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Emergency Department Boarding

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Emergency Medicine Physician

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Agenda

- What is ED Boarding?
- Oregon
- ED Physician Perspective
- Ethical Considerations

What is ED Boarding?

What is ED Boarding

An ED provider has seen a patient and determined they are not safe to be discharged but they have no where to go right now

Mental Health

- Stabilization
- Awaiting transfer to psychiatric facility

Addiction Medicine

- Awaiting transfer to detox facility
- Treatment of withdrawal

Elderly

- Awaiting SNF placement or other HLOC discharge

Admitted patients

- Awaiting an open bed in the hospital

What’s happening in Oregon?

OPB article "One in 10 of Oregon's hospital beds are occupied by patients ready to leave — with nowhere to go" by Amelia Templeton Jan 20, 2022

- Oregon's hospitals are close to running out of beds — and a backlog of patients waiting to move into the state's understaffed long-term care facilities is making the problem worse.
- "They may need a nursing home, a rehab bed, behavioral health support, or they may not even have a home to go to," said Becky Hultberg, President of the Oregon Association of Hospitals and Health Systems.
- "Roughly 10 percent of all adult hospital beds statewide being occupied by people ready for discharge"
- "Discharge delays are a longstanding issue the pandemic has made worse"
- One in 10 of Oregon's hospital beds are occupied by patients ready to leave — with nowhere to go - OPB

Oregon's hospitals are close to running out of beds like this one in the intensive care unit last August at Oregon Health and Science University in Portland.
Kristyna Wentz-Graff / OPB

Oregon ED statistics

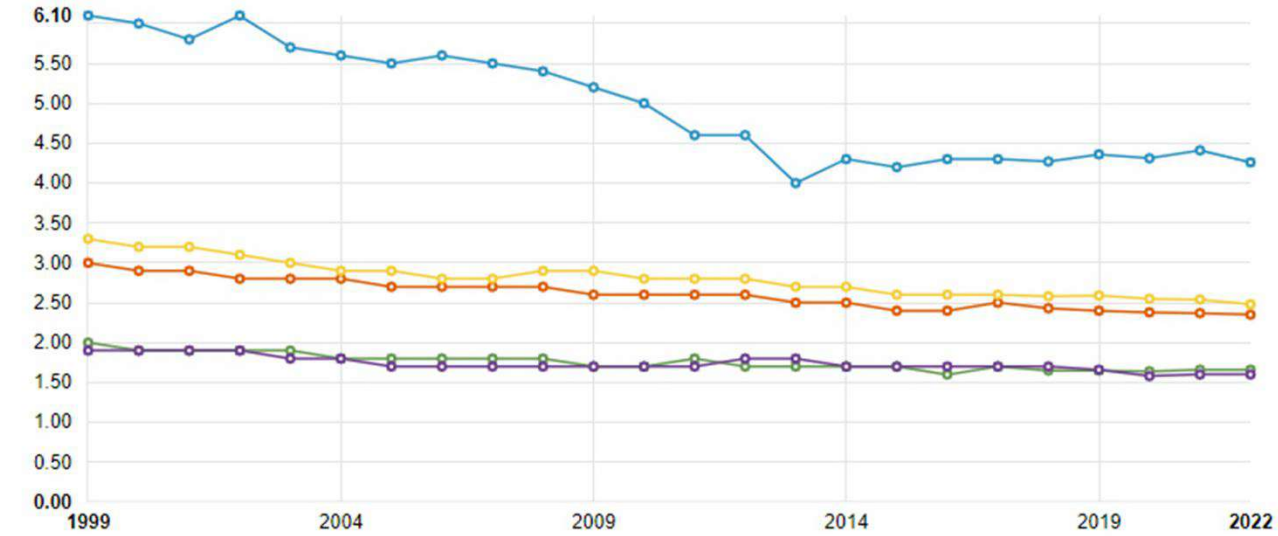
- 1 in 4 Oregonians seek ED care annually
- 1.3 to 1.6 million ED visits in Oregon each year
- ~75,000 Oregonians checked in, but left without being seen in 2022

- In Oregon, average length of stay has varied from 5.1 & 6.1 hours since 2018.
- In the past year, 46,911 Oregonians were in an ED for at least 24 hours
- 7,837 were in an ED for at least 72 hours.
- Vulnerable patient populations are much more likely to board for days.
  - • Those experiencing homelessness: 2.3 times* more likely
  - • Mental health patients: 4.4 times* more likely
  - • 65 years and older: 2.8 times* more likely

Nationwide Emergency Department Inventory, 2021 CMS Timely and Effective Care Data, 2022 Oregon Health Authority, 2024

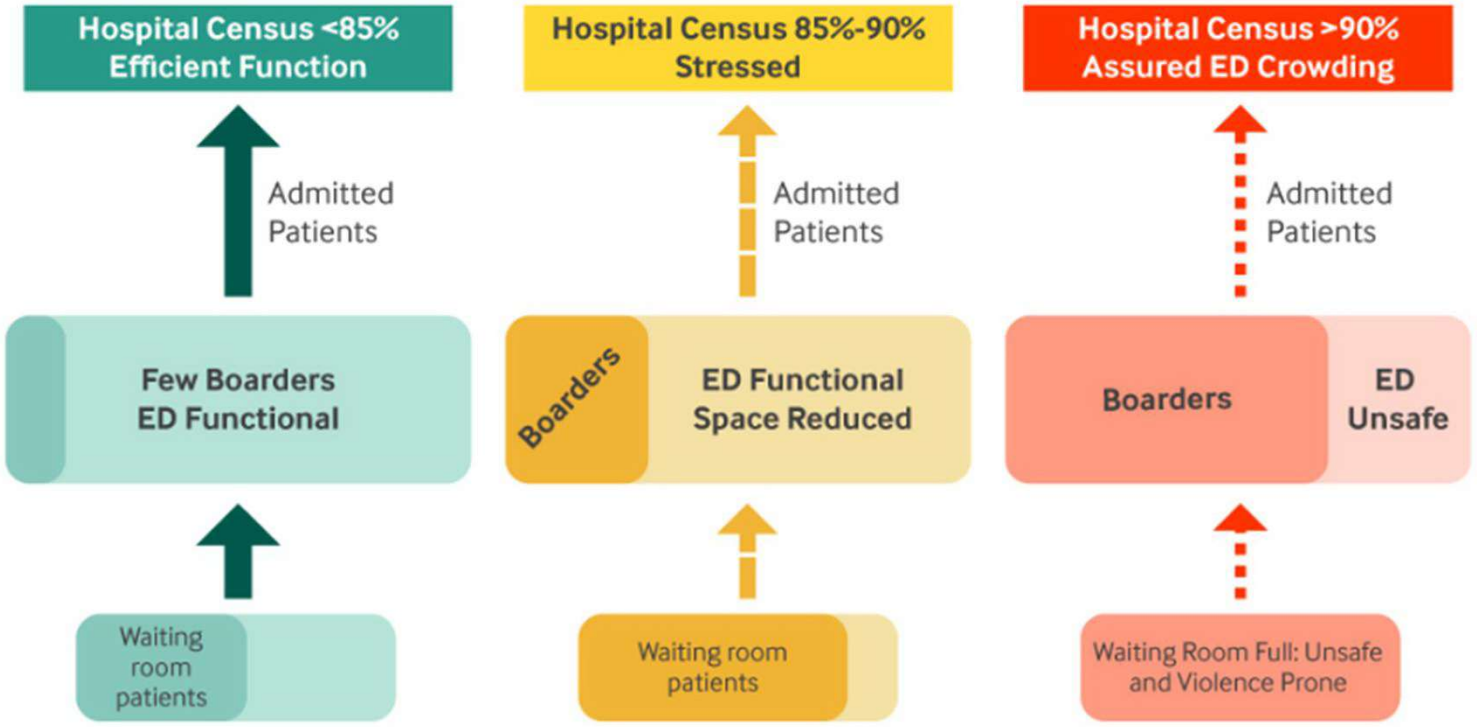
Background

- Oregon and Washington have the lowest hospital beds per capita in the United States
- Data from AHA →KFF
- [Hospital Beds per 1,000 Population by Ownership Type | KFF]



Location		2019	2020	2021	2022
		Total	Total	Total	Total
United States	**2.43**	**2.40**	**2.38**	**2.37**	**2.35**
Florida	2.58	2.59	2.55	2.54	2.48
North Dakota	4.27	4.36	4.31	4.41	4.26
Oregon	1.65	1.65	1.64	1.66	1.66
Washington	1.70	1.66	1.58	1.60	1.60

Impact of ED Boarding



Kelen et al, NEJM, 2021

What's the ED physician perspective?

"The impact of ED crowding on morbidity, mortality, medical error, staff burnout, and excessive cost is well documented but remains largely underappreciated."

Emergency Department Crowding: The Canary in the Health Care System

The solution for this serious threat to ED staff and harm to patients cannot come from a single department, but through engagement of and ongoing commitment by leaders throughout the hospital and, more broadly, by those in the payer and regulatory segments of the health care system as well.

Authors: Gabor D. Kelen, MD , Richard Wolfe, MD, Gail D'Onofrio, MD, MS , Angela M. Mills, MD, Deborah Diercks, MD, Susan A. Stern, MD, Michael C. Wadman, MD, and Peter E. Sokolove, MD Author Info & Affiliations

NEJM Catalyst | September 28, 2021 |

America College of Emergency Physicians

Emergency Department Boarding Stories

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In the waiting room

"We are a 28-bed ED and on a daily basis have 60+ patients in our department while consistently boarding around 20 patients. Wait times and the percentage of people leaving without being seen began to climb so as a result we have been forced to see patients from the waiting room.

I can't remember the last time I got to consistently see and examine patients appropriately in a room/bed, and not from a chair. I have seen people code in the waiting room and admitted people to the ICU from the waiting room. It's unsafe for patients and frankly unsafe for us too to have to go out into the waiting room dozens of times per shift."

Previous **Interrupting patient care**

Next **An afterthought**

Not a safe situation

We are a 25 bed ED but were using hallway beds numbered 1-18 as well on this particular day.

New placement

As relates boarding group home patients, we currently have six, boarding for 1,250-3,600 hours. In a...

We need help

Our rural facility is the only hospital in the greater region that is capable of managing a wide ran...

Emergency Department Boarding Stories

An afterthought

"We are a 38 bed ED, usually with 30-40 patients in the waiting room and many EMS patients waiting for rooms in the hallway. Patients come in agitated, acutely psychotic occasionally violent. We cannot provide these patients with high-quality medical care when they are waiting for a bed for hours/sometimes days. We also have critically ill patients requiring higher level of care who have to wait in hallways. It's not unheard of for these patients to decompensate before we are able to get them into a ED room.

> **How did we go from being healthcare heroes to an afterthought of the medical system?**

This is not sustainable. Saving beds for elective surgical patients while truly ill, critically ill patients waiting hallways in the emergency department is disheartening. It's unsustainable, morally wrong, and dangerous for staff and for patients. How did we go from being healthcare heroes to an afterthought of the medical system?"

Acts of bravery

"We are a large ED with 60 beds. We are regularly holding 45 to as many as 75 admitted patients daily in our department. Unless a patient is critically ill, we see most new patients in the waiting room. This is an extreme burden on our young, energetic, committed staff. We experience extreme staff shortages. In over 25 years of emergency medicine experience, I have never seen such critical shortages of space, staff and equipment.

> **Each day I fear that a patient or staff member will be harmed because of the critical situation in which we are required to serve.**

Despite the overwhelming situation, I see acts of bravery by our staff as they do their best in such extreme circumstances. Each day I fear that a patient or staff member will be harmed because of the critical situation in which we are required to serve. I pray that no one is harmed or dies."

Emergency Physician Perspective – From the Annals of Emergency Medicine June 2024

"It is morally distressing to watch elderly patients dropped off at the emergency room, with nowhere else to go, languish in our corridors, end up sicker than when they arrived as they wait for placement, and in some cases die from neglect. We are asleep at the wheel, and we are headed for a crash."

"The number of abusive patients is increasing all the time. It is unfathomable that it is the front-line workers who have been showing up for our population throughout the pandemic that get the brunt of people's frustrations with our broken health care system. Everyone deserves better. Patients, and nurses and doctors, we all deserve better."

"I feel like the entire system is collapsing and we in emerge are supposed to soak up all the failures .. I feel awful about trying to provide good care for my patients in the hallway, and constantly feel like I can't do a good job anymore and it makes me feel like a terrible doctor."

"I'm so tired of people talking about burnout. What I am feeling isn't burnout. It's moral injury. No amount of 'self-care' is going to get my patient to OR on time today when they need it, or a bed to be in, or a nurse to take care of my orders, or more docs to do this job, or computers to function with the EHR we now have, etc. It's not lack of self-care, it's being handicapped and unable to provide patients the level of care I am trained to provide, and that patients need and deserve."

"I still love the essence of emergency medicine: caring for patients and having the privilege of making their scary, horrible day a bit better. The environment is drowning me slowly, and it's increasingly difficult to come up for air. After 23 years in the ED, I don't think I'll last another year. I'm done.""

Ethical Considerations

Ethical Considerations

- This practice is unethical for several reasons," he writes. "The first is that ED boarding is associated with poorer outcomes and higher numbers of medical errors. It is also unethical because boarding is the major cause of ED crowding, which in [and] of itself can be hazardous. As the number of boarders increases, the effective capacity of the ED is reduced, which increases waits, as there are fewer active treatment spaces for the new, undifferentiated cases.”
- "So, permitting boards is a violation of beneficence, because it is not in the best interest of the patient being boarded, but also not in the best interest of the new, undifferentiated patient in the waiting room. Both can experience negative outcomes from this practice."

Kellermen, Arthur. Emergency room medicine and the ethics of boarding patients, Medical Ethics Advisor, Nov 1, 2010

Moral Distress and “Safe Discharges”

DATE: April 17, 2025 PRESENTED BY: Kevin Bibee, LCSW Care Management Social Work Supervisor

- Case Example
- Moral Distress
- “Safe discharge”

Roxanne

- 51-year-old cisgendered female.
- At least four-year history of houselessness.
- History of physical and mental disabilities, substance use disorder, and severe and persistent mental illness (SPMI).
- Appointed guardian and placed in facility for three weeks.
- Behaviors unmanageable at facility, discharged to hospital.
- Made racist comments to staff, yelling out, little patience, or frustration tolerance.

Moral Distress

- Literally nowhere to go
- Boarding in psych room for six days prior to transferring to an inpatient unit
- Regularly yelling out for help
- Made many racist statements
- Dependent for all ADLs

“Safe Discharge”

- Tent and sleeping bag?
- Shelter beds
- Medical respite beds
- Oregon ranked 47 overall nationally for mental healthcare by Mental Health America
- “Discharged to prior living situation”

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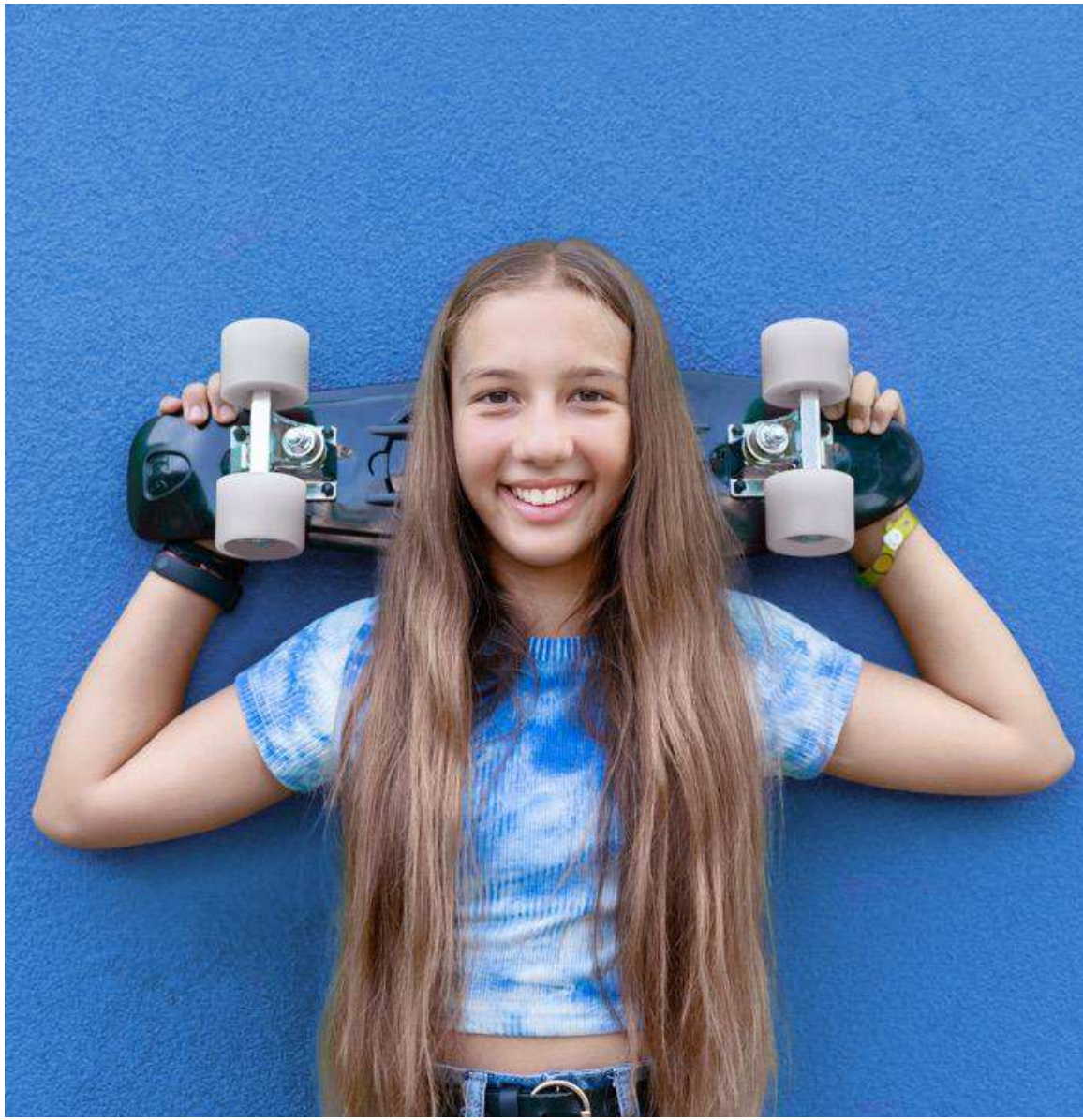
OHSU

Thank You



LEGACY HEALTH

Pediatric ED boarding
a comparison to the adult world

Andrew Lasky MD

April 17 2025

Emergency Department- goals of care

ASSESSMENT (EVALUATE)

STABILIZE (INTERVENTIONS)

DETERMINE DISPOSITION

DISCHARGE (EXIT ED)

Definitions of emergency department (ED) boarding

The practice of caring for admitted patients in the ED after hospital admission.

Or

The practice of holding admitted patients in the ED or other non-inpatient areas because no inpatient beds are immediately available.

Or

An ED provider has seen a patient and determined they are not safe to be discharged but they have no where to go right now.

Reasons for Emergency Department Boarding for adults

Mental Health	Addiction Medicine	Elderly	Admitted patients
Stabilization Awaiting transfer to psychiatric facility	Awaiting transfer to detox facility Treatment of withdrawal	Awaiting SNF placement or other HLOC discharge	Awaiting open bed in the hospital

Reasons for Emergency Department boarding for children/adolescents

Mental Health	Behavior Health (frequently a/w developmental delay)	Admitted patients Floor PICU
Awaiting transfer to inpatient psychiatric unit	Awaiting safe placement disposition	Awaiting open bed in the hospital

Inpatient hospital behavioral health units in OR*

- Asante Rogue Regional Medical Center, Medford: 24 adult beds
- Bay Area Hospital, Coos Bay: 13 adult beds
- Good Samaritan Regional Medical Center, Corvallis: 16 beds
- Mercy Medical Center, Roseburg: 12 beds (to open this spring)
- Oregon Health & Science University Hillsboro Medical Center: 21 geriatric beds
- PeaceHealth University District Eugene: 35 adult beds
- Providence Milwaukie Hospital: 19 geriatric beds
- Providence Portland Medical Center: 33 adult beds
- Providence St. Vincent Medical Center, Portland: 33 adult beds
- Providence Willamette Falls Medical Center: **16 adolescent beds, 6 child beds**
- Salem Hospital, Salem: 25 adult beds
- St. Charles Medical Center, Bend: 15 beds
- Willamette Valley Medical Center, McMinnville: unspecified number of beds for elderly patients

Standalone inpatient behavioral health centers

- Cedar Hills Hospital, Portland: 98 beds
- Unity Center for Behavioral Health, Portland: 85 adult beds, **22 adolescent beds**

***Does not include 704 state-owned psychiatric hospital beds.**

How many inpatient behavior health beds are available?

Inpatient hospital behavioral health units in OR

Adult ~429

Pediatric 44

= ~**469** beds

Case study- John

- John–13yo - h/o ASD, ADHD, and ODD
- Presents to RCH ED after making threats of violence to MOC after removal of patient's computer access.
- Patient has h/o aggressive behavior starting with biting MOC ~age 8.
- Recent 19-day stay at LSC ED after sexually aggressive behavior (groping over the close) of MOC. d/c'ed with new mental health services thru CCS-WISE
- MOC continued to feel threatened therefore patient brought to RCH ED.

Case study– Disposition *So, what is the problem?*

- Unsuccessful attempts to get mother to the hospital to work with outpatient support team to develop a safe behavioral plan for return home while awaiting longer-term placement.
- Does not currently meet criteria for higher level of psychiatric care in the state of the OR bc no acute unsafe event has occurred with no SI or attempt.
- Respite care/group home: Not currently available.
- CLIP State Hospital–residential long-term in WA–not currently available. Unknown wait time- initial estimate 30-90 days.
- Shelter placement: 1W a shelter refused because of previous threats to others, patient not developmentally appropriate for OR shelters.
- Kinship placement: MG POC have refused. None other known
- Foster home: Requires WA child protective services to take custody which agency declined as they do not feel neglect has occurred*.
- Police engagement: OR police have declined as patient not imminently unsafe as currently in hospital setting. WA police say they cannot take custody outside of WA.
- Legal: Petition of private dependency filed in court hearing (shelter care) scheduled in 1 week.
- Discharged to street: Not able to do this at this time. RCH requires guardian involvement to discharge patient of this age.


LEGACY
HEALTH
Thank
you!

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