

# THE PROBLEM OF AMBULANCE DIVERSION, AND SOME POTENTIAL SOLUTIONS

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## INTRODUCTION

An ambulance crew picks up a patient whose age, appearance, and symptoms all suggest that the patient is in the early stages of a heart attack. A member of the crew gathers the patient's medical history, while the driver contacts an emergency medical services (EMS)<sup>1</sup> dispatcher to indicate that the ambulance is bringing its passenger to the emergency department (ED) of a nearby trauma center for treatment and expects to arrive in seven minutes. The dispatcher responds that the ED is full and has declared that it is "on diversion,"<sup>2</sup> meaning that it is not accepting additional emergency patients. The dispatcher instructs the ambulance to go to the ED at another hospital slightly farther away. The ambulance crew complies and changes course for the other hospital, extending the trip, potentially at cost to the patient's health.<sup>3</sup>

Ambulance diversion is a tactic used by hospitals and EMS to solve the problem of overcrowded EDs. However, while diversion might solve the overcrowding problem of an individual ED, "it is a solution with its own problems,"<sup>4</sup> and cannot be considered a reliable

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1. For the purposes of this paper, the term "EMS" includes both EMS and paramedic systems. Though the two have been historically separate, this distinction for legal and operational purposes has mostly disappeared. Alexander E. Kuehl & Eileen F. Baker, *Medical Oversight*, in *PREHOSPITAL SYSTEMS AND MEDICAL OVERSIGHT* 301, 303 (Alexander E. Keuhl ed., 3d ed. 2002).

2. One text on the subject describes diversion or diversion status as "a situation in which an ambulance is forced to seek an alternate hospital destination other than that to which it would normally transport a patient, because the closest appropriate facility has declared that it is unable to accept patients as a result of a lack of normally available resources." Michael Casner et al., *Diversion and Bypass*, in *PREHOSPITAL SYSTEMS AND MEDICAL OVERSIGHT*, *supra* note 1, at 871.

3. See *INST. OF MED., HOSPITAL-BASED EMERGENCY CARE: AT THE BREAKING POINT* 41 (2006) [hereinafter *IOM, HOSPITAL-BASED EMERGENCY CARE*] ("[O]ver half of all ED events described as sentinel were caused by delayed treatment"); Theodore R. Delbridge & Donald M. Yealy, *Looking for a Solution . . . to the Solution?*, 44 *ANNALS EMERGENCY MED.* 304, 305 (2004) ("[W]e can envision a critically ill or injured patient for whom a few minutes really do matter.").

4. Delbridge & Yealy, *supra* note 3.

means of maximizing the delivery of emergency medical care among the EDs of a given region. Hospitals' use of diversion creates a collective action problem among hospitals, EMS units, and state and local governments, which is amplified by acute pressures on hospital capacity<sup>5</sup> and solvency.<sup>6</sup> Meanwhile, because the laws that hold emergency medical personnel liable for negligent conduct in relation to ambulance diversion are ambiguous at best, patients injured because of ambulance diversion may not have legal recourse for their injury.<sup>7</sup> This Note infers that the combination of pressure on hospital resources and a gap in legal protections for those injured allows some hospitals to employ ambulance diversion policies in a way that is harmful to patients, whether inadvertently or in order to achieve a relatively more profitable patient mix.<sup>8</sup>

This Note will spell out the operation of the collective action problem noted above, and then provide suggestions for how to reduce the frequency of ambulance diversions. Part I provides background information about the EMS and trauma systems in which ambulance diversion is prevalent, as well as diversion's basic logic and diverse features. Part II describes the relevant ways in which federal and state law regulate (and fail to regulate) hospitals and EMS and trauma system operations. Part III uses examples of diversion policies to describe diversion-related tactics and strategies available to hospitals. Finally, Part IV proposes three ways to reduce diversions: i) record and publish detailed regional data on patient transports, arrivals, diversions, treatments, admissions, and outcomes; ii) create substitutes for stretched ED services; and iii) consolidate resource-tracking and allocation within individual hospitals and among regional actors.

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5. See the discussion of ED crowding *infra* Part I.

6. According to the Joint Commission on Accreditation of Healthcare Organizations, "about 50 percent of short-term, acute-care hospitals are either insolvent or near insolvency." JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., GUIDING PRINCIPLES FOR THE DEVELOPMENT OF THE HOSPITAL OF THE FUTURE 11 (2008), <http://www.jointcommission.org/PublicPolicy/future.htm>.

7. See *infra* Part II.A (discussing the key federal law), II.B (discussing enforcement mechanisms), & II.C (discussing liability for EMS personnel).

8. This suspicion rests on an analogy of hypothesized patient selection to documented patterns of hospital price discrimination. Hospitals' variance of their prices can be ascribed to either of two motives: the hospital means to maximize profit by getting as much money as it can from consumers of its service offerings, or the hospital means "to cover their fully allocated total costs . . . in a way that conforms to prevailing distributive, social ethics." Uwe E. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, 25 HEALTH AFF. 57, 63 (2006). Reinhardt notes that the current market for hospital services puts pressure on all hospitals; non-profit hospitals have little choice but to behave like for-profit ones, such that the two distinct motives do not give rise to a functional difference. *Id.* at 64.

## I.

THE CONTEXT, LOGIC, AND FEATURES OF  
AMBULANCE DIVERSIONA. *The Scope of the Diversion Problem*

Since the early 1990s, more and more people have turned to EDs for medical care.<sup>9</sup> Diversion, previously a stopgap measure used by a hospital in the rare event that its ED should become extremely crowded,<sup>10</sup> has become an endemic feature of emergency care.<sup>11</sup> One study estimated that, in 2003, about 500,000 ambulances (an average of about one ambulance every minute) were diverted from their initial hospital destination.<sup>12</sup> Although diversion is more frequent among more densely populated areas,<sup>13</sup> it affects rural areas as well.<sup>14</sup>

The groundswell in ambulance diversion rates clearly owes to changes in the supply and demand relationship between EDs and incoming patients. That relationship can be broken down into three key elements:<sup>15</sup> (i) patient demographics (insurance status and types of

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9. See *infra* Figure 2.

10. See AM. MED. ASS'N COUNCIL ON MED. SERV., OVERCROWDING AND HOSPITAL EMS DIVERSION, REPORT 1 OF THE COUNCIL OF MEDICAL SERVICE 2 (2002) [hereinafter OVERCROWDING AND HOSPITAL EMS DIVERSION], [www.ama-assn.org/ama1/pub/upload/mm/372/cms102.doc](http://www.ama-assn.org/ama1/pub/upload/mm/372/cms102.doc).

11. CLAUDIA SCHUR ET AL., PROJECT HOPE CTR. FOR HEALTH AFFAIRS, EMERGENCY DEPARTMENT USE IN MARYLAND: A PROFILE OF USERS, VISITS, AND AMBULANCE DIVERSION iv (2003) (“[A]mbulance diversions . . . have risen fourfold between 1996 and 2001”), [http://mhcc.maryland.gov/health\\_care\\_expenditures/extramural/emergdept.pdf](http://mhcc.maryland.gov/health_care_expenditures/extramural/emergdept.pdf). According to the U.S. Government Accountability Office’s 2003 report on ED crowding (which examined 2001 data), two thirds of hospitals diverted ambulances in that year, and ten percent of hospitals were on diversion more than twenty percent of the time. This indicates that diversion is becoming more common in emergency medicine. GAO, HOSPITAL EMERGENCY DEPARTMENTS: CROWDED CONDITIONS VARY AMONG HOSPITALS AND COMMUNITIES, 03-460, at 10 (2003) [hereinafter GAO, HOSPITAL EDs].

12. Catherine W. Burt et al., *Analysis of Ambulance Transports and Diversions Among US Emergency Departments*, 47 ANNALS EMERGENCY MED. 317, 322 (2006).

13. CTRS. FOR DISEASE CONTROL, QuickStats: Percentage of Hospital Emergency Departments (EDs) Having to Divert Ambulances, by Selected Characteristics — United States, 2003, 55 MORBIDITY AND MORTALITY WEEKLY REP. 372, 372 (2006), available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5513a10.htm> (reporting that, in 2003, forty-five percent of US hospitals, sixty-five percent of hospitals in Metropolitan Statistical Areas (MSAs), and eighteen percent of non-MSA hospitals went on diversion).

14. Although hospitals in cities tend to divert ambulances more often than those in rural areas, the Institute of Medicine observed, “ED overcrowding is a nationwide phenomenon, affecting urban and rural areas alike.” IOM, HOSPITAL-BASED EMERGENCY CARE, *supra* note 3, at 39.

15. See Brent R. Asplin et al., *A Conceptual Model of Emergency Department Crowding*, 42 ANNALS EMERGENCY MED. 173, 173–80 (2003) (using an “input-throughput-output conceptual model” to describe patient flow at healthcare sites).

care sought); (ii) ED capacity to safely evaluate, treat, and disposition patients; and (iii) hospital capacity beyond the ED<sup>16</sup>—whether in the same hospital or at other institutions—to absorb patients screened and diagnosed in the ED. Federal law prohibits the ED from refusing emergency patients,<sup>17</sup> and, consequently, this relationship is a function of the level of demand for medical care on the one hand and the capacity to move patients through the ED on the other.<sup>18</sup> The two standard responses to ED crowding<sup>19</sup> are patient “boarding,” i.e., holding patients in the ED—including on gurneys in hallways—until space becomes available elsewhere in the hospital,<sup>20</sup> and ambulance diversion.<sup>21</sup>

The term “crisis” has been used to describe the state of U.S. medical institutions so frequently<sup>22</sup> that the term no longer inspires most readers to pay attention. However, several data points attest to the level of pressure felt by hospitals due to a bona fide crisis in health care financing and organization,<sup>23</sup> and one these points focuses in particular on hospital EDs. The graph below (Figure 1) shows not only that more patients are visiting fewer EDs, but also that the trends ap-

16. The State of Massachusetts and GAO each concluded independently, in 2002 and 2003, respectively, that hospital inpatient capacity was the primary predictor of ED crowding. See B.U. PROGRAM FOR MGMT. OF VARIABILITY IN HEALTH CARE DELIVERY, ROOT CAUSE ANALYSIS OF EMERGENCY DEPARTMENT CROWDING AND AMBULANCE DIVERSION IN MASSACHUSETTS 9 (2002) (finding “a strong association between lack of inpatient resources and diversion status”), [http://www.mass.gov/Eoohhs2/docs/dph/quality/healthcare/ad\\_emergency\\_dept\\_analysis.doc](http://www.mass.gov/Eoohhs2/docs/dph/quality/healthcare/ad_emergency_dept_analysis.doc); GAO, HOSPITAL EDs, *supra* note 11, at 1 (“[T]he factor most commonly associated with crowding was the inability to transfer emergency patients to inpatient beds.”).

17. See *infra* Part II.1.

18. A diagram published in the Institute of Medicine’s 2007 report on EDs emphasizes the ED’s prone position in the face of the resulting ED “crowding.” IOM, HOSPITAL-BASED EMERGENCY CARE, *supra* note 3, at 40, fig.2-2.

19. The medical and hospital management literature uses “crowding” to refer to instances when the large number of ED patients seeking care makes it impossible for all patients’ ailments to be treated timely.

20. See Arthur L. Kellermann, *Crisis in the Emergency Department*, 355 NEW ENG. J. MED. 1300, 1300–02 (2006). For examples of boarding, see David Holmberg, *The Patients in the Hallways*, N.Y. TIMES, June 10, 2007, at 14NJ.3; Zachary F. Meisel & Jesse M. Pines, *Waiting Doom: How Hospitals Are Killing E.R. Patients*, SLATE, July 24, 2008, <http://www.slate.com/id/2195851/>.

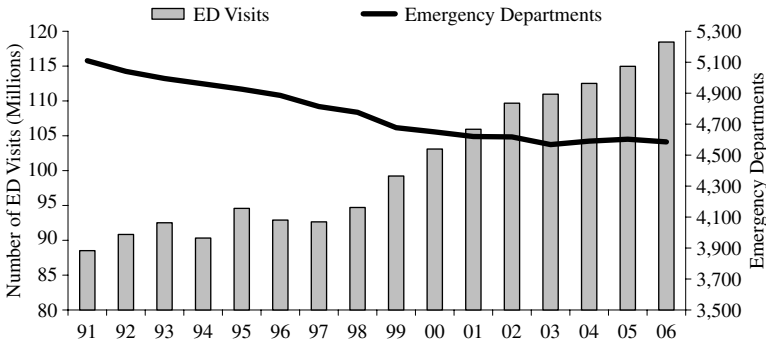
21. See DEREK DELIA, RUTGERS CTR. FOR STATE HEALTH POL’Y, EMERGENCY DEPARTMENT UTILIZATION AND SURGE CAPACITY IN NEW JERSEY, 1998–2003, 1 (2005) (“In its most extreme form, ED overcrowding leads to ambulance diversion.”), <http://www.cshp.rutgers.edu/PDF/ED%20Utilization%20and%20Surge%20Capacity%20in%20NJ.pdf>; CLAUDIA SCHUR ET AL., *supra* note 11 (“[A]mbulance diversions . . . have risen fourfold between 1996 and 2001.”).

22. A search in the Lexis’ “Major US Newspapers” database for the phrase “current health care crisis” returns at least one entry for every year since 1987.

23. See IOM, HOSPITAL-BASED EMERGENCY CARE, *supra* note 3, at 19.

pear relatively robust. In addition, the Institute of Medicine stated that “[n]ot only is ED volume increasing, but patients are presenting with more serious or complex illnesses.”<sup>24</sup>

FIGURE 1: NUMBERS OF EDs AND ED VISITS IN THE U.S. 1991–2006<sup>25</sup>



The reasons for these trends are complex<sup>26</sup> and beyond the scope of this Note. Their relevance, however, is clear: the most common response to the crowding that results from the growing gap between ED capacity and ED-based demand for medical services is ambulance diversion.<sup>27</sup> The prevalence of crowding and its harmful effects have become a focal point for newspapers and academic research as well as for hospital and ED administrators.<sup>28</sup> Although a number of respon-

24. IOM, HOSPITAL-BASED EMERGENCY CARE, *supra* note 3, at 39.

25. American Hospital Association & Avalere, *Trendwatch Chartbook 2008*, Chart 3.7 (2008), available at, <http://www.aha.org/aha/research-and-trends/chartbook/2008chartbook.html> (select “Chapter 3: Utilization and Volume”).

26. See DELIA, *supra* note 21, at 43 (“The causes for the surge in ED use and ED overcrowding at the present time appear to be very different from the ones that led to overcrowding in the 1980’s. . . . [T]he causes this time are closely tied to supply side issues such as bed capacity, labor force shortages, and the management of patient flow throughout the hospital.”); Casner et al., *supra* note 2, at 872–73 (listing likely causes of recent crowding trend); Samuel A. McLean & James A. Feldman, *The Impact of Changes in HCFA Documentation Requirements on Academic Emergency Medicine: Results of a Physician Survey*, 8 ACAD. EMERGENCY MED. 880, 881–83 (2001) (noting that 1996 changes to reimbursement requirements significantly increased the amount of ED staff and physician time devoted to paperwork).

27. This is evidenced by diversion’s frequent use as a proxy for levels of ED crowding. See R.P. Sheno, *Ambulance Diversion as a Proxy for Emergency Department Crowding: The Effect on Pediatric Mortality in a Metropolitan Area*, 16 ACAD. EMERGENCY MED. 116, 116 (2009).

28. See, e.g., IOM, HOSPITAL-BASED EMERGENCY CARE, *supra* note 3, at 40; Victoria M. Bradley, *Placing Emergency Department Crowding on the Decision Agenda*, 23 NURSING ECON. 14, 22 (2005); Steve Thompson, *Parkland Hospital: Was Aid Too Little, Too Late? Long Wait Common in ER May Have Cost Ex-Restaurateur His Life*, DALLAS MORNING NEWS, Oct. 5, 2008, at 1A (“What is certain is that over-

sive organizational and operational changes can increase somewhat the number of patients screened and treated without reducing the quality of care,<sup>29</sup> the problem of crowding persists.

In the midst of ED crowding, other trends in hospital staff composition and financing are draining previously reliable sources of personnel and revenue. In addition to a national shortage of nursing staff,<sup>30</sup> physician-owned specialty hospitals are taking healthier, better-insured patients and better-paying procedures away from full-service hospitals.<sup>31</sup> Yet these specialty hospitals do not share the Emergency Medical Treatment and Active Labor Act (EMTALA) burden<sup>32</sup> because they often do not maintain EDs.<sup>33</sup> As well as siphoning revenues from full-service hospitals, this steady defection of specialist doctors to specialty hospitals also reduces the number of on-call hours that those doctors make available to the full-service hospitals where they have privileges.<sup>34</sup> This trend, fully evident after

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crowding in the country's emergency departments is killing some, says . . . a nationally recognized professor of emergency medicine . . . ."); Reed Abelson & Melinda Sink, *Uninsured Put a Strain on Hospitals*, N.Y. TIMES, Dec. 9, 2008, at B1 ("Crowding is a national public health problem said . . . an emergency physician in Philadelphia.").

29. For various approaches to reducing crowding, see BRENT ASPLIN ET AL., ACEP TASK FORCE REPORT ON BOARDING, EMERGENCY DEPARTMENT CROWDING: HIGH IMPACT SOLUTIONS 6 (2008); Jonathan S. Olshaker & Niels K. Rathlev, *Emergency Department Overcrowding and Ambulance Diversion: the Impact and Potential Solutions of Extended Boarding of Admitted Patients in the Emergency Department*, 30 J. EMERGENCY MED. 351, 353–54 (2005); Sandra Schneider et al., *Rochester, New York: A Decade of Emergency Department Overcrowding*, 8 ACAD. EMERGENCY MED. 1044, 1049 (2001) (studying the strategies to reduce ED overcrowding in Rochester, New York).

30. Arthur L. Kellermann, *Crisis in the Emergency Department*, 355 NEW ENG. J. MED. 1300, 1301 (2006) ("The effects of emergency department crowding are exacerbated by a nationwide shortage of nurses.").

31. See Robert A. Berenson et al., *Hospital-Physician Relations: Cooperation, Competition, Or Separation?*, 26 HEALTH AFF. w31, w41 (2007) (reporting on the "medical arms race" for high net revenue patients between hospitals with EDs and specialist physicians who work in specialty clinics or hospitals).

32. The Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) prohibits hospitals with an ED from turning away patients who seek medical care. For more information on EMTALA, see *infra* Part II and Appendix.

33. See DEP'T OF HEALTH & HUMAN SERVS., FINAL REPORT OF THE EMTALA TECHNICAL ASSISTANCE GROUP TO THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES 13, 17 (2008) [hereinafter EMTALA TAG] (noting that specialty hospitals often do not have EDs, thereby ducking EMTALA obligations); *accord* Memorandum from Ctr. for Medicare & Medicaid Servs. Survey & Certification Group to State Survey Agency Dir., S&C-08-15, at 32 (Mar. 21, 2008), available at <http://www.ena.org/government/emtala/EMTALA-3-21-08.pdf>.

34. See Eileen Whalen, *Economic and Administrative Issues in Trauma Care*, in TRAUMA NURSING 19, 24 (Karen A. McQuillin et al. eds, 4th ed. 2009) (finding that

2001,<sup>35</sup> was encouraged by the 2003 revisions to federal regulations, which loosened the requirements for a hospital's on-call roster.<sup>36</sup>

The actual financial implications of these trends in demand, capacity, and financing are complex, and it would be a mistake to conclude simply that full-service hospitals must now to do more with less. Even before federal and state laws began forcing insurers to reimburse care received from an ED,<sup>37</sup> EDs were a major source of revenue for hospitals.<sup>38</sup> As the rate of ED visits have mounted in recent years, revenue-generating inpatient admissions have increasingly come through the doors of the ED rather than referral by a primary care physician.<sup>39</sup> This owes in part to the fact that, by preventing EDs from turning patients away, federal law has made EDs into both a safety net for those without insurance and, for those *with* insurance, an alternative to navigating the referrals and prior authorizations imposed on treatment access by private insurance policies.<sup>40</sup> Indeed, the evi-

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three-fourths of hospitals surveyed by the Institute of Medicine report difficulties in finding specialists to take emergency and trauma calls).

35. See Berenson et al., *supra* note 31, at w32.

36. See Robert Pear, *Emergency Rooms Get Eased Rules on Patient Care*, N.Y. TIMES, Sept. 3, 2003, at A1. See generally 42 C.F.R. § 489.24(j) (2009).

37. These laws were called "prudent layperson" laws because they compelled insurers to accept the self-assessment of a "prudent layperson" with regard to whether that person was in need of emergency care. Mark A. Hall, *The Impact and Enforcement of Prudent Layperson Laws*, 43 ANNALS EMERGENCY MED. 558, 558-59 (2004). Forty-seven states adopted such laws between 1995 and 2004. *Id.* at 558. The trend accelerated when Congress passed the Balanced Budget Act of 1997, PUB. L. NO. 105-33, which included provisions requiring that Medicaid and Medicare reimburse hospitals for emergency care using such a standard. See KEN KING, AM. COLL. EMERGENCY PHYSICIANS, ISSUE PAPER: PRUDENT LAYPERSON STATUS 3 (2002), [www.acep.org/workarea/showcontent.aspx?id=8896](http://www.acep.org/workarea/showcontent.aspx?id=8896).

38. See Alfred Sacchetti et al., *Contribution of ED Admissions to Hospital Revenue*, 20 AM. J. EMERGENCY MED. 30, 31 fig.1 (2002). The "prudent layperson" standard, which prevents insurers from refusing to reimburse for ED treatment because no qualifying emergency existed, seems to have protected hospitals access to reimbursement for ED care. See Hall, *supra* note 37, at 564 (finding a decrease in denials of ED claims by insurance companies due to the "prudent layperson" standard).

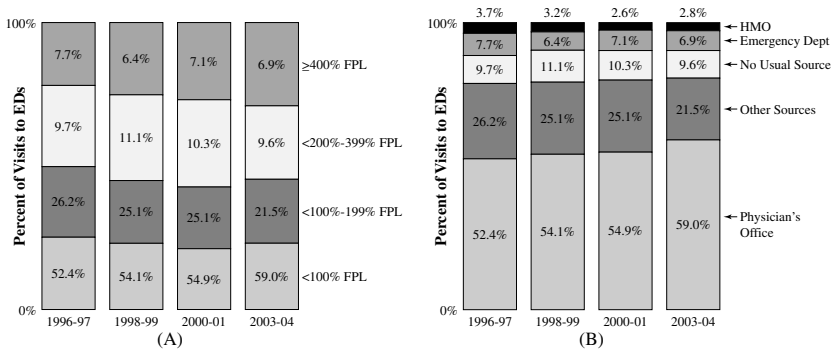
39. Interview with Cathy Boyne, Dir., Gilcrest Hospice Ctr., Greater Baltimore Med. Ctr., (Dec. 22, 2008); see also Glenn A. Melnick et al., *Emergency Department Capacity And Access In California, 1990-2001: An Economic Analysis*, HEALTH AFF. W4-136, W4-136, W4-140 (Mar. 24, 2004) (finding that ED visits generate net financial losses for the ED, but that the inpatient admissions arriving in the ED more than make up for those losses), <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.136v1>.

40. See Manya F. Newton et al., *Uninsured Adults Presenting to US Emergency Departments: Assumptions vs Data*, 300 JAMA 1914, 1918 (2008) ("Lack of accessible primary care is the factor most commonly named in determining why patients, regardless of their insurance status . . . seek care in the ED.") (emphasis added); see also, Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 BROOK. J.L. & POL'Y 695, 699 (2006) ("EMTALA is not likely a major



dence suggests that ED visits by patients in the latter category account for a disproportionate share of the overall increase in ED visits since the mid-1990s (see Figure 2, below).<sup>41</sup>

FIGURE 2: ED VISITS BY (A) FAMILY INCOME; (B) USUAL SOURCE OF PRIMARY CARE<sup>42</sup>



The meaning of these trends for hospitals' approaches to diversion would be clearer if there were a linear relationship between the frequency of diversions and net hospital revenue. If diversion were simply profitable, then one could expect money-maximizing hospital administrators to reduce ED capacity; and if diversion were simply a drain on net revenue, then hospitals would all try to avoid it all the time. However, revenues do not simply rise with diversion and fall with fully open EDs.<sup>43</sup> Instead, the "complex relationship between

culprit . . . in ED overcrowding and closures. Rather, greater pressures on the health-care system, pressures that EMTALA itself was meant in part to address, are to blame.").

41. See Peter Cunningham & Jessica May, Ctr. for Studying Health Sys. Change, *Insured Americans Drive Surge in Emergency Department Visits*, ISSUE BRIEF NO. 70, at 2 tbl.1 (2003) (estimating increase in the number of ED visits by privately insured patients to be more than double that of either Medicare-covered or uninsured patients).

42. Ellen J. Weber et al., *Are the Uninsured Responsible for the Increase in Emergency Department Visits in the United States?*, 52 ANNALS EMERGENCY MED. 108, 111 fig. 2 (2008).

43. See D.A. Handel & K. McConnell, *The Financial Impact of Ambulance Diversion on Inpatient Hospital Revenues*, 52 ANN. EMERGENCY MED. S87, S87-88 (2008); Philip L. Henneman, et al., *Emergency Department Admissions Are More Profitable Than Non-Emergency Department Admissions*, 53 ANNALS EMERGENCY MED. 249, 254-55 (2009) (challenging assumption that allocation of beds to non-ED patients will be more profitable than allocating beds to patients arriving through the ED). "In looking at why hospitals did not have the capacity to always meet the demand for inpatient beds from emergency patients, hospital officials, researchers, and others pointed to (1) financial pressures leading to limited hospital capacity to meet periodic spikes in demand for inpatient beds and (2) competition between admissions from the

ambulance diversion and hospital finances”<sup>44</sup> can be described as follows:

Consistent with the hypothesis that ambulance diversion is primarily caused by a lack of inpatient bed availability, hospital revenues tend to be higher during periods of diversion, and these higher revenues are driven primarily by electively admitted [non-emergency] patients. The higher revenues are not reflected in higher profitability, however. These findings suggest that high periods of diversion may be associated with greater revenue from electively admitted patients, but lost opportunities to increase overall profitability by offering greater inpatient availability to emergency patients.<sup>45</sup>

In other words, patients referred to the hospital by a doctor are a more reliable source of revenue, but so many patients present themselves at the ED (some of whom will have their care reimbursed handsomely) that hospitals lose out by turning patients away from the ED. Consequently, incentives to reduce patient access to the ED by diverting ambulances will likely vary with the circumstances of a particular region or market.

#### *B. Diversion and Triage: Shared Logic, Differing Bases for Legal Accountability*

Hospitals have long employed triage to sort patients based on the urgency of their medical need.<sup>46</sup> Triage staves off most harmful delays to patient treatment by optimizing the work of healthcare provid-

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emergency department and scheduled admissions such as surgery patients, who are generally considered to be more profitable.” GAO, HOSPITAL EDs, *supra* note 11, at 22.

44. Handel & McConnell, *supra* note 43, at S88.

45. *Id.* at 43.

46. Triage is generally the ED staff’s preliminary step in diagnosing a patient’s medical condition. Triage is an estimation of how urgently a condition must be examined further, not a full diagnosis, and does not necessarily entail the specification of the patient’s medical condition. For examples of triage, see LEXINGTON MEM’L HOSP., EMERGENCY DEPARTMENT TRIAGE, POLICY NO. 10-330 (2004) (describing 5-level triage regime) (on file with the NYU Journal of Legislation and Public Policy); Wendy W.H. Cheung et al., *An Advance Triage System*, 10 ACCIDENT & EMERGENCY NURSING 10, 14–16 (2002) (describing a system of advance triage); *see also* Paul Raeburn, *A Walk in the Shoes of an ER Nurse*, U.S. NEWS & WORLD REP., July 10, 2008, <http://health.usnews.com/articles/health/best-hospitals/2008/07/10/a-walk-in-the-shoes-of-an-er-nurse.html> (“Patients are assessed for urgency from 1 (unconscious or unresponsive) to 5 (sore throat, bruises) based on vital signs, complaints, appearance, and history. Level 1 patients are seen immediately, level 2 within 15 minutes, and the others less quickly. The lowest-ranked patients are shunted to the ‘Blue Zone,’ where they can be given lab tests and medications and sent home within a few hours.”).

ers, and properly conducted triage is a legally accepted feature of the standard of care.<sup>47</sup>

When the large number of ED patients seeking care makes it impossible to treat patients in a timely manner, even with properly conducted triage, the next logical step is to reduce the number of incoming patients by diverting ambulances.<sup>48</sup> Conceptually, diversion temporarily “closes” the ED’s doors to ambulances. In practice, diversion is an announcement made to ambulances about the status of emergency medical resources at a particular hospital. Some hospitals divert selectively, redirecting patients from an ED not because the ED is crowded, but because the patient en route is likely to need an ancillary facility or service (e.g., an MRI or a neurosurgical team) that is already fully in use and so unavailable.<sup>49</sup>

Diversion and triage share a common logic: upon reaching capacity, hospitals replace a first-come-first-served allocation of care with one that assigns available resources based on urgency of need. However, whereas an ED can be held legally responsible for the medical consequences of triage decisions,<sup>50</sup> a hospital is generally *not* responsible for the effects of its decision to divert ambulances.<sup>51</sup> Specifically, diverting may lengthen some patients’ ambulance travel times, increase opportunities for ambulance traffic accidents, interrupt continuity of care,<sup>52</sup> and reduce ambulance crews’ availability to transport

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47. Courts approach triage decisions much as they approach other medical decisions in general. *See, e.g.*, *South Fulton Med. Ctr. v. Poe*, 480 S.E.2d 40, 43–46 (Ga. Ct. App. 1996) (ruling against a nurse for a triage error using the same procedural and substantive approach as any other medical malpractice inquiry). In *Poe*, the majority rested its decision on the causal link between the decision of nurse “Gunnin [to classify] the baby as a ‘Priority 3,’ denoting that medical care would be required within eight hours, and the [fact that the] baby actually died during that time.” *Id.* at 110. The dissent, noting that the parents left the hospital before being seen by a physician, believed that the nurse’s triage classification was not the proximate cause of the baby’s death. *Id.* at 112–13 (Andrews, J., dissenting).

48. *See, e.g.*, BASIC LIFE SUPPORT POLICIES 20 (S. Tier Reg’l EMS Council & Emergency Advisory Comm. 1999) (on file with the NYU Journal of Legislation and Public Policy) (“A hospital is considered to be on diversion status when the hospital determines that its Emergency Department is operating at capacity AND that the acceptance of an additional patient may endanger the life of that patient or the patient(s) already present in the Emergency Department.”).

49. Such selectivity can be required, permitted, or prohibited, depending on the jurisdiction. *See infra* Part I.C.

50. *See, e.g.*, *Poe*, 380 S.E.2d at 42–44.

51. *See infra* Part II.

52. The term “continuity of care” refers to the features characteristic of an ongoing rather than a new treatment relationship between patient and doctor/facility. Those features would include easy access to medical records and additional anecdotal knowledge of medical history.

additional patients<sup>53</sup>—but the law gives a patient injured by diversion-related delay little means to challenge the decision to divert.

### C. EMS Systems: Home to a Variety of Diversion Policies

An EMS system is comprised of medical providers who operate on and off the hospital property, and who treat patients under the medical oversight of hospital-based physicians.<sup>54</sup> EMS “pre-hospital” providers include: first responders (police and firemen), paramedics, basic and advanced life support personnel, dispatchers, and the physicians who are designated as “medical command” for an EMS region. These providers are linked to one another and to regional hospitals by communications equipment, command hierarchies, and state and local laws and regulations.<sup>55</sup>

EMS operations have grown steadily since the inception of EMS systems in the 1970s,<sup>56</sup> and today every state in the United States is home to at least one EMS system.<sup>57</sup> However, a unitary diversion policy has yet to materialize. The fluctuation in federal support for EMS systems<sup>58</sup> and the variance among EMS systems in terms of or-

53. See Marc Eckstein & Linda S. Chan, *The Effect of Emergency Department Crowding on Paramedic Ambulance Availability*, 43 ANNALS EMERGENCY MED. 100, 103–04 (2004) (finding a significant correlation between hours of ambulance diversion and hours during which ambulances were out-of-service to answer additional calls in L.A. County); Delbridge & Yealy, *supra* note 3, at 304.

54. See ESSENTIALS OF EMERGENCY MEDICINE, 18–19 (Richard Aghababian, ed. 2006); INSTITUTE OF MEDICINE, EMERGENCY MEDICAL SERVICES: AT THE CROSSROADS 119 (2007) [hereinafter IOM, EMS].

55. *Id.* at 15, 119.

56. “Recent estimates indicate that more than 15,000 EMS systems and upwards of 800,000 EMS personnel (emergency medical technicians [EMTs] and paramedics) respond to more than 16 million transport calls annually.” *Id.* at 15 (alteration in original).

57. Nat’l Ass’n of State EMS Officials, State EMS Agencies, <http://www.nasemso.org/About/StateEMSAgencies/> (“Each state and territory in the United States has a lead Emergency Medical Services (EMS) agency.”).

58. Federal support for the creation of state-level EMS systems began with the National Highway Safety Act of 1966, 23 U.S.C. § 401 (2006), and continued with the EMS Systems Act of 1973, 42 U.S.C. § 300d (2006). The Department of Health Education and Welfare’s EMS grant program was eliminated in 1981 and more limited funding for EMS systems was made available to states in the form of block grants. IOM, HOSPITAL-BASED EMERGENCY CARE, *supra* note 3, at 355. Federal leadership and substantial funding have been partial and inconsistent ever since. For instance, the Trauma Care Systems Planning and Development Act of 1990 created funding to support adoption by states of a Model Trauma Care System Plan, but the Act went unfunded from 1995–2000. NAT’L HIGHWAY TRAFFIC SAFETY ADMIN., TRAUMA AGENDA FOR THE FUTURE, Appendix B, <http://www.nhtsa.dot.gov/people/injury/ems/emstraumasystem03/appendices-b.htm>. The exception to this sporadic support has been the politically robust EMS for Children program, established in

ganization, staffing, financing, and oversight<sup>59</sup> have led to a diversity of diversion policies, discussed below.

In recent years, practitioners and researchers have increasingly recognized that regional quality of care is poorly served by fragmented and ad hoc diversion policies.<sup>60</sup> In 2000, New York State's Commissioner of Health wrote, "diversion alone is not an effective solution to overcrowding. Hospitals must take steps to develop meaningful solutions to address these issues. Collaboration between hospitals and the pre-hospital providers is necessary."<sup>61</sup> A study of Baltimore-area hospitals provides support for this statement, finding that when multiple EDs are simultaneously on diversion, only twenty-three percent of patients en route to a diverting hospital were actually transported to an alternate hospital.<sup>62</sup> Several studies have confirmed the finding that diversion of ambulances from one ED often pushes other hospitals' EDs to divert as well,<sup>63</sup> supporting the conclusion that diversion decisions taken independently by individual hospitals are not effective for controlling regional demand for ED services and do

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1984. Am. C. of Emergency Physicians, *The Federal EMSC Program Initiative*, <http://www.acep.org/practres.aspx?id=33628> (last visited Dec. 19, 2008).

59. See IOM, EMS, *supra* note 54, at 31; ELLEN J. MACKENZIE & ANTHONY R. CARLINI, CONFIGURATIONS OF EMS SYSTEMS: A PILOT STUDY 10 (2008); Kuehl & Baker, *supra* note 1 at 304 ("Medical oversight models are as diverse as the systems they serve.").

60. See, e.g., L.A. Weichenthal et al., *The Impact of Suspension of Diversion on an Emergency Medical Service System*, 52 ANNALS EMERGENCY MED. S70, S70 (2008) (concluding from examination of a cessation of diversion in a particular region that "diversion does not help with the problems of ED crowding while negatively impacting the efficiency of out-of-hospital care providers"). In 2005, the National Association of State Emergency Medical Services Officials called upon the American Hospital Association and the Institute of Medicine to "work collaboratively to eliminate the practice of ambulance diversion . . ." NAT'L ASS'N OF STATE EMERGENCY MED. SYS. OFFICIALS, RESOLUTION 2005-02: DIVERSION AND TRANSFER OF PATIENT CARE (2008) <http://www.nasemso.org/Advocacy/PositionsResolutions/documents/Resolution2005-2.pdf>.

61. Letter from Antonia C. Novello, Comm'r, N.Y. State Dep't of Health, to N.Y. Hosp. Adm'rs (Dec. 11, 2000), <http://www.health.state.ny.us/press/releases/2001/edoverletter.htm>.

62. Melissa L. McCarthy et al., *Likelihood of Reroute During Ambulance Diversion Periods in Central Maryland*, 11 PREHOSPITAL EMERGENCY CARE 408, 413 (2007). Other studies have found different numbers for trauma patients, based, in part, on more straightforward prehospital trauma protocols and the high priority of trauma patients. See *id.*

63. See, e.g., Gary M. Vilke et al., *Approach to Decreasing Emergency Department Ambulance Diversion Hours*, 26 J. EMERGENCY MED. 189, 190-91 (2004) (finding that: (1) diversion in an ED was predicted by diversion at a neighboring hospital, and (2) delaying diversion at one ED reduced the frequency of diversion at neighboring EDs).

not reliably support the delivery of high quality emergency medical care.

Even if there is agreement that inconsistent diversion protocols make for bad regional policy, formulating a *good* regional policy means overcoming several large hurdles, beginning with the lack of relevant data comparing different approaches. Although organizations like the National Association of EMS Physicians (NAEMSP) publish position papers on how to construct diversion policies,<sup>64</sup> no set of guidelines serves as a national standard.<sup>65</sup> The current diversity among diversion policies is profound. The features that differ across jurisdictions include: (i) the authority assigned to actors involved; (ii) the mechanics of substantive and procedural requirements for decision makers; and (iii) the view taken of hospitals, either as monoliths or as assemblages of departments.

### 1. Authority

Who has the authority to make decisions about diverting ambulances, and how much leeway do the rules allow? These questions highlight one of the fault lines in the topography of diversion policies. Some states assign authority for policy formulation, implementation, and oversight to a state-level department of health.<sup>66</sup> Others delegate these roles to regional governmental authorities<sup>67</sup> or quasi-governmental organizations.<sup>68</sup> Most policies recognize concurrent authorities.<sup>69</sup>

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64. Cai Glushak et al., *Position Paper: Ambulance Diversion*, 1 Prehospital Emergency Care 100, 100–02 (1995), available at <http://www.naemsp.org/position.html> (click on “ambulance diversion”).

65. However, in 1991 (revised in 1999), the American College of Emergency Physicians released a policy statement regarding ambulance diversions, which may suggest a framework for a national policy. See generally, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (ACEP) AMBULANCE DIVERSION (reaff’d Oct. 2006), <http://www.acep.org/practres.aspx?id=29080>.

66. The Maryland and Massachusetts state governments are unusual for their high level of involvement in managing the EMS and trauma systems that govern, among other things, how ambulances are diverted. In Massachusetts, the State Department of Health recently redefined diversion policy for all Massachusetts EDs. Circular Letter from John Auerbach, Comm’r, and Paul Dreyer, Dir., The Commonwealth of Massachusetts Executive Office of Health and Human Servs., Dep’t of Pub. Health, to Chief Executive Officers, Mass. Acute Care Hosps. (July 3, 2008), [http://www.mass.gov/Eoohs2/docs/dph/quality/hcq\\_circular\\_letters/hospital\\_general\\_0807494.pdf](http://www.mass.gov/Eoohs2/docs/dph/quality/hcq_circular_letters/hospital_general_0807494.pdf).

67. Several of California’s counties elaborate on the state’s ambulance destination guidelines. See, e.g., NATASHA MIHAL & RENEE MOILANEN, REPORT, WHEN EMERGENCY ROOMS CLOSE: AMBULANCE DIVERSION IN THE WEST SAN FERNANDO VALLEY 17 (2005).

68. Kansas City, which spans the Missouri and Kansas border, has assigned implementation and oversight authority for regional diversion policy to the Mid-America Regional Council Emergency Rescue Committee (MARCER). See A COMMUNITY

Diversion policies also centralize authority to varying degrees: for example, while some require an ED Director to document decisions to declare diversion,<sup>70</sup> others require that an ED Director or hospital administrator submit a request to a regional EMS Medical Director.<sup>71</sup> In general, the title of Medical Director designates the physician who has ultimate “medical oversight” authority and responsibility in a given EMS or hospital system.<sup>72</sup> However, a given medical director’s location, institutional affiliations,<sup>73</sup> and scope of responsibility vary.<sup>74</sup> In addition, “[p]olitics and economics are omnipresent forces with which the [EMS] medical director must work as he attempts to craft and manage a prehospital care system.”<sup>75</sup>

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PLAN FOR DIVERSION 1, 3 (Org. & Mgmt. for Hosps. & EMS Agencies for the Greater Kansas City Metropolitan Area rev’d 2007), <http://www.marc.org/emergency/pdfs/diversionplan.pdf>. The plan was first implemented in May of 2002 and was most recently revised in March of 2007. *Id.* at 1.

69. *See, e.g.*, EMERGENCY MEDICAL SERVICES DIVERSION POLICY § 5.1-.2 (Ga. Region Four Emergency Med. Servs. 2001), <http://gaems.net/diversion/Diversion2.htm> (“EMS Directors/Fire Chiefs will be accountable for the overall management and administration of this policy. EMS Medical Directors will be responsible for all medical aspects of this policy.”).

70. *See, e.g.*, GENERAL POLICY AND PROCEDURE: AMBULANCE DIVERSION 1-25a (Washtenaw/Livingston MCA 2000) (“The diverting hospital must inform the EMS Medical Director within five (5) days of the duration and reason for the diversion. The EMS Medical Director will report all diversions to the medical control board.”), <http://www.co.livingston.mi.us/EMS/protocols/1-25.pdf>.

71. *See, e.g.*, AMBULANCE DIVERSION, No. 5700, §§ 3, 4 (Cal. Emergency Med. Servs. Authority (EMSA) 2008) [hereinafter CALIFORNIA EMSA] (giving instructions for “requesting diversion status”).

72. Since the mid-1970s, state EMS laws assigned legal responsibility for an EMS operation to a medical director. This practice has continued through the operational standardization of the medical director’s role, and it is now rare for EMS medical providers to operate without the direct or indirect oversight of a medical director. *See* Kuehl & Baker, *supra* note 1, at 301–02. Kuehl and Baker also point out that multi-person EMS Councils, rather than individual medical directors, sometimes hold some or all oversight authority. *Id.* at 301.

73. “In 40% of [surveyed] systems, [medical director] leadership is provided by a systemwide, in-house medical director who is a physician chosen or hired by the system’s coordinating organization. For another 50% of the systems, medical oversight is provided by an external director who is a physician administering from a remote organization, perhaps based at a local hospital. The percent of systems with a systemwide, in-house medical director is considerably higher for more urban areas and larger systems (52% for large metro areas compared to 26% for completely rural areas, 54% in large systems and 32% in small systems).” MACKENZIE & CARLINI, *supra* note 59, at 8.

74. *See id.* at 41 tbl.20 (measuring different types of responsibility, divided by state); David M. Williams, 2007 JEMS 200 City Survey, J. EMERGENCY MED. SERVS., Feb. 2008, at 48, 61.

75. Norm Dinerman, *Political Realities*, in PREHOSPITAL SYSTEMS AND MEDICAL OVERSIGHT, *supra* note 1, at 431.

## 2. *Mechanics of Diversion*

What procedural requirements must a hospital or ambulance service follow? Some policies require EDs to document a diversion's antecedent causes and duration; those that do generally also call for the regular collection and reporting of data on diversion use from all hospitals in the region.<sup>76</sup> Some jurisdictions limit hospitals' use of diversion to a specified duration.<sup>77</sup> Some jurisdictions authorize partial diversions if a CT scanner or neurosurgeon is not available,<sup>78</sup> while others prohibit such partial diversions.<sup>79</sup> Grounds for overriding a declared diversion can include the condition of the patient;<sup>80</sup> the status of the system;<sup>81</sup> and a patient's stated preference for a destination.<sup>82</sup> Some jurisdictions create categories of individuals whose transport may not be delayed by diversion;<sup>83</sup> others prohibit diversion altogether.<sup>84</sup> Finally, policies also vary in how they constrain a hospital's diversion status based on the diversion status of other hospitals in the region.<sup>85</sup>

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76. See, e.g., DIVERSION AMONG SALT LAKE EMS DISTRICT HOSPITALS, PROTOCOL No. 07 (2008), [http://sandy.utah.gov/fileadmin/downloads/fire/protocols/Protocol\\_No\\_07\\_Hospital\\_Diversion.pdf](http://sandy.utah.gov/fileadmin/downloads/fire/protocols/Protocol_No_07_Hospital_Diversion.pdf).

77. See, e.g., GAO, HOSPITAL EDs, *supra* note 11, at 46 (noting time limits for diversion in 2003 at hospitals in L.A. County, California; Maricopa County, Arizona; and Suffolk County, Massachusetts).

78. See, e.g., CALIFORNIA EMSA, *supra* note 71 § 2.1; HOSPITAL DIVERSION PROTOCOLS 4 (Central Shenandoah EMS Council 2007) (describing a diversion status for when “[a] hospital is unable to handle *certain types* of patients.” (emphasis added)), [http://www.csems.vaems.org/plans/hospital\\_diverson\\_fy2007.pdf](http://www.csems.vaems.org/plans/hospital_diverson_fy2007.pdf).

79. See Casner et al., *supra* note 2, at 876.

80. See GAO, HOSPITAL EDs, *supra* note 11, at 45 app.II; Casner et al., *supra* note 2, at 876.

81. See GAO, HOSPITAL EDs, *supra* note 11, at 45 app.II; Casner et al., *supra* note 2, at 877.

82. See GAO, HOSPITAL EDs, *supra* note 11, at 47 app. II tbl; see also Casner et al., *supra* note 2, at 876–87.

83. See GAO, HOSPITAL EDs, *supra* note 11, at 47 app. II tbl.

84. See Burt et al., *supra* note 12, at 322 (“Approximately 8.8% of hospitals reported state or local laws prohibiting diversion . . .”).

85. See, e.g., UPDATED HOSPITAL DIVERSION GUIDELINES 2 (N.J. Hosp. Ass'n 2001) (“Hospitals located in adjoining regions should (together) try to agree on a reasonable threshold for diversions so that no one hospital becomes swamped with patients.”); AMBULANCE DIVERSION INTERIM POLICY § 3.2 (Riverside County, Cal. Emergency Med. Servs. Agency 2004) (requiring notification of “surrounding hospitals” when starting and terminating diversion); REGIONAL AMBULANCE DIVERSION POLICY 2 § (C)(1)(b) (Southwest Va. Emergency Med. Servs. Council 2008) (“When the entire healthcare system is overloaded, all hospitals should open.”); PREHOSPITAL CARE MANUAL: EMERGENCY DEPARTMENT DIVERSION & TRAUMA CENTER BYPASS § III.G (Santa Clara County, Emergency Med. Servs. Agency 2008) (“When the facility is directed by the Agency and/or County Communications to open/remain open, it shall do so immediately. If facility staff considers the direction inappropriate, they



### 3. *View of a Hospital*

Does the diversion policy treat an ED as separate from the other departments in its parent-hospital, and, if so, to what degree? Whereas some policies view a hospital and ED as a unitary actor that speaks with one voice, other policies require decision makers to seek and act on more comprehensive information about some or all of a hospital's multiple departments. A hospital that relies on information that is more comprehensive may base diversion decisions on the capacity of specific teams or resources; for example, if the neuro-surgical team cannot handle more patients or an MRI scanner is in use.<sup>86</sup>

To illustrate how differences in authority, mechanics, and institutional transparency manifest, consider how the following four regions set the threshold at which an ambulance may override a regional hospital's diversion status. In Iredell County, North Carolina, hospitals have authority to begin, characterize, and terminate their own diversion status, and to determine whether a decision by EMS to override that status should be subject to potentially punitive administrative review.<sup>87</sup> Hennepin County, Minnesota, builds in greater flexibility for EMS personnel and encourages communication between EMS and hospitals in the event of judgment calls.<sup>88</sup> Milwaukee County, Wisconsin, assigns hospitals the authority to determine whether to enter diversion, but the policy itself, rather than the hospital, substantially directs EMS decision making during diversion.<sup>89</sup> Santa Clara County

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may discuss the situation with the Agency during regular business hours; however, additional diversion time shall not be granted.”).

86. See, e.g., AMBULANCE DIVERSION POLICY, No. 5400, 2–3 (Marin County Dep't of Health & Human Servs. 2009), <http://www.co.marin.ca.us/depts/HH/main/ems/documents/Policies/5400.pdf>. More probing policies might permit/require status updates on: (i) specialty care departments (e.g., burn units, trauma units); (ii) regional heart attack or stroke treatment units; and (iii) neurosurgical staff and facilities.

87. See AMBULANCE DIVERSION POLICY Procedure 7 (Iredell County Emergency Med. Serv. 2007) (“EMS personnel may override a hospital's diversion status only if bypassing a facility on diversion will jeopardize a patient's condition. Any decision to override will be automatically subject to internal administrative and medical review and will be forwarded the Quality Management Committee for review also.”), [http://www.iredellems.com/protocols/employees/ICEMS%20Protocol%20Web/Administrative%20Pages/ambulance\\_diversion\\_policy.htm](http://www.iredellems.com/protocols/employees/ICEMS%20Protocol%20Web/Administrative%20Pages/ambulance_diversion_policy.htm).

88. See AMBULANCE DIVERSION POLICY 3 (Hennepin County EMS System 2006) (“A hospital, regardless of its closed status, agrees to care for any patient when the ambulance provider determines that it is the most appropriate transport destination.”) (on file with the NYU Journal of Legislation and Public Policy).

89. See DIVERSION SYSTEM USER POLICY 1 (Milwaukee County Emergency Med. Serv. 2008) (“Four, and only four, exceptions to the diversion status are acceptable allowing [sic] ambulance transport to a hospital on ‘Divert’: (1) Specialty hospitals never close to their specialty (i.e., burns, pediatrics, etc.) (2) Hospitals never close to women in labor if that hospital is the closest most appropriate destination (i.e., patient

(similarly to Hennepin County) requires hospitals to specify which departments will not accept more patients, and to delegate decision making authority to EMS personnel.<sup>90</sup>

Policy choices like these may be informed by the geographic arrangement of a region's hospitals (greater distances between hospitals argue for lower override thresholds), by stakeholders' preferences and relative negotiating positions, or by some combination of these and other factors.<sup>91</sup> Whatever their origins, the comparative outcomes of these diverse policies are understudied<sup>92</sup> and remain largely opaque to policymakers.

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received prenatal care there) (3) A patient is a direct admit (4) A pre-arranged transport following EMTALA guidelines (i.e., patient recently discharged from that hospital or patient coming from an affiliated clinic site.”), [http://www.county.milwaukee.gov/ImageLibrary/User/jspitzer/Diversion\\_Policy\\_Users\\_update\\_March\\_26\\_2008.pdf](http://www.county.milwaukee.gov/ImageLibrary/User/jspitzer/Diversion_Policy_Users_update_March_26_2008.pdf).

90. PREHOSPITAL CARE MANUAL: EMERGENCY DEPARTMENT DIVERSION & TRAUMA CENTER BYPASS 6 § VI.B (Santa Clara County Emergency Med. Servs. Agency, 2008) (“The Trauma Center must identify which of the following limitations are in effect. 1. No available operating rooms, or: 2. No Neurosurgery. Advanced Life Support personnel (flight crews and paramedics) shall consider the specific type of service limitation and may either (1) continue transport to the destination or (2) bypass the facility and go to the next closest and most appropriate Trauma Center.”), [http://www.sccgov.org/SCC/docs/Emergency%20Medical%20Services%20\(DEP\)/attachments/8.21.07%20Policy%20603%20Open%20Comment%20Period.pdf](http://www.sccgov.org/SCC/docs/Emergency%20Medical%20Services%20(DEP)/attachments/8.21.07%20Policy%20603%20Open%20Comment%20Period.pdf).

91. In situations where geographic circumstances and EMS policies give ambulance crews flexibility to choose among a region's hospitals, hospital staff will often seek to curry favor by working to shorten ambulance turnaround times in the ED, by facilitating reimbursement filings or by making available hospital supplies for free. Interview with Cathy Boyne, *supra* note 39. Such ingratiating practices must stop short of what the law views as a “kick-back arrangement.” See Dep't of Health and Human Servs., OIG Advisory Opinion No. 07-02, 1–2 (March 2007) (describing a would-be arrangement between a hospital and ambulance service as violating Medicare anti-kickback provisions, 42 U.S.C. §§ 1128(b), 1128A(a) (2006)).

92. IOM, EMS, *supra* note 54, at 208 (“Policy makers and experts in the field have long recognized the paucity of information relating to EMS . . . .”); see also Nat'l EMS Research Agenda Writing Team, *National EMS Research Agenda*, 6 PREHOSPITAL EMERGENCY CARE, July/Sept. 2002, at S1, S1 (Supp. 3) (“Despite more than 30 years of dedicated service by thousands of EMS professionals, academic researchers, and public policy makers, the nation's EMS system is treating victims of illness and injury with little or no evidence that the care they provide is optimal.”); Theodore R. Delbridge et al., *EMS Agenda For the Future: Where We Are . . . Where We Want to Be*, 31 ANN. EMERGENCY MED. 251, 251 (1998) ([I]nitial EMS growth began with a lack of knowledge of the most efficient processes . . . .”). But see Nat'l EMS Info. Sys. (NEMSIS) Technical Assistance Ctr., *History of NEMSIS*, (outlining efforts to study EMS systems since 1973, culminating with the creation of a national EMS database), <http://www.nemsis.org/theProject/historyofNemsis.html>.

## II.

HOW EXISTING LAWS REGULATE (OR NEGLECT TO  
REGULATE) AMBULANCE DIVERSION

This section discusses the key federal and state laws that govern how hospitals and EMS actors may employ ambulance diversion to resolve the problem of crowding. While there is no statutory right to healthcare in the United States, the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA)<sup>93</sup> creates a legal obligation to provide *emergency* medical care, regardless of the ability to pay. EMTALA was passed “to combat the problem of ‘patient dumping;’ . . . the practice of transferring or discharging indigent or non-insured patients while their emergency conditions worsen.”<sup>94</sup> The law’s political impetus drew on stories<sup>95</sup> of hospital administrators and staff who, upon finding that a patient could not pay for medical services, refused to admit that patient, forced that patient to leave, or shunted that patient onto a (typically less well-equipped) public hospital.<sup>96</sup> Even though EMTALA stipulates that EDs may not engage in “patient dumping,” it does not effectively protect against hospitals improperly diverting patients so long as they follow procedure. This section argues that the combination of EMTALA and state tort law creates a gap in legal coverage precisely where diversions occur, such that patients injured by diversion lack recourse for that injury.

EMTALA’s most difficult task is to define its own scope, that is, to draw the line beyond which a hospital may lawfully ignore a patient in medical distress. Responding to criticisms of the law’s vagueness about that boundary, the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS)

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93. Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, § 9121(b), 100 Stat. 151 (codified at 42 U.S.C. § 1395dd (2006)). EMTALA was the initial name of the Act whose provisions came to be adopted with COBRA. Those provisions were spurred in part by a *60 Minutes* expose of for-profit hospitals’ commonplace practice of “dumping” (by refusal or transfer) indigent patients in order to avoid the cost of their care. See 131 Cong. Rec. 28,568 (1985) (statement of Sen. Durenberger).

94. *Lewellen v. Schneck Med. Ctr.*, No. 4:05-cv-0083-JDT-WGH, 2007 WL 2363384, at \*16 (S.D. Ind. 2007) (summarizing purpose of EMTALA).

95. David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29, 32–33 (1998); see also Robert Reinhold, *Treating an Outbreak of Patient Dumping in Texas*, N.Y. TIMES, May 25, 1986, at A4 (describing the problems of dumping in Texas).

96. See, e.g., Hyman, *supra* note 95, at 34–36 (describing a version of the classic tale of patient dumping); Robert Reinhold, *Treating an Outbreak of Patient Dumping in Texas*, N.Y. TIMES, May 25, 1986, § 4 at 4.

promulgated regulations<sup>97</sup> to clarify the boundary-defining provisions of the law. These regulations recognize a hospital's declaration of "diversionary status" as lawful, despite the general mandate that an ED must see all incoming patients. The logic of that exception is simple: if the arrival of another patient would cause an ED to exceed its useful capacity, then accepting more patients could *endanger* those additional patients. However, the exception for diversionary status is only partial: if a hospital is in "diversionary status" but an ambulance shows up anyway, the hospital must treat the arriving patient like any other.<sup>98</sup> In short, EMTALA creates a hole in the financial dike of U.S. healthcare, and diverting ambulances provides a partial and intermittent plug.

#### A. EMTALA's Relevant Legal Provisions<sup>99</sup>

Until the 1970s,<sup>100</sup> the legal principle of "no duty of care" protected medical providers from liability for refusing to care for a would-be patient.<sup>101</sup> The trend away from this premise began with the Hill-Burton Act of 1946,<sup>102</sup> under which a hospital is considered a "public service enterprise," that "should not be permitted to withhold its services arbitrarily."<sup>103</sup> That notion of public service was galva-

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97. *E.g.*, Special Responsibilities of Medicare Hospitals in Emergency Cases, 42 C.F.R. § 489.24 (2009).

98. *Id.*

99. EMTALA addresses emergency medical conditions as well as labor and childbirth. However, their substantive differences are generally not relevant to the issues of ambulance diversion, and this section refers only to the provisions dealing with emergency medical conditions.

100. See RAND E. ROSENBLATT, ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 64–65 (1997) (discussing successful efforts in the 1970s to expand access to hospitals); Sara Rosenbaum & Brian Kamoie, *Finding a Way Through the Hospital Door*, 31 J.L. MED. & ETHICS 590, 591 (2003) (noting more aggressive enforcement of laws relating to hospital access circa 1975).

101. See, *e.g.*, *Hurley v. Eddingfield*, 59 N.E. 1058 (Ind. 1901) (holding not liable a doctor who refused to undertake care of a patient who indicated reliance on that doctor).

102. Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (codified at 42 U.S.C. § 291 (2006)). Hill-Burton made available federal grants for hospital construction, but conditioned receipt of those grants on hospitals' undertaking to provide 20 years of charity care, 42 C.F.R. 53.111(a) (2009), and, for the duration of their existence, compliance with the "community service obligation" to make services available to all local residents. 42 U.S.C. § 291c(e) (2006).

103. *Payton v. Weaver*, 131 Cal. App. 3d 38, 47 (Cal. App. 1st Dist. 1982). This notion also appears in the logic that entitles a hospital to tax exempt status so long as that hospital maintains an ED in which all emergency patients are treated, regardless of their ability to pay. See *E. Ky. Welfare Rights Org. v. Simon*, 506 F.2d 1278, 1289 (D.C. Cir. 1974), *vacated on other grounds*, 426 U.S. 26, 30 (1976).

nized into more formal operative provisions when, in 1986, the passage of EMTALA forced ED doors open to all incoming patients.<sup>104</sup>

One of EMTALA's central features is its imposition of a legal duty on hospital EDs to provide "appropriate medical screening" and "stabilizing" treatment to any care-seeking individual.<sup>105</sup> Specifically, EMTALA directs the following:

[I]f any individual . . . comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition . . . exists.<sup>106</sup>

Since EMTALA's passage, courts and HHS have made several efforts to specify precisely what "comes to the emergency department" means. Defining the class of EMTALA-bound hospitals has been relatively easy: the current regulations, issued in 2003, impose EMTALA duties on any Medicare-participating hospital with an operationally defined "dedicated ED."<sup>107</sup> It has been more difficult, however, to

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104. Congress, which had to find Constitutional footing for its intercession in states' police powers, grounded EMTALA in the Spending Power granted by the U.S. Constitution, art. I § 8, cl. 1. Formally, therefore, EMTALA merely adds conditions to participation in Medicare, and does not pertain to hospitals that do not seek reimbursement for treatment of Medicare beneficiaries. However, practically all hospitals with an ED participate in Medicare, making EMTALA broadly applicable. See Ctrs. for Medicare & Medicaid Servs., *Certification and Compliance: Hospitals* ("A hospital accredited by the Joint Commission or AOA is deemed to meet all Medicare requirements for hospitals."), [http://www.cms.hhs.gov/CertificationandCompliance/08\\_Hospitals.asp](http://www.cms.hhs.gov/CertificationandCompliance/08_Hospitals.asp) (last updated Sept. 8, 2009).

105. Although EMTALA's statutory provisions focus on full-service hospitals, a 1989 legislative revision, Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106 (1989), and more recent regulations, promulgated in 2008, have clarified that hospitals with "specialized capabilities or facilities . . . shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities . . . regardless of whether the hospital has a dedicated emergency department." Medicare Program, 73 Fed. Reg. 48,434, 48,758 (Aug. 19, 2008), (codified at 42 C.F.R. § 489.24(f)(1)). The text further states that "once the individual was admitted, admission only impacted the EMTALA obligation of the hospital where the individual first presented." *Id.* at 48,656. This rule relates primarily to transfer patients, because most people seeking emergency care do not go to a hospital without a dedicated emergency department.

106. 42 U.S.C. § 1395dd(a) (2006) (emphasis added).

107. "Dedicated emergency department means 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 . . . as an emergency room or emergency department; (2) It is held out to the public . . . 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 . . . based on a represen-

define the geographic boundary beyond which such a hospital may lawfully ignore individuals in medical distress. EMTALA's regulations make hospital property the proxy for that border,<sup>108</sup> such that a patient seeking emergency care "comes to the ED" when that patient comes within 250 yards of any medical facility owned by a hospital with a dedicated ED.<sup>109</sup>

While the real property-based line provides a clear rule for most hospital actors, for other actors it remains hazy. In the past two decades, three courts and two regulatory rulemakings have wrestled with how to apply that rule to communications systems, which span the property-based line, and to ambulances, which traverse it constantly. EMTALA's relevance to these entities was largely unexplored until 1990, when Emerald Johnson's two-month-old daughter died after a dispatcher redirected her ambulance away from the University of Chicago's Hospital (UCH) to Cook County Hospital.<sup>110</sup> UCH's ED was fully open, but the hospital was in "partial bypass" owing to lack of available beds in the pediatric intensive care unit.<sup>111</sup> The Federal District Court determined that Ms. Johnson's daughter, whose ambulance never arrived on UCH property, had never "come to" UCH's ED, and so dismissed Ms. Johnson's EMTALA-based claim.<sup>112</sup> The Seventh Circuit panel that heard Johnson's appeal waffled in its decision<sup>113</sup> and delivered an ambivalent holding. On the one hand, Johnson's daughter, who had sought medical assistance through telemetry communications and paramedic services, was held never to have "come

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tative sample of patient visits . . . it provides at least one-third of all of its outpatient visits for treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment." Special Responsibilities of Medicare Hospitals in Emergency Cases, 42 C.F.R. § 489.24(b) (2009).

108. *See id.*

109. 42 C.F.R. § 489.24(b)(2)(ii).

110. *See Johnson v. Univ. of Chicago Hosp.*, 774 F. Supp. 510, 510 (N.D. Ill. 1991), *aff'd in part, rev'd in part*, No. 91-3587, 1992 U.S. App. LEXIS 25096 (7th Cir. 1992). *aff'd in part, rev'd in part*, 982 F.2d 230 (7th Cir. 1992), *amended by* No. 91-3587, 1993 U.S. App. LEXIS 5618 (7th Cir. 1993).

111. *Johnson*, 982 F.2d at 231.

112. *Johnson*, 774 F. Supp. at 513.

113. The panel initially reversed the District Court's determination 1992 U.S. App. LEXIS 25096, at \*11 ("Although [EMTALA] refers to individuals who come to the hospital, we agree . . . that an individual can seek medical assistance from a hospital through telemetry communications and paramedic services without coming to the hospital's emergency room."). Then, within two months, the Court of Appeals adopted the reasoning and conclusions of the dissent as better reflecting "the plain meaning of the statutory language." *Johnson*, 982 F.2d at 233. This reversal provides a subtle signal as to the potential for confusion over how EMTALA should be read to direct prehospital actors in situations when the hospital and prehospital system are substantially integrated.

to” UCH.<sup>114</sup> On the other hand, the Court also noted that “a hospital could conceivably use a telemetry system in a scheme to dump patients,” and “[i]f and when this issue is properly before us, the language and intent of the statute will have to be examined again.”<sup>115</sup>

HHS effectively codified *Johnson*’s ambivalent holding with a 1994 rulemaking that applied the property proxy to ambulances.<sup>116</sup> Under this rule, an individual who gets into a hospital-owned and operated ambulance thereby comes to that hospital’s ED,<sup>117</sup> whereas an individual who gets into an ambulance not owned or not operated by the destination hospital does not come to the ED until arriving on that hospital’s real property. In the latter case, “[a]n individual . . . 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.”<sup>118</sup> Had the rule stopped there, it would be clear enough, but HHS went on to add the following qualification: “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.”<sup>119</sup> Crucially, the rule offers no further definition of “diversion.”

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114. *Johnson*, 982 F.2d at 233. Notably, the panel still found for Ms. Johnson, but it did so without relying on a duty created by EMTALA. Instead, the panel concluded that the hospital had undertaken to care for Johnson’s daughter before turning her away, thereby breaching a duty imposed by state tort law. *Id.* at 232 (“Under Illinois law, liability can arise from the negligent performance of a voluntary undertaking. Johnson’s claim falls squarely under this rule.”) (citations omitted).

115. *Id.* at 233 n.7. The Illinois Department of Health responded to the *Johnson* holding by making two changes to the state’s EMS protocols. The Department (1) prohibited a hospital from declaring diversion status based on overcrowding in any non-ED department if the ED itself was not crowded; and (2) required that all decisions to divert be documented along with a written explanation of how the benefits of the diversion outweighed its potential for harm. Casner et al., *supra* note 2, at 875.

116. Medicare Program; Participation in CHAMPUS and CHAMPVA, Hospital Admissions for Veterans, Discharge Rights Notice, and Hospital Responsibility for Emergency Care, 59 Fed. Reg. 32,086, 32,121 (June 22, 1994) (“[P]roperty includes ambulances owned and operated by the hospital, even if the ambulance is not on hospital grounds.”).

117. 42 C.F.R. § 489.24(b) (2009); *accord* *Madison v. Jefferson Parish Hosp. Serv.* Dist. No. 1, Civ. A. No. 93-2938, 1995 WL 396316, at \*2 (E.D. La. 1995) (finding that one comes to the ED for EMTALA purposes upon placement in ambulance owned and operated by defendant hospital).

118. 42 C.F.R. § 489.24(b) (2009).

119. *Id.* In his dissent in *Arrington v. Wong*, Judge Fernandez of the Ninth Circuit highlighted that this qualification, “rather than adding clarity, adds an ambiguity.” 237 F.3d 1066, 1076 (9th Cir. 2001) (Fernandez, J., dissenting).

The relationship between EMTALA's property-based boundary and ambulances again became the subject of a dispute in *Arrington v. Wong*, a 2001 Ninth Circuit case involving a man whose non-hospital-owned ambulance was directed to a more distant ED as he suffered cardiac arrest.<sup>120</sup> Unlike *Johnson*, the defendant hospital in *Arrington* had not formally entered any sort of diversion status.<sup>121</sup> The *Arrington* court framed the issue as whether a hospital could lawfully divert a patient like *Arrington* to another hospital after notification that he was en route. The court's creative reasoning yielded an expansive interpretation of both EMTALA's "comes to" language and HHS' 1994 rule.<sup>122</sup> The court phrased its holding as follows: once ambulance personnel contact the hospital to announce their imminent arrival, "the hospital may not deny the individual access unless it is on 'diversionary status,' that is, it does not have the staff or facilities to accept any additional emergency patients."<sup>123</sup> This determination divided the Ninth Circuit from other circuits, which continue to hold that a patient riding in a non-hospital-owned ambulance does not come to an ED until arriving on the hospital's campus.

The language of HHS' 2003 rule—when an individual is in a non-hospital-owned ambulance, "[t]he hospital *may* direct the ambulance to another facility if it is in 'diversionary status'"<sup>124</sup>—does not seem to repudiate *Arrington*'s conclusion that "comes to" could mean "approaches" as well as "arrives at." The Agency's response to public comments, however, suggests that HHS meant to reject *Arrington*'s conclusion with its 2003 rule.<sup>125</sup>

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120. *Arrington*, 237 F.3d at 1068.

121. *See id.* at 1073.

122. That reasoning entailed two elements. First, the court stated that "comes to" was ambiguous because it could be read to mean either "arrives at" or "approaches" *Id.* at 1070–71. The court then looked to HHS' rule to clarify the statute's supposedly ambiguous meaning, but read the statement that "the hospital may deny access if it is in 'diversionary status,'" to signify that, *unless* a hospital was on diversion, it could not redirect an en route ambulance via radio. *Id.* at 1076.

123. *Id.* at 1072 (internal quotation marks omitted).

124. 42 C.F.R. § 489.24 (b)(4) (2009) (emphasis added).

125. Specifically, one commenter to the then-proposed 2003 rule "recommended that guidance . . . to the effect that hospitals have no EMTALA obligation with respect to individuals who are in ambulances that are neither hospital-owned and operated nor on hospital property, be incorporated into the regulatory language." Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals With Emergency Medical Conditions, 68 Fed. Reg. 53,222, 53,257 (Sept. 9, 2003). HHS's response was that they "agree that this statement of policy is accurate, but believe the proposed regulatory language makes this clear." *Id.*



Had HHS explicitly stated that radio contact with a non-hospital-owned ambulance does *not* trigger EMTALA duties, it might have prevented a First Circuit panel from recapitulating the *Arrington* position in *Morales v. Sociedad Española* in 2008.<sup>126</sup> The *Morales* court reasoned that “comes to” had an ambiguous meaning,<sup>127</sup> which, in turn, left the majority “to wonder whether, if an individual in a non-hospital-owned ambulance has not yet reached hospital property, a hospital may redirect the individual for virtually any reason (including the individual’s impecuniousness).”<sup>128</sup> The court found no clear answer to this question, either in the 2003 rule discussed above, or in the Guidelines. Having thus freed itself from the language of the statute, rule, and Guidelines, the *Morales* court grounded its expansive holding in EMTALA’s intent:

If a hospital were allowed to turn away an individual while she was en route to the hospital, an uninsured or financially strapped person could be bounced around like a ping-pong ball in search of a willing provider. That result would be antithetic to the core policy on which EMTALA is based.<sup>129</sup>

Currently, in the First and Ninth Circuits, an ambulance en route to a hospital that has made radio contact with ED staff to report its impending arrival “comes to” that hospital’s ED for EMTALA purposes.

What does this nearly twenty-year arc of case law and regulations mean for ambulance diversion under EMTALA? In all jurisdictions, EMTALA requires a hospital to treat an individual once she arrives at the ED, whether it is in diversion status or not,<sup>130</sup> and, in general, HHS regulations provide for some deference to “communitywide” diversion protocols.<sup>131</sup> In the First and Ninth Circuits, the diversionary

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126. The facts confronting the *Morales* court involved an ambulance that contacted a hospital that was not on diversion to warn of their arrival. The doctor who took the call abruptly hung up after the paramedic failed to answer his questions about the woman’s insurance status, and whether she had attempted to induce an abortion; the woman was then treated at a different hospital, and eventually brought suit for harms allegedly arising from the delay in treatment caused by the ambulance’s redirection. *Morales v. Sociedad Espanola de Auxilio Mutuo y Beneficencia*, 524 F.3d 54, 55–56 (1st Cir. 2008).

127. *Id.* at 58.

128. *Id.*

129. *Id.* at 61.

130. One group of experts has summarized the obligation to an arrived ambulance as follows: “The most conservative approach . . . would be to assume that EMTALA applies equally to a patient who is transported to a hospital on diversion, whether expressly or intentionally.” Casner et al., *supra* note 2, at 876.

131. See Medicare Program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. 53,222, 53,256 (Sept. 9, 2003) (“To avoid imposing require-

status defined by such protocols is currently the deciding factor when determining whether a hospital's redirection of an ambulance en route triggers EMTALA liability.<sup>132</sup> In other jurisdictions, because EMTALA's relationship to diversion protocols remains unclear, it is harder to predict the legal status of a non-hospital-owned ambulance that has announced its impending arrival to ED staff. In short, EMTALA, through statutory vagueness and inconsistent treatment by the courts, has failed to create a clear policy for ED admissions and has failed to provide adequate protection for injured patients.

### B. EMTALA Enforcement as a Sieve for Improper Ambulance Diversions

It has been observed that EMTALA is "all stick and no carrot,"<sup>133</sup> but EMTALA is enforced sparingly.<sup>134</sup> Furthermore, because EMTALA preempts state laws that conflict with its terms,<sup>135</sup> its rate of enforcement is not necessarily offset by enforcement activity at the state level.<sup>136</sup> The Act provides for three ways to enforce its provisions. First, any individual who suffers harm or any medical facility

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ments that are inconsistent with local EMS requirements, in the May 9, 2002 proposed rule, we proposed to clarify, at proposed revised § 489.24(b), in paragraph (3) of the definition of 'Comes to the Emergency Department,' an exception to our existing rule requiring EMTALA applicability to hospitals that own and operate ambulances."). The exception states that "an individual in an ambulance owned and operated by the hospital is not considered to have 'come to the hospital's Emergency Department' if . . . (i) The ambulance is operated under communitywide emergency medical services (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 on to hospital property." 42 C.F.R. § 489.24(b)(3) (2009).

132. Some regions beyond the jurisdictions of the First and Ninth Circuits have adopted policies reflective of the *Arrington* and *Morales* holdings. See, e.g., REGIONAL AMBULANCE DIVERSION POLICY § 3(f) (Southwest Va. Emergency Med. Servs. Council, Inc. 2008) ("In-bound EMS units/air medical units may not be redirected to another facility if the hospital is not formally on divert status consistent with these guidelines.").

133. Robert A. Bitterman, *Explaining the EMTALA Paradox*, 40 ANNALS EMERGENCY MED. 470, 471 (2002) (criticizing EMTALA for formalizing the traditional hospital practice of providing charity care to those who cannot pay without providing any support to aid in carrying the resulting burden).

134. See Yeh, *infra* note 142; see also Dana E. Schaffner, *EMTALA: All Bark and No Bite*, 2005 U. ILL. L. REV. 1021, 1028–29 (2005).

135. 42 U.S.C. § 1395dd(f) (2006).

136. Some jurisdictions have supplemental statutes prohibiting discriminatory refusal of hospital admission, but not all of these statutes include penalties, and the penalties they do impose are often nominal. See, e.g., FLA. STAT. ANN. § 395.1041(5) (West 2006); KY. REV. STAT. ANN. § 216B.400 (LexisNexis 2007); LA. REV. STAT. ANN. § 40:2113.4 (2008); UTAH CODE ANN. § 26-8a-501 (2007).

that suffers a financial loss due to an EMTALA violation may bring a civil suit under the Act against the violating hospital in federal court.<sup>137</sup> The EMTALA Technical Advisory Group reported in 2008 that, on average, eighty percent of civil actions are dismissed.<sup>138</sup> Second, the Centers for Medicare and Medicaid Services may terminate a violating hospital's participation in Medicare.<sup>139</sup> Third, HHS's Office of the Inspector General (OIG) may levy a civil monetary penalty on a violating hospital.<sup>140</sup> These provisions provide very little relief, however. HHS OIG reported that less than half of the roughly 400 EMTALA investigations undertaken each year from 1994–1998 confirmed a dumping violation, a tiny fraction of the roughly 97 million ED visits estimated to have occurred in 1999.<sup>141</sup> The numbers for fiscal year 2006 are on the same small order of magnitude: 744 complaints (of which 642 were surveyed) yielded 258 enforcement actions.<sup>142</sup> The low rate of enforcement against instances of improper ambulance diversion is in keeping with this general pattern: amid an estimate of approximately 501,000 ambulances diverted in 2003 alone,<sup>143</sup> OIG has recorded only thirty settlements from instances of the illegal diversion of a patient from an ED.<sup>144</sup>

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137. 42 U.S.C § 1395dd(d)(2) (2005).

138. EMTALA TAG, *supra* note 33, at 149. Observing that civil EMTALA claims are most often brought in order to pad weak cases, the Group recommended constraining the availability of the law's civil suit provision. *Id.* at 149–50.

139. 42 C.F.R. § 489.24(g) (2009). However, “[i]n practice, HCFA does not terminate a hospital's provider agreement if the hospital takes corrective action to prevent future violations.” DEP'T OF HEALTH AND HUMAN SERVS., OFFICE OF INSPECTOR GEN'L, OEI-09-98-00221, EMERGENCY MEDICAL TREATMENT AND LABOR ACT: THE ENFORCEMENT PROCESS 8 (2001) [hereinafter EMTALA: ENFORCEMENT PROCESS].

140. *Id.* § 1395dd(d)(1)(A) (2005).

141. EMTALA: ENFORCEMENT PROCESS, *supra* note 139. A 2001 GAO report on EMTALA made clear that an increase in enforcement actions from 1997–98 did not indicate a break with this pattern. GAO, EMERGENCY CARE: EMTALA IMPLEMENTATION AND ENFORCEMENT ISSUES, 01-747, at 24 (2001) [hereinafter GAO, EMERGENCY CARE] (“Between 1997 and 1998 there was a dramatic increase in the number of cases settled and the amount of fines collected. From 1995 to 1997, the OIG settled an average of about 16 cases per year and collected about \$997,000 in fines in total. From 1998 to 2000, it settled an average of 55 cases per year and collected about \$4.7 million in fines. According to the OIG, these increases reflected additional OIG staffing that resulted in the elimination of a backlog of cases rather than a surge in confirmed EMTALA violations.”).

142. Charlotte Yeh, CMS Reg'l Adm'r, EMTALA Anti-Dumping Update 5, Mar. 5, 2008, [www.ehcca.com/presentations/unaudio20080305/yeh.ppt](http://www.ehcca.com/presentations/unaudio20080305/yeh.ppt).

143. Burt et al., *supra* note 12, at 322.

144. Enforcement records tabulated from the Department of Health and Human Services. Dep't of Health and Human Servs., Office Inspector Gen'l, EMTALA Patient Dumping Archive, [http://oig.hhs.gov/fraud/enforcement/cmp/patient\\_dumping\\_archive.asp#2003](http://oig.hhs.gov/fraud/enforcement/cmp/patient_dumping_archive.asp#2003) (last visited Dec. 20, 2009).

EMTALA's inefficacy as a filter for improper ambulance diversion is evident not only from this lack of enforcement, but also from Congress and CMS' unwillingness to make EMTALA the basis for any further programmatic response to improper diversion. Ambulance diversion was a focal point of an interrogatory letter sent to CMS by Congressman Henry Waxman in 2007, inquiring after CMS' responses to the effects of ED crowding.<sup>145</sup> CMS' responses suggest that it felt bereft of any direct means under EMTALA with which to ameliorate high rates of ambulance diversion,<sup>146</sup> a view that is technically consistent with federal regulations' partial exception to a hospital's EMTALA duties for "diversionary status." CMS' answer, however, signals that it will not address diversion more directly without pressure from Congress.

*C. Legal Liability for Pre-Hospital Providers Under State Tort Law*

State tort law does not close the diversion-related legal gap left open by EMTALA. State sovereign immunity and Good Samaritan laws generally exempt pre-hospital medical providers and other EMS staff, including dispatchers and medical directors, from liability for harms arising from ordinary negligence in their conduct of pre-hospital duties.<sup>147</sup> To prevail against EMS personnel in court, a plaintiff must show that her injury resulted from an act or omission reflecting

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145. Letter from Rep. Henry Waxman, Chairman, Comm. on Oversight & Gov't Reform, to Leslie V. Norwalk, Acting Adm'r, Ctrs. for Medicare & Medicaid Servs. (June 22, 2007).

146. In April of 2006, CMS debunked the notion that a patient only "comes to" the ED once ED staff relieve the transporting ambulance crew of that patient. *See* Memorandum from Ctrs. for Medicare & Medicaid Servs. Dir. of State Survey and Certification Group to State Survey Agency Dirs., S&C-06-21, (July 13, 2006) (clarifying that the "parking" of patients in the ED hallway without screening or treatment could incur EMTALA liability), [http://www.aaem.org/emtala/emtala\\_cms.pdf](http://www.aaem.org/emtala/emtala_cms.pdf). A subsequent memorandum clarified further that the 2006 memorandum "should not be interpreted to mean that a hospital cannot ever ask Emergency Medical Services (EMS) staff to stay with an individual transported by EMS to the hospital when the hospital does not have the capacity or capability to immediately assume full responsibility for the individual." Memorandum from Ctrs for Medicare & Medicaid Servs. Dir. of State Survey and Certification Group to State Survey Agency Dirs., S&C-07-20 (Apr. 27, 2007), <http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-20.pdf>.

147. Carol J. Shanaberger & Spencer A. Hall, *Legal Issues*, in *PREHOSPITAL SYSTEMS AND MEDICAL OVERSIGHT*, *supra* note 1, at 395, 400. The authors further noted that "[t]he medical profession has had decades to develop standards and predictability in legal rulings involving medical malpractice. However, only recently has a patchwork of legal decisions involving EMS activities solidified sufficiently to provide some predictability." *Id.* at 395.

gross negligence, reckless disregard,<sup>148</sup> or wanton or willful conduct<sup>149</sup>—the threshold varies by jurisdiction, but is always higher than ordinary negligence.<sup>150</sup>

The shielding effect of statutory protections is evident from the types of lawsuits that succeed against EMS defendants. Using 2003–2004 insurance claims as a proxy, a team of researchers construed a taxonomy of successful claims against EMS personnel. In a summary of the article, the editors of the *Annals of Emergency Medicine* commented on the “surprisingly low rate of medical care related claims against EMS providers.”<sup>151</sup> The proportion of claims for injuries arising from “clinical management” (e.g., airway management errors and errors in dosing of medication administered) (twelve percent) was far smaller than the proportions of claims arising from traffic accidents (thirty-seven percent) or “patient handling” (e.g., jostling or bumping a gurney) (thirty-six percent).<sup>152</sup> Empirical studies of the quality of EMS medical care reflect that EMS personnel are fallible.<sup>153</sup> The low rate of successful claims for clinical management despite the occurrence of preventable injury likely owes, at least in part, to legal protections. It follows that a transfer from an ambulance to a hospital ED means shifting into a context of more substantial legal liability for harms arising from negligent conduct by medical care providers.<sup>154</sup>

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148. See, e.g., CONN. GEN. STAT. ANN. § 52-557b (West 2005 & Supp. 2009) (requiring a showing of more than “ordinary negligence”); MICH. COMP. LAWS. ANN. § 333.20965 (West 2001) (requiring “gross negligence or willful misconduct”).

149. See, e.g., OHIO REV. CODE ANN. § 4765.49(B) (West 2004 & Supp. 2009); see also *Johnson v. Univ. of Chicago Hosp.*, 982 F.2d 230, 232 (7th Cir. 1992) (“The immunity provision . . . insulates a telemetry system operator from liability for any activity that does not rise to the level of ‘willful or wanton misconduct.’”); *Mitchell v. Norwalk Area Health Servs.*, No. H-05-002., 2005 WL 2415995, at \*12 (Ohio Ct. App. 6th 2005) (“[T]he question is whether the acts in breaching that standard of care evidence of willful or wanton misconduct.”).

150. James Lockhart, *Causes of Action against Emergency Medical Technician or Emergency Medical Care Service for Improper Response to or Improper Treatment of Medical Emergency*, in 8 CAUSES OF ACTION 2d 415, at 432, § 6 (2008).

151. Henry E. Wang et al., *Tort Claims and Adverse Events in Emergency Medical Services*, 52 ANNALS EMERGENCY MED. 256, 257 (2008).

152. *Id.* at 259 tbl.1.

153. For example, improper airway management is a major cause of preventable death, and has been studied extensively. See Eileen M. Bulger & Ronald V. Maier, *Prehospital Care of the Injured: What’s New*, 87 SURGICAL CLINICS OF N. AM. 37, 38–41 (2007).

154. A key exception is the doctrine of “informed consent,” which states that an ambulance crew may not transport a patient to a destination without that patient’s actual or constructive consent. See *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 269–70 (1990); Jon Belding, *Patient Refusal: What to Do When Medical Treatment and Transport are Rejected*, 31 J. EMERGENCY MED. SERVS. 116, 117 (2006),

The same review of insurance claims also reported that of the eight percent of claims related to “response or transport-related events,” (including delays and “transportation to an inappropriate destination facility”), over seventy percent resulted in death.<sup>155</sup> The sample size (326 claims)<sup>156</sup> of the study is too small to justify a general inference from this proportion, but it bears noting that, of the total deaths in the population of claims (54), one-third (18) resulted from “response or transport-related events” cases<sup>157</sup>—a markedly higher rate than any other category of claim. This highlights the potential for ambulance diversion to create a gap in legal recourse for injured patients: delay has been shown to be a major cause of preventable death and disability,<sup>158</sup> yet EMS providers are largely immune from claims of transport delay owing to diversion. Furthermore, because EMTALA regulations make “diversionary status” the sole express means by which a hospital can legally seek to prevent patients from coming to the ED, if a diversion delays arrival or shunts an uninsured patient onto a less well-equipped hospital, that diverted patient is unlikely to prevail against the hospital in any suit for harms traceable to the diversion.

### III.

#### THE GAP IN LEGAL LIABILITY FOR IMPROPER AMBULANCE DIVERSION

##### A. *Tactical, Strategic, and Inadvertent Causes of Diversion Status*

EMTALA can serve as a check on some profit-driven patient selection tactics. In the First and Ninth Circuits, EMTALA’s enforcement mechanisms have been held to prohibit ED staff from redirecting an ambulance on non-medical grounds without having formally declared diversion.<sup>159</sup> More subtle tactics, however, are less likely to trigger an EMTALA enforcement action. For example, hospitals

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available at [http://www.jems.com/news\\_and\\_articles/articles/Patient\\_Refusal\\_What\\_to\\_do\\_medical\\_treatment.html](http://www.jems.com/news_and_articles/articles/Patient_Refusal_What_to_do_medical_treatment.html).

155. According to the study, there were eighteen deaths out of the twenty-five response or transport events (seventy-two percent). Wang et al., *supra* note 151, at 259 tbl. 2.

156. *Id.* at 258.

157. *Id.* at 259 tbl. 2.

158. See IOM, EMS, *supra* note 54, at 40–41 (“[A] study by the Joint Commission on Accreditation of Healthcare Organizations . . . revealed that more than half of all ‘sentinel’ ED events—defined as ‘an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof—were caused by delayed treatment.’”).

159. See *Morales v. Sociedad Espanola de Auxilio Mutuo y Beneficencia*, 524 F.3d 54, 59 (1st Cir. 2008); *Arrington v. Wong*, 237 F.3d 1066, 1074 (9th Cir. 2001) (find-

might develop an understanding with ambulance crews that leads the crews, based on indicia of a patient's ability to pay, to opt for a given ED without direct instructions from a hospital. Alternatively, doctors at a diverting ED might redirect an ambulance based on improper criteria, but seldom based on criteria reflective of blatantly mercenary logic.<sup>160</sup>

It is harder still to abate strategic uses of diversion that sidestep EMTALA's principle of acceptance of all comers. For example, in the 1990s, Knoxville, Tennessee was home to five hospitals, only one of which was for-profit. In that situation, the for-profit hospital could improve the profitability of its patient mix by reducing the size or capacity of its ED, while increasing the proportion of surgeons relative to its complement of internal medicine doctors.<sup>161</sup> Similarly, if a region is home to a private ambulance service as well as a public EMS system,<sup>162</sup> a hospital's doctors could potentially encourage their patients to avoid the diversion protocol that binds regional EMS ambulances, dispatchers, and EDs by calling a private ambulance company instead of dialing 9-1-1.<sup>163</sup> Both of these approaches select patients to maximize revenue, yet neither violates EMTALA. Finally, the amounts that hospitals charge and are paid for a given treatment vary widely, even in the same region,<sup>164</sup> making the ability to infer a given hospital's incentives vis-à-vis particular patients and treatments virtually impossible until one has access to its detailed financial information.

What is the relative proportion of profit-driven ambulance diversions to diversions motivated by a good faith desire to maintain the quality of care in an overwhelmed ED? Neither the empirical literature nor the last 10 years of EMTALA enforcement data suggest a conclusive answer.

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ing an EMTALA violation where an ED doctor redirected ambulance even though hospital was not in diversion).

160. As it is exceedingly difficult to predict a patient's medical needs remotely, the characteristics of a patient that are predictive of revenue are obscure, if not opaque, to the receiving hospital. Interview with John Ashworth III, Senior Vice President, Network Dev., Univ. of Md. Med. Sys. (Oct. 3, 2008).

161. Interview with Cathy Boyne, *supra* note 39.

162. The use of private ambulance services has become increasingly popular. *See, e.g.,* Richard Perez-Pena, *Not Counting on 911, Companies Hire Private Ambulances*, N.Y. TIMES, July 6, 2003, at 1.13 ("A growing number of big companies in Manhattan are bypassing the 911 system for their medical emergencies, and signing up instead with private ambulance services that hold out the promise—explicitly or not—of better, faster service.").

163. Interview with Cathy Boyne, *supra* note 39.

164. *See generally* Reinhardt, *supra* note 8.

*B. A Diversion Scenario from the Perspective of the Ambulance*

This section illustrates a hypothetical example of diversion and demonstrates that intentional steps by EMS and hospital actors can lead to improper but legally unassailable ambulance diversions.

Consider the following situation. An ambulance arrives to pick up a patient in medical distress. Two trauma centers are in the area, but the ambulance makes the pickup at a location nearer to the center where the patient's doctor has privileges and can therefore easily access the patient's medical records. That hospital is on diversion, however, and notifies the ambulances that its ED is at capacity, though it is not utterly overwhelmed.

In this scenario, there are two basic options available to the ambulance crew: go to the diverting hospital, or go to the non-diverting hospital. The ambulance crew will consider various factors, which may include: (i) the patient's condition (e.g., possible myocardial infarction); (ii) vital signs (e.g., heart rate, blood pressure); (iii) known medical history; (iv) preferred destination; (v) relationship to the doctor/hospital; and (vi) relevant situational factors, such as distance to each hospital, traffic, complement of services and medical staff available, reasons for the crowding that causes the diversion (e.g., flu season versus a multi-vehicle accident), severity of that crowding, and how long it will take for the crew to offload the patient at each hospital (i.e., "turnaround time"). Turnaround time can align or divide the interests of patient and crew. If the diverting hospital is known for asking crews to wait with patients in periods of diversion, then both the crew and the patient might both anticipate being better served by going elsewhere. If the diverting hospital is known for detaining ambulances, but not for delaying patient care, the crew might find its preference at odds with that of the patient.

The variety and potential importance of each of these factors illustrates the complexity of the destination decision,<sup>165</sup> even if deciding between just two options. Numerous sources of justification are available to support arguments in favor of each choice, whether the argument is made before or after the fact. A regional diversion policy can provide some degree of guidance—backed by some degree of sanc-

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165. Experts and practitioners disagree on this point. Compare Casner et al., *supra* note 2, at 874 ("Most [EMS] systems make the assumption that the diverted patient is better off in the back of the ambulance . . . ."), with Leadership Outlook, Crowding and Patient Flow: The Headbone's Connected to the Footbone—and Everything In-between, [http://www.leadershipoutlook.com/ed\\_adminops/index.html](http://www.leadershipoutlook.com/ed_adminops/index.html) (Feb. 15, 2004) ("[A]ny ED, regardless of how stressed, had more resources than did two paramedics on the ambulance.").



tion—for choosing based on all this information. However, as one group of experts observed in 2002, “[w]ith little objective science to guide these rapid decisions, it would be understandable for prehospital decision makers to feel on shaky ground when making [destination] determinations.”<sup>166</sup>

#### IV.

##### PROPOSALS OF HOW TO REDUCE RATES OF IMPROPER AMBULANCE DIVERSION

This section discusses three approaches to reducing rates of ambulance diversion generally, and of improper diversion in particular. The first approach would allocate funding and technical assistance via CMS and/or National Highway Traffic Safety Administration (NHTSA) to states for the purpose of recording and reporting ambulance destination, diversion, and, where feasible, hospital resource utilization. The second would reduce demand for ED services by supporting construction and operation of facilities to substitute for EDs in the provision of non-emergency care. The third would promote intensive integration of intra-hospital departments under a “hospitalist” and of EMS participants under regional medical directors.

##### A. *Data Reporting Infrastructure*

As the Institute of Medicine observed regarding the link between diversion and higher mortality rates, “[n]o agency has sponsored a systematic study to examine this question, and fears of legal liability inhibit candid disclosure of adverse events.”<sup>167</sup> Furthermore, because diversion policies are diverse in their provisions and implementation,<sup>168</sup> it is hard for researchers to show conclusively the extent to which ambulance diversion worsens patient outcomes.<sup>169</sup> By way of

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166. Casner, et al. *supra* note 2, at 874–75.

167. IOM, EMS, *supra* note 54, at 40.

168. *See infra* Part I.C.

169. *See* Edward E. Cornwell, III et al., Emergency Medical Services (EMS) vs Non-EMS Transport of Critically Injured Patients: A Prospective Evaluation, 135 ARCHIVES OF SURGERY 315, 315 (2000). There has also been disagreement among experts about the relationship between diversion and outcomes. *Compare* Julius Cuong Pham et al., The Effects of Ambulance Diversion: A Comprehensive Review, 13 ACAD. EMERGENCY MED. 1220, 1224 (2006) (noting that several studies failed to find a link between ambulance diversion and mortality rates), *with* Linda Green et al., *Ambulance Diversion and Myocardial Infarction Mortality* 13–14 (Colum. Univ. Bus. Sch., 2005) (identifying a statistically significant inverse relationship between city-wide rates of ambulance diversion and probability of surviving a heart attack), available at [http://www1.gsb.columbia.edu/mygsb/faculty/research/pubfiles/1347/Green\\_ambulance.pdf](http://www1.gsb.columbia.edu/mygsb/faculty/research/pubfiles/1347/Green_ambulance.pdf).

response, this proposal seeks to create two products: (i) a prodigious and rigorous data set; and (ii) an event-tracking and reporting infrastructure in every state that can support quality control and enforcement initiatives. Better information would enable better critiques of why and how hospitals conduct ambulance diversions—improving upon this Note’s view, for instance, which necessarily relies on anecdotes<sup>170</sup> and inferences from recent trends in hospital capacity and revenue.<sup>171</sup> Better information would also supply researchers and regulatory investigators with the specific and relevant data they need in order to identify opportunities for improvement, remediation, or proactive enforcement. NHTSA’s *EMS Research Agenda* has supported efforts to shed light on causes and effects in EMS systems since 2002,<sup>172</sup> but the *Agenda* is less specific and less ambitious than this Note’s proposed effort, which would set as its goal the widespread, if not comprehensive, tracking of ambulance destination and diversion events.

The following provides an example of how such an infrastructure might look. Any combination of CMS, HHS, and the NHTSA would provide funding. The responsible federal agency would then draft a request for proposal (RFP) for submission to state governments, describing parameters for data collection and qualifications for project staff. Only proposals suggesting that the state-run program would produce high quality, accurate, and usable data and proposals from regional governments would be accepted. Those accepted proposals would receive federal funding for variable costs, such as staff time. Continued funding beyond the six- and eighteen-month marks could be made conditional on meeting standards in a periodic program review. Technical assistance would be available from a small team of federal staff or seconded members of the NHTSA EMS Research

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170. See, e.g., *People v. Ford*, N.Y.L.J., Dec. 5, 1989, p. 1, col. 1 (N.Y. Sup. Ct. 1989); *People v. Flushing Hosp. & Med. Ctr.*, 471 N.Y.S. 2d 745, 750–51 (N.Y. Crim. Ct. 1983); Tami Abdollah, *Suit Accuses Kaiser of Blackballing; Nursing Assistant Says She Hasn’t Been Able to Get Work Since Aiding a Patient-Dumping Probe*, L.A. TIMES, Jan. 13, 2007, at B8; Ronald Sullivan, *Diversion of Ambulance Cited in Patient’s Death*, N.Y. TIMES, May 26, 1982, at B1; U.S. Dep’t of Health & Human Servs., Office of Inspector Gen’l, Patient Dumping: Emergency Medical Treatment and Active Labor Act, [http://www.oig.hhs.gov/fraud/enforcement/cmp/patient\\_dumping.asp](http://www.oig.hhs.gov/fraud/enforcement/cmp/patient_dumping.asp) (last visited Dec. 20, 2009).

171. See *supra* note 8 and *supra* Part I. Another indication is the recent trend of hospitals suing patients for unpaid fees. The Baltimore Sun recently ran a three-part series on hospitals that sue patients for unpaid hospital bills, finding that “[Maryland] hospitals filed more than 132,000 of these suits in the past five years, winning at least \$100 million in judgments.” Fred Schulte & James Drew, *In Their Debt / Part One of Three*, BALT. SUN, Dec. 21, 2008, at 1A.

172. See generally Nat’l EMS Research Agenda Writing Team *supra* note 92.

Agenda team. The period of federal funding would cease after three years, at which time a state could choose to take over the project, or to seek further partial federal support for further development of a sustainable and effective program.

### B. Stem Demand for ED Care

EDs in the U.S. are visited heavily by people seeking to avoid the financial or programmatic barriers to care imposed by various health financing instruments.<sup>173</sup> Many visit EDs for all manner of care, including both routine and urgent medical needs; studies estimate that “between 11 and 60% of ambulance transports to an emergency department were not medically necessary.”<sup>174</sup> The AMA Council on Medical Service has suggested that patients with acute (as opposed to emergent) medical conditions would receive superior care at a physician’s office or ambulatory or urgent care center than at an ED.<sup>175</sup> Providing substitutes for ED-based care is an indispensable part of short- and long-term approaches to reducing crowding and diversion.<sup>176</sup> As the AMA Council, among others, has observed, such substitute facilities can be more cost-effective.<sup>177</sup>

Siphoning patients with non-emergency medical needs from EDs is not a novel idea, and it occurs in the U.S. and abroad at the institutional, regional, and national levels. The Ambulance Service of Britain’s National Health Service, for instance, undertook a program in 2006 to train and authorize ambulance-based medical providers to treat some basic and even urgent medical needs in the field rather than retrieving all patients for treatment at a hospital.<sup>178</sup> Some proposals for alternatives to ED-based medical care in the U.S. have generated concrete and successful programs.<sup>179</sup>

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173. See *supra* Figure 2.

174. Matthew C. Gratton et al., *Prospective Determination of Medical Necessity for Ambulance Transport by Paramedics*, 7 PREHOSPITAL EMERGENCY CARE 466, 466 (2003).

175. OVERCROWDING AND HOSPITAL EMS DIVERSION, *supra* note 10, at 8.

176. See, e.g., Christina Stolarz, *Patients Flood Free Health Clinics*, DETROIT NEWS, Dec. 5, 2008, at A1 (describing the essential role of free health clinics in a down economy); Chris Rauber, *Saint Francis Whacks Ambulance Diversions*, S.F. BUS. TIMES, June 11, 2004, <http://sanfrancisco.bizjournals.com/sanfrancisco/stories/2004/06/14/newscolumn2.html> (describing the formation of “a medically supervised detox facility . . . [which] has played a significant role in lowering the ambulance diversion rate”).

177. OVERCROWDING AND HOSPITAL EMS DIVERSION, *supra* note 10, at 8–9.

178. See U.K. DEP’T OF HEALTH, TAKING HEALTHCARE TO THE PATIENT: TRANSFORMING NHS AMBULANCE SERVICES 18–21 (2006).

179. See, e.g., THE LEWIN GROUP, INC. & SAVE OUR ERS, REVISIONING THE DELIVERY OF HEALTH CARE SERVICES TO UNINSURED PATIENTS IN HARRIS COUNTY 4–6

The key difficulty in creating substitute institutions or services, however, is a basic one: doing so would risk formally establishing something like universal health care—a heavily contested idea in the U.S. Although such a policy would likely have salutary effects on ED crowding and on rates of ambulance diversions, the tail of ambulance diversion is too small to wag such a large political dog.

### C. *Improve Coordination Within and Among Provider Organizations*

This proposal focuses on creating and enforcing clear and consistent rules at the hospital and regional levels. Presumably, the reason these objectives have not been adopted is that medical care is provided by freestanding institutions, led by individuals whose performance is assessed in terms of whether one of those institutions succeeds relative to the others. As noted in Part I, however, this lack of integration tends to transform ambulance diversion from a solution into yet another problem for EDs, EMS, and patients. Hospitals, EMS systems, and states should each undertake coordination and enforcement initiatives, starting with the creation of a position responsible for achieving coordination and enforcement goals. This role should be filled by a “hospitalist” for hospitals, a Medical Director for EMS/trauma systems, and a state-level Executive Director for states, counties, and regions. These roles each have their own coordination problems, which are discussed in turn below.

#### 1. *Hospitals and Hospitalists*

By coordinating resources, hospitals can effectively speed up ED throughput. Two separate research teams each report lower rates of diversion following hospital-wide interventions devised to free up non-ED staff and in-patient beds. Each team argues for managing elective surgery schedules in a way that avoids unnecessarily creating resource scarcity during periods of predictably high rates of un-

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(2004) (describing the models implemented by other communities); Rebecca A. Schaefer et al., *An Emergency Medical Services Program of Alternate Destination of Patient Care*, 6 PREHOSPITAL EMERGENCY CARE 309, 312 (2002) (“[A] carefully planned and implemented program of alternate care destinations by EMT personnel for specific low-acuity diagnoses was associated with a 15% relative decrease (51.8% v. 44.6%) in the proportion of patients who received care in the ED when compared with a historical control group . . . .”); Christina Stolarz, *Patients Flood Free Health Clinics*, DETROIT NEWS, Dec. 5, 2008, at A1 (“[S]ome of [the clinics] are funded by partner hospitals, others through private donors or grants . . . .”).

scheduled visits through the ED,<sup>180</sup> an approach recently adopted at Massachusetts General Hospital.<sup>181</sup> Johns Hopkins' Bayview Medical Center recently created a program that it calls "active bed management."<sup>182</sup> That approach makes it the responsibility of a "bed czar" or "air traffic controller for all medical patients"<sup>183</sup> to identify opportunities for more intensive and effective resource utilization,<sup>184</sup> and also grants that bed czar the authority to refer resource conflicts to senior hospital staff.<sup>185</sup>

In sum, this proposal would make higher resource utilization and higher ED throughput hospital-wide goals by assigning a leadership role to the person or persons directly accountable for achieving those goals. However, such integration necessarily takes away some of the autonomy, resources, and authority held by particular departments, and thus requires committed backing by hospital administrators. In addition, because such an undertaking would likely require substantial financial commitment, modest state or federal governmental financial support could be instrumental in enabling its uptake.

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180. Eugene Litvak et al., *Emergency Department Diversion: Causes and Solutions*, 8 *ACAD. EMERGENCY MED.* 1108, 1109 (2001) ([T]he single most important factor contributing to ED diversion is the daily variability in the OR elective surgery caseload.”).

181. See HealthBlawg, *Ambulance Diversions to be Banned in MA*, <http://healthblawg.typepad.com/healthblawg/2008/09/ambulance-diversions-to-be-banned-in-ma.html> (Sept. 23, 2008, 01:45 EST).

182. Eric Howell, et al., *Active Bed Management by Hospitalists and Emergency Department Throughput*, 149 *ANNALS INTERNAL MED.* 804, 808–09 (2008) (identifying a link between Hopkins Bayview's "active bed management" program and improvements in throughput, quality of care, and abated ambulance diversion).

183. See, e.g., Wachter's World, *The Hospitalist as Bed Czar: Indispensability, But At What Cost?*, [http://community.the-hospitalist.org/blogs/wachters\\_world/archive/2008/12/12/the-hospitalist-as-bed-czar-indispensability-but-at-what-cost.aspx](http://community.the-hospitalist.org/blogs/wachters_world/archive/2008/12/12/the-hospitalist-as-bed-czar-indispensability-but-at-what-cost.aspx) (Dec. 12, 2008, 04:17 EST).

184. See, e.g., *id.* (“One hospitalist at a time serves on the ABM service, in 12-hour shifts. During this shift, the hospitalist has no other responsibilities, freeing him or her up to act as a full-time air traffic controller for all medical patients. This involves keeping up to speed on the bed status of all medical, step-down, and intensive care units, “prediversion” round in the ICU, evaluating (by phone or in person) all new admissions, expediting ED-to-floor transfers, and sundry other tasks.”).

185. See, e.g., *id.* (“When all hell breaks loose, the . . . hospitalist notifies the “Bed Manager”—[the Director of Hospital Medicine] or another senior hospitalist leader—who has the authority to activate resources or knock heads to free up beds or expedite transfers.”).

2. *Regional Coordination Under a Medical Director, and Medical Director Coordination Under a State-Level Executive Director*

Any effective regional diversion policy requires that real-time information about hospital and ambulance capacities be translated into medically rational decisions. To vie successfully with the scope, scale, and pressures of a regional EMS system, that translation requires investment, expertise, and accountability. Any regional ambulance diversion policy should begin by endowing the EMS Medical Director with adequate resources and authority to coordinate care among diverse institutions, and to enforce against noncompliance with agreed policies. Such endowment does not necessarily require state-level coordination, but linking regional and state efforts would promote the uniformity and enforcement of policy choices.

Intra-hospital integration and coordination is important, but it alone cannot abate ambulance diversion rates in a given region. One hospital's programmatic laxity can swamp neighboring hospitals with diverted patients, even if those neighboring hospitals make concerted efforts to allocate resources fully. Even in the absence of complementary intra-hospital efforts, inter-hospital coordination and integration can reduce the potential for ambulance diversion to harm patients. There are numerous examples of efforts in that direction,<sup>186</sup> but a particular program's success must be viewed critically: if hospitals report fewer hours on diversion, but with no positive adjustment in other indicators, such as number of diversions or rate of bed utilization, there could be reason to doubt that the outcomes reflect a tangible change for patients.

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186. See, e.g., ORG. & MGMT. FOR HOSPS. AND EMS AGENCIES 3–4 (Mid-Am. Reg'l Council 2007), <http://www.marc.org/emergency/pdfs/diversionplan.pdf> (assigning a quasi-governmental body responsibility for EMS, inter alia, to implement a web-based system that reports in real time “information on hospital emergency department status, hospital patient capacity, availability of staffed beds, and available specialized treatment capabilities”); A. Al-Darrab et al., *A City Wide Approach to Reduce Ambulance Diversion: The Hamilton Model*, 46 ANNALS EMERGENCY MED., Sept. 2005, at 40, 40 (Supp. 1) (finding that a city-wide revision to ambulance bypass guidelines was followed by reductions in total average hours per month spent on bypass and in total instances of bypass occurrences per month); Christine Bender, *California Emergency Department Diversion Project*, 13 EMERGIPRESS, Summer 2008, at 1, 3 (“Phase I [of the California Diversion Project] involved eight regions and ranked EMS and hospital practices in nine areas. . . . The goal of Phase II is to implement best practices within hospitals and measure “wall time” to determine how the changes are impacting emergency department wait times.”); Linda R. Brewster & Laurie E. Felland, *Emergency Department Diversions: Hospital and Community Strategies Alleviate the Crisis*, ISSUE BRIEF, (Ctr. For Studying Health Sys. Change, Washington, D.C.) Mar. 2004, at 1, 1–4.

The findings of Mihal & Moilanen's diversion policy program evaluation are indicative of the problems of half-hearted efforts at regional coordination. The authors identify three key problems: (i) protocols are unclear, and neither EMS nor hospital staff comply with existing regulations;<sup>187</sup> (ii) hospitals lack coordination regarding ambulance destination and diversion;<sup>188</sup> and (iii) the County has no centralized status-tracking system, and county authorities do not enforce their policies.<sup>189</sup> These problems—for which, in many cases, no one is directly accountable—are local, yet the pattern is prevalent nationally, and would-be solutions are conditioned on sustained financial and programmatic support. This circumstance inspired the National Association of EMS Officials to pass a resolution in 2008 requesting that the American Hospital Association and the Institute of Medicine convene with EMS Medical Directors “to work collaboratively to eliminate the practice of ambulance diversion.”<sup>190</sup> In the absence of integrative regional leadership, solutions have tended to be piecemeal,<sup>191</sup> and therefore, less effective at checking the outcomes observed by Mihal & Moilanen.

The history of federal EMS and trauma funding<sup>192</sup> illustrates that federal support has the potential to foster the development of coherent regional EMS systems. However, even though the issue of regional EMS systems development has climbed in rank on the federal agenda

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187. MIHAL & MOILANEN, *supra* note 57, at 17.

188. *Id.* at 24.

189. *Id.* at 33.

190. DIVERSION AND TRANSFER OF PATIENT CARE: RESOLUTION 2005-2 (Nat'l Ass'n of State Emergency Med. Sys. Officials 2008).

191. *See, e.g.*, Stephen V. Cantrill et al., NATIONAL HOSPITAL AVAILABLE BEDS FOR EMERGENCIES AND DISASTERS (HAVBED) SYSTEM (2005), <http://www.ahrq.gov/prep/havbed/havbed5.htm>. The EMS Director of Pinellas County, Florida, has established a website that tracks EMS vehicles geographically and in terms of their reported status in real-time. *See* Pinellas County Public Safety Services, <http://www.pinellascounty.org/911/ActCallsPub.htm> (last visited Dec. 20, 2008). Hospitals in Tennessee, (borrowing from programs in Mississippi and North Carolina) make use of a similar system, though one that tracks status on a daily basis rather than in real-time. *See* Sharon H. Fitzgerald, *Tennessee Implements Hospital Resource Tracking System*, NASHVILLE MED. NEWS, Jan. 2007, at 1, available at <http://host1.bondware.com/~nashmed30/news.php?viewStory=1406>. Georgia's Northside Hospital maintains a website intended to support real-time listings of ED and critical care bed availability in all regional hospitals. *See* Georgia Hospital Resource Report, <http://www.gaems.net/cgi-bin/diversion.pl> (last visited Jan. 26, 2009). When last visited, all but two hospitals had a status of “Update Required.” *Id.*

192. *See supra* note 58 and accompanying text.

since the 1990s,<sup>193</sup> the recent economic upheaval makes the future of federal support difficult to predict.

#### CONCLUSION

Increasing levels of crowding have pushed hospitals to divert patients more frequently, shunting them in ever-increasing numbers into a legal zone where no EMS or hospital actor is fully liable for medical outcomes. In addition to putting patients at risk and depriving them of legal protections, multiple hospitals' uncoordinated recourse to ambulance diversion also undermines diversion's own utility as a release valve for pressurized EDs and hospitals.

This Note proposes several solutions to this problem, including: 1) a program to improve the quality of information available about rates, causes, and effects of diversion; 2) support for efforts to reduce the current strain on EDs; and 3) better coordination of authority and resources within and among hospitals with an eye to reducing rates of diversion.

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193. Congressional hearings on the dearth of federal support for state-led EMS programs spurred political support for (reauthorized) Trauma Care Systems Planning and Development Act of 2007, Pub. L. No. 110-23, originally passed in 1990, defunded in 1995, and, after a 2002 reauthorization, funded by HHS at well below the congressionally authorized amount. See Robert R. Bass, President, Nat'l Ass'n of Emergency Med. Servs. Physicians, Briefing before the Institute of Medicine Committee: Emergency Medical Services in the United States (Feb. 3, 2004), at 38. A more novel bill, H.R. 3173, the Improving Emergency Medical Care and Response Act, submitted by Representative Waxman and then-Senator Barack Obama in April of 2007, did not make it out of the House Health Committee. See H.R. 3173, 110th Cong. (2007), available at, <http://www.govtrack.us/congress/bill.xpd?bill=h110-3173>.



## APPENDIX

EMTALA directs the following:

if any *individual . . . comes to the emergency department* and a *request* is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an *appropriate medical screening examination* [MSE] within the capability of the hospital's emergency department, including *ancillary services* routinely available to the emergency department, to determine whether or not an *emergency medical condition . . . exists*.<sup>194</sup>

“Comes to the ED” is the triggering event that activates the substantive terms in this provision. “Any individual” covers an intentionally sweeping category of persons, one that ignores ability to pay, insurance status, age, race.<sup>195</sup> “Request” encompasses literal and constructive indications of an individual's desire to receive care.

Guidelines issued in 1998 clarified that insurers and health maintenance organizations may not refuse to reimburse a hospital for an appropriate medical screening and treatment if a “prudent layperson” would believe such a screening was called for “based on the individual's appearance and behavior.”<sup>196</sup> EMTALA requires a hospital to perform an “appropriate medical screening examination”—a term whose definition is left to hospitals and the standard of care<sup>197</sup>—in order to determine whether the patient suffers from an “emergency medical condition.”<sup>198</sup> Once a hospital defines the substance of a

194. 42 U.S.C. § 1395dd(a) (2006) (emphases added).

195. *See, e.g., Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996) (noting that the use of “any individual” by Congress indicates an indifference to the hospital's motive in complying or failing to comply with EMTALA's terms); *Burditt v. U.S. Dep't of Health & Human Servs.*, 934 F.2d 1362, 1373 (5th Cir. 1991) (refusing to find that EMTALA's protections pertain only to the indigent and uninsured). Revisions to EMTALA in 1989 prohibit delaying an MSE in order to inquire after the patient's ability to pay or insurance status. *See Omnibus Budget Reconciliation Act of 1989*, Pub. L. No. 101-239 § 6211, 103 Stat. 2106, 2248 (1989) (codified as amended at 42 U.S.C. § 1395dd(h) (2006)).

196. *See Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates*, Part II, 67 Fed. Reg. 31,403, 31,473 (proposed May 9, 2002) (codified at 42 C.F.R. § 489.24 (2009)). The “prudent layperson” standard is defined as “a reasonable patient's perspective at the time of presentation of symptoms.” Special Advisory Bulletin on the Patient Anti-Dumping Statute, 64 Fed. Reg. 61,353, 61,357 (Nov. 10, 1999).

197. *See Power v. Arlington Hosp. Ass'n*, 42 F.3d 851, 856–59 (4th Cir. 1994) (examining EMTALA's requirements for hospitals when conducting an “appropriate medical screening examination”); *see also Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 879 (4th Cir. 1992).

198. 42 U.S.C. § 1395dd(e)(1) (2006) (“The term ‘emergency medical condition’ means—(A) a medical condition manifesting itself by acute symptoms of sufficient

standard MSE, however, EMTALA prohibits deviation from that standard MSE in any particular case.<sup>199</sup> Also prohibited is a screening so cursory that it departs from the standard in all but barest formality.<sup>200</sup> Further grounds for violation include “egregious and unjustified delay”<sup>201</sup> and a failure to make use of “routinely available ancillary services” from other departments (e.g., a consultation or diagnostic test) or on-call physicians beyond the ED.<sup>202</sup> Merely negligent compliance by a hospital with its own MSE procedures is not necessarily a violation,<sup>203</sup> and if there is no evident departure from standard MSE procedures, a plaintiff faces the high evidentiary hurdle of showing that discrimination against the patient somehow informed the hospital’s conduct in performing the MSE.<sup>204</sup> If an “appropriate MSE” finds no emergency condition, EMTALA’s obligations end; if a condition is

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severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) 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, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part . . .”). Neither EMTALA nor its associated regulations define the term “appropriate medical screening examination.”

199. See *Barber*, 977 F.2d at 879 (“The plain language of the statute requires a hospital to develop a screening procedure designed to identify such critical conditions that exist in symptomatic patients and to apply that screening procedure uniformly to all patients with similar complaints.”).

200. See *Griffith v. Mt. Carmel Med. Ctr.*, 831 F. Supp. 1532, 1538 n.4 (D. Kan. 1993) (finding that an “adequate screening” cannot be so deficient that it does not enable the hospital to determine whether the patient had an emergency medical condition).

201. *Marrero v. Hosp. Hermanos Melendez, Inc.*, 253 F. Supp. 2d 179, 194 (D.P.R. 2003).

202. See Medicare Program; Participation in CHAMPUS and CHAMPVA, Hospital Admissions for Veterans, Discharge Rights Notice, and Hospital Responsibility for Emergency Care, 59 Fed. Reg. 32,086, 32,100 (June 22, 1994) (“Therefore, if a hospital has a department of obstetrics and gynecology, the hospital is responsible for adopting procedures under which the staff and resources of that department are available to treat a woman in labor who comes to its emergency department.”); see also Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates, 73 Fed. Reg. 48,434, 48,663 (Aug. 19, 2008) (“A hospital may satisfy its on-call coverage obligation by participation in an approved community/regional call coverage program. . . .”); Memorandum from Dir., Ctr. for Medicaid and State Operations to Assoc. Reg’l Adm’rs & State Survey Agency Dir., S&C-02-35 (June 13, 2002); Memorandum from Steven A. Pelovitz, Dir., Ctr. for Medicaid and State Operations to Assoc. Reg’l Adm’rs & State Survey Agency Dirs., S&C-02-34 (June 13, 2002).

203. See *Summers v. Baptist Med. Ctr. Arkadelphia*, 91 F.3d 1132, 1137 (8th Cir. 1996) (EMTALA “does not guarantee proper diagnosis or provide a federal remedy for medical negligence.”).

204. See, e.g., *Bohannon v. Durham County Hosp. Corp.*, 24 F. Supp. 2d 527, 530–31 (M.D.N.C. 1998) (finding patient’s pre-treatment disclosure that he lacked medical insurance highly probative).

discovered, however, then EMTALA requires the hospital to “stabilize”<sup>205</sup> the patient in advance of either a “transfer” or discharge.<sup>206</sup> Thus, a hospital’s EMTALA obligation to an individual who has come to the ED ends when the individual is admitted as an inpatient, or is discharged or transferred after being stabilized.<sup>207</sup>

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205. 42 U.S.C. § 1395dd(e)(3) (2006) (“[S]tabilize means . . . 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.”) (internal quotation marks omitted).

206. § 1395dd(e)(4) (“[T]ransfer means 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 (A) has been declared dead, or (B) leaves the facility without the permission of any such person.”) (internal quotation marks omitted).

207. *See Bryan v. Rectors & Visitors of the Univ. of Va.*, 95 F.3d 349, 352 (4th Cir. 1996) (“The stabilization requirement is thus defined . . . without any reference to the patient’s long-term care within the system.”); 42 C.F.R. § 489.24(d) (2009); *CTRS. FOR MEDICARE & MEDICAID SERVS., STATE OPERATIONS MANUAL*, Tag A407 (2004).

