



Health Policy Committee

Approved by the OTA Board of Directors, February, 2007

Transfer of the Orthopaedic Trauma Patient: Criteria and Procedure

Purpose:

To provide guidelines regarding the criteria for transfer of patients from one emergency room to another emergency room for specialty specific care and outline an appropriate procedure for achieving such transfers.

Principle:

The primary criteria for all patient transfers should be the best interest of the patient. Transfers shall be performed when necessary services to evaluate or treat a patient are not available at the initial receiving facility. Whenever possible, prearranged transfer agreements should be in place to facilitate timely transfers of patients to facilities with the required level of care is available. This is especially recommended in locations where patients with complex problems are regularly transferred to certain regional centers where such higher level of care is provided. All patients should be appropriately evaluated by qualified physicians prior to transfer. Any needed emergency treatment and/or stabilization should be undertaken at the initial receiving facility prior to transfer. In all cases, the reason for transfer should be explained to the patient. No transfer should be undertaken without the consent of the patient or patient's representative. In the case that no party can provide consent and the transfer is judged to be in the best interests of the patient by the treating physician at the referring facility, the treating physician shall write a note explaining the reason for the transfer.

At institutions with limited capacity for the provision of orthopaedic services, efforts must be made to establish methods for appropriate patient evaluation, treatment and transfer that optimally provide for timely care of musculoskeletal injuries. Such optimization may require agreements between health care facilities and local orthopaedic surgeons who provide call-sharing between facilities or telemedicine consultation to appropriately apportion these services.

Transfer and triage agreements regarding the disposition of trauma victims should be developed considering the realities of local man-power circumstances with cooperation of local hospitals and orthopaedic surgeons. The efficient and timely care of patients with musculo-skeletal emergency conditions shall always be the goal of such agreements. The competitive market driven aspects of health care delivery must cede to the community needs for the proper disposition, evaluation and treatment of patients with emergent conditions. This requirement will require cooperation between hospitals, physicians, emergency responders and government to ensure the best available care and avoid the inefficiencies and difficulties associated with a haphazard approach.

Guidelines:

Trauma Transfer With Pre-Planned Transfer Agreement

Trauma networks involving two or more hospitals may be established to streamline patient referrals with specific conditions and under specified circumstances to optimize referral practices. Establishment of such networks would allow for better trauma care planning by both referring and receiving centers. Such transfer agreements should be encouraged and developed always realizing that transfers should never be based on financial criteria.

Transfer rules between hospitals should be developed on a hospital to hospital level within these guidelines by the administrations of the receiving and referring hospitals always involving the consultation and cooperation of the orthopaedic surgeons of both institutions.

In the circumstance wherein such an agreement has been implemented there would be no need for the local orthopaedist to get involved on an individual transfer. Similarly, there is no need for a local specialist to become directly involved if the initial hospital is on “bypass” status. In such cases, patients may be triaged expeditiously to the nearest appropriate hospital determined to have adequate facilities, services and personnel to treat the medical needs of the patient. This will help avoid delays and unnecessarily long distance transfers.

Trauma Transfers Without Pre-Planned Transfer Agreement

Except when such preexisting transfer arrangements are in effect, or when a hospital is on “bypass” status, transfer of patients for specialty care of musculoskeletal injuries should only be done following completion of a physical examination and review of radiographs by the qualified transferring physician. A **personal** evaluation including physical examination and review

of pertinent imaging studies must be performed by the physician requesting transfer.

The orthopaedic surgeon "on call" at the referring hospital must actively participate in the decision making for transfer of a patient to a "higher level of care" regarding musculoskeletal conditions. When a referring hospital with an orthopaedist on call requests a transfer to a "higher level" trauma center, it is the on-call orthopaedist's responsibility that there be contact with the receiving orthopaedic surgeon for "acceptance of transfer" prior to sending the patient. Direct contact should be made, physician-to-physician not through a physician assistant nor through a nurse. The "blind transfer" of patients for a higher level of care without the active participation of the "on-call" orthopaedic surgeon should only be permissible when medical circumstances necessitating expedited transfer for the welfare of the patient.

"Selective Call" wherein a physician on-call would respond to some patients with problems within their scope of practice presenting to the emergency room but not others is not professionally acceptable. When they are on duty, the "on-call" orthopaedic surgeon has the responsibility to respond for all orthopaedic patients without a prearranged consultant, presenting to their hospital emergency room requiring the attention of an orthopaedic surgeon. The "on-call" orthopaedic surgeon may not selectively respond to certain emergency patients and not others.

Transfer Without Consultation by the On Call Orthopaedic Surgeon

Doubtless, it is the duty of "on-call" orthopaedic surgeon to respond appropriately to requests for consultation from their emergency departments. However, in circumstances wherein an "on-call" orthopaedic surgeon does not or cannot respond in a timely fashion or refuses to consult the referring emergency room physician may for the sake of the patient's wellbeing contact the receiving orthopaedic surgeon. In such cases, the referring physician shall have evaluated the patient and explain to the receiving orthopaedic surgeon the circumstances necessitating the transfer without evaluation by the "on-call" orthopaedic surgeon including the name of the "on-call" orthopaedic surgeon. In all circumstances the referring physician shall be afforded all the respect and assistance required as needed to assure appropriate care and transfer of the patient.

Responsibilities of the Transferring Physician

An “on-call” orthopaedic surgeon or other transferring physician should provide initial temporizing treatments that fall within their capabilities (eg. irrigation and debridement, provisional external fixation, fracture and dislocation reductions, splinting). Afterward, the patient may be transferred to the receiving orthopaedic surgeon for further treatment. On occasion, it may be decided that it is in the patient’s best interest to defer basic orthopaedic treatment or stabilizing procedures (i.e. fasciotomy, reduction, splinting) to the receiving hospital. The transferring physician shall be expected to communicate the condition of the patient in question and discuss the appropriate course of action with the receiving specialist. The best medical interest of the patient shall be the determining factor in such decisions.

At the time of transfer all records including relevant imaging studies and a history and physical examination performed and signed by the transferring physician including the diagnosis and plan as discussed with the accepting physician shall be sent with the patient.

As transfers often protract the time of care appropriate orthopaedic first responder treatment and stabilization of injuries should be undertaken prior to transfer. (i.e. IV antibiotics for open fracture, reduction and splinting of dislocations or fractures when appropriate). The physical transfer of all patients should be performed in accordance with the principles as outlined in Resources for Optimal Care of the Injured Patient 1999

(Chicago, IL ACS)

As a means of fostering the communication and collegiality which assures optimal patient outcome, it is a reasonable professional expectation that receiving specialists report to the referring orthopaedic surgeon regarding the hospital course and future plan for patients received in transfer. The referring physician may reassume follow-up care when it is in the patient’s best interest with agreement and consultation by both surgeons (i.e., in the case of long distance transfer).

Summary

The transfer of patients with musculo-skeletal injuries is often necessary to insure appropriate treatment at an appropriate level of expertise and resource availability.

The primary goal of the transfer of trauma victims is the provision of appropriate care for the patient's injuries.

Transfer shall not be based on the payer status of the patient.

Transfers to receiving orthopaedic surgeons should be from physicians sufficiently trained in musculo-skeletal conditions to insure appropriate care and planning for patient's needs. In extreme circumstances exceptions may be made to avoid life or limb threatening delay.

All documentation including history and physical as well as laboratory and imaging studies must accompany the patient to avoid delay in treatment and duplication.

All necessary cooperation, planning and use of technology should be employed to best allocate emergency care resources within communities. The highest priority must always be given to the needs of the patient population. Led by physicians, hospitals and emergency service responders must wisely allocate often-scarce resources to appropriately distribute this care responsibility.

Regional Transfer agreements should be established to make necessary care accessible to patients in need in a timely fashion and avoid delays associated with long transfer distances or other logistical challenges.

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