Southwest Texas Regional Advisory Council

STRAC Emergency Department Diversion Memorandum of Understanding

Purpose

The purpose of this Memorandum of Understanding (MOU) is to establish a collaborative framework between regional hospitals, EMS agencies, and STRAC to define the roles, responsibilities, and procedures for diverting patients in situations where a healthcare facility reaches capacity or is unable to provide appropriate care. This MOU aims to ensure a coordinated and efficient response prioritizing patient safety, maintaining continuity of care, and reducing delays during periods of high demand or limited resources.

Background

Emergency Department Diversion has affected the San Antonio and South Texas emergency healthcare system for decades. In late 2000, a task force of stakeholders was assembled to better understand the causes and impact of diverting EMS ambulances from one emergency department (ED) to another. The San Antonio Diversion Task Force started the difficult task for developing an agreement to address all stakeholder concerns. STRAC defines diversion as a process of temporarily routing EMS patient away from overwhelmed EDs helping to ensure EMS patients do not experience delayed care or suffer potentially poor outcomes.

In 2010 the diversion task force efforts were transitioned to the STRAC Regional Emergency Department Operations Committee (ED Ops). Regional ED Ops is chaired by an emergency physician and co-chaired by an ED nurse director from one the area hospitals. Membership includes emergency physicians, ED nurse directors/managers, EMS operations/command staff, EMS Medical Directors and STRAC administrative staff. Committee membership is open and meets monthly.

The Regional ED Ops committee developed this Memorandum of Understanding to outline the agreement for Emergency Departments and EMS agencies to collaboratively work through the issue of diversion. All stakeholders recognize the complexity of diversion and its potential impact to quality patient care if all parties do not develop, implement, and follow the MOU rules that guide each organization's behavior. This is a living document and will be evaluated every three years by the Regional ED Ops committee for effectiveness. **The signatories to the MOU are attesting their organization will follow and enforce the rules, roles and responsibilities for their organizations as delineated in this MOU.**

Abbreviations/Definitions

AOC- Administrator on Call

Closed- The Hospital has suffered structural damage, loss of utilities, or an exposure threat that precludes transport of any patients to the ED. The actual status should be further defined in the comments section.

Diversion- Request by a facility to EMS when the facility has exceeded its capability/capacity which may result in the patient being rerouted.

Diversion Override- The changing of a hospital's status from Divert to Diversion Override as per the Diversion Override/MCI plan. (See attached)

EMResource- Website formerly known as EMSystem, which is the 24/7 portal to diversion and MCI information in the STRAC region. EMResource is maintained by Juvare.

EMS Agency- A 911 EMS provider in TSA-P, although in general, it refers to the EMS agencies in the Metro San Antonio area, which is defined as Bexar County and the counties contiguous to Bexar County.

HEART ALERT- Patients meeting HEART ALERT criteria. Generally, this is a STEMI patient. HEART ALERTS are routed to PCI centers.

Hospitals- Any acute care hospital in TSA-P.

Mandatory Diversion- The course of action taken by an EMS Agency or Authority Having Jurisdiction (AHJ) within the STRAC region. This level of diversion will include **ALL** patients to include "Alert Patients". ("All means all") Mandatory Diversion status is implemented for a two-hour period or as otherwise specified by EMS/AHJ. During this period, the facility cannot place themselves on Diversion or Open status.

MCI- Mass Casualty Incident

MEDCOM- Regional medical communications center handling trauma transfer requests, MCI activation, dispatch of STRAC Emergency Operations and EMTF assets and other regional issues as assigned. MEDCOM's primary # is 210-233-5815.

MIST Form- Report/communication tool to be used by receiving ED during EMS handoff.

Patient Parking- The practice of holding patients on the transport EMS agency's stretcher while awaiting a bed to for patient placement in the ED. This practice is considered patient parking even if the ED is processing and assuming care for the patient while they are on the EMS stretcher. The patient parking time stops when Transfer of Care (TOC) occurs after the patient is transferred off the

EMS stretcher and patient report is given between the paramedic and an emergency department nurse.

Primary POC- The EMS agency or hospital Point of Contact (POC) that is routinely available to handle diversion concerns daily. Examples would be Emergency Physicians, ED Directors, EMS shift commanders, etc.

Priority 123- The system adopted to identify the criticality of EMS patients. Priority 1 patients are most critical, Priority 2 patients are potentially critical, and Priority 3 patients are stable.

Psychiatric Facility- A licensed special care unit or freestanding facility providing 24-hour psychiatric services for diagnosing and treating mental illness under the supervision of licensed physicians and medical staff (e.g. RN, MSW, Psychologist).

Senior Administrative POC- The agency or hospital Point of Contact (POC) ultimately responsible for overseeing the organization's response to diversion issues and has the authority to speak on behalf of the organization. The Senior Administrative POC will handle concerns that cannot be resolved by the Primary POC. Examples would be System Directors, COOs, CEOs, EMS Chiefs, EMS Medical Directors, etc.

STRAC- Southwest Texas Regional Advisory Council

STROKE ALERT- Patients meeting the STROKE ALERT criteria. STROKE ALERTS are routed to Stroke Centers.

TRAUMA ALERT- Patients meeting Red/Blue TRAUMA ALERT criteria. TRAUMA ALERTS are routed to Trauma Centers.

TSA-P- Trauma Service Area-P. TSA-P is the 22-county region in and around San Antonio designated by the Department of State Health Services. (See attached map)

Transfer of Care (TOC)- TOC is complete when the MIST report is given from the EMS medic to the nurse or LIP completing the MIST form and the patient is moved from EMS gurney.

Transfer of Care (TOC) Delay- Two or more ambulances delayed in transferring care for 20 minutes or more at a receiving ED.

Procedure

All Diversion MOU signatories agree to support and adhere to these guidelines and policies developed in collaboration with STRAC. By signing this Memorandum of Understanding, each organization commits to the following:

1. Hospitals will utilize the EMResource website to adjust their diversion status. Each hospital ED and EMS agency will have a functioning computer terminal with Internet access,

configured with a recent version of an internet browser, always located in a prominent position in the department/center/station. It is recommended computers with network-type internet connections have a backup internet connection in case of network failure.

2. Each organization will ensure the EMResource website is active and functioning properly daily.
3. Each organization will ensure, at a minimum, appropriate POCs have EMResource accounts and have correct pager/phone/email information in EMResource to ensure quick notification and activation is feasible. Additional personnel are encouraged to be added to allow redundancy to the notification system.
4. Each organization will participate, as directed, with the MCI drills when they are conducted. This includes quick entry of Red/Yellow/Green bed availability and other critical information necessary for command decision-making.
5. Organizations agree to ensure personnel are knowledgeable with the Diversion MOU and any policies, procedures and appendices.
6. All organizations recognize and agree diversion status is a request from the hospital to the EMS agency. EMS agencies may transport patients with special medical circumstances to a facility on diversion if the EMS crew believes it may be in the patient's overall best interest. (Examples of special medical circumstances include but are not limited to patients discharged within 72 hours from the diverted facility; transplant patients; patients with recent surgery at the diverted facility; obstetrical patients, etc.) Additionally, patients without a special medical circumstance may insist on being transported to a diverted facility due to personal preference, physician direction, health plan guidance, or other non-medical reasons. Before transporting either of these types of patients (special medical circumstances and/or patients insisting to be transported to a facility on diversion), the EMS agency will inform the patient hospitals make diversion decisions based on patient safety and real time capabilities and EMS agencies use this information in determining the best transport location for each patient. The EMS crew will follow their agency's policies and procedures when transporting to a diverted facility for any reason. The reason for diversion override will be reported as a courtesy to the receiving Emergency Department.
7. Each organization will designate a Primary Point of Contact (POC) to address immediate concerns related to diversion and a Senior Administrative POC for escalated complaints or communications. These POCs should be role-based rather than person-specific (see definitions section for more details). MEDCOM will maintain and distribute an up-to-date contact list of Primary and Senior Administrative POCs to Diversion MOU signatories. Conflicts should initially be directed to the Primary POC. Complaints or conflicts should be reported to the Primary POC as soon as possible to allow for timely corrective action and accurate documentation of details. If unresolved, the issue can be escalated to the Senior Administrative POC.
8. Regional ED Ops Performance Improvement committee will assist with conflict resolution and system review. Any issues not resolved in the Regional ED Ops committee will be routed to the STRAC Executive Committee for further assistance.

9. Status change decisions will be made by the Primary POC or their designee in accordance with any pertinent facility guidelines. Personnel responsible for EMResource status changes will be assigned a unique password and will be responsible for its security.
10. EMS agencies will be considered "notified" within 5 minutes of any change to the EMResource Diversion website.
11. Each Hospital agrees if its diversion status changes from "Open" to any of the "Divert" categories, EMS units that have left the scene of an incident enroute to that facility shall complete the transport if determined necessary by the field EMS crew.
12. When in a "Divert" status
    a. Each Acute Care facility will update the system every two hours. If the status is not updated, the facility will revert to "Open" status.
    b. Each Psychiatric facility will update the system every four h ours. If the status is not updated, the facility will revert to "Open" status.
13. Hospitals are prohibited from requesting "informal diversion" not tracked in EMResource. This includes direct requests to medic units, EMS Supervisors, EMS dispatch, or MEDCOM.
14. Hospitals agree to divert utilizing only the EMResource divert categories.
15. All parties agree to limit comments on the website to pertinent operational information. Inappropriate comments are prohibited and may be removed by MEDCOM.
16. Hospitals not specifically on diversion to OB patients shall accept obstetrical patients (OB) greater than 20 weeks gestation. ED diversion status does not apply to this subpopulation of EMS patients, unless they are specifically on divert to OB patients.
17. Psychiatric patients will be considered either medical or trauma patients with respect to diversion decisions.
18. Hospitals will accept Priority 1 override patients at any time, regardless of diversion status. Priority 1 override patients are defined as patients in extremis, including:
    a. patients with BP<70
    b. CPR in progress
    c. patients in need of emergency airway control, and
    d. at the EMS Medical Director's direction.
19. Organizations agree to utilize the STRAC definition of pediatric patients for transport decisions. The definition of a pediatric patient is "not yet 17 years old, or 17 years old or over with a pediatrician as their primary care physician".
20. There is no penalty for a facility to go on diversion status.
21. Patient parking is discouraged. Hospitals should make every effort to transfer patients from the EMS stretcher and complete the **"Transfer of Care" (TOC) within 20 minutes of the patient's arrival.** Hospitals are also expected to communicate bed status and expected timeframes for patient transfers to EMS units waiting in the ED. If TOC delays exceed 20 minutes, EMS Dispatch will contact the hospital's Primary POC. If no resolution is reached, the EMS Agency may take appropriate actions, including escalating the complaint or placing the facility on Mandatory Divert. (See Definitions for Mandatory Divert details.) If

unresolved, the 911 agency or relevant authority will intervene. Ambulance providers can contact MEDCOM at (210) 233-5815.

22. Hospitals agree to participate in the San Antonio Fire/EMS Diversion Override/MCI plan. This plan is an operational document for the San Antonio EMS Division and outlines actions in Mass Casualty Incident (MCI) and other system overload scenarios to include the City Ice Plan. The plan is developed in conjunction with the local EMS Medical Directors, Regional ED Ops committee members, and Southwest Texas Regional Advisory Council (STRAC). The Diversion Override/MCI Plan defines procedures to follow should it occur that an unacceptable number of facilities within a specific geographic boundary are on diversion simultaneously. The plan will specify the override of any divert status of hospitals for a specified length of time until the city emergency is determined to be over.
23. A robust reporting module for diversion hours by facility is available through the EMResource website to each hospital, San Antonio EMS agency, and STRAC. The Regional ED Ops committee may review data regularly as the situation dictates.
24. Department of Defense (DoD) facilities retain the option to abstain from this Memorandum of Understanding during time of war or other national security concern or at any time at the DoD's discretion.

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Southwest Texas Regional Advisory Council

Term

This memorandum of understanding is in effect on the date on which it is signed and remains in effect until a written notification is received revoking the Memorandum of Understanding with the STRAC. All parties reserve the right to terminate this MOU at any time, with or without cause. Thirty (30) day written notification is required for termination of the MOU.

ORGANIZATION: _____

PRIMARY POC: _____

PRIMARY POC CONTACT NUMBER: _____

SENIOR ADMINISTRATIVE POC: _____

SENIOR ADMINISTRATIVE POC CONTACT NUMBER: _____

RAC Executive Director / CEO Signature: _____ **Printed Name: ERIC EPLEY** _____ **Date Signed:** _____	**Facility CEO Signature:** _____ **Printed Name:** _____ **Date Signed:** _____
EMS Agency Division Chief or AOR _____ **Printed Name:** _____ **Date Signed:** _____	**EMS Medical Director** _____ **Printed Name:** _____ **Date Signed:** _____

APPENDIX – A
EMS Wall Time White Paper

(January 2024)
Texas EMS Stakeholders,

On behalf of the Governor's Emergency Medical Services (EMS) and Trauma Advisory Council (GETAC), attached are guidelines to address EMS wall times in Texas. The EMS Committee of GETAC, working with the Medical Directors and EMS Education Committees, developed the attached principles. Please share this document with your colleagues as we address this local, statewide, and national issue together.

EMS/Trauma Systems Section

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EMS/Trauma Systems
Consumer Protection Division
Texas Department of State Health Services

EMS Wall Time White Paper

EMS and Hospitals have struggled for decades with getting incoming patients off EMS stretchers and into hospital beds or chairs in a timely fashion. In many regions this was first exacerbated when hospital administration began programs to no longer go on ambulance diversion. Many facilities had challenges during times of high volumes and the EMS wall times issue was born. Ambulance Patient Off-load Time begins when the EMS unit arrives at the destination and ends when the patient is in an Emergency Department (ED) bed/chair and report has been given to the designated hospital individual, signifying patient care has been transferred immediately upon arrival. EMS Wall Time occurs during the Patient Off-load Time whenever there is a delay in placing a patient in a bed/chair requiring the EMS crew to wait and continue to care for their patient.

During the COVID pandemic, this problem of increasing EMS Wall Times intensified exponentially with routine reports of EMS crews being held in ED's for over eighteen hours. This problem has persisted as staffing issues, high patient volumes, ED overcrowding and hospital through-put challenges have become constant problems in communities throughout the state and nation.

In 2006, the Center for Medicare and Medicaid Services (CMS) issued an opinion that addressed extended EMS Wall Times:

"This practice may result in a violation of the Emergency Medical Treatment and Labor Act (EMTALA) and raises serious concerns for patient care and the provision of emergency services in a community. Additionally, this practice may also result in a violation of 42 CFR 482.55, the. Conditions of Participation for Hospitals for Emergency Services, which requires that a hospital meet the emergency needs of patients in accordance with acceptable standards of practice.

A hospital has an EMTALA obligation as soon as a patient "presents" at a hospital's dedicated emergency department, or on hospital property (as defined at 42 CFR 489.24(b)) other than the dedicated emergency department, and a request is made on the individual's behalf for examination or treatment of an emergency medical condition. A patient who arrives via EMS meets this requirement when EMS personnel request treatment from hospital staff."

The Department of State Health Services has sought clarification from CMS who stands by the statements made in the above opinion. CMS has met publicly with the Governor's EMS and Trauma Advisory Council (GETAC) Committees and Regional Advisory Councils (RACs) across Texas and has provided technical assistance and explained the process for reporting ongoing issues if necessary.

The EMS Committee of GETAC, working with the Medical Director's Committee and the Education Committee developed the following principles to be used locally and regionally to address the problem with EMS Wall Times. This list of recommendations is meant to be used collectively rather than individually, to address this complex healthcare issue.

This paper will use the following terms to denote different time frames that are a part of an ambulance's time at a destination delivering a patient.

a) Ambulance Patient Off-Load Time: This time begins when the ambulance arrives at the destination and ends when the patient is in an Emergency Department (ED) bed/chair and

report has been given to the designated hospital individual, signifying patient care has been transferred. The acceptable Ambulance Patient Off-Load Time should be determined locally and/or regionally between EMS and hospital leaders.

b) EMS Wall Time: This time occurs during the Ambulance Patient Off-Load Time whenever there is a delay in placing a patient in a bed/chair requiring the EMS crew to wait and/or continue to care for their patient.

c) Ambulance Reset Time: This time begins when patient care has been transferred and ends when the ambulance is available for another call or departs the hospital. This time is the responsibility of the EMS agency.

d) Ambulance Turnaround Time: This is the total time an ambulance is at the hospital and is the sum of the Ambulance Patient Off-Load Time, any EMS Wall Time and the Ambulance Reset Time.

EMS Wall Times are not an EMS problem; it is a healthcare system problem

a) Everyone involved in these issues must agree that this is a systemic problem, and true solutions can only be developed with every part of the healthcare system involved. This goes beyond the EMS and ED leaders and includes various other players including the EMS Medical Director, the ED Medical Director, the Chief Nursing Officer, the House Supervisor, the Chief Executive Officer, the RAC Executive Director and others who should all work towards a systemic solution.

Identify an acceptable EMS Patient Off-Load Time

a) EMS unit availability across a community is dependent upon the EMS agency being able to turn units around reliably in a reasonable amount of time. ANY issue that delays this turnaround time must be seen by the receiving facility as a reduction in service to the community and responded to immediately, regardless of the time of day or day of week. This time is necessary to define so EMS Wall Times can be measured reliably.

Develop a process by which low-acuity patients can be placed in triage/waiting rooms

a) EMS Medical Direction, EMS agencies and ED leadership must be willing to place low acuity, non-urgent patients into the waiting room or triage areas. This should be a community wide process that is agreeable to medical direction of both the EMS agency and the ED staff.

b) The best practice for EMS agencies is to have a protocol that defines patients that are eligible to be placed in triage/waiting areas. This protocol should be developed in conjunction with the receiving facility(ies) and RACs.

Define data points to measure this across the state with data shared regionally and statewide

a) Data is critical to truly understanding this issue across the State. EMS leadership believes that Ambulance Patient Off-Load Time, and any associated EMS Wall Time is what should be tracked, not Ambulance Turnaround Time.

b) Develop a time capture process in a reportable format for local, regional, and state reporting.

Establish relationships between EMS leaders and the hospital executive team in addition to ED leadership

a) The role of the local EMS agency is critical to the hospital and vice versa. Too often, ED leadership is relegated the role of EMS relations and relationship management. This can be appropriate in many situations, but when there are larger issues or more systemic issues, the EMS Leaders must have a relationship with the hospital executive team so that these issues can be addressed rapidly. Too often, when there are significant issues like EMS Wall Times at a hospital, there is limited relationships with the individuals at the level that must address these issues. These relationships must be cultivated so that trust and collaboration come more easily during heightened tensions of large community issues.

Implement innovative treatment and transport models

a) EMS reimbursement and transport systems are rapidly changing, and it will be imperative that EMS systems of all sizes become competent and proficient in these new options rapidly. The days of everyone who calls 911 goes to the hospital are shifting and the better EMS integrates this into their normal operations, the larger impact this will have on EMS Wall Times.
b) Alternative destinations (i.e. Free-Standing Emergency Departments, Urgent Care Centers, and Behavioral Health Centers) can help EMS balance patient destinations and off-load ERs across the local jurisdiction and region.
c) Telehealth technology has improved and is beginning to integrate into EMS. This could also help EMS systems with triage and transport decisions.

Create operational guidelines for extended EMS Wall Times

a) Based upon community solutions built with everyone at the table, EMS should have operational guidelines on how to respond when EMS Wall Times begin to impact patient care and community resource availability. This guideline should be used as EMS Wall Times begin to develop to prevent extended and repetitive times from developing.
b) The solution to long wall times will require all levels of healthcare to work together to build a monitoring and notification system.

Involve Regional Advisory Councils

a) Regional Advisory Councils (RACs) must be involved in these relationships and solutions. These solutions should be built on the policies and guidance of the Regional Advisory Council (RAC) system. Very few of these issues only affect a single hospital and a single EMS provider. The more uniformity that can be built into these healthcare systems across a region or communities within the region, the better and more comprehensive the solutions will be.

Resolve immediate issues at the management level

a) EMS and hospital leaders should never allow this issue to create conflict or division between the EMS care providers and the ED clinical staff. The relationship between these clinicians should almost be seen as sacrosanct and protected as such. Issues should be immediately addressed at the management level within the agency/facility.

b) Keeping the patient and the community at the center of these discussions must remain the focus as the healthcare system works together for solutions.

Inclusion of rural and frontier communities along with their hospitals

a) While highly complex in a metro area with multiple EMS agencies and multiple hospitals, these communities are as equally complex with a single EMS agency and/or a single hospital when there are no other transport possibilities within a reasonable time frame or distance. This is another critical reason that this issue must include the RAC as the center of an effective solution. RACs are charged to solve regional issues within the Emergency Healthcare System and should ensure that the right leadership is a part of the solution.

Provide conflict resolution education to EMS field crews

This is another example where conflict resolution skills should be taught in EMS initial education courses as well as by EMS providers. Formally educated personnel would be beneficial to EMS/Hospital issues as personnel would be better prepared to effectively interact with ED staff during times of crisis while still maintaining the EMS – ED relationship. These skills would also be beneficial in almost every facet of a field provider's performance from patient interaction, scene safety, customer service issues and many others.