American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved June 2024

Emergency Medical Services Interfaces with Health Care Systems

Revised June 2024

Originally approved February 2018, replacing the following rescinded policy statements: Ambulance Diversion (1991-2018), Emergency Ambulance Destination (1983-2018), EMS Regionalization of Care (2013-2018), Interfacility Transportation of the Critical Care Patient and Its Medical Direction (1999-2018)

The American College of Emergency Physicians (ACEP) believes that emergency medical services (EMS) constitute an integral component in the continuum of acute medical care, and supports the following principles:

- EMS plays an essential role in the clinically effective, fiscally responsible regionalization of healthcare, providing acute medical assessment and interventional care contemporaneous with navigation of patients to the appropriate destination. Patients, particularly those with time-critical conditions, are best served in geographically appropriate health care facilities having the specialized capabilities and services, either on site or via appropriate communications modalities, required for their evidence-based, optimal clinical outcomes. Appropriate funding of coordinated continuum of care systems (eg. trauma systems) is essential to promoting the availability of regionalization of healthcare.

- EMS systems must have significant involvement, funding, and leadership decision-making authority in any regionalized system of healthcare to best provide necessary out-of-hospital acute assessment and care to patients, including safe, timely navigation of patients to the right destination at the right time.

- EMS destination protocols must be constructed with the substantive leadership of the EMS system's physician medical director(s), always based primarily upon evidence-based clinical rationale, while balancing patient safety and geographical operational realities.

- Healthcare facility requests for diversion of EMS transported patients are requests, not legal requirements, for EMS professionals operating with the leadership of the EMS system's physician medical director. Diversion requests should be kept to minimums in frequency and duration. Diversion request parameters that can be honored clinically and/or operationally are to be established by the EMS system's physician medical director(s). Of particular note, hospitals should not seek or expect relief from inpatient census spikes and/or inpatient movement inefficiencies by requesting diversion of EMS transported patients.

- To date, there has not been any evidence in peer reviewed medical literature that EMS diversion improves ED throughput or patient oriented outcomes.

- Healthcare facility requests for diversion of EMS transported patients must be weighed against the capabilities and needs of the geographically applicable served area. In situations where a multitude of area hospitals are experiencing overload such as, but exclusive to, system mass-casualty incident (MCI), the EMS physician medical director(s) may determine that all hospitals are "open" to EMS transported patients to avoid disproportionate burden on remaining hospitals also at or near capacity. In situations where a hospital is the unique provider of specialized clinical service(s) for a geographically applicable served area, the EMS physician medical director(s) may determine that such hospital remains "open" to EMS transported patients requiring such unique, specialized clinical service(s).

- Acute care to acute care or longer-term care interfacility EMS transportation of a patient represents an important component in that patient's treatment plan. Careful consideration must be given to the patient's present clinical care needs, factoring ongoing needs and those that could reasonably, potentially arise during the time of interfacility transport. Appropriate clinical personnel, assessment equipment, and treatment equipment are to accompany the patient in the clinically appropriate transport vehicle(s) involved in any interfacility transport. For more information, ACEP's "Appropriate Interfacility Patient Transfer" policy statement can be reviewed.

- During an acute care to acute care or longer-term care interfacility EMS transport, the patient's transferring physician ultimately bears the responsibilities for patient assessment in timely proximity to the transport, determining the clinically appropriate level and modality of the transport, securing legally appropriate acceptance of care for the patient at the destination healthcare facility, and communicating the salient details of the patient's condition and care plan, with both transport personnel and receiving physician(s). Transferring physicians are highly encouraged to consult with a physician medical director of the EMS system(s) intended to be involved in the patient's interfacility transport when considering necessary level of care during transport and the modality of transport (eg, ground or air rotor wing).

- During an acute care to acute care or longer-term care interfacility EMS transport, the patient's receiving physician ultimately assumes full responsibility of the care for the patient that they agreed to accept.

- During an acute care to acute care or longer-term interfacility EMS transport, the physician medical director(s) for the involved interfacility transport professionals ultimately bear(s) the responsibility to establish, maintain, and update necessary treatment protocols to promote the optimal provision of expected usual and customary interfacility transport care. Often, specialized critical care needs may be encountered in the interfacility transportation of patients. Physician medical director(s) of interfacility transportation services may choose to involve other specialty and subspecialty physicians in the crafting of clinical treatment protocols and/or in providing on-line medical consult services during transports.

- All EMS transports of patients should include the exchange of clinically relevant information, in oral and/or written formats as conditions warrant. Formal written documentation of provided care must be supplied to subsequently treating clinicians in clinically relevant timeframes.