September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

Dear Administrator Brooks-LaSure:

On behalf of the patients, physicians, and other health care practitioners that our organizations represent, we write to you today to request that the Centers for Medicare & Medicaid Services (CMS) take immediate steps to address the ever-growing crisis of patients boarding in emergency departments (EDs) by further expanding its addition of an "Emergency Services Readiness" standard to the existing Emergency Services Condition of Participation (CoP) (§ 485.618) recently proposed in the CY 2025 Hospital Outpatient Prospective Payment System (OPPS) and ASC Payment System Proposed Rule.

"Boarding" in the ED is a result of dangerous health system overload that puts admitted patients in a holding pattern as they wait for an inpatient bed or transfer to another facility. **Boarding kills patients**, with direct associations found between length of ED boarding and mortality.[1,2,3,4] It also leads to increased ambulance diversions,[5] increased adverse events, preventable medical errors,[6] lower patient satisfaction, clinical staff burnout,[7] violent episodes in the ED, and higher overall health care costs.

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. 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 (or even waiting room chairs) not set up for the extra monitoring they need. Patients may delay or avoid emergency care and risk their physical and mental health because of these

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[1] Singer AJ, Thode HC Jr, Viccellio P, Pines JM. The association between length of emergency department boarding and mortality. Acad Emerg Med. 2011 Dec;18(12):1324-9. doi: 10.1111/j.1553-2712.2011.01236.x. PMID: 22168198.
[2] Roussel M, Teissandier D, Yordanov Y, et al. Overnight Stay in the Emergency Department and Mortality in Older Patients. JAMA Intern Med. 2023;183(12):1378–1385. doi:10.1001/jamainternmed.2023.5961
[3] Chalfin DB, Trzeciak S, Likourezos A, Baumann BM, Dellinger RP. Impact of delayed transfer of critically ill patients from the emergency department to the intensive care unit. Crit Care Med. 2007;35(6):1477-83
[4] Berg LM, Ehrenberg A, Florin J, Östergren J, Discacciati A, Göransson KE. Associations between crowding and ten-day mortality among patients allocated lower triage acuity levels without need of acute hospital care on departure from the emergency department. Ann Emerg Med. 2019;74(6):345-56
[5] Shen Y-C, Hsia RY. Association between ambulance diversion and survival among patients with acute myocardial infarction. JAMA 2011;305(23):2440-2447. June 11, 2011. https://jamanetwork.com/journals/jama/fullarticle/901009..
[6] Epstein SK, Huckins DS, Liu SW, et al. Emergency department crowding and risk of preventable medical errors. Intern Emerg Med. 2012;7(2):173-180. Published 19 October 2011. https://link.springer.com/article/10.1007/s11739-011-0702-8.
[7] Loke, Dana E. et al. Clinicians' Insights on Emergency Department Boarding: An Explanatory Mixed Methods Study Evaluating Patient Care and Clinician Well-Being; Joint Commission Journal on Quality and Patient Safety, Volume 49, Issue 12, 663 - 670

systemic bottlenecks.[8] And in terms of overall readiness, the boarding crisis poses both a threat to public health and to national security, as many emergency physicians are deeply concerned about the system's ability to respond to a large-scale crisis when the frontline is already at a breaking point on any given "normal" day. The impact of another significant disease outbreak or mass casualty event while our health care safety net is already strained beyond its limits may have serious, life-threatening consequences for millions of patients.

Having available emergency department beds is crucial to the ability to manage acutely ill patients in a timely manner. When these spaces are occupied by admitted or observation patients who are boarding for prolonged periods, there is nowhere to care for new patients as they arrive to the ED; often these patients are left in the hallways and waiting rooms until space is available. The lack of space and capacity can create delays in care and increased morbidity and mortality. This is especially true in the case of obstetrical emergencies, where many conditions are truly time-sensitive, and delays can lead to tragic outcomes.

This crisis also disproportionately affects more vulnerable and historically disadvantaged populations. One study found that Black patients wait for about one hour longer than non-Black patients before they are transferred to an inpatient bed.[9] Another found that cognitive stressors, specifically overcrowding and patient load, are associated with increased implicit bias that may affect patient care.[10] Those with acute psychiatric conditions, especially children and adolescents, are particularly hard hit by boarding and may board for months at a time in noisy, chaotic EDs as they wait for an available psychiatric inpatient bed to open up somewhere.

Something must be done now to address this crisis. We appreciate the intent of CMS' proposed enhancements to the Emergency Services Readiness section of the existing emergency services standards for hospitals and CAHs. **But given that CMS' stated goal with this enhancement is "to improve the health and safety of all emergency services patients," we request additional language be added to begin to protect emergency patients from the hazards of boarding.**

Specifically, we are requesting additional operational modifications (see Appendix) that would require hospitals to have an actionable protocol to move emergency patients deemed to need inpatient admission or observation out of the ED when its capacity for such patients has been exceeded. The protocol would include load balancing plans for moving such patients out of the ED, alternative staffing plans for inpatients by non-ED staff, and contingency plans and arrangements with other hospitals and post-acute facilities to be able to transfer inpatients to the most appropriate site of care. The protocol would also include a target goal for the return to normal operations and standardized reporting on adherence to it as part of its Quality Assurance and Performance Improvement (QAPI) program.

CMS acknowledges the need for such action to address boarding when it notes in the proposed rule that it seeks to make changes due to reports it has heard that ED "readiness can be suboptimal, especially for obstetrical, geriatric, and pediatric populations, among others." We believe that adding a protocol on boarding

[8] Public Perspectives on Boarding in the Emergency Department; ACEP-Morning Consult Poll; October 2023.
[9] https://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2009.00381.x
[10] https://onlinelibrary.wiley.com/doi/10.1111/acem.12901

to the proposed modifications to the existing emergency readiness CoP represents a logical and much needed step that CMS can, and should, take now. Our proposed modification is flexible enough for hospitals of all sizes and geographic locations to comply. It allows hospitals to create their own protocols that, while adhering to the basic requirements of the CoP, can be tailored based on their staffing arrangements and overall workforce and their physical location and presence in the community.

We implore you to take this important step to address the major public health crisis of ED boarding, and to add this additional language to the emergency readiness CoP when you finalize the CoP in the CY 2025 OPPS final rule. If you have any questions, please contact Laura Wooster, MPH, ACEP's Associate Executive Director of Advocacy & Practice Affairs, at lwooster@acep.org.

Sincerely,

American College of Emergency Physicians
American Academy of Emergency Medicine
American Academy of Physical Medicine and Rehabilitation
American College of Osteopathic Emergency Physicians
American College of Radiology
American Psychiatric Association
Council of Residency Directors in Emergency Medicine (CORD)
Emergency Medicine Residents' Association
Emergency Nurses Association
National Association of Emergency Medical Technicians
Society for Academic Emergency Medicine

Appendix:
Proposed Emergency Services Condition of Participation (CoP)
Modification to Address ED Boarding

Key:

Black text = current CoP

Blue text = CMS' proposed addition in CY 2025 OPPS NPRM

Red text = ACEP & signatories' requested enhancement to that CMS proposed language

42 CFR § 482.55 - Condition of participation: Emergency services.

§ 482.55 Condition of participation: Emergency services.

The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice.

(a) Standard: Organization and direction. If emergency services are provided at the hospital—

(1) The services must be organized under the direction of a qualified member of the medical staff;

(2) The services must be integrated with other departments of the hospital;

(3) The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff.

(b) Standard: Personnel.

(1) The emergency services must be supervised by a qualified member of the medical staff.

(2) There must be adequate medical and nursing personnel qualified in emergency care to meet the written emergency procedures and needs anticipated by the facility.

(c) Standard: Emergency services readiness. In accordance with the complexity and scope of services offered, there must be adequate provisions and protocols to meet the emergency needs of patients.

(1) Protocols. Protocols must be consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions, including but not limited to patients with obstetrical emergencies, complications, and immediate post-delivery care.

(2) Provisions. Provisions include equipment, supplies, and medication used in treating emergency cases. Such provisions must be kept at the hospital and be readily available for treating emergency cases to meet the needs of patients. The available provisions must include the following:

(i) Drugs, blood and blood products, and biologicals commonly used in life-saving procedures;

(ii) Equipment and supplies commonly used in life-saving procedures; and

(iii) Each emergency services treatment area must have a call-in-system for each patient.

(3) Staff training. Applicable staff, as identified by the hospital, must be trained annually on the protocols and provisions implemented pursuant to this section.

(i) The governing body must identify and document which staff must complete such training.

(ii) The hospital must document in the staff personnel records that the training was successfully completed.

(iii) The hospital must be able to demonstrate staff knowledge on the topics implemented pursuant to this section.

(iv) The hospital must use findings from its quality assessment and performance improvement (QAPI) program, as required at § 482.21, to inform staff training needs and any additions, revisions, or updates to training topics on an ongoing basis.

(4) Readiness. Hospitals must have an actionable protocol developed and in place to move emergency patients deemed to need inpatient admission or observation out of the emergency service or department when that service or department's capacity for such patients is exceeded.

(i) This protocol should be implemented when the number of patients requiring inpatient hospitalization or observation exceeds 25% of the emergency service's dedicated treatment areas at any given time

(ii) The protocol shall include a load balancing plan for moving such patients out of the emergency department or other dedicated emergency service areas; alternative staffing plans for inpatients by non-ED staff and contingency plans and arrangements with other hospitals and post-acute facilities to be able to transfer inpatients to the most appropriate site of care.

(iii) The protocol should include a target goal for the return to normal operations.

(iv). A hospital must report its performance and adherence to the protocol in a standardized method as part of its QAPI program and use findings from these performance reports to help inform any additions, revisions, or updates to the protocol on an ongoing basis.