American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

# POLICY STATEMENT

Approved June 2024

# *Patient Autonomy and Shared Decision-Making in Emergency Medical Services and Mobile Integrated Healthcare Community Paramedicine Programs*

Revised June 2024 with current title

Originally approved June 2018 titled "Patient Autonomy and Destination Factors in Emergency Medical Services (EMS) and EMS-Affiliated Mobile Integrated Healthcare/Community Paramedicine Programs, replacing the following rescinded/sunsetted policy statements:

- Alternate Ambulance Transportation and Destination (2001-2018)
- Medical Direction of Mobile Integrated Healthcare and Community Paramedicine Programs (2014-2018)
- Refusal of Medical Aid (2000-2018)

The American College of Emergency Physicians (ACEP) believes that patients with medical decision making capacity (or legal guardians, health care agents or surrogates when applicable - hereinafter - [patients]) should actively participate in treatment plans formulated by healthcare professionals. These treatment plans may be developed utilizing standing order protocols and/or contemporaneous medical oversight in the provision of care by emergency medical services (EMS) systems. Such EMS systems may include traditional emergency response, as well as EMS-affiliated mobile integrated healthcare/community paramedicine (MIH/CP) programs. ACEP supports the following principles:

*Medical Decision-Making Capacity*: EMS systems programs must utilize a formal process for establishing a patient's medical decision-making capacity for dissent to medical assessment, treatment, and/or transportation. Key components in possessing medical decision-making capacity include the ability to understand the medical condition as presently assessed, the recommended further assessment, treatment, and/or transportation, and the alternatives, the benefits, and the refusal related risks of recommended further assessment, treatment, and/or transportation. Informed refusals, made with medical decision-making capacity, should be carefully documented in accordance with EMS systems' established policies and procedures developed by the system's physician medical director. These decisions should involve patients who should be provided reasonable health educational materials, including their right to future ability in accessing EMS care. Adherence to EMS established policies relating to medical decision-making capacity assessment and informed refusals should be measured elements in the continuous quality improvement activities within EMS systems.

*Alternatives to Emergency Department Destination*: Emergency departments are the most typical destinations for patients cared for by EMS systems. Some

patients with focused, differentiated healthcare needs, including those with established care providers willing to see them on an unscheduled, acute care basis, may potentially be safely and efficiently navigated to non-emergency department locations under local EMS medical director 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 payor type, healthcare coverage/insurance status, or any social/demographic element. When considering alternatives to ambulance response, transportation and/or alternative destinations, patient safety must always be the primary defining element. Destinations should be licensed with oversight by applicable authorities (state, federal, and/or tribal) and be staffed with qualified healthcare providers, also with oversight by applicable licensing authorities. The EMS 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 utilizing a prudent layperson standard of a medical emergency should always have access to emergency care services, including accessing emergency care via 911 (or equivalent) public safety answering points. These patients wanting emergency department-based evaluation and management should not be precluded or unfairly dis-incentivized 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 incentivized 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 and/or EMS-affiliated MIH/CP programs. Patients utilizing a prudent layperson standard of a medical emergency accessing emergency care via 911 (or equivalent) public safety answering points with acute, unscheduled, and undifferentiated medical conditions should be transported to an emergency department with clinical capabilities consistent with emergency care needs. Similar patients, but with stable, differentiated medical conditions, may be suitable for transportation to a destination other than an emergency department (eg, mental health facility, sobering center, physician's clinical office). Adherence to EMS and EMS-affiliated MIH/CP programs physician medical director established policies relating to destination should be measured elements in the continuous quality improvement activities within EMS systems and EMS-affiliated MIH/CP programs.