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EMTALA

A 30th Anniversary Journey

Steve Lipton

Cal. Society of Healthcare Risk Management

March 10, 2016

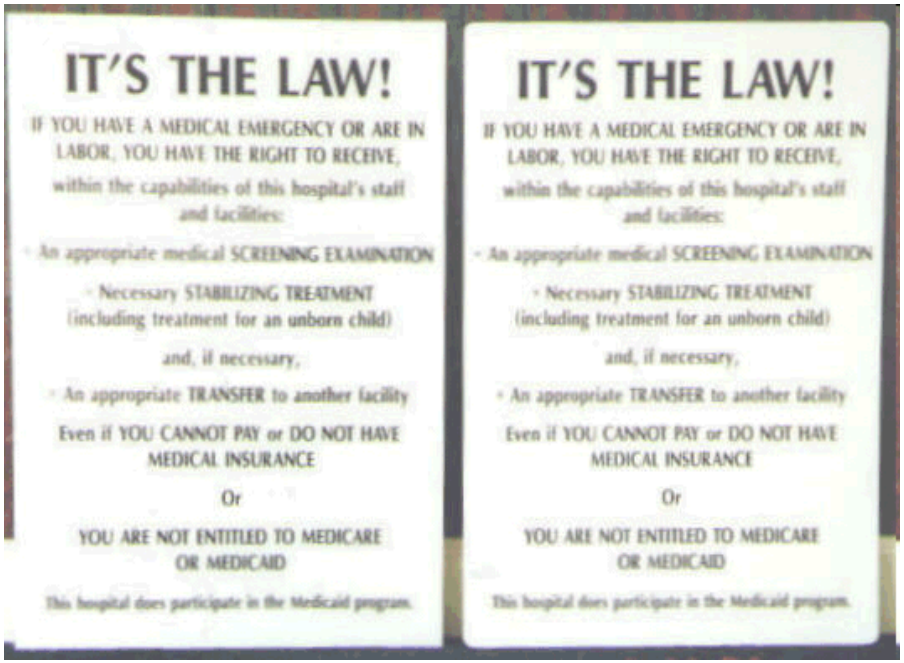


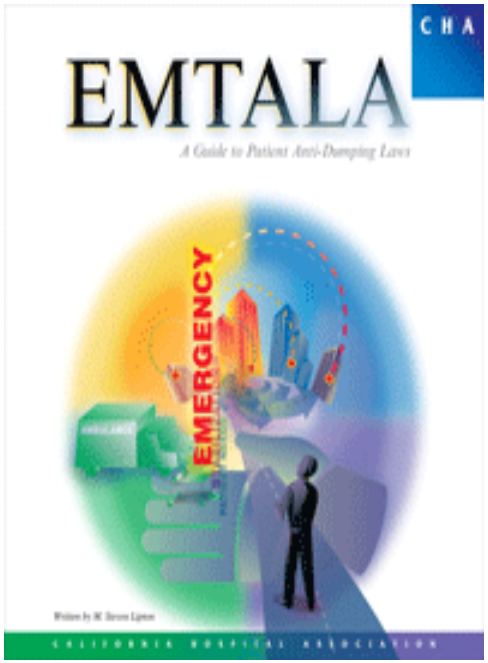




HAPPY ANNIVERSARY EMTALA







The Journey



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EMTALA
HOT TOPICS


GUARANTEED
TO MAKE YOU UNCOMFORTABLE
WHILE YOU SIT AND SWEAT IN
YOUR SEAT
HOT TOPICS
SERIES
TOO HOT TO HANDLE

What's HOT

- Psychiatric emergency patients
- Patient registration
- Acceptance of patient transfers
- Wall time
- OB Cases



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Psychiatric Patients





Psychiatric Patients
A Hot Bed of EMTALA Violations

- Triage/medical screening of psychiatric conditions
- Monitoring of psychiatric patients
- Security/elopement of psychiatric patients
- Transfer of psychiatric patients
- Acceptance of emergency psychiatric patients — requests for insurance information
- Discharge of psychiatric patients without transfer

Triage/Medical Screening

- **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."

Triage/Medical Screening

CMS: “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.”

Joint Commission: “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.” (PC.01.01.01)

Monitoring

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."

Involuntary Holds

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

Discharge of Psych Patient

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."

Transfer to Ambulatory Facility

CMS Letter (11-12-09)

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

Transfer to Ambulatory Facility

CMS Letter (11-12-09), cont.

- 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

Transfer to Ambulatory Facility

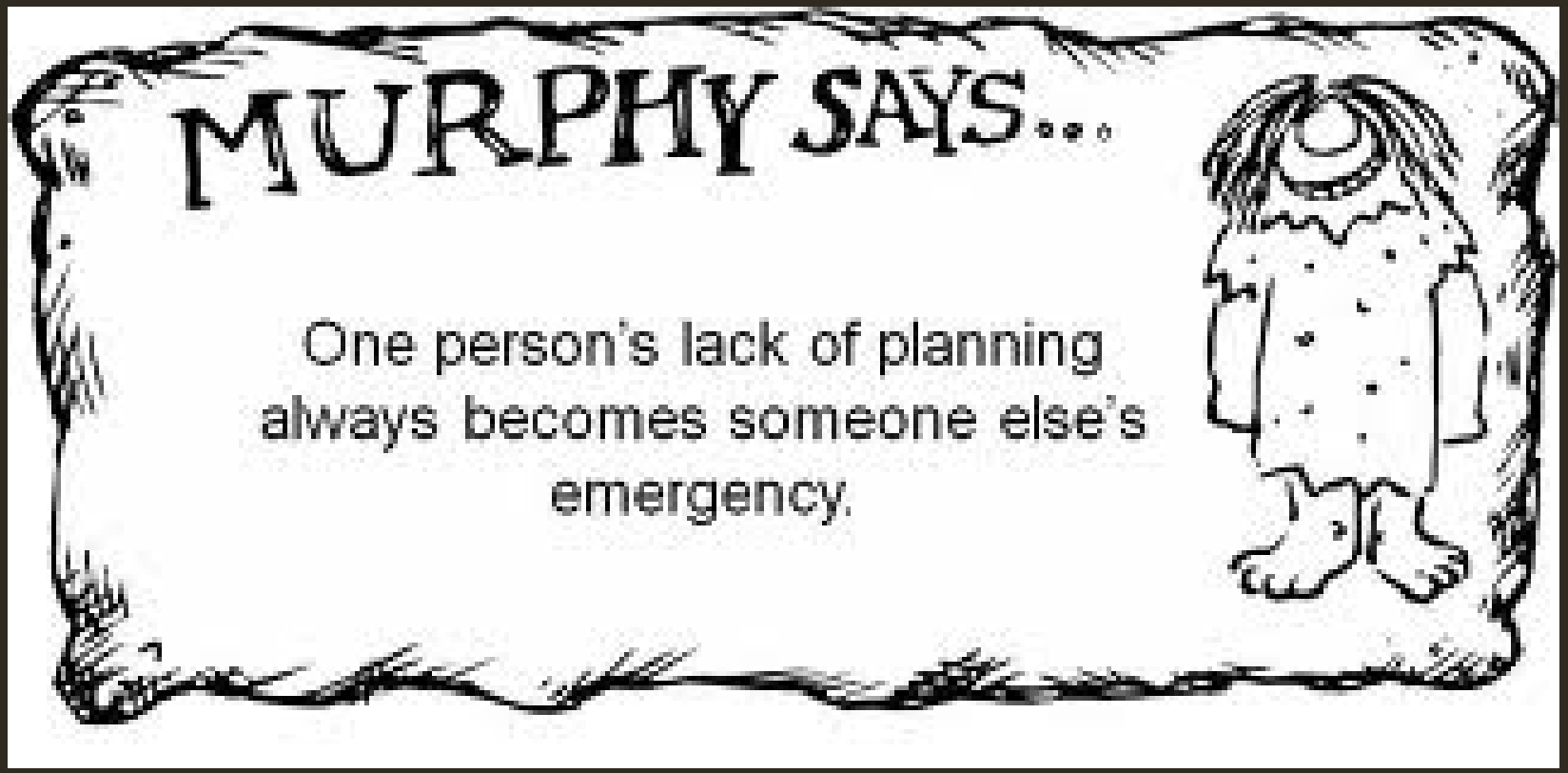
However ...

- Is there an EMTALA violation if the CSU sends the patient back to the hospital or another hospital if it cannot release the patient or find placement within 24 hours?

Why is LPS a Mess???

- Why don't we know when the 72-clock starts?
- Why does DHCS exercise no responsibility to interpret LPS?
- Why does each county decide what the law is?
- Why are professionals authorized to write a hold in one county not authorized to do so in an adjacent county?
- Why are custodial officers or professionals not required to arrange placement?
- Why are ED physicians not permitted to write holds in most counties?
- Why is copy of a 5150 application treated as a worthless document and used to deny placement or a transfer?
- Why do county departments of mental health not view psychiatric patients in an ED as their responsibility if the patients need a hold, evaluation and treatment under LPS?

Do you have a plan?



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Patient Registration



Patient Registration

- Hospitals may follow reasonable registration processes, including asking for insurance, so long as the inquiry does not delay screening or treatment
- CMS (May 9, 2012) — "aggressive debt collection"
  - "We would have serious concerns with the legality of any hospital policy or procedure that may discourage individuals from seeking emergency care, such as demanding that emergency department patients pay before receiving treatment."
  - May not delay screening or stabilizing treatment to inquire about payment or insurance status

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Acceptance of Patients

Acceptance of Patient Transfers

- Hospital Y receives a call from Hospital X seeking to transfer Patient A with an unstabilized emergency medical condition
- ED physician at Hospital X indicates that need for a procedure or an admission to a bed that is then not available at Hospital X

Acceptance of Patient Transfers

- Hospital Y has an unoccupied bed in the ICU and has the capability to stabilize Patient A's EMC; however (take your pick) —
  - The open bed is reserved for a patient in surgery who will need the bed after post-op
  - The open bed is temporarily reserved for an inpatient who may need an upgrade to ICU
  - The open bed is reserved if a trauma patient presents to the ED

Acceptance of Patient Transfers

- CMS definitions at 42 CFR 489.24(b)
  - **Capacity** means the ability of the hospital to accommodate the treatment of the transferred individual; it encompasses number and availability of qualified staff, beds and equipment and the hospital's past practices of accommodating patients in excess of its occupancy limits
  - **Capability** means that there is physical space, equipment, supplies and specialized services that the hospital provides, and level of care the personnel can provide, including on-call rosters

Acceptance of Patient Transfers

- Who decides on transfer acceptance?
  - Centralized transfer center
  - Decentralized process
- Do you have a transfer checklist?
  - Is this an EMTALA patient?
- Coordination between personnel
- ED, accepting physicians, unit personnel
- Safe hand-off if going off duty

Acceptance of Patient Transfers

- Documentation –
  - Incoming requests to accept transfer
  - Process to determine acceptance
  - Coordination with accepting physician
  - Communication of decision to sending hospital
  - Reasons for refusal (if applicable)
- QAPI –
  - Is acceptance process on the oversight screen?
  - Are refusals subject to review?

What is an “Open Bed?”

- The open bed is reserved for a patient in surgery who will need the bed after post-op
  - This may be a committed bed
- The open bed is temporarily reserved for an inpatient who may need an upgrade to ICU
  - This may be a committed bed, but temporarily
- The open bed is reserved if a trauma patient presents to the ED
  - This is an open bed

What is an “Open Bed?”

- Surveyors look at historical practices as to bed allocation –
  - Are they consistent between admitting patients from your ED and accepting patients from other hospital EDs?
- How do you manage competing requests for the same bed?

The Closer Hospital

- Can Hospital Y turn down a transfer if the receiving physician or the hospital feels there are other closer hospitals that could accept the patient

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Wall Time



Wall Time

- Issue: ED requests ambulance personnel to remain with patient due to capacity restraints in the ED
- CMS (S&C 07-20; April 27, 2007)
  - The patient has presented to the hospital, i.e., EMTALA obligations have been triggered
  - Hospital is not obligated in every instance to assume all responsibility for the patient
  - However, hospital “must still triage the individual’s condition immediately upon arrival to ensure that emergency intervention is not required and that the EMS provider staff can appropriately monitor the individual’s condition.”

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OB Patients

OB – The MSE

- Screening for labor requires documentation of the initial assessment of the expectant mother and unborn child
- Screening should include “ongoing evaluation of fetal heart tones, regularity and duration of uterine contractions, fetal position and station, cervical dilation, and status of membranes …”
- Further screening if patient not in labor and presenting complaint not addressed by OB personnel

OB -- Documentation

CMS 2567

- Five charts did not include physician orders for care or discharge
- In two of five charts, an OB physician examined the patient but did not chart his/her visit or findings
- In several charts, discussions with and orders from supervising physicians were inadequate
- In several records, charting was inconsistent (e.g., physician indicates an admission, and RN indicates a discharge, for a patient who was transferred)

ED without L&D On Site

CMS 2567 –

"...the hospital failed to conduct an appropriate MSE by failing to ensure fetal heart tones were taken and documented for __ of 30 sampled patients who were six months pregnant...These failed practices lead [*sic*] to the potential failure to identify patients with serious medical conditions."

Final Thoughts



Questions?

