California Hospital Association

June 17, 2025

Office of Administrative Law
300 Capitol Mall, Suite 1250
Sacramento, CA 95814

Submitted via email to staff@oal.ca.gov

Subject: Proposed Emergency Rulemaking – Implementation of Assembly Bill 40 (2023) – Ambulance Patient Offload Time

To whom it may concern:

As providers of emergency and acute care, hospitals play a vital role in the continuum of care for patients transported by emergency medical services (EMS) — and they are committed to ensuring people receive the right care, in the right place, at the right time. The California Hospital Association (CHA), on behalf of more than 400 hospitals and health systems, appreciates the opportunity to comment on the proposed Chapter 1.2 Ambulance Patient Offload Time (APOT) Emergency Medical Services Authority (EMSA) emergency regulations, which implement provisions of Assembly Bill (AB) 40 (2023), a bill that requires hospitals to submit APOT reduction protocols. CHA supports efforts to improve EMS operations and reduce ambulance patient offload delays and is pleased to see several improvements in this version of the regulations. However, additional changes — detailed below and in the attached document — are needed to address operational inefficiencies, enhance data accuracy, and improve quality of care.

Ensuring accurate APOT data is one of the key goals of AB 40. Hospitals across California are working to reduce their APOT times and rely heavily on data to decipher where operational improvements are needed. However, when hospitals compare their internal data to the data shared by their local emergency medical services agency, they often find discrepancies. To ensure the effectiveness of the APOT audit tool, it is essential that inaccurate data be corrected or omitted. As currently written, these regulations would allow discrepancies that cannot be resolved to go unaddressed, undermining the audit process.

It is crucial to establish a clear pathway for EMSA to correct data, ensuring the data being used by the EMS community is as accurate as possible. Under the regulations, EMSA would track discrepancies identified by hospitals and have a line of sight into overall data trends. A logical next step would be to also allow EMSA to determine whether any data discrepancies identified by hospitals warrant correction and, if so, make those changes. APOT data are shared publicly and are being used to improve quality of care — accuracy is imperative.

Hospitals also support EMSA's efforts to develop a secure data portal to help identify system bottlenecks and implement timely solutions and look forward to EMSA providing greater clarity about how the tool will be implemented. To ensure the tool is effective in reducing APOT, hospitals must be able to access real-time data. The attachment includes several other items detailing other areas of the regulations that require more clarity and guidance in order to be implemented effectively.

CHA is hopeful that AB 40 will facilitate improvements in data accuracy and EMS operations, helping to further our shared goal of ensuring all Californians have access to a consistently high standard of emergency and specialty care. Thank you for the opportunity to participate in this process.

If you have any questions, please contact me at slowe@calhospital.org or (916) 240-8277.

Respectfully,

Sheree Lowe
Vice President, Policy

CC: Craig Branson, craig.branson@emsa.ca.gov

Attachment: California Hospital Association Detail Comments

California Hospital Association Detail Comments

June 17, 2025

APOT Reg Text – AB 40

Title 22. Social Security

Division 9. Pre-hospital Emergency Medical Services

Chapter 1.2 Delivering Equitable and Person-Centered Care – APOT

Section	Notes/Comments
ARTICLE 1. General Provisions	
§ 100001.01 Authority and Application of this Chapter (a) This chapter, adopted pursuant to Health and Safety Code Section 1797.120.7, applies to all general acute care hospitals (GACHs) with emergency departments that receive ambulance-transported patients, as well as local EMS agencies (LEMSAs) and EMS transport provider agencies subject to ambulance patient offload time (APOT) monitoring and reporting under Sections 1797.120.5, 1797.120.6, and 1797.120.7. The purpose of this chapter is to establish statewide standards, protocols, and tools designed to improve the accuracy, efficiency, and timeliness of APOT within California's emergency medical services (EMS) system. (b) This regulation establishes requirements and procedures for the Emergency Medical Services Authority (hereinafter "EMSA"), LEMSAs, GACHs with an emergency department, and EMS transport provider agencies when standard APOT is exceeded.	

Note: Authority cited: 1797.1,1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.	
ARTICLE 2. Definitions	
§ 100002.01 Ambulance Patient Offload Delay (APOD). “Ambulance patient offload delay” or “APOD” is defined as an APOT, measured from the arrival of an ambulance patient at an emergency department ambulance bay (NEMSIS element eTimes.11) to the time that patient care is transferred to an emergency department gurney, bed, chair, or other acceptable location and the emergency department assumes responsibility for the care of the patient (NEMSIS element eTimes.12), which exceeds the APOT standard set by the LEMSA within whose jurisdiction the receiving GACH with an emergency department is located. Note: Authority cited: 1797.1,1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.	
§100002.02 Ambulance Patient Offload Time (APOT). "Ambulance patient offload time" or "APOT" is defined as the interval between the arrival of an ambulance patient at an emergency department ambulance bay (NEMSIS element eTimes.11) and the time that patient care is transferred to an emergency department gurney, bed, chair, or other acceptable location and the emergency	

department assumes responsibility for care of the patient (NEMSIS element eTimes.12). The technical specification for calculating APOT (APOT-1) is defined in Technical Specification to Calculate Ambulance Patient Offload Time (APOT) (Rev. 04/2025), which is incorporated by reference. Note: Authority cited: 1797.1,1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.	
§ 100002.03 Ambulance Patient Offload Time (APOT) Reduction Protocol. "Ambulance patient offload time reduction protocol" or "APOT reduction protocol" is a protocol developed by a GACH with an emergency department pursuant to Section 1791.120.6 of the Health and Safety Code that identifies specific criteria for activation of the protocol and contains actionable steps WITH THE INTENT to decrease APOD. Note: Authority cited: 1797.1,1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.	• For clarity purposes and to ensure consistent application of the statutory enabling language the following should be added "*with the intent*"
§ 100002.04 Ambulance Patient Offload Time (APOT) Standard. "Ambulance Patient Offload Time Standard" or "APOT standard" means the maximum length of time permitted for APOT, not to exceed thirty (30) minutes, 90% of the time, that is developed and adopted by each LEMSA to be applicable within its jurisdiction.	• The use of the word "permitted" carries a legal tone and will be interpreted differently and cause confusion in the field. Recommend it be changed to "target" which more clearly identifies the standard as a goal, objective, or aim.

Note: Authority cited: 1797.1,1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.	
§ 100002.05 Audit Tool. "Audit tool" means a standardized process utilizing a protected health information (PHI)-secure electronic portal developed and implemented by EMSA that is used by EMSA, GACHs with an emergency department, and LEMSAs for the purpose of evaluating, CORRECTING, and verifying data related to the transfer of care from EMS personnel to emergency department medical personnel. The audit tool includes mechanisms for validation by GACHs with an emergency department and LEMSAs and is capable of identifying discrepancies, ensuring data integrity, and supporting compliance with established APOT standards. Note: Authority cited: 1797.1,1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.	• For consistency purposes to ensure the audit tool is utilized to identify opportunities for improvement and quality assurance purposes the definition should contain the term "*correcting*".
§ 100002.06 Bi-Weekly. "Bi-weekly" means an interval of two weeks between occurrences. Note: Authority cited: 1797.1,1797.107, 1797.120, and 1797.120.5 Health and Safety Code.	

Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.	
§ 100002.07 California Emergency Medical Services Information System or CEMSIS. "California Emergency Medical Services Information System" or "CEMSIS" means the secure, standardized, and centralized electronic information and data collection system administered by EMSA which is used to collect statewide EMS and trauma data. Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, 1797.122, and 1797.176 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.	
§ 100002.08 Electronic Patient Care Record (ePCR) "Electronic patient care record" or "ePCR" means a real-time, patient care record that makeS information available securely to authorized users in a digital format capable of being shared electronically across more than one health care organization or within an electronic health record system. Note: Authority cited: 1797.107, 1797.122, 1797.176, 1831, Health and Safety Code	• Grammar correction – "that makeS"

Reference: Section: 1797.72, 1797.78, 1797.90, 1797.98e, 1797.122, 1797.125.09, 1797.227, 1798.175, 1831, Health and Safety Code.	
§ 100002.09 Electronic Signature. "Electronic signature," means a secure, electronic method of authentication in the form of an electronic signature used to confirm patient arrival (NEMSIS element eTimes.11) as well as the transfer of care time from EMS personnel to emergency department medical personnel (NEMSIS element eTimes.12) and populate a time stamp in NEMSIS element eOther.19. The time stamp is collected within the ePCR and the electronic signature is provided by emergency department medical personnel at the time of transfer of care. Note: Authority cited: 1797.1, 1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.	
§ 100002.10 Emergency Department. "Emergency department" means facilities which have been licensed by the California Department of Public Health (CDPH) as having an emergency department service level of "basic, comprehensive, or standby" and, for the purposes of this Chapter, includes any location ~~within the~~ IDENTIFIED BY A GACH with an emergency department where ambulance patients are received.	• Emergency Departments are NOT licensed by CDPH, rather they are an "Optional Services" requiring a special permit per Title 22 Section 70351. For accuracy and consistency purposes this definition should read: "Emergency Department" means that part of a general acute care hospital that has been approved by the California Department of Public Health to operate a standby, basic, or comprehensive emergency medical service.

Note: Authority cited: 1797.1, 1797.107,1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6 and 1797.120.7 Health and Safety Code.	• Recommend replacing the word "within the" to "identified by a GACH" to more accurately identify locations predetermined by a hospital to act as receiving areas for emergency department patients. These changes will bring consistency with the definitions of "Emergency Department" and "Emergency Department Ambulance Bay" see below.
§ 100002.11 Emergency Department Ambulance Bay. "Emergency department ambulance bay" means a designated location where ground transport ambulances park to offload patients at a GACH emergency department or ambulance receiving area ~~for the purposes of transferring, triaging, or admitting patients~~. In addition to a GACH emergency department, this also includes other locations authorized by the GACH to receive arriving ambulance patients. Note: Authority cited: 1797.1, 1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6 and 1797.120.7 Health and Safety Code.	• Patients are NOT transferred, triaged, or admitted within the ambulance bay. Transferring, triaging, or admitting of patients occurs within the walls of a hospital. Recommend striking that language for clarity purposes.
§ 100002.12 Emergency Department Medical Personnel. "Emergency department medical personnel" or "hospital staff," for the purposes of this Chapter, means a staff member of a GACH with an emergency department, ~~such as a physician, mid-level practitioner, or registered nurse,~~ authorized by the GACH to communicate with EMS personnel and receive transfer of care of EMS patients.	• For clarity purposes, recommend removing "such as a physician, mid-level practitioner, or registered nurse" so as not to leave readers with the impression these are the only staff who may be authorized by a hospital to perform this function. This change will also correct the misconception that physicians are "staff members". Hospitals are generally prohibited

Note: Authority cited: 1797.1, 1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6 and 1797.120.7 Health and Safety Code.	by California law from employing physicians – Corporate Practice of Medicine (CPOM).
§100002.13 Emergency Medical Services Transport Provider Agency. "Emergency medical services transport provider agency" or "EMS transport provider agency" means a public or private provider of emergency medical services authorized to perform patient transport within an EMS system. Note: Authority cited: 1797.1, 1797.107, 1797.120, and 1797.125.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6 and 1797.120.7 Health and Safety Code.	
§100002.14 General Acute Care Hospital or GACH. "General acute care hospital" or "GACH" is a hospital, licensed by CDPH, having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff which provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Note: Authority cited: 1797.1, 1797.107, 1797.120, and 1797.125.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6 and 1797.120.7 Health and Safety Code.	• Recommend also identifying Health and Safety Code Section 1250 (a) as an authority cited.

§ 100002.15 National Emergency Medical Services Information System or NEMSIS. "National Emergency Medical Services Information System" or "NEMSIS" means the national repository used to store secure, standardized, and centralized electronic EMS data from every state in the nation. Note: Authority cited: Sections 1797.107, 1797.120, 1797.125.5, and 1797.176 Health and Safety Code. Reference: Sections 1797.107, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.	
§ 100002.16 Small Rural Hospital "Small rural hospital" means an acute care hospital that meets either of the following: a) The criteria for designation within peer group six or eight, as defined in the report entitled Hospital Peer Grouping for Efficiency Comparison, dated December 20, 1982; or b) The criteria for designation within peer group five or seven and has no more than 76 acute care beds and is located in an incorporated place or census designated place of 20,000 or less population according to the 1980 federal census. Note: Authority cited: 1797.1, 1797.107,1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.195 Health and Safety Code.	

§ 100002.17 Thirty (30) minutes. "Thirty (30) minutes" for the purpose of APOT standard is defined as 1800 seconds. Note: Authority cited: 1797.1, 1797.107,1797.120, 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6 and 1797.120.7 Health and Safety Code.	
§ 100002.18 Transfer of care. "Transfer of care" means when an ambulance patient, who has arrived at the emergency department ambulance bay, is physically transferred to an emergency department gurney, bed, chair, or other acceptable location, and emergency department medical personnel receives the report and confirms the transfer of patient care with an electronic signature within the ePCR (NEMSIS element eOther.19). Note: Authority cited: 1797.1, 1797.107,1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6 and 1797.120.7 Health and Safety Code.	
§ 100002.19 Volunteer EMS Transport Provider Agency. "Volunteer EMS transport provider agency" means an EMS transport provider agency that is staffed primarily by unpaid or volunteer EMS personnel. Note: Authority cited: 1797.1, 1797.107,1797.120, 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6 and 1797.120.7 Health and Safety Code.	

Article 3 AUDIT TOOL METHODOLOGY FOR VERIFICATION OF CEMISIS DATA USED FOR APOT AND APOD REPORTING	
§ 100003.01 Verification of CEMSIS Data Used for APOT and APOD. (a) The ePCR shall serve as the legal record for all APOT and APOD data within the California EMS system.	
(b) The audit tool and verification process consist of the following: 1. EMSA shall make CEMSIS APOT and APOD data available to each licensed GACH with an emergency department, through EMSA's PHI-secure electronic portal. A. The GACH shall only have access to records within the PHI-secure electronic portal that pertains to patients transported to its emergency department. B. The GACH shall have view-only access to the following NEMSIS data elements from the ePCR for the purpose of matching an ePCR to the hospital's corresponding electronic health record (EHR) and validating patient arrival and transfer of care time data: i. EMS transport provider agency name (NEMSIS element dAgency.03) ii. LEMSA iii. Incident run number (NEMSIS element eResponse.03)	

iv. Incident date (earliest eTimes element in the ePCR) v. Receiving facility name (NEMSIS element eDisposition.01) vi. Receiving facility code (NEMSIS element eDisposition.02) vii. Patient first name (NEMSIS element ePatient.03) viii. Patient last name (NEMSIS element ePatient.02) ix. Patient date of birth (NEMSIS element ePatient.17) x. Patient gender (NEMSIS element ePatient.13) xi. Patient arrival at destination date/time (NEMSIS element eTimes.11) xii. Patient transfer of care date/time (NEMSIS element eTimes.12) xiii. Signature date/time (NEMSIS element eOther.19) xiv. Unit back in service date/time (NEMSIS element eTimes.13) xv. Type of person signing (NEMSIS element eOther.12) 2. If the GACH identifies any discrepancies between the CEMSIS-reported patient arrival (NEMSIS element eTimes.11) or transfer of care time (NEMSIS element eTimes.12) and the GACH's EHR, the GACH shall notify the relevant	

LEMSA and EMS transport provider agency or agencies of the discrepancy. 3. Upon receipt of the notification from the GACH, the LEMSA shall coordinate a collaborative review with the GACH and relevant EMS transport provider agency or agencies. 4. If the LEMSA and EMS transport provider agency or agencies agree with the discrepancy identified by the GACH, the relevant EMS transport provider agency shall correct the ePCR and resubmit the revised record by the 15th calendar day of the month following the reporting month. 5. For unresolved discrepancies: A. The APOT value shall default to the CEMSIS data patient arrival time (NEMSIS element eTimes.11), and transfer of care time (NEMSIS element eTimes.12), as defined in the Technical Specification to Calculate Ambulance Patient Offload Time (APOT) (Rev. 04/2025). B. The GACH shall also enter the hospital-verified values for patient arrival (NEMSIS element eTimes.11) and transfer of care time (NEMSIS element eTimes.12) into the PHI-secure electronic portal using the designated fields so that EMSA can analyze discrepancies and assess their impact on APOT calculations.	• (b)(5)(A) “unresolved discrepancies.” When disagreements cannot be resolved, they should be escalated to the regulating authority-EMSA. As currently written, favoring the data of one entity over another will undermine a robust validation process. Standard practice is to remove data when its validity is in question. Leaving in unresolved discrepancies undermines the necessity of these regulations as stated in “Article 1. General Provisions. The purpose of this chapter is to establish statewide standards, protocols, and tools designed to improve the accuracy, efficiency, and timeliness of APOT within California’s emergency medical services (EMS) system.”

	• (b)(5)(B) EMS transport providers and **not** hospitals record patient arrival time "NEMSIS element eTimes.11". Hospitals may be able to provide the "registration time" when the patient is brought in by EMS personnel and registered inside of the hospital at the hospital receiving desk. However, this is not a NEMSIS field. Clarity is needed to operationalize this section.
(c) The audit tool shall serve as a quality assurance and data validation instrument FOR LEMSA, HOSPITAL AND EMS PROVIDERS, in addition to a data collection tool. Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, 1797.122, and 1797.176 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.	• For clarity purposes recommend adding "for LEMSA, hospital, and EMS providers,"
ARTICLE 4. LOCAL EMS AGENCY ROLES AND RESPONSIBILITIES FOR APOT	
Each LEMSA shall: a) Develop and adopt a local APOT standard. The APOT standard shall not exceed thirty (30) minutes, ninety percent (90%) of the time. If a LEMSA has not adopted a local APOT standard, the standard shall be deemed to be thirty (30) minutes for ninety percent (90%) of ambulance patient offloads for the	

purposes of APOT reporting and compliance under this Chapter; b) Within thirty (30) calendar days of the effective date of the APOT standard, submit a copy of the APOT standard to EMSA to the email address: apot@emsa.ca.gov with the subject line: "LEMSA APOT Standard Submission – [LEMSA Name]" in an electronic format as either a PDF or Microsoft Word document; c) Include the APOT standard and any related APOT policies, protocols, or procedures in the Response and Transportation section of its annual EMS plan submission to EMSA; d) Submit any updates or revisions to the APOT standard occurring independent of the annual EMS plan submission to EMSA as an amendment to the local EMS plan within thirty (30) calendar days of the effective date of the update or revision; e) When directed by EMSA, participate in EMSA-hosted bi-weekly APOT coordination calls, as referenced in Article 7 of this Chapter; f) (f) In coordination with the relevant GACH(s) with an emergency department, EMS transport provider agency or agencies, and any other relevant LEMSA(s), review and validate APOT and APOD data submitted to CEMSIS by EMS transport provider agencies to resolve any discrepancies in the APOT or APOD data no later than the 15th calendar	

day of each month for data submitted in the preceding calendar month. Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, 1797.122, and 1797.176 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.	
ARTICLE 5. GENERAL ACUTE CARE HOSPITAL WITH AN EMERGENCY DEPARTMENT ROLES AND RESPONSIBILITIES FOR APOT	
§ 100005.01 General Acute Care Hospital (GACH) with an Emergency Department The GACH with an emergency department shall: a) At the time the emergency department medical personnel receives the physical transfer of patient care and report from EMS personnel, the emergency department medical personnel shall provide an electronic signature within the ePCR that confirms the transfer of care (NEMSIS element eTimes.12). The date/time stamp for this signature is captured within the ePCR as the NEMSIS element eOther.19; b) Develop and submit an APOT reduction protocol to EMSA. Submission shall be made electronically to the email address: apot@emsa.ca.gov with the subject line: "APOT Reduction Protocol – [Hospital Name]" in an electronic format as either a PDF or Microsoft Word document. The APOT reduction protocol shall be submitted to EMSA annually on or	• (b) There is no statutory authority for EMSA to require protocol submission "annually on or before June 30. Health and Safety Code Section 1797.120.6 clearly requires submission by September 1, 2024. See below:

before June 30th and shall include all required data elements and action plans defined in Ambulance Patient Offload Time (APOT) Reduction Protocol Checklist for General Acute Care Hospitals (GACH) with an Emergency Department (Rev. 04/2025), which is incorporated by reference; c) Implement the APOT reduction protocol within 10 business days of receiving email notification and direction from EMSA to do so. d) Notify EMSA no later than twenty-hour (24) hours after implementation of the APOT reduction protocol by email at: apot@emsa.ca.gov, to confirm compliance. e) When directed by EMSA, participate in EMSA-hosted bi-weekly calls to update and discuss implementation of the protocol and the outcomes. Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, and 1797.176 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7, Health and Safety Code.	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:……." Additionally, these regulations lack the authority to require annual submission. Current law requires: 1797.120.6 (b) A licensed general acute care hospital with an emergency department shall file its ambulance patient offload time reduction protocol with the authority and shall annually report any revisions to its protocol. The enabling statue clearly required initial submission by September 1, 2024, with any revisions being reported annually and NOT annual submission absent revisions. The "Ambulance Patient Offload Time (APOT) Reduction Protocol Checklist for General Acute Care Hospitals (GACH) with an Emergency Department (Rev. 04/2025) which is incorporated by reference;" also lacks statutory authority for inclusion in these regulations. This checklist requires many data fields which change on a frequent basis, including leadership phone numbers and hospital staffing details and would require extensive hospital resources to maintain and report. This checklist is an

	overreach and does not align with the legal scope of authority EMSA has and should be removed. • (d) EMSA lacks the statutory authority to require hospitals to report implementation of their APOT reduction protocol at any time, let alone within 24 hours of activation. Furthermore, most hospitals' APOT reduction protocols utilize real time tools like the National Emergency Department Overcrowding Score (NEDOCS). NEDOCS is the standard measure of patient volume and throughput in hospitals. This metric is critical to improving patient flow and operating efficiency. Hospitals use it to preemptively manage emergency department operations, communicate emergencies, and coordinate actions. These are implemented immediately in **real time** and may be activated multiple times each day. This section should be withdrawn due to its lack of authority and the inability of hospitals to activate this type of reporting.
ARTICLE 6. EMS TRANSPORT PROVIDER ROLES AND RESPONSIBILITIES FOR APOT	
§ 100006.01 EMS Transport Provider Agency An EMS transport provider agency shall: a) No later than 60 days from the effective date of these regulations, collect an electronic signature within the ePCR (NEMSIS element eOther.19) from emergency department medical personnel at the	

point of transfer of care for each patient transported to a GACH emergency department. b) Ensure the date and time entered for the "destination transfer of care" time (NEMSIS element eTimes.12) is viewable to the emergency department medical personnel. c) Be permitted to use GPS vehicle tracking technology or automatic vehicle location (AVL) technology to automatically populate or retrospectively verify the 'patient arrival at destination date/time' (NEMSIS element eTimes.11) documented within the ePCR. GACHs with an emergency department may validate GPS data annually in coordination with the EMS transport provider agency. d) When directed by EMSA, participate in EMSA-hosted bi-weekly calls to update and discuss implementation of the protocol and the outcomes. Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, 1797.122, and 1797.176 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.	
ARTICLE 7: EMERGENCY MEDICAL SERVICES AUTHORITY ROLES AND RESPONSIBILITIES FOR APOT	
§ 100007.01 Monthly Monitoring of APOT Data EMSA shall:	• (a) Hospitals do not submit APOT data, LEMSAs do.

a) Monitor monthly APOT data submitted by GACH(s) with an emergency department. b) Utilize data submitted to CEMSIS or the PHI-secure electronic portal to evaluate compliance with the APOT standards established by LEMSAs pursuant to Section 1797.120.5, subdivision (b). Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, 1797.122, and 1797.176 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.	
§ 100007.02 Exceedance of APOT Standards - Required Actions If a GACH with an emergency department reports an APOT that exceeds the LEMSA's adopted standard for the preceding month, EMSA shall initiate the following actions: a) Electronically notify the relevant LEMSA and the Commission on Emergency Medical Services of the exceedance within five (5) business days of verification; b) Direct the LEMSA to issue a notification to all EMS transport provider agencies operating within its jurisdiction regarding the GACH's APOT exceedance; c) Direct the GACH to immediately implement its APOT reduction protocol no later than five (5) business days after notification;	• GACHs do not submit APOT data, LEMSAs do. • c) Directing the GACH to immediately implement its APOT reduction protocol no later than five (5) business days after notification is not a realistic regulation. Requiring activation of the APOT

d) Convene and host bi-weekly coordination calls and/or virtual meetings with designated representatives from hospital administration, emergency department leadership, hospital employees, the LEMSA(s), and the affected EMS transport provider agency or agencies; 1. These EMSA-hosted bi-weekly meetings shall be used to review APOT reduction protocol implementation, address operational barriers, monitor outcomes, review the data validation tool, and propose corrective actions; 2. Meetings shall continue until such time as the GACH demonstrates sustained compliance with the adopted APOT standard for two (2) consecutive reporting periods, or as otherwise determined by EMSA. Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, 1797.122, and 1797.176 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.	reduction protocol based on data from the "preceding month" will not accomplish reduced APOD and should be removed. Hospitals trigger their reduction protocol often due to persistent over-capacity status in their EDs and their inability to turn patients away as dictated by existing state and federal EMTALA laws. Additionally, there is a time conflict between 100007.02 (c) which requires 5 business days and 100005.01 (c) which requires 10 business days.
§ 100007.03 Technical Assistance Program a) EMSA shall establish and maintain a technical assistance program to support eligible small rural hospitals and volunteer EMS transport provider	

agencies in meeting the requirements of Section 1797.120.5, including: 1. Implementation of electronic signature systems; 2. Integration with CEMSIS; 3. Deployment of the audit tool. b) Requests for technical assistance must be submitted using Form EMSA-TA-Request-1 (Rev. 04/2025), which is incorporated by reference. Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, 1797.120.5, 1797.122, and 1797.176 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.122 Health and Safety Code.	• (b) Form EMSA-TA-Request-1 (Rev. 04/2025), which is incorporated by reference requires hospital to provide "proof of rural designation". Hospitals are not provided with "proof" of their rural status by any governmental entity and therefore not able to comply with a requirement of this type. The Department of Health Care Access and Information (HCAI) State Office of Rural Health (SORH) is the entity who maintains evidence of rural designation. EMSA should work with SORH to receive this list.
§ 100007.04 Funding Support a) Subject to appropriation by the Legislature, EMSA shall administer a grant support program to provide financial assistance to eligible small rural hospitals and volunteer EMS transport provider agencies; b) Grant funds may be used for: 1. The purchase or upgrade of electronic data systems; 2. Personnel training for electronic signature or audit tool use; 3. System integration or compliance consulting services;	

4. Costs associated with participation in mandatory meetings under this Chapter. c) Eligible entities shall apply using Form EMSA-APOT-Grant-1(Rev. 04/2025), which is incorporated by reference, and must include the following information: (1) Proof of eligibility as defined in Sections 100002.15 and 100002.18 of this Chapter; (2) A brief description of current capabilities and needs; (3) A budget proposal and implementation timeline. d) Funding shall be awarded based on the availability of appropriated funds and will take into consideration the entity's geographic needs, call volume, and the extent of its volunteer or under-resourced status, as well as the total number of entities that have requested funding support. e) Recipients shall submit a post-award compliance and performance report using Form EMSA-Grant-Report-1 (Rev. 04/2025), which is incorporated by reference, within 90 days of project completion. Note: Authority cited: Sections 1797.1, 1707.107, 1797.120, 1797.102.5, 1797.122, and 1797. 1776 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.7, and 1797.122 health and Safety Code	• c) Requires rural hospitals to utilize the form EMSA-APOT-Grant-1(Rev. 04/2025), which is incorporated by reference "proof" of rural designation. Hospitals are not provided with "proof" of their rural status by any governmental entity and therefore not able to comply with a requirement of this type. The Department of Health Care Access and Information (HCAI) State Office of Rural Health (SORH) is the entity who maintains evidence of rural designation. (c)(1) has not captured the correct reference for proof of eligibility - 100002.15 is the definition of NEMSIS and 100002.18 is the definition of Transfer of Care.

§ 100007.05 Oversight and Accountability a) EMSA may audit any recipient of grant funding to ensure the funds are used in accordance with approved applications; b) Misuse of funds or failure to comply with reporting requirements may result in: 1. Requirement to return funds; 2. Disqualification from future support programs; 3. Referral to the appropriate oversight entity. Note: Authority cited: Sections 1797.1, 1797.107, 1797.120, and 1797.120.5 Health and Safety Code. Reference: Section 1797.102, 1797.120, 1797.120.5, 1797.120.6, and 1797.120.7 Health and Safety Code.	
Technical Specification to Calculate Ambulance Patient Offload Time (APOT)	
Ambulance Patient Offload Time (APOT) Reduction Protocol Checklist for General Acute Care Hospitals (GACHs) with an Emergency Department	• The *Ambulance Patient Offload Time (APOT) Reduction Protocol Checklist under* APOT reduction Protocol Action Plan states "The APOT reduction action plan **should** include strategies to manage APOT, including .....". The enabling statute at 1797.120.6 (a)(2) uses the term **"may".** May is permissive and should is more rigid and may be misinterpreted. For clarity purposes the word "may" should replace the word "should". • The *Ambulance Patient Offload Time (APOT) Reduction Protocol Checklist* seeks data not specified

	by AB 40 and thus should not be incorporated by reference into these emergency regulations (e.g., hospital surge plans, leadership phone numbers, hospital staffing details – all of which are subject to frequent change. Additionally, baseline hospital data are reported elsewhere, making this requirement redundant, time-consuming, and operationally burdensome. We recommend EMSA not require EDs to report on an annual basis numerous data elements that hospitals already submit on a more frequent basis through other required reporting (e.g., numbers of hospital beds, staffing, contact information – most of which is already held by the local EMS agency and numerous other state departments. Instead, the regulations should streamline the checklist to remove sensitive and unnecessary information and make submission of the remaining elements optional. Specific sections which exceed EMSA authority and should be removed include: ○ Hospital Information ○ Baseline Hospital Data ○ APOT Reduction Protocol Action Plan