AR EMS ADVISORY COMMITTEE – PROPOSAL FOR ADVISORY

Proposed Title: Review and Discussion of EMS Wall Times, Hospital Bed Delays, and Ambulance Patient Offload Times in Arkansas

Subcommittee: Sustainability and Efficiency Subcommittee

1. Describe the PROBLEM that the advisory is attempting to address

- Ambulance patient offload time (APOT), also referred to as "wall time" or "ambulance parking," is the interval between an ambulance's arrival at a receiving hospital and the point at which the patient is fully handed off to hospital staff. When this interval is prolonged, the ambulance and its crew remain out of service and unavailable to respond to other 911 calls, interfacility transfers, or mutual aid requests.
- National data confirms this is a large and growing problem, not an isolated or anecdotal one:
    i. Per the AHRQ Summit to Address Emergency Department (ED) Boarding (October 2024), the national median ED boarding time (from admission decision to inpatient bed placement) rose from 121 minutes in 2020 to 192 minutes in 2022, and under certain circumstances roughly a quarter of admitted patients remain in the ED more than seven hours after the admission decision.
    ii. The same report found that more than one in five hospital transports leave an ambulance out of service for an hour or more, and that EMS agencies nationally reported approximately 890,000 transports with delayed returns to service in 2023 — including isolated cases of a single crew held for more than 24 hours at one hospital.
    iii. Extended offload times reduce the number of ambulances available to respond to time-critical calls (cardiac arrest, stroke, trauma) within a coverage area, which the AHRQ report links to delayed response and increased morbidity and mortality risk on those subsequent calls.
    iv. Both the AHRQ summit and the ACEP Boarding Summit report identify ED and hospital boarding of already-admitted patients — driven by inpatient bed shortages, discharge bottlenecks, and misaligned financial incentives — as the principal upstream root cause of ambulance offload delay, not something EMS agencies or emergency departments alone can fix.
- On November 7, 2024, the National EMS Advisory Council (NEMSAC) sent a formal letter to the Federal Interagency Committee on EMS (FICEMS) describing ambulance patient offload delay ("APOD"), "wall time," and "parking" as a crisis that has existed since at least 2006 and is worsening rapidly — citing compromised patient care, disrupted EMS system availability, increased EMS costs, and worsening clinician burnout and workforce attrition as consequences.
- A review of the Arkansas EMS Rules found no provision addressing ambulance turnaround or offload time, hospital wall time, ambulance diversion, or ED overcrowding of any kind. As a result:
    i. There is no standardized statewide definition of when EMS-to-hospital patient handoff occurs, so even individual services or hospitals that informally track offload time may not be measuring the same interval the same way.
    ii. There is no mechanism to combine Arkansas's existing EMS data (collected through the state's NEMSIS-based EMS data system) with hospital-side data to identify which facilities, regions, or times of day or week contribute most to lost ambulance availability statewide.

iii. Without shared, credible data, individual EMS agencies raising concerns with individual hospitals have limited leverage, and the Committee itself currently has no factual basis on which to recommend targeted, evidence-based solutions.

- Other states have already moved to close this gap. Georgia's Department of Public Health operates a statewide Ambulance Patient Offload Time (APOT) program built on standardized NEMSIS data elements, with a goal of completing patient transfer within 20 minutes, 90% of the time, and quarterly/monthly public reporting by facility. California's AB 40 established a statewide APOT standard (offload within 30 minutes, 90% of the time), electronic time-stamped transfer-of-care signatures, mandatory hospital-filed annual offload-reduction protocols, and a state audit portal reconciling EMS and hospital data. Arkansas currently has no comparable statewide framework of any kind.

2. What is the end goal of the advisory and its associated recommendation(s)?

- The end goal of this advisory is not to immediately mandate a specific offload-time standard or penalty structure for Arkansas hospitals. Consistent with the AHRQ and ACEP summit conclusions that boarding and offload delay is a whole-system, hospital-capacity problem rather than something EMS or a single emergency department can solve alone, the Committee's immediate goal is to build the data foundation needed to understand and act on Arkansas's specific situation:
    i. Establish a standardized, statewide definition of ambulance patient offload time / "wall time," consistent with terminology used by NEMSAC, AHRQ, and NEMSIS, so that all EMS agencies and hospitals in Arkansas measure the same interval the same way.
    ii. Direct the ADH Section of EMS to work with Arkansas EMS agencies (through the state's existing NEMSIS-based EMS data system) and Arkansas hospitals or the Arkansas Hospital Association to begin systematically collecting offload-time and related boarding data on a defined, recurring basis.
    iii. Aggregate and analyze that data to quantify, statewide and by facility or region, the true scope of ambulance offload delay in Arkansas: total EMS unit-hours lost, the facilities or regions with the most significant impact, and time-of-day or seasonal patterns.
    iv. Use that data to identify a limited number of high-impact problem areas — specific facilities, regions, or systemic causes — where the Committee can focus subsequent, targeted recommendations.
    v. Report initial findings back to the full EMS Advisory Committee, along with a recommendation on whether Arkansas should adopt a formal statewide offload-time standard (comparable to Georgia's or California's) once baseline data is available.
- In short, this advisory asks the Committee to make Arkansas's wall-time and boarding problem visible and measurable before recommending a specific fix, so that any future policy the Committee proposes is targeted at the state's actual, documented problem areas rather than modeled solely on other states' experience.

3. What action will you be asking the target audience (i.e. State Legislature, Secretary of Health, Board of Health, Section of EMS, etc) take and is it in their statutory authority to take action?

- This advisory will ask the Arkansas Department of Health, Section of EMS, in collaboration with the AR EMS Advisory Committee Sustainability and Efficiency Subcommittee, to:

- Convene a joint workgroup with EMS agency representatives, hospital/emergency department representatives (in coordination with the Arkansas Hospital Association where appropriate), and ADH data staff to define standardized ambulance patient offload time data elements for Arkansas, consistent with NEMSIS and national terminology.
- Begin systematic, recurring collection of offload-time and related boarding data from Arkansas EMS agencies and participating hospitals.
- Analyze the resulting data to identify the scope of the problem statewide and the specific facilities or regions most responsible for lost ambulance availability.
- Report findings and a follow-on recommendation to the full EMS Advisory Committee.
- The ADH Section of EMS has statutory and regulatory authority over EMS agency licensure and EMS system data collection, including the data Arkansas EMS agencies already report through the state's EMS data system. Hospital-side data collection and any future hospital reporting requirement may require coordination with, or complementary authority from, the Arkansas Department of Health's hospital licensing functions, the Arkansas Hospital Association, or the Legislature, since hospitals are not themselves EMS-licensed entities under the Arkansas EMS Rules.

4. Is the action within the target audience's regulatory authority (Yes or No)? If no, what is the proposed solution to achieve the targeted recommendations?

- Partially. The ADH Section of EMS has clear authority to direct data collection from EMS agencies and to convene stakeholder discussion. Imposing a data-reporting or performance-standard requirement directly on hospitals, however, would likely require voluntary hospital or hospital-association participation, a formal data-sharing agreement, or — if a mandatory hospital-side reporting or performance requirement is ultimately recommended — action through the Department's hospital licensure authority, the Arkansas Legislature (as California did through AB 40), or coordination with CMS Conditions of Participation, which the AHRQ summit report identifies as an available federal policy lever.
- Proposed solution: the Section of EMS should pursue the initial phase described in Section 2 — standardized definitions and EMS-side data collection — fully within its own existing authority, while formally requesting voluntary participation from the Arkansas Hospital Association and individual hospitals for the hospital-side data. Any recommendation for a mandatory hospital reporting or performance standard would be reserved for later Committee and, if needed, legislative consideration once Arkansas-specific data is in hand.

5. Does federal or state guidance already exist for this topic? If so, is there a gap in the guidance provided for EMS? Will this advisory assist in closing that gap?

- Yes, substantial national attention already exists: NEMSAC's November 2024 letter to FICEMS; AHRQ's October 2024 ED Boarding Summit and resulting technical report; ACEP's independent Boarding Summit and report; and The Joint Commission's existing standard (in place since 2012) that ED boarding should not exceed four hours. None of this, however, is a binding requirement on Arkansas specifically — the AHRQ summit report notes that the Joint Commission's four-hour standard is routinely violated and lacks enforcement teeth absent federal action, and current federal guidance is oriented toward national policy levers (such as CMS Conditions of Participation) rather than state-level implementation.

- At the state level, a small number of states — including Georgia and California — have independently built their own statewide offload-time definitions, data systems, and standards, and the American Ambulance Association has published a multi-state "Wall Time Toolkit" of comparable models. Arkansas has not yet adopted any of these approaches.
- The gap for Arkansas specifically is that none of this national attention or other states' models have yet been translated into Arkansas-specific data, definitions, or policy. This advisory would begin closing that gap by starting with the foundational step — shared definitions and shared data — that NEMSAC, AHRQ, and ACEP each identify as a prerequisite to meaningful, targeted action.

National and Comparative State Data – EMS Wall Times and ED Boarding

Source / Model	Key Data or Requirement	Relevance to Arkansas
AHRQ Summit to Address ED Boarding (Oct. 2024)	National median ED boarding time rose from 121 minutes (2020) to 192 minutes (2022); more than 1 in 5 hospital transports leave an ambulance out of service for an hour or more; roughly 890,000 EMS trips nationally had delayed returns to service in 2023.	Establishes the scale and trend of the problem nationally; Arkansas currently has no comparable data of its own to know where it stands.
NEMSAC Letter to FICEMS (Nov. 7, 2024)	Describes ambulance patient offload delay ("APOD"), "wall time," and "parking" as a worsening crisis dating to at least 2006; recommends a longitudinal federal task force with meaningful EMS stakeholder representation.	Frames offload delay as an EMS system-availability and workforce issue, not solely a hospital-side problem — relevant to how the Committee should scope Arkansas's own review.
ACEP Boarding Summit Report	Recommends publicly available boarding quality measures (average boarding time, % of ED capacity consumed by boarders) and payment incentives tied to boarding time; cites an Oregon centralized data system that reduced boarding from 28 hours to 4.7 hours.	Demonstrates that standardized measurement and public reporting are foundational to any effective boarding-reduction strategy, before specific remedies are chosen.
Georgia APOT Program	Statewide NEMSIS-based data collection across all EMS agencies; goal of completing patient transfer within 20 minutes, 90% of the time; quarterly/monthly public reporting by facility.	A working statewide EMS-hospital data model built on the same NEMSIS data elements Arkansas EMS agencies already report.
California AB 40	Statewide APOT standard (offload within 30 minutes, 90% of the time); electronic time-stamped transfer-of-care signatures; mandatory hospital-filed annual reduction protocols; state audit portal reconciling EMS and hospital data.	An example of a state that progressed from data collection to an enforceable statewide standard once the scope of the problem was documented.
Arkansas (current state)	No statewide definition, data-collection requirement, or reporting mechanism for ambulance patient offload time exists anywhere in the Arkansas EMS Rules.	This is the specific gap this advisory is intended to begin closing.

Sources: AHRQ, Summit to Address Emergency Department Boarding: Technical Report (Oct. 2024); NEMSAC, Letter to FICEMS Re: EMS Wall Times Crisis in America (Nov. 7, 2024); ACEP, Boarding Summit Final Report; Georgia Department of Public Health, Office of EMS and Trauma, Ambulance Patient Offload Time program; California AB 40 (2023) and implementing APOT regulations.