The Emergency Medical Treatment Active Labor Act (EMTALA)

Health Care Policy

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Purpose

The purpose of this course is to allow the learner to become familiar with The Emergency Medical Treatment Active Labor Act (EMTALA). Homeless individual are exposed and susceptible to comorbidity and mortality. The conditions in which homeless individuals live make them vulnerable to poor health. For the two to three million homeless individuals in the United States, access to emergent health care is prudent for survival. Homeless individuals lack insurance and the ability to pay for healthcare needs.

Lack of the ability to pay creates significant barriers to emergent health care. Although local and federal assistance are available, lack of access to emergent medical treatment for the homeless is a significant health care problem. The Emergency Medical Treatment Active Labor Act (EMTALA) requires hospitals to care for the emergently ill homeless individual regardless of the individual's ability to pay. EMTALA specifies that health care organizations that

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participate in accepting Medicare provide emergent treatment. Medical screening and the stabilization of the individual must also be implemented prior to transferring out of the hospital. Access to emergent medical treatment for the homeless is a significant health care problem. The affect of EMTALA of 1986 and caring for homeless who present in hospital emergency rooms should be explored.

Introduction

Homelessness is the condition and a social category of people who lack housing because they cannot afford, or are otherwise unable to maintain, a regular, safe, and adequate shelter (Homeless Facts, 2009). Poor health is a chronic problem for the homeless. Individuals living on the street are exposed and susceptible to disease; furthermore, homeless children are unlikely to receive the necessary childhood vaccination (Homeless Facts, 2009). Homeless individuals lack insurance and the ability to pay for health care needs.

In 2003, the U.S. Department of Health and Human Services informed the public that there are between two to three million people in the United States experiencing homelessness each year. The number of homeless individuals continues to grow annually. According to Buck et al. (2005), the number of homeless individuals continues to grow. Even as this number grows, the homeless continue to be subjected to broad homeless profiling and stigmatization, both of which make it easier to ignore them when they have an underlying emergent medical condition, (Robertson & Cousineau, 2006). Research demonstrates that the homeless living without permanent shelter is associated with excess morbidity and mortality as well as increases in the risks of communicable diseases, injuries, hypothermia, malnutrition, and may exacerbate pre-existing conditions (Robertson, & Cousineau, 2006).

Access to medical treatment for the homeless is a significant health care problem. The Emergency Medical Treatment Active Labor Act (EMTALA) requires hospitals that participate in Medicare to provide a medical screening examination to any person who comes to the emergency department with an emergency medical condition regardless of the individual's ability to pay (United States General Accounting Office, 2001). EMTALA indicates that even if a hospital is forced to practice outside of its usual scope of practice, the patient must be stabilized prior to making the decision to transfer the individual out of the hospital. As long as the medical treatment rendered is safe and competent.

Under the federal EMTALA, discharges from the hospital are legally defined as "transfers," regardless of whether the discharge is from the emergency department or inpatient setting in addition these patients must be stabilized prior to discharge (Bitterman, 2011). Meanwhile, civil lawsuits are being filed across the nation due to area hospitals routinely involved in the dumping of indigent homeless patients (Blesch, 2008). Dumping of homeless patients is a violation of EMTALA. In the past, health care organizations were held liable for these actions. Efforts aimed at understanding the significant barriers experienced by the homeless when presented in health care emergency rooms with the effects of the EMTALA of 1986 are important. Health care organizations that are Medicare and Medicaid recipients should understand the importance of violating the 1986 EMTALA.

Hill (1991) illustrated that in order for the homeless to be viewed as a consumer, the approach requires that health care organizations begin to view and understand that the homeless people are an important sector of the patient population. Nonetheless, develop an understanding of the homeless needs and thoughtful solutions to his or her unique health care problems. Lack of the ability to pay creates significant barriers to a continuum of health care when homeless

individuals present in health care organizations emergency room. Lipton (2007) illustrated that in many communities, there are no resources for the homeless and little willingness by local politicians to fund homeless services.

Definition of Terms

Access: A way of entering, to make use of something (Willem, 2009).

Barriers: Any condition that makes it difficult to make progress (Willem, 2009).

Continuum of health care: Providing health care until illness or sickness has ceased.

EMTALA: Emergency Medical Treatment Active Labor Act (United States General Accounting Office, 2001).

Health and well-being: Existing without illness or free from sickness (Robertson & Cousineau, 2006).

Homelessness: A condition and a social category of people who lack housing because they cannot afford, or are otherwise unable to maintain, a regular, safe, and adequate shelter (Homeless Facts, 2009).

Homeless dumping: Dropping of ill or sick homeless individual from the hospital without making sure that the illness of sickness is cared for. Dropping off unhealthy or unstable homeless individuals without the illness ceasing (Lipton, 2007).

Medical screening: A strategy used in a population to detect a disease in individuals without signs or symptoms of that disease (Robertson & Cousineau, 2006).

Shelter: A place to sleep other than the outside (Homeless Facts, 2009).

Stabilize: To prevent further deteriorations of illness (Zibulewsky, 2001).

Standard of living: The way a person lives; poverty versus wealth (Homeless Facts, 2009).

Social category: How an individual is viewed by society or his or her surrounding peers (Homeless Facts, 2009).

Homeless individuals are without lodging and accommodation. These individuals also experience significant levels of poor health. Many homeless individuals experience no improvements in their health status until condition become chronic (Schanzer, Domimguez, Shrout, & Caton, 2007). As these disparities exist among the homeless, governmental health care programs were created to aid and assist.

Under the Emergency Medical Treatment Active Labor Act (EMTALA) of 1986 requires hospitals in the United States participating in Medicare to provide emergent treatment to the indigent. These hospital emergency rooms must grant emergent treatment regardless of the individual's ability to pay (United States General Accounting Office, 2001). The United States General Accounting Office (2000) and Congress recognized in the late 1980s that existing health care programs were not effectively meeting the needs of homeless.

Congress' concerns about the aptitude of homeless to obtain assistance through federal mainstream programs looked at ways to improve federal government programs. In the effort to improve the homeless' access to health care, the federal government focused on in-depth barriers to mainstream homeless programs (United States General Accounting Office, 2000).

When a homeless patient presents at the hospital with an emergency condition, the hospital must provide treatment. The treatment must include stabilizing the adverse health condition. The emergency room should provide competent and appropriate care before transferring patient to another facility. For example, a woman who presents to the emergency room in labor without medical insurance must be treated. The treatment of the labored women and her unborn child

will fall under the guidelines of an emergency condition. If the hospital does not treat and stabilize the women in labor, the health care organization may face grave ramifications.

Homeless individuals waiting in hospital emergency rooms are related barriers in identifying benefits, and addresses. The homeless patient presents in the hospital's emergency room, indicating that he or she does not have any insurance are triaged and told to wait. EMTALA of 1986 and the courts have focused special attention to the wait times experienced by the homeless. Patient-identifying documents are needed for the non-homeless and the homeless. These patient identifying processes are included in emergency room hospital practices for the insured and the uninsured. Emergency room wait times result in the homeless leaving with existing acute or chronic medical conditions (Markovchick & Pons 2003).

Homeless individuals lack a permanent address. Failure to provide the hospital emergency room with an address is a barrier to access and use of federal health care programs. When a homeless individual is hospitalized without an address or medical insurance care is rendered, and processes to enroll in Medicare are implemented. The process includes placing the homeless individual in a temporary living facility. The placement in the living facility is created to provide the federal government (Medicare) with an address. According to the United States General Accounting Office (2000), complying with federal programs paperwork requirements and regularly communicating with agencies and service providers is mandatory. Communication is difficult for a person who does not have a permanent address or a phone number.

When transferring the homeless to another location, the transferring physician is responsible. A physician must have sign a certificate. The certificate should include the patient's condition at the time of transfer as well as the medical benefits reasonably expected. Including the provision

of appropriate medical treatment at another medical facility outweigh the increased risks (Zibulewsky, 2001).

Transferring the patient without stabilization is considered a form of homeless dumping. Homeless dumping is prevalent and continues to increase. Homeless dumping occurs throughout the United States. Homeless dumping prior to stabilizing illness is a crisis and a violation of the 1986 EMTALA. Patients are dumped at homeless shelters that cannot follow up to provide treatment for current health conditions. Health care shelters are forced to call 911, resulting in re-admission (Lipton, 2007).

In 2008, a college hospital was involved in one of the largest court cases of homeless dumping to date (DiMassa & Winton, 2009). As part of the settlement, the hospital paid $1.6 million in penalties and charitable contributions to a host of psychiatric and social-service agencies. Hospital was also prohibited from transporting any homeless psychiatric patients discharged from their facilities to the streets or shelter (DiMassa & Winton, 2009). Health care organizations are being sued for homeless dumping, which is a continuous cycle. It appears that they are in an endless game of "cat and mouse." In other words, catch us involved in homeless dumping if you can.

The inverse care law has implications for health care and outcomes for vulnerable populations including low-income persons, racial, and ethnic minorities and the uninsured (Fiscella & Shin, 2005). The homeless experience barriers to health care access. The homeless are stigmatized by health care workers. The stigmatization occurs as a result lack of insurance, transport problems, confusion, and not knowing where to go when illness occurs (Willem, 2009). The stigmatism that the homeless face makes them reluctant to seek health care. Being reluctant to seek health care makes illness worse, requiring emergency services.

According to Nolan (2011), Americans are taking sides in the ongoing battle about the future of American health care and the homeless. Nonetheless, the homeless communities are the underrepresented groups that are vulnerable. Homeless individual have rights and should be treated with dignity. Homelessness remains a bewilderingly complex emergent health care challenge that has long thwarted simple solutions. The issues of homelessness and the EMTALA of 1986 involving emergent health care are so integrated that it is impossible to consider the former without investigating the latter (Nolan, 2011).

Lessening the barriers of the homeless would require the federal government to address several established multifaceted barriers that exist in federal health care programs.

- Improve processes by making it easier for the homeless to have access to federal health care assistance.
- Improve the amalgamation and management of federal health care programs.
- Develop ways to create communication for individuals without an address.
- Ensure that the local government is held accountable for provisions and access to health care (United States General Accounting Office, 2000).

Approval of EMTALA

The EMTALA of 1986 was passed due to the high incidence of patient dumping. Discharging a patient without properly stabilizing the individual is homeless dumping. Originally, EMTALA of 1986 was known as the patient antidumping statute. The antidumping statute is a part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

According Zondorak & McCormick (n.d.), Congress endorsed these antidumping necessities in the Social Security Act in 1986 because of an increasing number of reports that hospital emergency rooms were refusing to accept or treat patients with emergency conditions if the

patients did not have insurance (The Regan Report on Medical Law, 1998). Additionally observed in these practices is the financial burden placed on the hospital that includes the cost associated with caring for the homeless (uninsured). Under EMTALA of 1986, participating hospitals with emergency departments are required to deliver an appropriate medical screening examination.

Federal programs were designed to aid the homeless with the lack of barriers to access to health care. Nevertheless, the homeless are not informed about federal programs that can assist them with health care. According to the United States General Accounting Office (2000), although a lack of information about services can be an obstacle to low-income people, homeless people are less likely to have access to as many sources of information as people who are housed. The health care team has a direct influence on health care outcomes for the homeless. The collaboration of efforts with the health care team to break down the barriers to health care access for the homeless is imminent.

The Effects of EMTALA on Health Care Delivery

In 2008, the Medicare program made changes to the EMTALA. Under the regulations, hospitals are required to post conspicuously in the emergency department care provided under EMTALA (EMTALA, 2008). A written form specifying the rights of individuals under section 1867 of the act with respect to examination and treatment for emergency medical conditions should also be given to the patient (EMTALA, 2008).

The homeless are not linked with a community; therefore, they are uninformed of local and federal programs for health care. Zondorak and McCormick (n.d.) clearly illustrated that the Centers for Medicare and Medicaid Services (CMS) stated that EMTALA would continue to prohibit hospitals from seeking prior authorization. The intention of prohibiting prior

authorization is to prohibit a Medicare-participating hospital from seeking authorization required to stabilize an emergency medical condition (Zondorak & McCormick, n.d.). The intervention of prohibiting prior authorization can facilitate adequate patient emergent care in the hospital emergency room.

Additional effects of the EMTALA of 1986 on the health care delivery are the economic burden placed on health care organizations. Health care emergency departments struggle with the homeless frequent visits to the emergency room (Green Door, n.d.). On average, homeless individuals visit the emergency room five times per year. The cost for the health care organization can be immense. If the homeless individual has a chronic condition the expenditures are above average. People struggling with homelessness spend, on average, three nights per visit in the hospital, which can cost over $9,000. Of the large volume of emergency room visits made by the homeless, these visits could have been treated with preventative care (Green Door, n.d.). For these reasons, hospitals are reluctant to treat and care for the homeless.

The Social Forces That Have Shaped the EMTALA

Landers (2007) indicated that there is a vast and growing body of research documents the disparities in health care access and the homeless. These disparities also include treatment and outcomes of health care experiences based on social class in the United States. The homeless experience exclusion in health care that is a major social declination.

Homeless individuals are subjected to homeless profiling, which makes the homeless persons reluctant to obtain needed, regular medical health care (Robertson & Cousineau, 1986). Hill (2005) illustrated that for the homeless to be viewed as a consumer, the approach requires understanding the unique needs. Health care organizations should view the homeless persons as

an important sector of the patient population. They should develop an understanding of the homless' needs and consider thoughtful solutions to their unique health care problems.

The Ethical Forces That Have Shaped EMTALA

According to Buck, et al., (2005), the number of homeless individuals continues to grow. Even as this number grows, the homeless continue to be subjected to broad homeless profiling and stigmatization, both of which make it easier to ignore them when they have an underlying medical condition, (Robertson & Cousineau, 1986). The unethical treatment experienced by the homeless makes them reluctant to seek health care.

The Political Forces That Have Shaped the EMTALA

The political forces that have shaped the EMTALA of 1986 and delivery of services is the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. In 1986, the Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. The federal assistance program has also played a role in the political forces that have shaped the EMTALA of 1986. However, Congress created several health care programs to address the specific needs of the homeless and their families (United States General Accounting Office, 2000). Since these acts, there have been several amendments to the EMTALA of 1986 laws.

The Head Start program is a program instituted by the government that took on the holistic approach of individuals suffering from poverty. The program included health, nutrition, and education for the children. Once children were enrolled in the program, it gave similar privileges to the family. In 2007, the Head Start program was reauthorized to start including homeless children (The National Association for the Education of Homeless Children and Youth, NAEHCY, 2011). The reauthorization allowed for the homeless children and their families to

have access to health services includes screenings, health checkups, and dental checkups (NAEHCY, 2011).

The Legal Forces That Have Shaped EMTALA

Health care organizations must comply with the EMTALA of 1986 and all revisions to its statutes. Under section 489.24 of EMTALA, hospital emergency rooms must provide safe, competent, and effective care. The emergency room department must keep an on-call list of physicians who are on the hospital's medical staff with privileges that can provide treatment in an emergent situation. Failure to comply is a violation of the EMTALA. Additional violations under section 489.24 include failure to keep a central log of all homeless individuals who present in the emergency room. The log should be kept whether treatment is rendered or the patient refuses, is transferred, admitted, treated, stabilized and transferred, or discharged (EMTALA, 2008).

Smith (2005) conducted research on health care exclusion. In his work, he concluded that the exclusion was related to race and social class. Additionally, he described the history of a racially divided health care system in the United States and efforts during the middle of the 20th century to remove barriers impeding equal access to health care facilities and providers. Health care disparities occurred as a result of race and social class. The homeless and the indigent experienced segregation based on physician referral practices, insurance status, residential location, and nonresidential location (homeless). Landers' (2007) work documents that the federal government played an important, but diminishing role in addressing these challenges (Landers, 2007).

The United States should enforce the EMTALA of 1986. In addition, the country should pay special attention to identifying the causes of health care disparities for the homeless (Landers, 2007). Excluding a population from health care because they are different is a violation of the

Civil Rights Act. The federal government has programs to assist the homeless in overcoming barriers to access to health care. available to assist with the barrier that the homeless face with access to health care. Intervention implemented can facilitate adequate patient emergent care in the hospital emergency room that advocates the EMTALA of 1986 and other federal health care programs.

Recommendations and Conclusion

Health care organizations must comply with the EMTALA of 1986 and all revisions to its statutes. Recommendation for compliance include that the federal government assist and coordinate programs at the community level to reduce barriers to access to health care for the homeless. Furthermore, accountability for compliance is mandatory. Direct instruction with the local programs, and EMTALA statues available for health care access should be provided and implemented.

Health care organizations should use the social service department to identify creative ways to find shelter for the homeless. Without an address, the homeless will not benefit from local governmental health care programs. The health care organization will not receive payment for the services rendered, and the homeless person will be without a continuum of health care.

Health care organizations should implement a structured process outcome paradigm model to comply with the EMTALA. The paradigm model will have a direct influence on emergent care for the homeless. The recommendation will be to incorporate Donabedian's structure-process-outcome paradigm model. Donabedian's structure-process-outcome paradigm influence on emergent health care for the homeless consists of a structured processes and outcomes. These processes and outcomes have a direct influence on one another in relation to the quality of patient-centered emergent care and continuum of care for the homeless (Donabedian, 1980).

The analytic framework of the Institute of Medicine (2001) and the FACCT (Foundation for Accountability, 1997) antiquates with Donabedian's model. The antiquation clearly proves that safe, effective, patient-centered, timely, efficient, and equitable patient care has a direct influence on how an organizational system is structured. Using the structured paradigm model will result in a "win, win" outcomes. The health care organization will comply with EMTALA statues, receive payment for services rendered, and provide homeless patients with emergent quality initial and follow-up health care.

Stakeholders including health care organization administrators, health care providers, health care leadership team, and leaders in the community (local homeless shelter) would benefit from developing a collaborative approach that should be reinforced by values that include meeting the physical needs of the homeless. Health care leadership should then escalate those physical needs to resources aimed at provisions in shelter and health care access regardless of financial resources. Accrediting bodies can also include a plan of action on how health care organizations follow the EMTALA of 1986 and sited for deficiencies.

The health care team has a direct influence on what the patient outcome is going to be. Training the staff to feel empowered to deliver the best care possible is eminent. The plan is to collaborate with the health care team and then design a master plan to coordinate efforts that will follow EMTALA guidelines and deliver timely emergent care. Donabedian's structure-process-outcome paradigm model will bring together the local government and the leaders of health care organizations. The collaboration will meet the needs of the disadvantaged and comply with the EMTALA.

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