'Hospital Diversion' Is Perfectly Legal and Putting People at Risk. Here's What You Need to Know

This controversial policy diverts ambulances away from the nearest ER, and it could cost you your life in an emergency.

By **Barbara Brody**

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When California resident Mike Robinson woke up in the emergency room in late 2001, he immediately knew something was different. Robinson has severe epilepsy, and this wasn't the first time he'd wound up in the hospital without knowing precisely how he had gotten there.

In the past, however, the surroundings were familiar. That's because he had always been taken to the same hospital; his health insurance company at the time had asked him to designate a preferred facility, and he chose the one that his regular healthcare providers were affiliated with. He felt comfortable there—or at least as comfortable as one can feel when coming out of a major seizure.

This time, however, he was taken somewhere new. Robinson recalls fading in and out of consciousness in the ambulance and hearing someone say that they were "rerouting." He later learned that when the paramedics radioed his preferred hospital to say they were on the way, they were directed to bring him elsewhere. "It was a Saturday night, and they were overloaded," he tells *Health*.

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The practice of turning away ambulances is known as "ambulance diversion" or "hospital diversion," and it happens in many cities across the country. The typical scenario: A hospital is so jammed with patients that it can't accommodate any more, so administrators decide to declare the ER essentially closed to new patients coming in via ambulance. Paramedics are directed to bypass the facility in favor of another one, and while they aren't required to honor that request, they usually do.

Sometimes that switch goes smoothly, but it can also have serious consequences.

After waking up in an unfamiliar location, Robinson says that he ended up having to fight off a nurse who was trying to catheterize him (no matter that he was capable of urinating on his own), then argued with a doctor who grilled him about his mental status. The key problem, he says, was that the staff did not initially believe he had epilepsy, despite the fact the he wore a medical ID tag around his neck. Given their typical patient population, they assumed he was a drug addict or having some sort of psychiatric episode. In the meantime, he was not getting the treatment he needed.

Feeling frustrated and worried that his health was in jeopardy, Robinson ripped an IV out of his arm and checked himself out against medical advice. He popped a rescue medication he always carried with him, which prevented him from having a subsequent seizure.

Wisconsin resident Tiffany Tate was not as lucky. When she had a stroke in 2014, bystanders assumed the ambulance would take her to the nearest hospital, which happened to be certified as a Comprehensive Stroke Center. But that's not what occurred, because that hospital was on diversion.

Tate's ambulance brought her to a different hospital a few miles away that was not properly equipped to treat her, according to *USA Today*. She was then transferred to yet another hospital, but by the time she arrived hours had passed. That created a dangerous scenario, because when you're having a stroke, starting treatment promptly is crucial. ("Time is brain," is a common saying when it comes to strokes, since the longer you wait to restore normal blood flow, the more brain cells are lost.)

Tate eventually died.

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How could this happen?

Ambulance diversion is controversial yet perfectly legal, at least in most states. According to federal law, if you walk into a hospital on your own and request emergency care, the hospital is required to stabilize you. Yet there is no such nationwide policy that says hospitals can't instruct ambulances to take patients elsewhere.

According to a 2006 study in the *Annals of Emergency Medicine*, 45% of the emergency departments in the US had gone on diversion status at least once in the previous year. More recently, the *Milwaukee Journal Sentinel*, who also reported on Tate's story, conducted an investigation of the 25 largest cities in the country and found that 16 of them allow some level of ambulance diversion.

Last year, when Rhode Island resident Bob Kumins started having chest pain, his ambulance was diverted away from the closest two hospitals; fortunately, he survived. In 2017, Las Vegas resident Lawrence Quintana died after having a stroke; the ambulance that arrived at his home was diverted from the nearest hospital to a facility 70 miles away.

These are just a few examples of patients who've been affected by diversion. No one knows exactly how often diversion occurs, because there's no central organization dedicated to tracking diversion policies. "But I think it's safe to say that it's still relatively common across the country," David Tan, MD, an associate professor of emergency medicine at Washington University School of Medicine in St. Louis and president of the National Association of EMS Physicians, tells *Health*.

The effect diversion has on a given community can also vary widely. In some instances, a hospital might only be on diversion for a short period or on partial diversion—say, because the CT scanner isn't working. In that situation, it might make sense for a hospital to tell EMS not to bring in trauma patients or anyone with a suspected stroke. But it's also possible for a hospital in a highly populated area to go on full diversion status for hours, and the spillover could end up creating a domino effect: One ER reaches maximum capacity, ambulances start bringing patients to the next one until it gets full, then that one goes on diversion, and so on.

Pamela Portnoy-Saitta, DO, an emergency room physician in Long Island, New York, admits that diversion can be problematic but notes that it's not a clear-cut issue. "If someone having a stroke goes to the closest hospital [despite it being overcrowded], would she be seen sooner? Maybe," she tells *Health*. "We have a triage system and stroke patients are suppose to be seen 'first'... but then again, so are trauma patients and those with chest pain and those who are showing signs of sepsis." (According to the American College of Emergency Medicine, patients who should be seen in less than 14 minutes per guidelines are already often being seen in 37 minutes, due to hospital overcrowding.)

A related issue, says Dr. Tan, is that EMS workers can't just drop a patient at the door of the ER and take off. This has become a major problem in Florida, as so-called "wall time"—the period in which paramedics are sitting around in hospital hallways with a patient on a stretcher, waiting for hospital personnel to take over—has increased and led to dangerous delays. More EMTs who are stuck babysitting patients in hallways means fewer emergency workers available to attend to the needs of the next person who calls 911.

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No quick fixes

Some cities have decided on their own to get rid of ambulance diversion. "Where I live, in the greater St. Louis area, the hospital presidents got together many years ago and agreed to eliminate it," says Dr. Tan. But he notes that ending diversion, whether by choice or by official mandate, won't happen unless other measures designed to deal with overcrowding are addressed simultaneously. One important key is that most hospitals can't successfully end diversion on their own; coordinated strategies, in which medical centers in the same area work together to solve overcrowding issues, tend to be more effective.

How to set the ball in motion? Pressure from the public is one possible starting point. In St. Louis, during peak flu season, "ambulances would literally be driving in circles around the city looking for a hospital to take their patients," says Dr. Tan. "When that hit the news media, the hospital administrators got very embarrassed and said, 'No more.'"

Waiting for hospitals to make changes themselves, however, doesn't always work. The Massachusetts Department of Public Health (DPH) spent a decade encouraging hospitals to voluntarily limit diversion, but when that failed, they didn't give up: They declared an official ban. In 2009, Massachusetts became the first state to ban ambulance diversion.

The Massachusetts DPH warned hospitals about the new policy 6 months before it was scheduled to go into effect, which provided some time to prepare. The agency also offered advice about how hospitals might reconfigure their current processes in light of the impending change.

"DPH made several recommendations to hospitals, including examining internal hospital systems to be certain that they are configured for maximally efficient patient flow," Marita Callahan, director of policy in the DPH's Bureau of Health Care Safety and Quality, tells *Health*. Hospitals were also urged to "approach the problem of boarding patients as a hospital-wide problem, rather than only a problem in the [emergency department," she says.

It's very important to think about *hospital* overcrowding vs. emergency department overcrowding, adds Dr. Tan. "When hospital throughput has slowed because of overbooked operating rooms, too many elective procedures, etc., we can't move patients out of the ER and admitted to the hospital because it's already full," he explains.

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A model for change

When Massachusetts' ban went into effect, some concerned parties worried that it would lead to massive increases in overcrowding and wait times in the emergency room. But that isn't what happened: A 2013 study determined that "there was no increase in [emergency department] length of stay or ambulance turnaround at 9 Boston-area [emergency departments.]" Some hospitals even became more efficient at moving patients through the system, researchers reported.

Kim Moriarity, RN, director of emergency services at Lawrence General Hospital in Lawrence, MA, tells *Health* that spending some time identifying the "weakest links" made it much easier to successfully end diversion at her busy hospital than anyone had anticipated. Communication was key. "The emergency room would be drowning [in patients] and nobody else knew," she says. Now when the ER gets crazy, other departments are looped in; nurses who normally work on internal floors are summoned to help in the ER, and any extra beds (such as in the ICU, which Moriarity says is rarely full) get utilized.

Lawrence General also hired additional staff and rejiggered schedules to better match the demand. "It sounds unpredictable, and we do have a rogue day here and there, but the number of arrivals [in the ER] per hour per day is pretty steady," says Moriarity. Meanwhile, the hospital changed the standard discharge time: Patients

now leave before noon to avoid late-day backups, and everyone focuses on getting patients to where they need to be as quickly as possible. "If you're admitted and going to have surgery this afternoon, we'll send you to the pre-op area now," she says, rather than having you wait in the ER.

While hospitals in other states may benefit from implementing similar strategies, an individualized approach is important. "There's no specific prescription for how to solve the problem," says Dr. Tan, because individual hospitals and communities have unique challenges. However, he does believe that it's a issue that can—and should—be tackled on a local basis: A position statement from the group he leads, the National Association of EMS Physicians, urges hospitals and EMS agencies around the country to explore ways to "limit the time that ambulances are out of service because of diversion or offload delay."

At Dr. Tan's hospital in St. Louis, ending diversion went along with some physical changes to the facility: A larger emergency waiting room was created, along with a bigger triage area. The hospital also hired more staff. "I believe it's a best practice model," he says. "Ambulance services and hospitals need to work together to find solutions."