Targeted High-Risk Transfer Prioritization

Executive Summary

- Hospital capacity has reached unmanageable levels due to increased patient acuity, reductions in overall bed counts, and loss of rural hospitals and capabilities.
- All tertiary care hospitals in the state are being impacted by these trends.
- Patient and family dissatisfaction grows if the patient is held in the ED for extended periods due to the lack beds “upstairs”.
- Rural facilities would benefit financially from increased patient retention
- A **regional** standard has been developed to establish transfer guidelines that will benefit patients, families, rural healthcare facilities, and Covenant Health.
- There is **no proposed enforcement** of these guidelines, merely a request from the Regional Advisory Council to voluntarily utilize these guidelines to improve patient care and safety.
- There is little or no **COBRA-EMTALA** Risk, in fact pre-agreed determinations of what constitutes a time critical emergency should be protective.
B-RAC Interfacility Transfer Guidelines
Why?

- Our Tertiary Care Facilities are frequently overwhelmed with transfers in
- Rural hospitals count on Metropolitan Areas for the provision of tertiary care services
- Both Tertiary Care Hospitals are frequently at maximum capacity
- Urgent and Emergent Transfers are being boarded in our EDs due to lack of available beds in the ICUs and on the Floors.
- Patient satisfaction is impacted due to overcrowding and overutilization of the ED.
- Many rural hospitals are either closing or reducing their services due to lack of revenue. **TEXAS LEADS THE NATION IN HOSPITAL CLOSURES SINCE 2011.** (Twenty hospitals at last count have closed).
- As rural facilities contract, the bed crisis in Metropolitan areas is further escalated.
Rural Hospitals

Across Texas, some small-town hospitals have struggled to stay open. Since 2013, 15 rural hospitals have closed and officials worry that more of the state’s 163 rural hospitals could close if they face more cuts to Medicare and Medicaid.
Counties without doctors

In some parts of Texas, patients may drive to another county to even see a doctor. In fact, 27 counties have no physicians (red) and 22 only have one doctor (tan).
B-RAC Suggested Transfer Criteria to Maximize Regional Resources

RED CATEGORY
IMMEDIATE TRANSFER TO HIGHER LEVEL OF CARE (Time Critical Conditions)

Acute Trauma
Stroke symptoms Less than 24 hours old
Acute Cardiac Ischemia or Myocardial Infarction
Acute Limb Ischemia
Acute Vascular Insufficiency of any type
Acute Respiratory Distress
Acute Neurological Deficit
Septic Shock
Acute Peritonitis

YELLOW CATEGORY
PLEASE BE PREPARED TO HOLD IN THE REGIONAL FACILITY UNTIL BEDS ARE AVAILABLE

Diabetic Ketoacidosis
Complicated Pancreatitis needing intervention
Complicated Diverticulitis needing intervention
Pyelonephritis with perinephric abscess
New onset renal failure
Acute Psychiatric Crisis that has been medically cleared
Chest Pain with NORMAL ECG and NORMAL ENZYMES
Stroke with known onset greater than 24 hours ago

GREEN CATEGORY
THESE CONDITIONS SHOULD BE KEPT AND TREATED IN REGIONAL FACILITIES UNLESS EXTEMUATING CIRCUMSTANCES ARE PRESENT

Simple pneumonia
Pyelonephritis without abscess/UTI/cystitis
Cellulitis
Gastroenteritis
Influenzae or URI (viral or bacterial) without complication
Dehydration with mild/mod AKI
Uncontrolled DM
CHF exac in patient with known hx of CHF (uncomplicated)
COPD/asthma exacerbation (mild to moderate)
Fractures not requiring acute surgical intervention
Uncomplicated diverticulitis
Uncomplicated pancreatitis
Uncomplicated C diff colitis/diarrhea
Chronic pain (without neurologic deficit)
Impending Death with DNR Status
Children’s hospitals are unique resources that benefit all children through clinical care, research, pediatric medical education, and advocacy. As a vital safety net for children, children’s hospitals provide expert care for the most severe and complex medical problems.

The map in Figure 1 shows all hospital discharges of patients, based upon the county of residence of the patients, from the 10 children’s hospitals in Texas. As expected the most populous counties, such as Harris and Dallas typically have the most patients. Although Nueces (Corpus Christi) and Lubbock counties have high number of patients.

The map in Figure 2 shows the rate of discharges per 100,000 population. And again the most populous counties typically have the highest rates. However counties in and around Lubbock and Corpus Christi have high rates of discharges. The metropolitan areas containing these two cities are much smaller in population than the other metropolitan areas with children’s hospitals. So one could conclude if you build it they will come.

**Figure 1.** Map of the county of residence for all patient discharges from children’s hospitals in Texas for 2008. Counts are highest in counties with large populations.

**Figure 2.** Map of the rates patient discharges per 100,000 population. Rate is highest in counties near a children’s hospital.

Map Source: Center For Health Statistics, GIS
Acknowledgements: Children’s Hospital Association of Texas November 2011
# B-RAC Suggested Transfer Criteria to Maximize Regional Resources

## RED CATEGORY
**IMMEDIATE TRANSFER TO HIGHER LEVEL OF CARE (Time Critical Conditions)**

- Acute Trauma meeting Level I or II SPEMS Criteria
- Acute Respiratory Distress/ Unable to maintain SPO2 ≥ 90% with O2 maintaining SPO2 >90 %
- GCS ≤ 13 with or without trauma
- Open fracture proximal to wrist or ankle / Fractures with neurovascular compromise
- Septic Shock
- Post-Resuscitation
- Toxic Ingestion
- Partial thickness burns >10% or involves face, hands, feet, genitals, perineum or major joints, all 3rd degree burns, electrical burns, burn with inhalation injury, burn in addition to multiple trauma
- Status Epilepticus
- Ruptured appendicitis
- DKA
- Apnea <1 year old oh cardiac history
- Status Asthmaticus

## YELLOW CATEGORY
**PLEASE BE PREPARED TO HOLD IN THE REGIONAL FACILITY UNTIL BEDS ARE AVAILABLE**

- Fractures- Requiring surgical intervention (Not including open fx. Or fx with neurovascular compromise)
- Respiratory illness requiring minimal oxygen while
- Asthma
- Appendicitis without rupture
- Acute Psychiatric Crisis that has been medically cleared
- New Onset Seizures, currently stable
- New Onset Diabetes (not in DKA)
- Apnea > 1 year old and currently stable
- (Simple)Dehydration with IV access
- Septic Joint
- Initial SVT, Currently NSR
- Tylenol Ingestion - Non toxic (level <100mcg/ml after 4 hours of ingestion)
- Neutropenic with fever

## GREEN CATEGORY
**THESE CONDITIONS SHOULD BE KEPT AND TREATED IN REGIONAL FACILITIES UNLESS EXTEMATING CIRCUMSTANCES ARE PRESENT**

- Simple lacerations
- Sprains
- Nondisplaced fractures
- URI /Influenza without complication
- Medication refill
- C/O of syncope, but currently asymptomatic
- Cellulitis/ Osteomyelitis

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**Sacred Encounters  Perfect Care  Healthiest Communities**

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**Covenant Health**
B-RAC Suggested Transfer Criteria to Maximize Regional Resources

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OBSTETRICS
Proposed Results

• Appropriate utilization of Tertiary Care Beds in our state
• **Survival of our Rural Hospital Partners**
• Better Patient and Family Satisfaction
• SAFETY will be increased for those patients that must be transferred to higher levels of care.

*How can we help keep more patients (appropriately) in rural facilities?*