

MODEL BILL 1

HOSPITAL THROUGHPUT, CROWDING, AND EMERGENCY DEPARTMENT BOARDING ACCOUNTABILITY ACT

SECTION 1. SHORT TITLE

This Act shall be known and may be cited as the **Hospital Throughput, Crowding, and Emergency Department Boarding Accountability Act**.

SECTION 2. LEGISLATIVE FINDINGS AND PURPOSE

a. Findings

1. Timely access to emergency care is an essential component of the healthcare system and a critical public safety function.
2. Emergency departments serve as the primary point of access for patients requiring emergency evaluation, hospitalization, behavioral health treatment, trauma care, and disaster response.
3. Emergency department boarding and hospital crowding have become significant threats to patient safety, healthcare workforce sustainability, and access to timely emergency care.
4. Prolonged emergency department boarding is associated with increased mortality, delayed treatment, medical errors, prolonged patient suffering, ambulance diversion, and reduced access to emergency services.
5. Emergency department boarding is a measurable manifestation of hospital-wide crowding, capacity constraints, discharge delays, and throughput inefficiencies that prevent admitted patients from being transferred to appropriate inpatient beds in a timely manner.
6. Hospital crowding and emergency department boarding are influenced by multiple factors, including inpatient discharge practices, elective admission scheduling, inpatient bed management, weekend discharge capacity, ancillary service availability, and surge planning.
7. Evidence-based operational interventions have been shown to improve hospital throughput and reduce emergency department boarding.
8. Excessive boarding limits the ability of hospitals and emergency departments to provide timely care to new patients and impairs healthcare system readiness during emergencies, disasters, and public health crises.
9. Behavioral health boarding represents a particularly severe form of hospital crowding and reflects broader deficiencies in behavioral health treatment capacity and patient placement systems.
10. Standardized measurement, public transparency, and institutional accountability are necessary to improve hospital throughput, reduce emergency department boarding, and protect access to emergency care.
11. Data collection alone is insufficient to address hospital crowding and emergency department boarding and should be accompanied by institutional review and response mechanisms designed to promote meaningful operational improvement.

b. The purposes of this Act are to:

1. Establish standardized statewide measures of hospital crowding and emergency department boarding;
2. Promote public transparency and accountability regarding hospital throughput performance;
3. Require hospitals to maintain formal processes for reviewing and responding to excessive boarding;
4. Support evidence-based operational improvement efforts;
5. Improve patient safety and preserve access to timely emergency care throughout the State.

SECTION 3. DEFINITIONS

For purposes of this Act:

1. **Admission Order** means a documented order entered by a licensed practitioner admitting a patient to inpatient status.
2. **Behavioral Health Boarding** means the retention of a patient in the emergency department while awaiting admission, transfer, or placement in an appropriate psychiatric, substance use disorder, or other behavioral health treatment setting.
3. **Boarded Patient** means a patient who remains in the emergency department following entry of an Admission Order.
4. **Boarding Response Plan** means a written hospital-wide operational plan designed to address excessive emergency department boarding and hospital crowding.
5. **Boarding Time** means the elapsed time between entry of an Admission Order and the physical departure of the patient from the emergency department to an inpatient bed or other appropriate inpatient setting.
6. **Core Metrics** means the standardized measures established pursuant to Section 4 of this Act.
7. **Department** means the State Department of Health or its successor agency.
8. **Emergency Department Length of Stay for Admitted Patients** means the elapsed time between a patient's arrival in the emergency department and the patient's physical departure from the emergency department for an inpatient bed, calculated in accordance with Department specifications.
9. **Hospital** means a licensed acute care hospital that operates an emergency department.
10. **Hospital Crowding** means a condition in which hospital demand exceeds available inpatient capacity, resulting in delays in patient placement, admission, transfer, discharge, or treatment.
11. **Surge Protocol** means a written hospital-wide operational response plan activated in response to excessive emergency department boarding, hospital crowding, or capacity constraints.
12. **Throughput Review Team** means a multidisciplinary hospital team responsible for evaluating operational factors contributing to hospital crowding and emergency department boarding and recommending corrective actions.

SECTION 4. STANDARDIZED DATA SUBMISSION AND PUBLIC REPORTING

a. Monthly Submission

Each licensed acute care hospital operating an emergency department shall submit boarding data to the Department on a monthly basis.

Data shall be electronically submitted in a format prescribed by the Department and derived from the hospital's electronic health record system.

The chief executive officer, chief medical officer, or designee shall certify the accuracy of submitted data.

b. Core Public Accountability Metrics

The following metrics shall be publicly reported and displayed on the Department's emergency department boarding dashboard:

Metric 1: Percentage of admitted patients whose boarding time exceeds four (4) hours after completion of an admission order.

Metric 2: Median boarding time for admitted patients.

Metric 3: Median emergency department length of stay for admitted patients.

Metric 4: Ninety-fifth percentile emergency department length of stay for admitted patients.

Metric 5: Median behavioral health boarding time.

Metric 6: Percentage of behavioral health patients boarding greater than twelve (12) hours.

c. Operational Metrics

The following metrics shall be submitted to the Department and may be publicly reported:

1. Number of surge protocol activations;
2. Duration of surge protocol activations;
3. Daily inpatient occupancy;
4. Percentage of inpatient discharges before 11:00 a.m.;
5. Weekend discharge rates;
6. Other metrics established by Department rule.

d. Public Dashboard

The Department shall establish and maintain a publicly accessible dashboard displaying hospital-level boarding performance.

The dashboard shall:

1. Display statewide and hospital-specific performance;
2. Permit comparison across hospitals;
3. Display historical trends;
4. Be updated at least quarterly.

SECTION 5. BOARDING RESPONSE PLAN REQUIREMENT

Each hospital shall develop, maintain, and annually review a Boarding Response Plan.

The plan shall identify:

1. Responsible executive leadership;
2. Throughput Review Team membership;
3. Escalation procedures;
4. Internal communication processes;
5. Documentation requirements;
6. Corrective action procedures.

SECTION 6. MANDATORY BOARDING RESPONSE

a. Activation Thresholds

A hospital shall activate its Boarding Response Plan whenever:

1. More than ten percent (10%) of admitted patients board longer than four (4) hours during a reporting period; or
2. Any threshold established by Department rule is exceeded.

b. Required Response Activities

Upon activation, the hospital shall:

1. Notify executive leadership;
2. Convene the Throughput Review Team within seven (7) days;
3. Review inpatient bed utilization;
4. Review discharge barriers;
5. Review boarding drivers;
6. Identify corrective actions.

c. Documentation

The hospital shall maintain records of:

1. Threshold exceedance;
2. Activation date;
3. Findings;
4. Actions taken.

SECTION 7. CORRECTIVE ACTION REVIEW

If a hospital exceeds activation thresholds for three (3) consecutive reporting periods, the Department may require submission of a Corrective Action Plan.

The plan shall include:

1. Root cause analysis;
2. Proposed interventions;
3. Implementation timeline;
4. Performance targets.

SECTION 8. ANNUAL THROUGHPUT ASSESSMENT

Each hospital shall annually evaluate:

1. Inpatient discharge timing;
2. Weekend discharge capacity;
3. Elective admission scheduling patterns;
4. Ancillary service availability;
5. Behavioral health placement delays;
6. Other operational barriers contributing to boarding.

The assessment shall be submitted to the Department.

SECTION 9. RULEMAKING AUTHORITY

The Department may adopt rules necessary to implement this Act, including:

1. Reporting specifications;
2. Technical definitions;
3. Risk-adjustment methodologies;
4. Rural hospital modifications;
5. Additional boarding measures.