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Owner	Cynthia Price
Policy Area	Patient Rights
Applicability	St. Joseph Hospital

Emergency Medical Treatment & Active Labor Act

*Table of Contents: **click on words** to toggle "jump to" sections within the document*

ATTACHMENTS	RESPONSIBILITY

PURPOSE:

This Policy is intended to address the organization's legal obligations whenever a person comes to the hospital campus or to off-site hospital departments, requesting examination and treatment for a possible emergency condition or for the possible existence of active labor in a pregnant woman.

SCOPE:

This policy applies to St. Joseph Hospital and its associated departments.

BACKGROUND:

The Emergency Medical Treatment and Active Labor Act, 42 USC § 1395dd, ("EMTALA"), has been in effect since 1986 and it applies to all Medicare participating hospitals with Emergency Departments. Originally, it was intended to prevent the practice of "patient dumping" which was perceived by Congress to be a serious problem. Over the years, this law has been expanded by case law and by federal agencies.

POLICY:

Patients will receive a medical screening exam, stabilization, and transfer within the requirements of EMTALA

1. Medical Screening Exam: Any individual who comes to the hospital or affiliated department, including off-campus departments, requesting emergency services is entitled to a medical screening examination performed by qualified individuals. The purpose of the medical screening examination is to determine whether or not an emergency medical condition exists.
2. Stabilization: If an emergency medical condition exists, then the hospital is required to provide stabilizing treatment within its capability and capacity.
3. Transfer: Patients can be transferred to another hospital for stabilization; however, a transfer has to be performed within specified guidelines in order for the transfer to be considered an "appropriate transfer."
4. Departments outside of the Emergency Department shall provide initial treatment and stabilization within the capabilities of the services they provide and arrange for appropriate transfer, if necessary.

DEFINITIONS:

There are many terms used within this policy that are defined within the statute and regulations. Where indicated, terms are defined in **Appendix A**.

PROCEDURES:

1. Determine Whether EMTALA Applies

a. EMTALA applies when a person comes to the emergency department (ED) for examination or treatment. An EMTALA obligation is triggered for a hospital when an individual comes by themself or with another person, to a hospital's **dedicated ED** and a request is made 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 such a case, the hospital has incurred an obligation to provide an appropriate Medical Screening Examination (MSE) for the individual.

Note: the term "comes to the ED" should not be taken literally. Under the regulations, a person "comes to the ED" when they come anywhere on **hospital property.** The term "hospital property" means the entire main hospital campus as defined in §413.65(a), including the parking lot, sidewalk and driveway or hospital departments, including any buildings owned by the hospital that are within 250 yards of the hospital. Exclusions include other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other non-medical facilities.

A person is also considered to have "come to the ED" when they come via EMS and the ambulance is on hospital property. Should an ambulance arrive on hospital property with a person requesting examination and treatment, the individual must be provided an MSE, and, if indicated, stabilization and transfer as necessary. If the ambulance came to our ED by mistake, the patient requested another facility, is competent to make such a decision, and wants to go to another facility, then there is no EMTALA obligation. However, if the patient is felt to not be competent (mental illness, altered mental status, intoxication, etc.), then EMTALA applies and that patient needs to be provided a MSE in our ED.

b. if a person is on hospital property for diagnostic testing or treatment and during the time they are on hospital property, they develop symptoms or signs suggestive of an emergent medical condition and requests treatment (as outlined in 1.a. above), then EMTALA would apply.

2. **MEDICAL SCREENING EXAMINATION (MSE)**

a. Once the determination has been made that EMTALA applies, the person is entitled to a Medical Screening Examination (MSE).

b. The purpose of the MSE is to determine whether an **Emergency Medical Condition (EMC)**[2]or active labor exists.

Note: this applies to **all** patients with any type of condition, including those patients presenting with pain symptoms, psychiatric/addiction problems, and to obstetrical patients experiencing signs or symptoms suggestive of possible labor[2]. A MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC or not.

c. For purposes of satisfying EMTALA, **triage**[3] is not considered to be an **MSE**[4].

d. The MSE need not be performed within the ED itself as long as patients are treated

in a nondiscriminatory location. In most cases, the ED is the appropriate place for a MSE to take place. For patients presenting with signs/symptoms of possible active labor and certain pregnancy-related conditions, the MSE is usually performed in Labor and Delivery (L&D) (see policy Active Labor Medical Screening and Labor Evaluation). If delivery appears imminent at the time of presentation, then the MSE should be performed in the ED. Pregnant patients presenting with signs/symptoms of non-labor related problems will be provided a MSE in the ED (see Obstetric Patients Policy in ED Policy Manual).

e. Individuals coming to the ED must be provided a MSE appropriate to the individuals' presenting signs and symptoms, as well as the capability and capacity of the hospital. Depending on the individual's presenting signs and symptoms, an appropriate MSE can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures, such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or other diagnostic tests and procedures. Consultations and admission may be necessary to determine if an EMC exists.

f. A MSE is to be provided by a person or person(s) deemed qualified to perform the examination by the Board of Directors. A physician is qualified to perform the examination. However, the hospital's Board of Directors can authorize other types of practitioners to perform MSEs, as appropriate for the setting. Those individuals deemed appropriate to provide a MSE include: Physicians; Emergency Department credentialed PAs/APRNs; obstetricians and Certified Nurse Midwives (CNM) may determine if an EMC exists in a patient with a gynecological/obstetrical presentation, determine if a patient is in active labor or experiencing a pregnancy-related emergency. In Labor and Delivery, qualified Labor and Delivery RNs may perform labor-specific MSE in collaboration with the obstetrical provider (see policy Active Labor Medical Screening and Labor Evaluation).

g. There can be no delay in providing the MSE in order to ask for information regarding a patient's insurance. See section 7 below for more detail.

h. If a patient refuses to have a MSE performed, the physician/qualified provider should inform the patient of the risks and benefits of not conducting the MSE. The patient should be asked to sign that they refuse to have an MSE, utilizing the Refusal of Care/Leaving Against Medical Advice form, as appears in **Attachment 1**. If the physician/qualified provider is not present to speak with the patient, the patient should be asked to wait until the physician/qualified provider is available to speak personally with the them, or via phone. If the patient refuses to wait for the physician/qualified provider, then the nurse caring for the patient at that time should explain to the patient the risks and benefits of not conducting the MSE, as advised by the physician/qualified provider caring for that patient.

i. If an MSE determines that the patient does not have an EMC, then there are no further obligations under EMTALA. Of course, the patient should still be treated and handled appropriately within acceptable standards of care.

j. If an EMC exists, then the hospital is obligated to follow through with stabilization and/or transfer.

3. **STABILIZATION[5]**

   a. If an EMC exists, then the hospital is obligated to provide stabilizing treatment within its capability and capacity. It is expected that available hospital resources, including those of ancillary departments and specialists, will be utilized to provide both the MSE and stabilization.

   b. Capabilities of a medical facility mean that there is physical space, equipment, supplies, and specialized services that the hospital provides (e.g., surgery, psychiatry, obstetrics, intensive care, pediatrics, trauma care).

   c. ***Capabilities of the staff*** *of a facility* means the level of care that the personnel of the hospital can provide within the training and scope of their professional licenses. *This includes coverage available through the hospitals on-call roster*.

   d. Stabilization is achieved when no material deterioration of the emergency condition is likely, within reasonable medical probability, to result from, or occur during, the transfer or discharge of the patient. In the case of a pregnant woman found to be in active labor, stabilization occurs when she has delivered (including the placenta).

   e. A patient does not have to be stabilized when they request a transfer or when a determination has been made by a qualified person that a transfer is necessary because the hospital does not have the capacity or capability available to adequately provide for the patient's stabilization (See transfer section below). However, attempts at stabilization should be undertaken to the capacity and capabilities available at the time the EMC is discovered and up until, as well as during, transport of the patient to another facility.

   f. If the patient refuses to accept the proposed stabilizing treatment, the physician/qualified provider, after informing the patient of the risks and benefits of refusing the proposed stabilizing treatment, shall take all reasonable steps to have the individual sign the Refusal of Care/Leaving Against Medical Advice form.If the physician/qualified provider is not present to speak with the patient, the patient should be asked to wait until the physician/qualified provider is available to speak personally with the them, or via phone. If the patient refuses to wait for the physician/qualified provider, then the nurse caring for the patient at that time should explain to the patient the risks and benefits of not conducting the MSE, as advised by the physician/qualified provider caring for that patient.

      If the individual refuses to sign the form, then the physician/qualified provider or nurse speaking with the patient can note that on the form and/or within the medical record.

      The physician/qualified provider or nurse should offer assistance to the patient in finding follow-up care and make any appropriate referrals, as needed. This might include transfer to another facility.

4. **AUTHORIZATION FOR TRANSFER[6] - REQUIREMENTS**

   A hospital may not transfer a patient prior to their receiving stabilizing treatment unless:

   a. The patient, or their legal representative, requests a transfer, in writing as outlined on

the Patient Transfer Form , after being informed by the physician/qualified provider of the hospital's obligations under EMTALA, including the risks and benefits of the transfer.

OR

b. When the physician/qualified provider responsible for the patient certifies in writing on the Patient Transfer Form and in the medical record that the transfer is necessary for the patient to receive stabilizing treatment and that the medical benefits to be received by transfer to another facility outweigh the potential risk. Examples of the second scenario might include, but are not limited to, severe burn patients, serious head trauma, and/or other types of injuries or illnesses requiring tertiary level care.

5. **OTHER STEPS FOR AN APPROPRIATE TRANSFER**

   a. The transferring physician/qualified provider, or designated hospital employee, shall obtain the verbal consent of the receiving hospital before the transfer of a patient and shall make arrangements for the patient transfer with the receiving hospital.

   b. The physician/qualified provider responsible for the care of the patient shall document the patient's condition in the medical record prior to being transferred.

   c. The transferring physician and facility is responsible for the patient until the patient is received at the receiving facility, at which time care/responsibility is transferred to the receiving facility/physician. Therefore, the transferring physician needs to be available for communication with the transfer crew to answer questions, give additional orders, etc until the patient is received at the receiving facility.

   d. Copies of the patient's medical record shall be provided to the receiving hospital, including, but not limited to: history and physical exam, working diagnosis, treatment provided, test results, any relevant information regarding specialists contacted and the date and time of events, any other pertinent parts of the medical record, and informed written consent (Patient Transfer Form).

   e. The patient should be accompanied by personnel who are qualified to care for the patient during transportation, with adequate supplies and equipment to assure safe transport and in accordance with current State of New Hampshire EMS Prehospital Protocols. [If the patient is not being transported by EMS, the reason for this, as well as details of the pertinent discussion with the patient/legal guardian, must be included in the medical record.]

6. **CONSULTATIONS AND ON-CALL DUTIES**

Physicians on-call for the hospital perform such duties for the hospital for the purposes of providing evaluation, stabilization, and treatment of patients with an Emergency Medical Condition (EMC) and are not representing their own practice or group.

   a. If the medical screening examination indicates that the patient is experiencing an **emergency medical condition (EMC)** which requires evaluation, stabilization, and/or treatment beyond the capability of the physician or qualified provider performing the MSE, then they should consult an appropriate physician based upon the patient's preference and/or immediate need. The patient's request for consultation should be

honored, if possible, as long as the physician (or the person covering for that physician) is appointed to the medical staff of the hospital and is part of the formal call schedule, and the physician requested is appropriate for the EMC.

b. An appropriate attempt to contact the physician requested by the patient, or the appropriate physician from the on-call roster, requires that there be:

    i. A call to the physician's pager/answering service.

    ii. Attempts to reach the physician in the hospital.

    iii. A call to the physician at his office or at home.

    Thirty (30) minutes will be considered a reasonable time to carry out this procedure. Discussion will ensue between the physician/provider who performed the MSE and the on call physician to determine an appropriate time frame for the on call physician to present to the ED to evaluate the patient.

c. If the patient does not request a specific physician, or if the physician requested by the patient refuses the patient's request to come to the emergency department, or if the physician cannot be contacted within the 30 minute time period, then an appropriate physician from the on-call rotation list shall be called to provide the necessary consultation and/or evaluation, stabilization and treatment of the patient. Should the on-call physician not be available due to existing commitment (such as currently performing surgery either in the hospital or another facility or managing another patient with an EMC or due to circumstances beyond their control), such that delay would occur in tending to the patient in the ED with an EMC, then the physician/qualified provider would either contact the next person on the call roster or begin measures to transfer the patient to another appropriate facility for further evaluation, stabilization and treatment.

    Should a specialty not available to the hospital, or one that is normally available but on that given day is not, then the physician/qualified provider will take steps to transfer the patient with the EMC to an appropriate facility for further evaluation, stabilization, and treatment.

d. The on-call rotation list shall contain the names and phone numbers of the on-call physicians for each appropriate medical specialty and shall be maintained in the emergency department. A physician who has been appropriately called from the on-call rotation list cannot refuse to respond. Should such a refusal occur, the physician/qualified provider should immediately contact the ED Medical Director if the patient is in the ED and the President of the Medical Staff for patients in other areas of the hospital. The name and address of the on-call physician who refuses to come to the ED to evaluate a patient with an EMC is to be included on the Transfer Form sent to the receiving facility.

    Any such refusal shall be reported to the President/ CEO (or designee) for investigation and for further action.

e. The on-call physician is responsible for the appropriateness of any telephone orders given to the Emergency Department physician (or other qualified provider), based on the Emergency Department physician's (or other qualified provider's) verbal

description of the patient's medical condition. Beginning with any orders given over the telephone or thereafter, when the on-call physician provides or directs the primary care or treatment of that patient, that patient becomes the responsibility of the on-call physician.

f. Once the on-call physician has assumed the care of the patient, that patient's care shall be the responsibility of the on-call physician until the problem that prompted the patient's assignment of that physician is satisfactorily resolved and the patient has been discharged, admitted or transferred to the care of another physician or facility, all in accordance with this Policy.

g. If the Emergency Department physician and the on-call physician agree that a consultation with another specialist is warranted, and the consulting or on-call physician has not assumed responsibility for the patient, it shall be the responsibility of the Emergency Department physician to contact the other specialist. The care for the patient shall remain the responsibility of the Emergency Department physician until the second specialist is contacted and assumes responsibility for the care of the patient.

h. Physician extenders (PA, ARNP, etc) may not take ED call for a physician. However, at the discretion of the ED physician, and in conjunction with the on-call physician, the physician extender may provide initial evaluation of a patient in the ED. The on-call physician must remain available to come in to the ED if so requested by the ED physician and/or the physician extender.

i. If a patient in the ED needs consultation/evaluation/treatment by an on-call physician who feels that the patient would be better served by being evaluated in their office where they can provide a higher level of service than can be provided in the ED or hospital, then the patient can formally be transferred to that office. Formal transfer includes completion of the appropriate Transfer Forms and documentation as with any other transfer.

However, if the ED physician does not feel such a transfer is appropriate as the patient is not stable or is potentially unstable, then the on-call physician must present to the ED to evaluate the patient.

7. **PATIENT TRANSFERS**[6]

a. It is the **responsibility** of the **transferring physician/qualified provider** to:

1. Contact the receiving facility to arrange for transfer.
2. Complete the medical record, including a transfer/discharge summary/ED Record and assure that appropriate documents and imaging studies (with results) are included in the transfer.
3. Complete the Patient Transfer Form and Patient Transfer Documentation and Consent form; this includes specific orders for EMS personnel to follow, if appropriate. These forms need to be completed regardless of mode of transportation (i.e., EMS, helicopter, private vehicle, sheriff).

Please note that transportation conducted by Sheriff for a patient who is under an Involuntary Emergency Admission (IEA) does not require an

EMTALA form

4. Assure appropriate transportation for the patient; refer to Inter facility Transfer Protocol found in the State of NH EMS Prehospital Protocols for guidance.
5. Leave a number where EMS can reach you in the event of changes in the patient's status, clarification of orders, new orders.

8. **ACCEPTANCE OF PATIENT TRANSFERS TO ST. JOSEPH HOSPITAL**
    a. On call/on duty physicians are required to accept a patient in transfer from an outside facility on behalf of the hospital, assuming the patient is appropriate for the level of service the hospital provides and there is capacity to accept the patient. On-call/on duty physicians are acting as an agent of the hospital, not for themselves or their practice/group.
    b. On-call physicians should not accept patients from outside facilities without first discussing the case with the House Supervisor and any specialist who may need to be involved with the patient's care. The House Supervisor will help determine the hospital's capacity to accept such a patient. In the case of the Emergency Physician receiving a request to accept a patient in transfer, this will be done in conjunction with the on-call physician for the specialty likely to care for such a patient and the House Supervisor.
9. **PATIENT LOGS**
    a. All patients who come to the hospital for a possible emergency medical condition are to be "logged in". The records are to be kept, either in hard copy or in an electronic format, for a period of 5 years. This encompasses the Emergency Department Log for the Emergency Department.
    b. The Maternal Child Health Unit will maintain a separate log of all patient who are evaluated for possible active labor and other potential pregnancy-related emergencies. The records are to be kept, either in hard copy or in an electronic format, for a period of at least 5 years.
10. **PATIENT REGISTRATION AND INSURANCE**
    a. The hospital cannot delay the MSE in order to inquire about insurance coverage. However, this does not mean that the registration process cannot begin before or simultaneously with initiation of the MSE. If the patient is in acute distress, they should be brought to a treatment area for immediate care. However, if there is a delay due to the waiting time and the patient will have to wait in the normal course of operations, then insurance information can be obtained.
11. **ON CAMPUS – INSIDE MAIN HOSPITAL**
    a. All employees and staff should be aware that patients in the main hospital areas or departments who may possibly be experiencing an EMC, should be directed/ assisted to the Emergency Department [or, if appropriate, Labor and Delivery].
    b. If necessary, a Rapid Response should be activated by dialing 211 for anyone who collapses or appears that they are about to collapse.

12. **ON CAMPUS - OUTSIDE OF MAIN HOSPITAL (E.g. Medical Arts Building (MAB)SJN Physician Practices in the MAB , Parking Lot, Garage)**
    a. A person presenting in a vehicle with the intent of seeking emergency care and needing assistance should be assisted by hospital staff (ED personnel, security, etc.)
    b. Consideration will need to be made on a case-by-case basis as to whether or not the particular person needing assistance requires equipment and expertise beyond the level of training of the staff who would respond to the incident/person.
    c. Patients in the ED should not be abandoned to respond to an emergency outside of the main hospital. However, responding in a manner that a prudent, similarly trained person would do is appropriate.
    d. All employees and staff should be aware that patients seeking emergency care should be directed to the Emergency Department [or, if appropriate, Labor and Delivery]. This would include if a visitor or patient is found on the ground .
        i. This may require calling a Outpatient Rapid Response by dialing 211 and simultaneously 911, e.g., for true emergencies in the MAB, SJN Physician Practices in MAB and SJN Departments in the MAB as well as SJN parking lot)

13. **OFF MAIN CAMPUS LOCATION - (PHYSICIAN OFFICES, PHYSICAL THERAPY, PHLEBOTOMY Draw Stations)**
    a. For patients, staff, family, visitors, etc. who may be experiencing an EMC off campus,
        i. Summon 911 as needed for evaluation, initial treatment, and transport.
        ii. Stay with the individual until help arrives.
        iii. Evaluate and administer care to the level of capability of the staff and equipment available at such a department.
        iv. Contact the Emergency Department to notify them of the occurrence and of the pending arrival of the individual.
        v. Provide a written report of the occurrence.
        vi. If the individual declines EMS transport document such and obtain a written refusal, if it was felt that transport by EMS was indicated.

14. **MANAGEMENT OF THE PATIENT WHO HAS ELOPED FROM THE HOSPITAL AND NOW RETURNS**
    a. The patient who is discovered to have eloped from the inpatient setting will need to be reassessed to determine if a new EMC exists. A Code Amber will be activated, as deemed appropriate, after prudent search for the patient.
        i. For the patient found within the confines of the main hospital building (excluding the Medical Arts Buildings and attached parking garage), they will be returned to their room, whereby the physician in charge of that patient's care will be notified and provide a new MSE if there is concern for, or clear evidence of, a change in the patient's medical condition from baseline, and document such in the patient record.
        ii. For the patient found outside of the main hospital building, they will be

brought to the Emergency Department for a new MSE, conducted by the Emergency Provider.

15. **SIGNAGE**

Appropriate signage must be posted in conspicuous areas of the hospital where patients are likely to seek emergency care and in off-campus departments. Signs must provide, at a minimum the following language:

IT'S THE LAW!

If you have a medical emergency or are in labor, you have the right to receive, within the capabilities of this hospital's staff and facilities:

- **An appropriate medical screening examination**
- **Necessary stabilizing treatment (including treatment for an unborn child) and, if necessary**
- **An appropriate transfer to another facility even if you cannot pay or do not have medical insurance or you are not entitled to Medicare or Medicaid. This hospital does participate in the Medicare and Medicaid programs.**

REFERENCES:

Related Policies

- Department of OB/ GYN Labor and Delivery Policy Manual: Active Labor Medical Screening and Labor Evaluation
- Emergency Department Policy Manual: Obstetrical Patients in the Emergency Department, including Guidelines for the Assessment of the Unscheduled OB Patient Presenting to the Emergency Department
- Leaving Against Medical Advice (AMA) and Refusal of Care Policy
- Informed Consent Policy

ATTACHMENTS:

Appendix A:Definitions of EMTALA terms

Attachment 1:Refusal of Treatment Form

Attachment 2:Patient Transfer Form

RESPONSIBILITY:

Risk Manager, All Nursing Personnel, Director Emergency Services, all Security Personnel, All

Communications Personnel, all Admitting/Information Personnel, and all Ancillary Personnel

SUPERCEDES:

GA – 76

REFERENCES:

1. CMS – TAG: Interpretive Guidelines – Responsibility of Medicare Participating Hospitals in Emergency Cases. 2009
2. HCPro, Inc: EMTALA Compliance: Analysis of Recent Changes and Strategies to Manage Risk.
3. EMTALA and ED On-Call: How To Manage This Dilemma; ACEP Boston Scientific Assembly; Robert J. Bitterman, MD, JD, FACEP; 2009.
4. EMTALA: Providing Emergency Care Under Federal Law; ACEP; Robert J. Bitterman, MD, JD; 2012.

Attachments

Appendix A

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Amanda Jasper: MEDICAL STAFF MANAGER	05/2020
Emergency Services	Deepak Vatti: Physician ED	05/2020
HIS Form Approver	Julie West: ROI TECH	05/2020
	Beverly Robinson: DIRECTOR-RISK MGMT	05/2020