Navigating Risk in the Sea of Change

Risk Management's Role in EMTALA with Case Reviews

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Presenter(s)

Pamela Driscoll is a Senior Risk Manager at Dartmouth Hitchcock Medical Center with 21 years in Risk Management experience and Certified in Healthcare Risk Management. In her current role, Pam reviews all Dartmouth Health System EMTALA concerns, working closely with the Dartmouth-Hitchcock Transfer Center, Emergency Dept, member organizations, and Office of General Counsel. Pam has an undergraduate nursing degree, a Master's Degree from Dartmouth College, as well as, a diploma from Oxford where she studied healthcare management.

Learning Objectives

As a result of attending this session, participants will be able to:

1. Identify EMTALA requirements and responsibilities for sending and receiving facilities;

2. Understand the EMTALA CMS review process and potential penalties and the implications of EMTALA violations;

3. View Risk Management as a key stakeholder for assisting in the review and response of potential EMTALA violation.

Case examples will be provided during this presentation. Identifying information such as names, characters, places, events, locales, and incidents have been changed and any resemblance to actual persons or actual events is purely coincidental.

What Is EMTALA?

Emergency Medical Treatment and Labor Act - 1986
42 USC §1395dd; 42 CFR §§ 489.20 and 489.24

EMTALA was "designed principally to address the problem of 'patient dumping,' whereby hospital emergency rooms deny uninsured patients the same treatment provided paying patients, either by refusing care outright or by transferring uninsured patients to other facilities"

EMTALA Basics

- Patient “Comes to the Emergency Department”
- Receives a Medical Screening Exam (MSE)
- Diagnosed With an Emergency Medical Condition (EMC)
- Receives Stabilizing Treatment Within Capability of the Hospital
- Sending Facility Must Meet Requirements for Appropriate Transfer
- Receiving Facility is Required to Accept Patient When Hospital Has Specialized Capabilities And Has Capacity to Do So.
- On CALL Requirements

Medical Screening Exam (MSE)

Any individual who *comes to the emergency department* requesting an examination or treatment for a medical condition must receive an appropriate medical screening examination and -- if the patient is found to have an emergency medical condition -- stabilizing treatment within the capability of the Hospital.

EMTALA does not dictate the content of the MSE.

- The MSE varies according to the individual's presenting signs and symptoms. It can be as simple or as complex, as needed, to determine if an EMC exists.

EMTALA Obligations Begin …

EMTALA obligations begin when an individual "Comes to the Emergency Department". This means:

- Hospital's Dedicated Emergency Department (DED), or
- "Hospital Property" (250 yard rule: "Hospital Property" means the entire main Hospital Campus, including the parking lot, sidewalk and driveway)
- Hospital owned ambulance

Some Frequently Asked Questions

Q: Does a Psychiatric Emergency fall under EMTALA?

A: An individual expressing suicidal or homicidal thoughts or gestures, or determined dangerous to self or others, would be considered to have an EMC.

Q: Does EMTALA apply to urgent care?

A: It depends. EMTALA regulations define "hospital with an emergency department" to mean a hospital with a dedicated emergency department. In turn, the regulations define "dedicated emergency department" as any department or facility of a hospital that either (1) is licensed by the state as an emergency department; (2) is held out to the public as providing treatment for emergency medical conditions; or (3) in the preceding calendar year provided treatment for emergency medical conditions on an urgent basis for 1/3 of the visits to the department. An urgent care owned or operated by a hospital that provides emergency treatment in 1/3 of its cases may constitute a "dedicated emergency department." You should work with legal counsel to determine whether your urgent care center must comply with the requirements of EMTALA.

Diversion & Ambulance Services Impacted By EMTALA

Q: Can you divert an ambulance from your ED?

A: Yes, as long as an individual is not on hospital property (which includes 250 yard rule **or in a hospital owned and operated ambulance**). Hospital property includes ambulances owned and operated by the hospital.

Clinical/Patient Safety

What About Inpatients?

Q: Does EMTALA apply to inpatients?

A: No, EMTALA obligations are terminated once an individual is admitted for inpatient care.

However … EMTALA will apply after admission **IF** a hospital does not admit an emergency patient in good faith and then inappropriately transfers or discharges the individual without meeting stabilization requirements. (i.e., Hospitals that try to skirt EMTALA by admitting a patient then transferring them or discharging them even though they are not stable.)

Case Example

48 y.o. woman with significant obesity and w/o medical evaluation for many years, presented to OSH with abdominal pain, shortness of breath, ascites, and lower extremity ischemia. Imaging demonstrated a pelvic mass >30cm. Patient in need of GYN Surgical Oncology and ICU. Request for transfer to DHMC was denied due to critical capacity.

The following day, the patient arrived via car to the ED at DHMC. Pt was acutely ill with pleural effusions, onset lower limb ischemia, found to have right sided pneumothorax requiring chest tube placement, admission to ICU for pressors, and to the OR for exploratory laparotomy, complete hysterectomy and bilateral thrombectomy due to lower extremity limb ischemia.

Upon arrival, patient's mother advised that they were told by OSH, "*We can't do anymore for you here. You need care with a GYN surgeon. If we discharge you, we recommend you go to the Emergency Department at DHMC as they have those services.*"

What are some of the consequences of an EMTALA violation?

Hospitals:

- Subject to termination of its Medicare provider agreement
- Subject to monetary penalties
- Sued by the patient

Physicians:

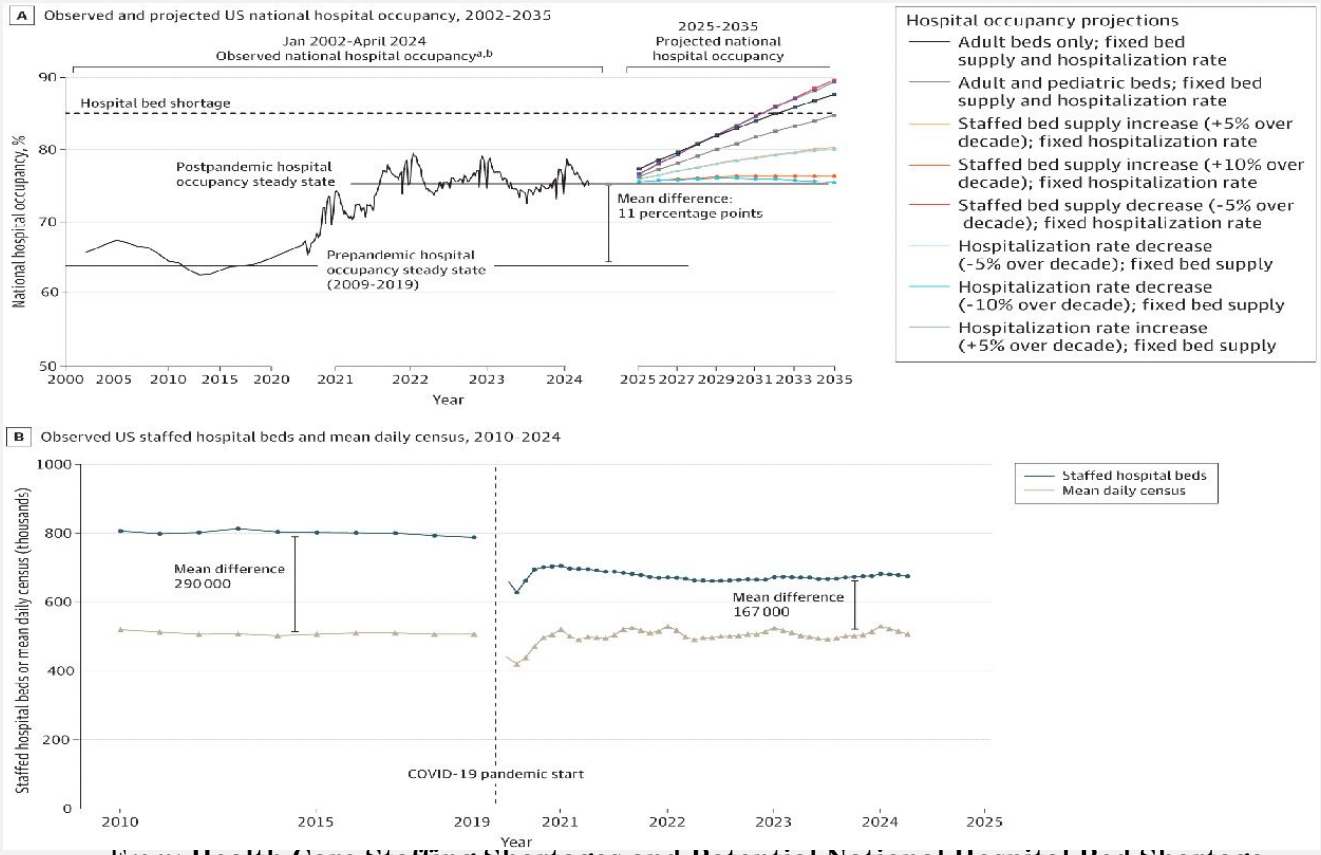
A Physician who violates EMTALA, including refusal or failure to appear within a reasonable amount of time (**on call providers**) resulting in an inappropriate transfer, may be:

- Subject to termination of his/her Medicare provider agreement
- Subject to penalties
- Sued by the patient

Viral Media Case - Maryland General Hospital, Baltimore, 2018

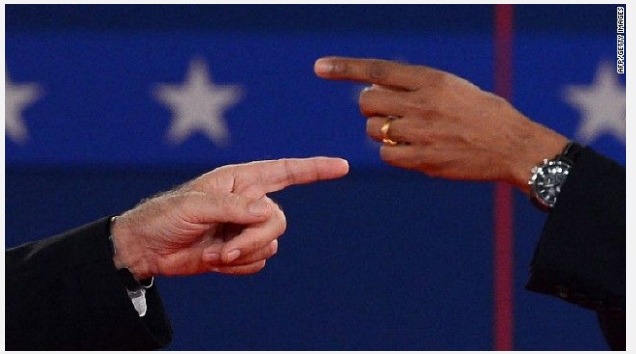
- January 9, 2018 -
- 22 y.o. patient presented to MGHs ED via ambulance. The patient was diagnosed with a contusion of the face, lip abrasion, and was discharged. The patient refused to sign the discharge forms, stating she was homeless. The patient was escorted by security off of UMMC's property wearing only a hospital gown and socks.
- The following day, a bystander found the patient at a bus stop outside the hospital in 30-degree weather. The bystander called 911 and she was returned to MGH. The patient was dazed and confused and hypothermic. She was discharged without receiving a medical screening examination or being stabilized. No Psychiatric examination was offered or performed.
- A photo/video taken by the bystander was posted and went viral ….

Tumultuous Times: Bed shortages & efforts to provide patients the care they need fuels frustration and EMTALA reporting tensions



From: **Health Care Staffing Shortages and Potential National Hospital Bed Shortage**

JAMA Netw Open. 2025;8(2):e2460645. doi:10.1001/jamanetworkopen.2024.60645



I'm Reporting You!

This is an EMTALA violation!

DHMC's Plan for Managing the Workload of an EMTALA Review While Trying to Maintain & Foster Relationships with Outside Hospitals that Could Be Reported

Identified Key Stakeholders to be Part of an EMTALA Review:

- Risk Management
- Medical Director & VP for Transfer Center
- Emergency Department Chair
- Chief Medical Officer
- Office of General Counsel

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D-H EMTALA Process Algorithm

Concern/Complaint

Risk Mgmt: Gather immediate facts -- Who, What When, Where

Does it appear to meet the definition of EMTALA?

Is an expansive review indicated?

Initiate Review

Staff interviews, record review, EMS records, audio recordings, capacity data

* Reach out to OSH to allow them to review & provide feedback

Conclusion/Plan

Review sent to OGC, CMO; If reportable, Risk Mgmt drafts letter and contacts OSH to allow them opportunity to self-report first.

Clinical/Patient Safety

Centers for Medicare and Medicaid Services
Division of Survey and Certification Operations
Office of the Regional Administrator
JFK Federal Building
Suite 2325
Boston, MA 02203-003
Fax:(617) 565-1083

Re: *Report of Possible EMTALA Violation*

Dear :

Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic (operating together as and referred to herein as "Dartmouth-Hitchcock") are submitting this report of a possible EMTALA violation at XXX Hospital, XXX, New Hampshire, arising out of the circumstances of a transfer of a patient to Dartmouth-Hitchcock by XXX Hospital.

On December 30, 20XX at approximately 11:00 am, the ED physician at XXX Hospital contacted the Capacity Control Center at Dartmouth-Hitchcock Medical Center (DHMC) requesting transfer of a XX y.o. woman who had delivered a baby XXX in the ED at 10:06 and placenta at 10:38 but was continuing to have some bleeding. The patient was treated in the ED XXXX Hospital with IV pitocin and misoprostol. DHMC accepted transfer of the patient for admission at DHMC.

XXXX Ambulance was contacted by XXX Hospital to provide transfer. We understand that the transport team was asked by XX to transfer the infant to DHMC in addition to the mother. We understand from the EMS team that they advised XXX Hospital that they did not have appropriate transport equipment for the infant, and that in discussion with the ED physician at XXX Hospital, it was determined that the infant would not be considered a formal transfer or require any care en route and therefore could be transported by XXX Ambulance as a "passenger" positioned on the chest of his mother enroute to DHMC. This is against NH EMS safety protocols. Upon arrival to DHMC, there was no transport form provided for the infant, and because there was no accepting provider, the newborn nursery was unaware of the infant's pending arrival. The infant was evaluated by the newborn nursery team, received required newborn screening evaluations, and was admitted for monitoring as well as lactation and nutritional assistance.

We have been told that XXX Hospital self-reported this incident to CMS on XXXXX , 20XX.

Please do not hesitate to contact me with any questions at (603) _____.

Case Example

8/21 at 2234

21 y.o. with fall from his mountain bike. We receive a call from outside facility asking for Neurosurgery. CT scan of lumbar and thoracic spine demonstrates L2 burst fracture with a retropulsion of the fragment causing greater than 50% canal stenosis and greater than 20 degree kyphosis. Per report at OSH, patient is "neurologically intact on exam with NO neurologic symptoms."

Neurosurgery Attending to OSH: ***"****This is a serious fracture requiring evaluation by neurosurgery and operative intervention. Unfortunately, we have been informed by the CCC that our hospital has no capacity to accept this patient at this time to any level of care even in the setting of this operative case. Therefore, we recommend transfer to another facility with neurosurgical capabilities (UVM or Boston). In the meantime, we strongly recommend keeping the patient flat, no movement."*

Capacity Coordination Center (CCC): *"Would you like assistance in trying to reach out to another facility for possible transfer?"*

OSH: *"No, we will call back if we need assistance."*

8/22 at 0536

Neurosurgery calls and asks the CCC to connect them with the OSH to check on the patient. The Neurosurgeon asks about DHMC capacity. When connected with the ED at the OSH, a nurse there advises us the patient was "discharged." Neurosurgeon: "Discharged? You mean transferred?" OSH RN: "No, he was discharged," (Followed by muffled speaking as if someone has their hand over the phone.) OSH RN comes back to the phone and, states, ***"oops, no, wrong words – he left AMA."***

Later that day ….

8/22 @ 1904

Patient arrives via personal vehicle to DHMC ED. Father asks for wheelchair to bring him in. Pt history includes he was seen at OSH _____ after he fell off his mountain bike yesterday. They told him he had a "burst" fx in his back and he needed surgery.

On exam, patient with worsening symptoms, including parasthesias of lower extremities and increased lower leg weakness. They repeat spinal imaging as well as get a CT of his head as patient also presents with noted facial trauma. Trauma alert called. Pt has several facial fractures and requires urgent neurosurgery operative intervention for impingement on spinal cord as well as facial fracture repair.

When we ask patient if he left OSH "AMA," he states he has no idea what that is. He advises us that "they" told him they could send him to Boston or if he drove to DHMC's ED himself, we would "have to take him."

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Case Example

- On June 12 DHMC received a call from a physician at an outside hospital requesting the transfer of an 85 y.o. patient with a history of aortic occlusion and onset bilateral leg pain, paralysis and no dopplerable pulses. This initial call led to multiple telephone calls, including a vascular consult, physician staff at both hospitals, and included the involvement, per standard protocol, of DHMC's is a trauma surgeon)

- On the evening of June 12, DHMC had NO bed capacity to meet the needs of this patient, who required operative services and a surgical intensive care bed. There were 153 bed requests on this evening and 44 patient denials. Our ED was a surge level 2, with 53 patients in the ED being treated at the time of the call and 11 boarders awaiting beds.

- The following ensued ….

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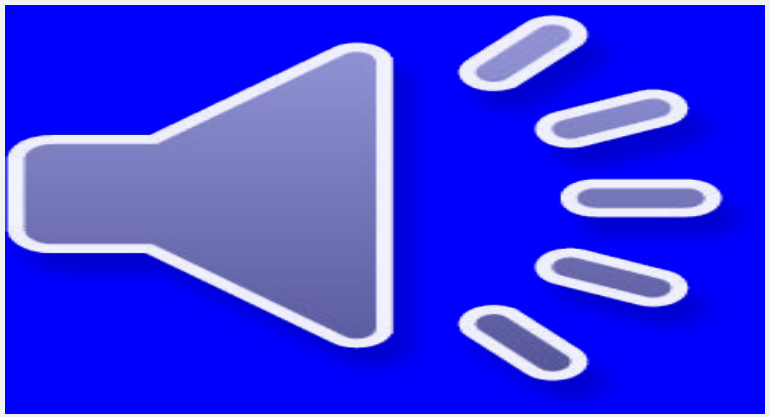

This recording has been edited. Names, places, dates have been removed or altered for de-identification. Any associations should be construed to represent a recreation of a situation for the purpose of teaching and education.

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Lessons Learned – Dealing with EMTALA Challenges

- EMTALA was meant to and has encouraged the safe care of emergent patients since 1986, yet it poses significant compliance challenges and hospitals are cited for violations and collegial relationships often strained. Understanding the potential pitfalls and best practices can help healthcare organizations avoid serious consequences.
- Make sure you have the facts and don't make assumptions. Provide an opportunity for both facilities to investigate and share findings.
- Be organized. Have a point person who understands and can put together an important clinical timeline of the facts, including discussions with staff involved, medical record review, and any information available.
- Don't make assumptions and don't be punitive or accusatory. Remember, everyone is trying to do their best for their patients.

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Questions?

"Personally, I wouldn't have signed it."

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