YOU CALL, WE DON'T HAUL –

Documenting Refusals, TIP, and Other Non-Transport Situations

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Overview

- EMS is in a new era of service delivery models
- As the transition to EMS as a "community health" resource continues, EMS documentation will need to keep pace
- This session is designed to re-think documentation for the EMS future

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Documentation in a New Era

- What we're documenting is a ***patient encounter***
- So naturally, this begs the question…

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"Who is a patient?"

This is an age-old question that must be reconsidered for the future of EMS delivery

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We've heard some quite broad definitions over the years…

"anyone you make contact with is a patient…"

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Is there a difference between a "patient" and a "patient who needs EMS?"

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Both of These Are "Patients"

- ***"I see my doctor every six months to have my blood checked…"***
- Not necessarily an "EMS patient"
- ***"I've been having chest pains for the past hour…"***
- This is an EMS patient

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Clearly, Not Every User of Healthcare Services is a "Patient"

- What about a completely healthy person who consults a plastic surgeon because they want their lips puffed up?
  - This is really a *consumer* or a *user* of the healthcare system utilizing services as a lifestyle choice

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Clearly, Not Every User of Healthcare Services is a "Patient"

- What about a completely healthy person who consults a plastic surgeon because they want their lips puffed up?
  - Perhaps when they are actually on the table having the procedure done, they are a *patient*….

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Who is an EMS "Patient?"

Any individual who wants or needs medical attention

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Who is an EMS Patient?

- Any individual who, at the discretion of the highest medical authority providing direct patient care, demonstrates a high index of suspicion for illness or injury requiring EMS care (EMS practitioner judgment)

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What's the Point of All This?

- Some EMS practitioners believe their documentation responsibilities stop if the person in front of them is not a "patient"

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Documentation Responsibilities Apply in Numerous Situations

- Treatment/Transport
- "Public service" calls
- "No patient found" calls

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Documentation Responsibilities Apply in Numerous Situations

- Refusals of treatment/transport
- Community paramedicine visits
- Transport to alternative destinations

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We Have a Legal, Moral and Professional Duty to Act

"In the simplest terms, a duty to act is a legal duty requiring a party to take necessary action to prevent harm to another person or the general public."

- David Givot, *Duty to Act, Assess, Treat and Transport*, EMS1, August 25, 2020

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Duty to Act?

- Patient contact is made
- Dispatched and then cancelled
- *Arrive on scene and no patient contact - YET*

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"Public Service" Calls

- Examples
  - Person slipped out of her chair and requires assistance getting back into it
  - Person needs assistance opening a vial of medication

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"No Patient Found"

- Examples
  - Bystanders report that driver got in his car and left the scene
  - Respond to an address or incident location and find nobody there

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Documentation Considerations in "Public Service" and "No Patient Found" Calls

- Whether or not there is a "patient" is a different consideration than "what should be documented"
- These calls should *not* be "no documentation" calls
- Even the fact that there *was* no patient is important to document

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We Need the Right Forms

- Terms like "refusal" and "AMA" really don't describe encounters where it is determined – or mutually-agreed – that no treatment or transport is necessary based on the patient's condition

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SAMPLE EMS "INFORMED DECISION-MAKING" FORM – Version 1.4

PATIENT ASSESSMENT

Patient Name: _____ Date: _____

(A) LEGAL CAPACITY

NOTE: If answer to at least one of the questions in this section is "YES," the patient may sign this form in most states. If "NO" to all, signature of legally authorized decisionmaker required. Check your state law for other exceptions.

Patient over 18? Yes___ No___ If minor, is patient married? Yes___ No___ If minor, is patient pregnant? Yes___ No___

Comments/Quotes/Observations: _____

(B) MENTAL CAPACITY

NOTE: If "YES" to any question in (B), Patient *may* lack capacity to refuse care, though this is a fact-specific determination and consultation with medical command is encouraged. Do not release Patient or allow to sign Form unless explanation noted or, if Patient is less than 18 years of age, the Form is signed by Parent or legal guardian.

Disoriented to: Person? Yes___ No___ Possible ETOH/drug use? Yes___ No___ Odor of ETOH? Yes___ No___
Place? Yes___ No___ Admitted by Patient? Yes___ No___ Unsteady gait? Yes___ No
Time? Yes___ No___ Slurred speech? Yes___ No___

Comments/Quotes/Observations: _____

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This is really a process of documenting "informed patient decision making"

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What is CID?

- ***Collaborative Informed Decisionmaking*** is a process by which individuals - or their responsible decisionmakers (RDs) - and EMS practitioners discuss the risks, benefits and alternatives of clinical decisions in all aspects of the EMS interaction and make informed decisions on each, and where the process is fully and accurately documented by the EMS practitioner.

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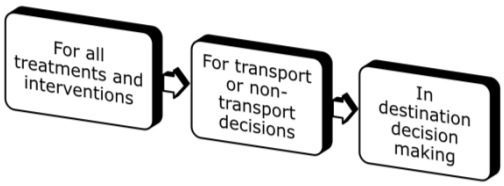
CID Should Occur in All Phases of the Patient Interaction



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Don't put too much emphasis on the magic power of a "refusal form" anyway

It's the documentation that counts…not merely the signature

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It's a detailed narrative that provides the real protection…

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Example 4

"Dispatched for vehicle crash at 3rd and Main. Upon arrival found a 28 year-old male standing outside his vehicle talking on cell phone, at times holding his chest and visibly wincing in pain. After he completed his call approx. 5 min. later, we interviewed him and asked him if he was injured. He was conscious, A&Ox4. He said he hit his chest on the steering wheel and that it's "pretty sore."

We asked pt if we could check him out and take his vital signs but patient said "no way, I have to get to work." We explained to him that hitting the steering wheel with his chest could cause serious internal injuries even though he may feel fine now.

We recommended that pt be transported to the hospital for evaluation and we offered to call his employer to explain. Patient replied that he understood completely but did not want to go to the hospital. We explained the risks of refusing medical care up to and including death from internal bleeding. Pt refused to sign refusal form."

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Example 4

- Even though this documentation lacks a signature on the refusal form, will this narrative protect the crew and the ambulance service?

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Of course…

- It's best to have *both* a detailed narrative and a refusal form signature from the pt or legal decision maker
- But a signature alone is not the cure-all

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The Real Legal Protection…

- Comes from explaining *and documenting:*
  - The possible illness or injury the pt may have
  - The risks of not receiving medical care and/or transport for that condition
  - The benefits of receiving treatment/transport
  - Alternatives for the pt (call 911, call Dr, go to ED, etc.)

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CID: Transport/Non-Transport

- Some pts may consent to treatment but not transport
- Some may consent to transport but not treatment(s)
- Some may decide against treatment and transport

All of these decisions are within the legal rights of the patient or responsible decisionmaker

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"Treat No Transport"

- This is another area where it's more "patient informed decision making" than a "refusal"
- More states are reimbursing for "TNT"
- Medicare ET3 pilot program (2020-2024) will reimburse for "treatment in place"

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"Treat No Transport"

- The Medicare ET3 program will require a consult with a "qualified health care practitioner" either on-scene or via telehealth
  - MD, PA, CRNP, etc.

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"Treat No Transport"

- Both from a liability and reimbursement perspective, it is critical that TNT documentation be:
  - Detailed
  - Clinically appropriate
  - Protocol-compliant

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"Treat No Transport"

- Remember, ultimately the decision to *not* transport a patient to a hospital may have to be explained to a skeptical jury

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Scenario

- Pt with severe abdominal pain and abnormal vitals (pulse 120, respirations 30, BP 90/40)
- Crew determines pt requires transport to nearest hospital and advises pt
- Pt says *"I get it, but I don't do hospitals. I'm not going. Whatever happens, happens."*

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Risks/Benefits

- In this case, crew must ensure that pt understands that his condition is serious and requires care that can only be provided in a hospital
- Crew must explain risks of not going to the hospital

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Alternatives

- Crew must also provide alternatives to the pt
  - Call 911 again if symptoms persist or worsen
  - Call your physician
  - Go to ED
  - Go to urgent care

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Documentation

- PCR must reflect that the patient was informed of benefits of hospital treatment, risks of not being transported, and alternatives in the event condition persists or worsens

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"Informed patient that he needed to be transported to nearest hospital immediately due to possible internal bleeding or other serious conditions. Patient responded 'I get it, but I don't do hospitals. I'm not going. Whatever happens happens."

Informed pt that he could call 911 again, call his Dr, or have someone take him to the ED or to an urgent care clinic if symptoms stay the same or get worse…"

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Quoting the Patient

- It is perfectly acceptable to quote or paraphrase the patient
- If quoting exactly, use quotation marks

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CID: Destination Decisionmaking

- Transport to ED is the norm
- Some hospitals have specific specialty, expertise or accreditations depending on pt condition
- EMS agencies and payors also expanding transport to alternative destinations

Deciding on the transport destination is a clinical decision – just like a treatment or intervention

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Transport to Alternative Destination

- In situations where the ambulance transports the pt to a non-acute care hospital setting, the documentation will require a thorough account of that decision

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Transport to Alternative Destination

- Under ET3 (and likely, other payers in the future), reimbursement may be made for transporting patients to care settings more appropriate for their condition than a hospital ED

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Transport to Alternative Destination

- This decision should be the result of ***collaborative*** discussions between:
  - EMS practitioners
  - Patient
  - Qualified health care practitioner

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Requires Documentation Of:

- Decisional capacity of pt or decision maker
- Agreement for transport to alternative site
- Discussion with QHP
- Clinical assessment, including why an alternative site is more appropriate
- Acceptance of the alternative destination

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Scenario 1

- Your assessment of a middle-aged male pt reveals evidence of STEMI
- You prepare the pt for transport to the accredited STEMI center, 18 miles away
- Pt instead says he wants to go to the local community hospital (non-STEMI), 5 miles away

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Specialty Facility Destinations

- EMS systems have protocols that often direct transport to facilities with specialty accreditations, such as:
  - Trauma
  - Stroke
  - Peds
  - STEMI

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Risks/Benefits

- As with other treatment decisions, transport directly to an accredited specialty destination facility – and bypassing a community hospital ED - for particular conditions has demonstrated clinical benefits
- Pt/RD must be informed of risks of a clinically inappropriate destination – and the CID interaction must be documented

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Scenario 2

- Transporting a patient with potentially unstable angina to the closest ED, ABC Hospital
  - During transport, you contact the ED to provide medical report
  - The ED informs you that it has no beds or staff available for additional emergency pts and that the hospital is on "diversionary status"

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Scenario 2

- You inform the pt that ABC Hospital has redirected you to another hospital and that you are now transporting him to XYZ Medical Center
  - The pt says "I don't care what they tell you, ABC Hospital is where my doctor is and that's where I've gone my whole life. You're taking me to ABC Hospital."

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ED Diversion Situation

- While it is true that under EMTALA, a facility on "diversionary status" must take your pt if you come to that facility, it doesn't mean it's clinically the best choice
  - Pt could experience transfer of care or treatment delays

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Risks/Benefits

- Crew must inform pt of the risks of transport to a facility on diversionary status and that must be documented
  - *"Informed pt that ABC Hospital's ER was full and experiencing significant treatment delays and that they directed us to XYZ Medical Center instead. Pt insisted on being taken to ABC anyway. Informed pt that treatment delays at ABC could be dangerous in his current condition…"*

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Protocol Compliance

- In both TNT and transport to alternative destination situations, documentation will need to reflect clinical protocol compliance
- Deviations between the protocol and the documentation provide an easy road map for plaintiffs' lawyers

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Community Paramedicine

- This service delivery model typically involves scheduled in-home visits for patients recently discharged from an acute care hospital
  - Compliance with treatment plans
  - Ensuring that pt is following his medication regimen
  - Following up with primary care providers

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Community Paramedicine

- Other models may involve alternatives to 911 responses for certain "high utilization, low acuity" calls
  - Substance abuse
  - Mental health

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Community Paramedicine

- These programs typically deploy specifically-trained Community Paramedics
- These services are closer to primary care
- Performed in close collaboration with health care facilities and primary care providers

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Community Paramedicine

- Documentation of CP/Mobile Integrated Healthcare interactions typically requires more detail in areas of:
  - Anatomy
  - Physiology
  - Pharmacology
  - Patient assessment

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Community Paramedicine

- While "traditional" EMS is episodic, Community Paramedicine may involve frequent, repeat visits by same providers
- This requires continuity in documentation over the period of CP visits

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Community Paramedicine

- Just like the collaborative, consent-based approach of TNT and alternative destinations, CP interactions require evidence of agreement with the treatment and plan of action

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Example 5

- "After evaluating the patient and reporting the findings to EMS medical control, a discussion between the patient/caretaker, Dr._____, and the CP was held. It was agreed by all parties that the best course of action for the patient is _____. The patient/caretaker understands and accepts Dr._____'s recommendation and is aware to contact their EMS Community Paramedicine point of contact if there is a change in the patient's clinical condition."

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One Final Issue: What About the "Handoff of Care?"

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People Used to Say…

- *"An EMS provider must hand over care to someone of equal or higher certification…"*
- *"If you don't, it constitutes abandonment…"*

Is this true?

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In the New Era of EMS…

- The name of the game is to deliver care in the most appropriate care settings
- There are many occasions where patients are transferred from "higher" levels of care to "lower" levels

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In the New Era of EMS…

- And there's a point where care is no longer needed and the handoff is…to nobody!

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Examples

- ALS assessment and transfer of care to BLS
- Physician delegation to non-physician practitioner
- Patient discharge
- Specialty care – mental health, addiction, etc.

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"Abandonment"

- Is withdrawing care – without making provisions for continued care – when care is needed
- EMS abandonment cases are few and far between

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Documenting Handoffs

- Important to document:
  - Who received care
  - Why the destination or provider was appropriate
  - Signature acknowledging receipt of the patient whenever possible

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Refusal Signatures

- Many EMS providers believe that their legal protection comes from the signed refusal form

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Refusal Signatures

- Yes, it's true that refusal forms typically contain a legal release or waiver of liability

I acknowledge that this advice has been explained to me by EMS personnel and that **I have read this form completely** and understand its provisions. I agree, on my own behalf (and on the behalf of the patient for whom I legally sign this document), to release, indemnify and hold harmless all EMS providers and their officers, members, employees or other agents, and the base / modified base hospital, from any and all claims, actions, causes of action, damages, or legal liabilities of any kind arising out of my decision, or from any act or omission of the EMS providers or their personnel, or the base / modified base hospital or their personnel.

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But courts are reluctant to enforce a release when the providers fail to explain to the patient – and document – the risks, consequences and alternatives

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It can't be *informed* consent without *information!*

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Refusal Documentation

- So, it may be good practice to get a refusal signature…
- …but the PCR narrative should be used to fully and accurately document the discussion of risks of a pt's decision against care and/or transport

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Refusal Documentation

- Also be sure to follow any applicable EMS system protocols, standing orders or medical control directives specific to your system

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Refusal Narratives

- When it comes down to it, a thorough refusal narrative offers much more legal protection than a refusal signature alone that lacks sufficient explanation or context

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Example

"Dispatched for vehicle crash at 3rd and Main. Upon arrival found a 28 year old male standing outside his vehicle talking on cell phone, exhibited no apparent injuries. After he completed his call approx. 5 min. later, we interviewed him and asked him if he was injured. He was conscious, A&Ox4. He said he hit his chest on the steering wheel and that it's a "little sore" but that "the car wasn't going very fast" at the time of impact.

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Example

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Patient replied that he understood completely
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Obtained signature on refusal form."

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Ideally…

- A well-documented refusal should contain *both* a thorough narrative *and* a signature of the patient or their legally authorized decisionmaker
- But most defense lawyers – if they had to choose – would take the narrative over the signature any day

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So, the primary focus shouldn't be simply getting a refusal form signed and going on your way.

The focus should be an informed patient decision based on discussion of risks and benefits of treatment.

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Conclusion

- As EMS delivery evolves and new service models are implemented, documentation must keep pace
- As the training, education and licensure of EMS practitioners advances, so to will documentation expectations

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Conclusion

- Expectations for EMS practitioner documentation:
  - Appropriate clinical terminology
  - Continuity with continuation of care and with other providers
  - Clinical accuracy
  - Timeliness
  - Detail

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Professional Philosophy

"Helping those who serve the caregivers is what I love to do. I strive to do my very best for every client, every time - so they can provide exceptional EMS for their communities."

Steve Wirth is a founding partner of Page, Wolfberg & Wirth. In a distinguished four-decade public safety career, Steve has worked in virtually every facet of EMS and was one of central Pennsylvania's first paramedics. Steve brings a pragmatic and business-oriented perspective to his diverse legal practice – he served for nearly a decade as senior executive of a mid-sized air and ground ambulance service, helping build the company from the ground up.

Steve is a dynamic and sought-after speaker at regional, state and national conferences on a variety of EMS law and public safety subjects. He has authored many articles, blogs, and book chapters on a wide range of EMS leadership, reimbursement, risk management, corporate compliance and workplace law topics. Steve co-authored the highly acclaimed and popular compliance manuals and video training programs produced by PWW. He is a past chair of the Panel of Commissioners for CAAS, the national ambulance accrediting body.