2022 Council Resolution 38: Focus on Emergency Department Patient Boarding as a Health Equity Issue

Council Action: **AMENDED AND ADOPTED**

Board Action: **ADOPTED**

Status:

SUBMITTED BY: Illinois College of Emergency Physicians

Purpose:

Use legislative venues and lobbying efforts, focus regulatory bodies to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; publish best-practice action plans for hospitals to improve ED capacity; and, define criteria to determine when an ED is considered over capacity and hospital action plans are triggered to activate.

Fiscal Impact:

Budgeted staff resources for advocacy initiatives and committee or task force support. Unbudgeted expenses of $20,000-$30,000 for an in-person meeting if needed. Unbudgeted and unknown additional costs could be required if data is needed from third-party sources.

Background:

WHEREAS, Health care is focusing on social determinants of health and health equity is a primary public health concern; and

WHEREAS, Emergency department boarding has grown significantly in the last several years; and

WHEREAS, Emergency department boarding is a widespread problem and a source of patient harm, and thus health inequity; therefore be it

RESOLVED, That ACEP, through legislative venues and lobbying efforts, focus regulatory bodies, i.e., Centers for Medicare & Medicaid Services, The Joint Commission, etc., to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; and be it further

RESOLVED, That ACEP publish best-practice action plans for hospitals to improve emergency department capacity; and be it further

RESOLVED, That ACEP, through task force work, define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

The resolution directs the College use legislative venues and lobbying efforts, focus regulatory bodies, i.e., Centers for Medicare & Medicaid Services (CMS), the Joint Commission, etc., to establish a reasonable matrix of standards including boarding times and handoff of clinical responsibility for boarding patients; publish best-practice action plans for hospitals to improve emergency department capacity; and, through task force work, define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

Emergency department boarding is a scenario where patients are kept in the ED for extended periods of time because of a lack of available inpatient beds or space in other facilities where they could be transferred. Shortages of physicians, nurses, and other health care providers across the health care continuum, exacerbated

by an influx of extremely sick patients (both due to COVID-19 cases as well as non-COVID-19-related cases resulting from delayed care during the pandemic), have significantly contributed to the growing issue of boarding.

Empirical studies have shown boarding contributes to worse patient outcomes and increased mortality related to downstream delays of treatment for both high- and low-acuity patients. In addition to disrupting the ED workflow and creating operational inefficiencies, it often also creates additional dangers, such as ambulance diversion, increased adverse events, preventable medical errors, more walkouts by patients, lower patient satisfaction, violent episodes in the ED, and higher overall health costs. This problem is only worsening as ED volumes return to normal levels after a substantial drop in visits during the early stages of the COVID-19 pandemic.

Reducing boarding and mitigating its effects on all patients is critical in improving patient outcomes and their overall health, especially for those with mental or behavioral health needs. In fact, ED boarding challenges disproportionately affect patients with behavioral health needs who wait on average three times longer than medical patients because of these significant gaps in our health care system. Some research has shown that 75 percent of psychiatric emergency patients, if promptly evaluated and treated in an appropriate location – away from the active and disruptive ED setting – have their symptoms resolve to the point they can be discharged in less than 24 hours, further highlighting the need to provide timely, efficient, and appropriate mental health care.

ACEP has been working on a study of ED boarding with the Emergency Department Benchmarking Alliance (EDBA). The EDBA report is in progress and is expected to be released by fall 2022. It is anticipated that this study will address Amended Resolution 48(21) Financial Incentives to Reduce ED Crowding. The resolution directed the College to study financial and other incentives that might be used to reduce emergency department crowding. ACEP will assess the next steps needed to further address the resolution once the report coordinated by the EDBA is released.

ACEP issued a report in 2016, developed by the Emergency Medicine Practice Committee, "Emergency Department Crowding: High Impact Solutions." The report was developed to identify and disseminate proven ways to decrease input, as well as novel approaches to increase throughput and increase output. This document is available on ACEP's resource page, "Crowding & Boarding," along with links to other relevant information papers, policy statements, resources regarding state approaches, and others.

Addressing boarding and crowding have been longstanding priorities of the College, and federal legislative and regulatory advocacy efforts continue as well. ACEP has reached out to both CMS and The Joint Commission to determine what federal action can be taken to address the issue. Addressing boarding and crowding have also been included as key priorities in communications with Congress during the 117th Congress as legislators in both the House and Senate develop legislative efforts to address the nation's mental health crisis, and ACEP staff continue to discuss potential solutions with legislators in both chambers.

Recently, in the Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment Systems (IPPS) final rule, CMS decided to remove the electronic clinical quality measure (eCQM) version of ED-2, the Admit Decision Time to ED Departure Time for Admitted Patients Measure from the Hospital Inpatient Quality Reporting (IQR) program beginning in the calendar year 2024 reporting period. In ACEP's comments on the FY 2022 IPPS proposed rule, we strongly opposed the removal of this measure to track how long patients wait before a decision is made to admit them—especially since ED boarding represents one of the single greatest threats to patient safety in the ED setting. ACEP's comments also noted that unlike other clinical areas for which multiple measures may exist, ED-2 is one of only measures to track this statistic and provide incentives or enforcement to help reduce wait times and boarding.

CMS' decision relied heavily on one meta-analysis of 12 studies that did not find a clear association between ED boarding and in-hospital mortality, thus concluding the costs associated with the measure outweigh its continued use in the program. Despite being provided with nearly 70 studies that clearly establish a link between boarding and patient mortality (many of which also detail the prevalence of psychiatric boarding), CMS finalized the policy and eliminated one of the only available measures to help track and mitigate boarding. We believe there was and continues to be validity and value in this measure and ACEP has asked Congress to work with CMS to reverse this decision, or alternatively, whether through legislative or regulatory action, develop a new and meaningful measure to determine how long an ED patient has waited before a medical decision has been made to admit the patient.

Stragegic Plan Reference:

Advocacy – Members believe that they can rely on ACEP to fight for emergency physicians across all

landscapes and levels, including federal, state, and local.

Practice Innovation – Members work with ACEP to revolutionize the management of acute, unscheduled care, by anticipating emerging trends in clinical and business practices and developing new career opportunities for emergency physicians.

Prior Council Action:

Amended Resolution 48(21) Financial Incentives to Reduce ED Crowding adopted. Directed the College to study financial and other incentives that might be used to reduce Boarding of admitted patients in the emergency department.

Resolution 21(21) Diversity, Equity, and Inclusion. Directed the College to convene a summit to collaborate with emergency medicine organizations to align efforts to address diversity, equity, and inclusion within the next year; create a road map to promote diversity, equity, and inclusion; embed diversity, equity, and inclusion into the strategic plan as well as the internal and external work of ACEP; and report to the 2022 Council the outcome of the summit and have a roadmap created to promote diversity, equity, and inclusion in the specialty of emergency medicine.

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted. The resolution directed ACEP to promote transparency in institutional data to better identify disparities and biases in medical care; continue to encourage training to combat discrimination for all clinicians; and continue to explore frameworks for integrating anti-discrimination into our emergency departments and institutions at all levels including, but not limited to, patients, families, medical students, staff, trainees, staff physicians, administration, and other stakeholders.

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted. Directed ACEP to work with the U.S. Department of Health and Human Services, the U.S. Public Health Service, The Joint Commission, and other appropriate stakeholders to determine action steps to reduce ED crowding and boarding.

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted. Directed ACEP to work with other organizations and stakeholders to develop multi-society policies that establish clear definitions for boarding and crowding and limit the number of hours and volume of boarders to allow for continued patient access and patient safety. Also directed that ACEP promote to other organizations and stakeholders known solutions to mitigate boarding and crowding, including but not limited to smoothing of elective admissions, increasing weekend discharges, discharge of patients before noon, full availability of ancillary services seven days a week, and implementation of a full-capacity protocol and promote legislation at the state and national level that limits and discourages the practice of emergency department boarding as a solution to hospital crowding.

Resolution 28(08) Nationwide ED Crowding Crisis not adopted. The resolution directed ACEP members to work with state medical associations and/or health departments to encourage hospitals and health care organizations to develop mechanisms to increase availability of inpatient beds. Salient provisions of this resolution were included in Substitute Resolution 25(08) State Department of Health Crowding Surveys.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted. Directed ACEP to investigate options to collect data from individual hospitals throughout the states regarding boarding and crowding, encourage members to work with their state medical associations and/or state health departments to develop appropriate mechanisms to facilitate the availability of inpatient beds and use of inpatient hallways for admitted ED patients, identify and develop a speakers bureau of individuals who have successfully implemented high-impact, low-cost solutions to boarding and crowding.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted. Directed ACEP to develop a position paper on the systematic changes in hospital operations that are necessary to ameliorate crowding and treatment delays affecting ED and other hospital patients.

Amended Resolution 26(07) Hallway Beds adopted. The resolution directed ACEP to revise the policy statement “Boarding of Admitted and Intensive Care Patients in the ED,” work with state and national organizations to promote the adoption of such policies, and to distribute information to the membership and other organizations related to patient safety outcomes caused by the boarding of admitted patients in the ED.

Resolution 39(05) Hospital Emergency Department Throughput Performance Measure referred to the Board of

Directors. Called for ACEP to work with CMS and other stakeholders to develop measures of ED throughput that will reduce crowding by placing the burden on hospitals to manage their resources more effectively.

Substitute Resolution 18(04) Caring for Emergency Department 'Boarders' adopted. Directed ACEP to endorse the concept that overcrowding is a hospital-wide problem and the most effective care of admitted patients is provided in an inpatient unit, and in the event of emergency department boarding conditions, ACEP recommends that hospitals allocate staff so that staffing ratios are balanced throughout the hospital to avoid overburdening emergency department staff while maintaining patient safety.

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted. Directed ACEP to develop a specific strategy to coordinate all activities related to emergency department and hospital crowding to support state efforts, analyze information and experiences to develop a resource tool to assist chapters in efforts to seek solutions to emergency department and hospital crowding at the local level.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted. The resolution called for ACEP to meet with appropriate regulatory agencies, including the AMA, JCAHO, and the American Hospital Association and other interested parties to establish monitoring criteria and standards that are consistent with ACEP's policy "Boarding of Admitted and Intensive Care Patients in the Emergency Department." The standard should address the prompt transfer of patients admitted to inpatient units as soon as the treating emergency physician makes such a decision.

Prior Board Action:

Resolution 48(21) Financial Incentives to Reduce ED Crowding adopted.

Resolution 21(21) Diversity, Equity, and Inclusion adopted.

April 2021, approved the revised policy statement "Cultural Awareness and Emergency Care;" revised and approved April 2020; reaffirmed April 2014; originally approved April 2008 with the current title replacing "Cultural Competence and Emergency Care" approved October 2001.

April 2021, approved the revised policy statement "Non-Discrimination and Harassment;" revised and approved June 2018 and April 2012 with the current title; originally approved October 2005 titled "Non-Discrimination."

Amended Resolution 43(20) Creating a Culture of Anti-Discrimination in our EDs & Healthcare Institutions adopted.

April 2019, approved the revised policy statement "Crowding;" revised and approved February 2013; originally approved January 2006.

October 2017, reviewed the information paper "Disparities in Emergency Care."

June 2017 approved the revised policy statement "Boarding of Admitted and Intensive Care Patients in the Emergency Department;" revised and approved April 2011, April 2008, January 2007; originally approved October 2000.

April 2017, reviewed the information paper "Implicit Bias and Cultural Sensitivity: Effects on Clinical and Practice Management."

Amended Resolution 13(16) ED Crowding and Boarding is a Public Health Emergency adopted.

June 2016, reviewed the updated information paper "Emergency Department Crowding High-Impact Solutions"

Amended Resolution 42(15) Prolonged Emergency Department Boarding adopted.

Substitute Resolution 25(08) State Department of Health Crowding Surveys adopted.

Amended Resolution 27(07) Hospital Leadership Actions to Ameliorate Crowding adopted.

Amended Resolution 26(07) Hallway Beds adopted.

April 2007, reviewed the information paper "Crowding and Surge Capacity Resources for EDs."

October 2006, reviewed the information paper “Approaching Full Capacity in the Emergency Department.”

Substitute Resolution 18(04) Caring for Emergency Department ‘Boarders’ adopted

Amended Resolution 33(01) ED Overcrowding: Support in Seeking Local Solutions adopted.

Amended Substitute Resolution 15(01) JCAHO Mandate for Inpatients adopted.

Council Action:

Reference Committee B recommended that Amended Resolution 38(22) be adopted.

RESOLVED, That ACEP, through legislative venues and lobbying efforts, focus regulatory bodies, i.e., Centers for Medicare & Medicaid Services, The Joint Commission, etc., to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; and be it further

RESOLVED, That ACEP publish best-practice action plans for hospitals to improve emergency department capacity; and be it further

RESOLVED, That ACEP, through task force work, **to** define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

The Council adopted Amended Resolution 38(22) on September 30, 2022.

Testimony:

Both asynchronous and live testimony unanimously supported the resolution. During asynchronous testimony, comments noted that emergency department boarding is a significant issue that must be addressed. The Reference Committee agreed with the testimony and also believes that the Board of Directors should be responsible for determining whether a task force is necessary to achieve this goal or if there are other more appropriate mechanisms that may be available.

Board Action:

The Board adopted Amended Resolution 38(22) on October 3, 2022.

RESOLVED, That ACEP, through legislative venues and lobbying efforts, focus regulatory bodies, i.e., Centers for Medicare & Medicaid Services, The Joint Commission, etc., to establish a reasonable matrix of standards including acceptable boarding times and handoff of clinical responsibility for boarding patients; and be it further

RESOLVED, That ACEP publish best-practice action plans for hospitals to improve emergency department capacity; and be it further

RESOLVED, That ACEP work to define criteria to determine when an emergency department is considered over capacity and hospital action plans are triggered to activate.

References:

https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0217

https://www.healthaffairs.org/do/10.1377/forefront.20220325.151088/

Implementation Action:

Assigned to Advocacy & Practice Affairs staff for federal and state advocacy initiatives.

Assigned second and third resolveds to the ED Boarding Task Force created by ACEP President Christopher Kang, MD, FACEP. Objectives also include: 1) create an agenda for a boarding summit along with recommendations for organizations to be represented; and 2) create a list of potential solutions to boarding with an emphasis on what the state/federal government can do to reduce boarding.

ACEP President Christopher Kang, MD, FACEP, met with senior officials of the Biden Administration in mid-October 2022 to discuss several issues and specifically recommended that the White House host a summit on ED boarding and workforce issues that would bring together key stakeholders from the clinician, hospital, nursing home, emergency medical services (EMS), and patient communities to discuss potential solutions. ACEP sent a letter to the White House calling attention to the boarding problems in the U.S. and formally asked the Administration to convene a meeting of stakeholders to identify immediate and long-term solutions. Many other medical organizations signed on to the letter. ACEP also sent a letter sent to the National Governors Association on November 9, 2022, that included a copy of the White House boarding letter. A template letter was also created for ACEP chapters to share the White House letter with their individual governors. ACEP began a communications campaign in November 2022 to keep members informed of the initiatives underway to address boarding. A resource page was created on acep.org and a digital storybook to highlight many of the stories ACEP collected.

The Emergency Medicine Practice Committee developed an ED Boarding Toolkit that will be available on the ACEP Website once it is finalized. The committee also revised the "Boarding of Admitted and Intensive Care Patients in the Emergency Department" policy statement and it was approved by the Board in February 2023.

ACEP hosted a Boarding Summit on September 27, 2023. Attendees included representatives from the Agency for Healthcare Research and Quality (AHRQ), Health & Human Services' Administration for Strategic Preparedness & Response-Biomedical Advanced Research and Development Authority (ASPR-BARDA), nursing homes/post-acute care, hospitals, psychiatry, nursing, emergency nursing, patients, National Governors' Association, Association for State and Territorial Health Officials, and others. The summit participants identified what they perceived as the causes of boarding, discussed barriers to overcome them, and then reached group consensus on areas to prioritize for addressing. The Summit proceedings were released on October 20, 2023. A listserve was created for continued collaboration with the group and others, as appropriate, for advocating at the state and federal level. Information about the Summit was publicized along with the results of public opinion polling that was conducted.

HHS announced in January 2024 that it will convene stakeholders through the Agency for Healthcare Research & Quality (AHRQ) to address boarding in the ED.

Background Information Prepared by: Ryan McBride

Reviewed by: Kelly Gray-Eurom, MD, MMM, FACEP
Melissa Wysong Costello, MD, FACEP
Susan E Sedory, MA, CAE