The Connecticut Emergency Department Boarding and Crowding Workgroup

Final report to the Connecticut Department of Public Health and the Connecticut State Legislature

December 18th, 2024

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1 Workgroup Composition

Connecticut Emergency Department Boarding and Crowding Workgroup Members:

Name and degree(s)	Affiliation
Greg Allard	Hartford Healthcare Director of EMS Affairs
Jonathon Bankoff MD	Chair, Middlesex Hospital Emergency Department
Matt Barrett JD MPA	Connecticut Association of Health Care Facilities/ Connecticut Center for Assisted Living
John C. Brancato MD	Division Head, Emergency Medicine, Connecticut Children's
Barbara Cass RN**	Department of Public Health
Lara Chepenik MD	Department of Psychiatry, Yale School of Medicine
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Charles C Dike MD MPH FACHE	Medical Director, Office of the Commissioner, Department of Mental Health and Addiction Services
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Lisa Freeman BA	Connecticut Center for Patient Safety
Daniel Freess MD	Connecticut College of Emergency Physicians
Rebekah Heckmann MD MPH MPA	Department of Emergency Medicine, Yale School of Medicine; Yale Center for Outcomes Research & Evaluation (CORE)
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Miriam Miller MPH**	Department of Public Health
Craig Mittleman MD	Chair, Lawrence and Memorial Emergency Department
Mag Morelli	LeadingAge Connecticut
Chris Moore MD*	Yale University School of Medicine
Mairead Painter	Long Term Care Ombudsperson
Phil Roland MD MHA	Cigna Healthcare, representing the Connecticut Association of Health Plans
Greg Shangold MD	Connecticut State Medical Society
Anumeha Singh MD	Chair, Hartford Hospital Emergency Department

* Co-chairs

** *As this report serves a set of recommendations to the Commissioner for the Department of Public Health, the Department of Public Health has not endorsed this report and representatives of the Department abstained from voting to release the report. The Department will review when shared with the Commissioner.*

2 Overview and Legislative Authority

The Connecticut Emergency Department Boarding and Crowding Workgroup was formed under the authority of Public Act 23-97[a] and began meeting in the fall of 2023. An interim report was filed in January 2024.[b] This final report is meant to supplement the report from 2024 and to provide our recommendations to the Commissioner of Public Health and the legislature regarding emergency department boarding and crowding. The legislation had four charges:

(1) The establishment of a quality measure for the timeliness of the transfer of an emergency department patient, who will be admitted to the hospital, out of the hospital's emergency department;

(2) The establishment of emergency department discharge units to expedite the discharge of patients from the emergency department;

(3) (A) An evaluation of the percentage of emergency department patients who are held in the emergency department after being admitted to the hospital and while waiting for an inpatient bed to become available, and (B) the development of a plan to decrease such percentage; and

(4) The reduction in liability for hospitals and their emergency the physicians when patient crowding of a hospital's emergency department has reached the point of causing significant wait times for patients seeking emergency department services.

The mission defined by our group based on this legislative authority was agreed as follows:

> *To understand the various factors that lead to emergency department overcrowding and boarding and to provide recommendations to relevant stakeholders, including the health and human services agencies, the legislature, hospitals, and other related industries, on quality measures and actionable interventions to limit boarding and ensure that all people presenting to Connecticut emergency departments have access to timely, equitable, and dignified care.*

Our full group has met monthly since October 26th, 2023, and has included a Quality Measures Subgroup, a Discharge Subgroup (which later combined with the Solutions Subgroup), a Solutions Subgroup, and a Psychiatric Emergency Services Subgroup. The agendas, minutes, and recordings of these meetings are available on the DPH website.[c]

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[a] https://www.cga.ct.gov/2023/act/Pa/pdf/2023PA-00097-R00SB-00009-PA.PDF

https://portal.ct.gov/-/media/dph/working-groups/ed-working-group-2024/ed-working-group-interim-report-2024.pdf

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

3 Abbreviations

ADs – avoidable days
AHEAD – All-Payer Health Equity Approaches and Development
AMA – American Medical Association
CHA – Connecticut Hospital Association
CMS – Centers for Medicare and Medicaid Services
CORE – Center for Outcome Research and Evaluation
DHD – delayed hospital discharge
DPH – Department of Public Health
DSS – Department of Social Services
ECCQ – Emergency Care Capacity and Quality
ED – Emergency Department
EMTALA – the Emergency Medical Treatment and Labor Act
ERISA - Employment Retirement Income Security Act
ICD – International Classification of Diseases
LOS – length of stay
LWBS – left without being seen
MA – Medicare Advantage
MUC – Measures Under Consideration
OEMS – Office of Emergency Medical Services
OHS – Office of Healthcare Strategy
PA – prior authorization
SD – standard deviation
TCOC – Total Cost of Care
URI – upper respiratory infection
UTI – urinary tract infection
VBC – value-based care

4 Executive Summary

"The most unstable patients present to the ED and we are unable to care for them because our departments are rife with admitted patients in our hallways."

- 2024 quote from an emergency physician surveyed by the Connecticut College of Emergency Physicians

Emergency departments (EDs) are the safety net of our healthcare system, delivering care 24/7 to more than 1.3 million Connecticut residents annually[d], regardless of ability to pay. EDs are a critical part of the healthcare system, providing care for acute problems such as trauma, heart attacks, and strokes. They are also essential in providing equitable access to care, particularly for people with fewer resources – children, the elderly, the working poor, those with mental health and substance abuse issues.

Most people in Connecticut are likely familiar with ED "crowding". They, or a family member, have likely experienced delays in care or care provided in a hallway. This working group was formed in response to this issue in order "**to advise the commissioner regarding methods to alleviate emergency department crowding and the lack of available emergency department beds in the state"**.

Many people continue to believe that ED crowding is a result of "overutilization". However, it is the practice of hospital boarding in the ED that has the greatest impacts on ED crowding and quality of care.

Boarding is the systematic practice of keeping patients in the ED after a disposition decision and is a *national public health crisis*[e] with widespread effects on patients (delays in care, missed diagnoses, harm, and death) and staff (increased burnout, workplace violence). It is the contention of the working group that ED "crowding" in Connecticut is primarily a result of hospital **boarding**, not ED "overutilization".

Boarding is a hospital and health systems issue, and even larger than that it is an issue of healthcare capacity and resources in the state. It requires attention and prioritization as a public health issue.

[d] https://portal.ct.gov/-/media/ohs/health-it-advisory-council/publications/ct-emergency-department--visit-trends_nov2022.pdf

[e] https://www.acep.org/siteassets/new-pdfs/advocacy/emergency-department-boarding-crisis-sign-on-letter-11.07.22.pdf

5 *** SUMMARY RECOMMENDATIONS ***

The following recommendations to address this significant public health issue are summarized below and in the report. It is understood that some of these recommendations require resources in a difficulty fiscal environment. New investments should not be made without the expectation for a return on investment in the health of our citizens. However, while there are some opportunities for efficiencies, change that will lead to improvements in quality of care and access will not be possible without investment in the system. Addressing underinvestment in Medicaid, as detailed in section 11 of this report and when compared to our sister states, is a priority, and should be linked to quality of care for our most vulnerable residents.

Our summary recommendations are:

1. Establishment of a Quality Measure on hospital boarding in the ED that would be
    - Implemented by the Office of Healthcare Strategy (OHS)
    - Publicly reported
    - Linked to a Medicaid value-based care payment model

2. Amend Section 19a-643-206 of Connecticut General Statues to Include Emergency Care data

3. Establishment and funding of a “Connecticut Emergency Department Ombudsman”

4. Medicaid payment reform
    - Increased resources
    - Incentives for value-based care and objectives

5. Formation of a working group focused on hospital discharge challenges

6. Support of the Connecticut mobile integrated health (MIH) initiative
    - To include investment through Medicaid payment

7. Special liability reform for emergency care

8. Implementation of a statewide information system for emergency care capacity, hospital capacity, and transfers

6 Workgroup Progress During 2024

Our group spent substantial time learning from national experts by inviting guest speakers to present at monthly meetings. These presentations are available on the recorded meetings on the DPH website[f] with dates and timestamps included below. Some of the key quotes and points by four of our speakers are summarized below. There were several themes that emerged and were emphasized by all speakers:

- **ED boarding is a solvable problem by hospitals, but requires incentives and resources**
- **Measurement and data are key**
- **Public reporting and incentives related to quality measures are required**

6.1 Speakers and Key Points

Todd Taylor MD, Vice President for Public Affairs, Arizona College of Emergency Physicians
4/17/24 11:36-27:00

"You are on the right track with state legislation"
"I've been chasing ED crowding for 32 years"
"I had one of my patients die in the hallway and went on a crusade"
- Notes that when he speaks nationally at least half of physicians in the audience have experienced a death as a result of crowding – "This is literally life and death"
- ED LOS improved in early 2000s, has steadily increased last 16 years
- Measure and manage
- We cannot look to the federal government to solve

"What we don't fix the plaintiff's lawyers will"
"What to do is not the problem"
"I believe **the solution is data** – you can't manage what you can't measure"
"Data creates motivation for change"
"Hospitals have been allowed to not be held responsible"
"They aren't required to have quality measures, or to report it"

Jesse Pines MD, Chief of Clinical Innovation, U.S. Acute Care Solutions (300 EDs in 30 states)
5/15/24 12:30-34:00

"Boarding is unquestionably associated with poor patient outcomes"
"There are a lot of things hospitals can do to fix boarding"
"Hospitals do not have incentives to fix it… perverse incentives exist to <u>not</u> address it"
"The profit maximizing incentive is to board"
"Connecticut is making a step in the right direction"
"The first step is **measurement and reporting**"

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

"Important to shine a light on it in a public way so that hospitals are held accountable"
"Directed incentives are required: bonuses and penalties"
"The goal is not to penalize, but to direct incentives to a public health problem"
"Fund EDs/hospitals to address hospital boarding"
"Boarding is not about patients coming in for low acuity things"

Bobby Redwood MD MPH
American College of Emergency Physicians Quality Improvement and Patient Safety
6/19/24 11:30-42:40

"ED Boarding is a public health issue"
"ED Boarding poses a significant risk to patient safety and hospital quality"
"Is **highly preventable** if appropriately measured with system-level responses"
"Data sharing and transparency are key"
"This is an opportunity for alignment"
"There are opportunities for statewide bed capacity coordination"

David Marcozzi MD MHS-CL
7/17/24 24:30 – 43:30

"You can't achieve high quality without access"
"Who is the code leader in Connecticut?"
"Continued study is needed, but action is required"
- Dr. Marcozzi commented on the fact that Maryland is 50th in the country in ED boarding/ length of stay, potentially related to the "Maryland All-Payer Model" that was implemented in Maryland in 2014 and is involving to a Total Cost of Care (TCOC) model, which may include Connecticut in the All-Payer Health Equity Approaches and Development (AHEAD) Model

6.2 Public Act 24-4

As a result of the recommendations from the working group's interim report, PA 24-4, "An Act Concerning Emergency Department Crowding" was passed and signed into law on May 9th, 2024. This law directs hospitals to analyze data regarding:

(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

Hospitals are required to analyze this data by January 1, 2025, and annually thereafter. By March 1, 2025, and annually thereafter, hospitals must report their findings and recommendations to Public Health Committee, including policies and procedures to reduce wait times in the EDs, methods to improve hospital admission, and root causes for delays in admission.

The passage of this legislation was groundbreaking. While there had been prior voluntary quality measures around ED care, PA 24-4 represents the first state law in the United States to require reporting of hospital boarding. The workgroup would like to thank the legislature for their courage in enacting this legislation. While our group had recommended curation of data and mandated public reporting through the Department of Public Health, this was not feasible given fiscal constraints. However, it has raised the attention of hospitals and agencies to the state and will provide a first and ongoing foothold into the data and understanding of issues needed to address the problem.

The passage of PA 24-4 is important in requiring hospitals to provide important data and to recommend solutions starting this year. However, the reporting of this data is not a quality measure and the data being provided currently lacks a "home" in an agency in the state. While the workgroup had initially suggested a data and quality measure be curated by DPH, on further investigation this may be more appropriately collected and curated by OHS, which will be discussed in this report. PA 24-4 requires hospital reporting through January of 2029. It is possible that PA 24-4 could be sunsetted or revised with the passage of legislation and/or the establishment of publicly available data and a quality measure, but the workgroup would recommend this ***only*** if it becomes redundant with other legislation.

The workgroup believes that PA 24-4 was a valuable first step and likely to be synergistic with next steps. The workgroup intends the recommendations of this report to build on the recommendations from the interim report, as well as legislative accomplishments so far, to provide long term, sustainable, and feasible approaches to the underlying issues of ED boarding and crowding.

7 Background: Boarding, Crowding, Overutilization, Public Health, and Hospitals

7.1 Terms: Crowding, Overutilization, and Boarding

ED "crowding" occurs when the volume of patients exceeds the available resources. Most people who have visited an ED are familiar with this – overflowing waiting rooms and people being evaluated and treated in hallways or even waiting room chairs.

The common perception of the public, and even those involved in policy or administration, is that ED crowding is primarily a result of "overutilization" – when high volumes of low acuity patients who should be getting care elsewhere but have gone the ED instead. However, it is now well established that one of the most important drivers of crowding is not overutilization but "boarding".[1] Boarding is the practice of keeping patients physically in the ED after a disposition decision has been made, typically to admit the patient to the hospital.

This group is not opposed to trying to address overutilization, and some of the root cause issues that should be addressed such as Medicaid payment reform and support for mobile integrated health (MIH) can help with this. However, it is crucial to understand that the major cause of ED crowding is hospital boarding. Overutilization occurs when patients with minor medical concerns that could be addressed elsewhere come to the ED. These visits can be taken care of quite expeditiously and are not the major cause of crowding. However, when admitted patients occupy ED beds for multiple hours and even days or longer this is a major cause of crowding, and the one our group has chosen to focus on.

7.2 State Level Recognition of Hospital Boarding in the ED as an Issue

There are three main Connecticut state entities that are relevant to the ED boarding and crowding issue: the Department of Public Health (DPH), the Office of Healthcare Strategy (OHS), and the Connecticut Hospital Association (CHA). It is important that these entities acknowledge the issue of boarding and its impact on ED care.

The workgroup notes that DPH has been involved in this group, which is a very positive step. The most recent published comprehensive reports from DPH are contained in "Healthy Connecticut 2020" which includes a 242 page "State Health Assessment"[g] coupled with a 176

[g] https://portal.ct.gov/-/media/departments-and-agencies/dph/dph/state_health_planning/sha-ship/hct2020/hct2020statehlthassmt032514pdf

page “State Health Improvement Plan”[h]. It should be noted that these reports were published in 2019, with data from before that date and that ED boarding is out of the general scope of these reports. It should also be noted that, while DPH can investigate complaints related to quality of care and patient safety in an ED, DPH does not have direct regulatory authority over ED boarding. However, it is the hope of the working group that future reports will discuss and acknowledge the issue of boarding.

OHS is currently in the process of finalizing the Statewide Health Care Facilities and Services Plan. A 246-page draft of this plan was first released in June of 2024[i], with public comment open through September 30, 2024. The workgroup provided public comment on this report in a letter dated 9/25/24 to recommend corrections and changes to the sections addressing ED utilization. The full text of this letter, including updated data on ED visits, is included in appendix 1. The main points of the letter were:

- While the report suggested ED visits are declining, this conclusion was supported using data following the COVID pandemic, and did not include more recent available data. EDs across the country experienced decrease volume during the pandemic, but those volumes have rebounded and are now predicted to exceed pre-pandemic levels. This is also evident in more recent available Connecticut data, particularly for busy urban EDs.

- The report concluded that hospital bed capacity in Connecticut is adequate. While there may be additional available beds in certain parts of the state, the report failed to acknowledge severe capacity issues at the busiest urban hospitals, and did not acknowledge the practice of boarding.

- The workgroup recommended that as OHS is assessing capacity and certificates of need (CONs) it should also be acknowledged that ***using ED space for admitted patients essentially amounts to having an inpatient bed without having to go through the CON process***. In fact, the prevalence and persistence of boarding may be a better measure of the need for increased hospital capacity. When hospitals are at or over capacity, they typically engage in boarding to alleviate some of the pressure on inpatient bed census.

The workgroup encourages OHS to include a definition and discussion of boarding in the current report, and to acknowledge the need to measure, understand, and do our best to minimize this practice when considering the facilities and services provided for the health care of Connecticut citizens.

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[h] https://portal.ct.gov/-/media/departments-and-agencies/dph/dph/state_health_planning/sha-ship/hct2020/hct2020statehlthimpv032514pdf.pdf

[i] https://portal.ct.gov/ohs/-/media/ohs/hsp/ohs-statewide-health-care-facilities-and-services-plan-2024.pdf

The Connecticut Hospital Association (CHA) represents over 90 hospitals and health-related organizations with a mission to "advance the health of individuals and communities". As of November 2024, CHA lists five "top priorities" for Connecticut hospitals[j]:

- Improving the health of Connecticut residents by supporting vital public health initiatives
- Enhancing the quality of care and patient safety through partnerships, education and training, safety collaboratives, and data analysis that promote and cultivate a culture of safety and continuous quality improvement
- Securing fair and adequate reimbursement that addresses hospitals' significant financial losses due to government not paying the full cost of care
- Building a strong workforce to mitigate the impact of severe and growing shortages of vital healthcare professionals at a time when the growing elderly population is increasing the demand for services
- Ensuring access to coverage and care, including resolving issues related to over-utilization and overcrowding of emergency rooms given a lack of primary and preventive care services

While the working group agrees with these priorities, many of which ultimately relate to ED crowding, however it continues to focus on "overutilization" and does not acknowledge the contribution of boarding.

On February 26, 2024, CHA provided testimony to the CT legislature regarding SB 181[k], which was ultimately enacted as PA 24-4[l], requiring hospitals to annually report data on boarding, along with recommendations to address root causes. This testimony acknowledged CHA's commitment to emergency care and did mention that a contribution to ED overcrowding is patients who are "waiting for admission to an inpatient bed".

The workgroup hopes that CHA will acknowledge the issue of boarding and will embrace our attempt to advocate for approaches to address some of the root causes as recommended in this report.

7.3 "Avoidable" ED Visits and the Prudent Layperson Standard

OHS has spent considerable resources trying to delineate what they call "avoidable ED visits". The list of the "top 10 reasons for avoidable visits" is listed in the chart below.

[j] https://cthosp.org/advocacy-center/

[k] https://cthosp.org/testimony/sb-181-an-act-concerning-emergency-department-crowding/

[l] https://www.cga.ct.gov/2024/ACT/PA/PDF/2024PA-00004-R00SB-00181-PA.PDF

ICD10 Code	ICD 10 Code Description	# of Visits	Percent of Statewide ED Visits	Percent of Statewide Avoidable ED Visits
N390	Urinary tract infection	16,411	1%	3%
R0789	Other chest pain	15,995	1%	3%
M545	Low back pain	14,047	1%	3%
R42	Dizziness and giddiness	12,258	1%	3%
J069	Acute upper respiratory infection	11,725	1%	2%
R509	Unspecified fever	9,240	1%	2%
R112	Nausea with vomiting	9,070	1%	2%
Z20828	Contact with and (suspected) exposure to unspecified communicable disease	8,923	1%	2%
R109	Unspecified abdominal pain	8,520	1%	2%
J029	Acute pharyngitis	8,060	1%	2%
	Total Top Ten Primary Reasons (All visits)	114,248	9%	24%

However, it is important to critically think about whether these visits can be categorized as avoidable simply based on an ICD code. Yes, most UTIs could be diagnosed and treated in a care environment other than an ED. However, a subset of these are serious and can even progress to sepsis, just as "unspecified fever" may represent a serious infection. To state that **"other chest pain"** is avoidable is easy *in retrospect*. However, "other chest pain" and "unspecified abdominal pain" represents a diagnosis ***after*** serious and life-threatening causes have been excluded, which is done most safely and expeditiously in an ED setting. Similarly, "Dizziness and giddiness" is an ICD-10 code that is used *after* exclusion of serious causes of dizziness, including acute stroke.

While some of these complaints could initially be addressed in settings other than EDs – and many of them are – patients typically only choose to go to an ED if they have no other access to care. While the workgroup applauds efforts to provide appropriate alternate care environments (particularly access to primary care and urgent care through increased Medicaid funding), it is essential that patients are not prevented from seeking care in the ED when they believe they need it. This is the basis of the "prudent layperson standard", which is federal law requiring emergency services to be covered, provided, and reimbursed based on a patient's perception that they have a medical concern or condition requiring emergency care or evaluation, regardless of the final diagnosis. This remains essential to the safety net of care that EDs provide.

Lastly, it is the unserious conditions that are easiest to deal with in the ED. Uncomplicated upper respiratory infections (URIs), sprained ankles, and sore throats may be able to be cared for elsewhere, but they are not what is causing ED crowding as they can be quickly discharged.

7.4 Lack of Data Regarding Emergency Department Care in Connecticut

There is remarkably little publicly available data on the state of ED care in Connecticut. Specifically, the working group has been unable to obtain publicly available data on the number of ED treatment spaces (private and/or hallway) in the state, or on boarding or length of ED stay for admitted patients.

While hospitals are required to submit data regarding the overall number of ED visits and the overall number of admissions[m], little other data exists or is accessible. Hospitals are currently required to submit annual reports that include detailed data as part of Section 19a-643-206.

7.4.1 Recommendation: Amend Section 19a-643-206 to Include Emergency Care

To better understand the state of ED care in Connecticut over time**, the workgroup recommends amending Section 19a-643-206 of the Regulations of Connecticut State Agencies to include specific measures related to the capacity of emergency care.**

The current regulations under this statute require reporting of annual and 12-month filing reports on detailed hospital data. There are currently approximately 20 required annual reports and approximately 18 12-month filing reports. The working group recommends that these filing reports be amended or added to included data on ED care in the state.

Data that should be included:

- Discrete ED entities within each hospital system
    - i.e. How many EDs are there within a given system, where they are located
    - Specialty EDs (pediatric, psychiatric)
    - Data should be reported overall by the system(s) and by discreet EDs
- Treatment spaces within each ED
    - Private treatment spaces
    - Routinely designated “hallway spaces”
- Number (and %) of patients who left without being seen (LWBS)
- Data on throughput measures
    - Overall mean LOS from ED arrival to ED departure
        - For all patients
        - For discharged patients
        - For admitted patients
        - Stratification by adult/ pediatric
        - Stratification by medical/psychiatric

[m] https://portal.ct.gov/ohs/health-systems-planning/hospital-financial-data/annual-and-12-month-filing-reports?language=en_US

7.5 The Emergency Department and Public Health

In 2007 then President George W. Bush declared "I mean, people have access to health care in America… After all, you just go to an emergency room".[n] While there has been some progress in the implementation of the Affordable Care Act, this remains true. EDs are the only place in the United States healthcare system where you are guaranteed under the federal Emergency Medical Treatment and Labor Act (EMTALA) to be evaluated and stabilized by a healthcare professional regardless of citizenship or insurance. EDs are thus a key part of the public health infrastructure in the United States.

A 2018 study found that at that time nearly half of all hospital-based care in the United States (47.7%) was provided by EDs, a percentage that had increased steadily over 14 years.[2] This study summarized:

> *"As an entry point to the health care system, the emergency department (ED) serves a critical role. The National Center for Health Statistics cites 44.5 ED visits per 100 persons in the United States in 2015, and 12% of these encounters resulted in hospitalization. In every community, EDs play an important social role, guaranteeing assistance to vulnerable populations, including uninsured and low-income individuals. Thus, EDs are an essential contributor to the health of a population, with the use of EDs a well-defined measure of this contribution."*

Nationally, ED visits rose from 141 million in 2021 to 155 million in 2022. In Connecticut in 2021 there were 1.3 million ED visits in a population of 3.6 million. While there was a slight dip in the volume of ED visits during the COVID period, it is expected that the volume of ED visits will rebound and exceed levels prior to COVID.

ED visits, along with hospital admissions, are heavily funded via public means (Medicaid and/or Medicare). The state should ensure that any taxpayer dollars used on healthcare are being used efficiently and effectively. As will be detailed below, the harms from hospital boarding and ED crowding are substantial. The 2022 letter to President Biden from the American College of Emergency Physicians (ACEP) and co-signed by over 30 other organizations emphasized that "**Boarding has become its own public health emergency".[o]**

The Connecticut Emergency Department Boarding and Crowding Workgroup maintains that this situation is a **public health issue** that requires state-level action.

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[n] https://www.chron.com/opinion/editorials/article/that-s-the-problem-president-bush-suggests-1814637.php

[o] https://www.acep.org/siteassets/new-pdfs/advocacy/emergency-department-boarding-crisis-sign-on-letter-11.07.22.pdf

7.6 Hospitals as a Public Good

Hospitals are largely funded through Medicare and Medicaid Reimbursement and most operate as non-profit entities. These tax benefits are provided because hospitals do, and are expected to, provide care for individuals and the community which are not fully compensated.

A 2017 piece in the Annals of Emergency Medicine entitled "Hospital Emergency Care as a Public Good and Community Health Benefit"[3] summarized this well:

> *"Partially as a result of EMTALA, the public has come to view the emergency care system as a public good… equally or more important than having a nearby library, public health clinic, fire department, or police department."*

The authors went on to emphasize three areas that EDs should focus on in improving the health of communities:

- Systems building for critical illness
- Continuous provision of comprehensive healthcare
- Preparedness and community resilience

While this article was written before COVID, its themes have only become more apparent as we lived through the COVID pandemic.

EDs are a ***key component of public access to healthcare***. When EDs are compromised by boarding they are not in a position to provide quality, dignified care to patients in the community. It is incumbent on the state, and the hospitals within the state, to provide the resources for adequate and appropriate space to care for patients as is required by federal law.

8 The Harms of Hospital Boarding in the Emergency Department

Hospital boarding of admitted patients in the ED constricts the space and resources available for the care of incoming and acute patients. It provides a sub-par environment for the care of admitted patients, who may wait for a "real" hospital bed on a harder emergency stretcher, often in hallways. It strains the staff who need to care for the boarded patients as well as any incoming patients. It leads to hallway and waiting room care, which can prevent proper evaluation and monitoring and compromise patient confidentiality. It creates an environment that is much more likely to foster violence against emergency staff, and engenders burnout and moral injury from staff who are forced to practice in an environment that is not conducive to the quality of care they seek to provide.

8.1 Testimony from Physicians About the Impact and Harm of Boarding

In January of 2024, the Connecticut College of Emergency Physicians (CCEP) conducted a survey of their membership on the issue of ED boarding in the state of Connecticut. They received nearly one hundred unique responses. Here are some excerpts from the responses to this survey:

> *"Boarding is causing harm to patients in our community. Some days nearly 90% of our emergency department is occupied by admitted patients; we effectively do not have an emergency department."*
>
> *"Many patients suffer in pain because we do not have room to treat them. Others have died in our waiting room and would not have if they had been treated and monitored in a regular care space."*
>
> *"Harm to staff cannot be overstated. We are not able to provide the care we know is best for our patients and cannot help people in need. We have to tell suffering people over and over again that we are sorry, but we cannot help them because we don't have any rooms. This causes moral distress, feelings of failure, and burnout."*
>
> *"We are blamed individually for the failings of the healthcare system as a whole. We are mistreated by patients and family members regularly. This is unsustainable."*
>
> *"ED Boarding is absurd. What other specialty would allow our workspace to be commandeered due to mismanagement and greed."*
>
> *"During the day, those unable to walk or are at risk for falling use bed pans and urinals with little privacy. Their calls and requests go unanswered while nurses are running around tending to their assignment of patients which are too many to be done with the appropriate care and attention. During the night, these patients struggle to get sleep under the brightness of the overhead lights and the regular noises and alarms that fill the space."*

"Hospitals need regulation to do the right thing. The most unstable patients present to the ED and we are unable to care for them because our departments are rife with admitted patients in our hallways."

"Patients suffer privacy indignities with significant boarding and people too close together, both historically, and during physical exam I've seen urinary catheterizations performed in the hallway, because there was literally no other place to put someone. They were suffering from urinary retention, and to leave them uncomfortable is crueler than to violate their privacy."

"I practice at a large tertiary care center. I have COUNTLESS stories of patients who are negatively impacted by boarding. We regularly have 60+ patients waiting for beds in our emergency department. This limits us from seeing patients and leads to unsafe wait times (often upwards of 8+ hours!) We have had multiple near miss events from the waiting room."

"We are consistently boarding at least 10 (sometimes up to 20-30) in our 47 bed ER (4 of those beds are Fast Track and 7 of them are dedicated behavioral health, so really 36 bed ER. This means that we are working through the same volume, perhaps even higher, in 1/3 to 1/2 of the beds. We are seeing people in hallways, outside of the x-ray room, in chairs."

"It is a massive problem. It leads to deaths."

8.2 How Boarding Affects Patient Care Directly

Boarding of admitted patients in the ED can have both direct and indirect impacts on patients and staff.

Patients who are sick enough to be admitted to the hospital remain in a care environment that is not conducive to healing. ED stretchers are smaller, cheaper, and harder than proper hospital beds. They are easier to move around and more compact but disrupt resting comfortably and can lead to serious pressure ulcers.[4] Boarded patients often remain in ED hallways, under fluorescent lights for long periods of time, again disrupting opportunities for rest and healing.

While some patients boarded in the ED may be seen by a hospitalist specializing in inpatient care, many continue to receive care from an emergency physician. Emergency physicians are not trained or experienced in providing inpatient care and must focus on incoming patients. Similarly, nurses who are assigned to boarded patients may have higher patient to nurse ratios than inpatient units and may have responsibilities for new incoming patients. These care factors may lead to an increase in lapses in care, medical errors, or untoward incidents including increased mortality.[5]

The poor effects of boarding, crowding, hallway and waiting room care on patient care have been well documented over decades. Some examples of specific published research include delays in appropriate administration and pain relief in patients with hip fractures and abdominal pain, adverse impacts on early treatment of sepsis, and delays in the appropriate treatment of asthma with increased length of stay.[6–9] There is higher risk of adverse outcomes

in patients with chest pain in crowded EDs.[10] Crowding can impact time to treatment of acute and time dependent conditions such as early antibiotics in pneumonia, overall mortality, impacting both safety and timeliness of care.[11] Increased mortality from ED boarding is particularly associated with elderly patients.[12]

Patients are literally dying in our EDs from the harms of boarding and crowding.

8.3 Downstream Effects: Left Without Being Seen, Hallway Care

When patients are forced to wait long periods of time for an evaluation they may leave prior to a full evaluation. The percentage of patients who check in to the ED but are then "Left without being seen" (LWBS) is a quality measure that has been tracked by CMS through the hospital outpatient quality reporting (OQR) program.

The combination of pressure to avoid LWBS and the lack of available space for the evaluation and treatment of incoming patients has led to hallway and even waiting room care. Patients are crammed into any available space, with little regard for privacy and poor effects on outcomes and workplace environment.

The problematic acceptance of hallway care has been well documented. A 2022 article summarized:

> *"ED crowding and hallway care will continue to worsen unless hospital leadership is willing to listen to ED staff concerns and address the problem on all levels of the hospital using previously proposed solutions. Emergency physicians should not fear termination for discussing this issue and its potential for poor clinical outcomes and ED staff morale."*[13]

Physicians may even be forced to go into a crowded waiting room and attempt to evaluate patients. A commentary in the Annals of Emergency Medicine in 2010 discussed the link between boarding and waiting room medicine, concluding with:

> *"Waiting room medicine may be technically feasible, but it is wrong. Patients deserve better. And because crowding makes a mockery of the concept of "surge capacity," our communities deserve better, too…we should ask ourselves whether devising an ever-expanding list of workarounds really protects our patients, or enables their abuse."*[14]

8.4 Staff Harms from Boarding and Crowding

It is hard to overstate the harms to all ED staff caused by trying care for patients in a chronically overcrowded setting that is flooded with admitted patients. Most emergency physicians entered their careers expecting busy and crowded periods of time, but when it is relentless with no end in sight it can be disheartening. Many professionals use the word "moral injury" to

describe what they are currently experiencing in trying to provide care in these situations as documented by stories collected by the American College of Emergency Physicians.[p]

For physicians, nurses, other professionals, and support staff practicing in this environment leads to burnout which can increase errors and decrease quality of care. This, compounded with staffing shortages, many choose to leave their jobs in the ED. A recent study in the Joint Commission Journal on Quality and Patient Safety reported that boarding highly contributed to the perception of burnout and documented high rates of verbal and/or physical abuse from boarded patients (including 86.8% of nurses).[15]

Workplace violence, particularly against healthcare workers, has reached epidemic proportions. Healthcare workers are five times more likely than other workers to experience and episode of workplace violence.[q] Even in the best of environments people who engage in caring for ED patients are among the highest risk of suffering an episode of workplace violence.[16] EDs that are crowded and have significant numbers of boarded patients are particularly prone to violence.[17] In addition to efforts to protect healthcare workers which many state legislatures have engaged in, initiatives to decrease ED boarding and crowding may have important effects in this area.

[p] https://www.acep.org/administration/ed-boarding-stories/Moral-injury

[q] https://psnet.ahrq.gov/perspective/addressing-workplace-violence-and-creating-safer-workplace

9 Developing and Implementing a Quality Measure for Boarding

One of the primary goals of the working group was "the establishment of a quality measure around boarding. The workgroup continues to believe that ***the establishment, monitoring, and incentivization of this quality measure is paramount in helping to address this issue***. Each one of the national experts the workgroup invited emphasized this approach as key. The workgroup also believes that a state level quality measure is indicated, even as it may be synergistic with efforts at the national level.

Boarding can be considered both an outcome measure and a process measure for quality. As an outcome measure boarding has the direct impact on patients discussed in section 8.

A process quality measure assesses things that can have an impact on the processes that seek to deliver higher quality care. Boarding impacts the process of care in the ED though impacts on delays in care, hallway care of other patients, workplace violence, and staff burnout.

9.1 National quality measures

In considering how to implement a quality measure around boarding it is important to look at prior and ongoing initiatives in this space. In the United States, at the national level, there are three relevant measures: ED-1[r], ED-2[s], and ECCQ (emergency care capacity and quality)[t]. Both ED-1 and ED-2 have been previously incorporated by CMS as *voluntary measures,* but both have been retired. ECCQ is a measure that is being developed by CMS and is currently on the Measures Under Consideration (MUC) list.[u]

9.1.1 ED-1 and ED-2

ED-1 has been part of the Emergency Medicine measure set with CMS. It measures the median times for departure from ED **arrival** to ED departure for admitted ED patients. It is stratified into an overall measure and a measure for psychiatric/ mental health patients. ED-2 is another measure from the Emergency Medicine measure set within CMS. It measures the median times from the **decision to admit** to ED departure.

9.1.2 ECCQ

[r] https://manual.jointcommission.org/releases/TJC2024B/MIF0164.html

[s] https://manual.jointcommission.org/releases/TJC2024A1/MIF0165.html

[t] https://mmshub.cms.gov/sites/default/files/Yale-CORE-ECCQ-Measure-Specifications.pdf

[u] https://p4qm.org/media/3166

The emergency care capacity and quality measure (ECCQ) is currently under consideration by CMS on the MUC list. This measure was developed under a contract with the Yale Center for Outcomes Research and Evaluation (CORE). It utilizes any of four measures in the numerator, with overall patients who present to the ED as the denominator.

1. The patient waited longer than 1 hour to be placed in a treatment space in the ED, or

2. The encounter ended without the patient undergoing a completed medical screening examination (MSE) by qualified medical personnel (QMP), or

3. The patient boarded (time from admission order to patient departure from the ED for admitted patients) in the ED for longer than 4 hours, or

4. The patient had an ED length of stay (LOS) (time from ED arrival to ED departure) of longer than 8 hours.

The workgroup carefully considered the above, prior, and currently proposed measures in preparing our recommendations for a state quality measure. The workgroup has chosen to focus specifically on boarding. This is because the LWBS rate is currently a required element by CMS and closely correlates with time waiting to be seen. While the data that the workgroup suggests being reported could easily be tweaked to look at these metrics the workgroup feels that focusing on the boarding metric will be more impactful. It should also be noted that the introduction of a state measure would in no way interfere with prior or suggested measures. While the ECCQ measure has not yet been required, mandating this at the state level anticipates any national requirements and is a good standalone state measure, *whether or not* these measures are not implemented at the national level.

The subsections below summarize discussions our group (and the quality measure subgroup) have had on this topic; the actual suggested measure is included at the end.

9.2 Quality Measure Considerations

9.2.1 Median or Mean?

Measurement of time by median and mean both have advantages and disadvantages. The median has been chosen for prior national quality measures in this space as it reduces the impact of outliers. Particularly in psychiatric care, there are sometimes cases that can stretch for days or even weeks, and a single such case could skew the mean without properly describing the experience of most patients. However, median data does not allow accurate calculation of the overall time for all patients, which can be calculated by multiplying the number of patients by the mean. Both median (and outlier %) and mean can be readily

calculated from data points that are easily extracted from the electronic health record. The workgroup thus **recommends that both median (with outlier ranges) and mean (with standard deviation) be reported**.

9.2.2 Admit decision or admit order?

Ideally, boarding time would be measured from the time when an admit decision is agreed upon. In many EDs, this decision time is essentially the same time that an admit order is entered in the electronic health record (EHR). However, there are some systems in which an admit decision may be reached, but an order is not entered. This may occur if the system is waiting for the bed to be physically available to put the order in. To measure this accurately, in some cases there may need to be an added timestamp incorporated into the EHR.

9.2.3 Boarding time vs. overall ED time

While the intent of this quality measure would be to measure the actual boarding time (time from admit *decision* to physically leaving the ED), this could differ due to differences in how EDs may timestamp the admit decision and/or admit order. The measurement of overall ED time, from physical ED arrival to physical ED departure is very standard and can provide an overall measure that also includes potential waiting room time as well as workup time and can help prevent any manipulation of data that would make boarding time appear better than it is.

9.2.4 Admission vs. observation (and ED observation vs. inpatient observation)

A decision to admit a patient to the hospital is fairly straightforward – it is an intent to get an inpatient bed with an inpatient physician caring for the patient. Observation is trickier because it is a billing status in which the patient technically is still an outpatient. There are two distinct types of observation. Observation can be performed with the *intent* for the patient to remain physically in the ED *under the care of an emergency physician*. This typically occurs when it is anticipated that the patient will be in the ED for a prolonged period of time but should continue to be managed by the emergency physician. This often occurs when a patient is severely intoxicated, or when diagnostic testing (such as a stress test or MRI) is needed that will not necessarily result in the need for admission. The workgroup would recommend that these patients not be included in boarding time. In certain cases, after ED observation, there may be a decision to observe or admit the patient under the care of an inpatient physician. If this occurs these patients may then cross into the boarding category.

The other type of observation is observation to an inpatient physician. This is an *intent* to get the patient to an inpatient bed, even though they remain an outpatient. This situation typically occurs when a patient is best cared for by an inpatient physician but is not expected to remain in the hospital for a prolonged period of time. An example would include a patient with a large kidney stone who is best cared for by a urologist but may be able to be discharged after a procedure.

The workgroup would suggest that for the purposes of measuring boarding, the category and timestamps for "admitted" patients should **include both straight inpatient admissions and observation that is *requested* under the care of an inpatient physician.** The rationale for including these "observation" patients in the same category as admitted patients is that there is no reason for them to physically remain in the ED. The workgroup would recommend that observation when the *intent* is for the care to remain under the emergency physician would be excluded from true boarding. The workgroup specifically emphasizes the "intent" here because even when a patient is intended to be placed in observation or admitted under the care of an inpatient physician they may in actuality remain under the care of the emergency physician while they are physically in the ED. This situation is what the workgroup is trying to avoid as it takes up space, time, and personnel that is more appropriately provided in inpatient space in the hospital.

9.2.5 The four-hour threshold for boarding

In an ideal world, mean and median boarding times for all admitted patients would be as close to zero as possible. A decision to admit would occur, a bed would be requested, and the patient would be moved to that bed. In the real world this is unlikely to be feasible. While the workgroup recommends that overall median and mean times be reported, it is convenient and actionable to look at the proportion of patients who cross certain thresholds for boarding. Selecting a threshold is somewhat arbitrary, however four-hours has long been accepted as a reasonable threshold in national and international efforts on this issue. This accounts for the time it may take to prepare a bed, ensure it is staffed, do a nursing report, transport the patient, etc. Ideally, there would be no patients physically in the ED four hours after the decision to admit. This is a concrete and feasible way to measure the volume and proportion of admitted patients that are affected by significant boarding and can allow "apples to apples" comparison across EDs. Compared to current practice, a large urban ED that boards fewer than 10% of admitted patients for fewer than 4 hours is probably doing quite well, however this still may represent six to ten patients a day, which could be a lot for a smaller ED. This also provides a discretely manageable goal to strive for – e.g. moving from 30% to 20% that are boarding more than four hours.

9.2.6 Units of measure and demographics – physical EDs and health systems

The workgroup believes it is essential that boarding be measured in the state of Connecticut based on *discrete physical EDs*. While there are several large health systems that may group separate EDs together for purposes of measurement, policy, or staffing, each physical ED has its own approach to patient care with different patterns and impacts. At a minimum, an ED that is physically at a separate address should be separately measured. Sometimes there may be discrete physical EDs at the same address. Examples of this may occur if there is a pediatric ED or a psychiatric ED at the same physical address as a general ED. In general, the workgroup

would recommend more granular reporting and measurement of distinct emergency department environments of care as much as possible.

The demographics for each physical ED should be reported. It is important that each department is delineated in terms of demographics and metrics of care, as these may differ substantially within overall systems of care.

9.2.7 Reporting period and burden of reporting

ED boarding and crowding may vary substantially over time. In particular, seasonal variation may contribute to differences. While there is a tradeoff between the frequency of reporting and the burden of reporting, the workgroup believes that with modern electronic health records these data points should be very readily available and can be set up to essentially automatically report data. The workgroup would recommend that data for the quality measure be reported monthly to understand how boarding varies across the year.

9.2.8 Home for a quality measure in Connecticut

While it is our hope that the concepts and measures described in this report will be of sufficient detail to allow development of a quality measure, it remains necessary to specify and collect reporting which requires an entity to oversee. The workgroup believes this is most appropriately hosted by the OHS in Connecticut. OHS mission is to implement "comprehensive data-driven strategies that promote equal access to high-quality health care, control costs, and ensure better health for the people of Connecticut." OHS currently maintains a Quality Council that the workgroup recommends should consider a boarding measure to be included. The workgroup would recommend that OHS and/or an appropriate measure steward be provided with the resources and directed to include quality measures of ED boarding into their measures, and that these quality measures be ***publicly available*** and used for ***value-based payment*** by state Medicaid.

9.2.9 Measure specifications

While the detailed measure specifications and reporting would need to be developed, collected, and reported by a home for this quality measure, based on consideration of the issues above, the Quality Measure Subgroup developed the following guidance on measure specifications to be considered:

Reporting Period

Recommended that data be reported ideally at least monthly, with dates specified.

Physical Space and Unit of Reporting

A given healthcare entity may oversee multiple EDs. Each physical/functional ED should be reported separately. At a minimum, any ED with a different street address should report data separately. In cases where there is a functionally different ED even at the same physical address it should be reported separately (i.e. pediatric or psychiatric ED).

Each reporting ED should include:

- The name and physical address
- The number of ED ***private*** treatment spaces available (not including "hallway" beds)
- The number of "hallway" (i.e. non-private spaces) that are routinely used for evaluation and treatment

Number of Visits and Demographics

Each reporting department shall report:

- Total number of patients presenting for treatment
    - Mean and Median Age in years +/- SD
    - Gender (percent M/F)
    - Insurance status:
        - Private insurance
        - Public insurance (Medicare/Medicaid)
        - Self-pay
    - Initial chief complaint medical or psychiatric (number/%)
    - Number (%) of patients placed in ED observation
    - Disposition
        - Left without being seen (LWBS)
        - Treated and released (including to facility or rehab)
        - Admitted (observation or full admit) to an inpatient facility
            - Medical/surgical
            - Psychiatric
        - Transfer

Boarding and Crowding Metrics

All times should be reported in minutes and/or hours (hours with at least two significant figures) as both means (SD) and medians (with 10%, 25%, 75%, and 90% ranges).

The following metrics should be reported for all patients, including for those who are discharged:

Overall length of stay (LOS), from physical arrival at the ED to physical departure

The following metrics should be reported by category:

Treat and release: overall LOS

Admit to medical/ surgical bed: overall LOS, time from admit/hospital observation decision* to physically leaving the ED

#/% of patients from admit/inpatient observation order to leaving ED

>4h, >6h, >12h, >24h

Admit to psychiatric bed: overall LOS, time from admit/hospital observation decision* to physically leaving the ED

#/% of patients from admit/inpatient observation order

>4h, >12h, >24h, >72h

Transfer: overall LOS

* Ideally the admit/hospital observation order should be temporally close to the "decision to admit." However, it is understood that in certain facilities there may be a separate time point for the "decision to admit" with an actual order only placed when the bed becomes available, which would make the time from the order to leaving the ED less meaningful. Facilities should use the most feasible and trackable time point from the decision to admit as being the time of the "order."

Key quality measure: boarding

Each department should report the overall proportion of patients who physically remain in the ED for four hours or more after the ***decision*** *to admit or place in hospital observation*, stratified by adult/pediatric and medical/psychiatric:

% of admitted/hospital observation in ED >4h after admit decision

- Overall
- Pediatric (<18yo) medical
- Pediatric (<18yo) psychiatric
- Adult medical
- Adult psychiatric

Each ED space should strive for boarding of four hours or more of all patients intended to be placed in inpatient or hospital observation status to be below 10% overall and at each strata. Departments may be compared via like demographics and trended over time.

Alternate de-identified encounter level data

An alternate approach to reporting overall metrics would be to report de-identified encounter level data from each physical ED. This is potentially less work if set up as an export from an

electronic health record. This should be provided in a .csv format with each row representing a patient encounter.

Columns would include:

- Age
- Gender
- Insurance status
- Medical or psychiatric chief complaint
- Date and time of initial presentation
- Disposition
    - LWBS
    - Treat and release
    - Admit medical/surgical
    - Admit psychiatric
    - Transfer
- Date/ time of admit (or inpatient observation) decision
- Occurrence of ED observation
- Date/ time of leaving ED

10 Solutions: Creation of an Emergency Department Care Ombudsman

The working group recommends that the state establish an Emergency Department Care Ombudsman to coordinate the implementation of our recommendations and monitor ED care throughout the state. This position would also coordinate work among state agencies and the relevant stakeholders to alleviate many of the challenges EDs continue to face.

The workgroup would envision the role of an ombudsman to include, though perhaps not be limited to:

- Understanding the patient care experience in the ED and looking at systemic issue and solutions (many of which are hopefully delineated in this report)

- Oversight of ED data and implementation of a quality measure to ensure Connecticut patients are cared for in a quality manner

- Interface with state agencies (DPH, OHS, OEMS, DSS) and entities (hospitals, CHA, CCEP, CT nursing) to ensure coordination of efforts to provide access to quality, equitable, and dignified care

- Ongoing advocacy for appropriate legislation, legislative relief, and resources to help hospitals address ED boarding and crowding

The workgroup understands this may be a significant investment but believe this may be an effective way to help operationalize the recommendations of this group going forward in a patient-centered way. Other options for continued attention to this issue could include establishment and funding of a designated position concerned with statewide ED care in DPH or OHS.

11 Solutions: Medicaid Payment Reform and Value Based Care

Improving Medicaid reimbursement rates in Connecticut legislatively can significantly help address ED boarding issues. ED boarding occurs when patients are held in the ED while waiting for inpatient beds, often due to insufficient capacity in other care settings or delays in transferring patients.

The working group recognizes that the Department of Social Services (DSS) is completing a Medicaid program rate study. This evidence-based analysis will provide a comprehensive view of CT Medicaid rates. It will assist both the administration and legislature in evaluating needs within the Medicaid program and developing holistic solutions that avoid singling out specific rate increase requests in isolation**.**

11.1 Background and Underpayment of Medicaid

Connecticut's chronic underinvestment in Medicaid significantly affects multiple sectors, including workforce retention, facility operations, and access to quality care. Underpayment hampers physician recruitment and retainment which is essential for comprehensive patient care. It also restricts investments in technology and data analytics, which are crucial for improving care delivery and minimizing ED utilization. Moreover, underpayment impacts hospital's investments in community programs that address upstream health determinants, further compounding ED usage.

According to the most recent OHS report, Medicaid reimbursement rates sit at around 62 cents on the dollar (i.e. $0.62 is paid for every dollar spent to provide care), a stark contrast to what is necessary to sustain quality care.[v] A February 2024 DSS Phase 1 report reviewed Connecticut Medicaid fee-for-service rates for behavioral health services (BHS), dental services, physicians, and other professional services providers and benchmarked Connecticut Medicaid rates to Medicare and peer states.[w] The study found that that the state has a decade-long track record of failing to assess the adequacy of these rates and highlighted the magnitude of our underfunding. Comparing Connecticut to other states further highlights the discrepancy. In 2019, the Kaiser Family Foundation published the Medicaid to Medicare ratio for different services in all states.[x]

	All Services	Primary Care	OB/GYN	Other

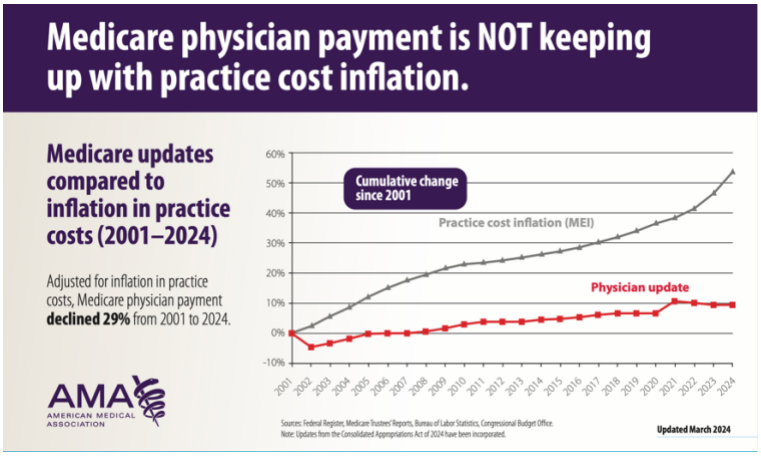
[v] https://cthosp.org/webfoo/wp-content/uploads/ohs_financial-stability-report_fy-2022.pdf

[w] https://ctnewsjunkie.com/wp-content/uploads/2024/02/CT-Medicaid-Rate-Study-Phase-1-Final-Report-February-2024.pdf

[x] https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&selectedDistributions=other-services&sortModel=%7B%22colId%22:%22Other%20Services%22,%22sort%22:%22desc%22%7D

Best	DE – 1.18	AK – 1.10	SC – 1.36	DE – 1.61
Average	0.72	0.67	0.80	0.78
CT	#30 @ 0.75	#22 @ 0.75	#30 @ 0.82	#42 @ 0.69

For many specialists, rates have been flat since 2007. A $100 charge in 2007 would be $155.77 now just to account for inflation. The AMA produced the chart below to show that Medicare also not kept up with inflation.[y]



The only noticeable increase happened in 2021 in response to the Covid-19 crisis. However, Medicare reduced the physician rate in 2024 and currently plans another reduction in 2025.

11.2 Increasing Medicaid reimbursement rates can help mitigate ED boarding in several ways

Enhanced Provider Participation: Higher Medicaid reimbursement rates can attract more healthcare providers to participate in the Medicaid program. This increases outpatient patient access to care. With increased access, patients are cared for before diseases progress and therefore do not arrive at EDs requiring admission. In 2019, Alexander and Schnell in the National Bureau of Economic Research, explain how a $45 increase in Medicaid payments would close over two-thirds of disparities in access for adults and would eliminate such disparities among children.[z] States with higher reimbursement rates generally report better access to care. For instance, Nebraska, which offers the highest Medicaid reimbursement rates, has better access to care compared to states with lower rates like Pennsylvania.[18] The Medicaid to Medicare ratio for Nebraskan Psychiatrists is 2.34 compared to Pennsylvanian Psychiatrists at 0.46. The opposite is also true. The Medicaid, CHIP Payment and Access

[y] https://www.ama-assn.org/system/files/2024-medicare-updates-inflation-chart.pdf

[z] https://www.nber.org/bh-20193/increased-medicaid-reimbursement-rates-expand-access-care

Commission in June 2021 showed how physicians were less likely to accept new Medicaid patients compared to Medicare or private insurance.

Increased Capacity for Mental Health Services: Improved reimbursement can expand mental health services, a significant factor in ED boarding. Enhanced rates can lead to more mental health providers accepting Medicaid, thereby increasing the capacity for psychiatric evaluations and inpatient psychiatric beds. This is critical as mental health crises are a major reason for prolonged ED stays.

Reduction in Uncompensated Care: Increasing Medicaid reimbursement rates can reduce the amount of uncompensated care that hospitals and providers face. This financial stability can allow hospitals to allocate more resources to inpatient beds and reduce the strain on EDs. EDs often serve as the frontline in assessing the effects of healthcare financing on patients. The unfunded, federal EMTALA law requires all patients presenting to an ED to be screened for a medical emergency and then stabilized within the capacity of the ED. Multiple studies have showed that transitioning patients to Medicaid from the uninsured improves access to care. Improved access to care allows doctors to manage chronic medical conditions and decrease the likelihood these diseases progress resulting in hospitalization. In 2003, when Oregon cutback on Medicaid, ED visits increased by 20% and so did hospital admissions.

Positive Impact on Health Outcomes: States with higher Medicaid reimbursement rates generally see better health outcomes due to improved access to various healthcare services. This can lead to a reduction in the overall demand for emergency services as patients receive timely and effective care in appropriate settings. According to recent data from the Kaiser Family Foundation (KFF), states that have increased their Medicaid reimbursement rates have reported better access to care and more stable healthcare systems.[aa]

Solutions: The DSS Commissioner Medicaid Study Report recommended tying to a percent of Medicare. However, Medicare is also woefully underfunded. A better solution is aligning CT Medicaid rates to a specific Medical Inflation benchmark. As long ago as 2001[bb], The American College of Emergency Physicians recommended that:

> *"Hospitals have the responsibility to provide quality patient care and optimize patient safety by ensuring the prompt transfer of patients admitted to inpatient units as soon as the treating emergency physician makes such a decision."*

Conclusion: EDs are too often the last resort for community members seeking care, often to help manage chronic medical conditions that should be managed in a community setting. Despite the ongoing challenges of rising labor costs and drug prices, inflation, and prior

[aa] https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2023-2024-introduction/

[bb] https://www.acep.org/patient-care/policy-statements/boarding-of-admitted-and-intensive-care-patients-in-the-emergency-department

authorization barriers, hospitals and ED providers remain dedicated to patient care. However, without proper recognition and resolution of these financial challenges, patients face delays and reduced access to timely care. It is essential that Connecticut supports our EDs as an essential community service analogous to the fire and police departments. Without this investment, the ability to provide quality care is jeopardized. Connecticut implementing higher Medicaid reimbursement rates can be a strategic legislative move to enhance overall healthcare delivery and specifically address the challenge of ED boarding.

12 Solutions: Addressing Hospital Discharge Challenges and Capacity

Probably the single most important issue to address to alleviate the boarding of hospital patients in the ED is to attempt to address hospital discharge challenges. When patients who are already in a hospital bed are unable to be discharged, this constrains the overall capacity of the hospital and patients then back up into the ED as newly admitted patients have no place to go. The occupation of inpatient hospital beds by patients no longer needing hospital level care drains resources of the hospital that could be used more efficiently.

Avoidable days (ADs) are days in the hospital when patients do not require hospital level care but remain in the hospital due to issues with discharge.[19] Delays in hospital discharge (DHDs) are another way to look at what causes ADs.[20] While many approaches to DHDs and ADs are local, the workgroup believes that some solutions do require action at the state level. In particular, prior authorization and conservatorship reform are highlighted.

12.1 Prior Authorization

Prior authorization (PA) is process where insurers require approval for coverage (medication, imaging, services) before a patient can access it as a covered service. While insurers maintain that PA is necessary to ensure that appropriate coverage is in place, others maintain it is used as a delay tactic to avoid providing coverage. A recent survey of physicians by the American Medical Association (AMA) found that 94% reported delays in necessary care and 78% reported that they abandoned recommended care due to PA problems.[cc] Delays in PA for medications can delay patient discharges from the hospital.[21]

There is a precedent among other states in establishing legislation to help address issues with PA. The AMA maintains a list of state legislative efforts in this area.[dd] The workgroup would recommend that a working group or task force examine what state legislation has been effective in this area and may be applicable and feasible in Connecticut.

As part of the working group, the Connecticut Health Insurance Association would like to note that:

- Emergency care is not subject to PA
- There are existing Connecticut regulations around utilization review
- State authority over health insurance policies and procedures, including PA, only extends to the fully insured population
- Medicare Advantage plans are governed by the federal government, as are self-insured employer plans which are covered by the Employment Retirement Income Security Act (ERISA)

[cc] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

[dd] https://www.ama-assn.org/system/files/prior-authorization-state-law-chart.pdf

- The insurance industry maintains that PA is intended to promote evidence-based, timely, and affordable care for patients
- Several insurers have recently announced steps to remove up to 25% of medical services from PA requirements[ee]

12.1.1 Connecticut Investigation into Medicare Advantage Programs

One of the issues with reforming PA may be that the state has little leverage over federally administered programs such as Medicare Advantage (MA). However, there may be some leverage at the state level in approving or denying the operation of these plans in the state.

In 2023, Connecticut enacted PA 23-171 "AN ACT PROTECTING PATIENTS AND PROHIBITING UNNECESSARY HEALTH CARE COSTS".[ff] This legislation included a provision to address how Medicare Advantage (MA) programs are implemented in the state, specifically under Section 18. This section requires that the Insurance Department, in consultation with OHS, investigate and report an analysis of the utilization management and provider payment practices of Medicare Advantage plans, including, but not limited to:

- the impact of such practices on the delivery of hospital outpatient and inpatient services, including patient placement, discharges, transfers and other clinical care plan
- the extent to which states have the authority to regulate Medicare Advantage plans

The workgroup recommends that the state (legislature, DPH, OHS, the Insurance Department) look carefully at this report and try to develop legislation or regulation that require MA programs to provide timely and appropriate PA.

12.2 Conservatorship Issues

Patients with conservatorship or guardianship who are occupying hospital beds without having any immediate medical needs presents a serious drain on healthcare resources and compromises the quality of care for acute medical patients. In many cases this is not because there are not potentially available solutions, but because the healthcare facility is unable to obtain consent or confirmation for treatment and/or disposition issues due to inability to contact a legally authorized representative.

The lack of the ability to obtain or contact a guardian or conservator can have significant impacts on ADs and DHDs. In one large Connecticut Hospital, it was estimated there was a loss of **more than 700 bed days in a hospital over a 5-month period** (personal communication,

[ee] https://www.ama-assn.org/practice-management/prior-authorization/2-big-insurers-take-small-steps-ease-prior-authorization

[ff] https://www.cga.ct.gov/2023/SUM/PDF/2023SUM00171-R02HB-06669-SUM.PDF

Hartford Hospital). This was manually tracked by Case Management of the hospital to show the impact of the issue. This represents a considerable amount of hospital capacity being used for patients who do not need ongoing medical treatment but are simply waiting for appropriate placement or legal proceedings to take place.

A recent study in Massachusetts estimated there were 10,824 avoidable hospital days in FY 2017, representing a loss of revenue of more than $20M, most of which occurred in large urban academic hospitals.[22] The loss of bed space as well as the drain on hospital resources from this issue could be a significant contributor to hospital capacity, boarding, and healthcare resources.

There is precedent among other states including Florida, Texas, and New York in passing state laws that streamline and monitor the conservatorship and guardianship process. The workgroup recommends that a working group on hospital discharge issues address whether some of these state level solutions might be applicable and effective in Connecticut.

12.3 Other Issues: Quantification and Qualification

Other issues regarding the issues of ADs and DHDs may include the lack of a timely response and/or availability of decision makers to accept patients for discharge or transfer from the hospital to another facility (skilled nursing facility, rehabilitation facility, mental health facility), particularly over weekends or holidays. There may be opportunities for leverage when these facilities accept state funding from Medicaid.

In some cases, there simply may not be a facility that is equipped to care for patients. For example, there are limited facilities in CT that can accept patients who are chronically ventilated using a tracheostomy. While these patients do not require hospital level care, they do require a facility with equipment and personnel to care for these patients. Mental health, particularly when also involving a substance or opioid use disorder, represents a particular bottleneck for occupying hospital space but not requiring acute or intensive care. More fully understanding which types of facilities may require increased capacity may help to mitigate ADs and DHDs.

In other cases, hospitals may be caring for patients who do not require hospital level care but who do not have access to funding or appropriate insurance that would allow them to be transferred to other facilities, even if these facilities may have capacity.

It is essential that the state of Connecticut provide an accurate assessment of how many avoidable days are occurring, specifically where they are occurring, and which specific causes are responsible in order to address them.

12.4 Statewide capacity assessment

The other issue is overall state capacity for care. While OHS maintains that overall, there is not a hospital bed capacity issue for the state, data suggest that certain hospitals are chronically at or over capacity[gg], leading to ED boarding and difficulties in providing timely and appropriate care. In the draft of the Statewide Healthcare Facilities and Services Plan OHS states that in "eight of the nine regional planning geographies, there is an estimated excess of current bed capacity", however the report goes on to state:

> *"In the short-term a misallocation of a hospital or region's acute care beds, by service line, could occur and even in the long-term, differences in average reimbursement per-stay could incentivize hospitals to over-allocate hospital bed capacity to more profitable service lines at the expense of other types of care. Of particular concern for the under-allocation of acute care beds for psychiatric and maternity/delivery service lines."*[hh]

The issue of misallocation is a crucial one. Potential solutions, which may include systems to facilitate appropriate transfers and may involve financial incentives to avoid misalignment should be investigated.

12.5 Recommendations

ADs and DHD are a drain on the state's resources that contribute to ED boarding and crowding. They constrain the abilities of hospitals to provide care to the citizens of the state. The state of Connecticut should look closely at this issue and investigate solutions at the state level.

The workgroup recommends that the state of Connecticut establish a working group and/or taskforce to address the issue of ADs and DHDs and overall capacity in Connecticut and to make recommendations to the state on solutions.

There is a precedent for this in the state of Oregon, which in 2023 passed House Bill 3396 establishing a Joint Taskforce on Hospital Discharge Challenges.[ii] It is expected that this task force will provide a report by early 2025 and could help serve as a template for Connecticut.

The working group recommends that this group include necessary stakeholders with a goal of:

1) Quantifying the burden and delineating causes of DHDs and ADs across the state
2) Providing recommendations for state level action including, but not limited to:
    a. Prior authorization reform
    b. Conservatorship/ guardianship reform
    c. Methods to better assess state capacity including methods to streamline appropriate transfers and avoid misalignment of capacity

[gg] https://dphhrswebportal.ct.gov/Reports

[hh] https://portal.ct.gov/-/media/ohs/hsp/ohs-statewide-health-care-facilities-and-services-plan-2024.pdf

[ii] https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/276953

d. Understanding overall state capacity that impedes appropriate hospital discharge
e. Best use of resources to address ADs, DHDs, and capacity issues

13 Local Hospital Solutions Including Discharge Lounges

An important theme that emerged from workgroup discussions and that was emphasized by many guest speakers is that ED boarding is a solvable problem, should hospitals choose to prioritize it. This does not mean that it is an easy problem or that it would not take resources, and it may involve changes that could be uncomfortable to some (such as adjustment of surgical operation schedules).

One of the charges of the 2023 legislation for the workgroup was to advise the commissioner on "**The establishment of emergency department discharge units to expedite the discharge of patients from the emergency department"**. In discussion with the group, there was consensus that this could most closely be compared to "discharge lounges", which downstream effects on boarding.[22] One of our group members noted that they currently are employing and expanding discharge lounges.

The working group is supportive of any interventions that may alleviate ED boarding and crowding, with discharge lounges representing one of many approaches. In addition to discharge lounges, a 2012 Health Affairs article entitled "Solutions To Emergency Department 'Boarding' And Crowding Are Underused And May Need To Be Legislated" highlighted many approaches that hospitals could use to address boarding, many of which are underutilized:[24]

Smoothing elective surgical and catheterization schedules	Distributes procedures evenly over the week to decrease peaks in demand for inpatient beds and need for procedure cancellations; shown to nearly eliminate boarding at Boston Medical Center and elsewhere
Scheduling early cardiac catheterizations	Performs catheterizations earlier in the day to expedite the freeing of unneeded beds reserved for post catheterization patients
Active bed management	Often assigns a "bed czar" to closely track bed use and address bottlenecks in flow into and out of beds; computerized systems are also often employed
Discharge lounge	Often moves patients to a lounge those awaiting discharge who no longer need to be in a bed, freeing up beds
Aggressive management and expediting of inpatient discharges	Increases attention to discharge planning from time of admission so that arrangements for home services or outpatient placement are more likely to be in place when the patient is medically ready for discharge

Monitoring of bed-cleaning turnaround time	Improves flow by simple monitoring and accountability
Simplified admission protocol	Simplifies often complicated procedures that emergency department and inpatient teams must follow before transferring patients to the floor; makes more steps occur in parallel, to expedite transfer
"Reverse triage"	Uses a system designed for creating capacity in disasters when the hospital is full: patients with the least need for inpatient beds can be discharged

More than 12 years ago, this article suggested that these solutions are available but underutilized and suggested that legislative pressure is needed to incentivize hospitals to adopt these strategies.

It is possible at the state level that DPH or OHS could try to facilitate communication of effective strategies. There probably is a role for CHA to do this as well. One possibility might be to establish a state-level grant to hospitals that provides resources to investigate strategies such as those mentioned above with outcomes that include measurable changes in ED boarding. These findings could then be disseminated.

Overall, the group is very supportive of hospital initiatives to reduce boarding in the ED, including but not limited to discharge lounges, but feel these initiatives are most effectively implemented by individual hospitals.

14 Solutions: Mobile Integrated Health

It is well established that mobile integrated health programs (MIH) can decrease ED visits, reduce inpatient admissions, and reduce costs. These goals are in alignment with the goals of the Emergency Department Boarding and Crowding Workgroup. Multiple states have successfully implemented MIH programs, and a recent study in JAMA Open concluded that "Compared with regular ambulance response, MIH was associated with a substantial reduction in the proportion of patients transported to the ED, leading to a substantial saving in total costs."[25] A more recent meta-analysis of 12 studies confirmed that MIH and "community paramedicine" (MIH-CP) reduces ED visit and also reduces hospitalizations.[26] This can have an important effect on health-care expenditures and also to impact ED and hospital capacity.

The ED Overcrowding and Boarding Workgroup is supportive of the Connecticut Emergency Medical Service organizations in their desire to get Mobile Integrated HealthCare (MIH) programs established and running.

Programs will be designed specific to community needs. There are members of this workgroup that will be an integral part of working with EMS to identify those needs. Furthermore, they will be at the table when these programs are structured, will provide feedback, and will ensure they evolve throughout their existence.

Legislation was passed in 2019 to allow DPH to develop and implement regulations governing MIH, within available appropriations. The appropriation was allocated to the agency for this work in 2021. Policies and procedures (with provisional and enforceable regulations) will go into effect in early 2025, allowing MIH to be licensed and operate. It is important that any investment in MIH be viewed as an ***investment***, rather than simply a "cost". While return on investment may not be immediate and should be carefully monitored, evidence suggests there is ample opportunity for overall cost savings and increased efficiencies.

In particular, the state should investigate the potential for **Medicaid reimbursement for MIH.** This may be essential to make an MIH program viable. This should be viewed as a state investment rather than an expenditure, with an opportunity for long-term cost savings and efficiencies.

15 Solutions: Special liability Reform

Another charge of PA 23-97 was for the workgroup to address liability reforms for emergency physicians in the face of ED crowding. The workgroup believes this could best be addressed by providing special liability protections for those who are providing emergency care for patients in largely substandard conditions. There is a precedent for this in other states. This is both the fair thing to do and could help address underlying practices that worsen boarding and crowding (defensive medicine). The workgroup specifically recommends legislation that raises the level of negligence for those that provide emergency care (emergency physicians, advanced practice providers, nurses, and specialists on call) from a preponderance of the evidence to "clear and convincing evidence of gross negligence".

15.1 ED Boarding and Crowding and Liability for Emergency Physicians

In June of 2023 the law firm of Defrancisco and Falgiatano posted a piece entitled "Boarding Patients in Emergency Room Hallways Can Increase the Risk of Medical Errors".[jj] It is a remarkably comprehensive piece on the practice and harms of boarding and states:

> *"emergency physicians (EP) are forced to provide care to patients with inadequate nursing support and a lack of privacy, which precludes a thorough history and physical examination… Patient care in ED hallways is fraught with delays and difficulties in initiating laboratory testing, providing medication, supervising intravenous lines, recording vital signs, monitoring cardiac activity, or responding to new patient symptoms, regardless of the cause. The problem is exacerbated when a physician must simultaneously care for an excess of patients in the hallway and in official ED beds, and extra physicians are frequently unavailable to share the burden. In addition to the risk of poor patient outcomes, physicians are at risk."*

While acknowledging that the environment emergency physicians are forced to practice in is largely responsible for harms, the article concludes by stating "If you or someone you love suffered injuries because of medical neglect or lack of treatment in an ED, call our office today."

There is no doubt this law firm would not hesitate to name an emergency physician in a lawsuit, even if the cause was from the environment of care that was beyond the control of the emergency physician. Given this situation, it is important to consider why emergency medical care may merit special liability protections at the state level.

[jj] https://www.syracusemedicalmalpracticelawyers.net/boarding-patients-in-emergency-room-hallways-can-increase-the-risk-of-medical-errors/

15.2 Why Emergency Care is Different From All Other Care in U.S. Medicine – EMTALA

EDs are the only place in the United States healthcare system where it is federally mandated to provide care 24/7 regardless of insurance status. This largely unfunded mandate is what has caused EDs to assume the role of the safety net for all medical care in the United States.

EMTALA was enacted as part of the Consolidated Omnibus Reconciliation Act (COBRA) which passed in 1986.[27] It states that Medicare-participating hospitals must provide a medical screening examination and stabilization to any individual who comes to the ED and requests an examination. This is independent of the patient's ability to pay, and the hospital is in fact forbidden to inquire about payment status prior to providing these services. The hospital is then obligated to treat/stabilize any emergency medical condition, or transfer to a facility that has the capability to do this. Facilities receiving transfers due to a need for higher level care are similarly obligated to accept patients under EMTALA. All 30 Connecticut EDs are subject to EMTALA regulations.

This is different than every other care area in United States healthcare. Outpatient clinics have no obligation to care for patients. They can refuse to see patients due to scheduling issues, availability of staff, or the insurance status of the patient. Aside from providing stabilizing care, hospitals have no requirement to admit patients, and inpatient units have no requirement to accept patients from the ED if their units are deemed full or they do not have available staff. This is the crux of the issue with boarding – no one else, except ED and emergency clinicians – is legally required to provide care to patients.

15.3 Liability in Emergency Medicine and the Current Environment of Care

Emergency physicians are among the most likely physicians to be sued among any healthcare providers. Even in the best of situations, emergency care is high risk. Emergency physicians need to rapidly evaluate multiple patients, be aware of all of their past medical history (even though they have typically just met), develop rapport and gather a history when patients are under stress, be able to filter out truly emergent complaints from the vast majority of non-emergent complaints, and be able to provide lifesaving care in a time critical situation. Most emergency physicians realized and accepted this as they entered their career. However, the recently increasing pressures of trying to do the job of emergency physicians in a markedly substandard environment needs to be recognized and protected. It is unfair and unsustainable to hold emergency physicians to a standard of care that would be applicable in an ideal care environment when they are practicing in one where patient care is often delayed or required to be provided in waiting rooms or hallways with substandard resources.

In a letter from the congressional budget office (CBO) to leading senators, the CBO asserts $54 Billion dollars could be saved over 10 years with liability reforms.[kk] 85% of the public believes the current legal system is responsible for rising medical costs. Connecticut ranked **35th in the nation** for our medical malpractice environment.

15.4 Arguments for Special Liability Protection in Emergency Medicine

The American College of Emergency Physicians (ACEP) has summarized key arguments for special liability protections in emergency care[ll]:

- *Emergency physicians must make immediate, lifesaving decisions regarding diagnosis and treatment without the benefit of a prior relationship to the patient and often without any knowledge of the patient's medical history.*

- *Emergency physicians are mandated by federal law (and in some cases, similar state laws) to treat anyone who comes to an emergency department, regardless of the nature, severity or complexity of their condition.*

- *Emergency physicians treat everyone regardless of their ability to pay and provide a large and growing amount of uncompensated and undercompensated care.*

- *Everyone will need emergency care at some point, whether they are young or old, rich or poor, insured or uninsured. It is imperative that the emergency care system remains viable and capable of providing high quality lifesaving care to the entire population.*

- *The high-risk nature of emergency medicine results in escalating liability insurance rates. These skyrocketing costs coupled with lost revenue from uncompensated care seriously threaten the future viability of the emergency care system.*

- *Many insurers will not write policies for emergency physicians, resulting in a crisis of availability, as well as affordability of insurance in many parts of the country.*

- *Other specialists providing essential on-call services to emergency patients are often in critically short supply, due largely to increased liability exposure, higher liability premiums and reduced reimbursements for providing emergency care. State liability laws should not act to further discourage these specialists from agreeing to provide vital on-call services to emergency patients.*

[kk] https://www.medscape.com/viewarticle/710364

[ll] https://www.acep.org/state-advocacy/liability-reform/enacting-special-liability-protection-for-emergency-care

- *Several other states have recognized the unique needs and circumstances of emergency care and have enacted special liability protections for emergency care providers, including placing lower caps on non-economic damages and requiring a higher standard of negligence that must be proven in emergency care cases.*

15.5 How Liability Concerns Impact Crowding, Boarding, and Resource Utilization by Emergency Physicians

Liability concerns are often paramount in the thinking of emergency physicians. They often feel that there is zero margin for error, based on a legal system that provides no buffer for a margin of error. A perception that there is no reasonable margin of error leads "defensive medicine". This is a pattern of overordering lab and imaging tests, over-consulting specialists, over-transferring patients to a higher level of care, and over-admitting patients. This results in increased resource utilization, longer throughput times, and an increase in unnecessary admissions, exacerbating the problem of inpatient capacity and boarding.

15.6 How Liability Concerns Can Impact Access to Specialists

Access to on call specialists is a key component of providing timely and equitable care. The absence of appropriate on call specialists can lead to substandard care and can also increase unnecessary admissions and transfers due to this unavailability (and concerns of liability). One reason that specialists may be reluctant or refuse to provide on call coverage is concerns about liability in the emergency care space. Raising the level of negligence for these providers will increase the likelihood that specialists will be willing to provide needed on call coverage, improving emergency care and reducing unnecessary transfers and admissions.

15.7 Recommendation: Raise the Level of Negligence

Raising the level of negligence to "clear and convincing evidence of the physician or healthcare provider showing gross negligence" rather than simply a "preponderance of evidence" is reasonable in the provision of emergency care, particularly given the current stresses on the system and on individual providers.

15.8 Precedent for Special Liability Reform

States that have passed special liability reform include Arizona, Texas, Florida, Georgia, South Carolina, Utah and West Virginia. The specifics of these state laws can be accessed via ACEP.[mm] In particular, the workgroup believes the wording of the Georgia law would be most feasible and expeditious in Connecticut:

[mm] https://www.acep.org/state-advocacy/liability-reform/enacting-special-liability-protection-for-emergency-care#:~:text=The%20new%20law%20states%20that,physician%20was%20%22grossly%22%20negligent.

in an action involving a health care liability claim arising out of the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, no physician or health care provider shall be held liable unless it is proven by clear and convincing evidence that the physician or health care provider´s actions showed gross negligence.

15.9 Concerns About Special Liability Reform

In discussion of special liability reform with the overall workgroup, it should be acknowledged that there were concerns raised about the potential impact of special liability reform on the ability of vulnerable patients to obtain just compensation should they be harmed. Any change in legislation should certainly consider this. The consensus of the group was that special liability reform could appropriately protect providers working in difficult circumstances while increasing access to care by conserving resources and making consultants more willing to provide emergency care.

16 Solutions: Incorporation of Statewide Information System

The ease with which data can be extracted from EHRs as of 2024 offers increased opportunities for efficiencies that can be realized using statewide information systems. Statewide information systems (SIS) can be a powerful tool in reducing ED boarding by enhancing the coordination and communication between hospitals, EMS, and other healthcare facilities. The state of Connecticut is behind many other states in adoption and use of an effective SIS. An effective SIS can help mitigate boarding through several mechanisms:

Real time bed availability. SISs can provide real-time data on bed availability across hospitals in the state, allowing emergency departments to quickly identify which hospitals have open beds for patients in need of admission. This can streamline patient transfers, reduce wait times, and prevent unnecessary boarding in the ED. This allows ED staff to make informed decisions on where to transfer patients, minimizing delays in admission.

Enhanced coordination. SIS platforms can facilitate better coordination between EMS, EDs, and other healthcare providers. Through these systems, EMS can alert EDs about incoming patients, prepare for faster triage, and directly connect with specialists or other hospitals if needed. In some states, EMS dispatchers have access to centralized systems that allow them to assess hospital capacity and direct ambulances to facilities that can safely accommodate patients, thereby reducing the need to "hold" patients in EDs while waiting for a hospital bed.

Patient flow analytics and tools. Statewide information systems can integrate predictive analytics tools that forecast patient volume trends, hospital capacity, and the likelihood of ED overcrowding based on historical and real-time data. These tools help hospitals prepare in advance for surges in ED demand, adjust staffing, and implement measures to prevent bottlenecks. States like California and Massachusetts have deployed patient flow management systems that predict bottlenecks in real-time. These systems can trigger alerts to hospital administrators when EDs are at risk of overcrowding, prompting them to take preemptive actions like reassigning staff or increasing capacity.

State level coordination during crisis. During periods of high demand (e.g., flu season, natural disasters, pandemics), statewide information systems can help coordinate surge capacity across hospitals. States can deploy resources more efficiently, including temporary surge units or transferring patients to less impacted facilities, which reduces ED overcrowding and boarding. During the COVID-19 pandemic, states like New York and Washington used statewide information systems to track hospital bed availability and coordinate patient transfers to ensure that patients received timely care without unnecessary delays in the ED.

The workgroup recommends that the state of Connecticut (including DPH, OHS, CHA) and/or the legislature explore the possibility of an expanded and enhanced SIS to help address ED boarding and crowding.

17 Conclusions and Acknowledgements

There are few responsibilities of a society that are more important than ensuring access to emergency and lifesaving healthcare, particular for our most vulnerable residents.

It is the hope of our group that the recommendations of our group can help move us closer to our goal of providing timely, equitable and dignified care to all residents of our state.

The workgroup would like to thank the Connecticut State Legislature, particularly the Public Health Committee, for their vision in establishing this workgroup. The workgroup would like to thank them for pushing to pass groundbreaking legislation in this area via public act 24-4. The workgroup hopes that the work reflected in this report is worthy of their expectations and that the legislature and state agencies will take the time to closely consider the issues and the recommendations of the workgroup going forward.

The workgroup would like to acknowledge the Connecticut Department of Public Health for their excellent logistical support and participation in this working group.

The workgroup would like to thank all members of the Connecticut Emergency Department Boarding and Crowding Workgroup who participated consistently over more than a year and donated their time to this endeavor. There are many talented people in our state who remain available to donate their time to a worthy cause should their expertise be asked moving forward.[nn]

Finally, the workgroup would like to acknowledge all the people who work tirelessly in emergency departments and hospitals in the state of Connecticut 24/7/365 to try to provide quality care to those who need it most, often in very challenging circumstances.

We hope that those who are in the positions to effect needed change will listen, respond, and act.

[nn] DPH and the Department of Administrative Services both have representation on the working group and chose to not endorse the report and abstained from voting to release the report.

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19 Appendix 1: Public Comment to OHS

This is the full text of the letter sent from the working group on 9/25/24 in reference to the Statewide Health Care Facilities and Services Plan draft.

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September 25th, 2024

To Whom It May Concern at the Office of Healthcare Strategy,

We write to submit public comment on the OHS draft Statewide Health Care Facilities and Services Plan from June 2024. This comment is submitted on behalf of the Connecticut Emergency Department Boarding and Crowding Workgroup. The workgroup was formed under CT PA 23-97 under the Department of Public Health "to advise the commissioner regarding methods to alleviate emergency department crowding and the lack of available emergency department beds in the state". These comments are from the undersigned members of the working group.

When considering overall "health care facilities and services", it is essential that OHS thoroughly understand issues related to appropriate space for care of patients in Connecticut Emergency Departments (EDs). Emergency Departments are a key part of the public health infrastructure and are integral to facilities and services provided to the citizens of Connecticut.

The draft report states that "utilization of EDs is trending downward in Connecticut" and presents data through 2021. Data and experience suggest this is not the case. While there was an **exception during the period of COVID, the number of ED visits in 2023 appears to be exceeding volumes from prior years**, as it was increasing prior to COVID. In particular, the busiest emergency departments in the state, which also are associated with highest hospital occupancy rates, have seen significant increases (over a 10% increase from 2017 to 2023). Data from the OHS Hospital Reporting System for three of these hospitals is in the table below. We would encourage DPH to use more recent available data in the report, and to accurately report the substantial increases we are seeing (at least in some of the busy EDs).

Emergency Department Visits from OHS HRS for three of the busiest CT EDs:

	2017	2018	2019	2020	2021	2022	2023
Hartford	103,690	106,922	107,583	95,902	101,713	107,367	108,196
YNHH	217,854	220,458	219,603	186,967	197,088	219,774	230,592
Bridgeport	90,445	91,311	96,588	92,092	101,486	113,122	115,275
Total:	411,989	418,691	423,774	374,961	400,287	440,263	454,063

The report then turns to ED capacity and discusses that "One measure of ED capacity is the time it takes to receive ED care, from when patients arrive to when they are discharged." It is true

that these care times are high in CT compared to national averages. However, the "various factors" included in the report do not consider the practice of ED boarding.

Boarding is the practice of holding a patient who has been admitted to the hospital (or placed in inpatient observation) in the emergency department. While state-level data on boarding are not currently available (though should be in 2025 based on CT PA 24-4) we believe any report on health care facilities and services needs to acknowledge that this practice is widespread and should be accounted for. Boarding takes up emergency department beds that would otherwise be used to assess and care for incoming patients, often forcing care to occur in hallways or even waiting rooms. Boarding is both poor for patient care and constricts the ability of the ED to provide timely care to incoming patients.

As OHS is assessing capacity and certificates of need (CONs) it should also be acknowledged that ***using emergency department space for admitted patients essentially amounts to having an inpatient bed without having to go through the CON process***. We feel it is incumbent on OHS to consider this when looking at capacity. In fact, the prevalence and persistence of boarding may be a better measure of the need for increased hospital capacity. When hospitals are at or over capacity, they typically engage in boarding to alleviate some of the pressure on inpatient bed census.

We encourage OHS to include a definition and discussion of boarding in the current report, and to acknowledge the need to measure, understand, and do our best to minimize this practice when considering the facilities and services provided for the health care of Connecticut citizens.

Sincerely,

The undersigned members of the Connecticut Emergency Department Boarding and Crowding Workgroup:

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