3 Legal & Regulatory FAQs

This section answers frequently asked legal and regulatory questions regarding emergency medical services (EMS) patient transfer delays.

Question: Does a paramedic's scope of practice include the ability to legally care for patients brought by EMS after arrival in an emergency department?

Answer: California Health and Safety Code, Division 2.5, and the associated California Code of Regulations provision (Title 22, Division 9, Chapter 4, Article 2, Section 100146) define the paramedic scope of practice, which allows paramedics to practice "while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital."[1] However, this provision does not provide for routine or extended continuation of care for patients transported by EMS personnel once the paramedic transfers responsibility to the hospital for the care of the patient. Care delivered to the patient while under the responsibility of EMS remains under the auspices of EMS. There are anecdotes of EMS personnel caring for patients for prolonged periods of time in an ED who call their medical control located outside of that hospital to receive an order to continue care. While waiting to transfer care, EMS personnel must continue the best possible care for the patient and may need to follow orders from their base station medical control, even if that physician is not on the hospital's medical staff; however, this may conflict with hospital staff privilege requirements and be a controversial issue for the receiving hospital. A patient's need for medication — such as additional pain medication — while waiting to transfer care suggests the need for more urgent transfer of responsibility for that care.

Question: When and where does EMTALA apply for patients brought to the ED by EMS?

Answer: EMTALA obligations are triggered when an individual presents to a dedicated emergency department seeking or in need of care for a medical condition, or when an individual presents on "hospital property" seeking or in need of care for an emergency medical condition. EMTALA is also triggered when an individual is being transported by a hospital-owned ambulance, or when a non-hospital owned ambulance arrives on hospital property. Many of these terms are further defined and clarified in regulation and the Centers for Medicare & Medicaid Services (CMS) State Operations Manual, Appendix V (the EMTALA

1 Health and Safety Code Section 1797.52. See also Health and Safety Code Section 1797.218.

Interpretive Guidelines),[2] including "emergency medical condition," "dedicated emergency department" and "hospital property."[3] EMTALA obligations of the hospital are not dependent upon or delayed by a report given by the EMS provider, but are triggered upon the person's arrival on hospital property as described above. Triage of the patient's condition must be provided "immediately upon arrival to ensure that an emergent intervention is not required and that the EMS provider staff can appropriately monitor the individual's condition."[4] The patient must receive a medical screening examination beyond initial triage, considering the emergency needs of the patients, the standard of care, and the capabilities of the hospital.

EMTALA does not specifically define the transfer of responsibility or the "formal acceptance" of a patient from EMS to ED staff.

If the hospital is accepting patients (i.e., "has capacity") and the individual has been brought to the emergency room, another area of hospital property, or is within an ambulance on hospital property and has requested to be examined, or (more commonly) EMS has requested that an examination take place on the patient's behalf, then the hospital's EMTALA obligations are triggered to triage and provide a medical screening examination by hospital designated physicians and staff.

Question: How are "triage" and "medical screening exam" defined?

Answer: **"Triage"** is the initial screening of the patient's presenting complaint, signs and symptoms, typically by a triage nurse, to determine the appropriate order for the patient to receive a medical screening exam. The triage nurse prioritizes when the patient will be seen by the physician or other qualified medical personnel for a medical screening exam. Triage is preliminary to the medical screening exam.

The **"medical screening exam"** (MSE) is the process required to evaluate the presenting condition of the patient to determine, within reasonable clinical confidence, if an emergency medical condition exists. The MSE process can be fairly simple and fast, or very complex and time-consuming requiring multiple tests and procedures; it really depends on the patient's condition. The CMS State Operations Manual, Appendix V (the EMTALA *Interpretive Guidelines*) and case law acknowledge that there is no prescribed process or timeframe for performing the MSE, because such a requirement could interfere with the hospital's ability to provide care to patients who need it the most urgently (e.g., if staff are responding to a trauma victim who needs all personnel).

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2 The State Operations Manual is written by CMS for its surveyors, but is available to hospital personnel and the general public to understand what CMS expects its surveyors to do and how they should interpret CMS requirements.

3 42 C.F.R. Section 489.24(b)

4 Memorandum from CMS to State Survey Agency Directors, S&C-07-20, April 27, 2007

Question: Has CMS or California Department of Public Health (CDPH) addressed the issue of delays in EMS patient transfer?

Answer: CMS has addressed the issue of EMS to ED patient transfer delays in two memoranda to State Survey Agencies. The first, S&C-06-21 (July 2006), states that:

> CMS recognizes the enormous strain and crowding many hospital emergency departments face every day. However, this practice is not a solution. "Parking" patients in hospitals and refusing to release EMS equipment or personnel jeopardizes patient health and impacts the ability of the EMS personnel to provide emergency services to the rest of the community…
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> This practice [delaying ambulance ED offload] may result in a violation of the Emergency Medical Treatment and Labor Act [sic] (EMTALA) and raises serious concerns for patient care and the provision of emergency services in a community. Additionally, this practice may also result in a violation of 42 CFR 482.55, the Conditions [sic] of Participation for Hospitals for Emergency Services…

A hospital that delays the medical screening examination or stabilizing treatment of a patient who arrives via transfer from another facility, by not allowing EMS to leave the patient, could also be in violation of EMTALA.

In response to requests for clarification, CMS provided additional guidance in CMS S&C-07-20 (April 2007), clarifying that S&C-06-21 does not mean that:

> a hospital will necessarily have violated EMTALA if it does not, in every instance, immediately assume from the EMS provider all responsibility for the individual, regardless of any other circumstances in the ED. For example, there may be situations when a hospital does not have the capacity or capability at the time of the individual's presentation to provide an immediate medical screening examination (MSE) and, if needed, stabilizing treatment or an appropriate transfer. So, if the EMS provider brought an individual to the dedicated ED at a time when ED staff was occupied dealing with multiple major trauma cases, it could under those circumstances be reasonable for the hospital to ask the EMS provider to stay with the individual until such time as there were ED staff available to provide care to that individual. However, even if a hospital cannot immediately provide an MSE, it must still triage the individual's condition immediately upon arrival to ensure that an emergent intervention is not required and that the EMS provider staff can appropriately monitor the individual's condition.

The CDPH Licensing and Certification Program also commented on EMS-ED patient "parking" in an All Facility Letter (AFL 07-04) issued on June 28, 2007:

> The CDPH realizes that there is crowding in many hospital emergency departments. There needs to be a different solution to this problem as "parking" patients in hospitals and refusing to release EMS equipment or personnel puts patients[sic] health at risk and jeopardizes the ability of the EMS staff to provide their important services to California's communities.

These communications clarify that it is not an acceptable practice to "park" patients as a routine response to ED overcrowding. A hospital cannot delay its EMTALA obligations with a delay in hand-off from EMS to a hospital gurney and staff. Rather, the appropriate response is dictated by the patient's condition and acceptable standards of care, along with the capacity and capability of the hospital. In other words, the clinically appropriate response will always be based on the circumstances at the time including the condition of the patient and whether the ED staff is occupied dealing with other more urgent or emergent cases.

Discussions with CMS regional staff its EMTALA Technical Lead further indicated the following:

1. There is some guidance in the CMS State Operations Manual, Appendix V (EMTALA *Interpretive Guidelines*). Appendix V states that:

   > Hospitals that deliberately delay moving an individual from an EMS stretcher to an emergency department bed do not thereby delay the point in time at which their EMTALA obligation begins. Furthermore, such a practice of "parking" patients arriving via EMS, refusing to release EMS equipment or personnel, jeopardizes patient health and adversely impacts the ability of the EMS personnel to provide emergency response services to the rest of the community. Hospitals that "park" patients may also find themselves in violation of 42 CFR 482.55, the Hospital Condition of Participation for Emergency Services, which requires that hospitals meet the emergency needs of patients in accordance with acceptable standards of practice.

2. CMS has not established a maximum acceptable time for transfer of responsibility from EMS to ED staff.
3. Any case brought to the attention of CMS will be considered on an individual basis, taking into account a full review of all relevant facts and circumstances including the other patients in, and demands on, the ED at the time, and the relative urgency of the patient brought in by EMS.
4. Anyone, including EMS personnel, can file an EMTALA complaint with the Centers for Medicare & Medicaid Services.
5. CMS states that there is no precedent that can be cited from CMS actions on prior complaints; CMS reviews each EMTALA complaint on a case-by-case basis.
6. EMTALA obligations do not supersede state nurse/patient ratio requirements.

Question: Does the California Health and Safety Code or Title 22 of the California Code of Regulations (also known as the California Administrative Code), address EMS patient transfer delays in the ED or provide flexibility to mitigate the problem?

Answer: Neither the Health and Safety Code nor Title 22 specifically addresses EMS patient transfer delays in the ED. Title 22 does, however, address emergency department beds and patient treatment areas specific to the emergency department service, including nurse-to-patient staffing ratios.

Program flexibility is addressed in Title 22, California Code of Regulations, Section 70129. While hospitals generally must maintain continuous compliance with licensing requirements, the law allows hospitals to use alternative ways to satisfy those requirements, if approved by CDPH. Some hospitals have received program flexibility approval to implement alternative systems and designs for appropriately handling emergency department patient flow and care units. Program flexibility is granted on a case-by-case basis, must be requested by the hospital, and approved by CDPH in writing. Section 70129 provides as follows:

> All hospitals shall maintain continuous compliance with the licensing requirements. These requirements do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects provided such exceptions are carried out with the provisions for safe and adequate care and with the prior written approval of the Department. Such approval shall provide for the terms and conditions under which the exception is granted. A written request plus supporting evidence shall be submitted by the applicant or licensee to the Department.

Some hospital actions may be limited or precluded under statute, regulation, or other rules, such as The Joint Commission accreditation standards.

Question: How have other states addressed the problem of EMS patient transfer delays?

Answer: Some examples of legislative and regulatory solutions are listed below.

1. Statutory limits for EMS transfer delays have been implemented by some jurisdictions.
2. The Nevada State Legislature passed Senate Bill 458 in late spring 2005 that created a standard of 30 minutes to transfer the care of patients from EMS to hospital staff.[5]
3. Massachusetts enacted a law effective Jan. 1, 2009, to prohibit ambulance diversion (except in the case of specified internal hospital

5 "SB 458: The Hospital Wait Bill," 8 News Now, Sept. 29, 2005; http://www.8newsnow.com/story/3918767/senate-bill-458-the-hospital-wait-bill

disasters) and monitor wait times. A March 2013 study found that no ED experienced an increase in ED length of stay or ambulance turnaround time despite an increase in volume for several EDs. There was an overall 2.2 minute decrease in ambulance turnaround time.[6] The legislation initially included fines if the time limit was exceeded, but these were dropped.

4. The British National Health Service Confederation adopted a report[7] urging "zero tolerance" for ambulance handover and turnaround delays. The Confederation recommended a national standard of 15 minutes for handover, with this standard allowing some "flex" rather than being an absolute 100% target. The NHS in London endorsed a financial penalty if a hospital did not meet a standard of 85% of handovers within 15 minutes and 95% of handovers within 30 minutes. The Confederation recommended that delays over one hour be regarded as unacceptable, and that financial penalties should be agreed to and consistently applied. The Confederation also noted that the London NHS considered any patient handover taking 60 minutes or more to be a serious incident that must be reported and investigated.

Question: Has The Joint Commission adopted standards regarding ED throughput?

Answer: Since EMS patient transfer delays are linked to ED overcrowding, which in turn is associated with boarding of admitted patients in the ED, The Joint Commission has instituted new measurement standards to focus attention and efforts on this problem of hospital and ED throughput. (Standard LD.04.03.11, EP 6)

> Boarding is the practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made. The hospital should set its goals with attention to patient acuity and best practice; it is recommended that boarding time frames not exceed 4 hours in the interest of patient safety and quality of care.[8]

The TJC position is aspirational, in light of the difficulties hospitals face regarding bed impaction, observation vs. inpatient status, and delays in transferring psychiatric patients.

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6 Burke, MD, Laura G., "The Effect of an Ambulance Diversion Ban on Emergency Department Length of Stay and Ambulance Turnaround Time," Annals of Emergency Medicine, March, 2013.

7 Zero tolerance: Making ambulance handover delays a thing of the past. NHS Confederation, May 2012. http://www.nhsconfed.org/resources/2012/12/zero-tolerance---making-ambulance-handover-delays-a-thing-of-the-past

8 R3 Report 1 Requirement, Rationale, Reference; The Joint Commission, Issue 4, December 19, 2012; http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&cad=rja&uact=8&ved=0CDcQFjAC&url=http%3A%2F%2Fwww.jointcommission.org%2Fassets%2F1%2F18%2FR3_Report_Issue_4.pdf&ei=6W6HU_eDGc7aoATA6oG4Ag&usg=AFQjCNHb7Fx8ZSFgnxneN_TvLE5eDwSmfw&bvm=bv.67720277,d.cGU

The National Health Service in Britain has also focused on throughput standards for ED patients as a solution to off-load delays, and recommended an ED throughput limit of 4 hours in 97% of patients. However, a British Broadcasting Corporation News report found that half of NHS EDs told the British Medical Association that pressure to meet the targets meant that patients were moved inappropriately.[9]

Question: Are there any contract-related issues regarding EMS patient transfer delays?

Answer: Local EMS agencies have contracts with many hospitals to receive ambulances, especially hospitals providing specialty systems of care such as trauma, stroke, or STEMI. These contracts have requirements for quality assurance and quality improvement through data collection, program management, and review of care. EMS patient transfer time expectations could be added to these contracts along with requirements for documentation, quality improvement and, potentially, fines for consistent outliers. Note that the contract must be possible to perform and use language such as "reasonable" or "best efforts" or "to the extent able." Contracts cannot use hard-stop language that cannot be met. Addressing transfer time expectations in a contract must be framed in terms of delivery goals that are subject to case-by-case review, consistent with the emergency needs of the patient, the standard of care, and the capabilities of the hospital.

Question: Are there any other potential legal issues regarding EMS patient transfer delays?

Answer: Health care providers may be exposed to liability from a professional negligence (medical malpractice) lawsuit if a transfer delay is excessive.

9 "Target 'putting A&E care at risk,'" British Broadcasting Corporation News, March 13, 2005; http://news.bbc.co.uk/2/hi/health/4339653.stm