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Assessing Suicide in Emergency Departments: The Emergency Medical Transfer and Active Labor Act (EMTALA)

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Literature Review

The assessment of depression and suicide in hospital Emergency Departments (ED) presents challenges and concerns for hospital administrators and mental health providers. Mental health providers and hospital administrators frequently cite the Emergency Medical Transfer and Active Labor Act (EMTALA) (also known as the "anti-dumping law) as a major concern when encountering patients who present for assessment of depression and suicide in a designated ED [1].

Congress passed the EMTALA statute in 1986 and over the intervening years it has been modified and clarified. The last clarification of EMTALA was issued by the Centers for Medicare and Medicaid Services (CMS) in 2003. The statute is regulated by CMS and the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS). EMTALA applies to all hospitals with a designated ED that receive Medicare funding, but does not only apply to Medicare beneficiaries; it applies to any individual who comes to an ED and requests medical examination and treatment. In short, EMTALA requires an ED to provide an "appropriate medical screening." Second, if it is determined that the individual has an emergency medical condition the hospital must provide "appropriate stabilization treatment" or a medically appropriate transfer must be arranged. Failure to comply with EMTALA can result in fines of up to $50,000 for each occurrence [2,3]. Finally, it should be noted that meeting EMTALA requirements does not protect providers from claims of medical negligence and professional liability [4]. What does this mean for mental health providers who conduct suicide screenings in an ED?.

CMS guidance and court rulings do provide some guidelines for conducting suicide screenings in an ED. While CMS doses not specify what an "appropriate medical screening" entails and leaves this determination to providers, the courts and CMS have ruled that medical screenings should be routine and universal. For mental health providers this means all individuals (regardless of gender, race, income or sexual orientation, language, etc.) presenting for suicide screening in an ED should receive the same screening procedures and protocols (e.g. BDI, PHQ9, mental status exam, etc.). Additionally, EMTALA does not require that a physician perform the screening. However, the designation of providers, other than physicians, who are qualified to provide screening should be delineated in the hospital or ED policies and by laws. Similarly, CMS does not specify what constitutes "appropriate stabilization treatment" [5]. However, when examining other medical cases, such as asthma, stabilization appears to occur when the acute crisis is resolved; the individual can breathe comfortably. This does not mean the individual's asthma has been successfully treated and in fact the discharge recommendation maybe to seek treatment for asthma. When applied to suicide, one would extrapolate that "appropriate stabilization treatment" would mean the suicidal crisis is resolved. However, the individual may well need additional treatment for his or her depression. Lastly, when it is determined that an ED cannot provide the appropriate "appropriate stabilization treatment" and a transfer to another hospital is necessary the provider must justify the need for the transfer and make appropriate transfer arrangements [6]. This requires the provider of a suicide screenings to weigh the risk and benefits of a transfer (e.g. hospital's lack of necessary facilities, appropriate providers, seriousness and lethality of the suicide attempt, risk of elopement, mode of transportation, etc.). Several guidelines will help ensure mental health providers and ED complies with EMTALA and also reduces their liability.

First, hospitals and ED should have policies and bylaws regarding who is authorized to provide suicide screening. These documents should specify the qualifications of these individuals. And, an ED should maintain a list of on-call providers who are authorized to provide suicide screenings. Second, the procedures and protocols for conducting suicide screenings should be specified and applied in all cases where an individual requests or requires a suicide screening. Third, ensure proper documentation. Documentation should include a description of the individual's condition and presenting complaint. Why a suicide screening is deemed necessary. Documentation should also describe the protocol and procedures used to screen for suicide and the results of the screening. If appropriate stabilization treatment is provided; how and when the suicide crisis is resolved, the patient's condition when he or she is dismissed from the ED and any follow up recommendations. However, if a transfer is required the mental health provider should document why the transfer is necessary and justify the transfer based on a risk assessment of transferring the patient. The provider should also ensure the receiving hospital will take the patient. If possible, the provider should discuss the transfer with the patient (documenting understanding), and provide the receiving hospital with their documentation and any other supporting documentation [7].

While the above is not intended as legal advice, the recommendations do help clarify the EMTALA statue, how it applies to suicide screenings in an ED and ways mental health providers and ED can reduce professional liability. However, ED directors and mental health providers should consult their legal counsel and compliance officers to ensure they are incompliance with EMTALA and when legal issues arise.

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