GEORGIA DEPARTMENT OF PUBLIC HEALTH

Kathleen E. Toomey, M.D., M.P.H., Commissioner / Brian Kemp, Governor

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Dear Hospital CEOs and EMS Agency Directors:

The Office of EMS and Trauma is leading an Ambulance Patient Offload Times Taskforce (APOT Taskforce or the "Taskforce") at the request of the Emergency Medical Services (EMS) Advisory Council (EMSAC). The request is the result of the sustained increase in the amount of time ambulances must wait to offload patients into the care of the hospital emergency department staff, commonly known as "wall times". The purpose of the APOT Taskforce is to foster communication between hospitals and EMS agencies in order to develop community-based solutions to decrease wall times and improve the healthcare system in Georgia.

Increased wall times are a concern for communities across the state because it means ambulances are not available to respond to 911 calls or interfacility patient transfer requests. Delays in transferring patient care from EMS to hospital staff are not new. They began to rise substantially during the COVID-19 public health emergency as hospitals and EMS agencies became increasingly strained due to surges in illnesses, injuries, and hospitalizations. Hospitals and EMS agencies continue to experience workforce shortages and resource limitations, affecting hospital bed availability and patient throughput at all points of the continuum of care.

The APOT Taskforce has been reviewing EMS patient offload times by region and hospital for the past 10 months and has worked together to develop the enclosed recommendations for both hospitals and EMS agencies. **The task force's main goal is to have EMS patients offloaded (patient handover/turnover of care) to hospital staff within 20 minutes or less 90% of the time after EMS arrival at a receiving hospital.**

Ambulance availability across a community is dependent upon the EMS agency's ability to turn units around in a reasonable amount of time. The current wall times are critically impacting the ability of Georgia's EMS agencies to dispatch EMS resources, resulting in a reduction in critical emergency services to the community. Hospital and EMS leaders must be engaged to tackle this problem and work toward a systemic solution.

Please review the following recommendations, and if you have any questions, email me at michael.johnson@dph.ga.gov. Thank you for all that you do for the health and well-being of Georgians.

Sincerely,

Michael B. Johnson, MS, NRP
Director, Office of EMS and Trauma

Ambulance Patient Offload Times (APOT) Taskforce

The Ambulance Patient Offload Times Taskforce (APOT Taskforce) is a 32-member task force that has a diverse representation of hospitals (16) and EMS (16) agencies from across the state. The APOT Taskforce has been meeting for the past several months and has established data collection criteria, an Ambulance Patient Offload Time definition, and a goal for ambulance patient offload times that seeks to balance the needs and resources of both hospitals and EMS agencies.

Purpose:

The purpose of the APOT Taskforce is to work collaboratively with hospitals and EMS agencies to define an Ambulance Patient Offload Time measurement, identify an acceptable goal for Ambulance Patient Offload Times, work to reduce ambulance patient offload times, and work with EMS Agencies and Emergency Departments in Georgia to make recommendations on best practices to offload ambulance patients in a timely manner.

Goal:

EMS patients are offloaded (patient handover/turnover of care) to hospital staff within 20 Minutes or less 90% of the time after EMS arrival at a receiving facility.

Definitions:

Ambulance Patient Offload Time (APOT): The time in begins when an EMS patient arrives at the receiving facility and ends when the EMS crew can transfer care of the patient to the receiving facility and leave the patient.

> APOT is measured from the EMS ePCR: Patient Arrived at Destination Date/Time (eTimes.11) to Destination Patient Transfer of Care Date/Time (eTimes.12)

90th Percentile: the value in a distribution (displayed in minutes) under which 90 percent of the values occur and above which 10 percent of the values occur.

Patient Arrived at Destination Date/Time (eTimes.11)*: The date/time the responding unit arrived with the patient at the destination or transfer point.

Destination Patient Transfer of Care Date/Time (eTimes.12)*: The date/time that patient care was transferred to the destination healthcare staff so the EMS staff can return to service.

Unit Back in Service Date/Time (eTimes.13)*: The date/time the unit was back in service and available for response (finished with the call, but not necessarily back in home location).

> Total EMS time at a receiving facility is measured from Patient Arrived at Destination Date/Time (eTimes.11) to Unit Back in Service Date/Time (eTimes.13). This time measurement will encompass ambulance patient turnover time to destination staff, and other EMS crew activities that need to be completed for the EMS crew and ambulance to

return to service. The EMS agencies use this time measurement to evaluate the total time at the receiving facility.

* The time elements above are national standard data elements (NEMSIS[1]) that all EMS agencies in Georgia are required to document.

Recommendations for all Agencies/Hospitals:

1. Efforts are patient-centered. Keep the patient and the community at the center of discussions and focus on healthcare system solutions.

2. Leadership Involvement. All EMS leaders and hospital executive teams should establish relationships and ongoing communication and partnerships in addition to the traditional EMS management and ED leadership relationships. The local EMS agency is critical to the hospital and vice versa. ED leadership is often left to the role of EMS relationship management. This is important in many situations, but when there are larger or more systemic issues, the EMS leaders and hospital executive teams can address the issues more rapidly. These relationships must be established so that trust and collaboration come more easily during heightened tensions due to larger community issues.

3. Resolve immediate issues at the management level. EMS and hospital leaders should never allow ambulance patient offload delays to create conflict or division between the EMS care providers and the ED clinical staff. The relationship between these clinicians should be respected and protected as such. Issues should be immediately addressed at the management level within the agency/facility.

4. Each agency and facility should track and monitor Ambulance Patient Offload Times using the same measurements and create operational guidelines for them. This will enable agencies/facilities to take preventive measures before ambulance patient offload times begin to extend, which can impact patient care or community issues. Ideally, these guidelines should be developed with everyone's input.
    a. EMS agencies have access to biospatial©[2] that can track Ambulance Patient Offload Times for their agency and utilize the defined APOT time measurement. Some EMS agency ePCR systems can also track Ambulance Patient Offload Times using the defined APOT time measurement.
    b. Hospitals can utilize EMR software system reports if the defined APOT time measures can be utilized. Biospatial also has a hospital interface available (biospatial Navigate©).

Recommendations for EMS Agencies:

1. EMS agencies should ensure EMS transport crews give as much advance notice to the ED of the inbound patient as possible. (Pre-arrival alert: Radio Report, etc.) Pre-arrival notification of at least 10-15 minutes prior to the arrival of all patients will assist EDs in

[1] https://nemsis.org/
[2] https://www.biospatial.io/

preparing for the patient's arrival and knowing all patients that are inbound to their facility.

2. Ensure EMS field personnel know the importance in the accuracy of documentation and understand the definition/intent of the data elements within the PCR. Fields being utilized to track patient offload times include:
    - Type of service Requested – eResponse.05 – Emergency Response (Primary Response Area), Emergency Response (Intercept), Emergency Response (Mutual Aid)
    - Patient Arrived at Destination Date/Time - etimes.11
    - Destination Patient Transfer of Care Date/Time – etimes.12
    - Transport Disposition – eDisposition.30 – Transport by this EMS Unit (this Crew Only), Transport by this EMS Unit, w/Member of Another
    - Destination Types – eDisposition.21 – Hospital-Emergency Department and Hospital-Non-Emergency Bed
3. Educate EMS transport crews on escalation processes in place when EMS crews are unable to turn over patients to ED staff.
4. Implement innovative treatment and transport models
    - 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 patient offload times.
    - 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.
    - Telehealth technology has improved and is beginning to integrate into EMS. This could also help EMS systems with triage and transport decisions.

Recommendations for Hospitals:

1. Develop a process for placing low-acuity patients in triage/waiting rooms. EMS Medical Direction, EMS agencies, and ED leadership must be willing to place low-acuity, non-urgent patients in the waiting room or triage areas. This should be a community-wide process that is agreeable to the medical direction of both the EMS agency and the ED staff.
    - Hospital staff at EMS entrance for triage and placement
    - Dismissal suite/lounge for inpatients and ER patients
    - ER Holding area for new arrival ER patients that cannot go to Triage and no ER beds available
2. Have escalation processes in place when there are no beds available for EMS patients.
    - Ongoing processes currently in place:

- NEDOCs score escalation policy
- Wall Time Alert policy
- Expedited admissions/bed placement for admits
- Practice/implement Surge Plan processes

3. Educate ED staff on escalation processes in place when EMS crews cannot turn over patients to ED staff.
4. Provide continuing education on Centers for Medicare and Medicaid Services (CMS) and Emergency Medical Treatment and Labor Act (EMTALA) requirements for patients arriving by ambulance.