SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

DESTINATION POLICY

EFFECTIVE DATE: 04/01/25 ***POLICY REFERENCE NO: 5000*** ***SUPERSEDES: 10/1/24***

1. PURPOSE

1.1. To identify the approved ambulance-transport destinations for the San Francisco EMS System.

1.2. To delineate clinical criteria when patients should be transported to a general or specialty care hospitals or other alternate destinations.

2. DEFINITION

Decision Maker: Generic term used in this policy to refer to whoever is making the transport destination decision for the EMS patient. This may include the patient, family, or medical personnel managing the patient's care. For patients with psychiatric illness, this may also include the custodian placing the 5150 involuntary hold.

3. POLICY

3.1. The Emergency Medical Services (EMS) Agency designates hospitals approved to receive ambulances according to Policy 5010 – Receiving Hospital. The EMS Agency Medical Director may approve Specialty Care Facilities or alternate destinations that support the mission of the EMS System to receive ambulance patients as either temporary or permanent additions to the EMS System.

3.2. Ambulances may only transport patients to the approved destinations listed in this policy. Prearranged inter-facility transports, as defined in Policy 5030 – Interfacility Transfers are exempt from this policy.

3.3. When a patient is in need of specialty treatment (e.g., OB/GYN, STEMI, etc.), the ambulance crew may bring the patient directly to that hospital's specialty care department if directed to do so by hospital staff.

4. DESTINATION DECISION

4.1. Hospital destination decisions for EMS patients shall be prioritized based on the following:

4.1.1. Patients meeting specialty care triage criteria;

4.1.2. Hospital diversion status and/or EMS Alert status (see Section 5);

4.1.3. Patient preference;

4.1.4. Family or private physician preference (if patient unable to provide information);

4.1.5. Patients without a preference who require no specialty care shall be transported to the closest open general medical designated hospital.

4.2. Should a patient bypass the closest open facility for Section 4.1.3. – 4.1.5., the rationale shall be documented in the Patient Care Report and by the Emergency Department triage nurse on intake. For any issues resulting in destination selection of an EMS patient based on the above criteria, an Exception Report shall be submitted to the EMS Agency.

4.3. Patients who are in law enforcement custody such as being under arrest, detained, and incarcerated:

4.3.1. All patients who are incarcerated (e.g., inmate from county jail or to/from court hearing) or in law enforcement custody who are transported from county jail booking/holding/parking areas must be taken to Zuckerberg San Francisco General Hospital (unless specialty is not available at ZSFG, e.g., burns).

4.3.2. Patients who are in Law Enforcement Custody who do not meet the conditions as described in previous subsection shall follow standard destination criteria, which allows for transport to any Receiving Hospital and are subject to Diversion and EMS Alert. Patients meeting Specialty Care criteria must be transported to the most appropriate specialty care facility.

4.4. Patients with medical needs meeting any of the Clinical Field Triage Criteria listed below will be transported to the most appropriate specialty care facility. Specialty care designations include the following:

4.4.1. Pediatric Medical

4.4.2. Pediatric Critical Medical

4.4.3. STAR (STEMI and/or Post Arrest with ROSC)

4.4.4. Replantation (Microvascular Surgery)

4.4.5. Burns

4.4.6. Obstetrics

4.4.7. Stroke

4.4.8. Trauma

4.4.9. LVAD

4.4.10. Post-Sexual Assault

4.4.11. Sobering

4.5. Destinations other than those listed in this policy require approval from the Base Hospital Physician prior to transport except in instances as noted in Policy 4030 Intercounty and Bridge Response.

4.6. In the event of a Multi-Casualty Incident (MCI), destinations will be determined in accordance with Policy 8000 – Multi-Casualty Incident.

5. EMS ALERT

5.1. **EMS Alert:** Automatic ambulance routing function to supplement Hospital Diversion. EMS Alert looks at a ratio of current EMS volume and ED size to provide a fluid, point-intime reflection of each hospital's EMS impact.

5.1.1. EMS Alert ratio is calculated as follows:

5.1.1.1. 60-Minute EMS Volume (Numerator): The sum of the units en route + units at-hospital + units cleared in the past 60 minutes.

5.1.1.2. ED Surge Cap (Denominator): Determined by the "30% or 5 Rule" which is 30% of a hospital's licensed ED bed count or 5, whichever is lowest.

5.1.1.3. Receiving Facilities that have changes to their licensed ED bed count shall notify the EMS Agency within 30 days.

5.2. EMS Alert status shall be followed by EMS Personnel, consistent with Diversion Policy 5020. EMSA shall add a dashboard to the monthly Hospital Report for EMS Provider compliance with EMS Alert.

5.3. Ambulances are not permitted to transport to a Receiving Facility while on EMS Alert except:

5.3.1. Patients who meet any criteria which would allow bypass of diversion (e.g. Trauma, stroke, STEMI, etc.)

5.3.2. Extenuating circumstances where a patient has specific clinical needs that require care at a certain facility (e.g., recent transport or <48-hour surgical patient requesting transport to the hospital that performed the procedure). These situations required approval from the Dispatch Rescue Captain or King American/AMR On-duty Supervisor prior to transport. EMS Alert bypass requires documentation of the extenuating circumstances within the Patient Care Record (PCR) and the name of the supervisor who approved the bypass.

5.3.2.1. Examples include, but not limited to:

- Recent organ transplant patient going to the hospital that performed the procedure
- Patient <48-hours post-surgery requesting transport to the hospital that performed the procedure
- Patient recently discharged (<2-hours) from an ED returning to the hospital where they were initially seen
- Patient with an EMS6 care plan in which EMS6 feels another hospital is not appropriate
- Patient with cancer receiving specialized care such as chemotherapy

5.4. EMS Alert Suspension: diversion suspension has no effect on EMS Alert. EMS Alert is suspended when the sum of hospitals on Diversion, Trauma Override, or EMS Alert is equal to or greater than 5. When EMS Alert is suspended, hospitals might receive 1 additional ambulance transport above their designated ratio each time EMS Alert is suspended.

5.5. In order to obtain EMS Alert and Hospital Diversion status, review of ReddiNet via mobile data terminal shall be the primary tool by EMS personnel. Calling DEC shall be a secondary option, such as in cases of equipment failure, to minimize radio traffic and routing errors.

6. CLINICAL FIELD TRIAGE CRITERIA

6.1. **Critical Airway:** Patients in whom EMS personnel cannot obtain adequate airway control should be transported to the closest Receiving Hospital regardless of diversion status. For

patients under age 18, the preference is for a critical pediatric medical hospital (CPMC Van Ness or UCSF Mission Bay) if ETA is equal to or less than any other receiving facility.

6.2. Adult Critical Medical: Patients with one (1) or more of the following conditions should be transported to the closest Receiving Hospital:

6.2.1. Airway obstruction or respiratory insufficiency with inadequate ventilation;

6.2.2. Hypotension with shock;

6.2.3. Status epilepticus;

6.2.4. Acute deteriorating level of consciousness without trauma.

6.3. Adult Medical: Patients who do not meet any of the following: critical airway, critical medical adult or specialty criteria, may be transported to any Receiving Hospital or Standby Receiving Hospital.

6.4. Pediatric Critical Medical:

6.4.1. Pediatric definition of <18 years old applies only to this policy for selection of a hospital destination. It does NOT apply to any patient treatment policies or protocols.

6.4.2. Patients under age 18 with 1 or more of the following conditions should be transported to the closest Pediatric Critical Medical receiving hospital):

6.4.2.1. Cardiopulmonary arrest or post-arrest;

6.4.2.2. Hypotension with shock;

6.4.2.3. Status epilepticus;

6.4.2.4. Acute deteriorating level of consciousness without trauma

6.5. Pediatric Medical: Pediatric definition of <18 (under 18) years old applies only to this policy for selection of a hospital destination unless already addressed where a pediatric patient meets specialty triage (e.g. Trauma Triage Criteria). It does NOT apply to all pediatric patient treatment protocols when providing medical care. Patients under age 18 years not meeting the criteria for Critical Medical Pediatric may be transported to any Receiving Hospital listed as “pediatric medical”.

6.6. ST Elevation Myocardial Infarction / Post Arrest with ROSC (STAR): Patients are considered to be STEMI patient if they meet the STEMI criteria as defined in Protocol 2.06 – Chest Pain/Acute Coronary Syndrome. Patients experiencing a STEMI shall be transported to a designated STAR Center according to the following hierarchy:

6.6.1. Cardiopulmonary arrest - Patients who are age 18 or over and are in cardiac arrest or those who are post-arrest with return of spontaneous circulation in the field;

6.6.2. Patients who are unstable and would experience a significant delay in their care by transport to a preferred STAR Center shall be transported to the closest, designated STAR Center;

6.6.3. Patient preference for transport to a specific Receiving Hospital that is designated as a STAR Center;

6.6.4. Family or private physician preference (if patient unable to provide information) for transport to a specific Receiving Hospital that is designated as a STAR Center;

6.6.5. Patients without a preference shall be transported to the closest Receiving Hospital that is designated as a STAR Center.

6.7. Stroke: Patients who are age 18 or over and are experiencing the symptoms of acute stroke (last seen normal within 24 hours prior to 911 call) and exhibiting an "abnormal" result on the Cincinnati Prehospital Stroke Scale (see Protocol 2.14 – Stroke) shall be transported to a designated Stroke Center according to the following hierarchy:

6.7.1. Patients who are unstable and would experience a significant delay in their care by transport to a preferred Stroke Center shall be transported to the closest designated Stroke Center;

6.7.2. Patient preference for transport to a specific Receiving Hospital that is designated as a Stroke Center;

6.7.3. Family or private physician preference (if patient unable to provide information) for transport to a specific Receiving Hospital that is designated as a Stroke Center;

6.7.4. Patients without a preference shall be transported to the closest Receiving Hospital that is designated as a Stroke Center.

6.8. Replantation: If the patient has any of the following amputations or devascularization injuries, they may be taken to the Replantation (Microsurgical)Facility of their choice or to the closest Replantation Center if the patient has no preference:

6.8.1. Isolated amputation or partial amputation distal to the ankle or wrist;

6.8.2. Extensive facial, lip, or ear avulsion;

6.8.3. Penile amputation;

6.8.4. If the patient meets trauma triage criteria, transport to a Trauma Center;

6.8.5. Simple avulsion lacerations of the distal phalanx will be transported to any open Receiving Hospital or the closest open Receiving Hospital if the patient has no preference.

6.9. Burns: Patients meeting the following critical burn criteria shall be transported to a Burn Center (unless critical burn pediatric patients as listed below):

6.9.1. Partial thickness burns > 10% of the total body surface area (TBSA);

6.9.2. Burns involving the face, eyes, ears, hands, feet, genitalia, perineum or major joints;

6.9.3. Full thickness or 3rd degree burns in any age group;

6.9.4. Serious electrical burns;

6.9.5. Serious chemical burns;

6.9.6. Inhalation injuries (including burns sustained in a closed space for purposes of facial burns);

6.9.7. Transport to Zuckerberg San Francisco General (ZSFG) Hospital Trauma Center if the critical burn adult or pediatric patient meets trauma triage criteria.

6.9.8. Critical burn pediatric patients, who do not meet trauma triage criteria, shall be transported to UCSF Mission Bay for initial stabilization.

6.9.9. Consult the Base Hospital for online medical direction if unclear on or uncertain of the most appropriate destination in a borderline case where the pediatric patient meets critical burn criteria.

6.10. Obstetrics: Pregnant patients who are over 20 weeks gestation (by patient history) with any condition that does not fall under other specialty center care AND pregnant patients of any gestational age with a pregnancy-related complaint that do not require another specialty center should be transported to the Obstetrics Specialty Care Facility of their choice or the closest open Obstetrics Specialty Care Facility if the patient has no preference.

6.11. Psychiatric (see 5000.2 Flowchart): The psychiatric criteria listed below apply to patients with signs and symptoms of a psychiatric illness, with or without a 5150 involuntary hold:

6.11.1. For patients with signs and symptoms of a psychiatric illness who are under law enforcement custody, refer to Section 4.3:

6.11.2. For patients with signs and symptoms of a psychiatric illness, the destination is based on the following:

6.11.2.1. Patient age;

6.11.2.2. Patients meeting specialty care triage criteria;

6.11.2.3. Hospital diversion and/or EMS Alert status;

6.11.2.4. For involuntary patients (e.g. a 5150 hold or conservatorship), the patient decision maker placing the hold will identify hospital destination.

6.11.2.5. Patient preference;

6.11.2.6. Family/guardian or private physician preference;

6.11.2.7. If no preference, hospital location ("geographically closest").

6.11.3. Should a patient bypass the closest open facility in Section 6.11.2.4. – 6.11.2.7., the rationale shall be documented in the Patient Care Report and by the Emergency Department triage nurse on intake. For any issues resulting in destination selection of an EMS patient based on the above criteria, an Exception Report shall be submitted to the EMS Agency.

6.11.4. Patients with signs and symptoms of a psychiatric illness less than 18 years old must go to medically appropriate pediatric designated Receiving Hospital.

6.11.5. Patients with signs and symptoms of a psychiatric illness AND WITH suspected or active medical complaints must go to medically appropriate Receiving Hospital. This includes:

6.11.5.1. Patients who are severely agitated or combative and whose combativeness prevents an assessment (vital signs or examination) and / or requires field sedation with midazolam.

6.11.5.2. Patients with any medication overdose or who show signs of potential toxicity from drugs or alcohol.

6.11.6. Patients with signs and symptoms of a psychiatric illness may go to directly Psychiatric Emergency Services (PES) at Zuckerberg San Francisco General (ZSFG) if it is open (not on divert) and are medically appropriate by meeting ALL of the following criteria:

6.11.6.1. Age 18 – 65 years.

6.11.6.2. Glasgow Coma Score of 13 or greater;

6.11.6.3. Pulse rate between 55 - 120;

6.11.6.4. Systolic blood pressure between 90 - 190;

6.11.6.5. Diastolic blood pressure between 60 - 110;

6.11.6.6. Respiratory rate between 12 - 24;
6.11.6.7. Temperature between 96.5 and 100.5°F (or 35 to 38°C);
6.11.6.8. Oxygen saturation greater than 94%;
6.11.6.9. Blood glucose level between 60 – 250;
6.11.6.10. No active bleeding;
6.11.6.11. No bruising or hematoma above clavicles;
6.11.6.12. No active seizure and;
6.11.6.13. No lacerations that have not been treated.

6.12. Trauma: Emergent patients meeting the criteria described in Policy 5001 – Trauma Triage Criteria will be transported to a Trauma Center

6.13. LVAD: Any patient with a left ventricular assist device (LVAD) should be transported to the LVAD Center that implanted the device (UCSF or CPMC Van Ness). Crews are authorized to BYPASS the closest San Francisco LVAD Center to get the patient to the LVAD Center that implanted their device no matter the patient's condition. If the LVAD Center that implanted the device is not in San Francisco, the patient should be transported to the closest San Francisco based LVAD Center.

6.14. Post-Sexual Assault: Any patient who self-identifies as a victim of sexual assault or abuse within the 72 hours prior to their activation of 911 services AND does not have an overriding medical complaint or meet any special care criteria listed in this policy should go to Zuckerberg San Francisco General Hospital. This also applies to pediatric patients who are identified as being victims of sexual assault or abuse.

6.15. Alternate Destination (Sobering Services): Intoxicated patients with no acute medical condition(s) or co-existing medical complaints may go to an approved sobering service, if the patient meets the following criteria:

6.15.1. Be at least 18 years or older;
6.15.2. Voluntarily consents or has presumed consent (when not oriented enough to give verbal consent) to go to an approved sobering service;
6.15.3. If going to the San Francisco Sobering Center, must not be on their "Exclusion List."
6.15.4. Be medically appropriate by meeting ALL of the following criteria:
6.15.4.1. Indication of alcohol intoxication from alcoholic beverage (odor of alcoholic beverages on breath, bottle found on person);
6.15.4.2. Glasgow Coma Score of 13 or greater;
6.15.4.3. Pulse rate between 55 - 120;
6.15.4.4. Systolic blood pressure between 90 - 190;
6.15.4.5. Diastolic blood pressure between 60 - 110;
6.15.4.6. Respiratory rate between 12 - 24;
6.15.4.7. Temperature between 96.5 and 100.5°F (35 and 38°C);
6.15.4.8. Oxygen saturation greater than 94%;
6.15.4.9. Blood glucose level between 60 – 250;
6.15.4.10. No active bleeding;
6.15.4.11. No bruising or hematoma above clavicles;

6.15.4.12. No active seizure and;

6.15.4.13. No lacerations that have not been treated.

6.15.5. If ALS transport by a Paramedic to Sobering Services, Paramedic shall hold Triage to Alternate Destination Accreditation under Policy 2050.

6.16. Alternate Destination (Veteran's Hospital [VA] Standby Facility): Any patient who identifies as a VA member, requests transport to the San Francisco VA Medical Center, and do not meet the following:

6.16.1. Critical airway

6.16.2. Critical medical adult or specialty criteria

6.16.3. If ALS transport by a Paramedic to San Francisco VA Medical Center, Paramedic shall hold Triage to Alternate Destination Accreditation under Policy 2050.

6.17. Additional Alternative Destination Information

6.17.1. If a patient meets above criteria, but requests transport to an emergency department, the patient shall be transported to a Receiving Facility.

6.17.2. If a patient is transported to an Alternate Destination and is found to no longer meet criteria, patient shall be immediately transported to a Receiving Facility.

6.17.3. Alternate Destinations shall send with each patient copies of all medical records related to the patient's transfer.

6.17.4. Transportation to an Alternate Destination shall not be based on or affected by a patient's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services or any other characteristic as defined as California Civil Code, Division 1, Section 51 except to the extent a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

7. AUTHORITY

7.1. California Health and Safety Code, Division 2.5, Sections 1798, 1798.163, and 1801-1857

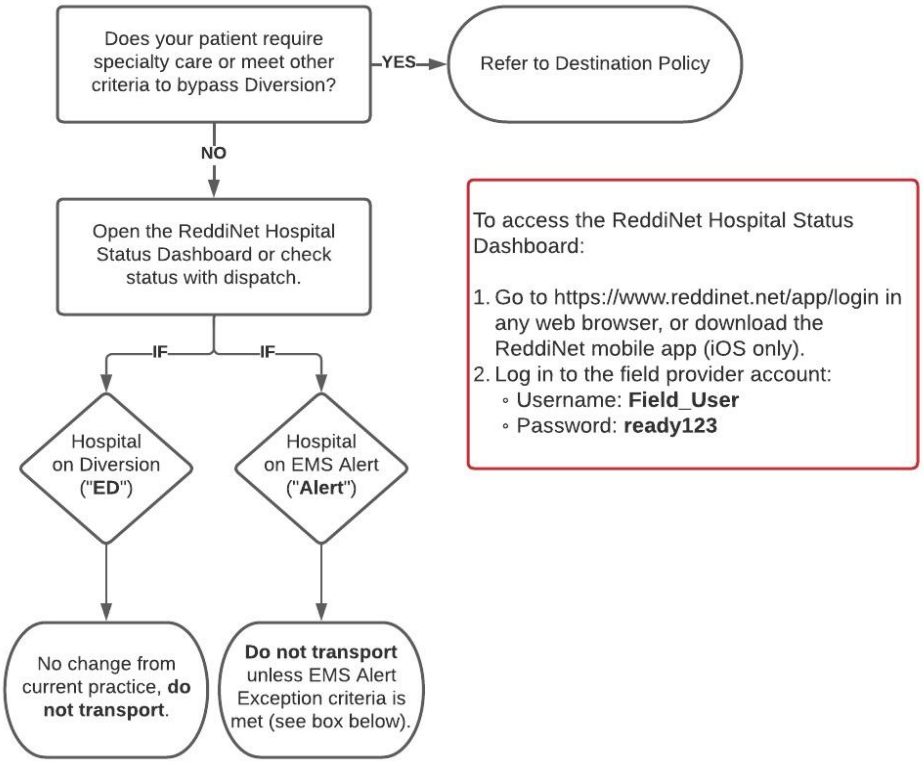
7.2. California Code of Regulations, Title 22, Division 9, Chapter 5

Appendix A

"EMS Alert" Guide Sheet

EMS Alert is a parallel system to Diversion. It provides a fluid, point-in-time reflection of each hospital's EMS impact based on current EMS activity in relation to a hospital's capacity. Background information, technical details, and FAQ can all be found in the EMS Alert section of the Policy & Protocol App, as well as on the EMS Agency webpage.

Instructions for using EMS Alert are below and are based on current guidance from the EMS Agency Medical Director. The EMS Memo with this information can also be found on the Policy & Protocol App and webpage.



EMS Alert Exception

Paramedics shall contact the Radio RC (SFFD ambulance) or King/AMR Supervisor (Private ambulance) if the patient meets the specialty cases outlined below. These personnel can only approve a patient going to an ED on EMS Alert in these specific cases.

- Recent organ transplant patient going to the hospital that performed the procedure
- Patient <48-hours post-surgery requesting transport to the hospital that performed the procedure
- Patient recently discharged (<2-hours) from an ED returning to the hospital where they were initially seen
- Patient with an EMS6 care plan, in which EMS6 feels another hospital is not appropriate
- Patients with cancer receiving specialized care such as chemotherapy

In the event that a provider cannot contact a supervisor after 2 attempts, EMS Alert bypass may be initiated. For other clinical scenarios not listed above, in which a Paramedic feels a patient should bypass, Base Hospital contact is required. This should be treated the same as Base Hospital destination consultation while a hospital is on Diversion. Bypass of EMS Alert requires documentation of extenuating circumstances and supervisor/physician name.