

**Connecticut Interfacility Transport Program
Best Practices and Implementation
2025**

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Purpose

A crucial aspect of the healthcare system involves the transportation of patients outside the traditional "911" system. To ensure patients receive the appropriate level of care, specialized treatment, and to alleviate hospital overcrowding, patients must be transferred between facilities. These transfers are carried out through various methods, including:

- Wheelchair transport
- BLS ambulance
- ALS ground ambulance
- Critical Care Transport Team (ground or air)

Each transport type often requires additional training beyond the initial certification that providers receive. In 2006, the National Highway Traffic Safety Administration (NHTSA) recognized this need and published a document defining levels of interfacility transport (IFT) and providing recommendations for staffing, among other considerations. Organizations like ASTNA, CAMPTS, and CAAS (among others) have also acknowledged the importance of clear policies, procedures, and educational standards to ensure the safe transport of IFT patients.

In 2012, the Connecticut EMS Advisory Board (CEMSAB) issued educational recommendations and requirements for paramedics to safely conduct ALS IFTs. These guidelines remained in use until around 2016. Recognizing the need for standardized IFT protocols, CEMSAB, in 2020, tasked its Protocol and Education Committees with creating guidelines and educational materials to ensure safe IFT patient transport across Connecticut.

The IFT Protocol Workgroup developed a set of protocols for conducting IFTs, acknowledging that the scope of an IFT can range from BLS to Critical Care Transport (CCT) (note: CCT-specific guidelines are not covered in these protocols). The IFT Education Workgroup also created foundational education recommendations to ensure providers are properly prepared for the IFT setting.

This document serves as guidance for services that already perform IFTs, as well as those seeking to implement such services. It includes example Sponsor Hospital agreements, quality improvement recommendations, and provides guidance on education and ongoing competency.

Definitions

IFT: Moving a patient from one licensed medical facility to another, often for specialized care or treatment.

CCT: Critical Care Team

SCT: The inter-facility (hospital-to-hospital) transfer of a critically ill or injured patient by ground or air ambulance when their condition requires ongoing care from specialists, like emergency or critical care nurses, respiratory therapists, or cardiologists. This transport involves medically necessary supplies and services exceeding the scope of a standard AEMT or Paramedic level.

Sponsor Hospital: Hospital that provides medical oversight for the transport service.

Clinical Care Supervisor/Manager: The individual(s) focuses on optimizing patient care within emergency medical services. This role often involves coordinating patient care transitions, developing and implementing care plans, and ensuring compliance with regulations. They also may lead teams, manage resources, and provide clinical oversight.

Quality Assurance: Encompasses the processes and systems used to ensure consistently high-quality patient care and minimize errors. It involves establishing policies, conducting regular audits, providing staff training, and continuously evaluating services to meet established standards. QA is a proactive approach focused on identifying and addressing potential issues before they impact patient outcomes, ensuring services are delivered safely, effectively, and consistently.

- Define quality
- Improving quality
- Measuring Quality
- Preventative
- Detective
- Corrective
- Assessment
- Documentation

Service Prerequisites

1. Licensed by state of CT
2. Sponsor Hospital Approval
 - Services and their Sponsor hospital should have an agreement concerning the following:
 - QA/QI process
 - Education (including Gap Analysis)
 - Scope
 - Equipment
3. Written Quality Improvement plan – agreed upon with Sponsor Hospital
4. Reporting – data submitted electronically
5. Education Plan
 - Initial and ongoing educational requirements
 - Initial and ongoing clinical competency validation requirements
 - Record keeping

Provider Prerequisites

1. Licensure/Certification

- CT Emergency Medical Technician
- CT Advanced Emergency Medical Technician
- CT Paramedic

2. Experience

- Should be decided for each level of provider between the sponsor hospital and service.
- Currently there are no specific recommendation for “experience” when it comes to ALS IFT. The closest comparison being CCT teams – which require multiple years of ALS experience prior to be hired. (Previously CT recommended 2 years of experience as a paramedic.)

3. Education

- Provider must be provided with education (as approved by their Sponsor Hospital) prior to performing an IFT. (Note: State Education and Training has developed a model for the recommended education)
- Provider must also demonstrate continued competency as agreed upon by service and Sponsor hospital.

Inter-facility Transfer Checklist

____ Sponsor Hospital Agreement

____ Education Plan: Attach training plan and attestation that education provided meets all educational recommendations for all levels of IFT provider.

____ Service Clinical Care Supervisor: Name, contact information and credentials

____ QI Plan: Copy of IFT Quality Improvement plan

____ Formulary and Equipment List

Example Agreement between Sponsor Hospital and Service

Service Information

Name:

Address:

Head of Service:

Title:

Email:

Telephone:

Service Clinical Supervisor:

Email:

Telephone:

Sponsor Hospital

Hospital Name:

Medical Control Coordinator:

Email:

Telephone:

Medical Director:

Email:

Telephone:

Include

- Formulary/Devices Allowed
- Education Plan
- Quality Improvement/Assurance Plan
- Date for review

Service Signature: _____

Date: _____

Medical Director Signature: _____

Date: _____

Frequently Asked Questions (FAQs)

1. Does my service have to perform Interfacility Transfers (IFTs)?

No, a licensed service is not required to perform IFTs. However, if a service chooses to do so, it is strongly recommended that they follow the suggested education and protocols.

2. Is there a specific timeline for implementing the IFT program?

No, there is no assigned timeframe. Each service should assess its own needs and develop an individualized implementation plan.

3. Does my service have to allow all the listed medications and devices?

No, each service, in coordination with its Sponsor Hospital, should develop its own approved formulary and list of permitted devices.

4. Do we need to complete all of the education modules at once?

No, education plans should be tailored to each service's needs and capabilities, in collaboration with the Sponsor Hospital.

5. Is this considered a credentialing or certification program?

No, the CT IFT education and protocols do not result in a formal credential or certification. Providers who complete the recommended training are considered **"IFT Trained EMTs or Paramedics."**

6. How often does the IFT training need to be refreshed?

Clinical competency should be evaluated annually. It is recommended that providers receive refresher training as determined in agreement with their Sponsor Hospital.

7. Where can I access the IFT training?

Minimum training recommendations are available on the **OEMS website**. Sponsor Hospitals may also enhance the training with additional modules or resources.

8. Who should I contact if I have questions?

Start by contacting your **Sponsor Hospital**. If additional information is needed, you may reach out to the **Protocol Committee** or the **Education/Training Committee**.

Appendix A – Quality Improvement

Suggestions for review: This may change as a program develops. As a program first starts it is recommended that a 100% review is completed on ALS IFT calls.

Peer review: Develop a group to peer review these calls and present regular case review sessions.

Sponsor Hospital: The service and their Sponsor hospital should have an agreement on how IFT call PCRs are to be received by the sponsor hospital for review.

Internal QA review: The individual service should have a specific plan for review that includes: what they are reviewing, documentation of review and remediation plans.

Potential Calls for review (Note: This will depend on age of program and volume a service sees)

- All ventilator transports
- All transports with vasopressors
- All chest tube transports
- Any transport with multiple medications/interventions
- STEMI
- Stroke
- Multi-system trauma

Suggested Review elements - Example QI Program

1. Documentation Accuracy & Completeness

- **Metric:** 100% of transport records should include clear, legible, and complete documentation of:
 - Patient condition at pickup and during transport
 - Interventions performed
 - Vital signs and monitoring data (i.e. uploading data from devices)
 - Equipment used (e.g., ventilator settings, arterial line status)
 - Medication administration (dose, route, time)
 - Signatures (crew, sending/receiving facility)
 - Copy of sending facility orders (i.e. goals of care, communication with receiving facility)

2. Timeliness

- **Response Time:** Measure the time from transfer request to arrival at the referring facility.
- **Scene Time (for EMS):** For EMS interfacility transfers, track the time from ambulance arrival at the scene to departure.
- **On-Time Trip Completion:** Ensure patients arrive at their destinations promptly for time sensitive interventions.

3. Equipment and Monitoring Appropriateness

- **Metric:** 100% of high-acuity transports (ventilator, arterial line, multiple medications must have:
 - Documentation of proper equipment function checks
 - Evidence of staff competency with the equipment
 - Documentation of any waveform monitoring (if applicable)
 - Safely securing of equipment for transport
- **Special Focus:** Transduced lines, mechanical ventilators, infusion pumps, medication doses/adjustments, TVP, chest tubes, drains etc.

4. Handoff Communication and Continuity of Care

- **Metric:** 100% of transports must include documented:
 - **Receiving report** (verbal and/or written)
 - **Hand-Off Tool:** Suggest using handoff tool (example)
 - **Report to proper personnel:** I.e. Intubated pt. to RT etc.
 - **Pre-notification: (this may change dependent on facility)**
 - **ED:** Receiving facility should receive notification from EMS prior to arrival, especially for high acuity patients, trauma and patients who had changes in status during transport.
 - **Floor/OR:** Obtain receiving floor's/physicians direct contact information. Contact them if have change in patient status or other concerns.
- **Risk Area:** Incomplete handoff can result in gaps in care or missed interventions

5. Protocol and Scope of Practice Compliance

- **Metric:** 100% of interventions must be within the provider's **scope of practice and current protocols**
- **Review Elements:**
 - Medications administered
 - Invasive procedures (e.g., management of A-lines, central lines)
 - Clinical decision-making that deviates from protocol must be clearly justified
 - Review written orders for any changes in treatment parameters

6. Adverse Events/Near Misses/Clinical Deterioration

Adverse Event: "Unintended injuries or complications caused by medical management rather than the underlying condition." (Skelly 2025)

- ✓ Product/Device related
- ✓ Patient protection events (i.e. elopement, custody issues)
- ✓ Care management events (medication errors)
- ✓ Environmental events (MVA, patient drop etc.)
- ✓ Criminal events

- **Metric:** 100% of adverse events must be:
 - **Reported**
 - Immediately: Receiving facility at time of transfer of care
 - As soon as possible to service (no longer than 12 hours)
 - With-in agreed upon time frames to Sponsor Hospital
 - **Reviewed** by the clinical or QA team
 - **Action Plan**
 - Review the case as per Sponsor Hospital QA/QI process
 - Re-education/Remediation plan
 - Discipline (if required)
 - Events should be tracked and integrated into yearly competencies and continuing education, including regularly scheduled case reviews
 - Ensure corrective action is reviewed and found to be effective.
 - **Track Trends:** Number and type of events per (# of transports) – depending on volume

Near Miss: “Potential to cause significant harm but does not do so, typically due to change rather than intervention.” (Skelly 2025)

- **Type of Event**
 - **No harm:** Incident reaches the patient, but no harm is caused due to early detection, intervention/treatment or incident reaches the patient but does not cause harm because of change.
 - **Near Miss:** Incident does not reach patient because of previously planned interventions and programs or incident doesn’t reach patient because of change or unplanned interventions.
- **Metric:** 100% of near miss events must be reported
 - **Reported**
 - Immediately: Receiving facility at time of transfer of care
 - As soon as possible to service (no longer than 12 hours)
 - With-in agreed upon time frames to Sponsor Hospital
 - **Reviewed** by the clinical or QA team
 - **Action Plan**
 - Review the case as per Sponsor Hospital QA/QI process
 - Re-education/Remediation plan
 - Ensure corrective action is reviewed and found to be effective.
 - Events should be tracked and integrated into yearly competencies and continuing education, including regularly scheduled case reviews
 - **Track Trends:** Number and type of events per (# of transports) – depending on volume

Clinical Deterioration:

- **Metric:** 100% of patients who experience clinical deterioration must be:
 - **Reported**
 - Immediately: Receiving facility at time of transfer of care
 - As soon as possible to service (no longer than 12 hours)
 - With-in agreed upon time frames to Sponsor Hospital
 - **Reviewed** by the clinical or QA team
 - **Action Plan**
 - Review the case as per Sponsor Hospital QA/QI process
 - Was it reasonably expected?
 - Could it have been prevented?
 - If event is found preventable, re-education/remediation plan as needed
 - Events should be tracked and integrated into yearly competencies and continuing education, including regularly scheduled case reviews
 - **Track Trends:** Number and type of events per (# of transports) – depending on volume

7. Legal Exposure and Incident Reporting

- **Metric:** Incident reports filed for all:
 - Equipment failures
 - Line dislodgement or bleeding
 - Missing documentation or signature
 - Discrepancies in reports between sending and receiving teams
 - Any others identified by individual agencies
- **Goal:** 100% of reportable incidents are filed, followed up, and resolved

8. Appropriateness of Transport

- **Metric:** Review transports for:
 - Appropriateness of patient selection for mode of transport
 - Appropriateness of clinical providers for transport
 - Timeliness of arrival and departure
 - Delays documented and justified
- **Legal Risk:** Delays without justification, or inappropriate mode of transport (e.g., BLS used when ALS or CCT was required)

Optional Benchmarks & Reporting

- Aim for >95% compliance in most categories
- Maintain <2% charting deficiencies that require correction
- Track trends quarterly and annually to identify educational needs or systemic issues

Appendix B – Education Standards

- There are no set number of hours required to complete this education. The primary objective is to ensure competency, recognizing that the time needed to achieve this may vary by individual provider. For reference, the previous program required approximately 24 hours of instruction, not including experiential “ride time.”
- Any educational program should include competency validation in knowledge, skill and a synthesis and application, provider comfort.
- A gap analysis should be conducted by services who have already provided education in some of these areas to ensure the correct modules are taught
- Modules should be taught by subject matter experts.
- Clinical experience should be included – this may include time in the ICU/ED or riding with a previously IFT trained provider or with direct medical oversight.

Recommended Minimum Education Modules (by level)

BLS	Paramedic	Optional (Sponsor Hospital Dependent)
Transport Operations	Transport Operations	Arterial Lines
BLS IFT Module	Medical/Legal	Transvenous Pacing (Cardiac)
Medical/Legal	Devices	Select devices from Devices module
Devices Module (as applicable)	NIV Management	Pediatrics
	Neurology	OB/Neonate (high risk)
	Sepsis	
	Cardiac	
	Endocrine/Metabolic	
	Respiratory	
	Toxicology	
	Trauma	
	Blood	
	OB/Neonate	
	Pediatric	
	Ventilator Management	

(Education will be posted on the OEMS website)

Appendix C – Protocols
[Connecticut Statewide EMS Protocols](#)

Appendix D: Example Formulary

Medications	Paramedic	IFT-A Paramedic	Comments
Acetylcysteine (Mucomyst)	Yes	Yes	
Amiodarone (Cordarone)	Yes	Yes	
Amrinone (Inicor)	No	Yes	
Antibiotics	Yes	Yes	
Atenolol (Tenorium)	Yes	Yes	
Ativan (Lorazepam)	Yes	Yes	
Atropine Sulfate	Yes	Yes	
Betamethasone (Celestone)	Yes	Yes	
Bumetanide (bumex)	Yes	Yes	
Calcium Chloride/Calcium Gluconate	Yes	Yes	
Captopril (Capoten)	No	Yes	
Cardene (nicardipine)	No	Yes	
Chemotherapy	No	No	with licensed staff
Cisatracurium (Nimbex)	No	Yes	Maintain only
Clevidipine (cleviprex)	No	Yes	
Diazepam (Valium)	Yes	Yes	
Diazoxide (Hyperstat)	No	Yes	
Diltiazem (Cardizem)	Yes	Yes	
Diphenhydramine (Benadryl)	Yes	Yes	
Diprivan (Propofol)	Yes	Yes	Pt must be intubated
Dobutamine (Dobutrex)	Yes	Yes	
Dopamine (Intropin)	Yes	Yes	
Eptifibatide (Integrilin)	Yes	Yes	
Epinephrine	Yes	Yes	
Esmolol (Brevibloc)	No	Yes	
Etomidate	No	Yes	
Fentanyl	Yes	Yes	
Fibrinolytic Active (IV running)	No	Yes	rtPA, activase, retivase, tenectaplaste
Fibrinolytic post	Yes	Yes	rtPA, activase, retivase, tenectaplaste
Furosemide (Lasix)	Yes	Yes	
Haldol	Yes	Yes	
H2 Blockers (Pepcid)	Yes	Yes	
Heparin	Yes	Yes	
Hydralazine (Apresoline)	No	Yes	
Hypertonic Saline	No	No	
Insulin	Yes	Yes	
Isoproterenol (Isuprel)	Yes	Yes	
K-Centra (blood product)	Yes	Yest	
Kepra (levetiracetam)	No	Yes	
Ketamine	Yes	Yes	
Labetalol (Normodyne)	Yes	Yes	
Levophed	Yes	Yes	
Lidocaine	Yes	Yes	
Lopressor (Metoprolol)	Yes	Yes	
Magnesium Sulfate	Yes	Yes	
Mannitol	No	Yes	

PROCEDURES / DEVICES

Procedure/device	EMT	Paramedic Non IFT	Paramedic IFT	Additional Staff/comments
Arterial lines	No	No	Yes	Yes – If on saline maintenance drip *NO – if needs to be transduced (i.e. on the monitor)
Balloon Pump	No	No	No	W/staff or Life Star
Blood /FFP/KCentra Administration	No	Yes	Yes	Changed 6/21 – can take w/o hanging for 15 minutes.
CBI drainage	No	Yes	Yes	
Central lines w/ medication running	No	Yes	Yes	Includes Hickman, PICC, Triple lumen NO: SWAN GANZ
Central line (capped)	Yes	Yes	Yes	
Chest tubes	No	No	Yes	
CPAP / BiPAP	No	Yes	Yes	Obtain settings
CVP Monitoring	No	No	Yes	
Dialysis catheter / shunt capped	Yes	Yes	Yes	
ECG Monitoring	No	Yes	Yes	
Epidural –capped	No	Yes	Yes	
Heimlich Valve	No	Yes	Yes	Only the valve, not attached to chest tube.
High Flow Nasal Cannula	No	No	No	Unable to support due to O2 demand – switch to NRB or BiPAP
ICP monitoring	No	No	No	W/staff or Life Star
Infusion Pumps	No	Yes	Yes	
Intravenous fluids	No	Yes	Yes	
Intravenous lock	Yes	Yes	Yes	
Intubated patients	No	Yes	Yes	
NG/OG Tubes	Yes (if not on suction)	Yes	Yes	
Pacing transcutaneous	No	Yes	Yes	
Pacing transvenous	No	No	Yes	
Patient controlled pumps	Locked pain medication only	Yes	Yes	For any other patient-controlled pumps please verify medication and contact Supervisor or Manager
Porta-Cath –capped	Yes	Yes	Yes	
PEEP	No	Yes	Yes	
Restraints	Yes	Yes	Yes	Check that receiving facility will take pt. restrained
Tracheostomy (ventilatory assist)	No	Yes	Yes	
Tracheotomy	Yes	Yes	Yes	
Ventilator	No	Yes	Yes	Obtain settings

Appendix E- Hand Off Form

Inter-facility Transport Worksheet

Run # _____

Patient Name	Admission Diagnosis
Reason for Transport	Receiving MD/RN
Destination, Unit, Room	Destination Phone No.

Paramedic: Please complete the following section prior to patient care turnover.

Vitals (from Staff)	Vitals (by Medic) (Prior to Transport)	ET Tube Size	Vent Mode
RR	RR	Depth (cm)	Vt
HR	HR	At the	RR
BP	BP	<input type="checkbox"/> Not intubated	PEEP
LS	LS		Pressure Support
SpO2	SpO2		FiO2

Intravenous Access			
IV	Location	Setting (ml/hr.)	Medication/Solution
1			
2			
3			
4			
5			
6			

Chest Tube
Location:
Suction:
Output:

Lab Values							
<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black; padding: 5px;">Na</td> <td style="border-right: 1px solid black; padding: 5px;">Cl</td> <td style="border-right: 1px solid black; padding: 5px;">BUN</td> <td rowspan="2" style="padding: 5px;">Gluc</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 5px;">K</td> <td style="border-right: 1px solid black; padding: 5px;">CO₂</td> <td style="border-right: 1px solid black; padding: 5px;">Creat</td> </tr> </table>	Na	Cl	BUN	Gluc	K	CO ₂	Creat
Na	Cl	BUN	Gluc				
K	CO ₂	Creat					

Foley Catheter
Need Emptying During Transport?
Volume:

Arterial Blood Gases				
pH	PaCO ₂	PaO ₂	HCO ₃	O ₂

To the Sending Physician: Please complete the following section prior to patient care turnover. This serves as your written orders for care during transport. Please include specific therapeutic goals, medication dose ranges or incremental adjustments. **Physician Section in Red**

Advanced Airway Confirmation	
Receiving Physician: Please sign here confirming that the advanced airway is in place at time of patient receipt.	
Physician Name	Physician Name

For the purposes of Direct Medical Oversight (DMO) during the transport the sending Physician must be available for consult until the patient is received by the accepting Physician.

Physician Name:	Direct Phone #
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Probable Complications – Please list the most likely complications that could occur during transport specific to this patient’s condition as well and the suggested intervention(s).

Drug and Therapy Administration			
---------------------------------	--	--	--

	Drug/Therapy	Titration Range	Therapeutic Goal
1			
2			
3			
4			
5			
6			

Additional Orders

Sending Physician - Please complete this section prior to patient care turnover.

Signatures	
Physician Name	Paramedic Name
Physician Signature	Paramedic Signature

Resources

Modules 1& 2 (Transport Operations/Legal) and General

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Module 3 - Devices

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