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

Chair Patterson, Vice Chair Hayden and members of the committee, my name is Dr. Craig Rudy, and I'm President of the Oregon Chapter of the American College of Emergency Physicians.

Sen. Patterson, we are grateful for your leadership on issue of hospital discharge challenges and emergency department boarding. Thank you for inviting me to share my experiences with you.

Boarding in the emergency department is a complex issue that lacks for a simple fix. It will take years of dedicated intervention. I am here before you however asking you all to remember that even incremental progress can help our patients.

As a member of the healthcare community working on the front lines, I see the challenges that the healthcare system, and more importantly, our patients face on a daily basis. The emergency department is the safety net of our healthcare system. We see anyone, anything, anytime. However, the emergency department also must be preserved and deterioration of this important public service means lack of access to life saving care for our community, including the most vulnerable among us. Emergency medicine is facing many challenges currently but one of the most severe is ED boarding.

Our hospitals are filled to capacity and admitted patients remain in the ED awaiting beds in the hospital. This means less space available for us to care for the steady stream of new patients. For anyone that has seen the iconic, "I Love Lucy" skit, she goes to work at a factory wrapping candy. Eventually the conveyor belt starts to overwhelm her and she begins to shove candy into her mouth as she cannot possibly keep up. Underlying the comedy, is fundamentally an issue of flow and bottlenecks. In

her case, she was the bottleneck. Boarding is a bottleneck at the end of the conveyor belt without a way off. ED boarding is a well-documented problem that has been present for years but has accelerated since the onset of the COVID pandemic and does not show signs of receding. Our patients suffer as a result.

A Day in the Life of an Emergency Physician

I would like to take you through a busy day in the emergency department. The first task when I arrive on shift is to meet with the charge nurse to identify how severe boarding is for the day. I attempt to identify at what point we can expect some in hospital discharges, how much staffing we have available, and when we will be able to accommodate opening hallway beds. Based on what information I receive, I begin to learn how the flow of my shift will unfold and where I will have to go to see patients. This might mean seeing the bulk of my patients in the hallway or even the triage rooms - sending them back to the waiting room, an unmonitored setting, while we await the results of their testing**.**

My first patient is a 26-year-old woman who presents with vaginal bleeding and abdominal cramping. She is 10 weeks pregnant with her first and scared that she is having a miscarriage. She is in severe pain and even more so, mental anguish. She has already been waiting 4 hours to get to a hallway bed. She has to suffer the indignity while she shares her private experience with me in the hallway lying on a small gurney in front of complete strangers.

I immediately progress to my next hallway patient, a middle-aged man, who presents with new onset kidney failure. He needs dialysis. Unfortunately, our hospital does not perform hemodialysis in the inpatient setting (as is the same at many hospitals in Oregon). Acute kidney failure is a life-threatening disease and he must now stressfully wait for a bed to be available at a hemodialysis capable hospital hoping that he does not have a severe consequence in the meantime.

As I return to the computer to place a few orders, I pass a few patients boarding in the hallway. 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 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.

Just as a I finish my orders, a code 3 ambulance report comes in for a patient in septic shock. We don't have a place to put them. Another boarding patient in an ED room must be moved to an already non-existent hallway bed so that this patient can enter a resuscitation room. Our charge nurse, heroically has kept us off of divert however this

was the last straw. The ED must go on divert. Ambulances will now be directed to take members of our community to other hospitals and further away from their family and community supports.

After meeting our new Code 3 ambulance patient and starting resuscitation, I return again to the computer to place orders. I review the growing list of patients in the waiting room. It is obvious based on review of triage, the waiting room has patients with: severe alcohol withdrawal, sepsis, kidney stones, child with an acutely broken arm, and significant head injuries. The number of patients in the waiting room has already begun to exceed the number of beds we have in the ED. It is clear to me that many of these patients will be seen in triage, if at all. The patient in the ED that concerns me the most is the patient that I have not yet had a chance to see and treat. If only but for the capacity to see them, we might prevent a severe disease from decompensating.

Meanwhile, an overhead alert is paged for a hallway a patient belonging to my colleagues. She is acutely decompensating and suspected to be in the process of dying. Her daughter makes it clear that the patient does not want heroic interventions and she wishes to transition to hospice. Nonetheless, the patient must experience the indignity of dying in the hallway until a room can be made available. Our charge nurse, again, will heroically find a way. The moral injury to the staff however is not lost on me.

I am here with a sense of urgency regarding the critical situation currently facing our emergency departments. My colleagues have become experts in hallway and waiting room medicine. By no means is this a reflection of any specific hospital. This is a collection of experiences shared by OCEP members and individual experiences I have collected over years in a variety of EDs. This is fundamentally, an equity issue. Our safety net is being ripped apart. Our most vulnerable patients are losing access to timely care and even suffering negative consequences. Each available bed has an exponential impact on the ability of the ED to function. A boarding patient occupies a bed for an entire day however that same bed used for acute patients can see several patients in a day. Each incremental decrease in ED boarding leads to exponential capacity expansion.

OR-ACEP Request

As the cliché goes, the emergency department is the canary in the coal mine. The story does not end well for the canary. We do not need perfection but we do urgently need action. Presumptive eligibility can decrease the number of patients occupying beds in the hospital and therefore decrease ED boarding. Furthermore, I would like to see us track ED boarding across a variety of standard metrics to use data to understand this problem and to see if our interventions are working.

Thank you for your time and attention. I’m happy to answer any questions.