Congress of the United States
Washington, DC 20515

May X, 2023

The Honorable Xavier Becerra
Secretary
The U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C., 2021

Dear Secretary Becerra:

We write to you today with deep concern about the growing public health crisis of patient "boarding," with emergency departments (EDs) across the country overflowing, gridlocked, and overwhelmed with patients waiting for the care they need and deserve. We ask the Department of Health and Human Services to take swift action to address the ever-growing strain on our nation's health care safety net by convening a task force of key stakeholders from throughout the health care system to identify both immediate and long-term solutions to this critical issue.

What is boarding? Patients who come to the ED are usually assessed and provided stabilizing treatment. A decision is then made that the patient is either well enough to go home, or that they require admission to the hospital or transfer to another facility for continued treatment. For admission, hospital inpatient beds traditionally require both physical bed space and adequate nurses to care for that patient. Unlike in the ED, most hospitals operate their inpatient areas under narrow nurse-to-patient ratios set by state laws, regulatory agencies, and accrediting bodies. If there are no available beds within the specific inpatient unit to which an ED patient needs transferring, that patient must wait, or be "boarded" in the ED--often for hours, sometimes days, or even weeks. The same issue of needed staff also holds true for transfer outside the facility, such as to an inpatient psychiatric facility or a skilled nursing facility.

Once the hospital's available inpatient beds are full, more patients must be accommodated by boarding in the ED, filling up valuable beds, hallways, and even seats in the ED waiting room. On top of this, EMS crews bringing emergency patients in via ambulance are often left waiting what can be hours to be able to safely hand over their patient to hospital ED staff, keeping them from being able to respond to new calls for help in the community. And throughout it all, walk-in patients continue to arrive to the ED and cannot be turned away under the federal Emergency Medical Treatment and Labor Act, or EMTALA's, requirements.

This is not "a COVID issue", and it won't go away when the public health emergency is lifted. Even with the worst of the COVID-19 pandemic now behind us, hospital emergency departments (EDs) all over the country are at, or even past, the breaking point, with no relief in sight. It led to a nurse in Washington calling 911 as her ED became completely overwhelmed with waiting patients and boarders. Her story is not unique--it is happening right now in EDs across the country, every day. To paint a broader picture of the distressing scope of the ED boarding problem, the American College of Emergency Physicians collected hundreds of firsthand accounts from emergency physicians who have shared their stories from the front lines.

Boarding affects patients of all kinds, regardless of their condition, age, insurance coverage, income, or geographic location. These excessive waits for needed care directly harm patients through worse outcomes, increased risk of medical errors, and even avoidable deaths.[1,2] One emergency physician account noted that in addition to average boarding times of more than 70 hours at their hospital, "…we have patients who unfortunately have died in our waiting room while awaiting treatment. These deaths were entirely due to boarding."

Emergency department boarding 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.[3] Another found that cognitive stressors, specifically overcrowding and patient load, are associated with increased implicit bias that may affect patient care.[4] Those with acute psychiatric conditions, especially children and adolescents, are particularly hard hit by boarding and may board for *months* at a time.

All the above-described long wait times are entirely outside of the control of the emergency department health care professionals diligently working to care for their patients; rather, they are the product of a multitude of factors, including decades' worth of misaligned economic incentives and systemic faults. These stressful working conditions only serve to accelerate the record levels of physician and nurse burnout as these professionals simply do not have the resources to keep up with the volume of patients coming in. As one emergency physician describes, "These kinds of working conditions are NOT sustainable, yet similar conditions continue all over the country. It's like a warzone everyday. No wonder doctors and nurses are leaving healthcare in droves and rates of depression and suicide are so high- working in those conditions day in and day out, not being able to provide the care and treatments we know patients need." The alarming health care workforce shortages that continue to worsen have been a major driver to the growing boarding crisis, which itself leads to more burnout, causing more to leave health care altogether.

If the system is already this strained, how will emergency departments be able to cope with a sudden surge of patients from a natural disaster, mass casualty event, or another disease outbreak? Our communities rely upon the safety net that our dedicated health care professionals provide, and we cannot accept these conditions as a "new normal." As another emergency physician stated,

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[1] [1] Morley C, Unwin M, Peterson GM, Stankovich J, Kinsman L. Emergency department crowding: A systematicreview of causes, consequences and solutions. *PLoS One*. 2018;13(8):e0203316. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0203316.

[2] Berg LM, Ehrenberg A, Florin J, Ostergren J, Discacciati A, Goransson 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 Sep;74(3):345-356. https://www.sciencedirect.com/science/article/pii/S0196064419303312?via%3Dihub.

[3] https://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2009.00381.x

[4] https://onlinelibrary.wiley.com/doi/10.1111/acem.12901

“The crisis is bigger than can be managed by a single hospital or even the medical system alone. We need help from policymakers."

Again, we urge you to convene a task force with broad stakeholder representation – including members of other federal agencies - on the emergency department boarding crisis as soon as possible to identify, develop, and implement both immediate and long-term solutions to this public health issue. Such a task force should include physicians, nurses, government representatives, EMS, hospitals, patient groups, and other entities who can help inform solutions to this urgent problem.

The next patient to come to an emergency department could be your friend, neighbor, colleague, or a loved one. Swift, collective action is required to stabilize the health care system and ensure they will have access to the lifesaving emergency care they need and deserve.

Sincerely,

Brian Fitzpatrick
Member of Congress

Debbie Dingell
Member of Congress