South Carolina Hospital Association Behavioral Health Patients in the Emergency Department: Legal Issues in Hospital Emergency Departments

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Premise of Presentation:

- The unavailability of behavioral healthcare services in South Carolina creates a multitude of issues that are coming to a crisis level, particularly for hospitals.
- Hospitals end up being the only entry/access point for individuals in need behavioral health services.
- This creates legal, ethical, safety, quality and financial issues for hospitals and patients in need of mental/behavioral health services.
- This presentation will:
  - Introduce various legal issues faced by hospitals; and
  - Discuss potential compliance and risk management strategies.
- The information provided and discussed is not intended to be a substitute for an individual hospital obtaining legal advice on these important issues.

Federal and State Laws Affecting EDs: EMTALA & Behavioral Health

- EMTALA: 42 U.S.C.A. 1395dd; 42 C.F.R. 489.20(r) & 489.24
  - Generally requires that when a patient *comes to the emergency department* of a hospital, the hospital must provide an *appropriate medical screening examination* within the *capability of the hospital's emergency department* to determine if an *emergency medical condition* exists and if it does exist, the hospital must either (1) *stabilize* the patient, or (2) *transfer* the patient in accordance with the terms of the EMTALA.
  - Emergency medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including psychiatric disturbances and/or symptoms of substance abuse)[only in 42 C.F.R. 489.24(b)] such that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily functions or serious dysfunction of any bodily organ or body part. 42 U.S.C.A. 1395dd; 42 C.F.R. 489.24(b).

Federal and State Laws Affecting EDs: EMTALA & Behavioral Health

- A participating hospital that negligently violates a requirement of EMTALA is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation.
- Any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of EMTALA is subject to a civil money penalty of not more than $50,000 fro each such violation.
- Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of EMTALA may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.
- Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of EMTALA may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.
- Statute of limitations for civil actions = 2 years.

Federal and State Laws Affecting EDs: EMTALA & Behavioral Health

- Is there EMTALA exposure for hospitals that do not provide behavioral health services?
- Baker v. Adventist Health: A hospital which operated an emergency room, but did not offer psychiatric treatment, and had no psychiatrists, psychologists, or any other mental health professionals on staff, did not have duty under EMTALA to provide a mental health screening for an emergency room patient who had reported suicidal ideations, and thus did not violate EMTALA when it called in a crisis worker from county medical health department, pursuant to its written policy, to screen the patient. The hospital was only required under EMTALA to provide a screening examination that was within its capabilities, which did not include mental health examinations. 260 F.3d 987 (9th Cir. 2001).

Federal and State Laws Affecting EDs: State Licensing Statute/Regulations

- No person, regardless of his ability to pay or county of residence, may be denied emergency care if a member of the admitting hospital's medical staff or, in the case of a transfer, a member of the accepting hospital's medical staff determines that the person is in need of emergency care. S.C. Code Ann. 44-7-260(E); S.C. Code Regs. 61-16 613.2.
- “Emergency care” means treatment which is usually and customarily available at the respective hospital and that must be provided immediately to sustain a person's life, to prevent serious permanent disfigurement, or loss or impairment of the function of a bodily member or organ. Id.
- Enforcement:
  - SCDHEC licensing action;
  - Potential for a $10,000 civil penalty for “reckless violation.”
- No cases interpreting this statute/regulation.

Federal and State Laws Affecting EDs: EMTALA & Behavioral Health

- Recommendations:
  - Medical Screening Examinations:
    - Be very aware of the screening services that are “within your capabilities” and utilize those services appropriately.
    - Follow your EMTALA policies and procedures for MSEs.
    - Identify qualified professionals who are able to conduct MSE in your Bylaws.
    - Document initial and ongoing screening.
  - Providing stabilizing treatment:
    - Appropriately utilize available services to stabilize the emergency medical condition.
    - Document initial and ongoing treatment provided.

Federal and State Laws Affecting EDs: CoPs

- 42 C.F.R. 482.55 Emergency Services: The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice.
- 42 C.F.R. 482.13 Patient Rights
  - (c)(2) right to receive care in a safe setting
  - (c)(3) right to be free from abuse/harassment
  - (e) Restraint or seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.
- Enforcement: Potential for issues with:
  - TJC, AOA or DNV Accreditation
  - Validation/Recertification survey

Accreditation Issues: TJC Behavioral Health Standards

- Provision of Care, Treatment, and Services (PC)
  - PC.01.02.11: Assessment of patients who receive psychosocial services to treat alcoholism or other substance use disorders.

  -PC.01.02.13: Assessment of patients with emotional and behavioral disorders.

Accreditation Issues: TJC Behavioral Health Standards Continued

- Rights and Responsibility of the Individual (RI)
  - RI.01.06.03: The patient has the right to be free from neglect, exploitation, and verbal, mental, physical, and sexual abuse.
  - See also TJC Sentinel Event Alert on preventing violence in the healthcare setting (June 3, 2010)
- National Patient Safety Goal Standards (NPSG)
  - NPSG.15.01.01: Identify patients at risk for suicide
  - See also TJC Sentinel Event Alert on preventing suicide (Nov. 17, 2010).

Accreditation Issues: TJC Behavioral Health Standards

- PC provisions dealing with restraints and seclusion: The hospital . . .
  - PC.03.05.01- uses restraints or seclusion only when justified or warranted by patient behavior that threatens the physical safety of the patient, staff or others.
  - PC.03.05.03- uses restraint or seclusion safely
  - PC.03.05.05- uses restraint or seclusion only upon physician order
  - PC.03.05.07- monitors patients who are restrained or secluded
  - PC.03.05.09- has written policies and procedures for use of restraints and seclusion
  - PC.03.05.11- evaluates and reevaluates the patient who is restrained or secluded
  - PC.03.05.13- continually monitors patients who are simultaneously restrained and secluded.
  - PC.03.05.15- documents the use of restraints and seclusion.
  - PC.03.05.17- trains staff to safely implement the use of restraints or seclusion
  - PC.03.05.19- reports deaths associated with the use of restraints or seclusion

Standard of Care: Why is this important?

- Negligence actions:
  - Duty
  - Breach of the duty
  - Causation
  - Damages
- Is there a duty owed by the hospital to the patient for the provision of emergency department services?
- Yes: A hospital has a nondelegable duty to provide emergency room services and is liable for the negligent acts of independent contractor emergency room physicians if a patient seeks services at the hospital as an institution and is treated by a physician who reasonably appears to be a hospital employee. Simmons v. Tuomey Regional Medical Center, 533 S.E.2d 312 (S.C. 2000).

What duty is owed? What is the standard of care for behavioral health patients in a general hospital?

- In Sloan v. Edgewood Sanitarium, the SC Supreme Court stated that "a hospital or sanitarium owes its patients or inmates a specific duty of care." "The hospital owes a duty to safeguard and protect the patient from any known possibility of self-harm or reasonably apprehended danger." "If [the hospital] neglects this duty . . . the hospital or sanitarium becomes liable for its negligence . . ." 80 S.E.2d 348, 351 (S.C. 1954).
- No South Carolina case makes a distinction for the standard of care between a general hospital that does not provide behavioral health services and a hospital that does.
- But . . .

What duty is owed? What is the standard of care for behavioral health patients in a general hospital?

- Courts in a few jurisdictions have recognized a separate standard of care for psychiatric and general hospitals.
- The Ohio Supreme Court stated "[a]s a general rule . . . the duty of a hospital toward its patients is to exercise such reasonable care for their safety as their known mental and physical condition may require, and that in a proper case this duty may extend to affording reasonable protection against self-inflicted injury." Johnson v. Grant Hospital, 291 N.E.2d 440, 444 (Ohio 1972).
- "A general hospital, which ordinarily does not and is not equipped to treat mental patients, should not be held to the same standard of care as a hospital which is operated and equipped to provide care for a patient who has displayed a tendency to commit suicide." Id. at 445 & 446.

Standard of care for behavioral health patients: Recommendations to limit liability

- It is not clear in South Carolina if a court would hold a general hospital to a different standard of care than it would hold a psychiatric hospital.
- Risk management:
  - Assume that a court would not hold a general hospital to a different standard.
  - Assess your capabilities:
    - Availability of psychiatric services (telemedicine)
    - Environment/safety considerations
    - Staffing
    - Education and training
    - Document document document
  - Understand your legal obligations
  - Develop, implement and adhere to policies and procedures to address behavioral health patients in the ED.
  - Review your malpractice insurance coverage.

Standard of care for behavioral health patients: Recommendations to limit liability

- Limiting your liability:
  - Governmental hospitals have statutory limitations on liability under the SC Tort Claims Act. ($1.2 million) S.C. Code Ann. 15-78-120.
  - Statutory limitation of liability for injury or death caused by employee of charitable organization ($1.2 million) S.C. Code Ann. 33-56-180.
    - Not applicable if the employee acted in a reckless, willful or grossly negligent manner.
  - Statutory limitation on noneconomic damages ($350K; $1.5 million)
    - Not applicable if the health care provider or health care institution:
      - is found to be grossly negligent, willful, wanton, or reckless, and such conduct was the proximate cause of the claimant's noneconomic damages; or
      - if the defendant has engaged in fraud or misrepresentation related to the claim;
      - or if the defendant altered or destroyed medical records with the purpose of avoiding a claim or liability to the claimant. S.C. Code Ann. 15-32-220.

Involuntary Commitment Process

- Separate statutory procedures for obtaining involuntary treatment for a person suffering from chemical dependency or mental illness.
- Definitions:
- Chemical dependency is defined as a chronic disorder manifested by repeated use of alcohol or other drugs to an extent that it interfered with a person's health, social, or economic functioning; some degree of habituation, dependence, or addiction may be implied. S.C. Code Ann. § 44-52-10(1).
- A person with a mental illness is defined as a person afflicted with a mental disease to such an extent that, for his own welfare or the welfare of others or of the community, he requires care, treatment or hospitalization. S.C. Code Ann. § 44-23-10(20).
- Determined by medical screening examination.

Involuntary Commitment Process: Emergency v. Non-Emergency Intervention

- Requirements for *non*-emergency involuntary commitment for chemical dependency
  - Recent acts of violence
  - Recent serious physical problems related to habitual and excessive use of drugs or alcohol
  - Numerous appearances before the court in the past year, repeated incidents with law enforcement, multiple prior treatment episodes, or testimony from family or members of the community proving the person's habitual and excessive incapacitation by drugs or alcohol
  - Petition for involuntary commitment filed with court along with a physician's certification that the person is chemically dependent
  - S.C. Code Ann. § 42-52-10(11) (1976); S.C. Code Ann. § 44-52-70.

Involuntary Commitment Process: Emergency v. Non-Emergency Intervention

- Requirements for *emergency* involuntary commitment for chemical dependency
  - Person poses a substantial risk of physical harm to himself or others if not immediately provided with emergency care and treatment and
  - Factual basis for belief of the specific type of harm thought probable
  - Person is believed to be unable to exercise judgment concerning their emergency care
  - Written certification by a licensed physician that the person is chemically dependent
  - S.C. Code Ann. § 44-52-50.

PART I (CHEMICAL DEPENDENCY)

AFFIDAVIT AND APPLICATION FOR INVOLUNTARY EMERGENCY ADMISSION FOR CHEMICAL DEPENDENCY

FOR FACILITY USE ONLY
Date Admitted
Facility Register No.
Approval of Facility Official
Signature Date

(Complete in Triplicate)
STATE OF SOUTH CAROLINA)
COUNTY OF _____)

IN THE MATTER OF:

Person alleged to be chemically dependent	Sex	Birth date	Age	Race	Marital Status

Street Address	City	County	State	Zip Code	Phone Number	Length of Time Residing There

TO THE FACILITY DIRECTOR:

Application is hereby made for the INVOLUNTARY EMERGENCY ADMISSION of the above-named person to

_____ for the following reasons:
Name of Treatment Facility

1. That the undersigned Applicant believes that the above-named person is chemically dependent and because of this chronic disorder of repeated and excessive use of alcohol and/or drugs poses a substantial risk of physical harm to self or others if not immediately provided with involuntary emergency care and treatment and that the above-named person is incapable of exercising judgment concerning emergency care.

2. That the specific type harm thought probable is _____
_____ based on
the following recent threats or attempts to seriously harm self or others _____.

3. That the Applicant understands that for Involuntary Emergency Admission to occur that the said person must be examined and Certified by at least one licensed physician (Part II, Certificate of Licensed Physician for Chemical Dependency) as required by Section 44-52-50, S.C. Code, 1976, as amended. If the Applicant has reason to believe that the said person will not or cannot be examined, Applicant has listed below his/her grounds for that belief and why the usual procedure for physician examination may not be followed:

_____
_____

4. For purposes of emergency notification, the next-of-kin family of allegedly chemically dependent person is _____
Name

Relation _____ Whose address is _____
RFD or Street City and State Zip Phone Number

SWORN to before me this

_____ day of _____, 20 _____.

_____
Notary Public for South Carolina or Probate Judge

My Commission Expires: _____

WHEREFORE, I, being duly sworn state that I am the Applicant above named, that I have read the Application, the allegations of which are true of my own knowledge, except those stated on information and belief.

FURTHERMORE, I understand (IF A FAMILY MEMBER) that I may be required to cooperate with and participate in the treatment process if requested by the treatment facility and ordered by the court.

X _____
Applicant's Signature

_____
Name of Applicant (typed or printed)

_____
Address of Applicant

_____
Phone Number of Applicant

_____
Relationship to Patient or Title, if any

(See reverse side which must be completed)

MUST PRINT ON PINK STOCK ONLY

PART I (CHEMICAL DEPENDENCY)
AFFIDAVIT AND APPLICATION FOR INVOLUNTARY EMERGENCY ADMISSION FOR CHEMICAL DEPENDENCY

IMPORTANT NOTICE: All patients receiving treatment in a State Department of Mental Health facility will be charged the established fee as approved by the South Carolina Mental Health Commission.

PERTINENT FINANCIAL RESPONSIBILITY INFORMATION

Present Name		Full Name at Birth if Different From Present	
Education Level	Social Security Number	Occupation	Monthly Income
Employer's Name	Address	If not employed, source of income: Retirement $ / Public Assistance $ / Other $	

HOSPITALIZATION INSURANCE Coverage including group insurance, Medicare, Medicaid, military medical care, etc.

Policy No. or HIB	Name of Insurance Co.	Address	If group insurance, name & address of firm

MILITARY SERVICE

Branch	Service Number	Dates of Service	Type Discharge	Monthly Pension	VA Claim No.

SCDMH CHEMICAL DEPENDENCY TREATMENT FACILITIES

Morris Village Alcohol and Drug Treatment Center
610 Faison Drive
Columbia, S.C. 29203

Serves all counties and mental health centers.

For admission and bed availability information:
Call: (803) 935-6432 DURING NORMAL OFFICE HOURS
(803) 935-6760 ALL OTHER HOURS

Has Voluntary, Involuntary and Adolescent (ages 13-17) programs.

NOTE: ADMINISTRATIVE PROCEDURE - FORMS, PART I AND PART II:
"Affidavit and Application for Involuntary Emergency Admission for Chemical Dependency, Part I" and "Certificate of Licensed Physician-Medical Examination for Chemical Dependency, Part II" must be completed in triplicate and accompany the person to the treatment facility.
ADMISSION MUST BE WITHIN FORTY-EIGHT HOURS OF THE DATE OF THE EXAMINATION AND CERTIFICATION OF THE LICENSED PHYSICIAN, (PART II).

MUST PRINT ON PINK STOCK ONLY

PART II
CERTIFICATE OF LICENSED PHYSICIAN
EXAMINATION FOR EMERGENCY ADMISSION

NAME OF PERSON EXAMINED _____ AGE _____ COUNTY OF RESIDENCE _____

PLACE OF EXAMINATION _____ HOUR AND DATE OF EXAMINATION _____

I, THE UNDERSIGNED LICENSED PHYSICIAN, have examined the above-named person and am of the opinion that the said individual:

☐ IS MENTALLY ILL AND because of this mental condition CURRENTLY POSES A SUBSTANTIAL RISK of physical harm to self and/or others to the extent that INVOLUNTARY EMERGENCY HOSPITALIZATION is recommended.

My recommendation for INVOLUNTARY EMERGENCY HOSPITALIZATION is based on the following symptoms and specific examples of behavior which indicate mental illness and probable risk of harm:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The person is therefore to be transported to _____
NAME OF SCDMH PSYCHIATRIC HOSPITAL

or to _____ for involuntary emergency admission.
NAME OF NON-SCDMH HOSPITAL

For admission to SCDMH hospital, Physician must complete Part II, Page 2, over.

_____, M.D. _____
SIGNATURE OF LICENSED PHYSICIAN S.C. LICENSE NUMBER

_____, M.D. _____
TYPED OR PRINTED NAME PHONE NUMBER

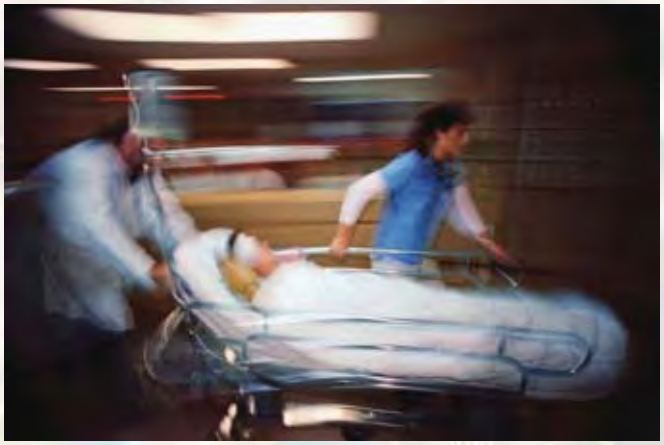
_____
ADDRESS

_____

All information MUST be typed or clearly printed

Involuntary Commitment Process: Emergency v. Non-Emergency Intervention

- Requirements for *emergency* involuntary commitment for mental illness
  - Person is likely to cause harm to himself or others if not immediately hospitalized and
  - Factual basis for the specific type of serious harm thought probable if person is not immediately hospitalized
  - A certification by a licensed physician that the person has been examined, found mentally ill, and likely to cause harm to himself
  - S.C. Code Ann. § 44-17-410.



APPLICATION FOR INVOLUNTARY EMERGENCY HOSPITALIZATION FOR MENTAL ILLNESS

FOR HOSPITAL USE ONLY
Date Admitted
Hospital Register No.
Approval of Hospital Official
Signature Date

(Complete in Triplicate)
STATE OF SOUTH CAROLINA)
COUNTY OF _____)

IN THE MATTER OF:

Person alleged to be mentally ill | Sex | Birthdate | Age | Race | Marital Status

Street Address | City | State | Zip | Phone # | Length of Time Residing There

TO THE HOSPITAL DIRECTOR:

Application is hereby made for the INVOLUNTARY EMERGENCY ADMISSION of the aboved-named person to a SCDMH Psychiatric Hospital

or to _____
NAME OF NON-SCDMH HOSPITAL

for the following reasons:
That the undersigned believes that the aboved-named person is mentally ill, and because of this mental condition is likely to cause serious harm to self or others if not immediately hospitalized.

1. The specific type of serious harm thought probable is:

_____

_____

2. That the applicant bases his/her belief on the following grounds:

_____

_____

3. That the applicant understands that for Involuntary Emergency Admission to occur that the said person must be examined and certified by at least one licensed physician (Part II, Certificate of Licensed Physician for Mental Illness) as required by Section 44-17-410, S.C. Code, 1976, as amended. If the said person has not been examined, listed below are the reasons:

_____

_____

4. That next-of-kin of allegedly mental ill person is _____
Name

Relation _____ Whose address is _____
RFD or Street | City and State | Zip | Phone Number

In case of next-of-kin cannot be contacted, notify _____

Relation | Address | City and State | Zip | Phone Number

SWORN to before me this

_____ day of _____, 20____.

_____
Notary Public for South Carolina or Probate Judge

My Commission Expires: _____

WHEREFORE, the undersigned requests that the person named above be admitted to a psychiatric hospital for treatment as authorized by law.

X _____
Applicant's Signature

_____
Name of Applicant (typed or printed)

_____
Address of Applicant

_____
Telephone Number of Applicant

_____
Relation to Patient or Title, if any

(See reverse side which must be completed)

APPLICATION FOR INVOLUNTARY EMERGENCY HOSPITALIZATION FOR MENTAL ILLNESS

IMPORTANT NOTICE: All patients receiving treatment in a State Department of Mental Health facility will be charged the established fee as approved by the South Carolina Mental Health Commission.

PERTINENT FINANCIAL RESPONSIBILITY INFORMATION

Present Name		Full Name at Birth if Different From Present	
Education Level	Social Security Number	Occupation	Monthly Income
Employer's Name	Address	If not employed, source of income: Retirement $	Public Assistance $ / Other $

HOSPITALIZATION INSURANCE Coverage including group insurance, Medicare, Medicaid, Military medical care, etc.

Policy No. or HIB	Name of Insurance Co.	Address	If group insurance, name & address of firm

MILITARY SERVICE

Branch	Service Number	Dates of Service	Type Discharge	Monthly Pension $	VA Claim No.

FINANCIAL REPRESENTATIVE Please list the name, address and telephone numbers of the person to receive financial statements and other media related to the personal financial affairs on behalf of the patient

Last Name	First Name	Middle Initial	Relation to Patient	Street Address or Rural Route & Box / City, State, Zip	Telephone

LIST OF SCDMH PSYCHIATRIC HOSPITAL

Division of Inpatient Services G. Werber Bryan Psychiatric Hospital 220 Faison Drive, Columbia, S.C. 29203 For information and prior to all admissions call: (803) 935-7143 – All Hours	Division of Inpatient Services Bryan Psychiatric Hospital Wellspring 2100 Bull Street, Columbia, S.C. 29202 For information and prior to all admissions call: (803) 898-2038 – All Hours	Division of Inpatient Services William S. Hall Psychiatric Institute 1800 Colonial Dr., P.O. Box 202 Columbia, S.C. 29202 Psychiatry Unit Forensic Unit Children's Unit For information and prior to all admissions call: (803) 898-1662 – All Hours
Patrick B. Harris Psychiatric Hospital P.O. Box 2907, Anderson, S.C. 29622 For information and prior to all admissions call: (864) 231-2600 – All Hours	Division of Inpatient Services Forensics Evaluation and Treatment Services 7901 Farrow Road, Columbia, S.C. 29203 For information and prior to all admissions call: (803) 935-6334 or (803) 898-2038 – All Hours	

NOTE: ADMINISTRATIVE PROCEDURE – FORMS:
"Application for Emergency Admission, Part I", and "Certificate of Licensed Physician, Part II", must be completed in triplicate and accompany the patient to the receiving hospital. The hospital must forward one copy to Judge of Probate of the county in accordance with 44-17-410(3) and retain one copy in the person's hospital record. ADMISSION MUST BE WITHIN SEVENTY-TWO HOURS OF THE DATE OF THE CERTIFICATION OF THE LICENSED PHYSICIAN, (PART II).

NOTE: TO LICENSED PHYSICIAN:

1. The licensed physician must consult with the local State Community Mental Health Center regarding the commitment/admission process and the available treatment options and alternatives in lieu of hospitalization at a state psychiatric facility. (Section 44-17-460, S.C. Code, 1976, as amended).
2. The licensed physician must also consult via telephone with the admitting physician of the receiving hospital regarding the appropriateness of admission and the persons mental and physical treatment needs.

NOTE: TO POLICE AND OTHER OFFICERS OF THE PEACE:
The certificate of a licensed physician authorizes and requires taking the proposed patient into custody. Section 44-17-440, South Carolina Code of Laws, 1976, as amended: "The certificate required by item 2 of Section 44-17-410 shall authorize and require any officer of the peace, preferably in civilian clothes, to take the individual into custody and transport him to the hospital designated by the certification. No person shall be taken into custody after the expiration of three days from the date of the certification. Any friend or relative may transport the individual to the mental health facility designated in the application, provided such friend or relative has read and signed a statement on the certificate which clearly states that it is the responsibility as an officer of the peace to transport the patient shall not be entitled to reimbursement from the State for the cost of such transportation. Any officer acting in accordance with the provisions of this article shall be immune from civil liability."

NOTE: TO FRIENDS AND RELATIVES:
It is the responsibility of an officer of the peace to provide timely transportation of the person alleged to be mentally ill to the designated mental health facility. However, by freely signing this statement, you can choose to assume that responsibility. Transportation must begin immediately. This form must be hand delivered by you to the admissions office of the designated mental health facility at the time of admission.

Date Signature of Friend or Relative/Relationship

PART II
CERTIFICATE OF LICENSED PHYSICIAN
EXAMINATION FOR EMERGENCY ADMISSION

Name of Patient	Sex	County of Residence	Date of Birth	Age

Are there prior admissions to SCDMH or other mental hospitals? ☐ Yes ☐ No	Where?	When?
Are there criminal charges? ☐ Yes ☐ No	If yes, give details (include county, type of charge).	

Reasons for psychiatric admission (specify symptomatology) (Not necessary to repeat if completed on Page1, over).

Medical Condition of patient

Is patient medicated prior to transporting? ☐ Yes ☐ No	If yes, give type, amount, route and when administered.

Medication – Maintenance Drugs

HEALTH OF PATIENT

Disease	Yes	No	Date(s)	Disease	Yes	No	Date(s)	Disease	Yes	No	Date(s)
Paralysis or Crippled Limbs				Cancer				**Homicidal or Suicidal Tendency**			
Blindness or Eye Trouble				TB or Lung Disease				**Mental Retardation or Dementia**			
Deafness or Ear Trouble				Heart or Hi Blood Pressure				**Syphilis**			
Epilepsy or Seizures				Tremors or Abnormal Movements				**HIV**			
Diabetes				Hepatitis				**Alcohol Abuse**			
Serious Allergies				Head Injury				**Drug Abuse**			
								Types Abused			

Patient's Operations

Name of treatment facility accepting admission	Name of treatment facility physician authorizing admission

ON THE BASIS OF MY PERSONAL EXAMINATION I BELIEVE THAT THE PERSON IS IN NEED OF INVOLUNTARY EMERGENCY PSYCHIATRIC HOSPITALIZATION. FURTHERMORE, THE PERSON HAS NO MEDICAL/SURGICAL CONDITIONS OR DISABILITIES THAT PRESENTLY REQUIRE A GENERAL HOSPITAL OR NURSING HOME LEVEL OF CARE AND IS MEDICALLY STABLE AND PHYSICALLY ABLE TO PARTICIPATE IN PSYCHIATRIC TREATMENT.

I have consulted with the _____ Community Mental Health Center regarding Preadmission Screening. If not, state clinical reason _____

SIGNATURE OF LICENSED PHYSICIAN ,M.D.	S.C. LICENSE NU MBER	NAME OF CENTER
TYPED OR PRINTED NAME ,M.D.	PHONE NUMBER	SIGNATURE OF FACE TO FACE SCREENER AND DATE
ADDRESS		PRINTED NAME OF SCREENER, TITLE AND ID #

All information MUST be typed or clearly printed

Involuntary Commitment Process: Emergency v. Non-Emergency Intervention

- Requirements for *non*-emergency involuntary commitment for mental illness
  - Petition filed in court along with certification by a licensed physician that the person is mentally ill and likely to cause harm to himself.
  - Court finds based on clear and convincing evidence that the person lacks capacity to make their own treatment decisions.
  - Court finds based on clear and convincing evidence that the person is likely to harm themselves or others.
  - S.C. Code Ann. 44-17-510; S.C. Code Ann. 44-17-580.

Involuntary Commitment: What are the risks?

- Allegations that private hospital and its employee submitted false affidavit in support of patient's involuntary commitment and unlawfully detained patient supported claim for false imprisonment under Mississippi law. Bass v. Parkwood Hosp., 180 F3d 234 (5th Cir. 1999)(apply Mississippi law).
- "To prevail on a claim for false imprisonment, the plaintiff must establish: (1) the defendant restrained the plaintiff, (2) the restraint was intentional, and (3) the restraint was unlawful." McBride v. School Dist. of Greenville County, 698 S.E.2d 845 (S.C.App.,2010).

Behavioral Health patient : Incapacitated and in need of a temporary guardian

- Incapacitated person is defined as any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause (except minority) to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person or property. S.C. Code Ann. § 62-5-101(1).

Behavioral Health patient : Incapacitated and in need of a temporary guardian

- Requirements for *temporary*, meaning 6 months or less, appointment of a guardian upon a court making emergency preliminary finding that:
  - a physician's written or oral certification to the court that the person is incapacitated
  - no guardian has been previously appointed and welfare of incapacitated person requires immediate action
  - appointed guardian is not effectively performing his duties or
  - no person appears to have authority to act on behalf of the incapacitated person or more than one person is authorized but cannot agree on whether certain care must be provided and an emergency exists (emergency means that a delay caused by (1) further attempts to locate a person authorized to make health care decisions or (2) proceedings for appointment of a guardian would present a serious threat to the life, health, or bodily integrity of the incapacitated person). S.C. Code Ann. § 62-5-310

Behavioral Health patient : incapacitated and in need of a temporary guardian

- Procedural requirements for appointment of a guardian
  - Court sends a visitor to the incapacitated person's residence to observe and report back to the court
  - Incapacitated person shall be appointed counsel if they have not already retained counsel
  - Court shall appoint two examiners to examine the person and report back to the court
  - S.C. Code Ann. § 62-5-303.

Forced Administration of Medication

- Patients who are subject to involuntary commitment are not always unable to make healthcare decisions.
  - Distinction between involuntary commitment for chemical dependency and for mental illness.
    - Chemical dependency: person is believed to be unable to exercise judgment concerning their emergency care.
- Unless a person is adjudicated to be incompetent and a guardian has been assigned, the person, even though involuntarily committed, must be determined to be “unable to consent” before medication can be administered without their consent.

Forced Administration of Medication

- Adult Health Care Consent Act: Unable to consent means "[u]nable to appreciate the nature and implication of the patient's condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner." S.C. Code Ann. 44-66-20(6).
- Must be certified by two physicians who have examined the patient;
- In an emergency, the certification may be made by a health care professional in writing that the delay in getting certification by two physicians would be detrimental to the patient's health.
- Medication can be administered with the consent of the surrogate decision-maker identified at S.C. Code Ann. 44-66-30.

Forced Administration of Medication

- If there is no surrogate decision-maker, then health care may be provided without consent if, “in the reasonable judgment of the attending physician or other health care professional, the health care is necessary for the relief of suffering or restoration of bodily function or to preserve the life, health, or bodily integrity of the patient.” S.C. Code Ann. 44-66-50.
- The health care provider is not liable for providing, in good faith, health care without consent unless the provision of care is negligent. S.C. Code Ann. 44-66-70 (D).
- Risk: Allegations of malpractice (there is no independent cause of action in SC for medical battery. Linog v. Yampolsky, 656 S.E.2d 355 (S.C. 2008).
- Important: Document, document, document.

Forced Administration of Medication: What are the risks?

- In action by involuntary mental patient against psychiatrist and state psychiatric hospital officials to enjoin them from forcibly administering drugs to him in absence of emergency situation, the court held that patient had constitutional right to refuse treatment. Antipsychotic drugs may be constitutionally administered to an involuntarily committed mentally ill patient whenever, in exercise of professional judgment, such action is deemed necessary to prevent patient from endangering himself or others; once that determination is made, professional judgment must also be exercised in the resulting decision to administer medication. Rennie v. Klein, 720 F.2d 266(3d Cir. 1983).

Use of force with behavioral health patients

- Recall the CoPs: Patient Rights: “All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.” 42 C.F.R. 482.13(e).

Use of force with behavioral health patients

- Any use of force must take the patient's rights into consideration:
  - Only when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member or others from harm.
  - Must be the least restrictive intervention that will be effective to protect the patient, a staff member or others from harm.
  - Must be used in accordance with the patient's care plan.
  - Must be implemented in accordance with safe techniques in accordance with hospital policy by trained staff (includes security).
  - Must be in accordance with a physician's order.
  - Appropriate consultations/face-to-face evaluations.
  - Appropriate monitoring
  - Must be discontinued at the earliest possible time.
  - Document, document, document.

Use of force with behavioral health patients

- When can a hospital escalate the use of force (use of a weapon)?
  - The use of deadly force against anyone on hospital property is almost unthinkable.
  - But, what if a behavioral health patient uses deadly force against a staff member, another patient or other?
  - There are cases where use of deadly force is found to be justified, but those cases are almost exclusively cases of home invasion and situations involving the police.
  - The Protection of Persons and Property Act allows “[a] person who is not engaged in an unlawful activity and who is attacked in another place where he has a right to be, including, but not limited to, his place of business, has no duty to retreat and has the right to stand his ground and meet force with force, including deadly force, if he reasonably believes it is necessary to prevent death or great bodily injury to himself or another person or to prevent the commission of a violent crime as defined in Section 16-1-60.” S.C. Code Ann. 16-11-440(C).

Use of force with behavioral health patients

- South Carolina law relating to permits for concealed weapons, maintains prohibitions on locations where concealed weapons may be carried. An individual may not carry a concealed weapon in hospitals, medical clinics, or other facilities for medical service unless expressly authorized by the "employer." S.C. Code Ann. 23-31-215(m)(10). A violation of this provision is classified as a misdemeanor and, upon conviction, may result in up to one year in prison, a fine of not more than one thousand dollars, and the possibility of the concealed weapons permit being revoked for a period of five years. Id.
- Pros/Cons of having security carrying guns
- Use of Police vs. Security

Telemedicine CoPs

- Various S.C. hospital EDs have been providing behavioral health services via telemedicine.
- On May 5, 2011, CMS issued its final rule on credentialing telemedicine physicians and practitioners to allow for a streamlined process of credentialing, reducing the burden of credentialing and privileging telemedicine providers.
- Background:
  - TJC standards provided for a mechanism whereby a hospital could rely on a distant TJC hospital's credentialing processes to grant telemedicine privileges.
  - Effective July 15, 2010, TJC is no longer specifically referenced under the Medicare/Medicaid "deeming" statute and, because CMS does not approve TJC's standards, hospitals can no longer rely on the TJC's processes.

Telemedicine CoPs

- CMS defines telemedicine in the preamble to the final rule as: “the provision of clinical services to patients by practitioners from a distance via electronic communications.”
- CMS defines telemedicine entity as one that “(1) provides telemedicine services; (2) is not a Medicare-participating hospital (therefore, a non-Medicare participating hospital that provides telemedicine services would be considered a distant-site telemedicine entity also); and (3) provides contracted services in a manner that enables a hospital or CAH using its services to meet all applicable CoPs, particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of a hospital or CAH.”

Telemedicine CoPs

- 42 C.F.R. 482.12: Governing body
  - (a)(8) requires that the governing body ensures that there is an agreement with the distant hospital that the provisions of 42 C.F.R. 482.22(a)(1) – (7) are met for physicians providing telemedicine services.
  - (a)(8) further allows the governing body to, in accordance with 42 C.F.R. 482.22(a)(3), grant privileges based on its medical staff recommendations that rely on information provided by the distant-site hospital.
  - (a)(9) requires that the governing body ensures that there is an agreement with the distant site telemedicine entity that the provisions of 42 C.F.R. 482.22(a)(1) – (7) are met for physicians providing telemedicine services.
  - (a)(9) further allows the governing body to, in accordance with 42 C.F.R. 482.22(a)(4), grant privileges based on its medical staff recommendations that rely on information provided by the distant-site telemedicine entity.

Telemedicine CoPs

- 42 C.F.R. 482.22 Medical Staff:
  - (a)(3) in lieu of traditional credentialing (482.22(a)(1) & (2)), the medical staff may rely on the credentialing and privileging decisions of the distant site hospital when making recommendations on privileges if the hospital's governing body ensures, through its written agreement the following:
    - The distant-site hospital is a Medicare participating hospital
    - The individual distant-site physician or practitioner is privileged at the distant-site hospital and provides a current list of the distant-site physician or practitioner's privileges at the distant-site hospital.
    - The individual distant-site physician or practitioner is licensed in the state in which the hospital whose patients are receiving the telemedicine services is located.
    - As to the individual distant-site physician or practitioner, the hospital has evidence of an internal performance review and the distant-site hospital sends the hospital the review for periodic appraisal (must include adverse events and complaints).

Telemedicine CoPs

- (a)(4) in lieu of traditional credentialing (482.22(a)(1) & (2)), the medical staff may rely on the credentialing and privileging decisions of the distant site telemedicine entity when making recommendations on privileges if the hospital's governing body ensures, through its written agreement:
  - the distant-site telemedicine entity's medical staff credentialing and privileging process and standards at least meet the standards at 482.12(a)(1) – (7) and 482.22(a)(1) – (2).
  - The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity and provides a current list of the distant-site physician or practitioner's privileges at the distant-site telemedicine entity.
  - The individual distant-site physician or practitioner is licensed in the state in which the hospital whose patients are receiving the telemedicine services is located.
  - As to the individual distant-site physician or practitioner, the hospital has evidence of an internal performance review and the distant-site telemedicine entity sends the hospital the review for periodic appraisal (must include adverse events and complaints)

Telemedicine CoPs

- 482.22(c)(6): Requires that the hospital's medical staff bylaws include criteria for determining privileges and a procedure for applying the criteria to individuals requesting privileges.
- Nearly identical provisions are added to 485.616 related to CAHs.
  - One additional provision exists for CAHs: CAH's are required to contract only with "one or more Medicare-participating providers in order to furnish other services to its patients. 485.635(c)(5) provides an exception to this requirement to allow CAHs to contract with non-Medicare participating telemedicine providers.

Telemedicine CoPs: "To Do" List

- Rule allows hospitals to continue to use traditional credentialing processes.
- The Medical Staff Bylaws must be amended to include:
  - criteria for determining telemedicine privileges; and
  - a procedure for applying the criteria to individuals requesting privileges. See 482.22(c)(6).
- Need to develop/enter into agreements with telemedicine providers.

Telemedicine CoPs: Practical questions and open issues

- Distinguishes the “curbside consult” between distant physicians and practitioners . . . But this could create confusion.
- What if the distant-site has significantly different privileges lists than the hospital?
- What if there are significantly different Medical Staff privileging requirements? (e.g., Board Certification requirements; malpractice coverage limits)
- Should you ask for a copy of the distant-site Medical Staff Bylaws?
- Should the hospital agree to provide peer review information to the distant-site hospital/telemedicine provider?
- Consider risk management issues: how would this “play” in light of an allegation of negligent credentialing?

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