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EMTALA: Shelter from the storm

by Ann McCullough and Ryan Morgan

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In the mid-1980s, a string of tragic and high-profile cases of community hospitals refusing emergency care to individuals who later died in the streets whipped the media into a frenzy over a trend referred to as "patient dumping." Anecdotal and empirical evidence identified a patient's inability to pay as the primary driver of hospitals refusing necessary emergency care.[1]

In response, Congress passed what we know today as the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires every Medicare participating hospital with an Emergency Department (ED) to provide a medical screening examination and stabilizing treatment to any individual who comes to the ED, regardless of the individual's ability to pay.[2] In the following decades, and particularly since the promulgation of EMTALA regulations by the Centers for Medicare & Medicaid Services (CMS),[3] hospitals have largely embraced this central EMTALA tenet. Although EMTALA compliance remains a complex and difficult task for any hospital, much of the CMS enforcement action has focused on EMTALA's more technical aspects, such as the responsibilities of on-call physicians, physician certification of transfers, the application of EMTALA outside of the ED, and refusal of incoming transfers.

Recently, classic patient dumping scenarios have been reported in the mainstream media; this time involving a very specific patient population — the homeless. Earlier this year, the Baltimore Sun reported about a hospital being cited for an alleged EMTALA violation after a patient it discharged was found slowly wandering the streets outside its facility in 30-degree weather in only a hospital gown and socks.[4] After being returned to the ED, the hospital put the patient in a taxi to a homeless shelter. The media attention led to a CMS investigation and citation for violating EMTALA.

With respect to EMTALA compliance, the homeless population presents unique challenges for hospitals. Mental illness, drug and alcohol dependence, and chronic conditions such as cardiovascular and renal disease occur with higher frequency in the homeless population. Moreover, the homeless condition makes disease management and medication regimen compliance difficult, exacerbating these underlying medical and psychiatric conditions. Consequently, homeless individuals are three times more likely to use the ED at least once per year than the general public.[5] This increased utilization may lead to a perception of "super-utilizers" who are well known to ED personnel. One result of this familiarity is that hospital personnel, including non-clinical personnel, may be less likely to strictly follow hospital EMTALA policies for each encounter. This is especially understandable in scenarios where the individual was previously seen only a few hours prior, as in the Maryland case noted above.