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The Cost of Delay: Ethical Concerns in ED Boarding

Melissa Denny, MD

KPNW Director of Medical Ethics &
Emergency Medicine Physician

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Objectives

- Understand ED Boarding
- Explore Ethical Concerns Involved in ED Boarding Patients
- Appreciate the Complexity of Solutions to ED Boarding

Understand ED Boarding

What is ED Boarding

An ED provider has seen a patient, provided stabilizing treatment and determined they need continued care in a setting designed to best address their needs.

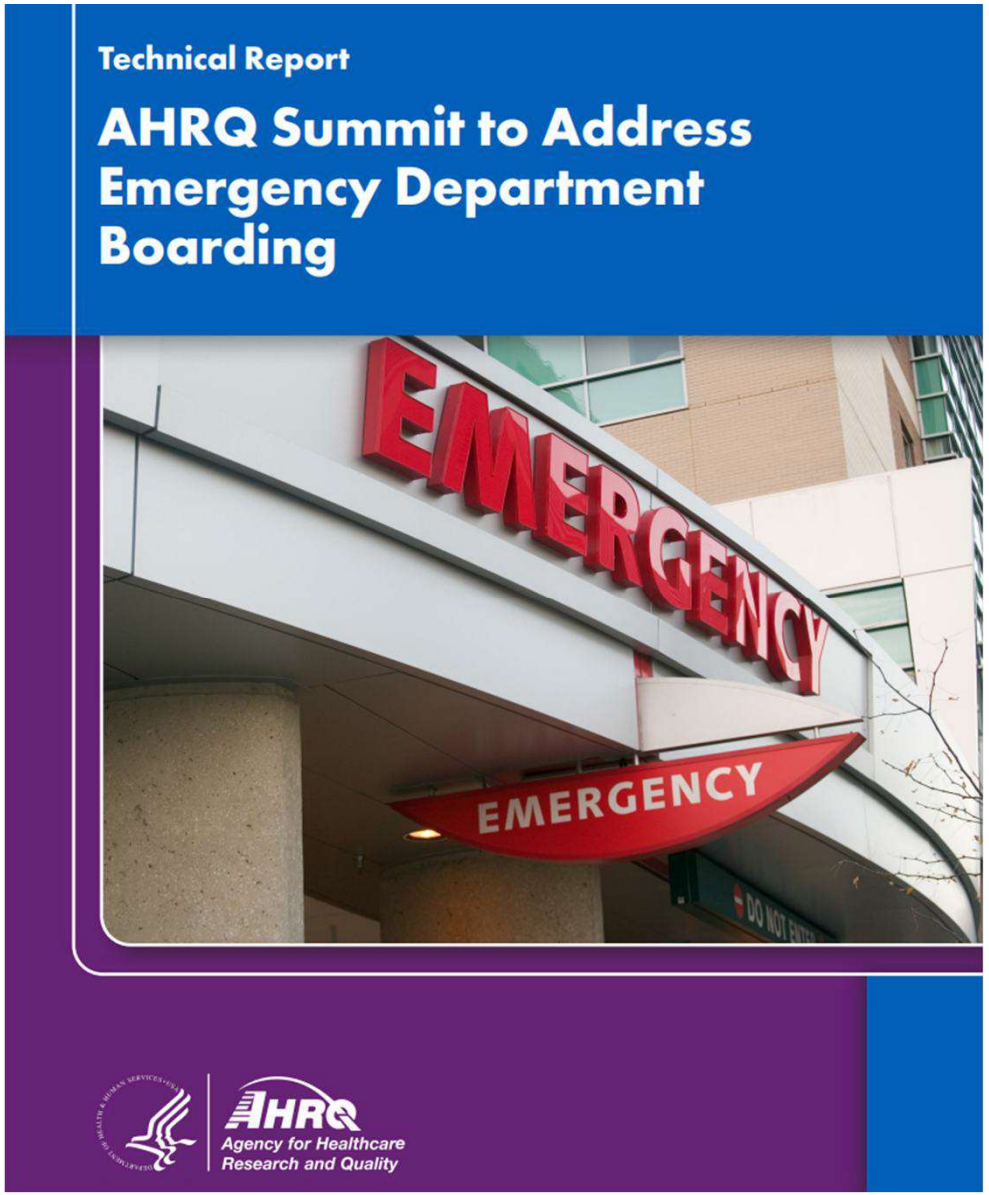
Mental Health	Addiction Medicine	Elderly	Admitted patients
• Awaiting transfer to psychiatric facility	• Awaiting transfer to detox facility	• Awaiting SNF placement or other HLOC discharge	• Awaiting an open bed in the hospital

What is ED Boarding?

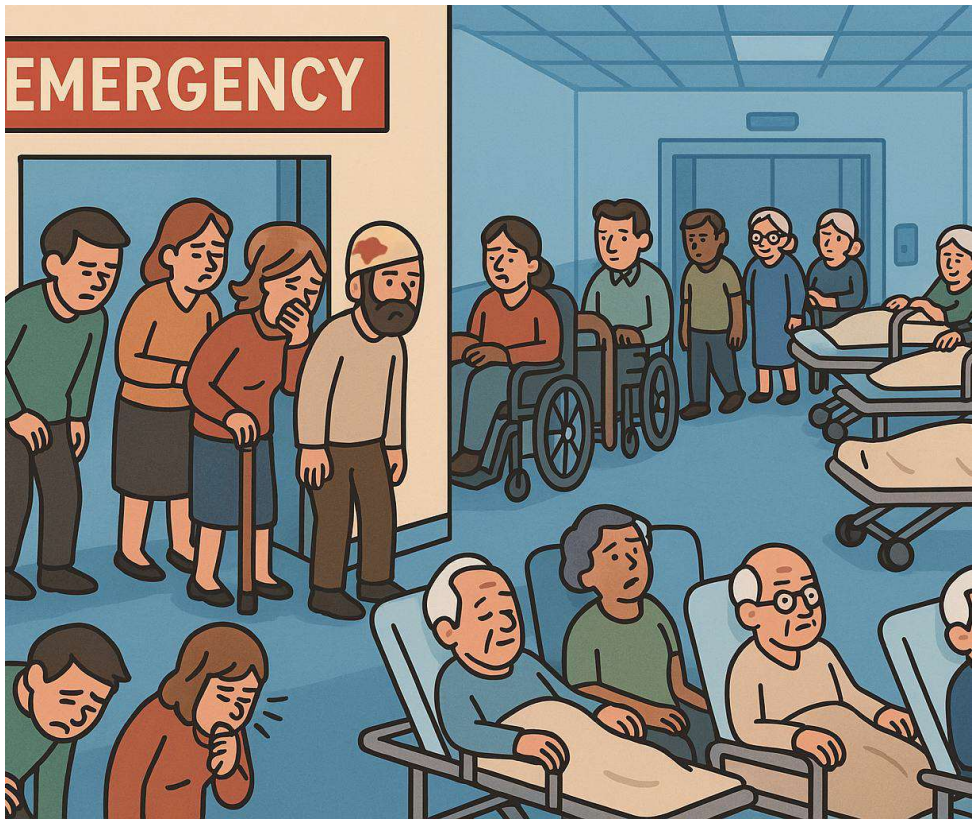
- Boarding is fundamentally an ED output problem
- ED has assessed, stabilized to best of ability, and determined best setting for pt to go
- ED Boarding often portrayed as an ED problem, it's not.
- ED doesn't control upstairs bed availability, SNF availability, psych bed availability
- Lack of control leads to moral distress

ED Boarding is a Misnomer

"ED boarding is a misnomer because the problem is not caused by or within the control of staff in the ED. Instead, the ED is where the symptoms of this hospital wide and health system-wide patient flow problem converge and appear"



ED Boarding vs Crowding



- Crowding – demand for ED services exceeds capacity
  - Input and throughput contribute
  - ED boarding contributes to ED crowding
  - ED crowding is NOT the direct cause of ED boarding

Transition of Care Delay/ED Holding

Observed as early as the 1980's and 1990's

Exacerbated during the COVID-19 pandemic

Remains at historically high levels

Stretched Resources

- For everyone, the problem is straining fewer resources.
- In 2023, Providence Health & Services, Oregon's largest hospital provider, had patients across its eight hospitals who stayed 5,700 extra days per month when they could have been discharged but didn't have a place to go
- For an average five-day stay in a hospital, that translates into an extra 1,140 patients a month.
- It' also the equivalent of admitting 37 patients a day and keeping them for five days.
- "It's a mind-blowing number " Dr. Ray Moreno, chief medical officer at Providence St. Vincent Medic Center in Portland and a task force member, said in an interview. "This is like building another hospital that could admit 37 patients a day and keep them for five days."

Oregon task force finds ways to prevent patients from boarding in hospitals | The Lund Report

Who?

A Day in the Life of an Emergency Physician

"Two are older adults who must sleep in the hallway tonight because we do not have anymore available beds in an emergency department room. Their sleep will be significantly disturbed as they will be sitting directly under fluorescent lights all night and exposed to a constant barrage of noise. They will also be exposed to a young adult male who becomes acutely agitated who yells at a nurse with multiple racial slurs while posturing in the doorway of his room, then throws his ice water at the wall, then spits in her face before trying to punch her. Fortunately, security is able to restrain the patient before the violence spills into the hallway."

Oregon Chapter
American College of
Emergency Physicians

Date: September 23, 2024

To: Sen. Deb Patterson, Chair
Sen. Cedric Hayden Vice-Chair
Members of the Senate Health Care Committee

From: Dr. Craig Rudy, President
Oregon Chapter of the American College of Emergency Physicians

Subject: Emergency Department Boarding

The Fall

The HLOC

- SNF – Skilled Nursing Facility
- Long Term Care
- ALF – Assisted Living Facility with nursing support
- MCU – Memory Care Units
- Residential Care Home
- Hospice or Palliative Care
- Home Health Care

The HLOC

“We are failing these patients. And I worry we are crossing an ethical line”

“Not only is this impacting our patients, but also the physicians providing this unacceptable care. The moral injury it is causing the physicians is remarkable. This is our burnout.” – Dr. Tyler Darnell

Harms

Transition of Care Delay/ED Holding Harms

- Delay in care
- Delay in home medications
- Increased adverse events
- Prolongs in-hospital length of stay
- Associated with staff and patient dissatisfaction
- Consumes already scarce ED resources → Unavailable for the care of new patients → potentially affecting outcomes of non-boarded patients
- Increases ED crowding
- Increases LWOT
- Increases inpatient mortality rates
- Increased risk of delirium
- Increased violence against health care workers

ED Boarding contributes to ED Crowding

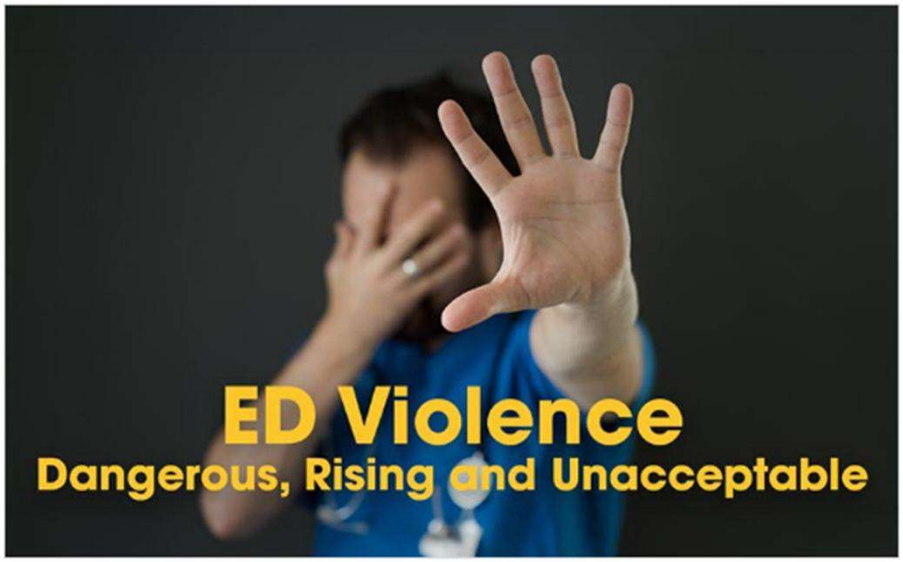
Emergency Department Crowding as Contributing Factor Related to Patient-Initiated Violence Against Nurses-A Literature Review - PubMed

Outcomes of ED Crowding			
Perception of Unfairness			
Medical-related	15	Assessment delay, medication delay, test delay, treatment delay, increased hospital stay, and increased waiting time.	Hwang et al. (2006), Pines et al. (2006), Pines, Localio, et al. (2007), Hwang et al. (2008), Mills et al. (2009), Pines, Prabhu, et al. (2010), Pines, Shofer, et al. (2010), Hong et al. (2013), Cremonesi et al. (2015), Wu et al. (2015), Tsai et al. (2016), Gaieski et al. (2017), Peltan et al. (2019), Hoot et al. (2021), Huang et al. (2022)
Cost-related	1	Increase in Cost.	Cremonesi et al. (2015)
Other Departments-related	4	Leaving the ED or being transferred to other departments are on the rise.	Asaro, Lewis, and Boxerman (2007), De Araujo, Khraiche, and Tukan (2013), Hoot et al. (2021), Huang et al. (2022)
Dissatisfaction	6	Impaired nursing perception, poor interpersonal care quality, decreased patient satisfaction, increased state anxiety scores, and negative patient experiences.	Pines, Localio, et al. (2007), Tekwani et al. (2013), Wang et al. (2017), Wang et al. (2020), Liyanage-Don et al. (2022), Berlyand et al. (2022)
Violent Behavior	2	Increase in violent incidents	Medley et al. (2012), Efrat-Treister et al. (2019)

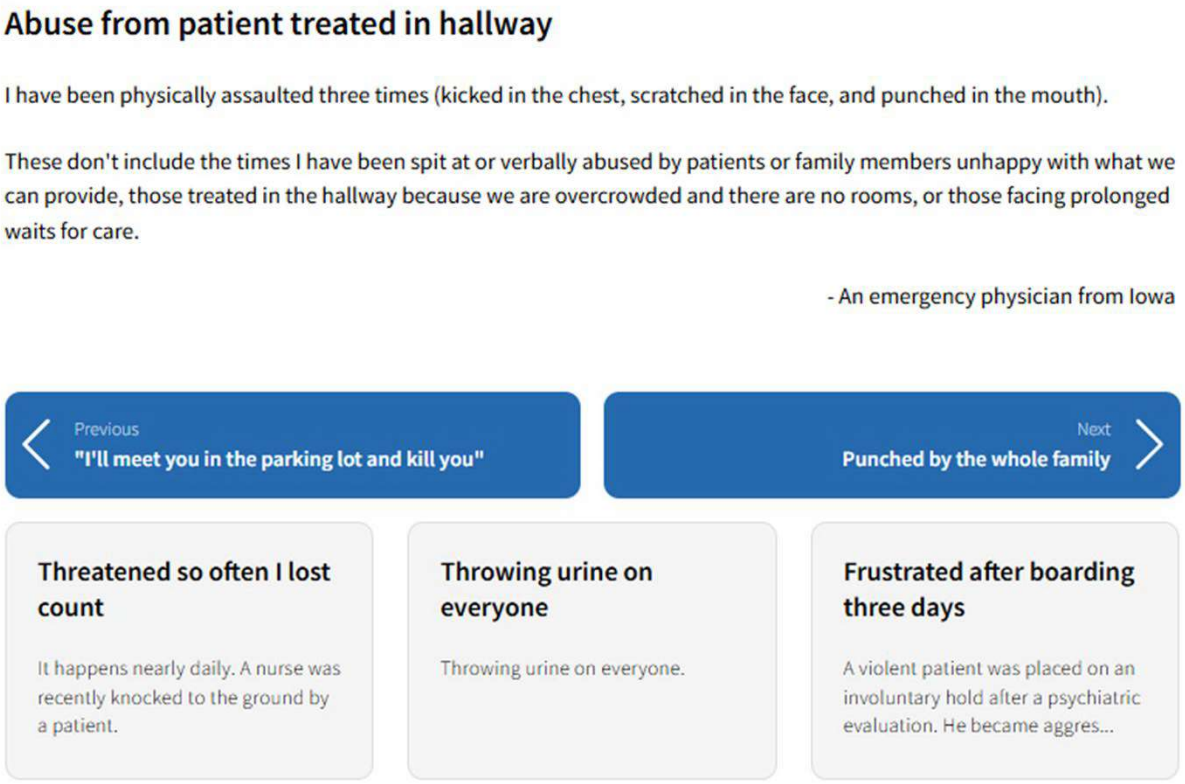
J Adv Nurs. 2025 Jan 23.

ACEP ED Violence

- Jan 2024 poll of ACEP members
  - 91% of Emergency Physicians said that they or a colleague were a victim of violence
  - 68% of those physicians said they did not feel their employer's response was appropriate
  - 50% said nothing was done



ACEP Emergency Department Violence Stories



[Abuse from patient treated in hallway | ACEP]

Association between delays to patient admission from the emergency department and all-cause 30- day mortality
Emergency Medicine Journal 2022

What this study adds

⇒ This study of over five million NHS patients shows an increase in all-cause 30-day mortality that is independently associated with delays to hospital admission from the ED rather than with crowding alone.

⇒ The standardised mortality rate starts to rise from 5 hours after the patient's time of arrival at the ED.

⇒ The increasing effect of long stays in the ED before inpatient admission can be measured and represented as a number needed to harm metric: after 6–8 hours, there is one extra death for every 82 patients delayed.

https://dx.doi.org/10.1136/emermed-2021-211572

Overnight Stay in the Emergency Department and Mortality in Older Patients JAMA 2023

Question Is spending a night in the emergency department (ED) associated with increased in-hospital mortality and morbidity among older patients?

Findings This French cohort study of 1598 patients 75 years and older, those who spent a night in the ED showed a higher in-hospital mortality rate and increased risk of adverse events compared with patients admitted to a ward before midnight. This finding was particularly notable among patients with limited autonomy.

Meaning These findings suggest that older patients, particularly those with limited autonomy, who spend the night in the ED awaiting hospital admission may have a higher risk of in-hospital mortality and morbidity; they should be prioritized for admission to a ward.

Overnight Stay in the Emergency Department and Mortality in Older Patients | Geriatrics | JAMA Internal Medicine | JAMA Network

Ethical Considerations

Principle Based Ethical Considerations

Justice: Who gets access?

- Boarding consumes limited ED resources
- Delays care for incoming emergencies
- Disproportionately affects vulnerable populations

Non-Maleficence

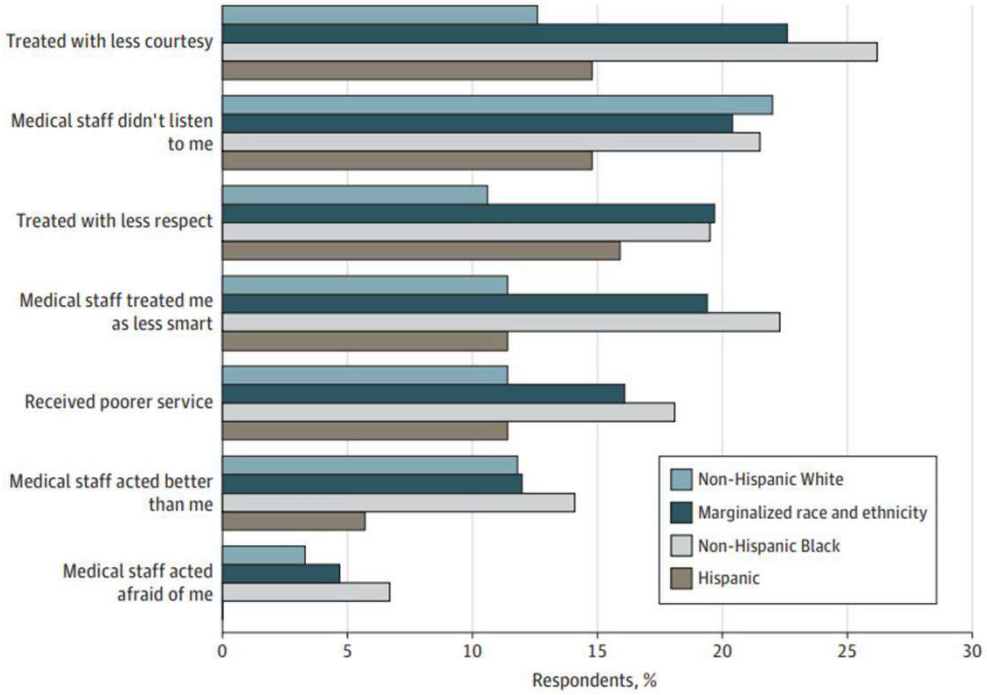
Beneficence

Autonomy

- Patient's awareness of boarding varies
- Informed decisions and consent
- Increased use of physical and chemical restraints→taking away pt autonomy

[Prolonged Boarding and Racial Discrimination and Dissatisfaction Among Emergency Department Patients | Equity, Diversity, and Inclusion | JAMA Network Open | JAMA Network]

Figure 1. Reasons for Experiences of Discrimination During Emergency Department Boarding by Racial and Ethnic Group



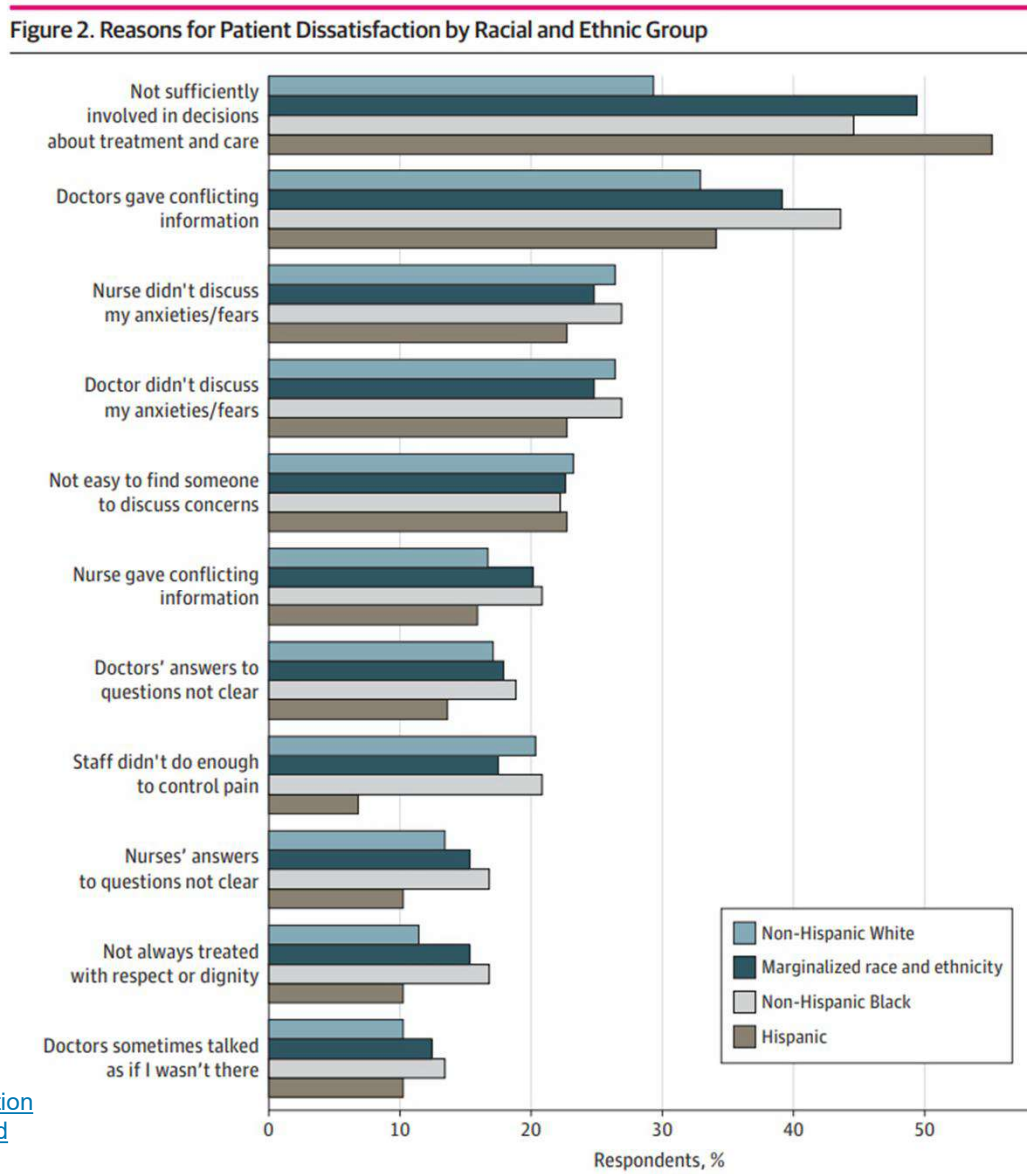
Question Is prolonged emergency department (ED) boarding associated with racial discrimination and dissatisfaction?

Findings In a cross-sectional study of 525 adults admitted to a large, urban medical center in Boston, Massachusetts, patients who boarded 24 hours or longer were 1.84 times more likely to report discrimination and 1.77 times more likely to report dissatisfaction with care, compared with those who boarded less than 4 hours.

Meaning These findings suggest that patients who board in the ED 24 hours or longer may experience more racial discrimination and dissatisfaction with care, which may exacerbate preexisting health inequities.

Prolonged Boarding and Racial Discrimination and Dissatisfaction Among Emergency Department Patients in JAMA 2024

- Almost 40% of pts felt inadequately involved in treatment decisions, particularly pts from marginalized groups
- Marginalized groups were more likely to report being treated with less courtesy and less respect



[Prolonged Boarding and Racial Discrimination and Dissatisfaction Among Emergency Department Patients | Equity, Diversity, and Inclusion | JAMA Network Open | JAMA Network]

Swedish Study of Boarding ED Patients

"The thematic structural analysis covers seven themes: Being in a state of uncertainty, Feeling abandoned, Fearing death, Enduring, Adjusting to the circumstances, Being a visitor in an unsafe place, and Acknowledging the staff, all illustrating that the participants were in a state of constant uncertainty and **felt abandoned** with no guidance or support from the clinicians. The conclusion is that the situation where patients are forced to wait in A&E, i.e., **boarding, *violates all conditions for professional ethics*, presumably causing profound *ethical stress* in the healthcare professionals involved.** Thus, boarding should be avoided."

Sub-Themes	Themes
Lacking information and piloting Mastering emotional stress Feeling hopeless	Being in a state of uncertainty
Feeling neglected Losing track of time Being an object Being in discomfort Dealing with loneliness Feeling helpless	Feeling abandoned
Expecting the worst Pondering on mortality	Fearing death
Being constantly aware of others' suffering Feeling empathy with other patients Gaining perspectives Having no rest due to constant noise Feeling exposed	Enduring
Justifying reasons for seeking care at A&E Adopting a positive approach Accepting facts Balancing expectations Mastering dependency Trying not to care	Adjusting to the circumstances
Fear of being infected Protecting one's belongings Feeling insecure Having no privacy	Being a visitor in an unsafe place
Feeling empathy with the staff Having pity for the staff Making no demands	Acknowledging the staff

Rantala A, Nordh S, Dvorani M, Forsberg A. The Meaning of Boarding in a Swedish Accident & Emergency Department: A Qualitative Study on Patients' Experiences of Awaiting Admission. Healthcare (Basel). 2021 Jan 12;9(1):66. doi: 10.3390/healthcare9010066. PMID: 33445751; PMCID: PMC7828189.

AMA Code of Ethics

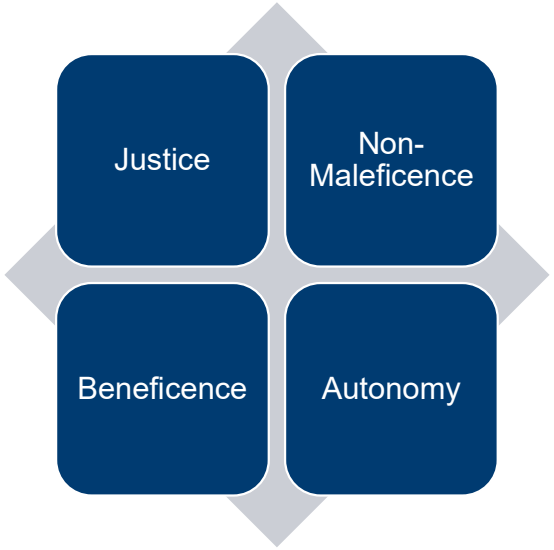
1. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
   - Significant moral distress among physicians related to the situation of ED boarding, crowding, hall beds, waiting room medicine
   - Situation they find themselves practicing does not seem to support the first Principle of AMA Code of Ethics

Can situations be ethical?

- Situations (facts) cannot be ethical or unethical, human choices and actions can be
- The human decisions that lead to and perpetuate the situation are potentially ethically problematic
- Change “boarding patients in the ED is unethical” to “boarding patients results from *potentially* unethical policies or decisions”
- A provider can only be judged on the decisions made in the situation

The Situation

- What is the ethical decision the ED physician should make?
  - Board in the ED awaiting placement?
  - Discharge to the street?



Solutions?

Lund Report

- House Bill 3396 passed by Oregon Lawmakers in 2023 set up the task force.
- 21-member state task force met to map out strategies to aid the flow of patients through hospitals and into appropriate settings, with an eye on vulnerable Oregonians who lack housing or a stable living environment

Oregon task force finds ways to prevent patients from boarding in hospitals

For more than a year, a state task force has tackled the problem of people stuck in hospitals with nowhere to go, taking up beds that others need

SHUTTERSTOCK

by BEN BOTKIN | OREGON CAPITAL CHRONICLE

NOVEMBER 14, 2024

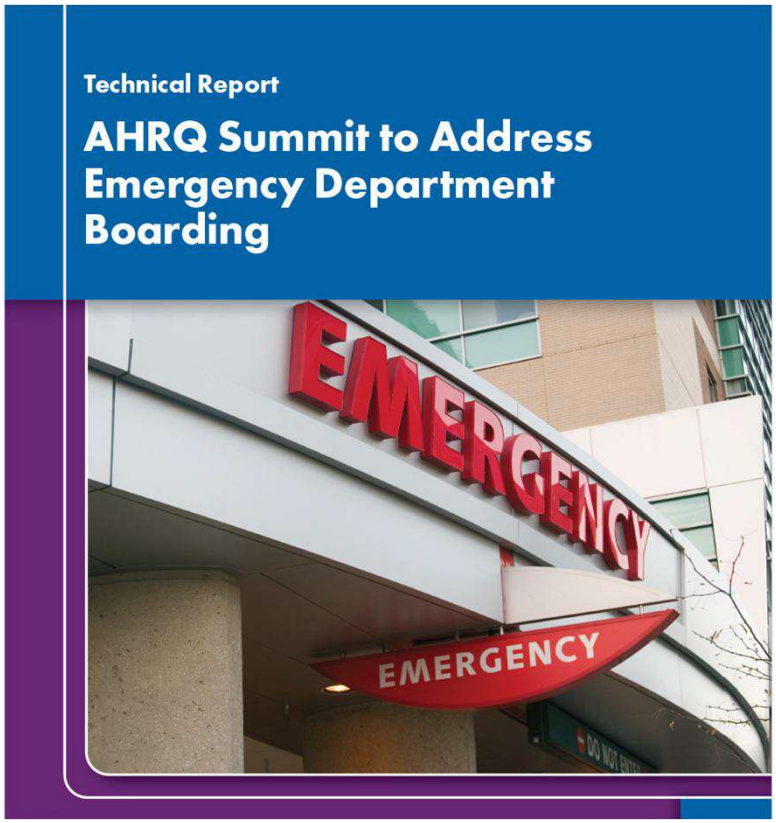
Across a sprawling system of nearly 60 acute-care hospitals, Oregonians take up beds they do not need while other patients board in emergency rooms for days on end with nowhere to go.

Recommendations of the Joint Task Force on Hospital Discharge Challenges December 2024

- 1. Update eligibility processes and workflows for long-term services and supports (LTSS)
- 2. Waive or streamline asset testing for LTSS
- 3. Increase support for legal guardians.
- 4. Refine the regulatory framework to support complex care.
- 5. Expand medical respite (MR) statewide.
- 6. Coordinated Care Organizations and Dual-Eligible Special Needs Plans.
- 7. Update reimbursement methods for Adult Foster Homes.
- 8. Extend the Post Hospital Extended Care benefit.
- 9. Leverage existing initiatives to develop the post-acute workforce pipeline.

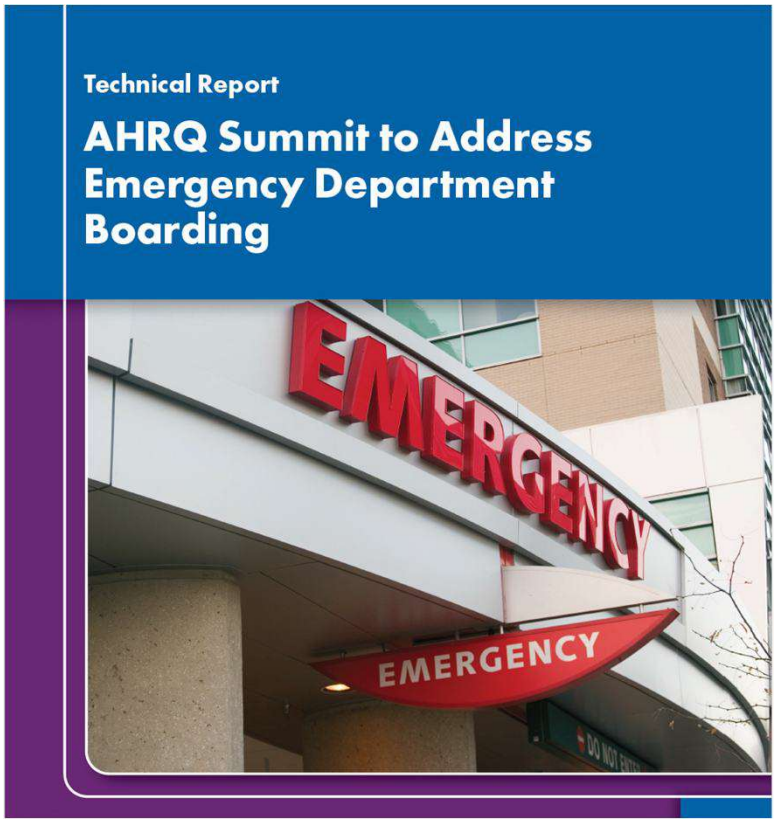
January 2025

- The Agency for Healthcare Research and Quality (AHRQ) Summit to Address Emergency Department Boarding convened in October 2024 to engage public and private partners, including patients and consumers; clinicians; hospital and health system leaders; policymakers; experts in emergency medicine, behavioral health, and other medical specialties; and others to identify actionable hospital-level and health system-level solutions to address ED boarding systematically.
- The Summit was held in response to a bipartisan letter sent by 44 members of Congress to the U.S. Department of Health and Human Services (HHS) requesting that HHS "identify, develop, and implement both immediate and long-term solutions" to the issue.



Three types of programs are commonly thought to reduce ED boarding but are **ineffective** because they primarily focus on ED input factors and not on drivers of boarding

- Programs to keep **low-acuity patients** out of the ED do not reduce boarding because low-acuity patients are rarely admitted to the hospital.
- **Alternative care programs** to keep patients out of the ED, such as expanded telehealth options or urgent care clinics, do not alleviate boarding for the same reason. However, these programs may still improve care processes for patients who receive these services.
- Programs designed to **reconfigure EDs and their processes**, such as ambulance diversion or building larger EDs, do not reduce boarding because these programs do not address hospital capacity or ED outflow.

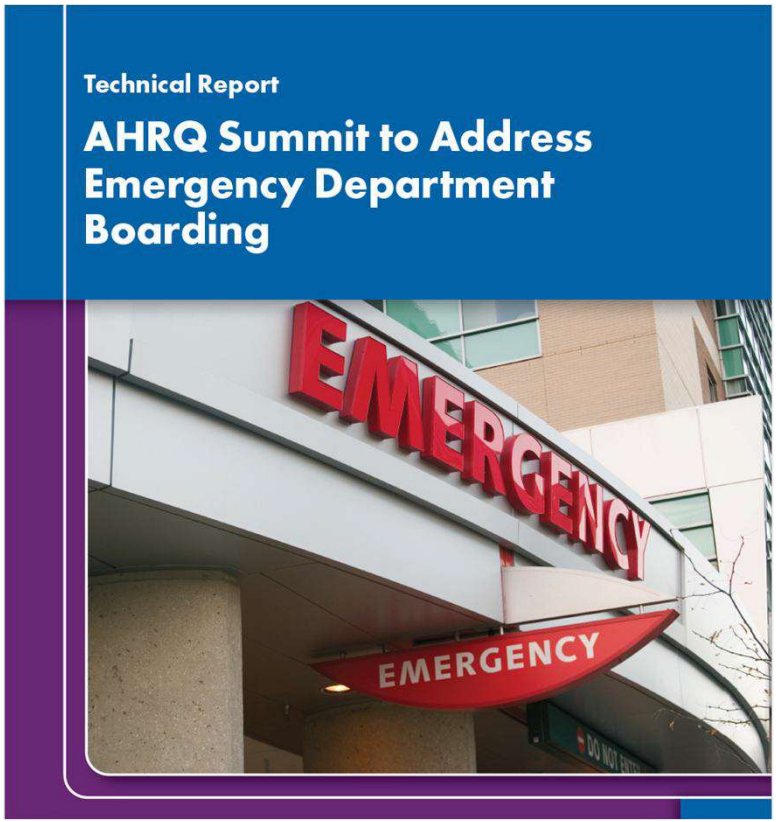


Proven solutions include the following:

- **Surgical smoothing** distributes elective surgeries more evenly across the full week to reduce peaks in inpatient bed demand and enable ED patients to move to inpatient units more rapidly.

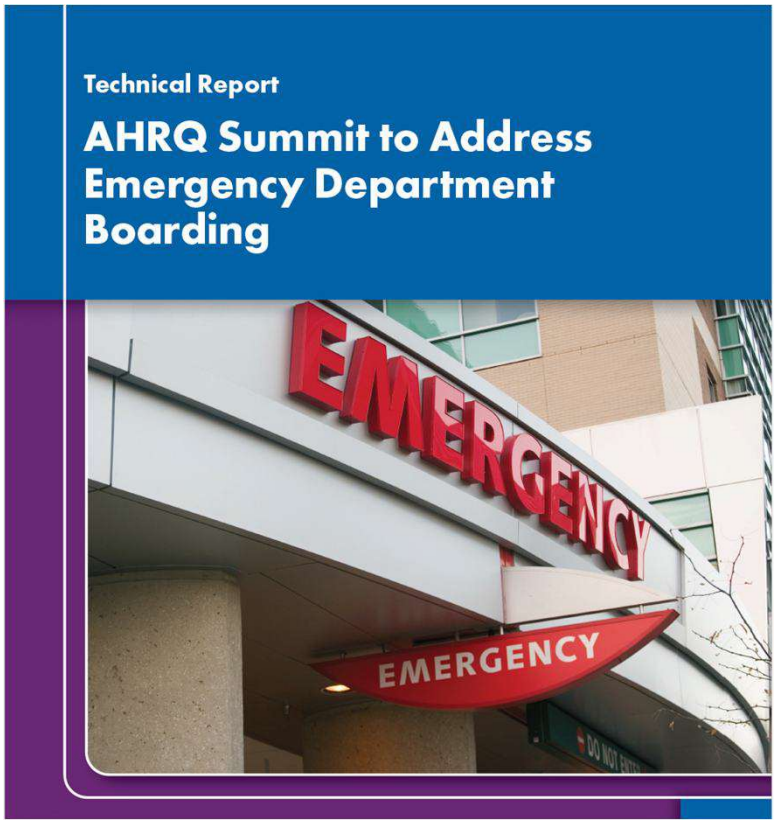
- **Streamlined discharges**, including discharging patients early in the day, planned weekend discharges, and using discharge lounges, make inpatient beds available more quickly for admitted ED patients.

- Hospital efforts to use **inpatient bed managers** to speed bed assignment, provide alternative services for **behavioral health patients**, and involve **executive leadership** in addressing the challenge are effective in reducing ED boarding.



Suggestions from Summit Participants

- **Measurement, standards, and public reporting** efforts could increase hospital and health system accountability for ED boarding.
- **Regional health data systems** could support sharing data about bed availability within a geographic region.
- **Aligning payment and incentive policies** could reduce boarding and would require minimizing any potential unintended consequences of payment changes.
- **Increased support to help rural hospitals** access telehealth consults and transfer patients needing higher-level care could reduce ED boarding in Critical Access Hospitals and other rural facilities.
- Diversion strategies that reduce the need for inpatient care among **behavioral health patients** may help reduce ED boarding because patients with acute behavioral health needs may be more likely to be admitted once brought to an ED, even if their needs could be met at an intermediate level of care.



ACEP

Individual Physician	• Can mitigate stressors • Order home meds, nic replacement, diet order
Department	• Management of the ED should facilitate resources to enable daily living, bathing, walking • Push for dedicated space with appropriate environment
Hospital	• Allocate resources to offer more meaningful care to boarding patients
Health Care systems/Government	

KP solutions

- Dedicated extended stay physician (ESP) during daytime to care for non-admitted boarding patients
- ESP order set including prn meds, hospital bed, diet
- Cohorting ESP patients
- Daily huddle with CC/SW, charge nurse, ESP physician

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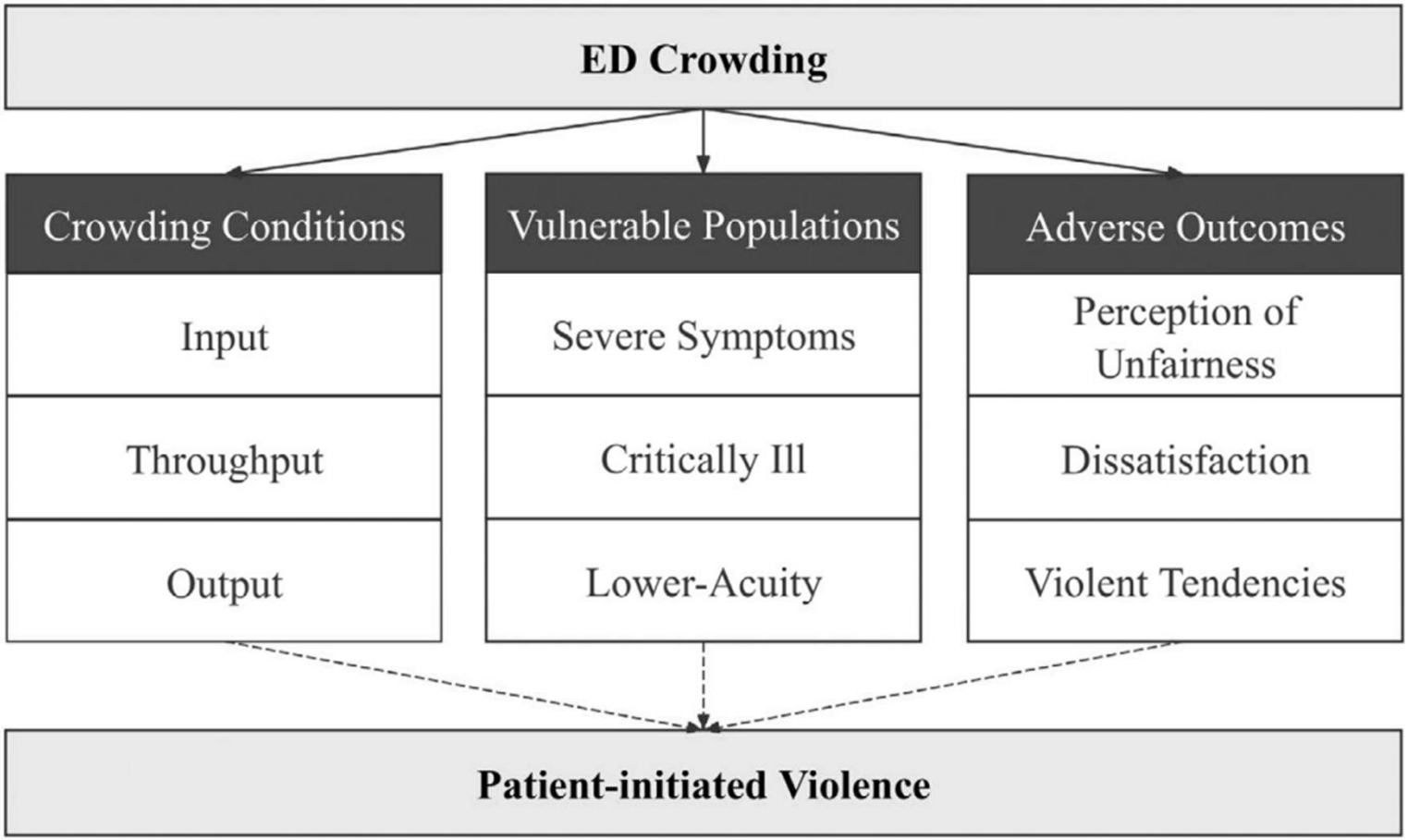

FIGURE 2 | The framework of ED crowding leads to patient-initiated violence.

