EMTALA
Practitioner Education

2024

MedEd Medical Affairs Education

BAPTIST HEALTH CARE

EMTALA

Legislative History

- Enacted in 1986 to stop the practice of "dumping" emergency room patients without insurance by refusing to admit them, refusing to accept their transfer, or transferring them in an unstable condition.
- "The avowed purpose of EMTALA was not to guarantee that all patients are properly diagnosed or even to ensure that they receive adequate care, but instead to provide an 'adequate first response to a medical crisis' for all patients and to 'send a clear signal to the hospital community…that all Americans, regardless of wealth or status, should know that a **hospital will provide what services it can when they are truly in physical distress.'"**

The EMTALA Answer Book, Moy, Mark, 2011

EMTALA Basics

- Hospitals must perform a Medical Screening Exam ("MSE") on any patient who comes to a "Dedicated Emergency Department" and asks for treatment of a medical condition.
  - Dedicated Emergency Department includes labor and delivery and some psychiatric intake facilities.
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- MSE is the processes required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an emergency medical condition or not. It is not an isolated event – it is an ongoing process.
  - If EMC , patient must be admitted or stabilized before transfer or discharge.
  - If no EMC, hospital's EMTALA obligations end with respect to that patient.

Emergency Medical Condition

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
  - placing the health of the person in serious jeopardy;
  - serious impairment of bodily functions; or
  - serious dysfunction of any bodily part or organ.

- In the case of a pregnant woman who is having contractions, an Emergency Medical condition arises when:
  - There is inadequate time to effect a safe transfer before delivery.
  - Transfer may pose a threat to the health or safety of the woman or the unborn baby.

Outpatients

- A person who has begun to receive outpatient care (other than emergency care) or who is an inpatient is NOT subject to EMTALA even if an emergency medical condition arises and patient is taken to the ER.
  - COP's apply to those patients.

After the MSE

- Patient is either stabilized for transfer or stabilized for discharge, or is admitted for further care.
  - Once a patient is admitted, EMTALA no longer applies, so long as the admission is in good faith.
  - Good faith admission = admitting physician expects that the patient will require at least a one night stay and did not admit to avoid EMTALA.

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Stable for Discharge

- Treating professional in ED determined with reasonable degree of clinical confidence, that the EMC has been resolved.
- Continued care including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow up care as part of the discharge instructions.
- The EMC must be resolved but the underlying medical condition may persist.

Stable for Transfer

- "Stable" means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer or (or the woman has delivered the baby and the placenta).
- Psychiatric patients are stable when they are protected and preventing from injuring or harming themselves or others.

Unstable Transfers

- No unstable transfers unless:
  - The patient or their representative consents in writing to the transfer after being informed of the hospital's obligations and the risks of transfer; or
  - A physician or qualified medical personnel certifies in writing that the benefits of the transfer outweigh the risks.
  - Patient as stable as possible
  - Receiving facility agreement to take patient
  - Delivery of medical records
  - Transfer done via appropriate methods and personnel.

Transfers

- Is a transfer by POV ever appropriate?
  - No
  - In some cases the patient needs immediate or quick attention elsewhere but transfer by ambulance seems like overkill and/or the patient does not want to pay.
  - In those cases:
    - ⇒ Consider whether patient really needs to be transferred or is actually stable for discharge with follow up care in BH ED or outpatient office.
    - ⇒ If not, offer ambulance if medically necessary and if patient refuses, document.
    - ⇒ How can a patient be stable enough to drive himself or ride with family members in a car but not stable enough for discharge?
  - Always offer ambulance and have patient refuse in writing.
  - Never turn away before screening; have patient sign refusal of screening form.

Who Must Accept a Transfer?

- Any hospital with specialized capabilities and capacity must accept transfers from any hospital in the US.
- When in doubt about obligation to accept, accept the patient and deal with it later through formal complaint process or through administrative channels.

Accepting Transfers

- ER Physician has authority to accept/deny all EMTALA transfers (sometimes coordinated via transfer center). ED physician in best position to determine capacity of ED.
- If patient needs stabilizing care in the ED, non-ER physicians do not have authority to accept or deny an EMTALA transfer on behalf of the hospital, even if they are on call.

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When can a hospital refuse transfer?

- Transferring hospital has equal capabilities (lateral transfer).
  Except when special circumstances arise, for example:
  - On-call specialist unexpectedly unavailable
  - Natural disaster
  - Physical plant issues (equipment broken).
- Hospital is at capacity (e.g., diversion or bypass)
  - "At capacity" is not a favored excuse. CMS does not like diversion.
  - CMS will require you to make any accommodations you've made in the past. For example, if you've ever bedded ER patients in hallways or called in extra staff, you have to do all of that before you can say you're at capacity.

Refusing Transfer

- Direct Admits from other Hospitals.
  - Process is better for patient but does not supersede EMTALA obligation.
  - If patient is stable and can wait for a bed, fine. If not, cannot hold up the transfer.
- Can't deny for lack of inpatient bed
  - It's ED capacity that is relevant.
  - Lack of beds on floors may cause backlog in ED to the point that the ED lacks capacity to take the patient due to space or staffing, in which case the hospital may refuse the transfer.

Calling in Specialist

- For ER patients, ER physician has final authority to call in specialist.
- For trauma patients, trauma surgeon has final authority to call in specialist.
- If disagreement, specialist needs to come in and argue about it later.

Enforcement Actions

Providence Hospital (2010)

- Providence refused to accept transfer when it had more specialized capabilities than transferring hospital.
- Patient deteriorated, had to go by helicopter, died that day.
- Providence paid $45,000.

Mobile Infirmary (2010)

- MI refused to accept transfer of patient with upper GI bleed.
- Patient transferred to another hospital 60 miles away after two hours of waiting
- En route, patient deteriorated and had to be transported by helicopter to receiving hospital where he/she died that day.
- Hospital paid $45,000 in fines.

Trident Health, SC (2014)

- EMS called hospital saying it had a patient on the way from the jail.
- When patient arrived, ED nurse informed EMS that they would not treat the patient because the hospital had a "no trespass" order on him.
- EMS took patient to another hospital.
- Hospital paid $40,000.00

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Enforcement Actions

Baptist—Princeton. Birmingham (2014)

- Subdural hematoma patient taken to hospital that could not provide neurosurgery.
- ED physician at first hospital called Baptist ED doc and was told that he needed to talk to the neurosurgeon.
- Call forwarded to the hospitalist who again referred ED doctor to the neurosurgeon.

Baptist Birmingham

- ED doc finally talked to neurosurgeon who said it sounded like the patient was brain dead.
- ED doc said she was not – they just had to paralyze her to intubate her.
- Neurosurgeon said he thought she was brain dead and refused transfer. As he hung up he said he would consult, but would not accept transfer.
- After finding out about neurosurgeon's refusal to talk to patient, Baptist called back original hospital and said they would
- accept, but patient had already been transferred to another facility.
- Baptist paid $40,000.00 in fines.

DHC Medical Center, Tuscaloosa (2014)

- Patient came to ED with GSW to abdomen.
- ED doc called on call general surgeon who said he could not come because he was performing an elective case.
- Surgeon finished that case and went on to another elective case.
- ED doc could not find another surgeon.
- Patient waited two hours in ED, never saw surgeon and died.
- •Hospital paid $40k in fines.

Paulding County Hospital, OH (2018)

- 33 week pregnant patient leaking fluids, pelvic pain, vomiting.
- RN took patient to exam room,
- Told her no OB coverage. She could start treatment at Paulding and be transferred later or her friend could drive her to another hospital where her OB was.
- No MSE
- Patient left POV for 30 minute drive.
- Delivered via c-section, no heartbeat.
- Hospital paid $50,000

Springhill Medical Center (2011)

- SMC failed to accept a transfer of patient with acute upper GI bleed.
- Patient accepted at hospital 100 miles away and died the next day.
- Hospital paid $45,000 in fines.

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Enforcement Actions

L.V. Stabler Memorial, AL (2018)

- 16 y/o 33 weeks pregnant, vaginal bleeding and pain.
- RN took vital signs and fetal heart rate.
- ED MD examined patient and called her OB.
- ED MD decided to send for monitoring to another hospital where her OB was.
- Discharged her with instructions to go 55 miles away.
- Delivered still born upon arrival.
- Hospital paid $20,000
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Houston County Community, TN (2018)

- 58 year old seeking treatment for blurred vision and dizziness.
- ED RN directed patient to a local eye doctor.
- Patient had cerebral infarction
- Hospital paid $25,000

San Mateo Medical Center, CA (2019)

- Patient came to ED with GSW to abdomen.
- ED doc called on call general surgeon who said he could not come because he was performing an elective case.
- Surgeon finished that case and went on to another elective case.
- ED doc could not find another surgeon.
- Patient waited two hours in ED, never saw surgeon and died.
- •Hospital paid $40k in fines.

Paulding County Hospital, OH (2018)

- 23-year old pregnant woman (25 weeks) presented to ED with complaints of abdominal pain, vaginal discharge and bleeding.
- No vaginal exam; no determination patient was in labor.
- MD arranged for transfer but told it would take 45 minutes for ambulance, so sent patient in own car.
- Patient delivered en route 26 minutes after leaving ED.
- Hospital paid $20k

Takeaways

- Even if we don't have specialized capabilities, we have obligation to stabilize patient to the best of our ability
- Patient awaiting transfer may be stable for transfer but still an EMTALA patient. Until the EMC is resolved, EMTALA still applies.
- Most EMTALA issues can be cured with good communication about patient's condition, what they need, what we can offer and when.
- Inpatient bed availability or accepting physician does not equate to ED capacity to take a transfer.