BY ORDER OF THE COMMANDER
59TH MEDICAL WING

59TH MEDICAL WING INSTRUCTION
41-122

13 NOVEMBER 2020
Certified Current on, 15 February 2024
Health Services

PATIENT TRANSFERS

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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RELEASABILITY: There are no releasability restrictions on this publication.

OPR: 59 MDOS/SGOE

Certified by: 59MDSG/CD
(Colonel Lynn Shinabery)

Supersedes: 59 MDWI 41-122, 8 November 2018

Pages: 10

This instruction implements Air Force Policy Directive 41-1, *Health Care Programs and Resources*. This 59th Medical Wing Instruction (MDWI) outlines procedures for transferring patients to and from the Wilford Hall Ambulatory Surgical Center (WHASC), 559th Medical Group (Reid Health Services Center and detached healthcare facilities), and 59th Dental Group (Dental Clinics). Herein WHASC clinics, 559 MDG, and 59 DG will be referenced as 59 MDW Lackland clinics. This publication applies to all personnel assigned, attached, or under contract to the 59th Medical Wing (MDW) with the exception of personnel working under the purview of the 959th Medical Group [Brooke Army Medical Center (BAMC)] and those at the 559th Medical Squadron (Joint Base San Antonio - Randolph). Transfer of patients from 59 MDW Lackland clinics is based on the patient's need for services and our ability to provide those services. The determination as to our ability to care for patients transferred out is based on all applicable 59 MDW, Air Force, and Department of Defense (DoD) regulations as well as the patient's consent for treatment. This instruction does not apply to the Air National Guard or Air Force Reserve. This instruction requires the collection and maintenance of information protected by the Privacy Act of 1974 authorized by Title 10, United States Code, Section 8013. Privacy Act System of Record F044 AF SG Q, Family Advocacy Program Record, applies. Collected information is "For Official Use Only." Request to release Privacy Act information to persons or agencies outside the Department of Defense (DoD) must be in accordance with (IAW) AFI 33-332, *Air Force Privacy and Civil Liberties Program*, DoDD 5400.7, *Freedom of Information Act*, and DoDM 6025.18, *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs*. Refer recommended changes and questions about this publication to the Office of Primary Responsibility using the AF Form 847, *Recommendation for Change of Publication.* Ensure that all records created as a result of

processes prescribed in this publication are maintained IAW AFI 33-322, *Records Management and Information Governance Program*, and disposed of IAW Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS).

SUMMARY OF CHANGES

This publication was substantially revised. Please read in its entirety. This rewrite of 59 MDWI 41-122 includes instructions for requesting an ambulance for non-stable patients through 911; instructions for transfer of patients to BAMC for direct admission to inpatient services, instructions for transfer of non-stable patients seen at Randolph Clinic, North Central Federal Clinic (NCFC) and Gateway Bulverde Clinic (GBC); and clinic transfers to the Family Emergency Center (FEC).

1. Transfer Guidance.

1.1. Transfer of care is made when the patient cannot be given the appropriate level of care in their current clinical location and currently available resources to sustain a particular patient's normal state of health. If the immediate patient needs exceeds the capabilities of the clinic then a patient transfer is warranted.

1.1.1. Transfers can be to another clinic, the Family Emergency Center or for hospital admission. All transfers must meet facility and Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.

1.1.2. 59 MDW Form 27, *Patient Transfer Record.*

1.1.2.1. Required when request Ambulance Services to transfer patients between facility locations.

1.1.2.2. Form required to be completed PRIOR to calling for Emergency Medical Services (EMS) transport.

1.1.2.3. Coordination conversation with accepting facility and/or provider MUST occur prior to filling out the 59 MDW Form 27.

1.1.2.4. If accepting facility is an emergency department (ED) then ED provider must accept the patient. This acceptance is also required if patient has to stop in the ED before continuing to the destination acceptance facility

1.1.3. For Intra-Facility Transfers.

1.1.3.1. A phone call to the receiving facility is warranted.

1.1.3.2. Ensure receiving facility has available resources to evaluate the patient.

1.1.3.3. Ensure receiving facility has accepted patient and is ready to receive the patient.

1.1.3.4. No Transfer Record is required.

1.1.4. For Inter-Facility Transfers.

1.1.4.1. If patient is capable of safe self-transportation to the receiving facility, referring facility ensures receiving facility has accepted patient and provides directions or escorts patient to receiving facility. A Transfer Record may or may not

be required but provider-to-provider coordination is essential and is required. Good documentation of the acceptance is required. Note acceptance documentation must on 59 MDW Form 27 to ensure EMTALA requirements are satisfied.

1.1.4.2. If patient requires non-emergent EMS transportation, proper provider-to-provider coordination is essential and a completed transfer form is REQUIRED to meet EMTALA, insurance and EMS guidelines. This information will be sent with the patient along with appropriate records. Referring facility MUST keep a copy of these records/documents and insert appropriate notes on the Transfer Record to satisfy EMTALA requirements

2. Care for Unstable Patients.

2.1. All 59 MDW Lackland Clinics will:

2.1.1. Call 911 from a Joint Base San Antonio - Lackland telephone. The Emergency Control Center (ECC) will dispatch an ambulance to transport the patient to the FEC, BAMC ED, or the nearest off-base ED, depending on the patient's clinical condition and the discretion of the paramedic. The MRC will dispatch to Lackland Emergency Medical Service (EMS) first. In the event all Lackland EMS are taxed, ECC will notify South West Texas Regional Advisory Committee for 911 response.

2.1.2. A minor patient will be transferred with an attendant (e.g., family member, legal guardian, or military escort in compliance with AFI 44-102, *Medical Care Management*) to ride in the back of the ambulance with the minor patient.

2.1.3. Make every attempt to stabilize the patient prior to arrival of EMS.

2.1.4. Provide documentation of treatment already performed and copies of all available records and diagnostic studies (lab work, electrocardiograms, x-rays, etc.) related to the patient's condition. Expedite transport based on patient's immediate condition, as necessary, in lieu of having all related documentation.

2.2. Evaluation of patients outside of the FEC, the attending medical provider will:

2.2.1. Determine when a patient is unstable and requires transfer to an ED in order to obtain appropriate medical care. The decision to transfer a patient is based on the patient's healthcare needs exceeding the clinic's Scope of Care.

2.2.2. Indicate the level of life support required for transfer: Basic Life Support, Advanced Cardiac Life Support, and Critical Care Transport.

2.2.3. Ensure the patient and appropriate family members/legal guardians are involved in all decisions regarding transfers and record their consent to be transferred.

2.2.4. Complete the 59 MDW Form 27 prior to EMS arrival. Have a copy ready for the EMS crew and maintain a copy to upload into the patient's medical record.

2.2.4.1. Document the clinical condition and clearly state the reason for transfer.

2.2.4.2. Include a summary of specific risks and benefits associated with transfer. Sufficient documentation is necessary to ensure coverage of transport by insurance. Failure could result in the completion of a statement of medical necessity by the

transferring provider at a later date or the patient may be responsible for the costs of the transfer.

2.2.5. Provide a hand-off to EMS.

2.3. An unstable but competent patient may refuse to accept a transfer. Refusal must be documented by the provider as "Against Medical Advice" in the patient's medical record prior to the patient being released from treatment.

2.4. Refer to **Attachment 2** for the Patient Transfer Algorithm.

3. Care for STABLE patients with urgent medical needs that exceed clinics' Scope of Care.

3.1. A patient is considered stable only when there is a reasonable probability of no deterioration of the medical condition likely to result from, or to occur during, the transfer. Documentation in the patient's record should clearly indicate the status of the patient's condition and the treatment provided to stabilize the patient.

3.2. The attending provider will:

3.2.1. Determine when a patient is stable, but has a condition that requires immediate attention. The decision to transfer a patient is based on the patient's healthcare needs exceeding the clinic's Scope of Care or capabilities.

3.2.2. Ensure the patient and appropriate family member/legal guardian are involved in all decisions regarding transfers, and record their consent to be transferred.

3.3. Transfer to the Family Emergency Center. The provider will call the FEC at (210) 292-7331 or (210) 292-8432 and request to speak to the Emergency Provider for case discussion and acceptance of patient. If both providers agree to the patient's transfer, the clinic nurse will provide a hand-off with a FEC Nurse for continuity of care. The FEC Nurse is responsible for notifying the FEC front desk personnel of a patient's pending arrival. Discussion between providers may lead to the conclusion the patient is better suited for direct admission or out-patient follow-up, rather than transfer of the patient to the FEC.

3.3.1. The clinic is responsible for ensuring the patient arrives at the FEC. In the WHASC, this may occur by ambulation or wheelchair. From outside the WHASC, this assumes the patient is stable enough to provide their own transportation to the FEC. (If not stable, refer to **para 2.1** for 911 response.) The patient will check-in at the front desk, just as any other patient seeking care in the FEC. The FEC front desk personnel will call the FEC Charge Nurse so they are aware the patient is present.

3.3.2. The Triage/Quick-Look Nurse will triage the patient and determine the patient's Emergency Severity Index category to decide on the most appropriate disposition for the patient (i.e. waiting room or available bed).

3.4. Clinic transferring a patient to BAMC for direct admission to inpatient services.

3.4.1. The provider will page the appropriate on-call service at BAMC; the Medical Officer of the day (MOD) service (210-513-9952) is the most common and can help reach the appropriate consultant service if there is a question. A list of "On-Call" providers (by specialty) is maintained in the FEC. Contact FEC team (210-292-7331) to obtain the appropriate "On Call" provider contact information. BAMC's consultant will contact the BAMC Bed Coordinator, then call the clinic back with the floor assignment.

3.4.2. The clinic will call FEC at (210) 292-7331 to request a stable patient transfer for admission. FEC will dispatch an ambulance to the clinic location. EMS will transport the patient to the pre-arranged floor at BAMC.

3.4.3. Complete the 59 MDW Form 27 prior to EMS arrival. Have a copy ready for the EMS crew and maintain a copy to upload into the patient's medical record. Document the clinical condition and clearly state the reason for transfer. Include a summary of specific risks and benefits associated with transfer. Sufficient documentation is necessary to ensure coverage of transport by insurance. Failure could result in the completion of a statement of medical necessity by the transferring provider at a later date or the patient may be responsible for the costs of the transfer.

3.4.4. In the event that the patient has been accepted for transfer, but the current clinic responsible for the patient is closing, the current clinic needs to coordinate with the FEC for holding said patient for transfer. If the transfer is imminent, the clinic will need to stay to hold the patient. If the transfer will not be completed in a reasonable time, transfer to FEC for holding will need to be coordinated, consistent with guidance in **paragraph 3.3**

3.5. Refer to **Attachment 2** for the Patient Transfer Algorithm.

4. Transferring Patients from WHASC Mental Health Clinic.

4.1. The WHASC Mental Health Clinic (MHC) will identify patients requiring in-patient level care. The attending medical provider will:

4.1.1. Page BAMC Mental Health (MH) consultation team pager: (210) 513- 2243 to request in-patient level care (pending medical clearance in the FEC). BAMC's consultant will contact the BAMC Bed Coordinator to arrange bed assignment on 6T. If BAMC beds are full, the requesting provider will coordinate care at a network facility.

4.1.2. Provide BAMC MH consultation team with MHC provider's pager or contact information and request BAMC consultation team re-engage referring provider to apprise of admission.

4.1.3. Call the FEC at (210) 292-7331 or (210) 292-8432 and request to speak to the Emergency Provider for case discussion and acceptance of patient for initiation of medical clearance. The clinic nurse will provide a hand-off with the FEC Charge Nurse for continuity of care. The Charge Nurse will ensure a room/bed is available prior to transferring the patient to the FEC.

4.1.4. Following medical clearance, FEC provider will notify the Mental Health Consultant at BAMC of medical clearance and coordinate transfer to BAMC or network facility through FEC.

4.2. WHASC Mental Health Clinic (MHC) will ensure the safety of the patient while awaiting transport.

4.2.1. A WHASC MHC technician will be assigned to ensure positive control of patient.

4.2.2. The MHC will engage the patient's command structure for further positive control support while in WHASC MHC to ensure command's awareness of their member.

4.2.2.1. If patient's command is unable/unwilling to report to WHASC MHC, the provider should recommend a representative from the patient's command meet the patient at the FEC. If command is unwilling/unavailable to emergently meet patient at WHASC FEC, advise command that the patient's disposition could include admission to BAMC in-patient mental health (210) 916-2069 or network facility.

4.2.2.2. Advise command they are responsible for maintaining acute positive control of patient in the unlikely event they are not admitted and they are likewise responsible for maintaining accountability of the patient while the patient is admitted and at the time of discharge. Encourage proactive command engagement with in-patient facility to accomplish this. Advise command the WHASC MHC will maintain high interest accountability during admission and following discharge.

4.3. The MHC is responsible for transporting the patient to the FEC by ambulation or wheelchair. Upon arrival at the FEC, MHC personnel will notify the front desk of the clinic transfer.

4.3.1. The front desk personnel will call the Charge Nurse, who will meet the patient at the front desk and direct them to the correct room/bed.

4.3.2. If the provider determines the patient is a flight risk, they will contact FEC at (210) 292-7331 to request a stable patient transfer by EMS from the MHC to the FEC.

4.4. Emergency Detention:

4.4.1. Involuntary Active Duty members – Medically clear patient in the FEC, then transfer for direct admission at BAMC or network facility.

4.4.2. Non-Active Duty – Medically clear patient in the FEC. San Antonio Police Department or Bexar County Sheriff is contacted for emergency detainment process.

4.5. All patients found to have behavioral health issues requiring Mental Health evaluation and/or admission that are originating outside the WHASC Mental Health Clinic will be sent from the clinic to BAMC ED via 911 for mental health consultation and medical clearance prior to admission.

5. Transferring patients from the FEC to a higher level of care.

5.1. FEC staff will call 911 for patients who meet Emergency Criteria per the FEC's Scope of Care. Refer to section 2.1 for guidance on 911 procedures.

5.2. FEC staff will coordinate direct admissions at BAMC. Refer to section 3.4 for guidance on direct admission.

6. Transferring active duty patients from North Central Federal Clinic (NCFC) to a higher level of care.

6.1. When the provider identifies a patient with apparent medical emergency.

6.1.1. Pull medical emergency cord in room to alert front desk and Veterans Administration (VA) nursing staff to respond for medical support IAW NCFC Memorandum of Agreement.

6.1.2. Alert all staff in area of the situation. Use runner if necessary to room 119/121 for VA nursing staff support.

6.1.3. Relocate patient to medical screening room once determined stable.

6.1.4. VA staff will call 911 to coordinate Emergency Medical Services (EMS) transportation to nearest Emergency Department for further evaluation as necessary.

6.1.5. Notify clinic leadership of situation as soon as possible.

6.1.6. Relocate other patients if necessary to ensure safety.

6.1.7. When EMS arrives provide warm hand-off of situation and note the hospital to which the EMS transports the patient.

6.1.8. Behavioral Health Clinic staff will contact the patient's chain of command to inform of medical emergency for situational awareness.

6.1.9. Behavioral Health Clinic staff will contact Brooke Army Medical Center (BAMC) Patient Administration Department (PAD), at 210-916-2788, to provide patient demographics and brief description of situation to ensure accountability for absent-sick rolls.

6.1.10. Behavioral Health Clinic staff will generate encrypted email to BAMC Behavioral Medicine Department Chairperson and other appropriate Army leaders using elements of mnemonic SBAR as a frame work for a structured method of patient status. BAMC Memo 040-224, Joint Commission Standard.

6.1.10.1. S- Situation: What is happening at the present time?

6.1.10.2. B- Background: What are the circumstances leading up to this situation?

6.1.10.3. A- Assessment: What do I think the problem is?

6.1.10.4. R- Recommendation: What should we do to correct the problem?

6.1.10.5. When communicating critical information about a patient requiring immediate attention, care providers may use the SBAR technique to introduce or update another provider on important specifics about a patient. BAMC Memo 40-226, Patient hand-offs: SBAR.

6.1.11. Behavioral Health Clinic staff will complete document of encounter in AHLTA.

7. Transferring patients from Gateway Bulverde Clinic (GBC) to a higher level of care.

7.1. Provider assesses patients to determine need for Emergency Medical Service level of care

7.1.1. If patient is able to ambulate, patient is escorted to Baptist Emergency Department located on the first floor of the GBC.

7.1.2. If patient requires emergent/urgent medical stabilization

7.1.2.1. Clinic staff activates emergency notification through dialing 911 or calling directly to first floor ER or sending runner.

7.1.2.2. Clinic staff will coordinate hand off to Paramedics or ER staff.

7.1.3. If patient is dependent or non-active duty, clinic staff will notify family members and document incident and care measures in patient's medical records.

7.1.4. If patient is staff or active duty, clinic staff will contact patient's chain of command with notification of incident.

7.1.5. Clinic staff will make appropriate notification to PAD.

7.1.6. Clinic providers will do follow up with Baptist Emergency Department within 72 hours.

7.2. Non-Emergent/Non-Urgent transfers, patients secure own personal transportation.

8. Transferring patient from Randolph Clinic to a higher level of care.

8.1. All Randolph AFB Clinic patient transfers will occur to a higher level of care to an off base emergency room.

8.2. Randolph AFB Clinic staff will call 911 for emergent patients who meet medical necessity for urgent or emergent transfer to higher level of care.

8.2.1. Emergent patients will be transferred by the contracted on base ambulance service.

8.3. Randolph AFB Clinic staff will call off base ambulance for non-emergent patients who are stable but with urgent needs that exceed the clinic's "Scope of Care".

8.4. Randolph AFB Clinic staff will communicate all treatment and care the clinic renders the patient to the EMS transport team members who will then transfer the patient to the closest appropriate emergency care facility or hospital.

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Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

AFPD 41-1, *Health Care Programs and Resources*, 3 October 2018

AFI 44-102, *Medical Care Management*, 17 March 2015

Prescribed Form

59 MDW Form 27, *Patient Transfer Record*

Adopted Form

AF Form 847, *Recommendation for Change of Publication*

Abbreviations and Acronyms

BAMC—Brooke Army Medical Center

DoD—Department of Defense

DoDD—Department of Defense Directive

DoDM—Department of Defense Manual

ED—Emergency Department

EMS—Emergency Medical Service

FEC—Family Emergency Center

GBC—Gateway Bulverde Clinic

IAW—In Accordance With

MDW—Medical Wing

MDWI—Medical Wing Instruction

MH—Mental Health

MHC—Mental Health Clinic

MOD—Medical Officer of the Day

MRC—Medical Response Center

NCFC—North Central Federal Clinic

PAD—Patient Administration Department

VA—Veterans Administration

WHASC—Wilford Hall Ambulatory Surgical Center

Attachment 2

PATIENT TRANSFER ALGORITHM

Figure A2.1. Patient Transfer Algorithm.