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INSIDE

RELIAS MEDIA

Thoughts on the Future and Laws Governing APP Practice

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It seems axiomatic to suggest the COVID-19 pandemic has radically changed more than the face of healthcare in the United States. Some are asking if state of emergency provisions that loosened or suspended pre-COVID-19 regulations will remain. One example is regulations that govern the scope of practice and supervision of advanced practice providers (APPs).

Although APP is used often to group nurse practitioners (NPs) and physician assistants (PAs) for simplicity's sake, there are pertinent differences in scope of practice and state regulations between the two. NPs have benefitted significantly from COVID-19-related regulatory changes, specifically those relaxing practice supervision requirements.

Twenty-two states temporarily waived some or all requirements of practice/collaboration agreements.[1] Only 10 states took no action, and the remainder already allowed fully unrestricted practice (meaning that no practice/ collaboration agreement was required.)[1] Two temporary waiver states, Kentucky and Tennessee, have sunsetted some or all of these waivers, and all other states have specific sunset provisions tied to expiration of gubernatorial orders or the formal end of the declared state of emergency.[1] PAs saw similar but much less far-reaching changes, with eight states (Maine, Michigan, New Jersey, New York, Louisiana, South Dakota, Tennessee, and Virginia) temporarily waiving required supervision agreements.[2]

One permanent change for both NPs and PAs came from the Home Health Care Planning Improvement Act, part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, signed into law on March 27. By one of the provisions of this act, APPs were permanently given the authority to order home healthcare for Medicare patients.[3] Still, most regulatory changes

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will sunset with the cessation of the state of emergency. Even before the pandemic, there had been a relatively wide variance between states regarding practice patterns and supervision/collaboration agreements. Typically, these are left to state boards or other entities for oversight.

Particularly in those states with consistently strong lobbies for APPs, it may not be surprising to see emergency measures used as leverage toward broader practice rights in the COVID-19 era. Although all the state-based orders expanding rights/easing regulations have either already expired or will sunset with the expiration of the state of emergency, what will happen after? If, as is widely supposed, it is not possible (and/or desirable) to return to business-as-usual, what might new practice patterns look like? How will that affect physician medico-legal liability as it relates to supervision of/collaboration with APPs?

Although it is impossible to predict with certainty, it seems likely the states with strong APP lobbies will be galvanized to permanently loosen practice restrictions, particularly if those lobbies have data to show that patients benefited from wider access to care because of loosened restrictions. These changes would be effected through the normal legislative channels (as opposed to emergency executive order method), creating the opportunity for testimony to be heard on key issues before legislation is passed.

There is a twofold need to pay heed to the legislative process. First, providers must be aware of when changes sunset in each state if they are currently engaging in expanded practice/looser supervision arrangements (whether in their own state or across state lines) to avoid running afoul of the law and licensing boards. Second, they must pay heed to new legislation that permanently loosens supervision/collaboration restrictions, which is likely to be considered in many states that do not already have fully unrestricted practice.

Not surprisingly, physicians remain enticing bait on the proverbial medical malpractice hook, regardless of their degree of involvement in patient care provided by APPs.[4] Until APPs are granted total independence (as is already true for NPs in some states), there will

KEY POINTS

- Some states already are sunsetting loose advanced practice provider (APP) practice restrictions.
- Nurse practitioners (NPs) probably are more likely than physician assistants to see long-lasting relaxation of practice supervision/collaboration restrictions, largely depending on existing state law and lobbying efforts.
- If a result of COVID-19 is more states allow wholly independent practice of NPs, physicians may see a commensurate decrease in malpractice risk in those states.
- Telehealth is here to stay.
- Telehealth could be a potential mechanism to satisfy the medical screening exam requirement of the Emergency Medical Treatment and Labor Act in a limited number of presentations for emergency care.

unlikely be a consistently successful argument that the supervision/collaborating physician is not just as liable as the APP in a medical malpractice action, even if he or she had no direct knowledge of the patient alleging malpractice.[5]

Even in states where fully independent practice is not allowed by law, particularly in rural and underserved areas, evolving practice patterns have established the validity of practice supervision/collaboration agreements that allow APPs to be the sole type of provider on site in the clinic, urgent care, and even emergency department (ED) setting.[6] Yet the fact the supervising/collaborating physician is neither consulted nor necessarily on site has not proven to be sufficient distance to avoid malpractice liability in the event of a claim. Although there is some regional variability, it remains true that for all named providers, diagnostic error is consistently among the most common type of claim, regardless of the type of healthcare provider who is sued.[7]

What does this mean for practice regulations and provider liability in the COVID-19 era? It seems unlikely there will be significant changes for PAs or for physicians supervising PAs, considering the lack of robust change in laws regulating PA supervisory relationships associated with COVID-19 and the relative dearth of states allowing PAs to practice without some form of supervision. However, there may be more change on the horizon for NPs. Traditionally, NPs have had a robust lobby and have enjoyed more success than PAs in achieving wholly independent practice rights. If NPs are successful expanding their base of states allowing independent practice, then those same states also may see a rise in NP malpractice risk and a relative decline in physician malpractice risk concordant with the degree of increase in independent practice. This, of course, is speculation, but it will be interesting to follow moving forward.

Telehealth regulations saw a more rapid, sweeping change than those governing APP practice during COVID-19, due in part to the involvement of the federal government. It is easier to make sweeping changes at the federal level, so relaxation of federal restrictions for reimbursement of telehealth visits for Medicare patients was noteworthy. Although there has been relative consistency across the nation at the state level regarding telehealth changes, state-specific changes are, by their nature, unique to the state, and most were issued in response to the federal mandates.

After the feds announced this change, the states rapidly followed suit to include reimbursement by private/state-based payors. Interestingly, the feds could have changed the policy of 85% reimbursement for non-supervised PAs at that time, too, essentially taking a significant step toward sanctioning non-physician-supervised PA care, but they did not. At least as far as PAs are concerned, we may not see ongoing, sweeping changes in practice supervision/collaboration.

But will the telehealth changes stick? It looks like at least some might. For instance, Michigan Gov. Gretchen Whitmer signed H.B. 5412-5416 into law on June 24, codifying that face-to-face/in-person contact may not be used as a condition for insurer reimbursement. This expanded telehealth reimbursement within state lines after the expiration/rescinding of relevant emergency orders, despite protestations from insurers.[8,9]

Other states have been catalyzing this change, too. For example, California and Georgia both recently passed laws not only permanently waiving the face-to-face/in-person requirement, but also requiring reimbursement parity for telehealth visits.[10] Additional states may follow suit.

If telehealth becomes permanently reimbursable in a much broader manner, what does this mean for emergency medicine? Emergency physicians (EPs) were early adopters of telemedicine, using the technology to advance care, particularly in rural/underserved areas (e.g., teleneuro, teleradiology, telepsychiatry, and teletrauma).[11]

However, to this author's knowledge, telemedicine has not been implemented as a method to

complete the medical screening exam (MSE) requirement of the Emergency Medical Treatment and Labor Act (EMTALA). Yet, given the anticipated permanent expansion of telehealth accessibility and reimbursement, this idea that EMTALA could play a role in completing the MSE has been considered in some circles. Could it work? Is it a good idea?

In brief, EMTALA requires hospitals with a dedicated ED to conduct an appropriate MSE for any patient who "comes to" the ED, whether it be by ambulance or other means, and to identify and stabilize existing emergency medical conditions (EMCs).[12] The term "comes to" was the subject of many lawsuits in the early days of EMTALA. Currently, telemedicine visits have not been included in its definition.

There is a range of complex and severe conditions that present to the ED. There still is value in physically examining a patient (as well as other diagnostics that are presently widely available only via in-person encounters). Thus, it seems many presenting complaints would not be adequately screened by a telemedicine MSE. However, there may be a limited number of less complex conditions that could be screened if the right circumstances existed, the scope of which would require a detailed analysis. Yet even if this is the case, would it benefit EPs to implement such a system, even in limited circumstances?

EPs have proven we are the experts in identifying and managing EMCs. In today's era, when patients already are self-selecting to urgent care centers and walk-in clinics (sometimes at a cost of significant delay in needed emergency care), EDs continue to effectively deliver EMTALA-related care nationwide. Thus, taking current events into consideration, a potential effective use of telemedicine MSEs would be during surge capacity situations, particularly those with high-risk encounters, such as with the COVID-19 pandemic.

In these limited situations, particularly those in which patients are self-selecting out of the ED in even greater numbers due to fear of exposure to infectious illness and/or when EDs are operating under surge conditions, telemedicine could deliver much-needed and appropriate MSEs. This concept has been applied in COVID-19-related care to direct certain patient traffic from the ED to alternate screening sites when screening criteria were met, thus decompressing crowded EDs and reducing exposure risk in a manner endorsed by the federal government.[12] Considering the COVID-19 pandemic is not over, and that other similar situations may arise, proactive consideration of this methodology in limited situations is appropriate.

COVID-19 is a catalyst for change. Eventually, we will have a clear, significant data set to analyze whether loosened restrictions on APP collaboration/supervision did expand access to care and improve outcomes. Additionally, a similar data set will exist regarding whether conducting certain health encounters remotely can expand access to care, improve outcomes, and lower costs.

Moving forward, it will be interesting to see whether similar long-term protections are passed and codified at both the state and federal levels of government, paving the way for a revolution in healthcare access and efficiency. ■

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Analysis: 1 in 6 EMTALA Settlements Involve OB Emergencies

About one in six Emergency Medical Treatment and Labor Act (EMTALA) settlements involve obstetric (OB) emergencies, according to a recent analysis.[1]

Sophie Terp, MD, the study's lead author, notes that there have been controversies about EMTALA's scope, but there can be no doubt this law applies to active labor; the word "labor" is right there in the title.

Terp and colleagues previously reviewed data on EMTALA-related civil monetary penalties for individual physicians and for psychiatric emergencies.[2,3] "My colleagues and I noted a number of interesting themes among cases related to labor and other obstetrical emergencies, and decided to evaluate these penalties systematically," says Terp, an assistant professor of clinical emergency medicine at the University of Southern California in Los Angeles.

Researchers analyzed 232 EMTALA-related Office of Inspector General (OIG) settlements that occurred between 2002 and 2018. During the study period, OB emergency settlements rose from 17% to 40%. "This is not surprising in the context of declining availability of obstetrical services in the U.S. during the study period," Terp offers.[4] Some key findings:

• More than one-third of cases involved a demand, a suggestion, or an offer to pregnant patients to proceed in a private vehicle to another hospital (usually, a facility where the regular obstetrician practiced).

"In many of these cases, the patient was turned away or discouraged from staying before they were entered into the log, or before an MSE [medical screening examination] was performed and documented," Terp says.

Even if patients choose to seek care elsewhere, an MSE could determine if the patient is stable for discharge. "It could also inform discussion of risks and benefits of leaving without stabilizing treatment or formal transfer," Terp suggests.

• Failure to make arrangements for necessary transfer was a common theme in OB settlements vs. those that did not involve OB.

Emergency department (ED) providers must identify a physician who is willing to accept the patient, confirm the receiving hospital has capacity to treat the mother, and has capability to treat the neonate. It also takes time for the transport team to travel to the sending hospital and bring the patient to the receiving hospital. "Labor is a time-sensitive condition. The issue tends to be that transfers take time," Terp observes.

• In one in five cases, the patient was a pregnant minor.

"Providers should be reminded of obligations to evaluate and stabilize minors," Terp says. If a minor presents to an ED and requests an exam or treatment for an emergency medical condition, that facility is legally obligated to perform that exam to learn if the patient's condition constitutes an emergency. Clinicians should not wait for parental consent to perform an MSE or treat the condition, Terp adds.

• A total of 13% of settlements involved labor and delivery triage areas specifically.

Under EMTALA, many labor and delivery evaluation areas can be designated as dedicated EDs. With that designation, clinicians working in these areas are required to follow transfer, screening, and stabilization requirements if positioned in a facility with a Medicare provider agreement, according to Terp.

Patients who present to the ED above a certain gestational age (typically from 18 to 20 weeks, depending on the hospital's policy) are immediately taken to the OB unit if the hospital provides OB care. "As far as CMS [Centers for Medicare & Medicaid Services] is concerned, that unit has all the same responsibilities as the main ED does with regard to EMTALA, albeit it's focused on OB patients," says **Todd B. Taylor**, MD, FACEP, a Phoenix-based EMTALA compliance consultant.

For EDs at hospitals without OB services, patients typically are managed in the ED. In some cases, there is not even an OB on staff at the hospital. "Since the ED has to manage the situation, it becomes more complicated," Taylor notes.

In many instances, the ED needs to transfer the patient to a hospital with OB services. "Anytime you are forced to transfer a patient because your hospital does not have the capability or capacity to treat the patient, there's going to be the opportunity for failure of some sort," Taylor observes.

Even if hospital transfer protocols are followed closely, some things are outside the ED's control. "There are many factors that go into a successful transfer, not the least of which is the availability of transport," Taylor notes.

For instance, delays of several hours are possible. "Even if you have the very best intentions, things can still go off the rails at times,"

Taylor says. For the most part, issues regarding OB and EMTALA are "fairly well-settled," Taylor says. "That's not to say there can't be failures in systems that can lead to issues, but I don't think it's systemic."

The tiny number of OB EMTALA civil monetary penalties per year suggests the vast majority of ED providers understand the law and know what to do, according to Taylor. The issue is there is considerable debate over what constitutes "active labor."

"This is usually determined retrospectively, setting up everyone for failure," Taylor laments.

During EMTALA investigations, there often are differing opinions on whether the patient was really in "active labor" at the time of the ED visit. "Women come to EDs all the time just to see if they are in labor. It's an inexact science, despite what EMTALA might imply," Taylor explains. Many travel to the closest ED just to find out if they need to go to the hospital where they plan to deliver.

"You are going to misjudge a few," Taylor admits. "That's reality, and sometimes it ends up being cited as an EMTALA violation."

One way to reduce risk is to always use an ambulance if OB patients are going to another hospital, and allow patients to refuse the ambulance if they insist on driving their own car. "In this regulatory environment, it's just not worth the risk," Taylor acknowledges. ■

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Lawsuits Allege Negligent ED Care Caused Hospitalized Patient's Poor Outcome

A young man with a history of recent hospitalization presented to an emergency department (ED) with fever and cough. After a chest X-ray revealed left lower lobe pneumonia, a hospitalist admitted the patient to the floor. No bed was available.

During the four hours the patient remained in the ED, his vital signs deteriorated and abnormal lab results returned. The ED nurse documented all this, but apparently did not inform the emergency physician (EP).

Finally, the patient was brought to the floor, but was found in acute respiratory collapse the next day. The patient was brought to the intensive care unit (ICU) and intubated, but died hours later. "This ended in a lawsuit with a seven-figure settlement," says **Stephen A. Barnes**, MD, JD, FACLM, a Houston-based attorney who represented the plaintiff.

The family sued the ED nurse, the EP, and the hospital. The lawsuit alleged the providers failed to timely admit the patient to the ICU, and failed to provide empiric antibiotics for nosocomial pneumonia. "Given the patient's recent hospitalization, this should not have been a presumed community-acquired pneumonia," Barnes says.

The plaintiffs also alleged the hospital failed to provide airway support, and failed to provide bronchoscopy and bronchoalveolar lavage.

"These actions were alleged to be required either in the ED, the ICU, or both, as a continuum of care," Barnes explains. The hospital settled the claim on behalf of the ED nurse. "The ED physician settled as well," Barnes adds. "This was based on a 'physical presence in the ED' theory of liability."

When ED patients are admitted but not yet transferred, that is a "point of weakness," Barnes suggests. "In many hospitals in this scenario, the 'attending' physician role is immediately reassigned to the admitting physician or hospitalist."

Yet ED nurses, not inpatient nurses, continue to care for the boarded patient. "It is dangerous for an ED nurse to rely on the electronic record to communicate significant abnormalities in this situation," Barnes cautions.

Boarded ED patients can become unstable rapidly. "Verbal communication of such information by the nurse

to the admitting physician is critical," Barnes stresses.

Equally important is for the ED nurse to immediately involve the EP if there are any concerning changes in patient status or critical lab values. "If a patient needed intubation while still in the ED, a reasonable and prudent nurse would grab the nearest ED physician," Barnes offers.

The ED nurse also can call the attending. "But regardless of who is the official 'attending,' the ED mindset should be that unless a patient is stable, physician 'boots at the bedside' are necessary," Barnes says.

The hospital can be sued for vicarious liability if ED nurses fail to involve the EP. "The hospital may also be sued for direct liability for failing to have (or enforce) policies and procedures mandating rapid communication of critical data to the ED physician, regardless of patient admission status," Barnes says.

It is difficult for the EP to avoid liability as the only doctor physically present when the situation went wrong. "I cannot overemphasize the jury mindset that imagines an ED as a close-knit box — an emergency room, not department — and thus assigns liability to the ED physician since that physician was 'right there' but did not take control," Barnes stresses.

EP defendants can say they were unaware of the patient's deteriorating condition. "But juries do not understand how that could be," Barnes reports.

To complicate the matter further, the hospitalist taking the handoff from the EP is not always the doctor who actually cares for the patient. "Information is often distorted, misinterpreted, and forgotten by the time it is transmitted to the accepting hospitalist," says **Andrew P. Garlisi**, MD, MPH, MBA, VAQSF, medical director of Geauga County (OH) EMS and University Hospitals EMS Training & Disaster Preparedness Institute.

Possible pitfalls include the patient going to an inappropriate setting (such as the ICU instead of telemetry), delayed antibiotics, or forgotten test results. "Wrongful disposition and delay in treatment compromises patient safety. Medical-legal consequences can be expected," Garlisi warns.

There also is the risk of the patient deteriorating in the ED after the hospitalist accepts the patient. "It is often difficult for the emergency physician to contact the hospitalist repeatedly to provide updates every time the status of the patient deteriorates," Garlisi says.

Hospitalists can insist the EP did not give enough information to avoid a catastrophic outcome. "Unless the phone conversation is recorded, which is unlikely, and could be submitted as evidence, the emergency physician is vulnerable in such situations," Garlisi notes.

Documentation by the EP should indicate what was stated, the hospitalist's response, any disagreements on what should be done, and final decisions made. But regardless of how excellent the documentation is, anytime a patient is transferred from the ED, this is "a high-risk time period for medical errors," says **Sandra L. Werner**, MD, MA, FACEP, clinical operations director in the department of emergency medicine at MetroHealth Medical Center in Cleveland. Here are three scenarios that come up in malpractice litigation:

• The boarded patient leaves the ED before an ordered medication is given, and nobody realizes it.

The patient might receive the drug hours later, or not at all. "The delay could potentially lead to an adverse outcome, as in delayed antibiotics in a septic patient, or anticoagulation reversal in a hemorrhagic stroke," Werner says.

• The boarded patient deteriorates in the time between when the EP called report and when the patient is physically transferred to the floor. For example, say the EP calls report at 2:00 p.m., but the bed is not ready until 5:00 p.m. "Sometimes, after report is called, the patient is out of the ED doc's mind," Werner notes.

During those three hours, no one reassesses the patient, or no one notes the worsening condition. Nothing is communicated to the admitting team. Someone with an infection might go into septic shock, or an asthma patient might worsen suddenly. "These patients would now need a higher level of care," Werner observes.

• The ICU doctor disagrees the patient needs ICU level of care, so the patient is admitted to a regular floor. "If the ED doc feels otherwise, they can ask the ICU doc to actually come see the patient. Or they could talk to the ICU doc's supervisor," Werner offers.

If an adverse outcome happens, the fact there were arguments about the appropriate disposition is going to be scrutinized. Some ED charts state something inflammatory (e.g., the ICU doctor "refused to accept" a patient). "This piece of documentation would surely be of interest to a plaintiff's attorney," Werner suggests.

If the patient is admitted to the ICU with no beds available and ends up boarded in the ED, "this, in itself, could be a problem," Werner cautions.

What if a patient should be in an ICU, but instead dies after remaining in the ED for a day? "I suspect family members might wonder if they received optimal care," Werner explains. ■

EMS Documentation Can Complicate Defense of ED Claim

Most emergency physicians (EPs) know they should review emergency department (ED) nursing documentation, but forget that some providers have documented things that happened before the patient even arrived at the ED.

"EMS [emergency medical services] providers' documentation is generally unavailable at the time of the ED visit. There is a lot of lost information from prehospital services," says **Alan Lembitz**, MD, chief medical officer at COPIC, a Denver-based medical professional liability insurance provider. "If you are a plaintiff attorney, that's really fertile ground. When EMS describes significant findings that would have changed your management if you would have known about it, that's a big deal."

Lembitz says paramedics' handwritten sheets usually provide a good description of the patient's condition and what happened in the field.

"With electronic charting, EMS providers often don't complete their trip sheet in real time," Lembitz notes.

Often, the EMS documentation is entered in a different system that is not readily available to the ED provider.

"It is easy to forget about the EMS run sheets because they are not always embedded in the EMR [electronic medical record]," says **Laura Pimentel**, MD, a clinical associate professor in the department of emergency medicine at the University of Maryland.

For this reason, some EMS reports are available only as hard copies. "Unless the physician specifically looks for the report, it is not likely that it will ever be seen," Pimentel explains. Some malpractice cases involve trauma patients discharged from the ED who later experience a bad outcome because of undetected injury. In that case, EMS records are scrutinized. For example, if EMS documented a bump on the patient's head, but there is no mention of it in the ED record, that is problematic for the defense.

"This could be used to show that the hospital had poor recordkeeping, and perhaps wasn't providing proper care and treatment to the plaintiff," says **Lori M. Shapiro**, Esq., claims team lead, professional liability in the Melville, NY, office of Sedgwick Claims Management Services.

The plaintiff attorney is going to ask these questions at deposition: Had there been a fall prior to EMS arriving? Was EMS told about that fall? Was the bump a result of the fall? Does the patient have a history of falls? Was there lack of consciousness? If so, for how long?

"Any and all of these things can go into the assessment and evaluation of the patient. Without this information, a diagnosis can be missed or delayed," Shapiro says.

There are other reasons for plaintiff attorneys to depose EMS providers.

"If there are different stories about what happened to the plaintiff before EMS arrived, counsel would want to see what the EMS records show," Shapiro says.

The following are some reasons why EMS providers could become involved in ED malpractice lawsuits:

• Specifics on what was stated when EMS arrived at the scene could become a pivotal issue. "If the EMS records state that the patient smelled of alcohol, and a witness said he had been drinking, but the ED records don't mention it, that could factor into a misdiagnosis," Shapiro explains. EMS records could come up if plaintiffs allege delayed diagnosis. "Both the plaintiff and defense will want to take a look at the EMS records to put together a timeline," Shapiro offers. Attorneys will be interested in how long it took EMS to arrive at the scene, how long it took EMS to arrive at the hospital, and how long it took the ED to evaluate the patient upon arrival.

• Plaintiff attorneys can use EMS testimony to show the plaintiff's condition before arriving at the ED, then the deterioration of the plaintiff after spending time in the ED. "They might be able to use that to show that there was a deviation in the standard of care in the ED that caused an injury," Shapiro says.

For instance, EMS records might show the patient appeared alert and oriented at first, but declined slightly by the time he or she arrived at the ED.

"A decline in a patient's health prior to treatment does not mean there is a deviation from the standard of care," Shapiro notes. "But having a timeline of events will certainly help to determine if there was."

• EMS testimony might corroborate the plaintiff's version of events. According to EMS documentation, the plaintiff was in need of immediate care.

Yet hospital records show the plaintiff waited several hours to be seen. In this kind of case, ED providers might blame EMS for not telling them pertinent information.

"But it's likely that the ED has policies and procedures in place that they are supposed to follow when accepting a patient brought in by EMS," Shapiro observes.

Conversely, the EMS version of events could help the defense discredit the plaintiff. That is the case if EMS testifies the patient said the stroke started 24 hours ago, but a family member later gives a much later time.

Also, it helps the defense if both providers' documentation is consistent in showing the patient stated the stroke symptoms started a day ago.

"The ED can use that information in support of their defense that they did not deviate from the standard of care, because this patient was outside the window for them to administer tPA," Shapiro explains.

• In some cases, the EMS run sheet contains important information the EP did not acknowledge or act on. "It is likely that the ED physician will be liable for not reviewing the report," Pimentel says. Sometimes, EMS testifies they verbally conveyed the information. "A he said/she said scenario never looks good for either party, particularly the physician," Pimentel offers.

• Problematic handoffs between EMS and the ED are a hurdle for the defense. It is best for the ED defense team if EMS testifies to a smooth handoff, with ED providers acting promptly on verbal reports. Of course, this does not always happen.

"EMS providers are appropriately offended and concerned for patient safety when they are ignored by hospital personnel," Pimentel says.

EMS may wait too long to be acknowledged, and ED providers completely disregard EMS' assessment of patient acuity. "It is likely that this would be exposed during a deposition," Pimentel adds. "The timeline alone is telling." ■

EDs Find Alternatives to Boarding Psychiatric Patients

A resource document from the American Psychiatric Association offers some solutions to the problem of boarding psychiatric patients.[1]

"We give practical ideas on treatment interventions in the ED [emergency department]," says **Kimberly Nordstrom**, MD, JD, the lead author and an emergency psychiatrist at University of Colorado Anschutz.

The idea is for the psychiatry and emergency medicine fields to work together on solutions and "get both groups talking," Nordstrom says. "We also wanted to think broader. What can the hospital do?"

One example is designating a quieter area for those with psychiatric issues. "That in itself can help to stabilize the patient," Nordstrom offers.

Some EDs are taking steps to reduce medical/legal risks by preventing the need for boarding in the first place. **Scott Zeller**, MD, has been working with several hospitals to rapidly create separate emPATH (emergency Psychiatric Assessment, Treatment, and Healing) units. The emPATH units handle all the ED's acute mental health patients.

"We are looking at what they can do for the psychiatric patient who might be a little different so they don't have people boarding and taking up beds that might be needed for other patients," says Zeller, vice president of acute psychiatric medicine at Vituity in Emeryville, CA.

The emPATH units treat highly acute psychiatric patients without involvement of law enforcement or jail. "Relying on police to detain for involuntary holds, as we know, sometimes can have unfortunate outcomes," Zeller observes.

Some ED psychiatric patients are on involuntary holds when they arrive on the emPATH units. Staff try to convert them to voluntary status as soon as possible. "The staff focus on collaboration and engagement rather than coercion," Zeller explains. Quick access to a psychiatrist means more patients become willing participants in their care, rather than staff forcing treatment. Moving psychiatric patients to a designated area, says Zeller, "is not pushing these people out the door. It's putting them into a much better, more therapeutic environment that's going to improve their situation."

The idea is to stop holding psychiatric patients indefinitely in noisy, crowded EDs, exacerbating agitation and anxiety. Instead, there is a chance to stabilize the emergency medical condition, as required by the Emergency Medical Treatment and Labor Act (EMTALA).

"This is much more in line with EMTALA, rather than just boarding them, and trying to transfer that responsibility elsewhere," Zeller notes.

Many hospitals were looking at implementing emPATH units. Concerns about overloaded EDs during the COVID-19 pandemic hastened this research. "With necessity being the mother of invention, we're able to ramp up the creating of these units in a much shorter time frame — less than 30 days," Zeller reports. If psychiatric

patients are boarded, it means all ED patients are going to wait longer. "That takes a bed completely out of commission at a time when [clinicians] are looking at how to increase capacity during a surge," Zeller says. EmPATH units free up beds while putting treatment of psychiatric patients more in line with how all other ED patients are treated. "If you come to the ED with an asthma attack, they will not sit you in a back room until they find you an asthma hospital," Zeller says.

Some patients improve so much that there is no longer a need for an inpatient bed after all. Many end up discharged home or to an outpatient community setting. "That preserves those beds for the patients who truly have no alternative," Zeller notes.

In the ED, there usually is not much time to start treatment, see how the person responds, then use that to guide the next stages and disposition. In an emPATH unit, there is plenty of time (usually up to 24 hours) to handle all this.

"Somewhere in the range of 75% of the patients who are thought to need inpatient care actually improve enough to be discharged," Zeller reports. These data refute the common misconception that it takes days or weeks to resolve highly acute psychiatric symptoms.

"The great majority of psychiatric emergencies can be treated to a subacute level in less than 24 hours," Zeller adds. ■

REFERENCE

1. Nordstrom K, Berlin JS, Nash SS, et al. Boarding of mentally ill patients in emergency departments: American Psychiatric Association resource document. *West J Emerg Med* 2019;20:690-695.

Same Issues Arise Repeatedly in ED Missed Sepsis Claims

When septic patients first arrive at emergency departments (EDs), they do not always appear to be that sick. Some are discharged home, and plaintiff attorneys later allege the patient was misdiagnosed.

The plaintiff in one such case was a young man who presented to an ED with a swollen right leg, with a mild temperature and elevated heart rate at triage. An ultrasound was negative for deep vein thrombosis. The patient returned to the ED waiting room, and waited four more hours. No additional vitals were obtained, despite an ED protocol requiring reassessment every two hours.

"The security guard took pity on him when he saw the patient laying on the floor because he was too uncomfortable to sit, and got him a pillow," says **David Sumner**, JD, a Tucson, AZ, medical negligence specialist with a multistate trial practice.

The hospital's security cameras recorded all this. Eventually, the patient left without ever undergoing evaluation. "He was emergently admitted at another ED hours later for cellulitis and sepsis, and died of complications," Sumner reports.

Plaintiff attorneys alleged the triage nurse at the first ED failed to recognize the implications of the swollen leg, failed to reassess the patient, and failed to recognize the ultrasound confirmed major cellulitis (indicating a higher acuity designation).

"The case settled before a lawsuit was even filed, shortly after the notice of claim was received," Sumner says. These issues arise repeatedly in missed sepsis ED claims:

• Problems with systemic inflammatory response syndrome (SIRS) alert protocols. "Some institutions exempt patients in the ED waiting room from SIRS alarms," Sumner explains. In the malpractice case described earlier, vital signs obtained at triage met criteria for a SIRS alert. However, the patient was missed because the protocol excluded patients who remain in the ED waiting room. Therefore, no alert appeared in the system.

The problem is there can be long delays between the patient's arrival and when the patient is brought back to a room.

"I have seen five- and six-hour delays due to high ED patient volumes and understaffing," Sumner recalls.

• Some SIRS alert protocols have too long of a lockout period for new alerts. Once a SIRS alert is taken off for a particular patient, some systems have a 12-hour lockout on new SIRS alerts for that patient. This time frame is dangerous.

"There are too many urgent conditions that can evolve from stable to critical within a 12-hour SIRS lock out period," Sumner warns.

One patient with acute pancreatitis worsened because of inadequate fluid management.

"It went undetected due to a 12-hour lockout for new SIRS alerts," Sumner explains.

• In some EDs, the threshold for a finding to be considered a "critical" lab value is too high. In some systems, it is a white blood cell count of at least 30,000. "There are too many patients who can be septic or have advancing SIRS without ever

having a count as high as 30,000," Sumner notes. The critical level values should not be set so high that the window of therapeutic benefit has passed.

"I see too many protocols where critical value thresholds are so high that the patient is near extremis before a critical lab is ever alerted," Sumner says.

Some septic patients experienced fatal complications. But despite high white blood cell counts, these patients never recorded a count of 30,000 or higher.

"If you look at the policy for critical level values and you say, 'Wow, if this value is that high, I am not sure we can successfully turn this around,' then the value is too high for an effective critical level communication policy," Sumner says. ■

Hospital's Quality Issues Can Cause Problems During ED Malpractice Litigation

If a hospital has below-average quality ratings, suboptimal satisfaction scores, or recent Emergency Medical Treatment and Labor Act violations, plaintiff attorneys will want the jury to know all about it. However, these are not necessarily going to be admissible in malpractice litigation.

A basic tenet of legal jurisprudence is that "if someone was convicted of a similar crime in the past, this fact cannot necessarily be admitted as evidence to prove the future propensity of committing the act in question," says **Rade Vukmir**, MD, JD, FCCP, FACEP, FACHE, president of Critical Care Medicine Associates and clinical professor of emergency medicine at Temple University and Drexel University. The same can be true for civil claims such as malpractice allegations. "You've now got a whole host of objective and subjective measures that are available to the public, examining different outcome measures and processes," Vukmir observes.

These include customer experience scores such as Press Ganey; the Hospital Consumer Assessment of Healthcare Providers and Systems survey; and objective quality scores published by ProPublica, The Leapfrog Group, and the Centers for Medicare & Medicaid Services. "Can any of it be used in malpractice? The answer is, it's an unknown," Vukmir explains. "This is uncharted territory. These are relatively new public disclosures."

The fact that an emergency physician (EP) has been sued before generally is not admissible. This is because "the probative value is viewed as not that significant compared to the case at hand. The prejudicial value might overwhelm fair evaluation process," Vukmir says. However, the concept of "habit evidence," where a provider's routine practice relates to the medical care at issue in the lawsuit, may be admissible. An EP defendant also can "open the door" by talking about the hospital's track record. For instance, the EP might state, "A two-hour delay in tPA [tissue plasminogen activator] administration could never have happened. Our ED [emergency department] has shorter door-to-drug times than any hospital in the state."

"Now, the probative value of the evidence could be more than the prejudicial value," Vukmir explains. The plaintiff attorney probably would be well-prepared to make an issue of it. "They do the research, and they are at the ready," Vukmir says.

Plaintiff attorneys may want to point out the ED allegedly has terrible scores on a publicly reported metric involving the condition the plaintiff presented with. "It might be true. But historically, civil litigation does not let you extrapolate how you generally do to how you did with this case," Vukmir says. Depending on the venue, the plaintiff is not necessarily allowed to connect how the hospital does with myocardial infarction (MI) patients in general, with one particular patient who alleges an MI was missed. "They are concerned only with the specific facts bearing on this particular patient," Vukmir says.

For this reason, if a plaintiff attorney asked how the ED performs on quality measures, the defense attorney would direct the EP not to answer. If the hospital is named in the lawsuit, then hospital-based data could be admissible in the right circumstances. There may be a particular reason such data are relevant to the case.

"Still, if the perception is that the hospital performed poorly on a quality measure, that doesn't mean that this individual patient's care was necessarily substandard," Vukmir adds. ■

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CME/CE QUESTIONS

1. **Which did researchers find regarding Emergency Medical Treatment and Labor Act (EMTALA) and obstetric (OB) emergencies?**
   a. Hospital policies inappropriately required pregnant patients to be transported by ambulance.
   b. Failure to arrange appropriate transfer was more common in OB-related settlements vs. cases that did not involve OB.
   c. Hospitals got into trouble because emergency department (ED) providers conducted medical screening exams without parental consent.
   d. Labor and delivery areas are no longer considered to be dedicated EDs under EMTALA.

2. **Which is recommended for ED nurses regarding boarded ED patients?**
   a. Rely on electronic documentation to communicate significant abnormalities.
   b. Immediately involve the emergency physician (EP) if there are any concerning changes in patient status.
   c. Contact the admitting physician instead of the EP if an admitted patient needs intubation while physically in the ED.
   d. Use the words "refused to accept" to explain why patients remained in the ED.

3. **Which is true regarding emergency medical services (EMS) providers and ED malpractice litigation?**
   a. Specifics on what was stated when EMS arrived at the scene could become a pivotal issue.
   b. EMS documentation typically cannot be used to prove an EP deviated from the standard of care.
   c. Evidence of the plaintiff's condition before arriving at the ED generally is inadmissible.
   d. Courts have consistently barred EMS providers from testifying about delays upon arrival to the hospital.

4. **Which is true regarding psychiatric patients held in EDs?**
   a. Few patients on involuntary holds offer psychiatric complaints.
   b. Immediate access to a psychiatrist lengthened the average ED stay.
   c. Most psychiatric emergencies can be treated to a subacute level in less than 24 hours.
   d. Patients held in regular EDs experienced significantly better outcomes than those moved to settings designated for psychiatric patients.