A Conversation About Difficult Inpatient Discharge Decisions

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July 17, 2009

Introduction

SWIDLER: Welcome everybody and thanks for coming. This conversation is going to be about the very difficult problems that can arise in discharging patients from hospital inpatient care to home or to a post-acute facility.

I read an Op-Ed piece last year that urged hospitals to study practices at companies like Toyota, and to strive to be more efficient and standardized. To run things more like a production line. And it occurred to me that the Toyota analogy would be a lot closer to what we face in hospitals if every now and then a chassis got up in the middle of production and walked out, or if the finished car refused to exit at the end of the production line, or if there was no place to send the car at the end of the production line. And in general, the analogy would be closer if cars on the production line had emotions, and individualized, often idiosyncratic, wishes and interests. Because those are the problems that we're dealing with, and they're not problems that Toyota is dealing with.

Key Laws and Regulations

SWIDLER: A good place to start is to note the relevant law in New York. The principal sources relating to hospital discharges in New York are the Medicare conditions of participation on discharges which are at 42 C.F.R. § 482.43, and the New York State regulations governing hospital discharges at 10 N.Y.C.R.R. § 405.9. In general, the obligations of hospitals relating to discharges are to provide discharge planning, to address the likelihood that a patient is going to need post-hospital services, to involve the patient and family in discharge planning, to respect the patient and family preferences when they're expressed, and to arrange and implement the discharge plan. Also, hospitals must give patients upon admission notice of their right to contest being discharged too early, and give that notice again when they are going to be discharged.

And, of course, one of the hospital's overriding obligations is to ensure that the patient has a discharge plan that meets his or her post-hospital needs,[1] and then is safely discharged in accordance with that plan. But as we will discuss at length, at times that obligation runs counter to other regulatory requirements, including obligations to respect the patient's autonomy rights, and the obligation not to allow a patient to stay after being discharged.[2]

So those are a hospital's general legal obligations relating to discharging patients. Pamela, do you have anything to add with respect to a hospital's mental health unit?

TINDALL-O'BRIEN: Obviously, we have additional statutes and regulations. We have Mental Hygiene Law § 29.15 and 14 N.Y.C.R.R. Parts 580 and 582, which have to do with discharge practices both at OMH-certified hospitals and Article 28 psychiatric units. The only thing I would like to remind us as we do go through this exercise, which I think is a terrific idea, is that as much as we can I'd like to think about children's issues as we're doing the adult issues. I know it wasn't something that you necessarily focused on, but, for example, when I was reading through the questions, one of the things that came up in my mind was the difficulties that we have with discharging children from hospitals. So if we

could keep that in mind a little bit, I would think that that would be also useful for this exercise.

SWIDLER: Thanks. I think that's a good point and it certainly comes up a lot.

Case 1—The Patient Who Won't Leave

One case I suspect we all encounter is the patient who won't leave when they're discharge-ready. This is one of the most difficult discharge problems to solve, and maybe I should have eased into our discussion with a simpler case. But let's try.

What we see again and again are cases like this: an elderly but decisionally-capable patient is admitted and treated for some condition like diabetes. The patient is stabilized and later is ready for discharge, but won't leave. The patient just says, "I don't feel ready to go home."

I'm interested to know, first, do all of you encounter this kind of problem, or am I just the lucky one that seems to run into this again and again? Or do we provide such good care at the hospitals where I work that people like staying there indefinitely?

FOUASSIER: We all encounter this for a variety of reasons we'll get into during the course of the conversation. Sometimes it's because the patient doesn't feel he or she will get proper treatment at home or there are other social issues. Sometimes there's a disagreement among the medical staff as to whether a patient's ready to go. Often we find that some members of our staff will advocate for patients beyond what I personally feel is necessary because, at the end of the day, we're care givers. We're interested primarily, if not exclusively, in making the patient feel better. That's a physical as well as an emotional state of mind. So because we're hospitals, it's something we run into all the time.

SWIDLER: In some ways it's an easier case if there's a dispute about whether the patient is discharge-ready. But just to sharpen the issue, let's say the patient is unequivocally discharge-ready. Let me ask it this way: What's the harm in letting the discharge-ready patient just stay in the hospital indefinitely, or at least an extra few days or weeks? After all we all pride ourselves on respecting patient autonomy.

FOUASSIER: Leaving aside the regulatory problem with letting a patient who's no longer acutely ill remain in an acute care hospital? There are a variety of problems. The patient continues to occupy an acute care bed which then can't be occupied by a patient who's stacked up in the emergency department. The patient could fall out of bed. The patient could develop decubiti. We run into these problems, all kinds of hospital-acquired infections and conditions as the patient stays. We have reimbursement issues and we try not to focus on those because we're routinely criticized for only being concerned about the money. But understand, we can't run our hospital on love and kisses. At the end of the day the financial consequences are also important. Who pays? We can't bill an insurance company for stays that are not medically necessary. That's fraud, and we would not want to do that anyway. The patient? If the patient has resources that's a possibility. But many of these patients do not. So the hospital ends up eating the cost of maintaining that patient, even a patient who's not acutely ill, is still going to require daily maintenance, a regimen of medication, feeding, physical or occupational therapy to keep the patient from getting sick.

HORWITZ: We all have problems with the patient who becomes very comfortable when they're in a hospital, whether it's the enjoyment of three squares a day or the attention from caring staff. Although the difficult discharge issues for years have been part and parcel of the discharge planning challenge, I am unaware of any regulatory statement of deficiency being issued for a violation of the regulations that indicate that inpatient hospitalization is limited to those requiring acute care—not long-term care and not custodial care. In some situations, and I'm certain Robert will get into this later, guardians have been appointed as a tactic to remove patients who otherwise refuse to leave. The basis of such a proceeding is that the patient has a "failure to understand" limitation reflected in a failure to understand that only acute care can be provided in the hospital setting.

In 1996, for example, this hospital successfully petitioned for the appointment of a guardian when a seemingly otherwise capable patient refused to leave. This case was upheld on appeal to the Third Department.[3] Clearly not all refusals to leave will satisfy the elements required for guardianship. If guardianship elements cannot be established, steps such as turning off the television and telephone service can be considered.

Other steps that can be considered include an eviction or a trespass action against the patient. In general, there are a number of considerations that must be balanced when determining whether to undertake such steps, particularly eviction or trespass. Eviction or trespass should be actions of last resort. One should be mindful of the public relations nightmare that could result, internally or externally, from such an action. It would not be unusual for the local newspaper to find a trespass or eviction action against a patient to be a matter of public interest; it also is not uncommon that a patient will either be related to or a friend of a hospital employee. I think it important that prior to the institution of an eviction

or trespass action, that counsel has the support of both senior administration and even the Board.

SWIDLER: Let me ask about that. Why would you bring an eviction action if you not only are permitted to discharge a patient who is discharge-ready, you are required to discharge the patient who is discharge-ready? Why can't you simply go over to the patient, once their procedural rights have all been fulfilled, and say, "You're discharged. You are not longer a patient. You're no different now from somebody who has wandered in off the street and is sitting on one of our beds."?

FOUASSIER: Assuming the patient can simply be escorted to the door and shown out, then clearly that's a remedy, but I think I share Jim's concern that often the political consequences of this type of activity have to be taken into consideration. Occasionally, a hospital is going to make a decision which might be against its financial best interests simply because it doesn't want to incur the heat. The guardianship is fine if you can make the argument that the patient is not only functionally limited but, like Jim said, is also incapable of understanding and appreciating the consequences of his own functional limitations. In a case where that clearly is not so, that's going to be a losing proposition and you're going to have to do something else. And that something else may very well be literally ejecting the patient from the premises if the patient is otherwise medically appropriate for that type of summary treatment. I for one would not recommend that my hospital engage in that even if the patient is completely hale and healthy. It's just too difficult to reconcile it in a public relations context. You know you're going to get hammered on it.

SWIDLER: What other avenues do hospitals take when faced with the patient who won't leave?

GOLDBERG: In our urban hospital setting, we have developed an informal core group who respond when a patient won't leave. It is not an uncommon occurrence, unfortunately. The group consists of me as the risk manager, the social worker and her supervisor and our public safety officers—usually at least two of them, depending on the situation. We also always include the head nurse, and sometimes the consulting psychiatrist, if one has been involved in the care. Practically speaking, patients who refuse to be discharged are generally not easygoing, compliant patients. They're often management problems, they can be loud and disruptive, and they can be physically intimidating or violent. It's important to involve the people who have the right skills and/or the best relationship with the patient to address the situation. We have never physically removed a patient. Sometimes the mere presence of a pair of serious and well-trained uniformed officers can be very effective. I think it's also worth observing that a patient who is medically ready for discharge but who will not leave the hospital—in addition to the problems that we've already mentioned—presents a morale problem for the health care team, the social workers and the case managers. It is distressing to the staff, and if the situation is not managed properly, it can create an atmosphere of disorder and a feeling of powerlessness—that a patient who is not sick can simply refuse to leave. Sometimes, the fact of a team working together can combat the feelings of powerlessness and lack of order—even if we are not always as expeditious as we'd like to be in these very difficult situations.

BARREIRO: I was just going to comment with respect to the guardianship alternative that Mental Hygiene Law § 81.16(b) gives us a dispositional alternative to the appointment of a guardian, of course, which is a protective order. There's some commentary to suggest that the court need not find incapacity to the extent that it would be required for appointment of a guardian in order to provide relief under that section, and so sometimes I think it can be politically possibly more palatable to obtain relief under Article 81, essentially a discharge order, as opposed to going to a proceeding for eviction. That's just something to keep in mind.[4]

MASSETT: Thank you. I just wanted to add on this scenario, but actually it comes into play in all of them when you're looking at not only the legal advice but the practical advice that hospitals need to take into consideration in crafting a response to a patient who won't leave is looking, one of the questions asked in the preparatory materials was, does the reason matter in some of them, and I think that if you look at the reason underlying, let's take the scenario we're dealing with right now, decisionally capable patient who is otherwise ready to go. The question being, well, why won't they go? In cases where it's just: I really like it here. The food is good and I live alone at home and I like your nursing staff. I want to hang out versus I do have some—notwithstanding my doctors all saying I'm ready to go home and that the home care people are going to take care of me—I have some fear and trepidation about whether I am really physically ready to go or not. I know we said that the appeals process would have all gone through but depending on what the underlying reason of the patient is, might determine which legal and operational approach you take. I think that there is, both from a public relations standpoint and if you choose to seek some type of judicial intervention, be it an 81 or be it an eviction or a trespass proceeding, if you've just got somebody hanging out in a bed because they like it here better, for all of those reasons taking that type of a judicial intercession is probably a lot more palatable. If the patient, notwithstanding of the appeals procedures,

still has concerns for their own personal health and safety, then you might forgo jumping into that judicial intervention process to try to figure out how to bring them some peace of mind around those issues and figure out if there are ways of addressing that so that they will consent to it. I think that in each of the cases, this one and the others, those things come into play.

SWIDLER: Marguerite, how would you weigh this scenario on your scale: The patient needs nursing home care. The nursing home that's willing to take the patient is not that attractive a place. Also the patient is not paying for care currently because they're on a DRG, but the patient would start paying immediately or at least soon if they're in the nursing home. So predictably patient is not in any particular rush to get transferred there. Where does that fall on your scale?

MASSETT: I would put that, all else being equal, meaning it's a nursing home, just not one of the more attractive ones on the, well, that's the place that's ready for you. This isn't a hotel where you can stay until your choice hotel becomes available. On that end, versus, I mean I suppose there are other issues of if it's a nursing home but instead of being 10 miles away from my family, it's 50 miles away from my family. Again, that's not so much just I want to be comfortable, that's there are some other social concerns.

FOUASSIER: These are things we do now. We wouldn't really be having this dialogue if we were able to convince these difficult patients to see the error in their ways. We really try hard to make these people understand that although it may not be a perfect solution, it's medically appropriate to go to, for example, a skilled nursing facility. It's when it crosses the line into an unreasonable resistance on the part of the patient. Sometimes you get different levels of sensibility amongst your own staff because the family doesn't want the patient to go because it's too far away. Somebody's mother heard from a friend that it was dirty or the food wasn't any good, and the hospital has to decide at what point in time the patient's concerns can no longer dictate the hospital's discharge policy. So we always try to make the difficult patient understand that while some of the concerns may have merit, at the end of the day he or she is better situated in a long-term care facility more appropriate for his or her needs. Where we run into problems is when we're unsuccessful in trying to convince the patient and have no other remedy but to compel the patient one way or another.

MASSETT: I indeed agree that there is that line that you have to find and say notwithstanding that we have not been able to cajole you into this situation, we are going to start taking the necessary legal and operational steps we need to make you go. I guess what I was suggesting is that sometimes, sometimes, not always, it's not just a matter of making the patient understand what you're saying. Sometimes they do understand what you're saying, but don't agree with you. Then you need to find out the underlying reason that they don't want to go.

I can give you an example. A case where a nursing home was ready to accept the patient, but the patient didn't want to go. The patient was an elderly woman who had always lived alone, and didn't have family. When someone who wasn't involved in her clinical care sat and talked with her for a few minutes, it was found out that she was actually just kind of scared of the unknown. She had gotten used to the nurses and she didn't know what the other place was going to look like. I know this sounds simple, and this is not the case in all those situations, but having her day nurse go with her when she checked into the nursing home made all the difference in the world.

All I'm suggesting, and I know not all situations are that simply answered, but really, hospitals shouldn't simply try to get the patient to understand that he or she has to go, listening to information from the other direction is also important. You might then realize that you're not with someone who's just trying to manipulate the system to stay in.

SWIDLER: Well it's interesting. My perception is that better listening, along with good social work and good clinical care, can reduce the frequency of this problem, but ultimately they can only reduce it. There still will be cases where the clinical team ends up phoning the hospital lawyer in exasperation. But I agree with you, the focus ought to be on reducing it first.

HORWITZ: Marguerite is right on the mark that the assessment must be on a case-by-case basis and that resort to legal intervention should be the last stop. The social workers, the case managers, the nurses, family, whomever, really should exhaust all other options to determine what issue the patient is facing.

The recent article published by Robert and others is quite interesting;[5] it delineates the ethical, medical and legal concerns. This concept of "justice" as we enter a new era of health care and health care reform is becoming more paramount than it was ten years ago. We have scarce resources, we've debedded a number of hospitals. A daily patient census can vary greatly, in a community hospital perhaps from 170 to 300 patients. There can be bed vacancies one day and the next patients stacked in the corridors. Difficult discharge patients during high volume times represent not only a waste of resources but the possibility that care and treatment for others will be delayed. The stakes are higher now; scare resource and de facto rationing compels us to find these answers

and perhaps take a harder line to discharge the difficult patient in a more timely fashion. Timely discharges are not only for the benefit of others but also for the benefit of the patient. And after all, hospitals are dangerous places for a host of reasons.

SWIDLER: It strikes me that mental health units have a higher percentage of these cases than other units, and it's a difficult population for a number of reasons. So let's consider the same scenario in the mental health unit: we now have a patient who has decisional capacity, maybe a voluntary patient. We identified a safe discharge for the patient, perhaps to a community residence, but the patient just doesn't particularly want to go to that community residence. "I've been there before, that place stinks." A suppose there isn't any other place that's ready to take them at the time. So, how much trouble are we in if we use self-help methods or just tell the patient, "You're out of here at 2 o'clock today"?

TINDALL-O'BRIEN: I think you'd probably have problems with the Office of Mental Health when it came time to look at your license! But there are several scenarios. One of the problems for persons with mental illness is that Article 81 doesn't work very well for most people who have mental illness if they don't have family members willing to act as guardian. If you don't have family members who are willing to act as the Article 81 guardian, then, in fact, it makes Article 81 difficult to pursue, unless the local Department of Social Services Adult Protective Services Unit is willing to act as the guardian.

The problem that we frequently have when we go for guardianships is there just isn't anyone who wants to act as the guardian. So, the guardianship has not worked well for us.

I would have to agree with Marguerite who said work with the social work staff, work with the physician; sometimes we've asked the hospital to take the person actually to the community residence to look at it, to talk to some people there, to be creative and to get consultations also. The OMH hospitals, the psychiatric centers can, in some instances, if there is a child with a multiple disability or some unusual circumstances, we've even obtained some sort of a clinical consultation as to how to best handle the patient. You know, our staff has been available for that on occasion.

We tend to see this much more, not in the adult side, but much more in the children's side where you have children in a psychiatric unit and the parents have had the respite of having the child in the unit, the child is difficult to handle at home and they just are exhausted from caring for the child and really don't want to take them back home, and yet the child doesn't need a community residence, doesn't need to be in intermediate care. So then the question is how do you get the family to agree to take the child home? Usually the only way that can be done is by building clinical supports around the family.

FOUASSIER: I know this sounds harsher than I intend, but why should the parents have that option? If it's a question of their incapacity to handle the child's needs, that's one thing. I can understand that. I realize it's difficult, but I'm weighing things here. I'm weighing strain on our health care system of decisions being made by parents that because it is difficult they'd rather not take their child back. If they decide that they just don't want to do it anymore, they can't do it anymore, they don't want to devote the emotional resources to it, should a hospital, for example, contact CPS? Is that a form of neglect? Is it abandonment? What do we do? Because we have an affirmative obligation to discharge this patient.

TINDALL-O'BRIEN: First of all we try to accommodate the parents, deal with them, set up the clinical supports necessary for them to take the child home under appropriate circumstances. But we have, on occasion, informed parents that if, in fact, they won't take the child home we will have to "hotline" them with the Department of Social Services Child Abuse hotline as guilty of medical neglect. So that has happened on occasion. It's not something that we like to do, it's not very helpful to the therapeutic relationship that the hospital has with the parents, but if necessary we have done it.

SWIDLER: I've seen this case a few times and when I've seen it, it's not the patient's first hospitalization and discharge, it's about the ninth or tenth or twelfth. So the family evidently is unable, or no longer able, to offer a safe discharge. So in some of these cases going home is not a safe discharge, and then we've got to find something else.

TINDALL O'BRIEN: And luckily, in New York State, we have a Home and Community-based waiver for children who are under the age of 18. So we do have the ability to build those supports around the parents, but not all children who are going to be released from an in-patient setting are necessarily eligible for that waiver, so it depends on their level of disability. But you know, we have on occasion found that if we talk to the parents or guardians about the fact that we might have to hotline them, that makes the problem go away. We have very seldom had to actually hotline them, but we have, on occasion, done that.

Case 2—The Family That Objects to the Proposed Discharge

SWIDLER: Well this is actually a good segue to the next case because we're now starting to talk about family decisionmaking for patients who lack capacity. So let me simply tweak our first example: An elderly patient in the general medical unit, but this time the patient is decisionally incapable, say with dementia. And say the patient was hospitalized for diabetes again. Now the patient is ready for discharge to a nursing home and the discharge planners have identified a nursing home that's ready to take the patient. But the family and adult children don't like that nursing home. Or they just aren't ready to have their mom discharged to it. Maybe their concern is that there is a limited Medicare benefit and after that the nursing home is going to start being a cost on them. For whatever reason it is, the family doesn't want the patient to go to the available nursing home. Are there any additional issues that are raised with the family decisionmaking that we haven't already encountered in connection with the capable patient case?

HORWITZ: I spoke with our Director of Case Management to get a sense of how often family difficulties impede our discharge. We have roughly about 15 patients a month where difficult discharges are caused by difficult family situations. Families will not cooperate for a variety of reasons. They may just not like the nursing home. Also, we're in a rural area and so our nursing homes can be anywhere within a 50 mile radius, which can be burdensome to families, particularly with transportation problems. So there may be disagreement with discharge plans. Perhaps the family is not providing the hospital or the Department of Social Services with the information necessary to file for Medicaid. Perhaps it is simply a dysfunctional family. We deal with these situations, and again legal tools are the last resort. But we've had some success by simply discussing with the family the fact that resort to guardianship may be required if we are unable to discharge the patient. We've successfully resorted to court proceedings in situations where a family member, even a health care agent or guardian, is not acting in the interest of the patient but primarily in their own interest or that of the family.

In our geographic area we have been fortunate that it ordinarily doesn't take months to obtain a court appointment of an Article 81 guardian. We can generally do it within a month. Now that is a month where the patient's not going anywhere, but generally those patients aren't going anywhere anyway. We also find that the nursing homes are very reticent to accept patients when the family does not want them there. So the appointment of a guardian may be the response to the family reluctant to endorse placement of the patient in a certain nursing home.

FOUASSIER: I wholeheartedly endorse that. We have become much more enthusiastic about pursuing guardianship when we feel that we've made good-faith efforts to convince the family members who are preventing the discharge, but they either cannot or will not see it our way. We institute the proceedings. Then we deal with the fact that guardians are becoming scarcer and scarcer (because fewer and fewer people want to serve) by framing our pleadings in a way that asks for very limited relief. We ask that the guardian be given only the powers necessary to facilitate the discharge. We find that where we need to seek a third-party guardian, usually an attorney, that the attorney is less reluctant to take it on even if there's very little chance of compensation, where the duties are limited. He or she will facilitate the discharge and the admission into the alternate level facility and then he or she can petition to be relieved, and it's done. Rather than a guardian who's on the hook for the long haul. In too many cases when we wait and wait and explore all kinds of other alternatives, three months down the road we find ourselves in the same situation and we end up falling back on the guardianship proceeding anyway.

SWIDLER: Is the guardianship proceeding a good process for the resolution of this kind of case, or is it just the best process now available? Is there a policy response to this that we should be considering?

FOUASSIER: Well, to the extent we soon may have the family surrogate decisionmaking act, it might help, but you may get the same resistance from a family member acting as a surrogate as you would from a family member not acting as a surrogate. The problem is not so much the decision to discharge, but the arrangements for subsequent admission somewhere else. Without someone legally authorized to admit the patient, you're not going to get an acceptance by the step-down facility. That's where we run into a problem. So, to the extent there is no person legally authorized to sign admission papers at, for example, the skilled nursing facility, then without the guardian we would not be able to facilitate the discharge. And, depending on the circumstances, a surrogate or guardian may not solve the problem.

Also, the problem may be financial. Simply having a guardian appointed doesn't mean there's suddenly a source of funding where there may not have been one yesterday. I suppose we'll get into that in a little while.

SWIDLER: Right, we will. But you raised the implications of the proposed Family Health Care Decisions Act.[6] And today is kind of a historic day because at 4:30 a.m. this morning the State Senate passed

the Family Health Care Decisions Act for the first time. There is a very good chance the Assembly will pass it before the year is out and that it will become law next June. That law would give family members clear legal authority to make decisions for incapable patients who didn't make the decisions previously themselves and who didn't appoint a health care agent.

Now, I've been an advocate for this law…forever. Since I was young. And I think it's an important law that we need, and it will be a great advance. On the other hand, when I think about discharge problems like the case we're discussing, you have to wonder: will the FHCDA make discharge disputes even more difficult for hospitals, by empowering family members more explicitly?

But then, to answer my own question, I would point out that the family member's legal obligation under the FHCDA will be to make the decision the patient would have wanted, if known, or else the decision that is in the patient's best interest. And, of course, the surrogate can only make a decision that the patient himself or herself could have made. So in our hypothetical case, applying that standard would lead you to the question of whether the patient himself or herself would have been able to oppose a discharge indefinitely. So at the end of the day I'm not sure that the act would really impact this kind of dispute one way or another. At least that's as far as I've been able to think it through.

BARREIRO: I was going to make a similar comment. In fact, we have a fact pattern coming up that is similar. Even having a health care proxy doesn't necessarily solve these problems. When that agent says, "Mom said, never send me to a nursing home," and there's no safe discharge plan other than a skilled nursing facility, you still have the problem. So guardianship is always going to need to be there to fill in the blanks. The FHCDA may, in fact, make it more difficult for some of these cases.

SWIDLER: Well, I think the issue comes down the limits of autonomy, whether exercised directly by the patient or by a surrogate on behalf of the patient. In these cases, the decision-maker may be stepping beyond what can be done in the name of autonomy.

TINDALL-O'BRIEN: One of the things that we have found in trying to discharge to skilled nursing facilities is that many facilities want not only someone to consent for the resident to enter the nursing facility, they want someone who is willing to make decisions once the person is in the nursing facility. And if you don't have involved family and friends, and you don't have a guardian, that can be a very difficult situation.

HORWITZ: That's a great point.

SWIDLER: That's an excellent point.

TINDALL-O'BRIEN: There's been some talk about having the surrogate decisionmaking committees[7] expanded to have some ability to be involved in nursing home cases, but that has not happened to date. But that's a very difficult situation in that it's not even getting the consent to enter the nursing home, it's who's going to make the decisions, the medical decisions, once the person is in the nursing home if they lack capacity. The nursing homes are not willing to take on that concern and that potential legal burden.

SWIDLER: Well, the FHCDA will help with that by clarifying who has authority among family members, and a process other than guardianship for getting treatment consent for residents without family. But frankly, even without the FHCDA, nursing homes are identifying from among family members a designated representative who can exercise at least some rights of the incapable resident.[8]

BARREIRO: Many contracts use the term "responsible party" as opposed to designated representative, although that term is also used. And that is the key problem, because as we all know the nursing homes, once they have these patients, cannot discharge for non-payment for all intents and purposes. It's very rare. So what the nursing home is concerned about is having a patient in a bed with no source of payment. Therefore, they're increasingly looking for someone to sign not just for the resident but as a responsible party or as a financial agent. Particularly under the new Medicaid rules, nursing homes need people who actually have access to the patient's financial information in order to make Medicaid applications, and that is where you get the problem. It's also a problem on the hospital discharge side, because the nursing homes, even those with available beds, are increasingly reluctant to take patients into them when they fear there is no source of payment. And there can be a long period of disqualification under the new rules.

MASSETT: Marguerite's exactly correct, there are times when the discharge problem is not just a dispute about a health care decision, or about where is a good place for me to go live, it is a problem about the underlying financial issues for the institution. If we're talking about an institutional discharge into a nursing home, a key question is how are payments going to be made? And it's not just a matter of the nursing home saying, look we want a responsible party to sign and be financially responsible for this particular patient. Even if you can find someone, they might not have the legal authority to marshal all of the information necessary to determine if there's Medicaid eligibility. Or even if they have the authority, they might be hiding some of those assets because, you know, they are trying to maintain it for the family.

So you have to worry not just about the door out of the hospital, but also the door into the nursing home. You have to deal with both of those issues or you're not going to be able to discharge a patient. So, the underlying business issues, or frankly the underlying financial issues, are going to be critical. I think this is why we have seen almost a three-fold increase in the number of Article 81's that we've been asked to do by hospitals. They are not just for health care decisionmaking, but also to give someone, as Alyssa said, the authority to collect the financial information. And to make the Medicaid application, if that's appropriate. Or to identify resources that are available to help pay the bills.

SWIDLER: Why a three-fold increase? Is that just the economy or is there something else going on in society that's driving that?

MASSETT: You know, we tried to find this out when we suddenly realized there was this huge increase. And this is probably over the last five to seven years. Certainly part of it is financial. As Jim said, and he's just right, we've shifted costs to hospitals by making them the only health care provider that is mandated to accept nonpaying patients, assuming they come in through the emergency department. Frankly, even when an attending physician admits a patient, you know, the hospital usually has to take them. So that has driven the need for guardianships to accomplish the later discharge.

The other thing is that prior to this time there were personal relationships developed between hospital discharge staff and various nursing homes in kind of a "we just have an understanding that you're going to take a few of these difficult situations every once in a while," and that's the way we kept it neat. Oddly enough, I think the increase in regulation in the health care industry, patient confidentiality, a lot of the fraud and abuse issue, etc. have started to kind of wear away these relationships that, previous to this time, would have permitted some of that happening. But I have to tell you, I think the biggest driver is financial.

HORWITZ: Yes. The last piece of this, we talked about getting the patient out of the hospital. Getting the patient into the nursing home. But what about coming back to the hospital? A lot of these patients, unfortunately, are going to be, I'm not going to call them frequent flyers, but they're in and out of the hospital on a number of occasions. I happen to like the Article 81 full-blown, so to speak, so I know Jim talked about a limited Article 81, at least where I live this is the only hospital, so we can fully anticipate and expect whenever one of our patients who has been discharged needs a readmission, they're going to be coming back here. So we don't want to go through these issues every time there's a discharge. I think that it's certainly not a panacea but it's been a great aid to us in terms of knowing who's going to consent, who's going to make the payments, who's going to make all kinds of arrangements with respect to the disposition of the patient when they're ready for discharge.

So I think the Article 81 has worked well, at least for us. I'm not sure that we've seen an increase, Marguerite, like you've had. We've had a fairly steady number. Actually maybe the numbers are going down a little bit. I like to think of that as a result of our case managers and social workers and practitioners perhaps getting better in terms of their discussions with patients. But it's certainly there and we certainly utilize it.

FOUASSIER: We can attribute some of our rather dramatic increases to the fact that the mindset of the hospital institutionally has changed. We simply can't afford to absorb the kinds of financial losses which we previously took for granted and we have to be more proactive in trying to cut those losses. And this, quite frankly, is one way to do it. I mean leaving aside the issue of the best interest of the patient, we simply can't afford to allow these people to stay.

Case 3—No Place to Go

SWIDLER: Let's turn to another example, the example of no place to go. I saw a good illustration of this in Jim Fouassier's article in the *Health Law Journal*.[9] He wrote about a ventilator-dependant dialysis patient who is morbidly obese, who needs nursing home care that can meet his specialized, high-cost, difficult-to-manage needs. Predictably a hospital is going to encounter great difficulty finding any facility to take the patient. But the patient doesn't need acute care any longer, and is ready for discharge. In fact, the patient is anxious to be discharged, and the hospital is anxious to discharge him. There's just no place to go.

The first question is, have you seen this before? How should facilities handle this?

BARREIRO: I'll tell you that recently we were consulted by a family member of a patient with this scenario. These are extremely difficult because of the paucity of facilities that can handle these patients. We don't have a lot of specialized facilities in Broome County, and so often we have to arrange discharges out of the area. And the patients are reluctant to go, family members are reluctant to consent to the discharge. Perhaps others are more experienced with this.

SWIDLER: Well, it's not like I expected you to have a quick, snappy answer to this. This is one of these problems that doesn't have a good solution. Except that we can all agree to beat up on Pamela and the State, and

ask them to beef up the care network that's available, and to take more difficult-to-discharge patients like this.

GOLDBERG: In New York City, we will eventually find a bed for a patient like this. It may take a long time, but it will happen. The more difficult problem—really intractable and also not uncommon—is the undocumented patient who has no insurance. This is the patient who will be with us for the duration, because there is simply no placement for a patient like this. I am sure that we've all read about the recent Florida case in which the hospital chartered a plane to send a severely brain-damaged patient to his mother in Guatemala, over the objection of the patient's legal guardian. No hospital wants to be in court or in the news under those circumstances. But when there is no Medicaid, there is no discharge planning.

There's an interesting article on the subject of medical repatriation by Joseph Wolpin in the Spring 2009 volume of the *Journal of Law and Medical Ethics* that explores the subject of medical repatriation from a legal and ethical perspective.[10]

SWIDLER: You said that a patient can end up with you "for the duration." Won't that gradually turn you into a chronic care facility, as these patients mount up?

GOLDBERG: Yes. And then it's a very hard situation for everyone, including the patients—some of whom need only relatively inexpensive, though continuing, aftercare, but who are uninsured.

In New York City the discharge of a homeless patient is another difficult situation. The NYC Department of Homeless Services has an application process that is designed to ensure that discharge from hospital to shelter is a plan of last resort. For the hospital, it is a very time-consuming bureaucratic process, taking from four to six weeks, and it only begins once the patient is medically ready or almost ready for discharge. I am not sure that it benefits anyone, including the patient. Most often, a patient will begin the process and stay in the hospital for a few weeks, awaiting shelter placement. Then the patient gets disgusted with the process and just leaves the hospital—but only after occupying a bed for several weeks that was needed for a sick patient.

TINDALL-O'BRIEN: The Office of Mental Health has the same problem in its hospitals. We have a lot of undocumented aliens. And if you can't get Medicaid and/or any kind of public assistance or SSI, it can be very difficult to move individuals out of the hospitals into an appropriate after-care placement. We have tended to take a lot of undocumented aliens into our family care program, which is almost like foster care for adults. But it is not necessarily a good fit, but it's the only fit because most of the after-care that's done in our system is done by not-for-profit providers who do not have the financial wherewithal to absorb a client who can't pay. So, it's a big problem for us too.

HORWITZ: Robert, you asked whether or not we might need any policy changes. Well, take a look at the categories of patients that nursing homes are reluctant to accept. We have nursing homes unwilling to accept patients that require high-cost medications, those that may be on IV antibiotics, those with MRSA, and of course the Medicaid-pending patient. My understanding of the Medicare/Medicaid anti-supplementation laws is that they preclude a hospital from participating in cost sharing.[11] Now I know there was a Syracuse plan, and Marguerite I'm not sure how familiar you are with that, where there was a consortium of hospitals that engaged in assisting nursing homes and supplementing their income to assist with those types of patients. But in the absence of a consortium, I don't think that a single hospital would be permitted to, for example, assist a nursing home with payment for those high-cost medications. I think that it might be worthy of some policy or legal change, legislative change or regulatory change, because frankly a hospital would be better off financially saying, "Okay, nursing home, we will assist you in the procurement of these high-cost medications, so long as you agree to take this patient." So that would be one suggestion, consideration.

SWIDLER: There you go, Marguerite: Why can't a hospital pay to *give* referrals, instead of to get them?

MASSETT: The problem is not on the hospital side. The hospital can certainly provide the support. The problem is, it's illegal for the nursing home to ask for it and accept it. The nursing home is risking regulatory retribution, depending on the payment source for that particular patient. That's where the issue is.

And Jim, I am familiar with the situation in Syracuse. We worked with the hospital executive council and the nursing home group to come up with a way for the hospitals to fund a generally available grant, not connected to any one particular patient. Nursing homes, to access some of that support and financial aid, had to agree to take certain difficult-to-place patients. And it's a nice model. I have to tell you, no nursing home has been challenged for this practice, which we think is defensible even in light of the regulatory prohibition on supplementation.

But I agree with Jim. We all understand that the evil that was meant to be prevented by that particular rule was where a nursing home would extort money from a family, particularly, saying, "I'm not going to get paid enough by Medicare or Medicaid to take care of your family member,

but if you make sure there's a little bit of extra on the side, everything's cool." We all know that's the evil that was meant to be prevented. But that's not this situation. And there should be a way from a policy perspective where you can distinguish a community cooperative standard to try to make sure that the most cost-efficient and best place for the patient is supported financially, rather than just lump it in with that other evil.

SWIDLER: I represent a health care system that has both hospitals and nursing homes, and we often have a case where a hospital in our system has a difficult-to-discharge patient, and calls me up to ask, "Can't you help us out and get one of our own nursing homes to take this patient?" And so we've discussed the idea of creating a fund within our own system, not tied to any particular patient discharge, but just tied to the overall quality and cost-effectiveness benefits of discharging expensive patients to nursing homes.

I think we can do it lawfully. But the problem that we've been encountering is the difficulty, basically, of figuring out an amount for that fund so that the hospitals don't feel they're paying too much and the nursing homes don't feel they're going to be stuck with endless costs associated with somebody who they might not otherwise have taken. But it is an area where I'm convinced there are mechanisms for hospitals to provide financial support to nursing homes in connection with transfers without violating the Medicare and Medicaid anti-supplementation rules.

MASSETT: Yes. It goes to my point, and I think Jim Fouassier made the point as well: that one can't ignore the financial cost shift and the financial issues underlying certain of these situations. And it's not just a case of noting that who can pay the most gets the best care, although there's an element of that. The core issue is the cost shift. Because that's part of what the national health care policy debate is about. There's just not enough money in the system.

BARREIRO: We see the same problem here and I think that creating a community fund is a great way to resolve it. And I think that you're right, it's not the same evil that was intended to be avoided by that broad prohibition on taking anything in consideration for the admissions.

SWIDLER: By the way, I've even heard Health Department officials speak in support of what was done in Syracuse to create that fund.

BARREIRO: I can't imagine that being challenged on policy grounds.

MASSETT: Yeah, I wouldn't think so. Although it, we'd probably all be disingenuous if we said we never heard of a hospital, one of our hospital client patients going to a nursing home with an oversized wheelchair, a special bed, or with a nurse who went down the street to help with IV antibiotics every once in a while. That happens all the time, that happens all the time. And it frankly is in the best interest of the patient often, so you've got to find a way that the law doesn't get in the way of that.

SWIDLER: Right.

BARREIRO: I agree.

SWIDLER: Also, regarding the no place-to-go issue, we often run into this in connection with mentally ill patients, mentally retarded patients and substance-abusing patients. In particular, we run into difficulty finding residential programs or even independent housing. This is a good chance to ask Pamela about what's going on in that area. I know, among other things, OMH is being sued by disability advocates groups arguing that the state has an obligation to provide a greater range of residential options, options to ease up the discharge of the patients from hospitals. What's going on with that?

TINDALL-O'BRIEN: Actually I'm involved in two cases. One has to do with patients that have been discharged, not just from the OMH hospitals, but also from Article 28 psychiatric units to nursing homes, who DAI alleges could be cared for in the community.[12]

SWIDLER: DAI? Disability Advocates Inc.?

TINDALL-O'BRIEN: Yes. The case has a lot of implications for us. At the state level, we're very concerned about it because it's holding the State of New York responsible for Article 28 discharges. Which I think is a leap that has never happened before. Just by the mere fact that we license the Article 28 hospitals, they are saying that it is a sufficient nexus to hold us responsible for the discharges that are done by the Article 28s.

SWIDLER: You know, I suspect my colleagues and I think that's a good idea.

TINDALL-O'BRIEN: I'm sure you would. We think it's a very bad idea.

SWIDLER: (Laughs).

TINDALL-O'BRIEN: So that's one of the cases. And the other one has to do with adult-home residents. And again, DAI wants the Office of Mental Health to create more housing.[13] I should note that the State of New York has more housing units per capita, by far, than any other state in the United States. We actually have about 31,000 housing slots, but the fact is that, you know, people who have mental illness, not all but many of them, have difficulty with employment and therefore are poor. They get SSI, they get SSDI, and they have a hard time, particularly in New York City, affording housing. You

know, the fact is there's not enough-low income housing in the United States. There's particularly not enough low-income housing in New York City, and most of our housing issues come up in New York City. My guess is, and I could be wrong on this, but my guess is that you don't see the issue as much up in Glens Falls as probably you do downstate, just because housing costs are so different.

And one of the things that I would like to make everybody aware of, is that there was a change in the OMH regulations regarding discharges from community residences and all of our licensed community housing to provide much more due process. And, in fact, you cannot discharge someone from a community residence if they go into an Article 28 hospital unless you follow the process and unless you meet the criteria that are set forth in that regulation.[14]

SWIDLER: I don't think I knew about that, when did that happen?

TINDALL-O'BRIEN: This is a relatively new regulatory change.

SWIDLER: Is there anything similar on the OMRDD side?

TINDALL-O'BRIEN: Nothing similar on the OMRDD side that I am aware of. It happened in January, 2007. There were changes to 14 N.Y.C.R.R. §§ 595.9 and 595.10. Basically the process that's been set up is if a community residence wants to discharge someone, first, they have to have appropriate reasons, they have to give notice, the community residence itself first has to look at the issue, then the resident can go to the local office of the Office of Mental Health for what you would call a "mediation session." If that isn't successful, then the resident can appeal to the Commissioner of Mental Health if he or she thinks that they should not be discharged from the residence. So it was an attempt by the Office Mental Health, which was sued on this issue, to make it clear that community residences are programs, that they are not housing the same way an unlicensed apartment is housing. And it was a way to try and keep those issues out of housing court, and yet provide appropriate due process to people that are in OMH-licensed housing.

SWIDLER: It's helpful to know that, because very frequently somebody's admitted to the hospital from an OMH-, OMRDD- or OASAS-licensed community residence. And later the residence won't take the patient back for whatever reason. So it is helpful to know what the process is with a discharge on that end.

TINDALL-O'BRIEN: And the important thing, also, for everybody to know, is that in every county in New York State there is something called the Single Point of Access, which is an entity run by different providers in the county. Local DSS is on it, there are a variety of people who are on it, and they are the ones that make decisions as to who should get priority access to housing. They prioritize who goes into OMH-licensed and supported housing. In New York City, however, because it's so much bigger, there is a SPOA, but the SPOA only handles what we call the difficult-to-place people, someone who could be difficult to place in regular housing. So the Single Point of Access, which in New York City is operated by a not-for-profit agency called the Center for Urban Community Services (CUCS), under contract with the State. CUCS acts as the SPOA and if a hospital is having problems placing a difficult client into OMH housing, they should be contacting CUCS and putting together a SPOA application. And that's something that all of your social work departments should know, regardless of whether you're in New York or whether or not you're in Glens Falls, that counties have set up this entity called SPOA, Single Point of Access, in order to assure that people who are most in need of housing can, in fact, access appropriate housing.

FOUASSIER: I had a question for Pam, a little bit off the beaten track about the new regulations on community residence procedures. Does the hospital have any remedy in a situation like this? Most regulations don't give the hospitals or any other providers any private right of action other than sanctions from the regulatory agency. What happens in a situation like this, where the hospital is dealing with a patient who is improperly discharged from a community residence?

TINDALL-O'BRIEN: I would suggest that the hospital's social worker call the field office, the OMH field office. We have five field offices located throughout the State of New York: Buffalo, Syracuse, the Hudson River Field office is in Poughkeepsie, the New York City office is in Manhattan, and we have one also in Long Island. I would suggest that you call the field office and talk to the housing person about the fact that you believe that this individual has been inappropriately discharged. The field office can look into it. In addition, they also act to assist in difficult-to-place discharges. If nothing else, they can hook you up with a SPOA. OMH operates 24 or 25 hospitals, so we are both a provider *and* a regulator. So we understand a lot of the issues that hospitals face, because we face them ourselves.

SWIDLER: I always say OMH has a reality check when they write regulations, because they have to follow them as well as dish them out.

Case 4—The Isolated Patient

SWIDLER: OK, now let's consider another case: the patient is ready for discharge and we've identified an appropriate discharge location, let's say a nursing home. But let's say that the patient lacks capacity and doesn't have any family or friend who is ready, willing and able to make decisions. And the nursing home won't take the patient unless there's somebody in place to either help arrange personal care or the financial matters. Do you encounter that problem? And what are some ways to address that?

BARREIRO: We've already spoken, you know, at length about the fact that increasingly hospitals are using Article 81 and certainly this fact pattern suggests relief under the statute. I thought it was probably worth mentioning that the Article 81 is applied with great variety throughout the state, and so it's very place-sensitive with respect to how the courts are going to receive your application. The hospitals have to be aware of that, particularly with respect to evidentiary issues.

For instance, if you have a patient who is not able to comment at all concerning the proceeding, it's one thing, but if you have a patient who's able to express to a court evaluator or counsel appointed for them by the court that they don't want a guardian, which is sometimes the case even with an individual described in the fact pattern, then the evidentiary rules are going to apply. And for a petitioning health care provider that can be problematic because the CPLR privileges as to doctors, nurses and social workers are applicable.[15] And there's a line of cases which suggest judges may sustain objections based on privilege if the health care provider is trying to admit testimony from a nurse or social worker.[16] And so, locally you have to know your judges and how they're likely to rule on these issues.

I think that increasingly there's going to be a move towards more uniformity in guardianship throughout the state so that even in places where judges have been more user-friendly, you're going to find the evidentiary rules may be more stringently applied. We get around it with first-hand observations from uncertified, not-licensed social workers or aides. Sometimes the lowest common denominator is the best testimony in these cases, oddly enough.

SWIDLER: Well, Alyssa, before you move on, are there any proposals to modify New York law to allow for the introduction of protected health information in connection with the guardianship proceeding? Because that just seems like basic common sense to allow that evidence in a guardianship proceeding where the issue is whether the patient has decisional capacity.

BARREIRO: Not that I am aware of. Well, the standard in guardianship is not a medical issue so much as a functional capacity issue.[17] And those are two different things. So what the court needs to hear is, you know, evidence concerning the patient's activities of daily living, their orientation, and their lack of understanding of their own limitations. So, again, it's truly lay testimony and there are plenty of cases concerning this issue. [18] So, clearly medical testimony is not required.

The problem a petitioning health care provider, whether it's a nursing home or a hospital, has is that often the only people it has to offer testimony, or the first ones it would think to call to testify, are health care professionals. So in many courts the objection, the evidentiary objection, will be sustained and you have to be prepared for that if you're in a jurisdiction or you're in a locality where your judges are going to block that testimony. I don't know if others that do these proceedings have that experience, but it's certainly the case in many courts throughout the state, and there are many decisions, one of which I can talk about actually.

It's United Health Services Hospitals.[19] The holding in that case was that the alleged incapacitated person has the right to remain silent. But that question only arose because family members who were supposed to show up to testify didn't, and the only other observations were from health care providers, including a hospital social worker and a nurse case manager who had been providing care in the community. Evidentiary objections to admission of health care provider testimony were sustained. The outcome was that no one was ready, willing or allowed to testify in the courtroom, and the case was dismissed.

HORWITZ: Just a question for Alyssa. It's interesting, we've been fortunate, we haven't had the privilege asserted, even though we've had counsel as well as court evaluators appointed. And this is over many, many years, so knock wood we've been lucky. But I'm just thinking, what would happen if we were unable to present any evidence? We'd be unable to sustain our clear and convincing evidence requirement. If the court finds that the guardian is not required, whether it's for lack of evidence or otherwise, does the legal presumption of competency attach to enable discharge of the patient who wants to leave, even though we think from an ethical perspective that there's going to be personal harm attendant to that? Is this different, from a liability perspective, from the mental health patient who is released because a hospital cannot sustain its burden of demonstrating through clear and convincing evidence the need for involuntary retention? From the hospital's perspective, on difficult discharges, I wonder if we're

dealing with different laws here, or if a finding by a court would enable us to discharge that patient?

FOUASSIER: No. No, you certainly would not want to do that. I certainly would not rely on the fact that I was not able to make out my *prima facie* case as a presumption that the patient has decisional capacity. And if I just may add here, in Suffolk County we sort of have the middle ground. The problem we see is not so much the nature of the witness as it is the nature of the evidence. We can have a social worker testify about his or her lay observations, but not about medical information.

BARREIRO: And that's an argument that I made. But in the United Health Services Hospital's case, the court rejected it. So it really is so judge-sensitive, there's such a lot of variation throughout the state. But, again, the guardianship advisory committee,[20] which I sit on, is moving towards creating more uniformity within the state. That may mean for folks who are lucky enough to be in jurisdictions like yours where the evidentiary rules aren't insisted upon, that it may be harder for you in the future.

The other thing is, just because you don't meet your evidentiary burden doesn't mean you're going to be able to discharge that patient, for all the reasons we spoke about before. No nursing home is going to take that patient if there's no one to make the Medicaid application or to make health care decisions.

SWIDLER: In the case that I'm suggesting where the patient is isolated and doesn't have family, who do you usually propose as the guardian? Is it Adult Protective Services, and are they usually cooperative in serving as guardian for these patients?

BARREIRO: This is also very sensitive to locality. So here in Broome we're very fortunate that the Commissioner of Social Services really never shies away from a case, and rarely relies upon conflict of interest as a means of avoiding service. We probably all know, Departments of Social Services are usually reluctant to take these cases because they have to assign case workers, they have to do annual reporting, they have to open up their own case reporting system. It's a drain on the county when these cases are assigned to them. So many times we find counties looking to kind of squirm out. But most times judges will appoint the commissioner of social services as the guardian of last resort. Again this is upstate counties where we don't have community guardianship programs.

I also want to remind everyone that there is a case out there, Samaritan Medical Center (*Marian E.B.*), which is a Fourth Department case.[21] It comes out of Jefferson County, which is a county which I hope is unique in the State, where the judge simply refuses to appoint the commissioner of social services over commissioner's objection, under any circumstances. The reported case concerns a woman in her 80s who had come from a trailer without running water, with cats in and out because it was open to the air. She had alienated all her family members. She was one of those really difficult patients that you don't like to have in your hospital beds for prolonged periods of time. We met our clear and convincing burden without a problem. But the judge denied the petition anyway because we had not proposed a guardian. The reason we hadn't proposed the Department of Social Services in that case is that this court in the past had simply refused to schedule hearings if we did. The case was reversed and sent back for a determination as to who should be the guardian, and unfortunately the Fourth Department reminded us that the statute allows for a creditor to serve in that capacity. The hospital was certainly a creditor in this case. I won't tell you how much it was owed, but for over a year this patient had been there with no source of payment.

In this case the patient was represented by mental hygiene legal service and that attorney advocated for the appointment of DSS, because what could be a worse guardian than the acute care hospital that would no longer have the patient in the bed?

Nonetheless that's what the judge did in this case, he appointed the hospital. The hospital reluctantly agreed to accept it and we narrowed down the orders as much as possible.

So it is possible that DSS will come in and argue it has a conflict or is otherwise unable to serve, claiming it really should not be the guardian for some reason, and then suggest to the court that the hospital be appointed. That's what this case stands for really.

TINDALL-O'BRIEN: Actually for people who have mental illness this happens all the time. Many county DSS agencies do not want to serve as guardians for persons with mental illness. If a patient has been in one of the OMH hospitals, DSS's attitude tends to be "they're yours." Even though we are a hospital like you are a hospital and therefore really don't have the ability to serve as a guardian. But that has been DSS's stance in most of the cases that I have been involved in. They don't want to act as guardian for a person who has a mental illness.

BARREIRO: Right, they feel they don't have the resources or the experience to deal with it. That's usually the excuse.

HORWITZ: Right. We deal with DSS in three counties and they are all reluctant to serve as guardians. But they will if need be. They do raise a conflict issue. I would

like to return, though, to the evidentiary question regarding the privilege precluding entry of the medical record of the alleged incapacitated person. Let's say we have a non-comatose patient who doesn't want to go to a nursing home and would be a risk for discharge to their home. This patient passes a mental evaluation assessment but is off a little bit. They have some activities of daily living issues. Is this panel of the opinion that the privilege should apply to hospitals and that as a matter of law consequently the hospital petitioner may be unable to sustain its burden of proof? In our counties we have been fortunate that the privilege issue, to my knowledge, has not been raised. I would be dismayed if the practice in other parts of the state were more uniformly applied. I can foresee where the presumption of competency coupled with application of privilege will be a significant barrier to the ability to sustain the burden, yet the liability and ethical concerns foreclose the discharge of a patient. Is the hospital stuck with that patient forever?

SWIDLER: Can I jump in to ask about one aspect of that? Doesn't the court evaluator have the ability under the statute to get access to the medical records? If so, the evaluator can use that in their presentation to the court I would assume?

BARREIRO: Let me address that. Certainly the court evaluator has the ability to get itself a court order to review medical records, and sometimes medical evidence can be admitted in that manner if there is no objection. Not all judges appoint a court evaluator. There are a number of judges that skip over the court evaluator and appoint counsel for the alleged incapacitated person, which the statute permits. And that is what happens to us here in Broome. And so in that case you must meet your evidentiary burden and you need to plan to do it without medical testimony, because that alleged incapacitated patient is represented by counsel who may well raise the evidentiary objection.

So, again, hopefully discussing it will raise awareness of the issue because I have heard of several cases that have been dismissed. Although judges often will try to get to some resolution. Their overriding concern is for the well-being and best interest of the alleged incapacitated person. I think in some cases, you may end up having to re-petition.

MASSETT: In Onondaga County, we have one judge who hears all of the 81s and who has very strict rules about not entering medical evidence into the record without over the objection of or without the consent of the patient. In those cases, however, the court may simply evaluate the patient him or herself. I mean, as you all know these hearings quite often happen right at the bedside in the hospital, and in many such cases it is plainly obvious whether you have a patient who has capacity or not. But we are precluded from providing any medical information.

But even in those cases, like the case you brought up, Jim, where the patient is oriented, but there is some decisional ability problems or judgment problems that give rise to concerns for the patient's safety if their discharge desires are followed through on, the judge, God bless him, is very good at talking these patients into consenting to the appointment of a guardian with limited powers for purposes of making discharge planning. And actually sometimes that is how you can get to that result. I am not saying that it is a solution for everyone, but if a patient can consent to the appointment of a guardian for themselves, then you don't have to deal with the evidentiary issue.

SWIDLER: I don't want this panel to end without some reference to the legislative proposal for transitional authorization panels, the "TAP" proposal that a few of us have worked on together.[22] All of us are familiar with it, but our readers are likely to be unfamiliar with it.

The TAP proposal is an approach to the problem of getting a discharge decision for the patient who lacks capacity, and is ready for discharge, but who is isolated and has nobody to make the discharge decision. Although the facility or a social services district could seek a guardianship as a way to make a discharge decision, that can be a very lengthy process, and can encounter the kind of procedural problems we are talking about. More importantly, it is not in the interest of the patient, or the facility, or the payors, or the other person who is waiting for that bed, to wade through the whole guardianship process just to get the OK to transfer a patient to an appropriate post-acute setting, when there is no dispute about the transfer. The idea is that there should be an administrative mechanism—a fair administrative mechanism—to evaluate the patient, see that he or she is actually discharge ready, and that there is an appropriate discharge option for them, that the patient lacks capacity to make this decision personally, and that there are no other appropriate surrogate-decision-makers. If so, that process could authorize the discharge and the expenditure of funds for that discharge. Then if there still is a need for the guardianship, it can take place after the discharge.

There is a legislative proposal in the Assembly, Bill No. 8647, that would create a demonstration program to test this out. And it will be interesting to see if one, if it is passed, and two, if it actually proves to be valuable.

I should add that even if the FHCDA passes, it is not going to address this problem. There will still be a need

for a device like TAP as an alternative to guardianship, and I think it is an idea worth testing. Any other views about this?

TINDALL-O'BRIEN: What I would say is that the surrogate decisionmaking committees have been very, very successful in our opinion, at getting consents for certain kinds of medical treatment without having to go the guardianship route. So if they are structured at all like the surrogate decisionmaking committees, I think that they would be very helpful.

SWIDLER: Well, the TAP proposal is similar to Article 80 in some ways. But one, it is a more streamlined process than the Article 80 panels, and two, it relates only to discharge and admission decisions, not treatment decisions. And three, the panel would have authority over the property decisions necessary to effectuate the discharge for a limited period of time until a guardianship could take place, if one is needed. So we will see how that works out. Yes, Alyssa?

BARREIRO: I will just say that I think it definitely has a role, even if the FHCDA passes. You know, we all have these cases where the family just doesn't agree and guardianship can be a cumbersome and slow process just to get someone appointed. But the transition proposal, I think, is excellent in that it is going to get the patient out of the hospital bed promptly, and you know, that is a good thing. The only limitation that I see is when you get that objecting patient. Unfortunately, a lot of times patients have just enough decisional capacity to say, "I don't want to go to the nursing home."

TINDALL-O'BRIEN: Has there ever been anyone who that said, "I want to go to the nursing home?"

SWIDLER: Well, I have to note, at Northeast Health we just built a new "Green House" model nursing home campus in Cohoes N.Y., which has separate homes with only 12 residents living in each, and a different approach to care provided in them. The model makes the prospect of entering a nursing home far more attractive. But OK, I agree, it's not like hospital patients welcome the news that they need to go to a nursing home.

Health Care Agent's Authority

BARREIRO: I have a question. What does the rest of the panel think about the authority of someone with the health care proxy to make the decision concerning whether a patient should or should not be discharged to a nursing home? I mean, when someone has a health care proxy, would you allow the agent to just sign the patient out against medical advice, for instance?

FOUASSIER: Maybe one way to ask this is: "What authority does the health care proxy actually bestow upon the agent? Is it the authority to make all medical decisions?" Because if the patient could discharge himself against medical advice, then the argument would be that the holder of the proxy, the agent, would be able to make the same decision in the place and stead of the patient.

SWIDLER: I think the agent would in theory have the authority to make a decision to discharge a patient AMA. However, they have to exercise their authority based on the patient's wishes, reasonably known, or else if they are not known, in the patient's best interest, and it is kind of hard for me to picture a scenario in which an agent can say, "I reasonably know that this incapable patient would want to have an unsafe discharge." And an unsafe discharge certainly would not be consistent with the best-interest standards. So I think there is a check and balance in the decisionmaking standard for the agent, even though the agent does have the same authority that a patient would have.

Now, I gather you also raised a technical issue of whether the agent's authority to make "a health care decision"[23] even encompasses a discharge decision. In my view, if the agent is making a hospital discharge decision that needs to be made, I'd be saying, "Absolutely yes, they can do it." Somebody has to make that decision and the agent is there, so I would reach the practical, and reasonably supportable, conclusion that the agent has this authority. But I have to admit, if the agent was about to make a terrible discharge decision, I'd be tempted to read the statutory language about their scope of authority more narrowly.

BARREIRO: I looked at it recently. The public health law, I think, gives the agent the ability to make decisions with regard to diagnosis and treatment. Do we read that broadly, or do we read that narrowly?

MASSETT: We have actually run into this question. Remember the comment that "there is the door out and the door in." Even if the hospital takes the position that the discharge plan and consenting to the discharge plan, which includes the admission to a nursing home, is a medical or a health care decision and therefore agent can do it, it's not much help unless on the nursing home side of it, the agent has the ability to provide a commitment relative to the financial admission agreement. So it's not enough for the health care agent to say, "Yeah, I agree to admit the patient." That comes with the financial obligation. True, not on the agent, but we will have to ask the agent, "Do you know where the assets are? Can you get to them? And can you make a Medicaid application?" That is where we have the problem.

GOLDBERG: I think it's illogical to say that we would allow a health care agent to withdraw or refuse care to the point of the patient's death, in the case, for example, of a terminal extubation or any other refusal of care, but then refuse the agent the right to choose what the physician has called an unsafe discharge. Of course the physician and the hospital have the obligation to protect a patient who lacks decisional capacity, so we have to look at the particular situation. But a discharge AMA might actually be consistent with the incapacitated patient's wishes. This is also a situation in which an ethics consultation can help sort out what the patient's wishes might have been or what would be in the best interests of this particular patient—given his or her own personality and values and religious or moral beliefs. A good ethics committee consultation can play an important role in a case like this.

HORWITZ: I think the question is in some respects an interesting academic question more than a practical matter. If we have a patient who does not have capacity, which of course we all know triggers a health care agent's authority, and if we are of the opinion that an unsafe discharge is being promoted by that agent, we will take steps to challenge that agent's authority, whether or not we think the statute empowers that agent or not. We do this because the agent would not be acting in the best interest of that patient. So, as a practical matter, I don't think it really makes much difference whether or not the statute authorizes that agent to effect a discharge decision, which I personally think, by the way, is a medical decision. But I think the effect would be the same.

MASSETT: Back to the situation that Jim brought up, where you have an incapacitated patient and a discharge plan, and the agent is saying, "No, I am going to sign the patient out AMA," I'm with Jim. If one of my hospital clients were to call me and say, "So, what do we do? Do we treat him just like the patient?" Because if a patient with capacity said, "Get me my pants and my shoes, I am going home," you get them their pants and their shoes and you let them go home, unless there is a capacity decision. But when it is the agent making that decision, there would be very few cases where we would recommend anything other than bringing an action to question or to have the agent's authority limited or changed.

You know, the only situation I can see not taking that step—if there is some evidence presented that the patient himself or herself said, "You know, if the decision comes down to it and I am, you know, I am terminal, I want to die in my home and that is where I want to go." If there is something in the record to show almost the clear and convincing evidence of what the patient would have wanted, which theoretically you could rely upon whether or not you had an agent, that would be the only circumstance that we would not advise the hospital, you know. If you have concerns about this agent who is wanting to discharge the patient AMA, we should seek some judicial intervention. And unfortunately, we see that situation not infrequently, and it is usually in a case where there is either some suspicion of elder abuse, or there is a suspicion that the family or the agent is really more interested in the financial assets being preserved of the patient, not in their best interest from a medical perspective.

SWIDLER: Happily, I haven't seen that very often, but I do occasionally see a case where the agent runs amok. But when an agent is about to make a dangerous, unsafe or idiosyncratic decision, I expect any of us would want to probe that agent closely to make sure that he or she is fulfilling his or her agent's duties and making the decision based on the patient's wishes and not based on his or her own idiosyncratic inclinations.

Public Policy Changes and Conclusion

HORWITZ: You had asked earlier, Robert, if there are any policy changes that we would suggest. I can't remember whose comment it was, but we talked about the obligation of the hospital from an EMTALA perspective to treat all patients that come to our door. I really think that we need a similar type of obligation and responsibility when nursing home beds are available. I think this should include a discussion to provide fiscal relief to the nursing homes.

BARREIRO: I think it is a laudable goal. There has to be coverage for that facility, because you remember that when the Medicaid regulations recently changed, they effectively talked about it in terms of being the "nursing home bankruptcy act." And that is the problem—that is why you are sensing more hesitancy on the part of the nursing homes to take these patients, because while it used to be that there may be a brief period of disqualifications for some financial improprieties by residents, now it can be a very long period of disqualifications. And that is not anything that gets discovered until after the nursing home patient is already in the bed. So it is a cost-shifting issue, and it is a big problem both for the hospital and for the nursing homes.

FOUASSIER: I for one would like to see some statement of policy actually instilling the hospital—bestowing upon the hospital more authority to make affirmative discharge decisions and implement them in the face of patient or patient/family opposition with perhaps some shield from liability in doing this. And again, I don't want to make it sound completely arbitrary and unilateral, but

where the physicians have certified that the patient is no longer acutely ill, where the insurance plans, if any, concur by refusing to pay for continued care, where there is a medically appropriate, acceptable placement that is subacute or long-term care facility, then the hospital can go ahead and effect the discharge over the opposition of the patient and the patient's family.

MASSETT: I certainly agree that we need to look at all the little idiosyncratic pieces of our current patchwork policy—the current statutes, regulations and policies we have to follow in implementing a discharge plan.

But there is part of me that also feels that, you know, is Article 81 perfect? It's not. Should you always have to seek judicial intervention? It has a lot of downsides. But first of all, I don't think that you are going to come up with a universal policy solution that solves all the issues. But also, there are times where judicial intervention is what is needed, either to protect the patient and the patient's rights, or to protect the facility. So I don't think that completely eliminating that guardianship process should be the ultimate goal. I think that we have to look at some of the aspects of the current patchwork that prevents sensible, streamlined decisions in some of the rather obvious cases from happening. But those cases in those gray areas, you know, that is what the courts are there for. That is how I feel.

SWIDLER: Anyone else. Should this be an issue on the national health care reform policy debate?

FOUASSIER: Well, I don't know whether with the full plate at the national level this is going to get on the national agenda, but it really is important because we would be hard-pressed to find a colleague in our situation who would not have had a plethora of problems similar to the ones we have discussed today. But, we are talking about Medicare going broke, health insurance premiums becoming unaffordable, hospital care becoming unaffordable. This is strictly going to devolve into a discussion of limited resources in all these varieties of contexts. And one drain on those resources is due to the ability of families and patients, for reasons that really don't have a lot to do with medical necessity, to dictate the kind of medical care that they want to receive. There isn't going to be an easy answer, but at the end of the day it is a question of the allocation of resources.

SWIDLER: Another way to view this is to note that the question here is the same question raised in almost all social policy issues, which is: "How do we get scarce resources to people that really need it, without leaking scarce resources towards people that don't really need it?" That is what we are discussing.

HORWITZ: I would actually endorse—I would endorse more discussion on the discharge planning issues. I think that this issue has been around for a long, long time. If we went on the American Health Lawyer's listserve, for example, in-house counsel, have been discussing the difficult discharge for a number of years. There really have been no good solutions. We reference the eviction, trespass and guardianship tools but these are all case-by-case and do not provide a satisfactory answer to a growing problem. I agree with Jim that the problem raises, in part, the rationing issue in part. I think the TAP concept is a great first step. Perhaps at least on a statewide basis, we can do more education and more discussion regarding this topic.

SWIDLER: You're reminding me of a story. We once asked our Ethics Committee what they thought of the idea of disconnecting the TV in the room of a patient who no longer needed inpatient care but wouldn't leave. The Ethics Committee was absolutely appalled that staff would even consider doing that, so we never did. But after the meeting someone quipped that the committee found that to be the most objectionable "plug-pulling" proposal it had ever seen!

Well, thank you all. After struggling with these issues so much in my own system, it is great to hear from colleagues who are encountering the same kind of problems, and to brainstorm with you. If nothing else, you know, this was helpful for the commiseration value.

So thank you all again very much. I thought this was a really valuable conversation as well as a really enjoyable one.

Endnotes

1. 10 N.Y.C.R.R. 405.9(f)(1).
2. *Id.*, 405.9(f)(7)(ii).
3. *In re Marguerite*, 226 A.D.2d 786 (3d Dep't 1996).
4. Another procedural approach to obtain a discharge order that may succeed in some localities is illustrated in a Kings County case decided just shortly before this panel discussion took place. *In re New York Methodist Hosp.*, 2009 NY Slip Op. 29328, 3 (Sup Ct., N.Y. Co. July 8, 2009) granted petitioner hospital's application by order to show cause, seeking judgment pursuant to Public Health Law § 2801-c requiring the respondent to discharge himself from the hospital and to accept placement in any appropriate skilled nursing facility offering admission.
5. R. Swidler, T. Seastrum and W. Shelton, *Difficult Inpatient Discharges: Ethical, Legal and Clinical Practice Issues*. 7 Am. J. Bioethics 23 (March 2008). *See also* J. Jankowski, T. Seastrum, R. Swidler and W. Shelton, *For Lack of a Better Plan: A Framework for Ethical, Legal and Clinical Challenges in Complex Inpatient Discharge Planning*, 21 Health Ethics Forum 311 (2009).
6. Assembly Bill 7729-C (2009) (Gottfried et al.); Senate Bill 3164-A (2009) (Duane et al.).
7. MHL Article 80. Surrogate Decisionmaking Committees.

8. 10 N.Y.C.R.R. § 415.2(f) (definition of "designated representative").
9. J. Fouassier, *The Perennial Problem Discharge—How It Hurts the Patient, the Provider, the Payer, and the Health Care System*, 14 NYSBA Health L. J. 38 (Winter 2009).
10. Wolpin, Joseph, "*Medical Repatriation of Alien Patients,*" 37 J. L. Med. & Ethics 152 (Spring 2009).
11. 42 U.S.C. § 1395cc(a); 42 C.F.R. § 489.20. *See generally*, OIG Supplemental Compliance Guidance for Nursing Facilities, 73 Fed. Reg. 56846 (Sept. 30, 2008).
12. *Joseph S. et al. v Hogan, et al. (BMC)(SMG),* No. 06-cv-1042.
13. *Disability Adcovates, Inc. v. David A. Paterson, Richard F. Daines, Michael F. Hogan*, 03-CV-3209 (NGG), decided September 8, 2009, 2009 U.S. Dist. LEXIS 80975.
14. 14 N.Y.C.R.R. §§ 595.9(c)(2); (f) and (g) and 595.10(a)(2)(vii).
15. CPLR 4504, CPLR 4507, 4508.
16. *E.g., In re Rosa B.* (1 A.D.3d 355, 767 N.Y.S.2d 33 (2005), *In re Lukia QQ*, 27 A.D.3d 1021 (3rd Dep't, 2006); *In re Bess Z.*, 27A.D.3d 568 (2nd Dep't 2006); *In re Marie H.*, 25 A.D.3d 704 (2d Dep't 2006); *See also In the Appointment of a Guardian for E.J.*, 13 Misc.3d 1223 (Bronx Co. 2006).
17. N.Y. Mental Hygiene Law § 81.02 (c).
18. In addition, the Court cannot require the Petition to contain medical information. N.Y. Mental Hygiene Law § 81.07(b)(3).
19. *In re A.G.* (*United Health Services Hospitals, Inc.),* 2004 NY Slip Op. 24454, 6 Misc. 3d 447. The holding has been inconsistently applied.
20. N.Y. Office of Court Administration Guardianship Advisory Committee, Hon. Thomas Aliotta, JSC, Chair.
21. *In re Marian E.B.*, 2007 NY Slip Op. 2186, 2 (N.Y. App. Div. 4th Dep't 2007).
22. Assembly Bill No. 8647-A (2009) (Canestrari).
23. N.Y. PHL § 2980.6.

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