# CRISIS HOLDS: Handling Residents Who Need Hospital Help

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(7-24)



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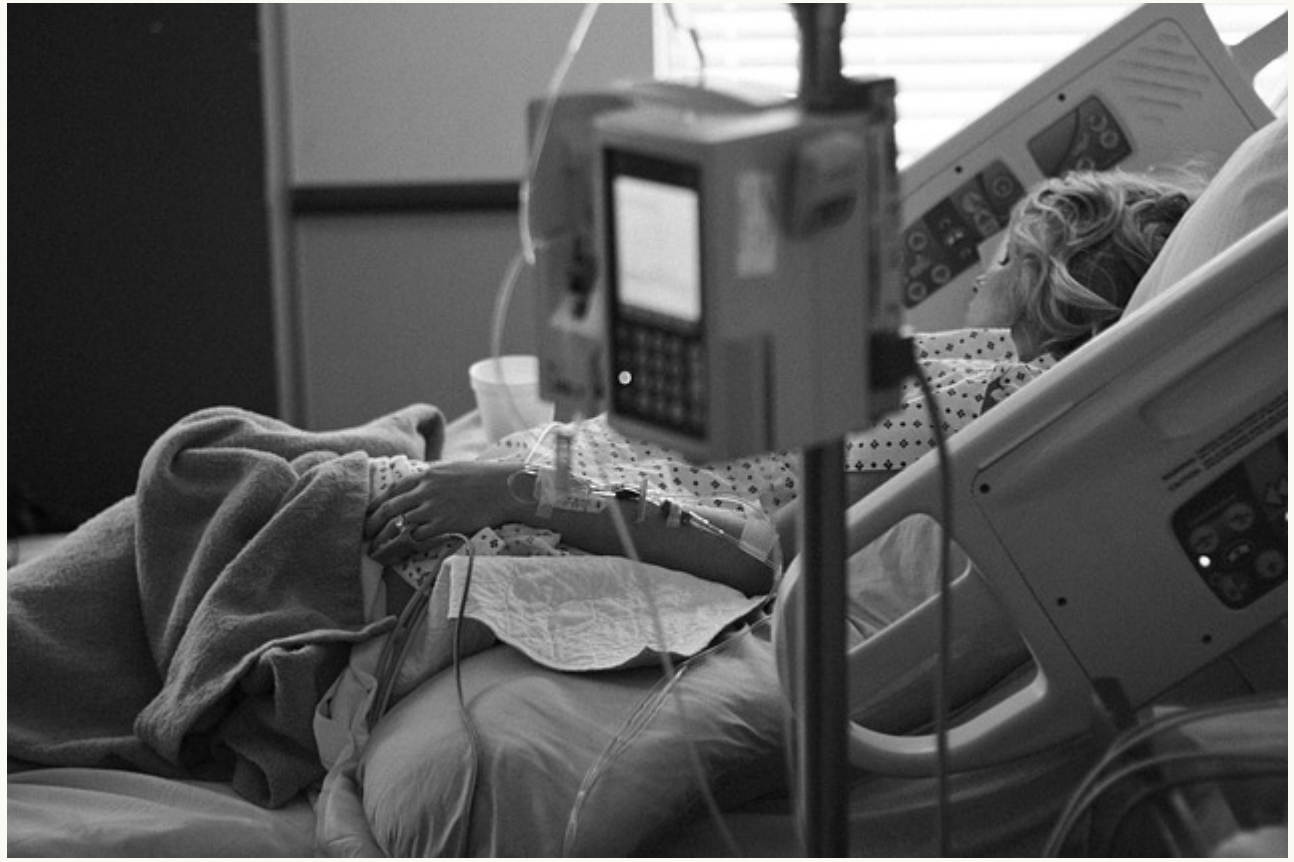
# Overview

- Background
- Legal overview
  - Treatment with consent
  - Mental holds
  - Crisis holds
- How emergency room physicians handle residents who are brought to the hospital
  - What we do
  - What you can do
- Accepting the return of residents

# Background S1247

- Why do we need this new law?
  - S1247: Protective Placement holds for individuals experiencing neurological crises
  - *The person must have a major neurocognitive disorder and pose a substantial risk of causing serious physical harm to themselves or others, as evidenced by behavior or clinical evidence.*
  - Patient focused

# Medical Treatment for Residents



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# Transferring Resident for Medical Care

## SKILLED NURSING FACILITY

- "The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

  (A) The transfer … is necessary for the resident's welfare and the resident's needs cannot be met in the facility;…

  (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident…."

(42 CFR 483.15(c))

## ASSISTED LIVING FACILITY

- "Each resident must have the right to be transferred or discharged only for medical reasons, for their welfare or that of other residents…."

(IDAPA 16.03.22.550.20)

- "The facility must have policies addressing … transfer of residents to, from, or within the facility."

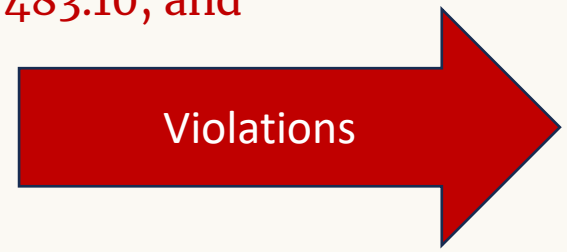
(IDAPA 16.03.22.152.02)

# Consent for Treatment

- General Rule: must have informed consent from resident or personal rep.

(IC 39-4503; IC 39-3316(12); 42 CFR 483.10; and IDAPA 16.03.22.550.12)

- Potential exceptions:
  - Emergency.
  - State authorizes care without consent, e.g.,
    - Mental hold.
    - Crisis hold effective 10/1/24.




- Acting without consent or authorization
  - Lawsuit (e.g., lack of informed consent, malpractice, battery, breach of contract, etc.)
  - Criminal action
  - Adverse administrative or licensure action (e.g., professional or facility license, Medicare regs, etc.)
  - Other?

# Consent:
# Adults and Emancipated Minors

- "PERSONS WHO MAY CONSENT TO THEIR OWN CARE. Any person, including one who is developmentally disabled … who comprehends the need for, the nature of, and the significant risks ordinarily inherent in any contemplated health care services is competent to consent thereto on his or her own behalf."

(IC 39-4503)

- "Consent to treatment includes refusal to consent to treatment."

(IC 39-4502)

# Consent: Incompetent Persons

- "PERSONS WHO MAY GIVE CONSENT TO CARE FOR OTHERS. (1) Consent for the furnishing of health care services to any person who is not then capable of giving such consent … may be given or refused in the order of priority set forth hereafter; provided however, that … the surrogate decision-maker shall not have authority to consent to or refuse health care services contrary to such person's advance care planning document or wishes expressed by such person while the person was capable of consenting to his or her own health care services:
  - (a) The court-appointed guardian of such person;
  - (b) The person named in another person's advance care planning …
  - (c) If married, the spouse of such person;
  - (d) An adult child of such person;
  - (e) A parent of such person;…
  - (g) Any relative of such person;
  - (h) Any other competent individual representing himself or herself to be responsible for the health care of such person.

(IC 39-4504)

# Consent: Incompetent Persons

- "(i) If the person presents a medical emergency or there is a substantial likelihood of his or her life or health being seriously endangered by withholding or delay in the rendering of health care services to such person and the person has not communicated and is unable to communicate his or her wishes, the attending health care provider may, in his or her discretion, authorize or provide such health care services, as he or she deems appropriate, and all persons, agencies, and institutions thereafter furnishing the same, including such health care provider, may proceed as if informed valid consent therefor had been otherwise duly given."

(IC 39-4504)

# Consent: Minors

- Must obtain consent from parent or guardian before providing health care services to an unemancipated minor.
- Parents may sue person who provides care without obtaining parental consent.
- Exceptions:
  - Minor is emancipated.
  - Blanket consent (whatever that means…)
  - Court order.
  - Life threatening emergency and parents are unavailable.

(IC 32-1015)

# Emergency Medical Treatment and Active Labor Act (EMTALA)

- If resident comes to hospital, hospital must provide:
  - Medical screening exam to determine if resident has an emergency medical condition;
  - Stabilizing treatment; and/or
  - Appropriate transfer to another facility.
- Subject to consent/refusal of consent.

- EMTALA obligations end if:
  - resident does not have emergency medical condition;
  - resident is stabilized even if emergency condition remains;
  - resident is admitted as inresident; or
  - resident or personal rep refuses care.

(42 USC 1395dd; 42 CFR 489.24)

# What if resident refuses consent?


- Competent resident generally has right to refuse care.
  - Document refusal.
- Incompetent resident generally lacks capacity to consent to or refuse care.
  - Look to personal rep.
  - In emergency, provide needed care while seek consent from surrogate.
- If resident is competent, does not have personal rep, personal rep refuses needed care, and resident poses risk to himself or others…?

# Mental Holds v. Crisis Holds

## MENTAL HOLD

- Mentally ill, i.e., "a condition resulting in a substantial disorder of thought, mood, perception, or orientation that grossly impairs judgment, behavior, or capacity to recognize and adapt to reality and requires care and treatment at a facility or through outpatient treatment."
- Not neurological disorder, neurocognitive disorder, developmental disability, physical disability, or any medical disorder.

(IC 66-317(11))

## CRISIS HOLDS (Effective 10/1/24)

- Neurocognitive disorder, i.e., "decreased mental function due to a medical disease other than a psychiatric illness, including Alzheimer's disease; frontotemporal lobar degeneration; Lewy body dementia; vascular dementia; traumatic brain injury; inappropriate use or abuse of substances or medications; infection with human immunodeficiency virus; Prion diseases; Parkinson's disease; or Huntington's disease."
- Not decreased mental function due to substance abuse or medications.

(IC 56-1903 and 66-317(13))

# Mental Holds v. Crisis Holds

## MENTAL HOLD

- Purpose: transfer and/or hold resident at hospital for evaluation and, if necessary, initiation and pendency of commitment proceedings.

(IC 66-326)

- Long-term solution.

## CRISIS HOLD

- Purpose: transfer and/or hold resident at hospital for short term to evaluate and address "acute crises due to an underlying medical condition."

(IC 56-1905)

- Temporary response.

# Mental Holds

- Police may detain person and take to hospital and/or hospital APP may detain resident if person "is gravely disabled due to mental illness or the person's continued liberty poses an imminent danger to that person or others."
  - "Gravely disabled" = as the result of mental illness, has demonstrated an inability to attend to basic physical needs; protect himself from harm; exercise sufficient behavioral control; or recognize that he is experiencing symptoms of a serious mental illness and lacks the insight into his need for treatment.
  - "Likely to injure himself or others" = a substantial risk that physical harm will be inflicted by the proposed resident upon his own person or on others.

(IC 66-326 and 66-317)

# Mental Holds

- Police or hospital must seek court order within 24 hours.
- If ordered by court:
  - Obtain evaluation by designated examiner.
  - Conduct commitment proceedings.
  - Person committed to custody of state.
- If determined not to be gravely disabled or pose risk to self or others, person is released.

(IC 66-326 to -329)

- In no event can person be detained under the "mental hold" statute for neurocognitive disorder.

(IC 66-329(13))

# Crisis Holds
# Effective 10/1/24

- Police may detain and take person to hospital or hospital healthcare provider may detain person to receive medical care if:
  - Have reason to believe the person has a neurocognitive disorder and
  - The person is "likely to injure themselves or others," i.e., substantial risk that serious physical harm will be inflicted by the person upon himself/herself or person lacks insight and unable or unwilling to comply with treatment such that person will, in reasonably near future, inflict serious physical harm on themselves or others.

(IC 56-1904)

# Crisis Holds
# Effective 10/1/24

- Someone must seek court order for temporary hold within 24 hours.
- Court may order evaluation by hospital healthcare provider, e.g., physician, PA, or APRN.
- If exam concludes person no longer meets criteria for crisis hold, person is treated as voluntary patient and may be released.
- If person meets criteria for protective hold, prosecutor files petition to continue hold pending protective placement.
- Friend, relative, spouse, guardian, healthcare provider, prosecuting attorney, or director of facility may apply for emergency protective placement to address "acute crisis due to underlying medical condition."
- Hearing to determine stay.
- Court may order protective custody at hospital for observation, care and treatment for up to 7 days.

(IC 56-1905)

# Crisis Holds
# Effective 10/1/24

*But what happens at end of 7 days…?*

- Obtain consent from patient or personal rep for continued hospital care?
- Return to facility?
- Transfer to another appropriate care setting?
- Other?

# Resident's Medical Care: Summary

- If resident is competent, rely on and document resident's consent/refusal unless resident fits criteria for mental hold or crisis hold.
- If resident is incompetent:
  - Provide needed emergent care consistent with resident's prior expressed wishes;
  - Seek consent from surrogate; and/or
  - Contact police or hospital to initiate:
    - Mental hold, if resident is mentally ill and either gravely disabled or likely to injure self or others.
    - Crisis hold if resident has neurocognitive disorder and is likely to injure self or others.

# Management of Geriatric Patients with Behavioral Issues in the ER

DR. JESSICA KROLL

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# Demographics and Epidemiology

**Aging Population Statistics:**

- The global population aged 65 and older is projected to reach 1.5 billion by 2050, nearly doubling from 2020.
- In the United States, the population aged 65 and older is expected to grow from 56 million in 2020 to 84 million by 2050.
- Prevalence of behavioral issues among elderly patients

**Impact on ER Services:**

- Geriatric patients account for about 15% of all emergency department (ED) visits in the United States.
- Common behavioral issues encountered

# Common Behavioral Issues in Geriatric Patients

**Types of Behavioral Issues:**

- Delirium
- Dementia-related behaviors
- Anxiety and depression
- Aggression and agitation

**Causes and Triggers:**

- Medical conditions (e.g., infections, metabolic imbalances)
- Medications
- Environmental factors (e.g., unfamiliar surroundings)

# Initial Assessment and Triage

**Comprehensive Assessment:**

- Medical history and current medications
- Physical and neurological examination
- Mental status evaluation

**Triage Considerations:**

- Prioritizing based on severity
- Immediate interventions for safety

# Diagnostic Workup

**Essential Diagnostic Tests:**

- Blood tests (e.g., CBC, electrolytes)
- Imaging studies (e.g., CT scan, MRI)
- Other relevant tests (e.g., urine analysis, EKG)

**Identifying Underlying Causes:**

- Medical conditions
- Medication side effects

# Management Strategies

**Non-Pharmacological Interventions:**

- Environmental modifications
- Communication strategies
- Behavioral therapies

**Pharmacological Interventions:**

- Medications for acute agitation
- Considerations for elderly patients (e.g., dosing, side effects)

**Lower Starting Doses:**

- Begin with the lowest effective dose and titrate slowly to avoid excessive sedation and adverse effects.

**Monitoring:**

- Continuous monitoring of vital signs and mental status.
- Monitor for side effects such as sedation, hypotension, respiratory depression, and extrapyramidal symptoms.

**Minimize Polypharmacy:**

- Avoid adding unnecessary medications.
- Review and manage existing medications to reduce the risk of interactions and adverse effects.

**Patient-Specific Factors:**

- Consider comorbid conditions such as cardiovascular disease, respiratory issues, and renal or hepatic impairment.
- Evaluate the risk-benefit ratio for each pharmacological intervention.

**Non-Pharmacological Measures:**

- Always consider non-pharmacological interventions first, and use medications as a last resort.
- Employ de-escalation techniques, environmental modifications, and behavioral strategies.

# Multidisciplinary Approach

**Team-Based Care:**

- Roles of different healthcare providers (e.g., physicians, nurses, social workers)
- Importance of family involvement

**Collaboration and Communication:**

- Effective handoff between providers
- Use of electronic health records

# Safety and Ethical Considerations

**Patient Safety:**

- Fall prevention strategies
- Managing aggression and agitation

**Ethical Issues:**

- Informed consent
- Respecting patient autonomy

# Challenges and Solutions

**Common Challenges:**

- Staffing and resource limitations
- Balancing medical and behavioral needs

**Proposed Solutions:**

- Enhancing training programs
- Leveraging technology and tools

# Returning to Facility


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# Returning to SNF

- "(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident … unless—
  (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;…
  (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
  (D) The health of individuals in the facility would otherwise be endangered…"

(42 CFR 483.15(c))

- Must follow documentation and process, including notice and resident's right to appeal.
- "The facility may not transfer or discharge the resident while the appeal is pending … unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility.

(42 CFR 483.15(c))

# Returning to SNF

- "***Permitting residents to return to facility.*** A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.
  (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident
    (A) Requires the services provided by the facility; and
    (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.
  (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges."

(4 CFR 483.15(e))

# Returning to SNF

**Emergency Transfers to Acute Care.**

- "When residents are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, NOT discharges, because the resident's return is generally expected.
- "Residents who are sent emergently to an acute care setting, such as a hospital, must be permitted to return to the facility. In a situation where the facility initiates discharge while the resident is in the hospital following emergency transfer, the facility must have evidence that the resident's status at the time the resident seeks to return to the facility (not at the time the resident was transferred for acute care) meets one of the criteria at §483.15(c)(1)(i)(A) through (D). Additionally, the resident has the right to return to the facility pending an appeal of any facility-initiated discharge unless the return would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that the failure to transfer or discharge would pose. (§483.15(c)(1)(ii))

(CMS SOM App. PP for 483.15(c))

# Returning to SNF

- The facility must "develop and implement policies that address permitting residents to return to the facility after a hospitalization or therapeutic leave. Specifically, residents who are hospitalized or on therapeutic leave are allowed to return to the facility for skilled nursing or nursing facility care or services. When a facility does not allow the resident to return, the facility has initiated a discharge, and the facility must comply with Transfer and Discharge Requirements at §483.15(c). The resident must be permitted to return and resume residence in the facility while an appeal of the discharge is pending."

(CMS SOM App. PP for 485.12(e))

# Returning to ALF

- "A residential care or assisted living facility shall not admit or retain any resident requiring a level of services … for which the facility is not licensed or which the facility does not provide or arrange for, or if the facility does not have the staff, appropriate in numbers and with appropriate skills, to provide."

(IC 39-3307(1))

- "A resident may be discharged for the following:…

  (b) The facility's inability to meet the resident's needs;

  (c) The resident's needs are greater than the level of care provided by the specific facility;

  (d) The resident is a danger to himself or others.

- "A resident shall have the right to appeal a discharge as established by dept rule."

(IC 39-3313(2))

# Returning to ALF

- "The admission agreement cannot be terminated, except under [IC 39-3313] as follows:
  a. Giving the other party thirty (30) calendar days written notice;...
  c. Emergency conditions that require the resident to be transferred to protect the resident or other residents in the facility from harm;
  d. The resident's mental or medical condition deteriorates to a level requiring care as described in [IC 39-3307] and Section 152 of these rules;...
  f. When the facility cannot meet resident needs due to changes in services, in-house or contracted, or inability to provide the services; or
  g. Other written conditions as may be mutually established between the resident, the resident's legal guardian or conservator, and the administrator of the facility at the time of admission."

(IDAPA 16.03.22.217)

# Questions?

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