



EMS  
to F

port  
R's

*It*

!!!

*Terrence V*

*CP, FAEMS*



# EMS Should NOT Transport to Free Standing ER's

*It All The Way to Go!!!*

*Raymond L. Miller, MD, FAEM, DABEMS  
Professor and Chief, Emergency Medical Services  
UT Southwestern Medical Center and  
Parkland Memorial Hospital*

A nighttime photograph of a city skyline, likely New York City, with numerous skyscrapers illuminated. The lights from the buildings are reflected in the water in the foreground. The scene is set against a dark blue night sky.

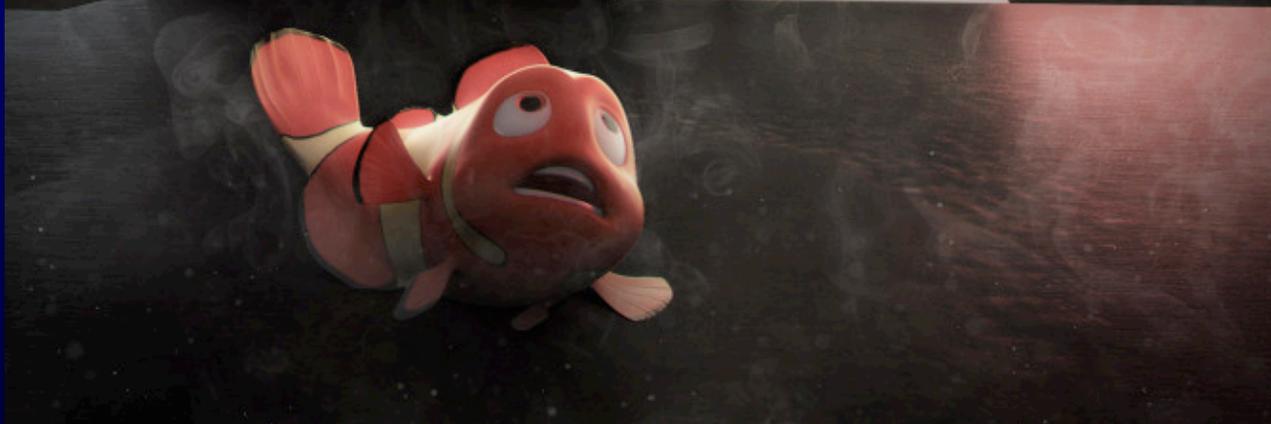
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Terry.....GET READY!!!!!!



# EMTALA

Don't break the LAW!

*“A patient presenting to a hospital with the complaint of an emergency medical condition must be stabilized utilizing all of the resources of the hospital until the emergency medical condition is stabilized, regardless of ability to pay.”*

# Types of “Free-Standing” ERs

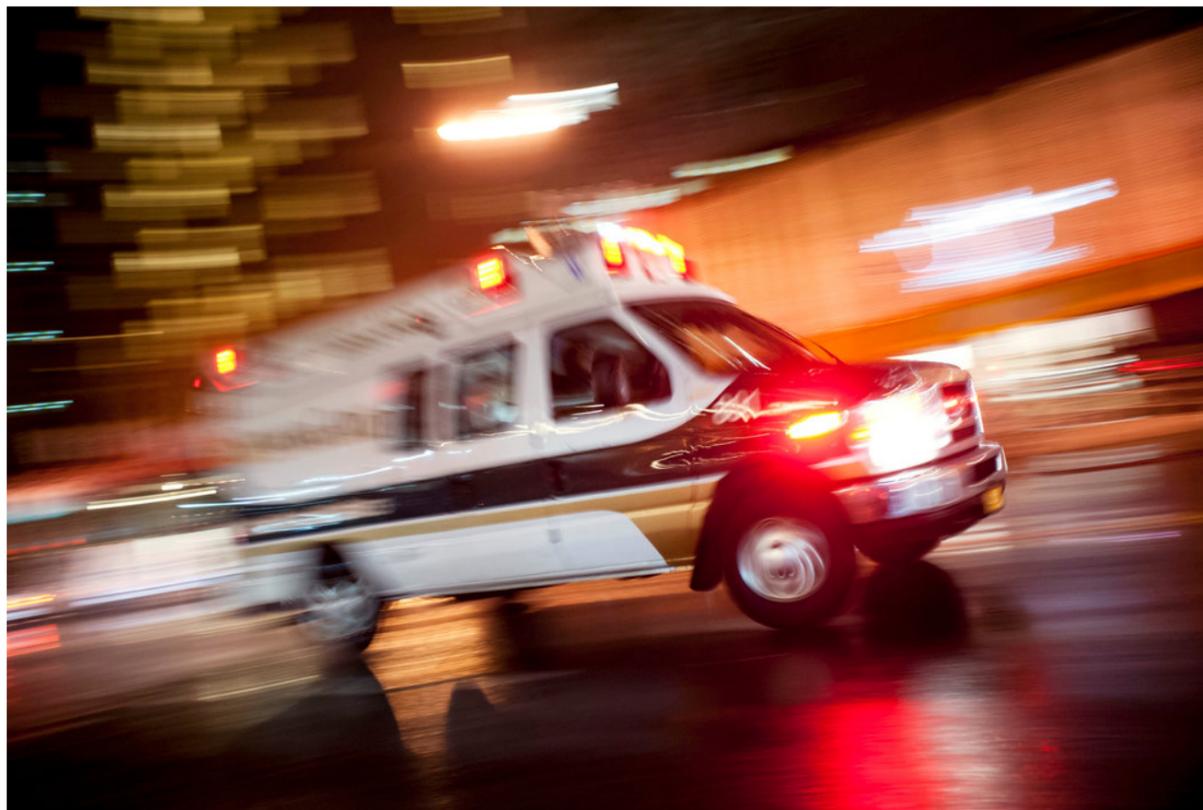
*Satellite: An extension of the hospital’s license and CMS license: EMTALA*

*Free-Standing: Not an extension of a hospital’s license: No EMTALA*

*Urgent Care Center: Not an extension of a hospital’s license: No EMTALA*

# Think the E.R. Is Expensive? Look at How Much It Costs to Get There

By ELISABETH ROSENTHAL DEC. 4, 2013



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# Price of Cab Fare

\$20 +/-

I would pose this question, Terry

*Why would a patient – **who called 911 with a potentially life-threatening emergency** – want transport to a non-hospital-based facility?*

....and, Terry, another question

*Would health insurance, Medicare, Medicaid, or the ACA pay for a trip to a non-hospital-based facility???*

# Facility Capabilities

*Hospital Satellite Facility: Robust!  
Code capable, EMTALA bound, CT,  
ultrasound, labs, direct transfer to the  
“mother ship” bypassing the ED*

# Facility Capabilities

*Free-standing facilities: Similar capabilities to the Satellites, but are not bound by EMTALA*



# Our experience in Dallas

*We toured a “Ritz Carlton” quality Free-Standing Center who wanted our EMS traffic.*

*They would do an MSE and, if no “emergency medical condition” was present, they would estimate the cost of the visit and require cash or a credit card prior to treatment.*

*They would NOT cover the cost of secondary transport to another facility.*

## Our experience in Dallas

*Needless to say, we would NOT transport patients to that facility.*

# A list of what should NOT be transported to Free-Standers

- *Stroke*
- *ACS/STEMI?*
- *Major Trauma*
- *Sepsis*
- *GI Hemorrhage*

# A list of what should NOT be transported to Free-Standers

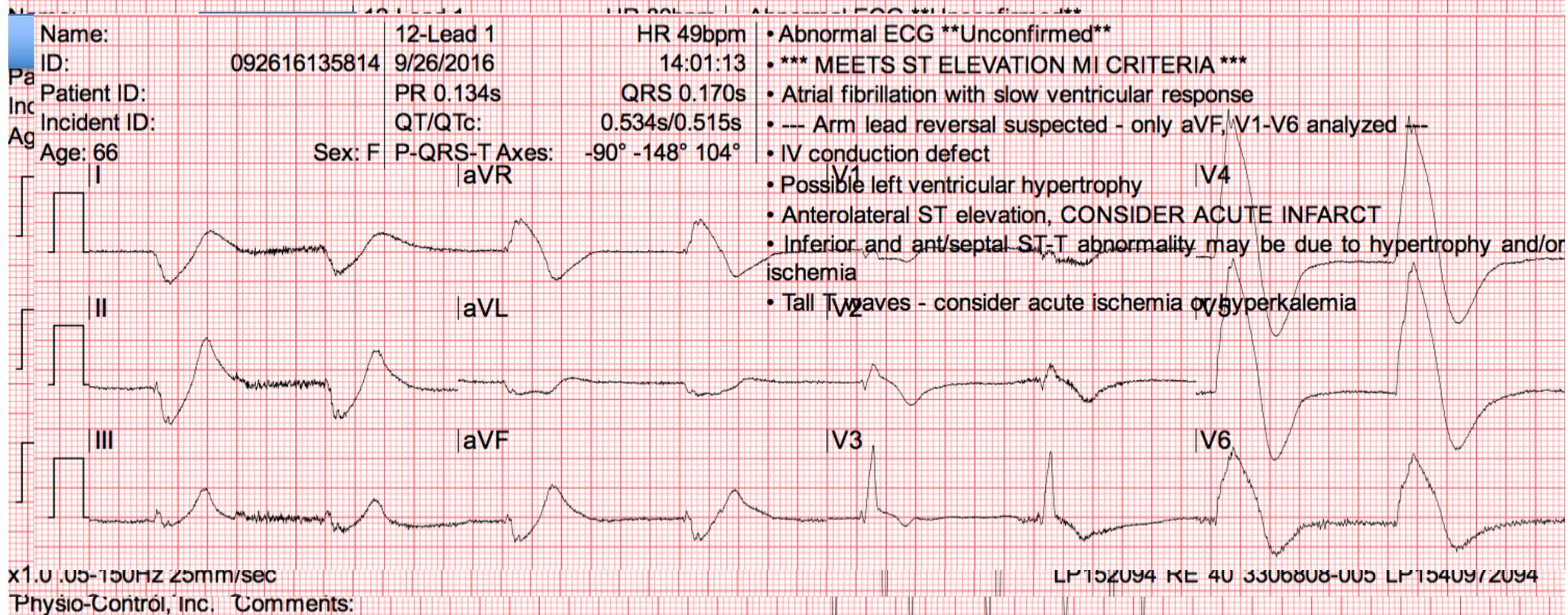


*Arguably, critically ill  
Advanced Life Support  
patients should not be  
transported there*

So...Terry, TERRY, *TERRY!!*

*Why take an ambulance, for  
a thousand dollar cab ride,  
on a BLS case to a  
Free-Standing Facility?*

# PERHAPS!!!!



*PERHAPS!!!!*

*Acute abdominal pain with  
stable vitals WHEN  
a ruptured ectopic  
is NOT suspected?*

*Maybe...*

*PERHAPS!!!!*

*Lacerations that appear  
uncomplicated*

*Strains and Sprains*

*(but why not call a CAB???)*

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## GETAC

### Non Traditional Emergency Care Facilities Destination Tool

In recent years, Texas has experienced rapid growth of non-traditional licensed emergency care facilities. Freestanding Emergency Centers (FECs), Hospital Outpatient Departments (HOPDs), etc., have created new appropriate options for the transport of the EMS patient. State law assigns the responsibility for the destination of the EMS patient to the EMS Medical Director. In many RACs in Texas, EMS Medical Directors have collaborated to establish common destination criteria for trauma, stroke, and STEMI populations. EMS Medical Directors and RACs are faced with more and more options of evaluating these non-traditional licensed emergency facilities as a possible destination for EMS patients is both time-consuming and complex.

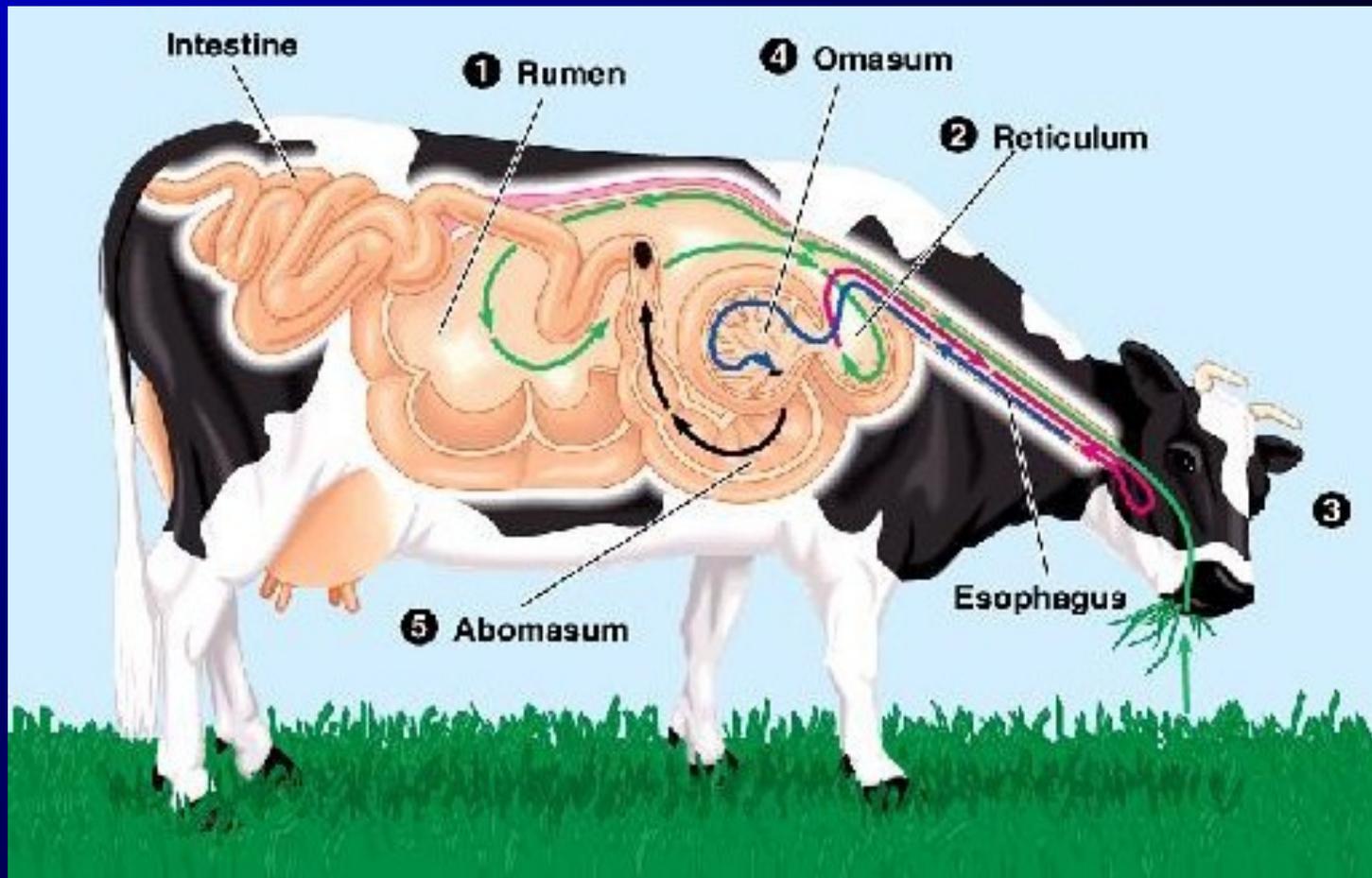
The Governors EMS and Trauma Advisory Council (GETAC) has developed this tool for EMS agencies and EMS Medical Directors to consider when evaluating non-traditional licensed emergency facilities for potential destinations for EMS patients.

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	Category I	Category II	Category III
Category Definition:	Highest Capabilities; consider appropriate EMS patients	Intermediate Capabilities; consider low acuity EMS patients	Lowest Capabilities: Routine EMS transport not recommended
Stroke - EMS agreement	YES	NO	NO
STEMI - card on call	24/7	NO	NO
STEMI - fibrinolytics	YES	NO	NO
STEMI - transfer agreement	YES	NO	NO
STEMI - EMS agreement	YES	NO	NO
Trauma - transfer agreement	YES	NO	NO
Trauma - EMS agreement	YES	NO	NO
Landing Zone Capabilities	Agreement or capability to use air ambulance	NO	NO
EMS Transfer agreements	YES	YES	YES
Active participation in RAC as defined by RAC Bylaws or SOPs	YES	YES	YES
Disaster participation	YES	YES	YES
Performance Improvement & Data submission requirements	YES	YES	YES
Ventilator	YES	YES	No
Difficult airway kit	YES	YES	No
12-Lead capability	YES	YES	YES
Video laryngoscopy	YES	YES	No
Communication with EMS: telephone/radio with established number for EMS	YES	YES	No
Stroke - neuro on call or N-tele	24/7	NO	NO
Stroke - transfer agreement	YES	NO	NO



# *Ruminations upon Closing*



A background image of an elderly man with grey hair, wearing a light-colored zip-up jacket, sitting in a chair and holding a black cane. He has a thoughtful or slightly sad expression. The image is semi-transparent and serves as a background for the text.

We take care of all conditions

- ✧ All ages
- ✧ All hours
- ✧ All scenes

*Terry, show us the way!!!*

Terry, come back from  
the edge of the plank.....



So TERRY

A photograph of a man and a woman laughing together, their faces close together. The woman is on the left, with long dark hair, and the man is on the right, with short dark hair and a light-colored sweater. They are both laughing heartily, with their mouths open and eyes squinted. The background is a plain, light color.

Let's Hear it!



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