EMTALA Made Simple

Clinical Quality Insights

Thursday, August 25, 2022

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- **Process Implementation**
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Simplify & Comply

Objectives

- **Develop strategies to meet the challenges that came to light during the pandemic, including staffing shortages and the increase of patient psychiatric conditions**
- **Identify successful approaches for coping with long waits for emergency department care and the challenges associated with boarded inpatients**
- **Clarify what it means to stabilize the patient or resolve an emergency medical condition**
- **Recognize the important differences between lateral and higher-level-of-care transfers**

Program slides are shared as a PDF in the Chat function.

Our Goal

To materially improve patient safety, quality, and outcomes.

Lisa Eddy
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Advisor to Healthcare Systems and Investors

> ***Simplify and comply.***

> ***Complex is easy. Simple is hard.***

Agenda

High-level Overview of EMTALA Requirement

Impact of the Pandemic on EMTALA Challenges and Strategies for Mitigation

Discussion / Questions

Agenda

High-level Overview of EMTALA Requirement

Impact of the Pandemic on EMTALA Challenges and Strategies for Mitigation

Discussion / Questions

Start with the end in mind … we will discuss these and other things at the end.

- What is the Left Before Conclusion of Care Rate?
  - 2% (low risk)
  - 4% (average risk)
  - >4% (high risk)
- Is Triage Accurate?
- Are ESI 2 patients seen promptly by a QMP (15-30 minutes)? *After a quick evaluation the QMP may decide it's OK for the patient to wait. If not, are they closely monitored?*
- Are vital signs taken for ESI 3 patients who wait longer than expected (2 hours? 4 hours? Your policy)
- Is there a follow-up process for ESI 2 patients who leave before the conclusion of care.
- For discharged patients, does the nursing note address the presenting compliant and abnormal conditions found during the stay?
- Are prolonged boarded inpatients managed like inpatients (vs. ED patients)?
- Are you documenting "stability for transfer"?
- Do emergency medicine Practitioners understand the role of tele-medicine and are they clear about when on-site, in-person evaluations are necessary?

Most Common Cause of CMS Termination Actions for Accredited Hospitals: EMTALA

Then come the Conditions of Participation

Tag	Condition	#			% Survey with Findings	% Survey with Findings	Cumulative %
A0115	PATIENT RIGHTS	109	2.20%	52.90%	0.529	36%	36%
A0385	NURSING SERVICES	46	1.00%	22.30%	0.223	15%	51%
A0700	PHYSICAL ENVIRONMENT	38	0.70%	18.40%	0.184	12%	63%
A0747	INFECTION CONTROL	22	0.40%	10.70%	0.107	7%	71%
A1100	EMERGENCY SERVICES	14	0.30%	6.80%	0.068	5%	75%
A0799	DISCHARGE PLANNING	12	0.30%	5.80%	0.058	4%	79%
A0940	SURGICAL SERVICES	11	0.20%	5.30%	0.053	4%	83%
A0489	PHARMACEUTICAL SERVICE	10	0.20%	4.90%	0.049	3%	86%
A0338	MEDICAL STAFF	8	0.20%	3.90%	0.039	3%	89%
A0618	FOOD AND DIETETIC SERVICES	7	0.10%	3.40%	0.034	2%	91%
A0576	LABORATORY SERVICES	6	0.10%	2.90%	0.029	2%	93%
A1151	RESPIRATORY CARE SERVICES	4	0.10%	1.90%	0.019	1%	94%
A1000	ANESTHESIA SERVICES	3	0.10%	1.50%	0.015	1%	95%
A0431	MEDICAL RECORD SERVICES	3	0.10%	1.50%	0.015	1%	96%
A0528	RADIOLOGIC SERVICES	3	0.10%	1.50%	0.015	1%	97%
A0652	UTILIZATION REVIEW	3	0.10%	1.50%	0.015	1%	98%
A1025	NUCLEAR MEDICINE SERVICES	2	0.00%	1.00%	0.01	1%	99%
A1123	REHABILITATION SERVICES	2	0.00%	1.00%	0.01	1%	100%
A1076	OUTPATIENT SERVICES	1	0.00%	0.50%	0.005	0%	100%

Source: CMS - QCOR

Significant Deficiencies
Excluding Governing Body and QAPI

February to August 2019

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality

Ref: QSO-21-22-Hospitals

DATE: **September 17, 2021**

TO: State Survey Agency Directors

FROM: Directors,
Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss

NOTE: This memorandum is being issued to remind hospitals of their existing obligation to comply with EMTALA and does not contain new policy.

Pre-Pandemic EMTALA Enforcement

ABOUT 190 60%

Complaints/reports related to EMTALA are investigated by the State Survey Agency on behalf of CMS … may also include review of one or more Conditions of Participation.

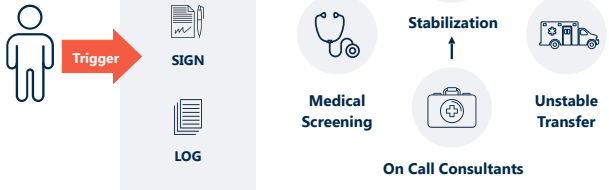
ABOUT 320 EACH YEAR

CMS	HHS-OIG	Individual
Termination Hospital Provider Agreement (strict liability) — Practitioner's Provider Status (flagrant or repeated violations)	Administrative Fines Hospital up to $106K per violation — Practitioner Up to $50K per violation	Damages Hospital A "duty" for the purposes of civil liability

ABOUT 30 (15%)

Three Triggers for EMTALA Requirements

EMTALA Requirements



EMTALA Applies When…

Trigger 1

Person Requesting Emergency Care
…OR
Apparently suffering from an life / limb threatening condition
…OR
LABOR

Anywhere on the property of a hospital

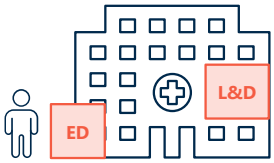
Includes hospital owned/ leased buildings within 250 yards of the main hospital.

Hospitals with a Dedicated Emergency Department have obligations for Medical Screening, Stabilization, and Transfer

Hospital buildings without a Dedicated Emergency Department must "respond and refer"

Trigger 2

Person Comes to a DEDICATED EMERGENCY DEPARTMENT
Requesting Evaluation or Care for any medical or surgical condition



Exceptions for some visits

A unit is a "Dedicated Emergency Department" if:

- Licensed by the state as an emergency department
- Holds out to the public that it provides care for emergency medical conditions (as defined)

OR

- 1/3 of the visits in the preceding calendar year actually provided treatment for Emergency Medical Conditions.

CASE STUDY

Failure to Medically Screen Belligerent Patients: Patient A

Patient A was a 24-year-old male who presented to [the] Emergency Department (ED) complaining of weakness and exhibiting altered mental status. He was reportedly aggressive and non-compliant with staff directions.

- When he was **leaving the ED he apparently collapsed**. A security guard, a hospital employee, put him in a wheelchair and **wheeled the patient off hospital property - where he was left on the ground**.
- Approximately four hours later the patient was found cold, with decreased responsiveness. He was transported to another hospital by ambulance. He died two weeks later.

All Case Studies are verbatim quotes from the Office of the Inspector General (HHS-OIG) notification of sanctions. HHS-OIG.gov

CASE STUDY

Failure to Medically Screen Belligerent Patients: Patient B (2 of 2)

Patient B was a 35-year-old male who presented to [the] ED accompanied by his girlfriend. The patient complained of shortness of breath and chest pain.

- The patient requested to see a physician and became **belligerent** when a nurse asked him why. That led to the patient being **escorted out of the ED by security**.
- Several minutes later, the patient returned to the ED. This time, the patient's girlfriend **drove up to the ambulance bay** and reported that the patient had suffered a seizure and was lying in her truck.
- She was informed by staff that they would not help get the patient out of the truck. In addition, the **security guard told her she had to leave**.
- The patient's girlfriend then took him to another hospital where he was pronounced dead within 20 minutes of his arrival.

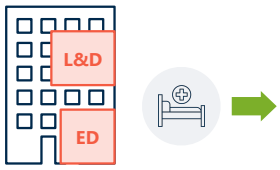
CASE STUDY

Failure to Medically Screen an Ambulance Patient

- A 79-year-old female presented to [an] Emergency Department (ED) by ambulance after being involved in a motor vehicle crash with multiple injured individuals.
- EMS contacted [the] ED for guidance about disposition of the injured individuals and the ED physician at RMC directed that the patient be taken to a trauma center.
- When one of the ambulances arrived in [the ED's] ambulance bay with the patient, a hospital nurse approached the ambulance and **told the driver that the patient was supposed to go to the trauma center**.
- The ambulance then transported the patient to the trauma center **without the patient receiving a medical screening examination**.
- During the transport, the patient's condition deteriorated, and she ultimately died at the receiving hospital.

EMTALA Applies When…

Trigger 3



The transferring hospital does not have the current capability and capacity to stabilize the Emergency Medical Condition

The receiving hospital must accept the transfer IF it has the current capability and capacity to provide stabilizing care (Even if it does not have a dedicated emergency department).

Reporting Requirement

CAPABILITY: currently available medical, surgical and technical services

CAPACITY: includes services or spaces typically used for overflow.

CASE STUDY

Failure of a Receiving Hospital to Accept an Appropriate Transfer

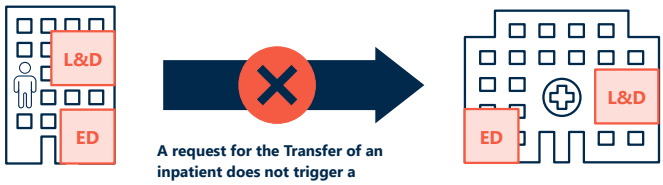
- Patient A was a 64-year-old women who needed specialized capabilities to stabilize her Emergency Medical Condition.
- Unlike the requesting hospital, [the receiving hospital] had the current capability to stabilize Patient A's Emergency Medical Condition. However, the operator at [the receiving hospital] refused to accept the patient because of a [hospital] **policy that prohibited the acceptance of Louisiana residents**.

CASE STUDY

Failure of a Receiving Hospital to Accept an Appropriate Transfer

- A hospital in the U.S. Virgin Islands contacted [the Hospital] and requested to transfer a patient who had a life-threatening Type A Aortic Dissection with Thrombus, which required immediate cardiothoracic surgical intervention.
- [the Hospital] declined to accept the transfer of the patient unless it received a **guarantee of payment**.
- The requesting hospital obtained the guarantee of payment, but [the hospital] still declined to accept the transfer because the request needed to be approved by a supervisor who would not be in until the following business day.
- A few hours later, the patient died while still at the hospital in the Virgin Islands.

EMTALA DOES NOT Apply to Inpatients



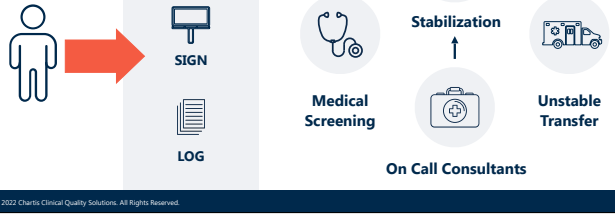
A request for the Transfer of an inpatient does not trigger a receiving hospital's EMTALA obligation.

Requirements Once EMTALA is Triggered

EMTALA Requirements: No Dedicated Emergency Department

Requirements Once EMTALA is Triggered

EMTALA Requirements



Medical Screening Examination

Medical Screening Includes, when indicated

- **Triage assessment and score (sequence of care)**
- **T3 Practitioner (T3 = Team Triage and Treatment)**
- **Main ED Practitioner**
- **Testing**
- **Consultation (also part of "stabilization")**

Can the Nurse be considered a Qualified Medical Person?

Tip: The Medical Screening Examination should not be considered complete until the Qualified Medical Person decides on a plan of treatment for the presenting complaint / condition.

Patient may still have hypertension, diabetes, or some underlying medical or surgical condition, but the immediate threat to life or limb has been resolved and severe pain has been addressed.

Examples of the Plan of Treatment:

No care or stabilization required

- There was no problem to resolve, or
- The complaint was fully resolved

The patient should see a care giver in

- the next few weeks
- tomorrow
- later today

Admit

Transfer

CAST STUDY

Delay in Medical Screening and Left Without Being Seen

- An individual presented to [the Hospital's] Emergency Department (ED) at 7:37 a.m. on January 10, 2016, complaining of "chest pain since last night, also nausea, vomiting, and diarrhea." He had a normal ECG during triage.
- After the individual was returned to the **waiting room, the spouse repeatedly asked for medical assistance** because the individual was lying on the floor due to worsening chest pain. When a nurse finally responded, she told the spouse that they would have to wait. The patient was **not reassessed following triage**.
- At 11:21 a.m. (about 4 hours after presentation), the medical record noted that the individual **left without treatment**.
- The individual presented to a second hospital at 11:25 a.m. where the individual received an emergency heart catheterization and was diagnosed with triple vessel disease.
- The individual needed an urgent coronary bypass and was sent back to [the Hospital's] where the individual underwent a triple coronary bypass the next day.

MEDICAL SCREENING EXAMINATION:

Patients Who Leave Before Discharge from the ED

EMTALA does not consider patients who decide to leave of their own volition and without intimidation to be a violation of the Medical Screening rule.

… However, the hospital must triage and monitor the patient as indicated. The hospital also has an obligation to encourage the patient to stay.

- **LBCC = Left Before Conclusion of Care**
- **LBT = Left Before Triage**
- **LWBS = Left Without Being Seen (by a Practitioner)**
- **Elope = Left After Being Seen but Before Discharge (Excluding AMA)**
- **AMA = Left Against Medical Advice**
- **Presented in Error = Not requesting evaluation**

Rule of Thumb	Low Risk	High Risk
LBCC	≤2%	>4%
LBT	Trace	Significant Number
LWBS	≤1%	>4%
Elope	Trace	Significant Number
AMA	No Risk	

Tip: Monitor and, when indicated, follow up on at least ESI 2 (and perhaps some ESI 3 patients) who leave before the conclusion of care.

CASE STUDY

Failure to Provide Medical Screening and Stabilization; Suicidal Patients

It was [the Hospital's] policy that patients found to have a blood alcohol level (**BAL) above 100 were to be discharged to local law enforcement** and taken to jail.

- **Patient A** was 25 years old when she called a crisis hotline and an ambulance was dispatched to her residence. She was transported to [the Hospital's] ED for evaluation of a possible **suicide attempt** by overdose.
  - Patient A's BAL was **422** and the ED physician discharged her into the custody of local law enforcement where she was detained in **jail** and expected to see a counselor.
- **Patient B** was 41 years old when he presented to [the Hospital] after **attempting suicide** by overdose. The patient was depressed, had a history of psychiatric problems, and had recently been admitted for electroconvulsive therapy.
  - Patient B's BAL was **288** and he was discharged into the custody of local law enforcement and taken to **jail**. The next day the patient was seen by a counselor in jail and then released from custody.
  - Patient B returned to [the Hospital] that evening after again attempting suicide by overdose where he was admitted to the intensive care unit in **guarded condition**.

CASE STUDY

Inappropriate Plan for Follow-up Care — Failure to Medically Screen

- The patient, a 22-year-old female, presented to [the Hospital's] Emergency Department via ambulance.
- The patient was diagnosed with a contusion of the face and lip abrasion, and was discharged.
- The patient refused to sign the discharge forms, stating that she was **homeless**.
- She refused to exit the premises and was **escorted by security off of [the Hospital's] property wearing only a hospital gown and socks**.
- The following day the patient retuned to [the Hospital's] via ambulance after a bystander called 911. The bystander found the patient at a **bus stop outside the hospital in 30-degree weather**.
- A nurse told the patient that she would need to go to a shelter if she did not have a place to stay. The patient was then discharged without receiving a medical screening examination or being stabilized.

CASE STUDY

Resolution of the Emergency Medical Condition Prior to Discharge — Inappropriate Transfer

- A patient, who had a **kidney** transplant and was on dialysis, was waiting in the parking lot of a local dialysis center when she experienced significant **shortness of breath**.
- The patient was transported by ambulance to [the Hospital's] emergency department, where she was diagnosed with **acute pulmonary edema and discharged to receive dialysis on an outpatient basis**.
- The patient arrived at the **dialysis center** where dialysis was started promptly, but the patient's condition **deteriorated** and she was taken back to [the Hospital's] emergency department where she was pronounced **dead**.

CASE STUDY

Failure to Medically Screen; Labor-Related Inappropriate Transfer

- A 23-year old pregnant woman presented to [the Hospital's] Emergency Department (ED) complaining of abdominal pain for about four hours, with some vaginal discharge and bleeding. She was approximately **25 weeks pregnant**.
- [the Hospital] **did not perform a vaginal exam** and did not determine **if the patient was in labor**.
- [the Hospital's] ED physician arranged for the patient to be **transferred to another hospital for a higher level of care**.
  - The ED physician was informed that it would take 45 minutes for ambulance transport to arrive at [The Hospital's] ED, so he recommended that the patient be **transferred by private vehicle**.
  - The patient **delivered her baby in her car** on the way to the receiving hospital and the **patient self-diverted to a different hospital**, where she arrived 26 minutes later.
  - The baby was not breathing upon arrival to the hospital and the Neonatal Intensive Care Unit was unable to resuscitate the baby.

We recommend ED transfer forms have 3 options

- Deterioration unlikely during transport
- Deterioration may happen during transport, but the risk of staying here are greater than the risk of deterioration during transport.
- Patient requests transfer against medical advice.

Transfer summaries may be separately required.

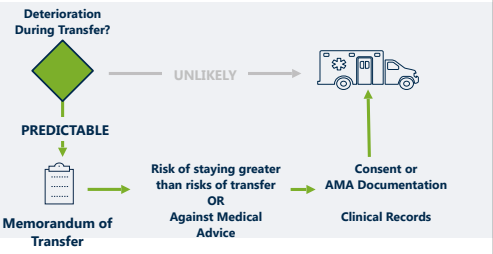
Stable for Transfer

Unstable Patient (AKA: Higher-Level-of-Care Transfers)

"Appropriate Transfer" of an unstable patient under EMTALA

We recommend ED transfer forms have 3 options

- Deterioration unlikely during transport
- Deterioration may happen during transport, but the risk of staying here are greater than the risk of deterioration during transport.
- Patient requests transfer against medical advice.



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Challenges and Strategies for Mitigation

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The Great (Healthcare) Resignation

1 in 5

healthcare workers left the field during the pandemic

30%

of nurses left the profession

The Impact on "Normal" Operations

The Great Resignation—the mass exodus of unsatisfied workers—has hit few industries harder than healthcare. According to some reports, the field has lost an estimated 20% of its workforce, including 30% of nurses.

Forbes

This year alone, nearly 1.7 million people have quit their healthcare jobs—equivalent to almost 3% of the healthcare workforce each month, according to the U.S. Bureau of Labor Statistics.

And a recent survey of 1,000 healthcare professionals showed that 28% had quit a job because of burnout.

Healthcare second largest sector hit by Great Resignation

healthcareITNews

Staff shortages throw a wrench in hospitals' compliance standards

HOSPITAL REVIEW

"As a result, these care providers are having to balance time spent on non-nursing work with providing direct patient care and saving lives," Dr. Dabrow Woods said. The heavier workloads have left less time for healthcare providers to focus on infection control efforts.

These shortages have led to a lack of familiarity with standard processes and procedures among travel workers or providers covering new shifts.

"When APPs are unavailable, providers don't always know the resource to contact in their place, which opens the communication doors and often breaks protocol."

Safety-Related Metrics Suffer

Hospital infection rates rose and fell with COVID-19 surges in 2021: 5 findings

Becker's Hospital Review – Wednesday, May 25th, 2022

CDC data shows healthcare-associated infection rates rose significantly in 2020 after years of decline, and many kept climbing in 2021.

Similar findings for CLABSI, CAUTI, for MRSA

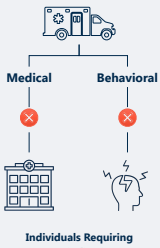
Ventilator-associate events rose 51% 1Q2021 and 60% in 3Q2021

Leapfrog urges CMS not to suppress hospital safety data

Leapfrog said the information CMS is seeking to curtail is critical

HEALTHCARE FINANCE

Staff Shortages and Broken Processes are Evident in Crowded ED Waiting Rooms



Individuals Requiring Hospitalization

For the Association of Academic Chairs of Emergency Medicine, Des Plaines, Illinois, USA

NEJM Catalyst

"The impact of ED crowding on morbidity, mortality, medical error, staff burnout, and excessive cost is well documented but remains largely underappreciated.

ED Crowding and Harmful Effects

ED crowding is not an issue of inconvenience. There is incontrovertible evidence that ED crowding leads to significant patient harm,[6] including morbidity and mortality related to consequential delays of treatment for both high- and low-acuity patients,[11,12] ambulance diversion,[13] increased adverse events,[14] and preventable error.[15] Acutely ill ED patients requiring urgent intervention leave without being seen (LWBS) due to prolonged waits.[16,17] Outcomes are worse for patients with prolonged boarding in the ED, which results in longer inpatient stays and higher costs of care.[18-20] ED crowding has also been associated with more patients being classified as higher acuity and increased hospital admissions, further exacerbating the problem.[21] ED crowding leads to increased violence toward staff, high clinician and nursing staff turnover, decreased provider productivity, increased staff distraction resulting in human error, and consequent legal action.[22,23] Crowding is a key contributor to high ED physician burnout, approaching 75%.[24] Finally, patient experience is poor — regardless of quality of care — when patients are forced to remain in the ED waiting room in various states of discomfort.[25]

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Regulators are beginning to catch up, so ask yourself a few questions

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  - 4% (average risk)
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