GUIDE FOR INTERFACILITY PATIENT TRANSFER

TABLE OF CONTENTS

INTRODUCTION

Project Background

The transfer of patients from one medical facility to another has become a national issue for Emergency Medical Services (EMS). Patient transfers between facilities or between facilities and a specialty care resource have increased as a result of regionalization, specialization, and facility designation by payers. The emergence of specialty systems (e.g., cardiac centers, stroke centers) often determines the ultimate destination of patients rather than proximity of facility. Transfer may be necessary if payers provide reimbursement only for specific facilities within their own plans.

Interfacility transfer (IFT) is provided by a variety of levels and types of personnel and agencies. Key issues include the IFT infrastructure, including the qualifications of those delivering the care. Meeting patient needs and maintaining continuity of care are only two of the many issues related to IFT.

Emergency Medical Services (EMS) at the National Highway Traffic Safety Administration (NHTSA) convened key national stakeholders to identify national EMS priority issues and to establish consensus-based guidelines for the EMS community. In January 2002, NHTSA convened an EMS Interfacility Transfer Planning Group to consider the current issues and to determine if national consensus guidelines would be useful in addressing these challenges. The planning group determined that consensus guidelines would be very useful to promote consistent high-quality patient care while allowing variation to meet specific local needs. The group identified the following areas that could benefit from such guidelines.

Ten Major Topics for IFT Guidelines:

- Cost reimbursements and funding for services
- Integration of IFT services in existing regional health care systems
- Research
- Provider education
- Liability
- Medical direction
- Human resources and staffing
- Legislation and regulation
- Best practices
- Definitions

A follow-up meeting of the Interfacility Transfer Planning Group was held in Alexandria, Virginia, on May 12-13, 2003. The NHTSA EMS Division identified appropriate organizations and invited their participation in the meeting. These organizations included:

- Air & Surface Transportation Nurses Association
- Air Medical Physician Association
- American Ambulance Association
- American College of Emergency Physicians
- Commission for Accreditation of Ambulance Services
- Commission on Accreditation of Medical Transport Systems
- Emergency Nurses Association
- Emergency Medical Services for Children
- International Association of Flight Paramedics (formerly known as the National Flight Paramedics Association)
- National Association of EMS Physicians
- National Association of EMTs
- National Association of State EMS Directors
- National Association of State EMS Training Coordinators

The president or executive director of each organization was asked to designate a representative to participate in a two-day meeting, and the completion of the IFT Guidelines document. This invitation resulted in the formation of the IFT Guidelines Work Group (Appendix A).

Guidelines for Definitions and Provider Education were completed as part of the agenda of the 2003 meeting. It was agreed that guidelines for the remaining eight major topics would be completed through an electronic process (eRoom). At several points, the document was informally reviewed by the organizations represented by the IFT Work Group members. This document is the result of that process. The guidelines contained in this document are based upon a combination of available objective evidence, a review of generally accepted practices, and the consensus of expert opinions in the field of IFT — in short, the best information available.

Purpose and Limitations of This Document

The intended audience for this guide is the agency providing IFT at the local, regional, or State level, as well as those involved with planning for IFT or dealing with IFT-related issues. This audience may include a variety of decision makers, such as program administrators, agencies with EMS jurisdiction, physicians providing medical oversight for IFT, or hospitals dealing with IFT-related issues.

The intent of this document is to provide general guidance. Given the variety of unique needs and demands placed on programs, local communities, and EMS systems, prescriptive standards would not be useful. In addition, specific standards may conflict with existing regulations or administrative rules. This document is not intended to serve as a benchmark.

This document can be used to provide general guidance, references and ideas for conducting a systematic assessment of the processes and personnel supporting IFT and how they can be enhanced to provide optimal delivery of care. The overarching principle adopted by the IFT Work Group was that all decisions should be motivated by the desire to optimize the process of IFT and the care given during transport. The ultimate goal is to match patient need with appropriate knowledge, skills, equipment, and an infrastructure to enable safe, effective, and efficient IFT.

Planning and Implementation Considerations

As with any analysis of program status, it is helpful to evaluate its current status before taking action. The three core functions of public health, published by the Institute of Medicine[1], provide a useful model for this process. These three functions are:

- Assessment – to collect, assemble, analyze, and make available relevant facts and figures including existing data, identified needs, and epidemiologic and other applicable information.

- Policy Development – efforts to serve the public interest in the development of comprehensive policies by promoting the use of a scientific knowledge base as a basis for decision-making, and leading in developing comprehensive policies.

- Assurance – efforts to assure that services necessary to achieve agreed-upon goals are provided either by encouraging actions by other entities, by requiring such action through regulation, or by providing services directly.

Assessment

The IFT Guide developed by the IFT Work Group can be used largely within the assessment phase, where it can serve as a template against which a State/region/locality could compare its own program. Before this process is begun, it is strongly recommended that the stakeholder group adopt a goal and a mission statement to identify and agree upon the ultimate goal for this and all other activi-

ties. An assessment tool can be developed once all stakeholders agree upon the ultimate mission/goal, and assessment strategies are established. The following represent general categories for assessment:

- current IFT system components;

- education and training of providers;

- legal status/legal authority including liability;

- medical oversight, including IFT protocols;

- cost reimbursement, and funding for services;

- integration of IFT services into existing health care systems; and

- staffing requirements for IFT.

Once stakeholders have endorsed the goal, needs are assessed and all relevant outcome and process information has been assembled and analyzed, a gap analysis will form the basis for action. A gap analysis is a comparison of the current situation to the desired state. A plan to move from the current state to the desired state is developed. The level of detail in the plan depends on the scope of the project.

Policy Development

Based upon the desired goal, the assessment and gap analysis form the basis for action. Strategies are identified to bridge the gap between the current situation and the desired state. Policy development and planning includes:

- informing, educating, and empowering people about IFT issues;

- mobilizing community and stakeholder partnerships to identify and solve IFT problems; and

- developing policies and plans that support individual and community efforts to improve IFT.

The strategies included for IFT policy development may include:

- legislation and administrative rule-making (for providers, such as EMS boards, nursing boards, medical boards, pharmacies, if needed, and others, e.g., respiratory therapists);

- legislation and administrative rule-making (for services);

- provider education:
  - meeting with organizations;
  - course development; and
  - other steps for policy;

- medical oversight:
  - critical care versus emergency department management;
  - IFT protocols;
  - destination protocols; and
  - other?

- education of various organizations/disciplines;

- cost reimbursement and funding:
  - meeting with third-party carriers; and
  - matching reimbursements with system design.

Assurance

Before strategies are deployed, performance measures should be established, which can be used to measure progress. As the implementation process moves forward, several surveillance methods can be used to evaluate achievements:

- data collection;

- evaluation of effectiveness, accessibility, and quality of IFT services and the infrastructure that supports IFT;

- enforcement of laws and regulations;

- quality improvement;

- ongoing system modification based on data; and

- feedback loops.

These three core functions may be repeated multiple times. The process of assessing, developing policy, and assuring is ongoing, and the deployment plan altered to account for changes or unanticipated circumstances. Utilizing the public health model may provide a framework and a

useful roadmap for all stakeholders in enhancing IFT. While most of this document's contents fall into the assessment category, some major topics include strategies for policy and assurance functions.

References

1. The Future of Public Health. (1988). Committee for the Study of the Future of Public Health. Division of Health Care Services. Institute of Medicine. Washington, D.C. National Academy Press.

Major Topic #1: Definitions

For the purpose of this document, the following definitions were adopted:

Critical Care Transport — The level of transport care that is provided to patients with an immediate life-threatening illness or injuries associated with single or multiple organ system failure. This level of care requires an expert level of provider knowledge and skills, a setting providing necessary equipment, and the ability to handle the added challenge of transport. Critical care transport requires a high level of medical direction and sophistication of care because of the patient's complex medical problems.

EMS System — A consolidated system of essential components designed to provide a coordinated, timely and effective response to medical emergencies. A comprehensive EMS system has each of the elements illustrated in the following diagram:
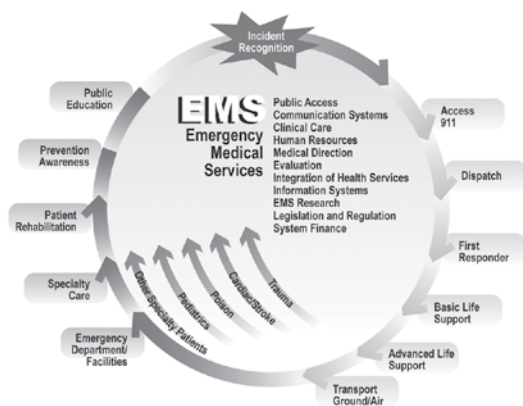
Facility — Licensed health care entity (e.g., hospital, clinic, rehab, nursing home)

Guideline — Something that is to be preferred, but that does not have the force of a standard. Providers/services are not held legally responsible for acting at this level of performance. A suggestion rather than a mandate.

Integrated Regional Health Care System – A regionally based system that provides its community members with seamless, comprehensive health care, including all who directly provide preventive services, acute care, and rehabilitation, as well as the components of the health care system that support their function. Examples of components providing support may include: insurance carriers, regulatory agencies, statutory public/government entities, consumer groups, and professional associations. In an integrated regional health care system, the efforts of all stakeholders are coordinated to ensure the active involvement of all entities in the process of planning, implementing, evaluating and problem solving.

Integration – The consolidation and coordination of separate units into a unified, harmonious whole.

Interfacility Transfer — Any transfer, after initial assessment and stabilization, from and to a health care facility. Examples would include:

- hospital to hospital;
- clinic to hospital;
- hospital to rehabilitation; and
- hospital to long-term care.

Levels of Patient Acuity – In order to provide safe and effective care, provider capabilities must match the patient's current and potential needs. It is important to have consistent terminology to define the levels of patient acuity. For each level, examples are provided of the types of needs the patient might have and the level of care likely to be required at each level.

- **Stable with no risk for deterioration** — Oxygen, monitoring of vital signs, saline lock, basic emergency medical care).
- **Stable with low risk of deterioration** — Running IV, some IV medications including pain medications, pulse oximetry, increased need for assessment and interpretation skills (advanced care).
- **Stable with medium risk of deterioration** — 3-lead EKG monitoring, basic cardiac medications, e.g., heparin or nitroglycerine

(advanced care +).

- **Stable with high risk of deterioration** – Patients requiring advanced airway but secured, intubated, on ventilator, patients on multiple vasoactive medication drips (advanced care +), patients whose condition has been initially stabilized, but has likelihood of deterioration, based on assessment or knowledge of provider regarding specific illness/injury.

- **Unstable** — Any patient who cannot be stabilized at the transferring facility, who is deteriorating or likely to deteriorate, such as patients who require invasive monitoring, balloon pump, who are post-resuscitation, or who have sustained multiple trauma (critical care or available crew with time considerations).

Medical Oversight – Medical authority and responsibility for all medical care provided by the service, including active day-to-day role in the function and management of the service as it relates to patient care activities. There are several terms that refer to the activities involved in medical oversight:

Prospective	Off-line	Indirect	E.g., protocol development
Concurrent	On-line/On-scene	Direct	E.g., giving orders via radio
Retrospective	Off-line	Indirect	E.g., quality management

Outcome Evaluation — Examines the effectiveness or efficacy of particular interventions on patient status. An outcome evaluation of IFT assesses a particular clinical aspect of patient care during IFT, and its impact on patient outcome.

Process Evaluation — Process evaluation focuses on the quality of implementation — how well the process was carried out. It examines operational and system efficiency. It would be difficult to arrive at the conclusion that a specific intervention caused a specific outcome if the process of achieving it was not carried out as intended.

Region – A particular area, zone, district, or territory. For the purpose of developing an IFT plan, a

region could be defined as the one EMS system or a combination of several EMS systems. A region can be defined and/or influenced by numerous determinants, such as:

- jurisdictions;
- geographic locations;
- service areas of providers;
- service areas of insurance carriers and
- referral patterns.

Service Area – The defined response boundaries, mutually agreed upon contractually and/or as designated by a regulatory body, to provide IFT within a single or combination of several EMS systems. A service area could be a region or part of a region, and can be defined and/or influenced by numerous determinants, such as:

- jurisdictions;
- geographic locations;
- service areas of providers; and
- service areas of insurance carriers.

Specialty Care Transport (SCT) – As defined by the Centers for Medicare & Medicaid Services (CMS) — is IFT of a critically injured or ill beneficiary by a ground ambulance vehicle including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

Standard — Is described as a basis for comparison; a reference point against which other things can be evaluated. Standards set a benchmark for subsequent work.

Transfer – The comprehensive infrastructure and process involved before, during, and after moving a patient from one location to another.

Transport – The physical process of moving a patient from one location to another.

Major Topic #2: Meeting Patient Needs

The overriding principle for all aspects of IFT is matching patient needs with adequate provider knowledge and skills, equipment and an infrastructure that provides seamless patient flow during transport. Any judgment should err on the side of caution in providing care at the level likely to be needed or potentially needed during IFT.

Interfacility transfer requires a unique set of skills distinct from the training of most hospital-based or prehospital providers. It is essential that personnel used to provide care during interfacility transfer be properly trained, familiar with the demands of providing care during ground or air transport, legally authorized to perform these skills, and prepared to handle the variety of patient contingencies that may arise during transport. Additional education will be needed to prepare all traditional providers for interfacility care, whether hospital or prehospital-based, but the specific focus of this additional education may vary depending on the provider's existing knowledge and skill base.

The discussion about provider education should start with a review of the questions to be asked:

- What are the specific needs of the patient?
- What types of practitioners are working in the field?
- What are the skills and knowledge levels these practitioners need for IFT?
- What type of training is required?
- What type of continuing education is necessary to assure knowledge and skills?

Since a variety of practitioners could be involved in interfacility transfer (paramedics, EMTs, nurses, physicians, respiratory specialists, etc.), attention should be focused on the knowledge, skills, and abilities required to match patient needs, as well as characteristics of effective education and training. Operational procedures and protocols must comply with State and local requirements as well as medical oversight.

Regardless of entry-level knowledge, skills, and abilities, there are basic transport skills and knowledge that anyone involved in IFT should possess:

Basic Knowledge and Skills:

Any health care professional providing care during IFT should demonstrate knowledge and skills related to:

- radio and communication technology;
- transport physiology;
- safety operations to include the vehicle (ambulance and/or aircraft) the patient, equipment, and all care providers on board;
- transport equipment;
- documentation;
- transport logistics;
- transfer protocol(s);
- patient records;
- physician orders;
- patient "packaging" for safety and accessibility;
- medical oversight; and
- evaluation of level of care needed by patient during transport.

Providers conducting interfacility transfers for patients in the "stable with low risk of deterioration" and "stable with medium risk of deterioration" should demonstrate knowledge, skills, and demonstrated abilities that include:

Advanced Knowledge and Skills:

- basic transport skills;
- IV insertion, monitoring and maintenance; including maintenance of central venous and intraosseous lines;
- all forms of medication administration;
- pharmacology at the DOT EMT- Paramedic National Standard Curriculum level;
- advanced airway management;
- ECG monitoring; and
- defibrillation, cardioversion, and transcutaneous pacing.

Providers involved in interfacility transfer of unstable, critically ill, or injured patients should have the ability to continuously monitor and assess the patient's condition and to intervene appropriately. At a minimum, this would require skill and knowledge in the areas of:

Critical Care Knowledge and Skills:

- advanced airway management;
- ventilator management;
- all forms of medication administration;
- pharmacology at the DOT EMT- Paramedic National Standard Curriculum level, plus advanced knowledge of vasoactive and antiarrhythmic drugs; and
- circulatory management and support.

Specialty Care Transport, as defined by the Centers for Medicare & Medicaid Services[1]

Specialty care transport (SCT) is interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

General IFT Provider Education Guidelines

Existing resources that establish minimum guidelines on provider education can be incorporated into education standards and guidelines. Desirable characteristics for provider education programs may include:

- Training and education that provide the knowledge and skills enabling providers to monitor and provide necessary care to maintain the stability of the patients' condition. This includes a working knowledge base and critical thinking ability related to the likely and potential complications associated with specific disease and injury processes, as well as complications associated with specific interventions.
- Sufficient clinical and field experience enabling providers to deal with varying levels of patient acuity.
- Initial and continuing education and training that is both didactic and hands-on, and of a sufficient time period to allow provider to demonstrate adequate knowledge and skills.
- Knowledge of assessment and intervention techniques specific to the provision of care required during IFT.
- Additional minimum requirements determined by the specific patient population being transported by providers.
- Continuing education requirements based upon data collected as part of a quality improvement/management program. Quality improvement data can include such information as frequency of specific clinical presentations, low-frequency/high-criticality interventions, patient outcomes, and issues related to concurrent and retrospective quality improvement.

References

1. Program Memorandum Intermediaries/Carriers. Transmittal AB-02/130. Subject: Definitions of Ambulance Services. September 27, 2002. Department of Health & Human Services. Centers for Medicare and Medicaid Services. Washington, DC.

Major Topic #3: Integration into Existing Regional Health Care Systems

For the purposes of this document, two types of integration were defined:

- horizontal – integration within existing health care system, and
- vertical – integration with other/neighboring health care systems.

Both are desirable in achieving seamless patient flow during IFT.

Highly specialized health care services (e.g., stroke centers, cardiac centers, trauma centers, high-risk obstetrics) may be more expensive than those services providing a general level of care. Integration may also avoid redundancy and promote the most efficient use of resources. IFT can be an important means to support integration and regionalization of health care services.

Considerations for a regional IFT plan include:

- delineation of legal authority and responsibilities;
- a definition of integration and a description of a region the stakeholders agree to (see Definitions, Major Topic #1);
- what is meant by an integrated regional health care system – components involved and how they interoperate;
- education of personnel in all system components;
- identifying synergies that can result from, and the overall value of a regional approach to integration of services;
- the need for and problems caused by integration of services across State lines (as it applies to IFT);
- benefits of open communication among stakeholders, particularly with third-party payers;
- the potential impact of regional integration on competition and service duplication; and

- transfer agreements and reciprocity of services and personnel.

To determine the current level of regionalized care and how IFT can be integrated, several questions may be helpful:

- What defines current practice related to regionalized health care? Factors may include:
  - ❏ referral patterns and
  - ❏ legal requirements such as contracts, agreements, memoranda of understanding.
- What currently triggers IFT? What services currently exist to fill this need? What needs continue to exist?
- What are current practices/processes regarding decisions related to mode of patient transfer and patient's destination facility?

Potential or perceived challenges in developing a regional plan for IFT:

- designated IFT providers may be perceived as curtailing competition;
- complications caused by interstate IFT system;
- quantity and quality of personnel needed to provide service;
- in a free market system, providers may choose not to participate, creating gaps in coverage; and
- unique challenges of providing IFT in urban areas and rural areas.

Potential or perceived benefits of developing a regional plan for IFT:

- avoiding duplication of services;
- leveraging limited resources;
- maintaining optimal skills, knowledge and abilities by assuring adequate patient volume;
- synergy of well-coordinated process may be applied to other EMS needs, e.g., disaster management;

- providing optimal care in a timely fashion, and
- self-determined cooperation and collaboration.

Strategies for overcoming challenges:
- open and constructive communication among stakeholders;
- education and active participation of all stakeholders including service providers, payers, administrators and regulators;
- transfer agreements/partnerships, and
- reciprocity among states for services and individual licensing.

Major Topic # 4: Medical Oversight

The Medical Director

The practice of critical care medicine is different from the practice of emergency medicine. Likewise, emergency medicine is different from EMS, and IFT is different from the portion of EMS providing prehospital care. Each is a distinct specialty with focused knowledge, skills, and abilities. Trying to find one medical director to wear all of these hats may not be easy, and it could take several physicians working together to provide the experience and expertise required for comprehensive IFT service.

Physicians in medical specialty usually practice within hospital walls (e.g., neonatology, thoracic surgery) and may not be familiar with the operational aspects of the IFT process. Specialists are more likely to require additional training to function efficiently in the out-of-hospital environment, and for them to function in medical direction capacity. It may be easier for physicians/medical directors who are familiar with EMS and/or IFT (e.g., EMS Medical Directors) to assume leadership of IFT programs. EMS physicians in general are familiar with what is involved in caring for patients in out-of-hospital settings.

The ideal IFT Medical Direction might be a cross-trained physician or through a collaborative working relationship between two (or more) physicians. If one physician is designated as medical director for an IFT program, that physician should function as medical director for the IFT program using other specialists as resources, rather than having several physicians serving as multiple medical directors. There should be assurance that the Medical Direction arrangement is consistent with applicable State laws and regulations.

Guidance for medical directors can also be found from multiple sources, including:

Air Medical Physician Association
Medical Direction and Medical Control of Air Medical Services
http://www.ampa.org/component/option,com_docman/task,cat_view/gid,23/Itemid,42/

American College of Emergency Physicians
Interfacility Transportation of the Critical Care Patient and Its Medical Direction (1999)
http://www.acep.org/webportal/PracticeResources/PolicyStatements/

National Association of EMS Physicians
Medical Direction of Interfacility Transports (2000)
Medical Direction for Air Medical Transport Programs (2002)
Physician Medical Direction in EMS (1997)
(table of contents:)
http://www.naemsp.org/Position%20Papers/Contents.html

Commission on Accreditation of Medical Transport Systems

Best Practices: A Collection of Outstanding Programs and Policies from Accredited Transport Services
http://www.camts.org

Medical oversight in IFT may take multiple forms:

Prospective	Off-line	Indirect	E.g., protocol development
Concurrent	On-line/ On-scene	Direct	E.g., giving direct orders via radio/ telephone
Retrospective	Off-line	Indirect	E.g., quality management, case review

Off-Line Medical Direction

Off-line medical direction includes those activities performed by the medical director that do not occur during actual transport. These duties are usually performed before transport (e.g., training, education, development of protocols) and after transport (e.g., chart review, case review, continuing or remedial education, quality improvement). The medical director is ultimately responsible for the care provided by the IFT service and should be involved in all aspects of IFT that have a direct, potential impact on patient care.

Role of Standardized IFT and Destination Protocols

Written orders from the transferring facility may suffice for the stable patient during most transfers, but on-line medical direction should be available at all times, in case unforeseen situations arise during transport. Off-line protocols can be developed as a basis for care during transport, but complexity of care for many patients seems to suggest that they may be of limited usefulness. A standard order sheet shared system-wide that can be individualized by the transferring physician may be more useful. Advance development of this form in conjunction with referring and/or accepting physicians may further facilitate the IFT process.

Unlike prehospital EMS, which may dictate that a patient be taken to the closest or most appropriate facility, IFT is a physician order to transport a patient from one specific location to another. Therefore, destination protocols are of very limited utility unless they address the event of a rapid deterioration of patient condition requiring transport to the nearest appropriate facility.

Consultation with Specialty Care

The medical director is ultimately responsible for the care provided by the IFT service. Therefore, it behooves the medical director to have access to specialists and consultants who are available for real-time (on-line medical direction) problem solving, and for protocol development, case review and post-transport consultation. It may be in the patient's best interest, and extremely helpful to both crew and medical director, to seek the opinions of those with extensive experience and expertise in medical specialties. One possible model includes a single medical director who receives input and assistance from other medical specialists (i.e., neonates, pediatrics, intra-aortic balloon pump, etc.) in drafting protocols, education, and case review for IFT.

On-Line Medical Direction

On-line medical direction includes those activities performed by the medical director that occur real time, during actual transport. On-line medical direction should be available at all times, in case unforeseen situations arise during transport.

Medical oversight and interfacility transfers: which medical director is liable for what part of interfacility transfer

Medical oversight is variable and depends on State and local regulations. As per the Emergency Medical Treatment and Labor Act (EMTALA), the referring physician is responsible for the patient being transferred from one facility to another, until the patient arrives at the receiving facility. On-line medical direction may be provided by the referring physician, the accepting physician, the transferring agency medical director, the medical director's proxy for specialty care issues, or some combination of the above. This often is determined by the State and local regulations, and may differ between jurisdictions. For example, in some jurisdictions, if the transport vehicle is owned by the receiving facility that liability begins when the crew assumes care of the patient.

While on-line medical direction may be provided by the referring physician, the accepting physician, the transporting agency medical director, the medical director's proxy for specialty care issues, it is essential that the roles of each are determined prior to transport and while the IFT system is developed. It may require a contract, a memorandum of understanding, or other legal documents between the agencies or jurisdictions. Whatever the case, it needs to be clearly defined in advance of transfer and not decided while transport takes place.

To anticipate possible situations where there may be confusion or difference of opinion regarding the bounds of responsibility and liability, IFT services should develop and adopt protocols for how crew members and the medical director will handle such situations. This protocol should include provisions to assure medical director responsibility is resolved prior to patient transport. Advance knowledge of this protocol by all stakeholders may be helpful in proactively addressing potential situations concerning medical oversight.

MAJOR TOPIC #5: LIABILITY

Optimally, decisions regarding system or service protocols and procedures, scope of practice of transport personnel, interagency and inter-jurisdictional agreements regarding transfer should be made prior to the need for interfacility transfer. The extent to which this is accomplished will make decisions easier and the IFT process more efficient. Potential liability has a major impact in making these decisions, and it behooves all stakeholders to have a strong working knowledge of the issue. Laws addressing liability and their interpretation vary widely from state to state. Specific information within this document may therefore be of limited use. It behooves those involved in IFT to become familiar with State laws and court decisions impacting liability in the jurisdiction(s) to be served by the IFT service. This major topic contains general information for consideration, including: definitions, delineations of liability for health care providers, regulations that affect liability, and practice guidelines.

Definition of Liability

Liability is generally defined as legal responsibility for one's acts or omissions. There are two forms:

- Direct Liability - Liability imposed directly on a person because of his or her own negligence, default, or legal undertaking.
- Indirect Liability - Liability that arises from a legal obligation owed to an injured party to pay damages for another's failure to perform or negligent act.

Liability of Each Health Care Professional

Every health care professional has a legal duty to exercise that degree of knowledge, care, and skill that is expected of a comparably trained practitioner in the same class in which he or she belongs, acting in the same or similar circumstances. The standard of care is based on laws, administrative orders, regulations, and guidelines established by entities or individuals with the legal authority to do so.

Liability of Direct Care Providers

Each program, hospital, or service employing health care professionals to provide direct care for patients during IFT is responsible for ensuring that policies, procedures, and protocols are in place for the care provided by the transport team. These documents should be consistent with laws, regulations, and administrative rules for the jurisdiction(s) in which IFT occurs. The IFT service should also maintain written policies addressing appropriate licensure and scope of practice for each team member, based upon the local, regional, and/or State laws and/or regulations in the geographical area(s) in which the team provides care and performs transports.

The IFT transfer service/program is responsible for the care rendered during transport. The program should establish written policies/protocols for all procedures, skills, or care the transport team members provide. Written documentation of education, skills, training, demonstrated abilities, initial and/or ongoing education, should be maintained, and all transport personnel should be familiar with program requirements. In addition, the transfer service should establish an ongoing program for quality assurance/quality management, which uses patient and referring facility/physician satisfaction surveys, chart reviews, case reviews, and peer reviews to identify problems or areas needing improvement as well as areas of strength that could serve as models for other IFT services.

The individual caregivers are responsible for the direct care they provide to the patient during transport. It is imperative that these personnel be familiar with the appropriate State practice acts (e.g., Medical Practice Act, Nurse Practice Act, EMS Act), licensing and/or certification regulations, and the limitations and responsibilities of their specific profession's scope of practice. It is the obligation of each licensed and/or certified professional to know and understand the standard to

which he or she will be held. Individuals providing direct care to the patient should not be pressured into functioning beyond their intended role, and must always function within the scope of practice for which they are prepared, trained, and legally authorized. Procedures should be in place that providers can use to handle situations placing them in questionable situations. Direct care providers may or may not choose to carry individual professional malpractice insurance in addition to what is provided by their employers.

Liability of Medical Directors

Medical practice acts vary from State to State as do statutes related to functions that may be performed under a physician's license. It is particularly important for the prehospital professional who functions under medical direction to understand the purpose of the law in their jurisdiction(s), and to be familiar with their State's Medical Practice Act, particularly as it pertains to liability and legal responsibilities.

Obtaining Liability Insurance

Physicians and other medical professionals pay insurance premiums to cover payments for awards resulting from lawsuits. They may need liability insurance to practice medicine; in most cases hospitals, physician groups, as well as many State laws require it. The cost of medical liability coverage varies by specialty and location. Physician specialists practicing emergency medicine, neurosurgery, orthopedics, obstetrics, and gynecology often have the highest premiums, because they perform procedures that have more risks of complications or because their patients have more serious illnesses or injuries.

The medical liability crisis is reported to have posed serious challenges to those physicians providing medical oversight, including those involved with IFT. For more extensive information, refer to Appendix D: Obtaining Liability Insurance.

Regulations that Affect Liability

EMTALA
Emergency Medical Treatment and Labor Act[1]

The Emergency Medical Treatment and Labor Act is a Federal law enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd). Referred to as the "anti-dumping" law, it was designed to prevent hospitals from refusing to treat patients or transferring them to charity or county hospitals because they were unable to pay or had Medicaid coverage. EMTALA requires hospitals with emergency departments to provide emergency medical care to everyone who needs it, regardless of ability to pay or insurance status. Under the law, patients with similar medical conditions must be treated consistently. The law applies to hospitals that accept Medicare reimbursement, and to all their patients, not just those covered by Medicare. For more information, refer to Appendix E: EMTALA.

Certificate of Transfer[2]

Certification of necessity for transfer is a requirement for reimbursement by the Centers for Medicare and Medicaid Services. The CMS definition of medical necessity is as follows:
Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case, in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance service
It is possible (but not likely) that a patient may require transfer and not meet the CMS definition of medical necessity. For more information, refer to Appendix F: Certificate of Transfer.

HIPAA
Health Insurance Portability and Accountability Act (HIPAA)[3]

The Health Insurance Portability and Accountability Act of 1996 is a law enacted to combat fraud, waste, and abuse in health insurance and the delivery of healthcare services; to improve access to long-term care services and coverage, and simplify the administration of health insurance. The program sets standards for the use and disclosure of protected health information along with measures to ensure the secure transmission and storage of medical records and other individually identifiable or demographic information. The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally. HIPAA regulations have implications for all IFT services transporting and transferring medical records or medical information from one facility to another. For more information on HIPAA, refer to Appendix G: HIPAA.

Federal, State, and Interstate Regulations

IFT providers are well advised to become familiar with any Federal, State, or interstate regulations that may have an impact on IFT service, as well as their relative jurisdictions. While it is not possible to include an exhaustive listing of these regulations, examples may provide illustration of the potential impact of regulations on IFT.

Example #1 – Federal Aviation Administration (FAA)

The FAA strictly governs the operations of aircraft in the United States under Title 14 of the Federal Code of Regulations. There are two Federal Aviation Regulations (FAR) that are applicable to air medical transport, FAR Part 91[4] and FAR Part 135[5]. FAR Part 91 addresses the "General Operating Flight Rules" and FAR Part 135 deals with "Commuter and On-Demand Operations and Rules Governing Persons on Board Such Aircraft."

Air medical transport programs are most commonly operating under Part 135. All commuter and on demand aircraft transporting passengers are required to comply with all Federal Aviation Regulations contained in Part 135.

Example #2 — State Regulation

EMS services usually derive their authority from State laws or regulations. These may include laws that allow the provision of emergency care. These statutes define scope of practice and frequently address protocols, communication, and medical oversight. There is great variation from State to State in these laws and regulations. Some grant licensure while others do not. It is important to be familiar with the State laws and regulations as they pertain to the practice of IFT within the jurisdiction(s) where IFT services are provided.

In some cases and for certain circumstances, Federal agencies may have jurisdiction (e.g., EMTALA, HIPAA, Federal Aviation Administration regulations on aircraft used as air ambulances). Specific roles and responsibilities in interfacility transfers will vary from State to State; it is important to understand these responsibilities. In some localities, the functions of IFT providers and/or services are enabled by a specific law or regulation.

Example #3 — Interstate Issues

Because some geographic areas do not have reasonable access to comprehensive or specialty services within their own state, referral patterns may exist that cross State lines. This situation makes it necessary to consider issues of interstate coordination and cooperation. Interstate issues can also arise for metropolitan areas that serve more than one State. In some cases, interested parties can develop official agreements under the auspices of State or local government agencies. In other cases, contractual or informal relationships develop between referral centers and community hospitals and EMS systems.

The stability of both official and informal arrangements depends on meeting the needs of all the groups involved and on addressing key issues, such as coordination of professional, legal, and regulatory requirements. Neighboring States often differ in such matters as certification and licensing requirements for institutions and practitioners, scopes of practice and guidelines for transfer. Interstate transfer agreements can address some of these differences to ensure that consistent and acceptable levels of care are rendered and that providers do not face liability risks related to differences in practice standards.

Practice Guidelines

Various terms are used to outline the expectations of performance within the EMS community. The terms "standards" and "guidelines" are frequently and erroneously used interchangeably. The Health Improvement Institute provides a generic definition for these similar terms.[6] A standard (or protocol) is described as "a basis for comparison; a reference point against which other things can be evaluated; 'they set the measure for all subsequent work.'" A guideline is explained as "something that is to be preferred, but that does not have the force of a standard." EMS standards and guidelines can be written to reflect a course of action for clinical as well as operational/management needs. For the purposes of this discussion, standards create an expectation while guidelines are generally thought to be a bit more flexible.

The Institute of Medicine (IOM) defines clinical practice guidelines as "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances."[7] Frequently promulgated by relevant professional organizations, societies, health care organizations, or government agencies, standards and guidelines are generally developed using verifiable, systematic literature searches and reviews of existing evidence published in peer-reviewed journals to establish best practice recommendations.

Perceived advantages of establishing clinical practice guidelines for IFT include:

- evidence-based reference for provider practice;
- direct linkage with improvement in patient clinical condition and outcome;
- direct linkage with reduced risk of morbidity and mortality;
- established benchmark for measuring performance;
- direct linkage with enhanced patient safety;
- comparison between agencies easier using similar guidelines;
- provides public and referring physicians/facilities a clearer understanding of the capabilities of any one IFT provider and
- gives provider a clear understanding of expectations and responsibilities.

Perceived disadvantages of establishing clinical practice guidelines for IFT include:

- use by the legal community to argue a breach in the standard of care when litigation ensues following a negative outcome (whether or not medical negligence actually exists);
- difficult and resource-intensive to develop and maintain;
- minimal flexibility for individual preferences, agency capabilities, changes in patient condition;
- difficult to establish for patients with multiple, complex diagnoses;
- balance between optimal clarity and minimal liability difficult to establish; may be too vague to be useful or too narrow to be legally "safe";
- might force IFT provider to meet unrealistic expectations regarding equipment, education, and maintenance of skills and
- guidelines do not have the force and effect of the law.

References

1. Emergency Medical Treatment and Labor Act. State Operations Manual. Appendix V – Interpretive Guidelines – Responsibilities of Participating Hospitals in Emergency Cases. (Rev. 1, 05-21-04). Department of Health & Human Services. Centers for Medicare and Medicaid Services. Washington, DC.

2. Certificate of Transfer. *Federal Register*, June 22, 1994 (59FR32086). Department of Health & Human Services. Centers for Medicare and Medicaid Services. Washington, DC.

3. Health Insurance Portability and Accountability Act. http://www.cms.hhs.gov/hipaa/. Department of Health & Human Services. Centers for Medicare and Medicaid Services. Washington, DC.

4. Code of Federal Regulations, Part 91. General Operating and Flight Rules. *http://ecfr.gpoaccess. gov/cgi/t/text/text-idx?c=ecfr&sid=c3a8e0947420 81e734f4dafc1496bf36&tpl=/ecfrbrowse/Title14/ 14cfr91_main_02.tpl*. U.S. Government Printing Office. Washington, D.C.

5. Code of Federal Regulations, Part 135. Operating Requirements: Commuter and On Demand Operations and Rules Governing Persons On Board Such Aircraft. *http://ecfr. gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=c 3a8e094742081e734f4dafc1496bf36&tpl=/ec-frbrowse/Title14/14cfr135_main_02.tpl*. U.S. Government Printing Office. Washington, D.C.

6. Clinical Practice Guidelines: Directions for a New Program, (1990), M.J. Field and K.N. Lohr (editors) Washington, DC: National Academy Press. Page 38.

7. Health Improvement Institute Quality Award. Standards. Definitions and Abbreviations. Health Improvement Institute. http://www.hii. org/index.html

MAJOR TOPIC #6: OPERATIONS

The overriding principle for all aspects of IFT is matching patient needs with adequate provider knowledge and skills, equipment and an infrastructure that provides seamless patient flow during transport. Any judgment should err on the side of caution in providing care at the level likely to be needed or potentially needed during IFT. Major Topics 2 and 4 address multiple considerations in providing optimal patient care. In addition to these, the operational aspects of IFT should be closely managed, to facilitate seamless patient flow during transport. Operations can include crew selection, staffing levels, the vehicle, equipment, communications, and standard operating procedures.

Crew Selection

Interfacility transfer requires a unique set of skills that is distinct from the training of most hospital-based or prehospital providers. To provide adequately for patient needs during IFT, selection of the transport personnel/crew should include a team capable of providing the level of care the patient's present condition requires; the likely and the potential needs of the patient throughout the transport. In many jurisdictions, prehospital and hospital health care professionals are legally authorized to perform tasks within a specific scope of practice, which may or may not match the clinical needs of the patient or the needs presented by the operational IFT environment.

In IFT program development, it is advisable to determine the knowledge, skills, and abilities necessary for the IFT patient population. Under the medical director's guidance, recurring referral patterns, patient populations, and frequently used modes of transportation should be assessed to determine necessary qualifications and training. The need for specialty care transports (i.e., neonatal, intra-aortic balloon pump) should be analyzed to make decisions on how to match patient needs with provider knowledge, skills, and abilities.

It is essential that personnel utilized to provide care during interfacility transfers be properly trained, familiar with the unique demands of providing care during ground or air transport, legally authorized to perform the skills, and prepared to handle the variety of patient contingencies. Multiple providers may be qualified to accompany the patient depending on their education, skill level, and legal authority. Additional education, under the guidance of the Medical Director, will be needed to prepare all traditional providers for interfacility patient care, whether hospital or prehospital-based, but the specific focus of this additional education may vary depending on the provider's existing knowledge base. Medical directors should be involved in training, education, and evaluation of crew knowledge, skills, and abilities, at each level of care, on an ongoing basis.

The crew should be educated and trained to care for the anticipated patient population using anticipated transport mode(s). Training can be provided by the transport agency or other legally recognized entity, but the medical director and transport agency should approve the level of education and training provided. Providers can also receive specialized education and training in specific areas (e.g., neonatal, cardiac, etc) appropriate for the patient population(s) being transported. There may also be a need for the use of other healthcare professionals (e.g., respiratory therapists) during transport. The crew must be able to provide quality care within their scope of practice including the use of transport equipment in the transport environment.

Minimum requirements for staff qualifications

Minimum requirements can be flexible without compromising care. For extensive information on suggestions for provider skills and knowledge, refer to Major Topic #2, Provider Education, which includes suggested knowledge, skills, and abilities related to IFT.

Staffing Levels

The number and right combination of personnel should be addressed in developing an IFT program. Staffing decisions should be determined by clinical patient care needs and operational requirements. Recurring referral patterns, patient populations, and frequently used modes of transportation should be assessed to determine necessary qualifications and training. The highest potential acuity level of the transported patient and the ability of the staff to respond appropriately in the transport environment should be a determinant of crew composition.

Many transfer services use the team concept in developing and deploying IFT. Predetermined staffing patterns with specific qualifications can be developed to match patient need and deployed when patient need is identified. Determination of the appropriate team composition can include consideration of the following:

- the availability of critical care and/or specialty care transport teams within a reasonable proximity;
- the modes of transportation and/or transport personnel available as options in the particular geographic area;
- specific circumstances associated with the particular transport situation (e.g. inclement weather, major media event, etc.);
- anticipated response time of the most appropriate team and/or personnel;
- established State, local, and individual transfer service standards/requirements;
- combined level of expertise and specific duties/responsibilities of the individual transporting team members;
- degree of supervision required by and available to the transporting team members;
- complexity of the patient's condition;
- anticipated degree of progression of the patient's illness/injury prior to and during transport;

- technology and/or special equipment to be used during transport; and
- scope-of-practice of the various team members.

The transport team leader should possess appropriate clinical experience and expertise, as well as the leadership skills necessary to direct the provision of patient care in the IFT environment. Unless a physician is included as one of the transport team members, a physician designated to provide medical direction should be available for consultation. An acceptable exception to this requirement may exist in those circumstances when, under supervision of the designated medical oversight physician, the transport team follows established written policies, protocols, and procedures.

Filling Staffing Needs

Although there may be variation in the minimum requirements and core knowledge, skills, and abilities that the members of the IFT team are required to possess, their combined expertise should provide for accurate patient assessment, formulation of an effective plan of care, implementation of appropriate interventions for the actual and potential patient problems that may be encountered, and evaluation of the patient's response to the care provided. Education and training specifically related to the characteristics and differences of delivering patient care in the transport environment must be provided prior to any performance of independent transport care activities by any member of the transport team.

The content and extent of required training will be dependent upon the job description and/or the specific set of duties for which the individual team member will be responsible. Qualified people may be hired or training provided for existing staff. Decisions favoring one approach over the other involve the availability of qualified staff, possible pay differentials based on knowledge and skills, providing training to existing staff, and the cost-effectiveness of comparable models.

The Vehicle

Vehicle selection should be driven by the IFT mission profile. State licensing requirements should be met, and the vehicle should be able to accommodate the necessary equipment. Vehicle selection should provide enough room for the patient, caregivers, and potential additional equipment and/or providers. As with any transport, all safety standards should be met. Redundant power, electrical, communication, and lighting systems should be provided.

Equipment

As with crew vehicle selection, determination of equipment should be based upon patient and operational needs. Equipment should comply with all minimum statutory and regulatory requirements, and provide for accurate patient assessment, implementation of appropriate interventions for the actual and potential patient problems that may be encountered, and evaluation of the patient's response to the care provided. Equipment should also provide all necessary functions to operate safely and accurately within the transport environment. Equipment lists are available from multiple sources. For more information, refer to Appendix B: References & Resources, References of General Interest.

Communication/Linkages Needed

Communication is essential for the safety of the crew and the optimal care of the patient. The crew must be able to communicate with the dispatch/ communication center, the receiving facility, the local public safety providers — EMS, fire and police, and on-line medical direction. Communication and data linkage should be available throughout transport. A redundant system should be in place in case the primary communication system fails.

Administrative Protocols/Standard Operating Procedures

A comprehensive IFT service requires administrative protocols to provide seamless patient flow during transport and to deal with challenges IFT may pose. Standard operating procedures are recommended to address such issues as mutual aid, communications, weather, and equipment maintenance and failure. More information on standard operating procedures can be found by referring to the Commission on Accreditation of Ambulance Services (CAAS). Both CAAS and the Commission on Accreditation of Medical Transport Systems offer helpful information as well as the opportunity for accreditation, which may have practical benefits for IFT services. The CAAS Web site can be accessed at: www.caas.org and the CAMTS Web site can be accessed at: www.camts.org.

Major Topic #7: Financial Considerations

Meeting the cost of IFT involves a thorough understanding of incurred expenses as well as mechanisms for reimbursement. While most payers make payment for services and equipment provided, identification of alternative funding sources may be necessary to cover the cost of providing "preparedness" (the day-to-day fixed and operating costs of IFT service). This may require creativity and collective thinking on the part of IFT stakeholders. A careful, comprehensive assessment of costs can be useful in meeting the financial needs for an ongoing IFT service.

Costs are incurred by an IFT service to assure a constant state of readiness, even if no patients are transported. IFT service assumes additional costs every time a patient is transported. The following is a list of considerations in determining fixed and other operating costs, and how these costs increase once patient care is initiated.

Fixed costs/readiness/surge capacity

- Labor — for those providers who are not volunteer.
- Equipment, medications, and supplies.
- Vehicle maintenance.
- Overhead for facility housing transport mode and/or administration.

Other operating costs

- Marketing – customer/hospital/facility education regarding the availability and capabilities of the IFT transfer services.
- Billing.
- Legal and accounting.
- Educational and continuing education costs.
- Licensure for providers.
- Administrative personnel.
- Field personnel --some services deal with this cost by using personnel on an independent contractor basis (to avoid this fixed cost).
- On-call pay.
- Dispatch center functions.
- Insurance.

- Quality Improvement.
- Infrastructure costs – additional costs related to function as part of an EMS system, e.g., communication.

Adding the cost of patient care

These costs include expenditures related to providing basic care to stable patients with very little or no risk for deterioration; and additional variable costs of fuel, supplies, equipment, and personnel.

Adding the cost of critical care

These costs include expenditures related to providing advanced care to all patients whose acuity surpasses that of stable patients and additional variable costs of fuel, additional supplies, equipment, and personnel to provide the required level of care.

Supply and demand — "back-up" capacity

Represents replacement (back-up/on call) crew, equipment and other infrastructure costs when the primary unit/ambulance is providing IFT services and/or payment for additional or higher-level medical personnel if needed, to assist in the transport. For the purposes of this document, discussion of back-up capacity is limited to the day-to-day capacity of any one IFT program to meet the demand for its services. The discussion will not include the capacity to handle an epidemic illness or injury, natural disaster, intentional acts of mass injury, otherwise known as "surge capacity."

Definition of level of service[1] (as defined by CMS, for service provided)

It is important for IFT services to understand how payers such as CMS define levels of service

- Basic Life Support (BLS) – where medically necessary, the provision of basic life support services as defined in the National EMS Education and Practice Blueprint for the EMT-Basic including the establishment of a peripheral intravenous line

- Advanced Life Support, Level 1 (ALS1) – where medically necessary, the provision of an assessment by an advance life support provider and/or the provision of one or more ALS interventions. An ALS provider is defined as a provider trained to the level of the EMT-Intermediate or Paramedic as defined in the National EMS Education and Practice Blueprint. An ALS intervention is defined as a procedure beyond the scope of an EMT-Basic as defined in the National EMS Education and Practice Blueprint.

- Advance Life Support, Level 2 (ALS2) – where medically necessary, the administration of at least three different medications and/or the provision of one or more of the following ALS procedures: manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway, intraosseous line.

- Specialty Care Transport (as defined by the Centers for Medicare & Medicaid Services) — SCT is interfacility transportation of a critically injured or ill beneficiary by an ambulance, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

- Emergency – Emergency response is a BLS or ALS1 level of service provided in immediate response to a 9-1-1 call or the equivalent. The immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take steps necessary to respond to the call.

Business Plan

It may be helpful for IFT stakeholders to write a business plan to develop strategies to meet the financial needs of the IFT service. Writing a business plan will provide essential information as well as a tool to track, monitor, and evaluate the financial status of an IFT service. There are many forms of business plans, but most have three purposes: communication, management, and planning. A comprehensive plan can be used to establish timelines and milestones, gauge progress and compare your projections to actual accomplishments, and it is a living document to be modified as financial considerations evolve and change. For more specifics on writing a business plan, refer to Appendix C.

Considerations

When developing and deploying a business plan, it is wise to consider circumstances specific to your service, community, and situation. These may include:

Urban Services and Rural Services

Urban

- While urban areas are assumed to have shorter transport times, transport times and costs can be increased by urban traffic congestion and diversion of ambulance patients by overcrowded EDs and hospitals.

Rural

Many of the problems of an urban service can be magnified in a rural service. Even including the Rural Adjustment Factor (RAF), which is defined by CMS as an adjustment rate applied to the payment amount for ambulance services when the point of pick-up is in a rural area, rural services may face additional financial challenges:

- Rural services may have difficulty finding trained and experienced personnel. Recruiting can be difficult for rural services. Pay differentials may contribute to the difficulty in recruiting.

- Training costs may include the additional cost of travel, as personnel often need to travel, either to provide or receive necessary training.

- For IFT, the mileage and hourly expenses may be magnified because transport is generally over longer distances. The transporting service must pay for fuel, wear and tear on the vehicle, and the time of the personnel. Longer transport times also mean that the personnel must be prepared for more contingencies with the patient, increasing the cost of readiness. This includes the cost of such things as a larger quantity and bigger selection of drugs and equipment.

- Shipping, fuel, and maintenance cost more in a rural environment. It is more difficult to get any material into the area, and that usually translates into higher prices.

- Rural services may be low-volume, and not be able to recoup fixed costs as easily as busier services.

Regional Planning

- Regional planning for reimbursement models can be key in minimizing cost. While reducing competition, regional planning can also reduce redundancy and resultant increase in expense.

- Trying to insure coverage by linking services within a designated locality can be facilitated by the linkage of the appropriate reimbursement plans.

Integrating CMS reimbursement rules with third-party payers

EMS offices can involve both public- and private-party payers in the IFT planning process. Medicare patients make up a significant portion of all ambulance patients; therefore Medicare rules set the standard for many payers and Medicare rules should be reviewed in the IFT planning process. For optimal simplicity and consistency, there should be agreement among all payers, on definitions and standards for medical necessity, service levels, practitioner level definition, covered services and other necessary elements of IFT.

Education and active participation of stakeholders

In the IFT planning process, stakeholders can educate third-party payers about what the IFT system includes and can involve them in the discussion of providing IFT services. At a minimum, such education includes:

- the difference among various payment levels;

- the discrepancy between the cost of providing preparedness versus fee for specific services provided;

- the difference between subsidized versus non-subsidized services and their impact on IFT services; and

- the difference between volunteer versus paid (or mixed) services — since fixed personnel costs would be different.

Significant financial gaps may be identified, requiring creativity on the part of all stakeholders to provide support for IFT. Billing of third-party payers is only one strategy for revenue. Other unconventional ideas may be useful in meeting the costs of IFT:

- in-kind support, such as contribution of equipment and/or services (if allowed);

- transition to an overall model of reimbursement for IFT through hospitals and/or physicians. Adopting this model may provide the IFT program with a broader range of reimbursable services than those included in transport reimbursement models.

References

1. Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Pub. 100-02. Chapter 10. Ambulance Services. *http://www.cms.hhs.gov/center/ambulance.asp*

MAJOR TOPIC #8: POLICY DEVELOPMENT

Policy development and planning includes strategies to:

- inform, educate, and empower people about IFT issues;
- mobilize State and community partnerships to identify and solve IFT problems; and
- develop policies and plans that support State and community IFT efforts.

In many communities there is no entity with authority or responsibility for management of IFT issues. In some States/communities, formal agreement among the stakeholders may be sufficient to implement IFT strategies. Frequently, however, legislation and regulation are necessary. Whether derived from government authority or established through formal stakeholder agreement, it is important the IFT policies, procedures, authorities and responsibilities be articulated carefully and communicated to all stakeholders.

Legislation, adopted by a governing body (e.g. State legislature, county council), usually establishes which government entity is responsible for management of IFT, delineates that agency's authority and responsibility and establishes other IFT parameters potentially including the need for a license. Frequently, the government agency, such as a state or county health department or State EMS Agency, is authorized to promulgate rules/regulations that may establish IFT licensure requirements including, for instance, personnel education and certification, safety, reporting procedures, medical direction and license suspension or revocation. Sometimes, these detailed requirements are determined by the governing body and are included in the legislation. In some States, IFT regulation authority may be contained in the State EMS agency's authorizing legislation.

A systematic process is recommended to assess the current status of and potential need for IFT legislation and regulation including finding the answers to the following questions:

- What local, State or Federal laws and regulations directly impact IFTs in your community?
- What agency has the authority and responsibility for implementing and enforcing these laws and regulations?
- What processes does the agency use to develop and to enforce regulations? How can you impact regulation development or modification?
- Do jurisdictions' regulations compliment each other or do they conflict?
- What gaps or issues can you identify in the legislation or regulations?
- Is there model legislation that may be helpful in this analysis?
- Do other jurisdictions have comparable legislation that could provide comparison?

In evaluating the adequacy of existing agreements, laws, regulations or policies, the following considerations may be important:

- definition of levels of patient acuity to assist in determining appropriate personnel to use during the IFT;
- standards of care;
- minimum requirements for education and training of IFT personnel;
- inter-jurisdictional transfer issues;
- requirement for data collection or utilization of data for performance improvement;
- authority to enforce regulations.

Persons interested in developing legislation or regulations for IFT should become familiar with their jurisdiction's system. For instance, visiting

with and involving State EMS Agency staff may be essential to improving IFT policy development and implementation. The State EMS Agency can usually provide good information on the status of

Legislation may be enabling. In June 2005, New Hampshire law was amended to enable alternative health care to participate in interfacility transfer if the availability of conventional providers exceeds 30 minutes, enhancing the ability of New Hampshire health care facilities to provide expedient transfer to patients requiring such service (S.B. 88). This law made it possible to use multiple IFT strategies without requiring any specific mode or crew composition.

IFT legislation, regulation and legal decisions. Understanding of the State's regulatory process and gaining support for authorizing legislation or regulations can reduce misunderstandings and conflict. For instance, many State EMS offices have an advisory council that provides advice on regulatory and EMS system issues. It may be important to have an individual experienced and interested in IFT issues attend the meetings and provide information on IFT issues. An ad hoc group can be formed to make recommendations for advisory council consideration.

Educating and involving third party payers may also be a key activity to improving your IFT system.

To obtain more information on statutes and administrative rules and how they affect EMS in your State, contact the State EMS office. A listing can be found at www.nasemsd.org, the Web site for the National Association for State EMS Officials.

MAJOR TOPIC #9: EVIDENCE

The guidelines contained in this document are based upon a combination of available objective evidence, a review of generally accepted practices, and the consensus of expert opinions in the field of IFT — in short, the best information available. In the current health care environment, however, the efficiency and efficacy of medical practice, policies, and operations are held to a higher standard of evidence than in the past. Ongoing evidence collection is the key to ensuring that IFT provides the best possible care in an optimal fashion.

The members of the IFT Workgroup concur with the authors of the EMS National Research Agenda who state, "...the lack of scientific knowledge about optimal patient care has confused clinicians and left them floundering to provide the best care without the guidance of good science." As with any other area of emergency care, the practices and processes involved in delivering IFT need objective evaluation to determine their impact and cost-effectiveness.

Evidence assessing the status of IFT services can range from "micro" to "macro" in scope. The level of detail will be determined by the questions to be answered, and may include some or all of the following strategies:

- Tracking/Monitoring
- Quality Management
- Case Review
- Performance Indicators
- Surveillance Methods Used in Assurance Phase
- Formal Research

Data Collection for IFT Evidence

- Uniform data definitions are essential to collect evidence that can enable multisite studies, and true comparison of IFT practice and methods of delivery.

- Databases such as the National EMS Information System (NEMSIS) and the National Trauma Data Bank can be used to ensure standard data elements and the optimal utility of data.

- Because patient volume within any one IFT service may be low, collaborative research can be conducted and used to derive results that can be applied to other groups of IFT patients and other systems of IFT delivery.

- The data for IFT research may require linkage with prehospital data, ED data, hospital data, and that of the institutions pre and post IFT, to study outcomes as well as process.

- The evidence collection process and data elements to be used for assessment and assurance are optimally identified as new/updated IFT service is planned and before its implementation, so data can be gathered before and after IFT is deployed.

Outcome and Process Evaluation

Assessing the status of the current practice of IFT includes two areas of study: (1) outcomes evaluation, and (2) process evaluation.

Outcome evaluation examines the effectiveness or efficacy of particular interventions on patient status. An outcome evaluation of IFT assesses a particular clinical aspect of patient care during IFT, and its impact on patient outcome. Examples of prime candidates for outcome evaluation include:

- Defining and ensuring adequate and effective patient care during IFT. The EMS Outcomes Project names six categories for patient outcome:[1]
    - ❏ survival
    - ❏ impaired physiology
    - ❏ limit disability
    - ❏ alleviate discomfort
    - ❏ satisfaction
    - ❏ cost-effectiveness

- Evaluation of best-model practices for different levels of providers and for different geographic areas

- Timing of transfer — When is it too early or too late to transfer patients?

- What practices are most effective in preventing infection during IFT?

- Does constant availability of medical direction make a difference in outcomes?

- Does the level of provider make a difference in outcome for particular acuity levels of patients?

Process Evaluation — It would be difficult to conclude that a specific intervention caused a specific outcome, if the process of achieving it was not carried out as intended.

Process evaluation focuses on the quality of implementation — how well the intended process was carried out. It examines operational and system efficiency. Examples include:

- Where can costs be reduced in operation and equipment and still provide optimal care?

- What system QI model works best to monitor the outcomes of patients in a particular region/State?

- Regional resource assessment and management.

- Additional training — what is important and what's not?

- Response time standards.

- Were protocols adhered to? Why or why not (related to system components)?

- Dispatch issues — call-taking, triage, personnel assignment, as they relate to IFT.

- Tracking referral patterns and trends to determine future patient population.

References

1. Maio, Ronald. Emergency Medical Services Outcomes Evaluation. U.S. Department of Transportation, National Highway Traffic Safety Administration. July, 2003.

MAJOR TOPIC #10: LESSONS LEARNED

This publication is distributed by the U.S. Department of Transportation, National Highway Traffic Safety Administration, in the interest of information exchange. As part of the IFT project, the IFT Work Group put out a call for information on existing IFT programs from a wide variety of organizations and individuals involved with IFT, in an effort to illustrate examples of lessons learned during the process of establishing and/or maintaining IFT service. This section includes the results of that call for information, and represents a self-selected group of IFT programs that may function as case studies to learn from, and/or act as resources for a variety of IFT information. Certainly many more programs could offer promising approaches than could be included here. Resources prevented an exhaustive and comparative selection process.

The respondents were contacted and extensively interviewed following a standardized format. The examples presented here had four characteristics in common:

- Replicable: Has the potential to be replicated in other settings or provides a basis that others could build upon.

- Purposeful: Practices were developed intentionally to address an identified problem or to achieve a goal. In some cases, a formal quality assurance program identified the need, in others the program was mandated by legislation. Some programs developed from grass-roots efforts.

- Operational: Practices included here have all been taken beyond the conceptual and planning stages, and have been implemented.

- Successful: Has some evidence that the plan implemented is achieving desired results. Measurement techniques vary with the nature of the practice, program, and organization.

Evidence of success could be anecdotal reporting, a formal quality assurance program, or published research involving control groups and peer review.

Although not criteria for inclusion, two other characteristics were present in these profiles: collaboration and evolution. All success is shared: Every organization interviewed benefited from and valued the work of people who had come before them. All programs continue to evolve as effectiveness is studied and the results are used to improve performance.

All those who submitted a profile of their IFT program expressed a willingness to share their information directly with other parties interested in IFT; therefore, contact information is included in each profile. The IFT Work Group hopes these examples encourage cooperative efforts between stakeholders in establishing IFT services.

The Work Group appreciates the participation of the services providing information about their programs. The examples offered are presented to stimulate further efforts to improve IFT and to support a network for sharing information. The opinions, findings, and conclusions expressed in this section (and the other sections of this document) are not necessarily those of the Department of Transportation or the National Highway Traffic Safety Administration. The United States Government assumes no liability for its contents or use thereof. If trade, manufacturers' or program names are mentioned, it is only because they are considered essential to the object of the publication and should not be construed as an endorsement. The IFT Work Group and the United States Government do not endorse specific products, manufacturers or programs.

Interfacility Transfer Guide:	
Program	**Contact Information**
Children's Hospital Medical Center of Akron Akron Children's Transport 1 Perkins Square Akron, OH 44308	Traci R. Sheipline, R.N., EMT-B 330-543-3246 tsheipline@chmca.org

Organization and Mission

Children's Hospital Medical Center of Akron (CHMCA) is a 253-bed freestanding pediatric facility. The hospital includes a level 3 neonatal intensive care units (NICU) and a level 2 trauma center. CHMCA also operates a burn unit that accepts all patients of all ages.

Akron's Children's Transport (ACT) operates three ground ambulances and works with other services that provide rotor-wing and fixed-wing air ambulances. ACT generally covers 22 counties in northeast Ohio, but will transport children by fixed-wing aircraft back to CHMCA from anywhere in the continental United States. The ambulances are staffed with a nurse, paramedic and respiratory therapist. ACT provides only interfacility transfer services.

More information is available at www.akronchildrens.org.

Systems Integration

In 2001, CHMCA implemented a centralized communications center to improve communications between referring physicians and CHMCA. CHMCA's performance improvement process identified that the prior system was ineffective and inefficient. Callers were getting lost in the system. Referring physicians who called in with a patient to be transferred were being left on hold for lengthy periods of time.

Under the current system, all transport and EMS calls come in to the communication center. When interfacility transfer is required, the referring physician, transport nurse, and physician providing medical direction at CHMCA confer about the patient. They discuss criticality, patient needs, and appropriate mode of transportation. Once the call is accepted, CHMCA handles all the coordination, even if the patient is not being transported to CHMCA.

Implementation Strategy

Once the performance improvement process had identified the need for a better approach, a transport steering committee consisting of management, the medical director for transportation, the vice president of nursing, and representatives from pediatrics, NICU, trauma, respiratory therapy, and pharmacy met monthly. The creation of the communications center was the result of the committee's work.

Because CHMCA was working on what was perceived to be a problem and because all the relevant stakeholders participated in developing the solution, the committee approach was successful in garnering internal support that has made the communications effective.

Implementing the communications center required building and equipping a dedicated facility. In addition to the hardware requirements, CHMCA had to update its clinical and operational databases in order for the system to work effectively. As a result, CHMCA is able to analyze 22 aspects of every transport: for example, origin, diagnosis, call volumes, frequency and distribution of calls, staff deployment, and a range of clinical and treatment variables.

Evaluation and Results

The communications center has been effective in decreasing response time from 15 minutes down to 10 minutes. In addition, because the whole team has the information necessary for that transport, it can set up necessary care faster. With the implementation of the communications center, the whole process is more efficient, particularly as it affects the referring physician. In the current system, a support staff member can place the initial call. When the team is assembled, the referring physician can join the call, maximizing the time the physician can spend with the patient.

CHMCA regularly surveys the referring physicians and has received very positive feedback. Also, referring physicians receive a letter describing where and to what service the patient was admitted. As a result the volume of transports has increased from 900 in 1999 to 1,468 in 2004. Referring physicians report satisfaction with their increased role in patient triage.

Education and Replication

One of the positive side effects of the improved working relationship has been requests by referring hospitals for CHMCA to send a team to do outreach at their facilities. The team addresses the capabilities of CHMCA and ACT. By going to the outlying facilities, the outreach team can work with the particular circumstances of the referring facility to enhance communication, preparation for transport, and follow-up.

Interfacility Transfer Guide:	
Program	**Contact Information**
Boston MedFlight 1727 Robins Street, Hangar 1727, Hanscom AFB Bedford, MA 01730	Suzanne Wedel, M.D., Medical Director 781-863-2213 Suzanne.Wedel@bostonmedflight.org

ORGANIZATION AND MISSION

Boston MedFlight (BMF) is a 501(c)(3) non-profit organization based in Bedford, Massachusetts, whose mission is to extend the tertiary care services of the major Boston hospitals to the citizens of Massachusetts and New England. The service is available 24 hours a day and seven days a week. BMF was formed by a consortium of Boston area hospitals to provide emergency medical critical care transport services. The consortium includes Beth Israel Deaconess Medical Center, Boston Medical Center, Brigham and Women's Hospital, Children's Hospital, Massachusetts General Hospital, Tufts New England Medical Center. BMF provides transport to the hospital deemed best able to meet the patient's needs, regardless of whether that hospital is a member of the consortium. BMF currently operates three helicopters, two ground ambulances and one fixed-wing air ambulance. Additional information is available at www.bostonmedflight.org.

Systems Integration

BMF has created a system of critical care transport with the goal of getting the sickest patients to the best care as fast as possible. BMF derives its strength and cost-effectiveness by functioning as a regional provider. The existence of BMF spares the members of the consortium the expense of operating separate critical care transport services. Earned revenue covers 92 percent of BMF expenses are covered by earned revenue; the hospital consortium funds the remainder. Although BMF strives to be efficient, it has no financial incentive to generate additional business volumes just to cover expenses.

As a regional provider, BMF achieves a volume of utilization of approximately 2,700 transports annually, a volume that would not be possible for an independent operator. The high volume means that BMF teams encounter even unusual cases frequently enough to keep skills at high levels of proficiency and its affiliation with the consortium of hospitals facilitates development and coordination of treatment and transportation protocols that strengthen the system and improve the quality of care. Having the choice of ground or air vehicles means that BMF can choose the most appropriate and effective mode of transport for that patient under the specific circumstances.

BMF has historically incorporated the quality assurance process into its operation. Every transport team member is responsible for a quality assurance project. Structured training time is built into the operating budget and schedule; team members are required to maintain their skills and certifications through extensive hands-on clinical training opportunities at all the member hospitals.

Implementation Strategy

BMF celebrated its 20th anniversary in June 2005. The system has evolved over that period of time. The genesis of BMF was a core group of surgeons and hospital executives who saw the need for helicopter transportation in the Boston area. Massachusetts regulates the establishment of new health services through its Determination of Need program and State health regulators expressed concern about the potential for the proliferation of competing and inefficient services. Hospital representatives also recognized that multiple providers meant less efficient operations, possibly encouraging the transfer of less acute patients just to make operations financially feasible. Hence, the six-hospital consortium formed BMF.

BMF has used its quality assurance process as a change agent to continually improve the quality of service it provides and as a tool to identify additional services that were needed. One example of that is the evolving recognition of critical care transport as a specialization separate from prehospital emergency medical services. Quality assurance has also helped BMF operate efficiently.

BMF has found that it needs to drive the development and acceptance of critical care transport protocols. Consortium hospitals have willing and effective partners in developing those protocols. Standardization of procedures has helped make the transport process achieve optimal clinical results while smoothing other operational issues.

Evaluation and Results

BMF conducts structured quality assurance activities to monitor the appropriateness and effectiveness of its services on an on-going basis. BMF's high degree of appropriate utilization indicates that the regionalization of the service effectively reduces the inappropriate utilization that is sometimes attributed to the existence of redundant and competing providers. Boston MedFlight with support from the sponsoring consortium hospitals has fostered an environment for research based practice. Since the inception of the program, there have been changes in clinical standards and current clinical research which has helped shape the BMF Standards of Care as well as its patient care policies and procedures. The BMF research program has been one of the components that make BMF a leader in the transport community. It has resulted in numerous publications and presentations at national and regional conferences.

Education and Replication

Boston MedFlight has worked with a number of organizations since its inception. Particularly in cases where BMF and another provider serve contiguous or overlapping areas, reliance on similar protocols is seen as a means of strengthening the system as a whole, as well as improving care on a case-by-case basis. The New England rotor-wing programs have formed the New England Air Alliance, which is a unique regional infrastructure designed to encourage collaboration instead of competition for critical care transport.

BMF personnel have published a variety of articles relevant to interhospital transfer. A partial bibliography can be found at www.bostonmedflight.org/research.html.

Interfacility Transfer Guide:	
Program	**Contact Information**
Patient Transport Services Children's Medical Center Dallas 1935 Motor Street Dallas, TX 75235	Jan Cody, R.N., L.P. Director Patient Transport Services 214-456-8436 jan.cody@childrens.com

Organization and Mission

Children's Medical Center Dallas is a 406-bed, non-profit tertiary care center and level I Trauma Center. This includes a 52-bed pediatric intensive care unit (PICU), over 50 outpatient clinics, an emergency department (ED) designed just for children, and a dedicated interfacility transport program. Children's service area is predominantly north central Texas, but it brings children to the hospital from all over the southwest.

Children's Transport Team was founded in 1989 when Children's Medical Center recognized that there were children in the community hospitals that needed pediatric specialized care before they arrived at Children's. The first year the teams completed 330 missions. In 1999 Children's Medical Center Dallas Patient Transport Services was the first pediatric transport team to be accredited by CAMTS and the first to be accredited in all three modes of transport: ground, fixed-wing aircraft (FWA), and rotor-wing aircraft (RWA). The program has grown throughout the years: the Children's Transport Team currently has over 60 staff members, and in 2004 they completed 3,516 transports.

Transfer Center

Children's Medical Center has established a transfer center that is staffed 24 hours a day with transfer coordinators (TCs) who are trained as EMTs or paramedics. The TCs are also certified flight communicators by NAACS (National Association of Air Medical Communication Specialists).

The Transfer Center coordinates all transfers into Children's. Transfer coordinators receive the initial phone call from the referring hospital and guide the rest of the process — from identifying an accepting physician to dispatching the team and flight following on RWA transports. Based on the information gathered in the initial conversation with the referral facility, the TC categorizes the patient as BLS (Basic Life Support), ALS-1 (Advanced Life Support), ALS-2, or SCT (Specialty Care Transport). They then determine the most appropriate destination for the child: Emergency Department (ED), Intensive Care Unit (ICU), or inpatient floor. Once this has been determined the TC notifies the appropriate accepting physician and dispatches the appropriate team in the appropriate vehicle. CMC's goal is to be out the door within 10 minutes of receiving the call.

Children's Medical Center uses a suite of software to connect the functions within the department. Computer-aided dispatch software is used to document information gathered during the call-taking process and dispatch of the teams. All clinical documentation is done using electronic charting software.

The computer-aided dispatch system, the electronic charting system, and a billing system are all connected with a mobile data communication system. This suite of products makes report writing and data collection simple and the possibilities almost unlimited.

Implementation Strategy

Patient Transport Services has reached out to referring hospitals to demonstrate the capabilities of the services and to improve the coordination of the transport, assuring that the referring hospital, the responding team, and the receiving hospital have a common set of expectations.

Patient Transport Services is a separate provider with its own Medicaid/Medicare number and it bills separately for transport services. Billers and collectors work closely with management and the clinical staff to provide payers with all needed information for claims processing.

CMCD decided to set up two levels of transport teams. Based on predefined medical protocols a critical care team consisting of a registered nurse, respiratory therapist, and emergency medical technician – certified emergency vehicle operator (EMT-CEVO) or a team of two paramedics might be dispatched. The paramedic team transports patients who are categorized as BLS or ALS-1 and are within a 60-mile radius of CMCD. All other patients are transported by the critical care teams.

The EMT-CEVO serves as safety officer on all rotor-wing aircraft transports. The CEVO gives position reports, assists the pilots by watching for any obstacles, assists the team with loading and unloading the patient, and briefs the family member prior to flight. All team members are trained as flight crewmembers and follow duty time limits developed by the FAA when flying. Training for both the safety officer's role and flight crewmembers was developed specifically for the transport staff members by the RWA pilots as a part of the implementation of the RWA program that went into service September 16, 2004.

Evaluation and Results

The dedicated billing function has significantly increased reimbursement with a high percentage of claims being paid the first time they are submitted. This allows Patient Transport Services to document the revenue it generates. Over the years this ability has enabled Patient Transport Services to garner the support for new programs.

Operating two levels of service has enabled CMCD to operate at an efficient volume of cases while keeping personnel expenses in line, due to the significant cost savings found comparing a team of two paramedics with the critical care team. Approximately a quarter of all transports are performed by the paramedic team.

Education and Replication

CMCD is aware that a number of other transport services have adopted the approach of dedicated transport teams and of two levels of teams. Details of that implementation are likely to vary with the particular needs of the operating organization (for instance, hospital-based or free standing) and with the scope of practice regulations in a given State.

Interfacility Transfer Guide:	
Program	**Contact Information**
IHC Life Flight 250 North 2370 West Salt Lake City, UT 84116	Renee S. Holleran, R.N., Ph.D., C.EN., C.C.R.N., C.F.R.N. Nurse Manager, Adult Transport Services 801-321-3322 reneeflightnurse@msn.com

ORGANIZATION AND MISSION

Intermountain Health Care (IHC) is an integrated health system that includes 20 hospitals, numerous clinics, and an insurance company. IHC serves Utah and southeastern Idaho. More information is available at www.ihc.com.

IHC Life Flight operates three rotor-wing aircraft 24 hours a day that provide scene and interfacility response within 150 miles of its bases in Salt Lake City and Provo, Utah. The RWA also supports search-and-rescue missions in the intermountain area. IHC operates three fixed-wing aircraft transporting patients throughout the west. A specially designed neonatal critical care ambulance is stationed at Primary Children's Medical Center in Salt Lake City. Life Flight provides interfacility transfer services over a seven-State area. Life Flight is accredited by CAMTS.

Medical Direction

Life Flight's approach to medical direction involves two intensivists and one emergency medicine physician. Life Flight perceived that interfacility transfer was being impaired by inconsistent understanding and expectations. In part this was due to the extreme variability in the size and nature of sending facilities and in the professional credentials and experience of clinicians, ranging from a physician's assistant in a very remote setting to more sophisticated hospitals transferring patients to a tertiary facility. Also, because of the large and sometimes sparsely populated service area, bringing clinicians to a central location for training was difficult logistically.

In part the inconsistency followed from the different levels of knowledge on the part of medical directors. Several types of physicians are involved, representing emergency medicine and other forms of critical care. Without specific training in medical direction of interfacility transfer, the physicians might lack a full understanding of the established protocols, optimal preparation for transfer, the capabilities and limitations of the crew, and the capabilities and limitations of the equipment.

IHC addressed this problem by developing a training program for medical direction, the goal of which is to improve the both the results and the process of the transfer. One concern was that the referring facility not feel alienated or patronized. IHC treats the transfer as a teaching opportunity. The medical director stays in contact with the referring facility while the aircraft is en route, addressing clinical issues and assuring that appropriate preparations are made so that the patient is as ready for transport as possible.

Implementation Strategy

Recognizing that gathering a group of physicians for training programs can be difficult logistically, IHC has developed the program so it can be distributed on DVD. This technology makes the learning available at a convenient time and place for the learner. Once the master is prepared reproduction and distribution are very economical. One of the approaches IHC used to build confidence in its service was to emphasize timely response because IHC had found that physicians working in a tertiary hospital might not fully understand the sense of isolation and need for prompt assistance experienced by colleagues in remote areas.

Evaluation and Results

Life Flight has found that the program has been effective in achieving the desired consistency. The entire team has greater confidence in each other and in the system.

Education and Replication

Dr. Frank Thomas, the physician who developed the original training program, has presented all over the world. The DVD format has made it easy and cost-effective to share with other organizations. The DVD has been recognized by CAMTS as a best practice.

Interfacility Transfer Guide:	
Program	**Contact Information**
Children's Hospital of San Diego 3020 Children's Way San Diego, CA 92123	Dana Patrick, R.N. Emergency Transport Program Coordinator 858-966-5973 dpatrick@chsd.org

Organization and Mission

Children's Hospital of San Diego (CHSD) is the San Diego region's only designated pediatric trauma center and the only area hospital dedicated solely to pediatric care. Since CHSD first opened its doors in 1954, its mission has been "to restore, sustain and enhance the health and developmental potential of children." More information is available at www.chsd.org.

The Emergency Transport Program was started in 1972, first for neonatal transport. When the hospital opened a pediatric ICU a second team was added for pediatric transport. CHSD transports approximately 1,000 pediatric and 800 neonatal patients annually.

Meeting Patient Needs

About five years ago, CHSD shifted to teams made up of a nurse and a respiratory therapist. Both members are completely cross-trained. With the approval from the respiratory care board, standard protocols were approved in advance, allowing both RTs and RNs to expand the scope of their capabilities. Although the nurse tends to be the primary staff member, they work as a team and responsibilities shift according to the needs of the patient. CHSD believes that the RN/RT teams are more effective because each team member understands the other's functions. If necessary, it provides redundant capabilities within a single team.

Separate teams are dedicated to pediatrics and neonates and they are pre-assigned to transport responsibilities. Although combining teams might be a means of leveling the workload, CHSD has found that it provides better care by having dedicated teams. When teams are not involved in transport, they provide defined supplemental staffing within the hospital.

The RN/RT team approach was conceived to improve the quality of care and simplify the administration of the service.

Implementation Strategy

Before changing the staffing, it was necessary to convince the team medical directors of the benefits, and then the teams needed to be trained. Preconceptions about the capabilities of respiratory therapists were addressed through training and testing and by setting high thresholds for prior experience. Teams went through 48 hours of pediatric training followed by written and performance tests. Team members must have five years of experience before applying for a transport position.

Evaluation and Results

CHSD holds transport morbidity and mortality conferences with the medical director and medical control officer. These conferences are held in a confidential environment so all parties can speak candidly.

The RN/RT team concept has produced positive results and helped recruitment.

Education and Replication

The CHSD RN/RT team approach may have potential for replication by other services.

APPENDIX A:

Members of IFT Guidelines Work Group

The EMS Program at the National Highway Traffic Safety Administration gratefully acknowledges the contributions made by the members of tie IFT Work Group. Without their generous donation of time and expertise, the completion of this document would not have been possible.

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Emergency Nurses Association
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National Association of EMS Physicians
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National Association of State EMS Directors
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National Association of State EMS Training Coordinators
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National Flight Paramedics Association
T.J. Kennedy, E.M.T.-P., F.P.-C.

International Association of Flight Paramedics
Ron Walter, B.S., N.R.E.M.T.-P.

National Highway Traffic Safety Administration
Drew Dawson, Director, Office of EMS
Laurie Flaherty, R.N., M.S.

Office of Rural Health Policy, HRSA
Blanca Fuertes, M.P.A.

Appendix B:

References and Resources for IFT

Emergency Medical Treatment and Labor Act

Health Law Resource Center
EMS & Helicopter Issues
www.medlaw.com/ems.htm

American College of Emergency Physicians
EMTALA – Main Points
http://www.acep.org/webportal/PracticeResources/issues/emtala/default.htm

Appropriate Interhospital Patient Transfer
http://www.acep.org/webportal/PracticeResources/issues/emtala/default.htm

Annals of Emergency Medicine
The EMTALA Paradox (2002)
http://www.annemergmed.com/issues#2002

eMedicine
COBRA Laws
www.emedicine.com/emerg/topic737.htm

Emergency Nurses Association
EMTALA Information (1998 – 2004)
www.ena.org/government/emtala/

Air Medical Physicians Association
Medical Condition List and Appropriate Use of Air Medical Conditions (2002)
http://www.ampa.org/component/option,com_docman/task,cat_view/gid,23/Itemid,42/

Centers for Medicare and Medicaid Services.
Appendix V of the State Operations Manual. Interpretive Guidelines — Responsibilities of Medicare Participating Hospitals in Emergency Cases.
http://www.cms.hhs.gov/EMTALA/

U.S. General Accountability Office
EMTALA Implementation and Enforcement
www.gao.gov/new.items/d01747.pdf

Examples of Federal Regulations

Federal Aviation Administration
Air medical services operate predominantly under two distinct parts of the Code of Federal Regulations (CFR), formerly known as the Federal Aviation Regulations: CFR Part 91 and Part 135.

Part 91 regulates flight operations for aircraft flying within U.S. airspace
ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=dd3aa7b9f3da5c3af094830596d3790b&rgn=div5&view=text&node=14:2.0.1.3.10&idno=14

Part 135 provides specific regulations for commuter and on demand air carriers, including air ambulances
ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=dd3aa7b9f3da5c3af094830596d3790b&rgn=div5&view=text&node=14:2.0.1.3.23&idno=14

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA.org
CMS has prepared a checklist to help you get started.
www.hipaa.com/

American Medical Association
HIPAA
www.ama-assn.org/ama/pub/category/4234.html

American College of Emergency Physicians
HIPAA Compliance Information (Updated 2005)
http://www.acep.org/webportal/PracticeResources/issues/admin/HIPAAComplianceInformation.html

Facts about Medical Liability Insurance Crisis
http://www.acep.org/webportal/PracticeResources/issues/medliab/default.html

Office for the Advancement of TeleHealth
Final HIPAA Privacy Rules (2001)
telehealth.hrsa.gov/pubs/hipaa.htm

Liability

American College of Emergency Physicians
Medical Professional Liability Insurance (2004)
www.acep.org/NR/rdonlyres/DD94E243-339F-4A02-983D-7563D42BCE74/0/MPLIpaperApril04.pdf

Facts about Medical Liability Insurance Crisis
www.acep.org/webportal/PatientsConsumers/HealthSubjectsByTopic/MedicalLiabily/correctrhtoric.htm

**Emergency Nurses Association
Position Statement**
Medical Professional Liability Insurance:
Malpractice Crisis (2003)
www.ena.org/about/position

U.S. Department of Health and Human Services
Special Update on Medical Liability Crisis (2002)
aspe.os.dhhs.gov/daltcp/reports/mlupd1.htm

National Council of State Legislatures
State Medical Liabilities Law Table (2002)
http://www.ncsl.org/programs/health/medmalncsl.htm

LAW.com
Dictionary of Legal Terms
dictionary.law.com/

Position Statements

American Academy of Pediatrics
Guidelines for Air and Ground Transport of Neonatal and Pediatric Patients
2nd Edition (1999)
www.aap.org/bst/showdetl.cfm?&DID=15&Product_ID=912

American College of Emergency Physicians
Interfacility Transportation of the Critical Care Patient and Its Medical Direction (1999)
http://www.acep.org/webportal/PracticeResources/PolicyStatements/

Professional Liability Insurance for EMS Medical Control Activities (1999)
www.acep.org/webportal/PracticeResources/PolicyStatements/EMS/ProfessionalLiabilityInsuranceforEMSMedicalControlActivities.htm

American College of Surgeons/Committee on Trauma
Interfacility Transfer of Injured Patients:
Guidelines for Rural Communities (2002)
https://web2.facs.org/timssnet464/acspub/frontpage.cfm?product_class=trauma

Air Medical Physicians Association
Medical Direction and Medical Control of Air Medical Services *http://www.ampa.org/component/option,com_docman/task,cat_view/gid,23/Itemid,42/*

Air and Surface Transportation Nurses Association
Staffing of Critical Care Air Medical Transport Services (2001)
www.astna.org/Position-papers/staffing.htm

Association of Air Medical Services
Appropriate use of Critical Care Ground Transport Services (2005)
www.aams.org/publications.html

Emergency Nurses Association
Care of the Critically Ill or Injured Patient During Interfacility Transfer (2002)
http://www.ena.org/about/position/

Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Pub. 100-02. Chapter 10. Ambulance Services.
http://www.cms.hhs.gov/center/ambulance.asp

Request for Medicare Payment – Ambulance. CMS Form 1491.
http://www.cms.hhs.gov/center/ambulance.asp

National Association of EMS Physicians
Medical Direction of Interfacility Transports (2000)
Medical Direction for Air Medical Transport Programs (2002)
Physician Medical Direction in EMS (1997)
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Society for Critical Care Medicine
Guidelines for the Intra and Interfacility Transport of Critically Ill Patients. (2004).
http://www.sccm.org/professional_resources/guide-lines/table_of_contents/index.asp

Pediatric Emergency Care

The state of pediatric interfacility transport: Consensus of the Second National Pediatric and Neonatal Interfacility Transport Medicine Leadership Conference (2002)
www.pec-online.com/pt/re/pec/abstract.00006565-200202000-00013.htm;jsessionid=B11uIWoslDR06awVX8h7HDSN8AfknBCJPlyDfuLd1W3MRzwodSog!368654479!-949856031!9001!-1?index=1&results=1&count=10&searchid=1&nav=search

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Air and Surface Transportation Nurses Association
Standards for Critical Care and Specialty Ground Transport

Standards for Critical Care and Specialty Fixed-Wing Transport
Standards for Critical Care and Specialty Rotor-Wing Transport
www.astna.org/pubs.html

Centers for Medicare and Medicaid Services
Navigating the Medicare Web Site
www.medscape.com/viewarticle/ 494892?src=mp

Definitions of Ambulance Services. Program Memorandum. Transmittal AB-02-130
www.cms.hhs.gov/manuals/pm_trans/ab02130.pdf

Request for Medicare Payment – Ambulance. CMS Form 1491.
www.cms.hhs.gov/providers/edi/cms1491.pdf

Commission on Accreditation of Ambulance Services
Accreditation Standards (2004)
www.caas.org/index1.html

Emergency Medical Services for Children
Trauma Triage, Transfer, and Transport
Guidelines (2002)
http://www.ems-c.org/Products/frameproducts.html
(Enter title into Title Search field.)

Emergency Nurses Association
Certification for Ground Transport Nurses
http://www.ena.org/bcen/ctrn/

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Services Systems**
Interhospital Transfer Guidelines Manual (2002)
www.miemss.org/Interhospital.pdf

**Minnesota Department of Health, Community
Health Division**
Public Health Core Functions, Essential Services,
and Goals
*www.health.state.mn.us/divs/chs/pdf/gdlinebkgrd1.
pdf#search='three%20core%20functions%20of%20p
ublic%20health*

National Rural Health Association
Rural and Frontier Emergency Medical Services
Agenda for the Future (2004)
www.nrharural.org/groups/sub/EMS.html

National Highway Traffic Safety Administration
Emergency Medical Services Agenda for the Future
*www.nhtsa.dot.gov/people/injury/ems/agenda/ems-
man.html*

Implementation Guide
*www.nhtsa.dot.gov/people/injury/ems/agenda/in-
dex.html*

Guide for Preparing Medical Directors
*www.nhtsa.dot.gov/people/injury/ems/
2001GuideMedical.pdf*

National EMS Research Agenda
*http://www.nhtsa.dot.gov/portal/site/nhtsa/menuite
m.2a0771e91315babbbf30811060008a0c/DEMyPS4
zjvEasDAYBAlHs1Qm9ncn71vGM2plOk6RHZGrZ
D1YKNjuK%2128012360*

NEMSIS
www.nemsis.org/

University of Maryland Baltimore County
Critical Care Emergency Medical Transport
Programtm
http://ehs.umbc.edu/CE/CCEMT-P/index.html

United States Small Business Administration
Elements of a Business Plan
http://www.sba.gov/starting_business/index.html

APPENDIX C:
Elements of a Business Plan

Before beginning, consider four core questions:

1. What service does your business provide and what needs does it fill?
2. Who are the potential customers for your service and why will they contract with you?
3. How will you reach your potential customers?
4. Where will you get the financial resources to start your business?

Prepare by following 10 preliminary steps:

1. Ask yourself why you are writing a business plan. Is it to raise capital or as a guide for running the business?
2. List your goals for starting the business and where you see the business in three to five years.
3. Clearly define your target audience.
4. Write a table of contents so you'll know exactly which sections you will need to research and find data to support.
5. Make a list of the data you will need to research. For example, you will need statistics on your demographic audience, your competition, the market, and so on.
6. List research sources that will be most helpful.
7. List your management team. If you are unsure of someone's availability, this is the time to determine whether or not they are on board. Gather biographical data on each person.
8. Start compiling all of your key financial documents. You can determine later which ones you will use in the business plan.

9. Read sample business plans. Since countless business plans have preceded yours, there is no need to reinvent the wheel. Look for business plans for businesses most similar to yours as a prototype to guide you. You can also talk with other business owners who have written plans before and seek out their expertise.
10. Determine which software program you will use to write your plan. You can use anything from a basic word-processing program to business plan software. You will need to use that which best suits your needs and level of complexity.

Once you are ready, begin with the understanding that the business plan is a work in progress and there will be several to follow as well as ongoing changes as your business progresses.

Elements of a Business Plan

1. Cover sheet
2. Statement of purpose
3. Table of contents
    a. The business
        i. Description of business
        ii. Marketing
        iii. Competition
        iv. Operating procedures
        v. Personnel
        vi. Business insurance

b. Financial Data

    i. Loan applications

    ii. Capital equipment and supply list

    iii. Balance sheet (costs and revenues)

    iv. Break-even analysis and financial gap analysis

    v. Pro forma income projections (profit and loss statements)
Three-year summary
Detail by month, first year
Detail by quarters, second and third years
Assumptions upon which projections were based

    vi. Pro forma cash flow

c. Supporting Documents

    i. Tax returns of principals for last three years

    ii. Personal financial statements

    iii. For franchised businesses, a copy of franchise contract and all supporting documents provided by franchisor

    iv. Copy of proposed lease or purchase agreement for building space

    v. Copy of licenses and other legal documents

    vi. Copy of resumes of all principals

    vii. Copies of letters of intent from all suppliers, etc.

Reference

1. Business Plan Basics. *http://www.sba.gov/starting_business/planning/basic.html*. U.S. Small Business Administration. U.S. Department of Commerce.

APPENDIX D:
EMTALA

The Emergency Medical Treatment and Labor Act is a Federal law enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd). Referred to as the "anti-dumping" law, it was designed to prevent hospitals from refusing to treat patients or transferring them to charity or public hospitals because they were unable to pay or had Medicaid coverage. EMTALA requires hospitals with emergency departments to provide emergency medical care to everyone who needs it, regardless of ability to pay or insurance status. Under the law, patients with similar medical conditions must be treated consistently. The law applies to hospitals that accept Medicare reimbursement, and to all their patients, not just those covered by Medicare.

Hospitals have three basic obligations under EMTALA

- First, they must provide all patients with a medical screening examination to determine whether an emergency medical condition exists without regard for ability to pay for services.

- Second, where an emergency medical condition exists, they must either provide treatment until the patient is stabilized, or if they do not have the capability, transfer the patient to another hospital.

- Third, hospitals with specialized capabilities are obligated to accept transfers if they have the capabilities to treat them. Medical care cannot be delayed by questions about methods of payment or insurance coverage.

No further EMTALA obligations exist if an appropriate medical screening examination identifies no emergency medical condition. No further EMTALA obligations exist if an identified emergency medical condition is stabilized. Additionally, the latest regulations now recognize that a patient with an emergency medical condition may be discharged with a plan to have subsequent treatment provided as an outpatient if such a plan is consistent with medical routine and does not jeopardize the patient's health.

EMTALA governs how patients may be transferred from one hospital to another. Under the law, a patient is considered stable for transfer if the treating physician determines no material deterioration will occur during the movement between facilities and that the receiving facility has the capacity to manage the patient's medical condition. EMTALA does not control the transfer of stable patients; however, patients with incompletely stabilized emergency medical conditions still may be transferred under EMTALA if one of two conditions exists, as follows:

- The patient (or someone acting on the patient's behalf) provides a written request for transfer despite being informed of the hospital's EMTALA obligations to provide treatment.

- A physician certifies that medical benefits reasonably expected from transfer outweigh the risk to the individual.

Once a decision is made to transfer the individual, the following steps must be taken:

- The transferring hospital must provide all medical treatment within its capacity, which minimizes the risk to the individual's health.

- The receiving facility must accept the transfer and must have space available and qualified personnel to treat the individual.

- The transferring hospital must send copies of all medical records related to the emergency medical condition. If the physician on call refuses or fails to assist in the patient's care, the physician's name and address must be documented on the medical records provided to the receiving facility.

■ Qualified personnel, with the appropriate medical equipment, must accompany the patient during transfer. The transferring physician, by law, has the responsibility of selecting the most appropriate means of transport to include qualified personnel and transport equipment.

Under EMTALA, patient care during transport is the responsibility of the transferring physician/hospital, until the patient arrives at the receiving facility. The transferring physician is also responsible for the order to transfer and for the treatment orders to be followed during the transport. This may conflict with State statutes, which in some instances, allow only authorized medical direction physicians to give orders to EMS personnel. EMTALA does not reference the transport service and its medical director, leaving ultimate medical responsibility and its transition during transport open for interpretation.

The legislation poses several additional complexities for individual hospitals and for an integrated EMS system in which transfers can play a considerable role:

■ First the level of service required before a patient transferred may not be clear; for hospitals with comparatively minimal emergency departments or with extremely overcrowded EDs, pressures for staffing and equipment may be intense.

■ Second, acceptable grounds for transfer need to be clearly defined. In some cases, the primary reason for transfer is explicitly defined, but many other cases may be less conclusive.

■ Third, who makes the assessment to determine that a patient is stable (and able to be transferred) or unstable may be a critical factor. Decisions may differ depending on the level of the practitioner, or between practitioners of the same level, or between the responsible practitioner at the transferring facility and the interfacility transfer team or its medical director.

As the scope of EMTALA has widened in an effort to make the law more effective, existing weaknesses in the delivery of care have created new problems: In the binding regulations published in 1994, the requirements for basic screening and stabilization pertained to patients anywhere on hospital property, including ambulances owned and operated by the hospital.

Since EMTALA was enacted, the national ED patient volume has increased and during the same time period, the number of hospital EDs has declined. As a result, fewer resources are available to meet an increasing legal obligation.

The discussion in the interpretive guidelines and case law obligated a hospital to accept an unstable patient if it has the capacity and has any equipment that the patient's condition requires that the referring hospital lacks. This disproportionately expands the obligations of EDs with more sophisticated capabilities, and increases the obligations placed on on-call physicians. Although EMTALA obligates hospitals to have a roster of on-call physicians who can complete medical screening examinations and provide stabilization for the services the hospital offers to its community, many hospitals are not able to fill their on-call rosters.

A recent decision by a Federal appeals court concluded that a patient coming to the ED triggers EMTALA obligations not only when the patient is on hospital property, but also while traveling toward the hospital. So, even when the decision to divert ambulance patients is reasonable, the ED may still be liable for EMTALA violation.

As providers grapple with new burdens, they confront difficult challenges that are a logical consequence of those new responsibilities. The net impact of these changes has resulted in a decrease in the availability of the services that the law was intended to promote.

APPENDIX E:
Certificate of Transfer

Certification of necessity for transfer is a requirement for reimbursement by the Centers for Medicare and Medicaid Services. The CMS definition of medical necessity is as follows:
"Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case, in which some means of transportation other than an ambulance could be utilized without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance service."

It is possible (but not likely) that a patient may require transfer and not meet the CMS definition of medical necessity.

The Centers for Medicare and Medicaid Services has issued regulations pertaining to the enforcement of this law. Regulations go into much greater detail than the statute. Proposed rules published in 1988 can be found in the Federal Register, June 16, 1988 (53FR22513). Interim final rules can be found in the Federal Register, June 22, 1994 (59FR32086). The authority supporting the statute is the taxing and spending clause of the Constitution. In essence, Congress has the right to demand certain services from vendors receiving Federal tax dollars. In the EMTALA statute, obligations are tied to hospitals' participation in Medicare. In fact, a hospital could relieve itself of EMTALA obligations by dropping out of the Medicare program, although this certainly would not be financially beneficial for the hospital.

APPENDIX F:
HIPAA

Health Insurance Portability and Accountability Act of 1996 is a law enacted to combat fraud, waste, and abuse in health insurance and the delivery of healthcare services; to improve access to long-term care services and coverage, and simplify the administration of health insurance. The program sets standards for the use and disclosure of protected health information along with measures to ensure the secure transmission and storage of medical records and other individually identifiable or demographic information. The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally. Key provisions of these new standards include:

- **Access to Medical Records.** Patients generally should be able to see and obtain copies of their medical records and request corrections if they identify errors and mistakes.

- **Notice of Privacy Practices.** Covered health plans, doctors, and other health care providers must provide a notice to their patients how they may use personal medical information and their rights under the new privacy regulation. Patients also may ask covered entities to restrict the use or disclosure of their information beyond the practices included in the notice, but the covered entities would not have to agree to the changes.

- **Limits on Use of Personal Medical Information.** The privacy rule sets limits on how health plans and covered providers may use individually identifiable health information. In addition, patients would have to sign a specific authorization before a covered entity could release their medical information to a life insurer, a bank, a marketing firm or another outside business for purposes not related to their health care.

- **Prohibition on Marketing.** The final privacy rule sets new restrictions and limits on the use of patient information for marketing purposes.

Pharmacies, health plans and other covered entities must first obtain an individual's specific authorization before disclosing their patient information for marketing.

- **Stronger State Laws.** The new Federal privacy standards do not affect State laws that provide additional privacy protections for patients. The confidentiality protections are cumulative; the privacy rule will set a national "floor" of privacy standards that protect all Americans, and any State law providing additional protections would continue to apply. When a State law requires a certain disclosure — such as reporting an infectious disease outbreak to the public health authorities — the Federal privacy regulations would not preempt the State law.

- **Confidential communications.** Under the privacy rule, patients can request that their doctors, health plans, and other covered entities take reasonable steps to ensure that their communications with the patient are confidential.

- **Complaints.** Consumers may file a formal complaint regarding the privacy practices of a covered health plan or provider.

HIPAA for Health Plans and Providers

The privacy rule requires health plans, pharmacies, doctors, and other covered entities to establish policies and procedures to protect the confidentiality of protected health information about their patients. These requirements are flexible and scalable to allow different covered entities to implement them as appropriate for their businesses or practices. Covered entities must provide all the protections for patients cited above, such as providing a notice of their privacy practices and limiting the use and disclosure of information as required under the rule. In addition, covered entities must take some additional steps to protect patient privacy:

- **Written Privacy Procedures.** The rule requires covered entities to have written privacy proce-

dures, including a description of staff that has access to protected information, how it will be used and when it may be disclosed. Covered entities generally must take steps to ensure that any business associates who have access to protected information agree to the same limitations on the use and disclosure of that information.

- **Employee Training and Privacy Officer.** Covered entities must train their employees in their privacy procedures and must designate an individual to be responsible for ensuring the procedures are followed. If covered entities learn an employee failed to follow these procedures, they must take appropriate disciplinary action.

- **Public Responsibilities.** In limited circumstances, the final rule permits — but does not require — covered entities to continue certain existing disclosures of health information for specific public responsibilities. These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or the cause of death; public health needs; research that involves limited data or has been independently approved by an institutional review board or privacy board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. The privacy rule generally establishes new safeguards and limits on these disclosures. Where no other law requires disclosures in these situations, covered entities may continue to use their professional judgment to decide whether to make such disclosures based on their own policies and ethical principles.

HIPAA Considerations for Prehospital Care Providers

- **Communications**

  Anyone involved in prehospital emergency medical service must take precautions to ensure that a patient's protected health information is protected and communicated to others strictly on a "need-to-know basis" — or as defined in the HIPAA standards, "Minimum Necessary." The regulation does not specifically state the mode of disclosure/transmission, so it is acceptable to pass on information in a written form, oral communication — discretion and a low voice is always advised when communicating orally and in a public setting, or via radio for the purposes of providing a radio "patch" to the receiving medical facility. In order to protect protected health information during a radio patch, information should be limited to what the receiving facility needs to know about the patient to prepare for the patent's arrival and treatment.

- **Exchanging Protected Health Information with Medical Facilities**

  As required under the Ryan White Act, prehospital care providers are mandated to provide a copy of their patient care report to the receiving medical facility upon arrival. This practice is permitted under HIPAA and does not violate the standards established in the privacy rule. Additionally, the HIPAA standards published in the final rule permit covered entities to share and exchange information with each other for the purposes of providing care/treatment, obtaining information for payment, and using the information for health care operations (i.e., quality assessment/quality improvement, education, etc.) without the consent or authorization of the patient or the patient's personal representative. Thus medical facilities may provide prehospital care providers with face sheets and other records for these purposes without patient consent or authorization.

- **Safeguarding Patient Information**

  As a standard practice, all covered entities must have systems in place that assures the secure handling and safe storage of patient's records containing protected health information.

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