SAN MATEO COUNTY HEALTH
EMERGENCY MEDICAL SERVICES

EMS POLICY	505
Effective:	**April 2025**
Approval: EMS Director **Travis Kusman, MPH**	Signed:
Approval: EMS Medical Director **Greg Gilbert, MD**	Signed:

PATIENT DESTINATION DETERMINATION

I. PURPOSE

This policy identifies the procedure for determining the appropriate receiving facility for patients transported by ground ambulance to the Emergency Department (ED) of an acute care hospital.

II. AUTHORITY

California Code of Regulations, Title 22, Division 9, §100096.03

III. DEFINITIONS

Emergency Medical Services Agency ("LEMSA") [or "Agency"]: The San Mateo County EMS Agency is designated as the Local Emergency Medical Services Agency (LEMSA) and is statutorily charged with primary responsibility for administration and medical control of emergency medical services in San Mateo County.

EMS Supervisor: A paramedic approved by the LEMSA responsible for operational and clinical leadership and supervision of emergency medical services at the provider agency level.

Patient: Any person for whom 9-1-1 services have been activated and that EMS personnel encounter (see Patient Contact) and who meets any of the following criteria:

1. Has a chief complaint or demonstrates illness or injury;
2. Is not oriented to person, place, time or event;
3. Requires or requests an assessment, field treatment, or transport; or
4. Is a minor who is not accompanied by a parent or legal guardian and appears to be ill or injured.

IV. POLICY

A. Patients transported as part of an EMS response should be taken to the Emergency Department staffed and equipped to provide care appropriate to the needs of the patient.

B. Patients may be transported to any receiving hospital as outlined in 519 – Receiving Hospitals.

C. Patients should be transported to hospitals within San Mateo County unless they are a critical specialty care patient (e.g., STEMI, stroke, trauma, burn, critical pediatric, or VAD). Stable, non-specialty care patients who request transport to an out-of-county facility other than Stanford may be permitted after consultation with a transport EMS Supervisor and a ringdown to the facility to gain acceptance prior to departing the incident scene.

D. Prehospital providers are responsible for the decision to transport with or without red lights and sirens ("RLS"). Consideration should be given to whether there are reasonable grounds to believe there is a life-threatening emergency and whether RLS ("code 3") is necessary and appropriate based on travel time, distance, patient, weather, and road conditions. The decision to transport with RLS ("code 3") should not be based solely on the destination decision or whether the patient meets specialty care criteria (e.g., STEMI, stroke, trauma).
   1. The hospital must be notified of the patient's code 3 acuity, even if transported code 2.

E. For destination requests not addressed in this policy, contact an EMS Supervisor for guidance.

V. PROCEDURE FOR DETERMINING DESTINATION

A. Hospital destination decisions for EMS patients shall be prioritized based on the following:
   1. Patient medical need:
      a. A patient with an unstable airway, defined as unable to ventilate with a BLS airway adjunct and BVM, shall be transported to the closest ED;
      b. Patients meeting trauma, STEMI or stroke criteria, or when there is a high index of suspicion that a patient meets such criteria, shall be transported to the most appropriate ED with trauma, STEMI or stroke specialty services;
      c. Unstable, non-specialty care patients shall be transported to the closest ED; or
      d. Field crews should contact the Base Hospital for guidance in situations where the appropriate choice of receiving facility is unclear to ambulance personnel.
   2. Patient preference;
   3. Family or private physician preference (if patient unable to provide information); and
   4. Patients without a preference who require no specialty care shall be transported to the closest open general medical designated receiving hospital, unless directed otherwise herein.

B. Standby Emergency Departments
   1. Patients with life threatening conditions that require emergent stabilization when a basic emergency department is not within a reasonable distance may be transported to a standby emergency department;

2. Patients with any condition(s) that the paramedic reasonably believes will result in discharge from the ED and not require hospital admission may also be transported to a standby emergency department;
3. Pediatric patients with the following complaints shall not be transported to a standby emergency department:
    a. Seizures without evidence of fever or lasting longer than 10 minutes;
    b. Symptomatic dehydration;
    c. Requiring ventilator support;
    d. Exacerbation of serious conditions or clinical deterioration;
    e. Long bone fractures or fractures involving joints; or
    f. BRUE (Brief Resolved Unexplained Event); and
4. All other patients, including specialty care patients shall not be transported to a standby emergency department.

VI. PATIENTS ON PSYCHIATRIC DETAINMENT

A. Patients placed on a legal detainment (e.g., a hold pursuant to W&I Code § 5150) in the field by a legally authorized person shall be assessed for the presence of a medical emergency. Based on the history and physical examination of the patient, prehospital personnel shall determine whether the patient is stable or unstable.

B. Medically stable patients shall be transported to San Mateo Medical Center or Mills-Peninsula Medical Center, whichever is closest or the patient's medical home for psychiatric services. Medically stable patients who are veterans, confirmed by a valid VA ID, may be transported to Palo Alto VA Medical Center.

C. Any patient who is determined to be unstable or meet specialty center criteria shall be transported to the closest appropriate facility.

D. A patient with a current history of overdose of medications shall be transported to the closest ED.

E. A patient with history of ingestion of alcohol or illicit street drugs shall be transported to the closest ED if there is any of the following:
    1. Altered mental status (e.g., decreased level of consciousness or extreme agitation);
    2. Significantly abnormal vital signs; or
    3. Any other history or physical findings that suggest instability (e.g., chest pain, shortness of breath, hypotension, diaphoresis).

VII. OBSTETRICAL PATIENTS

A. A patient is considered "obstetric" if pregnancy is estimated to be twenty (20) weeks or greater.

B. Obstetric patients should be transported to a hospital with in-patient obstetrical services in the following circumstances:
   1. Patients in labor;
   2. Patients whose chief complaint appears to be related to the pregnancy, or who potentially have complications related to the pregnancy;
   3. Obstetric patients meeting physiologic, anatomic, or mechanism trauma triage criteria shall be transported to a trauma center;
   4. The appropriate trauma center Base Hospital shall be consulted in determining destination for all other injured obstetrics patients.

C. Obstetric patients with unstable conditions where imminent treatment appears necessary to preserve the mother's life should be transported to the nearest basic ED; and

D. Stable obstetric patients should be transported to an ED of choice identified in Policy 519 – Receiving Hospitals if their complaints are unrelated to the pregnancy.

VIII. PATIENTS WITH BURNS

A. Hospital Selection:
   1. Burn patients with unmanageable airways or severe inhalation injuries shall be transported to the closest receiving facility;
   2. Adult and pediatric patients with burns and significant trauma shall be transported to the closest appropriate trauma center;
   3. Burn injuries that should be transported to a burn center include:
      a. Partial thickness burns greater than 10% total body surface area ("TBSA");
      b. Burns that involve the face, hands, feet, genitalia, perineum, or major joints;
      c. Full thickness burns in any age group;
      d. Electrical burns, including lightning injury;
      e. Chemical burns;
      f. Inhalation injury (mild, moderate)
      g. Burn injury in patients with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality;

IX. CARDIAC ARREST WITH RETURN OF SPONTANEOUS CIRCULATION

Patients who meet ROSC criteria should be transported to a STEMI Receiving Center.

X. INCARCERATED PATIENTS

A. Any incarcerated patient who is determined to be unstable or meet specialty center criteria shall be transported to the closest appropriate facility.

B. Routine transport of incarcerated patients should occur as follows:
   1. San Mateo County jail inmates should be transported to San Mateo Medical Center;

2. San Bruno jail inmates should be transported to Zuckerberg San Francisco General Hospital; and
3. Incarcerated patients from all other jail facilities should be transported to San Mateo Medical Center.

C. Stable patients under arrest, but not incarcerated, shall go to the closest appropriate ED.

D. Law enforcement may not dictate transport decisions.

XI. SEXUAL ASSAULT PATIENTS

A. Any sexual assault patient who is determined to be unstable or meet specialty center criteria shall be transported to the closest appropriate facility.

B. Stable patients who are suspected victims of sexual assault shall be transported to San Mateo Medical Center.

XII. TRANSFER OF CARE

A. It is the expectation of the Agency that at the earliest opportunity and within fifteen (15) minutes of a 9-1-1 ambulances arrival, hospital staff will accept report from EMS personnel and move the patient to an emergency department bed or have the patient seated in a hallway chair or waiting room, when appropriate. Prehospital and hospital personnel are expected to work cooperatively to ensure the timely and appropriate transfer of patient care and act to minimize offload delays.

B. If fifteen (15) minutes have elapsed following arrival of a 9-1-1 ambulance patient in the emergency department of a receiving hospital within San Mateo County and the patient has not been placed in an appropriate bed, any patient not on a legal psychiatric hold (5150), who meet ***all*** of the following criteria, may be placed in the emergency department waiting room or other appropriate location by prehospital personnel:

1. Normal vital signs
   a. Heart rate 60–100/ minute;
   b. Respiratory rate 10–20/ minute;
   c. Systolic BP 100–180 mmHg;
   d. Diastolic BP 60–100 mmHg;
   e. Room air pulse oximetry > 94%; and
   f. Alert and oriented to person, place, time, and situation;
2. No parenteral medications were administered by prehospital personnel except for an anti-emetic;
3. In the judgment of the Paramedic, the patient does not require continuous cardiac monitoring;
4. The patient does not require a saline lock or intravenous (IV) line. If a saline lock or IV line was placed in the prehospital setting, unless directly requested by hospital staff to

leave in place, it should be removed by the paramedic.

5. The patient can maintain a sitting position without adverse impact on their medical condition, dignity, or obvious risk of fall;
6. A verbal report and a copy of the prehospital run sheet is provided to a charge nurse or their designee prior to leaving the patient at the hospital; and
7. The location to which the patient was triaged is clearly documented in the prehospital electronic health record.

XIII. OTHER TRANSPORT CONSIDERATIONS

A. Refer to 519 – Receiving Hospitals for non-routine out-of-county transports. Contact an EMS Supervisor for guidance.

B. Routine specialty care patients may be transported to out-of-county hospitals without the need to contact an EMS Supervisor.

C. Patients with other specialty care needs (e.g., patients with LVADs, disease/illness specific treatments) should be coordinated through the patient's home facility and the Base Hospital. Specialty care patients meeting the definition of unstable shall be transported to the closest ED.