The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

JUDYANN BIGBY, MD
SECRETARY

JOHN AUERBACH
COMMISSIONER

Circular Letter: DHCQ 08-07-494

To: Chief Executive Officers, Massachusetts Acute Care Hospitals

From: John Auerbach, Commissioner
Paul Dreyer, PhD, Director

Subject: Changes to Ambulance Diversion Policies

Date: July 3, 2008

We write to inform you of a pending change in the Department of Public Health policy related to ambulance diversion. Ambulance diversion is defined as an active statement that patients who are arriving by ambulance will not be accepted by a receiving facility. Effective January 1, 2009, ambulance services may honor diversion requests **only** when a hospital's emergency department (ED)'s status is "code black," which means that it is closed to all patients due to an internal emergency.[1] The Department developed this new policy only after thoughtful deliberation and consultation with our Boarding and Diversion Task Force, the members of which include representatives from emergency departments, hospitals, professional associations and Emergency Medical Services.

While many hospitals have attempted to respond to ED overcrowding by diverting incoming ambulances to other hospitals, diversion creates its own problems and, of course, does not address any of the causes of ED overcrowding. In fact, diversion may increase crowding at neighboring hospitals, interfere with the patient's choice of hospital and the availability of medical records, increase ambulance transport times, and limit the availability of ambulances for the next call.

The Department has been communicating its concerns about emergency department crowding and ambulance diversion for a number of years, most recently in a letter dated December 29, 2007. That letter stressed that the ability of emergency departments to care for acutely ill and injured incoming patients must not be compromised by the need to care for patients who are

[1] Recent "code black" occurrences have resulted from fires, chemical or other environmental contamination, and flooding due to broken water mains.

boarding in the ED, and must be using 'code help' plans to respond quickly to bed shortages in times of need.

While hospitals in several Emergency Medical Services Regions have developed operational strategies to forgo diversion, this option remains a coping strategy for many. However, the Institute of Medicine (IOM), the National Quality Forum (NQF), multiple professional organizations such as the American College of Emergency Physicians, and national collaborative efforts of other stakeholders discourage the routine use of ambulance diversion and instead focus on the reduction of boarding of patients in the emergency department.

The Department recommends that hospitals attempt to adjust to this January 1, 2009 change in policy by examining their internal hospital systems to be certain that they are configured for maximally efficient patient flow. In so doing, we believe that the problem of boarding patients should be viewed as a hospital-wide problem rather than simply an emergency department problem. As evidence of the effectiveness of new policies, strategies, or other system changes resulting in improvements in patient flow through the ED, hospitals should be able to document reductions in the numbers of patients boarding in the ED. In preparation for this new policy we strongly encourage a review that all necessary steps have been taken to avoid ED overcrowding and boarding and that hospitals assess and, where applicable, document improvements. It is important to point out in this context that the Medicare Conditions of Participation require that inpatients boarding in the ED receive the same care and services that they would receive if they were in a bed on an inpatient unit, and this requirement is subject to enforcement just as is any Condition of Participation.

The Department recognizes that there can be circumstances where an "advisory" to EMS can allow prehospital providers to make decisions that are in the best interests of patient care. An example of this "notification of status" would be informing an EMS system that a CT scan is not available or neurosurgery is unavailable due to a sudden and unanticipated staffing situation. Assuming there are equidistant facilities, EMS could use this information on hospital status to make an appropriate transportation decision. However, the decision to transport the patient would remain with the discretion of the prehospital provider and based upon clinical situation and prehospital capability. It may still be in the best interests of a patient with head trauma and deteriorating mental status who is being transported by Basic Life Support to be transported to a facility even if a CT scan is not working in order to have airway control and stabilization prior to transfer to definitive care. Any "such notification of status" can be reviewed. Such considerations do not imply that "selective diversion" is an accepted designation.

We understand that the elimination of diversion as a response to ED overcrowding will create large operational changes for many hospitals. To assist the provider community with this change, we are working with stakeholders to share existing resources that have been shown to be effective in dealing with overcrowding by reducing boarding, rather than relying on ambulance diversion. Listed below are the links to the various resources that have been developed on this issue to assist you as you work toward incorporating this new policy in your current operations. The Department is also working with a small group of providers to develop additional resources and best practices that will be shared with the provider community to help further our joint goal

of no diversion in the state. You will be hearing from us and others shortly about these collaborative approaches.

Resources Related to Developing a No Diversion Policy:

- The National Quality Forum (NQF) - "National Voluntary Consensus Standards for Emergency Care Phase II: Hospital-Based Emergency Department Care". You can download the document at the bottom of this link: http://www.qualityforum.org/projects/ongoing/emergency/comments2/index.asp

- American College of Emergency Physicians (ACEP) – 2008 Task Force Report on Boarding http://www.acep.org/WorkArea/downloadasset.aspx?id=37960

- CMS ED measures in 2009 IPPS rule – HAC. See page 23652 of the 2009 Proposed Hospital Inpatient Prospective Payment System (IPPS) regulation: http://edocket.access.gpo.gov/2008/pdf/08-1135.pdf

  Federal Register/Vol. 73, No. 84/Wednesday, April 30, 2008/Proposed Rules

  POSSIBLE MEASURES AND MEASURE SETS FOR THE RHQDAPU PROGRAM FOR FY 2011 AND SUBSEQUENT YEARS

  Timeliness of Emergency Care Measures, Surgical Site Infections
  Median Time from ED Arrival to ED Departure for Admitted ED Patients.
  Median Time from ED Arrival to ED Departure for Discharged ED Patients.
  Admit Decision Time to ED Departure Time for Admitted Patients.

- Emergency Department Performance Measures and Benchmarking Summit: The Consensus Statement *http://urgentmatters.org/media/file/EDBA.pdf*

Cc: Anuj Goel, MHA
Abdullah, Rehayem, OEMS
EMS Regional Directors