



# Emergency Medical Treatment and Active Labor Act (EMTALA) and Telehealth in Critical Access Hospitals

## Executive Summary:

**Background:** Small critical-access hospitals (CAHs) have difficulty delivering emergency services because of EMTALA regulations requiring a physician to be available to stabilize emergency patients, even if a midlevel provider (a certified nurse practitioner or physician assistant) is covering the emergency department. Meeting this requirement is difficult for many safety-net providers who struggle to retain an aging physician workforce, recruit new physicians, and justify the cost of hiring locum tenens physicians. Not meeting the EMTALA requirement currently results in the closure of emergency rooms and the elimination of emergency-services access to area residents.

**Issue:** Currently EMTALA requires all hospitals, including CAHs, to maintain a list of on-call physicians who can be physically present to the hospital to stabilize patients with an identified emergency-medical condition. EMTALA specifically requires a physician to fill this role, even though the Medicare Conditions of Participation (CoP) allow a trained midlevel provider to cover the emergency room. The physician on call must be able to be physically present in a reasonable amount of time to stabilize the patient. This requirement is creating physician workforce shortages in rural areas which can decrease access to high quality emergency care.

## Recommended Policy Changes:

Change interpretation of the EMTALA on-call requirements to allow a telehealth physician to meet the on-call emergency care physician requirements, as long as the following requirements are met:

- 1) The telehealth provider is an emergency physician immediately accessible via two-way interactive video that meets the CMS requirements for telehealth
- 2) The onsite midlevel provider has received certification in ATLS, ACLS, PALS, and is able to meet the CAH CoP requirements
- 3) A Calling Tree is in place for extraordinary events, including national disasters, bioterrorism events, mass casualties, and other major trauma events.

In the alternative, provide an EMTALA waiver to Critical Access Hospitals to allow for this call arrangement.

**Background:** CAHs serve as important safety-net providers and key providers of emergency services. In rural and frontier areas, they may be the only providers of emergency services for hundreds of miles. However, these facilities face increasing challenges in delivering quality care and providing access to rural and frontier residents.

The challenges to providing care are compounded by a physician workforce shortage. Even with shared emergency department (ED), clinic and hospital responsibilities, the reliance of CAHs on family-practice physicians is tentative. Along with the rest of the United States, rural CAHs are facing increasing physician workforce shortages and at a higher rate than their urban counterparts. Rural hospitals compete with larger practices and urban facilities to recruit and retain physicians. On the individual level, rural recruitment challenges stem from four key issues:

- 1) General preference for urban amenities and lifestyle
- 2) Perception of lower compensation
- 3) Perception of isolation
- 4) Significant call responsibilities

While CAHs may require call coverage one in every two or three days, larger facilities can offer call one in every 28 days or no call at all.

In response to the physician shortage and recruitment difficulties, CAHs have adopted a variety of staffing models, including employing physicians, using midlevel providers with physician backup, contracting for physician coverage or any combination of the three. Many CAHs rely on emergency coverage provided by off-site, on-call providers, who are called in as the hospital is notified of a patient need for emergency services. Some facilities are even more vulnerable to the physician shortage and have concerns of maintaining emergency services at all. These hospitals face retirements, difficult recruiting prospects and the soaring costs of contracted physicians and locum tenens.

In short, the challenges of providing emergency services in rural areas include:

- Decreasing patient populations, which leads to smaller practices dividing the same amount of emergency room coverage
- Heavy emergency call duties, which leads to difficulty recruiting new physicians
- Emergency call burn-out which leads to difficulty retaining physicians
- Significant expense to the facility for locum tenens physicians, who may see few patients during their contracted hours of service
- Reliance on off-site, on-call physicians who have up to 30 minutes according to the CAH CoP to respond to the arrival of an emergency patient, creating care delays for critically ill patients.

**Issue:**

CAHs are subject to both the Medicare Conditions of Participation and the Emergency Medical Treatment and Active Labor Act.

The Medicare CoP for CAHs require that for provision of emergency care:

“ ... there must be a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care on call and immediately available by telephone or radio contact, and available onsite ...”

within 30 minutes for most facilities and within 60 minutes for facilities meeting frontier or other specific criteria.<sup>1</sup>

CAHs must also be in compliance with EMTALA. Section 1866(a)(1)(I)(iii) of the Act states:

“... as a requirement for participation in the Medicare program, that hospitals must maintain a list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition.”<sup>2</sup>

In other words, while the Medicare CoP allow a physician assistant or a nurse practitioner to provide emergency room coverage, EMTALA requires a physician to be on-call and ultimately responsible for the patient’s care. If a physician is listed as on-call and requested to evaluate and treat an individual, that physician must respond in person in a reasonable amount of time.<sup>3</sup>

The conflict between the Medicare CoP and EMTALA is significant. While CAHs may use a midlevel practitioner to cover the emergency room, they must also have a physician on call, who must be able to be physically present at the ED in “a reasonable amount of time.”

In practice, this results in having two providers on call; a midlevel on primary call and a physician on secondary or backup call. This arrangement does not alleviate the call coverage for the physician. For example, in a community of two physicians and two nurse practitioners, the physicians may have just as many on-call days as a community with only two physicians. In areas with limited provider workforce, locum tenens may be used to cover portions of this call, but at significant expense to the facility.

A study completed by the Upper Midwest Rural Health Research Center found that 63 percent of hospitals surveyed contracted for some or all of their ED coverage. Additionally, “One-third of hospitals that contract for ED coverage indicate that their primary reason for contracting is an insufficient number of physicians on the medical staff or problems recruiting physicians to cover the ED.”<sup>4</sup>

Locum tenens coverage is costly. Avera runs a locum tenens program that strives to keep locum tenens costs as low as possible for its rural facilities. Using the pricing data from this program, the cost for a locum tenens to cover a weekend is at least \$4,630. National firms charge up to 75 percent more. If a facility were to use the Avera locum tenens plan one weekend a month, total costs for a year would be at least \$55,000. Even with the high fees, the quality of care provided by locum tenens can be of dubious value. Both second-year residents, and retired pathologists can serve as emergency physicians, although they may have no training in emergency care.<sup>5,6,7</sup>

The emergency call burden and the cost of locum tenens lead to additional access problems. If hospitals cannot retain or recruit physicians and if the cost of locum tenens becomes prohibitive, they will struggle to continue to provide emergency-care access and maintain compliance with federal regulations. The most significant consequences of this are that hospitals without availability of an on-call physician must close their EDs, even if an emergency-trained and experienced midlevel is available.

## **Recommendations:**

### **Midlevel Providers and Telehealth Support**

Emergency telehealth programs operate by providing two-way video links between rural and tertiary-care EDs, allowing rural practitioners to contact emergency physicians or other specialists for a consult or other support. These types of telehealth regulations are currently recognized and allowed by CMS.11 Emergency telemedicine can solve several rural health care issues including:

- Providing access to specialists regardless of geography
- Leveraging the midlevel provider workforce
- Economically providing immediate access to quality emergency services

Emergency telehealth programs provide many benefits to rural patients, hospitals and physicians. They provide patients with access to board-certified emergency physicians and many of the specialists available at Level I and II trauma centers. This access can speed transfer arrangement, diagnosis and treatment, and ultimately result in better patient outcomes.

Emergency telehealth programs can also assist in provider recruitment. Physician residents are trained in major medical centers where the advice of a colleague or access to a consult is literally down the hall. New physicians considering a rural practice face the stark contrast between the resources of a major medical center and the isolation of being the only provider on call. Telehealth programs can help bridge this gap, providing access to colleagues as needed.

The goal of many emergency telemedicine programs is to support the rural physicians and reduce call requirements. Today, the program operates by offering the support of a colleague, or a consult for challenging emergency patients. In this model, telehealth may relieve some isolation of practicing in rural hospitals but will not eliminate the need for physician on-call coverage.

The proposed long-term solution for maintaining emergency-care access takes this concept one step further. To truly reduce call requirements and eliminate emergency-provider workforce shortages, EMTALA regulations should be changed to allow a telehealth physician to meet the physician requirement for emergency care, supported at the patient site by a trained midlevel provider. Only in this instance can call coverage for physicians truly be reduced, relieving many of the workforce and economic challenges to providing emergency care. In this scenario, the hospital with two physicians and two midlevels can split their call coverage among four providers instead of two. This results in a better work-life balance for physician and will improve physician retention and recruitment. This model will also reduce expenditure for locum tenens physicians.

### **Benefits of Emergency Telehealth:**

- Midlevel providers with requisite certifications in Advanced Trauma Life Support (ATLS), Advanced Cardiac Life Support (ACLS), and Pediatric Advanced Life Support (PALS) can provide high-quality emergency care with support of an emergency telemedicine program and access to specialists.
- Emergency telehealth programs can eliminate the time delay between patient arrival to the rural

ED and provider arrival to the rural hospital. Over a 12 month period, Avera eEmergency provided access to an emergency telehealth physician an average of 18 minutes prior to the arrival of the local physician for 123 cases. Another study of emergency telemedicine services demonstrated similar results.<sup>8</sup>

- Emergency telehealth programs can provide the specialty expertise of a board-certified emergency physician in a community that could not otherwise support that type of specialty.<sup>7</sup>
- The United States Congress and the Centers for Medicare & Medicaid Services have recognized the value and quality of telemedicine in providing care for rural patients. Congress and CMS have set specific telehealth reimbursement guidelines that provide reimbursement equal to that of a traditional consult.<sup>10</sup>
- Emergency telehealth programs can provide care that is equal to or better than traditional care. Several retrospective studies and a randomized controlled trial (RCT) have shown that diagnosis, treatment decisions, and patient outcomes are the same for those treated via telehealth and those treated by traditional means.<sup>7,8,9</sup>
- The RCT found patients to be equally satisfied with telehealth and traditional care: 98% vs 100% positive patient-doctor interaction; positive patient-nurse interaction 98% vs 98%; overall patient satisfaction 98% vs 95%.<sup>9</sup>
- Midlevel providers can help alleviate the rural physician shortage and relieve the emergency-call burden.<sup>7</sup>
- Midlevel providers can help sustain CAHs and maintain rural access to care by addressing both workforce and economic issues.<sup>7</sup>


#### **Financial Impact of Policy Recommendations:**

The policy recommendations are budget neutral as they do not propose coverage of services not currently reimbursed.

#### **Policy adopted May 2011.**

#### **References:**

1. 42 CFR § 485.618
2. 42 CFR § 489.20®(2)
3. 42 CFR § 489.20®(2)
4. Upper Midwest Rural Health Research Center. Policy Brief: Rural Emergency Department Staffing: Potential Implications for the Quality of Emergency Care Provided in Rural Areas. August 2007
5. American College of Emergency Physicians. Providers of Unsupervised Emergency Department Care. 2007. <http://www.acep.org>
6. American Academy of Emergency Medicine. Position Statement: Use of Non-Emergency Medicine Specialists in the Emergency Department. 2009. <http://www.aaem.org>
7. Galli R, Keith J, McKenzie K, Hall, G. TelEmergency: A Novel System for Delivering Emergency Care to Rural Hospitals. *Annals of Emergency Medicine*. 2008;51(3):275-284

- 
8. Bar-Sela SM, Glovinsky Y. A feasibility study of an Internet-based telemedicine system for consultation in ophthalmic emergency room. *J Telemed Telecare*. 2007;13:119-124
  9. Brennan J. Telemedicine in the emergency department: A randomized controlled trial. *J Telemed Telecare*. 1999;5:18-22.
  10. “Medicare Telehealth Services for the Physician Fee Schedule,” 75 Federal Register 228 (29 Nov. 2010), pp. 73310-73320
  11. Centers for Medicare & Medicaid Services. “Memorandum: Emergency Medical Treatment and Labor Act (EMTALA) On-Call Requirements and Remote Consultation Utilizing Telecommunications Media.” Released June 22, 2007. Available online at: <http://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter07-23.pdf?>

Authored by: Mandy Bell, BA; Deanna Larson, RN, BSN; Jay Weems, MBA; Don Kosiak, MD, MBA; Kyle Mickalowski, MPH, Lisa Kilawee, MPA