Final Meeting of Advisory Group for EMTALA

by Kathleen Ream, Director of Government Affairs

The EMTALA Technical Advisory Group (TAG) met for its final time in Washington, DC on September 17-18, 2007. Concerned that despite its efforts, the Department of Health and Human Services (HHS) has been unable to address the TAG's previous 31 recommendations in a timely manner, the TAG asked for an accounting of the status of the recommendations submitted up to this seventh meeting.

HHS reported that while no action was required for some of the recommendations, five others were implemented, and one still was in the process of implementation. The remaining 22 recommendations were under consideration. The TAG revisited its previous recommendation to "clarify a hospital's obligation under EMTALA to receive a patient who arrives by ambulance." This recommendation was one that the Centers for Medicare and Medicaid Services (CMS) adopted and implemented in Survey and Certification Letter 07-20, released April 27, 2007. The TAG suggested that HHS provide more guidance about EMTALA obligations in terms of the timeliness of triage and mitigating circumstances.

HHS staff stated that once the TAG's charter expires at the end of September, the HHS budget no longer will have adequate staff time allotted to follow up TAG activities. Staff suggested that changes to EMTALA regulations could occur through revisions to the inpatient and outpatient prospective payment systems, and statutory changes to EMTALA would require congressional action.

New Recommendations

To the remaining 22 recommendations, 23 more were added during this final TAG meeting. These include:

EMTALA Enforcement

To improve understanding about EMTALA among regional offices and state surveyors, the TAG recommended that CMS establish systems to:

- Improve consistency in regional office EMTALA interpretations and enforcement.
- Demonstrate surveyor competencies.

EMTALA and Inpatients

The Interpretive Guidelines (IGs) state that a hospital's EMTALA obligation ends when a patient is admitted to that hospital. However, the guidelines refer only to the hospital where the patient originally presented at the ED with an emergency medical condition (EMC). The regulation is silent on the obligation of a hospital with specialized capabilities to accept transfers of inpatients. To date, HHS is not enforcing any obligation on a hospital with specialized capabilities to accept the transfer of an inpatient.

Thus, the TAG recommended that HHS revise the IGs, regulations and statute as needed to clarify that:

- EMTALA does not apply when a patient develops an EMC after being admitted to a hospital.
- When a patient who is covered by EMTALA is admitted as an inpatient to the hospital and that patient's original EMC remains unstabilized, the obligation of a receiving hospital that has specialized capabilities is required to stabilize that patient's EMC under Subsection G of Title 42, U.S.C., 1395dd, is not altered.

Behavioral and Mental Health

Patients with psychiatric and/or behavioral health conditions are patients and should receive the same level of care and protections under EMTALA as those with medical conditions. The TAG recommended that HHS:

- Remove the current separate guidance on psychiatric EMCs so that the remaining rules apply equally to EMCs of either psychiatric or medical origin.
- Describe that a medical screening examination (MSE) should attempt to determine whether an individual is gravely disabled, suicidal or homicidal. The TAG supports the use of community protocols and services (e.g., police custody, nursing home settings) to determine whether an EMC exists or to ensure appropriate disposition of the patient to a safe setting.
- Explore education of ED physicians in general acute care hospitals without psychiatric services about the proper psychiatric MSE, discharge and transfer of patients with behavioral health conditions.
- Incorporate the following into the IGs:
  "The administration of chemical or physical restraints does not in itself stabilize a psychiatric EMC. It may, however, provide a temporary safe environment by minimizing risk during patient transport. Unless the hospital or physician can demonstrate that a patient is stabilized irrespective of the chemical and physical restraints, EMTALA still applies to the patient's care, any subsequent transfer and the duty of a hospital with specialized capabilities to accept that patient. For example, a patient presents to the ED actively suicidal with a plan and is determined to have an EMC. The patient is either administered a sedating medication or placed in physical restraints to prevent him/her from harming himself/herself. In this situation, the patient is still considered to have an unstabilized EMC because the patient's underlying suicidal intent persists."
- Review its position on community protocols – in consultation with state agencies and other stakeholders – in the area of mental health to address concerns regarding EMTALA transfer requirements that may conflict with state laws or local policies relating to involuntary detainment of patients needing appropriate psychiatric care.

Duties of Hospitals with Specialized Capabilities to Accept Patient Transfers

The TAG accepted a final report on this topic by its Action Subcommittee, which included seven suggestions addressing duties of transferring hospitals and nine suggestions addressing the duties of receiving hospitals.

continued on page 13

CEP America
EMERGENCY PHYSICIAN PARTNERS

We proudly welcome our newest contract to our National Emergency Physician Partnership!

CHRISTUS St. Michael Health System

Texarkana, Texas; September 1, 2007

★ Since 1975, **CEP America** has provided the following benefits:

- *Superior Compensation*
- *Challenging Work Environments*
- *Desirable Locations*
- *Comprehensive Practice Support*
- *Contract Stability for Emergency Physicians*

★ **CEP America's** democratic structure, innovative programs, and proven track record of superior emergency department performance are just some of the reasons why the majority of Partners choose to be "Career Partners" enjoying long-term, satisfying work opportunities.

★ **CEP America** now has 61 contract locations in five states – **Arizona, California, Georgia, Oregon and Texas** – caring for almost 3 million patients and growing.

*Contact John Gravette at **800.842.2619** or **johngravette@cep.com** if you are interested in opportunities to practice with this premier group.*

CEP AMERICA ED CONTRACTS

Alvarado Hospital
Kaweah Delta Hospital
Providence Holy Cross Medical Center
South Coast Medical Center
Sutter Delta Medical Center
Good Samaritan Hospital
John Muir Medical Center-Walnut Creek
Riverside County Regional Medical Center
Marin General Hospital
Palomar Medical Center
Pomerado Hospital
Saint Francis Memorial Hospital
Doctor's Medical Center-Modesto
Seton Medical Center
Regional Medical Center of San Jose
St. Bernardine Medical Center
Riverside Community Hospital
Saddleback Memorial Medical Center-Laguna Hills
Pomona Valley Hospital
Brotman Medical Center
Saint Louise Hospital
Sutter Roseville Medical Center
El Camino Hospital
San Mateo County General Hospital
San Gorgonio Memorial Hospital
St. Mary's Medical Center
Inland Valley Medical Center
Orange Coast Memorial Medical Center
Selma Community Hospital
Doctor's Medical Center-San Pablo
Alameda Hospital
Corona Regional Medical Center
Sequoia Hospital
Seton Medical Center Coastside
Sharp Chula Vista Medical Center
Arrowhead Regional Medical Center
Pioneers Memorial Hospital
Arroyo Grande Community Hospital
French Hospital
Redlands Community Hospital
Desert Regional Medical Center
Garden Grove Hospital
St. Rose Hospital
Madera Community Hospital
John Muir Medical Center-Concord
St. Mary Medical Center
Rideout Memorial Hospital
Community Hospital of Los Gatos
Adventist Medical Center (Oregon)
DeKalb Medical Center - Central (Georgia)
DeKalb Medical Center - Hillandale (Georgia)
Natividad Medical Center
Sun Health Boswell Hospital (Arizona)
Sun Health Del E. Webb Hospital (Arizona)
Santa Clara Valley Medical Center
Central Valley Hospital
Hanford Community Medical Center
Mercy Medical Center
Saddleback Memorial Medical Center-San Clemente
St. Elizabeth Community Hospital
CHRISTUS St. Michael Health System (Texas)

FAAEM
always means
board certified

AMERICAN ACADEMY OF EMERGENCY MEDICINE

14th Annual Scientific Assembly

Are you tired of the cold? Do you need to earn some CME? AAEM has the answer for you! Come to the AAEM 14th Annual Scientific Assembly February 7-9, 2008, at the Amelia Island Plantation in Amelia Island, FL. What better way to participate in educational sessions and earn CME than in a four diamond premier island resort? With the Atlantic Ocean on the east and the green marshland and intercoastal waterway on the west, this seaside paradise offers a wide range of activities for you and your family. Many tours are offered: guided segway, kayak, bike, maritime forest and tours with staff naturalists. A recreation department, pools, tennis courts; (*Tennis Magazine* rated Ameila Island as one of the Top 50 Greatest Tennis Resorts in the US), a nature center and the beach will entertain the entire family. Want to be on your own? Stop at one of the many shops or restaurants, go fishing, visit the fitness center or go golfing. Amelia Island offers four award winning golf courses with picturesque scenery and challenging greens. End your vacation with a sailing or day cruise charter on the beautiful Atlantic Ocean. You don't want to miss out on this opportunity to take in some warm weather and some education!

Scientific Assembly Invited Faculty:

Jim Adams, MD
"Pitfalls in Managing Conflict and Ethical Issues in the ED"

Peter DeBlieux, MD FAAEM
"Managing Respiratory Failure in the ED"

Joseph Lex, MD FAAEM
"Drugs and Devices from 2007 That Might Change Your Practice"

Robert Luten, MD
"Demystifying the Pediatric Airway"

Amal Mattu, MD FAAEM
"Cardiology Literature Updates: Best of the Year"

Ghazala Sharieff, MD FAAEM
"Shock in the First Month of Life"

Richard Shih, MD FAAEM.
"LLSA Article Review"

Corey Slovis, MD FAAEM
"Electrolyte Emergencies"

Jennifer Walthall, MD
"Top EM Pediatric Articles of 2007"

Robert Wears, MD MS FAAEM
"Patient Safety Problems"

James Wilde, MD
"Tough Pediatric Infectious Disease Cases"

Pre-Conference Courses:

Tuesday, February 5, 2008

Advanced Ultrasound

Presentation Skills and PowerPoint® for Emergency Physicians

Resuscitation for Emergency Physicians (2-day course)

Uniformed Services Course

Wednesday, February 6, 2008

Head CT and Abdominal CT for the Emergency Physician

Resuscitation for Emergency Physicians (2-day course)

Simulation Workshop

Reservation Deadline:

January 7, 2008

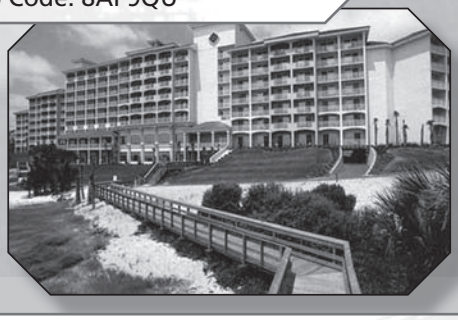
AAEM encourages attendees to make reservations by this date. After January 7, 2008, regular room rates may apply and availability may not exist. Reservations should be made directly with Amelia Island Plantation by either phone or online. To take advantage of our preferred rates, please use the group code listed below.

All rooms are subject to a $10.00/person/night resort service fee, plus applicable tax at 7%. Tax rate subject to change without notice. Oceanview Room: $189.00/night.

Hotel Information:

Amelia Island Plantation
6800 First Coast Highway
Amelia Island, FL 32034
Reservations: 888-261-6161
Online Reservations: www.aipfl.com
Group Code: 8AP9QU

February 7-9, 2008
Amelia Island Plantation
AMELIA ISLAND
FLORIDA



While at Amelia Island, don't forget to visit the AAEM/JEM Research Competition, Oral and Poster Presentations and AAEM's Photo Contest.

Register for the 14th Annual Scientific Assembly and Shuttle Bus Service at the following links: https://ssl18.pair.com/aaemorg/education/scientificassembly/registrationform.php
https://ssl18.pair.com/aaemorg/education/scientificassembly/transport.php

The TAG found that the term "specialized capabilities" is not clearly defined and that the current interpretation is subject to abuse, resulting in improper transfers. The TAG also recommended that HHS:

- Better define the terms "capacity" and "capability" and review regulations and IGs to ensure that the terms are used appropriately and consistently and that intent is clear throughout.

Stabilization and Follow-Up Treatment

The TAG recommended that HHS clarify that:

- An EMC does not need to be resolved to be considered stabilized for the purpose of discharge provided that, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care could be reasonably performed as an outpatient or later as an inpatient, and provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions.
- EMTALA only applies until a patient is stabilized, and a hospital has no EMTALA obligation to provide definitive treatment to the patient, although other rules (e.g., Medicare Conditions of Participation) may apply.

Deferred Care for Non-emergency Conditions

Although EMTALA only applies to patients with EMCs, the TAG members affirmed that there are ethical and policy implications when hospitals deny care to individuals with conditions not considered EMCs. Some TAG members believe that the number of patients "triaged out" of the ED is growing, generating problems for the healthcare system. Emphasizing that even though hospitals are not required under EMTALA to provide care, it is incumbent that emergency care addresses the larger context of access to care by attending to the issue of deferred care from the ED. The TAG recommended that HHS:

- Monitor and evaluate the consequences of "triaged out" and deferred care.

Referral from the ED to a Physician's Office

Noting that while the IGs state that generally a physician in the ED should not refer patients to his or her own office, such referral may be appropriate and even preferable to care in the ED. The TAG recommended that HHS:

- Revise the IGs to reflect that "There are circumstances under which a patient in the ED may be discharged or transferred to a non-hospital-owned physician's office for continuation of the MSE, for determination of whether an EMC exists, or for stabilization of an EMC."

Effect of EMTALA on Professional Liability Insurance Coverage and On-Call Coverage

EMTALA is a mandate that requires hospitals to care for patients with EMCs but provides no financial support to do so. The lack of funding and increased risk for physicians taking call combine as disincentives driving physicians away from taking ED calls. The TAG recommended that HHS support amending the EMTALA statute to include:

- Liability protection for hospitals, physicians and other licensed independent practitioners who provide services to patients covered by EMTALA.
- A funding mechanism for hospitals and physicians.

EMTALA and Private Right of Action

Eighty percent of the cases on private rights of action under EMTALA have been dismissed, suggesting that many such cases are inappropriate and may represent abuse of the legal system. More cases could have been brought to the court under some avenue other than the EMTALA private right of action. The TAG recommended that HHS:

- Seek revisions that would limit the private right of action for personal harm to only those circumstances in which there is no alternative route to claim damages through professional liability laws.

TAG chair, David Siegel, MD JD, Senior Vice President of Clinical Effectiveness and Medical Affairs for Meridian Health in Neptune, NJ, acknowledged that the TAG members "had covered a lot of ground and made significant contributions to improving EMTALA." The members were thanked for "taking time out from their very busy schedules to participate in the TAG and commended for their passion in working to benefit both patients and providers."

EMTALA Failure-to-Stabilize Petition to U.S. Supreme Court

On May 21, 2007, the United States District Court for the Southern District of Alabama affirmed the grant of summary judgment in favor of Defendant-Appellee North Mississippi Medical Center Inc. (NMMC) on all claims of the Plaintiff-Appellant Brenda L. Morgan (as personal representative of the estate of Thomas Henry Morgan, Sr., deceased). Morgan had argued that NMMC violated failure-to-stabilize provisions under EMTALA. Morgan v. North Mississippi Medical Ctr. (No. 06-16017 May 21, 2007 Docket No. 05-00499 CV-WS-B).

The Facts

While hunting, Thomas Henry Morgan, Sr., sustained injuries as a result of a 12-foot fall. Morgan presented at NMMC's ED where he was screened and diagnosed with a back injury and admitted to the hospital. While hospitalized, Morgan received an epidural injection as treatment, but also during this time, Morgan was unable to participate in physical therapy. Morgan declined to undergo an MRI examination, and after nine days, owing to concerns that he might develop bedsores or contract diseases in the hospital, Morgan was released. He died shortly after discharge. Morgan's spouse, Brenda L. Morgan, filed a claim on the deceased's behalf alleging that NMMC violated EMTALA when it "transferred her husband without stabilizing his fractured ribs or severe compression fractures in his lower vertebrae."

The Ruling

EMTALA mandates that a hospital provide necessary stabilizing treatment for an individual who comes to the hospital if the hospital determines the individual has an emergency medical condition (EMC). There was no dispute that NMMC was presented with an EMC when Morgan came to the hospital. A dispute arises as to the hospital's

continued on page 14

Washington Watch - continued from page 13

liability in regard to an individual with multiple EMCs, "even after admission as an inpatient, especially in a case where the hospital did not admit the patient for the EMC that was never stabilized," as in the Morgan case.

The appellate court noted that in 2003 the Centers for Medicare and Medicaid Services issued a final rule taking the position that a hospital's obligations "cease once the patient has been admitted to the hospital as an inpatient." Yet, other courts have observed that the stabilization requirement would not end once the patient is admitted "if a patient demonstrates in a particular case that inpatient admission was a ruse to avoid EMTALA's requirements." This latter point was cited as authority in Morgan's initial 2005 trial court decision [Morgan v. North Mississippi Medical Center, Inc., 403 F. Supp. 2d 1115, 1130 (S.D. Ala. 2005)].

In an appeal of this case the very next year, although the court denied NMMC's motion to dismiss the EMTALA claim, it did decide on summary judgment that the hospital "had not engaged in a ruse to avoid EMTALA's requirements when it admitted the patient." [Morgan v. North Mississippi Medical Center, Inc., 2006 U.S. Dist. LEXIS 74428 (S.D. Ala. 2006).] Rather, the court found that "NMMC stabilized the conditions it diagnosed even if it did not diagnose all of [Morgan's] injuries."

EMTALA is not to be used in place of a medical negligence claim under state law. Thus, the court noted that the relevant EMTALA issue "is not whether all of Mr. Morgan's serious health problems were identified as bases for admission, but whether he was admitted in good faith to stabilize those medical conditions that were diagnosed." The appeals court rejected Morgan's EMTALA claim as a matter of law, finding that Morgan "failed to substantiate her allegations" that NMMC admitted her husband "merely as a way to avoid complying with its EMTALA obligations."

This case is gaining some publicity because on October 17, 2007, Morgan appealed to the United States Supreme Court by applying to the Court for a writ of certiorari. The Court grants these petitions at its discretion and only when at least three of its nine justices believe that the case involves a sufficiently significant federal question in the public interest.

Morgan, as the petitioner, is asking for a review of the U.S. Court of Appeals' decision, arguing that the lower court's action "embraced the trial court's decision on EMTALA's reach that conflicts with decisions by other federal appeals courts . . ." and specifically questioning "whether EMTALA's obligation to stabilize emergency medical conditions ends once a patient is admitted." A decision on Morgan's petition should come down in mid-November. Should the Supreme Court deny the writ, it would be saying that it will let the lower court decision stand, particularly if the appellate court decision is found to conform to accepted precedents of previously decided cases.