



Trauma Advisory Council

March 15, 2011

3:00 p.m.

Minutes

MEMBERS PRESENT

Dr. Charles Mabry
Dr. Clint Evans
Dr. Lorrie George
Dr. James Graham
Dr. Alvin Simons
Dr. Mary Aitken
Dr. Paul Halverson (rep. by
Donnie Smith)
Myra Looney Wood
Freddie Riley
Dr. Barry Pierce
R. T. Fendley
Ron Peterson
Robert T. Williams
K. C. Jones
Jon Wilkerson
Carrie Helm

MEMBERS ABSENT

Dr. John Cone
Dr. Michael Pollock
Dr. Victor Williams
Ron Peterson
Ruth Baldwin
Colonel Winford Phillips
Vanessa Davis
Dr. Ronald Robertson
Terry Collins
Jamie Carter
Robert Atkinson

GUESTS

Dr. Michael Sutherland
Jimmy Sheffield
Donna Parnell-Beasley
Jon Swanson
Donald Reed
Dr. Chuck Mason
Theresa Jordan
Denise Carson
John Recicar
Gary Ragen
Scottie Trammell
Dwayne Aalseth
Tim Vandiver
Jeff Tabor
Carla Jackson
Milton Teal
John Badgley
Kristin Scalia
Monica Kimbrell
Tonja Kelly
Laura Guthrie
Janie Evans
John Benjamin
Stacy Wright
Chrystal Rhone
James Smith
Terry Bracey
Barbara Riba
Amy Fremann
Sarah Bemis
Keith Moore

GUESTS (Continued)

Lacey Robb
D'borai Cook
Don Adams
Heather McClanahan
Jerry Duncan
Ron Crane
Joanne Sullivan
Joseph Hennington

STAFF

Dr. Todd Maxson
Austin Porter
Bill Temple
Brian Nation
Detrich Smith
Diannia Hall-Clutts
Donnie Smith
Jim C. Brown
Joe Martin
Lee Crawford
Margaret Hollaway
Marie Lewis
Linda Lehing
Rick Hogan
Renee Patrick

I. Call to Order – Dr. James Graham, Chairman

The Trauma Advisory Council (TAC) meeting was called to order on Tuesday, March 15, 2011, at 3:05 p.m. by Dr. James Graham.

II. Welcome and Introduction

Dr. Graham welcomed all guests and members.

III. Approval of Draft Minutes From the February 15, 2011 Meeting

The TAC reviewed the February 15, 2011 minutes. A motion to approve was made by K.C. Jones and seconded by Jon Wilkerson. The previous minutes were approved with attendance corrections.

IV. Trauma Office Report – Bill Temple

Staffing

The Branch has eight candidates for the last Registered Nurse position. Interviews will begin late this week and should conclude early next week.

Grants

Mr. Temple informed the TAC that funds are being distributed and ADH processes seem to be working smoothly. He inquired of the TAC about the report format going forward. After discussion, the TAC requested an e-mail report in the future with significant events/milestones to be included in the verbal TAC meeting report.

Hospitals

Renee Patrick, Trauma Section Chief, reported on hospital grants. She noted that the status of funding is impacted depending on where each hospital is in the process. Currently, we have seven designated hospitals. These include The University of Arkansas for Medical Sciences (UAMS), Arkansas Children's Hospital (ACH), The Regional Medical Center in Memphis (The MED), Jefferson Regional Medical Center (JRMC) in Pine Bluff, Baptist Health – Little Rock, St. John's Hospital in Springfield, MO, and Christus Saint Michael Health System, Texarkana, TX.

Additional site reviews are scheduled for March (three) and April (ten). Additional designation site reviews are now being scheduled for May and June.

It is important to note that hospitals must have their budget in place by the date of their scheduled site visit. If they are approved, they can bill back to the site visit date. FY 2012 budgets will need to be completed soon in order to get grants in place. Information on deadlines will be forthcoming. Also, invoices must match the current approved budget. If not, a budget revision will need to be submitted and approved before any invoices can be submitted and processed.

Communications System

A two-day “train-the trainer” event with 60 attendees was held last week with Motorola. The installation of radios has begun with 31 radios being installed in ambulances at the end of last week. There was a radio set up for demonstration purposes at the TAC meeting. Dr. Clint Evans was chosen to demonstrate the radio by calling the call center. The demonstration test was completed successfully.

VARIOUS CONTRACTS AND SPECIAL ITEMS:

Image Transfers

ADH has signed off and this grant is at UAMS going through the signature process. The grant, with funding for both FY 2011 and FY 2012, has a start date of March 5, 2011. We do not anticipate any problems.

Burn Grant

This grant, for \$250,000 with the Burn Center at Arkansas Children’s Hospital, started March 1, 2011.

Special initiatives:

- The contracts for Dr. Maxson, Steve Bowman and MEMS are in our contract support office and should be ready in time for Legislative review and in place for July 1, 2011 start dates.
- The Request for Proposal (RFP) for the education piece is being written. It will be going through the review process and is expected to be released by April 1, 2011.
- The Injury Prevention grant to Arkansas Children’s Hospital is due to our contract support office next Monday, March 21, 2011.

- The Autopsy Bill is progressing through the legislature. It passed the House subcommittee and is on its way to the Senate.
- We anticipate that we will be having budget hearings at the legislature. When hearings are scheduled we will send an e-mail to the TAC members. It is certainly our intent and we believe the intent of the Governor's office to include carry over funds as was done for the previous year's budget. There are no questions that we are aware of regarding the Injury Prevention and Control budget.

V. ADH Medical Consultant Report – Dr. Todd Maxson

Dr. Maxson was recently at an American College of Surgeons' (ACS) meeting. At the top of the list on their Trauma System evaluation committee agenda is the upcoming Arkansas site visit review. An abbreviated ACS review team was here a couple of years ago and they are very excited and anxious to come and see the progress we have made in Arkansas.

Dr. Maxson emphasized that the Rules require three months of data for hospitals before they go through the site visit designation process. What this means is that the hospital has been engaged in performance improvement (PI) for at least a three month period and has documentation of that process working for this time. It is very important to have this documentation to review during the site visit and he noted that the PRQ is due six weeks before the site visit. This requirement must be adhered to for the process to work properly. PI needs to be able to be evaluated properly during the site review visit.

EMTALA Issues

There have been significant questions about EMTALA. Issues have revolved around what is required and what is not required. Dr. Maxson asked for and received answers to several questions from Sergio Mora, Arkansas State Representative for Medicaid and Medicare Services. (Please see the detailed attachment.)

VI. Trauma Registry – Marie Lewis

- Fourteen of the 15 NTRACS hospitals have completed their upgrade to 4.2
- On March 1, the registry staff started working with those 14 hospitals to complete their submissions to the state; we ran into a number of challenges that we are still working through
- As of March 15, five hospitals had successfully submitted to the state; we are working with each hospital individually to fix errors and complete the submissions
- March 28-29 is the AAAM AIS course
- May 5-6 is the Trauma Program Manager/Coordinator course

VII. TAC Subcommittee Meeting Reports

(Note: summaries are attached; only official action is documented in this section)

- Finance Subcommittee (R. T. Fendley – Chair) (see attached report)
Seven recommendations from the subcommittee were submitted by R. T. Fendley to the TAC in the form of a motion/recommendation that they be adopted. Dr. Charles Mabry seconded the motion. After discussion and questions, the motion was approved.
- EMS Subcommittee (Dr. Clint Evans - Chair) (see attached report)
Dr. Evans, on behalf of the subcommittee, made a motion that the backfill agreement, which was previously sent to TAC members by e-mail, be approved. The motion was seconded by K.C. Jones. The motion passed. Dr. Evans made a second motion from the subcommittee that the short-form to be used by EMTs and Paramedics for patient care improvements be approved. Dr. Charles Mabry and Myra Looney Wood seconded, simultaneously. The motion passed.
- Injury Prevention Subcommittee (Dr. Mary Aitken – Chair) (did not meet) No Report
Dr. Aitken reported by phone and said that progress is being made in all facets of IP. The subcommittee is very busy, but still in a holding pattern on some things.
- Hospital Designation (Mr. Jamie Carter, Chair) (see attached report)
The subcommittee voted to recommend to the TAC that Baptist Health Medical Center – Heber Springs' proposal to go from a Level III to a Level IV be approved. Dr. Maxson made this motion to the TAC, which was seconded by Dr. Mabry. The motion was approved.
- TRAC Subcommittee (Dr. Charles Mabry – Chair) (did not meet) No report.
- Rehabilitation Subcommittee (Jon Wilkerson – Chair) (see attached report)

VIII. Next Meeting Date

The next meeting will be held on Tuesday, April 19, 2011, at 3:00 p.m. The meeting will be held in Room 906 (Boardroom) at the Freeway Medical Building.

IX. Other

Dr. Graham thanked everyone for their time commitment and effort to help the TAC function.

Dr. Maxson inquired about the subcommittee meeting schedule and the possibility of a revised schedule. Dr. Graham said he will commit to working with the subcommittee chairs and ADH to

consider a better schedule for subcommittee meetings. This will include consideration of more teleconferencing possibilities. It was noted that we need to be considerate of all members.

X. Adjournment

Without objection, Dr. Graham adjourned the meeting at 4:30 p.m.

Respectfully Submitted,

Paul K. Halverson, DrPH, FACHE
Secretary Treasurer of the Trauma Advisory Council
Director and State Health Officer, Arkansas Department of Health

**Finance Sub-Committee
Of the
Trauma Advisory Council
Report to TAC
March 15, 2011**

These following budget recommendations are presented to the Trauma Advisory Council for their consideration:

- 1) To set aside \$300,000 of the carry-over funds to support a cost study of the components of the delivery system (\$250,000) and to fund the development of a longitudinal assessment tool to be utilized by the trauma system to track statewide progress (\$50,000).
- 2) To establish Education as its own line-item in the budget at a level of \$700,000 for fiscal year 2012.
- 3) To make 5% of the carry-over funds available to hospitals which undertake system leadership activities and exhibit exceptional quality in key areas. These funds will be paid on the basis of "Pay for Performance."
- 4) To recommend that the "Pay for Performance" programs referred to in #3 be covered in the grant contract language, thereby avoiding mid-year contract amendments.
- 5) The current deficit in hospital based funding for FY12 (\$135,173) be applied against the unobligated funds for FY12.
- 6) Increase funding for the Quality Review Initiative for FY12 to \$250,000.
- 7) To distribute remaining carry over funds according to the 2011 percentage split.

Trauma Advisory Council Rehab Subcommittee Minutes

March 15, 2011

Chair Jon Wilkerson, PT

In attendance: Austin Porter, ADH; Dr. Alan R. Phillips, PT, DPT, ARS; Cheryl Vines, ASCC; Lee Frazier, St. Vincent Rehab; John Bishop, PT, Baptist Health Rehab; Debbie Taylor, St. Vincent Rehab; Vicki Finch, St. Vincent Rehab; Dr. Lorrie George, Ph.D., OTR/L, UCA/OT; Dr. Tom Kiser, MD, ASCC

- I. Jon Wilkerson welcomed everyone to the subcommittee meeting on rehabilitation and thanked everyone for their participation. Introductions were made by those present. Jon explained to the group that the Trauma Advisory Council (TAC) had met and needed input into what needed to be completed for rehabilitation. It was decided to complete a needs assessment for the state. A contract was completed with the Arkansas Spinal Cord Commission (ASCC) with the assessment to be completed by the Director, Cheryl Vines.

- II. Cheryl Vines discussed the needs assessment and explained to the group that the assessment was to be completed in a 4 month period with a report of the findings compiled at that time. The assessment was started in January, 2011.

To date data has been collected from 29 hospitals in the state identified through the Arkansas Hospital Association (AHA). Three of those were identified as outpatient facilities, not hospitals. Three more may be the same. Three are also out of state, most notably The Med in Med in Memphis, TN, St. John's and Cox Medical Center both in Springfield, MO. Sixteen are in state. Eight are CARF accredited; one in spinal cord injury (SCI), and one in traumatic brain injury (TBI). There is one long term care facility for TBI, Timber Ridge. There are 500 rehab beds available in the state, 18 are designated for SCI and 19 are designated for TBI. There are 14 pediatric beds available at Arkansas Children's Hospital. There are 104 subacute beds available for adult TBI individuals.

One feature consistent with all facilities is that the Function Independence Measure (FIM) is used by all. Not all report to the Uniform Data System (UDS). Rehabcare has an internal mechanism for data.

The second identified area was the diversity of the medical directors. They were family practice, orthopedic surgery, internal medicine, preventive medicine and rehabilitation, etc.

The plan is to collect all the data and prepare the results of the assessment to the TAC in May, 2011.

III. Mr. Wilkerson reported that Dr. Todd Matson, MD was working with the American Council of Surgeons (ACS) to have them come here June 5-8, 2011 to provide consultation on what other states are doing June 5-8, 2011. This will also be to obtain information about what our needs are. The plan is to talk with rehabilitation individuals on June 6.

Austin Porter, an epidemiologist with the Arkansas Department of Health (ADH), was requested by Jon to review what the ADH has done. Mr. Porter reported that we are currently missing some candidates for rehab. Steve Bowman created a program for hospitals with discharge data. Injury Severity Scores (ISS) are used. This is extrapolated from the ICD-9 information from the acute hospital. At present you can't look at severity at discharge and we currently do not have a reliable rehab data base. The desire is to use outcome data from rehab to evaluate the entire trauma center. Example outcome measures are the FIM and Rancho Los Amigos Brain Injury Scale. Education will have to occur to ensure the quality of the data collected.

Jon emailed the group the information on the American College of Rehabilitation. He reviewed this with the group. The criteria were felt to be basic in context. A comment was made that our facilities are not that basic. CARF accreditation is the preferred accreditation to establish Centers of Excellence in standards.

Pre-admission to the system was discussed. Arkansas will provide each trauma client with a personal identification numbers. This number will follow the client throughout their continuum of care. This continues through rehabilitation, if the client is admitted to or through EMS. A bright orange wrist bracelet is used to signify the client is part of the trauma system. Education will have to be provided to all health care providers as to what the bracelet is, so it is ensured to stay on the client during the continuum.

A follow-up system was discussed. Using the FIM was identified. John Bishop informed the group that Baptist no longer uses the FIM for follow-up because they did not think that data was accurate.

Dr. Kiser led the discussion on pre-admission screening of the client prior to going to rehab. This is currently done by a nurse in most places. The group felt the screening of client for rehab would from the trauma system would best be done by a rehab expert.

IV. Budget and Goals

The budget off the set- up of the rehab component of the trauma system is \$500,000.00. The TAC designates how this money is utilized in building the system.

Jon discussed his goals thus far:

1. Complete the needs assessment contracted to the ASCC.
2. Identify data points and get agreements with rehab facilities to collect UDS data. This will require continuing educating for facilities. Level I & II systems will use N Track and Level III & IV will be web based. There are currently 3 full time registry people working.
3. Contact other states with robust/model rehab centers. Consultation fees will come out of the budget.
4. Look at ways to have people do research. Find someone to take on an academic pursuit about how rehab is done in our state and how it is completed in the public. The goal is to work the rehab model into public health. Jon will speak to the Dean of the College of Public Health and the various universities that educate rehab professionals.

V. Closing remarks

Jon thanked everyone for participating. He invited ideas to be shared through email.

The next meeting will be scheduled for the 2nd or 4th Monday in May.

Meeting adjourned.

Minutes respectfully submitted,

Alan R. Phillips, PT, DPT

**EMS Subcommittee
Meeting Summary
March 15th, 2011**

The EMS subcommittee met at 1:00 on March 15th. There were 21 people in attendance.

We started with discussion and updates on old business.

1. AWIN radios – These are now being referred to as trauma radios. There was discussion that these should be used only for contacting Trauma Comm, unless otherwise instructed in a disaster, and not for day to day operations. A training session was done with 56 attendees receiving instruction on the use of the new radios. These people are now qualified as trainers. A total of 31 radios had been installed at the time of the meeting, and it was expected the installs would be complete in June.
2. FY 2011 grant distributions – Going well
3. EMS data submission – There is a new specialist in EMS who will now focus on data collection. Greg assures us we continue to improve and will be able to enforce the deadline of 3/31/11 for fulfilling the data deliverable.
4. Backfill agreements – There was again much discussion about the backfill agreements. Several volunteer services were concerned that they would have difficulty meeting the requirements specified in the agreement. It was decided that, while not perfect, the current backfill agreement was a good start, and the recommendation was given to present the document as it stands to the TAC for approval.
5. Short forms – The final version of the short form was reviewed, and the committee recommended this be presented to the TAC for approval.

Greg discussed a new disaster notification system which should be in place shortly. This will use EMSsystems, and will facilitate rapid notification of services in a disaster.

The remainder of the meeting was spent discussing FY 2012 funding. A new version of the spreadsheet was reviewed. This includes new 2010 census data. There was much discussion on how to include out of state air services. It was felt that services based at Arkansas designated trauma facilities should not be excluded from funding. There was also discussion about including out of state services if they voluntarily reported a yet to be determined number of monthly calls in Arkansas.

Our next meeting will be April 19th, 2011, at 1300.

TAC Meeting March 15, 2011 - EMTALA Issues

Several questions have come up regarding hospital to hospital patient transfers and how EMTALA rules and regulations affect these issues. Dr. Maxson sent an e-mail to Sergio Mora with CMS, who responded to the stated questions as follows:

Question: Acceptance of trauma patients in transfer. We understand the CMS position is: Any person acting as an agent of the hospital may accept, on behalf of that hospital, a patient in transfer. That means specifically that this person, acting as the agent of the hospital, does not need to be a physician or a nurse, for that matter. Is this correct?

Response: The EMTALA requirement for transfer only speaks of the communication between “hospital to hospital” and “transferring facility to receiving facility.” There is no requirement to have a clinician to clinician transfer/acceptance transaction between Emergency Departments. This is the correct understanding of this requirement.

Reference: §489.24(e) Restricting Transfer Until the Individual Is Stabilized.

The EMTALA regulations at 42 CFR 489.24(b) define “transfer” as “...the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital.

The transferring hospital must obtain permission from the receiving (recipient) hospital to transfer an individual. The transferring hospital should document its communication with the receiving (recipient) hospital, including the date and time of the transfer request and the name and title of the person accepting the transfer.

Four Requirements for an Appropriate Transfer

1. §489.24 (e)(2)(i) - The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
2. §489.24(e)(2)(ii) - The receiving facility--
 - (A) Has available space and qualified personnel for the treatment of the individual; and
 - (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;
3. The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer
4. The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

Scenario: Hospital A receives a call for transfer and the request constitutes a higher level of care. Hospital A says: we must call the physician on-call for that specialty and get approval prior to acceptance of the patient. There are two questions under this scenario.

Question #1: If the physician does not call back within 30 minutes and hospital A refuses to accept until they hear from the physician, has the hospital committed a violation by not accepting in a timely manner?

Response: A hospital may have violated EMTALA requirements the moment they refuse to accept the transfer if it is discovered that they have the capacity (beds) and capability (personnel including on-call specialists) to treat the patient with an unstabilized emergency medical condition at the time the transfer request was made. See all the information below straight out of the EMTALA IG and under the recipient hospital responsibilities requirement. I have also included language from the IG in reference to the Physician “On call” list and requirements.

Reference: §489.24(f) Recipient Hospital Responsibilities

A Medicare-participating hospital that has specialized capabilities or facilities may not refuse to accept an appropriate transfer from another hospital of an individual with an unstabilized emergency medical condition who is protected under EMTALA and requires such specialized capabilities or facilities. This assumes that, in addition to its specialized capabilities, the recipient hospital has the capacity to treat the individual, and that the transferring, i.e. referring, hospital lacks that capability or capacity.

A hospital with specialized capabilities that delays the treatment of an individual with an emergency medical condition who arrives as a transfer from another facility could be in violation of EMTALA, depending on the circumstances of that delay.

§489.20(r)(2) On Call Physicians List and Related Responsibilities

In the case of a hospital (including both the transferring and receiving hospitals), to maintain: An on-call list of physicians who are on the hospital’s medical staff or who have privileges at the hospital, or who are on staff or have privileges at another hospital participating in a formal community call plan, in accordance with §489.24(j)(2)(iii), available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions who are receiving services under §489.24 in accordance with the resources available to the hospital;

The on-call list clearly identifies and ensures that the hospital’s personnel is prospectively aware of which physicians, including specialists and sub-specialists, are available to provide stabilizing treatment for individuals with emergency medical conditions. The list must be up-to-date, and accurately reflect the current privileges of the physicians’ on-call. Physician group names are not acceptable for identifying the on-call physician. Individual physician names are to be identified on the list with their accurate contact information. CMS expects a hospital to strive to provide adequate specialty on-call coverage consistent with the services provided at the hospital and the resources the hospital has available.

The hospital is responsible to establish policy in reference to the amount of time to reasonably respond to when being on call. A hospital must have written on-call policies and procedures and must clearly define the responsibilities of the on-call physician to respond, examine and treat patients with an EMC

“Thus, a hospital would be well-advised to establish in its on-call policies and procedures specific guidelines-- e.g., the maximum number of minutes that may elapse between receipt of a request and the physician’s appearance for what constitutes a reasonable response time, and to make sure that its on-call physicians and other staff are aware of these time-sensitive requirements”

In accordance with the on-call requirements specified in §489.20(r)(2), a hospital must have written policies and procedures in place--

To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control;

However, if a physician:

- Is on a hospital's on-call list;
- has been requested by the treating physician to appear at the hospital; and
- fails or refuses to appear within a reasonable period of time;

Both the hospital and the on-call physician who fails or refuses to appear in a reasonable period of time may be subject to sanctions for violation of the EMTALA statutory requirements.

On-call Physician Appearance Requirements

Although the on-call list requirement is found in Section 1866, which is the provider agreement section of the Act, Section 1867, the EMTALA section of the Act, provides for enforcement actions against both a physician and a hospital when a physician who is on the hospital's on-call list fails or refuses to appear within a reasonable period of time after being notified to appear.

If it is permitted under the hospital's policies, an on-call physician has the option of sending a representative, i.e., directing a licensed non-physician practitioner as his or her representative to appear at the hospital and provide further assessment or stabilizing treatment to an individual.

If a physician who is on-call typically directs the individual to be transferred to another hospital instead of making an appearance as requested, then that physician as well as the hospital may be found to be in violation of EMTALA

If a physician on-call does not fulfill his/her on-call obligation, but the hospital arranges in a timely manner for another of its physicians in that specialty to assess/stabilize an individual as requested by the treating physician in the DED, then the hospital would not be in violation of CMS' on-call requirements. However, if a physician on-call does not fulfill his/her on-call obligation and the individual is, as a result, transferred to another hospital, then the hospital may be in violation of CMS's requirements and both the hospital and the on-call physician may be subject to enforcement action by the OIG under the Act

Question #2: Physician (or physician's agent) calls back and refuses the patient. Is the physician or the physician's surrogate acting in this case as an agent of Hospital A (since hospital A passed the call) and does the refusal by the physician or physician's surrogate constitute a violation?

Response: Yes, the physician on call or his designated surrogate could respond to the call and if either fails to present themselves to the emergency department then the physician on call has violated the EMTALA requirement in reference to on-call responsibilities.

Reference: §489.20(r)(2) On Call Physicians List and related responsibilities (see above)

Question: If an EMS agency requests a helicopter rendezvous at the nearest helipad, and the helipad is on hospital property, does the hospital have any EMTALA requirements?

Response: The answer is, unequivocally no. The use of the hospital helipad by local ambulance services and statewide helicopters does not trigger any EMTALA obligations for the hospital that has the helipad on its property. This also applies when the helipad is being used for the purposes of transit, as long as the sending hospital has conducted a medical screening examination to transfer the individual to the helipad or a medical helicopter.

Question: What if the patient is not coming from a hospital? What if he/she is coming from a ground service? And, what if the actual EMS service is owned by the hospital? Does either of these trigger EMTALA requirements?

Response: If EMS activates medical helicopter evacuation of an individual with a potential emergency medical condition as part of its protocol, the hospital that has the helipad does not have an EMTALA obligation if they are not the recipient hospital, unless the request is made by EMS personnel, the individual, or legally responsible person acting on the individual's behalf for the examination and treatment by an emergency medical physician. It does not matter who owns the EMS agency; if the intent of the patient or the EMS agency is not to present to that hospital, but rather to use the helipad as a rendezvous point, it does not trigger any EMTALA responsibility for that hospital.