Objectives

- Discuss the prevalence of and resources for psychiatric care
- Describe the challenges faced by community hospitals when caring for psychiatric patients
- Explore strategies to mitigate risks associated with the care of psychiatric patients in community hospitals

History of the Problem

- 14% decrease in state psychiatric beds nationwide from 2005-2010
- Per capita state bed population is now at 1850 levels: 14 per 100,000 population
- 4,471 beds have been eliminated since 2010

History of the Problem

- Psychiatric boarding is inversely correlated to the number of psychiatric beds in each state
- Montana ranks 45th among all states for access to beds in 2016

Source: Mental Health America. 10/08/16

Prevalence of Mental Illness in Montana

- The Montana HELP Act (January 2016) expanded Medicaid to adults and brought an increase in the number receiving care for behavioral health.
  - 2013- 4,593 (+ 18 yr.)
    8,480 (0 -17 yr.)
  - 2016- 11,026 (+ 18 yr.)
    10,540 (0 -17 yr.)


Psychiatric Boarding

Definitions:
“The time spent waiting in a hospital emergency department for an inpatient hospital bed or transfer to another inpatient facility by patients with primary psychiatric conditions.”

**Psychiatric Boarding**

Definitions:
"The practice of detaining psychiatric patients, even though the hospital cannot treat them."

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**The cost of crisis**

- Sending individuals in a behavioral health crisis to jail, the emergency department or the hospital are high cost options and are often inappropriate or ineffective forms of response
- **Estimated costs**
  - Community-based services: $12 / day
  - Jail bed: $137 / day
  - Emergency room: $986 / day

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**Best practice models**

- **Alaska**
  - Behavioral health aids
    - Case management
    - Routine care and support
    - Medication adherence
    - Crisis intervention
  - Health hubs
    - Telehealth to remote areas
    - Support for aids and paraprofessionals by professionals in larger communities
Appropriate Treatment

- What constitutes “appropriate treatment”?  
  - Psychiatric evaluation  
  - Medication management  
  - Suicide risk assessment  
  - Monitoring plan  
  - Comprehensive discharge planning

Audience Poll

- What is the longest time psychiatric patients have boarded in your emergency department?  
  1. Less than 8 hours  
  2. 8 hours to 24 hours  
  3. 24-48 hours  
  4. More than 2 days

Discussion

- What are the biggest challenges you face in meeting the requirements of the law?
**Consistent Issues**
- Lack of standardized care relative to mental health patients
- Lack of resources during peak times
- Concerns related to maintaining a safe environment
- Lack of space tailored to the needs of this population
- Discharge planning issues
- Staff frustration and concerns about their safety
- Patient’s concerns about how they are treated

**Common Challenges**
- ED overcrowding
- Behavior escalation
- Symptom deterioration

**Common Challenges**
- Patient safety issues
- Employee safety issues
- Environmental issues
ED Overcrowding and Behavior Escalation

- Overcrowding
- Perception of Chaos
- Behavior Escalation

Symptom Deterioration

- Environmental overstimulation
- Lack of supervision
- Lack of diversionary activity
- Hunger or thirst
- Nicotine withdrawal
- Medication issues
- Suicidal thoughts

Employee Safety

- More than 70 percent of emergency nurses reported physical or verbal assault by emergency patients or visitors (2013).
Employee Safety

• Most of the violence occurred at night between 11pm and 7am.


Employee Safety

• More than 75 percent of emergency physicians experienced at least one violent workplace incident in a year.


Risk Mitigation Strategies

- Environmental
- Interventional
- Educational
Environmental Strategies

- Security
- Specialized units
- "Safe" rooms
- Cameras
- Panic buttons
- Multiple Exits
- Shelter-in-place areas

Security

- Emergency department access should be controlled
- All doors except main entrance should be badge-access or keypad access
- 24-hour on site security officer
- Direct line to local police

Specialized Units

- A separate area for behavioral health patients
- Designed for safety:
  - Minimize anchor points
    - Secure doors
    - Camera or direct monitoring area
    - Heavy or secure furniture
    - No objects that could be used for self-harm or to harm others
- Psychiatrically trained staff
- Soothing colors and lighting
Safe Rooms

- Designed to be safe for patients with suicidal ideation
- 1:1 is best option for acutely suicidal patients

Cameras

- False sense of security
- Must be monitored
- Can be an anchor point
- Inform patients

Panic Buttons

- Worn by staff members
- Strategically placed
- Computer-generated
Multiple Exits/Shelter-in-Place Areas

• Ideally, staff areas and patient rooms should have two exits
• Identify shelter-in-place areas such as copy/mail rooms with large equipment

Interventional Strategies

• Medical screening exam
• Suicide risk assessment
• Medication reconciliation
• Nicotine replacement
• Behavior de-escalation
• Diversionary activity

Medical Screening Exam

• Psychiatric history
• Medical history
• Substance abuse history
• R/O medical condition
### Suicide Risk Assessment

Joint Commission Sentinel Event Alert Issue 56:
- Review each patient’s personal and family medical history for suicide risk factors
  - Depression/bipolar disorder
  - Previous attempts or self-injury
  - History of trauma or loss
  - Bereavement


<table>
<thead>
<tr>
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### Suicide Risk Assessment

Joint Commission Sentinel Event Alert Issue 56:
- Review each patient’s personal and family medical history for suicide risk factors
  - Serious illness
  - Alcohol or drug abuse
  - Social isolation
  - History of aggression


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### Suicide Risk Assessment

Joint Commission Sentinel Event Alert Issue 56:
- Review each patient’s personal and family medical history for suicide risk factors
  - Recent discharge from psychiatric facility
  - Access to lethal means along with suicidal thoughts


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Suicide Risk Assessment

Joint Commission Sentinel Event Alert Issue 56:
• Screen all patients for suicidal ideation using an evidence-based tool
  - Patient Health Questionnaire (PHQ-9)
  - ED-SAFE Patient Safety Screener
  - Suicide Behaviors Questionnaire-Revised (SBQ-R)


Suicide Risk Assessment

Joint Commission Sentinel Event Alert Issue 56:
• Review screening questionnaires before the patient is discharged. If positive screen:
  - Obtain permission to contact friends, family or providers for corroborating information
  - HIPAA allows without permission if patient is a danger to self or others


Suicide Risk Assessment

Joint Commission Sentinel Event Alert Issue 56:
• Use assessment results to implement safety measures:
  - Implement 1:1 monitoring for high-risk patients
  - Make personal and direct referrals for lower-risk patients within 1 week of discharge

Suicide Risk Assessment

Joint Commission Sentinel Event Alert Issue 56:
• For all patients with suicidal ideation:
  o National Suicide Prevention Lifeline-1-800-273-TALK (8255)
  o Safety planning with possible coping strategies
  o Restrict access to lethal means


Medication Reconciliation

• Complete history of current prescription and non-prescription drugs
• Laboratory drug screening, if indicated
• Continue current psychiatric medications

Nicotine Replacement

• Ask about nicotine use
• Offer nicotine replacement for moderate to very dependent users
• Fagerstrom Test for Nicotine Dependence on Cigarettes
  http://www.nova.edu/gsc/nicotine_risk.html
Diversionary Activity

- Food/fluids
- Cards
- Soft music
- Magazines/books

Behavior De-escalation

- Train all ED staff members in de-escalation techniques
- Least-restrictive alternatives
- Practice frequently
- Pay attention to body language

Plan for Behavioral Emergencies

- Train and drill personnel
- Provide a secure environment:
  - 24-hour security
  - Closed-circuit cameras
  - Panic buttons (personal or multiple location)
  - Direct phone lines to local police
  - Control access and egress
Community Alliances

- Know your community resources
- Work to streamline transitions to other care settings
- Make appointments for patients

Empathy and Compassionate Care

- Examine personal biases
- Consider employing mental health professionals
- Survey patients
- Ask previous patients to serve on PI committees or focus groups

Thinking outside the box...

- Population management
  - Behavioral health coaches
  - Nurse navigators
Recommendations from the AHA

- Ensure community needs assessments include specific attention to behavior health illnesses.
- Review and evaluate your plan in light of community needs and available resources.
- Use a comprehensive financial and operational assessment to evaluate the benefits and value of behavioral health services to all operational components of the hospital.
- Develop a formal behavioral health plan that clearly defines the hospital role and relationship with other providers and community agencies.

Recommendation from the AHA

- Encourage and participate in developing a community-wide plan for people with behavioral health disorders and coordinate community agencies.
- Clearly communicate to public and private payers the costs required to care for behavioral health patients and the cost to society of not treating those patients.
Preliminaries

This presentation is similar to any other legal education materials designed to provide general information on pertinent legal topics. The statements made as part of the presentation are provided for educational purposes only. They do not constitute legal advice nor do they necessarily reflect the views of Holland & Hart LLP or any of its attorneys other than the speaker. This presentation is not intended to create an attorney-client relationship between you and Holland & Hart LLP. If you have specific questions as to the application of law to your activities, you should seek the advice of your legal counsel.

Written Materials

- Powerpoint presentation
- Stanger, Avoiding EMTALA Penalties
- CMS, EMTALA Interpretive Guidelines
- Montana Emergency Detention Statute, MCA 53-21-102 and 53-21-129
- CMS Restraint/Seclusion Regulation, 42 CFR 482.13(e)
- Stanger, Sample Telemedicine Credentialing Agreement
- OSHA, Preventing Workplace Violence: A Road Map for Healthcare Facilities
Limitations

- Addressing issues that commonly arise in ED in acute care hospitals.
- Additional rules or requirements exist for hospitals or other facilities licensed specifically to provide mental health care.
- Application depends on specific facts and circumstances.
  - Check the law or with your attorney when applying.

Most Important Rule

When in doubt...

- Do what you must to keep staff and patients safe.
- Document the circumstances, e.g., what you did and why.
  - You’ll probably be okay if you do this.
  - We’d rather defend against a regulatory violation or disruptive patient case than face serious injury to staff or others.

Overview

- Obligation to Provide Behavioral Health Services
- EMTALA
- Consent
- Detaining Patients
- Restraint and Seclusion
- Telehealth
- Privacy and Security
- Workplace Violence
Obligation to Provide Behavioral Health Services

- **Malpractice**
  - If they are your patient, you must comply with the applicable standard of care.

- **Licensure/Conditions of Participation**
  - Montana incorporates the CMS Conditions of Participation. (MAR 37.106.704)
  - Hospital and CAH providing emergency services “must meet the emergency needs of patients in accordance with acceptable standards of practice.” (42 CFR 482.55; MAR 37.106.704(4); see also 42 CFR 485.638)
  - Additional requirements apply if licensed for psychiatric services. (See MAR 37.106.430)

- **Joint Commission or other accreditation agencies**
  - Assess patients with emotional and behavioral disorders.

- **Emergency Treatment and Active Labor Act (“EMTALA”)**

Emergency Medical Treatment and Active Labor Act (“EMTALA”)

EMTALA Penalties

- **Civil penalties**
  - Physicians: $50,000 per violation.
  - Hospitals:
    - Less than 100 beds: $25,000 per violation
    - 100+ beds: $50,000 per violation

- **Hospitals may be sued for damages.**
  - Individuals who suffer personal harm.
  - Medical facilities that suffer financial loss.

- **Termination of Medicare provider agreement and exclusion from Medicare and Medicaid.** (42 USC 1395ddd(e); 42 CFR 1003.103(e))
EMTALA: Basic Responsibilities

- Participating hospital with a dedicated emergency dept must provide:
  - Emergency medical screening exam,
  - Stabilizing treatment for emergency conditions, and/or
  - Appropriate transfer of unstabilized person.

- Participating hospital with specialized capabilities must accept transfer of unstabilized person.
  - Unless on diversionary status.

- Cannot delay exam or treatment to inquire about payment.

(42 USC 1395dd; 42 CFR 489.20(r) and 489.24)

Diverting Patient

- Not in ambulance: hospital generally has no EMTALA duties until the patient comes to the hospital.
  - May direct off-campus patient to go elsewhere.
  - Exception: hospital with specialized capabilities receiving transfer.

- In ambulance: hospital may not divert inbound ambulance unless it is on diversionary status. Arrington v. Wong (9th Cir. 2001)
  - Document diversionary status, e.g., lack of beds, staff, equipment, and supplies.
  - May discuss or recommend treatment elsewhere, but do not divert unless on diversionary status.

(42 CFR 489.24(a))
Screening Exam

- If patient comes to hospital, hospital must perform screening exam within its capability.
  - By qualified medical personnel identified in document approved by governing body, e.g.,
    - Trained physicians, midlevels, nurses, or psychologists
    - On-call medical staff
    - Telehealth
  - Sufficient to rule out emergency medical condition.
    - May use local behavioral health provider. Baker v. Adventist HealthCare (9th Cir. 2001)
- If lack capability, may need to transfer patient to complete exam.

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))
- Individual expressing suicidal or homicidal thoughts or gestures or determined to be dangerous to self or others.
  (Interpretive Guidelines 489.24(d))

Stabilizing Treatment

- If medical screening exam reveals an emergency medical condition, hospital must provide either:
  - Stabilizing treatment within its capabilities, i.e.,
    - Care necessary to assure, within reasonable medical probability, that no material deterioration of condition is likely to result from or occur during transfer from facility,
    - For pregnant woman, delivery of child and placenta, or
    - For psych patients, protect patient from harming self or others.
  - An appropriate transfer to another facility.
- EMTALA ends once patient is stabilized or admitted.
  (42 CFR 489.24(d); Interpretive Guidelines)
Stable: General

- **Stable for Transfer**
  - No material deterioration of condition is likely, within a reasonable medical probability, to result from transfer. (42 CFR 489.24(b))
  - Emergency medical condition has resolved, even though underlying medical condition may persist. (Interpretive Guidelines 489.24(d))

- **Stable for Discharge**
  - Within reasonable clinical confidence, patient has reached a point where their continued care (including diagnostics or treatment) could be reasonably performed as an outpatient or later as an inpatient provided the patient is given a plan for appropriate follow-up care as part of discharge instructions. (Interpretive Guidelines 489.24(d))

Stable: Psychiatric Patients

- “Psychiatric patients are considered stable when they are protected and prevented from injuring or harming him/herself or others.”
- But be careful! “The administration of chemical or physical restraints for purposes of transferring an individual from one facility to another may stabilize a psychiatric patient for a period of time and remove the immediate EMC but the underlying medical condition may persist and if not treated for longevity the patient may experience exacerbation of the EMC. Therefore, practitioners should use great care when determining if the medical condition is in fact stable after administering chemical or physical restraints.” (Interpretive Guidelines 489.24(d))

Appropriate Transfer

- If patient is not stabilized, hospital may not transfer or discharge patient unless:
  - Either one of the following—
    - Patient or representative requests transfer, or
    - Physician certifies that benefits outweigh risks; and
  - Transfer is “appropriate” under regulations.
- Transfer = Movement outside hospital at direction of hospital personnel, including discharge.
  - Not if person leaves the hospital without permission.
  - Not movement within or between the same hospital.

(42 CFR 489.24(b), (d)(i); Interpretive Guidelines 489.24(a))
**Appropriate Transfer**

Transfers of unstable patients must be “appropriate”, i.e.,

- Transferring hospital provides treatment within its capability to minimize risk of harm to patient.
- Transferring hospital contacts receiving facility and facility agrees to accept the transfer.
  - Identify person with authority to accept for receiving facility.
- Transferring hospital sends:
  - Relevant records available at the time.
  - Name on-call physician who failed to respond, if any.
  - Additional records as soon as practicable.
- Transfer effected through qualified personnel with proper equipment, including life support measures.

(42 CFR 489.24(e)(2))

**Appropriate Transfers: Montana Law**

In cases where EMTALA does not apply, a hospital may not transfer a patient to another hospital using only a call to a 9-1-1 service. The hospital shall:

- Before the transfer, provide notice to the other hospital, including the reason for the transfer; and
- During the transfer, provide the medical records related to the patient’s current hospitalization.

(MCA 50-5-122)

**Appropriate Transfer**

- EMTALA allows transfer to another “medical facility.” (See 42 CFR 489.24(e))
- EMTALA does not necessarily require transfer to another hospital.
  - May be able to transfer to another behavioral health entity, e.g., crisis center, behavioral health center, etc.
  - Non-hospital is not required by EMTALA to accept the transfer.
  - Check with local CMS Region and state surveying agency.
Appropriate Transfer

- Hospital is not required to maintain EMS to transfer patients.
- Beware sending patient by private car.
  - Document that method of transport is appropriate, or that you offered appropriate transportation.
  - Ensure patient is accompanied by appropriate family member, friend or other.
  - Give appropriate instructions, e.g., go directly to other facility.
  - Document patient’s refusal to accept ambulance transport.

Recipient Hospital Responsibilities

- Participating hospital with “specialized capabilities” must accept transfer if it has capacity, e.g.,
  - Specialized equipment or personnel (e.g., mental health).
  - Special circumstances at transferring facility (“serious capacity problem”, 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))

Recipient Hospital Responsibilities

- “[I]f an individual is found to have an emergency medical condition that requires specialized psychiatric capabilities, a psychiatric hospital that participates in Medicare and has capacity is obligated to accept an appropriate transfer of that individual. It does not matter if the psychiatric hospital does not have a dedicated emergency department.”
Reporting Improper Transfers

- No obligation to self-report violations.
- Receiving hospital must report to CMS or state surveyors if it has reason to believe that it has received improper transfer of patient.
  - Other hospital “dumped” the patient.
  - Other hospital refused care.
  - Other hospital sent unstabilized patient without an appropriate transfer.
  (42 CFR 489.20(m))
- Liable for EMTALA penalties if fail to timely report.
- CMS Interpretive Guidelines require report within 72 hours.
  (Interpretive Guideline 489.20(m))
- Investigate facts before reporting!

Document, Document, Document

If it’s not in the chart, it didn’t happen.

- Appropriate exam.
- No emergency condition.
- Stable condition.
- Patient refused care or requested transfer.
- Certification that benefits of transfer > risks
- Appropriate transfer
- Patient refused care or left AMA

Patients Who Refuse
Exam, Treatment or Transfer

- Hospital must—
  - Offer exam, treatment or transfer.
  - Document the exam, treatment or transfer that was refused.
  - Document that risks and benefits were explained to patient.
  - Document basis for refusal of transfer.
  - Take reasonable steps to secure written informed refusal.
  - If patient refuses to sign, document refusal.
  (42 CFR 489.24(d)(3), (5))
Emergency Department Log

- Hospital must maintain central log on each individual who comes to DED seeking assistance, including:
  - Whether patient refused treatment.
  - Whether patient was refused treatment.
  - Whether patient was treated, stabilized, admitted, transferred or discharged.
- Hospital has flexibility in manner in which it maintains log.
- Central log may include records from other areas, e.g., pediatrics, labor & delivery, etc.

(42 CFR 489.20(r)(3); Interpretive Guidelines 489.20(r)(3))

Consent or Refusal of Consent

- Competent patient has right to consent to or refuse care. (See Montana Constitution Art. 2, Sect. 3 and 10; Armstrong v. State, 989 P.2d 364 [Mt. 1999])
- If patient is incompetent or refuses care, provider must ensure he/she has authority to detain or treat patient.
  - Advance directive from patient.
  - Consent from authorized personal representative consistent with statutory limits. (See MCA 50-9-106(2))
  - Emergency treatment for incompetent patient while seeking authority from personal rep. (See IMT & A Interpretive Guidelines; MCA 41-1-405)
  - Emergency detention pending commitment evaluation. (MCA 53-12-129)
  - Other?

Consent to or Refusal of Care
Competency

• “In order to give informed consent, the individual must have sufficient understanding to make a rational decision concerning treatment. Competence is presumed unless evidence to the contrary becomes obvious or known. Lack of competence to consent may be temporary or permanent. Reasons for lack of competence to consent include unconsciousness, mental illness or deficiency, or the influence of drugs, including medications or alcohol.” (MHA Healthcare Consent Manual (2010); see also MCA 72-5-101)

Detaining Patient

• A peace officer may take person into custody for evaluation by a “professional person” if an “emergency situation” exists, i.e.,
  – A person is in imminent danger of death or bodily harm by a person who appears to be suffering from mental disorder, or
  – The person who appears to be suffering from mental disorder is substantially unable to provide for his/her own basic needs.

• “Mental disorder” =
  – Organic, mental or emotional impairment that has substantial adverse effects on cognitive or volitional functions.
  – NOT drugs, alcohol, intellectual disability, or epilepsy.
  (MCA 53-21-102, 53-21-129(1))
  • A third party may request that the peace officer initiate the process. (In re G.J.P., 880 P.2d 1311 (1994)).

• “Professional person” evaluates the person, i.e.,
  – Medical doctor
  – Advanced practice nurse
  – Licensed psychologist, or
  – RN with clinical specialty in psychiatric mental health nursing.

• If professional person determines no emergency exists, person is released.
• If professional person agrees that the person is a danger to self or others, the person may be detained and treated until next business day.
• By the next business day, the professional person must either:
  – Release the person; or
  – File findings with county attorney triggering commitment proceedings.

• The professional person must file report with county attorney.
Detaining Patient

- County attorney makes arrangements for detention of person in a mental health facility.
- If facility does not have room at present, patient may be transferred to the state hospital or a behavioral health inpatient facility.
  - Professional person certifies the local facility does not have room.
- If professional person determines that behavioral health inpatient facility is the appropriate facility and a bed is available, the county attorney shall direct the person to the appropriate facility. (MCA 53-21-129)
- Be sure to comply with EMTALA.

Restraint and Seclusion

- COPs: “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.”
  - Restraint = manual method or device to
    - Manual method or device that reduces movement, or
    - Drug when used to manage behavior or restrict freedom, and is not standard treatment or dosage for condition.
  - Seclusion = involuntary confinement (42 CFR 482.13(e))
- For patients committed to a mental health facility, see also MCA 53-21-146.
Restraint and Seclusion

- Check and follow your policies, e.g.,
  - Per appropriate order.
  - By physician or licensed practitioner.
  - No standing or PRN order.
  - Renewed on short term basis as required in regulations.
- Least restrictive possible.
- Discontinued at earliest possible time.
- Monitored by physician, practitioner or trained staff.
- If used to manage violent or self-destructive behavior, face-to-face encounter within 1 hour by physician, licensed practitioner, or trained RN.
- Staff properly trained.
(42 CFR 482.13(e)-(f))
- Check accreditation requirements.

Telehealth

- Some facilities are offering behavioral health services through telemedicine.
  - e.g., InSight Telepsychiatry
- Consider associated legal issues:
  - Licensure
  - Credentialing
  - Laws governing telemedicine
    - Establishing practitioner-patient relationship
    - Remote prescribing
  - Informed consent
  - Standard of care
  - Patient abandonment
  - Liability insurance coverage
  - HIPAA security

HB 389 (2017) would have established telemedicine practice standards, but it did not pass.
Licensure

Hospital COPs

- “In all cases, healthcare professional must be legally authorized to practice in the state where the hospital is located.”
- “When telemedicine is used and the practitioner and patient are located in different states, the practitioner providing the patient care service must be licensed and/or meet the other applicable standards that are required by the state or local laws in both the state where the practitioner is located and the state where the patient is located.”

(Interpretive Guidelines for 42 CFR 482.11, .12 and .22)

Credentialing: Telemedicine

- COPs allow credentialing by proxy for telemedicine providers, i.e., originating site hospital may accept credentialing done by distant site if meet certain standards.
- Must have agreement between hospital/CAH and either a
  - Distant-site hospital that participates in Medicare; or
  - Distant-site telemedicine entity that provides services in manner that allows hospital/CAH to meet all COPs.
- Must satisfy certain requirements.
- Must be permitted by bylaws.

(42 CFR 482.12 and 485.616; 76 FR 25550 (5/5/11); CMS Transmittal 78 (12/22/11))

Credentialing: Telemedicine

- COPs only allow credentialing by proxy for telemedicine privileges.
- If practitioner provides non-telemedicine services, hospital must credential practitioner in traditional manner.
- For telemedicine services, hospital/CAH’s governing board has the option to:
  - allow medical staff to rely on credentialing done by distant hospital or entity under COPs, or
  - require med staff to credential each telemedicine provider.
Credentialing: Emergency Privileges

- Many state laws, regulations and/or bylaws allow facilities to grant temporary or emergency privileges.
  - Granted in limited circumstances, e.g.,
    - While normal credentialing process occurs.
    - Unique patient care need.
  - Subject to limited, preliminary review.
  - Privileges limited to no more than 60 days.
- Unclear how this would coordinate with telemedicine COPs.

Privacy and Security

HIPAA Privacy

- May not use or disclose protected health information ("PHI") without the patient’s authorization unless fit within a regulatory exception, e.g.,
  - For purposes of treatment, payment or healthcare operations. (45 CFR 164.506)
  - To prevent or lessen a serious and imminent threat to the health or safety of the person or public. (45 CFR 164.512(d))
  - To report a crime that occurred on the premises. (45 CFR 164.512(a)(3))
  - To law enforcement official having lawful custody of an individual if law enforcement represents the PHI is necessary for, e.g., health or safety of the individual or officers. (45 CFR 164.512(a)(5))
  - Another law requires the use or disclosure, e.g., report certain types of injuries. (45 CFR 164.512(a))
Montana Privacy Rules

- Places certain additional restrictions on providers who are subject to HIPAA. (MCA 50-16-801 et seq.)
  - Montana law is more restrictive than HIPAA.
- A provider may disclose health care info about an individual "for law enforcement purposes" if the disclosure is to:
  - law enforcement about the general physical condition of a patient being treated in a health care facility if the patient was injured by the possible criminal act of another; or
  - law enforcement authorities to the extent required by law, e.g.,
    - Treatment of injury from gunshot or stabbing
    - Child or adult abuse or neglect
  (MCA 60-16-805)
- Limited to disclosures "for law enforcement purposes."

Montana Privacy Rules

- In 2015, a bill was introduced in Montana to amend MCA to allow disclosures to law enforcement if allowed by HIPAA, but apparently the bill failed. (See 64th Legislature, SB0009)
- MCA continues to be more restrictive than HIPAA.
- But still likely can disclose per HIPAA those items not covered by MCA 50-16-805:
  - For purposes of treatment, payment or healthcare operations. (45 CFR 164.506)
  - To prevent or lessen a serious and imminent threat to the health or safety of the person or public. (45 CFR 164.512(j))
  e.g., to initiate an emergency detainment per MCA 53-21-129 or restrain combative patient.

HIPAA Security

- Must implement specified physical, technical, and administrative safeguards for e-PHI, including:
  - Transmission security. Implement technical security measures to guard against unauthorized access to [e-PHI] that is being transmitted over an electronic communications network.
  - Integrity controls (Addressable). Implement security measures to ensure that electronically transmitted [e-PHI] is not improperly modified.
  - Encryption (Addressable). Implement a mechanism to encrypt [e-PHI] info whenever deemed appropriate.
  (45 CFR 164.312)
- May apply to telehealth issues.
**HIPAA Business Associates**

- Other treatment providers are not business associates while providing treatment. (45 CFR 160.103)
- May need business associate agreement with vendors or other outsiders who assist with telemedicine, including:
  - Entity that transmits PHI and has regular access to PHI, not "conduit".
  - Entity that stores PHI.
- Exceptions:
  - Members of workforce.
  - You have control over person while onsite.
  - Members of organized health care arrangement ("OHCA")
    - Integrated delivery of patient care.

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**Workplace Violence**

- **Employees**
  - Workers comp likely covers claims by employees.
  - Hard to keep good employees in unsafe environment.
- **Non-employees**
  - May have cause of action for failing to maintain safe environment.
- **OSHA**
  - Employers must provide a workplace free from recognized hazards that are likely causing or likely to cause death or serious physical harm. (OSHA § 5(a)(1))
$12,000 fine + abatement action

www.osha.gov/dsg/hospitals/workplace_violence.html

www.osha.gov/dsg/hospitals/workplace_violence.html

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Do what you must to keep staff and patients safe.
Document the circumstances, e.g., what you did and why.
You’ll probably be okay if you do this.
We’d rather defend against a regulatory violation or disruptive patient case than face serious injury to staff or others.

Remember…

Questions

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