Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and Licensure
Chapter 20—Hospitals

PROPOSED AMENDMENT

19 CSR 30–20.092 Diversion *[Emergency Services in Hospitals]*. The department is amending the title of the rule and section (12). The department is removing sections (1) through (11).

PURPOSE: This amendment adds clarifying language related to the concept of diversion.

[(1) Each hospital providing general services to the community shall provide an easily accessible emergency area which shall be equipped and staffed to ensure that ill or injured persons can be promptly assessed and treated or transferred to a facility capable of providing needed specialized services. In multiple-hospital communities where written agreements have been developed among the hospitals in accordance with an established community-based hospital emergency plan, individual hospitals may not be required by the Department of Health to provide a fully equipped emergency service.

(2) A hospital shall have a written hospital emergency transfer policy and written transfer agreements with one (1) or more hospitals within its service area which provide services not available at the transferring hospital. Transfer agreements shall be established which reflect the usual and customary referral practice of the transferring hospital, but are not intended to cover all contingencies.

(3) Hospital emergency services shall be under the medical direction of a qualified staff physician who is board-certified or board-admissible in emergency medicine and maintains a knowledge of current ACLS and ATLS standards or a physician who is experienced in the care of critically ill and injured patients and maintains current verification in ACLS and ATLS. In pediatric hospitals, PALS shall be substituted for ACLS. With the explicit advanced approval of the Department of Health, a hospital may contract with a qualified consultant physician to meet this requirement.

(A) That physician shall be responsible for implementing rules of the medical staff relating to patient safety and privileges and to the quality and scope of emergency services.

(B) A qualified registered nurse shall supervise and evaluate the nursing and patient care provided in the emergency area by nursing and ancillary personnel. Supervision may be by direct observation of staff or, at a minimum, the nurse shall be immediately available in the institution.

(C) Any person assigned to the emergency services department administering medications shall be a licensed physician, registered nurse, EMT-paramedic or appropriately licensed or certified allied health practitioner and shall administer medications only within his/her scope of practice except for students who are participating in a training program to become physicians, nurses, emergency medical technician-paramedics who may be allowed to administer medication under the supervision of their instructors as a part of their training. Trained individuals from the respiratory therapy department may be allowed to administer aerosol medications when a certified respiratory therapy assistant is not available.

(4) Any hospital which provides emergency services and does not maintain a physician in-house twenty-four (24) hours a day for emergency care shall have a call roster which lists the name of the physician who is on call and available for emergency care and the dates and times of coverage. A physician who is on call and available for emergency care shall respond in a manner which is reasonable and appropriate to the patient's condition after being summoned by the hospital.

(5) Any hospital with surgical services that also provide emergency surgical services shall have a general surgical call roster which lists the name of the general surgeon who is on call for emergency surgical cases, and the dates and times of coverage. The surgeon who is on call for emergency surgical cases shall arrive at the hospital within thirty (30) minutes of being summoned. Patients arriving at a hospital that does not provide emergency surgical services and are found upon examination to require emergency surgery shall be immediately transferred to a hospital with the necessary services.

(6) All patients admitted to the emergency service shall be assessed prior to discharge by a physician or registered professional nurse.

(7) If discharged from the emergency department, other than to the inpatient setting, the patient or responsible person shall be given written instructions for care and an oral explanation of those instructions. Documentation of these instructions shall be entered on the emergency service medical record.

(8) There shall be a quality improvement program for the emergency service which includes, but is not limited to, the collection and analysis of data to assist in identification of health service problems, and a mechanism for implementation and monitoring appropriate actions. The quality improvement program shall include the periodic evaluation of at least the following: length of time each patient is in the emergency room, appropriateness of transfers, physician response time, provision for written instructions, timeliness of diagnostic studies, appropriateness of treatment rendered, and mortality.

(9) Written policies shall be adopted to assure that notification procedures are implemented concerning the significant exposure of prehospital emergency personnel to communicable diseases as required in 19 CSR 30-40.047.

(10) The emergency service medical record shall contain patient identification, time and method of arrival, history, physical findings, treatment and disposition and shall be authenticated by the physician. These records, including an ambulance report when applicable, shall be filed under supervision of the medical records department.

(11) There shall be a mechanism for the review and evaluation on a regular basis of the quality and appropriateness of emergency services.]

(1)*[(12)]* A hospital shall have a written plan that details the hospital's criteria and process for diversion. **Diversion may be due to the emergency department being overwhelmed with significantly critically ill or injured patients, or an overwhelming number of minor emergency patients, to the extent that the hospital is unable to provide quality care or protect the health or welfare of the patients it serves. A diversion also may be implemented if the hospital has resource limitations, such as, no available beds in specialty care units or general acute care, no surgical suites or shortages of equipment or personnel.** The plan must be reviewed and approved by the Missouri Department of Health **and Senior Services** prior to being implemented by the hospital. A hospital may continue to operate under a plan in existence prior to the effective date of this section while awaiting approval of its plan by the department.

(A) The diversion plan shall:

1. Identify the individuals by title who are authorized by the hospital to implement the diversion plan;

2. Define the process by which the decision to divert will be made;

3. Specify that the hospital will not implement the diversion plan until the authorized individual has reviewed and documented the hospital's ability to obtain additional staff, open existing beds that may have been closed or take any other actions that might prevent a diversion from occurring;

4. Include that all ambulance services within a defined service area will be notified of the intent to implement the diversion plan upon the actual implementation. Ambulances that have made contact with the hospital before the hospital has declared itself to be on diversion shall not be redirected to other hospitals. In areas served by a real time, electronic reporting system, notification through such system shall meet the requirements of this provision so long as such system is available to all EMS agencies and hospitals in the defined service area;

5. Include procedures for assessment, stabilization and transportation of patients in the event that services, including but not limited to, ICU beds or surgical suites become unavailable or overburdened. These procedures must also include the evaluation of services and resources of the facility that can still be provided to patients even with the implementation of the diversion plan;

6. Include procedures for implementation of a resource diversion in the event that specialized services are overburdened or temporarily unavailable; and

7. Include that all other acute care hospitals within a defined service area will be notified upon the actual implementation of the diversion plan. For defined service areas with more than two (2) hospitals, if more than one-half (1/2) of the hospitals implement their diversion plans, no hospital will be considered on diversion. For a defined service area with two (2) hospitals, if both hospitals implement their diversion plans, neither will

be considered on diversion. Participation in a real time, electronic reporting system shall meet the notification requirements of this section. If a hospital participates in an approved community wide plan, the community wide plan may set the requirement for the number of hospitals to remain open.

(B) Each incident of diversion plan implementation must be reviewed by the hospital's existing quality assurance committee. Minutes of these review meetings must be made available to the Missouri Department of Health and Senior Services upon request.

(C) The hospital shall assure compliance with screening, treatment and transfer requirements as required by the Emergency Medical Treatment and Active Labor Act (EMTALA).

(D) A hospital or its designee shall report to the department, by phone or electronically, upon actual implementation of the diversion plan. This implementation report shall contain the time the plan will be implemented. The hospital or its designee shall report to the department, by phone or electronically, within eight (8) hours of the termination of the diversion. This termination report shall contain the time the diversion plan was implemented, the reason for the diversion, the name of the individual who made the determination to implement the diversion plan, the time the diversion status was terminated, and the name of the individual who made the determination to terminate the diversion. In areas served by real time, electronic reporting system, reporting through such system shall meet the requirements of this provision so long as such system generates reports as required by the department.

(E) Each hospital shall implement a triage system within its emergency department. The triage methodology shall continue to apply during periods when the hospital diversion plan is implemented.

(F) Any hospital that has a written approved policy, which states that the hospital will not go on diversion or resource diversion, except as defined in the hospital's disaster plan in the event of a disaster, is exempt from the requirements of [*19 CSR 30-20.021(3)(C)12*] **this section**.

(G) If a hospital chooses to participate in a community-wide plan, the requirements of number of hospitals to remain open, defined service areas, as well as community notification may be addressed within the community plan. Community plans must be approved by the department. Community plans must include that each hospital has a policy addressing diversion and the criteria used by each hospital to determine the necessity of implementing a diversion plan. Participation in a community plan does not exempt a hospital of the requirement to notify the department of a diversion plan implementation.

AUTHORITY: sections 192.006 ***and 197.154****, RSMo, and* ***section*** *197.080[, RSMo 2000 and 197.154], RSMo Supp. [2007]* ***2018****.* This rule previously filed as 19 CSR 30-20.021(3)(C). Original rule filed June 27, 2007, effective Feb. 29, 2008.*

** Original authority: 192.006, RSMo 1993, amended 1995; 197.080, RSMo 1953, amended 1993, 1995; and 197.154, RSMo 2004.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) annually.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support or in opposition to this proposed amendment with the Missouri Department of Health and Senior Services, Division of Regulation and Licensure, Dean Linneman, Division Director, PO Box 570, Jefferson City, MO 65102-0570. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*