REDUCING THE REFUSAL RISK

These can be dangerous calls—know how to maximize both patient safety and your own

By Brian LaCroix, FACPE, NRP (ret.)

A 34-year-old type 1 diabetic couldn't be awakened in the morning by his spouse. He'd played in a softball tournament the previous evening, not eaten much, and drunk a few beers with friends. She called 9-1-1, and shortly after the paramedics started an IV and pushed some D50, the man sat up in bed and, looking slightly embarrassed, asked, "What are you guys doing here?"

Mom jumped to her feet as she realized she hadn't seen her 8-year-old for several minutes. Panic-stricken, she surveyed the community pool and finally caught a glimpse of his small body hovering near the bottom. Bystanders quickly pulled the child to the surface. By the time the ambulance arrived, he was awake, alert, and talking. The crew did an assessment, checked vital signs, and consoled his mother. All seemed well.

At 92 Iris still lived alone, took care of her own property, and traveled by bus on weekly grocery and pharmacy outings. This night she took a tumble. It wasn't much but left her with a nasty laceration on her forehead that would not stop bleeding. She didn't want to be a bother but finally felt the need for some help. She walked over to a neighbor, who called 9-1-1. When the crew arrived the bleeding had stopped, and Iris insisted she go home and back to bed.

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Leadership Perspective

No-loads, no-transports, patient refusals—call them what you like, but across the United States approximately a quarter of all ambulance responses result in patients being seen by EMS but never transported to a hospital.

Often leaving a patient where you found them is appropriate, but sometimes no-transports can pose extremely high risk in terms of patient safety and organizational exposure. In our examples above, most would probably agree a known diabetic who has a clear history, serial glucose checks to document the crisis has passed, and a responsible person to help monitor them is an appropriate candidate to stay home. In contrast, a pediatric near-drowning and an elderly head injury are quite different stories.

EMS agencies that pay little attention to no-transports do so at the peril of missing important clinical and operational markers. That doesn't mean organizations need to suffocate their staff and keep them from making well-informed decisions in the field. But it takes a bundle that includes organizational commitment, provider education, medical director engagement, and continuous quality review acumen to get this right.

Clinical Considerations

Many times EMS providers can take care of patients at scenes simply fine. When done properly this can avoid unnecessary rides in the ambulance, emergency department visits, and medical bills. To keep your patients safe in the process requires an evidence-based assessment process to determine whether patients can safely be managed without emergency transport to an acute care facility.

The National Association of EMS Physicians cautions, "A prerequisite to EMS provider decision to not transport requires, at a minimum, additional education for the providers, a quality improvement process, and stringent physician oversight."

Be clear with clinicians in your agency that no-transports are a big deal in terms of potential untoward outcomes. Treat this practice as the high-risk venture it is. Today

more than ever there is meaningful acceptance of using prehospital providers in ways that help care for our communities while empowering people to stay at home. Programs such as mobile integrated healthcare initiatives and the Emergency Triage, Treat, and Transport (ET3) model are real and growing progress in finding ways for prehospital providers to be part of the reinvention of American healthcare. Clear medical protocols, supportive education, and provider feedback, backed with a solid chart-review process, can help assure these practices are safe and honor the promise to do no harm.

Organizational Culture

There is a sign hanging inside a fire station in Hyannis, Md. It's above the door that separates the kitchen and the apparatus floor and reads, *I Am Here to Go on Calls!* Further commentary from fire blogger Nick Martin elaborates, *The firehouse is not where you go to take a nap, wash your car, watch TV, [or] do your part-time job.*

Every type of EMS agency can benefit from this message. It clearly sets a tone that as providers, it's not about us, it's about our patients. And while that may seem obvious, messages like this can serve a purpose. Sadly, there remain a handful of providers within our profession who work as hard at getting out of calls and transports as they would if they transported in the first place.

There is plenty of evidence that a lot of people who call for ambulances don't really need one. But consider this reality: The decision to not transport them is not the field provider's to make arbitrarily. We should follow evidence-based best practices, the thoughtful guidance of medical direction, and the policies of our organizations. Really good EMS providers are never cavalier about leaving a patient behind.

Education and Engineering

In-field tools and training for field personnel, such as the Paramedics Assessing Elders at Risk for Independence Loss (PERIL) checklist, can be helpful in predicting those who may experience a poor outcome if left alone. Such clinically based tools are not common in our profession. Too often EMTs and paramedics are somehow expected to develop a supernatural "spidey sense" about who might do well or poorly if not transported. In general it is best for field providers to operate from a default mind-set in favor of transport, but well-thought-out protocols vetted by trained quality officers and medical directors and tested in the real world can be helpful.

We might learn from other countries in Western Europe, Asia, and elsewhere that have actively explored alternative methods of triage, starting in the communication center. Often these progressive approaches result in not sending ambulances for low-priority calls. France, Sweden, Croatia, and others have adopted nationwide dispatch protocols that give telecommunicators extraordinary latitude in whether to send an ambulance or refer the caller to some other, more appropriate service.

The Economics

Most EMS providers are still paid only for transporting patients. That on average we only transport 75% of the people who call us means we forfeit payment for about 25% of the work we do. This is often chalked up to the cost of preparedness. Obviously we must be ready to respond to requests for service, whether it's a busy shift or a slow one. But except for some novel programs and pilot projects, we only get paid when we transport.

Imagine for a minute that you operate a restaurant, hardware store, or lawn service. Think about how long you would remain in business if you gave away a quarter of your services for free! That's exactly how EMS economics works in America.

Of course, fire departments, third services, and certain other organizations receive tax dollars and other subsidies. But this money is often far from what's needed to offset the cost of an ambulance operation. And the majority of services in America (approximately 60%) receive little or nothing in terms of tax dollars.

Nearly a decade ago NHTSA did a comprehensive analysis of EMS demographics in the United States. It still holds up as some of the best data we have available. At the time there were about 21,000 licensed ambulance services in the U.S. Approximately 40% were fire-based, and the remainder consisted of nonprofit, hospital-based, third-service, for-profit, and tribal groups. But it showed that regardless of an organization's tax status, its frequency of no-transports had a direct impact on the amount of revenue it received.

This is not to suggest ambulance crews should transport patents just to generate revenue. To the contrary, any such unethical practice should be rebuked in the strongest of terms. Rather, this is solely to point out the inequities of the financial system and the challenging balance EMS leaders must strike to attain both financial health and exceptional care.

Conclusion

Medical necessity, defined as when the patient's condition is such that use of any other method of transportation is contraindicated; social determinants of health, i.e., external and environmental conditions that put a patient in danger, such as an abusive household or lacking food or plumbing; and high-risk predictors like alcohol use, head injuries in the elderly, and other clinical indicators must drive our decisions about whether to transport patients to hospitals.

Great EMS organizations demand high-risk no-transport calls be reviewed using the industry's best quality review practices. Leadership should nurture a "patients first" culture that rewards clinicians who put service above self and holds accountable those who do not.

RESOURCES

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