Position Statement to Inform Local EMS Policies and Protocols for EMS Response without Patient Transport During Respiratory Infection Pandemics

INTRODUCTION AND INTENT:

The intent of this document is to provide local EMS agencies a recommended framework based on existing statutes, regulations, and identified best practices in the context of the current pandemic of COVID-19 for the evaluation of patients with minor illness consistent with COVID-19. With COVID-19 infections down trending, this document may also be considered as needed for other infectious respiratory pandemics.

As background, a joint policy on the non-transport of patients has existed between national ACEP and the National Association of EMS Physicians since 2009, the principles of which are highlighted in this document. Additionally, during the COVID-19 pandemic, the Centers for Medicare and Medicaid Services waived the need to transport patients for reimbursement, if a patient was not transported or received "treatment in place" as a result of EMS protocols from the COVID-19 public health emergency.

Prior to COVID-19, it was estimated that 20% or more of emergency medical service requests do not result in patient transport, and there is no agreed upon best practice to guide local EMS agencies (LEMSAs) regarding how these patients are identified, documented, managed, and reviewed for quality assurance.

AUTHORITY:

Health and Safety Code sections 1798 and 1797.220 provide for medical control under the authority of the Medical Director of the local EMS agency. Paramedic Regulations require the Medical Director of the local EMS agency to establish *"Requirements to be followed when it is determined that the patient will not require transport to the hospital by ambulance or when the patient refuses transport'* (CCR, Title 22, Division 9, Chapter 4, Section 100170(a)(5)). Thus, with patient consent and in accordance with protocols established by the Medical Director of the local EMS agency, paramedics may be authorized to respond to emergency calls without transport of patient, and after an appropriate assessment and providing any indicated treatment.

Each LEMSA should meet with local stakeholders to determine criteria for use of Assess and Refer policies. EMS Medical Directors should incorporate review of patients dispositioned under Assess and Refer policies as part of a quality improvement plan and share the results with stakeholders.

DEFINITIONS:

Respiratory Pandemic: When, as a result of a respiratory infection, there is a duly proclaimed state of emergency or local emergency declared pursuant to the California Emergency Services Act (Chapter 7 (commencing with Section 8550) of Division 1 of Title 2 of the Government Code"

Non-transported persons encompass several categories, defined below. For this policy, "Assess and Refer" patients are the subject of this non-transport focused document.

No patient found: EMS arrives on scene and no person/patient can be located.

Refusal of EMS care: Person/patient is on-scene, denies any medical or traumatic complaint and declines evaluation, treatment, or transport by EMS. In order to qualify for this category of non-transport, patients must be able to clearly demonstrate decision making capacity and display no urgent need for evaluation apparent to EMS personnel. Patients that do not have decision making capacity, i.e. intoxicated, would not qualify for non-transport.

Some examples include:

- Minor motor vehicle accident with passengers who are alert and ambulatory on scene, have no apparent injuries, and decline assessment.
- 911 was called by a third party for someone believed to need assistance, but who denies symptoms and declines evaluation or transport (e.g., wife calls for husband or anonymous caller for someone lying on sidewalk).

Refusal of Care Against Medical Advice (AMA): EMS personnel perform an evaluation and determine that emergent treatment and/or transport is warranted based on a reasonable suspicion of an ongoing medical emergency. In this case, a patient with decision-making capacity or their legal representative declines treatment and/or transport. Patients who are determined to be incapacitated may be treated against their will using implied consent, and patients placed on an involuntary hold may not refuse transport.

***Assess and Refer* (or *Release at Scene*):** A patient who, after an assessment by paramedics, does not meet criteria for an emergent medical condition or criteria for urgent treatment and/or transportation (Appendix A). We recommend that the patient meet all of the following conditions:

1. The patient consents to evaluation and treatment.
2. The patient has vital signs that fall within predetermined parameters and meets no other mandatory transport criteria. If the patient has abnormal vital signs or meets other transport criteria, has decision making capacity, and refuses transport, then the appropriate disposition is AMA and not Assess and Refer.
3. The patient demonstrates capacity and concurs with paramedics' recommendation not to be transported to an Emergency Department (ED).
4. The patient is clinically stable for referral to an alternate source of ongoing care such as: primary care physician, dental clinic, mental health clinic, or other community resource, and this resource is readily available within a reasonable

amount of time, based on the patient's condition.

5. The patient is able (i.e. is not intoxicated and has the mental capacity, transportation, and/or other resources) to obtain assistance and medically indicated follow-up.
6. The patient is able to readily recontact 911 should her or his condition worsen, fail to improve, or if the patient reconsiders her or his decision and desires ED transport.

The use of a Refusal of Care/AMA form is <u>not</u> appropriate in these cases.

Program Recommendations:
The following are recommendations and considerations for implementation of an "Assess and Refer" protocol for suspected COVID patients:

1. Activation Criteria for Assess and Refer Protocol
    1) In its URI Pandemic Assess and Refer Protocol, we recommend that a LEMSA articulate the metric or metrics that will serve as the activation criteria. Those metrics can include, but are not limited to the following: regional ED capacity, ambulance patient offloading times, ambulance emergency response availability, response time, or other metrics adopted by LEMSA or State EMS Authority.

2. <u>Medical Direction</u>

    We recommend that the Medical Director of the local EMS agency establish assess and refer policies, procedures, and protocols for the operation of the program, as well as strict quality assurance metrics. (CCR, Title 22, Division 9, Chapter 4, Section 100170(a)).

3. <u>Patient assessment and On-Scene Documentation with Electronic Patient Care Record (ePCR)</u>

    Electronic health records are required in Health and Safety Code 1797.227. EMS personnel shall complete a patient care record, on each patient response and encounter (CCR, Title 22, Division 9, Chapter 4, Section 100170 (a)(6) and 100171). For patients who are evaluated, minimum data elements are specified in (CCR, Title 22, Division 9, Chapter 4, Section 100171). (Appendix B)

    We recommend that the history and physical exam for Assess and Refer include the following:

    1) How EMS was notified and why;
    2) Description of the situation (e.g., upper respiratory type of symptoms);
    3) Objective findings, including a description of patient functional status (e.g., ambulatory, comfortable);
    4) Mental capacity to decline care, including mental status and lack of suspicion of known or suspected intoxication, and ability to follow-up.
        a. Excludes:
            - Persons experiencing homelessness (PEH) who are actively

unsheltered
- Active psychiatric illness potentially limiting decision making ability
- Pediatric patients
- Assisted living, skilled nursing facility and nursing home residents
- Those suspected to be intoxicated, or under the influence
- Patients with altered decision-making ability
- Patients without access to follow-up care, or understanding of how to access care
- Patients who have a language barrier and are without a translator

5) The nature of patient interaction;
6) Full set of vital signs and diagnostic evaluation as medically indicated for adult patients 18 years or older

Recommended vital sign parameters:

- Pulse ox ≥ 94% on room air
- RR ≥12 and ≤20 bpm
- SBP ≥100 mmHg
- HR ≤100 bpm
- Temperature ≥96.8°F (36°C) and <100.4°F (38°C)

Recommended criteria on historical and physical exam:

- No abnormal work of breathing
- No audible stridor, nor concern for impending airway or breathing compromise
- No history of cardiac, pulmonary, liver or renal issues
- No immune compromising conditions including: cancer, autoimmune disorders, or current immune modifying or suppressing medications
- No neurological or neurodevelopmental disorder that impairs decision making ability
- No history of diabetes
- No high-risk associated complaints including: shortness of breath, chest pain, lightheadedness, confusion, altered mental status
- Not pregnant

4. Patient Recommendations and Informed Consent

Procedures shall be established for providing verbal information to the patient regarding self-care and follow-up, and community resources with acknowledgment by the patient with mental capacity or their caregiver. We recommend that information be left with the patient in written or electronic form whenever feasible. This standard advice may include information on how to obtain assistance with transportation or local medical and/or social service resources, tailored to each EMS system.

Arranging alternate transportation with taxis, ride-share services, or other local transportation resources after EMS have responded may be a locally determined practice.

Patients that do not meet any of the transport criteria, have no language or cultural

barrier, and can reliably refuse care and/or transport, should be referred to their own primary healthcare provider or to an alternative care location avoiding transport to an acute care receiving facility by 911 EMS. Before care is terminated the patient must demonstrate the capacity and ability to reactivate the 911 system if the condition worsens, they change their minds, or they develop a new perceived emergent condition.

Consider inclusion of specific statements to be directed to the patient, in a language understood by the patient:

a. "It appears that you do not require immediate ambulance transport and/or care in the emergency department. You should seek care with your regular healthcare provider, clinic, or urgent care center. If you develop shortness of breath, weakness, persistent vomiting, or any new or worsening symptoms, please re-contact 9-1-1 immediately or go to your nearest ED."
b. "You should isolate yourself at home, practice appropriate social distancing, avoid contact with high-risk persons, and self-monitor your condition for worsening symptoms."
c. "Your isolation period should continue until at least ten days have passed since the beginning of your symptoms, your fever has resolved for 24 hours, AND your other symptoms have significantly improved. Please contact your regular healthcare provider or physician for further instructions.
d. "While many people want COVID-19 testing, not everyone who is sick needs testing. In many cases, the results will not change the management of those with mild illness. The desire for testing does not warrant transport to an ED by ambulance. If testing is desired, it should be coordinated with your usual healthcare provider."

The patient maintains and reserves all rights to be transported to the emergency department, and has the right to have a of change of mind regarding non-transport at any point during the process of assessment and/or referral.

5. Training

Additional training shall be provided to participating paramedics regarding the policies, procedures, and protocols that have been established. We recommend that written testing and scenario-based training be administered as part of the training.

At a minimum, the following training topics are recommended as they relate to Assess and Refer policy:

- Non-transport policies and procedures and protocols
- Evaluation of mental capacity, provision of informed consent and informed refusal of care
- Documentation standards
- Quality assurance standards
- Patient education
- Options for referral, including local social services, local clinics or urgent care
- Cultural competency
- EMS Resource Management
- Identifying patients on high-risk medications and high-risk conditions

6. Quality Improvement and Case Review

   Each basic and advanced life support service provider should include non-transport as a key performance indicator in their quality improvement program to evaluate variances in care and monitor compliance with LEMSA policy.

   The following items should be included in service provider and LEMSA QI plans:

   A. Determine and monitor the number and percent of non-transported patients.
   B. Perform case review on a defined percentage of non-transported patients. The sample reviewed should be representative of the population of non-transports.
   C. If feasible, identify and review cases of a recurrent 911 call to the specific address of a patient who has received Assess and Refer protocol within the 30 days.
   D. Review of all unusual occurrences, including patient/family complaints, exception reporting, and untoward outcomes.
   E. Identify paramedics and agencies with significantly higher use of non-transport and provide feedback to these outliers.

7. Data Collection

   The local EMS agency may establish specific data collection and ad hoc quality measures to assist with ensuring patient safety and quality. The Emergency Medical Directors Association of California (EMDAC) may recommend standard data elements or performance measures.

Appendix A
Policy Implementation (based on conversations with Anthem)

As September 1, 2018, Anthem Blue Cross (Anthem) reimburses appropriate and medically necessary care billed under HCPCS code A0998 (Ambulance response and treatment, no transport) by Emergency Medical Service (EMS) providers, applying a standard of medical necessity for non-transported patients. In this context, medical necessity is a contractual term that includes reasonableness, appropriateness, and standard of care. Only approved transport providers with a contract for EMS transportation can bill for the encounter under this CPT code, which does not include first responders. This code does not distinguish between ALS and BLS. Similar to other EMS services, Anthem will require only a billing statement and no additional documentation. They will monitor utilization data but do not intend to do detailed medical record review unless the utilization data suggests the need for more detailed review. Currently, the policy applies only to commercial plans and does not include MediCal or Medicare patients. To date, there has been limited uptake and use of this code in other states where the policy has been implemented.

The EMS provider must do a full assessment, follow medical protocols, and determine that the patient is stable and does not need transport. The type of patients that may meet these criteria are:

- Frequent EMS users that need non-medical services such as social services
- Medical services that are best met as an outpatient, such as medication refill;
- Some minor acute injuries such as a sprained ankle
- A diabetic patient on insulin only with a resolved hypoglycemic episode and able to eat
- A patient with a known seizure disorder with occasional break-through seizures, isolated resolved post-ictal symptoms, stable medication use, and no new underlying trigger

Anthem is interested in expanding the reimbursement to Community Paramedicine projects in the future.

Appendix B

Record Keeping

Title 22, Division 9. Prehospital Emergency Medical Services, Chapter 4. Emergency Medical Technician-Paramedic, Article 8. Record Keeping and Fees,§ 100171. Record Keeping.

(e) The paramedic is responsible for accurately completing the patient care record referenced in Section 100170(a)(6) which should contain, but not be limited to, the following information when such information is available to the paramedic:

(1) The date and estimated time of incident.

(2) The time of receipt of the call (available through dispatch records).

(3) The time of dispatch to the scene.

(4) The time of arrival at the scene.

(5) The location of the incident.

(6) The patient's:

(A) Name;

(B) Age;

(C) Gender;

(D) Weight, if necessary for treatment;

(E) Address;

(F) Chief complaint;

(G) History of present illness

(H) Past medical and surgical history

(I) Medication list

(G) Vital signs.

(7) Appropriate physical assessment.

(8) The emergency care rendered and the patient's response to such treatment.

(9) Patient disposition.

(10) The time of departure from scene.

(11) The time of arrival at receiving facility (if transported).

(12) The name of receiving facility (if transported).

(13) The name(s) and unique identifier number(s) of the paramedics.

(14) Signature(s) of the paramedic(s).