

**Foundations of Emergency Medicine**  
**Foundations III Guided Small Group Experience**

**Clinical Skills**  
**“Rural EM, Inter-Hospital Transfers and EMTALA”**

❖ **Agenda and Learning Objectives**

- Case Part I - Management of STEMI in a Limited Resource Setting (10 min)
  - Discuss acute management of STEMI in a resource limited setting
    - PCI vs Thrombolytics
- Case Part II - EMTALA and Inter-Hospital Transfers (15 min)
  - Discuss the basics of the EMTALA law
  - Discuss which transfers are appropriate, which are not and when hospitals can refuse transfers
- Case Part III – Thrombolytics in STEMI (5 min)
  - Discuss the difference between non-specific thrombolytics vs fibrin specific thrombolytics
  - Discuss the indications, contra-indications and dosing of thrombolytics for STEMI
- Case Part IV - EMS Personnel (5 min)
  - Understand different levels of EMS certification
  - Discuss different options for inter-hospital transfer
- Case Part V - Limited Resource Medicine (5 min)
  - Understand what defines a Critical Access Hospital
- Case Concludes (10 minutes)
  - Review Session Teaching Points

❖ **Note to Facilitators**

This is a session focusing on the management of a critically ill patient with a STEMI in a resource limited, critical access hospital. It addresses not only the medical care of the patient in a hospital lacking PCI capability but also the transfer process and EMTALA. Finally, the session concludes with a discussion of the various training EMS providers receive and a basic discussion of what constitutes a critical access hospital. To prepare for this session, please review these materials. The session is a large group question-based discussion and requires no other equipment. There are no small group activities during this session.

**❖ Case Part 1 - Management of STEMI in Limited Resource Settings (10 min)**

*You have graduated from your emergency medicine residency 14 months ago and took an excellent community job at a Level II trauma center in a city of approximately 250,000 people that fits you and your family just right. In addition to the Level II trauma center you work at, you moonlight once or twice a month at a small critical access hospital. You grew up in a small town and it improves your job satisfaction to use your skill set to help this community. This critical access hospital has 12 inpatient beds, sees 5-10 patients per day and is 45 miles from the nearest hospital. It is mostly staffed by APPs that are on-call and live within 30 minutes of the hospital. You generally work a 24-hour shift and sleep in the basement call room of the hospital when you are able. This is what you are planning on doing when you arrive at the hospital at 8pm on a Friday for your 2-hour shift. You walk in and are greeted by the 1 nurse on with you over these next 24 hours who tells you there is a patient waiting. A high school football player, MN, hurt his ankle in the 8-man football state playoff quarterfinals tonight. The nurse has already called the radiology tech in from home so MN can get an x-ray of his ankle.*

*You go exam MN and his ankle is NVI but he does have some posterior lateral malleolar tenderness so the x-ray is warranted. The head coach, KH, arrives to check on his player. You notice that KH appears SOB and is sweaty. KH explains it's just the adrenaline from the playoff game this evening causing his shortness of breath and that it began to rain outside so that is why he looks sweaty. The x-ray tech arrives and takes MN over for the x-ray.*

*You review and interpret the x-ray as negative for acute fracture or dislocation.*

*While telling MN the results of the x-ray, KH says, "Doc, I don't feel so good." You look over and KH is sitting in his chair, pale, diaphoretic and clutching his chest. KH, says "Feel like I got a bunch of weight sitting on my chest."*

*The nurse promptly gets KH into a gown and into the other bed in the ED. The x-ray tech, who is also the ED technician on call, goes and gets the EKG machine from the other end of the hospital while you gather some additional history and the nurse takes his vital signs.*

*You find out KH is a 50yo male with PMH HTN, HLD, Obesity (BMI 42) and type II diabetes whose mother had an MI at the age of 55. He says he has been having some increasing chest discomfort over the past week, mainly at practice after he demonstrates drills, but he didn't think much of it. Prior to the past week he has never had similar symptoms and this pain is much worse than he had been experiencing. He also feels nauseous and dizzy.*

*T: 99.0      HR: 83      BP: 110/80      RR: 25      O2: 99% on RA*

*On your focused physical exam, the patient appears ill. He is pale and diaphoretic. His lungs are clear bilaterally. His cardiac exam is regular rate and rhythm without rubs, murmurs or gallops. His radial pulses are 2+ and symmetric.*

*The technician returns with the EKG hands it to you.*

*You look at the EKG, diagnose a STEMI and emphatically call out, "Activate the Cath Lab!" Everyone stares blankly at you until you realize you are at a critical access hospital with no PCI capabilities. There are two nearby PCI centers, one 25 min by helicopter and 45 min by ground (OSH 1) and the other 30 min by helicopter and 50 min by ground (OSH 2).*

### **Discussion Questions with Teaching Points**

- **Is there benefit to Percutaneous Coronary Intervention (PCI) over thrombolytics?**
  - Yes - PCI has less incidence of death, nonfatal reinfarction and hemorrhagic stroke when compared to thrombolytics
- **If indicated, do thrombolytics have a survival benefit?**
  - Yes - reduction of death of 18 per 1,000 patients treated → this survival benefit is seen even after 10 years.
    - Primary benefit is for treatment within two hours of symptoms onset → the benefits decline by 1.6 lives saved per 1,000 for every hour after 2 hours
  - Thrombolysis can restore patency in 90% of infarcted vessels though only 50% are restored to normal patency
  - Up to 30% have coronary artery re-occlusion
- **If your hospital does not have capabilities to do PCI, would you give thrombolytics?**
  - Depends on how quickly you can get the patient to a PCI center
  - AHA favors primary PCI with transfer to a PCI capable hospital is obtainable within **120** min of first medical contact
  - If it will be > 120 min to the PCI center, there are no contra-indications and the symptoms have been present for < 12 hours, the AHA recommends thrombolytics
- **What is your plan with KH? Are you going to give thrombolytics or transfer?**
  - Optimally, you would not have to give thrombolytics now as you have two PCI capable centers < 120 min away

### **❖ Case Part II - EMTALA and Inter-hospital Transfers (15 min)**

*You tell KH that he is having a heart attack. You administer ASA, nitroglycerin, clopidogrel and a bolus of heparin followed an infusion.*

*You decide against administering thrombolytics at this time. You plan to transport the patient to the closest outside hospital (OSH) with PCI capabilities. Your hospital system has already set up a plan for the flight crew from the OSH to come and pick up STEMI patients via helicopter in these situations. You call OSH #1. The clerk at OSH #1 who answers the phone puts you on hold. You wait on hold for 5 minutes, which seems like 25 minutes, and after he returns to the phone he says “The triage doctor says he is too busy to talk right now and our hospital is full so we won’t be accepting the patient.” You hang up the phone speechless and feeling helpless.*

#### ❖ Discussion Questions with Teaching

- **What is EMTALA? What hospitals does it apply to? What does EMTALA require of Emergency Departments and Emergency Physicians specifically?**
  - EMTALA is a national law that covers the emergent medical care of patients (among other things)
  - It requires Medicare participating institutions with emergency departments to provide medical screening exams (MSE) to evaluate for an emergent medical condition (EMC) regardless of a patient’s demographics including insurance status
  - If an EMC is diagnosed, EMTALA requires the hospital to stabilize it prior to discharge, admit the patient for further treatment or arrange for appropriate transfer to an institution with the capability to treat that particular EMC
  - EMTALA also includes protections for women in labor including their unborn child and requires hospitals to treat and stabilize these patients or to transfer laboring mothers to an appropriate accepting hospital with obstetric services if the benefits outweigh the risks of transfer
  - EMTALA also includes requirements for AMA discharges and refusal of care (to be discussed in Session 1)
  - Finally, EMTALA requires hospitals with greater care capabilities to accept patients unless they lack either the specific capability requested (ie cath lab, stroke services) or capacity (ie personnel or space)
- **What triggers EMTALA? When is the EMTALA obligation complete?**
  - EMTALA is triggered when a patient (or their surrogate) requests treatment or evaluation on the hospital property (including grounds, sidewalks etc) or a reasonable layperson would conclude based on a patient’s appearance or behavior that the patient needs examination or treatment
  - The EMTALA obligation ends when the EMC is stabilized (though the underlying medical condition may still exist), the patient is admitted or the patient is transferred to an appropriate accepting hospital
- **Is the above scenario an EMTALA violation?**
  - It is difficult to tell based on the information given but as the accepting hospital cited neither lack of capability or capacity as grounds for refusal and all communication was done through a clerk, it is certainly concerning for a violation

- **When can a hospital decide to transfer a patient? What is an appropriate patient transfer?**
  - By patient request only after a full discussion of the risks and benefits of transfer and a signed transfer agreement
  - By physician request for two reasons:
    - The sending hospital lacks *capability* for certain care more commonly known as transferring to “a higher level of care” (ie consultant or particular intervention such as a cath lab)
    - This includes if the sending hospital is supposed to have a particular capability but a consultant is either refusing to see the patient or not responding to calls in a timely manner → this needs to be documented in writing and is obviously a liability for the sending hospital but the physician caring for the patient must do what’s in the patient’s best interest in the moment
    - The physician caring for the patient must exhaust all *reasonable* hospital policies surrounding lack of consultant response or refusal to see a patient based on how time sensitive the nature of the patient care needed is
    - The sending hospital lacks capacity to care for the patient due to space or personnel → this is a dangerous reason to transfer as many receiving hospitals can also make this argument as a reason to refuse transfer
  
- **On what grounds are hospitals allowed to refuse patients?**
  - Accepting hospitals are allowed to refuse *appropriate* transfers for only two reasons → a lack of capability (ie they don’t have the service needed) or capacity (ie they don’t have the space or personnel to care for the patient safely)
    - If the accepting hospital cites capacity as their reason for refusal, they must **not** have a history of accommodating similar patients in the past with temporizing measures (ie calling in other staff, moving patients to other units)
    - They should generally also be on official ambulance diversion
    - Unfortunately, the inpatient floors being full is not a reason to refuse an *emergent EMTALA* protected transfer unless the ED is also full and the ED lacks capacity (ie it is not safe to accept another patient)
    - This is **not** true of non-emergent non-EMTALA protected transfers (ie already hospitalized patients)
  - Accepting hospitals can argue a transfer is inappropriate (see below) → this is dangerous ground as the appropriateness is usually best determined by the physician at bedside in the sending hospital
  
- **When are transfers considered inappropriate?**
  - Transfers may be considered inappropriate if the sending hospital does actually have the capability to care for the patient
    - Examples of this are if a consultant at the sending hospital is not answering pages but the physician caring for the patient hasn’t escalated through their

normal hospital policies for this scenario (assuming there is time to do so based on the clinical scenario)

- Another example is transfer to a consultant that the patient is unlikely to need
  - Transfers may also be considered inappropriate if the sending hospital does have capacity to care for the patient but is claiming they do not
    - This occasionally occurs with refusal to admit or consult on a patient due to insurance status when the patient still has an un-stabilized EMC
    - Remember if their EMC is truly stabilized, even if they still need admitted, the EMTALA obligation ends
- **What are your next steps in this case?**
  - There is no correct answer in this case but many possible actions
    - 1) Call the first hospital again and ask to speak immediately to a physician due to the acuity of the patient
      - a. If they refuse to immediately connect you to a physician, ask the clerk under what EMTALA exemption (capability or capacity) they are refusing the transfer
      - b. If they cite capacity, ask if they have ever made capacity for similar patients in the past and if they have, remind them that they will need to accept this one also
    - 2) Decide the patient is too ill to deal with the first center again and call a second center with the plan to follow-up on the response from the first center as a possible EMTALA violation
  - This is a good time to remember that many institutions have transfer agreements already written up to help with commonly encountered scenarios that can ease the transfer process → residents should become familiar with these as they begin to work at different institutions
- **How do you report a possible EMTALA violation? What happens after you report? What are some of the possible repercussions of violating EMTALA?**
  - Reporting of EMTALA violations happens through the CMS website or via a phone call to CMS
  - Hospitals have 72 hours to report possible EMTALA violations and can be liable if they fail to report
  - After reporting, CMS will reach out to the hospitals and providers involved to determine if EMTALA was violated
  - Penalties for EMTALA violations can include fines to the hospital (up to \$50,000 per infraction) but also against individual physicians (ie a consultant who refuses to see a patient)
  - Physicians are often also liable under their hospital bylaws and can even be criminally liable for failing to provide appropriate care

- Finally, if the infraction is severe enough, the hospital can lose its reimbursements from Medicare → this will essentially shut a hospital down

### ❖ Case Part III – Thrombolytics in STEMI (5 min)

*You make the decision to contact OSH #2. In addition, you decide that KH is not going to be able to get to a medical center that does PCI within 120 minutes of first presenting to medical care. Therefore, you decide to treat him with thrombolytics.*

### ❖ Discussion Question with Teaching Points

- **What thrombolytics are available and how are they different?**
  - 2 classes of thrombolytics
    - Non-specific thrombolytics (i.e. streptokinase)
      - RR reduction of death in STEMI patients of 25%
    - Fibrin-specific thrombolytics (i.e. tPA, reteplase, tenecteplase)
      - tPA has 1% more reduction in RR of death in STEMI patients compared to streptokinase
  - Most hospitals carry tPA not streptokinase
  - Non-specific thrombolytics do not need concurrent heparin administration while specific thrombolytics (ie tPA) do
- **What are the indications for thrombolytics in STEMI? What are the contra-indications?**
  - Indications are:
    - Symptom onset within 12 hours
    - PCI capable hospital > 120 min away from *initial* medical contact
  - Contra-indications are (many are the same for stroke, most are relative not absolute):
    - ICH or history of ICH
    - History of CNS tumor or head trauma w/in 3 months
    - Neurosurgery or stroke within 3 months
    - Uncontrolled sBP > 180 or dBP > 110
    - Major surgery or bleeding event w/in 3 months
    - Bleeding disorder or significant blood thinners (unclear INR cutoff)
- **What is the dose for tPA in this case?**
  - It is a 3-hour protocol
  - For patients > 65 kg the dose is 100 mg over the first 60 minutes (with 5-10 mg of that being a bolus) followed by 20 mg over the next hour and 20 more mg over the hour after that
  - Remember, as noted above, to also give heparin

❖ **Case Part IV - EMS Personnel (5 min)**

*Your hospital only has tPA so you give it and continue the heparin infusion. You are now on the phone with OSH #2. OSH #2 will gladly accept the patient. However, they will not be able to send the flight crew and helicopter because of the weather. You glance outside, you see continuous lightning brightening the sky and hear a loud boom of thunder. OSH#2 asks if you would like them to send them their ground transport team or if your local EMS crew can bring the patient?*

*You realize your critical access hospital EMS services are volunteer based. The volunteers are all EMT-basic trained except for 2 advanced EMTs who rotate call schedules. The one advanced EMT is away on vacation and the one on call happens to be KH, your patient.*

❖ **Discussion Question with Teaching**

- **What are the different skills sets of EMS providers?**
  - **Emergency Medical Responder:** basic interventions such as CPR and basic airway maneuvers (i.e. jaw thrust) until additional EMS can arrive
  - **Emergency Medical Technician:** basic emergency medical care and transportation but no IV medications
  - **Advanced Emergency Medical Technician:** basic and limited advanced emergency medical care and transportation including IV medications
  - **Paramedic:** advanced emergency medical care including intubation and IV medications
  
- **What are your options to transport KH to OSH #2?**
  - He is not safe to send via basic EMT and you have no advanced EMTs or paramedics available so you have 2 choices:
    - You as the provider ride in the back of the ambulance with local EMS for transport → however, you would have to call in another provider for the critical access hospital as you would be over 30 minutes away
    - Have the OSH#2 ground crew come and get the patient while you monitor him in your local ED

❖ **Case Part V – Critical Access Hospitals (5 min)**

*You ultimately decide to have the OSH #2 EMS crew come and get KH. You feel as though that was the best decision for the patient and the community as it allows you to stay in the ED for other potential patients. When KH patient arrives to the OSH, his 2-hour post tPA EKG does not show a 50% reduction in ST elevations so he is taken to the cath lab and 2 stents are placed.*

*He survives and is able to watch his high school football team win the 8-man state football championship 3 weeks later.*



- **What defines a critical access hospital?**
  - 25 or less inpatient beds
  - At least 35 miles away from another hospital
  - Average length of stay < 96 hours for acute care patients
  - Provides 24/7 Emergency Care Services
    - Provider must be on site or on-call within 30 minutes at all times
  - Often develop agreements and protocols with surrounding hospitals regarding communication, referral, transfer, along with emergent and non-emergent transportation

#### ❖ **Case Teaching Points Summary**

- **Management of STEMI in a Limited Resource Setting**
  - Primary PCI is favored over thrombolytics if a patient can be transferred to PCI capable hospital within **120** minutes of first healthcare contact
  - Thrombolytics improve survival
    - Primary benefit is for treatment within 2 hours of symptom onset
- **EMTALA and Inter-hospital Transfers**
  - EMTALA covers the emergency medical care of patients and sets out guidelines for appropriate transfers between hospitals
  - Under EMTALA, ED physicians have an obligation to provide a “Medical Screening Exam” (MSE) to determine if a patient has an “Emergency Medical Condition” (EMC)
  - If an EMC is found, ED physicians are obligated to treat the patient regardless of ability to pay and arrange for appropriate transfer if their institution lacks the capability (ie services) or capacity (personnel or space) to care for the patient
  - Hospitals can only refuse transfer if they lack capability (ie cath lab is not functioning) or capacity (lack space or personnel to safely care for a patient) *and* have not increased their capacity in the past in similar situations through temporary measures (ie calling staff in)
  - EMTALA violations can result in significant fines to both hospitals and individual physicians and can even lead to loss of a hospital’s ability to care for Medicare patients
- **Types of Thrombolytics**
  - Non-specific thrombolytics (i.e. tPA) provide slightly better risk reduction of death when compared to fibrin specific thrombolytics
  - Dosing of tPA for STEMI is 100 mg over the first 60 min, 20 mg over the next hour and 20 mg over the last hour for a 3-hour protocol
  - Non-specific thrombolytic agents (i.e. tPA) should receive heparin while specific thrombolytics (i.e. streptokinase) should not

- **EMS Personnel**
  - There are different skills sets among EMS providers → know who you are working with in your area
  - Emergency Medical Responders are trained to provide CPR and basic airway assistance until Emergency Medical Technicians arrive
  - EMTs come in basic and advanced → basic cannot give IV medications while advanced EMTs can
  - Paramedics undergo even more training and can provide many IV medications and perform advanced airway interventions including intubation
  
- **Critical Access Hospitals**
  - Critical access hospitals provide an essential resource for rural communities
  - They are defined by small volumes, small inpatient capabilities and are often staffed with on-call providers many of whom are advanced practice providers (NPs and PAs)
  - Developing protocols with transferring facilities is essential to the functioning of critical access hospitals

## ❖ Facilitator Background Reading

Most trainees at large, academic training programs may never get the opportunity to work in a resource limited setting or a critical access hospital until their first moonlighting shift or their first shift as an attending. Nonetheless, it is important to think about how managing acute emergencies may be different in these settings and become familiar with the basics of inter-hospital transfers and EMTALA. Many inpatient physicians are unfamiliar with EMTALA regulations and it is vital that we as ED physicians understand it fully as we are often the ones facilitating transfer of EMTALA protected patients between hospitals.

### ***Critical Access Hospitals***

As of April 2018, there are 1346 critical access hospitals in the United States. To be classified as a critical access hospital, the hospital must meet several characteristics as set forth by the federal government. The most basic of these include: 25 or fewer inpatient beds, being 35 miles away from another hospital, average length of stay < 96 hours for acute care patients, provide 24/7 Emergency Care Services, provider must be on site or on-call within 30 minutes at all times and the hospital must develop agreements and protocols with surrounding hospitals regarding communication, referral, transfer, along with emergent and non-emergent transportation.

### ***Management of STEMI outside of a PCI center***

Management of a STEMI, whether in a PCI or non-PCI center, has the same goal – reperfusion of the coronary vessels. Evidence has shown the best way to do this is with primary percutaneous coronary intervention (PCI). When compared to thrombolytics, PCI has less incidence of death, nonfatal reinfarction and hemorrhagic stroke. That being said, the AHA recommends using thrombolytics for STEMI patients if the patient has no contraindications to thrombolytics, had symptom onset within 12 hours of seeking care and transfer to a PCI capable hospital is not possible within 120 minutes of first medical contact. Use of thrombolytics is associated with a survival benefit which has been seen for up to 10 years out and is greatest for treatment within 2 hours of symptom onset. However, up to 30% of patients may experience re-occlusion. Further, many interventional cardiologists will still take a patient to PCI if their 2-hour post treatment EKG shows less than a 50% resolution of the ST elevation. Given these factors, STEMI patients should be transferred to a PCI capable hospital for possible intervention even after being given thrombolytics.

### ***EMTALA: The Basics***

Hospitals that participate in Medicare and have an emergency department are required under EMTALA to do the following:

- Provide an appropriate medical screening exam (MSE) to any individual who comes to the emergency department (or is on the medical campus requesting emergent medical care)

- Provide necessary stabilizing treatment to an individual with an EMC (emergent medical condition) or an individual in labor
- Provide for an appropriate transfer of the individual if either the individual requests the transfer or the hospital does not have the capability or capacity to provide the treatment necessary to stabilize the EMC
- Not delay examination and/or treatment in order to inquire about the individual's insurance or payment status
- Not take adverse action against a physician who refuses to inappropriately transfer an individual with an emergency medical condition or against an employee who reports a violation of these requirements

### **When EMTALA is triggered**

Many of EMTALA's regulations are specifically applicable to hospitals with a dedicated Emergency Department. An EMTALA obligation is triggered for such a hospital when an individual comes to a hospital's dedicated emergency department and a request is made either by the individual or on the individual's behalf or a prudent layperson observer would conclude from the individual's appearance or behavior a need for examination or treatment of a medical condition. In this case, the hospital has incurred an obligation to provide an appropriate medical screening examination (MSE) for the individual and either stabilizing treatment or an appropriate transfer. The purpose of the MSE is to determine whether or not an emergency medical condition exists.

EMTALA can also be triggered if an individual who is not a hospital patient comes somewhere else on hospital property and either the individual requests examination or treatment for an emergency medical condition or if a prudent layperson observer would believe that the individual is suffering from an emergency medical condition. The term "hospital property" means the entire main hospital campus including the parking lot, sidewalk and driveway or hospital departments, including any building owned by the hospital that are within 250 yards of the hospital.

EMTALA also contains regulations covering the care of women in labor. "Labor" is defined to mean the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor, unless a physician, certified nurse-midwife or other qualified medical person acting within his or her scope of practice certifies that, after a reasonable time of observation, the woman is in false labor.

An infant that is born alive is an "individual" and the screening requirement of EMTALA applies to "any individual" who comes to the emergency department. If an infant is born alive in the emergency department and a request is made on that infant's behalf for screening for a medical condition (or if a prudent layperson would conclude, based on the infant's appearance or behavior that the infant needed examination or treatment for a medical condition), the hospital and physician could be liable for violating EMTALA for failure to provide such a medical screening examination to the infant.

### **Medical Screening Examination (MSE)**

The MSE must be conducted by an individual who is determined qualified by hospital by-laws or rules and regulations. The purpose of the MSE is to determine whether or not an emergency medical condition exists.

Emergency medical condition means:

1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
  - a. 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;
  - b. Serious impairment to bodily functions; or
  - c. Serious dysfunction of any bodily organ or part; or
2. With respect to a pregnant woman who is having contractions:
  - a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
  - b. That transfer may pose a threat to the health or safety of the woman or the unborn child

Hospitals may not attempt to coerce individuals into making judgments against their interest by informing them that they will have to pay for their care if they remain but that their care will be free or at a lower cost if they transfer to another hospital.

### **“Stabilization” of an EMC under EMTALA**

A hospital, regardless of size or patient mix, must provide screening and stabilizing treatment within the scope of its abilities to an individual with an emergent medical condition. Further, to comply with the MSE and stabilization requirements of §1867, all individuals with similar medical conditions are to be treated the same. The hospital must provide care until the condition ceases to be an emergency or until the individual is properly transferred to another facility. An inappropriate transfer or discharge of an individual with an EMC would be a violation of EMTALA.

The EMTALA regulation sets the standard determining for when a patient is stabilized. Section 42 CFR 489.24(b) defines stabilized to mean:

“... that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an “emergency medical condition” as defined in this section under paragraph (2) of that definition, that a woman has delivered the child and the placenta.”

An individual will be deemed stabilized if the treating physician has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved, although the underlying medical condition may persist. For example; an individual presents to a hospital complaining of chest tightness, wheezing, and shortness of breath and has a medical history of asthma. The physician completes a medical screening examination and diagnoses the individual as having an asthma attack

that is an emergency medical condition. Stabilizing treatment is provided to alleviate the acute respiratory symptoms. In this scenario the EMC was resolved and the hospital's EMTALA obligation is therefore ended but the underlying medical condition of asthma still exists. After stabilizing the individual, the hospital no longer has an EMTALA obligation. The physician may discharge the individual home, admit him/her to the hospital or transfer (the "appropriate transfer" requirement under EMTALA does not apply to this situation since the individual has been stabilized) the individual to another hospital depending on his/her needs.

A hospital's EMTALA obligation ends when a physician or qualified medical person has made the decision:

- That no emergency medical condition exists (even though the underlying medical condition may persist);
- That an emergency medical condition exists and the individual is appropriately transferred to another facility; or
- That an emergency medical condition exists and the individual is admitted to the hospital for further stabilizing treatment

### **Inter-Hospital Transfers**

In the case of individuals found to have an EMC, a hospital is required under EMTALA to provide stabilizing treatment within the capabilities of the hospital or to arrange and provide transfer to a hospital with capability to treat that particular EMC. Transfer of the individual to another hospital may be reasonable and permissible but the regulations establish a number of requirements that each transfer must meet in order to comply with EMTALA. If an individual's EMC has not been stabilized, prior to transferring the individual to another hospital, the sending hospital is required under EMTALA to pursue a transfer because either:

- the individual requests the transfer; or
- the expected benefits of the transfer outweigh the increased risks

In either case, the transfer must also always meet the four requirements of an "appropriate" transfer (see below).

The transfer requirements apply only to individuals who have been determined to have an EMC that has **not** been stabilized. The hospital has no further EMTALA obligation to an individual who has been determined not to have an EMC or whose EMC has been stabilized or who has been admitted as an inpatient. However, the hospital still has other obligations to the individual under the Hospital Conditions of Participation which are outside the scope of this session.

### Transfer at the Request of the Individual

A transfer may be made at the request of the individual with an EMC or of a person legally responsible for that individual. The hospital must assure that the individual or legally responsible person is first informed of the hospital's obligations under EMTALA, e.g., its obligation to provide stabilizing treatment within its capability and capacity, regardless of the individual's ability to pay. The hospital must also assure that the individual has been advised of the medical risks associated with transfer. After the

hospital has communicated this information, the individual's request for a transfer must be in writing. The request must include the reason(s) why the transfer is being requested and a statement that the individual is aware of the risks and benefits associated with the transfer. The individual or individual's representative must sign the written request.

#### Transfer with a Physician Certification

Alternatively, a transfer may be made when a physician certifies that the expected benefits of the transfer outweigh the risks. Specifically, a physician must certify that the medical benefits of being transferred outweigh the increased risks that result from being transferred. In the case of a pregnant woman in labor, the physician must certify that the expected benefits outweigh the risk to both the pregnant woman and the unborn child.

#### Women in Labor

Regardless of practices within a State, a woman in labor may be transferred only if she or her representative requests the transfer or if a physician or other qualified medical personnel signs a certification that the benefits outweigh the risks. If the hospital does not provide obstetrical services, the benefits of a transfer may outweigh the risks. The hospital must still meet the screening, treatment, and transfer requirements to reduce the risks of transfer as much as possible.

#### **Four Requirements for an Appropriate Transfer**

1. The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child prior to transfer
2. The receiving facility (a) has available space and qualified personnel for the treatment of the individual, and (b) has agreed to accept transfer of the individual and to provide appropriate medical treatment
  - a. The transferring hospital must obtain permission from the receiving (recipient) hospital to transfer an individual. The transferring hospital should document its communication with the receiving (recipient) hospital, including the date and time of the transfer request and the name and title of the person accepting the transfer.
3. The transferring hospital sends to the receiving facility **all** medical records related to the emergency condition which the individual has presented that are available at the time of the transfer. This includes documentation of a written consent to transfer. Additionally, if the transfer is due to the an on-call physician at the sending hospital failing to appear or refusing to provide care, this information must be documented and sent with the patient.
4. The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.
  - a. Emergency medical technicians 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. The physician at the **sending** hospital (not at the receiving hospital) has the responsibility to determine the appropriate mode, equipment, and attendants for transfer.

#### Refusal to consent to a transfer

For individuals who refuse to consent to a transfer, the hospital staff must inform the individual of the risks and benefits and document the refusal and, if possible, place a signed informed consent to refusal of the transfer in the individual's medical record. If an individual or the individual's representative refuses to be transferred and also refuses to sign a statement to that effect, the hospital may document such refusals as they see fit.

### **ACCEPTING TRANSFERS**

Any participating Medicare hospital is required to accept appropriate transfers if the hospital has the specialized capabilities requested and has the capacity to treat the patient. Again, this only applies to the transfer of patients with an *un-stabilized* EMC as protected under EMTALA (ie not inpatient transfers). Hospitals with specialized capabilities or facilities may include, but are not limited to, hospitals with burn units, shock trauma units, neonatal intensive care units or hospitals that are regional referral centers that serve rural areas such as described in this case. This requirement to accept an appropriate transfer applies to any Medicare-participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department

Hospitals may only refuse an EMTALA protected transfer if they lack either the **capability** to provide care, ie their cath lab is not functioning, or if they lack **capacity**, either personnel and space, and do **not** have a history of accommodating additional, similar patients. If a hospital generally has a record of accommodating additional patients by various means, such as moving patients from one unit to another, calling in additional staff or temporarily borrowing additional equipment from other facilities, then that hospital would be expected to take these steps for an EMTALA protected transfer also. The determination of a hospital's capacity would depend on the case-specific circumstances and the hospital's previous implementation of capacity management actions.

If a hospital refuses a seemingly appropriate EMTALA transfer, the physician at the transferring center should ask why the transfer is being refused (capability or capacity) and document such. If the receiving hospital is refusing a transfer using a capacity argument, it is reasonable for the sending physician to ask if the institution has taken temporizing measures to increase capacity in the past and if so, remind them they are required to do so for EMTALA transfers also.

Finally, many hospitals have pre-established transfer agreements with other hospitals for such specialized care such as stroke or STEMI which allows for easy transfer of emergent patients between institutions. It is important for residents to become familiar with such transfer agreements when they start moonlighting or ultimately start their first job out of residency.



## **EMS Personnel**

Knowing the training of and resources available to your EMS systems is important when working in any emergency department but become even more so when working at a critical access hospital. Decisions to transfer patient to a higher level of care should not be made without careful consideration, especially when transferring a patient could mean using the only available ambulance and EMS provider for the community to do so. EMS skills set vary vastly by training with Emergency Medical Responders being the least trained and paramedics being the most. Being familiar with the EMS capabilities in your community is vital.

### ❖ **References**

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