Expanding the Roles of Emergency Medical Services Providers: A Legal Analysis

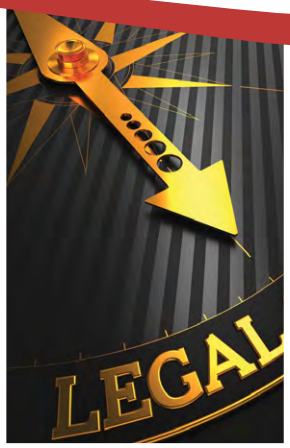

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Table of Abbreviations

ACA	Patient Protection and Affordable Care Act	EMTALA	Emergency Medical Treatment and Active Labor Act
ACO	Accountable Care Organization	HIPAA	Health Insurance Portability and Accountability Act
ASPR	Assistant Secretary for Preparedness and Response, HHS	HWPP	Health Workforce Pilot Project
ASTHO	Association of State and Territorial Health Officials	LPN	Licensed Practical Nurse
CDC	Centers for Disease Control and Prevention	MIH	Mobile Integrated Healthcare
CMS	Centers for Medicare and Medicaid Services	NACCHO	National Association of County and City Health Officials
CP	Community Paramedicine	NAEMT	National Association of Emergency Medical Technicians
HHS	Department of Health and Human Services	NHTSA	National Highway Traffic Safety Administration
ED	Emergency Department	NP	Nurse Practitioner
EHBs	Essential Health Benefits	OSHPD	Office of Statewide Health Planning and Development
EKG	Electrocardiogram	PA	Physician Assistant
EMS	Emergency Medical Services	RN	Registered Nurse
EMSA	Emergency Medical Services Authority	SDMAC	State Disaster Medical Advisory Committee
EMT	Emergency Medical Technician	TOPS	Top Options, Practices, or Solutions

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Executive Summary/Introduction

With support and guidance from the Office of the Assistant Secretary for Preparedness and Response (ASPR), the Association of State and Territorial Health Officials (ASTHO) seeks to identify feasible approaches to increasing the opportunities to engage emergency medical services (EMS) providers for day-to-day activities in communities across the United States. A primary component of this project is an exploration of state legal and policy issues as described by ASTHO as "Activity 1.3" of the larger proposal, summarized below:

ACTIVITY 1.3: ASTHO, in collaboration with the National Association of County and City Health Officials (NACCHO) and other partner organizations such as the National Association of State EMS Officials (NASEMSO) (an ASTHO affiliate), will conduct a review and analysis of the existing statutory and regulatory provisions that either facilitate, or impose barriers to, expanded roles of EMS. These include community paramedicine (CP) and mobile health services in daily operations and during disasters/public health emergencies. This review will also identify and catalogue promising strategies, tactics, practices and supporting resources to further integrate public health and EMS in building community resilience. This includes assessments of the roles of different types of consultative entities found in various state and local communities, such as State Disaster Medical Advisory Committees (SDMACs).

This project's primary objective is to conduct innovative and relevant legal and policy research to ascertain core issues that may impede activities of health professionals in routine community paramedicine (CP)[1] or mobile integrated healthcare (MIH) activities. In addition to identifying issues, this report examines potential law and policy best practices, options, or solutions, based in part on research of specific jurisdictions selected in collaboration with ASTHO and its advisory group. As per **Figure 1**, these jurisdictions include Arizona, California, Delaware, Florida, Georgia, Idaho, Illinois, Massachusetts, Mississippi, Montana, North Dakota, Oregon, and Utah.

Project Limits. Although the scope of this project is extensive, there are several limits:

1. Although there are many issues related to the roles of EMS professionals during declared emergencies, this project is focused on routine, day-to-day activities consistent with discussions with ASTHO and ASPR.
2. For the purposes of this report, licensing, certification, or scope of practice laws or policies related to EMS professionals are considered "fixed," and thus not subject to state-based amendments or alterations.
3. Primary legal themes entail potential issues and corresponding options, practices, or solutions regarding the extent of activities that EMS professionals, supervisors, and their entities conduct related to:
    a. Triggers for deploying providers (e.g., via request through 9-1-1 calls or other mechanisms).
    b. Assessing patients on site, in transport, or after arrival at the healthcare facility.
    c. Altering patients' treatment destinations (other than hospital emergency departments [EDs]), when applicable.

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Within these limitations, multiple legal and policy issues and approaches are ripe for exploration. Identifying and addressing these issues involve examining interrelated constitutional provisions, statutes, regulations, judicial cases, and policies within and across states. The project goal is to unravel and simplify these key legal issues, suggesting options, best practices, or solutions for practitioners and law and policymakers to effectuate continued expansion of the use of EMS providers nationally. Current and potential law and policy strategies are identified throughout the report in text boxes titled "Top Options, Practices, or Solutions" (TOPS), which are reproduced in **Table 1**, below, for ease of reference.

Project Organization. The report is divided into four major parts. **Part I** provides brief foundational information on core elements of existing projects and emerging approaches that may be adapted to expand EMS usage in new jurisdictions. **Part II** evaluates underlying legal "triggers" that authorize deployment of EMS personnel, and identifies new protocols, modifications, or waivers that may be necessary to authorize CP or similar initiatives in some jurisdictions. It also addresses coordinating limited resources, including contractual elements that support efficiency and avoid conflict, as well as initial liability concerns. **Part III** focuses on potential legal challenges and opportunities concerning expanding patient assessment. This section analyzes concerns related to scope of practice, standard of care, venue restrictions, and medical supervision requirements, as well as potential liability of EMS practitioners and organizations. It presents a series of options to enable EMS professionals to expand their roles while adhering to existing scope of practice limitations and health information privacy laws. **Part IV** explores legal and policy issues that may hinder or support the alteration of patient destinations through these initiatives, other than to hospital EDs. Key themes include the role of patient choice, potential for patient "dumping" or abandonment, reimbursement for services, impact of the Patient Protection and Affordable Care Act (ACA), and continued concerns over liability of practitioners, medical directors, and service providers.

Report Format: The format of this report, including citations and references, is consistent with the *Bluebook: A Uniform System of Citation*, the standard approach for legal reports.

Table 1. "Top Options, Practices, or Solutions" (TOPS) in Law or Policy Concerning Expanded EMS

"Top Options, Practices, or Solutions" (TOPS)
Ready, Set, Go: Legal Issues Underlying the Triggers for Expanded EMS Activities
TOPS # 1. Because existing trigger protocols in some states only address 9-1-1 EMS situations, state or local development of enhanced, flexible protocols under existing legal authority can provide oversight and address procedures such as clinic or health department referrals and home visits.
TOPS # 2. To support efficient use of CP, MIH, or similar programs, public and private sector entities must equitably share costs for essential resources and benefits of core services through contractual terms that seek advance agreements on issues of allocation.
TOPS # 3. In localities that are limited in their ability to contract with ambulance or other providers because of strict state or local bidding requirements, exceptions for localities to enter into new or expanded contracts for these programs may be considered.
TOPS # 4. To avoid potential liability for failures to properly operate or follow known triggers for EMS personnel, state and local government must avoid creating a special duty to provide care for specific individuals. Programs seeking to reduce their potential liability may frame implementation in broad terms related to communal health benefits rather than specific health services for identified persons.
On Closer Inspection: The Changing Nature of Patient Assessment and Corresponding Legal Challenges
TOPS # 5. Legal authority for EMS professionals to fully engage in activities like CP may be constrained by existing scope of practice limitations. Provisions authorizing ranges of activities, rather than specific and enumerated tasks, may facilitate expanding the traditional EMS role without altering legal scopes of practices.
TOPS # 6. Adherence to appropriate decision making tools (e.g., protocols and standing orders), medical supervision, and consultation requirements mitigates the risk of overstepping clinical decision making authority. Viewing follow-up care and similar actions as a continuation of, or prelude to, care by other medical professionals reflects key legal distinctions between medical and field diagnoses.
TOPS # 7. Nonemergency care may exceed lawful scopes of practice for EMS professionals. However, broadly defined scope of practice provisions may readily allow such care. Even narrower constructions may permit such care consistent with additional statutory authorizations or favorable interpretations of laws defining "emergency condition" or similar terms.
TOPS # 8. Medical professional oversight and supervision are required for EMS activities, but may be limited by physician availability. Expanded use of appropriate decision support tools and centralized on-line supervision models can increase the supervision potential of existing, available personnel, including non-physicians.
TOPS # 9. In the face of potential escalating liability claims, protections from ordinary negligence claims available to EMS personnel responding to an emergency may apply to other activities in select contexts. However, proper training, medical consultation, and observance of protocols and standing orders are essential to ensure that EMS practitioners with expanded roles comply with established standards of care.
TOPS # 10. To deter potential health information privacy violations or infringements, CP, MIH, or similar programs may require training for key personnel on privacy protections and develop of formal, HIPAA-compliant written policies addressing permissible uses and disclosures of identifiable health data.

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Down the Road: Altering Patient Destinations
TOPS # 11. CP, MIH, or similar programs that do not explicitly authorize alternative destinations for patients may rely on broad and flexible statutes and regulations with protocols and supporting flowcharts that allow sufficient discretion to alter destinations. Waivers may also permit pilot programs to transport patients to alternative destinations.
TOPS # 12. EMS licensing requirements based on necessity can limit opportunities to alter destination for patients in CP or similar programs. State and local officials with discretionary authority to approve ambulance licensure may interpret these regulations to include such programs, particularly those including nonemergency transport.
TOPS # 13. To address budget crisis limiting the expanded use of EMS providers, states may consider authorizing reimbursement for patient transport and EMS services through Medicaid programs for cases involving transportation to EDs or acute care centers.
TOPS # 14. To expand funding of CP, MIH, and similar projects through private health insurance, states may amend their benchmark plans to cover services including home health services, preventative care, and emergency services.
TOPS # 15. To avoid potential Emergency Medical Treatment and Labor Act (EMTALA) infractions, protocols determining patient destinations should clearly designate hospital EDs as the primary destination for any patient with a known or suspected emergency condition. Procedures should also require a patient's written informed consent, where possible, if the patient refuses emergency transport.
TOPS # 16. To avoid liability for patient abandonment, CP, MIH, and similar programs should ensure adequate patient monitoring and communication with appropriate healthcare facilities during medical care and transfer. These programs may also establish written policies regarding patient refusal and accompanying patient rights, as well as patient consent procedures for enrollment and mutually agreed upon outcomes.
TOPS # 17. False imprisonment and related claims can arise if patients are forcibly held or transported to locations without the patients' valid consent. Programs that use EMS providers in expanded roles should abide by patient choice regarding destination whenever possible. State emergency hold procedures for appropriate mental health patients should be relied on where applicable.
TOPS # 18. Liability protections stemming from vehicular transport of patients outside of an emergency setting are limited. States seeking to increase the use of EMS providers in expanded roles may consider extending immunity laws to nonemergency care consistent with a careful balancing of patient and community safety.
TOPS # 19. Medical directors should adequately supervise EMS practitioners operating in CP, MIH, or similar programs and set protocols that properly direct patients to appropriate medical facilities. Use of approved, vetted flowcharts or other tools may help protect against claims of negligence in the transportation of emergency patients, while still allowing flexibility to alter destinations as needed.

I. Setting the Stage: Brief Primer on Expanded EMS Practices

The National Highway Traffic Safety Administration (NHTSA) predicts that "EMS of the future will be community-based health management that is fully integrated with the overall health care system."[2] Expanded EMS roles and programs are increasingly bringing medical care to people and places in need across the United States.[3]

These programs offer tangible benefits for patients and communities to bridge gaps between emergency services and primary care.[4] For example, community paramedics may (1) provide in-home preventive services to patients who might otherwise go to the ED for primary care treatment, obviating unnecessary emergency visits, or administer influenza or other vaccines; (2) conduct home health visits for households with children younger than age 5 to assess potential risks of injuries; or (3) assess special public health needs. In turn, emergency physicians, nurses, and other medical personnel can focus on patients with urgent needs, leading to decreases in patient and provider costs for healthcare services across communities. [5]

CP services may especially benefit rural populations. One quarter of Americans live in rural areas,[6] but only 10 percent of physicians practice in these locales.[7] Other healthcare practitioners may provide essential care and improve healthcare access in these areas (e.g., NPs operating with full practice authority, as currently permitted in 20 jurisdictions),[8] but significant gaps in access remain. Accordingly, nearly 40 percent of existing CP programs serve rural areas.[9] Patients in these settings may be aging or elderly, impoverished, and in poor health due to a lack of preventive care and follow-up treatment.[10] Through CP, they may receive treatment for essential health services for which they otherwise may lack access.

STATE AND LOCAL PROGRAMS

State and local governments are in various stages of considering and implementing programs using EMS providers in expanded roles. Taos County, New Mexico, implemented one of the first CP programs in the United States in 1995. Local paramedics received enhanced training to provide the town of Red River's rural population with primary care and treatment. The program ended five years later when additional physicians established practices in the community, but it inspired the creation of other programs nationally.[11] In 1997, the University of Pittsburgh Medical Center established another early CP program known as Emed Health. Emed Health later became part of the larger Center for Emergency Medicine of Western Pennsylvania.[12]

States have approached program implementation in various ways. California authorized paramedics to perform specific activities outside their usual roles via regulation.[13] EMS personnel are statutorily required to transport patients to a hospital with at least a basic ED.[14] However, the state has provisionally accepted 12 CP pilot projects, which are awaiting final approval.[15] These pilot programs, if approved, will be authorized through a legislatively-enacted program called the Health Workforce Pilot Project (HWPP). HWPP calls for innovative projects to improve the effectiveness of healthcare delivery in a wide range of fields and permits limited waivers of restrictive state laws.[16]

Nebraska implemented a CP program legislatively with support from its state EMS Office program and Office of Rural Health, which sought statewide CP standards.[17] Minnesota initially offered a training program to interested paramedics, which later developed into a full CP program due in part to legislation establishing CP certification for EMTs in 2011.[18] Minnesota also authorized medical assistance reimbursement to cover CP services to high-risk individuals in 2012.[19] Colorado's program began through grassroots efforts.[20] Maine amended its statutes in 2012 to allow the state EMS Board to establish 12 pilot CP programs, which may last up to three years.[21] North Dakota's state

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legislature appropriated $276,000 in 2013 to research the potential for CP programs within the state.[22] Florida and Kentucky are developing new programs in 2014.[23] As noted by the Flex Monitoring Team—a collaborative effort between the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine—in its February 2014 report, determining which types of state-led programs are most effective is difficult given insufficient research and studies on CP nationally.[24]

In addition to state-based programs, local governments in San Francisco and Wake County, North Carolina, have run their own CP programs.[25] In Texas, Fort Worth's MedStar program directs advanced practice paramedics to patients who frequently call 9-1-1 for primary care. The program is credited with saving hospitals and state governments millions of dollars through more efficient use of local ambulances.[26] The CP program in rural Eagle County, Colorado,[27] links current EMS personnel to existing public health services. Under physicians' direction, paramedics obtain extra training to perform services like blood draws and wound care.[28]

The use and development of CP, MIH, and similar programs are increasing. Based on its survey of EMS personnel in October 2013, the National Association of Emergency Medical Technicians (NAEMT) found 232 unique CP programs and MIH programs in existence nationally, which represented 6 percent of the respondents.[29] Another 15 percent of the respondents indicated that their EMS systems were developing or considering similar programs.[30]

FEDERAL SUPPORT FOR PUBLIC/PRIVATE COLLABORATIONS

CP and MIH programs involve significant collaborations among federal, state, and local governments and private sector entities. Delivery models may include partnerships between municipalities, public hospitals, fire departments, EMS systems, home health organizations (also known as patient navigation organizations), nonprofits, and for-profit entities.[31] Federal agencies including ASPR, Centers for Medicare and Medicaid (CMS), and the Office of Rural Health Policy may help fund state and local programs demonstrated to be effective in terms of cost and quality.[32]

The Patient Protection and Affordable Care Act (ACA) offers potential opportunities to support an expanded role for EMS as an integral part of the healthcare system.[33] First, ACA is projected to significantly increase the number of insured Americans through expanded employer coverage, insurance subsidies, and expansion of Medicaid programs in 27 states (as of March 26, 2014).[34] HHS' list of 10 Essential Health Benefits (EHBs), which most health insurance plans must cover, includes ambulatory and emergency services, chronic disease management, and possibly preventive and wellness care, each of which may be provided via CP or similar programs. ACA also promotes accountable care organizations (ACOs), defined generally as a "group of healthcare providers who give coordinated care [and] chronic disease management…tied to achieving healthcare quality goals and outcomes that result in cost savings."[35] The flat rate, quality-driven reimbursement model for ACOs may further promote integration of CP or similar programs within hospitals and other providers given its cost-efficient medical care.[36] Finally, ACA funds community health centers and development of innovative primary care models, which may afford new resources for these programs.

FUTURE OF COMMUNITY PARAMEDICINE AND MOBILE INTEGRATED HEALTHCARE

CP and MIH have the potential to revolutionize how patients receive healthcare services, especially among rural, elderly, and economically disadvantaged communities. Although they vary, these programs are on the rise in conjunction with a national shift to MIH.[37] At a 2012 conference focused on CP, attendees suggested several goals related to its growth, including: (a) expanding health practitioners' roles beyond their basic EMT or paramedic qualifications;[38] (b) integrating CP with other health service providers; (c) designing CP services to fill major gaps in healthcare; (d) sharing information for effective, coordinated patient care; and (e) utilizing enhanced technology.[39]

The MIH's potential for expanded access to essential health services and increased cost savings suggests that it may be a viable future for EMS personnel.[40] However, realizing this goal will mean overcoming some significant challenges, including perceived or actual issues of law and policy that may impinge the expansion of EMS into CP, MIH, and similar services. These issues and related options, practices, or solutions are the foci of this Report, beginning with the potential legal and policy concerns related to the triggers for the deployment and expanded use of EMS personnel discussed next in Part II.

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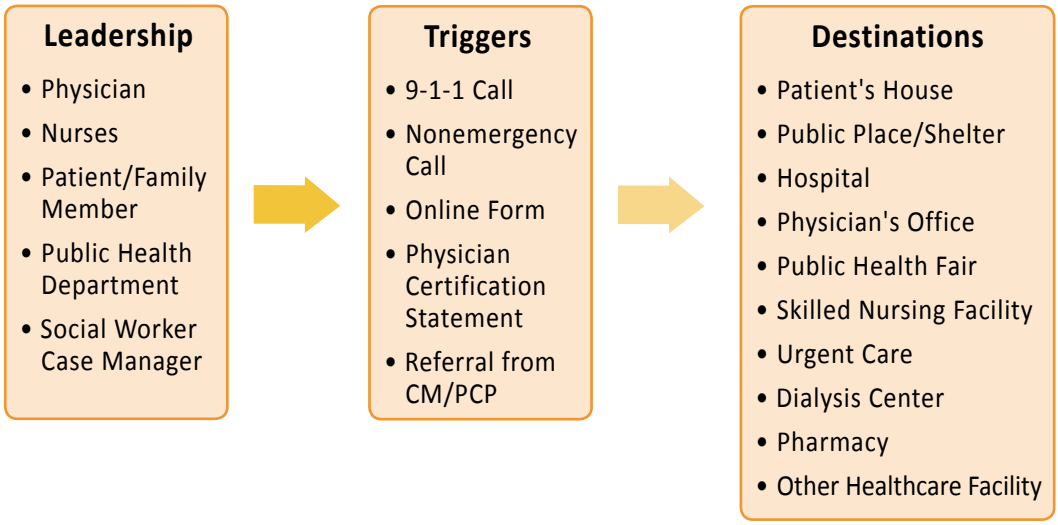
II. Ready, Set, Go: Legal Issues Underlying Expanded EMS Activity Triggers

EMS personnel seeking to address specific health needs of patients and communities must be empowered to provide care through existing or emerging legal "triggers," or authorizations. For physicians or nurses working in hospitals or health clinics, a typical trigger for providing care to patients is often either (1) the appearance of a new patient seeking care, or (2) the request by existing patients for additional health services. However, EMS personnel traditionally do not wait for patients at a fixed location. Rather, they are dispatched to patients' locations, often because the patient may be experiencing an emergency condition requiring rapid, stabilizing care and transportation to a hospital ED or other urgent healthcare setting. As illustrated in **Figure 1**, potential trigger options may arise through various dispatches via multiple means of communication designed to authorize deployment of EMS personnel to different destinations.

FIGURE 1: Triggers for EMS Activities



To the extent that CP, MIH, or similar programs expand the role of paramedics and other EMS personnel to fill healthcare gaps,[41] triggers for their deployment are changing. In Eagle County, Colorado, for example, CP personnel are authorized to respond not only through 9-1-1 dispatches, but also through requests from:

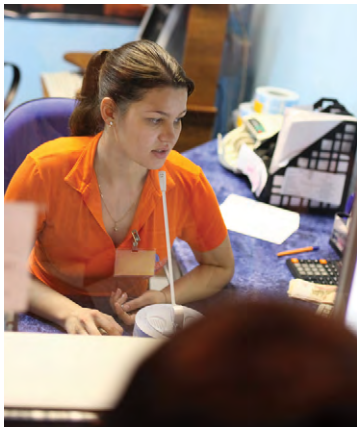
- Primary care providers seeking follow-up after a patient's recent appointment.
- State-based adult and child protection case workers who believe there is a known or potential unmet medical need in the home.
- Medical providers' orders as an alternative to a primary care provider conducting a medical, home-safety, or social assessment.[42]

There are additional triggers for these services. Localities recognize the overwhelming burden on the healthcare system of dispatching EMS resources via 9-1-1 to nonemergency callers. In 2008, 21 people in Fort Worth, Texas, called 9-1-1 at least twice per week. Together, they accounted for almost $1 million in ambulance charges.[43] The following year, Fort Worth's MIH program identified high-frequency users and developed individual care plans for them, including regularly scheduled

home visits by medical personnel. Since creating its "EMS Loyalty" program, Fort Worth is credited with saving more than $3.3 million in healthcare expenditures and reducing 9-1-1 calls from these patients by 86.2 percent.[44] Minnesota's CP program identifies patients in need prior to them arriving at the ED (e.g., via physician or clinic request).[45]

Local public health departments may ask EMS personnel to assist with community-based services (e.g., immunizations, disease investigations, blood draws, and fluoride varnish applications). Physicians' orders[46] can mobilize community paramedics to provide primary care services in a patient's home. While each visit necessitates a discrete order with physician instructions, these visits may be particularly beneficial for chronically ill patients who have difficulty getting to their medical providers' offices, frequently cancel their medical appointments, or require in-home monitoring following their recent hospitalizations.

Many ambulance companies use online request forms[47] or telephone numbers[48] for various providers, including physicians, nursing facilities, other healthcare providers, so patients or family members can request nonemergency transportation (e.g., from the patient's home to the physician's office, behavioral health office, urgent care, skilled nursing facility).[49] Determining who will pay for these services can be problematic, however. Medicare reimburses for nonemergency ambulance transport only when the patient's condition contraindicates another form of transportation because the patients is bed-confined or transport by ambulance is medically necessary.[50] Generally a physician certification statement completed by the patient's physician, stating that transportation is medically necessary, is required.[51] Allowing providers, patients, or family members to request medical assistance rather than mere transportation opens doors for EMS personnel to address multifarious, nonemergency situations. Yet, authorizing and establishing these varied triggers depends on law and policies across states.



AUTHORIZING AND ESTABLISHING PROTOCOLS

The authority to establish and use trigger protocols (i.e., policies and procedures relating to the dispatch of EMS or other CP/MIH personnel)[52] varies between state and local governments. Most existing trigger protocols determine how to prioritize emergency calls, what communication system should be used, what information EMS personnel should receive, and which ambulance supplier should be contacted.[53]

Programs in Texas and Las Vegas, for example, are working to establish trigger protocols designed specifically for CP/MIH programs, based in part on the model noted above in Eagle County, Colorado.[54]

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Although the types of protocols often remain the same, such as which communication system should be used and what information the EMS provider should receive, protocol content differs.[55] For example, Eagle County's CP manual outlines the specific procedures for clinic referrals, county health department referrals, and home visits. [56]

Developing new trigger protocols involves multiple entities, including state or local health departments or boards of emergency health services, supervising physicians, ambulance suppliers, and hospitals. State laws often assign broad discretion to local boards,[57] medical directors,[58] and even hospitals and ambulance suppliers[59] to develop detailed protocols. Arizona's statute concerning ambulance services dictates, "In consultation with the medical director of the EMS and trauma system, the EMS council and the medical direction commission, the director of the department of health services shall establish protocols for ambulance services."[60]

Supervising physicians or medical directors may also provide specific guidance in advance of a patient visit.[61] Although physicians' directives typically occur during patient visits, as discussed further in Part III, their orders may also include pre-visit directives for the purposes of CP. Variations in authorities to create new protocols and resulting oversight can impact how well and efficiently CP, MIH, and similar programs are implemented.[62]

Some states offer legal exceptions to protocol enforcement. California statutory law allows flexibility in the scope of practice of EMS professionals in rural areas.[63] "In rural or remote areas … where patient transport times are particularly long and where local resources are inadequate to support an EMT-P program for EMS responses, the director [of the EMS authority] may approve additions to the scope of practice of EMT-IIs serving the local system."[64] Illinois allows its EMS director or the Illinois Department of Public Health director to waive any state law regarding EMS where compliance is a "hardship,"[65] pursuant to requests by EMTs, hospitals, or others.[66] Such flexibility can facilitate the local practice of EMS providers in ways that may otherwise violate state protocols. As discussed further in Part III, although such changes may facilitate expanded roles for EMS providers by enhancing authority related to scope of practice, they generally will not provide specific, independent authorization for CP, MIH, or similar programs.

Although many existing engagement and dispatch protocols still address only 9-1-1 EMS, establishing new protocols and policies at the state or local level can enable implementation of novel EMS programs in rural, urban, or suburban areas. Conversely, insufficient coordination of limited resources can delay the implementation of new protocols. In 2005, for example, the American Heart Association released new guidelines to improve results of out-of-hospital cardiac arrest events.[67] It took about 450 days on average for EMS agencies to implement these guidelines.[68] In a study done by U.S. and Canadian researchers of 34 EMS agencies, 38 percent of the agencies reported implementation delays because of inadequate supplies and decision making issues.[69] New trigger protocols can improve coordination of limited resources, provision of and payment for supplies, and provider selection.

TOPS #1

To the extent that existing trigger protocols in some states only address 9-1-1 EMS situations, state or local development of enhanced, flexible protocols under existing legal authority can provide oversight and address procedures such as clinic or health department referrals and home visits.

COORDINATING LIMITED RESOURCES

Provision and Payment. Operationalizing programs that expand the use of EMS requires the acquisition of, and payment for, essential resources through effective coordination among state and local officials, participating physicians, and the EMS agencies involved. To ensure the availability of these resources, EMS providers should consider which entity is responsible for their provision consistent with contractual or other legal authority.

Many ambulance services are provided directly via municipal fire departments (or other public entities) without the need for specific contracts. However, in some jurisdictions, the provision of supplies for EMS may be addressed via contracts between (1) localities (including fire districts) and their preferred ambulance suppliers and (2) ambulance suppliers and their associated hospitals.[70] In a typical contract for emergency services, the ambulance company must procure and track essential supplies.[71]

Contracts for nonemergency services such as community outreach, public access defibrillation programs, and other health improvement projects also typically assign responsibility of program coordination, including provision of supplies, to ambulance suppliers. Where these suppliers are hospital-owned, like the Jeff STAT ambulance services operated by the Thomas Jefferson University Hospitals in Pennsylvania, New Jersey, and Delaware,[72] the hospital may directly pay for the supplies. This contractual approach may work well for CP or MIH programs because hospitals directly experience cost savings.[73] However, it may also be problematic if patients are served through EMS personnel who are not affiliated with the contracted hospital.

Under another contractual model, localities and private ambulance suppliers share these programs' costs and profits. Still, conflicts may arise. For example, Marengo Memorial Hospital and Iowa County disagreed over who owned a majority share of their county ambulance service.[74] To avoid divisiveness, shared contracts must contain terms to equitably split costs and profits.[75] The locality may also pay for some programs, such as when EMS personnel administer vaccines at a community health fair. For example, the CP program in Wake County, North Carolina, offers both in-home services and community health fairs with direct support from the county.[76]

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TOPS #2

To support efficient use of CP, MIH, or similar programs, public and private sector entities must equitably share costs for essential resources and benefits of core services through contractual terms that seek advance agreements on issues of allocation.

Limitations on Selection Among Competing Providers. Development of trigger protocols also raises issues of how providers are chosen. As with resources, local government decision makers, such as city councils and mayors, can choose the ambulance or other providers. If fire districts or departments do not provide EMS, these contracts may be exclusive, single-source agreements with private providers.[77]

Large, multi-million dollar county contracts with ambulance suppliers may lead to disputes.[78] Clackamas County, Oregon, awarded a $30 million ambulance contract to American Medical Response after having rejected it the previous month.[79] The county's approval came after American Medical Response threatened to sue on grounds that the county rejected the only contract in consideration.[80] Typically local government contractual decisions are upheld so long as they are not made in an arbitrary way. For example, a former Mississippi ambulance supplier in 2003 argued unsuccessfully that the county was bound to renew the contract so long as the ambulance company provided adequate services. [81]

Localities seeking to develop CP or MIH programs may have to determine whether they are contractually able to use different providers or must adhere to an existing contract. Contract negotiations between localities and providers may also be subject to state or local laws governing bidding processes among government contractors. In California, for example, each ambulance service area can establish an exclusive provider, but must follow a strict bidding system for selection to avoid antitrust issues[82] (except for providers acting in the same "manner and scope").[83] CP programs in such "grandfathered" areas may have to confine their services or engage in bidding processes.

Not all states place tight limitations on these contracts. In *Trans-Care, Inc. v. Board of Commissioners of the County of Vermilion*, in 2005, the Indiana Court of Appeals found that ambulance supplier contracts were not subject to the state's public purchasing statute because they were bids for personal services.[84] The court also held that the losing bidder could not legally contest the outcome of the bidding process, in part because public policy favors certainty in a contract concerning public safety.[85] Under similar legal guidance, localities may be better positioned to expand EMS of a current contracted ambulance service or opt for another provider. Even in jurisdictions that restrict ambulance suppliers, CP, MIH, or other similar programs may not be implicated if they do not offer emergency services or use ambulances.

TOPS #3

In localities limited in their ability to contract with ambulance or other providers because of strict state or local bidding requirements, exceptions for localities to enter into new or expanded contracts for these programs may be considered.

LIABILITY CONCERNING EMS RESPONSE

No matter how it is triggered, patients generally expect prompt assistance through EMS or CP. System failures related to inconsistent application, execution, or use of existing triggers may lead to patients bringing claims against responsible entities.[86] Patients or their families may argue that public or private entities are legally obligated to respond efficiently and professionally pursuant to triggers designed to mobilize personnel for persons in need.[87] Resulting liability claims may arise.

Whenever state or local governmental entities are directly involved in the administration of a CP, MIH, or a similar program, potential constitutional issues may arise. Patients may argue that failure to properly attend to persons seeking government-run EMS deprives patients of life or liberty interests in violation of constitutional principles of due process. However, the U.S. Supreme Court clarified in *DeShaney v. Winnebago County Department of Social Services* (1989) and subsequent cases that government is not required generally to provide citizens with protective services or aid.[88] Government's mere failure to assist or respond to individuals in need is not itself a constitutional violation.

In contrast, if government actors undertake steps to provide care for specific individuals, an affirmative duty to carry out these services may arise, leading to potential claims if services are performed negligently or the individual is within government's custody (e.g., a minor held via child protective services).[89] Whether an individual that requests a paramedic via a government-operated 9-1-1 system and relies on a response may be owed some "special duty" to assistance depends on the jurisdiction.[90] If EMS or CP services are determined via statute or regulation to benefit the entire community, courts tend to find they do not owe persons any special duties.[91]

For example, in the 1990 case *Johnson v. District of Columbia*, a woman called 9-1-1 and indicated that she needed an ambulance.[92] The dispatcher told her that an ambulance was coming. The woman suffered a heart attack, but no ambulance was sent. Still, the District of Columbia Court of Appeals determined that DC owed her no "special duty" because there was no (1) "specific undertaking to protect a particular individual," and (2) she was not entitled to rely on the service.[93] In such cases, government is effectively immune from liability based upon a failure to respond.[94] Parts III and IV discuss additional liability themes.

TOPS #4

To obviate potential liability for failures to properly operate or follow known triggers for EMS personnel, government must avoid creating a "special duty" to provide care for specific individuals. Programs seeking to reduce their potential liability may frame implementation in broad terms related to communal health benefits rather than specific health services for identified persons.

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III. On Closer Inspection: The Changing Nature of Patient Assessment and Corresponding Legal Challenges

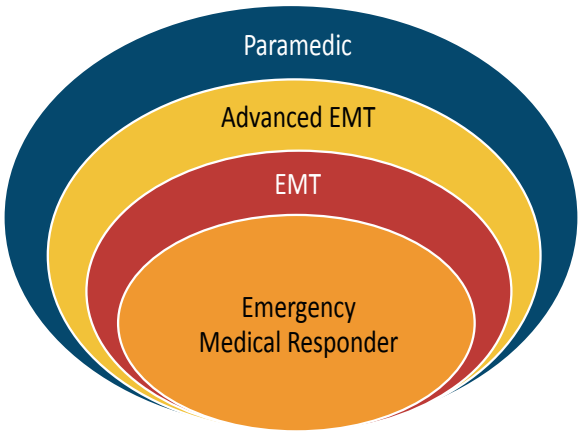
So long as EMS providers are responding to appropriate events via lawfully authorized triggers discussed in Part II, they may engage in a spectrum of routine and emergency patient assessment activities. Specific activities depend on the scope of practice associated with their professional designation and training, among other factors. Although many assessment activities translate readily to CP, expanding the role of existing EMS professionals presents potential legal impediments.

In addition to scope of practice limitations, EMS professionals may be restricted to practicing in certain locations (e.g., the scene of an emergency or in transit to a hospital) that might limit authority to engage in nonemergency care. Requirements that certain classes of healthcare professionals supervise EMS programs may pose practical and legal obstacles to broadening the community role of EMS. Potential civil liability may also increase as the roles of EMS professionals, supervisors, and entities expand through CP and MIH. Protecting patients' health information privacy throughout the delivery of nonemergency services in varied settings implicates additional law and policy concerns. Although these issues have the potential to impede expansion of EMS service, a bevy of legal options, practices, and solutions provide meaningful opportunities to address these concerns.

SCOPE OF PRACTICE FOR EMS PROFESSIONALS

Classifications. EMS personnel include a diverse range of professionals with specific training and education requirements, all of whom may play a potential role in CP and MIH. As illustrated in **Figure 2**, each professional classification also features a specific authorized scope of practice. EMS functions may be performed by individuals licensed or certified as emergency medical responders, EMT, advanced EMT, or paramedics, among other designations, each with broadly authorized scopes of practice.[95]

FIGURE 2: EMS Scopes of Practice



States vary in their approaches to distinguishing scope of practice between these classes of professionals, as per the examples in **Figure 3**. Florida recognizes two types of EMS personnel: (1) EMT and (2) paramedic.[96] Georgia statutes recognize three classes: (1) EMT; (2) paramedic; and (3) cardiac technician,[97] and state administrative regulations and guidance documents further distinguish EMT, EMT-intermediate, and advanced EMT licensure.[98] Idaho recognizes four classifications: (1) EMT; (2) advanced EMT; (3) emergency medical responder; and (4) paramedic.[99] Mississippi recognizes five classifications.[100] In each state, these classifications are associated with authorized scopes of practice.

FIGURE 3: Select State EMS Personnel Classification Examples

FLORIDA	GEORGIA	IDAHO	MISSISSIPPI
• Paramedic • EMT	• Paramedic • EMT • Cardiac Technician	• Paramedic • Advanced EMT • EMT • Emergency Medical Reponder	• EMT-Paramedic Critical Care • EMT-Paramedic • EMT-Intermediate • EMT-Basic • EMT Driver

Other healthcare professionals may also provide services as part of CP or MIH initiatives. These individuals (e.g., RNs, NPs, PAs, physicians, community health workers) also have specific scope of practice authorities and limitations with associated legal issues that may incorporate issues concerning EMS personnel. These professionals may also act in supervisory or delegating capacities with respect to EMS in some circumstances (e.g., when EMS responds to patients under the care of a home care nurse or referred by a NP with an independent practice), raising additional legal considerations underlying scope of practice, delegation authority, and liability.

Authorized Activities. Some basic patient assessment tasks may fall within the scope of practice for most, or all, classifications of EMS professionals. Other authorized patient assessment activities may "ramp up" with higher levels of training. For example, the NHTSA National EMS Scope of Practice Model recommends that all EMS professionals be allowed to perform manual blood pressure monitoring. However, it recommends that only advanced EMTs and paramedics perform blood glucose monitoring, and only paramedics perform electrocardiogram (EKG) interpretation or blood chemistry analysis.[101]

Utah has adopted NHTSA's education standards as the scope of practice for EMS professionals.[102] Idaho has considered NHTSA's model in developing and revising its scope of practice standards.[103] Some states (e.g., Georgia and California) authorize not only specific enumerated functions, but also broader activities ordered by a supervising physician and for which EMS professionals are properly trained to perform. Georgia specifically authorizes some categories of EMS professionals to perform:

- Comprehensive patient assessments.
- Taking and recording of vital signs.
- Basic and advanced airway management.
- Gastric decompression.
- Oxygen management via various devices.
- Management of soft tissue injuries and suspected fractures.
- Blood glucose monitoring.
- EKG initiation, monitoring, and interpretation.
- Blood sample collection.
- Medication administration.
- Prescription drug assistance.[104]

Georgia also authorizes paramedics to "perform any other procedures which they have been both trained and certified to perform" upon the order of a licensed physician.[105] California similarly

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authorizes paramedics[106] and EMTs[107] to perform additional functions when appropriately trained and authorized by the relevant medical director. These "local optional scopes of practice" may support development of CP, MIH, or similar programs by circumventing limiting aspects of scope of practice statutes, but do not specifically authorize such programs. Moreover, any additions to scopes of practice require approval of the California's Emergency Medical Services Authority (EMSA), among others.[108]

In states that explicitly list authorized EMS patient assessment activities, practice may be limited to these activities. Expanding the role of EMS personnel may also be constrained by explicit scope of practice limitations premised on emergency- and transportation-oriented conceptions of EMS patient assessment. For example, in a state with an exclusive list of authorized activities (e.g., Oregon),[109] a less traditional activity for EMS (e.g., vaccination in public health context) may fall outside the authorized scope of practice. In contrast, in a state that more broadly authorizes properly trained EMS personnel to perform activities upon physician orders (e.g., Delaware, Georgia, and California),[110] the range of legally permissible activities may be more expansive, allowing maximum utilization of EMS personnel at various certification levels. Alternatively, each activity may need to be specifically authorized by law, such as North Dakota's statutory authorization for paramedics to provide flu vaccination to adult patients as part of established medical protocols if the paramedic has completed the applicable training course (*see* citation for specific statutory language).[111]

TOPS #5

Legal authority for EMS professionals to fully engage in activities like CP may be constrained by existing scope of practice limitations. Provisions authorizing ranges of activities, rather than specific and enumerated tasks, may facilitate an expansion of the traditional EMS role without altering legal scopes of practices.

Standard of Care. Issues concerning scope of practice differ from the legally required standard of care.[112] As noted above, scope of practice—generally derived from statutes and regulations—dictates the boundaries of allowable activities and services among EMS personnel based on their level of licensure, certification, and training. In contrast, standard of care refers to the legal standard used to evaluate whether a health professional has adequately and appropriately performed these duties. The applicable standard of care depends on the circumstances in which care is delivered, as determined by general practice within the profession and locale.

The legal standard of care for health professionals, including EMS personnel, will generally be that of a reasonable professional of the same classification operating in like circumstances. Education and training requirements (commonly at the state level and tied to licensure or certification) play a significant role in defining specific standards of care. For example, California paramedics have a legal duty to conform their actions to the learning, skills, and degree of care generally used by reputable paramedics in the same or a similar location and circumstances.[113] A California court in 1990 upheld a jury verdict against a paramedic who failed to perform an adequate examination because his conduct was "an extreme departure from the standard of care for a paramedic in such a situation."[114] The paramedic performed only a visual examination on a man who had been in a fight and was being detained by police. The man later died of complications from sickle cell crisis that would have been uncovered and corrected if appropriate tests were performed consistent with the expected standard of care for paramedics.[115]

High-level education and training programs, from local programs to potential national curricula and education standards, can improve patient care and help to define legal standards for EMS professionals. Expanded EMS functions may depend on additional, targeted training reflecting specific patient care goals.

Clinical Decision Making. Among the limitations imposed by scope of practice restrictions is the distinction between clinical decision-making authority granted to physicians and some other medical professionals, such as PAs and NPs, compared to EMS personnel. Although these personnel may evaluate a patient's symptoms and presentation, EMS patient assessment does not include providing a medical diagnosis, which focuses on the root causes of a patient's illness or disease.[116] Furthermore, EMS personnel are not authorized generally to prescribe medications, though they may administer them in some jurisdictions when prescribed by a physician.[117] Still, EMS personnel, particularly paramedics, develop and use significant clinical decision-making skills. This includes developing differential diagnoses, field diagnoses, or field impressions based on clinical presentation and assessment to make critical decisions regarding patient care and implement a patient management plan.[118]

EMS personnel will likely increasingly use these clinical decision making skills through CP, MIH, and similar programs, which necessitates clear guidance as to the proper role of EMS personnel to avoid conflict with state scope of practice restrictions. Although distinctions between clinical decision-making by EMS personnel and prohibited medical diagnosis may be subtle, they are legally significant. EMS practitioners with expanded roles, like other health professionals, must determine the immediate causes of a patient's current symptoms, including relevant medical history, and initiate appropriate responses.

Clinical decision-making in traditional roles of EMS personnel rarely conflicts with the legal prohibition against their rendering medical diagnosis because care is typically transferred to physicians or medical teams (e.g., upon arrival at an ED or shortly thereafter). Legal conflicts may increase, however, in the context of expanded EMS roles. These expanded functions may also raise liability concerns. More extensive patient medical history evaluations, additional types of available care, and greater opportunities for patient contact may find these personnel straddling the line between EMS and the practice of nursing or medicine, particularly when care is provided primarily by EMS personnel, such as during a follow-up visit after hospital discharge. Follow-up care, prescription assistance, and chronic disease management, among other services, may be seen as extensions of primary or specialist care, rather than independent care events, thus providing appropriate context for clinical decision-making as part of this practice.

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TOPS #6

Adherence to appropriate decision making tools (e.g., protocols and standing orders), medical supervision, and consultation requirements mitigates the risk of overstepping clinical decision making authority. Viewing follow-up care and similar actions as a continuation of, or prelude to, care by other medical professionals reflects key legal distinctions between medical and field diagnoses.

Location Restrictions. Scopes of practice for EMS personnel may restrict not only the lawful types of activities, but also where such activities may take place. EMS personnel are generally authorized to assess and treat patients at the scene of an emergency, during patient transportation, or, in some jurisdictions, within a healthcare facility.[119] However, as further discussed in Part IV, some states may limit the circumstances in which EMS personnel may be deployed (e.g., responding to a medical emergency or transporting a patient to a hospital ED). These restrictions may also constrain EMS professionals' scopes of practice to only these circumstances, which may hamper anticipated broader settings for expanding EMS services.

For example, California EMTs are authorized to perform various functions only "[d]uring training, while at the scene of an emergency, during transport of the sick or injured, or during inter-facility transfer." [120] While patient assessment activities may be fully authorized in these settings, assessment at a patient's home or other locations for nonemergency purposes (e.g., oral health assessment, immunization, or post-discharge follow-up) may fall outside this authority. Other states (e.g., Idaho) more broadly authorize EMS personnel to provide services in various settings as part of documented and planned personnel and resource deployments.[121] A recent trend, especially in rural locations, also utilizes EMS personnel as team members within hospital EDs.[122]

Other laws may permit some patient assessment functions outside traditional EMS settings. Georgia authorizes EMS personnel to evaluate persons who present themselves with an "emergency condition,"[123] defined as "any medical condition of a recent onset and severity" that would lead a layperson to believe immediate medical care is necessary to protect against serious jeopardy to health, impairment of bodily functions, or serious dysfunction.[124] Similarly, Utah defines an "emergency medical condition" as one with symptoms, including pain, that are severe enough to lead a person to expect it would result in "placing the individual's health in serious jeopardy;" "serious impairment of bodily functions;" or "serious dysfunction of any bodily organ or part" absent immediate medical care.[125] Virginia defines "emergency medical services" as those in response "to an individual's perceived needs for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury."[126] Such provisions could facilitate assessment activities for conditions that are serious and sudden (but do not require hospital-based care) irrespective of where the assessment takes place, though other restrictions may apply.

Some states authorize EMS personnel to provide nonemergency care in some circumstances, but this may still be insufficient to enable the full range of activities contemplated in CP, MIH, or similar programs. For example, although Illinois authorizes EMS personnel to provide emergency and non-emergency services, it limits the definition of nonemergency services to care or monitoring "before or during transportation … to or from healthcare facilities."[127] Providing nonemergency care to patients who are not being transported to or from a healthcare facility may fall outside authorized EMS scope of practice in jurisdictions with similar definitions.

In contrast, other states explicitly allow EMS professionals to perform patient care and assessment functions in nonemergency and non-transportation-related circumstances. Florida permits properly trained paramedics and EMTs, as supervised by a medical director, to perform health promotion and wellness activities and blood pressure screenings in nonemergency situations. Paramedics can also immunize persons in nonemergency settings with county health department agreement.[128] These provisions encourage using EMS professionals in community healthcare.[129] Waivers and statutory flexibility in some other states may also further these expansions of the traditional role of EMS providers by authorizing location- or circumstance-dependent expansions of scope of practice.

TOPS #7

Nonemergency care may exceed lawful scopes of practice for EMS professionals. However, broadly defined scope of practice provisions may readily allow such care. Even narrower constructions may permit such care consistent with additional statutory authorizations or favorable interpretations of laws defining "emergency condition" or similar terms.

Supervision Requirements. Supervision requirements may curtail EMS personnel's independent abilities to conduct patient assessment activities in some jurisdictions. For example, Delaware authorizes paramedics to provide services only (a) under the supervision of a physician; (b) with voice contact monitored by a physician via radio or telephone; (c) as authorized by a physician for advanced life support; or (d) when the life of a patient is in immediate danger and direct voice communication fails or is not possible.[130] In states with similar provisions, this would require paramedics operating in CP, MIH, or similar programs to be supervised directly or through radio or telephone contact with a physician, much as they do for emergency care. In many instances, supervision requirements can be accomplished in large part through use of decision-support tools (e.g., standing orders, protocols).[131] However, alterations to standard procedures or standing orders generally require direct orders from a supervising medical professional, such as an approved base station physician.[132] Although every patient encounter is potentially unique, expanded functions may entail increased direct, real-time guidance.

Some jurisdictions (e.g., Arizona[133] and Oregon[134]) authorize only physicians to supervise EMS personnel. Georgia requires each ambulance service to be supervised by a medical adviser, who must be a physician.[135] Physician availability may place practical limitations on the extent of services that can be offered. Georgia allows various other medical professionals, including nurses, paramedics, and PAs, to communicate with EMS personnel to relay authorization for specific medical services.[136] Arizona lets physicians providing online medical direction to relay guidance through other individuals, including PAs, nurse practitioners, RNs, paramedics, and EMT-intermediates.[137]

Other states (e.g., Illinois and Montana) authorize a more expansive array of health practitioners to provide supervision for EMS, including PAs[138] or qualified RNs.[139] Designees may also provide advice or orders, but this may be limited to pre-hospital or inter-facility transport circumstances.[140] Treatment activities that incorporate assessment components that diverge from established protocols or guidelines may still require physician authorization in many states. This could be problematic in rural areas where there are an inadequate number of physicians appropriately trained, available, and willing to undertake these supervisory roles.[141] In some jurisdictions, other practitioners, such as NPs, may be able to help address such gaps either directly or as an intermediary,

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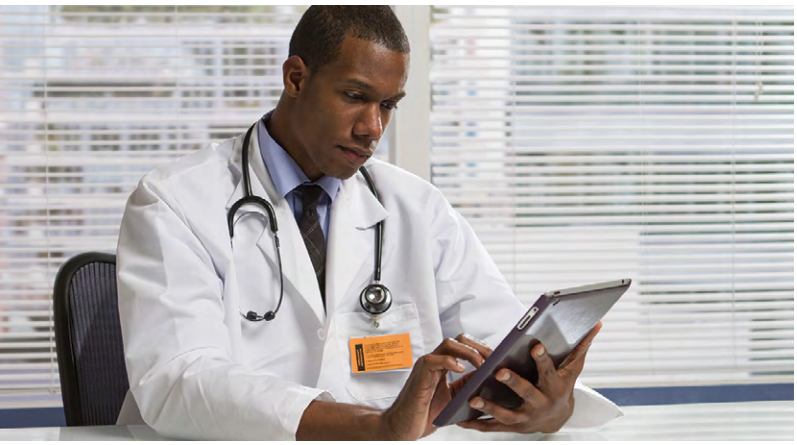


if legally permissible. Availability problems may be accentuated by potential need for multiple supervising practitioners with different specialties (e.g., primary care, specialty care, emergency care) to advise and supervise the full scope of clinical activities.[142] Emergency medicine physicians are authorized under their own scope of practice to provide guidance on a variety of medical issues, but they may not be ideally trained to respond to all the issues that may arise under CP, MIH, or similar programs. Models utilizing medical control hospitals, where feasible and appropriate, may help provide access to a wider variety of medical professionals.

Some states currently require physicians providing on-line medical direction for EMS to be emergency medicine specialists. For example, Arizona requires on-line physicians either to have emergency medicine certification, prior training in an emergency medicine residency program, or be currently practicing in emergency medicine.[143] Such limitations may exclude otherwise qualified individuals from providing on-line medical direction regarding relevant aspects of programs that expand the role of EMS providers.

Availability concerns of supervising practitioners can be mitigated through developing appropriate decision-support tools, including standing orders and treatment or triage protocols. These tools provide established training and guidance for engaging in specific patient assessment and care activities, and can allow EMS personnel to act without on-line medical direction.[144] Treatment protocols may be developed for precise functions (e.g., flu vaccination),[145] as well as broader disease evaluation and response (e.g., diabetes)[146] and specific populations (e.g., children with special healthcare needs).[147] Consistent with appropriate clinical decision making authority, treatment protocols and other decision-support tools allow physicians or other authorized health professionals to provide advance clinical guidance for patient assessment activities by EMS personnel, rather than requiring consultation for every step and component of clinical decision-making.

TOPS #8

Medical professional oversight and supervision are required for EMS activities, but may be limited by physician availability. Expanded use of appropriate decision-support tools and centralized on-line supervision models can increase the supervision potential of existing, available personnel, including non-physicians.

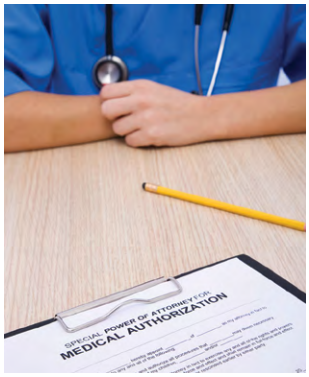
CIVIL LIABILITY AND AVAILABLE PROTECTIONS

EMS Personnel. Potential civil liability for EMS personnel engaged in CP or MIH activities may typically be grounded in claims of negligence, particularly malpractice. Negligence suits require a claimant to prove 4 elements: (1) a duty; (2) breach of that duty; (3) causation; and (4) damages. As discussed in Part II, a duty is generally established through the existence of some form of professional-patient relationship. A breach of that duty in the context of expanded EMS service may be shown if the practitioner's conduct did not meet the applicable professional standard of care. Causation and damages are established by proving that the failure to meet the standard of care caused or exacerbated a patient's injury.

Expanding the role of EMS personnel into new or emerging areas of patient assessment may escalate claims for malpractice if their actions fall below the required standard of care. For example, two Florida paramedics were found liable in a 1990 case for the death of a young child from congestive heart failure after they failed to transport her to a medical center following an inadequate examination and history without a physician consultation.[148] Proper training, physician consultation, and adherence to established protocols and other aspects of the standard of care will help insulate EMS personnel from liability in most circumstances. EMS personnel following an established protocol or standing order may be protected from liability in some jurisdictions,[149] provided they follow physician instructions[150] and their acts do not constitute "gross negligence" (involving a higher degree of carelessness than simple negligence) or intentional, "willful misconduct."[151]

EMS personnel may also be statutorily protected from liability in carrying out their duties at the scene of an emergency. For example, Illinois protects EMS personnel acting in the normal course of their duties unless their actions constitute willful and wanton misconduct (e.g., intentional harm or reckless disregard for safety).[152] Idaho protects EMS professionals from liability provided they do not behave recklessly or in a grossly negligent manner.[153] Georgia provides broad civil liability protection to persons licensed to provide ambulance service when rendering emergency care in good faith.[154] California provides similar protections for EMS personnel and several other professionals, such as police officers, who act in good faith and are not grossly negligent.[155] However, some states' statutory protections apply only to individuals who provide emergency services without compensation (e.g., Georgia),[156] which may severely limit their application to CP and MIH services. Administrative and transportation fees charged by government entities to defray a portion of costs for providing ambulance service may not be viewed as compensation,[157] but Medicaid reimbursement to contracted private ambulance service providers may, potentially rendering statutory protections inapplicable.[158]

These types of civil liability protections can also be limited to specific circumstances, such as the scene of an emergency or during patient transport. EMS personnel in Illinois receive protection for emergency and nonemergency services, but nonemergency services include only those before



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or during patient transport to or from a healthcare facility.[159] California protects EMS personnel providing services at the scene of an emergency, during transport, or for activities to protect patient health and safety when in "imminent peril."[160]

In states that do not specifically immunize pre-hospital care providers, protections may still be available under Good Samaritan laws, which broadly protect persons who provide care at the scene of an emergency. Some states (e.g., Florida)[161] explicitly include medical professionals under their Good Samaritan laws. In other states courts may scrutinize claims that Good Samaritan statutes apply to those with a pre-existing duty to provide aid, such as EMS personnel.[162] Additionally, Good Samaritan statutes typically apply only to care provided at the scene of an emergency or emergency care generally,[163] but not apply to many EMS activities in the context of CP, MIH, or similar programs. For example, a Wisconsin court found in 2006 that Good Samaritan protections applied only to care provided before transfer to a hospital or other location was possible and did not apply to nonemergency care provided hours after an initial assessment and evaluation.[164] Although this case involved laypersons, this legal interpretation of a Good Samaritan statute could also apply to care provided by EMS personnel as part of these programs. Courts may look to the legislative purpose in enacting Good Samaritan protections to determine how broadly to apply such provisions.[165]

TOPS #9

In the face of potentially escalating liability claims, protections from ordinary negligence claims available to EMS personnel responding to an emergency may apply to other activities in select contexts. Proper training, medical consultation, and observance of protocols and standing orders are essential to ensure that EMS practitioners with expanded roles comply with established standards of care.

Supervising Professionals and Entities. In addition to direct liability risks for EMS personnel, supervising professionals, hospitals, and other entities may also face liability for actions or omissions by these personnel under their control or direction. For example, in 1990 a Florida regional medical center was held liable for the death of a 5-year-old child because it failed to properly supervise, train, and instruct paramedics involved in the patient's care.[166] Even when EMS professionals individually are protected from civil liability, their employers may not be. In 1983, a Massachusetts city was precluded from claiming immunity for the actions of EMTs it employed that improperly transported a patient to a private home rather than a hospital.[167] While alternative protections may be available for some governmental entities under principles of "sovereign immunity" that bar lawsuits directly against the state, these protections often do not apply to municipalities or private-sector employers.

Some states extend liability protections to medical professionals who advise EMS personnel. Georgia, for example, immunizes physicians acting as medical advisers to ambulance services unless their conduct constitutes willful and wanton negligence.[168] Montana protects physicians, PAs, and RNs from civil liability who provide on-line medical direction to EMS, but only if (a) they do so without compensation or for limited compensation, and (b) their instructions are consistent with established protocols.[169] Utah similarly protects uncompensated physicians, PAs, and RNs who provide oral or written instructions to EMS professionals.[170]

PROTECTING PATIENT HEALTH INFORMATION PRIVACY

Like most other health professionals, EMS personnel must protect the privacy of identifiable patient health information consistent with federal and state health information privacy laws. EMS providers with expanded roles may obtain and use more sensitive patient information than is common in emergency response activities. For example, a more extensive patient history may be obtained while providing follow-up care after a hospital stay, compared to a focus on immediate medical history in responding to a sudden onset of symptoms requiring transportation to an ED.[171] Similarly, these professionals may utilize more sensitive patient information in performing prescription drug compliance functions, compared to emergency-focused EMS.[172] Some states provide explicit privacy protections for medical records related to EMS care, in addition to other privacy protections in state and federal law. Arizona does not allow the release of any information from medical records "developed and kept by a pre-hospital component of the statewide trauma system" without written consent by the patient or the patient's representative unless other laws permit or require such disclosures.[173]

Federal and state health information privacy laws apply to a wide variety of healthcare providers, insurers, and others. The HIPAA Privacy Rule[174] generally prohibits individuals and entities from acquiring, using, or disclosing individually identifiable health information without written authorization by the patient or the patient's representative except in limited, specific circumstances. State privacy laws may provide additional protections or apply to broader classifications of professionals and entities.

These privacy laws allow for use and disclosure of health data in limited circumstances without patient authorization, including, among other purposes, to: (1) provide or coordinate treatment or seek reimbursement; (2) perform healthcare operations, including quality assessment and improvement activities, and (3) notify appropriate governmental and contracted private entities based on specific public health purposes (e.g., communicable disease surveillance).[175] Mandatory reporting requirements for communicable diseases or suspected child or elder abuse may obligate EMS practitioners to provide patient information to designated public health and legal authorities, regardless of whether they are operating in a traditional or expanded role.[176] For these and other specifically authorized uses and disclosures, patient authorization, consent, or notification are not legally required under federal law, though state laws may provide additional requirements and discussions with the patient may be preferable in practice.

Increased patient contact and interaction through programs that expand EMS providers' roles will likely increase the amount of protected health information that these personnel acquire while performing their duties. Expanded access and use of existing data for specific purposes (e.g., protecting vulnerable populations during emergencies) raise further privacy concerns.[177] To avoid potential breaches and resulting administrative sanctions or civil liabilities, these personnel should be trained and supervised in their access, use, and disclosure of such data as their roles expand. Among other benchmarks, HHS sees privacy training and appropriate written policies as hallmarks of a well-designed CP program.[178]

TOPS #10

To deter potential health information privacy violations or infringements, CP, MIH, or similar programs may require training for key personnel on privacy protections and develop of formal, HIPAA-compliant written policies addressing permissible uses and disclosures of identifiable health data.

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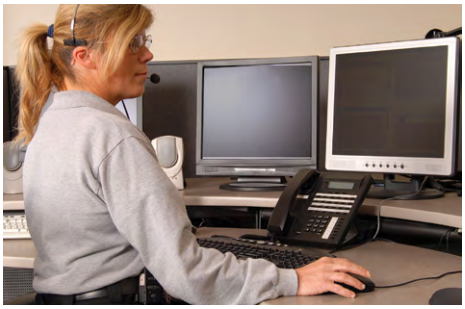
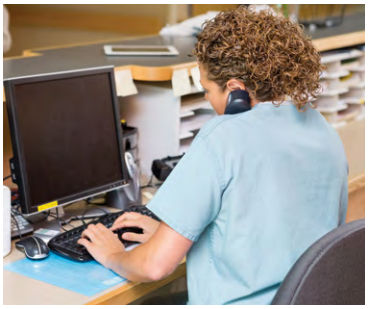
IV. Down the Road: Altering Patient Destinations

Assuming EMS personnel are lawfully triggered to respond and provide adequate patient assessment on the scene, they must then determine where to transport the patient when necessary. The typical destination for most patients following an interaction with EMTs or paramedics is the nearest hospital ED. However, in the context of CP, MIH, and similar programs, the ED may not be an appropriate or cost-effective facility to treat the patient, especially when all the patient needs is follow-up or other nonemergency medical care from the patient's primary care physician, urgent care clinic, or other source. This section focuses on issues of law and policy related to altering the patient's destination from the usual ED and acute care hospitals to other medical or care facilities.

As discussed in Part III, state statutes and regulations may limit EMS personnel's ability to practice outside of a pre-hospital setting, including requirements that patients be taken to the nearest ED. Absent statutory requirements, many states delegate the decision of patient destination to local trauma systems and designated medical control physicians, which often follow medical control protocols directing patient destination and care. Other legal obstacles arise from reimbursement structures. Possible EMTALA violations and other liability concerns may result in patients being funneled to hospitals rather than more appropriate facilities, hindering these expanded practices. Despite these legal hurdles, there are multiple options for programs to alter patient destinations.





LEGAL OPPORTUNITIES TO ALTER DESTINATIONS

Transporting patients to healthcare destinations other than EDs is legally supported in select ways. A few states, like Illinois, explicitly permit patients to be taken to alternate destinations, such as physicians' offices.[179] In some states, flexible legal provisions allow EMS personnel to take patients to the closest and most appropriate medical facility, whether it is an ED or a facility such as a behavioral health unit or urgent care. Additionally, a state's EMS structure may allow medical directors in charge of EMS personnel and ambulance services to establish written protocols directing patient care and destination as needed for the population, locality, and situation.

California's EMSA, noted in Part I, interprets its state's statutes to require EMS personnel to transport patients to a hospital with at least a basic ED[180] based on requirements to make available "advanced life support" [181] through EMS and delivery to an ED.[182] However, through its HWPP program, California has provisionally selected 13 CP pilot projects, four of which allow for patients' destinations to be altered.[183] Establishment of a HWPP allows for the temporary waiver[184] of health code sections that (a) limit destinations to which paramedics may transport patients, or (b) limit paramedics to providing services in emergency settings.

Arizona's director of health services, in conjunction with local EMS medical directors, can establish protocols allowing EMS personnel to transport patients without life-threatening conditions to the most appropriate healthcare institution based on patient choice and provider.[185] Healthcare institutions are defined broadly to incorporate "every place, institution, building or agency … that provides facilities with medical services, nursing services, health screening services, other health-related services, supervisory care services, personal care services or directed care services."[186] Consistent with this statutory allowance, the City of Mesa Fire Department has partnered with Mountain Vista Medical Center to create a PA Unit, which places PAs and NPs aboard smaller fire department units.[187] Not only can PAs and NPs prescribe drugs and suture small wounds, they can transport patients to numerous locations other than EDs, such as a behavioral health authority or a child's pediatrician, pursuant to statutory allowance.[188]

Delaware allows EMS personnel to take patients to locations other than EDs by defining "pre-hospital care" to include emergency medical care prior and during transport to hospitals and other facilities.[189] Similarly, Oregon allows EMS personnel and medical directors'[190] discretion to determine where to transport a patient.[191] Regulations setting the standards for area trauma system plans require EMTs and paramedics to follow the flowchart,[192] "Guidelines for Field Triage of Injured Patients,"[193] indicating when a patient must be taken to a level I or II trauma hospital (usually under clear emergency circumstances).[194] Otherwise, state or local medical control protocols, which set forth guidelines suggesting appropriate locations for patients based upon their present condition, are used to assess where patients are transported.[195]

TOPS #11

CP, MIH, or similar programs that do not explicitly authorize alternative destinations for patients may rely on broad and flexible statutes and regulations allowing sufficient discretion to alter destinations through protocols and supporting flowcharts. Waivers may also permit pilot programs to transport patients to alternative destinations.

LEGAL MANDATES TO TRANSPORT PATIENTS TO EDS

Although programs that expand the role of EMS providers could be instituted in many states based on explicit or interpretative authority, some states' laws may still require patient transport to an approved ED. In addition, licensing standards may dictate how patients are cared for, including where they must be transported.

Regulatory restraints in Massachusetts, for example, may forbid alternate destinations. Massachusetts' definition of "emergency medical services" appears to allow alternate destinations by defining these services to include pre-hospital assessment and treatment during transport to appropriate health-care facilities.[196] However, the state's Department of Public Health limits "appropriate healthcare facility" to an ED that is located within an acute care hospital or an approved satellite emergency facility.[197] For programs in Massachusetts to alter patient destinations, the department would likely have to amend this regulatory definition to include other healthcare facilities.

Licensing Requirements. Licensing requirements may present other obstacles, requiring patients to be taken to acute care facilities or permitting ambulance licensure only when deemed necessary. For example, a city ordinance in Independence, Missouri, only allows ambulance licenses to be issued when "public convenience and necessity require the proposed ambulance service."[198]

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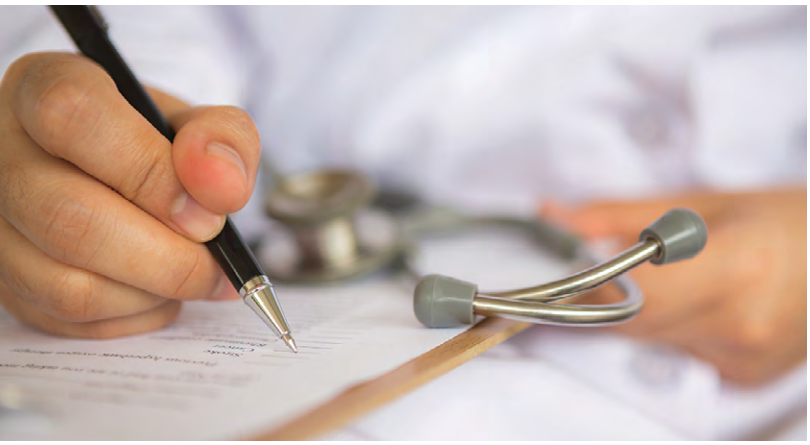
In 1997, Lifeguard Medical Services, a licensed emergency ambulance supplier in Missouri, applied for a license in Independence to provide nonemergency transport in the city.[199] Independence's health director denied the license on the basis that the service would not provide emergency care, and was thus unnecessary.[200] When challenged, a local court found that the city's health director was empowered to determine necessity in the jurisdiction and upheld the decision to deny the license for nonemergency transport.[201]

TOPS #12

EMS licensing requirements based on necessity can limit opportunities to alter destination for patients in CP or similar programs. State and local officials with discretionary authority to approve ambulance licensure may interpret respective regulations to include such programs, particularly those including nonemergency transport.

Contracts. As discussed in Part II, most EMS response and transport is delivered by local fire departments or public third-service agencies. Some localities, however, require contracts, memoranda of understanding, and prior approval between the municipalities and private EMS providers within their boundaries.[202] These agreements may restrict the types of healthcare facilities where patients may be taken.[203] Contracts between cities, hospitals, and ambulance services may limit patient destinations to previously contracted facilities. For example, Jersey City Medical Center (JCMC) has exclusively held the ambulance contract with Jersey City, New Jersey. Allegations that JCMC diverts patients to its own hospital chain against patient wishes based on internal policies led the city to consider offering contracts to new ambulance services.[204]



Hospitals may also contract with specific ambulance suppliers for nonemergency transport when a patient needs to be taken to a different facility.[205] A patient may prefer a specific provider. Patient choice may be a legally-recognized factor in selecting transportation for medical services, but it is not always determinative.[206] Fresno County, California, has a Hospital Diversion of Ambulance Patients policy that allows the patient to "refuse to be diverted to a facility that is not their primary choice. The ambulance crew will explain to the patient the reason for diversion. If the patient continues to refuse to be diverted, the ambulance crew will consult with the base hospital, have the patient sign a Refusal of Medical Care and Transport … form, [and] transport the patient to the hospital of patients choice (unless the facility is on General Diversion)."[207]

REIMBURSEMENT HINGED ON EMERGENCY MEDICAL CARE

While programs that expand the roles of EMS providers may improve access to healthcare and reduce overall costs, funding models for these programs can be problematic.[208] Many existing projects may not be reimbursed through private health plans or public insurance options like Medicaid or Medicare.[209] Instead they rely on external grants or other funding, leading to budget shortfalls. At the nexus of this funding dilemma are existing EMS reimbursement models that hinge on only paying for limited and essential emergency care. These approaches do not consider care by EMS personnel in settings outside the typical 9-1-1 response and emergency transportation framework as reimbursable.[210]

Public Insurance. Currently, CMS covers ambulance services through Medicare when an emergency exists or other transportation would be detrimental to the patient's health.[211] However, only certain destinations are reimbursed. Medicare covers ambulance transport to the nearest appropriate facility to obtain diagnostic or therapeutic services, as well as return transport under certain circumstances.[212] However, it only allows ambulance transport for emergencies and only to hospitals, critical access hospitals, skilled nursing facilities, the patient's home, and dialysis centers.[213] CMS specifically states that a "physician's office is *not* a covered destination."[214] Other possible destinations, such as behavioral health facilities or urgent care clinics, are not covered.

State Medicaid reimbursements for CP, MIH, or similar services vary, but tend to be limited. In 2012, Minnesota adjusted its Medicaid reimbursement policies to include CP programs that were legislatively authorized the year prior.[215] However, its coverage is limited to a set group of recipients that are known "common users" of EDs, identified as an individual (a) who has received ED services at least three times in a period of four consecutive months in the last year, or (b) whose primary care provider has determined that CP services would likely prevent admission or readmission to a hospital or skilled nursing facility, or allow discharge.[216]

TOPS #13

To address budget crises that limit expanding the use of EMS providers, states may consider authorizing reimbursement for patient transport and EMS services through Medicaid programs beyond cases involving transportation to EDs or acute care centers.

Private Insurance and ACA. ACA's healthcare reforms may change how CP or similar services are delivered and reimbursed, specifically through provisions governing EHBs and promoting ACOs. Pursuant to ACA, HHS set forth its list of 10 EHBs, establishing categories of healthcare services that must be covered by health plans sold on the individual and small group market (*see* Figure 4).[217]

FIGURE 4:

Ten Essential Health Benefits[218]

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CMS issued final rules specifying the EHB Benchmark and setting a minimum standard each plan must meet.[219] The exact benefits of plans differ across states, but essentially cover the same services,[220] including EMS.[221] What may vary significantly is the number of services (e.g., the number of office visits per year) that plans must cover, or who can provide the care (e.g., allowing only RNs from a licensed home health agency to make home visits).

Covered EMS are generally limited to actual emergency care, ED services, and transportation by ambulance to an ED during an emergency and nonemergency transport when medically required. For example, California's EHB benchmark limits "emergency transport/ambulance" to instances where an individual reasonably believes a medical condition "requires ambulance services" or the treating physician determines the patient "must be transported to another facility because [the patient's] condition is not stabilized and services are not available."[222] Although most EHBs require plan coverage of ambulance transport only in emergencies or when medically necessary, covered alternate destinations could include skilled nursing facilities, urgent care clinics, and behavioral health facilities.[223] EHBs may not include actual EMS care and transport, coverage of the patients' medical services upon arrival at other facilities may enhance the development of CP, MIH, and similar programs.

Additionally, EHBs merely set a floor for health insurance plans. States' EHB plans may extend coverage to EMS care. In Oregon, home health services are limited to services provided by RNs, LPNs, specific therapists, and social workers provided by licensed home healthcare agencies. Preventative care is limited to a routine physical once every year for those older than 60 years old or once every few years for those under 60.[224] CP, MIH, or similar programs serving patients covered under plans ruled by the EHBs in Oregon could not be reimbursed for programs utilizing preventative care screenings or home visits. Arizona limits the number of home healthcare service visits per year, but does not require the visits to be provided by a licensed home healthcare agency or specific types of health practitioners. Additionally, it allows coverage of only one physical and preventative care screening per year for adults.[225] In contrast, Colorado allows broader and more flexible reimbursements, eliminating many restrictions that would bar these programs from being reimbursed for preventative home healthcare.[226]

TOPS #14

To expand funding of CP, MIH, and similar projects through private health insurance, states may amend their benchmark plans to cover services including home health services, preventative care, and emergency services.

Role of Accountable Care Organizations (ACOs). ACA support for developing ACOs may incentivize hospitals and other clinic partnerships to support an expanded role for EMS. ACOs entail collaboration among doctors, hospitals, and other providers to coordinate care to Medicare patients as a means to lower their overall per patient costs, leading to financial incentives.[227] Abandoning the typical fee-for-service model, CMS pays approved ACOs a flat rate for providing care to a certain group of Medicare beneficiaries, rather than reimburse for each service provided,[228] and will not reimburse for patient readmissions within 30-days for the same medical condition.[229] Because ACOs are not paid by CMS each time a patient enters the ED, they may seek to partner with EMS providers

focused on efficient and cost effective healthcare outside of the ED when medically appropriate. Fort Worth's Medstar partners with a local ACO to provide overnight at-home visits to patients in-home who otherwise would require all-day observation in the hospital.[230]

LIABILITY RELATED TO TRANSPORTATION AND DESTINATION

As discussed in Parts II and III, EMS personnel and supervisors may be subject to many liability claims, but they can also be insulated from liability through various laws.[231] To the extent that these programs allow employees to set new destinations for patients beyond the ED and acute care settings, additional liability avenues may arise for EMS personnel, their medical directors, ambulance suppliers, and the healthcare institutions treating these patients.

The Emergency Medical Treatment and Labor Act (EMTALA). EMTALA[232] is a federal law designed to curb patient-dumping practices concerning under- or uninsured patients with emergency conditions, largely at Medicare-participating hospitals operating EDs.[233] Generally, EMTALA is invoked when a patient with an emergency condition, including active labor, comes to the ED and requests treatment.[234] EMTALA may apply beyond a traditional ED and include urgent care clinics, labor and delivery departments, and psychiatric departments, depending on the number of unscheduled emergency patients seen in the department.[235] In such cases, patients cannot be turned away, but rather must (1) be screened to determine if an emergency condition exists, and (2) if so, stabilized on site or transported to another facility that is willing and able to provide care with patient authorization.[236]

EMTALA's essential purposes may be thwarted through CP, MIH, or similar programs if patients with emergency conditions are improperly transported directly to other healthcare facilities (e.g., an outpatient center) that may refuse patients' admission because these entities are not covered by the act. Although this potential exists, there are safeguards to avoid it.

First, EMTALA's application is not limited solely to patients on participating hospital grounds. It also extends to hospital-owned ambulances. If a hospital ambulance engaged in CP, MIH, or similar activities receives a patient with an emergency condition, EMTALA prohibits the ambulance from dropping off the patient anywhere other than the hospital ED[237] absent patient authorization,[238] though there is an exception when participating in local EMS protocols.[239] In addition, EMTALA may apply to hospital-owned urgent care clinics that use the same Medicare billing number as the qualifying hospital.[240] These clinics are similarly required to screen and stabilize patients if transported to the site. Finally, most EMS personnel are attuned to the need to transport emergency patients to hospital EDs consistent with heir existing training and protocols.

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TOPS #15

To avoid potential EMTALA infractions, protocols determining patient destinations should clearly designate hospital EDs as the primary destination for any patient with a known or suspected emergency condition. Procedures should also require a patient's written informed consent (where possible) if the patient refuses emergency transport where possible.

Patient Abandonment. Patient abandonment concerns may arise if healthcare personnel terminate an existing, legally-recognized relationship with a patient without the patient's consent at an unreasonable time or without the patient having a sufficient opportunity to procure alternative care.[241] If the abandonment leads to direct harms to the patient, liability may flow. Although cases of patient abandonment are rare, the threat of liability is genuine. In the 1984 case *McCluskey v. United States*, an EMS practitioner left a patient unattended in a hospital lobby following a patient transfer without notifying the hospital of the patient's presence or condition, and the patient died.[242] The court found that the EMS provider and ambulance supplier were liable for abandoning the patient, leading to the patient's death.[243] In this case, the abandonment claim arose from leaving the individual without properly turning over care to the hospital staff. To obviate claims of patient abandonment when EMS personnel transport patients to hospital ED staff, EMS practitioners follow specific protocols.[244] The crux of these policies is that EMS personnel may not leave a patient until the receiving facility's staff (who are comparably trained, certified, and licensed)[245] are briefed on the patient's condition and assume care for the patient.[246]

Abandonment may also occur if a patient requiring advanced life support is transferred to a facility incapable of providing the necessary medical care.[247] In most 9-1-1 emergencies, hospital staff members know in advance when a patient is en route and the patient's condition. However, through CP, MIH, and similar programs, patients may be taken to different medical facilities (e.g., pediatrician's office) that do not usually interact with EMS personnel and are not subject to EMTALA, increasing the chance of inefficient or unsuccessful patient transfers and potential claims of abandonment. Newly-enacted regulations in Arizona require patients transported by EMS to healthcare facilities other than hospitals to first notify the institution of the intent to transport the patient and receive confirmation that the facility is willing to take the patient.[248]

Other issues of patient abandonment surface when a patient refuses medical treatment or transfer to an appropriate medical facility. In such cases, some EMS agencies require their personnel to contact medical control to determine whether the patient is sufficiently positioned to refuse treatment (e.g., competent adult compared to a minor in an emergency condition).[249] States like Louisiana statutorily endow residents with a right to refuse medical care and transport.[250] Massachusetts extends a right to refuse emergency medical care (though not absolute) based on court decisions and constitutional rights to privacy.[251] To combat issues arising from lack of consent, California pilot CP programs plan to institute a number of protocols and require specific CP consent forms. CP personnel will inform the patient of the program and what it entails. If the patient refuses treatment, CP personnel may immediately transport the patient to the nearest ED. In addition, policies will require patients who lack capacity to consent (e.g., inebriation, mental disability, minors) to be treated according to local EMS rules and regulations.[252]

TOPS #16

To avoid liability for patient abandonment, CP, MIH, and similar programs should ensure adequate communication with appropriate healthcare facilities and patient monitoring by personnel present during medical care and transfer. These programs may also establish written policies regarding patient refusal and accompanying patient rights, as well as patient consent procedures for enrollment and mutually-agreed-upon outcomes.

False Imprisonment/Inappropriate Medical Facility. Although rare, a patient may legally claim that he or she was falsely imprisoned by EMS personnel if forcibly held or transported to a destination without consent, especially if he or she lacks capacity due to age, homelessness, mental or developmental disabilities, or emotional distress.[253] For example, CP, MIH, and similar programs may involve EMS personnel transporting patients with mental health conditions to behavioral health facilities.[254] Following established protocols and emergency treatment and hold procedures, as applicable, can insulate EMS providers from resulting claims of liability.[255]

Sometimes patient choice can be at odds with the patient's well-being, financial interests, and EMS providers' liability.[256] In one case from 1991, a father sued following his son's death after the son was transported to a level II (rather than level I) trauma center based on the son's wishes, but contrary to EMS protocols given the son's condition.[257] The court agreed with the hospital and EMS service that applicable protocols require following a patient's wishes regarding hospital choice so long as the patient is capable of making a decision. In this case, the patient had the capacity to choose which hospital the ambulance took him.[258] Accordingly, some states and many EMS providers encourage EMTs and paramedics to transport patients to a hospital of the patient's choice, unless inappropriate or unreasonable based on the hospital's location or patient's condition.[259] In Arizona, for example, when the patient's condition does not "pose a threat to life or limb," factors to consider in determining destination include "patient choice, the patient's healthcare provider, specialized healthcare facilities, and local protocols."[260]

TOPS #17

False imprisonment and related claims can arise if patients are forcibly held or transported to locations without the patients' valid consent. Programs that use EMS providers in expanded roles should abide by patient choice regarding destination whenever possible. State "emergency hold" procedures for appropriate mental health patients should be relied on where applicable.

In Transit. Negligent operation of ambulance or other emergency vehicles presents potential liabilities for EMS personnel and their companies.[261] Many states' laws allow emergency vehicles to obviate common traffic laws, but do not fully insulate them from all liability when no intentional incidents lead to patient injuries.[262] New York, for example, allows emergency vehicles to exceed speed limits and proceed through red lights while responding to emergencies, but does not relieve the duty to "drive with due regard for the safety of all person nor … from the consequences of [one's] reckless disregard for the safety of others."[263] California similarly provides EMS personnel with

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exemptions to standard traffic laws and immunity protections, but only while responding to emergencies calls and situations.[264] Most jurisdictions apply immunity provisions only to designated emergency response vehicles (generally those with lights and sirens) during emergency response or transport, which would exclude most CP, MIH, or similar programs.

However, liability protections can extend to non-emergency transport in some states. Illinois law states that "any person … licensed or authorized who in good faith provides emergency or non-emergency medical services during a department-approved training course, in the normal course of conducting their duties, or in an emergency shall not be civilly liable as a result of their acts or omissions."[265] The Illinois Appellate Court has upheld this provision to apply to a patient's nonemergency transport to a nursing care facility.[266] This may extend immunity related to patient transport to these programs.

To the extent that programs using EMS providers in nontraditional ways increase transportation of patients to varied destinations, liability related to their transportation in ambulances or other vehicles may increase. A survey of EMS practitioners yielded that existing CP and MIH programs utilize a number of types of vehicles, including ambulances (65%), fire trucks (17%), SUVs (51%), cars (18%), and other response vehicles.[267] Use of nontraditional vehicles for emergency transport may heighten liability risks due to substandard restraint mechanisms for patients as compared to ambulances. Vehicular insurance policies can adequately protect personnel and their companies from personal liability, although the costs of these policies will likely rise.

TOPS #18

Liability protections stemming from vehicular transport of patients outside of an emergency setting are limited. States seeking to increase the use of EMS providers in expanded roles may consider extending immunity laws to nonemergency care consistent with a careful balancing of patient and community safety.

Medical Directors. Potential liability risks confront not only EMS personnel, but also medical directors, ambulance suppliers, and healthcare entities. Because most states' laws require a medical director to supervise EMTs and paramedics, resulting liability of these personnel may potentially extend to their director through vicarious liability. Vicarious liability states that a supervisor can be held liable for the actions of subordinates based largely on supervisory failures or negligence.

Extending liability for EMS personnel to medical directors depends, in part, on whether such personnel practice under the director's license. A common misconception in the EMS field is that EMTs and paramedics work under the medical director's license, which would make the medical director directly liable for EMS personnel's acts and omissions.[268] Generally, EMS personnel operate under their own state-authorized, limited licenses or certifications (e.g., Illinois).[269] In Texas, however, EMS personal actually practice under the medical director's license.[270]

Although successful lawsuits are few, online physicians and EMS medical directors can be liable to patients for giving inappropriate medical orders, failing to properly supervise, or because EMS personnel act negligently.[271] In *Estate of Stephanie Stephens v. Geoffrey Mount-Varner, MD,* an injured patient's estate alleged that the medical director of EMS personnel who provided her emergency care was liable for the wrongful acts of the personnel.[272] The claim was based on a DC Official Code section stating that the provision of pre-hospital care is under the license of the medical director.[273] However, the code clarifies that the director is not personally liable for the results of the medical direction of EMS personnel unless the director acts with willful misconduct or gross negligence.

Some states provide additional liability protections for any physician providing on-line medical control. Massachusetts extends liability protections for good faith acts and omissions to any physician providing on-line medical control in the course of EMS oversight.[274]

TOPS #19

Medical directors should adequately supervise EMS practitioners operating in CP, MIH, or similar programs and set protocols that fully and properly direct patients to appropriate medical facilities. Use of approved, vetted flow charts, or other tools may help insulate against claims of negligence in the transportation of emergency patients, while still allowing flexibility to alter destinations as needed.

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Conclusion

CP, MIH, and similar programs have the potential to bridge gaps between emergency medical services and primary care by utilizing existing EMS and other health personnel to increase patient access to care, lower healthcare costs, and improve health outcomes. Although programs that expand the role of EMS providers have clear benefits, there are multiple legal and policy hurdles stemming from the deployment and use of EMS and other personnel outside the normal emergency framework.

Statutory or regulatory constraints may limit the triggers for EMS personnel to known emergencies through 9-1-1 calls. They may be permitted to provide care and transport only under emergency conditions due to scope of practice limitations. Risks of liability may hinder active CP, MIH, or similar program participation among personnel, medical directors, and healthcare entities. Liability protections usually afforded to EMS and associated professionals generally apply only in emergency situations, leaving aside services provided by EMS personnel outside typical emergency responses. Healthcare reimbursement schemes may not include CP services causing programs to rely on grants or other resources. Restrictions on when and where patients may be transported to alternate destinations can thwart these programs.

Against these and other legal challenges, federal, state, and local governments, in partnership with private sector entities and stakeholders, are crafting meaningful options, best practices, and solutions. States are amending or waiving laws that prohibit or hinder these practices. Some jurisdictions are specifically authorizing CP reimbursement through pilot programs or Medicaid coverage. ACA provides new avenues for reimbursement and encourages hospitals and ACOs to establish cost-saving programs consistent with CP, MIH, and similar programs. Rapid and extensive development of these programs is contingent on successful navigation and resolution of key law and policy issues among partners within and across jurisdictions.

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[85] *Id.* at 1259.

[86] *See, e.g.,* La. Rev. Stat. Ann. § 33:4791.1(1)(A) (2014) ("The provision of consistently high quality emergency medical care, and any and all aspects attendant to ambulance operation to be provided within a medically acceptable response time is essential to the health, safety, and welfare of the state and its people.").

[87] *See, e.g.,* Archie v. City of Ravine, 627 F. Supp. 766 (E.D. Wis. 1986), *aff'd* 847 F.2d 1211 (7th Cir. 1988), *cert. denied*, 489 U.S. 1065 (1989) (failure to dispatch an ambulance to the home of a hyperventilating woman who later died did not violate the Due Process Clause).

[88] 489 U.S. 189 (1989). In *DeShaney*, a child was abused by his father. The Wisconsin Department of Social Services was aware of the circumstances but took no action to protect the child, leading to the child's permanent disability. On behalf of the child, the argument was that the State deprived the child of liberty interests in bodily integrity, in violation of the substantive component of the Fourteenth Amendment's Due Process Clause.

[89] Estelle v. Gamble, 429 U.S. 97 (1976) (holding that the Eighth Amendment requires government to provide healthcare to prisoners); City of Revere v. Massachusetts Gen. Hosp., 463 U.S. 239 (1983) (holding that the Fourteenth Amendment requires government to provide medical care to pretrial detainees).

[90] One jurisdiction has listed the requirements for establishing a special duty as: "1) [w]hether the victim . . . was in legal custody at the time of the incident . . . 2) [w]hether the state has expressly stated its desire to provide affirmative protection to a particular class or specific individuals." Jensen v. Conrad, 747 F.2d 185, 195-96, n.11 (4th Cir. 1984). Another jurisdiction's requirements are: "1) the municipality must be uniquely aware of the particular danger or risk to which plaintiff is exposed, 2) there must be allegations of specific acts or omissions on the part of the municipality, 3) the specific acts or omissions must be either affirmative or willful in nature, and 4) the injury must occur while the plaintiff is under the direct and immediate control of employees or agents of the municipality." Barth v. Board of Educ., 490 N.E.2d 77, 84-85 (Ill. App. Ct. 1986). The Restatement (Second) of Torts § 314A provides that "one who is required by law to take or who voluntarily takes the custody of another under circumstances such as to deprive the other of his normal opportunities for protection" gives rise to a special duty to aid or protect.

[91] Handley v. City of Seagoville, 798 F. Supp. 1267, 1272 (N.D. Tex. 1992); Hendon v. Dekalb County, 417 S.E.2d 705, 712 (Ga. Ct. App. 1992) (finding no liability to stroke victim for failure to respond to a 9-1-1 call); Doe v. Calumet City, 609 N.E.2d 689, 694 (Ill. App. Ct. 1992) (finding no liability for failure to respond to a 9-1-1 call).

[92] Johnson v. District of Columbia, 580 A.2d 140, 141 (D.C. 1990).

[93] *Id*. at 142; *see also* Wazner v. District of Columbia, 580 A.2d 127 (D.C. 1990) (A man called 9-1-1 requesting an ambulance because of bad headaches. The dispatcher suggested he take an aspirin and did not send an ambulance. Nine hours passed and a neighbor requested an ambulance again. The man with the headaches died of a stroke 2 days later. His daughter alleged the District breached its duty to provide an ambulance because the dispatcher was ill-trained or improperly supervised. The court held that D.C. was not liable because it owed the father no special duty.)

[94] Wazner, 580 A.2d at 136.

[95] *See, e.g.*, Nat'l Highway Traffic Safety Admin., National EMS Scope of Practice Model 28–31 (2007), *available at* http://www.ems.gov/education/EMSScope.pdf; "*What is EMS*?,", Nat'l Registry of Emergency Med. Technicians, https://www.nremt.org/nremt/about/What_is_EMS.asp (last visited April 6, 2014); Idaho Code Ann. § 56-1012.

[96] Fla. Stat. § 401.27.

[97] Ga. Code Ann. §§ 31-11-53, -54, -55.

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[108] Cal. Code Regs. tit. 22, § 100146(c) (2).

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[109] *See generally* Or. Admin. R. 847-035-0030 (listing authorized scope of practices for various categories of EMS personnel); *see also* Or. Admin. R. 847-035-0030(2) ("The scope of practice is the maximum functions which may be assigned to an emergency medical services provider by a Board-approved supervising physician.")

[110] Del. Code Ann. tit. 16, § 9807 (authorizing "such services as are set forth in the paramedic's certificate if … provided under the supervision of a physician.")

[111] N.D. Cent. Code § 23-27-04.9(1) ("A licensed emergency medical technician-paramedic working for a hospital or an emergency medical services operation may administer the influenza vaccine to an individual who is at least eighteen years of age if: a. The physician providing oversight for the emergency medical services operation or the hospital medical director has established protocols that meet department standards that may be based on the advisory committee on immunization practices of the federal centers for disease control and prevention; and b. The emergency medical technician-paramedic has satisfactorily completed a department-approved course on administering vaccines.")

[112] *See, e.g.,* Nat'l Highway Traffic Safety Admin., National EMS Scope of Practice Model 15 (2007), *available at* http://www.ems.gov/education/EMSScope.pdf. (distinguishing elements of scope of practice from those of standard of care).

[113] Cal. Civ. Prac. Torts § 32:39, Medical Malpractice (citing Wright v. City of Los Angeles, 219 Cal. App. 3d 318 (Cal. Dist. Ct. App. 1990).

[114] Wright v. City of Los Angeles, 219 Cal. App. 3d 318, 347–48 (Cal. Dist. Ct. App. 1990).

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[116] Or. Rev. Stat. Ann. § 682.025(3).

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[120] Cal. Code Regs. tit. 22, §§ 100063, 100146(c).

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[127] 210 Ill. Comp. Stat. 50/3.10(g).

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[131] *See, e.g.*, Del. Office of Emergency Med. Servs., Statewide Standard Treatment Protocol Delaware: Basic Life Support Protocols, Guidelines and Standing Orders for Prehospital and Interfacility Patients (2013), *available at* http://statefireschool.delaware.gov/pdfs/BLSStandingOrders2013.pdf (last visited May 23, 2014).

[132] *Id.* at 2.

[133] Ariz. Rev. Stat. Ann. § 36-2201(1).

[134] Or. Rev. Stat. Ann. § 682.245.

[135] Ga. Code Ann. § 31-11-50(a).

[136] Ga. Code Ann. § 31-11-60.1 (b).

[137] Ariz. Admin. Code § R9-25-205(D).

[138] Mont. Code Ann. § 50-6-302(8)–(9).

[139] 210 Ill. Comp. Stat. 50/3.10 (allowing Emergency Communications RNs to provide verbal authorization for various types of EMS).

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[141] *See, e.g.*, Joint Comm. on Rural Emergency Care, Nat'l Ass'n of State Emergency Med. Servs. Officials & Nat'l Org. of State Offices of Rural Health, State Perspectives Discussion Paper on Development of Community Paramedic Program 8 (2010), *available at* https://www.nasemso.org/Projects/RuralEMS/documents/CPDiscussionPaper.pdf.

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[143] Ariz. Admin. Code § R9-25-205(A).

[144] *See, e.g.,* Ariz. Admin. Code §§ R9-25-101(66) ("'Standing order' means a treatment protocol or triage protocol that authorizes an EMT to act without online medical direction."), R9-25-101(70) ('Treatment protocol' means a written guideline that prescribes … [h]ow an EMT shall perform a medical treatment on a patient or administer an agent to a patient; and …[w]hen online medical direction is required, if the protocol is not a standing order."); R9-25-101(71) ('Triage protocol' means a written guideline that prescribes … [h]ow an EMT shall … [a]ssess and prioritize the medical condition of a patient[; s]elect a health care institution to which a patient may be transported, and … [t]ransport a patient to a health care institution; and … [w]hen online medical direction is required, if the protocol is not a standing order.").

[145] N.D. Cent. Code § 23-27-04.9.

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[147] *See Emergency Medical Services for Children*, Health Res. & Servs. Admin., http://mchb.hrsa.gov/programs/emergencymedical/ (last visited May 22, 2014); *EMS for Children*, D.C. Dep't of Health, http://doh.dc.gov/service/ems-children (last visited May 23, 2014).

[148] Tallahassee Memorial Regional Medical Center, Inc. v. Meeks, 560 So. 2d 778 (Fla. 1990).

[149] *See, e.g.*, Bowden v. Cary Fire Protection Dist., 710 N.E.2d 548 (Ill. Ct. App. 1999).

[150] *See, e.g.*, Browning v. West Calcasieu Cameron Hosp., 865 So. 2d 795 (La. Ct. App. 3d Cir. 2003).

[151] *See, e.g.*, McCoy v. Hatmaker, 763 A.2d 1233 (Md. Ct. Spec. App. 2000).

[152] 210 Ill. Comp. Stat. 50/3.150(a); Meck v. Paramedic Services of Illinois, 695 N.E.2d 1321 (Ill. App. Ct. 1998).

[153] Idaho Code Ann. § 56-1014.

[154] Ga. Code Ann. § 31-11-8(a).

[155] Cal. Health & Safety Code § 1799.106.

[156] Ga. Code Ann. § 31-11-8(c).

[157] *E.g.*, Thomas v. DeKalb County, 489 S.E.2d 58, 61 (Ga. Ct. App. 1997).

[158] *E.g.*, Martin v. Fulton-DeKalb Hospital Authority, 551 S.E.2d 415 (Ga. Ct. App. 2001).

[159] 210 Ill. Comp. Stat. 50/3.150(a), 50/3.10(g).

[160] Cal. Health & Safety Code § 1799.106.

[161] Fla. Stat. § 768.13.

[162] *See* Willard v. Vicksburg, 571 So. 2d 972 (Miss. 1990) (declining to interpret a Good Samaritan statute, but recommending that the legislature review and amend the statute to clarify application to those with a duty to provide care).

[163] Fla. Stat. § 768.13.

[164] Meuller v. McMillian Warner Ins. Co., 290 Wis. 2d 571 (2006); *see also* 68 A.L.R.4th 294 (discussing application of Good Samaritan statutes generally).

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[165] *See, e.g.*, Leang v. Jersey City Bd. of Educ., 969 A. 2d 1097 (N.J. 2009) (finding that New Jersey's Good Samaritan Act did not apply to situations where care or transportation was provided to a person who was not the victim of an accident or emergency as envisioned by the legislature in passing the Act); *see also* 68 A.L.R.4th 294.

[166] Tallahassee Memorial Regional Medical Center, Inc. v. Meeks, 560 So. 2d 778 (Fla. 1990).

[167] Taplin v. Chatham, 453 N.E.2d 421 (Mass. 1983).

[168] Ga. Code Ann. § 31-11-8(b).

[169] Mont. Code Ann. § 50-6-317.

[170] Utah Code Ann. § 26-8a-601(1).

[171] *See* Kenneth W. Kizer, Karen Shore & Aimee Moulin, Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care, UC Davis, Inst. for Population Health Improvement 11 (2013), *available at* https://www.nasemso.org/Projects/RuralEMS/documents/IPHI_CommunityParamedicineReport_Final-070913.pdf ("Patients recently discharged from a hospital may benefit from assistance prior to regular scheduled follow-up care in understanding post-discharge instructions, medications, self-care, and the timing and importance of follow-up appointments. CPs could review these with patients and, if applicable, their families. The CP could ensure there is a safe home environment for the patient to recover in and could provide feedback to primary care and emergency care providers about the patient's function at home … CPs will need additional training with protocols for patient assessment, and there will need to be greater and potentially additional types of online medical control … for consultation on patients with complex medical conditions …").

[172] *See Beyond 911: State and Community Strategies for Expanding the Primary Care Role of First Responders*, Nat'l Conference of State Legislatures, http://www.ncsl.org/research/health/expanding-the-primary-care-role-of-first-responder.aspx (last visited May 9, 2014).

[173] Ariz. Rev. Stat. Ann. § 36-2220(B).

[174] U.S. Dep't of Health & Human Servs., Summary of the HIPAA Privacy Rule (2003), *available at* http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html.

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[191] Or. Rev. Stat. Ann. § 682.027.

[192] Or. Rev. Stat. Ann. § 333-200-0080 Exhibit 2.

[193] Or. Admin. R. 333-200-0080(4); Or. Rev. Stat. Ann. § 333-200-0080 Exhibit 2.

[194] Or. Rev. Stat. Ann. § 333-200-0080(4); Or. Rev. Stat. Ann. § 333-200-0080 Exhibit 2.

[195] Or. Rev. Stat. Ann. § 333-200-0080(4); Or. Rev. Stat. Ann. § 333-200-0080 Exhibit 2.

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[233] Emergency Medical Treatment and Active Labor Act, § 1867, 42 U.S.C.A. § 1395dd; Beller v. Health and Hosp. Corp. of Marion County, Indiana, 703 F.3d 388 (7th Cir. 2012).

[234] Emergency Medical Treatment and Active Labor Act, § 1867, 42 U.S.C.A. § 1395dd.

[235] Dedicated Emergency Department under EMTALA is defined as "any department or facility of the hospital that either 1) is licensed by the state as an emergency department; 2) held out to the public as providing treatment for emergency medical conditions; or 3) on one-third of the visits to the department in the preceding calendar year actually provided treatment for emergency medical conditions on an urgent basis." 42 C.F.R. § 489.24 (b) (4).

[236] Emergency Medical Treatment and Active Labor Act, § 1867, 42 U.S.C.A. § 1395dd.

[237] 42 C.F.R. § 413.65(b).

[238] Hospitals meet the stabilization requirement of EMTALA if they offer further treatment, explain the risks and benefits of the treatment to the patient, and the patient refuses. 42 C.F.R. §489.24(d)(1) & (3). Hospitals should attempt to get patients' written informed consent. Id. Courts have found that patients have the right to refuse emergency medical treatment, but the right is not absolute. *Norwood Hospital v. Munoz*, 409 Mass. 116, 122-126 (citing to a common law right and statutory right of privacy). Other states' statutes specifically provide a person rights to refuse medical treatment (Nothing contained [in the Louisiana Medical Consent Law] shall be construed to abridge any right of a person 18 years of age or over to refuse to consent to medical or surgical treatment as to his own person, LA. REV. STAT. ANN.§ 40:1299.56) which courts have used to defeat a plaintiff's claim that paramedics were liable for failing to bring the patient to an ED following refusal of medical care by a competent adult. *Lemann v. Essen Lane Daiquiris, Inc.*, 923 So.2d 627, 636 (La. 2006).

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[250] Nothing contained [in the Louisiana Medical Consent Law] shall be construed to abridge any right of a person eighteen years of age or over to refuse to consent to medical or surgical treatment as to his own person. LA. REV. STAT. ANN. § 40:1299.56 (1975).

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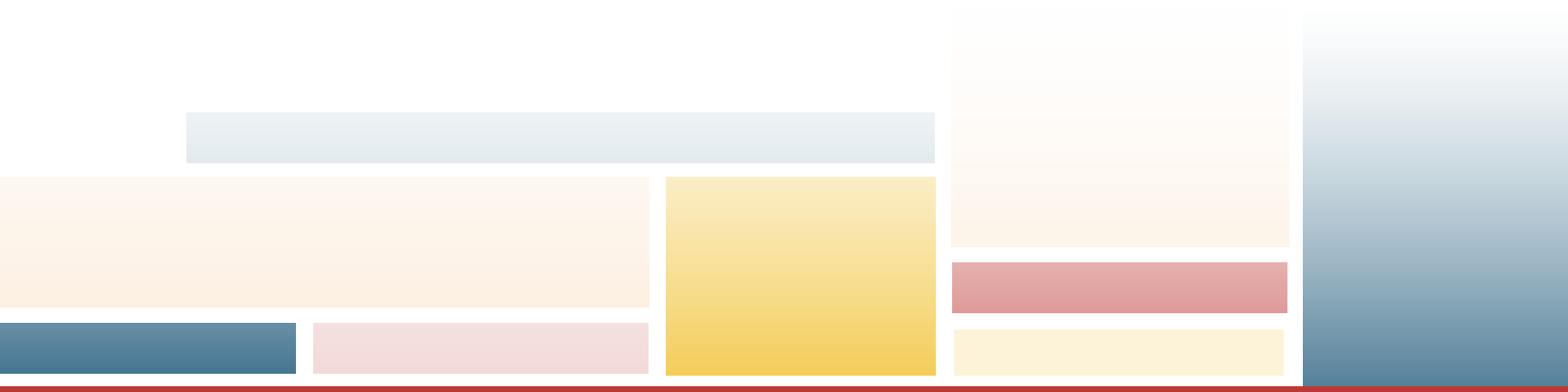

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