GUIDELINES FOR DIVERSION STATUS AND APOT STANDARD

I. AUTHORITY:

California Health and Safety Code, Division 2.5, 1797.120; 1797.220; 1798 (a) (b)

II. APPLICATION:

This policy defines the Emergency Receiving Center (ERC) and Specialty Center procedure for requesting diversion when it is no longer safe for that facility to accept ALS and BLS ambulance-transported patients. It also establishes the county standard for Ambulance Patient Offload Times (APOT) as required by the California EMS Authority mandate.

ERCs and specialty centers shall minimize the duration and occurrence of diversion. No patient can be diverted from any center prior to the posting of diversion status on the ReddiNet® System except for internal disruption.

III. OBJECTIVES:

A. To assure the transport of a patient with an emergency medical condition to an appropriate ERC/Specialty Center that is safely staffed, equipped, and prepared to provide emergency medical care.

B. To provide standard definitions for ERC/Specialty Center closure and diversion requests.

C. To provide a mechanism for ERCs/Specialty Centers to:

1. Temporarily divert ambulance-transported patients when unable to safely provide emergency medical care;
2. Advise EMS system participants of diversion status; and
3. Identify the conditions which made the diversion request necessary.

D. To assure service provider units (fire, ambulance) are not unreasonably removed from their area of primary response when transporting patients to an ERC/Specialty Center.

E. Establish a standard for Ambulance Patient Offload Times (APOT).

IV. CLOSURE CATEGORIES:

A. ERC or specialty center may request diversion of ambulance-transported patients for the following reasons and using the following terminology:

1. Closed: ED Saturation - ED resources are fully committed and it is unsafe to accept additional in-coming patients. CCERCs can use this designation as well.

2. Closed: Trauma (TRAUMA CENTERS ONLY) - Trauma center is unable to provide trauma care for incoming trauma victims due to lack of an available trauma surgeon, trauma team, or surgical suite because of commitment to another trauma patient.

3. Closed: Internal Disruption – A physical problem exists at the ERC which would make it unsafe for the facility to accept any additional patients. (*e.g.*, fire, bomb threat, power outage, flooding, telephone outage)

4. Closed: CT Scanner – CT scanner is unavailable or out-of-service.

5. Closed: Cardiac – Cardiovascular Receiving Center (CVRC) unable to provide care for

STEMI patient due to cath lab occupied or disabled, cardiologist unavailable, or encumbered cath lab team.

6. Closed: Neuro – Stroke-Neurology Receiving Center (SNRC) unable to provide care to stroke patient due to thrombectomy suite occupied or disabled, neurointerventionalist/neurosurgeon/neurologist unavailable, CT scanner not functional, or encumbered thrombectomy team.

V. MECHANISM:

A. Request for ERC diversion status:

1. Notification of diversion will be made by the ReddiNet® system.

2. The following questions (on ReddiNet®) will be answered accurately:

a. Empty Emergency Department beds
b. Admitted patients in Emergency Department beds
c. Other patients in ED beds
d. Patients waiting in ED lobby/waiting room

3. The ReddiNet® comment section shall be utilized to include the estimated time of re-opening the Emergency Department.

4. The last names of the Emergency Physician, Emergency RN, ReddiNet® Operator, and any other authorized designee will be filled in as the diversion authorizers.

5. ERCs shall make every effort to reopen as soon as possible. Upon immediate improvement in capacity to provide emergency care, the Emergency Department will reopen and use ReddiNet® to alert the EMS system.

6. After two (2) hours of diversion, the ReddiNet® system will generate an audible alarm, alert light, and a popup window with questions that the ReddiNet® Operator must answer for the ERC to continue on diversion. If additional diversion is required, the ERC will update facility diversion status and answer diversion questions (# 2 above) and provide the name of the Hospital Administrator notified of the situation in the comment section.

B. Specialty Centers – Trauma, Cardiovascular, Comprehensive Children's, and Stroke-Neurology Receiving Centers:

1. Destination for specialty center patients is determined by Base Hospital (BH) contact. The contacted BH has authority for final destination determination.

2. Trauma criteria patient destination should be to the nearest open Trauma Center. This includes a Trauma Center that is open for trauma but closed due to ED Saturation.

3. Acute myocardial infarction ("Acute MI") criteria patients should be routed to the nearest open ERC that is an OCEMS designated CVRC with an available cardiac catheter laboratory and team.

4. Patients meeting Stroke-Neurology triage criteria should be routed to the nearest open ERC that is an OCEMS designated SNRC. Transfers of acute Stroke-Neurology patients to a SNRC from one of that center's spoke hospitals should be accepted for rapid or direct admission by the SNRC if just closed due to ED Saturation but otherwise has capability.

5. Requests for transport of pediatric patients to a Comprehensive Children's Emergency Receiving Center (CCERC) should be routed to the nearest open OCEMS designated CCERC even if closed to trauma.

C. Special Circumstances

1. If the three receiving centers most accessible to an incident location are reporting "Closed: ED Sat", the diversion request of each ERC will not be honored and the patient will be transported to the most accessible appropriate receiving center, regardless of its open/closed status.

2. If the two closest Trauma Receiving Centers are reporting "Closed: Trauma" and an ALS unit estimates an extended transport time to the next open Trauma Receiving Center, the BH will determine and authorize transport to the most appropriate receiving Trauma Center.

3. If both CCERCs are on diversion, this designation will be disregarded and both shall be considered open for ambulance patients.

4. If the two SNRCs or CVRCs most accessible to a patient's location are both reporting "Closed: Neuro or Closed: Cardiac", the diversion status will not be honored and the patient will be transported to the nearest appropriate receiving center.

5. If an ERC is listed as "Closed: ED Sat", this will automatically place the facility's SNRC and CVRC on diversion as well. Exception: transfer from a spoke hospital to the SNRC for direct admission to the stroke service.

VI. PROCEDURE:

A. Receiving Center Responsibilities

1. Each OCEMS receiving hospital must have a written ERC-wide response plan which addresses the steps to be followed and the appropriate ERC administrative staff to be notified when high patient volume within the ED or other situations as identified in Section IV necessitates temporary diversion of additional ambulance-transported patients.

2. Orange County ERCs must use the ReddiNet® system to notify all Orange County ERCs and Orange County Communications (OCC) of the reason(s) for closure, using only the terminology specified in Section IV of this document. Should the ReddiNet® system not be functioning, telephone notification is acceptable.

B. OCEMS Responsibilities

1. OCEMS shall monitor the frequency and duration of ERC requests for diversion of ambulance-transported patients and prepare a summary of ERC closures and distribute to all system participants on a periodic basis.

2. OCEMS may perform periodic, unannounced site visits of ERCs requesting bypass of ambulance-transported patients to ensure compliance with all guidelines. Frequency of site visits will be at the discretion of OCEMS.

C. ReddiNet® /H.E.A.R. Central Point Responsibilities

1. Upon request, OCC shall advise fire dispatch, ambulance dispatch, ALS, and BLS providers of an ERC's current status.

D. Base Hospital Responsibilities

1. Final authority for paramedic-escorted patient destination rests with the BH physician. The BH physician will honor an ED or specialty center diversion request provided that the ALS unit estimates that it can reach an "open" facility within a safe period of time.

2. Utilizing the Orange County Medical Emergency Data System (OC-MEDS), BHs will identify and evaluate the electronic patient care records of prehospital patients that were diverted from the nearest ERC and track the reason for diversion.

VII. APOT STANDARD

A. The APOT shall be defined as the time interval between the arrival of an ambulance patient at an emergency department (the ambulance comes to rest in the ambulance bay) and the time that the patient is transferred to an emergency department gurney, bed, chair, or other acceptable location and the emergency department assumes responsibility for care of the patient.

B. The standard for APOT is derived from ambulance time data collected over a 4 year span for patient offload times at Orange County ERCs.

1. The APOT standard will represent the median time for the 90th percentile of all offload times across the county for all ERCs.

2. After also considering the value for the upper limit of the interquartile range, the APOT standard for OCEMS is set at 30 minutes.

3. This standard will apply to all ERCs in Orange County.

4. Data will also be reported to EMSA.

C. OCEMS will review this standard on a yearly basis and may adjust it, if necessary, based on changes in the median for the 90th percentile of APOTs at Orange County ERCs.

VIII. AMBULANCE INTERVENTIONS FOR PROLONGED APOTS

A. Ambulance companies licensed to provide service in Orange County shall be authorized to implement the following interventions when confronted with APOTs exceeding 60 minutes:

1. After arriving at an ERC with a BLS patient, attempting to give report, and waiting 60 minutes inside the emergency department unable to transfer care, EMS personnel may place the patient in the hospital ED waiting room if ALL the following criteria are met:

- Patient held by the ambulance crew for at least 60 minutes inside the ED or outside the ambulance in another structure (tent, on a tarp, etc)
- Patient ≥ 18 years of age or pediatric patient accompanied by adult
- Normal mental status with decision-making capacity and GCS = 15
- Ambulatory without difficulty and without assistance (as appropriate for age)
- Not on a psychiatric hold (5150), in custody, or suicidal
- No chest pain, syncope, or acute neurologic symptoms (examples include no focal weakness, slurred speech, dizziness/vertigo)
- Normal vital signs for adults
  - SBP ≥ 100
  - RR between 12 and 20
  - HR between 60 and 100
  - Pulse oximetry ≥ 95% on room air
  - For pediatric patients, normal vital signs per age

EMS personnel may initiate this directive by first contacting the triage or charge nurse and informing them that the patient's wait time has exceeded 60 minutes. If told that they must remain, EMS personnel may then provide a verbal patient report and place the patient in the waiting room. Before leaving, EMS personnel will document the following in the PCR:

- All the criteria the patient met for off-loading in the waiting room
- Time of transfer
- The name of the person to whom report was given.

Obtaining the signature of the triage nurse is desirable but not necessary. If the triage nurse declines report, place the patient in the waiting room and document refusal of report and/or signature in the PCR.

2. ERCs may not allow more than 1 ambulance crew to be held in the department for more than 60 minutes. When a second ambulance crew arrives with another patient and is held in the emergency department for more than 15 minutes, the first ambulance crew may retrieve a cot from their ambulance or from an ambulance supervisor, place the patient on the cot in the emergency department, inform the charge or triage nurse of this action, give report if able to do so, and then leave the ERC.

   This action will be repeated each time an ambulance crew is held in the ERC for more than 60 minutes and a second crew is held for more than 15 minutes. With this action in place, no ERC should be holding more than one ambulance for more than 60 minutes. This applies to all ambulances, ALS and BLS staffed. It does not apply to patients on a psychiatric hold (5150), in custody, or who are suicidal.

3. Ambulances that have arrived at an ERC with a patient who called 911 but who has been held in the ambulance by emergency department directive for more than 1 hour may depart for another ERC after notifying the triage or charge nurse that they are leaving. It is important for all ERCs to note that refusing to off-load patients from a 911 dispatched ambulance for more than 60 minutes causing the ambulance to leave for another ERC potentially risks an EMTALA violation and potential investigation by the California Department of Public Health.

4, Hospitals holding patients in ambulances or ambulance crews/paramedics within their emergency departments for longer than 60 minutes may be reported to the OCEMS Duty Officer. The 90% APOT for such institutions will be obtained from the EMS

APOT/Diversion Dashboard. If the 90% APOT for that hospital is greater than 60 minutes, OCEMS will place the hospital on diversion for 2 hours using the ReddiNet. This may be repeated if the situation remains unchanged.

B. The EMS Duty Officer shall have the authority to place an ERC on diversion to resolve any unique situation that is not specifically addressed by this policy.

NOTE: Time elapsed while a patient is being held inside the ambulance after arrival at the ERC counts toward the 60-minute time limit for any actions authorized by this policy.

Approved:

Carl H. Schultz, MD
OCEMS Medical Director

Tammi McConnell, RN, MSN
OCEMS Administrator

Original Date:	06/1988
Review Date(s):	4/2014; 9/2018; 11/2020; 2/2022
Revised Date(s):	8/31/2012; 2/10/2021; 3/25/2022
Effective Date:	4/1/2022