



MEMORANDUM



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Subject:

Hospital Closure and Diversion Policy

I. Background and Purpose

Overcrowding in hospital emergency departments has reached epidemic proportions across the United States. Jurisdictions are faced daily with the difficult decision of which hospitals to close or divert and for how long. This leads to the risk of compromise in access to emergency care for millions of people nationwide annually.

Washington, D.C. fares no better and faces its own unique challenges, including: a population that at least doubles during the day with commuters and visitors; a growing and aging resident population with relatively poor health outcome indicators; a finite level of hospital-based emergency medical care resources; closure and diversion levels that have peaked in recent years; and ambulance drop-off times that are higher than the national average.

In light of these and other factors, the following new policy will be implemented with the goal of ensuring that no single aspect of the District's Emergency Medical Care System is unduly burdened by the challenges listed above, while also striving to achieve the highest possible quality of patient care. The intent of the policy, arrived at in the spirit of collaboration and partnership, is to establish the process that the D.C. Fire and Emergency Medical Services Department (Fire and EMS) and district hospitals will follow for hospital closure and diversion, and for transferring patients to hospitals.

Note: this policy assumes normal operational circumstances. Under declared disaster or Mass Casualty Incident circumstances, the time limit restrictions and closure requirements outlined in Section V are suspended.

II. F&EMS System Asset Management Officers

1. The Unified Communications Center (UCC), through Fire and EMS' EMS Liaison Officers (ELOs) will continuously monitor and actively manage the number of Fire and EMS transport units at or en route to each District hospital to avoid the "stacking" of transport units at any one facility at any given time.
2. Hospitals may contact the ELOs 24 hours a day at 202-373-3713.
3. Fire and EMS providers will contact the UCC to check hospital status on all calls, either at the scene or upon departure from the scene.

4. Fire and EMS providers will pre-alert the receiving hospital for every Priority 1 and 2 run using the recorded hospital or "H" channel 1 with a concise report of the patient's status.

III. Daily Capability

1. In the event that hospitals' capability to receive patients is diminished in any way, including due to equipment malfunction or staff shortages, hospitals will provide Fire and EMS ELOs with the relevant information at the earliest time possible.
2. It will be assumed that all hospitals will be operating at their usual capacity unless Fire and EMS is notified otherwise.
3. When hospitals identify these operational challenges, senior-level administrative officials will attempt to remedy shortfalls in receiving capability at the earliest opportunity.

IV. Hospital Personnel Authorized to Request Diversion and Closure

1. Hospitals will submit to the Fire and EMS Medical Director a list of personnel and positions authorized to request alterations in emergency transport capability status.
 - a. This list and any future modifications will be submitted in electronic format to the Office of the Medical Director at Michael.WilliamsD@dc.gov.
 - b. The individuals on this list should be senior-level clinicians or administrators.
 - c. Hospital administration will keep the list up-to-date and notify Fire and EMS of any changes.
 - d. Fire and EMS will distribute current information from the lists to the appropriate operational employees.
2. Hospital administrations will provide the Fire and EMS Medical Director with 24-hour contact numbers for their Medical Directors and Emergency Department Directors.
 - a. This information and any future modifications will be submitted in electronic format to the Office of the Medical Director at Michael.WilliamsD@dc.gov.
 - b. The Fire and EMS Medical Director will keep this information confidential and it will only be used by the Medical Director.

V. Closure and Diversion Procedure

1. Possible statuses for receiving facilities will be as follows:
Open (regular operations);

Diversion (unable to accept new patients unless bypassing the facility is likely to be life-threatening due to the perceived acuity of illness/injury); and

Closed (unable to accept any patients due to extraordinary operational system failure(s), i.e. power failure, flooding, water supply failure, etc.). It is anticipated that closure will be a rare event.

2. Requests to rotate will no longer be granted.
3. Hospitals may request diversion or closure by calling 202-373-3713. This is the only number that will be used to request a change in status.
4. Only authorized personnel as designated pursuant to section IV (I) will be granted diversion/closure by Fire and EMS. Surrogates will not be granted diversion on behalf of authorized personnel.
5. When a hospital requests and is granted diversion, Fire and EMS ELOs will immediately begin diverting transport units to other facilities, unless the operational needs of the city dictate otherwise.
6. Diversion will be granted for a maximum of two-hour increments. Requests to extend beyond the two hour period will follow the same procedures as the initial request.
7. When a hospital requests and is granted closure, Fire and EMS ELOs will immediately designate the requesting hospital as closed and activate appropriate Fire and EMS emergency operational plans. Fire and EMS ELOs will also contact the hospital Medical Director or his/her designee to determine if Fire and EMS can provide any emergency assistance with the operational challenge, such as back-up generators, emergency water supply, etc.
8. Hospitals that are designated as closed will remain closed until the Hospital Medical Director or his/her designee notifies Fire and EMS ELOs that they are able to re-open.
9. Once diversion/closure has been granted:
 - a. Fire and EMS ELOs will notify neighboring EMS provider jurisdictions of the diversion/closure.
 - b. The ELO will notify all field supervisors of closures immediately.
10. F&EMS will send an EMS Supervisor to each hospital that is on Diversion for more than one hour.
11. The Medical Director and the hospital-designated authorized point of contact of each hospital holding a transport unit for more than one hour will be notified immediately by the Fire and EMS Medical Director.

VI. Transfer of Care Procedure

1. Upon arriving at a receiving facility, Fire and EMS providers will not initiate new medical care once across the threshold of the facility. Examples include, spiking new IV bags, starting O₂, immobilization, and restraint application.


2. Fire and EMS providers will, however, continue any and all pre-hospital care initiated during the transport until the patient has been triaged or until the time-limit detailed below, whichever occurs first. Examples include continuing pre-hospital O₂, maintaining IV's begun in the field until they run out, and maintaining splints applied in the field.
3. Hospitals will designate personnel to assess patients brought by Fire and EMS transport units with the goal of transferring care and releasing the unit within 25 minutes of the patient's arrival to the ED. Transfer of care includes movement of the patient to hospital-owned equipment, i.e. bed, stretcher, waiting room chair, etc.
4. Transfer of care will be documented by EMS providers who will submit completed run sheets or electronic patient care (ePCR) screens to hospital triaging personnel, who will be expected to sign the run sheet or ePCR screen.
5. In the event that transfer of care is delayed for longer than 25 minutes, the F&EMS provider will contact the ELO, who will contact the authorized hospital point of contact and attempt to resolve the delay in patient transfer and unit release.
6. If the Fire and EMS provider is still unable to obtain a signature, this fact will be documented by the Fire and EMS provider in lieu of the signature itself, and the Fire and EMS ELO will inform the authorized hospital personnel that the process outlined in paragraph 7 below will be followed.
7. Patients who have been assessed by the hospital and are placed in a stable category (ESI 3-5 e.g.) will be escorted to the waiting room intake area by Fire and EMS personnel and presented to the hospital's ambulatory patient intake personnel for management in the same fashion as other ambulatory patient arrivals. The Fire and EMS crew will then go back in service.

VII. Medical Directors Council

The Fire and EMS Medical Director will form a Medical Directors Council which will meet monthly to assess progress of implementation of this policy, review monthly closure, diversion and ambulance drop-off time data, address system-wide issues, and share potential solutions. The Council will examine these trends on both a local and regional level, with the long-term goal of supporting a regional dashboard that will allow all appropriate stakeholders to have real-time situational awareness of the emergency health system.

VIII. Legal Protections

All currently extant legal protections for all parties that would be expected to pertain to potential interactions between Fire and EMS and hospital entities will remain in place until changed by law or rule.


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Fire & EMS Chief