Boarding Workgroup: Update and Next Steps

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Boarding Workgroup Members

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Boarding Position Paper - Big Overview

- Canary in the Coal Mine
- ED Crowding is Direct Link to Health Care Financing
- Largely Underappreciated/Unrecognized

Why Boarding Persists

- Health Care Finance Incentive — Crowding is Assured
- Inadequate Capacity
- Failure of Regulators/Payors/Legislatures
- Misunderstanding the Issue
- Tragedy of the Commons

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HCF Misaligned Incentive

- Consolidation (mergers and acquisitions)
  - Financial Survival Necessity
  - Profit Motive for Some
- Hospitals: Thin Margins
  - Electives, Surgeries, Transfers Preferred
- Nursing Shortage

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Inadequate Capacity / Insatiable Demand

- 1,000+ hospital Mergers in last 15 years
  - 50% of all hospitals
  - AMC's particularly affected as system feeds the center
- Demand is up, capacity is down
- Post Discharge Facility Bed Blocking: SNF, NH, Rehab
- Lack of Primary Care
- Lack of Psych Care
- ICU: Pts with poor prognosis

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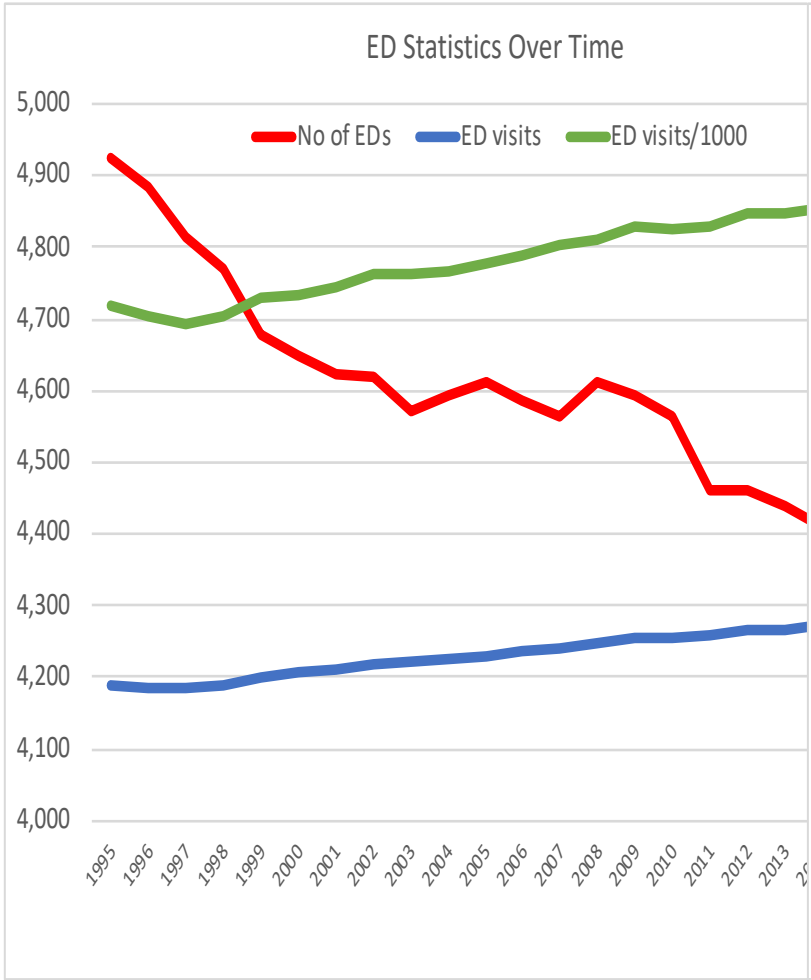
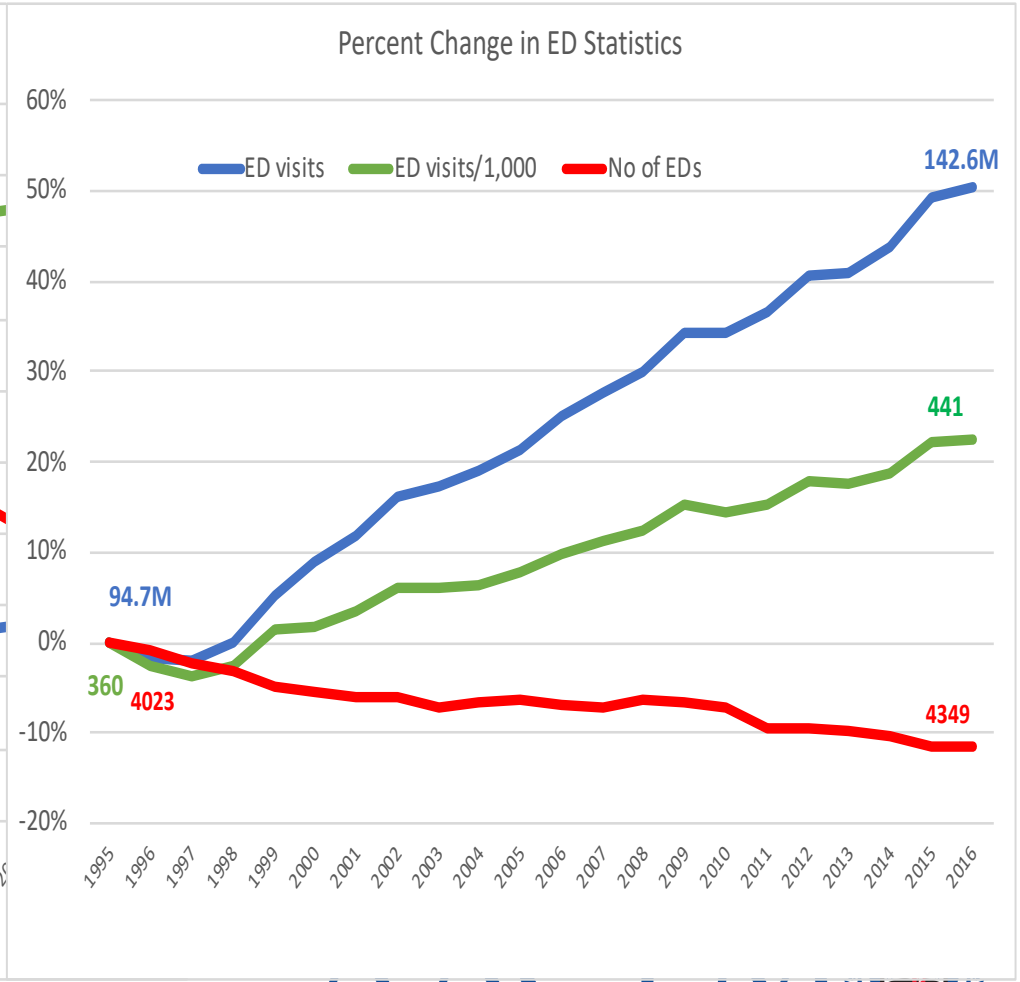
Inadequate Capacity / Insatiable Demand





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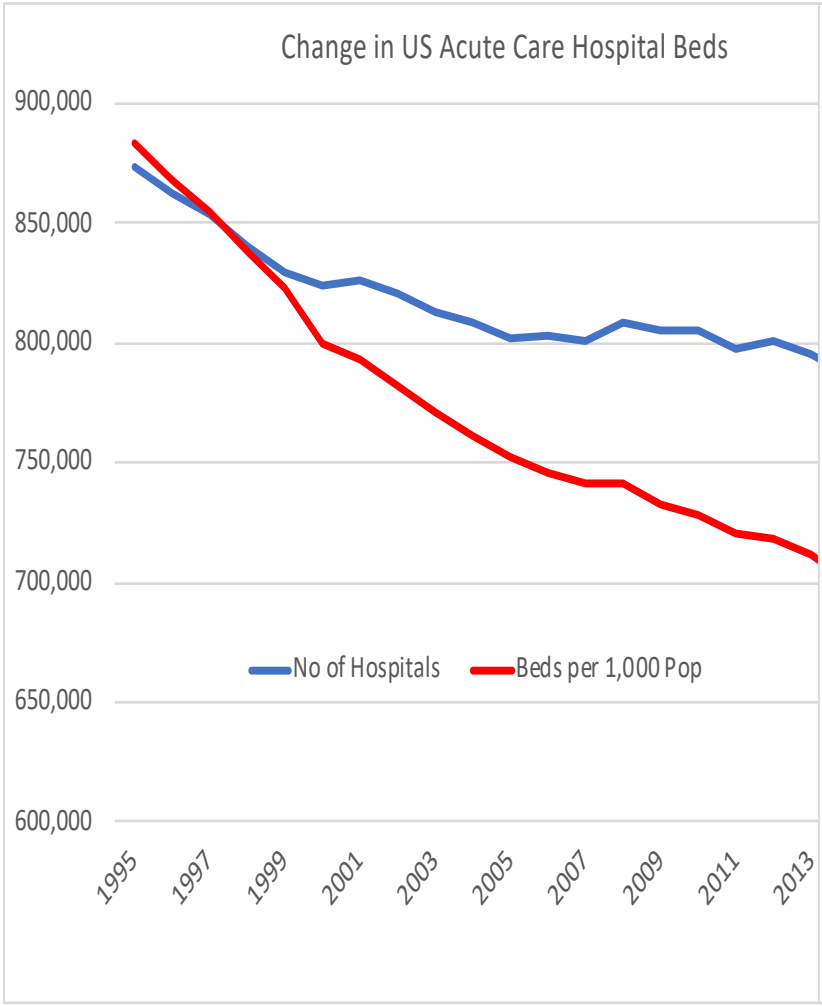

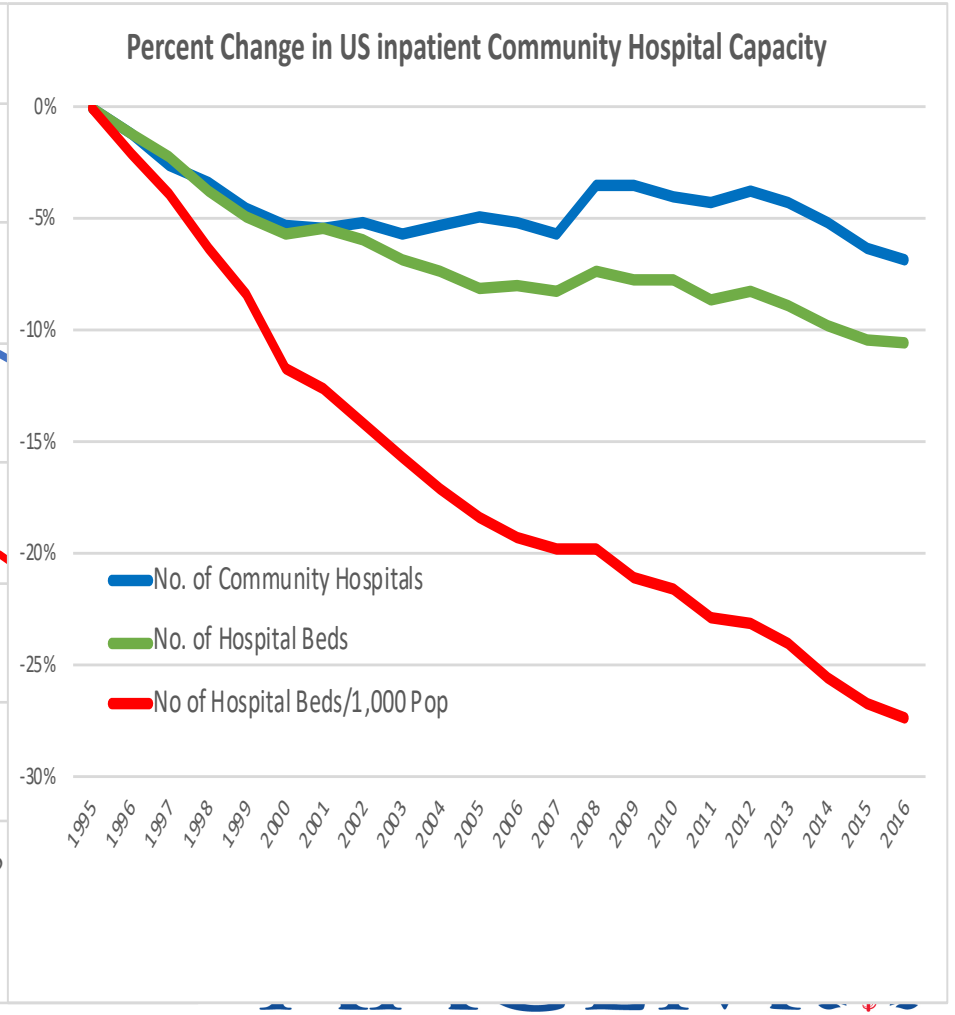

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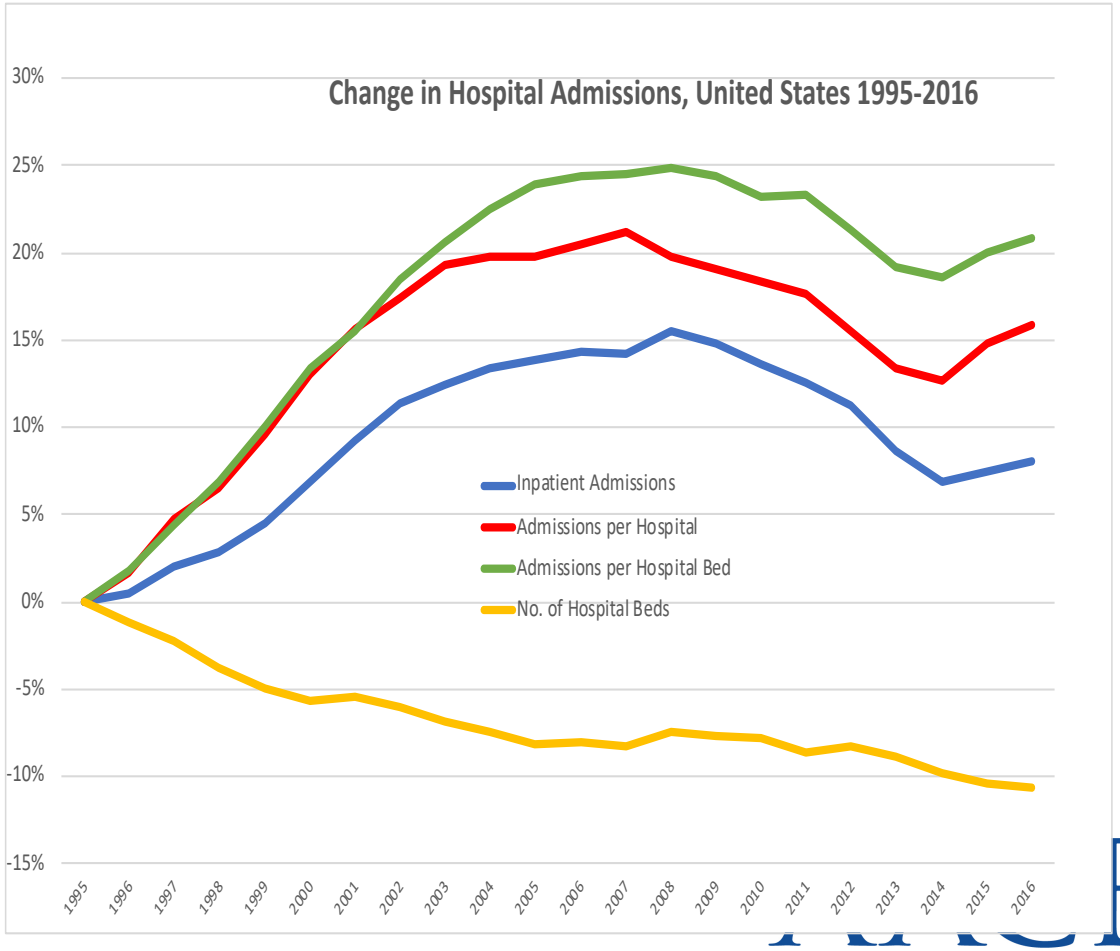

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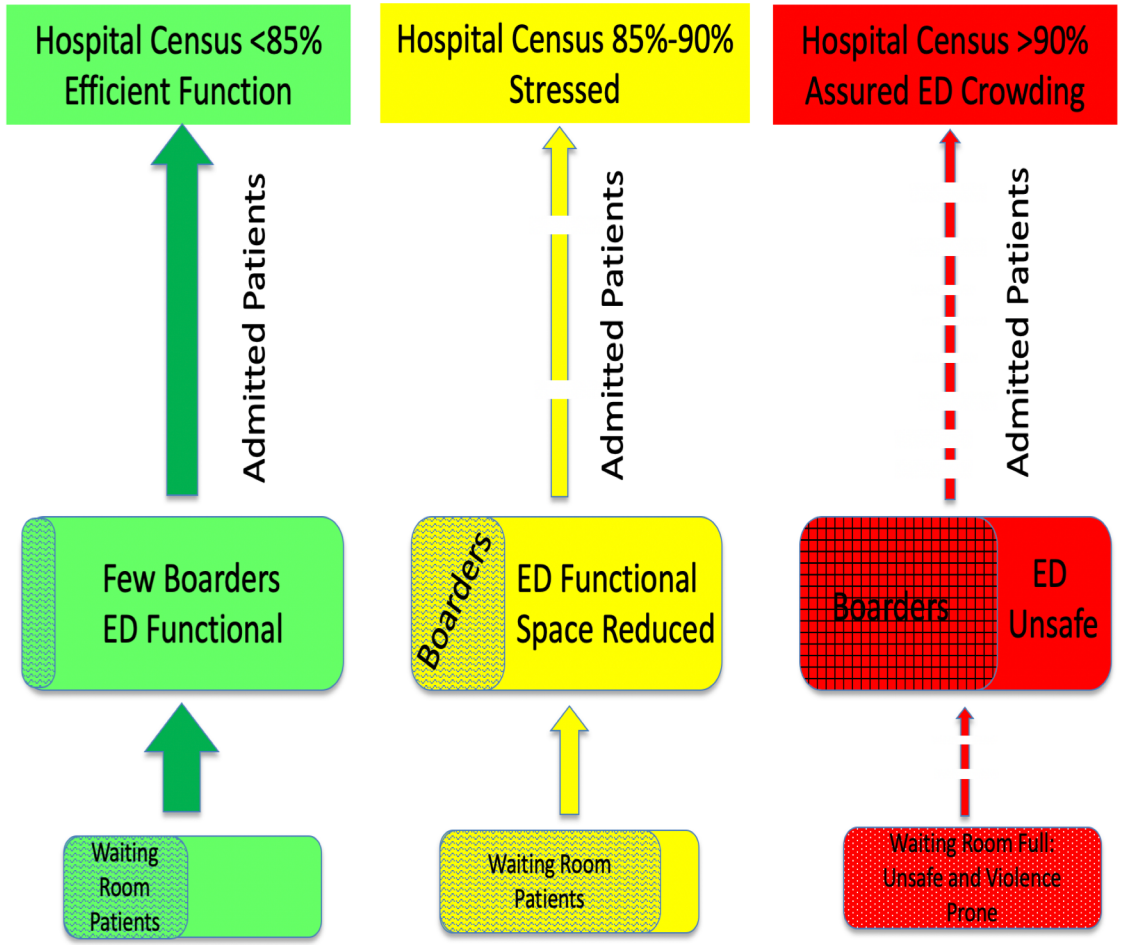
Squeeze of the ED

Figure 1. Impact of Boarding on ED Function



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Boarding Position Paper

1. Agencies
   - 4-hours rule--guideline
2. Misunderstood Issue
   - Inconvenience
   - Pts don't need to be there
   - ED Management/Productivity
3. Tragedy of the Commons
   - ED: everything to everyone

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Boarding Solutions

Helpful but not Aimed at Core Issues

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Boarding Causes and Solutions

Causes of Crowding

Health System Impacts
- Decreased national inpatient capacity
- Lack of primary care capacity
- Lack of national/local capacity for:
  - Skilled Nursing Facilities
  - Rehabilitation
  - Respite
  - Lack of specialty access
  - Psychiatric Services (inpatient and outpatient)
  - Addiction Services (inpatient and outpatient)
- Lack of access related to underinsurance
- Failure to tackle ethical issues in end of life care

Hospital Factors
- Financial structure promotes hospital crowding
- Lack of after-hours care options
- Hospitals not structured to meet 24/7 operational demand
  - Crises fatigue

Input Factors
- Rising ED volume
- Lack of primary care
- Inability of PCPs to accommodate acute needs
- Patient preference of ED or PCP
- Patient self-assessment regarding illness severity
- EMTALA
- Consultant Preference

Throughput Factors
- Increased patient complexity requires increased time and resources
- Availability of time-intensive technology
- Preference for patient work-up and testing in ED
- Teaching Mission
- Laboratory and radiology reporting
- ED nursing shortages
- Electronic Medical Records demands on time
  - Multiple provider distractions (e.g., immediate EKG reads, taking referrals, irritant nonbeneficial abnormal lab calls, etc).

Output Factors, Access Block
- ED boarding from high hospital census or operational inefficiency
- Nurse report blocking
- Housestaff training program related delays
- Admission batching by ED
- Daily patient discharge significantly later than new admission need

Solutions

Traditional Solutions	Comment
ED Input	
Establish UCC near by	Not likely to affect underinsured
Triage low acuity patients out	Need alternate venue; EMTALA Issues
Extend Primary Care hours/availability	Helpful, may incur costs
Ambulance Diversion	Not helpful
ED Throughput	
Physician/provider at triage	Decreases ED LOS for discharged patients; decreases LWBS but waits for treatment thereafter persist.
Bedside Registration	Helpful
Creation of Fast-Tracks	Helpful, doesn't decrease boarding, costly
Improving ancillary turnaround times	Helpful
Increased ED staffing	Helpful if started understaffed
Increasing ED size (redesign-more beds)	Not always helpful, costly
Increasing ED size (adding hallway beds)	Helpful, stresses staffing ratios, privacy issues
Output (hospital-based solutions)	
Availability of ancillary services off-hours	Helpful, costly
Opening unstaffed beds	Helpful, requires incremental staffing
Redistributing inpatient service beds	Helpful
Boarding on inpatient hallways	Proven effective, patient preferred, decreases both ED and inpatient LOS
Admitting service (MD, Nurses or both), provide care for the admitted patient	Helps free up ED staff, but doesn't alleviate crowding per se
Stop electives and transfers	Usually too late, but helpful
Bed Czar	Allows dispassionate, agnostic bed allocation; Requires true authority
Align inpatient discharges with admission flow	Very effective
Core Issue Solutions	
Address crowding as institutional high priority	Key to addressing crowding
Align financial incentive to prevent crowding	Should decrease inpatient census on key services
Treat ED crowding as a "disaster" response	Essentially, patient risks are similar
Use alternate SOC during times of severe crowding	High risk situation is similar to a disaster
Develop predictors of unsafe ED conditions and trigger crowding surge plan	Should prevent unsafe conditions from occurring Surge plan is a must for patient safety
Regulatory agencies, payors, and legislatures should establish actionable expectation for hospitals	Key to addressing crowding

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Proposed Positions – Global

1. Must recognize as a major patient safety issue

2. Reform health care financing; Hospital reimbursement

3. Regulators should hold hospitals accountable

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Proposed Positions – Hospital and Health System

1. Visible committed hospital leadership with aligned incentives
2. Boarding: 1 hour is ideal; 90% up in 4 hours
3. All need an actionable surge plan — real teeth
4. Crowding is predictable: All should have pre-crowding pre-emptive trip wire actions
5. Boarding in inpatient hallways is safer; should be universal
6. ED budget reconciliation for uncompensated inpatient care

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Discussion Questions

- What additional actions can the Boarding Workgroup and Executive Committee take to help AACEM members with ED boarding?

- What insight can you share with other AACEM members regarding ED boarding (i.e., an intervention that is working, an intervention that failed, a unique situation you have encountered, etc.)?

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