Psychiatric Emergency Department Boarding among Youth in Oregon

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Psychiatric Emergency Department Boarding among Youth

K. John McConnell, PhD

October 1, 2025

Accessible research. Healthier health care.

OHSU Center for HEALTH SYSTEMS EFFECTIVENESS

What is emergency department (ED) boarding?

Joint Commission definition: holding patients in the ED after the decision to admit or transfer has been made

Centers for Medicare & Medicaid Services (CMS) benchmark at 4 hours or more after admission decision

Why does psychiatric ED boarding happen?

Lack of inpatient, stepdown, and residential bed supply

ED boarding is less about the ED or hospital itself and more about downstream shortages and systemic fragmentation

What is known?

1. Boarding is worse for patients with mental health conditions
2. Boarding is often more common among youth than adults
3. Nationally, boarding rates have approximately tripled since 2017

What we studied

Boarding rates among Medicaid-enrolled children

National data from 2022

Boarding defined conservatively: 3-7 days in the ED

1 in 8 visits results in boarding event

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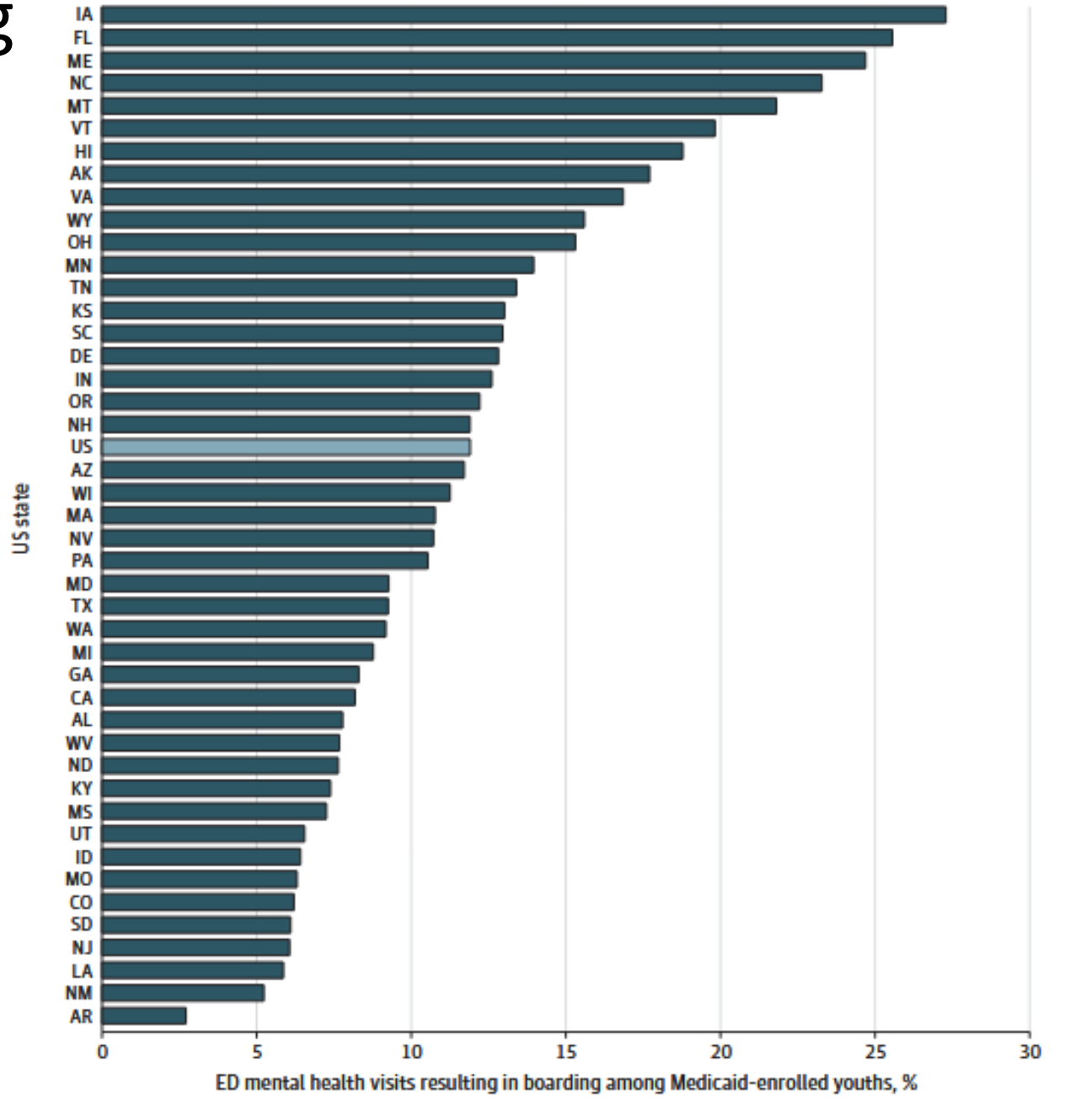
Research Letter

Variations in Psychiatric Emergency Department Boardin for Medicaid-Enrolled Youths

K. John McConnell, PhD; Thomas H. A. Meath, MPH; Lindsay N. Overhage, BA

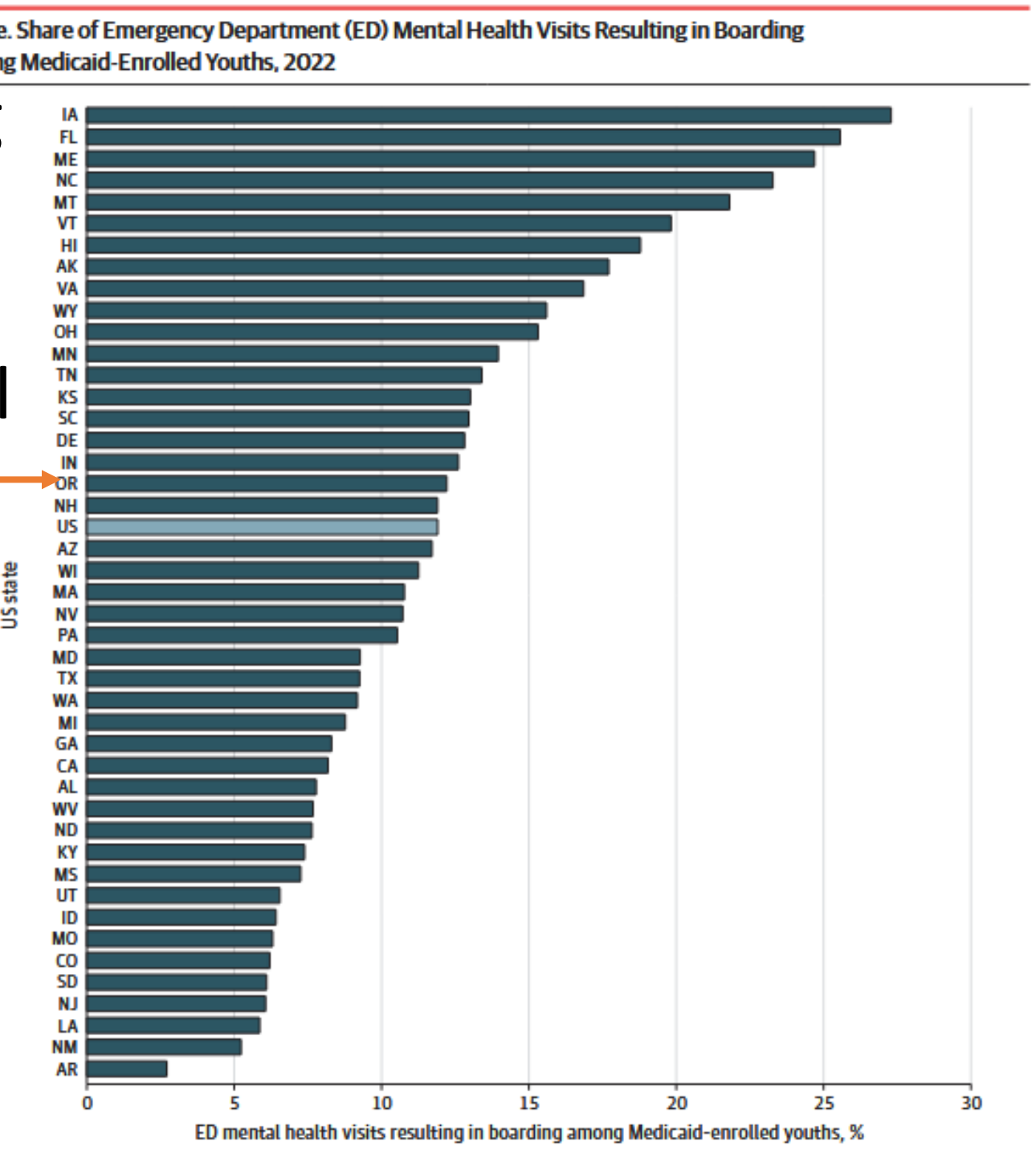
Figure. Share of Emergency Department (ED) Mental Health Visits Resulting in Boarding Among Medicaid-Enrolled Youths, 2022



1 in 8 visits results in boarding event

Oregon slightly above national average

Large variations across states



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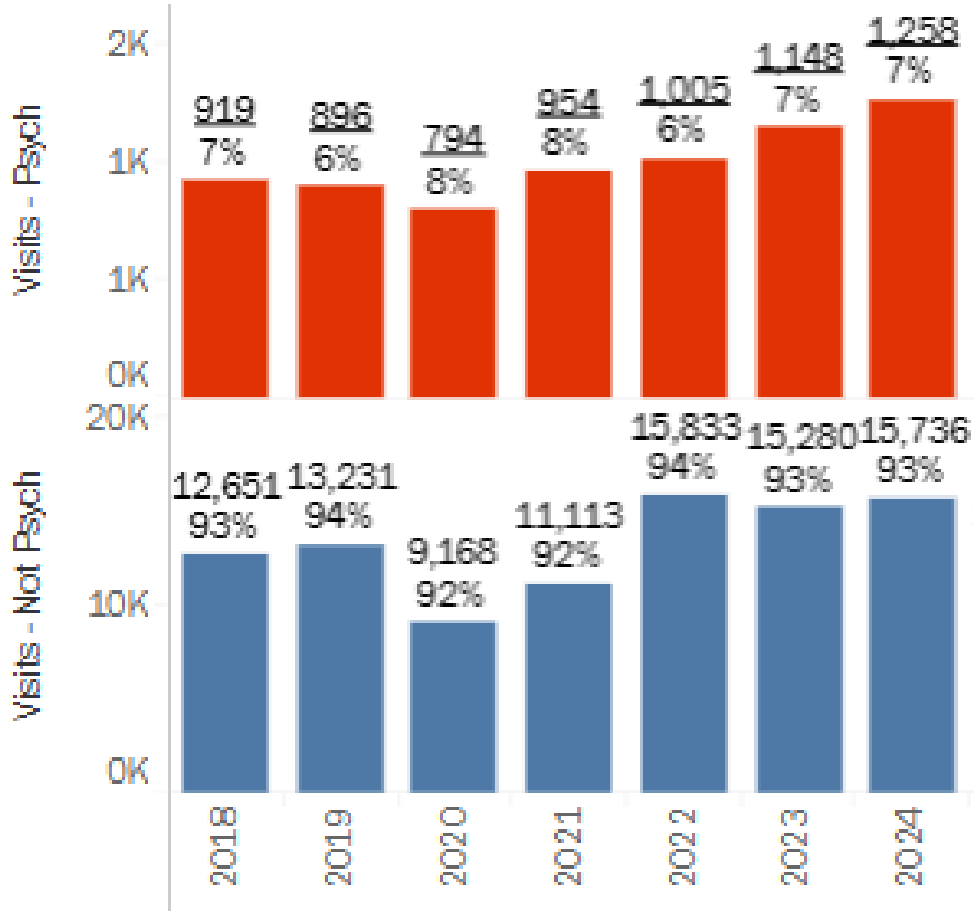
Pediatric Boarding in EDs and Hospitals

Pediatric Boarding in EDs and Hospitals

- Boarding rates have remained high for over a decade
- Efforts to decrease boarding have helped but have not fixed the problem
- We need to address the systemic issues that contribute to boarding, rather than trying to make ED boarding “better.”

Total Behavioral Health Visits and Non-Behavioral Health Visits



Pediatric behavioral health visits

- Since 2020, # of annual visits has steadily increased
- 58% increase in volume between 2020-2024

Pediatric non behavioral health visits

- # has been steady since the pandemic

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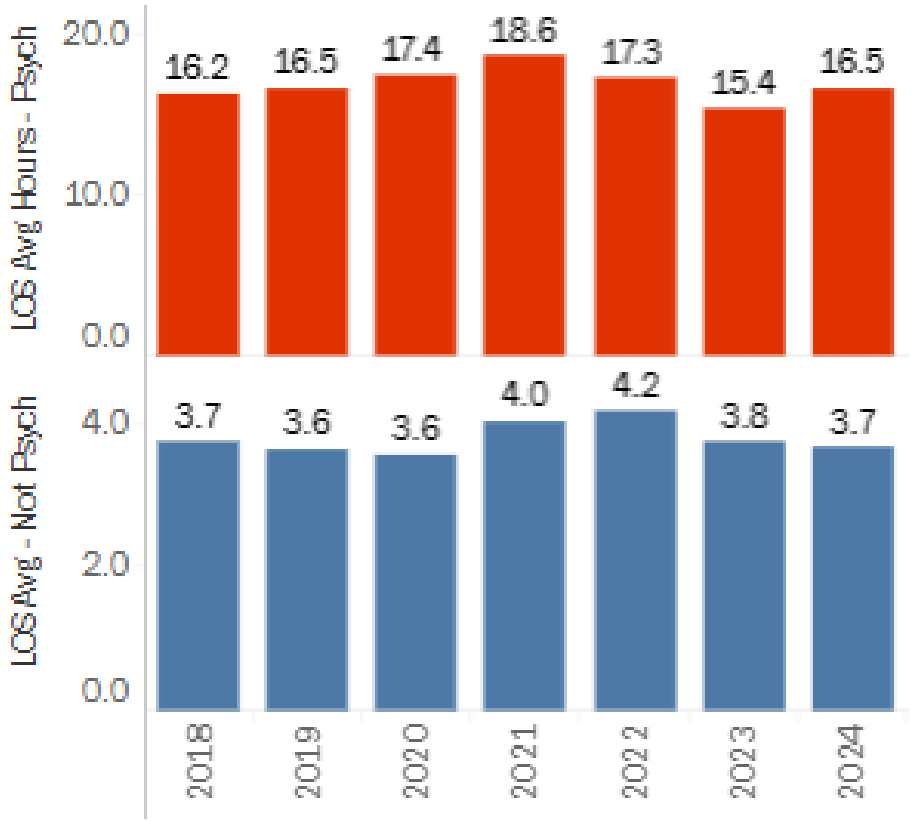
Average Length of Stay for Behavioral Health and Non-Behavioral Health Visits



- Length of stay steady over time for both non-BH and BH visits (despite increased BH volume)
- However, BH LOS is 3-5 times the length of non-BH LOS
- This is despite many efforts at OHSU and state level to decrease boarding

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OHSU Behavioral Health Efforts

Investments to:

- Transfer some youth from the ED to the pediatric wards for boarding
- Increase staffing, workflows, improve quality of care
- Strengthen coordination with community providers
- Provide behavioral health bridging care to facilitate discharges
    - OHSU Bridge Clinic.
    - Also Lifeworks NW, Randall Children's bridge clinics

State Development/Expansion of Behavioral Health Crisis and Intensive Care for Youth

OHA crisis services :

- 988
- Mobile Crisis Intervention Services (MCIS)
- Mobile Response and Stabilization Services (MRSS)

Community based services:

- In-home Intensive Behavioral Health Treatment (IIBHT)

Specialty Programs:

- ODHS: Nest, CBIT, Resource Support Network
- I/DD: EASY, HDE Pilot
- Juvenile Justice: Walden Crossing

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From: **Pediatric Inpatient Psychiatric Capacity in the US, 2017 to 2020**

JAMA Pediatr. 2024;178(10):1080-1082. doi:10.1001/jamapediatrics.2024.2888

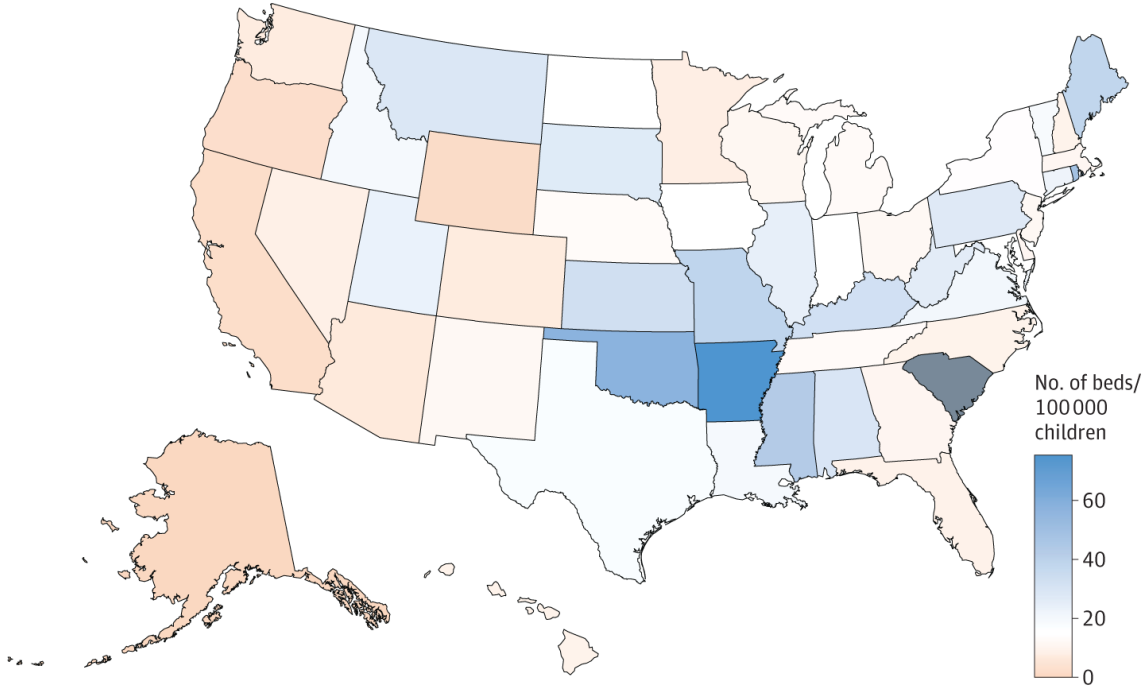


Figure Legend:

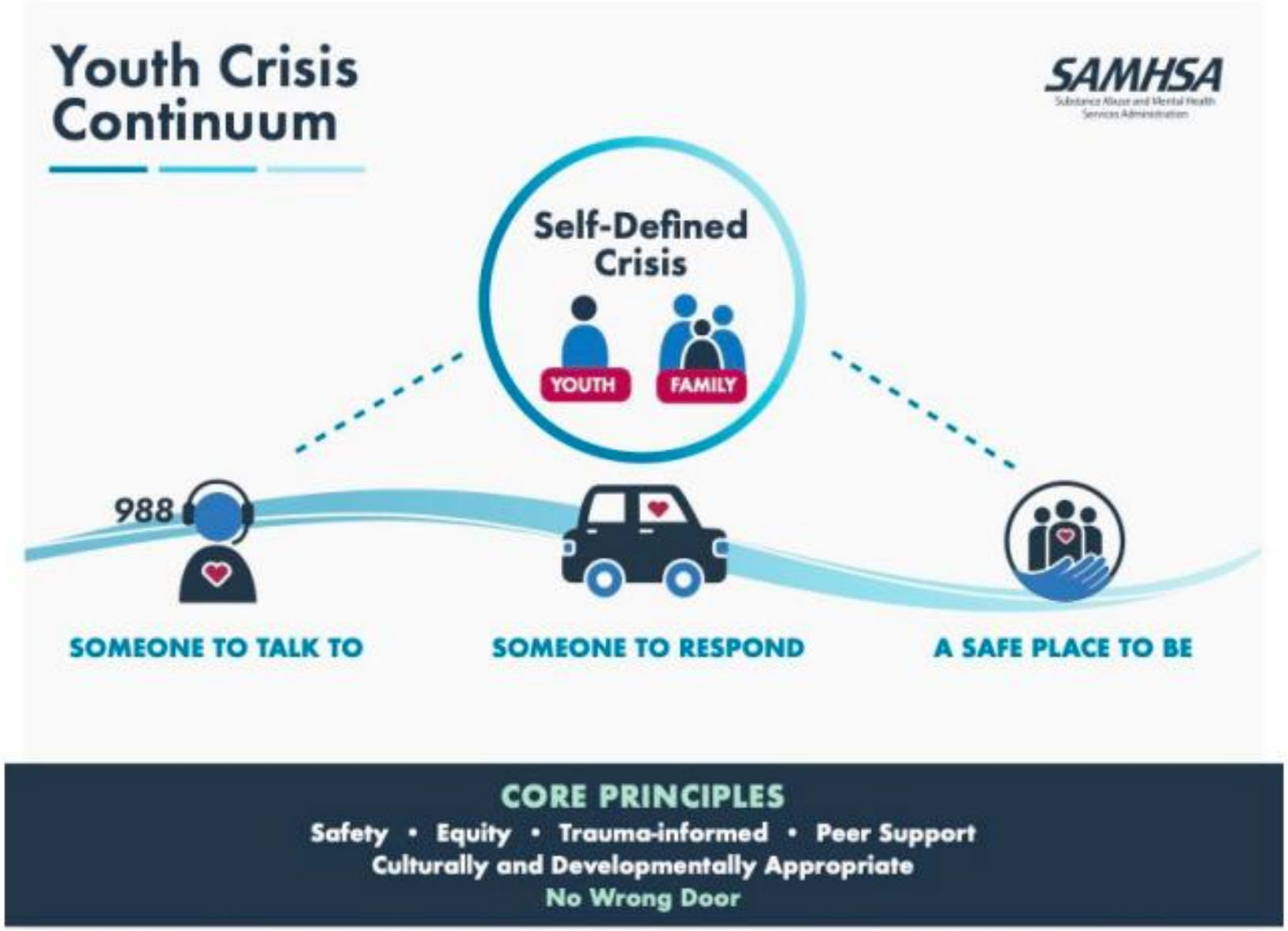
Pediatric Inpatient Psychiatric Beds per 100 000 US Children in 2020States in blue have greater than the national median number of beds (>15). States in tan have fewer than the national median number of beds (<15). South Carolina (gray) did not have any hospitals with available bed counts.

Who Is Most Likely to Board

Youth with behavioral health needs and:

- aggression
- Intellectual / developmental disabilities (I/DD)
- medical complexity (eating disorders, diabetes, etc)
- in the foster care system or with high social/family complexity
- with substance use disorder

These youth are often unable to get the care they need because of systemic limitations.


Youth Crisis Continuum
SAMHSA
Substance Abuse and Mental Health Services Administration
Self-Defined Crisis
YOUTH
FAMILY
988
SOMEONE TO TALK TO
SOMEONE TO RESPOND
A SAFE PLACE TO BE
CORE PRINCIPLES
Safety • Equity • Trauma-informed • Peer Support
Culturally and Developmentally Appropriate
No Wrong Door

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☑ ☑ ☒

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Oregon Youth Need a Full Continuum of Care

- Preventive, early, upstream and community-based care are essential
- Some youth will still have behavioral health crises.
- We need to ensure that those children have “a safe place to be” by having enough crisis, residential and inpatient care options
- Our goal should be zero ED boarding, not *decreased* ED boarding.

Recommendations

1. **Continue to invest** in preventive, early-intervention services, as well as community-based crisis and intensive outpatient services.

2. **Crisis stabilization units**. Short-term behavioral health units, usually attached to an ED, that provide a therapeutic environment and may reduce the need for inpatient admission

3. **Increase residential and inpatient beds (in process).**

4. **Med-psych unit for youth.**

5. **Specialized residential/ inpatient for youth with I/DD and BH needs.**

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National policy perspectives (many are in process in Oregon already)

1. Run a real-time, statewide bed & placement system
2. Add the right beds in the right places
3. Set a short list of public outcome targets
4. Align dollars with results
5. Ensure results are tracked and achieved

Thank you