Special FOCUS

Implications of the Emergency Medical Treatment and Labor Act (EMTALA) During Public Health Emergencies and on Alternate Sites of Care

Andrew R. Roszak, JD, MPA, Frances R. Jensen, MD, CDR-USPHS, Richard E. Wild, MD, JD, MBA, FACEP, Kevin Yeskey, MD, and Michael T. Handrigan, MD, CDR-USPHS

ABSTRACT

Hospitals throughout the country are using innovative strategies to accommodate the surge of patients brought on by the novel H1N1 virus. One strategy has been to help decompress the amount of patients seeking care within emergency departments by using alternate sites of care, such as tents, parking lots, and community centers as triage, staging, and screening areas. As at any other time an individual presents on hospital property, hospitals and providers must be mindful of the requirements of the Emergency Medical Treatment and Labor Act. In this article we review the act and its implications during public health emergencies, with a particular focus on its implications on alternative sites of care. (*Disaster Med Public Health Preparedness.* 2009;3(Suppl 2):S172–S175)

Key Words: Emergency Medical Treatment and Labor Act, medical surge, alternate sites of care, capacity, H1N1, triage, emergency department

As described in the Institute of Medicine's 2006 report, *Hospital-based Emergency Care: At the Breaking Point*, hospital emergency departments (EDs) across the United States are routinely operating near or at full capacity, leaving little to no reserve capacity to accommodate a surge in patient demands during a public health emergency.[1] The surge in ED visits during the spring 2009 wave of the H1N1 influenza pandemic served as a reminder of this vulnerability. In anticipation of the return of the virus this fall, planners have implemented innovative continuity of operations plans, including strategies using call centers and Web-based triage systems that help potentially infected people determine the most appropriate place to seek care and augmented use of home health care workers and use of alternative care facilities to provide care for patients while offloading traditional clinical care sites. Although the use of alternate sites of care is appealing, the Emergency Medical Treatment and Labor Act (EMTALA) has been perceived as a barrier to development, adoption, and effective use.[2] In this article, we review EMTALA and its implications during public health emergencies, with a particular focus on its implications on alternative sites of care.

ALTERNATE SITES OF CARE

Although the individual definitions and concepts vary, alternate sites of care are venues that can be activated to expand the ability of a community to care for patients.[3] These are generally located in buildings of convenience or on mobile sites. For example, during the 1918 pandemic, airplane hangars, churches, and schools were used as alternative sites to provide basic care. Although there is a literature supporting the use of such sites, published information about the complex legal relation between EMTALA and such sites is sparse.

EMTALA HISTORY

EMTALA was signed into law in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 to ensure public access to emergency services regardless of ability to pay.[4] EMTALA imposes specific obligations regarding the screening, stabilization, and transfer of patients on Medicare-participating hospitals with dedicated EDs, as well as obligations concerning acceptance of transfers for Medicare-participating hospitals with specialized capabilities.

WHEN DOES EMTALA APPLY?

EMTALA regulations apply when an individual comes directly to a dedicated ED (DED) and requests examination or treatment of a medical condition (or if a request is made on his or her behalf), as well as when an individual presents elsewhere on hospital property for what may be an emergency medical condition. A request will be considered to have been made on the individual's behalf if a prudent layperson observer would believe, based on the individual's appearance or behavior, that he or she needs examination or treatment for an emergency medical condition.

It should be noted that the definition of *hospital property* is expansive. The term hospital property includes the main hospital campus, which also encompasses the parking lot, sidewalk, and driveways, in addition to any parts of the hospital that are within 250 yards of the main buildings.[5] The definition also includes hospital-owned or -operated ambulances but excludes entities on the campus that are not part

of the hospital, such as physician offices, skilled nursing facilities, rural health clinics, and so forth. Furthermore, the definition does not include parts of the hospital that are off the main campus, although a hospital can have an off-campus DED that is subject to EMTALA.[5]

Depending on where an individual is physically located on the hospital's campus and the nature of the request, a presentation may or may not trigger an EMTALA obligation. For example, a request for physical therapy at a hospital's on-campus physical therapy department would not trigger an EMTALA obligation.[6] Similarly, if an individual presents to a DED and requests services that are not for a medical condition, such as preventive care services (immunizations, allergy shots, flu shots), then the hospital is not obligated to provide a medical screening examination (MSE) under EMTALA.[7] However, if a request for physical therapy was made within a hospital's DED, EMTALA would be triggered because the individual is requesting examination or treatment for an underlying medical condition, thus triggering an obligation for the hospital to perform an MSE.[6]

MSE UNDER EMTALA

In all instances when EMTALA applies, Medicare-participating hospitals with DEDs have a legal obligation to provide an appropriate MSE to determine whether an emergency medical condition (EMC) exists. As defined by statute, an EMC means "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part."[8] The definition also includes a pregnancy for which there is inadequate time to effect a safe transfer before delivery or when the transfer may pose a threat to the woman or unborn child.[9]

The MSE required under EMTALA must be more than merely logging in an individual or performing a quick triage assessment to assign priority for examination.[10] The MSE must be performed by a qualified medical professional (QMP): a physician, nurse practitioner, physician's assistant, or in some instances a specially trained nurse, all acting within their state's scope of practice laws. Depending on the individual's presentation, the QMP, in accordance with their hospital's policies and procedures, has discretion regarding the complexity of the MSE. The MSE can involve a wide variety of actions, ranging from attaining a brief history and physical examination to a complex process that involves performing ancillary studies and procedures.[10] In some cases, a brief questioning by the QMP would be sufficient to show that there is no emergency medical condition present.[10] In any event, the MSE must be reasonably calculated by the QMP to identify emergency medical conditions, and if this assessment is beyond the experience or qualifications of the QMP, the hospital must use other appropriate staff (including on-call physicians) and capabilities, as appropriate, to complete the screening.[11–13] If the initial screening determines that the individual does not have an EMC, then the hospital's EMTALA obligations end.[13–15]

STABILIZATION OF AN EMC

If, after screening, the hospital determines the individual has an EMC, then the hospital must provide either stabilizing treatment, within the capabilities of the staff and facilities available, or arrange for an appropriate transfer.[16] This transfer must be the result of a request from the unstable individual, either after being informed of the risks and benefits of the transfer or after a physician has determined that the benefits of the transfer outweigh its risks. In addition, transfer of an individual with an unstabilized EMC must include all of the following 4 elements: First, before implementing a transfer, a hospital is required to provide stabilizing treatment within its capabilities and facilities. Second, the recipient hospital must have the available space and qualified personnel for the treatment of the individual and have agreed to accept the transfer and provide the appropriate medical treatment. Third, necessary medical records must accompany individuals being transferred to another hospital. Fourth, the transfer must be effected through qualified personnel and transportation equipment, including the use of medically appropriate life support measures during the transfer.[17] Furthermore, if a transfer to a hospital with specialized capabilities is deemed necessary for the stabilization of the EMC, the recipient hospital must accept the transfer unless it does not have adequate capacity at the time of the transfer request.

EMTALA AND PUBLIC HEALTH EMERGENCIES

In the event of an overwhelming influx of patients resulting from public health emergencies such as a pandemic, it is conceivable that long lines and delays in evaluation and treatment may occur. These circumstances warrant a hospital's using an effective triage system at the time of an individual's presentation to evaluate the individual's priority to be seen for screening or treatment. Timeliness of the MSE and stabilizing care are essential components of their adequacy. In the event of an EMTALA complaint investigation, objective medical reviewers determine whether the timing of the MSE or treatment was appropriate, given the individual's presenting signs and symptoms. Indeed, several hospitals have been cited by Centers for Medicare and Medicaid Services (CMS) for not providing an appropriate MSE and have been subject to penalties by the Office of Inspector General when clinical circumstances have indicated that the individual was not seen in a timely manner.[18] In addition, it is an express violation of the EMTALA statute to delay providing an appropriate medical screening examination to inquire about the individual's method of payment or insurance status.[19] Thus, for a hospital to adhere to the EMTALA regulations, it must develop and implement an efficient and effective triage system that is capable of handling a sudden

surge of individuals and quickly prioritize those patients that need immediate care, regardless of the circumstances.

IMPLICATIONS OF EMTALA FOR ALTERNATE CARE SITES

As indicated above, there is great interest in establishing alternative care sites (ACSs) as a component of a disaster plan as a method to alleviate the expected overcrowding in EDs that may develop during the upcoming influenza season. Hospitals with DEDs and the communities they serve have several options in this regard, depending on the physical location of the ACS and its administrative relationship to the hospital. Below we describe 3 situations: a hospital-based alternative screening site, an off-campus site established and staffed by a hospital, and an off-hospital site established by a community.

Hospitals may set up alternative screening sites on their main campus. The MSE does not have to take place in the DED but the EMTALA obligations of the hospital still apply to these sites.[20] The MSE can be performed at any location on the hospital campus that the hospital designates (eg, another clinic, another department, in tents or parked mobile units) as long as an individual who presents to the ED for a MSE is logged into a central system before the redirection to that location and the individual is clearly redirected to the alternative location with signs and directions, and/or is even physically taken there by hospital personnel.[20] In addition, all individuals must be redirected to an on-campus ACS without evidence of discrimination. The person doing the redirecting should be qualified—eg, an RN—to recognize when an individual is obviously in need of immediate treatment and should not be redirected.[20]

At the ACS, as always, the content of the MSE varies according to the individual's presenting signs and symptoms and is determined by the clinical judgment of the QMP performing the MSE. Once again, the goal of the MSE is to determine whether the individual has an EMC that requires further evaluation and treatment for its stabilization; if so, then the hospital must provide the necessary stabilization (or appropriate transfer) required by EMTALA, including moving them as needed from the ACS to another on-campus department.

Hospitals may also set up influenza-like illness (ILI) screening facilities at off-campus, hospital-controlled sites in the community. The site will not be considered a DED if the hospital does not hold it out to the public as a place that provides care for EMCs on an urgent basis without requiring an appointment.[8] That is, the site clearly must be understood as a location for the sole purpose of screening for ILIs. It is expected that this type of facility would be developed as a partnership between the hospital and the community as part of a local or state emergency preparedness plan. For this type of ACS, EMTALA requirements do not apply; however, as required under the Medicare Hospital Conditions of Participation, the off-campus site should be staffed with medical personnel who are trained to evaluate individuals with ILIs and if an individual is found to be sufficiently ill to warrant additional evaluation and treatment, then the hospital would need to arrange for the appropriate transfer and/or referral.[21] The ACS may be considered part of the hospital for billing and reimbursement purposes, as long as the general requirements for off-site hospital departments are met.

Finally, other organizations within a community may set up screening clinics at alternate locations within the community itself, at schools, private physician's offices, city health departments, recreation centers, places of worship, and so forth. There is no EMTALA obligation at these sites because EMTALA applies only to hospitals that participate in Medicare.[22] Good practice suggests that these clinics coordinate with local hospitals and EMS for the transportation of ill individuals from the screening clinics to a facility that can further evaluate and treat those who require additional help.

Of note, if an individual happens to come directly to the ED for screening of an ILI, that individual cannot be directed by any hospital personnel to seek care at an ACS located off the hospital campus; he or she can only be directed to an ACS that is located on the hospital campus.[20]

EMTALA WAIVERS

Due to the limited nature of EMTALA waivers and the infrequency with which they are issued, it is important for hospital administrators, staff, and counsel to recognize what is and is not waived. Furthermore, due to the very nature of the requirements regarding when a waiver may be issued, the emergency event or condition is highly likely to occur ahead of any decision regarding the issuance of waivers. Therefore, hospitals should not rely on EMTALA waivers being in effect during the initial onset of an emergency, although a waiver may be issued with retroactive effect.

In the event of a public health emergency, the Secretary of Health and Human Services may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program requirements under section 1135 of the Social Security Act, including temporarily waiving some EMTALA requirements.[23] To do this, the HHS Secretary must first declare a public health emergency, and the President must issue a declaration under the Stafford Act or the National Emergencies Act[24]; the Secretary must invoke his or her waiver authority, including notifying Congress at least 48 hours in advance and the waiver itself needs to include the waiver of the EMTALA requirements discussed below. (The waiver may also extend to 1 or more of the Conditions of Participation for various types of health care facilities, etc, at his or her discretion.) In addition, the hospital taking advantage of a waiver must first activate its own disaster protocol and the state must have also activated its emergency preparedness plan or pandemic preparedness plan. If a waiver is issued, then CMS will provide notice of an EMTALA waiver to the covered hospitals through its regional offices and/or state agencies.

An EMTALA waiver applies in only 2 situations.[25] The first involves the inappropriate transfer of individuals who have not been stabilized.[26] As discussed above, under normal circumstances, a hospital may transfer an unstable individual protected under EMTALA only if the individual requests the transfer or a physician certifies that the expected benefits of the transfer are reasonably assumed to outweigh the risks of the transfer. In addition, the hospital must meet the 4 criteria to ensure that the transfer is an "appropriate transfer." When an EMTALA waiver is issued, sanctions for an inappropriate transfer do not apply, as long as the transfer is necessitated by the circumstances of the emergency, the hospital does not discriminate on the basis of the patient's ability to pay, and the hospital is covered by the waiver. The patient's medical condition need not arise from the declared emergency; however, the transfer itself must be necessitated by the circumstances of the emergency (eg, loss of power, flooding of operative suites, inaccessible medications).

The second situation in which an EMTALA waiver applies is the redirection or relocation of an individual by a hospital to an alternative location to receive medical screening. In contrast to the redirection/relocation to ACS plans described above, the hospital is not required to log in all of those who come to their DED and does not have to provide an MSE site on its campus. To be covered by an EMTALA waiver, this relocation or redirection must be pursuant to a state emergency preparedness plan or, if the emergency is caused by a pandemic outbreak, a state pandemic preparedness plan.[27] This protection ensures that hospitals are not turning away people without the appropriate authority and that this effort is coordinated throughout the community and state.

Once issued, EMTALA waivers are in effect for the 72-hour period after implementation of the hospital's disaster protocol.[28] If a waiver is issued due to a pandemic infectious disease, however, then the EMTALA waiver will remain in effect until the public health emergency declaration is terminated.[29]

CONCLUSIONS

In anticipation of a worsening pandemic, hospitals and communities are reevaluating their existing plans to deal with the expected surge in individuals coming to EDs. Establishment of an ACS can be an EMTALA compliant and potentially effective way of meeting the demand for emergency care while fulfilling the ethical and legal obligations required of the institution. Hospital administrators, practitioners, legal counsel, community emergency planners, and response agencies can and should work to together to identify and establish practical, effective, and innovative solutions.

About the Authors

Drs Jensen and Wild are with the Centers for Medicare and Medicaid Services. Mr Roszak, Dr Yeskey, and Dr Handrigan are with the Office of the Assistant Secretary for Preparedness and Response.

Address correspondence and reprint requests to Andrew R. Roszak, JD, MPA, US Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, Senior Public Health Advisor, Emergency Care Coordination Center, Switzer Bldg Room 5217, 200 Independence Ave SW, Washington, DC 20201 (e-mail:andrew.roszak@hhs.gov).

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Authors' Disclosures

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