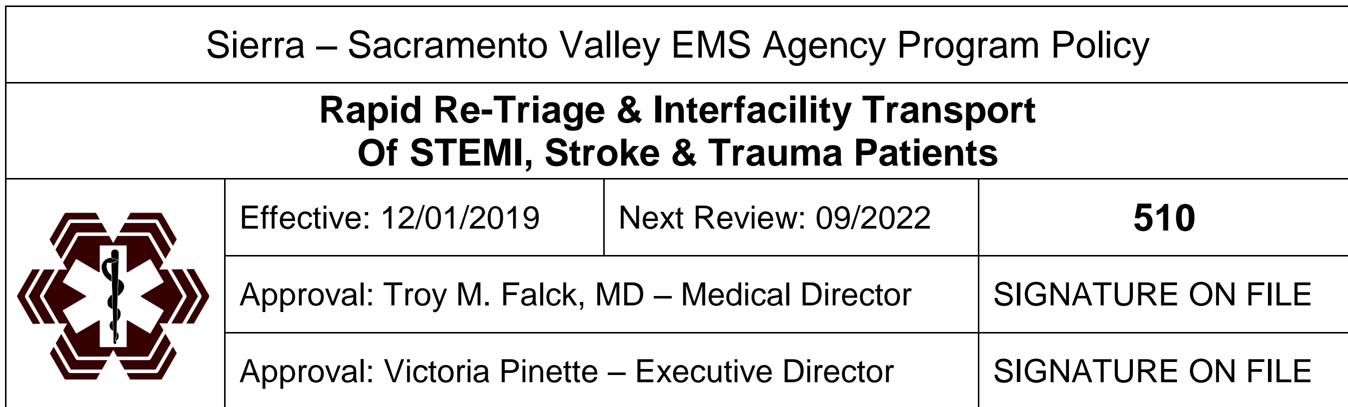

Sierra – Sacramento Valley EMS Agency Program Policy			
Rapid Re-Triage & Interfacility Transport Of STEMI, Stroke & Trauma Patients			
	Effective: 12/01/2019	Next Review: 09/2022	**510**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
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PURPOSE:

To establish the procedures for rapid re-triage and interfacility transport (IFT) of acute STEMI, stroke and trauma patients whose clinical condition requires a higher level of care than can be provided at the sending facility. This process involves direct ED to ED transfer of patients that have not been admitted to the hospital.

AUTHORITY:

A. California Health and Safety Code, Division 2.5, Chapter 2 § 1797.67 & 1797.88, Chapter 6 § 1798.102, 1798.150, 1798.170 and 1798.172.

B. California Code of Regulations, Title 22, Division 9, Chapter 7, 7.1 & 7.2

DEFINITIONS:

A. **STEMI Patient Rapid Re-Triage –** The rapid evaluation, resuscitation and transfer of a STEMI patient from a STEMI Referral Hospital (SRH) to a STEMI Receiving Center (SRC).

B. **Stroke Patient Rapid Re-Triage –** The rapid evaluation, resuscitation and transfer of an acute stroke patient from a non-stroke facility to a stroke receiving center.

C. **Trauma Patient Rapid Re-Triage –** The rapid evaluation, resuscitation and transfer of a seriously injured patient from a non-trauma facility, or a lower level Trauma Center, to a Trauma Center that can provide a higher level of trauma care.

POLICY:

A. STEMI patients shall be accepted for transfer by a SRC unless the SRC is on STEMI diversion or internal disaster.

B. Acute stroke patients requiring a higher level of care than can be provided at the sending facility, should be accepted for transfer by a stroke receiving center unless the stroke receiving center is on stroke diversion or internal disaster.

C. Trauma patients meeting ‘Emergency’ (“Red Box”) or ‘Urgent’ transfer re-triage criteria shall be accepted for transfer unless the Trauma Center is on trauma diversion or internal disaster.

RAPID RE-TRIAGE AND IFT PROCEDURES:

A. STEMI Patients:

1. A 12-lead EKG should be obtained within ten minutes of patient arrival at a SRH.
2. The timeline goals for SRH identified STEMI patients are <90 minutes SRH arrival-to-SRC first intervention for walk in patients and <120 minutes 911 call-to-SRC first intervention time for EMS patients initially transported to a SRH.
3. If SRH arrival-to-SRC first intervention is anticipated to be >90 minutes, administration of lytic agents should be considered in patients that meet thrombolytic eligibility criteria. The goal for door to thrombolytics is <30 minutes for these patients. Contact the SRC early to discuss coordination of care.
4. Immediately after a STEMI patient is identified, contact the SRC to arrange an ED to ED transfer. The SRC will assist in advising the appropriateness of transfer for primary PCI, and contact the SRC interventional cardiologist as needed.

B. Acute Stroke Patients:

1. Evaluate patients with signs/symptoms of an acute stroke as soon as possible.
2. Acute stroke patients requiring a higher level of clinical care than can be provided at the sending facility should be transferred as soon as possible.
3. Contact the closest most appropriate stroke receiving center to discuss patient status and request transfer. If transfer is accepted, arrange for appropriate transport resources based on patient condition and needs.

C. Trauma Patients:

1. Rapid re-triage and transfer of trauma patients shall be based on the North Regional Trauma Coordinating Committee Guidelines for Transfer to a Trauma Center criteria (incorporated into this policy for reference).
2. Emergency Transfer (“Red Box”) Trauma Patients:
    - The goal is to transfer patients meeting any ‘Emergency Transfer’ (“Red Box”) Trauma Re-Triage Criteria within one (1) hour of arrival at the sending facility.

- Contact the closest appropriate Trauma Center as soon as possible and identify the patient as meeting “Red Box” criteria.

3. Urgent Transfer Trauma Patients:

   - The goal is to transfer patients meeting any ‘Urgent Transfer’ criteria within four (4) hours of arrival at the transferring facility.
   - Contact the closest most appropriate trauma center to discuss patient status and request transfer. If transfer is accepted, arrange for appropriate transport resources based on patient condition and needs.

D. IFT Procedures:

1. Unless medically necessary, avoid using medication drips that are not in the paramedic scope of practice to avoid transfer delays.

2. If patient care has been initiated that exceeds the paramedic scope of practice, the sending hospital may consider sending a nurse or other qualified medical staff with the ground ambulance. Air ambulances or nurse staffed ground critical care transport (CCT) units may also be utilized if necessary and their response time is appropriate.

3. The patient should be ready for transport and records/staff should be prepared and available for EMS transport personnel upon arrival to the sending facility. Availability of records should not delay transport of patients in need of emergency transfer. If complete documentation is not sent with the ambulance, it should be faxed/electronically transmitted to the receiving hospital in sufficient time that it will arrive prior to the patient if possible.

4. For patients requiring emergency transfer, contracted advanced life support (ALS) transport providers should be utilized when agreements are in place and the transport unit is available within ten (10) minutes of the initial request. The jurisdictional ALS transport provider may be requested via 9-1-1 when the contracted ALS provider is not readily available.

Guidelines for Transfer to a Trauma Center

North Regional Trauma Coordinating Committee

Emergency Transfer: *Call the Trauma Center for immediate consult and/or acceptance. Avoid unnecessary studies that would delay the transfer. The goal is transfer within 1 hour of arrival.*

- Systolic blood pressure <90 mm Hg
- Labile blood pressure despite 2L of IV fluids or requiring blood products to maintain blood pressure
- GCS ≤8 or lateralizing signs
- Penetrating injuries to head, neck, chest or abdomen
- Fracture/dislocation with loss of distal pulses &/or ischemia
- Pelvic ring disruption or unstable pelvic fracture
- Vascular injuries with active arterial bleeding

Urgent Transfer: *Call the Trauma Center and initiate transfer as soon as any of the following are identified. Avoid unnecessary studies. The goal is transfer within 4 hours of arrival.*

Physiologic

- For a child, labile blood pressure despite 20 ml/kg of fluid resuscitation
- Patients requiring blood products to maintain their blood pressure

Note:
1. For pediatric patients, systolic blood pressure <70 plus 2 times the age should suggest hypotension
2. Systolic blood pressure <110 may represent shock in patients >65 years of age

Extremity Injuries

- Amputation of extremity proximal to wrist or ankle
- Open long-bone fractures
- Two or more long-bone fracture sites*
- Crush injury/mangled extremity

*A radius/ulna fracture or tibia/fibula fracture are considered one site

Neck & Thoracic Injuries

- Tracheobronchial injury
- Esophageal trauma
- Great vessel injury
- Major chest wall injury with ≥3 rib fractures &/or pulmonary contusion
- Pneumothorax or hemothorax with respiratory failure
- Radiographic evidence of aortic injury
- Known or suspected cardiac injury

Neurological Injuries

- GCS deteriorating by 2 points during observation
- Open or depressed skull fracture
- Acute spinal cord injury
- Spinal fractures, unstable or potentially unstable
- Neurologic deficit

Abdominal Injuries

- Evisceration
- Free air, fluid or solid organ injury on diagnostic testing

Pelvic/Urogenital

- Bladder rupture

Burn Injuries

- Second or third-degree thermal or chemical burns involving >10% of total body surface area in patients <15 years or >55 years of age
- Second or third-degree thermal or chemical burns involving the face, eyes, ears, hands, feet, genitalia, perineum, and major joints
- Third-degree burns >5% of the body surface area in any age group
- Electrical burns, including lightning injury
- Burn injury with inhalation injury

Co-Morbid Factors

- Adults >55 years of age with significant trauma
- Significant torso injury with advanced co-morbid disease (cardiac or respiratory disease, insulin-dependent diabetes, morbid obesity, immunosuppression or End Stage Renal Disease requiring dialysis)
- Patients taking anti-coagulant medication or platelet inhibitors
- Children <14 years of age with significant trauma
- Traumatic injury and pregnancy >20 weeks gestation

Note: All transfers must be in accordance with both state and federal EMTALA laws

Reference: American College of Surgeons, Committee on Trauma, Interfacility Transfer of Injured Patients: Guidelines for Rural Communities, 2002