

**The Miriam Hospital
Administrative Manual**

Subject:
Emergency Medical Screening,
Treatment, Transfer and On-Call
Roster Policy

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(Director)

(Executive)

I. PURPOSE

The provision of emergency services at The Miriam Hospital (the “Hospital”) is an integral part of the Hospital’s service to the community under its charitable mission. The Hospital is known as a place where any sick or injured person may come for care regardless of his or her ability to pay. Additionally, the federal government has enacted an “anti-dumping” law known as the Emergency Medical Treatment and Active Labor Act or “EMTALA” to ensure patient access to emergency care. EMTALA mandates how hospitals must prepare for and respond to patients who come to the hospital seeking treatment of an emergency medical condition.

The purpose of this Policy is to articulate the rules and procedures to be followed at the Hospital to ensure compliance with EMTALA and service of the Hospital’s charitable mission. This Policy is divided into the following six sections:

- A. PRESENTING FOR CARE AND MEDICAL SCREENING EXAMINATION
- B. NO DELAY IN SCREENING OR EXAMINATION
- C. STABILIZATION, TREATMENT, DISCHARGE
- D. ON-CALL ROTATION RESPONSIBILITIES
- E. PATIENT TRANSFERS TO A MEDICAL FACILITY
- F. ACCEPTING PATIENT TRANSFERS

II. ELIGIBILITY

This policy applies to Lifespan employees and other workforce members, and to health care professionals when they are providing services together with the Lifespan provider affiliates.

The term “workforce” is defined as an employee, provider, volunteer, trainee or other person whose conduct, in the performance of work for the Lifespan provider affiliate, is under the direct control of such affiliate, whether or not the person is paid by the affiliate.

III. POLICY

A. PRESENTING FOR CARE AND MEDICAL SCREENING EXAMINATION

- (1) Any individual who comes to the Hospital Emergency Department requesting examination or treatment shall be provided with an appropriate medical screening examination.
- (2) An individual will also be considered to have come to the Hospital Emergency Department if the individual is on Hospital property (including its parking lots, driveways, or sidewalks) and is requesting care for what may be an emergency condition, or if someone has requested care on his or her behalf. Hospital property is the Hospital's campus, defined as an area that is 250 yards around the Hospital building, but excluding areas or structures that are not part of the Hospital, such as private physician offices, entities such as skilled nursing facilities that participate separately in Medicare, or restaurants, shops or other non-medical facilities.
- (3) EMTALA does not apply to individuals who come to off-campus outpatient clinics that do not routinely provide emergency services, or to those who have begun to receive scheduled, non-emergency outpatient services at the main campus (for example, routine laboratory tests). State licensing laws, Federal hospital conditions of participation and malpractice laws still apply to these sites, however. Thus, such locations should have emergency protocols in place to handle individuals who might develop emergency conditions while in these settings.
- (4) Additionally, EMTALA does not apply after a patient has been seen, screened and admitted for inpatient services, unless the admission is made in bad faith to avoid EMTALA requirements. Individuals who are “boarded” in the Emergency Department after admission are considered inpatients for purposes of EMTALA if they have been admitted with the expectation that they will remain at least overnight and occupy a bed in the hospital. The inpatient “expectation” must be documented in the patient’s medical record.
- (5) When EMTALA does apply, the medical screening examination shall include, as appropriate, ancillary services routinely available to the Emergency Department.

The medical screening examination must be similar for patients presenting with similar symptoms.

- (6) In providing a medical screening examination, the Hospital shall not discriminate against any individual because of diagnosis, financial status, race, color, national origin, or handicap.
- (7) The purpose of the medical screening examination is to determine if an individual is experiencing an emergency medical condition.
 - (a) An "emergency medical condition" is a condition manifesting symptoms (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) which, in the absence of immediate medical attention, are likely to cause serious dysfunction or impairment to a bodily organ or function, or serious jeopardy to the health of the individual or unborn child.
 - (b) A pregnant woman who is having contractions is considered to be in an "emergency medical condition" if there is not enough time safely to transfer the woman prior to delivery, or if a transfer would pose a threat to the woman or her unborn child.
- (8) If an individual presents to the emergency department and requests doctor-ordered care or treatment and the nature of the request makes it clear that the medical condition is not of an emergency nature, the Hospital is required only to perform a screening examination appropriate to determine that the individual does not have an emergency medical condition.
- (9) In addition to staff physicians, the following practitioners may perform medical screening examinations: house officers, physician assistants, registered nurses and advanced practice nurses, all when practicing within their job descriptions and at a level of expertise appropriate for evaluation of the condition of the individual in question under the circumstances. ("qualified medical personnel").

B. NO DELAY IN SCREENING OR EXAMINATION

- (1) There shall be no delay in providing a medical screening examination or follow-up treatment for an emergency medical condition in order to inquire about the patient's method of payment or insurance status.
- (2) For patients who are enrolled in a managed care plan, prior authorization from the plan shall NOT be required or requested before providing an appropriate medical screening examination and/or initiating necessary stabilizing treatment. Neither the performance of the medical screening examination nor the provision of stabilizing treatment will be conditioned on a patient's completion of a financial responsibility form or payment of a copayment.

- (3) Patients who inquire about financial responsibility for emergency care will be encouraged to delay such discussions until after the completion of the medical screening examination and the initiation of stabilizing treatment, if necessary. These patients will also be told that the Hospital will provide a medical screening examination and stabilizing treatment, regardless of their ability to pay,
- (4) If a patient withdraws his or her request for examination or treatment, an appropriately trained individual from the Emergency Department staff will discuss the medical issues related to a "voluntary withdrawal." In the discussion, the Emergency Department staff member will:
 - (a) offer the patient further medical examination and treatment as may be required to identify and stabilize an emergency medical condition;
 - (b) inform the patient of the benefits of the examination and treatment, and of the risks of withdrawal prior to receiving the examination and treatment; and
 - (c) take all reasonable steps to secure the patient's written informed consent to refuse such examination and treatment.
 - (d) document in the medical record a description of risks discussed and of the examination and/or treatment that was refused.
- (5) If a patient leaves the Emergency Room prior to the medical screening exam or stabilizing treatment without notifying Hospital personnel, this should be documented. The documentation must reflect, at a minimum, that the patient had been at the Hospital and the time the patient was discovered to have left the premises. Triage notes and additional records must be retained.

C. STABILIZATION, TREATMENT, DISCHARGE

- (1) Except as set forth below, a patient experiencing an emergency medical condition must be stabilized prior to being discharged or transferred. A patient is considered to be stabilized when the treating physician has determined, with reasonable clinical confidence, that the patient's emergency medical condition has been resolved.
- (2) If a patient who has capacity to consent does not consent to treatment that has been recommended to stabilize an emergency medical condition after being informed of the risks and benefits of the treatment and the risks of refusing such treatment, the patient's refusal shall also be documented in the medical record. The medical record should contain a description of the examination and/or treatment offered and indicate that the patient was informed of the risks and benefits of such. For questions about whether a patient has capacity to consent, please refer to Hospital Administrative Policy A-22 on Medical Decision-Making.

- (3) A patient may be discharged after the emergency medical condition has been resolved or after a determination has been made that the patient is sufficiently stable for discharge. "Stable for discharge" means that continued care, including diagnostic work-up and/or treatment, can be safely performed on an outpatient basis, or later on an inpatient basis, provided the patient is given a plan for appropriate follow-up care with discharge instructions.

D. ON-CALL ROTATION RESPONSIBILITIES

- (1) The chairperson of each department, on behalf of the Hospital, shall be responsible for developing an on-call rotation schedule that includes the name and pager number of each physician in the department who is required to fulfill on-call duties. On-call rotation schedules shall be maintained through the On-call Scheduling System on the Lifespan Intranet.
- (2) Members of the Medical Staff have an obligation, but not a right, to share on-call duties. Medical Staff members who are relieved of on-call responsibilities for any reason may be assigned other duties so that all members share as equitably as possible in Medical Staff responsibilities.
- (3) The on-call rotation schedule may be general (e.g., medicine or surgery) or by specialty (general surgery, orthopedic surgery, hand surgery, plastic surgery), as determined by the Hospital and implemented by the relevant department chairpersons. The Medical Executive Committee shall review the on-call schedule and make recommendations to the Senior Vice President of Medical Affairs when formal changes are to be made or when legal and/or operational issues arise.
- (4) The department chairperson shall consider the needs of patients in developing the on-call rotation, including when certain specialties will not be covered because of a lack of physicians.
- (5) When possible, transfer arrangements with a hospital that can provide specialty service should be made to cover the service when there is no on-call physician scheduled to provide coverage. If a patient presents needing care when a specialty is not covered, the patient should be transferred in accordance with this policy. In the absence of such a transfer agreement, the Hospital should have a policy or protocol that outlines the steps to be followed in these situations.
- (6) If the scheduled on-call physician is unable to respond due to circumstances beyond the physician's control, the Emergency Department physician shall determine whether to attempt to contact another such specialist on the Medical Staff, or immediately arrange for a transfer pursuant to this policy.
- (7) A physician may be on call at the Hospital and at another hospital at the same time, provided the physician advises the Hospital of his or her simultaneous call obligations in advance and has arranged for appropriate physician backup. The backup physician must be available to provide on-call coverage if the scheduled on-call physician is required to be at the other hospital.

- (8) A physician may perform elective surgery at the Hospital while he or she is on call, provided the physician has arranged for appropriate physician backup who is available to provide on-call coverage.
- (9) If there are a limited number of physicians in a given specialty, the Medical Executive Committee may recommend, subject to Board approval, that physician backup call is not practical either when a physician is providing simultaneous call or when a physician is performing elective surgery while on call. In these situations, the on-call physician shall notify the Hospital in advance when he or she will be unavailable for call and the Hospital shall notify EMS that the service is not available.
- (10) As a general rule, physicians will not be permitted to resign privileges included in the core and may be required to participate in a general on-call schedule even if they have limited their practice. Physicians will be expected to maintain sufficient competence in all privileges included with the core. If a physician does not feel clinically competent to take general call, it shall be the physician's responsibility to arrange for appropriate coverage. If a physician responds to a call and requires additional expertise to take care of the patient, the physician should attempt to stabilize the patient and request an appropriate consult.
- (11) Members of the Medical Staff will not be permitted to relinquish specific clinical privileges for the purpose of avoiding on-call responsibility.
- (12) When an on-call physician is contacted by the Emergency Department and requested to respond, the physician must:
 - (a) be immediately available, at least by telephone, to the Emergency Department
 - (b) respond in person, if so requested, within a reasonable time period. Generally, response is expected within 30 minutes. The Emergency Department physician, in consultation with the on-call physician, shall determine whether the patient's condition requires the on-call physician to see the patient immediately. The determination of the Emergency Department physician shall be controlling and shall be recorded in the medical record.
- (13) Physician Assistants ("PAs") and Certified Registered Nurse Practitioners ("CRNPs") may be used to assist the on call physician in responding to call. Any decision to use a PA or CRNP should be made by the on-call physician, based on the individual's medical needs and the capabilities of the Hospital and must be consistent with hospital policies and/or protocols.
- (14) An on-call physician is responsible for the care of a patient through the episode that created the emergency medical condition, including office follow-up related to that episode. An on-call physician shall not, in the Hospital or during an office

follow-up visit, require insurance information or a copayment before assuming responsibility for care of the patient.

- (15) An on-call physician's unavailability when on-call, refusal to respond to a call from the Emergency Department or any other violation of this Policy is a serious matter. Such violations can result in an investigation of the Hospital and the physician involved, a fine of up to \$50,000 per incident (imposed by the government), civil lawsuits and/or exclusion from participation in Medicare and Medicaid programs for the Hospital and/or the physician. Accordingly, any questions about a physician's compliance with this Policy shall be referred to the Senior Vice President of Medical Affairs.

E. PATIENT TRANSFERS TO A MEDICAL FACILITY

- (1) A patient in an emergency medical condition may be transferred to another medical facility before stabilization if:
 - (a) after being informed of the risks of transfer and of the Hospital's treatment obligations, the individual requests to be transferred ("patient-initiated transfer"); or
 - (b) based on the information available at the time of transfer, the physician determines that the medical benefits to be received at another medical facility outweigh the risk to the patient of being transferred (including, in the case of a woman in labor, the risks to the unborn child) and a certification to this effect is signed by the physician ("physician-initiated transfer").
- (2) Appropriate steps shall be taken and treatment provided to minimize the risks associated with the transfer.
- (3) When a patient requests a transfer, the physician shall discuss the risks associated with the transfer and the services that will be provided if the patient is not transferred. If the patient continues to request a transfer, reasonable steps must be taken to obtain written confirmation of this request from the patient. If the patient directs the transfer against the advice of the physician, this shall be noted in the patient transfer form. If the patient refuses to sign the form, all pertinent information, including a description of the proposed transfer, shall be recorded in the patient's medical record.
- (4) When a physician initiates the transfer, the Emergency Department or on-call physician shall complete the transfer certification form, which must include a summary of the risks and benefits of transfer. Reasonable steps shall also be taken to secure the written consent of the patient to the transfer. If the patient refuses to sign the form, all pertinent information shall be recorded in the patient's medical record. In the absence of a physician at the time of transfer, a qualified medical personnel may sign the transfer certification, but only following consultation with a physician and determination by the physician that the transfer

is appropriate. The physician must countersign the certification within 24 hours of the patient's transfer. If a patient does not consent to the transfer that is recommended by a physician, steps shall be taken to obtain this refusal in writing. The writing must indicate that the patient has been informed of the risks and benefits of the transfer and must state the reasons for the patient's refusal. The patient's medical record must also contain a description of the proposed transfer that was refused.

- (5) In all cases of patient transfer, consent of the receiving hospital must be obtained and documented in the patient's medical record before the transfer. This consent is to include that the receiving hospital has available space and qualified personnel to provide treatment to the patient. The patient's condition must also be documented in the medical record prior to the transfer.
- (6) Copies of the patient's medical record, including, but not limited to, symptoms, preliminary diagnosis, treatment provided, test results, and informed written consent or transfer certification, shall be sent with the patient to the receiving hospital.
- (7) The transfer of a patient shall be carried out by qualified personnel using transportation equipment appropriate for the patient's medical condition.

F. ACCEPTING PATIENT TRANSFERS

- (1) The Hospital (including the Emergency Department physician and staff physicians) shall not refuse to accept requests for transfers if the patient is in need of the specialized capabilities or facilities available at the Hospital. The only exception to this prohibition is if the Hospital lacks the capacity safely to treat the patient.
- (2) The person who conducts the screening exam at the hospital seeking to transfer has ultimate authority to decide the scope of treatment the patient requires and whether an emergency transfer is necessary. It is permissible for the receiving Hospital physician or other practitioner to ask questions to verify the appropriateness of the outside physician's clinical judgement. However, if the outside physician believes an emergency medical condition exists and that transfer is necessary, the Hospital must accept the patient if it has capacity.
- (3) EMTALA does not apply when the hospital accepts transfer of a patient who was admitted as an inpatient at the transferring hospital, so long as the receiving hospital admits the patient as an inpatient upon arrival. EMTALA would apply if the transferred patient arrives at the ED and it is unclear whether an inpatient admission will occur.

IV. PROCEDURE

If a Lifespan employee or a Lifespan professional staff member has a *question concerning the interpretation or applicability* to a particular circumstance of any of the laws or regulations referred to in this Policy, such Lifespan employee or Lifespan professional staff member should first consult with his/her supervisor(s) and if his/her supervisor(s) is unable to answer the question or provide any guidance or, if, because of the circumstances, it would be inappropriate to discuss the matter with his/her supervisor(s), then such Lifespan employee or Lifespan professional staff member should contact the Corporate Compliance Office or the Office of the General Counsel for advice.

If any Lifespan employee or Lifespan professional staff member is aware of any violation or threatened violation of this Policy, or *suspects* a violation of this Policy has occurred, such Lifespan employee or professional staff member must report the matter to the Corporate Compliance Office or the Office of the General Counsel. No adverse action will be taken against any party who reports, in good faith, any violation or apparent or threatened violation