California Hospital Association
Rural Health Care Symposium

Managing Challenging Patients in Your ED

Thursday, February 19, 2015
4:30 p.m. – 5:30 p.m.

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The Nature of the Challenge – Part 1

- A person who appears to be “under the influence” and who is clearly exhibiting mental health issues (DTS/DTO or GD) is dropped off at your ED by local law enforcement.
- The person may or may not be on a 5150 hold.
- It is late at night, on a weekend.
- The person looks like he may be homeless.
- He has no ID, no money with him, and no apparent insurance coverage; he is non-responsive to your questions about whether he is covered by MediCal.
- He tells you his name, but a quick check of your records indicates that this is likely his first encounter with you.
The Nature of the Challenge – Part I (cont.)

- You do not know the name(s) of any of his other healthcare providers (or, they won’t talk to you “because of HIPAA”).

- Your County may or may not have a 24/7 mobile crisis team (and... it is late at night, on a weekend); your County may or may not have a designated LPS-designated facility; you may or may not have a psychiatrist/psychologist on call or available via telemedicine.

- The patient is uncooperative and becomes more loud and agitated when staff try to interact with him.

- Temperatures are expected to drop to the high teens tonight, OR your hospital is located near a major highway with truck traffic/or near a body of water/or close to a high bridge. **Your patient is now indicating a desire to leave.**
Sound familiar?

Wait....there’s more....
The Nature of the Challenge – Part 2

- The patient has been placed on a 5150 hold, or is being detained per Health and Safety Code 1799.111, but there is *difficulty finding a bed

- (Or, a bed has been found, but now there is difficulty finding transportation)

- *...hours pass...then days...
The Nature of the Challenge – Part 2 (cont.)

Have you ever asked yourself:

*Is it just me, or is this problem getting worse?*
The Nature of the Challenge
(yes, it is getting worse!)

- Number of psychiatric hospitals in United States
  - 1995 – over 1,500
  - 2010 – fewer than 450

- Number of psychiatric units in United States
  - 1995 – over 1,500
  - 2010 – fewer than 300

- Number of EDs – 1995 to 2010 (DOWN 18%)

- Population of United States – going UP
California Hospital Association:

- 5-14% of patients in the ED are there for behavioral health needs;
- 26/58 (45%) counties have no designated inpatient psychiatric beds;
- 47/58 (81%) have no child/adolescent beds;
- 56/58 (97%) have no geri-psych beds;
- 50/58 (86%) have no chemical dependency beds;
- the wait time for a bed in some counties is 14 days (average)
- 2012 Study: Average adult waits over 10 hours after decision is made for a psychiatric admission
(yes, it is getting worse) cont.

– ACEP Survey:
  • 79% ED Administrators reported boarding problems (keeping patient in ED after decision to transfer or admit)
  • A third of those, routinely kept patients 8 hours or more!
Others have noticed too...

– **The Joint Commission**
  
  • 1/1/14 – new Leadership (LD) standard (“the patient flow standard”) includes requirement that in hospitals that have determined there is a population at risk for boarding due to behavioral health emergencies, the hospital leadership will communicate with behavioral health care providers and/or authorities serving the community to foster coordination of care for this population.
  
  • Elements of Performance (EP) standards include requirements for a process that supports better patient flow, locations for patients that are safe, monitored, and cleared of dangerous items, orientation and training for any staff caring for such patients (including for example, medication protocols and des-escalation techniques), and assessments, reassessments and care that is consistent with the patient’s identified needs.
Others have noticed too...(cont)

- **US Commission of Civil Rights – September 2014 Report: Patient Dumping** includes specific findings:
  - Current lack of data collection that identifies EMTALA complaints by category means there is no good data on the number of patients with psychiatric disability who are disproportionately impacted by patient dumping
  - EMTALA violations/enforcement is primarily complaint-driven, and patients disabled with psychiatric conditions likely under-report EMTALA violations due to diminished capacity or access to resources
  - Problem likely much bigger than we think (anecdotal data suggests poor follow-up on “reverse dumping” complaints)
Legal/Regulatory Framework

- 5150 law – SB 364
  - Now gives us two routes for dealing with a patient who has been placed on a 5150 hold:
    - 1) provide crisis intervention and evaluate as to need for further detention and
    - 2) transport to designated hospital where patient will be evaluated at the door to determine whether he can be served voluntarily or in a less restrictive setting (e.g., outpatient services)
  - Hopefully this will “help” with “through-put” and move folks on to appropriate care
BUT, there are still huge gaps (and variations in interpreting) the law:

- What does the law say about the “step” between the hold and actual admission into a designated facility? Hint:
- Who can write a hold (varies)?
- Who can “lift” a hold (varies)?
- Who is legally responsible to find a bed for an unstable psychiatric emergency?
- Who is legally responsible for keeping a 5150 patient from leaving?
- Who is legally responsible to transport the patient?
- What happens to a hold when the patient is admitted for medical care?
Legal Framework - EMTALA

– When does EMTALA begin?

– What is an appropriate medical screening examination (MSE)?

– What is an emergency medical condition (EMC)?

– What stabilizing treatment is required?

– What is an appropriate transfer?

– When must a hospital accept a transfer?
When Does EMTALA Begin?

- Four Paths
  - Individual presents to “dedicated emergency department” (ED/OB) seeking/in need of examination or treatment for a **medical** condition
  - Individual presents elsewhere on hospital property seeking/in need of examination or treatment for potential **emergency** condition
  - Individual in a hospital-owned/operated ambulance that is not operating under emergency medical services (EMS) direction
  - Individual in a non-hospital owned/operated ambulance on hospital property
EMTALA – Core Obligations

– Medical screening examination
– Further examination and stabilizing treatment for an emergency medical condition
– On-call coverage
– Transfer/discharge of patients
– Acceptance of patients with unstabilized emergency conditions requiring a higher level of care
– No delay of required services, including transfers, for insurance or payment reasons
When is an “Emergency Medical Condition” Stabilized?

- When is an emergency condition stabilized?
  - **EMTALA regulations**: when no material deterioration is likely, within reasonable medical probability, to result from or occur during the transfer of the patient to another medical facility (or woman having contractions has delivered the baby/placenta)
  - **Interpretive Guidelines**: an emergency condition is not stabilized until the condition, within reasonable medical confidence, is “resolved”
  - **Warning**: disputes or misunderstandings arise when “stable” is used to describe a patient who has an unstabilized emergency medical condition
  - An emergency patient with a stabilized EMC, as determined by the sending physician, is not covered by EMTALA
Scenario 1 – The Facts

- Patient A presents to the ED of Hospital X in the custody of a police officer, or an EMT directed by a police officer to take Patient A to the ED
  - Hospital X is not a designated facility
  - Hospital X does not provide psychiatric services
  - Neither the ED physicians nor any other staff members are authorized to detain a person involuntarily under Section 5150
Scenario 1 – The Facts

– Police officer has written an application for involuntary detention (5150)

– Presenting complaint: suicidality based on reported ingestion of lethal drugs and several bloody lacerations that may be self-inflicted

– Police or EMT indicate that Patient A tried to escape enroute to the hospital
Scenario 1 – Issues

- Patient care issues –
  - Assessment of the patient’s condition (medical screening)
  - Monitoring of the patient
  - Safety/security of the patient – elopement risk
  - Placement/disposition following medical clearance

- Legal/Risk Issues
  - Adequacy of the medical screening
  - Stabilization and monitoring
  - Secure environment – elopement risk?
  - Transfer or discharge
Scenario 1 – Triage

- **CMS 2567**: “__ of 48 sampled patients who presented to the ED with psychiatric emergencies, including suicidal ideations and altered level of consciousness:
  - (a) were not initially assessed and placed at the appropriate level of acuity
  - (b) were delayed in receiving an MSE to determine whether an emergent medical condition existed.”
Scenario 1 – Triage (cont.)

- Special training for the triage staff—able to recognize risk and communicate well
- Plan for managing psychiatric patients pending the MSE
  - Staff awareness of patient condition/needs
  - Room placement
  - Minimize risk of harm to self/others
  - Minimize risk of elopement
Scenario 1 – MSE

- CMS Guidance: “For individuals with psychiatric symptoms, the medical records should indicate an assessment of suicide or homicide attempt or risk, orientation, or assaultive behavior that indicates danger to self or others.”
Scenario 1 – Provision of Care

- The Joint Commission (PC.01.01.01): “Hospitals that do not primarily provide psychiatric or substance abuse services have a written plan that defines the care, treatment and services or the referral process for patients who are emotionally ill or who suffer the effects of alcoholism or substance abuse.”
Scenario 1 — Psych EMC EMTALA

- EMTALA regulations define an emergency medical condition as including “psychiatric disturbances”
- EMTALA Interpretive Guidelines
  - In the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an EMC
Stabilization of Psychiatric EMC

- **EMTALA**: when no material deterioration is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the facility

- **California law**: same as EMTALA regulations
Stabilization of Psychiatric EMC (cont.)

**EMTALA Interpretive Guidelines**

“Psychiatric patients are considered stable when they are protected and prevented from injuring or harming him/herself or others.”

- Restraints for transfer “may stabilize a psychiatric patient for a period of time and remove the immediate EMC ...”
- But ...
Stabilization of Psychiatric EMC (cont.)

**EMTALA Interpretive Guidelines**

But ...

“... underlying medical condition may persist and if not treated for longevity the patient may experience exacerbation of the EMC.”

“Therefore, practitioners should use great care when determining if the medical condition is in fact stable after administering ... restraints.”
Scenario 1 — Monitoring

EMTALA – does not differentiate between treatment of medical and psychiatric patients

- Further examination following MSE is required if EMC or possible EMC
- Periodic monitoring for all patients
- Stabilizing treatment within hospital capability for patients with an EMC or possible EMC
- Documentation of patient status
- Compliance with transfer and discharge rules
Scenario 1 — Monitoring (cont.)

- **CMS 2567** — “… the facility failed to ensure that two ... patients who presented to the ... ED ... with psychiatric diagnoses (including suicidal and homicidal ideations or an altered level of consciousness) received ongoing assessments and monitoring to ensure stabilization of an emergent condition ... These failures resulted in the potential for the undetected deterioration of an emergency medical condition which would place patients at risk for harm, including elopement.”
Scenario 1A – Next Steps

— ED physician —
  • Determines that Patient A is “medically clear”
  • Examines Patient A for suicidal ideation; and
  • Monitors Patient A for six hours
— ED physician concludes that Patient A’s psychiatric condition, within reasonable clinical probability, is “stabilized”
— Patient A is still under a 5150 hold
Scenario 1A – Next Steps (cont.)

- ED physician is not authorized to release the hold; what can ED physician do?
  - Discharge the patient?
  - Transfer the patient to a designated facility?
    - Is this an EMTALA transfer?
      - Call the law enforcement agency that wrote the hold?
      - Call the County and ask for assistance?
Scenario 1A – Risk Factors

Authority to hold the person involuntarily if the custodial officer or county-authorized professional is not present in the ED:

- Is the patient still subject to involuntary detention?
  - What is the obligation of a peace officer to the detained person?
  - Is the obligation transferred to the ED physician?
  - Is there a difference if the person was detained by a mental health worker?
- Can the involuntary hold be enforced if the patient wants to leave?
- Can hospital personnel restrain the person from leaving the facility?
  - Does the hospital have an obligation to obtain a sitter or security to watch the patient?
  - What is the procedure if the patient tries to elope or does elope?
- How long can the ED hold a person under involuntary detention if no placement?
Psychiatric EMC v. 5150 Hold

Similarities, but not congruence –

– Psychiatric EMC applies to any person based on the clinical judgment of an ED physician or other qualified professional designated by the medical staff

– 5150 hold is applied to a person “involuntarily” based on probable cause by a peace officer or a county-authorized professional
Psychiatric EMC v. 5150 Hold (cont.)

Similarities, but not congruence –

– A psychiatric EMC may not meet the probable cause standard for a 5150 involuntary hold
– A 5150 involuntary hold does not always mean that a person has a psychiatric EMC
– A determination that a patient’s psychiatric EMC is stabilized does not itself alter the status of a 5150 involuntary hold
EMTALA and Involuntary Holds

- There is nothing in the EMTALA statute that addresses involuntary holds
  - This is a state process
- EMTALA surveyors often use the involuntary hold as a variable in determining the presence of a psychiatric EMC
  - Documentation must be clear as to whether the ED physician has determined if the psychiatric EMC is stabilized
Scenario 1A – Reassessment

- County mental health worker arrives to reassess the involuntary detention of Patient A —
  - The mental health worker determines that Patient A will accept voluntary treatment in her community that is more than 25 miles from the hospital
  - The mental health worker releases the hold, and advises the ED physician that Patient A may be discharged to her community in accordance with a treatment plan described by the mental health worker in her written reassessment of Patient A
Scenario 1A – Discharge

- **EMTALA Interpretive Guidelines** — Discharge home with follow-up instructions.
- An individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions ... Hospitals are expected within reason to assist/provide discharged individuals the necessary information to secure the necessary follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital.
Scenario 1A – Discharge (cont.)

– The ED physician advises staff of the discharge plan
– Patient A wants to leave the hospital; but
  • Refuses to contact a family member or friend to pick her up since it is after midnight; and
  • Refuses to stay at the hospital until morning; and
  • Indicates that she does not have the money to pay for a taxi or other transportation to her residence
– What is the obligation of the hospital?
Scenario 1A

- CMS 2567 –
- “... the hospital failed to comply with ... [EMTALA] when Patient 1 was diagnosed with a psychiatric emergency medical condition and the hospital did not fully implement the stabilizing measures as determined by the mental health crisis worker ... The stabilizing measures identified by ... [the crisis worker] were located in Patient 1’s home town and Patient 1 was discharged without a means to get to her home, a distance of [___] miles from the hospital.”
Scenario 1B – The Facts

– ED physician —
  ▪ Determines that Patient A is “medically clear”
  ▪ Examines Patient A for suicidal ideation; and
  ▪ Monitors Patient A for six hours
– ED physician concludes that Patient A’s psychiatric condition is not “stabilized” and orders staff to arrange a transfer
– Patient A is still under a 5150 hold
Scenario 1B — Sending Hospital Obligations

Under EMTALA, the transfer of a patient with a psychiatric EMC is no different than the transfer of a medical patient with an EMC

- Continued monitoring and treatment
- Obtain acceptance of a receiving facility
- Physician certification of the transfer
- Transfer of patient records
- Appropriate means of transportation
- Reassessment at time of departure
Scenario 1B — Receiving Hospital Obligations

- **CMS Guidelines:** A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or, with respect to rural areas, regional referral centers may not refuse to accept from a referring hospital within the boundaries of the U.S. an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

- This is regardless of whether the hospital has a dedicated emergency department and does not apply to inpatients.
Scenario 1B — Where to Transfer???

— Must the receiving facility be a designated LPS hospital?
  ▪ In the county network?
    — Whose county if out-of-county patient?
  ▪ Out-of-county network?
— Must the receiving facility be a hospital?
— Must the receiving facility be located in California?
Scenario 1B — How Far to Transfer???

– Hospital X calls Hospital Y seeking acceptance of the transfer
– Hospital Y has capacity and capability to accept the transfer, but the representative stated, “it is too far”
– Hospital X calls CMS that Hospital Y refused to accept a patient determined to have a unstabilized psychiatric condition
– Does this warrant an investigation?
Scenario 1B — How Far to Transfer???

– YES!
– Under EMTALA, a hospital with capacity or capability cannot refuse to accept a patient based solely on location and where this hospital “thinks” the sending hospital should send the patient
– Hospital Y will be investigated for recipient hospital obligations
Scenario 1B – Receiving Hospital or Facility

Types of psychiatric receiving facilities –

- Acute hospital with inpatient psychiatric unit (locked or unlocked?)
- Acute psychiatric hospital (designated/non-designated)
- Psychiatric health facility (PHF)
  - Medicare certified or not certified?
- Crisis stabilization unit (CSU)
  - Does it qualify as a psychiatric receiving facility under EMTALA?
Scenario 1B – Receiving Facility

CMS Letter (11-12-09)

Question to CMS: must an EMTALA ED transfer be hospital to hospital?


- An appropriate transfer under EMTALA does not require in all cases that the receiving facility must be a hospital
- A transfer to a CSU or other non-hospital facility is not automatically a violation of EMTALA
Scenario 1B – Receiving Facility CMS Letter (11-12-09)

However ...

- The sending physician, in certifying the transfer, must have a reasonable clinical confidence that the CSU has the capability to stabilize the patient’s behavioral emergency
  - If the sending physician does not have the clinical confidence that the CSU can stabilize the condition, the physician should arrange a transfer to a level of care higher than the CSU

**Note:** a CSU is not subject to EMTALA unless operated under a hospital provider number
Scenario 1B — Resources to Find Designated Facilities

http://www.dhcs.ca.gov/provgovpart/Pages/MH-Licensing.aspx

- Lanterman-Petris-Short (LPS) Act Designated Facilities
- Find a Mental Health Treatment Facility

**WARNING:** No guarantees that webpages are available and up to date
Scenario 1B — Release of Psych Patients to Police

CMS 2567

“The record of Patient __ was reviewed ... a ___-year old female ... with a chief complaint of suicidal ideation and attempt

“The ED record indicated that the patient was treated for lacerations ..., then discharged in the custody of the PD, to be transferred to the acute psychiatric hospital at Hospital __ for psychiatric evaluation and stabilization.”
Scenario 1B — Release of Psych Patients to Police

CMS 2567 (cont.)

“The record did not contain evidence a physician explained the risks and benefits of the transfer to the patient, the receiving facility agreed to accept the transfer of the patient, the medical records were sent to the receiving facility, or the patient consented to the transfer.”
Consent and Other Issues

- Refusal of medical care? Is medical screening part of involuntary treatment? Or does patient have a right to refuse, e.g., labs?
- What if patient has been kicked out of his home as a result of his behavior (and has never been to a homeless shelter)?
- What if patient is comfortable “on the streets” – e.g., can you discharge to a park?
Risk Reduction Checklist

- Find out who can write a hold in your County and create a list with contact information and availability
- Find out who can “lift” a hold (create a list/contact info)
- If your County “contracts” for beds, create a list with phone numbers/contact info of those “designated facilities” where patients can go for psychiatric care
- Meet with County and decide who will stay with the client (may vary depending on day/time/aggressiveness)
Risk Reduction Checklist -continued

- Find out who is available to transport the patient (list times/days/contact info)

- Ask/help County develop policies on what happens when patient is admitted for medical care (e.g., “Mental Health will reassess when patient is ambulatory if physician sees need; hospital will contact Mental Health”)

- Work with County resources and social service agencies to develop plan for discharge of homeless patients
Risk Reduction Checklist -continued

- Be flexible when creating MOUs and policies, recognizing that things change and unique situations present themselves!
- Consider MOU with Crisis Stabilization Unit so it is clear that patient who has unstable psych emergency will get proper care if you decide to transfer patient there
- If you haven’t secured a bed and 24 hours (H&S 1799.111), or 72 hours (5150), has passed, consider a call to County Patients’ Rights Advocate to advise them of situation
- Train your staff to document vital signs (as they monitor patient) and to document every phone call on patient’s behalf
Risk Reduction Checklist -continued

- Make sure County MH staff is invited to EMTALA training so they understand “your world”
- Train your staff about their EMTALA responsibilities (and CMS expectations re: screening exam, stabilization, and safe transfer plans for an unstable patient)
- Train your staff about EMTALA documentation and audit it!
- Try to meet with law enforcement and County MH on regular basis to strengthen “community bond”
- Meet, when necessary to trouble-shoot issues that come up from time to time
Resources and Links


• Link to Find Mental Health Facilities:
  
  [http://www.dhcs.ca.gov/provgovpart/Pages/MH-Licensing.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/MH-Licensing.aspx)
Resources and Links (cont.)

Lanterman-Petris-Short (LPS) Act Designated Facilities

Find a Mental Health Treatment Facility

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Questions?