EMTALA TRAINING

Emergency Medical Treatment and Labor Act

Sometimes called: “Anti-Dumping Law” or “COBRA”

Fall 2015
Overview of EMTALA

Purpose: To prevent "patient dumping"
- Refusing to provide exam and treatment to ED patients unable to pay
- Transferring ED patient without meeting the EMTALA requirements

If an individual “Comes to the Emergency Department”

And a request is made for examination or treatment of a medical condition or if the patient is in need of treatment

Then the hospital must provide an appropriate medical screening exam (MSE) to determine whether an emergency medical condition (EMC) exists

• If no emergency, EMTALA obligation is over, but other standards apply.
• If an EMC exists, then stabilize and/or appropriately transfer the patient.
Breaking Down EMTALA: What Does “Comes to the ED” Mean?

A person, who is not already a patient, “Comes to the ED” when the patient presents requesting or in need of treatment for an emergency medical condition -

In the Emergency Department

On Hospital Property
(on main campus including sidewalks, parking lots, driveway within 250 yards of hospital)

In an Ambulance that has arrived on our campus or within 250 yard of the campus - even if we are on Critical Advisory or have told the ambulance not to come
EMTALA Central Log

• MLH must keep a Central Log on each individual who “Comes to the ED” seeking help that says whether the person –
  – refused treatment
  – was refused treatment,
  – was transferred, admitted and treated, stabilized and transferred, or discharged.

• The purpose of the Central Log is to track the care provided to each individual who comes to the hospital seeking care for an emergency medical condition.

• It is important to complete each step in the Depart Process to ensure an accurate Central Log.
Breaking Down EMTALA: What is an “Emergency Medical Condition”?

- Definition: When the lack of immediate medical attention could result in:
  - placing the health of an individual or unborn child in serious jeopardy OR
  - serious impairment to bodily function OR
  - serious dysfunction of any bodily organ or part
- A patient is assumed to have an EMC if they are:
  - Intoxicated / impaired
  - Psychiatric patient: suicidal / homicidal
  - Pregnant, having contractions or in labor
EMTALA Starts When Ambulance Arrives

- As soon as ambulance arrives on MLH property; EMTALA obligations begin (even if the patient remains on the ambulance stretcher).
- Medical Screening Exam and stabilizing treatment may not be delayed by keeping a patient on an ambulance stretcher.
- Even if the ED is on diversion / critical advisory status, we must conduct a medical screening exam on patients who arrive by ambulance on hospital property.
  - It is important to verify that an ambulance is not on property before diverting to another ED.
What Does EMTALA Require?

Once a person “Comes to the ED,” we must:

✓ Provide an appropriate **Medical Screening Exam** to determine whether an “Emergency Medical Condition” is present

If EMC exists we must:

✓ **Stabilize** within our capability and capacity

AND/OR

✓ Appropriately **transfer**
The Medical Screening Exam

Hospital must provide an appropriate exam by Qualified Medical Personnel within the capability of the hospital’s emergency department, to determine whether or not an emergency medical condition exists.

• Exam must be “appropriate”
  – Suitable for the symptoms presented and
  – Conducted in an unbiased and non-discriminatory fashion

• Exam must be performed by:
  – Qualified Medical Personnel (e.g., physician, nurse practitioner or physician’s assistant, labor and delivery nurse) as designated in the Medical Staff governance documents

• Initial assessment or triage by an ED nurse ≠ MSE
The Medical Screening Exam – L&D

- For pregnant women, the medical records should show evidence that the MSE included ongoing evaluation of:
  - fetal heart tones,
  - regularity and duration of uterine contractions,
  - fetal position and station,
  - cervical dilation, and
  - status of the membranes (i.e., ruptured, leaking, intact)

- Should assess and reassess both woman and fetus separately to ensure the patient remains stable

- Should ideally separately document for woman and fetus
Don’t Delay MSE

We **can not delay** exam or necessary stabilizing treatment to inquire about insurance coverage or method of payment.
Patient with Altered Level of Consciousness

• Patients with an altered LOC (alcohol, behavioral, neurological, etc.) must be seen by a provider prior to leaving the facility, even if they want to leave before the MSE or treatment.

• Restraining the patient prior to the MSE would be appropriate ONLY if all other less restrictive measures have failed.

• Do not allow a mentally unstable patient to leave AMA.
Psychiatric Conditions Covered by EMTALA

• History of drug ingestion in a patient with coma or impending coma
• Depression with feelings of suicidal hopelessness
• Delusions, severe insomnia, or helplessness
• History of recent assaulting, self-mutilating or destructive behavior
• Objective documentation of inability to maintain nutrition in an individual with altered mental status
• Impaired reality testing accompanied by disordered behavior (psychotic)
Suicidal Patients

• If patient expresses suicidal or homicidal thoughts or ideations to the triage nurse, patient becomes an involuntary ED patient until determined otherwise by the psych exam.

• **Both the medical and mental health assessments should be cleared and documented prior to disposition, even if there are no apparent medical issues.**
Full Registration of ED Patients

• Patient Access may begin full registration of ED patients *once the patient is in an ED bed.*

• If ED provider enters room to complete the MSE, Patient Access staff should *stop* the registration process and allow the provider to examine the patient.

• MLH policy requires that the registration process *not delay the medical screening exam and/or treatment.*
  – Registration processes should not encourage an individual to leave or discourage a patient from staying.

• **Do not ask for the patient’s copayment until after the physician has seen the patient**
Definition – “Stabilize”

- Under EMTALA law, “stabilize” means that it is unlikely that any significant deterioration of the patient’s condition is likely to occur during transfer:
  - Women in labor, are stable, only if: (1) provider or labor & delivery nurse has certified false labor, or (2) woman has delivered child and placenta.
    - Must screen and document condition of woman and child.
  - Psychiatric patient that is suicidal or homicidal is stable if no longer a threat to self or others.
    - Must screen and document both the medical and mental condition.
- Once stable, EMTALA obligation is over, but other standards of care still apply.
Stable v. Unstable

• **Stable patients:** When a patient no longer has an Emergency Medical Condition, EMTALA regulations no longer apply.
  – To be considered *stable*, the EMC that caused the individual to seek care in the ED must be resolved

• **Unstable patients:** When a patient has an Emergency Medical Condition that has not been resolved
  – If a hospital is unable to stabilize an individual within its capability, an appropriate transfer should be implemented.
When can the ED transfer an unstable patient?

Hospital may transfer an unstable patient if –

1. Patient/legal representative gives an informed consent to be transferred after being told of the risks and Hospital’s obligations; and

2. Physician certifies benefit of transfer outweighs the risk to patient (and fetus, if applicable); and

3. The transferring facility has provided an appropriate medical screening exam and the patient receives medical treatment that minimizes risk to patient’s health (and health of fetus, if applicable); and
When can the ED transfer an unstable patient (cont.)?

4. The receiving facility accepts the transfer, agrees to provide appropriate medical treatment for the patient, and has the capacity and qualified personnel to medically treat the patient; and

5. The transferring facility provides copies of all available medical records related to the emergent condition that the patient presented to the emergency department with; and

6. The transfer is facilitated by qualified personnel with appropriate transportation equipment, as required. This includes the use of necessary and medically appropriate life support measures during the transfer.
Interfacility Transfer Process

• When transferring a patient to another facility, the *Interfacility Transfer* form must be completed

• Page 1 of the form must be verified by a physician
  – This section of the form includes: diagnosis, information about the accepting facility/physician, mode of transportation, level of response, reason for transfer, risk of transfer or transport, and the physician certification
    • *A physician may certify a transfer because the patient needs services that are beyond the capabilities of the transferring facility*
  – The date and time of the physician certification should be close in time to the date and time of transfer
Interfacility Transfer Process

• Page 2 of the form includes:
  – Patient informed consent (to be signed by the patient or patient representative)
    • If patient chooses to go by private vehicle, then this consent should be indicated on the form.
  – Patient condition at time of transfer (to be completed by RN or physician)
  – Transfer checklist (to be completed by RN or physician)

• ALL elements of the Interfacility Transfer form (including the transfer checklist) must be completed before the patient departs the ED if time allows.
Interfacility Transfer Process

• Transfers must be effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.
  – *EMTs may not always be “qualified personnel” for purposes of transferring an individual under these regulations.*
  – *Depending on the individual’s condition, there may be situations in which a physician’s presence or some other specialist’s presence might be necessary.*

• Level of transportation must be determined by the physician
  – Included would be:
    • Type of transfer vehicle
    • Equipment
    • Attending personnel
Ensuring Safe Medical Transport

The physician must ensure a safe transfer by...

- Selecting the appropriate mode of transportation (ALS ambulance, BLS ambulance, Critical Care ambulance, etc.)
- Selecting what additional personnel is needed for transport (MD, RN, Respiratory Therapist, etc.)
- Identifying and selecting additional equipment needed for transport (Ventilator oxygen, IV, Telemetry Monitor, etc.)
- Evaluating the patient prior to the transfer (usually within 30 minutes)
Ensuring Safe Medical Transport

The Registered Nurse must ensure a safe transfer by...

- Ensuring the ambulance requisition form reflects the same mode of transportation, additional personnel, and appropriate equipment as selected by the physician
- Reporting any changes in the patient’s condition immediately to the physician
- Obtaining vital signs before transfer departure (usually within 10 minutes)
- Completing the Transfer Checklist at the time of transfer departure
- Ensuring that the Interfacility Transfer Form is completed in its entirety and is completed correctly
- Upon departure, the registered nurse must verify that the patient leaves with the transportation and equipment as selected by the physician on the Interfacility Transfer Form.
Ambulance Requisition

The purpose of the Ambulance Requisition Form is to ensure that patients are transferred safely utilizing the most appropriate mode of transportation and ensuring that the appropriate personnel and equipment will be present during the patient transport.

This online form is found on Molli using the following steps:
- From the home page, select forms
- Select adult hospitals
- Select “ambulance requisition”
- Enter your associate login information
- Fill out the requisition completely. Red asterisks indicate required fields. Be sure to double-check to ensure that the information entered corresponds with what the physician has selected on the Interfacility Transfer Form.
Transfer Requests

• When making a transfer request to Centracom or the Transfer Center, it is essential to convey the correct information so that the correct mode of transportation is arranged.

• ED staff should use the web-based transfer request form on MOLLI. This process will ensure that all required elements are conveyed to Centracom and the Transfer Center.

• Verify that the type of transportation provided matches what the physician requested on the Interfacility Transfer Form.

• Patient should be reassessed prior to transfer to ensure that the level of transportation is still appropriate.
Can a Hospital refuse to accept an incoming transfer?

• A Hospital that has the capability and capacity **CANNOT REFUSE** to accept a proper transfer **regardless of where the transfer comes from** (no matter how far away the transferring facility is).

  – Capacity means that there is a bed available.
  – Capability means that there is a physician, equipment, etc., available.
Inpatients

- EMTALA does not apply to patients admitted to the hospital (inpatients).
  - “Observation” status IS subject to the EMTALA obligations.
- The hospital has satisfied its requirements under EMTALA:
  - If the hospital screens an individual and finds an the patient has an emergency medical condition, and
  - The hospital then admits the patient in good faith in order to stabilize the condition (or appropriately discharges or appropriately transfers).
AMA or LWBS

• If an individual leaves Against Medical Advice (AMA) or Leaves Without Being Seen (LWBS) of their own free will, the hospital is not in violation of EMTALA, if you document:
  – Hospital informed individual (or person acting on behalf of individual) of risks of leaving or refusing care; and
  – Individual signed the AMA/LWBS form
    • If refuses to sign ABA/LWBS form, document that hospital used its best efforts to obtain a signature.

• WE MAY NOT SAY ANYTHING TO THE PATIENT THAT MAY BE VIEWED AS COERCING OR ENCOURAGING THE PATIENT TO LEAVE
What Not to Say: Examples of Coercion

“The Med is located just a few blocks away on Jefferson Avenue.”

“You can stay here, but you will probably have to be transferred to another facility.”

“We don’t provide OB services here at University.”

“Sometimes insurance doesn’t cover ED visits.”

“There will most likely be a 2 hour wait.”

Even if a patient asks, we cannot make any statements that appear to steer them away from the ED.
EMTALA’s “D” Rules

• Don’t delay or deny emergency treatment
• Don’t discriminate in providing emergency treatment
• Don’t refuse to accept transfers where we have capability and capacity to treat
• Document!!
Physician Responsibilities: On-Call

• On-call physicians should be contacted by a provider if services are needed after the examination.
• On-call physicians should respond to Hospital calls/requests for emergency on-site coverage within a reasonable time.
  • MLH defines “reasonable time” as 30 minutes.
• If a scheduled on-call physician fails to respond or is unavailable due to elective surgeries or being on call for another facility, the ED physician or designee should attempt to obtain the services of another appropriate physician from the Hospital’s medical staff.
• If available call coverage and capability exists at another MHMH hospital, the patient may be transferred to that other facility for further care.
Physician Responsibilities: On-Call (cont)

• Unless otherwise contractually agreed, physicians on-call are allowed to schedule elective surgeries and take call at other facilities.
  – If taking call at two facilities simultaneously, the physician must notify MHMH so back up call lists or specific procedures can be developed.

• Any changes to call availability shall be communicated to Medical Staff Services for corrected call coverage posting.
  – If an unavoidable change occurs after hours or during the course of the call requirement, the physician should notify the facility ED and/or transfer center directly and also notify Medical Staff Services the next calendar day.

• An on-call physician who fails to respond within 30 minutes will be in violation of hospital policy (subject to disciplinary action) and may be found to be in violation of EMTALA.
Physician Responsibilities: Requests for Transfer & Documentation

• MLH Emergency Department physicians are authorized to accept ED to ED transfers
  – If an on-call physician is contacted by a physician outside of the MLH system, the on-call physician MUST call the MLH ED to determine capacity prior to accepting the patient on his service.

• A request for transfer should be documented along with the response to the request, and the basis for any denial of the request.
Reporting Inappropriate Refusals of Transfers

• Transfers due to on-call physician refusal/failure to appear
  – Sending hospital must document and provide name and address of the on-call physician who failed to appear to recipient hospital.

• Any suspicion by Medical Staff of Associates that the Hospital may have inappropriately refused to accept a transfer from another facility should be promptly reported for investigation:
  – Directly to the Compliance Officer at 901-516-0567 or
  – Compliance Hotline at 1-888-220-2163
Possible Penalties for Violating EMTALA

• **Hospitals**
  – May face fines between $25,000 and $50,000 per violation.
  – A hospital may be terminated from its Medicare provider agreement.

• **Providers**
  – May be fined $50,000 per violation
    • In 2012 a Physician taking call at Vanderbilt was personally fined $35,000 for refusing to see a patient.
  – A physician may be excluded from Medicare/Medicaid programs.

• **Lawsuits**
  – A patient who suffers from the violation may sue in civil court.
  – A receiving facility, having suffered financial loss as a result of another hospital’s violation of EMTALA, can bring suit to recover damages.