

Emergency Department Boarding: A Public Health Crisis

In recent months, hospital emergency departments (EDs) have been brought to a breaking point. This is not due to a novel problem, but rather a decades-long, unresolved problem known as patient “boarding,” where patients are held in the ED following stabilization and care awaiting an inpatient bed to become available, or space in a tertiary facility to be transferred to.

Over the last year, **boarding has significantly worsened nationwide and become its own public health emergency.** ACEP collected more than [140 personal stories](#) from emergency physicians across the country and nearly all respondents (97%) cited boarding times of more than 24 hours, with one third having had patients stay more than one week, and 28% more than two weeks. Our nation’s safety net is on the verge of breaking beyond repair, and EDs are gridlocked and overwhelmed with patients waiting. And this breaking point is entirely outside of the control of highly skilled emergency physicians, nurses, and other ED staff doing their best to keep everyone attended to and alive.

This is not a “COVID” issue, and it will not resolve when the public health emergency ends. Any emergency patient can find themselves boarded, regardless of their condition, age, insurance coverage, income, or geographic area. Even patients sick enough to need intensive care may board for hours in ED stretchers not set up for the extra monitoring they need. But boarding does not just affect those waiting to be moved out of the ED. When ED beds are already filled with boarded patients, other patients are decompensating and, in some cases, dying while in ED waiting rooms during their tenth, eleventh, or even twelfth hour of waiting to be seen by a physician. As well, ambulances often must remain out of service as EMS crews often wait for hours to safely hand over their patient to hospital ED staff.

“At peak times which occur up to 5 days per week we have more patients boarding than we have staffed beds. High numbers have included last week when our 22-bed emergency department had 35 boarders and an additional 20 patients in the waiting room...In addition, we have patients who unfortunately have died in our waiting room while awaiting treatment. These deaths were entirely due to boarding.”

- anonymous emergency physician
<http://acep.org/boarding-stories>

While the causes of ED boarding are multifactorial, unprecedented and rising staffing shortages throughout the health care system have recently brought this issue to a crisis point, further spiraling the stress and burnout driving the current exodus of excellent physicians, nurses, and other health care professionals.

Ample research supports the conclusion that ED crowding leads to increased mortality. Boarding can also lead to ambulance diversion, increased adverse events, preventable medical errors, lower patient satisfaction, violent episodes in the ED, and higher overall health care costs. ED boarding also disproportionately affects vulnerable and historically disadvantaged populations. Those in mental health crises, often children or adolescents, board for months in chaotic EDs while waiting for a psychiatric inpatient bed to open anywhere. Patients with behavioral health needs wait on average three times longer than medical patients, but research has shown that 75 percent of psychiatric emergency patients, if promptly evaluated and treated in an appropriate location – away from the active and disruptive ED setting – have their symptoms resolve to the point they can be discharged in less than 24 hours, further highlighting the need to provide timely, efficient, and appropriate mental health care.

There is no one-size-fits-all solution to ED boarding, due to its numerous drivers, causes, and breadth of stakeholders involved. But there are steps that Congress and the Administration should take to help address this crisis. A bipartisan “Dear Colleague” letter is currently circulating urging the Administration to swiftly establish an ED Boarding Task Force with broad stakeholder representation, including emergency physicians, nurses, government representatives, emergency medical services (EMS), hospitals, patient groups, and other entities who can help identify problems and inform solutions to this urgent problem.

Additionally, the bipartisan “Improving Mental Health Access from the Emergency Department Act,” introduced by Reps. Raul Ruiz, MD and Brian Fitzpatrick and Sens. Shelley Moore Capito and Maggie Hassan, would help address a significant component of psychiatric boarding by providing grants to EDs to increase access to follow-up psychiatric care for patients, such as expedited placement, increase telepsychiatry support, expanded availability of inpatient psychiatric beds, increased coordination with regional service providers, and regional bed availability tracking and management programs. This legislation passed the House during the 117th Congress in a unanimous voice vote, and we urge Congress to ensure this legislation is included in any must-pass health care legislation this year.

ACEP urges legislators to sign the bipartisan Dear Colleague letter urging the Administration to swiftly convene an ED Boarding Task Force with broad stakeholder representation; and, to cosponsor the bipartisan “Improving Mental Health Access from the Emergency Department Act.”

ACEP asked its members to share examples of the life-threatening impact the recent uptick in boarding has brought to their emergency departments.

Over 140 stories were anonymously collected. Scan to read more or visit acep.org/boarding-stories



“— High numbers have included last week when our 22 bed emergency department had 35 boarders and an additional 20 patients in the waiting room. Longest boarding time this month was over 200 hours with averages around 70 hours per patient. In addition, we have patients who unfortunately have died in our waiting room while awaiting treatment. **These deaths were entirely due to boarding.**

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

“— Patients sit for days, unbathed, not ambulated, using urinals standing in corners in view of everyone. A patient I admitted 3 days ago stopped me asking, "Why?" **Hands reach out from gurneys as I pass asking for food, water, help to the bath-room, a blanket, or someone to simply talk to and show they care.**

“— This summer we experienced the odd circumstance of becoming the “home” for a 9 year old boy after he was dropped off by police and DSS...Our little friend had no normal attachment. He had no ability to control his anger when disappointed. He needs a loving stable home, **yet here he was in our adult emergency department, wearing mesh O.R. panties and cut off paper scrubs. For months.**

“— It is heartbreaking to find someone who could be my grandmother languishing in pain for hours before we are finally able to see and evaluate her. We are in a crisis and although we do everything we can to McGyver solutions to the problem while we are on shift, there is only so much we can do from the ground. **We cannot fix this problem in the ED, we need help.**

“— We are a top nationally ranked hospital that, due to budget issues, has now **prioritized transfers and surgery admissions over ED admissions.**

“— I urge both health system managers and governmental officials to **reevaluate the need for surge capacity, as a matter of public safety.** The cuts in hospital bed capacity and service capabilities over recent years, in the name of efficiency, have left us with an inadequate system for such emergencies.