COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Patient Diversion / Emergency Department Closures	Policy Number 402
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I. PURPOSE: To define the procedures by which Emergency Medical Services (EMS) providers and/or Base Hospitals (BH) may:

A. Transport emergency patients to the most accessible medical facility that is staffed, equipped, and prepared to administer emergency care appropriate to the needs of the patient.

B. Provide a mechanism for a hospital in the Ventura County (VC) EMS system to have patients diverted away from its emergency department when it has been determined that the hospital is not staffed, equipped, and/or prepared to care for additional or specific types of patients.

C. Limit situations in which Advanced Life Support (ALS) units are unreasonably removed from their area of primary response when transporting patients to a medical facility

II. INTENT: The intent of this policy is to better define processes and terminology related to hospital diversion and the transportation of patients from the primary hospital / hospital catchment area to another. Diversion is a disruptive process to the EMS system as a whole and must be minimized to limit impacts on the patients we serve. Criteria have been established to better define when a hospital may divert, and requirements have been outlined to ensure hospitals that do divert patients are not doing so inappropriately.

III. AUTHORITY: California Health and Safety Code, Title 22, Sections 1797.220 and 1798; California Code of Regulations (CCR), Title 13, Section 1105(c); CCR Title 22, Sections 100096.02 and 100253

IV. POLICY: Hospitals may divert patients according to the guidelines and procedures described below. This policy shall not negate prearranged interhospital triage and transport agreements approved by VC EMS. Additionally, Basic Life Support (BLS) patients will be transported to the

nearest emergency department unless a patient requests transport to a different facility, or when a facility is closed by internal disaster.

V. DEFINITIONS:

A. **ALS Patient:** A patient who meets the criteria for base hospital contact, in accordance with VCEMS Policy 704 – Guidelines for Base Hospital Contact or VCEMS Policy 0720 – Guidelines for Limited Base Contact.

B. **BLS Patient:** A patient whose illness or injury requires BLS care or a patient in a BLS unit, irrespective of the level of care required for the patient's illness or injury.

C. **CALDOCs:** A computer-based program that calculates resource saturation in the emergency department using length of stay, lobby waiting, throughput, and other variables. CALDOCs score can range from 1 (normal operations) to 6 (severe over capacity).

D. **Emergency Department Work Index Scale (EDWIN):** a quantitative tool used to measure how busy or crowded an emergency department (ED) is and overall workload of emergency department clinicians. EDWIN is calculated by using a formula that takes into account the number of patients, the number of physicians, and the number of treatment bays. EDWIN score can range from <1.5 (Not Busy / Manageable) to >2 (Overcrowded).

E. **Emergency Severity Index (ESI):** A 5-level triage algorithm used in emergency departments for the purposes of prioritizing patients based on acuity and resource needs. ESI categories range from 1 (most urgent) to 5 (least urgent).

F. **National Emergency Department Overcrowding Scale (NEDOCS):** A scoring system that assesses how crowded an emergency department (ED) is. The NEDOCS score is a standardized way to measure ED crowding, which can be used to help with resource allocation and targeted interventions. NEDOCS score can range from 00 (Not Busy) to 200 (Dangerously overcrowded).

G. **Non- Divertible Patient Conditions:**

1. Unable to adequately ventilate, secure a patent airway, control hemorrhage, or ensure adequate perfusion. Patients who remain unstable will not be diverted from the closest appropriate facility.
2. Specialty Care - Patients meeting STEMI, Stroke, Trauma, Cardiac Arrest / ROSC criteria will not be diverted from the closest appropriate specialty care center unless on diversion for that category.

VI. PROCEDURE

A. DIVERSION REQUEST CATEGORIES

Hospitals will determine the need for diversion in accordance with this policy and based upon established internal standard operating procedures / guidelines that are reviewed by appropriate facility leadership on a regular basis. A hospital may request that ambulances be diverted for the following reasons using the following terminology:

1. **Internal Disaster**

Hospital's emergency department cannot receive any patients (ALS or BLS) because of at least one of the following conditions (as outlined in Reddinet) present:

Power Outage (Generators are Functioning)
Power Outage (Generators not Functioning)
Fire
Bomb Threat
Explosion
Flooding
HAZMAT (with contamination of Patient Care Areas)
Safety and Security Compromised
Phones Down
Water Disruption / Contamination
Active Shooter
Cybersecurity

NOTE: Activation of a hospital's internal policies/plans to handle staffing shortages, diversion and/or throughput (see Section VI.D.3) shall not constitute an internal disaster.

2. Emergency Department Saturation

All Emergency Department treatment beds are full (EDWIN >2, NEDOCS 141 to 200, CALDOCs 5 or 6, or equivalent) and:

a. 30% or greater of the ED has patients who fall into the ESI triage categories 1 or 2, including those ED beds occupied by admitted patients, and
b. hallway expansion/surge beds as well as admitted patients in the waiting room.

c. Additional ED Saturation guidelines are outlined in Section C – Procedure (page 7) and Section D - Considerations (page 8) below.

3. CT Scanner Inoperative

Hospital's CT scanner is not functioning and therefore not the ideal destination for patients with blunt or penetrating head trauma, truncal trauma, or a prehospital Stroke Alert patient.

4. STEMI Receiving Center (SRC) Unavailable

Hospital is unable to accept a "ST segment Elevation Myocardial Infarction (STEMI) Alert" patient due to unavailability of their Cath lab or Cath lab staff. Allowable criteria for SRC diversion shall be limited to the following circumstances:

a. Inpatient Emergent case
b. ED Emergent case
c. Equipment failure with no secondary/backup suite available
d. Inadequate staffing

Criteria will be documented, and diversion times tracked, in Reddinet. Diversion will be activated and de-activated promptly in Reddinet to avoid unnecessary diversion of STEMI patients to other SRCs.

5. Thrombectomy Capable Acute Stroke Center (TCASC) Unavailable

Hospital is unable to accept a "Large Vessel Occlusion (LVO) Alert" patient due to unavailability of their TCASC/Interventional Radiology staff. Allowable criteria for TCASC diversion shall be limited to the following circumstances:

a. Critical equipment unavailable
b. Interventional Radiology unavailable
c. Stroke team encumbered

Criteria will be documented, and diversion times tracked, in Reddinet. Diversion will be activated and de-activated promptly in Reddinet to avoid unnecessary diversion of LVO patients to other TCASCs

B. PATIENT DESTINATION

1. Internal Disaster
    a. A hospital on diversion due to internal disaster shall not receive patients (ALS or BLS).
    b. Base hospitals shall not direct ALS units to transport patients to any medical facility that has requested diversion due to an internal disaster.
2. Diversion requests will be honored provided that:
    a. The involved ALS unit estimates that it can reach an "open" facility without compromising the patient's condition
    b. The patient does not exhibit a non-divertible condition in the field.
3. Destination while adjacent hospitals are on diversion
    a. If multiple adjacent facilities are experiencing ED saturation at the same time, patient may be transported to a further emergency department not experiencing ED saturation. In these situations, the normal transport time shall not be *extended* by more than twenty (20) minutes.
    b. Patient request should be honored, regardless of hospital diversion status at the receiving destination (excluding internal disaster).
        i) This includes situations where patient or authorized representative is requesting transport to a specific facility for the purposes of keeping patients in their "medical home."
4. BLS ambulances will notify receiving hospitals of their impending arrival as early as possible and will provide an accurate estimated time of arrival.
5. Notwithstanding any other provisions of this policy, and in accordance with VCEMS Policy 604 -Transport and Destination Guidelines, final authority for patient destination rests with the Base Hospital.

C. PROCEDURE FOREMERGENCY DEPARTMENT DIVERSION

1. ED Diversion will be implemented in accordance with this policy and with internal hospital standard operating procedures / policies and will be continuously evaluated to determine if the required conditions persist.
2. Once it has been determined that all criteria for ED Diversion is met, the hospital emergency department representative will authorize the appropriate Reddinet user to activate ED diversion, ensuring that all required information is

entered accurately at that time, and that measures are taken internally to mitigate the impacts of ED overcrowding.

3. An impacted facility may place themselves on ED diversion only when it has been determined that the appropriate diversion criteria outlined above exist within the emergency department. All required information will be entered into the appropriate Reddinet fields at the time of diversion.
    a. A facility will not be granted more than 240 minutes of total ED diversion time in a single 24-hour period (measured from 00:00:00 hours to 23:59:59 hours).If at any point a facility is on ED diversion for 120 consecutive minutes, Reddinet will automatically open the hospital to ALS 9-1-1 traffic.
    b. In order for a facility to go back on ED diversion, personnel will need to evaluate and confirm that the appropriate criteria are met within the emergency department and document the required information in Reddinet.
    c. These conditions may be altered by the EMS Agency Duty Officer, in consultation with the EMS Agency Medical Director, if there are extenuating circumstances present.

D. CONSIDERATIONS RELATED TO DIVERSION

1. An effective emergency medical services system is the result of prehospital clinicians, emergency department personnel (including leadership), and hospital administrators working together as a team to care for ill and injured patients.
2. Prolonged periods of ED diversion and ambulance patient offload times (APOT) are not an emergency department problem alone. These issues are the result of dynamics and challenges within the hospital itself, in addition to external stressors and influences that exist as part of the broader EMS system. Regardless, prolonged diversion and extended APOT have a direct impact on the EMS provider agencies tasked with responding to 911 calls and provided high-quality prehospital care.
3. A facility that utilizes ED diversion may be subject to review by the Ventura County EMS Agency and may be required to submit verifiable data affirming conditions necessitating diversion were present in the ED during the applicable diversion window.

a. This data will be submitted to the EMS Agency Duty Officer within five business days of review notification.

4. Each hospital will have an internal policy(ies) or plan(s) that appropriately address hospital surge (e.g. surge plan, diversion procedures, patient throughput plan, etc.). The processes described in this document(s) should outline a multidisciplinary team approach to ensure the ability of the facility to remain open and to flex to surge capacity, thereby preventing or minimizing time of hospital diversion and APOT and downstream impacts on the emergency department team and EMS provider agencies.
   a. This plan(s) and/or standard operating procedure(s) will be submitted to VCEMS for review as part of the facility's approval as a receiving and/or base hospital, in accordance with VCEMS Policy 410 – ALS Base Hospital Standards and Policy 420 – Receiving and Standby Hospital Standards.
5. Per the Emergency Medical Treatment and Labor Act (EMTALA), the responsibility for patient care lies with the receiving facility once the patient being transported via ambulance arrives at the hospital property. Hospital staff shall make every effort to offload patients from ambulance gurneys as soon as possible.
6. Hospitals that have a consistently prolonged APOT will make every effort to offload patients as soon as possible, and will request EMS surge assistance as appropriate, in accordance with VCEMS EMS Policy 141 – Hospital EMS Surge Assistance.
7. Hospital personnel will acknowledge and provide a visual assessment of patients arriving via ambulance within 10 minutes of arrival in the ED to determine whether the patient needs an ED treatment bay or can be sent to other areas of the emergency department.