

**Joint Position Statement:
Guidelines for Hospital
Ambulance-Diversion Policies**

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**Medical Advisory Committee,
Pennsylvania
Emergency Health Services Council**

**Pennsylvania Chapter,
American College of Emergency Physicians**

This will be updated and revised.
The current draft is available at
www.pitt.edu/~kconover/ftp/diversion.pdf
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I. Purpose

This is a broad general guide to creating and revising policies hospitals use to determine “divert” status. “Divert” status is when ambulances are instructed not to bring patients to that hospital’s Emergency Department.

II. Intent and Authority

- A. The prime reasons for creating this guide are to ensure quality care of patients in hospital Emergency Departments; specifically, to minimize temporary overcrowding situations, and thus, working at a system level, to decrease medical error in hospital Emergency Departments.
1. A secondary reason is to provide a set of guidelines which may protect hospitals from additional local, state and federal regulation of diversion status. If hospitals can show that, by comparison with this guide, they have implemented a strong and well-thought-out response to ED crowding, then regulators and legislators will be less likely to impose draconian laws and regulations.
 2. Another secondary reason is to provide legislators and regulators a yardstick by which to measure hospital’s diversion policies. Some hospitals reportedly used “Condition Red” routinely to close their Emergency Departments. This protected beds for paying direct admissions and elective surgery, even though the Emergency Department wasn’t busy. This in turn caused EMS agencies to ignore “Condition Red” altogether. Other hospitals saw the ED as a source of money, and reportedly vowed never to go “Condition Red” no matter how bad the ED got, and no matter how dangerous the ED might be for patients, and no matter how much emergency physicians or nurses pleaded for “Condition Red.”
 3. We hope that this guideline will help hospitals reach some uniformity in how they deal with diversion issues, reducing such problems.
- B. This guide is purely advisory.

1. PaACEP and the PEHSC Medical Advisory Committee do not wish to establish detailed and specific model policies, because they might be taken as authoritative. Instead, this guide provides a broad outline of what *Hospital Ambulance Diversion Policies* might include, providing a wide selection of “best practices” from which hospitals may pick and choose.
 2. This guide helps hospitals develop their own *Hospital Ambulance-Diversion Policies*, specifically addressing decision-making within the hospital staff and administration.
 3. Individual hospitals are encouraged to develop *Hospital Ambulance-Diversion Policies* that reflect local medical directives and practices. In particular, hospitals should coordinate with their Regional Emergency Medical Services Councils to ensure that hospital policies mesh well with local EMS needs.
- C. This statement is **not** intended to address regional, state or interhospital issues, notification, or other related issues. It focuses on the way hospital staff and administration make decisions about when and whether to “go on divert,” and what to do when they do “go on divert.” Companion documents may be developed that address other issues.
- D. It has been widely observed that ED overcrowding is a symptom of hospital crowding, lack of nurses, lack of beds due to a cutback in hospital expansion, and problems with the healthcare system in general. Indeed, editorials in medical journals detail this on a regular basis. In particular, the June 2003 issue of *Emergency Medicine News* <http://lipweb003.lww.com/product/0,1255,1054%252D0725,00.html#> offers a series of readable articles on the topic. The August, 2003 issue of *Annals of Emergency Medicine* offers a series of more scholarly articles on the topic.(1-3) A recent Congressional General Accounting Office (GAO) report confirms that ED overcrowding is in large part due to hospital overcrowding and boarding of admitted patients in the Emergency Department.(4)
- E. While acknowledging these issues, this Guide focuses more narrowly on short-term ED overcrowding that causes ambulance diversion, leaving questions of ED and hospital efficiency, and larger health-care system issues, to other forums.

III. Definitions

- A. **EMTALA:** This law is known as the “anti-dumping act,” “COBRA” (from “Consolidated Omnibus Budget Reconciliation Act,” where it first appeared), and the “Patient Transfer Act,” but usually as **EMTALA**. It requires that all patients who Come to the Hospital and who Requested Examination or Treatment for a Medical Condition be provided a Medical Screening Exam to identify any potential Emergency Medical Condition (which includes many conditions that emergency medicine and EMS professionals may not consider acute emergencies, e.g., ear infections). It also requires stabilization of such patients prior to transfer or discharge, and prohibits hospitals from

treating emergency patients or transferring emergency patients differently based on their medical insurance, or lack of medical insurance, at least not until there is Commencement of Stabilizing Treatment and the patient is Stable for Transfer. (The underlined terms have specific legal meanings and are defined and explained in the documents in the Bibliography section, below.)

- B. **Ambulance Diversion:** The practice of telling EMS services “don’t bring patients to our ED by ambulance right now, we are too busy/full to care for them adequately.”
- C. **Divert Status:** When a hospital has officially notified EMS services that the ED is very busy, and to not to bring patients to the hospital’s ED. This may include a variety of levels of “diversion,” see below.
- D. **Condition Yellow:** “The Emergency Department is busy but not overwhelmed. Patients presenting to the Emergency Department via EMS may experience significant delays in treatment due to the current volume and/or acuity of patients already in the Emergency Department. EMS personnel should inform the patient of this situation and consider transporting the patient to another facility if the patient consents. *To simplify discussion, this particular definition, used by the EMS Institute (see Background section near end) will be used throughout the Guideline.*
- E. **Condition Red:** “All of the usually available resources in the Emergency Department are overwhelmed such that receipt of additional patients will result in the inability to care for them safely. Patients may not be brought to the Emergency Department unless EMS personnel perceive the patient to be suffering from an immediately life-threatening illness or injury.” *To simplify discussion, this particular definition, used by the EMS Institute (see Background section near end) will be used throughout the Guideline.*

IV. Principles

- A. **Policy Needed:** It is critical that hospital personnel and administration be guided by a formal hospital policy on ambulance diversion. Having such a policy will:
 1. Minimize uncertainty, anxiety and staff conflict when having to decide on “divert” status.
 2. Provide decision-makers with criteria to ensure they are making an appropriate and defensible decision.
 3. Provide hospitals with a guide to appropriate actions to take when “on divert.”
 4. Allow hospital administrators to demonstrate their planning to accrediting organizations, to local, regional and state Emergency Medical Services councils, and to county and State health departments.
 5. In Pennsylvania, since February 2002, by [order of the state health](#) department (VII.B, below), every hospital is required to have such a policy.

- a) This order states that hospitals must have written diversion policy, the policy must include criteria for diversion, must identify a physician or high-ranking administrator who decides on diversion, and must identify who is notified of diversion. This order also specifies that diversion for more than 8 hours (or more than 12 out of 24 hours) is reportable to DOH.
 - b) However, this order doesn't say anything about what hospitals have to do when on divert (i.e., nothing about cancelling elective admissions or procedures), and allows hospitals to use whatever criteria they want to use for diversion. Therefore, there is more room for the state to be more specific if diversion continues to be a major problem. We hope that this Guideline will help hospital craft policies that will protect hospitals from more draconian regulation and oversight by the state health department.
6. Pennsylvania law prohibits having patients in the halls in the Emergency Department **or** on the floor unless in compliance with the hospital's disaster or emergency plan.
- a) The Pennsylvania Code, Title 28, Chapter 117, section 101.172. Patient limits, states: *The number of patients admitted to any area of the hospital shall not exceed the number for which the area is designed, equipped, and staffed except in cases of emergency, and then only in accordance with the emergency or disaster plan of the hospital.* The relevant sections of the Pennsylvania Code are available online at:
<http://www.pacode.com/secure/data/028/028toc.html>.
 - b) Hospitals are licensed for a certain number of beds for both inpatients and for outpatient units.
 - (1) A hospital is licensed for a certain number of inpatient beds. If a hospital wants to exceed these limits, for example, boarding admitted patients in outpatient units such as a post-anaesthesia recovery room, or the Emergency Department, then this requires activation of the hospital's emergency or disaster plan.
 - (2) Outpatient units such as the Emergency Department are licensed for a certain number of patients. If the ED is busy enough that active ED patients must be put on gurneys in the hallway, then this requires activation of the hospital's emergency or disaster plan.
 - c) Hospital and ED overcrowding result in several phone calls every month from irate patients to the Department of Health. One recent example: a patient who had been "boarded" in the Recovery Room for 3 days when the

hospital's ICU beds were full, and was being charged for an ICU stay. Another was a patient admitted from the Emergency Department but who had been waiting in the Emergency Department hall for three hours. This is creating an increased focus on such overcrowding issues within the Department of Health.

- B. Decision Input:** Hospital Ambulance-Diversion Policies must include input from many people and disciplines within a hospital, including physicians, nurses, and administrators. However, the impact of such decisions fall disproportionately on the clinical Emergency Department staff, and this guide strongly recommends that any hospital policies be constructed with input, review and consensus from all who directly provide emergency care in the Emergency Department.
- C. Emergency Department Status Determines Diversion:**
1. Criteria for “divert” status has, in different places and times, been based on different criteria:
 - a) the number of beds available (e.g., one area in Florida reportedly requires 110% occupancy prior to diversion),
 - b) the number of beds of a particular type available (e.g., ICU beds),
 - c) the number of beds that can be adequately staffed by nurses, or
 - d) the status of the Emergency Department.
 2. However, the ***EMTALA Interpretive Guidelines - Responsibilities Of Medicare Participating Hospitals In Emergency Cases***, Tag 406, Rev 2., 05-98, p V-18 state: *A hospital may deny access to patients when it is in “diversionary” status because it does not have the staff or facilities to accept any additional emergency patients at that time.* This is the only provision in EMTALA law or regulation allowing a hospital to refuse emergency patients. Regardless of local, regional or state policies, procedures, regulations or laws, Federal law and attendant regulations specifically focus on **emergency** patients. Therefore, it is against Federal law for a hospital to go on “divert” unless the Emergency Department cannot accept single more patient without endangering all the patients in the Emergency Department. So, it is the degree of crowding within the Emergency Department—not the number or type of inpatient beds—that, under Federal law, determines “divert” status for EMS personnel bringing patients from the field (i.e., not transfers from another hospital). And when there is a conflict between this Federal law and state or local law or regulations, it is the Federal law that prevails. Therefore, it is unlawful for a hospital to refuse emergency patients by ambulance unless it meets the requirements of Federal law, above.

3. The above notwithstanding, the ED is an integral part of the hospital, and since the status of the rest of the hospital impacts the ED, it is entirely reasonable for those assessing the ED's status to use the status of the rest of the hospital (i.e., bed availability) and its impact on the ED in making decisions about whether it is safe to accept more patients in the ED or not.
4. It *is* acceptable under EMTALA for a hospital whose Emergency Department is "on divert" to accept certain transfers directly to hospital beds, as described below.

D. Stabilization and Transfer; Specialized Beds

1. Once a patient Comes to The Hospital, and has a Medical Screening Exam, the patient *can* be transferred, based on insurance or other payment issues, or based on the patient's special needs, once the patient has completed his or her Medical Screening Exam and once his or her Emergency Medical Condition has had Commencement of Stabilizing Treatment, sometimes called Initiation of Stabilizing Care. The hospital must also ensure that the patient is Stable for Transfer (a different stability than Commencement of Stabilizing Treatment.) The terms Medical Screening Exam, Emergency Medical Condition, and Stable for Transfer have specific legal meanings under the Emergency Medical Treatment and Active Labor Act; see <http://www.pitt.edu/~kconover/emtala-draft.pdf> for details.
2. The patient can be transferred, even before the Medical Screening Exam is completed, and even before the hospital has initiated stabilizing care for the Emergency Medical Condition—but only if the hospital doesn't have the capacity to care for the patient. Examples include an unstable trauma patient at a non-Trauma Center, or a patient who needs an ICU bed at a hospital whose ICU beds are all full.
3. Therefore, for purposes of *interhospital* transfer of stabilized patients, information on availability of specialized beds can be useful. However, based on a clear reading of Federal EMTALA law, this information cannot be used to refuse ambulance patients ("emergency patients") from the field. When an ambulance is en route to an Emergency Department with the capacity to accept additional patients *in the ED*, it is not lawful for the hospital to refuse a patient because initial assessment suggests the patient may need specialized inpatient care. The current interpretation of EMTALA also requires hospital-owned ambulances to transport patients to their "home" hospital. The only exceptions are when ambulance redirection is in accordance with Regional EMS Protocols as described below.

E. Regional EMS Trauma (and other) Bypass Protocols:

1. EMS regions within Pennsylvania and in other states have developed protocols for EMS services to bypass the nearest hospital, in favor of a more distant hospital with special

capabilities for a particular illness or injury pattern. This is very different and distinct from the “diversion” on which this Guide focuses. CMS recognizes these regional or state EMS protocols as valid reasons to “bypass” a patient to another hospital. This is not considered “diversion” in EMTALA terms.

- a) The classic example of such a “bypass” protocol is for trauma patients. Many states designate hospitals with special trauma capabilities as Trauma Centers. In Pennsylvania, the Pennsylvania Trauma Systems Foundation accredits trauma centers at several levels. Regional or state EMS “trauma bypass” protocols direct EMS providers to take some patients directly to a trauma center, bypassing other nearby hospitals with less capacity to care for trauma patients. The decision to go directly to a trauma center is based on a combination of objective and subjective criteria, sometimes with online medical direction. Often such patients can be taken quickly to a trauma center by an EMS helicopter service. Similarly, regional EMS protocols often direct that, unless it causes a long delay in arriving at a hospital, severe burn patients should be taken from the scene directly to a burn unit.
 - b) Another example where special capabilities might make a difference in patient outcome is hypothermic cardiac arrest—there is evidence that such patients will likely do better if transferred directly to a hospital with emergency cardiac bypass capability.
 - c) Recently, some hospitals have started offering urgent cardiac catheterization 24 hours a day, and there is evidence that such care is superior to thrombolytics for those with acute coronary artery occlusion.
2. Trauma and burn bypass protocols have been in effect nationwide for many years, and are accepted as the standard. In most states, and certainly in Pennsylvania, trauma center and burn unit criteria have been well-established and generally well-accepted. However, hypothermic cardiac arrest, urgent cardiac catheterization, and other bypass protocols are newer and more controversial. The question of which hospital has which capabilities is a thorny one, with significant implications for the bottom line at hospitals. For instance, does the difference in quality of care for acute myocardial infarction rise to a level that bypassing a closer hospital makes sense?
 3. There may be other reasons to effect a bypass of nearby hospital in favor of a more distant one. For example, if a hospital’s CT scanner were broken, it would not make sense for a patient with an acute CVA or potential head bleed to be taken such a hospital. Some regional EMS plans call for an advisory to EMS agencies in such a situation. An example is in the plan of the

Emergency Health Services Federation EMS Region (north-central Pennsylvania), available online at:

<http://hospitals.ehsf.org/hospitalstatusprogram.pdf>

This plan provides “divert” status for some ten different types of patient services (e.g., OB/GYN, General Surgery). However, most of these advisories are relevant only to inpatient transfers. As the plan notes: “The only diversions relevant to Prehospital personnel are ED, CT/Neuro, and TRAUMA. All others are to be used as reference purposes only.”

4. When a patient would otherwise refuse EMS services if not allowed to go to the hospital of choice, EMS providers are faced with a difficult choice. In the EHSF plan described above, the medical command physician must be contacted by the EMS personnel, and the medical command physician makes final decisions about the hospital destination. The Kansas City area diversion protocol has a provision for transporting to a facility on diversion in such a situation. EMS does notify the hospital that this is occurring but does not ask permission, or offer an opportunity for the hospital to refuse the patient.

V. Content and Format of Hospital Ambulance-Diversion Policies

A. Content of Hospital Ambulance-Diversion Policy

A Hospital Ambulance-Diversion Policy must answer the following specific questions:

- Who makes the decisions?
- How are these decisions made? Are there objective criteria for making these decisions?
- How are these decisions recorded?
- Once these decisions are made, what actions are taken? Who is responsible for implementing these measures?

B. Hospital Ambulance-Diversion Policy Format and Integration with Disaster Plan

The Hospital Ambulance-Diversion Policy should be part of the hospital's Disaster Plan. In particular, if an ED is crowded enough that patients must be placed in the hallways, in excess of the ED's licensed capacity, then Pennsylvania state law requires the hospital activate its disaster or emergency plan. See [above](#), section IV.A.6.

1. When the Emergency Department is overwhelmed with patients, it doesn't matter whether the overload is from a multi-casualty incident, a major disaster, an influenza epidemic, the closing or “Condition Red” of a nearby Emergency Department, a blue moon, or no discernible cause. The hospital's response should focus on the emergency department patient overload situation, regardless of cause. [In January 2004, during a flu epidemic, the Rhode Island Department of Health required that any hospital on diversion either implement its disaster plan or](#)

explain to the health department why it had not done so.*

Specifically, the memo says:

January 7, 2004

Dear Hospital Administrator:

As you know, the Department of Health has been monitoring the Interagency Nextel Hospital Communication Network used to report emergency department diversion status. In recent days it has become apparent that hospitals within Rhode Island are experiencing significant and often continuing problems of Emergency Department overcrowding and ambulance diversion. The Department has also received reports and concerns from licensed Emergency Medical Services (EMS) that the increased diversions of their vehicles are resulting in unacceptably long transports that place their patients at undue risk and that also decrease their service availability to their communities.

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Effective immediately and until further notice, no hospital will be permitted to divert EMS vehicles absent a "Code Red"[†] diversion declaration (Note: this Department will require subsequent documentation from any hospital regarding the nature and extent of any such declared internal disaster and the steps the hospital has taken to mitigate this situation.) Please communicate this directive to your Emergency Department immediately. The 08:00 and 16:00 roll call will be continued with respect of the collection of bed availability. The midnight roll call is suspended until further notice.

The Department is immediately notifying all licensed EMS providers of this directive. I ask that you give this matter your full personal attention and that you initial such actions as may be appropriate to assure that your hospital provides appropriate and timely care to individuals who are transported via EMS or who otherwise present to your Emergency Department. The Department recognizes the significance of this directive and I will be scheduling a meeting with the chief executive officer of all the hospital as soon as possible. The Department suggests that you consider immediate actions to address this situation. Among the actions you may wish to take are the following:

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* Utilize all available inpatient beds in managing admissions from the Emergency Department. Maintaining admitted patients within the Emergency Department for extended periods is not acceptable.

* Emergency Department overcrowding is a hospital-wide problem. Hospital administration should be proactive and accountable in addressing overcrowding situations. A high level

* Personal communication, Dr. Charles Pattavina, Brown University.

† Note that "Code Red" in the RI context means an internal disaster declaration for a hospital, not a "Condition Red" diversion status as with the EMSI policy quoted in this document.

administrator should frequently visit the Emergency Department particularly during peak periods to assess staffing levels, monitor patient care services and determine the facility's ability to appropriately respond to all patient care needs.

* Utilize facility-wide staffing resources, as in the case of disaster preparedness, to address periods of peak utilization. Emergency Department utilization/volume and the number of admissions from the ED should be tracked to determine trends and identify necessary resources.

* Discharge planning activities and particularly patient placement efforts should be handled on a priority basis.

* Hospitals must evaluate staffing levels on a hospital-wide basis.

* If the Emergency Department is stressed, the hospital should designate an individual(s) to act as a bed monitor to ensure that all available beds are promptly identified and made available for admissions from the Emergency Department. Such monitors would assume hospital-wide responsibility and facilitate moving patients from the ED to the floors. In periods of peak demand and ED overcrowding, the monitor(s) should coordinate the distribution of patients to the floors to reduce the ED census and provide for the even distribution of admitted patients throughout the hospital. All hospital beds, including all beds with monitors, should be identified and considered in determining bed assignments. As a temporary emergency measure, the use of beds in solariums and hallways near nursing stations may be considered consistent with a facility-wide plan to alleviate ED overcrowding.

* ~~Regardless~~ of where an admitted patient is located within a facility, staffing, services, privacy, infection control and confidentiality protections must be consistently in place.

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* Hospitals should assure that ancillary services are available to ED staff on a priority basis to allow for the prompt disposition of patient care needs. Transport services should be available 24 hours per day to meet patient needs and to allow for the timely transfer of admitted patients. Emergency Department staffing needs should be assessed on a regular basis to address periods of peak demand and census.

* EMS personnel should not be detained in a hospital ED. patient care responsibilities must be transferred promptly to ED staff, and patient care needs met by hospital staff.

In considering short-term and long-term solutions to this issue, Department staff will continue to work with hospitals and EMS providers to address Emergency Department volume and diversion practices. Greater attention will be given to identifying and analyzing ED volume, admissions from the ED, inpatient lengths of stay, discharge planning initiatives and quality indicators.

Our mutual goals must be to respond appropriately to

community needs and ensure patients safety by promoting quality patient care and protecting the rights of all patients. This can only be fully accomplished by working together. Each hospital should take immediate steps to devise and implement a current and appropriate plan for responding to Emergency Department overcrowding and ambulance diversion. I ask that personally make every effort to attend the meeting to be scheduled regarding this matter. Should you have any questions in this matter, please contact Donald C. Williams at (401) 623-0423.
Sincerely,
Patricia A. Nolan, M.D., M.P.H.
Director of Health

2. “Condition Yellow” should be integrated in the Disaster Plan as a low-level disaster plan activation. This means that the hospital should institute aggressive actions to improve the situation, and to avoid a “Condition Red” situation. This should be the same as the measures the hospital takes to deal with a multi-casualty incident that expected to briefly overwhelm the Emergency Department’s capacity.
3. Hospitals may also want to develop their own “Condition Pale Yellow” plan for when the ED becomes congested—something that helps prevent “Condition Yellow” or “Condition Red” situations.
4. “Condition Red” should be integrated in the Disaster Plan as a moderate-level disaster plan activation. This means the hospital should institute immediate aggressive actions to alleviate the situation. This should be the same as the measures that the hospital takes to deal with a large multi-casualty incident that is expected to overwhelm the Emergency Department’s capacity for an extended period.
5. Standard measures for multi-casualty incidents generally include some or all of the following
 - a) calling in additional housekeeping staff,
 - b) calling in additional nursing staff, and
 - c) calling in a backup emergency physician, and
 - d) opening closed units, and
 - e) canceling all elective admissions and elective surgery.
6. Indeed, some areas **require** that all hospitals on “divert” cancel all elective admissions and surgery. Such requirements by local or state agencies may, in the end, be maladaptive—by limiting hospital flexibility. Canceling elective admissions and surgery is an administrator’s tool, and should be listed as an option in the hospital’s diversion plans. Usually, such cancellations will not improve short-term ED congestion, and this drastic option will seldom be needed. Yet, a hospital’s plan should provide thoughtful and graded provisions for dealing with “Condition

Yellow” and “Condition Red” disasters. Such evidence of good intentions to meet community needs, even if at a significant cost, may prevent regulation from state and regional agencies requiring specific and drastic actions such as cancelling all elective admissions and surgeries.

C. Decision-Makers for Hospital Ambulance-Diversion Policy

Hospitals vary widely in who makes decisions about divert status. Some hospitals use a senior administrator for all decisions, others have the senior emergency physician on duty make all decisions, others have the charge nurse in the ED make the decision, and still others have the hospital nursing supervisor make all decisions. Some use a mix of decision-makers.

In Prince Georges’ County, Maryland, one hospital administration basically refused to go “on divert” no matter how overcrowded their ED might be. Emergency physicians and emergency nurses were excluded from the decision-making process. After many incidents where paramedics were standing in the ED waiting for hours to transfer a patient to an ED bed, the county finally decided that paramedics could put the hospital “on divert” regardless of what the hospital administration says, since the hospital administration proved unable to perform their duties to EMS services. This extreme measure was due to extremely poor decision-making on the part of a hospital administration. The goal of this Guide is to help hospitals develop plans that prevent such drastic measures.

One approach to decision-making, and one that makes sense, is to leave the responsibility for “Condition Yellow” as a shared one between ED personnel and hospital administration, but the decisions about “Condition Red” made solely by the Emergency Department staff. This eliminates delays in declaring a “Condition Red” situation (which may be critical to patient safety in the Emergency Department). Another option to eliminate delays in “Condition Red” declarations is to include administrators in the decision-making, but with a time limit: if the administrator cannot be reached within 15 minutes to make a decision, the ED staff places the institution on “Condition Red.”

The decision for diversion should be made by the emergency physician in the emergency department in coordination with nursing and/or administrative staff. [Guidelines for Ambulance Diversion. Emergency Medical Services Committee of the American College of Emergency Physicians, October 1999]

D. Criteria for Ambulance Diversion

1. In some areas, there are official state or regional criteria that hospitals must use or certify to go on divert status; in other areas, the criteria are left to the hospital or the hospital’s decision-maker. Pennsylvania currently leaves this up to the hospital, and one of the goals of this Guideline is to help keep it that way. Flexibility, if not abused, seems likely to result in better overall patient care. Patients vary in the amount of

attention they need, staffing levels vary, and nursing and physician staff vary in experience levels. Thus some factors that affect the capability of an Emergency Department to care for patients are difficult to quantify. Therefore, we recommend, not rigid criteria, but a set of fairly-specific guidelines that can be used by clinical staff in the Emergency Department to determine need for divert status.

2. Critical patients in the ED should be identified as to the level of nursing care (2:1, 1:1) by the physician in the ED, in consultation with the physicians in the critical care unit where they are destined, and if the nurses are not available to care for the patient at this level of care in the ED, this would mandate a Condition Yellow situation—if such a Condition Yellow situation lasts for more than an hour, it automatically changes to Condition Red. There are some moves to mandate patient:nurse ratios, including for the ED. For example, a new California law that takes effect January 1, 2004, mandates certain ratios. For the ED, the ratio is 4:1 for “generic” patients, 2:1 for ICU-bound patients, and 1:1 for trauma patients. These ratios specifically exclude charge nurses, managers, triage nurses, and base radio nurses.
3. Rochester, NY hospitals must, before diversion, meet three of the following conditions:
 - a) no available inpatient beds,
 - b) no available ICU beds,
 - c) 40 percent of ED beds occupied by boarders,
 - d) four-hour wait to be seen.*
4. Overlook Hospital, in Summit, NJ, has developed a detailed grid of those criteria used for various levels of diversion, and the interventions to be taken. The table is reproduced in the American College of Emergency Physicians’ [Responding To Emergency Department Crowding](#). (See Bibliography). Some of the items in Overlook’s grid:
 - a) C (Census)
 - (1) % ED bed occupancy
 - (2) admission cycle time
 - (3) critical care beds available and length of critical care holds in the ED
 - b) A (Acuity)
 - (1) number of 1:1 critical care patients, and length of time in the ED
 - (2) time until patients seen by emergency physician
 - (3) number of conscious sedation patients

* Rochester, NY uses this criterion, per Dr. Eric Davis <Eric_Davis@URMC.Rochester.edu>

- (4) number of psychiatric patients requiring constant observation
 - (5) number of patients requiring transfer to another facility
 - (6) number of patients requiring social service intervention
 - (7) turnaround time for chemistry (more or less than 60 minutes)
 - (8) turnaround time for plain x-rays (more or less than 30 minutes)
 - (9) pediatric critical care transfer
- c) O (Other)
- (1) Availability of equipment: IV pumps, pulse oximeters, linen, monitors,
 - (2) computer and network status
 - (3) pneumatic tube system functioning
 - (4) number of area hospitals on divert
 - (5) weather emergency
 - (6) community emergency
- d) S (Staffing)
- (1) number of standard ED staff positions unfilled
 - (2) number of agency or “float” nurses from outside ED

E. Condition Yellow Actions

There are many recommendations for dealing with hospital and ED overcrowding and the nursing shortage. Many of these recommendations focus on long-term “fixes” for making EDs more efficient, for recruiting or retaining staff, or for fixing the healthcare system as a whole. The literature shows that “ED overcrowding” is actually a problem that has its roots outside the ED, and reflects hospital crowding and systemic healthcare system problems.(5) The literature also shows that patients boarded in the Emergency Department have a longer length of stay than those admitted directly to the floor, and that inpatient care provided in the ED is understandably inferior to that provided on an inpatient floor, which has recently been a powerful stimulus to decrease ED “boarding.”(6, 7) Others focus on persuading the hospital administration that they should be proactive in dealing with the Emergency Department in general. (This is to counteract hospital management advisors such as MGMA and HCAB who have said to give the Emergency Department short shrift in favor of activities with better profit margins.) However, this Guideline focuses solely on first-aid measures that may be taken when diversion occurs. There are many good suggestions in the literature, and a selection of the best are reproduced here. Hospitals vary widely in the way their systems work—we recommend that a hospital **consider** and discuss all of these actions, and then build a plan that incorporates

those that seem most appropriate for that particular hospital, likely those that seem less radical. If, despite its plan, a hospital continues to have significant problems with diversion, then it should review this list and implement some of the more radical suggestions.

1. Administrator Actions:

In many hospitals, Condition Yellow declarations automatically include a response of administrative personnel to the ED, to survey the situation personally, to interact with patients and their families (and defuse patient complaints), and to aid in moving patients out of the ED to the floors. During a Condition Red situation, the administrator often remains in the ED to continue managing the situation. In the words of a December 11, 2000 letter from the Commissioner of the State of New York Department of Health to hospital administrators: *...Emergency Department overcrowding is a hospital-wide problem. Hospital administration must be proactive and accountable in addressing overcrowding situations. The hospital's Chief Executive Officer should frequently visit the Emergency Department particularly during peak periods to assess staffing levels, monitor patient care services and determine the facility's ability to appropriately respond to all patient care needs.*

2. Staff Call-In:

In a Condition Yellow situation, the hospital must evaluate staffing levels. Sometimes the problem is lack of emergency physicians, sometimes lack of emergency nurses, lack of ICU or floor nurses, sometimes simply lack of beds in the hospital. *Ambulance diversion should occur only after the hospital has exhausted all internal mechanisms to avert a diversion, which includes calling in overtime staff.* [Guidelines for Ambulance Diversion. Emergency Medical Services Committee of the American College of Emergency Physicians, October 1999] The Condition Yellow plan should provide for an assessment of staffing levels, and:

1. Calling in backup housekeeping personnel whenever cleaning beds on the floors delays admissions.
2. Calling in backup ED, floor or ICU nurses when needed.
3. Calling in a backup emergency physician (this also requires having a backup call schedule for emergency physicians).
4. Calling in additional attending or resident physicians and surgeons (e.g., the classic teaching hospital "medical admitters") to speed Emergency Department admissions.

3. No-Delay Admissions

When the ED is on Condition Yellow, nursing staff from the floors generally respond to the ED to pick up patients, rather than ED nursing staff transporting patients to the floor. Or, additional people are pulled from administrative duties to help

with moving patients to the floor. Admissions from the ED should not be delayed for shift change, or because of difficulty in getting floor nurses to receive report, for whatever reason—in some hospitals, if for some reason the nurse on the floor is not available for report, the patient is immediately taken to the floor and the nurse calls the ED for report when she is available to do so.

4. Not Accepting Transfers

If the hospital's ED is on Condition Yellow or Condition Red, it is lawful to accept transfers from another hospital directly to the floor. However, some public health officials feel that some hospitals have used Condition Red to refuse emergency patients while continuing to accept paying direct admissions or transfers without strenuous efforts to decompress the Emergency Department, or even in the absence of ED overcrowding, as a measure to avoid caring for indigent patients in the Emergency Department.

5. Boarding Admitted Patients

- a) Many years ago, when hospitals got overcrowded, it was common to put patients in solariums and lounges. But over the past few decades, with expanded EDs, and expanded ED capabilities, it has become traditional to keep admitted patients in the ED, sometimes even in the hallway, when no bed is available. In earlier years, this was a great rarity. But now with few hospital beds compared to demand, and nursing shortages, this has become more and more of an issue, enough so that admitted patients in the ED may fill them to the point where they cannot care for incoming emergency patients.
- b) Over the past few years, to deal with EDs full of admitted patients, many hospitals have developed what is called a "Full Capacity Protocol."
- c) Fairfax Hospital, in northern Virginia, has an ED that has 22 beds and sees roughly 78,000 patients a year. After careful analysis, they determined that 10 patients waiting more than 4 hours for a floor bed triggers aggressive action. The nursing supervisor comes to the ED, determines where patients boarding in the ED would go if there were beds, and then transfers the patients to these wards to be in the hall. Hospitals can scale this policy to the size of their EDs, and use it to move admitted patients from the ED during a Condition Yellow incident or other Disaster Plan activation. The director of the ED there, speaking at a national emergency medicine meeting, pointed out the following. The hospital administrators pointed out that state, federal and JCAHO regulations (including HIPAA) prohibited

exceeding nursing ratios, or having patients in the halls, which precluded admitting any more patients to the floor than the hospital is “allowed” to admit. Yes, he pointed out, but all these regulations applied to the Emergency Department as well as the floor—and after investigating the issue, the administrators agreed, and they decided to distribute the overcrowding more evenly throughout the hospital.

- d) The ED at the State University of New York, Stonybrook, was faced with a similar situation in their ED. They implemented such a “Full Capacity Protocol” with moving patients to the floor. They found this encouraged those working on the floor to get these patients into beds as a priority, speeding the admission process, and improving patient satisfaction. Indeed, this resulted in a Governor’s Workforce Champion Award and a 2001 Press-Ganey award for improving patient satisfaction, which stated in part *The team instituted a “full capacity protocol” that identifies steps taken when the ED is full. The protocol decompresses the ED during periods of peak volume by reducing the number of patients held in the ED and admitting patients to acute units regardless of bed availability.* An unexpected side benefit was decreased length of stay (LOS)—moving patients with atypical chest pain from the ED to the hallway on the floor resulted in a decrease in LOS from 6.2 to 5.4 days.(8) Given studies have shown that EDs are poor at providing inpatient-type care,(9, 10) this is not surprising.
- e) In the words of a December 11, 2000 letter from the Commissioner of the State of New York Department of Health to hospital administrators: *...As a temporary emergency measure, the use of beds in solariums and hallways near nursing stations should be considered consistent with a facility-wide plan to alleviate ED overcrowding.* And as Peter Vicellio, M.D., the chair of the ED at SUNY Stonybrook pointed out in his interview in the June 2003 *Emergency Medicine News*, the New York State Health Department now insists that hospitals use such a protocol.
- f) A similar full capacity protocol was implemented at William Beaumont hospital in Michigan, with similar positive results.
- g) Although distributing “boarded” patients to the floors tend to get them into beds faster, there may be less drastic methods to improve patient admission flow than to simply send the patients to the floors.

- (1) In an effort to speed admissions from the ED, some hospitals have developed incentive or “fee for service” plans for floor nurses, to keep them from “hiding” ready beds and delaying ED admissions.
- (2) Others have developed a draconian “zero-tolerance” plan, where taking report from the ED is a floor nurse’s top priority, and refusals to take report are reportable.
- (3) The ED at Washington Hospital Center (Washington, DC) sent its own housekeeper around the hospital to find beds that were empty, to clean them, and then tell the ED to send up a patient.
- (4) Mercy Hospital of Pittsburgh, learning from the hospitality industry, provides discharged patients (or their family, or ambulance transport personnel) with a laminated card with a number to call and quickly “check out,” thus providing immediate information about bed availability.

F. Condition Red Actions

Condition Red actions continue all Condition Yellow actions but go on to institute more stringent measures to decompress the ED.

1. Staff Support:

In a Condition Red situation, some hospitals have social service respond to help ED staff manage their social situation so that they can work overtime, and have Dietary bring meals (at hospital expense) to the ED for staff, so they can continue to work without either (1) having to take a break to eat, or (2) making medical errors due to hypoglycemia.

2. Prioritize

The Federal Centers for Medicare and Medicaid Services (CMS), previously known as HCFA, is responsible for enforcing the provisions of the Emergency Medical Treatment and Active Labor Act (EMTALA). Turning away emergency patients via diversion is seen as an emergency expedient. If diversion is used routinely to turn away emergency patients, while the hospital continues to accept non-emergency elective admissions, and continue with elective and even cosmetic surgery, and a complaint is filed with CMS, it is likely that the Federal government will impose a strict Plan of Correction on the hospital. Therefore, hospitals, whether from fear of CMS and EMTALA citations, or from recognizing a public-service need, are starting to include in their Condition Red response (which, after all, should be the same as their moderate-level disaster response), the canceling of all elective surgery and elective admissions, and even canceling outpatient procedures to free staff to help with the disaster situation in the Emergency

Department. *Hospitals should not go on diversion to save beds for either elective admissions or potential deterioration of hospitalized patients. Hospital diversions should not be based on financial decisions.* [Guidelines for Ambulance Diversion. Emergency Medical Services Committee of the American College of Emergency Physicians, October 1999]

3. **“Bed Czar”**

Several hospitals, where overcrowding has become a critical problem, have developed a “bed czar” system where a physician or nurse practitioner is given great power to manage beds. In some hospitals, the bed czar can discharge patients to a “discharge hospitality area” staffed by R.N.s when the only thing delaying discharge is the attending rounding to finalize the discharge; in some cases, bed czars actually discharge the patient. *Designate a physician or Advanced Practice Nurse “bed czar” with authority to (1) make decisions on inpatient bed transfers and discharges, (2) notify relevant medical staff members of an impending patient overload, (3) cancel elective admissions, elective surgeries and scheduled diagnostic procedures, and (4) initiate full or partial hospital diversion after consultation with the ED medical director and the on-call administrator or their designees ... A “utilization czar” program was instituted at the University of Arizona Hospital in Tucson, and within 18 months, the ED crowding crisis situation was mitigated, the ED was profitable for the first time, and patient satisfaction increased to unprecedented levels for the hospital’s peer group.* –American College of Emergency Physicians’ [Responding To Emergency Department Crowding](#). (See Bibliography)(11) However, implementing a “bed czar” is a drastic measure, and requires significant support from the hospital administration and medical staff. One large teaching hospital in Philadelphia tried a physician “bed czar” for their telemetry unit. The resistance from the other physician staff was strong, and after less than a year, the program failed.

4. **Temporary Facilities**

- a) Some hospitals have “fast-tracks” that are only open a portion of the day, and they will use these areas for longer periods as needed, i.e., during the night.
- b) Some hospitals have designated conference rooms, cafeteria space after hours, and other space for a temporary Emergency Department.
- c) One hospital (Good Samaritan, Phoenix), during its high-census period of the year, temporarily expanded by setting up a temporary structure (tent) in the parking lot to use as a fast-track for non-critical Emergency Department patients. –American College of Emergency Physicians’ [Responding To Emergency Department Crowding](#). (See Bibliography)

- d) A very large (5000+ bed) affluent private tertiary teaching hospital in Taipei was faced with rapidly-burgeoning ED volume, due to rapid expansion of the suburbs of one of the fastest-growing urban area in the world. In 1997, they had an average of 100 patients waiting in the ED for admission, and they even had a separate 20-bed room simply for ventilated patients waiting for admissions to the various intensive care units. Not having Phoenix's climate, their responses to such a critical situation were to put two patients in each treatment room/area (less likely to be successful in the West, where privacy is culturally more important), and to use portable screens to convert a large portion of the beautiful main hospital lobby into an Emergency Department holding area.

5. **EMS Response to "Condition Red"**

- a) In some areas, some hospitals reportedly used "Condition Red" routinely to close the Emergency Department to protect beds for paying direct admissions and elective surgery, even though the Emergency Department wasn't that busy. This overloaded other hospitals, and was viewed by the other hospitals, and by the state health departments, as acting against the public interest. While no legal action was taken against such hospitals by Centers for Medicare and Medicaid Services or the state, this resulted in regulations by state health departments such as the Pennsylvania state policy on diversion, reproduced [below](#) (VII.B)
- b) Prehospital providers knew what was happening. And so they routinely used "patient request" (which, as used by experienced EMS providers, is a very flexible concept) to ignore the hospital's "Condition Red"—and bring patients there essentially at a normal rate.
- c) Unfortunately, this brush tarred all hospitals in the area. And as a result, EMS providers routinely ignored "Condition Red" declarations by *any* hospital. For those hospitals that waited until their Emergency Departments were at a true crisis point, this resulted in truly dangerous situations. Some "Condition Red" instructions to EMS, such as [those of Pennsylvania's EMSI Region](#) (VII.C.1, below), are very clear that the only reasons to override a "Condition Red" is a critical situation where a few minutes' difference might mean life or death. Nonetheless, this "patient request override" has become ensconced as part of the EMS oral tradition in some areas, so that EMS providers all believe that patient request negates a "Condition Red" declaration. Some EMS providers even believe that it is unlawful for them to ignore patient request, and that

patient request thus overrides any “Condition Red” status.

- d) If a region’s “Condition Red” or equivalent allows exceptions to “Condition Red” diversion only for immediately life-threatening situations, hospitals should investigate any incident where a EMS unit seems to have violated a “Condition Red” diversion. All confirmed “Condition Red” violations should be viewed as “sentinel events” and should be formally referred for investigation by the EMS service director and medical director. Although such an instance may be justified, this should be confirmed by investigation. These events and investigation results should be reported to the Regional Councils on a regular basis (quarterly or annually) depending on the incidence of Condition Reds occurring in the region. And, if a particular EMS agency violates “Condition Red” status on a regular basis, this should be reported to the state health department. Keeping “Condition Red” only for very serious situations, and making EMS providers take it seriously, is the best way to provide for patient safety in a community’s EDs.

VI. Bibliography

1. EMTALA

- 1.1. A detailed tutorial on EMTALA is available at <http://www.pitt.edu/~kconover/ftp/emtala-draft.pdf>
- 1.2. The official *Interpretive Guidelines* put out by HCFA in 1998 are available online at http://www.hcfa.gov/pubforms/07%5Fsom/somap_v_001_to_012.htm and an excerpt is provided as an appendix below.
- 1.3. Published EMTALA materials, especially the November 9, 1999 document put out by HCFA, are available on the websites below.
- 1.4. On May 9, 2002, CMS published proposed modifications to EMTALA policies in the Federal Register (67(90): 31470 et seq, available at http://www.access.gpo.gov/su_docs/aces/aces140.html). Even though they are “proposed” they offer insight into official CMS thinking, which may be of use now.
- 1.5. The EMTALA forum at www.medlaw.com contains wide-ranging discussions of EMTALA issues.
- 1.6. Frew’s book on EMTALA containing past forum discussions is available at the above website.
- 1.7. Dr. Dan Sullivan’s EMTALA website at www.thesullivangroup.com contains a variety of cases and other references about EMTALA.

- 1.8. The book “Providing Emergency Care Under Federal Law: EMTALA” (Robert A. Bitterman, M.D., J.D., FACEP) is available through the American College of Emergency Physicians (www.acep.org).

2. Diversion

- 2.1. Pennsylvania’s Emergency Health Services Council (north-central PA EMS region) has a diversion plan available online at:
<http://hospitals.ehsf.org/hospitalstatusprogram.pdf>

3. Hospital and ED Overcrowding

- 3.1. Responding To Emergency Department Crowding: A Guidebook for Chapters. A Report of the Crowding Resources Task Force, American College of Emergency Physicians (American College of Emergency Physicians, August 2002) is available online at
<http://www.acep.org/download.cfm?resource=681>.

VII. Background: Appendices

A. EMTALA Interpretive Guidelines

The Emergency Medical Treatment and Active Labor Act specifies that hospitals can refuse an ambulance only when hospital facilities are overwhelmed. The Office of Inspector General Interpretive Guidelines state:

INTERPRETIVE GUIDELINES - RESPONSIBILITIES OF MEDICARE PARTICIPATING HOSPITALS IN EMERGENCY CASES, Tag 406, Rev 2., 05-98, p V-18:

A hospital may deny access to patients when it is in "diversionary" status because it does not have the staff or facilities to accept any additional emergency patients at that time. However, if the ambulance disregards the hospital's instructions and brings the individual on to hospital grounds, the individual has come to the hospital and the hospital cannot deny the individual access to hospital services.

INTERPRETIVE GUIDELINES - RESPONSIBILITIES OF MEDICARE PARTICIPATING HOSPITALS IN EMERGENCY CASES, Tag 411, Rev. 2 5-98, p V-34

(e) Recipient hospital responsibilities. A participating hospital that has specialized capabilities or facilities (including, but not limited to such facilities as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers) may not refuse to accept from a referring hospital within the boundaries of the United States, an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual."

INTERPRETIVE GUIDELINES: §489.24(e) Recipient hospitals only have to accept the patient if the patient requires the specialized capabilities of the hospital in accordance with this section. If the transferring hospital wants to transfer a patient because it has no beds or is overcrowded, but the patient does not require any "specialized" capabilities, the receiving (recipient) hospital is not obligated to accept the patient. If the patient required the specialized capabilities of the

intended receiving (recipient) hospital, and the hospital had the capability and capacity to accept the transfer but refused, this requirement has been violated. Lateral transfers, that is, transfers between facilities of comparable resources, are not sanctioned by §489.24 because they would not offer enhanced care benefits to the patient except where there is a mechanical failure of equipment, no ICU beds available, or similar situations. However, if the sending hospital has the capability but not the capacity, the individual would most likely benefit from the transfer.

The number of patients that may be occupying a specialized unit, the number of staff on duty, or the amount of equipment on the hospital's premises do not in and of themselves reflect the capacity of the hospital to care for additional patients. If a hospital generally has accommodated additional patients by whatever means (e.g., moving patients to other units, calling in additional staff, borrowing equipment from other facilities), it has demonstrated the ability to provide services to patients in excess of its occupancy limit. For example, a hospital may be able to care for one or more severe burn patients without opening up a "burn unit." In this example, if the hospital has the capacity, the hospital would have a duty to accept an appropriate transfer of an individual requiring the hospital's capabilities, provided the transferring hospital lacked the specialized services to treat the individual. The provisions of this requirement are applicable only when the sending hospital is located within the boundaries of the United States. Medicare participating hospitals with specialized capabilities or facilities are not obligated to accept transfers from hospitals located outside of the boundaries of the United States.

B. Pennsylvania State Policy on Hospital Diversion Plans

DATE: January 30, 2002

*SUBJECT: Division of Acute and Ambulatory Care Provider
Bulletin No. 2002-1*

HOSPITAL DIVERSION POLICY

TO: Hospital Administrators

*FROM: Sandra M. Knoble, Director
Division of Acute and Ambulatory Care
Bureau of Facility Licensure and Certification*

BACKGROUND:

The Pennsylvania Department of Health has observed an increase in the number of hospitals that go on emergency department divert during the last two years. This practice is a serious problem since it can have the effect of reducing access to care. It is particularly problematic when all hospitals in a geographic area go on divert. We want to remind all hospitals that, despite their divert status, they must provide for an appropriate medical screening examination for any individual who comes to the emergency department and who requests

examination or treatment for a medical condition. Also, hospitals are subject to state and federal sanctions for failing to provide such screening to all patients who present during the divert period.

This policy provides guidance on the Department's expectations regarding: 1) content of the hospital's diversion policy and 2) reporting of occurrences of diversion under 28 Pa. Code §51.3(f) ("Chapter 51.").

POLICY:

The Pennsylvania Department of Health hereby adopts the following policy.

Each hospital must have a written diversion policy. This policy should be developed in consultation with the regional emergency medical service (EMS) council, or its successor. This policy must describe those things that will trigger consideration of going on divert and what criteria will be used to go on divert. The policy should include and define the levels of divert to be used internally. These levels may be determined by the number of hours the facility is on divert status or some other unit of measurement. The policy must specifically identify a high-ranking physician or administrator who must personally approve and document each decision to go on divert. The individual approving the diversion may differ depending on the level of diversion invoked.

The hospital policy must identify who inside and outside the hospital will be notified of a decision to go on divert and contain a description of how the decision will be communicated to them. Notification of divert to outside entities must include the EMS system and public safety answering points (PSAPs/911 centers).

The decision of a hospital to go on divert (either total or a lower level) when the diversion is for eight continuous hours or more than 12 hours in a 24-hour period is a Chapter 51 reportable event to the Department of Health (Note: notification of your regional EMS council does not substitute for notification of the Department). The written report of the event must contain the date and time when the hospital went on divert, date and time when the hospital went off divert, the reasons for divert and what the hospital did to avoid the divert status.

This policy is effective immediately. The Department will verify adherence to this policy as part of regular survey inspections, complaint survey inspections and incident survey inspections.

Please share this information with your staff.

Questions regarding this policy should be directed to:

*Division of Acute and Ambulatory Care
Bureau of Facility Licensure and Certification,
Pennsylvania Department of Health
Telephone: 717-783-8980
Email at: paexcept@health.state.pa.us*

C. Existing Hospital Ambulance Diversion Classification

1. EMSI Policy

The *EMS Institute (EMSI)* is the EMS Council for five counties and the City of Pittsburgh in southwestern Pennsylvania. Around the turn of the millennium (December 2000), EMSI changed its hospital diversion status condition definitions to refer, not to the number or type of beds or nurses available in the hospital, but to the conditions in the Emergency Department. Similar diversion classifications are used in other regions. Below is a verbatim excerpt from the plan.

Attached is a policy on hospital Emergency Department status. The policy goes into effect December 12, 2000.

The policy establishes a 4 color code for Emergency Department status: green, yellow, red, and black. It is the hospital's responsibility to determine its status within that continuum. However, once a hospital determines that its status is not green (normal operations) then this policy requires the hospital to notify the appropriate County Emergency Operations Centers (911) in order to allow orderly and appropriate re-direction of ambulances.

EMSI is adopting this policy to ensure that our patients can obtain appropriate care as expeditiously as possible. This was occasionally problematic during the flu season last year. We hope that the adoption of this policy will help avoid the long travel times which sometimes occurred last year. It should also help hospitals meet the coordination requirement of 28 PA CODE 117.15.

Reporting will initially be by phone. However, a web site will be set up in the near future. Security measures, to eliminate erroneous status changes, will be in place by January 1, 2001.

GENERAL:

- *The terms "Divert", "Diversion", "Bypass" (and equivalent terms) are no longer recognized as valid and will be disregarded by EMS.*
- *In the event that a patient is redirected from one facility to another facility for reasons of a Condition Red or Condition Yellow status, such event must be noted on the trip sheet including the fact that the patient or patient's family was notified of this situation.*
- *Patients assessed at the scene and perceived by EMS personnel to be experiencing an immediately life-threatening illness or injury, shall be transported to the nearest appropriate facility and may not be redirected unless that facility has been reported as in "Condition Black"*

Condition Green:

- *The Emergency Department is open with no restrictions.*
- *This is the default status for all Emergency Departments unless another condition has been specified.*

Condition Yellow:

- *The Emergency Department is busy but **not** overwhelmed. Patients presenting to the Emergency Department via EMS may experience significant delays in treatment due to the current volume and/or acuity of patients already in the Emergency Department. EMS personnel should inform the patient of this situation and consider transporting the patient to another facility if the patient consents.*
- *This condition automatically terminates in 4 hours unless renewed.*
- *Use of this condition is not reportable to the Pennsylvania Department of Health under Title 28, Chapter 51, Section 51.3 of the Pennsylvania Code.*

Condition Red:

- *All of the usually available resources in the Emergency Department are overwhelmed such that receipt of additional patients will result in the inability to care for them safely. Patients may not be brought to the Emergency Department unless EMS personnel perceive the patient to be suffering from an immediately life-threatening illness or injury.*
- *If the majority of geographically adjacent hospitals are also on "Condition Red" then all hospitals revert to "Condition Green." The County EOC Medical Director is responsible for determining when this situation exists. He or she may establish a policy to make this determination in his/her absence.*
- *This condition automatically terminates in 2 hours unless renewed.*
- *Use of this condition is reportable to the Pennsylvania Department of Health under Title 28, Chapter 51, Section 51.3 of the Pennsylvania Code.*

Condition Black:

- *A hospital/facility may be reported in "Condition Black" when an emergency situation or catastrophic event exists that renders the entire facility as being unsafe. Examples of such events include but are not limited to: Fire, explosion, bomb threat, gun fire, nuclear/biological/chemical incidents, etc.*
- *No patients shall be transported to facilities that are reported as in "CONDITION BLACK."*

- *Use of this condition is reportable to the Pennsylvania Department of Health under Title 28, Chapter 51, Section 51.3 of the Pennsylvania Code.*

Closed: *A hospital/facility no longer maintains an appropriate receiving department for EMS. [added in a later revision]*

D. Existing Hospital Ambulance-Diversion Policies

1. Mercy Hospital of Pittsburgh

POLICY NUMBER: 213

Administrative Policies and Procedures

TITLE: EMERGENCY DEPARTMENT STATUS POLICY

POLICY: The Pittsburgh Mercy Health System (PMHS) will ensure that its patients can obtain appropriate medical care as expeditiously as possible. As such, PMHS has established a 4-color code for Emergency Department status: green, yellow, red, and black.

It is the responsibility of Mercy Hospital of Pittsburgh and Mercy Providence Hospital to determine its status within the established 4-color code continuum. However, once the hospital determines that its status is not green (normal operations) then this policy requires the hospital to notify the appropriate County Emergency Operations Centers (911) in order to allow orderly and appropriate redirection of ambulances.

DEFINITIONS:

Status Green – The Emergency Department is open with no restrictions. This is the default status for all Emergency Departments unless another condition has been specified.

Status Yellow – The Emergency Department is busy but not overwhelmed. Patients presenting to the Emergency Department via EMS may experience significant delays in treatment due to the current volume and/or acuity of patients already in the Emergency Department. EMS personnel should inform the patient (if not a Trauma, Burn, or OB patient) of this situation and consider transporting the patient to another facility if the patient consents.

Status Red – All of the usually available resources in the Emergency Department are overwhelmed such that receipt of additional patients will result in the inability to care for them safely. Patients may not be brought to the Emergency Department (unless a Trauma, Burn, or OB patient) unless the EMS personnel perceive the patient to be suffering from an immediately life-threatening illness or injury.

- If the majority of geographically adjacent hospitals are also on “Condition Red” then all hospitals revert to “Condition Green”. The County EOC Medical Director is responsible for determining when this situation exists.

Status Black - An emergency or catastrophic event exists that renders the entire facility as being unsafe. Examples of such events include but are not limited to: fire, explosion, bomb threat, gunfire, nuclear/biological/chemical incidents etc. No patients shall be

transported to facilities that are reported as in “Condition Black”. This includes Trauma, Burn, or OB patients.

PROCEDURES:

I. The DEM manager/designee, Charge Nurse, and Senior Attending DEM physician in collaboration with the Clinical Supervisor shall evaluate the conditions in the DEM with relation to the attached EMSI Regional Policy Status definitions.

II. The Clinical Supervisor should have current information regarding status and availability of inpatient beds in the institution for consideration in status decision making.

III. If a determination is made by the above individuals that a Condition change is necessary due to conditions that exist is the DEM and bed availability, the Administrator On-Call shall be notified.

A. In addition to the need for status change related to DEM volume and inpatient bed availability, a status change may also be indicated in relation to an emergency situation or catastrophic event that renders the entire facility unsafe (refer to condition black).

IV. If the Administrator On-Call supports a recommendation of status change to condition red or black, he/she shall notify the Chief Operating Office (COO) for final authorization.

NOTE: Changes to department status excludes Trauma, Burn, and OB patients at Mercy Hospital as per EMSI Reg. Policy unless specifically designated per Administrative Policy 214 – Trauma Bypass Protocol.

V. The Clinical Supervisor shall also notify the following of status changes:

A. EMSI via authorized website access.

B. Mercy TACC

C. Clinical Supervisor at the other System Acute Care Facility.

D. Pennsylvania Department of Health (condition red or black) as per Title 28 Chapter 51, section 51.3 of PA code utilizing the designated Chapter 51 report form.

VI. Condition status will automatically revert to green unless renewed by the facility within the following time frames:

A. yellow - 4 hours

B. red - 2 hours

C. black - indefinite, must be lifted by direct notification by facility.

POLICY SOURCE:

* 28 PA CODE 51.3

* 28 PA CODE 117.15

* PA Dept of Health

* Emergency Medical Service Institute (EMSI) of Southwestern Pennsylvania Regional policy on Hospital Emergency Room Status

ORIGINATION DATE: 03/02/01

CROSS REFERENCE:

- Administrative Policies & Procedures
214 – Trauma Bypass Protocol

2. Allegheny General Hospital

ALLEGHENY GENERAL HOSPITAL

Pittsburgh, Pennsylvania

Policy Manual No. 1415

SUBJECT: DIVERSION OF PATIENTS FROM THE HOSPITAL

DATE: April 21, 2003

I. This policy rescinds any previous publications covering the same material.

II. PURPOSE

To provide guidelines for Emergency Department staff and hospital in situations where no further patients can be accepted to the facility.

III POLICIES

A External Incidents

These guidelines apply in situations where there is potential for maximum patient capacity to be exceeded in the Emergency Department as a result of a rapid influx of critical patients and when arrival of additional patients with emergent conditions might require additional beds or staffing not available in the Emergency Department.

1 If the situation is related to a mass casualty incident, the Emergency Department charge nurse or attending physician will dial x1111 to enact the hospital Emergency Operations Plan.

2 If the situation is not related to any single incident, the Emergency Department charge nurse or the attending Emergency Medicine physician will notify the chair of the Department of Emergency Medicine, as well as the Director of Nursing On-Call or Manager of Hospital Operations to facilitate movement of any patients awaiting bed placement. The Emergency Department charge nurse and the attending Emergency Medicine physician will then enact the department procedure for mobilization of additional Emergency Department staff.

3 If the situation continues beyond maximum patient capacity in the Emergency Department, enact policy section B, "Internal Incidents".

B Internal Incidents

These guidelines apply in situations where maximum capacity has been reached in the Emergency Department, and it becomes necessary to consider diverting out-of-hospital providers.

1 The Emergency Department charge nurse and/or attending physician responsible for the North Station will notify the Director/Supervisor of Patient Placement or Manager of Hospital Operations of the situation.

2 The above individuals and the Chair of the Department of Emergency Medicine (when in the hospital) will meet in the Emergency Department to discuss the final determination of any patients who can be moved out of the Emergency Department. Consideration is made as

to any patients who have been stabilized, and are awaiting beds who could be transferred from the Emergency Department to another accepting facility and/or other means of opening additional beds.

3 The Emergency Department charge nurse and/or attending notifies LifeFlight Control to page the following for patient triage within their clinical areas:

a Department Chairs

b Critical Care Directors of Nursing 7:00 a.m. - 3:30 p.m.; after 3:30 p.m., the Charge Nurses in the Critical Care Units

c PACU Operating Room Supervisors

d Director of Nursing On-Call

e Manager of Hospital Operations

f Director/Supervisor of Patient Placement

4 If the Chair of the Department of Emergency Medicine is not available in the hospital, the situation will be relayed to the Chair by the attending physician responsible for the Emergency Department. In addition, the Administrator On-Call is notified prior to an alert being initiated. The Administrator On-Call is responsible for initiating options to prevent diversion status.

5 The Chair of the Department of Emergency Medicine will then place the Emergency Department on one of the following levels of alert:

a Code Yellow - Alert to EMS that patients arriving to the Emergency Department may experience significant delays in treatment. Per regional policies, EMS should inform patients of this situation and consider transporting patients not yet on hospital property to another facility if the patient consents. This condition terminates in four hours unless renewed.

b Code Red Response - An internal alert to key areas and personnel within the hospital that the Emergency Department is approaching Code Red status. All available in-house personnel on the Code Red Response Team report to the Emergency Department. This condition may or may not be paged prior to Code Red, depending on severity and temporal relationship.

c Code Red - Alert to EMS that receipt of additional patient will result in the inability to care for them safely. EMS should not bring patients to the Emergency Department unless the patient is perceived to be suffering from an immediately life threatening illness or injury. This condition terminates in two hours unless renewed.

d Code Black - An alert to EMS that the entire facility has experienced a catastrophic event which includes, but is not limited to: fire, explosion, bomb threat, gunfire, bio-chemical or nuclear incident. EMS should not transport patients to facilities in Code Black.

6 Proper notification of Emergency Department status to EMS is made by the LifeFlight Communications Center once notified of Emergency Department status by the department Chair (LifeFlight

Communications procedure number 511). Notification includes local EMS and AGH hospital administrative personnel.

7 When in a Code Yellow, Code Red or critical care bed alert (refer to Hospital Policy #1410), trauma patients will not be diverted without prior discussion between the attending trauma surgeon, attending Emergency Medicine physician and Administrator On-Call. Diversion of other patients not on hospital property will be discussed on a case by case basis between the accepting attending physician, Emergency Medicine attending physician, the Administrator On-Call, the Director of Nursing On-Call (or the Manager of Hospital Operations) and the communications specialist in the LifeFlight Control Center. Following the outcome of such discussion, the communication specialist will provide direction to local EMS services and maintain a log of any necessary diversions.

8 When in Code Red, the LifeFlight helicopter will not be dispatched for inter-facility patient transfers to return to AGH other than trauma or high risk OB. Delays will not occur in dispatching the LifeFlight aircraft in response to a scene run. Attempts will be made to find another appropriate receiving facility.

9 Any patients arriving to the Emergency Department will receive appropriate examination and stabilization and thereafter be considered for a transfer to another facility as appropriate.

10 The Emergency Department charge nurse and/or attending physician responsible for the North Station will notify the Director of Nursing On-Call or Manager of Hospital Operations of any changes in the capacity of the Emergency Department that impacts a prior decision regarding diversion status.

11 Patient Placement will notify the Emergency Department charge nurse, the attending physician responsible for the North Station, and the LifeFlight Control Center of any changes in status that may impact bed availability.

C Enactment of Hospital Emergency Operations

These guidelines apply to situations where the hospital has gone into an emergency operations response limiting the ability of the facility to care for patients.

1 The incident commander of the disaster will consult with appropriate clinical personnel to determine the impact of the disaster on patient care.

2 The decision to divert/transfer patients from the facility will be made by the incident commander, who will notify the managers responsible for the affected areas, including those listed in the Hospital's Emergency Operation Plan.

D Reporting of Hospital Diversions

1 If the hospital has been in Code Red status for eight consecutive hours or for more than twelve hours in a twenty-four hour period, the status must be reported to the Department of Health.

2 Reporting is initiated by the Department of Emergency Medicine on the Chapter 51 reporting form.

3 Within 72 hours of each Code Red event of eight consecutive hours or greater, or more than twelve hours in a twenty-four hour period, a root cause analysis will be performed (see attached form).

Connie M. Cibrone,
President and Chief Executive Officer

3. Thomas Jefferson University Hospital *DRAFT*

Thomas Jefferson University POLICIES AND PROCEDURES (DRAFT)

Category: Administrative

Title: HOSPITAL DIVERSION

Policy

Hospital Diversion to Fire Rescue pre-hospital care providers and Police is enacted in order to provide safe appropriate emergency care to all those who request service.. The diversion policy is exclusive of the Hospital Disaster Policy and is enacted only when the Emergency Department is unable to care for additional patients without compromising the care of the other patients currently under treatment in the Emergency Department.

Purpose

The Emergency Department is committed to providing quality care to all those who request services at all times. The Emergency Department strives to avoid divert status, however, under defined circumstances diversion is necessary to preserve the safety of the current patients needing emergency care. The diversion policy is implemented in compliance with the Delaware Valley Hospital Council and City of Philadelphia Police/Fire Rescue Services. The Fire Department attempts to comply with requests for diversion but will continue to bring patients to the ED when it is operational& necessary or in the best interest of the patient.

Authority

The authority to request Hospital Diversion lies with the Chairman of Emergency Medicine or designee in collaboration with the Hospital Administrator responsible for the Emergency Department or the Hospital Administrator on-call.

Diversion Classification

Acuity Diversion

Definition: The acuity level of newly admitted ED patient maximizes the nursing and/or medical resources required for that level of acuity.

Pre-Diversion Triggers: Three critically ill patients requiring continuous bedside one to one interventions/monitoring by medical and/or nursing personnel.

Pre-Diversion Actions: (TJH)

1. ED Attending and ED charge nurse will evaluate ED activity/volume in ICA, UCA and waiting area against available ED care providers.
2. Notify ED manager/ED CNS/Nursing Supervisor to mobilize additional nursing resources to the ED.
3. Notify ED Chairman or designee to mobilize additional medical resources to the ED,

Pre-Diversion Actions: (MHD)

1. ED Attending and ED charge nurse will evaluate activity/volume in ED and waiting area against available ED care providers.
2. Notify ED manager/Nursing Supervisor to mobilize additional nursing resources to the ED.
3. Notify ED Chairman or designee to mobilize additional medical resources to the ED,

Criteria for activation: Inability to provide additional nursing or medical care resources for the current ED volume within the next hour.

Notification List: (TJH)

1. Hospital Administration through TJUH paging system to obtain approval for diversion, (RECOMMENDATION AS TO WHICH SPECIFIC HOSPITAL ADMINISTRATOR SHOULD BE NOTIFIED FOR APPROVAL)
2. EMS/Police via direct call to Fire communications center at 215-686-1377 and Police Communications Center at 215-686-3128
3. Private Ambulance services via direct call to ambulance service list
4. JEFFSTAT through TJUH paging system
5. Central Scheduling/Transfer Center

Notification List: (MHD)

1. Nursing Supervisor will notify the Administrator on-call to obtain approval for diversion.
2. EMS/Police via direct call to Fire communications center at 215-6861377 and Police Communications Center at 215-686-3128
3. Private Ambulance services via direct call to ambulance service list
4. JEFFSTAT phone: 800-533-3121

Units of Measurement for medical divert: Minimum of two-hour closure with re-evaluation at one-hour intervals.

Diversion in Progress Actions: (TJH)

1. Activate rapid transit of patients to available in-house beds 2, Notify Trauma Service
3. Notify ED case manager
- 4, Notify support services: environmental services, transportation 5. Notify ED Leadership staff

Diversion in Progress Actions: (MHD)

1. Activate rapid transit of patients to available in-house beds
2. Notify House Staff and Residents to provide interim orders for in-house admission patients.

Admission Capacity Diversion

Definition: The ED is critically filled to volume capacity with multiple levels of patient categories without identified disposition and without in house bed availability.

Pre-Divert Triggers: (TJH)

- Occupancy Alert System (OAS) system on Red light
- Greater than 8 admissions without in-house bed availability
- One critical care patient requiring high intensity resources and four admissions without in house bed availability.
- The average wait time for patients to be seen after triage is greater than 4 hours.

Pre-Divert Triggers: (MHD)

- Greater than 6 admissions without in-house bed availability
- One critical care patient requiring high intensity resources and four admissions without in house bed availability.
- The average wait time for patients to be seen after triage is greater than 4 hours.

Pre-Diversion Actions: (TJH)

1. ED attending, charge nurse, ED manager and/or Nursing Supervisor will review patient census, dispositions, and ED capacity,
2. Notify Transfer Center to evaluate future bed availability.
3. Notify ED Case manager and/or Case Management Department
4. Notify Support services; environmental services and department of transportation.
5. Notify Patient Services
6. Notify Radiology for ED patient prioritization,
7. Notify Hospital Administration.
8. Notify Department of Surgery/Department of Medicine

Pre-Diversion Actions: (MHD)

1. ED attending, charge nurse and ED management will review patient census, dispositions, and ED capacity and notify Nursing Supervisor.
2. Notify Nursing Supervisor and Bed Management to evaluate future bed availability.
3. Notify Hospital Administration.
4. Notify Case management
5. Notify Department of Medicine / Department of Surgery.

Criteria for Activation: Emergency Department and Hospital capacity have been reached with no immediate empty, clean, staffed available beds.

Notification List: (TJH)

1. Hospital Administration through the hospital paging system to obtain approval for diversion. (RECOMMENDATION NEEDED HERE FOR WHICH SPECIFIC HOSPITAL ADMINISTRATOR WILL GIVE APPROVAL)
2. EMS/Police via direct call to Fire Communications center at 215-686-1377 and Police communications Center at 215-686-3128.
3. Notify Central Scheduling and the Transfer Center
4. Private Ambulance services via direct call to ambulance service list.
5. JEFFSTAT through the TJUH paging system.
6. Notify Case Management
7. Notify Radiology Services

Notification List: (MHD)

1. Nursing Supervisor will notify the Administrator on-call to obtain approval for diversion,
2. EMS/Police via direct call to Fire Communications center at 215-686-1377 and Police communications Center at 215-686-3128.
3. Private Ambulance services via direct call to ambulance service list.
4. JEFFSTAT phone: 800-533-3121
5. Notify Case Management

Unit of Measurement for Administrative Diversion:

Diversion required for four hours with re-evaluation at one hour intervals.

Diversion in Progress Actions: (TJH)

1. ED medical staff and nursing staff to expedite disposition status of non admission patients
2. ED charge nurse and ED attending to review with transfer center the sequence of next available beds.
3. Notify Radiology for ED patient prioritization
4. Notify Transportation service for ED patient prioritization
5. Notify Environmental services for ED patient prioritization

When the Emergency Department is on diversion for eight continuous hours or more the twelve hour in a twenty-four hour period a DOH CH 51 Incident Report is to be filled out by the Nursing Supervisor and placed in the Diversion Log Book.

Diversion in Progress Actions: (MHD)

1. ED medical staff and nursing staff to expedite disposition status of non admission patients
2. ED charge nurse and ED attending to review with Nursing Supervisor the sequence of next available beds, when the Emergency Department is on diversion for eight continuous hours or more the twelve hour in a twenty-four hour period a DOH CH 51 Incident Report is to be filled out by the Nursing Supervisor and placed in the Diversion Log Book.

Procedure for Diversion Activation

Steps	Responsible Party
1. Complete Notification System	ED Attending/ED charge Nurse
Internal Notification:	
Hospital Administration	ED Attending TJH Nursing Supervisor MHD
Nursing Supervisor	ED Charge Nurse
JEFFSTAT	ED clerical staff
Central Scheduling/ Transfer Center	ED Charge Nurse TJH
 External Notification:	
EMS/Police	
Communication Centers	ED clerical staff TJH ED clerical staff MHD
Private Ambulance Services	ED clerical staff
2. Evaluate Diversion Status	ED Attending/ED charge Nurse
3. Document re-evaluation status	ED Attending/ED Charge Nurse
4. Complete ED Diversion Report with attached staffing sheets and ED census report.	ED Charge Nurse TJH
5. Document Diversion on Hospital Director Report	Nursing Supervisor
6. DOH Reporting	VP Neuro/Surgery and Trauma TJH Risk Management MHD
 Responsibility for maintenance of policy: Vice President for Neuro/Surgery and Trauma	

References

1. Schneider SM, Gallery ME, Schafermeyer R, Zwemer FL. Emergency department crowding: a point in time. *Ann Emerg Med* 2003;42(2):167-72.
2. Asplin BR, Magid DJ, Rhodes KV, Solberg LI, Lurie N, Camargo CA, Jr. A conceptual model of emergency department crowding. *Ann Emerg Med* 2003;42(2):173-80.
3. Fields WW. Calculus, chaos, and other models of emergency department crowding. *Ann Emerg Med* 2003;42(2):181-4.
4. General Accounting Office. Hospital emergency departments: Crowded conditions vary among hospitals and communities. Washington, DC: General Accounting Office; 2003. Report No.: GAO-03-460.
5. Schneider S, Zwemer F, Doniger A, Dick R, Czapranski T, Davis E. Rochester, New York: a decade of emergency department overcrowding. *Acad Emerg Med* 2001;8(11):1044-50.
6. Richardson DB. The access-block effect: relationship between delay to reaching an inpatient bed and inpatient length of stay. *Med J Aust* 2002;177(9):492-5.
7. Clark K, Normile LB. Delays in implementing admission orders for critical care patients associated with length of stay in emergency departments in six mid-Atlantic states. *J Emerg Nurs* 2002;28(6):489-95.
8. Sorelle R. A real solution to overcrowding. *Emergency Medicine News* 1993;25(6):1,8-10.

9. Bazarian JJ, Schneider SM, Newman VJ, Chodosh J. Do admitted patients held in the emergency department impact the throughput of treat-and-release patients? *Acad Emerg Med* 1996;3(12):1113-8.
10. Sobie JM, Gaves D, Tringali A. ED "hold" patients: is their care also being held? *J Emerg Nurs* 2000;26(6):549-53.
11. Spaite DW, Bartholomeaux F, Guisto J, et al. Rapid process redesign in a university-based emergency department: decreasing waiting time intervals and improving patient satisfaction. *Ann Emerg Med* 2002;39(2):168-77.