



Slides Loading...Please Wait



www.mchb.hrsa.gov/emsc



MCHB/EMSC

February 2008 Webcast

**Introduction to Interfacility
Transfer Agreements and
Guidelines**

February 13, 2008



www.mchb.hrsa.gov/emsc



Moderator:
Dan Kavanaugh



www.mchb.hrsa.gov/emsc



**When Minutes Count
Making Transfers Work for Critically
Ill and Injured Children**

**A Look At EMSC
Performance
Measures
#66 D and #66 E**



Diana G. Fendya, MSN (R), RN
EMSC National Resource Center
DC National Children's Medical Center



www.nrcb.nyaa.gov/emsc



Objectives:

- Describe the need for interfacility transfer
- Review performance measures #66d/e
- Identify components of interfacility transfer guidelines
- Discuss implications of transfer guidelines to clinical outcomes for children






**Emergency Care Visits
And Children**

2003 nearly 114 million Americans sought emergency care or 1 out of every 3 individuals.

Children under the age 18 account for approximately 27% of these visits.




*Committee on the Future of Emergency Care in the United States Health System. Board on Health Care Services. (2006) Emergency Care for Children. Growing Pains: Washington District of Columbia: National Academies Press



The Truth About Kids and Emergency Care

Most of the 31,000,000+ children/adolescents who visit an ED each year are 3 years and under.

Over 13,000,000 of these visits are injury related, the others medical emergencies.




30 million children will receive emergency care this year.

www.morbidity.gov/emsc



The Truth About Kids and Emergency Care (cont.)

Subset of children who visit ED's perhaps more frequently because of special health care needs.






The Truth About Kids and Emergency Care

89% of pediatric emergency department visits occur in rural or remote facilities.



Marianne Gausche-Hill, Pediatrics. (2007) Pediatric Preparedness of US Emergency Departments: A 2003 Survey. American Academy of Pediatrics.

www.morbidity.gov/emsc



EMSC Mission

The mission of the Emergency Medical Services for Children (EMSC) program is:

- to ensure **state-of-the-art emergency medical care** for the ill or injured child and adolescent;
- to ensure that pediatric services are **well integrated** into an emergency medical services (EMS) system and backed by **optimal resources**;
- to ensure that the **entire spectrum of emergency services**, including primary prevention of illness and injury, acute care, and rehabilitation, is provided to children and adolescents as well as adults.



www.meds.ny.gov/emsc



EMSC Strives For:

State of the art pediatric emergency medical care that is well integrated into the EMS system backed with optimal resources inclusive of the entire spectrum of emergency services.




www.meds.ny.gov/emsc



HOSPITALS




www.meds.ny.gov/emsc



Hospital Variation

- Less than 5 % of all hospitals in US are recognized as pediatric or children's hospitals.
- 52% of hospitals admit children but do not have a separate pediatric ward or department.
- 10% of hospitals have a PICU.

Kimberly Middleton. Advance Data. (2006) Availability of Pediatric Services and Equipment in Emergency Departments: United States, 2002-03. US Department of Health and Human Services




www.hhs.gov/emsc



Hospital Variation

- 51.7% of hospitals without a PICU do have written transfer agreements with facilities that do have PICUs.
- 83.8% of hospitals without a pediatric trauma service have written pediatric transfer agreements to send patients to another hospital.

Kimberly Middleton. Advance Data. (2006) Availability of Pediatric Services and Equipment in Emergency Departments: United States, 2002-03. US Department of Health and Human Services






The Truth About Emergency Departments and Kids

Pediatric Preparedness of US Emergency Departments

Objective of the study: Evaluate compliance with AAP/ACEP pediatric-preparedness guidelines among US emergency departments.

Marianne Gausche-Hill. Pediatrics. (2007) Pediatric Preparedness of US Emergency Departments: A 2003 Survey. American Academy of Pediatrics






The Truth About Emergency Departments and Kids (cont.)

There is a variety of ED configurations—4% of non-children’s hospitals surveyed have a separate area in which to see children.

64% of EDs have \geq board-certified emergency physicians available 24 hours a day.

18% of EDs surveyed had pediatric emergency medicine sub-specialists available.

6% of those emergency departments surveyed had all the recommended pediatric supplies.



Marianne Gausche-Hill, Pediatrics. (2007) Pediatric Preparedness of US Emergency Departments: A 2003 Survey. American Academy of Pediatrics.

www.meds.nyu.edu/medec



The Truth About Emergency Departments and Kids (cont.)

ED Policies Listed in AAP/ACEP Guidelines

Child Maltreatment	Informed consent
Sedation	Illness and injury triage
Immunization status	Transfers for definitive care
Death in ED	Mental health emergencies
Disaster Plan	DNR
Physical restraint	Communication with Prvt.MD
Family issues/family presence	

Only 26% had all 13 policies



Marianne Gausche-Hill, Pediatrics. (2007) Pediatric Preparedness of US Emergency Departments: A 2003 Survey. American Academy of Pediatrics.



The Truth About Emergency Departments and Kids (cont.)

74% of EDs surveyed reported having transfer plans for:

- Trauma
- Medical or Surgical Intensive Care
- Reimplantation Care
- Burn Care
- Psychiatric Care
- Perinatal Care
- Child Maltreatment



Marianne Gausche-Hill, Pediatrics. (2007) Pediatric Preparedness of US Emergency Departments: A 2003 Survey. American Academy of Pediatrics.



What about EMTALA?

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal statute that dictates how a patient may:

- Refuse treatment
- Be transferred under unstable medical condition

EMTALA ends once the patient is admitted from ED status to inpatient status

42 CFR 489.24(d)(2)



www.childrensnmc.org



The Truth About Emergency Departments and Kids

Pediatric Preparedness of US Emergency Departments

AAP/ACEP Guidelines were and are supported by 17 professional organizations and have been published in two professional journals but only 59% of ED managers were knowledgeable about them.



Marianne Gausche-Hill. Pediatrics. (2007) Pediatric Preparedness of US Emergency Departments: A 2003 Survey. Pediatrics. 119(5):e10-15



Emergency Guidelines Reference:

American Academy of Pediatrics, Committee on Emergency Medicine, American College of Emergency Physicians, Pediatric Committee. Care of Children in the Emergency Department: Guidelines for Preparedness, Pediatrics, 2001; 107:777-781



www.childrensnmc.org



EMSC Performance Measures - #66D and #66E

66d. The percentage of hospitals that have written pediatric inter-facility transfer guidelines.

66e. The percentage of hospitals that have written pediatric inter-facility transfer agreements.




www.mccc.nyx.gov/EMSC



Performance Measures #66D/E

Why are they important?

The most severely ill and injured children sometimes need specialized care that is only available in selected hospitals.

Without effective inter-facility transfer agreements and guidelines, the timely and appropriate transfer of patients to the right level of emergency care might be delayed or might not even occur. These delays could result in very negative patient outcomes.




www.mccc.nyx.gov/EMSC



Improving the Outcomes of Critically Ill and Injured Children

Evidence has shown that the best outcomes for critically ill and injured children are achieved when treated at facilities most prepared to address their needs.

Hospitals should have Inter-facility Transfer Agreements (written formalized arrangements between health care facilities) in place that specify alternate care sites for those essential resources not readily available for critically ill and injured pediatric patients.




www.mccc.nyx.gov/EMSC



Improving the Outcomes of Critically Ill and Injured Children (cont.)

Agreements facilitate planning and assist hospitals in considering the management of patients needing transport to care in advance of such a situation — rather than forcing providers to cope with these issues during the incident.




www.meds.ny.gov/emsc



Improving the Outcomes of Critically Ill and Injured Children (cont.)

Inter facility agreements and guidelines are also essential when resources are limited or exhausted and alternate care sites must be considered – need to increase surge capacity and MCI.





www.meds.ny.gov/emsc



For children this pre-planning can and does make a difference in outcomes!

C
h
i
l
d
r
e
n
:





www.meds.ny.gov/emsc



A Transfer Guideline is:

A decision making process for identifying those patients needing transfer as well as the critical steps to be implemented in the actual safe transfer of the patient to a specified facility.

 www.mccc.nycc.gov/emsc



Critical Elements of Guidelines:

1. Process for initiation of transfer. This includes identifying those needing to be transferred, defining the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communication).



Hospital B



Hospital C



Hospital A

 www.mccc.nycc.gov/emsc



Critical Elements of Guidelines: (cont.)

2. Process for selecting the appropriate care facility.



Hospital B



Hospital C

 www.mccc.nycc.gov/emsc



Critical Elements of Guidelines: (cont.)




3. Process for selecting the appropriately staffed transport service to match the patient's acuity level (level of care required by patient, response time required, equipment needed in transport, etc.)




 www.mddc.nydc.gov/emsc



Critical Elements of Guidelines: (cont.)

4. Process of preparation for patient transfer (including obtaining informed consent)

- Patient stabilization needs
- Diagnostic tests to be completed or not completed
- Essential supplies to accompany the patient enroute – i.e. blood/fluids/airway needs
- Collecting needed documentation



 www.mddc.nydc.gov/emsc



Critical Elements of Guidelines: (cont.)

5. Plan for transfer of patient information (e.g. medical record, copy of signed transport consent), personal belongings of the patient, and provision of directions and referral institution information to family.




 www.mddc.nydc.gov/emsc



Critical Elements of Guidelines: (cont.)

6. Process for return transfer and follow-up communications of the pediatric patient to the referring facility as appropriate.






 www.mddc.nyaa.gov/EMSC






Performance measures #66d, and #66e are all about getting children the right care at the right time and assuring that hospitals have prepared in advance a process to assist in the transfer of children.




 www.mddc.nyaa.gov/EMSC



Contact Information:

Diana G. Fendya, MSN (R), RN
Trauma/Acute Care Specialist
EMSC National Resource Center
DC National Children's Medical Center
dfendya@cnmc.org




www.mddc.nyaa.gov/EMSC



Questions and Answers

Thank you for attending this event.
Please complete the evaluation directly
following the webcast.

Archives of the event are located at
<http://www.mchcom.com>


