Transfer of Low Acuity Suspected COVID-19 Admitted Patients to UHNBC

1. Every case for transfer requires honest and respectful communication between accepting and sending physicians.
2. This process is specific to COVID-19 patients (known or suspected) and does not apply to non-COVID patients transferred for other reasons.
3. This applies to patients requiring hospitalization
4. This applies to patients whose clinical condition alone might not be sufficient to require a higher level of care except that they require isolation until tests shows negative COVID-19.
5. This applies primarily to the Northern Interior and North East Health Service delivery areas. Facilities in question include Mackenzie, Valemount/McBride, Fort St James, Fort Nelson, Tumbler Ridge and Chetwynd. Some circumstances may lead to other small communities needing this support.
6. This applies primarily to facilities that struggle with isolation and/or are sufficiently distanced that rapid transfer may not be possible if deterioration occurs.
7. Use of triage intensivist for COVID-19 based advice is an option even if not immediately requiring intensive care.
8. Factors that must be taken into account during discussion leading to decision for transfer and related to the best management of the patient:
    a) The receiving physician has the best awareness of the receiving site to manage the patient as described.
    b) The sending physician has the best awareness of the needs of the patient relative to the ability of the sending site to manage. The small sending sites in question often have a mix of long term care and acute care in the same areas, often have very limited ability to call in extra staff, and often will risk complete closure if an outbreak occurs with spread to staff or other patients.
    c) The clinical presentation of the patient should be the primary driver of any transfer decision. This should include Medical Orders for Scope of Treatment (MOST) assessment. Duration of symptoms is also an important factor. Transfer cannot be precluded or dependent on whether a specific Lab or Diagnostic Imaging (DI) test has been performed prior to transfer except in those cases where having a diagnostic test performed prior to transfer will impact the decision to transfer or have an immediate impact on patient care, and can be done in a timely manner. Many facilities have limited ability to perform Lab and Diagnostic Imaging testing and these studies may not change the need for transfer. Specifically, transfer should not be dependent on the availability of a COVID-19 test result. (As per NH Risk Stratification Tool to Guide Level of Care for Adult Patients with COVID-19.)

d). If transfer to definitive care is anticipated, do not delay transport – **notify PTN immediately**. Follow the NHA COVID-19 Transport Referral Pathways and NH Regional Transfer Algorithm for Novel Coronavirus (COVID-19): Version 2.

Transfer discussions to include:

- Complexity of transfer, availability of transport resources and the referring care team's ability to accommodate and manage the patient's care needs if the patient was to deteriorate quickly.
- Patient to be accepted if the receiving site has capacity and the sending site has indicated this is beyond the capacity of their facility to safely isolate and monitor the patient.
- Escalation to the appropriate medical leadership in real time, if the sending and receiving sites cannot agree.

If the patient is accepted and it is determined after the fact to be an inappropriate transfer, this will be escalated to the medical directors to investigate, manage and track.

9. Once decision has been made to transfer to UHNBC – transfer to Internal Medicine and then determine if suitable for Family Practice management.