Emergency Department Boarding and Crowding Working Group

May 15, 2024 | 3:00-4:00pm

Meeting Minutes

Members present: Jonathan Bankoff, John Brancato, Phil Davis, Charles Dike, Dock Fox, Daniel Freess, Rebekah Heckmann, Beth Liebhardt, Renee Malaro, Jennifer Martin, Miriam Miller, Craig Mittleman, Chris Moore, Gregory Shangold

Members absent: Greg Allard, Matt Barrett, Barbara Cass, Lara Chepenik, Michael Holmes, Mag Morelli, Mairead Painter, Phillip Roland, Anumeha Singh

Others present: Liz Dupont-Diehl, Mike Dugan

Introduction

- Chris called the meeting to order at 3:04pm
- The group approved the minutes from April 17
    - John Brancato moved, and Craig Mittleman seconded

Discuss SB 181

- SB 181 was signed into law on Friday, May 10
- The ED working group members advocated for the public reporting of boarding/crowding data
- The bill was modified to have hospitals report their data directly to the legislature
- Chris said that this is the first state-level measure that requires some level of reporting of this data in the US
- Jonathan Bankoff commented that this group should be proud of the work they have been able to move forward on short order

Discuss national ECCQ measure

- Rebekah gave an update on the national measure – many of the core aspects of this measure are points that are central to this group
    - This measure is moving more quickly than typical measures move
- She anticipates that her team will be defending this measure in front of a national endorsement body in the next few months – this measure could go live as soon as 2025

Presentation by Jesse Pines

- Chris introduced Jesse Pines, Chief of Clinical Innovation, US Acute Care Solutions (USACS)
- Jesse Pines presented on the capacity and non-capacity reasons that drive ED boarding
- He expressed that boarding is fixable, but it takes energy and leadership. At present, hospitals do not have incentives to fix it
    - Hospitals get more revenue from direct admits like cancer patients – the status quo maximizes capacity for the more lucrative patients

- Jesse brought up a few potential policy solutions, including:
    - Measurement and reporting
    - Directed incentives such as bonuses or penalties for hospitals
    - A more severe solution: CMS or other insurers could not pay for boarding patients
- Jesse also spoke of the unintended consequences of mandating boarding restrictions, such as rush decisions for some patients
- Maryland is implementing a policy to measure crowding, and starting in 2026 there will be some bonuses awarded to hospitals, around 10% related to boarding and crowding
- Additional policy solutions brought up by Jesse:
    - Rethinking the nursing workforce – allowing technicians to put in IVs or other procedures usually reserved for RNs
        - Putting efforts to increase and broaden the healthcare workforce
    - Fund EDs/hospitals to address boarding
    - Expand downstream capacity
        - Boarding is not an emergency department problem: for example, psychiatric patients will sit in EDs for days or weeks, waiting for inpatient beds
        - Changing rules around SNFs – rethinking the three-day rule
        - Reforming prior authorization for downstream rehab and skilled nursing

Discussion/Question and Answer Section with Jesse Pines

- John Brancato asked about any pediatric-specific causes of ED crowding and boarding in pediatric EDs and children's hospitals
    - Jesse's team has not focused on pediatrics, but many of the solutions presented are more broadly applicable to all hospitals – although there is more room for innovation, these general solutions will help alleviate pediatric boarding as well
- Chris asked about what Jesse thinks the state's role is in addressing this problem, and what his top three solutions would be best
    - Jesse answered that more data is better, and that pushing for measurement and public reporting is good. Additionally, he values hospital-level incentives tied to this data, ideally carrots at the beginning and sticks later.
- Gregory Shangold asked if there are any states that have altered Medicaid rates to increase care access or implemented prior authorization reform for nursing home and psychiatric patients, and whether there is any evidence of these helping ED boarding in other states
    - Jesse expressed that the Medicaid solution is less likely to directly affect boarding, but prior auth for psychiatric patients is definitely in the causal pathway for long boarding periods.
- Phil Davis asked for more takeaways from the UK "Corridors of Shame" approach
    - In the UK, the hospitals were required to get 98% or more of patients in within four hours, or else the administrators would lose their positions – several hospital administrators lost their positions in the NHS
    - Four hours was too short for all patients, eight hours may be a more reasonable time point – Australia learned from the UK that four hours was too harsh
- Jesse Pines said that measuring the decision to admit to departure time is too variable, length of stay for admitted patients makes more sense

Subgroup Updates

- Quality measures
    - This subgroup is waiting for more progress from the national level before they continue
    - Chris asked if members need any assistance collecting mock-up quality measure data, Jonathan Bankoff and Gregory Shangold are working with data staff, they need more time at the moment
- Discharge subgroup and solutions subgroup are combining forces since there was overlap
    - Jonathan Bankoff
    - The two top/bigger priorities of members are conservatorship, and prior authorization, along with some back-end reforms that will require less of a lift
    - Miriam added that nurse staffing plans is something that has been submitted to the legislature, she will flag when the report is out
- Behavioral health subgroup
    - The group has not met, but Charles Dike would like to join in the conversation on conservators

Action items/Input on future agendas

- Dr. David Marcozzi will be joining the group's meeting to speak in June
- The meeting adjourned at 3:57pm