



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

**Date:** January 17, 2008

**To:** Emergency Department Medical Directors  
Sponsor Hospital EMS Coordinators  
CMED Center Directors

**From:** J. Robert Galvin, M.D., M.P.H., M.B.A.  
Commissioner

**Re:** Revision to the Hospital Diversion Guidelines

Please review the attached guidelines regarding hospital diversions. These guidelines should be used as a template for regional and local coordination if hospital diversions are necessary.

This is a revision to the established guidelines, which were initially put into place, in 2002. The Connecticut EMS Medical Advisory Committee and the EMS Advisory Board have both provided extensive review and discussion on the subject of hospital diversions and I am supportive of the revisions.

Encl.



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## STATE-WIDE DIVERSION GUIDELINES

### NON-MCI CONDITIONS

Diversion should be utilized by an institution only as a last resort when patient safety within the institution may be jeopardized due to very high volume, or when the institution is not able to offer some of its normal services (such as CT scans). Diverting an ambulance can potentially place that patient at increased risk; therefore the welfare of the institution's patients as well as the welfare of potential arrivals must be carefully weighed.

Before diversion due to volume is contemplated, the institution shall have attempted everything possible to ensure that the Emergency Department does not become filled with admitted patients waiting to go to other areas of the hospital. Departments filled with admitted patients are impeded in their ability to treat emergent patients and are delayed in treating new arrivals.

Prior to diversion, the institution should have exhausted all avenues to prevent reaching this point. Some of the ways to ensure this are: expediting discharges, bringing additional staff into the hospital, paying overtime/bonuses for staff to pick up shifts, bringing additional beds into service, and considering the cancellation of elective admissions or procedures for that day or the next.

Those regions with a diversion policy already in place should make sure the same components contained herein are included in their protocols. Any concerns or need for variation of the regional policies should be brought before the CEMSMAC prior to implementation. All regional policies should be sent to the CEMSMAC to be kept on file.

#### There are two types of diversion:

- **Emergent Operational Diversion** due to an acute natural disaster such as a fire, burst pipes, electrical shut-down, etc., a threat/act of violence, or Haz Mat contamination, that directly or indirectly affects the ED operation and patient safety. This also includes issues involving the rest of the hospital (fire, loss of electricity, loss of water, loss of the operating rooms, etc.)

Emergent operational diversion may be required due to blocked routes of travel to the hospital secondary to an emergent situation.

In those cases where the ED may need to go on diversion acutely, only C-Med needs to be notified. C-Med will in turn notify the surrounding hospitals.

- **Emergent Medical Diversion** for high ED census, lack of hospital beds of any category, or imaging malfunctions:



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- The hospital that wishes to divert must obtain the permission from those hospitals it wishes to divert to. Those found to accept must be in a reasonable distance from the diverting hospital due to the fact that ambulances will not travel large distances out of their assigned areas unless there is an MCI declared.
- C-Med will only accept the diversion status if it has the names of the responsible parties at the diverting and accepting hospitals.
- The C-Med center in the region where the diversion is occurring, will notify all the other area hospitals by a general toned announcement .
- The C-Med center where the diversion is occurring will notify the neighboring C-Med center if diverting ambulances are crossing over to that region.
- Diversion must be formally renewed every four hours with C-Med and the accepting hospitals. If the time expires and the diverting hospital has not extended diversion with the permission of the accepting hospital(s), CMED will announce that the diverting hospital has resumed normal operation.
- As the internal or external reasons for diversion improve, it is expected that the diverting institution cancels its diversion status as soon as possible.
- As conditions change, any hospital may remove itself, at any time, from the accepting list by notifying the diverting hospital and C-Med.
- If a hospital that is contemplating diversion finds no accepting hospitals, it cannot divert.
- If a diverting hospital has lost all those institutions that were accepting, it must cease to divert unless it can find an alternate accepting hospital.
- In the event that severe weather conditions exist, C-Med may advise the diverting and receiving hospitals of these conditions. The final decision to implement/continue diversion will rest with the involved hospitals.

Scene providers should use the state trauma diversion criteria as well as the attached diversion criteria for guidance and contact medical control for destination decisions.

**A hospital regardless of his diversion status must accept a patient who is so unstable that, in the opinion of the ambulance crew, the patient must be taken to the closest hospital. On-line medical direction must be contacted in this circumstance to discuss final destination.**