

Arkansas Department of Health
Office of Preparedness and Emergency Response, Section of EMS
Arkansas EMS Advisory Committee
Advisory and Recommendations

Arkansas Act 856 (2025) EMS Treatment-in-Place (TIP) Model Guidelines

As prepared by the Clinical Practices Subcommittee

A. Executive Summary

Emergency Medical Services (EMS) in Arkansas function as a healthcare entity delivering medical evaluation, treatment, and clinical decision-making under physician medical direction. Every EMS response constitutes a medical encounter performed under physician-approved standing orders and clinical oversight.

Historically, EMS systems have been structured around mandatory transport to emergency departments (EDs). However, modern EMS practice recognizes that not every ambulance encounter requires transport. Many low-acuity patients receive definitive evaluation and treatment on scene, and safe non-transport may be clinically appropriate when performed within a structured, physician-governed framework.

Arkansas EMS systems are increasingly expected to operate as mobile healthcare providers rather than transport-only services. Enabling treatment in place (TIP):

- Recognizes EMS clinicians as licensed medical professionals practicing under physician supervision
- Supports delivery of definitive care at the top of scope
- Reduces unnecessary ambulance transports
- Mitigates strain on overburdened emergency departments
- Improves rural access to appropriate care
- Reduces unnecessary healthcare expenditures for patients and the system

Treatment in place does NOT expand EMS scope of practice. Rather, it formalizes completion of EMS medical care on scene when clinically appropriate and when patients decline transport after a medical evaluation.

This document serves as a model guideline from the Arkansas Department of Health (ADH) Section of EMS, which is created, reviewed, and approved by the Arkansas EMS Advisory Committee, per the statutory authority granted under Act 856 of the 2025 Arkansas General Assembly. Under Act 856, EMS agencies may perform TIP without a physician telemedicine consultation when operating under these approved guidelines and their medical director oversight.

Key clarifications of Act 856 and this guideline are as follows:

- TIP may be billable to insurers when performed under state-approved guidelines
- TIP does not guarantee reimbursement or payment per Act 480 of the 2023 General Assembly or Act 856 of the 2025 General Assembly, and the ADH Section of EMS makes no such claims or guarantees
- Payment remains dependent on payer policies and documentation
- Medical director governance remains required
- EMS scope of practice remains unchanged

This guideline provides a standardized framework to support safe statewide adoption, and the Arkansas EMS Advisory Committee has written the following guidelines and clinical pathways for consideration and adoption by individual EMS agencies, with consultation from their agency medical director:

1. Treatment-in-Place of Patients with General Illness
2. Treatment-in-Place of Patients with Lift Assist Without Injury
3. Treatment-in-Place of Patients with Hypoglycemia
4. Treatment-in-Place of Patients with End-of-Life Care
5. Treatment-in-Place of Patients with Asthma Exacerbation
6. Treatment-in-Place of Patients in Out-of-Hospital Cardiac Arrest



Arkansas EMS Advisory Committee Treatment-in-Place Guidelines For Patients With General Illness



Definition: Treatment in Place (TIP) refers to completion of EMS medical evaluation and/or treatment on scene, which may consist of assessment only, assessment with monitoring, or evaluation with treatment, followed by a non-transport disposition chosen by the patient after EMS has recommended transport. TIP is considered completed medical care, not abandonment.

1. General Principles of TIP:
 - a. All EMS encounters are medical evaluations performed under physician standing orders. Medical assessment, clinical evaluation, monitoring, and decision-making constitute medical treatment, regardless of patient disposition.
 - b. Transport to definitive care should be recommended in all cases. However, patients with decision-making capacity may decline transport after evaluation.
 - c. TIP requires structured documentation and patient education.
 - d. TIP must follow approved clinical guidelines for general assessment and treatment of patients by the EMS agency.
 - e. TIP does not replace physician- or hospital-based care.
 - f. TIP does not authorize EMS clinicians to provide outpatient, primary care, or diagnostic services, and does not expand the scope of practice or treatment authority.
2. Patients with General Illness may be considered for TIP with (including, but not limited to):
 - a. Mild upper respiratory viral symptoms.
 - b. Minor nausea or limited episodes of vomiting or diarrhea.
 - c. Fatigue or generalized weakness.
 - d. Other minor conditions not considered to be high-risk or require emergent or urgent transport or evaluation in an emergency department.
 - e. High-utilizers with low acuity medical complaints, well-known to the EMS agency, who are at their baseline physical and mental status.
3. Inclusion Criteria:
 - a. Expected mental status (or patient at their baseline, per reliable bystanders).
 - b. Vitals within age-appropriate expected parameters.
 - c. No high-risk comorbid symptoms.
 - d. Decision-making capacity intact, or guardian/MPOA available to make decisions for

- patient.
 - e. Symptoms are mild, considered low-risk, or improving compared to initial complaint.
 - f. No concerning findings on assessment.
 - g. Patient (or guardian) understands risks and declines transport.
 - h. A safe environment exists for the patient.
4. Initial Actions:
- a. Perform assessment and care per EMS agency's Universal Care and other applicable protocols or guidelines relevant to the patient's complaint or nature of illness.
 - b. Identify and manage immediate life-threatening conditions.
 - c. Obtain and document a medical assessment appropriate to the patient's presentation, including vital signs and relevant clinical findings (including pertinent negatives, if applicable).
5. Medical Evaluation and Recommendations:
- a. Based on assessment findings, determine the need for ambulance transport.
 - b. When clinically appropriate, recommend transport to a hospital, agency-approved alternative destination, or other appropriate facility.
 - c. Explain the findings, recommendations, risks, benefits, and alternatives to the patient or legal decision-maker in clear, understandable language.
6. Decision-Making Capacity:
- a. Before non-transport disposition, EMS clinicians shall assess and document the patient's decision-making capacity, including the ability to:
 - i. Understand their condition.
 - ii. Understand risks and benefits of non-transport vs transport.
 - iii. Communicate a consistent decision.
 - b. In situations where patients lack decision-making capacity, EMS shall follow their agency's protocols and policies for refusal. EMS transport should be strongly encouraged.
7. Care Pathway:
- a. Following medical evaluation, EMS care shall proceed along one of the following pathways:
 - i. Transport-Level Care
 - 1. Patient is evaluated and managed with the intent to transport.
 - 2. Transport proceeds if the patient agrees.
 - ii. Treatment-in-Place (TIP)
 - 1. Patient receives EMS treatment and/or evaluation on scene.
 - 2. Care is completed under physician-approved standing orders and per EMS agency protocols or guidelines.
 - 3. TIP constitutes completed EMS medical care and is not a refusal of care. Documentation should reflect the full patient encounter.
 - 4. When TIP includes treatment or intervention, EMS clinicians may only

perform the assessments, interventions, and medication administration explicitly allowed by the EMS agency's protocols or guidelines.

iii. Limited Evaluation

1. Patient or legal representative limits or terminates further assessment or treatment after initial EMS contact.
2. Risks of limiting care must be explained and documented.
3. A PCR is required for all Limited Evaluation encounters and must document the assessment elements completed, those assessment elements declined, and the patient's stated decision.

8. Final Disposition Decision:

a. Following completion or limitation of EMS care, one of the following disposition outcomes shall be determined:

i. Transport

1. Patient agrees to ambulance transport.

ii. Patient Declines Ambulance Transport

1. EMS recommended transport, and patient or legal representative declines transport after medical evaluation and discussion of risks. Follow all local EMS agency protocols and policies for documentation of patient refusal of transport, including relevant signatures, audio recordings, etc.

iii. Patient Declines Further EMS Treatment or Assessment

1. Patient or legal representative declines continued EMS care before completion of assessment or treatment.

9. On-Line Medical Control and Medical Oversight:

a. Medical oversight consultation should be strongly considered for:

i. High-risk non-transport decisions.

1. Follow EMS agency existing policies, procedures, protocols, or guidelines for refusal of care/AMA.
2. Discussion of risks of refusal should come directly from the online medical control physician.
3. Consider video/audio recording for improved risk management.

ii. Uncertain decision-making capacity by the patient or legal guardian.

iii. Any situation where EMS clinicians request guidance.

b. Follow local EMS agency protocols for engaging online medical control with patient refusal of care.

10. Guardianship:

a. Consent for minors and other special patient populations should follow established EMS agency protocols, policies, and guidelines for guardianship, power of attorney, and advanced directives.

b. All efforts should be made to get consent directly from the patient or legal guardian.

c. EMS clinicians shall document the name and legal authority of the decision-maker.

d. When a legal decision-maker is unavailable, and delay would endanger the patient,

implied consent applies.

11. Follow-Up Care:

- a. EMS agencies may consider scheduled follow up communications (callback within 4-24 hours) with patients and also encourage them to activate the 911 system if they change their mind about being transported or if things worsen.
 - i. If available, consider internal referral or scheduled follow-up with Community Paramedicine or Mobile Integrated Health.
- b. If reasonable and time permits, EMS clinicians should consider coordinating with the patient's already established primary care, home health services, or specialty physicians as appropriate. During normal business hours, consider assisting the patient with contacting their healthcare professionals and notify them of your assessment findings and any treatments offered. These offices may be more willing to work the patient into a close follow-up appointment hearing from a trained medical professional. This further establishes EMS as a medical authority and healthcare professional and simultaneously achieves the goal of assisting patients obtain follow-up care for management of their chronic conditions. Any such attempts should be documented in the ePCR, including the name and role of the individual whom EMS contacted.
- c. Provide instructions and escalation guidance if symptoms worsen or recur.
- d. For EMS agency high utilizers well known to the EMS agency, consider additional resources such as community social work or hospital-based case management.

12. EMS Quality Management and Data Collection

- a. EMS agencies should review all episodes of TIP for appropriateness of assessment, treatments provided on scene (if any), and documentation (including detailed assessment, interventions, description of discussion of risks or education provided, signatures, recordings, appropriate disposition, etc.).
- b. EMS agencies should ensure they are using the appropriate dispositions for TIP encounters (per NEMSIS V3.5 Definitions):
 - i. eDisposition.27 (only the following):
 1. Patient Contact Made
 - ii. eDisposition.28 (any of the following):
 1. Patient Evaluated and Care Provided
 2. Patient Evaluated and Refused Care
 3. Patient Evaluated, No Care Required
 4. Patient Refused Evaluation/Care
 - iii. eDisposition.29 (any of the following):
 1. Initiated and Continued Primary Care
 2. Assumed Primary Care from Another EMS Crew
 3. Back in Service, No Care/Support Services Required
 4. Back in Service, Care/Support Services Refused
 - iv. eDisposition.30 (only the following):
 1. Patient Refused Transport
 2. Do NOT use "No Transport" in TIP encounters



Arkansas EMS Advisory Committee
Treatment-in-Place Guidelines
For Patients With Lift Assist
Without Injury



Definition: Treatment in Place (TIP) refers to completion of EMS medical evaluation and/or treatment on scene, which may consist of assessment only, assessment with monitoring, or evaluation with treatment, followed by a non-transport disposition chosen by the patient after EMS has recommended transport. TIP is considered completed medical care, not abandonment.

1. General Principles of TIP:
 - a. All EMS encounters are medical evaluations performed under physician standing orders. Medical assessment, clinical evaluation, monitoring, and decision-making constitute medical treatment, regardless of patient disposition.
 - b. Transport to definitive care should be recommended in all cases. However, patients with decision-making capacity may decline transport after evaluation.
 - c. TIP requires structured documentation and patient education.
 - d. TIP must follow approved clinical guidelines for general assessment and treatment of patients by the EMS agency.
 - e. TIP does not replace physician- or hospital-based care.
 - f. TIP does not authorize EMS clinicians to provide outpatient, primary care, or diagnostic services, and does not expand the scope of practice or treatment authority.
2. Patients with Lift Assist Without Injury may be considered for TIP with (including, but not limited to):
 - a. Mechanical fall from loss of balance, trip, slip, stumble, etc.
 - b. Prolonged sitting position and unable to stand and mobilize
3. Inclusion Criteria:
 - a. Expected mental status (or patient at their baseline, per reliable bystanders).
 - b. No obvious injuries or concerning findings on exam; no high-risk comorbid symptoms.
 - c. Patient did NOT hit head or have syncope or loss of consciousness.
 - d. Vitals within age-appropriate expected parameters.
 - e. Decision-making capacity intact, or guardian/MPOA available to make decisions for patient.
 - f. The cause of the fall was NOT due to weakness, lightheadedness, near syncope, or other similarly concerning feature.

- g. Patient able to ambulate at their baseline, with or without their normal assistive devices.
- h. There is no concern for recent increased frequency of falls, and there is no concern that the patient will fall again or require assistance with mobilization in the near future.
- i. Patient (or guardian) understands risks and declines transport.
- j. A safe environment exists for the patient.

4. Initial Actions:

- a. Perform assessment and care per EMS agency's Universal Care and other applicable protocols or guidelines relevant to the patient's complaint or nature of illness.
- b. Identify and manage immediate life-threatening conditions.
- c. Obtain and document a medical assessment appropriate to the patient's presentation, including vital signs and relevant clinical findings (including pertinent negatives, if applicable).

5. Medical Evaluation and Recommendations:

- a. Based on assessment findings, determine the need for ambulance transport.
- b. When clinically appropriate, recommend transport to a hospital, agency-approved alternative destination, or other appropriate facility.
- c. Explain the findings, recommendations, risks, benefits, and alternatives to the patient or legal decision-maker in clear, understandable language.

6. Decision-Making Capacity:

- a. Before non-transport disposition, EMS clinicians shall assess and document the patient's decision-making capacity, including the ability to:
 - i. Understand their condition.
 - ii. Understand risks and benefits of non-transport vs transport.
 - iii. Communicate a consistent decision.
- b. In situations where patients lack decision-making capacity, EMS shall follow their agency's protocols and policies for refusal. EMS transport should be strongly encouraged.

7. Care Pathway:

- a. Following medical evaluation, EMS care shall proceed along one of the following pathways:
 - i. Transport-Level Care
 - 1. Patient is evaluated and managed with the intent to transport.
 - 2. Transport proceeds if the patient agrees.
 - ii. Treatment-in-Place (TIP)
 - 1. Patient receives EMS treatment and/or evaluation on scene.
 - 2. Care is completed under physician-approved standing orders and per EMS agency protocols or guidelines.
 - 3. TIP constitutes completed EMS medical care and is not a refusal of care. Documentation should reflect the full patient encounter.
 - 4. When TIP includes treatment or intervention, EMS clinicians may only

perform the assessments, interventions, and medication administration explicitly allowed by the EMS agency's protocols or guidelines.

iii. Limited Evaluation

1. Patient or legal representative limits or terminates further assessment or treatment after initial EMS contact.
2. Risks of limiting care must be explained and documented.
3. A PCR is required for all Limited Evaluation encounters and must document the assessment elements completed, those assessment elements declined, and the patient's stated decision.

8. Final Disposition Decision:

a. Following completion or limitation of EMS care, one of the following disposition outcomes shall be determined:

i. Transport

1. Patient agrees to ambulance transport.

ii. Patient Declines Ambulance Transport

1. EMS recommended transport, and patient or legal representative declines transport after medical evaluation and discussion of risks. Follow all local EMS agency protocols and policies for documentation of patient refusal of transport, including relevant signatures, audio recordings, etc.

iii. Patient Declines Further EMS Treatment or Assessment

1. Patient or legal representative declines continued EMS care before completion of assessment or treatment.

9. On-Line Medical Control and Medical Oversight:

a. Medical oversight consultation should be strongly considered for:

i. High-risk non-transport decisions.

1. Follow EMS agency existing policies, procedures, protocols, or guidelines for refusal of care/AMA.
2. Discussion of risks of refusal should come directly from the online medical control physician.
3. Consider video/audio recording for improved risk management.

ii. Uncertain decision-making capacity by the patient or legal guardian.

iii. Any situation where EMS clinicians request guidance.

b. Follow local EMS agency protocols for engaging online medical control with patient refusal of care.

10. Guardianship:

a. Consent for minors and other special patient populations should follow established EMS agency protocols, policies, and guidelines for guardianship, power of attorney, and advanced directives.

b. All efforts should be made to get consent directly from the patient or legal guardian.

c. EMS clinicians shall document the name and legal authority of the decision-maker.

d. When a legal decision-maker is unavailable, and delay would endanger the patient,

implied consent applies.

11. Follow-Up Care:

- a. EMS agencies may consider scheduled follow up communications (callback within 4-24 hours) with patients and also encourage them to activate the 911 system if they change their mind about being transported or if things worsen.
 - i. If available, consider internal referral or scheduled follow-up with Community Paramedicine or Mobile Integrated Health.
- b. If reasonable and time permits, EMS clinicians should consider coordinating with the patient's already established primary care, home health services, or specialty physicians as appropriate. During normal business hours, consider assisting the patient with contacting their healthcare professionals and notify them of your assessment findings and any treatments offered. These offices may be more willing to work the patient into a close follow-up appointment hearing from a trained medical professional. This further establishes EMS as a medical authority and healthcare professional and simultaneously achieves the goal of assisting patients obtain follow-up care for management of their chronic conditions. Any such attempts should be documented in the ePCR, including the name and role of the individual whom EMS contacted.
- c. Provide instructions and escalation guidance if symptoms worsen or recur.
- d. For EMS agency high utilizers well known to the EMS agency, consider additional resources such as community social work or hospital-based case management.

12. EMS Quality Management and Data Collection

- a. EMS agencies should review all episodes of TIP for appropriateness of assessment, treatments provided on scene (if any), and documentation (including detailed assessment, interventions, description of discussion of risks or education provided, signatures, recordings, appropriate disposition, etc.).
- b. EMS agencies should ensure they are using the appropriate dispositions for TIP encounters (per NEMSIS V3.5 Definitions):
 - i. eDisposition.27 (only the following):
 1. Patient Contact Made
 - ii. eDisposition.28 (any of the following):
 1. Patient Evaluated and Care Provided
 2. Patient Evaluated and Refused Care
 3. Patient Evaluated, No Care Required
 4. Patient Refused Evaluation/Care
 - iii. eDisposition.29 (any of the following):
 1. Initiated and Continued Primary Care
 2. Assumed Primary Care from Another EMS Crew
 3. Back in Service, No Care/Support Services Required
 4. Back in Service, Care/Support Services Refused
 - iv. eDisposition.30 (only the following):
 1. Patient Refused Transport
 2. Do NOT use "No Transport" in TIP encounters



Arkansas EMS Advisory Committee Treatment-in-Place Guidelines For Patients With Hypoglycemia



Definition: Treatment in Place (TIP) refers to completion of EMS medical evaluation and/or treatment on scene, which may consist of assessment only, assessment with monitoring, or evaluation with treatment, followed by a non-transport disposition chosen by the patient after EMS has recommended transport. TIP is considered completed medical care, not abandonment.

1. General Principles of TIP:
 - a. All EMS encounters are medical evaluations performed under physician standing orders. Medical assessment, clinical evaluation, monitoring, and decision-making constitute medical treatment, regardless of patient disposition.
 - b. Transport to definitive care should be recommended in all cases. However, patients with decision-making capacity may decline transport after evaluation.
 - c. TIP requires structured documentation and patient education.
 - d. TIP must follow approved clinical guidelines for general assessment and treatment of patients by the EMS agency.
 - e. TIP does not replace physician- or hospital-based care.
 - f. TIP does not authorize EMS clinicians to provide outpatient, primary care, or diagnostic services, and does not expand the scope of practice or treatment authority.
2. Patients with Hypoglycemia may be considered for TIP with:
 - a. Episode of hypoglycemia with symptoms fully resolved.
 - b. Use of oral glucose or intravenous dextrose to correct episode of hypoglycemia.
3. Inclusion Criteria:
 - a. Expected mental status (or patient at their baseline, per reliable bystanders).
 - b. Vitals within age-appropriate expected parameters.
 - c. Repeat glucose > 80 mg/dL after treatment (either oral or intravenous).
 - d. No seizure activity.
 - e. Not on long-acting sulfonylureas (e.g. glipizide, glyburide, glimepiride).
 - f. Able to tolerate oral intake and is eating in presence of EMS.
 - g. No complicating symptoms or comorbidities (chest pain, SOB, intoxication, sepsis, etc).
 - h. Decision-making capacity intact, or guardian/MPOA available to make decisions for patient.

- i. Patient (or guardian) understands risks and declines transport.
 - j. A safe environment exists for the patient.
4. Initial Actions:
 - a. Perform assessment and care per EMS agency's Universal Care and other applicable protocols or guidelines relevant to the patient's complaint or nature of illness.
 - b. Identify and manage immediate life-threatening conditions.
 - c. Obtain and document a medical assessment appropriate to the patient's presentation, including vital signs and relevant clinical findings (including pertinent negatives, if applicable).
5. Medical Evaluation and Recommendations:
 - a. Based on assessment findings, determine the need for ambulance transport.
 - b. When clinically appropriate, recommend transport to a hospital, agency-approved alternative destination, or other appropriate facility.
 - c. Explain the findings, recommendations, risks, benefits, and alternatives to the patient or legal decision-maker in clear, understandable language.
6. Decision-Making Capacity:
 - a. Before non-transport disposition, EMS clinicians shall assess and document the patient's decision-making capacity, including the ability to:
 - i. Understand their condition.
 - ii. Understand risks and benefits of non-transport vs transport.
 - iii. Communicate a consistent decision.
 - b. In situations where patients lack decision-making capacity, EMS shall follow their agency's protocols and policies for refusal. EMS transport should be strongly encouraged.
7. Care Pathway:
 - a. Following medical evaluation, EMS care shall proceed along one of the following pathways:
 - i. Transport-Level Care
 1. Patient is evaluated and managed with the intent to transport.
 2. Transport proceeds if the patient agrees.
 - ii. Treatment-in-Place (TIP)
 1. Patient receives EMS treatment and/or evaluation on scene.
 2. Care is completed under physician-approved standing orders and per EMS agency protocols or guidelines.
 3. TIP constitutes completed EMS medical care and is not a refusal of care. Documentation should reflect the full patient encounter.
 4. When TIP includes treatment or intervention, EMS clinicians may only perform the assessments, interventions, and medication administration explicitly allowed by the EMS agency's protocols or guidelines.
 - iii. Limited Evaluation

1. Patient or legal representative limits or terminates further assessment or treatment after initial EMS contact.
 2. Risks of limiting care must be explained and documented.
 3. A PCR is required for all Limited Evaluation encounters and must document the assessment elements completed, those assessment elements declined, and the patient's stated decision.

8. Final Disposition Decision:
 - a. Following completion or limitation of EMS care, one of the following disposition outcomes shall be determined:
 - i. Transport
 1. Patient agrees to ambulance transport.
 - ii. Patient Declines Ambulance Transport
 1. EMS recommended transport, and patient or legal representative declines transport after medical evaluation and discussion of risks. Follow all local EMS agency protocols and policies for documentation of patient refusal of transport, including relevant signatures, audio recordings, etc.
 - iii. Patient Declines Further EMS Treatment or Assessment
 1. Patient or legal representative declines continued EMS care before completion of assessment or treatment.

9. On-Line Medical Control and Medical Oversight:
 - a. Medical oversight consultation should be strongly considered for:
 - i. High-risk non-transport decisions.
 1. Follow EMS agency existing policies, procedures, protocols, or guidelines for refusal of care/AMA.
 2. Discussion of risks of refusal should come directly from the online medical control physician.
 3. Consider video/audio recording for improved risk management.
 - ii. Uncertain decision-making capacity by the patient or legal guardian.
 - iii. Any situation where EMS clinicians request guidance.
 - b. Follow local EMS agency protocols for engaging online medical control with patient refusal of care.

10. Guardianship:
 - a. Consent for minors and other special patient populations should follow established EMS agency protocols, policies, and guidelines for guardianship, power of attorney, and advanced directives.
 - b. All efforts should be made to get consent directly from the patient or legal guardian.
 - c. EMS clinicians shall document the name and legal authority of the decision-maker.
 - d. When a legal decision-maker is unavailable, and delay would endanger the patient, implied consent applies.

11. Follow-Up Care:

- a. EMS agencies may consider scheduled follow up communications (callback within 4-24 hours) with patients and also encourage them to activate the 911 system if they change their mind about being transported or if things worsen.
 - i. If available, consider internal referral or scheduled follow-up with Community Paramedicine or Mobile Integrated Health.
- b. If reasonable and time permits, EMS clinicians should consider coordinating with the patient's already established primary care, home health services, or specialty physicians as appropriate. During normal business hours, consider assisting the patient with contacting their healthcare professionals and notify them of your assessment findings and any treatments offered. These offices may be more willing to work the patient into a close follow-up appointment hearing from a trained medical professional. This further establishes EMS as a medical authority and healthcare professional and simultaneously achieves the goal of assisting patients obtain follow-up care for management of their chronic conditions. Any such attempts should be documented in the ePCR, including the name and role of the individual whom EMS contacted.
- c. Provide instructions and escalation guidance if symptoms worsen or recur.
- d. For EMS agency high utilizers well known to the EMS agency, consider additional resources such as community social work or hospital-based case management.

12. EMS Quality Management and Data Collection

- a. EMS agencies should review all episodes of TIP for appropriateness of assessment, treatments provided on scene (if any), and documentation (including detailed assessment, interventions, description of discussion of risks or education provided, signatures, recordings, appropriate disposition, etc.).
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 - i. eDisposition.27 (only the following):
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 - ii. eDisposition.28 (any of the following):
 1. Patient Evaluated and Care Provided
 2. Patient Evaluated and Refused Care
 3. Patient Evaluated, No Care Required
 4. Patient Refused Evaluation/Care
 - iii. eDisposition.29 (any of the following):
 1. Initiated and Continued Primary Care
 2. Assumed Primary Care from Another EMS Crew
 3. Back in Service, No Care/Support Services Required
 4. Back in Service, Care/Support Services Refused
 - iv. eDisposition.30 (only the following):
 1. Patient Refused Transport
 2. Do NOT use "No Transport" in TIP encounters



Arkansas EMS Advisory Committee
Treatment-in-Place Guidelines
For Patients With End-of-Life Care



Definition: Treatment in Place (TIP) refers to completion of EMS medical evaluation and/or treatment on scene, which may consist of assessment only, assessment with monitoring, or evaluation with treatment, followed by a non-transport disposition chosen by the patient after EMS has recommended transport. TIP is considered completed medical care, not abandonment.

1. General Principles of TIP:
 - a. All EMS encounters are medical evaluations performed under physician standing orders. Medical assessment, clinical evaluation, monitoring, and decision-making constitute medical treatment, regardless of patient disposition.
 - b. Transport to definitive care should be recommended in all cases. However, patients with decision-making capacity may decline transport after evaluation.
 - c. TIP requires structured documentation and patient education.
 - d. TIP must follow approved clinical guidelines for general assessment and treatment of patients by the EMS agency.
 - e. TIP does not replace physician- or hospital-based care.
 - f. TIP does not authorize EMS clinicians to provide outpatient, primary care, or diagnostic services, and does not expand the scope of practice or treatment authority.
2. Patients requiring End-of-Life Care may be considered for TIP with:
 - a. Episode of definitive treatment provided within patient's existing advanced directives, POLST, or MOLST.
 - b. Episode of care coordinated with contracted home health or hospice agency.
 - c. Discussion between patient, family, or legal guardians indicates that patient's goal is to remain at home.
3. Inclusion Criteria:
 - a. Patient engaged in home health, hospice care, or other EOL care plans in collaboration with another healthcare agency, or family has the care plan immediately available and knowledgeable about patient's current wishes and expected clinical course.
 - b. Patient, family, or guardian requesting focus on comfort and dignity, with interventions such as oxygen therapy, comfort positioning, pain control (per EMS agency guidelines or existing patient care plan), anxiolysis, antiemetics, or non-invasive ventilation for

- work of breathing.
 - c. Decision-making capacity intact, or guardian/MPOA available to make decisions for patient.
 - d. Patient (or guardian) understands risks and declines transport.
 - e. A safe environment exists for the patient.
4. Initial Actions:
- a. Perform assessment and care per EMS agency's Universal Care and other applicable protocols or guidelines relevant to the patient's complaint or nature of illness.
 - b. Identify and manage immediate life-threatening conditions.
 - c. Obtain and document a medical assessment appropriate to the patient's presentation, including vital signs and relevant clinical findings (including pertinent negatives, if applicable).
5. Medical Evaluation and Recommendations:
- a. Based on assessment findings, determine the need for ambulance transport.
 - b. When clinically appropriate, recommend transport to a hospital, agency-approved alternative destination, or other appropriate facility.
 - c. Explain the findings, recommendations, risks, benefits, and alternatives to the patient or legal decision-maker in clear, understandable language.
6. Decision-Making Capacity:
- a. Before non-transport disposition, EMS clinicians shall assess and document the patient's decision-making capacity, including the ability to:
 - i. Understand their condition.
 - ii. Understand risks and benefits of non-transport vs transport.
 - iii. Communicate a consistent decision.
 - b. In situations where patients lack decision-making capacity, EMS shall follow their agency's protocols and policies for refusal. EMS transport should be strongly encouraged.
7. Care Pathway:
- a. Following medical evaluation, EMS care shall proceed along one of the following pathways:
 - i. Transport-Level Care
 - 1. Patient is evaluated and managed with the intent to transport.
 - 2. Transport proceeds if the patient agrees.
 - ii. Treatment-in-Place (TIP)
 - 1. Patient receives EMS treatment and/or evaluation on scene.
 - 2. Care is completed under physician-approved standing orders and per EMS agency protocols or guidelines.
 - 3. TIP constitutes completed EMS medical care and is not a refusal of care. Documentation should reflect the full patient encounter.
 - 4. When TIP includes treatment or intervention, EMS clinicians may only

- perform the assessments, interventions, and medication administration explicitly allowed by the EMS agency's protocols or guidelines.
- iii. Limited Evaluation
 - 1. Patient or legal representative limits or terminates further assessment or treatment after initial EMS contact.
 - 2. Risks of limiting care must be explained and documented.
 - 3. A PCR is required for all Limited Evaluation encounters and must document the assessment elements completed, those assessment elements declined, and the patient's stated decision.
8. Final Disposition Decision:
- a. Following completion or limitation of EMS care, one of the following disposition outcomes shall be determined:
 - i. Transport
 - 1. Patient agrees to ambulance transport.
 - ii. Patient Declines Ambulance Transport
 - 1. EMS recommended transport, and patient or legal representative declines transport after medical evaluation and discussion of risks. Follow all local EMS agency protocols and policies for documentation of patient refusal of transport, including relevant signatures, audio recordings, etc.
 - iii. Patient Declines Further EMS Treatment or Assessment
 - 1. Patient or legal representative declines continued EMS care before completion of assessment or treatment.
9. On-Line Medical Control and Medical Oversight:
- a. Medical oversight consultation should be strongly considered for:
 - i. High-risk non-transport decisions.
 - 1. Follow EMS agency existing policies, procedures, protocols, or guidelines for refusal of care/AMA.
 - 2. Discussion of risks of refusal should come directly from the online medical control physician.
 - 3. Consider video/audio recording for improved risk management.
 - ii. Uncertain decision-making capacity by the patient or legal guardian.
 - iii. Any situation where EMS clinicians request guidance.
 - b. Follow local EMS agency protocols for engaging online medical control with patient refusal of care.
10. Guardianship:
- a. Consent for minors and other special patient populations should follow established EMS agency protocols, policies, and guidelines for guardianship, power of attorney, and advanced directives.
 - b. All efforts should be made to get consent directly from the patient or legal guardian.
 - c. EMS clinicians shall document the name and legal authority of the decision-maker.
 - d. When a legal decision-maker is unavailable, and delay would endanger the patient,

implied consent applies.

11. Follow-Up Care:

- a. EMS agencies may consider scheduled follow up communications (callback within 4-24 hours) with patients and also encourage them to activate the 911 system if they change their mind about being transported or if things worsen.
 - i. If available, consider internal referral or scheduled follow-up with Community Paramedicine or Mobile Integrated Health.
- b. If reasonable and time permits, EMS clinicians should consider coordinating with the patient's already established primary care, home health services, or specialty physicians as appropriate. During normal business hours, consider assisting the patient with contacting their healthcare professionals and notify them of your assessment findings and any treatments offered. These offices may be more willing to work the patient into a close follow-up appointment hearing from a trained medical professional. This further establishes EMS as a medical authority and healthcare professional and simultaneously achieves the goal of assisting patients obtain follow-up care for management of their chronic conditions. Any such attempts should be documented in the ePCR, including the name and role of the individual whom EMS contacted.
- c. Provide instructions and escalation guidance if symptoms worsen or recur.
- d. For EMS agency high utilizers well known to the EMS agency, consider additional resources such as community social work or hospital-based case management.

12. EMS Quality Management and Data Collection

- a. EMS agencies should review all episodes of TIP for appropriateness of assessment, treatments provided on scene (if any), and documentation (including detailed assessment, interventions, description of discussion of risks or education provided, signatures, recordings, appropriate disposition, etc.).
- b. EMS agencies should ensure they are using the appropriate dispositions for TIP encounters (per NEMSIS V3.5 Definitions):
 - i. eDisposition.27 (only the following):
 1. Patient Contact Made
 - ii. eDisposition.28 (any of the following):
 1. Patient Evaluated and Care Provided
 2. Patient Evaluated and Refused Care
 3. Patient Evaluated, No Care Required
 4. Patient Refused Evaluation/Care
 - iii. eDisposition.29 (any of the following):
 1. Initiated and Continued Primary Care
 2. Assumed Primary Care from Another EMS Crew
 3. Back in Service, No Care/Support Services Required
 4. Back in Service, Care/Support Services Refused
 - iv. eDisposition.30 (only the following):
 1. Patient Refused Transport
 2. Do NOT use "No Transport" in TIP encounters.



Arkansas EMS Advisory Committee
Treatment-in-Place Guidelines
For Patients With
Asthma Exacerbation



Definition: Treatment in Place (TIP) refers to completion of EMS medical treatment on scene, which may consist of assessment only, assessment with monitoring, or evaluation with treatment, followed by a non-transport disposition chosen by the patient after EMS has recommended transport. TIP is considered completed medical care, not abandonment.

1. General Principles of TIP:
 - a. All EMS encounters are medical evaluations performed under physician standing orders. Medical assessment, clinical evaluation, monitoring, and decision-making constitute medical treatment, regardless of patient disposition.
 - b. Transport to definitive care should be recommended in all cases. However, patients with decision-making capacity may decline transport after evaluation.
 - c. TIP requires structured documentation and patient education.
 - d. TIP must follow approved clinical guidelines for general assessment and treatment of patients by the EMS agency.
 - e. TIP does not replace physician- or hospital-based care.
 - f. TIP does not authorize EMS clinicians to provide outpatient, primary care, or diagnostic services, and does not expand the scope of practice or treatment authority.
2. Patients with Asthma Exacerbation may be considered for TIP with:
 - a. Encounter for wheezing or shortness of breath in a history of asthma with symptoms fully resolved.
 - b. Use of albuterol nebulizer, albuterol/ipratropium nebulizer, or the patient's albuterol metered dose inhaler.
3. Inclusion Criteria:
 - a. Expected mental status (or patient at their baseline, per reliable bystanders).
 - b. Vitals within age-appropriate expected parameters (allowance for mild tachycardia as a result of the use of bronchodilators).
 - c. Mild wheezing responsive to bronchodilator therapy.
 - d. No respiratory distress following completion of treatment.
 - e. SpO₂ at 94% or greater following therapy (or at baseline for COPD).
 - f. No new oxygen requirement (or at baseline home oxygen requirement).
 - g. No persistent dyspnea, tachypnea, or increased work of breathing.

- h. No chest pain, fevers, or other concerning concomitant symptoms.
- i. Decision-making capacity intact, or guardian/MPOA available to make decisions for patient.
- j. Patient (or guardian) understands risks and declines transport.
- k. A safe environment exists for the patient.

4. Initial Actions:

- a. Perform assessment and care per EMS agency's Universal Care and other applicable protocols or guidelines relevant to the patient's complaint or nature of illness.
- b. Identify and manage immediate life-threatening conditions.
- c. Obtain and document a medical assessment appropriate to the patient's presentation, including vital signs and relevant clinical findings (including pertinent negatives, if applicable).

5. Medical Evaluation and Recommendations:

- a. Based on assessment findings, determine the need for ambulance transport.
- b. When clinically appropriate, recommend transport to a hospital, agency-approved alternative destination, or other appropriate facility.
- c. Explain the findings, recommendations, risks, benefits, and alternatives to the patient or legal decision-maker in clear, understandable language.

6. Decision-Making Capacity:

- a. Before non-transport disposition, EMS clinicians shall assess and document the patient's decision-making capacity, including the ability to:
 - i. Understand their condition.
 - ii. Understand risks and benefits of non-transport vs transport.
 - iii. Communicate a consistent decision.
- b. In situations where patients lack decision-making capacity, EMS shall follow their agency's protocols and policies for refusal. EMS transport should be strongly encouraged.

7. Care Pathway:

- a. Following medical evaluation, EMS care shall proceed along one of the following pathways:
 - i. Transport-Level Care
 - 1. Patient is evaluated and managed with the intent to transport.
 - 2. Transport proceeds if the patient agrees.
 - ii. Treatment-in-Place (TIP)
 - 1. Patient receives EMS treatment and/or evaluation on scene.
 - 2. Care is completed under physician-approved standing orders and per EMS agency protocols or guidelines.
 - 3. TIP constitutes completed EMS medical care and is not a refusal of care. Documentation should reflect the full patient encounter.
 - 4. When TIP includes treatment or intervention, EMS clinicians may only

- perform the assessments, interventions, and medication administration explicitly allowed by the EMS agency's protocols or guidelines.
- iii. Limited Evaluation
 - 1. Patient or legal representative limits or terminates further assessment or treatment after initial EMS contact.
 - 2. Risks of limiting care must be explained and documented.
 - 3. A PCR is required for all Limited Evaluation encounters and must document the assessment elements completed, those assessment elements declined, and the patient's stated decision.
8. Final Disposition Decision:
- a. Following completion or limitation of EMS care, one of the following disposition outcomes shall be determined:
 - i. Transport
 - 1. Patient agrees to ambulance transport.
 - ii. Patient Declines Ambulance Transport
 - 1. EMS recommended transport, and patient or legal representative declines transport after medical evaluation and discussion of risks. Follow all local EMS agency protocols and policies for documentation of patient refusal of transport, including relevant signatures, audio recordings, etc.
 - iii. Patient Declines Further EMS Treatment or Assessment
 - 1. Patient or legal representative declines continued EMS care before completion of assessment or treatment.
9. On-Line Medical Control and Medical Oversight:
- a. Medical oversight consultation should be strongly considered for:
 - i. High-risk non-transport decisions.
 - 1. Follow EMS agency existing policies, procedures, protocols, or guidelines for refusal of care/AMA.
 - 2. Discussion of risks of refusal should come directly from the online medical control physician.
 - 3. Consider video/audio recording for improved risk management.
 - ii. Uncertain decision-making capacity by the patient or legal guardian.
 - iii. Any situation where EMS clinicians request guidance.
 - b. Follow local EMS agency protocols for engaging online medical control with patient refusal of care.
10. Guardianship:
- a. Consent for minors and other special patient populations should follow established EMS agency protocols, policies, and guidelines for guardianship, power of attorney, and advanced directives.
 - b. All efforts should be made to get consent directly from the patient or legal guardian.
 - c. EMS clinicians shall document the name and legal authority of the decision-maker.
 - d. When a legal decision-maker is unavailable, and delay would endanger the patient,

implied consent applies.

11. Follow-Up Care:

- a. EMS agencies may consider scheduled follow up communications (callback within 4-24 hours) with patients and also encourage them to activate the 911 system if they change their mind about being transported or if things worsen.
 - i. If available, consider internal referral or scheduled follow-up with Community Paramedicine or Mobile Integrated Health.
- b. If reasonable and time permits, EMS clinicians should consider coordinating with the patient's already established primary care, home health services, or specialty physicians as appropriate. During normal business hours, consider assisting the patient with contacting their healthcare professionals and notify them of your assessment findings and any treatments offered. These offices may be more willing to work the patient into a close follow-up appointment hearing from a trained medical professional. This further establishes EMS as a medical authority and healthcare professional and simultaneously achieves the goal of assisting patients obtain follow-up care for management of their chronic conditions. Any such attempts should be documented in the ePCR, including the name and role of the individual whom EMS contacted.
- c. Provide instructions and escalation guidance if symptoms worsen or recur.
- d. For EMS agency high utilizers well known to the EMS agency, consider additional resources such as community social work or hospital-based case management.

12. EMS Quality Management and Data Collection

- a. EMS agencies should review all episodes of TIP for appropriateness of assessment, treatments provided on scene (if any), and documentation (including detailed assessment, interventions, description of discussion of risks or education provided, signatures, recordings, appropriate disposition, etc.).
- b. EMS agencies should ensure they are using the appropriate dispositions for TIP encounters (per NEMSIS V3.5 Definitions):
 - i. eDisposition.27 (only the following):
 1. Patient Contact Made
 - ii. eDisposition.28 (any of the following):
 1. Patient Evaluated and Care Provided
 2. Patient Evaluated and Refused Care
 3. Patient Evaluated, No Care Required
 4. Patient Refused Evaluation/Care
 - iii. eDisposition.29 (any of the following):
 1. Initiated and Continued Primary Care
 2. Assumed Primary Care from Another EMS Crew
 3. Back in Service, No Care/Support Services Required
 4. Back in Service, Care/Support Services Refused
 - iv. eDisposition.30 (only the following):
 1. Patient Refused Transport
 2. Do NOT use "No Transport" in TIP encounters.



Arkansas EMS Advisory Committee
Treatment-in-Place Guidelines
For Patients In
Out-Of-Hospital Cardiac Arrest



Definition: Treatment in Place (TIP) refers to completion of EMS medical evaluation and/or treatment on scene, which may consist of assessment only, assessment with monitoring, or evaluation with treatment, followed by a non-transport disposition after collaboration between EMS clinicians and survivors on scene. TIP is considered completed medical care, not abandonment.

1. General Principles of TIP in Out-of-Hospital Cardiac Arrest:
 - a. All EMS encounters are medical evaluations performed under physician standing orders. Medical assessment, clinical evaluation, monitoring, and decision-making constitute medical treatment, regardless of patient disposition.
 - b. Prioritizing the resuscitation of medical cardiac arrests on scene over rapid transport is evidence-based for improved chances of return of spontaneous circulation.
 - c. TIP requires structured documentation and patient education.
 - d. TIP must follow approved clinical guidelines for general assessment and treatment of patients by the EMS agency.
 - e. TIP does not replace physician- or hospital-based care.
 - f. TIP does not authorize EMS clinicians to provide outpatient, primary care, or diagnostic services, and does not expand the scope of practice or treatment authority.
2. Patients in Out-of-Hospital Cardiac Arrest may be considered for TIP with:
 - a. EMS-initiated resuscitation and continued resuscitation on scene until field termination
3. Inclusion Criteria:
 - a. Patient in active cardiac arrest and received on-scene resuscitation attempts by EMS, including but not limited to basic or advanced airway management, chest compressions, IV/IO access, ACLS medications, and/or defibrillation.
 - b. Patient worked on scene until criteria met for field termination.
4. Initial Actions:
 - a. Perform assessment and care per EMS agency's Universal Care and other applicable protocols or guidelines relevant to the patient's complaint or nature of illness.
 - b. Identify and manage immediate life-threatening conditions.

- c. Obtain and document a medical assessment appropriate to the patient's presentation, including vital signs and relevant clinical findings (including pertinent negatives, if applicable).
5. Medical Evaluation and Recommendations:
 - a. Based on assessment findings, determine the need for ambulance transport.
 - b. When clinically appropriate, recommend transport to a hospital, agency-approved alternative destination, or other appropriate facility.
 - c. Explain the findings, recommendations, risks, benefits, and alternatives to the legal decision-maker in clear, understandable language.
6. Decision-Making Capacity:
 - a. While decision-making capacity cannot be determined in out-of-hospital cardiac arrest, it is important to engage survivors and family members on scene and notify of the intent to perform resuscitation on scene for the benefit of improved return of spontaneous circulation chances.
7. Care Pathway:
 - a. Following medical evaluation, EMS care shall proceed along one of the following pathways:
 - i. Transport-Level Care
 1. Patient is evaluated and managed with the intent to transport.
 2. Transport proceeds per EMS agency protocols for out-of-hospital cardiac arrests.
 - ii. Treatment-in-Place (TIP)
 1. Patient receives EMS treatment and/or evaluation on scene.
 2. Care is completed under physician-approved standing orders and per EMS agency protocols or guidelines.
 3. TIP constitutes completed EMS medical care and is not a refusal of care. Documentation should reflect the full patient encounter.
 4. When TIP includes treatment or intervention, EMS clinicians may only perform the assessments, interventions, and medication administration explicitly allowed by the EMS agency's protocols or guidelines.
 - iii. Limited Evaluation
 1. Patient or legal representative limits or terminates further assessment or treatment after initial EMS contact.
 2. Risks of limiting care must be explained and documented.
 3. A PCR is required for all Limited Evaluation encounters and must document the assessment elements completed, those assessment elements declined, and the patient's stated decision.
8. Final Disposition Decision:
 - a. Following completion or limitation of EMS care, one of the following disposition outcomes shall be determined:

- i. Transport
 - 1. Patient requires ambulance transport.
 - ii. No Transport
 - 1. EMS performed on-scene resuscitation until field termination criteria met.
- 9. On-Line Medical Control and Medical Oversight:
 - a. Medical oversight consultation should be utilized if the EMS clinician requires assistance with differential diagnosis, treatment options, or transport decision-making.
 - b. Follow local EMS agency protocols for engaging online medical control.
- 10. Guardianship:
 - a. Consent for minors and other special patient populations should follow established EMS agency protocols, policies, and guidelines for guardianship, power of attorney, and advanced directives.
 - b. All efforts should be made to get consent directly from the legal guardian.
 - c. EMS clinicians shall document the name and legal authority of the decision-maker.
 - d. When a legal decision-maker is unavailable, and delay would endanger the patient, implied consent applies.
- 11. EMS Quality Management and Data Collection
 - a. EMS agencies should review all episodes of TIP for appropriateness of assessment, treatments provided on scene (if any), and documentation (including detailed assessment, interventions, description of discussion of risks or education provided, signatures, recordings, appropriate disposition, etc.).
 - b. EMS agencies should ensure they are using the appropriate dispositions for TIP encounters for out-of-hospital cardiac arrests (per NEMSIS V3.5 Definitions):
 - i. eDisposition.27 (only the following):
 - 1. Patient Contact Made
 - ii. eDisposition.28 (only the following):
 - 1. Patient Evaluated and Care Provided
 - iii. eDisposition.29 (any of the following):
 - 1. Initiated and Continued Primary Care
 - 2. Assumed Primary Care from Another EMS Crew
 - iv. eDisposition.30 (only the following):
 - 1. No Transport