GAO

Report to the Chairman, Committee on the District of Columbia, House of Representatives

April 1987

HEALTH CARE

Patient Transfers From Emergency Rooms to D.C. General Hospital

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GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

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April 30, 1987

The Honorable Ronald V. Dellums
Chairman, Committee on the
District of Columbia
House of Representatives

Dear Mr. Chairman:

This report, issued at your request, discusses the transfer of patients from metropolitan area hospital emergency rooms to D.C. General Hospital.

As requested by your office, unless you publicly announce the report's contents earlier, we will not make additional distribution for 30 days. At that time, we will send copies to the Mayor of the District of Columbia, D.C. General Hospital, the other hospitals visited, and other interested parties; we will make copies available to others on request.

Sincerely yours,

Richard L. Fogel
Assistant Comptroller General

Executive Summary

Purpose

There have been many changes in the past 3 to 4 years concerning the way hospitals are reimbursed for care by the government and private insurers. Consequently, one of the concerns of many people has been that private hospitals may be "dumping" patients on public hospitals to escape having to treat people who may not have the financial means to pay for their care. Representative Ronald V. Dellums, Chairman of the House Committee on the District of Columbia, asked GAO to find out whether this situation was occurring in the Washington metropolitan area. Specifically, GAO was asked to determine

- what the policy and procedures are for transferring patients from hospital emergency rooms to D.C. General;
- whether Washington metropolitan area hospitals are familiar with the policy and procedures;
- whether Washington metropolitan area hospitals are violating the transfer policy and procedures;
- what the characteristics are of patients transferred to D.C. General; and
- how professional medical organizations view transfers and how other metropolitan areas across the country deal with them.

Background

D.C. law requires that D.C. General Hospital treat all Washington, D.C., residents regardless of their ability to pay for the care received. The D.C. government provides the hospital with funds to offset the cost of treating these residents (see p. 9). The hospital has adopted a transfer policy and procedures outlining the conditions under which it will accept transfers of D.C. residents from other hospital emergency rooms (see p. 14.)

Although the transfer policy and procedures were disseminated to metropolitan area hospitals, there is no formal or enforceable arrangement whereby metropolitan area hospitals are required to follow them. However, D.C. General Hospital keeps a record of what it perceives to be violations of its transfer policy (see pp. 15-16 and 22).

GAO reviewed transfers to D.C. General Hospital that occurred in fiscal year 1985 and compared D.C.'s transfer policy with those of five public hospitals in other metropolitan areas (see pp. 10 and chap. 6).

Results in Brief

Washington metropolitan area hospitals were familiar with D.C. General Hospital's transfer policy and procedures and generally abided by them.

Where an infrequent violation occurred, the transferred patient's life was not jeopardized as a result of the violation (see pp. 15 and 22-37).

Four potentially life-threatening cases (three were ultimately determined not to be transfer violations; for the fourth, there was a difference of medical opinion concerning the patient's stability for transfer) are indicative of communication problems that can be experienced in the transfer of patients, even when there is a transfer policy in place (see pp. 27-37).

Over 80 percent of the transfers to D.C. General Hospital were made because the patients were unable to pay for the cost of their care. Such economic transfers are permitted given D.C. General Hospital's legislative mandate to serve D.C. residents unable to pay for care. The D.C. government reimburses D.C. General for the approximate cost of treating these transfers (see pp. 14 and 39-40).

GAO's Analysis

D.C. General's transfer policy requires a physician at the transferring hospital to telephone a specified physician at D.C. General's emergency care center to discuss the patient's condition and to request acceptance of the transfer (see p. 14).

Transfer Policy Known and Followed

Washington metropolitan area hospital officials said that they were generally well acquainted with the transfer policy and procedures; had few, or no, problems with them as implemented; and generally had little or nothing to offer as suggestions for improvement (see pp. 14-17).

GAO estimates that there were 868 patients transferred to D.C. General Hospital during fiscal year 1985. For the metropolitan area hospitals visited, GAO reviewed a total of 30 cases in which D.C. General Hospital records indicated that a transfer had been made during fiscal year 1985 in violation of policy and procedures.

On the basis of D.C. General Hospital records and information GAO obtained from the transferring hospitals, the acting director of D.C. General's emergency care center concluded that there were 12 transfer violations of a technical or minor nature. He determined that one additional transfer had been made under potentially life-threatening circumstances. In this case, the transferring hospital's emergency room director disagreed with D.C. General's acting emergency care center director concerning the patient's stability for transfer. D.C. General's emergency

care center acting director concluded that the remaining 17 incidents were not transfer violations, even though they had been recorded as such (see pp. 22-38).

Characteristics of Transferred Patients

The composite of a patient transferred to D.C. General was a 37-year-old black, unemployed male who was transferred by private ambulance. He was more likely to be suffering from illness than injury. Thirty-eight percent of the transferees were treated and released by the D.C. General Hospital emergency care center staff. Of those admitted to the hospital, the average length of hospital stay was 8.5 days. Fiscal year 1985 transferees incurred charges that GAO estimated to total $3.5 million, an average of $4,053 per transfer (see pp. 38-40).

Professional Organizations' and Other Jurisdictions' Transfer Guidelines

A number of medical organizations, such as the American College of Emergency Physicians and the American Hospital Association, have adopted policy statements and, in some cases, guidelines to ensure that patients are not endangered by transfers from one hospital to another (see pp. 44-47).

Like D.C. General Hospital, all five public hospitals outside of the Washington metropolitan area, according to their representatives, provide care to residents regardless of ability to pay. Officials at four of the hospitals indicated that, like D.C. General Hospital, they have a documented transfer policy and procedures to govern patient transfers. Each hospital receives funding to help pay for the care of patients who do not have some type of third-party coverage (insurance) and cannot pay for their care (see pp. 48-54).

Recent Federal Transfer Guidelines

Effective August 1986, the Consolidated Omnibus Budget Reconciliation Act of 1985 requires any hospital receiving federal Medicare funds to examine all patients coming to the emergency room to determine if an emergency medical condition exists or if the patient is in active labor. If so, the hospital is prohibited from transferring the patient, except under certain circumstances. Violations of this act could result in a hospital's suspension or termination from the Medicare program and civil action against the hospital and transferring physician (see pp. 8-9).

Recommendations

GAO is making no recommendations since the overall policy was working well in the Washington metropolitan area, and federal legislation has been passed addressing the transfer issue.

Agency Comments

GAO sought comments on a draft of this report from D.C. General Hospital, the D.C. Government, and the nine metropolitan area hospitals visited during the review. Comments were received from Providence Hospital; the Washington Hospital Center; and the Department of Defense, on behalf of DeWitt Army Hospital. The comments are included as appendixes I to III.

Providence Hospital and the Washington Hospital Center provided some clarifying information, which is discussed in the report where appropriate. The Department of Defense said that it agreed with GAO's findings and conclusions applicable to it.

Contents

Abbreviations

AFDC	Aid to Families With Dependent Children
DCGH	D.C. General Hospital

Introduction

Background

Although little is known nationwide about the transfer of patients between hospital emergency rooms, various reports concerning transfers in specific localities, including Washington, D.C., suggest that they are common, may be hazardous, and disproportionately affect the poor and minority group members. "Dumping" or, a more polite term that is sometimes used, economic transfer has been described as a controversial practice where some hospitals avoid admitting or keeping poor or uninsured patients by sending them to hospitals willing to bear the costs. The practice is not new, but has increased since the early 1980's, largely as a result of cuts in federally sponsored health care financing programs such as Medicare and Medicaid. In most cases, the dumping ground is the nearest city or public hospital.

In May 1985, Representative Ronald V. Dellums, Chairman, House Committee on the District of Columbia, requested that we review the transfer of patients from the Washington metropolitan area hospital emergency rooms to D.C. General Hospital (DCGH).

Recent Development

In April 1986 the President signed federal legislation effecting the transfer procedures for patients from virtually all hospital emergency rooms across the country. Effective August 1986, a provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law No. 99-272) requires any hospital receiving federal Medicare funds to provide for the examination of any patient, including non-Medicare patients, coming to the hospital's emergency room. The examination is to determine if an emergency medical condition exists or if the patient is in active labor. If such a condition or active labor exists, the hospital must, within the staff and facilities available to it, provide for the medical examination and treatment required to stabilize the patient or monitor the labor.

The law defines an emergency medical condition as one that manifests itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in (1) seriously jeopardized patient health, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. Active labor occurs when (1) delivery is imminent, (2) there is inadequate time to make a safe transfer to another hospital before delivery, or (3) a transfer may pose a threat to the health and safety of the patient or unborn child.

If an unstabilized emergency medical condition or active labor exists, the hospital may not transfer the patient unless (1) the patient requests a transfer, (2) a physician (or other qualified medical person) certifies that the medical benefits expected from treatment at another facility outweigh the increased risks to the patient's condition resulting from the transfer, or (3) the patient, or a legally responsible person acting on the patient's behalf, refuses to consent to an examination or treatment.

To make an appropriate transfer, a receiving facility must have available space and qualified personnel; the facility must agree to accept the transfer and provide appropriate medical treatment. The transferring hospital must provide the receiving hospital with appropriate medical records of the examination and treatment already provided. In addition, the transfer must be made by qualified personnel and include the use of necessary and medically appropriate life support measures during the transfer.

These requirements for an appropriate transfer do not apply if an emergency patient has been stabilized before transfer or if the transferred patient is not in an emergency condition. The act defines a "stabilized" patient as one who has received the necessary medical treatment to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from the transfer. Delivery services must be provided to women in active labor because they cannot be stabilized, as required by the act.

The Secretary of Health and Human Services must report to the Congress, by early 1987, the methods to be used for monitoring and enforcing this emergency treatment and transfer provision. If a hospital knowingly, willfully, or negligently fails to meet the patient treatment and transfer requirements, the Secretary can suspend or terminate the hospital's participation in the Medicare program. In addition, a hospital and physician responsible for knowingly violating the law are each subject to a civil penalty of not more than $25,000 for each violation. A civil action may be brought against the hospital by (1) any individual suffering personal harm as a direct result of the hospital's violation of the treatment and transfer provisions or (2) any hospital suffering financial loss as a direct result of another hospital's violation.

D.C. General Hospital

The District of Columbia's only public acute care hospital, DCGH, is a 500-bed institution located on federal property in southeastern D.C. The D.C. Council, which consists of elected representatives from each of the city's

eight wards (see fig. 1.1) plus four at-large members, is responsible for approving the hospital's budget after the hospital submits it to the mayor's office. The Congress, which authorized a federal payment of about half a billion dollars for the D.C. government in fiscal year 1985, annually reviews DCGH's operating and capital budgets because the Congress has oversight responsibility for the District of Columbia's budget and legislative initiatives.

DCGH is operated by an 11-member commission appointed by the mayor with the consent of the council. Like many large urban public hospitals, DCGH treats a great number of uninsured patients and serves as the family physician for many of them. According to the D.C. General Hospital Commission Act (D.C. Law no. 1-134), which reorganized the administration of the hospital under the 11-member commission in 1977, any D.C. resident needing medical care and unable to obtain it elsewhere can be treated and, if necessary, admitted to the hospital. No D.C. resident is to be refused care if unable to pay for it.

To fulfill this commitment, the D.C. government provides an annual appropriation to the hospital aimed at compensating it for the cost of indigent care less patient reimbursement. The D.C. government appropriation is also intended to compensate the hospital for services provided to federal and D.C. government-supported long-term care facilities and the D.C. Department of Corrections. For fiscal year 1984, the $43.1 million appropriation represented 49 percent of the hospital's $88.6 million total budget; for fiscal year 1985, the appropriation increased to $45.5 million, which was 47 percent of a $96.5 million total budget.

Objectives, Scope, and Methodology

Our review objective was to gather information on the issue of patient transfers to DCGH, including the transfer policy and procedures, the patients transferred, and apparent violations of the policy and procedures. We also obtained information on patient transfers to five other public hospitals, outside of the Washington metropolitan area.

We reviewed DCGH's written policy and procedures for patient transfer and discussed them and actual practices with DCGH staff, including the executive director at the time, the acting director of the hospital's emergency care center, and the hospital registration staff. We also discussed the policy and procedures with D.C. government officials and with the former DCGH emergency care center director who drafted them.

We visited seven private D.C. hospitals, one Virginia hospital, and one Maryland hospital (see fig. 1.1)—which collectively made 96 percent of the fiscal year 1985 transfers to DCGH—interviewing hospital officials about the following: their awareness of DCGH's transfer policy, any problems experienced with the policy and procedures, and any suggestions for improvement. We also discussed the various hospital officials' reasons for transferring patients to DCGH and their overall perceptions about metropolitan area hospitals' dumping patients on DCGH.

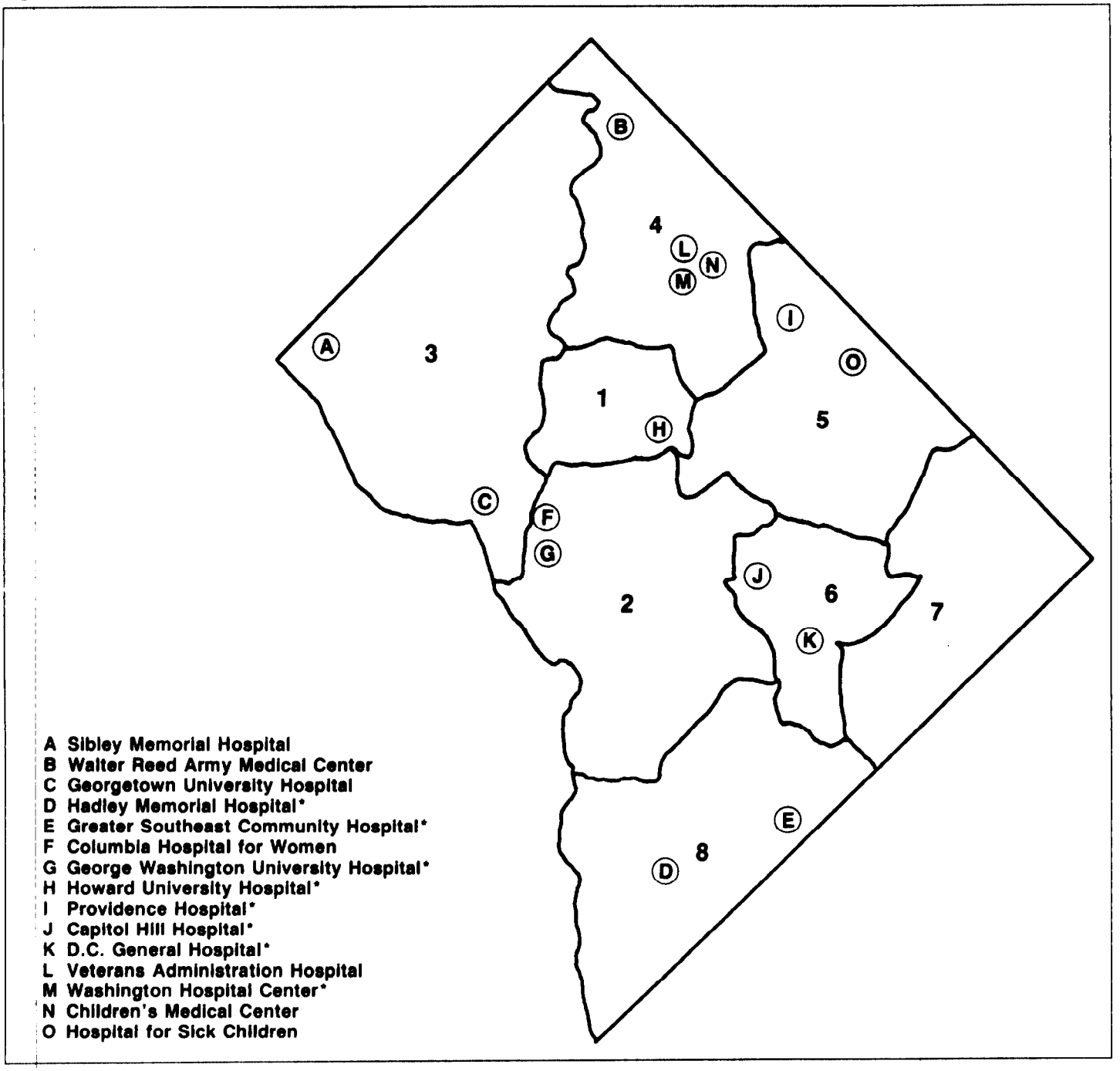
Using DCGH records, we randomly selected a sample of 100 recorded transfers, from a universe of 923, made to the hospital during fiscal year 1985. Our review showed that 94 percent of our sample were actual transfers and, therefore, we adjusted the universe to 868. We are 95 percent confident that profile data developed for our sample can be projected to the adjusted universe of transfers, with an error of about plus or minus 10 percentage points. Sampling errors for charge and cost data are included in chapter 4.

For each sampled transfer, using DCGH records, we recorded basic demographic data such as race, age, sex, employment status, and address. We used the transferred patient's address, if in the District of Columbia, to determine the city ward in which he or she resided. For each patient in the sample, we gathered information on the transferring hospital; reasons for, and methods of, transfer; the disposition of the patient (treated and released or admitted); hospital charges; and length of stay as reflected by DCGH records. By averaging data, such as length of stay and charges for admitted transfers, we were able to compare these averages for DCGH's transferred patients with averages for all its patients.

We attempted to verify DCGH data, particularly data recorded on patient transfer report forms, when possible. Although we generally found corroborating data, we did not attempt to test the accuracy of all DCGH records used to prepare this report. If we were unable to reconcile data discrepancies, we included the discrepancy where appropriate. For example, in our description of an alleged transfer violation (see p. 35), we included the conflicting information concerning the patient's race and age.

We obtained information for all fiscal year 1985 transfers where there was an indication in DCGH records that the transfer was not made in accordance with its transfer policy. Where appropriate, we discussed individual cases with staff of the transferring hospital to obtain additional information on the circumstances of these transfers. We did not

Figure 1.1: Hospitals in the District of Columbia, by Ward



*Visited during review. In addition, Dewitt Army Hospital in Virginia and Prince George's Hospital in Maryland were visited.

attempt to determine whether individual transfers were medically appropriate, but we did obtain opinions of officials from the hospitals and from the acting director of the DCGH's emergency care center.

To put the transfer situation in the Washington metropolitan area into perspective, we obtained information on recent federal legislation affecting patient transfers. We spoke with representatives of public hospitals in five areas outside of the Washington metropolitan area: Alameda County, California; Boston, Massachusetts; Chicago (Cook County), Illinois; Dallas, Texas; and San Francisco, California. We obtained information on their transfer policies and payment methods for the care of patients without any medical coverage or any means to pay for the care. In addition, we obtained information on studies of patients transferred to four public hospitals in these areas. We also identified the positions of various medical organizations on patient transfers.

We sought comments on a draft of this report from D.C. General Hospital, the D.C. Government, and the nine metropolitan area hospitals visited during the review. Comments were received from Providence Hospital; the Washington Hospital Center; and the Department of Defense, on behalf of DeWitt Army Hospital. The comments are included as appendixes I to III.

Providence Hospital and the Washington Hospital Center provided some clarifying information, which is discussed in the report where appropriate.

Except for not testing the accuracy of all DCGH records used to prepare this report, our review was performed in accordance with generally accepted government auditing procedures.

DCGH Transfer Policy and Procedures; Area Hospitals' Reasons for Transfer

DCGH's transfer policy, an informal arrangement between DCGH and Washington metropolitan area hospitals, generally allows hospitals to make economic transfers (that is, transfers of those who cannot pay for their care) as long as the patients are stable and the transferring hospital follows the appropriate procedures (that is, obtaining DCGH's acceptance of the transfer and providing appropriate medical records concerning the patient and the treatment provided). Officials at most hospitals we visited told us they were familiar with the DCGH transfer policy and procedures. In general, they had no problems with the policy and procedures as implemented, and most had little to offer as suggestions for improvement. One official, however, questioned the legality of DCGH's putting conditions on transfers when the law requires it to treat D.C. residents who cannot obtain care elsewhere.

Although most hospital officials acknowledged making economic transfers, they generally said that they did not believe a dumping problem exists in the Washington metropolitan area because (1) the DCGH policy allows the transfer of indigent patients and (2) emergency room directors and hospitals communicate and cooperate with each other.

DCGH's Transfer Policy and Procedures

DCGH's transfer policy permits economic transfers under certain circumstances. Specifically, the policy permits accepting (from other acute care hospitals) the transfer of D.C. residents who need acute care, including those who cannot pay, when established medical procedures are followed.

The procedures require the following: (1) The physician in the transferring hospital's emergency room must telephone the medical officer-in-charge at DCGH's emergency care center to confirm that D.C. General is capable of providing care to the patient in question. This includes confirming that a bed is available, if hospital admission is needed (as contrasted with emergency room treatment only), and that the patient can be safely transferred without endangerment to life or aggravation to the underlying illness or injury. (2) Before being admitted to a hospital ward, all transfers must go to DCGH's emergency care center, where a patient evaluation is made to ensure that the patient is sufficiently stabilized for transport to the ward. DCGH is obligated by the policy to evaluate transfers to determine the extent to which medical care is required and if admission is needed. (3) Generally, the transferring hospital is solely responsible for stabilizing the patient, selecting the transportation mode, and treating or monitoring the patient's condition while in transit. (4) A written record of the problem, the treatment provided, and the

patient's status at the time of the transfer is to accompany the patient being transferred. This record should include the following:

- Personal information, such as the patient's name, address, and age.
- Medical information, such as the history of the illness or injury and the patient's vital signs.
- Names of the transferring and accepting physician.

There are certain situations when DCGH will not accept a transfer. For example, a patient not requiring admission but only needing observation would not be accepted for transfer. DCGH will also not accept transfers when DCGH is on "reroute" status for ambulance cases, that is, when DCGH's emergency room is full of ambulance cases and other "stretcher patients." In addition, as a general policy, DCGH also will not accept for transfer a patient who requires intensive care or who has been admitted to another hospital and provided care. According to the DCGH emergency care center's former director, who was responsible for drafting the transfer policy and procedures, this last restriction was included to prevent a hospital's dumping a patient on DCGH after exhausting the patient's insurance benefits.

Although not specifically covered in its transfer policy, DCGH's practice is not to accept the transfer of a major trauma (a sudden, significant injury) patient until that patient has undergone a 24-hour observation period at the transferring hospital.

After experiencing significant increases in the reported number of patients transferred from metropolitan area hospitals, the DCGH commission approved the transfer policy and procedures in November 1983. According to the executive director at the time, the transfer policy and procedures were sent to area hospitals and discussed at a monthly hospital association meeting. He told us that a meeting was also held with each hospital to discuss concerns or problems, but DCGH did not ask the area hospitals to enter into a formal arrangement whereby they agreed to abide by the policy and procedures.

Area Hospitals' Comments

Officials at eight of the nine Washington metropolitan area hospitals we visited told us they were familiar with DCGH's policy and procedures concerning the transfer of patients. The one hospital whose officials told us they were not familiar with the policy and procedures was DeWitt Army Hospital in Ft. Belvoir, Virginia. Although a military facility, DeWitt sometimes provides emergency treatment to inmates of D.C.'s

prison facility in nearby Lorton, Virginia. DeWitt's procedures for patient transfers, however, are similar to DCGH's: physician-to-physician communication concerning the patient's condition; stabilization of the patient; and, at the time of transfer, a written record of the problem, treatment given, and status of the patient.

Of the eight hospitals whose officials were familiar with DCGH's transfer policy and procedures, officials at seven said they were not aware of problems with their implementation. The director of the eighth hospital, Howard University Hospital, however, questioned the legality of DCGH's policy. He told us he did not understand how DCGH can legally say it will accept transfers only under certain conditions when it is, by law, the hospital of last resort for D.C. residents. He suggested that DCGH should accept patients who have been admitted to other hospitals and those needing long-term care.

As discussed on page 10, according to D.C. law, any D.C. resident needing medical care and unable to obtain it elsewhere can be treated and admitted to DCGH even if unable to pay for the care. However, in the case of a patient who has already been admitted to another hospital, it could be argued that the admission of the patient to that hospital is an indication that the patient has been able to obtain care elsewhere. Therefore, DCGH might have justification to refuse such a transfer. We recognize that there may be some medical services that metropolitan area hospitals cannot provide (see p. 17). In cases where a patient has been admitted to a hospital, DCGH would be required to accept the transfer if the patient needs a service that cannot be provided at the transferring hospital.

Although officials at Greater Southeast Community Hospital told us they did not have problems with the policy and procedures as implemented, they indicated that the transfer system between hospitals could be improved by agreement on medical definitions that differ. For example, Greater Southeast officials said that DCGH's definition of trauma cases is more restrictive than theirs, which has caused DCGH to reject the transfer of some trauma patients that Greater Southeast feels are medically acceptable for transfer. Washington Hospital Center officials also alluded to a definitional problem with trauma cases when discussing violations of DCGH transfer policy (see p. 26).

Although Capitol Hill Hospital officials said they were not aware of problems with DCGH's transfer policy and procedures as implemented,

the director of the emergency room expressed concern about DCGH's frequent reroute status. He said that since Capitol Hill Hospital is the closest hospital to DCGH, frequent reroute status for DCGH results in D.C. ambulances taking some emergency cases, which would normally go to DCGH, to Capitol Hill Hospital; because an extremely small percentage of these ambulance cases have some type of insurance, Capitol Hill Hospital eventually transfers those suitable for transfer to DCGH, once reroute status is lifted; Capitol Hill must admit those not suitable for transfer. The director also said that these are usually patients who cannot pay and who would have been at DCGH if it were not for the designated reroute status. He described this rerouting as an example of the transfer policy being used to dump patients on Capitol Hill Hospital.

Area Hospitals' Reasons for Transfers

At Washington metropolitan area hospitals we visited, officials told us they transfer patients to DCGH for a variety of reasons, including honoring patients' requests to be transferred and transferring patients who are in the custody of the police department or the D.C. Department of Corrections. In addition, Capitol Hill, DeWitt, and Hadley Hospitals officials told us they would transfer a patient if DCGH could provide specialized medical care not available at their hospitals. Officials at the remaining six hospitals, however, said they have the ability to provide any kind of care that DCGH could provide.

The patient's inability to pay, however, was the reason most frequently cited by hospital officials as influencing the decision to make a transfer to DCGH. Other than DeWitt, which transfers Lorton prisoners, George Washington University Hospital and Howard University Hospital were the only hospitals whose officials told us they do not make economic transfers.

Officials at each hospital visited said they do not deny treatment to patients needing immediate medical care. Likewise, officials at each hospital, except DeWitt, said they recommend for transfer only those patients they feel will require admission. If officials believe a patient should be released after receiving emergency treatment, they said they will provide the needed treatment and will not attempt to transfer the patient to DCGH. The DeWitt officials explained that admission to DCGH is not a consideration for them in making a transfer decision. Nonetheless, they said many prisoners sent to DeWitt eventually need admission to DCGH because the Lorton facility usually sends them patients needing stabilization; Lorton sends many others not needing stabilization directly to DCGH.

If DCGH rejects a requested transfer, however, because DCGH is on reroute status or lacks available beds, officials at most of the hospitals indicated that they may hold patients in the emergency room, rather than admit them, until DCGH is willing to accept the transfers. The Howard University Hospital director told us Howard would not normally hold patients in the emergency room, except when patients were in custody or requested transfers to DCGH because they had been treated there earlier. Officials at DeWitt and Prince George's Hospitals said they would admit the patient and make the transfer after DCGH went off reroute status or had available beds.

Officials at several hospitals indicated that the course of action they would take, if DCGH was on reroute status or lacked available beds, is dictated by various factors, such as the following: the patient's condition, the kinds of care their hospitals can provide, bed availability at their hospitals, expected duration of reroute status at DCGH, and the patient's insurance status. Hadley Memorial Hospital officials said, for example, that they would attempt to transfer a patient to another hospital if the patient was insured and the condition was not serious. If the patient was indigent, however, Hadley officials said they would hold the patient in their emergency room because other hospitals would not accept the transfer. Patients in serious condition would be admitted to the hospital, according to Hadley officials.

"Dumping"

In general, hospital officials visited did not believe there is a "dumping" problem in the District of Columbia. Greater Southeast officials said that economic transfers are not dumps in the District of Columbia because there is a policy in place that allows for the transfer of indigent patients. These officials defined dumping as transferring an unstable patient or transferring a patient without communication between physicians. They did not believe that dumping occurs in the District because of the tight, small community of emergency-room directors who communicate with each other and because D.C. hospitals cooperate with each other.

George Washington University Hospital officials, who saw dumping as an increased health risk to the patient, said they were not sure if dumping existed because George Washington does not receive economic transfers. They speculated, however, that the District of Columbia is probably better than most cities with regard to the level of dumping that

may occur for the following reasons: the high quality of emergency-room care available, the manageable size of the District, and the manageable number of hospitals in the District. Some of these same factors were also mentioned by Howard, Capitol Hill, and Washington Hospital Center officials as reasons why they do not believe that there is a dumping problem in the District when compared with areas in other parts of the country.

Providence Hospital officials said that, if dumping includes economic transfers, there is still a problem with it, even though DCGH has a policy of accepting these transfers. They said that a transfer further complicates an already complicated system because there is an added burden on the patient and on the physician who must judge the patient's condition. In her comments on a draft of this report (see app. I), the President of Providence Hospital wrote that "the community must assume some responsibility for payment" for uncompensated care if economic transfers are to stop. She supported direct compensation to hospitals for uncompensated care.

Economic Transfers

Officials at five of the six hospitals that make economic transfers said they do not provide patients with any option other than the transfer (see table 2.1). According to Greater Southeast Hospital officials, for example, unemployed patients or patients without insurance would be told that they are being transferred to DCGH because they can receive free care there. According to Capitol Hill Hospital officials, when physicians tell their patients that they can receive free care care at DCGH, most patients agree to the transfer. Essentially, patients are not given the option of staying at Capitol Hill. However, if patients were to refuse transfer, they would be admitted, according to Capitol Hill officials. Washington Hospital Center officials said they also explain the financial incentives to transfer to DCGH. But if the patients are stable and refuse the transfer to DCGH, they are given the option of signing themselves out of the hospital, although they would have to acknowledge that they were leaving against medical advice. Officials also indicated that free care at the Hospital Center is an option if beds are available.

In commenting on a draft of this report (see app. II), the President of the Washington Hospital Center wrote that it has never been the policy of the hospital to recommend patients' leaving against medical advice. In a subsequent discussion with the Center's President, he said that patients who refuse to transfer to DCGH were, and still are, told that they may

sign themselves out of the hospital against medical advice. However, he said that they do not encourage people to sign out.

Hospital policy is to give uninsured patients the option before admission of paying a deposit to cover part of the estimated cost, according to the President of Providence Hospital in responding to a draft of this report. She also said that some hospital staff had not been providing this information, and the hospital has taken appropriate corrective steps.

Table 2.1: Area Hospital Officials' Responses to Question Concerning Patient Options

Hospital visited	Patients recommended for transfer to DCGH for economic reasons provided any options?
Capitol Hill	No
DeWitt	[a]
George Washington	[a]
Greater Southeast	No
Hadley Memorial	No
Howard	[a]
Prince George's	No
Providence	No
Washington Hospital Center	Yes

[a]Question was not applicable because hospital officials claimed they do not make economic transfers.

Alleged Transfer Violations

We reviewed information on the circumstances surrounding 30 of 39 cases where DCGH recorded a violation of its transfer policy and procedures during fiscal year 1985. This review led the acting director of DCGH's emergency care center to conclude that 14 of the cases were either referrals or appropriate transfers. Twelve of the remaining 16 cases were considered technical violations, and 4 were thought to be potentially life-threatening violations. However, after we presented the acting director with additional information gathered during a more detailed review of these 4 cases, he concluded that the transferring hospitals did not violate the transfer policy in 3 of the 4 cases. There is a difference of medical opinion concerning the appropriateness of the transfer in the remaining case.

Violation Procedure

After a transfer has been completed, if the DCGH medical officer-in-charge believes that a violation of DCGH's transfer policy or procedures has occurred, it is noted on the patient's transfer report form. Violations can be on the part of either the transferring hospital, the DCGH staff, or both. The acting director of the DCGH emergency care center later reviews these forms, along with the patient's emergency treatment record, to confirm the transfer violation. These forms are then used to generate internal monthly reports that summarize violation information.

There are no procedures in place for the review and follow-up of suspected transfer violations. Although DCGH keeps records of suspected violations, they are not reviewed on a case-by-case basis with the transferring hospitals, nor is summary information concerning suspected violations routinely provided to transferring hospitals. The chief executive officer of Capitol Hill Hospital told us, however, that DCGH periodically provided him with information on cited transfer violations, but only because he requested it. Additionally, we found that, on a couple of occasions, a DCGH medical officer telephoned the transferring hospital's emergency room to complain about an alleged violation of the transfer policy and procedures. For the most part, however, officials at the hospitals we visited told us they were not aware that DCGH thought they were violating the transfer policy until we questioned them about specific cases.

Review of Specific Cases

We identified a total of 39 cases that DCGH staff recorded as violations of the transfer policy and procedures for fiscal year 1985. We reviewed 30 of these cases and discussed them with officials of the transferring hospitals and the acting director of DCGH's emergency care center. The

remaining 9 alleged violations were made by hospitals that we did not visit (because of the relatively small number of transfers they made during fiscal year 1985) or by county fire department ambulances transporting emergencies from Maryland (which did not appear to involve a violation on the part of a transferring hospital).

Based on the results of our discussions with officials of the transferring hospitals and information we obtained from DCGH records, the acting director of DCGH's emergency care center concluded that 14 of the 30 incidents were not violations of DCGH transfer policy and procedures (see table 3.1). Of the 16 incidents where he believed a violation had occurred, we separated them into two categories: technical and potentially life-threatening transfers. We made a more detailed review of the four incidents where he thought the transfer had been made under potentially life-threatening circumstances, that is, where a hospital had allegedly transferred an unstable patient or a patient needing intensive care.

Table 3.1: Review Results for 30 Incidents of Alleged Transfer Violations, Fiscal Year 1985

Hospitals visited	Technical	Potentially life-threatening	Total	Referrals or appropriate transfers (not violations)
Capitol Hill	•	•	•	5
DeWitt	1	•	1	•
George Washington	3	•	3	2
Greater Southeast	3	•	3	4
Hadley Memorial	1	1	2	1
Howard University	1	1	2	1
Prince George's	•	•	•	•
Providence	1	2	3	•
Washington Hospital Center	2	•	2	1
Total	**12**	**4**	**16**	**14**

Referrals

Ten of the 30 incidents reviewed were referrals; that is, they were not transfer violations and, accordingly, should not have been recorded as such. Typically, in these 10 incidents, a patient would go to a hospital's emergency room where treatment was provided. In certain instances, when the patient was unable to pay for the care provided, emergency room staff might advise the patient to go to DCGH for follow-up care.

For example, a 59-year-old male patient walked into the DCGH emergency care center for treatment on October 24, 1984. According to the DCGH transfer report form, which had been prepared by a clerk on the patient's arrival, Capitol Hill Hospital had violated the transfer policy and procedures by partially treating the patient and telling him to go to DCGH. When we questioned Capitol Hill officials about this incident, they told us their records indicated that the patient had indeed been treated and released from their emergency room—7 days earlier. Capitol Hill officials had advised this patient, who could not pay for his care, to go to DCGH for follow-up care.

Although this incident should not have been recorded as a transfer violation, it is typical of a practice employed at DCGH through the first quarter of fiscal year 1985. DCGH recorded a transfer violation in cases where a patient, on arrival at DCGH's emergency care center, indicated an earlier visit to another hospital. DCGH stopped this practice in January 1985, when DCGH officials realized that these incidents were referrals that were not covered by the transfer policy. Each of the 10 referrals included in the 30 incidents we reviewed occurred in either October or November 1984.

Appropriate Transfer

Based on the results of our discussions with officials of the transferring hospitals and information we obtained from DCGH records, the acting director of DCGH's emergency care center concluded that four of the reviewed incidents were appropriate transfers. They should not have been recorded as transfer violations because proper transfer policy and procedures had been followed.

Two of these incidents, although appropriate transfers, gave the acting director some concern because, in his opinion, more information concerning the patient's condition could, or should, have been provided during the telephone conversation requesting the transfer. In one incident, the acting director thought the physician should have mentioned a patient's history of heroin drug abuse when requesting transfer of the patient, who had been vomiting and complaining of stomach pains. Even though the drug abuse history was on the transferring hospital's medical record that accompanied the patient to DCGH, the drug abuse was not mentioned during the telephone conversation. In the other incident, the history not provided concerned the patient's sexual preference. According to the acting director, the fact that the patient was a male homosexual is critical information that a physician should have when considering the suitability for transfer of a patient with chills, a fever,

cough, and an elevated white blood count. The transferring hospital records sent with the patient did not indicate the patient's sexual preference. This led the acting director to observe that the omission of this history was due to either the transferring physician's lack of experience in making a diagnosis or the physician's choosing to withhold critical information.

Technical Violations

As shown in table 3.1, the acting director of DCGH's emergency care center categorized 12 of the reviewed incidents as technical violations of DCGH's transfer policy and procedures; that is, the transfer was made under conditions he did not consider to be life-threatening.

Technical violations generally resulted from the failure of the transferring hospital to receive acceptance of the transfer from the medical officer-in-charge at DCGH's emergency care center. In two of the cases, this failure to receive proper acceptance was due to differences between DCGH and transferring hospitals concerning the transfer of major trauma (or what DCGH refers to as "code yellow") patients.

The following cases are presented as examples that illustrate problems encountered with technical violations:

Case 1. The violations, according to the DCGH transfer report form, were that the transferring hospital sent an emergency room patient to DCGH's emergency care center (1) without prior authorization from the medical officer-in-charge and (2) after partially treating the patient.

According to DCGH records, a 21-year-old male with a hand injury arrived at DCGH's emergency care center at approximately 4:30 a.m.; he had driven from George Washington University Hospital's emergency room, where he had gone for treatment. George Washington Hospital staff told the patient to go to DCGH because they had been unable to reach his insurance company to verify his coverage. While at George Washington Hospital, the patient's hand was X-rayed and he was given the X-ray, which he brought to DCGH. The patient was diagnosed at the DCGH emergency care center and referred to DCGH's orthopedics unit.

George Washington officials told us that the patient arrived at their emergency room at 1:50 a.m. with a 2-week-old injury. They acknowledged that they had X-rayed it, but provided no treatment. They said that, in their judgment, the patient needed care and admission, but not immediately. They said they told him to go to DCGH, and they telephoned

a DCGH orthopedic resident, who accepted the patient. They acknowledged that they had technically violated the DCGH transfer policy by not telephoning the medical officer-in-charge. Because the patient was sent to DCGH for lack of insurance, they also observed that this incident was an exception to their policy of not making economic transfers.

Case 2. The violations, according to the DCGH transfer report form, were that (1) the transferring hospital sent an emergency room patient to DCGH's emergency care center without prior authorization from the medical officer-in-charge, and (2) DCGH inpatient service accepted the patient without coordinating with the medical officer-in-charge.

According to DCGH records, a 27-year-old male pedestrian, under the influence of alcohol, was taken by ambulance to Washington Hospital Center after being struck by an automobile. The DCGH medical officer-in-charge rejected the request of the Washington Hospital Center emergency room physician to transfer the patient because DCGH classified him as a code yellow (major trauma) patient. The DCGH medical officer told the Washington Hospital Center emergency room physician to keep the patient, who had no insurance, for 24-hour observation and then request transfer to DCGH. The case was discussed with the DCGH trauma surgeon, who concurred that the patient should not be accepted for transfer.

Rather than wait until the end of the 24-hour-observation period, a Washington Hospital Center orthopedic resident called a physician in DCGH's orthopedic service to discuss the direct admission of the patient to DCGH, thereby bypassing the transfer through the DCGH emergency care center. After discussing the case with the DCGH medical officer-in-charge, however, the physician in orthopedics told the Washington Hospital Center physician that the medical officer-in-charge had agreed to accept the transfer of the patient, who was then sent to DCGH. But according to the medical officer, he had not agreed to accept the patient.

Washington Hospital Center officials agreed that the DCGH emergency care center, by DCGH standards, considered the patient to be a code yellow and thus not eligible for transfer for 24 hours. After the patient was evaluated at the Washington Hospital Center, however, he was determined not to be a major trauma case by the hospital's standards and, therefore, could be transferred. The director of the Washington Hospital Center emergency room stressed that, even though Washington Hospital Center had technically violated DCGH's transfer policy in this particular case, the patient had not been placed at risk by the transfer.

Concerning the transfer of code yellow patients, we attempted to locate some type of documentation stipulating that they should be observed for 24 hours before transfer. We were unable to find such documentation in DCGH's transfer policy, its code yellow policy, or D.C.'s regulations on trauma care. Although the acting director of DCGH's emergency care center believed that there was documentation of the 24-hour-observation period, he could not provide us with any. Additionally, he told us that he seemed to recall a meeting of the Trauma Subcommittee of the Mayor's Emergency Medical Services Advisory Committee where there was citywide concurrence among hospitals that trauma victims should be observed at least 24 hours before transfer.

The executive director of D.C.'s Office of Emergency Health and Medical Services, through which the mayor's advisory committee operates, told us she was not aware of such a requirement, nor was she aware of a consensus among Washington metropolitan area hospitals to keep patients for a 24-hour-observation period before transferring them. Rather, the consensus seems to be that as long as the patient is stable, he or she can be transferred. The chairman of the mayor's advisory committee also told us that he is not aware of a required 24-hour-observation period.

Potentially Life-Threatening Cases

Information is presented below on each of the four cases where, initially, DCGH believed a patient was transferred under conditions DCGH considered to be life-threatening, that is, the patient was unstable, in need of intensive care, or both. After a detailed review of available information concerning these cases, the acting director of the DCGH emergency care center concluded that the transfer policy and procedures had not been violated in three of the four cases. For case 1, there is a difference of opinion between physicians concerning the appropriateness of the transfer. Each of the cases, however, is indicative of communication problems experienced in the transfer of patients.

Case 1
Race: Black
Age: 30
Sex: Male
Length of stay at DCGH: 7 days
Final diagnosis: Pulmonary tuberculosis with lung abscess
Disposition of patient: Expired at DCGH
Transferring hospital: Providence
Reason for transfer (per DCGH transfer report form): No insurance
DCGH charges: $24,171
Disposition of charges: Bad debt
Nature of violation(s) (per DCGH transfer report form): Sent an unstable patient; sent patient needing intensive care

According to DCGH records, a physician at Providence Hospital called DCGH's medical officer-in-charge at 2:35 a.m. to request transfer of a stable patient with a diagnosis of pneumonia and alcohol abuse. Other information communicated to the medical officer-in-charge included the patient's vital signs; the fact that he had a blood-tinged "productive cough" (that is, coughing up mucus or sputum), a fever, and chills; and the fact that he had previously undergone a thoracotomy (surgical incision of the chest wall). The DCGH medical officer accepted the patient for transfer at 2:40 a.m., and the patient arrived at DCGH by ambulance about 5:00 a.m., at which time the patient was categorized as "emergent"; according to the acting director of the emergency care center, this is the hospital's most critical category, where seconds to minutes count in the treatment of the patient. The medical officer determined that the patient was unstable and in need of intensive care.

According to DCGH records, the requesting physician at Providence understated the amount of the patient's hemoptysis (spitting up of blood from the lungs or bronchial tubes). On arrival at the emergency room, the patient immediately coughed up 100 cubic centimeters of dark red blood. According to the medical officer's notes, the ambulance crew that transported the patient stated there was "a bucket of dark red blood by his bedside in which he had been coughing and he continued to cough large amount[s] on transfer."

The medical director of Providence Hospital's emergency room does not believe that Providence violated DCGH's transfer policy. According to the medical director, the patient was in the Providence emergency room from approximately 1:00 a.m. until transfer to DCGH at 4:40 a.m. The

director indicated that the patient was first evaluated at 1:10 a.m. and was last seen by a physician at 4:00 a.m. The director noted that Providence records do not support the allegation that the patient had been coughing up large amounts of blood or that there was a bucket of blood with the patient, as indicated on the DCGH transfer report form. The director added that he was confident the nurse would have recorded this if it had happened.

Concerning the patient's stability, the Providence emergency room director told us that it is a matter of clinical judgment; however, his review of the patient's records supported the fact that he was stable for transfer at the time of leaving Providence's emergency room, although he was certainly ill and in need of admission. The director told us that the patient's condition was due to a combination of chronic and acute problems, some of which can be attributed to alcoholism. The director concluded that he agreed with the Providence emergency room physician's management of the patient and could not see any reason for the physician to misrepresent the condition of the patient or to inappropriately transfer him. The risk of transferring an unstable patient would be too great, the director said; he has never felt pressured by the hospital or medical staff to do so.

According to the acting director of DCGH's emergency care center, in his clinical judgment, the records that accompanied the patient from Providence Hospital show that the patient was unstable when he left Providence. The director acknowledged, however, that the Providence records do not necessarily indicate that the patient was in need of intensive care at Providence. But the director stated that a comparison of the Providence records accompanying the patient with DCGH's emergency treatment records shows a deterioration in the patient's condition, to the point where the patient was not only unstable but in need of intensive care by the time he arrived at DCGH.

Concerning the patient's hemoptysis, the DCGH emergency care center acting director pointed out that the Providence records show that the patient was "coughing blood." Further, the director said that a critical part of the patient's history—a blood count (hematocrit) of 26.6 percent—was apparently not communicated to the DCGH medical officer-in-charge. Specifically, the blood count was apparently not mentioned to the DCGH medical officer-in-charge, as it was not recorded on the transfer report form, according to the acting director. He also observed that the blood count, which is indicative of substantial blood loss, was available

to the transferring physician because it was on the same Providence laboratory report used to communicate other aspects of the patient's history.

Case 2
Race: Black
Age: 40
Sex: Male
Length of stay at DCGH: 31 days
Final diagnosis: Malignant hypertension with renal failure
Disposition of patient: Discharged
Transferring hospital: Hadley Memorial Hospital
Reason for transfer (per DCGH transfer report form): Financial
DCGH charges: $29,372
Disposition of charges: Covered by Medicaid; DCGH applied for Medicaid eligibility after patient was admitted
Nature of violations(s) (per DCGH transfer report form): Sent an unstable patient; sent patient needing intensive care

According to the Hadley Memorial Hospital records (in the patient's medical file at DCGH and accompanying him to DCGH), the patient had arrived at Hadley's emergency room at 3:15 a.m. by D.C. ambulance. He had experienced flulike symptoms a week earlier and complained of shortness of breath, pain in the rib cage, loss of appetite, and blurred vision. His blood pressure was recorded at 217/104, various laboratory tests were made, and some medication was provided to treat the blood pressure. He was diagnosed as experiencing renal failure and transferred to DCGH for admission. His discharge condition was listed as satisfactory on the assessment record completed at Hadley.

According to DCGH records, a physician at Hadley called DCGH's medical officer-in-charge at 7:00 a.m. to request transfer of a stable D.C. resident with a diagnosis of renal failure, possibly chronic renal failure. The transfer report form indicates that medical information was provided, including the patient's blood pressure, which was recorded as being 217/104. The DCGH medical officer agreed to the transfer at 7:03 a.m.

According to an addendum to the patient's transfer report form, which the DCGH medical officer said she made after his arrival, the patient experienced an acute change in blood pressure to 212/140 at Hadley. According to the addendum, however, DCGH personnel were not notified

of the change until 8:30 a.m., after the patient was placed in an ambulance and was en route to DCGH. The patient was transferred by a basic life-support ambulance crew without arrangements for intravenous blood or other fluids. According to DCGH records, the patient arrived at DCGH at 8:31 a.m., at which time he was categorized as emergent. After receiving treatment in DCGH's emergency care center, he was admitted to the hospital's medical intensive care unit at 9:15 a.m., in critical condition, with diagnoses of malignant hypertension and renal failure.

When we discussed this case with Hadley officials, it became apparent that they had records relative to the patient's treatment at Hadley that were not in the DCGH file. The officials told us that their policy is to send the patient's complete chart when making a transfer, but they were unable to document that they sent the complete chart in this particular case. Records on file at Hadley confirm the change in blood pressure recorded by DCGH. In fact, according to Hadley's records, the patient's blood pressure was taken at least five times, with the following results: 3:15 a.m, 217/104; 5:20 a.m., 220/110; 6:30 a.m., 230/140; 8:15 a.m., 212/147; and 8:30 a.m., 210/140. The records are inconclusive, however, concerning the number of blood pressure readings communicated to the DCGH medical officer-in-charge. The director of Hadley's emergency room speculated that perhaps the Hadley physician who requested the transfer at 7:00 a.m. only looked at the face sheet of the patient's chart, which just had the 3:15 a.m. reading on it. The Hadley emergency room director told us that a second physician reassessed the patient. According to this physician's notes, which were not in the DCGH file, the patient was conscious, alert, and oriented at 8:30 a.m.[1] ; he did not complain of any chest pain or shortness of breath. The patient's blood pressure was elevated, and he required kidney dialysis. DCGH had been told about the patient's condition, according to this physician's notes.

Hadley's emergency room director told us this patient was transferred primarily for medical, not financial, reasons (financial reasons were indicated on the DCGH transfer report form). Specifically, the patient's condition required kidney dialysis, and Hadley does not have dialysis facilities. The director acknowledged, however, that this patient was transferred to DCGH, as opposed to Greater Southeast Community Hospital, for the following reason: although Greater Southeast is closer to

[1]The patient could not have been at Hadley at 8:30 a.m. and in an ambulance shortly before 8:30 a.m., arriving at DCGH at 8:31 a.m., as reflected by each institution's records. We cannot determine which of these times is accurate.

aware, at the time, that Hadley did not have dialysis facilities. According to the DCGH acting director, if all the information had been initially communicated, DCGH would not have recorded the transfer violations in this case.

Case 3
Race: Black
Age: 72
Sex: Male
Length of stay at DCGH: 7 days
Final diagnosis: Lung cancer, atrial fibrillation
Disposition of patient: Expired at DCGH
Transferring hospital: Howard University Hospital
Reason for transfer (per DCGH transfer report form): No insurance
DCGH charges: $5,744
Disposition of charges: Covered by Medicare and Medicaid
Nature of violation(s) (per DCGH transfer report form): Sent patient needing intensive care

According to DCGH's transfer report form, a physician from Howard University Hospital called DCGH's medical officer-in-charge, requesting the transfer of a patient with a diagnosis of severe dehydration and a history of cancer. DCGH accepted the patient for transfer at 12:10 a.m. The patient, found to have recurrent atrial fibrillation (irregular heartbeat) on arrival at DCGH, was in need of intensive care, according to the DCGH record. This information was not reported during the telephone communication, according to the medical officer. After being examined and evaluated in DCGH's emergency care center, the patient, in poor condition, was admitted at 2:30 a.m. to the hospital's coronary care unit. According to a Howard transfer form in the patient's medical files at DCGH and at Howard, medical records were sent with the patient. The Howard medical records, however, were not in the patient's DCGH medical file.

Records on file at Howard University Hospital indicate that the patient arrived at Howard about 6:30 p.m. the evening before the transfer. According to Howard University Hospital officials, the patient was in an unstable condition at the time, not eating or drinking much since his recent discharge from DCGH. (DCGH records show that the patient had been discharged from DCGH 5 days earlier, after being treated for atrial fibrillation.) According to the Howard University Hospital medical director, the patient's major problem was dehydration. Howard

director added that he found it strange, however, that Howard did not document the electrocardiogram on its record. He said that this lack of documentation, coupled with the handwritten date, leads him to suspect that perhaps the patient had made an earlier visit to Howard University Hospital. If this was indeed the case, the acting director said, and had he been made aware of it at the time of a transfer request, that he would normally ask for a more current electrocardiogram before agreeing to accept the transfer. There is no evidence that the patient had made an earlier visit to Howard, according to the Howard University medical director. He could not explain why the electrocardiogram results were not documented on the emergency care record.

Case 4
Race: Conflicting information in DCGH records; according to the Providence Hospital emergency room director, the patient was white
Age: 17 per DCGH records; 27, according to the Providence emergency room director
Sex: Male
Length of stay at DCGH: 15 days
Final diagnosis: Spontaneous pneumothorax and interstitial pneumonitis
Disposition of patient: Expired at DCGH
Transferring hospital: See description of incident
Reason for transfer: See description of incident
DCGH charges: $31,499
Disposition of charges: Bad debt
Nature of violation(s) (per DCGH transfer report form): Sent an emergency room patient to DCGH's emergency care center without prior authorization from the medical officer-in-charge; failed to send medical record or information describing the patient's condition as outlined in the policy; sent an unstable patient; partially diagnosed the patient and told to go to, or sent to, DCGH

According to DCGH's transfer report form, the patient arrived at DCGH's emergency care center by car after a diagnosis of pneumothorax (accumulation of air or gas in the chest cavity, occurring as a result of disease or injury) was made by a private physician and X-rays were taken at Providence Hospital. Neither the private physician nor the emergency room director from Providence called the medical officer-in-charge. On arrival at DCGH, the patient was categorized as urgent, a category not as severe as emergent, where the patient's condition requires medical attention within a few hours, according to the acting director of DCGH's emergency care center.

Observations

Our discussions with Washington metropolitan area hospital officials and our review of the 30 cases of alleged transfer violations that occurred during fiscal year 1985 indicate that metropolitan area hospitals, on a voluntary basis, generally appear to be abiding by DCGH's transfer policy and procedures. Our review of the cases indicates, however, that communication problems can occur even when there is a policy in place to govern the transfer of patients. But, overall, the policy seems to be working as intended, without endangering the patients who are being transferred. Further, federal legislation now prohibits any hospital that receives Medicare funds from transferring an unstable patient, except under specific circumstances. This legislation also requires the Secretary of Health and Human Services to report to the Congress on the methods that will be used for monitoring and enforcing the emergency treatment and transfer provision.

For the above reasons, we are not making recommendations in this report.

Reasons for Transfer

Based on information in DCGH records, we estimate that at least 83 percent of the transfers were made because the patient was indigent or lacked insurance. Other reasons for transfer included incarceration, lack of beds, and previous treatment at DCGH. Information concerning the reason for transfer was not recorded in about 6 percent of the cases.

Method of Transfer

DCGH records indicate that the transfer was made by ambulance in about 65 percent of the cases and by other means, such as by private vehicle or taxicab, in about 10 percent of the cases. The method of transfer was not recorded for the remaining 25 percent of the transfers. Ambulance transfers are usually made by private ambulance companies because D.C. fire department ambulances do not transfer patients from one hospital emergency room to another except in certain infrequent emergency situations.

Diagnosis

Based on information recorded on the transfer report form concerning the patient's diagnosis, we estimate that about 73 percent of those transferred were ill and about 19 percent had an injury. Of the remaining 8 percent transferred, information was either not recorded or we were unable to determine from the transfer report form if the diagnosis was illness or injury.

Disposition of Transfer

Although officials at each hospital we visited, except DeWitt, told us they believe those patients they transferred to DCGH needed admission to a hospital, 38 percent of the transfers to DCGH were treated in the emergency care center and released. The remaining 62 percent were admitted to DCGH after being evaluated and treated in the emergency care center. Transfer admissions represented 3.7 percent of total fiscal year 1985 admissions to DCGH.

Length of Stay at DCGH

For those transfers admitted to DCGH, their stays ranged from 1 to 69 days, with the average 8.48 days. This is slightly less than the average stay of 8.66 days for all DCGH admissions in fiscal year 1985.

Charges

We estimate that the total charges for all fiscal year 1985 transfers were $3.5 million (with a sampling error of plus or minus $1.5 million), with an average charge of about $4,053 (plus or minus $1,690) per transfer. The average charge per treated and released transfer, however, was

Table 4.2: Comparison of D.C. Population With Fiscal Year 1985 Transfers to DCGH, by Race

Race	D.C. population[a] (universe: 638,895)	Transfers (universe: 868)
Black	70.3%	93.6%
White	26.9	3.2
Other	2.8	3.2
Total	**100.0%**	**100.0%**

[a]Based on U.S. Bureau of the Census data, 1980.

The average age of transfers was 37 years, ranging from 18 to 67. As shown in table 4.3, very few (3 percent) of the transfers were 65 and over. This may be explained by the fact that the number of D.C. residents over age 65 living in DCGH's primary service area is small when compared with the District as a whole. It may also be explained by the fact that residents aged 65 and over are likely to have Medicare coverage; transferring hospitals, consequently, would be reluctant to transfer these residents because the hospitals can receive reimbursement that is adequate to cover most of their costs. Sixty percent of the transfers were between ages 25 and 44.

Table 4.3: Comparison of D.C. Population With Fiscal Year 1985 Transfers to DCGH, by Age

Age	D.C. 1985 population[a]	Percent	Transfers to DCGH	Percent
Under 18 years	141,900	22	0	0
18-64 years	416,500	65	840	97
65 years and over	80,700	13	28	3
Total	**639,100**	**100**	**868**	**100**

[a]Projection based on 1980 Census data.

Although females represent slightly more than half of the population in DCGH's primary service area, they accounted for less than 27 percent of the transfers to DCGH. According to DCGH records, one out of five transfers was employed, but employment status information was not available for an almost equal number of transfers (see table 4.4). Over half the transfers were unemployed, according to DCGH records.

Based on our sample results, none of the transfers came from ward 3—the city's most affluent ward, which is located in the westernmost part of the city. This ward ranked lowest in unemployment, Medicaid-eligible population, recipients of AFDC, and reported cases of tuberculosis. It did, however, have the highest death rate from heart disease.

- To assure the safety and appropriateness of each proposed transfer, all interfacility transfers of emergency patients should be subject to the sound medical judgment and consent of the transferring and receiving physicians.

The association also adopted a recommendation that county medical societies be urged to develop, in conjunction with their local hospitals, procedures and interhospital transfer agreements addressing the issue of economic transfers of emergency patients. At a minimum, the association said these procedures and agreements should address the condition of the patient transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. It was also recommended that state medical associations be urged to encourage and provide assistance to their county medical societies as they develop procedures and interhospital agreements.

American College of Emergency Physicians

The American College of Emergency Physicians, in its policy statement on patient transfers adopted in August 1985, recognizes that there can be a variety of reasons for a transfer, including the following: responding to a request from the patient or the patient's representative, receiving the benefit of more appropriate facilities or services, and economic considerations. The college's earlier position on patient transfers, adopted in September 1977, specifically stated that socioeconomic considerations should be disregarded in the transfer of patients.

Like the recent federal legislation and the position of the American Medical Association concerning patient transfers, the American College of Emergency Physicians recognizes that patients should not be transferred to another facility without first being stabilized, except when medically necessary. Stabilization would include adequate evaluation and initiation of treatment to assure that the transfer will not, within reasonable medical probability, result in death or loss (or serious impairment) of bodily parts or organs. The statement further describes stabilizing steps that should be completed for patients before transfer, including the following:

- Establishing and assuring an adequate airway (passageway for air to the lungs).
- Initiating control of hemorrhage.
- Stabilizing and splinting the spine or fractures when indicated.
- Establishing and maintaining adequate access routes for fluid administration.

Joint Commission on Accreditation of Hospitals

According to the Joint Commission on Accreditation of Hospitals' Accreditation Manual for Hospitals, patients should be transferred in accordance with a community-based hospital emergency plan. Unless extenuating circumstances are documented in the patient's record, no patient should be arbitrarily transferred to another hospital if the hospital where the patient is initially seen can provide adequate care. A patient should not be transferred until the receiving hospital has agreed to accept the patient and the patient is sufficiently stable for transfer. Responsibility for the patient during transfer should be established, and all pertinent medical information should accompany the patient being transferred. The manual does not specifically address economic transfers.

physician telephone conversations related to the transfer of emergency patients.

According to a study of patient transfers[1], the transfer of patients from private to public hospital emergency rooms is common in Alameda County. Transfer primarily involved uninsured or government-insured patients, disproportionately affected minority group members, and sometimes placed patients in jeopardy. The study found that, in 1981, 458 patients were transferred from 14 private hospitals to Highland General Hospital between January 1 and June 30. Sixty-nine percent were male. Fifty-five percent were white; 30 percent, black; 6 percent, with Spanish surnames; and 9 percent, other. Thirty-three percent of Alameda County's population was nonwhite, according to the study. Fifty-three percent of the transfers were admitted to Highland General Hospital. The 458 transfers represented 2 percent of the hospital's emergency room visits, and the 272 admissions represented 6.5 percent of all hospital admissions.

A group of four physicians participating in the study reviewed Highland General Hospital's records for 103 patients identified as high risk for adverse effects of transfer. On the basis of recorded information alone, the physicians judged that 33 of the patients received substandard care, either because they were at risk for life-threatening complications in transit or because urgently needed diagnosis or therapy was delayed.

At the time of our review, Highland General Hospital had, what its director described as, informal guidelines to govern the transfer of patients to Highland. He said that formal guidelines were before the County Board of Supervisors for approval. These guidelines, drafted by a transfer committee of the East Bay Hospital Conference, allow for economic transfers. The guidelines specify basic responsibilities, procedures to be followed in making a transfer, and clinical considerations for the transferring physician. Additionally, procedures for monitoring and reviewing the appropriateness of transfers are included.

Boston, Massachusetts

According to the chief executive officer of Boston City Hospital, the hospital provides care to all residents regardless of ability to pay. Unlike

[1]David U. Himmelstein, M.D., and others, "Patient Transfers: Medical Practice as Social Triage," American Journal of Public Health, May 1984, vol. 74, no. 5, pp. 494-497.

- lack of management information systems that could promptly detect potential free care or bad debt patients so as to allow transfer at the time of examination.

A February 1984 study by a Boston City Hospital economic transfer task force, composed primarily of physicians and registered nurses, however, reported that Boston area hospitals were turning patients away or making economic transfers. According to the study, the Massachusetts hospital reimbursement law, in effect at the time, encouraged hospitals to reduce care provided to patients without insurance or with inadequate insurance. The study also indicated that reports of economic transfers became a common occurrence only after a state hospital reimbursement law went into effect in October 1982. That law was replaced by legislation creating the pooling arrangement described above.

Chicago (Cook County), Illinois

According to state law, adequate health care is a fundamental right of Illinois residents regardless of their ability to pay. Cook County Hospital receives funds from the county government to help pay for care.

Member hospitals of the Metropolitan Chicago Health Care Council, in cooperation with the Emergency Medical Services Commission of Metropolitan Chicago, have prepared a guide for patient transfers among hospitals. According to the guide, a medically indigent patient in stable condition may be transferred to Cook County Hospital. Prior approval by the receiving hospital is required, and physician-to-physician telephone consultation is necessary in most cases. In addition to sending a record of the problem and treatment already provided, the transferring hospital should inform the patient of the transfer and obtain appropriate consent. The guide is also similar to DCGH's transfer policy in that transfers of admitted patients are not allowed unless the transferring hospital is unable to provide appropriate inpatient care.

According to the results of a study of patient transfers to Cook County Hospital,[2] 42 hospitals transferred 467 patients from their emergency rooms to Cook County Hospital between November 20, 1983, and January 1, 1984. The average age of the patients was 36 years, and 78 percent were male. Seventy-seven percent were black; 81 percent were unemployed. The average length of hospital stay was 9.5 days. Of the

[2]Robert L. Schiff, M.D., and others, "Transfers to a Public Hospital, A Prospective Study of 467 Patients," The New England Journal of Medicine, February 27, 1986, vol. 314, no. 9, pp. 552-557.

the necessary approval for transfer. Medical hotline calls are recorded, thereby providing an effective quality assurance tool with the capability of generating a transcript of the call for subsequent review by any involved party.

Patients transferred without approval or without appropriate stabilization are to be reviewed by medical, legal, and administrative staff; appropriate action is to be taken through peer review channels. As at DCGH, an incident report is generated for all transfers which, in the opinion of the Parkland physicians, are inappropriate. Unlike DCGH, however, each report is sent to the medical director and administrator of the transferring institution for review and comment.

Two years of experience with its transfer policy leads Parkland officials to believe that it works. The number of transfers has decreased. Overall patient stability has improved, and hotline compliance has improved to the point where it appears that the transfer hotline has become an accepted and responsible mechanism for coordinating patient transfers.

The Texas legislature recently passed legislation, effective April 1, 1986, that establishes minimum standards governing the transfer of patients. All hospitals are required to have a transfer policy that provides for

- notification to the receiving hospital before transfer,
- confirmation by the receiving hospital that it will accept responsibility for the patient's medical treatment and hospital needs,
- the use of medically appropriate life-support measures to stabilize a patient before transfer and to sustain the patient during transfers,
- the use of appropriate personnel and equipment for the transfer, and
- the transfer of all necessary records for continuing the patient's care.

If a hospital substantially fails to comply with the transfer legislation, it could have its license suspended or revoked. The legislation also provides for civil penalties if hospitals fail to adopt, implement, and enforce a transfer policy in accordance with the act.

San Francisco, California

San Francisco General Hospital, like Highland General Hospital, is required to provide care to all residents regardless of ability to pay. In addition to receiving state funds to help pay for the care of medically indigent adults, San Francisco General also receives local government funds to help cover its uncompensated care burden.

Comments From Providence Hospital

Celebrating 125 Years of Caring

March 10,1987

Mr. Richard L. Fogel
Assistant Comptroller General
Human Resources Division
General Accounting Office
Washington, DC 20548

Dear Mr. Fogel:

After carefully reviewing your draft report: "Health Care: Patient Transfers From Emergency Rooms to DC General Seem Appropriate", I want to commend your staff for an excellent and balanced report. Your report presented the appropriate conclusion that area hospitals "generally appeared to be abiding" by DC General's transfer policy.

Of the 83 transfers from Providence Hospital, three cases were listed by DC General as violating their transfer policy. Of those three cases of possible violations, two cases were mentioned as "potentially life threatening".

In one of these two cases, your staff reported that "the DCGH emergency care center acting director concluded that this was not a transfer because the burden of care was on the private physician, not the Providence Hospital emergency room".

In the other case, you correctly noted that there was a "difference of opinion between physicians concerning the appropriateness of the transfer". We have reviewed both cases and are confident that actions taken by our staff were appropriate.

Your report says that "a difference of opinion concerning the patient's stability for transfer" in the "potentially life-threatening cases" is "indicative of communication problems that can be experienced in the transfer of patients even when there is a transfer policy in place".

Our institution would not like to transfer patients for economic reasons. There is an inherent potential danger in any transfer. Our mission and history is full of charity care for those who cannot pay for health care. However, the community must assume some responsibility for payment to hospitals for uncompensated

Comments From the Washington Hospital Center

THE WASHINGTON HOSPITAL CENTER

March 3, 1987

Mr. Richard L. Fogel
Assistant Comptroller General
U.S. General Accounting Office
Human Resources Division
Washington, D.C. 20548

Dear Mr. Fogel:

We have reviewed the GAO Report which you have submitted to us in its preliminary form. We find there is only one item of significance in the study upon which to comment. The study consisted of a review of 868 patient transfers in 1985 from metropolitan area hospitals to D.C. General Hospital. Of these, some 39 cases (4.5%) were at first considered violations of the DCGH policy on patient transfers. This number was later reduced to 30 (3.5%), 14 of which were finally determined to be appropriate; leaving only 16 (1.8%) in question. Within this final number, only two transfers from the Washington Hospital Center were labeled "technical" violations of the DCGH policy and were fully explained by the Hospital Center's Emergency Room Medical Director.

Now on pp. 19-20.

We found one error in the report which should be corrected. On pages 26-27, under discussion of economic transfers, Hospital Center "officials" are quoted as offering alternatives to patients who refuse transfers to D.C. General. The report states that after the financial incentives are explained, if a stable patient still refuses transfer, he or she is offered the option of signing AMA. Free care is mentioned as an option if beds are available. Although this may have been the opinion of our last Emergency Room Medical Director, it is not now, nor has it ever been the policy of this Hospital to recommend patients leaving against medical advice.

I hope these comments will be helpful to you. Please let us know if you have any questions in this regard.

Sincerely yours,

Dunlop Ekker
President

cc: John M. Nelson, M.D.
John M. Shiver

110 IRVING ST., N.W., WASHINGTON, D.C. 20010

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Hadley and has dialysis facilities, Greater Southeast would have probably been reluctant to accept this particular patient since he did not have insurance coverage.

In regard to the patient's stability, the Hadley emergency room director told us that he believed the Hadley staff, from an emergency room perspective, provided appropriate care and made proper arrangements to transfer the patient to a facility where better treatment could be given. He said that looking at blood pressure readings alone does not prove that the patient was unstable for transfer; in spite of the elevated blood pressure, the prime consideration was the patient's need for dialysis treatment, which could not be administered at Hadley.

Concerning the need for intravenous fluids during the transfer, the director said that it was a judgment call; the transferring physician thought the patient's blood pressure could best be handled by DCGH. Nonetheless, some medication was provided at about 7:45 a.m. to bring the blood pressure down, but the Hadley emergency room director told us that it did not have time to work before the actual transfer (about 8:30 a.m.). The director noted that he probably would have admitted the patient to the intensive care unit if, for some reason, the patient had to remain at Hadley.

According to the acting director of DCGH's emergency care center, the Hadley records that are in the patient's file at DCGH show that the Hadley staff failed to document the change in blood pressure. He also said that the Hadley records sent with the patient to DCGH show that the patient's care was incomplete. Specifically, the acting director said there is no indication in the records that the patient was thoroughly assessed for complaints of blurred vision and shortness of breath or that the patient was treated for the symptoms recorded at Hadley. The acting director said that the patient should have been provided with intravenous medication but was not.

When presented with the information provided to us by Hadley's emergency room director, DCGH's emergency care center acting director agreed that the patient's condition warranted transfer for medical reasons, even though his condition was critical and in need of intensive care. The acting director maintained, however, that important information was omitted. Specifically, he said that all available blood pressure readings should have been communicated. In addition, he said that the requesting physician should have stated that Hadley did not have dialysis facilities. The DCGH medical officer-in-charge told us she was not

hydrated the patient by providing intravenous fluids. Howard also performed an electrocardiogram (to diagnose abnormalities of heart action), which, according to the medical director, did not indicate that the patient had atrial fibrillation. According to the Howard record, the patient was transferred to DCGH in stable condition. In regard to the violation listed on the DCGH transfer report form, the Howard medical director questioned the patient's need for intensive care. He told us he did not think the patient would have been admitted to intensive care if he had remained at Howard because intensive care is not needed to hydrate a patient.

The medical director emphatically disagreed with the DCGH record, which indicated that the patient was transferred because he lacked insurance. The director told us the following:

- The patient was transferred because he had recently been treated at DCGH.
- There would be no reason for the transferring physician to misrepresent the patient's insurance coverage.
- It was against Howard policy to make economic transfers (according to Howard records, the patient had Medicaid coverage).

It cannot be conclusively determined whether the Howard emergency treatment records accompanied the patient to DCGH. The Howard transfer form in the patient's DCGH medical file and DCGH's failure to record a violation for failure to send the medical records, however, indicate that the records were sent when the transfer was made. Nonetheless, there is no indication on Howard's transfer form that a copy of the electrocardiogram or a description of the electrocardiogram results was sent to DCGH. Further, there is no entry concerning an electrocardiogram on Howard's emergency care record. The electrocardiogram in the Howard file has a hand-recorded date, which is a day earlier than the day the patient went to the Howard emergency department. An emergency nursing record in the Howard file indicates, however, that the electrocardiogram was performed on the day the patient went to the Howard emergency room.

When presented with the information provided by Howard officials, the DCGH emergency care center's acting director said that, assuming the electrocardiogram was misdated, he did not believe that Howard violated the policy by transferring a patient who needed intensive care. The acting director said that it was the patient's atrial fibrillation, on arrival at DCGH, that caused DCGH to record the violation. The acting

DCGH records indicate that the patient was admitted in fair condition, complaining of shortness of breath, nonproductive cough, and diaphoresis (copious perspiration), which had begun 4 days earlier. According to the records, the patient stated that, on the day of admission, he had gone to Providence Hospital where a chest X-ray was taken, revealing a 10-percent pneumothorax; the patient was transferred to DCGH.

The emergency room director at Providence Hospital told us that he did not believe Providence violated the DCGH transfer policy because the Providence emergency room was not primarily responsible for the patient and did not transfer the patient. Furthermore, he said the patient was stable at Providence. The emergency room director said that a private physician, who is also an attending physician at Providence, had seen the patient in his office and suspected that the patient had acquired immune deficiency syndrome, commonly referred to as AIDS. The private physician, according to the emergency room director, personally brought the patient to Providence for a chest X-ray. After ordering the X-ray, the private physician reportedly brought the patient to the Providence emergency room and asked the director to examine the patient. The emergency room director said he examined the patient, who was not in acute distress. The director said he then called the private physician to determine what he wanted Providence to do for the patient. The private physician said he would take care of the patient.

According to the emergency room director, the private physician was primarily responsible for the care of the patient. The emergency room director, although unaware of it at the time, said that the private physician had sent someone from his office to take the patient to DCGH in a private car. The director said he first became aware of this when he received a call from someone at DCGH complaining about an inappropriate transfer.

In regard to a notation in the records at Providence that the patient was transferred to DCGH, the emergency room director told us that he believes he entered the information on the record after he received the phone call from someone at DCGH concerning the incident. After reviewing the statements made to us by the Providence Hospital emergency room director, the DCGH emergency care center acting director concluded that this was not a transfer because the burden of care was on the private physician, not the Providence Hospital emergency room. Consequently, the acting director said he did not believe that Providence violated the transfer policy in this case.

Profile of Patient Transfers to DCGH

According to DCGH records, the vast majority of the fiscal year 1985 transfers to DCGH were made because the patients were recorded as being indigent or lacking insurance. The patients were usually sent by private ambulance and likely to be suffering from illness rather than injury. About 60 percent of the patients were admitted to DCGH, where they stayed for about 8.5 days and incurred average charges in excess of $6,400. DCGH was subsidized for the care of these transfers through the payment it received from the D.C. government.

A composite of a patient transferred to DCGH can be described thus: black, 37-year-old unemployed male, living in a ward with the largest portion of the city's public housing and the highest population of its Medicaid eligibles and recipients of Aid to Families With Dependent Children (AFDC).[1]

Number of Transfers

As shown in table 4.1, we estimate that there were 868 patients transferred to DCGH from other hospitals during fiscal year 1985. This represents about 1 percent of the more than 80,000 visits made to DCGH's emergency care center, which DCGH claims makes it the District's busiest emergency department. The two hospitals nearest DCGH, Capitol Hill and Greater Southeast, accounted for about 46 percent of the transfers.

Table 4.1: Estimated Transfers to DCGH, by Hospital, Fiscal Year 1985

	Patient transfers	
Transferring hospital	**Number**	**Percent**
Capitol Hill	213	25
DeWitt	37	4
George Washington University	9	1
Georgetown University	9	1
Greater Southeast	185	21
Hadley Memorial	102	12
Howard University	56	6
Prince George's	18	2
Providence	83	10
Walter Reed	9	1
Washington Hospital Center	129	15
Others	18	2
Total	**868**	**100**

[1]A federal-state program that helps needy families in which there are children who are deprived of the financial support of one of their parents for reasons such as death, disability, and absence from the home.

$245 (plus or minus $92) and $6,417 (plus or minus $2,583) per admitted transfer. According to a DCGH financial officer, DCGH charges $1.00 for each $0.80 it costs the hospital to provide services. Applying a cost-to-charge ratio of 4 to 5 to the average charge for admitted transfers, we estimate that the average cost per admitted transfer was $5,134, which is $184 more than DCGH's average cost per inpatient discharge, $4,950, for fiscal year 1985. This $184 difference, however, is not statistically significant because of the large sampling error involved.

Because DCGH received very little of the sampled charges from the patients, their private insurance companies, Medicare, or Medicaid, we cannot reliably estimate charges recovered from these sources for the universe of transfers. Sample results, however, indicate that DCGH recovered less than 14 percent ($52,133 of $380,994) of the total charges from these sources. The remaining charges were eventually written off. However, as part of the overall $45.5 million subsidy DCGH received from the D.C. government, DCGH was compensated for the approximate cost of providing medical care to those transfers unable to pay for it.

For fiscal year 1985, the amount of the subsidy was determined through negotiation. As such, it was not tied to the number of indigent or other patients using the hospital, nor was it based upon detailed case-by-case information on actual services rendered. DCGH and the mayor's office have agreed to institute a billing system, effective in fiscal year 1987, by which the District would reimburse DCGH for services to the indigent on a per-patient basis.

Demographic Characteristics

As shown in table 4.2, the race of those transferred to DCGH was predominantly black. Although not corresponding to the percentage of blacks in the District's total population, the percentage of black transfers corresponds to the percentage of blacks in DCGH's primary service area, which it defined as those census tracts in the District from which at least 1 percent of its patients originated. According to data in DCGH's long-range plan for fiscal years 1984-89, blacks account for almost 96 percent of the total population in DCGH's primary service area.

Table 4.4: Employment Status of Transfers to DCGH, Fiscal Year 1985

Employment status	Number	Percent
Employed	175	20.2
Unemployed	480	55.3
Not available	166	19.1
Jailed	37	4.3
Retired	10	1.1
Total	**868**	**100.0**

Almost one-third of the transfers had addresses located in ward 8 (see table 4.5). This ward, stretching along the southernmost part of the District (see fig. 1.1), has the largest portion of public housing and the highest unemployment rate in the city. In addition, it has the city's highest population of Medicaid eligibles and recipients of AFDC.

Table 4.5: DCGH Transfers, by Ward, Fiscal Year 1985

Ward	Number	Percent	Rank
1	92	10.6	4
2	65	7.4	7
3	0	0	8
4	74	8.5	6
5	138	16.0	2
6	111	12.8	3
7	83	9.6	5
8	277	31.9	1
Other	28	3.2	
Total	**868**	**100.0**	

Ward 5, although ranking second in transfers to DCGH, had half as many transfers as ward 8. The most populated ward in the city, Ward 5 ranks third in the number of Medicaid eligibles and recipients of AFDC. It ranks highest in deaths from cirrhosis of the liver and third (after wards 1 and 2) in the number of reported cases of tuberculosis.

Wards 5 and 8, together with ward 6, accounted for more than 60 percent of the transfers. DCGH and Capitol Hill Hospital, which transferred more patients to DCGH than any other area hospital, are located in ward 6. This ward has the lowest population of any ward in the city, but approximately 18 percent are Medicare and Medicaid eligibles. In addition, ward 6 has one of the highest accident-caused-death rates.

Several Professional Medical Organizations' Positions on Patient Transfers

Several professional medical organizations have adopted positions on patient transfers. They are generally consistent about (1) the need for proper communication between representatives of the transferring and receiving hospitals before the transfer of a patient takes place and (2) the circumstances necessary for the transfer of an unstable patient.

American Medical Association

The American Medical Association, at its June 1986 annual meeting, adopted a report that included recommendations for addressing economic transfers. According to the report (prepared by the Association's Council on Medical Service), some health care facilities, given current economic competitive pressures, believe that their own financial survival necessitates the transfer of patients unable to pay, or pay fully, for their care.

The report goes on to state that, where economic transfers of emergency patients had been reported, proprietary and nonprofit hospitals generally appear to transfer patients to the emergency rooms of public hospitals. Typically, such transfers are made based on hospitals' operating policies, some of which are publicly announced while others are quietly implemented. These policies include (1) directing emergency departments to transfer all uninsured or government-insured patients, (2) limiting the amount of indigent care that can be provided, and (3) placing quotas on the number of indigent patients treated.

According to the report, although the council's review of available information found cases of unstable patients being transferred, most economic transfers appear to be made when the patient is stable. Based on its study of the issue, the council believes that specific agreements and procedures (here, including hospital protocols) should be developed at the local community level. The American Medical Association adopted the following set of principles to serve as a reference point for communities to develop procedures and interhospital agreements for the transfer of indigent patients:

- All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of ability to pay.
- An interfacility transfer of an unstable patient should be made only for appropriate medical purposes, that is, when, in the physician's judgment, it is in the patient's best interest to get needed medical care at the receiving facility rather than the transferring facility.

- Initiating adequate fluid or blood replacement or both.
- Determining that a patient's vital signs (blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion (injection of fluid into an artery in order to reach tissues). The vital signs should remain within these parameters for sufficient time before transfer to be reasonably certain that the signs will not deteriorate during the transfer. There may be instances, however, when it is not possible to stabilize a patient's vital signs because the hospital does not have the appropriate personnel or equipment needed to address the underlying problem. In such cases, the other stabilizing steps should be carried out and the transfer completed as quickly as possible.

The American College of Emergency Physicians also prescribes guidelines that should be observed for patient transfers. These include the following:

- A patient should be transferred to a facility appropriate to meet the patient's medical needs, with adequate space and personnel available to care for the patient.
- A physician or other responsible medical personnel designated by the hospital must agree to accept the patient before the transfer takes place.
- Communication between responsible persons at the transferring and receiving hospitals for purposes of exchanging clinical information should take place before the transfer.
- Once a patient is accepted for transfer, an appropriate medical summary and other records (including laboratory results, copies of electrocardiograms, and X-rays) should be sent with the patient.
- A patient should be transferred by a vehicle that has appropriately trained personnel and life-support equipment. At times, it may be necessary for additional specialized personnel from the transferring or receiving hospital to accompany the patient.

American Hospital Association

The American Hospital Association has made the following statement as part of a patient's bill of rights: A patient has the right to expect that, within its capacity, a hospital will make a reasonable response to a request for patient services, including evaluation, service, and referral, as indicated by the urgency of the case. In addition, when it is medically permissible, a patient may be transferred to another facility only after receiving complete information concerning the needs for, and alternatives to, the transfer. The receiving facility must accept the patient before the transfer is made. The statement does not specifically address economic transfers.

Transfer Policy and Indigent Care Funding in Five Other Areas

Officials representing five public hospitals in metropolitan areas across the country told us that, like DCGH, their hospitals guarantee care to residents regardless of ability to pay. Four of them have a documented policy to govern the transfer of patients to their institutions. In each area, the hospital receives some type of funding to help pay for the care of indigent patients.

Alameda County, California

According to California law, each county is required to provide care to its residents regardless of ability to pay. Accordingly, Highland General Hospital, Alameda County's major public hospital, is required to provide care to county residents even if they are unable to pay for their care. The county hospital director told us that the hospital receives 26 percent of its budget from the county government. The hospital also receives state funds to help pay the cost of serving medically indigent adults.

The East Bay Hospital Conference, a trade association of hospitals for two California counties, Alameda and Contra Costa, reported that the vast majority of problem transfers in Alameda County appear to be confined to the transfer of medically indigent adults from private hospitals to Highland Hospital. Specifically, the problems included

- a patient's arriving in a significantly different condition from that explained by telephone;
- transferring a patient in an unstable condition, even though the transferring hospital had the capability to treat the patient;
- disagreement between the transferring and receiving physicians concerning whether the patient should be transferred; and
- sending patients to Highland without notification or providing notification when the patient was en route.

Among the factors identified as contributing to the problem transfers were (1) lack of clear administrative procedures, (2) inadequate emergency room backup of specialty physicians at the transferring hospitals, and (3) lack of a procedure for evaluating problem transfers. It was also recognized that the basic underlying problem was the issue of uncompensated care coupled with government and third-party policies to increase competition, which limit the transferring hospitals' ability to shift costs to other payors. The conference's recommendations included adoption of transfer guidelines that provide a mechanism for evaluating problem transfers and the installation of a recording system to tape all

DCGH and other public hospitals contacted, however, there is no documented transfer policy or procedures for hospitals to follow in making transfers to Boston City Hospital.

The state of Massachusetts passed legislation, effective October 1, 1985, that, according to the Boston City Hospital chief executive officer, eliminates the need for hospitals to make economic transfers. The legislation, passed as a 2-year interim measure, provides for a pooling arrangement to compensate hospitals for the cost of care to those who cannot pay. The pool is financed by a uniform surcharge added to the prices hospitals charge to all but government payors. Hospitals whose free care or bad debt expenses are higher than the surcharge amount receive the difference from the pool. Hospitals whose free care and bad debt expenses are lower than the surcharge amount pay the difference into the pool. A rate-setting commission reviews the surcharge during the year to protect against a pool shortage that would develop if hospitals increased their overall level of free care.

According to Boston City Hospital's chief executive officer, even though there may have been more of an incentive for economic transfers before the pooling arrangement, transfers were not much of a problem because of the very good relationship Boston City Hospital had with other hospitals in the city. He said that Boston City Hospital has been the recipient of social rather than economic transfers. As an example, he indicated that a hospital may be inclined to transfer a drug addict not because of the lack of insurance but because of the nature of the medical problem.

In December 1983, Health Systems, Inc., issued a report on free care in Boston's emergency service. According to the report, there was a consensus among the emergency service personnel interviewed that economic transfers were neither widespread nor increasing in volume. Although many felt that there were occasional economic transfers, no single hospital was cited by a majority of those interviewed as a known offender. The low volume of economic transfers was believed to result from various factors, including the

- perceived relative lack of significance a hospital's emergency room activity had on the hospital's financial performance,
- nonrecognition of the effect of bad debt and free care on a hospital's financial performance,
- predominant coverage of hospital emergency rooms by staff who were generally not interested in the hospital's financial performance, and

245 patients for whom information on the reason for transfer was available, 87 percent were transferred because they lacked insurance. Total charges for the transferred patients amounted to $3.35 million, of which 84 percent was nonreimbursable.

The study included a clinical assessment of patient stability based on the transferring hospitals' records. Of the 435 records that had sufficient information to allow a determination of stability, 106 (24 percent) were classified as being in an unstable condition.

According to the acting director of Cook County Hospital, however, there are circumstances when it is appropriate to transfer an unstable patient. For example, he said that the transfer of a major trauma patient to Cook County Hospital in an unstable condition could be in the patient's best interest: Cook County Hospital is the only major trauma center in the region and can, therefore, better treat the patient than a transferring hospital not equipped to do so.

Dallas, Texas

Parkland Memorial Hospital is an acute care institution owned and operated by the Dallas County Hospital District. Parkland is mandated by law to provide care free of charge to indigent Dallas County residents for which it receives tax revenue. Parkland also provides services to paying patients and certain others who require services that are otherwise unavailable to them.

According to Parkland's vice president, there was a noticeable increase in the number of patients transferred to Parkland in early 1983. In August 1983, the hospital adopted a transfer policy to assist physicians and hospitals in the appropriate mechanisms by which transfers to Parkland should or should not be made. The policy was distributed in booklet form to hospitals, nursing homes, and private physicians throughout a nine-county area in north central Texas.

The transfer policy details procedures for patient stabilization and financial criteria for acceptance of patient transfers. According to the policy, no patient should be transferred without notification of, and acceptance by, an admitting physician and the administrator on duty.

Patient transfers to Parkland are coordinated through a 24-hour medical hotline staffed by registered nurses with emergency physician backup. A call to the hotline enables the transferring physician to discuss a patient's condition with the appropriate Parkland physician and obtain

For medically indigent adults who are residents of other California counties, San Francisco General's policy is to provide emergency care at no cost to the county of residence. San Francisco General will contact the patient's county of residence to request and arrange for transfer once the patient is stabilized. San Francisco General requests that other counties apply the same policy for San Francisco residents who go to the emergency room of other counties' hospitals.

By memorandum addressed to the chief administrators and emergency room medical directors of San Francisco hospitals, San Francisco's director of health has specified guidelines concerning the medical stability required for transfers between emergency departments and the procedures to be followed in transferring patients to San Francisco General. To be stable for transfer, patients should have a stable blood pressure and pulse and be breathing on their own. Patients whose vital signs (pulse, blood pressure, and respiration) require an intensive level of monitoring are not considered stable for transfer, according to the guidelines. Patients whose blood pressure is low, extremely high, or fluctuating rapidly are also not considered stable for transfer.

care if we are not to transfer patients for economic reasons. I support the idea of direct compensation to individual hospitals for uncompensated care. My institution will be happy to assist Chairman Dellums and the Congress in understanding and resolving the uncompensated care issue, since it is the cause of 23% of all transfers and impacts quality of care issues.

Now on p. 20.

In another area of your report (table 2.1 on p. 28), you stated that patients were not given any options other than transfer to DCGH. It should be noted that our policy is to indicate to all self pay patients that they have the option before admission of providing a deposit that covers part of the estimated cost of their total hospital stay. Our internal review indicates that some staff members have not been providing this information to all patients. We have taken appropriate steps to correct this problem.

If possible, I would appreciate receiving a copy of the finished report.

Your fine report looks at one small piece of the many health issues that the Congress should address. More important issues require our concerted attention.

Sincerely,

Sister Catherine Norton
President

Comments From the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

13 March 1987

Mr. Frank C. Conahan
Assistant Comptroller General
National Security and
International Affairs Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Conahan:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report, "HEALTH CARE: Patient Transfer from Emergency Rooms to D.C. General Seems Appropriate," dated January 8, 1987 (GAO Code 118141/OSD Case 7233).

The Department has reviewed the report. The DoD concurs with those findings and conclusions applicable to the Defense Department and has no further comments. The Department appreciates the opportunity to comment on this draft report.

Sincerely,

for William Mayer, M.D.

United States
General Accounting Office
Washington, D.C. 20548

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