



Arkansas Department of Health

4815 West Markham Street • Little Rock, Arkansas 72205-3867 • Telephone (501) 661-2000

Governor Mike Beebe

Nathaniel Smith, MD, MPH, Director and State Health Officer

March 21, 2014

Re: Emergency Medical Treatment and Active Labor Act (EMTALA)

Dear _____ :

Our Arkansas trauma system is a great success and has brought many valuable improvements to the delivery of care for injured patients. The system was designed to be inclusive, meaning that every hospital in the state was given the opportunity to participate at a level commensurate with its capability and capacity. Almost every hospital has elected to participate, and Arkansas is better for it.

The Arkansas Trauma Communications Center (ATCC) has been one of the greatest drivers of our success and has significantly expedited the transfer of injured patients within the system. The “dashboard” utilized by the ATCC affords our system the opportunity to match patient needs to the real time capability and capacity of the trauma centers.

The uniqueness of our inclusive trauma system and the ATCC has led to circumstances that fall under the jurisdiction of the Centers for Medicare and Medicaid Services (CMS) and federal EMTALA guidelines. In short, a hospital’s participation in the trauma system as a designated trauma center is voluntary, but compliance with EMTALA guidelines is not.

A trauma center may choose to represent itself as not possessing capability and capacity for a particular service (or services) on the “dashboard.” To do so is a statement of diversion of patients for this service(s) and the ATCC will not direct patients to that facility. If, however, during this period of diversion, the center creates additional capacity or obtains the capability for this service(s), it must then offer the service(s) to all trauma patients.

It might be useful to look at a hypothetical example. A trauma center is on Charlie Temp for orthopedic surgery. The ATCC therefore operates under the assumption that the hospital is not accepting such patients and will divert these patients away from that facility. If, during that time, a patient presents to the same facility by private vehicle with an orthopedic injury and the facility stabilizes and then admits or calls in an orthopedist to care for the patient, it has:

- a. created capacity and provided capability to the local patient who self-presented;
- b. denied others in the system who would have normally been recommended by the ATCC to be transported or transferred to that facility the benefit of that capability and capacity; and,
- c. violated federal EMTALA regulations.

The remedy for these situations is for the facility to determine what steps can be taken and under what circumstances it can extend its usual capability and capacity to accommodate more patients and to determine its limits of capability and capacity. When such limits are reached it may and should go on diversion, but should treat all patients the same, regardless of whether they are transported/transferred through the trauma system or self-present. A facility may not accept by EMS transport/hospital transfer a patient who has a specialty need for which it is on diversion, but if a patient self-presents with a similar injury, the facility would be required to perform a screening medical exam and stabilize the patient within its capacity, and then transfer that patient since it ostensibly lacks the capability or capacity to definitively care for the patient.

These questions were recently posed to Sergio Mora with CMS in Dallas, Texas. Please find Mr. Mora's verbatim response below.

"Hey Todd, the short answer to your question is that a hospital cannot expand their capacity or capability on a case by case basis. If they are listed as not having capacity and capability on your dashboard, then they should also just screen and transfer out any "local ambulance traffic and walk ins". If they are using this method to circumvent their EMTALA obligations, then we can certainly justify an EMTALA violation. Let me know if this answers your question.

Sergio A. Mora, MHA | Texas State Representative | Division of Survey and Certification | Centers for Medicare and Medicaid Services, Dallas TX | P (214)767-5499 | F (443)380-6503 | sergio.mora@cms.hhs.gov"

We want to emphasize that enforcement of EMTALA regulations falls under CMS jurisdiction. However, since this issue has come up several times in our system over the last couple of years, we believe it is important that we all have a common understanding of what is and is not allowable under EMTALA. If there are specific questions that remain, please do not hesitate to e-mail us at the Trauma Section of the Arkansas Department of Health and we can offer clarification and/or work with our colleagues at CMS to find the answers. We would prefer such inquiries in writing so that we can be consistent in our responses. Please note that an electronic copy of this letter has been forwarded to your Trauma Medical Director and Trauma Program Manager.

Sincerely,



R. Todd Maxson, MD, FACS
Trauma Medical Consultant
Arkansas Department of Health



William C. Temple, JD
Branch Chief
Trauma/Injury and Violence Prevention

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