Southwest Virginia EMS Council
Ambulance Diversion Plan

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A. PURPOSE: This policy provides guidance for EMS agencies, providers, and hospitals in the Southwest Virginia region specifically related to ambulance destination transport decisions resulting from diversion declarations. For the purpose of this plan, the term hospital refers to a medical facility with an emergency department who routinely receives ambulance transports. Goals of this plan include:

1. Ensuring the prompt and efficient delivery of emergency medical care to the citizens of this region in a manner that prevents unnecessary delays and/or overburdening of emergency medical services system components
2. Assuring that destination decisions consider patient care needs, safety, and outcomes
3. Standardizing terms associated with hospital diversion to ensure clarity and consistency
4. Promoting collaboration between prehospital providers and acute care facilities
5. Defining indications and contraindications
6. Fostering appropriate communication to support collaboration

B. SCOPE: This policy pertains to all hospitals and all licensed EMS agencies located in the Southwest Virginia region as defined in Virginia Department of Health regulations. The policy will have the highest impact on the hospitals and agencies of planning district 1, planning district 2, and planning district 3; however, it is recognized that diversion status of the hospitals within these areas can have a significant impact on neighboring hospitals in surrounding areas and states.

C. DEFINITIONS

The status of hospitals to receive patients will generally fall into one of the categories defined below. In the event that a hospital declares a diversion, proper information should be provided to EMS agencies to clearly define the type of diversion status.

a) ***Open:*** **Unrestricted access to all EMS agencies**.

The facility is available to receive all in-bound ambulance traffic

b) ***Full Diversion*****: Indicates that patient load is utilizing all current emergency department/hospital resources. EMS units are advised to transport to another health care facility if possible.**

Due to excessive call volume not related to a disaster event, facilities may not have adequate resources to properly care for additional patients.

c) ***Special Diversion:*** **States that specific services are unavailable or are currently being utilized to maximum capacity. EMS units are advised to**

transport to another health care facility, if possible, for patients needing these specific services.

1. Due to unusual circumstances, the hospital may be unable to care for patients requiring specialty care (i.e., neuro, operating room, trauma, etc.) that would normally be within the hospital's capability; therefore, declaring Special Diversion (i.e., CICU Diversion, PICU Diversion, NICU Diversion, TRAUMA Diversion, Operating Room Diversion, Neurosurgery Diversion). Ambulances are cautioned to consider this in dealing with patients who may be better served by another location. Patient/Department specific inter-facility transfers should not be accepted while on Special Diversion.

2. If the emergency department is unable to safely accept in-bound EMS ambulance traffic, they may declare an ER/ED Special Diversion.

3. If a facility has utilized all house monitor beds, it may be necessary to declare Critical Care Diversion, thereby ceasing to accept inter-facility transfers. In-bound EMS units with probable critical patients may be diverted to other facilities. Hospitals should not hold Critical Care or Specialty beds for elective procedure patients.

4. When hospitals do not have the proper or working equipment to care for specific patient groups, it may be necessary to declare a Special Diversion. Examples may include STEMI Diversion, Stroke Diversion or Trauma Diversion.

d) *Disaster Alert:* Current event has exceeded hospital's capability to manage event, outside resources or aid is anticipated or needed.

Disaster Alert means that the facility is closed to ambulance traffic. The facility is currently involved in a mass casualty incident (MCI), and the hospital has instituted its internal/external disaster plan. All in-bound EMS units not involved in the current MCI are to be diverted to other locations.

e) Closed:* Dangerous Situation/Hospital Experiencing Event Dangerous to Life Safety (i.e. Active Shooter*)

EMS units should not transport patients to a closed facility under any circumstances until it is declared open. To knowingly do so may place the lives of the patient and EMS crew in danger.

D. POLICY ELEMENTS:

1. ***HOSPITAL GUIDELINES***: Hospitals may become overwhelmed by excessive patient volume, which exceeds the capacity for staff to adequately treat and monitor patients. This may be due to a lack of hospital resources, inability to provide patient specific services, or a shortage of qualified healthcare providers. To alleviate this temporary situation and ensure optimal care for all patients, a receiving hospital—after completing a process established by the medical facility—may declare a diversion of acute patients, whereby ambulances are diverted to other area hospitals. The following are recommended guidelines in the establishment of diversion policies:

a) Diversion criteria should be based on the defined capacities or services of the hospital.

b) When the entire regional healthcare system is overloaded, all hospitals should open. When all area trauma centers are on total/ED diversion, all trauma centers should be re-opened.

c) Diversion should be declared only after the hospital has exhausted all internal resources to meet the current patient load, including any necessary call-backs of staff, step-downs, expedited discharges, opening of "virtual" beds, and similar mechanisms to address the patient load.

d) Hospital diversions should not be based on financial decisions. Hospitals should not go on diversion to hold available bed space for anticipated elective admissions or withhold call-backs or delay opening additional resources due to cost considerations. While on diversion, hospitals must make every attempt to maximize bed space, screen and defer elective admissions or procedure, and use all available personnel and facility resources to minimize the length of divert status. Hospital medical staff will cooperate in promptly assessing all current admissions for appropriate early discharge.

e) Diversion is temporary, and the hospital must return to open status as quickly as possible.

2. ***EMS GUIDELINES***: EMS agencies may develop operating procedures in collaboration with their operational medical director related to transport. Final determination of the patient's destination rests with the Attendant-In-Charge or agency caring for and transporting the patient consistent with agency policies. Generally, stable patients may be transported to the hospital of their choice. Critical patients should be transported to the closest most appropriate facility. EMS providers and agencies may bypass any hospital on diversion and transport to the next closest facility that is staffed and equipped to receive the patient. EMS personnel may disregard the diversion status if, in the opinion of the Attendant-In-

Charge, it is prudent to do so. Recommendations for EMS agencies and providers related to hospital diversion transport decisions include:

a) If, in the judgment of the Attendant in Charge (AIC), the patient is stable to the extent that extra transport time will not negatively impact or cause harm to the patient, the EMS agency should bypass the diverted facility. If uncertain as to the stability of the patient, an AIC may seek advice from the on-line medical control physician.

b) Unstable patients and/or patients with airway obstruction, uncontrollable airway, uncontrollable bleeding, shock, who are in extremis, or with CPR in progress should be taken immediately to the closest appropriate hospital without regard to the hospital's diversion status. Under no circumstances should an ambulance with a cardiac arrest patient be diverted from the closest facility.

c) An Attendant-In-Charge who believes acute decompensation is likely to occur if the patient is diverted to a more distant hospital **ALWAYS** has the option to take the patient to the closest Emergency Department regardless of the diversion status. The AIC also has the option to ask via radio or phone to speak directly to an Emergency Department Physician and request online medical direction in determining the most appropriate receiving facility. Facility destination determination is ultimately the responsibility of the Attendant-In-Charge.

d) An Attendant-In-Charge may disregard diversion if there are significant weather/traffic delays or if experiencing a mechanical problem.

e) Certain hospitals and EMS agencies may have internal policies/agreements that supersede diversion status. These policies should be in writing and provided to all affected EMS agencies. The EMS agency should contact their primary transport hospital(s) to determine what internal policies concerning diversion exist. Hospitals will post a copy of their unique diversion policies in a conspicuous place in their emergency department. A copy of these policies will also be provided to the Southwest Virginia EMS Council. Contact information is included in this document.

f) When adjacent hospitals are on diversion, diversion status should be disregarded by EMS agencies.

g) An agency may disregard diversion in order to ensure that a locality does not have a lapse or significant delay in EMS coverage.

h) When a mass casualty incident has occurred and overwhelms the entire EMS system, possibly resulting in multiple diversions of local healthcare facilities, EMS agencies should disregard diversion status and transport to the closest appropriate facility.

3. ***EDUCATION***: EMS personnel and hospital staff, particularly those working in emergency departments, should maintain familiarity with the regional hospital diversion plan. At a minimum, annual update training related to hospital diversion plan elements is recommended for both prehospital and hospital personnel.

4. ***LEGAL RESTRICTIONS***: When following these guidelines for the direction of patients during periods of diversion, it is recognized that hospitals within the region are regulated by state and federal laws and regulations regarding care and transport of patients including the federal Emergency Medical Treatment & Labor Act (EMTALA). EMTALA was enacted in 1986 by Congress to ensure public access to emergency services regardless of ability to pay. Provisions of EMTALA may not be modified or waived by this policy. More information about EMTALA may be obtained from the Centers for Medicare and Medicaid Services (CMS) website, https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html.

Specifically, this policy does not modify the obligation of hospitals to comply with one or more of the following EMTALA requirements:

a) Hospital-owned ambulances/air medical services are required to transport from the scene of an accident, injury or illness to the hospital which owns the ambulance unless operating under a central community plan for ambulance destinations that determine the destination hospital for the patient in the field or unless the patient or person acting on behalf of the patient formally requests transport to another destination.

b) Hospital-owned ambulances/air medical services may not be diverted by their home hospital.

c) A patient in a ground or air ambulance not owned by the hospital who presents on hospital property (as defined by EMTALA) may not be denied an appropriate medical screening examination, any necessary stabilizing treatment, and or transfer in compliance with EMTALA standards.

d) Hospitals are required to accept transfers of patients under EMTALA when they possess greater capabilities than the hospital seeking to transfer the patient and the requested destination has available space

and personnel or the capability of providing care, even if that exceeds the facility's number of licensed beds. Beds may not be held open for anticipated elective admissions or contingent in-house use. All unassigned beds are deemed available.

e) In-bound EMS may not be re-directed to another facility if the hospital is not formally on diversion consistent with these guidelines.

5. ***NOTIFICATION PROCEDURE*****:**

The following recommendations relate to declarations of diversion status by hospitals. Proper notification procedures are essential to ensure timely transport and treatment of patients and to promote the health and safety of our communities.

a) Diversion should only be declared after the hospital has exhausted all internal resources to meet the current patient load, including any necessary call-backs of staff, step-downs, expedited discharges, opening of "virtual" beds, and similar mechanisms to address the patient load.

b) The emergency room physician, department supervision, and hospital administration should make the decision for diversion jointly. Appropriate hospital representatives should be notified as soon as possible of the diversion status. All personnel with diversion decision power must be identified and titles prospectively documented for reference. Diversion policies and protocols are established by the individual medical facility.

c) Healthcare facilities should develop and publicize, in conjunction with the Council, processes to ensure EMS agencies are notified of diversion issues that may impact patient transport decisions.

d) Notification processes should address local EMS agency notification as well as agencies that routinely transport to the facility.

e) Hospitals should update diversion status in the appropriate online notification systems. EMS agencies should obtain access to and routinely monitor diversion status.

All Ballad Health facilities utilize the Healthcare Resource Tracking System. HRTS provides for event activation and management locally, regionally or state-wide including tracking of hospital status. HRTS is used by all Ballad Health hospitals. HRTS information, including support and assistance, can be obtained from their website at https://www.tn.gov/health/cedep/cedep-emergency-

preparedness/temarr/hrts-training.html. A status board showing the current diversion state of all Ballad Health facilities is integrated into the Council's mobile app and is available for download free of charge for iOS and Android devices.

VHASS is a web-based hospital communication and diversion status board system owned and operated by the Virginia Hospital and Healthcare Association and the Virginia Department of Health as part of the Hospital Preparedness Program (HPP). This system is utilized by Virginia healthcare facilities in our region. There is no public access available for integration into the Council's mobile app. Individual EMS agencies may request a user account and access to the VHASS access by contacting the Far Southwest Virginia Healthcare Coalition at 855-581-7800.

Public safety access centers (dispatch center) may request access hospital status systems by requesting access. It is recommended that these centers include these monitoring systems on the dispatch consoles.

f) Hospitals should notify surrounding area hospitals that will be impacted due to the diversion.

g) Immediately upon cancellation of diversion status, surrounding hospitals and EMS agencies should be notified. Dispatch centers should also be contacted and requested to issue a general announcement regarding the cessation of diversion status. Electronic notification systems should be updated appropriately to reflect current hospital status.

h) The Council will integrate web-based hospital status notification system information, whenever possible, into its website and/or mobile app.

E. QUALITY MONITORING

1. All hospitals shall keep a diversion record on each instance. The record should include the administrative clearance process followed for declaring a diversion, the type of diversion, and facts supporting the decision to declare the diversion.

2. Hospitals (individually or as a system) will provide representation to the Southwest Virginia EMS Council's Healthcare Facilities Committee. The committee will meet quarterly and will review the Hospital Diversion Plan at least annually.

3. Decisions to disregard a hospital's diversion may be referred for review by the Regional Medical Direction committee and the provider's agency by the receiving hospital by completing a Performance Improvement Referral Form, which may be obtained from the Council's website under the "Performance Improvement" tab.

F. PLAN UPDATE AND REVIEW

The Regional Hospital Diversion Plan is reviewed annually and updated triennially to address any identified regional needs. Comments and suggestions regarding the plan are collected from system stakeholders, and the plan is approved by the Southwest Virginia EMS Council Board of Directors at their regularly-scheduled meeting. Authority to review and make recommendations concerning this plan may be delegated by the Board of Directors to any subcommittee of the Board. Comments and suggestions concerning this plan or regional hospital diversion policies are accepted on a continuous basis and should be submitted in writing to the Southwest Virginia EMS Council:

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