National Emergency Medical Services Advisory Council

DRAFT

Advisory and Recommendations

Title: **Strategies to Address the Crisis of Increased Ambulance Patient Offload Times**

As prepared by the Subcommittee on **Sustainability & Efficiency**

A. Executive Summary

For decades, Emergency Medical Services (EMS) has been evaluating, treating, and transporting patients to receiving facilities (i.e. hospitals) for ongoing and definitive patient care. Upon arrival at the facility, EMS will typically provide a verbal and/or written handoff report, transfer the patient from the EMS stretcher to the hospital bed or stretcher, and often obtain a signature from the receiving facility staff as verification of the handoff being completed. This total time from arrival of the ambulance and patient at the facility until the handoff is complete is known as the "Ambulance Patient Offload Time," or APOT. It may also be known as "wall time." However, when significantly delayed, it may be known as "offload delay," "parking," or "Ambulance Patient Offload Delay," or APOD. In some extreme cases, "wall time" includes a backlog of patients on ambulance stretchers who remain outside in the parking lot or ambulance bay and have not even been able to make it into the hospital yet (California Professional Firefighters, 2023).

Extended APOT times cause significant delays in the transition of care from the EMS service to the healthcare facility, leading to compromised patient care, diminished patient experience, disruption to continuity of EMS services, delayed responses to life-threatening or time-sensitive emergencies, threats to public safety and the existing EMS safety net for that community, increased costs for the provision of EMS services, worsening financial strain for EMS agencies, an increase in morale injury, burnout, and mistreatment of EMS clinicians, and overall suffering morale which further exacerbates EMS recruitment and retention woes (Alley, 2022). While hospitals and receiving facilities can go on diversion or delay status and limit the amount of ambulance traffic arriving at their facility, EMS does not have the same luxury to divert emergency calls for several hours while they recuperate their resources and decompress their backlog.

Since at least 2006, the Centers for Medicare and Medicaid Services (CMS) has been issuing letters, memorandums, and clarifying guidance to encourage the rapid transfer of care from EMS to the receiving facility under the authority of the Emergency Medical Treatment and Labor Act (EMTALA) of 1986. Per EMTALA, the responsibility of the receiving facility to accept, assess, and stabilize the patient begins when the patient arrives within 250 yards of the facility with the intent to seek medical care. Not only has the crisis of increased EMS APOT not improved, it has seemed to worsen in many parts of the country.

Recognizing that continuing to utilize the authority of EMTALA or reminding receiving facilities of their obligations under EMTALA as an isolated solution are unlikely to yield different results, the NEMSAC seeks to urgently evaluate the multifactorial causes of this crisis and offer additional supplemental advice and recommendations to the Federal Interagency Committee on EMS (FICEMS) and its member agencies to definitively address this growing dilemma.

B. Recommendations

National Highway Traffic Safety Administration

Recommendation 1:

- The U.S. Department of Transportation and the National Highway Traffic Safety Administration (NHTSA) should provide broad education to the national EMS audience about their streamlined online reporting options for EMTALA violations and the criteria for which an EMTALA violation has occurred as it relates to significantly delayed handoff of EMS patients to a receiving facility.

Federal Interagency Committee on Emergency Medical Services
NEMSAC recommendations for consideration to FICEMS via NHTSA

Recommendation 1:

- Via FICEMS member DHHS and CMS, provide expanded regulatory and subregulatory guidance and additional interpretation of the existing EMTALA obligations for healthcare facilities to expeditiously receive the EMS-transported patient and release the EMS agency back into service. Strengthen language regarding the ease of EMTALA violation reporting and resources being provided to EMS to enable such reports, as well as the financial consequences for each individual violation.

Recommendation 2:

- Via FICEMS member DHHS, make use of CMS accrediting organization (AO) programs to influence development of standards for appropriate handoff between EMS and the receiving facility within the specified timeframe. Compliance with these standards should be tied to the receiving facility's accreditation with the AO.

Recommendation 3:

- Via FICEMS member DHHS, utilize AHRQ to generate patient-centric measures and metrics related to ED boarding of admitted patients and utilize CMS AO programs to tie compliance of both reporting and following the measure with accreditation. Specifically, the CMS measure "Admit Decision Time to ED Departure Time for Admitted Patients"

is scheduled to sunset in 2024 and is currently the only available measure to track this statistic and provide incentives and reinforcement to help reduce wait times and boarding.

Recommendation 4:

- Via FICEMS member DHHS, make use of CMS AO programs to establish required standards for a maximum length of time for admitted patients to remain boarded in the ED. Currently, Standard LD.04.03.11 was revised and went into effect January 1, 2014, with "Element of Performance," EP 6 stating "it is recommended that boarding time frames not exceed 4 hours in the interest of patient safety and quality of care." NEMSAC requests that this be changed into a requirement instead of a recommendation (Joint Commission, 2012).

Recommendation 5:

- Via FICEMS member DHHS, issue guidance to covered entities (i.e. receiving facilities) regarding their potential liability under the Federal False Claims Act and language regarding the Federal Anti-Kickback Statute because of EMS providing remuneration to supplement and augment the hospital's staffing shortages and operational deficits during extended "wall time."

Recommendation 6:

- Via FICEMS member DHHS, provide clarifying language to covered entities (i.e. receiving facilities) on the risks of allowing EMS practitioners to function as non-credentialed providers within the healthcare facility for extended periods (beyond 25 minutes), with commentary as needed regarding the potential Federal Anti-Kickback Statute.

Recommendation 7:

- Via FICEMS member DHHS, establish a standardized time expectation for appropriate handoff as additional interpretative guidance in the Hospital and Critical Access Hospital (CAH) Conditions of Participation that tie to 42 CFR 482.55. NEMSAC suggests language that mandates a handoff to ensure that EMS is available to respond to another call within 30 minutes of arrival at the receiving facility, 100% of the time, as an industry best practice and proposed standard. Utilizing CMS AO programs, non-compliance with this mandate should be tied to accreditation and/or financial penalties for the receiving facility.

Recommendation 8:

- Via FICEMS member DHHS, provide additional interpretative guidance in the Hospital and Critical Access Hospital (CAH) Conditions of Participation that tie to 42 CFR

482.55 that any delay in EMS patient handoff beyond the 30-minute ceiling should result in automatic notifications to hospital administrators to allow for situational awareness and the opportunity to work directly with ED leadership to rectify the problem and protect and sustain the local EMS system.

Recommendation 9:

- Via FICEMS member DHHS, broadly publicize the streamlined national EMTALA complaint intake web portal for all covered entities.

Recommendation 10:

- As requested in the "Letter to FICEMS to Address Wall Time Crisis in America", NEMSAC recommends that FICEMS member DHHS ask AHRQ to expedite the publication of the proceedings, action items, and/or summary of ED-related activities and engagements from the Roundtable in May 2024.

Recommendation 11:

- As requested in the "Letter to FICEMS to Address Wall Time Crisis in America", NEMSAC recommends that FICEMS member DHHS work with partner agencies to urgently act on the action items from the Roundtable which directly impact EMS wall times and delayed patient offload times.

Recommendation 12:

- As requested in the "Letter to FICEMS to Address Wall Time Crisis in America", NEMSAC recommends that FICEMS member DHHS expand the AHRQ's "Roundtable" to a longitudinal "Task Force" on the ED boarding crisis to continue evaluating causal factors and the success of implemented action items to reduce EMS wall times and delayed patient offload times. Additionally, the NEMSAC respectfully requests that EMS stakeholders be a significant roleplayer on the Task Force for meaningful insight and contribution to both the causes and solutions for delayed APOT. Suggestions for appropriate stakeholders can be provided by the NHTSA Office of EMS.

C. Scope and Definition

Extended APOT is not a new problem, but existing efforts to address this crisis have not seemed to work. Simply stated, a strategy focusing only on an increased understanding and enforcement of EMTALA will likely not work to produce any changes or improvements in the crisis of increased ambulance patient offload times. Instead, stakeholders must evaluate the underlying causes and factors driving the worsening crisis of increased APOT and mitigate them. Specifically, the crisis of ED boarding and overcrowding is a larger and broader topic that should be urgently addressed and additional information on this can be found below in the Strategic Vision section of this advisory.

Dating back to at least 2006, CMS has been issuing letters to State Survey Agency Directors regarding the problem with increased "wall time" of ambulances and the serious concerns for violation of EMTALA, in addition to downstream patient care consequences and limited provision of emergency services for the involved community (Centers for Medicare and Medicaid Services, 2006). Recognizing the rapidly escalating problem with delayed APOT and EMS "wall times," CMS issued additional revisions in 2008 to Appendix V of the State Operations Manual for interpretive guidelines for responsibilities of Medicare participating hospitals in emergency cases, with page 38 explicitly stating:

> Hospitals that deliberately delay moving an individual from an EMS stretcher to an emergency department bed do not thereby delay the point in time at which their EMTALA obligation begins. Furthermore, such a practice of "parking" patients arriving via EMS, refusing to release EMS equipment or personnel, jeopardizes patient health and adversely impacts the ability of the EMS personnel to provide emergency response services to the rest of the community. Hospitals that "park" patients may also find themselves in violation of 42 CFR 482.55, the Hospital Condition of Participation for Emergency Services, which requires that hospitals meet the emergency needs of patients in accordance with acceptable standards of practice (Centers for Medicare and Medicaid Services, 2008).

Although written guidance from federal authorities has been appreciated, it has not resulted in any significant action or improvement in this dilemma. As a result, many states and local EMS jurisdictions have been attempting to mitigate this problem independently. For example, California has introduced AB1223 (2015), AB2961 (2018), AB40 (2022), and AB379 (2023) in attempts to standardize, regulate, and report on EMS offload times. Specifically, AB40 requires EMS agencies to develop a standard not to exceed 30 minutes, 90% of the time, for ambulance patient offload times and report the adopted time to the local EMS authority (AB 1223, 2015), (AB 2961, 2018), (AB 40, 2023), (AB 379, 2023).

The NEMSAC is not endorsing this specific metric as outlined in AB40. In fact, we believe the standard should have 100% compliance requirement for 30 minutes or less for EMTALA enforcement. Of course, the NEMSAC understands there will always be instances where the receiving facility is engaging in emergent patient care and may not be able to receive the EMS patient immediately upon arrival. However, this does not absolve the receiving facility of their EMTALA requirement to perform a medical screening examination (MSE) by a qualified medical provider (QMP) and determine the ability of EMS to continue providing ongoing care and assessment of the "parked" patient. Recognizing the occasional circumstances where additional time is required, the NEMSAC recommends that any delays beyond this should trigger immediate communication channels between hospital administration and ED leadership to rectify the problem to protect and sustain the local EMS system.

Furthermore, while some states may have specific language regarding what constitutes an EMS handoff in a more formal sense, there is no federal regulatory language or statutes for the requirement of a formal verbal report or the requirement of an available ED bed as stipulations

for the EMS handoff process to proceed, and should strongly be considered to stop being used as reasons why EMS must remain "on the wall" with their patient. The myth that the hospital is not responsible for the patient unless they receive a formal handoff and provide a physical signature to EMS has been thoroughly clarified and demonstrates a lack of understanding of EMTALA which could result in financial penalties for the receiving facility.

D. Analysis

The financial impacts of the crisis of increased APOT on EMS is significant. As a result of EMS remaining in the ED for extended periods, communities are deprived of already limited EMS resources to respond to additional emergencies, both for the individual citizen as well as for large-scale catastrophic community events, thus reducing our national readiness. The devastating financial impact on an already financially strained EMS system is five-pronged:

1. **Unreimbursed Care:** EMS is providing countless hours of uncompensated care in the hospital to a patient for whom the hospital has already incurred obligations under EMTALA and will likely also be billing a facility charge. EMS is reimbursed on a mileage basis, without regard for additional time spent at the hospital caring for a patient on behalf of the hospital. Once the transport is complete, under current payment structures, EMS generated no additional revenue to cover their expenses, including the expense of personnel caring for a patient at a hospital. NEMSAC has written advisories extensively outlining this problem with many recommendations, most recently with the Biennial State of EMS System Financing (National EMS Advisory Council, 2023).

2. **Opportunity Cost:** Due to missing current and future emergency calls while "waiting on the wall" in the ED, the EMS agency is not able to generate additional revenue. Currently, due to EMS still only being paid as a transportation commodity for taking patients to hospitals, missing additional emergency calls will lead to lost revenue.

3. **Labor Cost:** EMS agencies are spending their limited financial resources to pay their staff, sometimes at overtime rates, to sit in the hospital and provide uncompensated care where the hospital is not fulfilling its legal responsibility to care for the patient, per EMTALA rules. In addition to not being reimbursed for the care provided, the agency is also having to pay their staff to provide ongoing care to supplement the lack of staffing from the receiving facility.

4. **Operational Cost:** As a result of offload delays in the ED with their patient, the next emergency response to a call is often from an ambulance that is traveling from a much further distance to cover the region that is uncovered. Those extra miles to respond to the call are not reimbursed under current models but does result in increased wear and tear on emergency vehicles with no commensurate increase in revenue to compensate for it.

5. **Community Cost:** As a result of EMS patient offload delays, EMS cannot respond to additional emergencies within their respective community, often leading to preventable mortality and morbidity and lives lost unnecessarily (California Professional Firefighters,

2023). The consequence of increased EMS "wall time" results in a reduction of that community's emergency preparedness as well as a reduction of whole community resilience.

E. Strategic Vision

As previously stated, it is imperative that to truly address the crisis of increased ambulance patient offload times, stakeholders must address the underlying crisis of ED boarding and overcrowding. In the opinion of NEMSAC, this is the primary driving factor causing the strain and burden on EMS as EMS must continue to perform despite the worsening environments and circumstances.

In November 2022, NEMSAC finalized an advisory titled "Strengthening Emergency Medical Services (EMS) and Hospital Relationships to Improve Efficiencies and Positively Impact Patient Outcomes (National EMS Advisory Council, 2022)," with three specific recommendations designed to ultimately improve offload times and transfer of care. To date, these recommendations have not been implemented and the "wall times" crisis has worsened further and is now a critical tipping point for an already strained EMS profession (Beresford, 2023), (Huffman, 2023), (Brown, Rose, & Barnes, 2022), (Wolffe, 2023), (Kazan, 2022).

It cannot be overstated enough that the primary problem driving the worsening "wall time" crisis is hospital overcrowding and ED boarding. While well documented in the Emergency Medicine literature for over 20 years, the COVID-19 pandemic has worsened this problem over the past few years, primarily due to staffing shortages (Chervoni-Knapp, 2022). Underlying factors such as inadequate hospital staffing, the practice of hospitals boarding admitted patients in EDs for prolonged periods, poor hospital throughput, overutilization of emergency departments for low acuity complaints, lack of adequate outpatient primary care resources, and lack of reimbursement for Treatment-in-Place (TIP) and Transport-to-Alternative-Destinations (TAD) are all implicated in hospitals deliberately delaying EMS offload and transfer of care. EDs and their limited staff are being squeezed with an influx of patients from both the front door and the back door, with limited egress options for the patients. Even more concerning is that this practice of optional hospital management is becoming more commonplace and widespread, leading to this "parking" of ambulances becoming the accepted norm among receiving facilities, but to the detriment of the EMS system and the community's emergency preparedness.

In November 2022, the American College of Emergency Physicians (ACEP) and 34 other organizations sent a letter to the President to invite impacted stakeholders to develop long-term solutions (American College of Emergency Physicians, 2022). Simultaneously, ACEP convened a Summit with 14 other private and public stakeholder organizations in September 2023 to evaluate and analyze the causes of ED boarding (American College of Emergency Physicians, 2023). Additionally, in December 2023, Secretary Becerra from the Department of Health and Human Services wrote a three-page letter charging the Agency for Healthcare Research & Quality (AHRQ) "to use its unique statutory authority to improve healthcare nationwide and its ability to work with HHS partners to convene a multistakeholder Director's Roundtable" (Becerra, 2023). The timeline was set at six months from December 2023, with

action items targeted toward AHRQ and CMS, and that Roundtable meeting occurred in May 2024.

While NEMSAC as well as the EMS community at large is appreciative of the efforts and attention focused toward reducing EMS wall times and delayed APOT, actionable change has been slow. Understanding this problem has been present for many years and continues to worsen, EMS is now at a critical tipping point today where many communities around the country have reduced emergency response capabilities and emergency preparedness because of EMS patient offload delays in the hospitals. As a result, NEMSAC has recommended that FICEMS ask AHRQ to expedite publication of the proceedings, action items, and/or summary of ED-related activities and engagements from the Roundtable in May 2024, as well as continue to work with partner agencies to urgently act on action items from the Roundtable which directly impact EMS wall times and delayed patient offload times.

Additionally, the NEMSAC strongly recommends that FICEMS work with its members, including AHRQ, to expand the Roundtable to a longitudinal "Task Force" on the ED boarding crisis to continue evaluating causal factors and the success of implemented action items to reduce EMS wall times and delayed patient offload times. Additionally, the NEMSAC respectfully requests that EMS stakeholders be a significant roleplayer on the Task Force for meaningful insight and contribution to both the causes and solutions for delayed APOT, with subject matter experts who intricately understand and can represent both sides of the issue. Suggestions for appropriate stakeholders can be provided by the NHTSA Office of EMS.

As a final point of consideration for FICEMS, EMS agencies and EMS practitioners who provide uncompensated or free labor to hospitals are supplying those hospitals with a clear financial benefit. These unit-hour costs paid by the EMS agency are considered remuneration to supplement and augment the hospital's staffing shortages. Where financial remuneration exists between parties that are in a position to make patient referrals to one another, the Federal Anti-Kickback Statute is in danger of being violated and can be the basis of liability under the Federal False Claims Act (Page, Wolfberg, and Wirth, 2021). There is extensive expert opinion regarding the many nuances of this complex problem and additional information can be found in the references included at the end of this advisory (Page, Wolfberg, and Wirth, 2021), (Page, Wolfberg, and Wirth, 2021).

Over the past several years, many EMS professional organizations have been leading the call for actionable change and to hold hospitals and receiving facilities accountable for this dilemma, but without success. The sense of urgency is rapidly increasing among EMS agencies and industry stakeholders as their ability to provide continuous emergency medical services for their community is becoming increasingly strained and compromised. The principal goal is the safety and best possible care for the patient, including the patients not yet contacted while awaiting EMS arrival at the scene of their emergency.

While the consequences of increased APOT are seemingly simple to understand, the multitude of causes and potential solutions are admittedly complex and will require effective collaboration and communication between local EMS jurisdictions and hospital leadership to definitively

rectify this dangerous problem which is negatively impacting multiple facets of EMS patient care, operations, and public safety. The NEMSAC feels strongly that support from FICEMS and implementation of the above recommendations will have a positive impact on addressing this urgent crisis and improve the continuity of EMS services around the country.

F. References

AB 1223. (2015, September 30). *Emergency Medical Services: Ambulance Transportation*. Retrieved from http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_1201-1250/ab_1223_bill_20150930_chaptered.html

AB 2961. (2018, September 21). Retrieved from https://ctweb.capitoltrack.com/Bills/17Bills/asm/ab_2951-3000/ab_2961_93_C_bill.pdf

AB 379. (2023, July 10). Retrieved from https://trackbill.com/bill/california-assembly-bill-379-emergency-medical-services/2353418/

AB 40. (2023, September 12). Retrieved from https://legiscan.com/CA/text/AB40/id/2840723

Alley, C. (2022, March 16). *Hospital Delays: The Toll It Takes On Our Employees*. Retrieved from EMS1: https://www.ems1.com/ems-management/articles/hospital-delays-the-toll-it-takes-on-our-employees-6UxcaVpgVDDl3SIm/

American College of Emergency Physicians. (2022, November 7). *Letter to White House*. Retrieved from https://www.acep.org/siteassets/new-pdfs/advocacy/emergency-department-boarding-crisis-sign-on-letter-11.07.22.pdf

American College of Emergency Physicians. (2023, October). *Summit on ED Boarding*. Retrieved from https://www.acep.org/siteassets/new-pdfs/advocacy/acep-boarding-summit-final-report.pdf

Becerra, X. (2023, December 18). *Secretary of Health and Human Services*. Retrieved from https://www.acep.org/siteassets/new-pdfs/advocacy/boarding-response-to-rep.-dingell.pdf

Beresford, L. (2023, October 24). *ER Boarding Problems Get Dumped on EMS*. Retrieved from EMS World: https://www.hmpgloballearningnetwork.com/site/emsworld/er-boarding-problems-get-dumped-ems

Brown, S., Rose, J., & Barnes, D. (2022, August 31). *EMS Perils from Hospital Overcrowding*. Retrieved from Agency for Healthcare Research and Quality (AHRQ); Patient Safety Network: https://psnet.ahrq.gov/web-mm/ems-perils-hospital-overcrowding

California Professional Firefighters. (2023, July 6). *Stuck On The Wall.* Retrieved from https://www.cpf.org/news/news-updates/stuck-on-the-wall-ambulance-delays-hamper-ems-response

Centers for Medicare and Medicaid Services. (2006, July 13). *EMTALA - "Parking" of Emergency Medical Service Patients in Hospitals.* Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter06-21.pdf

Centers for Medicare and Medicaid Services. (2008, March 21). *Revised State Operations Manual Appendix V - EMTALA.* Retrieved from CMS.gov: https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/policy-and-memos-to-states-and-regions-items/cms1209114

Chervoni-Knapp, T. (2022, June). The Staffing Shortage Pandemic. *J Radiol Nurs, 41*(2), 74-75.

Huffman, A. (2023, January). *Annals of Emergency Medicine*. Retrieved from From "A Campfire to a Forest Fire": The Devastating Effect of Wait Times, Wall Times and Emergency Department Boarding on Treatment Metrics: https://www.annemergmed.com/article/S0196-0644(22)01275-6/pdf

Joint Commission. (2012, December 19). *R3 Report: Requirement, Rationale, Reference.* Retrieved from https://www.jointcommission.org/-/media/tjc/documents/%20standards/r3-reports/r3_report_issue_4.pdf

Kazan, C. (2022, March 31). *Breaking Down The Wall*. Retrieved from National Association of EMS Physicians: https://naemsp.org/2022-3-31-its-time-to-deconstruct-the-wall/

National EMS Advisory Council. (2022, November). Retrieved from EMS.gov: https://www.ems.gov/assets/FINAL---[ai]---Strengthening-EMS-&-Hospital-Relationships-to-Improve-Efficiencies-and-Impacts-to-Patient-Outcomes---2022NOV03.pdf

National EMS Advisory Council. (2023, November). *Biennial State of EMS System Financing.* Retrieved from ems.gov: https://www.ems.gov/assets/FINAL----[se]---2023-Biennial-State-of-EMS-Systems-Funding----2023NOV16.pdf

NHTSA. (2019, January). *EMS Agenda 2050: A People-Centered Vision for the Future of Emergency Medical Services.* Retrieved from EMS.gov: https://www.ems.gov/pdf/EMS-Agenda-2050.pdf

Page, Wolfberg, and Wirth. (2021, November 16). *Ambulances Held Hostage: Can the Hospital Make You Stay?* Retrieved from EMS1: https://www.ems1.com/ambulance/articles/ambulances-held-hostage-can-the-hospital-make-you-stay-jQESFoe1BQTrtUYc/

Page, Wolfberg, and Wirth. (2021, December 9). *Ambulances Held Hostage: EMS Strategies for Reducing Ambulance Offload Times*. Retrieved from EMS1: https://www.ems1.com/legal/articles/ambulances-held-hostage-ems-strategies-for-reducing-ambulance-offload-times-O7IAjXyCm8FlANnY/

Page, Wolfberg, and Wirth. (2021, December 2). *Ambulances Held Hostage: Should We Stay or Should We Go?* Retrieved from EMS1: https://www.ems1.com/et3/articles/ambulances-held-hostage-should-we-stay-or-should-we-go-gtRkwCKqscPPW0Hg/

Wolffe, K. (2023, November 9). *NPR*. Retrieved from Sacramento County Has Some of the Highest ER Wait Times in the State: https://www.capradio.org/articles/2023/11/09/sacramento-county-has-some-of-the-highest-er-wait-times-in-the-state/