Arizona Emergency Medical Systems, Inc.

RED BOOK
CHAPTER 8

Transfer of Care
Guideline Statements on Prehospital Diversion

DISCLAIMER

The AEMS Red Book is designed to be a resource document for use by Medical Direction Authorities responsible for the administrative, organizational and on-line medical direction of pre-hospital EMS personnel. It specifically recognized that variations from the guidelines contained within are not only acceptable, but also appropriate, depending on the individual circumstances of the involved areas and organizations.

By Statute and Rule, all advanced life support pre-hospital EMS personnel shall have administrative and online medical direction. These guidelines are not meant to act as a substitute, proxy or alternative to that medical direction. Any conflict between these guidelines and the individual EMS provider's medical direction shall default to the Administrative or On-Line medical direction.

This manual sets forth guidelines deemed by AEMS to be within the acceptable standard of medical care. It is specifically recognized that there are acceptable variations from these procedures and protocols, which may also satisfy the standard of care. This manual does NOT define, limit, expand or otherwise purport to establish the legal standard of care.

Arizona Emergency Medical Systems, Inc. (AEMS)

Purpose:
The establishment of efficient standard Pre-hospital Diversion Guidelines for the Central Arizona Regional Emergency Medical Services System.

Background
Historically, in the Central (AEMS, Arizona Emergency Medical Systems) Region of Arizona "Diversion" (a.k.a. bypass, flagging) has had a negative connotation. Throughout the United States, the negative sentiment regarding this concept has changed. Governed by cooperative community efforts and prospective planning, Prehospital Diversion can be a solution to the serious problems of saturation of emergency departments, trauma services, and potentially, hospital resources.

According to the American College of Emergency Physicians (1999) the increasing frequency of hospital/emergency department overcrowding, and unavailable emergency department resources, each EMS system (group of hospitals and prehospital agencies working cooperatively for the provision of patient care) must develop mechanisms to address patient diversions by health care facilities:

- Identify situations in which necessary resources are not available and temporary ambulance diversion is required
- Notify EMS System personnel and providers (prehospital and hospital) of such occurrences
- Regularly review and update the hospital's diversion status
- Provide for safe, appropriate and timely care of patients who continue to enter the EMS system during these periods of diversion
- Notify EMS system personnel and providers (prehospital and hospital) immediately when the situation that caused the diversion has been resolved
- Explore solutions that address the causes for diversion and implement policies that minimize the need for diversions;
- Provide for the periodic review of policies and guidelines governing diversion.

The mechanisms must include the establishment of diversion and patient destination policies for the EMS System based on ACEP's Guidelines for Ambulance Diversion.

The American College of Emergency Physicians approved "Guidelines for Ambulance Diversion" in January of 1999. The following document has been prepared in accordance with the recommendations established by ACEP and formulated into guidelines specific to the Central (AEMS) Region.

Each emergency department and/or trauma service will be responsible for analyzing their own activation of Prehospital Diversion. This will be done through established internal procedures.

EMSystem

Arizona Hospital and Healthcare Association with assistance from the Phoenix Fire Department developed the EMSystem to facilitate the management of diversion in the Central Region. The EMSystem is a web-based program providing real-time hospital emergency department diversion status information. Awareness of local area EMS resource limitations and capacity is vital to effective management of daily EMS system demands and mass casualty incident situations.

EMSystem Functions

Hospital Emergency Department Diversion Status: Participating hospitals update their ED diversion status (open, caution, closed, or really closed) at defined intervals. The regional status screen displays the status of each hospital in the region. The 911 or dispatch center then uses the displayed information to appropriately triage EMS units to area ED's. Hospital and EMS services also view the Regional Status Page to assess system capacity and bottlenecks.

Mass Casualty Incident Support: Unplanned acute medical emergencies involving significant numbers of ill or injured people requires instantaneous EMS resource allocation. Dispatch centers enter MCI details selecting the facilities required to respond. Each facility then enters their ability to accept immediate, delayed and minor patients allowing timely, accurate and dynamic EMS triage disposition decisions.

Arizona Emergency Medical Systems, Inc.

Guidelines on Prehospital Diversion
#2000-01

Approved by Board: May 17, 2000   Developed by: Diversion Task Force
Revision submitted: July 18, 2001
Revision submitted:
RETRACTION OF PREVIOUS POLICY STATEMENTS

Retracting previous policy statements #9701.

Diversion Guidelines, Edited, Reviewed and Approved by Board: December 17, 2003
Revisions Submitted May 18, 2005
Approved by AEMS Board June 15, 2005
Revisions submitted and approved by Board July 19, 2006
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Addition of Appendix I submitted and approved by Board August 15, 2007
Clarification of statement (IV–Categories, E) submitted and approved by Board October 31, 2007
Revisions submitted *Sept 17, 2008*
Revisions submitted to and approved by Governing Board, October 15, 2008
Revisions submitted to and approved by Governing Board, October 21, 2009

PROCEDURE: AEMS GUIDELINES ON PREHOSPITAL DIVERSION

I. PURPOSE

The standard of care in the AEMS Region will include guidelines for prehospital diversion of patients in accordance with the American College of Emergency Physicians Policy Statement regarding Ambulance Diversion (Appendix B). Patients presenting to an emergency department/trauma service by means other than the prehospital system are not subject to prehospital diversion.

II. GOAL

Each patient shall be assured safe, appropriate and timely medical care through the development of a system-wide process to objectively direct and redirect patients to receiving emergency departments and trauma services based on the current capabilities and status of potential destination facilities.

III. DEFINITIONS

A. *Emergency Medical Services (EMS) system* shall be defined as a group of hospitals and prehospital agencies working cooperatively for the provision of prehospital patient care.

B. *Emergency* has the same meaning as A.A.C. R9-10-201, “an immediate threat to the life or health of a patient.”

C. *EMSystem*™ refers to an Internet-based resource management system that includes the capability to monitor prehospital diversion status among hospitals statewide.

D. *Emergency /Trauma Saturation* for a hospital means the emergency department and/or trauma service are at maximum capacity, currently providing treatment to acutely ill or injured patients and, temporarily, prefer not to receive additional patients with an emergency medical condition.

E *Hospital Saturation* means a situation in which both Emergency/Trauma and inpatient fully committed resources have decreased to a level predefined in each facility's policies and procedures.

F. *Facility* is an emergency department or trauma service that receives patients transported by prehospital care providers.

G. *Regional sectors* mean emergency departments or trauma services located in proximate geographic areas. This term applies to the cooperative effort of notification of saturation or disaster status via the EMSystem™. The regional sectors are

Northwest:	**Central Sector:**
Arrowhead Hospital	Arizona Heart Hospital *
Banner Thunderbird Medical Center	Banner Good Samaritan Medical Center
Banner Del E. Webb Medical Center	Carl T. Hayden VA Medical Center*
Banner Walter O. Boswell Medical Center	Maricopa Medical Center
John C. Lincoln Hospital–Deer Valley	Phoenix Children's Hospital *
Southwest Sector:	Phoenix Indian Medical Center*
Maryvale Hospital	Phoenix St. Luke's Medical Center*
John C. Lincoln Hospital–North Mountain	St. Joseph's Hospital & Medical Center
West Valley Hospital	Casa Grande Regional Medical Center *
Phoenix Baptist Hospital	
Banner Estrella Medical Center	

Southeast Sector:	**Northeast Sector:**
Banner Baywood Medical Center	Mayo Clinic Hospital
Banner Baywood Heart Hospital	Paradise Valley Hospital
Banner Desert Medical Center	Scottsdale Healthcare Osborn
Banner Gateway Medical Center	Scottsdale Healthcare Shea
Chandler Regional Medical Center	Scottsdale Healthcare Thompson Peak
Gilbert Hospital	Payson Regional Medical Center *
Arizona Regional Medical Center	
Mercy Gilbert Medical Center	
Mountain Vista Medical Center	
Tempe St. Luke's Hospital	
Cobra Valley Hospital*	

* Facility does not participate in diversion rotation

H. *EMSystem*™ Color Coding

Communication of Hospital Diversion Status

Several requests have been made by area Fire Agencies and Hospitals requesting the revision of terminology used by Communications Centers broadcasting to pre-hospital personnel. The requested revisions are:

Open	Open (shows green) to all patients.
Caution	Caution (shows yellow) Hospital to Hospital communications tool; does not affect Pre-hospital agencies.
Rotation	Rotation (shows as orange) Open Per Sector Guidelines
Divert	Divert ED Diversion/Bypass (shows as red) Indicates ED/Trauma Saturation; facilities will continue to receive patients whose conditions may be adversely affected by transport to a further facility and those patients who adamantly request transport to that facility.
Code Purple	Diversion/Bypass (shows orange) Indicates hospital saturation; facilities will continue to receive patients whose conditions may be adversely effected by transport to a further facility.
Closed	Closed (shows black) Indicates an Internal Plant failure or Emergency. Facility will not receive any patients.

IV. CATEGORIES

The following are acceptable prehospital diversion categories. The declaration of prehospital diversion in one category does not necessarily indicate a facility is on prehospital diversion in any other category.

A. Trauma Service Saturation
A trauma service has fully committed resources and is not available for additional incoming Level I trauma patients.

B. Facility Internal Disaster
Through policy and procedure established by the internal disaster plan of a hospital, the facility or hospital cannot receive any patients due *to* (physical plant failure (e.g., fire, bomb threat, hostage situation, loss of utilities, computers, flood, natural disaster etc.). If there is a community-wide event, hospitals will accept patients in their ED.

C. Emergency Department Saturation
An emergency department has fully committed resources.

1. Saturation of inpatient critical care or medical/surgical beds shall not be used as a sole reason to initiate prehospital diversion.

2. Prehospital patients with an emergency medical condition shall be accepted by the closest appropriate categorized facility regardless of hospital status, when transportation to a more distant facility could pose a further significant risk to the patient.

3. Serious, but stable patients may be routed or re-routed in accordance with the provider's on-line medical control.

4. On-line medical control shall remain available at all times from ALS Base hospitals, regardless of their diversion status.

5. Each sector is responsible for determining what constitutes sector overload and development of an established hospital rotation plan. See appendix D.

D. Hospital Saturation:
Each hospital will develop policies and procedures to identify solutions and appropriate actions to ensure bed availability and adequate resources to meet the needs of all patients during times of hospital saturation, including but not limited to the following actions.

1. Deploying pre-emptive strategies to avoid prehospital diversion and alternative resources to decompress hospital saturation (See Appendix A).

2. Implementing EMSystem™ Purple Status – time limitation one hour.

3. To implement code purple status, a hospital must have activated its hospital saturation plan to maximize bed space, available personnel and resources.

4. After one hour, hospitals will re-evaluate; if hospital conditions continue, the hospital may continue on code purple based on Sector Guidelines. Each sector is to develop a rotation communication plan, for communication to dispatch, regarding how many facilities may be on hospital saturation simultaneously.

5. Critical patients shall be accepted by the closest categorized facility when transportation to a more distant facility could pose a significant risk to the patient. All transports to a facility on diversion will be reviewed by sector representatives.

6. Prehospital personnel may continue to patch to a base hospital on code purple for medical direction.

E. Other Considerations

1. **Patients Financial Status**
   Information regarding a patient's financial status and/or the facilities with which a patient's healthcare insurance contracts are not acceptable criteria for the declaration of a prehospital diversion or for the routing or re-routing of patients.

2. **Reserved Beds**
   Hospitals should not initiate prehospital diversion to reserve beds for elective admissions, potential deterioration of hospitalized patients, or for potential outside transfers.

3. **Designated Stroke Centers**
   Designated Stroke Centers will accept all patients who meet the stroke criteria regardless of ED diversion.

V. FACILITY RESPONSIBILITIES

A. Procedure Development

Each facility will develop policies and procedures for managing prehospital diversion, including:

1. Identifying individuals authorized to initiate prehospital diversion.

2. Notification protocols in the event that the EMSystem™ is inoperable, that include at a minimum:

   a. other facilities and prehospital agencies within the regional sector
   b. communication center(s)/agencies
   c. other facilities and agencies, as appropriate (Some jurisdictions may require notification of local law enforcement.)
   d. notification data that includes the:
      1) category and reason for prehospital diversion.
      2) time of initiation of prehospital diversion.

3. A record of the prehospital diversion should be maintained by the hospital after each episode, which includes a record of appropriate approval, type of prehospital diversion and reason, time of prehospital diversion initiation and conclusion.

B. Individuals Authorized to Initiate Prehospital Diversion

Each facility shall prospectively identify the individuals authorized with decision-making and notification authority, in the event that prehospital diversion becomes necessary. The minimum number of individuals authorized to recommend prehospital diversion include the on-duty emergency department clinical nurse manager and emergency physician/trauma surgeon, and the hospital administrator or their designee. Individuals authorized to initiate Prehospital Diversion, will have a working knowledge of this document.

C. Facility Continuing Quality Improvement (CQI)

1. Each facility will determine the method for its own internal prehospital diversion Continuing Quality Improvement Program, to include problem identification and resolution. (See Appendix A)

2. Sector Responsibilities

   a. On an annual basis, at the beginning of each calendar year, each sector shall identify committee membership to include at a minimum:

      1. One representative from each sector facility, prehospital agency, Communications Center and other members as deemed appropriate.
      2. Select a chair

3. Sector meetings need to occur at least quarterly, and as needed to review pre-hospital diversion practices and problem resolution. At a minimum, all EMSystem code purples and facility internal disasters will be reviewed.

4. Each sector will review aggregated data regarding the factors contributing to and duration of prehospital diversion.

5. Aggregate sector information and reported trends reviewed and discussed at sector meetings will be submitted to the AEMS Diversion Task Force and AEMS Patient Management Functional Group.

VI. NOTIFICATIONS OF PREHOSPITAL DIVERSION

A. Initiation of Prehospital Diversion

1. The person(s) responsible to initiate prehospital diversion will update the EMSystem™.

B. Automatic Time Period for Prehospital Diversion

1. Prehospital diversion is in effect for a maximum of three (3) hours for ED/Trauma Saturation with ongoing required. Periodic updates of prehospital diversion status during this time may be provided to the appropriate dispatch agencies.

2. Code Purple is in effect for a maximum of one (1) hour before re-evaluation is required.

C. Cancellation of Prehospital Diversion

1. At such time that prehospital diversion is canceled, EMSystem™ shall be updated. In the event that the EMSystem™ is inoperable, facilities must notify the communications centers and facilities originally notified.

VII. DATA

A. Responsibilities of ALS Base Hospitals and Receiving Hospitals

1. Emergency department nurse managers/directors and prehospital managers/coordinators will investigate concerns from prehospital providers regarding questionable or inappropriate use of prehospital diversion. The trends and issues identified by prehospital providers will be analyzed, documented in writing, and submitted to their regional sector meeting for discussion.

NOTES

1. American College of Emergency Physicians Ambulance Diversion Policy #400205. (Appendix B)

2. Emergency Medical Treatment and Labor Act (P.L. 99-272; 42 United States Code Section 1395dd).

3. Orange County EMSA Policy/Procedure: Guideline for Hospitals Requesting Bypass of Paramedic Escorted Patients. May 1992.

4. Wilson AG: Appendix I. Sample Rerouting Policy. in: Kuehi A (ed): NAEMSP EMS Medical Directors Handbook. St. Louis. C V Mosbey. 1989. pp 375-3 77.

APPENDIX A

INDIVIDUAL HOSPITAL RESPONSE STRATEGIES FOR SATURATION

Hospital saturation response strategies may be implemented within facilities or regional sectors to assist both local emergency medical services agencies and general acute care hospitals.

1. ED SATURATION/PREHOSPITAL DIVERSION

- Increase staffing, open any unstaffed critical care beds
- Eliminate elective surgeries and diagnostic procedures
- Transfer critical care patients to step-down or other beds as appropriate
- Request prehospital diversion from EMSystem™
- Media release discouraging non-emergency visits
- Activate emergency preparedness plan
- Evaluate inventory of equipment and supplies
- Give ED patients priority over elective admissions
- Inpatient units' accommodation of "excess" patients

2. HOSPITAL SATURATION/PREHOSPITAL DIVERSION

- Increase staffing, open any unstaffed medical/surgical/ICU/CCU/Tele beds
- Eliminate elective surgeries and diagnostic procedures
- Early transfer of patients to extended care facilities or to home, as appropriate
- Activate emergency preparedness plan
- Evaluate inventory of equipment and supplies
- Utilization of discharge holding areas
- Decline acceptance of outside transfers, unless no other resource is immediately available
- Use of ancillary units (e.g., hospital PACU, outpatient surgery PACU)

3. DISASTER

- Activate emergency preparedness plan
- Local proclamation of disaster
- State proclamation of disaster
- Federal proclamation of disaster

APPENDIX B

Ambulance Diversion

As an adjunct to this policy statement, Emergency Medical Services Committee has prepared a Policy Resource Education Paper (PREP) titled "Guidelines for Ambulance Diversion."

Policy number 400205
Approved by the ACEP Board of Directors January, 1999

This policy statement was prepared by the EMS Committee and replaces the statement, "Ambulance Diversion/Destination Policies," approved by the ACEP Board of Directors November 1991.

The American College of Emergency Physicians (ACEP) believes that each EMS system must develop mechanisms to address patient diversions by health care facilities. These mechanisms must include the establishment of diversion policies for the EMS system that include agreements between facilities regarding when to divert patients and when to accept diverted patients. These cooperative agreements between hospitals and out-of-hospital agencies must be designed to:

- Identify situations in which necessary hospital resources are not available and temporary ambulance diversion is required.
- Notify EMS system personnel and providers (out-of-hospital and hospital) of such occurrences.
- Provide for the safe, appropriate, and timely care of patients who continue to enter the EMS system during periods of diversion.
- Notify EMS system personnel and providers (out-of-hospital and hospital) immediately when the situation that caused the diversion has been resolved.
- Explore solutions that address the causes for diversion and implement policies that minimize the need for diversions.
- Provide for the periodic review of policies and guidelines governing diversion.

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ARIZONA ADMINISTRATIVE CODE
TITLE 9. HEALTH SERVICES
CHAPTER 10. DEPARTMENT OF HEALTH SERVICES

HEALTH CARE INSTITUTIONS: LICENSURE

ARTICLE 2. HOSPITALS

[Emergency Services Summarized – Effective October 1, 2002]

R9-10-203. Administration

C. An administrator shall require that:

1. Hospital policies and procedures are established, documented, and implemented that:
    - f. Cover diversion, including:
        - i. The criteria for initiating diversion;
        - ii. The categories or levels of personnel or medical staff that may authorize or terminate diversion;
        - iii. The method for notifying emergency medical services providers of initiation of diversion, the type of diversion, and termination of diversion; and
        - iv. When the need for diversion will be reevaluated;
5. Licensed capacity in an organized service is not exceeded except for an emergency admission of a patient. If the licensed capacity of an organized service is exceeded:
    - a. A medical staff member reviews the medical history of a patient scheduled to be admitted to the organized service to determine whether the admission is an emergency; and
    - b. A patient is not admitted to the organized service except in an emergency;

R9-10-206. Personnel

An administrator shall require that:

1. Personnel are available to meet the needs of a patient based on the acuity plan required in R9-10-208(C)(2);
2. Personnel assigned to provide medical services or nursing services demonstrate competency and proficiency according to criteria established in hospital policies and procedures;

R9-10-208. Nursing Services

C. A nurse executive shall require that:

2. An acuity plan is established and documented to determine the types and numbers of nursing personnel necessary to provide nursing services to meet the needs of the patients;
3. The acuity plan in subsection (C)(2) is implemented;

R9-10-216. Emergency Services

A. An administrator of a general hospital or a rural general hospital shall require that:

1. Emergency services are provided 24 hours a day in a designated area of the hospital;
2. Emergency services are provided as an organized service under the direction of a medical staff member;
3. The scope and extent of emergency services offered are documented;
4. Emergency services are provided to an individual, including a woman in active labor, requesting emergency services;
5. If emergency services cannot be provided at the hospital to meet the needs of a patient in an emergency, measures and procedures are implemented to minimize risk to the patient until the patient is transported or transferred to another hospital;
6. A roster of on-call medical staff members is available in the emergency services area;
7. There is a chronological log of emergency services that includes:
   a. The patient's name;
   b. The date, time, and mode of arrival; and
   c. The disposition of the patient including discharge, transfer, or admission; and
8. The chronological log required in subsection (A)(7) is maintained:
   a. In the emergency services area for a minimum of 12 months from the date of the emergency services; and
   b. By the hospital for an additional four years.

B. An administrator of a special hospital that provides emergency services shall comply with subsection (A).

C. An administrator of a hospital that provides emergency services but does not provide perinatal organized services, shall require that emergency perinatal services are provided within the hospital's capabilities to meet the needs of a patient and a neonate, including the capability to deliver a neonate and to keep the neonate warm until transfer to a hospital providing perinatal organized services.

R9-10-231. Disaster Management

An administrator shall require that:

1. A disaster plan is developed and documented that includes:
   a. Procedures for protecting the health and safety of patients and other individuals;
   b. Assigned personnel responsibilities; and
   c. Instructions for the evacuation, transport, or transfer of patients, maintenance of medical records, and arrangements to provide any other hospital services to meet the patients' needs;
2. A plan exists for back-up power and water supply;
3. A fire drill is performed on each shift at least once every three months;
4. A disaster drill is performed on each shift at least once every 12 months;
5. Documentation of a fire drill required in subsection (3) and a disaster drill required in subsection (4) includes:
   a. The date and time of the drill;
   b. A critique of the drill; and
   c. Recommendations for improvement, if applicable; and
6. Documentation of a fire drill or a disaster drill is maintained by the hospital for 12 months from the date of the drill and provided to the Department for review as soon as possible after a Department request but not more than four hours from the time of the request.

Central Sector Diversion

"Rotation Mode" for

ED Saturation

The following guidelines have been adopted by the Central Sector Diversion committee to facilitate a smooth closure process when multiple hospitals must be on diversion for ED saturation.

1. Banner Good Samaritan, St. Josephs and Maricopa Medical Center will be included in the Central Sector Diversion procedure. Arizona Heart Hospital, Phoenix Children's Hospital, Phoenix Indian Hospital, St. Luke's Hospital and Veterans Hospital in the central sector will not be impacted by this policy and will not be forced open.

2. Banner Good Samaritan, St. Joseph's Hospital and Maricopa Medical Center may not be on ED diversion simultaneously.

3. When 2 of the participating hospitals are on diversion and the 3rd reaches saturation, the alarm room will be contacted by the 3rd hospital.

4. The 3rd hospital will identify the need for closure indicating to the alarm room they are the 3rd hospital in the central sector to go down and enter their closure status on the EMSystem followed by the comment "rotation mode" for all 3 hospitals.

CONTINUED: Central Sector Diversion "Rotation Mode" for ED Saturation

5. The PFD alarm room will proceed to notify the hospital that closed first that the central sector is going into "rotation mode" and they must open for 1 hour.

6. After that first hour, hospital #1 will notify hospital #2 that they must open for 1 hour while hospital #1 closes. After hospital #2 has been open for 1 hour they will notify hospital #3 to open while they close. (1st on / 1st off).

7. The rotation will continue until one or more of the affected Hospitals can stay open.

Considerations:

- Any problems with compliance going on or off diversion during rotation mode will be handled by the alarm room.
-
- The alarm room will notify the pre-hospital manager by E-mail within 24 hours if they encounter any problems going into "rotation mode".
- Smaller hospitals in the central sector must be aware of closures and try to stay open or if they must close, open as soon as possible.
- QI will be done by the central sector anytime the rotational mode is used.

The following hospitals are part of the Central sector:

- Arizona Heart Hospital
- Good Samaritan
- Maricopa Medical Center
- Phoenix Children's Hospital
- Phoenix Indian Hospital

* St. Lukes Hospital
* St. Josephs Hospital
* Veterans Hospital

CONTINUED: Central Sector Diversion "Rotation Mode" for ED Saturation

Central Sector Diversion

"Rotation Mode"

Example:

In the following chart Hospitals "A" and "B" are closed and Hospital "C" now needs to go on diversion. Since all 3 hospitals in the Central sector may not close at the same time, the following rotation will be used. "A" as "first on first off" will open first.

Hospitals	1st Hour	2nd Hour	3rd Hour	4th Hour	5th Hour
A	Open	Closed	Closed	Open	Closed
B	Closed	Open	Closed	Closed	Open
C	Closed	Closed	Open	Closed	Closed

- Except for "B" (the 2nd hospital to open is closed for one hour initially), all hospitals are open for one hour and closed for two hours.

NORTH EAST SECTOR ROTATION

Communication between hospitals will occur when the need arises to rotate for diversion.

1. Only one hospital may be on diversion in this sector at one time.

2. If a second hospital needs to go on diversion, communication with first hospital on diversion will be made, to assess if they can open. If first hospital is unable to open the rotation process will begin. A rotation option for one hour intervals will take place, with reevaluation if needed.

3. If diversion issues arise, notify the Pre-Hospital Manager/ Coordinator.

SOUTH EAST Diversion

A meeting was held this morning to address the upcoming season and the issues and concerns that arise which affect the EMS System and the SE Sector Hospitals. Effective April 1st, 2003 the Phoenix online form went into effect for completion by all hospitals prior to going on diversion. In an attempt not to create more work for the nurses who are already taxed under the system, please follow the procedures below. *In completing the Phoenix On-Line form, one of the questions is # of ED beds; this indicates how many beds are in the ED; not how many beds are staffed. Another question is beds occupied; this indicates how many patients are in ED beds, regardless of whether they are holds or ED treatment. The # of ED beds should always be the same unless an ED expands or downsizes.*

1. Length of diversion:

A hospital on diversion may remain on diversion for a period not to exceed 3 hours; if no other facilities are on diversion or need to go on diversion. If a facility has been on diversion for a time period approaching 3 hours, the Southwest EMS Communications Supervisor or Lead will contact the other SE Sector hospitals to determine the status of their ED. If any other SE Sector hospital needs to go on diversion, the Supervisor or Lead will re-contact the original facility and advise them that we need them to open. If they request we "force them open",
simply follow the guidelines for opening a facility and indicate in the comments "Opened per SE Sector AEMS guidelines".

2. Requesting a facility go on diversion per SE Sector Guidelines:

Prior to placing a facility on diversion, an on duty District Manager must be dispatched to the facility to evaluate the situation. If it is determined by the District Manager that units at the facility are indeed delayed and it is necessary to place the facility on diversion, the Southwest EMS Communications Supervisor or Lead will update the status of the facility in the EMSystem and needs to obtain the information to complete the Online "Phoenix form". This information can be obtained by either asking to speak with the charge nurse to obtain the information or via the District Manager on scene. The Comments should include " Placed on diversion per AEMS SE Sector Guidelines". At the end of 1 hour the situation can be reevaluated via the charge nurse at the facility based on the status of the system. If additional hospitals have gone on diversion during that period, the Opening of SE Sector Hospital Guidelines should be initiated.

3. Opening SE Sector Hospitals:

When the third hospital in the East Valley Sector goes on diversion, there will be several contributing factors to determine who remains on bypass and who opens. Factors taken into consideration are:
Percentage Occupied ?
Other Factors within the facility ?
How many ambulances are at any given facility ? This total is to include ALL ambulances from all agencies, not just Southwest Ambulances.

Are we on altered protocol ?

CONTINUED: SOUTH EAST Diversion Committee Proposal

This information will be collected by the SWA Communications Supervisor or Lead on duty. The EMS supervisor or Lead will call the Southeast Sector Hospitals to gather the information beginning with the facility that has been on diversion for the longest. If the first facility called agrees to voluntarily come off of diversion, then the other 2 can remain closed. If the hospital is unable to come off of diversion, the other 2 facilities will need to be called to obtain the appropriate information. When calling the East County hospitals, you will be calling all of those on diversion and speaking with the Charge Nurse in the ER.
** A reasonable amount of time should be given to the Charge Nurse to come to the phone**
If you are unable to make contact with the Charge Nurse, please document that information on the form and continue the process.

Once this information has been obtained, a determination will be made by Southwest Ambulance Communications which one facility will be placed on diversion for an hour. The other 2 facilities will be placed on Caution indicating in the Comments section " Opened per SE Sector AEMS guidelines" . The facility remaining on diversion will be contacted at the end of the hour to return to caution. Each facility requested to open the previous hour will also be re-contacted to determine updated information. One of the facilities opened during the previous hour will be placed on diversion. This process will be repeated in a 1 hour rotation until the majority of the facilities are able to remain open. This too will be monitored by SWA Comm. Supervisors.

In the event that there is a system overload in the Southeast Sector where the majority of the hospitals are unable to assist by following the guidelines, please follow the agreed upon guidelines and ask the charge nurse to have the on call administrator from their facility contact you . When the on call administrator from the hospital calls, explain the situation of the sector and explain why the facility was placed on Caution. Seek their assistance with any additional solutions they may have to assist during the crisis period. As always please document who you spoke with and what was determined.

West Sector Diversion

The West Sector is divided into two sub-sectors, the Northwest and the Southwest. The sector division is listed below:

Northwest	Southwest
Arrowhead	John C. Lincoln North Mountain
JCL- Deer Valley	Phoenix Baptist
Boswell Memorial	Maryvale
Del Webb	Banner Estrella
Banner Thunderbird	West Valley

Each sub-sector will follow the same rotation guidelines.

- Only two hospitals can be on diversion simultaneously in each sub-sector.
- The 3rd hospital on diversion prompts the ROTATION guideline to begin.
- The Phoenix Regional Dispatch Center will initiate rotation by calling the hospital that has been on diversion the longest and placing them on rotation. ROTATION opens that hospital for 1 hour.
- After the first hour, the hospital on rotation will call the hospital that has been on diversion the longest and ask them to open per rotation guidelines.
- The Phoenix Regional Dispatch Center will assist in maintaining the continuity of the rotation if necessary.

May 19, 2005
Appendix E

Approved by AEMS Board: February 18, 2004

Rotation Mode" for Trauma Saturation

The following guidelines have been adopted by the Diversion committee to facilitate a smooth closure process when multiple hospitals must be on diversion for Trauma saturation.

1. Banner Good Samaritan, St. Josephs, John C Lincoln North Mountain, Scottsdale Healthcare Osborn and Maricopa Medical Center will be included in the Trauma Diversion procedure.

2. All 5 Trauma Centers cannot be on diversion simultaneously.

3. When 2 of the participating Trauma Centers are on diversion and the 3rd reaches saturation, the 3rd Trauma Center will close and notify the 2 closed Trauma Centers.

4. When the 4th Trauma Center becomes saturated, it will close and notify all other Trauma Centers. The Trauma Center that has been on closure the longest time will open and start the Trauma Rotational Mode. This will be indicated on the EMSystem followed by the comment "rotation mode" for all Trauma Centers.

5. The order used will be 1st on, 1st off.

6. The following is the Rotational Mode for the Five Trauma Centers

Rotational mode when the fourth Trauma Center needs to go on Diversion

Hospital	A	B	C	D	E
On Diversion	*X*	*X*	*X*		
Off Diversion				*X*	*X*

*Hospital A is first on Diversion, Hospital B is second on Diversion, Hospital C is third on Diversion, Hospital D is fourth on Diversion, and Hospital E is fifth on Diversion.

Rotational Mode When Fourth Center Needs to Go On Diversion

Hospital	A	B	C	D	E
On Diversion		*X*	*X*	*X*	
Off Diversion	*X*				*X*

*Hospital A is first on and would be first off for I hour. During the one hour communication should occur between all five trauma centers regarding the status and

the ability of their facility to come off diversion and/or if they would need to stay on diversion.

Rotational Mode at the Beginning of the Second hour on Rotational Mode

Hospital	A	B	C	D	E
On Diversion	*X*		*X*	*X*	
Off Diversion		*X*			*X*

*This applies only after communication with all centers and the fifth center *does not need* to go On Diversion and enter the Rotation
The following rotation will apply if E does not need to go On Diversion:

- After 2 hours, C & E would be open
- After 3 hours, D& E would be open

Rotational Mode If The Fifth Trauma Center Needs to Go On Diversion

Hospital	A	B	C	D	E
On Diversion			*X*	*X*	*X*
Off Diversion	*X*	*X*			

- The first two centers that have been On Diversion the longest will be opened up, follow by the third center, the fourth center and the fifth center.

7. Communication is vital to ensure at least two centers will be open at all times.

8. The rotation will continue until three or more of the affected Hospitals can stay open.

Considerations:

- Any problems with hospital compliance going on or off diversion during rotation mode will be reported to the Trauma Coordinators by the Phoenix Alarm Room or the Southwest Ambulance dispatch center.
- Monitoring of trauma diversion will be the responsibility of the trauma centers.
- Facility Internal Disaster

  Through policy and procedure established by the internal disaster plan of a hospital, the facility or hospital cannot receive any trauma patients (physical plant failure (e.g., fire, bomb threat, hostage situation, power outage, flood, natural disaster etc.).

APPENDIX F

Approved by AEMS Board October 21, 2009

Southeast Sector Patient Destination Alternative Program

This program was approved by the AEMS Governing Board on April 15, 2009.

The following patient destination alternative guidelines for the southeast sector of the central region were approved by the AEMS Governing Board on December 20, 2006 and were in effect from December 20, 2006 until April 15, 2009 as part of a Pilot Project. The Pilot Project, having been deemed a success, was terminated on April 15, 2009 and the tenets, standards, and monitoring criteria were declared usual operating procedures and guidelines for the sector. For the southeast sector, these guidelines replace current guidelines established in Chapter 8 of the Redbook, as amended July 19, 2006. These patient destination alternative guidelines apply only to hospitals and EMS providers within the southeast sector and shall not apply to hospitals and EMS providers in the other sectors.

Page 8-1 through 8-5: No Change. Guidelines in Redbook, Chapter 8, as amended July 19, 2006, will apply to the southeast sector.

Page 8-6: Changed. Southeast sector hospitals will only use the EMSystem color-coding designations of green, yellow, purple and black as prescribed below:

Open	Open (shows green) to all patients.
Caution	Caution (shows yellow) Hospital-to-Hospital communications tool; does not affect Pre-hospital agencies.
Divert Facility	Divert Facility (shows as purple) Indicates hospital wide saturation (surge capacity) and hospital has met usual criteria for diversion. Under medical direction, these facilities will continue to receive patients whose conditions may be adversely affected by transport to a further facility. Patients who request transport to the facility after being advised of their surge capacity status as outlined in Appendix G may be transported there, but EMS shall document this request.
Closed	Closed (shows black) Indicates an internal plant failure or emergency. Facility will not receive any patients.

Pages 8-7 and 8-8: Changed. The following "diversion" categories apply to the southeast sector and replace the categories listed in Chapter 8 of the Redbook, as amended July 19, 2006. Hospitals may initiate diversion under these categories.

A. Trauma Service Saturation
A trauma service has fully committed resources and is not available for additional incoming Level I trauma patients. (Currently this diversion category is not utilized in the southeast sector as no hospitals in the sector operate a designated trauma center.)

C. Facility Internal Disaster
Through policy and procedure established by the internal disaster plan of a hospital, the hospital cannot receive any patients due to physical plant failure (e.g., fire, bomb threat, hostage situation, loss of utilities, computers, flood, natural disaster etc.). Diversion under an internal facility disaster is listed as "closed" on the EMSystem and is color-coded black. If there is a community-wide disaster, hospitals will accept patients in their ED.

D. Hospital Surge (Divert Facility):
A hospital is experiencing "surge capacity" defined as "any incident, circumstance or situation, whether expected or unexpected, that significantly compromises a hospital's ability to effectively manage patients in one or more units within the limits of its medical infrastructure, resources and state licensure requirements. This situation may result from a variety of factors, including sustained overcapacity, a sudden influx of patients, and unexpected reductions in staff due to a flu epidemic or illness, or overcapacity that reaches a point at which the hospital can no longer decompress."

Pages 8-9 through 8-11: Changed. The following protocols relating to facility responsibilities, notification requirements and data analysis replace those listed in the Redbook, Chapter 8, as amended July 19, 2006, unless otherwise noted.

V. **Participant Responsibilities**

A. In order to implement diversion, a hospital shall:

7. Implement its overcapacity plan, including strategies listed in Appendix A for avoiding pre-hospital diversion.

8. Open an internal incident command center to respond to surge capacity, coordinate resources and communicate with other healthcare providers as necessary.

9. Identify persons authorized to implement diversion. These persons must have authority to allocate resources hospital wide (e.g., senior level managers.)

10. Review scheduled procedures/admissions with medical staff. Non-emergent procedures and admissions shall be rescheduled if medically appropriate.

11. Notify Mesa and Phoenix alarm rooms that the hospital has reached surge capacity and plans to initiate diversion. Inform the alarm room of the current wait time in the emergency department. Request pre-hospital agencies send a command officer or appropriate designee to the hospital for additional information.

12. Notify administrations of other southeast sector hospitals that the hospital has reached surge capacity and is initiating diversion.

13. Re-evaluate diversionary status every two hours and update dispatch centers and other hospitals. If the hospital's surge capacity continues and no other sector hospitals plan to implement diversion, the hospital may continue on diversion until the situation is averted. If more than one hospital is experiencing surge capacity and needs to implement diversion, the hospitals must implement a multiple-facility emergency incident command center with pre-hospital participation.

14. Accept critically ill patients regardless of diversionary status, if transportation to a more distant facility would pose a significant risk to the patient. Transports to a hospital on diversion will be subject to review by the Administrative Oversight Committee.

15. Continue to provide on-line medical control, if a base hospital, regardless of diversion status.

B. Hospitals may not initiate diversion to reserve beds for elective admissions, potential deterioration of hospitalized patients, or for potential outside transfers.

C. Designated Stroke Centers will accept all patients who meet acute stroke criteria regardless of the hospital's diversionary status.

VI. **<u>Notification and Communication Requirements</u>**

A. Hospitals shall provide contact information to each other and to pre-hospital providers for persons authorized to initiate diversion.

B. During a diversion event contact information for the hospital incident commander shall be listed on the EMSystem.

C. Hospitals shall notify the Mesa and Phoenix alarm rooms and other sector hospitals of diversionary status as prescribed under section V(A), paragraphs 5 through 7. All stakeholders will agree to participate in periodic emergency operations center training exercises.

D. If more than one hospital in the sector needs to initiate diversion at the same time, the hospitals shall set up a multiple-facility emergency incident command center with pre-hospital participation as prescribed in Section V (A), paragraph 7 of this addendum to Chapter 8 of the REDBOOK.

E. Pre-hospital providers shall provide patients with a standard layperson description of the hospitals divert facility status to include wait times submitted to them pursuant to Section V(A), paragraph 5 of this addendum to Chapter 8 of the REDBOOK, with the understanding that those wait times are an estimate and only indicative of the situation at that point in time. This description is included in Appendix G

VII. Data Analysis and Oversight

A. Sector Committee

1. The southeast sector may maintain the sector committee it has established pursuant to section V(C), paragraph 2 of the Redbook, Chapter 8, as amended July 19, 2006, and that committee may continue to meet as scheduled prior to the implementation of the pilot project extension.

2. Notwithstanding subsection A, paragraph 1 of this section, data elements prescribed by AEMS and delineated under subsection B of this section shall be reviewed by an Administrative Oversight Committee at least twice a year.

B. Administrative Oversight Committee

1. The AEMS Executive Council upon recommendation of the AEMS Governing Board shall appoint an Administrative Oversight Committee to review data as prescribed in paragraph 3 of this subsection and make recommendations to the Governing Board for system quality improvement.

2. The Administrative Oversight Committee shall consist of representatives from key components of the EMS system as outlined in Appendix H.

3. The Administrative Oversight Committee shall meet at least twice a year and shall review data collected by hospital and pre-hospital providers for quality improvement purposes, including but not limited to reducing diversion hours throughout the sector and improving ambulance off-load times.

C. Post-Event Analysis

1. In addition to the committees prescribed in subsections A and B of this section, hospitals and pre-hospital providers may convene ad hoc groups to review individual diversion events.
2. Any participant in the event may call a meeting, and all participants shall attend the meeting. This includes any hospital that initiated diversion or participated in an emergency command center.

Pages 8-12 through 8-20: No change

Pages 8-21 and 8-22: Changed. Under the diversion alternative program, Hospitals in the southeast sector will not have pre-established rotation protocols. As such, pages 8-21 and 8-22 are eliminated and replaced with the following:

A. Hospitals shall notify other hospitals in the sector and pre-hospital providers when they are initiating diversion, as prescribed in the pilot project diversion guidelines.

B. If more than one hospital has reached surge capacity and expresses the need to initiate diversion to pre-hospital and the other hospitals, each facility involved shall implement its incident command center and participate in a joint emergency command center. Hospitals and pre-hospital providers shall cooperate with each other to determine how patient load is to be managed throughout the system.

Pages 8-23 through 8-25: No change

APPENDIX G

Approved by the AEMS Board December 20, 2006

STANDARD PATIENT DIVERT FACILTY ADVISEMENT STATEMENT

The hospital that you have requested to be transported to is reporting excessive volume of patients seeking medical aid. They are reporting patient wait times of _______. These times are an estimate and only indicative of the situation at that facility at this point in time.

APPENDIX H

Approved by the AEMS Board December 20, 2006

COMPOSITION OF SOUTHEAST SECTOR ADMINISTRATIVE OVERSIGHT COMMITTEE

The following is the recommended membership for the southeast sector Administrative Oversight Committee:

One senior level manager from each hospital system in the southeast sector.
One senior level manager from a hospital system from outside the southeast sector.
Two representatives from the private ground ambulance industry.
One senior officer from a southeast sector fire department.
One senior officer from a fire department outside of the southeast sector.
One representative from an air ambulance provider.
Two representatives from an emergency department. [physicians/nurse]
**Communications and dispatch specialist.
**An additional upper level administrator from each hospital system in the southeast sector.

**These categories were added by actions of the AEMS Governing Board during the duration of the Pilot Project.

It is understood that ad hoc subcommittees may be formed as deemed necessary by the Administrative Oversight Committee.

APPENDIX I

Approved by the AEMS Board August 15, 2007

Patient Off-Load / Transfer of Care Tracking Program

The Phoenix Fire Department has been utilizing the following benchmarks for a pilot program that has been designed to track patient off-load / transfer of care times at the Valley's hospitals.

Benchmarks

1) Patient Arrival to the Hospital: When an ambulance arrives at an Emergency Departments unloading area with a patient, one of the ambulance attendants will either enter the "At Hospital" code via their ambulance's mobile computer terminal (MCT), or they will notify their communications center and advise of their unit's "at hospital time". This " At Hospital Benchmark" will mark in CAD the actual time of day the patient arrives to the hospital.

2) Patient Off-Load / Transfer of Care Time: For actual patient off-load / transfer of care to occur, the following 2 key components need to be met:

A) The patient has been off-loaded from the ambulance gurney.

B) The ambulance transport ticket/form has been signed by a person authorized to receive the patient at the hospital, **after the patient report has been given.**

After both of these events have occurred, the (*actual time of day) should be documented on the ambulance transport ticket/form next to the signature of the person receiving the patient. If the person receiving the patient does not document the time, then the ambulance personnel will make note of the time. When this has been completed, the "Off-Load / Transfer of Care Benchmark" has been met. (*In an attempt to try and maintain accuracy in times, Atomic Clocks should be utilized whenever possible.)

3) CAD entry of the patient off-load / transfer of care time: When an ambulance crew is ready to go back in service, they will need to do one of the following:

A) If the unit is equipped with an MCT, then 3 areas of a patient transfer mask will need to be filled out and processed through CAD prior to their unit being allowed to go back in service.

These areas are: 1) The patient's name, 2) the patient's date of birth, and 3) the actual patient off-load / transfer of care time.

B) If the unit is not equipped with an MCT, then the unit will need to contact their communications center, and advise of their patient's off-load / transfer of care time.

When this has been completed, the "CAD Entry Benchmark" has been met, and the actual patient off-load / transfer of care time has been entered into the system.

PFD Pt OL/TOC tracking program 2007/RG