A Federal Regulatory Visit is on the Horizon: Are You Prepared for a Survey?

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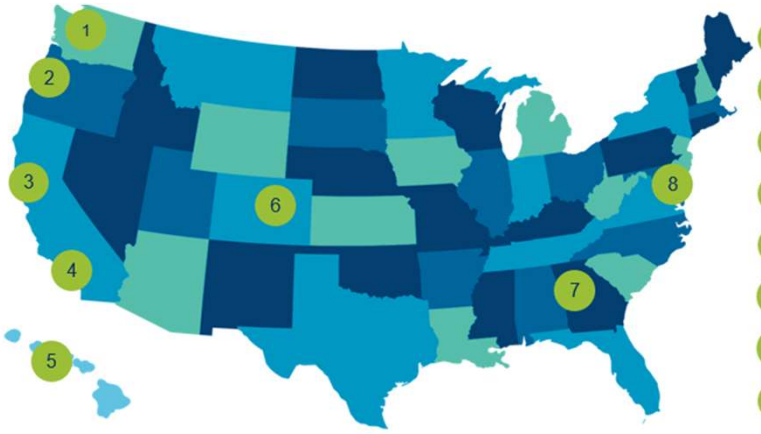
Permanente Medical Groups



1. Washington Permanente Medical Group (WPMG)
2. Northwest Permanente, P.C., Physicians and Surgeons (NWP)
3. The Permanente Medical Group, Inc. (TPMG)
4. Southern California Permanente Medical Group (SCPMG)
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SESSION AGENDA

I. Overview of the federal Emergency Medical Treatment and Active Labor Act (EMTALA), including COVID-19 implications, and the potential consequences of non-compliance

II. Understand what is involved in preparing for a CMS visit
   - What to expect during the visit
   - What are the strategies for addressing CMS findings to avoid penalties and reputational harm

III. Learn how the organization has implemented a rigorous monitoring plan – both short-term and long-term – to sustain compliance

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Disclaimer

The information contained in this presentation is not intended to convey or constitute legal advice and is not a substitute for obtaining legal advice from a qualified attorney. You should not act upon any such information without first seeking qualified professional counsel on your specific matter.

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What is EMTALA?

The Emergency Medical Treatment and Labor Act (EMTALA) was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

It was adopted in response to studies that found that emergency patients had been turned away or transferred in an unstabilized condition ("dumped") to public and charity hospitals due to insurance or financial reasons.

The Center for Medicare & Medicaid Services (CMS) published federal rules for the enforcement of EMTALA in 1994.

EMTALA Regulations with Interpretive Guidelines and Investigation Procedures (Appendix V of the CMS State Operational Manual): https://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/downloads/som107ap_v_emerg.pdf

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EMTALA overview

EMTALA is a federal law requiring Medicare hospitals with dedicated emergency departments:

- To provide a medical screening exam to any person who comes to the Emergency Department seeking medical treatment or on hospital property in need of emergency medical treatment, regardless of their ability to pay.
- If an emergency medical condition exists, the hospital will provide stabilizing treatment before discharging or appropriately transferring the patient.

"Dedicated emergency department" includes Labor & Delivery

EMTALA – core obligations

- Provide an appropriate Medical Screening Examination (MSE) – does an emergency medical condition (EMC) exist?
- Provide necessary stabilizing treatment to an individual with an EMC or to an individual in labor
- On-call coverage
- Provide for an appropriate transfer/discharge
- Accept patients with unstabilized emergency conditions requiring a higher level of care (receiving hospital with specialized services)
- Maintain a central log of anyone who "comes to the emergency department …"

Who is protected by EMTALA?

An individual who "comes to the Emergency Department" is defined as either of the following:

- An individual who presents to the "dedicated emergency department" and requests treatment of a medical condition; or
- An individual who presents on hospital property and requests treatment for an emergency medical condition

"Prudent layperson" standard applies to both situations above

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Hospital property

Hospital property (also referred to as the "campus of a hospital") is defined in the Medicare and EMTALA regulations to include the following:

- The main hospital building
- The physical area immediately adjacent to the hospital's main buildings
- Other areas and structures that are part of the hospital located within 250 yards of the main building
- Sidewalks, driveways, and parking lots

Excluded areas:

- Facilities on/off hospital property (e.g., physician offices), not operating under the hospital's Medicare provider number
- Restaurants, shops, or other non-medical facilities

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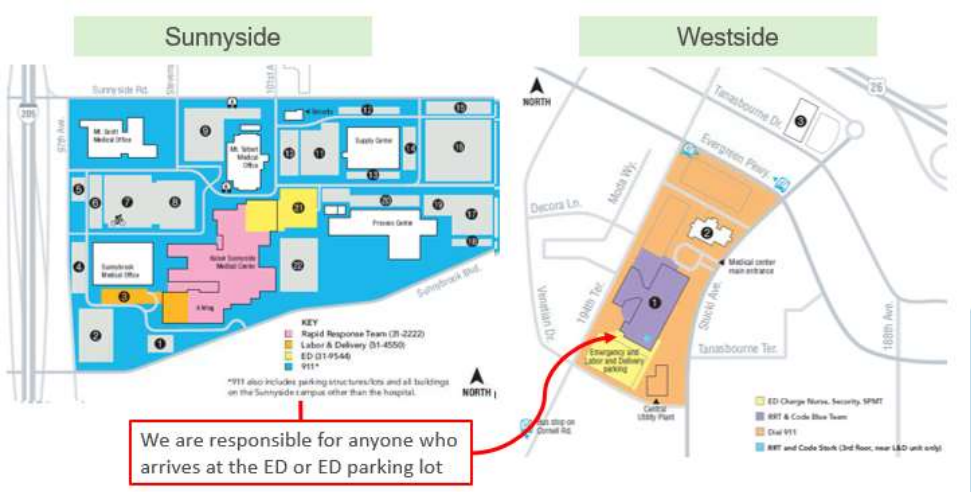
EMTALA maps



Medical screening exam

- Used to identify or rule out an emergency medical condition (EMC); triage is not screening
- Performed by physician or other qualified medical personnel identified in hospital bylaws
- Conducted without delay (i.e., patient registration may need to wait until screening is conducted)
- Based on the capability of the hospital — resources, staff, ancillary services routinely available to the hospital

What is an Emergency Medical Condition?

1. A medical condition manifesting itself 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:
    - Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
    - Serious impairment to bodily functions; or
    - Serious dysfunction of any bodily organ or part; or
2. With respect to a pregnant woman who is having contractions:
    - That there is inadequate time to effect a safe transfer to another hospital before delivery; or
    - That transfer may pose a threat to the health or safety of the woman or the unborn child

Delay in examination or treatment

Under EMTALA a hospital *may not delay* providing an appropriate medical screening examination or further treatment, including transfer, in order to:

- Inquire about the individual's method of payment or insurance status
- Seek, or direct the individual to seek, authorization from the individual's insurance for screening or stabilization services

Labor & Delivery

Labor & Delivery Departments must comply with all of the EMTALA obligations

A pregnant woman with an emergency medical condition is only considered stable if any one of the following occurs:

- The contractions stop
- The baby and placenta have been delivered
- A QMP certifies after a reasonable time of observation that the woman is in false labor

As of 2006, a certified nurse midwife may also certify false labor without consulting with a physician.

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What is a "transfer" under EMTALA?

CMS: Section 42 CFR 489.24 (d) defines transfer as:

"…the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by, affiliated with, or associated directly or indirectly with the hospital…"

- Any time the patient leaves the campus of the hospital, including discharge, unless AMA or deceased
- Roundtrip transfer: must be EMTALA compliant transfer with documentation, certification, and acceptance by the receiving hospital
- Transfer for specialized testing (such as MRI or cardiac angiography) with the intent to return: still an EMTALA transfer
- Transfer to hospitals of equal capacity and capability: patient must be stabilized according to EMTALA's definition for stability

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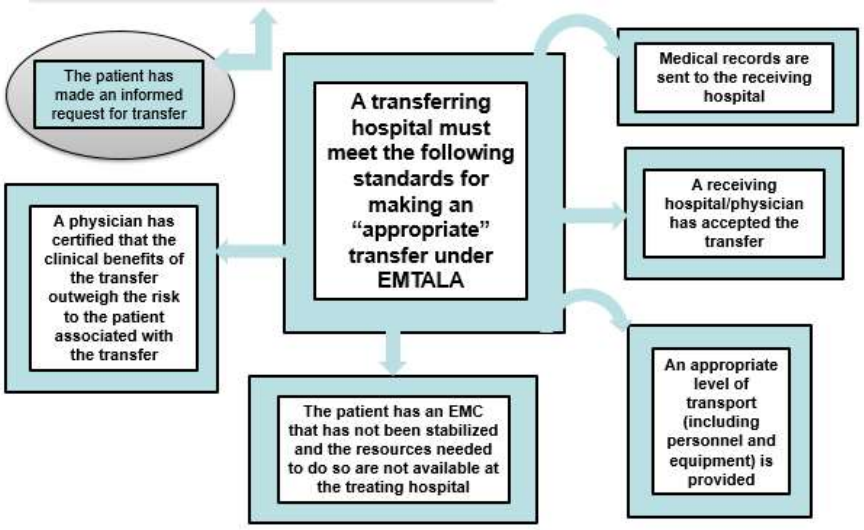
What is an appropriate transfer?



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Transfer obligations of receiving hospitals

Receiving hospitals

- ✓A hospital having the specialized capability and capacity to treat may not refuse a transferred patient with EMC in need of such specialized care.
- ✓A hospital with specialized capabilities could be in violation of EMTALA if there is evidence of a delay in care based on patient's ability to pay or other discriminatory basis.
- ✓A hospital must report, within 72 hours, if it has a reason to believe an improper transfer occurred.
  - Failure to report may trigger Medicare termination notice
  - Applies to hospitals in the same system/organization

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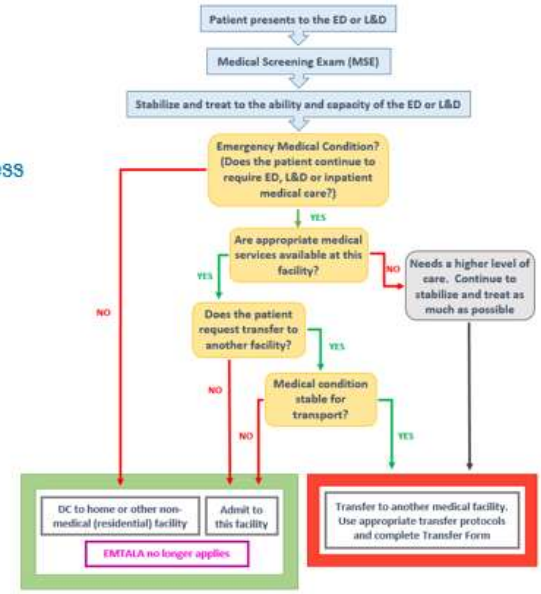
EMTALA Flow Chart

EMTALA Flow Chart

Aids decision making process for transfers and when EMTALA applies

Details in next few slides…



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EMTALA signage

- Post conspicuously in all dedicated ED and Labor & Delivery entrance(s), waiting room(s), and admitting and treatment areas.
- Specify EMTALA rights of individuals with emergency medical conditions and women in labor.
- Specify whether hospital participates in Medicaid.
- Keep wording clear and in simple terms.
- Ensure signage is in languages understandable by population served by the hospital.

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Slide 19

KLC2 This is hard to see. If you can make it bigger?
Kimberly L. Carlson, 2/6/2020

On-call physician requirements

- Hospitals are required to maintain a list of physicians who are on-call to provide treatment necessary to stabilize an individual with an EMC.
- CMS allows flexibility in maintaining panels of on-call physicians in a manner that best meets the needs of the hospital patients.
- On-call physicians must respond when:
  - ✓ Called to evaluate a patient to determine if an EMC exists
  - ✓ Called to provide stabilizing treatment in ED and L&D
  - ✓ Requested to accept a transfer
- Written on-call policies and procedures should establish time frames for on-call physician to respond to calls and come to the hospital.

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Enforcement & penalties

- CMS has the authority to conduct complaint and enforcement surveys
- EMTALA survey: Focus on initial allegation of violation and the discovery of additional violations
- Office of Inspector General (OIG) has the authority to impose civil monetary penalties (CMP) against:
  - ✓ Hospitals 100+ beds = up to $100,000/violation
  - ✓ < 100 beds = up to $50,000/violation
  - ✓ Any physician responsible for the MSE, treatment, or transfer of an individual and negligently violates EMTALA is subject to a fine of $100,000/violation (not covered by professional liability)

Access U.S. Department of HHS/Office of Inspector General, "Civil Monetary Penalties & Affirmative Exclusions," for previous years' Civil Monetary Penalties assessed via settlement agreement

https://oig.hhs.gov/fraud/enforcement/cmp/index.asp

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Essential elements for EMTALA compliance

- Hospital EMTALA Policy
  - ✓ Policies/procedures for key departments (ED, L&D, Patient Registration, Security)
- Central Log for ED and L&D patients who present for care
- EMTALA map of "hospital property"
- Signage posted in required locations
- On-call lists
- Transfer form for all EMTALA transfers
- Medical Staff Bylaws, Rules, and Regulations relating to EMTALA
- Ambulance protocols
- EMTALA training & education for all hospital staff, including temp/agency staff
  - ✓ Tailored to audience
  - ✓ Track & document completion

EMTALA vulnerabilities

Be Aware of Risky Situations:

- Patients arriving by ambulance – MSE required if present on hospital property – even if hospital is on diversionary status (same for walk-ins)
- Patients with mental health symptoms (delusional, confused) who may have an underlying medical issue: ALWAYS DO MSE.
- Patients with psychiatric emergencies: ALWAYS DO MSE.
- Patients who present to ED with unruly or other behavioral issues: Do not escort them out of the hospital until they receive MSE & are deemed stable.
  - ✓ Make sure security staff is trained on EMTALA
- Patient arriving to ED with police escort: ALWAYS DO MSE.
- Patient arriving to ED or L&D asking for "Urgent Care." Once they arrive in the ED, they should be treated like any other ED patient: ALWAYS DO MSE.
- L&D patients presenting in ED. Develop policy to determine when MSE will be done in ED or in L&D. Escort every patient to L&D.

EMTALA enforcement – complaint driven

Per CMS State Operations Manual; Appendix V – Interpretive Guidelines

- The investigation of a hospital's policies/procedures and processes and any subsequent sanctions are initiated by a complaint.
- CMS Regional Office evaluates & authorizes all complaints and refers cases to the State Agency that warrant an investigation.
- If the results of a complaint investigation indicate that a hospital violated EMTALA, the hospital may be subject to termination of its providers agreement and/or the imposition of civil monetary penalties (CMP).
- CMPs may be imposed against hospitals or individual physicians.

Information from Oregon Health Authority

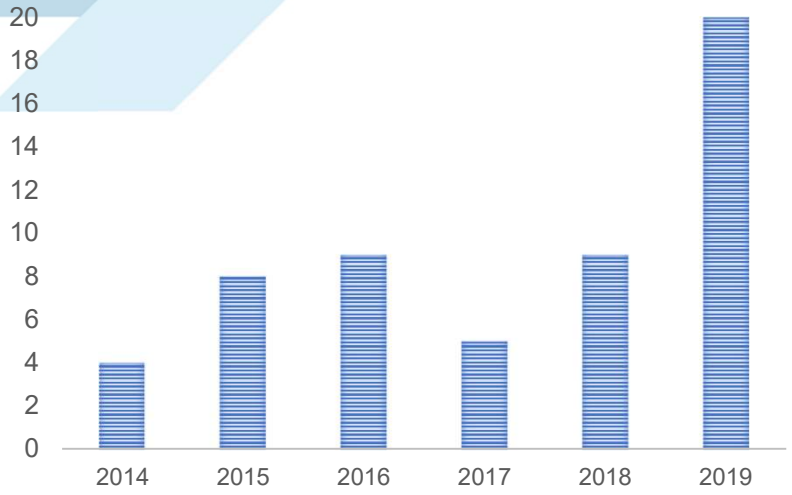
EMTALA COMPLAINT UPDATE

November 12, 2019

Dana Selover, MD, MPH – HCRQI Section Manager
Anna Davis, JD – Health Facility Survey & Certification Manager

Public Health Division

EMTALA complaint frequency



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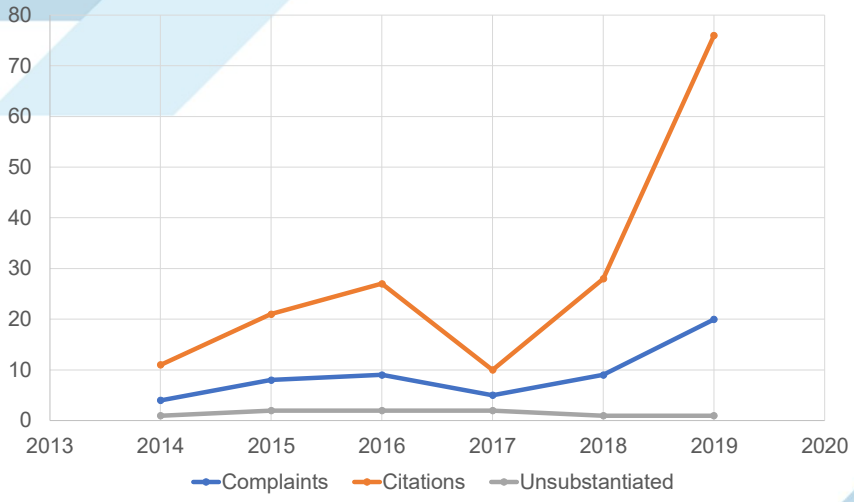
EMTALA frequency



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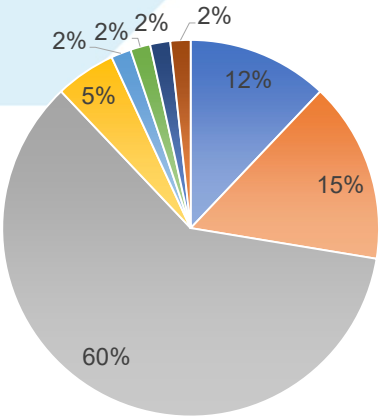
2014-2019 source of EMTALA complaints



- Patient/ Family
- Self
- Another hospital
- HCRQI
- Accrediting organization
- Advocacy organization
- Unknown
- Staff

N= 58 complaints

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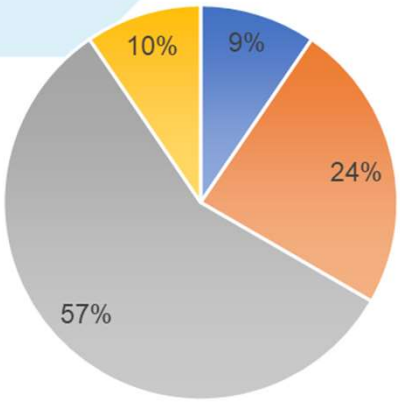
Source of 2019 EMTALA complaints



- Patient/ Family
- Self
- Another hospital
- HCRQI

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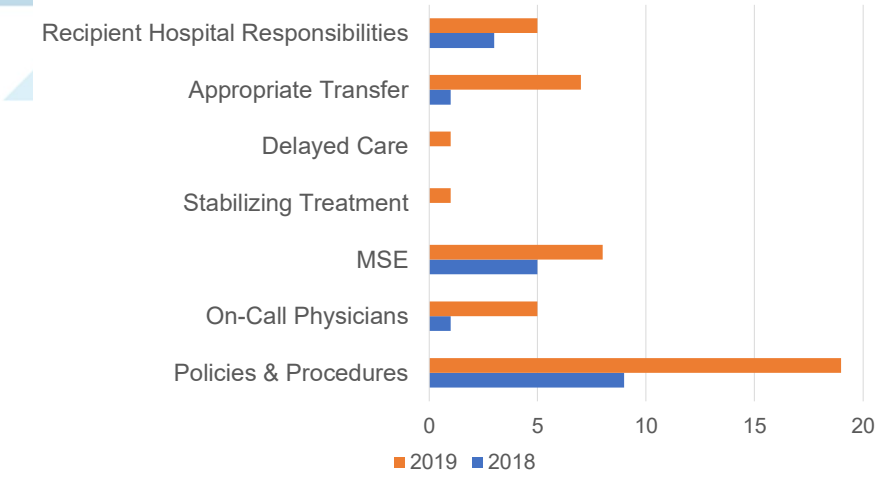
2018-2019 EMTALA complaint allegations



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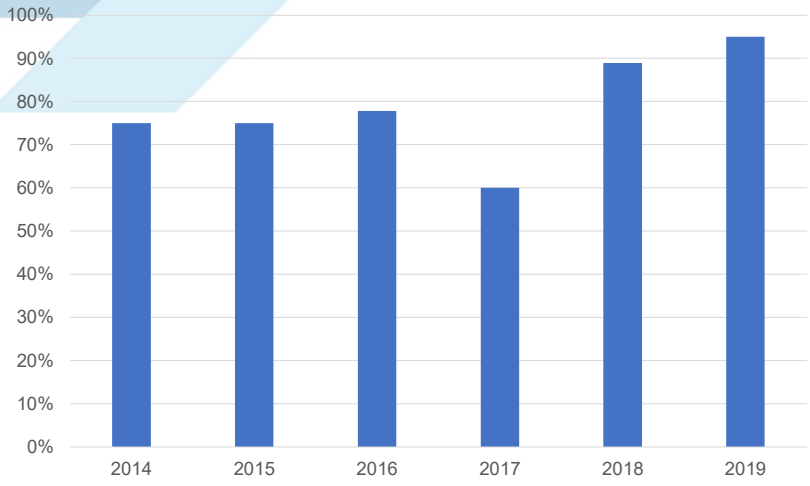
Percent of substantiated EMTALA complaints



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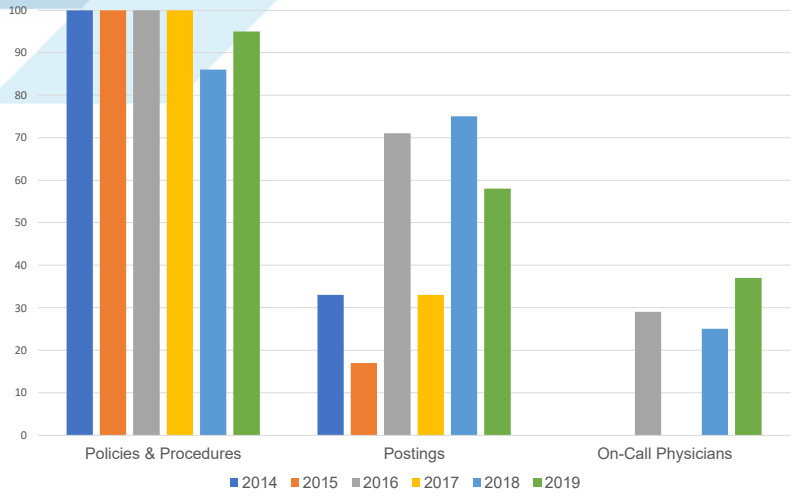
Substantiated EMTALA complaints included these findings



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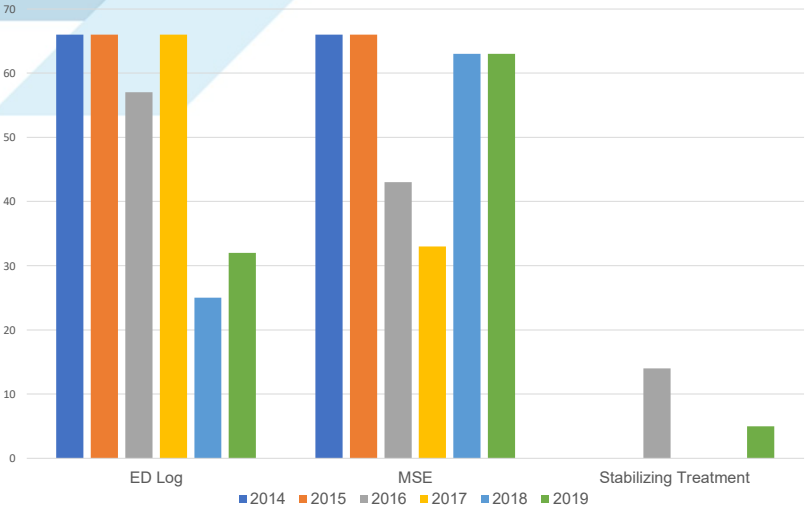
Substantiated EMTALA complaints included these findings



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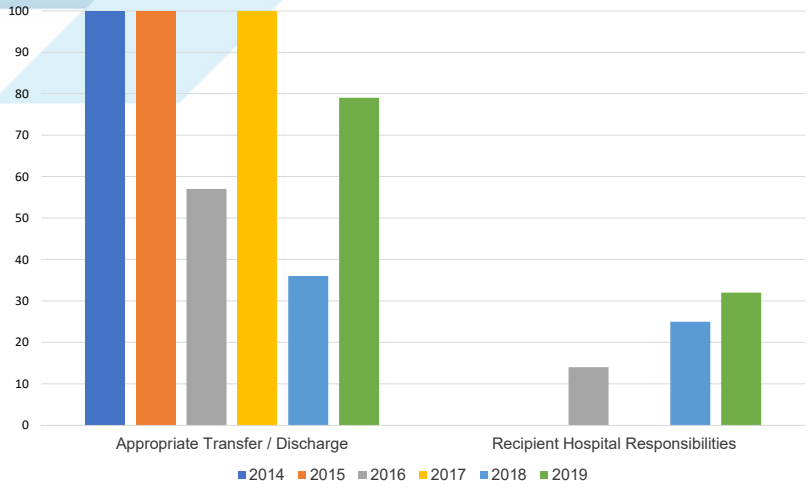
Substantiated EMTALA complaints included these findings



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EMTALA solutions

Training opportunities
Success measures

- Triage
- MSE
- Transfer

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COVID-19 and EMTALA implications

CMS Guidance Issued on March 9, 2020 – Updated March 30, 2020

Minimum Requirements

- MSE to everyone who comes to the ED to determine if EMC exists
- Provide necessary stabilizing treatment of EMC within hospital's capability and capacity
- Provide for transfers of individuals with EMCs when appropriate
- Accept appropriate transfers of patients with EMCs for higher level of care within hospital's capability and capacity

EMTALA Waivers

- Direct or relocate individuals to an alternative off-campus site for MSE. (CMS has approved)
- Allow transfers normally prohibited under EMTALA of individuals with unstable EMCs, so long as necessitated by the circumstances of the declared emergency

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COVID-19 and EMTALA implications

Alternative Screening Sites

- Hospitals may set up alternative screening sites on campus
- Hospitals may set up screening at off-campus, hospital-controlled sites

Medical Screening Exam

- Hospital expected to immediately isolate patients who come to the ED with possible COVID-19, consistent with accepted standards of practice for COVID-19 screening
- Hospitals expected to provide MSE and initiate stabilizing treatment within capacity & capability while maintaining isolation requirements for COVID. Lack of PPE not a reason to decline an MSE
- Hospital governing bodies must still approve QMPs to perform MSEs, but they may request a section 1135 waiver to allow MSE to be performed by QMP authorized by hospital within scope of practice and licensure

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COVID-19 and EMTALA implications

Transfer and Stabilization

- Transfer to designated facility with COVID-specific unit in accord with PHE or pandemic plan, following MSE and determination that patient is stable for transfer
- CMS will consider CDC's recommendation at the time of the event in assessing whether a hospital had the requisite capability and capacity

Using Telehealth

- Hospitals may perform MSEs via telehealth
- QMPs performing MSEs via telehealth may be on-campus (using telehealth to self-isolate) or offsite. MSE must be conducted within their scope of practice under state law and as approved by the hospital's bylaws, rules, or regs.
- Telehealth evaluation of persons who have not physically presented to the hospital does not trigger any EMTALA obligations.

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COVID-19 and EMTALA implications

Enforcement

Complaints regarding inappropriate transfers or refusal to accept an appropriate transfer – CMS will consider various factors, including patient condition, screening/treatment activities, referring hospital's capabilities, recipient hospital's capabilities/capacity, and nationally-recognized guidelines for COVID-19 screening and assessment.

References

- Centers for Medicare & Medicaid Services. *Emergency Medical Treatment and Labor Act (EMTALA) requirements and implications related to coronavirus disease 2019 (COVID-19)*, March 30, 2020. QSO-20-15 Hospital-CAH-EMTALA REVISED (PDF)
- U.S. Department of Health and Human Services. Waiver or modification of requirements under section 1135 of the Social Security Act, March 13, 2020.
- Centers for Medicare & Medicaid Services. COVID-19 emergency declaration blanket waivers for health care providers
- FAQs for Hospitals and Critical Access Hospitals regarding EMTALA, April 30, 2020. https://www.cms.gov/files/document/frequently-asked-questions-and-answers-emtala-part-ii.pdf

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Indications that an EMTALA visit may be on the horizon

- Patient complaint
- Another hospital reported a potential violation against your hospital
- Accreditation or other regulatory body findings or hints

Note: You may not have any reason to believe your hospital is being investigated for an EMTALA violation

Be aware:

- EMTALA visits are usually unannounced
- CMS/State Agency survey will not be limited to the case under investigation

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How to prepare for an EMTALA survey?

- Notify key hospital leaders, as well as Quality, Compliance, Risk Management, and Legal
- Gather the relevant documents: P&Ps, investigative report of incident, central log for ED/L&D, transfer form, Medical Staff Bylaws, any corrective action to address alleged EMTALA concern
- Identify staff/clinicians involved; ensure completion of EMTALA training; ensure appropriate licensure/certifications/credentials for individuals are current
- Perform inspection of ED and L&D, including signage, central log, transfer forms, policies, training logs, etc.
- Re-educate staff/clinicians about key EMTALA obligations
- Plan for initiating Command Center
- Identify individuals and their roles – who will act as greeter, escort, scribe, runner, etc.; who will send out communication to key hospital and organizational leaders
- Develop a communication plan following surveyor arrival

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EMTALA obligation – reminder to staff

Emergency Medical Treatment and Active Labor Act

ACCESS TO EMERGENCY CARE FOR EVERYONE WHO COMES TO OUR HOSPITAL

IF ANYONE COMES TO OUR HOSPITAL SEEKING EMERGENCY CARE, NOTIFY CAREGIVER IMMEDIATELY OF THEIR ARRIVAL SO THEY CAN BE EXAMINED.

THIS APPLIES:

- Even if we are on divert
- To women who may be in labor
- To anyone who may have an emergency medical condition
- When an individual walks in to our facility
- When an individual presents on our property, including parking lots, sidewalks, outside the hospital building
- When an ambulance pulls up on our property

ALWAYS MAKE ANYONE SEEKING CARE FEEL WELCOME IN OUR HOSPITAL. IT IS OUR DUTY TO PROVIDE INITIAL CARE TO ANY PATIENT – NO MATTER WHAT.

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What to expect during the survey

- Surveyor(s) will arrive at the hospital and explain reason for visit
- Appointed person will greet the surveyors, validate their credentials, escort them to private room
- Initiate the Command Center
- Initiate communication plan to notify key leaders
- Surveyor will hand over “complaint” or allegation (reason for visit), which will usually include affected patient/MRN
- No “entrance conference” held
- Surveyor will request documents for inspection
- Immediately begin gathering requested documents and other relevant information, such as key evidence, data, camera surveillance, etc.

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What to expect during the survey (continued)

- Surveyor will ask for time in private to review the Central Log and other documentation
- Surveyor will identify 10-20 patients on the log for whom they will request the relevant ED or L&D medical record
  - Dispositions flagged: No MSE, transferred, left AMA, blanks in log
- Surveyor will conduct inspections at the hospital
  - Likely to include ED or L&D tours
  - Validate EMTALA signage
  - Observe or question staff or clinicians about EMTALA-related practices
- Surveyor may ask to interview staff/clinicians – prep them!
- Surveyor may ask to review camera surveillance

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What information is reviewed during survey?

Documents requested by surveyor may include:

- EMTALA P&Ps
- Central log for past 6 months
- Index of ED and OB policies
- Medical staff bylaws
- List of all hospital services
- Investigation conducted by the hospital
- Staff/clinician schedules for past month
- List of transferred patients for past year
- EMTALA transfer form
- Any corrective actions taken to address the EMTALA allegation
- Any corrective actions taken to address the EMTALA allegation
- Current medical staff roster
- Credentials and personnel files for selected staff/clinicians
- EMTALA training logs
- Medical staff meeting minutes for past 12 months
- Schedule of on-call physicians for past 6 months

NOTE: Survey conducted by Oregon Health Authority on behalf of CMS Region 10

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What Information is reviewed during survey?

Checklist of items reviewed in each medical record:

- Arrival time of patient
- Means of arrival (ambulance, self, law enforcement)
- Chief complaint
- Triage time
- Level of Emergency Severity Index (ESI)
- Time vitals taken
- Time of MSE (based on ESI level)
- Name of physician/QMP conducting MSE
- Delay in MSE?
- Name of on-call physician, if consult done
- Was there an EMC?
- If EMC, was stabilizing treatment done (e.g., labs, EKG, imaging, medication, etc.)
- Review AMA form or other documentation for AMA or eloped patients
- Check for completion of transfer form for each transferred patient, including physician documentation of transfer risks
- Check for name of accepting physician at receiving facility
- Check for accuracy of disposition of each patient in central log

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Conclusion of survey

What to expect when survey is completed:

- Survey is typically multiple days (2-4), depending on severity of the allegation.
- Surveyor will provide estimated time when survey will be completed on final day.
- Surveyor will offer to do an “exit conference” or “debrief” of potential findings, if any.
- Any potential findings are subject to CMS review and approval.

Note: Don’t wait for CMS letter!! Begin developing a “plan of correction” (POC) to address any potential findings. Time frame for responding to CMS findings is typically short (10 days).

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What if CMS issues an EMTALA finding?

Letter from CMS addressed to the hospital will advise that:

"under 42 CFR 489.53, a hospital that violates the provisions of 42 CFR 489.20 and/or 42 CFR 489.24 is subject to termination of its provider agreement. Consequently, it is our intention to terminate [name of hospital]'s participation in the Medicare program. The projected date on which the agreement will terminate is [specified date]."

"You will receive a "Notice of Termination" letter no later than [specified date]. This final notice will be sent to you concurrently with notice to the public in accordance with regulations at 42 CFR 489.53."

- Letter specifies how the hospital can avoid termination action and notice to the public.
- Letter states what must be included in an acceptable plan of correction (POC).
- Letter specifies the "latest completion date" in the POC and to submit POC within 10 days.
- Letter will include CMS 2567 Form, listing all relevant CFR citations and related findings.

Immediately notify hospital leaders and legal counsel; identify who will be on point to develop POC

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What must be included in the plan of correction?

Acceptable POC must contain the following elements:

- The plan of correcting each specific deficiency cited;
- The plan should address improving the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective; and
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

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Slide 50

KLC4 tried to simplify language -- please doublecheck accuracy
Kimberly L. Carlson, 2/7/2020

Tips for Effective Plan of Correction

- Include all required elements for “acceptable plan of correction”
- Find template on-line with columns that include:
  - ✓ ID Prefix Tag (cut/paste from 2567 form)
  - ✓ Summary Statement of Deficiencies (cut/paste from 2567 form)
  - ✓ Provider’s plan of correction
  - ✓ Completion date
- Provider’s plan of correction should include for each deficiency:
  - ✓ Immediate actions taken – upon identification of this deficiency
  - ✓ Monitoring and tracking procedures
- Other tips:
  - ✓ Identify accountable individual by position
  - ✓ Include projected completion dates for items not completed (minimal)
  - ✓ Be explicit and descriptive of each item in POC
  - ✓ Call CMS investigator with any questions

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Short-Term Monitoring Plan

- Short-term monitoring included developing internal plan of correction to address identified risks
- Collaboration needed from Quality; Compliance; Accreditation, Regulation and Licensure; nursing and physician leadership in Emergency Department and Labor & Delivery Department
- Developed dashboard with each element on the EMTALA transfer form and Central Log to measure & track compliance (tailored to a hospital’s risks)
- Emergency and L&D Department completed dashboard weekly for each transfer and for central log accuracy
  - ✓Random “Over Audits” were conducted by a neutral clinical nurse to ensure accuracy

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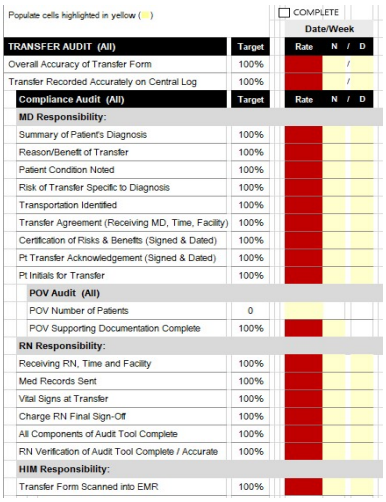
Dashboard Elements – Example



Populate cells highlighted in yellow ( )

COMPLETE

TRANSFER AUDIT (All)	Target	Rate	Date/Week N / D
Overall Accuracy of Transfer Form	100%		/
Transfer Recorded Accurately on Central Log	100%		/
Compliance Audit (All)	**Target**	**Rate**	**N / D**
MD Responsibility:			
Summary of Patient's Diagnosis	100%		
Reason/Benefit of Transfer	100%		
Patient Condition Noted	100%		
Risk of Transfer Specific to Diagnosis	100%		
Transportation Identified	100%		
Transfer Agreement (Receiving MD, Time, Facility)	100%		
Certification of Risks & Benefits (Signed & Dated)	100%		
Pt Transfer Acknowledgement (Signed & Dated)	100%		
Pt Initials for Transfer	100%		
POV Audit (All)			
POV Number of Patients	0		
POV Supporting Documentation Complete	100%		
RN Responsibility:			
Receiving RN, Time and Facility	100%		
Med Records Sent	100%		
Vital Signs at Transfer	100%		
Charge RN Final Sign-Off	100%		
All Components of Audit Tool Complete	100%		
RN Verification of Audit Tool Complete / Accurate	100%		
HIM Responsibility:			
Transfer Form Scanned into EMR	100%		

CENTRAL LOG (All)	Target	Number
Number of Log Entries with Missing Information	0	
Compliance Audit (Sample)	**Target**	**Rate N / D**
Overall Accuracy of Central Log Entries	100%	
Reason for Visit	100%	
Room	100%	
Disposition	100%	
MSE Done	100%	
LWBS (All)	**Target**	**Rate N / D**
Three (3) Calls	100%	
Nursing Documentation	100%	
Correct Disposition	100%	
AMA / ELOPEMENT (All)	**Target**	**Rate N / D**
MD Documentation	100%	
Nursing Documentation	100%	
Form Complete (or Documented)	100%	
Correct Disposition	100%	

Dashboard Data – Importance

What did the hospital do with the data collected?

- Department managers reported data weekly to hospital quality and compliance
  - ✓ As compliance accuracy improved, frequency lessened
- Dashboard was reviewed at Hospital Quality Council and Compliance Committee
- Dashboard overview was shared with Hospital Senior Leadership Team monthly and Regional Operations Quality Group quarterly
- Key information cascaded throughout hospital and organization

Training & Education

Hospital-Wide Effort to Educate All Hospital Staff and Clinicians

Extensive training developed and delivered to the following groups based on roles:

- ED and L&D staff and physicians
- On-call physicians and specialists with hospital privileges
- Regional transport center clinicians
- Hospital registration staff
- Security staff
- Volunteers
- All other hospital staff

Training plan: Live training for key departments and a plan for ongoing annual training

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Other Monitoring Efforts

- Incorporate EMTALA checks in routine compliance & quality assessments in patient care areas, such as Tracers
- Each weekday the hospital conducts a Daily Operations Briefing with leadership attendance
  - ✓ This venue has been used to discuss EMTALA transfers and the accuracy of the EMTALA transfer form
  - ✓ The number of EMTALA transfers are reported by ED and L&D leadership as well as any discrepancies on the transfer form

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Long-Term Monitoring Plan

- Self-Assessment Tool developed by Kaiser Permanente National Compliance Office
  - ✓ For use by all hospital regions
  - ✓ Based on CMS Interpretive Guidelines, Appendix V
  - ✓ Identifies required EMTALA elements in detail for all impacted departments
  - ✓ Each department will complete self-assessment
  - ✓ Goal is for hospitals to focus on any identified vulnerabilities
- Educating new physician leaders on EMTALA risks for facilities and individually
- Ongoing, open discussions with hospital physicians regarding scenarios and fact patterns impacting EMTALA, including questions about incidents at contracted hospitals
- Providing other community hospitals with “friendly” EMTALA compliance tips when opportunities are identified

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QUESTIONS?

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