



## Determining the Appropriate Level of EMS Clinician for Patient Transport

### PURPOSE

To establish a standardized process for determining the appropriate level of EMS clinician to accompany a patient during transport when there is discordance between the level of clinician dispatched and the level of clinician required following on-scene patient assessment. This policy affirms that decisions to request, cancel, downgrade, or release ALS resources must be based on direct patient assessment, clinical judgment, and clear communication between EMS clinicians; while ensuring patient safety, supporting appropriate utilization of resources, and maintaining clear documentation and escalation pathways.

### SCOPE

This policy applies to EMS responses in which the level of EMS clinician dispatched does not match the patient's acuity as determined by an on-scene clinical assessment. This policy provides a framework for using structured patient assessment and clinical judgment to align EMS clinician level with actual patient acuity.

### BACKGROUND

Dispatch decisions are made with limited initial information and may either underestimate or overestimate patient needs. Information available at the time of dispatch is often incomplete and may not reflect patient complexity, comorbid conditions, or evolving clinical presentations, resulting in potential mismatch between the level of EMS clinician dispatched (ie ALS or BLS) and the patient's actual acuity once assessed.

Once on scene, EMS clinicians are expected to perform a thorough and complete assessment of the patient, incorporating history, physical examination, vital signs, response to initial care, and available diagnostic testing. This broader clinical picture provides insight into both the patient's current clinical needs as well as the potential for change during transport, including the possibility of clinical deterioration and/or the need for escalation of care.

### POLICY

#### 1. General Considerations for ALS Treatment and Transport

Following a thorough and complete patient assessment, Paramedic (ALS) involvement is generally indicated when patient presentation, assessment findings, diagnostic information, interventions performed, or anticipated clinical course suggest a need for advanced clinical management on scene and/or during transport. These considerations apply to situations in which a Paramedic has not yet arrived on scene or been requested, as well as to situations in which the call was dispatched ALS and a downgrade (defined as a Paramedic clinician releasing care to an EMT clinician) is being considered.



The following Table identifies features that favor Paramedic (ALS) involvement. This Table is not exhaustive nor exclusive, and any one bulleted feature favors Paramedic involvement:

Patient Presentation	Assessment Findings
<ul style="list-style-type: none"> <li>■ Actual or potential airway compromise</li> <li>■ Respiratory distress, increased work of breathing, or hypoxia</li> <li>■ Circulatory compromise or signs of shock</li> <li>■ Chest pain, anginal equivalent, or suspected acute coronary syndrome</li> <li>■ Syncope or near-syncope</li> <li>■ Active or refractory vomiting</li> <li>■ Severe or poorly controlled pain</li> <li>■ Infants and young children (&lt;2 years) with high-risk or concerning complaints</li> </ul>	<ul style="list-style-type: none"> <li>■ Abnormal level of consciousness (AVPU not Alert)</li> <li>■ Markedly abnormal vital signs, including in adults or age-appropriate for children:               <ul style="list-style-type: none"> <li>■ Heart rate &lt;50 or &gt;120 beats per minute</li> <li>■ Respiratory rate ≤8 or ≥30 breaths per minute</li> <li>■ Systolic blood pressure &lt;100</li> <li>■ Oxygen saturation &lt;90% on room air</li> </ul> </li> <li>■ Abnormal blood glucose values (&lt;70 mg/dL or &gt;300 mg/dL) when associated with altered mental status</li> <li>■ Pain severity that remains severe (score ≥ 7) despite initial measures</li> </ul>
Diagnostic Findings (if available)	Interventions and Anticipated Care Needs
<ul style="list-style-type: none"> <li>■ 12-lead ECG evidence of ischemia, infarction, or other acute pathology</li> <li>■ New or clinically significant dysrhythmias identified on cardiac monitoring</li> </ul>	<ul style="list-style-type: none"> <li>■ Interventions beyond the BLS scope have been performed or are reasonably anticipated</li> <li>■ Medications beyond oxygen, oral glucose, or bronchodilators are indicated</li> <li>■ There is a reasonable expectation that advanced airway, cardiovascular, neurologic, or analgesic management may be needed during transport. This includes serial ECG monitoring in patients with ongoing symptoms of acute coronary syndrome</li> <li>■ There is risk of clinical deterioration or likelihood that escalation of care may be required before arrival at the destination</li> <li>■ There is opportunity to meaningfully relieve suffering through Paramedic-level interventions</li> </ul>

## 2. EMT request for Paramedic

An EMT may request a Paramedic at any time when, based on their assessment, the patient's condition, anticipated clinical course, or potential for deterioration exceeds or is reasonably expected to exceed the scope of their ability to manage at the EMT level during transport.

An EMT should request Paramedic involvement when assessment findings, diagnostic information, response to initial care, or anticipated needs suggest that advanced assessment, monitoring, or



intervention may be required prior to arrival at the receiving facility (see above Table). This includes situations in which patient acuity is unclear, evolving, or may reasonably worsen during transport.

ALS resources may be requested:

- At the time of initial patient assessment,
- After reassessment if patient condition changes,
- When new information becomes available (e.g., diagnostic findings, response to treatment).

When ALS involvement is indicated, the EMT should consider the most timely and appropriate means of accessing ALS-level care, which may include:

- Intercept by a responding or available ALS (Paramedic) unit, or
- Expedited transport to the nearest appropriate receiving facility capable of providing ALS-level evaluation and intervention.

In circumstances where the receiving hospital represents the closest or most readily available ALS resource, and where transport time is short relative to ALS response or intercept time, direct transport to the hospital may be appropriate. This decision should be informed by patient condition, anticipated need for prehospital ALS intervention, transport time, and when indicated, consultation with Medical Control.

Regardless of the initial decision, EMTs retain responsibility for ongoing patient assessment and management to their scope of ability throughout transport, unless otherwise relieved by a Paramedic clinician or hospital staff. The EMT may request ALS (Paramedic) involvement at any point if patient condition deteriorates or clinical concern increases.

### **3. Cancellation of Paramedics by EMTs**

A responding Paramedic may be canceled by an EMT on scene under the following circumstances:

- The EMT has personally assessed the patient, and;
- The patient does not require evaluation or management by a Paramedic based on potential injury, medical condition, or complaint (See Table above)

The EMT canceling the Paramedic will be responsible for completing appropriate documentation, including documenting the decision to cancel the Paramedic.

Paramedics providing service with a non-transport/non-ALS service shall have the authority to supersede the EMT's decision to cancel a responding ALS unit.

The transporting EMT is ultimately responsible for patient care and may call back a canceled Paramedic if they are uncomfortable caring for the patient, regardless of who canceled the Paramedic.

Once the Paramedic has made visual contact with a patient, they shall follow the "Paramedic Release to EMT" process outlined below.

### **4. Paramedic Release to EMT**

Patient contact is defined by the paramedic's visual contact with the patient.



An ALS unit (defined as an ambulance or first response unit staffed by a Paramedic responding with an agency certified to operate at the ALS level) who makes patient contact may transfer care of a patient to a BLS unit after the following:

- The Paramedic has completed an assessment of the patient, which includes, but is not limited to:
  - Focused subjective assessment including the history of the problem.
  - Complete medical history including current medications, allergies, and recent hospitalizations.
  - Assessment of all pertinent systems.
  - A complete set of vital signs including blood pressure, pulse, respirations, level of consciousness, and skin color/temperature.
  - A 12 lead ECG in all patients with chest pain, anginal equivalent, or suspected acute coronary syndrome.
- The Paramedic believes that the patient's condition does not currently, and will likely not in the near future, warrant paramedic-level assessment or care.
- The Paramedic provides a complete verbal handoff to the EMT, including relevant assessment findings and anticipated clinical needs, and will confirm mutual agreement that the patient is appropriate for BLS care and transport. The Paramedic must accompany the patient to the hospital if the EMT expresses any discomfort with assuming care for the patient. This is regardless of whether or not the Paramedic believes any ALS procedures are warranted. However, it is the obligation of the EMT to communicate to the Paramedic if they are not comfortable with managing the patient.

After the call, the Paramedic will complete a Prehospital Care Report (PCR) which includes documentation of the assessment performed, physical findings, pertinent negatives, and vital signs. In cases where both the EMT and Paramedic are from the same agency, it is acceptable for the ALS assessment to be completed as an addendum on the transporting provider's PCR.

Approved by the Monroe-Livingston REMAC **DRAFT**