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EMTALA With Updated COVID-19 Implications
Nursing
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Overview and history

The **Emergency Medical Treatment and Active Labor Act (EMTALA)**, also known as the patient anti-dumping statute, was passed in 1986 by Congress as a part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) in order to ensure that individuals with an emergency medical condition are not denied life-saving services and treatment. EMTALA was enacted due to the concern that some hospitals were refusing to treat patients who didn't have insurance or who were unable to pay for services rendered. Prior to EMTALA, there were reports of situations where treatment was not provided, or patients who were unstable for transfer to another facility were transferred improperly, and sometimes without consent, from the receiving facility. EMTALA applies to anyone who presents for emergency services to a hospital that participates in the Medicare program, and hospitals are subject to termination of its Medicare provider agreement should they fail to comply with EMTALA regulations. While EMTALA applies to all hospitals participating in the Medicare program, it offers protection for anyone seeking emergency services, not only Medicare patients. (1, 6)

Definitions related to EMTALA

There are several definitions related to EMTALA that are useful in determining whether or not a hospital is following EMTALA guidelines. (3, 4)

Emergency medical condition (EMC) - 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:

1) 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;
2) Serious impairment to bodily functions; or
3) Serious dysfunction of any bodily organ or part; or
4) With respect to a pregnant woman who is having contractions—

a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
b. That transfer may pose a threat to the health or safety of the woman or the unborn child. (4)

Dedicated emergency department - 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 room or 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 provided 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. (4)

Campus - the physical area immediately adjacent to the provider’s main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider’s campus. (3)

Hospital property - the entire main hospital campus, including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital’s main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities. (4)

Patient - An individual who has begun to receive outpatient services as part of an encounter, other than an encounter that the hospital is obligated by this section to provide; or an individual who has been admitted as an inpatient, as defined below. (4)

Inpatient - an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight. (4)

Comes to the emergency department - with respect to an individual who is not a patient (as defined above), the individual:

1) Has presented at a hospital's dedicated emergency department, as defined in this section, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;
2) Has presented on hospital property, as defined in this section, other than the dedicated emergency department, and requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment;
3) Is in a ground or air ambulance owned and operated by the hospital for purposes of examination and treatment for a medical condition at a hospital's dedicated emergency department, even if the ambulance is not on hospital grounds. However, an individual in an ambulance owned and operated by the hospital is not considered to have "come to the hospital's emergency department" if:
    a. The ambulance is operated under communitywide emergency medical service (EMS) protocols that direct it to transport the individual to a hospital other than the hospital that owns the ambulance; for example, to the closest appropriate facility. In this case, the individual is considered to have come to the emergency department of the hospital to which the individual is transported, at the time the individual is brought onto hospital property;
    b. The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance; or

4) Is in a ground or air non-hospital-owned ambulance on hospital property for presentation for examination and treatment for a medical condition at a hospital's dedicated emergency department. However, an individual in a non-hospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. The hospital may direct the ambulance to another facility if it is in "diversionary status," that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital's diversion instructions and transports the individual onto hospital property, the individual is considered to have come to the emergency department. (4)

Capacity - the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment, and the hospital's past practices of accommodating additional patients in excess of its occupancy limits. (4)

Labor - the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor. (4)

Stabilized means, with respect to an "emergency medical condition" as defined above, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, for a woman who presents in labor, both the child and the placenta have been delivered. (4)

Transfer - the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who has been declared dead, or leaves the facility without the permission of any such person. (4)

Provisions under EMTALA

The major provisions under EMTALA for Medicare participating hospitals that provide emergency medical services include:

- When an individual presents to a hospital's emergency department (ED) requesting an examination or treatment for a medical condition, the hospital must provide an appropriate medical screening examination (MSE) to determine if an EMC exists. The medical screening examination should include ancillary services that are routinely available to the ED to determine if an EMC exists. (4)

- Individuals who are qualified to perform the initial medical screening examinations must be determined by hospital bylaws or rules and regulations. (4)

- A minor (child) can request an examination or treatment for an EMC. The hospital is required by law to conduct the examination if requested by an individual or on the individual's behalf to determine if an EMC exists. Hospital personnel should not delay the MSE by waiting for parental consent. If after screening the minor, it is determined than no EMC is present, the staff can wait for parental consent before proceeding with further examination and treatment. (8)

- If an individual comes to a hospital's dedicated ED requesting an examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an EMC. A hospital may, if it chooses, have protocols that permit a qualified medical person (QMP), such as a Registered Nurse (RN) to conduct specific MSE(s) if the nature of the individual's request for examination and treatment is within the scope of practice of the QMP. (8)

- If an individual presents to an ED and requests pharmaceutical services (medication) for a medical condition, the hospital generally would have an EMTALA obligation. The circumstances surrounding why the request is being made would confirm if the hospital has an EMTALA

obligation. If the individual requires the medication to resolve or provide stabilizing treatment of an EMC, then the hospital has an EMTALA obligation. Hospitals are not required by EMTALA to provide medication to individuals who do not have an EMC simply because the individual is unable to pay or does not wish to purchase the medication from a retail pharmacy, or did not plan appropriately to secure prescription refills. (8)

- Signs must be posted in the dedicated ED specifying the rights of individuals with emergency medical conditions and women in labor who come to the dedicated ED for health care services, and indicate on the signs whether the hospital participates in the Medicaid program. The sign must be in clear, simple terms and written in language(s) that the population served by the hospital will understand. (8)

- A hospital may not delay the medical examination or treatment to inquire about the patient's payment method or insurance status. Hospitals may not seek authorization from the individual's insurance company for screening services or services required to stabilize an emergency medical condition until after the hospital has provided the appropriate medical screening examination required by EMTALA to the individual, and has initiated any further medical examination and treatment that may be required to stabilize the patient's emergency medical condition. (8)

- Hospitals may follow reasonable registration processes, which include asking whether an individual is insured and what the insurance is, as long as the inquiry does not delay screening or treatment. The registration process permitted in the dedicated ED typically consists of collecting demographic information, insurance information, whom to contact in an emergency and other relevant information. The registration process must not unduly discourage individuals from remaining for further evaluation. (8)

- The ED physician as well as any non-physician practitioner involved in the emergent treatment may contact the patient's primary physician at any time to obtain advice or information about the patient's medical history that may be relevant to the medical examination and treatment, as long as this does not prolong or delay the required screening services or treatment. (4)

- If the individual is screened and it is determined that the individual has presented to the ED for a non-emergent purpose, the hospital's EMTALA obligation ends for the individual upon completion of the medical examination. (5)

- If it is determined that an emergency medical condition does exist, the hospital is required, within the staff and facilities available at the hospital, to provide further medical examination and treatment in order to stabilize the condition. (9)

- If the hospital offers the individual further medical examination and treatment, and informs the individual (or person acting on their behalf) of the risks and benefits of further examination and treatment, but the individual refuses to consent to further examination and treatment, the hospital should take all reasonable steps to obtain written informed consent to refuse the examination and treatment. (9)

- The hospital must maintain a central log of individuals who come to the dedicated ED seeking treatment and indicate whether these individuals: refused treatment, were denied treatment, were treated, admitted, stabilized, and/or transferred, or were discharged. (5)

- Hospitals are not relieved of their EMTALA obligation to screen, provide stabilizing treatment, and/or an appropriate transfer to individuals because of prearranged community or state plans that have designated specific hospitals to care for selected individuals (e.g., Medicaid patients, psychiatric patients, pregnant women). Hospitals located in those states which have state/local laws that require particular individuals, such as psychiatric or indigent individuals, to be evaluated and treated at designated facilities/hospitals may violate EMTALA if the hospital disregards the EMTALA requirements and does not conduct a MSE and provide stabilizing treatment or conduct an appropriate transfer prior to referring the individual to the state/local facility. If, after conducting the MSE and ruling out an EMC (or after stabilizing the EMC) the sending hospital needs to transfer an individual to another hospital for treatment, it may elect to transfer the individual to the hospital so designated by these state or local laws. Hospitals are also prohibited from discharging individuals who have not been screened or who have an emergency medical condition to non-hospital facilities for purposes of compliance with state law. The existence of a state law requiring transfer of certain individuals to certain facilities is

not a defense to an EMTALA violation for failure to provide a MSE or failure to stabilize an EMC, therefore, hospitals must meet the federal EMTALA requirements or risk violating EMTALA. (8)

- If a screening examination reveals an EMC and the individual is told to wait for treatment, but the individual leaves the hospital, the hospital did not "dump" the individual unless:
    1) The individual left the emergency department based on a "suggestion" by the hospital;
    2) The individual's condition was an emergency, but the hospital was operating beyond its capacity and did not attempt to transfer the individual to another facility. (8)

- Hospitals may not attempt to coerce individuals into making judgments against their interest by informing them that they will have to pay for their care if they remain but that their care will be free or at a lower cost if they transfer to another hospital. An individual may only refuse examination, treatment, or transfer on behalf of a patient if the patient is incapable of making an informed choice for him/herself. (8)

- If an individual leaves a hospital against medical advice (AMA) on his or her own free will (no coercion or suggestion), the hospital is not in violation of EMTALA. (8)

- Hospital obligations under EMTALA end once an individual is admitted to the hospital for inpatient care, even if the patient remains un-stabilized after inpatient admission. CMS believes that existing hospital Conditions of Participation (CoPs), along with patients' rights under state law, provide safeguards for inpatients. However, a hospital cannot admit a patient with no intention of treating the patient, and then inappropriately discharge or transfer the patient without having met the stabilization requirement. Doing so may result in consequences under EMTALA and the applicable Medicare CoPs. (7)

Patient transfers to another facility under EMTALA

If the hospital is not equipped to stabilize the individual, an appropriate transfer to another facility should be arranged. If the patient refuses to be transferred to an appropriate facility, the hospital should take all reasonable steps to obtain written informed consent to refuse the transfer. The written

document must indicate the person has been informed of the risks and benefits of the transfer and state the reasons for the individual's refusal. (8)

If an individual at a hospital has an emergency medical condition which has not been stabilized, the hospital may not transfer the patient unless:

A. The transfer is an appropriate transfer, as described in the section below; and
    1. The individual (or a legally responsible person acting on the individual's behalf), after being informed of the hospital's obligations and the risk of transfer, requests a transfer in writing to another medical facility. The request must state the reason for the request and indicate that he or she is aware of the risks and benefits of the transfer;
    2. A physician has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the risks to the individual and, in the case of labor, to the unborn child; or
    3. If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital) has signed a certification after a physician, in consultation with the person, has made the determination that the benefits of the transfer outweigh the risks. (4)

An **appropriate transfer** to a medical facility is a transfer:

1. In which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
2. In which the receiving facility:
    a. Has available space and qualified personnel for the treatment of the individual, and
    b. Has agreed to accept transfer of the individual and to provide appropriate medical treatment;
3. In which the transferring hospital sends to the receiving facility all medical records (or copies), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests, and the informed written consent or certification (or copy), and the name and address of

any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

4. In which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer. (4, 9)

Regardless of practices within a State, a woman in labor may be transferred only if she or her representative requests the transfer and if a physician or other qualified medical personnel signs a certification that the benefits outweigh the risks. If the hospital does not provide obstetrical services, the benefits of a transfer may outweigh the risks. A hospital cannot cite State law or practice as the basis for transfer. (8)

Hospitals that are not capable of handling high-risk deliveries or high-risk infants often have written transfer agreements with facilities capable of handling high-risk cases. The hospital must still meet the screening, treatment, and transfer requirements. (8)

Hospitals with specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers) are obligated to accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions. (8)

A hospital must report to CMS or the state survey agency within 72 hours any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of EMTALA. Failure to report improper transfers may subject the receiving hospital to termination of its provider agreement. (8)

Hospitals should not take adverse action against a physician or qualified medical personnel who refuse to transfer an individual with an emergency medical condition, or against an employee who reports a violation of these requirements. (8)

Medical and other records related to individuals transferred to and from the hospital must be maintained for a period of five years from the date of the transfer. (5)

EMTALA provisions regarding on-call physicians and responsibilities

A hospital must have written policies and procedures in place:

1. To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control;
2. To provide that emergency services are available to meet the needs of individuals with emergency medical conditions if a hospital elects to:
    a) Permit on-call physicians to schedule elective surgery during the time they are on call
    b) Permit on-call physicians to have simultaneous on-call duties;
    c) Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers. The formal community call plan must include the following elements:
        1) A clear delineation of on-call coverage responsibilities; that is, when each hospital participating in the plan is responsible for on-call coverage.
        2) A description of the specific geographic area to which the plan applies.
        3) A signature by an appropriate representative of each hospital participating in the plan.
        4) Assurances that any local and regional EMS system protocol formally includes information on community-call arrangements.
        5) A statement specifying that even if an individual arrives at a hospital that is not designated as the on-call hospital, that hospital still has an obligation to provide a medical screening examination and stabilizing treatment within its capability, and that hospitals participating in the community call plan must abide by the regulations governing appropriate transfers.
        6) An annual assessment of the community call plan by the participating hospitals. (5)

Hospital administrators and the physicians who provide the on-call services have flexibility regarding how to configure an on-call coverage system. Several options to enhance this flexibility are permitted under the regulations. It is crucial, however, that hospitals are aware of their responsibility to ensure that they are providing sufficient on-call services to the meet the needs of their community in

accordance with the resources they have available. CMS expects a hospital to strive to provide adequate specialty on-call coverage consistent with the services provided at the hospital and the resources the hospital has available. (5)

The hospital must maintain a list of physicians who are on-call to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition. Physician group names are not acceptable for identifying the on-call physician, and individual physician names are to be identified on the list. If a staff physician is on-call to provide emergency services or to consult with an emergency room physician in the area of his or her expertise, that physician would be considered to be available at the hospital. A determination as to whether the on-call physician must physically assess the patient in the emergency department is the decision of the treating emergency physician. His or her ability and medical knowledge of managing that particular medical condition will determine whether the on-call physician must come to the emergency department. The decision as to whether the on-call physician responds in person or directs a non-physician practitioner (physician assistant, nurse practitioner, orthopedic tech) as his or her representative to present to the dedicated ED is made by the responsible on-call physician, based on the individual's medical need and the capabilities of the hospital and applicable State scope of practice laws, hospital bylaws, and rules and regulations. The on-call physician is ultimately responsible for the individual regardless of who responds to the call. (8)

EMTALA obligations related to ambulances and use of hospital helipads

Hospital property includes ambulances owned and operated by the hospital, even if the ambulance is not on the hospital campus. An individual in a non-hospital-owned ambulance, which is on hospital property is considered to have come to the hospital's emergency department. An individual in a non-hospital-owned ambulance not on the hospital's property is not considered to have come to the hospital's emergency department when the ambulance personnel contact the hospital by telephone or telemetry communications. If an individual is in an ambulance, regardless of whether the ambulance is owned by the hospital, a hospital may divert individuals when it is in diversionary status because it does not have the staff or facilities to accept any additional emergency patients at that time. However, if the ambulance is owned by the hospital, the diversion of the ambulance is only appropriate if the hospital is being diverted pursuant to community-wide EMS protocols. If any ambulance (regardless of whether or

not owned by the hospital) disregards the hospital's instructions and brings the individual on to hospital campus, the individual has come to the hospital and the hospital has incurred an obligation to conduct a MSE for the individual.

If an individual is brought to the hospital via ambulance, and the hospital deliberately delays moving the individual from the EMS stretcher to an emergency department bed, this does not delay the point in time at which their EMTALA obligation begins.

If an EMS provider brought an individual to the ED at a time when ED staff was occupied dealing with multiple major trauma cases, it could under those circumstances be reasonable for the hospital to ask the EMS provider to stay with the individual until such time as there were ED staff available to provide care to that individual. However, even if a hospital cannot immediately complete an appropriate MSE, it must still assess the individual's condition upon arrival to ensure that the individual is appropriately prioritized, based on his/her presenting signs and symptoms, to be seen by a physician or other QMP for completion of the MSE. The hospital should also assess whether the EMS provider can appropriately monitor the individual's condition.

The use of a hospital's helipad by local ambulance services or other hospitals for the transport of individuals to tertiary hospitals located throughout the State does NOT trigger an EMTALA obligation for the hospital that has the helipad on its property when the helipad is being used for the purpose of transit as long as the sending hospital conducted the MSE prior to transporting the individual to the helipad for medical helicopter transport to a designated recipient hospital. The sending hospital is responsible for conducting the MSE prior to transfer to determine if an EMC exists and implementing stabilizing treatment or conducting an appropriate transfer. Therefore, if the helipad serves simply as a point of transit for individuals who have received a MSE performed prior to transfer to the helipad, the hospital with the helipad is not obligated to perform another MSE prior to the individual's continued travel to the recipient hospital. If, however, while at the helipad, the individual's condition deteriorates, the hospital at which the helipad is located must provide another MSE and stabilizing treatment within its capacity if requested by medical personnel accompanying the individual.

If, as part of the EMS protocol, EMS activates helicopter evacuation of an individual with a potential EMC, the hospital that has the helipad does NOT have an EMTALA obligation if they are not the recipient

hospital, unless a request is made by EMS personnel, the individual, or a legally responsible person acting on the individual's behalf for the examination or treatment of an EMC. (8)

EMTALA obligations related to law enforcement requests

Depending on the circumstances, a hospital may be required under EMTALA to conduct a MSE when law enforcement officials request an exam for a patient. If an individual is brought to the ED and law enforcement personnel request that emergency department personnel draw blood for a blood alcohol testing (BAT) only and does not request examination or treatment for a medical condition, such as intoxication, and a prudent layperson observer would not believe that the individual needed such examination or treatment, then the EMTALA's screening requirement is not applicable to this situation because the only request made on behalf of the individual was for evidence. However, if for example, the individual in police custody was involved in a motor vehicle accident or may have sustained injury to him or herself and presents to the ED, a MSE would be warranted to determine if an EMC exists.

When law enforcement officials request hospital emergency personnel to provide clearance for incarceration, the hospital has an EMTALA obligation to provide a MSE to determine if an EMC exists. If no EMC is present, the hospital has met its EMTALA obligation and no further actions are necessary for EMTALA compliance.

This principle also applies to sexual assault cases. (8)

EMTALA obligations related to psychiatric emergencies

In the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an EMC.

Psychiatric patients are considered stable when they are protected and prevented from injuring or harming him/herself or others. The administration of chemical or physical restraints for purposes of transferring an individual from one facility to another may stabilize a psychiatric patient for a period of time, removing the immediate EMC, but the underlying medical condition may persist, and if not treated for longevity the patient may experience exacerbation of the EMC. Therefore, practitioners should use

great care when determining if the medical condition is in fact stable after administering chemical or physical restraints. (8)

EMTALA requirements and implications related to coronavirus disease 2019 (COVID-19) and options for managing extraordinary ED surges

For the duration of the COVID-19 national emergency, CMS is waiving the enforcement of section 1867(a) of EMTALA. This will allow hospitals, psychiatric hospitals, and CAHs to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, in accordance with the state emergency preparedness for pandemic plan. (13)

Every hospital or CAH with a dedicated ED is required to conduct an appropriate MSE of all individuals who come to the ED, including individuals who are suspected of having COVID-19, and regardless of whether they arrive by ambulance or are walk-ins. (11)

Every ED is expected to have the capability to apply appropriate COVID-19 screening criteria when applicable, to immediately identify and isolate individuals who meet the screening criteria to be a potential COVID-19, and to contact their state or local public health officials to determine next steps when an individual meeting the screening criteria is found. (11)

It is a violation of EMTALA for hospitals and CAHs with EDs to use signage that presents barriers to individuals who are suspected of having COVID-19 from coming to the hospital. (11)

However, use of signage designed to help direct individuals to various locations on the hospital property for their MSE would be acceptable. In addition, it is acceptable for a hospital to post signage informing individuals who are seeking COVID-19 testing about alternative community locations (non-hospital controlled sites) for COVID-19 testing but do not want a medical screening exam or think they have an emergency medical condition. (11)

Hospitals may not refuse to allow individuals with suspected cases of COVID-19 into their ED. (11)

Hospitals may not decline to perform a MSE on an individual who comes to their ED with potential or suspected COVID-19 due to a lack of PPE or specialized equipment/facilities. (11)

In the case of individuals with suspected or confirmed COVID-19, hospitals and CAHs are expected to consider current guidance of CDC and public health officials in determining whether they have the capability to provide appropriate isolation required for stabilizing treatment and/or to accept appropriate transfers. (11)

The lack of ICU capabilities does not exempt a hospital from performing a MSE and initiating stabilizing treatment for individuals with known or suspected COVID-19 who come to the hospital's ED seeking examination or treatment. (11)

In regards to asking patients to wait in their car or outside of the hospital while awaiting evaluation: the MSE requirement of EMTALA requires that it be timely depending on the presenting signs and symptoms of the individual. Hospitals must perform an appropriate examination by a QMP to determine if the patient has an EMC. If the individual, after an appropriate medical screening exam, meets the CDC criteria for potential COVID-19 and is determined to have no signs or symptoms that require immediate medical attention, then this would not present a direct EMTALA violation. In cases where a request is made for medical care that is unlikely to involve an EMC, the individual's statement that s/he is not seeking emergency care, together with brief questioning by the QMP would be sufficient to establish that there is no EMC and the hospital's EMTALA obligation would be satisfied. However, the hospital should have a system in place to monitor those patients that opt to wait in their own vehicle to ensure that their condition has not deteriorated while awaiting further evaluation. Failure to do so could expose the hospital to a potential MSE violation because the MSE was not done timely. (11)

Hospitals with capacity and the specialized capabilities needed for stabilizing treatment are required to accept appropriate transfers from hospitals without the necessary capabilities. However, the receiving hospital may refuse the transfer if they do not have the capacity to provide the necessary care and services. Hospitals should coordinate with their State/local public health officials regarding appropriate placement of individuals who meet specified COVID-19 assessment criteria, and the most current standards of practice for treating individuals with confirmed COVID-19 infection status. (11)

All Medicare-participating hospitals with specialized capabilities are required to accept appropriate transfers of individuals with EMCs if the hospital has the specialized capabilities an individual requires for stabilization as well as the capacity to treat these individuals. This recipient hospital obligation applies regardless of whether the hospital has a dedicated emergency department. (11)

In the event of any EMTALA complaints alleging inappropriate transfers or refusal to accept appropriate transfers, CMS will take into consideration the public health guidance in effect at the time. (11)

Alternative screening sites may be set up in different locations, detailed below. (11)

1. **<u>Hospitals may set up alternative screening sites on campus.</u>**

- The MSE does not have to take place in the ED. A hospital may set up alternative sites on its campus to perform MSEs.
    - Individuals may be redirected to these sites. Whether the individual is seen at the alternate on-campus site or in the ED, they should be logged in where they are seen. Individuals do not need to present to the ED, first, and if they do present to the ED, they may still be redirected to the on-campus alternative screening location for logging and subsequent screening.
    - This is a triage function and the person providing the redirection from the ED should be qualified (e.g., an RN) to recognize individuals who are obviously in need of immediate treatment in the ED. Hospital non-clinical staff stationed at other entrances to the hospital may provide redirection to the on-campus alternative screening location for individuals seeking COVID-19 testing.

- The content of the MSE varies according to the individual's presenting signs and symptoms. It can be as simple or as complex, as needed, to determine if an EMC exists.

- MSEs must be conducted by qualified personnel, which may include physicians, nurse practitioners, physician's assistants, or RNs trained to perform MSEs and acting within the scope of their State Practice Act. Hospitals may request a waiver to allow MSEs to be performed by qualified medical staff authorized by the hospital, such as registered nurses, who are acting

within their scope of practice and licensure, yet are not designated in the bylaws to perform MSEs.

- Hospitals may use telehealth equipment to perform the MSE by qualified medical personnel (QMP). The QMP may be on-campus (and using telehealth to self-contain) or offsite (due to staffing shortages). Either way, the QMP must be performing within the scope of their State Practice Act, and approved by the Hospital's Governing Body to perform MSEs.

- The use of telehealth to provide evaluation of individuals who have not physically presented to the hospital for treatment does not create an EMTALA liability.

- The hospital must provide stabilizing treatment (or appropriate transfer) to individuals found to have an EMC, including moving them as needed from the alternative site to another on-campus department. (11)

2. <u>Hospitals may set up screening at off-campus, hospital-controlled sites.</u>

- Hospitals and community officials may encourage the public to go to off-campus sites to be screened for COVID-19 instead of the hospital. Normally, a hospital may not tell individuals who have already entered an ED to go to the off-site location for the MSE — such a redirection usually only occurs to an on-campus alternative site. However, CMS has approved via 1135 waiver for the COVID-19 pandemic the ability to re-direct patients to an offsite location for screening, in accordance with a state emergency preparedness or pandemic plan.

- Unless the off-campus site is already a dedicated ED of the hospital, as defined under EMTALA regulations, EMTALA requirements do not apply.

- The hospital should not hold the site out to the public as a place that provides care for EMCs in general on an urgent, unscheduled basis. They can hold it out as a respiratory or potential/presumed COVID-19 patient screening center.

- The off-campus site should be staffed with medical personnel trained to evaluate individuals with respiratory or potential/presumed COVID-19 symptoms.

- If an individual needs additional medical attention on an emergent basis, the hospital is required, under the Medicare Conditions of Participation, to arrange referral and/or transfer. Prior coordination with local emergency medical services (EMS) is advised to develop transport arrangements. (11)

3. **Communities or hospitals may set up testing stations at sites not under the control of a hospital (such as a mall or retail parking lot).**

- There is no EMTALA obligation at these sites, even if hospital personnel assist with the testing.

- Hospitals and community officials may encourage the public to go to these sites instead of the hospital for COVID-19 testing. However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the COVID-19 testing until they have been provided a MSE and it is determined that they do not have an emergency medical condition.

- Communities and hospitals are encouraged to staff the sites with medical personnel trained to evaluate individuals with respiratory or potential/presumed COVID-19 symptoms.

- There should be protocols or a process in place to deal with patients who arrive in medical distress and need transport to a hospital, which may be as simple as calling 911.

- Drive-through testing sites that have been established for COVID-19 testing purposes-only do not have EMTALA implications. (11)

EMTALA obligations when screening suggests possible COVID-19

If, during the MSE, the hospital concludes that an individual who has come to its ED may be a possible COVID-19 case, consistent with accepted standards of practice for COVID-19 screening, the hospital is expected to isolate the patient immediately to the extent of its capacity and capability or implement appropriate respiratory hygiene (i.e., place a mask on the patient and appropriate PPE for healthcare personnel, etc.) to minimize potential for transmission and direct the patient to an alternate site for testing if available. Although levels of services provided by EDs vary greatly across the country, it is

CMS's expectation that all hospitals are able to, within their capability, provide MSEs and initiate stabilizing treatment, while maintaining the isolation requirements for COVID-19 and coordinating with their State or local public health officials, who will in turn arrange coordination, as necessary, with the CDC. (11)

EMTALA waivers

In accordance with Section 1135 of the Act, an EMTALA waiver may only be issued when:

1. The President has declared an emergency or disaster under the National Emergencies Act or the Stafford Act; and
2. The Secretary of HHS has declared a public health emergency (PHE); and
3. The Secretary has exercised his/her waiver authority and notified Congress at least 48 hours in advance of exercising his/her waiver authority. (5)

In order for an EMTALA waiver to apply to a specific hospital or CAH:

1. The hospital or critical access hospital (CAH) must activate its disaster protocol; and
2. The State must have activated an emergency preparedness plan or pandemic preparedness plan in the emergency area, and any redirection of individuals for a MSE must be consistent with such plan. It is not necessary for the State to activate its plan statewide, so long as it is activated in the area where the hospital is located. It is also not necessary for the State plan to identify the specific location of the alternate screening sites to which individuals will be directed, although some may do so. (5)

Hospitals and CAHs operating under an EMTALA waiver will not be sanctioned for:

1. Redirecting an individual who "comes to the emergency department" to an alternate location for a MSE, pursuant to a State emergency preparedness plan or, as applicable, a State pandemic preparedness plan. Even when a waiver is in effect, there is still the expectation that everyone who comes to the ED will receive an appropriate MSE, if not in the ED, then at the alternate care site to which they are redirected or relocated. (5)
2. Inappropriately transferring an individual protected under EMTALA, when the transfer is necessitated by the circumstances of the declared emergencies. Transfers may be inappropriate under EMTALA for a number of reasons. (5)

However, even if a hospital/CAH is operating under an EMTALA waiver, the hospital/CAH would not be exempt from sanctions if it discriminates among individuals based on their ability to pay for services, or the source of their payment for services when redirecting or relocating them for the MSE or when making inappropriate transfers. (5)

All other EMTALA-related requirements and EMTALA requirements continue to apply, even when a hospital is operating under an EMTALA waiver. For example, the statute does not provide for a waiver of a recipient hospital's obligation to accept an appropriate transfer of an individual protected under EMTALA. (As a reminder, even without a waiver, a hospital is obligated to accept an appropriate EMTALA transfer only when that recipient hospital has specialized capabilities required by the individual and the requisite capacity at the time of the transfer request.) (5)

Duration of EMTALA waivers

Except in the case of waivers related to pandemic infectious disease, an EMTALA waiver is limited in duration to 72 hours beginning upon activation of the hospital's/CAH's disaster protocol. In the case of a public health emergency (PHE) involving pandemic infectious disease, the general EMTALA waiver authority will continue in effect until the termination of the declaration of the PHE. However, application of this general authority to a specific hospital/CAH or groups of hospitals and CAHs may limit the waiver's application to a date prior to the termination of the PHE declaration, since case-specific applications of the waiver authority are issued only to the extent they are necessary, as determined by CMS. (5)

If a State emergency/pandemic preparedness plan is deactivated in the area where the hospital or CAH is located prior to the termination of the public health emergency, the hospital or CAH no longer meets the conditions for an EMTALA waiver and that hospital/CAH waiver would cease to be in effect as of the deactivation date. Likewise, if a hospital or CAH deactivates its disaster protocol prior to the termination of the public health emergency, the hospital or CAH no longer meets the conditions for an EMTALA waiver and that hospital/CAH waiver would cease to be in effect as of the deactivation date. (5)

Waiver request process

Hospitals or CAHs seeking an EMTALA waiver must demonstrate to CMS that application of the waiver to their facility is necessary, and that they have activated their disaster protocol. CMS will confirm with the

SA whether the State's preparedness plan has been activated in the area where the hospital or CAH is located. CMS will also seek to confirm when the hospital activated its disaster protocol, whether other measures may address the situation in a manner that does not require a waiver, and other factors important to the ability of the hospital to demonstrate that a waiver is needed. (5)

Penalties for EMTALA violations

The enforcement of EMTALA is a complaint-driven process, meaning that the investigation of a hospital's policies/procedures and processes and any subsequent sanctions are initiated by a complaint. If the results of a complaint investigation indicate that a hospital violated one or more of the anti-dumping provisions of EMTALA, a hospital may be subject to termination of its provider agreement and/or the imposition of civil monetary penalties (CMPs). CMPs may be imposed against hospitals or individual physicians for EMTALA violations. (5)

Physicians may be excluded from participating in Medicare and State health care programs as a penalty for violating EMTALA. In addition, private individuals who experience harm as a result of a physician's or hospital's failure to provide stabilizing treatment may file a civil suit against the hospital to obtain damages available under the personal injury laws of that state in which the hospital is located. (2)

Examples of confirmed EMTALA violations

The following are examples of confirmed EMTALA violations which have occurred. In these cases, the accused hospitals were given either 23 or 90 days (depending on the violation) to submit an acceptable corrective action plan, or be terminated from the Medicare program.

- An uninsured patient with suicidal symptoms was put into a taxi for transfer to another hospital without being examined.

- A patient who was bleeding at a dialysis shunt site was not screened or stabilized before transfer to a receiving hospital that had not been notified.

- A hospital refused to accept transfer of an unstable patient with multiple traumas from a motor vehicle accident.

- Obstetrics patients were screened by nurses when hospital policy did not indicate that they were qualified to do screening.
- An insured patient with a rash received screening while an uninsured patient with the same symptoms was sent to a clinic without screening.
- A possible sexual assault victim who arrived in an ambulance was sent to another hospital without screening, and there was no evidence in the record that the receiving hospital was notified or had agreed to accept the patient.
- Before examining a patient with chest pain, the hospital called his physician, who denied insurance coverage for the emergency visit. The hospital told the patient he would be responsible for the cost of his visit, and the patient decided to leave and see his physician later that day.
- A patient from a skilled nursing facility was diagnosed with pneumonia and medicated but sent back to the skilled nursing facility without a physician determination that he was stable; he returned later in worse condition and died. (10)

EMTALA case studies

1. An individual presents to the ED with an injury to his eye. A MSE is performed by the ED physician, and the physician makes the decision to consult with the on-call ophthalmologist regarding the case. The ophthalmologist agrees to see the patient; however, he requests that the patient come to his office because equipment needed to fully assess the patient is available at the office. Is this acceptable?

Yes. When a physician is on-call for the hospital and seeing patients with scheduled appointments in his/her private office, it is generally not acceptable to refer emergency cases to his or her office for examination and treatment of an EMC. The physician must come to the hospital to examine the individual if requested to do so by the treating physician. If, however, it is medically indicated, the treating physician may send an individual needing the specialized services of the on-call physician to the

physician's office if it is a provider-based part of the hospital (i.e., department of the hospital sharing the same CMS certification number as the hospital). It must be clear that this transport is not done for the convenience of the specialist but that there is a genuine medical reason to move the individual, that all individuals with the same medical condition, regardless of their ability to pay, are similarly moved to the specialist's office, and that the appropriate medical personnel accompany the individual to the office. (5)

2. An individual undergoing outpatient dialysis at the hospital experiences an emergency complication related to the procedure. Does the hospital have an obligation to provide a MSE for this patient?

No. If an individual experiences an EMC while receiving outpatient care, the hospital does not have an obligation to conduct a MSE for that patient. This patient has adequate protections under the Medicare CoPs and state law. (5)

3. You are a nurse practitioner (NP) for a cardiologist who is on call. The cardiologist has been called by the ED physician to come in and see a patient who is experiencing an acute myocardial infarction. The ED physician has specifically requested that the actual physician come and evaluate the patient due to the nature of the situation. The cardiologist then notifies you, and asks you to go and see the patient, because he thought that a NP could handle the situation. Is this appropriate?

No. There are some circumstances in which the non-physician practitioner can provide the specialty treatment more expeditiously than the physician on-call. However, the designated on-call physician is ultimately responsible for providing the necessary services to the individual in the ED, regardless of who makes the in-person appearance. Furthermore, in the event that the treating physician disagrees with the on-call physician's decision to send a representative and requests the actual appearance of the on-call physician, then the on-call physician is required under EMTALA to appear in person. (5)

4. You are caring for an individual in the ED, and the ED physician has consulted with an on-call surgeon regarding coming to see the patient. The on-call surgeon is currently in surgery, performing an elective surgery, which will delay him coming to see your patient for some time. Is performing elective surgeries while on call for the ED an EMTALA violation?

No. A hospital may have a policy to prohibit elective surgery by on-call physicians to better serve the needs of its patients seeking treatment for a potential emergency medical condition; however, CMS has not issued any rule or interpretative guidelines that prohibit a physician from performing surgery while on-call. It is expected that if a physician has agreed to be on-call at a particular hospital during a particular period of time, but has also scheduled elective surgery or a diagnostic or therapeutic procedure during that time, that physician and hospital must have a back-up plan in the event that they are called while performing elective surgery. (5)

5. You are serving as the triage nurse in a busy ED. You have a patient who has requested a MSE, but must wait in the waiting area until a QMP is available to determine if an EMC exists. You have triaged the patient, and she complains of abdominal pain. Her vital signs are all normal, and she is sitting quietly in the waiting area alone in no obvious distress. Because of your initial assessment, would it be appropriate to not ever further assess this patient until a QMP becomes available to determine if this patient has an EMC?

No. Triage entails the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital, in order to prioritize when the individual will be seen by a physician or other QMP. An MSE is not an isolated event. It is an ongoing process that begins, but typically does not end, with triage. Depending on the individual's presenting signs and symptoms, an appropriate MSE can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures, such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans, and/or other diagnostic tests and procedures. The medical record must reflect continued monitoring according to the individual's needs until it is determined whether or not the individual has an EMC and, if he/she does, until he/she is stabilized or appropriately transferred. There should be evidence of this ongoing monitoring prior to discharge or transfer. (5)

6. A pregnant woman presents to the ED, where she quickly gives birth to an infant boy while still in the ED. Her OB/GYN was present for the delivery. The infant appears healthy, but the mother would like the infant to undergo a MSE. Is the hospital required under EMTALA to provide a MSE for the infant?

Yes. An infant that is born alive is a "person" and an "individual," and the screening requirement of EMTALA applies to "any individual" who comes to the emergency department. If an infant was born alive in a dedicated emergency department, and a request was made on that infant's behalf for screening for a medical condition (or if a prudent layperson would conclude, based on the infant's appearance or behavior, that the infant needed examination or treatment for a medical condition), the hospital and physician could be liable for violating EMTALA for failure to provide such a medical screening examination. (5)

7. An individual presents to the ED and states that his family physician instructed him to go to the ED to have a non-emergency test performed. Is the hospital required under EMTALA to perform a MSE for this individual?

No. However, for a hospital to be exempted from its EMTALA obligations to screen individuals presenting at its emergency department for nonemergency tests (for example, if an individual has consulted with their physician by telephone and the physician refers the individual to a hospital emergency department for a nonemergency test) the hospital must be able to document that it is only being asked to collect evidence, not analyze the test results, or to otherwise examine or treat the individual. (5)

8. An individual presents to the ED requesting an allergy shot. Is the hospital required under EMTALA to perform a MSE for this individual?

No. If an individual presents to a dedicated emergency department and requests services that are not for a medical condition, such as preventive care services (immunizations, allergy shots, flu shots) or the gathering of evidence for criminal law cases (sexual assault, blood alcohol test), the hospital is not obligated to provide a MSE under EMTALA to this individual. (5)

Conclusion

EMTALA regulations are a substantial factor when considering how hospitals and physicians will provide emergency care. EMTALA compliance is crucial, and requires collaboration and cooperation from physicians, medical personnel, and hospital administrators. EMTALA education should be offered to all hospital employees to ensure that anyone who may come in contact with individuals seeking medical

care has a proper understanding of EMTALA guidelines. Hospitals should have EMTALA compliance policies and procedures in place, and should strive to be prepared for an EMTALA investigation before the situation arises.

References

1. American Academy of Emergency Medicine. (2022). EMTALA. https://www.aaem.org/resources/key-issues/emtala

2. American College of Emergency Physicians. (2022). Understanding EMTALA. https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/

3. Code of Federal Regulations. (2022). §413.65 Requirements for a determination that a facility or an organization has provider-based status. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-E/section-413.65

4. Code of Federal Regulations. (2022). §489.24 Special responsibilities of Medicare hospitals in emergency cases. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-489/subpart-B/section-489.24

5. Centers for Medicare and Medicaid Services. (2019). State Operations Manual Appendix V-Interpretive Guidelines-Responsibilities of Medicare Participating Hospitals in Emergency Cases. U.S. Department of Health and Human Services. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf

6. Department of Health and Human Services Centers for Medicare and Medicaid Services. (n.d.). 42 CFR Parts 413, 482, and 489. Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions. https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/Downloads/CMS-1063-F.pdf

7. Department of Health and Human Services Centers for Medicare and Medicaid Services. (2012). 42 CFR Part 489. Medicare Program; EMTALA: Applicability to Hospital Inpatients and Hospitals with Specialized Capabilities. https://www.gpo.gov/fdsys/pkg/FR-2012-02-02/pdf/2012-2287.pdf

8. Department of Health and Human Services Centers for Medicare and Medicaid Services. (2008). CMS Manual System, Pub. 100-07 State Operations. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter08-15.pdf

9. Social Security Administration. (n.d.). Examination and treatment for emergency medical conditions and women in labor. https://www.ssa.gov/OP_Home/ssact/title18/1867.htm#t

10. United States General Accounting Office. (2001). Report to Congressional Committees. Emergency Care EMTALA Implementation and Enforcement Issues. https://www.gpo.gov/fdsys/pkg/GAOREPORTS-GAO-01-747/pdf/GAOREPORTS-GAO-01-747.pdf

11. Centers for Medicare and Medicaid services. (2020). Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Implications Related to COVID-19 (Revised). U.S. Department of Health and Human Services. https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/emergency-medical-treatment-and-labor-act-emtala-requirements-and-implications-related-covid19

12. American College of Emergency Physicians. (2020). ACEP COVID-19 Field Guide. https://www.acep.org/corona/covid-19-field-guide/regulations-and-liability/emtala/

13. Centers for Medicare and Medicaid services. (2021). COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. U.S. Department of Health and Human Services. https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

Implicit Bias

How does it affect healthcare?

What is implicit bias?

Implicit attitudes are thoughts and feelings that often exist outside of conscious awareness, and thus are difficult to consciously acknowledge and control. (Hall et al., 2015).

Implicit (subconscious) bias refers to the attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control. (The Joint Commission, 2016).

Implicit biases affect behavior through a two-phase process: biases are activated in the presence of a member of a social group and then are applied so that they affect the individual's behavior related to that group member. In the healthcare context, for instance, implicit biases may be activated when a provider is interacting with an African American patient, particularly under conditions that tax her cognitive capacity (e.g., stress, time-pressure, fatigue, competing demands), and can then influence how she communicates with and makes decisions about her patient. (Burgess et al, 2017).

Why does implicit bias matter?

Implicit (unconscious) biases can create gaps between good intentions and good outcomes in the health care field. (The Ohio State University, 2020.)

Based on the available evidence, physicians and nurses manifest implicit biases to a similar degree as the general population. The following characteristics are at issue: race/ethnicity, gender, socio-economic status (SES), age, mental illness, weight, having AIDS, brain injured patients perceived to have contributed to their injury, intravenous drug users, disability, and social circumstances. (FitzGerald & Hurst, 2017).

The implicit biases of concern to health care professionals are those that operate to the disadvantage of those who are already vulnerable. Examples include minority ethnic populations, immigrants, the poor, low health-literacy individuals, sexual minorities, children, women, the elderly, the mentally ill, the overweight and the disabled, but anyone may be rendered vulnerable given a certain context.

Why does implicit bias matter?

Implicit biases among health care providers are associated with the following negative effects on patient care:

- inadequate patient assessments
- inappropriate diagnoses and treatment decisions
- less time involved in patient care
- patient discharges with insufficient follow-up

The terms "health care disparities" and "health care inequities" refer to the poorer health outcomes observed in minority and other vulnerable patient groups compared with those observed in majority or dominant patient populations. Disparate patient outcomes are associated with age, sex, religion, socioeconomic status, sexual orientation, gender identification, disability, and stigmatized diagnoses (for example, HIV, obesity, mental illness, and substance abuse). (Narayan, 2019.)

Why does implicit bias matter?

Implicit bias isn't limited to race. The Implicit Association Test (IAT) measures attitudes and beliefs that people may be unwilling or unable to report.

For example, when the IAT was administered at an obesity conference, participants implicitly associated obese people with negative cultural stereotypes, such as "bad, stupid, lazy and worthless."

Implicit gender bias among physicians also may unknowingly sway treatment decisions.

Women are three times less likely than men to receive knee arthroplasty when clinically appropriate. One of the stereotypical reasons for this inequity and underuse problem is that men are viewed as being more stoic and more inclined to participate in strenuous or rigorous activity.

(The Joint Commission, 2016).

Why does implicit bias matter?

People of color face disparities in terms of morbidity, mortality, and health status. Black, Hispanic, and Indigenous Americans have higher infant mortality rates than White and Asian Americans. The premature death rate from heart disease and stroke is highest among Black Americans. Race and ethnicity are not the only demographic factors associated with disparity in health outcomes. Women are more likely to experience delayed diagnosis of heart disease compared to men, as well as inferior heart attack treatment. Sometimes, these disparities intersect, as in the case of childbirth, where the United States is one of the few countries experiencing a rise in the maternal mortality rate, and Black women are nearly four times as likely to die during childbirth as are White women. (Whitmer, 2020)

Healthcare providers in a certain geographic area may equate certain races and ethnicities with specific health beliefs and behaviors (e.g., "these patients" engage in risky behaviors, or "those patients" tend to be noncompliant) that are more associated with the social environment (like poverty) than a patient's racial/ethnic background or cultural traditions. (Stanford University, 2020).

How does implicit bias develop?

The ability to distinguish friend from foe helped early humans survive, and the ability to quickly and automatically categorize people is a fundamental quality of the human mind. Categories give order to life, and every day, we group other people into categories based on social and other characteristics.

This is the foundation of stereotypes, prejudice and, ultimately, discrimination.

Social scientists believe children begin to acquire prejudices and stereotypes as toddlers.

Once learned, stereotypes and prejudices resist change, even when evidence fails to support them or points to the contrary.

People will embrace anecdotes that reinforce their biases, but disregard experience that contradicts them. The statement "Some of my best friends are _____" captures this tendency to allow some exceptions without changing our bias. (Teaching Tolerance, 2020).

How does implicit bias develop?

Scientific research has demonstrated that biases thought to be absent or extinguished remain as "mental residue" in most of us. Studies show people can be consciously committed to egalitarianism, and deliberately work to behave without prejudice, yet still possess hidden negative prejudices or stereotypes.

A growing number of studies show a link between hidden biases and actual behavior. In other words, hidden biases can reveal themselves in action, especially when a person's efforts to control behavior consciously flags under stress, distraction, relaxation or competition. (Teaching Tolerance, 2020).

Research has frequently focused on the amygdala, a structure in the medial temporal lobes. The amygdala receives direct input from all sensory organs, enabling it to respond rapidly to immediate threats in advance of more elaborative cognitive processing. It plays a central role in arousal, attentiveness and triggering the flight-or-fight response, reacting to social threats in exactly the same way it reacts to physical ones. Unconscious bias, then, is the immediate, reflexive, defensive reaction to the “other.” (Korn Ferry Institute, 2015).

How do I recognize implicit biases?

One way to discover implicit biases is to pay attention to gut feelings.

Nurses can ask themselves if they anticipate unpleasant experiences when caring for any particular group of patients, or if any particular group of patients makes them feel uncomfortable, anxious, or fearful.

Such feelings may indicate implicit bias and prompt self-reflection. Thoughtfully reflecting on the meaning and origin of such feelings and whether they influence the quality of relationships with patients can help nurses acknowledge and control previously unrecognized biases. (Narayan, 2019).

How do I recognize implicit biases?

Take one or more of the free Implicit Association Tests (IATs) available at Project Implicit (https://implicit.harvard.edu/implicit/education.html). Developed by Harvard, there are 14 instruments for measuring some of the most prevalent biases—those related to race, ethnicity, skin color, religion, age, gender, overweight or obesity, sexual orientation, or disability.

Learning about potential biases can enable people to employ strategies to reduce them or mitigate their effects on future interactions. The IATs are reliable and valid research instruments, and should not be used to diagnose bias but rather as educational tools.

Implicit bias is different from prejudice. Implicit bias means we have the instinctive tendency to evaluate other groups against the norms of our own groups. Prejudice, on the other hand, means that one feels consciously and overtly that some groups are inferior, an attitude that can be used to justify discriminatory actions. (Narayan, 2019).

But I really don't think I'm biased

There's a reason it's called unconscious bias.

It's because hard-wired biases operate at a level that is beneath our conscious awareness. Even if we sincerely believe we're being fair and objective, stereotypes may still be influencing our opinions - without us being aware of it. (Stanford University, 2020).

We may consciously reject negative images and ideas associated with disadvantaged groups (and may belong to these groups ourselves), but we have all been immersed in cultures where these groups are constantly depicted in stereotyped and pejorative [derogatory] ways. (FitzGerald & Hurst, 2017).

Challenges in reducing implicit biases

Some types of interventions focus more on declarative knowledge – what you know – than on procedural knowledge – knowing how to do something.

Understanding implicit bias as a score on the IAT also may engender the view of implicit bias as a fixed trait that one can do little about.

Issues of race and racism are emotionally fraught and politically charged. The idea that healthcare providers may contribute to racial disparities may contradict their core beliefs and values, including beliefs that they treat everyone equally and that racial inequality is a thing of the past. Burgess, 2017.

How to reduce implicit bias

1. **Stereotype replacement** — Recognizing that a response is based on stereotype and consciously adjusting the response
2. **Counter-stereotypic imaging** — Imagining the individual as the opposite of the stereotype.
3. **Individuation** — Seeing the person as an individual rather than a stereotype (e.g., learning about their personal history and the context that brought them to the doctor's office or health center)
4. **Perspective taking** — "Putting yourself in the other person's shoes"
5. **Increasing opportunities for contact with individuals from different groups** — Expanding your network of friends and colleagues or attending events where people of other racial and ethnic groups, gender identities, sexual orientation, and other groups may be present
6. **Partnership building** — Reframing the interaction with the patient as one between collaborating equals, rather than between a high-status person and a low-status person

The Institute for Healthcare Improvement (2017)

How to reduce implicit bias

7. **Emotional regulation** — People who have good emotional regulation skills and who experience positive emotion during clinical encounters may be less likely to view patients in terms of their individual attributes, and to use more inclusive social categories. It's easier to empathize with others when people view themselves as being part of a larger group. (The Joint Commission, 2016).
8. **Mindfulness** — A "mode of awareness" that can be enacted in different situations, including those which are emotionally challenging (Burgess, 2017).
9. **Habit replacement** — Implicit bias is like a habit that can be broken through a combination of awareness of implicit bias, concern about the effects of that bias, and the application of strategies to reduce bias. (Devine et al, 2012).
10. **Take care of yourself** — Protect your mental resources. Do things to protect your mental energy, such as getting sufficient sleep, finding ways to reduce stress and taking mental breaks throughout the day to refocus on being present with your patients. (van Ryn, 2016.)

How to reduce implicit bias

The Institute for Healthcare Improvement (2017) also offers practical tips to combat implicit bias in healthcare, drawn from the book Seeing Patients: Unconscious Bias in Health Care, by Dr. Augustus White.

- Have a basic understanding of the cultures your patients come from.
- Don't stereotype your patients; individuate them.
- Understand and respect the tremendous power of unconscious bias.
- Recognize situations that magnify stereotyping and bias.
- Know the National Culturally and Linguistically Appropriate Services (CLAS) Standards. (Available at https://thinkculturalhealth.hhs.gov/clas/standards)
- Do a "Teach Back." Teach Back is a method to confirm patient understanding of health care instructions that is associated with improved adherence, quality, and patient safety.
- Assiduously practice evidence-based medicine.

Recommended viewing

Institute for Healthcare Improvement. (2020).

How Does Implicit Bias Affect Health Care?
http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Anurag-Gupta-How-Does-Implicit-Bias-Affect-Health-Care.aspx

What Are the Harms of Not Addressing Bias in Health Care?
http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Anurag-Gupta-What-Are-the-Harms-of-Not-Addressing-Bias-in-Health-Care.aspx

What Is Bias, and What Can Medical Professionals Do to Address It?
http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Anurag-Gupta-What-Is-Bias,-and-What-Can-Medical-Professionals-Do-to-Address-It.aspx

Why Shouldn't Providers Judge Patients' Choices?
http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Nia-Zalamea-Why-Shouldnt-Providers-Judge-Patients-Choices.aspx

References

Burgess, D. J., Beach, M. C., & Saha, S. (2017). Mindfulness practice: A promising approach to reducing the effects of clinician implicit bias on patients. Patient education and counseling, 100(2), 372-376. https://doi.org/10.1016/j.pec.2016.09.005

Devine, P. G., Forscher, P. S., Austin, A. J., & Cox, W. T. (2012). Long-term reduction in implicit race bias: A prejudice habit-breaking intervention. Journal of experimental social psychology, 48(6), 1267-1278. https://doi.org/10.1016/j.jesp.2012.06.003

FitzGerald, C., & Hurst, S. (2017). Implicit bias in healthcare professionals: a systematic review. BMC medical ethics, 18(1), 19. https://doi.org/10.1186/s12910-017-0179-8

Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., ... & Coyne-Beasley, T. (2015). Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: a systematic review. American journal of public health, 105(12), e60-e76. https://doi.org/10.2105/AJPH.2015.302903

Institute for Healthcare Improvement (2017). How to Reduce Implicit Bias. http://www.ihi.org/communities/blogs/how-to-reduce-implicit-bias

Korn Ferry Institute. (2015). Understanding Bias and the Brain. https://www.kornferry.com/insights/articles/understanding-bias-and-brain

Narayan, M. C. (2019). Addressing implicit bias in nursing: a review. AJN The American Journal of Nursing, 119(7), 36-43. doi: 10.1097/01.NAJ.0000569340.27659.5a

References

Stanford University. (2020). Unconscious Bias in Medicine. https://online.stanford.edu/courses/som-ycme0027-unconscious-bias-medicine-cme

Teaching Tolerance. (2020). Test Yourself for Hidden Bias. https://www.tolerance.org/professional-development/test-yourself-for-hidden-bias

The Joint Commission. (2016, April). Implicit bias in health care. https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/joint-commission-online/quick_safety_issue_23_apr_2016pdf.pdf?db=web&hash=A5852411BCA02D1A918284EBAA775988

The Ohio State University. (2020). Mitigating Implicit Bias In Health Care: Aligning Outcomes With Intentions. https://u.osu.edu/breakingbias/

Van Ryn M. (2016). Avoiding Unintended Bias: Strategies for Providing More Equitable Health Care. Minnesota medicine, 99(2), 40–46. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5476527/

Whitmer, G. (2020). Executive Directive No. 2020-7: Improving equity in the delivery of health care. https://content.govdelivery.com/attachments/MIEOG/2020/07/09/file_attachments/1491769/ED%202020-07.pdf