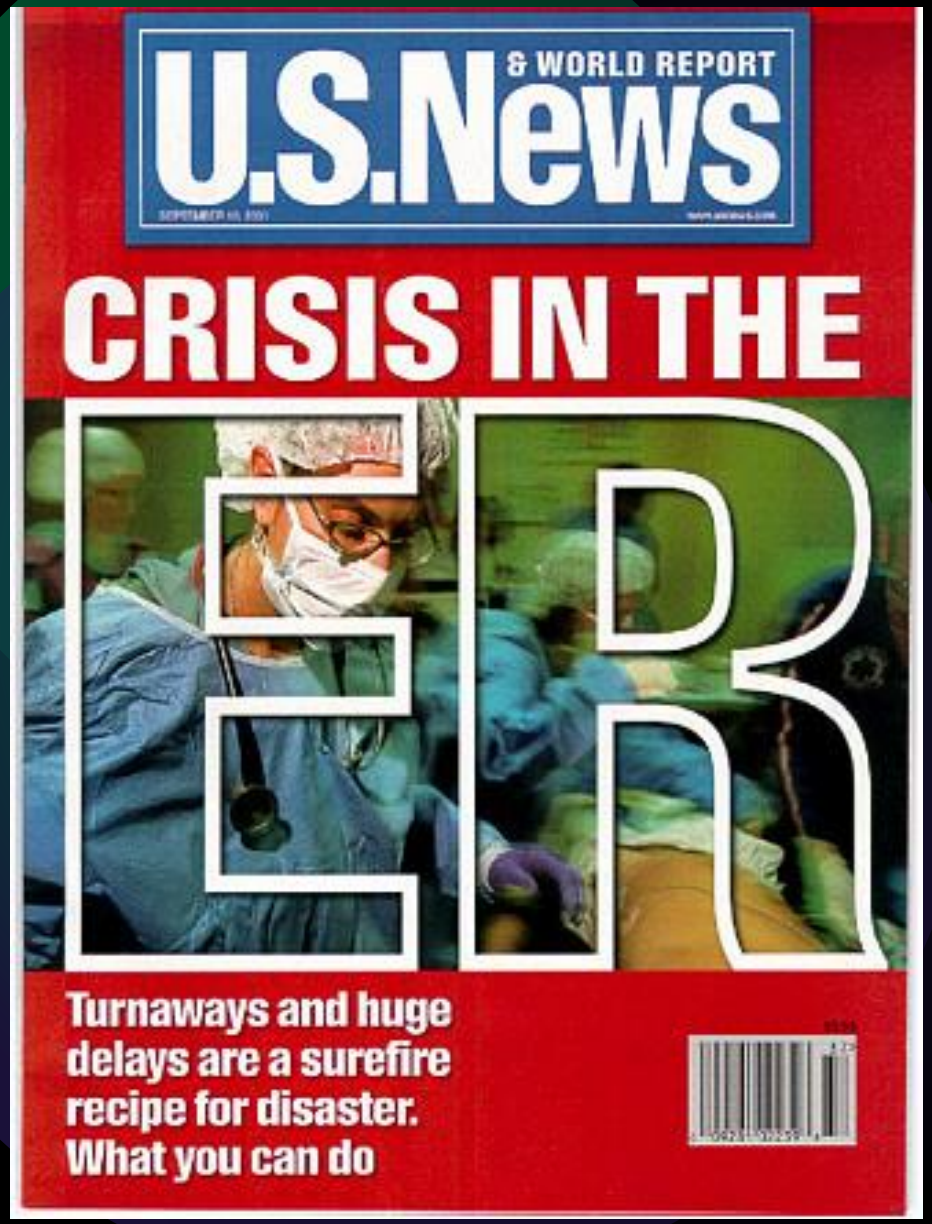
Emergency Departments And Public Health

Measurements to find Solutions

CHRIS MOORE MD

PROFESSOR, YALE SCHOOL OF MEDICINE

CO-CHAIR, CONNECTICUT EMERGENCY DEPARTMENT BOARDING AND CROWDING WORKGROUP



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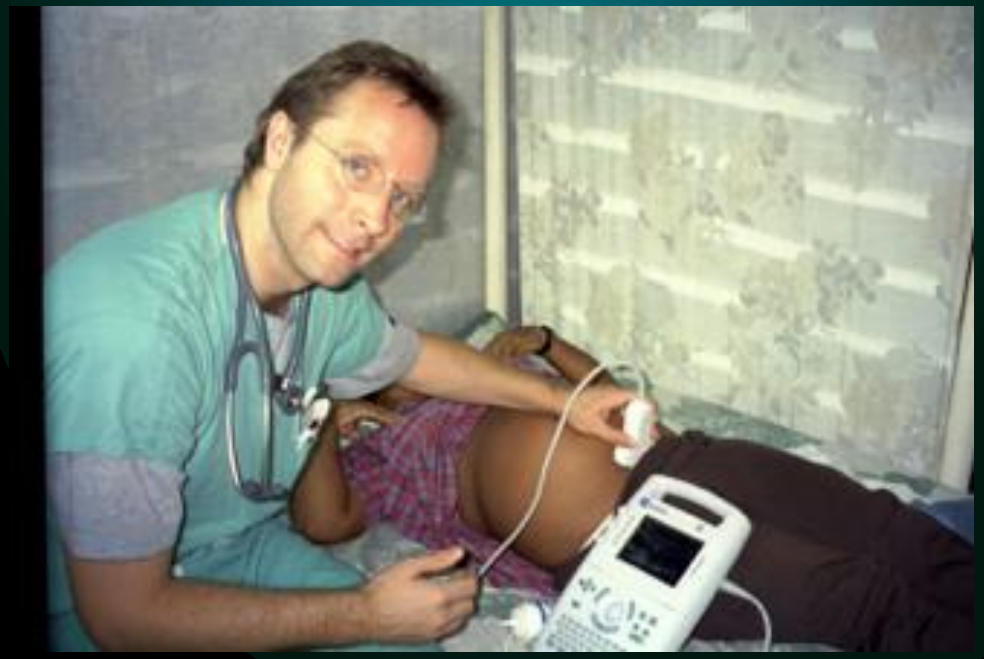

CT patients are waiting days in emergency rooms for a hospital bed. Lawmakers want to know why

Connecticut Public Radio | By Sujata Srinivasan
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Mario Tama / Getty Images

ER boarding is the result of longstanding health care problems — population health, increasing acuity of patients, primary care access, prior insurance authorization, and transportation to other medical facilities, Dr. Arjun Venkatesh, chief of emergency medicine at Yale, said. Patients in the overloaded Emergency Room at Providence St. Mary Medical Center amid a surge in COVID-19 patients on January 5, 2021 in Apple Valley, California.

“I mean, people have access to health care in America… After all, you just go to an emergency room.”

-George W. Bush
2007

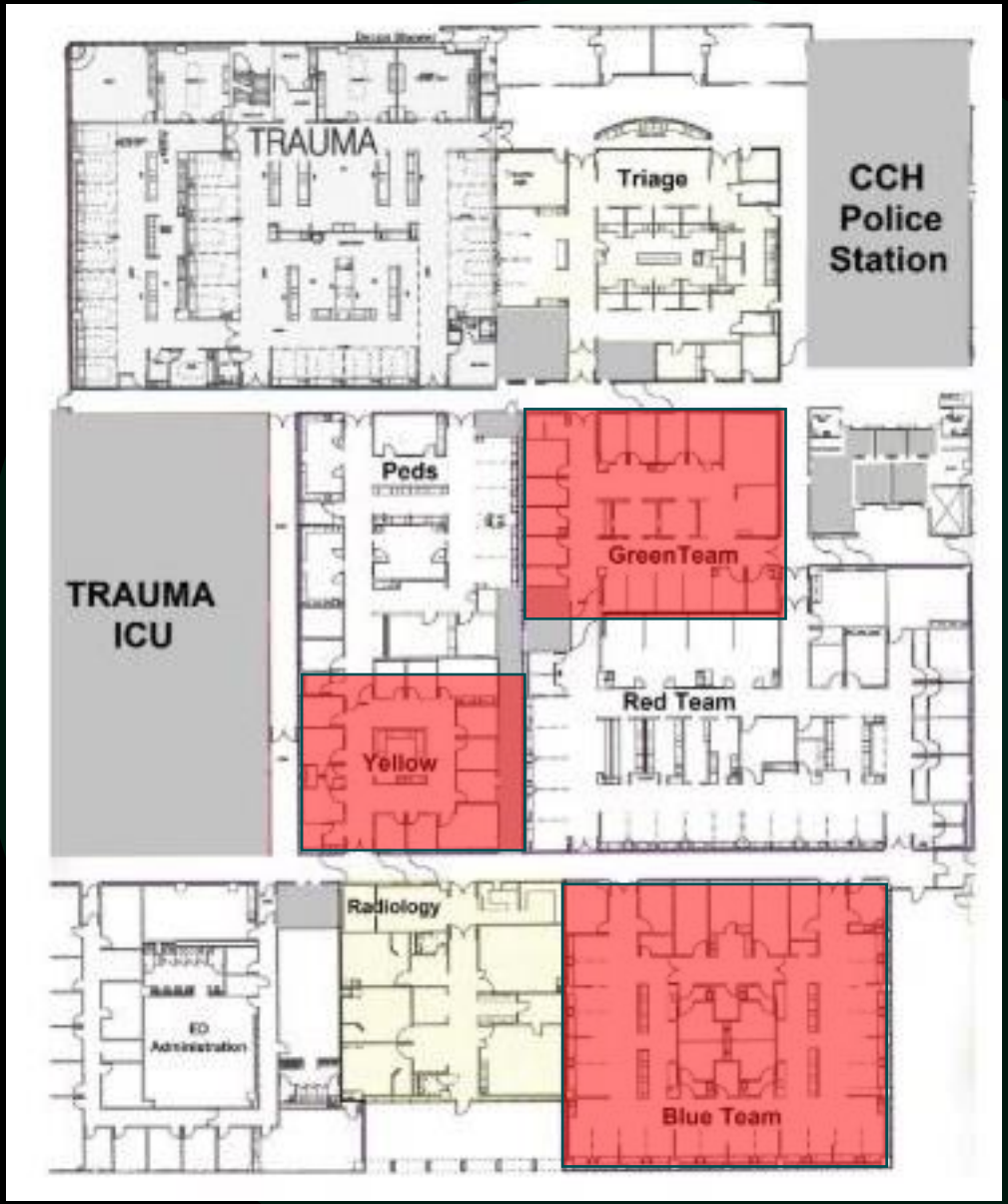
If you had to pick *one* measure of health system capacity,
equity of access,
and preparedness,
what would it be?

** ED Boarding **

- Why
- What exactly to measure
- How to measure it
  - Federal measures
  - State measures
- Legislation

ED Boarding: patients in ED after work-up is complete and disposition decided

ED Crowding: capacity overwhelmed



- Large ED – 70 treatment spaces
- 100K ED visits per year
- Boarding:
  - Can sometimes occupy 40-80 beds
  - Forces hallway care, waiting room care, delays in care

What the public thinks is the problem

Input

Throughput: ED workup

Admit

Staffed bed available and ready

Hospital

No beds

BOARDING

Discharge

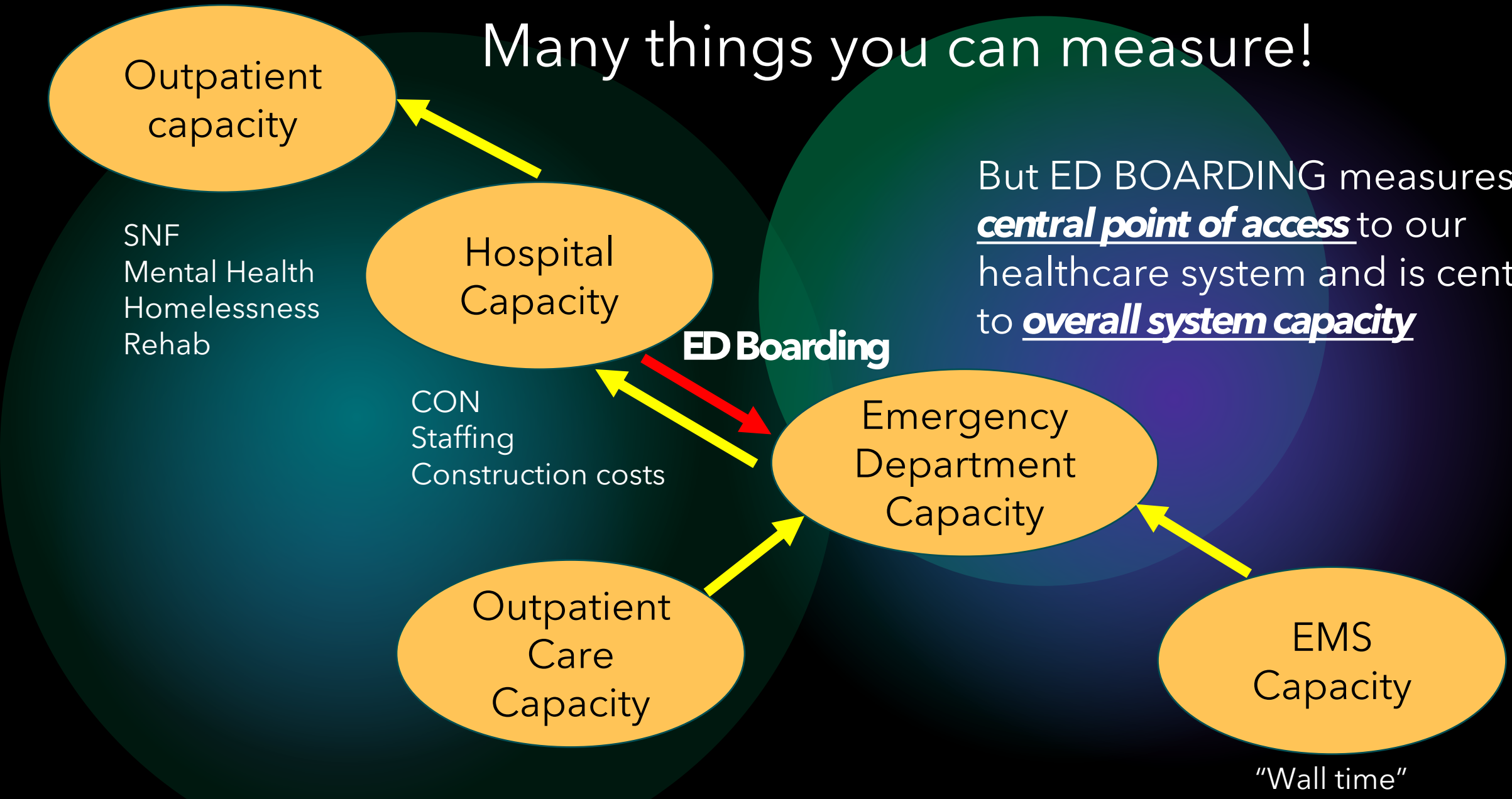
Can't leave

Home or facility

Discharge

What emergency physicians know is the problem

Many things you can measure!



But ED BOARDING measures the ***central point of access*** to our healthcare system and is central to ***overall system capacity***

Oregon

OR HB 3396:

Joint Task Force on Hospital Discharge Challenges

Capacity
Access
Equity
Preparedness

Connecticut

CT PA 23-97:

Emergency Department Boarding and Crowding Workgroup

https://portal.ct.gov/dph/working-groups/ed-working-group

Boarding – why measure it?

- Boarding is bad for patients
  - Mortality, morbidity for individual patients
  - Impairs ability to care for incoming patients
  - Boarding leads to hallway (and waiting room care), LWBS, bad outcomes
- Boarding is bad for healthcare workers
  - Workplace violence
  - Burnout → worsening boarding
- Boarding is a central measure of overall healthcare capacity and access
  - Encompasses bed capacity, staffing, inability to discharge patients
  - Measurement provides a baseline, informs capacity, can quantify effects of interventions

Quality measure?

- **Outcome** measure
  - Boarding is a bad outcome: 80yo admitted patient under fluorescent lights for 3 days
- **Process** measure
  - Causes decreased throughput
  - Impacts care: hallway care, workplace violence, burnout

What to measure?

- Overall length of stay in the emergency department from arrival to d/c: both median and mean
  - Stratify by admitted and discharged patients
  - Stratify by mental health/substance abuse and medical/surgical
- Length of time from admit ***decision*** to admit (mean and median)
  - % of patients in ED for more than 4 hours after admit decision/ order
  - Consider # of patients in ED for more than 4, 12, 24, 72 hours

Federal measures

- ED-1 – median time from ED arrival to departure for admitted patients (stratified by mental health)
- ED-2 – admit decision time to ED departure time for admitted patients (stratified by mental health)
- ECCQ – "emergency care capacity and quality" - currently under consideration by CMS – four numerator elements:
  - > 1hour to placement in a treatment space
  - Left without being seen
  - Boarded for 4h our greater
  - Overall ED LOS 8h or greater

} Voluntary

State measures

- States have the ability to do this faster and probably better
- Perhaps less ability to financially incentivize
- CT: PA 24-4

Substitute Senate Bill No. 181

Public Act No. 24-4

AN ACT CONCERNING EMERGENCY DEPARTMENT CROWDING.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective from passage*) (a) Not later than January 1, 2025, and annually thereafter until January 1, 2029, each hospital in the state with an emergency department shall, and each hospital operated exclusively by the state may, directly or in consultation with a hospital association in the state, analyze the following data from the previous calendar year concerning its emergency department: (1) The number of patients who received treatment in the emergency department; (2) the number of emergency department patients who were admitted to the hospital; (3) for patients admitted to the hospital after presenting to the emergency department, the average length of time from the patient's first presentation to the emergency department until the patient's admission to the hospital; and (4) the percentage of patients who were admitted to the hospital after presenting to the emergency department but were transferred to an available bed located in a physical location other than the emergency department more than four hours after an admitting order for the patient was completed. Each such hospital shall utilize such analysis with the goals of (A) developing policies or procedures to reduce wait times for admission to the hospital after a patient presents to the emergency department, (B) informing potential

Substitute Senate Bill No. 181

methods to improve admission efficiencies, and (C) examining root causes for delays in admission times.

(b) Not later than March 1, 2025, and annually thereafter until March 1, 2029, each hospital that conducts an analysis pursuant to subsection (a) of this section shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health, regarding its findings and any recommendations for achieving the goals described in subparagraphs (A) to (C), inclusive, of subdivision (4) of subsection (a) of this section.

Approved May 9, 2024

Lessons from Connecticut

- Initially tried to have a quality measure curated by Department of Public Health (DPH)
  - They attached a fiscal note to the bill - ~$400K – untenable
  - Law requires direct reporting to legislature
    - Heavy handed and somewhat inflexible
- Good things:
    - First state in the country to require reporting
    - Does require reporting on “root causes”
- Players: DPH, OHS (Office of Healthcare Strategy), CHA (CT Hospital Association)

by JAKE THOMAS | THE LUND REPORT PREMIUM

SEPTEMBER 12, 2024

Oregon's hospitals have too many patients with nowhere to go.

Solutions floated for Oregon's hospital boarding problem

Using hospitals to hold people who don't need to be in a hospital is having ripple effects across the state's health care system

- Note: this appears to refer to "Hospital Boarding" rather than specifically to Emergency Department Boarding

Oregon

- Each state is different
- Did meet with Drs. David Lehrfeld (EMS Director) and Dana Selover (Healthcare Regulation and Quality Improvement) briefly from OHA
- Met briefly with Helene Anderson from Apprise
- Oregon is well positioned to collect data
- However – Oregon does not currently have (publicly available) data on ED boarding

Things to consider

- How to collect data
- Who should curate
- Public availability of data
- Legislation
- Funding

Summing up

- Emergency Department Boarding is a key measure of healthcare system capacity, access to care, and is both a quality and an equity issue

- Measuring it is important to understand extent of the problem, measure impact of any interventions, and public availability may be helpful

Questions?