Inter Facility Transfer Tool Kit

for the Pediatric Patient

ENA Emergency Nurses Association — Safe Practice, Safe Care

EMSC Emergency Medical Services for Children — National Resource Center

STN Society of Trauma Nurses

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Acknowledgements

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Introduction

Dear Healthcare Partners:

Scarcity of pediatric medical specialists for critically ill and injured children often requires today's providers and medical systems to plan for the inter facility transport of pediatric and neonatal patients. In 2012, more than 10,500 severely injured children were transferred to access higher levels of care and specialty services.[1]

Moving a very sick or critically injured infant or child from one facility to another facility is both complex and stressful to the child, family and staff. Preplanned processes can reduce the strain of unfolding events, ensure that the handoff of the pediatric patient's care is smooth, and increase the safety of the transfer.

The Emergency Nurses Association (ENA), the Society of Trauma Nurses (STN), and the EMS for Children (EMSC) National Resource Center have collaborated to ensure that hospitals and providers can better address these important processes. Resources included in this tool kit support efforts in establishing agreements or memorandums of understanding to facilitate transfer of children to specialty resources when needed. Additionally, the tool kit will aid in the development of pediatric transfer guidelines to assist staff as they work to ensure safe and timely inter facility transfer. Contents are reflective of both current literature and the best practices of hospitals around the country.

Background and Significance:

Consider the following:

- Approximately 27% of all emergency department visits consist of children younger than age 18;[2] and rural or remote facilities care for approximately 89% of all pediatric emergencies.[3]
- Though research has shown outcomes for critically ill and injured children are optimized at hospitals with specific pediatric resources and expertise,[4, 5] pediatric specific critical care areas are only available in 10% of all hospitals.[6]
- Therefore, transfer of critically ill and injured children from receiving emergency departments to pediatric specialty facilities is an essential component of pediatric emergency care.[7]
- Additionally, the 2009 Joint Policy Statement of Guidelines for Care of Children in the Emergency Department, issued by the American College of Emergency Physicians, the American Academy of Pediatrics, and the Emergency Nurses Association states that hospitals lacking higher levels of pediatric care should have transfer guidelines and agreements for transfer of children to pediatric specialty facilities.[8]

Overview of Toolkit Materials

The tool kit consists of 10 sections, each of which provides guidance on specific components associated with inter facility transfer. Users may find all sections helpful or may prefer to focus on individual sections depending on one's unique situation.

Though designed as a kit to aid in developing organized transfer processes for the pediatric patient, all of the information in the kit has applicability for all patients requiring transfer for specialty resources.

Examples or templates may be utilized as is or revised to meet the requirements of individual facilities. A case study section includes two real life scenarios that involve pediatric transfer and the complexities that ultimately impacted patient/family outcomes.

Toolkit Sections

- Section 1 – Introduction to the Tool Kit
- Section 2 – An Algorithm for Developing Inter Facility Transfer Processes – the algorithm will serve as a guide to facilitate tool kit use in the development of inter facility transfer agreements and guidelines.
- Section 3 – Standards and Regulation Considerations Associated with Inter Facility Transfer – includes important often complex concerns the provider may have in regards to the Emergency Medical Treatment and Labor Act (EMTALA), the Health Insurance Portability and Accountability Act (HIPAA), as well as Joint Commission considerations. Additionally the user will find a table listing states with regulations requiring hospitals to have transfer processes in place for services that they cannot provide.
- Section 4 – Talking Points for Establishing Inter Facility Transfer Agreements– identifies important points for addressing the need for inter facility transfer agreement and guidelines as discussions occur with hospital leadership.
- Section 5 – Inter Facility Transfer Agreements – contains examples of several types of agreements and a memorandum of understanding that the user can download and adapt for institutional use.
- Section 6 – Inter Facility Transfer Guidelines – includes examples of hospital transfer guidelines, including: pediatric triage considerations, i.e. patients to be considered for possible transfer; preparation for transfer, i.e. consent to be signed; and a transfer checklist.
- Section 7 – Family Considerations – provides numerous resources addressing cultural considerations and family-centered care.
- Section 8 – Follow-up Communications and Quality Improvement Planning – addresses opportunities to improve and build upon organized transfer processes.
- Section 9 – Inter Facility Case Presentations – presents two pediatric case scenarios reflective of the complexities associated with inter facility transfer.
- Section 10 – Inter Facility Transfer Library – contains manuscripts and documents supporting organized transfer processes, as well as a glossary.

We are thankful for the efforts and work of the collaborative group in developing this tool kit. Additionally, we thank you, the user, for accessing this tool and helping to ensure both timely and safe transfer of children when specialty care is needed.

Sincerely,

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Footnotes

[1]American College of Surgeons, Committee on Trauma, Pediatric National Trauma Data Base Report, 2012. http://www.facs.org/trauma/ntdb/pdf/ntdb-pediatric-annual-report-2012.pdf

[2]Institute of Medicine. Emergency Care for Children. Growing Pains. Washington, DC: The National Academies Press; 2007. Committee on the Future of Emergency Care in the United States Health System.

[3]Gausche-Hill M, Schmitz C, Lewis RJ. Pediatric preparedness of US emergency departments: a 2003 survey. Pediatrics. 2007;120

[4]Kanter RK. Regional variation in child mortality at hospitals lacking a pediatric intensive care unit. Critical Care Medicine 2002;30:94Y99.

[5]Pracht EE, Tepas JJ 3rd, Langland-Orban B, et al. Do pediatric patients with trauma in Florida have reduced mortality rates when treated in designated trauma centers? Journal of Pediatric Surgery. 2008;43:212Y221.Joint policy statement guidelines for care of children in the emergency department. Pediatrics. 2009;124:1233Y1243

[6]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.

[7]Woodward GA, Insoft RM, Pearson-Shaver AL, et al. The state of pediatric interfacility transport: consensus of the second National Pediatric and Neonatal Interfacility Transport Medicine Leadership Conference. Pediatric Emergency Care. 2002;18:38Y43.

[8]Joint policy statement guidelines for care of children in the emergency department. Pediatrics. 2009;124:1233Y1243.

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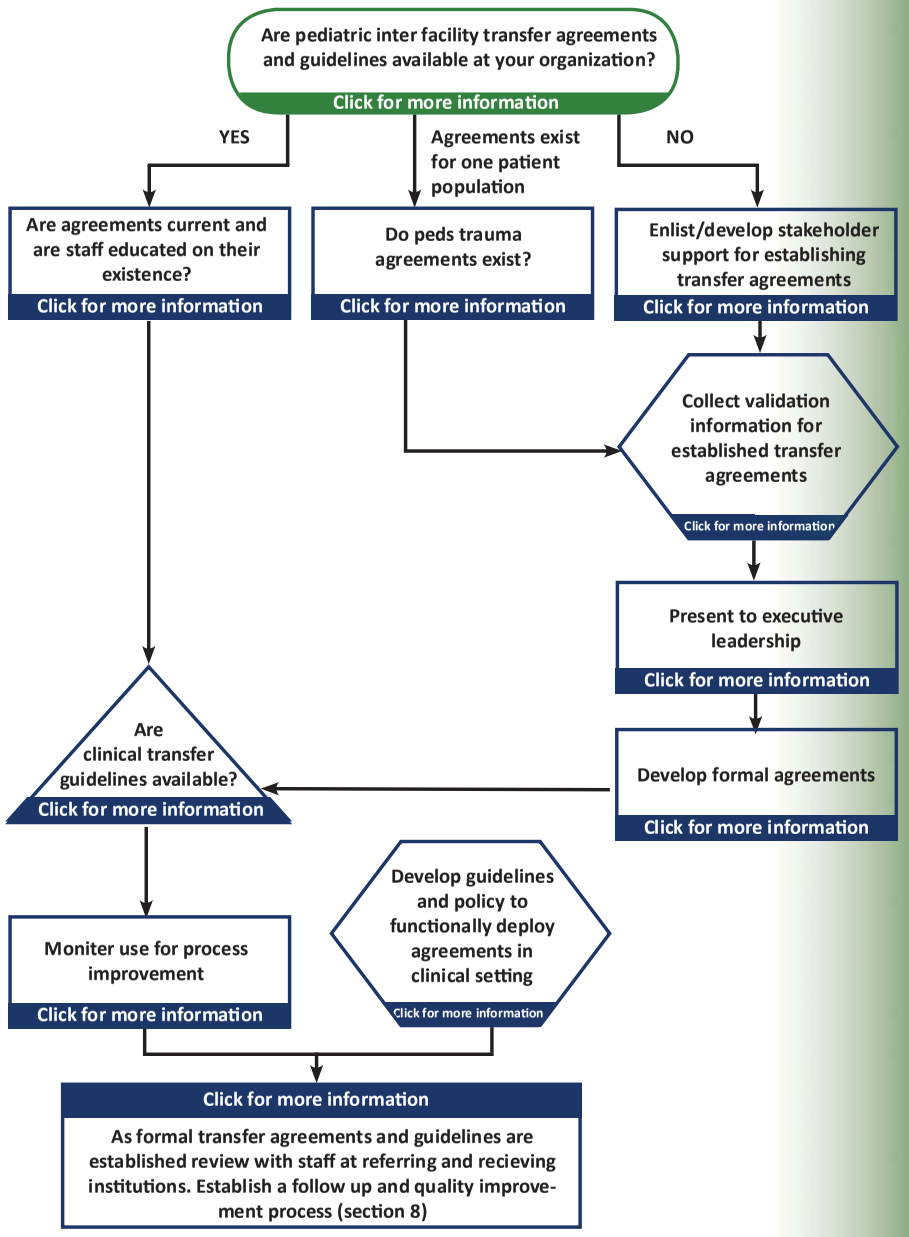
Algorithm for Developing Inter Facility Transfer Processes

Evidence based practice suggests rapid triage and transfer of critically ill and injured pediatric patients is crucial to reducing the overall mortality and morbidity of this patient population. Organized processes may also be paramount when mass casualty incidents quickly overwhelm existing standard operating procedures. The overarching goal of the pediatric inter facility transfer toolkit is to help facilities establish agreements and develop guidelines for ensuring safe and expeditious transfer of the pediatric patient when higher level(s) of care and resources are required and when mass casualty necessitates patient movement outside of traditional local or regional patient flows.

This section provides a mapping algorithm that a facility or an individual within a facility may find useful as they work to establish inter facility transfer processes. The Agreement and Guideline Algorithm provides a step-by-step process for the establishment of agreements and guidelines while referencing examples and information from other toolkit sections. The algorithm has been constructed to be used by any facility regardless of size or scope of service.



Section Three

Rules and Standards and Inter Facility Transfer

Appropriate transfer of pediatric patients from one facility to another requires thoughtful design, thorough planning, and ongoing monitoring. Inter facility transfer programs are subject to review related to compliance with key laws, elements of performance defined in accreditation programs, and prevailing professional standards and guidelines. Variability in state laws makes it necessary for inter facility transfer design teams to have a knowledge base of the legal requirements of their state.

Licensed health care professionals participating in care responsibilities during transfer events also have personal accountability for assuring that they are practicing within the boundaries of their scope of practice and license. A primary starting point for any inter facility transfer program for pediatric patients is an awareness of the policies and procedures currently in existence with the facility.

While all laws, regulations, and standards are subject to ongoing revisions over time, the following list provides identified areas of importance related to rules and regulations.

1. Emergency Medical Services for Children Performance Measures 76 and 77. The EMS for Children Program has identified two performance measures in the establishment of inter facility transfer agreements and guidelines.

2. The Emergency Medical Treatment and Labor Act (EMTALA). This act became a federal law in 1986 and was designed to prevent hospitals from refusing to treat patients or transferring them to public hospitals when they were unable to pay. For more information, read a Legal Issues in Inter Facility Transfer: EMTALA Issue Brief is available.

3. Certificate of Transfer. Under EMTALA, a hospital may not transfer an individual with an unstabilized emergency medical condition unless a physician signs a certification stating that the benefit to the individual of receiving treatment at another medical facility outweighs the risk of being transferred. Certificates of transfer are required by the Centers for Medicare and Medicaid Services in order for reimbursement to occur.

4. The Health Insurance Portability and Accountability Act. This act set standards for the use and disclosure of protected health information as well as measures to ensure proper storage and transmission of medical records.

5. Federal Aviation Administration. Federal regulations related to air medical transport are available under the Federal Code of Regulations and apply to patients being transported by air.

6. State and Territorial Regulation (see the EMS for Children National Resource Center's State and Territorial Regulations Authorizing Pediatric Interfacility Transfer Guidelines or Agreements). Wide variations of state laws and regulations exist related to the provision of emergency care. In some instances, the interfacility transport process is specified in state regulations. In addition, when referral crosses state lines there may be specification in state regulation that apply.

7. Standards of Practice. Defined standards of emergency care, including transfer needs for adult and pediatric nurses, have been identified by the Emergency Nurse Association.

8. The American Nurses Association, the Joint Commission Accreditation of Hospitals, and the Centers for Medicare and Medicaid Services also have standards addressing transfer of patients (see Standards Addressing Organized Inter Facility Transfer Processes.)

9. The following professional organizations address the need for organized transfer processes through a variety of educational offerings.

   - Trauma Nurse Core Course
   - Emergency Nurse Pediatric Course
   - Transport Nurse Advanced Trauma Course
   - Advanced Trauma Care for Nurses
   - Rural Trauma Team Development Course, Chapter 7, Transfer to Definitive Care
   - Advanced Trauma Life Support, Chapter 13, Transport:

10. Emergency Nurses Association's 2010 Inter Facility Position Statement

Section Four

Talking Points for Establishing Interfacility Transfer Agreements

The documents provided in this section are designed to provide support for the establishment of inter facility transfer agreements to streamline the transfer of critically ill children from general emergency departments to facilities offering more specialized pediatric care.

Some particular points of interest include:

- Establishing a relationship between facilities via transfer agreements and guidelines may help to mitigate unnecessary transfers of children.
- Emergency Medical Treatment and Active Labor Act (EMTALA) implications associated with transfers may be avoided by establishing transfer agreements. While the Centers for Medicare and Medicaid Services (CMS) clearly articulates the duty of specialty hospitals to accept patients from more general facilities, the courts have been more ambiguous – sometimes articulating the failures of transferring facilities to adequately stabilize patients.
- An organized inter facility transfer process with clearly articulated steps and roles may improve outcomes in critically ill or injured children.
- Inter facility transfer agreements and guidelines may assist the physician ahead of time in the selection of an appropriate destination and mode of transport for critically ill and injured children.
- The Emergency Nurses Association (ENA) and the Society of Trauma Nurses support the use of transfer agreements and guidelines to facilitate rapid and safe transfer of all patients.

Published Documents Supporting the Need for Inter Facility Transfer Processes

- EMS for Children Face Sheet on Performance Measures 76 and 77 (EMS for Children National Resource Center) – Provides an overview of the advantages of having transfer agreements in place, as well as the requirements for transfer guidelines.
- Inter Facility Transports (Blackwell, TH) – The transfer process, including stabilization of the patient and transfer of the unstable patient, is covered in this manuscript. Supports coordination of the process, communication, and review of transfers for appropriateness. Outlines considerations for selection of mode of transport.
- Position Statement Care of the Patient During Inter Facility Transfer (ENA) – Supports the use of transfer agreements to facilitate rapid, safe transfer.
- Organized Inter Facility Transfer Process (Fendya, et al) – Calls for a closer look at the effect of transfer agreements and guidelines on timely pediatric transfers.
- Inter Facility Transfers of Non-critically Ill Children (Li, et al) – Speaks to the number of transfers that were either discharged from the tertiary center emergency department or within 24 hours of the transfer. Points out the importance for transfer criteria and addressing the readiness of emergency departments to care for children.
- Transfer Agreements Help Hospitals Comply With Antidumping Laws (Kingsolver, JC) – Provides a legal overview of the value of transfer agreements.
- *Issue Brief* June 2009 (EMS for Children National Resource Center) – Supports transfer agreements and guidelines through discussion of EMTALA implications when transferring both inpatients and unstable emergeny department patients in the context of uncertainty with court rulings vs. CMS interpretations.
- *Issue Brief* May 2010 (EMS for Children National Resource Center) – Discusses EMTALA liability issues that can arise in the case of an inter facility transfer. Supports transfer guidelines and agreements and their importance in establishing the terms of the transfer to clarify respective duties and methods for assuring the proper execution of those duties.

Section Five

Inter Facility Transfer Agreements and Memorandums of Understanding

Specialty care for children, i.e., pediatric neurosurgeons and pediatric specific critical care units, is often limited in availability. Many hospitals do not have the specialty resources needed to care for critically ill and injured children. It is essential that hospitals lacking pediatric specialty care proactively identify partnering facilities capable of providing the needed resources while identifying and streamlining effective transfer processes.

An inter facility hospital agreement and memorandum of understanding (MOU) may be defined as a written document of understanding between a referring facility (e.g., community hospital) and another hospital. The agreement identifies collaborative roles in the provision of additional needed care resources and specific duties as they relate to the inter facility transfer of patients. Often they include guidelines that outline procedural and administrative policies for transferring critically ill patients to facilities that provide specialized care or services not available at the referring facility.

A pediatric specific agreement or MOU formalizes arrangements for consultation and the timely transport of the pediatric patient to additional care resources. Having established hospital transfer agreements or MOUs can also provide opportunities to craft transfer guidelines to expedite the safe movement of patients to the essential resources when time may be critical.

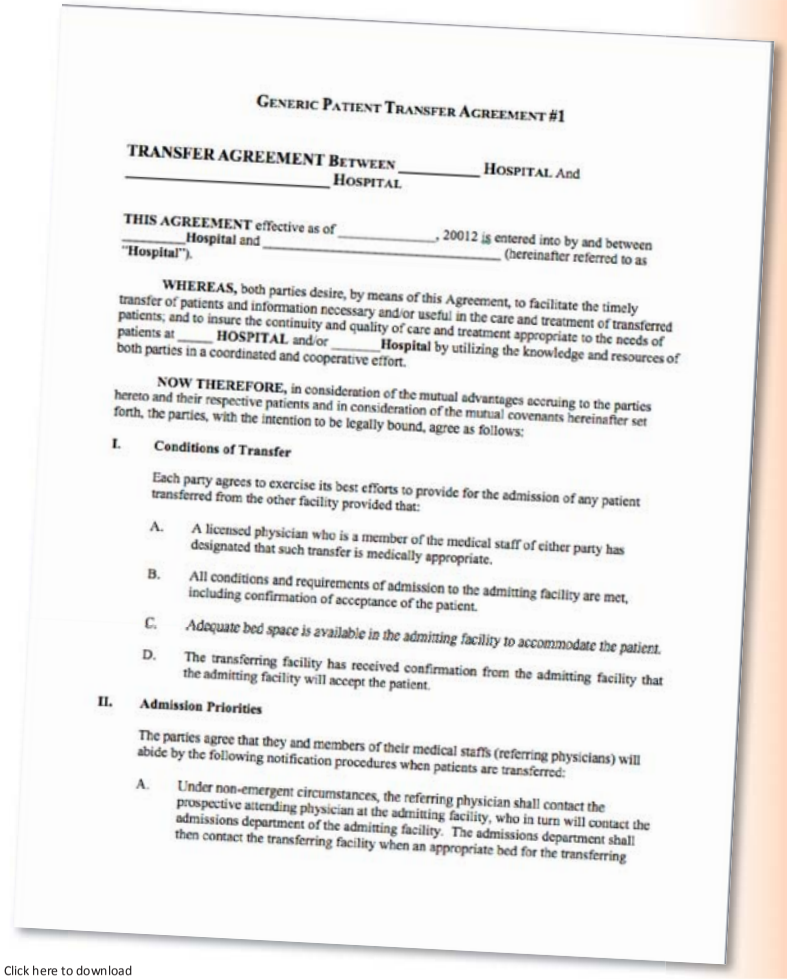
This section contains several blank examples of hospital agreements as well as MOUs that have been utilized to ensure that arrangements and access to specialty resources are available to pediatric patients.

Example agreements in this section include:

- Generic Patient Transfer Agreement #1
- Generic Patient Transfer Agreement #2
- Specific Service Pediatric Transfer Agreement (Trauma and Non-Trauma Pediatric Patient)
- Hospital Inter-System/Network Transfer Agreement
- Pediatric Inter Facility Transfer Memoradum of Agreement

Generic Patient Transfer Agreement #1

This type of agreement is common between smaller community hospitals and larger facilities or medical centers where additional care resources may be available. The agreement is not restrictive to a specific patient population (i.e., pediatric) or diagnosis (i.e., burns). The collaborative relationship covers all patients needing additional resources not readily available at the receiving institution.



GENERIC PATIENT TRANSFER AGREEMENT #1

TRANSFER AGREEMENT BETWEEN _____ HOSPITAL And _____ HOSPITAL

THIS AGREEMENT effective as of _____, 20012 is entered into by and between _____**Hospital** and _____ (hereinafter referred to as "**Hospital**").

WHEREAS, both parties desire, by means of this Agreement, to facilitate the timely transfer of patients and information necessary and/or useful in the care and treatment of transferred patients; and to insure the continuity and quality of care and treatment appropriate to the needs of patients at _____ **HOSPITAL** and/or _____**Hospital** by utilizing the knowledge and resources of both parties in a coordinated and cooperative effort.

NOW THEREFORE, in consideration of the mutual advantages accruing to the parties hereto and their respective patients and in consideration of the mutual covenants hereinafter set forth, the parties, with the intention to be legally bound, agree as follows:

I. Conditions of Transfer

Each party agrees to exercise its best efforts to provide for the admission of any patient transferred from the other facility provided that:

A. A licensed physician who is a member of the medical staff of either party has designated that such transfer is medically appropriate.

B. All conditions and requirements of admission to the admitting facility are met, including confirmation of acceptance of the patient.

C. *Adequate bed space is available in the admitting facility to accommodate the patient.*

D. The transferring facility has received confirmation from the admitting facility that the admitting facility will accept the patient.

II. Admission Priorities

The parties agree that they and members of their medical staffs (referring physicians) will abide by the following notification procedures when patients are transferred:

A. Under non-emergent circumstances, the referring physician shall contact the prospective attending physician at the admitting facility, who in turn will contact the admissions department of the admitting facility. The admissions department shall then contact the transferring facility when an appropriate bed for the transferring

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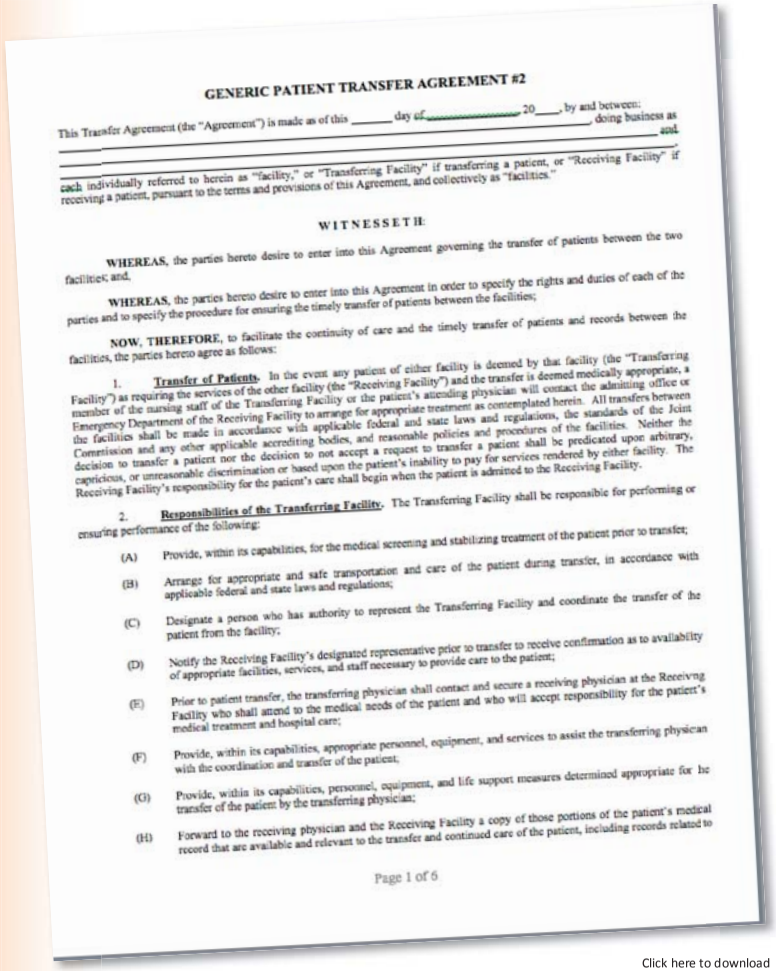
Generic Patient Transfer Agreement #2

This type of agreement is common between smaller community hospitals and larger facilities or medical centers where additional care resources may be available. The agreement is not restrictive to a specific patient population (i.e., pediatric) or diagnosis (i.e., burns). The collaborative relationship covers all patients needing additional resources not readily available at the receiving institution.



GENERIC PATIENT TRANSFER AGREEMENT #2

This Transfer Agreement (the "Agreement") is made as of this _____ day of _____, 20___, by and between: _____, doing business as _____ and _____, each individually referred to herein as "facility," or "Transferring Facility" if transferring a patient, or "Receiving Facility" if receiving a patient, pursuant to the terms and provisions of this Agreement, and collectively as "facilities."

WITNESSETH:

WHEREAS, the parties hereto desire to enter into this Agreement governing the transfer of patients between the two facilities; and,

WHEREAS, the parties hereto desire to enter into this Agreement in order to specify the rights and duties of each of the parties and to specify the procedure for ensuring the timely transfer of patients between the facilities;

NOW, THEREFORE, to facilitate the continuity of care and the timely transfer of patients and records between the facilities, the parties hereto agree as follows:

1. **Transfer of Patients.** In the event any patient of either facility is deemed by that facility (the "Transferring Facility") as requiring the services of the other facility (the "Receiving Facility") and the transfer is deemed medically appropriate, a member of the nursing staff of the Transferring Facility or the patient's attending physician will contact the admitting office or Emergency Department of the Receiving Facility to arrange for appropriate treatment as contemplated herein. All transfers between the facilities shall be made in accordance with applicable federal and state laws and regulations, the standards of the Joint Commission and any other applicable accrediting bodies, and reasonable policies and procedures of the facilities. Neither the decision to transfer a patient nor the decision to not accept a request to transfer a patient shall be predicated upon arbitrary, capricious, or unreasonable discrimination or based upon the patient's inability to pay for services rendered by either facility. The Receiving Facility's responsibility for the patient's care shall begin when the patient is admitted to the Receiving Facility.

2. **Responsibilities of the Transferring Facility.** The Transferring Facility shall be responsible for performing or ensuring performance of the following:

(A) Provide, within its capabilities, for the medical screening and stabilizing treatment of the patient prior to transfer;

(B) Arrange for appropriate and safe transportation and care of the patient during transfer, in accordance with applicable federal and state laws and regulations;

(C) Designate a person who has authority to represent the Transferring Facility and coordinate the transfer of the patient from the facility;

(D) Notify the Receiving Facility's designated representative prior to transfer to receive confirmation as to availability of appropriate facilities, services, and staff necessary to provide care to the patient;

(E) Prior to patient transfer, the transferring physician shall contact and secure a receiving physician at the Receiving Facility who shall attend to the medical needs of the patient and who will accept responsibility for the patient's medical treatment and hospital care;

(F) Provide, within its capabilities, appropriate personnel, equipment, and services to assist the transferring physician with the coordination and transfer of the patient;

(G) Provide, within its capabilities, personnel, equipment, and life support measures determined appropriate for the transfer of the patient by the transferring physician;

(H) Forward to the receiving physician and the Receiving Facility a copy of those portions of the patient's medical record that are available and relevant to the transfer and continued care of the patient, including records related to

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Click here to download "Generic Patient Transfer Agreemnt #2" to your desktop.

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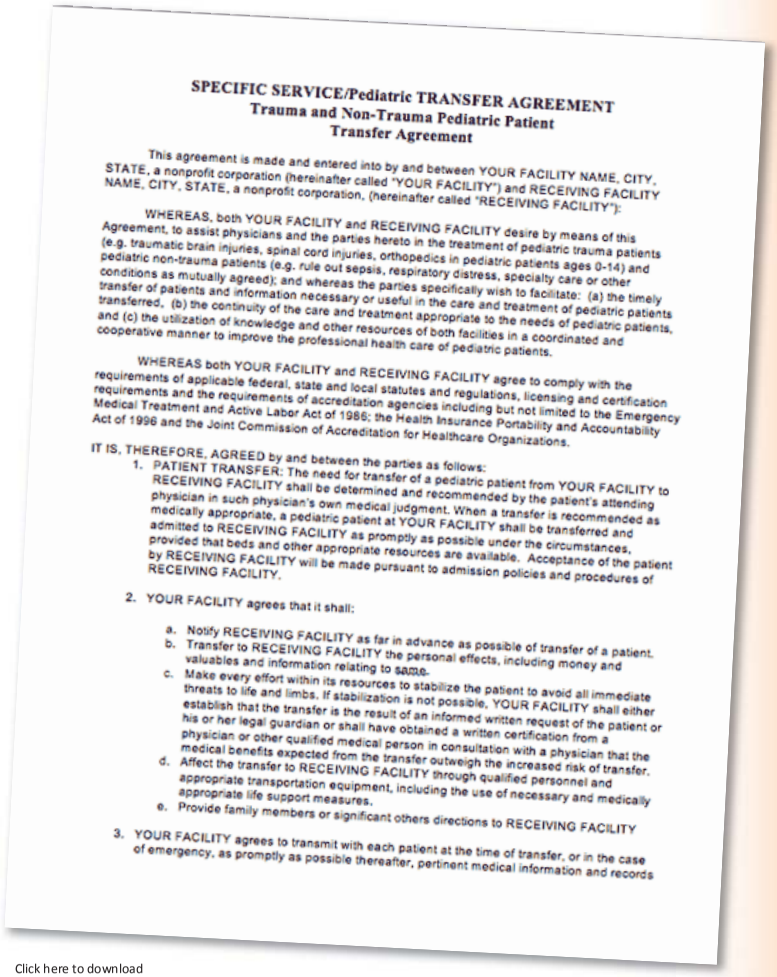
Specific Service Pediatric Transfer Agreement (Trauma and Non-Trauma Pediatric Patient)

This type of agreement would be made between a facility with minimal pediatric resources and a children's hospital or a hospital with extensive pediatric resources. The transferring facility desires a collaborative working relationship between themselves and a hospital with specific pediatric resources.



SPECIFIC SERVICE/Pediatric TRANSFER AGREEMENT
Trauma and Non-Trauma Pediatric Patient
Transfer Agreement

This agreement is made and entered into by and between YOUR FACILITY NAME, CITY, STATE, a nonprofit corporation (hereinafter called "YOUR FACILITY") and RECEIVING FACILITY NAME, CITY, STATE, a nonprofit corporation, (hereinafter called "RECEIVING FACILITY"):

WHEREAS, both YOUR FACILITY and RECEIVING FACILITY desire by means of this Agreement, to assist physicians and the parties hereto in the treatment of pediatric trauma patients (e.g. traumatic brain injuries, spinal cord injuries, orthopedics in pediatric patients ages 0-14) and pediatric non-trauma patients (e.g. rule out sepsis, respiratory distress, specialty care or other conditions as mutually agreed); and whereas the parties specifically wish to facilitate: (a) the timely transfer of patients and information necessary or useful in the care and treatment of pediatric patients transferred, (b) the continuity of the care and treatment appropriate to the needs of pediatric patients, and (c) the utilization of knowledge and other resources of both facilities in a coordinated and cooperative manner to improve the professional health care of pediatric patients.

WHEREAS both YOUR FACILITY and RECEIVING FACILITY agree to comply with the requirements of applicable federal, state and local statutes and regulations, licensing and certification requirements and the requirements of accreditation agencies including but not limited to the Emergency Medical Treatment and Active Labor Act of 1986; the Health Insurance Portability and Accountability Act of 1996 and the Joint Commission of Accreditation for Healthcare Organizations.

IT IS, THEREFORE, AGREED by and between the parties as follows:

1. PATIENT TRANSFER: The need for transfer of a pediatric patient from YOUR FACILITY to RECEIVING FACILITY shall be determined and recommended by the patient's attending physician in such physician's own medical judgment. When a transfer is recommended as medically appropriate, a pediatric patient at YOUR FACILITY shall be transferred and admitted to RECEIVING FACILITY as promptly as possible under the circumstances, provided that beds and other appropriate resources are available. Acceptance of the patient by RECEIVING FACILITY will be made pursuant to admission policies and procedures of RECEIVING FACILITY.

2. YOUR FACILITY agrees that it shall:

   a. Notify RECEIVING FACILITY as far in advance as possible of transfer of a patient.
   b. Transfer to RECEIVING FACILITY the personal effects, including money and valuables and information relating to same.
   c. Make every effort within its resources to stabilize the patient to avoid all immediate threats to life and limbs. If stabilization is not possible, YOUR FACILITY shall either establish that the transfer is the result of an informed written request of the patient or his or her legal guardian or shall have obtained a written certification from a physician or other qualified medical person in consultation with a physician that the medical benefits expected from the transfer outweigh the increased risk of transfer.
   d. Affect the transfer to RECEIVING FACILITY through qualified personnel and appropriate transportation equipment, including the use of necessary and medically appropriate life support measures.
   e. Provide family members or significant others directions to RECEIVING FACILITY

3. YOUR FACILITY agrees to transmit with each patient at the time of transfer, or in the case of emergency, as promptly as possible thereafter, pertinent medical information and records

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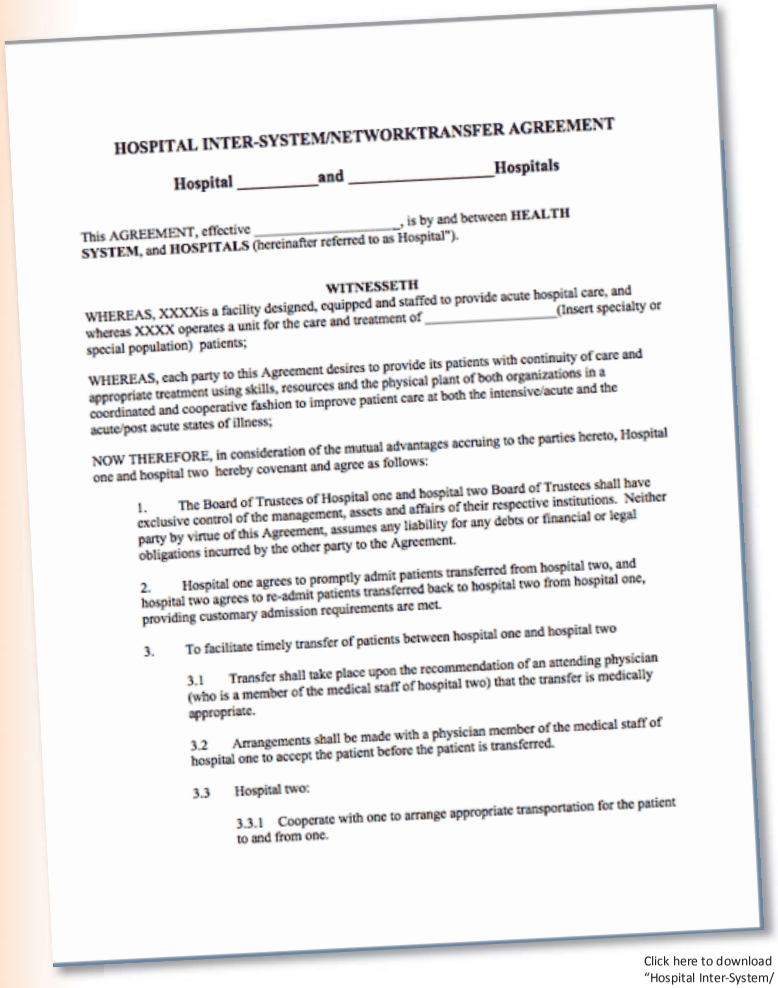
Hospital Inter-System/Network Transfer Agreement

This type of agreement might be used by members of a multi-hospital system in which two or more hospitals are owned, leased, sponsored, or contract managed by a central organization. A network agreement may be in place when a group of hospitals, physicians, other providers, insurers and/or community agencies work together to coordinate and deliver a broad spectrum of services to their community.



HOSPITAL INTER-SYSTEM/NETWORKTRANSFER AGREEMENT

Hospital _____and _____Hospitals

This AGREEMENT, effective _____, is by and between **HEALTH SYSTEM**, and **HOSPITALS** (hereinafter referred to as Hospital").

WITNESSETH

WHEREAS, XXXXis a facility designed, equipped and staffed to provide acute hospital care, and whereas XXXX operates a unit for the care and treatment of _____(Insert specialty or special population) patients;

WHEREAS, each party to this Agreement desires to provide its patients with continuity of care and appropriate treatment using skills, resources and the physical plant of both organizations in a coordinated and cooperative fashion to improve patient care at both the intensive/acute and the acute/post acute states of illness;

NOW THEREFORE, in consideration of the mutual advantages accruing to the parties hereto, Hospital one and hospital two hereby covenant and agree as follows:

1. The Board of Trustees of Hospital one and hospital two Board of Trustees shall have exclusive control of the management, assets and affairs of their respective institutions. Neither party by virtue of this Agreement, assumes any liability for any debts or financial or legal obligations incurred by the other party to the Agreement.

2. Hospital one agrees to promptly admit patients transferred from hospital two, and hospital two agrees to re-admit patients transferred back to hospital two from hospital one, providing customary admission requirements are met.

3. To facilitate timely transfer of patients between hospital one and hospital two

3.1 Transfer shall take place upon the recommendation of an attending physician (who is a member of the medical staff of hospital two) that the transfer is medically appropriate.

3.2 Arrangements shall be made with a physician member of the medical staff of hospital one to accept the patient before the patient is transferred.

3.3 Hospital two:

3.3.1 Cooperate with one to arrange appropriate transportation for the patient to and from one.

Click here to download "Hospital Inter-System/ Network Transfer Agreement" to your desktop.

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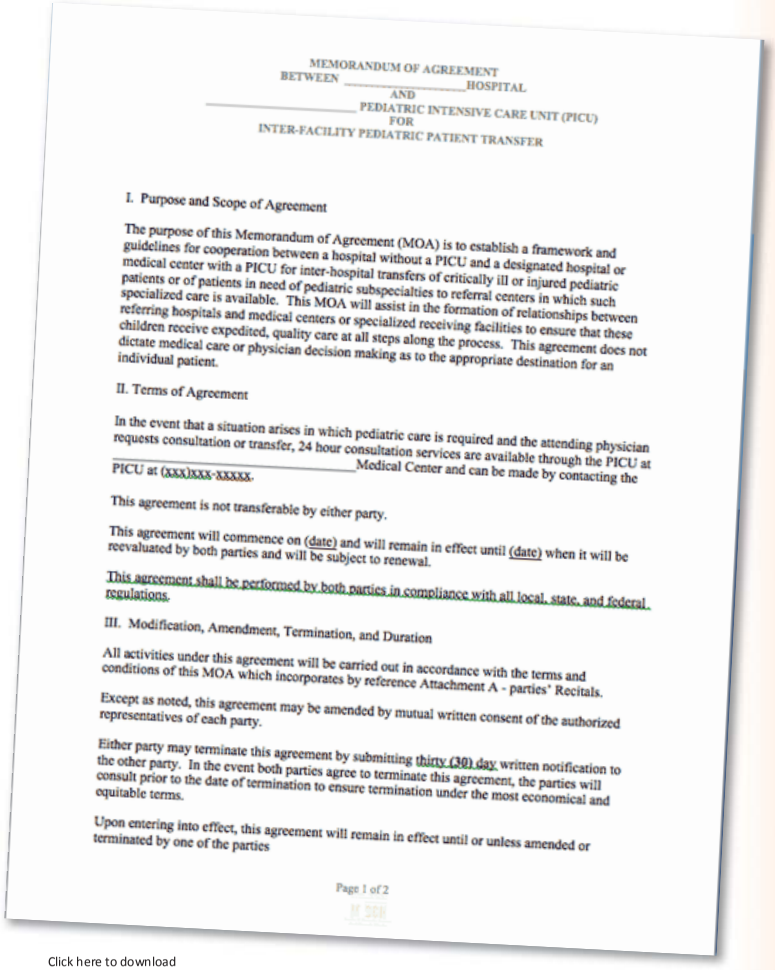
Pediatric Inter Facility Transfer Memoradum of Agreement

A Memorandum of Understanding (MOU) may more easily be established between two institutions as opposed to a formal transfer agreement. MOUs or Memorandum of Agreements are developed when two facilities want to work together on a common goal or action but do not want to enter into a formal agreement, i.e., ensuring access to pediatric specialty care when needed.



MEMORANDUM OF AGREEMENT
BETWEEN _____HOSPITAL
AND
_____ PEDIATRIC INTENSIVE CARE UNIT (PICU)
FOR
INTER-FACILITY PEDIATRIC PATIENT TRANSFER

I. Purpose and Scope of Agreement

The purpose of this Memorandum of Agreement (MOA) is to establish a framework and guidelines for cooperation between a hospital without a PICU and a designated hospital or medical center with a PICU for inter-hospital transfers of critically ill or injured pediatric patients or of patients in need of pediatric subspecialties to referral centers in which such specialized care is available. This MOA will assist in the formation of relationships between referring hospitals and medical centers or specialized receiving facilities to ensure that these children receive expedited, quality care at all steps along the process. This agreement does not dictate medical care or physician decision making as to the appropriate destination for an individual patient.

II. Terms of Agreement

In the event that a situation arises in which pediatric care is required and the attending physician requests consultation or transfer, 24 hour consultation services are available through the PICU at _____Medical Center and can be made by contacting the PICU at (xxx)xxx-xxxxx.

This agreement is not transferable by either party.

This agreement will commence on (date) and will remain in effect until (date) when it will be reevaluated by both parties and will be subject to renewal.

This agreement shall be performed by both parties in compliance with all local, state, and federal regulations.

III. Modification, Amendment, Termination, and Duration

All activities under this agreement will be carried out in accordance with the terms and conditions of this MOA which incorporates by reference Attachment A - parties' Recitals.

Except as noted, this agreement may be amended by mutual written consent of the authorized representatives of each party.

Either party may terminate this agreement by submitting thirty (30) day written notification to the other party. In the event both parties agree to terminate this agreement, the parties will consult prior to the date of termination to ensure termination under the most economical and equitable terms.

Upon entering into effect, this agreement will remain in effect until or unless amended or terminated by one of the parties

Page 1 of 2

Click here to download "Pediatric Inter Facility Transfer Memoradum of Agreement " to your desktop.

Download

Inter Facility Guidelines for Pediatric Transfer

As defined by the EMS for Children Program (see EMS for Children performance measure 76), safe and timely transfers to a specialty care center are better coordinated through the presence of inter facility transfer guidelines. These guidelines should include the following components:

- Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communications).
- Process for selecting the appropriate care facility.
- Process for selecting the appropriately staffed transport service to match the patient's acuity level (level of care required by patient, equipment needed in transport, etc.).
- Process for patient transfer (including obtaining informed consent).
- Plan for transfer of patient medical record.
- Plan for transfer of copy of signed transport consent.
- Plan for transfer of personal belongings of the patient.
- Plan for provision of directions and referral institution information to the family.

Effective stabilization and timely transport of a critically ill and/or injured child is very important in the reduction of further harm and negative outcomes. Severely ill and injured children have the potential to deteriorate quickly, making initial stabilization and identification or triage of those requiring additional resources important in developing transfer processes.

This section includes the following resources:

1. Examples of pediatric triage criteria/considerations for children often benefitting from transfer for additional medical care and resources.
    - Pediatric Critical Care
    - Pediatric Surgery
    - Pediatric Burns
2. Example transfer checklists for referral, care considerations during actual transfer, and essential patient information to accompany the patient:
    - Patient medical record and testing information
    - Care giver information, both referring and receiving information
    - Transport information
    - Parent information including consents and directions

Pediatric Critical Care: Example Considerations for Transfer

The following criteria are to serve as guidelines for directing the transfer of critically ill or injured patients to a higher level of care. Exceptions can be made upon consideration of the individual patient's needs, and after consultation with nursing, subspecialists, and attending physicians involved. Availability of appropriate support services, including radiology and laboratory/pathology services, in a timely fashion may determine necessity of transfer.

The parent(s), primary care physician, physician of record, and consultants have the final say in the location of the care of the patient, taking in to account the following criteria:

The following patients should be considered for transfer to a higher level of care:

1. Patient with multi-organ system failure
2. Patient requiring constant bedside attendance for six hours or more
3. Patient requiring ongoing input from a subspecialist or the subspecialist requests transfer to another facility
4. Patient requiring cardiovascular surgical input or attention
5. Patient with renal failure requiring dialysis
6. Transplant recipient patient with transplant-related clinical issues
7. Patient with specific infectious diseases (e.g. HIV) that require pediatric ID input
8. If for any reason it is in the patient's best interest to be transferred to another facility (e.g. social, insurance, equipment only available at another facility, etc)

In addition, the following factors may also impact determination of the appropriate location for the care of a patient:

1. Pediatric Intensive Care Unit divert status
2. Admissions and transfers from emergency departments
3. Trauma patients' disposition is at the discretion of the Trauma Service
4. Nursing or support personnel feel patient's status or needs exceeds their comfort level

This list of guidelines will be under constant review, and criteria can be added or removed, depending on further evolution of the patients' needs.

Pediatric Surgery: Example Considerations for Transfer

The following criteria are intended to serve as guidelines for directing the transfer of pediatric surgical patients to a higher level of care. Exceptions can be made upon consideration of the individual patient's needs, and after consultation with nursing, subspecialists, and attending physicians involved. Availability of operating room time and appropriate support services, including radiology and laboratory/pathology services, in a timely fashion may determine necessity of transfer.

The pediatric surgeons have the final say in the location of the care of their patients, taking in to account the following criteria:

Neonates

1. Patients with known cardiac defects in utero should be delivered at the tertiary care center
2. The following conditions should be sent to tertiary care center after delivery due to the issues of complex surgery, multiple surgical procedures, and the need for multiple consultants
   - Omphalocele
   - Gastroschisis
   - Trachoesophageal Fistula
   - Congenital Diaphragmatic Hernia
   - Spinal defects
   - Bowel obstructions
3. Patients having the following surgical conditions may be appropriate to stay at a general pediatric care facility, depending upon patient condition and facility capabilities.
   - Patent ductus arteriosis
   - Hernia repair
   - Lumps and bumps
   - Perforated necrotized bowel (This is on a case-by-case basis. Stable babies with a perforation may be operated on at the surgeon's discretion. Sicker babies will be transferred. A neonatologists must agree to be in house for six hours or longer if these cases are to be done.)
4. Surgeon will schedule anesthesia if not same day admission.

Infants, Toddlers, Children

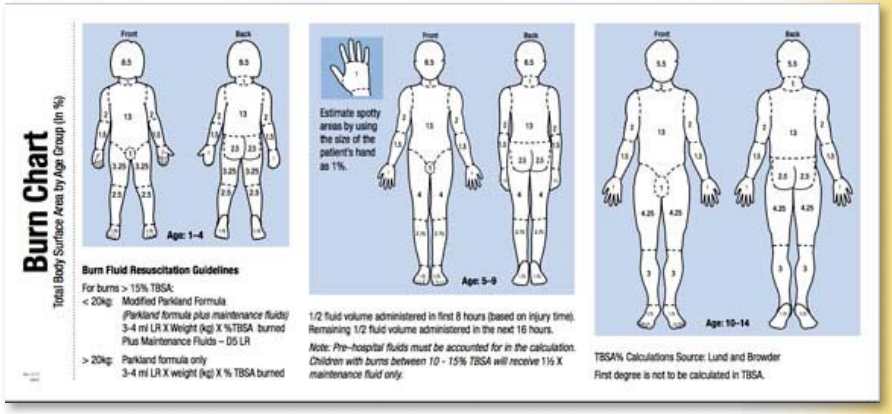
1. Patients presenting to the emergency department will be stabilized and treated.
2. Patients requiring the following surgery will be admitted to _____ unless appropriate clinical support is not available.
   - Hernia repair
   - Abscesses
   - Empyema (This is on a cases-by-case basis. Sicker children requiring ventilator support pre-op or with significant signs of sepsis should be considered for transfer to _____. More stable patients may be operated on at _____ at the surgeons discretion but an intensivist must be present in house post-op for at least six hours to address any respiratory issues, unless mutually agreed upon by the surgeon and intensivist.)
   - Appendectomy
   - Foreign bodies of the airway and esophagus (assuming adequate endoscopy carts are maintained
   - Intussusception (assuming an attempt at a therapeutic barium enema can be obtained by a trained pediatric radiologist prior to surgery.)
3. Those surgical patients needing the following conditions should be considered for transfer to _____ for PICU placement:
   - Multi-organ system issues (two or more systems or oncology)
   - Ventilator support expected to be needed for greater than 48 hours
   - Need for bedside physician presence for six hours or longer
4. Trauma patients will be managed by the trauma surgeons and managed by the pediatric intensivist. Pediatric surgery may be consulted and will treat or transfer based on collaboration with the trauma surgeon and intensivist.
5. The surgeons of _____agree to make in-house consults on all requested patients unless it is clear that the patient meets transfer criteria and waiting for the consult would only delay appropriate medical care.

Pediatric Burns: Example Considerations for Transfer to Burn Center

The following criteria are to serve as guidelines for directing the transfer of pediatric burn patients to a burn center. Exceptions can be made upon consideration of the individual patient's needs, and after consultation with nursing, subspecialists, and attending physicians involved. Availability of appropriate support services, including social service, pediatric nurtritionist, and rehabilitation, may also determine necessity of transfer.

The following patients should be considered for transfer to a burn center:

1. Partial thickness burns greater than 10% total body surface area (TBSA)
2. Burns that involve the face, hands, feet, genitalia, perineum or major joints
3. Third degree burns in any age.
4. Electrical burns, including lightning
5. Chemical burns
6. Inhalation injury
7. Burn injury with preexisting medical disorder
8. Burn injury with associated trauma
9. Burn injury in patients that require special social, emotional, and/or long-term rehabilitative intervention



Click here to download "Pediatric Burn Center Referral Criteria/Guidelines for Stabilization" to your desktop.

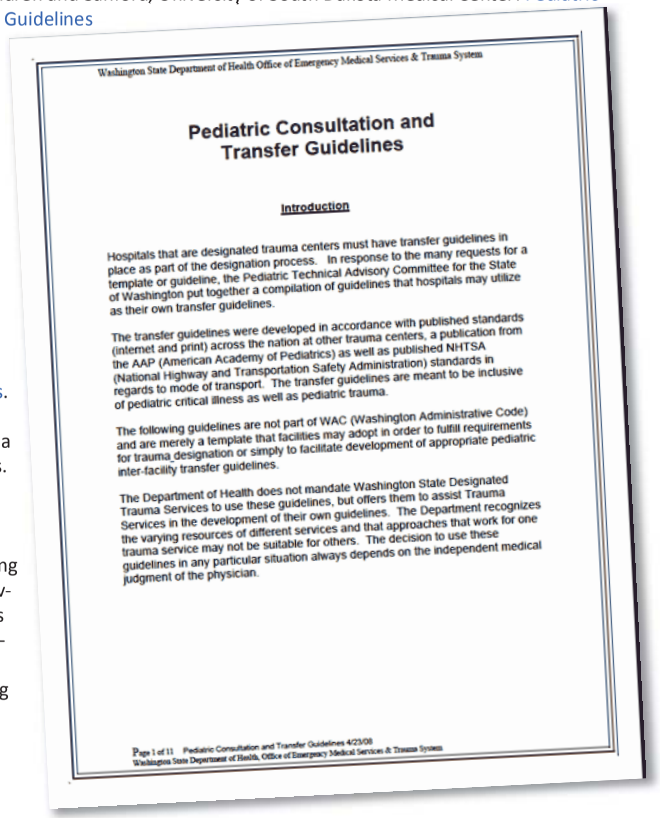
Download

Pediatric Inter Facility Consultation and Transfer Guidelines

In 2005, the EMS for Children Program established 10 performance measures to guide the activities of state EMS for Children grantees. Performance measures 76 and 77 address the need for hospitals to have inter facility transfer guidelines and agreements in place for the pediatric patient. The goal of the measures is to ensure that all children have access to pediatric specialty care that is not available at every hospital.

The following states and their EMS for Children Advisory Committees developed inter facility transfer guidelines to provide assistance to hospitals as they develop their own transfer processes.

- California EMS for Children: Interfacility Pediatric Trauma and Critical Care: Consultation and/or Transfer Guidelines
- Maryland EMS for Children: Maryland EMS Inter-hospital Transfer Resource Manual
- South Dakota EMS for Children and Sanford, University of South Dakota Medical Center: Pediatric Consultation and Transfer Guidelines
- Washington State Department of EMS and Trauma Systems: Pediatric Consultation and Transfer Guidelines



Washington State Department of Health Office of Emergency Medical Services & Trauma System

Pediatric Consultation and Transfer Guidelines

Introduction

Hospitals that are designated trauma centers must have transfer guidelines in place as part of the designation process. In response to the many requests for a template or guideline, the Pediatric Technical Advisory Committee for the State of Washington put together a compilation of guidelines that hospitals may utilize as their own transfer guidelines.

The transfer guidelines were developed in accordance with published standards (internet and print) across the nation at other trauma centers, a publication from the AAP (American Academy of Pediatrics) as well as published NHTSA (National Highway and Transportation Safety Administration) standards in regards to mode of transport. The transfer guidelines are meant to be inclusive of pediatric critical illness as well as pediatric trauma.

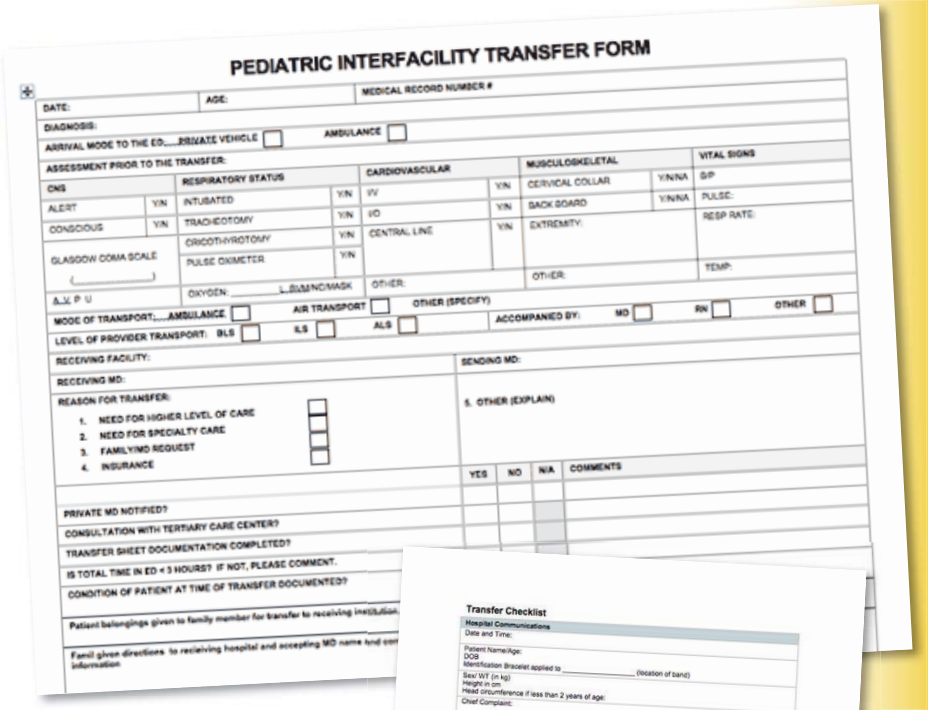
The following guidelines are not part of WAC (Washington Administrative Code) and are merely a template that facilities may adopt in order to fulfill requirements for trauma designation or simply to facilitate development of appropriate pediatric inter-facility transfer guidelines.

The Department of Health does not mandate Washington State Designated Trauma Services to use these guidelines, but offers them to assist Trauma Services in the development of their own guidelines. The Department recognizes the varying resources of different services and that approaches that work for one trauma service may not be suitable for others. The decision to use these guidelines in any particular situation always depends on the independent medical judgment of the physician.

Page 1 of 11 Pediatric Consultation and Transfer Guidelines 4/23/08
Washington State Department of Health, Office of Emergency Medical Services & Trauma System

In addition, the Pennsylvania Trauma Systems Foundation shared its Required Inter Facility Transfer and Consulation guidelines. The Trauma Center Association of America (TCAA) also shared its Pediatric Trauma Inter Facility Transfer Guidelines. The TCAA guidelines define physiologic and anatomic criteria for transfer of pediatric patients. The guidelines also include details on how to recognize the patient needing transfer, the responsibilities of the transferring facility, collaboration with receiving trauma surgeon, expeditious transfer modes, and recommendations regarding limiting diagnostic testing, especially imaging diagnostics.

Example Inter Facility Transfer Guideline Checklists



PEDIATRIC INTERFACILITY TRANSFER FORM

DATE: AGE: MEDICAL RECORD NUMBER #

DIAGNOSIS:

ARRIVAL MODE TO THE ED: PRIVATE VEHICLE ☐ AMBULANCE ☐

ASSESSMENT PRIOR TO THE TRANSFER:

CNS		RESPIRATORY STATUS		CARDIOVASCULAR		MUSCULOSKELETAL		VITAL SIGNS
ALERT	Y/N	INTUBATED	Y/N	IV	Y/N	CERVICAL COLLAR	Y/N/NA	B/P
CONSCIOUS	Y/N	TRACHEOTOMY	Y/N	I/O	Y/N	BACK BOARD	Y/N/NA	PULSE:
GLASGOW COMA SCALE (_____)		CRICOTHYROTOMY	Y/N	CENTRAL LINE	Y/N	EXTREMITY:		RESP RATE:
A V P U		PULSE OXIMETER	Y/N					TEMP:
		OXYGEN: _____ L @ NC/MASK		OTHER:		OTHER:		

MODE OF TRANSPORT: AMBULANCE ☐ AIR TRANSPORT ☐ OTHER (SPECIFY) ACCOMPANIED BY: MD ☐ RN ☐ OTHER ☐

LEVEL OF PROVIDER TRANSPORT: BLS ☐ ILS ☐ ALS ☐

RECEIVING FACILITY: SENDING MD:

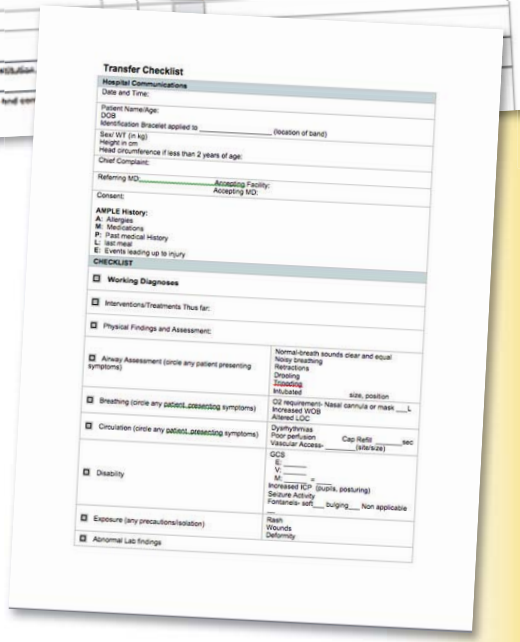
RECEIVING MD:

REASON FOR TRANSFER:
1. NEED FOR HIGHER LEVEL OF CARE
2. NEED FOR SPECIALTY CARE
3. FAMILY/MD REQUEST
4. INSURANCE
5. OTHER (EXPLAIN)

	YES	NO	N/A	COMMENTS
PRIVATE MD NOTIFIED?				
CONSULTATION WITH TERTIARY CARE CENTER?				
TRANSFER SHEET DOCUMENTATION COMPLETED?				
IS TOTAL TIME IN ED < 3 HOURS? IF NOT, PLEASE COMMENT.				
CONDITION OF PATIENT AT TIME OF TRANSFER DOCUMENTED?				
Patient belongings given to family member for transfer to receiving institution				
Famil given directions to recieving hospital and accepting MD name and con information				

Click here to download "Pediatric Interfacility Transfer Form" to your desktop.

Download



Transfer Checklist

Hospital Communications
Date and Time:
Patient Name/Age:
DOB
Identification Bracelet applied to _____ (location of band)
Sex/ WT (in kg)
Height in cm
Head circumference if less than 2 years of age:
Chief Complaint:
Referring MD: _____ Accepting Facility:
Accepting MD:
Consent:

AMPLE History:
A: Allergies
M: Medications
P: Past medical History
L: last meal
E: Events leading up to injury

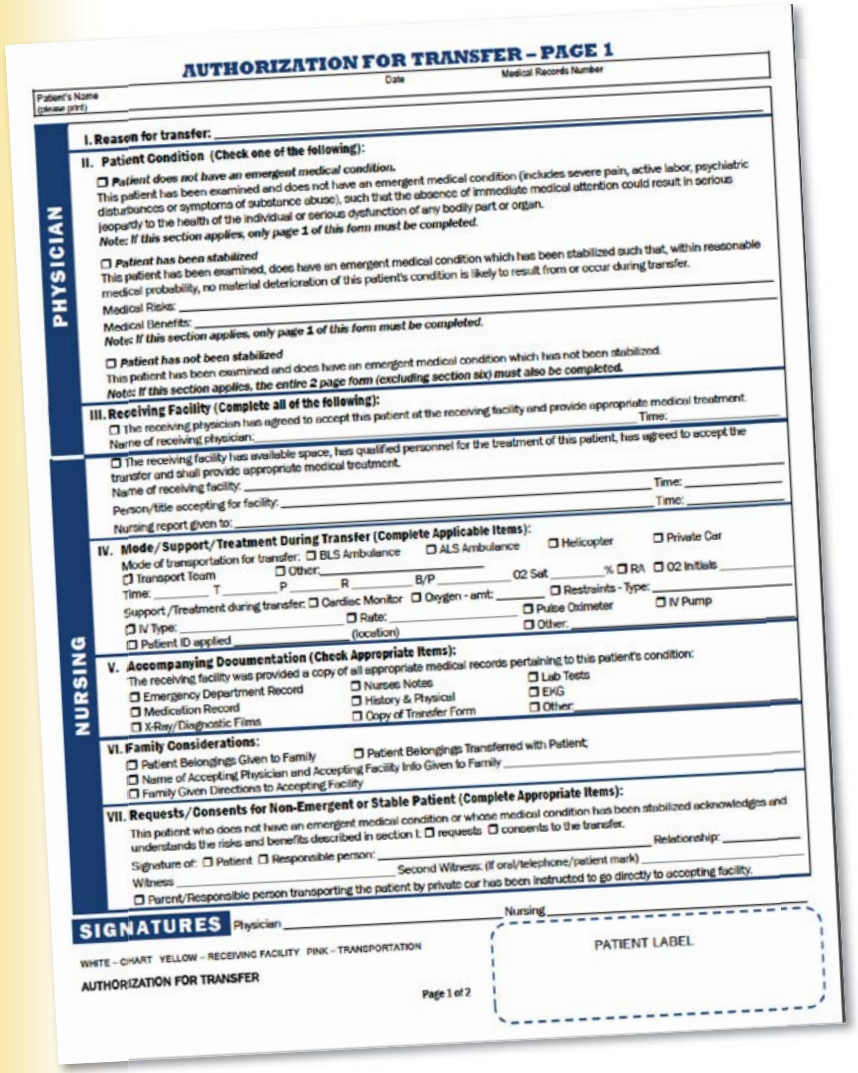
CHECKLIST

- ☐ Working Diagnoses
- ☐ Interventions/Treatments Thus far:
- ☐ Physical Findings and Assessment:
- ☐ Airway Assessment (circle any patient presenting symptoms): Normal-breath sounds clear and equal / Noisy breathing / Retractions / Drooling / Snoring / Intubated _____ size, position
- ☐ Breathing (circle any patient presenting symptoms): O2 requirement- Nasal cannula or mask ___L / Increased WOB / Altered LOC
- ☐ Circulation (circle any patient presenting symptoms): Dysrhythmias / Poor perfusion Cap Refill _____sec / Vascular Access- _____(site/size)
- ☐ Disability: GCS E: _____ V: _____ M: _____ / Increased ICP (bupils, posturing) / Seizure Activity / Fontanels- soft___ bulging___ Non applicable
- ☐ Exposure (any precautions/isolation): Rash / Wounds / Deformity
- ☐ Abnormal Lab findings

Click here to download "Transfer Checklist" to your desktop.

Download

Example Inter Facility Authorization for Transfer



AUTHORIZATION FOR TRANSFER – PAGE 1

Patient's Name (please print) _____ Date _____ Medical Records Number _____

PHYSICIAN

I. Reason for transfer: _____

II. Patient Condition (Check one of the following):

☐ *Patient does not have an emergent medical condition.*
This patient has been examined and does not have an emergent medical condition (includes severe pain, active labor, psychiatric disturbances or symptoms of substance abuse), such that the absence of immediate medical attention could result in serious jeopardy to the health of the individual or serious dysfunction of any bodily part or organ.
Note: If this section applies, only page 1 of this form must be completed.

☐ *Patient has been stabilized*
This patient has been examined, does have an emergent medical condition which has been stabilized such that, within reasonable medical probability, no material deterioration of this patient's condition is likely to result from or occur during transfer.
Medical Risks: _____
Medical Benefits: _____
Note: If this section applies, only page 1 of this form must be completed.

☐ *Patient has not been stabilized*
This patient has been examined and does have an emergent medical condition which has not been stabilized.
Note: If this section applies, the entire 2 page form (excluding section six) must also be completed.

III. Receiving Facility (Complete all of the following):

☐ The receiving physician has agreed to accept this patient at the receiving facility and provide appropriate medical treatment.
Name of receiving physician: _____ Time: _____

☐ The receiving facility has available space, has qualified personnel for the treatment of this patient, has agreed to accept the transfer and shall provide appropriate medical treatment.
Name of receiving facility: _____ Time: _____
Person/title accepting for facility: _____ Time: _____
Nursing report given to: _____

NURSING

IV. Mode/Support/Treatment During Transfer (Complete Applicable Items):

Mode of transportation for transfer: ☐ BLS Ambulance ☐ ALS Ambulance ☐ Helicopter ☐ Private Car ☐ Transport Team ☐ Other: _____
Time: _____ T _____ P _____ R _____ B/P _____ O2 Sat _____ % ☐ RA ☐ O2 Initials _____
Support/Treatment during transfer: ☐ Cardiac Monitor ☐ Oxygen - amt: _____ ☐ Restraints - Type: _____
☐ IV Type: _____ ☐ Rate: _____ ☐ Pulse Oximeter ☐ IV Pump
☐ Patient ID applied _____ (location) ☐ Other: _____

V. Accompanying Documentation (Check Appropriate Items):

The receiving facility was provided a copy of all appropriate medical records pertaining to this patient's condition:
☐ Emergency Department Record ☐ Nurses Notes ☐ Lab Tests
☐ Medication Record ☐ History & Physical ☐ EKG
☐ X-Ray/Diagnostic Films ☐ Copy of Transfer Form ☐ Other: _____

VI. Family Considerations:

☐ Patient Belongings Given to Family ☐ Patient Belongings Transferred with Patient: _____
☐ Name of Accepting Physician and Accepting Facility Info Given to Family
☐ Family Given Directions to Accepting Facility

VII. Requests/Consents for Non-Emergent or Stable Patient (Complete Appropriate Items):

This patient who does not have an emergent medical condition or whose medical condition has been stabilized acknowledges and understands the risks and benefits described in section I. ☐ requests ☐ consents to the transfer.
Signature of: ☐ Patient ☐ Responsible person: _____ Relationship: _____
Witness _____ Second Witness: (If oral/telephone/patient mark) _____
☐ Parent/Responsible person transporting the patient by private car has been instructed to go directly to accepting facility.

SIGNATURES Physician _____ Nursing _____

PATIENT LABEL

WHITE – CHART YELLOW – RECEIVING FACILITY PINK – TRANSPORTATION

AUTHORIZATION FOR TRANSFER Page 1 of 2

Click here to download "Authorization for Transfer" to your desktop.

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Cultural and Family Considerations in Inter Facility Transfer

Family-centered healthcare is an approach to patient care characterized by mutually beneficial collaboration between patient, family, and health professionals. Children rarely enter an emergency department or health care setting alone. A family member/caretaker or an entire family may accompany them. Therefore, family-centered care is paramount when caring for the pediatric patient.

Families have the greatest influence over the health of their children and should be considered essential partners in both the planning and implementation of health plans. Numerous professional organizations have developed position statements supporting family-centered care for the pediatric patient. During high stress situations, illness or injury necessitating emergency care, family-centered care can be both comforting to patient and family while helpful to providers delivering care.

Local community emergency departments and hospitals are often the first destination for many ill or injured children – most pediatric emergency visits occur in community or local emergency departments. Community hospitals are often close to home and perceived as comforting when care is provided by neighbors and trusted friends who are known in the community.

Transfer of the pediatric patient for additional specialty services can cause additional concern and stressors on both the child and family unit. As community providers discuss the need for transfer and the process that will unfold, it is important that this discussion be on a level that family and child, if appropriate, can understand while being culturally sensitive.

The links below may be helpful in accessing information on family-centered care, health literacy, and cultural competency to aid in development of your facility's transfer guidelines and family transfer information sheets. Additionally, a separate list of published resources sharing information on family considerations and concerns as they relate to facility transfer is provided.

- Family-Centered Care in the Emergency Department: A Self-Assessment Inventory. Developed by the Emergency Nurses Association, this tool addresses Family Participation in Care; Family Support; Information and Decision Making; Service Coordination and Continuity; Personnal Practices and Training; Environment and Design, among other important components of family-centered care.

- Family Presence During Invasive Procedures and Resuscitation in the Emergency Department. Developed by the Emergency Nurses Association in 1995 and reapproved in 2010.

- MCH Definition of Family-centered Care. Posted to the Family Voices website, this Maternal and Child Health Bureau document defines family-centered care and lists the principles of family-centered care for children.

- Family Self-Assessment Tool Kit – Provider Guide. Developed by Family Voices, this tool is designed to increase outpatient health care settings' and families' awareness about the implementation of family-centered care and to provide an organized way for health care settings to assess current areas of strength and identify areas for growth, plan future efforts, and to track progress.

- Health Literacy and Cultural Competency. Maintained by the Agency for Healthcare Research and Quality, this website contains patient guides to encourage more patient/family involvment in self healthcare, as well as fact sheets, podcasts, and video presentations.

- Health Literacy Interventions and Outcomes, by Berkman et al. This article provides a systematic review of health care service use and health outcomes of individuals with low health literacy and the interventions designed to improve outcomes.

- Improving Patient Safety Through Informed Consent for Patients with Limited Health Literacy, by Wu HW et al. This document shares recommendations to guide health care organizations striving to meet the requirement for an effective informed consent process.

- Clear Communication: A NIH Health Literacy Initiative. Maintained by the National Institutes of Health, this website provides an overview of health literacy, a 2010 Healthy People Objective, and includes numerous resources and tools to assist in developing communication strategies for a range of diverse audiences.

- Health Literacy Online. Developed by the Department of Health and Human Services' Office of Disease Prevention and Health Promotion, this online guide provides tools for developing health websites and includes a downloadable guide to writing and designing easy-to-use health websites.

Documents Addressing Family Considerations as Related to Inter Facility Transfer

- Safety Threats and Opportunities to Improve Interfacility Care Transitions; Insights from Patients and Family Members, by Jeffs L., et al. *Patient Prefer Adherence*. 2012;6:711-8. doi: 10.2147/PPA.S36797. Epub 2012 Oct 5. This paper explores family members detected safety threats across care transitions and strategies that may improve care transitions from acute care hospitals to complex continuing care and rehabilitation health care organizations.

- The cost of family-oriented communication before air medical inter facility transport, by Macnab et al. *Air Med Journal*. 2001 Jul-Aug;20(4):20-2. Communication with parents by transport teams can ease stress associated with transferring children to tertiary care. This paper reports on a study conducted to determine the duration of family-oriented visits prior to transfer and potential additional costs and benefits.

- Should parents accompany pediatric inter facility ground ambulance transports? Results of a national survey of pediatric transport team managers, by Woodward, et al. *Pediatric Emergency Care*. 2001 Feb;17(1):22-7. Reports results of a survey of parents and specialty transport team members regarding value of parents accompanying the pediatric patient during inter facility transport, a period of time of family unit high stress.

Quality Improvement and Follow up Considerations Surrounding Inter Facility Transfer

Inherent safety risks and costs are associated with the transfer of patients. When a pediatric patient is transferred to access specialty care, the team providing care for child and family has been extended beyond the referring facility to include transfer providers, EMS, and potentially a specialty team, as well as the care providers at the receiving facility. Monitoring transfer processes for opportunities of improvement while providing follow-up communications on patient outcome and condition are important components for the collaborative team of both referring and receiving institutions. Additionally, each transfer should be reviewed to assure that it was appropriate. Inappropriate patient transfers can tax scarce resources and can be inconvenient to families.

Quality improvement or performance improvement has many definitions. Below are some of the more common descriptions of the process.

Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier
Continuous Quality Improvement (CQI) seeks to improve the provision of services with an emphasis on future results. Like total quality management, CQI uses a set of statistical tools to understand subsystems and uncover problems, but its emphasis is on maintaining quality in the future, not just controlling a process.

Once a process that needs improvement is identified, a team of knowledgeable individuals is gathered to research and document each step of that process. Once specific expectations and the means to measure them have been established, implementation aims at preventing future failures and involves the setting of goals, education, and the measurement of results. If necessary, the plan may be revised on the basis of the results, so that the improvement is ongoing.

Centers for Disease Control and Prevention
Quality improvement in public health is the use of a deliberate and defined process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality services or processes which achieve equity and improve the health of the community. (Source: Riley et al, "Defining Quality Improvement in Public Health", JPHMP, 2010, 16(10), 5-7.)

Systems performance improvement is defined as positive changes in capacity, process and outcomes of public health as practiced in government, private and voluntary sector organizations. Performance improvement can occur system-wide as well as with individual organizations that are part of the public health system. It involves strategic changes to address public health system (or organizational) weaknesses and the use of evidence to inform decision making. (Source: National Public Health Performance Standards Program)

Performance management is the practice of actively using performance data to improve the public's health. This involves the strategic use of performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results. Ideally, these practices should be integrated into core operations, and can occur at multiple levels, including the program, organization or system level. (Source: Turning Point Performance Management Collaborative, 2003.)

Health Resources Services Administration
Quality improvement includes regular measurement of care processes and outcomes to analyze the performance of the system of care. It involves the implementation of solutions to improve care and the monitoring of their effectiveness, with the goal of achieving optimal health outcomes for patients. Ongoing cycles of change and re-measurement are implemented to test and try different ideas to determine which practices result in improved care.

Quality improvement activities in clinics can range from a single team focusing on improving one aspect of care to a comprehensive quality improvement program with many teams working on a wide variety of improvement projects, with a well-established plan and an oversight committee.

The methods of quality improvement are based on core principles that are readily translated into a practical approach and integrated into the clinical care delivery system.

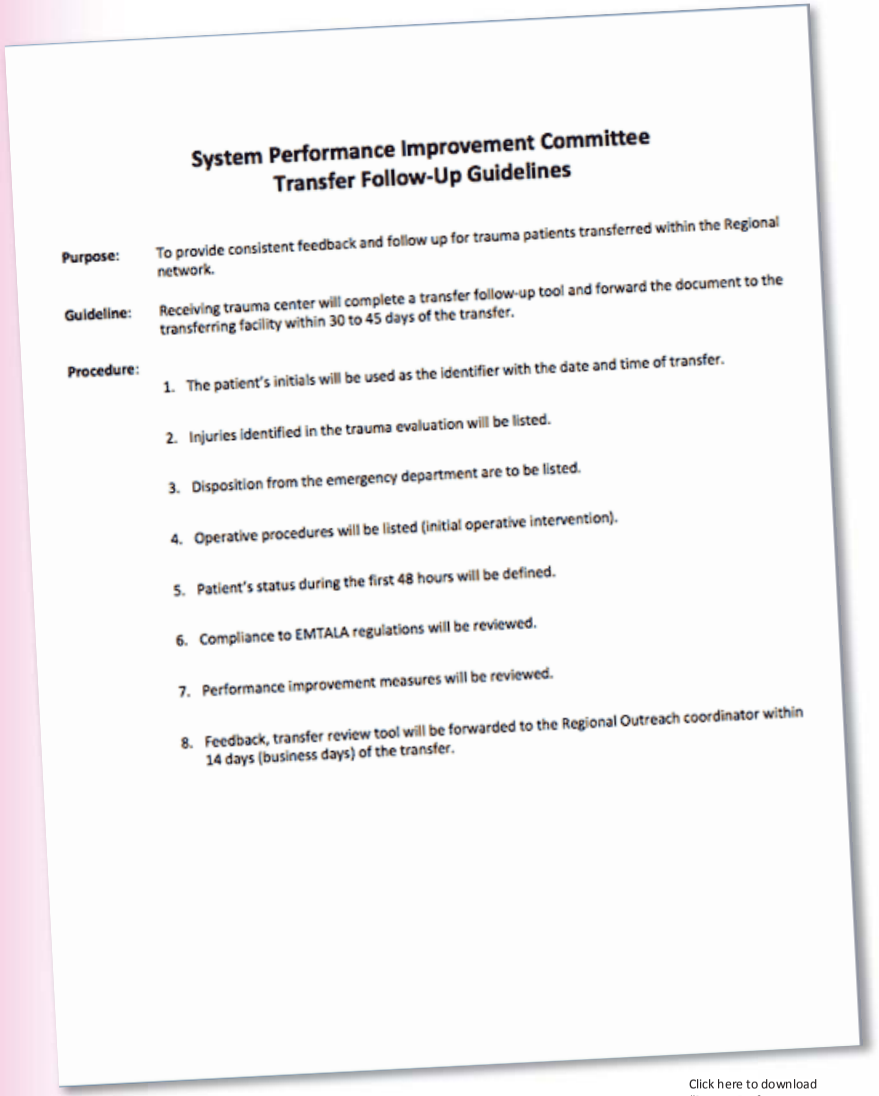
Joint Commission on Accreditation
Performance Improvement is the systematic process of detecting and analyzing performance problems, designing and developing interventions to address the problems, implementing the interventions, evaluating the results, and sustaining improvement.

Quality Improvement Tools

This section contains the following tools for guiding quality improvement activities around patient transfer:

- System Performance Improvement Committee Transfer Follow-up Guidelines
- Routine Follow-up Communication Form between a Trauma Center and a Referring Facility
- Routine Follow-up Letter between a Trauma Center and a Referring Facility

System Performance Improvement Committee Transfer Follow-up Guidelines



System Performance Improvement Committee
Transfer Follow-Up Guidelines

Purpose: To provide consistent feedback and follow up for trauma patients transferred within the Regional network.

Guideline: Receiving trauma center will complete a transfer follow-up tool and forward the document to the transferring facility within 30 to 45 days of the transfer.

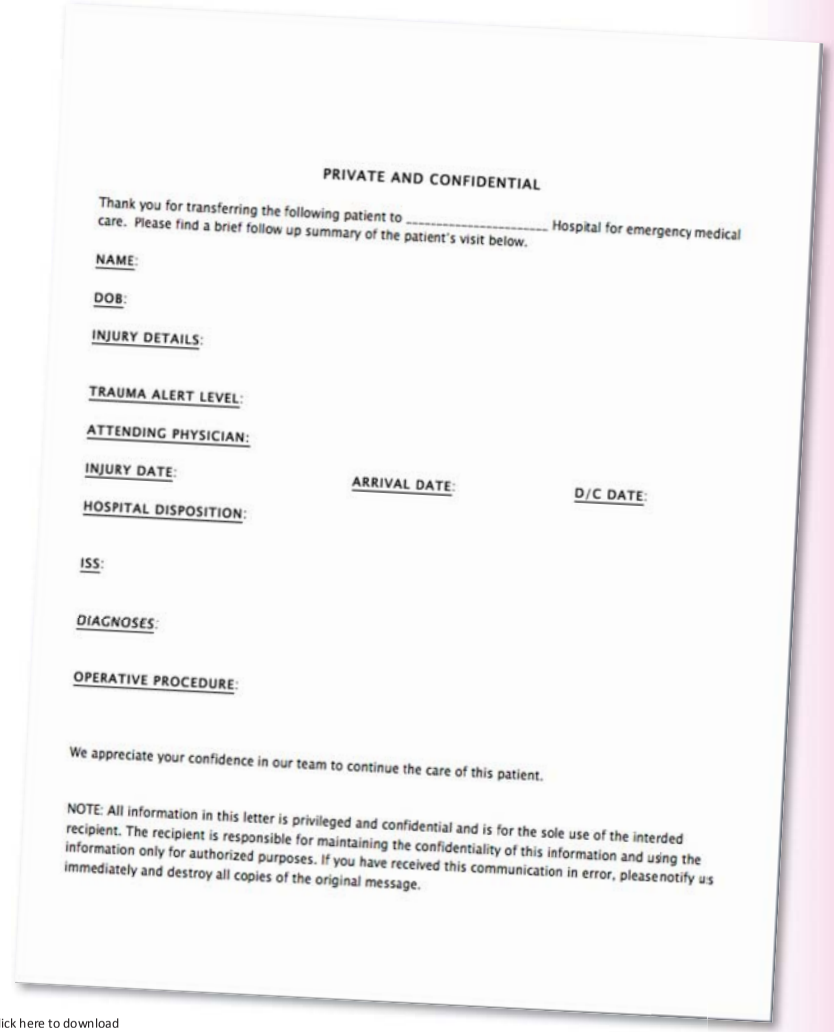
Procedure:

1. The patient's initials will be used as the identifier with the date and time of transfer.
2. Injuries identified in the trauma evaluation will be listed.
3. Disposition from the emergency department are to be listed.
4. Operative procedures will be listed (initial operative intervention).
5. Patient's status during the first 48 hours will be defined.
6. Compliance to EMTALA regulations will be reviewed.
7. Performance improvement measures will be reviewed.
8. Feedback, transfer review tool will be forwarded to the Regional Outreach coordinator within 14 days (business days) of the transfer.

Click here to download "System Performance Improvement Committee Transfer Follow-up Guidelines" to your desktop.

Download

Routine Follow- up Communication Form between A Trauma Center and a Referring Facility



PRIVATE AND CONFIDENTIAL

Thank you for transferring the following patient to _____ Hospital for emergency medical care. Please find a brief follow up summary of the patient's visit below.

NAME:

DOB:

INJURY DETAILS:

TRAUMA ALERT LEVEL:

ATTENDING PHYSICIAN:

INJURY DATE: ARRIVAL DATE: D/C DATE:

HOSPITAL DISPOSITION:

ISS:

DIAGNOSES:

OPERATIVE PROCEDURE:

We appreciate your confidence in our team to continue the care of this patient.

NOTE: All information in this letter is privileged and confidential and is for the sole use of the interded recipient. The recipient is responsible for maintaining the confidentiality of this information and using the information only for authorized purposes. If you have received this communication in error, pleasenotify us immediately and destroy all copies of the original message.

Click here to download "Routine Follow- up Communication Form between a Referring Facility and a Trauma Center" to your desktop.

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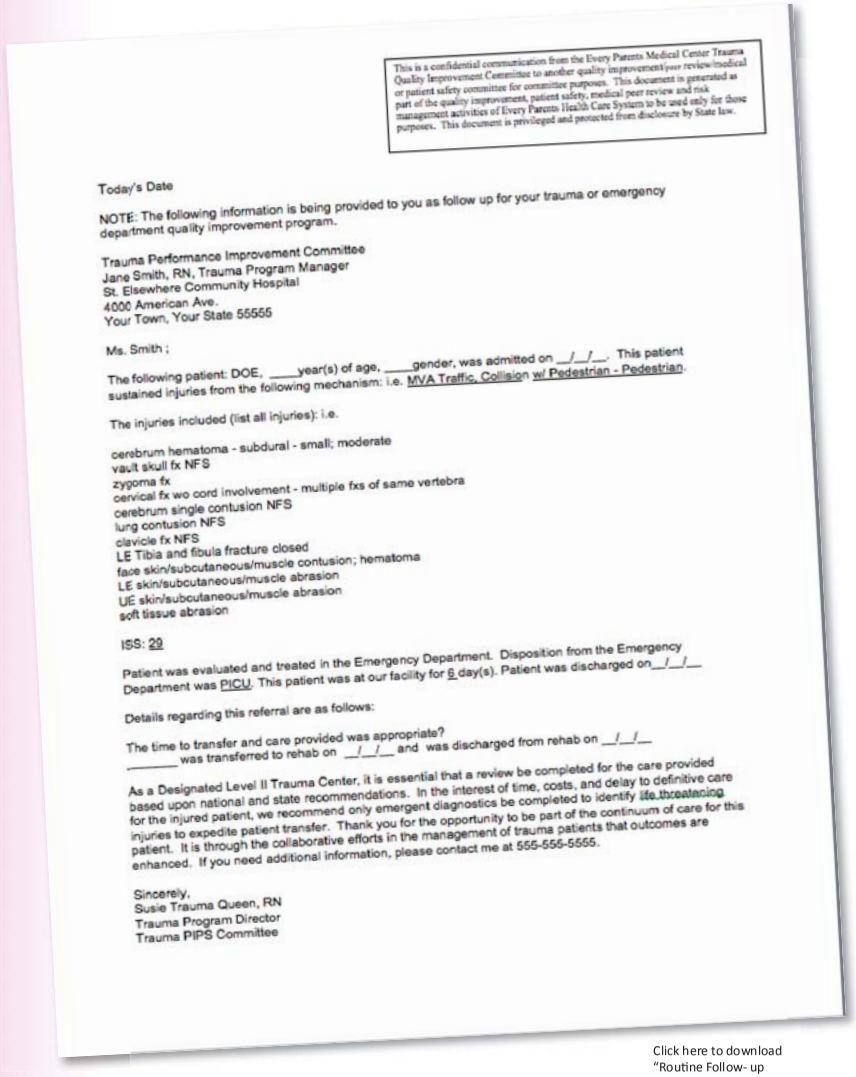
Routine Follow- up Letter between a Trauma Center and a Referring Facility



This is a confidential communication from the Every Parents Medical Center Trauma Quality Improvement Committee to another quality improvement/peer review/medical or patient safety committee for committee purposes. This document is generated as part of the quality improvement, patient safety, medical peer review and risk management activities of Every Parents Health Care System to be used only for those purposes. This document is privileged and protected from disclosure by State law.

Today's Date

NOTE: The following information is being provided to you as follow up for your trauma or emergency department quality improvement program.

Trauma Performance Improvement Committee
Jane Smith, RN, Trauma Program Manager
St. Elsewhere Community Hospital
4000 American Ave.
Your Town, Your State 55555

Ms. Smith ;

The following patient: DOE, ____year(s) of age, ____gender, was admitted on __/__/__. This patient sustained injuries from the following mechanism: i.e. MVA Traffic, Collision w/ Pedestrian - Pedestrian.

The injuries included (list all injuries): i.e.

cerebrum hematoma - subdural - small; moderate
vault skull fx NFS
zygoma fx
cervical fx wo cord involvement - multiple fxs of same vertebra
cerebrum single contusion NFS
lung contusion NFS
clavicle fx NFS
LE Tibia and fibula fracture closed
face skin/subcutaneous/muscle contusion; hematoma
LE skin/subcutaneous/muscle abrasion
UE skin/subcutaneous/muscle abrasion
soft tissue abrasion

ISS: 29

Patient was evaluated and treated in the Emergency Department. Disposition from the Emergency Department was PICU. This patient was at our facility for 6 day(s). Patient was discharged on__/__/__

Details regarding this referral are as follows:

The time to transfer and care provided was appropriate?
_____ was transferred to rehab on __/__/__ and was discharged from rehab on __/__/__

As a Designated Level II Trauma Center, it is essential that a review be completed for the care provided based upon national and state recommendations. In the interest of time, costs, and delay to definitive care for the injured patient, we recommend only emergent diagnostics be completed to identify life threatening injuries to expedite patient transfer. Thank you for the opportunity to be part of the continuum of care for this patient. It is through the collaborative efforts in the management of trauma patients that outcomes are enhanced. If you need additional information, please contact me at 555-555-5555.

Sincerely,
Susie Trauma Queen, RN
Trauma Program Director
Trauma PIPS Committee

Click here to download "Routine Follow- up Letter between a Trauma Center and a Referring Facility" to your desktop.

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Pediatric Case Presentations and Inter Facility Transfer

This section of the tool kit features two actual situations in which inter facility transfer was required to access pediatric specialty resources. Both cases provide a vehicle to envision the complexities of inter facility transfer and support the necessity for comprehensive transfer plans at all facilities that include inter facility transfer agreements and guidelines.

Case Study One: 8-month-old with Abdominal Injury

The first case is one in which a mother shares the story of her toddler's injury, the local emergency department providing care, the early identification of the need for pediatric specialty services, and the difficulties encountered while trying to transfer the child, which may have been eliminated if an organized transfer processes had been in place.

As an educated mother of two children, Melanie Jarreau, MBA, never fathomed that her local hospital would not be equipped to provide her child with the appropriate life sustaining treatment necessary for her to overcome injuries sustained in an accident. Her local regional hospital lacked the resources her child needed, necessitating her transfer to a larger facility. However, it was a lack of planning and preparation that ultimately cost her daughter her life.

In September of 2003 her 8-month-old child, Skylar Grayce, sustained an abdominal injury as a result of an adult tripping and falling on her. Shortly after the accident Skylar began demonstrating signs of shortness of breath. Melanie immediately took her to her pediatrician. He examined her briefly and requested she be directly admitted to the local hospital for observation and x-rays. After an almost two hour wait for x-rays, Melanie learned that Skylar sustained an internal abdominal injury requiring surgical repair.

The local hospital did not have pediatric surgeons on staff nor a pediatric intensive care unit (PICU), which physicians believed Skylar would need for aftercare. Therefore, it was decided that it would be in Skylar's best interest to transfer her to a hospital with resources that could better accommodate her unique pediatric needs.

Upon learning the extent of Skylar's injuries and being informed that she would have to be transferred, Melanie was a little uneasy to say the least. However, after speaking to friends and loved ones, she was reminded they were less than an hour away from two of the best pediatric hospitals in the state. Melanie was a little relieved and confident that Skylar would now receive the best possible care. Melanie was not prepared for the time and effort it would take for a hospital to accept and take care of her baby.

The first hospital was contacted. After an hour the hospital responded that it was not in a position to accept Skylar because of a full PICU and two other babies were awaiting admission. A second hospital was contacted and they agreed to accept Skylar. Melanie quickly learned that the accepting hospital would be sending their own transport team to pick her up because they were better equipped to care for Skylar

in the event something went wrong during the transport. That sounded okay in theory but the roundtrip would take two hours. Two additional hours of critical time would pass.

Three hours after receiving word from the accepting hospital the transport team arrived. They began examining Skylar and preparing her for transport. Once Skylar arrived at the accepting hospital she was prepped and went into surgery approximately ten hours after the initial examination by medical personnel. It took surgeons two hours to repair her internal injuries. She fought a strong battle over the next few days and the hospital provided extensive resources to help her recovery, including extra corporeal membrane oxygenation, a heart-lung bypass procedure. In spite of these extreme efforts, her body could not fight any longer. Due to complications, Skylar's life support was terminated on a Sunday afternoon at 3:10 p.m.

Skylar's death did not result from the accident. It was the result of precious time lost in her treatment. She died of heart failure caused by the extra stress placed on her heart when her body went into septic shock during the 10 hour wait for treatment. This loss of life could have been prevented had Skylar received the proper medical care in a timely fashion. Since her death, Skylar's family has spent countless hours on raising public awareness on the importance of hospital interf acility pediatric transfer agreements and how not having those in place impacted Skylar's short life.

> *"It is imperative that our children receive the proper medical attention in a timely manner to better improve their chances of survival. I urge you to get involved now before you too fall victim to a lack of system organization as my family did. We lost our precious daughter, but we have vowed to do everything possible to prevent any further loss of life, especially the lives of children. Your advocacy can help save a child's life!"*
>
> *– Melanie Jarreau (Skylar's mom)*

Case Study Two: 16-month-old with Popcorn Aspiration

The second case identifies the value of triage criteria being included as part of facility transfer guidelines while also emphasizing the need for follow up communications with referring facilities. Loop closure and identification of opportunities to improve care are important benefits and elements of the transfer process.

A 16-month-old toddler presents to the multigenerational emergency department at 4:00 pm following a choking episode after eating popcorn at a Halloween Party at his church around 1:00 pm. He is alert, speaking clearly at his baseline, shows no respiratory distress, no cyanosis, and no drooling. He is able to drink apple juice without difficulty. For more information about this case study, download the slide set "Looked Who Popped Into Your ED... A Pediatric Transfer Case Scenerio."

Inter Facility Transfer Library Resources

Care of the critically ill or injured child can present a challenge for all providers on the emergency care team. This is especially true in community hospitals where the opportunity to care for critically ill or injured children is infrequently. The anxiety provoking event can be compounded tenfold when suddenly the team realizes they don't have the resources necessary to provide definitive care and they have no plan in place to facilitate moving the patient to another care facility where the resources of personnel, equipment, and services are available.

Anticipation and preparation can play a huge role in helping facilities prepare, in advance, so that transfer of the patient can be done in an organized and seamless manner. Having pre-arranged transfer agreements and pre-established criteria detailing which patients may need to be transferred can decrease the anxiety in the heat of battle.

The library section of the Inter Facility Transfer Tool Kit is a rich resource for the development of a robust plan for interfacility transfer of pediatric patients. Transferring and receiving facilities alike can find applicable resources. In this section, the following resources can be found:

- Supporting manuscripts related to inter facility transfer
- Transfer criteria established by states and regions to guide providers in making decisions regarding what patients may need to be considered for transfer.
- Links to courses that help personnel become prepared to care for children in a variety of clinical settings.
- Resources that reference the need for organized inter facility transfer processes.

Resource Tools

American College of Emergency Physicians Policy, Appropriate Interhospital Patient Transfer. This policy statement outlines the characteristics of an appropriate interfacility transfer, highlighting the legal requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA). It specifically focuses on the medical screening exam and the patient stabilization requirement within the capabilities of each healthcare facility.

Guide For Interfacility Patient Transfer. Developed by the National Highway Traffic Safety Admistration, this document can be used to provide general guidance, references, and ideas for conducting a systematic assessment of the processes and personnel supporting inter facility transfer and how they can be enhanced to provide optimal delivery of care.

Clear Communication: A NIH Health Literacy Initiative. This website provides an overview of health literacy, a 2010 Healthy People Objective. It also provides numerous resources and tools to assist in development of communication strategies for a range of diverse audiences.

Emergency Medical Treatment and Labor Act (EMTALA). This act became a federal law in 1986 and was designed to prevent hospitals from refusing to treat patients or transferring them to public hospitals when they were unable to pay.

Emergency Nurses Association, 2010 Position Statement on Inter Facility Transfer. This statement supports the use of organized transfer processes including establishment of agreements.

Emergency Nurse Standards of Practice. Defined standards of emergency care, including transfer needs, for adult and pediatric nurses have been identified by the Emergency Nurse Association.

EMS for Children Fact Sheet on Performance Measures 76 and 77. The EMS for Children Program has identified two performance measures in the establishment of inter facility transfer agreements and guidelines. This fact sheet provides an overview of the advantages of having transfer agreements in place as well as the components that should be included in transfer guidelines.

Family-Centered Care in the Emergency Department: A Self-Assessment Inventory

Family Presence During Invasive Procedures and Resuscitation in the Emergency Department

Family Self-Assessment Tool Kit – Provider Guide

Federal Aviation Administration. Federal regulations related to air medical transport are available under the Federal Code of Regulations and apply to patients being transported by air.

Health Insurance Portability and Accountability Act (HIPAA). This act set standards for the use and disclosure of protected health information as well as measures to ensure proper storage and transmission of medical records.

Health Literacy and Cultural Competency. This Agency for Healthcare and Research-supported website provides tools for providers to improve patient communications. The site also contains patient guides to encourage more patient/family involvement in self-healthcare. The website includes fact sheets, podcasts and video presentations.

Health Literacy Online. This site provides tools for developing health websites and includes a downloadable guide to writing and designing easy-to-use health web sites.

Issue Brief June 2009. This fact sheet focuses on transfer agreements and guidelines through a discussion of Emergency Medical Treatment and Active Labor Act (EMTALA) implications when transferring both inpatients and unstable emergency department patients in the context of uncertainty with court rulings vs. CMS interpretations.

Issue Brief May 2010. This fact sheet discusses EMTALA liability issues that can arise in the case of an inter facility transfer. Supports transfer guidelines and agreements and their importance in establishing the terms of the transfer in order to clarify respective duties and methods for assuring the proper execution of those duties.

MCH Definition of Family Centered Care

National Highway Traffic Safety Administration Guide for Interfacility Patient Transfer. This document is intended for EMS agencies providing interfacility transfers at the local, state, and regional levels, as well as those involved in transfer planning. It can be used to provide general guidance, references, and ideas for conducting a systematic assessment of the processes and personnel supporting interfacility transfers, and how they can be enhanced to provide optimal patient care.

Pediatric National Trauma Data Base (NTDB) Report, 2012. This report provides recent data collected from NTDB contributing trauma centers inclusive of major mechanisms of injury, injury severity scores, discharge status including transfer to pediatric trauma centers etc.

Standards Addressing Organized Inter Facility Transfer Processes. This resource identifies those states having regulatory standards in place requiring hospitals to have agreements/guidelines in place which may help validate the need for organized processes when approaching hospital administrators.

Advanced Trauma Care for Nurses (ATCN). This course is designed for the registered nurse interested in increasing his/her knowledge in the management and care of the multiple trauma patient.

Advanced Trauma Life Support (ATLS). This course teaches a systematic, concise approach to the early care of the trauma patient. It is helpful in guiding care for the injured patient in emergency departments.

Emergency Nursing Pediatric Course (ENPC). This national standardized 16-hour course is designed to provide the learner with pediatric emergency nursing knowledge and psychomotor skill experience. The content is presented through lecture material, accompanying slide presentations, and dedicated time for learning and practicing six psychomotor skill stations.

Rural Trauma Team Development Course (RTTDC). This course focuses on rural receiving facilities and the fundamental elements of injury resuscitation. Course content includes key concepts relative to organization of the trauma receiving area, utilization of available resources and regional system relationships in a way that is straightforward and easy to understand.

Trauma Outcomes and Performance Improvement Course (TOPICS). This course is designed for all members of the trauma team who participate in the on-going assessment, evaluation and improvement of trauma care. TOPIC focuses on the on-going assessment of the continuum of trauma care with a structured review of process and discussions of strategies to monitor trauma patient outcomes.

Trauma Nurse Core Course (TNCC). This course is a standardized, 16-20 hour course integrating the trauma nursing process into the content while providing the learner with core-level trauma knowledge and psychomotor skill experience.

Transport Nurse Advanced Trauma Course (TNATC). This three-day educational experience focuses on care of the trauma patient during initial resuscitation and transport. Course content includes: transport physiology, safety, neurological trauma, shock, thoracic and abdominal trauma, trauma in pregnancy, pediatric trauma, legal aspects of transport, burn trauma, airway and ventilator management and crisis management.

American Academy of Pediatrics Manual, 3rd, Guidelines for Air & Ground Transport of Neonatal & Pediatric Patients. This manual provides guidelines for health care professionals who make decisions about the emergency inter facility transport of children. Though focused on pediatric specialty teams this text

also includes valuable information on legal considerations of transfer/transport and quality improvement as well as family centered care.

EMSC Performance Measure Manual. This manual contains information on all 2006 EMSC Performance Measures. Performance Measure 76 and 77 address the need for all hospitals to have inter facility transfer agreement available for pediatric patients as well as guidelines that include specific components to facilitate safe, timely and family centered transfer.

Health Literacy Interventions and Outcomes, by Berkman et al. This resource provides a systematic review of health care service use and health outcomes of individuals with low health literacy and the interventions designed to improve outcomes. Disparities in health outcomes and effectiveness of interventions among different sociodemographic groups were also examined.

Institute of Medicine. Emergency Care for Children. Growing Pains. Convened in 2003, the Institute of Medicine examined the emergency care system in the United States to create a vision for the future while making recommendations for improvements. Findings and recommendations were presented in three reports. The pediatric report describes the challenges of emergency care for children and their impact on the outcomes of critically ill and injured children.

Inter facility Transports, Seminars in Respiratory and Critical Care Medicine, by Blackwell TH. 2002 Feb. 21;(1)11-8. The transfer process, including stabilization of the patient and transfer of unstable patients is covered in this manuscript. Importance of communication coordination and the review of transfers for appropriateness is also stressed.

Organized Inter facility Transfer Processes, by Fendya DG, et al. *Pediatric Emergency Care* 2011:27;900-6. doi: 10.1097/PEC.0b013e318230277e. While providing national information on availability of hospital transfer agreements and guidelines this manuscript calls for a closer look at the effect of transfer agreements and guidelines on timeliness of pediatric inter facility transfers.

Regional Variation in Child Mortality at Hospitals Lacking A Pediatric Intensive Care Unit, by Kanter RK. *Critical Care Medicine* 2002;30:94Y99. This paper explores regional variation in failure to utilize existing regional pediatric intensive care units (PICUs) and impact on pediatric mortality.

Inter facility Transfers of Non-critically Ill Children to Academic Medical Centers, by Li J, et al. *Pediatrics* 2012 July 130 ;(1);83-92. doi: 10.1542/peds.2011-1819. Epub 2012 Jun 4. This paper addresses the number of transfers that were either discharged from the tertiary center ED or within 24 hours of the transfer and thus emphasizes the importance for transfer criteria and addressing the readiness of EDs to care for children.

Safety Threats and Opportunities to Improve Interfacility Care Transitions; Insights from Patients and Family Members, by Jeffs L., et al. Patient Prefer Adherence. 2012;6:711-8. doi: 10.2147/PPA.S36797. Epub 2012 Oct 5. This paper explores family members perceived safety threats across care transitions and strategies that may improve care transitions from acute care hospitals to complex continuing care and rehabilitation health care organizations.

Transfer Agreements Help Hospitals Comply With Antidumping Laws, by Kingsolver JC. *Kentucky Hospital Magazine*, 1990 Summer;7(3):22-3. Provides a legal overview of the value of transfer agreements.

The Cost of Family-oriented Communication before Air Medical Inter Facility Transport, by Macnab AJ, et al. *Air Med Journal.* 2001 Jul-Aug;20(4):20-2. Communication with parents by transport teams can ease stress associated with transferring children to tertiary care. This paper reports on a study conducted to determine the duration of family-oriented visits prior to transfer and potential additional costs and benefits.
Golden Hour, The Handbook of Advanced Pediatric Life Support, 3rd edition, Nichols D. et al, Pennsylvania, Pa: Elsevier, Inc.;2011. Contains a nice section on transfer of the pediatric patient including guidelines to assist staff in both administrative components and patient care considerations.

Policy Statement Guidelines for Care of Children in the Emergency Department. This policy statement focuses on the essential resources (medications, equipment, policies, and education) and staff to ensure that hospital emergency departments are prepared to care for and – when necessary -- transfer children of all ages, from neonates to adolescents. The guidelines are consistent with the recommendations of the Institute of Medicine's (IOM) 2006 report Future of Emergency Care in the United States Health System.

The state of pediatric interfacility transport: Consensus of the second National Pediatric and Neonatal Interfacility Transport Medicine Leadership Conference, by Woodward GA, Insoft RM, Pearson-Shaver AL, et al. *Pediatric Emergency Care*. 2002;18:38Y43.

Should parents accompany pediatric inter facility ground ambulance transports?, by Woodward GA, et al. *Pediatric Emergency Care*. 2001 Feb;17(1):22-7. Reports results of a survey of parents and specialty transport team members regarding value of parents accompanying the pediatric patient during inter facility transport, a period of time of family unit high stress.

Improving Patient Safety Through Informed Consent for Patients with Limited Health Literacy, by Wu HW, et al. National Quality Forum; 2005. This document shares recommendations to guide health care organizations striving to meet the requirement for an effective informed consent process.

Glossary

Certificate of Transfer - Under the Emergency Medical Treatment and Labor Act (EMTALA), a hospital may not transfer an individual with an unstabilized emergency medical condition unless a physician signs a certification stating that the benefit to the individual of receiving treatment at another medical facility outweighs the risk of being transferred. Note that a hospital's EMTALA obligations apply to individuals who present at a hospital seeking emergency care and are subsequently diagnosed with an emergency medical condition; they do not, however, apply to hospital inpatients, whether such patients are admitted after being diagnosed with an emergency medical condition or are admitted for elective (non-emergency) diagnosis or treatment.

Family-centered Care – An approach to patient care characterized by mutually beneficial collaboration between patient, family, and health professionals.

Inter Facility – The movement of a patient from one facility to another, such as from one hospital to another hospital; from an urgent care center to a hospital; or from a hospital to a rehabilitation center.

Inter Facility Agreement – A recorded document of understanding and intention between two or more parties with respect to the effect upon their relative rights and duties as they relate to inter facility transfer of patients.

Inter Facility Guideline – Defines the process/steps and responsibilities that should be addressed by caretakers when planning to transfer a patient to another facility for additional care resources. These processes ensure both organized and safe transfer of the patient.

Injury Severity Score (ISS) – An established medical score to assess trauma severity. It correlates with mortality, morbidity, and hospitalization time after trauma. It is used to define the term major trauma.

Memorandum of Agreement (MOA) or Memorandum Cooperative Agreement (MCA) – A document written between parties who agree to cooperate on a project or meet an agreed upon objective.

Memorandum of Understanding (MOU) – A document describing a mutual agreement between two or more parties. It expresses a union of parties for an intended common line of action.

Pediatric Patient – Generally defined as a newborn to less than 18 years. Note that the definition of the pediatric patient may be state and/or hospital specific. The following classifications are commonly used for the pediatric patient.

- Neonate is defined as a newborn to 3 months of age.
- Infant is defined as a 3 - 18 month old baby.
- Child is defined as 18 months to 12 years of age.
- Adolescent is defined as 13 years through 17 years of age.

Performance Improvement – The systematic process of detecting and analyzing system performance problems, designing and developing interventions to address the problems, implementing the interventions, evaluating the results, and sustaining improvement.

Quality Improvement – A recognized method for the analysis of performance and disciplined efforts to improve it. Quality improvement includes regular measurement of care processes and outcomes to analyze performance.

Regional Quality Improvement – Quality improvement initiatives within a service area, geographic area, state, or municipality that involves multiple facilities or care service organizations.

Regulation – A rule put forth by a government or a non-government, administrative entity that mandates a certain enforceable code of practice; a regulating principle.

Standard – An authoritative statement by which the quality of practice, service, or education can be evaluated.

Tertiary Pediatric Care Facility – Pediatric tertiary care facilities provide highly specialized pediatric equipment, pediatric critical care capabilities, and pediatric medical subspecialists. Tertiary pediatric care facilities are often affiliated with medical schools and serve as teaching centers for pediatric subspecialists. Children will often be referred from smaller hospitals to a tertiary pediatric hospital for major operations, consultations with sub-specialists and, when required, sophisticated intensive care.

Transfer Triage Criteria – A process for quickly identifying or sorting injured or ill patients who may require additional resources and thus would benefit from transfer to another facility.

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