SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

AMBULANCE PATIENT OFFLOAD ~~TURNAROUND~~ TIME (APOT) STANDARD
PUBLIC COMMENT NOVEMBER 2026

EFFECTIVE DATE: ~~10/1/26~~xx/xx/xx *POLICY REFERENCE NO: 4000.1* *SUPERSEDES: ~~7/1/25~~10/1/26*

~~1. PURPOSE~~

~~1.1. To define the goals for ambulance turnaround and patient offload times.~~

~~2. BACKGROUND~~

~~2.1. Patient transfer from ambulance to hospital is a critical part of emergency care, both for the individual patient at the hospital and to preserve the availability of ambulances to answer 911 calls for medical assistance throughout the San Francisco EMS System.~~

~~3.~~1. DEFINITIONS

1.1. **Ambulance arrival at the Emergency Department (ED) (eTimes.11)** – The time the ambulance stops (actual wheel stop) at the location outside the ~~hospital~~ general acute care hospital (GACH) ED where the patient is unloaded from the ambulance. This data element is reflected in DEC's Computer Aided Dispatch (CAD) system.

1.2. **Ambulance decontamination delay** – Notification is made to Division of Emergency Communications (DEC) by EMS personnel that excessive post-call cleaning or decontamination is needed to place ambulance back into service. This may apply to Code 3 transports and some Code 2 calls in which excessive body fluids, infestation, or hazards (e.g. glass) are present that could potentially expose EMS personnel or patient on a subsequent call. A decontamination delay is not declared for routine Code 2 transports or patient care.

1.3. **Ambulance delayed in triage** – Notification is made to DEC by ambulance crew that a back-up is occurring at GACH triage, intake, or with movement of patient off gurney. Declaration may be made after: 10 minutes from the time the ambulance parks at a GACH as noted in CAD. Once patient is physically moved off gurney, subsequent notification to DEC is required to indicate there is no longer a delay.

1.4. **Ambulance level** – The quantity of available ambulances in the EMS system.

~~3.1.~~

~~3.2.~~1.5. **Ambulance patient offload time (APOT-1)** – ~~The time when a patient is physically removed from the ambulance gurney to hospital equipment and transfer of care has been completed, as recorded by a signature from an ED nurse or doctor in a patient's EMS electronic patient care report (ePCR).~~ The interval between the arrival of an ambulance patient at an ED bay and the time the patient is transferred to an ED gurney, bed, chair and the ED

assumes responsibility for care of the patient. APOT-1 is calculated in minutes by subtracting eTimes.12 minus eTimes.11.

~~3.3.~~**1.6. Ambulance return to service time (eTimes.13)** – The time the ambulance is response ready after transporting a patient to a ~~hospital~~ GACH ED.

~~**3.4. Offload time interval** - The period of time between ambulance arrival at the ED and ambulance patient offload time.~~

~~**3.5. Ambulance level** – The quantity of available ambulances in the EMS system.~~

~~3.6.~~**1.7. Ambulance turnaround interval** - The period of time between ambulance arrival at the ED (eTimes.11) and ambulance return to service time (eTimes.13).

~~**3.7. Ambulance decontamination delay** – Notification is made to Division of Emergency Communications (DEC) by EMS personnel that excessive post-call cleaning or decontamination is needed to place ambulance back into service. This may apply to Code 3 transports and some Code 2 calls in which excessive body fluids, infestation, or hazards (e.g. glass) are present that could potentially expose a EMS personnel or patient on a subsequent call. A decontamination delay is not declared for routine Code 2 transports or patient care.~~

~~**3.8. Ambulance delayed in triage** – Notification is made to DEC by ambulance crew that a back-up is occurring at hospital triage, intake, or with movement of patient off gurney. Declaration may be made after: 10 minutes from the time the ambulance parks at a hospital as noted in CAD. Once patient is physically moved off gurney, subsequent notification to DEC is required to indicate there is no longer a delay.~~

1.8. APOT Electronic Signature (eOther.19) – An electronic signature within the ePCR used to confirm transfer of care by the Physician or Registered Nurse. eOther.19 is not used in the APOT-1 interval calculation but shall be used as independent verification of eTimes.12 documented manually by EMS personnel.

1.9. General Acute Care Hospital (GACH) – A hospital, licensed by the California Department of Public Health, having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which providers 24-hour inpatient care including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services.

1.10. Medic to Follow – An event where a 9-1-1 call is pending and no ambulance is available to respond.

1.11. National/California Emergency Medical Services Information System (NEMSIS/CEMSIS) – The national (or California) repository used to store secure, standardized, and centralized EMS data. The four NEMSIS elements for APOT are eTimes.11, eTimes.12, eTimes.13, and eOther.19 as defined in this Section.

1.12. Technical Specification to Calculate APOT – The standardized state-wide guidance document on data elements, inclusion/exclusion criteria, and calculation methodologies to ensure statewide uniformity in APOT reporting and analysis. This specification uses NEMSIS data elements.

~~3.9.~~ **Transfer of Care (eTimes.12)** – The time an ambulance patient is physically transferred to an ED gurney, bed, chair, or waiting room and ED staff received a patient report. eTimes.12 is

manually entered by EMS personnel. The transfer of care time is independently confirmed by a Physician or Registered Nurse with an electronic signature in the prehospital care record (ePCR) (eOther.19).

2. PURPOSE

2.1. Patient transfer from ambulance to GACH is a critical part of emergency care, both for the individual patient at the GACH and to preserve the availability of ambulances to answer 9-1-1 calls for medical assistance throughout the San Francisco EMS System.

2.2. To define the goals for ambulance turnaround and patient offload times.

2.3. To comply with state statutory and regulatory requirements.

~~4.~~3. POLICY

~~4.1.~~**3.1.** The goal for the offload time interval is 20 minutes or less, 90 percent of the time (APOT-1). Under ~~Health and Safety Code 1797.120.5~~Health and Safety Code 1797.120.5 and upper threshold under Section 8~~10.1~~, the APOT-1 standard shall not exceed 30 minutes, 90 percent of the time.

~~4.2.~~**3.2.** The goal for the ambulance turnaround interval is 30 minutes or less, 90 percent of the time.

3.3. ~~Receiving facility~~GACH staff may perform minimal risk procedures (e.g. blood draw etc), while the staff continue~~s~~ to work on finding a location for the patient in the ED or waiting room. ~~Hospitals~~ GACHs shall not administer medications.

3.4. EMS provider agencies and GACHs are required to provide training to all field personnel and ED staff on APOT documentation procedures, time intervals, and Policy 4000.1.

4. TRANSFER OF CARE AND DOCUMENTATION

4.1. EMS personnel shall ensure that the following data elements are documented accurately:

- **4.1.1.** Correct GACH destination
- **4.1.2.** Correct area within GACH (e.g. ED, non-ED for IFT admissions)
- **4.1.3.** Arrival at ED (eTimes.11)
- **4.1.4.** Transfer of Care (eTimes.12)
  - **4.1.4.1.** The APOT clock stops and Transfer of Care occurs when the ambulance patient is physically moved to an ED gurney, bed, chair, or waiting room and a patient report is given.

4.2. Prior to signing the ePCR, Physician and Registered Nurse GACH staff shall:

- **4.2.1.** Ask EMS personnel to view the ePCR to verify the manually documented Transfer of Care time (eTimes.12).
- **4.2.2.** If Transfer of Care time (eTimes.12) is documented within 2 minutes, sign the ePCR which is recorded as (eOther.19). See Appendix A for examples of ePCR signature screenshots.
- **4.2.3.** Document the EMS personnel's Transfer of Care time (eTimes.12) in the GACH's Electronic Health Record (EHR) to avoid a mismatch between EMS and GACH times.
- **4.2.4.** If there is a discrepancy when signing for patient, the times shall be reconciled in the

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moment. If GACH staff notice EMS personnel did not get a signature at the exact moment in time of Transfer of Care or there is an unresolved discrepancy (e.g. EMS personnel went to ambulance, asked for signature later, or obtained no signature at all). GACH staff shall take the following steps:

4.2.4.1. Sign the ePCR and hand-write in the correct time within the ePCR signature box.

4.2.4.2. Obtain the unit number, arrival time, and EMS provider agency.

~~**4.3.**~~ Send an email within 12 hours to exceptionreport@sfgov.org, which will be forwarded to the appropriate EMS provider agency.

5. PARAMEDIC/EMT-INITIATED OFFLOAD

5.1. Unless a bed is immediately available to offload patient, EMS personnel, Paramedic or EMT, should offload patients directly to a San Francisco ~~hospital~~ GACH ED waiting room under the following conditions:

5.1.1. The patient is logged and/or registered on the ED patient tracking board.

5.1.2. The patient meets the following criteria:

5.1.2.1. No complaint or assessment finding that is suggestive of the need for time-sensitive intervention, examples include but are not limited to:

- Uncontrolled bleeding
- Chest pain
- Difficulty breathing
- Active seizure
- Acute psychiatric/combativeness

5.1.2.2. Patient is 18 years or older or is a minor accompanied by a parent/guardian who has decision-making capacity.

5.1.2.3. A minimum of two sets of stable vital signs (age appropriate **Normal Pediatric Vital Signs**) at patient's baseline or within alternate destination criteria EMSA Policy # 5000.2 (Triage to Alternate Destination Eligibility Criteria)~~**Policy 5000.2 Triage to Alternate Destination Transport Eligibility Criteria**~~.

5.1.2.4. Alert and oriented to person, place, time, and situation

5.1.2.5. No intravenous, intraosseous, intramuscular or intranasal medications were administered by prehospital personnel (including bystander use of Naloxone) that require close monitoring. Examples of acceptable medication may include: ibuprofen, ketorolac, normal saline, ondansetron, olanzapine (with documented patient improvement).

5.1.2.6. In the judgement of the Paramedic, the patient does not require continuous cardiac or respiratory monitoring.

5.1.2.7. The patient does not require a saline lock or intravenous (IV) line. If a saline lock or IV line was placed in the prehospital setting, it can be removed by the paramedics. No patient with IV access shall be placed in an ED waiting room.

5.1.2.8. The patient can maintain a sitting position without adverse impact on their medical condition, dignity, or obvious risk of fall. The patient should have the ability to ambulate by walking or with an assistive device (wheelchair, walker)

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and with minimal assistance.

5.1.2.9. The patient is not on a 5150 hold, expressing suicidal ideation to self or thoughts/intent to harm others and/or clinically intoxicated with drugs or alcohol.

5.1.2.10. The location to which the patient was triaged must be clearly documented in the prehospital ePCR.

5.1.2.11. If the patient does not initially meet above criteria, EMS personnel will continue to monitor. The patient should be reassessed every 15 minutes. If the patient eventually meets criteria to offload to ED waiting room with two consecutive 15-minute assessments (30 minutes minimum), offload to waiting room may occur.

5.1.2.12. By electing to use this option, the ambulance shall return to service within 10 minutes of patient movement off gurney and turnover to ED waiting room.

5.2. Documentation

5.2.1. If patient is being offloaded into the waiting room, a verbal report and a copy of the prehospital run sheet must be provided or available to a charge nurse or their designee prior to leaving the patient at the ~~hospital~~GACH.

5.2.1.1. EMS personnel will make every effort to complete an in-person transfer of care to an accepting ED staff with clinical authority to accept patients.

5.2.1.2. If ED staff are unwilling to accept report or sign documentation, EMS shall document in ePCR. ~~(Electronic Patient Care Report).~~

5.2.1.3. For any patient transported to the ED waiting room, EMS personnel shall document:

- The specific criteria met for waiting room placement
- Name and title of the person notified
- Patient disposition, including:
  - Location
  - Waiting room chair
  - Wheelchair

6. APOT ALERT DECLARATION

6.1. EMS personnel shall work collaboratively with ~~hospital~~ GACH staff to identify offload delays, develop solutions, and formulate a plan for patients currently waiting on gurneys. Every attempt shall be made to triage patients to alternative waiting spaces such as waiting areas, fast track areas, wheelchairs, or hallways spaces.

6.2. The on-duty EMS Supervisor (e.g. Rescue Captain at DEC), monitoring APOT, shall call the Emergency Department Charge Nurse to confirm ambulance offload delays and obtain an ETA to transfer care.

6.3. Should all reasonable attempts to offload patients to other areas fail AND criteria is met below, the EMS Supervisor shall declare an "APOT Alert:"

6.3.1. APOT Alert Criteria:

6.3.1.1. 1 or more ambulances delayed for 60 minutes or greater regardless of

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Ambulance Level.

6.3.1.2. 1 or more ambulances delayed for 30 minutes or greater with Medic to Follow event(s).

6.3.2. An APOT Alert:

6.3.2.1. Is a formal declaration, similar to an MCI Yellow or Red Alert.

6.3.2.2. Is for situational awareness to all field ambulance crews.

6.3.2.3. During a declared APOT Alert, a ~~Receiving Facility~~GACH's Stroke and STEMI specialty care designation is temporarily suspended if a patient is equidistant to another facility by traffic or distance. Crews should avoid transporting these patients to the impacted ~~Receiving Facility~~GACH if at all possible and safe to do so based on patient condition and other equidistant ~~Receiving Facilities~~GACH with the same specialty care designation.

6.3.2.4. Is in effect until ambulances are cleared from the ~~Receiving Facility~~GACH.

6.3.3. Steps for DEC:

6.3.3.1. When announcing Diversion, advise of "APOT Alert" declaration.

6.3.3.2. Send a notification to all crews via CAD Mobile Data Terminals advise of APOT Alert and to avoid taking Stroke and STEMI patients to the affected ~~Receiving Facility~~GACH with an active APOT Alert if equidistant to other ~~Receiving Facilities~~GACHs.

6.3.3.3. Post banner on ReddiNet announcing the APOT Alert at the affected ~~Receiving Facility~~GACH.

6.3.3.4. Sent ReddiNet message to EMS ~~Providers~~provider agencies, EMSA, and affected ~~Receiving Facility~~GACH announcing APOT Alert declaration.

6.3.3.5. Notify ~~SF~~ EMS Agency (EMSA) Duty Officer.

6.3.3.6. Send follow-up message when APOT Alert secured.

6.3.4. Steps for ~~Receiving Facility~~GACH:

6.3.4.1. Charge nurse shall immediately notify House Supervisor and Administrator on Call.

6.3.4.2. Consider activation of HICS (Hospital Incident Command System)

6.3.4.3. Consider activation of emergency surge plans including use of:

- Alternate treatment spaces (ie tents, unoccupied ~~hospital~~ GACH wards/floors)
- Staff call-ins, modification of nursing ratios

6.4. Steps for field EMS Supervisor:

6.4.1. A field EMS Supervisor should be dispatched after an APOT Alert is declared.

6.4.2. Upon arrival to the facility, the EMS Supervisor shall identify themself and check-in with ED Charge Nurse and/or ~~Hospital~~ GACH Supervisor to confer about the cause of the ambulance offload delay.

6.4.3. EMS Supervisor shall ensure any EMS patients meeting Section 5 criteria are offloaded to waiting room. EMS Supervisor shall notify ED Charge Nurse and/or ~~Hospital~~ GACH Supervisor that continued delays may lead to re-triage to other ~~Receiving Facilities~~GACHs should all other options fail.

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6.4.4. Immediately re-triage patients to other ~~Receiving Facilities~~GACHs that are less impacted if the time to transport and transfer care to another ~~Receiving Facility~~GACH is less than the estimated time to transfer care at the facility with the declared APOT Alert. The patient shall be asked and must consent prior to re-triage to another ~~Receiving Facility~~GACH. Re-triage of any patient must be done as a last resort in order to protect public safety and health (e.g. no ambulances available to respond to 911 call).

6.4.4.1. For any re-triage of patients to other ~~Receiving Facilities~~GACHs, ~~the EMS Agency~~EMSA shall review the incident and forward to California Department of Public Health for ~~Emergency Medical Treatment and Active Labor Act~~Emergency Medical Treatment and Active Labor Act (EMTALA) violations.

6.5. Documentation

6.5.1. The following shall be documented in the ePCR:

6.5.1.1. Detailed description of attempts to offload patient and transfer care to ~~hospital~~ GACH staff

- Reasonable attempts include but not limited to:
  - Multiple attempts to obtain a signature for the ePCR
  - Multiple attempts to provide a patient report either written or verbal
  - Attempt to interact with an ED supervisor, charge nurse, and/or ~~hospital~~ GACH administrator
  - Attempt to utilize EMS Supervisor in offloading patient

6.5.1.2. Any additional transports to other facilities

6.5.1.3. Patient deterioration due to delays in patient transfer

6.6. Upon conclusion of the APOT Alert, the EMS Supervisor shall:

6.6.1. Announce the APOT Alert is secured.

6.6.2. File an exception report to ~~the EMS Agency~~EMSA within 12 hours.

7. DATA COLLECTION, AUDIT PROCESS, AND QUALITY IMPROVEMENT

7.1. APOT Audit Process (GACH)

7.1.1. GACHs may participate in the state-led APOT audit process to identify discrepancies. GACH APOT appeals or discrepancies must be submitted through the state EMS Authority APOT portal.

7.1.2. GACHs are encouraged to review APOT records for discrepancies over the course of the month. Appeals must be submitted no later than the 10th of the month for the preceding month's data.

7.1.3. EMSA will not accept, forward, nor review GACH APOT audit submissions after the 10th of the month.

7.1.4. GACHs should not submit appeals for the following scenarios. EMSA will not forward the following to EMS provider agencies for review:

7.1.4.1. Transfer of Care (eTimes.12) and APOT Electronic Signature (eOther.19) are within 2 minutes.

7.1.4.2. Using GACH triage time as the basis for the APOT appeal. Ambulance arrival at the ED bay is the correct data element and reflected in CAD (eTimes.11).

7.1.4.3. The appealed APOT-1 interval is thirty (30) minutes or less.

7.2. APOT Audit Process (EMSA)

7.2.1. Upon receipt of the City-wide APOT Audit report, further assess and remove any APOT appeals meeting Section 7.1.4 criteria.

7.2.2. Forward APOT appeals to each EMS provider agency for review within one (1) business day of receipt of the APOT audit report from the state EMS Authority.

7.2.3. Provide NEMSIS/CEMSIS data to GACHs and EMS provider agencies, as requested, for process improvement efforts.

7.3. APOT Audit Process (EMS provider agencies)

7.3.1. Upon receipt of APOT appeals from GACHs throughout the month, either through EMS provider agency quality improvement activities or through the state APOT report, review each appeal or discrepancy for accuracy.

7.3.2. Should the EMS provider agency agree with the appeal or discrepancy, correct the ePCR and resubmit the revised ePCR no later than the 15th calendar day of the month for the preceding month. EMS provider agencies should notify EMSA of the revised record(s).

7.3.3. Should the EMS provider agency disagree with the appeal or discrepancy, notify EMSA and provide the basis for the unresolved discrepancy.

7.3.4. To limit the number of APOT appeals and discrepancies, EMS provider agencies must track organizational APOT-1 trends, metrics, and secondary/revised submissions by individual EMS personnel to identify opportunities for continuous improvement, additional training, and operational oversight.

7.4. Quality Improvement

7.4.1. EMS provider agencies should complete quality improvement activities for patients placed in the ED waiting room:

7.4.1.1. Patients that met offload criteria were placed in the waiting room.

7.4.1.2. Appropriate feedback given to EMS personnel for patients who did not meet criteria.

7.4.2. EMSA will report monthly the following ("GACH Report"):

7.4.2.1. Offload time interval for each EMS provider agency at each ED.

7.4.2.2. Ambulance turnaround interval for each EMS provider agency at each ED.

7.4.2.3. System aggregate intervals for patient offload and ambulance turnaround intervals at each ED.

7.4.2.4. EMSA shall publish the report to key partners and publicly post APOT times by GACH on the EMSA website.

7.4.3. EMSA will focus on identifying the root causes for delays, surges in demand and to what extent diversion impacts offload and turnaround intervals.

~~7.~~**7.4.4.**

~~**7.1.** All interval measurements shall be reported monthly (on the first business day of the month) to the EMS Agency in an approved electronic format.~~

~~**7.2.** Turnaround time data submitted by providers shall include date, time, location, call~~

~~disposition (Code 2 or Code 3), arrival time at hospital, ambulance patient offload time and ambulance return to service time.~~

~~**8. QUALITY IMPROVEMENT**~~

~~**8.1.** Providers should complete quality improvement activities for patients placed in the ED waiting room:~~

~~**8.1.1.** Patients that met offload criteria were placed in the waiting room~~

~~**8.1.2.** Appropriate feedback given to EMS personnel for patients who did not meet criteria~~

~~**8.2.** The EMS Agency will report monthly the following ("Hospital Report"):~~

~~**8.2.1.** Offload time interval for each provider at each ED.~~

~~**8.2.2.** Ambulance turnaround interval for each provider at each ED.~~

~~**8.2.3.** System aggregate intervals for patient offload and ambulance turnaround intervals at each ED.~~

~~**8.3.** The EMS Agency will focus on identifying the root causes for delays, surges in demand and to what extent diversion impacts offload and turnaround intervals.~~

~~9.~~8. QUALITY ASSURANCE

~~9.1.~~8.1. Based on the ~~Hospital~~ GACH Report, ~~the EMS Agency~~EMSA may take action on a ~~Receiving Facility~~GACH, as detailed in EMSA Policy # 5010 (Receiving Hospital Standards)~~**Policy 5010 Receiving Hospital Standards**~~, who have a:

~~9.1.1.~~8.1.1. 90th percentile APOT-1 time under 30 minutes, but greater than the 20-minute standard, ~~the EMS Agency~~EMSA will continue to monitor via quality improvement in subsequent months

~~9.1.2.~~8.1.2. 90th percentile APOT-1 time over 30 minutes for two (2) consecutive months

~~9.1.2.1.~~8.1.2.1. ~~The EMS Agency~~EMSA shall refer to corrective action plan process as detailed in Policy 5010

~~10.~~9. AUTHORITY

9.1. California Health and Safety Code, Division 2.5~~,~~ §§~~Sections~~ 1797~~1~~.120, 1797~~1~~.120.5-7, 1797.204, 1797.206, 1797.220, 1797.224, 1797.225, 1797.252, and 1798.

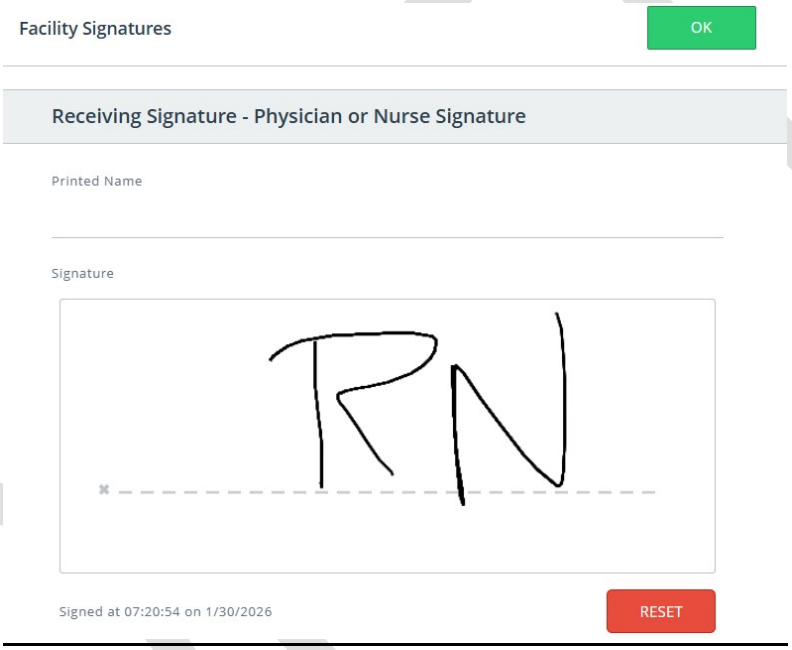
9.2. California Code of Regulations, Title 22, Chapter 1.2 §§ 100001.01-100007.05.

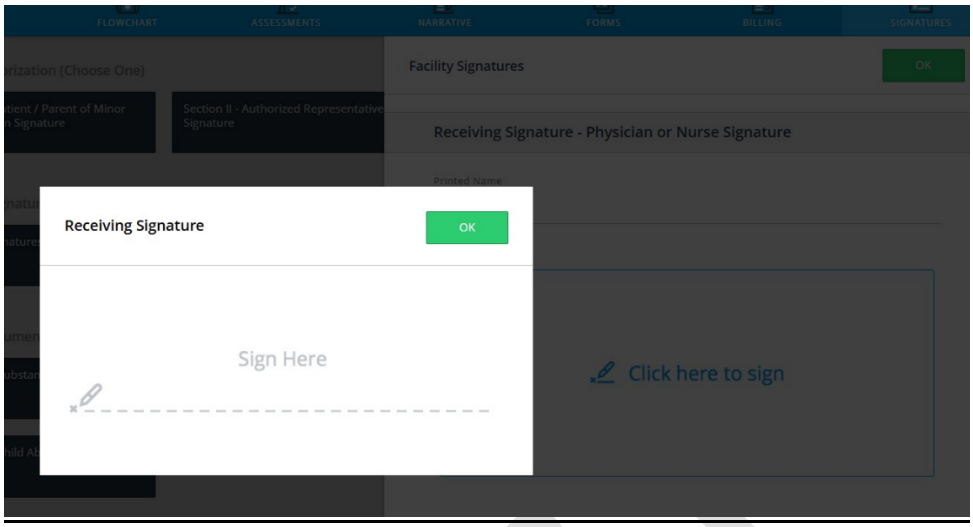
9.3. Technical Specification to Calculate Ambulance Patient Offload Time (Rev. 03/2026)

~~10.1.~~9.4. 42 U.S.C. § 1395dd (Emergency Medical Treatment and Active Labor Act)

APPENDIX A: EPCR SIGNATURE SCREENSHOTS FOR GACH STAFF SIGNATURE (eOther.19)

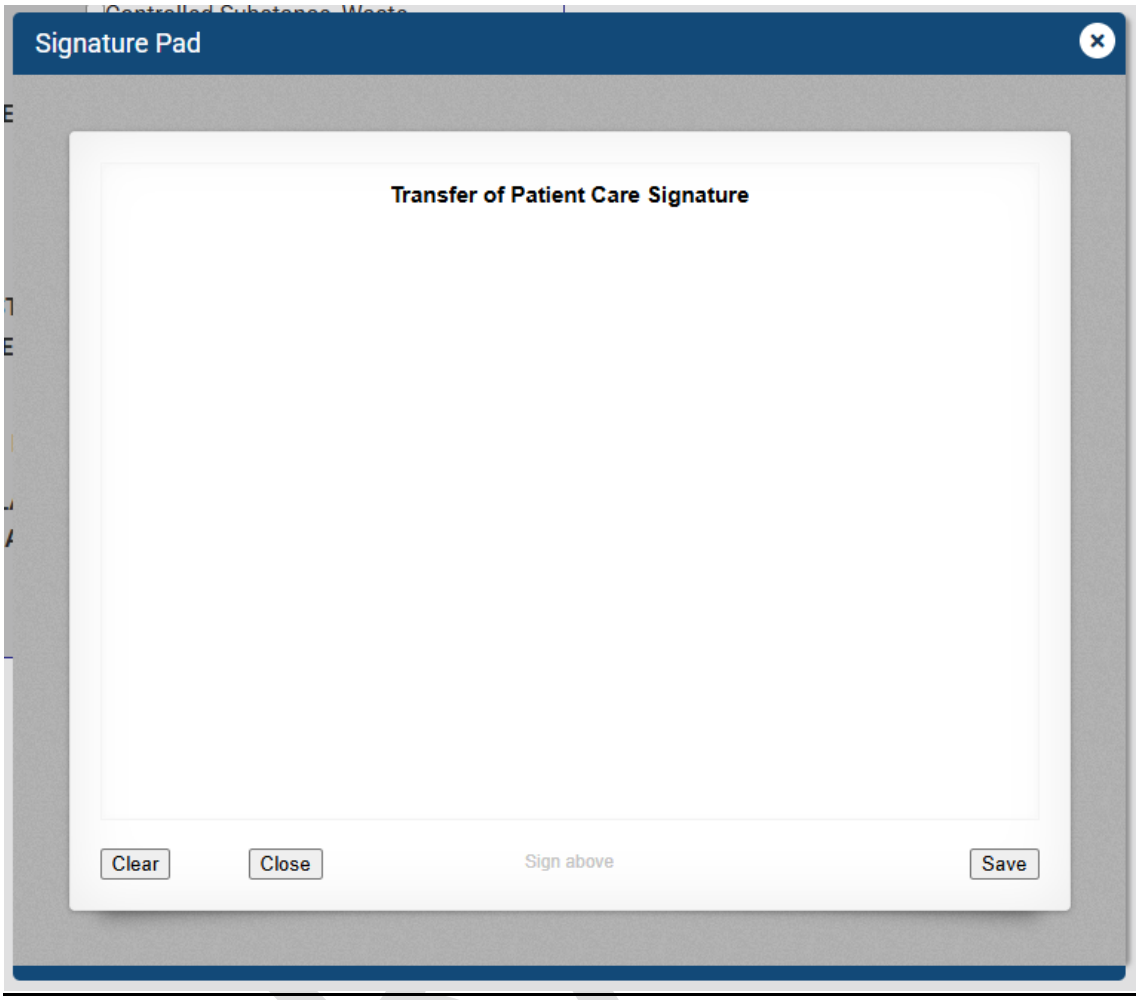
San Francisco Fire Department:
eOther.19 is captured when facility clicks (ok). The time is listed at the bottom of the signature block.



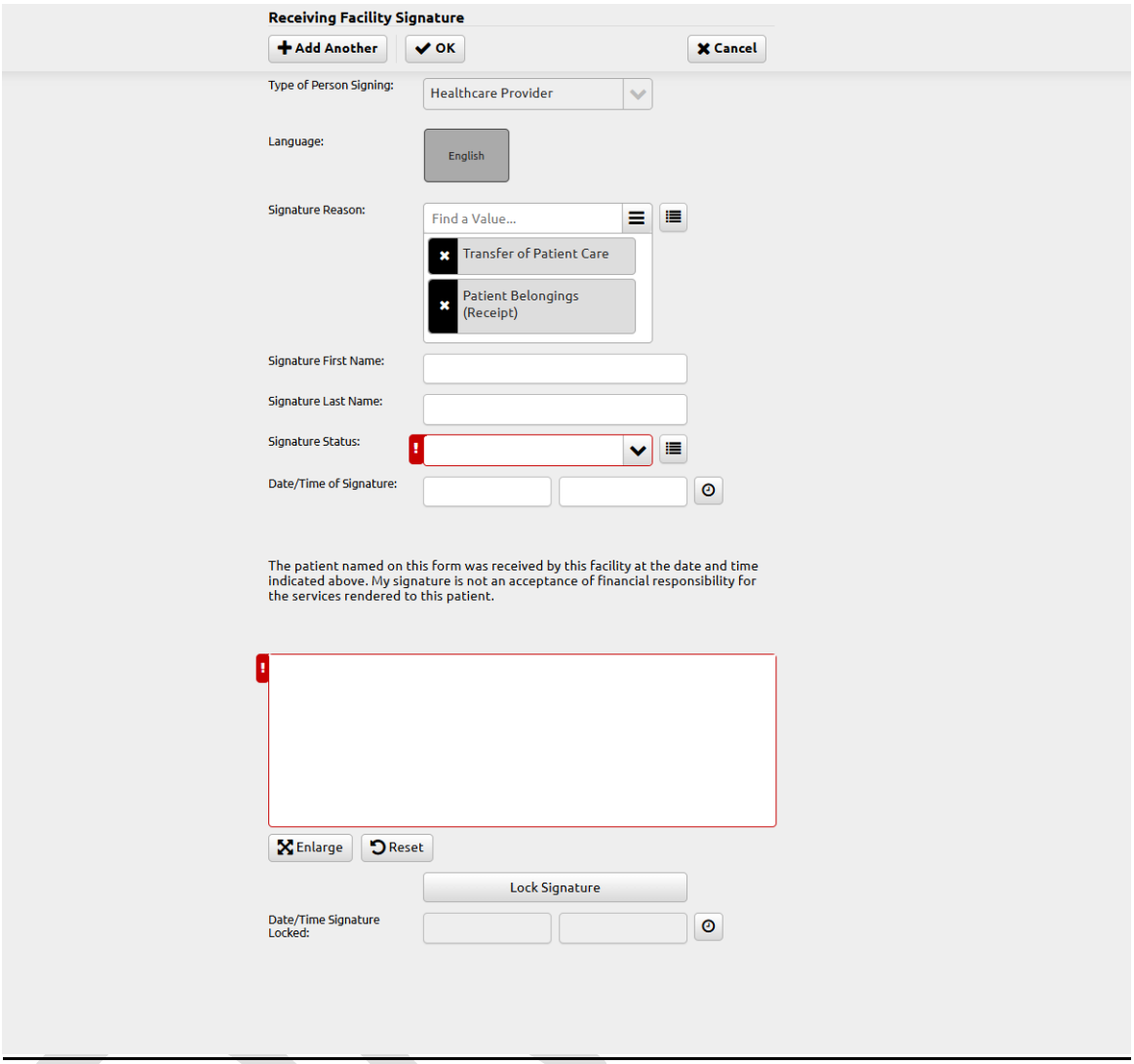


King American Ambulance:
eOther.19 is calculated when staff click “save”

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AMR
eOther.19 is time listed when signature is locked


Receiving Facility Signature
Add Another
OK
Cancel
Type of Person Signing:
Healthcare Provider
Language:
English
Signature Reason:
Find a Value...
Transfer of Patient Care
Patient Belongings (Receipt)
Signature First Name:
Signature Last Name:
Signature Status:
Date/Time of Signature:
The patient named on this form was received by this facility at the date and time indicated above. My signature is not an acceptance of financial responsibility for the services rendered to this patient.
Enlarge
Reset
Lock Signature
Date/Time Signature Locked: