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'Patient dumping' charges in Los Angeles call attention to care of homeless

Los Angeles hospital accused, but most hospitals face same dilemma

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A Los Angeles hospital is under fire for what critics call "patient dumping" after local media aired footage of a homeless woman who had been treated and then dropped off at a shelter in the downtown area known as Skid Row, where she wandered aimlessly on the sidewalk in a hospital gown. Though the issues involved are far more complex than the local media portray, legal experts and hospital administrators agree that there are lessons for risk managers.

The first lesson: Never send a patient out onto the street in a hospital gown or without shoes. Beyond that, the solutions are more challenging, starting with a commitment to helping indigent patients find help after treatment and ending with an effort to make your work in that regard visible to the community.

The California incident is focusing attention on a problem that has long vexed risk managers: What to do with patients who have been treated and are ready for discharge, but who have nowhere to go or refuse to go. That was the genesis of the incident in Los Angeles, in which staff at Kaiser Permanente hospital put a 63-year-old woman into a taxi and had her dropped off outside a shelter downtown. The woman was wearing only a hospital gown and socks and appeared disoriented in the news footage.

EXECUTIVE SUMMARY

A controversy in Los Angeles is focusing attention on how to discharge homeless patients without inviting liability and criticism. Experts advise going the extra mile to find placement even though your actual obligation is limited.

- Document efforts to find after care or shelter for the patient.
- Avoid the impression that you just dumped a patient on the street.
- There is some obligation to investigate post-discharge options.

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The office of the Los Angeles district attorney has issued statements confirming that it is investigating the incident but calls to the office from *Healthcare Risk Management* were not returned. Kaiser Permanente spokesman **Jim Anderson** tells *HRM* that the hospital staff violated policy by discharging the woman in a hospital gown. The hospital also is investigating whether the woman was delivered to the shelter in an appropriate manner.

“Putting someone in a taxicab in a hospital gown is a violation of our policy. That simply shouldn’t have happened,” he says.

Soon after the controversy erupted, the hospital issued a statement offering “our deepest

apologies to our patient and to the community. Our handling of this case violated our own standards and practices and is contrary to our mission and values. This should not have happened. We are extremely upset that it did. We will take appropriate steps to make sure it does not happen again.” The statement went on to say that the hospital routinely helps homeless patients gain access to the resources they need — food, shelter, services — as part of the discharge process.

The controversy in Los Angeles also may be fueled by longstanding debates regarding funding for indigent care, the homeless problem, and other social issues, plus infighting among different agencies about how to solve those problems.

Avoid appearance of not caring

Adrienne E. Marting, JD, a health care practice attorney with Powell Goldstein in Atlanta, says while she sympathizes with hospitals that struggle with appropriate discharge for homeless patients, the Kaiser facility made a crucial error when it discharged the patient in a hospital gown. Any hospital that leaves a patient in a hospital gown out on the street is vulnerable to claims of patient abandonment, Emergency Medical Treatment and Labor Act (EMTALA) violations, or at the very least, violations of the Medicare Conditions of Participation pertaining to discharge planning, she says.

The incident speaks as much about the need for more homeless shelters as anything else, Marting notes. “Many hospitals are under incredible financial stress and simply cannot afford to house medically stable patients just because they have nowhere else to go,” she says. “Hospital risk managers should develop referral agreements with homeless shelters, nursing homes, drug and mental health facilities to ensure the proper disposition of patients who are stable for discharge.”

That advice is seconded by **Linda Stimmel, JD**, partner and co-founder of Stewart Stimmel in Dallas and **Mary Jean Geroulo, JD**, an attorney with the firm who previously was a hospital administrator for 10 years and dealt with this difficult issue. They both say risk managers should review policies and procedures to make sure they adequately address the needs of homeless patients, but they also acknowledge that hospitals can be caught in a no-win situation.

Stimmel says it is a common problem for hospital administrators to have homeless patients who have nowhere to go, but even more difficult is the patient who refuses to leave even when you

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have a shelter or other facility.

"I've had clients facing this, and my first advice is to document every step you take to help that person, every single thing you do," she says. Show all the diligent work you've done to help this person and the competency exams to show that they can understand what you're telling them, Stimmel says. "We have advised clients to escort patients out of the hospital and put them in a cab, and to pay the cab fare to a homeless shelter where you've arranged for them to stay," she says.

Effort required by Medicare COP

Geroulo points out that helping homeless patients with discharge is more than just a good, caring thing to do. Hospitals are obligated under the Medicare Conditions of Participation to assess every patient regarding what follow-up care and discharge planning is needed. It is not sufficient to simply inform the patient about the need for follow-up care; the hospital must assess what resources are available to the patient and assist with obtaining the necessary help.

"If they don't meet that obligation, they can be found out of compliance with that condition of participation and Medicare will force them to put changes into their system to show they are complying," Geroulo says. "But if the staff does everything they're supposed to do and the patient is competent but refuses to leave, then the hospital may have no other option but to discharge the

patient against the patient's will. That may be anything from putting him in a cab and sending him to the shelter or assisting her with a bus pass so she can go wherever she chooses to go."

The key for risk managers, in determining where your obligation and potential liability ends, is whether you have met that Medicare Condition of Participation, Geroulo says. Once you have met that requirement, then the question becomes exactly how you get the person out of your facility. Geroulo says in her years as a hospital administrator, she saw instances in which patients reluctant to be discharged had to be escorted off the premises by security — an unfortunate but necessary step.

She notes that though the issue can be difficult to resolve, ultimately the hospital does not have an obligation to make people who were homeless when they entered the facility not homeless when they leave. There is nothing wrong with sending a patient to a homeless shelter after treatment, Stimmel and Geroulo say. **(See article, this page, for more advice on how to deal with discharging homeless patients, and p. 65 for concerns about EMTALA.)**

Though tough love sometimes is warranted, Stimmel and Geroulo agree with other observers about the Los Angeles hospital's key mistake, emphasizing that they would never approve of a homeless patient being sent out in a hospital gown. Even if the patient flatly refused to change clothes, she should have been sent with something to put on when she chose.

"The hospitals I represent would go buy a set of clothes, use some from the donated clothes bin, anything to get some real clothes on that person before they go out on the street," she says. Spending a few dollars on a shirt and pants is worth it, if necessary, Stimmel says. "What the Los Angeles hospital did was silly," she says. "It was asking for trouble and bad publicity." ■

Document diligently, send patients with needed items

When you must discharge a homeless patient with nowhere to go, make sure you document extremely well and avoid making mistakes that can cast your hospital in a bad light, experts advise. Here are some tips:

- **Document like you've never documented before.**

Document in detail everything you've done to try to help this patient find somewhere to go, says **Mary Jean Geroulo**, JD, an attorney with Stewart Stimmel in Dallas. When Geroulo was a hospital administrator, she encouraged staff to meticulously record every step taken to find shelter or other resources.

Staff should document who they called, what they offered, and the patient's response. If you called 20 shelters or step-down facilities, document every single one rather than writing that you "called 20 places looking for shelter." Be sure to record any resistance from the patient to the options you offer. You want to create a record that shows not just that you tried to help the patient, but exactly how hard you tried.

"That's where some hospitals drop the ball," Geroulo says. "They actually do put a lot of effort into helping the patient, but then they can't prove it when someone claims they didn't."

You may have to get tough

- **Play hardball when necessary.**

Not all patients who have nowhere to go are really without options, notes **Linda Stimmel**, JD, partner and co-founder of Stewart Stimmel. Often, for instance, an elderly patient has financial resources and could go home with a relative, but the family refuses to help. Sometimes the patient is reluctant to leave the hospital as well.

You still should work to provide options to the patient, such as placement in other facilities, but if the patient still will not leave the hospital, you may have to get tough, Stimmel says. Many times she has advised client hospitals to call in the family and give them an ultimatum.

"We've told them that we will start billing for the care, and we're going to file a lawsuit to get guardianship of the patient and take payment out of the patient's estate. Whatever money she has will be eaten up by the hospital bills," Stimmel says. "You can't imagine how quickly they take the patient home. It works about 70% or 80% of the time."

Reid Cocalis, JD, an attorney with the law firm of Gordon Hargrove in Fort Lauderdale, FL, says he also has worked with hospitals to use that strategy. In one case, an elderly woman could not leave because her son would not make any arrangements for her care. Cocalis had to pursue an elder abuse complaint with the adult protective services

agency by pointing out that the son was diminishing the woman's assets by forcing her to stay at the hospital.

"Only when he was faced with that complaint did he consent to the discharge and arrange appropriate home care for her," he says. "Usually, once you file a motion with the court, they know that you're serious and you don't even need to proceed through with the court proceeding."

- **Provide essentials for the patient.**

The clothing issue is not negotiable. Any clothing is better than a hospital gown. But Geroulo also says it is a good idea to send the patient with a comfort kit of items such as a toothbrush, toothpaste, and soap.

- **Send paperwork with the patient.**

The patient should have documents showing his or her current status and how the discharge took place, suggests **Leila Narvid**, JD, an attorney with Sideman & Bancroft in San Francisco. Particularly with patients who are mentally challenged or a substance abuser (but competent for discharge), it is a good idea for them to carry a summary of the most current treatment and what efforts were made to provide aftercare and shelter.

"That way, if they do seek help elsewhere, the other party will have the information to know what they need and what's been done for them already," Narvid says.

- **Consider sending an escort with the patient.**

Many hospitals send a staff member with the patient when delivering him or her to a shelter or other location. While that is not always feasible for a busy facility, it is a good idea when possible, Stimmel says. The escort can help ensure the patient gets to the proper location and can record the final step, such as whether the person entered the shelter or refused. ■

SOURCES

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Plaintiffs may push cases alleging EMTALA violations

Plaintiffs' attorneys soon may use the discharge of homeless patients to push the boundaries of the Emergency Medical Treatment and Labor Act (EMTALA), cautions **John Wagner**, JD, an attorney with Nossaman Guthner in San Francisco. While the definition of stabilization largely has been a medical decision, he says the issue of homeless patients may change that definition.

"I think we're going to see some cases in which plaintiffs' attorneys argue that the patient isn't really stabilized within the meaning of EMTALA until the follow-up is done and the stitches are removed or the follow-up X-rays are taken," Wagner says. "Everyone leaves the emergency department with a form saying what you need to do after you leave, and if it's clear that the patient has no means to follow up, attorneys are going to argue that they weren't really stable when they left your facility."

Attorneys likely will argue that merely telling the patient what to do after discharge is insufficient and that you must ensure it is possible for the patient to follow those instructions, he says. But wouldn't that mean that homeless patients would never meet the definition of stable for EMTALA and be eligible for discharge?

"I think some plaintiffs will argue that position, and obviously there can be bigger motive behind that in terms of changing how homeless people are treated," Wagner says. "One of the next waves of EMTALA litigation is going to be what stabilization means when there are no supporting resources."

Leila Narvid, JD, an attorney with Sideman & Bancroft in San Francisco, is skeptical about whether plaintiffs could be successful with such an argument. She says EMTALA is fairly clear about what stabilization means and says it would be

difficult for an attorney to argue that it includes follow-up care. For instance, if a patient presents with malignant cancer and obviously needs follow-up care in the near future, there still is no EMTALA issue, she says.

"As long as there is no emergency condition, the facility could still refuse treatment, even though you need follow-up therapy," she says. "I'd see the issue in the same way if a homeless patient clearly needs follow-up care after you have stabilized and provided care. As long as there is no emergency medical condition, EMTALA does not apply."

However, Narvid notes that there is nothing to stop states from enacting laws that are stricter in this regard than EMTALA. That could be a bigger risk than plaintiffs stretching the definition of stabilization, she says.

"I think as long as you have made the good-faith effort to find a shelter for this person, you're in the clear as far as EMTALA is concerned," Narvid says. "Once that person is stabilized, your EMTALA obligation ends. A hospital would be well advised to go beyond that, but not because of EMTALA." ■

Avoid risk from obese with specific policies, rules

(Editor's note: This is the last of a two-part series on the liability risks associated with treating morbidly obese patients. Last month's Healthcare Risk Management explored the obligations to prepare for these patients. This month's issue details how one insurer has provided specific guidelines to mitigate the risk.)

As Americans get bigger and hospitals see more large patients seeking bariatric surgery, risk managers are worried about the increased liability risk they pose. These patients can be injured if you do not have the proper equipment for patients of this size, and you may need to change policies and procedures to protect both the patient and your staff.

One insurer has addressed the problem head on with a set of guidelines for its clients who provide bariatric surgery. PHT Services (PHTS) in Columbia, SC, provides risk management services to South Carolina's health care industry, and **Brian J. Teusink**, CPA, CCM, AIAF, executive vice president and chief risk officer, says the company developed the guidelines after realizing that its members were caring for obese patients more frequently than in

SOURCE

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