American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

# Policy Solutions to Emergency Department Boarding

Patients "boarding" in the emergency department (ED), or those placed in a holding pattern while waiting for admission or transfer, are overwhelming emergency physicians, care teams, and staff who do all they can to treat or stabilize every patient that needs care. Boarding has become its own public health emergency. Our nation's safety net is on the verge of breaking beyond repair. EDs are gridlocked and overwhelmed with patients waiting – waiting to be seen; waiting for admission to an inpatient bed in the hospital; waiting to be transferred to psychiatric, skilled nursing, or other specialized facilities; or, waiting simply to return to their nursing home. And this breaking point is entirely outside the control of the highly skilled emergency physicians, nurses, and other ED staff doing their best to keep everyone attended to and alive.

To illustrate the stark reality of this crisis, the American College of Emergency Physicians (ACEP) asked its members to share examples of its life-threatening impacts. The stories paint a picture of an emergency care system already near collapse. On November 7, ACEP and 34 other organizations representing patients, public health officials, fire/EMS, clinicians, and nurses sent a letter to President Biden urging the Administration to convene a summit of stakeholders from across the health care system to identify immediate and long-term solutions to this urgent problem.

The causes of ED boarding and crowding are multifactorial, with many of them out of the control of the individual hospital or ED team. The following proposed solutions therefore span across many aspects of the health care system.

## Transparency

- Mandated information sharing to allow for creation of a regional dashboard of available beds that EDs can consult when needing to place patients. This could be web-based or follow a call-center model, operated by a neutral third-party data broker to ensure protection of proprietary data. More limited models of this concept have been implemented in Washington state and in Texas.
- Creation and expansion of robust quality metrics with additional public reporting that measure ED throughput and boarding.
  - Modify CMS measure OP18 (Median Time from ED Arrival to ED Departure for Discharged ED Patients) to create a bright line standard (e.g., 4 hours) with a percentage performance (i.e. measure and report the *percentage* of ED visits that exceeded a certain time frame, rather than just the current median time in minutes that allows everyone to fail together and not reduce the ranking).
  - Instead of sunsetting the measure in 2024, CMS must maintain the ED-2 "Admit Decision Time to ED Departure Time for Admitted Patients" measure in the Hospital Inpatient Quality Reporting Program--one of the only measures available to track this statistic and provide incentives/enforcement to help reduce wait times and boarding. Consider tying percentage performance to a bright line time standard rather than measuring absolute times, and adding additional public reporting of performance.

## Reduce Regulatory Burdens

- When a particular threshold of hospital and ED capacity is reached, trigger temporary waiver of regulatory requirements related to screening questions and other non-essential paperwork for patients presenting to the ED to minimize administrative burden.
- When ED capacity reaches a threshold, specific federal tort standard and liability protections are triggered, such as around evaluation and access of care, left without being seen (LWOBS), or delays in diagnoses, treatment, or disposition.
- Eliminate completely or at least impose strict time limits for prior authorization by Medicare Advantage plans for transfer of Medicare patients to skilled nursing facilities (SNF). Recent estimates by the American Hospital Association note this process can take three days, but can be even longer if additional information is required or a denial needs to be appealed. As well, prior authorization reviews often are on hold during weekends, adding additional waiting time.
- Investigate whether certificate of need processes that limit hospitals from expanding beds in some states should be temporarily lifted.

## Mental Health

- Implementation of incentives to expand the mental health work force, and expand psychiatric care capacity such as additional psychiatric beds outside of acute care hospitals, expanded community clinics, etc.
- Implementation of broadband infrastructure to support telehealth and telepsychiatry services, alleviating buildup of psychiatric patients in the ED.
- Repeal of the Institutions for Mental Disease (IMDs) exclusion so Medicaid beneficiaries can be released from the ED and receive psychiatric inpatient treatment.
- Additional training, resources, and technical improvements for newly established 988 Suicide and Crisis Lifeline to ensure patients are being directed to appropriate alternative care options, rather than just driving even more patients in mental health crisis to the ED.

## Realign Financial Drivers

- Creation of an extended ED visit professional code after patient is in the ED for greater than six hours.
- Require CMS to adopt existing CPT recommendation that emergency physicians may bill for both the ED E/M code and the inpatient/observation care in instances where the patient remains under the care of the ED physician for more than 12 hours.
- Creation of reimbursement incentives for hospital systems to transfer patients outside of their system in limited cases of extreme boarding.
- Promotion of value-based initiatives that help improve acute care and transitions from the ED back to the community, such as an expanded Hospital at Home program, and the ACEP-developed Acute Unscheduled Care Model (AUCM), which could each reduce the current need for prolonged detailed work ups for dischargeable patients, as well as longer observation period to assure safety of discharge that occur as a result of limited to no outpatient follow-up care being accessible to many patients.
- Tie additional financial incentives and penalties to measures of crowding and boarding such as OP-18 and ED-2.
- Develop incentives to enable skilled nursing and long-term care facilities to expand capacity and accept patients from the ED outside of core business hours; consider penalties for refusing patients without documentation of legitimate limitations for doing so.
- Creation of new add-on payment that accounts for EMS wall time in the ED waiting to offload a patient.

## Operational Modifications

- Creation of “holding for discharge rooms” elsewhere in hospital that allow patients who are near discharge to receive final discharge instructions—thereby freeing up ED beds.
- Relaxation of inpatient hallway bed restrictions to allow for automatic use of inpatient hallway bedding if a patient is boarding in the ED greater than 4 hours, and less than 10 percent [or similar threshold] of ED beds are unoccupied.
- New CMS Condition of Participation requiring hospitals to develop contingency plans when inpatient occupancy exceeds 85 percent [or similar threshold], including a load balancing plan and an identification and utilization plan of alternative space and staffing for inpatients when greater than a certain percentage of ED licensed bed capacity is occupied.
- Expansion of surgical and procedural schedules to seven days, thereby spreading out elective procedures and smoothing out the availability of inpatient beds within hospitals.

## Workforce

- Creation and support of incentives for programs for nursing school and nurses including but not limited to tuition reimbursement and housing subsidies.
- Adding an additional $45 million in funding for the Health Resources and Services Administration’s (HRSA) Preventing Burnout in the Health Workforce Program to fund a new round of grants to address stress, burnout, and suicide in the health care workforce.
- To incentivize physicians to work in rural areas and staff Rural Emergency Hospitals (REHs), the 5 percent additional facility payment that REHs can now receive should be extended to them as well. CMS can create an add-on code or modifier that clinicians append to claims for services delivered in REHs, setting its value at five percent of the PFS rate for each CPT code that is billed.