



MOUNT SINAI HEALTH SYSTEM POLICY & PROCEDURE

Mount Sinai Beth Israel
Mount Sinai Brooklyn
Mount Sinai Hospital
Mount Sinai Morningside
Mount Sinai Queens
Mount Sinai West
New York Eye & Ear Infirmary

POLICY TITLE:	Emergency Treatment, Stabilization, Transfer of Patients and EMTALA (Emergency Medical Treatment and Labor Act)		
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I. PURPOSE

The purpose of this policy is to ensure compliance with EMTALA related to the treatment and stabilization of patients with emergency medical conditions, vis-à-vis physician availability and



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response, patient transfer to alternate health care facilities, reporting of inappropriate transfers, maintenance of an Emergency Central Log, and other related requirements.

EMTALA requires Medicare-participating hospitals with dedicated emergency departments (see definitions, below) to screen and treat individuals for emergency medical conditions in a non-discriminatory manner, regardless of their ability to pay, insurance status, gender, sexual orientation, national origin, race, creed or color. Medicare-participating hospitals are those that accept payment from the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) under the Medicare program. All MSHS hospitals participate in Medicare.

II. POLICY

In compliance with the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, Mount Sinai Health System (MSHS) hospitals with dedicated emergency departments (DED) offer emergency medical care, as indicated by an individual's medical condition, to all individuals arriving at an MSHS hospital for emergency examination or treatment, without regard to the individual's insurance status. This practice includes all patients who present themselves for treatment, including patients who are transferred to an emergency department at any of the MSHS hospitals. MSHS hospitals' obligation under this policy ends when a physician or qualified medical person has made a decision that (a) no emergency medical condition exists (even though the underlying medical condition may persist); (b) an emergency medical condition exists and the individual is appropriately transferred to another facility consistent with this policy; or (c) an emergency medical condition exists and the individual is admitted to an MSHS Hospital for further treatment. For the purposes of this policy, all MSHS hospitals have a DED, except the New York Eye and Ear Infirmary of Mount Sinai.

III. SCOPE

This policy applies to all members of the MSHS workforce, including, but not limited to: employees, medical staff, trainees, students, volunteers, physician office staff, and other persons performing work for or at MSHS.

LOCATIONS SUBJECT TO THIS POLICY

This policy applies to anyone who seeks emergency medical treatment and is on/in:

1. A MSHS Hospital campus, including parking lots, sidewalks and driveways;
2. A MSHS Hospital's Emergency Department;
3. An on-campus or off-campus department or facility that is perceived by the public as a place that provides emergency care on an urgent basis without a previously scheduled appointment (e.g., Labor & Delivery, psychiatric units);
4. An on-campus or off-campus department or facility that provides at least one-third of its outpatient visits to treat emergency conditions on an urgent basis without a previously scheduled appointment;
5. All MSHS Hospital's Offsite Provider Based Facilities
6. A MSHS Hospital-owned ambulance, even if not on MSHS grounds, except if the ambulance is operated under community-wide Emergency Medical Service ("EMS") protocols. In such an instance, this policy applies only if the ambulance is directed to transport the individual to the Hospital and as of the time the individual is brought onto Hospital grounds; and
7. A non-MSHS Hospital-owned ambulance as of the time that the individual is brought onto Hospital grounds.



IV. DEFINITIONS

Dedicated Emergency Department (DED): A DED is any department or facility of the Hospital, regardless of whether it is located on or off the main Hospital campus that meets at least one of the following requirements:

1. It is licensed by the state in which it is located under applicable state law as an emergency department;
2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; OR
3. During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment

All MSHS hospitals, except the New York Eye and Ear Infirmary of Mount Sinai, have a DED.

Emergency Central Log: A comprehensive record maintained of all individuals who come to a MSHS Hospital seeking emergency care

The Emergency Central Log includes patients presenting to the emergency department, as well as those presenting to any other area of the Hospital that may be considered a DED, such as a Labor and Delivery Unit, where applicable.

Emergency Medical Condition (EMC): A medical condition manifested by acute symptoms of sufficient severity (including, e.g., 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:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy; or
 2. Serious impairment of bodily functions; or
 3. Serious dysfunction of any bodily organ or part;
- OR, with respect to a pregnant woman who is having contractions:
4. There is inadequate time to effect a safe transfer to another hospital before delivery; or
 5. The transfer may pose a threat to the health or safety of the woman and/or the unborn child

Emergency (that requires a Medical Screening Examination): A condition that a lay person requesting emergency treatment perceives as an emergency

Immediately Available: Ability to have an ambulance arrive at the requesting facility within 10 minutes of request

Labor: The process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta

- a. **Early labor** is defined by cervical dilation of 0-3 cm, contractions in the range of 5-20 minutes apart and lasting approximately 30-45 seconds.
- b. **Active labor** is defined by cervical dilation of 4-8 cm, contractions in the range of 3-5 minutes apart and lasting approximately 60 seconds.
- c. **Transition** is defined by cervical dilation of 8-10cm, contractions in the range of 2-3 minutes apart and lasting approximately 60-90 seconds.

A woman experiencing contractions is considered to be in true labor unless a physician, certified nurse-midwife, or other qualified medical person certifies that, after an assessment and a reasonable period of observation, the woman is in false labor.

Medical Screening Examination (MSE): The process required to determine with reasonable clinical confidence whether an emergency medical condition does or does not exist



Offsite Provider-Based Facility (OPBF): Any facility located off of the Hospital campus that operates as an outpatient department of the Hospital for Medicare payment purposes ("provider-based status").

Qualified Medical Personnel: Individuals approved by the Hospital, in accordance with criteria established by the Medical Staff and approved by the Board of Trustees, to perform an MSE

Non-physician qualified medical personnel may include physician assistants and nurse practitioners, who are individually determined to be so qualified.

Stabilize: The provision of medical treatment for the patient's emergency medical condition that is necessary to ensure, within reasonable medical probability that no clinical deterioration is likely to result from, or occur during, a transfer of the individual from a facility.

In the case of a pregnant woman who is having contractions, the woman is considered stable if a qualified medical person determines that she is at low risk of delivering while in transit. Alternatively, if the woman is determined by a qualified medical person to be at risk of delivering while in transit, stabilization requires the delivery of the fetus/child and placenta **prior** to transfer.

A patient is deemed stabilized if and when the treating attending physician determines, within reasonable clinical confidence, that the emergency medical condition has been resolved or that further deterioration has been averted.

STAT Transfer: An emergency patient transport that has been requested by a licensed health care professional from a sending facility and accepted by a licensed receiving physician in a licensed health care facility

Transfer: The movement, including discharge, but excluding elopements or discharges against medical advice, of a living patient to another facility at the direction of any person employed by or acting on behalf of a MSHS hospital

Transfer does not include movement of an individual who has been declared dead or who voluntarily leaves the facility against medical advice (AMA) or without being evaluated (LWOBE).

Triage: A sorting process to determine the order in which patients will be provided a medical screening examination and treatment by a qualified medical person based on the acuity of the chief complaint and presenting symptoms

Triage is not the equivalent of, or substitutes for, a medical screening examination and does not determine the presence or absence of an emergency medical condition.

V. PROCEDURE

A. Utilizing the Emergency Central Log

Persons who present for emergency medical attention or who appear to need emergency medical attention, as assessed by a qualified medical person, will be entered into an *Emergency Central Log* ("Log"). The Log is used to track the care provided to such individuals. The Log contains specific patient information, including:

1. Patient name
2. Patient age
3. Patient gender
4. Date and time patient presented
5. Means of arrival
6. Chief complaint
7. Medical record and encounter number



8. Discharge date and time
9. Attending physician
10. Disposition, categorized as:
 - a. Treated and released
 - b. Treated and admitted
 - c. Stabilized and transferred
 - d. Transferred
 - e. Discharged
 - f. Refusal of treatment
 - g. Against medical advice (AMA)
 - h. Elopement
 - i. Expired

B. Provision of a Medical Screening Examination

Every individual who comes to a MSHS Emergency Department for examination or treatment or who presents anywhere on the premises as defined above (*see III. Scope - Locations Subject To This Policy*), stating that s/he has an emergency, will be given an appropriate medical screening examination to determine whether an emergency medical condition exists.

The medical screening examination will be:

1. Performed by a qualified medical person;
2. Conducted in accordance with Emergency Department/Hospital policies and procedures; AND
3. Appropriate for determining whether an emergency medical condition exists.

The screening examination, as medically indicated, will use the services and facilities available in the Emergency Department and also any appropriate ancillary services routinely available to the Emergency Department. If the screening examination reveals that an emergency medical condition exists, the patient (a) will be given treatment to stabilize the condition; or (b) will be transferred to another medical facility in accordance with this policy.

All persons seeking emergency care will receive their medical screening examination without regard to ethnicity, religion, national origin, citizenship, age, gender, sexual orientation, preexisting medical condition(s), physical or mental disability, insurance status, economic status, or ability to pay for medical treatment.

The Hospital may complete a full registration of the patient, including asking for insurance information, but only after triage, and only so long as the registration process does not delay the medical screening examination and stabilizing treatment. The Hospital will not seek, or direct an individual to seek, authorization from the individual's insurance company for screening or stabilization services. An Emergency Department physician may contact the individual's personal physician(s) to obtain information regarding the individual's medical history and needs that may be relevant to the screening and medical treatment so long as the consultation does not delay emergency services.

Patients who present with an emergency medical condition to an *Offsite Provider-Based Facility* will not be turned away. The staff will provide an assessment and stabilizing treatment within their capabilities and, if appropriate, arrange for a transfer in accordance with the policy: *EMTALA for Offsite Provider-Based Facilities*.

The medical record of the patient will reflect the findings of the medical screening examination, including the results of any tests performed and their analyses, along with a determination whether a medical emergency does or does not exist.



C. Patients Determined Not to Have an Emergency Medical Condition

Patients who are found, after an appropriate medical screening examination, not to have an emergency medical condition will be treated for their medical problems, discharged and/or referred for further services, as appropriate, in light of the patient's medical condition. If the patient is transferred to another institution, the steps set forth in the transfer section of this policy will be followed.

D. Refusal to Consent to Examination, Treatment or Transfer

The Hospital will offer a patient medical screening, treatment, and/or transfer in accordance with this policy. If a patient (or a person acting on behalf of the patient) refuses to consent to the offered screening, treatment and/or transfer, then the patient (or person) will be advised of the risks of declining the offered screening, treatment and/or transfer and of the reasonably foreseeable consequences of a refusal to consent and the provision of such information will be documented in the medical record. Reasonable steps will be taken to obtain the patient's written refusal (or that of the person acting on behalf of the patient) on the appropriate refusal to consent/transfer form.

E. Provision of Stabilizing Treatment

If the medical screening examination reveals that an emergency medical condition exists, the Hospital will provide care within its capacity and capabilities to stabilize the condition before the patient can be discharged or transferred. An emergency medical condition is stabilized when sufficient treatment has been provided to ensure, within reasonable medical probability, that:

- With respect to a transfer, the treating physician has determined that no clinical deterioration of the condition is likely to result from or occur during the transfer; OR
- With respect to discharge, the treating physician has determined that the emergency medical condition has resolved and that continued care can be reasonably performed on an outpatient basis.

With respect to a pregnant woman with contractions presenting to a hospital lacking services required for the delivery:

1. If the attending physician determines that there is insufficient time to effectuate a safe transfer to a hospital with the necessary resources before delivery;
OR
2. If a transfer, itself, may pose a threat to the health or safety of the woman or the unborn child;

then stabilization means delivery of the fetus/infant and placenta at the presenting facility. For hospitals that do not have post-partum and nursery units, after the delivery such patients and their infants will be transferred to an appropriate facility, in accordance with the procedures for an EMTALA-compliant transfer (see below).

With respect to a pregnant woman with contractions presenting to a hospital lacking services required for the delivery, if the attending physician:

1. Determines that there is no immediate risk of delivery; AND
2. Determines that the medical benefits of transfer outweigh the risks; AND
3. Documents such determinations in the patient's medical record;

the patient may be transferred before delivery to an alternative facility, in accordance with the procedures for an EMTALA-compliant transfer.

F. Transfer of Patients with Emergency Medical Conditions from an MSHS Facility

Patients with emergency medical conditions may be transferred from an MSHS facility under a variety of circumstances and for a variety of reasons.



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- For transfers that require an immediately available ambulance (i.e., “life rescue”) the sending site may call both 911 and the MSHS Transfer Center.
- All other patient transfers from any MSHS site, including hospitals and *Offsite Provider-Based Facilities*, should be managed through the MSHS Transfer Center.

To be compliant with EMTALA, staff will follow the guidelines below.

A transfer will be deemed an “**appropriate transfer**” only when all four of the following conditions are met:

1. The sending facility first 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;
2. The receiving facility . . .
 - a. Has available space, the necessary equipment, and qualified personnel for the treatment of the patient as anticipated from the sending facility's description of the patient; and
 - b. Has agreed to accept transfer of the patient and to provide appropriate medical treatment;
3. The sending facility provides to the receiving facility all medical records (or copies, thereof) that are available at the time of the transfer related to the emergency medical condition with which the patient has presented, and;
4. The transfer is conducted by qualified personnel using appropriate transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

Staff arranging transfers will follow these requirements:

1. All efforts, including all necessary medical measures, will be taken to minimize any risk to the patient undergoing a transfer.
2. The **sending attending physician** will perform and/or ensure that **ALL** of the following actions are performed:
 - a. Ascertain, and then document in the patient's medical record, that:
 - i. An attending physician at the receiving facility has agreed to accept and treat the patient;
 - ii. There is available space/bed at the receiving site; AND
 - iii. There are qualified personnel and the necessary equipment to treat the patient at the receiving site
 - b. Participate in a physician-to-physician telephone handoff conversation with the receiving physician
 - c. Issue a physician's order for the transfer in the patient's medical record
 - d. Document all of the following in the patient's medical record in accordance with the Hospital's standard descriptions of patients requiring specialized emergency care, triage protocols, and formal written transfer agreements:
 - i. Specifically why the patient cannot receive the necessary care locally and, therefore, requires transfer to another facility designated to receive and provide definitive care for such patients;
 - ii. The patient's medical condition at the time of transfer; and
 - iii. Specific risks and benefits of the proposed transferDiscuss these items with the patient (or responsible person)
 - e. Complete the relevant form (*Physician Certification / Consent to Transfer* or *Physician Certification / Request for Transfer against Medical Advice*) and, if at all possible, obtain a witnessed signature of consent
 - f. Perform and document (or ensure that a qualified designee performs and documents) a reassessment (including an evaluation of recent vital signs, laboratory and imaging studies) that was performed within one (1) hour prior to transfer
 - g. Complete the provider section of the *Patient Transfer Summary*

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3. A **registered nurse** at the sending site will perform **ALL** of the following actions:
 - a. Conduct a telephone handoff conversation with a registered nurse at the receiving facility and document in the patient's medical record that it occurred
 - The handoff must not delay the transfer
 - b. Obtain and document a complete set of vital signs just prior to departure, and notify the sending attending physician of any change from prior status
 - c. Complete the documentation on the Registered Nurse section of the *Patient Transfer Summary* form
4. All medical records, consents, and other records relevant to the individual's emergency medical condition available at the time of transfer will be sent to the receiving facility with the patient. Copies of the following records/forms will accompany the patient to the receiving facility:
 - a. Medical record relating to the patient's medical condition, including results of ancillary tests
 - b. Patient Transfer Summary Form
 - c. *Consent to Transfer* or the *Request for Transfer Against Medical Advice* form
5. Appropriate personnel, equipment, and life support measures will be used in the transfer. The facility will not transfer an individual until his/her emergency medical condition has been stabilized, except in accordance with an appropriate written patient request or medical certification as set forth in this policy.
6. The facility may honor a written request for transfer by a patient with a non-stabilized emergency medical condition (or a person acting on that patient's behalf) after informing the patient (or such person) of the Hospital's obligation to provide screening and treatment and explaining the risks, benefits, alternatives, and all other relevant information regarding the transfer. Also, a patient may be transferred without being stabilized if a physician certifies in writing that the medical benefits of transfer outweigh the risks of transfer for the patient. The transfer form must include a summary of the benefits and risks to the patient related to transfer.
7. The Administrator-on-Call (AoC) will be informed of:
 - i. Patient/family initiated transfers against medical advice prior to the transfer
 - ii. Patient refusal to consent to transfer

The AoC may notify Risk Management and/or Legal Affairs for guidance.
8. A patient's preference of a receiving facility will be respected, but only so long as the facility accepts the transfer, there is an accepting physician, and the attending physician determines that the facility is sufficiently proximate given the patient's condition. The decision to transfer will be made by the attending physician.

When clinically appropriate, consideration should be given to transfer patients within MSHS hospitals. For all MSHS facilities whose location is not most proximate to a MSHS hospital, a transfer agreement must be established with a nearby non MSHS full service facility for cases where the individual's condition is deteriorating so rapidly that taking the time to move the individual to the nearest appropriate MSHS hospital would jeopardize the life or health of the individual(s). As part of this agreement a process must be established to ensure that all EMTALA requirements regarding transfer to the non MSHS hospital are accomplished in a timely manner.

G. SPECIAL CIRCUMSTANCE: EMTALA-Compliant Transfer of a Patient with an Emergency Medical Condition from an MSHS Offsite Provider-Based Facility (as opposed to from an MSHS hospital)

The management of a patient at a Hospital's *Offsite Provider-Based Facility* who has been determined, based on a medical screening exam, to have an emergency medical condition will be prioritized to the most proximate Emergency Department within the MSHS, depending on the acuity and specific needs of the patient. Staff will contact the MSHS Transfer Center for transport to the appropriate MSHS Emergency Department. If the best interests of the patient require transfer to an Emergency Department of a facility outside of MSHS, staff will follow the

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process for **EMTALA-Compliant Transfer of a Non-Stabilized Patient from an MSHS Facility**, outlined below.

NOTE 1: For additional details, refer to the separate policy: EMTALA for Offsite Provider-Based Facilities.

NOTE 2: Throughout this policy, reference is made to actions required of an attending physician. In some circumstances, however, Offsite Provider-Based Facilities may not be staffed by an attending physician. In those situations, actions that fall to an attending physician will be the responsibility of an appropriately designated qualified medical person.

H. SPECIAL CIRCUMSTANCE: EMTALA-Compliant Transfer of a Non-Stabilized Patient from an MSHS Facility

Patients with an emergency medical condition who have not been stabilized may be transferred from an MSHS facility to another health care facility, if they meet one of the conditions outlined below. During the pendency of the transfer process, the facility will provide medical treatment within its capacity to minimize risks to the patient's health and, in the case of a pregnant woman, to the unborn child's health.

An EMTALA-compliant transfer from an MSHS facility of a non-stabilized patient can ONLY occur in the following instances:

1. The attending physician determines and documents that the patient's emergency medical condition exceeds the capabilities of the facility to stabilize the patient and the medical benefits reasonably expected from the provision of appropriate medical treatment at the receiving facility outweigh the risk of transfer.
- OR**
2. The patient (or legally responsible person) makes a written request for transfer, and the patient (or legally responsible person) has been informed of (a) the Hospital's obligations to stabilize the patient; and (b) the risks and benefits of a transfer.

Regarding a request for a transfer against medical advice, the attending physician and the patient (or legally responsible person) must complete the *Request for Transfer Against Medical Advice* form, which will serve as the patient's written request. One copy of the form will be placed in the medical record and one copy sent with the patient. If the patient refuses to complete his/her portion of the form, staff will document such refusal in the patient's medical record, but will not delay the transfer. Risk Management and Legal Affairs should be notified for guidance at the time of the request.

I. Selection of a Receiving Facility for an EMTALA-Compliant Transfer from an MSHS Facility

If the attending physician determines that the patient's emergency medical condition puts the patient in immediate danger of losing life or limb or, with respect to a pregnant woman, danger to the unborn child, the attending physician will transfer the patient to a proximate receiving facility that has agreed to accept the transfer and provide appropriate medical treatment. The selection of the receiving facility will be based upon the best interests of the patient and, in the case of a pregnant woman, the unborn child, and will take into consideration the capacities and capabilities of the various potential receiving site options.

For transfers that require an immediately available ambulance (i.e., life rescue) the sending site will call both 911 and the MSHS Transfer Center

For patients who require transfer and their emergency medical condition has been stabilized, the attending physician will call the MSHS Transfer Center to request transfer.



J. EMTALA-Compliant Receipt of a Patient Referred for Transfer to an MSHS Facility

1. All requests from facilities that seek to send a patient to an MSHS facility should be directed to make arrangements through the MSHS Transfer Center.
2. The Hospital will NOT refuse to accept an “appropriate transfer” of a patient who requires specialized emergency services or facilities available at the Hospital, provided that:
 - a. the specialized emergency services or facilities are not available at the sending facility or at a reasonably proximate affiliate of the sending facility ; AND
 - b. such services are immediately available at the Hospital.

An “appropriate transfer” is when there is a request to transfer a patient with an emergency medical condition from a facility that cannot adequately treat (or fully stabilize) the patient to an MSHS facility that has the ability to adequately treat the patient.
3. In the event that the Hospital receives a request to accept an “appropriate transfer” for management of a patient with a condition typically treated by the Hospital, but Hospital staff believe that they lack either the capacity or the capability to treat the referred patient, the staff alleging that they cannot manage the case must immediately escalate this issue to the Hospital’s Chief Medical Officer (CMO), his/her designee, or the Administrator on Call (AoC). The CMO, his/her designee, or AOC will rapidly investigate and evaluate the circumstances, then make a final determination regarding the decision to accept or reject the transfer and communicate this decision directly to the MSHS Transfer Service and the applicable clinical service(s). In the event that the CMO or AoC determines not to accept the transfer, s/he will record, in detail in an internal note to file, the specifics of the situation and the rationale that was used to reject the transfer. This determination will also be recorded by the MSHS Transfer Service.

K. “Inappropriate Transfer” from a sending facility (as determined upon patient arrival to a receiving MSHS facility)

An “**inappropriate transfer**” means that a facility has denied care, limited care, discharged the patient, or transferred the patient to another facility under the following circumstances:

1. The patient arrives at the Hospital, having come from another medical facility; **AND**
2. The patient has an emergency medical condition (as defined above); **AND**
3. The patient is unstable (as defined above) upon arrival; **AND**
4. One or more of the following appears to be true:
 - The patient was refused examination at the prior facility;
 - The patient was refused treatment at the prior facility;
 - The patient was discharged in an unstable condition (unless the patient voluntarily left without being evaluated, left against medical advice, left prior to completion of an attempted medical screening examination, or requested / insisted upon a transfer after being informed of the risks of transfer);
 - The patient was transferred to the Hospital without prior acceptance;
 - The patient's condition was intentionally misrepresented to the Hospital to obtain acceptance for the transfer;
 - The patient was transferred with inadequate personnel and/or equipment to safeguard the patient;
 - The patient was transferred without accompanying medical records, **UNLESS** delay for records would jeopardize the patient; **OR**
 - The patient was transferred as a result of a failure or refusal of an on-call physician to attend the patient when requested by the Emergency Department physician.

L. Procedure for Reporting an Inappropriate Transfer

Any member of the clinical staff, administrative staff, or medical staff of an MSHS hospital who has reason to suspect that a patient has been received at the Hospital as a result of an inappropriate transfer (see above), will complete an incident report and submit it to their Department Leadership prior to the completion of the shift during which the patient was received. When the incident has been reported by one member of the staff, other members are

relieved of the duty to report the same incident, but nothing precludes the submission of multiple reports.

1. The Department Leadership, in collaboration with the Quality Management Department, will review the incident and obtain such information as is reasonably necessary to validate or explain the facts of the incident. The Quality Management Department, when appropriate, will work with the Departments of Risk Management, Corporate Compliance, and Legal Affairs to review the matters of the case.
2. Where it is determined that a violation has occurred, the Quality Management Department will submit a report to the CMS Regional Office, ensuring that notification of the incident is received by CMS within 72 hours of the purportedly improper transfer or discharge from the prior facility. Notice of any reports to CMS must be given to the CMO of the Hospital that received the patient.
3. The Quality Management Department will maintain a file of all EMTALA-related incident reports and all notifications to CMS, and records of incidents will be maintained for at least five (5) years from the date of the incident.

M. On-Call Physicians

The Hospital maintains a list of on-call attending physicians who are responsible, if called, to provide treatment necessary to stabilize a patient with an emergency medical condition after the initial screening exam and within the capabilities of the treating facility. For those services not provided by the hospital, an on-call schedule is not required, but coverage is addressed with a plan by the individual hospital (e.g., via transfer agreements).

In some circumstances, the on-call attending physician may work with other providers (e.g., trainees and allied health practitioners), overseeing their involvement. For purposes of this policy, these providers are referred to as “on-call designees.”

When an Emergency Department physician determines that a patient requires the input of an on-call attending physician, the Emergency Department physician, through established mechanisms, will attempt to contact the on-call attending physician or on-call designee who will respond by telephone within 10 minutes.

If the Emergency Department physician deems that in-person consultation is necessary, the on-call attending physician/designee will, by default, arrive within 60 minutes, or sooner if necessary. The Emergency Department physician may stipulate that the on-call attending physician, not a designee, must present in-person. If the patient is considered stable and the input of the on-call physician/designee is deemed not to be emergent, the Emergency Department physician may determine, in a discussion with the on-call attending physician/designee, that an arrival time of greater than 60 minutes is acceptable based upon the nature of the case.

If the on-call attending physician cannot respond due to circumstances beyond his/her control, the on-call attending physician and his/her specialty service must have a back-up/secondary on-call and/or an adequate escalation plan to respond and must notify the Emergency Department and the AoC, as a representative of the Hospital. If an on-call attending physician is unable to manage the case, s/he must provide an effective solution, including, if necessary, finding specific coverage elsewhere. The Emergency Department physician is not responsible for finding coverage for the on-call attending physician.

If an on-call attending physician/designee refuses to accept responsibility for being on-call or does not respond to a call from the Emergency Department, the Emergency Department physician will document such in the medical record and immediately notify the Hospital's relevant Department Chair and/or CMO, who will attempt to resolve the coverage gap by whatever means necessary. Additionally, subsequent to the acute situation, if the Chair of the involved department(s) has not already been notified, s/he will be notified to investigate. On-call



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attending physicians/designees who do not or refuse to respond may be subject to disciplinary action, as appropriate. The Hospital's list of on-call attending physicians will be retained for a minimum of six (6) years.

N. Non-Retaliation

MSHS will not take adverse action against a physician or other qualified medical person because such person has refused to authorize the transfer of an individual with a non-stabilized emergency medical condition to a facility outside of MSHS nor will it retaliate against a physician or any other personnel for reporting in good faith an apparent EMTALA violation.

O. Medical Records

The Health Information Management Department shall retain the medical records and other records relating to patients transferred to or from the Hospital for a minimum of six (6) years from the date of transfer, or longer if required by other applicable law or Hospital policy. The Hospital's list of on-call physicians will be retained a minimum of six (6) years.

P. Posting of Signage

A sign must be conspicuously posted in the Hospital's Emergency Department and in all other places likely to be noticed by individuals entering the Emergency Department, as well as those individuals waiting for examination and treatment (e.g., the entrance, admitting area, waiting room, treatment area) specifying the rights of individuals with emergency medical conditions and women in labor who come to the Emergency Department or Labor and Delivery for health care services and indicating whether the facility participates in the Medicaid program. The wording of the sign(s) must be clear and in simple terms and language(s) that are understandable by the population served by MSHS.

Q. Internal Hospital Monitoring and Enforcement

MSHS will internally monitor and enforce compliance with this policy and applicable federal and state requirements through the MSHS Hospital's Quality Management program.

VI. REFERENCES

- The Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. §1395dd
- US DHHS Medicare and Medicaid State Operations Manual, App. V, Interpretive Guidelines for Responsibilities of Medicare Participating Hospitals in Emergency Cases



**Mount
Sinai**

MOUNT SINAI HEALTH SYSTEM POLICY & PROCEDURE

REVIEW/REVISION HISTORY

MSHS	<i>Reviewed</i>	06/18	11/22						
	<i>Revised</i>	11/20							
MSBI/MSB	<i>Reviewed</i>	11/03	06/05	08/05	06/07	02/09	04/11	03/13	08/15
	<i>Revised</i>	11/03	06/05	08/05	02/09	03/13	08/15	07/17	08/17
		06/18	11/20						
MSH/MSQ	<i>Reviewed</i>	1976	11/93	09/97	05/98	05/99	02/00	05/18	
	<i>Revised</i>	09/90	06/91	05/94	01/95	12/95	10/96	08/01	04/12
		06/18	11/20						
MSM/MSW	<i>Reviewed</i>	07/09	07/12	07/15					
	<i>Revised</i>	06/18	11/20						
NYEE	<i>Reviewed</i>	06/18							
	<i>Revised</i>	11/20							



APPENDIX A: Expectations of On-Call Physicians

1. Each Clinical Department and/or Service in the Hospital maintains a schedule of On-Call Attending Physicians to ensure 24/365 access to coverage for all patients who may require the expertise of that Department/Service.
2. Each Graduate Medical Education (GME) Program in the Hospital maintains a schedule of its trainees to ensure appropriate patient coverage and educational value, while simultaneously adhering to GME duty hours rules.
3. In some circumstances, Clinical Departments and/or Services in the Hospital may also maintain a schedule of On-Call Allied Health Practitioners (e.g., Physician Assistants and Advanced Practice Nurses) who may work as subordinates to the On-Call Attending Physician (see item 4, below).
4. On-call schedules are entered into the electronic on call schedule application by each clinical department or service on call schedule application administrator on a timely basis, i.e., at least two weeks prior to the period that the schedule covers, and are kept current by the Department Chair, Service Leader or GME Program Director, who may delegate that responsibility to others within the Department/Service/Program. Mount Sinai Health System Access Services department/Clinical Command Center supports the electronic on call application and any clinical department and/or service requiring administrator access to the on call application to manage their schedule may contact Access Services
5. In circumstances when an On-Call Attending Physician delegates some on-call responsibilities to trainees and/or allied health practitioners (aka "On-Call Designees"), the On-Call Attending Physician is responsible for overseeing their involvement in the care of his/her patients.
6. On-call schedules are populated with the specific names and contact information of the On-Call Attending Physician, any Back-Up On-Call Attending Physicians, and, if utilized, subordinate On-Call Designees (collectively referred to as "On-Call Practitioners").
7. Since the on-call schedules are populated with the specific names and contact information of the On-Call Practitioners, those individuals are each personally responsible to ensure that . . .
 - a) their contact information is always up to date and known to their Department/Service/Program;
 - b) their contact information enables communication with them within ten (10) minutes; and
 - c) any changes that they make to the schedule are immediately communicated in writing to their Department/Service/Program.
8. Within the capabilities of the Hospital, and when requested by the Emergency Department Physician, the On-Call Attending Physician is responsible to provide the treatment required to stabilize a patient with an emergency medical condition, after the initial screening examination has been performed by the Emergency Department Physician.
9. When an Emergency Department Physician determines that a patient requires the input of an On-Call Attending Physician, and attempts to contact the On-Call Attending Physician through established mechanisms, the On-Call Attending Physician (or On-Call Designee) will respond within 10 minutes in a manner that permits discussion between the Emergency Department Physician and the On-Call Attending Physician.
10. If the Emergency Department Physician believes that in-person consultation is necessary, he/she will inform the On-Call Attending Physician (or On-Call Designee), who will, by default, arrive within 60 minutes, or sooner if deemed necessary by the Emergency Department Physician.
11. Based upon the nature of the case, if the Emergency Department Physician deems that



- a) the patient is stable, and
- b) the required input of the On-Call Attending Physician/Designee is not emergent,

the Emergency Department Physician may determine, in a discussion with the On-Call Attending Physician (or On-Call Designee), that an arrival time of greater than 60 minutes is acceptable.

12. The Emergency Department Physician retains sole discretion to require that the On-Call Attending Physician, NOT an On-Call Designee, present in-person.
13. When requested to accept a patient in transfer from another facility, the On-Call Attending Physician (NOT an On-Call Designee) will promptly determine if s/he is able to accept the transfer based upon available information and appropriate criteria in accordance with the MSHS Policy: *Emergency Treatment, Stabilization, Transfer of Patients and EMTALA (Emergency Medical Treatment and Labor Act)*.
 - a) If ABLE to accept the transfer, the On-Call Attending Physician assists in making the appropriate patient placement arrangements (i.e., standard nursing unit, Step-Down Unit, Intensive Care, Emergency Department, etc.), in collaboration with the Transfer Center.
 - b) If UNABLE to accept the transfer, the On-Call Attending Physician will provide justification for that determination and assist in identifying an alternative receiving site for the patient.

Under EMTALA, acceptable rationale for declining a transfer are limited to . . .

- a) insufficient resource capacity (beds, staffing, equipment, etc.), or
- b) inappropriate acuity match between the patient's needs and the facility's capabilities.

In situations subject to EMTALA, lack of financial clearance is NOT a reason to decline a transfer. Refer to MSHS Policy: *Emergency Treatment, Stabilization, Transfer of Patients and EMTALA (Emergency Medical Treatment and Labor Act)* for detailed information.

14. The On-Call Attending Physician will promptly communicate all relevant information regarding the treatment plan to other attending staff, On-Call Designees, and clinical staff, as necessary.
15. If the On-Call Attending Physician cannot respond due to circumstances beyond his/her control, the On-Call Attending Physician and/or his/her Department/Service must . . .
 - a) Immediately provide a Back-Up Attending Physician who will respond and/or an effective escalation plan to identify coverage, and
 - b) promptly notify the Emergency Department, the Hospital Administrator-on-Call, and the Telecommunications Operators.

The Emergency Department Physician is NOT responsible for finding coverage for the On-Call Attending Physician.

16. If the On-Call Attending Physician is unable to manage the case, s/he must provide a timely and effective solution, including, if necessary, finding prompt specific coverage elsewhere, and facilitate access to that alternative coverage.
17. If the On-Call Attending Physician/Designee (i.e., the individual listed on the on-call schedule or otherwise identified by his/her Department/Service as being on-call) refuses to accept responsibility for being on-call or does not respond to a request from the Emergency Department, the Emergency Department Physician will document such in the medical record and immediately notify the Hospital's relevant Department Chair and/or Chief Medical Officer, who will attempt to resolve the coverage gap by whatever means necessary.

Additionally, subsequent to resolving the acute situation, if the relevant Department Chair/Service Leader has not already been notified, s/he will be requested to investigate.

18. On-Call Attending Physicians/Designees who do not or who refuse to respond when requested may be subject to disciplinary action, up to and including termination of appointment to the Medical Staff.



APPENDIX B: EMTALA Quick Reference Guide

WHAT IS EMTALA?

EMTALA is the Emergency Medical Treatment and Labor Act. It is a federal law that forbids Medicare-participating hospitals from “dumping” patients out of emergency departments. The law protects ALL people seeking medical care in emergency departments, not just Medicare beneficiaries.

WHERE DOES EMTALA APPLY?

- MSHS hospital campus, including parking lots, sidewalks, and driveways
- MSHS hospital Emergency Department
- An on-campus or off-campus department or facility that is perceived by the public as a place that provides emergency care on an urgent basis without previously scheduled appointment (e.g., Labor and Delivery, psychiatric units)
- All MSHS Offsite Provider Based Facilities (OPBF)
- A MSHS hospital-owned ambulance, even if not on MSHS grounds
- A non-MSHS hospital-owned ambulance as of the time that an individual is brought onto MSHS grounds

WHAT IS AN EMERGENCY MEDICAL CONDITION (EMC)?

Medical condition manifested 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:

1. Placing the health of the individual (or with respect to a pregnant woman, the health of her unborn child) in serious jeopardy; or
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part:

Or with respect to a pregnant women who is having contractions:

4. There is inadequate time to effect a safe transfer to another hospital before delivery; or
5. The transfer may pose a threat to the health or safety of the woman and/or unborn child

PROCEDURES TO COMPLY WITH EMTALA

1. **SCREEN** - A Medical Screening Exam (MSE) must be performed to determine whether an emergency medical condition exists. The MSE must include all of the following:
 - a. Performed by a qualified medical person (MD, NP, PA)
 - b. Conducted in accordance with ED/Hospital policies and procedures
 - c. Appropriate for determining whether an emergency medical condition exists

REFUSAL: If a patient refuses to consent to a medical screening exam, treatment, and/or transfer, advise the patient of reasonably foreseeable consequences of a refusal to consent and document in the medical record. Take reasonable steps to obtain the patient's written refusal.

2. **TREAT** – Provide necessary stabilizing treatment to an individual with an Emergency Medical Condition (EMC) or an individual in labor.
3. **TRANSFER** – 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 treatment necessary to stabilize the EMC. Use the MSHS EMTALA checklist.



Transfers from an MSHS Facility to another Healthcare Facility

EMERGENCY MEDICAL CONDITION?	STABILIZED?	HOW TO TRANSFER
YES	NO*	Life Rescue (need immediately available ambulance) – CALL 911 <u>and</u> MSHS Transfer Center
YES	YES	Transfer via the MSHS Transfer Center
NO	YES	Transfer via the MSHS Transfer Center

*Patients with an EMC who have not been stabilized may be transferred from an MSHS facility to another health care facility ONLY if they meet one of the conditions below:

- a) The attending physician determines and documents that the patient's emergency medical condition exceeds the capabilities of the facility to stabilize the patient and the medical benefits reasonably expected from the provision of appropriate medical treatment at the receiving facility outweigh the risk of transfer.

OR

- b) The patient (or legally responsible person) makes a written request for transfer, and the patient (or legally responsible person) has been informed of (a) the Hospital's obligations to stabilize the patient; and (b) the risks and benefits of a transfer.

RECEIVING A PATIENT REFERRED FOR TRANSFER TO AN MSHS FACILITY

All requests from facilities that seek to send a patient to an MSHS facility should be directed to make arrangements through the MSHS Transfer Center.

The Hospital will NOT refuse to accept an "appropriate transfer" of an individual who requires emergency specialized capabilities or facilities available at the receiving Hospital, provided that:

1. the specialized emergency services or facilities are not available at the sending facility or at a reasonably proximate affiliate of the sending facility ; AND
2. such services are immediately available at the receiving Hospital.

An "appropriate transfer" is when there is a request to transfer a patient with an emergency medical condition from a facility that cannot adequately treat (or fully stabilize) the patient to an MSHS facility that has the ability to adequately treat the patient.

In the event that the Hospital receives a request to accept an "appropriate transfer" for management of a patient with a condition typically treated by the Hospital, but Hospital staff believe that they lack either the capacity or the capability to treat the referred patient, the staff alleging that they cannot manage the case must immediately escalate this issue to the Hospital's Chief Medical Officer (CMO), his/her designee, or the Administrator on Call (AoC).



APPENDIX C: EMTALA Checklist –Transfer to Another Facility

Use this checklist to ensure requirements are met for an EMTALA-compliant transfer of a patient from an MSHS facility to another healthcare facility.

Patient Name: _____ MR# _____

Date: ____/____/____

Sending Site Attending Physician Responsibilities:

<input type="checkbox"/>	1. Ascertained and documented in the patient's medical record, that: <ul style="list-style-type: none"> <input type="checkbox"/> An attending physician at the receiving facility has agreed to accept and treat the patient; <input type="checkbox"/> There is available space/bed at the receiving site; AND <input type="checkbox"/> There are qualified personnel and the necessary equipment to treat the patient at the receiving site
<input type="checkbox"/>	2. Participated in a physician-to-physician telephone handoff conversation with the receiving physician.
<input type="checkbox"/>	3. Issued a physician's order for the transfer in the patient's medical record
<input type="checkbox"/>	4. Documented all of the following in the patient's medical record in accordance with the Hospital's standard descriptions of patients requiring specialized emergency care, triage protocols, and formal written transfer agreements: <ul style="list-style-type: none"> <input type="checkbox"/> Specifically why the patient cannot receive the necessary care locally and, therefore, requires transfer to another facility designated to receive and provide definitive care for such patients <input type="checkbox"/> The patient's medical condition at the time of transfer <input type="checkbox"/> Specific risks and benefits of the proposed transfer
<input type="checkbox"/>	5. Discussed above (#4) with the patient or responsible person.
<input type="checkbox"/>	6. Completed the relevant form (<i>Physician Certification / Consent to Transfer</i> or <i>Physician Certification / Request for Transfer against Medical Advice</i>) and, if at all possible, obtain a witnessed signature of consent
<input type="checkbox"/>	7. Performed and documented (or ensured that a qualified designee performed and documented) a reassessment (including an evaluation of recent vital signs, laboratory and imaging studies) that was performed within one (1) hour prior to transfer
<input type="checkbox"/>	8. Completed the provider section of the <i>Patient Transfer Summary</i>

Sending Site Registered Nurse Responsibilities:

<input type="checkbox"/>	9. Conducted a telephone handoff conversation with a registered nurse at the receiving facility and documented in the patient's medical record that it occurred <i>Note: Inability to complete telephone handoff at time of transfer should not delay the transfer. Handoff conversation can occur while the patient is en route to receiving facility.</i>
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<input type="checkbox"/>	10. Obtained and documented a complete set of vital signs just prior to departure, and notify the sending attending physician of any change from prior status
<input type="checkbox"/>	11. Completed the documentation on the Registered Nurse section of the <i>Patient Transfer Summary</i> form
Other Sending Site Responsibilities:	
<input type="checkbox"/>	12. Copies of the following records/forms accompanied the patient to the receiving facility: <ul style="list-style-type: none"> <input type="checkbox"/> Medical record relating to the patient's medical condition, including results of ancillary tests <input type="checkbox"/> Patient Transfer Summary Form <input type="checkbox"/> Consent to Transfer or the Request for Transfer Against Medical Advice form
<input type="checkbox"/>	13. Appropriate personnel, equipment, and life support measures were used in the transfer. The facility will not transfer an individual until his/her emergency medical condition has been stabilized, except in accordance with an appropriate written patient request or medical certification as set forth in the MSHS EMTALA policy.
<input type="checkbox"/>	14. TRANSFERS OF PATIENTS WITH NON-STABILIZED EMERGENCY MEDICAL CONDITIONS: A. Patient Requested Transfer <ul style="list-style-type: none"> <input type="checkbox"/> Obtained written request for transfer by the patient (or a person acting on that patient's behalf) <input type="checkbox"/> Informed the patient (or such person) of the Hospital's obligation to provide screening and treatment and explaining the risks, benefits, alternatives, and all other relevant information regarding the transfer. <u>OR</u> B. Medical Benefits of Transfer Outweigh the Risks of Transfer <ul style="list-style-type: none"> <input type="checkbox"/> Physician certifies in writing that the medical benefits of transfer outweigh the risks of transfer for the patient. <input type="checkbox"/> The transfer form includes a summary of the benefits and risks to the patient related to transfer.
<input type="checkbox"/>	15. Administrator-on-Call (AoC) was notified if: <ul style="list-style-type: none"> <input type="checkbox"/> Patient/family initiated transfer against medical advice <input type="checkbox"/> Patient refused to consent to transfer