EMS Wall Time White Paper

EMS and Hospitals have struggled for decades with getting incoming patients off of EMS stretchers and into hospital beds or chairs in a timely fashion. In many regions this was first exacerbated when hospital administration began programs to no longer go on ambulance diversion. Many facilities had challenges during times of high volumes and the EMS wall times issue was born. Ambulance Patient Off-load Time begins when the EMS unit arrives at the destination and ends when the patient is in an Emergency Department (ED) bed/chair and report has been given to the designated hospital individual, signifying patient care has been transferred immediately upon arrival. EMS Wall Time occurs during the Patient Off-load Time whenever there is a delay in placing a patient in a bed/chair requiring the EMS crew to wait and continue to care for their patient.

During the COVID pandemic, this problem of increasing EMS Wall Times intensified exponentially with routine reports of EMS crews being held in ED's for over eighteen hours. This problem has persisted as staffing issues, high patient volumes, ED overcrowding and hospital through-put challenges have become constant problems in communities throughout the state and nation.

In 2006, the Center for Medicare and Medicaid Services (CMS) issued an opinion that addressed extended EMS Wall Times:

> *"This practice may result in a violation of the Emergency Medical Treatment and Labor Act (EMTALA) and raises serious concerns for patient care and the provision of emergency services in a community. Additionally, this practice may also result in a violation of 42 CFR 482.55, the. Conditions of Participation for Hospitals for Emergency Services, which requires that a hospital meet the emergency needs of patients in accordance with acceptable standards of practice.*
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> *A hospital has an EMTALA obligation as soon as a patient "presents" at a hospital's dedicated emergency department, or on hospital property (as defined at 42 CFR 489.24(b)) other than the dedicated emergency department, and a request is made on the individual's behalf for examination or treatment of an emergency medical condition. A patient who arrives via EMS meets this requirement when EMS personnel request treatment from hospital staff."*

The Department of State Health Services has sought clarification from CMS who stands by the statements made in the above opinion. CMS has met publicly with the Governor's EMS and Trauma Advisory Council (GETAC) Committees and Regional Advisory Councils (RACs) across Texas and has provided technical assistance and explained the process for reporting ongoing issues if necessary.

The EMS Committee of GETAC, working with the Medical Director's Committee and the Education Committee developed the following principles to be used locally and regionally to

address the problem with EMS Wall Times. This list of recommendations is meant to be used collectively rather than individually, to address this complex healthcare issue.

This paper will use the following terms to denote different time frames that are a part of an ambulance's time at a destination delivering a patient.

- Ambulance Patient Off-Load Time: This time begins when the ambulance arrives at the destination and ends when the patient is in an Emergency Department (ED) bed/chair and report has been given to the designated hospital individual, signifying patient care has been transferred. The acceptable Ambulance Patient Off-Load Time should be determined locally and/or regionally between EMS and hospital leaders.
- EMS Wall Time: This time occurs during the Ambulance Patient Off-Load Time whenever there is a delay in placing a patient in a bed/chair requiring the EMS crew to wait and/or continue to care for their patient.
- Ambulance Reset Time: This time begins when patient care has been transferred and ends when the ambulance is available for another call or departs the hospital. This time is the responsibility of the EMS agency.
- Ambulance Turnaround Time: This is the total time an ambulance is at the hospital and is the sum of the Ambulance Patient Off-Load Time, any EMS Wall Time and the Ambulance Reset Time.

- **EMS Wall Times are not an EMS problem; it's a healthcare system problem**
    a. Everyone involved in these issues must agree that this is a systemic problem and true solutions can only be developed with every part of the healthcare system involved. This goes beyond the EMS and ED leaders and includes various other players including the EMS Medical Director, the ED Medical Director, the Chief Nursing Officer, the House Supervisor, the Chief Executive Officer, the RAC Executive Director and others who should all work towards a systemic solution.

- **Identify an acceptable EMS Patient Off-Load Time**
    a. EMS unit availability across a community is dependent upon the EMS agency being able to turn units around reliably in a reasonable amount of time. ANY issue that delays this turnaround time must be seen by the receiving facility as a reduction in service to the community and responded to immediately, regardless of the time of day or day of week. This time is necessary to define so EMS Wall Times can be measured reliably.

- **Develop a process by which low-acuity patients can be placed in triage/waiting rooms**
    a. EMS Medical Direction, EMS agencies and ED leadership must be willing to place low acuity, non-urgent patients into the waiting room or triage areas. This should be a community wide process that is agreeable to medical direction of both the EMS agency and the ED staff.

   b. The best practice for EMS agencies is to have a protocol that defines patients that are eligible to be placed in triage/waiting areas. This protocol should be developed in conjunction with the receiving facility(ies) and RACs.

- **Define data points to measure this across the state with data shared regionally and statewide**
   a. Data is critical to truly understanding this issue across the State. EMS leadership believes that Ambulance Patient Off-Load Time and any associated EMS Wall Time is what should be tracked, not Ambulance Turnaround Time.
   b. Develop a time capture process in a reportable format for local, regional, and state reporting.

- **Establish relationships between EMS leaders and the hospital executive team in addition to ED leadership**
   a. The role of the local EMS agency is critical to the hospital and vice versa. Too often, ED leadership is relegated the role of EMS relations and relationship management. This can be appropriate in many situations, but when there are larger issues or more systemic issues, the EMS Leaders must have a relationship with the hospital executive team so that these issues can be addressed rapidly. Too often, when there are significant issues like EMS Wall Times at a hospital, there is limited relationships with the individuals at the level that must address these issues. These relationships must be cultivated so that trust and collaboration come more easily during heightened tensions of large community issues.

- **Implement innovative treatment and transport models**
   a. 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 EMS Wall Times.
   b. 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.
   c. Telehealth technology has improved and is beginning to integrate into EMS. This could also help EMS systems with triage and transport decisions.

- **Create operational guidelines for extended EMS Wall Times**
   a. Based upon community solutions built with everyone at the table, EMS should have operational guidelines on how to respond when EMS Wall Times begin to impact patient care and community resource availability. This guideline should be used as EMS Wall Times begin to develop to prevent extended and repetitive times from developing.

b. The solution to long wall times will require all levels of healthcare to work together to build a monitoring and notification system.

- **Involve Regional Advisory Councils**
  a. Regional Advisory Councils (RACs) must be involved in these relationships and solutions. These solutions should be built on the policies and guidance of the Regional Advisory Council (RAC) system. Very few of these issues only affect a single hospital and a single EMS provider. The more uniformity that can be built into these healthcare systems across a region or communities within the region, the better and more comprehensive the solutions will be.

- **Resolve immediate issues at the management level**
  a. EMS and hospital leaders should never allow this issue to create conflict or division between the EMS care providers and the ED clinical staff. The relationship between these clinicians should almost be seen as sacrosanct and protected as such. Issues should be immediately addressed at the management level within the agency/facility.
  b. Keeping the patient and the community at the center of these discussions must remain the focus as the healthcare system works together for solutions.

- **Inclusion of rural and frontier communities along with their hospitals**
  a. While highly complex in a metro area with multiple EMS agencies and multiple hospitals, these communities are as equally complex with a single EMS agency and/or a single hospital when there are no other transport possibilities within a reasonable time frame or distance. This is another critical reason that this issue must include the RAC as the center of an effective solution. RACs are charged to solve regional issues within the Emergency Healthcare System and should ensure that the right leadership is a part of the solution.

- **Provide conflict resolution education to EMS field crews**
  a. This is another example where conflict resolution skills should be taught in EMS initial education courses as well as by EMS providers. Formally educated personnel would be beneficial to EMS/Hospital issues as personnel would be better prepared to effectively interact with ED staff during times of crisis while still maintaining the EMS – ED relationship. These skills would also be beneficial in almost every facet of a field provider's performance from patient interaction, scene safety, customer service issues and many others.