

Emergency Medical Conditions, EMTALA, and Hospital Transfers
(AHCA is the final authority on all EMTALA issues)

Rights of Persons While Held under the Baker Act

Q. I'm an emergency physician and our hospital's risk manager indicates that the rights of persons held under the Baker Act are suspended while being held in our ED. Is this correct?

NO. The federal EMTALA law defines psychiatric emergencies and substance abuse emergencies to be "emergency medical conditions" even absent any other medical conditions. Patients have the same rights and hospitals have the same responsibilities to meet the emergency needs of individuals brought to their premises regardless of the nature of the emergency. Hospitals are responsible for the stabilization of persons with "emergency medical conditions" and must maintain their safety until released or transferred after all such conditions have been stabilized. Further, Chapter 395, FS governing licensure of Florida hospitals requires that any hospital holding a person under the Baker Act must ensure that all rights are provided to such patients. A special section pertains just to emergency departments of hospitals.

Emergency Medical Condition (EMC) Defined

Q. How is an emergency medical condition defined in the Baker Act?

The Baker Act has no separate definition for an emergency medical condition; it refers to the hospital licensure law for this definition, as follows.

395.002 Definitions.-- As used in this chapter:

- (8) "Emergency medical condition" means:
 - (a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
 1. Serious jeopardy to patient health, including a pregnant woman or fetus.
 2. Serious impairment to bodily functions.
 3. Serious dysfunction of any bodily organ or part.
 - (b) With respect to a pregnant woman:
 1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;
 2. That a transfer may pose a threat to the health and safety of the patient or fetus; or
 3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.
- (9) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

Medical Conditions of Persons under the Baker Act

Q. A patient was placed involuntary under the Baker Act at an ED and then was transferred to us because the patient is pregnant and the baby's heart rate was not stable. The issue is that this particular patient will remain at our hospital which is a non-receiving facility most likely for 6 weeks until the birth of the baby. I know that the Baker Act clock has stopped

because she is not medical stable, but is there any rule and/or suggestion in regards to how often the doctors need to re-access the patient and/or document that she still meets the criteria for involuntary status?

The clock for the involuntary examination only stops for an emergency medical condition— not just for medical conditions the patient might be experiencing.

394.463(2), FS Involuntary examination.

(f)A patient shall be examined by a physician or clinical psychologist at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.

(g)A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 **must be examined by a receiving facility within 72 hours.** The 72-hour period **begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition.** If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

(h)One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

- 1.The patient must be examined by a designated receiving facility and released; or
- 2.The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

(i)Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

- 1.The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;
- 2.The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;
- 3.The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or

4.A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition

shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(3)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

395.002(8), FS “Emergency medical condition” means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to patient health, including a pregnant woman or fetus.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;
2. That a transfer may pose a threat to the health and safety of the patient or fetus; or
3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

If the attending physician continues to document the emergency status of the patient, the clock isn't ticking. The only purpose of stopping the Baker Act involuntary examination clock is the presumption that a psychiatric examination cannot be performed while a patient is in the middle of a medical emergency. It isn't intended to be used to hold a person against their will for an extended period of time without due process. If the medical emergency is that of the fetus, there may be no reason why the mother can't be evaluated and her due process rights protected. The Baker Act offers no authority to medically examine or medically treat a patient – it is only for the purpose of obtaining a psychiatric examination and short-term psychiatric treatment. Other laws must be used for the purpose of medical intervention.

This type of situation where a patient's medical condition is too serious to be addressed by a psychiatric facility has been handled on occasion by the medical hospital working with the nearest Baker Act receiving facility. The receiving facility's administrator/designee can sign a petition with the opinions of two psychiatrists (or one psychiatrist and one psychologist) that the person held at your hospital meets the criteria for involuntary placement. This results in a public defender being appointed to represent the wishes of the patient and a hearing can be conducted on the petition at your hospital within 5 working days of the petition being filed. One of the two doctors providing opinions must provide testimony at the hearing. If the patient wishes to delay the hearing, with concurrence of counsel, the hearing can be “continued”.

394.4599 Notice.

(2) INVOLUNTARY PATIENTS.—

(c) The written notice of the filing of the petition for involuntary placement must contain the following:

4. Notice that the patient, the patient's guardian or representative, or the administrator may apply for a **change of venue** for the convenience of the parties or witnesses **or because of the condition of the patient.**

394.467 Involuntary inpatient placement.

(5) CONTINUANCE OF HEARING.—The patient is entitled, with the concurrence of the patient's counsel, to **at least one continuance of the hearing. The continuance shall be for a period of up to 4 weeks.**

A Guardian Advocate can also be appointed to provide express and informed consent for mental health treatment as well as for medical treatment.

A person with an acute psychiatric condition held at your hospital should have this condition treated to the extent medically appropriate considering her advanced pregnancy. I assume that your hospital has a psychiatric consultant. The fact that your hospital isn't designated as a receiving facility and doesn't have a psychiatric unit, wouldn't relieve you of meeting the patient's medical and legal needs while hospitalized.

Q. I work at a freestanding BA receiving psychiatric facility with limited medical capabilities. Sometimes we get patients dropped off that are medically inappropriate for our facility. However, they do not require emergency medical treatment at the time. Most times the surrounding medical-surgical facilities with psychiatric units will not take the patient. This leaves us in a bad situation with a potentially medically compromised patient. In these situations, what does the law require we do?

Many people with medical needs can be served in a free-standing psychiatric facility by bringing those medical services into your facility. If these individuals have emergency medical conditions, the resolution is relatively simple – a transfer via EMS to the nearest ED can be arranged. However, as you pointed out the individuals you reference don't have emergency medical conditions – just medical needs.

If there is no emergency "medical" condition, the federal EMTALA law doesn't apply. A transfer between receiving facilities under the state's Baker Act law requires the destination hospital to provide prior approval for the transfer. Under these circumstances, there is no legal basis for requiring a public or private receiving facility to accept the transfer. There is no legal remedy to address this issue as long as the individual meets the criteria for involuntary examination/placement since you have no authority to discharge the person from your facility.

You obviously cannot retain an individual whose medical needs exceed the capability of your free-standing psychiatric hospital. To do so would jeopardize your license, your accreditation, and the safety of the people you serve. If the person is on voluntary status and if you can arrange for the medical treatment as an overlay to your inpatient psychiatric treatment, that would be ideal. However, if that's not possible and/or the individual meets the criteria for involuntary examination, a general hospital with psychiatric capability should accept the transfer as each of them is able to provide a medical overlay on its psychiatric unit or a psychiatric overlay on a med/surg unit.

If the person is on a voluntary status and capable of making well-reasoned, willful and knowing decisions about his/her medical and mental health treatment (definition of competence to consent), he/she can go to whatever facility desired.

If there is no emergency medical condition as defined in 395.002(8), FS, the federal EMTALA and the provisions of 395.1041 Access to emergency services and care wouldn't apply. The definition is as follows:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to patient health, including a pregnant woman or fetus.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;
2. That a transfer may pose a threat to the health and safety of the patient or fetus; or
3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

If the person is “dropped off” with you, you must perform the medical screening evaluation required by EMTALA to confirm that no emergency medical condition exists, beyond the psychiatric. Since your facility isn’t designated as a “receiving facility” under the Baker Act and can only retain persons who meet voluntary criteria, you must transfer persons appearing to meet criteria for involuntary examination or involuntary placement.

Negotiating agreements with medical hospitals designated as receiving facilities may be the only alternative. You could also arrange for non-emergent medical treatment to be provided to such persons in your facility or transfer the person to a nearby willing medical hospital while you continue to provide a psychiatric overlay. You may also wish to consult with the other hospitals owned by your corporation in other areas of the state to see how they deal with this problem.

Q. We have a Baker Acted patient admitted to the medical wing of a Baker Act receiving facility because patient refuses to eat or drink for several days, Patient is grossly delusional and claims to not have a stomach and refuses to eat anything. The patient does not have a legal guardian. There is a psychiatric consult; however patient refuses all medications including psychotropic medications. Does the Baker Act provide any direction for this type of situation? Should the hospital initiate petition for guardian advocate in order to initiate treatment with psychotropic medication while the patient is on the medical floor? If the answer is yes to the above and the patient is appointed a guardian advocate who has authorized psychotropic medication, but the patient refuses medication

The entire hospital is designated as a Baker Act receiving facility – not just the psychiatric unit. It is up to your administration and clinical leadership to decide where any individual’s medical and psychiatric needs can be best met in your hospital. This may mean a psychiatric overlay on a medical unit or a medical overlay on the psychiatric unit.

You would be required to file a petition for involuntary placement within the first 72 hours after the arrival of a person on involuntary status at the hospital, unless the clock stopped because a physician had documented in the chart that the person had an emergency medical condition – not just that he/she was being treated for a medical condition.

It would be entirely appropriate for the receiving facility to file a petition for involuntary placement while the person still resided on a medical unit once the two psychiatric opinions were obtained.

If the person has a family member or friend willing to serve as a health care proxy, the physician could document the person’s incapacity or incompetence and the proxy could begin making medical and mental health decisions the proxy believed the person would have made had he been competent to do so. This could provide the interim authority for treatment until a guardian advocate was appointed by the court. If the person has no family member or friend to serve in this role, the advance directive statute also permits an independent LCSW under certain circumstances to act as proxy.

The Baker Act, as Florida’s Mental Health Act, cannot be used as authority to provide any medical treatment or forced feeding until such time as a circuit court had appointed a guardian advocate with the express authority to consent to medical as well as mental health treatment. Until that time, you would need to rely on other statutes for this authority. Other options open to you for life saving emergency medical intervention including DCF Adult Protective Services, Florida’s Medical Consent Act, and Probate Rule 5.900 (Expedited Judicial Intervention). You may wish to request assistance from your Risk Manager and/or hospital attorney.

Q. We have a patient admitted on a voluntary basis for an eating disorder. She has been found to be competent. She has been pulling out her feeding tubes and her physician that treats her disorder (not her hospital psychiatrist) has ordered that the staff put her in restraints and reconnect her feeding tubes. What do we do?

The Baker Act can't be used to authorize any medical treatment or re-connection of feeding tubes; it is only for psychiatric examination and psychiatric treatment. Further, since she has been found to be able to make "well-reasoned, willful, and knowing medical and mental health decisions) she not only has the right to consent but to refuse consent to treatment. If a physician had found her incompetent to consent, a health care proxy could be designated (she has family involved) who could give "substitute judgment" in consenting to whatever they believed she would have consented to if competent.

Otherwise, a petition could be filed with the court under Probate Rule. 5.900 seeking expedited judicial intervention. In any case, you should call your risk manager ASAP and/or your hospital attorney. This woman's safety must be ensured, but within the limits of the law.

The appropriateness of the woman to be a voluntary in the unit is questionable. Voluntary status requires that the person have a mental illness, be competent to provide express and informed consent, and be suitable for treatment. There are the issues of competence to consent (see definition of express and informed consent and incompetent to consent to treatment). Finally, there is the issue of suitability since you indicate you have no treatment program available for that diagnosis.

Q. Is informed consent required for blood and urine tests at a Baker Act receiving facility? What about at an ER that is not an RF?

The Baker Act, as Florida's Mental Health Act, doesn't govern consent to medical procedures or care – the Medical Consent laws must be followed instead. If a person refuses or isn't competent to provide informed consent for such procedures and no health care proxy is available to provide such consent on the person's behalf, such procedures could only be conducted when the physician believes the person lacks capacity to decide and has a life-threatening condition. This would apply whether the ER was a part of a receiving facility or not.

Q. I am the Medical Director of a hospital group. There is a common scenario we encounter on general hospital units. The patient wants to leave, but their medical condition dictates that they stay in hospital. They may be a bit confused, or not; usually they're disagreeable. There is no clear indication of "mental illness" and definitely no indication for inpatient psychiatric care. These patients are often placed under BA-52 because the medical attendings think this is the only way to hold these patients against their will. I have discussed this with them many times, taking the position that the Baker Act has no bearing because they are on a medical unit and the Baker Act only serves to get them to a psych unit once they are cleared, and that the Baker Act is inappropriate if they don't meet the definition of mental illness. If inpatient psych care is not in the plan, why use a Baker Act? I suppose that delirium could meet the legal definition for mental illness, but I see that as a loose use of the term.

You're correct in all aspects regarding the issue you raise in your message – it is indeed a most difficult one and one without an easy answer. As you point out, the use of the Baker Act to prevent the release of a person who may be refusing or unable to determine the need for medical treatment would be inappropriate and could expose the physician and the hospital to liability.

Chapter 766.103, F.S. is Florida's Medical Consent Law must guide your physicians in their authority to treat.

(1) This section shall be known and cited as the **"Florida Medical Consent Law."**

(2) In any medical treatment activity not covered by s. 768.13, entitled the "Good Samaritan Act," this act shall govern.

(3) No recovery shall be allowed in any court in this state against any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractic physician licensed under chapter 460, podiatric physician licensed under chapter 461, dentist licensed under chapter 466, advanced registered nurse practitioner certified under s. 464.012, or physician assistant licensed under s. 458.347 or s. 459.022 in an **action brought for treating, examining, or operating on a patient without his or her informed consent when:**

(a) 1. The action of the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community as that of the person treating, examining, or operating on the patient for whom the consent is obtained; and

2. A reasonable individual, from the information provided by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant, under the circumstances, would have a general understanding of the procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures, which are recognized among other physicians, osteopathic physicians, chiropractic physicians, podiatric physicians, or dentists in the same or similar community who perform similar treatments or procedures; or

(b) The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure had he or she been advised by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant in accordance with the provisions of paragraph (a).

(4)(a) A consent which is evidenced in writing and meets the requirements of subsection (3) shall, if validly signed by the patient or another authorized person, raise a rebuttable presumption of a valid consent.

(b) A valid signature is one which is given by a person who under all the surrounding circumstances is mentally and physically competent to give consent.

It's always better to follow a law that applies to medical consent, than the Baker Act which would offer little authority for the provision of medical treatment or detention for other than psychiatric examination and psychiatric treatment. The Baker Act, **Chapter 394, 459(3), F.S.**, governs the Right to Express and Informed Patient Consent for persons held appropriately held under the Baker Act. It does include the following provision regarding medical care:

(b) In the case of medical procedures requiring the use of a general anesthetic or electroconvulsive treatment, and prior to performing the procedure, express and informed consent shall be obtained from the patient if the patient is legally competent, from the guardian of a minor patient, from the guardian of a patient who has been adjudicated incapacitated, or from the guardian advocate of the patient if the guardian advocate has been given express court authority to consent to medical procedures or electroconvulsive treatment as provided under s. 394.4598.

(d) The administrator of a receiving or treatment facility may, upon the recommendation of the patient's attending physician, authorize emergency medical treatment, including a surgical procedure, if such treatment is deemed lifesaving, or if the situation threatens serious bodily

harm to the patient, and permission of the patient or the patient's guardian or guardian advocate cannot be obtained.

In the above circumstance, the Hospital Administrator would be the only other entity authorized to provide consent for the procedure and only if the Baker Act was appropriate in the first place due to the individual's psychiatric condition.

Other alternatives include:

- Chapter 765, F.S. governing advance directives and health care surrogates/proxies is ideal for any situation in which the patient has identified a surrogate via an advance directive or has a relative or close personal friend to serve as a health care proxy to provide the legally authorized consent for admission and treatment of a person once a physician documents the patient lacks capacity or competence to make his/her own decisions..
- Chapter 709, F.S. governing Durable Medical Power of Attorney provides a special type of advance directive (statute substantially amended effective 11/2011), as follows:

709.08, FS Durable power of attorney.

(1)CREATION OF DURABLE POWER OF ATTORNEY.—A durable power of attorney is a written power of attorney by which a principal designates another as the principal's attorney in fact. The durable power of attorney must be in writing, must be executed with the same formalities required for the conveyance of real property by Florida law, and must contain the words: "This durable power of attorney is not affected by subsequent incapacity of the principal except as provided in s. 709.08, Florida Statutes"; or similar words that show the principal's intent that the authority conferred is exercisable notwithstanding the principal's subsequent incapacity, except as otherwise provided by this section. ..

- Chapter 401.455, F.S. governs situations when an "incapacitated" person appears to have an emergency medical condition in a pre-hospital or ED situation, as follows:

401.445 Emergency examination and treatment of incapacitated persons.

(1)No recovery shall be allowed in any court in this state against any emergency medical technician, paramedic, or physician as defined in this chapter, any advanced registered nurse practitioner certified under s. 464.012, or any physician assistant licensed under s. 458.347 or s. 459.022, or any person acting under the direct medical supervision of a physician, in an action brought for examining or treating a patient without his or her informed consent if:

(a)The patient at the time of examination or treatment is intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent as provided in s. 766.103;

(b)The patient at the time of examination or treatment is experiencing an emergency medical condition; and

(c)The patient would reasonably, under all the surrounding circumstances, undergo such examination, treatment, or procedure if he or she were advised by the emergency medical technician, paramedic, physician, advanced registered nurse practitioner, or physician assistant in accordance with s. 766.103(3).

Examination and treatment provided under this subsection shall be limited to reasonable examination of the patient to determine the medical condition of the patient and treatment reasonably necessary to alleviate the emergency medical condition or to stabilize the patient.

(2)In examining and treating a person who is apparently intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent, the emergency medical technician, paramedic, physician, advanced registered nurse practitioner, or physician assistant, or any person acting under the direct medical supervision of a physician, shall proceed wherever possible with the consent of the person. If the person reasonably appears to be incapacitated and refuses his or her consent, the person may be examined, treated, or

taken to a hospital or other appropriate treatment resource if he or she is in need of emergency attention, without his or her consent, but unreasonable force shall not be used.

(3) This section does not limit medical treatment provided pursuant to court order or treatment provided in accordance with chapter 394 or chapter 397. (*chapter 394 and 397 don't provide authority for medical treatment except as cited above*)

401.45` Denial of emergency treatment; civil liability.

(1)(a) Except as provided in subsection (3), a person may not be denied needed prehospital treatment or transport from any licensee for an emergency medical condition.

(b) A person may not be denied treatment for any emergency medical condition that will deteriorate from a failure to provide such treatment at any general hospital licensed under chapter 395 or at any specialty hospital that has an emergency room.

(2) A hospital or its employees or any physician or dentist responding to an apparent need for emergency treatment under this section is not liable in any action arising out of a refusal to render emergency treatment or care if reasonable care is exercised in determining the condition of the person and in determining the appropriateness of the facilities and the qualifications and availability of personnel to render such treatment.

(3)(a) Resuscitation may be withheld or withdrawn from a patient by an emergency medical technician or paramedic if evidence of an order not to resuscitate by the patient's physician is presented to the emergency medical technician or paramedic...

(4) Any licensee or emergency medical technician or paramedic who in good faith provides emergency medical care or treatment within the scope of their employment and pursuant to oral or written instructions of a medical director shall be deemed to be providing emergency medical care or treatment for the purposes of s. 768.13(2)(b).

- Chapter 415, FS governs Adult Protective Services. If you have a patient who is a vulnerable adult who "lacks capacity to consent" meaning a mental impairment that causes lack sufficient understanding or capacity to make or communicate responsible decisions concerning person or property, including whether or not to accept protective services. Self-neglect must result in inability to provide the care, supervision, and services necessary to maintain one's physical and mental health, including, but not limited to,, medical services, which a prudent person would consider essential for well-being. "Neglect" is repeated conduct or a single incident of carelessness which produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death. You would need to have staff report such self-neglect to the DCF Abuse Registry.
- Probate Rule 5.900 that governs expedited judicial intervention concerning medical treatment procedures provides for a petition to be filed with the court and an order for treatment when a patient lacks the capacity to make requisite medical treatment decisions.

The Florida Medical Practice Act identifies the many grounds for disciplinary actions that can be taken against physicians by the Department of Health's Board of Medicine. Some of these include failing to perform any statutory or legal obligation and failing to comply with the requirements of chapter 381.026, F.S. that governs the Florida Patient's Bill of Rights. This law requires among many other things that patients have a right to be given information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis as well as the right to refuse any treatment, except as otherwise provided by law. This means that when a patient can't provide consent, a legally authorized substitute decision-maker would have to provide the consent, except where life threatening medical intervention is documented.

Using the Baker Act to force medical treatment or prevent AMA has resulted in law suits against hospitals for battery and false imprisonment. Attorneys for the hospital would have to guide you in resolving the problem you raise, but I'm sure they would agree with both of us that use of the Baker

Act to address the behavior of a person not meeting criteria for purposes never intended by the statute would not be an option.

Q. We have been told by receiving facilities that they cannot accept patients on dialysis or with other chronic medical issues, despite the fact that they are medically cleared and do not require admission or acute treatment for an ongoing chronic medical issue. Is this true? If yes, are their specific limitations? First instinct is that we would have our psychiatrist/psychologist evaluate, but the evaluating psychiatrist feels they cannot complete the Baker Act and patient needs placement in a psychiatric setting, what are our options.

If a facility is licensed as a free-standing psychiatric hospital or as a crisis stabilization unit, it can refuse transfers because of it lacks capability to meet medical needs of a patient. However, if it is a psychiatric unit located in a licensed general hospital, it must either provide a psychiatric overlay on a medical unit or a medical overlay on its psychiatric unit. It cannot hold itself out as a general hospital yet fail to meet the conditions of a general hospital.

Q. What kind of medical issues shouldn't be considered barriers to transfer to CSU's and free-standing psychiatric hospitals?

Some medical conditions recently reported to be barriers to accepting a transfer include:

- Refusal because the person uses a cane, crutches, or a walker that could be used as a weapon. This is not acceptable due to ADA -- the person can be offered a wheelchair if needed while in the facility.
- Refusal because the person has a companion animal because staff said the patient couldn't be allowed to take the animal outside and the staff didn't have the time to do so. Another ADA situation.
- Refusal for being overweight if they need assistance in transferring -- staff don't have specialized beds, equipment, etc
- Refusal of transfers of persons who are incontinent --Use of adult diapers would solve the problem?
- Blood Alcohol Level is a frequent barrier. All CSU's should be able to care for an intoxicated person who otherwise meets criteria for involuntary examination under the Baker Act unless the person can't walk/talk or appears to be medically unstable.
- Psychiatric units of some general hospitals are refusing to accept transfers of persons with medical conditions (not emergency medical conditions) because they say they aren't staffed to provide medical care. This is unacceptable because they are licensed as general hospitals -- not specialty hospitals. They must either bring the medical care onto the psych unit or place the patient on a medical unit with psych treatment and a sitter.

The American's with Disabilities Act (ADA) would certainly preclude some of the above from being used as a reason for denial of a transfer – accommodations must be made whenever possible. However, there are some conditions requiring sterile environment, contagious illnesses, IV therapy, and other medical conditions that could not be accepted in a non-medical or non-hospital environment. Each DCF Circuit was to have developed a set of protocols dealing with medical barriers to admission to free-standing facilities.

In any case, a medical barrier to transfer should be well-documented and not based on convenience of staff or contrary to federal/state laws. Further, a receiving facility (CSU or hospital) must accept any person brought by law enforcement for an involuntary examination. If the CSU determines the person has an acute physical problem requiring a hospital-based examination or treatment, the

patient can be sent by EMS. The officer should NEVER be told to take the person to the ER for "medical clearance". Some facilities have the person brought by law enforcement sent to a hospital for "medical clearance" with no intention of accepting the person back from the hospital once cleared.

Q. What recourse does a hospital ER have when a patient refuses or seems incapable of consenting to medical treatment such as daily dialysis that is necessary to preserve his life/health? Can a receiving facility refuse to accept a transfer of such a patient?

First is that a person who is capable of making his/her own health care decisions, has the right to consent or refuse consent to treatment. A number of appellate cases support state law (765, F.S.) and the state constitution in upholding a person's right to refuse unwanted medical intervention. Simple refusal of medical care, even if it was determined to constitute self-neglect or could lead to death, wouldn't be sufficient to warrant initiation of an involuntary examination under the Baker Act.

Second is the definition of mental illness in the Baker Act. The law defines it as:

(18) "Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology. For the purposes of this part, the term does not include retardation or developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

This means the person must have some type of serious thought or mood disorder that substantially interferes with his ability to meet the ordinary demands of living.

Third is the criteria for initiating an involuntary examination under the Baker Act.

394.463 Involuntary examination.--

(1) CRITERIA.--A person may be taken to a receiving facility for involuntary examination if there is reason to believe that the person has a mental illness and because of his or her mental illness:

(a)1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or

2. The person is unable to determine for himself or herself whether examination is necessary; and

(b)1. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or

2. There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

The man would have to have a mental illness as defined in the law and because of that mental illness, have refused or been unable to determine the examination is necessary. Refusal for purposes other than mental illness would not suffice. Further, the professional initiating the examination would have had to reach his/her conclusion that the man met each of the above criteria based on his/her own observations.

Finally, if every dialysis provider in a geographic area refused life-saving treatment to a person, a report to the Agency for Health Care Administration should be filed. In any case, a report to Adult

Protective Services might be appropriate since this man may be a vulnerable adult who is suffering from self-neglect.

Now with regard to your specific question, it is entirely appropriate for a receiving facility to decline a person due to medical instability because it is a free-standing psychiatric facility that doesn't have the capability of managing such a medical condition. However, a general hospital also designated as a receiving facility under the Baker Act has, by virtue of its licensure, the capability of managing the man's medical condition while also conducting his psychiatric examination. This may require a medical overlay on its psychiatric unit or a psychiatric overlay on its med/surg unit. However, it cannot refuse a transfer of a person with an emergency medical condition (even if just a psychiatric or substance abuse emergency) from a hospital that doesn't have the capability of meeting the person's specialized needs.

Q. Someone in our corporate office told us that in some states there is an ability to deny service to a patient at one location, but find them services elsewhere for their care. They base this denial on something called "caregiver fatigue". Have you ever heard of this? Is this something that would go against any rules in the Baker Act?

The federal EMTALA law would require all hospitals to "accept" any person to evaluate for an emergency medical condition, even if only of a psychiatric or substance abuse nature. The state's Baker Act would also require you to "accept" any person brought by law enforcement for involuntary examination.

Both laws refer to acceptance and examination – not to admission. If you can find an alternate facility with the capability and capacity to meet the person's needs that is willing to accept the pre-admission transfer and it has nothing to do with inability to pay for care, such a transfer is generally appropriate. As a general full-service hospital, you have the capability and capacity to meet people's emergency needs. Prior to admission of a person with an emergency psychiatric condition, the person or legal representative would have to consent to the transfer as well as having a willing destination facility.

Once an admission occurs and EMTALA is no longer a factor, the state's Baker Act transfer provisions apply as follows:

394.4685 Transfer of patients among facilities.--

(3) TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.--

(a) A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.

(b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

(c) A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.

(4) TRANSFER BETWEEN PRIVATE FACILITIES.--A patient in a private facility or the patient's guardian or guardian advocate may request the transfer of the patient to another private facility at any time, and the patient shall be transferred upon acceptance of the patient by the facility to which transfer is sought.

As you can see above, the post-admit transfer from your hospital to another willing receiving facility can be accomplished without patient consent.

“Caregiver Fatigue” as a reason for a transfer is questionable. Assuming that all the above conditions are met, this might be acceptable. Transfers are sometimes expedited when the patient is an employee of the facility or a close relative of an employee. Also when the patient has assaulted an employee or a restraining order has been issued. You may want to run this issue by your hospital attorney or risk manager.

Q. Can a Receiving Facility refuse to accept a transfer of a person on Baker Act involuntary status from an ER who has been medically cleared but requires ongoing oxygen?

Traditionally metal oxygen canisters could be used as a weapon; thus constituting a reason to refuse otherwise appropriate transfers. However, staff from receiving facilities state that the need for oxygen should not be a barrier for transfer to any receiving facility because oxygen can now be administered through small "concentrators" that have very short tubes that are less likely to be used as weapons. In such cases, an exclusion related to oxygen may be inappropriate.

Q. I have question on "determination that person does not meet involuntary placement". An involuntary examination form was completed at a nursing home and the resident was sent to our hospital ER for medical clearance. Once cleared by our ER physician, we were unable to transfer. As a result, we have to admit the person to a medical floor on an inpatient basis. The attending physician states the patient is not medical cleared psychiatrically. How long do we continue to wait for clearance? Can the attending physician determine that person does not meet involuntary placement and complete the appropriate form? Is the nursing home held accountable to accept patient back?

Your hospital has just 12 hours to transfer a person under involuntary examination criteria after a physician determines the emergency medical condition (as defined in 395.002, FS) is stabilized or found not to exist. There is no maximum length of time for the EMC – some may be stabilized in an hour while others may take weeks. This presumes that a person can't be psychiatrically examined while an emergency medical condition exists. However, an emergency medical condition and having medical issues may be two entirely different situations. Just having medical issues wouldn't be legally sufficient to warrant depriving a person of liberty. If the physician is holding the person longer than 12 hours past the stabilization of an emergency medical condition, you should contact hospital administration to discuss the potential liability. The attending physician at a hospital examining/treating an emergency medical condition is authorized to conduct the involuntary examination and release the person (or convert to voluntary status) if the person doesn't meet involuntary placement criteria.

Long-term care facilities must understand that the Baker Act cannot be used to avoid their federal and state obligations to do adequate discharge planning for residents who cannot be served in their facilities. Hospital ER's and Baker Act receiving facilities are NOT discharge destinations – they are merely facilities to which long-term care residents meeting certain criteria can be transferred for purposes of examination and treatment of acute care conditions. The nursing home should be reported to AHCA and it is likely to be cited for failure to conduct legally required discharge planning as have other SNF's in the state.

Q. We are a free-standing facility that received a patient on a Baker Act. The doctor found him to be incompetent to consent to treatment and filed a petition for placement as well as a Guardian Advocate. Due to his mental illness the public defender requested a continuance and appointment of a Guardian Advocate. The patient stopped eating prior to admission due to his illness and this continued while at our facility. He had to be transferred and admitted to a

medical facility due to critical labs and dehydration. Is he still under the involuntary placement order -- can the Advocate make extraordinary treatment decisions in order to tube him for feeding and continue the IV fluids? He was discharged on record because he can't be on inpatient status in two places at one time but his mental illness as well as his medical illness is not being addressed. If the clock stops on the Baker Act, what does it mean for the order?

The Baker Act states that the guardian advocate is discharged when the patient is "discharged" from an order for placement or transferred to voluntary status. If the patient wasn't discharged from the Baker Act (even though an administrative or financial discharge occurred) and the patient wasn't transferred to voluntary status, the Guardian Advocate may still be active. While a person under involuntary orders who requires specialized treatment in another unit or facility may have some type of administrative or financial "discharge" recorded in such records, the clinical record should reflect the person was "transferred" for such care. This is similar to a transfer to the state hospital that keeps the entire legal framework intact.

The only reference to the "clock stopping" is within the 72-hour involuntary examination period. It doesn't stop pending the involuntary placement hearing or once an involuntary placement order has been entered. The court can, if the patient requests it, continue the hearing for another period or could grant a request for a change of venue to conduct the hearing at the medical hospital.

If the Guardian Advocate was given authority by the court to consent to medical treatment, he/she would have authority to consent to tube feedings and IV treatment. The only procedures that require extraordinary authority of the court in a separate hearing are: abortion, sterilization, electroconvulsive treatment, psychosurgery, and experimental treatments.

If the person who was appointed guardian advocate is a relative or a friend, that person could also serve at the same time as the patient's health care proxy. This wouldn't expire when the patient was transferred to another facility if the patient remained incapacitated or incompetent to make his/her own health care decisions. If the Guardian Advocate was an "adult trained and willing to serve", he/she wouldn't have standing to serve as the patient's proxy.

Q. I am a case manager with a client diagnosed with Paranoid Schizophrenia. One of the ongoing symptoms of his illness is a lack of trust in doctors; he is afraid they will commit him, so he will only go to the ER in the middle of the night when there are the fewest people there. Last night he went to the ER with chest pain and shortness of breath. The tests all pointed to the need for immediate medical treatment, but the client left AMA. The doctor says the client needs to be hospitalized immediately. I took the client to the ER again, but he refuses to stay. I am told that he does not meet criteria for involuntary examination as a danger to self; this is a medical rather than a psychiatric issue. I was advised to contact DCF Adult Protective Services and let them follow up. What can be done?

The Baker Act doesn't offer any authority to perform any medical examination or medical treatment – other statutes would have to be used instead. In this case:

1. Once a physician had determined him to lack competence/capacity to make medical decisions a family member or close personal friend could be designated as the man's health care proxy to give consent to whatever they believed he would have wanted if he had been competent to consent on his own.
2. If the man has a life threatening condition and there is reason to believe that he would have consented to the medical examination or treatment if he had the capacity to do so, the physician could have initiated the treatment.

3. The hospital's attorney could assist in getting expedited judicial intervention for medical treatment (Probate Rule 5.900).
4. If the man was over the age of 60 or disabled and suffered from self-neglect due to his incapacity, a referral to DCF Abuse Registry could have achieved the necessary result.

A person doesn't need to be overtly "dangerous to self or others" to meet the criteria for an involuntary examination under the Baker Act. It could be after an authorized profession has determined:

Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services (394.463(1)(b)1., FS)

If this man has a mental illness as defined in the Baker Act, has refused or is unable to determine that a psychiatric examination is needed, and is either self-neglectful or dangerous to self or others as a result, the criteria is met. However, this only authorizes psychiatric examination and would not be the right instrument to seek medical care for someone who can't make such decisions on his/her own. He could be held for psychiatric examination and while at the hospital, one of the other alternatives could be used to initiate medical examination and treatment.

Q. What should our hospital do to keep a person's legal status intact (including a guardian advocate) when the person's medical condition requires a discharge to a medical facility?

Hospitals can do some type of an administrative discharge for the purpose of preventing billing on two units for the same day of care, but can't do a Baker Act "discharge" if the patient continues to meet the involuntary placement criteria. The guardian advocate appointed by the court would be automatically discharged and would no longer have authority to provide consent to psychiatric or medical treatment as authorized by the court. If the guardian advocate was a family member or close personal friend, he/she might be able to act as a health care proxy to provide consent to medical treatment. However, if the GA is an "adult trained and willing to serve" he/she wouldn't have authority under chapter 765 to serve as a proxy.

EMTALA Applicability

Q. Could you verify with AHCA that the federal EMTALA law still applies and that a local hospital-based receiving facility can't deny a requested transfer from an out of area indigent person with an emergency psychiatric condition?

Both federal EMTALA and state emergency access laws would still apply regarding emergency services (including psych emergencies). But, as always, the hospital can limit access to non-emergency services for those who do not have the ability to pay for non-emergency services.

Q. We admit all of our patients to an 8 bed crisis unit until we assess their safety and acuity before admitting them to our larger open psychiatric inpatient unit. We recently had a patient come into our ED and our crisis unit was full. So we immediately started to call around to see if there were open beds in the community. We found another facility with an open bed and they accepted the patient. We received a call from that facility the next day and they wanted to know if our crisis was still full because they wanted to send her back. Since, both facilities are providing the same level of care our psychiatrist said no. So I wanted to make sure that we are following the rules, we do not want violate any rules, laws.

The issue you raise is really governed by federal and state laws overseen by AHCA rather than the Baker Act. As you know, under EMTALA, you can't refuse to admit a person with an emergency condition based on inability to pay if you have the capability and capacity to manage their care. The federal EMTALA law and the state's hospital licensing law address this issue. CMS includes psychiatric and substance abuse emergencies as "emergency medical conditions", even in the absence of other medical conditions.

Your hospital certainly has the capability of dealing with the entire range of emergency psychiatric and medical conditions, but you raise the issue of whether you have the capacity if your "CSU" is full. The federal law would require you to arrange for capacity issues for indigent persons in the same way you would do so for paying patients.

The state's hospital licensing laws have some definitions as well as two provisions that might apply to your situation:

395.002, FS Definitions

(25) "Service capability" means all services offered by the facility where identification of services offered is evidenced by the appearance of the service in a patient's medical record or itemized bill.

(26) "At service capacity" means the temporary inability of a hospital to provide a service which is within the service capability of the hospital, due to maximum use of the service at the time of the request for the service.

395.1041 Access to emergency services and care.—

(3)(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. **When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.**

Since your CSU is licensed the same as your other unit and it's your hospital's choice to use the CSU as an assessment site, you may want to determine if you can expedite persons through this unit by discharge or transfer to free up a CSU bed, rather than denying admission, especially if the person is indigent.

Once your obligations under the federal EMTALA law and the state's hospital licensing laws have been met, the Baker Act transfer provisions apply, as follows:

394.4685 Transfer of patients among facilities.

(3)TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.—

(a)A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.

(b)A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

(c)A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.

(4)TRANSFER BETWEEN PRIVATE FACILITIES.—A patient in a private facility or the patient's guardian or guardian advocate may request the transfer of the patient to another

private facility at any time, and the patient shall be transferred upon acceptance of the patient by the facility to which transfer is sought.

It appears that you should consider the entire capacity licensed by AHCA and that the state law requires that you accept the return of the patient once you again have the capacity. Again, capability isn't an issue because as a general hospital, you can meet the behavioral and medical needs of the patient. However, repeated transfers can be detrimental to the patient's care and should be minimized whenever possible.

Q. For some reason lately our behavioral health beds for the district have been full and above capacity. We even have exceeded our capacity by 10% to accommodate behavioral health patients so they could begin receiving treatment. The Baker Act states that we can exceed our capacity by 10% for individuals that need our services. Once we take the extra 2 patients, we cannot accept any more patients on the unit? Is this correct? The ED physician would like to know if we go above our capacity(behavioral health), can the behavioral health patient be admitted to the hospital in another bed, until the behavioral health bed becomes available. I told him no, we could only admit over by the 10% listed in the Baker Act.

The Baker Act is Chapter 394, Part I – it doesn't address census issues. However, Chapter 394, Part IV governing publicly funded mental health and substance abuse services addresses census for "public" receiving facilities – not "private" receiving facilities. According to Part IV, a CSU (public receiving facility) can't exceed its licensed capacity by more than 10%, or for more than 3 consecutive working days, or for more than 7 days in a month. No reference is made to private receiving facilities such as yours.

Hospitals are governed by the federal EMTALA law and chapter 395, FS. The federal EMTALA law would require you to go over census for indigent patients with emergency medical conditions (including behavioral health emergencies) if you do so for paying patients.

Your entire hospital is designated as the receiving facility – not just the behavioral health unit. If the needs of the patient require him/her to be placed in a medical bed instead of a specialized psychiatric bed for his/her needs to be met, that would be a clinical management decision of the hospital. In fact, as a general hospital, you would be expected to provide a psychiatric overlay for persons on a Baker Act in med/surg units and a medical overlay for such persons on your behavioral health unit if clinical needed.

Q. Are the CSU's governed under EMTALA to provide us with the name of an accepting physician upon transfer? Are there any guidelines that you are aware of that would mandate a physician to physician communication before acceptance, besides the fact that it is in the best interest of the patient.

A CSU isn't governed under the federal EMTALA law – this law only governs hospitals. However, The Centers has a specialty licensed psychiatric hospital on the same site as the state regulated CSU. This hospital and related facilities are subject to EMTALA. In any case, the accepting facility may not know at the time of acceptance or transfer which physician will be assigned to attend that patient. The facility, in accepting the patient's transfer, is obligated to provide all needed care, including the care of a physician.

There are no requirements for physician to physician communication prior to acceptance. This is usually done through a nurse to nurse contact. This is generally sufficient and since CSU's and

psychiatric hospitals don't generally have a physician present on a 24/7 basis, it is also more practical.

Q. A local public receiving facility has told us that because they are a CSU, they have the right to refuse BA patients and send them to our private receiving facility, regardless of whether or not they are full and it is not an EMTALA violation. Could you please clarify this for me?

Since this is a receiving facility under the state's Baker Act law, it must "accept" any person brought by law enforcement for involuntary examination. If it doesn't have the space or programming to meet the person's needs, it can attempt to find another willing receiving facility to accept the requested transfer. As this facility is a "public" receiving facility, the following statutory language applies:

394.4685 Transfer of patients among facilities.--

(2) TRANSFER FROM PUBLIC TO PRIVATE FACILITIES.--A patient who has been admitted to a public receiving or public treatment facility and has requested, either personally or through his or her guardian or guardian advocate, and is able to pay for treatment in a private facility shall be transferred at the patient's expense to a private facility upon acceptance of the patient by the private facility.

As you can see, any request for such a transfer has to be at the request of the patient/rep (not the facility) and it can only be carried out upon acceptance by the private facility.

The other side of this issue is the federal EMTALA law. The information you've been given may not be correct because this public receiving facility is identified by the Agency for Health Care Administration as an adult psychiatric hospital licensed under chapter 395, in addition to its adult CSU and CSSU licensed under chapter 394. They are all co-located at the same address. A hospital would have to accept any person coming to its premises on voluntary or involuntary status and conduct a medical screening examination within the capability of the hospital to provide. Only after that would the hospital be able to seek an appropriate transfer of a patient for whom it lacked the capacity or capability to meet the patient's needs to a hospital with such capability and capacity. Denial or delay of treatment due to a person's inability to pay would be a violation of the federal EMTALA law as well as the State's Baker Act law.

AHCA has cited other free-standing psychiatric hospitals in Florida for EMTALA violations, even those designated as public receiving facilities under contract with DCF. Of course, AHCA is the final arbiter of whether an action is a violation of EMTALA.

Even if federal EMTALA wasn't applicable in a given situation, the state's Baker Act does apply. In any case, the public receiving facility for your locale, has a special responsibility, as follows:

65E-5.351 Minimum Standards for Designated Receiving Facilities.

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

Q. A general hospital ER Medical Director said in a public meeting *"If a person who is under a Baker Act comes to the emergency room due to a medical emergency and the ER physician documents that the medical emergency condition has been stabilized, or not longer exists, EMTALA no longer applies"*. We agree with this portion but when asked about the mental health emergency due to the Baker Act that EMTALA seems to also consider an emergency medical condition, he then added *"Even if the person is still under a Baker Act, (and the*

physician does not do the examination to release the person or make them voluntary because they don't want to or their administration is not comfortable with them doing that) but the ER physician documents that they do not believe that there is still a mental health emergency, EMTALA no longer applies and the transfer could occur without any notification to the receiving facility" How would a receiving facility would know that the physician did not feel there was still a mental health emergency if they arrive with a Baker Act still in effect without prior notification and acceptance from the receiving facility. Also the receiving facility would see this as an EMTALA violation as they would have no prior knowledge of the physician's documentation that they do not believe that the person has a mental health emergency with the Baker Act still in effect. His answer was "*one has nothing to do with the other, I do many other (medical) transfers that are not emergencies, I do make a courtesy call to set them up for the transfer but it is not required as EMTALA no longer applies*".

It just seems that a Baker Act is THE indicator of a possible mental health emergency, especially to us at a Baker Act Receiving Facility. Is this doctor really correct in saying that all he has to do is document that he does not believe that there is medical OR mental health emergency & that EMTALA would no longer apply and therefore the hospital would not be required to notify the receiving facility prior to a transfer? (Keep in mind the transfer is still required because the Baker Act is still in effect as far as the physician is concerned.)

You and your medical director are correct. A psychiatric or substance abuse emergency is an emergency medical condition, even absent any other medical condition. As long as the psychiatric emergency continues and the patient hasn't been admitted to the hospital, EMTALA continues. If the ER physician has determined that psychiatric care would be beneficial, but that the legal criteria for involuntary examination or involuntary placement isn't currently met, he/she has documented that the patient is stable for discharge instead of stable for transfer. The ER could then convert the patient to voluntary status and still refer him/her to a public or private receiving facility or to home with aftercare services recommended.

Notifying the receiving facility would always be required prior to a transfer, regardless of EMTALA.

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.--

(g) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

(h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or

2. The patient **must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.**

Without sharing in advance of a transfer all medical records from the hospital and a review of those records by a receiving facility staff to determine the capability of the facility to manage any medical needs of the patient, this statutory requirement wouldn't be met. Further, it requires a notification to the receiving facility within 2 hours of medical stabilization. The law is clear that the receiving facility must be notified in advance of the transfer and approval received prior to the transfer.

It isn't just the Baker Act itself that applies, but also the hospital licensure law that has the following provisions:

395.003(5)(a) governing licensure of all hospitals states "Adherence to patient rights, standards of care, and examination and placement procedures provided under part I of chapter 394 shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment".

(5)(b)"Any hospital that provides psychiatric treatment to persons under 18 years of age who have emotional disturbances shall comply with the procedures pertaining to the rights of patients prescribed in part I of chapter 394".

395.1041(6) RIGHTS OF PERSONS BEING TREATED.--A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

395.1055(5) governing rules and enforcement states "The agency shall enforce the provisions of part I of chapter 394, and rules adopted thereunder, with respect to the rights, standards of care, and examination and placement procedures applicable to patients voluntarily or involuntarily admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment".

Each of these provisions in the hospital licensing law clearly identifies the responsibilities of all hospitals that hold a person under the provisions of the Baker Act to comply with all related Baker Act requirements, regardless of whether it is designated as a receiving facility.

Q. Does the Baker Act or the hospital licensure law govern access to emergency services?

The Baker Act is limited to psychiatric examination and psychiatric treatment. Section 395.1041, FS governing Access to emergency services and care governs medically necessary transfers, as follows:

(3)(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

(3)(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

Q. Which facilities are subject to the federal EMTALA law?

Any public, private, or non-profit hospital that offers services for medical, psychiatric or substance abuse emergency conditions is obligated to comply with all of the EMTALA requirements found in 42 CFR 489.20 and 489.24. This would include a freestanding psychiatric hospital that receives persons with emergency psychiatric conditions. All licensed general hospitals are required to comply with section 395.1041, F.S. A hospital that does not offer emergency services is not required to comply with EMTALA. Conversely, a facility that is not licensed as a hospital, such as a CSU, nursing home, assisted living facility, outpatient clinic or doctor's office is not required to comply with EMTALA or section 395.1041, F.S.

Q. Who is subject to the federal EMTALA Transfer law?

EMTALA applies to all transfers of persons from and to hospitals of persons with an emergency medical condition; this by federal definition includes psychiatric and substance abuse emergencies. An involuntary examination under Baker Act or protective custody under the Marchman Act would constitute such emergencies. EMTALA doesn't apply to CSU's at all; it applies to any transfer of a person out of and into a hospital of a person who has an emergency medical condition.

EMTALA discourages lateral transfers to other hospitals, much less downward substitutions of care for persons in emergency medical conditions. It defers to state and local plans to do so in some cases such as CSU and detox facilities established and funded by the state solely for indigent persons. Once the person's emergency medical condition has been stabilized (defined as unlikely to experience a deterioration in condition during or as a result of the transfer) and other required conditions for an appropriate transfer have been met, the person can be transferred to a facility that has the capability and capacity to manage the person's condition and has agreed to accept the person, based on review of medical records. If the transferring hospital is a designated receiving facility, it must have the consent of the patient or legal representative; if not a designated receiving facility, a physician can certify the benefits of the transfer outweigh the risks.

Q. There are some difference in requirements between the federal EMTALA law and the state's Baker Act law. Which should we follow?

The federal EMTALA law always takes precedence over the state's Baker Act when the two laws are in conflict – if not in conflict, hospitals must comply with both laws. EMTALA no longer applies once a person has been admitted to a hospital because the federal Conditions of Participation are believed to be sufficient to protect the rights of patients. In those cases, the Baker Act transfer provisions apply and the state law clearly provides that a person can be transferred between facilities.

Q. I am a MSW Case Manager. If a person under a Baker Act is brought to us through the ER and admitted due to a medical need, does EMTALA then no longer apply once they are medically stable for transfer to a psych facility?

EMTALA requires all licensed hospitals to accept any person and to conduct a medical screening examination regardless of the person's ability to pay to determine if the person has an emergency medical condition, even if of a psychiatric or substance abuse nature even absent any other medical issues. If the person has an emergency, the hospital must admit or transfer the person. If the person is admitted, EMTALA no longer applies. It is presumed that the federal Conditions of Participation provide sufficient protections for patients after admission.

If a person on pre-admission status has an emergency for which your hospital doesn't have the capability or capacity to treat and your physician has certified that the transfer risks are outweighed by the benefits, you can seek a transfer to another hospital or facility that has the capability and capacity to meet the person's emergency needs, regardless of the person's ability to pay. This must be done within 12 hours after your physician has documented that the medical emergency has been stabilized or found not to exist. A licensed hospital that has the capability and capacity cannot discriminate against a person on pre-admission status with an emergency medical condition unable to pay for care.

However, you should attempt to send the patient to a hospital or facility that accepts the person's insurance. If the person has no insurance, you should attempt to transfer the person to a public receiving facility under contract with DCF. Even if the medical emergency has been stabilized, most public receiving facilities have minimal capability of addressing medical issues. Each DCF circuit should have developed some type of "MEDICAL STABILIZATION GUIDELINES" that should assist you.

Q. EMTALA obligations still must be met when a patient is under a Baker Act. They still must be logged in the central log and they still must receive a Medical Screening Examination. Is that correct?

Whenever the federal EMTALA law and the state's Baker Act are in conflict, the EMTALA law prevails. When they are not in conflict, both must be followed. In every case where EMTALA applies, EMTALA must be followed. Even free-standing specialty psychiatric hospitals are subject to EMTALA, within their capability, since an emergency psychiatric or emergency substance abuse condition is considered an emergency medical condition under EMTALA. One Class 3 free-standing psychiatric hospital in another part of Florida recently faced significant sanctions from CMS/AHCA for failing to meet EMTALA requirements.

If your mental health unit is part of the general hospital license issued by AHCA, it may need to get clarification from AHCA as to whether it can act as a specialty hospital in such cases. CMS has recently been very active in some parts of the country in investigating hospitals with general licenses for sending patients out on 911 calls. Further, if the address listed on your designation letter for the receiving facility is the same as for the general hospital, DCF would consider all parts of the hospital to be subject to the receiving facility designation. If the address on the designation letter for the MHU is different from the main hospital building, the designation would only apply to the MHU.

Medical Clearance

Q. What does the BA law say about patients that are placed on 23 hour holds at the front door (prior to admission) that need to go out for medical clearance? Technically, there is no paperwork associated with a 23 hour hold and the medical facility feels uneasy holding someone without paperwork.

The Baker Act doesn't reference "23-hour holds". Everything on timing for involuntary examination (72 hours) starts on the individual's arrival at the receiving facility door, not upon admission, physician orders, or upon transfer onto the inpatient unit itself. Everything on the premises of the receiving facility is considered part of the receiving facility itself.

A person is either on voluntary or involuntary status – there isn't any other category. If you have people on 23-hour hold who are not permitted to leave the facility, that period of time would count against the 24 hours to be certified by a physician as competent to consent to voluntary admission or the 72-hour period for involuntary examination, even though they hadn't been formally admitted to your facility.

If a person is on "voluntary" status when sent from a receiving facility to a medical hospital, the medical facility would have no basis for holding the person against his/her will unless an authorized professional at the medical facility initiated an involuntary examination. However, if River Point had initiated an involuntary examination prior to sending the person to the medical facility, the person could be held (but not necessarily medically examined or medically treated). The 72-hour clock is only stopped for an emergency medical condition, not for "medical clearance" per se. The period of time in which a person is deprived of liberty for involuntary examination (short of an emergency medical condition) is limited to 72 hours.

Q. Is it appropriate for a receiving facility or a CSU licensed under Chapter 394 to routinely utilize emergency departments to require "medical clearance" for persons under the Baker Act? If not, is there a suggested course of action for the emergency personnel to take?

NO. On occasion it is appropriate for a CSU to request treatment of an "acute medical condition" prior to admitting a person. 65E-12, FAC only permits a CSU to refer a person out for an acute physical condition -- not for "medical clearance". Medical clearance only arises when a person is being returned to a CSU after evaluation or treatment of an acute physical condition.

These might include cases where there is reason to believe the person has ingested a toxic substance, has suffered a severe injury, is suffering an acute medical crisis, is in need of intensive nursing care, receiving intravenous fluids, or may require a sterile environment, etc. In such cases, admission to such a free-standing psychiatric facility may be inappropriate until a medical clearance rules out such identified conditions or it is determined that the facility to which the person would be transferred has the capability to manage the person's medical needs. In summary, if a person with an emergency medical condition presents to a Baker Act receiving facility that does not have the capability or capacity to treat emergency medical conditions, it would be appropriate for the receiving facility personnel to call 911 to arrange EMS assistance to transfer the person to a facility that could provide this service.

However, it is never appropriate for a CSU to routinely require persons be medically screened at an emergency department before admission or to refer all intoxicated persons for blood levels unless an emergency medical condition was suspected. A nursing assessment of persons is required at a CSU and, if conditions are noted which suggest the need for acute medical treatment; the CSU would be required to refer the person to a hospital. If a CSU routinely requires "medical clearance" of persons from emergency departments, such practice should be documented and reported to DCF for investigation.

Q. Do receiving facilities have the right to require medical clearance before accepting persons on involuntary status, particularly those coming from law enforcement? Does it make a difference if the receiving facility is private or public, in terms of any right to require medical clearance?

No. The Baker Act is quite clear that "The nearest receiving facility must accept persons brought by law enforcement officers for involuntary examination". There is no exception to this -- not even medical emergencies. Once the officer arrives at a public or private receiving facility, the staff can call 911 to get an ambulance if they believe the person has an acute medical condition requiring emergency examination or treatment. The person should never be put back in a cruiser for the officer to further transport in such a circumstance. The person should instead be referred by the CSU to the nearest ER, regardless of whether the hospital has psychiatric capability.

Once the person has been taken to a hospital that is not designated as a receiving facility for evaluation or treatment of an emergency medical condition, the person must be transferred to a designated receiving facility at which appropriate medical treatment is available within 12 hours of a physician determining the person's medical condition has stabilized or that an emergency medical condition does not exist.

In the latter situation, the CSU can request medically necessary tests be done by the sending hospital that that allow CSU staff to confirm that it can provide necessary medical treatment prior to accepting the person. All medically required tests should be requested at one time so that the transfer for psychiatric examination is not delayed.

In exchange for receipt of public funding, chapter 65E-5.351(5) FAC requires that a public receiving facility that is affiliated with a publicly funded community mental health center ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness. A public receiving facility should take the leadership in solving problems.

Q. EMTALA obligations still must be met when a patient is under a Baker Act. They still must be logged in the central log and they still must receive a Medical Screening Examination. Is that correct?

Whenever the federal EMTALA law and the state's Baker Act are in conflict, the EMTALA law prevails. When they are not in conflict, both must be followed. In every case where EMTALA applies, EMTALA must be followed. Even free-standing specialty psychiatric hospitals are subject to EMTALA, within their capability. Even an emergency psychiatric or emergency substance abuse condition is considered an emergency medical condition under EMTALA. One Class 3 free-standing psychiatric hospital in another part of Florida recently faced significant sanctions from CMS/AHCA for failing to meet EMTALA requirements.

If your mental health unit is part of the general hospital license issued by AHCA, it may need to get clarification from AHCA as to whether it can act as a specialty hospital in such cases. CMS has recently been very active in some parts of the country in investigating hospitals with general licenses for sending patients out on 911 calls. Further, if the address listed on your designation letter for the receiving facility is the same as for the general hospital, DCF would consider all parts of the hospital to be subject to the receiving facility designation. If the address on the designation letter for the MHU is different from the main hospital building, the designation would only apply to the MHU.

EMTALA / Medical Screening

Q. If a person comes in under the Baker Act into the ED, refusing to have any labs drawn, and the receiving center won't take her unless labs are done, what is the next step? Can they be forced to submit to lab work? Do we notify anyone in particular about the issue?

The Baker Act is only the Florida Mental Health Act and doesn't address issues of medical examination or medical treatment. However, if the individual has what may be an emergency medical condition, chapter 401 provides immunity to EMS and ED personnel to exam and treat such an individual, as follows:

401.445 Emergency examination and treatment of incapacitated persons.

(1) No recovery shall be allowed in any court in this state against any emergency medical technician, paramedic, or physician as defined in this chapter, any advanced registered nurse practitioner certified under s. 464.012, or any physician assistant licensed under s. 458.347 or s. 459.022, or any person acting under the direct medical supervision of a physician, in an action brought for examining or treating a patient without his or her informed consent if:

(a) The patient at the time of examination or treatment is intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent as provided in s. 766.103;

(b) The patient at the time of examination or treatment is experiencing an emergency medical condition; and

(c) The patient would reasonably, under all the surrounding circumstances, undergo such examination, treatment, or procedure if he or she were advised by the emergency medical technician, paramedic, physician, advanced registered nurse practitioner, or physician assistant in accordance with s. 766.103(3).

Examination and treatment provided under this subsection shall be limited to reasonable examination of the patient to determine the medical condition of the patient and treatment reasonably necessary to alleviate the emergency medical condition or to stabilize the patient.

(2) In examining and treating a person who is apparently intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent, the emergency medical technician, paramedic, physician, advanced registered nurse practitioner, or physician assistant, or any person acting under the direct medical supervision of a physician, **shall proceed wherever possible with the consent of the person. If the person reasonably appears to be incapacitated and refuses his or her consent, the person may be examined, treated, or taken to a hospital or other appropriate treatment resource if he or she is in need of emergency attention, without his or her consent, but unreasonable force shall not be used.**

(3) This section does not limit medical treatment provided pursuant to court order or treatment provided in accordance with chapter 394 or chapter 397. *(the Baker and Marchman Acts only address treatment of mental illness and substance impairment)*

401.45 Denial of emergency treatment; civil liability.

(1)(a) Except as provided in subsection (3), a person may not be denied needed prehospital treatment or transport from any licensee for an emergency medical condition.

(b) A person may not be denied treatment for any emergency medical condition that will deteriorate from a failure to provide such treatment at any general hospital licensed under chapter 395 or at any specialty hospital that has an emergency room.

(2) A hospital or its employees or any physician or dentist responding to an apparent need for emergency treatment under this section is not liable in any action arising out of a refusal to render emergency treatment or care if reasonable care is exercised in determining the condition of the person and in determining the appropriateness of the facilities and the qualifications and availability of personnel to render such treatment.

If the person's medical condition could be of an emergency nature, the above statutory provisions should give you the authority of drawing the lab specimens. However, if not of an emergency nature and solely because the receiving facility desires such lab tests to be done, it is doubtful that you have any authority to force such intrusive drawing of specimens.

The findings of the physician who has actually examined the individual should be provided more weight than a set of policies requiring lab work. However, the receiving facility shouldn't be accepting transfers of individuals from hospitals unless they are confident they can meet the person's medical as well as their psychiatric needs. In such a situation where an individual's psychiatric condition may be the basis of refusal of consent for lab work and there is no evidence otherwise that the person has medical condition, a physician to physician consult may resolve the transfer problem.

Q. Some Baker Act receiving facilities have been requesting specific labs be completed prior to accepting a patient that has already been medically cleared for transfer. I was under the impression that this should not be done. Is it a violation or just a nuisance that they are requesting further testing once medically cleared?

A receiving facility doesn't have the authority to demand specific lab tests be done and the physician who has seen the patient should be better equipped to determine the patient's needs than a physician who has not. However, the receiving facility does have the final authority as to whether to accept a transfer. The statute states:

394.463 Involuntary examination.

(2)(h)One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

- 1.The patient must be examined by a designated receiving facility and released; or
- 2.The patient must be transferred **to a designated receiving facility in which appropriate medical treatment is available.** However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

A receiving facility shouldn't be expecting your hospital to do routine lab or diagnostic testing it should do on its own, but it must determine prior to accepting the transfer that it has the capability of meeting any ongoing medical needs of the patient. Since free-standing psychiatric facilities (hospitals and CSU's) don't have their own laboratories, it could be dangerous to accept a transfer if repeat testing is needed. This issue is a medical one that should be worked out between your ED physician and the medical director of the receiving facility.

Q. Must all patients be sent to an ER for a medical screening exam if they are on the same campus before they can be admitted to a mental health unit?

No. However, each person brought to a licensed hospital (including those brought directly to a mental health unit) must have a medical screening examination within the full capability of the hospital. The law doesn't specify that it must take place **at** the ED, but if the mental health facility is located on the same campus as the general hospital (250 yards) or operates under the general hospital license, it may then be necessary to conduct the MSE at the mental health unit using the same standards as if it had taken place at the ED.. You may want to run this answer by the AHCA staff in your region or at a minimum, by your corporate compliance staff, to ensure that they give you the same answer. Since

AHCA is the state agency tasked by CMS with investigating EMTALA complaints, you want to be sure you get the final word from them.

EMTALA applies to all hospitals, even those that are licensed as specialty free-standing psychiatric hospitals. It does not apply to other types of facilities such as crisis stabilization units that are not licensed as hospitals. A free-standing hospital accepts persons on an unscheduled basis for examination and treatment of emergency psychiatric conditions. Even though a free-standing psychiatric hospital may not have a distinct ED, it still meets the criteria of providing emergency services for emergency medical conditions since psychiatric emergencies and substance abuse emergencies are considered by CMS to be the same as any other EMC regarding a hospital's legal responsibilities.

A hospital is responsible for providing a medical screening within its full capability for persons regardless of their ability to pay – no more and no less. A free-standing psychiatric hospital would be expected to do vitals, history, physical examination, etc. It would not be expected to do the full array of medical diagnostic and laboratory testing that a general hospital's ED would do. If the free-standing hospital believed a person to have an emergency medical condition as defined in 395.002, beyond its capability, it would arrange a safe and appropriate transfer of the patient to the nearest ED; typically through a 911 call for EMS transport. This should never take the place of the basic medical services that should be available in any 24-7 healthcare facility. EMTALA is based on the premise that every transfer of a person with an emergency medical condition (even of just a psychiatric or substance abuse nature) is inherently dangerous. An unnecessary transfer in which a free-standing hospital transfers a person it should be able to care for may be an EMTALA violation itself.

Even non-hospital CSU's are required to have certain medical services available. They can't send people out for "medical clearance"; only for treatment of an "acute physical condition"

65E-12.107, F.A.C. Minimum Standards for Crisis Stabilization Units (CSUs).

(1)(b) **Referral.** Individuals referred, or to be referred, to a receiving facility under chapter 394, part I, F.S., who also require treatment for an acute physical condition shall be delivered and, if appropriate, admitted to an emergency medical or inpatient service for health care until medically cleared and stabilized to meet the CSU's medical criteria as prescribed in its policies and procedures. Medical clearance shall be documented in the clinical record.

65E-5.107(2), F.A.C. Admission.

(b) 2. Initial Assessment.

All persons admitted to a CSU shall be provided a nursing assessment, begun at time of admission and completed within 24 hours, by a registered nurse as part of the assessment process.

(c) Physical Examination. All persons admitted to a CSU shall be provided a physical examination within 24 hours of admission, based on program policies and procedures. The physical examination shall include a complete medical history and documentation of significant medical problems. It shall contain specific descriptive terms and not the phrase, "within normal limits." General findings shall be written in the clinical records within 24 hours.

394.459 (2)(c), F.S. Right to Treatment

Each person who remains at a receiving or treatment facility for more than 12 hours shall be given a physical examination by a health practitioner authorized by law to give such examinations, within 24 hours after arrival at such facility.

65E-12.105, F.A.C. Minimum Staffing Standards.

- (2)(a) Every CSU and SRT shall have at least one psychiatrist as primary medical coverage as defined in section 394.455(24), F.S. Back-up coverage may be a physician who will consult with the psychiatrist. The psychiatrist or physician shall be on call 24-hours-a-day and will make daily rounds...
- (2)(b) The psychiatrist shall be responsible for the development of general medical policies, prescription of medications, and medical treatment of persons receiving services. Each person shall be provided medical or psychiatric services as considered appropriate and such services shall be recorded by the physician or psychiatrist in the clinical record.
- (3) Sufficient numbers and types of qualified staff shall be on duty and available at all times to provide necessary and adequate safety and care. The program policies and procedures shall define the types and numbers of clinical and managerial staff needed to provide persons with treatment services in a safe and therapeutic environment.
- (4) At least one registered nurse shall be on duty 24-hours-a-day, 7-days-a-week.
- (5) At no time shall the minimum on-site available nursing coverage and mental health treatment staff be less than the following for shifts from 7:00 a.m. until 11:00 p.m. to assure the appropriate handling and administration of medication and the completion of nursing assessments:

If you believe unnecessary transfers to your ER are being made, you may want to report this to AHCA and DCF.

Q. What authority does the Baker Act provide to administer medical examination and medical treatment to persons unable or unwilling to provide express and informed consent to such intervention?

The Baker Act is Florida's Mental Health Act and cannot be used to justify the examination and treatment of non-psychiatric medical conditions without the express and informed consent of the person or his/her legally authorized substitute decision-maker. The Baker Act provides no such authority, other than the required physical examination following admission to a receiving facility. A person is considered incompetent to consent to treatment when his or her judgment is so affected by mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment. Neither can the Baker Act be used to hold a person against his or her will at a hospital for medical examination or treatment; it can only be used for initiating psychiatric examination and psychiatric treatment.

Q. Transfers from a Medical Unit to a Baker Act Receiving Facility: Patients that arrive through the Emergency Department under the Baker Act may require inpatient acute care for treatment before they can be medically stable for transfer to a Receiving Facility. Case Management and Administrative Supervisors will be responsible to coordinate the transfer of patients once medically cleared. Is a psychiatric consult is required or not?

No. However, if the person is in your care for any period of time, you may wish to have a psychiatric consult to treat the person to reduce symptoms. This may also avoid the need for the transfer as well.

Q. Can an ARNP give medical clearance at the hospital?

EMTALA clearly leaves to each hospital the right to determine what medical professionals are authorized to perform its medical screenings required under federal law. However, this should be specified in hospital policy and not decided on a case by case basis, based on who is available to do the medical screenings and certainly not on the basis of a person's ability to pay. Even the extent of

the medical screening will be highly individualized and should be based on the presenting symptoms. Some CSU's want the same diagnostic and laboratory tests done on everyone – this shouldn't be the case.

Q. If a medical screening examination is conducted by qualified medical personnel of the emergency department in accordance with EMTALA and the emergency physician determines that the person is not suffering from a medical emergency, can a designated receiving facility require that the emergency department conduct additional tests, such as blood alcohol or toxicology tests, prior to the receiving facility accepting the person? Is there a suggested course of action in situations where this might be a perceived problem?

A Baker Act receiving facility cannot require an emergency department to conduct certain tests on a person under the Baker Act prior to accepting the person. However, if a hospital-based receiving facility believes that a person's emergency medical condition has not been stabilized or the emergency medical condition continues to exist, this may be a violation of section 395.1041, F.S. and the federal EMTALA law. Further, a free-standing psychiatric facility is prohibited by law from admitting any person for whom it does not have appropriate medical treatment available. This may require CSU staff to determine in advance if the person requires services beyond its medical capability. Recurring problems should be documented and reported to DCF districts which contracts for Baker Act services.

Q. When a person is Baker Acted, and the need arise for medical attention that may keep the person in the hospital for a few days, do the days continue during the hospital stay or are they postponed until the person is medically cleared and ready for discharge back to the Baker Act Facility?

The 72-hour clock stops during the period in which a physician documents the presence of an emergency medical condition. The clock starts again as soon as the physician documents that the condition has been stabilized or didn't exist. Simply being in a medical bed, absent an emergency medical condition, wouldn't stop the clock.

Q. Our hospital (non-receiving facility) had an inpatient under a Baker Act who also had medical issues. When he was cleared medically, we attempted to transfer him to various receiving facilities. The receiving facilities said that the patient had a high acuity level and they could not accept the transfer, even those facilities licensed as general hospitals. In addition, the patient had a need for skilled care and there was a warrant out for his arrest. He waited in our medical hospital for 5 days for a transfer. The psychiatrist finally came in and evaluated the patient. The patient's care is being coordinated with a Skilled Unit. How could this have been handled better?

Even though a person's EMC has been stabilized, he may have significant medical care needs that exceed the ability of a non-hospital, non-medical facility to manage. However, that should never be the issue for a receiving facility located in a general hospital. In that case, a medical overlay on the psychiatric unit should be arranged or a psych overlay on a medical unit. Since this man apparently needs skilled nursing care, it is far more appropriate to discharge him to that setting than to another acute care facility. However, no SNF will accept him with a Baker Act pending. Hopefully, the psychiatrist also provided some medication to address the psychiatric emergency so he wasn't left with an untreated condition. The psychiatrist may have also determined that the criteria for involuntary placement were not met – if so, that should be documented in the chart and the Baker Act would no longer be a factor.

Baker Act Involuntary Examination / Release / Placement

Q. I have questions about the timeline w/ Baker Act. Once we have cleared a patient in the ER, how long do we have to get them placed? I have had patient in the ER over 24 hours waiting on beds. If a patient requires medical intervention and has to be admitted but then is cleared, how long can we hold them on Baker Act? We had situation in past where patient was here for a week waiting for psych placement. No one would accept him. We requested a psychiatrist consult, but he refused to see the patient so we never had anyone to evaluate his mental health issues. How long is the Baker Act in effect? My concern is that we infringed on patient rights by keeping him on same Baker Act for stay. One physician tried to revoke the Baker Act but after speaking w/ patient and him agreeing not to swallow anything again to harm himself. However, another physician said he couldn't revoke so it was put back on from initial date.

The Baker Act recognizes that a psychiatric examination may not be possible while a patient is undergoing a medical emergency. Therefore, the law provides you up to 12 hours after the individual's emergency medical condition has been stabilized or determined not to exist to arrange a transfer of a person under involuntary status:

394.463 Involuntary examination.

(2) (g) A person for whom an involuntary examination has been initiated who is being **evaluated or treated at a hospital for an emergency medical condition** specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination (**physician** or *clinical psychologist*) and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient **may be offered voluntary** placement, if appropriate, **or released directly from the hospital providing emergency medical services**. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

(h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or
2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

There is no remedy in the Baker Act for when you are unable to place within the time allowed by law. In summary, within 12 hours after a physician has documented an emergency medical condition either has been stabilized or doesn't exist, you must either release the person if not meeting involuntary criteria or transfer that person to a designated receiving facility. Failure to do so can result in liability for your hospital and staff. However, there are frequently times in which no designated receiving facility has both the capacity and capability to accept transfers from medical hospitals.

You can consider the following options to expedite the release or transfer of persons who have been brought to your hospital under the involuntary provisions of the Baker Act:

- **Examination & release by ED physician** if Mandatory Initial Involuntary Exam is conducted and person doesn't meet criteria for involuntary placement.
- Examination and release by contract psychologist or physician
- Have consult psychiatrist treat pending person's transfer or release..
- Retain for medical treatment with psychiatric care by receiving facility.
- Transfer to "a" designated receiving facility able to manage the person's medical condition – not the nearest facility.
- If unable to transfer within the 12 hour period, report to DCF MH Program staff and request assistance in transferring.

This reporting to DCF/MH staff documents that you've tried in good faith to transfer within the legally permitted time frame. Your transfer log maintained in the ED should reflect the date/time of each request for a transfer, which facilities were called, which staff member spoken with, and the exact reason given for refusing the transfer.

Hospitals use various methods to retain persons in their ED or medical units awaiting transfers. It is critical that your staff not allow persons held under the involuntary provisions of the Baker Act to depart until a physician or clinical psychologist has performed the mandatory examination and found them not to meet the criteria. Hospitals report using interventions such as:

- Expediting the medical screening and release when possible or transfer when necessary of patient to a receiving facility
- Place into a gown/remove shoes
- Use specialized ID band for persons at risk of wandering or alarm device
- Locate person at back of ER, farthest from exit doors
- Have a secured area where people at risk of wandering or elopement can be held until examined
- Provide close observation – whistles?
- Provide 1 on 1 trained staff if necessary
- Provide video monitoring
- Use chemical or mechanical restraints if warranted under the federal Conditions of Participation behavioral restraint standards.

Your attorney will be able to better advise on what to do with an individual once the 12 hours has expired, including the liability of potential "false imprisonment" for holding a person longer than permitted by law for whom you've fully documented the individual's condition and your hospital's good faith efforts to achieve the transfer versus the liability for "wrongful death". The Bakeracttraining.org website may assist you – there is a special course just for ED settings, that focuses on federal EMTALA requirements as well as the Baker Act.

Q. I'm a psychiatrist in charge of consultation in two large medical facilities that aren't designated as Baker Act receiving facilities. Can a professional certificate initiated by me be lifted by another MD that is not a psychiatrist? If not, can a telephonic consultation with me supporting his decision provide some legal backing?

The Baker Act authorizes any Florida licensed physician (medical or osteopathic) or clinical psychologist to perform the involuntary examination.

394.463(2)(g)A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when **the attending physician** documents that the patient has an emergency medical condition. **If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination (physician or psychologist) and is found as a result of that examination not to meet the criteria** for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), **the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services.** The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

(h)One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

- 1.The patient must be examined by a designated receiving facility and released; or
- 2.The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

The above material refers to the actual involuntary examination, which is a little different than the approval of a person's release or discharge. However, if your hospitals were designated as Baker Act receiving facilities, the law requires that "the patient may not be released by the receiving facility or its contractor **without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician** with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection."

Since your hospitals aren't receiving facilities, any physician or psychologist can approve the person's release or discharge once the exam has been performed and documented in the chart. In any case, even with a receiving facility, the approval of a psychiatrist, psychologist or ED physician doesn't specifically require face-to-face contact – just approval. In response to your specific question, another non-psychiatric physician can perform the exam and approve the release of the individual. A telephonic consultation would be more than acceptable, but not required in your situation.

Q. I have a patient in my ED who has been here before, and also to every other psychiatric facility in the area. This man. was arrested from the inpatient psychiatric unit several weeks ago when he threatened the LEO who was on a 1:1 with him. The LEO charged him with a felony and brought him to jail. Since that time he's been released, and is in our ED. The ED physician BA'd him due to Psychosis. None of the surrounding psychiatric facilities will accept him back due to his violent history; (ie: assaulting staff, damaging physical property, etc.) My question is: What is the requirement under the FI. Statute , of the private (us) and public receiving facilities for this type of patient as it relates to finding immediate placement under the BA ?

Every receiving facility, public or private, has the responsibility to "accept" any person brought by law enforcement for involuntary examination. If that receiving facility doesn't have the capacity or

capability to meet the person's specialized needs, it should seek a transfer of the person to a willing facility that does have the ability to provide the needed care. This doesn't seem to be the case in this situation as the man came to your hospital's ED on his own – not with law enforcement.

The only exception in the Baker Act to "accepting" a person is if currently charged with a felony

394.462(1) FS Transportation to a Receiving Facility.

(g)When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under this part, such person shall first be processed in the same manner as any other criminal suspect. The law enforcement agency shall thereafter immediately notify the nearest public receiving facility, which shall be responsible for promptly arranging for the examination and treatment of the person. A receiving facility is not required to admit a person charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide mental health examination and treatment to the person where he or she is held.

This would have only applied if a law enforcement officer had a person in custody under the Baker Act who was also arrested for a felony. This isn't the case with the individual you described as he had already been arrested and taken to jail and subsequently released.

However, your hospital is subject to the federal EMTALA law, requiring you to accept all persons and to perform a medical screening exam to determine if an "emergency medical condition" exists, even of a psychiatric or substance abuse nature.. Apparently your ED physician confirmed that a psychiatric emergency did in fact exist by initiating the Baker Act involuntary Examination. Once your hospital has met all of its requirements under EMTALA, it can seek such a transfer, pursuant to the Baker Act:

394.4685 Transfer of patients among facilities.

(2)TRANSFER FROM PUBLIC TO PRIVATE FACILITIES.—A patient who has been admitted to a public receiving or public treatment facility and has requested, either personally or through his or her guardian or guardian advocate, and is able to pay for treatment in a private facility shall be transferred at the patient's expense to a private facility upon acceptance of the patient by the private facility.

(3)TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.—

(a)A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.

(b)A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

(c)A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.

(4)TRANSFER BETWEEN PRIVATE FACILITIES.—A patient in a private facility or the patient's guardian or guardian advocate may request the transfer of the patient to another private facility at any time, and the patient shall be transferred upon acceptance of the patient by the facility to which transfer is sought.

In the case of transfers from private to public receiving facilities, you can "request" the transfer even if the person or his/her legal representative doesn't concur. However, before the transfer can take place, the public receiving facility would have to agree to the transfer. If any public or private receiving facility doesn't have the beds or doesn't have the capability to manage the person's medical condition, it can certainly refuse the transfer. However, simply refusing because the person is dangerous to self or others due to his mental illness seems questionable. Receiving facilities are designated by DCF for the purpose of examining and treating persons who are dangerous to self or others as a result of

mental illness. Your obligation and that of the other local private or public receiving facilities to accept, examine, and treat a person like this would be the same as to any other person meeting criteria for involuntary status. Just having a history of violence wouldn't limit your responsibility to provide the legally required examination and treatment.

Q. A patient showed up in the ER today. He had been previously Baker Acted then jailed from May to October. I was told by the psychiatrist this BA which was initiated prior to his incarceration was still valid. Is this correct info?

This is difficult to answer this question without more information. The law prescribes how a person under the involuntary provisions of the law should be handled if criminal charges are present, as follows:

394.462 Transportation.

(1)TRANSPORTATION TO A RECEIVING FACILITY.—

(f)When any law enforcement officer has custody of a person based on either noncriminal or minor criminal behavior that meets the statutory guidelines for involuntary examination under this part, the law enforcement officer shall transport the person to the nearest receiving facility for examination.

(g)When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under this part, such person shall first be processed in the same manner as any other criminal suspect. The law enforcement agency shall thereafter immediately notify the nearest public receiving facility, which shall be responsible for promptly arranging for the examination and treatment of the person. A receiving facility is not required to admit a person charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide mental health examination and treatment to the person where he or she is held.

A receiving facility cannot release a person unless a psychiatrist, psychologist or ED physician authorizes the release and the determination must be made within 72 hours of arrival.

394.463 Involuntary examination.

(2)(f)A patient shall be examined by a physician or clinical psychologist at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.

An administrator only has the authority to release or discharge a person who doesn't meet the criteria for involuntary placement. One would presume that such a determination was made prior to the patient leaving the hospital in May or that a public receiving facility was tasked with the responsibility of providing the examination and treatment of the person:

394.469 Discharge of involuntary patients.

(1)POWER TO DISCHARGE.—**At any time a patient is found to no longer meet the criteria for involuntary placement,** the administrator shall:

(a)Discharge the patient, unless the patient is under a criminal charge, in which case the patient shall be transferred to the custody of the appropriate law enforcement officer;

- (b) Transfer the patient to voluntary status on his or her own authority or at the patient's request, unless the patient is under criminal charge or adjudicated incapacitated; **or**
- (c) Place an improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.

As a result of the above, one would have to assume that the involuntary status initiated prior to his incarceration is not valid and a new examination would have to be initiated for this episode.

Q. I have a question about clients who are at the hospital and become medically cleared. We have been suffering with extremely high census so bringing clients over from hospitals have been a challenge. In some very rare cases the hospital discusses "starting a Petition" and then having us, as the CMHC second the opinion and file the Petition with the Courts. It is my understanding that a Petition/Hearing can only be initiated by the Baker Act Receiving Facility. Is that true? Secondly, can the hospital force the situation and request that a BA Hearing be conducted in the hospital? Our State Attorney's office and Magistrate have made it quite clear they will not do a BA Hearing at the Medical Hospital. I need some clarification as to who is responsible for the Petition process in these circumstances.

As you know, the Baker Act statute requires a non-designated hospital holding an individual on involuntary status to transfer that person within 12 hours of medical stabilization to a designated receiving facility or such a designated receiving facility must conduct the examination and release the individual. This presumes that a physician or psychologist at the hospital hasn't examined the person and released the person directly within that 12-hour period.

However, if the individual can't be transferred due to medical or capacity issues, it is still necessary to protect the legal rights of the person. If that means the hearing must take place at the medical hospital, the Baker Act permits a change of venue from the usual hearing site, as follows:

394.4599 Notice.

(2) INVOLUNTARY PATIENTS.—

(c) The written notice of the filing of the petition for involuntary placement must contain the following:

1. Notice that the petition has been filed with the circuit court in the county in which the patient is hospitalized and the address of such court.

2. Notice that the office of the public defender has been appointed to represent the patient in the proceeding, if the patient is not otherwise represented by counsel.

3. The date, time, and place of the hearing and the name of each examining expert and every other person expected to testify in support of continued detention.

4. Notice that the patient, the patient's guardian or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the patient.

5. Notice that the patient is entitled to an independent expert examination and, if the patient cannot afford such an examination, that the court will provide for one.

(d) A treatment facility shall provide notice of a patient's involuntary admission on the next regular working day after the patient's arrival at the facility.

(e) When a patient is to be transferred from one facility to another, notice shall be given by the facility where the patient is located prior to the transfer.

This actually occurred once when a woman in late pregnancy at a hospital couldn't be transferred to a CSU for medical reasons. The CSU performed one of the two psychiatric exams required for the petition and the administrator filed the petition with the court. The hearing was conducted at the

hospital and the woman was transferred to the CSU as soon as her baby was delivered. This method protected the medical and legal needs of the individual.

One final issue is that while the CSU may not have the capability or capacity to accept a transfer, it remains responsible for ensuring the “centralized provision and coordination of acute care services for eligible individuals with an acute mental illness”, as follows:

65E-5.351 Minimum Standards for Designated Receiving Facilities.

- (1) Any facility designated as a receiving facility failing to comply with this chapter may have such designation suspended or withdrawn.
- (2) Each receiving facility shall have policies and procedures that prescribe, monitor and enforce all requirements specified in Chapter 65E-5, F.A.C.
- (3) Each receiving facility shall assure that its reception, screening, and inpatient services are fully operational 24-hours-per-day, 7-days-per-week.
- (4) Each receiving facility shall have a compliance program that monitors facility and professional compliance with Chapter 394, Part I, F.S., and this chapter. Every such program shall specifically monitor the adequacy of and the timeframes involved in the facility procedures utilized to expedite obtaining informed consent for treatment. This program may be integrated with other activities.

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

This may not be very helpful when you're really slammed, but as the public receiving facility serving your County, you must work with each hospital to help them find a receiving facility that can meet the medical, psychiatric and legal needs of individuals under the Baker Act

Q. I need clarification about who is able to release a person under the Baker Act from an ED of our receiving facility (after they have evaluated the patient and determined that he or she no longer meets criteria). Looking over the manual, it indicates that a physician, clinical psychologist, or psychiatrist is able to release a patient. Does the physician HAVE to be an emergency room physician, or any physician in the hospital can release the patient? Also, I had been told that the nearest receiving facility for indigent clients would be responsible to evaluate a patient under the Baker Act (12 hours after medical clearance) in our non-receiving facility hospital. If a patient has insurance, who would be responsible to provide this evaluation? The hospital does not have an inpatient psychiatric unit, but they do have psychiatrists who have hospital privileges provide consults. These psychiatrists, however, generally don't examine patients in the emergency room.

The sections of the Baker Act that apply to your questions are as follows:

394.463(2) INVOLUNTARY EXAMINATION.—

(f) A patient **shall be examined by a physician or clinical psychologist at a receiving facility** without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others. The patient may **not be released by the receiving facility** or its contractor **without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician** with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.

(g)A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. **If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination (any physician or clinical psychologist as specified above) and is found as a result of that examination not to meet the criteria** for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), **the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services**...

(h)One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or
2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

In summary, what the above says is that when a person under Baker Act involuntary examination status is brought to the ED of a hospital that isn't a receiving facility for examination or treatment of an emergency medical condition, the person can, after examination by any physician (not just an emergency physician) or clinical psychologist, be released directly from the ED. The person is required to be released within 12 hours after a physician determines the emergency medical condition has been stabilized or doesn't exist. It is only at a designated receiving facility in which the professionals authorized to approve the release of a person from involuntary examination status are limited to a psychologist, clinical psychologist, or ED physician.

You'll note that the language of the statute is that the person must be examined by a designated receiving facility (not necessarily the nearest) and released from the ED within the 12 hours or a transfer of the person be made from the ED to a designated receiving facility. It doesn't require the receiving facility to provide such a psychiatrist, psychologist or ED physician to conduct the examination as the alternative transfer could be chosen instead.

The Baker Act doesn't address who is responsible for payment issues. The state Attorney General has opined that the patient is responsible for such costs, or the patient's insurance company when one exists. When the patient is indigent, the AG states that public receiving facilities (those that have legislatively appropriated Baker Act funds) can provide the service. However, the cost of emergency services of a psychiatric nature for indigent persons at a private facility is to be handled the same way as any other emergency condition.

If your ED physicians won't conduct the Baker Act involuntary exams and the consulting psychiatrists who practice at your hospital won't conduct them either, the problem is somewhat of the hospital's own making. As often as not, persons waiting past 12 hours for transfer no longer meet the criteria for involuntary placement and are filling up a transfer wait list unnecessarily. Many hospitals have had great success in contracting for a community psychologist to conduct the examinations and directly release patients who no longer meet criteria.

Before releasing a person on involuntary status who hasn't been cleared by a physician or clinical psychologist, whether before or after the 12 hour period has expired, should be reviewed with your hospital's risk manager as substantial liability could result.

Q. A patient was medically cleared in our ED and despite efforts, so far we do not have an accepting psych facility. The 72 hours have elapsed since medical clearance. Is ongoing documentation sufficient to continue with psych placement efforts? Do we need a new Baker Act form? The attending MD says it's illegal to do a second Baker Act form during same admission. We are waiting for input from the consultant on-call psychiatrist. The patient reportedly continues to meet Baker Act criteria, but is unfunded.

The 72 hour period you reference in your message doesn't apply to your hospital – it only applies to designated receiving facilities. You, as a non-receiving facility only have 12 hours after a physician documents that a medical emergency has stabilized or doesn't exist to arrange a transfer of a person to a designated receiving facility, unless your physician has directly released the person from your ED.

However, I'm assuming that you are continuing through the 12 hours (and longer if necessary) to fully document each attempt to transfer the individual to a receiving facility and possibly even notifying DCF/Circuit SAMH staff if you can't meet the legal deadlines. I would expect that your Risk Manager and attorneys would advise you that individuals who continues to meet the involuntary examination/placement criteria be retained at your facility rather than risking a wrongful death/injury as a result of release.

If a physician or clinical psychologist has examined the individual and documented him/her to be both willing and able to become voluntary (competent to consent to voluntary requires ability to make well-reasoned, willful and knowing medical and mental health decisions), the person can be transferred to voluntary status. If the individual condition later deteriorates and he/she again meets criteria for involuntary status again, a new BA-52 could be initiated by a physician, psychologist, or any of the other mental health professionals authorized in the statute. Of course, during the interim period on voluntary status, the individual would be free to request discharge from the facility.

There is no specified period of "liberty" between the end of an involuntary examination period and the beginning of another – it is the documentation found in the chart that reflects a change in clinical condition of the patient and the individual's willingness and competence to be transferred to voluntary status. You just don't want to convert a person to voluntary status solely for the purpose of initiating a new involuntary examination period.

Q. Can we do another BA form to extend the 12 hour period after medical stabilization to transfer a person on involuntary status to a receiving facility? I thought a patient must be free of the Baker Act for a period of time (this is not defined, but I would think at least several hours or even the next day) and if patient is still in our facility he could be re-evaluated by psychiatrist or psychologist on our staff, and a new Baker Act could be done. Is that illegal if it is within the same hospitalization?

As you know, your hospital is responsible for transferring a medically cleared individual under Baker Act involuntary status within 12 hours after a physician documents medical stability, as follows:

394.463 Involuntary examination.--

(2) Involuntary Examination.--

(g) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing

emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

(h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or

2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

The law doesn't offer any remedy when inability to transfer within this legally prescribed timeframe occurs. However, most risk managers and attorneys would advise you to never release a person who continues to meet involuntary criteria even though the timeframe has been exceeded.

Your physician is correct that a second Certificate should not be completed. It doesn't achieve any legal extension since it is the individual's right not to be held for longer than the permitted period, not the right of a hospital ER or receiving facility to have a longer period in which to conduct the examination. Your documentation of each effort to transfer the individual to a designated receiving facility with the capacity and capability of managing the individual's needs is your only recourse.

In addition, self-reporting to AHCA and/or DCF is helpful to document your good faith effort to meet your legal responsibilities. Some hospitals send an email or fax a report to a designated person at DCF and/or AHCA. If you aren't using identifiable patient information, HIPAA shouldn't be a problem. Your ER transfer log should reflect each receiving facility you contact with the date, time, name of person spoken with, and verbatim response from the receiving facility personnel. A denial or delay in transfer may be because of capacity, capability, need for follow-up diagnostic or laboratory tests, etc. It should never be because of inability to pay for care. In any case, AHCA or DCF personnel need to be aware of the issues faced in your community.

Q. We received some corporate legal advice and I wonder about whether it is correct for when a patient wants to leave after the deadline following medical clearance. Is it legal to allow them to stay until the bed comes through? I didn't know that one could not renew the Baker Act if it expires without finding a bed. Is that true? Also, again, the question of how many hours to find a bed after medical clearance, 12 or 2? If a patient wants to leave after the deadline, the lawyer is saying we cannot hold them. But, is it legal to allow them to stay until the bed comes through? The following was sent to us by our attorney:

“We cannot re-Baker Act patients. The Baker Act form should be signed once by the responsible authorized individual. Re-signing another Baker Act form after the 72 hour involuntary examination period has expired is illegal and does not improve our position. We have 12 hours following medical clearance to transfer or release a patient. There is a common belief that we have 72 hours, and that is not correct. While the Baker Act involuntary examination period lasts 72 hours, that time period is for the entire examination process. An acute care hospital has only 12 hours following

medical clearance to get the patient to a receiving facility. Each attempt should be documented. If intake says they are full DCF has instructed our hospitals to contact the administrators listed on the attached list”

Yes, the information provided to you by your corporate attorney is absolutely correct. While they may not be the answers you would want, they are ones DCF gives routinely in writing and in training sessions. Unfortunately, the myth throughout the state at general hospitals that aren't designated as receiving facilities is contrary to fact. The fear is that the facility might be accused of “false imprisonment” if held for longer on the original initiation. It is unlikely that there is an attorney or risk manager that would prefer a wrongful death to an allegation of false imprisonment.

This is the whole point of notifying DCF Mental Health office when a person is held longer than the legal limit – to document the hospital's good faith effort to comply with the law, tied to the documentation of your continuing efforts to transfer the patient to a willing receiving facility. Retaining the patient in the meantime is really your only option for safety reasons when the system breaks down. You're fortunate to have legal staff that has such a good grasp on the Baker Act.

Q. If a patient has an initial 72 hours to find a receiving facility, then a medical emergency stops the clock for 24 hours, when the clock starts again, do we have 48 hours or 12 hours?

The maximum period a non-receiving facility can legally hold a person after medical clearance is 12 hours – not 72 hours. It is only a designated receiving facility that has the ability to hold for up to 72 hours. Regardless of whether the facility where the person is held is a designated receiving facility or not, the clock would resume where it left off when the emergency medical condition was documented by a physician. That would be the remainder of the 12 hours or the remainder of the 72 hours, depending on the status of the facility. There is no provision for stopping the clock for a medical emergency for 24 hours – only the period documented by a physician from start to stop of the emergency. This may be substantially less or more than 24 hours.

Q. When a client has been BA'd to a hospital and admitted to a medical inpatient unit for treatment and they are cleared medically, does the 12 hour transfer rule apply? More specifically, if our psychiatric ED is above capacity and our inpatient beds are full what responsibility do we have to honor the 12 hour transfer rule?

The “12-hour” transfer rule only applies to non-receiving facilities. If your facility is designated, you have 72-hours in which to conduct the examination and either release the person, convert to voluntary, or file a petition. All units on the premises, including the ED, are considered the receiving facility – not just the psychiatric unit. It is up to hospital management where an individual is placed where medical and psychiatric needs can best be met.

Remember that the 72-hour clock starts upon an individual's arrival at the ED and only stops for an “emergency medical condition” – not just for medical examination or treatment. It stops when a physician documents an EMC exists and starts back up when a doctor documents that the EMC has been stabilized or doesn't exist.

If your facility doesn't have the capability or capacity to manage a person's EMC, it can request a transfer of the person to another facility and can execute the transfer after acceptance by the other facility. However, if your facility goes over census for paying patients with EMC's, it must use the same methods to go over census for non-paying ones

Q. A 25 y/o patient was brought to the ED under a police Baker Act and found to be medically unstable. He was admitted and later medically cleared by the attending physician. Now the Baker Act clock starts. Within the 2 hours we notified receiving facilities - no beds. We continued to look for beds and notified DCF/MH that we were unable to place the patient and continued to look for beds. Now, to complicate things, the patient's parents are here and have contacted their attorney. The attorney contacted me to inform me we had to let the patient go as we have not complied with the law and placed the patient within 12 hours. I explain to the attorney that we were continuing to look and the 72 hours was still in effect since we could not find a receiving facility with a bed. He instructed the parents to take the patient and leave - which they did. I instructed our nurses to contact the police and the police came and agreed with the attorney that we could not hold the patient. Where did we go wrong?

The attorney and the police were correct – you only have 12 hours after the individual's emergency medical condition has been stabilized or found not to exist in order to arrange the transfer to a designated receiving facility. You aren't restricted to just the "nearest" receiving facility in such situations, but can reach out to receiving facilities in other counties and regions of Florida. The 72 hours applies to the period time the receiving facility has to actually conduct the examination and either release the person, convert to voluntary, or file a placement petition with the court. On the other hand, it doesn't appear that you did anything wrong if you documented your good faith efforts to comply with the law and informed DCF of the problem. You may wish to use email messages for this purpose so DCF and you have written documentation that this notification took place.

This situation illustrates why ED physicians or hospitalists be willing to conduct the examination and release persons not meeting criteria or that medical hospitals contract with clinical psychologists to come to the hospital to do such exams. However, this only is helpful if the patient in fact doesn't meet the criteria for involuntary **placement** and can be released instead of being transferred. If the hospital has a consulting psychiatrist, treatment be provided to stabilize the patient for release with follow-up care.

However, if your physicians and/or consulting psychiatrist believe the person does meet criteria and can't be released and no receiving facilities will accept the transfer, you are caught between risk of "false imprisonment" and potential of a "wrongful death" situation. Most hospital risk managers would recommend not releasing a person documented as continuing to meet the criteria.

You were caught in a situation with no legal remedy. This appears to be an "elopement", a situation that the Baker Act doesn't directly address except after a court hearing has been conducted and law enforcement is requested to assist in finding/returning the person under a placement order to the receiving facility. Since this individual's departure was demanded by an attorney and he was accompanied by family and the attorney when he left your hospital, and law enforcement couldn't assist, you did all you could have done at that point.

However, you should implement some of the above recommendations for persons who can be released and work with DCF about expedited transfers when they cannot.

Q. I thought that our non-receiving facility hospital had to attempt to find a receiving facility for 72 hours. Am I to understand that after 12 hours and no bed availability the patient can leave if he wants? We unfortunately don't have a psychiatrist on staff that will respond to consults -- he is choosy. Is there anything we can do to get a receiving facility to send someone to evaluate?

Legally, a hospital (non-designated) only has 12 hours to transfer a person after the emergency medical condition has been stabilized (see section h.2. below):

394.463(2) Involuntary examination.

(g)A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

(h)One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

- 1.The patient must be examined by a designated receiving facility **and released**; or
- 2.The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

While section (h)1 suggests that an examination by designated receiving facility is an alternative, there isn't any place in the state where this option is used because none of the public receiving facilities is funded to send a physician or clinical psychologist out to ED's to do this. Some hospitals have contracted with a receiving facility for this service in the past, but to my knowledge, none do it now. You may wish to attempt negotiating with one of the public or private receiving facilities in your section of the state to provide this service. As you can see from the statutory verbiage, this is only for release of the patient and doesn't entail transfer to a receiving facility bed.

Please note that a psychiatrist isn't needed to complete this examination and authorize release. It can be done by any physician or clinical psychologist. Even if your hospital doesn't have a psychiatrist willing to consult, you could contract with a psychologist to perform this function by granting privileges.

Generally, hospitals won't release a person who continues to meet the criteria for involuntary placement even if the 12 hour period has expired. The liability for patient harm is just too great. However, this implies that your doctor would be attending to the person's needs and documenting that the criteria appears to be met. This is the justification for retaining beyond the 12 hour period, along with your hospital's continued documented efforts to transfer to a willing receiving facility.

Q. My question is about patients who are in an acute care hospital who have signed a voluntary form requesting an inpatient psych admission. If the patient is waiting for a transfer to inpatient psych hospital and decides they don't want to go, can they be held until the psychiatrist determines whether or not they meet involuntary status? I know the form states they will be released within 24 hours of their request for discharge unless they meet involuntary status. Can the LCSW initiate a Baker Act providing they meet criteria or should they be evaluated by the psychiatrist?

If a person has signed an application for voluntary admission to a receiving facility, it should be based on his/her willingness **and** capacity to make the decision. Simple refusal of examination without meeting each of the other involuntary exam criteria shouldn't result in an initiation of the examination. People have the right to refuse examination or treatment if capable.

However, if after the person at a non-designated hospital ED was permitted to sign the voluntary form, he/she became unwilling to accept the transfer to a receiving facility and otherwise appeared to meet the criteria for involuntary examination, you would be better off to have one of the authorized mental health professionals (including an LCSW) initiate the examination pending transfer. This would constitute documentation as to why you weren't releasing the person. The purpose of the psychiatric examination within the 12 hours and release within 24 hours is to determine if the individual meets the criteria for involuntary "placement", not involuntary examination. This is generally done in a designated receiving facility and must be followed by the filing of the petition with the Clerk of Court within two court working days if criteria is met.

Further, if a transfer under such circumstances ensues, you might want to have the person on involuntary status so a demand for release en route doesn't result in a catastrophe.

Q. Could a simplified checklist be designed to assist in proper decision-making by ED staff when dealing with an involuntary "Baker Act" patient who presents an immediate risk of substantial harm to self or others? If so what should be included on the checklist? I think this would be of help as ED staff are uncomfortable dealing with the involuntary psychiatric patient.

Checklists and forms tend to drive the correct implementation of laws and generally improve documentation of clinical decision-making. I would have to give much more thought to what should be included on the checklist before responding to your specific question. Of most importance would be gathering the concerns of ED physicians and staff. The Florida College of Emergency Physicians and the Security & Risk Management section of the Florida Hospital Association could be consulted in preparing such a checklist.

Q. Can any hospitalist or any other physician (outside of the ED physician) working in a medical hospital that is NOT a receiving facility do the examination and upon the results and completion of that exam release a person who is currently on a Baker Act (BA52a or b)?"

Yes. In a hospital that isn't designated as a receiving facility, the law only requires that:

- An "attending physician" document the person has an emergency medical condition.
- While at the hospital examining or treating an individual for an emergency medical condition, any physician licensed under chapter 458 or 459, FS (or psychologist) can conduct the "Initial Mandatory Involuntary Examination".
- Any physician licensed under chapters 458 or 459, FS (or psychologist) can offer voluntary placement or release the person directly from the hospital.

It is only in a designated receiving facility where the documented approval of a psychiatrist, psychologist or attending emergency department physician is required for a person on involuntary status to be released.

Q. If facility A completes the first and second opinions of a BA-32 and a hearing is scheduled, but the client has a medical condition requiring being sent out for medical treatment to Facility B (med psych). The client is admitted for treatment at facility B and may be there for several

days to several weeks. As they are admitted to Facility B, they must be discharged from Facility A. What is the legal status? Is the 32 status pending medical clearance? If the client is discharged from one facility and admitted to another, does the second facility now need to initiate a new legal status? Can someone be held on a medical status indefinitely or does the legal status then need to change once they are admitted to the other facility? Is court just continued until the client is returned? This doesn't quite make sense because then it seems like someone could be held indefinitely. How does the admission/discharge status affect medical clearance and legal status?

Once the petition for involuntary placement is filed with the court, the person remains on involuntary status pending action of the court or a finding that he/she doesn't meet criteria.

The court has several options:

1. The court can grant continuances if the patient/attorney request it.
2. It can grant a change of venue to have the hearing conducted at the medical hospital.
3. It can dismiss the petition if no continuance is granted and no evidence is presented to support the continued detention of the patient.

In the latter situation, there is no reason why a new involuntary can't be initiated after a period of liberty. The only glitch in the above scenarios is if the patient was "discharged" from the receiving facility to the medical facility instead of "transferred". A receiving facility only has the power to discharge a person when the criteria are no longer met. This is why facilities should "transfer" instead of "discharge" a person for medical treatment -- just like a person is transferred to a state hospital. A transfer retains the involuntary status -- a discharge does not. A back office administrative or financial discharge may be accomplished as long as the clinical record clearly notes that a transfer for medical treatment is being done.

The Baker Act allows for a medical interruption of an involuntary examination (72 hours plus the period during which a medical emergency takes place), but there is no other reference to stopping the clock once the exam period is over.

Q. if a patient is either taken to an ER or is in some type of non-baker act facility and is given a full exam by a psychiatrist there and determined not to meet criteria, is it appropriate to release the patient without having to actually go to a Baker Act receiving facility? Examples are being in an ER w/ psychiatric consultation available or being in the hospital for medical treatment and examined while being treated. Regarding the "clock" of 72 hours, my understanding is that the clock starts when the Involuntary Exam is initiated on a present patient or when a LEO picks up a patient either on an Ex Parte order or on his own initiative, and that the clock stops – held in suspension – once an attending physician determines that the patient needs emergent or immediate medical treatment. This treatment can be very brief or very long, either way the Baker Act Involuntary Examination requirement is still in force until a qualified examiner conducts the examination. Once an attending physician writes the discharge order for medical treatment the clocks starts back up again right where it left off when suspended at the outset of medical treatment, unless the exam has taken place in the hospital and patient is determined to not meet criteria. Is this correct?

The Baker Act was amended in 1996 to eliminate the need for a person under the involuntary provisions of the law to go to a designated receiving facility if he/she was already determined by a physician or psychologist at a hospital not to meet the involuntary placement criteria.

This Initial Mandatory Involuntary Examination that must be done before the ER physician or psychologist releases the person is defined in chapter 65E-5.2801, FAC to include the following:

The 72-hour clock actually begins when a person on involuntary status is presented to a hospital or other receiving facility or if initiated at a hospital, as soon as signed by the professional initiating. The clock only stops when a physician documents that an emergency medical condition (as defined in federal and state laws) exists. It starts back up again when the EMC is stabilized or found not to exist. It doesn't stop just because a person may need medical attention – only for an emergency medical condition.

Q. Can a Psychiatrist admit Baker Act patients with a psychiatric diagnosis to a Medical Surgical Unit in a Baker Act Receiving Facility, if the psychiatric unit is full or if the patient does not meet criteria for admission to the psychiatric unit ?

Your entire hospital is designated as the receiving facility. This means that it is up to your administrator where a person held under the Baker Act can best be served – psychiatric unit, ER, ICU, or a med/surg unit. Wherever in the hospital the person is held would have to meet all the legal, safety, and clinical needs of the patient, whether that means providing a psychiatric overlay on a medical unit or a medical overlay on a psychiatric unit.

Short of a determination that a person had an emergency medical condition (72-hour clock stops), the examination would have to be conducted and if believed to meet criteria for involuntary inpatient placement, the petition filed with the court within the 72 hours permitted by law, regardless of which unit of hospital the patient was placed.

Yes – the psychiatrist can admit a person with a psychiatric diagnosis to a medical unit as long as all requirements are met.

Q. Our general medical hospital has a psychiatric unit and is designated is a receiving facility. We have a screening and assessment area just outside of the ED. If a patient is screened and determined not to meet criteria for an admission, the psychiatrist examines the patient and releases the Baker Act or else disagrees with the screener and gives admission orders. Since we are a receiving facility, can we keep the patients in the screening and assessment area for a longer period than 12 hours after medical clearance?

The 12-hour issue is not applicable to your hospital because your whole hospital is considered the designated receiving facility. That section of the law only applies to hospitals that aren't designated.

In your situation, you have up to 72 hours in which to conduct the examination before releasing the person, converting to voluntary or filing the petition with the court. The Baker Act law and rules don't direct where the patient is to be held while in your receiving facility. If you can provide the necessary examination and the array of treatment services while the person is in this area, it would be permitted

Q. We have a Baker Act patient who is currently under custody of the County Jail. He has just been medically cleared. Can he return to Jail and be evaluated by one of their psychiatrists or does he need to go to our psych receiving facility under their watch?

If a Baker Act involuntary examination had been initiated by the court, law enforcement or a mental health professional, the exam must be conducted by a physician or psychologist at a hospital or designated receiving facility. It cannot be performed at the jail because the definition of a receiving facility expressly excludes jails.

This means that your emergency physician can conduct the exam and release the inmate back to the jail if the inmate is found not to meet involuntary placement criteria. The other alternative is for your public receiving facility to accept the inmate's transfer and conduct the examination at the facility. One final alternative is for the public receiving facility to send a physician or psychologist to where ever the inmate is held and provide the examination there if it can't provide adequate security – this might be at the jail.

Q. As our hospital is a Baker Act receiving facility, Are we required to initiate the Petition for Involuntary Placement if a Baker Act patient is not medically cleared for transfer to our psych unit or does the 72hrs stop until such time that the patient is medically cleared?

The 72-hour clock starts to tick as soon as the person arrives at the hospital. It stops when a physician documents that an emergency medical condition exists and starts back up again as soon as the emergency medical condition has been stabilized or determined not to exist. Any time sitting in the ER waiting for a bed is counted against the 72 hour maximum as is the time sitting on a medical unit waiting for transfer. Even a person who has a medical condition that isn't of an emergency nature is presumed to be able to undergo the psychiatric examination for which he/she was brought to the facility.

394.463 Involuntary examination.--

(2)(g) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

(h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or
2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available.

The above provisions don't link together well since they were actually written to address circumstances when a person was taken to an ER of a non-designated hospital and still required the involuntary examination at a receiving facility. However, to read it any differently would mean that a hospital designated as a receiving facility wouldn't be able to stop the clock at all for an emergency medical condition.

The determination that the person's "medical condition has stabilized or that an emergency medical condition does not exist" is left to the person's attending physician. This is a clinical decision that is not defined in the Baker Act.

You may have some individuals with a continuing medical condition who require a medical overlay on the psychiatric unit or a psychiatric overlay on a medical unit.

The rights of persons held under the Baker Act are protected in all hospitals, even those that aren't designated as receiving facilities as required by Florida's hospital licensing statute. Since all parts of Delray Medical Center are considered the receiving facility, the hospital would be required to conform to the Baker Act as it relates to persons held for involuntary examination or involuntary placement:

395.003(5)(a) Adherence to patient rights, standards of care, and examination and placement procedures provided under part I of chapter 394 shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment.

(5)(b) Any hospital that provides psychiatric treatment to persons under 18 years of age who have emotional disturbances shall comply with the procedures pertaining to the rights of patients prescribed in part I of chapter 394.

395.1041(6) RIGHTS OF PERSONS BEING TREATED.--A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

395.1055(5) The agency shall enforce the provisions of part I of chapter 394, and rules adopted thereunder, with respect to the rights, standards of care, and examination and placement procedures applicable to patients voluntarily or involuntarily admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment.

Assuming that the person doesn't have an emergency medical condition, the clock is ticking and a petition for involuntary placement would have to be filed with the clerk of court within 72 hours of stabilization of the person's medical condition.

Q. What is required for an emergency physician to release a person from involuntary examination status from an ER?

Any licensed physician or clinical psychologist must conduct and document in the chart the Initial Mandatory Involuntary Examination, as follows:

- Thorough review of any observations of the person's recent behavior;
- Review "Transportation to Receiving Facility" form (#3100) **and**
- Review one of the following:
 - ✓ "Ex Parte Order for Involuntary Examination" or
 - ✓ "Report of Law Enforcement Officer Initiating involuntary Examination" or
 - ✓ "Certificate of Professional Initiating Involuntary Examination"
- Conduct brief psychiatric history; and
- Conduct face-to-face examination in a timely manner to determine if person meets criteria for release.

In addition, there must be documentation that the patient doesn't meet the criteria for involuntary inpatient placement or involuntary outpatient placement under the Baker Act. The 3102 form is recommended for this use.

Q. Is an ER or a receiving facility required to conduct the Initial Mandatory Involuntary Examination prior to transferring a patient to another receiving facility that has the capability and capacity to meet the patient's needs?

No. While a person can't be discharged / released from involuntary status at an ER until examined by a physician or psychologist, when the person is being transferred under the provisions of the federal EMTALA law or state Baker Act law, the examination can be conducted at the destination facility.

Q. A psychiatric evaluation is not required prior to the transfer to a Baker Act Receiving Facility if the Professional Certificate has been completed either by law enforcement or the ED Physician. Is this also true for transfers from a medical floor?

Yes. Since the purpose of initiating an involuntary examination is to obtain a psychiatric examination, it would result in an unnecessary delay to require a psychiatric exam before being sent from a medical floor to a designated receiving facility

Q. Is an emergency department of a non-receiving facility required by the Baker Act to provide a psychiatric consult prior to the transfer of a person to a receiving facility?

No. The Baker Act law and rule do not require that the ED provide a psychiatrist to evaluate the person's condition -- that would occur upon arrival at the receiving facility. Requiring a psychiatric examination in an emergency department prior to transferring a person to a receiving facility is generally a waste of resources, duplicative, and creates unnecessarily delays. Such an examination prior to transfer is not required under the Baker Act.

However, the ED physician is permitted to perform the exam and, if the person doesn't meet the criteria for involuntary inpatient or outpatient placement, can directly release the person or convert a competent person to voluntary status. This assumes that the hospital doesn't have a higher standard that requires a psychiatrist evaluation. This applies regardless of county and whether the person was or was not admitted for medical care at the non-receiving facility.

Q. Our ED physicians refuse to release any persons from the Baker Act so we've had to admit persons pending transfer. The only psychiatrist who comes here tells our doctors that only a psychiatrist can release a BA. What should we do?

The Baker Act requires that the involuntary examination be conducted by a physician or clinical psychologist at a receiving facility without unnecessary delay and that the person not be released by the receiving facility without the documented approval of a psychiatrist, a clinical psychologist or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician.

The law further states that "if the patient is examined at a hospital providing emergency medical services by a profession qualified to perform an involuntary examination (physician or clinical psychologist as specified above) and is found as a result of that examination not to meet the criteria for involuntary placement, the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services."

Therefore, the law is explicit that a non-psychiatric emergency physician is authorized at either a

receiving or non-receiving facility to perform the examination and authorize the direct release of the person after documenting the person doesn't meet the criteria for involuntary placement. A psychiatrist is not required to perform the examination or to approve the release.

Q. If a hospital ED staff believes that people are being needlessly transported to the ED by law enforcement personnel under the Baker Act, but who are found not to meet Baker Act criteria, what is the best course of action for staff to follow to stop such apparently inappropriate use of the Baker Act?

If emergency departments receive persons from law enforcement for any reason, including persons under the Baker Act, the ED must comply with both s.395.1041, F.S. and the EMTALA law. If a facility does not have the capability to relieve or eliminate the psychiatric condition of a person under involuntary status, an appropriate transfer to a facility having the capability and capacity to care for the person must be initiated after all EMTALA requirements are met. If there is a pattern of problems that cannot be resolved in direct communications with the law enforcement agency, DCF should be notified and assistance requested to clarify roles and responsibilities.

Stabilization

Q. I'm a sheriff's deputy. I followed EMS to the hospital ED for an elderly Baker Act who had made suicidal threats. Hospital staff asked me to stay to guard the man in the hospital due to a battery on hospital staff the previous day. The man was loud but not violent and needed to be cleared medically before he could be transported to the CSU. I explained that I would not be staying because the man was not violent -- just loud. Hospital staff stated that an unidentified police officer stated the previous day that a deputy should guard their Baker Acts. Staff stated that they would not try to detain the man if he decided to leave. The hospital staff also expressed concern that the man might disrupt the care of other patients due to his volume. The hospital staff contacted their supervisor who again requested me to stay. I informed her what staff had said and she called a hospital security guard to sit with the man. How should this have been handled?

There is little or no connection between a battery on hospital staff the previous day by a different person and the need for the officer to stay with this man while in the ED. The Baker Act specifies the duties of a law enforcement officer; none of these duties involve an officer remaining at the hospital with a patient brought for medical examination or treatment. If this man had been brought to the hospital without the officer following EMS, there would have been no issue.

Hospital staff threatening to take no action should the man attempt to exit the ED should be reminded of their duty under EMTALA for stabilization of patients as well as for liability should one exit and experience injury or death as a result. The hospital's Risk Manager could attest to this.

Hospitals have many patients – medical as well as psychiatric in nature – who are disruptive. They are in pain, disoriented, under anesthesia in post-surgery, and otherwise vocalize in inappropriate ways. Hospital staff members are (or should be) trained to deal with these situations and shouldn't expect a law enforcement professional to do their jobs for them. What methods do law enforcement officers have to keep patients quiet that aren't available to trained medical personnel?

The Assistant Director bringing in a security guard employed by the hospital was the appropriate response – it should have been the first recourse once the patient and the paperwork was presented to admission staff. Many hospitals contract for a certified law enforcement officer to be present in their ED's. Perhaps they should consider this practice.

Q. If a Baker Act receiving facility sends a person on involuntary status to our ER for examination or treatment of a medical issue, is the sending facility responsible to send a sitter with the patient?

No. The Baker Act doesn't require a receiving facility to send a sitter with a patient referred to a general hospital for an acute medical condition. This would apply to a person on voluntary status, involuntary examination, petition for involuntary placement filed, or order for involuntary placement entered. The Baker Act law and rules are silent on this issue. Crisis Stabilization Units are not licensed as hospitals. They are governed by the Baker Act, by the 65E-5 rules, and they have to comply with the following CSU rules:

Minimum Standards for Crisis Stabilization Units (CSUs) (65E-12.107(1), F.A.C.)

Referral. Individuals referred, or to be referred, to a receiving facility, who also require treatment for an acute physical condition shall be delivered and, if appropriate, admitted to an emergency medical or inpatient service for health care until medically cleared and stabilized to meet the CSU's medical criteria as prescribed in its policies and procedures. Medical clearance shall be documented in the clinical record.

Receiving facilities located as part of general or free-standing hospitals are governed by the Baker Act (394, FS and 65E-5, FAC), hospital licensure (395.1041), EMTALA, JCAHO, and by the CMS Conditions of Participation. None of the above requires that a sitter be provided by the sending facility. However, EMTALA requires the ED receiving the referred patient to ensure the stabilization of a person with an emergency medical condition, even one solely of a psychiatric or substance abuse nature. JCAHO National Patient Safety Goal #15 requires even general hospital treating persons who have emotional or behavioral disorders to identify persons at risk for suicide and to address the patients' immediate safety needs. This may include elopement that would lead to suicidal behavior.

Florida's hospital licensing law has numerous provisions about the responsibility of upholding Baker Act rights of persons held for medical examination or treatment, regardless of whether the hospital is designated as a receiving facility, as follows:

395.1041(6) Rights Of Persons Being Treated.--A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

Every reference places the responsibility for patient safety on the facility where the patient is at. Practice around the state is consistent with this.

Q. If a CSU refers a person to an emergency room for examination or treatment of an acute physical condition, is it required to provide staff to remain at the hospital with the person?

No. There is no requirement that the CSU staff remain with a referred patient, once a responsible hand-off of the patient (with clinical records) is performed. Once the person is presented, federal EMTALA requirements that apply to the hospital (and not to a CSU) must be followed. This includes the medical screening to determine if an emergency medical condition exists, which includes an emergency psychiatric condition. This places responsibility on the hospital staff to be sure the person is stabilized, which may include safely retaining him/her at the ED until an appropriate transfer back to

the CSU can be arranged, along with the other EMTALA requirements for an appropriate transfer.

It is important that the ED staff arrange a meeting with the CSU staff to determine if some of the referrals haven't risen to the level of "acute physical problem", beyond the ability of a CSU to manage. You may also want to have all such documentation of names, dates, times, etc so that you can speak in specifics, rather than generalities in meeting with the staff of the district DCF/MH office.

Q. Our receiving facility had to 911 a patient out who was in withdrawal and could no longer be treated here. The patient went to a general hospital that is now calling our CSU asking to send a sitter to be with this patient. I can see nothing in the Baker Act Handbook that indicates this as a requirement. In fact, it would be a legal nightmare. Who would the sitter be responsible to? What if she did something at the hospital that resulted in harm to the patient? Who would be responsible?

A CSU has no obligation to provide a sitter for a person sent to a hospital for an emergency medical condition. Few if any CSU's in the state have the capacity to provide such a service. Since this was an emergency medical condition, the hospital has the responsibility to provide for the patient's care. The CSU should accept the return of the patient once stabilized if it can manage the person's medical needs.

Q. Does a Marchman patient admitted to the hospital require a sitter the same as a Baker Act?

There is no statutory or regulatory requirement for either a Baker or Marchman Act patient to have a sitter assigned. However, the risk exhibited in each case should be considered independently. Hospital policies and procedures should govern when sitters are assigned.

If the medical professional believes the person to be at risk of elopement or of harm to self/others, the least intrusive/restrictive form of protection should be applied. With some, a room next to the nurse's station may suffice. Others may need close observation in the form of a sitter. If you have more than one such patient of the same gender, I don't know why one sitter couldn't suffice for two patients sharing a room. In some cases, restraint (chemical or mechanical) or seclusion might have to be considered using the CMS/JCAHO standards for behavioral or medical restraints, as appropriate. It might even be possible for certain patients to be housed on the secured psychiatric unit and have their medical needs met there.

Q. Appendix H of the 2008 Baker Act Handbook says that sitters of BA patients in the ER "must be trained to their responsibilities." It is very clear about what to do when someone is aggressive, but not when they are just non-compliant. If a patient who has been placed on a 52 says that he is leaving, but does not become aggressive, but simply continues to walk out of the room and toward an exit; does the hospital staff have the right to restrain that person and are we obligated to do so? The appendix later refers to meeting requirements for restraint/seclusion, but some patients may not appear or say anything that lends one to think "immediate danger" but is still on involuntary status. If a hospital policy instructs that this patient be notified that law enforcement will be called if they leave, have we fulfilled the hospital obligation if that person is not aggressive and is not evidencing any behavior that clearly needs restraint to keep them from hurting him/herself? I also need clarification on the staff responsibility portion. If that person is not evidencing aggression, but is on a Baker Act, do hospital sitters need that restraint training? Do they have the right to prevent a person from leaving the facility? Is the hospital staff responsible to prevent the non-aggressive eloper on a 52 or are we only supposed to call the police?

As you know, the issues you raise are more likely addressed in the federal EMTALA law, CMS conditions of participation, JCAHO accreditation standards, your hospital policies and procedures, etc. The Baker Act is only one law of several that pertain. You need to comply with the most restrictive of any of the regulations that apply to your facility on any given issue. You mention reference to Appendix H of the 2008 Baker Act Handbook. However, Appendix I includes information regarding Orders for Emergency Treatment Including Restraints and Seclusion. It also makes reference to rules governing restraint and seclusion that were in the process of promulgation at the time of printing that have since taken effect. You may want to review Appendix I and the new restraint rules.[[65E-5.180](#) Right to Quality Treatment.]

The Florida Hospital Association has agreed for some period of time to get a work group together to develop model policies governing searches, elopements, restraint/seclusion in ED's, and other related subjects. In any case, federal and state laws as well as accreditation standards must be reflected in such policies as well as community standards for safe and effective stabilization of persons served.

DCF sponsored training always include emphasis that individuals who are on involuntary status whose condition hasn't been stabilized for discharge must be prevented from leaving a hospital or receiving facility. Appendix H of the 2008 Baker Act Handbook which includes a listing of methods often used by hospitals around the state to ensure safety. It is up to each hospital to define its procedures that are necessary to achieve that safety.

Some hospitals around the state have retained "sitters" who had no knowledge of what to do if the person tried to leave – they just sit. Perhaps a different title would suggest a more involved role and responsibility. At a minimum, the sitter must immediately notify security and/or the charge nurse on the unit so the person can be prevented from leaving the room or the facility. Sitters should also be trained in verbal de-escalation and redirecting individuals. If the sitter is authorized by the facility and trained to perform additional interventions, they should be held to that standard. Some hospitals are equipping sitters with a whistle to blow if assistance of other staff is needed.

Many individuals are on involuntary status not because they are aggressive but because they are unable to determine whether the examination is necessary (instead of refusal) and suffering from self-neglect (instead of harm to self/others). Such persons who are passively dangerous are equally in need of protection as those who are more actively dangerous. In many cases, such individuals can be redirected by a skilled person from leaving a safe area. One of the eligibility criteria for designation of receiving facilities in 65E-5.350 (5)(j) ,FAC states:

For general hospitals, a description of the means utilized to create or approximate a distinct psychiatric emergency reception and triage area that minimizes individual's exposure to undue and exacerbating environmental stresses while awaiting or receiving services.

Some hospitals have secured a portion of the ED so elopements can be minimized. While this may be considered a form of seclusion, individuals have freedom of movement within the area and have access to television, food, beverages, bathrooms, and other persons. This can dramatically reduce or eliminate use of restraint for non-compliant persons.

A policy that requires telling individuals that law enforcement will be notified if they attempt to leave wouldn't be sufficient. In some cases, implementation of such a policy might even escalate a person with severe mental illness. Telling a person this would certainly not suffice to meet the requirement for ensuring an individual's safety; particularly one whose judgment and insight may be so impaired as to make them unable to understand or appropriately respond to such information. My assumption is that if you've documented every effort to redirect such a non-aggressive person, you've used verbal interventions, you've had a physician examine, you've placed him/her in the most secure environment

available in the hospital, and initiated appropriate treatments, and the person is still heading out the door, you'll then use whatever interventions are necessary to prevent their exiting.

The Florida Administrative Code for the Baker Act includes a number of references that may assist you, including:

65E-5.180 Right to Quality Treatment.

(5)(c) A clinical safety assessment shall be accomplished at admission to determine the person's need for, and the facility's capability to provide, an environment and treatment setting that meets the person's need for a secure facility or close levels of staff observation.

(7) (b) Staff training.

Staff must be trained as part of orientation and subsequently on at least an annual basis. Staff responsible for the following actions will demonstrate relevant competency in the following areas before participating in a seclusion or restraint event or related assessment, or before monitoring or providing care during an event:

1. Strategies designed to reduce confrontation and to calm and comfort people, including the development and use of a personal safety plan,
2. Use of nonphysical intervention skills as well as bodily control and physical management techniques, based on a team approach, to ensure safety,
3. Observing for and responding to signs of physical and psychological distress during the seclusion or restraint event,
4. Safe application of restraint devices,
5. Monitoring the physical and psychological well-being of the person who is restrained or secluded, including but not limited to: respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by facility policy associated with the one hour face-to-face evaluation,
6. Clinical identification of specific behavioral changes that indicate restraint or seclusion is no longer necessary,

(c) Prior to the Implementation of Seclusion or Restraint.

1. Prior intervention shall include individualized therapeutic actions such as those identified in a personal safety plan that address individual triggers leading to psychiatric crisis. Recommended form CF-MH 3124, Feb. 05, "Personal Safety Plan," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for the purpose of guiding individualized techniques. Prior interventions may also include verbal de-escalation and calming strategies. Non physical interventions shall be the first choice unless safety issues require the use of physical intervention.
2. A personal safety plan shall be completed or updated as soon as possible after admission and filed in the person's medical record.
 - a. This form shall be reviewed by the recovery team, and updated if necessary, after each incident of seclusion or restraint.
 - b. Specific intervention techniques from the personal safety plan that are offered or used prior to a seclusion or restraint event shall be documented in the person's medical record after each use of seclusion or restraint.
 - c. All staff shall be aware of and have ready access to each person's personal safety plan.

65E-5.330 Training.

(1) In order to ensure the protection of the health, safety, and welfare of persons treated in receiving and treatment facilities, required by Section 394.457(5)(b), F.S., the following is required:

(a) Each designated receiving and treatment facility shall develop policies and procedures for abuse reporting and shall conduct training which shall be documented in each employee's personnel record or in a training log.

(b) All staff who have contact with persons served shall receive training in verbal de-escalation techniques and the use of bodily control and physical management techniques based on a team approach. Less restrictive verbal de-escalation interventions shall be employed before physical interventions, whenever safety conditions permit.

Even hospitals that aren't designated as receiving facilities under the Baker Act are required by their license must adhere to the rights of persons who are being held under the Baker Act, as follows:

- 395.003(5)(a) governing licensure of all hospitals states "Adherence to patient rights, standards of care, and examination and placement procedures provided under part I of chapter 394 shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment".
- 395.1041(6) Rights Of Persons Being Treated.--A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

The Baker Act states that a receiving facility can't hold a person for involuntary examination for longer than 72 hours – it also states the person can't be released without the approval of a psychiatrist, psychologist, or ER physician. Therefore, an AMA shouldn't enter into the equation. A hospital that isn't designated as a receiving facility is required to transfer or authorize the release of the person within the 12 hour period. However, there is no remedy in the Baker Act for something that can't legally happen if the person can't be released and can't be transferred.

One additional consequence to keeping people in ER's for more than the 12 hours permitted by law is that since the 72-hour clock is ticking once the person's emergency medical condition has stabilized or found not to exist, there is often insufficient time for the receiving facilities to then obtain the 2 expert examinations, the administrator/designee's signature, and file the petition with the court within the 72-hour period. The filing itself can be postponed until the first working day if the 72 hours runs out on a weekend or legal holiday. If the 72-hour period runs out on a weeknight, there may be substantially less than 72 hours in which to get all this done. If not done within the 72 hours, the public defender will get any petition dismissed once it gets to a hearing.

Q. Our hospital doesn't have a mental health unit. Our physician initiated an involuntary examination but the person is not yet medically stable for transfer. However, the person wants to leave AMA. Can we hold the person?

In the scenario you present, you must hold the person until it is determined that the person doesn't meet the criteria for involuntary inpatient/outpatient placement. Your non-psychiatric physician is authorized to make this determination or the patient can be transferred within 12 hours to a designated receiving facility for the determination to be made.

The Baker Act is entirely consistent with EMTALA which wouldn't allow you to discharge or transfer any person with an emergency medical condition (includes psychiatric and substance abuse emergencies as well as other medical emergencies). If a person is being held on an involuntary status, it is by definition an emergency medical condition. It is unlikely that the person would have the capacity to provide express and informed refusal to screening/stabilization while involuntary examination was being conducted.

If seclusion or mechanical restraints are necessary and appropriate under federal CMS regulations, you may consider these in addition to chemical restraints. You may have to keep the person with a sitter if constant monitoring can't be provided by ED staff. You may also wish to keep persons waiting for psychiatric transfer in an area of the ED as far away from exit doors as possible. Some hospitals place such persons in gowns or monitor them by video. Whatever methods are used, it is essential that no person under involuntary status be allowed to exit the hospital until the psychiatric emergency is over or a transfer to a receiving facility occurs.

Preventing Elopements

Q. I'm a psychologist working at a general hospital that isn't a receiving facility. I am going to be giving a talk to the security guards from various medical hospitals soon, and I have a question. If a person is under a Baker Act, and they leave the facility should (or could) a security guard put "hands-on" to keep the person from running away, for safety? Or is it more advisable to call the law enforcement agency to find that person? I understand you cannot say definitively as each case is different. I would however appreciate perhaps a "rule of thumb" for the security guards to use.

It's great that the security staff is getting this training. The Florida Hospital Association agreed at one time to develop several "model" policies and procedures for their members -- one on elopements, another on searches in ED's, and one on use of restraint/seclusion. Such common policies and procedures would establish significant protection for the hospitals and staff by using an accepted "community standard" for such practices. It is unknown if this ever materialized.

You should work closely with the Risk Manager of your hospital to ensure that whatever you tell the security staff complies with your own corporate policies and procedures and if applicable, any JCAHO standards or federal Conditions of Participation. You want to avoid any allegations of battery or false imprisonment that might result from elopement events.

In the meantime, it is critical that your staff not allow persons held under the Baker Act to depart until a physician or clinical psychologist has performed the mandatory examination and found them not to meet the criteria. The St. Petersburg Times ran an excellent news story in 2009 on such problems in the Tampa Bay area.

Hospital staff generally use an array of interventions to prevent elopements, including the least restrictive method. Hospitals report using interventions such as:

- Expediting the medical screening and release when possible or transfer when necessary of patient to a receiving facility
- Place into a gown/remove shoes
- Use specialized ID band for persons at risk of wandering or alarm device
- Locate person at back of ER, farthest from exit doors
- Have a secured area where people at risk of wandering or elopement can be held until examined
- Provide close observation – whistles?
- Provide 1 on 1 trained staff if necessary
- Provide video monitoring
- Use chemical or mechanical restraints if warranted under the federal Conditions of Participation behavioral restraint standards.

However, if an individual attempts to elope, hospital staff will always attempt to stop the person from leaving the building, even if it means "hands on". They will generally do the same as long as the patient is on the "premises" of the property. However, once off the premises, staff generally calls on

law enforcement to find the person, take into custody, and return the person to the facility. They definitely don't want to chase the patient into oncoming traffic in an attempt to return the individual to the hospital. It is much better to prevent the elopement in the first place. Many hospitals also contract with a local law enforcement agency to have a uniformed officer present at all times in the ED.

Q. Has the Forgione Law provided a means to decrease the risk of elopement? What was the intent of the law and how does it provide for enforcement of the "memorandum of understanding". Have all counties now developed these documents?

All areas of Florida have developed a Memorandum of Agreement between law enforcement and designated Baker Act receiving facilities. DCF may have maintained a central file of these executed agreements. As you know, the statutory language only referred to designated receiving and treatment facilities – not to general hospitals that are not designated by DCF as Baker Act receiving facilities. Since the law doesn't cover ERs in hospitals that aren't designated, it falls short of providing the scope of protection that would be needed. It also seems places the onus on the law enforcement agency to obtain the Memorandum of Agreement with each receiving/treatment facility in its jurisdiction which could potentially thwart such an agreement from being finalized if the facility didn't agree with the terms. It also is limited to the transportation of the person in custody and the transfer of that custody to the facility – it doesn't address the security of the person after the transfer of custody takes place. I believe all of these factors, if addressed, would have strengthened the law, but DCF would have no basis for promulgating rules without specific statutory authority to do so.

Q. In your opinion, are there any other strong measures or system changes that could be adopted by facilities without a designated secure area to prevent elopement?

Facilities use a variety of interventions to prevent elopements. All facilities are urged to prevent persons from leaving an ER prior to examination and even after examination if the result of that exam is that the individual appears to meet involuntary criteria. Use of the least restrictive method is recommended. Hospitals generally report using interventions such as:

- Expedite the individual's evaluation & release/transfer, treating as appropriate.
- Allow a trusted companion to stay unless contra-indicated.
- Place individual into a gown/remove shoes
- Use specialized ID band for persons at risk of wandering or alarm device
- Locate person at back of ER, farthest from exit doors
- Provide close observation – whistles?
- Provide 1 on 1 trained staff if necessary
- Provide video monitoring
- Use chemical or mechanical restraints if warranted under the federal CoP's and JCAHO behavioral restraint standards.

Q. Don't receiving facilities and non-receiving facilities have a duty to prevent an involuntary patient referred under the Baker Act from eloping? Is there an ambiguity in the Baker Act Handbook or in the statutes? Does the "Forgione Law" address this problem? Is there an issue with reimbursement for medical evaluation of Baker Act patients? How are facilities reimbursed for Baker Act evaluations if the patient is uninsured?

The entire facility is incorporated in the "designation" -- not just the psychiatric unit. It is up to hospital management whether the person on a Baker Act hold is placed in the ED, the ICU, a medical unit, or

on the psychiatric unit. Regardless of the unit on which the individual is held, examined, or treated, the same procedures must be followed.

The Baker Act statute, Florida Administrative Code (rules), and the Handbook are all consistent -- a physician or psychologist at a receiving facility must conduct a Initial Mandatory Involuntary Examination of any person on involuntary status without unnecessary delay for the purpose of determining whether the individual meets the criteria for release. Within 72 hours of arrival, the individual must be released, transferred to voluntary status, or a petition filed with the Clerk of Court for involuntary "placement".

A hospital that isn't designated as a receiving facility to which an individual on involuntary status is brought for medical examination or treatment is required to release the individual after the Initial Mandatory Involuntary Examination if found not to meet the criteria for involuntary placement, to transfer the individual to voluntary status, or to transfer the individual to a receiving facility that can manage any medical problems the individual may still have. There is no provision for allowing a person who has been determined by a judge, a law enforcement officer or a mental health professional to walk away from a hospital or receiving facility without such an examination to be first completed.

Even though the federal EMTALA law permits a patient to refuse the required "medical screening examination", if the individual is at a hospital with documentation of a serious psychiatric disorder, it would be unwise of the hospital to permit the patient to refuse without documentation that this was an "informed" refusal.

The "Forgione Law" only addresses the transport and "handoff" of the person on involuntary status -- not what happens after the person is accepted at the receiving facility. This law doesn't address non-receiving facility hospitals -- only receiving and treatment facilities as defined in the Baker Act.

Regarding reimbursement issues for medical evaluation of Baker Act patients, this is also governed by the federal EMTALA law and chapter 395, FS. There can be no delay or denial of care for persons with an emergency condition because of inability to pay. The Florida Attorney General has addressed the issue of payment for uninsured persons in two opinions that I've summarized below:

Attorney General Opinion 74-271 Regarding Involuntary Hospitalization in Psychiatric Facility. A circuit court judge may order a patient involuntarily hospitalized at a private psychiatric facility not under contract with the State provided that the patient meets the statutory criteria for involuntary hospitalization, the facility has been designated by DCF, and the cost of treatment is to be borne by the patient, if he is competent, or by his guardian if the patient is incompetent. When state funds are to be expended for involuntary hospitalization of a patient in a private psychiatric facility, such facility must be under a contract with the state.

Attorney General Opinion 93-49 Regarding Who is Responsible for the Payment of an Involuntary Baker Act Placement, 1993 WL 384795 (Fla. A.G.) Attorney General Robert A. Butterworth advised the Board of County Commissioners for Lafayette County, FL that the county is not primarily responsible for the payment of hospital costs, however, a county may be liable for hospital costs in the event a person is arrested for a felony involving violence to another person, and the arrested person is indigent. Depending upon the Baker Act patient's ability to pay, the patient is responsible for the payment of any hospital bill for involuntary placement under the Baker Act, however, if the patient is indigent, the Department of Health and Rehabilitative Services (HRS) is obligated to provide treatment at a receiving facility and HRS provides treatment for indigent Baker Act patients without any cost to the county.

Q. What is the definition of a "secure designated area" and is this the reason our CSU has effectively no elopements? Can this strategy be safely adopted by the ED at other receiving facilities and at medical non-receiving facilities performing medical evaluations on these patients?

Many hospitals have designated a secured section of their ED for persons with severe psychiatric conditions. This prevents elopements and permits specially trained personnel to deal with the acute care needs of these individuals. This also prevents these individuals from being alarmed by medical emergencies that may be occurring in the ER as well as preventing these psychiatric symptoms from alarming medical patients who are being served. These units are generally locked.

Q. Is there any standard or protocol for the training of hospital/ ED security guards? In order for a facility to use the least restrictive means of detaining the patient (as required by CMS and Joint Commission), and if these methods fail after the police have handed off the patient, how can the patient safely be restrained without injury to themselves or hospital personnel?

We are unaware of any standard or protocol for training hospital security staff. Seclusion and restraint can be used where it is documented that a person is at imminent risk and less restrictive alternatives are not effective. In the case of a person on involuntary status under the Baker Act, a judge, law enforcement officer, or mental health professional has found there to be a substantial likelihood of the person causing serious bodily harm in the near future as evidenced by recent behavior. This, when added to documentation of observations by clinical staff at the facility, can often justify the use of interventions. In the "Forgione" case, the patient had been court ordered to the facility, had eloped from the facility, and had kicked out the cruiser window when being returned to the hospital. These are the very behaviors that should be considered by clinical staff in determining what is necessary for the safety of any individual in their care.

Q. To what extent is staff at an emergency room required to physically prevent a person under involuntary examination from eloping? Should nursing or medical tech staff attempt to restrain such an individual or should they wait for the arrival of security staff and/or police officers?

Staff should make every effort to divert a person who may be showing exit seeking behavior. Prevent the person from leaving the ER using the least restrictive method. Hospitals report using interventions such as:

- Conduct the examination of the person quickly so the transfer can be expedited.
- Place into a gown/remove shoes
- Use specialized ID band for persons at risk of wandering or alarm device, baby alarms, or whistles
- Locate person at back of ER, farthest from exit doors
- Provide close observation
- Provide 1 on 1 trained staff if necessary
- Provide video monitoring
- Use chemical or mechanical restraints if warranted under the federal Conditions of Participation behavioral restraint standards.

The first obligation is for safety which certainly involves avoidance of elopement or other high-risk behavior while in the facility. If this means holding the person in a locked area without a formal admission, this wouldn't violate the Baker Act law or rules.

Medications can only be administered with the consent of a competent adult (competent to make well-reasoned, willful, and knowing treatment decisions) or by a legally authorized substitute decision-maker (guardian or health care surrogate/proxy) after full disclosure. The only alternative is an

emergency treatment order after a physician documents the nature and extent of imminent danger. However, if informed consent or circumstances supporting an ETO are fully documented, treatment in advance of admission is fine and often takes place in ERs and other settings prior to admission or transfer.

With regard to use of restraints or seclusion in a pre-admission period, these interventions are also fully acceptable if they meet the most restrictive of JCAHO standards, CoP behavioral health restraint standards, DLC policy and procedures, and Baker Act standards. Pre-admission or post-admission status is not a deciding factor. All rights of the patient and responsibilities of the receiving facility apply when the person is on the premises, regardless of their legal status.

Q. If a hospital ER has multiple persons on involuntary examination status waiting for transfer, can it leave them in a locked area for safety reasons and preventing elopements as long as there are cameras that are monitored at the desk (without staff in the room)?

It is the hospital's responsibility to retain persons pending medical screening and stabilization, prior to transferring persons to its psychiatric unit or to a receiving facility. If a person is locked up for behavioral reasons in a room of the ED, this would be considered seclusion under the federal Conditions of Participation. However, if the person has been identified as meeting the criteria for involuntary examination under the Baker Act and documentation exists that the person is at imminent risk of danger (assault, suicide, elopement, etc.), seclusion or restraint can certainly be justified. There is no specific requirement in the Baker Act that a staff member physically remain in a seclusion room with a person.

Some hospitals have used a single sitter in the doorway of a room that has multiple persons awaiting transfer to receiving facilities. Others place these persons in a room at the back of the ED, farthest away from any exit doors. Some put them in gowns or use video monitoring to reduce elopements. In any case, the ideal is to expedite the person's transfer and, if the volume is sufficient, you might consider creating a psychiatric ED in part of the existing ED. This would provide secure space and a specially trained staff.

Q. Are prevention measures to keep a patient from leaving the ER different if the patient on involuntary status was admitted to hospital as medically clear and waiting for transfer to a receiving facility?

The same obligation exists to keep a person with a serious mental illness being held for Baker Act examination, whether the person is in the ED or being medically stabilized as an inpatient. You just need to be sure you're in compliance with the federal Conditions of Participation for behavioral restraints. This is regulated by CMS and JCAHO standards as well as the Baker Act.

Q. I work for a large healthcare system and have a question regarding an eloping Baker Act patient. Can the hospital's staff members, e.g. security officers, legally pursue an eloping patient off the hospital's immediate property in order to take the eloping patient back into protective custody? My immediate supervisor is adamant that we may not legally pursue these patients off hospital property even though they may present an imminent danger to themselves or others. I would greatly appreciate any information that you might be able to provide me in reference to this subject.

There isn't any prohibition in the Baker Act for staff to pursue an eloping person off the grounds of a hospital. However, most hospitals limit such pursuit through their policies and procedures to just their

own grounds and leave further pursuit to law enforcement. They probably don't want to chase the person into oncoming traffic or risk the safety of staff. However, if the person is standing in a busy roadway, it seems inhumane not to attempt to encourage the person back to the point of safety. You may wish to consult the hospital's risk manager, compliance officer, or legal counsel for assistance.

Q. We had a situation recently in which a Baker Act patient escaped from the ED and ran into a parking lot adjacent to the hospital. Two of our security officers then assisted the ambulance crew in taking the patient back into custody at that off-campus location. I was not aware of any provisions in the Baker Act law prohibiting such an action and I have yet to see any written policy or other directive from my organization that specifically forbids such an action. In addition, Florida Statute 776.07 Use of Force to Prevent Escape seems to authorize this type of action although it refers to "arrested" persons and not specifically to Baker Act patients.

The main point is to make sure the hospital doesn't allow the person to get that far and that law enforcement should be called immediately. By following the person onto the adjacent parking lot doesn't seem to increase risk to the staff or the person. Your assistance to the ambulance crew was altogether appropriate.

The statutory provision you referenced:

776.07 Use of force to prevent escape.--

(1) A law enforcement officer or other person who has an arrested person in his or her custody is justified in the use of any force which he or she reasonably believes to be necessary to prevent the escape of the arrested person from custody.

(2) A correctional officer or other law enforcement officer is justified in the use of force, including deadly force, which he or she reasonably believes to be necessary to prevent the escape from a penal institution of a person whom the officer reasonably believes to be lawfully detained in such institution under sentence for an offense or awaiting trial or commitment for an offense.

You may want to be cautious in relying on this provision because of the point you raised about "arrest" or "offense". Further, it only allows law enforcement or correctional officers to use this statute. Unless your security personnel are certified as either, you would have no protection under this statute.

Hospitals have an obligation to maintain the safety of persons in their care and custody. Always the least restrictive interventions should be considered, but more restrictive may be necessary in many cases where justified. There isn't any prohibition in the Baker Act for staff to pursue an eloping person off the grounds of a hospital. However, most hospitals limit such pursuit through their policies and procedures to just their own grounds and leave further pursuit to law enforcement.

Q. A local Baker Act receiving facility is encountering elopements of involuntary patients in the ED. All Baker Act patients brought to the hospital by law enforcement come through the ED, even those who don't have emergency medical conditions. I understand that if a law enforcement officer transporting a person for involuntary examination believes that the person has an emergency medical condition, the person may first be transported to a hospital for emergency medical treatment. I also understand that once the patient is in the Emergency Department the hospital is obligated to comply with all EMTALA requirements. This particular hospital has the psychiatric inpatient unit located separately from the hospital main building. I am of the opinion that patients brought by LEO with no emergency medical conditions should

be taken directly to the psychiatric inpatient unit that offers greater security preventing elopements and the needlessly utilization of the ED.

While the psychiatric unit does provide the most secure environment for a person who may be prone to elopement, the hospital is also subject to the federal EMTALA law which requires each person brought to a hospital to undergo a medical screening. If this screening can be conducted at the hospital's psychiatric unit instead of the ED, it is likely that the federal requirements could be met. Given that the entire hospital, if the psychiatric unit is at the same address, is part of the designated receiving facility, regulators (DCF) probably wouldn't object to law enforcement taking the person directly to the psychiatric unit. However, it is critical that AHCA be consulted on this issue since AHCA is the state agency responsible for overseeing the federal EMTALA law. If AHCA concurs, there shouldn't be a problem.

Q. When we have a medically cleared person on a Baker Act at our ER who is waiting for acceptance at a receiving facility what are our options for preventing elopements? I have physically stood in front of the patient so she cannot leave. I asked law enforcement for assistance and they arrived and repeated to the patient that she cannot leave, sign out AMA or refuse transportation to a psychiatric facility. As soon as they leave, she is making gestures like she's going to walk out of the EMS doors onto a major highway. Our ED doctors won't see persons when the previous day doctor initiated the Baker Act. I cannot get a physician's order for antipsychotic medication or physical restraints. We do not have a seclusion room or staff that can sit 1-on-1 with the patients. Law enforcement officers cannot stay with her in the ED as they have to get back on the road. Our psychiatry staff refuses to see consults on Baker Acts. What other options do I have to keep her in my ED until they are accepted? I've been told that we cannot apply physical restraints to medically cleared Baker Acts. To do so could be battery or false imprisonment.

Some of the problems mentioned are unique to your facility and to your physicians and these may need to be addressed with your risk management and compliance staff. You should make every reasonable effort to prevent the person from leaving the ER using the least restrictive method:

- Place into a gown
- Locate person at back of ER, farthest away from exit doors
- Provide close observation
- Provide 1 on 1 if necessary
- Provide video monitoring
- Use chemical or mechanical restraints if warranted under the federal Conditions of Participation behavioral restraint standards.

Q. How do we manage Baker Act patients waiting for transfer in our ER to prevent elopement?

It is essential that no person meeting criteria for involuntary examination under the Baker Act be allowed to leave the ED until stabilized or transferred. Some hospitals prevent persons from leaving the ER using the least restrictive method in the following ways:

- Place into a gown and remove shoes.
- Store person's belongings in a locker
- Locate person at back of ER, farthest away from exit doors
- Provide close observation
- Provide 1 on 1 if necessary with a trained sitter
- Provide video monitoring

- Use chemical or mechanical restraints if warranted under the federal Conditions of Participation behavioral restraint standards.

Q. Our hospital isn't designated as a receiving facility. We are in the process of revising our ER Baker Act policy. One of the changes we are implementing is to provide more protection for patients under the Baker Act who have not yet been medically cleared. In the past, restraints were a last resort and consequently there were elopements. We need to know where it is recommended that we restrain patients, if necessary, to prevent elopement/provide protection for the patient. It makes sense that if we have declared a patient a danger to themselves or others, then they would require protection from elopement.

Mechanical and chemical restraints for medical and behavioral reasons should always be the last resort in ensuring the safety of patients and others. Always, less restrictive interventions should be employed if at all possible. Hospitals use a variety of alternatives to prevent elopements, including but not limited to:

- Close observation
- Placing patients in gowns
- Placing patients in an area of the ED farthest from exit doors
- Use of one to one sitters
- Video monitoring
- Use of medications consented to by a competent patient or his/her proxy
- Placing a patient on an inpatient unit that offers greater security

Use of restraints be used to prevent elopements can only be used by a hospital if consistent with Conditions of Participation for behavioral restraints -- including imminent risk. However, the hospital staff must always measure the risk of a wrongful death suit against the risk of an allegation of false imprisonment or a regulatory citation. Most attorneys and risk managers would prefer the latter to the former, especially if clinical staff had clearly documented the danger presented by the patient and why less restrictive alternatives had been considered but rejected. You do need to ensure that patients aren't able to exit your hospital until a physician has documented that they are competent to refuse the required medical screening and, if found to have a psychiatric crisis (this is an emergency medical condition), that they not be able to leave until stabilized.

Hospitals have not always taken sufficient advantage of health care proxies for persons determined by a physician to lack capacity to make treatment decisions. In such cases, the proxy can consent to a treatment plan, including psychotropic medications, even in an ED situation. Of course, not everyone will be competent to consent or have a surrogate or proxy available in person or by phone to make such decisions. In those cases, emergency treatment orders for medication may be required under certain danger situation; possible mechanical restraints might also be justified. In any case, the federal CMS conditions of participation and JCAHO standards will probably apply to your hospital.

It is suggested that you work with your risk manager and with your hospital attorney to weigh the risks vs. the benefits of various alternatives for ensuring the safety of your patients. There isn't an absolute answer on this issue because each situation is different, requiring a different set of alternatives to ensure the safety of patients.

Informed Consent for Treatment & Transfer

Q. We have an elderly patient that was brought to the ED under a BA-52. This patient had overdosed, left a suicide note and a copy of a DNR. The ED physician wants to honor the DNR

and not treat. I along with attorney/risk manager feel that the patient should be treated until she can be evaluated by a psychiatrist. Any guidance ethically and legally would be greatly appreciated. .

This isn't a Baker Act question, but you noted that your risk manager/attorney is actively involved. Terminology in your inquiry needs clarification. A DNR is an order signed by a physician, generally after diagnosis of a terminal condition, end stage condition, or vegetative condition. An advance directive is signed by a **competent** adult designating preferences for care wanted or not wanted for end of life decisions under certain circumstances.

There is reference to DNR's in chapter 401, FS that clarifies that such a DNR order in order to be valid must be signed by the patient's physician, as follows:

401.45 Denial of emergency treatment; civil liability.

(3)(a) Resuscitation may be withheld or withdrawn from a patient by an emergency medical technician or paramedic if evidence of an order not to resuscitate by the patient's physician is presented to the emergency medical technician or paramedic. An order not to resuscitate, to be valid, must be on the form adopted by rule of the department. The form must be signed by the patient's physician and by the patient or, if the patient is incapacitated, the patient's health care surrogate or proxy as provided in chapter 765, court-appointed guardian as provided in chapter 744, or attorney in fact under a durable power of attorney as provided in chapter 709. The court-appointed guardian or attorney in fact must have been delegated authority to make health care decisions on behalf of the patient.

However, "Life Prolonging Procedures" are also governed under chapter 765, Advance Directives statute. The Legislature found the following:

765.102 Legislative findings and intent.

(1) The Legislature finds that every **competent adult** has the fundamental right of self-determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment. **This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession.**

(3) The Legislature recognizes that for some the administration of life-prolonging medical procedures may result in only a precarious and burdensome existence. In order to ensure that the rights and intentions of a person may be respected even after he or she is no longer able to participate actively in decisions concerning himself or herself, and to encourage communication among such patient, his or her family, and his or her physician, the Legislature declares that the laws of this state recognize the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures, or to designate another to make the treatment decision for him or her in the event that such person should become incapacitated and unable to personally direct his or her medical care.

765.101 Definitions.

(14) "Principal" means a **competent adult** executing an advance directive and on whose behalf health care decisions are to be made.

In order to be valid, Florida law requires an advance directive be witnessed by two adults (certain requirements pertain) – they should be able to state the person is of sound mind at the time of witnessing the principal's signature on the directive.

The procedure is as follows:

765.302 Procedure for making a living will; notice to physician.—

(1) **Any competent adult** may, at any time, make a living will or written declaration and direct the providing, withholding, or withdrawal of life-prolonging procedures **in the event that such person has a terminal condition, has an end-stage condition, or is in a persistent vegetative state.** A living will must be signed by the principal in the presence of two subscribing witnesses, one of whom is neither a spouse nor a blood relative of the principal. If the principal is physically unable to sign the living will, one of the witnesses must subscribe the principal's signature in the principal's presence and at the principal's direction.

(2) It is the responsibility of the principal to provide for notification to her or his attending or treating physician that the living will has been made. In the event the principal is physically or mentally incapacitated at the time the principal is admitted to a health care facility, any other person may notify the physician or health care facility of the existence of the living will. An attending or treating physician or health care facility which is so notified shall promptly make the living will or a copy thereof a part of the principal's medical records.

(3) A living will, executed pursuant to this section, establishes a rebuttable presumption of clear and convincing evidence of the principal's wishes.

765.304 Procedure for living will.—

(1) If a person has made a living will expressing his or her desires concerning life-prolonging procedures, but has not designated a surrogate to execute his or her wishes concerning life-prolonging procedures or designated a surrogate under part II, the attending physician may proceed as directed by the principal in the living will. **In the event of a dispute or disagreement concerning the attending physician's decision to withhold or withdraw life-prolonging procedures, the attending physician shall not withhold or withdraw life-prolonging procedures pending review under s. 765.105.** If a review of a disputed decision is not sought within 7 days following the attending physician's decision to withhold or withdraw life-prolonging procedures, the attending physician may proceed in accordance with the principal's instructions.

(2) Before proceeding in accordance with the principal's living will, it must be determined that:

(a) The principal does not have a reasonable medical probability of recovering capacity so that the right could be exercised directly by the principal.

(b) The principal has a terminal condition, has an end-stage condition, or is in a persistent vegetative state.

(c) Any limitations or conditions expressed orally or in a written declaration have been carefully considered and satisfied.

765.105 Review of surrogate or proxy's decision.

The patient's family, the health care facility, or the attending physician, or any other interested person who may reasonably be expected to be directly affected by the surrogate or proxy's decision concerning any health care decision may seek expedited judicial intervention pursuant to rule 5.900 of the Florida Probate Rules,

Probate Rule 5.900 that governs Expedited Judicial Intervention Concerning Medical Treatment Procedures generally takes more time than you may have available in an emergency situation. If there is doubt as to the patient's mental condition at the time she prepared an advance directive or what her decision would be currently, Most doctors would treat first and seek clarification later.

The only reference to suicide in the law is that withholding life-prolonging procedures for a person with a terminal, end stage or vegetative condition doesn't constitute suicide. However, it doesn't reference care provided to a person who has attempted suicide, without such a terminal condition.

765.309 Mercy killing or euthanasia not authorized; suicide distinguished.—

(1) Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing or euthanasia, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

(2) The withholding or withdrawal of life-prolonging procedures from a patient in accordance with any provision of this chapter does not, for any purpose, constitute a suicide.

Immunity from liability is addressed, but only in the context of following a valid advance directive. If the advance directive was prepared by a principal who was not competent at the time of preparation, I believe you would have a duty to treat in order to further investigate the competency of the person.

765.109 Immunity from liability; weight of proof; presumption.

(1) A health care facility, provider, or other person who acts under the direction of a health care facility or provider is not subject to criminal prosecution or civil liability, and will not be deemed to have engaged in unprofessional conduct, as a result of carrying out a health care decision made in accordance with the provisions of this chapter. The surrogate or proxy who makes a health care decision on a patient's behalf, pursuant to this chapter, is not subject to criminal prosecution or civil liability for such action.

(2) The provisions of this section shall apply unless it is shown by a preponderance of the evidence that the person authorizing or effectuating a health care decision did not, in good faith, comply with the provisions of this chapter.

A final consideration is Florida's medical consent law found in chapter 766, FS. It permits medical treatment without consent if within the standards of the professional practice and if the patient **would reasonably**, under all the surrounding circumstances, have undergone such treatment

766.103 Florida Medical Consent Law.—

(1) This section shall be known and cited as the "Florida Medical Consent Law."

(3) No recovery shall be allowed in any court in this state against any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractic physician licensed under chapter 460, podiatric physician licensed under chapter 461, dentist licensed under chapter 466, advanced registered nurse practitioner certified under s. [464.012](#), or physician assistant licensed under s. [458.347](#) or s. [459.022](#) in an action brought for treating, examining, or operating on a patient without his or her informed consent when:

(a)1. The action of the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant in obtaining the consent of the patient or **another person authorized to give consent for the patient** was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community as that of the person treating, examining, or operating on the patient for whom the consent is obtained; **and**

2. **A reasonable individual**, from the information provided by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant, under the circumstances, would have a general understanding of the procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures, which are recognized among other physicians, osteopathic physicians, chiropractic physicians, podiatric physicians, or dentists in the same or similar community who perform similar treatments or procedures; **or**

(b) **The patient would reasonably, under all the surrounding circumstances, have undergone such treatment** or procedure had he or she been advised by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant in accordance with the provisions of paragraph (a).

(4)(a) A consent which is evidenced in writing and meets the requirements of subsection (3) shall, if validly signed by the patient or another authorized person, raise a rebuttable presumption of a valid consent.

(b) A valid signature is one which is given by a person who under all the surrounding circumstances is mentally and physically competent to give consent.

What may be most important at this point is to contact family members to determine, to the extent possible the mental state of the patient at the time of signing the advance directive. If the patient is currently physically or mentally unable to communicate a willful and knowing health care decision, the physician can designate a family member or close personal friend as the patient's health care proxy, if no other person had been designated in the advance directive and could provide the decisions the patient would have wanted if competent to make those decisions (or use a best interest standard if the patient's choices were unknown).

Q. We have an elderly patient that has had several suicide attempts. The patient came to our ED and then was sent to the psychiatric facility that the insurance company dictates that covers this patient's care. This patient was brought to us last night via rescue for an overdose with long history of substance abuse issues and was intubated. The ED physicians and intensivists did not expect the patient to live and decided to terminally wean from the ventilator. The patient did not die. The family signed a DNR and has requested hospice. None of the psychiatrists feel like they can overturn the Baker Act (BA-52). My questions: can we place the patient on a DNR? Can we send the patient to hospice? Can the psychiatrist overturn the Baker Act? The patient is responsive, follows commands, however is not able to voice wishes at this time.

This is a really tough one. It's too bad the Baker Act was initiated – the patient could have been handled solely as a medical patient, avoiding some of these issues. First of all, any psychologist or psychiatrist can perform the initial mandatory involuntary examination and release the person directly. Further, the administrator of a receiving facility has a duty to release any person who doesn't meet involuntary placement criteria and who doesn't want (or is incompetent) to be on voluntary status.

394.463(2) Involuntary examination.

(i) Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;
2. The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;
3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or
4. A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(3)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

394.469 Discharge of involuntary patients.

(1) **POWER TO DISCHARGE.**—At any time a patient is found to no longer meet the criteria for involuntary placement, the administrator shall:

- (a) Discharge the patient, unless the patient is under a criminal charge, in which case the patient shall be transferred to the custody of the appropriate law enforcement officer;
- (b) Transfer the patient to voluntary status on his or her own authority or at the patient's request, unless the patient is under criminal charge or adjudicated incapacitated; or
- (c) Place an improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.

One of the criteria for involuntary placement is that there is no less restrictive alternative, as follows:

394.467 Involuntary inpatient placement.

(1) CRITERIA.—A person may be placed in involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:

- (b) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

Therefore, if your local hospice has agreed to accept the man into care, it would be an appropriate “available less restrictive alternative” even if his medical condition isn’t expected to improve. Further, if his psychiatric condition is stabilized and he is too fragile to act on any suicidal ideation, the “danger” criterion isn’t applicable either.

Finally, if the man has a relative or close personal friend who can serve as a health care proxy, such a proxy has the authority to request his transfer to another facility once he is determined by the psychiatrist to no longer meet placement criteria. If this man is truly terminal, he shouldn’t be in a psychiatric setting – hospice is very well equipped to deal with his medical needs.

Q. I’m an attorney and need clarification on the rules for how to proceed with a person who is in a hospital having a cardiac issue and making statements about suicide. For example, is the examination by a physician required 12 hours after they fill out the BA52, 12 hours after the medical issue has been cleared, or neither? How do we legally treat the medical emergency if the patient isn’t competent to consent?

The 12-hour period identified in the law only applies after a person’s emergency medical condition has been stabilized, as documented by a physician. The 12 hours is the period after medical stabilization in which a hospital must transfer the person to a designated receiving facility. If the person is in the ED of a designated receiving facility, the 12-hour provision doesn’t apply at all – only the 72-hour period (not including the medical emergency period) in which to release, transfer to voluntary status, or file a petition for involuntary placement with the Clerk of Court.

If the person has cardiac issues that meets the definition of an “emergency medical condition in s.395.002(8), FS, the 72-hour clock isn’t ticking:

(8) “Emergency medical condition” means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to patient health, including a pregnant woman or fetus.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

If your question also has to do with consent for medical treatment of a person with an emergency medical condition, the Baker Act as Florida's Mental Health Act doesn't have any applicability to consent for medical treatment and can't be used as the authority to provide any medical examination

or medical treatment except for the physical examination provided within 24 hours of a person's arrival at a receiving facility. While a hospital couldn't use the Baker Act as authority to provide any medical treatment -- only psychiatric examination and psychiatric treatment, they might want to consider other alternatives for providing medical treatment for persons without consent such as one or more of the following that I've included extracts from statutes that you probably deal with regularly, as follows:

One that applies in pre-hospital or ED settings is chapter 401, FS that governs EMS:

401.445 Emergency examination and treatment of incapacitated persons.

(1) No recovery shall be allowed in any court in this state against any emergency medical technician, paramedic, or physician as defined in this chapter, any advanced registered nurse practitioner certified under s. 464.012, or any physician assistant licensed under s. 458.347 or s. 459.022, or any person **acting under the direct medical supervision of a physician, in an action brought for examining or treating a patient without his or her informed consent if:**

(a) The patient at the time of examination or treatment is intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent as provided in s. 766.103;

(b) The patient at the time of examination or treatment is experiencing an emergency medical condition; and

(c) The patient would reasonably, under all the surrounding circumstances, undergo such examination, treatment, or procedure if he or she were advised by the emergency medical technician, paramedic, physician, advanced registered nurse practitioner, or physician assistant in accordance with s. 766.103(3).

Examination and treatment provided under this **subsection shall be limited** to reasonable examination of the patient to determine the medical condition of the patient and treatment reasonably necessary to alleviate the emergency medical condition or to stabilize the patient.

(2) In examining and treating a person who is apparently intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent, the emergency medical technician, paramedic, physician, advanced registered nurse practitioner, or physician assistant, or any person acting under the direct medical supervision of a physician, **shall proceed wherever possible with the consent of the person. If the person reasonably appears to be incapacitated and refuses his or her consent, the person may be examined, treated, or taken to a hospital or other appropriate treatment resource if he or she is in need of emergency attention, without his or her consent, but unreasonable force shall not be used.**

(3) This section does not limit medical treatment provided pursuant to court order or treatment provided in accordance with chapter 394 or chapter 397.

401.45` Denial of emergency treatment; civil liability.

(1)(a) Except as provided in subsection (3), a person may not be denied needed prehospital treatment or transport from any licensee for an emergency medical condition.

(b) A person may not be denied treatment for any emergency medical condition that will deteriorate from a failure to provide such treatment at any general hospital licensed under chapter 395 or at any specialty hospital that has an emergency room.

(2) A hospital or its employees or any physician or dentist responding to an apparent need for emergency treatment under this section is not liable in any action arising out of a refusal to render emergency treatment or care if reasonable care is exercised in determining the condition of the person and in determining the appropriateness of the facilities and the qualifications and availability of personnel to render such treatment.

(3)(a) Resuscitation may be withheld or withdrawn from a patient by an emergency medical technician or paramedic if evidence of an order not to resuscitate by the patient's physician is presented to the emergency medical technician or paramedic. An order not to resuscitate, to

be valid, must be on the form adopted by rule of the department. The form must be signed by the patient's physician and by the patient or, if the patient is incapacitated, the patient's health care surrogate or proxy as provided in chapter 765, court-appointed guardian as provided in chapter 744, or attorney in fact under a durable power of attorney as provided in chapter 709. The court-appointed guardian or attorney in fact must have been delegated authority to make health care decisions on behalf of the patient.

(b) Any licensee, physician, medical director, or emergency medical technician or paramedic who acts under the direction of a medical director is not subject to criminal prosecution or civil liability, and has not engaged in negligent or unprofessional conduct, as a result of the withholding or withdrawal of resuscitation from a patient pursuant to this subsection and rules adopted by the department.

In other than emergency situations, Chapter 766.103, FS, Florida's medical Consent Act governs authorization for medical care by a competent patient, a legally authorized substitute decision-maker, or without authorization in emergencies.

766.103 Florida Medical Consent Law.--

(1) This section shall be known and cited as the "Florida Medical Consent Law."

(3) No recovery shall be allowed in any court in this state against any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractic physician licensed under chapter 460, podiatric physician licensed under chapter 461, dentist licensed under chapter 466, advanced registered nurse practitioner certified under s. 464.012, or physician assistant licensed under s. 458.347 or s. 459.022 in an action brought for treating, examining, or operating on a patient without his or her informed consent when:

(a)1. The action of the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community as that of the person treating, examining, or operating on the patient for whom the consent is obtained; and

2. A reasonable individual, from the information provided by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant, under the circumstances, would have a general understanding of the procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures, which are recognized among other physicians, osteopathic physicians, chiropractic physicians, podiatric physicians, or dentists in the same or similar community who perform similar treatments or procedures; or

(b) The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure had he or she been advised by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant in accordance with the provisions of paragraph (a).

(4)(a) A consent which is evidenced in writing and meets the requirements of subsection (3) shall, if validly signed by the patient or another authorized person, raise a rebuttable presumption of a valid consent.

(b) A valid signature is one which is given by a person who under all the surrounding circumstances is mentally and physically competent to give consent.

Obviously, the above standard for consent is lower than the "well-reasoned, willful and knowing" standard in the Baker Act. If the person lacks capacity and has a relative or friend to serve as a proxy, the hospital could arrange for substitute decision making by the proxy under the following standard.

765.101 Definitions (Advance Directive Statute)

(9) "Informed consent" means consent voluntarily given by a person after a sufficient explanation and disclosure of the subject matter involved to enable that person to have a general understanding of the treatment or procedure and the medically acceptable alternatives, including the substantial risks and hazards inherent in the proposed treatment or procedures, and to make a knowing health care decision without coercion or undue influence.

Adult Protective Services might also be an option, although the Abuse Registry tends to refuse calls about persons in hospitals on the presumption that they can't self-neglect in such a setting. However, the following definition of "capacity" might apply:

415.102 (Adult Protective Services) Definitions of terms used in ss. 415.101-415.113.--As used in ss. 415.101-415.113, the term:

(3) "Capacity to consent" means that a vulnerable adult has sufficient understanding to make and communicate responsible decisions regarding the vulnerable adult's person or property, including whether or not to accept protective services offered by the department.

Finally, if nothing else is possible, the Rules of Probate Procedures might offer some option, but it would involve the hospital's attorney filing a petition with the circuit court, as follows:

Rule of Probate Procedures Rule 5.900 governing Expedited Judicial Intervention Concerning Medical Treatment Procedures, allows for the court to consider ordering medical treatment that may be opposed by the patient or family members.

Q. We face the problem in this area of have no LCSW who wishes to be a proxy prior to the court hearing. We have approached the Professional Associations, asked other facility LCSW's but have received no positive responses. At one time we had court approved "proxy" but 2 years ago it was decided that they could only be appointed after the hearing. I think my best approach is to work on getting the court to reverse that decision so we can use the proxy prior to the hearing

Unfortunately, Chapter 765, FS doesn't recognize anyone not on the prioritized list of persons eligible to serve. Therefore, the court has no jurisdiction to appoint a person not on that list.

765.401 The proxy.

- (1) If an incapacitated or developmentally disabled patient has not executed an advance directive, or designated a surrogate to execute an advance directive, or the designated or alternate surrogate is no longer available to make health care decisions, health care decisions may be made for the patient by any of the following individuals, in the following order of priority, if no individual in a prior class is reasonably available, willing, or competent to act:
 - (a) The judicially appointed guardian of the patient or the guardian advocate of the person having a developmental disability as defined in s. 393.063, who has been authorized to consent to medical treatment, if such guardian has previously been appointed; however, this paragraph shall not be construed to require such appointment before a treatment decision can be made under this subsection;
 - (b) The patient's spouse;
 - (c) An adult child of the patient, or if the patient has more than one adult child, a majority of the adult children who are reasonably available for consultation;
 - (d) A parent of the patient;
 - (e) The adult sibling of the patient or, if the patient has more than one sibling, a majority of the adult siblings who are reasonably available for consultation;

- (f) An adult relative of the patient who has exhibited special care and concern for the patient and who has maintained regular contact with the patient and who is familiar with the patient's activities, health, and religious or moral beliefs; or
- (g) A close friend of the patient.
- (h) A clinical social worker licensed pursuant to chapter 491, or who is a graduate of a court-approved guardianship program. Such a proxy must be selected by the provider's bioethics committee and must not be employed by the provider. If the provider does not have a bioethics committee, then such a proxy may be chosen through an arrangement with the bioethics committee of another provider. The proxy will be notified that, upon request, the provider shall make available a second physician, not involved in the patient's care to assist the proxy in evaluating treatment.** Decisions to withhold or withdraw life-prolonging procedures will be reviewed by the facility's bioethics committee. Documentation of efforts to locate proxies from prior classes must be recorded in the patient record.
- (2) Any health care decision made under this part must be based on the proxy's informed consent and on the decision the proxy reasonably believes the patient would have made under the circumstances. If there is no indication of what the patient would have chosen, the proxy may consider the patient's best interest in deciding that proposed treatments are to be withheld or that treatments currently in effect are to be withdrawn.

You might consider asking the court to expedite the hearing to appoint a guardian advocate who can be an "adult trained and willing to serve". Such a person is not eligible to serve as a proxy, but can be appointed as a guardian advocate.

394.4598 Guardian advocate.

(1)The administrator may petition the court for the appointment of a guardian advocate based upon the opinion of a psychiatrist that the patient is incompetent to consent to treatment. If the court finds that a patient is incompetent to consent to treatment and has not been adjudicated incapacitated and a guardian with the authority to consent to mental health treatment appointed, it shall appoint a guardian advocate. The patient has the right to have an attorney represent him or her at the hearing. If the person is indigent, the court shall appoint the office of the public defender to represent him or her at the hearing. The patient has the right to testify, cross-examine witnesses, and present witnesses. The proceeding shall be recorded either electronically or stenographically, and testimony shall be provided under oath. One of the professionals authorized to give an opinion in support of a petition for involuntary placement, as described in s. 394.4655 or s. 394.467, must testify....

The Summary Reference on Substitute Decision Making found on Appendix C-4-5 in the 2011 Baker Act Handbook might be of help to you in comparing the standing and authority of various types of substitute decision-makers under the various laws.

You may want to speak with other hospitals or long-term care facilities in your locale about the possible reciprocal agreement for LCSW's to serve in this capacity. Another option is for the court to consider the appointment of a guardian advocate to make treatment decisions for the individual in advance of the hearing on involuntary placement.

Q. Could you please clarify for us, when a patient is being transferred from our psychiatric ED, or inpatient unit to another psychiatric facility, (most likely due to funding reasons) can that patient still be transferred if they refuse to sign the transfer form? My understanding is that under EMTALA, if the person refuses to sign the transfer form, and the sending hospital can provide the same level of care, then the patient cannot be forced to transfer. The patient, however, will be informed that they will be responsible for the payment accrued. Does this law

still stand? We found out that out psych ED are transferring patient to CSUs and other Community Mental Health Centers solely based on the fact that they are Baker Acted (involuntary).

You are correct. If a person with an emergency psychiatric condition is being transferred from your hospital ER (a designated receiving facility) to another designated receiving facility, consent of the patient or legal representative would be required for it to be an appropriate transfer under the federal EMTALA law. However, if the person's emergency psychiatric condition has been fully stabilized or if the transfer is post-ER from the inpatient unit, EMTALA no longer applies. Post-admission transfers are governed by the federal Conditions of Participation.

Being on involuntary status under the Baker Act doesn't deprive persons of any federal or state protected rights – in fact, they have more rights than persons on voluntary status. The person's legal status under state law wouldn't permit a breach of federal EMTALA law.

Once EMTALA is no longer an issue, the Baker Act transfer provisions apply:

394.4685 Transfer of patients among facilities.--

(3) TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.--

(a) A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.

(b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

(c) A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.

As you can see from this section of the Baker Act, the patient may be transferred upon his/her request or upon the request of a private receiving facility.

Q. If a hospital is not a Baker Act Receiving Facility, it must transfer a Baker Act patient to a Baker Act Receiving Facility after stabilization with or without the patient's or legal guardian's consent?

If the sending hospital doesn't have licensed psychiatric beds, it wouldn't have the capability or capacity to care for the person's emergency psychiatric condition. The ED physician could then, after disclosing the risks/benefits of the transfer to the patient, certify that the benefits of the transfer outweigh the risks. While consent may still be desirable, it is not necessary in such situations.

Q. When we transfer a patient to another Baker act facility, should they sign a consent form? What do we do if they refuse to sign the consent?

Since your hospital has licensed psychiatric beds and is designated as a receiving facility, it cannot transfer a person with an emergency medical condition (including a psychiatric emergency) from the ED without his/her consent (or that of a legal representative) unless it doesn't have the capability or capacity. Capacity is easy – every bed on your psychiatric unit is filled and you don't go over census even for paying patients. Capability might include the patient being a minor if you have no pediatric psychiatric beds. It cannot be for payment reasons. If you have both the capability and capacity to treat the patient and the need for transfer is just for payment reasons and the patient refuses, you may have to admit the patient to your inpatient psychiatric unit. If the person has a health care proxy,

the proxy is authorized by federal and state law to request a transfer on behalf of the patient. If you do a transfer because of lack of capability or capacity, all other requirements of EMTALA must still be met. Once the patient is admitted, EMTALA no longer applies and the staff would have to comply with federal Conditions of Participation for transfer

Q. Can you comment on the discrepancy between counties in using administrative transfers? The majority of facilities in our county will not accept transfers from other receiving facilities when the patient refuses and/or is unable to sign the EMTALA form and the doctor signs that the patient should be transferred. Is this correct?

While the patient's consent or that of his/her legal representative is always desirable for transfers, it is only legally required when the transfer is from a hospital that has the capability and capacity to meet the person's condition. In these situations, the reason for the transfer is usually financial. Financial reasons don't relieve the sending hospital of its duties under EMTALA. If it is from a hospital that has no psychiatric capability, a physician or other medical professional approved by the sending hospital can certify that the benefits of the transfer outweigh the risks.

After admission to a hospital, EMTALA no longer applies. Instead, governance falls under the federal Conditions of Participation. When transfers occurring after admission are from one receiving facility to another receiving facility the Baker Act also applies. The section of the Baker Act governing transfers between been facilities is found in 394.4685, FS.

Q. If a patient presents to the ED of a non-psych hospital with a Baker Act and needs to be transferred to a Baker Act receiving facility does the patient have to sign an EMTALA transfer form before we can transfer the patient? Can the patient refuse to transfer? We had a situation recently that all the local Baker Act receiving facilities were full and the closest facility was two counties away. The patient was medically cleared from the ED perspective and the psychiatrist did not see the patient in the ED. The patient refused to sign the EMTALA transfer form. He hadn't been determined "unable to agree" to the evaluation, just "refused" to accept voluntary admission. Can we have two physicians sign the EMTALA form based on medical necessity?

Since you have no licensed psychiatric beds and aren't designated as a receiving facility, your hospital doesn't have the capability and capacity to meet the emergency medical condition (Psychiatric) of persons brought to you under the involuntary examination provisions of the Baker Act. Therefore, a certification by the physician is sufficient to document that the benefits of the transfer outweigh the risks will suffice – consent of the patient/legal representative is not required. This, of course, is after your hospital has performed all of its other duties required for an appropriate transfer under EMTALA (MSE, stabilization for transfer, sharing of records, approval of destination facility, and arranging safe/appropriate transport).

Q. A designated receiving facility accepted the transfer of a person from our ER (not a designated receiving facility). They changed their minds when they heard that we could not get the person to sign consent for transfer. Even the person's family was in accord with the plan. If the person is being transferred on an involuntary basis, why would consent to transfer be required to accomplish this? We were able to transfer to another hospital which did not require this.

This is an issue governed by EMTALA and by the Baker Act. People don't lose any rights simply due to the fact that they are on involuntary status – they actually have more rights/protections under that

status. Since your hospital is a general hospital without psychiatric services, it doesn't have the capability or capacity to meet the needs of a person with a psychiatric emergency. While it is always desirable to seek the consent of the patient or their legal representative, it is not required from your hospital – a certification from a physician that the benefits of transfer outweigh the risk of the transfer should suffice. This would not suffice for the transfer of a person from one receiving facility to another that requires the consent of the patient/legal representative because the sending hospital has the capability/capacity to meet the patient's needs. Such a lateral transfer is discouraged by EMTALA, but usually considered acceptable with the consent of the patient/representative.

You would have to meet all your other EMTALA requirements that condition an appropriate transfer. When the federal EMTALA law is in conflict with the state's Baker Act law, EMTALA takes precedence. When no conflict exists, hospitals must follow both.

Q. What do we do about patients who are brought to a Baker Act receiving facility and then refuse to sign the EMTALA form to be transferred to a contracted facility designated by the Managed Care Company in which they are enrolled? I have had several hospitals refuse to transfer enrollees from either their ER or the inpatient unit unless the enrollee signs a EMTALA form, either by choice of the enrollee or if the hospital deems the enrollee incompetent to sign. They state that they are in violation of the EMTALA laws if they transfer the enrollee to where the insurance company designates if the enrollee has not signed authorization to do so. Therefore they admit the enrollee to their facility and state that we are required to authorize the admission to that facility regardless if they are a contracted provider or not. I thought that insurance companies had the right to transfer their enrollees to their nearest contracted facility and that it was not a violation of EMTALA laws.

If a person is at a hospital-based receiving facility, the person cannot be forced to transfer to another facility solely for reasons of insurance. However, if the person is at a hospital that isn't designated as a receiving facility, the person can be transferred without his/her consent if a physician documents that the benefits of the transfer outweigh the risks. As you know, CSU's aren't subject to EMTALA. Once the transfer is determined to be appropriate as described above and meeting all the other conditions necessary for an appropriate transfer under EMTALA, the transfer doesn't need to be to the nearest receiving facility, but rather to a facility that can not only manage the person's medical condition but corresponds with their financial situation. To a public receiving facility if indigent and to any receiving facility that accepts the person's public or private insurance if insured.

If the person has a court-appointed guardian or health care surrogate/proxy currently making the person's health care decisions, this substitute decision maker can request a transfer on behalf of the patient – they are considered to be standing in the shoes of the patient. Therefore, if the person lacks capacity at the time to make his/her own health care decisions and has a relative or close personal friend willing to serve as proxy, that person can request the transfer on behalf of the patient.

The issue of whether you have responsibility to pay for care in an out-of-network facility would presumably be covered in your contracts with subscribers and providers. It is not addressed in the Baker Act. You may need to check with AHCA to see if it is addressed in either EMTALA or chapter 395, FS.

Q. Can a hospital ED transfer a person under involuntary provisions of the Baker Act to a receiving facility without the person's consent?

Only if the hospital doesn't have the capability or capacity to meet the person's needs. This means that if the hospital is part of a designated receiving facility, it generally cannot transfer a person

without the person's consent (or that of his/her legal representative). If the hospital doesn't have licensed psychiatric beds, a physician can generally certify that the benefits of the transfer outweigh the risks. Section 395.1041, F.S. and the federal EMTALA law permit transfers of persons who have come to a hospital as a result of an emergency medical condition, only when one of the following has occurred:

- (a) When the person, or a person who is legally responsible for the person and acting on the person's behalf, after being informed of the hospital's obligation pursuant to section 395.1041, F.S. and the risk of transfer, requests that the transfer be effected; or
- (b) If a physician or other qualified medical personnel, certifies that the benefits to the condition of the person outweigh the risks associated with the transfer.

It is not appropriate to simply note that a transfer is being done because the person was "Baker Acted". Initiation of an involuntary examination doesn't deprive people of any right assured under federal or state law – they actually have enhanced rights under the law.

Q. A person with no insurance was Baker Acted in our psych ER by a physician. He was willing to be transferred to another facility, but the physician checked the box which says "person is unable to determine for himself whether examination is necessary" on the BA-52. The Psych ER staff felt that due to this, we could not transfer the patient (that he was incompetent to make a decision regarding transferring to another facility). Is this correct? And to make it more general, what are the circumstances that would indicate we can transfer a Baker Acted patient from our ER to another facility.

Legal and clinical experts recognize a sliding scale of competency -- someone can be incompetent to understand the full consequences of all forms of psychotropic medications, but be competent to know that he doesn't want to pay a hospital bill. Once the other requirements of EMTALA are met, if the person expresses a desire to go to another facility that is unlikely to bill the person for care, that should suffice. It will help to have some type of documentation of what the person was asked and how they responded: Once all EMTALA requirements are met, the person can be transferred from one receiving facility to another under provisions of the Baker Act.

Forms/Paperwork

Q. I don't see that the *Application for and Notice of Transfer to Another Receiving or Treatment Facility* form is required for all Baker Act patients transferring from the acute care hospital to the psychiatric hospital. Is it up to the transferring and receiving facility whether it is used? Is it needed when an EMTALA transfer form is completed from the ED?

This form is only applicable to transfers between receiving facilities and isn't applicable to you as an ED not associated with a designated Baker Act receiving facility. There are however two recommended forms that do apply to your situation and – Form 3101 titled "Hospital Determination that Person Does Not Meet Involuntary Placement Criteria" and Form 3102 titled "Request for Involuntary Examination after Stabilization of Emergency Medical Condition" One can be used for the direct release of a person from your hospital. The second one can be used if your emergency physician believes the person continues to meet the criteria for involuntary examination/placement and requests transfer of the person to a receiving facility for examination.

Q. A local hospital ER is being required by a receiving facility to provide the original Baker Act and the original EMTALA form as a condition of accepting the transfer. Up to now they were sending the original Baker Act and a copy of the EMTALA form. Is this correct?

There is no requirement in the Baker Act law or rules that the original of the involuntary examination form (or any other form for that matter) be sent. All references to “originals” were removed from the rules and forms in 2005 – there never was any reference to such in the statute. There remain references to “copies” in various places to mean that a document – original or “copy” must remain in medical records or accompany the patient. However, a copy of an original should suffice unless there is reason to believe it has been altered in some way. Original forms generally do not need to be sent to a destination hospital when a transfer is done. Any artificial barrier to such a needed transfer might be a problem for the destination hospital.

Transfers

Q. I am attempting to educate a physician as to why it is was NOT illegal for a psychiatric facility to decline as a TRANSFER to their Psych Facility for a patient admitted through our ER following a suicide attempt who was not a Baker Act as she voluntarily agreed to have treatment. I would like to provide the physician with the appropriate section of the Baker Act statute that would addresses this particular issue. Can you provide me with direction or the statute section?

Under the federal EMTALA law, a hospital with psychiatric capability and capacity is prohibited from delaying or denying a transfer of a patient with an emergency medical condition (includes emergency psychiatric and emergency substance abuse conditions even when no other medical issues are present) based on the patient’s inability to pay. However, if the destination hospital doesn’t have the space or programming or no emergency condition exists, it can legally deny the transfer.

Under the state’s Baker Act, a doctor at a hospital providing emergency medical services can perform the involuntary examination and transfer the patient to voluntary status or release him/her directly without sending to a receiving facility.

394.463(2) Involuntary examination.

(g)A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. **If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination (physician or psychologist) and is found as a result of that examination not to meet the criteria for involuntary** outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient **may be offered voluntary placement, if appropriate, or released directly from the hospital** providing emergency medical services. ...

(h)**One of the following must occur within 12 hours** after the patient’s attending physician documents that the patient’s medical condition has stabilized or that an emergency medical condition does not exist:

- 1.The patient must be **examined by a designated receiving facility and released**; or
- 2.The patient must be **transferred to a designated receiving facility in which appropriate medical treatment is available**. However, the receiving facility must be notified of the transfer within 2 hours after the patient’s condition has been stabilized or after determination that an emergency medical condition does not exist.

As you can see above, if the emergency physician doesn't release a person on involuntary status, the hospital providing the emergency medical examination or treatment must transfer to a receiving facility within 12 hours after the person is medically cleared. It can be to any receiving facility – not necessarily the nearest.

What complicates your situation is that the patient was on **voluntary** status so the above provision from the Baker Act wouldn't apply. This means that the doctor must have found her willing and able to make "well-reasoned, willful, and knowing medical and mental health decisions" – the legal definition for competence to provide express and informed consent. This might imply that no emergency psychiatric condition existed at the time of examination and the woman was legally able to leave the hospital and go directly to whatever facility she chose.

Many people "agree" to treatment, but will not follow-through, are too ill to understand the nature of their illness and will agree to anything, or sometimes try to manipulate staff to exit the facility. The criteria for involuntary examination includes people who refuse examination as well as those who are unable to determine the need for the exam. The latter may be "agreeing", but might not meet the criteria for express and informed consent.

Q. In order to educate the medical staff, I'm trying to understand whether a BA receiving facility has an obligation to accept a requested transfer of a non-Baker Act patient for inpatient treatment

No receiving facility is required to accept any transfer if it doesn't have the capability or capacity to serve the patient. A hospital-based receiving facility cannot refuse a patient with an emergency condition based on the person's inability to pay.

Chapter 395, FS governs licensure of Florida hospitals. The section relating to access to emergency services may assist you in training your staff:

395.1041 Access to emergency services and care.

(3)EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.—

(a)Every general hospital which has an emergency department shall provide emergency services and care for any emergency medical condition when:

- 1.Any person requests emergency services and care; or
- 2.Emergency services and care are requested on behalf of a person by:
 - a.An emergency medical services provider who is rendering care to or transporting the person; or
 - b.Another hospital, when such hospital is seeking a medically necessary transfer, except as otherwise provided in this section.

(b)Arrangements for transfers must be made between hospital emergency services personnel for each hospital, unless other arrangements between the hospitals exist.

(c)A patient, whether stabilized or not, may be transferred to another hospital which has the requisite service capability or is not at service capacity, if:

- 1.The patient, or a person who is legally responsible for the patient and acting on the patient's behalf, after being informed of the hospital's obligation under this section and of the risk of transfer, **requests** that the transfer be effected;
- 2.A physician has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another

hospital outweigh the increased risks to the individual's medical condition from effecting the transfer; or

3.A physician is not physically present in the emergency services area at the time an individual is transferred and a qualified medical person signs a certification that a physician, in consultation with personnel, has determined that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer. The consulting physician must countersign the certification; provided that this paragraph shall not be construed to require acceptance of a transfer that is not medically necessary.

(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital **with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity.**

When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

(f) In no event shall the provision of emergency services and care, the acceptance of a medically necessary transfer, or the return of a patient pursuant to paragraph (e) be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, **insurance status, economic status, or ability to pay for medical services.** except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred.

However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

(i) Each hospital offering emergency services shall post, in a conspicuous place in the emergency service area, a sign clearly stating a patient's right to emergency services and care and the service capability of the hospital.

Q. What, if any, is the obligation of a receiving ER to accept the transfer of a medically cleared BA patient from a non-receiving facility ER if the receiving facility has no psych beds to admit patient to. Another words, the patient would wait in the receiving facility's ER until a bed opened. If the patient has been in the non-receiving facility ER for more than 12 hours does that factor in?

The issue you raise is governed by the federal EMTALA law, overseen in Florida by AHCA. However, the following information from the state's hospital licensing law will be helpful

395.002 Definitions.

(26) "At service capacity" means the temporary inability of a hospital to provide a service which is within the service capability of the hospital, due to maximum use of the service at the time of the request for the service.

(3)EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.—

(a)Every general hospital which has an emergency department shall provide emergency services and care for any emergency medical condition when:

- 1.Any person requests emergency services and care; or
- 2.Emergency services and care are requested on behalf of a person by:
 - a.An emergency medical services provider who is rendering care to or transporting the person; or
 - b.Another hospital, when such hospital is seeking a medically necessary transfer, except as otherwise provided in this section.

(b)Arrangements for transfers must be made between hospital emergency services personnel for each hospital, unless other arrangements between the hospitals exist.

(c)A patient, whether stabilized or not, may be transferred to another hospital which has the requisite service capability **or is not at service capacity, if:**

- 1.The patient, or a person who is legally responsible for the patient and acting on the patient's behalf, after being informed of the hospital's obligation under this section and of the risk of transfer, **requests** that the transfer be effected;
- 2.A **physician has signed a certification** that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another hospital outweigh the increased risks to the individual's medical condition from effecting the transfer;

(e)Except as otherwise provided by law, **all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity.**

When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

(f)In no event shall the provision of emergency services and care, the acceptance of a medically necessary transfer, or the return of a patient pursuant to paragraph (e) be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(g)Neither the hospital nor its employees, nor any physician, dentist, or podiatric physician shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is made after screening, examining, and evaluating the patient, and is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition or a determination, exercising reasonable care, that the hospital does not have the service capability or is at service capacity to render those services.

(h)A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred.

As you see above, the transfer from the ED can be to any hospital that has the capability (psychiatric) and the capacity (bed space) to meet the individual's emergency needs. While your hospital has the

capability, it didn't at the time of the requested transfer have the capacity. The ED should have continued to seek out a Baker Act designated hospital or CSU that had both the capacity and capability if Baptist and Lakeview couldn't accept the transfer. No purpose would have been served by holding the individual in your ED awaiting a bed vs the ED of the transferring hospital. If your hospital ever goes over census for paying patients, it would be expected to use the same methods of dealing with excess census for indigent patients. Otherwise, you wouldn't be required to go over census for anyone.

Once the federal EMTALA requirements are met the Baker Act provides the following:

394.463(1) Involuntary Examination

(h)One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

- 1.The patient must be examined by a designated receiving facility and released; or
- 2.The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

Q. I cannot find a provision for the Involuntary Baker Acts at an acute care hospital after 72 hours of medical clearance. There has been an occasion that we were unable to find a receiving facility that has accepted our patient. We do reach out to facilities in several different districts, not just ours. The patient may be denied based on bed availability, facility not taking insurance, facility not taking patients outside their district etc. We will notify DCF after 12 hours if we have not found an accepting receiving facility. We want to do right by our patients and by the Back Act. What would be our options at the 72nd hour?

There is no remedy in the Baker Act for what you describe, although it isn't an unusual event. The Baker Act only allows you as a non-receiving facility up to 12 hours after medical clearance to transfer an individual under involuntary status to a designated receiving facility. The 72-hour period only applies to the period receiving facilities have to examine the individual before release or filing involuntary placement petition with the court.

Your hospital attorney and risk manager would probably advise you to risk a "false imprisonment" allegation rather than a wrongful death in releasing a person who had been found to be "dangerous to self or others" due to his/her mental illness. The best defense against a false imprisonment suit for keeping a person more than 12 hours following medical clearance is your own documentation that you had made every reasonable effort to achieve an appropriate transfer of the individual and that you had reported your barriers to a timely transfer to the DCF Circuit Office.

You have a number of options open to you before the 12-hours runs out. These include having your own ED physicians examine the person and release if not meeting the criteria for involuntary placement. Many emergency physicians refuse to do this even though legally eligible to do so, creating much of the transfer problem. Your hospital can also contract with a psychologist or physician to perform these exams and authorize direct release from your hospital or transfer to voluntary status. Your physician can order medications that might help to stabilize a person for discharge with a follow up appointment for his/her mental illness, eliminating the need for transfer.

A licensed hospital with the capability and capacity to meet the emergency mental health needs of an individual on a pre-admit basis cannot refuse the transfer because of inability to pay – this would be a violation of the federal EMTALA law as well as Chapter 395, FS governing hospital licensure. If

inability to pay is the reason given by a licensed hospital for refusing a transfer, you should document this on the ED transfer log and make sure this included in your self-report to DCF. Refusing to accept an "out of district" transfer wouldn't be acceptable either – there is no geographic limit on accepting a person with emergency medical condition, even of a psychiatric nature absent other medical issues.

Your hospital personnel should meet with DCF Circuit/Region mental health personnel to discuss any ongoing issues related to transfers. There is probably an acute care workgroup in your locale working to address this and other Baker Act related problems.

Q. Am I correct that there is no authority under the Baker Act to transfer someone involuntarily to a facility in another state (when they did not come from that state)?

Chapter 394, Part II is the Interstate Compact on Mental Health that governs this issue. However, the Compact only governs transfers of persons in state mental health treatment facilities. DCF/HQ may be able to clarify this issue for you. Part II is included in this response for your convenience.

There was one case where a judge in another state entered an order for a person to be hospitalized. The person eloped to Florida and law enforcement from the other state showed up to take the person into custody from a hospital in this state. DCF General Counsel's Office advised that a legal order from another state should be given full faith and credit by Florida. The person was released to the officers who transported him back to this state.

However, your question seems to be whether a person under involuntary status (examination or placement?) can be transferred from a Florida facility to a facility in another state.

Chapter 394.4685, FS governs transfers of patients among facilities. While one might presume this is limited to designated facilities within the state of Florida, its use of the term "facility" could be any hospital, community facility, public or private facility, or receiving or treatment facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who appear to have a mental illness or have been diagnosed as having a mental illness....(definition #10).

394.4685 Transfer of patients among facilities.

(4)TRANSFER BETWEEN PRIVATE FACILITIES.—A patient in a private facility or the patient's guardian or guardian advocate may request the transfer of the patient to another private facility at any time, and the patient shall be transferred upon acceptance of the patient by the facility to which transfer is sought.

The Baker Act refers to "transfers" in 394.4685 as well as from a hospital ED to a receiving facility in 394.463. A person can only be "discharged" when found to not meet the criteria for involuntary placement -- including availability of a less restrictive appropriate placement. Such a placement may be out of state with family.

Every effort should be made to transfer the person to a facility even if out of state, assuming that the family can provide for the person's needs and the person agrees to the transfer. While it's the right thing to do, the best mechanism to use to make it happen is unclear .

The cleanest way is to make the person voluntary and release to the custody of family unless there is reason to believe the family cannot safely arrange the transport of the person to the out of state facility. The only other alternative might be for the facility where the person is located to petition the court for an order transferring the person to the other jurisdiction, although its unknown if this has ever happened.

Q. I am having a great degree of difficulty with a private med/surg hospital. A deputy brought 2 patients from this hospital today without so much as a call. I spoke with the Chief Nursing Officer who said "they were medically cleared, so we let them sit outside until the Deputy arrived". I said, "are you aware that what occurred is an EMTALA Violation"? She acted as though this was news to her, but this hospital is notorious for this behavior. I would like to know who I should contact regarding these client rights violations. Can you help me?

The practice you describe is unacceptable in terms of hospital liability as well as patient safety. The hospital's Risk Manager (safety) should be contacted as well as the Compliance Officer (EMTALA). I have to believe that both would want to correct this practice. The sending hospital is responsible for arranging safe and appropriate method of transfer of persons with emergency medical conditions (EMC). CMS defines psychiatric emergencies and substance abuse emergencies as EMC's, even absent other medical conditions. A person on Baker Act involuntary examination status is considered to have a psychiatric emergency. An emergency physician can conduct the exam and find the individual doesn't meet criteria, transferring to voluntary status or directly releasing the individual from the hospital. However, if the emergency physician hasn't done this, the individual must be protected until an appropriate transfer can be arranged, which requires prior consent by the accepting facility.

The staff should also be aware that state law governing hospital licensure provides the following regarding persons held under the Baker Act at any hospital, regardless of whether it is a receiving facility:

395.003(5)(a) governing licensure of all hospitals states "Adherence to patient rights, standards of care, and examination and placement procedures provided under part I of chapter 394 shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment".

(5)(b)"Any hospital that provides psychiatric treatment to persons under 18 years of age who have emotional disturbances shall comply with the procedures pertaining to the rights of patients prescribed in part I of chapter 394".

395.1041(6) RIGHTS OF PERSONS BEING TREATED.--A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

395.1055(5) governing rules and enforcement states "The agency shall enforce the provisions of part I of chapter 394, and rules adopted thereunder, with respect to the rights, standards of care, and examination and placement procedures applicable to patients voluntarily or involuntarily admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment".

395.1065(4) governing criminal and administrative penalties states "In seeking to impose penalties against a facility as defined in s. 394.455 for a violation of part I of chapter 394, the agency is authorized to rely on the investigation and findings by the Department of Health in lieu of conducting its own investigation".

The deputy should just walk the person back into the ED and advise the staff to transfer the patient in accord with federal EMTALA requirements. Further, the deputy should follow CCSO policy which is to

provide such transfer only when requested by DLC. You can also report this to the AHCA area office. DCF can also work with their counterparts at AHCA to remedy the situation.

Q. Our hospital attorney has asked if a facility is at or over capacity and requests that an individual be transferred to a second facility which is not at capacity, does the second facility have a legal obligation to accept the transfer? Also, if facilities are required to disclose their current census to other facilities upon request?

A facility is required to go over capacity for indigent patients if it does so for paying patients. If it never goes over capacity for any patients, it can refer to other hospitals with the capacity and the capability to manage the individual's specialized emergency needs.

The federal EMTALA law governs pre-admission care for persons with emergency medical conditions, including emergency psychiatric and emergency substance abuse conditions. However, Florida's hospital licensure law doesn't make the distinction between pre and post admission regarding access to emergency services and care. Some provisions of that law are found below:

395.1041 Access to emergency services and care.

(3)EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.—

(b)Arrangements for transfers must be made between hospital emergency services personnel for each hospital, unless other arrangements between the hospitals exist.

(c)A patient, whether stabilized or not, may be transferred to another hospital which has the requisite service capability or is not at service capacity, if:

1.The patient, or a person who is legally responsible for the patient and acting on the patient's behalf, after being informed of the hospital's obligation under this section and of the risk of transfer, requests that the transfer be effected;

2.A physician has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another hospital outweigh the increased risks to the individual's medical condition from effecting the transfer; or

3.A physician is not physically present in the emergency services area at the time an individual is transferred and a qualified medical person signs a certification that a physician, in consultation with personnel, has determined that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer. The consulting physician must countersign the certification; provided that this paragraph shall not be construed to require acceptance of a transfer that is not medically necessary.

(d)1. Every hospital shall ensure the provision of services within the service capability of the hospital, at all times, either directly or indirectly through an arrangement with another hospital, through an arrangement with one or more physicians, or as otherwise made through prior arrangements. A hospital may enter into an agreement with another hospital for purposes of meeting its service capability requirement, and appropriate compensation or other reasonable conditions may be negotiated for these backup services.

(e)Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the

transferring hospital and the transferring hospital shall receive the patient within its service capability.

(f) In no event shall the provision of emergency services and care, the acceptance of a medically necessary transfer, or the return of a patient pursuant to paragraph (e) be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

(j) If a hospital subject to the provisions of this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency medical condition exists and shall direct the persons seeking emergency care to a nearby facility which can render the needed services and shall assist the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(k) 1. Emergency medical services providers may not condition the prehospital transport of any person in need of emergency services and care on the person's ability to pay. Nor may emergency medical services providers condition a transfer on the person's ability to pay when the transfer is made necessary because the patient is in immediate need of treatment for an emergency medical condition for which the hospital lacks service capability or when the hospital is at service capacity. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for the transport or otherwise supply insurance or credit information promptly after the transport is rendered.

With regard to the two specific questions raised by your attorney:

1. The second facility only has the legal obligation to accept the transfer if it has the capability and capacity to meet the person's needs and cannot discriminate against the person based on inability to pay or other non-medical reasons.
2. Facilities aren't required to disclose their current census to other facilities upon request. DCF circuit offices can request and maintain information on such census information on designated receiving facilities for purposes of coordination of care.

The questions the attorney is raising might most appropriately be referred to AHCA that regulates hospital services and the federal and state laws governing access to emergency care.

Q. Is there jurisdictional law preventing member transfer between counties? A facility may have an EMTALA violation if they refuse acceptance. Case Managers run into situations where a member may have been brought in by law enforcement to the nearest facility ER under a "Baker Act" for evaluation with an accompanying medical history or complication. The facility is out of network for their health insurance plan. Once they are medically cleared in the ER ,

can a transfer take place in a network facility in another county for the mental health evaluation, or should that receiving hospital keep the member until the psych evaluation is completed? According to what I understand, the member should be seen in the ER under EMTALA, and not Baker Act Rules. Many of the facilities indicate members are unable to get transferred, because they must go to court in the county that the Baker Act was initiated. If the member hasn't received the first or second mental health evaluation, then it is questionable if further commitment is even needed. Is it true that once medically stable the receiving hospitals have 12 hrs. to transfer to a treatment facility (Only state hospitals are treatment facilities), correct? Can you tell me where I can find a comprehensive list of state hospitals by county?

Once a hospital ED has performed its responsibilities under the federal EMTALA law, it may inquire about the patient's method of payment if any. It can then make the transfer to a receiving facility willing to accept the transfer, even if not the nearest to the ED. This might be due to ongoing medical needs of the individual, age, specialized programming, or method of payment. However, a hospital cannot refuse to accept the transfer of an individual with an emergency psychiatric condition on the basis of inability to pay if it has the capability and capacity to meet the individual's needs. Further, Chapter 395.1041, F.S. states:

(3)EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.—

(e)Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, **unless another prior arrangement is in place** or the geographically closest hospital is at service capacity. ..

This provision about "another prior arrangement" would also justify the transfer to a facility that isn't the nearest. If the cost of the transfer is borne by the health insurance plan and not the sending hospital, it is much more likely that the individual's transfer to the more distant facility using the required "safe and appropriate method of transfer" will be accommodated. Once the medical conditions are addressed by the ED, there is no reason to delay a transfer to a receiving facility to conduct a psychiatric examination. That would duplicate the examination that would be required upon arrival at the receiving facility.

People have a statutory right to request a transfer from one facility to another and there is no legal reason why a petition for involuntary placement must take place in the same county or circuit in which an involuntary examination was initiated.

The civil state hospitals are the only designated "treatment" facilities. They are located in Macclenny (NE Florida), Chattahoochee (NW Florida) and Broward (south Florida). Persons can only be transferred to state hospitals from community based receiving facilities after a Transfer Evaluation is conducted.

Q. Could a hospital Baker Act receiving facility that does not have an inpatient psychiatric treatment unit for minors request a transfer under EMTALA of a Baker Acted minor who is in their ER to the ER of a facility that does have an inpatient psychiatric treatment unit for minors?

If a Baker Act Receiving Facility in a licensed hospital has the capability (serves minors) and has capacity (beds available), it cannot force a transfer over the objections of a person with an emergency psychiatric condition due to inability to pay. However, if it doesn't have licensed beds for minors, it wouldn't have the capability to manage the child's condition and a physician could certify that the benefits of a transfer outweigh the risks.

Q. I was speaking with one of our area hospitals yesterday, which is not a receiving facility. They asked if they have a client that they have been unable to transfer to a receiving facility and the 72 hours of the Baker act is up (meaning they have had the client for at least 3 days not including medical treatment time), can they re-baker act the client?

“Re-Baker Acting” a person is not appropriate. Some ED’s would like to stretch the maximum amount of time. It is the individual’s right not to have their liberty denied for more than 72 hours (plus the time during which a medical emergency exists) for the purpose of psychiatric examination – not for a facility to have whatever time is involved in arranging for such an examination.

There is no remedy in the law for what shouldn’t ever happen – having persons held for more than 12 hours after medical clearance at a non-receiving facility, much less 72 hours. I’ve learned from attorneys, through the many wrongful death law suits I’ve been involved in, that allowing a person to depart who hasn’t been determined by a physician or psychologist to no longer meet the involuntary criteria is the ultimate danger.

While the person is at the hospital, the record should reflect a continuous status of meeting those criteria – this may be a hospital’s only defense against a possible false imprisonment complaint. If the clinical record documents that a person isn’t meeting the criteria any longer, the person should be released. As I’ve suggested on numerous occasions, if the ER physician isn’t willing to conduct the examination, the hospital(s) should contract with and privilege a clinical psychologist to conduct the examinations. You’ll find that a large percentage will be able to be released directly without requiring a transfer to a receiving facility.

Licensed hospitals must protect the rights of persons held under the Baker Act as required by Florida’s hospital licensing law.

Q. Are hospitals allowed to chemically sedate and subjects to transport subjects who may be violent? We have been asked numerous times to take subjects because they fear that their ambulance drivers are in harm’s way. I feel that by taking a violent subject and placing him in the back of our patrol vehicle and driving 45 minutes to another facility is extremely dangerous and taking on liability that is not ours.

All designated receiving facilities have the capability of using mechanical and chemical restraints if the person is imminently dangerous and such restraints are the least restrictive method of assuring the safety of the individual and staff. This applies while in the ED as well as during transport.

As indicated above, the transferring hospital is responsible for the transfer of the individual from its ED to any other facility. In fact, if from the ED to another hospital, use of law enforcement rather than appropriately staffed and equipped medical transport could pose a violation of the federal EMTALA law subjecting the hospital to potential loss of Medicare/Medicaid certification and a \$50,000 fine.

Even the Baker Act governs the issue to transfers and when it is from a private receiving facility to a public receiving facility (New Horizon CSU), the responsibility for and cost of the transfer is that of the transferring facility:

394.4685 Transfer of patients among facilities.
(3)Transfer from Private to Public Facilities.—

(a) A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.

(b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. **The cost of such transfer shall be the responsibility of the transferring facility.**

Q. I'm having difficulty finding definitive documentation regarding length of time we are to keep previous years of the Baker Act Log; if you can you lead me in the right direction on this, it would be most appreciated.

This issue is governed by Florida's Hospital licensing statute, as follows:

395.1041 Access to emergency services and care.

(4) Records of Transfers; Report of Violations.—

(a) 1. Each hospital shall maintain records of each transfer made or received for a period of **5 years**. These records of transfers shall be included in a transfer log, as well as in the permanent medical record of any patient being transferred or received.

2. Each hospital shall maintain records of all patients who request emergency care and services, or persons on whose behalf emergency care and services are requested, for a period of **5 years**. These records shall be included in a log, as well as in the permanent medical record of any patient or person for whom emergency services and care is requested.

(b) Any hospital employee, physician, other licensed emergency room health care personnel, or certified prehospital emergency personnel who knows of an apparent violation of this section or the rules adopted under this section shall report the apparent violation to the agency within 30 days following its occurrence.

Q. Last week we had a patient under a BA with Veteran benefits. The patient was with us in the next county. In the past we have routinely transferred patients who are under a BA to the VA Hospital when they have benefits. I was told by VA staff that the VA does not take out-of-county Baker Acts.

The VA, as a federal agency, operates under its own system and rules. However, refusal to accept a transfer of an out-of-county residents with an emergency medical condition (even a psychiatric or substance abuse emergency without other medical complications) from a referring ED might possibly constitute a federal EMTALA violation. Even federal VA hospitals are subject to EMTALA. A senior attorney from AHCA has written that EMTALA doesn't require a person to be transferred to the nearest receiving facility.

Regarding the state's Baker Act statute and rules, such a policy/practice would be unacceptable. A transfer can be to any receiving facility (not necessarily the nearest). DCF or your facility administrator should contact the VA hospital administrator to discuss this policy. It sounds questionable that an eligible veteran would be denied care based solely on what county he/she resides. The VA Hospital Administrator may not be aware that this "policy" has been developed.

Q. Under what circumstances would it be permissible to transfer a psychiatric patient from our inpatient med/surg bed of a non-receiving facility hospital to one of our sister facilities (designated receiving facility) in a neighboring county for inpatient psychiatric care?

There is no reason why you couldn't transfer a person from your medical hospital to to a sister hospital in a neighboring county even if a closer receiving facility was available. Chapter 395.1041,

FS requires that transfers be made to the geographically closest hospital with the capability and capacity, **unless another prior arrangement is in place**, as follows:

395.1041 Access to emergency services and care.

(3)EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.—

(e)Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

This issue came up previously where a private hospital-based receiving facility serving adults in one area of the state had an agreement to immediately transfer insured minors to a sister hospital in another part of the state, despite there being receiving facilities closer that served minors. AHCA had no problem with this practice as it represented a “prior arrangement”. The only difference in that circumstance and yours is that it was a transfer from one receiving facility to another rather than from an ED to a receiving facility.

A senior attorney from AHCA has responded to this very question about ED transfers to receiving facilities. I would always defer to AHCA for any questions about EMTALA. He has continued to state that such a transfer is not required to be to the nearest receiving facility.

However, your question relates to a transfer of an inpatient to a receiving facility and neither EMTALA nor the states Emergency Access law applies to post-admission.

Q. I work for a public receiving facility with an adult CSU. A non-receiving ED called and told us they had a 14 year old that was medically cleared. The ED said that they had tried the psychiatric facility for children in our circuit and was told that no beds were available and to contact us as we were responsible for placement. Our adult unit was at full capacity as well. What are my responsibilities as the public receiving facility? What are the ED's responsibility?

There is no requirement that a transfer from a local ED must come to the “nearest” receiving facility in the same locale, if that receiving facility doesn’t have the capability or capacity to manage the person due to age, medical condition, etc. The only reason that can’t be used is inability to pay, a subject that cannot even be raised as an element in the decision-making.

As the public receiving facility in your area, you do have the responsibility to coordinate acute care services, as follows:

65E-5.351 Minimum Standards for Designated Receiving Facilities.

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

While you may not be able to accept a minor due to your licensure, you would still need to assist the ED to find another site for the minor even if it is out of your geographic area. The hospital is responsible under the federal EMTALA law to get prior agreement by the accepting facility and to make the arrangements for safe and appropriate transport to that facility.

Q. When patients are Baker Acted and in the hospital, who is responsible for finding them a bed in a receiving facility? Is it the receiving facility or the hospital? Also, who is responsible for doing their initial Baker Act evaluation?

The burden has fallen on the sending hospital to locate a receiving facility that can manage the patient's care (capability) and that has space (capacity). This is consistent with the federal EMTALA law as well as with the state's Baker Act. However, the Baker Act rules require in section 65E-5.351(5), FAC governing Minimum Standards for Designated Receiving Facilities that a "public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness". This places some responsibility on the public receiving facilities to assist hospitals to find an appropriate accessible receiving facility, even if the CSU has no available capacity or capability.

The hospital has a number of options:

- Evaluate the patient and release if any one of the more stringent criteria for involuntary placement aren't met.
- Treat the patient – often this stabilizes the person and he/she can be released directly
- Have the public receiving facility send a physician or psychologist to the ER to assess the patient
- Have the public receiving facility initiate an involuntary placement petition with the courts while the patient stays at the hospital. A change of venue can allow the court hearing to take place at the hospital.
- Transfer the patient to a more distant receiving facility that has capability and capacity.
- Call DCF & AHCA and report the failure to transfer within the 12 hours. Documentation of good faith effort to meet the legal requirements would generally suffice to prevent sanctions from the state.

A physician or psychologist at a general hospital can perform the initial examination and release the person directly. However, if the person must be sent to a designated receiving facility, it isn't necessary for the ED to have a psychiatrist perform an examination on site because this would just delay the transfer to a receiving facility where a psychiatric examination would be performed.

Q. If a receiving facility is not on diversion, can they refuse a transfer of a patient because they are "full" or have "no beds"?

Yes. If the hospital or other designated receiving facility doesn't have capacity (available bed), it can refuse the transfer and the sending ED must attempt to transfer the patient to another facility that has capacity. If the destination hospital ever goes over census for paying patients, it must go over census for non-paying patients.

Q. If a receiving facility is attached to an acute care facility can they refuse patients because the psych unit is full or must they accommodate the patient on a medical unit until a bed on the psych unit is available?

If the destination hospital makes accommodations like providing a psychiatric overlay to a patient in a medical bed for any patients, it must do so for non-paying patients. Otherwise, it is not required to go over the number of beds licensed for psychiatric purposes.

Q. How should we deal with a receiving facility that refuse transfers and how do we clarify a legitimate refusal vs. bogus?

No hospital that has the capability or capacity can refuse a transfer of a person with an emergency medical condition (even if of an emergency psychiatric or emergency substance abuse nature). If such hospitals demand payment information as a condition of deciding whether or not to accept the transfer, federal and state law violations have occurred. This is why DCF/AHCA should be notified. Both regulatory agencies can check hospital census logs to verify capacity issues.

Q. Our hospital ER receives quite a few people who either have been sent for medical clearance along with a Baker Act or are "Baker Acted" in the ER, many require transfer to a receiving facility where the involuntary examination can be conducted. When this area's receiving facilities are full, other facilities out of the area are explored. Receiving facilities in other districts not accepting transfers even when all the beds in this area are full. One hospital agreed to accept a transfer if he signed a paper stating he agreed to go there.

A receiving facility requirement for a signed agreement probably relates to EMTALA. EMTALA requires that for a transfer to be appropriate, it must be requested by the patient/legal representative. However if the sending hospital doesn't have the capability and capacity to meet the person's emergency medical condition (including psychiatric and substance abuse emergencies), the physician at the sending hospital can certify that the benefits of the transfer outweigh the risks. While patient consent is always desirable, in an emergency, a hospital without psychiatric capability can certify the transfer without patient consent.

Q. Receiving Facilities in an adjoining county refuse to accept Baker Acts transfers from our county unless we state how the patient will get back. I understand that a receiving facility that has the capacity and capability to accept the Baker Act also has a responsibility in the discharge planning process to address transportation issue. Is this correct?

Yes. Refusing to accept medically necessary transfers under the Baker Act from your area unless you first states how the patient will get back creates an artificial barrier to accepting an emergency transfer and should be reported to AHCA if it continues. 395.1041(3)(e) states under Access to emergency services and care.--

Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity.

DCF circuit staff can help you deal with this issue. Your interpretation of the law is correct that a receiving facility that has the capacity and capability to accept the Baker Act also has a responsibility in the discharge planning process to address transportation issue. However, the receiving facilities in a different county may have little knowledge of the aftercare resources in your county and you may need to assist in the discharge and aftercare planning activities.

Q. When a person is transferred from an ER to our receiving facility, can we ask the person to sign an Authorization for Release of Information before being seen by the admitting psychiatrist?

Yes. A person can sign an authorization for release of information before being seen by the admitting psychiatrist unless there is clear indication that the person doesn't understand the nature or consequences of such a release. The federal EMTALA law actually requires the release of all relevant medical records prior to asking for the destination facility's approval to accept the transfer of the person to its facility.

Q. Must written transfer agreements be executed among / between transferring hospitals relative to EMTALA? If so, are examples available relative to transfers of persons with psychiatric disorders?

No. There is no provision under EMTALA or the Baker Act law that requires hospitals to enter into written transfer agreements.

Q. In real time, when faced with the above issues, who do we call to report refusal of receiving facilities to accept transfers or to get some direction?

Local AHCA and DCF staff can be called or otherwise contacted. Since they are not readily accessible at night and on weekends, you could email or fax such reports or call them on the next working day.

Q. How can you monitor or verify if a receiving facility truly has no beds?

Your facility can't verify. However, when transfers can't be accomplished within the provisions of the Baker Act, staff should contact DCF and AHCA so the record will reflect good faith efforts to comply with the law. It also lets the regulatory agencies know if there is some systematic problem existing in the community. Both those agencies have the ability to see census logs in the hospitals to determine if capacity was available on the dates/times a transfer was requested. Their involvement also helps sometimes to get a patient moved to a more appropriate facility.

Q. We are currently experiencing a problem with a local hospital in transferring a Baker Acted patient. They are advising us that they are NOT a catchment facility and only take insured patients. Has the designation changed for them? I looked on the Florida Baker Act website and they are still listed as a public receiving facility. Is there anything you can recommend we do to resolve this?

This request was referred to the DCF Circuit Office as the issue you raise is related to local practice. This practice doesn't comply with the federal EMTALA law or the State's Baker Act law / rules. Any such delay or denial of care for a person in an acute psychiatric condition once his/her medical condition has been stabilized should not occur unless the facility to which you are referring has no beds available or cannot safely manage the person's emergency condition. Ability to pay should have no bearing on the issue.

Q. The nearest receiving facility to our hospital has advised us that the psychiatrist only visits the unit once a day. They claim to not have anyone on call that can review Baker Act transfers. They can only contact the on call MD if a person is brought directly to the facility. Is this legal? Can they delay a possible transfer for this reason? They have advised us that they do have beds available but the MD is not there to review the chart and they claim to be unable to call for transfer reviews. How do you suggest we handle this?

This inquiry was referred to the DCF Circuit Office as the issue is related to local practice. Acceptance of transfers from an ER is usually based on a nurse to nurse consult, requiring a physician's approval only if the person's condition is one of the barriers identified in the approved "Medical Exclusions" negotiated among hospitals and other receiving facilities. The hospital has telephone access to the psychiatrist when needed, including for approval of a requested transfer. The Circuit DCF staff can work with the receiving facility to correct these issues.

Nearest Facility for Transfer?

Q. When all the area facilities are at capacity with no availability within a given time frame; can we transfer across county lines to another Baker Act receiving facility?

Yes.

Q. Our county has an agreement with a company to transport BA'd patients out of our county hospital. Once the patient is medically cleared at the ED, the county interprets the BA Statute to mean that the ambulance MUST bring the patient to the nearest BA receiving facility, (because they interpret the law to mean that they are substituting the services of the County Sheriff). My question is: As the nearest receiving facility, are we in compliance with our current practice as follows: #1. We accept the referral via fax/phone and review clinical and financial information. We assist the ED to determine appropriate placement based on all data and accept/admit as appropriate. We refer to the appropriate setting as it pertains to the patient's clinical needs and the patient's choice and/or in-network providers. Finally, if we cannot assist the ED in finding an appropriate placement for whatever the reason, we admit the pt. providing we have the capacity and capability. In other words, are we required to admit ALL of their referrals? OR Since the BA patient is in the ED, and is now ready to be transferred, is it the responsibility of the ED to find a BA receiving facility, closest or otherwise who can serve the patient's medical/psychiatric/financial needs best, obtain an acceptance from the BA receiving facility, then contact the contracted Transport Company to take the patient to a BA receiving facility/physician/in-network provider who has accepted the patient because they can best serve of the patient's clinical/financial needs. If the latter is true, then we should expect that all possible avenues would be explored so that the patient receives services in the facility that will best serve his/her care needs. If it's the nearest, fine, if it's not, that's o.k. too. Thank you for any clarification you can provide.

While "transport" under the Baker Act to a receiving facility is a law enforcement responsibility, transfers from one medical facility to another is not. The "transfer" of a person with an emergency medical condition (including a psychiatric emergency even without other medical issues) from one hospital to another hospital is governed by the federal EMTALA law, not by the Baker Act.

The Baker Act requires a law enforcement officer to transport a person under involuntary status to the nearest receiving facility unless a Transportation Exception Plan has been approved (none in your area) or the person has an emergency medical condition that requires medical attention. In the latter case or when the involuntary examination has been initiated by the ED staff, a conflict between the state's Baker Act and the federal EMTALA law may arise. In such cases, the federal law must be followed and EMTALA governs what is an appropriate transfer.

Since law enforcement has no responsibility to provide transfers of persons with emergency conditions between hospitals, the county medical contract provider wouldn't be substituting the service of the Sheriff's Office. Even if there was some responsibility under the Baker Act, the

provision of the law governing people who have been taken first to a hospital for the examination or treatment of a medical condition can be subsequently transferred to **“a”** receiving facility –not the “nearest” receiving facility. The provisions of the Baker Act governing transfer between designated receiving facilities make no reference to “nearest”.

A concern in your scenario is any perceived consideration of the individual’s inability to pay as a basis for a hospital-based receiving facility refusing a transfer. If so, this may be considered “reverse dumping” under EMTALA if a hospital has the capability and capacity to manage the individual’s emergency condition. Even if a person’s inability to pay isn’t the basis of a delay or denial of a transfer, knowledge of this indignity may be incorrectly alleged to be the real reason for the refusal. Some facilities only ask about insurance status of a patient after the decision is made to accept a transfer – for the purpose of assigning a physician. Even the State’s hospital licensing law speaks to the issues raised in your inquiry:

395.1041(3) Access to emergency services and care.

(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the **geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity.**

When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

(f) In no event shall the provision of emergency services and care, the acceptance of a **medically necessary transfer**, or the return of a patient pursuant to paragraph (e) be based upon, or affected by, the person’s race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, **insurance status**, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred.

In consultation with senior staff at AHCA, they have stated that “another prior arrangement” as an alternative to the geographically closest facility can be on a case-by-case basis or pre-planned system of care.

You are not required to admit all referrals if you lack either the capacity or capability to manage the person’s care. A delay or denial can’t be based on inability to pay. However, it may be based on age of the person if you don’t have a pediatric psychiatric unit. I understand you operate under a general hospital license, you may not be able to refuse a person who has medical issues in addition to a serious psychiatric condition, since the person could be placed in a medical unit with psychiatric overlay or a psychiatric unit with medical overlay.

The second alternative in your inquiry is preferred. ED staff should be aware of which receiving facilities have contracts with which insurers so as to expedite patient transfers to the facility at which their insurance will pay without necessitating subsequent transfers or to a public receiving facility that has the state and county matching Baker Act funding for persons unable to pay for their own care.

You probably know which insurers have contracts with which facilities – even though these may change from time to time. Your close collaboration with all ED's in your area could be of great assistance to those hospitals. By ED staff making the appropriate transfer referrals in the first place helps to prevent private receiving facilities from refusals based on inability to pay. It will eliminate unnecessary transfers and expedite the psychiatric evaluation needed by the individual. Hopefully, it will also improve continuity of patient care, speed up the individual's ultimate release, and reduce cost of health care.

Q. We've been discussing ways to move patients more quickly and efficiently through our ED. One of the problems we are encountering is a significant delay in moving patients that are Baker Acted. It is our experience that we commonly refer to what we think to be the nearest appropriate receiving facility, wait for the facility to review the medical information, and finally be advised by the prospective receiving facility that either the patient is medically inappropriate for their setting or that there are no available beds. This can take a significant amount of time. One of the options we are discussing is to make referrals to more than one Baker Act Receiving Facility in the event that the transfer is declined by any particular agency. Is there anything in the statutes that would prohibit us from referring to several receiving facilities at the same time? I do have concerns about having protected healthcare information out to agencies that will not be accepting the patient. Are these concerns valid?

It is an accepted practice by ED's throughout the state to submit a request for transfer of persons under the Baker act to multiple facilities at once in order to expedite the psychiatric examination for which they are being held. Given that you only have 12 hours permitted by law once the individual has been medically cleared, you really have no choice but to expedite this process.

I've attached a letter from a senior attorney at AHCA stating that you aren't required to send to the nearest receiving facility. Even the Baker Act states in this situation that the referral should be made to "a" receiving facility (not the nearest) that can manage the individual's condition.

While you are considering the privacy rights of the individuals, the federal HIPAA law excludes treatment from prohibited communications, but does encourage only communicating that which is minimally necessary. The Baker Act provides that information can be provided as needed for the treatment of the patient.

394.4615 Clinical records; confidentiality.

(3) Information from the clinical record may be released in the following circumstances:

(b) When the administrator of the facility or secretary of the department deems release to a qualified researcher as defined in administrative rule, an aftercare treatment provider, or an employee or agent of the department is necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, aftercare planning, or evaluation of programs.

You may want to prioritize referrals of unfunded persons to public receiving facilities that have the DCF funding to accept indigent persons. However, even private receiving facilities must accept transfers of persons with emergency psychiatric conditions from ED's regardless of ability to pay if the facilities have the capacity and capability of managing the person's care.

You should discuss any systems issues directly with your DCF Regional Office. You have a Baker Act Advisory Committee that meets in your locale -- ED's should be at the table.

Q. A patient seen as involuntary, but was refused admission at the VA because unit was at capacity. Does the nearest Baker Act facility rule apply or can the patient be transported by ambulance to a more distant VA for treatment? Additionally, if in different county, does another involuntary admission process need to be repeated? Can civilian hospitals in another county transfer patients for treatment under the Baker Act or does the patient have to remain in the same county or nearest Baker Act Facility?

The nearest receiving facility must “accept” a person brought by law enforcement on involuntary status, but is not required to “admit” the person if lacking the capability and capacity to meet the person’s needs. In such situation, transfer to another facility is required. If the Palm Beach facility is a licensed general or free-standing hospital, it would be required to “accept” and examine any person, whether on voluntary or involuntary status per the federal EMTALA law.

Once at a receiving facility and a transfer is required, there are many exceptions to the requirement in the EMTALA law and the state’s hospital licensing law on transfer to the geographically closest facility. I’ve attached a letter on the subject from a Senior Attorney with AHCA on the subject as it relates to EMTALA and corresponding state law.

The state’s Baker Act establishes the following procedures for transferring among receiving facilities:

394.4685 Transfer of patients among facilities.

(2)TRANSFER FROM PUBLIC TO PRIVATE FACILITIES.—A patient who has been admitted to a public receiving or public treatment facility and has requested, either personally or through his or her guardian or guardian advocate, and is able to pay for treatment in a private facility shall be transferred at the patient’s expense to a private facility upon acceptance of the patient by the private facility.

(3)TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.—

(a)A patient or the patient’s guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.

(b)A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

(c)A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.

(4)TRANSFER BETWEEN PRIVATE FACILITIES.—A patient in a private facility or the patient’s guardian or guardian advocate may request the transfer of the patient to another private facility at any time, and the patient shall be transferred upon acceptance of the patient by the facility to which transfer is sought.

The VA hospital is considered a “private” receiving facility because it doesn’t contract with DCF for Baker Act appropriated funds. A person must be taken to the nearest receiving facility unless a Transportation Exception Plan has been approved by the Board of County Commissioners and the DCF Secretary. No such Plan has been approved in your county, although they exist in nearby counties for specific purposes.

Once accepted at a receiving facility in your county, arrangements for safe and appropriate transport can be arranged from that facility to your hospital. It is irrelevant that your hospital is in a different county or judicial circuit from where the Baker Act involuntary examination was initiated. Clearly, any patient in a receiving facility has the right to request a transfer, but in any case, the destination facility has the right to accept or deny the transfer as long as it isn’t on the basis of ability to pay for care.

Regarding your specific question, there shouldn't be another BA-52 completed because that could result in more than 72 hours of deprivation of liberty for the patient. Within 72 hours of the person's arrival at the first hospital or receiving facility, you would be required to file a BA-32 petition for involuntary "placement", unless the person is released or is willing and able to apply for voluntary status. Before converting to voluntary status, a physician must certify that the individual is competent to make well-reasoned, willful, and knowing medical and mental health decisions.

Q. When patients are transferred from the ED, are we obligated to start from the closest facility and work our way out regardless of insurance? I've had some conflicting answers in the past. FL statute 395.1041 does reference this practice but when I've spoken with DCF, I was told we can refer non-funded patients to the public facilities first and funded to any facility regardless of distance from the ED or from within the hospital. Is this correct?

No – you aren't required to start with the closest facility and work your way out regardless of insurance. EMTALA is based on the premise that all transfers of persons with emergency medical conditions (includes psychiatric and substance abuse emergencies, even in the absence of other medical problems) create imminent risk, so if a transfer is required, it is best to send to the nearest appropriate facility that won't require any subsequent transfer due to insurance or other factors. I've attached a letter from a senior attorney from AHCA that deals with this issue.

Chapter 395, FS governs hospital licensure and access to emergency services – it states the following:

395.1041 Access to emergency services and care.

(3)EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.—

(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the **geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity.**

When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

(f) In no event shall the provision of emergency services and care, the acceptance of a medically necessary transfer, or the return of a patient pursuant to paragraph (e) be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. **No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred.**

As you can see above, it is ideal to send a person to the geographically closest hospital, but only if it has the capability and capacity, or unless you have another prior arrangement in place. DCF/HQ staff and I have spoken to the Director of AHCA's hospital section about the meaning of "prior

arrangement” and she said this could be on a systemic basis or a case-by-case basis. Finally, the Baker Act speaks to this issue as well.

394.463(2) Involuntary examination.

(g) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient’s clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

(h) **One of the following must occur within 12 hours after the patient’s attending physician documents that the patient’s medical condition has stabilized or that an emergency medical condition does not exist:**

1. The patient must be examined by a designated receiving facility and released; or
2. The patient must be **transferred to a designated receiving facility in which appropriate medical treatment is available.** However, the receiving facility must be notified of the transfer within 2 hours after the patient’s condition has been stabilized or after determination that an emergency medical condition does not exist.

The above provision cites transfer from an ED to “a” designated receiving facility in which appropriate medical treatment is available (if applicable) – not the “nearest” receiving facility. If the patient’s emergent medical needs have been stabilized and yet is still on involuntary status under the Baker Act and continues to have medical issues beyond the capability of a CSU or free-standing psychiatric hospital to meet, you could immediately request transfer to a general hospital that has psychiatric capability.

Q. If a person is Baker Acted from a designated receiving facility, is it illegal to transport them to another receiving facility in another county if this is where this person resides? Does it matter if they are in a DC facility?

The Baker Act requires the person on involuntary status to be taken initially to the nearest receiving facility -- regardless of law enforcement jurisdiction or county lines, assuming there isn't an approved Transportation Exception Plan or medical emergency. There isn't any legal reason why a person can't be transferred from a receiving facility in one county to a receiving facility in another county where the person resides. However, there may be logistical reasons. For instance, if a person has been held for examination for over 24 hours, it may not be possible for a destination facility to complete its examination of the person within the 72 hours permitted by law – especially if the person appears to meet the criteria for involuntary placement and two doctors must exam and document, with a petition filed with the court. Further, if the person is in a receiving facility where a 1st and 2nd opinion have already been completed and a BA32 petition for inpatient placement had been filed with the court, it is unlikely that a transfer could take place until after the hearing was conducted, since one of the two doctors would have to be present to testify at the hearing. Hopefully, the court uses the

model court order form that doesn't specify a particular facility. The form was designed to facilitate a person's right to transfer.

The destination facility would have to agree to the transfer. Most public receiving facilities stay very full these days and they aren't anxious to take transfers. However, if there is space and if the person wants to be transferred to his/her home county, they have the right to do so. DCF and the Florida Department of Corrections have negotiated agreements for civil commitments and release at end of sentence.

Q. What is the proper destination for a child to be transferred if the "nearest" receiving facility is out of county compared to one that is in-county. In this case the parents preferred that the child go to the out-of-county (nearest) facility so that's where the child eventually was transported. I have had the understanding that "nearest" receiving facility meant within the same County.

An AHCA senior attorney confirmed that even under EMTALA, once a transfer has been found to be appropriate, the person doesn't need to be sent to the geographically nearest facility. The issue of county lines shouldn't be an issue if the person has insurance to pay for the cost of care. However, transfer of a person relying on a public receiving facility should be encouraged to stay within the DCF circuit due to funding allocation issues if the facility has the capability and capacity to meet the person's needs. The closest receiving facility may also improve continuity of care and expedite linkage to an aftercare appointment.

The transfer from a hospital ER is governed by the federal EMTALA law instead of the Baker Act, and in such case, there is no requirement that the person be transferred to the "nearest" receiving facility (that requirement of 'nearest' is for primary transport by law enforcement). The person can be sent by an ER to any receiving facility that has the capability of treating the child. Of course, the sending hospital is required to perform the medical screening, stabilize, obtain consent from parent / guardian / or legal representative for the transfer, and get the ok of the receiving facility. With that in mind, if the patient/parent/ legal guardian wanted the child to be transported to a specific receiving facility of their choice that should be alright (even if out of county).

Q. Our hospital recently had an adult held for involuntary examination in a hospital ED and a family member insisted that he go back to his home county to receive his treatment. The facility in the home county had no beds while closer, in-county, facilities had capacity. Is it our responsibility to get the person to a receiving facility after doing our due diligence?

Any transfer from a hospital would have to first comply with federal EMTALA requirements. However, the response would be different based on whether the sending hospital is a receiving facility or not. One of those EMTALA requirements is the consent of the person or their legal representative to the transfer from a hospital with the capability and capacity to serve the person (such as designated receiving facility). However, if the sending hospital doesn't have the capability or capacity (non-receiving facility hospital) a certification of a physician that the benefits of transfer outweigh the risk may suffice even if the person refuses.

If the person refuses any transfer except to a distant facility, you may end up keeping the person at your receiving facility. If that more distant receiving facility doesn't have the capacity, it must deny the transfer anyway. If the person/representative refuses the transfer from a non-designated facility, the facility may initiate the transfer to the nearest appropriate receiving facility assuming physician certification has been provided.

Q. Facilities in our county are trying to help facilities in an adjoining county with their lack of Baker Act beds. However, I want to ensure that we are complying with the law when we accept a patient from an emergency department or medical unit from another county. Is the receiving facility with appropriate medical capability nearest to the medical facility responsible to either examine the patient or accept transfer of the patient whose medical condition has stabilized?

EMTALA refers to capability and capacity of a destination hospital – both are required for a hospital to be responsible to accept from a sending hospital that doesn't have such capability and capacity. With regard to the Baker Act, the law refers to "a" designated receiving facility in which appropriate medical treatment is available. This is the only place in the Baker Act that doesn't require the "nearest" receiving facility.

Q. If a receiving facility with appropriate medical capability nearest to the medical facility has no available beds, should a transfer to another receiving facility with appropriate medical capability be attempted?

Generally yes. EMTALA is based on the premise that all transfers of persons with emergency medical conditions (including psychiatric and substance abuse emergencies) are inherently dangerous, it is important that the number of transfers be minimized. Since the sending hospital may ask for payment information after it meets its obligations under EMTALA, the sending hospital should direct the person to a facility that not only has capability/capacity, but one that is licensed to serve the age of the patient and accepts the person's insurance. If no insurance, attempts should be made to transfer the person to the nearest public receiving facility: Section 395.1041, F.S. governing Access to emergency services and care states

(3)(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

(3)(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

Q. Would the process be any different for transfers crossing county lines?

No. However, when one receiving facility is full, many receiving facilities in the same region are also full. Many CSU's place highest priority on residents of their own locale before taking transfers from

another. However, EMTALA wouldn't allow licensed hospitals to use such an excuse as long as closer receiving facilities had no capability/capacity to accept the transfer.

Q. If a receiving facility can provide a certain (medical) service are they obligated to take an involuntary patient?

Yes, if it also has the capacity (available beds).

Q. A receiving facility in the area will not accept any Baker Act patient unless we sign a transfer agreement which says we will take the patient back after the psychiatric evaluation. So, BA patients are delayed/refused admission until we succumb to signing their agreement. How legal is that for the patient? The receiving facility doctors listen to report on a proposed Baker Act patient then demand that we run more lab work on the patient before they will tell us if they will accept the patient which a emergency physician has already determined is medically stable, has assessed and initiated a BA on. Is this necessary or is there someone we can approach at the State level regarding these issues?

The receiving facility has no right to refuse a transfer of a person from a hospital ER that doesn't have the capability/capacity to meet a person's emergency medical condition (even of just a psychiatric or substance abuse nature). This could be a violation of the federal EMTALA law as well as chapter 395.1041, FS. With regard to your question about repeated lab tests, the receiving facility can't require you to do more tests, but it can refuse to accept the transfer of a person who it believes may be medically unstable. The Baker Act states in 394.464(2):

- (h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:
1. The patient must be examined by a designated receiving facility and released; or
 2. The patient must be transferred to **a designated receiving facility in which appropriate medical treatment is available.** However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

If the receiving facility is a free-standing psychiatric hospital, it probably doesn't have its own laboratory, as would a general hospital. By the time a repeat lab test for certain conditions was ordered, conducted, and adverse results returned, the patient could be in critical condition. DCF has multiple plans prepared by various communities that reflect negotiated agreements between emergency physicians at general hospitals and free-standing psychiatric facilities. These documents might be a starting point for your staff to work with the receiving facility in developing local guidelines for the safe transfer of persons between your facilities. The DCF Circuit staff can assist as needed in this process.

Transfers under the Baker Act

Q. Is it acceptable for a psychiatrist and/or medical doctor who is affiliated with a mental health/SA facility to transfer clients to another SA/facility with no prescription and no medications?

If the facility is designated as a Baker Act receiving facility, it is required to do certain things as part of discharge planning, as specified below:

65E-5.1303 Discharge from Receiving and Treatment Facilities.

(1) Before discharging a person who has been admitted to a facility, the person shall be encouraged to actively participate in treatment and discharge planning activities and shall be notified in writing of his or her right to seek treatment from the professional or agency of the person's choice and the person shall be assisted in making appropriate discharge plans. The person shall be advised that, pursuant to Section 394.460, F.S., no professional is required to accept persons for psychiatric treatment.

(2) Discharge planning shall include and document consideration of the following:

(a) The person's transportation resources;

(b) The person's access to stable living arrangements;

(c) How assistance in securing needed living arrangements or shelter will be provided to individuals who are at risk of re-admission within the next 3 weeks due to homelessness or transient status and prior to discharge shall request a commitment from a shelter provider that assistance will be rendered;

(d) Assistance in obtaining a timely aftercare appointment for needed services, including continuation of prescribed psychotropic medications. Aftercare appointments for psychotropic medication and case management shall be requested to occur not later than 7 days after the expected date of discharge; if the discharge is delayed, the facility will notify the aftercare provider. The facility shall coordinate with the aftercare service provider and shall document the aftercare planning;

(e) To ensure a person's safety and provide continuity of essential psychotropic medications, such prescribed psychotropic medications, prescriptions, or multiple partial prescriptions for psychotropic medications, or a combination thereof, shall be provided to a person when discharged to cover the intervening days **until the first scheduled psychotropic medication aftercare appointment**, or for a period of up to 21 calendar days, whichever occurs first.

Discharge planning shall address the availability of and access to prescribed psychotropic medications in the community;

(f) The person shall be provided education and written information about his or her illness and psychotropic medications including other prescribed and over-the-counter medications, the common side-effects of any medications prescribed and any adverse clinically significant drug-to-drug interactions common between that medication and other commonly available prescribed and over-the-counter medications;

(g) The person shall be provided contact and program information about and referral to any community-based peer support services in the community;

(h) The person shall be provided contact and program information about and referral to any needed community resources;

(i) Referral to substance abuse treatment programs, trauma or abuse recovery focused programs, or other self-help groups, if indicated by assessments; and

(j) The person shall be provided information about advance directives, including how to prepare and use the advance directives.

(3) Should a person in a receiving or treatment facility meet the criteria for involuntary outpatient placement rather than involuntary inpatient placement, the facility administrator may initiate such involuntary outpatient placement, pursuant to Section 394.4655, F.S., and Rule 65E-5.285, F.A.C., of this rule chapter.

65E-5.1304 Discharge Policies of Receiving and Treatment Facilities.

Receiving and treatment facilities shall have written discharge policies and procedures which shall contain:

(1) Agreements or protocols for transfer and transportation arrangements between facilities;

(2) Protocols for assuring that current medical and legal information, including day of discharge medication administered, is transferred before or with the person to another facility; and

(3) Policy and procedures which address continuity of services and access to necessary psychotropic medications.

As you can see, the facility is required to provide medications or prescriptions for medications or some combination of prescriptions and medications until the aftercare appointment. If the aftercare appointment corresponds with a transfer to another facility that has access to prescriptions and/or medications, that would meet the requirement of the Baker Act rules. Generally, a facility accepting a transfer won't accept medications on behalf of a patient – they want to prescribe their own to ensure that the meds are actually what they are supposed to be. Many facilities don't have an outpatient pharmacy license and can't provide the actual medications to persons following discharge.

If the transferring facility is not a Baker Act receiving facility, other rules would apply.

Q. We have a case that was admitted to the hospital, here for several days and cleared medically and then required transfer to a behavioral health BA facility. Do these rules still apply?

The federal EMTALA law governs the transfer of a person with an emergency medical condition (including emergency psychiatric and substance abuse conditions, even absent any other medical issues) from an ED to a hospital that has the capacity (beds) and capability (programming) to meet the person's needs. If the destination hospital has the capability and capacity, it cannot delay or deny the transfer based on the person's inability to pay for care. In fact, the state's hospital licensing law has the following provision:

395.1041 Access to emergency services and care.

(1)LEGISLATIVE INTENT.—The Legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals and physicians to every person in need of such care. The Legislature finds that persons have been denied emergency services and care by hospitals. It is the intent of the Legislature that the agency vigorously enforce the ability of persons to receive all necessary and appropriate emergency services and care and that the agency act in a thorough and timely manner against hospitals and physicians which deny persons emergency services and care. It is further the intent of the Legislature that hospitals, emergency medical services providers, and other health care providers work together in their local communities to enter into agreements or arrangements to ensure access to emergency services and care. The Legislature further recognizes that appropriate emergency services and care often require followup consultation and treatment in order to effectively care for emergency medical conditions.

(f)In no event shall the provision of emergency services and care, the acceptance of a medically necessary transfer, or the return of a patient pursuant to paragraph (e) be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, **insurance status, economic status, or ability to pay for medical services,** except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(h)A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred.

However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

If there is evidence that the transfer was delayed or denied because of insurance issues or because of inability to pay for care, you may wish to discuss this with the Compliance Officer of your hospital. At that point a decision could be made as to whether or not a report of a possible EMTALA violation should be made to the Agency for Health Care Administration.

The federal EMTALA regulations were changed a few years ago to limit applicability to pre-admission situations. However, Chapter 395, FS has not been amended and the information included from Florida Statutes governing transfers is still current. There may be a violation of state law in post-admission situations, but probably not a violation of EMTALA. There are many attorneys who believe that while EMTALA doesn't apply to the sending hospital post-admission, it may still apply to a destination hospital that refuses the transfer of a person with an unstabilized emergency medical condition (including psychiatric emergencies) due to inability to pay. However, this issue would have to be reviewed by your own hospital attorney and/or compliance officer. It is generally presumed that the federal Conditions of Participation provide sufficient protections for transfer or discharge of an admitted patient.

Q. Under what circumstances would it be permissible to transfer a psychiatric patient from our ED in one county to one of our receiving facilities in an adjoining county for inpatient psychiatric care?

There is no reason why you couldn't transfer a person from your ED to either of your receiving facilities in the next county. Chapter 395.1041, FS requires that transfers be made to the geographically closest hospital with the capability and capacity, **unless another prior arrangement is in place**, as follows:

395.1041 Access to emergency services and care.

(3)EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.—

(e)Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

This issue came up previously where a private hospital-based receiving facility serving adults in one area of the state had an agreement to immediately transfer insured minors to a sister hospital in another part of the state, despite there being receiving facilities closer that served minors. AHCA had no problem with this practice as it represented a "prior arrangement". The only difference in that circumstance and yours is that it was a transfer from one receiving facility to another rather than from an ED to a receiving facility.

A senior attorney from AHCA has responded by memorandum to this very question about ED transfers to receiving facilities. He has continued to state that such a transfer is not required to be to the nearest receiving facility. AHCA remains the lead agency for any questions about EMTALA.

Q. I work for Emergency Services at a public receiving facility serving adults. A non-receiving ER called about a 14 year old that was medically cleared. The ER said that they had tried the receiving facility serving minors that refused the transfer due to lack of available beds.. The ER was told to contact us as we are responsible for placement. Our unit was at full capacity as well. What are our responsibilities as the public receiving facility? What are the ER's responsibility?

There is no requirement that a transfer from a local ED must come to the receiving facility in the same locale, if that receiving facility doesn't have the capability or capacity to manage the person due to age, medical condition, etc. The only reason that can't be used is inability to pay, a subject that cannot even be raised as an element in the decision-making. As the public receiving facility in your area, you do have the responsibility to coordinate acute care services, as follows:

65E-5.351 Minimum Standards for Designated Receiving Facilities.

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

While you may not be able to accept a minor due to your licensure, you would still need to assist the ED to find another site for the minor even if it is out of your geographic area. The hospital is responsible under the federal EMTALA law to get prior agreement by the accepting facility and to make the arrangements for safe and appropriate transport to that facility.

Q. We have a 26 y/o female on a Baker Act who is medically cleared for transfer to a psych facility. Patient is on dialysis, HIV and requires assistance with daily activities/ uses wheelchair. Patient has been referred to all receiving facilities in general medical hospitals in our area, but they all have refused to accept her. She is not safe to return to her ALF and she is actively expressing suicidal ideations. We don't know what else to do at this point. Is there anything that can be done to transfer this patient to a psych facility or equal level of care?

DCF Circuit staff will want to follow up on the reasons why these general hospitals with licensed psychiatric beds that are designated as receiving facilities under the Baker Act have refused to accept the transfer. If they have the capacity and the capability to meet the patient's needs, they should accept the transfer. Since it appears the patient had been admitted to your hospital and was not on emergency status, the federal EMTALA law may not be applicable to your situation. However, if there is a patient who is acutely mentally ill, a receiving facility should be able to accept, examine, and treat the patient.

Q. A patient was medically cleared at our hospital. Despite efforts, so far we don't have an accepting psych facility and the 72 hrs have elapsed since medical clearance. Is ongoing documentation sufficient to continue with psych placement efforts? Do we need a new Baker Act form? Our attending MD says it's illegal to do a second Baker Act form during the same admission. We are waiting for a consultant psychiatrist on call input. This unfunded patient reportedly continues to meet Baker Act criteria.

As you know, your hospital is responsible for transferring a medically cleared individual under Baker Act involuntary status within 12 hours after a physician documents medical stability, as follows:

394.463 Involuntary examination.--

(2) Involuntary Examination.--

(g) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

(h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or

2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

The law doesn't offer any remedy when inability to transfer within this legally prescribed timeframe occurs. However, most risk managers and attorneys would advise you to never release a person who continues to meet involuntary criteria even though the timeframe has been exceeded.

Your physician is correct that a second Certificate should not be completed. It doesn't achieve any legal extension since it is the individual's right not to be held for longer than the permitted period, not the right of a hospital ER or receiving facility to have a longer period in which to conduct the examination. Your documentation of each effort to transfer the individual to a designated receiving facility with the capacity and capability of managing the individual's needs is your only recourse.

In addition, self reporting to AHCA and/or DCF is helpful to document your good faith effort to meet your legal responsibilities. Some hospitals send an email or fax a report to a designated person at DCF and/or AHCA. If you aren't using identifiable patient information, HIPAA shouldn't be a problem. Your ER transfer log should reflect each receiving facility you contact with the date, time, name of person spoken with, and verbatim response from the receiving facility personnel. A denial or delay in transfer may be because of capacity, capability, need for follow-up diagnostic or laboratory tests, etc. It should never be because of inability to pay for care. In any case, AHCA or DCF personnel need to be aware of the issues faced in your community.

Q. When does the 12 hour rule apply to hospitals that are non-receiving facilities? Does any transfer to a CSU from a hospital that is a non-receiving facility fall under the 12 hour rule or are there exceptions? This statute is confusing to us because EMTALA states that psychiatric and substance abuse are considered to be emergency medical conditions (EMC's) and the hospital physician defines an EMC. As a CSU we would need to know when this rule takes effect so we can request the form entitled "Request for Involuntary Examination after Stabilization of Emergency Medical Condition" whenever a non-receiving hospital requests a transfer. Should we create a protocol for accepting people from hospitals when our contracted beds are full (or near full). This is new concept for our CSU and it is generating a

lot of interest. We think this is a fair way to accept people from hospitals as it puts a priority on hospitals without psychiatric services.

The 12 hour period begins when the person under involuntary examination status arrives at a hospital ER for examination or treatment of an emergency medical condition (EMC). The clock stops when a physician documents that an EMC exists and starts back up when the doctor documents that such an EMC has been stabilized or doesn't exist.

All transfers from hospitals to designated receiving facilities, whether public CSU or private hospital, from non-receiving facility ER's fall under this provision. The federal EMTALA law does include psychiatric emergencies as EMC's, but since a hospital with no psychiatric capability or capacity must transfer a person with a psychiatric EMC to a specialty facility that does have such capability or capacity and no time frame is included in EMTALA, it defaults to the State law that has such a 12-hour timeframe.

One CSU has established a protocol for accepting hospital transfer in which staff would accept all involuntary brought by law enforcement as required by law regardless of census. Regarding transfers from other facilities, they would accept in the following order up to their licensed capacity:

- Transfers from non receiving facility hospital ER's
- Transfers from receiving facility hospital ER's
- Transfers from non receiving facility hospital medical units
- Transfers from receiving facility hospital medical units

Within each of these four transfer categories, the CSU would take those with the greatest acuity. Discussion also took place later about taking those who were more likely to be held longest over those likely to be examined and released, along with those with no source of funding prioritized over those with public/private insurance.

Q. Our hospital had a 29-year old woman held under the Baker Act who has a long history of psychiatric hospitalizations, including at the state hospital. Besides the psychiatric diagnoses, she also swallows objects. She was medically cleared for transfer last week for a period of several days, during which time our hospital was unable to arrange a transfer. While trying to arrange the transfer, she swallowed more objects and needed to be kept until the objects passed. She was medically cleared again this morning and none of the receiving facilities will accept her. The facilities refuse on the basis of insurance (her Medicare HMO will probably only pay 3-5 days), lack of available beds, or inability to meet her needs. Since we are a general hospital with no psychiatric capability and the patient is under Baker Act involuntary examination status, the hospital is required to transfer her to a designated receiving facility within 12 hours of medical stabilization. She is currently on a one-to-one sitter and security to prevent her from accessing any objects prior to being transferred to address her psychiatric needs. What do we do?

It seems unacceptable that all of these receiving facilities refused the transfer. While this individual is a very difficult high-risk patient, she would be much safer at a secured behavioral health facility than at a general med/surg hospital. AHCA probably also needs to be involved in this issue as well as DCF.

While public receiving facilities might refuse a person based on medical reasons or lack of beds, they still are obligated as a condition of their designation to ensure coordination of acute care services for eligible individuals. Lack of a bed doesn't equate to lack of responsibility for arranging placement of eligible individuals, as follows:

65E-5.351 Minimum Standards for Designated Receiving Facilities.

- (1) Any facility designated as a receiving facility failing to comply with this chapter may have such designation suspended or withdrawn.
- (2) Each receiving facility shall have policies and procedures that prescribe, monitor and enforce all requirements specified in Chapter 65E-5, F.A.C.
- (5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

Q. Since our general hospital doesn't have a psychiatric unit, we don't have a psychiatrist on staff or the capability to treat any psychiatric issues. When we try to transfer any Baker Act patients to designated receiving facilities, we have been encountering the same request from a major receiving facility in our area to submit along with the clinical information, a list of all the facilities contacted and what the response was from each. My questions regarding this are: Can a receiving facility request documentation of all previous attempts to other facilities? Also, can they request that we re-submit to other facilities before they accept responsibility? Is there a specified number of times that we need to contact each receiving facility before referring the patient to this facility?

The issue you raise is related to the federal EMTALA law and to the State hospital licensing law governing Access to Emergency Services and Care. EMTALA prohibits any hospital that has the capability or capacity to manage the emergency condition of a patient (including psychiatric or substance abuse conditions, even absent any other medical conditions) from delaying or denying a transfer from a hospital that doesn't have such capability or capacity.

The state law is in some cases even more restrictive than the federal law. Two provisions from state law are as follows:

395.1041(3), F.S.

(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred...

The first provision above only requires the transfer to be to the nearest facility if those facilities have both the capability and capacity to manage the patient. In any case, the law allows for "other prior arrangements" to go to hospitals that are further away. AHCA, the state agency that oversees both the federal EMTALA law and the state's Access to Emergency Services and Care law has not defined whether such other prior arrangements are systematic or are on a case-by-case basis.

A senior attorney for AHCA has written a letter including regarding seven related questions. One of them is as follows:

Transfers under the Baker Act are to be consistent with both State and Federal Law. Transfers from an Emergency Department are subject to both Florida Statutes Chapter 395 and the Federal 'EMTALA' Law. What does the Agency for Health Care Administration consider to be a proper transfer of a Baker Act patient from an Emergency Department (when there is no consent signed by the patient or patient's representative) that is considered consistent with both Florida State Law and the Federal Law)? That is, (assuming that any medical emergency conditions have already been cleared or stabilized) should the Baker Act patient be transferred from the Emergency Department to:

- a. an appropriate receiving facility with capability and capacity, or
- b. to the most appropriate receiving facility with capability and capacity, or
- c. is the patient required to go to the nearest receiving facility with capability and capacity?
- d. or is the "capability and capacity" requirement even necessary?

Under the Florida Statute (§ 394.463(h)), the patient must be transferred to a "designated receiving facility" (which is defined in §394.455(26) as "any public or private facility designated by the department (DCF) to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment."). See also §394.461 where the designation of receiving and treatment facilities is specified. Under the Federal Statute (42 U.S.C. § 1395dd(c)(2)), an "appropriate transfer" is a transfer where the receiving facility has capacity and capability to treat the individual and has "agreed to accept transfer of the individual and to provide appropriate medical treatment."

Thus, the answer to question part "a" is yes, the Baker Act patient should be transferred from the Emergency Department to an appropriate receiving facility with capability and capacity. The answer to part b is no, the patient does not have to go to the most appropriate receiving facility with capability and capacity. The answer to part "c" is no, the patient is not required to go to the nearest receiving facility with capability and capacity. Finally the answer to part "d" is yes the "capability and capacity" requirements are necessary.

This delay of a medically necessary emergency transfer appears to be inappropriate. DCF and AHCA may intervene in this matter.

Q. Can you please tell me who to contact for a good faith self-report to both AHCA and DCF when our hospital isn't able to transfer a patient within the 12-hours allowed by law?

Contact the Regional or Circuit DCF Mental Health Program staff and ask who handles Baker Act related issues. DCF can probably provide you the contact information for their counterparts at AHCA. You may want to send this "self-report" by email as DCF and AHCA probably aren't available at night and on weekends. This would also ensure you and those state agencies have a written record of your report.

Q. It is getting extremely difficult to transfer Baker Act patients to receiving facility within by the 72 hour cut off time. Unfortunately, what we are seeing is that patient's are being discharged home with outpatient psychiatric follow-up instructions. Can a Baker Act be reinstated after the initial 72 hours is up?

While the Baker Act requires a non-designated hospital to transfer a patient under a Baker Act involuntary examination within 12 hours of medical stabilization and the exam period actually expires after 72 hours, most risk managers would advise you not to release a person who appears to still meet the criteria for involuntary placement. It sometimes comes down to a dilemma of exceeding the maximum period permitted under the law or risking a wrongful death. There is no remedy in Baker Act for failure to transfer within the 12 hour period.

Your practice of discharging people home with follow-up instructions is entirely appropriate if the persons no longer appear to meet the criteria for involuntary placement. In fact, sending persons who don't appear to meet criteria on to a receiving facility for examination makes the problem even more serious by having them compete for scarce beds with persons who actually do need to be in a locked psychiatric facility for examination. Many people stabilize quickly without necessitating such a transfer.

It is the patient's right not to have his/her liberty denied for the purpose of Baker Act involuntary examination for longer than 72 hours. Stacking one BA-52 on top of another doesn't legally extend the period under which you're authorized to hold the patient.

You have a number of options:

- You can transfer the person to any receiving facility; not just the nearest one.
- Your own emergency physicians are authorized to perform the examination and release the person directly when psychiatrically stable
- You can contract with a clinical psychologist to come to your ER to perform the examination and release the patient if he/she doesn't meet criteria Contract with a psychologist to conduct the mandatory initial involuntary examination and release if the emergency physicians aren't willing to do so.
- Have the psychiatric consultant used by your hospital examine and treat the person in the ER to psychiatrically stabilize & release.
- Request that the receiving facility conduct the involuntary examination on site at your hospital and release.
- Have receiving facility psychiatrist or psychologist examine the person at your hospital and file the BA-32 petition with the court, placing top priority for admission of the person to the first available bed.
- If person can't be transferred to a receiving facility because of medical reasons, the Baker Act permits a change of venue for the hearing "because of the condition of the patient".
[394.4599(2)(c)4]

Any hospital that is unable to meet its legal duty to transfer the patient within the 12 hours permitted by law should contact DCF and/or AHCA to self-report. This report can result in any one of several outcomes: It documents good faith effort to comply with law (log date/time of each call, person spoken to, exact response received), they may be able to help in expediting the needed transfer, and it informs them of receiving facility bed shortages. DCF and AHCA can also verify the actual census at receiving facilities in your area to ensure that correct information about availability of beds is accurate.

Q. Often we will have a patient who has been hospitalized in a medical setting and is under a BA52. Once they are medically cleared the 72 hour clock starts, but sometimes there are no beds available in the area or the patient needs additional medical care (i.e. dressing changes) that a psych facility cannot provide. We have a psychiatrist evaluate the patient to see if they still meet involuntary status or voluntary but the problem still exist -- no appropriate beds. I have read in the Baker Act training manual that stability for transfer occurs at the time

of transfer not any earlier. Medical clearance for a hospital and receiving facility are two different things. Is the BA52 still on hold until we find a bed that can provide the appropriate care?

You are correct that there are some differences in stability for purposes of hospitals (EMTALA) and all receiving facilities under the Baker Act. EMTALA requires that stability for transfer be documented at the time of the transfer, while the Baker Act starts the 12 hour clock at the time in which a physician documents that the emergency medical condition is stabilized or found not to exist, after which the person must be transferred to a receiving facility. When the person no longer has an emergency medical condition (a psychiatric or substance abuse emergency even absent any other medical issues is defined as an EMC by CMS), EMTALA no longer applies. At that point, only the Baker Act and any federal Conditions of Participation apply.

The Baker Act however applies to all hospitals as well as to receiving facilities holding a person under the authority of the Baker Act.

395.003(5)(a) governing licensure of all hospitals states “Adherence to patient rights, standards of care, and examination and placement procedures provided under part I of chapter 394 shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment”.

395.1041(6) RIGHTS OF PERSONS BEING TREATED.--A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

The Baker Act requires a non-designated hospital to transfer a patient under a Baker Act involuntary examination within 12 hours of medical stabilization and the exam period actually expires after 72 hours. You cannot legally hold a person after this period. However, most risk managers would advise you not to release a person who appears to still meet the criteria for involuntary placement. It sometimes comes down to a dilemma of exceeding the maximum period permitted under the law or risking a wrongful death. There is no remedy in the Baker Act for failure to transfer within the 12 hour period. It is the patient’s right not to have his/her liberty denied for the purpose of Baker Act involuntary examination for longer than 72 hours.

You have a number of options:

- You can transfer the person to any receiving facility; not just the nearest one.
- Your own emergency physicians are authorized to perform the examination and release the person directly when psychiatrically stable. Discharging persons home with follow-up instructions is entirely appropriate if the persons no longer appear to meet the criteria for involuntary placement. In fact, sending persons who don’t appear to meet criteria on to a receiving facility for examination makes the problem even more serious by having them compete for scarce beds with persons who actually do need to be in a locked psychiatric facility for examination. Many people stabilize quickly without necessitating such a transfer.
- You can contract with a clinical psychologist to come to your ER to perform the examination and release the patient if he/she doesn’t meet criteria Contract with a psychologist to conduct the mandatory initial involuntary examination and release if the emergency physicians aren’t willing to do so.
- Have the psychiatric consultant used by your hospital examine and treat the person in the ER to psychiatrically stabilize & release.

- Request that the receiving facility conduct the involuntary examination on site at your hospital and release. (this can rarely be accommodated because CSU's are not funded to provide a physician or psychologist for this purpose).
- Have receiving facility psychiatrist or psychologist examine the person at your hospital and file the BA-32 petition with the court, placing top priority for admission of the person to the first available bed.
- If person can't be transferred to a receiving facility because of medical reasons, the Baker Act permits a change of venue for the hearing "because of the condition of the patient".
[394.4599(2)(c)4]

Any hospital that is unable to meet its legal duty to transfer the patient within the 12 hours permitted by law should contact DCF and/or AHCA to self-report. This report can result in any one of several outcomes: It documents good faith effort to comply with law (log date/time of each call, person spoken to, exact response received), they may be able to help in expediting the needed transfer, and it informs them of receiving facility bed shortages. DCF and AHCA can also verify the actual census at receiving facilities in your area to ensure that correct information you are given about availability of beds in public and private receiving facilities is accurate.

Q. I am with DCF and attended our monthly county Baker Act meeting this morning and was asked a question from a medical hospital employee regarding what procedure should be followed when an individual who is in a medical hospital under a Baker Act is still in the hospital 72 hours after being medically cleared due to the medical hospital not being able to secure a bed for this individual at a Baker Act receiving facility. I know in the Baker Act Manual it states an individual must be transferred out of the medical hospital within 12 hours of being medically cleared. Our hospitals have been having an issue lately in finding a facility with an open bed and they have had at least one individual stay in their facility for the entire 72 hours after medical clearance. This individual apparently stated to the psychologist at the hospital and to the medical doctor at the hospital if released they would commit suicide. The individual stated how and when they would perform the act. What can they do?

While the Baker Act requires a non-designated hospital to transfer a patient under a Baker Act involuntary examination within 12 hours of medical stabilization and the exam period actually expires after 72 hours, most risk managers would advise a hospital not to release a person who appears to still meet the criteria for involuntary placement. It sometimes comes down to a dilemma of exceeding the maximum period permitted under the law or risking a wrongful death. There is no remedy in Baker Act for failure to transfer within the 12 hour period.

There are a number of options:

- The person can be transferred to any receiving facility; not just the nearest one.
- The hospital's own emergency physicians are authorized to perform the examination and release the person directly when psychiatrically stable
- The hospital can contract with a clinical psychologist to come to your ER to perform the examination and release the patient if he/she doesn't meet criteria Contract with a psychologist to conduct the mandatory initial involuntary examination and release if the emergency physicians aren't willing to do so.
- Have the psychiatric consultant used by the hospital examine and treat the person in the ER to psychiatrically stabilize & release.
- Request that the receiving facility conduct the involuntary examination on site at the hospital and release.

- Have receiving facility psychiatrist or psychologist examine the person at the hospital and file the BA-32 petition with the court, placing top priority for admission of the person to the first available bed.
- If person can't be transferred to a receiving facility because of medical reasons, the Baker Act permits a change of venue for the hearing "because of the condition of the patient".
[394.4599(2)(c)4]

Any hospital that is unable to meet its legal duty to transfer the patient within the 12 hours permitted by law should contact DCF and/or AHCA to self-report. This report can result in any one of several outcomes: It documents good faith effort to comply with law (log date/time of each call, person spoken to, exact response received), they may be able to help in expediting the needed transfer, and it informs them of receiving facility bed shortages. DCF and AHCA can also verify the actual census at receiving facilities in your area to ensure that correct information about availability of beds is accurate.

You might even want to examine length of stay data for your public receiving facility. If it is longer than 3-4 days, that may contribute to the problem. You also may want to check to see if the rate of discharges from the local public receiving facilities over weekends is at or near any other day of the week. Some hospitals in your vicinity have complained that the CSU turns down referrals of indigent persons and calls the hospitals on the same day seeking referral of insured people. While DCF and the county probably don't fund all of the beds at that facility, resulting in the need to have some level of privately funded patients. However, this practice can elicit negative comments by local hospitals.

Q. Once a person is medically cleared in a non-designated hospital ER but unable to get into a Baker Act facility, on what legal basis can the hospital continue to hold the person if the individual requests to leave?

Once an involuntary examination has been initiated, the initial mandatory involuntary examination must be conducted by a physician or a psychologist. The ED physician can conduct the examination and is authorized to release the person directly from the ED if found not to meet the criteria for involuntary placement. The statute prohibits a receiving facility from holding a person for longer than 72 hours for examination. However, when a person is held at a non-receiving facility hospital after medical examination or treatment, the law requires a receiving facility to either conduct the examination or to accept a transfer of the patient within 12 hours of medical stabilization. It need not be the nearest receiving facility. There is no remedy in the law or rules for failing to follow the law. I recommend that the ED contact AHCA and DCF to report itself for inability to comply -- keeping a log of all calls made, date, time, person spoke with, response received. This document good faith effort on the part of the ED and keeps DCF informed of problems in the community acute care system.

Some ED's don't clear the patient until a transfer is approved, although some receiving facilities won't consider a request for transfer until after medical clearance. Some ED's have been known to stack one BA-52 on top of another, believing this to provide authorization to keep patients. It doesn't. Finally, the hospital's risk manager would probably take the position of picking between potential law suits -- risk of false imprisonment versus wrongful death. Most would choose the former.

Q. We are a small rural hospital – the closest receiving facility is in another county. We frequently have Baker Acts brought to the ER for medical clearance and if they can't be cleared in the ER we have to admit them. Once they are medically cleared, then we contact the receiving facility for transfer. If they don't have a bed, we end up with the patient here for 2-5 days- medically cleared, but not getting the appropriate care. We have to provide security around the clock. I was reading the Baker Act Handbook, and it states “within 12 hours after

pt has been medically cleared, the receiving facility must: examine and release the person from the hospital, or accept transfer of pt to receiving facility in which appropriate medical treatment is available. Does this mean the receiving facility must accept the patient even if it doesn't have an available bed in the Psych unit?

A hospital that isn't designated as a receiving facility is required to transfer a person within the 12 hour period to a facility that has the capability and capacity to manage the person's emergency medical condition – in this case a psychiatric emergency. The statutory provision is as follows:

394.463 Involuntary examination.--

(2)(h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or
2. The patient **must be transferred** to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

This doesn't state that a receiving facility must accept within the 12 hours – just that your hospital must transfer within the 12 hours. Unfortunately, there is no remedy in the Baker Act for something that can't legally happen if the person can't be released and can't be transferred. This gets more complicated with the addition of the federal EMTALA law.

EMTALA prohibits release of a person with an emergency medical condition (including those of a psychiatric or substance abuse nature) until stabilized for release or transfer. When a conflict between the federal EMTALA law and the state Baker Act law occurs, the federal law prevails. Allowing a person to leave the hospital prior to stabilization would expose the hospital to huge liability of up to \$50,000 per event and possible loss of Medicare and Medicaid. An EMTALA violation doesn't have to result from an adverse incident – just failure to abide by the federal law is sufficient.

In addition to the federal EMTALA law, you and other hospitals also have to comply with chapter 395, FS, the state's hospital licensing law, as follows:

395.1041(3) Access to emergency services and care.--

(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the **geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity.**

When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

Once the medical stabilization occurs, a non-receiving facility ED can:

- Transfer the person to "**a**" designated receiving facility able to manage person's medical condition – not necessarily the nearest facility.
- Encourage an emergency physician conduct the mandatory initial involuntary examination and release the person when psychiatrically stable.
- Contract with a psychologist to conduct the mandatory initial involuntary examination and release if the emergency physicians aren't willing to do so.
- Have a psychiatric consultant examine and treat the person in ER to psychiatrically stabilize & release.

- Have receiving facility physician or psychologist come to the ED to conduct the involuntary examination and release.
- Have a receiving facility psychiatrist/psychologist examine the person at the hospital and file the BA-32 (petition for involuntary placement) with the court, placing top priority for transfer/admission of the person to the first available receiving facility bed.
- If the person can't be transferred to a receiving facility because of medical reasons, the Baker Act permits a change of venue for the hearing "because of the condition of the patient". [394.4599(2)(c)4]
- If unable to transfer within the 12 hour period, the hospital can report itself to DCF and AHCA & request assistance in transferring.

The hospitals should report to DCF/AHCA the date/time of each call attempting to transfer, name of person talked to, and the response. This documents the hospital's good faith effort to comply with the law, lets the regulatory agencies know the problem exists, and helps on occasion to facilitate the transfer. DCF circuit staff might want to arrange for this to be done by email on a 24/7 basis, since this often occurs on nights or weekends – the Monday morning staff may not have the information to make the report. Some hospitals may resist doing this electronically for fear of a HIPAA violation. In that case, they could do it by phone or otherwise. DCF and AHCA have the right to check on the census at the receiving facilities to ensure they are actually full, not just trying to avoid a transfer. It also alerts AHCA when a hospital-based receiving facility may be refusing or delaying a transfer due to a person's inability to pay -- "reverse dumping".

DCF and AHCA can check to see if a receiving facility's discharge rate is the same on weekends as it is on weekdays. If not, the facility may not have discharge planners working on weekends and the covering psychiatrists may not be willing to discharge persons for the attending psychiatrists. These are unacceptable practices, given the shortage of publicly funded beds, the high risk of keeping acutely ill persons in ER's, and violation of the liberty interests of persons under the Baker Act.

What should never happen is for the ER physician to stack one BA-52 on top of another. This is clearly illegal – it is the person's right not to have their liberty denied for more than 72 hours for purposes of psychiatric examination – not the facility's right to have 72 hours in which to complete the examinations/filing. Some receiving facilities insist that a new Baker Act involuntary examination be initiated as a condition of accepting a transfer in order that they have a full 72 hours in which to initiate an involuntary placement petition, regardless of how long a person may have already been held at the ER for examination.

One additional consequence to keeping people in ER's for more than the 12 hours permitted by law is that since the 72-hour clock is ticking once the person's emergency medical condition has stabilized or found not to exist, there is often insufficient time for the receiving facilities to then obtain the 2 expert examinations, the administrator/designee's signature, and file the petition with the court within the 72-hour period. The filing itself can be postponed until the first working day if the 72 hours runs out on a weekend or legal holiday. If the 72-hour period runs out on a weeknight, there may be substantially less than 72 hours in which to get all this done. If not done within the 72 hours, the public defender will get any petition dismissed once it gets to a hearing.

Q. We had a case where a 16 y/o girl overdosed. The hospital ER was willing to medically release her, but the receiving facility in that county had no beds available. A receiving facility in a distant county agreed to accept her, but no one (including the sheriff's department) was willing to transport and the hospital would not call an ambulance. She was held at the hospital where she proceeded to tear the room up. Everything was removed from her that wasn't necessary. Doesn't the hospital only have 12 hours to transport her after medical clearance and since a bed was located, wasn't the hospital responsible for transport?

The originating hospital was indeed responsible for arranging for safe and appropriate transport of the patient with an emergency medical condition to a facility where her specialized needs could be met. An emergency psychiatric condition and an emergency substance abuse condition are considered by the federal government as emergency medical conditions. Transport of such a person from one hospital to another hospital by other than appropriately equipped/staffed medical transport would be considered an EMTALA violation by CMS and AHCA. An EMTALA violation may result in up to a \$50,000 fine and loss of Medicare and Medicaid certification.

Q. What does an ED physician do when a Baker Act patient has been medically cleared and the 72 hours are over? (Psych receiving facilities with no beds, AHCA/DCF notified) The psychiatrist on our staff has come in and seen the patient and recommended the patient be held for inpatient treatment and assessment and writes "extend Baker Act." The patient has now been held in the ED for 6 days. My response has been to tell the ED physician and staff that we should make every attempt to keep the patient and that we would rather face a false imprisonment charge than a wrongful death. I have also told them not to go in and tell the patient that the Baker Act has expired but if the patient becomes aware that the physician should do everything in their power to convince the patient to stay if they are a threat to self or others. If the patient insists on leaving, I have instructed them to call the police and let them know that the patient has left and was under a Baker Act and is still a harm to self or others.

Your response to the ED physicians is correct. There is no way to totally avoid liability in these situations, but your advise clearly is the best available. The hospital informing AHCA and DCF when the transfer takes longer than 12 hours permitted by law is correct as is your policy to never release persons if they meet involuntary examination or involuntary placement criteria. You probably keep a log containing the date/time of each call attempting to transfer, name of person talked to, and the response. This documents the hospital's good faith effort to comply with the law, lets the regulatory agencies know the problem exists, and helps on occasion to facilitate the transfer. The DCF Circuit Office would be your contact. DCF Circuits might want to arrange for this to be done by email on a 24/7 basis, since this often occurs on nights or weekends – the Monday morning staff may not have the information to make the report. DCF and AHCA have the right to check on the census at the public and private receiving facilities to ensure they are actually full, not just trying to avoid a transfer. It also alerts AHCA when a hospital-based receiving facility may be refusing or delaying a transfer due to a person's inability to pay -- "reverse dumping".

Mondays are the day when most of these complaints emerge. Whether it is because the volume is higher or because of what appears to be a slow down in accepting transfers over the weekends -- only DCF and AHCA can also check to see if the receiving facility's discharge rate is the same on weekends as it is on weekdays. If not, the facility may not have discharge planners working on weekends and covering psychiatrists may not be willing to discharge persons for the attending psychiatrists. These are unacceptable practices, given the shortage of publicly funded beds, the high risk of keeping acutely ill persons in ER's, and violation of the liberty interests of persons under the Baker Act.

In the meantime, the hospital should:

- Encourage its emergency physicians to conduct the mandatory initial involuntary examination and directly release the person when psychiatrically stable.
- Contract with a psychologist to conduct the mandatory initial involuntary examination and release if the emergency physicians aren't willing to do so for liability reasons.
- Have a psychiatric consultant examine and treat the person in the ER so he/she can be psychiatrically stabilized and released.

- Get the receiving facility to conduct the involuntary examination and release.
- Get the receiving facility psychiatrist/psychologist to examine the person at the hospital and file the BA-32 with the court, placing top priority for admission of the person to the first available bed.
- If the person can't be transferred to a receiving facility because of medical reasons, the Baker Act permits a change of venue for the hearing "because of the condition of the patient". [394.4599(2)(c)4]

What cannot legally be done is to stack one BA-52 on top of another to extend the 72-hour period allowed by law for a person to be detained for involuntary examination under the Baker Act. In any case, the person needs to be prevented from leaving the ER while a psychiatric emergency exists (an emergency medical condition per CMS) using the least restrictive method. Some hospital use the following interventions:

- Place into a gown and remove shoes
- Locate person at back of ER, farthest away from exit doors
- Provide close observation
- Provide 1 on 1 if necessary
- Provide video monitoring
- Consider use of color wrist ID bands to indicate "wandering" behavior for persons with dementia, head injury, mental illness, etc.
- Use chemical or mechanical restraints if warranted under the federal Conditions of Participation behavioral restraint standards.

The federal EMTALA law prohibits release of a person with an emergency medical condition (including those of a psychiatric or substance abuse nature) until stabilized for release or transfer. When a conflict between the federal EMTALA law and the state Baker Act law occurs, the federal law prevails. Allowing a person to leave the hospital prior to stabilization would expose the hospital to huge liability of up to \$50,000 per event and possible loss of Medicare and Medicaid. An EMTALA violation doesn't have to result from an adverse incident – just failure to abide by the federal law is sufficient.

Q. I am the Director of Case Management at a hospital that is not a receiving facility. When a patient is here under the Baker Act, being treated for a medical condition and has been medically cleared for discharge to a Baker Act receiving facility, does the Baker Act expire after 72 hours while waiting for a bed to become available? My understanding is that since we are not a designated Baker Act receiving facility, the Baker Act does not expire after 72 hours of waiting for a bed.

Since your hospital has no licensed psychiatric beds and isn't designated by DCF as a receiving facility, you are primarily governed by the federal EMTALA law. However, many people with a Baker Act involuntary examination initiated also have experienced an overdose or other trauma in which the Baker Act states the person can be taken to the closest ED, regardless of whether it is designated. Once at such an ED, chapter 394.463(2) states:

(g) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination

[physician or clinical psychologist] and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met. (h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or
2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

There is a presumption that the person's psychiatric condition can't be evaluated while experiencing a medical emergency. You only have 12 hours after the emergency medical condition is stabilized or found not to exist to transfer the patient in compliance with EMTALA to a designated receiving facility. It doesn't need to be to the nearest if that facility doesn't have the capacity or capability to manage the person's care. While the examination period does in fact expire 72 hours after arriving at your ED (plus the period of medical emergency), Your risk manager and/or compliance officer would probably advise you not to release the person as long as he/she continues to meet the criteria for involuntary status under the Baker Act. Releasing such a person could be a violation of EMTALA and could result in a wrongful death and substantial liability. In the meantime, the hospital should consider:

Q. Please clarify the transfer of patients from Private to Public Facilities. Once the patient has been admitted to an inpatient unit, is it necessary for the patient to agree to transfer, or can the patient be transferred per request of Private Facility and acceptance by Public Facility without patient's signed consent? Also, can referral information be sent without patient's signature for release of information?

The federal EMTALA law was changed several years ago to limit EMTALA applicability to emergency departments only. The federal Conditions of Participation apply after admission, including transfers and discharge. Therefore, after admission to a hospital takes place, EMTALA doesn't apply but the Baker Act does in governing transfers from hospitals that are designated as receiving facilities. The Baker Act provisions governing this are in chapter 394.4685

394.4685 Transfer of patients among facilities.--

(3) TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.--

- (a) A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.
- (b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.
- (c) A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.

A transfer (after admission) from a private receiving facility to a public receiving facility can be at the request of the patient or solely at the request of the private receiving facility. This is not the case for transfers from public to private or between private receiving facilities.

Regarding your question about sending clinical records with the person without prior authorization, the federal HIPAA law permits the transfer of clinical records for treatment purposes (in addition to operations and payment purposes) without consent. Where EMTALA applies, federal law requires the provision of such clinical records.

While consent from a patient if competent, or a proxy when not, may be desirable, federal and state laws do provide for some release of information without authorization. In fact, the Baker Act requires such release when a public receiving facility transfers a person to a hospital for medical or psychiatric treatment, as follows:

394.4573 Continuity of care management system; measures of performance; reports.--

(2) The department is directed to implement a continuity of care management system for the provision of mental health care, through the provision of client and case management, including clients referred from state treatment facilities to community mental health facilities. Such system shall include a network of client managers and case managers throughout the state designed to:

(d) Require that any public receiving facility initiating a patient transfer to a licensed hospital for acute care mental health services not accessible through the public receiving facility shall notify the hospital of such transfer and send all records relating to the emergency psychiatric or medical condition.

Q. If our ER contacts DCF because the 12 hour clock is running down to transfer a patient to a receiving facility, what will DCF do? Is the local DCF office phone manned 24/7?

Neither DCF nor AHCA is available 24/7. The best way to contact is by email or fax if your hospital policies allow for such information transmission. This provides you with written documentation of your attempts to transfer the patient within the 12 hours after medical stabilization permitted by law. DCF can not only verify the census of the receiving facilities that refused the transfer, it informs them of the problem, and on occasion, it will result in expedited transfer. DCF can also verify that receiving facilities are fully staffed on weekends and are discharging patients at the same rate as on any other day of the week.

Q. How can transfers be arranged between receiving facilities?

Transfers from any licensed hospitals must first meet all requirements of the federal EMTALA law. Once those are met, the requirements of the state's Baker Act apply. The Baker Act [s.394.4685, FS] provides the following:

(1) Transfer Between Public Facilities.--

(a) A patient who has been admitted to a public receiving facility, or the family member, guardian, or guardian advocate of such patient, may request the transfer of the patient to another public receiving facility....

(b) When required by the medical treatment or mental health treatment needs of the patient or the efficient utilization of a public receiving or public treatment facility, a patient may be transferred from one receiving facility to another, or one treatment facility to another, at the department's discretion, or, with the express and informed consent of the patient or the patient's guardian or guardian advocate, to a facility in another state. Notice according to

the provisions of s. 394.4599 shall be given prior to the transfer by the transferring facility. If prior notice is not possible, notice of the transfer shall be provided as soon as practicable after the transfer.

- (2) Transfer From Public To Private Facilities.--A patient who has been admitted to a public receiving or public treatment facility and has requested, either personally or through his or her guardian or guardian advocate, and is able to pay for treatment in a private facility shall be transferred at the patient's expense to a private facility upon acceptance of the patient by the private facility.
- (3) Transfer From Private To Public Facilities.--
 - (a) A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.
 - (b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.
 - (c) A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.
- (4) Transfer Between Private Facilities.--A patient in a private facility or the patient's guardian or guardian advocate may request the transfer of the patient to another private facility at any time, and the patient shall be transferred upon acceptance of the patient by the facility to which transfer is sought.

Q. If a person arrives at a hospital ER and is admitted - usually to the ICU, once the physician declares the person medically stable, how soon must the person be transferred?

It doesn't matter whether the person was only examined in the ED or was admitted to the hospital for a matter of days, the 12 hours deadline still applies if the sending hospital is not designated as a receiving facility. The clock only stops for an emergency medical condition as defined in s.395.002 -- not for just any medical treatment the person may undergo. Also, the transfer must be to a receiving facility in which appropriate medical treatment is available.

Q. What recourse do we have if no accepting Baker Act receiving facility can be located for a person on involuntary status within the 12 hour time frame permitted for transfer?

The Baker Act doesn't provide a remedy to a situation that can't legally happen. The hospital should start referring immediately upon the person's medical clearance and document each contact with the date, time, location, person talked to, and his/her response. If it appears the person won't be transferred within the permitted 12 hour period, DCF and AHCA should be contacted at the first possible time to report it. What cannot be done is to re-initiate another BA-52 on top of the first one. Neither should a person be released who still meets the criteria for involuntary placement. However, an emergency department physician may conduct the exam and if the person doesn't meet the involuntary placement criteria, the examination and findings can be documented in the chart and the person can be either released or, if competent, converted to voluntary status.

Q. After an involuntary examination was initiated, a man taken to an ER for medical treatment. It took three days before a bed at one of our receiving facility became available, but by this time his Baker Act expired. Should the ER physician initiate another involuntary examination or is it the responsibility of the receiving facility to initiate a new Baker Act once the person arrives at the facility? Who is responsible to transfer the person from the hospital to the receiving facility under these circumstances?

There isn't a remedy in the law for the problem you raise. The Baker Act requires that within 12 hours of stabilization, either the receiving facility conducts the exam at the hospital and releases the patient or accepts the transfer if it has the ability to provide needed medical treatment.

394.463 (2) Involuntary Examination

(h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or
2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

(i) Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;
2. The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;
3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or
4. A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(3)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

It is never appropriate to stack one BA-52 on top of a previous one -- this illegally extends the 72-hour period in which a person can be held for involuntary examination under the Baker Act. The only thing that stops the 72-hour clock is the documented presence of an emergency medical condition. Once the condition has been stabilized or found not to exist, the clock begins to tick again. It is the person's right not to have his or her liberty denied for more than the time permitted under the law, not a facility's right to have the full period of time to perform the exam. This conflict can happen whenever a transfer situation takes place. A new BA-52 should never be initiated unless the person has had some period of freedom.

Even if the public receiving facilities in your locale don't have a single bed into which the person can be transferred, they still bear some responsibility for the patient:

65E-5.351 Minimum Standards for Designated Receiving Facilities.

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

Your ER's and receiving facilities may wish to consider:

1. Examination and direct release by the ED physician if Mandatory Initial Involuntary Exam is conducted and person doesn't meet criteria for involuntary inpatient or involuntary outpatient placement.

2. The receiving facility physician or psychologist can go to the ED to conduct the examination and authorize the person's release, avoiding the need for transfer.
3. The medical hospital can retain the person for medical treatment with psychiatric care by receiving facility.

Remember, the transfer must be made to "a" designated receiving facility able to manage the person's medical condition – not the nearest facility. This may require a transfer to a receiving facility outside your county if it is the nearest one with capability and capacity. The sending hospital can inquire about the person's ability to pay so the transfer may be to a facility at which the person's insurance (if any) will pay. However, the destination hospital cannot base its decision to accept a transfer on a patient's ability to pay.

I strongly recommend to all ER's that if they are unable to transfer within the 12 hour period, they should report themselves to DCF and AHCA & request assistance in transferring. This may result in an expedited transfer, but will at a minimum, document the hospital's good faith effort to meet its legal duty.

AHCA and DCF can verify the census logs at each of the public and private receiving facilities in your county on the three days in which the hospital was seeking a transfer. It is hard to believe that not a single discharge was made during this period at any facility that would have created capacity for the person's transfer. DCF should check facility practices in a couple of areas -- discharges from CSU's on weekends should be no less than any other day of the week. On-Call physicians often provide coverage but are hesitant to discharge another doctor's patients. This is unacceptable in a time of limited resources. Further, some facilities don't have their discharge planners working on weekends the same as on weekdays. This also shouldn't happen. Especially due to high rates of recidivism that fill beds unnecessarily, it is important that all receiving facilities increase their efforts to assist persons with their aftercare planning that must include provision of access to prompt aftercare appointments and access to psychotropic medications upon discharge as required in the Baker Act rules.

With regard to your question about who actually is responsible for the transfer, the sending hospital is responsible under the federal EMTALA law for arranging safe and appropriate transport of a person under emergency conditions.

Q. Psychiatric patients come into our ER and are treated, stabilized and assessed. If they are indigent, they need to go to the CSU because it is the CSU that gets funding for the Indigent population. More and more patients are saying they do not want to go to the CSU, hence we are admitting them to our hospital psychiatric unit and are unable to get any compensation from these patients. Can we "make" them go to a facility that gets the State funding for their care? I would like to see something in writing that states either that this population has to be admitted to the private receiving facility or even if they protest and refuse to go, can be transferred to the CSU.

When the federal EMTALA law is in conflict with the state Baker Act law, the federal law takes precedence. When they are not in conflict, you must follow both. The whole basis of EMTALA is that transfers of persons with emergency medical conditions (acute psychiatric and substance abuse conditions are EMC's per federal definition) are inherently dangerous. EMTALA generally doesn't condone lateral transfers, much less downward substitutions of care solely due to a patient's inability to pay when an emergency medical condition exists.

One of the requirements for a transfer to be considered appropriate is that it must be consented to by the patient/legal representative or certified by a physician who has documented that the benefits outweigh the possible risks. For hospitals that do not have psychiatric capability, the physician can

easily certify the risk/benefit issue. However, for hospitals that have licensed psychiatric beds, such a certification would not be appropriate since the hospital has the capability and capacity to meet the patient's emergency needs. In such cases, a transfer would be solely due to financial reasons, which would be a violation of the federal law.

It is assumed that your ED physicians are assessing capability of the patient to make informed decisions. If incapacitated, a proxy can be designated for those patients who have a relative or friend willing and able to serve in this capacity. In such cases, the proxy serving as the authorized decision-maker on behalf of the patient has the authority under state law to request a transfer of the patient to another facility.

EMTALA no longer applies once the patient has been admitted to inpatient status. Therefore, only the Baker Act would apply at that point.

Q. What is considered a reasonable amount of time to wait for a bed to open?

You must transfer within 12 hours to be in compliance with the law.

Q. I have questions regarding the acceptance of transfers of patients across county lines. There have been occasions when a hospital in the next county will request to transfer a patient to our facility for psychiatric care because there are no available beds in the facilities serving that county. Our facility has been discouraged by DCF and AHCA in the past from accepting transfers across county lines. There have been times that we were able to find a bed when we place calls to that county's receiving facilities on behalf of the requesting facility. This may be due to a change in availability since the initial call was placed.

Based on Baker Act statutes, are there any reasons that we should not be accepting such transfers across county lines? What level of diligence is required by the sending facilities prior to contacting a facility in another county? Is there a requirement for the sending facility to contact DCF to assist in finding a bed in their own county? If so, is there a special contact person/number to facilitate bed placement in that county? Does the sending facility in that county have any obligation to show proof that they have contacted all appropriate hospitals in their county for bed availability prior to contacting hospitals outside of their county for a transfer? Lastly, could our facility be at risk of an EMTALA violation if we do not accept such transfers when we are called if we do have the bed availability to accept the patient?

The primary reason you shouldn't refuse a request for transfer from an adjoining county is it could constitute a violation of the federal EMTALA law and Chapter 395, FS, resulting in serious consequences to your hospital.

395.1041 Access to emergency services and care.-- (3)(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

EMTALA doesn't make any exception for county lines. There is no reason that transfers can't be made across county or circuit lines under the Baker Act either. Based on the statutory reference above, the sending hospital should always have documented the date and time of each call, who they

spoke with, and what reason was given for failing to accept the transfer. Therefore, your question about documenting all contacts with nearer facilities is in the affirmative.

While your assistance to the referring hospital is appreciated, the public receiving facilities in that county should be taking on this role:

65E-5.351 Minimum Standards for Designated Receiving Facilities.

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

The reason that hospitals should contact DCF and AHCA when a transfer cannot be accomplished within the 12 hours permitted by law after medical stabilization is so the census at the receiving facilities that have refused the transfer can be verified by a regulatory agency

Q. What is the obligation of a receiving facility to a non-receiving facility ER when all receiving facilities in the district are on overflow? When the 12 hours has passed after medical clearance, does there need to be another medical clearance done by hospital?

If no receiving facility that has the capability of managing the person's medical condition is available to receive the transfer, the receiving facility should at a minimum have a physician or psychologist conduct an examination to determine if the person can be released directly from the hospital, averting the need for transfer. This assumes that the hospital's own physician has chosen not to perform the examination or has performed it and believes the person appears to meet the criteria for involuntary inpatient or involuntary outpatient placement. The federal EMTALA law (but not the state's Baker Act) may require a second medical clearance closer to the time of transfer. Stabilization for transfer is determined at the time of transfer – not at some earlier period.

Q. Once a person's medical condition has stabilized and ED staff has contacted a designated receiving facility, is it the responsibility of the receiving facility to accept that person within 12 hours? If a receiving facility refuses to accept the person, what process should be followed by the emergency department personnel to ensure that person receives proper care under the Baker Act?

It is the responsibility of the emergency department to contact a designated receiving facility within 2 hours after the person's emergency medical condition has been stabilized or determined not to exist. It is the receiving facility's responsibility to either accept transfer of the person when it has appropriate medical treatment available or to have its physician or clinical psychologist conduct the initial mandatory involuntary examination and release the person or transfer to voluntary status, if competent. The federal EMTALA regulations and the Baker Act require the sending hospital to provide safe and appropriate transportation of the person to the receiving facility, unless other appropriate transportation arrangements can be made.

If a receiving facility refuses to accept the person, another receiving facility should be contacted or the person should be retained at the hospital in which the emergency department is located until resolution is reached. If the receiving facility that refused to accept the person is a part of a hospital subject to EMTALA, a report to the Agency for Health Care Administration may be appropriate if the refusal was based on the financial status of the person. If the receiving facility is designated under Chapter 394, F.S., a complaint may be directed to the district office of DCF (funding source) or the Agency for Health Care Administration (licensure).

Q. What is the current view of a patient who has been "re-Baker Acted" at a hospital because he or she could not be transferred to a receiving facility within 72-hours (typically due to lack of bed availability) and the patient is still considered to be in imminent danger of harming himself or others?

A 2nd involuntary examination on the same person without any intervening period of liberty is not legal. A person can only be held for involuntary examination a maximum of 72 hours. In fact, as you know, a person can only be held for up to 12 hours after medical stabilization in a facility not designated as a receiving facility. The non-designated ER's need to push the system to accept persons on involuntary status within the 12 hours or, at a minimum, report themselves to AHCA/DCF for non-compliance.

This documents the good faith effort of the sending hospitals to comply with the law, lets the regulatory agencies know of a system problem, and provides them an opportunity to assist the hospital in negotiating a transfer.

Q. The Baker Act involuntary examination statute states that "one of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist: 1. the patient must be examined by a designated receiving facility and released ; or 1. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available." My question is, does this 12 hours mentioned in this part of the statute refer only to non-designated receiving facilities or to all ER's regardless if they are licensed as a receiving facility?

The question arises from our district / circuit because an emergency room is also a designated receiving facility(private) that sees a large number of indigent clients in need of emergency psychiatric care. Many times beds are an issue and the public CSU unit has no beds available. Although an examination by a psychiatrist should be as soon as possible, it is the position of this ER (a private designated receiving facility) that clients in the ER must be examined within 12 hours. My thinking from reading the statute is the 12 hours mentioned only applies to non designated facilities that have no psychiatric capability and no level of care settings). My understanding is in designated facilities this needs to happen within 24 hours whether the designated facility is an ER or not.

You have to read the section you cited in the context of several paragraphs included below. If a hospital is designated as a receiving facility, it has 72 hours in order to conduct the involuntary examination before the person must be released, converted to voluntary status or an involuntary inpatient placement petition filed with the court. This is covered in subparagraph (f).

Subparagraph (g) intervenes in cases in which a person is examined for an emergency medical condition, which could occur at a hospital-based receiving facility or an ER at a general hospital that isn't designated and doesn't have psychiatric capability.

In either case, the clock stops for the period of the emergency medical condition and starts back up when the emergency has been stabilized or found not to exist. If the person is at a hospital that is a designated receiving facility, the facility has the 72 hours plus whatever period of time the person is documented as having an emergency medical condition in which to conduct the involuntary examination. If the person is at a hospital ER that isn't designated, the person must be transferred within 12 hours after the emergency medical condition has been stabilized to a facility that is designated in order for the involuntary examination to be conducted.

The "12 hour rule" has no applicability to designated receiving facilities. It also doesn't extend the period of time permitted for the involuntary examination to be conducted. It only serves to move the patient along in a timely way from a non-receiving facility to a receiving facility so there isn't an unnecessary delay in conducting the examination and ensures the earliest possible release in cases in which the involuntary inpatient placement criteria aren't met.

394.463(d) Involuntary examination.--

(f) A patient shall be examined by a physician or clinical psychologist at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.

(g) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

(h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or
2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

Any physician or psychologist at the ER is authorized by law to conduct the involuntary examination and authorize the direct release of the person from the ER if not meeting the criteria.

Q. When our facility is full and we're transporting a suicidal patient to another facility; if the patient is voluntary, should the patient ever be put on a Baker Act? Some here have argued that the patient may be at risk due to labile mood or decision to act on the suicidal thoughts instead of agreeing to an admission, in other words change their mind half way during the transport. But others argue that it is unlawful to Baker Act someone who states they are willing to be admitted.

This is a question you may want to refer to your hospital risk manager as it applies more to federal EMTALA compliance and possibly to federal Conditions of Participation than to the state's Baker Act.

While you never want to falsify a document to allege a person meets criteria for involuntary status simply for purposes of transport if such criteria isn't met, one expert suggests that your hospital liability remains until the patient is admitted at the destination hospital. Robert Bitterman is both an attorney and an emergency physician – his book “Providing Emergency Care under Federal Law: EMTALA” is published by the American College of Emergency Physicians. Dr. Bitterman believes that any person who is actively suicidal or homicidal has an emergency medical condition under CMS definitions and must remain stabilized during transfer -- chemical, mechanical and legal restraints may be required. By legal restraints, he means “involuntary” status so the patient won't be able to demand release en route. Some transport firms believe that they must release any person on voluntary status upon demand.

The Baker Act involuntary examination criteria require that a person either “refuse” or be “unable to determine examination is necessary”. A refusal is clear. However, inability to determine the necessity of the examination may include any person who isn't able to make well-reasoned, willful and knowing decisions about his/her medical/mental health care. It can also be a person who may have severe impulse control problems and be unable to follow through on a request for treatment. It may be a person who rapidly changes his/her mind about care. It may also be a person who is attempting to manipulate staff so as to elope. A person may “agree” to the transfer or admission, but still meet involuntary criteria.

Q. If a patient is on a medical unit under a Baker Act and it is documented the patient is medically cleared, when does the clock start ticking -- when the doctor writes the patient is medically clear in the chart or when the patient leaves the medical hospital?

The clock actually starts back up as soon as the physician documents that the emergency medical condition has stabilized or doesn't exist.

394.463(2) Involuntary examination.--

(g) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

(h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or
2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

These provisions were enacted by the Legislature after a widely reported problem was documented in which people in one area of the state were stacked up in ER's waiting for transfer to receiving facilities. It was intended to ensure a rapid transfer was done so the person's liberty wouldn't be unnecessarily denied while awaiting the involuntary examination.

Q. I am working with the hospital regarding the fact that the entire hospital is a receiving facility not just the inpatient unit. The main question that I am being asked is, (for Baker Act patients); When does the clock start ticking when the patient has been admitted to a medical floor? My response was; when the medical condition has been stabilized and the patient can participate in the evaluation. Who decides when the condition has stabilized? My second question is somewhat more complicated in that regardless of whether the patient has been medically stabilized, if they are Baker Acted and in need of psychotropic medication then don't we have to follow 394 and file the legal documentation as we would any patient that was on the inpatient psych unit?

DCF has always considered the entire premises at the address of the designation letter as the receiving facility. This has been part of the official training and has been included in many responses provided by DCF. DCF has not designated only a certain number of beds in the past and it has always interpreted the law to mean the whole facility, not just a certain number of beds or only one unit (not others), DCF is confirming with AHCA this position now and we expect to hear confirmation soon.

With regard to your two specific questions:

1. When does the clock start ticking when the patient has been admitted to a medical floor? My response was; when the medical condition has been stabilized and the patient can participate in the evaluation. Who decides when the condition has stabilized?

The 72-hour clock starts to tick as soon as the person arrives at the hospital. It stops when a physician documents that an emergency medical condition exists and starts back up again as soon as the emergency medical condition has been stabilized or determined not to exist. Any time sitting in the ER waiting for a bed is counted against the 72 hour maximum as is the time sitting on a medical unit waiting for transfer. Even a person who has a medical condition that isn't of an emergency nature is presumed to be able to undergo the psychiatric examination for which he/she was brought to the facility.

394.463 Involuntary examination.--

(2)(g) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency

medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

(h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or
2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available.

The above provisions don't link together well since they were actually written to address circumstances when a person was taken to an ER of a non-designated hospital and still required the involuntary examination at a receiving facility. However, to read it any differently would mean that a hospital designated as a receiving facility wouldn't be able to stop the clock at all for an emergency medical condition.

The determination that the person's "medical condition has stabilized or that an emergency medical condition does not exist" is left to the person's attending physician. This is a clinical decision that is not defined in the Baker Act.

You may have some individuals with a continuing medical condition who require a medical overlay on the psychiatric unit or a psychiatric overlay on a medical unit.

2. Regardless of whether the patient has been medically stabilized, if they are Baker Acted and in need of psychotropic medication then don't we have to follow 394 and file the legal documentation as we would any patient that was on the inpatient psych unit?

Yes. If the person is being held under the Baker Act, express and informed consent for all psychiatric medications would have to be in accord with the requirements of the Baker Act statute and rules, wherever the patient was being held in the receiving facility. Even hospitals that aren't designated as receiving facilities are required to comply with all aspects of chapter 394, FS for persons held under the Baker Act, as follows:

395.003(5)(a) Adherence to patient rights, standards of care, and examination and placement procedures provided under part I of chapter 394 shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment.

(5)(b) Any hospital that provides psychiatric treatment to persons under 18 years of age who have emotional disturbances shall comply with the procedures pertaining to the rights of patients prescribed in part I of chapter 394.

395.1041(6) RIGHTS OF PERSONS BEING TREATED.--A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

395.1055(5) The agency shall enforce the provisions of part I of chapter 394, and rules adopted thereunder, with respect to the rights, standards of care, and examination and placement procedures applicable to patients voluntarily or involuntarily admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment.

Assuming that the person doesn't have an emergency medical condition, the clock is ticking and a petition for involuntary placement would have to be filed with the Clerk of Court within 72 hours of stabilization of the person's medical condition.

Q. It was my understanding that if a patient is medically clear and in a hospital bed, the 72 hours begins. If the 72 hours ends prior to the patient getting to a psychiatric bed, a psychiatrist can examine the patient and write a new Baker Act based on current presentation. Please advise regarding the part about the legality of the psychiatrist's re-evaluation and writing a new Baker Act.

The Baker Act limits the period of time a person's liberty can be restricted for the purpose of involuntary examination to 72-hours plus the period in which a physician has documented the presence of an emergency medical condition.

394.463 Involuntary examination.--

(2) INVOLUNTARY EXAMINATION.--

(f) A patient shall be examined by a physician or clinical psychologist at a receiving facility without unnecessary delay and may, upon the order of a physician, be given emergency treatment if it is determined that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist, a clinical psychologist, or, if the receiving facility is a hospital, the release may also be approved by an attending emergency department physician with experience in the diagnosis and treatment of mental and nervous disorders and after completion of an involuntary examination pursuant to this subsection. **However, a patient may not be held in a receiving facility for involuntary examination longer than 72 hours.**

(g) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

(i) Within the 72-hour examination period or, if the 72 hours ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;
2. The patient shall be released, subject to the provisions of subparagraph 1., for voluntary outpatient treatment;
3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient, and, if such consent is given, the patient shall be admitted as a voluntary patient; or
4. A petition for involuntary placement shall be filed in the circuit court when outpatient or inpatient treatment is deemed necessary. When inpatient treatment is deemed necessary, the

least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(3)(a). A petition for involuntary inpatient placement shall be filed by the facility administrator.

There is no provision in law for subsequent BA-52's to be initiated as this would result in depriving the person of their liberty beyond the period allowed by law. Stacking one "Baker Act" on top of another doesn't extend the lawful period. This will be apparent to the Public Defender should a petition for involuntary placement be subsequently filed with the court. It would also be apparent to any plaintiff attorney who would review the record.

The only event that stops the 72-hour clock is the documentation by a physician of an emergency medical condition. Once the EMC is stabilized or found not to exist, the clock is ticking even if the patient continues to have medical needs or remains in a medical bed. An EMC is presumed to preclude an examination from taking place, but the mere presence of a medical condition or retention in a medical bed wouldn't preclude the psychiatric examinations from taking place.

Since your hospital is designated as a receiving facility – not just the psychiatric unit – it is essential that the patient be examined within the 72 hour period allowed by law even if this means that a psychiatric overlay is provided on the medical unit or a medical overlay be provided on the psychiatric unit. In this way, the person's due process rights can be protected while their medical and psychiatric needs are met.

Q. I am a Case Manager Supervisor at a general hospital—a non-psych facility. We have a young man who is under a Baker Act in our ICU. The doctors have medically cleared him; however we cannot get acceptance at any of our Baker Act receiving facilities. The issue is that his Phenobarbital level is still above the normal range. The intensivist who is following insists that he stable as "phenobarb levels vary greatly among individuals and a lot of patients keep elevated levels chronically". A psychiatrist is actually following this patient and agrees that he is medically stable and has discussed the issue with the receiving facility psychiatrist, who still refuses. As we are out of compliance with the Baker Act (cleared now for almost 48 hours), I tried to reach AHCA. I was transferred to the Risk Management/Pt Safety section, where I spoke with a secretary who transferred me to multiple voice mail, to no avail. I am at a loss as to how to proceed with the self-reporting and obtaining assistance with this issue.

If the psychiatrist at the receiving facility refused the transfer after a physician to physician consult, there isn't any way to intervene to expedite the transfer. A free-standing non-medical psychiatric facility should make every effort to accept transfers whenever possible, but if they believe it would endanger the safety of the patient, they must refuse.

You should contact both DCF Circuit staff as well as AHCA regional staff if you can't comply with the 12 hour requirement for transfer. You may want to obtain an email address for each so you can do the notification at any hour of any day, including weekends. You may want to use patient numbers instead of patient names to avoid any risk of a HIPAA violation. You probably have an ER log in which you record all efforts to transfer, including date, time, person spoken to and verbatim response for each call. This will document your good faith effort to comply with the law and ensure both AHCA and DCF are aware of problems arising in your county. If this is a recurring problem with your local receiving facilities, DCF and/or AHCA staff may be able to assist you in working out some system resolution for future reference.

Q. We are in a general hospital, not designated as a receiving facility. Does a BA expire if the time clock runs out before the patient is evaluated by a receiving facility (RF), or a representative thereof? If not, what should we do? Should patients be “re-Baker-acted?” What should we do if a RF insists on a psych eval before they’ll accept the transfer? Do RF’s have the autonomy to refuse a transfer? If so, what are the reasons? Can a Baker Act be initiated by telephone or e-mail? Fax? In the past, RF’s have refused to accept a transfer because the BA they rec’d was not the original (i.e., a photocopy.) If a patient was seen at 5pm, and by 7pm was agitated, threatening suicide, and insisted on leaving ama, would it be possible for the person who examined the patient 3 hours earlier to complete a BA form and fax it to the nurses’ station? If a RF refuses the patient because of bed capacity and the patient is medically stable but requires psychiatric care, can we transfer the patient to the RF emergency room for the appropriate care the patient needs? Doesn’t the law require the RF to come to our facility and evaluate the patient regardless of their ability to accept? How can we enforce this? What do we do with a patient that no longer need medical care and requires the stabilization of a psych condition? We have no psych ward and our concern is how to keep the patient safe. Who can help us

A Baker Act involuntary examination must take place within 72 hours of the person’s arrival at a hospital or receiving facility. The only event that extends this period is the period during which an emergency physician documents the person has an emergency medical condition. The 72-hour clock begins again as soon as a physician documents the emergency medical condition has been stabilized or doesn’t exist. The law requires that a non-receiving facility hospital such as transfer a patient within 12 hours of medical clearance to a designated receiving facility if it doesn’t release the patient directly from the ED. While the involuntary examination period may expire, your facility cannot release the person as long as the acuity of the condition continues or you’ll be likely to face a wrongful death instead of possible false imprisonment. The choice is not a good one.

As you know, a hospital that isn’t designated as a receiving facility is required to transfer a person within the 12 hour period to a facility that has the capability and capacity to manage the person’s emergency medical condition – in this case a psychiatric emergency. The statutory provision is as follows:

394.463 Involuntary examination.--

(2)(h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or
2. The patient **must be transferred** to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

This doesn’t state that a receiving facility must accept within the 12 hours – just that your hospital must transfer within the 12 hours. Unfortunately, there is no remedy in the Baker Act for something that can’t legally happen if the person can’t be released and can’t be transferred. This gets more complicated with the addition of the federal EMTALA law.

EMTALA prohibits release of a person with an emergency medical condition (including those of a psychiatric or substance abuse nature) until stabilized by the ED for release or transfer. When a conflict between the federal EMTALA law and the state Baker Act law occurs, the federal law prevails.

Allowing a person to leave the hospital prior to stabilization would expose the hospital to huge liability of up to \$50,000 per event and possible loss of Medicare and Medicaid. An EMTALA violation doesn’t have to result from an adverse incident – just failure to abide by the federal law is sufficient.

The Baker Act doesn't authorize any medical examination or treatment, nor does it authorize preventing a person hospitalized for medical reasons from leaving AMA. Other laws than the Florida Mental Health Act must be used in such circumstances. People have a right to refuse medical treatment, even to the point of death, if they have the capacity to make this decision.

Should patients be "re-Baker-acted?" No. A patient has the right to not be detained for more than 72 hours for involuntary examination before being released or a petition being filed with the court for involuntary placement. However, it doesn't mean that your hospital risk manager would concur with the release of the person if continuing to meet the criteria for involuntary status.

What should we do if a RF insists on a psych eval before they'll accept the transfer? A receiving facility should never require a psychiatric evaluation prior to accepting the transfer of a patient for the purpose of psychiatric evaluation. This would be an artificial barrier to the timely transfer of a patient under the Baker Act. Such a demand should reported to AHCA.

Do RF's have the autonomy to refuse a transfer? If so, what are the reasons? Yes, receiving facilities must refuse a transfer if they are unable to manage the medical condition of the patient or aren't licensed to serve minors (capability). They also must refuse a transfer if they don't have beds (capacity). However, they cannot refuse a person on the basis of inability to pay if the psychiatric condition is still of an emergency nature and the patient hasn't yet been admitted to inpatient care.

395.1041(3) Access to emergency services and care.--

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

Can a Baker Act be initiated by telephone or e-mail? Fax? In the past, RF's have refused to accept a transfer because the BA they rec'd was not the original (i.e., a photocopy.) If a patient was seen at 5pm, and by 7pm was agitated, threatening suicide, and insisted on leaving ama, would it be possible for the person who examined the patient 3 hours earlier to complete a BA form and fax it to the nurses' station?

A Baker Act can only be initiated by an authorized mental health professional based on an evaluation completed within 48 hours of the professional signing the form. If the professional knows the person and has had a phone call directly with the person, this might suffice for the evaluation. However the law requires that the professional's conclusion that the criteria appears to be met must be based on the mental health professional's own observations. This might be verbal (by phone) as well as in person (visual). Basing it on an email could create too much doubt as to whether the patient was the actual writer. A transfer of a person being held on a BA-52 can be initiated by telephone or by email. This is the usual method used throughout the state.

No – a receiving facility shouldn't refuse a transfer based on not having original documents. All reference to original documents were deleted from the Florida Administrative Code and Baker Act forms in 2005 – no reference was ever in the statute.

If a RF refuses the patient because of bed capacity and the patient is medically stable but requires psychiatric care, can we transfer the patient to the RF emergency room for the appropriate care the patient needs? No. You can't do a transfer from your ER to another facility without having prior consent from the destination facility, as one of a number of conditions for an appropriate transfer under the federal EMTALA law.

Doesn't the law require the RF to come to our facility and evaluate the patient regardless of their ability to accept? How can we enforce this? No. The law requires you to transfer the patient within 12 hours after stabilization to a receiving facility that can provide appropriate medical treatment or that a receiving facility examine and release the person.

394.463 Involuntary examination.--

(2)(h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient must be examined by a designated receiving facility and released; or
2. The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

Rarely is a receiving facility staffed with physicians or psychologists to visit ED's for purposes of conducting such examinations. The law doesn't specify which receiving facility is responsible – just that the person should be sent to “a” receiving facility. Once the medical stabilization occurs, a non-receiving facility ED can:

- Transfer the person to “a” designated receiving facility able to manage person's medical condition – not necessarily the nearest facility.
- Encourage an emergency physician to conduct the mandatory initial involuntary examination and release the person when psychiatrically stable.
- Contract with a psychologist to conduct the mandatory initial involuntary examination and release if the emergency physicians aren't willing to do so.
- Have a psychiatric consultant examine and treat the person in ER to psychiatrically stabilize & release.
- Have receiving facility physician or psychologist come to the ED to conduct the involuntary examination and release (this rarely happens due to the cost to the receiving facility and only applies when person is to be released, not transferred).
- Have receiving facility psychiatrist/psychologist examine the person at the hospital and file the BA-32 (petition for involuntary placement) with the court, placing top priority for transfer/admission of the person to the first available receiving facility bed.
- If the person can't be transferred to a receiving facility because of medical reasons, the Baker Act permits a change of venue for the hearing "because of the condition of the patient".
[394.4599(2)(c)4]
- If unable to transfer within the 12 hour period, the hospital can report itself to DCF and AHCA & request assistance in transferring.

What do we do with a patient that no longer need medical care and requires the stabilization of a psych condition? We have no psych ward and our concern is how to keep the patient safe. Who can help us? If the hospital has tried multiple receiving facilities and can't find one to accept the transfer within 12 hours, it should report to DCF/AHCA the date/time of each call attempting to transfer, name of person talked to, and the response. This documents the hospital's good faith effort to comply with the law, lets the regulatory agencies know the problem exists, and helps on occasion to facilitate the

transfer. DCF circuit staff might want to arrange for this to be done by email on a 24/7 basis, since this often occurs on nights or weekends – the Monday morning staff may not have the information to make the report. Some hospitals may resist doing this electronically for fear of a HIPAA violation. In that case, they could do it by phone or otherwise. DCF and AHCA have the right to check on the census at the receiving facilities to ensure they are actually full, not just trying to avoid a transfer. It also alerts AHCA when a hospital-based receiving facility may be refusing or delaying a transfer due to a person's inability to pay -- "reverse dumping".

DCF and AHCA can check to see if a receiving facility's discharge rate is the same on weekends as it is on weekdays. If not, the facility may not have discharge planners working on weekends and the covering psychiatrists may not be willing to discharge persons for the attending psychiatrists. These are unacceptable practices, given the shortage of publicly funded beds, the high risk of keeping acutely ill persons in ER's, and violation of the liberty interests of persons under the Baker Act.

While retaining the persons at non-receiving facility hospitals, staff should prevent the person from leaving until all federal and state requirements are met, using the least restrictive method. Hospitals report using the following interventions:

- Place into a gown and remove shoes
- Use wrist bands that identify the person as at risk of wandering
- Locate person at back of ER, farthest away from exit doors
- Provide close observation
- Provide 1 on 1 if necessary with trained "sitters"
- Provide video monitoring
- Use chemical or mechanical restraints if warranted under the federal Conditions of Participation behavioral restraint standards.

Q. I am the social worker at a general hospital; we don't have psych in our hospital, nor do we have any psychiatrists on call or on staff. Lately, we have been getting an enormous numbers of Baker Acts - mostly self pays. Our receiving facilities have been full, and these patients are being placed on a waiting list. We've had as many as 30 at a time. What should we be doing if they have been medically cleared, sitting here for 72 hours, and the Baker Act has expired?

As you know, a hospital that isn't designated as a receiving facility is required to transfer a person within the 12 hour period to a facility that has the capability and capacity to manage the person's emergency medical condition – in this case a psychiatric emergency. The statutory provision is as follows:

394.463 Involuntary examination.--

(2)(h) One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

1. The patient **must** be examined by a designated receiving facility and released; or
2. The patient **must be transferred** to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

This doesn't state that a receiving facility must accept within the 12 hours – just that your hospital must transfer within the 12 hours. Unfortunately, there is no remedy in the Baker Act for something that can't legally happen if the person can't be released and can't be transferred. This gets more complicated with the addition of the federal EMTALA law.

EMTALA prohibits release of a person with an emergency medical condition (including those of a psychiatric or substance abuse nature) until stabilized by the ED for release or transfer. When a conflict between the federal EMTALA law and the state Baker Act law occurs, the federal law prevails. Allowing a person to leave the hospital prior to stabilization would expose the hospital to huge liability of up to \$50,000 per event and possible loss of Medicare and Medicaid. An EMTALA violation doesn't have to result from an adverse incident – just failure to abide by the federal law is sufficient.

In addition to the federal EMTALA law, you and other hospitals also have to comply with chapter 395, FS, the state's hospital licensing law, as follows:

395.1041(3) Access to emergency services and care.--

(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity.

When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

Once the medical stabilization occurs, a non-receiving facility ED can:

- Transfer the person to “a” designated receiving facility able to manage person's medical condition – not necessarily the nearest facility.
- Encourage an emergency physician to conduct the mandatory initial involuntary examination and release the person when psychiatrically stable.
- Contract with a psychologist to conduct the mandatory initial involuntary examination and release if the emergency physicians aren't willing to do so.
- Have a psychiatric consultant examine and treat the person in ER to psychiatrically stabilize & release.
- Have receiving facility physician or psychologist come to the ED to conduct the involuntary examination and release (this rarely happens due to the cost to the receiving facility and only applies when person is to be released, not transferred).
- Have receiving facility psychiatrist/psychologist examine the person at the hospital and file the BA-32 (petition for involuntary placement) with the court, placing top priority for transfer/admission of the person to the first available receiving facility bed.
- If the person can't be transferred to a receiving facility because of medical reasons, the Baker Act permits a change of venue for the hearing "because of the condition of the patient". [394.4599(2)(c)4]
- If unable to transfer within the 12 hour period, the hospital can report itself to DCF and AHCA & request assistance in transferring.

The hospitals should report to DCF/AHCA the date/time of each call attempting to transfer, name of person talked to, and the response. This documents the hospital's good faith effort to comply with the law, lets the regulatory agencies know the problem exists, and helps on occasion to facilitate the transfer. DCF circuit staff might want to arrange for this to be done by email on a 24/7 basis, since this often occurs on nights or weekends – the Monday morning staff may not have the information to make the report. Some hospitals may resist doing this electronically for fear of a HIPAA violation. In that case, they could do it by phone or otherwise. DCF and AHCA have the right to check on the census at the receiving facilities to ensure they are actually full, not just trying to avoid a transfer. It also alerts AHCA when a hospital-based receiving facility may be refusing or delaying a transfer due to a person's inability to pay -- "reverse dumping".

DCF and AHCA can check to see if a receiving facility's discharge rate is the same on weekends as it is on weekdays. If not, the facility may not have discharge planners working on weekends and the covering psychiatrists may not be willing to discharge persons for the attending psychiatrists. These are unacceptable practices, given the shortage of publicly funded beds, the high risk of keeping acutely ill persons in ER's, and violation of the liberty interests of persons under the Baker Act.

What should never happen is for the ER physician to stack one BA-52 on top of another. This is clearly illegal – it is the person's right not to have their liberty denied for more than 72 hours for purposes of psychiatric examination – not the facility's right to have 72 hours in which to complete the examinations/filing. I've heard that some receiving facilities insist that a new Baker Act involuntary examination be initiated as a condition of accepting a transfer in order that they have a full 72 hours in which to initiate an involuntary placement petition, regardless of how long a person may have already been held at the ER for examination.

One additional consequence to keeping people in ER's for more than the 12 hours permitted by law is that since the 72-hour clock is ticking once the person's emergency medical condition has stabilized or found not to exist, there is often insufficient time for the receiving facilities to then obtain the 2 expert examinations, the administrator/designee's signature, and file the petition with the court within the 72-hour period. The filing itself can be postponed until the first working day if the 72 hours runs out on a weekend or legal holiday. If the 72-hour period runs out on a weeknight, there may be substantially less than 72 hours in which to get all this done. If not done within the 72 hours, the public defender will get any petition dismissed once it gets to a hearing.

While retaining the persons at non-receiving facility hospitals, staff should prevent the person from leaving until all federal and state requirements are met, using the least restrictive method. Hospitals report using the following interventions:

- Place into a gown and remove shoes
- Use wrist bands that identify the person as at risk of wandering
- Locate person at back of ER, farthest away from exit doors
- Provide close observation
- Provide 1 on 1 if necessary with trained "sitters"
- Provide video monitoring
- Use chemical or mechanical restraints if warranted under the federal Conditions of Participation behavioral restraint standards.

Q. We aren't a receiving facility. When we do get a patient that is a BA, we have to hold them until a bed is available. The floor nurses feel uncomfortable letting this patients' roam the hallways with the sitter. In Risk Mgmt. we thought it would be best to keep them in their room with the sitter because we are not a locked facility and these particular patients can be impulsive. What can you tell me about this? Also, if the patient is waiting for a room at a

receiving facility and the 72 hours is up, does the patient turn voluntary even if he has not received any psychiatric treatment?

Regarding keeping a patient in his/her room for extended periods, this would be considered "seclusion" under the Baker Act and possibly under JCAHO and federal Conditions of Participation. Even hospitals that aren't designated as receiving facilities are required to extend all rights to patients being held under the Baker Act.

394.455(29) "Seclusion" means the physical segregation of a person in any fashion or involuntary isolation of a person in a room or area from which the person is prevented from leaving. The prevention may be by physical barrier or by a staff member who is acting in a manner, or who is physically situated, so as to prevent the person from leaving the room or area. For purposes of this chapter, the term does not mean isolation due to a person's medical condition or symptoms.

Seclusion would require more imminent danger than just the fear that a person would be impulsive

65E-5.180(7) **Seclusion and Restraint for** Behavior Management Purposes. All facilities, as defined in Section 394.455(10), F.S., are required to adhere to the standards and requirements of subsection (7).

(a) General Standards.

3. Seclusion or restraint shall be employed only in emergency situations when necessary to prevent a person from seriously injuring self or others, and less restrictive techniques have been tried and failed, or if it has been clinically determined that the danger is of such immediacy that less restrictive techniques cannot be safely applied.

However, elopement or other adverse behavior may be of real concern as you have a duty to maintain the safety of the patient. A well-trained sitter may be able to encourage a person to voluntarily stay in the room and redirect him/her when necessary. A psychiatric consult could also provide treatment that may reduce the patient's impulsivity or exit seeking behavior.

This problem could generally be resolved by the rapid transfer of a patient to a designated receiving facility. The law requires this to take place within 12 hours of medical stabilization. Hospitals should consider reporting to DCF and AHCA each time they are unable to meet this requirement. You probably keep a log containing the date/time of each call attempting to transfer, name of person talked to, and the response. This documents the hospital's good faith effort to comply with the law, lets the regulatory agencies know the problem exists, and helps on occasion to facilitate the transfer. The DCF Circuit Office would be your contact. DCF Circuits might want to arrange for this to be done by email on a 24/7 basis, since this often occurs on nights or weekends – the Monday morning staff may not have the information to make the report. DCF and AHCA have the right to check on the census at the public and private receiving facilities to ensure they are actually full, not just trying to avoid a transfer. It also alerts AHCA when a hospital-based receiving facility may be refusing or delaying a transfer due to a person's inability to pay -- "reverse dumping".

However, if the patient is still with you after 72 hours and is unwilling or unable (not able to make well-reasoned, willful and knowing decisions about his medical or mental health care, he/she cannot be converted to voluntary status. You also can't stack one BA-52 on top of another. The public receiving facility in your area, even when a bed isn't available, is legally responsible for assisting in the coordination of the patient's care.

65E-5.351 Minimum Standards for Designated Receiving Facilities.

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

In any case, you can't release the patient who still meets involuntary criteria and may not be able to convert to voluntary status. You may just have to assume the risk of keeping the person against the law as compared to releasing the person that may result in a wrongful death.

Q. A nurse case manager at a local hospital had questions about when the clock starts and stops for a person with an emergency medical condition. They received a person by the Sheriff with a Baker Act, but are not a receiving facility. The ER determined that the person did need medical treatment so admitted them. Now that the person is medically stabilized, they have 2 hours to notify the receiving facility and the receiving facility has 12 hours to accept the person or evaluate them and release. What if the receiving facility takes longer than 12 hours and the person wants to sign out AMA and/ or leaves? I assume the police would have the right to pick them up?

The hospital should inform AHCA and DCF if the transfer takes longer than 12 hours, but should never release persons if they meet involuntary examination or involuntary placement criteria. The hospitals are stuck between picking which law suit they want to defend against -- false imprisonment or wrongful death. Their attorneys and risk managers prefer the former.

The Baker Act states that a receiving facility can't hold a person for involuntary examination for longer than 72 hours – it also states the person can't be released without the approval of a psychiatrist, psychologist, or ER physician. Therefore, an AMA shouldn't enter into the equation. A hospital that isn't designated as a receiving facility is required to transfer or authorize the release of the person within the 12 hour period. However, there is no remedy in the Baker Act for something that can't legally happen.

The hospitals should report to DCF/AHCA the date/time of each call attempting to transfer, name of person talked to, and the response. This documents the hospital's good faith effort to comply with the law, lets the regulatory agencies know the problem exists, and helps on occasion to facilitate the transfer. Districts might want to arrange for this to be done by email on a 24/7 basis, since this often occurs on nights or weekends – the Monday morning staff may not have the information to make the report. DCF and AHCA have the right to check on the census at the receiving facilities to ensure they are actually full, not just trying to avoid a transfer. It also alerts AHCA when a hospital-based receiving facility may be refusing or delaying a transfer due to a person's inability to pay -- "reverse dumping".

Most of these complaints occur over weekends and on Mondays, whether it is because the volume is higher or because receiving facilities are slower to accepting transfers over the weekends. DCF and AHCA can also check to see if the receiving facility's discharge rate is the same on weekends as it is on weekdays. If not, the facility may not have discharge planners working on weekends and covering psychiatrists may not be willing to discharge persons for the attending psychiatrists. These are unacceptable practices, given the shortage of publicly funded beds, the high risk of keeping acutely ill persons in ER's, and violation of the liberty interests of persons under the Baker Act.

Most attorneys wouldn't accept a case of false imprisonment on a contingency fee case, nor would a jury recommend for the plaintiff if the hospital correctly documented the acuity of the person and its attempts to transfer the person within the 12 hours.

In the meantime, the hospital should:

- Encourage its emergency physicians to conduct the mandatory initial involuntary examination and release the person when psychiatrically stable.
- Contract with a psychologist to conduct the mandatory initial involuntary examination and release if the emergency physicians aren't willing to do so for liability reasons.
- Have a psychiatric consultant exam and treat the person in the ER so he/she can be psychiatrically stabilized and released.
- Get the receiving facility to conduct the involuntary examination and release.
- Get the receiving facility psychiatrist/psychologist to examine the person at the hospital and file the BA-32 with the court, placing top priority for admission of the person to the first available bed.
- If the person can't be transferred to a receiving facility because of medical reasons, the Baker Act permits a change of venue for the hearing "because of the condition of the patient". [394.4599(2)(c)4]
- Prevent the person from leaving the ER using the least restrictive method:
 - Place into a gown
 - Locate person at back of ER, farthest away from exit doors
 - Provide close observation
 - Provide 1 on 1 if necessary
 - Provide video monitoring
 - Use chemical or mechanical restraints if warranted under the federal Conditions of Participation behavioral restraint standards.

One additional consequence to keeping people in ER's for more than the 12 hours permitted by law is that since the 72-hour clock is ticking once the person's emergency medical condition has stabilized or found not to exist, there is often insufficient time for the receiving facilities to then obtain the 2 expert examinations, the administrator/designee's signature, and file the petition with the court within the 72-hour period. The filing itself can be postponed until the first working day if the 72 hours runs out on a weekend or legal holiday. If the 72-hour period runs out on a weeknight, there may be substantially less than 72 hours in which to get all this done. If not done within the 72 hours, the public defender will get any petition dismissed once it gets to a hearing. It is this issue that has caused some receiving facilities to insist the ER physician stack one BA-52 on top of another. This is clearly illegal – it is the person's right not to have their liberty denied for more than 72 hours for purposes of psychiatric examination – not the facility's right to have 72 hours in which to complete the examinations/filing. When a transfer occurs, these time frames may be somewhat different.

The federal EMTALA law prohibits release of a person with an emergency medical condition (including those of a psychiatric or substance abuse nature) until stabilized for release or transfer. When a conflict between the federal EMTALA law and the state Baker Act law occurs, the federal law prevails. Allowing a person to leave the hospital prior to stabilization would expose the hospital to huge liability of up to \$50,000 per event and possible loss of Medicare and Medicaid. An EMTALA violation doesn't have to result from an adverse incident – just failure to abide by the federal law is sufficient.

Q. If we are full in our psych unit, and timely placement is the focus, are we bound by the 12 hour expectation, or just that we are showing good faith efforts to place?

The 12-hour provision of the Baker Act to transfer a person from a non-designated hospital after the examination and treatment of an emergency medical condition doesn't apply to your hospital because a person in your ER is already in a Baker Act receiving facility. The entire hospital is designated – not just the psychiatric unit. The only way it applies is that you can add the number of hours in which a physician has documented the presence of an emergency medical condition to the 72-hours permitted

for the completion of the involuntary examination before the petition for involuntary placement must be filed with the court.

If you believe that the individual must be transferred from your hospital to another designated receiving facility either before or after being in the ER, you can accomplish that through the receiving facility to receiving facility transfer provisions of the Baker Act, as follows:

394.4685 Transfer of patients among facilities.--

(3) TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.--

(a) A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.

(b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

(c) A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.

(4) TRANSFER BETWEEN PRIVATE FACILITIES.--A patient in a private facility or the patient's guardian or guardian advocate may request the transfer of the patient to another private facility at any time, and the patient shall be transferred upon acceptance of the patient by the facility to which transfer is sought.

Crisis Stabilization Units (CSU's)

Q. Are CSU's governed by EMTALA with the obligation to accept transfers?

EMTALA only applies to hospitals. However, some public receiving facilities are licensed as Class III free standing psychiatric hospitals under chapter 395, FS. If these hospitals accept persons on an unscheduled emergency basis, they are also subject to EMTALA. Public receiving facilities licensed as CSU's under chapter 394 wouldn't be subject to EMTALA.

There is no provision that would require a CSU to accept a transfer. In fact, the statute governing transfers to public receiving facilities clearly states that the "patient may be so transferred upon acceptance of the patient by the public facility" and that the "public facility must respond to a request for the transfer...within 2 working days...".

394.4685 Transfer of patients among facilities.

(3) TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.—

(a) A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.

(b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

(c) A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.

There isn't anything in the rule to contradict or expand on the statutory language other than the following provision that requires a public receiving facility to ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness:

65E-5.351 Minimum Standards for Designated Receiving Facilities.

(1) Any facility designated as a receiving facility failing to comply with this chapter may have such designation suspended or withdrawn.

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

Rules governing Continuity of Care include the following:

65E-5.1304 Discharge Policies of Receiving and Treatment Facilities.

Receiving and treatment facilities shall have written discharge policies and procedures which shall contain:

(1) Agreements or protocols for transfer and transportation arrangements between facilities;

This means that even if the CSU doesn't have the capacity or capability to accept a transfer, it still has an obligation to coordinate the system of care to ensure that people needing service can get it. CSU's were established under state statutes in the late 70's to provide an alternative to more expensive inpatient psychiatric care for indigent persons. As not for profit, tax exempt, state funded programs, they have an obligation to take the lead on serving indigent persons, although demand for service far exceeds the state's available funding. CSU's often have contracts with public and private insurers just as private receiving facilities often have to serve indigent persons due to their medical needs or lack of capacity in the public facilities.

The FAC governing funded Baker Act care is as follows:

65E-5.400 Baker Act Funded Services Standards.

(1) Applicability. Designation as a public receiving facility is required for any facility licensed under the authority of Chapter 395 or 394, F.S., to be eligible for payment from Baker Act appropriations. Designation does not in and of itself represent any agreement to pay for any services rendered pursuant to Chapter 394, Part I, F.S., or this chapter. Public receiving facilities, under contract with the department, serve as a local focal point for district or region public information dissemination and educational activities with other local Baker Act involved entities and public agencies.

(2) Baker Act Funding.

(a) Only public receiving facilities, pursuant to Section 394.455(25), F.S., and only the costs of eligible Baker Act services provided to diagnostically and financially eligible persons may be paid with Baker Act appropriations.

(b) Baker Act services shall first be provided to acutely ill persons who are most in need of mental health services and are least able to pay.

(c) Persons receiving Baker Act funded services must meet financial eligibility criteria as established by the federal poverty guidelines. **Public receiving facilities may provide Baker Act funded services to acutely ill persons who are financially ineligible if the total number of days of service paid for with Baker Act funds for financially ineligible persons does not exceed 20 percent of the total number of days paid for with Baker Act funds.**

(d) An individual's diagnostic and financial eligibility shall be documented on mandatory form CF-MH 3084, Feb. 05, "Baker Act Service Eligibility," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter.

(3) This section applies to all Baker Act funded providers. All services including hospital inpatient facilities, crisis stabilization units, short-term residential treatment programs, and children's crisis stabilization units providing services purchased by the department under this chapter shall be consistent with licensure requirements and must comply with written facility policies and procedures.

There may be language that may be in contract between DCF and CSU's that deals with this subject. Since the state pays for "availability" of services in CSU and detox programs, such programs shouldn't be placing otherwise ensured people into beds funded by the state.

Several years ago DCF required each circuit to work with the receiving facilities and ED's to develop Medical Exclusionary Guidelines for facilities that were unable to provide extensive medical care to persons held under the Baker Act. These guidelines should assist in adding predictability to what types of persons can be served in non-hospital, non-medical acute care psychiatric settings. The DCF circuit offices should take the lead in working with their CSU's as well as private receiving facilities and ED's to resolve local transfer problems.

Q. Does the Baker Act require a CSU to provide a staff member to accompany a patient to an ER while the patient is medically examined or treated?

There is no requirement in law or rule that compels a CSU to provide a staff member to accompany a patient to an ER while the patient is medically examined or treated. CSU's generally will not provide this service as it is the ER's responsibility to ensure the safety of persons in their care. ER's would prefer CSU's to provide this as it substitutes for a one-on-one, shares liability, etc. It is similar to demanding that law enforcement officers remain at ER's because they provide security, their own restraining devices, and are available to provide the transfer to a receiving facility once the patient is stabilized – none of which is a law enforcement responsibility. The federal EMTALA law and the CMS conditions of participation place these duties on the hospital. CSU's aren't staffed or funded to do this and free-standing private psychiatric hospital would be unlikely to extend this service or be expected to do so. A common policy in a given geographic area might help to reduce such conflict.

Q. A question has come up where we are not sure of the requirements for providing medical treatment for clients who are on our Crisis Stabilization Unit.

The Baker Act statute only refers to physical examinations being provided to each person who remains at your facility for at least 12 hours. Other requirements in rule governing medically related services that must be provided by a CSU are as follows:

394.459 (2)(c), F.S. Right to Treatment

Each person who remains at a receiving or treatment facility for more than 12 hours shall be given a physical examination by a health practitioner authorized by law to give such examinations, within 24 hours after arrival at such facility.

However, the rules implementing the Baker Act that apply to all receiving facilities also have certain requirements, as follows:

65E-5.107(2), FAC

(2) Admission.

(a) All persons admitted to a CSU shall be admitted pursuant to chapter 394, part I, F.S., and chapter 65E-5, F.A.C. Each CSU shall provide admission services on a 24-hour-a-day, 7-days-a-week basis.

(b) 2. Initial Assessment.

All persons admitted to a CSU shall be provided a nursing assessment, begun at time of admission and completed within 24 hours, by a registered nurse as part of the assessment process.

(c) Physical Examination. All persons admitted to a CSU shall be provided a physical examination within 24 hours of admission, based on program policies and procedures. The

physical examination shall include a complete medical history and documentation of significant medical problems. It shall contain specific descriptive terms and not the phrase, "within normal limits." General findings shall be written in the clinical records within 24 hours.

- (e) Laboratory Work. Laboratory work and other diagnostic procedures deemed necessary shall be performed as ordered by the physician or psychiatrist.
- (3) Medical Care.
 - (a) The development of **medical care policies and procedures** shall be the responsibility of the psychiatrist or physician. The policies and procedures for medical care shall include the procedures that may be initiated by a registered nurse in order to alleviate a life threatening situation. Medication or medical treatment shall be administered upon direct order from a physician or psychiatrist, and orders for medications and treatments shall be written and signed by the physician or psychiatrist.
 - (b) There shall be no standing orders for any medication used primarily for the treatment of mental illness.
 - (c) Every order given by telephone shall be received and recorded immediately only by a registered nurse with the physician's or psychiatrist's name, and signed by the physician or psychiatrist within 24 hours. Such telephone orders shall include a progress note that an order was made by telephone, the content of the order, justification, time and date.
 - (d) Physical, medical and nursing care standards shall provide for continuity and follow-up of acute medical problems.
 - (e) Referral to Hospital Inpatient Care. The CSU shall have access to a hospital inpatient unit to assure that individuals being referred are admitted as soon as necessary.
 - (f) Transportation. The CSU shall provide or have access to transportation to a hospital inpatient unit on an emergency basis when necessary.
 - (g) Laboratory and Radiology Services.
 - 1. Requirement. The CSU shall provide or contract with licensed laboratory and radiology services commensurate with the needs of the persons receiving services.
 - a. Emergency. Provision shall be made for the availability of emergency laboratory and radiology services 24 hours a day, 7 days a week, including holidays.
 - b. Orders. All laboratory tests and radiology services shall be ordered by a physician or psychiatrist.
 - c. Records. All laboratory and radiology reports shall be filed in the clinical record.
 - d. Specimens. The CSU shall have written policies and procedures governing the collection, preservation and transportation of specimens to assure adequate stability of specimens.
 - 2. Contracts. When the CSU depends on an outside laboratory or radiology clinic for services, there shall be a written contract detailing the conditions, procedures and availability of work performed. The contract shall be reviewed and approved by the CSU director or administrator.

Finally, the Crisis stabilization Unit rules have even more requirements regarding staffing and medically related services:

65E-12.107, F.A.C. Minimum Standards for Crisis Stabilization Units (CSUs).

(1) Emergency Screening. All persons who apply for admission pursuant to section 394.4625, F.S., or for whom involuntary examination is initiated pursuant to section 394.463, F.S., shall be assessed by the CSU or by the emergency services unit of the public receiving facility. Each receiving facility shall provide emergency screening services on a 24-hours-a-day, 7-days-a-week basis and shall have policies and procedures for identifying individuals at high risk. No person can be detained for more than 12 hours without being admitted or released...

(1)(b) Referral. Individuals referred, or to be referred, to a receiving facility under chapter 394, part I, F.S., who also **require treatment for an acute physical condition** shall be delivered

and, if appropriate, admitted to an emergency medical or inpatient service for health care until medically cleared and stabilized to meet the CSU's medical criteria as prescribed in its policies and procedures. Medical clearance shall be documented in the clinical record.

The above rule only permits referral by CSU's to hospitals for emergency medical treatment that has been identified by the CSU as needed – not “medical clearance”. When the emergency medical condition has been medically stabilized, the hospital staff shall then provide documentation of medical clearance of that condition before the person is returned to the CSU. CSU's shouldn't depend on hospital ED's to provide first aid, primary care, or non-emergency interventions.

Additional requirements of CSU's include:

65E-12.106 Common Minimum Program Standards.

- (9) Quality Assurance Program. Every CSU and SRT shall comply with the requirements of section 394.907, F.S.
- (b) Process. The quality assurance program shall conduct two separate complementary review processes on a monthly basis to include peer review and utilization review. The effects of the peer and utilization reviews shall ensure the following:
 - 8. There has been appropriate **handling of medical emergencies.**
- (17) Pharmaceutical Services.
 - (a) Every CSU and SRT shall handle, dispense or administer drugs in accordance with chapters 465, 499, and 893, F.S.
 - (b) The professional services of a consultant pharmacist shall be used in the delivery of pharmaceutical services. Standards, policies and procedures shall be established by the consultant pharmacist for the control and accountability of all drugs kept at the program.
 - (c) Medication Orders. All orders for medications shall be issued by a Florida licensed physician.
- (18) Emergency Medical Services. Every CSU or SRT shall have written policies and procedures for handling medical emergency cases which may arise subsequent to a person's admission. All staff shall be familiar with the policies and procedures.
 - (b) Cardiopulmonary Resuscitation and Choke Relief. All nurses and mental health treatment staff shall be trained to practice basic cardiopulmonary resuscitation (CPR) and choke relief technique at employment or within 6 months of employment and have a refresher course at least every 2 years. There shall be one person on the premises at all times who is CPR certified and proficient in choke relief techniques. Training shall be documented in the personnel record of the employee. Consent for referral and the disclosure of vital information is not required in life-threatening situations.
 - (c) Medical Kit and Emergency Information. A physician, psychiatrist, consultant pharmacist and registered nurse, designated by the program director or administrator, shall select drugs and ancillary equipment to be included in an emergency medical kit. The kit shall be maintained at the program and safeguarded in accordance with laws and regulations pertaining to the specific items included. A list of emergency programs and poison centers shall be maintained near a telephone for easy access by all staff.

Finally, the Florida Administrative Code governing CSU's requires a psychiatrist to provide primary medical coverage and to provide medical treatment as needed by the persons served in the CSU, as follows:

65E-12.105, F.A.C. Minimum Staffing Standards.

- (2)(a) Every CSU and SRT shall have at least one psychiatrist as primary medical coverage as defined in section 394.455(24), F.S. Back-up coverage may be a physician who will consult with the psychiatrist. The psychiatrist or physician shall be on call 24-hours-a-day and will make daily rounds...

(2)(b) The psychiatrist shall be responsible for the development of general medical policies, prescription of medications, and medical treatment of persons receiving services. Each person shall be provided medical or psychiatric services as considered appropriate and such services shall be recorded by the physician or psychiatrist in the clinical record.

(3) Sufficient numbers and types of qualified staff shall be on duty and available at all times to provide necessary and adequate safety and care. The program policies and procedures shall define the types and numbers of clinical and managerial staff needed to provide persons with treatment services in a safe and therapeutic environment.

(4) At least one registered nurse shall be on duty 24-hours-a-day, 7-days-a-week.

(5) At no time shall the minimum on-site available nursing coverage and mental health treatment staff be less than the following for shifts from 7:00 a.m. until 11:00 p.m. to assure the appropriate handling and administration of medication and the completion of nursing assessments:

None of the above requirements can be waived – a CSU must provide them or risk losing its license and/or designation. However, strong linkages between CSU's with hospitals in the community can be negotiated. It is in the interest of nearby hospitals to avoid unnecessary demands on their emergency departments. Some CSU's have gotten support from those hospitals to strengthen their medically related services.

As part of treatment planning, your staff would have assessed the health needs of the individual. While not all of those needs can and should be met while the individual is in your CSU, it is essential that the individual's discharge plan reflect referrals to meet those needs. The referrals could be to a primary care physician, the health department, or to the person's case manager (if one is assigned) to help link the individual with those needed services. Many counties fund health clinics for low income people, along with their medications. There are Free Clinics in many communities or federally funded health clinics providing similar services.

The major difficulty is getting individuals to follow up on these referrals. There is no way to force them to accept the needed medical care – only to make "warm handoffs" that will maximize the chance of the person actually showing up for appointments made for them.

Q. Does a CSU have any responsibility with a patient who was sent to our facility for medical clearance? The ex parte was signed nearly 24 hours prior to the patient arriving in our ED for evaluation. We have exhausted many efforts trying to get the patient to a facility for treatment.

The medical center that first accepted the patient questioned the legitimacy of the ex parte order – this is unacceptable. They need to realize that the purpose of accepting the person is to have a physician or psychologist examine the person to decide if he really does meet the criteria? The initiation is done on the basis of "reason to believe" the criteria are met and in this case was initiated by a circuit court judge who is not a mental health professional.

Regarding the CSU who received the patient from the first medical center sending the man to the ER in the first place, they shouldn't do this for the purpose of "medical clearance" -- only when its nursing staff have identified a person's need for treatment of an acute physical condition, as follows:

65E-12.107 Minimum Standards for Crisis Stabilization Units (CSUs).

In addition to sections 65E-12.104, 65E-12.105, and 65E-12.106, F.A.C., above, these standards apply to CSU programs.

(1) Emergency Screening. All persons who apply for admission pursuant to section 394.4625, F.S., or for whom involuntary examination is initiated pursuant to section 394.463, F.S., shall be assessed by the CSU or by the emergency services unit of the public receiving facility.

Each receiving facility shall provide emergency screening services on a 24-hours-a-day, 7-days-a-week basis and shall have policies and procedures for identifying individuals at high risk. No person can be detained for more than 12 hours without being admitted or released. Everyone for whom involuntary examination is initiated pursuant to section 394.463, F.S., shall receive a face-to-face examination by a physician or clinical psychologist prior to release. The examination shall include a psychiatric evaluation, including a mental status examination, or a psychological status report.

(b) Referral. Individuals referred, or to be referred, to a receiving facility under chapter 394, part I, F.S., who also require treatment for an acute physical condition shall be delivered and, if appropriate, admitted to an emergency medical or inpatient service for health care until medically cleared and stabilized to meet the CSU's medical criteria as prescribed in its policies and procedures. Medical clearance shall be documented in the clinical record.

You may want to check the record to ensure that the CSU hasn't substituted the ER for its own responsibility to provide a nursing assessment, diagnostic testing, etc. Just because it is a non-medically licensed CSU doesn't mean it isn't required by rule to have some level of medical services, including:

Initial Assessment. All persons admitted to a CSU shall be provided a nursing assessment, begun at time of admission and completed within 24 hours, by a registered nurse as part of the assessment process.

Physical Examination. All persons admitted to a CSU shall be provided a physical examination within 24 hours of admission, based on program policies and procedures. The physical examination shall include a complete medical history and documentation of significant medical problems. It shall contain specific descriptive terms and not the phrase, "within normal limits." General findings shall be written in the clinical records within 24 hours.

Right to Treatment (394.459 (2)(c), F.S.)

Each person who remains at a receiving or treatment facility for more than 12 hours shall be given a physical examination by a health practitioner authorized by law to give such examinations, within 24 hours after arrival at such facility.

Minimum Staffing Standards 65E-12.105(2), F.A.C.

Every CSU and SRT shall have at least one psychiatrist as primary medical coverage as defined in section 394.455(24), F.S. Back-up coverage may be a physician who will consult with the psychiatrist. The psychiatrist or physician shall be on call 24-hours-a-day and will make daily rounds...

The psychiatrist shall be responsible for the development of general medical policies, prescription of medications, and medical treatment of persons receiving services. Each person shall be provided medical or psychiatric services as considered appropriate and such services shall be recorded by the physician or psychiatrist in the clinical record.

Many CSU's try to exclude people with canes, crutches and walkers – claiming these to be weapons. This is unacceptable as the person could be provided a wheelchair while in the CSU. We've heard others being prevented access if they have service animals, are incontinent, or morbidly obese. All of these could easily be ADA violations. One additional one is the need for oxygen because the tanks could be used as weapons or the tubing used for self-harm. Again, this may not be valid because of the availability of the small wearable concentrators that many professional consider safe in any setting.

However, certain medical conditions, including those requiring a totally sterile environment may be beyond the ability of CSU's or free-standing psychiatric hospitals to manage. This may be the

situation in which a medical hospital that has a psychiatric unit is the appropriate place to transfer. In that case a medical overlay on to psych unit or a psych overlay on the med/surg unit could be accommodated.

Finally, your emergency physicians could examine the man and release him if he doesn't meet the criteria for involuntary inpatient or involuntary outpatient placement. A transfer to a receiving facility only needs to take place when it appears those criteria are met.

Q. If a CSU sends a patient to an ER for medical clearance, does it have any responsibility for taking the patient back and then arranging for transfer to a more appropriate facility?"

The following provision in the rules applies::

65E-5.351 Minimum Standards for Designated Receiving Facilities.

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

Specific Authority 394.461(4) FS. Law Implemented 394.461(4) FS. History—New 11-29-98.

This places some responsibility on public receiving facilities to assist in placement even if they don't have a bed or the capability of managing the conditions of certain patients.

Q. I serve as Director of Case Management at a general hospital without psychiatric capability. We had a patient admitted for suicide ideation who was medically cleared two days later and all clinical information was faxed to the CSU. The CSU was on overflow and couldn't accept the patient. The CSU in the next county didn't have any beds and a hospital two counties away had a bed, but they didn't have a MD who would accept a self pay patient. The patient has several outbursts, tried to escape and we tried daily to obtain a bed. The local CSU finally accepted the transfer, but the CSU Director stated I should be calling DCF when I have a transfer issue. What is achieved by this?

Lack of capacity and capability at receiving facilities are legitimate reasons for refusing a transfer. However, refusal by physicians to accept self-pay patients is not. EMTALA isn't an issue in your scenario because the patient had been admitted to your facility. However, the person's emergency psychiatric condition had not been stabilized and prompt transfer was obviously needed. It appears that the patient waited 9 days in your hospital after medical clearance -- the Baker Act permits only 12 hours once a physician determines the emergency medical condition has stabilized or doesn't exist.

However, you really can't release a person who continues to meet the involuntary placement criteria because of the patient's safety and your facility's liability. Facilities use one or more of the following interventions:

- Transfer to "a" designated receiving facility able to manage person's medical condition within 12 hours – not the nearest facility. You can go further than just your surrounding counties when necessary.
- Encourage your emergency physicians to conduct the mandatory initial involuntary examination and release the person when psychiatrically stable.
- Contract with a psychologist to conduct the mandatory initial involuntary examination and release if the emergency physicians aren't willing to do so.
- Have a psychiatric consultant examine **and treat** the person in ER to psychiatrically stabilize & release.

- Ask the CSU to conduct the involuntary examination and release.
- Ask for the CSU's psychiatrist / psychologist to examine the person at the hospital and file the BA-32 petition with court, placing top priority for admission of the person to the first available bed.
- If the person can't be transferred to a receiving facility because of medical reasons, the Baker Act permits a change of venue for the hearing "because of the condition of the patient". [394.4599(2)(c)4]. The CSU to file the petition with the court while the patient remained in your care.

I recommend that if a hospital can't meet the 12-hour limit for transfer, staff contact DCF and AHCA to self-report. This does several things:

- Documents your good faith effort to comply with law (log date/time of each call, person spoken to, exact response received)
- Seeks state help in expedited transfer
- Informs regulatory agencies of bed shortages
- DCF and AHCA can verify census at the receiving facilities when they state they are at capacity

The CSU as a designated public receiving facility has certain obligations to assist even if it doesn't have available beds. Chapter 65E-5.351(5), FAC states that "a public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness."

Q. Can a public provider refuse transfers from private provider citing that since treatment has been started it would disrupt \ impact continuity of care? It appears that an individual has clear right under 394 to request such a transfer. Logically, if you can't use a right it doesn't exist. Please advise.

While a public receiving facility has no obligation to accept any particular request for transfer for valid reasons such as availability of beds and programming, refusal of a transfer of an indigent person from a private receiving facility for the reason that "since treatment has been started it would disrupt \ impact continuity of care" wouldn't be acceptable.

Since the law requires persons to be taken by law enforcement to the nearest receiving facility, that means that an indigent person is as likely to be taken to private receiving facilities as to a public facility. Our system has been built on subsequent transfer of such persons to a more appropriate receiving facility when necessary. Not providing access to the state funded beds for indigent persons invites private receiving facilities to give up designation and further reduce capacity of the system.

Assuming the public receiving facilities maintain an average length of stay similar to other CSU's around the state (3-4 days or so) and are not consistently full with financially eligible people (indigent and non-Medicaid), they should be accepting such transfers if the transfer can be made timely enough to obtain the expert opinions needed when an involuntary petition is to be filed. Considering that DCF is paying for availability of beds - not beds actually filled - there may be a financial incentive to keep beds empty. This reduces costs and workload. However, Baker Act dollars are too scarce to waste.

Q. Does a public receiving facility (CSU) in our community have any responsibility to help our hospital find an available bed when a transfer is needed?

Yes. The Florida Administrative Code has the following provision:

65E-5.351 Minimum Standards for Designated Receiving Facilities.

(5) A public receiving facility that is affiliated with a publicly funded community mental health center shall ensure the centralized provision and coordination of acute care services for eligible individuals with an acute mental illness.

While a public receiving facility may refuse a transfer if it doesn't have an available bed, it is still responsible for assisting in finding a bed for persons meeting involuntary criteria. If there is conflict between two free-standing psychiatric hospitals in the same community, (one public and one private) they should work this out on behalf of the people in need of acute care. If the differences are based on patient ability to pay, that shouldn't be the deciding factor. Public receiving facilities have the benefit of tax exempt status as well as having all state Baker Act appropriations. They don't have the choice as to whether or not to work with other community partners to ensure access to acute care services.

Q. Is a CSU allowed to ask for insurance information, from a hospital or another facility, prior to stating if they will accept the patient?

A CSU that is not also licensed as a free-standing hospital, may ask for insurance information from a hospital or other facility prior to deciding whether to accept a referral. One would hope that they are asking for the purpose of maximizing the number of indigent persons accepted rather than seeking out those who are insured and can pay for their care in private receiving facilities. However CSU's that are also licensed under chapter 395, FS as hospitals and are subject to the federal EMTALA law cannot make ability to pay for care a condition for acceptance of a person with an unstabilized psychiatric condition. Any inquiry that could result in the delay or denial of care based on inability to pay could result in a fine of up to \$50,000 and loss of Medicare and Medicaid certification.

Q. We got a call from a hospital ER that they had medically cleared a person whose involuntary examination was initiated by law enforcement, but they were unable to get the two crisis units near them to accept a patient for evaluation since the patient was diagnosed with retardation and only spoke Creole. She had not been taking her medication and she was cutting herself with objects in her room and was violent. Can CSU's refuse to accept patient for evaluation based upon what is on the Baker Act form?

The Baker Act requires a person for whom an involuntary examination has been initiated must be accepted at a receiving facility for the examination to actually be conducted, as follows;

394.462 Transportation.--

(1) TRANSPORTATION TO A RECEIVING FACILITY.--

(j) The nearest receiving facility must accept persons brought by law enforcement officers for involuntary examination.

Law enforcement officers aren't expected to be diagnosticians. They may initiate examinations on some people in which the behavior turns out to be a result of something other than mental illness – medical, developmental, behavioral, etc. However, once the involuntary examination has been done by a mental health professional (physician or clinical psychologist) and the person is found not to have a mental illness as defined in the Baker Act or to not meet the criteria for involuntary placement, the person must be converted to voluntary if eligible, released, or custody under a different statute must be initiated. Having a diagnosis of retardation doesn't preclude a person from also having a co-existing disorder of mental illness. A receiving facility should accept the transfer and have a

psychiatrist or psychologist conduct the examination to determine if the person also has a mental illness and otherwise meets the criteria for involuntary placement.

Q. Can a CSU refuse to accept transfer of indigent persons under the Baker Act from an emergency department if the CSU is at full capacity? Is it appropriate for a CSU to repeatedly refuse to accept transfer of indigent persons under the Baker Act from an emergency department if the CSU is utilizing its bed space for paying persons, such as persons with managed care plans? If not, is there a suggested course of action for emergency department personnel to take?

Statutorily, CSU's serving adults are limited in size to a maximum of 30 beds; those serving minors are limited to 20 beds. The law prevents CSU's from exceeding their licensed capacity by more than ten percent, nor may they exceed their licensed capacity for more than three consecutive working days or for more than seven days in a month. Exceeding these limits would subject persons to a potentially dangerous environment and the CSU to loss of license.

DCF contracts, to the extent of its appropriations, with CSUs for the continuous availability of a certain number of beds (capacity), not on an as-used basis. Therefore, a CSU may be filled to its contract capacity on a specific day with indigent persons (up to 20% of the persons served by a CSU's may be financially ineligible under federal poverty guidelines), while still having beds available for purchase from other funders, including managed care organizations. However, if a persistent problem occurs in accessing care for indigent persons, a complaint should be made to the DCF district office.

Q. What do we do when the public receiving facility won't accept transfers within the 12 hours permitted by law, stating that it has no available beds?

Most CSU's go over licensed capacity on occasion. In fact, chapter 394.87511), F.S. states the following:

Notwithstanding the provisions of subsection (8), crisis stabilization units may not exceed their licensed capacity by more than 10 percent, nor may they exceed their licensed capacity for more than 3 consecutive working days or for more than 7 days in 1 month.

While facilities should attempt to avoid excess census when possible, they are required by statute to accept any person brought by law enforcement for involuntary examination. This may mean quicker assessments of persons on involuntary examination status by a physician or psychologist that would lead to quicker release when appropriate. It may mean tighter criteria for persons on voluntary status. It certainly would mean that the CSU should have criteria established as to when transfers from ED's will be accepted and in what priority order. ED's that routinely transfer inappropriate persons to a CSU should be addressed, as the Baker Act shouldn't be used as a discharge destination for people who may need some type of service but don't meet Baker Act criteria. First priority should be from ED's that aren't associated with a hospital that has psychiatric capability.

Emergency physicians are authorized to conduct the initial mandatory involuntary examinations and release people directly from the ED without transfer of persons to a receiving facility. Hospitals with ED's may wish to contract with a psychologist to perform these exams while the patients are still in the ED and release them directly when appropriate. Other hospitals that have done this have released up to 60% directly, eliminating the need for a transfer to a receiving facility. Some even contract with the public receiving facility's psychologist for this purpose.

Q. Can a public Baker Act Facility refuse to accept a stable patient at any time?

A public receiving facility must refuse any transfer of a patient who requires medical care or treatment beyond that available in a free-standing, non-medical facility. It can also refuse due to non-availability of beds. With regard to medical issues, a person may no longer have an emergency medical condition, but still be unable to be managed in a crisis stabilization unit. The federal EMTALA law requires that the sending hospital obtain the consent of a destination facility prior to the transfer and that all necessary medical information be provided in advance for the facility to ensure its capability to manage the patient's needs.

Q. Are CSU's required to accept the transfer of indigent persons up to its licensed capacity or funded capacity?

CSU's exist to serve indigent persons. The benefits derived by CSU's from their tax exempt status and the state/county appropriated funds place a responsibility on them to coordinate care for persons with acute psychiatric conditions. Failure to do so could be a cause for action against the CSU's designation.

However, those CSU's that don't accept transfers above the DCF funding levels should be aware that DCF is funding beds even when those beds aren't filled – they are funded on an availability basis. The CSU can fill them when census is over the funded level just as they keep the funding received from the state when the census is below the funded level.

DCF can check on the actual census of each publicly funded CSU in the district to determine how many persons were admitted, what percentage were financially eligible, and the average length of stay. If the ALOS exceeds the statewide ALOS, it reduces the number of persons who can be stabilized in the funded/licensed beds. DCF staff might also want to check on the CSU's policies for accepting transfers, specifically whether it accepts up to the licensed or the funded capacity and what priority is placed on whether the transfer is initiated from designated or non-designated facilities

Q. Our hospital recently transferred a person to a CSU on a voluntary basis. We had initially thought to send her on an involuntary basis, but she improved over her stay here and was willing to go voluntarily. The CSU insisted that a Baker Act involuntary form must accompany a person on voluntary status. This seems like a contradiction in terms. Can a CSU require as a condition of acceptance that a person be sent on an involuntary basis?

The law and rules are consistent that a person can be transferred to a CSU on voluntary status. The CSU cannot make it a condition of transfer that the person be sent on involuntary status when the person doesn't meet that criteria. A person may be acutely ill and highly suicidal but still be able to make the decision to seek and consent to treatment.

EMTALA: Insurance & Payment

(AHCA is the final authority on all issues related to EMTALA)

Q. What is “reverse dumping” under the Federal EMTALA law?

This occurs when a sending hospital doesn't have the capability and capacity to handle a type of emergency medical condition (such as child psychiatric emergency) refers to the nearest hospital that does have such capability and capacity, but that destination hospital refuses the transfer or requires proof of ability to pay for care – this is the definition of Reverse Dumping.

A sending hospital, after meeting all other EMTALA transfer requirements, can consider the payment status of the person in determining which facility the person will be sent – hopefully avoiding yet another transfer for the person. The sending hospital can consider state/local plans for how certain special populations are served – thus allowing a lateral or even a downward substitution of care if in accord with the plan. However, it would not allow a destination hospital to refuse a transfer for financial reasons or require pre-certification of insurance or sending of a face sheet with insurance information as a condition of acceptance.

Q. Does the revised version of the Baker Act provide any guidelines on the steps that the Non-Baker Act Receiving facilities should take when Baker Act patients are medically cleared and are waiting for placement but the Receiving facilities are at capacity or will not accept the patients due to payer source issues? What is expected of the Non-Baker Act Receiving facility if the Baker Act 72 hour timeframe expires and the patient is still waiting for placement at a Receiving Facility?

Your hospital still must comply with all requirements related to rights of persons held under the Baker Act, as a condition of licensure:

395.003(5)(a) governing licensure of all hospitals states “Adherence to patient rights, standards of care, and examination and placement procedures provided under part I of chapter 394 shall be a condition of licensure for hospitals providing voluntary or involuntary medical or psychiatric observation, evaluation, diagnosis, or treatment”.

(5)(b) “Any hospital that provides psychiatric treatment to persons under 18 years of age who have emotional disturbances shall comply with the procedures pertaining to the rights of patients prescribed in part I of chapter 394”.

395.1041(6) RIGHTS OF PERSONS BEING TREATED.--A hospital providing emergency services and care to a person who is being involuntarily examined under the provisions of s. 394.463 shall adhere to the rights of patients specified in part I of chapter 394 and the involuntary examination procedures provided in s. 394.463, regardless of whether the hospital, or any part thereof, is designated as a receiving or treatment facility under part I of chapter 394 and regardless of whether the person is admitted to the hospital.

395.1055(5) governing rules and enforcement states “The agency shall enforce the provisions of part I of chapter 394, and rules adopted thereunder, with respect to the rights, standards of care, and examination and placement procedures applicable to patients voluntarily or involuntarily admitted to hospitals providing psychiatric observation, evaluation, diagnosis, or treatment”.

395.1065(4) governing criminal and administrative penalties states “In seeking to impose penalties against a facility as defined in s. 394.455 for a violation of part I of chapter 394, the agency is authorized to rely on the investigation and findings by the Department of Health in lieu of conducting its own investigation”. *[Facility is defined as (10) “Facility” means **any hospital**, community facility, public or private facility, or receiving or treatment facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who appear to have a mental illness or have been diagnosed as having a mental illness. “Facility” does not include any program or entity licensed pursuant to chapter 400 or chapter 429.]*

395.3025 Patient and personnel records; copies; examination.--

(1) Any licensed facility shall, upon written request, and only after discharge of the patient...

(2) This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by the provisions of s. 394.4615.

(3) This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.

Further, your hospital cannot retain a person against his/her will or without express and informed consent for psychiatric examination or psychiatric treatment, with the exception of your obligations under the federal EMTALA law and the state's hospital licensure law.

Regarding the Baker Act and person who have been brought to your ED for medical examination and medical treatment, the following provisions apply:

394.463 Involuntary examination.

(2)(g)A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient placement pursuant to s. 394.4655(1) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient placement or involuntary outpatient placement must be entered into the patient's clinical record. Nothing in this paragraph is intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital prior to stabilization, provided the requirements of s. 395.1041(3)(c) have been met.

(h)One of the following must occur within 12 hours after the patient's attending physician documents that the patient's medical condition has stabilized or that an emergency medical condition does not exist:

- 1.The patient must be examined by a designated receiving facility and released; or
- 2.The patient must be transferred to a designated receiving facility in which appropriate medical treatment is available. However, the receiving facility must be notified of the transfer within 2 hours after the patient's condition has been stabilized or after determination that an emergency medical condition does not exist.

Within 12 hours after a physician has documented an emergency medical condition either has been stabilized or doesn't exist, you must either release the person if not meeting involuntary criteria or transfer that person to a designated receiving facility. Failure to do so can result in liability for your hospital and staff. However, there are frequently times in which no designated receiving facility has both the capacity and capability to accept transfers from medical hospitals. Your reference to a "72-hour" period only applies to receiving facilities. You'll have to work this issue out with your attorneys, risk managers, and compliance officer.

You can consider the following options to expedite the release or transfer of persons who have been brought to your hospital under the involuntary provisions of the Baker Act:

- Examination & release by ED physician if Mandatory Initial Involuntary Exam is conducted and person doesn't meet criteria for involuntary placement.
- Examination and release by contract psychologist or physician

- Have consult psychiatrist treat pending person's transfer or release..
- Retain for medical treatment with psychiatric care by receiving facility.
- Transfer to "a" designated receiving facility able to manage the person's medical condition – not the nearest facility.
- If unable to transfer within the 12 hour period, report to DCF MH Program staff and request assistance in transferring.

This reporting to DCF/MH staff documents that you've tried in good faith to transfer within the legally permitted time frame. Your transfer log maintained in the ED should reflect the date/time of each request for a transfer, which facilities were called, which staff member spoken with, and the exact reason given for refusing the transfer.

As I've covered in Baker Act trainings, hospitals use various methods to retain persons in their ED or medical units awaiting transfers. It is critical that your staff not allow persons held under the Baker Act to depart until a physician or clinical psychologist has performed the mandatory examination and found them not to meet the criteria.

Hospital staff generally use an array of interventions to prevent elopements, including the least restrictive method. Hospitals report using interventions such as:

- Expediting the medical screening and release when possible or transfer when necessary of patient to a receiving facility
- Place into a gown/remove shoes
- Use specialized ID band for persons at risk of wandering or alarm device
- Locate person at back of ER, farthest from exit doors
- Have a secured area where people at risk of wandering or elopement can be held until examined
- Provide close observation – whistles?
- Provide 1 on 1 trained staff if necessary
- Provide video monitoring
- Use chemical or mechanical restraints if warranted under the federal Conditions of Participation behavioral restraint standards.

However, if an individual attempts to elope, hospital staff will always attempt to stop the person from leaving the building, even if it means "hands on". They will generally do the same as long as the patient is on the "premises" of the property. However, once off the premises, staff generally calls on law enforcement to find the person, take into custody, and return the person to the facility. They definitely don't want to chase the patient into oncoming traffic in an attempt to return the individual to the hospital. It is much better to prevent the elopement in the first place. Many hospitals also contract with a local law enforcement agency to have a uniformed officer present at all times in the ED.

You ask what to do when a refusal is related to a payor source issue. This shouldn't happen as Florida's hospital licensure law and the federal EMTALA law prohibit discrimination against a person with an emergency medical condition (including psychiatric and substance abuse emergencies) based on inability to pay.

395.1041 Access to emergency services and care.

(3)Emergency Services; Discrimination; Liability Of Facility Or Health Care Personnel.—

(a) Every general hospital which has an emergency department shall provide emergency services and care for any emergency medical condition when:

1. Any person requests emergency services and care; or
2. Emergency services and care are requested on behalf of a person by:
 - a. An emergency medical services provider who is rendering care to or transporting the person; or

b. Another hospital, when such hospital is seeking a medically necessary transfer, except as otherwise provided in this section.

(d)1. Every hospital shall ensure the provision of services within the service capability of the hospital, at all times, either directly or indirectly through an arrangement with another hospital, through an arrangement with one or more physicians, or as otherwise made through prior arrangements. A hospital may enter into an agreement with another hospital for purposes of meeting its service capability requirement, and appropriate compensation or other reasonable conditions may be negotiated for these backup services.

(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

(f) In no event shall the provision of emergency services and care, the acceptance of a medically necessary transfer, or the return of a patient pursuant to paragraph (e) be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred.

However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

Q. Our hospital is presently not a receiving facility. We have a patient that over the weekend was Baker Acted and subsequently cleared from a medical point of view. The patient is insured with a Managed Care Company. We spoke with the nearest receiving facility and they stated that they had a psychiatric bed but the psychiatrist was not accepting the case because in her opinion the patient could be discharged to an ALF. This psychiatrist knows the patient from previous admissions however she had not evaluated the patient here. Our supervisor spoke with a supervisor at the receiving facility and she was told that she could not find a psychiatrist to accept the patient and that it would need to wait until Monday anyway because Humana was closed and they could not obtain an authorization for the admission. In a case like this can they not accept the patient due to no insurance authorization?

The federal EMTALA law governs the transfer of a person with an emergency medical condition (including emergency psychiatric and substance abuse conditions, even absent any other medical issues) from an ED to a hospital that has the capacity (beds) and capability (programming) to meet the person's needs. If the destination hospital has the capability and capacity, it cannot delay or deny the transfer based on the person's inability to pay for care. In fact, the state's hospital licensing law has the following provision:

395.1041 Access to emergency services and care.

(1)LEGISLATIVE INTENT.—The Legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals and physicians to every person in need of such care. The Legislature finds that persons have been denied emergency services and care by hospitals. It is the intent of the Legislature that the agency vigorously enforce the ability of persons to receive all necessary and appropriate emergency services and care and that the agency act in a thorough and timely manner against hospitals and physicians which deny persons emergency services and care. It is further the intent of the Legislature that hospitals, emergency medical services providers, and other health care providers work together in their local communities to enter into agreements or arrangements to ensure access to emergency services and care. The Legislature further recognizes that appropriate emergency services and care often require followup consultation and treatment in order to effectively care for emergency medical conditions.

(f)In no event shall the provision of emergency services and care, the acceptance of a medically necessary transfer, or the return of a patient pursuant to paragraph (e) be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, **insurance status, economic status, or ability to pay for medical services,** except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(h)A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred.

However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

If there is evidence that the transfer was delayed or denied because of insurance issues or because of inability to pay for care, you may wish to discuss this with the Compliance Officer of your hospital. At that point a decision could be made as to whether or not a report of a possible EMTALA violation should be made to the Agency for Health Care Administration.

Q. Baker Act patients with no insurance often wait for days in our ER for transfer; our private insurance patients get placed quickly. We've called facilities up to 90 miles away that have beds but will not accept the patient due to no insurance coverage.

Hospitals designated as receiving facilities should not ask about the funding status of a patient in need of transfer when determining whether to accept the transfer. The hospital licensure statute states:

395.1041 Access to emergency services and care.--

(3) Emergency Services; Discrimination; Liability Of Facility Or Health Care Personnel.--

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not

require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

While you as the sending hospital, can ask information from the patient after completing your duty under EMTALA, a destination hospital cannot because this could cause a delay or denial of needed specialty care -- referred to as "reverse dumping" under EMTALA. A hospital that isn't designated as a receiving facility is required to transfer or authorize the release of the person within the 12 hour period. However, there is no remedy in the Baker Act for something that can't legally happen. You should inform AHCA and DCF if the transfer takes longer than 12 hours, but should never release persons if they meet involuntary examination or involuntary placement criteria. Sometimes hospitals are stuck between picking which law suit they want to defend against -- false imprisonment or wrongful death. Their attorneys and risk managers prefer the former if they have to choose. The federal EMTALA law prohibits release of a person with an emergency medical condition (including those solely of a psychiatric or substance abuse nature) until stabilized for release or transfer.

It is recommended that hospitals in this situation report to DCF/AHCA the date/time of each call attempting to transfer, name of person talked to, and the response. This documents the hospital's good faith effort to comply with the law, lets the regulatory agencies know the problem exists, and helps on occasion to facilitate the transfer. Districts might want to arrange for this to be done by email on a 24/7 basis, since this often occurs on nights or weekends -- the Monday morning staff may not have the information to make the report. DCF and AHCA have the right to check on the census at the receiving facilities to ensure they are actually full, not just trying to avoid a transfer

Most of these complaints occur over weekends and on Mondays, whether it is because the volume is higher or because receiving facilities are slower to accepting transfers over the weekends. DCF and AHCA can also check to see if the receiving facility's discharge rate is the same on weekends as it is on weekdays. If not, the facility may not have discharge planners working on weekends and covering psychiatrists may not be willing to discharge persons for the attending psychiatrists. These are unacceptable practices, given the shortage of publicly funded beds, the high risk of keeping acutely ill persons in ER's, and violation of the liberty interests of persons under the Baker Act.

In the meantime, the hospital should:

- Encourage its emergency physicians to conduct the mandatory initial involuntary examination and release the person when psychiatrically stable.
- Contract with a psychologist to conduct the mandatory initial involuntary examination and release if the emergency physicians aren't willing to do so for liability reasons.
- Have a psychiatric consultant exam and treat the person in the ER so he/she can be psychiatrically stabilized and released.
- Get the receiving facility to conduct the involuntary examination and release.
- Get the receiving facility psychiatrist/psychologist to examine the person at the hospital and file the BA-32 with the court, placing top priority for admission of the person to the first available bed.
- If the person can't be transferred to a receiving facility because of medical reasons, the Baker Act permits a change of venue for the hearing "because of the condition of the patient".
[394.4599(2)(c)4]

One additional consequence to keeping people in ER's for more than the 12 hours permitted by law is that since the 72-hour clock is ticking once the person's emergency medical condition has stabilized

or found not to exist, there is often insufficient time for the receiving facilities to then obtain the 2 expert examinations, the administrator's signature, and file the petition with the court within the 72-hour period. If not done within the 72 hours, the public defender will get any petition dismissed once it gets to a hearing. It is this issue that has caused some receiving facilities to insist the ER physician stack one BA-52 on top of another. This is clearly illegal – it is the person's right not to have their liberty denied for more than 72 hours for purposes of psychiatric examination – not the facility's right to have 72 hours in which to complete the examinations/filing.

Q. Can receiving facilities request insurance authorization prior to accepting transfers of persons from ER's? Where is this addressed in statute?

This is governed in the hospital licensure law as follows:

395.1041 Access to emergency services and care.--

(3) Emergency Services; Discrimination; Liability Of Facility Or Health Care Personnel.--

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

Q. We had a minor treated in our ER for an overdose. The ER nurse stating that the private receiving facility wouldn't accept her until we got insurance authorization. I got the authorization so that the patient could go, but it resulted in a delay.

The practice you describe appears to be direct violation of state law as well as federal EMTALA. You are obligated to refer such practices to AHCA or be in breach of EMTALA yourself. You may want to run this past your compliance officer or hospital administration before you do so.

CMS defines an emergency medical condition to include psychiatric emergencies and substance abuse emergencies, even absent any other medical conditions. Reverse dumping under EMTALA by a hospital with capability and capacity failing to promptly accept a transfer of a patient with an emergency medical condition from a hospital without such capability and capacity is equal to an ER failing to initially accept a person for medical screening.

395.1041(3) Access to emergency services and care.--

(f) In no event shall the provision of emergency services and care, the acceptance of a medically necessary transfer, or the return of a patient pursuant to paragraph (e) be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

Q. A receiving facility in our area refuses to accept transfers of anyone who is "self pay." Can it do this?

Refusal by a hospital to accept the transfer of anyone with an emergency medical condition (including psychiatric and substance abuse emergencies) who is "self pay," is a clear case of "reverse dumping" under the federal EMTALA law and State law.

395.1041 Access to emergency services and care.--

(3)(f) In no event shall the provision of emergency services and care, the acceptance of a medically necessary transfer, or the return of a patient pursuant to paragraph (e) be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred. However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

Your understanding that after a person's medical condition has been stabilized, the sending hospital may discuss the issue of payment for inpatient psychiatric treatment is correct since it is to everyone's best interest that only a single transfer take place – to a setting where the person's insurance will pay or to a public receiving facility for "self-pays". However, this is up to the sending facility and not to a destination facility to determine.

Q. If an indigent person with an acute psychiatric disorder presents to a private freestanding hospital in need of admission, what is the receiving facility's obligation relative to EMTALA? Can the person be refused admission based upon financial criteria? Can the person be referred to another hospital without the consent of the hospital to which the person is to be transferred?

NO. A freestanding psychiatric hospital that offers psychiatric emergency services must comply with the EMTALA requirements, including the provision of medical assessment and stabilization within the capability of the hospital to any individual presenting to the hospital. The EMTALA law recognizes that certain prearranged community or state plans may identify certain hospitals that will care for selected individuals. When an indigent person presents to a private receiving facility, the initiating facility must comply with the screening and stabilization requirements of EMTALA.

After the screening and stabilization requirements are met, the initiating facility may appropriately transfer an indigent person, in accordance with the transfer requirements of section 395.1041, F.S. and EMTALA, as well as s.394.4685(3), FS of the Baker Act. Transferring a person to another hospital without the prior consent of the hospital to which the person is proposed to be transferred would not be considered an appropriate transfer.

Q. Can a hospital refuse to accept a transfer of a person solely on the basis of the person's indigency?

NO. If the transfer is being sought from a hospital that doesn't have the capacity or capability of conducting an involuntary examination under the Baker Act to a general hospital with psychiatric services or a free-standing psychiatric hospital, and that hospital refuses the transfer because of the person's indigency, it would constitute "reverse dumping" under EMTALA.

Q. If a non-designated hospital makes an error in determining whether or not a person has insurance, can a receiving facility refuse the person due to the person's insurance status?

Once contact is made with a designated receiving facility, whether public or private, by an initiating facility, if that hospital has the capability and capacity to care for the person, the receiving hospital is required to accept the person pursuant to section 395.1041, F.S. and the EMTALA regulations. A private receiving facility may transfer a person (pursuant to the transfer requirements contained in s. 394.4685, F.S., s.395.1041, F.S. and the EMTALA regulations) to a public receiving facility for further treatment after the person has been screened and stabilized.

Q. When the Public Baker Act Facilities have no bed availability, and a general hospital-based receiving facility either refuses to accept or has no bed availability, what is our course of action?

A transfer from an ED can be made to any designated receiving facility – not just the nearest receiving facility. One would hope it will be to a facility where the patient's needs can be met (psychiatric, medical, and financial), eliminating the need for subsequent transfers. A licensed hospital subject to the federal EMTALA law, cannot refuse transfer of a person with an emergency medical condition (includes psychiatric and substance abuse emergencies) due to inability to pay – only due to lack of capability/capacity. In fact, if the hospital goes over census for paying patients, it must do the same for non-paying patients.

If you can't arrange a transfer to a designated receiving facility inside or outside your county within the 12 hours permitted after medical stabilization, your only choice is to notify AHCA and DCF that you're unable to meet your legal requirements; ensuring that you've documented each facility called with the date, time, staff name, and reason for refusal. This, at a minimum, documents your good faith effort to comply with the Baker Act.

Q. A receiving facility (not the nearest to the ER) conditioned the acceptance of a transfer of a patient on a Baker Act upon the pre-payment equal to five days of care. Once she was received, she was allegedly told that she wouldn't be released until she paid the funds owed.

These issues may be involved with the Baker Act (394), the hospital licensing law (395) and the federal EMTALA law.

First is the Baker Act Right to Treatment that requires a receiving or treatment facility to collect appropriate reimbursement for the cost of care, but can't deny care because of inability to pay.

394.459 Rights of Patients

(2) RIGHT TO TREATMENT.--

(a) A person shall not be denied treatment for mental illness and services shall not be delayed at a receiving or treatment facility because of inability to pay. However, every reasonable effort to collect appropriate reimbursement for the cost of providing mental health services to persons able to pay for services, including insurance or third-party payments, shall be made by facilities providing services pursuant to this part.

There is nothing that would keep a hospital from presenting a bill for payment once it had met any EMTALA requirements, as long as the care wasn't being delayed or denied.

The Florida Attorney General has issued a couple of opinions over the years on this subject that are summarized below that place the responsibility for paying for involuntary examination/placement on the patient, except under certain circumstances.

Attorney General Opinion 93-49 Regarding Who is Responsible for the Payment of an Involuntary Baker Act Placement, 1993 WL 384795 (Fla. A.G.) Attorney General Robert A. Butterworth advised the Board of County Commissioners for Lafayette County, FL that the county is not primarily responsible for the payment of hospital costs, however, a county may be liable for hospital costs in the event a person is arrested for a felony involving violence to another person, and the arrested person is indigent. Depending upon the Baker Act patient's ability to pay, the patient is responsible for the payment of any hospital bill for involuntary placement under the Baker Act, however, if the patient is indigent, the Department of Health and Rehabilitative Services (HRS) is obligated to provide treatment at a receiving facility and HRS provides treatment for indigent Baker Act patients without any cost to the county.

Attorney General Opinion 74-271 Regarding Involuntary Hospitalization in Psychiatric Facility. A circuit court judge may order a patient involuntarily hospitalized at a private psychiatric facility not under contract with the State provided that the patient meets the statutory criteria for involuntary hospitalization, the facility has been designated by DCF, and the cost of treatment is to be borne by the patient, if he is competent, or by his guardian if the patient is incompetent. When state funds are to be expended for involuntary hospitalization of a patient in a private psychiatric facility, such facility must be under a contract with the state.

The only time the Baker Act doesn't require a person to be taken to the nearest receiving facility is when medically cleared at an ER prior to transfer to a receiving facility for psychiatric examination as is the circumstances in this case. The Baker Act under these circumstances simply requires that the person be sent by the ER within 12 hours after medical clearance to a receiving facility that has the appropriate medical treatment available.

Access to Care is governed by the state's hospital licensing law in 395.1041, FS. The following provision may be most applicable:

395.1041(3)(e), FS

Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

This section requires transfer to the geographically closest hospital that has the capability (programming) and capacity (bed space), unless another prior arrangement is in place. AHCA has indicated verbally to that such a prior arrangement may be a systematic one or on a case-by-case basis.

A senior attorney from AHCA has written that the federal EMTAL law and the state hospital statute do not require that the transfer be to the nearest receiving facility.

The patient could be held for a period of up to 72 hours for psychiatric examination. Within that time, she would have to be released, converted to voluntary (if willing and able), or a petition for involuntary placement filed with the circuit court. The facility may have anticipated that she would have a five day LOS, based on her presenting symptoms and on the facility's average length of stay. It may have also included the cost of the physician that is billed separately.

Even though the patient and her husband didn't believe she met the criteria for the Baker Act, only a psychiatrist or psychologist could perform the legally required examination and approve her release. This is required to be done "without necessary delay" which isn't defined in the law -- any time within 72-hours would meet the letter of the law, but perhaps not the spirit of the law which promotes the least restrictive available and appropriate setting. On occasion, a person's clinical condition may deteriorate after admission and a longer length of stay might possibly be warranted. However, this should be fully documented in the patient's clinical record. She has a right to access and obtain a copy of the record.

Just because a person is held only for the 72 hours or even less doesn't mean that the person didn't "appear to meet the criteria" specified in law to initiate an involuntary examination. Even if it is determined she in fact did meet each of the other criteria for involuntary placement in terms of acuity of mental illness and either self-neglect or active harm to self or others, but for whom a less restrictive, available and appropriate alternative is identified, she would have to be released.

However, if the patient was indeed told she wouldn't be released unless the money was paid, that would be a direct violation of the law that only allows for up to 72 hours for exam unless a petition is filed. If they had acted on this alleged threat and kept her longer than permitted by law, this might be considered "false imprisonment".

Express and informed consent to admission and treatment is explicitly defined in the Baker Act [394.455(9), FS] as:

"Express and informed consent" means consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion.

Clearly such a demand would be considered as force, duress and coercion.

No person held at this or any receiving facility should be pressured to stay "voluntarily" or for whom a petition for involuntary placement is withdrawn immediately before a court hearing. This pattern exists when physicians don't want to testify at judicial hearings. DCF staff make an unannounced visit to the facility and interview the current patients about their willingness to stay as well as their competence to provide express and informed consent. This means they must have a sustained ability to make well-reasoned, willful, and knowing decisions about their medical and mental health treatment. Otherwise they would have to be held on an involuntary basis that protects their due process rights because they would be assigned a public defender to protect their legal interests. It is unlikely that persons with sufficient acuity to warrant payment by insurers for extended inpatient care would meet this test of competence.

Q. I'm trying to figure out the obligation of managed care organizations to reimburse out of network private Baker Act Receiving Facilities for post-stabilization services. A Baker Act patient comes to a private Baker Act receiving facility that doesn't participate in the patient's plan. The patient / legal guardian doesn't consent to transfer to another private facility and the Public facilities don't consent to the transfer. The Patient has stabilized, but not to the point that the hospital may discharge him. What is our responsibility?

It comes down to contracts between managed care companies and their providers. This might even be directed to the State Insurance Commissioner as well as to AHCA.

The only additional issue to that already addressed specifically in the Baker Act User Reference Guide is that once a person is admitted, EMTALA no longer applies. Since the hospital in question is designated as a receiving facility and it is seeking to transfer the person to another receiving facility on a post-admission basis, the Baker Act transfer provisions apply, as follows:

394.4685 Transfer of patients among facilities.--

(3) TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.--

(a) A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.

(b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

(c) A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.

(4) TRANSFER BETWEEN PRIVATE FACILITIES.--A patient in a private facility or the patient's guardian or guardian advocate may request the transfer of the patient to another private facility at any time, and the patient shall be transferred upon acceptance of the patient by the facility to which transfer is sought.

A private facility can transfer an individual either with consent or, in the absence of consent, on its own power to a public facility. However, in transfers between one private facility and another private facility, the request must be from the patient, guardian, or guardian advocate. No ability for a private facility to initiate an unwanted transfer.

If there isn't any guardian or guardian advocate appointed by the court – usually there isn't especially at an ER – a person's health care surrogate or proxy could also request the person's transfer from one facility to another once a physician found the person to lack capacity to make his/her own health care decisions. This could be any adult relative or friend of the patient if an advance directive hasn't named another party.

Finally, once the emergency condition has been stabilized, there is no reason why the hospital shouldn't make the patient and/or his /her legal representative aware of the related costs of service at the out-of-network hospital that will be the responsibility of the patient to pay and that would be paid by the insurance if service was provided by a network facility.

Q. If a plan does not pay the facility and the facility can't transfer the patient because the patient or legal guardian has not consented to transfer, could the State of Florida assist the facility in getting paid by the plan? If yes, what would be the process? If yes, what would be the reimbursement rate?

No. According to statute, the state of Florida can only reimburse public receiving facilities that have contracts with the State. Private receiving facilities are ineligible for reimbursement.

Q. Transfer of Baker Act Patients without Insurance -- Pursuant to Fla. Stat. 394.4685(3)(b), if a patient is without insurance, can a Baker Act Receiving Facility transfer a Baker Act patient after stabilization without the patient's or legal guardian's consent?

Once all requirements for an appropriate transfer under the federal EMTALA law are met, Chapter 394.4685(3), FS would apply for transfers from private receiving facilities to public receiving facilities. In such cases, the transfer can result from the request of the patient/legal representative or from the private receiving facility. In any case, the acceptance of the patient by the public receiving facility prior to the transfer is required.

Q. Transfer of Baker Act Patients with Insurance -- If the patient is not indigent and/or has commercial insurance, the Baker Act does not address whether a Baker Act Receiving Facility may transfer a Baker Act patient after stabilization without the patient's or legal guardian's consent?

If the patient is stabilized for transfer and all EMTALA requirements have been met, the transfer provisions of the Baker Act apply. The Baker Act doesn't currently address either the transfers from Public to Private receiving facilities or between private receiving facilities without request by the patient or his/her legal representative. Generally, such persons wish to be transferred to a receiving facility at which his/her insurance will pay, but there is no requirement to do so.

Sending hospitals should be aware of what contracts destination hospitals have with various payers to reduce risk of a patient having to undergo subsequent transfers for financial reasons. In addition to EMTALA considerations, Florida's hospital licensure law has the following provisions:

395.1041 Access to emergency services and care.—

(3)(e) Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

(3)(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not

delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred...

At this time, EMTALA no longer applies post-admission or once the emergency medical condition is stabilized (including any emergency psychiatric or emergency substance abuse conditions).

Q. Once a person's emergency medical condition has been stabilized, can hospital personnel inquire about the person's insurance even if the hospital has not psychiatrically screened or examined the person's psychiatric condition?

Effective July 1, 1996, section 395.1041(h), F.S. was amended to allow hospital personnel to inquire as to a person's ability to pay as long as the inquiry does not in any way delay the provision of emergency services and care being provided to the person. This is consistent with EMTALA.

Q. After the determination of the person's insurance status has been made, is it appropriate to transfer the paying persons to the nearest private receiving facility (even if it bypasses a closer public receiving facility) and indigent persons to the nearest public receiving facility (even if other private receiving facilities are closer) for psychiatric screening, examination and placement?

In a non-designated hospital, the transfer destination of a person under the Baker Act to a designated receiving facility, after the person has been medically screened and stabilized, may be decided based on the person's paying status. The transfer must be in accordance with the transfer and consent requirements found in s. 395.1041, F.S., and the EMTALA law.

Q. Clarify where a person should be transferred if the person has insurance, but the nearest private receiving facility is not on the person's insurance plan. Would it be acceptable to bypass the geographically closest private receiving facility and transfer the person to the receiving facility where that person's insurance will act as a source of funding?

Given that the person must be transferred anyway from the non-designated hospital to a designated receiving facility, as long as an appropriate transfer is initiated pursuant to section 395.1041, F.S. and the EMTALA law, then the person may be transferred to the nearest private receiving facility that takes the person's insurance.

Q. If a hospital has a person on involuntary status, must that person be transferred to the nearest receiving facility regardless of facility status and person's insurance?

There is no requirement that the person be transferred to the nearest receiving facility. Obviously, if the nearest receiving facility can meet the person's clinical and financial needs and it has the capacity to accept the person, this is the ideal situation. However, if the nearest facility doesn't have either the capacity (space), capability (psychiatric unit), or the person has insurance that pays only at another facility, the person should be transferred to the next closest receiving facility that does have the capability, capacity, and financial standing. However, no hospital can refuse to accept a transfer solely on the basis of the person's inability to pay for care.

Transfers between receiving facilities are governed by 394.4685 FS and 65E-5.310, FAC as well as by EMTALA if the transferring facility is a hospital. However, transfer from hospitals providing emergency medical treatment that are not designated as receiving facilities are governed by the federal EMTALA law and by 394.463(2)(g) and (h), F.S. In either situation, once the person is at a hospital or receiving facility and all other federal and state laws are met, they can be transferred to the most appropriate facility, rather than the nearest one.

Q. Are there situations where persons might be transferred from a hospital ED to a receiving facility other than the “nearest” facility, if the more distant facility might have better capabilities to treat the person or if person’s financial status otherwise dictates?

The Agency for Health Care Administration has determined that when a transfer from an emergency department to a designated receiving facility must take place and all other EMTALA requirements have been met, the transfer destination may be decided based on the person’s paying status. The person may be transferred to the nearest private receiving facility that takes the insurance of the person, or in the absence of a payment source, the transfer destination of a person may be to a publicly funded receiving facility (CSU) with the capacity and with the capability to manage the person’s medical condition, even if not the closest facility. In any case, the transfer can take place only after the person has been medically screened and stabilized and be in accordance with the transfer requirements found in s. 395.1041, F.S., and the EMTALA law. This requires that the Baker Act receiving facility agree to the transfer prior to the transfer of the person.

Q. If a private facility happens to be the closest receiving facility, but the transferring hospital is informed the facility has no beds or does not take the person’s insurance, should the hospital send the person to the nearest public receiving facility?

A person with no public or private insurance would most appropriately be sent to a public receiving facility because that facility is established for the purpose of serving persons without other sources of payment and multiple transfers are never in the best interest of good care. However, if the person with an emergency mental health condition is at a private receiving facility that has the capability and capacity to meet the person's needs and the person refuses the transfer to a public receiving facility, the hospital doesn't have the right to force such a transfer pursuant to federal law. However, the hospital may bill the person for the cost of care rendered.

Q. Can a private receiving facility that is over its licensed capacity transfer a person who is medically stable but with no insurance to a public receiving facility against the person’s wishes?

Transfers of persons from private to public receiving facilities are governed by s.394.4685(3), F.S. This section of the law allows a person or his/her guardian or guardian advocate to request a transfer and the transfer to take place once it has been approved by the public facility. Further, it allows a private facility to request the transfer if the public facility agrees to accept the transfer. The law gives the public facility up to 2 working days to respond to a private facility's request, although such decisions are routinely made much quicker than this.

However, the private receiving facility is a licensed hospital, and as such, it is also governed by the federal EMTALA law. An emergency medical condition includes psychiatric and substance abuse emergencies. EMTALA is based on the basis that transfers are inherently dangerous and discourages them unless certain criteria are met. These include conducting the medical screening

within the capability and capacity of the hospital to perform, stabilization, agreement of the person or his/her legal representative to the transfer, sharing of all relevant medical records with the destination hospital, approval of the destination hospital, and providing a safe/appropriate means of transportation. Only then can the payment source (or lack of payment) be considered. Transfer of a person who refuses consent can only be performed when the sending hospital doesn't have the capability or capacity to meet the person's needs.

EMTALA requires any hospital that goes over licensed or staffing capacity for any person must do so for indigent persons as well. It cannot make such accommodations just for paying persons. However, if the hospital never goes over census for any person, it is not required to go over census for an indigent person.

In the circumstances mentioned, when an indigent person refuses consent to the transfer at a time when a specified receiving facility is over capacity, the hospital has the capability to meet the person's needs but not the capacity. There is some possible risk of an EMTALA violation by selectively picking an indigent person for the transfer over a paying person, but EMTALA does recognize state/local plans for serving such persons. The only reason for a CSU to exist and receiving state funding is to serve persons who don't have the ability to pay for private care.

Uninsured persons served by a facility may be informed, after the facility has met its EMTALA obligations; that they will receive a bill for the full cost of care they receive at the hospital. Most persons will agree to a transfer if it means they will not get a bill or that the bill will be based on their ability to pay.

Q. If a person arrives at our facility on an involuntary status during non-business hours and we are told that the person has insurance, only to find out on Monday that there is not any insurance, should the public receiving facility in the county where the person originated be contacted, informed of the situation and a transfer initiated? Can the public receiving facility refuse to accept the person when a bed is available and insist that a court order is needed?

With regard to the Baker Act situation you describe, the issue will be governed by the Baker Act transfer provisions as well as by the federal EMTALA transfer requirements.

Regardless of whether it is business or non-business hours, you are required to accept any person arriving at your hospital and provide a "medical screening" within the full capability and capacity of your hospital. Since you are a free-standing psychiatric hospital, this screening would generally be limited to psychiatric issues and nursing assessment. Psychiatric and substance abuse emergencies are considered by the federal government to be emergency medical conditions under EMTALA. If the person meets criteria for involuntary examination or placement under the Baker Act, you can presume the EMTALA transfer requirements will apply. This means that your hospital would stabilize the person for transfer, obtain the person's consent to the transfer, send the person's records to the destination facility, obtain the destination facility's consent for the transfer, and provide for a safe and appropriate method of transportation. Only then has your responsibility under EMTALA been met and issues of payment/insurance can be discussed without risk of an EMTALA violation.

Since you are a designated private receiving facility seeking to transfer a patient to another receiving facility, chapter 394.4685 in addition to EMTALA must also be followed.

Another issue is that there is only 72 hours from the arrival of the person at the first facility in which to conduct the examination. If a petition for involuntary placement has to be filed with the court, it must be done within this period. If an entire weekend has elapsed, another receiving facility might refuse the transfer because it wouldn't have time to get two psychiatrists to examine the person, obtain the

administrator's signature, and file it with the clerk of court in a timely way. In these cases, the original facility may have to keep the person until the court hearing has taken place.

Q. I have had to admit several unfunded involuntary patients to our private receiving facility lately due to the fact that they needed dialysis while treating their mental illness. This happened because several non-receiving facilities refused the patient stating they don't take dialysis patients despite the fact that their facility does provide dialysis services to their medical patients. One of the patients was denied admission at several facilities because of "Having no Beds" yet another (funded) patient was accepted by this same receiving facility.

Some psychiatric units of general hospitals have begun refusing to accept transfers of persons who need medical treatment -- saying that they can't meet the patients' medical needs on their psychiatric units. This may have more to do with staff convenience than it does with capability. These hospitals are licensed as general hospitals and have the benefit of being able to bill Medicare and Medicaid as a result of that licensure. They know that if they receive a patient through their own ED who needs dialysis or other medical intervention, they must provide it. They can't make a distinction between an admission and a transfer from another hospital that doesn't have the capability and capacity to provide this care. A hospital that does have the capability and capacity to treat a person's condition cannot discriminate against a requested transfer of a person from a facility that doesn't have the capability and capacity, based on inability to pay. To do so would be a reverse EMTALA violation. The destination hospital should never request information on the patient's insurance or ability to pay (including pre-cert) in determining whether or not to accept the transfer.

Q. Is it legal for the free standing hospital, a private receiving facility, to refuse to accept the transfer of a medically stable involuntary (BA52) person from a local hospital emergency department based solely on payment source (regular Florida Medicaid) when the referring hospital is not a designated receiving facility and doesn't have the ability / capacity to provide psychiatric services?

A hospital must have both the capability (licensure and programming) and capacity (bed space) to be legally obligated to accept a transfer of a person with an emergency psychiatric condition from another hospital that doesn't have such capability or capacity. However, if it does have both capability and capacity, it cannot refuse an otherwise appropriate emergency due to the person's inability to pay.

Q. Is it legal for the free standing hospital to accept an involuntary (BA52) person presented from law enforcement, take the person to the non-designated local hospital emergency department for medical clearance, and then not accept the person back from the hospital because the person does not have an insurance type the facility can successfully bill (regular Florida Medicaid)?

State hospital licensing law [395.1041(3)(e), FS] governing access to Emergency care states:

Except as otherwise provided by law, all medically necessary transfers shall be made to the geographically closest hospital with the service capability, unless another prior arrangement is in place or the geographically closest hospital is at service capacity. When the condition of a medically necessary transferred patient improves so that the service capability of the receiving hospital is no longer required, the receiving hospital may transfer the patient back to the transferring hospital and the transferring hospital shall receive the patient within its service capability.

Once the general hospital ER stabilizes the person's medical condition, Emerald Coast would be required to accept the patient back as long as it had the capability and capacity to meet the patient's needs. Type of insurance is irrelevant.

Q. Is it legal for the free standing hospital to refuse to accept transfer of a person with Medicaid and Medicare coverage from one of the non-designated hospital emergency departments because the person "used all their Medicare days and now only has Medicaid"?

No. chapter 395.1041(3), FS states:

(f) In no event shall the provision of emergency services and care, the acceptance of a medically necessary transfer, or the return of a patient pursuant to paragraph (e) be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(h) A hospital may request and collect insurance information and other financial information from a patient, in accordance with federal law, if emergency services and care are not delayed. No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred.

Q. Is it legal for the free standing hospital to perform only a "financial screening" of an involuntary (BA52) person presented by law enforcement, refuse to accept the person presented by law enforcement, instruct law enforcement to take the person to the public receiving facility instead, and then notify the public receiving facility after the person is en route?

No. A person cannot have an examination or treatment of an emergency medical condition (even of a psychiatric emergency absent a medical condition) delayed or denied due to inability to pay. Not only is this practice prohibited for hospitals under the federal EMTALA law, it would be a violation of the Baker Act, as follows:

394.459 Rights of patients.--

(2) Right to Treatment.--

(a) A person shall not be denied treatment for mental illness and services shall not be delayed at a receiving or treatment facility because of inability to pay. However, every reasonable effort to collect appropriate reimbursement for the cost of providing mental health services to persons able to pay for services, including insurance or third-party payments, shall be made by facilities providing services pursuant to this part.

394.462 Transportation.--

(1) Transportation to a Receiving Facility.--

(j) The nearest receiving facility must accept persons brought by law enforcement officers for involuntary examination.

Once a law enforcement officer presents a person to a receiving facility for involuntary examination, the officer's responsibility for the person is over. Any subsequent transfer of the patient is the responsibility of the sending facility and must comply with federal and state statutes.

Q. Is it legal for the free standing hospital to require payment up front (i.e. \$2000) before accepting transfer of a person who's payment status is "self pay-exceeding poverty guidelines" from a non-designated hospital or from the public receiving facility when the public receiving facility is at capacity and doesn't have any beds available to admit the person? Related question: Is it legal for the free standing hospital to refuse to accept transfer of an indigent person (meets federal poverty guidelines) from the public receiving facility when the public receiving facility is at capacity, unless the public receiving facility agrees to pay them for the person's services (i.e. \$350/day)?

It would be illegal to delay a transfer from another hospital ER that doesn't have the capability and capacity to meet the person's emergency psychiatric needs because of a requirement for pre-payment of cost. As stated above:

No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer. In addition, a hospital may not require any contractual agreement, any type of preplanned transfer agreement, or any other arrangement to be made prior to or at the time of transfer as a condition of receiving an individual patient being transferred.

Q. Is it legal for the free standing hospital to refuse to accept transfer of a person from the public receiving facility based only on payment source when the public receiving facility is at capacity?

Yes, the federal EMTALA law only governs hospital responsibilities for emergency care and for transfers from one hospital to another. The Baker Act governs transfers between receiving facilities when EMTALA is not an issue, as follows:

394.4685 Transfer of patients among facilities.--

(2) Transfer from **Public to Private** Facilities.--A patient who has been admitted to a public receiving or public treatment facility and has requested, either personally or through his or her guardian or guardian advocate, and is able to pay for treatment in a private facility shall be transferred at the patient's expense to a private facility upon acceptance of the patient by the private facility.

(3) Transfer from **Private to Public** Facilities.--

(a) A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.

(b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

(c) A public facility must respond to a request for the transfer of a patient within 2 working days after receipt of the request.

If a transfer from a public receiving facility that is not a licensed hospital to a private receiving facility is sought, the state's Baker Act requires the person to be able to pay for treatment and such a transfer be prior approved by the private facility.

Q. If a delay or denial of care due to issues of inability to pay occurs, is there a legal obligation to report these incidents to AHCA or some other type of regulatory body since these situations may possibly violate federal or state laws or regulations?

A report to the Agency for Health Care Administration can be made of any violations of federal or state laws governing access to emergency care.

Transportation

Q. An EMT has told our emergency screeners that if a patient tells them in transport she/he doesn't want to go to the ER, they will have to pull over and let him out of the ambulance. The last one told the screener that we have custody of the patient so we could go in the ambulance with the patient and they would assist us. The EMT said that the hospital doesn't have custody until they reach the hospital. The Ambulance Service is run by the hospital. My question is: If medical takes precedent over the mental health, does the medical not start when the EMT takes him from our facility for evaluation/treatment? Can we legally get in the ambulance? Without an ETO for Restraint, how could we hold him /her if they were attempting to get out of the ambulance? Legally, could we obtain an ETO for transport out of the facility? If someone is in a medical crisis we are not equipped to care for them and cannot transport ourselves. Non-emergency transport will not transport anyone on a Baker Act so we have to call an ambulance. We have transported patients to the ER when they are not in crisis but need possible treatment. We always call a report to the ER so they know why the patient is coming and when. When the MHT's arrive with the patient, the ER tells my tech they can't leave until the patient is taken to a room to be evaluated. That can be a lengthy wait. Staffing is difficult enough for the unit and to have staff held at the ER when the hospital has security guards doesn't sound right.

There is no requirement that your staff accompany a person from your facility to a hospital ED and it is a rare occurrence when public or private receiving facilities around the state provide staff for this purpose. Assuming that the person is on involuntary status, that information (or a copy of the initiating form) should be sufficient for EMS to retain the person until arriving at the other end. However, if the person is on voluntary status, EMS may have some concern about risk of "false imprisonment" or "battery" if the person wishes to exit the ambulance and passes the "mini mental status exam".

Most Risk Managers would recommend that when faced with an allegation of false imprisonment or wrongful death, the former could more easily be defended with sufficient documentation than the latter, not to mention the consequences of the decision.

Included at the bottom of this response are the sections out of the EMS statute governing immunity from liability for providing examination or treatment to persons believed to have a life threatening condition who are incapacitated from alcohol, other drugs, or any other condition that could impair the person's judgment.

The federal EMTALA law governs the responsibilities of hospital EDs serving individuals with emergency medical conditions, including those conditions of a psychiatric or substance abuse emergency nature, even absent any other medical condition. The hospital is the responsible party for stabilizing the person's condition, not the person or organization that might have called EMS to

provide the transport to the ED. Your own organization's policies and procedures should answer your question about whether you have the authority to enter the ambulance, but it is questionable why you would do so. As staff of a non-hospital, non-medical, free-standing psychiatric program, you don't have the training to perform the medical examination/treatment for which the person is being sent to the ED. There is no purpose served in accompanying the person in the ambulance. An ETO for restraints or seclusion from your facility physician wouldn't be appropriate unless the physician had first documented the nature and extent of the danger exhibited by the person.

As a CSU regulated by Chapter 65E-12, FAC, you should only be referring individuals to ED's who "require treatment for acute physical conditions". Unfortunately, some CSU's send persons out for "medical clearance", routine diagnostic/laboratory testing, etc. I've enclosed some sections of this rule as it governs CSU responsibility for providing limited medical services:

Minimum Standards for Crisis Stabilization Units (CSUs) (65E-12.107(1), F.A.C.)

Referral. Individuals referred, or to be referred, to a receiving facility, who also require treatment for an acute physical condition shall be delivered and, if appropriate, admitted to an emergency medical or inpatient service for health care until medically cleared and stabilized to meet the CSU's medical criteria as prescribed in its policies and procedures. Medical clearance shall be documented in the clinical record.

Initial Assessment. All persons admitted to a CSU shall be provided a nursing assessment, begun at time of admission and completed within 24 hours, by a registered nurse as part of the assessment process.

Physical Examination. All persons admitted to a CSU shall be provided a physical examination within 24 hours of admission, based on program policies and procedures. The physical examination shall include a complete medical history and documentation of significant medical problems. It shall contain specific descriptive terms and not the phrase, "within normal limits."

General findings shall be written in the clinical records within 24 hours.

Minimum Staffing Standards 65E-12.105(2), F.A.C.

Every CSU and SRT shall have at least one psychiatrist as primary medical coverage as defined in section 394.455(24), F.S. Back-up coverage may be a physician who will consult with the psychiatrist. The psychiatrist or physician shall be on call 24-hours-a-day and will make daily rounds...

The psychiatrist shall be responsible for the development of general medical policies, prescription of medications, and medical treatment of persons receiving services. Each person shall be provided medical or psychiatric services as considered appropriate and such services shall be recorded by the physician or psychiatrist in the clinical record.

Sufficient numbers and types of qualified staff shall be on duty and available at all times to provide necessary and adequate safety and care. The program policies and procedures shall define the types and numbers of clinical and managerial staff needed to provide persons with treatment services in a safe and therapeutic environment.

At least one registered nurse shall be on duty 24-hours-a-day, 7-days-a-week.

If your facility is meeting the above requirements and an individual appears to need treatment for an acute physical condition, I recommend that the person be transferred on an involuntary basis (assuming the criteria is met) and that a copy of documentation of this status be sent with the EMS staff. This should be sufficient to retain the person during transit and at the ED until the person can be returned to your facility.

401.445 Emergency examination and treatment of incapacitated persons.

(1) No recovery shall be allowed in any court in this state against any emergency medical technician, paramedic, or physician as defined in this chapter, any advanced registered nurse practitioner certified under s. 464.012, or any physician assistant licensed under s. 458.347 or s. 459.022, or any person acting under the direct medical supervision of a physician, in an action brought for examining or treating a patient without his or her informed consent if:

(a) The patient at the time of examination or treatment is intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent as provided in s. 766.103;

(b) The patient at the time of examination or treatment is experiencing an emergency medical condition; and

(c) The patient would reasonably, under all the surrounding circumstances, undergo such examination, treatment, or procedure if he or she were advised by the emergency medical technician, paramedic, physician, advanced registered nurse practitioner, or physician assistant in accordance with s. 766.103(3).

Examination and treatment provided under this subsection shall be limited to reasonable examination of the patient to determine the medical condition of the patient and treatment reasonably necessary to alleviate the emergency medical condition or to stabilize the patient.

(2) In examining and treating a person who is apparently intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent, the emergency medical technician, paramedic, physician, advanced registered nurse practitioner, or physician assistant, or any person acting under the direct medical supervision of a physician, **shall proceed wherever possible with the consent of the person. If the person reasonably appears to be incapacitated and refuses his or her consent, the person may be examined, treated, or taken to a hospital or other appropriate treatment resource if he or she is in need of emergency attention, without his or her consent, but unreasonable force shall not be used.**

(3) This section does not limit medical treatment provided pursuant to court order or treatment provided in accordance with chapter 394 or chapter 397.

401.45` Denial of emergency treatment; civil liability.

(1)(a) Except as provided in subsection (3), a person may not be denied needed prehospital treatment or transport from any licensee for an emergency medical condition.

(b) A person may not be denied treatment for any emergency medical condition that will deteriorate from a failure to provide such treatment at any general hospital licensed under chapter 395 or at any specialty hospital that has an emergency room.

(2) A hospital or its employees or any physician or dentist responding to an apparent need for emergency treatment under this section is not liable in any action arising out of a refusal to render emergency treatment or care if reasonable care is exercised in determining the condition of the person and in determining the appropriateness of the facilities and the qualifications and availability of personnel to render such treatment.

(3)(b) Any licensee, physician, medical director, or emergency medical technician or paramedic who acts under the direction of a medical director is not subject to criminal prosecution or civil liability, and has not engaged in negligent or unprofessional conduct, as a result of the withholding or withdrawal of resuscitation from a patient pursuant to this subsection and rules adopted by the department.

Many of your questions are unrelated to the Baker Act and should more appropriately be directed to the Department of Health that governs EMS services or to your own organization's attorney.

Q. Should we avoid voluntary transfers based on transport companies being prone to release voluntary transfers if patients wish to be released during transports? It seems to be that to avoid any liability all patients should be Baker Acted.

While you wouldn't ever misrepresent a person's condition in sending under involuntary conditions if he/she didn't appear to meet the criteria, your hospital and physician remain liable for the person's stabilization until he/she is accepted at the destination facility. Further, some medical transport companies will not retain a person on voluntary status who insists on being released. Most people believe that "legal restraints" assist in avoiding a person leaving AMA during medical transport.

Individuals have the right to be on voluntary status if they not only desire this, but are clearly able to make well-reasoned, willful, and knowing decisions about their health and mental health care – definition of express and informed consent. However, many sending hospitals are cautious about transferring persons with psychiatric emergencies without "legal restraints" because transport companies are prone to release individuals on voluntary status at any time they change their minds during the transport and withdraw their consent. The sending hospital and emergency physician remain liable under the federal EMTALA law for not only arranging safe and appropriate transport to a specialty hospital, but for the safety of the individual until acceptance at the destination facility.

Most emergency physicians and hospital administrators wish to send on an involuntary basis to ensure the individual will not be prematurely released and will be accepted on the other end, so the psychiatric examination that has been initiated can actually be provided. You may want to run this by the Risk Manager or Compliance Officer at your hospital.

Q. Can Baker Act patients refuse to be transported to a Receiving Facility from an ED that is not a Baker Act Receiving Facility? The Baker Act Handbook tells us the patient does not have to consent (although this obviously desirable) and can therefore be transported in spite of their refusal. Is this interpretation accurate?

Yes. If a hospital has no licensed psychiatric beds, it doesn't have the capability of meeting the needs of a person with an emergency psychiatric condition (an emergency medical condition under EMTALA). Therefore, after all other conditions of an appropriate transfer have been met, a physician at that hospital's ED can certify that that benefits of the transfer outweigh the risks and transfer the person without the person's consent or that of their legal representative.

Q. Who is responsible for transporting persons under the Baker Act from an ER to receiving facilities?

The transferring hospital is responsible for arranging a safe and appropriate method to transport a person to a receiving facility, as required by EMTALA, regardless of whether the receiving facility is nearby or in a remote location.

Q. If a person is at a receiving facility and requests transfer to another receiving facility due to their insurance or because they are indigent, who is responsible for arranging and paying for the transportation? There has been a community agreement that if the patient is going to a facility that is contracted with their insurance, the facility that will be receiving the patient will arrange for the transportation (usually getting the insurance to pay for the transport). If the patient is going to a CSU then the sending facility arranges for the transport. However, we understand that EMTALA states it is the sending facility's responsibility to provide transportation for the patient. Who should be arranging and paying for the transfer?

The issue you raise isn't governed solely by the Baker Act – it is primarily governed by the federal EMTALA law. EMTALA requires that in order for a transfer to be appropriate, the sending hospital is responsible for **arranging** safe and appropriate transportation, among other requirements. If the

“arrangement” is for the destination facility to voluntarily pay for the transportation cost, that might meet the federal requirement. It certainly seems to be a reasonable and fair method of allocating the costs, but the practice would need to be reviewed by AHCA and CMS. In any case, such a transfer between receiving facilities would require the person’s consent to the transfer and the destination facility’s prior agreement to accept the person.

All transport of persons being transferred from non-receiving facility hospitals to receiving facilities are governed by EMTALA rather than the Baker Act. In these situations, a physician can certify the necessity of the transfer (when the person is refusing to consent to the transfer) because the sending hospital doesn’t have the capability to provide the psychiatric examination and treatment. Most non-receiving facility hospitals consider it their responsibility to provide for the transfer of the person to a receiving facility.

Law Enforcement

Q. Can an ER discharge persons who have been brought to the hospital by law enforcement directly back to law enforcement once they have been medically treated and cleared, without notifying a designated receiving facility? Does the hospital have to inform the receiving facility of the person’s medical condition and get permission prior to the transfer?

The Baker Act allows in s.394.463(2)(g) for an emergency physician at a hospital where a person has been taken for evaluation or treatment of an emergency medical condition to conduct the "Initial mandatory involuntary examination" and to determine that the person doesn't meet the criteria for involuntary inpatient or involuntary outpatient placement. In such cases, the emergency physician is authorized to offer voluntary placement to a competent person if appropriate or to release the person directly from the hospital. There is no requirement that the physician in such cases contact a receiving facility.

The hospital's responsibility under EMTALA is to conduct a medical screening within the facility's capability and capacity to determine if an emergency medical condition exists (includes psychiatric and substance abuse emergencies). If the physician at the hospital doesn't determine an emergency exists, EMTALA no longer applies. However, if such an emergency exists, the person cannot be released or transferred until stabilized. For a transfer to be appropriate under EMTALA a number of requirements exist, including the consent of the person or physician certification, prior transfer of all records, prior approval by the destination facility, and providing a safe/appropriate method of transportation.

A law enforcement officer's duty is over once he/she has presented the person and the required paperwork to the ER where the person has been taken for evaluation or treatment of an emergency medical condition. Law enforcement agencies are under no obligation to further transport the person after medically cleared. That is the duty of the hospital under EMTALA.

Q. We recently had a patient who was Baker Acted by a police officer and taken to an ER that is not a receiving facility by EMS for medical clearance. The ER physician called the officer back to transport the patient to a receiving facility after he was cleared, and was upset that the officer did not stay with the patient the whole time he was in the ER. In addition, the ER physician had the officer take the patient to another ER that is a receiving facility without calling ahead to be certain a bed was available. The sending ER physician documented very carefully that the patient was medically stable and was only being transported to another ER because of his involuntary status. Is the officer required to transport and should the officer

have stayed with the patient in this case? Did the ER physician do the correct thing by sending this patient to another ER that is a receiving facility?

You've described a series of EMTALA violations that should be reported to AHCA for investigation. A law enforcement officer is required to take a person under involuntary examination status to the nearest designated receiving facility. One exception to this is when the officer believes that a person has an emergency medical condition as defined in s.395.002, FS, regardless of whether the hospital is a designated receiving facility. This should not be for "medical clearance" – it should only be for an emergency. If an individual is taken to a crisis stabilization unit and found by nursing staff to "require treatment for an acute physical condition", the person shall be delivered and, if appropriate, admitted to an emergency medical or inpatient service for health care until medically cleared and stabilized to meet the CSU's medical criteria as prescribed in its policies and procedures".

If officers are taking individuals to ER's for "medical clearance" instead of for emergency medical conditions, they should receive training. If CSU's are refusing to accept individuals on involuntary status from law enforcement and requiring officers to further transport a person for "medical clearance", a violation of the Baker Act would have occurred.

The Baker Act law and rules are very specific about a law enforcement officer's responsibility. It is to take a person into custody when an involuntary examination has been initiated and to take the person to the nearest receiving facility. If the person has an emergency medical condition as described above, the person can be taken to a non-designated hospital ER. However, at that time the EMTALA law takes effect and governs the medical screening, stabilization and transfer processes. In no case is a law enforcement officer tasked with the responsibility for providing security at the hospital, as this is part of the stabilization requirement of the hospital. It is also not the officer's responsibility to provide secondary transfer of the individual from the hospital to the receiving facility – arranging for the safe and appropriate transfer lies with the hospital. Law enforcement transfer of a person under EMTALA from one hospital to another may be an EMTALA violation.

The physician needs to be informed that psychiatric emergencies and substance abuse emergencies are "emergency medical conditions" under the federal EMTALA law. Persons with such conditions, even absent any other medical condition, have the same rights and the facilities/physicians have the same responsibilities as if the individual had instead suffered a head injury or a heart attack.

EMTALA requires that any transfer of a person with an emergency medical condition (including psychiatric and substance abuse emergencies) can only take place after the receiving hospital has authorized the acceptance of the individual. Even the Baker Act transfer provisions require that the destination receiving facility provide prior consent to the transfer. Further, s.394.463(2)(h)2, F.S. only permits a transfer of a person from an ED to a receiving facility at which appropriate medical treatment is available. This can only be ascertained by prior contact with the designated receiving facility.

In response to your specific questions:

1. Is the officer required to transport and should the officer have stayed with the patient in this case? **No**
2. Did the ER physician do the correct thing by sending this patient to another ER that is a receiving facility? **Not unless prior approval was obtained from the receiving facility**

Communication with EMS is important so the protocols they follow are also consistent with the law. Obviously, a person with a medical emergency needs to be taken to the nearest hospital ED that is equipped to manage the condition. However, the Baker Act doesn't address EMS taking persons

under involuntary status to the nearest “receiving facility” – only law enforcement personnel are specified in this law.

Q. If an LEO brings a patient to an ED for medical clearance and that LEO is willing to transport the patient to the nearest receiving facility is that acceptable? I know that in the Baker Act Statute it states that the facility that is medically clearing is responsible for the safe transport of the patient. Would that at all play into EMTALA and the fact that although a “medical” emergency may be cleared the patient is still considered to have a “psych” emergency?

While any formal interpretation of EMTALA would need to come from the Agency for Health Care Administration, AHCA staff has provided a written interpretation of this issue. She says that a transfer of a person with an emergency medical condition (EMC), even of a psychiatric or substance abuse nature, from one hospital ER to another hospital requires safe and appropriate transport, including proper medical personnel:

It is improper transferring with an officer when the patient is "unstable and being transferred from a hospital to a hospital". EMTALA laws state that the hospital must conduct a proper transfer with proper medical personnel.

The public receiving facility in your locale is a free-standing adult psychiatric hospital licensed under chapter 395, FS. Thus a transfer of an adult from your hospital ER to the receiving facility would be a hospital to hospital transfer. The receiving facility also has a children’s crisis stabilization unit that isn’t licensed as a hospital and other provisions might be possible for method of transport.

“Willingness” of the officer to perform the transfer isn’t the issue – such willingness at the request of the hospital wouldn’t relieve the hospital of its obligations under the federal law.

If the Baker Act involuntary examination is still in effect at the time of the transfer, one must presume that the patient isn’t psychiatrically stable and thus the EMC is still in effect. Of course, even absent the issue of method of transport, all other requirements of an appropriate transfer would still be required including providing all medical records to the destination hospital and obtaining prior approval of the transfer.

Since your hospital is also a receiving facility, once all EMTALA responsibilities have been fulfilled, the Baker Act transfer provisions would also apply. Transfer from a private receiving facility to a public receiving facility

394.4685 Transfer of patients among facilities.--

(3) TRANSFER FROM PRIVATE TO PUBLIC FACILITIES.--

(a) A patient or the patient's guardian or guardian advocate may request the transfer of the patient from a private to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility.

(b) A private facility may request the transfer of a patient from the facility to a public facility, and the patient may be so transferred upon acceptance of the patient by the public facility. The cost of such transfer shall be the responsibility of the transferring facility.

Q. A response to a question in the Baker Act Handbook about Receiving Facilities Responsibilities states that the officer's duty is only to transport and to stay with the individual ONLY IF "...acting in a dangerous manner, beyond the ability of the hospital to manage...", otherwise one can assume that the officer does not need to stay. This is clear; however, the

section makes no reference to children under a BA, MA or on police hold. There are times when children under the age of 14 are brought into the children's ED under a BA,MA and/or police hold (which means I can't take them in Psy ED) and they have to wait for admission to the children's unit. Most of the time officers are willing to stay with the child, sometimes not. Is it the responsibility of the children's emergency department to secure the child that is on a police hold?

It is the responsibility of the hospital ER to stabilize any person, regardless of age. This includes prevention of elopement as well as any other type of harm while in the custody of the hospital or a receiving facility.

Even the Handbook reference to the officer staying during an emergency is citing standard practice; not any requirement from the Baker Act, EMTALA, or other local, state, or federal standard. It shouldn't be used to transfer responsibilities from the staff of the hospital to maintain the safety of its patients to law enforcement whose only legal responsibility is to take a person into custody and deliver to the nearest receiving facility (or hospital).