DIFFICULT DISCHARGES FOR IDAHO HOSPITALS

Kim C. Stanger

IHA Convention

(10-23)

Holland & Hart

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Written Resources

- Copy of .ppts
- Stanger, Nokes, and Carlson, *Difficult Discharges: Sending Patients Out Without Getting Into Trouble*, 14 J. of Health & Life Sciences Law 60 (10/20), available at https://www.hollandhart.com/files/95636_4-difficult-discharges_journal_oct_20_final.pdf.

The Problem

COMPETENT PATIENT

- Wants to leave but needs care.
  - ➢ *Document AMA or initiate mental hold.*
- Appropriate for transfer or discharge from hospital but:
  - Refuses to leave.
  - Noncompliant with treatment.
  - Needs additional care and other care settings are unavailable.
    - Patient lacks resources.
    - Bad behavior.
    - Other?

INCOMPETENT PATIENT

- Wants to leave but needs care.
  - ➢ *Obtain surrogate consent or mental hold.*
- Appropriate for transfer or discharge from hospital but:
  - Noncompliant with treatment.
  - Needs additional care and other care settings are unavailable.
    - Patient lacks resources.
    - Bad behavior.
    - Other?

The Problem

Keeping the patient unnecessarily

- Cost to system.
  - Hospital: $2,683/day (2022)
  - Nursing home: $300/day (2021)
  - ALF: $117/day (2021)
  - Home health: $181/day or $28.50/hour (2021)
- Diversion of resources from needy persons.
- Physical and emotional drain on staff.
- Liability risk.
- Risk of harm to patient.
- Adverse administrative action (e.g., licensure, OSHA, etc.).

VS

Discharging the patient improperly

- Personal injury liability.
- Contract liability.
- Medicare/Medicaid participation.
  - Conditions of participation
- Adverse licensing action.
  - Loss or restriction of license.
  - Monetary penalties.
- Adverse publicity.
  - Damage to reputation.
  - Cost to respond.


The New York Times
Baltimore Hospital Patient Discharged at Bus Stop, Stumbling and Cold
(1-11-18)
THE SACRAMENTO BEE
Nevada buses hundreds of mentally ill patients to cities around country
Modern Healthcare
Calif. hospital pays $1 million to settle patient-dumping case
(6/24/16)
Forbes
Outrageous! Nursing Home Illegally Dumps Elderly Resident They Don't Want
(11/2/17)
AARP
Nursing Homes: Stop Dumping Patients
AARP Foundation sues to combat cruel evictions
(11/15/17)
60 MINUTES
Dumped On Skid Row
Anderson Cooper Reports On The Practice Known As "Hospital Dumping"
(5/17/07)
Los Angeles Times
Hospital agrees to pay $450,000 to L.A. to settle homeless patient dumping lawsuit.
(10/25/16)

Legal Parameters

Competency: Consent or Refusal

- "PERSONS WHO MAY CONSENT TO THEIR OWN CARE. Any person … who comprehends the need for, the nature of and the significant risks ordinarily inherent in any contemplated health care services is competent to consent thereto on his or her own behalf. Any health care provider may provide such health care services in reliance upon such a consent ~~if the consenting person appears to the health care provider securing the consent to possess such requisite comprehension at the time of giving the consent~~."

(IC 39-4503, effective 7/1/23)

Incompetency: Surrogate Decision-Makers

"PERSONS WHO MAY GIVE CONSENT TO CARE FOR OTHERS. Consent for … health care services to any person who is not then capable of giving such consent … or who is a minor may be given or refused in the [following] order of priority…

(a) The court appointed guardian of such person;

(b) The person named in another person's advance care planning document…

(c) If married, the spouse of such person;

(d) An adult child of such person;

(e) A parent of such person;

(f) The person named in a delegation of parental authority…

(g) Any relative of such person;

(h) Any other competent individual representing himself or herself to be responsible for the health care of such person…"

(IC 39-4504, effective 7/1/23)

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Emergency Medical Treatment and Active Labor Act (EMTALA)

- Hospital with dedicated emergency department
  - If patient comes to hospital, must provide screening exam, stabilizing treatment, and/or appropriate transfer.
  - Cannot transfer or discharge a patient with an emergency medical condition (EMC) unless:
    - Condition stabilized;
    - Patient admitted in good faith as an inpatient;
    - Patient refuses care or requests transfer; or
    - Physician certifies that benefits > risks, and transfer is appropriate.
- Hospital with specialized capability cannot refuse a transfer of patient who needs specialized capabilities.

(42 USC 1395dd; 42 CFR 489.24(e))

EMTALA: Penalties

- Termination of Medicare provider agreement and exclusion from Medicare and Medicaid.
- Civil penalties
  - Hospitals:
    - < 100 beds: $54,833* per violation
    - ≥ 100+ beds: $111,597* per violation
  - Physicians: $111,597* per violation.
- Hospitals may be sued for damages.
  - Individuals who suffer personal harm.
  - Medical facilities that suffer financial loss.

(42 USC 1395dd(d); 42 CFR 1003.103(e); 45 CFR 102.3)

EMTALA:
Emergency Medical Condition

"Emergency medical condition" =

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in
  - Placing the individual's health in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any bodily organ or part.

(42 CFR 489.24(b))

- In case of psychological condition, individual is expressing suicidal or homicidal thoughts or gestures or determined to be dangerous to self or others.

(EMTALA Interpretive Guidelines at 489.24(d))

EMTALA: Stabilized

"Stabilized" =

- Statute/regulations: "no material deterioration … is likely … to result from or occur during the transfer of the individual from a facility." (42 CFR 489.24(b))
- Interpretive Guidelines:
  - "Stable for transfer" = EMC has been resolved although underlying medical condition may persist.
  - "Stable for discharge" = "individual has reached the point where his/her continued care … 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."

(EMTALA Interpretive Guidelines at A-2407)

EMTALA: Ending Obligations

- EMTALA ends once the patient is:
  - Determined not to have an emergency condition,
  - Emergency condition is stabilized, or
  - Admitted in good faith as inpatient.
- Admission terminates EMTALA obligations for treating hospital and receiving facility with specialized capabilities that would have otherwise been required to accept the patient.
  - ***Beware admitting patient if you intend to transfer patient to another hospital.***

(45 CFR 489.24)

- Must still comply with:
  - Standard of care
  - Hospital conditions of participation

Personal Injury Damages

- Once you assume care, you assume duties to comply with standard of care until you properly terminate the duty.
- Breach of duty may be:
  - Lack of informed consent by competent patient or surrogate decision-maker
  - Patient Abandonment
    - Professional licensing statutes (*see, e.g.*, IC 54-1814)
    - Common law tort liability if patient injured, unless:
      - Patient agrees to withdrawal from care; or
      - Comply with following:
        - Notify patient of withdrawal from care,
        - Give sufficient time to transfer care to another appropriate provider, and
        - Provide necessary care in the meantime.
  - Battery, kidnapping, others?

Idaho Hospital Licensing Regulations

- Hospital administration shall provide a procedure to screen each patient for discharge planning needs. If discharge planning is necessary, a qualified person shall be designated responsible for such planning.

(IDAPA 16.03.14.200.04)

- If hospital offers psychiatric services, it must have a discharge planning process, which includes consideration for continued care and services in the community after discharge, placement alternatives, and utilization of community resources must be initiated on admission and carried out to ensure that each patient has a documented plan for continuing care that meets his individual needs. Provision must be made for exchange of appropriate information with outside resources.

(IDAPA 16.03.14.470.07)

Hospital Medicare Conditions of Participation (CoPs)

- Must engage in discharge planning for inpatients.
  - Must identify patients who are likely to suffer adverse health consequences absent adequate discharge planning.
  - Must provide discharge planning evaluation, including assessment of the patient's capacity for self-care or care by others post-discharge.
  - Must prepare discharge plan if evaluation indicates need or physician requests it.
    - Must counsel with patient and family.
    - Must include list of post-acute care providers as appropriate.
  - Must arrange for initial implementation of discharge plan.
  - Must transfer or refer patients and medical info to appropriate facilities, agencies or services as needed.

(42 CFR 482.43)

- Additional guidance is pending. (See SOM App. A)

Critical Access Hospital (CAH) CoPs

- Must engage in discharge planning for inpatients.
  - At early stage of hospitalization, must identify patients who are likely to suffer adverse health consequences absent adequate discharge planning.
  - Must provide discharge planning evaluation.
  - Must include patient's need for post-CAH services, availability of services, and patient's access to services.
  - Upon request of patient's physician, must prepare discharge plan and assist in its implementation.
  - Must assist patients, family or representatives in selecting post-acute care providers.
  - Must transfer or refer patients and medical info to appropriate facilities, agencies or services as needed.

(42 CFR 485.642, added 2019; see also IDAPA 16.03.14.200.04)

- Additional guidance pending. (See SOM App. W).

CMS Discharge Planning CoPs

"We understand that situations may arise where patients may prefer not to participate in the discharge planning process. For patients that decline to participate in the discharge planning process or leave the hospital or CAH against medical advice, we expect hospitals to document in the medical record the patient's refusal to participate in the discharge planning process, and that such attempts to include the patient and/or the patient's caregiver in the discharge planning process were made by hospital staff."

(84 FR 51855; *see also id.* at 51853-54)

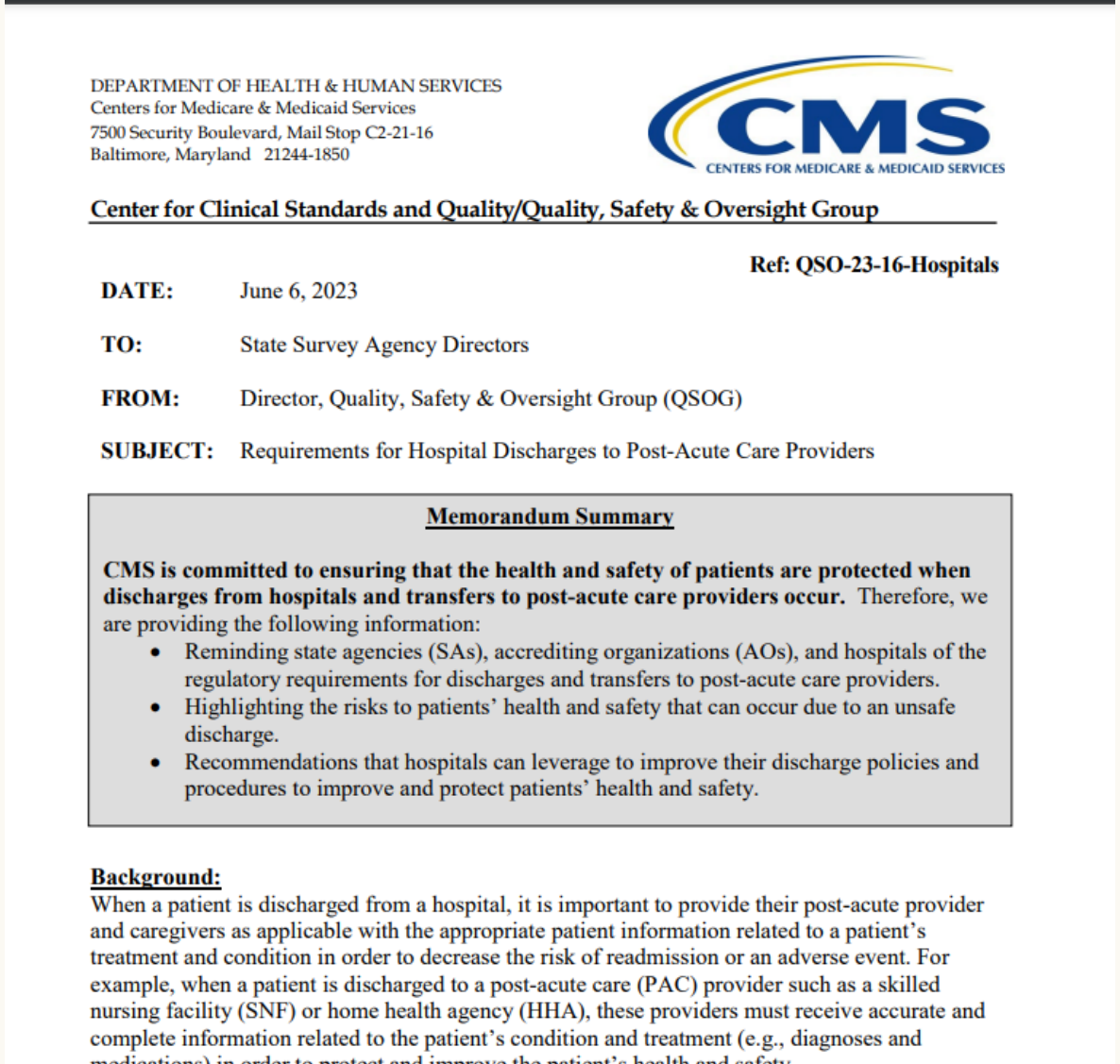
CMS Discharge Planning CoPs

"[H]ospitals have certain constraints on their ability to accomplish patient transfers and referrals...

- A patient may refuse transfer or referral; or
- There may be financial barriers limiting a facility's, agency's, or ambulatory care service provider's willingness to accept the patient. In such cases the hospital does not have financial responsibility for the post-acute care services. However, hospitals are expected to be knowledgeable about resources available in their community to address such financial barriers, such as Medicaid services, availability of Federally Quality Health Centers, Area Agencies on Aging, etc., and to take steps to make those resources available to the patient. For example, in most states hospitals work closely with the Medicaid program to expedite enrollment of patients eligible for Medicaid."

(CMS SOM App. A for 482.43(d))

CMS Discharge Planning CoPs



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

Ref: QSO-23-16-Hospitals

DATE: June 6, 2023

TO: State Survey Agency Directors

FROM: Director, Quality, Safety & Oversight Group (QSOG)

SUBJECT: Requirements for Hospital Discharges to Post-Acute Care Providers

Memorandum Summary

CMS is committed to ensuring that the health and safety of patients are protected when discharges from hospitals and transfers to post-acute care providers occur. Therefore, we are providing the following information:

- Reminding state agencies (SAs), accrediting organizations (AOs), and hospitals of the regulatory requirements for discharges and transfers to post-acute care providers.
- Highlighting the risks to patients' health and safety that can occur due to an unsafe discharge.
- Recommendations that hospitals can leverage to improve their discharge policies and procedures to improve and protect patients' health and safety.

Background:

When a patient is discharged from a hospital, it is important to provide their post-acute provider and caregivers as applicable with the appropriate patient information related to a patient's treatment and condition in order to decrease the risk of readmission or an adverse event. For example, when a patient is discharged to a post-acute care (PAC) provider such as a skilled nursing facility (SNF) or home health agency (HHA), these providers must receive accurate and complete information related to the patient's condition and treatment (e.g., diagnoses and

- QSO-23-16-Hospitals (6/6/23) focuses on providing information to post-acute care providers, not guaranteeing continuing or post-acute care.

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Patient's Discharge Appeal Rights

- Must give "Important Message from Medicare" to Medicare inpatients and obtain signature no later than 2 days after admission.
- Most give follow up notice at least 2 days before discharge.
- Patient may request expedited review from QIO.
  - Timely request: patient not financially liable (except copays and deductibles) until noon on day following QIO decision.
  - Untimely request: patient financially liable after discharge date or date specified by QIO.
  - Hospital must provide Detailed Notice of Discharge.
- Patient may obtain expedited reconsideration by the QIC.
- Hospital may request expedited review by QIO if physician disagrees.

(42 CFR 405.1205 *et seq.*)

OSHA
General Duty Clause

- "Each employer … shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees."

(29 USC 654)

- "Workplace violence is a recognized hazard within the healthcare industry and as such, employers have the responsibility via the Act to abate the hazard. The Occupational Safety and Health Administration (OSHA) relies on the General Duty Clause for enforcement authority."

(CDC, https://wwwn.cdc.gov/WPVHC/Nurses/Course/Slide/Unit5_4)

Health Insurance Portability and Accountability Act (HIPAA)

- May disclose protected health info for purposes of treatment, payment or certain healthcare operations without patient's authorization. (45 CFR 164.506)
- "Treatment" = "provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another." (45 CFR 164.501)
- May only disclose minimum necessary. (45 CFR 164.514)

Discrimination

STATUTES

- 42 CFR part 90
- Title VI of Civil Rights Act of 1964
- Section 504 of Rehabilitation Act of 1973
- Americans with Disabilities Act
- State laws

PROTECTED CLASS

- Disability
- Age
- Sex
- National origin
- Race
- Religion

Discrimination

- "These statutes and their implementing regulations require that covered entities administer their services, programs and activities in the most integrated setting appropriate to individuals with disabilities and prohibit covered entities from utilizing criteria or methods of administration that lead to discrimination.... [H]ospitals should ensure that their discharge practices comply with applicable Federal civil rights laws and do not lead to needless segregation."

(Hospital Interpretive Guidelines at A-0799; *see also* 80 FR 68130).

Contract Limitations

PATIENT CONTRACTS

- Admission agreements
- Financial conditions
- Patient rights forms
- Others?

Network contracts

- Care obligations
- Review processes
- Others?

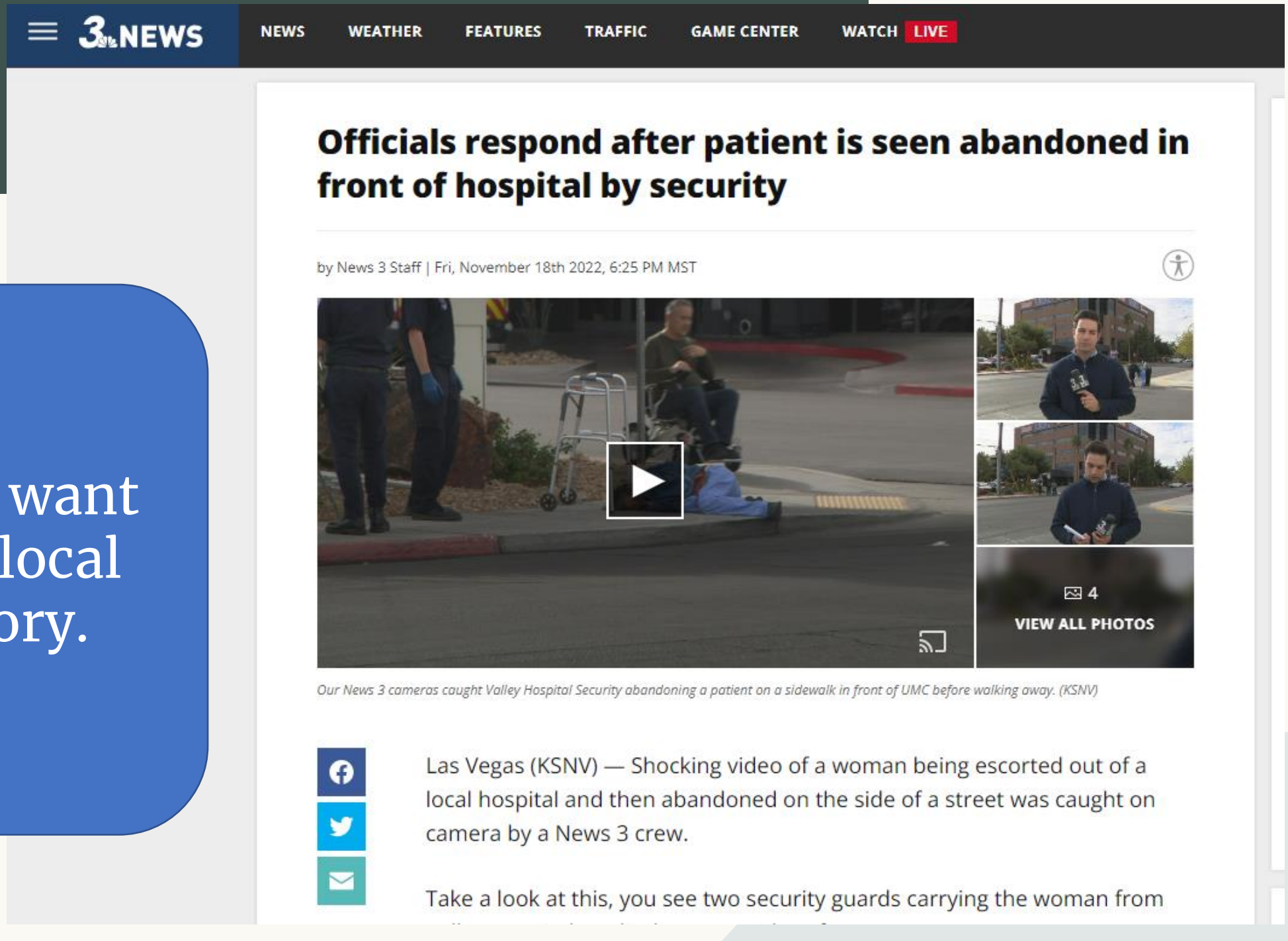
PAYER CONTRACTS

- Payment for medically unnecessary servicies
- Coverage terms and conditions
- Pre-authorizations
- Utilization review
- Patient appeals of care or coverage determinations

See National Committee for Quality Assurance ("NCQA") standards.

Bad Press

You don't want to be the local news story.



3 NEWS | NEWS | WEATHER | FEATURES | TRAFFIC | GAME CENTER | WATCH LIVE

Officials respond after patient is seen abandoned in front of hospital by security

by News 3 Staff | Fri, November 18th 2022, 6:25 PM MST

4 VIEW ALL PHOTOS

Our News 3 cameras caught Valley Hospital Security abandoning a patient on a sidewalk in front of UMC before walking away. (KSNV)

Las Vegas (KSNV) — Shocking video of a woman being escorted out of a local hospital and then abandoned on the side of a street was caught on camera by a News 3 crew.

Take a look at this, you see two security guards carrying the woman from

Suggestions

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Avoid Taking the Patient if Possible

- May generally refuse to accept if:
  - EMTALA does not apply, e.g.,
    - Patient has not come to the hospital for emergency care.
    - Patient is not in inbound ambulance while hospital on divert.
    - If contacted by hospital for transfer:
      - Receiving hospital lacks specialized capabilities, or
      - Patient was admitted at transferring hospital.

    (*See* 42 CFR 489.24)
  - No existing or continuing patient relationship that would trigger duty of care or patient abandonment.

Begin Discharge Planning Promptly

- Confirm anticipated needs.
- Secure payer sources.
  - Medicare/Medicaid
  - VA benefits
  - Private payers (e.g., employee benefits, etc.)
  - ACA plans
  - Others?
- Line up post-discharge resources.
  - Post-acute care providers, e.g., SNF, ALF, HHA, etc.
  - Community-based resources.
- Educate patient from the outset about discharge process so patient understands and is preparing for discharge.

Consistent with CoPs

Understand and Address Patient or Representative's Concerns

CONCERNS / MOTIVES

- Ignorance re options and costs.
- Feels not medically ready to leave.
- Fear about leaving hospital setting or transferring to new care setting.
- "Gains" from remaining in hospital.
- Cause of behavioral problems.
- Reason for noncompliance with medications or treatment.
- Others?

RESPONSE

- Ask and listen.
- Involve appropriate care team in response, e.g., practitioner, discharge planner, social worker, etc.
- Involve family, if appropriate and consistent with HIPAA.
- Arrange for post-care provider to visit.
- Explain liability for costs and prohibitions on continued stay.

Establish Patient Contracts

- Establish patient responsibility policies or documents.
  - Professional and respectful conduct.
  - Participate in care plan.
  - Responsible for payment.
- Include in admission documentation.
- Behavior contracts if patient not complying.
  - Expectations and responsibilities.
  - Consequences if fail to comply.
- May be helpful if more drastic action needs to be taken in future, including lawsuit, polices involvement, etc.

Locate Alternative Care Settings, Providers or Resources

- State hospital, dementia facility (Syringa), Southwest Idaho Treatment Center, secure treatment facility, etc.
- Interstate compact for mentally deficient
- State programs to facilitate care.
- Other appropriate hospitals.
- Skilled nursing, assisted living, memory care.
- Mental or behavioral health center.
- Residence with home health.
- Family or other appropriate caregiver.
- Hotel or apartment.
- Half-way house or transitional housing.
- Other community resources
- Other?

The most common solution.

- May be in another state.
- Usually depends on whether the patient has a payer source.
  - ➢ *Secure funding source as soon as possible.*

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Secure Funding Source

GOVERNMENT PROGRAMS

- Medicare
- Medicaid
- VA benefits
- CHIP
- Supplemental Security Income (SSI)
- Social Security Disability Insurance (SSDI)
- Food stamps
- Others?

PRIVATE PAYERS

- Insurance
- Insurance exchange
- Employee benefits
- Patient assets
- Family resources
- Community resources, e.g.,
  - Cash assistance
  - Housing subsidies
- Other?

Medicaid for Elderly or Adults with Disabilities

Healthcare coverage for adults with disabilities and elderly adults who may need services

Explore this Section

- About Medicaid for Elderly or Adults with Disabilities
- Apply for Medicaid for Elderly or Disabled Adults
- Apply for Adult with Developmental Disabilities Programs
- Assisted Care and Facilities +
- Services for Adults with Developmental Disabilities +
- Manage my Adult with Disabilities Medicaid

About Medicaid for Elderly or Adults with Disabilities

Medicaid covers adults with intellectual and development disabilities as well as adults with physical disabilities. Medicaid also covers elderly individuals who may need additional services to help them live as independently as possible. The goal of the Medicaid program is to get the right care at the right place at the right cost with the right outcomes. After Medicaid eligibility is determined, and individual will have an assessment regarding the level of care required to help meet individuals needs and care.

Overview of Medicaid Programs

Individuals who are elderly or live with a disability can be eligible for Medicaid coverage if they meet the following criteria:

- Live in Idaho
- Be a U.S. citizen or eligible non-citizen
- Have a disability diagnosis under the Social Security Act (or)
- Be over the age of 65 years
- Meet certain income and resource guidelines

Those with **Developmental Disabilities** can receive services specific to their disability when they meet certain criteria.

MEDICAID/MEDICARE PARTICIPANTS

Idaho Medicaid Health Plan Booklet

Find information about Medicaid's healthcare benefit plans.

Medicaid Health Plan Booklet

EMTALA Transfer to Hospital with Specialized Capabilities

- Participating hospital with "specialized capabilities" must accept transfer if it has capacity, e.g.,
  - Specialized equipment or personnel (e.g., mental health, trauma, etc.)
  - Special circumstances at transferring facility ("serious capacity problem", e.g., mechanical failure, no beds, no call coverage for specialty, etc.).
- May refuse transfers if:
  - Transferring hospital has similar capabilities but be careful.
  - Transferring hospital admitted the patient as inpatient.
  - Transfer from outside the United States.

(42 CFR 489.24(f))

EMTALA Transfer to Hospital with Specialized Capabilities

- EMTALA obligations not limited to state boundaries; may transfer patient across state lines.
- Beware transfers over long distances.
  - "Hospitals that request transfers must recognize that the appropriate transfer of individuals with unstabilized emergency medical conditions that require specialized services should not routinely be made over great distances, bypassing closer hospitals with the needed capability and capacity."

(EMTALA Interpretive Guidelines)

Commitment Proceedings for "Mentally Ill"

- Initiate 24-hour "mental hold" per IC 66-326 *et seq*.
  - Notify county prosecutor, who files petition with court within 204 hours.
  - Court orders designated exam.
  - If designated exam confirms patient's status, reports to court.
  - Court orders expedited commitment proceeding.
- Initiate formal commitment proceedings per IC 66-329 *et seq*.
  - Any caregiver or practitioner.
- If successful, patient is committed to state hospital.

But…

Commitment Proceedings for "Mentally Ill"

- Commitment proceedings only apply to those who are mentally ill and either:
  - "Gravely disabled" due to mental illness, or
  - "Likely to injure himself or others."

(*See* IC 66-317, -326, and -329).

- "Mentally ill" = a condition resulting in a substantial disorder of thought, mood, perception, orientation that grossly impairs judgment, behavior, or capacity to recognize and adapt to reality and requires care and treatment at a facility or through outpatient treatment.

(IC 66-317(11) and -329(13)(a), as amended in 2022)

Commitment Proceedings for "Mentally Ill"

- "Mentally ill" is not—
  - A neurological disorder, a neurocognitive disorder, a developmental disability, a physical disability, or any medical disorder that includes psychiatric symptomology or is primarily impaired by substance use, unless in addition to such condition, such person is mentally ill. (IC 66-317 and -329(13)(a), as amended in 2022)
  - A neurocognitive disorder, i.e., decreased mental function due to a medical disease other than a psychiatric illness, including (a) Alzheimer's disease; (b) frontotemporal lobar degeneration; (c) Lewy body dementia; (d) vascular dementia; (e) traumatic brain injury; (f) inappropriate use or abuse of substances or medications; (g) infection with human immunodeficiency virus; (h) prion diseases; (i) Parkinson's disease; or (j) Huntington's disease. (IC 66-317(13) and -329(13)(a), as amended in 2022)

Commitment Proceedings for "Mentally Ill"

- "Gravely disabled" = a person who, as the result of mental illness, has demonstrated an inability to:

  (a) Attend to basic physical needs, such as medical care, food, clothing, shelter, or safety;

  (b) Exercise sufficient behavioral control to avoid serious criminal justice involvement; or

  (c) Recognize that he is experiencing symptoms of a serious mental illness and lacks the insight into his need for treatment, whereby the subsequent absence of treatment may result in deterioration of his condition…

(IC 66-317(12))

Commitment Proceedings for "Mentally Ill"

- "Likely to injure himself or others" =

  (a) A substantial risk that physical harm will be inflicted by the patient upon himself or others…; or

  (b) The patient lacks insight into his need for treatment and is unable or unwilling to comply with treatment and, based on his psychiatric history, clinical observation or other clinical evidence, if he does not receive and comply with treatment, there is a substantial risk he will continue to physically, emotionally or mentally deteriorate to the point that he will, in the reasonably near future, inflict physical harm on himself or another person.

(IC 66-317(10)

- Not expressly linked to "mentally ill", but commitment proceedings are limited to those who are "mentally ill."

Commitment Proceedings for "Mentally Ill"

- "Nothing in [Title 66 chapter 3] or in any rule adopted pursuant thereto shall be construed to authorize the detention or involuntary admission to a hospital or other facility of an individual who:

  (a) Has a neurological disorder, a neurocognitive disorder, a developmental disability as defined in section 66-402, Idaho Code, a physical disability, or any medical disorder that includes psychiatric symptomology or is primarily impaired by substance use, unless in addition to such condition, such person is mentally ill; [or]

  (c) Can be cared for privately with the help of willing and able family or friends in such a way as to no longer present substantial risk to himself or others, provided that such person may be detained or involuntarily admitted if such person is mentally ill and presents a substantial risk of injury to himself or others if such care is not adequate."

(IC 66-329(13))

Commitment Proceedings for "Mentally Ill"

- Under "mental hold" process:
  - If designated examiner determines the patient is not "mentally ill" and/or does not meet commitment criteria, and
  - "If no petition is filed within twenty-four (24) hours of the designated examiner's examination of the person, the person shall be released from the facility."

(IC 66-326(4))

- But beware:
  - EMTALA obligations
  - CoPs
  - Malpractice, patient abandonment, etc.

Commitment Proceedings for "Developmentally Disabled"

- Spouse, guardian, relative, friend, licensed physician, prosecutor, or head of facility may initiate proceedings to commit person to custody of DHW if person is:
  - Developmentally disabled person,
  - Likely to injure himself or others, and
  - Lacks capacity to make informed decision about treatment.
- Evaluated by interdisciplinary team designated by DHW director.
- Court makes determination.

(IC 66-406)

Commitment Proceedings for "Developmentally Disabled"

"Developmental disability" = chronic disability that appears before the age 22 and:

- Is attributable to an impairment, such as intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; and
- Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and
- Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are of lifelong or extended duration and individually planned and coordinated.

(IC 66-402)

Commitment of Criminal Defendant

- In criminal case, judge may order criminal defendant to be evaluated to determine competency to stand trial. If incompetent, court may order the defendant committed to custody and treatment for DHW for limited period.

(IC 18-212)

- May be committed to secure treatment facility under IC 66-1404.

Commitment to DHW Secure Treatment Facility

- To be admitted to DHW secure treatment facility, person must have:
  - Primary diagnosis of a developmental disability and a diagnosis for serious mental illness.
  - Be an adult.
  - Meet one of the following criteria:
    - Be charged with a crime per IC 18-212; or
    - Be civilly committed per IC 66-401 et seq.
  - Be found by court to present substantial threat to safety of others if not evaluated or treated in secure facility.

(IC 66-1404)

Commitment Proceedings: Gap?

- Idaho has commitment proceedings for:
  - Mentally ill (IC 66-329 et seq.)
  - Developmentally disabled (IC 66-406 et seq.)
- What about others?
  - Organic or neurological disorders beginning after age 22?
  - Problems caused by drugs or alcohol?
  - Homelessness?
  - Others?

Negotiate Subsidy from DHW or Other Payers

- Work with DHW to find an appropriate solution, care setting, and/or funding for appropriate care.
- Negotiate with DHW to cover costs or provide supplemental support, e.g.,
  - 1 on 1 sitter.
  - Additional care providers.
  - Additional costs for care rendered by hospital.
  - Other?
- May require:
  - Political pressure.
  - Threat of or actual lawsuit.

Work with DHW to Find Solution

- For those patients who are in the care or custody of DHW, may need to discuss the DHW's obligation (if any) to care for the patient, pay for care, or find an appropriate facilty.
  - Minors who are in the care or custody of DHW, *e.g.*, where parents were not able or unwilling to care for child.
  - Adults who are otherwise in the care or custody of DHW.

Lawsuit Against to Confirm State Responsibility, if Any

- *Olmstead v. L.C.*, 527 US 581 (1999): ADA Title II requires states to provide care for persons with mental disabilities in the community wherever possible rather than in an institutional setting.
  - Other theories?
- Relief
  - Declaration of rights or absence of obligation by facility.
  - Injunction requiring state to take certain actions.
  - Recover cost of care.
  - Other?

Return to Transferring Nursing Facility

- Medicare/Medicaid nursing facilities must satisfy certain conditions to transfer or discharge, e.g.,
  - Limited permissible reasons.
  - 30 days' advance notice.
- Exceptions allow for immediate transfer or discharge if:
  - Necessary for resident's welfare.
  - Patient endangers the safety or health of other residents.
- Must hold bed for 7 days unless patient satisfies discharge criteria.
- If patient not allowed to return, must provide appropriate notice.
- Patient has certain appeal rights.

(42 CFR 483.15(c), -483.10(a)(2), (c), and (g)(14); Hospital Interpretive Guidelines)

Return to Transferring Assisted Living Facility

- Idaho assisted living facilities must satisfy certain conditions to transfer or discharge, e.g.,
  - 30 days' advance notice unless it is emergency.
- Exceptions allow for immediate transfer or discharge if emergency conditions require resident to be transferred to protect the resident or other residents in the facility from harm.
- Patient has certain appeal rights for discharge.

(IDAPA 16.03.22.150, -.217.03 and -.550.20)

- Additional terms may appear in admission agreement.

Return to Transferring Facility

- Returning to transferring LTC facility may not be a practical solution.
  - Facility will usually claim discharge was for safety of patient or other residents.
  - Facility may satisfy discharge criteria prior to or after returning.
  - Facility will return patient to hospital.

Involve Appropriate Surrogate Decision-Maker

- If patient is incompetent, may need authorized surrogate decision-maker to consent to care, transfer, *etc.*
  - Determine whether patient has a durable power of attorney or similar advance care planning document that has been triggered.
  - See persons identified in IC 39-4504.
  - Bring action to appoint a guardian.
    - Check with county Board of Guardians.
    - Locate other person to service as guardian.

    But guardian is not necessary if another person under IC 39-4504 is available.
- May need to explain or confirm authority of surrogate decision-maker in discussions with receiving facility.

Report Neglect

- "Child neglect" = without proper parental care and control, or subsistence, medical or other care or control necessary for his well-being because of the conduct or omission of his parents, guardian or other custodian or their neglect or refusal to provide them

(IC 16-1602)

- "Vulnerable adult neglect" = failure of a caregiver to provide food, clothing, shelter, or medical care, the absence of which impairs or threatens sustainable life or health of a vulnerable adult.

(IC 39-5302)

- May prompt action by parent, caregiver, and/or DHW.

Reduce Benefit of Staying

- Provide notice to patient.
- Eliminate privileges, especially if patient is a trespasser, *e.g.*,
  - TV or other entertainment.
  - Favorable room arrangements.
  - Unnecessary meals or care.
  - Extra meal choices.
  - Other benefits?
- Do not eliminate needed care or violate standard of care.

Subsidize Care in Other Setting

- May be cheaper than keeping patient at hospital.
- Pay for partial costs that patient may have post-discharge for limited period of time, e.g.,
  - Additional amounts in long-term care or other setting.
  - Hotel, apartment or house.
  - Transportation costs to another location or appropriate care setting.
    - But not "Greyhound" therapy
  - Care provider, e.g., home health or mental health.
  - Needed medications or supplies.
  - Other?
- *But…*
  - Don't simply "dump" patient.
  - Consider fraud and abuse laws (discussed below).

Subsidize Care in Other Setting

- Pay for all or part of premiums to secure insurance, e.g.,
  - Insurance
  - ACA healthcare insurance exchange if allowed by plan.
  - COBRA coverage.
  - Others?
- *But…*
  - Consider limitations in insurance coverage concerning who may pay.
  - Consider fraud and abuse laws.

Subsidize Costs: Fraud and Abuse Laws

- Anti-Kickback Statute
  - e.g., payments or subsidies to induce referrals.
  - ➢ But payments are likely not offered to induce referrals.

  (42 USC 1320a-7b)
- Civil Monetary Penalties Law
  - e.g., payments on behalf of patient to induce patient to receive services.
  - ➢ But payments may not be offered to induce services from a particular provider.
  - ➢ "Remuneration" does not include:
    - Certain remuneration to financially needy individuals, and
    - Payment which promotes access to care and poses low risk of harm.

  (42 CFR 1003.110)

Subsidize Costs: Fraud and Abuse Laws

- Anti-supplementation rules generally prohibit SNFs from charging additional amounts for services covered by Medicare or Medicaid.

(42 USC 1395cc(a) and 1320a–7b(d); 42 CFR 489.20 and 447.15)

- "[A] SNF may not condition acceptance of a beneficiary from a hospital upon receiving payment from the hospital … in an amount greater than the SNF would receive under the PPS. For Medicare and Medicaid beneficiaries, a nursing facility may not accept supplemental payments, including, but not limited to, cash and free or discounted items and services, from a hospital or other source merely because the nursing facility considers the Medicare or Medicaid payment to be inadequate…"
  - Does not apply to non-Medicare/Medicaid covered services.
  - Does not prevent donations unrelated to specific patients.
  - Does not apply to legitimate arrangement to reserve beds.

(*OIG Supplemental Compliance Program Guidance*, 73 FR 56846)

Call the Police

- Battery Against a Health Care Worker
  - Battery on any licensed, certified or registered health care worker or employee of a hospital, medical clinic or medical practice, when the victim is in the course of performing his or her duties or because of the victim's professional or employment status under this statute, shall be subject to imprisonment in the state prison not to exceed three (3) years.
  - Penalties: prison up to 3 years.

(IC 18-915C)

- State does maintain facility for criminally violent offenders.

Call the Police

- Criminal Trespass
  - Person remains on the real property of another without permission, knowing or with reason to know that his presence is not permitted. A person has reason to know his presence is not permitted when, except under a landlord-tenant relationship, he fails to depart immediately from the real property of another after being notified by the owner or his agent to do so.
  - Penalties:
    - If leaves when ordered: $300.
    - If fails to leave when ordered: $500 to $1000 + up to 6 months in jail.
    - Restitution.
    - Additional penalties of trespasser caused damage.

(IC 18-7008)

Call the Police

- May be a temporary solution.
  - Police or prosecutors unlikely to pursue charges against patient who lacks capacity.
  - Police may return the patient to the hospital if patient needs ongoing care.
- Benefit:
  - May provide some immediate protection or relief for staff.
  - May confirm to staff that you are looking out for them.
  - Patient may remain in police custody, thereby perhaps tapping police resources.
  - May support lawsuit or other further action.
  - May strengthen defense against OSHA, licensure, or other action.
- Risk:
  - May interfere with ability to transfer care to another setting.

Lawsuit for Civil Trespass

- Civil Trespass =
  - Person enters or remains upon the real property of another person without permission.
  - Remedies
    - Damages are greater of $500 or damage actually caused by trespass.
    - Reasonable attorneys' fees.
    - Reasonable costs in investigating trespass.

(IC 6-202)

- May be used as a threat against competent patient or family.

Lawsuit for Costs of Care

- Ensure compliance with Medicare, Medicaid and/or private payer arrangements.
- Ensure compliance with Idaho Patient Act (IC 48-301 et seq.)
- Bases for suit.
  - Breach of contract.
    - Check patient financial policies to confirm terms, e.g., costs of litigation, collection fees, attorneys' fees, etc.
  - Benefit conferred.
  - Civil trespass.
  - Other?

Lawsuit for Injunctive Relief

- File a lawsuit seeking court order, *e.g.*,
  - Confirming right of hospital to discharge patient.
  - Confirming right of hospital to medicate or take other action.
  - Requiring patient to be transferred to another care setting.
  - Requiring patient or legally responsible person to pay.
  - Requiring guardian or other caregiver to accept responsibility to care for patient.
  - Prohibiting return to facility.
    - Consider EMTALA implications.
  - Other relief?
- Courts will be leery of imposing requirements on other persons.

Lawsuit for Injunctive Relief

- Bases for arguments in lawsuit.
  - Hospital not licensed for long-term care.
  - Inappropriate care setting.
  - Excessive costs.
  - Misconduct by patient.
    - Civil trespass. (IC 6-202)
    - Assault on healthcare worker. (IC 18-915C)
    - OSHA general duty clause, i.e., obligation of employer to provide safe environment.
    - Interference with hospital's ability to care for others.
  - Other arguments/concerns?

Lawsuit for Injunctive Relief

- Document your compliance with applicable statutes and regulations.
  - E.g., discharge plans, notice, appeals, etc.
- Show that patient is appropriate for discharge.
  - Patient no longer requires hospitalization or relevant level of service.
  - Other, more appropriate care is available to patient.
  - Patient is competent or has authorized surrogate.
  - Patient has refused to fulfill his/her responsibilities, e.g., cooperate in care; act in professional manner; abusive; consent to discharge; etc.
- Show that patient is utilizing space and services that are needed for more urgent cases.
  - Cost of care
  - Facility is beyond capacity; turns patients away; etc.

Trespass and/or Injunction Cases

- *In re New York Methodist Hosp.*, 885 N.Y.S.2d 392 (2009) (injunction requiring patient to leave hospital)
- *Midstate Med. Ctr v. Doe*, 898 A.2d 282 (Conn. 2006) (injunction to transport patient to subacute care facility)
- *Wyckoff Heights Med. Ctr v. Rodriguez*, 741 N.Y.S.2d 400 (2002) (injunction requiring patient to leave hospital)
- *Jersey City Med. Ctr. V. Halstead*, 404 A.2d 44 (N.J. 1979) (injunction allowing hospital to remove patient)
- *Lucy Webb Hayes Nat'l Training School v. Geoghegan*, 281 F. Supp. 116 (D.D.C. 1967) (injunction against trespassing patient who refused to leave)
- Others

Trespass and/or Injunction Cases

- "(A hospital) has a moral duty to reserve its accommodations for persons who actually need medical and hospital care and it would be a deviation from its purposes to act as a nursing home for aged persons who do not need constant medical care but who need nursing care.... Hospitals have a duty not to permit their facilities to be diverted to the uses for which hospitals are not intended." *Lucy Webb Hayes*, 281 F. Supp. at 117.

- Hospital "owes a duty to the public which it serves to take all steps necessary to ensure that adequate care is available to those in need of it, and this includes the removal of patients no longer in need of medical care." *Jersey City Med. Ctr*, 404 A.2d 44.

In Any Lawsuit, Beware HIPAA

- Beware HIPAA confidentiality concerns.
  - HIPAA permits use or disclosure of protected health information for "health care operations," including litigation. (45 CFR 164.501 and .506)
  - Limit disclosures to minimum necessary. (45 CFR 164.514)
- Consider impact of federal laws.
  - EMTALA
  - Conditions of Participation
  - Other?

Utilize Ethics Committee

- Assist patients, families, and providers in negotiating some of the difficult ethical, interpersonal, and communication dilemmas.
- Analyze the situation from an ethical perspective and provide recommendations or confirmation and support for difficult choices.
- Assist with communication issues and dispute resolution.
- Bioethics consult can help both as evidence of process followed to arrive at conclusion and validate ultimate decision.

Long Term Solution

- Identify and establish community resources, especially behavioral health.
- Increase funding for appropriate care settings.
  - Reimbursement to hospital for costs.
  - Transitional care programs.
  - Mental and behavioral health programs.
  - Community programs, *e.g.*, shelters, respite care, *etc.*
- Establish network of facilities willing to accept patients.
- Establish agreements with long term care facilities by which hospital will agree to treat patient if facility receives patient back.
- Establish workgroup among hospitals and other stakeholders to consider alternatives.

Possible Legislation

- Allow hospital to discharge patient who meets discharge criteria.
- Modify commitment proceeding statute to extend beyond "mental illness" or "developmentally disabled."
- Impose "bed-hold" requirement on long term care facilities and/or require facility to accept patient back.
- Reduce or loosen standards for assisted living facilities so that they may accept more problem patients.
- Provide immunity to hospitals that attempt to care in good faith.
- Others?

Possible Legislation

- Conform hospital's ability to discharge patient. For example, see North Carolina statute:

  "Authority of administrator; refusal to leave after discharge. The case of a patient who refuses or fails to leave the hospital upon discharge by the attending physician shall be reviewed by two physicians licensed to practice medicine in this State, one of whom may be the attending physician. If in the opinion of the physicians, the patient should be discharged as cured or as no longer needing treatment or for the reason that treatment cannot benefit the patient's case or for other good and sufficient reasons, the patient's refusal to leave shall constitute a trespass. The patient shall be guilty of a Class 3 misdemeanor."

(North Carolina Gen. Statutes § 131E-90)

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