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Updates and Implications for EMTALA and California's Involuntary Treatment Laws

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Ms. Macklin is a trusted advisor to a range of inpatient and outpatient behavioral health care providers, along with hospitals and health systems. She has counseled many of California's hospitals on unsettled areas of law, with an emphasis on compliance with the Emergency Medical Treatment and Labor Act (EMTALA). Her work with providers includes advising on licensing and accreditation, Medicare and Medi-Cal reimbursement, federal and state privacy and confidentiality requirements, and operational issues. She also helps California providers navigate voluntary and involuntary treatment under the Lanterman-Petris-Short Act (LPS Act).

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In his role at the Jewish Family Service of San Diego, Mike Phillips provides instruction and training for the behavioral health community, including providing information on due process rights for individuals receiving behavioral health treatment throughout the County of San Diego. He also oversees permanent supportive housing programs throughout the Coachella Valley, and safe parking programs throughout San Diego County. He is currently consulting at the state level on behavioral health reform, including participation in the statewide Behavioral Health Action Coalition, and provides both local and statewide law enforcement training on behavioral health issues.

Disclosure of Relevant Financial Relationships

Alicia Macklin, Esq., reports no relevant financial relationships or relationships she has with ineligible companies of any amount during the past 24 months.

Mike Phillips, Esq., reports no relevant financial relationships or relationships he has with ineligible companies of any amount during the past 24 months.

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Don't Wait Until It's An Emergency: Understanding EMTALA and What's New in California's Involuntary Treatment Laws

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Disclaimer

- This presentation is solely for **educational purposes** and the matters presented herein do not constitute legal advice with respect to your particular situation.
- The presentation does not constitute legal advice, or its application to the delivery of health care services.
- Attendees should consult with their own legal counsel and/or risk management for advice and guidance.

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Agenda

EMTALA

- Old law, new dilemmas amid new responsibilities for hospitals
- AB 1316 – requiring Medi-Cal managed care plans to pay for beneficiaries experiencing a mental health crisis

2023 Changes to the LPS Act ** UPDATES **

- SB 43 – County-by-County implementation of new definition of "gravely disabled" (and *SB 1238*!)
- SB 929 – Phase II of data collection requirements

2024 New Laws

- SB 1238 – definition of "designated facilities"; addressing individuals with severe substance use disorder
- SB 1184 – administration of antipsychotic medication to involuntarily detained individuals
- AB 2154 – patient rights' handbook requirements

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EMTALA Refresher

EMTALA Core Obligations

- Medical screening examination
- Further examination and stabilizing treatment for a patient with an emergency condition
- On-call coverage
- Transfer/discharge of patients
- Acceptance of unstabilized ED patients requiring a higher level of care
- No delay of required services for insurance or payment reasons

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Application of EMTALA Rules to Psychiatric Patients

Basic Principles:

- CMS considers medical and psychiatric EMCs to be co-equal
- EMTALA rules and guidance do not address involuntary holds

"Hospitals are not relieved of their EMTALA obligation to screen, provide stabilizing treatment and/or an appropriate transfer to individuals because of prearranged community or State plans that have designated specific hospitals to care for selected individuals (e.g., Medicaid patients, psychiatric patients, pregnant women)."

- *Int. Guidelines, Tag A-2406/C-2406*

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ATTENTION PLEASE!

- Medical screening exams
- Patient safety and monitoring, security, elopement
- Acceptance of transfers

Medical Screening Exams

Core requirements – recap

- The MSE is intended to determine, within reasonable clinical confidence, the presence or absence of an EMC
- The MSE must be performed by *qualified medical personnel* designated by the hospital
- Triage is not medical screening
- Must be provided in non-discriminatory manner to all patients presenting with same/similar signs and symptoms

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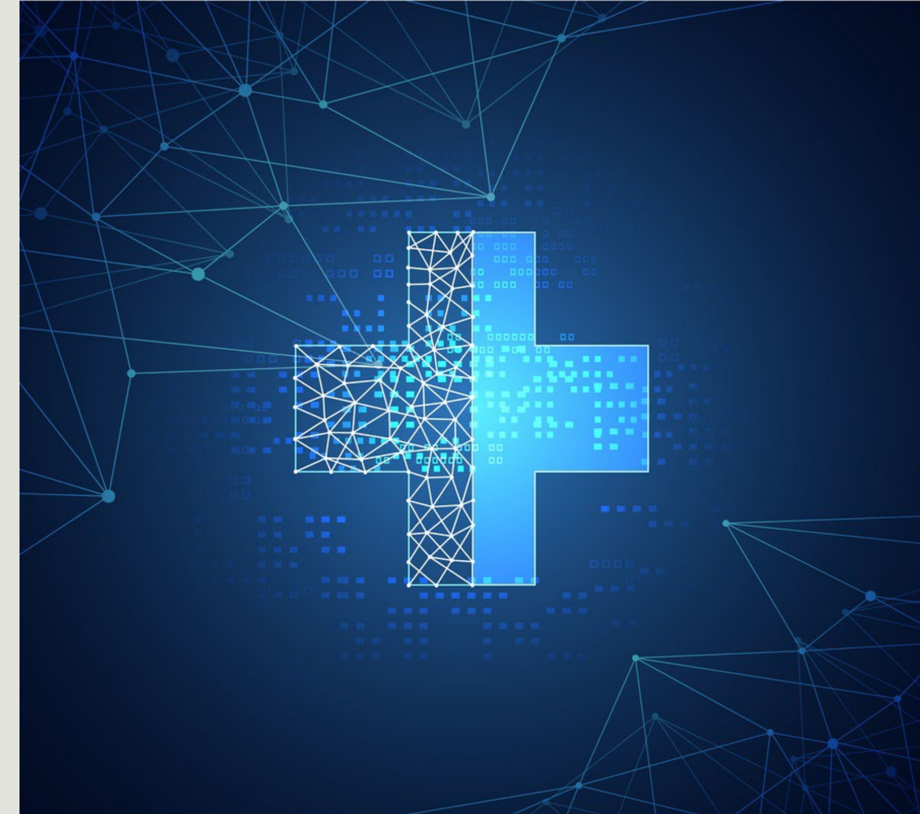
Medical Screening Exams

Last three years, failure to provide an appropriate MSE cited by CMS in ~75% of enforcement actions.

Important issues:

- Appropriate scope of MSE?
- Use of resources are available to ED?
- Where to perform?
- Labor and Delivery patients?
- Psychiatric patients?



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Psychiatric Emergency Medical Condition v. 5150 Hold

- 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 Emergency Medical Condition (EMC) is based on a **clinical judgment** of an ED physician or other qualified professional designated by the hospital medical staff

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Monitoring Patients

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."

OIG Settlement — "[the facility failed] to provide further medical examination and treatment to patient...who was brought to [the ED] for psychiatric assessment. The psychiatrist who performed [patient's] medical screening examination determined that [the patient] had an elevated risk of harm to himself and others....ordered that [patient] be monitored and observed every 15 minutes while in crisis .... ***The ED staff failed to perform the ordered safety observations and [patient] was found dead in his room approximately 2.5 hours after the last safety check."***

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Elopement or Refusal

- Before the MSE?
  - Issue with wait times?
  - Financial reasons?
  - Need adequate documentation
- After the MSE?
  - Inform of risks and benefits of refusing further examination and treatment
  - Again, need adequate documentation!

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Acceptance of EMTALA Transfer

- An ED patient with an EMC that is not stabilized?
  - » Whose judgment prevails?
- What is your process for a transfer request?
- How are transfer requests documented?
- How are disputes handled in real time?
- *EMTALA Manual Appendix T* – transfer checklist and script – step-by-step process to evaluate requests

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Acceptance of Transfers & Psychiatric Patients

- No distinction under EMTALA rules
- Receiving hospital cannot refuse an appropriate transfer if it has the capacity and capability to stabilize the individual's EMC

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AB 1316 – Psychiatric Emergency Medical Conditions

- Clarifies that psychiatric emergency medical conditions, as defined under state law, do **<u>not</u>** depend on whether patient is *involuntary* or *voluntary*
- Requires Medi-Cal coverage for emergency services necessary to relieve or eliminate a psychiatric emergency medical condition, regardless of whether the beneficiary is voluntary or involuntary
- Does not permit transfers that conflict with LPS Act or EMTALA

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Updates Regarding 2025 Legislative Changes

Legislative Intent of the LPS (Lanterman-Petris-Short) Act

1. To end inappropriate, indefinite, and involuntary commitment
2. To provide prompt evaluation and treatment
3. To guarantee and protect public safety
4. To safeguard individual rights through judicial review
5. To provide individualized treatment, supervision, and placement

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Legislative Intent of the LPS (Lanterman-Petris-Short) Act (cont.)

6. To encourage full use of existing agencies, professional personnel, and public funds to accomplish these objectives, and to prevent duplication of services

7. To protect persons with mental health disorders and developmental disabilities from criminal acts

8. To provide consistent standards for protection of personal rights of persons receiving services

9. To provide services in the least restrictive settings appropriate to the needs of each person

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Criteria to Detain

1. Danger to Self
2. Danger to Others
3. Grave Disability

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Burden of Proof for Grave Disability / Probable Cause

- To constitute probable cause to detain a person pursuant to section 5150, a state of facts must be known to the peace officer (or other authorized person) that would lead a person of ordinary care and prudence to believe, or to entertain a strong suspicion, that the person detained is mentally disordered and is a danger to himself or herself or is gravely disabled. In justifying the particular intrusion, the officer must be able to point to specific and articulable facts which, taken together with rational inferences from those facts, reasonably warrant his or her belief or suspicion.
- *People v. Triplett* (1983)

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SB 43 and Involuntary Holds

(h) (1) For purposes of Article 1 (commencing with Section 5150), Article 2 (commencing with Section 5200), *Article 3 (commencing with Section 5225),* and Article 4 (commencing with Section 5250) of Chapter 2, and for the purposes of Chapter 3 (commencing with Section 5350), "gravely disabled" means ~~either~~ *any* of the ~~following:~~ *following, as applicable:*

(A) A condition in which a person, as a result of a mental health disorder, *a severe substance use disorder, or a co-occurring mental health disorder and a severe substance use disorder,* is unable to provide for ~~his or her~~ *their* basic personal needs for food, clothing, ~~or shelter.~~ *shelter, personal safety, or necessary medical care.*

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New Definitions

- “Severe substance use disorder” means a diagnosed substance-related disorder that meets the diagnostic criteria of “severe” as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders
- This is six or more of the eleven symptoms listed in the substance-related disorder criteria

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New Definitions (cont.)

- “Personal safety” means the ability of one to survive safely in the community without involuntary detention or treatment pursuant to this part
- “Necessary medical care” means care that a licensed health care practitioner, while operating within the scope of their practice, determines to be necessary to prevent serious deterioration of an existing physical medical condition which, if left untreated, is likely to result in serious bodily injury as defined in section 15610.67

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What Will the New Definition Apply to?

- **5150** or 72-hour detention
- **5256 (b)** or new probable cause hearings (as of January 1, 2023) that occur when someone is detained pursuant to 5150, beyond 72 hours (AB-2275)
- **5250** or 14-day hold
- **5270.15 or 5270.70** (30-day hold for grave disability only) and (as of January 1, 2023) a second 30-day hold (grave disability only)
- **5350** or LPS Conservatorship

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Minors?

- Under age 18, not emancipated
- "Gravely disabled minor" is defined as –
  - a minor who, as a result of a mental disorder, is unable to use the elements of life that are essential to health, safety, and development, including food, clothing, and shelter, even though provided to the minor by others. Intellectual disability, epilepsy, or other developmental disabilities, alcoholism, other drug abuse, or repeated antisocial behavior do not, by themselves, constitute a mental disorder.
- However, any minor held beyond 72 hours shall be pursuant to the LPS Act.

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Other SB 43 Changes

- Section 1799.111 of the Health and Safety Code (24-Hour Immunity for Detention at Non-LPS Facilities) – language is modified to reflect the new definition of gravely disabled
- New hearsay exception for LPS Conservatorship (Re)Appointment
- Alternative options to be considered before LPS conservatorship: AOT and the Care ACT
- Data reporting requirements

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SB 929 – Data Collection

BHIN 23-015 – April 2023

- Phase I of data collection
  - » Items 1, 2, 3 and 4

BHIN 23-013 – March 2024

- Phase II of data collection

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LPS Designated and Approved Facilities

WIC §5402(a) (amended) – current data being collected:

- (1) Number of persons in designated and approved facilities
  - » admitted or detained for 72-hour evaluation and treatment,
  - » admitted for 14-day and 30-day periods of intensive treatment, and
  - » admitted for 180-day post-certification intensive treatment in each county
- (18) And, for each person above, whether they were admitted or detained for:
  - » Danger to self
  - » Danger to others
  - » Grave disability due to a mental health disorder
  - » Grave disability due to a severe substance use disorder
  - » Grave disability due to a mental health disorder and a severe substance use disorder

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LPS Designated and Approved Facilities (cont.)

WIC §5402(a) (amended) – current data being collected:

- (2) Number of persons transferred to mental health facilities pursuant to section 4011.6 of the Penal Code.
- (3) Number of persons for whom temporary conservatorships are established.
- (4) Number of persons for whom conservatorships are established.
- (5) Number of persons
  - » admitted or detained for 72-hour evaluation and treatment, 14-day and 30-day periods of intensive treatment, or 180-day post-certification intensive treatment *either once, between two and five times, between six and eight times, and greater than eight times*
- (10) Demographic information including.
- (11) Number of county contracted beds.

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“Other Entity” Data Reporting

Phase II Data Requirements Attachment C

Terminology	Definitions
Designated and Approved Facility	For the purposes of W&I Code Section 5402, “designated and approved facility" or "facility designated by the county for evaluation and treatment” means a facility that is designated by a county board of supervisors to provide assessment, evaluation, crisis intervention, and treatment under the LPS Act (W&I Code § 5000, et seq.) or the Children’s Civil Commitment and Mental Health Treatment Act (W&I Code § 5585, et seq.) and approved by the Department pursuant to Section 821 of Title 9 of the California Code of Regulations.
Other Entity	For the purposes of W&I Code Section 5402, “each other entity involved in implementing Section 5150” means any facility, entity, or person not included as a designated facility that is involved in implementing W&I Code Section 5150. Other entities involved in implementing W&I Code Section 5150 include, but are not limited to: (a) Peace officers, as defined by Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2 of the Penal Code. (b) Professional persons designated by a county behavioral health director pursuant to W&I Code Section 5121 to perform functions under section 5150, including, but not limited to, members of mobile crisis teams. (c) Hospital emergency rooms/departments.

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Other Entities

WIC §5402(a) (amended) – current data being collected:

- (1), (18) Number of persons admitted or detained for 72-hour hour evaluation and treatment for:
  - » Danger to self
  - » Danger to others
  - » Grave disability due to a mental health disorder
  - » Grave disability due to a severe substance use disorder
  - » Grave disability due to a mental health disorder and a severe substance use disorder
- (2) Number of persons transferred to mental health facilities pursuant to section 4011.6 of the Penal Code.
- (5) Number of persons detained or admitted for 72-hour evaluation and treatment either once, between two and five times, between six and eight times, and greater than either times.
- (10) Demographic information.
- (11) Number of country contracted beds.

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What Else is Coming Up …

- *SB 1238* – definition of “designated facilities”; addressing individuals with severe substance use disorder
- *SB 1184* – administration of antipsychotic medication to involuntarily detained individuals
- *AB 2154* – patient rights’ handbook requirements

SB 1238 – Designated Facilities

- Expands **range of facilities that can treat individual with severe substance use disorder**
    - Authorizes counties to designate appropriate facilities, subject to DHCS requirements, for one or more services, including evaluation and treatment and intensive treatment
    - DHCS to approve county designation of facilities
- DHCS, in consultation with stakeholders, will issue **updated regulations regarding designation requirements**
- DHCS will issue **guidance regarding Medi-Cal reimbursement for covered services provided to individuals with severe substance use disorder**

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SB 1184 – Anti-Psychotic Medication

Court Rules Mental Patients May Reject Forced Drugging

By KATHERINE BISHOP

Special to The New York Times

SAN FRANCISCO, Dec. 21 — A panel of the State Court of Appeal has ruled that mental patients who are involuntarily committed to health facilities for short-term crisis care may refuse to take anti-psychotic medications.

In a unanimous ruling Wednesday, the court said patients could not be forced to take the medication unless a judge determined that they were incapable of making an informed decision about their medical care.

Forced administering of powerful mind-altering drugs "involves moral and ethical considerations not solely within the purview of the medical profession," the court said.

The ruling excludes those cases in which emergency intervention is needed to save the patient's life or prevent injury to the patient or others. It is expected to affect the treatment of tens of thousands of patients statewide.

California law provides a set of strict guidelines under which a person can be involuntarily committed for periods of 72 hours to 14 days. While detained, the person is frequently medicated, often by forcible injection.

Drugs Substitute for Restraints

Commonly prescribed anti-psychotic medications, including Thorazine, Haldol, Mellaril, Stelazine and Prolixin, are most commonly used to treat chronic schizophrenia. Many mental health professionals believe the drugs eliminate the need for straitjackets and other physical restraints in the hospital and help control delusions and hallucinations that prevent the patient from functioning in the community.

In recent years, these drugs have come under increasing attack from advocates of mental patients' rights, in part because of side effects including drowsiness, restlessness, blurred vision and an irreversible involuntary movement of facial muscles known as tardive dyskinesia.

The case here involved St. Mary's Hospital and Medical Center of San Francisco, a private hospital that contracts with the city for some public patients. It was brought on behalf of patients including Eleanor Riese, 44 years old, who developed physical symptoms after the frequent administering of anti-psychotic medication.

In its ruling, the court said that while state law does not explicitly say that involuntary patients may refuse medication, it does extend to all patients the right to refuse medical treatment unless a judge finds after an evidentiary hearing that they are incompetent to make such a decision.

Case May Be Appealed

Morton P. Cohen, a lawyer and professor of law at Golden Gate University Law School in San Francisco who represented the patients, said that the people most likely to be treated with the drugs in a short-term care situation were either those experiencing a crisis such as suicidal feelings, or chronic patients, many of whom are among the homeless population, who can make decisions about their treatment even though they may be delusional.

Ezra Hendon, the Oakland lawyer who represented the hospital, said the case may be appealed to the State Supreme Court.

"I think the decision is unfortunate because it proceeds from a fundamentally illogical premise that you can take people and treat them against their will and then give them the right to refuse treatment," Mr. Hendon said.

It is not yet known how the courts will deal with the increased need for judges to make rapid determinations as to patients' competence.

Administration of anti-psychotic medication for patients involuntarily detained under the LPS Act

- Emergency
- If patient does not refuse medication following disclosure of specific information
- *Riese* petition and court order process

Source: The New York Times, D23 (Dec. 22, 1987)

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SB 1184 – Updates to Capacity Determinations

NEW!

Request a new determination of capacity at any time in the 48 hours prior to the end of the current duration period, under certain circumstances

Exigent circumstances – order for treatment shall remain in effect provided:

- Petition for new determination has been filed prior to expiration of current order
- Attestation of exigent circumstances documented in medical record
  - *Note*: reporting obligations to county behavioral health director
- Hearing within 24 hours
- Used only one time per individual during applicable detention period

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AB 2154 – Patients’ Rights Handbook

Rights for Individuals In Mental Health Facilities

Admitted Under the Lanterman-Petris-Short Act

California Department of Health Care Services

If a person is involuntarily detained, the facility shall offer and provide a copy of the patients’ rights handbook to a family member IF:

- Person authorizes disclosure of their detainment information pursuant to Section 5328.1
- Family member is physically present at facility and has knowledge that the individual is involuntarily detained there
- Family member has been notified of the person’s presence pursuant to Section 5328.1
- Person consents to family member being provided handbook

If provided, shall also offer to the involuntarily detained person

Questions?

Thank you

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APPENDIX

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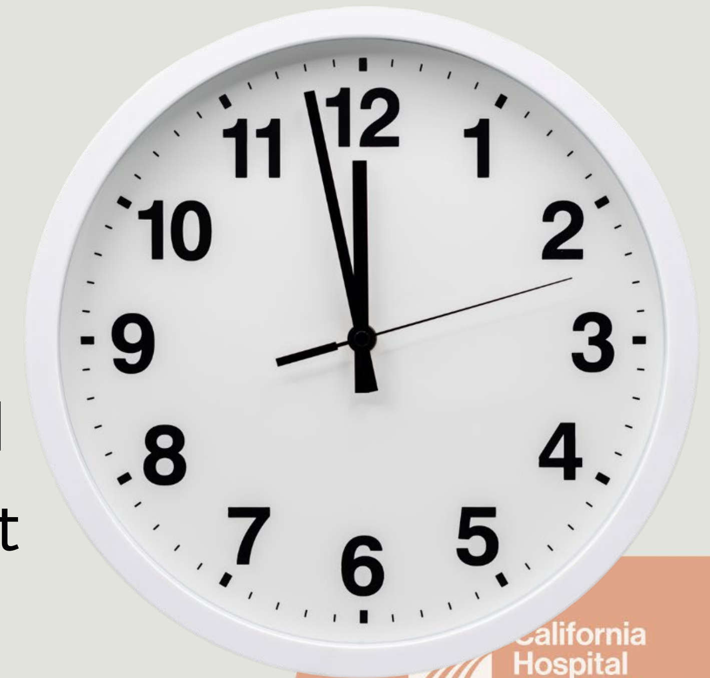
AB 2275 – the 5150 clock and due process

- **72-hour clock starts when the custodial hold is placed at WIC §5150**
  - §5151 specifically notes the start time from when detention first begins at §5150
- **New due process rights begin:**
  - when the clock "strikes" 72 hours, and
  - the patient still meets criteria, and
  - is unwilling to receive voluntary services, and
  - has not been certified for intensive treatment



AB 2275 – the 5150 clock and due process

New due process rights at 72 hours include:

- Notification of Patients' Rights Advocate
- Notification of individual designated by county to provide information to patient
- Scheduling of hearing to occur before end of Day 7
- Provision of assistance (attorney, PRA) to patient in preparing for hearing

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