Overview

- EMTALA Violations related to Behavioral Health
- Application of EMTALA to Behavioral Inpatient Facilities
- Behavioral Health and EMTALA – the Crosswinds
- Accepting Patient Transfers
EMTALA Violations Related to Behavioral Health

- Failure to provide emergency services to patient presenting to the hospital –
  - EMTALA risk of “holding out” as or having a “de facto” dedicated emergency department
  - Failure to meet Medicare conditions for emergency assistance if no dedicated emergency department
EMTALA Violations Related to Behavioral Health

Failure to provide an adequate medical screening
- Documenting the medical and behavioral screening
- Assessment of suicide or homicide attempt or risk, orientation or assaultive behavior that indicates a danger to self or others
- Continued monitoring of patient (even if crisis team is present)
- Re-evaluation at departure or discharge

Failure to provide an appropriate transfer
- Can 5150s be considered “stabilized”
- Selection of an appropriate facility (transfers to PHFs and CSUs)
- Use of appropriate transportation
  - Crisis team vans and police transport
  - Private vehicles
- Transfer or discharge?
  - Discharge and aftercare instructions

Failure to accept an appropriate transfer
- Refusal based on financial considerations
- Requiring prior authorization
- Refusal to accept out-of-county transfers
An individual presents at the entrance to a behavioral health facility seeking immediate attention (may be medical or behavioral)

- Does EMTALA apply???
- If yes, what are the obligations of the facility?
- If not, what are the obligations of the facility?
EMTALA Obligations of Behavioral Health Facilities

Does EMTALA apply to the behavioral facility?

- Is the facility a Medicare-participating hospital?
  - If yes, EMTALA applies
  - If no, EMTALA does not apply
    - A PHF that is not certified as a Medicare-participating hospital is not subject to EMTALA

EMTALA Obligations of Behavioral Health Facilities

Full-Coverage of EMTALA –

- Applies only if the behavioral facility has a “dedicated emergency department” or DED
- Having a DED is not dependent on state licensure

EMTALA Obligations of Behavioral Health Facilities

A DED is any department of the hospital, that meets at least one of the following requirements:

- Licensed as an emergency department; or
- Held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
- One-third of all walk-ins receive treatment for emergency conditions in the past calendar year
What you need to know:

- How do you advertise your hospital to the public if no organized emergency services?
- Monitor your walk-ins – if 33%+ walk-ins in the past year with emergency conditions, EMTALA applies
- Reverse advertising – “No emergency services”

If no emergency services are provided –

- Must comply with the Medicare conditions of participation for hospitals without emergency services
- Must comply with the EMTALA accepting hospital obligation

Medicare conditions for hospitals without emergency services –

- If emergency services are not provided, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment and referral when appropriate
- Regardless if the hospital has an ED or not, the hospital must have the capability to provide basic emergency care interventions
EMTALA Obligations of Behavioral Health Facilities

Appraisal, Initial Treatment and Referral
- Hospital must ensure that an RN is immediately available as needed to provide care
  - There must be one RN qualified to conduct an assessment that enables him/her to recognize the need for emergency care
- Physician, on-site or on-call, must provide appraisals or medical direction to on-site staff conducting an appraisal

EMTALA Obligations of Behavioral Health Facilities
- Physician, on-site or on-call, can provide initial emergency treatment or medical direction to on-site staff to provide initial emergency treatment
- Expectation that hospital can evaluate the patient population in order to anticipate potential emergency scenarios and develop the policies, procedures and staffing that would enable it to provide safe and adequate initial treatment of an emergency

EMTALA Obligations of Behavioral Health Facilities
- A hospital must have medical staff policies and procedures to address scenarios when an individual’s emergency needs exceeds hospital’s capability
  - When a individual requires referral or transfer and appropriate handling and transport of patient
- 42 CFR §482.43(d)—Discharge Planning
  - Hospital must transfer to appropriate facilities that can treat patient’s condition
  - Hospital must send necessary medical information to receiving hospital
Other Obligations of Medicare Participation –

- Physician On-Duty or On-Call AT ALL TIMES (42 CFR §482.12(c)(3))
- A Responsible Physician for Each Patient (42 CFR §482.12(c)(4))
- RN Supervision and Availability at all Times (42 CFR §482.23(b))
  - RN must be immediately available to provide care when needed
- Right to Care in a Safe Setting (42 CFR §482.13(c)(2))

EMTALA Accepting Hospital Obligation

- Applies to all hospitals, whether or not they provide emergency services
- New EMTALA Interpretive Guidelines (2009) provide that accepting hospitals must have on-call rosters

The Crosswinds of EMTALA and State Laws
The Crosswinds of EMTALA and State Laws

The EMTALA Winds—
“Hospitals located in those States which have state/local laws that require particular individuals, such as psychiatric or indigent individuals, to be evaluated and treated at designated facilities/hospitals may violate EMTALA if the hospital disregards the EMTALA requirements and does not conduct an MSE and provide stabilizing treatment or conduct an appropriate transfer prior to referring the individual to the State/local facility.”

The State Winds—
- Patients may be detained involuntarily for evaluation and limited treatment of a mental disorder resulting in a danger to self/others or grave disability (5150)

The EMTALA Winds—
EMTALA does not recognize the concept of a hold!!!
- Implications for informed right to refuse treatment or transfer
Stabilization for Behavioral Emergency Patients

- Patients who are a danger to self/others are considered to have an emergency condition under EMTALA
  - EMTALA does not recognize grave disability
- Psychiatric emergencies are considered to be stabilized if the individual is protected and prevented from injuring self/others, but…

…CMS guidance indicates that the sending physician using restraints to stabilize the emergency condition may be at some risk of an EMTALA violation since the use of restraints may stabilize the condition for a period of time while the underlying condition may persist and become exacerbated if not treated in a timely manner

**Outcome:** CMS will generally assume that an individual on a 5150 has an unstabilized emergency condition, and will apply EMTALA to the transfer of the individual to a designated facility
The mobile crisis unit is called to ED to assess a patient brought in from home by his caretaker.

Caretaker notes patient suffered a traumatic brain injury that has left him partially disabled.

The patient is reportedly prone to periodic episodes of rage and aggressive behavior and earlier that day had lashed out at the caretaker verbally, threw a hammer at her and then chased her down the hall before tripping on the hallway rug and falling to the floor and hurting his wrist.

X-rays revealed no wrist fracture, but a supportive wrap is applied and treatment instructions given.

The Crisis Team is called and asked to assess the patient for application of a 5150 hold under the “danger to others, or to himself or herself” standards within the law.

A Crisis Team member interviews the patient and finds that he is still enraged at the caretaker for an undetermined reason.
Case Study

- Crisis Team declines to place the hold because behavior is the result of an organic brain injury and not a “mental disorder”
- Caretaker advised that the Crisis Team refused to place the patient on a hold

Case Study

- The treating ED physician remains very concerned about the patient’s continuing behavior
- The hospital is not designated by the county and has no psychiatric services
- The caretaker is clearly frightened by the patient and is refusing to take him home

Case Study

What treatment or placement options, if any, should the hospital consider?
- Keep the patient for observation under a 24-hour hold?
- Discharge the patient?
- Call the police?
- Call a psychiatric facility?
  - Can it refuse the patient without a hold?
  - Is transfer feasible without a hold?
- Call your local member of the Board of Supervisors?
Case Study

- Despite caretaker’s concerns for safety, hospital discharges the patient to another relative willing to take the patient home
- Patient later that day attacks and kills the caretaker
- Does the caretaker have a cause of action against the hospital?

Issues to Consider

- What is the effect of the Crisis Team assessment (and its refusal to find the patient “holdable”) on whether the patient has an “emergency medical condition?”
- Can the hospital seek alternative placement and detain the patient for 24-hour period while attempting to find placement?
- Did the hospital meet its EMTALA obligations during the patient stay?

W & I Code 5150

Welfare and Institutions Code (WIC) Section 5150

- When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team provided by Section 5651.7, or other professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation.
72-Hour vs. 24-Hour Holds—Who May Initiate a Hold

72-Hour Hold
- Peace officer
- Attending staff
  - Broader than hospital usage of “attending”
- County-designated mobile crisis team member
- Other county-designated professional persons

24-Hour Hold
- Treating physician
- Clinical psychologist with medical staff privileges
- Clinical psychologist with clinical privileges
- Certain state hospital psychologists

24-Hour Hold—Conditions for Immunity

(1) The person cannot be safely released from the hospital because, in the opinion of the treating physician, or certain psychologists, the person, as a result of a mental disorder, presents a danger to self, others or is gravely disabled

(2) The hospital staff, treating physician, or appropriate licensed mental health professional, has made and documented repeated unsuccessful efforts to find appropriate mental health treatment for the person
(3) The person is not detained beyond 24 hours

- A person detained under this section must be credited for the time detained in the event he or she is placed on a subsequent 5150

- A 24-hour hold does not affect hospital obligation to comply with all state laws and regulations for psychiatric patients relating to:
  - Seclusion and restraint; and
  - Psychiatric medications

- Persons who are detained retain their legal rights regarding consent for medical treatment

What if No 5150 Hold Instituted Within 24-Hour Period?

Options:

- Continue detention of patient (without legal authority)
- Stop involuntary detention; permit patient to voluntarily remain while arranging services
  - Raises issue of “voluntary” ambulance transfer of psych patients
What if No 5150 Hold Instituted Within 24-Hour Period?

Options:
- Let patient leave upon expiration of 24-hour hold with no follow up (EMTALA violation?)
- Let person leave non-designated facility and contact:
  - PET team to go out and evaluate patient for psych hold
  - Police to go out and evaluate patient for psych hold

Liability to the Caretaker for Releasing the Patient

Moses v. Providence Hospital and Medical Centers (6th Circuit; 2009)
- Spouse took estranged husband to Michigan hospital due to physical and psychiatric symptoms (hallucinations, delusions, threatening behavior)
- Spouse told ED staff that she feared for her life
- Hospital admitted patient, but not to the psychiatric unit
- Patient killed spouse 10 days after discharge
- Estate of spouse sued hospital

Liability to the Caretaker for Releasing the Patient

- Court rejected the argument that inpatient admission barred an EMTALA claim
  - 6th Circuit has applied EMTALA to inpatients for over 10 years
  - Ignored CMS regulations
- Court held that a third-party has standing to sue under EMTALA for personal harm by a patient discharged from a hospital in violation of EMTALA
- Full court rejected reconsideration of the decision
- Is this decision persuasive???
Accepting Patient Transfers

EMTALA Obligations of Behavioral Health Facilities

A hospital must accept a transfer if the following exist:

1. The patient presented to the transferring hospital seeking or in need of emergency care and treatment
2. The patient has an emergency medical condition that is not stabilized (and is not an inpatient)

EMTALA Obligations of Behavioral Health Facilities (cont.)

3. The transferring physician determines that the patient requires further examination and treatment in order to stabilize the emergency medical condition
4. The transferring hospital does not have the capability or capacity to stabilize the patient’s emergency condition
5. The receiving hospital has the capability and capacity to treat the patient (including an accepting physician)
EMTALA Obligations of Behavioral Health Facilities

A hospital may refuse a transfer or an emergency patient with an EMC only if—
1. The patient is an inpatient at the transferring hospital
2. The transferring hospital is located outside of the United States

EMTALA Obligations of Behavioral Health Facilities (cont.)

3. The patient’s EMC is stabilized as determined by the transferring physician
4. The receiving hospital does not have the present capability and capacity to treat the patient
5. The transferring hospital has the present capability or capacity to stabilize the patient’s emergency condition

Accepting Patient Transfers

Ask the Right Questions:
1. Is the patient an ED patient?
2. Does the patient have an EMC?
3. Is the EMC stabilized?
4. What is the reason for the transfer?
   What are the patient’s clinical needs?
5. Does the sending hospital have the present capacity/capability?
6. Document the answers
Accepting Patient Transfers

Ask the Right Questions:
1. Is an appropriate bed available?
2. Is there appropriate staff?
3. Is an attending physician available?
4. Are the patient’s needs within the scope of our admitting policies and capabilities
5. Document your answers

Accepting Patient Transfers

Considerations for Receiving Hospital and Physician
- Can I ask for pertinent clinical information?
- Can I request copies of the patient record?
- Can I talk with the transferring physician?
- Can I ask if an on-call physician was contacted?

DON’T ASK !!!
- Patient insurance/financial status until after a transfer of a patient with an EMC has been accepted
- Anything else related to money (e.g., preadmission deposit)
Accepting Patient Transfers

EMTALA Interpretive Guidelines:
“The requirements against delays or disparate treatment based on financial or insurance status “applies equally to both referring and receiving (recipient) hospitals … Therefore, it may be a violation if the receiving hospital delays acceptance of an individual with an unstabilized EMC pending receipt or verification of financial information …”

Accepting Patient Transfers

- Don’t pick EMTALA compliance fights while the patient is waiting for transfer
- Don’t refuse a transfer because the sending hospital does not have a physician on call to see the patient
- Trigger the chain of command if inappropriate physician refusal to accept an emergency patient
- Accept the patient, then deal with the issue administratively after having made sure you have all of your facts straight

Chain of Command

Critical component
- Addressing an on-call refusal at the receiving hospital
- Addressing intra- and inter-hospital disputes on a real time basis
New State Legislation—Transfers of Behavioral Emergency Patients

- A hospital may transfer a patient with an psychiatric emergency medical condition to another inpatient facility to relieve or eliminate the emergency condition if the transferring physician believes, within reasonable clinical confidence, that there will no material deterioration in the patient’s condition from the transfer.

New State Legislation—Transfers of Behavioral Emergency Patients (cont.)

- “Psychiatric emergency medical condition” is defined as a mental disorder that manifests itself by acute symptoms of sufficient severity, rendering the patient as being either—
  - An immediate danger to self/others; or
  - Immediately unable to provide for or utilize food, shelter or clothing, due to the mental disorder (i.e., grave disability).

New State Legislation—Transfers of Behavioral Emergency Patients

- The sending hospital must seek to identify and notify the patient’s health or aligned provider.
  - If the patient is transferred to a non-contract hospital, the plan may arrange a transfer to a contract facility if safe to do so (in the judgment of the treating provider).
- The receiving hospital must also notify the health plan of the patient’s transfer following admission.
New State Legislation—Transfers of Behavioral Emergency Patients

- Providers are not required to seek prior authorization of emergency services and care to a patient who has a psychiatric emergency medical condition, except as required by law.
  - Emergency services and care to relieve or eliminate a psychiatric emergency condition, include an admission or transfer to an inpatient psychiatric unit or facility that does not conflict with LPS.
- Purpose of legislation was to remedy the problem of hospitals being denied payment for rendering emergency care to health plan members with a psychiatric emergency.

Questions

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