SUMMIT ON BOARDING

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

Issue Background

Patients "boarding" in the emergency department (ED), or those placed in a holding pattern while waiting for an inpatient bed after admission to the hospital or transfer to another facility, 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. 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.

Boarding is a systemic problem that hinder patients' access to care. Any emergency patient can find themselves boarded, regardless of their condition, age, insurance coverage, income, or geographic area. Patients in need of intensive care may board for hours in ED beds not set up for the extra monitoring they need. Those in mental health crises, often children or adolescents, board for months in chaotic EDs while waiting for a psychiatric inpatient bed to open anywhere. Patients may delay or avoid emergency care and risk their physical and mental health because of these systemic bottlenecks, sometimes just to be seen.

Boarding and ED crowding are not caused by ED operational issues or inefficiency; rather, they stem from broader health system dysfunction. Boarding and ED crowding lead to increased cases of mortality related to downstream delays of treatment for both high and low acuity patients. Boarding can also lead to ambulance diversion, increased adverse events, preventable medical errors, lower patient satisfaction, violent episodes in the ED, emergency physician and staff burnout, and higher overall health care costs.

In November 2022, ACEP and 34 other organizations sent a letter to the White House asking the President to convene a summit or task force on this issue with all impacted stakeholders so that we could together collaborate on near- and longer-term solutions. Because we had not yet received a formal response to the letter, ACEP convened our own Summit to analyze the causes of boarding, discuss barriers to overcoming these causes, and identify priority areas to pursue in creating systemwide solutions.

Summit Overview

The following organizations were represented at the Summit:

- American College of Emergency Physicians
- Agency for Healthcare Research and Quality (AHRQ)
- American Hospital Association
- American Nurses Association
- American Psychiatric Association
- America's Essential Hospitals
- Apprise Health Insights
- Administration for Strategic Preparedness and Response (ASPR)/Biomedical Advanced Research and Development Authority (BARDA)

- Association of State and Territorial Health Officials
- Emergency Nurses Association
- International Association of Fire Chiefs
- LeadingAge
- National Association of Emergency Medical Technicians
- National Alliance on Mental Illness
- National Governors' Association

The summit opened with brief presentations by ACEP President Christopher Kang, MD, and David Sklar, MD, Chair of ACEP's Boarding Task Force, who shared six recommendations of issues and solutions as background; these are incorporated into the Appendix for refence.

The Summit agenda that followed centered around a facilitated discussion of the causes of boarding, potential solutions to the issue, and past and present barriers that have resulted in it being such a long-standing issue. Participants then identified consensus solutions to prioritize for action.

Causes of Boarding

Summit participants discussed the multifactorial causes of boarding through seven predetermined frameworks, as listed below. Based on the robust discussion and identification of multiple challenges within each framework, Summit participants determined the most significant and consequential causes of ED boarding (see Appendix for full list of causes).

1) Transparency
   - Variations in reimbursement mechanisms and models across states and payers

2) Regulatory Challenges
   - Inadequacy of psychiatric bed availability
   - Medicaid Institutions for Mental Disease (IMD) exclusion

3) Mental Health
   - Inadequacy of community-based mental health care
   - Lack of crisis stabilization services

4) Financial Drivers
   - Improper emergency medical services (EMS) reimbursement
   - Inadequate reimbursement for psychiatric services

5) Operational Modifications
   - Barriers to discharging patients to inpatient services

6) Workforce
   - Lack of experience in nursing/nursing turnover
   - Inadequate nursing pathways and educational opportunities

7) Other
   - Inadequate housing/access to care/social determinants

Current Efforts and Potential Solutions

To inform the Summit's discussion on potential solutions to the boarding crisis and action items to achieve those solutions, participants discussed current efforts to reduce boarding and potential further actions that could be incorporated into wider systemic solutions, with a focus on local, state, and federal governmental actions and the incorporation of technology and data in mitigating the boarding crisis.

Current Efforts

Government Role	• Increases in investment in public health measures and preventive health
	   o Creation of ED dashboards to define the problem
	   o CMS creation of flexibilities for Medicaid, including waivers to address social determinants of health such as temporary housing for psychiatric patients who have no home to be discharged to or programs for proper nutrition education
	• Implementation of state-sponsored care coordinators in community health programs
	• State-based regulatory changes to address workforce needs including:
	   o Streamlined licensure and certification requirements
	   o Expanding available clinical slots for nursing programs
	   o Reimbursing paramedics as community health workers
	• Medicaid reimbursement of mobile crisis response units in Alaska and Arizona
	• Implementation of the new 988 crisis response line

Technology Role	• Oregon, Hawaii models of resource-tracking including hospital capacity and staffed bed availability
	   o Interoperable between EMS, EDs, and inpatient facilities
	   o Information only available to health care entities
	• Georgia Coordinating Center tracking ED capacity and wait-times
	   o Available to the public

Other	• Enhanced role of community paramedicine and telehealth • 24/7 nurse call centers • Hospital-at-home model

Potential Solutions

Government Role	• Increased investment in public health and preventive health efforts
	• Shift to evidence-based policymaking
	   o Including empirical data
	   o Consistent evaluation and reevaluation of needs based on ongoing collected data
	• Community conversations of complex issues as a driver of systemic change
	• Testing different payment reform models
	   o Because of the current difficulties and expenses surrounding waiver requests on a state basis, CMS could create pre-approved Medicaid waiver templates
	• Transformation of primary care delivery models including physician extenders and community health workers
	• Financial incentives to increase the coordination of specialty referrals and mental health support to create a more cohesive continuum of care and collaboration between points the health care spectrum
	• Scope of practice laws
	• Realignment of Joint Commission focus on boarding and staffing issues
	• Federal and state review to launch better training programs for RNs and long-term care workers
	• State- or federal-based regulatory and legislative initiatives to address workforce issues
	   o Increasing slots for nursing programs
	   o International visas for health care workers

	o Up-front educational grants versus loan repayment o Additional incentives for nursing instructors o Creation of incentives for health care workers in rural areas including pathways of community health workers to nursing o Stackable certifications
Technology Role	• Centralized, standardized resource tracking, including consideration of public-facing data • Payment allocation and sustainability for ongoing technological projects • Increased state and local access to preparedness data
Other	• Review of data and effectiveness of all CMMI models to inform further innovative solutions

Critical Priorities, Barriers, and Potential Actions

Based on identification of major causes and conception of possible and actual remedies to these problems, the Summit's participants engaged in a structured group decision-making exercise to identify consensus priorities for action within three of the original frameworks: Mental Health, Financial Drivers, and Workforce.

Mental Health

Priority	Barriers	Solutions
Crisis Stabilization	• Lack of available services • Inadequate funding and reimbursement • Complex medical/psych patients need specialized care that may not be available	• Northwell Health model - schools send kids to crisis response units at the hospital itself to evaluate • Crisis Now Model in AZCA • EmPATH units
Community-based health interventions	• Lack of available resources • Complex medical/psych patients need specialized care that may not be available • Inadequate funding and reimbursement • Long-term care patients not having a responsible party • Community engagement	• CMS Waiver for mental health • Medicaid in schools • Engage with patient advocacy groups to create a collaborative workgroup

Financial Drivers

Priority	Barriers	Solutions
EMS reimbursement remodel	• Lack of political will and momentum	• Reimburse for care coordination/ navigation instead of just transport • Federal legislative and regulatory advocacy
Sufficient Medicaid reimbursement	• Lack of political will and momentum • Lack of awareness around available Medicaid waivers	• Advocacy to ensure Medicaid pay at least Medicare reimbursement rates to induce people to perform those services • Increased communication around available Medicaid waivers, templates to facilitate cumbersome and expensive application process. • San Antonio Reg Care Coordination model • Exploration of Safer Communities Act funding

Workforce

Priority	Barriers	Solutions

Turnover/ lack of experience in nursing	• Threat of violence/verbal abuse in the ED
	  o HCWs face highest level of workplace violence
	  o Reformation of the environment for nurses - nurses are asked to do extraneous tasks, do not feel respected
	• Large number of nurses planning to leave profession due to burnout, unpreparedness
	• Deterioration of respect and safety zone of the hospital
		• Community partnerships with police to combat ED violence
		• SAVE Act
		• Implementation of community care/social workers in the ED

Improved nursing pathways	• Staffing ratios and standards
	• Inadequate nursing slots and pathways
		• State- or federal-based regulatory and legislative initiatives to address workforce issues
		  o Increasing slots for nursing programs
		  o International visas for health care workers
		  o Student loan and grant remodel
		  o Additional incentives for nursing instructors
		  o Creation of incentives for health care workers in rural areas including pathways of community health workers to nursing
		  o Stackable certifications

Next Steps

The Summit reached a consensus opinion that continued collaboration and dialogue around these issues is imperative to create and implement solutions. Suggestions included creating a listserv for continued conversation around advocacy strategies at the state and federal level, and sharing talking points and other tactics. Summit participants also suggested further stakeholder engagement, including increased patient advocacy and government agency participation, with the potential to hold another Summit.

Appendix

Full List of Boarding Causes Raised in Summit

1) Transparency
   - Variations in reimbursement mechanisms and models across states and payers

2) Regulatory Challenges
   - Hospital flow/being able to move patients, often due to insurance
   - Complex patients (mental health + physical)
   - Medicare 190-day cap for lifetime services
   - Lack of quality measures to ensure standards are met
   - EMTALA impact
   - Observation status
   - Inadequacy of psychiatric bed availability
   - Medicaid Institutions for Mental Disease (IMD) exclusion

3) Mental Health
   - Inadequacy of community-based mental health care
   - Lack of crisis stabilization services
   - Complex mental health patients
   - Lack of mental health beds

4) Financial Drivers
   - Priority variable for ED vs surgical inpatient, etc.
   - Admission via ED vs scheduled admission
   - Public payers underpaying
   - Improper emergency medical services (EMS) reimbursement
     - Reimbursement only if transported
     - Teleparamedicine reimbursement challenges
   - Inadequate reimbursement for psychiatric services
   - Impact of nursing on hospital bottom-line
   - Financial rewards vs penalties for boarding

5) Operational Modifications
   - Patients "lost" in the system/unable to navigate system
   - Barriers to discharging from inpatient
   - EMS transport limited for transfer to nursing home, etc
   - Acute transport barriers
   - Throughput inefficiencies within hospital system
   - Psychiatric bed availability
   - Designated bed spaces
   - Barriers to discharging patients to inpatient services

6) Workforce
   - EMS units closing
   - Lack of specialists
   - Lack of experience in nursing/nursing turnover
   - Inadequate nursing pathways and educational opportunities
   - Community mental health service
   - Housing needs closer to rural sites
   - Training slot availability
   - Burnout spiral worsening shortages

7) Other
- Inadequate housing/access to care/social determinants
- Incentivize community health nursing during training

Full List of Solutions Raised in Summit

ACEP Boarding Task Force Recommendations

- Payment incentives for hospitals that adjust the current fee for service ED payments with a sliding scale of modifiers including penalties and rewards based on boarding times
- Develop reportable, publicly available boarding quality measures to include average boarding time, the percentage of ED patient capacity reduced by boarders, and the total number of patients and hours of boarding per day.
- Eliminate emergency physician liability related to delays in care due to excessive boarding, with hospitals assuming liability for any bad outcomes related to delays in care caused by boarding.
- Implement incentives and penalties for long-term care facilities to accept patients round the clock.
- Temporarily lift Certificate of Need (CON) processes that can limit a hospital's ability to expand inpatient bed capacity in some states.
- Explore alternative locations for psychiatric and social boarding of patients awaiting placement through development of pilot programs.

Summit Participant Recommendations

Technology

- Access to data can drive efficiency
  - Oregon experience: 28 hours reduced to 4.7 hours
- Capturing avoidable days
  - Include pater types
  - Utility in quantifying why people are stuck
- Reimbursement for transfer to more appropriate care
- What data/info available to the public?
- Ensure states have access to data (preparedness officers, etc)
  - Provide off-the-shelf solutions to build uptake
  - Who is paying for these tools?

Mental Health

- Connect child pysch to schools to provide services (Northwell, NY Project Teach)
  - State funding
- Flexible waivers for high acuity
- Child patient navigators
- Crisis Now model in AZ
- Standardize smart form
- CMS waiver mental health in schools
- EmPATH units California
- State pays for peer-to-peer services
- Geriatric psychiatry
  - Long term care challenging

- o Responsible party issues
- Medicaid re-entry
  - o Waiver options
  - o Connect to community care

Workforce

- Data to supplement narratives
- Primary care transformation (physician extenders, community health workers)
- Scope of practice laws
- Joint Commission and QIOs more focus on staffing ratios
- New models that incentivize coordinated care
  - o Collaborative care, hub & spoke
  - o Need financial incentives
- Expedition of visas, increase GME, scholarship/loan repayment
- Upfront funding of education vs. loan repayment.
- Open up more spots in public institutions
- Nurse educator shortages
- Stackable certifications
- Community paramedicine
  - o Reimbursement (certified in TX as community health workers)
- Mobile crisis units
  - o FMAP waiver, low pickup
  - o 50-70% drop in EMS and ED visits when used (AZ success)
- Federal and local review of requirements for allied health workers to reduce dependency on RN instructors
- LTC training

Regulatory Changes

- Evidence-based policymaking
- Defining terms (what exactly is an ICU patient, for example)
- Data needs, dashboards
- States exploring Medicaid flexibilities on housing, food, etc
  - o Care coordinators
- Testing different payment reform models
- More pre-approved CMS Medicaid waivers (costs ~$1.5 million for a state to develop its own)
  - o Waiver templates
- CO & WA post-acute incentives for nursing homes to increase patients (public)
- 24/7 Nurse Call Centers
- Review data from all CMMI models
- Hospital-at-Home model
  - o Eliminate current requirement for ED visit for entry
- Models to consider
  - o San Antonio Reg Care Coordination
  - o Safer Community Act
  - o Caregiver support/training
    - ▪ Incentives for living near relatives