

State and Local Efforts to Address Boarding and Crowding

An information paper developed by the 2008-2009 ACEP State Legislative/Regulatory Committee, Ann Marie Garritano, MD, FACEP, primary author.

In an effort to identify state and local efforts to address crowding and boarding problems, ACEP's State Legislative/Regulatory Committee conducted an informal survey of state chapters and contacted individual physicians in some states where chapter leaders were not available. The survey respondents were asked whether boarding/crowding was problematic in their states and, if so, whether any legislative, regulatory or other efforts had been made at either the local or state level to remedy the situation. The results of this survey are not unexpected.

Representatives from all fifty states, the District of Columbia, Government Services and Puerto Rico were contacted and all but six (Alaska, Idaho, Montana, Nebraska, Wisconsin and Wyoming) reported problems. Alabama, Indiana, Kansas, Missouri, New Mexico, North Dakota, Tennessee and Utah reported few problems. Respondents indicated that most of the significant crowding and boarding problems lasted, on average, less than 24 hours with peak patient volumes appearing to occur during the winter and thought to correlate with influenza outbreaks.

While the vast majority of chapters surveyed reported some degree of problems with crowding and boarding, most have not embarked on any direct efforts to address the issue through legislative or regulatory processes. Several, however, noted efforts to address the issue by working directly with hospital administrators or others at the local level. Some of these efforts noted by chapters include:

- In some hospitals in the Los Angeles area and in South Dakota's larger cities, disaster preparedness plans are now activated to relieve serious crowding conditions.
- Colorado uses EMS software designed to allow ambulance services to view the real-time patient load at various hospitals, thus minimizing diversion times.
- Delaware has also implemented an EMS protocol aimed at limiting diversions by heading each EMS district with a Department of Public Health employee who monitors diversions.
- Vermont is also working with EMS to decrease diversions and distribute patient volume.
- Maine has attempted to decrease the number of pain management patients frequenting emergency departments by establishing a system-wide policy of only providing two day refill prescriptions to patients requiring narcotics. These patients are subsequently referred to primary care physicians who have agreed to see these patients within 48 hours.
- In Texas individual hospitals have developed a "code ____" protocol which is enacted whenever the emergency department is over capacity. Unfortunately, the survey respondent indicates that this system has been used inconsistently and with mixed results.
- The Puerto Rico chapter received an ACEP grant to study crowding and boarding and published a report in 2004 which suggested the need for increased staffing during peak patient volume periods and the need to relocate admitted patients out of the emergency department. Chapter representatives say that support from hospital administration was requested, but has yet to yield results.

In some states, efforts have been made to use the media to draw public attention to the crowding problem in hopes of pressuring policymakers or other stakeholders to take action. In Washington, Harbor View invited the media to a leadership summit to explain the crowding crisis. The West Virginia chapter held a town hall meeting and invited policymakers, the state medical society, the hospital association and the press. These media outreach efforts were deemed successful in raising awareness of the problem with key audiences.

While many of the efforts to directly address issues related to crowding and boarding problems have largely involved local efforts with local stakeholders, some chapters and other interested parties have pursued state legislative and regulatory initiatives to help alleviate these problems.

In 2007, the Massachusetts chapter supported Senate Bill 1330 which would require the Department of Public Health to establish guidelines for prompt admission by establishing a reasonable time in which patients must be relocated from the emergency department to an appropriate inpatient destination. This bill also would mandate protocols for hospitals to track and identify length of stay patterns and deviations, and create a data collection and monitoring program to help the department measure compliance. An incentive payment program would also be created to provide supplemental payments to hospitals that meet new guidelines. While this bill did not pass, the Department of Public Health subsequently adopted a policy that banned the practice of ambulance diversion in the state as of January 2009, except for extreme conditions in which a hospital is closed to all patients due to an internal emergency. The new policy notes that diversion creates its own problems without addressing the primary causes of crowding. The department also urged hospitals to improve patient flow to reduce boarding and instructed them to document steps taken to reduce the number of boarded patients.

In December 2000, the New York Commissioner of Health wrote a letter to hospital administrators addressing the issues of crowding and boarding and offering practicable strategies and establishing work groups to investigate and address the problem. Unfortunately, this effort did little to solve the ongoing challenge and in 2004 a bill was first introduced in the state legislature requiring all admitted emergency patients be relocated after four hours to an appropriate alternative location. All hospitals would be required to have a monitoring system and develop a plan to prevent diversions. All hospitals would be required to report six or more ambulance diversions per month or 25 per year. The bill has been reintroduced in subsequent legislative sessions, but has not passed.

In 2004, the New Jersey Department of Health and Senior Services issued a letter to hospitals granting permission for boarded patients to be moved to inpatient hallways while awaiting a bed.

In the past few legislative sessions, the Connecticut chapter has pursued a bill that would require hospitals to establish a protocol to move patients out of the emergency department once they are admitted, and track and report crowding information to the Department of Public Health. The department would be required to establish a state-wide mechanism for tracking and reporting crowding and, within a year, develop best practice protocols for addressing hospital crowding. The original bill also included other less desirable sections, but subsequent versions have been focused on the crowding problem. However, the measure has not been enacted.

In 2008 legislation was introduced in California which would require every licensed hospital to assess the condition of its department every three hours and calculate and record a NEDOCS (National Emergency Department Overcrowding Scale) score. The bill would also require that every hospital develop and implement a full capacity protocol by January 2010. These protocols would be filed annually with the Office of Statewide Health Planning and Development and with JCAHO. In the original bill language, once a NEDOCS score shows that severely or dangerously overcrowded conditions have been reached, the hospital may use hallways, conference rooms, and waiting rooms as temporary patient care areas.

However, due to strong opposition by the nurses association, the California chapter removed specific references to the use of hallway beds in the 2009 version of the bill, but the bill still provides hospitals with leeway in determining appropriate temporary areas to place admitted patients. Despite the increased flexibility given to hospitals to address ED overcrowding, the California Hospital Association has expressed opposition to the bill due to the requirement hospitals calculate a NEDOCS score. They claim that frequent calculation of this objective score would be burdensome and is too rigid and not applicable to all hospitals.

The Pennsylvania chapter has devoted significant effort to engage the governor's office, state health officials and the hospital association in active discussions on ways to reduce crowding and boarding. The chapter held a town hall meeting and developed a white paper to educate the governor's office and others on the crowding problem. After securing the governor's office support for action, subsequent meetings were held with key stakeholders and the chapter was able to get support for pilot projects for a few hospitals to begin implementing full-capacity protocols, based on the full capacity protocol developed in New York.

A few states passed laws directed specifically at EMS activities. Arizona passed legislation eliminating requirements that ambulances must take all patients to an emergency department, irrespective of the patients' issues or preferences. The law is intended to reduce some crowding problems by allowing patients to be taken to more appropriate alternative places of care. In Nevada, the EMS lobby successfully pursued legislation in 2005 to address the impact that crowding has on EMS personnel, who were forced to wait extended periods of time with patients who were waiting to be seen in the emergency department. The law now requires hospitals to move any patient arriving by ambulance into a bed, gurney or other appropriate location to receive emergency services within 30 minutes of arrival.

The holding of psychiatric patients was reported as an enormous problem in some states, many of which faced the closing of psychiatric inpatient facilities over the last few years due to lack of funding. Frequently, after these patients are evaluated in emergency departments, there are often no psychiatric beds available for inpatient admission. The South Carolina survey respondent reported that many small, rural hospitals are being overwhelmed because their few emergency department beds are routinely occupied by psychiatric patients, many of whom wait days for inpatient placement. New Hampshire has only one psychiatric hospital left in the entire state. The Nevada chapter provided perhaps the most desperate example of psychiatric patient boarding; where in Clark County there is no psychiatric facility to transfer patients, some of whom spend weeks in the emergency department.

Chapters report a variety of local and legislative initiatives designed to ease the problems related to the boarding of psychiatric patients. Maine has adopted the ACEP clearance guidelines to aid in managing the psychiatric patient load. In North Carolina, local emergency departments are working with the state hospital association and the state medical society to identify local hospitals capable of handling psychiatric patients. The survey respondent from Ohio hopes that insuring the mentally ill will decrease emergency department visits in this population of patients. A mental health parity bill has been introduced in the state.

Other legislative efforts to address the problem of boarded psychiatric patients include Connecticut, where legislation has been introduced to require the Departments of Mental Health and Addiction Services and Social Services to establish a two-year behavioral health services pilot program in up to five regions of the state. The pilot programs would be charged with developing and implementing innovative methods for improving emergency department outcomes for adults with behavioral health needs. The New Jersey chapter is currently working with the state hospital association in support of three bills aimed at addressing the problem of psychiatric holds in the emergency department. The effort included a survey by the hospital association which showed the extent of the problem facing the state's emergency

departments. The bills would require the Division of Mental Health Services to identify available mental health services, develop procedures to enable hospitals to promptly transfer psychiatric patients from the emergency department to an appropriate treatment setting, and establish standardized admission protocols and medical clearance criteria for admission to a psychiatric facility. A bill was also introduced in Maryland which was intended to expedite admission determinations for psychiatric patients and a 2009 bill in Montana would pay for more psychiatric beds and fund stipends to pay psychiatrists for providing on-call services to emergency psychiatric patients.

The most significant cause of crowding in the emergency department is the boarding of admitted patients, not the care of non-urgent patients (which accounted for only 12 percent of emergency department cases in 2004, according to the CDC.) As the emergency department becomes oversaturated with admitted patients who no longer require emergency care, the department's ability to care for patients, particularly those in need of urgent assessment is seriously impeded. Boarding is an extremely serious patient safety issue, as shown in the results of a 2007 ACEP survey, in which 200 emergency physicians reported knowledge of patient who had died because of boarding. Additionally, crowded emergency departments have a greatly reduced capacity to manage a mass casualty event or disaster. The need to address this serious problem is obvious and it is hoped that some of the local and state advocacy efforts outlined in this information paper can serve as models for other ACEP chapters to support their efforts related to this critical issue. Copies of many of the bills and regulations mentioned in this paper are available in the state advocacy section of the ACEP web site, by clicking [on this link](#).