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HILLCREST BAPTIST MEDICAL CENTER

EMERGENCY MEDICAL SCREENING, TREATMENT, TRANSFER AND ON-CALL ROSTER POLICY

A. PRESENTING FOR CARE AND MEDICAL SCREENING EXAMINATION

(1) Any individual who comes to the Medical Center 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 Medical Center Emergency Department if the individual is on Medical Center property (including its parking lot, driveway, or sidewalk) and is requesting care for what may be an emergency condition or someone has requested care on his or her behalf. Medical Center property is the Medical Center's campus, defined as an area that is 250 yards around the main hospital building, but does not include other areas or structures that are not a part of the Medical Center, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately in Medicare.

(3) Rules concerning patients who present to an Emergency Department of the hospital other than the main building's Emergency Department, and ambulances, are provided in Appendices A and B to this Policy.

(4) The medical screening examination shall include ancillary services routinely available to the Emergency Department. The medical screening examination must be similar for patients presenting with similar symptoms.

(5) In providing a medical screening examination, the Medical Center shall not discriminate against any individual because of diagnosis, financial status, race, color, national origin, or handicap.

(6) 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, is 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 to safely transfer the woman prior to delivery or a transfer would pose a threat to the woman or her unborn child.

(7) 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 Medical Center is required only to perform a screening examination appropriate to determine that the individual does not have an emergency medical condition.

(8) A medical screening examination may be performed by an Emergency Department physician, another physician, or a non-physician practitioner who is qualified to conduct such examination ("qualified medical personnel").

(9) A list of the categories of qualified medical personnel who have been approved by the Board to perform medical screening examinations is attached as Appendix A.

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 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 co-payment.

(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 Medical Center 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) ask the patient to sign a "Withdrawal of Request for Emergency Care" form (Form #1 Withdrawal of Request for Emergency Care), which shall be completed by the Emergency Department staff member. If the patient refuses to sign the form, a description of risks discussed and of the examination and/or treatment that was refused shall be documented.

(5) If a patient leaves the Medical Center Emergency Room prior to the medical screening exam or stabilizing treatment without notifying Medical Center personnel, this should be documented. The documentation must reflect that the patient had been at the Medical Center and the time the patient was discovered to have left the premises. Triage notes and additional records must be retained.

C. STABILIZATION AND TREATMENT BEYOND THE CAPABILITY OF THE EMERGENCY DEPARTMENT

(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) An Emergency Department physician shall be responsible for the general care of all patients presenting to the Emergency Department until the patient's private physician, or an on-call physician, assumes that responsibility or the patient is discharged or transferred.

(3) A patient may request that a particular physician be contacted to provide necessary stabilizing treatment. If the physician is on the Medical Center's Medical Staff, an attempt will be made to contact the physician.

(4) If the patient does not request a specific physician, or a requested physician is unavailable to come to the Medical Center, or the requested physician does not respond within 30 minutes, the physician listed on the on-call rotation schedule shall be contacted to provide the necessary consultation or treatment for the patient.

(5) The patient must consent to any proposed stabilizing treatment in accordance with standard Medical Center protocols related to informed consent for treatment.

(6) If a patient 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, reasonable steps shall be taken to obtain the patient's signature on the "Refusal of Stabilizing Treatment" form. [Form #2.] 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.

(7) As soon as the on-call physician (or the physician requested by the patient) provides or directs the treatment of the patient, including giving any orders over the telephone, the patient becomes the responsibility of that physician.

(8) The patient shall remain the responsibility of the on-call physician (or the physician requested by the patient) until the episode of illness or injury that prompted the patient's assignment to that physician is satisfactorily resolved and the patient has been discharged or transferred.

(9) 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 Medical Center, 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 in the Emergency Department for five years.

(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. Removing a member from the on-call schedule, for any reason, does not trigger the hearing and appeals procedures in the Medical Staff Bylaws.

(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 Medical Center and implemented by the relevant department chairpersons. The Executive Committee shall review the on-call schedule and make recommendations to the Chief Executive Officer 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. When there is a limited number of physicians available to provide call coverage, physicians may be required to provide call coverage, on average, once every four days.

(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 Medical Center should have a policy or protocol that outlines the steps to be followed in these situations.

(6) In an effort to reduce the number of cases that will need to be transferred, the Medical Center will attempt to keep local Emergency Medical Services informed of the dates and times when certain specialties are not available.

(7) 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.

(8) A physician may be on call at the Medical Center and at another hospital at the same time, provided the physician advises the Medical Center 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.

(9) A physician may perform elective surgery at the Medical Center while he or she is on call, provided the physician has arranged for appropriate physician backup who is available to provide on-call coverage.

(10) If there is 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 Medical Center in advance when he or she will be unavailable for call and the Medical Center shall notify EMS that the service is not available.

(11) 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 then request an appropriate consult or institute an appropriate transfer, whichever is in the patient's best interest.

(12) Members of the Medical Staff will not be permitted to relinquish specific clinical privileges for the purpose of avoiding on-call responsibility.

(13) When an on-call physician is contacted by the Emergency Department and requested to respond, the physician must do so 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 in this regard.

(14) Physician Assistants ("PAs") and Advanced Registered Nurse Practitioners ("ARNPs") may be used to assist the on-call physician in responding to call. Any decision to use a PA or ARNP should be made by the on-call physician, based on the individual's medical needs and the capabilities of the Medical Center and must be consistent with hospital policies and/or protocols.

(15) 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 Medical Center or during an office follow-up visit, require insurance information or a co-payment before assuming responsibility for care of the patient.

(16) A refusal or failure of an on-call physician to timely respond shall be reported immediately to the President of the Medical Staff and the Chief Executive Officer, who shall review the matter and determine how to address the situation. If the refusal or failure to respond is found to be deliberate, or if it is a repeated occurrence, the matter shall be referred to the Executive Committee for further investigation and appropriate disciplinary action. Otherwise, appropriate action may be imposed.

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 Medical Center'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. [Form #3 Patient Direction To Transfer Prior To Stabilization Of Emergency Medical Condition]. 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. [Form #4 Physician Certification For Transfer And Patient Consent]. 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. [Form #5 Refusal To Consent To Transfer]. 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. The medical record shall also include the name and address of any on-call physician who failed or refused to appear within a reasonable period of time to provide examination or treatment to the patient.

(7) The transfer of a patient shall be carried out by qualified personnel using transportation equipment appropriate for the patient's medical condition.

(8) The Medical Center shall maintain the medical records of all patients transferred to or from its facility for a period of five years.

F. ACCEPTING PATIENT TRANSFERS

(1) When a request is made to accept the transfer of a patient from another facility, the Nursing Supervisor on call shall be contacted to determine whether there is adequate capability and capacity to treat the patient.

(2) The Medical Center (including the Emergency Department physician and staff physicians) shall not refuse to accept requests for transfers from the Emergency Department of another hospital if the patient is in need of the specialized capabilities or facilities available at the Medical Center. The only exceptions to this prohibition are if the Medical Center lacks the capacity to safely treat the patient or if the specialized capabilities are not contemporaneously available and alternative accommodation is not possible.

APPENDIX A

EMERGENCY DEPARTMENTS OTHER THAN THE MAIN MEDICAL CENTER EMERGENCY DEPARTMENT

(1) Any provider-based unit or facility of the Medical Center, also known as a Medicare-recognized department of the Medical Center, and which is described under the definition of Dedicated Emergency Room below, is considered to come under EMTALA, and so the terms of this Policy. This is the case whether the department of the Medical Center is located on campus or off campus.

(2) Any patient who comes to a satellite hospital Emergency Department must be screened and treated in accordance with this Policy, and all EMTALA record keeping requirements shall be observed for all patients.

(3) Since the satellite Emergency Department does not have the resources of the main Emergency Department, the Medical Center and its Medical Staff shall develop policies and procedures on the proper implementation of this Policy's requirements for each such Emergency Department (i.e., screening, treatment, etc.).

(4) If it is in the patient's interest to be transferred to another Emergency Department, the staff at the satellite Emergency Department where the individual has presented shall determine whether to transfer the patient to the Medical Center's main Emergency Department or to another Emergency Department. The latter situation requires a transfer made pursuant to the provisions of this Policy. Transporting the patient to the Medical Center's main Emergency Department is considered to be a "patient movement" and does not have to be performed pursuant to the transfer provisions of this Policy.

(5) A "Dedicated Emergency Department" means any department or facility of the Medical Center, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

(i) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

(ii) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions

on an urgent basis without requiring a previously scheduled appointment; or

(iii) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

APPENDIX B

AMBULANCES

(1) Once an individual is treated by a hospital-owned ambulance, that individual has "presented" to the Medical Center's Emergency Department.

(2) However, local and state EMS rules are to be followed, and are treated as an exception under EMTALA. If EMS rules dictate that the hospital-owned ambulance bring the patient to the nearest hospital, this rule may be followed and there shall be no violation of EMTALA.