SAN FRANCISCO EMERGENCY **MEDICAL SERVICES AGENCY**

INTERFACILITY TRANSFERS
PUBLIC COMMENT NOVEMBER 2026

EFFECTIVE DATE: x/x/xx ***POLICY REFERENCE NO: 5030*** ***SUPERSEDES: 10/1/25***

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1. PURPOSE

1.1. Define the San Francisco EMS Agency requirements pertaining to interfacility transfers by ambulances

1.2. Establish procedures to arrange, facilitate, and track interfacility transfers

1.3. Identify appropriate level of care and method transport within the San Francisco EMS System

2. POLICY

2.1. Hospitals shall comply with all applicable Federal, State, and Local laws, regulations, and policies governing the access, treatment, and transfer of patients.

2.2. Hospitals shall develop written policies governing patient transfers and ensuring compliance with all applicable laws, regulations, and policies.

2.3. Hospitals shall have contingency plans in place to transfer patients without use of system 9-1-1 resources.

2.4. Hospitals shall develop written transfer agreements with Receiving Facilities offering specialty care services not readily available or on-site.

2.4.1. All hospitals within the City and County of San Francisco shall develop a written transfer agreement with a:

2.4.1.1. LEMSA designated Trauma Center and a Pediatric Trauma Center

2.4.1.2. Hospital that has been identified as a Comprehensive Pediatric Receiving Center

2.4.1.3. EMS designated Adult and Pediatric Burn Center

2.4.1.4. Regional referral centers for specialized pediatric care (i.e. spinal cord injury, behavioral health, and rehabilitation).

2.5. No transfer will take place without the transferring physician ensuring that:

2.5.1. The patient received an appropriate medical screening examination and medical treatment within the transferring facility's capacity that minimizes the risks to the patient's health;

2.5.2. There is a receiving physician;

2.5.3. The receiving facility has the capacity to care for the patient and has consented to receive the patient;

2.5.4. All available medical records regarding the patient's diagnosis and care have been made available to the receiving facility;

2.5.5. The patient has no emergency medical condition or has a stabilized emergency medical condition;

2.5.6. An appropriate method of transport is arranged;

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2.5.7. There will be attendance by appropriately licensed or certified personnel with the essential equipment and medications needed to ensure appropriate treatment during transport.

2.6. The sending physician is responsible for approving the category of qualifications of transporting personnel

2.6.1. Determining level of care necessary for transport will be done in accordance with Section 3.5.

2.6.2. When determining the necessary qualifications, consideration must be given to the length of time the patient is expected to be in the care of the transporting personnel, the patient's condition at the time of transfer, and the likelihood of the patient's condition deteriorating during the transport

2.6.3. When a reasonable possibility exists that a patient may deteriorate during the transport, the sending physician will require the attendance of personnel capable of caring for the patient in the event of such deterioration

2.7. The sending physician remains responsible for the patient until such time as the patient arrives at and is accepted by the intended receiving facility and receiving physician.

2.7.1. Medical control of prehospital personnel remains with the EMS Agency Medical Director and the Base Hospital Physician.

2.7.2. Prehospital personnel will not exceed their scope of practice while caring for patients during interfacility transfers

2.7.3. Registered Nurses accompanying patients on transports will operate under the medical control of the sending physician.

2.8. The primary provider of emergency response to 9-1-1 requests in San Francisco shall not do interfacility transport except when:

2.8.1. A helicopter has landed and has an unstable patient requiring emergent transport to a hospital and the pre-arranged ground transport has failed to provide service

2.8.1.1. Helicopters shall not leave the sending facility without prearranged ground transport from the landing site to the intended receiving hospital

2.8.2. A critical trauma patient requires emergent transport to a local Trauma Center in accordance with a written transfer agreement

2.8.3. An unstable patient requires emergent transport from an Emergency Department to another the sending hospital cannot, and delay in receiving such care poses an imminent threat to the patient's health (examples may include: STEMI Activation, Stroke/Large Vessel Occlusion (LVO), OB emergency, etc).

2.9. All incidents under Section 2.7 and 2.8 require an Exception Report be filed with the EMS Agency within 24 hours of the incident.

2.9.1. Responsibility for filing the report rests with the sending physician except in the case of helicopters, in which case the helicopter crew is responsible.

3. PROCEDURE

3.1. Sending hospital, under the direction of the sending physician, shall arrange for appropriate method of transportation.

3.1.1. **Non-911 Basic Life Support ambulance (BLS)** – to send stable patients between acute care facilities or to sub-acute care facilities (including home).

3.1.2. **Non-911 Advanced Life Support ambulance (ALS)** – to send stable patients that require cardiac monitoring or may require intervention that is within the Paramedic Scope of Practice and for non-life-threatening conditions.

3.1.2.1. In the event of sudden, unexpected patient deterioration the paramedic in attendance will treat the patient according to existing ALS protocols and/or Base Physician direction

3.1.3. **Critical Care Transport-Paramedic (CCT-P)** – for sending stable patients requiring continuous therapy not included in the paramedic basic scope of practice, patients who have a reasonable expectation of deterioration during the transport, or unstable patients requiring transfer for specialty care.

3.1.4. **Critical Care Transport (RN)** – for sending stable patients requiring continuous therapy not included in the paramedic scope of practice, patients who have a reasonable expectation of deterioration during the transport, or unstable patients requiring transfer for specialty care.

3.1.5. In the event a patient with an emergent medical condition is not stabilized or a patient requiring CCT level care requires immediate transport and the only available ambulance is either BLS or ALS:

3.1.5.1. The sending physician must accompany the patient (or designate a qualified individual to accompany the patient) with all essential equipment and medications.

3.1.5.2. In the rare exception a physician or qualified individual is unable to accompany a patient for a point-to-point interfacility transfer within the City and County of San Francisco limits:

- Consider Base hospital consultation, discontinue interventions and/or medications outside of the provider's Scope of Practice for a short period of time, when it would be safe to do so, and replace with in-scope alternatives if possible (e.g. temporarily discontinue ventilator and manually ventilate intubated patient, replace out-of-scope vasopressor with epinephrine drip, discontinue out-of-scope sedative and replace with midazolam IVP).
- The patient outcome may result in severe morbidity or mortality by not completing the transfer to specialty center.
- The EMS Agency Duty Officer must be notified, and an Exception Report must be submitted.

- The EMS Agency will consider forwarding the incident to the California Department of Public Health to review for an EMTALA violation. The EMS Agency will meet with Receiving Facility staff to review status as an EMS Receiving Facility.
- When the patient has not consented to or requested the transfer, the sending physician is solely responsible for the clinical decision to send the patient, and the outcome is subject to standard rules regarding clinical outcomes.

3.2. Sending hospital will transfer care to the transport personnel and provide all documentation needed to continue care of the patient at the receiving facility.

3.2.1. Transfer of care includes a verbal report to the transporting personnel from the sending physician or nurse caring for the patient at the time of transport.

3.2.2. Transporting personnel will be provided with patient information necessary to continue care of the patient and complete any required patient care reports.

3.3. Transporting personnel will assume cand continue care of patient until such time as patient care is transferred to the receiving facility staff along with all documents necessary to continue care of the patient.

3.3.1. Transporting personnel will provide advance notification via radio while enroute to the receiving facility if:

3.3.1.1. The patient is a transfer for higher level of care; and

3.3.1.2. The patient's destination is the receiving facility's Emergency Department.

3.3.2. Transfer of care includes a verbal report to the receiving facility staff assigned to care for the patient.

3.4. Patient belongings, supplies, and equipment shall only be transported with the patient in such amounts that can be safely secured in the ambulance.

3.4.1. Transport personnel will not assume responsibility for controlled substances or medications in unsealed packages.

3.5. Guidelines for determining level of care

3.5.1. The following table identifies the minimum level of care required for the type of care needed or equipment required during transport.

4. AUTHORITY

4.1. California Health and Safety Code, §§ 1797.204, 1797.206, 1797.222, 1798.170, & 1798.172

4.2. California Code of Regulations, Title 22, §§ 100066.02, 100091.01, 100091.03, 100097.02, 100111.03, & 100139

The Scope of Practice shall not exceed the limits defined under Policy 2000 for EMT and Paramedic personnel, and Policy 4070 and Section 12 and for Critical Care Paramedic (CCP).

Table 1: EMS Scope of Practice

Level of Care	**Staff**	**Patient Type**	• **Scope of Practice Includes***
Basic Life Support (BLS)	EMT	Stable *(E.g. 4 rib fracture on 4L NC O_2)*	• IV locked • O2 cannula or mask • Equipment: nasogastric tube, gastric tube, foley catheter, patient-controlled device (e.g. insulin pump)
Advanced Life Support (ALS) Paramedic	Paramedic	Stable *(E.g. non-emergent cardiac cath lab)* Stabilized May need blood pressure and respiratory, monitoring and support *(E.g. intracranial hemorrhage on clevidipine drip)*	• IV fluids (e.g. LR/NS) • CPAP. No ventilator. • Cardiac monitoring • Equipment: chest tube water seal, arterial line capped • Medications: all meds permitted in local scope of practice *except no* IV pump infusion
Critical Care (CCT – RN or CCT- CP)	CCT-RN CCT-P		• Intubated stable ventilator settings, BIPAP, high flow • Cardiac monitoring, blood pressure monitoring • Equipment (CCT-RN only): transvenous pacer, arterial line, intracranial pressure line, mechanical circulatory support (Impella®, Intra-aortic balloon pump, ECMO) • Medications: titratable IV medications
9-1-1 Advanced Life Support (ALS)	Paramedic	Same scope of practice as ALS above Patient type: stabilized patient with time sensitive emergency requiring definitive treatment. • Includes: Emergent Trauma • May include: STEMI Activation, Stroke/LVO, OB emergency	

* If medications /interventions exceed the EMS scope of practice an extended service provider (MD/NP/PA/RN) must accompany the patient.

‡ 9-1-1 EMS resources are **only** indicated when appropriate interfacility transportation is not available quickly enough for a time sensitive emergency.