Arizona Emergency Medical Systems, Inc.

RED BOOK

CHAPTER 5

Transfer of Care Guideline

Statement on Prehospital Diversion

DISCLAIMER

The **AEMS Red Book** is designed to be a resource document for use by Medical Direction Authorities responsible for the administrative, organizational and on-line medical direction of prehospital EMS personnel. It specifically recognized that variations from the guidelines contained within are not only acceptable, but also appropriate, depending on the individual circumstances of the involved areas and organizations.

By Statute and Rule, all advanced life support prehospital EMS personnel shall have administrative and online medical direction. These guidelines are not meant to act as a substitute, proxy or alternative to that medical direction. Any conflict between these guidelines and the individual EMS provider's medical direction shall default to the Administrative or On-Line medical direction.

This manual sets forth guidelines deemed by **AEMS** to be within the acceptable standard of medical care. It is specifically recognized that there are acceptable variations from these procedures and protocols, which may also satisfy the standard of care. This manual does **NOT** define, limit, expand or otherwise purport to establish the legal standard of care

Arizona Emergency Medical System, Inc. (AEMS)

Purpose:

The establishment of an efficient standard Prehospital Diversion Guidelines for the Central Arizona Regional Emergency Medical Services System.

Background:

Historically, in the Central (AEMS, Arizona Emergency Medical Systems) Region of Arizona "Diversion" (a.k.a. bypass) has had a negative connotation. Throughout the United States, the negative sentiment regarding this concept has changed. Governed by cooperative community efforts and prospective planning, Prehospital Diversion can be a solution to serious problems of saturation of emergency departments, trauma services, and potentially, hospital resources.

The American College of Emergency Physicians (ACEP) originally spoke on this topic in 1991. A policy statement was approved by the ACEP Board of Directors in September 1991 titled, "Ambulance Diversion/Destination Policies". It was again approved by the ACEP Board of Directors January 1999 as retitled, "Ambulance Diversion" and reaffirmed by the ACEP Board of Directors October 2006; and April 2012.

As an adjunct to this policy statement, ACEP's Emergency Medical Services Committee developed a Policy Resource Education Paper (PREP) titled, Guidelines for Ambulance Diversion. (See appendix A)

ACEP feels Diversion protocols must include the establishment of diversion and patient destination policies for the EMS System based on ACEP's Guidelines for Ambulance Diversion.

Each emergency department and /or trauma service will be responsible for analyzing their own activation of Prehospital Diversion. This will be done through established internal procedures.

EMResource

The Arizona Hospital and Healthcare Association with assistance from the Phoenix Fire Department developed the EMResource to facilitate the management of diversion in the Central Region. The EMResource is a web-based program providing real-time hospital emergency department diversion status information. Awareness of local area system EMS resource limitations and capacity is vital to effective management of daily EMS system demands and mass causality incident situations.

EMResource Functions

Hospital Emergency Department Diversion Status: Participating hospitals update their ED diversion status (Open, Caution or Closed) at defined intervals. The regional status screen displays the status of each hospital in the region. The 911dispatch center then uses the displayed information to appropriately triage EMS units to area Hospital Emergency Centers. Hospital and EMS services also view the Regional Status page to assess system capacity and bottlenecks.

Mass Casualty Incident Support: An unplanned acute medical emergency involving significant numbers of ill or injured people requires instantaneous EMS resource allocation. Dispatch centers enter MCI details selecting the facilities required to respond. Each facility then enters their ability to accept immediate, delayed and minor patients allowing timely, accurate and dynamic EMS triage disposition decisions.

Arizona Emergency Medical Systems, Inc.

Guidelines on Prehospital Diversion
#2000-01

Approved by Board: October 15, 2014 Developed by: Diversion Task Force
Revision submitted: October 15, 2014

Retraction of Previous Policy Statements

Retracting previous policy statements #9701

Diversion Guidelines, Edited, Reviewed and Approved by Board: December 17, 2003
Revisions Submitted May 18, 2005
Approved by AEMS Board June 15, 2005
Revisions submitted and approved by Board July 19, 2006
Revisions submitted and approved by Board December 20, 2006
Addition of Appendix I submitted and approved by Board August 15, 2007
Clarification of statement (IV – Categories, E) submitted and approved by Board October 31, 2007.
Revisions submitted September 17, 2008
Revisions submitted to and approved by Governing Board, October 15, 2008
Revisions submitted to and approved by Governing Board, October 21, 2009

Procedure: AEMS Guidelines on Prehospital Diversion

1. **Purpose**
   The standard of care in the AEMS Region will include guidelines for prehospital diversion of patients in accordance with the American College of Emergency Physicians Policy Statement regarding Ambulance Diversion (Appendix B). Patients presenting to an emergency department/Trauma service by means other than the prehospital system are not subject to prehospital diversion.

2. **Goal**
   Each patient shall be assured safe, appropriate and timely medical care through the development of a system-wide process to objectively direct and redirect patients receiving emergency departments and Trauma services based on the current capabilities and status of potential destination facilities.

3. **Definitions**

   A. Emergency Medical Services (EMS) system shall be defined as a group of hospitals and prehospital agencies working cooperatively for the provision of prehospital patient care.

   B. Emergency has the same meanings as A.A.C. R9-10-201, “an immediate threat to the life or health of a patient.” See appendix B

   C. EMResource refers to an Internet-based resource management system that includes the capability to monitor prehospital diversion status among hospitals statewide.

   D. Emergency/Trauma Saturation for a hospital means the emergency department and/or Trauma service are at maximum capacity, currently providing treatment to acutely ill or injured patients and temporarily prefer not to receive additional patients with and emergency medical condition.

   E. Hospital Saturation means a situation in which both Emergency/Trauma and inpatient fully committed resources have decreased to a level predefined in each facility’s policies and procedures.

   F. Facility is an emergency department or Trauma service that receives patients transported by prehospital care providers

G. Regional sectors mean Emergency Departments or Trauma Services located in proximate geographic areas. This term applies to the cooperative effort of notification of saturation or disaster status via the EMResource.

The regional sectors are

West Sector:	**Central Sector:**
Arrowhead Hospital	Arizona Heart Hospital
Banner Del E. Webb Medical Center	Banner Good Samaritan Medical Center
Banner Estrella Medical Center	Carl T. Hayden VA Medical Center*
Banner Thunderbird Medical Center	John C. Lincoln Hospital – North Mountain
Banner Walter O. Boswell Medical Center	Maricopa Medical Center
John C. Lincoln Hospital- Deer Valley	Phoenix Baptist Hospital
Maryvale Hospital	Phoenix Children's Hospital
NPEC: North Peoria Emergency Center*	Phoenix Indian Medical Center*
St. Joes Westgate Hospital*	Phoenix St. Luke's Medical Center
Sonoran Health Emergency Center*	St. Joseph's Hospital & Medical Center
West Valley Hospital	
West Valley Buckeye Emergency Center*	
Southeast Sector:	**Northeast Sector:**
Banner Baywood Medical Center	Mayo Clinic Hospital
Banner Casa Grande Medical Center	Paradise Valley Hospital
Banner Desert Medical Center	Scottsdale Healthcare Osborn
Banner Ironwood Medical Center	Scottsdale-Healthcare Shea
Banner Goldfield Medical Center	Scottsdale Healthcare Thompson Peak
Banner Gateway Medical Center	Payson Regional Medical Center*
Chandler Regional Medical Center	
Gilbert Hospital	
Mercy Gilbert Medical Center	
Tempe St. Luke's Hospital	
Cobra Valley Hospital	

***Facility does not participate in Diversion rotation**

H. EMResource Color Coding

Communication of Hospital Diversion Status: Several requests have been Made by area Fire Departments, Ambulance Agencies and Hospitals requesting the revision of terminology used by Communications Centers broadcasting to prehospital personnel. The requested revisions are:

Open (shows green) to all patients

Caution (shows yellow) this is a hospital to hospital communications tool; does not affect Prehospital agencies

Divert ED, Diversion/Bypass (shows as red) Indicates ED/Trauma Saturation; facilities will continue to receive patients whose conditions may be adversely affected by transport to a further facility and those patients who adamantly request transport to that facility.

Closed (shows black) indicates an Internal Plant failure or Emergency, facility cannot Receive any patients

4. Categories

The following are acceptable prehospital diversion categories. The declaration of prehospital diversion in one category does not necessarily indicate a facility is on prehospital diversion in any other category.

A. Trauma Service Saturation
A trauma service has fully committed resources and is not available for additional incoming trauma patients.

B. Facility Internal Disaster
Through policy and procedures established by the internal disaster plan of a hospital, the facility or hospital cannot receive any patients due to a physical plant failure (e.g., fire, bomb threat, hostage situation, loss of utilities, critical equipment loss, flood, natural disaster etc.). If there is a community-wide event, hospitals will accept patients.

C. Emergency Department Saturation
An emergency department has fully committed resources.

1) Saturation of inpatient critical care or medical/surgical beds shall not be used as a sole reason to initiate prehospital diversion.

2) Prehospital patients with threat to life or limb medical conditions shall be accepted by the closest appropriate categorized facility regardless of hospital status, when transportation to a more distant facility could pose a further significant risk to the patient.

3) Serious, but stable patients may be routed or re-routed to appropriate categorized facility in accordance with the provider's on-line medical control.

4) On-line medical control shall remain available at all times from ALS Base hospitals, regardless of their diversion status.

5) Each sector is responsible for determining what constitutes sector overload and development of an established hospital rotation plan. See appendix C

D. Facility Saturation

Each hospital will develop policies and procedures to identify solutions and appropriate actions to ensure bed availability and adequate resources to meet the needs of all patients during times of hospital saturation, including but not limited to the following actions.

1) Deploying pre-emptive strategies to avoid prehospital diversion and alternative resources to decompress a saturated facility.

2) Critical patients shall be accepted by the closest categorized facility when transportation to a more distant facility could pose a significant risk to the patient.

    a. **Designated Stroke Centers:** Designated Stroke Centers will accept all patients who meet regionally defined stroke criteria regardless of ED diversion.

E. Other Considerations

1) Patients Financial Status

Information regarding a patient's financial status and/or the facilities with which a patient's healthcare insurance contract is not an acceptable criteria for the declaration of a prehospital diversion or for the routing or re-rerouting of patients.

2) Reserved Beds

Hospitals should not initiate prehospital diversion to reserve beds for elective admissions, potential deterioration of hospitalized patients, or for potential outside transfers.

5. Facility Responsibilities

A. Procedure Development

Recommend that each facility will develop policies and procedures for managing prehospital diversion, including:

1) Each facility shall prospectively identify the individuals authorized with decision-making and notification authority, in the event that prehospital diversion becomes necessary. The minimum number of individuals authorized to recommend prehospital diversion include the on duty emergency department clinical nurse manager and emergency physician/trauma surgeon, and the hospital administrator or their designee. Individuals authorized to initiate prehospital diversion, will have a working knowledge of this document.

2) Each facility will determine the method for its own internal prehospital diversion continuing quality improvement program,(to include problem identification and resolution)

B. Sector Responsibilities

1) On an annual basis, each sector shall identify committee membership to include at a minimum:

a) One representative from each sector facility, prehospital agency, Communications Center and other members as deemed appropriate.

2) Sector meetings shall occur as needed to review prehospital diversion practices and problem resolution and will report annually and as needed to the AEMS Board of Governors.

6. Notifications of Prehospital Diversion

A. Initiation of Prehospital Diversion

1) The person(s) responsible to initiate prehospital diversion will update the EMResource.

2) Diversion status will be reassessed within three (3) hours.

B. Cancellation of Prehospital Diversion

1) At such time that prehospital diversion is canceled EMResource shall be updated. In the event that the EMResource is inoperable, facilities must notify the communications centers and facilities originally notified.

7. Data

Responsibilities of ALS Base Hospitals and receiving hospitals: Any unresolved trends or issues regarding diversion identified by any providers will be analyzed, documented in writing and submitted to their regional sector meeting for discussion.

Notes

1. American College of Emergency Physicians Ambulance Diversion Policy Statement. (Appendix A)

2. Emergency Medical Treatment and Labor Act (P.L. 99-272; 42 united States Code Section 1395dd)

Appendix A

Ambulance Diversion

Reaffirmed by the ACEP Board of Directors October 2006; and April 2012

Revised and approved by the ACEP Board of Directors January 1999 titled, "Ambulance Diversion"

Originally approved by the ACEP Board of Directors September 1991 titled, "Ambulance Diversion/Destination Policies"

As an adjunct to this policy statement, ACEP's Emergency Medical Services Committee developed a Policy Resource Education Paper (PREP) titled, Guidelines for Ambulance Diversion.

The American College of Emergency Physicians (ACEP) believes that each EMS system must develop mechanisms to address patient diversions by health care facilities. These mechanisms must include the establishment of diversion policies for the EMS system that include agreements between facilities regarding when to divert patients and when to accept diverted patients. These cooperative agreements between hospitals and out-of-hospital agencies must be designed to:

- Identify situations in which necessary hospital resources are not available and temporary ambulance diversion is required.
- Notify EMS system personnel and providers (out-of-hospital and hospital) of such occurrences.
- Provide for the safe, appropriate, and timely care of patients who continue to enter the EMS system during periods of diversion.
- Notify EMS system personnel and providers (out-of-hospital and hospital) immediately when the situation that caused the diversion has been resolved.
- Explore solutions that address the causes for diversion and implement policies that minimize the need for diversions.
- Provide for the periodic review of policies and guidelines governing diversion.

http://www.acep.org/Clinical---Practice-Management/Ambulance-Diversion/

Appendix B

State of Arizona
Administrative Code

TITLE 9. HEALTH SERVICES
CHAPTER 10. DEPARTMENT OF HEALTH SERVICES

HEALTH CARE INSTITUTIONS: LICENSING

ARTICLE 2. HOSPITALS

R9-10-203. Administration

A. An administrator shall require that:

1. Hospital policies and procedures are established, documented, and implemented that:

g. Cover diversion, including:

i. The criteria for initiating diversion;

ii. The categories or levels of personnel or medical staff that may authorize or terminate diversion

iii. The method for notifying emergency medical services providers of initiation of diversion, the type of diversion, and termination of diversion; and

iv. When the need for diversion will be reevaluated;

5. Licensed capacity in an organized service is not exceeded except for an emergency admission of a patient. If the licensed capacity of an organized service exceeded:

a. A medical staff member reviews the medical history of a patient scheduled to be admitted to the organized service to determine whether the admission is an emergency; and

b. A patient is not admitted to the organized service except in an emergency;

R9-10-206. Personnel

An administrator shall require that:

1. Personnel are available to meet the needs of a patient based on the acuity plan required in R9-10-208(C)(2);
2. A personnel member who provides medical services or nursing services demonstrate competency and proficiency according to criteria established in hospital policies and procedures;

R9-10-208 Nursing Services

C. A nurse executive shall require that:

2. An acuity plan is established and documented to determine the types and numbers of nursing personnel necessary to provide nursing services to meet the needs of the patients;

3. The acuity plan in subsection (C)(2) is implemented

R9-10-216. Emergency Services

A. An administrator of a general hospital or a rural general hospital shall require that:

1. Emergency services are provided 24 hours a day in a designated area of the hospital;

2. Emergency services are provided as an organized service under the direction of a medical staff member;

3. The scope and extent of emergency services offered are documented;

4. Emergency services are provided to an individual, including a woman in active labor, requesting emergency services;

5. If emergency services cannot be provided at the hospital to meet the needs of a patient in an emergency, measures and procedures are implemented to minimize risk to the patient until the patient is transported or transferred to another hospital;

6. A roster of on-call medical staff members is available in the emergency services area;

7. There is a chronological log of emergency services that includes:

    a. The patient's name;
    b. The date, time, and mode of arrival; and
    c. The disposition of the patient including discharge, transfer, or admission; and

8. The chronological log required in subsection (A)(7) is maintained:

    a. In the emergency services area for a minimum of 12 months from the date of the emergency services; and
    b. By the hospital for an additional four years

B. An administrator of a special hospital that provides emergency services shall comply with subsection (A).

C. An administrator of a hospital that provides emergency services but does not provide perinatal organized services, shall require that emergency perinatal services are provided within the hospital's capabilities to meet the needs of a patient and a neonate, including the capability to deliver a neonate and to keep the neonate warm until transfer to a hospital providing perinatal organized services.

R9-10-231. Disaster Management

An administrator shall require that:

1. A disaster plan is developed and documented that includes:
    a. Procedures for protecting the health and safety of patients and other individuals;

    b. Assigned personnel responsibilities; and

    c. Instructions for the evacuation, transport, or transfer of patients, maintenance of medical records, and arrangements to provide any other hospital services to meet the patients' needs;

2. A plan exists for back-up power and water supply;

3. A fire drill is performed on each shift at least once every three months;

4. A disaster drill is performed on each shift at least once every 12 months;

5. Documentation of a fire drill required in subsection (3) and a disaster drill required in subsection (4) includes:

    a. The date and time of the drill;
    b. A critique of the drill; and
    c. Recommendations for improvement, if applicable; and

6. Documentation of a fire drill or a disaster drill is maintained by the hospital for 12 months from the date of the drill and provided to the Department for review as soon as possible after a Department request but not more than four hours from the time of the request

Appendix C

Central Sector “Rotation Mode” Guidelines

August 2014

The following guidelines have been adopted by the Central Sector Diversion committee to facilitate a smooth closure process when multiple hospitals must be on diversion for
ED saturation.

1. Banner Good Samaritan, St Josephs and Maricopa Medical Center MIHS will be included in the Central Sector diversion guideline. All other hospitals in Central Sector will not be impacted by this guideline and will not be required to participate.

2. Banner Good Samaritan, St. Joseph’s Hospital and Maricopa Medical Center MIHS may not be on "Divert" status simultaneously.

3. When 2 of the participating hospitals are on diversion and the 3rd identifies the need to go on diversion, they will contact PFD Alarm Room

    a. The 3rd hospital will identify the need for diversion and inform PFD Alarm Room of the need to initiate the Central Sector Rotation Mode.

    b. They will then enter their diversion status on the *"EMResource"* site.

4. The PFD alarm room will proceed to notify the hospital that closed first that the Central Sector is going into “rotation mode” and they must open for 1 hour. After that first hour, hospital #1 will notify hospital #2 that they must open for 1 hour while hospital #1 returns to "Divert" status. After hospital #2 has been open for 1 hour they will notify hospital #3 to open while they close. (1st on / 1st off).

5. The rotation will continue until one or more of the 3 hospitals can remain open.

Considerations:

- Any problems with compliance going on or off diversion during rotation mode will be handled by the alarm room.
    - The alarm room will notify PFD Unit “959” (for intervention) if they encounter issues with the utilization of the “rotation mode”.
    - PFD Unit “959” may involve available resources to ensure compliance
    - If issues cannot be resolved, all participating facilities will not be recognized by EMS. This will continue until one of the participating facilities can remain open without the need to initiate a “Divert” status.
    - A root cause analysis (RCA) of the situation will be conducted by representatives of the involved agencies/facilities. Results will be released to Central Sector members and reported to AEMS.
- Other hospitals in the Central Sector should maintain awareness of changes in diversion status and try to remain open or if the initiate “Divert”, open as soon as possible.

- When the rotation mode is initiated, a review will be conducted by the Central Sector Chair and representatives of the involved facilities. Results will be reported t the Central Sector Committee.

The following hospitals are part of the Central Sector:

Arizona Heart Hospital	Phoenix Children's Hospital
Banner Good Samaritan Regional Medical Center	Phoenix Indian Hospital
Carl Hayden Veterans Hospital	Phoenix St. Luke's Hospital
John C. Lincoln North Mountain Medical Center	St. Joseph's Hospital
Maricopa Medical Center	
Phoenix Baptist Hospital	

Example:

In the following chart Hospital "A" and "B" are on Diversion and Hospital "C" now needs to go on diversion. Since all 3 hospitals in the Central Sector may not close at the same time, the following rotation will be used. "A" as "first on first off" will open first.

Hospitals	**1st Hour**	**2nd Hour**	**3rd Hour**	**4th Hour**	**5th hour**
A	**Open**	**Divert**	**Divert**	**Open**	**Divert**
B	**Divert**	**Open**	**Closed**	**Closed**	**Open**
C	**Divert**	**Divert**	**Open**	**Divert**	**Divert**

Northeast Sector Rotation

Communication between hospitals will occur when the need arises to rotate for diversion.

1. Only two hospitals may be on diversion in this sector at one time.
2. If a third hospital needs to go on diversion, communication with first hospital on diversion will occur. If first hospital is unable to open the rotation process will begin. A rotation option for one hour intervals will take place, with reevaluation.
3. If diversion issues arise, notify the Pre-hospital Manager/Coordinator

AEMS SOUTHEAST SECTOR DIVERSION AND OFF-LOAD/TRANSFER OF CARE SPECIAL POLICIES AND PROCEDURES

Since a formal action on April 15, 2009 of the AEMS Board of Governors, Prehospital Ambulance Diversion and Off-Load/Transfer Of Care(TOC) practices in the Southeast (SE) Sector have been monitored by the "AEMS SE Sector Patient Destination Alternative Program Administrative Oversight Committee", more commonly referred to as the "SE Sector Diversion Oversight Committee" (The Committee). The Committee meets at least quarterly, and elects a Chairperson or Co-Chairpersons from the active Committee membership. It is the Chairperson's responsibility to provide agendas and meeting minutes to the members, maintain appropriate meeting frequency and ensure adherence to AZ Open Meeting Laws. The Committee membership categories, as approved by the AEMS Board of Governors are:

1. Senior Level Manager-Dignity Health Care
2. Senior Level Manager-Banner Health Care
3. Senior Level Manager-Iasis Health Care
4. Senior Level Manager from a hospital system from outside the SE Sector
5. One representative from the private ground ambulance industry-Southwest Ambulance
6. One representative from the private ground ambulance industry-PMT Ambulance
7. One Senior Officer from a SE Sector fire department
8. One Senior Officer from a fire department outside of the SE Sector
9. One representative from an air ambulance provider
10. A representative from an Emergency Department (physician or nurse)
11. A representative from an Emergency Department (physician or nurse)
12. Communications and Dispatch Specialist
13. Additional Upper Level Administrator-Dignity Health Care
14. Additional Upper Level Administrator-Banner Health Care
15. Additional Upper Level Administrator-Iasis Health Care.

FUNCTIONS AND RESPONSIBILITIES OF THE COMMITTEE

Using available data sets from EMS and hospital providers:

A. Analyze all episodes of Diversion in the SE Sector, with the goal being to do a root cause analysis of all episodes and to ensure that interfacility and interagency communications were in place and being used.
B. Analyze all episodes of simultaneous Diversions in the SE Sector, with the goals being to bring the numbers of these episodes as close to zero as feasible.
C. Monitor ambulance Off-Load/TOC times, with the goal of universal SE Sector adherence to standards promulgated by The Committee.
D. As situations warrant, take up issues that increase the numbers and durations of Diversion in the SE Sector, or adversely affect Off-Load/TOC times.

REPORTING REQUIREMENTS

The Committee will report its activities periodically and as requested to the AEMS Functional Group and the AEMS Board of Governors. Additional reports will be furnished to the AEMS Board of Governors or the AEMS Executive Committee as requested.

The Committee, as a result of actions within The Committee, will from time to time request approval of said actions from the AEMS Board of Governors.

The Committee will make public its data sets, meeting minutes, activities or findings upon written request but only after approval of the AEMS Board of Governors, the AEMS Executive Committee, or the Chairperson of AEMS, along with the provider of the data set being requested.

West Sector Diversion

- Arizona General Hospital (No rotation)
- Arrowhead Hospital
- Banner Boswell Medical Center
- Banner Del Webb Medical Center
- Banner Estrella Medical Center
- Banner Thunderbird Medical Center
- JCL Deer Valley
- Maryvale Hospital
- NPEC: North Peoria Emergency center (No rotation)
- St Joe's Westgate (No rotation)?
- Sonoran Health Emergency Center (No rotation)
- West Valley Hospital
- West Valley Buckeye Emergency center (No rotation)

When hospitals need to go on diversion follow AEMS Red Book guidelines.

West Sector rotation guide lines

- Rotation begins when 2 adjacent facilities are on diversion or 3 facilities in the West sector are on at the same time.

- The Phoenix Regional Dispatch Center will initiate rotation by calling the hospital that has been on diversion the longest and placing them on rotation. "ROTATION" opens that hospital for 1 hour. A courtesy call should be placed to the dispatch center when the hospital that prompts rotation goes on diversion.

- If diversion is needed after the first hour for either a contiguous hospital or 3rd hospital on rotation in the West sector, the hospital that is on rotation will call the hospital that has been on diversion the longest to request them to go on rotation per guidelines.

- The Phoenix Regional Dispatch Center will assist in maintaining the continuity of rotation if necessary

Level 1 Trauma Center "Rotation Mode" Guidelines

The following guidelines have been adopted by the Diversion Committee to facilitate a smooth process when multiple Level 1 Trauma Centers must be on diversion for Trauma Saturation. Consideration for the geographical locations is made to maintain reasonable transport times for Level 1 trauma patients.

1. Trauma Center is defined as a healthcare facility designated by AZDHS as a Level 1 Trauma Center.

2. Pediatric Trauma Centers will not be included in this guideline.

3. At no time shall any three contiguous Trauma Centers be on "Divert" simultaneously.
    a. "Contiguous" is defined as closest to each other geographically.

4. When two of three contiguous Trauma Centers are on "Divert" and the third reaches saturation, the third Trauma Center will go on "Divert" and initiate the Rotation Mode by notifying the other two Trauma Centers and the Alarm Room of this change. The Trauma Center that has been on "Divert" the longest will open for a period of two (2) hours. After the first two hours, Trauma Center #1 will notify Trauma Center #2 to open while they return to "Divert." At the end of the next two hours, Trauma Center #2 will then notify Trauma Center #3 to open while they return to "Divert."
    a. Status changes will be entered and displayed on the EMResource website.
    b. The first Trauma Center to go on "Divert" will be the first to open during Rotation Mode.
    c. The following model shall be utilized for Rotation Mode:

Trauma Center	Hour 1	Hour 2	Hour 3	Hour 4	Hour 5	Hour 6	Hour 7	Hour 8	Hour 9	Hour 10
TC#1	Open	Open	Divert	Divert	Divert	Divert	Open	Open	Divert	Divert
TC#2	Divert	Divert	Open	Open	Divert	Divert	Divert	Divert	Open	Open
TC#3	Divert	Divert	Divert	Divert	Open	Open	Divert	Divert	Divert	Divert

5. Communications between Trauma Centers will be maintained to ensure that 1 of 3 geographically contiguous Trauma Centers remain open.

6. This Rotation Mode will continue until one or more of the affected Trauma Centers can open.

Considerations:

- Any problems with Trauma Center compliance during the rotation mode will be reported to the Trauma Coordinators by any and all involved agencies/facilities

- Monitoring of trauma diversion will be the responsibility of the Trauma Centers.

- A review will be conducted by Trauma Coordinators whenever the rotation mode is initiated.

- Facility Internal Disaster: when activated (as per policy and procedure established by the Internal Disaster Plan of a hospital) the facility or hospital cannot receive any trauma patients

- Mass Casualty Incident Support: Unplanned acute medical emergencies involving significant numbers of ill or injured people require instantaneous EMS resource allocation. Dispatch centers enter MCI details selecting the facilities required to respond. Each facility then enters their ability to accept immediate, delayed and minor patients allowing timely, accurate and dynamic EMS triage disposition decisions.

Appendix D

Approved by the AEMS Board December 20, 2006

Standard Patient Divert Facility Advisement Statement

The hospital that you have requested to be transported to is reporting excessive volume of patients seeking medical aid. They are reporting patient wait times of _____. These times are an estimate and only indicative of the situation at the facility at this point in time.