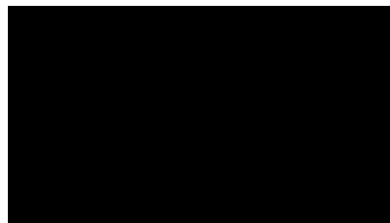


EMTALA and Behavioral Health

2019 HCCA Compliance Institute

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EMTALA In The News



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Assumption of Basic Understanding of EMTALA

- ▶ Presentation focus is on behavioral health issues in the context of EMTALA obligations and enforcement
- ▶ We are assuming a basic level of understanding of EMTALA rules
- ▶ If you are not fully aware of the EMTALA rules, there is a handout with the basic elements

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EMTALA General Rule: Screen, Treat, Transfer or Discharge

- ▶ HOSPITAL MUST PROVIDE MEDICAL SCREENING EXAM (MSE) within capability of Hospital Emergency Department to determine whether an EMERGENCY MEDICAL CONDITION (EMC) exists
 - ▶ If EMC is found, then
 - ▶ TREAT or
 - ▶ TRANSFER
- 42 C.F.R. Part Section 489.24(a)
- Behavioral Health (BH) and Chemically Dependent (CD) patients are included in this requirement -may also present with conditions that pose a serious physical threat
 - BH screening *in addition to* MSE - MUST use ancillary services available

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Examination/ Determination of EMC for BH/CD Patients

- ▶ Physician or qualified medical personnel (QMP) (i.e., medical personnel who are qualified by a hospital to conduct “appropriate medical screening examinations”) must examine an individual to determine whether EMC exists.
- ▶ Qualifications necessary for BH screening?

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Medical and Behavioral Health Screening Risks

- ▶ 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 (both medical and behavioral) at departure or discharge

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State Laws: "72 Hour Holds" / "5150s"

- ▶ Involuntary "72 hour holds" brought to hospital by law enforcement
 - ▶ Local law enforcement typically brings person to hospital emergency department (transfers may be required where hospital does not have specialized services or capacity.)
 - ▶ Often called 5150 hold because that is usually the number of the section of the state Code, which allows a person with a mental illness to be involuntarily detained for a 72-hour psychiatric hospitalization against their will for up to 72 hours *before a hearing is required*.
 - ▶ Often state laws also allow a qualified officer or clinician/hospital to involuntarily confine a person deemed to have certain mental disorders for several days, following being involuntarily held for 72 hours under a Section 5150 hold.

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Medical and Behavioral Health Screening Risks/Potential Violations

- ▶ Failure to provide an appropriate transfer
- ▶ Can 5150s be considered "stabilized"?
- ▶ Selection of an appropriate facility (transfers to psych units of other acute care hospitals or psych hospitals vs. intermediate care facilities; selection of facility for children and adolescents)
- ▶ Use of appropriate transportation
 - ▶ Crisis team vans and police transport
 - ▶ Private vehicles
- ▶ Transfer or discharge?
- ▶ Discharge and aftercare instructions

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Medical and Behavioral Health Transfer Violations

- ▶ Failure to accept an appropriate transfer
- ▶ Refusal based on financial considerations
- ▶ Requiring prior authorization
- ▶ Refusal to accept out-of-county transfers

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Case Study #1

- ▶ A female patient with a history of alcohol abuse and depression presented to your hospital's emergency department. At the time, she was intoxicated and had suicidal ideation. The emergency physician suggested that she speak with a counselor in the ED, but the patient refused to talk with the counselor. The emergency physician subsequently contacted law enforcement and had her committed to police protective custody. This was "5150" hold. Later the patient filed an EMTALA claim stating she was detained in a jail overnight with no psychiatric care.

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EMTALA Impacts

- ▶ Did an EMC exist?
- ▶ Did a transfer occur?
- ▶ If a transfer did in fact occur, was an appropriate stabilization provided?

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Case Study #2

- ▶ A male patient presented to your hospital's emergency department with complaints of homicidal ideation and acute depression. The patient stated that he feared hurting himself and his wife and that he had visual hallucinations. Patient had presented previously to your hospital in which time it was learned that he had access to firearms. After an examination, the patient was discharged from the emergency department with a prescription for a mild anti-depressant. Shortly after discharge, he killed his wife, two of his children and himself.

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EMTALA Impacts

- ▶ What was the EMC?
- ▶ Did an examination in line with the stated EMC occur?
- ▶ Was the patient's EMC stabilized prior to discharge?

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Case Study #3

- ▶ Your hospital operates a psychiatric unit that is located within the main hospital. As the Compliance Officer, you are reviewing EMTALA and transfers as part of your annual work plan. In speaking with the admission team and reviewing the request logs you find that:
 - ▶ A local hospital had requested a transfer of a patient. The hospital's psychiatric unit received the call at 8pm but has a policy that restricts transfers to certain business hours. The patient transfer was therefore refused.
 - ▶ A request was received from the same hospital earlier in the month. The patient met criteria for admission but had been a patient at the facility in the past and was known to be "aggressive." The patient transfer was refused on grounds that the patient was too aggressive for the unit.
 - ▶ Another facility requested a patient with psychiatric and substance abuse issues be transferred to your facility due to your specialized psychiatric capabilities. All of the transfer paperwork had not yet been received but staff noted that the transfer was refused due to the fact that the unit does not specialize in treating patients primarily suffering from substance abuse.

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EMTALA Impacts

- ▶ Can a hospital limit their hours of operation?
- ▶ What issues surface around past patient history?
- ▶ Can a denial of a transfer occur on the grounds of capabilities?

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Enforcement Trends: Patients With Psychiatric EMCs

- ▶ Transferring patient without first documenting appropriate MSE and stabilizing treatment in original ED
- ▶ Boarding patients in the ED without sufficient (and ongoing) Psychiatric care
- ▶ Discharging patients to follow up with their primary care physicians without examination by a Psychiatrist
- ▶ Security intervening with violent patients, preventing adequate MSE and stabilizing treatment
- ▶ Referring patients to law enforcement without first providing sufficient MSE and stabilizing treatment
- ▶ Means of transfer

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Enforcement Trends: Quality of Care Questions as EMTALA Violation?

- ▶ Does patient outcome have any bearing on MSE sufficiency?
- ▶ Who is a QMP for patients experiencing a behavioral health EMC?
 - ▶ Are ED patients with Psychiatric EMCs required to be examined by a Psychiatrist or other mental health professional, if those services are available?
 - ▶ What documentation is required from the ED Provider to be considered an adequate MSE?
- ▶ Patient who leaves AMA?
 - ▶ Is there capacity?
 - ▶ Must there first be an evaluation for involuntary treatment?

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Questions?

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