

A FULL HOUSE



Updated Hospital Diversion Guidelines



INTRODUCTION:

The problems plaguing the nation's health delivery system are in many ways coming to a head in the highly charged world of the hospital emergency department (ED). Nowhere is that more evident than in New Jersey.

With more than 3.3 million people passing through the doors of Garden State emergency rooms yearly, an increase of 25% from 2001, hospitals and emergency service providers are faced with the challenge of continuing to provide prompt, quality care while preventing long waits and overcrowding. Emergency visits to New Jersey's 82 acute-care hospitals have increased by more than 600,000 patients during the last five years alone.

And, emergency department physicians and administrators say overcrowding – once a seasonal problem linked to flu outbreaks and other winter woes – has become a more chronic, year-round worry. Also, the ongoing prospect of domestic terrorism places additional strain on the system.

This document examines some of the reasons for emergency room overcrowding and the apparent increased practice of hospitals diverting patients to other facilities for periods of time when inadequate resources are available to treat patients. These guidelines also redefine and standardize some common terms and criteria for hospital diversions, recommend management practice changes and offer best practice examples of how some hospitals are taking steps minimizing the use of bypass and divert practices.

PERSPECTIVE: OVERCROWDING

For many people, the emergency department is the window to the hospital – their entry point to an array of services and settings. Looking through that window today gives a snapshot view of what ails the nation's healthcare system.

Declining reimbursement, staff shortages, an aging population, the rising number of uninsured, increasing numbers of undocumented aliens seeking care, more patients using the ED as a substitute for a primary care physician and the impact of managed care have combined to put added strain on hospital operations.

Compounding all of the above is an increasing unavailability of inpatient beds. The logic is simple. If a bed isn't available on a patient floor, a patient in need of admission is likely to be held in the emergency department. Although data shows that the statewide average occupancy rate for maintained beds hovers around 72 percent, it is not uncommon for specialty units at most hospitals to be running at capacity. In addition, hospitals may have available beds but not appropriate staffing to cover them.

Financial pressures add to the mix. Reimbursement cuts in Medicare, Medicaid and lagging charity care funding combine with managed care's payment practices to hold margins razor thin. In the past, when hospitals had a financial cushion, they were more likely to keep beds open, staffed and waiting for patients. No longer is that the case.

PERSPECTIVE: DIVERSION

There was a time when the hardest part of emergency medical services was getting patients to the hospital quickly and safely. Now, with improvements in pre-hospital-provider training, basic life support proficiency, the proliferation of MICUs and the state's trauma network, patients experience fewer problems reaching the hospital's doorstep.

Today, the challenge is finding a hospital ED with the resources to take on additional patients. During the past year, New Jersey hospitals have had to temporarily close their doors to ambulances with alarming frequency when ED resources are extended or a compromise of patient care may occur. Increasingly, BLS squads and MICUs are notified that the hospital cannot accept additional emergency patients and are directed to bring their ill and injured charges to other area hospitals.

While such "diverting" appears logical, when a hospital gets too full and closes its door even for a few hours, no one wins. The practice also raises a number of red flags regarding communications, accountability and public perception.

STANDARDIZATION

DIVERSIONS DEFINED

First and foremost, it should be noted that diversion is an advisory status, not a mandate. Ambulances with critically ill patients can utilize an emergency department that's on divert and be assured that they won't be turned away.

It's also understood that hospitals must make every reasonable effort to avoid "diversion" and develop policies that encourage efficient use of resources. When divert status can't be avoided, it's then imperative to develop policies that universally acknowledge and define the various types of diversion taking place.

However, there's a problem. Hospitals, rescue squads, paramedics and emergency medical dispatchers very often use different terms to describe diversions. In the past, terms such as "closed," "bypass," "selective divert," "treat and transfer," and "stabilize and transfer" have all been used, sometimes interchangeably, to refer to a facility's ability to accept patients.

Because each term has a different meaning, a standard set of accepted terminology should be defined and its use promoted. The following terms have been proposed by the New Jersey Hospital Association's Emergency Divert and Bypass Focus Group with input from the state Department of Health and Senior Services and various other interested parties. This terminology is being shared and reviewed by the state's Emergency Medical Services Council and other state emergency management agencies.

- **ED Divert:** The hospital **emergency department** cannot accept any additional patients transported by ambulance.
- **Full Divert:** The **entire hospital**, including the ED, is unable to admit any additional patients (ambulance, walk-in emergency, critical care, general admission).
- **Critical Care Divert:** No intensive care unit (ICU) beds or critical/coronary care unit (CCU) beds are available.

- **Special Services Divert:** Ambulances carrying patients requiring **specialty services** (psych, obstetrical, pediatric, substance abuse, etc) must be diverted. For example, a hospital would go in pediatric divert if it was unable to admit any pediatric patients. Burn patients should never be diverted from a burn center and trauma patients should never be diverted from a trauma center.

- **Facility Divert:** Hospital cannot take any patients due to fire, power outage or an internal disaster, etc.

This standard hospital diversion terminology can be easily applied to basic and advanced life support providers of emergency medical services.

ED Divert =	BLS and ALS Divert
Full Divert =	BLS and ALS Divert
Critical Care Divert =	ALS Divert
Special Services Divert =	BLS and/or ALS Divert depending on specific patient category
Facility Divert =	Absolute BLS and ALS Divert

THRESHOLDS

That said, there are a number of measures all hospitals can take.

- Hospitals located in adjoining regions should (together) try to agree on a reasonable threshold for diversions so that no one hospital becomes swamped with patients.
- Diversions should be limited to a maximum number of hours, with the situation re-evaluated immediately following.
- Diversions may also be overridden by the emergency physician in charge when medical judgment indicates that the diverting hospital can handle a certain patient better than the alternative hospital.

PLANNING IN-HOUSE:

With a threshold determined, it is imperative that a hospital-wide “diversion policy” be established in regard to emergency room issues, bed status, treat-and-transfer/treat-and-hold, responsible staff members, termination of divert status and documentation. Some points to consider:

EMERGENCY DEPARTMENT ISSUES

Sometimes the ED receives several severely ill or injured patients at once or a crush of routine emergencies and has no choice but to call a diversion. But if the hospital is frequently diverting patients, the hospital’s performance improvement process should be evaluated and changes made to minimize the need for diversions. The number of physicians and nurses employed in the emergency department and the tasks assigned to each should also be examined. And “fast tracks” should be established to move simple or non-emergency cases quickly through the ED. Finally, BLS ambulances, MICUs and paid EMS providers must be briefed on appropriate hospital transfer. Some pre-hospital providers prefer to bring patients to the nearest hospital rather than the most appropriate. For example, trauma patients delivered to a hospital not equipped to handle major trauma cases can bring the ED to a standstill.

It should be noted that diverting patients to other hospitals is a particular hardship for volunteer rescue squads, paid EMS responders and hospital-based MICU paramedics. Asking these emergency service providers to drive extra distances and maintain levels of optimal care places added burden on professionals who struggle against the clock and also need to comply with patient wishes. **Diversion should be explained to the patient and family as well as the fact that a prolonged wait may face them. If the patient still insists on transport to the diverting hospital, the ED physician at that hospital and dispatch entity should be notified.**

Key players in the emergency services equation often face manpower shortages just like the rest of the healthcare system. Hospital staff must realize and appreciate the demands placed on these pre-hospital professionals and treat them with the same level of cooperation and respect they are accustomed to.

BED STATUS

Another way to minimize diversions is to actively manage the available inpatient beds. Patients should be discharged throughout the day in order to most efficiently utilize beds. Holding areas can be established where patients can await transportation home. And the use of critical care beds should be reviewed so that once patients are stabilized, they are promptly transferred out of the unit.

TREAT AND TRANSFER/TREAT AND HOLD

Sometimes the ED may need to resort to Treat and Transfer or Treat and Hold procedures. This means that any patients (arriving by transport) in the ED will be treated, but once stabilized, they will either be transferred to another hospital for admission or held in the ED to await an open bed. In all these cases EMTALA guidelines must be followed. Patients and their family members must be involved in this decision as the patient’s physician may not have privileges at the other hospital, the family may not have transportation to the hospital, or a long ambulance ride may compromise the patient’s condition. Again, staffing must also be considered, as an ED or critical care nurse may accompany the patient and be gone for an extensive period of time.

Finally, patients who are in need of admission obviously should be transferred to a hospital where there are beds to admit them. As a result, Satellite Emergency Departments should never receive patients who need to be admitted.

RESPONSIBLE STAFF MEMBERS

Every hospital should designate one staff member (and one only) who is responsible for and has authority to call for a diversion. That staff member should be familiar with the entire hospital bed and manpower supply, and should have authority over the patient care departments, the admitting department, the discharge planning department and utilization review. Often this responsibility is given to the chief operating officer.

TERMINATION OF DIVERT STATUS

Hospitals must communicate to first-aid squads and MICUs the termination of a diversion. Otherwise, ambulances will continue to transport patients elsewhere unnecessarily. An ED divert should automatically terminate two hours after it is called; a diversion of any other category after four hours. The diversion, should of course, be reevaluated periodically.

DOCUMENTATION

All “diverts” should be recorded and in a log maintained in the ED, and used regularly to determine if changes in hospital procedure could minimize the frequency of diversions. This log should be accessible to administrative staff and the Department of Health and Senior Services if requested.

COMMUNICATING A DIVERSION:

Communicating a diversion to the appropriate organizations is critical. If BLS squads, paid EMS providers and MICUs are not aware of a divert, they will continue to deliver patients to the hospital’s door. Emergency medical dispatch centers must know of a hospital’s diversion status to coordinate pre-hospital care services; other area hospitals can prepare for a heavier load of patients if they know to expect it. Important considerations for hospitals:

1. Designate (in advance) a communications liaison to inform area BLS, MICUs, dispatch centers, police and other area hospitals of the hospital’s diversion status.
2. Also designate a transfer liaison to coordinate transfers into another hospital and to receive transfers from other hospitals.
3. Establish a method of distributing patients if all hospitals are on divert. Possibilities include rotation, by hospital catchment area, and by patient request.

SPECIAL CONSIDERATIONS FOR TRAUMA CENTERS:

The state’s ten designated trauma centers may be particularly affected during overloads as trauma centers should never go on ground divert to other hospitals. In preparing for periods of heavy utilization, trauma centers should have several levels of back-up staffing on call at any given time. They should also be prepared to cancel elective surgeries to accommodate the need for additional trauma surgery. Fly-by protocols should be in place for hospitals not able to receive patients via helicopter.

During periods of heavy utilization, trauma centers should encourage MICU’s to stringently adhere to established state triage protocols. Patients with anatomic or physiologic abnormalities meeting criteria should be transported to the trauma center. Cases meeting only ‘mechanism of injury’ criteria should be transported to other hospitals with adequate facilities under these circumstances.

BEST PRACTICE MODELS: SOME EXAMPLES

Hospitals statewide have made an administrative commitment to operational efficiency in an effort to reduce the need to divert.

Realizing that a backup in the emergency department can usually be traced back to the patient floors, one hospital has developed a new program called Code Purple. The goal of the program is to reduce bottlenecks in the ER and streamline the admitting and discharge process. Code Purple is comprised of a hospital-wide team with members from key hospital areas including the Emergency Department, Nursing Services, Admitting, Radiology, Lab, Housekeeping and Transportation Services.

Under the program, the emergency department physician and charge nurse continually assess the number of patients in the department. In the event patient volume increases beyond a certain point, other areas of the hospital are alerted before a major problem occurs. If the Code Purple is put into action, inpatient units create short-term holding areas where care may be given for newly admitted patients. Patients who have been discharged are moved to a separate area to await a ride home, housekeeping is dispatched to clean beds, and radiology staff assists in the prompt completion of Emergency Department X-ray studies. The end result: quicker turnaround of patient beds.

Other hospitals have designated beds in their emergency rooms as “fast track.” These areas allow ED staff to quickly evaluate and treat patients with less serious illnesses and injuries.



At a central Jersey facility, the recent addition of an eight-bed fast track area has helped move patients through the emergency department through quick evaluation by an ER nurse. This fast track area includes separate staff members who work from noon to midnight every day.

For many hospitals, the 15/30 emergency room guarantee is also helping reduce wait times. Under the guarantee, patients will see a nurse within 15 minutes of arrival in the emergency room and a physician within 30 minutes, or the visit is free.

According to officials at various hospitals using this guarantee, the 15/30 approach has had a positive impact, basically eliminating the need for the waiting room while improving customer service.

CONCLUSIONS:

Since the causes of hospital and emergency department overcrowding are many, the solutions must be equally multifaceted. Given that, communication and coordination are key components in both avoiding the need for divert status, yet implementing successful diversion guidelines when necessary.

Internally, hospital administrative staffs should review these recommendations thoroughly and should consider implementing as many as possible. Externally, hospitals that serve the same or adjacent communities should work together to ensure that when diversions do occur, a rational, mutually agreed upon notification procedure is followed.

Again, key highlight points to remember when attempting to circumvent or, when necessary, initiate divert status:

- Diversion is an advisory status, not a mandate. Critically ill patients or patients with life threatening emergencies must be seen and treated at the nearest emergency department. Ambulances should not be turned away.
- Patients have the right to go to the facility of their choice, regardless of divert status, but they should be made aware of the implications of divert, including increased waiting times.
- A hospital should make every reasonable effort to avoid diversion.

- Standard terminology should be used in describing divert status.
- Every hospital should designate a staff member with the responsibility and authority for calling as well as terminating a diversion.
- Hospitals should actively manage available inpatient beds and discharge patients throughout the day.
- A discharged patient holding area, staffed by a nurse, may be created for patients awaiting transportation home.
- Prompt discharges to long term care facilities, hospices and home health agencies should be facilitated.
- If critical care units are regularly on divert, added licensed beds may need to be applied for from the state.
- “Treat and Hold” and “Treat and Transfer” procedures should be reviewed regularly, with patient privacy and comfort needs considered.
- Diversions should terminate within a certain period of time.
- Each hospital should record divert activity in a standardized, centrally located log. When feasible, use of a central phone messaging or internet-based recording system is recommended.
- Each hospital should designate both a communications liaison and a transfer liaison to coordinate those activities with BLS responders, MICUs, dispatch centers and neighboring hospitals.
- Overburdened emergency service responders, must be treated with equal courtesy and respect by hospital staff.
- When all hospitals in a given area are on divert, a rotation strategy for fairly and evenly distributing patients to each hospital may be considered.
- Trauma centers should have several levels of backup staffing on call to support trauma services during overloads as well as encourage MICU paramedics to initiate more stringent field triage protocols. Trauma centers should never go on ground divert. Burn centers should never under any circumstances divert burn patients.
- Hospitals must work with each other to develop and coordinate mutually acceptable solutions to patient overloads.

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