EMTALA

COMPLIANCE

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In this course, we will:

- Explain the Emergency Medical Treatment and Labor Act (EMTALA)
- Review the EMTALA process
- Discuss EMTALA violations and penalties
- Understand the importance of EMTALA compliance

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Introduction

EMTALA violation settlements:

- Failure to provide medical screening examinations
- Failure to stabilize
- Inappropriate transfers
- Failure to transfer
- Failure to accept appropriate transfers

In 1987 approximately 31 million Americans did not have health insurance, and emergency departments across the country were refusing to see, or immediately transferring, patients who were unable to pay—a practice known as "patient dumping."

In response, Congress enacted the Emergency Medical Treatment and Labor Act (aka Anti-Dumping Act) to ensure **all patients receive the same emergency medical care, without discrimination and regardless of their ability to pay.**

Despite the Affordable Care Act, EMTALA provisions are still needed today. The National Center for Health Statistics reports that 31.1 million individuals of all ages did not have health insurance in 2021.

In this course, we will review key elements of the EMTALA statute and process.

Let's get started!

What Is EMTALA?

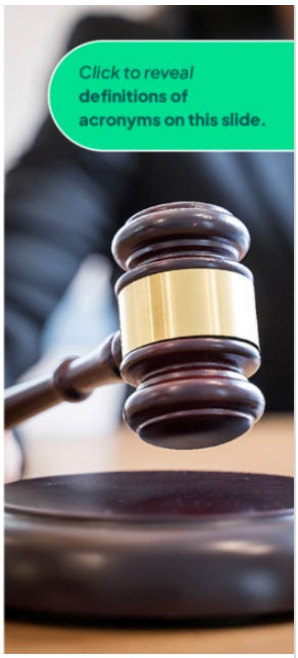
COMPLIANCE

What Is EMTALA?

History

1986	2003	2007
Congress enacts EMTALA as part of COBRA	The revised Final Rule takes effect and CMS establishes the EMTALA TAG taskforce to review regulations, offer application assistance, and solicit input from providers, investigators, state survey agencies, QIOs, and the public	TAG charter expires and some recommendations are implemented while others are left under consideration

Numerous court cases have also changed how EMTALA is applied, and CMS continues to consider revisions and updates to the statute.



What Is EMTALA?

An Obligation

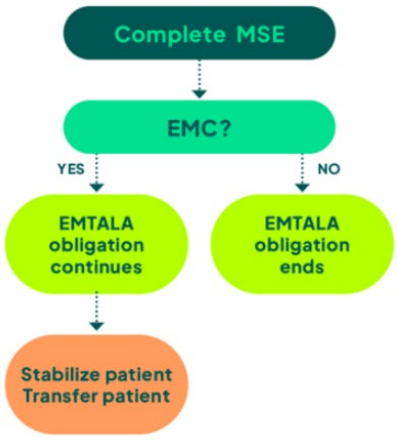
The EMTALA obligation is triggered when an individual requests emergency medical care at a **DED**, or anywhere on the hospital campus, including cancer, children's, long-term care, psychiatric, and rehabilitation hospitals.

Regardless of diagnosis, ability to pay, socioeconomic status, race, religion, disability, or national origin, the hospital is required to provide:

- An appropriate MSE by a physician or QMP
- Stabilizing treatment or an appropriate transfer if an EMC exists

EMTALA obligation ends when:

- A determination is made that no EMC exists.
- The condition ceases to be an EMC.
- The patient has been admitted to inpatient status.
- The patient has been appropriately transferred to another facility.



EMTALA Rule

The term "hospital property" means the main hospital campus (within 250 yards), the parking lot, sidewalks, driveways, and hospital departments, including buildings owned by the hospital. Off-campus facilities (i.e., provider offices) are not included.

Click to reveal **definitions of acronyms on this slide.**

Emergency Medical Condition

The term "emergency medical condition" refers to a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in::

- Placing the health or safety of the patient or unborn child in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Tip

Under EMTALA, if a minor can request an examination or treatment for an EMC, the hospital is required to determine whether an EMC exists and should not delay awaiting parental consent.

Dedicated Emergency Department

A dedicated emergency department is defined as meeting **one of the following criteria,** regardless of whether the location is on or off the main hospital campus.

DED		
Licensed by the state as an emergency department (ED), including critical access hospitals (CAHs)	Presented to the public as providing care for EMCs on an urgent basis	Provided at least one-third of services as EMC on an urgent basis in the previous calendar year

CLICK HERE TO VIEW A VIDEO ON THE EMTALA COMPLIANCE CHECKLIST.

EMTALA Tip

EMTALA obligation applies to hospital-owned/operated ambulance transports not under emergency medical service (EMS) direction or any ambulances on hospital property.

Q

What defines a DED?

a. Licensed by the state as an emergency room/department

b. Communicated to the public as a place that provides care for EMCs on an urgent basis

c. The preceding calendar year, it provides at least one-third of its visits for treatment of EMCs on an urgent basis

d. All the above

A

What defines a DED?

d. All the above

Rationale:

A dedicated emergency department must either be licensed by the state as an emergency room/department, be communicated to the public as a place that treats EMCs, or at least one-third of its visits provide treatment of EMCs or other urgent care.

EMTALA Process

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EMTALA Process

Medical Screening Exam

An MSE is an ongoing process that begins with triage and continues until a physician or QMP has determined, with reasonable clinical confidence, the presence or absence of an EMC.

An MSE may require:

- Problem-focused medical history
- Comprehensive physical examination
- Checking vital signs at regular intervals
- Any necessary lab testing or radiological imaging

- Once a patient has presented to a DED, the hospital cannot tell the patient to go to the off-site location for the MSE.
- Unless the off-campus site is already a dedicated ED (DED) of the hospital, as defined under EMTALA regulations, EMTALA requirements do not apply.
- Triage alone is not an MSE.

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EMTALA MSE Requirements

- Medical record documentation must reflect continued monitoring according to the patient's needs until it is determined whether or not the patient has an EMC.
- Hospitals and critical access hospitals (CAH) with DEDs are required to conduct an MSE on all individuals who come to the ED, including those suspected of having an infectious disease (e.g., COVID-19). EDs are expected to screen and isolate such patients and contact appropriate health officials for further instruction.
- In some cases, the MSE must be thorough enough to rule out any physical cause. For example, for psychiatric patients or patients who appear intoxicated, an MSE must rule out causes such as trauma, disease, or medication reactions.
- Hospitals must display signs with the EMTALA provision within clear view.

Qualified Medical Personnel

MSEs must be performed by a physician or nonphysician QMP working in consultation with a physician.

Nonphysician QMPs performing MSEs must:

- Act in accordance with state and hospital bylaws
- Perform MSEs as described in their job description
- Be within their scope of practice

Physicians must be on-call to back up QMPs.

Examples of QMPs include:

- Physician assistant (PA)
- Nurse practitioner (NP)
- Certified nurse-midwife (CNM)
- Certified midwife (CM)

EMTALA Rule
Medical specialty consults who provided care for an EMC must also provide outpatient follow-up care for that condition regardless of the patient's ability to pay.

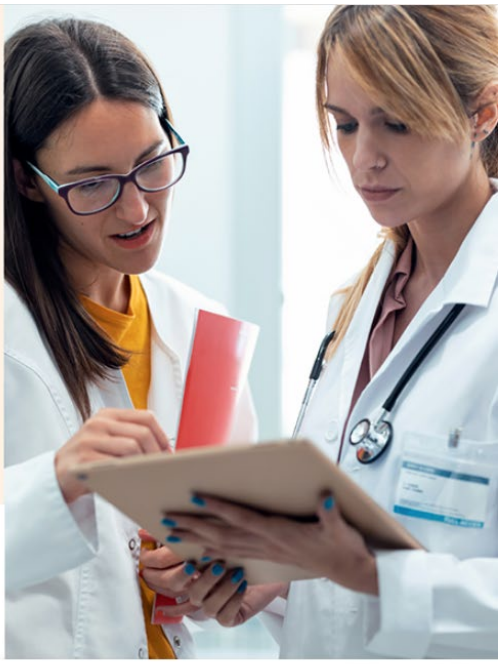
EMTALA Process

On-Call List

Hospitals must maintain an on-call list of medical staff physicians with privileges so that ED staff know which physicians, specialists, and subspecialists (e.g., neurologists), are available.

If an on-call physician fails to respond timely or come to the ED, both the physician and the hospital are in violation of EMTALA. The time the physician is notified and the response (or transfer) time should be documented in the medical record.

The hospital board of directors is accountable to ensure hospital policies meet EMTALA on-call responsibilities, and policies are typically set through staff bylaws or department procedures.



EMTALA Rule
If a hospital offers a specialty service to the public, that service should be available through on-call coverage in the emergency department.

EMTALA Process

EMC - Obstetrics (OB)

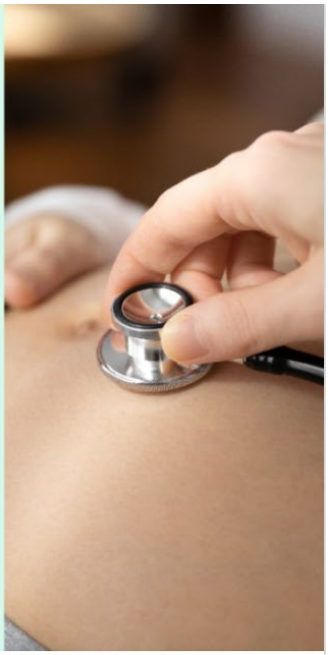
A pregnant patient having contractions has an EMC and is only deemed stable when:

- The infant and placenta are delivered.
- Contractions cease.
- A physician, certified nurse-midwife, or other QMP confirms the patient is in false labor.

Considerations for such transfers include:

- Is the patient likely to deliver before they can be transferred safely to another facility?
- Does transfer pose a threat to the health or safety of the patient or the unborn child?

CMS states a pregnant patient in labor cannot be transferred unless they or their legally allowed representative requests a transfer and a physician or QMP in consultation with a physician certifies the benefits to the patient and/or unborn child outweigh the risk of transfer.



EMTALA Process

Stabilizing Care

The EMTALA legal definition of "stabilized" means:

- No material deterioration of the patient's condition is likely from transfer of the individual from a facility or with respect to a pregnant patient who is in labor, to deliver, including the placenta.
- In other words, appropriate medical care and treatment is provided until the EMC is not at risk for deterioration or loss of life or limb.

EMTALA Rule
Of 230 EMTALA-related settlements between 2002 and 2018, psychiatric emergencies accounted for 19% of OIG civil monetary penalties. Failure to provide an MSE or stabilization were the most common citations. Settlement penalties associated with psychiatric emergencies are nearly triple compared to nonpsychiatric cases.

EMTALA Process

Appropriate Transfer

Under EMTALA, transfer must be medically necessary and the transferring hospital must make every reasonable effort to stabilize patients (including unborn infants) and minimize risk throughout transfer.

Transferring Hospital

- Sends all pertinent medical records to the receiving facility
- Provides QMP and/or transportation equipment, including medically appropriate life support measures during the transfer
- Follows other requirements as the Secretary of HHS may find necessary

Receiving Facility

- Has available space and qualified personnel to treat the patient
- Has agreed to accept the transfer and provide appropriate medical treatment
- Promptly reports (within 72 hours) to CMS or the state survey agency when it suspects it may have received an improperly transferred patient

The receiving hospital may refuse the transfer if they do not have the capacity to provide the necessary care and services.

Transfer of Unstable Patient

The EMTALA appropriate transfer rule states if an individual has an **unstable EMC,** the hospital may not transfer the individual unless:

Patient requests transfer

The hospital may transfer a patient with an unstable EMC if the individual/legal representative requests transfer in **writing,** having been informed of EMTALA rules and transfer risk.

EMC requires specialized care

Hospitals with specialized capabilities or facilities (e.g., burn units, trauma centers, neonatal intensive care units) are **required to accept** an appropriate transfer of a patient needing specialized care as space allows.

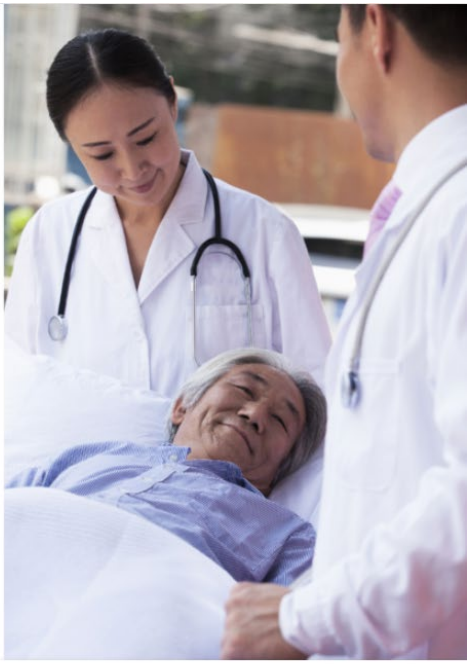
Physician legally certifies transfer

A physician (or QMP with physician cosignature) may certify transfer benefits outweigh risk.

Physician-Certified Transfer

- **Physician certifies transfer benefits outweigh risk.**
  A physician (i.e., a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which they perform such function or activity) has **certified in writing** that, based upon the information available at the time of transfer, the medical benefits **outweigh the increased risk** to the individual, and in the case of labor, the unborn child, from effecting the transfer.

- **Physician cosigns QMP certification for transfer.**
  A QMP signs the certification form in consultation with a physician who is not physically present in the emergency department at the time the patient is transferred. The physician must cosign the certification form.



EMTALA Process

Refusal of Care or Transfer

An individual, or person acting on behalf of the individual, may refuse further medical exam, treatment, or transfer to another medical facility.

In such instances, under EMTALA, the hospital must:

- Inform the individual or their representative of the risks and benefits of the examination, treatment, or transfer
- Take all reasonable steps to secure **written informed consent** from the individual or representative refusing care

EMTALA Tip
Moving a patient between hospital departments (e.g., ED to radiology) or facilities that have the same Medicare provider number is usually not considered an EMTALA transfer. However, hospitals should have written protocols for movement, especially for nonpatients who suffer problems on hospital property.

Matching Exercise

Match the terms with the descriptions.

RESET SUBMIT

MSE	Exam to establish presence of an emergency medical condition
EMC	Condition with qualifying acute, severe symptoms
Triage	Does not fulfill medical screening exam requirement
QMP	Physician, physician assistant, nurse practitioner, etc.

EMTALA Enforcement

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Violation and Penalties

A single occurrence of noncompliance with the EMTALA requirements constitutes a violation and is sufficient for an adverse recommendation. CMS reviews all EMTALA complaints. If a complaint appears to be valid, CMS refers the case to the QIO to investigate.

If the EMTALA violation is proven:

1. CMS initiates the process to terminate the hospital's Medicare provider agreement.
2. To avoid termination, the hospital must submit a corrective action plan (e.g., staff education and training) to CMS within 23 days.
3. The hospital and its corrective action plan may be monitored for 90 days to ensure implementation of the policy and procedure changes necessary to comply with EMTALA.

There is a two-year statute of limitations for civil enforcement of any violation.

Penalties

If the OIG/QIO investigation determines an EMTALA violation has occurred, a fine may be imposed.

Fines are:

- Up to $25,000 per violation for hospitals with fewer than 100 beds.
- Up to $104,826 per violation for hospitals with 100 beds or more
- $50,000 per violation for individual physicians, including on-call physicians

These fines are NOT covered by malpractice insurance.

Hospitals may be sued for personal injury in civil court under a "private cause of action."

A receiving facility, having suffered financial loss as a result of another hospital's violation of EMTALA, can bring suit to recover damages.

In very rare instances, hospitals and physicians have been terminated from Medicare because of EMTALA violations.

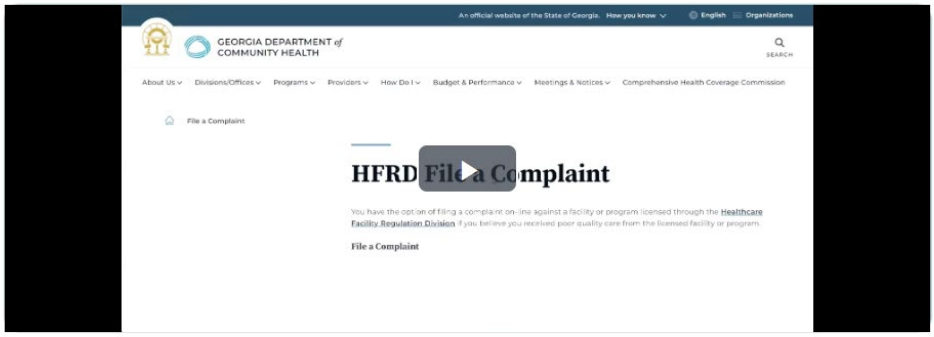
Common Violations

The Supreme Court has ruled no improper financial motive must be proven to find a hospital in violation of EMTALA.

Settlements have been for violations of:

- Failure to screen for an EMC
- Failure to stabilize a patient with an EMC
- Inappropriate transfers of a patient with an EMC
- Failure to transfer a patient with an EMC
- Failure to accept appropriate transfers

Penalties have been up to three times higher for psychiatric and labor- and OB-related citations than for those outside these parameters. (Psychiatric, labor and OB-related patient-dumping complaints account for 36% of all settlements prior to 2019).



Q & A Exercise

Which potential penalty is NOT associated with EMTALA violations?

1. Monetary fines

2. Imprisonment

3. Termination of Medicare provider agreement

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Q & A Exercise

Which potential penalty is NOT associated with EMTALA violations?

2. Imprisonment

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EMTALA Exceptions

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Helipad Use

There are a few exceptions in which EMTALA is not triggered or waived.

Two of these involve helipad use:

EMTALA is not applied when a hospital's helipad is used by an ambulance service or other hospital to transfer an individual to a tertiary hospital, as long as an MSE was performed prior to transporting the individual to the helipad.

If as part of the EMS protocol a helicopter evacuation is activated, the hospital with the helipad does not have an EMTALA obligation if they are not the recipient hospital.

However, EMTALA obligation is triggered when:

- An MSE was not performed prior to transporting the patient to the helipad.
- The patient's condition deteriorates while on the helipad, and medical personnel accompanying the individual request another MSE.
- A request is made by EMS personnel, the patient, or a legally responsible person acting on behalf of the patient for examination or treatment of an EMC.

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EMTALA Exceptions

Major Disaster or Public Health Emergency Waiver

When the president has declared a major disaster or emergency **and** the secretary of HHS has declared a public health emergency, the secretary can determine that a waiver of sanctions is necessary for some hospitals in the emergency area or only hospitals in a portion of the emergency area.

EMTALA sanctions may be waived during the national emergency period for:

- An inappropriate transfer
- Direction or relocation of a patient to receive an MSE
  - At an alternative location pursuant to an appropriate state emergency preparedness plan
  - In the case of public health emergency involving a pandemic infectious disease, pursuant to a state pandemic preparedness plan

EMTALA Exceptions

Major Disaster or Public Health Emergency Waiver

To qualify for an EMTALA waiver, a hospital must implement its disaster protocol and notify CMS it has done so. Under a state of emergency, the waiver only waives EMTALA sanctions for 72 hours from the time the hospital implements its disaster protocol.

If a public health emergency involves a pandemic infectious disease, the wavier will be in effect until the termination of the declaration of the public health emergency.

EMTALA Tip
An EMTALA waiver does not apply to actions brought by individuals or hospitals who allege harm due to EMTALA violations, nor does it waive sanctions for individual physician or receiving hospital if they have capacity to treat the patient.

EMTALA Violation Examples

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EMTALA Violation Examples

An elderly man arrived at a university hospital emergency department by ambulance. He was complaining of severe jaw pain following a physical assault. His information was not entered into the ED log. He did not receive an appropriate MSE or stabilizing treatment and died in the waiting room.

The hospital agreed to pay a $50,000 fine.

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EMTALA Violation Examples

A middle-aged man presented to the emergency department. He appeared intoxicated and smelled of alcohol. The man was confused, had slurred speech, and was unsteady on his feet. He was belligerent and had vomit all over himself. He wouldn't give his name, and staff were unable to identify him. The nursing staff determined his vital signs were stable, but did not provide a medical screening exam. Instead they sent him to the homeless shelter in a taxi cab without bringing the case to the attention of the emergency room physician.

The man lost consciousness in the cab and was brought back to the hospital by paramedics, where it was determined he had a depressed skull fracture and a large subdural hematoma. While waiting for neurosurgical consultation and surgery to decompress the intracranial bleed, he went into cardiopulmonary arrest and died.

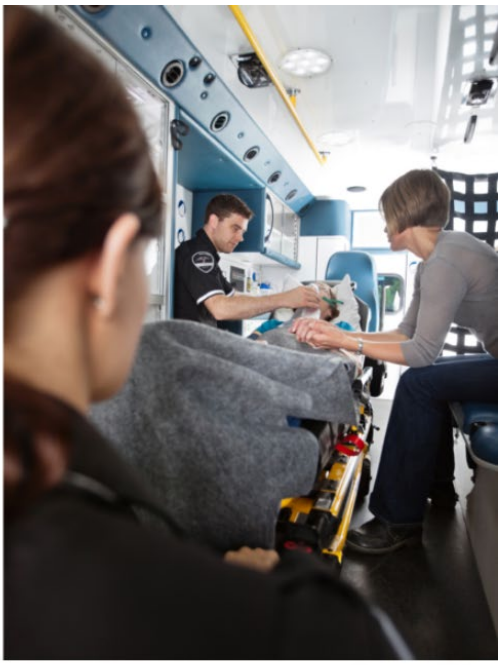
Lab results that became available after his death showed his blood alcohol concentration was 0.07%.

The hospital was found in violation of EMTALA and fined $50,000.

EMTALA Violation Examples

A possible sexual assault victim arrived by ambulance to the emergency department and was sent to another hospital without screening. There was no evidence in the medical record that the receiving hospital was notified or had agreed to accept the patient.

The transferring hospital was fined $25,000.



In Conclusion

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In Conclusion

This course provided an overview of the EMTALA statute and its provisions. We discussed the process involved in MSEs to determine whether or not an EMC is present and appropriate transfers. The course also covered EMTALA violations and penalties.

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Course Completion

Congratulations

You have now finished the course. Please close the window and exit to complete the postcourse quiz.

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Area/ Department	Transfer Center
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Tags	Guideline

MHC Acute Care Transfers

Purpose

The purpose of this policy is to define the process for acute care transfers into and out of Munson Health Care (MHC). This guideline is for internal use only. It will be used to facilitate education and serve as a resource for staff facilitating transfers to and out of any MHC Facility.

Guidelines

Consultation

A. All acute care pediatric (except neonatal) and adult patient (except Rehab and long term care) transfer requests into, within and out of any MHC facility must be initiated through the Transfer Coordinator at MHC - Patient Placement and Transfer Center. The Transfer Coordinator can be contacted at (231) 392-0777.

B. All requests for consultations for any specialty services not available at the requesting site, must be imitated through the Transfer Coordinator at MHC - Patient Placement and Transfer Center. The Transfer Coordinator can be contacted at (231) 392-0777.

Transfer Coordinator Receives Call

A. The Transfer Coordinator is to be prepared for all calls and have a working knowledge of current bed and staffing status. The Transfer Coordinator gathers basic information related to the request and documents details in TCIQ software. Calls are received on a recorded line and available to be linked via Call Copy software to each transfer case file by the transfer coordinator.

B. Based on acuity and current location, information needed to begin transfer process includes:

1. Provider and facility name, requesting the transfer and a return phone number.
2. Is this a Trauma, ST-Segment Elevation Myocardial Infarction (STEMI) or Stroke tissue plasminogen activator (tPA)?
3. Is physician or specialty being requested available?
4. Current Diagnosis?
5. Does the patient need an intervention? Procedure or surgery needed?
6. Will the patient need/possibly need an Intensive Care Unit (ICU) level of care?
7. Telemetry needed? Respiratory/ventilator support required?
8. If a recent procedure was performed - who performed it and where?
9. Other major active problems/co-morbidities present?
10. Is the patient already an established patient of the specialty service being requested?

C. **Transfer Coordinator Immediately Assesses Bed/Staff Availability - If Unable to Meet Transfer Need**

1. Bed/staff availability will be assessed using the capacity bed board in Pre-Admit Tracking. If a bed is not available or necessary specialty is not on call for services, the Transfer Coordinator may re-direct the transfer to another facility after conferring with the Administrative Supervisor. The Administrative/Nursing Supervisor will follow the escalation process and contact the Chief Nursing Officer (CNO), Chief Medical Officer (CMO), and/or Administrator on-call for transfer refusals due to bed capacity. Refusal details are documented in TCIQ and will include any institutional and/or physician refusal reasons. The Hospitalist (HNM) group is always on-call unless they have contacted the Transfer Coordinator/Administrative Supervisor in advance and stated they are at capacity. If bed capacity is a temporary situation, the patient is stable and can wait at the current facility, they will be transferred as soon as a bed becomes available. Unstable patients may be brought to the Emergency Department (ED), when capacity is not exceeded. This decision will be made jointly by the Administrative Supervisor, Transfer Coordinator, and ED Physician.

D. **If Bed Available, Transfer Coordinator Contacts Specialty Physician for a Conference Call with the Referring Physician**

1. The Transfer Coordinator finds out if the transferring physician/staff wants to hold or be called back when the MHC physician responds. If they prefer a call back, the Transfer Coordinator obtains their callback/pager number.

Stable Transfer

A. The MHC physician/provider is paged; the page is repeated every 10 minutes until the physician responds.

B. If there is no response after two attempts, the switchboard will be contacted to reach the physician via an alternative route (cell, office, home).

C. If there is no response within 20 minutes of switchboard contact, the section chief or department chairman will be paged. The CMO and/or the administrator on-call may also serve as a resource as needed.

Unstable Transfer

A. The Munson Medical Center (MMC) physician is paged; the page is repeated every 5 minutes until the physician responds.

B. If there is no response after two attempts, the switchboard will be contacted to reach the physician via an alternative route (cell, office, home).

C. If there is no response within 20 minutes, the section chief or department chairman will be paged. The Vice President (VP) of Medical Affairs and/or the administrator on-call may also serve as a resource as needed.

D. When the MMC physician responds the Transfer Coordinator initiates a conference call with the transferring physician/facility. The Transfer Coordinator will remain on the line for the duration of the call to answer questions and remain informed of transfer needs. Details are then documented in TCIQ software. The MMC physician may elect to have the patient sent over without a conference call; although, transferring physicians appreciate speaking to a physician prior to a patient transfer.

Transfers Directly to a Unit or Service

A. Once transfer is accepted, the Transfer Coordinator or Admitting Representative pre-registers the account in STAR and assigns a bed number in Pre-Admit Tracking. The Transfer Coordinator gives unit phone number to the sending facility for a nurse to nurse report. The Transfer Coordinator sends a text page to the accepting physician, via TelmedIQ, with the estimated arrival time (ETA).

ED to ED Patient Transfers

A. If the specialist has accepted the patient for admission and plans to see the patient in the ED, the Transfer Coordinator notifies the ED charge nurse via Teams chat and sending copy of the TCIQ record to the ED printer. The specialist is listed as the "accepting" physician.

B. If the specialist is available but wants the ED physician to see the patient first, the Transfer Coordinator calls the ED physician, documents details in Transfer Center and notifies ED charge nurse by sending a copy of the TCIQ record to the ED printer. The ED provider is listed as the "accepting" physician.

C. If the specialist is available to see the patient but is not sure if patient will need his/her service as the primary service, the Transfer Coordinator offers to connect the specialist and the ED physician on the phone at the request of either physician. The Transfer Coordinator then offers to connect the ED physician with the referring physician from the other institution. The ED physician becomes the 'accepting' physician for the purpose of transfer.

D. **If no specific specialty is identified or a specific specialty needed is unclear, the transfer coordinator will refer the case to the ED physician. The ED physician will determine the need for a conversation with the transferring ED physician and/or any given specialty. The ED**

physician is listed as the 'accepting' physician.

E. Note: Patients with some emergencies (e.g. intra-abdominal bleeding/ruptured aortic aneurysm) and those that are critical and need to stabilized, must be met in the ED by the specialist. In addition, patients transferring to the Intensivist are never brought to MMC ED prior to the Intensivist speaking to the referring physician. The Intensivist may choose to admit directly to the unit or to the ED depending on the patient's needs.

F. **If the ED physician is concerned about available services or believes the ED is at capacity and should not accept a transfer, his/her concerns need to be addressed immediately. The Administrative Supervisor, Administrator on call are to be notified immediately and a determination will be made.**

G. The Administrative Supervisor and Administrator on call will review the case involved and work with the administrator on-call for final decision. The decision to reject a transfer, which would seem to be appropriate given the resources available and specialties on-call, or to 'close the hospital to transfers' for any given time, must be made with the involvement and full knowledge and support of the administrator-on-call AND the medical director for system transfers/director of the transfer center. See the Admission and Staffing Plan During Maximum Capacity policy.

High Risk Maternal Transfers

A. Obstetric (OB) transfers with gestational age of 22 weeks - 35 6/7 weeks shall be determined to be high risk.

B. The Transfer Coordinator will page and assemble the following for the transfer call with the referring provider: OB Hospitalist, OB Patient Care Coordinator (PCC), Neonatal Intensive Care Unit (NICU) On Call Provider, and the NICU PCC for coordination of transfer.

Trauma Transfers

A. The Transfer Coordinator will page the Trauma Surgeon and Trauma Physician Assistant (PA) on-call. The Transfer Coordinator will wait up to 5 minutes; if no response they will re-page. If no response, after second attempt, the Transfer Coordinator will then page the back-up trauma surgeon. The referring physician, MMC trauma surgeon and the trauma PA will be connected for a group conference call. The Transfer Coordinator will notify the MMC ED charge nurse of transfer acceptance via telephone and send copy of the TCIQ record to ED printer. The MMC Trauma Surgeon may be unable to accept the transfer if resources are not available to provide appropriate care. The Transfer Coordinator will offer to connect the sending facility with another acute care hospital to facilitate the transfer.

STEMI Transfers

A. The transfer Coordinator will follow the STEMI Alert Transfer Coordinator Checklist Guidelines.

Transport Arrangements

A. The Transfer Coordinator will make ***all acute care ground*** transportation arrangements and documents details in TCIQ. When air transport is requested, the sending ED will call the

AeroMed flight communications center directly for emergent helicopter transfers. This only applies to ED patients. Inpatient transfers needing flight transport will be arranged by the Transfer Center

B. The referring provider will identify either air or ground transport. If air is not an option, due to weather or availability, then a ground crew with a higher skill level will be considered. Referring provider will also determine if the patient requires a STAT or a non emergent transport.

C. Transportation via Privately Owned Vehicle (POV) for convenience or preference must be communicated by the referring provider prior to the patients departure.

D. Once transportation is arranged, the Transfer Coordinator will text page the patient's ETA to the accepting physician via TelmedIQ.

E. If and when there are additional transportation needs identified, such as HFNC or BiPap for safe transportation, these should be identified via clear communication between the accepting and the sending providers. This information will be relayed to the EMS services to ensure they are able to accommodate the clinical needs of the patient.

Patient Information

A. The Transfer Coordinator requests the following information via fax request form to be sent with the patient:

1. History & Physical, Progress Notes, Discharge Summary, ED Note, Consultation notes, Radiology Images & Reads, Nursing Documentation & Face Sheet not available to MMC via PowerChart.
2. Transfer coordinators will reinforce the requirement of these documents for all transfers into MHC from non-MHC facilities - this is to ensure safe care transitions.

Data Collection

A. All transfer details are documented in TCIQ in real time whenever possible; otherwise, they are transcribed as soon as possible.

Hand-Off Communication

A. A nurse-to-nurse report is expected prior to transferring the patient. The Transfer Coordinator will provide the transferring facility a number to call report. It is recommended that the report follow the SBAR format.

B. Any change in clinical condition of the patient must be communicated prior to the transfer as this could influence level of care determination and specialty services involvement in the care.

Bed Assignment

A. If it is determined the patient will go directly to an inpatient-nursing unit, the Transfer Coordinator assigns a bed in Transfer Center/Pre-Admit Tracking. If the patient is to go to the ED and the unit they will be placed is known, a bed assignment may be obtained at the time of the transfer request, but the bed assignment will not be communicated to the transferring facility.

Document ID: 070.G025

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	4/2/2025
System Transfers Steering Committee	Michael Frye: Interim Chief Medical Officer - East Region	3/31/2025
Document Owner	Lisa White: Sys Dir MHC Transfer Center	3/25/2025

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, MHC Corporate (Home Health, Dialysis, NMSA, etc.), Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

Status Active PolicyStat ID 15416865

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Next Review	11/25/2028

Owner	Joseph Santangelo: Chief Medical Quality & Safety Officer
Area/ Department	Medical Staff
Applicability	MHC Hospital System w/KMHC (MMC, Cadillac, Charlevoix, Grayling, KMHC, Otsego, Manistee, POMH)
Tags	Guideline

Transfer of Patients within Munson Healthcare for Diagnostic Procedures

Purpose

To define the process of transferring patients between Munson Healthcare (MHC) facilities for the purpose of diagnostic studies only.

Scope

Munson Healthcare (MHC) has adopted this policy for all of its subsidiaries, including but not limited to Munson Medical Center (MMC), Munson Healthcare Cadillac Hospital (CAD), Munson Healthcare Charlevoix Hospital (MHCH), Munson Healthcare Grayling Hospital (GRY), Munson Healthcare Manistee Hospital (MHMH), Munson Healthcare Otsego Memorial Hospital (OMH), and Paul Oliver Memorial Hospital (POMH). Kalkaska Memorial Health Center (KMHC) has also adopted this policy. MMC, CAD, MHCH, GRY, MHMH, OMH, POMH and KMHC are each a “hospital” as used in this policy.

Policy

All patients being transferred within MHC for the purpose of obtaining diagnostic studies must be initiated and facilitated by the MHC Transfer Center.

Procedure

A. Providers at a MHC hospital can arrange for the transfer of patients to another MHC facility to undergo diagnostic testing or studies according to this policy. This policy shall also govern the return of the patient to the MHC facility which made the request for diagnostic testing or studies.

1. **Transfer of Inpatients during Radiology Department routine business hours**
    a. During regular business hours, inpatients may be transferred directly to another MHC Radiology Department for diagnostic or therapeutic procedures facilitated by the MHC Transfer Center in accordance with established process.
    b. If there are any labs required for the procedure the referring provider will enter the labs to be done prior to transfer.
    c. The Transfer Center Coordinator will reach out to the MHC Radiology scheduler to set up date and time for the procedure and then update referring site.
    d. The Transfer Center shall arrange for transportation utilizing an appropriate EMS provider. EMS is to stay with the patient through the procedure and return the patient to the referring hospital, unless complication result requiring the patient to remain at the facility performing the procedure.

2. **Transfer of Unstable Emergency Room [TB1] (ER) Patients**
    a. Transfers of emergency department (ED) patients who have an emergency medical condition that is not stable to another MHC facility for diagnostic testing or studies not available at the hospital (either generally not available or not presently available) should be done at all times in compliance with and consistent with Emergency Medical Treatment & Labor Act (EMTALA) requirements and the MHC EMTALA/Physician On Call Policy. Such transfer will only be appropriate when requested by the patient or when a physician, or other qualified medical personnel, certifies in writing that the benefits of the transfer outweigh the risks of transfer.
    b. Under these circumstances, the physician seeking to transfer the patient to another MHC facility for diagnostic testing or studies will contact the MHC Transfer Center that will then assist in the coordination of the requested transfer. The Transfer Center will confirm that the receiving facility has space and personnel to receive the transfer and facilitate a provider to provider conversation that establishes a plan and authorized agreement by the receiving facility to accept the transfer. There should be limited circumstances where an MHC facility is unable to receive a transfer of this nature.
    c. Prior to any such transfer, medical treatment within the capability of the facility must be provided that will minimize the risk to the patient. All records related to the emergency medical condition for which the person

presented must be provided to the receiving facility and the transfer must done by qualified personnel with the appropriate equipment.

d. Once the patient is received by the other MHC facility, clinical responsibility and administration of appropriate care will then be assumed by the receiving physician.

e. Transfers back to the original facility do not need to be conducted in compliance with EMTALA requirements and the MHC EMTALA policy.

f. The receiving facility shall communicate (e.g., telephonic report or documentation within the medical record) with the transferring hospital its findings of the medical condition and a status report of the individual during and after the procedure.

3. **Special Circumstances/Radiology Downtime**

a. In the event of a radiology downtime at an MHC facility, both ED patients and admitted inpatients may be transferred to another facility to undergo the ordered radiology study and then return to the originating facility. This does not apply to POMH, MHCH, and KMHC.

b. The physician or APP caring for the patient will place the order for the radiology study in the electronic medical record.

c. EMS transport will be requested and arranged by the sending facility through the Transfer Center.

d. Communication will be made between the on-duty supervisors at the sending facility and the receiving facility to coordinate with the radiology department of the receiving facility.

e. The patient will remain a patient of the sending facility under the care of the original physician or APP for the entire duration of the radiology transfer. There is no need for an accepting physician at the receiving facility where the radiology study will be performed.

f. The patient will be registered as an outpatient at the receiving facility and undergo the ordered study.

g. EMS will remain with the patient as the patient receives the radiology study and transport the patient back to the original facility. Local medical control authority protocols shall be in effect while the patient is in the care of EMS.

h. Should there be a change of condition of the patient necessitating emergent evaluation while receiving the radiology study, the patient shall undergo evaluation at that facility's ED and care will be assumed by the ED physician or APP at that facility.

i. In the case of a critical time-sensitive radiology finding called to the ordering clinician, it may be prudent to have the patient diverted to the ED of the facility where the radiology study was performed based on clinician discretion. The ordering clinician will contact the emergency physician or APP at that facility to discuss the patient case and care will be assumed

by the receiving facility emergency physician or APP. The patient will then become a patient of that ED. If transfer to a higher level of care is necessary, this will be initiated through the MHC Transfer Center per the usual procedure.

j. Certain conditions will necessitate immediate transfer of a patient to a higher level of care prior to performing any radiology studies. This is upon the discretion of the treating clinician. For these cases, transfer will be initiated through the MHC Transfer Center.

General Considerations

The day of transfer: Transfer Coordinator will send an FYI page to the entity hospitalist and surgical group on call to advise of planned over and back procedure. If the patient experiences a medical emergency during the procedure, an MRT or code will be called, and care will be escalated appropriately with intervention and admission to the appropriate service if warranted.

Approval Signatures

Step Description	Approver	Date
System Policy Oversight Committee	Terri Fries: Document Mgmt Spec	11/26/2025
Provider Leadership Council	Joseph Santangelo: Chief Medical Quality & Safety Officer [AO]	11/26/2025
Med Staff Leads (MEC)	Nicole Karbginsky: Sr Spec Lead Med Staff Services SNE - East Region	9/18/2025
Med Staff Leads (MEC)	Jennifer Mathews: Sr Spec Lead Med Staff Services SNE - Central Regi	8/18/2025
Med Staff Leads (MEC)	Kimberly Loveland: Sr Spec Lead Med Staff Services SNE - South Region	7/29/2025
Med Staff Leads (MEC)	Teresa Smith: Coord Medical Staff Services	7/10/2025
Document Owner	Joseph Santangelo: Chief Medical Quality & Safety Officer [AM]	6/30/2025

Applicability

Cadillac Hospital, Charlevoix Hospital, Grayling Hospital, Kalkaska Memorial Health Center, Manistee Hospital, Munson Medical Center, Otsego Memorial Hospital, Paul Oliver Memorial Hospital

Standards

No standards are associated with this document

To start: March 9th 2026

1. D6 staff will update the D6/CAC MMC group Teams Chat daily confirming staffed bed capability and # of planned discharges. D6 team will also update the chat when/if there are any changes in capacity capability.
2. Transfer Center receives request for D6 admission from any ED screener (Provider, CMH, CAC worker)
3. If there is a D6 bed available, Transfer Coordinator will create a case in TCIQ identifying the following information:
    a. Diagnosis/Symptoms - Reason requiring inpatient psychiatric admission
    b. Voluntary/Involuntary
    c. Guardian?
    d. Jail Hold?
    e. Behavioral issues/outbursts?
    f. Medically cleared Y/N
    g. Significant chronic health issues
    h. Ambulation (Independent, wheelchair, walker, cane)
    i. Recent use of drugs/alcohol?
    j. Presently intoxicated?
    k. Withdrawal symptoms
    l. CMH or insurance auth?
4. Transfer Center request CMH screen and the legal paperwork be sent via RightFax to #231-213-8725
5. Transfer Center Pages Admitting Psychiatrist via Perfect Serve notifying of request for admission- No need to wait for paperwork to be faxed
6. Admitting psychiatrist reviews information and either accepts, declines, or asks for more information.
7. Next Steps for transfers from Hospitals **outside of Munson Medical Center**
    a. Patients accepted for admission to D6
        i. Transfer Center notifies Admitting Team via the TC Admitting Teams Chat of patient acceptance to D6 for account creation. Information in the chat should include originating site, accepting provider, and admitting diagnosis
        ii. Admitting team creates PRT
            1. Notifies Transfer Center when PRT completed via Teams Chat
            2. Pages Admitting provider to notify account is completed – *At this time, provider may enter orders*
        iii. Transfer Center notifies D6 PCC and confirms bed number assignment
        iv. Transfer Center notifies ED Screener of acceptance providing bed number and nurse to nurse report number
        v. Transfer Center coordinates transportation
            1. *If patient was picked up and taken to the ED by law enforcement, law enforcement will transport to Munson Medical Center

vi. Transfer Center to update the referring ED of EMS transport ETA via the referring hospital's Teams Chat
vii. When patient leaves facility – Transfer Center to notify D6 in chat of ETA

b. Declined patients

i. Transfer Center documents reason for decline **and** notifies referring ED/CAC/CMH staff of decline. Transfer Coordinator to offer to connect the ED provider with Psychiatrist for consultative needs if desired
ii. Psychiatrist will also document in Powerchart reason for decline

c. Patient's that Psychiatrist has requested more information

i. Transfer Coordinator requests additional information from referring provider/CMH/CAC worker
ii. Psychiatrist and Charge nurse review concerns (medical / behavioral acuity)
iii. Psychiatrist or D6 PCC notifies Transfer Center of decision to admit
iv. If declined, follow directions under section b.

For Munson Medical Center ED/And or Crisis Access Center accepted admissions to D6

Communication continues in the D6 TC Teams Chat.

CAC/CMH CMH works directly with the Psychiatrist and the D6 PCC/Charge

CAC/D6 PCC notify Admitting Team of acceptance

Once Admitting has completed the registration the account will show up on the TeleTracking ED direct admit tab

Transfer Coordinator then

- Confirms bed number from D6 PCC
- Select the "Ready to Admit" icon on the tracking board and writes the bed number in the comment section
- For patients located in MMC ED -Calls the ED bedside nurse to tell them of the bed information
- **For patients located at the Crisis Center** – Transfer Coordinator call 231-213-1050 to notify the Crisis Center that bed is ready and provide bed number

Admitting Team pages provider when registration is complete so that they may enter orders

EMS GUIDELINES FOR EMS TRANSPORT

When talking to the hospital about the transfer you are setting up, EMS agencies generally require the following items: (Some agencies need more than others)

General Information:

1. Location of Patient
2. Type of transport: BLS (Basic Life Support), ALS (Advanced Life Support), OB, NICU, CRITICAL CARE
3. Medical Needs:
   - 02
   - IV
   - Cardiac Monitor
   - Medications
   - Intubated/Vented
   - Trauma Equipment
   - Spinal Precautions
4. Patient airway status: Vented or Not
5. Weight of patient: Bariatric may need bariatric cot or if it is an air transport weight is needed.
6. Paperwork completed and signed by provider

BLS:

1. IV @ 250ml/hr our less
2. Albuterol
3. 02
4. IV loc
5. Suction

ALS:

1. Monitor
2. IV with pump over 250 ml/ hr
3. IVs with any kind of medication
4. Intubated on a vent
5. Central Line
6. Chest Tube
7. Heate High Flow 02 (HHHF)
8. BiPap
9. Cpap

SCT:

1. Consider the amount of medications running
   a. Propofol
   b. Fentanyl
   c. Levafed
   d. Any sedation medication
2. Vent/ Intubated
3. Typically train wreck patients
4. Always ask the provider if they would like Air for the patient vs ground when Critical Care transports especially distance out of hospital

Behavioral Health patients are a little different in needs:

1. For a pediatric patient you will need to ask if parent is riding with or following
2. Most facilities require paperwork signed by the parent for the patient to be transported by the crew if they are not going or following the ambulance.
3. The paperwork will need to be faxed to the receiving facility before transfer can leave facility.
4. Another question is finding our if patient is voluntary or certified regardless of age
5. If the patient is certified, the original paperwork must go with the crew and a copy left with the referring hospital in the patient's chart.
6. Most patients are BLS, very few are ALS

OB transport may have an OB RN go with the crew depending on the status of the patient

NICU transport will usually have a specific team that will go by ground or air. The NICU team has all their own equipment.

EMS Levels of Care

MMR MOBILE MEDICAL RESPONSE

Transfer Resources

	Basic Life Support (BLS)	Advanced Life Support (ALS)	Critical/Specialty Care Transport (CCT/SCT)
Crew Member Attending To Patient	EMT	Paramedic	Paramedic trained in critical care
Cardiac Monitor	No	Yes	Yes
IV Access	Already established peripheral IV	Yes; may establish peripheral IV or intraosseous (IO) access	Yes; may utilize central lines
IV Fluids	Saline lock or 0.9% NaCl @ KVO	All types at any rate; may adjust rate	All types at any rate; may adjust rate
IV Medications	None infusing during transport	Yes (antibiotics, pain meds, antiemetics, etc.)	Yes, including blood products and vasopressors
Oxygen	Nasal cannula or non-rebreather	Nasal cannula or non-rebreather	All modalities; high-flow nasal cannula, CPAP/BiPap, mechanical ventilator
Airway Management	BVM, oro- & nasopharyngeal, supraglottic airways available if patient decompensates	All modalities including endotracheal intubation	All modalities including endotracheal intubation
Other Devices	None	None	Chest tubes, balloon pumps, CVP monitoring, intracranial pressure monitoring
Patient Condition	Stable	Stable	Critical, guarded, potentially unstable
Priority	NON-EMERGENT	NON-EMERGENT (non-stat) or EMERGENT (stat) Patient condition dependent	EMERGENT (stat)

EMS Levels of Care

Additional Resources

Aeromedical EMS: Helicopter or Fixed Wing

Crew members include Flight RN and Flight Paramedic, both trained in critical care

Minimal out-of-hospital transport time

Have rapid sequence intubation capabilities

Fixed wing requires ground transport to & from airport, helicopter EMS does not

Always considered Critical Care Transport

Other Considerations

An RN may be sent with a BLS crew to achieve ALS status

Specialized staff such as respiratory therapy, perfusionist for balloon pumps or ECMO, pediatric RN, ICU RN, etc. can be sent on transport if felt necessary by the sending provider or may be requested by EMS crew

MMR's ventilators can accommodate patients weighing 5 kg or greater

MMR
MOBILE MEDICAL RESPONSE

TeleTracking

TRANSFER CENTER IQ QUICK REFERENCE GUIDE (QRG)

Munson Healthcare
Client # 0017899
Project: P02888

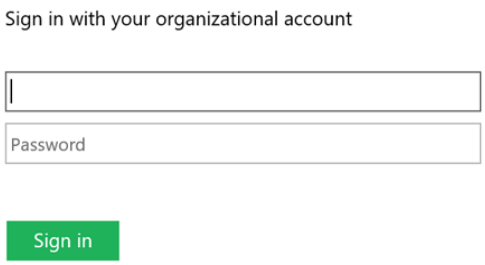
Deborah Hall, Exec. MSN, CPHQ, CNML, RN, Senior Workflow Consultant

TCIQ Version

QUICK REFERENCE GUIDE NEW CASE

1.1 LOGGING IN

1. Go to the TeleTracking Icon to log in.

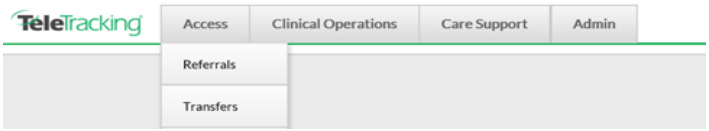


2. Type your username and password in the appropriate boxes. Use the credentials with which you normally sign in to your facility's network unless you have received an email with different instructions.
3. Select "Sign In."

➢ The page of the application that is appropriate for your role appears.

1.2 UNDERSTANDING THE TABS

1. Access – To access Transfer Center, hover over the Access tab and select "Transfers."



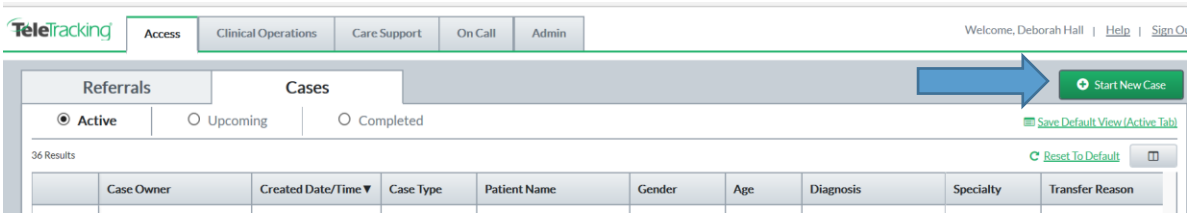
2. Admin – Only available for users with administrative rights.
3. Worklist – The Worklist will be available upon logging in. This is a representation of all open cases.

NEW CASE

2.1 CREATING A NEW CASE

A new case is initiated by telephone contact from a requesting facility to your transfer center staff. When the transfer center receives notification of perspective incoming transfers, pertinent information

including referring facility, patient name, referring physician, requested services as well as clinical and disposition is gathered and entered the application.

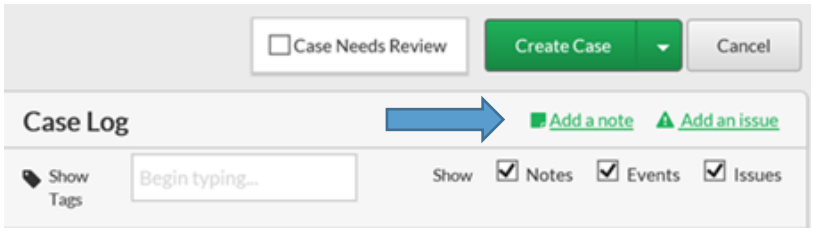


1. To begin a new case, click on "**Start New Case.**"

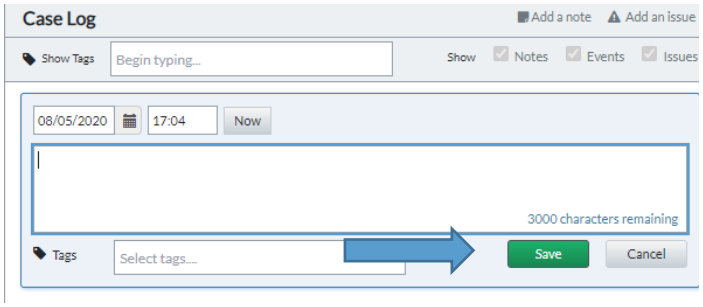
2.2 CASE LOGS

The ability for an on-going log. Also, includes all time stamps and communication within the case. Can add additional notes and make issues for any case needing further follow-up.

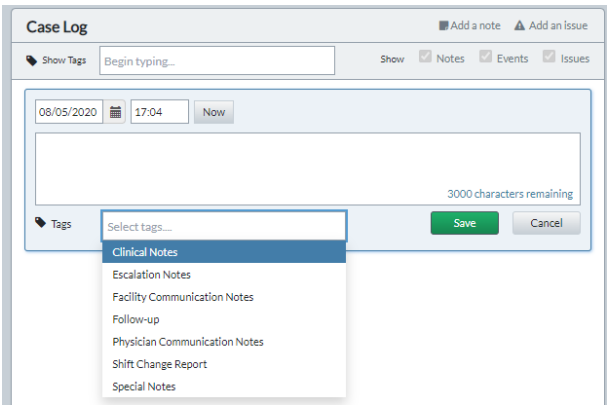
1. To add a note, click on **"Add a note."**



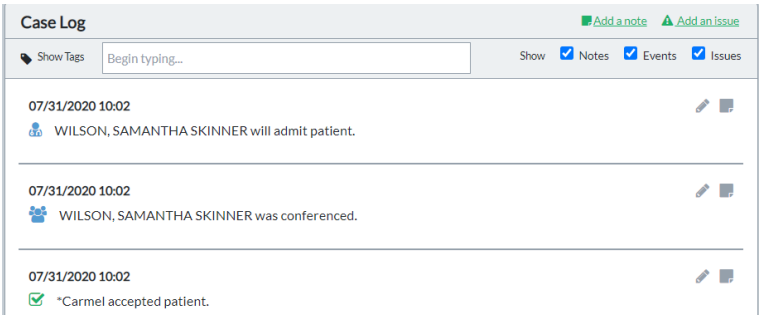
Once note text is entered, immediately click "**Save"** within the note card before navigating to another part of the patient record or application. If you need to go back and finish a note, you can always edit your note.



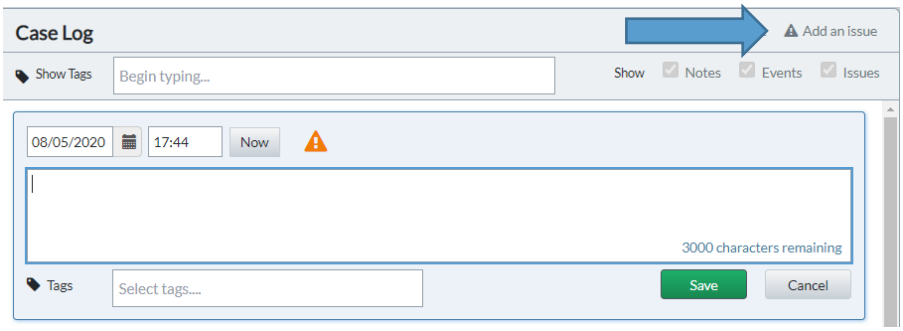
2. Notes can also be tagged for ease of reporting.



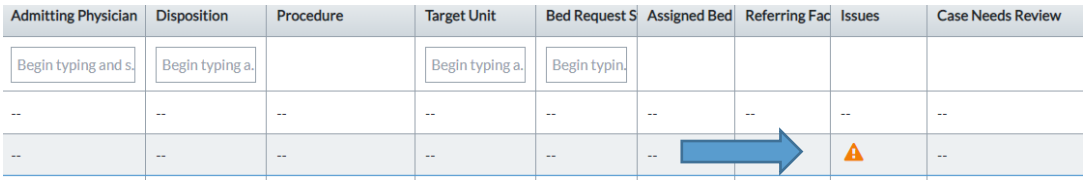
3. Notes will display after clicking "**Save.**"



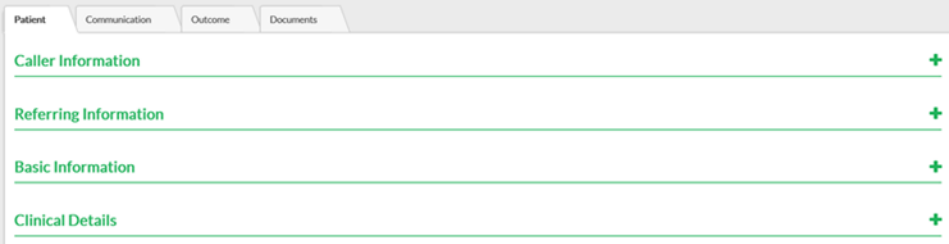
4. If there is an issue with a case, you can add an issue to show an alert in the Worklist column view. Click Save once issue notes have been entered/completed.



5. The Issue alert will show in Worklist view.



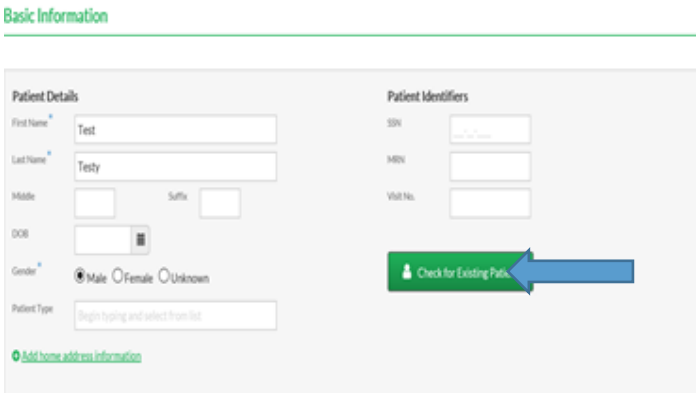
UNDERSTANDING THE TABS FROM START NEW CASE OPTION/PATIENT TAB



3.1 GENERAL INFORMATION ON PATIENT

1. Caller Information – Information on who is calling and a call back number
2. Referring Facility – Name and contact information of referring facility
3. Reason for Transfer – Reason for potential referral
4. Referring Physician – Name of Physician requesting referral
5. Basic Information – General Patient Information

Once you complete the name, DOB, and gender click "Check for Existing Patient."

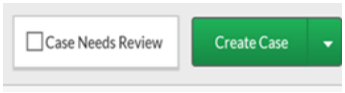


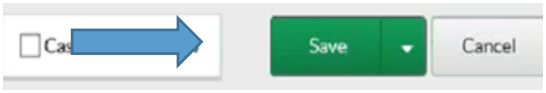
Make sure the patient identifiers match and you are selecting the correct patient from the list of choices that appear. If the identifiers do not match, do not use.

3.2 REQUIRED FIELDS TO SAVE CASE

1. Caller's Name – Information on who is calling and a call back number
2. Patient Details – First/Last Name and gender

Once Completed, click the "Create Case" and it will change to a Save Button.

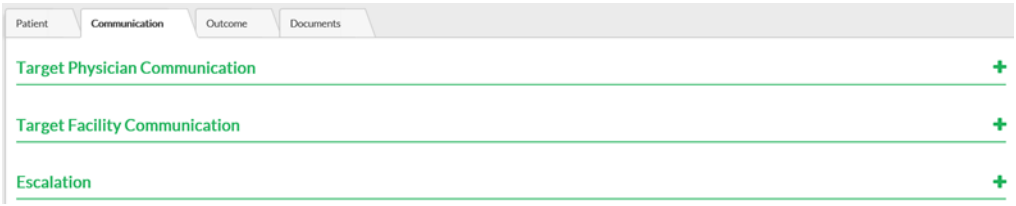




3.3 FACILITY COMMUNICATION

1. Preferred – Initial location of request
2. Destination - Facility where the patient will be transferred

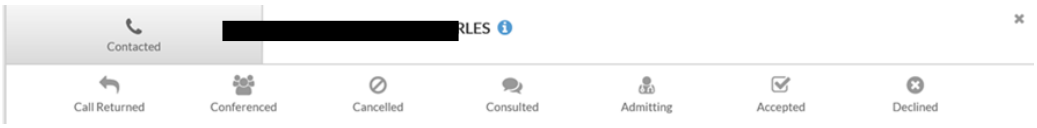
COMMUNICATION TAB



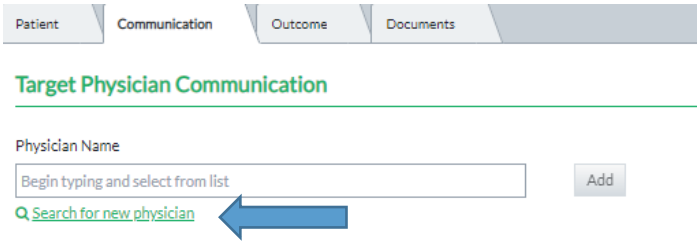
4.1 TARGETED PHYSICIAN COMMUNICATION

1. Type in the last name of the potential accepting physician and click "Add."

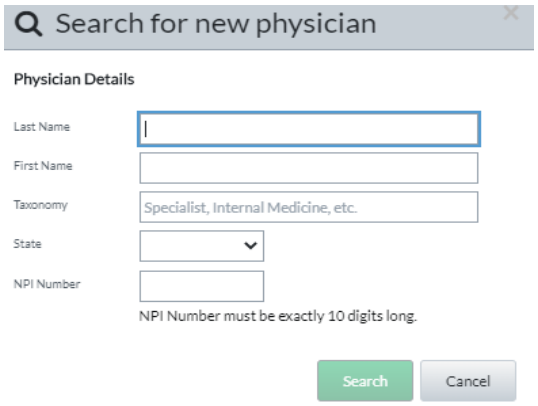
Then the below will appear:



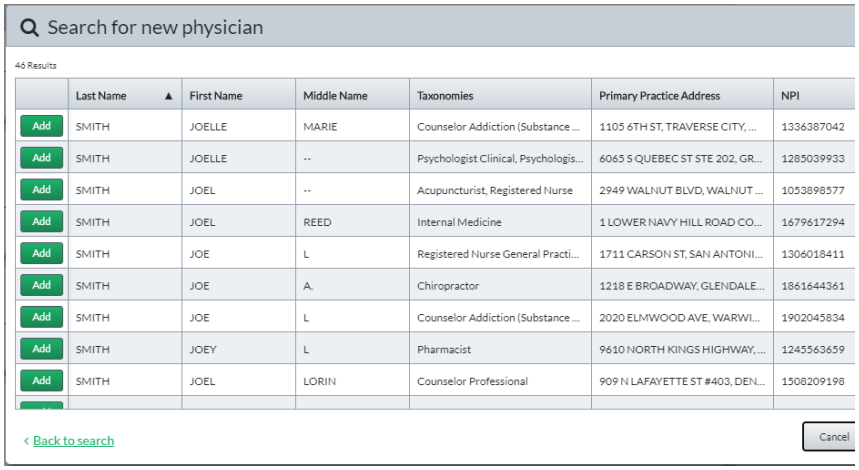
2. If the physician does not show up in the drop-down list, use "Search for new physician."



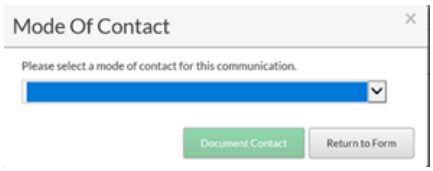
3. Physician search box will appear. This will search the NPI (National Physician Index) lookup.



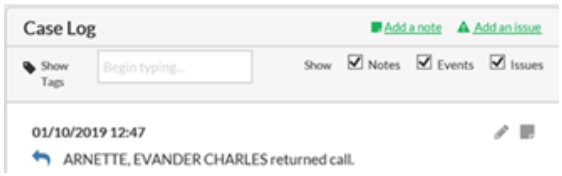
4. Type Physician last name and first name, then click Search.



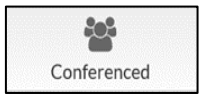
5. Click **"Add"** for the appropriate physician. The physician is now in the list of referring and targeted physicians for future searches.
6. Clicking **"Contacted"** provides a time stamp and will prompt you to select the mode of contact.

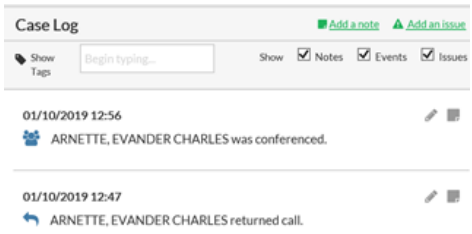


7. Click **"Call Returned"** when physician calls back. This will automatically add a time stamp and update the Case Log.

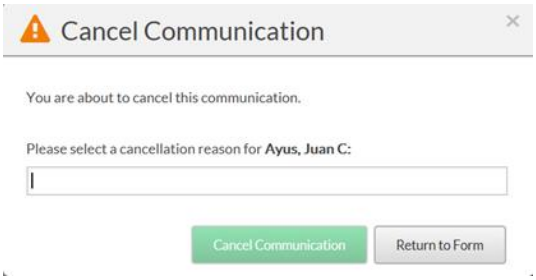


8. Click **"Conferenced"** when 3-way communication is established. This also updates the Case Log.

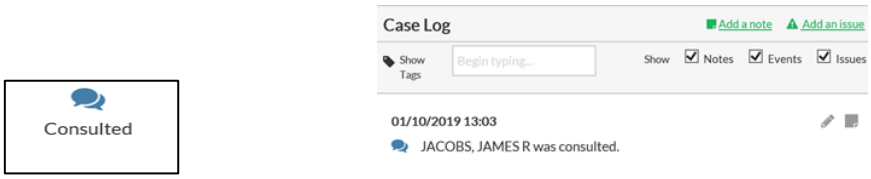




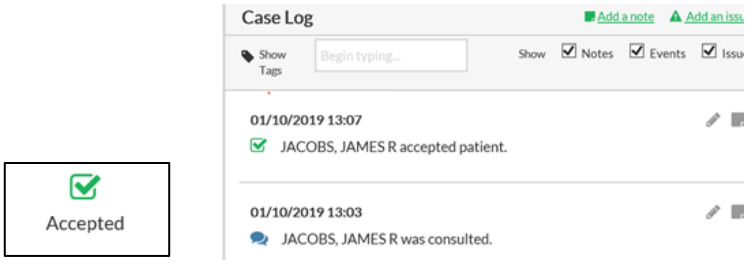
9. Clicking "**Cancelled**" will automatically prompt a reason to be documented.



10. Click **"Consult"** if the physician has agreed to consult also updating the Case Log.



11. Click **"Accepted"** if physician has agreed to accept patient also updating Case Log.

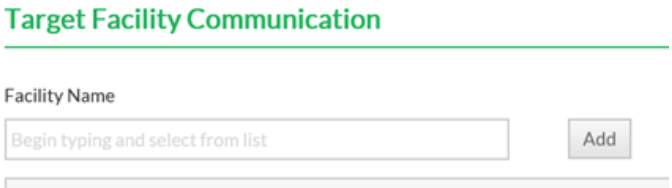


12. Clicking **"Declined"** will automatically prompt a reason to be documented.

13. Click **"Admitting"** when physician agrees to admit the patient.

Note: This action must be the last action taken for the admitting physician. If another action is chosen after "admitting", the physician's name will not cross to CMS.

4.2 TARGETED FACILITY COMMUNICATION

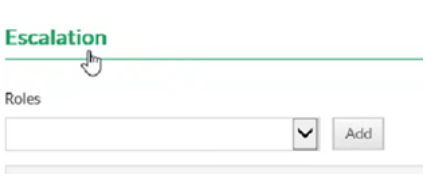


1. Type in Targeted facility and click **"Add."**

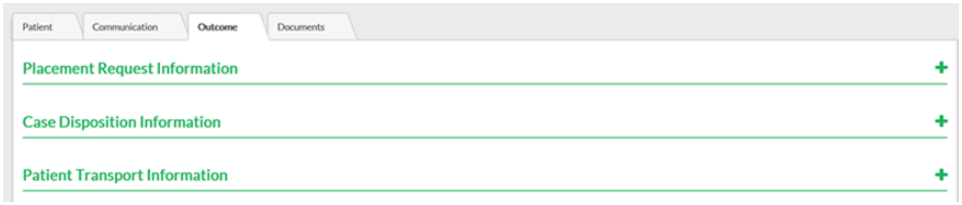
2. Click **"Contacted"** when calling facility. This will add a time stamp and update the Case Log.

4.3 ESCALATION COMMUNICATION

Gives you the ability to document communication for escalation issues. This will add a timestamp and updates the case log.



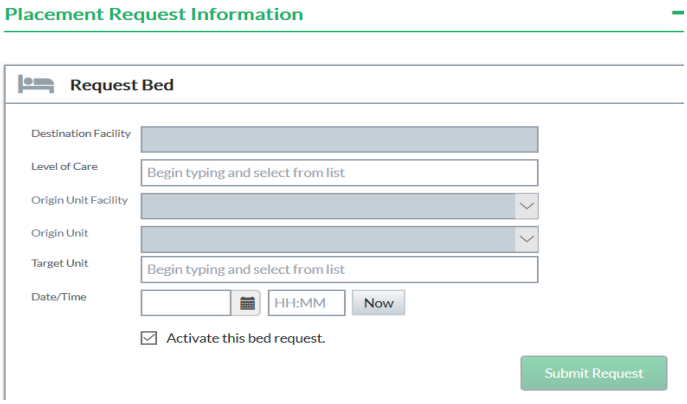
OUTCOME TAB



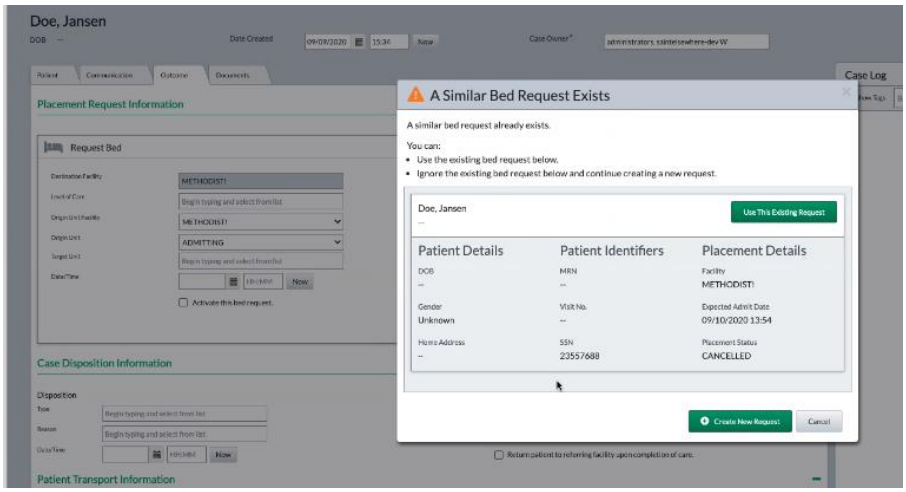
5.1 PLACEMENT/BED REQUEST INFORMATION

1. Bed Request Details – Add level of care, target unit, admit date and time.
2. Bed Assignment Details – Bed assignment and bed assignment timer details.
3. Activate bed request (defaults) – If bed request is for future date "unclick" and update for expected day of admission.

Note: Records should not be open in both TCIQ and CMS.



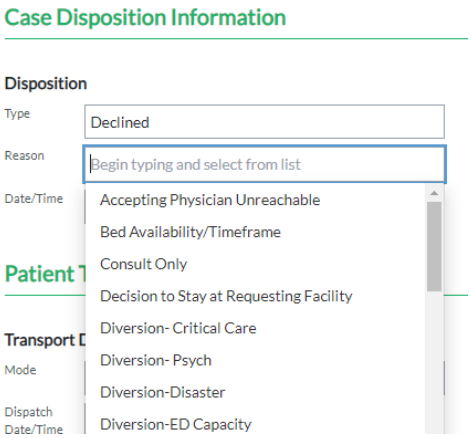
4. It is recommended to preregister the patient prior to submitting a bed request. If preregistered, you will see the below message indicating the BR is matching with the preregistration.



5. Validate correct patient and select **"Use this Existing Request."**
6. Save and close case window after bed request is submitted.

5.2 CASE DISPOSITION INFORMATION

1. Disposition – Patient Accepted, Declined, or Cancelled
2. Reason – If declined, then a reason code must be added.



3. Referring Facility Notified – Person and time referring facility notified of acceptance or decline.

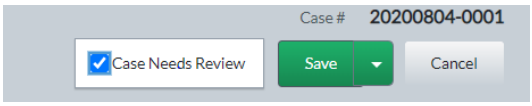
5.3 PATIENT TRANSPORT INFORMATION

1. Transport Details – Mode and dispatch date and time
2. Contact Details – Name and number of contact
3. Patient Arrival Details – Time, date, and where patient is to go upon arrival (ex. Cath Lab, IR)

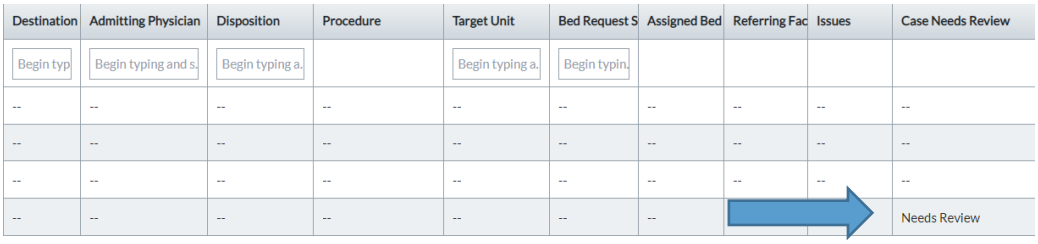
CASE REVIEW

5.4 CASES THAT NEED SUPERVISOR REVIEW

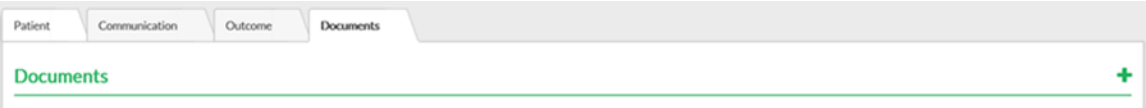
1. If a case needs to be reviewed by your Supervisor or Manager, click inside the check box **"Case Needs Review."**



2. "Needs Review" will display in the Worklist column. "Case needs review" will need to be filtered into the column display of Worklist.



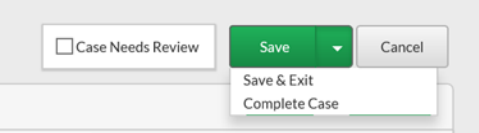
DOCUMENTS TAB



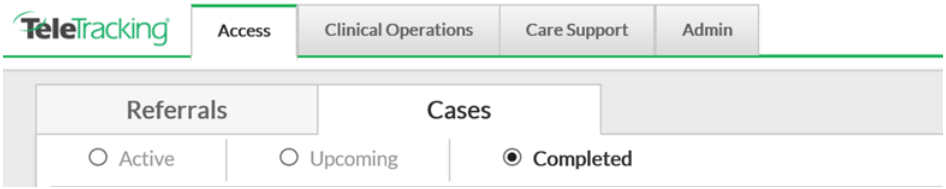
Up to 5 documents can be stored and attached to the case for immediate retrieval.

COMPLETING AND CLOSING CASE

Once all required fields are completed and the patient is placed in bed in the ADT, the case can be completed. Select **"Complete Case."**



When "Complete Case" is clicked, the record will fall off the Worklist. The case will be housed in the Completed tab.



NOTES:

6.1 Cases should not be left open. You should save your work and close the case window.

6.2 Always sign out of the application when you are done for the day. Do not "x" out of the application.

6.3 Admitting physician must be clicked last in sequence of physician card in order for it to flow from TC to CMS.

PLEASE UTILIZE THIS METHOD GOING FORWARD TO REQUEST BED IN TCIQ

If anyone needs help with this process, please reach out to Nicole, Renee, Kristen or myself for training

- **Click OUTCOME TAB: (3rd Tab on Case)**
- **PLACEMENT REQUEST INFORMATION** (This information is used to put patient on the direct tab)
- **Required** for Standard Work Process
- **PRT MUST BE CREATED**, Admitting should put the registration # with the MRN# on the "Patient Tab" with the patient details
- Unclick "Activate this bed request"
- Click "Submit Reqest"
- A list of PRT's will display in a box
- **BE VERY CAREFUL TO CHOOSE THE PRT THAT IS THE PATIENT'S ADMITTING REGISTRATION**
- Patients can have multiple PRT's for Radiology, Procedures, Cardiac procedures etc
- Admitting should be entering the (FIN & PRT#) and (MRN) next to the patient details on the "Patient" tab
- If there is no PRT listed, get the correct # from admitting. Corrin and I can also look up the PRT through STAR.
- You may have to scroll down the list to find the admitting PRT
- Once you find the correct PRT listed click "Use This Existing Request"
- The information will populate in the requested bed information
- The bed request will show "Inactive" but once a bed is assigned in teletracking it will update in TCIQ with the assigned bed
- Go to teletracking
- Click on the "Patient Search" icon
- Enter the patient information (You can use last name, MRN whichever you choose)
- Make sure to pick the PRT that has the date requested as well as all information matches the TCIQ and admitting
- On the right-hand side of the patient placement details, click on "Origin Unit"
- Click on MHC MMC
- Click on Bed Management
- Click on "Target Unit" and place where the patient is anticipated going (ie A2, A3 etc) if you know, if not leave all else blank
- Click on "Assigned Bed" if you know where the patient is going and enter the bed number and choose from the bed that populates for placement
- Click "Save & Close"
- Click on the "RED" time it will change to "GREEN"
- Click "Refresh"
- Go to the "Directs/ Ext Transfer tab
- The patient should be on the list
- In TCIQ the bed should be under the "Request Bed"
- On the TCIQ transfer list "REQUESTED BED" will display in red until a bed is assigned
- Once a bed is assigned it will change to "ASSIGNED" and have the bed # listed in "Assigned Bed"

	Phone for Transfers	Distance Miles	Trauma Level	Adv Gastroenterology	Bariatric Surgery	Burns	Cardiology	Continuous EEG	ENT	General Surgery	Hyperbaric O2 Therapy	Infectious Disease	IR	Maxillofacial	Nephrology	Neurology	OB/Gyn	Oncology	Orthopedics	Ophthalmology	Oral Surgery	Peds	Plastic Surgery	Pulmonary	Stroke	Transplants	Urology	Vascular Surgery		
Ann Arbor VA	734-845-5279/ Fax# 734-845-5997	239	1	X			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X		
Beacon Kalamazoo Borgess	Patient Admission Transfer Hub: 269-226-4852	192	2	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X		
Bronson Methodist Hospital	269-341-7477/ Fax# 269-341-8037	192	1	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X			X	X	X	X		X	X		
Cleveland Clinic	216-448-7000 Option 2/ Fax# 216-636-6535	408	1	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X		
Corewell Dearborn	248-898-0880 Corewell East Transfer Center			X	X		X			X							X	X							X					
Corewell Royal Oak Beaumont	248-898-0880 Corewell East Transfer Center		1	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
Corewell Troy	248-898-0880 Corewell East Transfer Center			X			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X		X	X		
Corewell Helen Devos	888-936-0005 Corewell West Transfer Center	142	1	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X		X	X		
Corewell Blodgett	888-936-0005 Corewell West Transfer Center			X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X		X	X		
Corewell Butterworth	888-936-0005 Corewell West Transfer Center			X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X		X	X		
Corewell Health Ludington	X	94	4				X		X	X		X	X	X	X	X	X	X	X	X	X	X		X	X		X	X		
Corewell Health Zeeland	X	164					X		X	X		X	X	X	X	X	X	X	X	X	X	X		X	X		X	X		
Covenant One Call Center (Cooper, Harrison)	989-583-6280 (ask for Patient Placement dept)	156	2				X		X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X		
Detroit Children's	844-994-8436	255	1	X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X		X	X		X	X		
Detroit Receiving (DMC) Adults	844-362-2364 Transfer Line	255	1	X		X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X		X	X		X	X		
Detroit VA	313-576-1000 EXT 64851	255		X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X		X	X		X	X		
Henry Ford Providence Park Novi	833-836-9695 Transfer Line	255	2				X			X					X	X	X	X					X				X			
Henry Ford Providence Southfield	833-836-9695 Transfer Line	255	2	X	X		X			X					X	X	X	X									X			
Henry Ford Genesys	833-836-9695 Transfer Line		2					X		X					X	X	X	X							X	X		X			
Henry Ford Detroit	866-434-2337 Transfer Line	255	1	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
Henry Ford Jackson	866-434-2337 Transfer Line	216		X	X		X		X	X		X	X	X	X	X	X	X	X	X	X	X		X	X		X	X		

OVER

	Phone for Transfers	Distance Miles	Trauma Level	Adv Gastroenterology	Bariatric Surgery	Burns	Cards	Continuous EEG	ENT	General Surgery	Hyperbaric 02 Therapy	Infectious Disease	IR	Maxiofacial	Nephrology	Neurology	OB/Gyn	Oncology	Orthopedics	Ophthalmology	Oral Surgery	Peds	Plastic Surgery	Pulmonary	Stroke	Transplants	Urology	Vascular Surgery		
Henry Ford Rochester (Crittenton)	833-836-9695 Transfer Line	189					X		X	X		X	X	X	X	X	X	X	X	X		X	X	X	X	X	X		
Henry Ford St John Detroit	866-434-2337 Transfer Line	255	1	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
Henry Ford West Bloomfield	866-434-2337 Transfer Line	231		X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X		X	X		X	X		
Hurley Flint	810-262-9429 ER/ 810-262-7465 IP	190	1	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
Mayo Clinic	507-255-2910	673	1	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
McLaren Flint	888-892-3687 Transfer Line		3	X		X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X		X	X		X	X		
Mclaren Greater Lansing	1-517-975-7176 Secure Unit # 517-975-6000	182	3	X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X		X	X		X	X		
McLaren Petoskey/Cheboygan	231-487-4990	67	2				X									X	X	X	X											
U of M West (Metro Health GR)	ER to ER 800-962-3555 Direct Admit 734-764-3289	142	2	X			X	X	X	X		X	X	X	X	X	X	X	X	X	X	X		X	X		X	X		
Munson Cadillac	231-392-0777	47	4				X		X	X					X		X	X	X								X			
Munson Charlevoix	231-392-0777	50	4						X	X							X	X	X								X			
Munson Grayling	231-392-0777	50	4				X		X	X							X	X	X								X			
Munson Kalkaska	231-392-0777	25	4							X																				
Munson Manistee	231-392-0777	66							X	X					X				X								X			
Munson Otsego	231-392-0777	60	4						X	X			X				X	X	X								X			
Munson Paul Oliver (POMH)	231-392-0777	40	4						X										X								X			
MyMichigan Transfer Center (see all hospitals below)	989-839-3114 Transfer Line																													
MyMichigan Alpena	989-839-3114 Transfer Line	127	3				X			X					X		X	X	X	X					X			X			
MyMichigan Clare	989-839-3114 Transfer Line		4				X			X	X							X	X	X					X						
MyMichigan Gladwin	989-839-3114 Transfer Line						X			X								X	X												
MyMichigan Gratiot	989-839-3114 Transfer Line				X		X			X	X		X				X	X	X	X							X				
MyMichigan Midland	989-839-3114 Transfer Line	127	2	X	X		X			X			X				X	X	X	X			X	X			X				
MyMichigan Sault Ste Marie (War Memorial)	989-839-3114 Transfer Line				X		X		X	X					X	X	X	X	X			X		X			X				
MyMichigan St Mary's Saginaw	989-839-3114 Transfer Line			X	X		X			X			X					X	X							X					
MyMichigan Tawas	989-839-3114 Transfer Line						X											X													
MyMichigan West Branch	989-839-3114 Transfer Line	93	3				X			X							X	X	X	X					X						
Saginaw VA	989-497-2500 EXT 13108	156		X			X	X				X		X			X			X					X			X			

OVER

	Phone for Transfers	Distance Miles	Trauma Level	Adv Gastroenterology	Bariatric Surgery	Burns	Cards	Continuous EEG	ENT	General Surgery	Hyperbaric 02 Therapy	Infectious Disease	IR	Maxilofacial	Nephrology	Neurology	OB/Gyn	Oncology	Orthopedics	Ophthalmology	Oral Surgery	Peds	Plastic Surgery	Pulmonary	Stroke	Transplants	Urology	Vascular Surgery		
U of M Sparrow	517-364-1111	182	1	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		
Trinity Health St Joseph Ann Arbor	877-433-0333 Transfer Line		1	X			X	X	X	X		X	X	X	X	X	X	X		X	X	X		X	X	X	X	X		
Trinity (Mercy) Health Saint Mary's GR	616-685-4800 Trinity Express	142	2	X			X	X	X	X		X	X	X	X	X	X	X		X	X	X		X	X	X	X	X		
Trinity Health Chelsea	734-593-5270 Transfer Line	131	4				X										X		X					X						
Trinity Health Muskegon	616-685-4800 Trinity Express		2	X	X		X	X								X	X	X								X				
U of M	1st Call: 734-615-0930/ Fax# 734-615-2329	239	1	X			X	X	X	X		X	X	X	X	X	X	X		X	X	X		X	X	X	X	X		
U of M MLine-Consults	Mline Direct: 800-984-8870/ Consults 734-936-3856																													
U Of M Motts Children	800-984-8870 Transfer Line	239	1	X			X	X	X	X		X	X	X	X	X	X	X		X	X	X		X	X	X	X	X		
U of M MLine- Stroke	800-962-3555																													
U of M MLine- OMFS	800-962-3555													X																
Dwayne Waters ED-Prisoner	517-780-5911																													
PSYCHIATRIC HOSPITALS																														
My Michigan Alpena	989-356-7258	127																												
Trinity St Mary's GR	616-685-6611	142																												
My Michigan SSM Behavioral Health Kinchloe	906-748-0785 Nursing Sup	158																												
Henry Ford Kingswood	248-398-3200	255																												
Cedar Creek Hospital	989-403-6022	159																												
My Michigan Gratiot Alma	989-466-7170	130																												
Brightwell Behavioral Health	517-318-5907	182																												
Forest View Hospital	616-942-9610	142																												
Havenwyck Hospital	248-373-9200	226																												
Harbor Oaks Hospital	586-684-4574	242																												
Kalamazoo Psychiatric	269-337-3000	192																												
Pine Rest Hospital		142																												
StoneCrest Center	866-504-1421	255																												
Caro Center	989-673-3191	180																												
McLaren Cheboygan																														

OVER

Specialized Services: Gastroen/ ID/ Nephrology/ Nuerology/ Oncology/Pulmonary/ Trauma/ General & Vasc & Neuro/ ENT/ IR

	Stress	Echo	MRI	TEE	Holidays
Cadillac	M,T,W,F 6a/ On call Thursday, Sat, Sun	M-F 7:30-4p	M-F 6:30a-2:30p/ Sat & Sun 7:30a-Noon	N/A	No
Charlevoix					
Grayling	M-F 7a-3p/ On Call for inpatients only on Sun 8a-Noon	M-F 7a-3p	M-F 7a-5:30p/ On call on Sat 8a-Noon	NA	
Kalkaska	NA	Tues & Thurs by appt only setup thru Central Scheding/ No walk in	M-F 8a-4:30 by appt through Central Scheduling		
Manistee	Tues & Thurs 7a-3p (if staff available)	M-F (1 tech that also does US avail unless off or vacation)	M-F 7a-3p (Only 1 tech if on vacation or off, no avail)	NA	No
Otsego	M-F 8a-5p No weekends	M-F 8a-5p No weekends	M-F 7a-5p No weekends	N/A	No
Paul Oliver	NA	NA	Fridays until 7p (Scheduled thru Central Scheduling)	NA	No
Medical Center					

Regional Hospital Capabilities

Service	Cadillac	Charlevoix	Grayling	Kalkaska	Manistee	MMC	Otsego	Paul Oliver
CTA	M-Su 24hrs/day						24/7	
Echo	M-F 7:30-4P		M-F 7a-3P	T/Th by appt only setup thru Central Sched/ No Walk In	M-F only 1 tech avail unless on vacation/ same tech does US		M-F 8a-5P No Weekends	NA
ENT	Per PerfectServe Schedule					X	N/A	
IR					Radiologist on site 8a-4p on M & W can do thora & paracentecis	X	M-W - 7a-5p	
MRI	M-F 6:30a-2:30p/ Sat & Sun 7:30a-Noon		M-F 7a-5:30p/ On call Sat 8a-Noon	M-F 8a-4:30p by appt through Central Scheduling	M-F 7a-3p(Only 1 tech if on vacation or off no availability		M-F 7a-5p No weekends	
Nephrology	Dialysis M-Sun				no		N/A	
Stress Test	M,T,W,F 6A/ On call Thurs, Sat & Sun		M-F 7a-3p/ On call for inpatients only on Sun 8a-Noon	NA	Tues & Thurs 7a-3p as staffing allows		M-F 8a-5P No Weekends	
TEE	N/A		NA		NA		N/A	NA
Urology	Per PerfectServe Schedule						based on call schedule- OMH does not have urology daily	
US	M-F 0600-2200/ On call 2200-0600 (M-F)/ On call Sa-Su same hours				1 tech avail unless on vacation/ same tech does US		M-F 730a-730p OC-730p-730a	
Holidays	No				NO		No	No

Regional Hospitals	Cardiology	CTA	CTP	Continuous EEG	ENT	Gastroenterology	General Surgery	Hemodialysis	Infectious Disease	Nephrology	Neurology	OB/Gyn	Oncology	Ophthalmology	Peds	Pulmonary	Esophageal Scope	Stroke	Urology	Vascular Surgery	Regional Hospitals	CT	CT Days/Times	ECHO	Echo Days/Times	EKG	EKG Days/Times	Dialysis	Dialysis Days/Times	IR	IR Days/Times	MRI	MRI Days/Time	Nuclear Radiology	Nuclear Rad Days/Times	Stress Test	Stress Test Days/Times	US	US Days/Times	TEE	HOLIDAYS
Cadillac					x- based on call schedule		☑	☑		☑		☑			☑				x- based on call schedule		Cadillac	☑	24/7	☑	M-F 7:30a-4p		M-F 7a-4p	☑	M-Su	N/A		☑	M-F 0630-2000. Sa-Su 0730-1200	☑		☐	M, W, F 0600-1530, T 0600-1630, Th- oncall (0600-1200), Sa-Su on-call for only Stress tests (0600-1200).	☑	M-F 0600-2200/ On call 2200-0600 (M-Su) for only 3 exams/ On call Sa-Su same hours	☐	NO
Charlevoix							☑	☐		☐		☑			☐		x		on call schedule		Charlevoix	☑	24/7	☐		☑	M-F 7a-4p	☐		N/A		☑	Thurs & Sunday	☑	Nuclear medicine T/TH with ability to do nuclear stress test if the tracer is ordered by 7am the day of the test.	☑	Treadmill EKG stress testing M-F 9-4.	☑	24/7	☐	NO
Grayling		x	x				☑	☐		☐		☑			☐		x		x		Grayling	☑	24/7	☑	M-F 7:30a-3p	☐	24/7			N/A	M & W only	☑	M-F 7a-3p; T-F 5:30p; Sat OC 8a-12p	☑	M-F 7a-3p; Sun 8a-12p	☑	M-F 7a-3p; On Call for IP only on Sun 8a-Noon	☑	Sun-Sat 7a-8p; Restricted OC 8p-7a	☐	NO
Kalkaska							☐	☐		☐		☐			☐						Kalkaska	☐		☐		☐		☐		N/A		☐		☐		☐		☐		☐	NO
Manistee	n/a	x	n/a	n/a		n/a	☐	☐		☐		☐			☐						Manistee	☑	24/7	☑	M-F days on most days			☐		☑	Radiologist on site 8-4p M & W can do Thoracentecis & Paracentecis	☑	M-F 7-3 most days	☐		☐		☑		☐	NO
Otsego		☑	☑				☑	☐		☐		☑			☐		☑		x- based on call schedule		Otsego	☑	24/7	☑	M-F 8a-5p No weekends	☑	24/7	☐		☑	M-F 7a-5p No weekends	☑	M-F 7-5p; No weekends	☑	M-F 8a-5p No weekends	☑		☑	M-F 730a-730p OC-730p-730a	☑	NO
Paul Oliver							☐	☐		☐		☐			☐						Paul Oliver	☐						☐				☐		☐		☐		☐		☐	NO

Please complete any kind of surgerys you can do at your hospitals that would help with patients that would be appropriate for your facilities:
Surgery Specialtys

Cadillac PEDS- the specialty provider presumes care of patient. We do have competent RN staff to care for PEDs pts.

Regional Hospitals	CT	CT Days/Times	ECHO	Echo Days/Times	EKG	EKG Days/Times	Dialysis
Cadillac	☑	24/7	☑	M-F 7:30a-4p		M-F 7a-4p	☑
Charlevoix	☑	24/7	☐		☑	M-F 7a-4p	☐
Grayling	☑	24/7	☑	M-F 7:30a-3p	☐	24/7	
Kalkaska	☐		☐		☐		☐
Manistee	☑	24/7	☑	M-F days on most days			☐
Otsego	☑	24/7	☑	M-F 8a-5p No weekends	☑	24/7	☐
Paul Oliver	☐						☐

Dialysis Days/Times	IR	IR Days/Times	MRI	MRI Days/Times	Nuclear Radiology
M-Su	N/A		☑	M-F 0630-2000. Sa-Su 0730-1200	☑
	N/A		☑	Thurs & Sunday	☑
	N/A		☑	M-T 7a-6:30p; F 7a-5:30p; Sat OC 8a-12p	☑
	N/A		☐		☐
	☑	Radiologist on site 8-4p M & W can do Thoracentecis & Paracentecis	☑	M-F 7-3 most days	☐
	☑	M-F 7a-5p No weekends	☑	M-F 7-5p; No weekends	☑
			☐		☐

Nuclear Rad Days/Times	Stress Test	Stress Test Days/Times	US	US Days/Times	TEE
	☐	M, W, F 0600-1530, T 0600-1630, Th- oncall (0600-1200), Sa-Su on-call for only Stress tests (0600-1200).	☑	M-F 0600-2200/ On call 2200-0600 (M-Su) for only 3 exams/ On call Sa-Su same hours	☐
Nuclear medicine T/TH with ability to do nuclear stress test if the tracer is ordered by 7am the day of the test.	☑	Treadmill EKG stress testing M-F 9-4.	☑	24/7	☐
M-F 7a-3p; Sun 8a-12p	☑	M-F 7a-3p; On Call for IP only on Sun 8a-Noon	☑	Sun-Sat 7a-8p; Restricted OC 8p-7a	☐
	☐		☐		☐
	☐		☑		☐
M-F 8a-5p No weekends	☑		☑	M-F 730a-730p OC-730p-730a	☑
	☐		☐		☐

HOLIDAYS
NO
NO
NO
NO
NO
NO
NO

Transfer Center Process

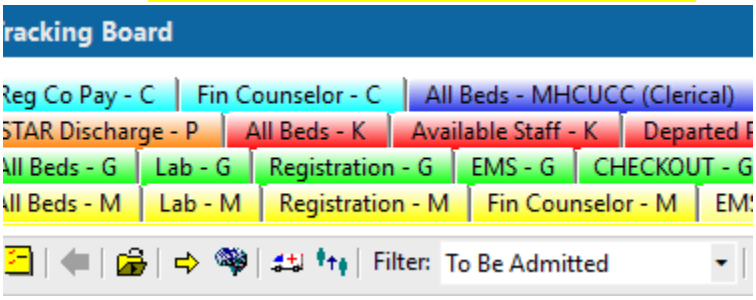
A team's chat has been set up with key members from Radiology including the PACs teams and transfer center employees. Please follow the process below as the transfer system is not available at this time to Radiology and we will use the process from now on.

- Transfer center team will put into the chat if images are needed to be sent out or retrieved from another site.
    - Chat will include:
        - Patient name and DOB
        - MR if available
        - Type of images
        - Site where they are to be sent or Site where they are to be requested from
            - Electronic transfer is the preferred method
                - Radiology is starting to phase out burning and receiving CDs
                    - Patients who request exam for their personal use will be encourage to get the images via email
                - On 3/1/22 Munson Radiology will be moving PowerShare for image exchange
                    - PowerShare is available for most hospitals across the nation
        - Provider requesting images
- Radiology will respond in the chat that images are being requested or sent
    - Radiology team will retrieve images
        - Once images are available an order for Outside Images will be placed in Radnet with date of the exam of when it was done
            - The order date/time should not be changed
    - Once the images are available in RadNet the Radiology team will notify the transfer center via the chat
    - Radiology team will send out exams on transfer patients
        - These will be sent electronically if at all possible
            - If CDs need to be burned Radiology staff will burn CD via the process set up
                - If the person burning the CDs is off site they will contact the Front Office to send the CD to unit or ED
- Radiology PACs Team will monitor the chat Sunday night starting at 2300 until Friday night at 2300
    - Can be paged via Smartweb PACS ON CALL ID 672 if no immediate response in teams
- From Friday night at 2300 to Sunday night at 2300 the chat will NOT be monitored.
    - Please page via Smartweb PACS ON CALL ID 672

PRE-ARRIVAL ENTRY

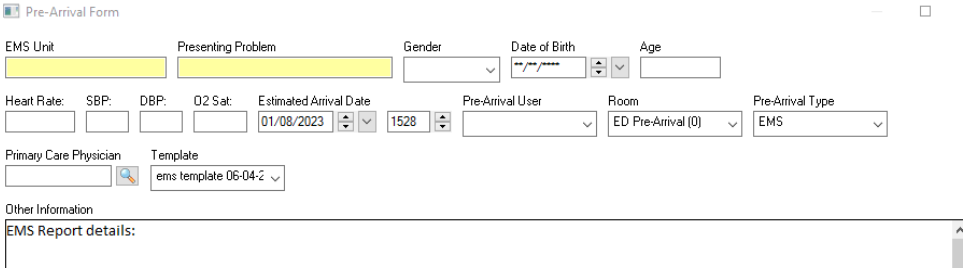
STEP 1:

Click on the "To be admitted tab on power chart/ firstnet" Click on the *AMBULANCE* icon



STEP 2:

This box opens, click on the box that reads *PRE-ARRIVAL TYPE*

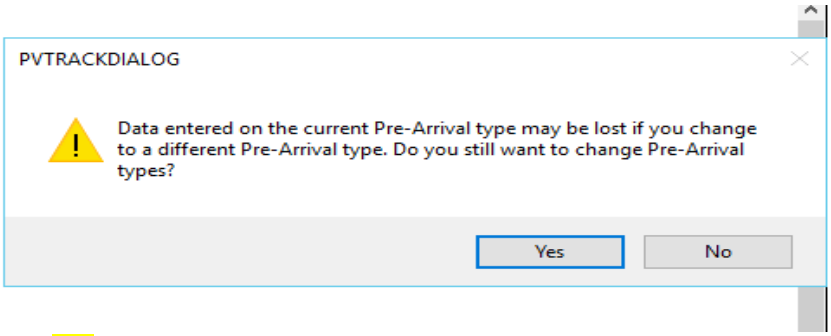


STEP 3:

When you click on the *PRE-ARRIVAL TYPE* box, 2 Options will display: (EMS/ TELEPHONE TRIAGE)

- ★ Click on the *TELEPHONE TRIAGE* option

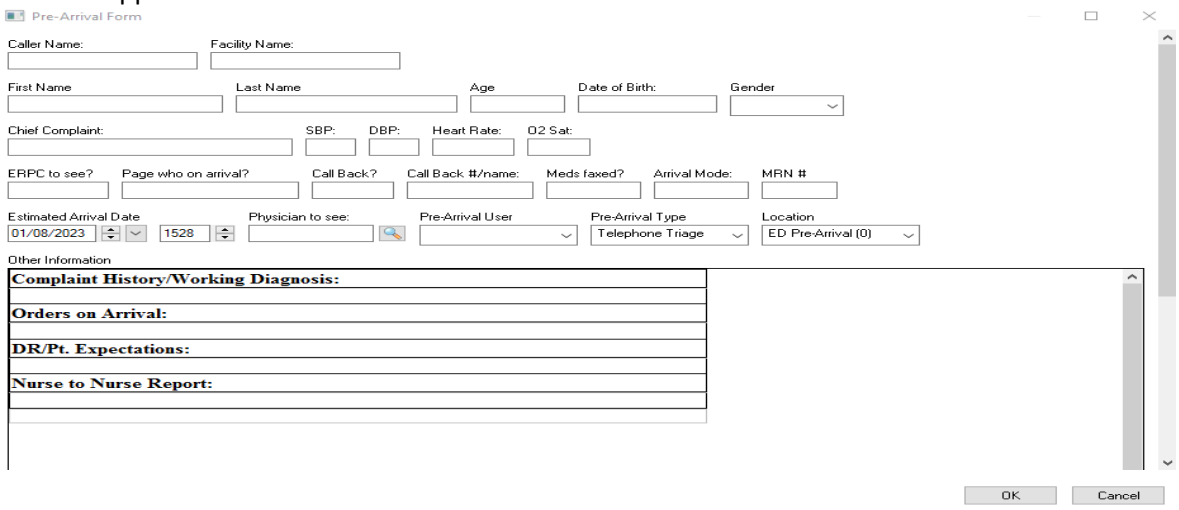
This box will display:



Click on *YES*

STEP 4:

This box appears



Enter Caller Name (This is whoever is calling in the pre-arrival)
Enter Facility Name (The Facility the patient is coming from)(Clinic, Urgent Care, Cowel Cancer, Nursing home etc)
Enter Patient First Name
Enter Patient Last Name
Enter Age &/ or Date of Birth
Enter Chief Complete
Enter Vitals if given by clinic
Enter Arrival Mode (Ask how patient is coming to the ED)
Enter the medical complaint/ hx/ working DX:

- Does not have to be lengthy, can be quick excerpt of patient condition.
- State pertinent events going on with patient
- State Dr's expectations with patient (Needs CT/ Needs Lab/ Needs admit to hospitalist etc)

You can look up MRN of patient in power chart to add to the pre-arrival, but it is not necessary
Click Ok

The pre-arrival will show on the all Beds in pink

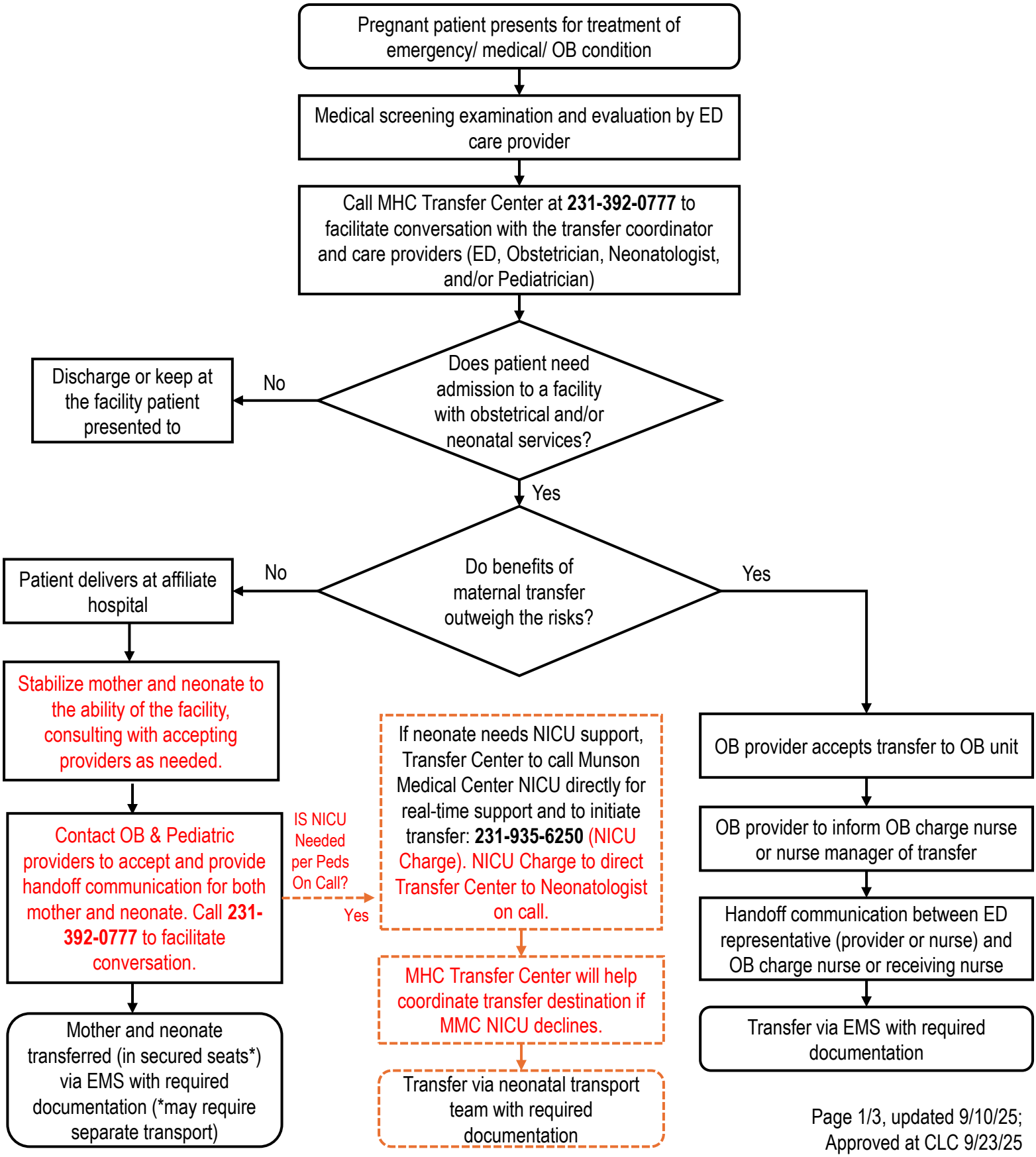
MUNSON HEALTHCARE

UPDATED 2/10/26 – changes appear in red

Maternal/ Neonatal Triage & Transfer Guidelines

For obstetrical and neonatal patients presenting to an ED facility without dedicated obstetrical and neonatal services

At any point during this process the needs of the patient and her fetus(s) necessitate an individualized plan of care. This algorithm is meant as a guide only.



Requirements:

- Consent of patient or legal guardian
- Acceptance by receiving care provider/ facility
- Transport by EMS
- Medical records – to include maternal prenatal documentation (see Appendix A)

Transfer Location Capabilities

*This table is intended as a **general guide**. Provider judgment should be applied on a case-by-case basis.*

Location	Obstetric* Services	GYN Services	Neonatal/ Pediatric Services
Munson Medical Center, Traverse City	Yes, including high risk	Yes, including high risk	Yes, NICU and pediatrics
Cadillac Hospital	Yes (≥34 weeks gestation)*	Yes	Stable ≥35 weeks gestation neonates**
Charlevoix Hospital	Yes (≥34 weeks gestation)*	Yes	Healthy newborns only**
Grayling Hospital	Yes (≥34 weeks gestation)* with physician mix (OBGYN and FPOB)	Yes, with physician mix (OBGYN and FPOB)	Healthy newborns only**
Otsego Memorial Hospital, Gaylord	No**	No	No**
Manistee Hospital	No**	No	No**
Covenant Healthcare, Saginaw	Yes	Yes	Yes, NICU and pediatrics
McLaren Northern Michigan, Petoskey	Yes (≥36 weeks gestation)	Yes	Healthy newborns only
MyMichigan, Alpena	Yes	Yes	Healthy newborns only
MyMichigan, West Branch	Yes	Yes	Healthy newborns only

* Obstetric Services refers to antepartum, intrapartum, and postpartum patient care. The gestation period of ≥ 34-week aligns with the Medical Control Authority OB Destination Protocol, which states that EMS will transport a patient at 34 weeks gestation (or greater,) who is having contractions/active labor but delivery not imminent, to the closest OB capable facility.

**If delivery occurs in ED and neonate is under 36 weeks gestation, transfer to MMC. If the neonate is ≥ 36 weeks and stable, may transfer to the closest OB unit.

Appendix A: Maternal Prenatal Documentation

Checklist: Maternal Prenatal Information to Accompany Mother and Baby

Ensure the following information is documented and accompanies the mother and newborn during transfer or delivery:

🔍 Maternal Screening & Lab Results

- HIV, Hepatitis B & C, Syphilis
- Blood Type and Antibody Screen
- Rubella immunity status
- Group B Streptococcus (GBS) status and/or swab
- Chlamydia and Gonorrhea screening
- Urine toxicology screen

🌡️ Maternal Clinical Observations

- Highest recorded maternal temperature
- Any symptoms of abruption, bleeding, or pelvic infection
- Rupture of membranes (ROM): time and date
- Amniotic fluid characteristics

🧬 Specimens to Accompany Transfer

- Placenta and umbilical cord (for pathology or toxicology if indicated)

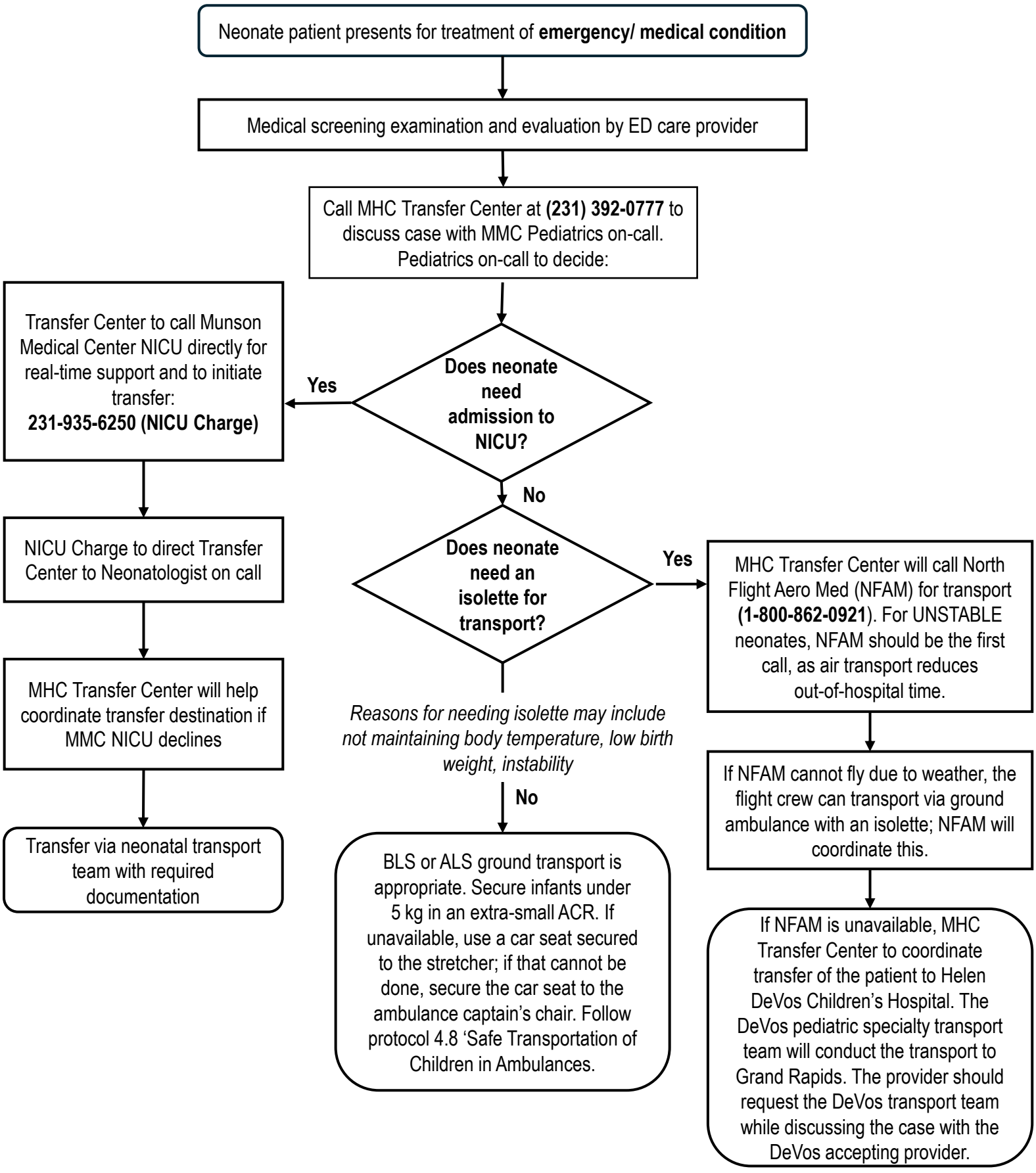
🚨 Additional Considerations

- Contact NICU as needed for support (231-935-6250)

Appendix B: Process for transfers of neonatal patients **DRAFT** UPDATED 2/10/26

For neonatal patients presenting to an ED in a facility without dedicated neonatal services

At any point during this process the needs of the patient necessitate an individualized plan of care. This algorithm is meant as a guide only.



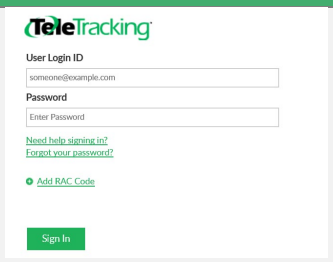
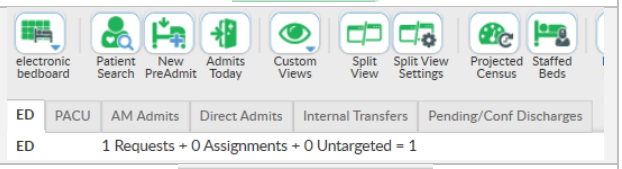
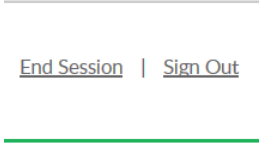
PATIENT PLACEMENT

Patient Placement staff have one of the most important roles within a hospital. Although they may not provide direct patient care in this role, their clinical expertise and problem-solving skills ensure that patients are safely and efficiently getting the appropriate care that they need. They are truly, Care Traffic Control. Although they often make it look effortless, their work is not easy in the slightest. They not only manage a constant stream of patient bed requests, but they spend an incredible amount of time on the phone trying to sort out what beds are available. With the use of TeleTracking, Patient Placement Departments will be able to:

- Efficiently manage bed requests for all admissions and transfers.
- See real-time bed capacity and availability as patients are being admitted and discharged
- Use precision placement tools to ensure patients are assigned the most appropriate beds the first time.
- Communicate with Nursing and Case Management for discharges to ensure bed availability as needed.
- Receive real-time notifications regarding all bed requests.
- Reduce the amount of bed request related phone calls.
- Use predictive tools to help project future capacity needs.

This Reference Guide provides step-by-step instructions for the functionality needed to complete the designed Patient Flow processes and workflows specific to the department.

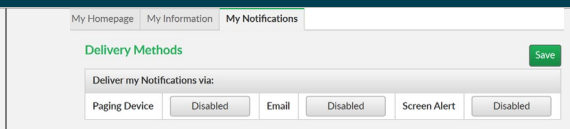
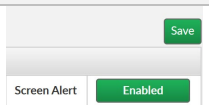
LOGGING IN/OUT

1. Launch TeleTracking and input your User Login ID and Password. Click Sign In button.	
2. From the Clinical Operations menu, click on PreAdmitTracking®	
3. You will now see the Patient Placement view	
To Log Out: 4. In the upper-right corner, click on sign out or end session. • **End session**-if you are signed into multiple sessions or workstations, select end session to end the current session. • **Sign out**-if you are signed into multiple sessions (or multiple workstations), sign out will close all sessions on all workstations.	

SCREEN ALERTS

Screen Alerts are the primary communication tool used by Patient Placement staff. Once Screen Alerts are activated, Patient Placement can manage all communication related to Bed Requests as well as receive free text Instant Notify messages from departments. By using Screen Alerts, Patient Placement will see a significant reduction in the amount of phone calls related to bed requests, allowing staff to focus on placement tasks without constant interruption.

ACTIVATING SCREEN ALERTS

1. From the home screen, click on My Notifications tab to display the Delivery Methods section.	
2. In the Deliver my Notifications Via section, click the gray Disabled button. It will now show Enabled and will be Green. 3. Click Save	
4. Once saved, click Sign Out in the top right corner and Log back in.	
5. You will now see Alerts button at the top of your screen.	
6. You will see the following potential Alert activity:	 Gray-No New Alert activity  If Flashing-New Message  Not Flashing-Unread Message
NOTES: • Screen Alerts only need enabled once per user. Alerts will continue to display unless disabled in My Notifications. • Alerts (messages) will stay in the Alerts box until you delete them. It is best to delete your alerts (messages) once you have read them. • If an alert or message is sent to more than one person, deleting the message in your account will NOT delete message for other users	

MANAGING BED REQUESTS

Managing bed requests is an essential piece of patient flow for Patient Placement. As bed requests are entered into the system by requesting areas, Patient Placement is provided with valuable information that allows them to quickly make the best clinical decisions regarding which beds patients get assigned to. Bed requests come from intake areas including ED and Procedural Areas as well as Inpatient Units in the form of transfers. Although requests come from different areas, it does not change the way that Patient Placement manages them in TeleTracking. Bed request workflows follow the same basic process:

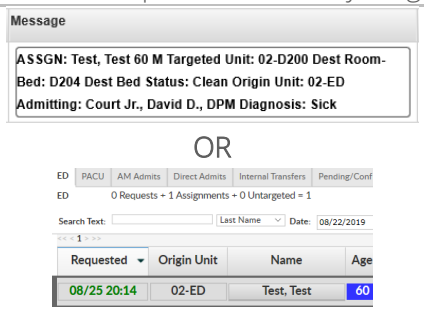
1. Requesting Area creates a bed request
2. Patient Placement/TC Targets the most appropriate unit based on information provided in the request
3. Requesting Area Activates the Ready to Move (RTM) Timer
4. Patient Placement Provides a Bed Assignment to the Requesting and Receiving Units
5. Requesting Area and Receiving Unit coordinate report and movement of patient to the Assigned Bed
6. Patient occupies the Assigned Bed in ADT System closing out the Bed Request

In this section, you will learn about the three main components of Bed Request functionality for Patient Placement: Targeting Units, the RTM Timer, and Assigning Beds.

TARGETING A UNIT

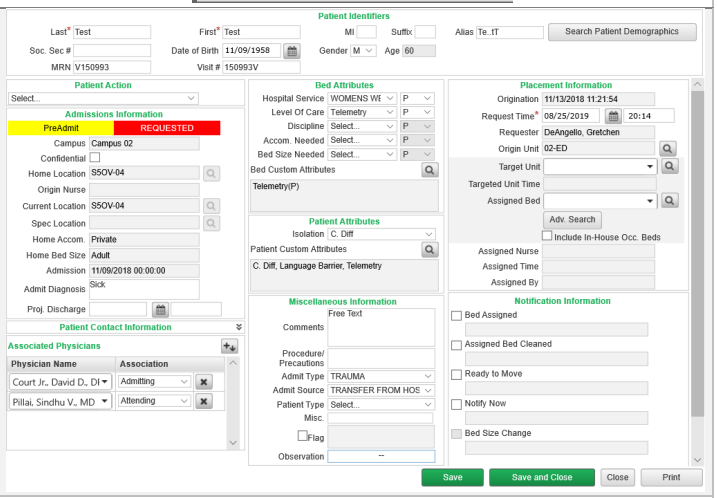
When a patient needs to be admitted or transferred, the Requesting Area enters a bed request into TeleTracking. Within that request, it is the Requesting Areas responsibility to provide Patient Placement with details about the patient to ensure the right target unit is chosen. Once Patient Placement reviews request details, they Target a Unit.

1. Once a Screen Alert message is received for a bed request, either click directly in the message or identify the patient from the appropriate tab and click on their name.

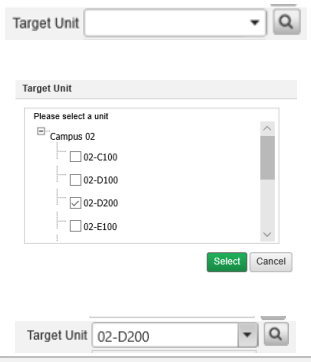


2. The Patient/Placement Details box will open, and you can review the information provided in the request. You will be able to see the following:

   - Admit Diagnosis
   - Associated Physicians
   - Level of Care
   - Bed Custom Attributes-if applicable
   - Isolation
   - Patient Custom Attributes
   - Comments-if applicable
   - Origin Unit



3. Once the information is reviewed and a decision is made, the unit can now be targeted.
4. In the Placement Information section click on the magnifying glass to the right of Target Unit.
5. Identify the unit you wish to select and click on the check box, click Select.
6. You will now see the Target unit display.
7. Save and Close the record.



Once the unit is Targeted, a notification is sent to the Targeted Unit. This allows them to know that they are expecting a new patient and they will also now have access to all patient information provided in the request. The targeted unit can now start planning for the patient and can ensure that appropriate beds are prioritized. At this point, Patient Placement will not complete any further action with the bed request until the Requesting Unit activates the RTM Timer.

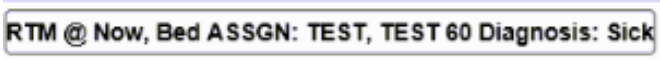
THE RTM TIMER

The RTM Timer is an important patient flow tool used to ensure that Patient Placement is only assigning 'Ready Beds to Ready Patients'. This is an extremely important process because it means we are no longer holding beds for patients that may not be ready to occupy them for hours. Along with proactive discharge planning, this process will significantly improve overall flow within a health system and ensure that busy areas like ED's and PACU's do not get backed up.

NOTES:

- It is important to remember that it is the responsibility of the Requesting Area to activate the timer when appropriate, not Patient Placement.
- A final bed assignment should NOT be provided by Patient Placement until the RTM is activated.

1. Once the Requesting Unit activates the RTM Timer, Patient Placement will receive a Screen Alert with details. This message will start with RTM @ Now. Once this message is received, it is now OK to Assign a Bed to the patient.



THE RTM TIMER AND PROJECTED RTM TIMER

The RTM Timer is an important patient flow tool used to ensure that Patient Placement is only assigning 'Ready Beds to Ready Patients'. This is an extremely important practice because it means we are no longer holding beds for patients that may not be ready to occupy them for hours. Along with proactive discharge planning, this process will significantly improve overall flow within a health system and ensure that busy areas like ED's and PACU's do not get backed up. Your Health System has elected to use a specific RTM function called the Projected Ready to Move. This type of RTM Timer allows users to identify the patient as either ready 'Now' or they can set a future time to when they think the patient will be ready. Projected RTM's are commonly used in Procedural Area requests based on estimated recovery times.

NOTES:

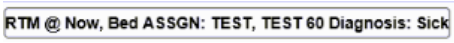
- It is important to remember that it is the responsibility of the Requesting Area to activate the timer when appropriate, not Patient Placement.
- A final bed assignment should NOT be provided by Patient Placement until the RTM @ Now message is received.

1. Once the Requesting Unit activates the RTM Timer, Patient Placement will receive a Screen Alert with the details. There are two different types of RTM messages that you will receive.

    - RTM @ Now-This means the patient is Ready to Move now, and the Requesting Area needs a bed assignment as soon as possible.

    - RTM@ Time-A specific time will be identified in the message. This means that a Projected RTM has been set. The time displayed will be the future time when the Requesting Area will need the bed. If Patient Placement receives a Projected RTM message, a bed assignment should NOT be provided just yet. Once the projected time arrives, Patient Placement will automatically get a second Screen Alert identifying the patient as RTM @ Now. At that point, it is now OK to Assign a Bed.

RTM Now:



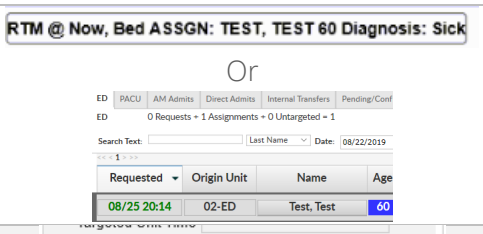
Projected RTM:

ASSIGNING A BED

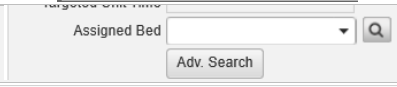
Once the RTM @ Now screen alert is received, it is now ok to Assign a Bed. From the moment that Patient Placement received the initial Bed Request, planning for providing an assignment was initiated. Remember that Patient Placement has already targeted the unit based on patient needs and bed availability. Once the unit was targeted, the Receiving Unit could see the patient details and could then plan for which bed they want Patient Placement to assign. The Receiving Unit does this by identifying what we call Bed Assignment Priorities.

Bed Assignment Priorities are a way for Nursing Units to communicate the order they want Patient Placement to assign their beds. Therefore, when it is time to Assign a bed, Patient Placement will look for the priorities set on the unit to guide them in their decision. If no priorities are selected, Patient Placement should use their best judgement based on the patient's needs and current bed availability

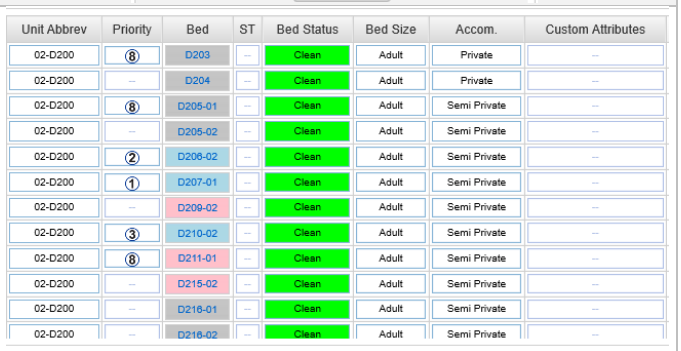
1. Once a Screen Alert is received with an RTM @ Now message, either click directly in the message or identify the patient from the appropriate tab and click on their name.



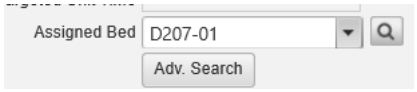
2. From the Patient Placement Details box, identify the Assigned Bed section. Click on the Adv. Search button.



3. Adv. Search provides info about bed availability on unit.
   - **Unit Abbrev**-Unit Name
   - **Priority-**Bed Assignment Priority that Nursing Unit set. Lowest number should be assigned first if criteria is met. If lowest priority is not a match, look for the next lowest one.
   - **Bed**-Provides Bed Number and Gender info.
     - Blue-Male Bed
     - Pink-Female Bed
     - Gray-Either Gender
   - **ST-**Patient Status information. For example, if a bed is occupied but that patient is in a discharge status, it will show that bed as potentially available.
   - **Bed Size**-Bed Size present in the room
   - **Accom**-Private or Semi-Private Rooms
   - **Custom Attributes-**Identifies if the location has special features that set it apart from others. Ex-Near the Nurses Station or Negative Pressure
4. Once preferred bed is determined, click Bed Number to set.
5. You will now see the Assigned Bed appear
6. Save and Close the Record



Unit Abbrev	Priority	Bed	ST	Bed Status	Bed Size	Accom.	Custom Attributes
02-D200	⑧	D203	--	Clean	Adult	Private	--
02-D200	--	D204	--	Clean	Adult	Private	--
02-D200	⑧	D205-01	--	Clean	Adult	Semi Private	--
02-D200	--	D205-02	--	Clean	Adult	Semi Private	--
02-D200	②	D206-02	--	Clean	Adult	Semi Private	--
02-D200	①	D207-01	--	Clean	Adult	Semi Private	--
02-D200	--	D209-02	--	Clean	Adult	Semi Private	--
02-D200	③	D210-02	--	Clean	Adult	Semi Private	--
02-D200	⑧	D211-01	--	Clean	Adult	Semi Private	--
02-D200	--	D215-02	--	Clean	Adult	Semi Private	--
02-D200	--	D218-01	--	Clean	Adult	Semi Private	--
02-D200	--	D218-02	--	Clean	Adult	Semi Private	--



Once the bed is assigned, both Requesting, and Receiving Units get a notification alerting them of the assignment. If there are issues with the assignment, the Receiving Unit should alert Patient Placement to provide a new assignment.

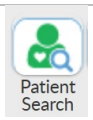
NOTE:

- When the bed is assigned, it will remain on the tab as a Bed Request until the patient has arrived in the unit. Once the patient occupies their new bed, the request will then fall off the list.

PATIENT SEARCH

Specific patient records can be found by using the Patient Search functionality. Patient Search will allow you to search for any patient that is registered in ADT System.

1. Left click on the Patient Search icon.



2. In the Search Text field, type the patient's Visit Number and select the Visit Number search option from the drop-down menu. Click Search to see the results.

NOTE: Visit Number is the preferred search method in order to ensure the correct patient record is always being used.

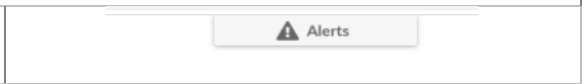
ENTERING DIRECT ADMITS

Most patients admitted to hospitals enter through Intake Areas such as the ED or Procedural Area. However, some patients are admitted directly to a unit from places like Physician Offices and Long-Term Care Facilities. These requests need to be entered into the system so the Receiving Unit and Admitting know a new patient is coming.

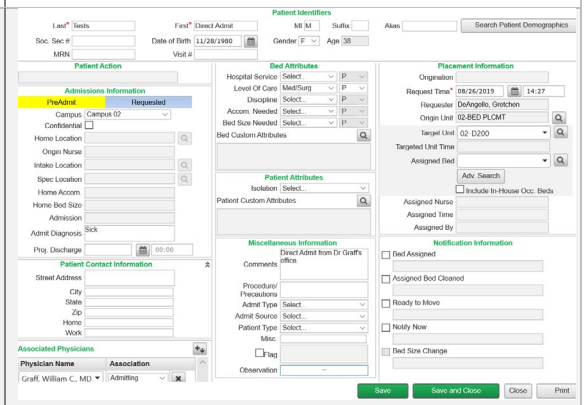
NOTE:

- Direct Admits differ from other bed requests in that Patient Placement will often need to provide a Bed Assignment at the time the request is entered into the system. Therefore, Patient Placement is responsible for activating the RTM Timer for Direct Admits.

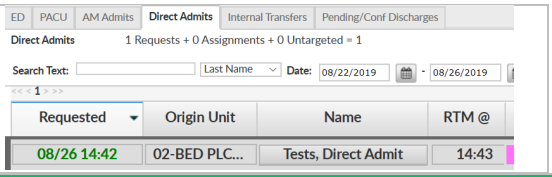
3. Direct Admits will be entered via the TC application, a bed request will be created once the TC agent has completed the call.



4. A shell Patient/Placement Details box will open, after you select the alert message
5. Enter / verify the
6. information that you received about the patient
   - Last Name
   - First Name
   - Age/DOB
   - Gender
   - Admit Diagnosis
   - Comments-Include that Patient is a Direct Admit, where they are coming from, and if they are an Inpatient or Observation patient.
   - Origin Unit- Transfer Center Origin Unit
   - Target Unit
7. Save and Close the record



8. Identify the Patient on the Direct Admit tab and single click on the RTM @ Timer. You will see a time appear.
9. Click back on the name of the Patient and assign the bed as you would for any bed request.



THE ANTICIPATED ADMITS LIST

Surgical patients can account for a large percentage of hospital admissions and managing these requests is critical to efficient patient flow. Ensuring that we plan for these admissions not only helps keeps everyone informed, but it also helps keep patients moving efficiently and safely out of recovery areas without causing backups. The Anticipated Admits list is used to manage procedural patients that are expected to be admitted post-procedure.

- The Anticipated Admissions List will be created by: PRE-OP OR SCHEDULER FOR EACH FACILITY
- Procedural Areas can also put surgical add-ons on the list to quickly incorporate them into the daily plan
- Once the list is created, Patient Placement is responsible for Targeting the unit that will receive the patient.

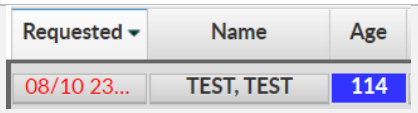
BUILDING THE ANTICIPATED ADMITS LIST (KNOW THE PROCESS)

1. Left click on the Patient Search icon.

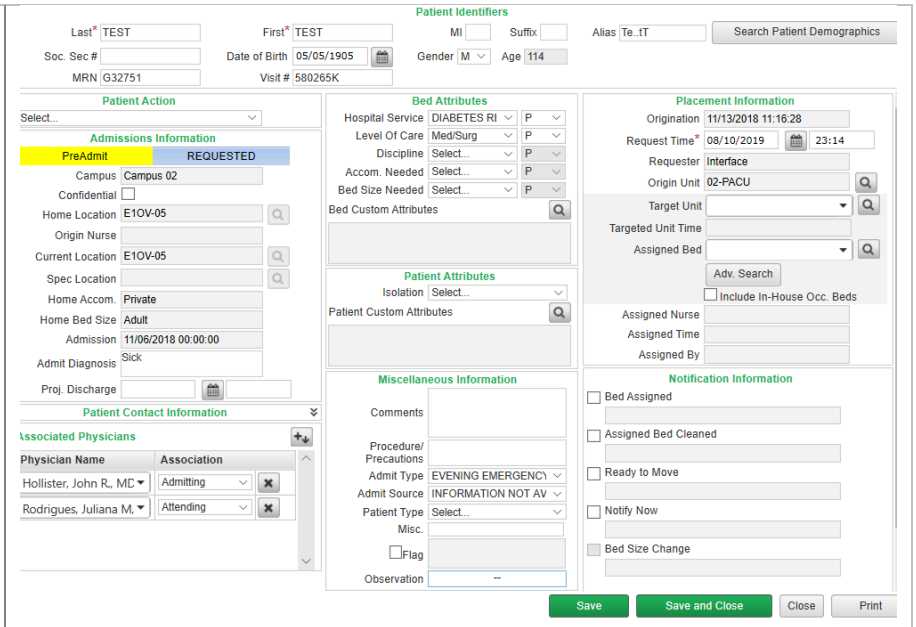
2. In the Search Text field, type the patient's Visit Number and select the appropriate search option from the drop-down menu. Click Search to see the results.

   NOTE: Visit Number is the preferred search method in order to ensure the correct patient record is always being used.

3. Identify correct patient from the search results and click on the patient's name. This will open the Patient Placement Details box.



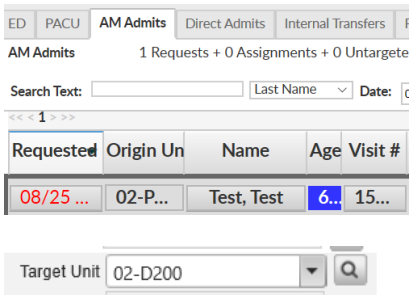
4. Update/Verify the following data items below. Save and Close the record once completed.
    - Level of Care
    - Origin Unit
    - Target Unit
5. Save and Close the record.



Once the Anticipated Admits List is built, the Targeted Units will now be able to see these patients.

TARGETING ANTICIPATED ADMITS

1. Click on the Anticipated Admits Tab
2. Click on the Patient's name
3. Review the information provided in the Patient/Placement Details box, and Target the appropriate unit.
4. Save and Close the record
5. Complete for the remaining patients on the Anticipated Admits tab



BEDTRACKING FUNCTIONALITY

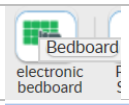
Environmental Services (EVS) play a very important role in Patient Flow. The work they do ensures that as patients are discharged, beds are quickly and safely turned over for the next patients waiting to occupy them. Without an automated system, it is often up to busy unit staff to communicate their bed cleaning needs verbally. BedTracking is the automated system used for all Bed Cleaning functionality. As patients are discharged, EVS staff are notified in real-time that the beds are now empty and ready to be cleaned. Not only can EVS see the vacated beds, but Patient Placement can see them too, allowing for transparency in bed capacity.

Although Patient Placement primarily works out of the PreAdmit application, there are some important functions in BedTracking that Patient Placement can use to help facilitate more patient flow.

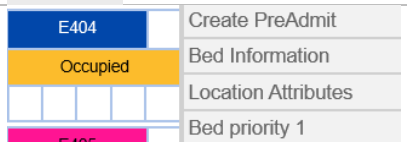
REQUESTING A BED CLEANING MANUALLY

As patients are discharged the beds will automatically dirty and notify EVS staff in TeleTracking. However, on rare occasions a bed might need to be dirtied manually.

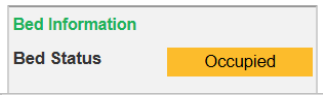
1. Click on the electronic whiteboard icon and chose the appropriate bedboard.



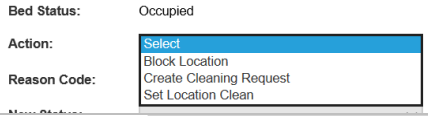
2. Identify the bed that needs to be dirty
3. While holding down the Shift button on your keyboard, Click on the bed. You will see a pop-up box appear.
4. Select, Bed Information. This will open the Bed Detail screen



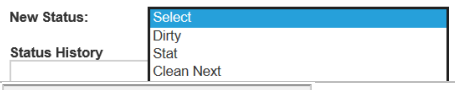
5. From the Bed Detail screen, click on the colored Bed Status.



6. A new box will open, click on the Action drop-down and select, Create Cleaning Request.



7. Once selected, you will see the New Status column available. Select the appropriate status and then click, Submit.

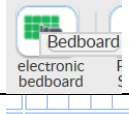


8. The Bed Status will update to show the new status

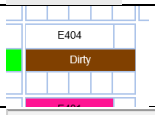
CANCELLING A CLEANING REQUEST

If EVS staff is no longer needed to clean a bed, it must be cancelled in the system. When a cleaning request is cancelled, a Reason Code explaining why the request needed cancelled is required.

1. Click on the electronic whiteboard icon and chose the appropriate bedboard.

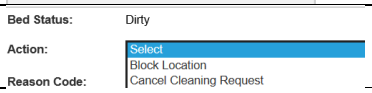


2. Identify the bed that needs cancelled and click on the bed. This will take you directly to Bed Information.

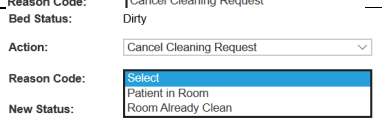


3. Click on the Bed Status button.

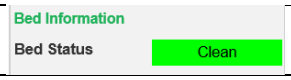
4. A new box will open, click on the Action drop-down and select, Cancel



5. Once selected, you will see the Reason Code column available. Select the appropriate reason and then click, Submit.



6. The Bed Status will update to show the new status

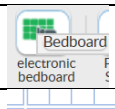
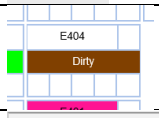
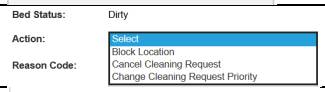
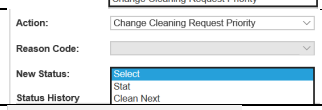
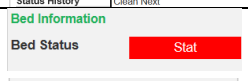


UPGRADING A CLEANING STATUS PRIORITY

As patients are discharged and beds are now empty, Patient Placement staff are often eager to assign those beds to their awaiting bed requests. If there are several dirty beds throughout the hospital, Patient Placement may have a specific bed they need cleaned over others. Patient Placement staff can upgrade cleaning status priorities in the system to communicate this request to EVS staff. There are two types of upgrade priorities: Clean Next and Stat.

Clean Next-Identifies the bed as the next bed that should be cleaned. If EVS staff is currently cleaning a bed and a Clean Next request comes through, they will finish the current bed and move on to the Clean Next directly after

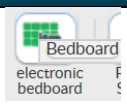
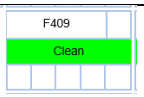
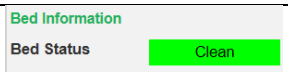
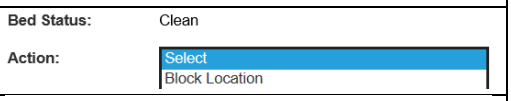
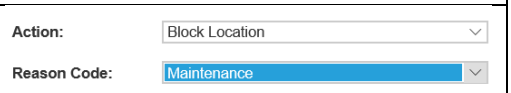
Stat Clean-Identifies bed needs cleaned immediately. If EVS is currently cleaning a bed and a Stat Clean request comes through, they will Suspend the current bed and start the Stat right away. Stat cleans should be used sparingly and reserved for true emergencies.

1. Click on the electronic whiteboard icon and chose the appropriate bedboard.	
2. Identify the bed that needs upgraded and click on the bed. This will take you directly to Bed Information.	
3. Click on the Bed Status button.	
4. A new box will open, click on the Action drop-down and select, Change Cleaning Request Priority	
5. Once selected, you will see the New Status column available. Select the appropriate status (Stat or Clean Next) and then click, Submit.	
6. The Bed Status will update to show the new status	 or 

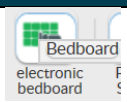
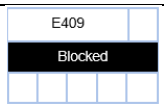
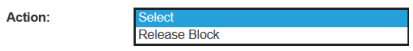
BLOCKED BED FUNCTIONS

There are situations when a bed may be empty, but it is not able to be used for a patient (ex: maintenance issues). Patient Placement can temporarily block a location in the system to ensure the bed doesn't appear available for admissions. Your hospital has defined the Blocked Bed reason codes you will find in the system. Once the block is no longer needed, Patient Placement will also be able to release the block.

BLOCKING A BED

1. Click on the electronic whiteboard icon and chose the appropriate bedboard.	
2. Identify the bed that needs blocked and click on the bed. This will take you directly to Bed Information.	
3. Click on the Bed Status button.	
4. A new box will open, click on the Action drop-down and select, Block Location	
5. Once selected, you will see the Reason column available. Select the appropriate reason and click, Submit.	
6. The Bed Status will update to show the new status	

UNBLOCKING A BED

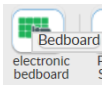
1. Before unblocking the bed, please confirm with the Nursing Unit if the bed needs to be cleaned by EVS once unblocked. 2. Click on the electronic whiteboard icon and choose the appropriate bedboard.	
3. Identify the bed that needs unblocked and click on the bed. This will take you directly to Bed Information.	
4. Click on the Bed Status button.	
5. A new box will open, click on the Action drop-down and select, Release Block	
6. Once selected, you will see the New Status column available. Select the appropriate status and click, Submit. 7. The Bed Status will update to show the new status **NOTE**: If a bed that is being unblocked is currently occupied, you will need to select 'Clean' as the new Bed Status. Once you click submit, you will see the status update to Occupied.	

REOCCUPYING A DISPLACED PATIENT

As patients are admitted and discharged, the TeleTracking electronic bedboard will update appropriately. However, sometimes patients accidentally get displaced from the system due to user error or not following appropriate TeleTracking process. If this happens, Patient Placement can Reoccupy the patient back into their bed.

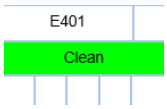
NOTE: Patient Placement is the only group of users that can complete this function.

1. Click on the electronic whiteboard icon and chose the appropriate bedboard.

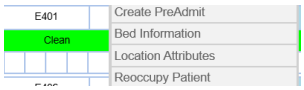


2. Identify the bed that needs reoccupied and click on the bed. This will take you directly to Bed Information.

NOTE: In order to reoccupy a patient, the bed needs to be in a Clean status. If bed is not Clean, please see section on Cancelling a Cleaning Request before proceeding.

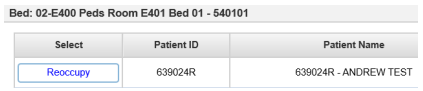


3. While holding down the Shift button on your keyboard, click on the bed.
4. Select, Reoccupy Patient

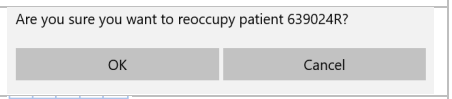


5. Identify the correct patient and click on the Reoccupy button

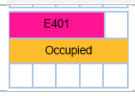
NOTE: Be careful to choose the correct patient, it might not be the first one listed.



6. You will receive a pop-up message asking if you are sure you want to reoccupy the patient, click OK if you are sure.



7. You will now see the bed occupied with the patient.

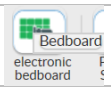


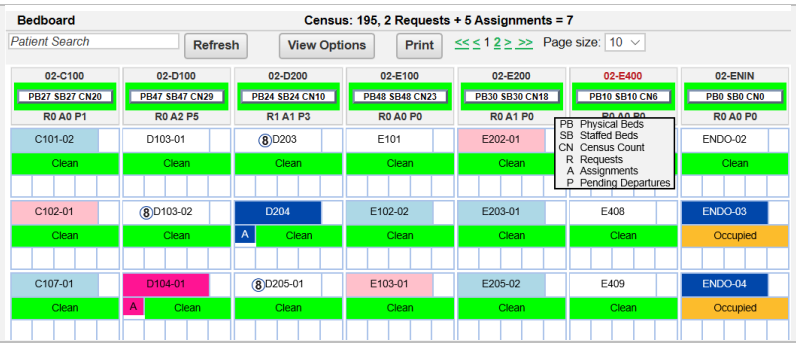
The electronicbedboard

The electronic bedboard is one of the most important tools to Patient Placement staff. When using the electronic bedboard, Patient Placement can perform functions as well as see the real-time status of every bed in the hospital, helping them to efficiently manage patient flow.

NOTE: In this section, we will provide a general overview of the electronic bedboard view. There are other sections within this reference guide that will refer to specific functions that can be completed in electronic bedboard.

1. Click on the electronic bedboard icon and chose the appropriate bedboard. The bedboard will open in a separate window.





CENSUS INFORMATION:

Census: 195, 2 Requests + 5 Assignments = 7

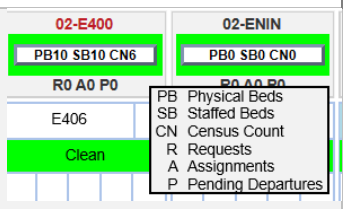
Census: Overall census of units included in bedboard. Some units may not be present based on your hospital's design.

Requests: Number of active bed requests that DO NOT have a bed assignment.

Assignments: Number of active bed requests that DO have a bed assignment.

=Combined total of Requests and Assignments

UNIT INFORMATION:

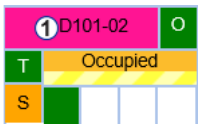


Unit Name: Appears at the top of each column.
PB: Physical Beds-Licensed physical bed count of unit.
SB: Staffed Beds-Current staffed beds.
CN: Census Count-Current unit census.
Colored Border represents unit capacity:

- Green-Bed Available
- Yellow-Nearing Capacity
- Red-At Capacity

R: Requests- Number of active unit bed requests that DO NOT have a bed assignment.
A: Assignments- Number of active unit bed requests that DO have a bed assignment.
P: Pending Departures-Patients leaving unit as a Pending/Confirmed Discharge or Transfer.

BED INFORMATION:



ROW 1: 

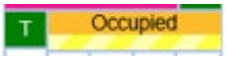
- Bed Number
- Gender-Denoted by background color
  - 

 Dark Pink-The bed is occupied by or assigned to a female patient.
  - 

 Dark Blue-The bed is occupied by or assigned to a male patient.

- E122-02 Light Pink-The bed can accommodate female patients but is not assigned or occupied.
- E120-02 Light Blue-The bed can accommodate male patients but is not assigned or occupied.
- E121-01 White-Gender unknown or the bed can accommodate patients of both genders

- Bed Assignment Priorities-Display to the left of the Bed Number. See Assigning a Bed section for more information.
- Observation Status-If the patient is in an observation status, you will see an 'O' displayed. The background color will change from green to yellow to red the longer the patient is in an observation status.

ROW 2: 

- Bed Status-written and indicated with a background color.
  - Dirty-Dirty (Brown)
  - Clean Next-Clean Next (Gray)
  - Stat-Stat (Red)
  - In Progress-In Progress (Yellow)
  - Suspended-Suspended (Dark Green)
  - Delayed-Delayed (Tan)
  - Clean-Clean (Green)
  - Blocked-Blocked (Blocked)
  - Occupied-Occupied (Orange)

- Patient Status-Displays the patient status for the patient either coming to or departing from a location.
  - **A** with a **blue** background A-Assigned patient is male.
  - **A** with a **pink** background A-Assigned patient is female.
  - **A** with a **white** background A-Assigned patient's gender unknown.
  - **T** with a **white** background T-Pending Transfer that has not been given a bed assignment
  - **T** with a **green** background T- Pending Transfer that has been given a bed assignment
  - **c** (lowercase) with a **red** background c -Confirmed Discharge with a discharge date after today or if there is no projected discharge date identified
  - **C** (uppercase) with a **red** background C -Confirmed Discharge with a discharge date for today
  - **d** (lowercase) with a **blue** background d -Pending Discharge with a discharge date after today or if there is no projected discharge date identified
  - **D** (uppercase) with a **blue** background D-Pending Discharge with a discharge date for today

Row 3: S

- Bed Attributes-Identified characteristics associated with a bed. For example, Near the Nurses Station. Bed Attributes are represented with a color background.
- Patient Attributes-Identified information related to a patient. For example, Fall Risk or Confused. Patient Attributes are represented with a number, letter, or symbol.

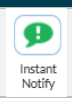
NOTE: Hovering the mouse over an Occupied bed will display additional information including Patient Name, Placement Status, Bed Attributes, Patient Attributes

INSTANT NOTIFY COMMUNICATION

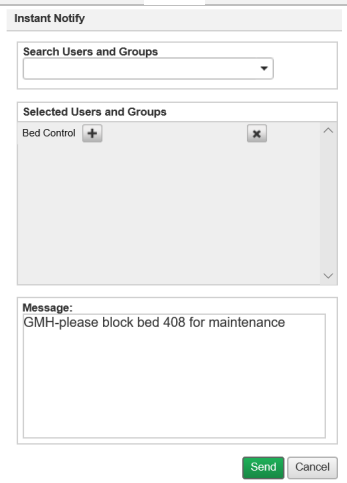
Instant Notify is a quick way to send non-urgent messages to groups like Patient Placement and Admitting. By using Instant Notify you are helping to reduce phone traffic to these busy areas, allowing them to focus on urgent matters. An example of when it would be appropriate to send an Instant Notify would be to let Patient Placement know a room needed blocked for maintenance. Instant Notify should not be used to communicate emergencies.

SENDING AN INSTANT NOTIFY

1. Click the Instant Notify icon to open the Instant Notify dialog box.

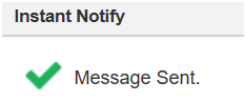


2. In the Search Users and Groups field, type a few letters of the User or Group to find the recipient. Repeat the process for additional recipients.
3. Type the contents in the Message section then click Send. You will see a notification at the top of the box that confirms the message has been sent.
4. Click cancel when finished to close the Instant Notify box.



NOTES:

- Patient Placement Notification group name: TBD
- Admitting Notification group name: TBD
- Be careful not to hit the Send button multiple times. Each time you click the button, the message will resend.
- If an Instant Notify is being sent to 25 or more users, you will get a pop-up message alerting you that you are sending the message to a large group of users. This is normal application behavior and are OK to proceed.
- These messages are reportable so be mindful of message content.
- If your Patient Placement department covers multiple hospitals, users sending messages to Patient Placement should include a campus identifier Patient Placement staff sees the correct messages. For example, if they were sending a message from General Medical Hospital, they could compose a message like: 'GMH-please block bed 408 for maintenance'



REPLYING TO AN INSTANT NOTIFY

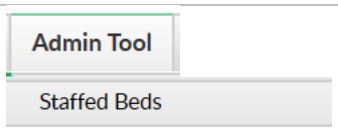
1. Access the Screen Alerts dialog box by clicking on the Alerts icon at the top of the screen.

2. The Screen Alerts webpage opens. To the right of each received message are two columns, Reply and Reply all. Click the appropriate option.
3. Compose the message and click, Send.

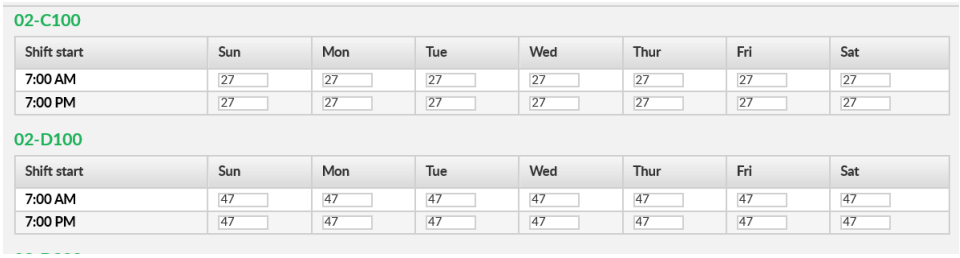
UPDATING STAFFED BEDS

Staffed Beds is a functionality that identifies if units are not currently staffed to capacity. When the Staffed Bed number is updated per shift, Patient Placement can easily see which units are staffed to take new patients if there are empty beds. Using Staffed Beds also helps Hospital Leadership capture more accurate information for current census for units that do not always staff to full capacity.

1. Click on the Admin Tool Tab at the top of the screen and select Staffed Beds



2. Identify the unit, day, and the shift and update the number as appropriate.
3. Continue until all units are completed and click Save. You will now see the SB (Staffed Bed) numbers on the bedboard update to the new values.



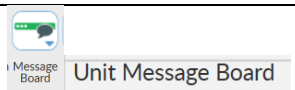
NOTES:

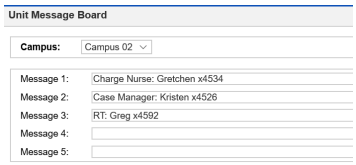
- Staffed Bed numbers only need to be updated if the Number is inaccurate
- If Patient Placement attempts to Target a unit that is already at capacity, an error message will display to alert them of the conflict.

MESSAGE BOARD

The Message Board is an additional communication tool that can contain messages from a Campus or Unit level. The Campus Message board is controlled by Patient Placement and contains information relevant to all Nursing Units. The Unit Message board is controlled by the unit and is only meant to be seen by that unit. Campus Messages will display on the left of the screen and Unit Messages display on the right. Message Board functionality can only be accessed in the PatientTracking Portal™ application.

1. To access the Message Board, click on the icon and select Unit Message Board in PatientTracking Portal™



2. Type you message in one of the five Message options. 3. Click Save when finished	

NOTES:

- If more than one message is posted, they will rotate automatically every 5-15 seconds depending on your hospital's settings. Hovering over the Message Board to see all messages at once.
- Messages do not expire. If a message is no longer relevant, it must be removed, or it will continue to display.
- These messages are not reportable but please still be mindful of what is being displayed.

ICU – **Critical care**, must have pulmonology or surgical critical care admitting, only floor other than A7 and B2 that can have a patient with stroke orders (NIH), can do CRRT

B2 – **Stepdown** (brain bleeds, traumas, etc), can have patients with stroke orders, can't take isolation patients

A2 – **Critical care/stepdown** (acuity adaptable) Post op hearts and lungs, can do CRRT/balloon pumps/Impella

A3 – **Critical care/stepdown** (acuity adaptable) TAVRs, can do Impella/balloon pumps

A4 – **Telemetry**, post cardiac cath lab (except groin approach)

A7 – **Telemetry**, stroke

C2 – **Telemetry**

C4 – **Telemetry,** surgical

C3 – **Pediatrics**, (anyone under 21 is considered pediatrics) can also send female gen med,

B3 – **Med surg**, a lot of surgeons like their post ops to go here

B4 – **Med surg**

D4 – **Med surg**, ortho

D5 – **Med surg**, oncology

D6 – **Psych**

LEVEL OF CARE v13

Purpose: Provide general guidelines for patient placement admission and as condition changes.

Goal: Admit every patient to the right bed, with the right resources, at the right time.

BOLD Items: indicate a requirement for specific level of care

Definitions of Level of Care

Unit	**Medical Surgical Telemetry General Care** **A4, A7, B3, B3S, B4, C2, C3, C4, D4, D5**	**Intermediate/ Progressive Care** **B2, A2, A3** Intermediate Care areas Moderately stable with an elevated risk for instability-high intensity care & vigilance with limited monitoring technology	**Critical Care** **Pavilion ICU, A2, A3** Acutely/critically ill with high risk for actual or potential life-threatening health problems: high intensity care and vigilance with variety of invasive & non-invasive monitoring technology
General Interventions	IV antibiotics, IV chemotherapy, laboratory, and radiographic work etc.	Interventions such as non-invasive ventilation, IV infusions or titration of vasodilators or antiarrhythmic substances.	Invasive interventions not provided anywhere else such as CSF fluid drainage or intracranial pressure management (ICP), invasive mechanical ventilation, vasopressors, intra-aortic balloon pump (IABP), left ventricular assist device (LVAD), or continuous renal replacement therapy (CRRT).
Assessment: Physical/Risk Assessment/POC/ Diagnostics/Sepsis	Every 4-8 hours Routine VS (includes routine post diagnostic & post-procedures VSq15-30 min until stable) Complete nursing assessments Q8h Daily, BID labs or diagnostics Chronic critical lab values with monitoring or acute critical lab values requiring non-intensive or protocol-driven interventions (i.e., fluid restrictions, blood transfusion, PO/PR medications, SSI, hypoglycemia, etc.) Positive sepsis screen without signs of end-organ failure with LA < 2.0	Every 2-4 hours: complete nursing assessments Q4h POC testing 4 or more times/shift (excludes AC/HS frequency) Q2-4-hour labs &/or diagnostics with changes in condition requiring advanced monitoring & skilled assessment, anticipated 4-8 hours Critical lab values requiring intensive interventions/resuscitation in any of the following: K, INR, pCO2, bicarb, Hgb etc. (i.e., more than one-time tx) Advanced monitoring includes cardiac monitoring, **arterial pressure monitoring, central venous pressure monitoring** **Positive sepsis screen: Severe sepsis (organ dysfunction) LA ≥ 2.0 and/or unresponsive to initial fluid bolus**	Every 30min-1hr for ≥ 2hours with instability and interventions required Q1-2hr labs & or diagnostic with changes in condition requiring advanced monitoring and skilled assessment for more than 4-8 hours Advanced monitoring includes **intra-abdominal pressure monitoring, intracranial pressure monitoring, pulmonary artery pressure monitoring or invasive cardiac output measurement** **Positive severe sepsis screen with 2 or more SIRS criteria, Lactic acid ≥ 4.0 or persistent hypotension after fluid bolus (Septic shock: LA≥4.0; and/or refractory hypotension with IV fluid bolus)**
Neuro, ETOH, Withdrawal	Q2-4 hr Neuro checks & PRN Neurovascular checks Q4 (except for limited post-procedure monitoring) CIWA monitoring; phase I Syncope requiring monitoring (+Tele)	Q2hr Neuro checks with deficits &/or minor changes CIWA≥ or =15 less than 6 times in 12 hours-Phase 1 Traumatic Brain Injury with GCS≥ or =8, without intracranial monitoring Stable spinal cord injury	Frequent neuro checks with significant deficits & or changes (Neuro or neurovascular checks q2h or more frequently) Unstable neurological status **CIWA phase II, C IWA≥15x3 consecutive checks** **Organ donation-Gift of Life**

	Stroke without intervention/TIA (+Tele) Stable post TPA or post thrombectomy stroke patients after 24 hours		**Stroke patients post-tPA and post-thrombectomy (first 24 hours)** **External ventriculostomy/ lumbar drain** **Unstable cervical spine** **Brain death**
Respiratory	Stable on RA/NC; oxygen requirements ≤ 40% Chronic sleep apnea For home O2 patients: Stable on home O2 or up to 2xnormal rate if ≥ 40% Stable /home use non-invasive ventilation (Tabletop CPAP/BiPAP with sleep)	**Acute change in status requiring O2≥ 40%** **For home O2 patients: 2-4x normal rate with signs and symptoms of distress** Continuous SPO2 or ETCO2 Suctioning ≥ q4 hours Heated high-flow cannula or non-invasive ventilation (BIPAP or CPAP) with stable or decreasing oxygen needs Respiratory or metabolic acidosis PH:7.2-7.3 Elevated O2 needs with increased risk of respiratory or airway instability Intermittent NIPPV (BiPAP) or BiPAP with improving O2 needs	**Mechanical ventilation** Acute or impending respiratory failure Patient with unstable respiratory status or airway Continuous NIPPV (BiPAP) or BiPAP with maximum support or worsening O2 needs Adult heated high flow (AHHF) O2 with increasing O2 needs **Respiratory or metabolic acidosis: PH ≤7.2 with respiratory compromise**
Cardiac/Peripheral Vascular Cardiovascular Procedures & Devices	Stable arrhythmia: afib/aflutter with Cardizem (+Tele) New arrhythmia with stable HR (+Tele) Prolonged QT interval (+Tele) Chest pain without evidence of MI (+Tele) Stable NSTEMI or stable non-ischemic myocardial injury (+Tele) Bedside planned cardioversion (+Tele) Post cardiac catheterization (diagnostic or closure device) (+Tele): Refer to guidelines Stable post-procedure patients requiring routine post-procedure monitoring and assessment	Arrhythmia with minor changes to BP and HR, requiring advanced monitoring and skilled assessment Recent ICD firing Immediate post-MRT, if needed Post-cardiac catheterization (with sheath) Refer to unit guidelines Stable post-procedure patients requiring post-procedure monitoring and assessment for more than 4 hours Stable complex post-procedure patients Post-procedure patients with elevated risk of instability Stable post-TAVR VT ablations Perivalvular Leak Repair **Pericardial drain** Refer to CCL Post-Procedure Unit Admit Guidelines for more detail Stable temporary pacing (epicardial only)	**Unstable arrhythmia with SBP≤90 and MAP≤60** **Acute STEMI, Targeted Temperature Management** **Immediate post cardiac arrest** Hypertensive emergency with continuous infusion Unstable post-procedure/OR IABP Ventricular assist device: Impella, implanted LVAD, CentriMag Transvenous or transcutaneous pacing Unstable temporary epicardial pacing Vascular checks every hour or more frequently (with the exceptions of routine post-procedure monitoring).

Complete IV/Medications	Refer to "IV Push/Infusion Chart" Continuous IV medications, requiring minimal titration &/or intervention per MMC policy Epidural/PCA pain management	Refer to "IV Push/Infusion Chart" Continuous IV medications, requiring moderate titration &/or intervention Procedural sedation	Refer to "IV Push/Infusion Chart" **Initiation or titration of multiple IV medications with maximum titration and or intervention for hemodynamic management** **DKA requiring insulin drip** **Sedation/Paralytics**
Therapies/Devices	Q4-8 hour full I&O measurement JP drain, hemovac, NG, Tube feeding, chest tube, tracheostomy requiring standard monitoring/care CAPD Q4-6-hour exchanges/cycler Basic groin management: post procedure	Q2hr full I&O measurement ≥4hours CAPD q2-4hr exchanges **Groin management** **Sheath removal** **CADD pumps for Pulmonary Hypertension (Veletri, Remodulin A3)**	Q1-2hr full I&O measurement CAPD q2-4-hour exchanges **CRRT, Targeted Temperature Management (Arctic Sun), Impella, IABP/LVADs** **Temporary internal or external pacemaker** (may exclude epicardial) TPA with EKOS Ultrasound **CSF drainage device with or without pressure monitoring** Rotorest/Progressa ICU bed TAVR/Structural Heart cases require Critical Care for first 4-12 hours Open heart surgery cases require CC for first 6-12 hours until patient is extubated or delined TPA or PE/CVA require CC for first 12-16 hours Post-tracheostomy tube insertion requires critical care

One Patient Record Updated Accommodation Codes:

- Effective January 25th, with One Patient Record Updates, the "Bed Type Requested" order will be changing to "Accommodation/Level of Care-MMC Code." This order will still allow specific bed/unit location requested; however, the following accommodation codes could be seen on **<u>any unit</u>** and **<u>does not define the Level of Care</u>**:
  - ICU/Critical Care
  - ICU/Critical Care w Iso
  - Intermed/PCU/Step Down
  - Intermed/PCU/Step Down w Iso
  - Med-Surg
  - Med-Surg w Iso
  - Observation
  - Oncology
  - Oncology w ISO
  - Pediatrics
  - Pediatrics w ISO
  - Surgery

Level of Care Document Considerations:

- ✓ Critical Care Intensivists Providers (Surgical Critical Care & Pulmonary Critical Care [SCC & PCC]) accept any medical, surgical, neuro, trauma, intensive care level patients. SCC & PCC patients are placed in ICU, in the appropriate level of care for their current needs.
- ✓ All cardiology patients are placed on A3 or A4, in the appropriate level of care for their current needs.
- ✓ For any patient requiring telemetry with THV as the attending or consulting, place on A3 or A4, according to level of care needs. It may be necessary to move patients to accommodate this request.
- ✓ For CTS service, patients will be placed on A2.
- ✓ It is not necessarily best practice to equally distribute admissions to all departments. The attending and consulting provider, the patient needs, and the level of care should all be considerations.

Stroke ICU: All Medical Surgical Neuro Trauma ICU level patients may be admitted to ICU. SCC provides care for: Post thrombectomy, emergent and non-emergent stents, aneurysm clippings and coils, emergent and non-emergent.

PCC providers will manage ischemic strokes requiring critical care, hemorrhagic strokes requiring critical care, post TNK patients. This includes admissions from the ED, transfers from other floors, and transfers from outside facilities.

CEA procedures under Vascular Surgeons: CEA may be admitted first in A2 &A3 under the care of the Hospitalist Providers. If no bed available in A2 & A3, these patients may be admitted to ICU, under the care SCC or PCC teams.

CIWA Phase 2 & DKA Patients: Hospitalists will continue to provide medical management of these patients. These patients may be admitted to A3 or A2 areas, will be receiving critical care level of care and cared for by critical care RNs. Sound and PCC providers will collaborate on a case by case basis to determine level of care required and the most appropriate attending service. Intensive care may be needed.

MUNSON HEALTHCARE
IV MEDICATION ADMINISTRATION GUIDELINES

Definitions

Level 1	Units with general nursing and monitoring capabilities (ex. med-surg).
Level 2	Intermediate and telemetry units. RNs working on these units have more advanced training and advanced monitoring resources (i.e. telemetry) are present. Level 2 may be further divided into level 2a (telemetry units) or level 2b (step-down units) where applicable.
Level 3	Critical and emergency care units (including operating rooms). Licensed clinicians working on these units are trained to respond to emergencies and manage critically ill patients. Advance monitoring and treatment resources are readily available.
OB	Birthing units and units dedicated to the care of antepartum and postpartum patients. OB units follow level 1 criteria except where noted.
PEDS	Any unit caring for patients 18 years of age or less. Peds may be further subdivided as **level 1, level 2, and level 3** according to the criteria above.

Exclusions

- Chemotherapy/antineoplastic agents
- Biologics and immune therapies typically restricted to outpatient administration (ex. Infliximab, vedolizumab)
- Blood and blood components
- Contrast and radiopharmaceuticals
- Parenteral nutrition
- Basic IV hydration fluids (ex. 0.9% normal saline, 5% dextrose, Normosol, lactated ringers)
- Non-intravenous parenterally administered drugs (IM, SQ)

During emergency situations (ex. code blue or MRT/PRT with provider present), refer to level 3 guidelines regardless of location. Patient may be treated as level 3 as long as critical care trained RN and/or provider remain present with patient until transfer to higher level of care.

All intermittent and continuous infusions should be administered via infusion pump with dose error reduction software using drug and site of care specific infusion profiles, when available.

Related Policies

- Viewing Medication Administration
- Viewing Extravasation Management
- Viewing Standard Adult Guidelines for Titratable Continuous Infusions
- Viewing USP <800> Handling Hazardous Drugs in Healthcare Settings

Site	Level 1 Units	Level 2 Units (with telemetry monitoring and tele trained and/or ACLS certified nursing staff)	Level 3 Units	OB Units	Peds
MHC Cadillac		3A, 3B, 2BSC	ED, ICU, PACU	OB	ED, OR, PACU, OB newborn
MHC Charlevoix		MedSurg	ED, OR, PACU	OB	ED, OR, PACU, OB newborn
MHC Grayling		2North, OPS	ED, CCU, OR, PACU	OB	ED, OR, PACU, OB newborn
Kalkaska Memorial Hospital		MedSurg	ED, OR, PACU		ED, OR, PACU
MHC Manistee		MedSurg	ED, OR, PACU		ED, OR, PACU
Munson Medical Center (Traverse City)	• B3 • B4 • C1/C2Rehab • C3 (non-peripartum adults) • D4 • D5 • D6 • Pre-op surgery • General radiology • Non-invasive cardiology	• 2a: C2, A4, A7, C4 • 2b: MPR, A2 (intermediate), A3 (intermediate), B2	• ICU • ED • PACU • OR • A2 (critical) • A3 (critical) • IR • CCL	• OB • C3 (pregnant or immediate post-partum)	• Level 1: C3 general and newborn, OB newborn, Pre-op, phase 2 PACU, radiology • Level 2: C3 intermediate • Level 3: NICU, ED, OR, Phase 1 PACU
MHC Otsego		MedSurg	ICU, ED, OR, PACU	OB	OB newborn
Paul Oliver Memorial Hospital	Acute Care		ED, OR, PACU		ED

MUNSON HEALTHCARE
IV MEDICATION ADMINISTRATION GUIDELINES

Medication	IV Push	IV Infusion
Acetaminophen (Ofirmev, Tylenol)	NA	• All areas • Infuse over 15 minutes
Acetazolamide (Diamox)	• All areas • Maximum rate 150mg/min	NA
Acetylcysteine (Acetadote)	NA	• All areas • Intermittent or continuous infusion
Acyclovir (Zovirax)	NA	• All areas • Infuse over minimum 1 hour • Maintain adequate hydration during therapy • Irritant with vesicant-like properties
Adenosine (Adenocard)	• **Adult level 2 by tele credentialed RN and 3, Peds level 3** • Rapid IV Push (1-2 seconds) as proximal to vein as possible followed by rapid saline flush • Must be on cardiac monitor during administration	• **Cath Lab only** • Continuous infusion • Peripheral line only
Albumin (Flexbumin, Albutein, others)	NA	• All areas • Max infusion rate 1-2 mL/min (may infuse more rapidly if shock present)
Alprostadil (Prostin VR)	NA	• **Peds level 3** • Continuous infusion
Alteplase (Activase, Cathflo)	• All areas (for catheter clearance only); **Adult level 3 for PE** • Instill into catheter for 30min dwell, then aspirate • Policy: Clearing Occluded Central Venous Catheters Link	• **Adult level 3 – MMC only** • Continuous infusion • Policy: Alteplase for Catheter-Directed Thrombolysis Link
Amikacin	NA	• All areas • Infuse over 30-60min
Aminocaproic acid (Amicar)	NA	• All areas • Intermittent infusion over 15-60min or continuous infusion
Aminophylline	• **Cardiac stress test units only** for reversal of dipyridamole or regadenoson-induced adverse reactions Administer over 30-60 sec. • Policy: Guidelines for Pharmacologic Stress Testing Using Regadenoson Link	NA
Amiodarone (Nexterone)	Code blue only with provider present	• **Adult level 2 and 3, Peds level 3** • Vesicant properties • Intermittent or continuous infusion • Central line preferred • 0.2 micron in-line filter required for peripheral administration • Telemetry required
Amphotericin B liposomal (Ambisome)	NA	• All areas • Administer over 2 hours initially, may reduce to 1 hour if initially tolerated • Not compatible with saline; flush before and after with D5W • 1.2-micron filter recommended • Monitor for infusion-related reactions. Pre-medications (acetaminophen, antihistamine, steroid) MAY be used. Stop infusion and notify provider for respiratory distress • Maintain adequate hydration. Pre-infusion of saline may be used to decrease risk of nephrotoxicity
Ampicillin	NA	• All areas • Infuse over minimum 10-15min
Ampicillin-Sulbactam (Unasyn)	NA	• All areas • Infuse over 15-30min
Aprepitant (Cinvanti, Aponvie)	• **Restricted to pre-op areas and oncology (D5)** • IV push over 30 sec • Flush line with 0.9% sodium chloride before and after administration	NA
Angiotensin II (Giapreza)	NA	• **Adult level 3** • Continuous infusion • Irritant with vesicant-like properties • Central line required
Antivenin crotalide (Crofab, Anavip)	NA	• **Adult and peds level 2 and 3**

MUNSON HEALTHCARE
IV MEDICATION ADMINISTRATION GUIDELINES

Medication	IV Push	IV Infusion
		• Initiate infusion at 25-50mL/hr for first 10 minutes. If tolerated, increase to 250mL/hr or to a rate to allow infusion of dose over 1hr • Monitor for allergic or infusion-related reactions and discontinue or decrease rate if infusion reactions occur
Argatroban	NA	• All areas • Continuous infusion
Atropine	• **Adult level 2 and 3, Peds level 3** • Other areas in code blue/MRT only • Rapid IV push • Must be on cardiac monitor during administration	NA
Azithromycin (Zithromax)	NA	• All areas • Infuse over 1 hr
Aztreonam (Azactam)	NA	• All areas • Infuse over 20-60 min
Benztropine (Cogentin)	• All areas • Slow IV push	NA
Bivalirudin (Angiomax)	• **Adult level 2 and 3**	• **Adult level 2 and 3** • Continuous infusion
Bumetanide (Bumex)	• All areas • Slow IV Push over 1-2 minutes	• All areas • Continuous infusion
Butorphanol (Stadol)	• All areas	NA
C1 Esterase Inhibitor (Berinert, Cinryze)	• All areas • Administer at a rate of 4mL/min	NA
Caffeine and Sodium Benzoate	NA	• All areas • Administer through 0.2-micron filter
Caffeine citrate (Cafcit)	• **Cardiac stress test units only** for reversal of dipyridamole or regadenoson-induced adverse reactions • Administer over 3-5 minutes	• **Peds level 3** • Infuse over 10-30 min (dose dependent)
Calcium chloride	• **Emergent use and immediate post-op cardiothoracic surgery only** • Rapid IV push in cardiac arrest or over 5-10min in pediatric cardiac arrest, max rate 100mg/min in non-code situation • **Vesicant** • Central line or intraosseous only unless during cardiac arrest • Must be on cardiac monitor during administration	• **Adult level 2 and 3, peds level 3 (intermittent); Adult level 3 (continuous)** • **Vesicant** • Intermittent infusion over 1 hour or continuous infusion • Central line required
Calcium gluconate	• **Adult level 2 and 3, Peds level 3, OB** • Cardiac arrest: Rapid IV push • Non-cardiac arrest: max rate 200mg/min • **Vesicant**	• All areas (intermittent); **adult level 3 (continuous)** • **Vesicant**
CeFAZolin (Ancef, Kefzol)	• **All adult areas** • IV push over 3-5 minutes	• All areas • Intermittent infusion over 30-60 min or continuous infusion (adult only) 6-8gm over 24hr
Cefepime (Maxipime)	• **All adult areas** • IVPB preferred; IV push acceptable during IV fluid shortages, per P&T approval • IV push over 2-5 min	• All areas • Infuse over 30 min
Ceftaroline (Teflaro)	NA	• All areas • Infuse over 60 min
Ceftazidime (Fortaz, Tazicef)	• **All adult areas** • IVPB preferred; IV push acceptable during IV fluid shortages, per P&T approval • IV push over 3-5 min	• All areas • Infuse over 30min
Ceftazidime-avibactam (Avycaz)	NA	• All areas • Infuse over 2 hours
Ceftolozane-tazobactam (Zerbaxa)	NA	• All areas • Infuse over 1-3 hours (indication specific)
CefTRIAXone (Rocephin)	• **All adult areas** • IV push over 5 min	• All areas • Infuse over 30min

Medication	IV Push	IV Infusion
		• Avoid in children under 1 month of age
Chlorothiazide (Diuril)	• All areas • IV push over 3-5 min	NA
Chlorpromazine (Thorazine)	NA	• All areas • Intermittent infusion, maximum rate 1mg/min (0.5mg/min peds) • To reduce risk of hypotension, patient must be lying down during infusion and for 30 min after completion • Vital signs q15 min for 1hr
Ciprofloxacin (Cipro)	NA	• All areas • Infuse over 60 min • Large vein preferred
Clindamycin (Cleocin)	NA	• All areas • Infuse over 10-60 min (max rate 30mg/min)
Cosyntropin (Cortrosyn)	• All areas • IV push over 2min • Contact lab prior to administration to coordinate timing of associated lab monitoring	NA
Cyclosporine (Sandimmune) **HAZARDOUS DRUG**	NA	• All areas • Infuse via provided DEHP-free, low sorption, non-filtered tubing • Intermittent or continuous infusion • Monitor for anaphylaxis: continuous observation for the first 30 min, then q1 hr vitals for first 4 hours, then routine (minimum q4 hr during infusion)
Dalbavancin (Dalvance)	NA	• All adult areas (typically restricted to ED) • Infuse over 30 min • Flush line before and after with dextrose 5%
DAPTOmycin (Cubicin)	• All **adult** areas • IV push over 2 min	• All areas • Infuse over 30 min (60 min in children under 7 years old)
Dantrolene (Ryanodex)	• **Adult and peds level 2 (interventional units) and Level 3, OB** • Level 1 with provider present • **Vesicant** • Crisis dose rapid IV Push; follow up doses over at least 1min • Policy: Malignant Hypothermia Guidelines Link	NA
Deferoxamine (Desferal)	NA	• All areas • Intermittent or continuous infusion • Max rate 15mg/kg/hr • Monitor for infusion reactions
Desmopressin (DDAVP)	• All areas • Max IV push dose = 4mcg	• All areas • Infuse over 10-30min
DexAMETHasone (Decadron)	• All areas • Max IV push dose = 10mg • IV push over at least 1min (may give more slowly if patients experience tingling sensation)	• All areas • All doses over 10mg, infuse over 15-30min
DexmedeTOMIDine (Precedex)	• **Restricted to credentialed provider** • **Policy: Sedation Link**	• **Adult and peds level 3** • Continuous infusion
Dextran (LMD)	NA	• All areas • Administer through 0.2-micron filter • Monitor for anaphylaxis: continuous observation for the first 30min, then q1hr vitals for first 4 hours, then routine (minimum 4hr during infusion)
Dextrose 10%	NA	• All areas • **Irritant**
Dextrose 25%	• **All peds areas** • **Irritant/vesicant** • Central line preferred • For peripheral administration, dextrose 10% infusion is preferred outside of emergency situations • Policy: Hypoglycemia Protocol for the Pediatric Patient Link	NA

MUNSON HEALTHCARE
IV MEDICATION ADMINISTRATION GUIDELINES

Medication	IV Push	IV Infusion
Dextrose 50%	• All areas • **Irritant/vesicant** • For infants and children younger than adolescence, use dextrose 25% • Central line preferred • For peripheral administration, dextrose 10% is preferred outside of emergency situations • **Policy: Hypoglycemia Management Protocol – Adults** Link • **Policy: Hypoglycemia Protocol for the Pediatric Patient** Link	NA
Dextrose 20% or 70%	NA	• **Adult and peds level 3** • For use along with high-dose insulin for calcium channel blocker/beta blocker toxicity or hypertriglyceridemia • **Vesicant; central line required** • Guideline: Dextrose Titration Guideline for Hypertriglyceridemia Link • Guideline: Management of Calcium Channel Blocker and Beta Blocker Toxicity Link
Diazepam (Valium)	• All areas • IV push at max rate of 5mg/min (adults) or 2mg/min (peds)	NA
Digoxin (Lanoxin)	• **Adult level 2 and 3, OB, peds level 3** • **Vesicant** • IV push over at least 5min • Cardiac monitoring required	NA
Digoxin Immune FAB (Digifab, Digibind)	NA	• **Adult level 2 and 3, peds level 3** • Administer over at least 30 min (may administer more rapidly if cardiac arrest is imminent)
Dihydroergotamine (DHE) **HAZARDOUS DRUG**	• All areas • IV push over 2-3 min	NA
Diltiazem (Cardizem)	• **Adult level 2 and 3** • A single dose may be given in level 1 areas with provider present and continuous ECG monitoring and q15 min vitals for 1hr post administration. • IV push over 2 min	• **Adult level 2 and 3** • Level 2 units may elect to transfer patient based on existing monitoring resources and availability of trained staff. Verify with unit or hospital nursing leadership. • Continuous infusion
Diphenhydramine (Benadryl)	• All areas • IV push at max rate of 25mg/min	NA
DOBUTamine	NA	• **Adult and peds level 3** • **Adult level 2(b) (fixed rate only)** • Continuous infusion • **Vesicant**
DOPamine	NA	• **Adult and peds level 3** • **Adult level 2(b) (fixed rate only)** • Continuous infusion • **Vesicant** • Central line recommended • **Policy: Adult Guidelines for Peripheral Administration of Vasopressor Therapy** Link
Doxercalciferol (Hectorol)	• All areas	NA
Doxycycline (Doxy)	NA	• All areas • Infuse over at least 1 hr • **May be an irritant**
Droperidol (Inapsine)	• All areas • Slow IV push (2-5 min recommended) • Cardiac monitoring required for > 2 doses in 24 hours of >2.5mg single doses	NA
Enalaprilat (Vasotec)	• All areas • IV push over 5 min • BP q15 min for 1 hour post administration	NA
EPHEDrine (Akovaz, Emerphed)	• **Adult level 3, OB**	NA

MUNSON HEALTHCARE
IV MEDICATION ADMINISTRATION GUIDELINES

Medication	IV Push	IV Infusion
EPINEPHrine (Adrenalin)	• **Adult and peds level 3** • **Vesicant**	• **Adult and peds level 3** • Continuous infusion • **Vesicant –** central line **required** • In emergent situation, may initiate peripherally, with central line placed ASAP
Epoetin (Retacrit, Procrit, Epogen)	• All areas • Usually administered via hemodialysis line (SQ preferred in most other indications)	NA
Eptifibatide (Integrelin)	• **Adult level 2(b) and 3**	• **Adult level 2(b) and 3** • Continuous infusion
Ertapenem (Invanz)	NA	• All areas • Infuse over 30min
Erythromycin (Erythrocin)	NA	• All areas • Administer over 20-60min • **May be an irritant**
Esmolol (Brevibloc)	• **Adult level 2(b) and 3** • IV push over 30-60sec • **Vesicant**	• **Adult level 2(b) and 3** • Continuous infusion • **Vesicant; central line recommended**
Estrogens, conjugated (Premarin) **HAZARDOUS DRUG**	NA	• All areas
Etomidate (Amidate)	• **Restricted to privileged provider or with privileged provider present during emergent intubation.** • Policy: Sedation Link • IV push over 30-60sec • **Irritant – avoid administration into small vessels**	NA
Factor Anti-inhibitor Coagulant Complex (Feiba)	• All areas • Max dose = 1000 units • IV push at a rate of 2 units/kg/min	• All areas • Doses greater than 1000 units • Infuse at a rate of 2 units/kg/min
Factor VII (NovoSeven, SevenFact)	• All areas • IV push over 2-5 minutes	NA
Factor VIII (Xyntha, Wilate, Humate, others)	• All areas • Refer to package insert for administration guidelines	NA
Factor IX (Benefix, Alprolix, others)	• All areas • Refer to package insert for administration guidelines	NA
Famotidine (Pepcid)	• All areas • IV push over at least 2 minutes	NA
Fat Emulsion (Intralipid, others)	• All areas (with provider present) • Policy: Lipid (Intralipid Fat Emulsion) Rescue Guidelines for Systemic Local Anesthetic Toxicity and Other Highly Lipid Soluble Drugs Link	• All areas • Typically infused in conjunction with parenteral nutrition
Fentanyl (Sublimaze)	• **Adult and peds level 3, OB** • **Adult level 1 and 2: palliative care on MMC D5 or procedural analgesia with provider present** • IV push over 1-2 minutes	• **Adult and peds level 3** • Continuous IV infusion
Fluconazole (Diflucan) **HAZARDOUS DRUG**	NA	• All areas • Infuse over 1-2 hours; max rate 200mg/hr
Flumazenil	• All areas • IV push at a rate of 0.1-0.2mg/min • Viewing Flumazenil Protocol	NA
Folic acid	NA	• All areas • Intermittent infusion over 30 min or continuous infusion
Fomepizole (Antizol)	NA	• **Adult and peds level 2 and 3** • Infuse over 30 min
Fosaprepitant (Emend)	NA	• All areas • Infuse over 20-30 min
Foscarnet (Foscavir)	NA	• All areas • Administer at max rate of 1mg/kg/min • Pre-hydration recommended to mitigate risk of nephrotoxicity
Fosphenytoin	NA	• All areas

IV MEDICATION ADMINISTRATION GUIDELINES

Medication	IV Push	IV Infusion
(Cerebyx) **HAZARDOUS DRUG**		• Emergent use/loading doses: max rate 150mg/min (2mg/kg/min pediatrics, 10-30min in neonates) • Non-emergent use/maintenance doses: infuse over 30min (adults) or at a max rate of 1-2mg/kg/min (peds) with max 100mg/min
Furosemide (Lasix)	• All areas • Slow IV push over **at least** 1 min (max rate 40mg/min)	• All areas • Continuous infusion
Ganciclovir (Cytovene) **HAZARDOUS DRUG**	NA	• All areas • Infuse over at least 1 hour • **May be an irritant**
Gentamicin	NA	• All areas • Infuse over 30-120min
Glucagon (GlucaGen)	• All areas • IV push over 1 min for diagnostic procedures • IV push over 3-5 min for other indications	• **Adult level 2 and 3, peds level 3** • Continuous infusion • Guideline: Management of Calcium Channel Blocker and Beta Blocker Toxicity Link
Glycopyrrolate (Robinul)	• All areas • IV push over 1-2 min	NA
Granisetron (Kytril)	• All areas • IV push over 30 sec	NA
Haloperidol lactate (Haldol)	• All areas • IV push at maximum rate 5mg/min • Doses over 2mg: telemetry or ECG monitoring during and for 2-3 hours post-administration recommended	NA
Heparin	• All areas	• All areas • Continuous infusion
HydrALAZINE (Apresoline)	• All areas • IV push over 2 min	NA
Hydrocortisone (SoluCortef)	• All areas • Max dose = 500mg • IV push over at least 30 sec	• All areas • IVPB for doses greater than 500mg • Infuse over 10-30 min
HYDROmorphone (Dilaudid)	• All areas • IV push over 2-3 min	• All areas • Continuous infusion or PCA
Hydroxocobalamin (Cyanokit)	NA	• **Adult and peds level 3** • Infuse through vented tubing, per instructions in kit
Ibuprofen lysine (Neoprofen)	NA	• **Peds level 3 (NICU only)** • Infuse over 15 min
Ibutilide (Corvert)	• **Adult level 2 or 3** • **Provider must be present during administration** • IV push over 10min	NA
Idarucizumab (Praxbind)	• All areas • IV push over maximum 5-10 min per vial • Flush before and after with 0.9% sodium chloride	• All areas • Infuse each vial over maximum 5-10 min • Flush before and after with 0.9% sodium chloride
Imipenem-cilastatin (Primaxin)	NA	• All areas • Infuse doses 500mg or less over 20-30 min, doses greater than 500mg over 40-60 min • If patient experiences nausea during administration, slow infusion rate
Immune Globulin (IVIG) (Octagam, Gammagard, others)	NA	• All areas • Infuse per product-specific recommendations
Indocyanine green (IC Green)	Restricted to pre-op/surgical areas	NA
Insulin, regular (Humulin R, Myredlin)	• All areas	• **Adult level 3, OB, peds level 2 and 3** • Continuous infusion
Iron sucrose (Venofer)	• All areas • Max IV push dose = 200mg (peds = 100mg) • IV push over 2-5min	• All areas • IVPB for all doses >200mg (adult) or >100mg (peds) • Infusion rate varies by dose, range 1.5-4 hr (adult) or 30-90min (peds) • Monitor for signs and symptoms of hypersensitivity during infusion and for 30min after completion
Isoproterenol (Isuprel)	NA	• **Adult level 2(b) or 3** • Continuous infusion

MUNSON HEALTHCARE
IV MEDICATION ADMINISTRATION GUIDELINES

Medication	IV Push	IV Infusion
Ketamine (Ketalar)	• **Adult and peds level 3** • **Restricted to credentialed provider only UNLESS low dose (0.25-0.5mg/kg, max 40mg) for analgesia** • IV push over at least 1min	• **Adult and peds level 3** • Continuous infusion for sedation or pain or IVPB over 40min for treatment resistant depression • Low dose continuous infusion (up to 0.3mg/kg/hr or 30mg/hr) may be given for palliate care, restricted to **MMC D5**
Ketorolac (Toradol)	• All areas • IV push over at least 15sec	NA
Labetalol (Trandate)	• **Adult level 2 and 3, OB, peds level 3** • IV push at rate of 10mg/min	• **Adult level 2b and 3** • Continuous infusion
Lacosamide (Vimpat)		• All areas • Infuse over 30-60 min
Leucovorin	NA	• All areas • Intermittent infusion at max rate of 160mg/min (recommended rate varies by indication)
LevETIRAcetam (Keppra)	• All **adult** areas • Max IV push dose 1000mg • IV push over 2-5min	• All areas • IVPB over 5-15min
LevOCARNitine (Carnitor)	• All areas • IV push over 2-3min	NA
LevoFLOXacin (Levaquin)	NA	• All areas • Infuse over 60 min (250-500mg) or 90 min (750mg) • Maintain adequate hydration
Levothyroxine (Synthroid)	• All areas • IV push at max rate 100mcg/min	• **Level 3** • Continuous infusion
Lidocaine	• **Adult level 2 by tele credentialed RN and 3, peds level 3** • IV push at rate of 25-50mg/min (may be given more rapidly in cardiac arrest)	• **Adult level 2 and 3, peds level 3** • Continuous infusion
Linezolid (Zyvox)	NA	• All areas • Infuse over 30-120 min
Lorazepam (Ativan)	• All areas • Immediately prior to use dilute with an equal volume of saline • IV push at max rate of 2mg/min	• **Adult and peds level 3** • **D5 for palliative sedation** • Continuous infusion • Administer through 0.2-micron filter
Magnesium sulfate	**During cardiac arrest only**	• All areas (intermittent): **adult and peds level 3, OB (continuous)** • Intermittent infusion at usual rate of 1gm/hr (may be given more rapidly for some indications)
Mannitol (Osmitrol)	NA	• All adult areas, **peds level 3** • Administer through 1.2-micron filter
Meperidine (Demerol)	• All areas • Dilute to 10mg/mL or less with saline immediately prior to administration and administer slow IV push	NA
Meropenem	NA	• All areas • Infuse over 15-30min
Mesna (Mesnex)	NA	• All areas
Methadone (Dolophine)	NA	• All areas
Methocarbamol (Robaxin)	NA	• All areas • Administer while patient in recumbent position, and maintain position for at least 10-15 min following infusion
Methylene blue (Provay blue, others)	• All areas • Slow IV push over several minutes	NA
Methylergonovine (Methergine) **HAZARDOUS DRUG**	• **Adult level 3, OB** • IV push over at least 1 min for emergency use only (otherwise give IM)	NA
Methylprednisolone (SoluMedrol)	• All areas • Doses up to 125mg • Slow IV push	• All areas • Doses greater than 125mg • Infuse over 30-60 min • Larger doses may be administered more quickly when used for acute spinal cord injury
Metoclopramide (Reglan)	• All areas • Doses up to 10mg	• All areas • Doses greater than 10mg

IV MEDICATION ADMINISTRATION GUIDELINES

Medication	IV Push	IV Infusion
	• Slow IV push over 1-2 min • Rapid administration may cause transient restlessness/anxiety	• Infuse over at least 15 min
Metoprolol (Lopressor)	• **Adult level 2 and 3** • IV push over 1 min	• **Adult level 1** • Infuse over 30-60 min • Monitor HR and BP after infusion and at minimum q4hr while receiving IV metoprolol
Metronidazole (Flagyl)	NA	• All areas • Infuse over 30-60 min
Micafungin (Mycamine)	NA	• All areas • Infuse over 1 hr • If patient experiences an infusion reaction, slow infusion rate • Flush with 0.9% sodium chloride prior to administration
Midazolam (Versed)	• **Adult and peds level 3** • **May give in procedural areas for anxiety** • IV push over 2 min	• **Adult and peds level 3** • Continuous infusion
Milrinone	NA	• **Adult level 2(b) and 3, peds level 3** • Continuous infusion
Morphine	• All areas • IV push over 4-5 min	• All areas • Continuous infusion or PCA
Multiple vitamins (Infuvite)	NA	• All areas
Mycophenolate mofetil (CellCept) **HAZARDOUS DRUG**	NA	• All areas • Infuse over at least 2 hr
Nafcillin	NA	• All areas • Infuse over 30-60 min or continuous infusion
Nalbuphine (Nubain)	• All areas • IV push over 2-3 min	NA
Naloxone (Narcan)	• All areas • IV push over 30 sec • Policy: Standing Order/Protocol for Adult Naloxone (Narcan) Link	• All adult areas, **peds level 2 and 3** • Continuous infusion for epidural related pruritis (all areas) or opioid overdose (peds and adult level 2(b) or 3)
Neostigmine (Prostigmin)	• **Adult and peds level 3** • IV push over at least 1 min	• **Adult level 2(b) or 3** • Infuse over 60 min for colonic pseudo-obstruction
Nicardipine (Cardene)	NA	• **Adult level 2 or 3** • Continuous infusion • Irritant – administer through central line or large peripheral vein
NitroGLYcerin	IV push by provider only in procedural areas	• **Adult level 2 or 3** • Continuous infusion
NitroPRUSside (Nipride)	NA	• **Adult level 3** • Continuous infusion
Norepinephrine (Levophed)	NA	• **Adult and peds level 3** • Continuous infusion • **Vesicant; central line preferred** • Policy: Adult Guidelines for Peripheral Administration of Vasopressor Therapy Link
Octreotide (Sandostatin)	• All areas • IV push over 3 min (usually given SQ)	• All areas • Continuous infusion
Ondansetron (Zofran)	• All areas • Max IV push dose = 8mg • IV push over 2 min	• All areas • Doses > 8mg IVPB over 15 min
Orphenadrine	• All areas • IV push over 2-5 min	NA
Oxacillin	NA	• All areas • Intermittent infusion over 30 min or continuous infusion
Oxytocin (Pitocin) **HAZARDOUS DRUG**	NA	• **Adult level 3, OB** • Continuous infusion
Pantoprazole (Protonix)	• All areas • IV push over 2 min	NA

IV MEDICATION ADMINISTRATION GUIDELINES

Medication	IV Push	IV Infusion
Pamidronate (Aredia) **HAZARDOUS DRUG**	NA	• All areas • IVPB rate varies by indication (usual range 2-24 hours)
Papaverine	• **Adult level 3** • IV push over 1-2 min	NA
Penicillin G (Pfizerpen)	NA	• All areas • IVPB over 15-30 min or continuous infusion
Pentamidine (Pentam)	NA	• All areas • IVPB over 60-120 min • **Irritant with vesicant-like properties**
PENTobarbital (Nembutal)	• **Adult level 3** • Slow IV push at max rate of 50mg/min • May be an irritant	• **Adult level 3** • IVPB at rate not to exceed 50mg/min or continuous infusion • **May be an irritant** • Administer through 0.2 micron filter
PHENobarbital	NA	• **Adult level 2b and 3 and peds level 3** • Infuse at max rate of 50-100mg/min (over 15-60 min in neonates) • **May be an irritant;** large vein preferred
Phentolamine (Regitine)	• **Adult level 3** • Rapid IV bolus	NA
Phenylephrine (NeoSynephrine, Biorphen, Vazculep)	• **Adult level 3, OB** • IV push over 20-30 sec	• **Adult and peds level 3** • Continuous infusion • **Vesicant; central line recommended** • Policy: Adult Guidelines for Peripheral Administration of Vasopressor Therapy Link
Phenytoin (Dilantin)	NA	• All areas • Infuse at max rate 50mg/min • **Vesicant; central line or large peripheral vein/large gauge catheter required** • Administer through 0.2micron filter • Flush line before and after with 0.9% sodium chloride
Physostigmine	• **Adult and peds level 3** • IV push at max rate 1mg/min (adult) or 0.5mg/min (peds)	NA
Phytonadione (AquaMephyton, Vitamin K)	NA	• All areas • Infuse at max rate of 1mg/min
Piperacillin/Tazobactam (Zosyn)	NA	• All areas • Infuse over 30 min to 4 hr (longer infusion times preferred in adult patients after initial loading dose)
Potassium acetate	NA	• All areas • Policy: Parenteral Potassium Supplementation Policy – Adult Link • Policy: Parenteral Potassium Supplementation – Pediatric Link • **Vesicant/irritant at concentrations > 10mEq/100mL**
Potassium chloride	NA	• All areas • Policy: Parenteral Potassium Supplementation Policy – Adult Link • Policy: Parenteral Potassium Supplementation – Pediatric Link • **Vesicant/irritant at concentrations > 10mEq/100mL**
Potassium phosphate	NA	• All areas • Policy: Parenteral Potassium Supplementation Policy – Adult Link • Policy: Parenteral Potassium Supplementation – Pediatric Link • **Vesicant/irritant (concentration dependent)**
Pralidoxime (Protopam)	• **Adult and peds level 3** • IV push in emergent situation only; IVPB preferred • Dilute to 50mg/mL with sterile water for injection and administer IV push over at least 5 min	• **Adult and peds level 3** • Infuse over 15-30 min (consider slower rates up to 60 min in peds)

IV MEDICATION ADMINISTRATION GUIDELINES

Medication	IV Push	IV Infusion
Procainamide	NA	• **Adult level 2 and 3** • Intermittent infusion at 20-50mg/min and continuous infusion
Prochlorperazine (Compazine)	• All areas • Slow IV push at max rate 5mg/min • Rapid administration may cause transient restlessness/anxiety	NA
Propofol (Diprivan)	• **Adult and peds level 3** • **Restricted to privileged provider or with privileged provider present during emergent intubation.**	• **Adult and peds level 3** • Continuous infusion
Propranolol	• **Adult level 2 and 3, peds level 3** • IV push at max rate 1mg/min	NA
Protamine	• All areas • IV push max dose 50mg over 10 min	• All areas • Max rate 5mg/min
Prothrombin Complex Concentrate (Balfaxar, Kcentra)	• All areas • Max dose = 1000 units • IV push at a rate of 3 units/kg/min (max 210 units/min	• All areas • Doses greater than 1000 units • Infuse at a rate of 3 units/kg/min (max 210 units/min)
Pyridostigmine	• **Adult level 3** • Slow IV push	NA
Pyridoxine (Regonol)	• All areas	NA
Regadenoson (Lexiscan)	• **Cardiac stress test units only** • IV push over 10 sec followed immediately by saline flush • Policy: Guidelines for Pharmacologic Stress Testing Using Regadenoson Link	NA
Remdesivir (Veklury)	NA	• All areas • IVPB over 30-120 min • **May be an irritant**
Remifentanil (Ultiva)	NA	• **Adult level 3 - MMC only** • **Administration restricted to anesthesia provider**
Rifampin (Rifadin)	NA	• All areas • IVPB over 30 min to 3 hr • **May be an irritant**
Rocuronium	• **Adult and peds level 3** • Rapid IV push • Administer by provider or with provider present unless patient already on ventilator	• **Adult and peds level 3** • Continuous infusion
Sincalide (Kinevac)	• **Diagnostic testing only** • IV push over 30-60 sec	NA
Sodium bicarbonate	• **Adult level 2 and 3, peds level 3** • Slow IV push • **Vesicant**	• All areas • IVPB over 2 hours or continuous infusion
Sodium chloride 23.4%	• **Adult level 3 - MMC only** • Policy: Hypertonic Saline 23.4% Guideline Link	NA
Sodium chloride 3%	NA	• All areas (continuous infusion); **adult level 2 or 3, peds level 3 (intermittent)** • Max infusion rate level 1 areas = 30mL/hr • Central line required for continuous infusion rates > 50mL/hr • **Irritant with vesicant-like properties** • Policy; Hypertonic 3% Sodium Chloride Intravenous Administration Guidelines Link
Sodium ferric gluconate (Ferrlecit)	• **Restricted to dialysis** • IV push at rate of 12.5mg/min	• All areas • Infuse over 1-2 hr • Monitor for signs and symptoms of hypersensitivity during infusion and for 30min after completion
Sodium phosphate	NA	• All areas • Infuse at maximum rate 15 mmol/hr
Sodium tetradecyl (Sotradecol)	• **Adult level 3**	NA
Sodium thiosulfate	NA	• All areas • Infuse over 10-60 min (rate varies by indication) • Continuous infusion in combination with nitroprusside **(adult level 3)**

MUNSON HEALTHCARE
IV MEDICATION ADMINISTRATION GUIDELINES

Medication	IV Push	IV Infusion
Sotalol	NA	• **MMC Cath lab only** • Infuse over 1 hr
Succinylcholine	• **Adult and peds level 3 by provider or with provider present** • Rapid IV push	NA
Sugammadex (Bridion)	• **Adult and peds level 3** • Rapid IV push over 10 sec	NA
Tacrolimus (Prograf) **HAZARDOUS DRUG**	NA	• **Adult level 3** • Continuous infusion • Administer with PVC-free tubing
Tocilizumab (Tyenne, Actemra, others)	NA	• All areas • Infuse over 60 min
Tenecteplase (TNKase)	• **Adult level 3** • IV push over 5 sec	NA
Thiamine (Vitamin B1)	• All areas • Max IV push dose = 200mg • IV push over 1-2 min	• All areas • For doses > 200mg • Infuse over 15-30 min
Tigecycline (Tigacil)	NA	• All areas • Infuse over 30-60 min
Tobramycin	NA	• All areas • Infuse over 20-60 min
Tranexamic acid (Cyklokapron)	NA	• All areas • Infuse at max rate 100mg/min
Trimethoprim/ sulfamethoxazole (Bactrim)	NA	• All areas • Infuse over 30-90 min
Valproate sodium **HAZARDOUS DRUG**	NA	• All areas • Infuse over 60 min (max 20mg/min); may give more rapidly in status epilepticus (3-10mg/kg/min in adults or 1.5-4mg/kg/min in peds)
Vancomycin	NA	• All areas • Infuse over at least 60 min (max rate 10-15 mg/min) • If patient develops maculopapular rash on face, trunk, neck, and/or upper extremities during administration, slow infusion rate • **Irritant**
Vasopressin (Vasostrict)	NA	• **Adult and peds level 3** • Continuous infusion • **Vesicant; central line required**
Vecuronium	• **Adult and peds level 3** • Rapid IV push • Administer by provider or with provider present unless patient already on ventilator	• **Adult and peds level 3** • Continuous infusion
Verapamil	• **Adult level 2 and 3** • IV push over 2-3 min	• **Adult level 2 and 3** • Continuous infusion
Voriconazole (Vfend) **HAZARDOUS DRUG**	NA	• All areas • Infuse over 1-3 hr
Zidovudine (Retrovir) **HAZARDOUS DRUG**	NA	• All areas • Infuse over 1 hr
Zoledronic acid (Zometa) **HAZARDOUS DRUG**	NA	• All areas • Infuse over at least 15 min • Ensure adequate hydration prior to administration

Manistee Patient Criteria Placement Table —
FINAL 3/15/24

	Medical / Surgical		Intermediate Care Transfer to Cadillac		Critical Care Transfer to Cadillac or TC depending on sub specialty need
RN Ratios	**1:5-6**				**1:1-3**
NA Ratios	**1:10-12** **12 is ideal.** **KEEP** **Low acuity**				**1:5-6** **The Transfer List** **The Where List:** **Where does the patient go –** **1. Cadillac** **2. MMC**
Routine Assessments & Vital Signs	Q4-8hr Routine VS (includes routine post-diagnostic and post-procedure VS q15-30min until stable) Positive sepsis screen w/ Lactic Acid < 2.0		Criteria from Med/Surg AND Q2hr for > 4 hours **Positive sepsis screen w/ HR > 120 over 2hrs, Lactic acid = 2.5, and/or hypotension unresponsive to fluid bolus**		Q2hrs or more often **Positive severe sepsis screen with 2 or more SIRS criteria, Lactic acid > 4, and/or persistent hypotension after fluid bolus**
Diagnostics	No special considerations for lab draws		Criteria from Med/Surg AND POC testing more than every 3 hours consistently		Q1-2hr labs and/or diagnostics with changes in condition requiring advanced monitoring and skilled assessment for more than 4-8 hours Advanced monitoring includes cardiac monitoring, **arterial pressure monitoring, central venous pressure monitoring**
Neuro	Q4hr Neuro checks CIWA monitoring Syncope requiring monitoring (+Tele) Stroke without intervention / TIA (+Tele)		Criteria from Med/Surg AND Consecutive CIWA scores of 7 or more		Frequent neuro checks with significant deficits and/or changes **CIWA > 15 x 3 consecutive checks or use of restraints**

Manistee Patient Criteria Placement Table ---
FINAL 3/15/24

Respiratory	Stable on RA/NC, 02 requirements < 40% Chronic sleep apnea For home 02 patients: stable on home 02 or up to 2x normal rate if greater than 40% Stable non-invasive ventilation (CPAP Do not admit to med surg on BiPap or Heated Hi Flo. If this is needed in ER, initiate in ER. Must be weaned and stable before admit (one hour stable after d/c). Otherwise transfer to Cadillac. Post operative patients with sleep apnea.		Criteria from Med/Surg AND O2 requirements greater than 40% Non-invasive ventilation		Acute/impending respiratory failure **Mechanical ventilation** Heated high-flow cannula or non-invasive ventilation for acute respiratory changes (V60 BiPAP or CPAP dependent) **Respiratory or metabolic acidosis: pH < 7.2 with respiratory compromise**
Cardiac / Peripheral Vascular	[illegible] HR (Tele) Chest pain w/o evidence on MI (+Tele) Syncope with minimal risk and normal EKG				**and MAP < 60** **Immediate post-cardiac arrest** Hypertensive emergency with continuous infusion Invasive hemodynamic monitoring
Complex IVs / Medications	See Pharmacy IVP medication list No titratable drips on med surg except heparin. /PCA pain management with EtCO2 monitoring Post - Procedural sedation monitoring		Multiple continuous IV medications Titratable IV infusions requiring infrequent changes		See Pharmacy IVP medication list **Initiation or titration of multiple IV medications with maximum titration and/or intervention for hemodynamic management** **DKA requiring insulin drip**
Therapies / Devices	Q4-8hr full I/O measurement JP drain, hemovac, NG, tube feeding, chest tube, tracheostomy requirement standard monitoring/care				**Sedation/Paralytics** Q1-2hr full I/O management COPD Q2-4 hr exchanges

MMC Transfer Center Service Line Agreement Detail

Service Line	Diagnosis/Presentation	Who will admit	Required Consults	Notes
Cardiology	STEMI	Auto Accept ED to ED Transfer ED Provider Cardiology	HM consult as requested	
	Unstable Ventricular Arrhythmias	Cardiology	HM consult as requested	
	Cardiogenic Shock	Cardiology	HM consult as requested	
	ICD Discharge	Cardiology	HM consult as requested	
	Complete heart block not secondary to reversible causes (not due to metabolic cause)	Cardiology	HM consult as requested	
	Heart block with syncope	Cardiology	HM consult as requested	
	Severe systolic heart failure requiring vasopressor support	Cardiology	HM consult as requested	
	Outpatient procedures that require observation/admission - Structural heart (TAVR, Mitral clip, Watchman, ASD closure) - Device extractions - Complex ablation - Complex PCI - Postprocedural hemotoma	Cardiology	HM consult as requested	
	Elective admission for initiation of antiarrhythmic treatment	Cardiology	HM consult as requested	
	All other cardiac patients including (but not limited to) hemodynamically stable NSTEMI, CHF, and Arrhythmias	Hospitalist	Cardiology	
	Stable admissions from cath lab requiring - CTS evaluation - Diuresis - Arrhythmia management (stable)	Hospitalist will admit	Cardiology consult as requested	
	Unstable patients	ED to ED transfer		
TACS/Surgery	Traumatic pneumothorax	TACS	HM if requested	Includes any traumatic PTX regardless of size
	Traumatic hemothorax	TACS	HM if requested	
	Traumatic subdural hemotoma	TACS	HM if requested	Neurosurgery ove protocol
	Rib fractures: 3 or more ribs, flail segment, pulmonary contusion, oxygen requirement	TACS	HM if requested	
	Rib Fracture(s) : Isolate, minimal pain, no respiratory compromise	HM	TACS Tertiary Survey	
	Fracture(s) isolated to single extremity	HM	TACS Tertiary Survey	No other traumatic injuries
	Complex joint injury	TACS	HM if requested	
	All other trauma admissions	TACS	HM if requested	
	Bowel obstruction or volvulus (**with** CT evidence **and** abdominal pain or intractable nausea/vomiting	TACS	HM if requested	
	Possible bowel obstruction (without clear CT evidence or symptoms inconsistent with obstruction (+bowel function	HM	TACS if requested	
	Acute uncomplicated diverticulitis (bleeding)	HM	TACS if requested	CERNER message to on-call TACS attending for appropriate follow-up with his surgical office
	Complicated diverticulitis (perforation, abscess, or procedural intervention needed)	TACS	HM if requested	
	Acute cholecystitis	TACS	HM if requested	
	Colitis (ischemic, inflammatory, infectious)	HM	GI or TACS if requested	Early TACS consult can be requested if operative status unclear at admission. TACS to take over primary if OR required.
	Choledocholithiasis	HM	GI + TACS consult	TACS consult after ERCP
	Choledocholithiasis post/Surgery	TACS (assumes admitting attending role in PACU)	HM to sign off unless clarified	
	Post-operative complication related to TACS-performed surgery	TACS	HM if requested	
	Post-operative ileus	TACS (following TACS surgery only)		Management of Post op Ileus defers to the service who performed surgery (urology, ortho, etc.). HM or primary surgical service admits based on admitting relationship
	Necrotizing fasciitis	TACS	HM if requested	
	Patient with External Ventricular Drain (EVD) placed for ICH (traumatic or spontaneous)	High risk for additional procedures: SCC Low risk for additional procedures: PCC		Neurocritical Care determines level of risk for additional procedures. Goal: minimize multiple handoffs between PCC and SCC
	Transfer out of SICU	TACS: All Trauma/ACS patients HM: All other patients		HM/TACS assumes care upon arrival to non-critical unit. Sign-out by SICU team required prior to transfer.
Pulm CC	DKA Patients with a **pH >7**	Hospitalist		
	DKA Patient with a **pH <7**	Pulm Critical Care/Intensivist		
	BIPAP Patients weaned off BIPAP in the ED prior to the 4hr mark	Hospitalist		
	BIPAP Patients	Pulm Critical Care/Intensivist		Regardless of code status
	Vasopressors	Pulm Critical Care/Intensivist		
	Shock Patients	Pulm Critical Care/Intensivist		Patients that have not responded to initial volume resuscitation
	MOSF (Multi-organ system failure)	Pulm Critical Care/Intensivist		
	CRRT (Continuous Renal Replacement Therapy)	Pulm Critical Care/Intensivist		
	Intubated Patients	PulmCritical Care/Intensivist		Those patients not managed by SCC or Neuro CC
	Stroke tPA	Pulm Critical Care/Intensivist	Neuro CC consult	
	Stroke Thrombectomy	Surgical Critical Care		
	Emergent and non emergent stents, aneurysm clippings and coils	Surgical Critical Care		
	Urology Admissions			
Urology			**consider need for early Urology involvement (on transfer line or ER) if marked with (*)**	
	Elective Urological Procedures	Urology	HM if requested	
	Urologic admissions via ER/Transfer	HM	Urology Consult	
	Post Operative Complication	HM	Urology Consult	Complication directly related to recent urologic surgery (including ileus)
	Obstructive/Renal Presentations			
	Uncomplicated Ureterolithiasis	HM	Urology Consult	May have intractable Pain, N/V, UTI in absence fever/severe leukocytosis, hydronephrosis, AKI
	Complicated Ureterolithiasis	HM	*Urology consult	UTI with severe leukocytosis, fever or Sepsis
	Acute Urinary Retention unable to place Foley	HM	Urology Consult	*Urgency determined by degree of retention
	Stent Malfunction	HM	Urology Consult	Urgency determined by complicating factors
	Acute Obstruction (Bilateral Ureteral or with Solitary Kidney)	HM	Urology Consult	*Urgency determined by complicating factors and degree of renal dysfunction
	Hemorrhagic Presentations			
	Hematuria	HM	Urology Consult	*Early Urology consult if hemodynamic instability not responsive to resuscitation efforts
	Penile/Scrotal Emergencies and Traumatic Presentations			
	Testicular Torsion	HM	*Urology consult	
	Paraphimosis	HM	*Urology Consult	With edema, suspected ischemia with failed bedside reduction by EM
	Infectious Presentations			
	Fournier's gangrene or infection of the perineum/genitalia	HM	*Urology Consult	With signs of necrotizing or rapidly progressing infection
	Emphysematous Pyelonephritis	HM	*Urology Consult	High mortality rate, discuss with urology early
	Emphysematous Cystitis or prostitis	HM	Urology Consult	

Airway/Breathing

Stridor, angioedema, airway burns

Epiglottitis concern

Difficult airway history + current instability

On BiPAP/CPAP or HFNC

Escalating O2 requirement

Severe asthma/COPD not clearly resolving

Massive PE concern with RV strain

Circulatory Instability

On pressors OR likely to need them

SBP <100 with concerning trajectory

Rising lactate in sepsis

Active GI bleed (melena, hematemesis, hematochezia)

Postpartum hemorrhage concern

Ruptured ectopic concern

Cardiac Emergencies

STEMI

Ongoing ischemic chest pain

Dynamic ECG changes

Suspected aortic dissection

Unstable arrhythmias (VT, high-grade block)

Syncope + abnormal ECG

Neuro Conditions That Deteriorate Fast

Acute stroke

Intracranial hemorrhage

SAH concern

Status epilepticus or recurrent seizures

Altered mental status of unclear etiology

Spinal cord compression

VP shunt malfunction

Active Bleeding/High Re-bleed Risk

GI bleed requiring transfusion

Splenic injury (even non-op)

Trauma patients not fully cleared

Post-op hemorrhage

Time-Sensitive Surgical/Procedural

Ectopic pregnancy

Testicular torsion

Ovarian torsion

Necrotizing fasciitis

Compartment syndrome

Acute limb ischemia

Septic joint

Obstructing stone with sepsis

Mesenteric ischemia

High-Risk Sepsis/Toxic Patients

Rapidly progressive soft tissue infection

Meningitis / encephalitis

Toxic shock

Neutropenic sepsis

DKA/HHS with mental status change

Overdose needing airway watch or antidote titration

Metabolic/Toxic Swingers

Severe hyperkalemia

Tumor lysis syndrome

Symptomatic hyponatremia (<120)

Refractory hypoglycemia

TCA or cardiotoxic overdose

Acetaminophen OD in treatment window

Pediatrics

Fever in infants <60–90 days

Respiratory distress (HFNC, apnea risk)

Suspected non-accidental trauma

Congenital heart disease + acute illness

System Triggers - Use ED to ED if

Patient requires a procedure in the ED

Patient requires diagnostics unavailable at sending facility

Patient requires emergent surgical or IR procedure

Item
Stridor, angioedema, airway burns
Epiglottitis concern
Difficult airway history + current instability
On BiPAP/CPAP or HFNC
Escalating O2 requirement
Severe asthma/COPD not clearly resolving
Massive PE concern with RV strain
On pressors OR likely to need them
SBP <100 with concerning trajectory
Rising lactate in sepsis
Active GI bleed (melena, hematemesis, hematochezia)
Postpartum hemorrhage concern
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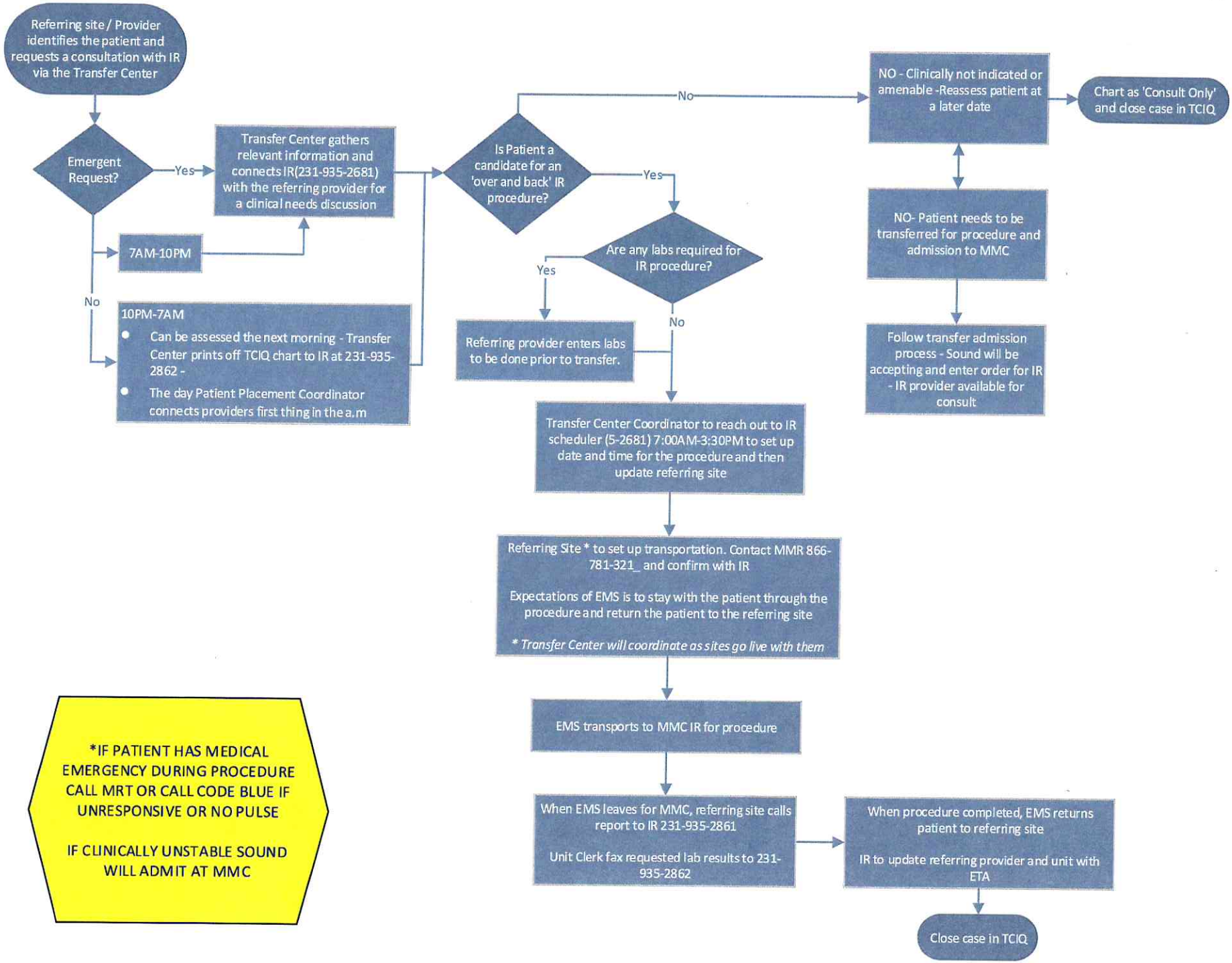
STEMI
Ongoing ischemic chest pain
Dynamic ECG changes
Suspected aortic dissection
Unstable arrhythmias (VT, high-grade block)
Syncope + abnormal ECG
Acute stroke
Intracranial hemorrhage
SAH concern
Status epilepticus or recurrent seizures
Altered mental status of unclear etiology
Spinal cord compression
VP shunt malfunction
GI bleed requiring transfusion
Splenic injury (even non-op)
Trauma patients not fully cleared
Post-op hemorrhage
Ectopic pregnancy
Testicular torsion
Ovarian torsion
Necrotizing fasciitis
Compartment syndrome
Acute limb ischemia
Septic joint
Obstructing stone with sepsis
Mesenteric ischemia
Rapidly progressive soft tissue infection
Meningitis / encephalitis
Toxic shock
Neutropenic sepsis
DKA/HHS with mental status change
Overdose needing airway watch or antidote titration
Severe hyperkalemia

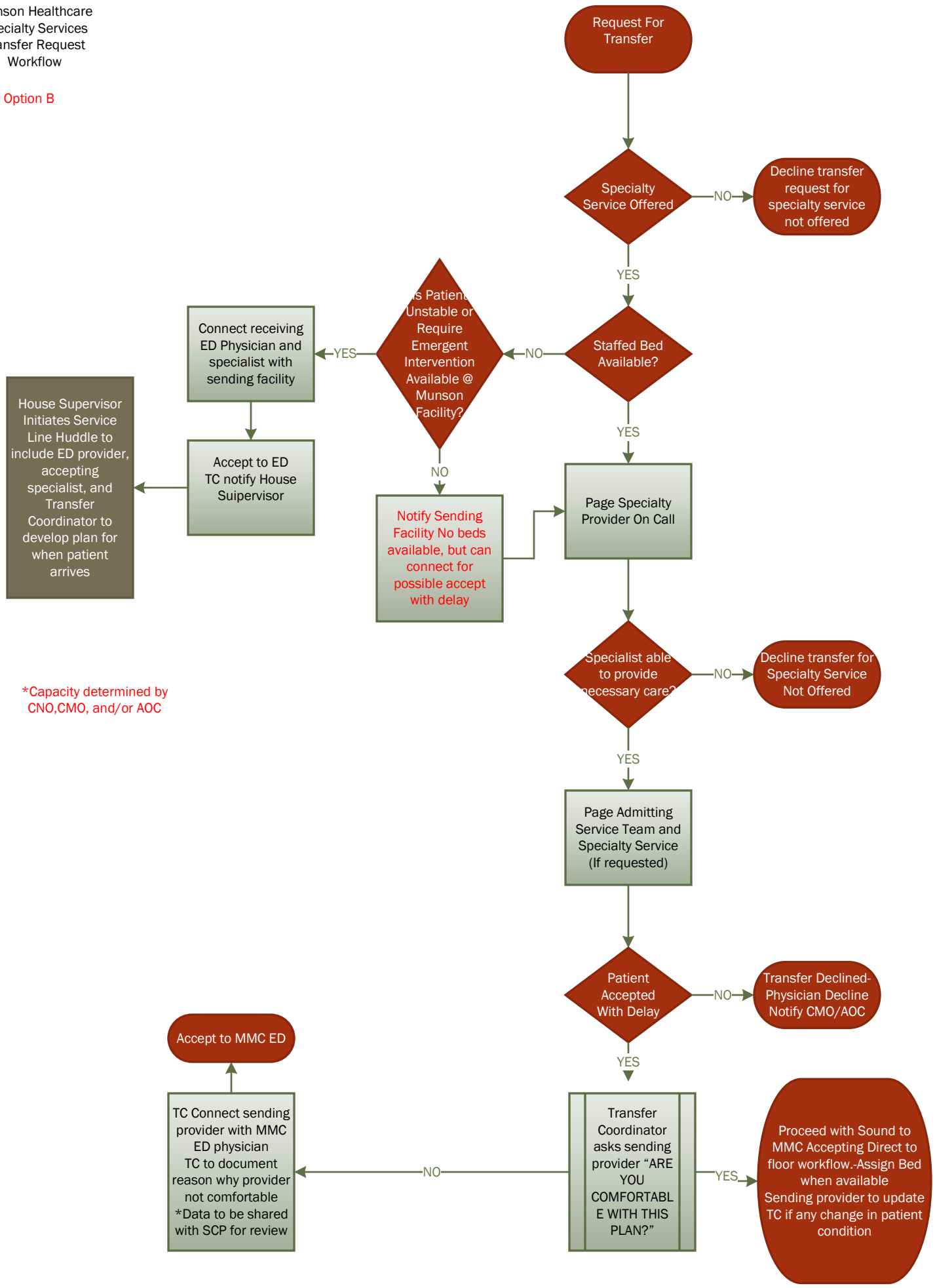
Tumor lysis syndrome
Symptomatic hyponatremia (<120)
Refractory hypoglycemia
TCA or cardiotoxic overdose
Acetaminophen OD in treatment window
Fever in infants <60–90 days
Respiratory distress (HFNC, apnea risk)
Suspected non-accidental trauma
Congenital heart disease + acute illness
Patient requires a procedure in the ED
Patient requires diagnostics unavailable at sending facility
Patient requires emergent surgical or IR procedure

IR


Referring site / Provider identifies the patient and requests a consultation with IR via the Transfer Center
Emergent Request?
Yes
Transfer Center gathers relevant information and connects IR(231-935-2681) with the referring provider for a clinical needs discussion
7AM-10PM
No
10PM-7AM
Can be assessed the next morning - Transfer Center prints off TCIQ chart to IR at 231-935-2862 -
The day Patient Placement Coordinator connects providers first thing in the a.m
Is Patient a candidate for an 'over and back' IR procedure?
No
NO - Clinically not indicated or amenable -Reassess patient at a later date
Chart as 'Consult Only' and close case in TCIQ
Yes
Are any labs required for IR procedure?
Yes
Referring provider enters labs to be done prior to transfer.
No
NO- Patient needs to be transferred for procedure and admission to MMC
Follow transfer admission process - Sound will be accepting and enter order for IR - IR provider available for consult
Transfer Center Coordinator to reach out to IR scheduler (5-2681) 7:00AM-3:30PM to set up date and time for the procedure and then update referring site
Referring Site * to set up transportation. Contact MMR 866-781-321_ and confirm with IR
Expectations of EMS is to stay with the patient through the procedure and return the patient to the referring site
* Transfer Center will coordinate as sites go live with them
EMS transports to MMC IR for procedure
When EMS leaves for MMC, referring site calls report to IR 231-935-2861
Unit Clerk fax requested lab results to 231-935-2862
When procedure completed, EMS returns patient to referring site
IR to update referring provider and unit with ETA
Close case in TCIQ
*IF PATIENT HAS MEDICAL EMERGENCY DURING PROCEDURE CALL MRT OR CALL CODE BLUE IF UNRESPONSIVE OR NO PULSE
IF CLINICALLY UNSTABLE SOUND WILL ADMIT AT MMC

Munson Healthcare
Specialty Services
Transfer Request
Workflow

Option B



*Capacity determined by CNO,CMO, and/or AOC

STANDARD WORK DOCUMENT

Process: ED→IP Workflow
Date: 5/30/2024, Updated 7/30/2024, Updated 8/20/2024
Author: Britany Scott, Tori Sykes, Chelsey Patterson
Purpose: To provide a standard workflow process for ED→IP after admission order is placed

Who	Process:
Transfer Center	Targets patient to appropriate unit. Review of labs, orders, and vitals should occur during this process to ensure proper targeted unit is selected. Assigns bed based on bed priority/comment or phone call to targeted unit. (Goal: RTM to Bed Assign 15 minutes) + Enters call time (10 minutes)
ED RN	1. Calls IP unit for report at call time, if RN unavailable reports to PCC/Charge RN. a. Call times remain in place for all colors- if Code Triage, call times become immediate 2. Notifies ED PCC/Charge RN that report was given- (All units except (B3, B4, D4, D5 where automatic transport is used) **If IP RN is ready for report and ED has not called for report- IP RN should initiate call to ED RN for report**
ED PCC/ Charge RN	Enters Transport request based on appropriate guidelines *Transport is automatically dispatched from ED→GMB Units (B3, B4, D4, D5) when a clean bed is assigned.
Transport	1. Transport dispatched (automatically when clean bed assigned for GMB). a. Delay of up to 10 minutes allotted if automated transport triggers prior to ED call time 2. Transporter checks in with ED RN for handoff. If patient not ready, transport job is canceled. 3. Patient is transported to unit
Transfer Center	
Transfer Center	Target patients to patient unit prior to assignment. If no bed priority or patient placement comment is present, a phone call to the assigned unit must occur prior to placement.
Nursing Supervisor	
Nursing Supervisor	Be attentive to patient flow goal times and assist with barriers If barriers exist, escalate to PCC first, if unable to resolve barrier within 15 minutes then escalate to unit manager.
PCC/Charge RN	
PCC/ Charge RN	If bedside RN is unavailable for report- PCC will take ED RN report to reach goal of 1 call to unit. Utilize bed priorities at all times, and indicate patient preferred placement in comments as able. Be attentive to patient flow goal times and assist with barriers. If unable to resolve barriers escalate to Nursing Supervisor, if unable to resolve together within 15 minutes then escalate to unit manager.
Unit Manager	
Unit Manager	Be attentive to patient flow goal times and assist with barriers when escalated by PCC or nursing supervisor.

Patient safety to be a priority with the goal of right patient placed in right level of care the first time.

STANDARD WORK

Process Title:	**Munson Regional Hospital Transfers**			**Date created:**	**09/30/2024**
Author:	**Lisa White**	**Staff Involved:**	**Regional Hospital House Supervisors, TRC Team**	**Last revision:**	**03/10/2023, 09/09/2024,09/24/2024**
Purpose:	**Outline process for transfers into MHC regional hospitals**				
Scope:	**MHC Regional Hospitals**			**Cadence:**	

Step	Who/Role	Process Description: Key points and reason why	Example/Image
1	Provider	Provider identifies need for consult or transfer	
2	Provider	Calls Transfer Center at 231-392-0777 for all transfers. Option to enter CAP if NON EMERGENT Transfer	
3	Transfer Coordinator	Pages appropriate specialist and or hospitals to discuss patient plan and identify accepting provider- YOU MUST document that regional placement was explored prior to transfer to MMC • For Transfer to **Cadillac**: first contact House Supervisor at 231-876-7366 to confirm staffed bed availability then page appropriate specialist and or hospitalist to discuss patient plan and identify accepting provider. *After 7:00 PM – page **Nocturnal APP working on site-** • For Transfer to **Charlevoix**: first contact House Supervisor at 231-547-8568 to confirm staffed bed availability then page appropriate specialist and or hospitalist to discuss patient plan and identify accepting provider. *After 7:00 PM page **"Hospitalist Telehealth Nocturnist Regional Support"** • For Transfer to **Grayling**: first contact House Supervisor at 989-348-0803 to confirm staffed bed availability then page appropriate specialist and or hospitalist to discuss patient plan and identify accepting provider. *After 7:00 PM – page **Nocturnal APP working on site-** • For Transfer to **Manistee**: first contact Manistee charge nurse at 231-398-1120 to confirm staffed bed availability then page appropriate specialist and or hospitalist to discuss patient plan and identify accepting provider. *After 7:00 PM page **"Hospitalist Telehealth Nocturnist Regional Support"** • For Transfer to **Otsego**: first contact House Supervisor at 989-731-9234 or if there is no House Supervisor on call the department directly to confirm staffed bed availability. ICU 989-731-2107 and Med surg 989-731-2101. Next, page appropriate specialist and or hospitalist to discuss patient plan and identify accepting provider. *After 7:00 PM – page **Nocturnal APP working on site-**	

Step	Who/Role	Process Description: Key points and reason why	Example/Image
4	Transfer Coordinator	• Communicates with house supervisor, or if no house supervisor, with the charge nurse on the receiving unit to confirm bed assignment and identify nurse phone # for nurse to nurse report off • Arranges for all ground EMS transport – Stat-Air transports to be arranged by sending facility • Sends IM to TEAMS Group to "Pre-Register patient" include name, and DOB, accepting provider, diagnosis and inpatient or Obs status if known • Calls Outgoing Hospital with EMS status ad requests call back when EMS leaves sending facility	
5	PAS	• Creates account • Notifies Transfer Center that "Pre Reg Complete" in TEAMS group • Pages account # to providers to start using for order entry	
6	Sending Facility Primary Nurse	• RN Calls report to receiving hospital RN that was identified by Transfer Coordinator • RN or designated staff, when transfer occurs and EMS leaves facility, the sending hospital will call Transfer Center or enter in the Teams chat notifying that patient is underway.	
7	Transfer Coordinator	• Communicate ETA to accepting facility and accepting provider	
8	Transfer Coordinator	• TCIQ case is closed once patient arrives at accepting facility	

Other Documents or Standard Work Processes that impact this one:	Additional Notes
•	
•	
•	

STANDARD WORK

Continuous Improvement

Process Title:	**Air Transports for ED Transfers**			**Date created:**	**08/15/2024**
Author:	**Lisa White**	**Staff Involved:**	**MHC Emergency Dept staff, Transfer Center**	**Last revision:**	
Purpose:	**Standardize process for coordination of STAT Air Transportation needs from MHC Emergency Departments**				
Scope:	**Munson Healthcare EDs**			**Cadence:**	

Step	Who/Role	Process Description: Key points and reason why	Example/Image
1	ED Provider	ED provider identifies that patient will need to be transferred and requires STAT air transport	
2	ED staff (unit clerk, RN)	Sending facility should start the transport process by calling **North Flight Aero Med Flight Communications** at 616-391-5330 or 800-862-0921 Required information: 1. Location of Patient 2. Type of transport: ALS, OB, NICU, CC 3. Medical equipment/ extras needed for the patient: • Oxygen (Nasal Canula, Mask, etc, & what rate) • IVs (Peripheral, Central line, and number of IVs) • Pumps (How many, what medications, what rate, blood or blood products) • Cardiac Monitor or other monitors – • Intubate/Vented (vent settings) • Trauma needs (Spinal precautions, traction splints etc) • Weight of patient • Weight of passenger if allowed	
3	ED Provider	Contact Transfer Center to begin facilitation of transfer to higher level of care	
4	Transfer Coordinator	Follow established process to coordinate transfer of patient.	
5	Transfer Coordinator	Once patient is accepted and bed number confirmed, communicate with sending ED and ED provider the accepting facility, provider, bed number, and number to call report	

Step	Who/Role	Process Description: Key points and reason why	Example/Image
6	ED unit clerk or RN,	Once flight team has left with patient contact Transfer Center at 231-392-0777 to notify patient is on the way with ETA.	
7	Transfer Coordinator	If patient transferring to a Munson facility page provider and floor with ETA If transferring outside of Munson Healthcare, notify accepting facility transfer center of ETA	

Additional Notes

If weather does not permit for air, and STAT ground transportation is needed Transfer Center Coordinator will follow established process for coordinating transfer and contact EMS company with accepting facility and bed assignment

North Flight Aero Med Should ALWAYS BE THE FIRST CONTACT FOR AIR SERVICE

Process Title: Blocking Beds and Unblocking Beds In Teletracking **Date created:** 12/13/2023

Author: Lisa White **Staff Involved:** Transfer Center Team Members and MMC House Supervisors **Last revision:** 01/02/2024

Purpose: To create a standardized process for temporarily taking beds offline and managing bed availability

Scope: Applies to Medical Center Inpatient Beds **Cadence:** Daily

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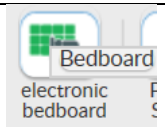
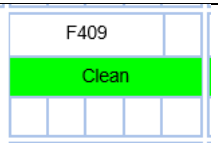
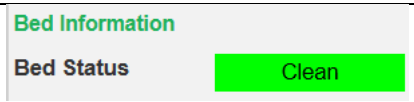
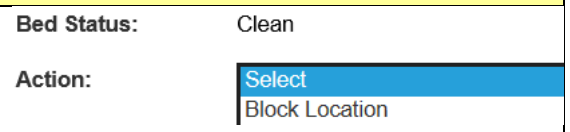
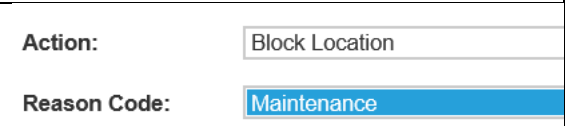
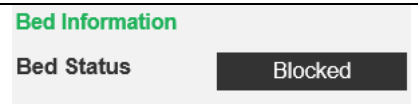
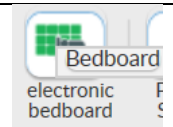
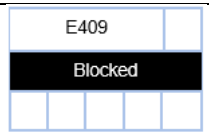
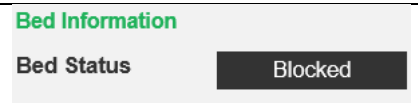
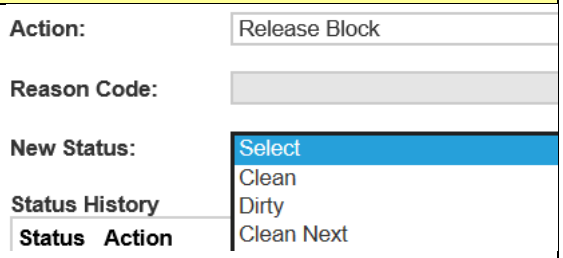
Step	Who/Role	Process Description: Key points and reason why	Example/Image
	Transfer Center Team and MMC House Supervisors have permission to block beds	There are situations when a bed may be empty, but it is not able to be used for a patient (ex: maintenance issues, or patient behaviors). Patient Placement can temporarily block a location in the system to ensure the bed doesn't appear available for admissions. Once the block is no longer needed, Patient Placement will also be able to release the block.	
	Transfer Center Team Members	When a request is received to block a bed identify: 1. Reason for request to block the bed 2. Expected length of time that bed will be offline 3. Ask if other alternatives have been explored	
1	Transfer Center Team Members	To block a bed: Click on the electronic whiteboard icon and chose the appropriate bedboard.	
2	Transfer Center Team Members	Identify the bed that needs blocked and click on the bed. This will take you directly to Bed Information.	
3	Transfer Center Team Members	Click on the Bed Status button.	

Step	Who/Role	Process Description: Key points and reason why	Example/Image
4	Transfer Center Team Members	A new box will open, click on the Action drop-down and select, Block Location	
5	Transfer Center Team Members	Once selected, you will see the Reason column available. Select the appropriate reason and click, Submit.	
6	Transfer Center Team Members	The Bed Status will update to show the new status	
7	Transfer Center Team Members	*Blocked beds will be reviewed and status updtated in Teletracking daily to determine:* 1. *Reason for ongoing bed blocking* 2. *Update on expected time to release bed blocking*	
8	Transfer Center Team Members	Unblocking a Bed: Before unblocking the bed, please confirm with the Nursing Unit if the bed needs to be cleaned by EVS once unblocked.	
9	Transfer Center Team Members	Click on the electronic whiteboard icon and choose the appropriate bedboard.	
10	Transfer Center Team Members	Identify the bed that needs unblocked and click on the bed. This will take you directly to Bed Information.	
11	Transfer Center Team Members	Click on the Bed Status button.	
12	Transfer Center Team Members	A new box will open, click on the Action drop-down and select, Release Block	

Step	Who/Role	Process Description: Key points and reason why	Example/Image
13	Transfer Center Team Members	Once selected, you will see the New Status column available. Select the appropriate status and click, Submit. The Bed Status will update to show the new status	

Additional Notes

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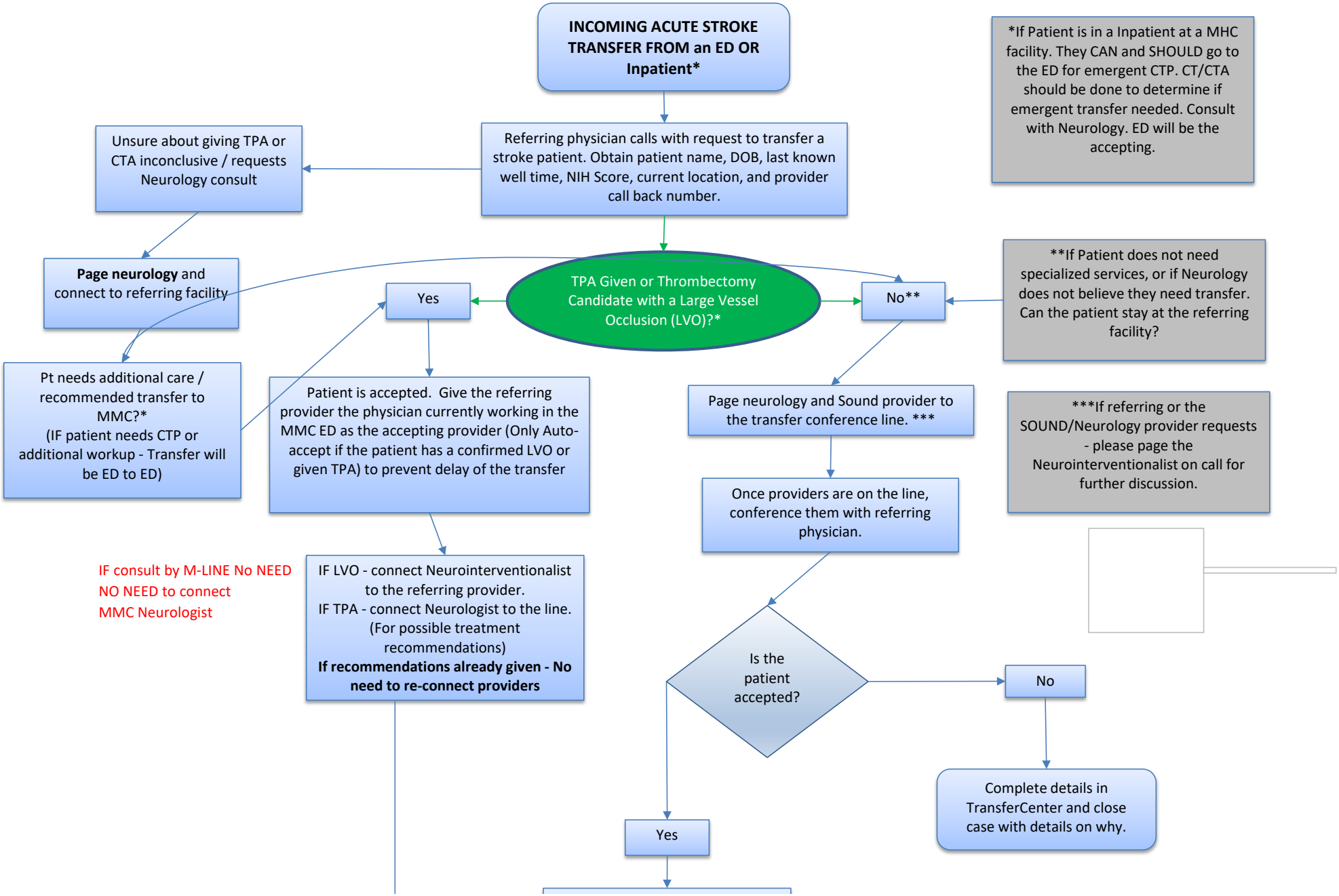
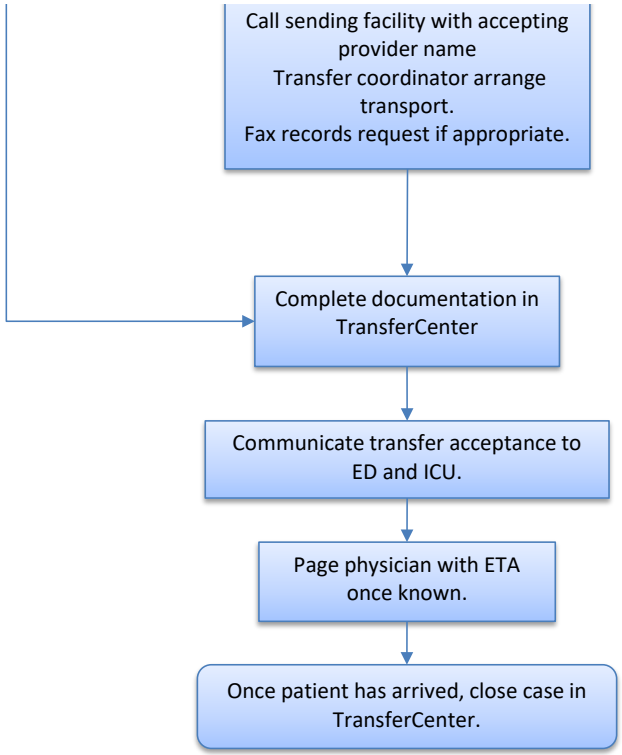

INCOMING ACUTE STROKE TRANSFER FROM an ED OR Inpatient*
*If Patient is in a Inpatient at a MHC facility. They CAN and SHOULD go to the ED for emergent CTP. CT/CTA should be done to determine if emergent transfer needed. Consult with Neurology. ED will be the accepting.
Referring physician calls with request to transfer a stroke patient. Obtain patient name, DOB, last known well time, NIH Score, current location, and provider call back number.
Unsure about giving TPA or CTA inconclusive / requests Neurology consult
Page neurology and connect to referring facility
TPA Given or Thrombectomy Candidate with a Large Vessel Occlusion (LVO)?*
Yes
No**
**If Patient does not need specialized services, or if Neurology does not believe they need transfer. Can the patient stay at the referring facility?
Pt needs additional care / recommended transfer to MMC?*
(IF patient needs CTP or additional workup - Transfer will be ED to ED)
Patient is accepted. Give the referring provider the physician currently working in the MMC ED as the accepting provider (Only Auto-accept if the patient has a confirmed LVO or given TPA) to prevent delay of the transfer
Page neurology and Sound provider to the transfer conference line. ***
***If referring or the SOUND/Neurology provider requests - please page the Neurointerventionalist on call for further discussion.
Once providers are on the line, conference them with referring physician.
IF consult by M-LINE No NEED
NO NEED to connect
MMC Neurologist
IF LVO - connect Neurointerventionalist to the referring provider.
IF TPA - connect Neurologist to the line. (For possible treatment recommendations)
If recommendations already given - No need to re-connect providers
Is the patient accepted?
No
Complete details in TransferCenter and close case with details on why.
Yes


Call sending facility with accepting provider name
Transfer coordinator arrange transport.
Fax records request if appropriate.
Complete documentation in TransferCenter
Communicate transfer acceptance to ED and ICU.
Page physician with ETA once known.
Once patient has arrived, close case in TransferCenter.

STANDARD WORK

MUNSON HEALTHCARE
Continuous Improvement

Process Title:	**GIP Direct Admission Process Munson Medical Center**			**Date created:**	**06/28/2025**
Author:	**Lisa White**	**Staff Involved:**	**<who is using the Standard Work>**	**Last revision:**	
Purpose:	**To provide a standardized process to admit Munson Hospice GIP patients directly to D5 at Munson Medical Center**				
Scope:	**Munson Hospice, Transfer Center Team, Medical Center Admitting Team, D5**			**Cadence:**	**Ongoing**

Step	Who/Role Performs Step	Process Description: Key Tasks, Why
1	Hospice RN and Medical Director	Hospice RN consults with Hospice Medical Director determining need for hospice General Inpatient Admission (GIP) to meet patient clinical needs
2	Hospice RN and Medical Director	Establish plan with first consideration of admission to be at Munson Hospice House. If patient's treatment plan can be carried out at Munson Hospice House. RN will follow the Hospice process for admission and arrange EMS transportation
3	Hospice RN	Patient requires admission to Munson Medical Center -D5: Contact Transfer Center at 231-392-0777 to request direct admission to D5 for GIP hospice care. Provide patient information and RN call back number
4	Transfer Center Team	Follow direct admission process: • Contact Admitting who will create PRT# • Identify and assign bed# of D5 • Obtain phone number for nurse to nurse to report • Coordinate non emergent EMS transport to Munson Medical Cetner – D5 with bed number- *EMS transport is billed to hospice, not the patients insurance Once completed, call back hospice RN to provide bed # and number for nurse-to-nurse report and status of EMS pick up time Case may then be closed in TCIQ
5	Admitting Team	Follow current process and Page Hospice Provider with the PRT# to allow for order entry into Powerchart
6		

Other Documents or Standard Work Processes that impact this one:	
Hospice GIP Admission Policy	

Other Documents or Standard Work Processes that impact this one:	

STANDARD WORK

Process Title:	**STEMI Transfers**			**Date created:**	**04/03/2024**
Author:	**Lisa White**	**Staff Involved:**	**TC, Cardiology, ED**	**Last revision:**	**10/2024**
Purpose:	**Create an Auto Accept Process for STEMI Transfers**				
Scope:	**System wide**			**Cadence:**	

Step	Who/Role	Process Description: Key points and reason why	Example/Image
1	Transfer Coordinator	Receives call for transfer of patient with a STEMI	
2	TC	Create case in TCIQ, Obtain all necessary information: Patient is Auto Accepted identifying Physician on for that shift as accepting provider	
3	Transfer Team Member	Initiate EMS transport	
4	TC/Team	Page Cardiologist on call to 231-392-0777 Noting STEMI to connect with sending provider via recorded line	
5	TC/Team	Communicate STEMI transfer to MMC ED and A3 via Teams and printing off TCIQ intake to ED printer	
6	TC/Team	Notify ED and page cardiology provider when ETA obtained	
7	TC team	Complete and close case in TCIQ when patient has left sending facility	

Other Documents or Standard Work Processes that impact this one:	Additional Notes
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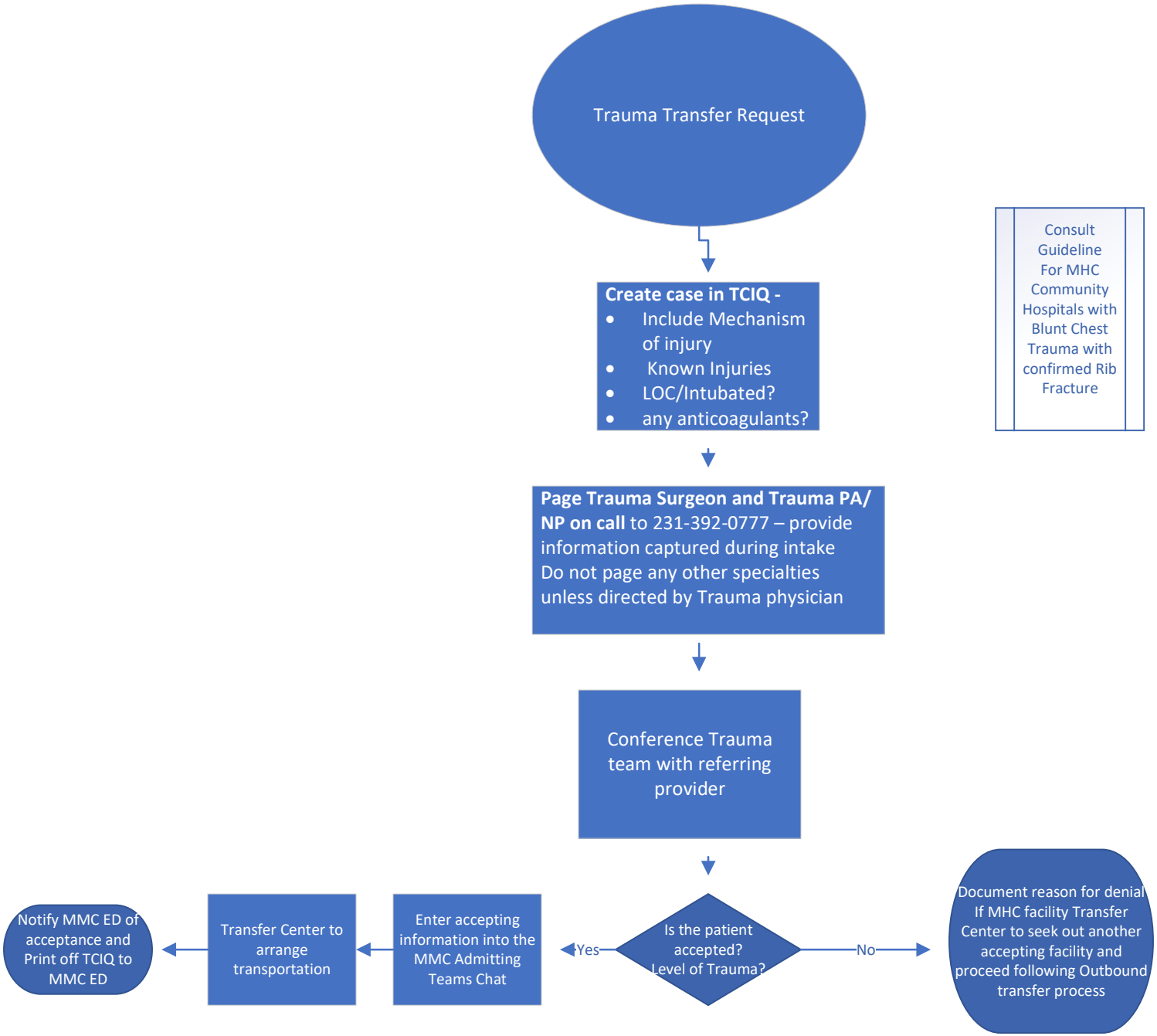
Trauma Transfer Request
Create case in TCIQ -
Include Mechanism of injury
Known Injuries
LOC/Intubated?
any anticoagulants?
Consult Guideline For MHC Community Hospitals with Blunt Chest Trauma with confirmed Rib Fracture
Page Trauma Surgeon and Trauma PA/ NP on call to 231-392-0777 – provide information captured during intake
Do not page any other specialties unless directed by Trauma physician
Conference Trauma team with referring provider
Is the patient accepted? Level of Trauma?
Yes
No
Enter accepting information into the MMC Admitting Teams Chat
Transfer Center to arrange transportation
Notify MMC ED of acceptance and Print off TCIQ to MMC ED
Document reason for denial If MHC facility Transfer Center to seek out another accepting facility and proceed following Outbound transfer process