability to direct referrals/requests for transfer to the appropriate specialty service and provider. General principles for directing referrals will be guided by the following principle:

- a. The Access/Transfer Center should contact the provider or specialty that has been requested by the transferring/requesting provider. Exceptions may include pre-existing protocols in place such as STEMI and Endovascular Clot Retrieval processes.
- b. The Access/Transfer Center RN will page or call the physician on-call per the ED/Unassigned On-Call paging list. If there is no response after fifteen (15) minutes, the RN will attempt to contact the on-call physician again. If there continues to be no response after thirty (30) minutes, the RN will escalate the lack of response by activating the Hospital Policy on Chain of Command.
 - i. Contact a partner of the physician or a consulting physician for this patient as appropriate.
 - ii. If unsuccessful, contact the Chief of the Division that the physician reports to
 - iii. If unsuccessful, contact the Chief Medical Officer

- c. If the referring physician does not know whom to request or does not request a specific specialist or provider, the RN will contact the most clinically appropriate physician or specialist based on the information they have received from the referring physician.
- d. Patients should be referred to the physicians and specialists that are able to manage the primary issue of concern within their scope of practice.
- e. If a patient that is being referred does not meet specific criteria for specialist referral or the reason for transfer is unclear, the consultation will be referred to the Hospitalist admitting for the Emergency Department.
- f. It should be and is understood that the condition of the patient may not be clearly established at the time of the transfer, that multiple medical problems may be present, or that previously undiagnosed problems may be identified once the patient arrives at Peninsula Regional Medical Center.
- g. Unless EXPLICITLY directed by the accepted provider at PRMC or by defined protocols such as STEMI, all patients transferred to the facility shall present to the Emergency Department to be evaluated by the accepting provider and/or the Emergency Department provider.

II. Time Sensitive Calls

All calls received by the Access/Transfer Center RN will be screened and will be determined to be routine, time sensitive or emergent. Examples of emergent requests for transfer include, but may not be limited to:

- a. Code STEMI
- b. Code Stroke/Endovascular needs
- c. Trauma
- d. Ruptured Abdominal Aortic Aneurysms
- e. Obstetrical emergencies

** For time sensitive/emergent calls: The Access/Transfer Center RN will page or call the physician on per the on-call paging schedule. If there is no response within five (5) minutes, the RN will attempt to make contact again. If there is no response after ten (10) minutes, the RN will contact the Emergency Department charge doctor for initial acceptance and then continue to page the appropriate on-call specialist.

III. Specialty Referrals

Referring physicians that request to speak with a specific specialist that is on-call at Peninsula Regional Medical Center should be placed in contact with that specialist unless it is an inappropriate request (i.e., ortho for an abdominal injury). Any case in which a specialist inappropriately declines to accept a patient transfer or consultation will be referred to the Chief Medical Officer for

review of the case. The process under the general information Section I, Part "B" should be followed in an effort to provide the patient needing services the most appropriate plan of care if that includes transfer to PRMC and the declination will be reported to the Chief Medical Officer even if the patient is eventually accepted.

IV. ED to ED Transfers

The referring physician should request to speak to the ED charge physician if they desire to have an ED-to-ED transfer. The PRMC ED physician will abide by the following guidelines:

- a. The accepted patient will be routed to the most clinically appropriate physician or specialist as soon as possible after transfer.
- b. The referral and acceptance of a patient to the ED should be based on the knowledge that the specialists at PRMC are able to manage the primary issue or concerns of the patient's care within their scope of practice.
- c. If a patient presents with an established relationship with a specialist, the ED provider shall make every effort to involve that provider in the care of the patient.
- d. Patients without an established relationship with a specialist will be directed as per Hospital Policy to the most appropriate on-call specialist for unassigned patients.
- e. Patients whose condition is unclear or do not fit into specialized categories upon arrival to the Emergency Department should be directed to the Hospitalist for admission if needed.
- f. It is understood that the condition of the patient may not be clearly established at the time of the transfer, that multiple medical problems may be present, or that previously undiagnosed problems may be identified once at PRMC. All treating physicians will consult other specialists as clinically indicated and consider transferring care of the patient to the most appropriate specialists for admission or if indicated transferring the patient to another facility for an even higher level of care.

Cindy Lunsford, Executive Vice President/COO/CNO

Dr. Charles B. Silvia, M.D., Vice President, Medical Affairs/CMO