

**OCO INVESTIGATION OF
COVID-19 MORTALITIES AT COYOTE RIDGE CORRECTIONS CENTER (CRCC)
CONDUCTED BY PATRICIA H. DAVID MD MSPH CCHP,
DIRECTOR OF PATIENT SAFETY AND PERFORMANCE REVIEW**

Summary of Concern

In May 2020, CRCC experienced an outbreak of COVID-19. The SARS-CoV-2 virus – the virus responsible for COVID-19 – spread through sections of the facility and, in June 2020, two incarcerated individuals died as a result of COVID-19 infection. This report reviews the circumstances surrounding these deaths, and provides an assessment of key contributing factors as well as recommendations to improve processes and prevent additional deaths at CRCC and other DOC facilities across Washington.¹

OCO Statutory Authority

- Per RCW 43.06C.005, OCO was created to assist in strengthening procedures and practices that lessen the possibility of actions occurring within DOC that may adversely impact the health, safety, welfare, and rehabilitation of incarcerated individuals, and that will effectively reduce the exposure of DOC to litigation.
- Per RCW 43.06C.040, OCO has the authority to receive, investigate, and resolve complaints related to incarcerated individuals' health, safety, welfare, and rights.

OCO Investigative Process

As part of this investigation, OCO reviewed the following documents:

- Medical charts

¹ OCO's *Investigation of the Coronavirus Disease 2019 (COVID-19) Outbreak at Coyote Ridge Corrections Center*; available at <https://oco.wa.gov/reports-publications> once published.

- DOC Policies 600.000 Health Services Management
- 610.010 Offender Consent for Health Care
- 610.040 Health Screenings and Assessments
- 610.650 Outpatient Services
- 890.620 Emergency Medical Treatment
- Washington DOC Health Plan (a.k.a. Offender Health Plan)
- DOC Screening, Testing, and Infection Control Guideline, Versions 17 and 20²
- Centers for Disease Control and Prevention (CDC) Interim Guidance on Management of Coronavirus Disease 2019 in Correctional and Detention Facilities

In addition, OCO also reviewed DOC Incident Management Response System Reports and obtained information from the CRCC Health Services Manager, Facility Medical Director, a Health Services Administrator from DOC Headquarters, and DOC's Chief Medical Officer. (Three DOC nurses who had relevant involvement in the patients' care did not respond to OCO's requests for interview.) OCO also had conversations with representatives from Kadlec Regional Medical Center, Providence St. Peter Family Medicine Residency Program, the Washington Nursing Care Quality Assurance Commission, the Washington Medical Commission, and the American Correctional Association.

Case Summaries

Patient A

Patient A was a 63 year old Black man with multiple chronic conditions that identified him as at increased risk of severe illness from COVID-19.^{3,4} There is no documentation of any complaints consistent with possible COVID-19 until 5/31/2020, when nursing was called to assess Patient A due to respiratory difficulty. He reported that he developed a sore throat the night prior, and it had

² Version 17 was in effect at the time of these patients' deaths.

³ From Centers for Disease Control and Prevention (CDC). Coronavirus Disease 2019 (COVID-19). People with Certain Medical Conditions. Available at <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>

⁴ From CDC. Older Adults. Available at <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html#:~:text=As%20you%20get%20older%2C,people%20in%20their%2050s.>

become worse; he additionally was experiencing a cough which increased with activity, and that he was feeling weak and unable to stand without help. The on-call provider was contacted, and Patient A was sent to the ER via ambulance that same day.

At the hospital, he reported that over the past week, he had been having progressive shortness of breath with persistent cough, fever, myalgias, and fatigue. His cough progressed to become productive of bloody sputum and he developed a fever, which prompted his transfer to the hospital. He reported that another incarcerated person had confirmed COVID-19, and that he himself had not been tested at the facility. Tests confirmed the diagnosis of COVID-19, and he received treatment. Unfortunately, Patient A passed away on 6/17/2020.

Patient B

Patient B was a 72 year old non-White, non-Hispanic⁵ man who had several pre-existing medical conditions; although none of those pre-existing conditions conveyed an increased risk of severe illness due to COVID-19, his age still identified him to be at higher risk. The records do not demonstrate any complaints indicating potential COVID-19 illness until 6/13/2020, when Patient B declared a medical emergency and reported two days of diarrhea and intermittent abdominal upset. Nursing noted that he was having chills and was profusely sweating; his heart rate was rapid and erratic, and oxygen saturation was low. Initially his temperature was documented to be within normal range, but quickly escalated to a fever. He was sent to the ER that same day.

Upon arrival at the hospital, he reported a four-day history of diarrhea after eating; in addition, he developed a fever one day prior. He tested positive for COVID-19 and received treatment, but ultimately passed away on 6/22/2020.

Key Finding and Recommendations

Delay in access to care

⁵ Race is designated to be “other” by DOC.

In both cases, the patients did not seek treatment at the onset of their symptoms. At the hospital, both patients reported symptoms for 4-7 days prior to their report to the institutional staff. Since neither patient sought care at symptom onset, there was a resulting delay in testing and treatment. Furthermore, because symptoms were not reported at the outset, Patient A was not isolated from other individuals prior to being sent to the hospital.

Learning Point: Although these patients' reasons for delay in seeking treatment is unknown, information gathered during this investigation as well as through the OCO's investigation into the COVID-19 outbreak at CRCC⁶ found that conditions of medical isolation – e.g. minimal recreational activities, lack of interpersonal interaction, lack of access to personal belongings, foul-tasting water, and DOC's practice of treating those in medical isolation in the same manner as those in administrative segregation – were, according to CRCC staff, “not conducive to healthy recovery” and were instead a hindrance to self-reporting. Thus, evaluating current efforts to encourage self-reporting would be a reasonable quality improvement endeavor. Delayed self-reporting may potentially result in adverse health outcomes due to postponed treatment, and may also lead to continued transmission within shared housing spaces.

Considerations: OCO commends DOC on taking action to meet some of the recommendations from prior OCO reports, such as suspending all co-pays related to COVID-19, providing those in isolation with a broader selection of books and other printed materials, and ensuring access to personal property. To continue these efforts to improve self-reporting by potentially infected members of the population, OCO provides additional suggestions, most of which have been outlined in several OCO publications as noted:

- Improving conditions of confinement for those in medical isolation⁷, potentially including:
 - Increased free phone calls with family
 - Ensured JPay access, if possible, including video visitation
 - Basic art materials (colored pencils, paint, clay), origami, and other crafts

⁶ From OCO's *Investigation of the Coronavirus Disease 2019 (COVID-19) Outbreak at Coyote Ridge Corrections Center*. Available at <https://oco.wa.gov/reports-publications> once published.

⁷ From OCO's *Recommendations Related to the DOC COVID-19 Response*. Available at <https://oco.wa.gov/sites/default/files/COVID-19%20Workgroup%20Report%20Final.pdf>

- Working radio and television for every cell
- Food treats (energy bars, popcorn, occasional cookies and other sweets)
- Daily showers or at least every other day
 - OCO acknowledges that DOC has permitted those in isolation to return to a regular shower schedule after seven days, but we continue to lift up the need for more frequent skin cleaning in those who are COVID-19 positive
- Physical recreation activities, preferably out of cell, but at least in-cell
- Communicating regularly with those in isolation about the duration and purpose of their medical isolation period, so that the individuals are not left wondering what is happening and how long they will remain.⁸
- Communicating regularly with those in the general population about the need to report symptoms immediately to protect everyone.⁹
 - A good example of this type of communication is the video created by CRCC Superintendent Uttecht which speaks to the importance of self-reporting. Changing this video on a regular basis to perhaps include some CRCC Health Services staff would keep the information fresh.
- Communicating, on a weekly basis, information such as number of positive cases at their facility, proper personal hygiene, and significance of social distancing; ensuring an individual's COVID-19 related complaints are addressed, whether through the grievance program or otherwise.¹⁰

OCO is aware that there are factors other than the conditions in medical isolation which may be a barrier to self-reporting. Ultimately, performing medical surveillance via daily mass

⁸ From CDC. Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities. Available at <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>

⁹ One notable example is the video message to the population created by CRCC Superintendent Uttecht.

¹⁰ From OCO's *Recommendations Related to the DOC COVID-19 Response*. Available at <https://oco.wa.gov/sites/default/files/COVID-19%20Workgroup%20Report%20Final.pdf>

screening of the entire population when an outbreak occurs^{11,12} may be the most efficient means of identifying those who are potentially infected.

- Although the combination of temperature check and symptom screening questions may not identify asymptomatic or pre-symptomatic individuals, daily mass screening of the entire population can identify those who are symptomatic and may be hesitant to self-report.
 - In the cases of Patient A and Patient B, mass screening could have identified their symptoms earlier in their disease processes and enabled them to get testing and treatment sooner than they did.
 - Earlier identification would also have resulted in removal of Patient A from the general population, thereby preventing him from potentially transmitting the SARS-CoV-2 virus to others.¹³
- Daily mass screening in the context of a medical surveillance program can help inform leadership of the spread of disease through the facility, and direct the efficient use of resources toward a prevention focus.
- To reduce concerns regarding staff workload, DOC should consider utilizing trained and appropriately paid incarcerated workers whose job it would be to conduct screenings and provide daily reports.

Additional Quality Improvement Consideration

At one point during Patient B's hospital stay, he required an invasive procedure and could not himself provide consent. A hospital nurse attempted to obtain consent by reaching out to a CRCC nurse. The CRCC nurse attempted to reach four people to obtain consent¹⁴: The facility medical duty officer on call,¹⁵ the practitioner duty officer on call, the HSM, and the FMD. However, per

¹¹ Ibid.

¹² From Minnesota Department of Health. COVID-19 Toolkit: Information for Long Term Care Facilities. Identify Infections Early. Available at <https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf>

¹³ By the time Patient B developed symptoms, CRCC was already on lockdown.

¹⁴ Based on chart documentation and email communication.

¹⁵ DOC clarified that this refers to the on-call nursing supervisor.

the CRCC nurse's note, no answer was received. The CRCC nurse additionally informed the ICP of this request from the hospital, but did not receive guidance since this was a medical matter and not within the ICP's scope. After an hour and twenty minutes, the CRCC nurse returned the hospital nurse's call, and learned that hospital providers had proceeded with care without information from DOC because the need had become emergent.

Interviews with staff reflect some additional confusion with regards to this process for obtaining consent. The FMD explained that DOC staff are not permitted to give consent for any outside procedures or interventions, and that the appropriate pathway for obtaining consent when a patient is in the hospital is 1) the patient, 2) the family, 3) the hospital ethics committee. The CMO agreed, explaining that DOC employees are not able to act as decision-makers for outside procedures and referring OCO to DOC 610.010 *Offender Consent for Healthcare*. However, this policy – written in 2015 – indicates that, if emergency medical treatment is needed and no surrogate decision maker is available, “permission to treat will be obtained from the Chief Medical Officer or Chief of Dentistry, as applicable and if time permits.”¹⁶

To be clear, Patient B ultimately received the necessary procedure, so any potential delay in obtaining consent did not contribute to his death. However, the conflicting information regarding the proper procedure for obtaining consent for outside treatment suggests that the process should be made clearer:

- OCO recommends that DOC 610.010 be updated and clarified to reflect any desired changes to the process for emergency medical treatment when a patient is unable to give consent and no surrogate is available.
- Once updated, a review of the working agreements between DOC and regional hospitals should be conducted by Health Services administrative leadership, so that the hospitals where incarcerated individuals receive treatment are aware of DOC's process.
- The updated policy should be reviewed with all Health Services staff so that calls requesting permission for treatment are promptly directed to the appropriate decision maker(s).

¹⁶ DOC 610.010, III. G. 1-2.

Finally, given the difficulty the CRCC nurse had in reaching a decision maker to answer an urgent medical question and the long delay (80 minutes) without response suggests that the process for reaching an on-call provider and/or administrator could be improved. According to a DOC Headquarters Health Services Administrator, there is no written policy or protocol dictating on-call responsibilities; rather, if the on-call provider does not answer within a “clinically appropriate time frame,” the facility is to call the Headquarters Medical Duty Officer. However, in the community, hospitals establish policies which delineate the responsibilities of the on-call physician, to ensure institutional compliance with the provisions of the federal Emergency Medical Treatment & Labor Act (EMTALA).¹⁷ Although EMTALA may not be directly applicable to DOC work, developing similar policies within DOC’s health system could be considered as part of the agency’s ongoing patient safety efforts. Thus, OCO suggests clarification of the process for reaching an on-call practitioner to avoid any delays in response that may affect care:

- One suggestion would be to develop a clear on-call escalation list for the nurses at each facility, ultimately including the directions to contact the Chief Medical Officer and/or the Health Services Administrator when the on-call practitioner or FMD cannot be reached.
- In addition, firm guidelines on the wait time for response before moving on to the next contact person should be established, so that facility nurses are not waiting for extended periods of time for a response from on-call staff.
- Finally, any policy regarding the provision of on-call coverage should specify methods for monitoring and ensuring compliance.

¹⁷ See Appendix A for a generic example from the community, which contains information that may be helpful when developing future policies and protocols.

Appendix A

EMTALA - MODEL Facility Policy

POLICY NAME: EMTALA – Provision of On-Call Coverage Policy

DATE: (facility to insert date here)

NUMBER: (facility to insert number here)

This policy reflects guidance under the Emergency Medical Treatment and Labor Act (“EMTALA”) and associated State laws only. It does not reflect any requirements of The Joint Commission or other regulatory entities. Each facility should ensure it has policies and procedures to address such additional requirements. No facility may edit this policy in a manner that would remove existing language. Additions to this policy should be easily identifiable (*e.g.*, in another color, different font or italicized text).

The definitions in the Company EMTALA Policy, LL.EM.001, apply to this and all other Company and facility EMTALA policies.

PURPOSE: To establish guidelines for the hospital, including a specialty hospital, and its personnel to be prospectively aware of which physicians, including specialists and sub-specialists, are available to provide additional medical evaluation and treatment necessary to stabilize individuals with emergency medical conditions (“EMCs”) in accordance with the resources available to the hospital as required by EMTALA, 42 U.S.C. § 1395dd, and all Federal and State regulations and interpretive guidelines promulgated thereunder.

POLICY: The hospital must maintain a list of physicians on its medical staff who have privileges at the hospital or, if it participates in a community call plan, a list of all physicians who participate in such plan. Physicians on the list must be available after the initial examination to provide treatment necessary to stabilize individuals with EMCs who are receiving services in accordance with the resources available to the hospital. The cooperation of the hospital’s medical staff members with this policy is vital to the hospital’s success in complying with the on-call provisions of EMTALA. The hospital should make its privileged physicians aware of their legal obligations as reflected in this policy and the Medical Staff Bylaws and should take all necessary steps to ensure that physicians perform their obligations as set forth herein and in each document.

PROCEDURE:

Develop an On-Call Schedule. The facility’s governing board must require that the medical staff be responsible for developing an on-call rotation schedule that includes the name and direct telephone number or direct pager of each physician who is required to fulfill on-call duties. Practice group names and general office numbers are not acceptable for contacting the on-call physician. Individual physician names with accurate contact information, including the direct telephone number or direct pager where the physician can be reached, are to be put on the on-call list. The hospital **MUST** be able to contact the on-call physician with the number provided on the list. If the on-call physician decides to list an answering service number as the preferred method of contact, his/her mobile phone number must be

provided to the hospital as a backup number to reach the on-call physician. The backup number will be used by hospital and Transfer Center personnel when the On-Call Physician does not respond to calls in a timely manner. Each physician is responsible for updating his or her contact information as necessary. Each hospital shall provide a copy of the daily on-call schedule to the Transfer Center.

The on-call schedule may be by specialty or sub-specialty (*e.g.*, general surgery, orthopedic surgery, hand surgery, plastic surgery), as determined by the hospital and implemented by the relevant department chairpersons. The Medical Executive Committee (“MEC”) shall review the on-call schedule and make recommendations to the CEO when formal changes are to be made or when legal and/or operational issues arise.

The hospital shall keep local Emergency Medical Services advised of the times during which certain specialties are unavailable.

Only physicians that are available to physically come to the ER may be included on the on-call list. A physician available via telemedicine does not satisfy the on-call requirements under EMTALA.

Specialty Hospital Call. A specialty hospital such as a psychiatric, orthopedic, or heart hospital that does not operate an emergency department is still subject to EMTALA requirements, and must maintain an on-call list and accept appropriate transfers when requested to do so.

Records. The hospital must keep a record of all physicians on-call and on-call schedules for at least five years. Any on-call list must reflect any and all substitutions from the time of first posting of the list. These records may be in electronic or hardcopy format.

Maintain a List. Each hospital must maintain a list of physicians who are on-call for duty after the initial examination to provide treatment necessary to stabilize an individual with an EMC. The Medical Staff Bylaws or appropriate policy and procedures must define the responsibility of on-call physicians to respond, examine, and treat patients with an EMC. Factors to consider in developing the on-call list include: the level of trauma and emergency care afforded by the hospital; number of physicians on the medical staff who are holding the privileges of the specialty; other demands on the physicians; frequency with which the physician’s services are required; and the provisions the hospital has made for situations where the on-call physician is not available or not able to respond due to circumstances beyond his or her control. The hospital is expected to provide adequate specialty on-call coverage consistent with the services provided at the hospital and the resources the hospital has available.

In addition, the on-call list requirement applies to any hospital with specialized capabilities that is participating in the Medicare program regardless of whether the hospital has a DED. Specialty Hospitals must have appropriate on-call specialists available for receiving those individuals transferred pursuant to EMTALA. Hospitals should verify that the privileges of each on-call physician are current as to the procedures that each on-call physician is able to perform and the services that each on-call physician may provide.

The on-call list maintained for the main hospital Emergency Department shall be the on-call list for the hospital, including any Off-Campus Provider-based Emergency Departments.

Physician's Responsibility. The hospital has a process to ensure that when a physician is identified as being "on-call" to the DED for a given specialty, it shall be that physician's duty and responsibility to assure the following:

1. Immediate availability, at least by telephone, to the ED physician for his or her scheduled "on-call" period, or to secure a qualified alternate who has privileges at the hospital if appropriate.
2. If a Transfer Center is being utilized to contact the on-call physician, the on-call physician must respond to the Transfer Center within a reasonable timeframe (generally, within 30 minutes).
3. Arrival or response to the DED within a reasonable timeframe (generally, response by the physician is expected within 30 minutes). The ED physician, in consultation with the on-call physician, shall determine whether the individual's condition requires the on-call physician to see the individual immediately. The determination of the ED physician or other practitioner who has personally examined the individual and is currently treating the individual shall be controlling in this regard.
4. The on-call physician has a responsibility to provide specialty care services as needed to any individual who comes to the Emergency Department either as an initial presentation or upon transfer from another facility.
5. The on-call physician has a responsibility to notify the Medical Staff Office of changes to the on-call schedule.

Authority to Decline Transfers. The on-call physician does not have the authority to refuse an appropriate transfer on behalf of the facility.

Only the CEO, Administrator-on-Call ("AOC"), or a hospital leader who routinely takes administrative call has the authority to verify that the facility does not have the capability and capacity to accept a transfer. Any transfer request which may be declined must first be reviewed with this individual before a final decision to refuse acceptance is made. This requirement applies to all transfer requests, regardless of whether the transfer request is facilitated by a Transfer Center representative or the facility's CEO designee or ED physician. For purposes of this requirement, a Nursing Supervisor, House Supervisor or other similarly titled position is not considered to be an equivalent of the AOC.

Financial Inquiries. Medical Staff Members who are on-call and who are called to provide treatment necessary to stabilize an individual with an EMC may not inquire about the individual's ability to pay or source of payment before coming to the DED and no facility employee, including Transfer Center employees, may provide such information to a physician on the phone.

Physician Appearance Requirements. If a physician on the on-call list is called by the hospital to provide emergency screening or treatment and either fails or refuses to appear within a reasonable timeframe, the hospital and that physician may be in violation of EMTALA as provided for under section 1867(d)(1)(C) of the Social Security Act. If a physician is listed as on-call and requested to make an in-person appearance to evaluate and treat an individual, that physician must respond in person within a reasonable amount of time. For those physicians who do not respond within a reasonable amount of time, the Chain of Command Policy should be initiated.

Note: Each facility should define a reasonable timeframe – generally that timeframe should not be greater than 30 minutes.

If, as a result of the on-call physician's failure to respond to an on-call request, the hospital must transfer the individual to another facility for care, the hospital must document on the transfer form the name and address of the physician who refused or failed to appear.

Call by Non-Physician Practitioners. The ED physician must be able to first confer with the on-call physician. Midlevel practitioners (usually physician assistants or advanced practice registered nurses) who are employed by and have protocol agreements with the on-call physician, may appear at the hospital and provide further assessment or stabilizing treatment to the individual only after the on-call physician and ED physician confer and the on-call physician so directs the licensed non-physician practitioner to appear at the hospital. The individual's medical needs and capabilities of the hospital, along with the State scope of practice laws, hospital bylaws, and rules and regulations, must be thoroughly reviewed prior to implementing this process. The designated on-call physician remains ultimately responsible for providing the necessary services to the individual in the DED regardless of who makes the first in-person visit. If the ED physician does not believe that the non-physician practitioner is the appropriate practitioner to respond and requests the on-call physician to appear, the on-call physician must come to the hospital to see the individual.

Selective Call and Avoiding Responsibility. Medical Staff Members may not relinquish specific clinical privileges for the purpose of avoiding on-call responsibility. The Board of Trustees is responsible for assuring adequate on-call coverage of specialty services in a manner that meets the needs of the community in accordance with the resources available to the hospital. Exemptions for certain medical staff members (*e.g.*, senior physicians) would not per se violate EMTALA-related Medicare provider agreement requirements. However, if a hospital permits physicians to selectively take call ONLY for their own established patients who present to the DED for evaluation, then the hospital must be careful to assure that it maintains adequate on-call services, and that the selective call policy is not a substitute for the on-call services required by the Medicare provider agreement.

Providing Elective Surgeries or Other Therapeutic or Diagnostic Procedures While On-Call. The hospital shall have in place policies and procedures to ensure that specialty services are available to meet the needs of any individual with an EMC if the hospital permits on-call physicians to schedule elective surgeries during the time that they are on-call. An on-call physician who undertakes an elective surgery while on-call must arrange for an appropriate physician with comparable hospital privileges to serve as back-up to provide on-call coverage and notify the facility of such determination. The facility will ensure that the DED is familiar with the back-up arrangement for any physician performing elective procedures.

Simultaneous Call. Physicians are permitted to have simultaneous call at more than one hospital in the geographic area; however, the physician must provide the hospital with the physician's on-call schedule so that the hospital can have a plan in place to meet its EMTALA obligation to the community. This plan could include back-up call by an additional physician or the implementation of an appropriate transfer. An on-call physician may not choose the hospital in which to treat a patient purely for the physician's convenience (*e.g.*, if a physician is on-call for both Hospitals A and B, is at Hospital B, but

is requested to come to Hospital A by the Hospital A ED physician, the on-call physician is obligated to treat the patient at Hospital A).

Back-up Plans and Transfers. The hospital shall have in place a written plan for transfer and/or back-up call coverage by a physician of the same specialty or subspecialty for situations in which a particular specialty is not available or the on-call physician cannot respond due to circumstances beyond the physician's control. The ED physician shall determine whether to attempt to contact another such specialist or immediately arrange for a transfer. The hospital must be able to demonstrate that hospital staff is aware of and able to execute the back-up procedures.

Appropriate transfer agreements shall be in place for those occasions when an on-call specialist is not available within a reasonable period of time to provide care for those individuals who require specialty or subspecialty physician care and a transfer is necessary. A list of facilities with which the hospital has transfer arrangements and the specialties represented shall be available to the individual or Transfer Center responsible for facilitating the transfer. The transfer agreements shall not include financial provisions for EMTALA transfers.

Transfer to Physician's Office. When a physician who is on-call is in his or her office, the hospital may NOT refer individuals receiving treatment for an EMC to the physician's office for examination and treatment. The physician must come to the hospital to examine the individual if requested by the treating physician.

Community Call Plan. A community call plan is designed to meet the needs of the communities served utilizing the resources within the region. A community call plan facilitates appropriate transfers to the hospital providing the specialty on-call services pursuant to the plan, but does not relieve any hospital of any EMTALA obligations with respect to transfer. Even though a hospital may participate in a community call plan, the hospital must still accept appropriate transfers from non-participating hospitals.

Any community call plan must be approved by Operations Counsel and meet all applicable federal and state regulations and guidelines.