Transfer of New York Hospital Inpatients Without Consent To Relieve Overcrowding: Legal, Ethical and Operational Issues

By Robert N. Swidler

During the most recent COVID-19 surge, overcrowded and understaffed hospitals were forced to consider transferring inpatients to other hospitals—whether or not the transferred patient or family consented to the transfer. On December 21, 2021, the New York State Department of Health issued a remarkable "Dear CEO Letter," authorizing such transfers subject to various requirements.[1] This article examines the need for such transfers, the law regarding consent to transfer, the DOH directive, and some ethical and operational issues raised by transferring a patient without consent.

More Patients, Less Staff

During the harsh winter of 2021-22, clinical staff in hospitals across New York State faced extreme stress on two fronts:

First, there was an awful, disheartening spike in inpatient admissions for treatment of COVID-19. While the new and now prevalent Omicron variant is less lethal than previous variants, it is far more contagious.[2] The spread of the virus in the community, abetted by opposition to vaccination, resulted in an unprecedented surge of individuals requiring hospitalization—far more than in prior COVID-19 waves.[3]

Second, this wave, unlike previous waves, was accompanied by a severe shortage of hospital nurses and other clinical staff.[4] To some extent the nursing shortage is simply an example of "the Great Resignation" that is affecting many businesses in this state and beyond. But there are additional drivers specific to hospital nurses. In particular, RNs:

- decided to leave for non-hospital nursing jobs that are less stressful and safer, with less exposure to COVID-19;
- decided to leave the field of nursing entirely for jobs that are less stressful and safer;
- were attracted away from their full time hospital jobs by offers from temporary staffing agencies that pay far more for part-time work (and that pass that cost, plus the cost of their profit, along to hospitals);
- were terminated from their hospital jobs for failure to comply with New York's vaccination mandate for health care workers;
- are temporarily unable to work because they are COVID-19-positive or exposed and are quarantined while recovering; or because they need to care for a loved one who is COVID-19 positive or exposed;
- must stay at home to care for a child because schools are closed or operating remotely.

A January 7, 2022 *New York Times* article captured the situation concisely and perfectly: "More Patients, Fewer Workers, Omicron Pushes New York Hospitals to the Brink."[5]

The Hypothetical Case

On the front lines of New York's hospitals, more patients and fewer workers has translated into situations like one described in the *New York Times* with stark brevity: "In Covid Ward, 2 Nurses Race to 36 patients."[6]

But more generically, it forced resource allocation decisions in scenarios such as this hypothetical case:

> A hospital ICU has 30 beds but only enough staff to care for 20 patients. At the moment it is full with 20 patients. There are three patients in the Emergency Department who need to be admitted to intensive care as soon as possible. Other area hospitals report that their ICUs are also full.

In such instance, what are the options, legal and otherwise?

Finding More Staff and Beds

Obviously the preferred solution is to find more staff and more beds. It may be possible to accomplish this to some extent by different strategies, such as redeploying staff from other units to the ICU, offering higher pay, placing orders with staffing agencies, or striving to attract experienced nurses out of retirement.[7] But those strategies have their limits and may not address an immediate need.

Providing a Lower Level of Care

Another approach is to rely upon fewer ICU staff than optimal, or stretch ICU resources in other extraordinary respects. But such approaches could compromise quality of care and expose patients to safety risks. Moreover, it could depart from the usual standard of care, and expose the facility and staff to liability risks. Notably, the New York State Legislature initially accepted, then resoundedly rejected the principle of protecting hospitals and staff from liability

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for decisions they were forced to make as a result of the COVID-19 surge.[8] Finally, such approach would accelerate staff burnout and thereby exacerbate the staff shortage.

The Triage Approach

The most drastic option is to triage access to the ICU; that is, to deny care to some who need it. Triaging of scarce ICU beds could take different approaches.[9] It could for example allocate beds/staff:

- on a first-come first serve basis, denying ICU care to anyone who shows up after the ICU is full;
- by a "lottery" type approach, in which medically eligible patients are randomly selected or excluded;
- by an approach that involves continuously scoring patients based on clinical criteria, in an effort to select the patients for whom ICU care would most likely be life saving.

In 2015, years before the COVID-19 pandemic, the New York State Task Force on Life and the Law proposed guidelines for the allocation of ventilators in an influenza pandemic.[10] Its proposal relied principally on clinical criteria, specifically sequential organ failure assessments or "SOFA scoring." As explained by the Task Force, its approach was designed "to save the most lives in an influenza pandemic where there are a limited number of available ventilators. To accomplish this goal, patients for whom ventilator therapy would most likely be lifesaving are prioritized."[11]

During the first wave of COVID-19 in Spring 2020, when New York hospitals had a shortage of ventilators (as well as many other resources), a great deal of attention was devoted to allocation proposals such as the Task Force's guidelines.[12] However, Governor Andrew Cuomo declined to endorse such approach or to protect hospitals that implemented it.[13] As a result, hospitals in New York were left to their own devices should ventilator allocation decisions be necessary. Thankfully, the COVID-19 wave and associated ventilator use subsided before triaging became widespread. But the most recent Omicron wave has raised anew the potential need for triaging patients—in this instance due to the scarcity of nurses or beds, not ventilators.

Notably, the denial of ICU care for a particular patient does not mean the denial of all care. The patient could potentially be provided with care in another inpatient unit within that unit's capability, or provided with comfort care. But there is no evading the fact that the patients denied ICU care would not be receiving the level of care they would otherwise expect to receive.

The Transfer Option

A far less drastic approach to address the scarcity of ICU beds and staff than triaging involves transferring some ICU patients to other hospitals that have ICU capacity. In the hypothetical above, other hospitals in the same region have a similar shortage, so transfers might have to be to more distant facilities, e.g., 50 miles away or more.

The prospect of transferring an ICU patient to a distant hospital is awful. The transfer itself could potentially impact the health or safety of the patient. It almost certainly will place enormous additional stress, burden, and travel expense on the patient's family members. It will hamper the family's ability to monitor and assist in the patient's hospital care. And in many if not most instances it understandably will generate patient or family objection and anger.

Even so, transfer to a distant hospital is far less extreme than denying ICU care to a patient who needs it to survive. It can be viewed as a next-to-last resort.

The Law Regarding Consent to Transfer

As illustrated by the hypothetical case, this article discusses transfers with specific attributes, i.e., transfers:

- of a hospital inpatient;
- to another distant hospital;
- to relieve overcrowding, during a public health emergency.

Because the focus here is on the transfer of an *inpatient*, federal EMTALA regulations are inapplicable.[14] And because the focus here is on a transfer to *another hospital*, the issues, and to some extent the regulations, are different from those raised by difficult discharges of inpatients to their home or to a nursing home.[15] Finally, because the focus here is on the transfer to relieve overcrowding during a public health emergency, there are considerations that transcend the preferences or best interests of the transferred patient.[16]

With that preface, here are the legal sources relevant to consent for inpatient intrahospital transfers:

1. *Federal Conditions of Participation* (CoPs). Federal Hospital CoPs (42 CFR Part 482) do not specifically require or even address consent to the transfer of a hospital patient. However, the hospital CoPs on discharge planning emphasize that discharge planning and transfers must be "consistent with the patient's goals for care and his or her treatment preferences."[17] Read one way the "consistent with preferences" provision gives the patient veto power over any transfer the patient dislikes. A more reasonable reading is that the patients preferences are limited by the available options. There is no caselaw construing the discharge CoPs as applied to an inpatient transfer to another hospital to relieve overcrowding.
2. *The Joint Commission standards*. Like the CoPs, the Joint Commission standards for hospitals do not specifically require patient consent to a transfer, but also call for respect for the patient's preferences.[18]

3. *NYS Department of Health (DOH) Regulations*. DOH hospital regulations (10 N.Y.C.R.R. Part 405), like CoPS and the TJC standards, do not specifically require patient consent to a transfer. In fact, in some instances the regs require a hospital to transfer a patient, without reference to consent.[19] But the most relevant regulations with respect to such transfers are as follows:

• 10 N.Y.C.R.R. § 405.8(h) states:

> (7) The hospital shall ensure that no person presented for medical care shall be removed, transferred or discharged from a hospital based upon source of payment. Each removal, transfer or discharge shall be carried out after a written order made by a physician that, in his/her judgment, such removal, transfer or discharge will not create a medical hazard to the person or that such removal, transfer or discharge is considered to be in the person's best interest despite the potential hazard of movement. Such a removal, transfer or discharge shall be made only after explaining the need for removal, transfer or discharge to the patient and to the patient's family/representative and prior notification to the medical facility expected to receive the patient.[20]

• 10 N.Y.C.R.R. § 400.9, Transfer and Affiliation Agreements, lists several regulatory requirements for transferring patients, such as a requirement that "the personal, alternate or staff physician requests or agrees to the admission, transfer or discharge unless the patient or resident signs out or is signed out against medical advice."[21] It does not refer to patient or decision-maker consent.

• 10 N.Y.C.R.R. § 360.2(a)(4)(i) provides that health care facilities, if directed by the commissioner, must rapidly discharge, transfer, or receive patients, while protecting the health and safety of such patients and residents. It also directs DOH to coordinate with health care facilities to balance individual facility patient load and allows it to promulgate further directives to specify the method and manner of transfer or discharge.

4. *Executive Orders*

Governor Hochul issued two Executive Orders that implicate inpatient transfers to other hospitals:

> • Executive Order No. 4 declares a statewide disaster emergency due to health care staffing shortage and allows the DOH commissioner to waive or suspend DOH regulations 400.9 405.9(h)(7) to the extent necessary to permit hospitals to transfer patients, as authorized by the commissioner, if necessary due to staffing shortages, provided such facilities take all reasonable measures to protect the health and safety of such patients and residents and to comply with EMTALA.[22]

> • Executive Order No. 11 declares a disaster emergency in New York State thereby giving DOH authority under 10 N.Y.C.R.R. Part 360 to activate the Surge and Flex Health Care Coordination System.[23]

The DOH Dear Administrator Letter

On December 21, DOH issued a Dear Administrator letter that authorizes the interhospital transfer of inpatients to relieve overcrowding.[24] The letter states that its purpose is:

> to explain how the Department expects general hospitals in New York State to work together to implement load balancing (shifting patients among hospitals to alleviate overcrowding when possible) during the State disaster emergency declared under Executive Order No. 4 and the State disaster emergency declared under Executive Order No. 11. As general hospitals in some regions of the State reach capacity, it may be necessary to transfer patients to general hospitals that have available beds either in that region or in other regions of the State dependent upon when and where there is bed availability.[25]

After noting its authority under Executive Orders 4 and 11, it states that

> in the case of a patient who is admitted at a general hospital (sending hospital) but must be transferred to another general hospital (receiving hospital), because the sending hospital is at or near capacity and must therefore triage which patients it can care for, 10 N.Y.C.R.R. § 400.9 and § 405.9(h)(7) are SUSPENDED to the extent necessary to permit general hospitals

to transfer such patients to a receiving hospital, if necessary because the sending hospital has reached capacity.[26]

With respect to consent, the letter states:

> If the health care decision-maker does not consent to the transfer, the patient may nevertheless be transferred so long as the health care-decision maker is advised of the benefits of the transfer and the risks of remaining at the facility. The health care decision-maker may sign the patient out against medical advice if there is no consent to the transfer.[27]

Other parts of the letter emphasize that the transferring hospital must still meet several other regulatory and additional requirements:

- the hospital must comply with EMTALA (although again, EMTALA is inapplicable to inpatients);
- there must be a written physician's order that, in the physician's judgment, such transfer:
  - will not create a medical hazard to the person or that such removal, and
  - is considered to be in the patient's best interest despite the potential hazard of movement;
- the transfer can be made only after explaining the need for removal, transfer or discharge to the patient or other authorized health care decision-maker;
- there must be prior notification to the medical facility expected to receive the patient;
- the patient or other authorized health care decision-maker must be consulted prior to a transfer to another facility;
- any objections regarding transfer must be documented in the patient's chart and include a description of who spoke with the patient and/or legal representative, and what was discussed with the patient and/or their legal representative;
- the hospital must maintain a record of transfers from the hospital, including the date and time of the hospital reception or admission, name, sex, age, address, presumptive diagnosis, treatment provided, clinical condition, reason for transfer and destination (i.e., receiving hospital);
- a copy of that information must accompany the patient and become part of the patient's medical record.

More generally, the letter advises hospitals to "continue to work with the Department's Surge Operations Center (SOC)."[28] Accordingly, hospitals would be well advised to inform DOH of any impending transfers over objection.

One of these letter's requirements seems problematic on its face—the requirement that the physician must determine that the transfer is "in the patient's best interest despite the potential hazard of movement."[29] This is based on a similar clause in the DOH hospital discharge regulation at § 405.8(h)(7). Such requirement made sense when the transfer was in furtherance of the treatment of the patient. But when the purpose of the transfer is to alleviate hospital overcrowding, it may well not be in the best interests of that individual patient. Inasmuch as DOH letter is explicitly for the purpose of "load balancing" it should have explicitly modified that "best interests" requirement and relieved physicians of this attestation item. Perhaps DOH reasoned that a transfer is in the best interests of a patient when the alternative is the denial of care. Or perhaps DOH recognized that a fair system to transfer patients to alleviate overcrowding is in the best interests of all patients.

Ethical Considerations

The practice of transferring a patient over objection to relieve overcrowding is defensible from an ethical standpoint, provided certain ethical safeguards are in place.[30]

Obviously any such transfer sharply conflicts with, indeed overrides, the autonomy of the patient being transferred. But circumstances make it impossible to uphold the autonomy of every patient who wishes to remain in the particular hospital. There is no right to autonomy at the expense of other's autonomy. For that reason, the case for autonomy is weaker in connection with a demand for treatment or resources than in connection with a decision to forgo treatment or resources.

Rather, the principal ethical values implicated here are justice (the fair allocation of scarce resources) and non-malfeasance (the obligation to do no harm).[31]

The DOH directive barely addresses the fair allocation of resources; it does not prescribe any standard or process for the selection of patients to be transferred. Other DOH regulations and other federal laws speak to this somewhat by prohibiting discrimination based on race, age, disability, payor source and so forth. But hospitals are left on their own to identify who is transferred and who remains. However, the DOH letter does emphasize the need to ensure the safety of any transfer, and thus upholds the principle of non-malfeasance.

As it turns out, in this instance the values of justice and non-malfeasance are aligned: The selection criteria seek those patients who can most safely be transferred. As a result, patients who start from a lower baseline of health (some disabled persons, some black and minority patients, some low income persons) are *less* likely to be selected for involuntary transfer. This is in striking contrast to the allocation of ventilators based on SOFA scoring, where patients who start from a lower baseline of health may be disadvantaged in the competition for a ventilator.[32]

Moreover, hospital decisionmakers should recognize that some families are less able than others to bear the financial burden of traveling to the recipient hospital than others. That is a legitimate non-clinical, ethical consideration rooted in justice and should be reflected in involuntary transfer policies.

Even so, hospitals and attending physicians must at all times guard against racism, ableism, and other biases in the process of selecting who is transferred. And hospitals should establish policies and oversight procedures to ensure justice and nonmalfeasance in selection—as well as regulatory compliance.

Finally, while it may be unrealistic to secure patient consent to a transfer, providers have ethical obligations relating to their communications and interactions with the patients who are being transferred and their families. Those obligations include the need to explain why they are being transferred and the selection criteria that was used, to hear and try to take into account any special considerations, concerns and requests and—above all—to treat the patient being transferred and their family with respect and compassion.

Operational and Other Considerations

Based largely on the DOH Letter, a hospital may transfer an inpatient to another hospital to alleviate overcrowding without the patient/decision-maker's consent, and even over his or her objection provided the various safeguards and requirements are met. Even so, there are other significant considerations and barriers when the patient / family adamantly refuse the transfer.

- ***Consent to the transportation.*** While the transferring hospital may not require consent, the ambulance company or other transportation company may insist upon consent before transporting the patient. DOH offered in its directive to provide or arrange assistance in the transport in some instances, but this remains a significant operational barrier. But it would have been more helpful if the DOH Letter, in instances where it waived the need for consent to transfer, also specifically waived the need for consent to transport (assuming such action was within its emergency powers).
- ***Consent to admission to the recipient hospital.*** The recipient hospital will necessarily seek the patient/decisionmaker's consent to admission. Here is another operational barrier to an involuntary transfer. It is not clear whether DOH could solve this problem with its emergency authority. It appears that the principal solution has to involve discussing with the patient or decisionmaker their limited options and seeking the necessary consent.
- ***Kidnapping?*** In some circumstances the taking of a person from one place to another against their will constitutes the federal and state criminal offense of kidnapping.[33] Certainly the offense of kidnapping was not designed or intended to apply to the interhospital transfer of an ICU patient. But apart from statutory intent, in this instance the patient or decision-maker has options, though awful ones. First the DOH directive explains that "The health care decision-maker may sign the patient out against medical advice if there is no consent to the transfer."[34] Second as discussed previously there may be an option to remain the hospital in a medical unit or with comfort care. The option to leave AMA or to receive non-ICU care, practical or not, neutralizes the inapt case for kidnapping.
- ***Payment.*** Private health insurance generally covers hospitalization at participating (in-network) hospitals, and emergency care at remote hospitals. A transfer from a network hospital ICU to an out of network ICU due to overcrowding probably does not constitute emergency care for the patient. The health plan might insist upon the right to prior approve the transfer, or else deny payment. This could be another barrier to an involuntary transfer. However, the state Department of Financial Services could eliminate the need for such payer approvals, much as it did for patient transfers within a managed care provider network.[35]
- ***Emotional toll on staff.*** The principal burden of any involuntary transfer falls on the patient and the patient's family. That cannot be minimized. But recognition needs to be given to the toll any such confrontation will take on staff. Health care workers are under enormous stress even in normal times. That stress was amplified exponentially as a result of the pandemic.[36] The obligation to implementing involuntary transfer adds greatly to that burden, as it requires heart-wrenching selections among severely ill patients, dealing with angry family members, grappling with complex bureaucratic requirements, and facing concerns about civil liability and regulatory sanctions. Those who undertake this thankless deserve support, and the recognition that their role is essential to save lives.

Conclusion

As of this writing the latest Omicron surge has receded, and so has the need for involuntary transfers. But a new subvariant is spreading,[37] so this article may be of more interest than just an historical document. But in either case, it highlights one among many instances in which DOH, to its credit, recognized and supported extraordinary and controversial steps that hospitals and their staff needed to take to save the most lives in this pandemic.

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Endnotes

1. *General Hospital Patient Transfers for Load Balancing During State Disaster Emergency*, NYS Department of Health, DHDTC DAL# 21-14 (Dec. 21, 2021) (hereinafter "DOH Letter"). Reproduced at the end of this article.
2. *See* Centers for Disease Control and Prevention (hereinafter CDC), *Omicron Variant—What You Need to Know,* https://www.cdc.gov/coronavirus/2019-ncov/variants/omicron-variant.htmlwebsite on Feb. 2, 2022.
3. *See* CDC, *Staff Shortages*, https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html.
4. *See, e.g.*, Ian Cook, *Who is Driving the Great Resignation*? Harvard Business Review (Sept. 15, 2021), https://hbr.org/2021/09/who-is-driving-the-great-resignation.
5. NY Times (Jan. 27, 2022), https://www.nytimes.com/2022/01/07/nyregion/ny-hospitals-omicron-covid.html.
6. NY Times (Jan. 16, 2022), paper version. The online headline is *What the Omicron Wave Looks Like in One Brooklyn E.R.*, https://www.nytimes.com/2022/01/15/nyregion/brooklyn-omicron-cases.html.
7. *See* n.3 above.
8. *See* The Emergency Disaster Treatment and Protection Act, NY PHL Article 30-D (2020) and subsequent NY Laws, Chapter 96 (2021) repealing PHL Article 30-D.
9. *See* NYS Task Force on Life and the Law, *Ventilator Allocation Guidelines*, (November 2015), https://www.health.ny.gov/regulations/task_force/reports_publications/#allocation (hereinafter *Task Force Ventilator Allocation Guidelines*) at p.13. (discussing various allocation approaches).
10. *Task Force Ventilator Allocation Guidelines,* n.9 above.
11. *Task Force Ventilator Allocation Guidelines* at p.5.
12. *See* e.g., *N.Y. May Need 18,000 Ventilators Very Soon. It is Far Short of That,* NY Times (March 17, 2020).
13. The governor issued an Executive Order that briefly protected some health care professionals from liability for acts or omissions "in support of the State's response to the COVID-19 outbreak." Executive Order 202.10 (March 23, 2020). That Executive Order, which never protected hospitals, was superseded by legislation that was broader in some respects and narrower in others and was later repealed. Public Health Law 30-D, repealed Ch. 96, 2021. *See also* note 8 above.
14. 42 CFR § 489.24, *Special Responsibilities of Medicare hospitals in emergency cases*. However, the CMS State Operations Manual warns that "If the surveyor discovers during the investigation that a hospital did not admit an individual in good faith with the intention of providing treatment (i.e., the hospital used the inpatient admission as a means to avoid EMTALA requirements), then the hospital is considered liable under EMTALA and actions may be pursued." State Operations Manual, Appendix V—*Interpretive Guidelines— Responsibilities of Medicare Participating Hospitals in Emergency Cases.*
15. *See* 10 N.Y.C.R.R. § 405.9(h). I joined other authors in writing about inpatient discharges to home or nursing care a few times in the past. See e.g., R. Swidler, T. Seatrum, W. Shelton, *Difficult Hospital Inpatient Discharge Decisions: Ethical, Legal and Clinical Practice Issues*, American J. of Bioethics (March 2007) p. 23; R. Swidler et al., *A Conversation About Difficult Inpatient Discharge Decisions*, NYSBA Health L., J. (Fall 2009) p. 108.
16. Notably, the issue of need for the acute care bed figures in some of the nursing home discharge cases as well. *See, e.g.*, *United Health Services Hosps. v. J.W*., No. 2013-62, 2013 WL 10350229 (N.Y. Sup. Ct. 2013) (In ordering discharge-ready patient to accept discharge, the court explained that the patient's continued presence in an acute care bed had caused other patients in need of such a bed to be held for extended periods in the hospital ER).
17. 42 CFR § 482.43 introductory paragraph:

    The hospital must have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to preventable hospital readmissions.
18. *See* The Joint Commission standard on Provision of Care Treatment and Services PC 04.02.01.01 and Rights and Responsibilities of the Individual, RI 01.02.01.01..
19. 10 N.Y.C.R.R. 405.6(b)(1)—Quality Assurance Program (The QA Committee must review care to ensure that the hospital "is transferring those patients for whom the hospital does not have the capacity to provide care, except under conditions of disasters and/or emergency surge that may require admissions to provide care to those patients."
20. 10 N.Y.C.R.R. § 405.8(h)(7).
21. 10 N.Y.C.R.R. § 400.9(c)(1).
22. Executive Order 4, No. 4: Declaring a Statewide Disaster Emergency Due to Healthcare Staffing Shortages in the State of New York (ny.gov).
23. Executive Order 11, No. 11: Declaring a Disaster Emergency in the State of New York (ny.gov).
24. DOH letter. *See* n.1 above.
25. DOH letter, p.1
26. DOH letter, p.1-2.
27. DOH letter, p.2.
28. DOH letter, p.2.
29. DOH letter, p.1.
30. *See* Michael Nurok, MBChB, Ph.D., Michael K. Gusmano, Ph.D., and Joseph J. Fins, M.D., MACP, FRCP, *When pandemic biology meets market forces—managing excessive demand for care during a national health emergency*, 67 J. of Critical Care (Feb. 2022), pp. 193-94. https://doi.org/10.1016/j.jcrc.2021.09.018 (identifying ethical principles in the allocation of ICU beds in times of crises. The article addresses the need for potentially distant transfers for ICU care—but does not address the issue of transfer consent).
31. *See* T. Beauchamp and J. Childress, *Principles of Biomedical Ethics* (1979), identifying four principles of medical ethics that have proven enduring: respect for autonomy, non-maleficence, beneficence, and justice.
32. *See, e.g.*, Michelle M. Mello, J.D., Ph.D., Govind Persad, J.D., Ph.D., and Douglas B. White, M.D., *Respecting Disability Rights—Toward Improved Crisis Standards of Care*, 383 NEJM E-26(1) (July 30, 2021); Rabia Belt, Celina Malavé and Camila Strassle, *Disability and Health in the Age of Triage*, Harvard Law Review Blog (July 1, 2020).
33. *See* N.Y. Penal Law Article 135, Kidnapping, Coercion and Related Offenses.
34. DOH letter, p.2.
35. *See* NYS Dep't of Financial Services Circular Letter No.1, Coronavirus and the Suspension of Certain Utilization Review Requirements, at https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2022_01.
36. On the moral distress of clinicians during COVID-19, *see* Janet Dolgin, Renee McLeod-Sordjan, Walter Markowitz, and Maria Sanmartin, *A novel ethical approach to moral distress during COVID 19 in New York*, 16 J. Clinical Ethics (2021) pp. 330-340.
37. NY Times, A New Subvariant is Spreading Rapidly in the United States (May 4, 2022).

Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

December 21, 2021

DHDTC DAL#: 21-14
General Hospital Patient Transfers for
Load Balancing During State Disaster Emergency

Dear Chief Executive Officer:

The purpose of this guidance is to explain how the Department expects general hospitals in New York State to work together to implement load balancing (shifting patients among hospitals to alleviate overcrowding when possible) during the State disaster emergency declared under Executive Order No. 4 and the State disaster emergency declared under Executive Order No. 11. As general hospitals in some regions of the State reach capacity, it may be necessary to transfer patients to general hospitals that have available beds either in thatregion or in other regions of the State dependent upon when and where there is bed availability.

Under Executive Order No. 4, as continued, the following may be waived or suspended:

> "Section 400.9 and paragraph 7 of subdivision h of section 405.9 of Title 10 of the NYCRR, to theextent necessary to permit general hospitals and nursing homes licensed pursuant to Article 28 ofthe Public Health Law that are treating patients during the disaster emergency to discharge, transf er, or receive such patients, as authorized by the Commissioner of Health if necessary due to staffing shortages, provided such facilities take all reasonable measures to protect the health and saf ety of such patients and residents, including safe transfer and discharge practices, and to comply with the Emergency Medical Treatment and Active Labor Act (42 U.S.C. section 1395dd) and any associated regulations."

In addition, Executive Order No. 11 satisfies the requirement that there be a declared State disaster emergency in order to give the Department authority under 10 NYCRR Part 360for the Commissioner of Health to activate the Surge and Flex Health Care Coordination System. Under 10 NYCRR §360.2(a)(4)(i):

> "Health care f acilities regulated by the Department shall, if directed to do so by the Commissioner, rapidly discharge, transfer, or receive patients, while protecting the health and saf ety of such patients and residents, and consistent with the Emergency Medical Treatment andActive Labor Act (EMTALA). The Department shall coordinate with health care facilities to balance individual facility patient load, and may promulgate further directives to specify the method and manner of transfer or discharge."

This DAL does not alter established federal EMTALA law, regulations, and guidance.The federal State Operations Manual for Medicare provides guidance regarding the federal regulations, including 42 CFR §489.24(f), under which patients who present at a hospital but have not been admitted may be transferred to another hospital, which would be required to accept the patient transfer.

Consistent with the Commissioner's authority under the Surge and Flex regulations, inthe case of a patient who is admitted at a general hospital (sending hospital) but must be transferred to another general hospital (receiving hospital), because the sending hospital is at or

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near capacity and must therefore triage which patients it can care for, 10 NYCRR §400.9 and §405.9(h)(7) are SUSPENDED to the extent necessary to permit general hospitals to transfer such patients to a receiving hospital, if necessary because the sending hospital has reached capacity. Both the sending hospital and the receiving hospital must continue to at all times take all reasonable measures to protect the health and safety of such patients, including safe transfer and discharge practices, and they must comply with EMTALA and associated federal regulations and guidance.

Regarding consent by the patient or other authorized health care decision-maker, federal rules under Conditions of Participation (COPs) for Medicare and Medicaid are comparable to the provisions of 10 NYCRR §405.9(h)(7). Each removal, transfer or discharge shall be carried out after a written order made by a physician that, in the physician's judgment, such removal, transfer or discharge will not create a medical hazard to the person or that such removal, transfer or discharge is considered to be in the patient's best interest despite the potential hazard of movement. Such a removal, transfer or discharge shall be made only after explaining the need for removal, transfer or discharge to the patient or other authorized health care decision-maker and prior notification to the medical facility expected to receive the patient. The patient or other authorized health care decision-maker must be consulted prior to a transfer to another facility. If the health care decision-maker does not consent to the transfer, the patient may nevertheless be transferred so long as the health care-decision maker is advised of the benefits of the transfer and the risks of remaining at the facility. The health care decision-maker may sign the patient out against medical advice if there is no consent to the transfer.

Any objections regarding transfer must be documented in the patient's chart and includea description of who spoke with the patient and/or legal representative, and what was discussed with the patient and/or their legal representative. The record should also reflect which physician made the determination to transfer the patient and why. The hospital must maintain a record of transfers from the hospital, including the date and time of the hospital reception or admission, name, sex, age, address, presumptive diagnosis, treatment provided, clinical condition, reason for transfer and destination (i.e., receiving hospital). A copy of this information must accompany the patient and become part of the patient's medical record.

General hospitals should do everything they can to work with patients and their legal representatives prior to a transfer using this suspension. General hospitals should also be aware of any logistical issues that arise when a patient is transferred.

General hospitals should continue to work with the Department's Surge Operations Center (SOC). The Department will make every effort to assist with transportation using the FEMA National Ambulance Contract (NAC). New York's hospitals have done an incredible job working together to continue to provide care to all New Yorkers during the COVID-19 State of Emergency, and the Department expects that they will continue to do so. However, in the event that a sending hospital is unable to obtain the consent of the receiving hospital to accept a patient transfer, *the Department will use the SOC to direct the receiving hospital to accept the patient transfer where medically appropriate*.

Sincerely,

Dorothy M. Persico