American College of Emergency Physicians®

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TOOLKIT FOR ENACTING MEANINGFUL LEGISLATIVE AND REGULATORY SOLUTIONS FOR ED BOARDING AND HOSPITAL CROWDING

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Executive Summary:

Emergency department (ED) boarding and hospital crowding are solvable challenges, but only with focused, prioritized action. This toolkit presents a phased strategy for reducing ED boarding through a combination of hospital-level operational reforms, targeted state policy interventions, and accountable enforcement mechanisms. The goal is to drive measurable, near-term improvements without relying on new funding or long-term federal fixes.

Important: Metrics Should Follow Action, Not Precede It

Most legislators, and many physicians, expect mandated reporting of ED boarding metrics. However, **data collection must serve implementation,** not precede it. For decades, the healthcare system has invested in measuring boarding without requiring corrective action. This toolkit endorses metrics only when directly tied to mandated operational responses, such as surge protocol activation, discharge targets, or staffing requirements. **Passive data reporting without consequences has failed, and should not continue or be endorsed by any organization or governmental body.**

1. **Immediate Priority: Legislatively Mandated Hospital-Based Operational Reforms (Require Zero Funding)**
   These solutions are fully within hospital control and offer the fastest, most impactful path to improvement.
   Legislative or regulatory action should prioritize:
   - Elective admission smoothing to avoid midweek surges
   - Early discharge protocols to free beds by late morning
   - Weekend discharge and ancillary services to maintain 7-day flow
   - Surge response protocols triggered by real-time boarding thresholds
   - Licensing or accreditation linkage to throughput compliance

   These reforms require no additional funding, only accountability and leadership.

2. **Secondary Priority: State-Level Supportive Policies (Require Funding)**
   To sustain hospital progress, states should pursue policy and funding solutions that address broader system bottlenecks:
   - Presumptive Medicaid eligibility for timely discharge of uninsured patients
   - 7-day insurer authorization mandates for post-acute placements
   - Expansion of SNF, rehab, and behavioral health capacity
   - Real-time bed coordination platforms
   - Centralized escalation offices for stalled discharges

   These interventions should be pursued after or in parallel, **but not before**, hospital reforms.

3. **Structural Federal Barriers: Acknowledge - Understand the Limits of Federal Levers**
   Unfunded mandates like EMTALA, chronic underpayment, and national bed shortages are real, but outside state or hospital control. They merit federal advocacy but should not delay immediate action for items 1 and 2 above.

4. **Avoid Ineffective or Counterproductive Measures**
   - Metric reporting requirements without tied actions
   - Financial penalties that incentivize metric manipulation
   - Awareness campaigns without operational reform
   - Overly broad, bundled mandates that dilute accountability

Executive Summary Conclusion

Start with what can be fixed now: **hospital operations.** Tie metrics to action, not data transparency for its own sake. Pursue supportive state policy reforms where feasible. Avoid distractions, delays, or dependence on federal change. This toolkit offers a focused, actionable roadmap for reducing ED boarding through enforceable, evidence-based reforms that improve patient care, starting today.

Introduction

Purpose of the Toolkit

This toolkit supports policymakers, healthcare leaders, and community stakeholders in crafting legislative and administrative solutions to reduce emergency department (ED) boarding and hospital crowding. It outlines root causes, highlights effective policy options, and promotes collaborative strategies to improve patient outcomes, reduce delays, and enhance hospital operations.

Scope: Key Definitions

- **ED Boarding:** When admitted patients remain in the ED due to unavailable inpatient beds, leading to delays, overcrowding, and worsened outcomes.
- **Hospital Crowding:** A mismatch between inpatient demand and hospital capacity that disrupts admissions, discharges, and care across hospital units.
- **Patient Throughput Challenges:** Inefficiencies in patient movement—from ED arrival to discharge or transfer—caused by delays in admissions, diagnostics, and care coordination, contributing to system-wide congestion.

Why ED Boarding and Hospital Crowding Matter: The Impact on Patient Outcomes, Staff, and the Healthcare System

ED boarding and hospital crowding have widespread negative consequences for patients, healthcare workers, and hospitals. These challenges are not just logistical issues—they directly affect safety, quality of care, and healthcare system efficiency.

1. **Impact on Patient Outcomes**
   - **Increased Medical Error:** Boarding delays timely assessment and treatment, raising the risk of missed diagnoses, medication errors, and treatment complications.
   - **Increased Mortality:** Multiple studies, including those published in Annals of Emergency Medicine, JAMA Internal Medicine, and PLOS One, have found a clear association between ED boarding and higher mortality rates. Each additional hour of boarding can increase the risk of death by up to 1%.
   - **Longer Hospital Stays and Readmissions:** Boarding leads to delays in treatment and disposition, which extend overall hospital length of stay and increase the chance of readmission.

2. **Impact on Hospital Staff**
    - **Burnout and Stress:** ED crowding is a leading cause of burnout among nurses and physicians. High stress, moral injury, and constant triage under pressure contribute to workforce fatigue and reduced well-being.
    - **Staff Turnover and Job Dissatisfaction:** Overwhelmed staff are more likely to leave their positions, worsening staffing shortages and straining the care environment even further.

3. **Impact on the Healthcare System**
    - **Increased Costs:** Boarding drives up operational costs due to longer stays, increased testing, and delayed discharges. The AHA estimates ED boarding costs hospitals over $2 billion annually.
    - **Systemic Bottlenecks:** Poor coordination across care settings (e.g., delays in post-acute care placement) leads to longer hospital stays and blocks access for other patients.
    - **Reduced Access to Emergency Care:** Crowded EDs impair timely triage and treatment for new emergencies like trauma, stroke, or cardiac arrest, directly harming patient outcomes.

Solving ED boarding and hospital crowding requires coordinated efforts at both the policy and hospital levels. The following sections of this toolkit outline actionable, evidence-based strategies for improving flow, capacity, and care coordination across the system.

Problem Analysis

Emergency department (ED) crowding and boarding are symptoms of a broken patient flow system. The primary culprits fall into three categories:

- Hospital operations are misaligned with the demands of 24/7 emergency care, often due to outdated workflows and lack of coordination.
- System-level barriers outside the hospital (mental health, rehab beds, insurance delays) block timely discharge and placement, creating backlogs.
- Federal structural issues (like EMTALA) and chronic underfunding worsen these problems but are harder for states to fix directly.

To prioritize action, it helps to separate these into what states and hospitals can fix vs. what they must navigate but can't directly change.

Systemic Realities That Matter, But Are Outside Immediate Control

These are real, high-impact issues, but state policymakers and hospital leaders have limited ability to fix them alone. They require long-term federal advocacy or market shifts.

- **EMTALA's unfunded mandate**
  Emergency departments are legally required to evaluate and stabilize all patients, regardless of insurance or ability to pay. But there's no dedicated funding to support this.
- **Chronic underpayment by Medicaid (and uninsured care)**
  Medicaid often pays less than the cost of care, and hospitals serving large numbers of Medicaid or uninsured patients face structural financial instability.

- **National inpatient bed reductions since the 1970s**
  The U.S. has far fewer inpatient beds per capita than it once did. Rebuilding capacity takes years and federal investment.

Actionable Problems That States and Hospitals Can Address

Fixable Hospital-Based Operational Failures

These issues are within the control of hospitals but may need policy nudges, regulatory standards, or incentives to fix.

- **Weekday-centric hospital operations**
  Most hospital services run 9–5, Monday–Friday, even though EDs and acute care run 24/7. This creates backlogs on weekends and slow responses at night.
- **Late-day inpatient discharges**
  Discharges often happen after 2–3 PM, leaving too little time to clean and turn over beds for waiting ED patients.
- **Few weekend discharges**
  Lower weekend staffing means discharges drop sharply on Saturdays and Sundays, even when patients are medically ready.
- **Batching of elective procedures**
  Surges in scheduled procedures early in the week flood inpatient units, making it harder to admit emergent patients from the ED.
- **No operational triggers tied to real-time boarding data**
  Even when hospitals track ED boarding data, they rarely have automatic response protocols (e.g., canceling elective surgeries or opening surge units).

External Systemic Barriers (State-Addressable)

These are community-level gaps or payer-related policies that states can influence over time with legislation, funding, or partnerships.

- **Shortage of skilled nursing, rehab, and long-term care beds**
  Patients often "languish" in hospital beds for days because there's nowhere else to send them.
- **Insurance authorization delays for post-acute care**
  Delays in approvals from private insurers and Medicaid keep patients in beds longer than medically necessary.
- **Limited behavioral health and addiction treatment beds**
  Psychiatric patients, including children, are often boarded in EDs for days awaiting placement.
- **Lack of community-based palliative, hospice, or home care options**
  Patients who could be managed at home or elsewhere stay in hospitals due to system gaps.
- **Medicaid pending eligibility gaps**
  Uninsured or undocumented patients who likely qualify for Medicaid often face discharge delays while their application is pending. This stalls transfers to SNFs, rehab, and behavioral health facilities.
- **Fragmented care coordination between hospitals, SNFs, and behavioral facilities**
  Patients remain hospitalized because facilities operate in silos, with no shared tools for referrals or updates.

- **No centralized escalation mechanism for blocked discharges**
  When discharges stall due to payer disputes, missing paperwork, or placement refusals, there is often no authority or escalation path to intervene.

The Role of Data: Essential for Targeted Action

Regardless of where the problem lies, data collection and transparency are essential but must be actionable and enforceable. Metrics like average ED wait times, boarding duration, and discharge timing can:

- Identify breakdowns in flow
- Inform policy and hospital benchmarking
- Track the impact of interventions over time

States should consider requiring hospitals to report these metrics regularly and to implement mandated internal triggers based on thresholds. For data to drive meaningful change, it must be paired with clear mandates and accountability.

The following chart further details these contributing factors and their specific impact on ED boarding and crowding. Chart adapted from Emergency Department Crowding: The Canary in the Healthcare System, Kelen et. al. NEJM Catalyst, 2021.

Cause Type	Problem	Why the Problem Occurs
Health System Level	Financial pressures drive crowding	Hospitals increase inpatient volume to maximize revenue, straining their operational capacity.
	Reduced inpatient bed capacity	National inpatient capacity has decreased significantly since 1975, limiting available beds.
	Insufficient primary care	Lack of primary care access causes preventable ED visits and hospitalizations due to unmanaged conditions.
	Limited skilled nursing and rehab facilities	Patients ready for discharge stay in inpatient beds, as SNFs or rehab centers lack capacity.
	Limited psychiatric and addiction services	EDs often hold patients for days waiting for placement due to scarce mental health resources.
	Gaps in coverage for underinsured patients	Inadequate insurance leads to deteriorating conditions and avoidable ED visits and admissions.
Hospital Factors	Leadership lacks focus on ED issues	Hospital priorities may not align with immediate ED capacity needs, slowing response to crowding.
	Non-24/7 hospital operations	Hospital services mainly operate during business hours, leaving gaps in after-hours inpatient support.
	Limited after-hours care options	Lack of off-hours care drives patients to the ED for manageable conditions, increasing crowding.
	Inpatient nurse shortages	Staffing shortages, especially post-COVID, limit functional bed availability and increase crowding.
	Acceptance of crowding as routine	Frequent ED crowding has become a tolerated norm, reducing urgency to resolve underlying issues.
ED Input Factors	High ED volumes	Surges in patient volume, often after weekends and holidays, stress ED resources.
	Inflexible primary care scheduling	Inability to get timely appointments leads patients to seek ED care for non-emergency issues.
	Preference for ED diagnostics	Fast diagnostics and insurance coverage drive referrals to ED for rapid evaluations.

Cause Type	Problem	Why the Problem Occurs
ED Throughput Issues	Increased complexity of cases	More complex patients require extended time and resources to evaluate and treat.
	Delays in ancillary services	Slow response from labs, radiology, and consultants extends ED stay times.
	EMR documentation burdens	Extensive documentation requirements slow down providers, reducing patient flow.
ED Output Factors	Access block due to high census	Limited inpatient beds block ED discharges, causing crowding.
	Late inpatient discharges	Discharges often occur late in the day, reducing bed turnover for ED admissions.
	Bed set-asides for specific patients	Holding beds for certain cases limits overall availability for incoming ED patients.
	Extended stays for end-of-life patients	Patients with poor prognoses occupy inpatient beds due to a lack of end-of-life planning resources.
	EMS Transfer Delays	Faced with challenges in transferring patients efficiently when EDs are full and when EMS is short-staffed.

Current Challenges with Existing Legislation

Despite numerous efforts at the state and federal levels to address ED boarding and hospital crowding, current legislative initiatives have largely failed to produce sustainable solutions. These shortcomings stem from a combination of inadequate policy enforcement, insufficient funding, and systemic issues that extend beyond the scope of individual pieces of legislation. Key challenges include:

- **A fragmented healthcare system,** where policies often focus on isolated issues, such as expanding hospital capacity, without addressing broader systemic factors like post-acute care shortages, mental health resource gaps, or outpatient care needs.
- **Insufficient funding and resources** have also hindered effective solutions, as many states lack the necessary financial investment to implement meaningful changes, particularly in staffing, training, technology, and infrastructure.
- **Limited regional coordination** between healthcare systems exacerbates crowding, as a shortage of beds in one facility can overwhelm neighboring hospitals. While some states have made attempts at regional coordination, these efforts are often voluntary or underfunded, leading to inconsistent results.
- **Lack of comprehensive legislation** means that many laws aimed at addressing ED crowding are narrow in scope and fail to address the broader systemic issues, including mental health care access and regional capacity coordination. Furthermore, enforcement of existing regulations is often lax, allowing hospitals to continue practices that contribute to crowding.

The table below further illustrates these challenges and their root causes.

Reason for Failure	Explanation
Fragmented Health System	Legislative solutions often address specific issues rather than coordinating across the full continuum of care, leading to limited impact.
Lack of Clear Accountability	Laws frequently lack enforcement mechanisms or clear accountability, allowing hospitals to delay or ignore mandates without consequence.
Insufficient Funding and Resources	Many legislative efforts do not provide adequate funding, leaving hospitals without the resources needed to effectively implement changes.
Short-Term Focus	Policies may focus on immediate reductions in ED crowding without addressing underlying causes like bed shortages and inadequate community resources.
Resistance from Healthcare Stakeholders	Hospitals and healthcare organizations may resist mandates they view as too costly, disruptive, or burdensome to existing workflows.
Complexity of Implementation	Legislation often requires extensive coordination, which is challenging in a fragmented healthcare landscape with multiple independent players.
Data Gaps and Insufficient Monitoring	Inconsistent data reporting and monitoring hinder the ability to track outcomes and enforce improvements over time.
Limited Scope of Legislation	Laws may apply only to specific groups (e.g., psychiatric patients), failing to address broader issues affecting all ED patients.
Unaligned Financial Incentives	Payment structures may continue to reward hospitals for keeping inpatient beds occupied, indirectly contributing to crowding by not freeing up capacity.
Inadequate Regional Coordination	Legislative efforts often lack mechanisms for regional bed-sharing or coordination across facilities, limiting the ability to address high census.
Focus on Downstream Solutions	Many policies target symptoms (e.g., ED wait times) rather than upstream issues, like lack of primary care access or inadequate community support services.
Burdensome Regulatory Requirements	Complex compliance requirements can strain already limited hospital resources, diverting attention from patient care to administrative tasks.
Low Public Awareness	Insufficient awareness or understanding of the impact of ED boarding among the general public limits political and financial support for robust solutions.

Current State Legislation Addressing ED Boarding and Crowding

There is minimal legislation aimed directly at the issue of ED boarding and crowding. Enacted legislation only requires data reporting and does not mandate solutions so it is unclear whether this will improve the boarding and crowding problem in the future.

Enacted Legislation

Connecticut - Public Act No. 24-4 (2024)

- **Focus:** Requires hospitals to analyze and report data on ED crowding, patient volume, and boarding times.
- **Requirement:** Hospitals must develop strategies to reduce crowding and submit annual reports to the Department of Public Health.
- **Purpose:** To improve hospital responses to ED boarding and ensure transparency on wait times and patient flow.

Pending Legislation

Connecticut Pending Legislation (SB 487 - 2025)

- **Strengthening Data Reporting & Policy Enforcement** – Expands on Public Act 24-4 by reinforcing hospital obligations to track and report ED boarding metrics, while ensuring policies to mitigate crowding are not just developed but actively implemented.
- **Legislative Oversight & Continuous Evaluation** – Establishes ongoing legislative review of emergency department conditions, with mechanisms for state-level intervention if hospitals fail to comply with boarding reduction strategies.

Legislative Strategies

1. Hospital-Based Solutions Within Institutional Control (Priority #1)

To improve patient outcomes, reduce medical errors, and alleviate workforce strain, legislation should require hospitals to implement evidence-based operational strategies proven to reduce ED boarding and crowding. These measures should be mandated, not optional, and measurably enforced.

- **Mandate elective admission smoothing across weekdays**
  Require hospitals to distribute elective admissions more evenly across the week to avoid Monday–Wednesday bed shortages that lead to downstream ED boarding.
- **Require hospitals to implement early inpatient discharge protocols**
  Establish institutional targets for discharging a defined percentage of inpatients by late morning (e.g., 11 a.m.) to open capacity for ED admissions and reduce hospital-wide gridlock.
- **Expand discharge and ancillary services to weekends**
  Mandate minimum staffing levels for physical therapy, case management, and discharge planning on Saturdays and Sundays, enabling safe and timely weekend discharges.
- **Link hospital licensing or accreditation to compliance with throughput optimization standards**
  Incorporate these operational strategies into ongoing regulatory oversight, with site visits or independent audits tied to hospital licensing or certification processes.
- **Tie boarding data to required operational responses**
  Require hospitals to define and activate internal surge protocols once ED boarding exceeds a specified threshold (e.g., >6 hours for admitted patients), rather than treating data reporting as a passive requirement.

2.State-Level Policy Levers to Enable Institutional Effectiveness (Priority #2)

Many causes of ED boarding fall outside individual hospital control. States can address these through targeted policy and funding interventions that remove structural bottlenecks and realign financial incentives. These should be done after or in parallel with hospital-based solutions but should not be the initial priority.

- **Create presumptive Medicaid eligibility for ED patients**
  Enable temporary point-of-care coverage for eligible but uninsured patients, reducing discharge delays and preventing unnecessary inpatient stays.

- **Ensure 7-day insurer accountability for post-acute authorizations**
  Mandate that insurers make prior authorization decisions for skilled nursing, rehab, and behavioral health placements within a set timeframe (e.g., 4 hours), including weekends.
- **Support expansion of post-acute and behavioral health capacity**
  Provide direct state investment, financing tools, or regulatory relief (e.g., certificate-of-need reform) to grow system capacity for discharge destinations.
- **Require statewide real-time coordination for inpatient and post-acute transfers**
  Mandate hospital and post-acute provider participation in a state-supported platform for real-time bed availability and referrals. Enable regional load balancing and reduce discharge delays through shared data, faster handoffs, and coordinated surge protocols.
- **Establish centralized escalation for blocked discharges**
  Create regional or state-level offices to resolve stalled discharges due to payer, paperwork, or placement issues, using arbitration, enforcement tools, and/or reporting to identify systemic barriers.
- **Fund emergency care as a public good**
  Allocate state-level funding to support emergency departments as 24/7 safety-net infrastructure, recognizing their role in absorbing system strain. This includes:
  - » Stabilizing ED staffing and inpatient surge capacity
  - » Investing in critical ancillary services required for patient flow
- **Offer throughput-based incentives, not penalties**
  Replace punitive measures with positive performance-based funding tied to adoption of high-impact interventions (e.g., smoothing, early discharge, weekend discharges), discouraging gaming while encouraging meaningful system redesign.

3. Federal Alignment and Strategic Advocacy Priorities

Where system-level reforms require national coordination or funding, state advocacy should align with federal initiatives such as the ABC-ED Act and ACEP's broader strategy.

- **Support implementation and funding of the ABC-ED Act**
  Encourage state agencies to seek federal grants through the ABC-ED Act (if passed) to modernize emergency care infrastructure, including:
  - » Real-time hospital capacity dashboards
  - » Crisis standards of care protocols
  - » Regional surge response planning
- **Advocate for Medicaid reimbursement parity with Medicare for ED services**
  Federal underpayment contributes to hospital financial instability and disincentivizes the expansion of inpatient capacity or staffing. Parity is essential for sustainable care.
- **Request federal action on EMTALA funding**
  Advocate for federal financial support to offset the uncompensated care burden imposed by EMTALA, which mandates care without a corresponding funding mechanism.

4. Cross-Cutting Principle: Data Transparency with Enforceable Accountability

Data reporting is essential to understanding and addressing ED boarding, but it must be a part of the solutions, not a function without action. Transparency without action enables inertia; real improvement comes only when data is directly linked to mandatory institutional responses and oversight.

- **Mandate public reporting of ED boarding metrics for implemented solutions**
  After solutions are implemented, require hospitals to report standardized boarding measures, including median boarding time for admitted patients and the number boarding over 4 or 8 hours. Public availability of these metrics empowers stakeholders and sets the foundation for accountability.
- **Tie reported data to required operational and regulatory responses**
  Data must not be collected for transparency alone. Establish thresholds that trigger specific actions—such as activation of internal surge protocols, submission of remediation plans, or external regulatory review for persistent underperformance.
- **Prioritize structural mandates over penalties or awareness campaigns**
  Financial penalties often create perverse incentives or drive metric manipulation. Public education alone cannot overcome systemic barriers. Legislative and regulatory efforts should focus on required operational reforms and capacity investments, not reactive punishment.

Administrative and Regulatory Solutions Based on Legislative Strategies

To ensure that legislative intent translates into real-world improvements, state agencies and regulators must adopt clear administrative rules, oversight mechanisms, incentives, and implementation frameworks. The following solutions are designed to enforce compliance, track progress, and support hospitals in executing mandated strategies.

1. Operational Oversight and Compliance Monitoring

- **Incorporate throughput standards into hospital licensing and accreditation**
  State health departments should update licensing criteria to require compliance with elective smoothing, early discharge protocols, and weekend discharge capacity. Compliance should be verified through:
  - » Regular site inspections
  - » Review of EHR-derived patient flow data
  - » Annual certification of adherence to operational standards
- **Establish mandatory internal surge protocol triggers**
  Require all licensed hospitals to submit and regularly update written surge protocols. These must be activated when ED boarding exceeds defined thresholds (e.g., >6 hours for admitted patients), with documentation submitted to regulators for data collection.
- **Require hospitals to conduct internal patient flow audits annually**
  Hospitals must identify and address internal factors contributing to discharge delays (e.g., consult turnaround times, late-day discharge cultures). Reports must be submitted to the health department with corrective actions.

2.State-Funded Technical Assistance and Incentives

- **Create a state-funded hospital throughput improvement program**
  Offer grant funding, expert consultation, or technical assistance to hospitals implementing smoothing, early discharge, and weekend staffing strategies. Participation could be incentivized through:
  - » Bonus Medicaid payments
  - » Preferential access to other funding streams (e.g., facility upgrades)
- **Administer Medicaid throughput incentives through hospital performance dashboards**
  Tie disbursement of bonus Medicaid payments to publicly reported metrics (e.g., smoothing compliance, early discharge %, weekend discharge rate), updated quarterly.
- **Launch a "Throughput Readiness Scorecard" pilot**
  Develop a standardized assessment tool to benchmark hospital readiness across domains such as discharge timing, staffing flexibility, and data-driven decision-making. Publicize results to support quality improvement and transparency.
- **Provide implementation waivers with technical support for rural hospitals**
  Allow rural or critical access hospitals to submit alternative compliance plans if throughput targets are unachievable due to workforce or geography. Require demonstration of good-faith effort and timeline for adaptation.

3.Data Infrastructure and Enforcement Mechanisms

- **Mandate real-time reporting of ED boarding data to the state health department**
  Require hospitals to submit de-identified, real-time or near real-time data on ED boarding, updated daily or weekly. Build dashboards to identify trends, outliers, and regions requiring intervention.
- **Track and report behavioral health boarding delays separately**
  Require hospitals to disaggregate ED boarding data for behavioral health patients. Prioritize grant funding or facility expansion approvals for hospitals with prolonged BH boarding rates exceeding 12 hours.
- **Link boarding data to regulatory review and action plans**
  Hospitals meeting approved metrics can become eligible for enhanced funding, technical assistance, or public recognition upon demonstrated progress in reducing boarding times. Hospitals exceeding defined boarding thresholds for multiple weeks should:
  - » Submit corrective action plans with timelines
  - » Participate in targeted quality improvement support programs coordinated by the licensing body
- **Mandate participation in regional coordination platforms**
  Require hospitals and post-acute providers to enroll in state-coordinated real-time bed coordination systems. Offer technical onboarding and financial support, with incentives for participation.

4.Administrative Policy Alignment with State-Level Levers

- **Ensure 7-day payer compliance through insurance oversight divisions**
  Task the state insurance commissioner or Medicaid authority with enforcing 7-day-a-week authorization response mandates, including penalties for delays and quarterly public reporting of payer compliance rates.

- **Streamline presumptive Medicaid eligibility processes**
  Coordinate between emergency departments, hospitals, and Medicaid offices to create point-of-care digital enrollment pathways. This could include:
  - » Allowing hospitals to submit basic eligibility screening forms electronically
  - » Issuing temporary patient IDs pending full enrollment determination
- **Accelerate certificate-of-need (CON) reform or waiver processes**
  Prioritize fast-track approval for new skilled nursing, rehab, and behavioral health capacity—especially in regions with high ED boarding. Consider:
  - » Waiving CON requirements in areas with identified discharge bottlenecks
  - » Providing low-interest capital for facility expansion
- **Define minimum ancillary staffing ratios for discharge readiness**
  Establish benchmarks for weekday and weekend staffing of key discharge-related roles (e.g., case management, PT, pharmacy). Require hospitals to meet these benchmarks to qualify for throughput incentives.
- **Establish a public transparency board on ED throughput**
  Create a public-facing committee to review hospital performance, advocate for patient rights, and make policy recommendations based on dashboard data and community experience.

5.Federal Program Alignment and Grant Administration

- **Establish a state-level Emergency Care Infrastructure Office (ECIO)**
  This office would coordinate applications for federal funding through the ABC-ED Act and other programs, ensuring that:
  - » Hospitals receive technical support for capacity dashboards and surge planning
  - » Emergency care infrastructure is prioritized in state budget planning
  - » Grant funds are equitably distributed based on ED volume, regional need, and demonstrated planning

Prioritized Action Plan for Hospital and ED Throughput Reform

Start with high-impact hospital-led changes that are within control:

- Mandate elective admission smoothing
- Require early inpatient discharges
- Expand weekend discharge and ancillary staffing
- Tie compliance to hospital licensing/certification
- Activate surge protocols based on boarding thresholds

*Use data from the start, but only if it triggers mandatory action and is linked to implemented solutions, not just reporting.

Next, pursue state-level policies to support hospitals:

- Presumptive Medicaid eligibility
- 7-day insurer authorization accountability
- Post-acute care capacity expansion

- Real-time bed coordination platforms
- Centralized discharge escalation offices
- Throughput-based positive incentives

In parallel, establish regulatory oversight and technical support:

- Compliance monitoring and audits
- Grant-funded throughput improvement programs
- Public performance dashboards tied to incentives
- Rural hospital compliance waivers

Avoid or de-emphasize:

- Data reporting without action
- Penalties that encourage gaming the system
- Public outreach without clear tools
- Bundling post-acute and payer reforms into hospital mandates

Summary Roadmap

Priority Level	Action	Goal/Benefit	Timeline
Start Here	Smoothing, early discharge, weekend staffing, surge protocols tied to licensing	Quick, measurable impact	3-6 months to legislate, 6-12 months to implement
Try Next	Medicaid eligibility, insurer accountability, capacity growth, bed coordination	Address external system bottlenecks	12-24 months
In Parallel	Regulatory monitoring, technical support, incentives, rural waivers	Support and enforce compliance	Ongoing
Avoid	Passive data reporting, penalties, public outreach, bundled reforms	Prevent wasted effort	Immediate

Appendices

1. Quick Start Checklist for Reducing ED Boarding and Hospital Crowding (Appendix 1)
2. Drafting Guidance Outline for Model Legislation & Regulatory Rulemaking: Structured framework providing clear, practical recommendations on how to draft, implement, and enforce effective legislation and administrative rules for improving hospital throughput and emergency department flow. (Appendix 2)
3. Collaboration Agreement Template: Example agreements for hospital partnerships, nursing home transfers, and urgent care coordination (Appendix 3).
4. Metrics for Monitoring and Evaluation: Sample metrics and evaluation frameworks to measure the success of implemented strategies over time (Appendix 4).
5. Additional Resources: Links to federal resources and funding opportunities, and reference articles on boarding and crowding (Appendix 5).

Appendix 1

Quick Start Checklist for Reducing ED Boarding and Hospital Crowding

Step 1: Start with Hospital Fixes (Months 3–6)

These actions are high-impact, immediately doable, and require no new funding. Legislation or regulation should mandate these reforms with clear expectations for measurement.

- ☐ Mandate elective admission smoothing across weekdays
- ☐ Require early inpatient discharge protocols (e.g., % discharged before 11 a.m.)
- ☐ Expand weekend discharge and ancillary staffing (PT, pharmacy, case management)
- ☐ Link hospital licensing or accreditation to throughput compliance
- ☐ Require boarding-triggered surge protocols (e.g., action required if boarding>6 hours)

Each solution should be passed with a clear requirement that its effectiveness will be measured, not studied in advance of implementation.

Step 2: Add State-Level Support (Months 12–24)

These interventions address broader system barriers that hospitals can't fix alone. They can be developed in parallel once hospital-based reforms are underway.

- ☐ Enable presumptive Medicaid eligibility at the point of care
- ☐ Require 7-day insurer authorizations for SNF, rehab, and behavioral health
- ☐ Expand post-acute and behavioral health capacity through targeted investment or fast-tracked approval
- ☐ Require hospitals and post-acute facilities to join a real-time bed coordination platform
- ☐ Establish a state-level escalation office for resolving blocked discharges

Avoid Common Pitfalls

- Don't delay action to collect more data
- Don't rely on financial penalties—they encourage gaming
- Don't bundle system-level and hospital reforms into a single mandate
- Don't wait on federal fixes for structural issues outside state control

Summary: Act First, Measure by Design

- Build solutions with embedded accountability
- Start with operational reforms hospitals control
- Add supportive state policy where needed
- Avoid distractions, delays, or performative solutions

Appendix 2

Drafting Guidance Outline for Model Legislation & Regulatory Rulemaking

The Drafting Guidance Outline is designed to be plug-and-play, offering a flexible menu of legislative and regulatory options. It's not intended to be implemented in full, but rather to help advocates and policymakers identify the most practical, high-impact strategies tailored to their state's specific needs and political environment.

I. Legislative Guidance

1. Hospital-Based Solutions Within Institutional Control

- Mandate elective admission smoothing across weekdays
  - » Insert into Public Health Code under Hospital Licensing or Quality Improvement sections.
  - » Define "elective admission," "smoothing," and compliance metrics in statute or delegated rules.
  - » Require periodic reporting and verification by health department.
  - » Include language authorizing incentives tied to Medicaid or state funding programs.
  - » Provide exemptions or modified standards for rural/small hospitals.
- Require hospitals to implement early inpatient discharge protocols
  - » Add as discharge planning requirements within hospital quality statutes.
  - » Set numeric thresholds (e.g., % discharges before 11 a.m.) with flexibility for hospitals.
  - » Include data submission requirements and timelines.
  - » Authorize state health department to issue supportive guidance and incentives.
  - » Coordinate with federal CMS discharge planning regulations.
- Expand discharge and ancillary services to weekends
  - » Amend hospital staffing and service provision statutes or Medicaid reimbursement rules.
  - » Define minimum weekend staffing as percentage of weekday levels.
  - » Require hospitals to report staffing and service utilization data.
  - » Encourage pilot projects and funding programs through Medicaid or state grants.
- Link hospital licensing or accreditation to compliance with throughput standards
  - » Amend hospital licensing statutes to include throughput compliance as a licensing criterion.
  - » Require annual compliance reporting with audit certification.
  - » Authorize nonpunitive technical assistance programs and incentive mechanisms.
  - » Specify expedited license renewals or funding prioritization for compliant hospitals.
- Tie boarding data to required operational responses
  - » Incorporate into emergency preparedness or hospital quality improvement laws.
  - » Define "boarding threshold" and required internal surge protocol activations.
  - » Require timely reporting of surge activations with detailed data.
  - » Mandate state provision of model protocols and technical assistance.
  - » Establish quality-based funding or public recognition incentives.

2.State-Level Policy Levers to Enable Institutional Effectiveness

- Create presumptive Medicaid eligibility for ED patients
  - » Add provisions within state Medicaid plan or Public Health Code enabling temporary enrollment at point of care.
  - » Define eligibility criteria and enrollment process.
  - » Authorize electronic submission of eligibility forms by hospitals.
  - » Provide for issuance of temporary patient identifiers.
  - » Tie funding and staffing incentives to presumptive eligibility utilization.
- Ensure 7-day insurer accountability for post-acute authorizations
  - » Amend insurance oversight statutes to require timely prior authorization decisions including weekends.
  - » Set maximum decision timeframes (e.g., 4 hours) in statute or rules.
  - » Establish penalties or reporting requirements for insurers failing deadlines.
  - » Require quarterly public reporting on insurer compliance.
  - » Coordinate enforcement with state insurance commissioner or Medicaid agency.
- Support expansion of post-acute and behavioral health capacity
  - » Include provisions in certificate-of-need (CON) or health facility licensing laws to fast-track or waive CON for needed facilities.
  - » Create authority for low-interest loans or grants for capacity expansion.
  - » Require prioritization of regions with documented discharge bottlenecks.
  - » Authorize data-driven allocation of funds linked to ED boarding metrics.
- Require statewide real-time coordination for inpatient and post-acute transfers
  - » Mandate participation in state-operated bed coordination platforms via hospital licensing or Medicaid conditions.
  - » Define platform standards, data reporting, and regional coordination protocols.
  - » Authorize state funding or grants to support implementation and participation.
  - » Require hospitals and post-acute providers to submit utilization and availability data regularly.
- Establish centralized escalation for blocked discharges
  - » Create regional/state offices or ombudsman within Health Department or Medicaid agency to resolve discharge delays.
  - » Provide authority for arbitration, reporting, and enforcement actions.
  - » Require hospitals to report blocked discharge cases within specified timeframes.
  - » Ensure funding and staffing for escalation offices.
- Fund emergency care as a public good
  - » Add language to state health budget statutes or Medicaid plan recognizing emergency care as critical infrastructure.
  - » Authorize dedicated state funding streams for ED staffing stabilization and surge capacity.
  - » Define eligible ancillary services for funding support.
  - » Provide for performance-based funding tied to throughput improvements.

- Offer throughput-based incentives, not penalties
  - » Codify incentive structures in Medicaid reimbursement or hospital quality programs
  - » Link funding to verifiable throughput metrics and documented operational practices (e.g., smoothing protocols, early discharge)
  - » Require independent validation through audits, data review, or inspections
  - » Avoid punitive penalties tied to boarding metrics, which can lead to gaming
  - » Define clear metrics to prevent workarounds like internal boarding or delayed order entry
  - » Allow flexible compliance plans for rural hospitals with required timelines and reporting
  - » Include public reporting to increase transparency and reputational accountability

3. Federal Alignment and Strategic Advocacy Priorities

- Support implementation and funding of the ABC-ED Act
  - » Apply for federal grants to expand real-time bed tracking and care coordination
  - » Codify roles for Emergency Care Infrastructure Offices or similar entities to administer funds and lead implementation
  - » Pilot cross-site care models for older adults and behavioral health patients
  - » Develop public dashboards and regional surge protocols
  - » Align state efforts with federal emergency care infrastructure investments
- Advocate for Medicaid reimbursement parity with Medicare for ED services
  - » Pass resolutions or statutes supporting federal parity.
  - » Require state Medicaid programs to study and report on reimbursement disparities.
  - » Engage with federal advocacy groups through official state channels.
- Request federal action on EMTALA funding
  - » Enact state resolutions urging federal funding support.
  - » Coordinate with federal representatives for legislative advocacy.

4. Cross-Cutting Principle: Data Transparency with Enforceable Accountability

- Mandate public reporting of ED boarding metrics
  - » Require standardized metrics and regular reporting by hospitals linked to solutions.
  - » Include data collection methods and public dashboard requirements.
  - » Authorize state health department to publish and maintain public data portals.
  - » Only report metrics if they are tied to required operational responses and improvements.
- Tie reported data to required operational and regulatory responses
  - » Define boarding thresholds that trigger required hospital actions and state interventions.
  - » Include provisions for corrective action plans and technical assistance.
  - » Require regular progress reporting and follow-up.
- Prioritize structural mandates over penalties or awareness campaigns
  - » Codify preference for operational reform requirements and funding incentives.
  - » Limit or exclude punitive financial penalties linked to boarding data.
  - » Encourage data-driven system redesign and capacity investment.

II. Administrative and Regulatory Rulemaking Guidance

1. Operational Oversight and Compliance Monitoring

- Incorporate hospital throughput standards into licensing and certification criteria.
- Develop rulemaking authority to define smoothing, discharge timing, weekend staffing levels, and surge protocols.
- Specify data submission formats, timelines, and audit procedures.
- Create standardized internal patient flow audit templates and reporting requirements.
- Establish regular site inspections and data reviews to verify compliance.

2. State-Funded Technical Assistance and Incentives

- Draft rules authorizing grant programs and bonus Medicaid payments tied to throughput metrics.
- Develop hospital performance dashboards to transparently show incentive eligibility.
- Pilot "Throughput Readiness Scorecards" with standardized assessment criteria.
- Provide waivers and alternative compliance plans for rural or resource-limited hospitals.
- Include requirements for documentation of good-faith efforts in alternative plans.

3. Data Infrastructure and Enforcement Mechanisms

- Define data standards, frequency (e.g., daily/weekly), and privacy protections for real-time ED boarding data submission.
- Separate behavioral health boarding data reporting and establish priority funding triggers.
- Mandate corrective action plans for hospitals exceeding boarding thresholds.
- Detail participation requirements in regional bed coordination platforms, including data sharing protocols.
- Specify enforcement authority and processes for addressing non-compliance with reporting or operational mandates.

4. Administrative Policy Alignment with State Levers

- Establish insurer accountability mechanisms, including timelines, penalties, and public reporting through insurance division rules.
- Streamline presumptive Medicaid eligibility via electronic enrollment systems and temporary ID issuance procedures.
- Accelerate certificate-of-need reforms through expedited approval rules or waivers in bottleneck regions.
- Set minimum staffing ratios for discharge-related services through hospital staffing regulations.
- Create public transparency committees or boards with defined roles and data access protocols.

5. Federal Program Alignment and Grant Administration

- Create rules establishing Emergency Care Infrastructure Offices or similar entities.
- Define grant application and fund distribution processes tied to ED volume and regional need.
- Provide for technical assistance programs funded through federal grants.
- Include state-level planning and coordination requirements for crisis standards and surge protocols.

Appendix 3

Collaboration Agreement Template

SAMPLE COLLABORATION AGREEMENT

Between
[Hospital Name]
[Address]
[Contact Person, Title]
and
[Partner Organization Name] (e.g., Nursing Home, Emergency Department/Hospital, EMS Provider)
[Address]
[Contact Person, Title]

Effective Date: [MM/DD/YYYY]
Review Date: [MM/DD/YYYY]

1. Purpose

The purpose of this agreement is to establish a collaborative framework between [Hospital Name] and [Partner Organization Name] to facilitate timely patient transfers, reduce emergency department boarding, and improve patient care coordination.

This partnership aims to:

- Expedite hospital-to-nursing home transfers for medically stable patients.
- Ensure direct admissions from community emergency departments to inpatient units, bypassing the ED when appropriate.
- Improve EMS and hospital coordination for patient transport and alternative care pathways.

2. Roles & Responsibilities

2.1 Hospital Responsibilities

[Hospital Name] agrees to:

1. Designate a hospital transfer coordinator to liaise with [Partner Organization Name] and ensure timely patient movement.
2. Provide real-time bed availability data to [Partner Organization Name] for smoother patient transitions.
3. Implement a direct admission process for urgent care patients meeting inpatient criteria, bypassing the ED when feasible.
4. Ensure timely medical record exchange to facilitate seamless transitions.

2.2 Partner Organization Responsibilities

[Partner Organization Name] agrees to:

1. Accept eligible hospital discharges within an agreed-upon timeframe to free up inpatient capacity.
2. Maintain a priority admissions protocol for hospital-referred patients to expedite transfers.
3. Communicate capacity status daily to [Hospital Name] to ensure efficient patient placements.
4. Coordinate with hospital discharge teams to ensure proper post-transfer care planning.

3. Patient Transfer & Coordination Protocols

3.1 Transfer Procedures from Hospital to Nursing Home

1. Eligibility Criteria: Patients must be medically stable, have appropriate discharge orders, and meet facility admission criteria.
2. Notification: The hospital will notify the nursing home within [X] hours of discharge readiness to arrange transport.
3. Documentation: The hospital will provide a transfer summary, medication list, and care plan before patient arrival.
4. Response Time: The nursing home will confirm bed availability within [X] hours and arrange admission within [Y] hours.

3.2 Direct Admission from Community Emergency Department to Hospital

1. Emergency physicians may refer patients directly to inpatient care, bypassing the ED if the patient meets pre-established admission criteria.
2. The hospital will provide a dedicated admission hotline for emergency physicians to ensure seamless patient intake.
3. EMS or hospital transport services will facilitate the transition within [X] hours of the referral.

4. Data Sharing & Communication

1. Parties will use a shared electronic platform (if available) to communicate real-time bed availability and transfer status.
2. Weekly coordination calls will be held to discuss transfer issues, patient flow challenges, and process improvements.
3. Both parties will comply with HIPAA regulations and other applicable privacy laws to ensure secure patient data sharing.

5. Performance Metrics & Evaluation

5.1 Key Performance Indicators (KPIs)

The parties agree to track the following metrics:

- Average transfer time from hospital to nursing home.
- Percentage of direct admissions bypassing the ED.
- Number of delayed transfers due to capacity issues.

5.2 Review & Adjustment

- This agreement will be reviewed annually to assess effectiveness.
- Modifications may be made based on performance outcomes and mutual agreement.

6. Dispute Resolution

In the event of a disagreement regarding this agreement's execution, both parties agree to:

1. Attempt good-faith negotiations to resolve the dispute.
2. Escalate unresolved issues to designated leadership representatives for mediation.
3. If necessary, engage a neutral third-party mediator to facilitate resolution.

7. Term & Termination

1. This agreement shall remain in effect for [X] years from the effective date.
2. Either party may terminate the agreement with [X] days' written notice if unable to meet the terms of the collaboration.
3. In the event of termination, both parties agree to work collaboratively to ensure a smooth transition for patients.

8. Signatures

By signing below, both parties acknowledge their commitment to the terms of this collaboration agreement.

[**Hospital Name**]

Signature:_____
Name: [Hospital Administrator]
Title: [Chief Medical Officer/CEO]
Date: [MM/DD/YYYY]

[**Partner Organization Name**]

Signature:_____
Name: [Facility Administrator]
Title: [Director of Nursing/CEO]
Date: [MM/DD/YYYY]

Appendix 4

Sample Emergency Department Boarding and Hospital Overcrowding Reduction Metrics

These metrics provide a data-driven framework to measure hospital overcrowding, efficiency of patient flow, and effectiveness of coordination efforts. Data can be chosen based on practicality and state needs.

1.ED Throughput and Capacity Metrics

- Total ED volume (number of patients seen per day/week/month).
- Median ED length of stay (from arrival to discharge or admission).
- Percentage of patients leaving without being seen (LWBS) – Indicator of overcrowding.
- Time from ED arrival to provider evaluation (door-to-doc time).
- Time from ED arrival to inpatient admission decision (decision-to-admit time).
- Time from admission decision to inpatient bed placement (boarding time).
- Total number of ED boarders (patients waiting for inpatient beds).
- Percentage of admitted patients boarded for more than 6, 12, or 24 hours.
- Percentage of behavioral health patients boarded for more than 6, 12, or 24 hours.

2.Hospital-Wide Bed Management & Discharge Efficiency

- Total inpatient bed occupancy rate.
- Percentage of inpatient discharges completed before noon.
- Average inpatient length of stay (LOS).

- Number of delayed discharges due to lack of post-acute care placements.
- Time from discharge order to actual patient departure from the hospital.
- Number of elective surgery patients admitted to the hospital by day of week.
- Hospital-wide diversion hours per month (when the ED is at capacity and unable to accept ambulances).

3. Transfer & Coordination Metrics (Hospitals, EDs, Nursing Homes)

- Total number of direct admissions from community EDs to inpatient units (bypassing the ED).
- Time from community ED referral to hospital bed placement.
- Time from hospital discharge to nursing home admission (delays in post-acute transfers).
- Percentage of nursing home referrals rejected due to capacity issues.
- Total number of interfacility transfers facilitated per month.

4. Patient Flow & EMS Metrics

- EMS offload time (time from ambulance arrival to patient handoff in the ED).
- Total number of ambulance diversion incidents per month.
- Number of EMS transports redirected to alternative care facilities if allowable (e.g., urgent care, clinics).
- Percentage of EMS calls resulting in admission vs. outpatient treatment.
- Percentage of 911 calls triaged to alternative care settings if available in the area (nurse triage programs, telehealth, urgent care).

5. Patient Experience & Outcome Metrics

- Patient satisfaction scores related to ED wait times.
- Percentage of patients reporting excessive wait times.
- Rate of patient complaints related to ED delays or boarding.
- Rate of adverse events or complications linked to prolonged ED stays (e.g., falls, infections, death).

6. Financial & Operational Metrics

- Cost per ED visit (with and without admission).
- Revenue loss from patients leaving without being seen (LWBS).
- Financial impact of prolonged ED boarding on hospital reimbursement.
- Cost savings from successful alternative care diversion strategies.

7. Connecticut's ED Data Collection Metrics (Incorporated for Reference)

The Connecticut bill includes the following (taken directly from the bill):

- The number of patients who received treatment in the emergency department.
- The number of emergency department patients who were admitted to the hospital.
- For patients admitted to the hospital after presenting to the emergency department, the average length of time from the patient's first presentation to the emergency department until the patient's admission to the hospital.
- The percentage of patients who were admitted to the hospital after presenting to the emergency department but were transferred to an available bed located in a physical location other than the emergency department more than four hours after an admitting order for the patient was completed.

Implementation & Monitoring

- Frequency of data collection: Daily, weekly, or monthly based on practicality and state implementation.
- Comparison against benchmarks: State averages, historical trends, or national ED performance standards.
- Integration with technology: Real-time dashboards and predictive analytics for identifying trends.

Appendix 5

Federal Resources and Funding Opportunities

- Agency for Healthcare Research and Quality (AHRQ):
  - » Research Funding Announcement: AHRQ has recognized the detrimental effects of ED boarding, including higher mortality rates and increased medical errors. They have announced a "Special Emphasis" on research to reduce boarding, highlighting available funding opportunities for relevant studies.

References

1. Abir S, et al. Strategies for Sustaining Emergency Care in the United States. RAND Corporation; Year TBD.
2. American College of Emergency Physicians. Boarding Patients in Emergency Departments Nearly Doubles Daily Cost of Care, Study Finds. October 2024.
3. American College of Emergency Physicians. Support the Addressing Boarding and Crowding in the Emergency Department (ABC-ED) Act (H.R. 2936): Advocacy Brief. 2024.
4. American College of Emergency Physicians, Emergency Medicine Practice Committee. Emergency Department Crowding: High Impact Solutions Report. May 2016.
5. Arizona College of Emergency Physicians. Best Practices: Emergency Department Crowding and Ambulance Diversion.
6. Bouda Abdulai AS, Mukhtar F, Ehrlich M. United States' Performance on Emergency Department Throughput, 2006 to 2016. Ann Emerg Med. 2021;78(1):174-190.
7. Boudi Z, Lauque D, Alsabri M, et al. Association Between Boarding in the Emergency Department and In Hospital Mortality: A Systematic Review. PLoS One. 2020;15(4):e0231253.
8. Connecticut. Public Act No. 24-4 (2024).
9. Connecticut. Pending Legislation SB 487 (2025).
10. Franklin BJ, Vakili S, Huckman RS, et al. The Inpatient Discharge Lounge as a Potential Mechanism to Mitigate Boarding and Crowding. Ann Emerg Med. 2020;75(6):704–714.
11. Jayaprakash N, Pflaum C, Gardner Gray J, et al. Critical Care Delivery Solutions in the Emergency Department: Evolving Models in Caring for ICU Boarders. Ann Emerg Med. 2020;76:709–716.
12. Janke AT, Burke LG, Haimovich A. Hospital 'boarding' of patients in the emergency department increasingly common, 2017–24. Health Aff (Millwood). 2025;44(6).
13. Kelen GD, Wolfe R, D'Onofrio G, et al. Emergency Department Crowding: The Canary in the Health Care System. NEJM Catalyst. 2021;2(1).
14. Milne K. Can an ED Psych Unit Decrease Hospital Admission and Boarding Time? ACEP Now. May 2022.

15. Mohr NM, Wessman BT, Bassin B, et al. Boarding of Critically Ill Patients in the Emergency Department. Crit Care Med. 2020;48(8):1180-1187.
16. Schwartz H, Reilly A, Burke C. An Actionable, Visual Dashboard Approach to Boarding. ACEP Now December 2023.
17. The Joint Commission. Patient Flow Through the Emergency Department (R3 Report | Requirement, Rationale, Reference). Issue 4. December 19, 2012.
18. Welch S. Hospital Wide Strategies for Reducing Inpatient Discharge Delays and Boarding. ACEP Now. July 2021.
19. Welch S. Survival Tactics for Emergency Department Boarding. ACEP Now. March 2024.