U.S. COMMISSION ON CIVIL RIGHTS

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COMMISSION BRIEFING

PATIENT DUMPING

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FRIDAY, MARCH 14, 2014

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The Commission convened in Suite 1150 at 1331 Pennsylvania Avenue, Northwest, Washington, D.C. at 9:30 a.m., Martin R. Castro, Chairman, presiding.

PRESENT:

MARTIN R. CASTRO, Chairman

ROBERTA ACHTENBERG, Commissioner

GAIL HERIOT, Commissioner

PETER N. KIRSANOW, Commissioner*

DAVID KLADNEY, Commissioner

MICHAEL YAKI, Commissioner*

MARLENE SALLO, Staff Director

** Present via telephone*

STAFF PRESENT:

BARBARA de LA VIEZ, Deputy Director, ERO

LILLIAN DUNLAP

PAMELA DUNSTON, Chief, ASCD

YASMIN ELHADY

NICHOLAS GINSBERG

JENNIFER HEPLER, Parliamentarian

MYRNA HERNANDEZ

EILEEN RUDERT

JACOB SIMS

ROREY SMITH, General Counsel, OGC

MICHELE YORKMAN, Director, IT

COMMISSIONER ASSISTANTS PRESENT:

ALEC DEULL

KENESHIA GRANT

CARISSA MULDER

JUANA SILVERIO

ALISON SOMIN

KIMBERLY TOLHURST

PANELISTS:

- MARILYN DAHL, HHS CMS
- RICHARD ELLIOTT, Mercer University School of Medicine & School of Law
- GINA GREENWOOD, Baker Donelson
- EILEEN HANRAHAN, HHS OCR
- BRENT MYERS, University of North Carolina School of Medicine
- STACI PRATT, ACLU
- SUSAN PRESTON, Goodell, Devries, Leech & Dann, LLP
- SANDRA SANDS, HHS OIG
- KATHARINE VAN TASSEL, University of Akron School of Law
- HERNÁN VERA, Public Counsel

A G E N D A

I. INTRODUCTORY REMARKS..........................5

II. PANEL I - Government Panel...................8
- Marilyn Dahl - HHS CMS
- Sandra Sands - HHS OIG
- Eileen Hanrahan - HHS OCR

III. PANEL II - Advocate/Practitioner Panel......55
- Susan Preston - Goodell, DeVries, Leech & Dann, LLP
- Staci Pratt - ACLU
- Gina Greenwood - Baker Donelson
- Hernán Vera - Public Counsel

IV. PANEL III - Scholar Panel..................118
- Katharine Van Tassel - University of Akron School of Law
- Richard Elliott - Mercer University School of Medicine & School of Law
- Brent Myers - University of North Carolina School of Medicine

V. ADJOURN BRIEFING 161

P R O C E E D I N G S

(9:30 a.m.)

CHAIRMAN CASTRO: Okay, it is 9:30. This meeting will come to order.

I'm Chairman Marty Castro of the U.S. Commission on Civil Rights. I want to welcome everyone this morning to our briefing on the topic of Patient Dumping.

I. INTRODUCTORY REMARKS

CHAIRMAN CASTRO: The topic of Patient Dumping is one that a lot of Americans may not know about. It's a health care issue that has come to our attention that we feel is important for the Commission to take a look at, and ultimately to prepare a report to the President and Congress on our findings and recommendations as it relates to the issue of Patient Dumping.

I personally believe that health care is a civil right. What we see here, as we'll hear from our panelists, and as those of us who had the benefit of reviewing the materials in advance, have seen that Patient Dumping is essentially the economic discharge, early discharge of patients in various categories. Today we're going to focus primarily on the mentally disabled, but we've seen, as well, homeless individuals

1 who are being discharged prematurely from hospitals.
2 We see the impact on minority communities, especially
3 the undocumented, and we also see that folks who are
4 uninsured may be victims of this condition we call
5 Patient Dumping.
6 Today we have a number of experts in this
7 area that will help educate and inform this Commission
8 on those issues so that we can better understand the
9 impact of this topic on Americans, and be able to better
10 inform the President and Congress.
11 In particular, we're going to look at how
12 the Emergency Medical Treatment and Active Labor Act,
13 EMTALA, a federal law, is implicated here, and whether
14 or not it's sufficiently functioning to protect
15 individuals that are being victims of the issue of
16 Patient Dumping.
17 In order to learn about this we have with
18 us this morning and throughout the briefing 10
19 distinguished speakers. They're going to provide us
20 with a diverse array of viewpoints on this topic.
21 Speakers have been divided between three panels. Panel
22 I will consist of our government officials, Panel II
23 will consist of advocacy and industry practitioners,
24 and Panel III will conclude with a scholarly overview
25 from scholars who will give their perspectives on this

1 topic.
2 During each briefing each panelist will
3 have seven minutes to speak. After the panelists have
4 made their presentation Commissioners will then have
5 the opportunity to ask you questions. We'll also have
6 an allotted period of time, and I will recognize
7 Commissioners when they have the opportunity to speak.
8 I will, as always, endeavor to be fair in passing out
9 the opportunity to ask questions. But in order to
10 maximize the time between Commissioners and panelists
11 in their ability to question and answer, we are going
12 to ask everyone to make sure you use your fair share
13 of time. I'm going to strictly enforce the time. You're
14 going to see there's a system of lights here, kind of
15 like traffic lights. When the light is green, it means
16 you go; yellow start wrapping up; red I'm going to stop
17 you. And hopefully I won't have to stop folks, and I'll
18 try to be compassionate and not cut you off in mid
19 sentence, but if you do see that light come on just try
20 to wrap it up as quickly as you can. Again, I'm going
21 to ask my fellow Commissioners to also be very
22 considerate in the length and focus of their questions
23 to be concise. I know at times questions do require
24 follow-ups, and I'll do the best I can to allow my
25 colleagues to do a follow-up, but I'd like them to focus

1 with one question at a time so we have the opportunity
2 to maximize our interaction with you. So, with those
3 brief housekeeping issues out of the way, I'd like to
4 introduce our first panel.
5 Our first panelist this morning is Marilyn
6 Dahl, Director of the Division of Acute Care Services
7 within the Survey and Certification Group at the
8 Centers for Medicare and Medicaid Services. Our second
9 panelist is Eileen Hanrahan, Supervisory Civil Rights
10 Analyst in the Office of Civil Rights, the U.S.
11 Department of Health and Human Services. And our third
12 panelist is Sandra Sands, Chief of Counsel in the Office
13 of the Inspector General of the U.S. Department of
14 Health and Human Services.
15 I'll ask you to each raise your right hand
16 and now swear or affirm that the information that you
17 are about to provide to us is true and accurate to the
18 best of your knowledge and belief. Is that correct? It
19 is? Great, thank you.
20 (Witnesses sworn.)
21 **II. PANEL 1 - GOVERNMENT PANEL**
22 CHAIRMAN CASTRO: Ms. Dahl, please proceed.
23 You've got seven minutes.
24 MS. DAHL: Thank you.
25 CHAIRMAN CASTRO: You're welcome.

1 MS. DAHL: The Survey and Certification
2 Group is charged with enforcing the compliance of
3 Medicare participating providers and institutional
4 suppliers of health care services with Medicare
5 Conditions of Participation or Coverage. And in the
6 case of hospitals and critical access hospitals, they
7 also assess compliance with the Emergency Medical
8 Treatment and Labor Act, commonly referred to as
9 EMTALA.
10 My prepared statement runs much longer
11 than the time that you've allotted so I'll abridge my
12 presentation now, but you have the whole statement for
13 your record.
14 Section 1867 of the Social Security Act
15 establishes certain requirements for Medicare
16 participating hospitals. There are also some
17 provisions of Section 1866 of the Act governing the
18 Provider Agreement between Medicare and a provider
19 which also are related to EMTALA and its enforcement.
20 Enforcement mechanisms pertain to
21 enforcement actions that CMS may take with respect to
22 the hospital's Medicare Provider Agreement, as well as
23 actions the U.S. Department of Health and Human
24 Services Office of Inspector General may take with
25 respect to hospitals and physicians.

1 Section 1867 of the Act also provides for
2 a private right of action by individuals and medical
3 facilities, but CMS has no role in these civil
4 litigations.
5 I'd like to talk briefly about hospital
6 obligations under EMTALA. Depending on their
7 characteristics, hospitals may be subject to either or
8 both of two different types of EMTALA obligations. The
9 first is obligations of hospitals with an emergency
10 department toward individuals who come to the emergency
11 department. And the second is obligations of hospitals
12 with specialized capabilities to accept transfers.
13 If an individual comes to the emergency
14 department, the hospital is required to conduct an
15 appropriate medical screening examination within the
16 capabilities of that hospital to determine if the
17 individual has an emergency medical condition. If the
18 individual is found to have an emergency medical
19 condition, the hospital must provide further
20 examination and treatment within its capabilities and
21 capacity to stabilize the emergency medical condition,
22 or the hospital must transfer the individual to another
23 facility if it lacks the capability to stabilize.
24 Hospitals are not permitted to delay screening or
25 stabilizing treatment in order to inquire about an

1 individual's method of payment or insurance status.
2 Hospitals are required to provide screening and
3 stabilizing treatment regardless of an individual's
4 ability to pay.
5 The statutory definition of an emergency
6 medical condition contains provisions focusing on
7 pregnant women in labor, as well as provisions for all
8 other cases. For the latter, it's a condition that is
9 manifested by acute, severe symptoms including severe
10 pain that lead to a reasonable expectation that absence
11 of immediate medical care would result in serious
12 jeopardy to the individual's health, serious
13 impairment of one or more bodily functions, or serious
14 dysfunction.
15 In addition to provisions specific to
16 women in labor, the EMTALA statutory definition of
17 stabilize means that one can reasonably expect that the
18 individual's condition will not materially deteriorate
19 during or as a result of transfer. And transfer includes
20 both the notion of discharge, as well as what we
21 normally think of transfer. It's the movement of an
22 individual out of the hospital at direction of hospital
23 staff. If a hospital lacks capability to stabilize, it
24 is not only allowed but expected to transfer an
25 unstabilized individual to a hospital that has the

1 required stabilization capabilities.
2 In some cases, required stabilizing
3 treatment could be definitive treatment. For example,
4 you come in with appendicitis and they perform surgery
5 and remove the appendix. In other cases, particularly
6 with individuals who have underlying chronic diseases,
7 hospitals are required to address the acute episode but
8 are not required to provide ongoing treatment of the
9 underlying disease.
10 Individuals who come to a hospital's
11 emergency department with symptoms of severe
12 psychiatric disturbances present particular
13 challenges. We have elaborated on the definition of an
14 emergency medical condition to clarify that an
15 individual is considered to have a psychiatric
16 emergency medical condition if he or she is expressing
17 homicidal or suicidal thoughts or gestures, and is
18 determined to be a threat to self or others.
19 There are also challenges in terms of
20 determining when an individual with a psychiatric
21 emergency medical condition has been stabilized,
22 particularly if chemical or physical restraints have
23 been used in order to prevent the individual from
24 harming themselves or others. And we encourage
25 practitioners to use great care trying to make that

1 determination.
2 Psychiatric hospitals typically are not
3 thought of as having emergency departments, but under
4 the definitions that our regulations have made for what
5 it means to be a dedicated emergency department, they
6 may, in fact, meet the EMTALA definition. We look at
7 how a unit functions rather than what it's labeled as.
8 And often labor and delivery units are considered
9 emergency departments, as are in some cases psychiatric
10 hospital units.
11 In the specialized type of emergency
12 departments they are not expected to have the full range
13 of capabilities that a typical general hospital
14 emergency department would have. If, for example, an
15 individual came to a psychiatric emergency department
16 with self-inflicted wounds and they — it would be
17 expected that the psych hospital would transfer that
18 individual to a hospital that could treat those wounds,
19 even though they also have psychiatric emergency
20 conditions. EMTALA's focus is on assuring that every
21 individual who comes to the emergency department is
22 screened appropriately and stabilized if found to have
23 an emergency medical condition. Accordingly, CMS makes
24 no distinctions with respect to whether an individual
25 coming to an emergency department has a disability or

1 not.

2 Hospitals with specialized capabilities
3 are required to accept appropriate transfers from other
4 hospitals. It doesn't matter if they have an emergency
5 department themselves. So, psychiatric hospitals, for
6 example, if they have the capability and an available
7 bed at the time transfer is needed, are expected to
8 accept a transfer of a patient who needs admission at
9 that hospital.

10 I see I have very little time so I'll stop
11 here and answer your questions.

12 MS. SANDS: Good morning. Enforcement of
13 EMTALA is bifurcated between CMS and OIG with CMS having
14 primary responsibility. Section 1867(d) of the Social
15 Security Act provides that a "participating hospital
16 that negligently violates a requirement of EMTALA is
17 subject to civil money penalties of not more than
18 $50,000 or not more than $25,000 in the case of a
19 hospital with less than 100 beds for each such violation
20 of EMTALA."

21 In addition, "any physician who is
22 responsible for the examination, treatment, or
23 transfer of an individual in a participating hospital
24 including a physician on call for the care of such an
25 individual and who negligently violates a requirement

1 of EMTALA is subject to civil money penalty of not more
2 than $50,000 for each such violation, and if the
3 violation is gross and flagrant or repeated, is subject
4 to exclusion from participation in Medicare and state
5 health care programs."
6 OIG has the authority to pursue these
7 administrative remedies. EMTALA also provides for
8 private civil enforcement against participating
9 hospitals in cases in which an individual suffers
10 personal harm as a direct result of a participating
11 hospital's violation of EMTALA.
12 In these cases, the individual may obtain
13 damages available for personal injury under the law of
14 the state in which the hospital is located, and such
15 equitable relief as is appropriate. OIG does not have
16 a designated role in a private civil case, and is rarely
17 aware of such cases before they are resolved in the
18 federal courts.
19 OIG receives its EMTALA cases from CMS
20 after CMS has found a hospital to be in non-compliance
21 with its EMTALA obligations, and CMS has completed its
22 enforcement action against a hospital. The case is
23 first reviewed by OIG for the purpose of making a
24 recommendation on whether OIG should pursue its
25 administrative remedies against a hospital and/or a

1 responsible physician, or exercise its prosecutorial
2 discretion and close the case.
3 Federal regulations require that OIG take
4 into account several factors in determining the amount
5 of a penalty for EMTALA violations. One factor in
6 determining whether OIG will pursue a case is whether
7 an Administrative Law Judge would agree that a higher
8 versus lower penalty is justified in the case.
9 In general terms, these factors include
10 the degree of culpability of the respondent, the
11 seriousness of the condition of the individual seeking
12 emergency treatment, other instances where the
13 respondent failed to meet its obligations under EMTALA,
14 respondent's financial condition, the nature and
15 circumstances of the violation, and other matters as
16 justice might require.
17 OIG also considers issues related to
18 whether an enforcement action would help educate and/or
19 emphasize a hospital's or physician's responsibilities
20 under EMTALA.
21 OIG then either closes the case or decides
22 to pursue it. The vast majority of pursued cases are
23 resolved through negotiated settlements. On occasion,
24 the case goes to trial before a Departmental Appeals
25 Board. An unfavorable opinion by the Administrative Law

1 Judge may be appealed by either party to the Appellate
2 Division of the DAB. If respondent chooses to appeal
3 after that, the appeal would be filed directly with the
4 appropriate United States Court of Appeals.
5 OIG has reviewed and pursued cases
6 involving psychiatric emergencies throughout our
7 enforcement history. Two such recent cases include
8 enforcement actions against Carolina's Medical Center
9 in North Carolina, and Duke University Hospital, also
10 in North Carolina. Both cases were resolved by
11 settlement agreements.
12 Effective December 3rd, 2013, OIG entered
13 into a settlement with Carolina's Medical Center for
14 a maximum penalty of $50,000 to resolve allegations
15 that it did not provide an appropriate medical
16 screening examination or stabilizing treatment to
17 patient K.C. OIG alleged the following facts. On May
18 16th, 2010, K.C. presented to Carolina's emergency
19 department with complaints of homicidal ideation and
20 acute depression. He stated that he feared hurting
21 himself and his wife, and that he had visual
22 hallucinations.
23 A little over two weeks earlier he
24 presented to Carolina's emergency department with
25 similar complaints, and at that time Carolina's learned

1 that K.C. had access to firearms. After what OIG alleged
2 was a cursory examination, K.C. was discharged from the
3 emergency department with a prescription for a mild
4 antidepressant. Shortly after discharge, K.C. killed
5 his wife and two of his children. When police came to
6 his home he killed himself.
7 Effective September 5th, 2012, OIG entered
8 into a settlement with Duke University Health System
9 doing business as Duke University Hospital for
10 $180,000. The settlement resolved allegations that
11 Duke violated EMTALA by failing to accept five
12 appropriate transfers of individuals with unstable
13 emergency medical conditions who required the
14 stabilizing specialized capabilities available at
15 Duke's Williams unit, a 19-bed adult psychiatric unit
16 located within Duke's main hospital.
17 OIG alleged the following. Three of the
18 patients were refused transfer by Duke because Duke
19 impermissibly restricted transfers to the Williams
20 unit to certain business hours. The restrictive
21 schedule was not reflective of Duke's specialized
22 capabilities available at the times the transfers were
23 requested.
24 One of the other two patients was refused
25 transfer because he was too aggressive, a charge that

1 the government's investigation did not support. The
2 fifth patient was refused transfer because the Williams
3 unit did not treat patients primarily suffering from
4 substance abuse, and Duke had yet to receive the
5 patient's lab results that would indicate whether or
6 not substance abuse was an issue. OIG did not find that
7 the facts of this case justified such a refusal. Thank
8 you.
9 MS. HANRAHAN: Good morning, and thank you
10 for the opportunity to be here today. My office, the
11 Office for Civil Rights, does not enforce EMTALA, but
12 we do enforce federal civil rights laws that have a
13 bearing on Patient Dumping issues.
14 Under these civil rights laws,
15 discrimination on the basis of race, color, national
16 origin, sex, age, or disability, and in some instances
17 religion, is prohibited by recipients of federal
18 financial assistance. We enforce these laws in a number
19 of ways. We investigate complaints. We receive
20 approximately 15,000-18,000 complaints a year; of
21 these about 3,000 are civil rights complaints, the
22 balance are health information privacy complaints
23 which we also enforce. We can conduct compliance
24 reviews where we have reason to believe that an entity
25 that's receiving federal financial assistance may be

1 discriminating, and we also provide technical
2 assistance and conduct public outreach, and education
3 and training efforts.
4 Under these laws, if we have reason to
5 believe that a violation has occurred, we do have
6 authority to take steps to terminate federal financial
7 assistance. We can also refer a case to the Department
8 of Justice for enforcement.
9 I want to talk about three of the civil
10 rights laws that specifically relate to the dumping of
11 patients on the basis of a psychiatric disability. One
12 of the laws we enforce is Section 504 of the
13 Rehabilitation Act of 1973, and that prohibits
14 disability discrimination by recipients of federal
15 financial assistance. We also enforce Title II of the
16 Americans with Disabilities Act. That covers state and
17 local government agencies and we enforce that with
18 respect to their health and social service programs.
19 And under these laws, the denial of care to an
20 individual with a psychiatric disability or the
21 transfer, or relocation, or discharge of such a patient
22 on the basis of the patient's psychiatric condition,
23 or the severity of his or her illness by a facility that
24 otherwise has the ability to provide appropriate
25 services, would be discrimination.

1 We also enforce the Hill-Burton Act. Under
2 the Hill-Burton Act which was passed in 1946, entities
3 including hospitals receive federal financial
4 assistance in exchange for their agreement to provide
5 certain assurances.
6 The Community Service Assurance under
7 Hill-Burton requires recipients of Hill-Burton funds
8 to make services available to persons residing in or
9 employed in the facility's service area available to
10 persons without regard to their race, color, national
11 origin, or creed.
12 In addition, a Hill-Burton facility must
13 make emergency services available to any person without
14 consideration of any ground other than the person's
15 need for the service or the availability of those
16 services at the facility.
17 Finally, a Hill-Burton facility also is
18 prohibited from discharging a patient who is seeking
19 emergency services unless the individual no longer
20 needs those services, or the individual has received
21 those services and is stabilized.
22 There are about 6,800 Hill-Burton
23 facilities in the country, and the great majority of
24 these are hospitals. So, we can receive a case that is
25 filed by an individual directly alleging a violation

1 of one of these laws. CMS also has authority to refer
2 cases to OCR that it has reviewed under EMTALA where
3 it may believe that the facts also may constitute a
4 violation of one of the laws that OCR enforces.
5 In the past three years, we had 60 cases
6 or so under the Hill-Burton Act, and almost all of these
7 were referrals from CMS. We did review those cases, and
8 in many instances the hospitals had already taken
9 corrective action pursuant to action from CMS. In some
10 instances, we did require some additional corrective
11 action, and this related primarily to procedural
12 requirements like the posting of a notice in a
13 Hill-Burton facility that refers to the Community
14 Service obligation or other procedural requirements
15 under the civil rights laws that generally apply to
16 recipients of federal financial assistance.
17 Many of these cases related to the failure
18 to stabilize a patient or to conduct a medical screening
19 exam prior to discharging a patient, and we are very
20 interested in the issue of Patient Dumping and continue
21 to be alert for any signs that it is a systemic issue.
22 Thank you.
23 CHAIRMAN CASTRO: Thank you, Ms. Hanrahan.
24 We will now open the floor to questions from
25 Commissioners. Commissioner Kladney.

1 COMMISSIONER KLADNEY: Thank you, Mr.
2 Chairman. Ms. Dahl, you mentioned that specialized
3 hospitals didn't need full-spectrum emergency rooms.
4 Isn't that what you said?
5 MS. DAHL: Yes.
6 COMMISSIONER KLADNEY: In my state, the
7 Department of Health and Human Services had their
8 clinic shut down at their specialized hospital saying
9 they needed a full-spectrum emergency room. Do you know
10 anything about that?
11 MS. DAHL: Well, I can't comment on the
12 particular case in your state since that's still an open
13 investigation. What I can say is to elaborate on the
14 general principle.
15 First I should say that under the Medicare
16 requirements no hospital is required or obligated to
17 offer an emergency department. It is an optional
18 service under Medicare. And there are certain types of
19 specialty hospitals that typically do not. For example,
20 a rehabilitation hospital is highly unlikely to have
21 an emergency department. But we do have a number of
22 tests for what constitutes an emergency department and,
23 therefore, an activity that's subject to EMTALA. So,
24 we look at what they're actually doing, not only at how
25 they're licensed, or one of the other tests is how they

1 hold themselves out to the public. And the third test
2 is do they take walk-in patients, and a certain
3 percentage of them are found to have emergency medical
4 conditions and need stabilizing treatment.
5 We have su—regulatory guidance that we
6 issue that expands upon the EMTALA regulations. It is
7 not our expectation that a specialty hospital that
8 offers a narrower range of services would have an
9 emergency department that would be able to treat the
10 broad spectrum of emergencies that say a general
11 community hospital has. So, for example, a labor and
12 delivery unit typically is considered to be an
13 emergency department no matter what they call it, but
14 we don't expect them to be able to deal with heart
15 attacks. So, they would, depending on what the
16 capabilities are within that hospital, they may need
17 to move them elsewhere in the hospital, or if they lack
18 the capability in that hospital they would be expected
19 to make an appropriate transfer.
20 COMMISSIONER KLADNEY: Another question I
21 have is when you talk about specialized transfers,
22 stabilization and transfer, I get confused. And, if I
23 may, just — I've talked to several doctors around the
24 country, and actually I guess a couple of weeks ago four
25 ERs were closed in Las Vegas because they were full,

1 a lot to do with psychiatric patients. And the other
2 doctors I talked to around the country, as well. The
3 ER doctors believe they have to keep the patient in the
4 ER until he is stabilized. Then there's no reason to
5 transfer them, and they release them. I thought if he's
6 in a stable-type condition, either through restraints
7 or chemically, that he could be transferred to a
8 specialized hospital. I mean, where am I confused,
9 because I am?

10 MS. DAHL: Well, first I should say EMTALA
11 is extraordinarily complex. It is also something that
12 is extraordinarily fact-dependent. You know, you've
13 seen one case, you've seen one case, and the facts are
14 not just the legal facts but they're the clinical facts.

15 The concept of stabilization is
16 challenging, particularly because the EMTALA statutory
17 definitions are not the way the terms are typically used
18 by clinical individuals. But the EMTALA — EMTALA deals
19 with an acute episode, and the EMTALA obligation ends
20 when the individual is considered stabilized. If an
21 individual is stabilized, as that term is understood
22 under EMTALA, they can — first of all, EMTALA ceases
23 at that point. And depending on the clinical facts, the
24 individual may be discharged back to the community.
25 There may be reasons to transfer the individual, or to

1 admit the individual. So, from the EMTALA perspective,
2 if the person is stabilized, there is not an obligation
3 on the part of the hospital where the individual
4 appeared to provide treatment beyond what was needed
5 to stabilize them, nor are they obligated to transfer
6 the individual elsewhere. They may seek to do that, but
7 it is not within the framework of the EMTALA umbrella.
8 COMMISSIONER KLADNEY: I understand that.
9 My problem is how do we — what is the solution when ERs
10 are filling up, people are sitting in the chairs, they
11 have medical emergencies and they can't get in to see
12 anybody when, in fact, you could take some of those
13 other patients and transfer them to a specialized
14 hospital, creating room for people — I mean, this
15 happened —
16 MS. DAHL: Well —
17 COMMISSIONER KLADNEY: Please. This
18 happened not just in Las Vegas. I've talked to people
19 in California. UCLA has a psychiatric hospital right
20 next door, right next door, they never accept
21 transfers. UCSF has a psychiatric hospital right next
22 door, never accepts transfers. The ERs fill up and they
23 have people in the chairs, and they can't get any
24 service.
25 MS. DAHL: Well, first what I would say is

1 if, in fact, those facilities believe that is the case,
2 they should be submitting complaints to us about that
3 so that we can investigate that. If a psychiatric
4 hospital has an available bed that's appropriate, for
5 example, if someone needs a locked unit and they don't
6 have any beds in a locked unit, we wouldn't consider
7 them to have capacity at that time. But if they have
8 the right capabilities and an available bed, they are
9 expected under EMTALA to accept an appropriate
10 transfer, and we expect the sending hospital to make
11 an effort to transfer an unstabilized individual to a
12 place where they can be stabilized expeditiously.
13 We do hear anecdotally that it is often
14 difficult to find appropriate placements whether
15 that's due to a lack of capacity. We have made a lot
16 of efforts over the past few years, we changed our
17 regulations to make it very explicit that a specialized
18 hospital does not have to have an emergency department
19 to have the obligation to accept appropriate transfers.
20 In various states, some of our medical officers have
21 attempted to educate psychiatric facilities in those
22 states about their obligations. But there does have to
23 be both capability and capacity.
24 There do appear, anecdotally we hear, to
25 be problems in terms of there being capability and

1 capacity at the time when they're needed. But, again,
2 if we should — someone should file a complaint with us
3 so that we could actually investigate if, in fact, a
4 hospital that has the capability and capacity has
5 refused to accept a transfer under EMTALA.
6 I will clarify, though, that if the patient
7 was admitted at the first hospital, the EMTALA
8 obligation has ended. And, therefore —
9 COMMISSIONER KLADNEY: Gets admitted into
10 the hospital from the ER.
11 MS. DAHL: Admitted in the first hospital
12 from the ER into the hospital. At that point, the EMTALA
13 obligation is fulfilled and under our regulations there
14 is no obligation for any other hospital to accept a
15 transfer. But, typically, you would not be admitting
16 a psychiatric patient if you didn't have a psychiatric
17 unit. Now, if they're a patient that has both
18 physical-medical issues as well as psychiatric,
19 perhaps you have to admit them to deal with the physical
20 condition, and then you may have some difficulty in
21 terms of a placement if you need to send them to another
22 facility.
23 COMMISSIONER KLADNEY: When we look at the
24 IMD —
25 CHAIRMAN CASTRO: Okay. Commissioner

1 Kladney, we're going to — I appreciate you've got a lot
2 of questions.
3 COMMISSIONER KLADNEY: I've got a lot of
4 questions.
5 CHAIRMAN CASTRO: We're going to move on to
6 some other Commissioners. I'll try to come back to you
7 because we do have a limited amount of time.
8 COMMISSIONER KLADNEY: Thank you, Mr.
9 Chairman.
10 CHAIRMAN CASTRO: Also, I've got a couple
11 of — the Staff Director has also indicated she has some
12 questions, so any of the Commissioners on the phone I'm
13 going to make a list here. So, it'll be me, Staff
14 Director, Commissioner Achtenberg, Commissioner
15 Heriot. Any Commissioner —
16 COMMISSIONER YAKI: Commissioner Yaki.
17 CHAIRMAN CASTRO: Okay. All right. So, I
18 have a question for Ms. Sands regarding the penalties.
19 A couple of questions, actually.
20 Do you know who actually ends up being
21 responsible for paying those penalties? And what I'm
22 asking is do the hospitals end up getting their
23 insurance companies to pay for this, or does this come
24 out of their pockets? So, the question really is focused
25 on how much does it really hurt them.

1 And secondly, to what extent are these
2 — what is done with the civil penalties once they're
3 collected? Where do they go? Do they support any
4 programming?
5 MS. SANDS: I am not sure about the
6 insurance for the hospitals. My general understanding
7 is that in most states these penalties are not paid for
8 by insurance companies. However, I know that there has
9 been some discussion of insurance coverage for EMTALA
10 violations, so I think that that would be a
11 state-by-state inquiry, and I'm not in a position to
12 really tell you what is happening generally.
13 CHAIRMAN CASTRO: Okay. And where do these
14 civil penalties end up once they're assessed and
15 collected?
16 MS. SANDS: My belief is they go back to the
17 Medicare Trust Fund.
18 CHAIRMAN CASTRO: Okay. But you're not
19 sure. You believe?
20 MS. SANDS: I'm pretty sure that that's
21 where they go.
22 CHAIRMAN CASTRO: Okay.
23 MS. SANDS: If that's wrong, I'll let you
24 know.
25 CHAIRMAN CASTRO: Okay, thank you. Madam

1 Staff Director, and then after that Commissioner
2 Achtenberg.
3 MS. SALLO: Ms. Dahl, just to follow up on
4 a comment that you made. You said — you indicated the
5 hospital should file a complaint with your division,
6 so would it be safe to say that you are made aware of
7 EMTALA violations through self-reporting?
8 MS. DAHL: No. That does happen in some
9 cases. I would not consider a complaint by another
10 hospital to be self-reporting. The largest sources of
11 the complaints that we get are from patients and their
12 families, or from other hospitals. Sometimes
13 complaints come from staff within a hospital, sometimes
14 we become aware of something that's been reported in
15 the media.
16 I should also say that the complaints
17 typically go to the states. CMS has what we call a
18 Section 1864 Agreement with all of the states in the
19 country, as well as the District of Columbia, and some
20 of the — and Puerto Rico, and some of the other
21 territories, for them to conduct what we call surveys.
22 They're onsite inspections on behalf of CMS to assess
23 compliance with Medicare requirements, and in the case
24 of long-term care, and some other types of facilities,
25 also some Medicaid requirements. So, most typically the

1 complaints will come in from a variety of sources to
2 the state. And they'll be generalized complaints. I
3 don't know that it happens all that often that someone
4 submits a complaint and says I'm filing an EMTALA
5 complaint, but the states, as they're reviewing the
6 complaints, they will recognize that the nature of the
7 complaint may raise an issue of EMTALA compliance. They
8 are then required to contact one of the 10 regional CMS
9 offices of Survey and Certification folks. We operate
10 in a decentralized manner here, so they would go to
11 their regional office and say we believe we have an
12 EMTALA complaint, and they seek authorization to
13 investigate it.
14 In the overwhelming majority of cases, the
15 regional office will authorize an investigation. And,
16 as I said, it can also be the case that if the region,
17 or if we in the central office, see something in the
18 media that looks like it may raise EMTALA issues, we'll
19 contact the region and say have you gotten a complaint
20 about this? Are you aware of this? If not, we can
21 self-generate the complaint and go out and have the
22 state do an investigation.
23 Sometimes regional staff who are also
24 federal surveyors will accompany a state team that's
25 conducting an investigation, but most of the time it

1 is strictly a state team that is conducting the
2 investigation according to federal policy and
3 procedures.
4 MS. SALLO: And just one more question. You
5 had indicated during your statement that at some point
6 some federal officers have gone into hospitals and have
7 attempted to educate. So, it sounds like there is a
8 component with your agency as to providing some sort
9 of training.
10 MS. DAHL: It's not so much formal. We will,
11 for example, a particular state may say to us that they
12 have — there are some issues around say those
13 psychiatric hospitals understanding their recipient
14 hospital responsibilities. And I think that actually
15 our regional folks do a lot more of this. They interact
16 on a routine basis with their state hospital
17 associations and will generally deal with whatever
18 might be the hot issues of the moment.
19 MS. SALLO: Okay, thank you.
20 CHAIRMAN CASTRO: Commissioner Achtenberg.
21 COMMISSIONER ACHTENBERG: Thank you, Mr.
22 Chairman.
23 Ms. Hanrahan, is there — do you have an
24 opinion about the limitations of a solely
25 complaint-driven process when it comes to potential

1 civil rights violations? And, specifically, it seems
2 to me that with regard to labor and delivery, as well
3 as the mental health situations that were being
4 referred to, that those are two kinds of cases that
5 typically might have civil rights implications. So, I'm
6 wondering how you see the limitations of a
7 complaint-driven process when it comes to the civil
8 rights implications of these kinds of cases.
9 MS. HANRAHAN: I think we would agree that
10 having only authority to investigate complaints is very
11 limited, so we do have authority to conduct compliance
12 reviews. So, we can accept data from organizations or
13 individuals, we can conduct our own research whether
14 it's in newspapers, or on websites, or through
15 stakeholder meetings, to identify any instances where
16 we believe that there may be discrimination, so we do
17 open compliance reviews.
18 I think it is true that in some instances
19 individuals are reluctant to file complaints for
20 various reasons, or they do not necessarily highlight
21 where the greatest discrimination may be occurring, so
22 I think having the authority to do compliance reviews
23 is essential. We also do a fair amount of outreach,
24 sometimes listening sessions with stakeholder
25 organizations. And I think those are also very helpful,

1 and sometimes training for entities either as a group
2 or individually, we can provide technical assistance.
3 And I think that is true that the issues
4 that you highlight are issues where individuals with
5 psychiatric disabilities may not necessarily be in a
6 position to file a complaint. Sometimes we will have
7 complaints filed by individuals, physicians, or by
8 family members or friends. And a complaint can actually
9 be filed by any person. The person does not need to be
10 a victim of discrimination. They need not necessarily
11 have anything to do with the facility, so — and a person
12 can file as many complaints as they wish to file. So,
13 I think there's a certain amount of flexibility to try
14 to accommodate those types of discrimination that are
15 less likely to lend themselves to being initiated
16 through a complaint filed by an individual who suffered
17 discrimination.
18 And, yes, on the labor issues we do have
19 authority under Section 1557 of the Affordable Care Act
20 now to investigate sex discrimination in health care
21 programs. Previously, sex discrimination in health
22 care was not prohibited under federal civil rights
23 laws, so that is a new authority that would allow us
24 to address those types of issues, as well. And, of
25 course, the psychiatric disabilities, we do see those

1 under existing authority, under 504 and the ADA and
2 those, as well, are covered by 1557. But that's more
3 of a supplementary coverage in the case of psychiatric
4 disabilities because we already have had authority to
5 address those issues.
6 COMMISSIONER ACHTENBERG: The compliance
7 capability, is that also complaint-driven? You have to
8 have — you said you have to have reason to believe that
9 there is a problem before you can launch a compliance
10 review —
11 MS. HANRAHAN: Yes. We generally will
12 target complaint reviews, so if we have some data or
13 it can be anecdotal information from individuals that
14 there may be an issue going on at a particular facility,
15 or across a number of facilities with respect to a
16 particular issue, then we can open a compliance review.
17 COMMISSIONER ACHTENBERG: So, you have no
18 independent ability to seek data from institutions — I
19 mean, I understand —
20 MS. HANRAHAN: We do have authority — yes,
21 we do have authority to seek data, so institutions are
22 required to maintain any data or information that the
23 Director directs. And we do have authority to request
24 access to information, and sometimes we'll use that to
25 identify whether there may be issues.

1 COMMISSIONER ACHTENBERG: So, you do that
2 on a — for all 6,800 institutions, or —
3 MS. HANRAHAN: We do not. It depends, so we
4 usually will request data where we have some reason to
5 believe that there may be an issue, and that can vary.
6 For example, we look for data under the Olmstead
7 Community Service requirements with respect to
8 institutionalization of individuals, and that is
9 outside the context really of a compliance review or
10 a complaint investigation.
11 COMMISSIONER ACHTENBERG: So, there's no
12 compliance data that they're obligated to provide
13 affirmatively.
14 MS. HANRAHAN: No, we do have authority to
15 survey Hill-Burton facilities. I don't believe that we
16 have done that in the recent past, although we have done
17 that in the more distant past.
18 COMMISSIONER ACHTENBERG: Thank you very
19 much.
20 CHAIRMAN CASTRO: Commissioner Heriot.
21 COMMISSIONER HERIOT: I get the feeling
22 that the majority of these cases involve psychiatric
23 problems. About what proportion of the violations
24 you're running into are acute psychiatric episodes as
25 opposed to some other kind of medical emergency?

1 MS. DAHL: First of all, I don't think we
2 have any data to suggest the majority of cases are
3 psychiatric. We do not collect data on the nature of
4 the emergency medical condition because the EMTALA
5 enforcement scheme is focused on what are the
6 requirements, and which of the requirements were not
7 fulfilled, so we really couldn't say.
8 I would kind of doubt it based anecdotally
9 that the majority of the EMTALA violations have to do
10 with psychiatric cases. I do think that psychiatric
11 cases can be particularly challenging in terms of
12 making the clinical determinations, as well as we hear
13 making placements, making transfers. But we get a very
14 wide range of EMTALA cases, and I really don't think
15 you could say that most of them have to do with
16 psychiatric cases. Sandra's got considerably longer
17 history with EMTALA than I do, and may have more of a
18 feel just —
19 COMMISSIONER HERIOT: If it were close to
20 a majority that would still be disproportionately
21 psychiatric. If you were even close to a majority, that
22 would be disproportionately psychiatric.
23 MS. DAHL: I don't — I would not — we don't
24 have the data based on the nature of the condition. I
25 just am skeptical that that would be the case.

1 COMMISSIONER HERIOT: How are hospitals
2 compensated for their services?
3 MS. DAHL: There is no provision in EMTALA
4 related to compensation. Hospitals are expected to
5 provide the screening, and as applicable the
6 stabilization services. And the subject of how they're
7 compensated for is just simply outside the scope of
8 EMTALA.
9 I will note that the Affordable Care Act
10 does include a provision that requires private insurers
11 who offer emergency or cover emergency services to
12 cover those services when they're out of network, and
13 that that provision cross-references to the EMTALA
14 provision in terms of the definition of what's an
15 emergency medical condition, what screening, what
16 stabilization is.
17 COMMISSIONER HERIOT: So, I assume, and
18 maybe I'm wrong, that some — there's some controversy
19 then about whether some hospitals end up with more
20 EMTALA issues than others, that they feel that they are
21 forced to provide services more than other hospitals
22 would have to provide them.
23 MS. DAHL: I think that some hospitals feel
24 that by their nature they get — of where they're
25 located, and the communities that they serve that they

1 may have more cases that involve the uninsured. It
2 doesn't necessarily make them more EMTALA cases.
3 COMMISSIONER HERIOT: Why wouldn't it?
4 MS. DAHL: I'm sorry?
5 COMMISSIONER HERIOT: Why wouldn't it, if
6 they have more people in the community that are
7 uninsured, why wouldn't they have more cases where they
8 aren't compensated?
9 MS. DAHL: Because anyone who comes to an
10 emergency department is an EMTALA case.
11 COMMISSIONER HERIOT: Yes, but you assume
12 that the hospitals that are in communities that have
13 a higher level of uninsured — lack of insurance would
14 have more people coming. People don't randomly choose
15 hospitals, they go to the one near them.
16 MS. DAHL: No, actually I believe that
17 there's pretty widespread use of emergency departments
18 by insured as well as uninsured populations.
19 COMMISSIONER HERIOT: We're talking about
20 disproportionality, not whether every hospital doesn't
21 face this, but whether some hospitals will face it more
22 than others.
23 MS. DAHL: If your question is are there
24 some hospitals who end up providing more uncompensated
25 care than others, I think the answer is yes. But I don't

1 know that that's necessarily specifically tied to
2 EMTALA.
3 CHAIRMAN CASTRO: Okay, we're going to move
4 on to Commissioner Yaki. And then I'm going to have one
5 follow-up question, and then I'll give it to
6 Commissioner Kladney to close out the show. Okay? Thank
7 you.
8 COMMISSIONER YAKI: Thank you very much,
9 Mr. Chairman, and to the panelists, thank you for your
10 time.
11 I'm Commissioner Michael Yaki, and I'm
12 sorry I couldn't be with you today, but I'm in San
13 Francisco today where it is going to be about 75 degrees
14 and sunny.
15 (Laughter.)
16 CHAIRMAN CASTRO: And you're stuck on the
17 phone all day.
18 COMMISSIONER YAKI: (Laughing) yes, but
19 it's mobile. So, I guess my question is sort of a factual
20 predicate for what we're trying to do here today, and
21 that is the issue of what kind of civil rights
22 violations are being implicated here? Because,
23 obviously, EMTALA is a broad category, 504s is a
24 separate category. The people who may be undiagnosed
25 or not yet, for example, under an SSDI-type definition,

1 are sort of I guess part of the gray area that we're
2 talking about here. And I think that Commissioner
3 Achtenberg was trying to touch upon it, but how would
4 we better get a measure on the — a handle on the measure
5 or quantification of how much of these Patient Dumping
6 cases may involve, for lack of any better phrasing, a
7 violation of an individual's civil rights? How do we
8 find that? How do we measure, quantify, or other than
9 self-reporting, other than someone files a lawsuit,
10 other than someone files a complaint. We have a lot of
11 data collection points throughout the Department of
12 Justice, for example. I'm not too sure, it sounds like
13 we have that kind of data collection point at — inside
14 CMS, or HHS. And, obviously, that would be a
15 quantification of this to understand the scope and
16 impact of this problem. It's something that is very
17 important for us in terms of what kind of
18 recommendations we would make, so I'd like to know what
19 you know about it, what your best guess is, or what you
20 might suggest would be a way in order to collate and
21 find this kind of data in terms of civil rights
22 violations themselves.
23 MS. HANRAHAN: This is Eileen Hanrahan with
24 OCR. We have a case data system currently. It does not
25 at this time allow us to search by type of disability,

1 so we were not able to conduct a search, for example,
2 of individuals with psychiatric disabilities and
3 complaints raising those issues.
4 It does allow us to search by authority,
5 so we could look under Section 504, we could look under
6 the Hill-Burton Act, and it does allow us to search by
7 basis generally so we could isolate race cases, or
8 disability cases, or sex discrimination cases. So, I
9 think that looking at the cases that were referred under
10 Hill-Burton, for example, and that does cover every
11 basis other than the individual's need for the service,
12 or the facility's ability to provide the service, so
13 it would include all of the civil rights bases, as well
14 as the inability to pay specifically under the
15 Hill-Burton Act.
16 Looking at those cases, we could
17 conceivably go through case by case and do some data,
18 I guess, analysis and identify categories of cases that
19 raise specific civil rights issues. As I mentioned,
20 most of these cases were closed based on corrective
21 action taken because, at the time that they came to OCR,
22 the facility had generally already changed policies and
23 procedures, and those would be the types of steps that
24 we typically would require as a remedy for a civil
25 rights violation.

1 In some instances we did require some
2 additional corrective action, but for the most part in
3 looking at what would have been a discrimination issue
4 we didn't necessarily need to even reach the
5 determination of whether it was, in fact, a civil rights
6 violation because if it were, we would have required
7 the type of relief that had been taken. So, I guess,
8 you know, there are different ways that data systems
9 could be configured so that we could, for example, I
10 guess, establish a Patient Dumping issue area, and then
11 investigators would need to enter data that would look
12 specifically at that issue.
13 We could, alternatively, look at a very
14 large number of cases that we have now, but that would
15 be more of a case-by-case research issue, and would be
16 pretty time-consuming. I don't know that the Justice
17 Department, which you mentioned, collects this type of
18 data either but, I mean, obviously we could configure
19 data systems in different ways to try to get different
20 types of data and prepare that data for analysis.
21 COMMISSIONER YAKI: Okay, thank you.
22 CHAIRMAN CASTRO: Thank you. My question is
23 — well, I'd like each of you to address it, but portions
24 of it relate to some things that you each have said.
25 Ms. Hanrahan, you mentioned the civil

1 rights laws that you enforce also protect against
2 national origin discrimination. EMTALA, I believe, is
3 applicable to anyone regardless of their immigration
4 status. And, Ms. Dahl, you talked about stabilization
5 also means that the patient will not materially
6 deteriorate during the transfer.
7 I have seen and read about a lot of cases
8 which are known either as medical repatriation or
9 international Patient Dumping, where we're seeing
10 undocumented patients who are being returned to their
11 home countries. We're also seeing legal permanent
12 resident aliens that are victimized, I mean literally
13 hundreds of these cases. Could you speak a bit to that
14 issue, and how your particular offices have dealt with
15 or addressed that issue?
16 MS. HANRAHAN: Well, when we were doing our
17 search of data in preparation for the briefing we were
18 primarily focused on individuals with psychiatric
19 disabilities —
20 CHAIRMAN CASTRO: Right. Understood.
21 MS. HANRAHAN: — as we had understood that
22 was the topic of the hearing. We did do a search of our
23 system as well as canvass each of our regional offices
24 to identify any cases that may not have made it into
25 the system. And of those, I don't know of any that

1 involve that type of issue, which isn't to say that
2 there weren't some. And we could go back and see if there
3 were, but we have seen issues like that in other areas
4 so it would not be a surprise if that also happened in
5 this area. But I don't have the data at this point to
6 say that we have a record of it.
7 CHAIRMAN CASTRO: Yes, if you could provide
8 that data to me that would be great.
9 MS. HANRAHAN: Okay.
10 CHAIRMAN CASTRO: Ms. Sands? I'm sorry, Ms.
11 Dahl.
12 MS. DAHL: I have heard only anecdotally of
13 a case like that, frankly, that I read about it in the
14 newspapers, so I really don't know the facts firsthand.
15 Did not involve EMTALA because it had to do with an
16 inpatient who had some continuing conditions that were
17 obviously going to persist for a long period of time.
18 And the patient no longer required an acute level of
19 care.
20 It's outside the scope of the Medicare
21 Hospital Conditions of Participation in terms of
22 discharge planning to — a hospital is required to do
23 its best to identify appropriate sources of care in the
24 community. They're not required to pay for them if
25 nobody else is available to pay for them. And at least,

1 again, this is just secondhand knowledge reading in the
2 newspapers. I think there was a case of a repatriation
3 back to an individual's home country where there were
4 some assumptions made about ability to care. But I think
5 the — from reading the review, it looked like it was
6 something that was kind of outside the scope of our
7 Medicare Hospital Conditions of Participation.
8 CHAIRMAN CASTRO: Okay, thanks. Do you have
9 anything, Ms. Sands, on that?
10 MS. SANDS: I've worked on EMTALA
11 enforcement since 1989, and I have a general
12 recollection of two cases that involved violations of
13 EMTALA, but also raised issues related potentially to
14 repatriation. Neither of them were very recent.
15 CHAIRMAN CASTRO: Okay, thank you.
16 Commissioner Kladney.
17 COMMISSIONER KLADNEY: Thank you, Mr.
18 Chairman. Ms. Sands, how many hospitals have been
19 excluded from Medicare participation since you've been
20 doing this in 1989?
21 MS. SANDS: I think that might be a question
22 that's more appropriate for Ms. Dahl—
23 COMMISSIONER KLADNEY: Fine.
24 MS. SANDS: because the OIG doesn't have the
25 authority to exclude them.

1 COMMISSIONER KLADNEY: They do.
2 MS. DAHL: Well, technically, we don't
3 exclude. We will terminate a Medicare Provider
4 Agreement. It is a very rare occurrence. In any given
5 year there is just a handful of hospitals that undergo
6 an involuntary termination from the Medicare program,
7 and that's because our goal is to have the facility come
8 back into compliance. We realize that hospitals provide
9 essential sources of care to their communities, so our
10 primary focus in enforcement is to see that they come
11 back into compliance.
12 And I would also say that hospitals are
13 very highly motivated. Our typical enforcement process
14 for EMTALA basically says, you know, if we find a
15 violation, then you have a certain amount of time to
16 come back into compliance or you face potential
17 termination of your Medicare agreement. And that also
18 has implications for Medicaid reimbursement, and for
19 hospitals that's generally a catastrophic event. So,
20 they're very highly motivated, when we have found
21 issues, to fix them.
22 COMMISSIONER KLADNEY: The IMD Exclusion,
23 you're running a demonstration project now, and, at
24 least according to the press release, you are.
25 MS. DAHL: It's another part of CMS I'm

1 really not competent to speak about.
2 COMMISSIONER KLADNEY: If we could, post-
3 hearing perhaps, request information on that, and if
4 there's been any interim reports, and like what kind
5 of resources were needed to partake in that, I'd really
6 appreciate that.
7 MS. DAHL: I'll refer that to the
8 appropriate folks.
9 COMMISSIONER KLADNEY: Thank you. And then
10 there was -- this thing about the ERs filling up and
11 closing down really has my interest because, obviously,
12 it creates an issue for people coming to the ER in dire
13 straits.
14 Is there — absent the transfer, is there
15 any way — there's a waiver I read in the statute, in
16 case of emergencies for — that some of this can be
17 waived in terms of stabilization and transfers?
18 MS. DAHL: The only waiver provision is
19 under Section 1135, in an area that has been declared
20 a disaster by the President and a public health
21 emergency by the Secretary. And it's a time-limited
22 waiver, if I recall correctly. I think it's limited to
23 48 or 72 hours.
24 COMMISSIONER KLADNEY: Seventy-two hours.
25 MS. DAHL: So, that's generally a

1 non-issue. —To go back to your initial question — well,
2 I've sort of lost the train of how you opened up the
3 question, if you wouldn't mind.
4 COMMISSIONER KLADNEY: That's okay. We
5 covered most of that before, I think.
6 And, finally, this complaint-driven
7 process, so there's lots of civil enforcement that you
8 never hear about. Is that correct?
9 MS. DAHL: We have no role in any private
10 right of action, and we, just like my colleague
11 indicated, will never know about it unless there's been
12 a federal court case decision on it, and that somehow
13 comes to our attention. It really does not involve our
14 enforcement procedures.
15 COMMISSIONER KLADNEY: Do you think that's
16 good for your program?
17 MS. DAHL: I don't really think that that's
18 something I can speculate on. Congress chose to make
19 available this alternative, but it can be in addition
20 to. Someone can file a complaint that we will
21 investigate, and that has — that can happen
22 independently of the fact of whether or not they're
23 pursuing a private right of action.
24 COMMISSIONER KLADNEY: Do you have the
25 manpower to do investigations, unannounced

1 investigations and things like that?

2 MS. DAHL: Manpower for conducting surveys
3 is always a challenge, but we prioritize EMTALA
4 investigations as the very highest priority for the
5 states to go out and do. So, we do get those done. We
6 get roughly about 500 complaints a year that we
7 investigate.

8 COMMISSIONER KLADNEY: Thank you very much.

9 CHAIRMAN CASTRO: Are there any other
10 questions? Commissioner Yaki.

11 COMMISSIONER YAKI: Yes.

12 CHAIRMAN CASTRO: Go ahead.

13 COMMISSIONER YAKI: I had one very simple
14 question, and maybe it's too simple, but you read in
15 the news about certain hospitals, certain — having a
16 practice of literally buying the Greyhound ticket,
17 putting the patient on a bus and sending them to another
18 jurisdiction, another state. I guess I just want to ask
19 the panelists, is there anything about that that
20 strikes you as fundamentally wrong as a practice,
21 regardless of whether the person — what state that
22 person, —what condition that person may be in, and is
23 there any way that federal regulation can stop that
24 practice from happening, whether it's because they're
25 a sort that receives federal funding or what have you,

1 but just the very notion that you can pack someone up,
2 put them on a Greyhound and send them somewhere else
3 to be someone else's problem. I feel — what is your
4 reaction, and should the federal government tell these
5 hospitals just as a flat — as a matter of policy, no,
6 you can't do that. You receive federal funds. You can't
7 put someone on a bus and send them to another
8 jurisdiction to become someone else's problem
9 regardless of whether or not what medical condition
10 they may or may not have.
11 MS. DAHL: Rather than speculate about the
12 general advisability of doing things one way or the
13 other, I think it's important to realize, as I said,
14 hospitals are subject to two different types of
15 Medicare regulations. One is EMTALA, which is extremely
16 focused on the acute type of emergency event. Hospitals
17 are also subject to the Medicare Hospital Conditions
18 of Participation, one of which concerns discharge
19 planning. And there is a statutory basis for what
20 hospitals have to do for discharge planning.
21 And we have over the past couple of years
22 been increasing our focus on discharge planning. And,
23 in general, the agency has been looking at the issue
24 of preventable readmissions, and care transmission,
25 care transitions from one setting to another,

1 specifically from hospital acute care settings to
2 post-acute care settings. And I would say that it would
3 take a careful look at the particular individual’s
4 discharge plan in order to determine that that was, in
5 fact, an appropriate type of discharge plan for an
6 individual.
7 CHAIRMAN CASTRO: Anyone else want to
8 answer that? No. Commissioner Kirsanow, are you on the
9 phone? Do you have a question to wrap up?
10 COMMISSIONER KIRSANOW: I am, Mr. Chair,
11 thanks, but I do not at this point.
12 CHAIRMAN CASTRO: Okay. Then what we will
13 do is conclude this first panel. Thank you to each of
14 the panelists for your input. We appreciate it very
15 much. And as you begin to move off, we will ask the
16 members of the second panel to begin to move forward
17 and join the front so that we can start the second panel
18 as quickly as possible. Thank you. Commissioners, don’t
19 walk too far away.
20 (Whereupon, the proceedings went off the
21 record at 10:35 a.m., and went back on the record at
22 10:39 a.m.)
23 CHAIRMAN CASTRO: All right. We’re going to
24 begin. I hope you all were here earlier and understand
25 the system of lights. You’ll each have seven minutes

1 and when the light gets yellow, that means start
2 wrapping up. When it turns red, hopefully you'll
3 conclude.
4 I also want to just let everyone know we
5 know that there are active pieces of litigation
6 involved on this issue, and some of you may be involved.
7 And we're not here to litigate these cases in this
8 forum, we are here to try to get as much information
9 from you all about the topic, in general, so that we
10 can then present a report on the issue rather on
11 individual litigation. So, I know you'll be cooperative
12 with us in that area.
13 So, let me introduce briefly our
14 panelists. We have a number of panelists with us on
15 Panel II. The first is Susan Preston. She's an attorney
16 specializing in professional negligence at Goodell,
17 DeVries, Leech & Dann, LLP. We also have Staci Pratt
18 who is the Legal Director of the Nevada American Civil
19 Liberties Union. Gina Greenwood is Of Counsel on health
20 care matters at Baker Donelson. And our third panelist
21 is Hernan Vera, President and Chief Executive Officer
22 of Public Counsel. Pleased to see you. I know we met
23 my first visit, official visit to Los Angeles. Do we
24 have — am I missing somebody? No, I think we've got
25 everybody. Right? So, what we'll do now is begin with

1 you, Ms. Preston, so you've got seven minutes.

2 **III. PANEL II**

3 **ADVOCATE/PRACTITIONER PANEL**

4 MS. PRESTON: Thank you. Good morning. I
5 understand the Commission was interested primarily in
6 the questions of whether the mentally ill are being
7 denied adequate care in the context of EMTALA, and
8 whether there is a systemic neglect in the treatment
9 of those patients. I'd like to start a little bit first
10 with the former of the issues because I believe it's
11 a fair statement that the treatment of mental illness
12 is and has been an unwanted stepchild in the American
13 health system.

14 As the number of inpatient psychiatric
15 facilities has dwindled over the past four decades,
16 there has been inadequate investment in
17 community-based treatments and social services support
18 to the mentally ill. And I understand that's the only
19 evidence-based treatment that has been found to make
20 a difference in long-term outcome. And as a
21 consequence, the number of patients with mental
22 disorders and substance abuse problems seeking
23 treatment in emergency departments has skyrocketed.

24 In 2003, Dr. Steven Sharfstein from the
25 Sheppard and Enoch Pratt Hospital estimated that 2.5

1 million ED visits occurred annually for mental health
2 disorders. In 2007, the Bazelon Center for Mental
3 Health Law published that one in eight, or nearly 12
4 million visits annually, were due to mental illness
5 and/or substance abuse since the last seven years and
6 the recession, but those numbers have undoubtedly only
7 increased.
8 All too often, there is simply nowhere else
9 for patients with mental health issues to turn for
10 treatment. And largely because there are inadequate
11 inpatient and outpatient resources for the treatment
12 of mentally ill, lengths of stay in the emergency
13 department are reportedly three times higher for
14 psychiatric patients than others.
15 Rather than being causes of neglect, I
16 submit emergency departments and inpatient facilities
17 for psychiatric treatment are struggling daily with the
18 consequences of the larger systemic neglect of the
19 mentally ill.
20 I think it's important to understand what
21 EMTALA was enacted to address, and what it was enacted
22 not to address. It was enacted to assure access to
23 emergency medical care in emergency departments. It
24 bears emphasizing that it was not intended to ensure
25 quality of care.

1 EMTALA has played an important role, and
2 in my opinion it has largely succeeded in preventing
3 patients, including those with mental illness, from
4 being turned away from emergency departments, but I
5 should point out that I practice law in Maryland, the
6 only state in the union that was until this year
7 exempted from Medicaid's prospective payment system in
8 favor of the fee-for-service system, lessening the
9 economic pressures that lead to Patient Dumping.
10 Once treated in the emergency department,
11 however, it is hard to judge whether nationally
12 appropriate screening evaluations to detect both
13 medical and psychiatric emergency medical conditions
14 and stabilization of such conditions when found are
15 being consistently applied.
16 Anecdotally, I know the hospitals that I
17 represent have spent considerable time and effort in
18 developing processes to attempt to insure screening
19 evaluations are appropriate, and that stabilization is
20 provided. For example, most require annual
21 competencies of providers who work in emergency
22 departments and on-call physicians to the emergency
23 departments. Education is also provided by many of
24 those hospitals on the elements of clinical decision
25 making that need to be considered to determine whether

1 a psychiatric symptom is medically-based, or whether
2 a patient is a danger to themself or others requiring
3 stabilization.
4 Electronic medical records have been
5 developed to prompt providers to obtain from all
6 patients the information that is needed in making these
7 clinical judgments, but at the end of the day it is still
8 a clinical judgment that determines whether an
9 emergency medical condition is present, and what
10 interventions will likely prevent deterioration.
11 The hospital-based psychiatrists to whom
12 I have spoken tell me that if anything, more patients
13 are being referred for inpatient treatment than needed,
14 not that patients are being inappropriately or
15 prematurely discharged. And I think this is a
16 reflection of the fact that even the most sensitive and
17 most specific evaluations for conditions such as
18 suicidality are falsely positive 99 percent of the
19 time.
20 The only academic study I could find on the
21 incidence of economically-motivated refusals to treat
22 under EMTALA found only 4 percent of confirmed
23 violations, and that involves six cases of identifiable
24 failures to treat for economic reasons. That's reason
25 enough that EMTALA should exist, but one could

1 certainly not conclude that there is a systemic failure
2 to treat the mentally ill, based either upon the number
3 of EMTALA violations found by CMS, or based upon the
4 number of cases that are filed claiming damages.
5 Understandably, these are under-estimates given a
6 complaint-driven system. If there truly is a systemic
7 problem, enforcement by exception rather than
8 surveillance should be abandoned, but I believe that
9 such enforcement would largely prove there is
10 compliance with EMTALA. What failures there are arise
11 primarily from the difficulty in applying a statute
12 that was not written for chronic psychiatric conditions
13 in mind. Thank you.
14 CHAIRMAN CASTRO: Thank you. Ms. Pratt. Are
15 you going to talk into the mic? Thanks.
16 MS. PRATT: Greetings. Thank you for the
17 opportunity to comment today. I'd like to begin with
18 a video. Can I queue that up? No sound. Technicals.
19 CHAIRMAN CASTRO: And we should put some of
20 her time back for that. It's not her fault. Time out.
21 MS. PRATT: Thank you. I appreciate it.
22 CHAIRMAN CASTRO: Start the game clock
23 again.
24 MS. PRATT: All right.
25 (Off microphone comment.)

1 CHAIRMAN CASTRO: Yes, why don't we do that.
2 Why don't you start and then we'll try to queue it up,
3 figure out what's going on.
4 MS. PRATT: Okay. Well, I wanted to begin
5 with the words of James Brown.
6 CHAIRMAN CASTRO: Again, your microphone,
7 please.
8 MS. PRATT: Oh, sorry, here we go. I wanted
9 to begin with the words of James Brown. His story, his
10 suffering and the chain of events leading to his
11 abandonment by Rawson-Neal Psychiatric Hospital
12 represent a call to action. Let's first begin with who
13 he is.
14 James is a 48-year old schizophrenic man
15 who was involuntarily committed to Rawson-Neal
16 Psychiatric Hospital on February 9th, 2013. Enduring
17 auditory hallucinations, acute psychosis, and strong
18 suicidal impulses, he needed stabilization and
19 professional care. Instead, he received cursory
20 services and a discharge to Greyhound Bus by taxi. These
21 are his discharge papers, and that's what they say.
22 The listed address on the discharge form
23 signed by the Rawson-Neal registered nurse identifies
24 the address on discharge as Greyhound Bus Station to
25 California. For this journey he received a three-day

1 supply of medication and several bottles of Ensure. He
2 received no money, and no identification.
3 The state agencies and employees
4 responsible for his treatment and care under EMTALA
5 made no arrangements for any follow-up care for his
6 psychiatric and medical needs, and provided no advance
7 notice of James' arrival to any person or agency in
8 Sacramento, California.
9 James knew no one in Sacramento. He was
10 simply instructed to call 911 when he arrived. Without
11 a phone and still delusional and suicidal, he wandered
12 homeless on the streets. Eventually, through the
13 assistance of a homeless shelter and a police officer,
14 he found his way to the UC Davis Emergency Center and
15 then Heritage Oaks Hospital where he was finally
16 treated and stabilized.
17 Admission notes reveal that James stated
18 that "I was looking for a bridge to jump off from and
19 kill myself. I'm tired of trying to survive. I can't
20 make it on the streets no more."
21 Sadly, his experience was not isolated.
22 Greyhound Bus receipts demonstrate that more than 1,000
23 individuals were bused from Rawson-Neal to cities
24 across the United States over the past three years.
25 Rawson-Neal sent at least 325 of them to California

1 alone.

2 Patients typically were dispatched by taxi
3 to Las Vegas Greyhound Station and put on buses alone
4 and sometimes heavily medicated for journeys that in
5 many cases span multiple states and several days. These
6 reports show no arrangements for treatment or care were
7 made; thus, short-term warehousing of patients
8 followed by routine discharge to Greyhound Bus
9 reflected the norms of practice at Rawson-Neal.

10 Rawson-Neal's client transportation
11 policy as reformulated in 2009 stated that one goal was
12 to remove the burden of treatment from the State of
13 Nevada. This was the same year that the policy
14 eliminated the need for supervision and approval by the
15 agency director for out-of-state transports. This was
16 also the year that Rawson-Neal entered its ongoing
17 contract with the Greyhound Bus Company.

18 An unabashed focus on cost savings
19 apparently drove the decision to put bus patients with
20 unstable psychiatric needs out of state. One must ask
21 how did this system continue unabated? How was this
22 practice not discovered and addressed? The abandonment
23 of psychiatric patients took place over a series of
24 years unchecked.

25 Unfortunately, we believe that the EMTALA

1 enforcement structure is broken. It is loose,
2 ill-formed, and lacks the type of consistent oversight
3 necessary to make the guarantees of EMTALA meaningful.
4 As you know, at its core, EMTALA
5 enforcement process is complaint-driven. When a
6 complaint is received by the state survey agency, or
7 the regional offices of the Centers for Medicaid and
8 Medicare Services, the regional office has the power
9 to authorize an investigation. This is typically
10 handled by the state agency, in Nevada's case, the
11 Nevada Department of Health and Human Services through
12 the Bureau of Health Care Quality and Compliance.
13 Numerous complaints were forwarded to the
14 Bureau for investigation between early 2009 and late
15 2012 relating to patient discharge practices and
16 inadequate staffing. With one small exception, such
17 complaints were summarily dismissed after cursory
18 reviews. Instead, it took the power of the media to
19 bring attention to this matter.
20 In March 2013, the Sacramento Bee began a
21 series of investigatory articles on Rawson-Neal and the
22 impact that Patient Dumping practices on the State of
23 California. Following public uproar, investigations
24 finally took on a serious character. Intensive reviews
25 of patient screening exams and discharge practices

1 began. These investigations culminated with a thorough
2 analysis conducted for the first time by an independent
3 federal contractor employed by CMS on July 26, 2013.
4 Finally, a searching examination of patient discharge
5 files demonstrated that staff consistently failed to
6 substantiate the stability of patients on discharge,
7 or document any follow-up appointments for after-care.
8 So, what does this story tell us? It is time for change.
9 We believe there needs to be a proactive
10 federal investigatory structure, that CMS can and
11 should provide independent proactive federal
12 investigations of psychiatric emergency providers
13 through federal contractors, not state survey agencies
14 on a randomized basis.
15 We believe that for problem facilities CMS
16 should institute independent monitors to insure
17 compliance with corrective action plans and EMTALA
18 mandates. We also think there is the possibility of
19 using fines aggressively to fund an anti-dumping fund
20 which would support independent investigation and
21 proactive work on CMS' behalf.
22 As you know, the Office of Inspector
23 General may seek civil monetary penalties against
24 hospitals and physicians who violate EMTALA.
25 Nonetheless, it is rare. Public Citizen found that

1 between EMTALA's enactment in 2001, 975 cases were
2 referred to OIG for penalties. Only 27 percent of
3 referred violators actually received penalties.
4 We think that there's also an opportunity
5 to engage in negotiated continuation in Medicare, based
6 on a facility's willingness to fund remedial and
7 oversight efforts. Right now, EMTALA provides for a bar
8 or suspension for Medicare participation for hospitals
9 that violate the statute. The problem is, so many of
10 them are too big to fail. We think there should be an
11 additional administrative check on discharges where
12 all prospective discharge and transfer orders should
13 be subject to a second layer of approval. We think there
14 should be reporting in very detailed fashion to CMS on
15 a quarterly basis which identifies the failure to
16 obtain secondary approval on discharge decisions in the
17 absence of data in after-care planning fields.
18 Finally, I'd just like to say James and
19 others like him struggle with mental illness and
20 poverty, and they can no longer endure our
21 disintegrating system of emergency mental health care.
22 Thank you.
23 (Off microphone comment.)
24 CHAIRMAN CASTRO: We did receive the link
25 in advance, and I know I watched it. I'm sure my other

1 Commissioners did, so if you haven't, I would encourage
2 the Commissioners to look at that, so sorry about the
3 technical difficulties.
4 MS. PRATT: Thank you. No worries.
5 CHAIRMAN CASTRO: Ms. Greenwood.
6 MS. GREENWOOD: Yes, thank you very much.
7 Commissioners, thank you for allowing me to be here
8 today. It is truly an honor to sit before you as an
9 expert on the area of EMTALA and mental health.
10 I also want to thank you for taking a
11 proactive view of this. I truly believe, although my
12 primary clients are hospitals, that the mental health
13 patients in this country are the faceless, nameless,
14 defenseless population that is often forgotten and is
15 ill-perceived in our mental health — in our communities
16 at large. So, I challenge you and I thank you for
17 addressing this issue.
18 I want to give you a little bit of my
19 background, who I am, and why I'm here. First of all,
20 I had a prepared statement which I've now just
21 completely thrown out the window based on all your
22 questions, so hang with me here.
23 I work at a national law firm. Most of my
24 clients are hospital clients, physician clients, but
25 I also represent psychiatric advocacy agencies, and

1 also represent psychiatric facilities. I have a very
2 personal reason for wanting mental health addressed in
3 this country, which I don't feel comfortable sharing
4 on the record. It has nothing to do with me personally,
5 but I can just tell you it is an issue that is very close
6 to my heart.
7 I worry about people like James. I worry
8 about them every day, but I caution this Commission in
9 coming down with a heavy-handed regulatory scheme to
10 try to fix the problem that exists. To me, there is a
11 problem. Our mental health system is in dire straits.
12 We are in a dire crisis.
13 I would challenge you to, rather than
14 focusing so much on the EMTALA law, which I believe that
15 CMS has addressed fully as saying it does cover our
16 psychiatric patients, they are required to be screened
17 and stabilized and/or appropriately transferred),
18 rather than increasing enforcement of EMTALA, I would
19 like for you to really focus hard on some of the
20 unintended consequences that might result from that.
21 Our hospitals in this country are regulated beyond
22 degree. They are overwhelmed with the amount of
23 regulations that they have to comply with. And I'm
24 afraid if we take the bad apple cases of this country
25 and try to do mass regulation and mass legislation to

1 address some really bad apples, that we are going to
2 come up with some unintended consequences.
3 I can tell you from training physicians in
4 hospitals across this country that mental health
5 patients are viewed not in a positive light by ED
6 physicians, and the reason is EMTALA is an unfunded
7 mandate. It’s a requirement. It has heavy-handed
8 consequences if you do not comply and, therefore, it
9 creates a negative consequence of the mentally ill in
10 this country being perceived as problems, as frequent
11 flyers in our EDs.
12 I would suggest to this Commission that —
13 you asked for solutions, Commissioner Kladney. Let me
14 give you some. Let me offer you some practical solutions
15 for this problem. Form a task force, figure out, gather
16 the data you need. I believe the Commissioner on the
17 phone said where’s the data? There are ways to capture
18 this data, and I’m going to talk about that before we
19 finish. Form a task force, figure out what is the extent
20 of the problem. Is James the exception to the rule? I
21 realize that involves 1,500 patients but is that the
22 exception to the rule, or are we seeing a systemic
23 problem across this country? Use your data
24 appropriately. Think about the unintended consequences
25 to the mentally ill. Focus on a campaign to educate this

1 country on what mental illness looks like.

2 Mental illness is not always about truly
3 just a mental or psychological issue. A lot of times
4 there is a medical root cause. I find that our ED
5 physicians are not appropriately trained to address and
6 to identify mental illnesses at their medical root
7 causes.

8 I find that yes, we have a great law called
9 EMTALA that requires us to appropriately transfer
10 patients, but where the heck are we going to transfer
11 them? Our states have decreased funding of mental
12 health institutions across this country. Focus on
13 figuring out which states have appropriate mental
14 health facilities where transfers can be made to and
15 which ones do not, and I can assure you if you address
16 that problem, you won't be busing James to California
17 any more. You would have appropriate facilities. You'll
18 have facilities with the capacity to treat.

19 The issue it relates to, do we have
20 education of our teachers, of our first responders, our
21 policemen, our ED physicians, our ambulance drivers?
22 Do they know how to address mental illness? Do they know
23 how to identify it? Do they know when it's really mental
24 illness or some diabetic episode where insulin is low,
25 or a potassium deficiency? Do they understand what

1 mental illness looks like? And do they understand that
2 these people are truly defenseless? Do they understand
3 that their hospitals are receiving different types of
4 reimbursement? Do they get that although EMTALA
5 obligations may end which are very punitive, believe
6 me, there is nothing worse than getting one of those
7 letters from CMS that you're about to be thrown out of
8 the Medicare program and penalized by the OIG. Do they
9 understand that the conditions of participation kick
10 in after EMTALA stops, that requires them to continue
11 with the patient-physician relationship? What kind of
12 education is being done?
13 I can assure you, I operate out of Atlanta,
14 Georgia, and I can assure you that Region IV does a very
15 good job of trying to communicate with providers
16 through the Georgia Hospital Association. I have been
17 involved in conferences where I've spoken with these
18 guys. They try to educate. They need more money to be
19 able to do that.
20 OCR does a fabulous job of educating on privacy, but
21 I think that they could be given some money to educate
22 on EMTALA.
23 But the most important thing beyond
24 education of first responders, ED physicians and the
25 public at large about what does mental health look like,

1 but making sure that we have funding at the community
2 level, that we look at our infrastructure at the
3 community level, and that we figure out what is broken,
4 how do we best send our monies into these communities,
5 whether it's through reimbursement for certain codes
6 for mental health illnesses, whether it's by assigning
7 social workers upon discharge to truly address the
8 needs of our mentally ill.
9 And, lastly, I would say that it would be
10 appropriate to form a task force to really investigate
11 our data to figure out how to make these things happen
12 with a focus of truly trying to think about the Jameses
13 of this world, trying to figure out how can James have
14 appropriate treatment, have a meaningful day where he
15 can feel like he is somebody in this country, as a
16 citizen of this country. And how can we make sure he
17 has safe housing at the end of the day?
18 And I promise you, if you follow the money
19 you will find the root of the problem. If you fund this,
20 if you figure out a way to fund this, then you will solve
21 the problem, and you will make the Jameses of this world
22 the heroes rather than the pains in the behinds of the
23 ED physicians. Thank you.
24 CHAIRMAN CASTRO: Thank you, Ms. Greenwood.
25 Mr. Vera.

1 MR. VERA: Thank you. Good morning, Mr.
2 Chair, Commissioners, Director and Staff, it's also an
3 honor for me to address you, so thank you for the
4 opportunity.
5 I wanted to focus on a subset of the problem
6 that we're talking about which is the homeless patient
7 dumping. I think Ms. Pratt started to cover this, and
8 I'd like to expand on it. So, I'd like to cover three
9 areas, essentially. One, how we as a society really came
10 to know about this problem, how it came to our
11 attention, what steps advocates and public officials
12 have taken so far on it, and what recommendations I and
13 others have to address the situation. So, if we can go
14 to the next slide.
15 In 2006, this is really when Americans as
16 a society really woke up to the problem, that was with
17 Carol Ann Reyes. She was at that time a 63-year-old
18 homeless woman with early stages of dementia living in
19 a park in Gardena when on March 20th, 2006 she was treated
20 by Kaiser. She was taken by taxi across town 15 miles
21 and dumped on the sidewalk of Skid Row. And in a lot
22 of other situations she probably would have gone
23 unnoticed, but there was a video camera outside the
24 Union Rescue Mission and it caught her wandering up and
25 back in a daze, and she was brought in.

1 Now, Anderson Cooper, 60 Minutes, it hit
2 all the national media and it started bringing to light
3 the attention of what happens in the intersection of
4 our health care crisis and our homelessness crisis when
5 homeless patients are put at greater risk by being taken
6 to an area that they're not familiar with. Next slide,
7 please.
8 The next year we had another situation that
9 was similar in many respects. Gabino Olivera was and
10 is a paraplegic man living in a van who was treated by
11 a hospital, Hollywood Presbyterian. He was put in a van,
12 taken to a park near Skid Row and left there without
13 his wheelchair, so onlookers saw him dragging himself
14 away in the gutter with his discharge papers in his
15 teeth. So, I have to say it has been one of the greatest
16 professional privileges of my career to have
17 represented both Gabino and Carol Ann Reyes, and that's
18 how I personally got involved with this. Next slide,
19 please.
20 So, what did we do? First of all we sued,
21 we sued with the ACLU of Southern California, Ms.
22 Pratt's coworkers and colleagues, and the LAC
23 Attorney's office brought a separate action. And aside
24 from the individual settlements, really what came out
25 of it that we're very proud of was the adoption of a

1 best practices discharge protocols that those
2 hospitals adopted, but what’s better is we’ve gotten
3 calls, many calls from hospitals and hospital
4 associations saying we’d like your discharge
5 protocols. Can we get a copy of those? That really warms
6 our hearts when we get that before we have to sue. So,
7 litigation unfortunately has continued. We’ve brought
8 suit on behalf of six other hospitals since then. We
9 have two under investigation, and the LAC Attorney’s
10 Office has done much more, as well.
11 But briefly I think for our discussions
12 here, and we focused on EMTALA, and I’ll get back to
13 it at the end when I talk about solutions, we’ve had
14 to use state law theories because EMTALA, as Ms. Pratt
15 said, is too loose, too broken, doesn’t have the right
16 provisions in it for us to really attack it, so we’ve
17 essentially used state law theories and medical
18 negligence to say you, the hospital and the doctors,
19 put this patient who may have been stabilized in a more
20 dangerous situation, and knew that he or she really
21 could not have proceeded with their next medical steps
22 in that situation. Let’s go to the next slide, please.
23 So, what other solutions are there? One is
24 additional legislation, and California tried that, SB
25 275. In 2007, Senator Gil Cedillo, we worked with him,

1 drafted a bill that essentially would make it a
2 misdemeanor with fines up to $10,000 for transporting
3 a patient to a place other than his or her residence
4 without very clear and explicit and informed consent.
5 That bill passed through both the House and Senate but
6 was vetoed by Schwarzenegger.
7 LA City Council passed a similar ordinance
8 a year after that essentially does much of the same
9 without some of the penalties, but at least in LA
10 because it was such a problem, it wasn't isolated. They
11 had reports in the two months after the Carol Ann Reyes
12 case of 55 other dumping examples there just in LA. And
13 we've had stories from San Francisco, Boston, New York,
14 and Chicago from other advocates. Next slide, please.
15 Other than legislation what we've looked
16 at is to start creating a broader regional
17 conversation, and we believe it should be national, on
18 how to address best practices. So, this last year we
19 sponsored at the California Endowment a regional
20 hospital symposium to bring together hospital
21 representatives, and advocates, and housing providers
22 to figure out how to do this right. And over 50
23 representatives from hospitals attended, and we felt
24 that we got some good momentum and created a task force,
25 to Ms. Greenwood's point, to look at how we can refine

1 those best practices, but that's well underway. Next
2 slide.
3 And EMTALA, I think I commend all of you
4 for really looking at this issue. We feel that, while
5 it has helped certainly in cases where patients are
6 rejected or not accepted, or transferred improperly,
7 this issue here is similar to Ms. Pratt's client where
8 the homeless really are dumped. They're left, they are
9 put in a worse situation with — in areas that they don't
10 know, and EMTALA really is not a solution for that at
11 all. Next slide.
12 Finally, the dissemination or
13 distribution of best practices. If there can be a way
14 for there to be better communication with the
15 regulators for the community education that Ms.
16 Greenwood was talking about; that, of course, would be
17 important, but the areas that we're talking about are
18 good psychiatric assessments, referrals to
19 recuperative beds, needs assessments, training for the
20 social workers, tracking of their belongings so they're
21 not left in hospital gowns, as Ms. Reyes was. Last
22 slide.
23 And, finally, and my time is up so I won't
24 say too much more, but essentially if we can as a society
25 create incentives for more recuperative beds, and

1 regionally we're starting to do that. And the
2 Affordable Care Act has some incentives for this, that
3 is part of the solution, as well. Thank you.
4 (Off microphone comment.)
5 (Ms. Pratt's video was played.)
6 MS. PRATT: Thank you for showing that.
7 CHAIRMAN CASTRO: Commissioners on the
8 phone, if we have questions, let me know.
9 COMMISSIONER KLADNEY: Thank you, Mr.
10 Chairman.
11 CHAIRMAN CASTRO: Commissioner Kladney, go
12 ahead.
13 COMMISSIONER KLADNEY: In regards to Ms.
14 Preston's presentation, and Ms. Greenwood's
15 presentation, you talk about funding. There's the IMD
16 Exclusion regarding Medicaid. Do you think if they got
17 rid of that and they started funding mental health
18 through Medicaid, that would go a long way toward being
19 able to provide funds and take the crush off hospitals
20 and ERS?
21 MS. GREENWOOD: I would need to really
22 research that to opine on that. I'm not a funding or
23 reimbursement expert by any stretch of the imagination.
24 In general —
25 COMMISSIONER KLADNEY: Well, they don't pay

1 now.

2 MS. GREENWOOD: Okay. Well, if they don't
3 pay now and it would send money, yes, I think it would
4 help. The main issue, you've nailed it. I mean, it's
5 money, is the fact that we don't have enough beds to
6 send them to, and there's not enough reimbursement for
7 different types of mental health codes, and coding
8 diagnoses basically.

9 COMMISSIONER KLADNEY: And no community
10 health centers.

11 MS. GREENWOOD: And no community crisis
12 intervention centers in many states. A lot of the state
13 mental health facilities have been closed, and there's
14 no data. How many times did we hear today we don't have
15 any data? And I have a couple of thoughts on how we might
16 get some data, if you're interested.

17 CHAIRMAN CASTRO: Commissioner Kladney,
18 could you — I had a request from Commissioner Heriot
19 to define, was it LMD?

20 COMMISSIONER HERIOT: IMD.

21 COMMISSIONER KLADNEY: IMD, it's
22 Institutional Mental Disease.

23 CHAIRMAN CASTRO: Okay, thank you.

24 COMMISSIONER KLADNEY: From an Institution
25 of Mental, I think of or for Mental Disease. I can't

1 remember which.

2 CHAIRMAN CASTRO: Okay, thank you.

3 COMMISSIONER KLADNEY: It's an exclusion in

4 Medicaid and, therefore, the homeless Medicaid

5 patients, or actually a lot of homeless people show up

6 without Medicaid because they're not even on SSI.

7 MS. GREENWOOD: That's right.

8 COMMISSIONER KLADNEY: The hospitals are

9 not reimbursed for them at all.

10 MS. GREENWOOD: Right.

11 COMMISSIONER KLADNEY: Same thing with

12 disabled people who are not mentally issues. A lot of

13 them don't have SSI and Medicaid, and the hospitals

14 don't get paid for them in the ER.

15 MS. PRATT: Could I add to that. I think

16 following the money —

17 COMMISSIONER KLADNEY: No.

18 MS. PRATT: Sorry. No, I think following the

19 money is really important, I do. You know, and there

20 was a question today, is this just a bad apple

21 situation? And I would say no, and the reason is the

22 money. If you look at the cost of transporting patients

23 for Rawson-Neal, it's $205,000 over five years to send

24 them out of state, 60 bucks a bus ticket. Right? Five

25 hundred dollars a day inpatient treatment.

1 At the time this occurred, mental health
2 funding in the State of Nevada went down about $80
3 million over the course of several years, so follow the
4 money and it will show you this is going to be a systemic
5 practice because there is a financial incentive to
6 discharge homeless psychologically-troubled patients
7 to the street.
8 COMMISSIONER KLADNEY: and I'd like to ask
9 Mr. Vera, and perhaps — oh, you wanted to say something?
10 MS. PRESTON: I think we've been talking
11 about this in the context of EMTALA, and I think it's
12 important to point out that EMTALA does not apply to
13 the inpatient setting.
14 MS. PRATT: Right.
15 MS. PRESTON: So, Ms. Pratt's clients'
16 problems is outside the scope of EMTALA to the extent
17 that they were inpatients.
18 MS. PRATT: Actually —
19 MS. PRESTON: To the extent they were not,
20 then that applies.
21 MS. PRATT: Yes, they were not inpatients.
22 In fact, what happened was there was no stabilization
23 as EMTALA requires, and that's really what we are
24 troubled about. There truly was a system in place where
25 there was a cursory review of the patient's condition,

1 and there were notations on the record that said
2 stabilized, but in fact it was not the case. And this
3 was revealed in CMS's own investigations, there were
4 no actual authenticating documents to show
5 stabilization took place.
6 COMMISSIONER KLADNEY: What I'd also like
7 to inquire actually, Ms. Preston, you hit on it is that
8 it doesn't apply to inpatient and, therefore, even in
9 your document that you — your statement that you
10 submitted, you said an ER can actually discharge into
11 the hospital, and then the EMTALA requirement is not
12 placed on them any longer. And they could actually
13 discharge an unstable patient.
14 MS. PRESTON: So long as it is a good faith
15 admission.
16 COMMISSIONER KLADNEY: Right.
17 MS. PRESTON: So, for example, the one case
18 from the Sixth Circuit which is the only Circuit to have
19 applied it in the context of the inpatient. This was
20 a patient who had been provided services for almost
21 seven days, and EMTALA was not intended to establish
22 a federal standard of care. And that's essentially what
23 the Sixth Circuit was doing, because the question there
24 was, would a reasonably competent physician have
25 discharged that patient given his condition that had

1 not been addressed, allegedly not been addressed? And
2 if it is covered by state law, then why does there need
3 to be an additional federal regulation on top of the
4 state law because it was —
5 COMMISSIONER KLADNEY: So, they have
6 medical negligence is what you're saying.
7 MS. PRESTON: Yes, exactly.
8 COMMISSIONER KLADNEY: Okay.
9 MS. PRESTON: So, I don't think there needs
10 to be a whole regulatory environment on top of available
11 state penalties because, the medical malpractice
12 environment being what it is, has driven the cost of
13 health care up, and hospitals out of business, so I'm
14 not sure it's a helpful step to cure the problem by
15 putting a regulatory environment over — on top of the
16 state law licensing applications and damage
17 requirements that are already there.
18 COMMISSIONER KLADNEY: Okay. Mr. Vera's got
19 something to say.
20 MR. VERA: Thank you. I would respectfully
21 take issue with that. I think although the state law
22 claims certainly are there, I think what's needed is
23 a greater deterrence effect by having more regulatory
24 oversight, by having the type of administrative
25 oversight reporting, all these suggestions that Ms.

1 Pratt made, because I think, unfortunately, unless
2 non-profits bring these cases, they don't have the type
3 of clear damages that invite the plaintiff's attorney
4 market in the same way that other cases do. They take
5 a lot of time, and what clear damages are there for
6 someone like a Ms. Reyes, let's say for example, who
7 wandered in her hospital gown? What attorney is going
8 to take that case for two years, a private attorney.
9 So, the market isn't there. I don't think that we have
10 the same deterrent effect that we need.
11 COMMISSIONER KLADNEY: If I may say, in my
12 state we have limitations on medical negligence.
13 MS. PRATT: We do.
14 COMMISSIONER KLADNEY: And it's severe in
15 terms of what a person will bring. Just one more area,
16 Mr. Chairman.
17 CHAIRMAN CASTRO: Let me just quickly ask,
18 any Commissioners on the phone have questions so I can
19 keep track? Anybody here?
20 COMMISSIONER YAKI: Yes, I do.
21 CHAIRMAN CASTRO: Okay. So, Commissioner
22 Kladney, one more question, then I'm going to go to
23 Commissioner Yaki, and then Commissioner Achtenberg.
24 COMMISSIONER KLADNEY: Great. Thank you,
25 Mr. Chairman.

1 CHAIRMAN CASTRO: And then we'll come back
2 to you, as I promised before.
3 COMMISSIONER KLADNEY: Okay. I have plenty
4 of questions.
5 CHAIRMAN CASTRO: Okay.
6 COMMISSIONER KLADNEY: Before the panel
7 started, I asked you if you were familiar with the
8 Beverly Hospital Case, and that's just a recent case
9 that settled by the City Attorney in Los Angeles. And
10 in there he talks about a patient safety zone, he talks
11 about discharge policies with psychosocial assessments
12 on admission and on release. He talks about a homeless
13 patient informed consent discharge form, a homeless
14 patient identity form, respite beds, stuff like that.
15 And you said you were familiar with all that. That was
16 all done, some of it with EMTALA, but a lot of it with
17 the California statute, and it was also done with an
18 injunction, wasn't it?
19 MR. VERA: Yes, but I think the point is it
20 shouldn't have to be like that, it shouldn't have to
21 be local prosecuting agencies to — when they find out
22 about it to do that. But I think what's positive about
23 it is that since it has come to light there are best
24 practices now that I think our federal regulators can
25 do to really distribute it widely, so that in other

1 cities we don't require a Mike Feuer to do that to get
2 those —
3 COMMISSIONER KLADNEY: But the CMS lady
4 said they do no training with EMTALA around the country.
5 Would that be good for your people?
6 MS. GREENWOOD: I truly believe that we
7 really have to be cautious of unintended consequences.
8 I think mentally ill in this country are perceived in
9 such an ill manner. They are considered to be a pain,
10 you know, a thorn in our sides, and it's a sad situation.
11 And I'm afraid if we continue to just put heavy-handed
12 regulations in place that's not going to change. It's
13 going to get worse.
14 COMMISSIONER KLADNEY: So, no training. Is
15 that what you're saying?
16 MS. GREENWOOD: No, absolutely not. My next
17 thing is —
18 COMMISSIONER KLADNEY: That was my
19 question.
20 MS. GREENWOOD: Well, I'm sorry. I missed
21 your question. I do believe that we need education. We
22 need research to figure out what medical root causes
23 are, we need education on what those are so that we can
24 better train people to identify mental illness versus
25 medical health illnesses, and we need treatment. We

1 need money for treatment, and we need beds. I mean, we
2 need facilities, we need crisis intervention. And I do
3 think training is key.
4 I think the regional offices of CMS are
5 willing to provide a lot of that training. I know that
6 Region IV has, so I think it’s a great idea.
7 MS. PRATT: And if I could just add to that,
8 too. I think one of the things we’re talking about is
9 civil rights. Right? Is that not the context for this
10 discussion? And I believe, fundamentally, that the
11 federal government has an important role in ensuring
12 civil rights. I don’t think we can leave it to private
13 litigation on behalf of individuals who are homeless,
14 who are mentally ill, and who lack access to the system
15 to protect themselves. I think that’s the reason EMTALA
16 exists, and making sure that the guarantees of EMTALA
17 are meaningful is a core obligation of the federal
18 government.
19 I believe that we’re a society, if you look
20 at the history of the enforcement of civil rights, which
21 has depended on civil enforcement that is through the
22 regulations and through the regulators. And I don’t
23 think, given what happened to not only James Brown, but
24 the 1,500 others patients at Rawson-Neal, and the
25 financial incentives for the system to continue, that

1 the feds can step back.
2 As you mentioned, Nevada has very serious
3 limits on medical malpractice. There aren't going to
4 be private cases on this. Complaints rarely even arise
5 because people are disempowered. It's when people are
6 most vulnerable, and when people lack access to power,
7 that the federal government must step in.
8 COMMISSIONER KLADNEY: Mr. Chairman, I'd
9 like to add this to the record. It's a Stipulation and
10 Final Order in the Beverly Hospital Case that I was
11 talking about with Mr. Vera.
12 CHAIRMAN CASTRO: Okay. I will accept this
13 and put it into the record. Thank you, Commissioner.
14 Commissioner Yaki, please proceed with your questions.
15 Commissioner Yaki?
16 COMMISSIONER YAKI: Sorry.
17 CHAIRMAN CASTRO: That's okay.
18 COMMISSIONER YAKI: I'm having a little
19 trouble with the mute-unmute button here. Thank you
20 very much.
21 CHAIRMAN CASTRO: It's really complicated,
22 yes.
23 COMMISSIONER YAKI: I know, I know. The
24 question I had, someone talked about the money, and
25 without a doubt part of the problem that we have here

1 is the money. Having been a sitting County Supervisor,
2 as Commissioner Achtenberg was, as well, in San
3 Francisco, one of the things that we identified early
4 on is that there are money streams that can actually
5 follow some of these people that create more, for lack
6 of a better word, of an economic incentive for
7 institutions to actually treat them rather look at the
8 cost-benefit analysis of buying a Greyhound bus ticket
9 and kicking them off to the next state.
10 I wonder to what extent a better proactive
11 effort at — especially with a lot of these folks who
12 are mentally ill, who probably could qualify for SSGI,
13 who probably — who need help signing up under the
14 expanded Medicaid provisions under the Affordable Care
15 Act, how you think that might help address this
16 situation, if at all? Or if you think it doesn't, and
17 the responsibility still lies with hospital resources,
18 why you think that's the case?
19 CHAIRMAN CASTRO: Anybody?
20 MR. VERA: I'll take a crack at part of it.
21 At the symposium, we talked with hospital
22 representatives about how the penalties for
23 readmission are now giving hospitals more incentive to
24 come up with plans where, if they can reduce their
25 readmission rates for the homeless who are oftentimes

1 repeat users, then that's in their financial best
2 interest.
3 I think we're sometimes conflating two
4 issues here in this discussion. One is that there are
5 a lot of things we can do as a society to do better by
6 our brothers and sisters with mental illness, and those
7 are complex issues, they're expensive issues, but we
8 shouldn't let the enormity of that situation make us
9 throw up our hands about the more direct things that
10 we can do, I think, as regulators and as people
11 concerned about civil rights, about how to create more
12 deterrence for the types of direct actions for which
13 we do have best practices.
14 It's not true to say that there are no
15 services, there are no beds. Yes, there are, and you
16 can find them. We were able to find housing for Ms. Reyes
17 very quickly. There's convalescent institutions,
18 senior centers, others that have nurses, there are
19 beds. It's not that there isn't any, and there are best
20 practices; hospitals do want to do better. But I think
21 others don't have the right incentives, and I think what
22 we're talking about could really create those.
23 MS. GREENWOOD: And I respectfully
24 disagree. I mean, I really think you have to — on the
25 bed part only. You really have to look, figure it out,

1 study it, research it, and figure out where are there
2 deficiencies in beds. I know that they have been closing
3 according to my sources. I have not done the statistical
4 research on this, but there has been a dramatic decrease
5 in funding of mental health beds and treatment, and
6 crisis intervention systems, and closing of a lot of
7 these facilities in many states. I can't cite for you
8 the states, I can't give you the numbers, but I would
9 hope that this Commission would have the power and the
10 authority to have a task force to research that.
11 Someone mentioned data, I believe it was
12 Commissioner Heriot. Am I saying that correct? One of
13 the ways that we might — we have a unique opportunity
14 right now with the use of electronic health records to
15 capture data that we never could capture before.
16 Providers are required in order — under their enhanced
17 reimbursement schemes for Medicare and Medicaid, to
18 have electronic health records or they are penalized
19 if they do not. And they're required to show meaningful
20 use of those. They collect clinical quality measures
21 to address certain types of data. And I think it's a
22 unique opportunity to collect data about the mentally
23 ill.
24 And I would encourage this Commission to
25 encourage the use of those records to figure out what

1 is the problem so we know we're not just legislating
2 something based on what we're hearing in the news, but
3 we're actually studying the problem and figuring out
4 what is the extent of the problem. And is it systemic,
5 is it isolated to certain states? What are the ratios
6 of disproportionate care as you mentioned earlier, and
7 use that data appropriately.
8 I would not encourage, you know, a lot of
9 additional requirements on hospitals to collect data
10 they're not already collecting, but to the extent
11 they're required to collect data anyway, why not make
12 that one of the standards?
13 MS. PRATT: And to add to that, you know,
14 currently hospitals are under an obligation to report
15 to CMS a variety of things. One of those things deals
16 with after-care planning. We found specifically in
17 Rawson-Neal, and we looked intensively at the records,
18 those fields were empty. Why did that not trigger the
19 need for oversight? I respectfully understand the need
20 for data and research. Are we going to allow this
21 situation to continue? How many more James Browns do
22 we need to see on the screen before we know that there
23 is not consistent oversight?
24 They had the opportunity — this policy
25 that said we want to remove the burden on the State of

1 Nevada for providing care, went into place in 2009.
2 There were 10 instances of complaints specifically
3 about patient discharge practices. Nothing was done.
4 When we look at the provision of
5 information and the failure to really oversee it, the
6 time is now. We are in a crisis. And while we certainly
7 always have the opportunity to research and to identify
8 additional data streams, in the meantime how many of
9 these individuals who are struggling with mental health
10 and homelessness are going to suffer, and are going to
11 be sent on Greyhound buses across the country?
12 CHAIRMAN CASTRO: Commissioner Yaki, do you
13 have a follow-up?
14 COMMISSIONER YAKI: No, I'm good. Thank
15 you.
16 CHAIRMAN CASTRO: Commissioner Achtenberg.
17 COMMISSIONER ACHTENBERG: Thank you, Mr.
18 Chairman. To Ms. Pratt and Mr. Vera, assuming for a
19 moment that there is not going to be additional federal
20 laws to address this issue, and assuming for a moment
21 there is not going to be an enhanced regulatory scheme
22 as prescribed by CMS or the division of HHS in charge
23 of overseeing discharge planning, no new regulatory
24 framework. And assume, as well, that there's going to
25 be no new infusion of dollars to address the chronic

1 problems that the research has unfolded, and that your
2 anecdotal stories have underscored.
3 In terms of the data that we already
4 collect, in terms of the forms that are already required
5 for hospitals and other facilities to fill out so they
6 can get whatever modest reimbursement is being offered
7 through Medicare or whatever the reimbursement
8 mechanism is, what would you recommend that we
9 recommend with regard to, you know, how this system
10 could be improved? And would you comment, as well, in
11 addition to data, whether or not a more proactive review
12 process could be fashioned within existing statutory
13 authority, regulatory authority, as well?
14 MS. PRATT: So, to address that, I think
15 those raise very important questions. Naturally, we
16 would prefer to see a more systemic approach to reform,
17 but given the constraints that you have provided —
18 COMMISSIONER ACHTENBERG: Just —
19 MS. PRATT: Yes, I would say this, there are
20 mechanisms currently available. The best review that
21 took place at Rawson-Neal was one conducted by
22 independent federal contractors put together by CMS.
23 CMS already has the authority to do that. The question
24 is how often will they use it? How often will they
25 accompany state survey agencies in reviewing

1 facilities?

2 COMMISSIONER ACHTENBERG: They have the

3 authority to do it once a complaint has been —

4 MS. PRATT: Has been provided. But as we

5 heard previously, they also have the authority to

6 initiate investigations on their own based on news

7 reports and things like that. So, what I would suggest

8 is there is an opportunity for CMS to take a more active

9 role in independent investigations. I feel sometimes

10 when you use the state survey agency, you're using an

11 agency that has good relationships with the hospitals,

12 and are not always in a position to conduct a full and

13 thorough oversight of what's happening in the facility.

14 So, CMS has the authority to do that.

15 In addition, CMS already requires the

16 provision of data from its providers. There are very

17 specific after-care planning fields that can be filled

18 out in detail. And it wouldn't take a major reformation

19 of the legal structure for CMS to say to agencies, look,

20 I want to have very detailed information in your

21 after-care planning.

22 In the case of Mr. Brown and similar

23 patients, all there was was a cursory notation of

24 stabilized. There was no notation of which hospitals

25 did you call, because none were called. There was no

1 notation of which shelters did you seek a bed in,
2 because none were reached out to. So, I think that there
3 are tools like that that would make independent
4 hospitals more accountable. CMS needs to review those
5 on a proactive basis, and if it sees consistently that
6 those areas are empty and not detailed, it needs to take
7 action and put in an independent federal investigator.
8 COMMISSIONER ACHTENBERG: And are you aware
9 of protocols that exist aided, presumably, by the
10 wonders of technology that could make that kind of
11 approach a more common practice?
12 MS. PRATT: Yes, I think we can — based on
13 the current structure of the information that has to
14 be provided, there are protocols in place, and computer
15 systems that require that information. So, I think
16 there's a way to beef that up, but I don't think it takes
17 a fundamental revolution in terms of making that
18 happen.
19 COMMISSIONER ACHTENBERG: Thank you. Mr.
20 Vera.
21 MR. VERA: Can I add to that? Again, given
22 the constraints of your question, I would point this
23 Commission to Code of Federal Regulation 42 Section
24 482.43, and that CFR requires under — it's the
25 implementing regulation for EMTALA — requires

1 hospitals to not only treat their homeless but have
2 developed appropriate discharge policies particular to
3 that population.
4 I don't know if it's happening, although
5 I suspect based on the earlier panel that it's not, I
6 don't know whether those discharge policies are being
7 transmitted to the regulators, whether they're being
8 reviewed, whether they're being compared. I mean, we've
9 seen discharge policies on two pages. Who's looking at
10 that? Is that correspondence going to the hospital
11 saying this is Joe. It doesn't sound like that's going
12 on, and I — based on what I heard I think that that's
13 well within the authority of the regulators to do now.
14 So, I think that's one place where there is already a
15 requirement to have the discharge protocols, but in our
16 experience on the ground many of them are woefully
17 deficient, and given existing authority they could be
18 made better with some review.
19 CHAIRMAN CASTRO: Madam Staff Director.
20 MS. SALLO: So, everyone keeps referring to
21 the after-care planning, and I'm assuming that, with
22 after-care planning, referrals to community mental
23 health services would fall under that?
24 MS. PRATT: Yes.
25 MS. SALLO: So, my question from a data

1 collection viewpoint is, are we keeping track of
2 referrals to community mental health centers, and
3 whether those centers are denying acceptance of these
4 patients for services? And at the same time, if I'm
5 homeless and I'm referred to a community mental health
6 center, and I don't have like a stable home and a place
7 to receive the mail and/or a phone, how do I even access
8 those services, which to me just means that it's all
9 around a very dysfunctional system.
10 MS. PRATT: Absolutely. I think that there
11 is a requirement to provide those services under the
12 implementing regulations. That is a given. The problem
13 is implementation and oversight of implementation.
14 What we see is that, in fact, those services are not
15 being provided, and that there is no real consequence
16 for that. You know, penalties are rare, decertification
17 almost never takes place, so what's left? You know,
18 what's going to happen to give people a real incentive
19 not to do that? You have to get into the weeds and
20 actually say it's not enough to have a discharge policy
21 on paper, we want to see are you implementing it. Do
22 you or your social workers really call and find out if
23 there's a bed, notate that, name the person, name the
24 time, name the place. It's a blank field in the ones
25 that we have reviewed.

1 COMMISSIONER KLADNEY: So, what you're
2 saying, basically, is you think that CMS ought to be
3 doing investigations not just on complaints but
4 actually initiating investigation — not an
5 investigation but an audit or a survey on their own.
6 MS. PRATT: I think they need to be
7 proactive. I think that that's their role in making sure
8 that EMTALA is meaningful, that they need to initiate
9 those types of investigations and oversight efforts to
10 insure something happens.
11 COMMISSIONER KLADNEY: And I wonder if Ms.
12 Preston or Ms. Greenwood would agree with you?
13 MS. PRATT: I doubt it.
14 (Laughter.)
15 MS. PRESTON: I mean, let's be realistic.
16 I mean, we are dealing with limited funds for everybody,
17 so if you're talking about targeted investigations,
18 you're talking about money that's being well spent,
19 potentially. But if you're talking about surveillance,
20 then you really have to decide where you can spend the
21 funds, and that goes for hospitals as well as for CMS.
22 So, in an environment that we live in currently where
23 there are limited funds, how best to use those funds
24 to make sure that you get the biggest bang out of them.
25 So, respectfully, I think if you are going to do

1 something like Ms. Pratt is suggesting, it's going to
2 drain both the surveillance, CMS's funds, as well as
3 the hospital funds.
4 (Off microphone comment.)
5 MS. PRATT: Yes, my idea is this, that there
6 should be an escalation in the imposition of fines for
7 bad actors, and that money goes into a pool to fund the
8 investigation. I mean, that —
9 (Off microphone comment.)
10 MS. PRATT: They are involved with that. I
11 mean, there is a — I think most hospitals —
12 COMMISSIONER KLADNEY: Oh, I have to ask the
13 question again? I forgot what it was. Pardon?
14 (Off microphone comment.)
15 COMMISSIONER KLADNEY: Thank you very much,
16 Ms. Greenwood. Yes, should they?
17 MS. GREENWOOD: They do. Let's make sure we
18 understand all the different regulatory schemes that
19 are available right now for enforcement. And this is
20 why I keep saying statutes, and regulations, and
21 enforcement is not always the answer. We've got tons
22 of statutes out there to regulate the stuff.
23 First of all, in order to be a hospital in
24 most states, I'm assuming all states, you have to be
25 licensed by the state. They have their own set of rules

1 and regulations that you have to comply with. You are
2 subject to inspection on annual to tri-annual basis so
3 you're subject to those. You can be kicked out of your
4 licensure, you can be fined and penalized for those.
5 Secondly, you get your Medicare and your Medicaid
6 certifications. That's your CMS Conditions of
7 Participation. They have nothing to do with the EMTALA
8 rules. There's a Condition of Participation that
9 relates to emergency services. There's another one that
10 relates to discharge planning. Hospitals under
11 accreditation by Joint Commission or DMV, they have
12 dean status and they are surveyed one to three years
13 for those kinds of things. Then you have EMTALA on top
14 of that. Then you have medical malpractice liability
15 and negligence. And believe it or not, health care
16 professionals really do go into the practice of health
17 care wanting to treat patients. The problem is
18 resources, the problem is funding. And I promise you,
19 if you follow the money, quit worrying about the
20 regulatory scheme, if you educate and follow the money
21 you will solve this problem, making sure that we don't
22 create for mentally ill in this country even more bad
23 feelings about them as individuals.
24 Now, remember I started this by saying I
25 have a very personal reason for wanting you to be

1 careful about unintended consequences. I live with
2 daily how people look at mental health patients in this
3 country. I hear it, I see it in my training, and I'm
4 telling you if you come down heavy-handed on this, you
5 will create a very adverse situation for mental health.
6 Educate, research, train, and fund if you really want
7 to help the mentally ill in this country.
8 CHAIRMAN CASTRO: I'll give it back to the
9 Staff Director. She did have a follow-up question after
10 her first one.
11 MS. SALLO: We've mentioned data
12 collection, so I guess for my own working knowledge,
13 which laws or regs require this data collection to
14 occur, and what type of data collection must occur?
15 Because I've heard that surveys are done based on
16 complaints filed, but I would like to get a better
17 picture as to where the data is coming from and where
18 the requirements are coming from.
19 MS. PRATT: From what I can see, the CMS
20 operations manual that is provided to the hospitals and
21 the state survey agencies details the type of
22 information that's required. And a lot of times those
23 are through the technical agreements and the technical
24 requirements of that relationship.
25 What we believe is that there is an

1 opportunity to increase that. And I think when we're
2 talking about data, when we're talking about
3 circumstances, I think we need to be mindful of this
4 reality. You know, there have been times in our
5 country's history when we have legislated against
6 discrimination. And we've done so because we don't
7 believe that private actors on their own can handle
8 these issues. It's been true on racial issues, it's been
9 true on issues related to sex discrimination. And often
10 the response to that has been no, no, no, don't talk
11 about that. That's stigmatizing. I think we live in a
12 system that's stigmatizing, and in order to respond to
13 that we have to be willing to increase our regulatory
14 oversight.
15 I don't think change always happens on its
16 own, particularly when you deal with vulnerable
17 populations, when you deal with folks who are homeless
18 and mentally ill. Yes, there are many people who regard
19 individuals in that situation with contempt. And I'm
20 sad to say it can include health care professionals.
21 And the reality is there are times when folks are in
22 a situation where they do not stabilize patients, and
23 they throw them away to the street. And I think that's
24 something we have to be very mindful of.
25 CHAIRMAN CASTRO: I have a question. Mr.

1 Vera, actually, I know you all said there's not a lot
2 of data out there, but I was curious to see that the
3 patients that you highlighted in your presentation both
4 have Hispanic surnames. I don't know to what extent
5 there's any data that's collected on whether you see
6 a disparate impact on people of color, in particular,
7 Latinos. Obviously, it could be that Latinos are
8 over-represented in that geographic area, but anything
9 on that aspect of this?
10 MR. VERA: You know, we've seen it — thank
11 you, Mr. Chair. We have seen it in Los Angeles just
12 because of the demographics, but I think my hunch would
13 be that this affects the homeless at large in all its
14 demographics, and I think it's — so my hunch would be
15 that it affects all of them. In areas where there are
16 predominantly Latino, you are going to see more. Many
17 of our clients have been like Gabino Olivera, but I
18 think it's going to affect everyone. And I think to the
19 extent that we can get data, that would be great, but
20 it affects everyone equally. And I agree with Ms. Pratt
21 that if we can shine a light on this a little bit more
22 and get the information — if it had to be reported, if
23 public officials, prosecutors, advocates could have
24 access to the information about where were people left,
25 where? Right? I mean, give us the address. That, I

1 think, on its own would go pretty darned far.

2 CHAIRMAN CASTRO: So, basically, you're

3 saying Patient Dumping is an equal opportunity

4 violation.

5 MR. VERA: Yes.

6 CHAIRMAN CASTRO: Yes, that's unfortunate.

7 Also in the prior panel, I asked the panelists about

8 the issue of medical repatriation, international

9 repatriation, sending immigrants, particularly

10 undocumented, but sometimes documented immigrants back

11 to their home country where they are no longer

12 stabilized, no longer able to be cared for and many die.

13 Do any of you have any information on that issue, or

14 that topic?

15 MS. GREENWOOD: I do not. I've never

16 represented any case that involved that.

17 MS. PRATT: I can't speak specifically to

18 that situation, but sadly it would not surprise me given

19 the practices that we've seen in Nevada in relationship

20 to the treatment of individuals who are undocumented.

21 Unfortunately, and we're in proximity to Arizona where

22 there are also similar issues, so I don't know for a

23 fact, but it's something I'd be happy to investigate.

24 CHAIRMAN CASTRO: Thank you. Yes, Mr. Vera?

25 MR. VERA: All I would add on that, Mr.

1 Chair, is that there's pending litigation in the
2 Central District of California that we're a part of,
3 and the ACLU, as well, involving undocumented immigrant
4 detainees who lack mental capacity, so they have
5 significant, severe mental health issues to the extent
6 that they lack capacity. We're litigating the right to
7 counsel, and they raise it because even with orders,
8 even with the light of all that we're still seeing
9 significant deportation of clients with significant
10 mental illness and other medical conditions. So, it's
11 not the medical repatriation by hospitals, but it's our
12 government sending people back who they know have
13 significant mental health needs, who have — well, all
14 kinds of conditions that prevent them from really
15 lacking capacity, and they're being deported every day.
16 That's what we're litigating.
17 CHAIRMAN CASTRO: Thank you, Mr. Vera. Any
18 other questions from Commissioners?
19 COMMISSIONER YAKI: I have —
20 CHAIRMAN CASTRO: Commissioner Yaki?
21 COMMISSIONER YAKI: Yes. Thank you very
22 much, Mr. Chairman.
23 CHAIRMAN CASTRO: Go ahead.
24 COMMISSIONER YAKI: Again, just a
25 follow-up. I talked briefly about resources. I just

1 want to hark back on it a little bit. To what extent
2 do we see the institutions that are doing something as
3 sort of classic private nonprofit versus
4 county-operated? Is there any distinction between
5 whether they're a disproportionate share of hospitals
6 or not? And then finally, is there any, I guess,
7 aggressive outreach by you and by all of your
8 organizations to get each of these individuals signed
9 up under the Affordable Care Act, whether or not that
10 might have an impact or incentive for some of these
11 institutions to provide proper treatment for them,
12 given the fact that they may actually now be in the
13 insured rather than the uninsured column?
14 CHAIRMAN CASTRO: Anybody?
15 MS. PRATT: I guess I can respond at least
16 to the second half of your question in that I think one
17 thing that would certainly help address part of this
18 problem is making sure that psychiatric hospitals have
19 on staff individuals whose job it is to facilitate the
20 access of homeless individuals to social revenue
21 streams. I think many times folks come into the ER and
22 they may be in a situation where they could access some
23 of those systems, but they're homeless, they're
24 mentally ill, so it could be difficult for them to
25 actually achieve that. So, I would recommend that that

1 be part of the mandate that psychiatric hospitals have.
2 In our case, we were dealing with a
3 situation where we had a hospital that was run through
4 the county and the state so, you know, I can only speak
5 to that circumstance. I don't know, Mr. Vera, if you
6 have —
7 MR. VERA: One other idea or development
8 that's come through the symposium on some of the best
9 practices, many hospitals are trying to coordinate
10 electronic records that really could help our delivery
11 of services to the homeless because if someone comes
12 in and the doctor has no idea what's been — what
13 medications were given before, what other treatment was
14 given, where they stayed. And you can imagine a
15 situation where if you had all that information at your
16 fingertips social workers could make better decisions,
17 doctors could make better decisions. So, I think that
18 that's one development that we're excited about that
19 could really assist the discharge policies being more
20 robust, being better and be more successful.
21 MS. GREENWOOD: We have also seen
22 demonstration programs in my state, and I'll focus back
23 on this. They're trying to make sure that patients upon
24 discharge from state hospitals, particularly the
25 hospital in Savannah, that they had a meaningful day,

1 adequate treatment, and safe housing. They were paired
2 with social workers at discharge, and they were trying
3 to seek a Medicaid code in order to have this reimbursed
4 so they could be followed so they had some sort of
5 support system.

6 To me, the problem with homelessness is
7 finding safe housing, and making sure that they feel
8 supported so that they stay under safe care of having
9 a home. And I — you know, that's just hard. It's hard
10 to follow these patients upon discharge, and that's why
11 I feel like, you know, really if we want to effect change
12 we've really got to study the issue. We've got to figure
13 out at a community level what do we need to support these
14 patients? Rather than just more and more legislation,
15 let's figure out what we really need. Spend that money
16 on looking at the problems, at the root causes down at
17 the community level, you know, how are these patients
18 being supported when they're discharged from
19 hospitals?

20 CHAIRMAN CASTRO: We have one minute left
21 so, Madam Staff Director, I know you have a final
22 question.

23 MS. SALLO: Real quick. Based on the
24 comments that were just made, health care advocates,
25 do the hospitals have health care advocates that can

1 step in and work with the patients prior to discharge,
2 or upon discharge?
3 MS. GREENWOOD: Hospitals typically have,
4 you know, social workers and discharge planners.
5 Pursuant to the Conditions of Participation they're
6 required to have appropriate discharge planning. If
7 they don't they technically could be charged with a
8 standard or condition level of deficiency which could
9 lead to termination and other issues.
10 How — do they have someone to follow
11 post-discharge? I'm not aware of anything. I think some
12 communities have programs set up like that, but I would
13 say that's probably the exception rather than the rule.
14 I don't have any statistical data for you, though.
15 MS. SALLO: Thank you.
16 MS. PRESTON: I think some hospitals, for
17 example, in downtown Baltimore have aligned themselves
18 with Community ACT teams which sort of are the
19 transitional providers between acute care facilities
20 and outpatient. And, unfortunately — and it's not — you
21 know, it's been labeled a very expensive alternative
22 to providing care. It's not. It's about $1,100 per
23 patient a month, and there are two community assertive
24 active teams in Baltimore serving a population of
25 almost a million, so that is one way the state,

1 particularly, could, and counties could particularly
2 bridge that gap, which I think some of the teaching
3 hospitals have availed themselves of.
4 MS. PRATT: In the State of Nevada there was
5 a social worker on staff but who failed to engage in
6 the discharge planning. And states have failed to
7 invest in mental health care, as well, you know,
8 reducing those commitments. I would just say that I
9 think it's time to pay to fix the problem, not study
10 the problem.
11 CHAIRMAN CASTRO: Commissioner Kladney has
12 asked for one last question —
13 COMMISSIONER KLADNEY: To be brief —
14 (Simultaneous speech.)
15 CHAIRMAN CASTRO: — I'm being
16 magnanimous, go ahead.
17 COMMISSIONER KLADNEY: True, true, really
18 brief. The Director's question got this in my head.
19 Actually, I had it written down. I just didn't know if
20 I had time to ask it. And this doesn't just deal with
21 mental health patients. This deals with all sorts of
22 patients that are in the ER, in the hospital or in pain,
23 they have issues, they can't think straight. Are there
24 patient advocates? Is that a good idea for the ERs that
25 there be patient advocates to help them make decisions

1 in regards to medical care, or discharge, or things like
2 that? And you can come right down the line because I
3 know poor Ms. Preston hasn't hardly said anything to
4 me.
5 MS. PRESTON: I guess it would depend on
6 state by state who is alternative decision maker for
7 the patient, and that would really — in Maryland
8 there's a hierarchy of people who can make decisions,
9 and in the absence of a spouse, you know, children, et
10 cetera, et cetera, they might — but that would be very,
11 I think, difficult to implement nationwide and even
12 statewide.
13 MS. PRATT: I think when you look at the
14 issue of the ability to provide knowing and informed
15 consent, I think that that's one where this issue
16 arises, particularly when we hear stories where they
17 say that an individual patient consented to discharge.
18 I don't think that's meaningful if you have someone who
19 has an acute psychosis going on, or is struggling with
20 other issues. So, I think the more social service help
21 you can provide to the individual the better, so having
22 a patient advocate with the appropriate understanding
23 can be very helpful.
24 MS. GREENWOOD: I don't disagree, and I
25 think that's a good idea. If you're talking about

1 advocate in the sense of someone who could help, I think
2 that exists in a lot of hospitals, they're called social
3 workers and discharge planners. But I would be in
4 support of having advocates post-discharge, you know,
5 where they could follow the patient, make sure they're
6 getting everything they need from housing to treatment,
7 and have a meaningful day. And if you can find ways to
8 get that reimbursed as a professional service through
9 Medicaid or whatever programs, I think that that would
10 greatly reduce the diving into the deep end that we see
11 of mental health patients. We call it the deep end of
12 our jails, our city parks, and our hospital EDs, and
13 we're trying to avoid those deep ends. So, I think in
14 order to do that — I also think we need better
15 communication between our police. There needs to be a
16 data bank to be able to track individuals on the streets
17 for our first responders. And rather than maybe taking
18 them to an ED setting, perhaps they need to go to a
19 crisis intervention system, or go to that patient
20 advocate to see what's going on with that patient.
21 Opening Doors to Recovery was a
22 demonstration project done out of the Savannah Regional
23 Hospital. You might want to look at results. I don't
24 have the results of that. It's called Opening Doors to
25 Recovery. It was sponsored by NAMI Georgia. And you

1 might want to look at — I don't know what the results
2 were of that, but they basically put advocates upon
3 discharge of 100 mental health patients discharged from
4 the state hospital there. It might be a good — I think
5 that we — when I say research I don't mean — I just think
6 we need to look at the demonstration projects that have
7 been — in some sort of systemic way, some sort of plan
8 and organize way and figure out hey, what was working
9 and what wasn't, and in which states have we broken?
10 Is it just Nevada, or is it everybody that's broken?
11 From what I'm seeing a lot of people are broken, and
12 I don't disagree, don't spend a whole lot of time fiddle
13 faddling around researching it. Get the money in the
14 community level to get the treatment to the patients
15 that's needed.
16 MR. VERA: Briefly, one other model that
17 works and is a growing movement is called Medical/Legal
18 Partnerships. And the idea is to embed attorneys and
19 social workers but from nonprofits in the facilities
20 so that they can help the patients access, and not just
21 the homeless but access their other rights, whether
22 they have habitability issues in their units as
23 tenants, or education issues that affect their health.
24 We have two attorneys, for example, sited
25 at medical facilities and those are paid for by federal

1 funds that flow through contracts to us. So, yes, there
2 are models like that to embed neutral third-party
3 advocates to say hey, you know what, we can do an SSI
4 application for you on this, or you know what, we'll
5 find something in conjunction with the social worker
6 on staff. But it does cost money.
7 CHAIRMAN CASTRO: Commissioner Achtenberg
8 has asked for a question, and that will be the last
9 question. I really mean it.
10 COMMISSIONER ACHTENBERG: Just very
11 briefly, what use can we put technology to to ascertain
12 compliance with all the regulations and specifications
13 that already exist? And whoever has thought about this,
14 please respond.
15 MS. PRATT: I think the current reporting
16 structure for regional offices and for the individual
17 facilities requires data transfers on a periodic basis.
18 That already exists, that already happens. That's the
19 kind of technology you can also use to have an automatic
20 download of the after-care planning fields. Those are
21 the fields we're talking about, did you call for a
22 shelter, did you find out if they are eligible for SSI?
23 I think having a data trigger, if these
24 fields are empty, or if they appear to only have cursory
25 information, that should trigger a flag. And that flag

1 should say we need some proactive oversight here.
2 Something is happening, so I think that's within the
3 stream of the current technology. Those downloads take
4 place currently on a regular basis. Let's just make sure
5 those fields are comprehensive, meaningful, and not
6 cursory. So, I think we can use the technology we have
7 to provide that from that piece of the reporting aspect
8 of it.
9 CHAIRMAN CASTRO: Okay, thank you. We're
10 going to wrap it up at this point. I'm sorry. We do want
11 to get the other panel in here and give them their fair
12 share of time. So, thank each of you for your time. We
13 appreciate it very much, very informative. And we can
14 ask the third panel to begin to come up to the podium,
15 please.
16 (Whereupon, the proceedings went off the
17 record at 11:56 a.m., and went back on the record at
18 12:01 p.m.)
19 CHAIRMAN CASTRO: All right. We're going to
20 resume now with our final panel. First of all, I'd like
21 to introduce each of our panelists. Our first panelist
22 is Katharine Van Tassel, a law professor at the
23 University of Akron Law School. I understand that your
24 flight yesterday got cancelled and you came in on a
25 redeye this morning. We really appreciate that going

1 above and beyond; Dr. Richard Elliott, Professor and
2 Director of Ethics at Mercer University School of
3 Medicine and Law, as well as our third and final
4 panelist, Dr. Brent Myers of the University of North
5 Carolina School of Medicine.
6 I'll ask each of you to raise your right
7 hand and swear or affirm that the information that you
8 are about to provide us is true and accurate to the best
9 of your knowledge and belief. Is that true?
10 (Witnesses sworn.)
11 CHAIRMAN CASTRO: Okay. Please proceed, Ms.
12 Van Tassel. And could you speak into your microphone?
13 Is it on? Just push the little green button.
14 MS. VAN TASSEL: Okay, how is that, better?
15 CHAIRMAN CASTRO: Good.
16 MS. VAN TASSEL: Okay.
17 **IV. PANEL III - SCHOLAR PANEL**
18 MS. VAN TASSEL: Thank you, Chair Castro and
19 Commissioners for the opportunity to speak to you
20 today. I applaud the Commissioners for taking up the
21 complex question of the effectiveness of the Emergency
22 Medical Treatment and Labor Act, also known as EMTALA.
23 I share your goal of improving the quality of access
24 to emergency medical treatment for all people,
25 including those with mental health disabilities.

1 As you know, the legal system often lags
2 behind scientific development, sometimes by decades.
3 Unfortunately, EMTALA has proven to follow this general
4 rule. In the three decades since EMTALA's passage in
5 1986, health care delivery has changed dramatically
6 with stunning advances in medical science and the
7 advent of major national movements towards
8 evidence-based medical care and systems-based quality
9 improvement. These sweeping changes have left EMTALA
10 far behind, so far out of touch with current practice
11 that it is now harming rather than helping the cause
12 of equal access to emergency care.
13 In my oral statement today and in my far
14 more detailed written statement, I suggest that EMTALA
15 be modernized by moving disparity reduction efforts
16 from the sole domain of EMTALA in the civil rights arena
17 into an alternative but coexisting and complementary
18 world of health care quality regulation and continuous
19 quality improvement.
20 The failure to modernize EMTALA has had
21 three serious consequences. First, EMTALA ignores many
22 disparities in emergency treatment rather than erasing
23 them. Second, it discourages the adoption of written
24 protocols based upon best practices relied upon by
25 modern medical practice. And, third, it allows the

1 introduction of bias and stereotypes and treatment
2 choices that can be particularly harmful to those with
3 mental health disabilities. All three of these problems
4 can be traced back to EMTALA's outdated link with the
5 customary care model of medical practice.
6 With regard to the first serious
7 consequence, why does this out-of-date link to
8 customary care model of medical practice result in the
9 laws ignoring disparities rather than eliminating
10 them? The simple answer is that the very nature of the
11 customary care model allows for disparate treatment of
12 patients.
13 So, what is customary care? As a general
14 matter, customary care is subjective and is based upon
15 the practice style of particular physicians based upon
16 tradition or personal clinical experience and not on
17 objective scientific evidence.
18 The best way to explain what customary care
19 is is to explain what it is not. It is not evidence-based
20 care. Evidence-based treatment choices are grounded in
21 empirical data generated by clinical outcomes and
22 effectiveness research. This empirical data suggests
23 the optimum treatment for a rapidly growing number of
24 clinical conditions, and is used to create written
25 clinical practice guidelines or best practices.

1 The problem is that, in the absence of
2 written protocols based upon clinical practice
3 guidelines, treatment choices for the same condition
4 can vary widely among physicians. Importantly, these
5 differences in treatment choices often occur among
6 physicians within the same hospital.
7 For example, while many physicians provide
8 a simple aspirin within 24 hours of a heart attack to
9 decrease mortality by 30 percent, many still do not
10 provide this simple, inexpensive lifesaving treatment.
11 To avoid the disparate emergency treatment
12 of those with mental health disabilities under
13 customary care practices and to encourage the uniform
14 use of best practices, several major physician and
15 nursing organizations recently joined together with
16 the American Academy of Emergency Medicine to recommend
17 the adoption of the Emergency Care Psychiatric Clinical
18 Framework. This framework advocates the adoption of
19 treatment protocols based on clinical practice
20 guidelines for the emergency treatment of those with
21 mental health disabilities.
22 The adoption of written protocols based on
23 best practices seems just plain common sense, so why
24 isn't it happening? This brings us to the second
25 serious consequence of EMTALA's problematic link to

1 customary care treatment choices, the creation of a
2 major roadblock to the adoption of written protocols
3 that could reduce treatment disparities and result in
4 better outcomes.
5 Currently, most EMTALA cases, I'm talking
6 on the civil side, never reach the merits as they're
7 being dismissed on summary judgment. This dismissal of
8 EMTALA cases based on procedural grounds is made
9 possible by the broad range of possible treatment
10 choices that the customary care model of medical
11 practice allows. Adopting written protocols would
12 seriously limit the use of this procedural strategy;
13 thus, the current system disincentivizes the use of,
14 and the adoption of, written protocols that could go
15 a long way to erasing disparate treatment.
16 Finally, with regard to the third serious
17 consequence, how does EMTALA's outmoded link to the
18 customary care treatment model allow for the use of bias
19 and stereotyping in making treatment care choices?
20 Well, because physicians are human, and like all human
21 beings they have unconscious biases and stereotypes
22 that have been created by their own personal life
23 experiences.
24 The studies are clear that these
25 unconscious biases and stereotypes can influence

1 physician judgments about patient suitability for
2 particular tests, procedures, and treatments. The use
3 of stereotyping or bias is particularly problematic
4 with those who suffer from mental health conditions.
5 Identifying emergency physical conditions
6 in those who are also suffering from psychiatric crises
7 is very difficult because these conditions are often
8 hidden behind the presenting psychiatric condition.
9 Without written protocols these bias and stereotypes
10 can distract a physician from investigating a physical
11 condition that may be triggering the psychiatric
12 emergency.
13 I suggest the root cause of disparate
14 treatment that comes from unconscious bias or
15 stereotypes is another form of human error. To reduce
16 human error and to encourage the use of written
17 protocols and checklists, I suggest the adoption of a
18 cross systems reform approach that will move disparity
19 reduction efforts from the sole domain of EMTALA and
20 civil rights into an alternative, and, as I said,
21 complementary world of health care quality regulation
22 and continuous quality improvement.
23 My proposal involves just two simple
24 steps. EMTALA should be modified to require that proof
25 of equal treatment is based on written protocols. At

1 the same time, the regulations for the Centers of
2 Medicare and Medicaid Services should be modified to
3 require that these written protocols be based on
4 evidence-based best practices. This solution allows
5 the courts to focus on equality and CMS to focus on
6 quality. This solution facilitates the use of data
7 collected under the Affordable Care Act provisions to
8 track the outcomes of these written protocols in order
9 to continuously improve them to increase quality and
10 decrease disparities.
11 This simple approach is also
12 forward-thinking in that it allows EMTALA to evolve and
13 work hand-in-hand with scientific advances in medical
14 care. Of note, in the near future, based on personalized
15 medicine, equal care will mean different care for each
16 individual based on each individual's unique genetic,
17 epigenetic, and microbiome profile. My suggested
18 changes would facilitate our progress to this
19 personalized medicine idea. Thank you very much.
20 CHAIRMAN CASTRO: Thank you, Professor. Dr.
21 Elliott.
22 DR. ELLIOTT: Thank you, and I certainly
23 agree that we — thank you, Dr. Myers. We have a lot of
24 biases we bring to our practices, and if we can
25 eliminate some of those and look at the real evidence

1 we're all going to be a lot better off.
2 And I apologize to Rorey Smith for a second
3 here because, after sending him far too many copies of
4 my statement, I'm going to throw it out and just speak
5 from a few notes. But I've heard so many wonderful
6 things, it's been a wonderful opportunity, in the hope
7 that maybe we can get something done about this, but
8 also it's just been a pleasure listening to all these
9 speakers. And I've learned a lot here, so I'm very
10 grateful to you for having this hearing. Thank you.
11 I was on KNPR out of Las Vegas a few weeks
12 ago. They'd heard about this hearing, and they looked
13 up the speakers, and I must have been at the bottom of
14 the list but they ended up calling me. And on this panel
15 they had a social worker from a homeless shelter in Las
16 Vegas who's been part of this discharge problem they've
17 had, and she described a number of patients. One she
18 described, well several, they came to the shelter being
19 discharged from the hospital still wearing hospital
20 gowns, being unable to bathe themselves, clothe
21 themselves. In some ways this is even worse than the
22 busing problem. These people are being discharged in
23 pretty much a hospitalized condition. And, of course,
24 there's all these reports of people being put on buses
25 and sent to other states, and it just made me think we're

1 here not only to look at the civil rights of patients,
2 protecting patients, but also our public agencies,
3 they're entrusted with looking after our safety, too.
4 And to what extent have they violated this in
5 discharging people to the streets who are in such poor
6 condition, they're in hospital gowns and can't bathe
7 themselves, can't take medication.

8 And I want to echo something Mr. Vera said
9 a few minutes ago. I work sometimes in public clinics
10 in Phoenix, and it is a regular situation there that
11 patients will show up to my office just discharged from
12 a hospital without a bit of paperwork. Now, they're not
13 in hospital gowns but I have no idea what's happened
14 to them in the hospital. Were there any behaviors
15 dangerous to themselves or others? What medications are
16 they on? I have no information. I'm supposed to provide
17 care, and I think Mr. Vera noted that as one of the
18 breakdowns in our system. And I see it every day out
19 there. And it's a fine system, and it's no individual
20 fault, but it's just a breakdown in the system.

21 Now, my exposure to EMTALA came some years
22 ago when I was CEO at a hospital, and you're going to
23 love this, Dr. Myers. They transported a dead person
24 from a hospital 100 miles away because this person had
25 died of AIDS, and this was back in the days when dying

1 of AIDS was pretty stigmatizing. And they didn’t want
2 that because they’d never had a patient with AIDS in
3 their hospital. That was their story. So, this patient
4 died and they sent him to our hospital, and we were
5 supposed to pronounce him dead. That way this death from
6 AIDS would be recorded on our books and not theirs.
7 And I was new at the hospital, and I was
8 kind of surprised, and then I found a number of patients
9 being sent to us in short order with no mental illness.
10 They were sent there because they needed medical
11 treatment. They were poor, and they couldn’t afford it,
12 so they’d send them to us. They needed dialysis, or
13 their diabetes is out of control. We’d look at them and
14 say oh, this person shouldn’t be here. We’d send them
15 back to the hospital, and guess what, we paid the bills.
16 So, we saw a number of what we would consider EMTALA
17 violations. These hospitals had sent them to us, hadn’t
18 accurately described their conditions, and we had to
19 send them back at our cost. And that got me interested
20 in this area, actually got me pretty angry about it,
21 that these patients are being shifted back and forth
22 and without any regard for their participation, their
23 rights, or their autonomy.
24 I teach Ethics. I think I’ve written in
25 here somewhere about the violations of the Principles

1 of Medical Ethics and how they're violated. I don't know
2 that I want to go over all that right now. It's written
3 in here, I'll be glad to answer any questions about that
4 if you have them. But I do want to address something
5 else.
6 Another comment one of our panelists made
7 was about it really isn't about bad apples, about this
8 dumping problem, whether it's from communities into
9 — from hospitals into communities, or from one hospital
10 into another. It's not so much about bad apples. And
11 it's not just about insufficient funding. There sure
12 isn't enough funding in the system, we need it. But
13 somebody else briefly mentioned, and I wanted to
14 reinforce, it's perverse economic incentives. It's the
15 way things are funded, so we're siloed, we're bunkered,
16 or whatever the latest jargon for this is. Every
17 agency's got its own budget, and they're trying to do
18 the best they can with this budget, and so not only are
19 they supposed to look after patients, they've got to
20 protect their slice of the pie, too.
21 They all say oh, you can't do good until
22 you do well, meaning we have to keep our financial
23 viability going. Well, that's true. Well, one of the
24 things we can do, and there are models around the
25 country for doing this, is to find a way to link the

1 financial interests of agencies so they can provide
2 better care from a pot of money where they all benefit
3 when patients do well overall, and not just do well in
4 the hospital, or do well in the clinic. And that's one
5 of the solutions out there that doesn't require more
6 money. And Commissioner Achtenberg gave that nice
7 question about if you didn't have any more money in the
8 system, what would you do? Well, probably not going to
9 get more money in most cases, but I would redirect it
10 to change the financial incentive so that there is a
11 more cooperative environment to link services so that
12 patients benefit from an overall system of care, and
13 not these current non-systems that we seem to have.
14 And I just want to close, everybody's been
15 calling for more studies, and I agree. I mean, how can
16 you argue against more studies? I'm a teacher and I'm
17 supposed to be in favor of that. But one of the things
18 I hope that we get from this, not just more data that
19 tells us how bad the problem is, or where the problems
20 are, but to identify more of these model programs. And
21 I think another panel member mentioned the ACT,
22 Assertive Community Treatment program. That's just one
23 example of a model program that can reduce emergency
24 room crowding, provide better care for patients, and
25 is either revenue-neutral or sometimes decreases

1 overall cost to the systems with these innovative
2 programs. So, yes, I think more study, but with partly
3 the goal to identify model programs. I thank you very
4 much for your time.
5 CHAIRMAN CASTRO: Thank you, Dr. Elliott.
6 Dr. Myers.
7 DR. MYERS: Thank you. Good afternoon, and
8 thank you very much for the invitation. I do have to
9 say that as a native North Carolinian you know this is
10 important to me because the ACC tournament just started
11 15 minutes ago, and we are still sitting here.
12 CHAIRMAN CASTRO: And you're not going to
13 have good video capabilities here.
14 DR. MYERS: If we could go to the next slide,
15 please. I just have one disclosure. I will be citing
16 a paper in my written comments for which I'm a founding
17 co-editor, and I just want to put that potential
18 conflict up. We can go to the next slide now.
19 Good afternoon. I speak both as a Board
20 Certified Emergency Physician, as well as a
21 Subspecialty Board Certified Physician in Emergency
22 Medical Services. And from that, I come with two
23 perspectives. From the in-hospital perspective, I will
24 refer to what I call the traditional EMTALA
25 perspective. I stand on the inside at the hospital and

1 look into the community. And from that perspective we
2 function very well for the trauma patient, and for the
3 heart attack patient, and for the OB patient. The
4 EMTALA-covered care functions seamlessly.
5 Yet, when the patient with mental health
6 or substance abuse crosses those magic sliding glass
7 doors into my emergency department, I have nothing to
8 offer. I have no inpatient psychiatric bed, I have no
9 psychiatrist who can come see the patient in the
10 hospital, and they are boarded. They're in my hospital
11 for an average of about 14 hours with just a sitter at
12 their side for every mental health patient that
13 arrives. And that cuts the number short, with all due
14 respect to our first panelist, those patients are
15 admitted to my hospital to a medicine service with no
16 psychiatrist available while we are waiting on
17 placement into a mental health facility.
18 A shift two weeks ago when I went into my
19 facility there were — I have 14 beds in my area of the
20 emergency department, seven of them were occupied with
21 mental health hold patients waiting to go somewhere
22 besides there, which again was impeding care outside
23 for others.
24 My perspective as an EMS physician is
25 somewhat different. I sit in the community and look out

1 for all of the possible avenues of care for those
2 patients. As our subspecialty has developed, this has
3 become referred to as the Mobile Integrated Health Care
4 Practice. In other words, we are no longer reflecting
5 back to our history of EMS, which is where we began.
6 Right? We began in the 1970s to respond to traffic
7 accidents, and as such we are still, from the federal
8 perspective, a transportation benefit. We are
9 reimbursed to take patients to hospitals, specifically
10 to Medicare-receiving general hospitals with emergency
11 departments. And if we go elsewhere we have no
12 reimbursement at all from the EMS perspective, so
13 speaking of an alignment of incentive, we have an
14 overcrowded emergency department, and the only way my
15 EMS system can recoup costs is to continue taking
16 patients there whether they may need to go there or not.
17 Indeed, 5 to 10 percent of the entire U.S.
18 population accesses health care through the EMS system
19 every year. This is no longer a trauma response, this
20 is an access to health care, and particularly an access
21 to health care for those who are otherwise
22 disenfranchised. So, there are many that are now
23 calling for us to move away from the colloquial "You
24 call, we haul, that's all" philosophy, which is how EMS
25 has come to be known, and move more toward moving

1 patients to an appropriate locus of care, be that
2 primary care, be that a mental health facility, be that
3 telemedicine, be that home health, or any other
4 patient-centered approach.
5 Thus, my experience from within the
6 EMTALA-governed facility says that we are holding
7 patients based on EMTALA rules without providing
8 appropriate care; whereas, my experience outside says
9 there's more appropriate loci of care in the community
10 to which we can refer these patients. So, from this we
11 have a novel program, an advanced practice paramedic
12 program where these patients then are screened in the
13 out-of-hospital setting, and we determine the
14 appropriate locus of care and offer treatment options
15 to the patients.
16 This program was recently highlighted in
17 the New York Times, and will soon be presented at the
18 Society of Academic Emergency Medicine in Dallas in May
19 of this year, and I will take this opportunity to
20 briefly highlight this initiative. Unfortunately, I
21 think my Apple to Microsoft thing has not done well with
22 the slide, so I have hard copies of the actual
23 protocols.
24 Our program involves several reproducible
25 protocol-driven evaluation steps. Before I go into

1 details, I just want to go over a few introductory
2 remarks regarding our governance and philosophy. All
3 of the treatment protocols and evaluations go through
4 three levels of review prior to implementation. The
5 program is reviewed by the Deputy Medical Director and
6 myself. It is then reviewed by our Community Impact
7 Board which is called the Peer Review Committee which
8 is in the state statute, so it's approved by the
9 community. And finally it is approved by the North
10 Carolina Office of EMS Medical Director, so there are
11 three levels of review for each of these.
12 Second, patients retain the right of
13 choice, and great care is taken for those who have
14 diminished capacity. Individuals are evaluated under
15 this protocol in an identical manner to all other
16 patients that encounter the EMS system with choice of
17 destination offered to those who demonstrate capacity.
18 We have simply expanded the choice to include mental
19 health facilities or substance abuse facilities to the
20 extent that we are not being reimbursed to do so because
21 we think it is the right to do.
22 Some may appropriately question whether a
23 patient who is acutely suicidal retains capacity. It
24 is worth noting that every EMS system in the United
25 States routes patients with diminished capacity on a

1 daily basis. Consider the trauma patient who is
2 unconscious. We move that patient to a trauma center,
3 not to the nearest facility, on a daily basis. We are
4 simply applying the same logic to say someone with a
5 mental health or substance abuse crisis needs to go
6 directly to a facility that can immediately monitor and
7 care for them.
8 Finally, patient safety and outcomes are
9 part of our ongoing assurance process. We have monthly
10 interactions with reviews for outcomes for these
11 patients to insure not only the inbound but the outbound
12 portion of their care is appropriate.
13 Practically then this program functions
14 very simply in the following way. You are screened in
15 one of two ways, either through the 911 Center or once
16 EMS arrives on the scene and determines you have a
17 primary substance abuse or mental health complaint. We
18 go through the protocols, a well-person check,
19 alternative screening. These are, again,
20 community-based standards, protocolized and
21 reproducible.
22 If the patient passes all these criteria,
23 we offer options to the patient. They may choose to
24 accept them, or choose not to. And if they choose not
25 to, they are again offered treatment to the standard

1 emergency department if that's what they would like.

2 Between July the 1st of 2012 and July the

3 1st of 2013, 1,503 patients in our community were

4 evaluated, 34 percent of those met diversion criteria,

5 61 percent chose that option to go to a non-local ED,

6 but rather to appropriate locus of care. Only four of

7 those 315 or about 2 percent were transported out of

8 the facility within 90 minutes of arrival, none of whom

9 had a significant thing requiring a medical

10 intervention.

11 Among those patients who did receive

12 alternative destination, 63 percent or nearly 200 out

13 of the 315 were treated and discharged home with

14 immediate follow-up rather than requiring admission to

15 a psychiatric facility. They were retained in the

16 community with a community-based center.

17 So, in conclusion, we think this program

18 for acute mental health issues allows a significant

19 number of patients to go to the right locus of care the

20 first time. We think it meets the triple aim of improved

21 health care and lower cost. And thank you very much.

22 CHAIRMAN CASTRO: Thank you, Dr. Myers.

23 Commissioner Kladney, would you like to open with the

24 first question?

25 COMMISSIONER KLADNEY: Yes.

1 CHAIRMAN CASTRO: All right, go ahead.
2 COMMISSIONER KLADNEY: Yes, I would, Mr.
3 Chairman. My first question, Ms. Van Tassel, does your
4 concern or support for the written protocols extend to
5 discharge?
6 MS. VAN TASSEL: Yes.
7 COMMISSIONER KLADNEY: I mean, would you
8 standardize discharges throughout?
9 MS. VAN TASSEL: I would, actually. And
10 we're talking about data collection. What I would do
11 is I would actually have protocols, as Mr. Vera had
12 suggested, that were fairly standardized, and that were
13 also a part of the CMS review process so that we're,
14 once again as Commissioner Achtenberg had mentioned,
15 trying to fit things in within the system that we
16 already have. If we, in fact, required written
17 protocols under EMTALA that included discharge
18 planning and that were also — so that we were talking
19 about quality, excuse me, equality under the court
20 system, but that were also being monitored by CMS under
21 the continuous licensure reviews and certification
22 process, then we'd be able to fit the whole thing
23 together. And written protocols exist out there, as
24 you've heard. And they're quite good, as we've heard
25 from our doctors here on the panel, as well.

1 COMMISSIONER KLADNEY: Dr. Myers, do you
2 think that as an ER doctor everything should have a
3 written protocol, or there should be some leeway for
4 the doctor to use his expertise?
5 DR. MYERS: So, an example —
6 COMMISSIONER KLADNEY: Or hers?
7 (Off microphone comment.)
8 DR. MYERS: I apologize. So, I think there
9 is a way to do this that allows community-based input
10 that is still an evidence-based program. So, for
11 example, in the State of North Carolina there are
12 statewide EMS protocols that all paramedics are to
13 follow, but each community may make modifications to
14 those protocols so long as there's an evidence-based
15 reason to do so.
16 I hesitate to say this because some of my
17 physician colleagues may disagree, but I often get
18 concerned when the term, "Well, I used my clinical
19 judgment," makes me very nervous in some situations.
20 And the reason that makes me nervous is that means maybe
21 I don't know what the best evidence-based treatment
22 was. So, in many situations yes, clinical judgment is
23 required, but in a lot of other situations we can, to
24 use a — I was an English major at Chapel Hill, so I can
25 make up words, a protocolizable thing. And these things

1 are protocolizable, and we try to run away from the fact
2 that they are, but in point of fact they truly are. And
3 how we take care of a heart attack victim, there's
4 little room for debate about how we need to do that in
5 most circumstances. There will always be exceptions,
6 but in most circumstances there should be little room
7 for debate. There should be little room for debate in
8 what we do with an individual who has a substance abuse
9 issue, or a mental health issue acutely in the
10 community, as well.
11 COMMISSIONER KLADNEY: And Mr. Elliott,
12 could you give us an example of your linked financial
13 interests to patients and the community? I followed
14 what you were saying, but I'm trying to get like a
15 concrete answer.
16 DR. ELLIOTT: I was pretty vague about that.
17 The Robert Wood Johnson Foundation funded a number of
18 pilot projects around the country around this model of
19 linking services through some common funding. I'm
20 probably trivializing the idea, but that was at the core
21 of it.
22 One example that I know well in Georgia
23 links a small amount of hospital budget to community
24 services, so community mental health centers can
25 increase their funding if they provide for the sickest

1 patients in the community.

2 Now, in the past the incentive for
3 community mental health centers was to neglect the
4 sickest patients because they cost a lot of money to
5 take care of. You've got an acutely decompensated
6 schizophrenic, what's the cheapest thing to do for the
7 clinic? Let them go to the hospital, that costs you
8 nothing. So, you didn't have to develop a sort of
9 community treatment program, or crisis stabilization
10 units, or other programs that could help people
11 function in the community. But by linking the hospital
12 funding to the community funding so that community
13 mental health centers could recover some of their costs
14 for developing these programs, the hospital census
15 would decline, and it did, communities developed
16 programs more suited to the needs of patients in the
17 community. That's an example of linking funding.
18 There's other ways of doing it, too. Jails are doing
19 it with community mental health centers and hospitals
20 around mental health courts, so there's these other
21 models of collaborative programmatic development and
22 funding.

23 COMMISSIONER KLADNEY: Thank you.

24 DR. MYERS: If I may just very briefly echo,
25 these are not new dollars. I think that's the most

1 important component of all of this. These are dollars
2 that exist today. We just align the incentive with the
3 desired outcome.
4 DR. ELLIOTT: That's a good plan.
5 CHAIRMAN CASTRO: Madam Staff Director.
6 MS. SALLO: Dr. Myers, in reference to your
7 protocol, is that something that's used outside of
8 North Carolina, the protocols that you use? And if so,
9 can it be used by police officers per se out in the
10 street? Is it that simple that it can be implemented,
11 because what comes to mind is the State of Florida where
12 we have the Marchman Act, and we have the Baker Act.
13 So, under the Baker Act an officer can make a
14 determination out on the street that you need to be put
15 under a psychiatric hold, or an officer can indicate
16 that you need to be put into a substance abuse facility
17 and put a hold on you. So, would that be available in
18 order to kind of make sure that everyone is following
19 the same type of process in states that do allow those
20 type of Acts to be put in place?
21 DR. MYERS: So, I think there are two parts
22 to the question there. I think the first is have these
23 protocols been adopted outside of North Carolina? I
24 would say that is in process.
25 MS. SALLO: Okay.

1 DR. MYERS: We are meeting ironically with
2 the Medical Director of Sacramento who I know very well
3 to look about implementing these in two weeks. We're
4 sitting down and sharing these protocols with him. They
5 are part of that national publication that I
6 referenced, and they've been adopted from there. And
7 I really don't have a way of tracking how many other
8 places are using them, but they are certainly available
9 at the national level. So, yes, they are shared and are
10 being implemented.
11 The second question as it relates to does
12 this go down as far as a law enforcement officer? I would
13 say from our perspective we think that it requires a
14 paramedic-level screen.
15 MS. SALLO: Okay.
16 DR. MYERS: We want to — patient safety is,
17 obviously, the most important component of this, and
18 what we don't want to do is have patients who have
19 underlying medical conditions that rightly need to be
20 in a general service emergency department referred out.
21 So, there are very particular ways that that is done
22 and it's protocolized, but it's protocolized probably
23 at the paramedic or above level.
24 We have cooperated with law enforcement,
25 and you may have heard about the crisis intervention

1 officer, that 40-hour training block. We teach that and
2 sit in that with law enforcement in our community so
3 that they understand at what point their level of
4 screen, if you will, should stop and that they should
5 require a medical screen on top of that, so I think they
6 work in cooperation, but I do not think an officer
7 independently could come to the conclusion in some of
8 these patients.
9 MS. SALLO: Thank you.
10 MS. VAN TASSEL: Just to follow-up just as
11 a cautionary note, and I laud the program that you're
12 working in, Dr. Myers. I think it's terrific,
13 especially that it's protocol-based and
14 evidence-based. But just a cautionary note that it
15 appears that what may be happening here is that you're
16 setting up a separate and unequal pathway for those
17 people with mental disabilities. And I think it was Dr.
18 Elliott, doing a little bit of research on line and
19 following some of your work on line, who pointed out
20 that 50 percent of those people who have presenting with
21 a psychiatric crisis have medical conditions that are
22 operating at the same time, and that 21 percent have
23 an active medical condition that's actually
24 exacerbating the psychiatric crisis, or actually
25 causing it in the first place.

1 So, under EMTALA it — the rules say that
2 the ambulance needs to take the individual to a
3 emergency room and have that individual screened by an
4 appropriate medical and qualified individual. So, the
5 problem that I see here is that if you've got a mental
6 health illness that you are basically being diverted
7 before you can see somebody who is a physician who is
8 qualified to be able to divert you into these two
9 different paths, so I — that just raises a red flag for
10 me. And then what I would just add into that is that
11 perhaps a way to be able to deal with that is through
12 the psychiatric advance directives where, you know, I
13 wonder if somebody who is having a psychiatric crisis
14 can actually make an informed choice about where they
15 want to go, and whether they're willing to take on the
16 risk of not having a physician screen them for some
17 underlying medical condition. And, yet, if you have a
18 psychiatric advance directive which is, you know, a
19 wonderful way for an individual with a psychiatric
20 condition to say what they want to have done if they
21 are in crisis, then that might bypass that. So, I just
22 wanted to add that cautionary note. Thank you.
23 CHAIRMAN CASTRO: Dr. Myers.
24 DR. MYERS: I just want to respond to that.
25 CHAIRMAN CASTRO: Sure.

1 DR. MYERS: With all due respect, EMTALA
2 does not apply to emergency medical services, so the
3 EMS is not bound by EMTALA in any way at all. So, EMTALA
4 relates to facilities, and it is a Medicare-receiving
5 emergency department. County-based EMS services are
6 not in any way governed by EMTALA.
7 Having said that, we want to do the right
8 thing for patients, so I think the reason that this is
9 being adopted the way that it is, is this is not only
10 for mental health patients. And I think that's the
11 difference, is that in the communities we have a screen
12 for falls in assisted living facilities, we have a
13 screen for — so we are not disproportionately looking
14 only at mental health facilities, we are looking across
15 the community to say is reflexive transport to an
16 emergency department ideal for a variety of patients
17 and conditions, not the least of which including mental
18 health. Your points are well taken.
19 CHAIRMAN CASTRO: I have some questions,
20 and I know Commissioner Achtenberg does. Are any of the
21 Commissioners on the phone interested in asking
22 questions so I could put you in the queue? No?
23 Commissioner Heriot, you're fine over there? Okay. So,
24 I have a couple of questions.
25 Professor, you mentioned in your written

1 remarks that typically the folks that are the victims
2 of Patient Dumping fall into three main categories, the
3 uninsured, the mentally disabled, and minorities.
4 Could you speak a little bit to the topic of minorities
5 and the impact Patient Dumping has on them based on your
6 information and data?
7 MS. VAN TASSEL: I'm actually putting two
8 things together.
9 CHAIRMAN CASTRO: Okay.
10 MS. VAN TASSEL: In other words, we don't
11 have — I think one of the great benefits of the
12 Affordable Care Act is that it mandates data
13 collection, and that all of — we talked a lot about data
14 here today. And there's a provision that basically says
15 that hospitals have to collect data and disaggregate
16 it according to minority status, disability status,
17 according to gender, et cetera, so that we're going to
18 have an awful lot more data that we're going to be able
19 to track on the actual outcomes, which is one of the
20 reasons why I think this is an ideal time to have
21 — improve our systems and not have a bad apples
22 approach, but to have a systematic change so that we're
23 using written protocols in order to provide equal
24 treatment to everyone.
25 I'm putting together two things, and one

1 is that is the whole idea of stereotypes and bias, is
2 that we come to the table, all of us as human beings,
3 with certain ideas about other individuals based upon
4 our own particular life experiences, so I actually take
5 a look at the ways that we provide health services
6 across the country. And there certainly is, and I think
7 that the Commission has looked at this in the past, is
8 that there's certain data that suggests that different
9 population groups are being provided with different
10 levels of health care.
11 A very interesting study that just came out
12 that after adjusting for confounders, black patients
13 were less likely to receive any analgesic or narcotic
14 analgesic than white children when they are actually
15 presenting at the emergency room with something like
16 abdominal pain. And that causes me great concern that
17 children are actually being treated differently based
18 upon the way they look. Okay?
19 So, if you put those two things together,
20 if we had written protocols, if we had people, and we
21 know the way that we should be treating individuals with
22 pain that's a result of certain conditions, there are
23 protocols, and that would allow us to get rid of some
24 of these biases and stereotypes that sometimes
25 individuals, all individuals use when they're making

1 decisions, especially when they're making decisions
2 under a great deal of stress and pressure in the
3 emergency room.
4 CHAIRMAN CASTRO: Do you have — I'll ask any
5 of the other panelists, do you have any information on
6 the topic of medical repatriation?
7 MS. VAN TASSEL: Yes. Actually, I have
8 several articles, and I will follow up with you. I don't
9 have the citations right here.
10 CHAIRMAN CASTRO: Okay.
11 MS. VAN TASSEL: But I actually did do a
12 little looking at the question of medical repatriation,
13 which is a pretty scary thing, and have some good
14 articles to be able to send to you, and I will after
15 the program today.
16 CHAIRMAN CASTRO: All right, I appreciate
17 that. Do you have anything on that?
18 DR. ELLIOTT: Well, we get cases described
19 to us, somebody sent back to Mexico who needs dialysis
20 and it's unclear they're ever going to get dialysis,
21 or they may get it briefly but transportation will be
22 an issue. But it's almost a death sentence in these
23 cases.
24 Ethically, there's no question that it's
25 unconscionable, that we have an obligation. Once we

1 have that physician-patient relationship, it doesn't
2 matter what country they're from. They're a human
3 being, they are getting medical care, and we're pretty
4 darned sure they're not going to get that same care when
5 they go home. So, I find it repugnant to do that. I'm
6 not going to say there are never circumstances to send
7 people home if they have adequate medical care
8 facilities, and the appropriate social supports,
9 wonderful, great, do it. But this idea of, again using
10 the definition of dumping you gave about sort of
11 economically motivated discharges, it's wrong.
12 CHAIRMAN CASTRO: I've got one more
13 question, then I'll cede the floor to Commissioner
14 Achtenberg.
15 Dr. Elliott, you presented us with some
16 slides in your materials, and one of them, in
17 particular, talks about the transinstitutionalization
18 of patients, and you call it the criminalization of the
19 mentally ill. Could you speak a little bit to that
20 topic?
21 DR. ELLIOTT: Yes, that's something that
22 the National Alliance for the Mentally Ill really did
23 us all a great service by pointing this out and
24 mentioning the data. And I forget if somebody mentioned
25 it earlier or not, but the largest mental hospital in

1 the country these days is the Los Angeles County Jail.
2 We used to have in 1954, 550,000 inpatients
3 in the United States when our population was 175,000.
4 Now we have 60 some-odd thousand inpatients, and it's
5 not that they're not in institutions any more, and some
6 are just homeless, but they've gone to jails, or
7 prisons, or other — or nursing homes, or other kinds
8 of shelters. And it's due largely to the failure of the
9 Community Mental Health Centers Act which was
10 well-intended, and lots of people were willing to take
11 the millions of dollars that came with it, but they
12 didn't want to treat the sickest patients. So, we've
13 had a failure to develop actual systems of care in this
14 country to look after the needs in the community of our
15 patients. And I know I'm on a soapbox here, but what
16 better place to be on a soapbox, I guess, than talking
17 to you guys about this.
18 It's been a tremendous failure to care for
19 these folks, so they left the hospitals with this
20 promise that these wonderful medications and the
21 Community Mental Health Centers Act would do the job,
22 and we failed miserably, and we're still failing. And
23 until we look at our whole systems and take it
24 seriously, there's going to be a lot of homeless and
25 folks in jails and prison because that's where they end

1 up.

2 CHAIRMAN CASTRO: Thank you, doctor.

3 Commissioner Achtenberg.

4 COMMISSIONER ACHTENBERG: Dr. Myers, if you

5 could, what kinds of mechanisms, if any, have been

6 provided as a result of the Affordable Care Act that

7 enhance data collection, or make sure that we're

8 collecting the right data, create systems for

9 monitoring the data either technologically or

10 otherwise so that things can become actionable, if you

11 will, and closer to real time than not, and other forms

12 of system improvement?

13 DR. MYERS: Thank you very much for that.

14 I think there's a great incentive for data exchange and

15 sharing of data that has been very helpful to us. We

16 live in a very competitive health care environment.

17 Duke, UNC, and Wake Med are the three largest providers

18 in our metro area, and they obviously have staffs whose

19 entire job is to annihilate the other.

20 (Laughter.)

21 DR. MYERS: So, the notion now is that in

22 our metro community within the next 14 months every one

23 of those systems will be on the exact same medical

24 record. We will have a community-wide health care data

25 exchange through those three competitive systems, and

1 they have included EMS in those systems. We are
2 bidirectionally exchanging data today such that when
3 we leave the hospital we have — they have our
4 information and then every 24 hours we learn the
5 outcomes of our patients so that we can provide realtime
6 evidence-based quality management. That will include
7 the mental health facilities to whom we are
8 transporting these patients today. They are part of
9 that systemwide data exchange, so the ability to have
10 realtime data that is on a community-wide standpoint
11 is tremendous for us, and I think is a key to monitoring
12 for patient satisfaction and patient safety.
13 CHAIRMAN CASTRO: Commissioner Kladney?
14 And before you go, any other Commissioners on the phone
15 want to get in the queue? I'm sorry. Dr. Elliott, go
16 ahead.
17 DR. ELLIOTT: I just wondered if I could
18 expand a little bit on this criminalization, because
19 I think I did you a disservice by not explaining why
20 they're in jails and prisons. It's not because of rapes
21 and murders most of the time. They're in there because
22 of minor offenses that wouldn't happen if they had an
23 adequate treatment system. It's these kind of dine and
24 dash offenses, public indecency, vagrancy, those sorts
25 of things are what's outrageous. And because they're

1 poor and mentally ill, they languish in jails before
2 they're ever brought to trial at great expense to the
3 public. And, of course, they're not getting appropriate
4 treatment. That's why the criminalization occurs,
5 because they're untreated and a lot of times the local
6 police are just picking them up to sort of clean the
7 streets up a little bit. They shouldn't be in jails to
8 begin with. If they were treated properly, they
9 wouldn't be.
10 CHAIRMAN CASTRO: Thank you, doctor.
11 Commissioner Kladney.
12 COMMISSIONER KLADNEY: Thank you, Mr.
13 Chairman. Dr. Myers, before you became a witness we
14 talked, and the question has arisen about being an EMS
15 person with an ambulance. If you're not attached to a
16 hospital, EMTALA doesn't apply to you. Is that correct?
17 DR. MYERS: That is correct. There are
18 basically four systems under which EMS operates in the
19 United States, one is fire-based, one is third-service
20 which we are, we are a governmental entity but we are
21 not attached to the fire nor the police department,
22 we're a third service, if you will, under third-service
23 public safety. There are private ones that simply are
24 contracted with the community, and then there are those
25 that are hospital-based. There are some interesting

1 statutes as it relates to even does EMTALA apply to the
2 hospital-based EMS agency, but it does not apply to any
3 of the other agencies. And that's been over and over
4 in our state, and that's pretty quick.
5 COMMISSIONER KLADNEY: But if you make a
6 decision to start taking a patient to a hospital, you
7 are required to complete that trip, or can you divert?
8 DR. MYERS: We divert all the time. In other
9 words, we'll have a patient going to a small community
10 hospital whose initial EKG was negative, and then en
11 route the EKG changes, and they have now developed a
12 myocardial infarction en route, so at that point we will
13 call the first community hospital and say no, we're
14 going to the STEMI-receiving center so we can go
15 directly to the cath lab and we will turn.
16 The interesting notion is that within our
17 state there are required hospital destination guides
18 for certain conditions such that if a patient is no
19 longer able to provide consent, then we take them based
20 on those, so that's for STEMI stroke, those high-acuity
21 illnesses. Otherwise, it is patient-based. It does not
22 have to be that either, however, and I would like to
23 emphasize many EMS agencies across the country use a
24 nearest hospital approach regardless. And that is
25 perfectly acceptable, as well, regardless of the

1 patient desire, so it can be interpreted many different
2 ways.
3 COMMISSIONER KLADNEY: Thank you, sir.
4 MS. VAN TASSEL: If I could just add, and
5 I apologize for interrupting. I agree 100 percent with
6 Dr. Myers. EMTALA applies to emergency services that
7 are provided by the hospital, so an ambulance that's
8 actually owned by and directed by the hospital is
9 covered by EMTALA, and not the three other ones that
10 Dr. Myers was referring to. So, I support him 100
11 percent on that.
12 DR. MYERS: And most across the country are
13 not hospital-based, so that would be the other way that
14 —
15 CHAIRMAN CASTRO: Commissioner Kladney.
16 COMMISSIONER KLADNEY: No, sir.
17 CHAIRMAN CASTRO: Anybody else have any
18 additional questions? Any of the Commissioners on the
19 phone?
20 COMMISSIONER YAKI: Yes, this is
21 Commissioner Yaki.
22 CHAIRMAN CASTRO: Go ahead, Commissioner.
23 COMMISSIONER YAKI: Yes. I mean, I guess,
24 I — in some ways, and this has been a very illuminating
25 briefing hearing, but my — I just want to come back to

1 the main point which is what's the likely populations
2 of individuals whose civil rights are being violated?
3 Is it the mentally ill, is it the physically
4 handicapped? Is it minorities? I guess just from your
5 front line experience and seeing what happens to the
6 individuals who you believe are being mistreated, do
7 you — what would your observations be like? This is for
8 all three.
9 MS. VAN TASSEL: I guess for — this is
10 Katharine Van Tassel. I guess for me is if you just track
11 — it's based on insurance status. Right? So, if you are
12 — if you track the proportion of individuals who are
13 uninsured, you can pretty much figure out which of the
14 groups are the most at risk for Patient Dumping. The
15 biggest problem that we have right now is that there
16 is no data collection, so there isn't an ability to say
17 is there a particular group that's being
18 disproportionately impacted by Patient Dumping, and I
19 think this is one of the reasons why we do need to have
20 far better tracking. And this is one of the reasons why
21 I propose — make the proposal that I do, is for, one,
22 to have protocols that are institutionalized so that
23 we're treating people with best clinical practices
24 across the board. And that under the Affordable Care
25 Act, that we're following up on the data collection

1 efforts which will allow us to determine whether a
2 particular hospital in a particular area is having
3 really bad outcomes, and therefore should be
4 investigated. It would trigger an investigation into
5 possible EMTALA violations.
6 DR. ELLIOTT: This is Richard Elliott, and
7 I agree with Professor Van Tassel about the
8 under-insured being the largest group, but the mentally
9 ill themselves present problems in emergency rooms that
10 are tough for emergency room docs and the whole staff
11 that we heard a little bit about before. So, even the
12 more adequately insured mentally ill are sometimes hard
13 for emergency rooms to manage capably. And you'll find
14 either EMTALA violations, mostly EMTALA violations
15 when they're inappropriately transferred just because
16 the emergency room doesn't want to have to deal with
17 it. Even if somebody has insurance, that's a problem,
18 you've got somebody yelling and screaming, and just
19 making life hard for folks in there. So, I do think the
20 mentally ill constitute a separate but smaller group,
21 the mentally ill and insured. I agree with that.
22 And I just want to say on this, this notion
23 of evidence-based medicine and protocols, I agree with
24 it, but it really is a goal, and it's not really
25 achievable very often.

1 I wrote a sort of silly little piece on
2 evidence D-based medicine because when I looked at some
3 of these protocols what I found is they were driven by
4 drug companies. It depends how you develop them, and
5 so much of what's out there that looks like a protocol
6 really isn't very fair. And there just, frankly, isn't
7 that much science about a lot of decisions that we have
8 to make. And I agree with your observation, Dr. Myers,
9 that clinical judgment sometimes is a weak substitute
10 for real knowledge, but we only have so much real
11 knowledge. When you look at the literature there's
12 really so much out there that you can rely on, so it's
13 tough. It's a goal, and we've got to aim for it, and
14 it should be something worth keeping in mind, but it's
15 tough to get there.
16 DR. MYERS: And just really quick to go to
17 those patients that are disenfranchised by this, I
18 think there's a persistent Patient Dumping issue which
19 would be the patients that cycle in and out of the
20 system. In other words, they are seen, they are
21 appropriately done, they meet all EMTALA definitions
22 and you see them again next week because we haven't
23 fixed their problem. Those are the disenfranchised
24 individuals, so we have to look at it from a
25 community-based perspective. You can't look at it from

1 an institutional-based perspective. And when we do
2 that, I think then we take the familiar faces and move
3 them in.
4 In our community we have familiar faces
5 being assessed. They were seen more than four times in
6 30 days. We went from 80 out of our million patients
7 in the population to 39 by implementing this program,
8 and it's not that the patients aren't getting care, they
9 just don't have to do it through the 911 system. They
10 can do it through their community-based care, so I think
11 that is an underlying piece. It's not just a single
12 encounter, we need to look at these encounters over
13 time.
14 CHAIRMAN CASTRO: Thank you, doctor.
15 COMMISSIONER ACHTENBERG: You saved a lot
16 of money, too.
17 DR. MYERS: The nice thing is that oh, by
18 the way, good care is less expensive.
19 CHAIRMAN CASTRO: Right. Well, thank you.
20 This brings us to the end of our program. I want to take
21 the opportunity to thank each of you on this panel and
22 all the panelists that served today. This has been
23 extremely informative for us, and we're looking forward
24 to being able to put together a report based on what
25 you've shared with us. I also want to thank my fellow

1 Commissioners for their efforts and the questions they
2 asked. And, of course, I don't want to forget to thank
3 our Staff who put this panel together, these panels
4 together, not only from the substantive perspective,
5 but from the logistics of bringing all of it to you
6 today.
7 Lastly, I just want to make sure that
8 everyone knows that our record on this briefing is going
9 to remain open for the next 30 days, so if panelists
10 or members of the public would like to submit materials
11 they can do so in one of two ways. They can mail them
12 to us here at the U.S. Commission on Civil Rights,
13 attention to the Office of Federal Civil Rights
14 Evaluation, 1331 Pennsylvania Avenue, N.W., Suite
15 1150, Washington, D.C. 20425, or technology-based via
16 email to publiccomments@usccr.gov, that's
17 P-U-B-L-I-C-C-O-M-M-E-N-T-S@U-S-C-C-R.gov.
18 **V. ADJOURN BRIEFING**
19 CHAIRMAN CASTRO: It is now 12:51 and this
20 concludes the hearing two minutes early, so we landed
21 on time, on time arrival, folks. Thank you, everybody.
22 (Whereupon, the proceedings went off the
23 record at 12:51 p.m.)
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