Ambulance Patient Offload Time (APOT) Reduction Protocol

This protocol meets the requirements stated below:

SEC. 2. Section 1797.120.6 is added to the Health and Safety Code, to read:

1797.120.6. (a) A licensed general acute care hospital with an emergency department shall, by September 1, 2024, develop, in consultation with its emergency department staff, and its exclusive employee representatives, if any, an ambulance patient offload time reduction protocol that addresses all of the following factors:

(1) Notification of hospital administrators, nursing staff, medical staff, and ancillary services that the local EMS agency standard for ambulance patient offload time has been exceeded for one month.

(2) Mechanisms to improve hospital operations to reduce ambulance patient offload time, which may include, but are not limited to, activating the hospital's surge plan, transferring patients to other hospitals, suspending elective admissions, discharging patients, using alternative care sites, increasing supplies, improving triage and transfer systems, and adding additional staffing.

(3) Systems to improve general hospital coordination with the emergency department, including consults for emergency department patients.

(4) Direct operational changes designed to facilitate a rapid reduction in ambulance patient offload time to meet the local EMS agency standard adopted pursuant to subdivision (b) of Section 1797.120.5.

DEFINITIONS:

A. APOT Standard: AB 40 Statute 1797.120.5 requires an APOT standard of less than 30 minutes, 90% of the time for general, acute care hospitals with EDs
B. Ambulance Arrival Time: The time an ambulance wheels stop in the EMS bay outside the ED where the patient will be unloaded from the ambulance
C. Ambulance End Time: The time a patient is transferred to an ED gurney, bed, chair, or other acceptable location and the emergency department assumes responsibility for care of the patient as signified by an electronic signature on EMS Patient Care Report (ePCR).
D. Ambulance Patient offload time (APOT): The interval between the arrival of an ambulance patient at an ED and the time the patient is transferred to an ED gurney, bed, chair, or other acceptable location and the ED assumes responsibility for care of the patient
E. Ambulance Patient Offload Delay (APOD): The occurrence of a patient remaining on an ambulance gurney and/or the receiving facility staff has not assumed patient care beyond the EMS agency-approved APOT standard of 30 minutes

PURPOSE:

A. To create a protocol that can be used by Medical Centers to respond to exceedance of the APOT Standard, maintain APOT within the state standard, respond proactively to daily fluctuations in ED capacity and throughput, and maintain the highest quality care for our patients and communities. Hospital leaders, ED physicians and managers, and applicable represented staff worked together to implement the Ambulance Patient Offload Time (APOT) Reduction Protocol described below.

Ambulance Patient Offload Time (APOT) Reduction Protocol

Names of Team Members Completing Form*: *Greg Smith (Kaiser Permanente NCAL Regional Medical Director for EMS and Ambulance services), Rachel Wyatt (Chief Operating Officer), Jennifer Stewart (Associate Chief Administrative Officer), Maya Leggett (Assistant Physician In Chief for Hospital Operations), Karen Hansen (ED Service Director), Andrew Elms (Physician In Chief), Amy Richards (EMS Liaison), Beata Ciesielski (Continuum Administrator), James Sinclair (ED nurse), Jennifer Williams (ED nurse), Veronica Madrigal-Zamora (Business Consultant)

Medical Center*: *Kaiser Foundation Hospitals – South Sacramento

Date:* *8/19/2024

Step 1: Define Local APOT Threshold to trigger escalation protocol

- Last month's reported APOT1 (90th percentile offload time as reported to the state)
- No. of Ambulances waiting to offload (i.e. maximum # of ambulances on the wall before protocol is triggered)
    - Threshold: Total wait time of all ambulances greater than 20 minutes
- Longest APOT
    - Threshold: 20 minutes

Step 2: Select who will initiate APOT escalation

- ED Charge RN or ED ANM
- MICN escalation to AMN

Step 2A: Turn on Operations Watch List (OWL) Notification System (OWL application build in progress)

- Facility will plan to utilize OWL notifications once build is complete

Step 3: Persons who are recipients of the escalation

- ED Nurse Manager
- ED Director
- ED Chief or ED MD Admin on call
- Associate Chief Administrative Officer
- APIC of Hospital Operations
- CWD Director
- COO
- CNE
- Kaiser Permanente NCAL Regional Medical Director for EMS and Ambulance services
- House Supervisor
- Pre-hospital Liaison
- Continuum Administrator

Step 3A: Mode of communication that will be used to notify staff

- Text

Step 3B: Additional components and metrics to communicate for escalation notice

- Number and type of patients in the ED pending admission to hospital
- Overcrowding scores (i.e. NEDOCs)
- Number of waiting room patients and or wait time
- Boarding patients that decrease ED capacity but are not pending admission to medical hospital

Step 4: Levers to Mitigate APOT

INFLOW

- Ambulance Offload – Offload ambulances directly to waiting room
- Ambulance Offload – Utilize Ambulance Triage RN to assess patients using clinical criteria
- Consolidate ambulances on the wall – *With prior EMS approval, assign one ambulance crew / EMS supervisor to monitor 2-4 patients and release transport crews back to field*
- Activate hospital surge plan
- Repatriations – Review capacity to accept Repatriations; follow escalation process if unable to accept repatriations

Step 5: Coordinate APOT reduction protocol activation and monitor decompression

- Establish a local APOT work group / committee to ensure sustainability and compliance with AB40 requirements. Recommended membership: ED director, ED chief, COO, ACAO, CNE, APIC hospital operations, government relations, ASQO, EMS liaison physician.
    - The APOT workgroup will report out monthly to MEC
- Plan discussed at ED and Hospital Operation Huddles until APOT exceedance is resolved
- Consider Opening Local Command Center to streamline communication and execute strategies for effective throughput in ED and inpatient space
- If escalation protocol is triggered externally (i.e. by county within service area), attend report-outs with county to communicate execution of de-escalation protocol