Advisory Panel Starts Shaping EMTALA Policy

The technical group's physician members hope its final report will make on-call service more workable.

BY CHRISTINE KILGORE
Contributing Writer

As the technical advisory group examining the Emergency Medical Treatment and Labor Act wraps up its work, some of its 55 recommendations are already finding their way into federal regulators' approaches to emergency on-call policies and specialty hospitals' responsibilities.

Despite those advances, the panel cautioned that larger issues within EMTALA remain to be addressed.

The panel put its efforts to rest in April with a final report that its physician members hope will make on-call service more workable and improve the statute's effects in the trenches.

"One of our overarching goals was to encourage attending physician participation in the on-call system, to make it easier and more practical for physicians and hospitals to work together and fulfill their obligations," said Dr. David M. Siegel, an emergency physician and lawyer who chaired the technical advisory group (TAG). "A lot of the clarifications and definitions we provided should have some impact if adopted."

The advisory panel met seven times over 3 years to advise the Secretary of the Department of Health and Human Services on how to improve guidance and enforcement of EMTALA. The 19-member advisory group included Centers for Medicare and Medicaid Services (CMS) staff, the inspector general of HHS, various patient and hospital representatives, and physician representation.

CMS Considers On-Call Crisis

Several of the panel's recommendations to improve on-call systems already have been implemented or are under serious consideration.

The CMS changed its interpretive guidelines, for instance, to clarify that a treating physician has final say on whether an on-call physician should come to the emergency department, and that he or she may use a variety of methods, including telemedicine, to communicate.

CMS also has begun to make it clear that specialty hospitals are not exempt from EMTALA obligations. Furthermore, in a draft Inpatient Prospective Payment System regulation for fiscal year 2009, the agency is now proposing that hospitals be allowed to group together and form community call to meet their on-call responsibilities.

The TAG's other recommendations cover a broad swath of issues, from improvement in EMTALA enforcement to review of "triage out" practices and improvement in medical screening exams and care for psychiatric patients, said Dr. Siegel, senior vice president at Meridian Health in Neptune, N.J.

The panel "had a fairly circumscribed charge, in that they weren't being asked to tackle the big problems lurking behind EMTALA," said Barbara Tomar, director of federal affairs for the American College of Emergency Physicians.

"They did a tremendous job in dealing with some incredibly technical and complex issues … in simplifying and clarifying language, and in refining what [EMTALA] means," she added.

The panel did not let its limited charge—and the broader issues—go unnoticed. It included in its list of recommendations two "high-priority" items: HHS should amend EMTALA to include liability protection, and it should develop a funding mechanism for hospitals and physicians who provide care covered by the statute.

The panel also filed its report with a letter urging HHS to not only adopt the recommendations, but to give "serious consideration" to the larger, systemic issues that are fueling on-call problems across the country.

"No matter what we put together, the TAG recommendations will not solve the ongoing on-call crisis," said panel member Dr. Mark Pearlmutter, chief of the Caritas Emergency Medical Group at St. Elizabeth's Medical Center, Boston.

Can Community Call Deliver?

Like other TAG recommendations, the request for CMS to clarify its position on "shared or community call" and permit formal arrangements is a recognition of local variations. It's also a reflection of how the emergency care environment has changed overall since 2003, when EMTALA regulations were revised to allow on-call physicians more flexibility.

The advisory panel's conclusion that participation in community call plans can "satisfy [hospitals'] on-call coverage obligations"—a notion that CMS is now seeking comment on—is "a new option on the table," said Ms. Tomar.

"It's a recognition of the fact that you no longer have full contingents of on-call doctors waiting at every hospital … that if you can get a community to pull together doctors to serve different hospitals on different days and connect that with your EMS system, you've got a potential plan," she said.

The panel received testimony from leaders of various regional call pilot projects around the country "that [the projects] really worked," Dr. Pearlmutter said. "It was very clear this was something we needed to recommend."

It may not always be possible to implement such plans successfully—at least one solid regional effort recently collapsed, Tomar noted. In that light, the panel clearly stated in its recommendation that hospitals must have backup plans, and that a community call arrangement does not negate a hospital's obligation under EMTALA to perform medical screening exams.

The TAG's final report also is sprinkled with high-priority recommendations aimed at making it clear that patients may not be transferred unnecessarily, and that hospitals must have—and review annually—plans for on-call coverage for services they regularly offer to the public. That includes specialty hospitals without dedicated emergency departments.

The 2006 Inpatient Prospective Payment System final rule adopted another related recommendation: Hospitals with specialized capabilities but no EDs are bound by the same responsibilities under EMTALA as specialty hospitals with dedicated EDs.

Inpatient Transfers Hotly Debated

The advisory group closed with heated debate, when questions were raised near the end of the panel's seventh and final meeting last September about whether EMTALA should apply to the transfer of inpatients who are never fully stabilized.

The panel was presented with several scenarios, such as a patient who comes in with chest pain and is admitted with a probable diagnosis of angina—but who is found with additional testing to have a dissecting thoracic aneurysm or other life-threatening surgical emergency that the admitting hospital is unable to address.

"We heard testimony about hospitals getting on the phone and trying to transfer that patient to a receiving facility that refused, citing they had no obligation to do so," Dr. Pearlmutter recalled.

After several votes, the panel narrowly recommended that EMTALA be extended to cover inpatient transfers, but only if the patient has not been stabilized for the condition requiring admittance.

"Deciding what to recommend," Dr. Pearlmutter said, "was a difficult, deliberate process."

In the end, the contentious recommendation became one that CMS ran with. Like the community call recommendation, it made its way into the draft Inpatient Prospective Payment System regulation for fiscal year 2009.

In a series of recommendations on psychiatric issues in the emergency setting, the group again "spoke to the issue that EMTALA requirements have not recognized the need for local responses," Ms. Tomar said.

The advisory panel said, for instance, that physicians and hospitals can use community protocols, services, and resources to help determine whether psychiatric emergency medical conditions exist, and how and where patients should be placed and cared for. ■

For a copy of the EMTALA technical advisory group's final report, visit www.magpub.com/emtala/EMTALA%20Final%20Report_final.pdf.

Proposed EMTALA Policy Changes

Other high-priority recommendations in the EMTALA TAG's final report include:

► HHS should improve the consistency of EMTALA interpretations and enforcement across CMS regions, establish intermediate sanctions for less serious violations, and establish an appeals process for hospitals and providers.

► While taking calls selectively may violate EMTALA, taking calls for patients with whom the physician has a preexisting relationship should not be considered "selective call."

► An emergency medical condition does not need to be resolved to be considered stabilized for the purpose of discharge—as long as it is determined that the patient's care can be reasonably performed as an outpatient or later as an inpatient, and as long as the patient receives a plan for follow-up care.

► HHS should monitor and evaluate, however, the consequences of deferred care and of patients being "triaged out."

► A psychiatric medical screening exam should attempt to determine whether an individual is suicidal, homicidal, or gravely disabled (poses a danger to oneself because of extremely poor judgment or inability to care for oneself)—though such a determination does not necessarily mean the patient has an emergency medical condition.

► Hospitals with specialized behavioral health capabilities should be required to accept the transfer of patients who are gravely disabled and have an emergency medical condition, if these hospitals have the necessary resources and capacity and the transferring hospital does not.

► The use of chemical or physical restraints may provide a temporary safe environment by minimizing risk during patient transport, but it does not in itself stabilize a psychiatric emergency medical condition. Unless the hospital or physician can demonstrate that a patient is stabilized regardless of the restraints, EMTALA still applies.