

Be the Voice



EMTALA in the Psychiatric Environment

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Disclaimer Slide

- This presentation is intended to provide information regarding EMTALA, the obligations of behavioral health facilities, psychiatric detention laws and involuntary holds
- The presentation does not constitute legal advice, or its application to the delivery of emergency health care services
- Attendees should consult with their own legal counsel and/or risk management for advice and guidance



Overview

- Application of EMTALA Rules to Psychiatric Patients
- EMTALA Obligations of Behavioral Health Facilities
 - Accepting Hospital Obligations
- State Law Tensions
 - LPS and 5150 Process
 - 1799.111 Holds



EMTALA Violations Related to Behavioral Health

P E N A L T Y



Application of EMTALA Rules to Psychiatric Patients





Psychiatric Emergency Medical Condition (EMC)

- CMS guidelines: an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others
- California hospital licensing law: a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:
 - An immediate danger to himself or herself or to others; or
 - Immediately unable to provide for, or utilize, food, shelter, or clothing, due to mental disorder



Stabilization



- When no material deterioration is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from the facility.



Transfer of Psychiatric Patients

Transfer subject to
same rules whether
medical or
psychiatric EMC





Transfer of Psychiatric Patients: Placement

- No designated inpatient facility in 40% of CA counties
- Limited beds available for specialty populations
- CSUs and PHFs
 - Restrictions on admissions, medical clearance and service limitations
 - *Generally* not subject to EMTALA unless Medicare certified



Transfer of Psychiatric Patients: Placement (cont.)

Transfer to a CSU?

- EMTALA transfers made to a “receiving facility”
- Historical view?
- No formal guidance



Transfer of Psychiatric Patients: Placement (cont.)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 52-12-25
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations/Survey and Certification Group

November 12, 2009

- A transfer to a CSU or other non-hospital facility is not automatically a violation
- But, “transfer to a medical facility that lacked the capacity to stabilize the EMC would not be consistent with EMTALA.”
- Hospitals should assess capabilities of a CSU to provide stabilizing treatment



Transfer of Psychiatric Patients: Placement (cont.)

Recommendations/Experience with CSU Transfers

- Transfer agreements
- Clear communication with CSUs
- Expect surveyor criticism!
 - Examples of violations issued in two cases
 - Discomfort by some CDPH surveyors that CSUs are not licensed facilities



EMTALA Obligations of Behavioral Health Facilities





An individual presents at the entrance to a behavioral health facility seeking immediate attention (may be medical or behavioral) –

Go to www.menti.com and use the code **54 03 17**

Does EMTALA apply?

0%
Yes

0%
No

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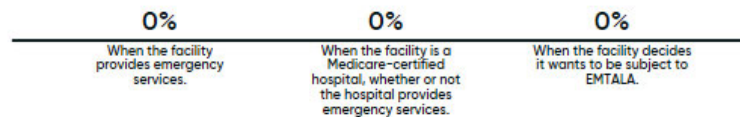
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EMTALA Obligations of Behavioral Health Facilities

Go to www.menti.com and use the code 68 18 42

When is a facility subject to EMTALA obligations?



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EMTALA Obligations of Behavioral Health Facilities

Is the facility a Medicare-participating hospital?



EMTALA!



EMTALA does not apply.



EMTALA Obligations of Behavioral Health Facilities

Full Coverage of EMTALA?

- Only applies if behavioral facility has a dedicated emergency department (“DED”)
- Having a DED is *not* dependent on state license



EMTALA Obligations of Behavioral Health Facilities: DED





EMTALA Obligations of Behavioral Health Facilities

If no emergency services provided

- Must still comply with the Medicare conditions of participation for hospitals without emergency rooms
- Must still comply with the EMTALA accepting hospital obligations



EMTALA Obligations of Behavioral Health Facilities

Medicare CoPs for hospitals without emergency services

- Appraisal, initial treatment, and referral when appropriate
- Capability to provide basic emergency care interventions
- Discharge planning (New regulations effective November 29, 2019)



EMTALA Obligations of Behavioral Health Facilities

Other obligations of Medicare Participation

- Physician On-Duty or On-Call AT ALL TIMES (42 CFR § 482.12(c)(3))
- Responsible Physician for Each Patient (42 CFR § 482.12(c)(4))
- RN Supervision and Availability at all times (42 CFR § 482.23(b))
- Right to Care in a Safe Setting (42 CFR § 482.13(c)(2))



EMTALA Accepting Hospital Obligation

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-19-15-EMTALA

DATE: July 02, 2019
TO: State Survey Agency Directors
FROM: Director
Quality, Safety & Oversight Group
SUBJECT: Frequently Asked Questions on the Emergency Medical Treatment and Labor Act (EMTALA) and Psychiatric Hospitals

Memorandum Summary

- **EMTALA and Psychiatric Hospitals:** Medicare-participating psychiatric hospitals are required to comply with EMTALA requirements.
- **Frequently Asked Questions:** CMS is providing the attached Frequently Asked Questions document to address common inquiries from psychiatric hospitals regarding compliance with EMTALA.

Background

Medicare-participating hospitals, including psychiatric hospitals, are required to comply with EMTALA. The requirements are consistently applied in hospitals and critical access hospitals with emergency departments and labor and delivery departments. At times, however, there is confusion or misconceptions regarding EMTALA obligations in psychiatric hospitals.

The attached Frequently Asked Question document addresses common inquiries specific to EMTALA compliance in psychiatric hospitals. Intake or assessment areas in psychiatric hospitals may meet the threshold of “dedicated emergency department” as defined in the EMTALA regulations at §489.24(b) and be required to meet EMTALA screening and stabilization requirements. **In addition, since psychiatric hospitals offer specialized services, they are required to meet the recipient hospital requirements at §489.24(f).**

EMTALA Accepting Hospital Obligation

- Applies to all hospitals, whether or not they provide emergency services
 - *Interpretative Guidelines Tag A-2411/C-2411*



EMTALA Accepting Hospital Obligation



- When does a hospital *have* to accept a transfer?
- When can a hospital *refuse* a transfer??



EMTALA Accepting Hospital Obligation

Ask the Right Questions....

- Is the patient an ED patient?
- Does the patient have an EMC?
- Is the EMC stabilized?
- What is the reason for the transfer? What are the patient's clinical needs?
- Does the sending hospital have the present capability/capacity?



Document. Document. Document.



EMTALA Accepting Hospital Obligation

Ask the Right Questions....

- Is an appropriate bed available?
- Is there appropriate staff?
- Is an attending physician available?
- Are the patient's needs within the scope of our admitting policies and capabilities?



Document. Document. Document.



EMTALA Accepting Hospital Obligation

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
- Anything related to money (e.g., preadmission deposit)



EMTALA Accepting Hospital Obligation

“...as a practical matter, any hospital with specialized capabilities and facilities that refuses a request to transfer an unstabilized patient risks violating ... [EMTALA]...to the extent it chooses to second-guess the medical judgment of the transferring hospital.”

– *St. Anthony Hospital v. DHHS*



If Patient Has an Unstabilized EMC...

- The sending hospital may arrange an appropriate transfer to any accepting facility, within or outside of the county or state, that has the capacity and capability to stabilize the psychiatric EMC
- Absent an exception, a receiving facility cannot refuse acceptance of an appropriate transfer if it has the capacity and capability to stabilize the psychiatric EMC



Work Collaboratively!





EMTALA and State Law Tensions



INFORMATION OVERLOAD



LPS and the 5150 Process

Steps in the pre-hospitalization process

- Involuntary detention by a peace officer or an authorized person based on probable cause, and...
 - Diversion for assessment, evaluation and crisis intervention, or
 - Placement of the person at a county-designated evaluation and treatment facility
- Person must receive an assessment by an authorized professional before an inpatient admission



LPS and the 5150 Process (cont.)

- **A 5150 hold is not a clinical determination**
- A 5150 hold allows a peace officer or a designated professional to detain a person, upon probable cause, that the person, due to a mental disorder, is dangerous to self or others, or gravely disabled



Designated Facilities

Types of designated facilities –

- Acute hospital with inpatient psychiatric facility or unit
- Acute psychiatric hospital
- Psychiatric health facility (PHF)
 - Many are not Medicare certified
- Crisis stabilization unit (CSU)
 - Most are not licensed facilities

As of October 2019 –

- 153 designated inpatient facilities (includes PHFs)
- 29 designated CSUs and outpatient facilities



Resources to Find Designated Facilities

Lanterman-Petris-Short (LPS) Act Designated Facilities

<https://www.dhcs.ca.gov/Documents/LPS-24hr.pdf>

<https://www.dhcs.ca.gov/Documents/LPS-Outpatient-CSU.pdf>

<https://www.dhcs.ca.gov/Documents/LPS-Otherfacilities.pdf>

Find a Mental Health Treatment Facility

<https://www.dhcs.ca.gov/Documents/PsychiatricHealthFacility.pdf>

WARNING: No guarantees that webpages are available and up to date



Psychiatric EMC v. 5150 Hold

Similarities, but not congruence –

- A 5150 hold is based on **probable cause** by a peace officer or a county-authorized professional as a legal mechanism to take a person involuntarily to a designated facility for an assessment of a behavioral health condition
- Psychiatric EMC is based on a **clinical judgment** of an ED physician or other qualified professional designated by the hospital medical staff



Psychiatric EMC v. 5150 Hold

Similarities, but not congruence –

- A psychiatric EMC may not meet the probable cause standard for a 5150 hold
- A 5150 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
- Documentation must be clear as to whether the ED physician has determined if the psychiatric EMC is stabilized



Psychiatric EMC v. 5150 Hold (cont.)

The practical reality – stabilized or unstabilized

- EMTALA does not recognize involuntary holds, but
- Surveyors often use the 5150 hold as a variable in determining the presence of a psychiatric EMC
- **Responsibility:** ED physician must determine if a psychiatric EMC is stabilized or unstabilized
 - County professionals may advise as to 5150 status, but cannot interfere with the judgment or responsibility of the ED physician
- **Critical:** medical clearance or a transfer of an ED psychiatric patient does not mean that the psychiatric condition is stabilized



Psychiatric EMC v. 5150 Hold (cont.)

The practical reality – transfer decisions

- **Responsibility:** If the psychiatric EMC is unstabilized, the treating physician determines the transfer decision process
 - County professionals may advise or help arrange placement, but they **cannot** direct or interfere with the responsibility of the treating physician or the hospital to seek placement
 - EMTALA overrides the county network of facilities



EMTALA vs. County Policies

- **Basic Rules to Live By:**
 - EMTALA = Federal law
 - LPS = State Law
 - EMTALA > Conflicting State Laws
- **Know your EMTALA obligations!**
 - If patient's psychiatric EMC is not stabilized, hospital personnel must follow EMTALA, not directions that conflict with the EMTALA obligations, including screening, treatment and transfer



EMTALA vs. County Policies (cont.)

Types of conflicts:

- Refusal by county personnel to respond to EDs
- Interference by county personnel with treating physician as to whether a psychiatric EMC is stabilized
- Interference by county personnel in transfer decisions and limitations as to facility placement



EMTALA vs. County Policies (cont.)

Examples of conflicts:

- Out-of-county resident –
 - County of hospital will not respond to E.D.
 - County of residence will not accept the patient
- County LPS training manual: “Sending 5150 detainees to hospitals NOT designated by [the department] is illegal.”
- Interference in restricting designated facilities to accept out-of-county patients





The 1799.111 Hold Is it a Practical Alternative?



**How many hospitals here use
or have used the 1799.111
hold?**



1799.111 Disclaimer

- §1799.111 is an orphan law in the family of involuntary hold laws and immunities tucked away in the State emergency medical systems law
 - It has nothing to do with LPS or Licensing
- Legal interpretations of §1799.111 —
 - There is no state agency or county department that has authority to interpret §1799.111
 - There are no cases *interpreting or applying* §1799.111
 - There are no Attorney General opinions interpreting or applying §1799.111



1799.111 — Basic Requirements

- Must be an acute or psychiatric hospital that is **NOT** a county-designated LPS facility
- Applies to the licensed professional staff, or physician providing emergency services, in any department of the hospital
- No civil or criminal liability —
 - For detaining a person if statutory conditions are met; or
 - For the actions of a detained person after release from the detention at the hospital if statutory conditions are met



1799.111 — Other Conditions

- The hospital must comply with all state laws and regulations relating to seclusion and restraint, and psychiatric medications for psychiatric patients
- The detained person retains his/her legal rights regarding consent for medical treatment
- The person must be credited for time detained if he/she placed on a subsequent 5150 hold



1799.111 — Resources

- Additional information and resources:
 - CHA Mental Health Manual, Ch. 3
 - CHA EMTALA Manual, Ch. 6 (pp. 6.29-6.32)
- Documentation:
 - Form 12-12 in the CHA Mental Health Manual for documentation of a 1799.111 hold



1799.111 — Advantages?

advantages

- No County involvement
- Does not require paperwork or 5150 application
- But must document the patient record
- Lacks the stigma and record of a 5150 hold



1799.111 — Advantages?

advantages

- Provides treatment alternative and flexibility
- May help in obtaining authorization for post-stabilization services?
- Immunities



1799.111 — Disadvantages?

disadvantages

What happens if the 24-hour period expires and no transfer??



1799.111 – Other Questions

- If you find placement, can you transfer a person under a 1799.111 hold to a designated facility if the person refuses to consent to the transfer?
- Will CDPH/CMS treat a 1799.111 hold different than a 5150 hold for EMTALA purposes?
- If a patient arrives on a 5150 hold placed by law enforcement, and the custodial officer leaves the hospital –
 - Is the 5150 hold still valid?
 - Can you treat the 5150 as lapsed?
 - Can you convert the patient to a 1799.111 hold?

Opportunities to Improve Collaboration





Communication

- Hospitals and counties
- Hospitals and behavioral health facilities (including acute psychiatric hospitals)
- ***Don't work in isolation!!***





Sharing of Best Practices

- Emergency psychiatric evaluation
- Behavioral patient care management
- Patient security and elopement avoidance
- Psychiatric telemedicine consultations
- Use of 1799.111 holds as alternative to expiring 5150 holds
- Hospital access to 24-hour hotlines



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Thank You

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Questions?

Raise your hand or submit a question at
www.menti.com and enter code 95 34 60