

Policy Statement

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Patient Autonomy and Destination Factors in Emergency Medical Services (EMS) and EMS-Affiliated Mobile Integrated Healthcare/Community Paramedicine Programs
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The American College of Emergency Physicians (ACEP) believes that patients with medical decisionmaking capacity (or legal guardians, health care agents, or surrogates, when applicable) should actively participate in treatment plans formulated by health care professionals using standing order protocols or contemporaneous medical oversight in the provision of care by emergency medical services (EMS) systems and EMS-affiliated mobile integrated health care/community paramedicine (MIH/CP) programs, and supports the following principles:

- **Medical Decisionmaking Capacity:** EMS systems and EMS-affiliated MIH/CP programs must use a formal process for establishing a patient's (or legal guardian's, health care agent's, or surrogate's, when applicable) medical decisionmaking capacity for dissent to medical assessment, treatment, or transportation. Key components in possessing medical decisionmaking capacity include the ability to understand the medical condition as presently assessed; the recommended further assessment, treatment, or transportation; and the alternatives, the benefits, and the refusal-related risks of recommended further assessment, treatment, or transportation. Informed refusals, made with medical decisionmaking capacity, should be carefully documented in accordance with EMS and EMS-affiliated MIH/CP programs physician medical director-established policies, and involved patients,

legal guardians, health care agents, or surrogates should be provided reasonable health educational materials, including their right to future ability in accessing EMS (or EMS-affiliated MIH/CP programs when applicable).

Adherence to EMS and EMS-affiliated MIH/CP programs physician medical director-established policies relating to medical decisionmaking capacity assessment and informed refusals should be measured elements in the continuous quality improvement activities within EMS systems and EMS-affiliated MIH/CP programs.

- **Alternatives to Emergency Department (ED) Destination:** EDs are the most typical destinations for patients cared for by EMS systems and frequent destinations for patients cared for by EMS-affiliated MIH/CP programs. Some patients with focused, differentiated health care needs, including those with established care providers willing to treat them on an unscheduled, acute care basis, may potentially be safely and efficiently navigated to non-ED locations, using local EMS and EMS-affiliated MIH/CP programs physician medical director-established policies. These policies should substantively factor clinical necessity and continuity of care plans, particularly when advocating for patients with chronic illness in the complex infrastructure of health care delivery. Patients must be treated equitably in all treatment and destination considerations, avoiding discrimination by payer type, health care coverage or insurance status, or any social or demographic element.

When alternatives to ambulance response, ambulance transportation, or non-ED destinations are considered, patient safety must always be the primary

defining element. Destinations should be licensed with oversight by applicable authorities (state, federal, or tribal) and be staffed with qualified health care providers, also with oversight by applicable licensing authorities. The EMS and EMS-affiliated MIH/CP programs physician medical director must be integrally involved in the spectrum of such considerations, from dispatch center algorithms to on-scene patient assessment protocols to alternative transport mode and alternative destination criteria.

ACEP's core beliefs include that patients using a prudent layperson standard of a medical emergency should always have access to emergency care services, including access to emergency care by 911 (or equivalent) public safety answering points. These patients wanting ED-based evaluation and management should not be precluded or subjected to unfair disincentives from those services by EMS systems, EMS-affiliated MIH/CP programs, or payers. EMS systems and EMS-affiliated MIH/CP programs should not be financially influenced and provided incentive to specifically direct patients to lowest available levels of care. In other words, the patient clinical concerns and needs must predominate the services provided over any level of care-based

remuneration potentials for EMS systems or EMS-affiliated MIH/CP programs.

Patients using a prudent layperson standard of a medical emergency and accessing emergency care by 911 (or equivalent) public safety answering points with acute, unscheduled, and undifferentiated medical conditions should be transported to an ED with clinical capabilities consistent with emergency care needs. Similar patients, but with stable, differentiated medical conditions, who may be suitable for transportation to a destination other than an ED (eg, mental health facility, sobering center, physician's clinical office) must be afforded at that alternative destination a medical screening examination and stabilizing treatment by a qualified medical professional in accordance with the Emergency Medical Treatment and Labor Act. Adherence to EMS and EMS-affiliated MIH/CP programs physician medical director-established policies relating to destination should be a measured element in the continuous quality improvement activities within EMS systems and EMS-affiliated MIH/CP programs.

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