

Alaska Native Medical Center
Emergency Medical Services and Emergency Medical Treatment and Labor Act
(EMS/EMTALA) Administrative Procedure # 713-04B
Reference Policy: EMS/EMTALA Policy #713 B

1. Purpose:

To ensure all individuals at the Alaska Native Medical Center (ANMC) accredited campus are aware of their eligibility for essential emergency medical services and that ANMC staff adequately document their compliance with the Emergency Medical Services and Emergency Medical Treatment and Labor Act (EMS/EMTALA) Policy and related procedures, EMTALA, and other applicable requirements.

2. Scope:

All personnel with responsibility to provide healthcare on the accredited ANMC Campus, including healthcare professionals, contractors, residents, non-physician interns, students, and volunteers who provide medical care for inpatients and outpatients and appropriate administrative staff.

3. Definitions:

The terms used in this procedure are defined in EMS/EMTALA Definitions Procedure.

4. Procedure:

ANMC staff will document their compliance with the requirements of the EMS/EMTALA Policy and related procedures:

4.1. **List of On-Call Physicians:** ANMC will maintain an updated list of physicians and practitioners who are “on-call” and ensure it is available to the Care Coordination Center, the Emergency Department, and Labor and Delivery Unit in accordance with the EMS/EMTALA On-Call Procedure.

4.1.1. The Telecommunications Department (ANMC Switch Board Operators) will maintain copies of the lists for at least five years.

4.2 **Central Logs:** The Emergency Department (ED) and Labor & Delivery (L&D) will each maintain a central log of all individuals who request or are provided emergency medical services pursuant to EMS/EMTALA Policy and related procedures.

4.2.1. The Nursing House Supervisors prospectively conduct an audit of the Emergency Out-of-Hospital Transfer Record for every patient transferred from ANMC to another facility, prior to transfer. This log is maintained electronically in the Central Nursing Office.

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- 4.2.2. Retroactive reviews of the central logs kept in ED and L&D will be conducted in the Service Center by designated staff and the results will be reviewed by the respective Service Center Medical Director (SCMD),
- 4.2.3. Information in the logs will be kept for at least five years by the respective departments.
- 4.2.4. Each log will include the following information:
 - 4.2.4.1.. Name and birth date of the individual seeking assistance;
 - 4.2.4.2.. Health record number;
 - 4.2.4.3. Date and time arrived;
 - 4.2.4.4. Time discharged, transferred, or admitted;
 - 4.2.4.5. Name(s) of the physician(s) or qualified medical personnel who provided the emergency Medical Screening Examination;
 - 4.2.4.6. Name(s) of the physician(s) or qualified medical personnel who provided treatment;
 - 4.2.4.7. The individual’s chief complaint and/or medical diagnosis; and
 - 4.2.4.8. The disposition of the individual, such as:
 - 4.2.4.8.1. Refused a Medical Screening Examination, treatment, or transfer;
 - 4.2.4.8.2. Was refused a Medical Screening Examination or treatment by ANMC;
 - 4.2.4.8.4. Was stabilized and transferred;
 - 4.2.4.8.5. Was admitted;
 - 4.2.4.8.6. Was stabilized and discharged; or
 - 4.2.4.8.7. Was determined not to have an Emergency Medical Condition.

- 4.3. **Maintain EMTALA Records for at Least Five Years:** ANMC will maintain medical and other records related to individuals with Emergency Medical Conditions who are treated and/or transferred to or from ANMC, including the “Emergency Out-of-Hospital Transfer Record” for at least five years.

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4.4. **Notification of Rights:** ANMC will post signs notifying individuals of their eligibility to receive a Medical Screening Examination and, if needed, stabilizing treatment and/or an appropriate transfer.

4.4.1. The signs will be posted conspicuously in places likely to be noticed by all individuals entering or waiting for care in the emergency department, labor and delivery, and other appropriate locations.

4.4.2. The signs must be visible from anywhere in the area or at a distance of twenty (20) feet, whichever is less.

4.4.3. The signs will state:

IT'S THE LAW!

If you have a medical emergency or are in labor, even if you cannot pay or do not have medical insurance or you are not entitled to Medicare or Medicaid, you have the right to receive, within the capabilities of this hospital's staff and facilities:

- An appropriate Medical Screening Examination,
- Necessary stabilizing treatment (including treatment for an unborn child) and if necessary,
- An appropriate transfer to another facility.

This hospital does participate in the Medicaid program.

4.4.4. ANMC will ensure its translators are familiar with this information and can provide it in appropriate circumstances to individuals who speak other common languages

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Responsibility:	President ANMC Medical Staff; ANTHC-ANMC Clinical Risk Consultant and SCF Risk Manager
Written:	April 21, 2009
Approval	ANMC Executive Management Team with concurrence of Joint Operating Board
Date approved	6/25/09, 11/20/13,10/25/13,5/2017
Approved as Interim Procedure	ANMC Administrator 5/20/09
Date last reviewed:	4/2009, 7/21/09, 10/25/13.5/2017
Date last revised:	New, 7/13/09,5/2017
Supersede:	None, ANMC Procedure # 713-04 with edit corrections as to processes, change in status from Interim to Permanent ANMC Procedure

Official Signature on File
o/s: Roald Helgesen
ANMC Administrator

5/17/2017
Date

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OUT-OF-HOSPITAL TRANSFER RECORD
 Instructions to complete this form on next page

TRANSFERRED FROM	TRANSFERRED TO
REFERRING PHYSICIAN	RECEIVING PHYSICIAN/SERVICE
TIME LEFT / DATE	CONDITION AT TIME OF TRANSFER
MODE OF TRANSFER	PERSONNEL ESCORTING PATIENT

<p style="text-align: center; font-weight: bold; font-size: small;">PREPARATION FOR TRANSFER OF PATIENT</p> <input type="checkbox"/> IV Fluid Type: _____ Rate: _____ <input type="checkbox"/> Cardiac Monitor <input type="checkbox"/> Spineboard <input type="checkbox"/> C-Collar <input type="checkbox"/> NG Tube <input type="checkbox"/> Foley Catheter <input type="checkbox"/> ET Tube <input type="checkbox"/> Oximeter <input type="checkbox"/> Contract Health Notified <input type="checkbox"/> Approvals Signed and Information Regarding the Transfer Explained to Patient	<p style="text-align: center; font-weight: bold; font-size: small;">WITH TRANSFERRED PATIENT</p> <input type="checkbox"/> Copy of Medical Record (including H&P, Flow Sheets, Treatments, etc.) <input type="checkbox"/> Copy of Health Summary <input type="checkbox"/> Copy of ALL Lab Results <input type="checkbox"/> Copy of EKG <input type="checkbox"/> Copy of X-Rays and/or Reports <input type="checkbox"/> Personal Belongings (Clothing, Wallet, Valuables, etc.) <input type="checkbox"/> All Dressings, Immobilization Devices, IV Lines, Catheters, Functional and Secured at Time of Transfer
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REFERRING PHYSICIAN CERTIFICATIONS (Check relevant item below)			
<input type="checkbox"/> In my medical opinion, this patient has no emergency medical condition or has been stabilized, and transfer at this time is appropriate.			
<input type="checkbox"/> An emergency medical condition (including a pregnant patient with contractions) exists and transfer at this time is appropriate.			
PHYSICIAN'S NAME (Print)	PHYSICIAN'S SIGNATURE	DATE	TIME

REFERRING PHYSICIAN CONSULTATION CERTIFICATION (Check relevant item below)			
<input type="checkbox"/> I have explained to the patient (and/or his or her legal representative) all of the expected medical benefits to be gained by the transfer, the medical risks posed by the transfer, and why I believe the expected medical benefits of transfer outweigh risks posed by transferring the patient.			
Diagnosis/Condition/Criteria for Transfer:			
Document specific risks/benefits to specific patient:			
<input type="checkbox"/> Patient or legal representative concurs and requests transfer.			
<input type="checkbox"/> Patient or legal representative does not agree to the transfer although it is in my medical judgement that the expected medical benefits associated with the transfer outweigh the medical risks posed by the transfer.			
PHYSICIAN'S NAME (Print)	PHYSICIAN'S SIGNATURE	DATE	TIME
PATIENT OR REPRESENTATIVE'S NAME (Print)	SIGNATURE OF PATIENT/REPRESENTATIVE	DATE	TIME

PATIENT'S IDENTIFICATION (Addressograph)	NAME (First, M.I., Last)
	ADDRESS (Street, P.O. Box)
	CITY/STATE
	DATE OF BIRTH (MM/DD/YY)
	RECORD NO.

ANMC, Medical Executive Committee, HRC Approved 05/09