**Department of Veterans Affairs** **VHA DIRECTIVE 2009-069**
**Veterans Health Administration**
**Washington, DC 20420** **December 16, 2009**

# VHA MEDICAL FACILITY EMERGENCY DEPARTMENT DIVERSION POLICY

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive establishes policy and procedures for Department of Veterans Affairs (VA) Emergency Department (ED) and Medical Facility Diversion. This Directive identifies the conditions that must be met before ED diversion is deemed appropriate.

## 2. BACKGROUND

a. ED crowding was first described approximately 17 years ago in the medical literature. Since that time, over 120 papers and reports dealing with this topic have appeared in peer reviewed medical journals. Most recently, an extensive report by the Institute of Medicine on United States emergency care identified this as one of the most important issues facing the medical community.

b. The causes of ED crowding include fewer hospitals with EDs nationwide, increasing numbers of patients, nursing shortages, growing numbers of uninsured patients, declining reimbursement, difficulties obtaining appropriate on call specialty coverage, and excess numbers of admitted patients being held in EDs.

c. ED crowding is not caused by increased ED volume alone; an ED can be busy without being "crowded." Crowding refers to a situation where the demand for ED services exceeds the available supply and is a function of patient volume, patient acuity, physical space, and numbers of on-duty staff. Additional factors such as efficiency and the ability to move admitted patients to beds on inpatient units affects whether crowding occurs.

d. VA recognizes the commitment to accommodate and provide emergency care to eligible Veterans (see current VHA policy regarding standards for nomenclature and operations in VHA EDs). Every reasonable effort to provide emergency services will be made. However, there are occasions when continuing to be available may stress the system and create potentially harmful situations for patients currently being cared for on site.

e. VHA EDs must support and participate in the existing Emergency Medical Services (EMS) system serving their catchment area and receive and treat patients from the EMS System. The policy set forth in this Directive provides a standard approach to diversion and identifies pertinent facility interventions when ED and medical facility diversion is imminent. ***NOTE:*** *VA medical facilities are encouraged to collaborate with and participate in local non-VA organizations designed to coordinate care in the event of diversion or internal disaster emergencies.*

**THIS VHA DIRECTIVE EXPIRES DECEMBER 31, 2014**

f. **Definitions**

(1) **Walk-in patient.** A walk-in patient is a patient without an appointment who presents to the ED for evaluation of a relatively minor injury or illness. These patients may arrive on foot, by private vehicle, or public transportation and do not require or receive services from the EMS prior to arrival.

(2) **Ambulance Patient.** An ambulance patient is a patient arriving by an ambulance accessed by EMS and is assisted by pre-hospital care providers for a condition that requires or potentially requires emergent intervention while en route to the hospital.

(3) **Referred Patient.** A referred patient is a patient that was referred or sent to the VHA medical facility or ED by a provider in a VA or non-VA hospital or clinic for further evaluation, treatment and/or admission.

(4) **Advanced Life Support (ALS) Patient.** An ALS patient is a patient being transported by ambulance accessed by EMS and being assisted by pre-hospital care providers for a condition that requires or may require advanced cardiac care or life support.

(5) **Basic Life Support (BLS) Patient.** A BLS patient is a patient being transported by ambulance accessed by EMS and being assisted by pre-hospital care providers for a condition that does not require advanced cardiac care or life support.

(6) **Open Status.** Open status is a medical facility that can accept all patients for which it is designated to provide care.

(7) **Alert Status.** Alert status is a medical facility condition that precedes diversion when appropriate. Examples of conditions leading to alert status may include, but are not limited to, the following: a situation where the number of available inpatient medical facility beds is less than the average number of daily admissions, admitted patients are being held in the ED due to lack of available medical facility inpatient beds, there is only one available Intensive Care Unit (ICU) bed or one acute care bed available. Each medical facility's policy must outline the necessary conditions that must be met before alert status is deemed appropriate and include interventions to prevent progression to diversion status when possible. The Chief of Staff, or designee, must be notified immediately by the ED staff or the Medical Facility Bed Coordinator or Nursing Supervisor when alert status is being considered.

(8) **Patient Demand.** Patient demand includes when a VA patient, who is being transported by ambulance, requests to go to a VHA ED. This is a patient demand that must be honored except under one of the following conditions:

(a) The facility is on internal disaster diversion, or

(b) An assessment by a certified EMS provider in direct radio or telephone contact with the VA ED provider indicates that complying with the patient's request could result in further harm

to the patient from a delay in obtaining appropriate treatment. For example, a trauma patient must go to the nearest trauma center in the area designated by local EMS protocol.

(9) **Diversion.** Diversion is the situation where any or all patients arriving by ambulance or referred from an outside VA or non-VA facility (who would normally be treated by the receiving facility) cannot be accepted because the appropriate care, services, or beds are not available, staffing is inadequate or a disaster has disrupted normal operations. In this situation, patients are diverted to another facility for care and treatment. The Chief of Staff, or designee, must be notified immediately by the ED staff or the Bed Coordinator or Nursing Supervisor when diversion status is being considered. Diversion does not apply to walk-in ED patients.

(10) **Advanced Life Support (ALS) Diversion.** ALS Diversion is the diversion of patients that require advanced life support or advanced monitoring. This includes diversion of patients with acute myocardial infarction or unstable vital signs because of insufficient ICU or monitored beds in the facility and the ED. Patient demands are accepted (see subpar.2f (8)).

(a) The medical facility and ED may go on ALS diversion only under one of the following circumstances:

1. When all but one of the available inpatient monitored beds are occupied and only one monitored bed remains in the ED, or

2. The safe limits of treatment capacity have been reached. This means the ED is overcrowded with patients or there is not enough qualified staff to care for the patients currently in the department and the addition of any more patients would constitute an immediate danger to that patient or those already in the ED.

(b) While on ALS diversion, the ED can still receive ambulances if one of the following conditions exist:

1. The patient is a BLS patient and does not need ALS care;

2. All EDs in the community or local region are on either ALS diversion or ALS and BLS diversion status (see subpar. 2f (11));

3. The patient refuses to be transported to any other facility and requests transport to VA; or

4. The patient has an acute, life threatening emergency, such as an unmanageable airway, is being given CPR or has uncontrolled hemorrhage, and VA is the closest facility.

(11) **ALS and BLS Diversion.** ALS and BLS diversion is the diversion of all patients regardless of the need for monitoring; for example: diversion of patients regardless of the level of care needed for treatment because facility beds are unavailable or there are insufficient numbers of staff to care for additional patients. Patient demands are accepted (see subpar.2f(8)).

(a) The ED and medical facility may close to ALS and BLS ambulances only under one of the following circumstances:

1. When all but one of the available monitored hospital beds are occupied, all other inpatient beds are occupied and only one unoccupied monitored bed remains in the ED, or

2. The safe limits of treatment capacity have been reached. This means the ED is overcrowded with patients or there are not enough qualified staff to care for the patients currently in the department and the addition of any more patients would constitute an immediate danger to that patient or those already in the ED.

(b) While on ALS or BLS diversion, the ED can still receive ambulances if one of the following conditions exist:

1. All EDs in the community or local region are on ALS or BLS diversion status;

2. The patient refuses to be transported to any other facility and requests transport to VA; or

3. The patient has an acute, life threatening emergency, such as an unmanageable airway, is being given CPR, or has uncontrolled hemorrhage, and VA is the closest facility.

(12) **Internal Disaster Diversion.** Internal disaster diversion is the diversion of all patients regardless of the level of care needed for treatment. The facility may have lost electricity, water, sustained physical damage to structure or be overwhelmed by current patient load. Patient demands are not accepted. Internal disaster diversion does not apply to walk-in patients.

(a) The facility Director, or designee, may authorize internal disaster diversion of the ED and medical facility in the event of an unplanned disaster situation involving the facility, such as a loss of utilities, necessary staff, or equipment. The ED and facility may also go on internal disaster diversion when all of the following conditions occur simultaneously:

1. There are no available beds in the hospital and no available beds in the ED, and

2. There are multiple overflow patients in the ED, and no hospital beds will be available for at least 4 hours, and

3. The acceptance of another patient would constitute an immediate danger to that patient or to patients already present in the ED, and

4. The Director, or designee, has been notified and concurs with internal disaster diversion.

(b) The ED can receive ambulances while on internal disaster diversion if one of the following conditions exist:

1. The patient has an acute, life threatening emergency, such as an unmanageable airway, is being given CPR, or has uncontrolled hemorrhage and VA is the closest facility; or

2. All EDs in the community or local region are on internal disaster status.

**3. POLICY:** It is VHA policy that each VHA medical facility with an ED must have an appropriate policy in place for implementation of diversion, including alert status with steps to be taken to avoid diversion whenever possible.

**4. ACTION**

a. **National Director for Emergency Medicine.** The National Director for Emergency Medicine is responsible for providing national guidance to ensure a standardized approach for the provision of safe, quality care within VHA's EDs. For the purpose of this Directive, this includes:

(1) Policy and directions for the receipt and treatment of patients from the EMS System, and

(2) A standardized approach for outlining the acceptable conditions that must be met before diversion is deemed appropriate and the processes and interventions that are to follow.

b. **Veterans Integrated Service Network (VISN) Director.** The VISN Director is responsible for ensuring each facility having an ED, within the VISN, has a policy in place to deal with diversion.

c. **Medical Facility Director.** The medical facility Director, or designee, is responsible for:

(1) Ensuring when ED diversion occurs, the ED's medical facility goes on diversion as well.

(2) Ensuring the internal disaster status is reviewed at least every 2 hours by the nurse manager or charge nurse and the bed coordinator or nursing supervisor; and the Director, or designee, is updated at that time in order to make the determination to continue or discontinue disaster status.

(3) Providing adequate oversight of bed availability, including ongoing monitoring of bed availability and communication of bed availability to necessary VA and non-VA staff.

(4) Ensuring that policy is in place and procedures are defined and followed for initiating and discontinuing diversion status during administrative and non-administrative hours. Policies developed at each facility must include the following:

(a) Interventions which are to be considered when VHA medical facility diversion is imminent (i.e., alert status is in force) includes: situations where the number of available medical facility inpatient beds is less than the average number of daily admissions, there are admitted patients holding in the ED due to lack of available medical facility inpatient beds, or there is only one available ICU bed or one acute care bed available.

(b) The ED Physician, Attending Physician, or Medical Officer of the Day (MOD) on duty in charge of the ED, in cooperation with the ED Nurse Manager or Charge Nurse must be allowed to decide if alert status, ALS or ALS and BLS diversion is appropriate.

(c) ED and medical facility diversion status is a direct reflection of inpatient bed availability and as such has an effect on the ability to safely accept and care for transfers from outside VA and non-VA facilities. Inter-facility transfers, (i.e., transfers from VA or non-VA facilities) are not to be accepted while the ED and medical facility is:

1. On ALS and BLS diversion status;

2. On internal disaster diversion status; or

3. On alert status.

(d) Patient transfers requiring monitored beds will not be accepted if the receiving facility is on ALS diversion status (see current VHA policy on inter-facility transfers).

(e) The fact that the ED must never turn away an ambulatory patient or a patient that has arrived by ambulance.

(f) A medical screening is always performed in accordance with the provisions of title 42 Code of Federal Regulations (CFR), Emergency Medical Treatment and Labor Act. Patients may be referred to a clinic for further evaluation and treatment if deemed appropriate after being medically screened.

(5) Making the final decision whether or not the ED and medical facility initiates internal disaster diversion status.

(6) Ensuring that accurate tracking of the frequency, total time on diversion, and reasons for diversion occurs. These data must be reviewed on a quarterly basis as part of the performance monitoring and improvement process (see subpar. 4d(7)(c)).

d. **Chief of Staff.** The Chief of Staff, or designee, is responsible for:

(1) Establishing ED and medical facility criteria for alert status based on bed availability, staffing, emergency situations, etc., which indicates that the potential for initiating diversion is high.

(2) Identifying interventions to manage the alert status and ensuring proper steps are initiated to continue the provision of safe, efficient quality care to patients currently being cared for. These actions may include, but are not limited to:

(a) Limiting the number of elective scheduled admissions;

(b) Rescheduling or canceling of surgical procedures;

(c) Discharging current stable inpatients;

(d) Transferring appropriate patients to other VA or non-VA facilities, as outlined in current VHA policy for inter-facility transfers;

(e) Adjusting the availability and number of staff; and

(f) Prioritizing admissions to acute care.

(3) Establishing medical facility specific criteria related to initiation and termination of diversion status.

(4) Communicating with VHA medical facility personnel regarding bed control issues.

(5) Communicating with the Chief(s) of Staff at other VHA and non-VHA facilities regarding bed availability as needed.

(6) Establishing collaborative partnerships with local and regional emergency services or officials, such that the VA ED can be included in the community's available emergency resources continuum. This includes VHA ED staff participation in the regional EMS organization and in region-wide real time monitoring of diversion status.

(7) Designating an individual to maintain data in the diversion tracking data base and ensuring that these data are reviewed on an ongoing basis. Data collected must include:

(a) Exact reason for diversion.

(b) Number of hours the ED and medical facility is on diversion.

(c) Number of days that the ED and medical facility is on diversion for any time period. The metrics of this data is reviewed by the medical facility on a quarterly basis, as part of the performance monitoring and improvement process, includes:

1. Total number of days during the quarter the ED and medical facility is on diversion to ambulance arrivals or to inter-facility transfers during any part of the day; and

2. Total number of hours during the quarter the ED and medical facility is on diversion to ambulance arrivals or to inter-facility transfers.

| | **Diversions During the Quarter** |
|---|---|
| **1** | **The total number of days** during the quarter the ED was on diversion for any part of the day should be reported. ***NOTE:*** *Enter number of days.* |
| **2** | **Total number of hours** of ED diversion during the quarter. Diversion is defined as those periods when the ED is closed to EMS arrivals. ***NOTE:*** *Enter number of hours.* |

(8) Initiating the diversion, when appropriate, based on the lack of appropriate available beds, the needed services cannot be provided, the staffing is inadequate, or the disaster has disrupted normal operations.

(9) Terminating the diversion status as soon as possible after resolution of the problems leading to diversion status.

e. **ED Physician, Attending Physician or MOD.** The ED Physician, Attending Physician, or MOD on duty in charge of the ED, in cooperation with the ED Nurse Manager or Charge Nurse, is:

(1) Responsible for deciding if alert status, ALS or ALS and BLS diversion is appropriate. This decision is made after consultation with the Bed Coordinator or Nursing Supervisor confirming the lack of available beds or staffing resources that could be used to avoid diversion status.

(2) Not authorized to activate internal disaster diversion. This determination can only be made by the medical facility Director, or designee.

f. **Nursing Supervisor or Bed Coordinator.** The Nursing Supervisor or Bed Coordinator is responsible for providing timely and accurate information regarding bed status and availability to the Nurse Manager or Charge Nurse and the responsible ED physician or MOD.

## 5. REFERENCES

a. Position Statement on Emergency Department Crowding: Present and Future Directions, American Academy of Emergency Medicine, July 2006.

b. Institute of Medicine, Committee on the Future of Emergency Care in the U.S. Health System. Emergency Medical Services at the Crossroads. Washington, DC: National Academy Press; 2006.

c. Institute of Medicine, Committee on the Future of Emergency Care in the U.S. Health System. Hospital Based Emergency Care at the Breaking Point. Washington, DC: National Academy Press; 2006.

d. New York State Department of Health Bureau of Emergency Medical Services,

No. 06-01, January 11, 2006, "Emergency Patient Destinations and Hospital Diversion."

**6. FOLLOW-UP RESPONSIBILITY:** The Office of Patient Care Services (11), Medical-Surgical Services (111) is responsible for the contents of this Directive. Questions may be referred to the National Director for Emergency Medicine at (202) 461-7120.

**7. RECISSIONS:** None. This VHA Directive expires December 31, 2014.

Gerald M. Cross, MD, FAAFP
Acting Under Secretary for Health

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