

November 7, 2022

The President  
The White House  
1600 Pennsylvania Avenue NW  
Washington, D.C. 20500

Mr. President:

There is no question that Americans have suffered great loss of life and endured financial hardships, across all sectors, over the past 32 months due to the COVID-19 pandemic. Frontline healthcare workers risked their lives, provided care during physically and emotionally demanding situations, and bore witness to their patients' goodbyes to loved ones from afar.

Yet, in recent months, hospital emergency departments (EDs) have been brought to a breaking point. Not from a novel problem – rather, from a decades-long,<sup>1</sup> unresolved problem known as patient “boarding,” where admitted patients are held in the ED when there are no inpatient beds available. While the causes of ED boarding are multifactorial, unprecedented and rising staffing shortages throughout the health care system have recently brought this issue to a crisis point, further spiraling the stress and burnout driving the current exodus of excellent physicians, nurses and other health care professionals.

**Boarding has become its own public health emergency.** Our nation's safety net is on the verge of breaking beyond repair; EDs are gridlocked and overwhelmed with patients waiting – waiting to be seen; waiting for admission to an inpatient bed in the hospital; waiting to be transferred to psychiatric, skilled nursing, or other specialized facilities; or, waiting simply to return to their nursing home. And this breaking point is entirely outside the control of the highly skilled emergency physicians, nurses, and other ED staff doing their best to keep everyone attended to and alive.

Any emergency patient can find themselves boarded, regardless of their condition, age, insurance coverage, income, or geographic area. Patients in need of intensive care may board for hours in ED beds not set up for the extra monitoring they need. Those in mental health crises, often children or adolescents, board for *months* in chaotic EDs while waiting for a psychiatric inpatient bed to open anywhere. Boarding doesn't just impact those waiting to receive care elsewhere. When ED beds are already filled with boarded patients, other patients are decompensating and, in some cases, dying while in ED waiting rooms during their tenth, eleventh, or even twelfth hour of waiting to be seen by a physician. The story recently reported<sup>2</sup> about a nurse in Washington who called 911 as her ED became completely overwhelmed with waiting patients and boarders is not unique – it is happening right now in EDs across the country, every day.

*“At peak times which occur up to 5 days per week we have more patients boarding than we have staffed beds. High numbers have included last week when our 22 bed emergency department had 35 boarders and an additional 20 patients in the waiting room...In addition, we have patients who unfortunately have died in our waiting room while awaiting treatment. These deaths were entirely due to boarding. Our boarding numbers have unfortunately skyrocketed in the wake of covid as a consequence of increasing surgical volumes and decreasing inpatient nurse staffing.”*  
--anonymous emergency physician

To illustrate the stark reality of this crisis, the American College of Emergency Physicians (ACEP) recently asked its members to share examples of the life-threatening impact the recent uptick in boarding has brought to their emergency departments. Excerpts of the responses received, as well as key findings from a qualitative analysis of the submissions, are included in this letter to summarize aspects of the problem. The full compilation of anonymized stories, attached as an appendix, paint a picture of an emergency care system already near collapse. As we face this winter's “triple threat” of flu, COVID-19 surges, and pediatric respiratory illnesses that are on a sudden rise, **ACEP and the undersigned organizations hereby urge the Administration to convene a summit of stakeholders from across the health care system to identify immediate and long-term solutions to this urgent problem.** If the system is already this strained during our “new normal,” how will emergency departments be able to cope with a sudden surge of patients from a natural disaster, school shooting, mass casualty traffic event, or disease outbreak?

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<sup>1</sup> Andrulis DP, Kellermann A, Hintz EA, Hackman BB, Weslowski VB. Emergency departments and crowding in United States teaching hospitals. *Ann Emerg Med.* 1991 Sep;20(9):980-6. doi: 10.1016/s0196-0644(05)82976-2. PMID: 1877784.

<sup>2</sup> [“Silverdale hospital short on staff calls 911 for help after being overwhelmed with patients”](#)

## Background

Imagine a short-staffed restaurant with seating for 40, with a long line of starving customers that cannot be turned away. The chef and line cooks are desperately trying to keep up to provide safely prepared and high-quality meals. They create space for an extra 15 diners in a back hallway and assign one server to attend to them all. But there are 50 more customers waiting to come into the dining room to eat. They serve as many as possible in chairs in the lobby with a much more limited menu. Now imagine that those who are fed never leave and stay there until they need food again. Meanwhile, Uber Eats and other delivery service orders are also coming in, and the delivery drivers crowd the room further, waiting to pick up orders.

In this simplified analogy, the restaurant is the emergency department; the chef, line cooks, hosts, and waitstaff all comprise the emergency care team; the meals are the emergency care itself; and the Uber Eats drivers are emergency medical service (EMS) crews bringing in more patients. Customarily, patients who arrive to the ED via walk-in are checked in and either directed to a treatment area or the waiting room to wait until space is available, depending on the severity of illness. Once space becomes available, they are taken back into the treatment area for a completion of the clinical assessment and any needed treatment. A decision is then made that the patient is either well enough to go home or requires admission to the hospital for continued treatment. Inpatient beds traditionally require both a physical bed space (patient room) and nurses to care for that patient. Unlike in the ED, most hospitals have ratios of nurses to patients for inpatient beds to promote quality of care and patient safety that are set by state laws, regulatory agencies, and accrediting bodies. If there are no available (staffed) beds within the specific unit to which the patient needs transferring, the patient must wait, or be “boarded” in the ED, often for hours, sometimes days or even weeks. The same issue of required staffing ratios holds true for transfer outside the facility, such as to an inpatient psychiatric facility or a skilled nursing facility. As well, patients that arrive in an ambulance via EMS must be appropriately screened by ED staff before the EMS crew can release the patient and return their ambulance to service. So once the hospital’s available inpatient beds are full, more ED patients are boarded and must be accommodated in the ED, filling up valuable ED beds and even hallways. Unless the ED can go on diversion status (which is becoming increasingly difficult), more patients continue to show up via EMS. Needed ambulances must be taken out of service as the EMS crews must often wait hours with their patient in the ED before they can safely hand them over to ED staff. And through this all, walk-in patients continue to arrive to the ED and cannot be turned away under the federal Emergency Medical Treatment and Labor Act, or EMTALA, requirements.

Boarding and ED crowding are not caused by ED operational issues or inefficiency; rather, they stem from misaligned economic drivers and broader health system dysfunction.<sup>3</sup> Boarding and ED crowding lead to increased cases of mortality related to downstream delays of treatment for both high and low acuity patients. Boarding can also lead to ambulance diversion, increased adverse events, preventable medical errors, lower patient satisfaction, violent episodes in the ED, and higher overall health care costs. Much has been written on causes of and potential solutions to boarding, but the issue persists, due in part to its many derivative factors, the disparate stakeholders involved, and misaligned economic incentives.

## Preventable Patient Harm

There is ample evidence that boarding harms patients and leads to worse outcomes, compromises to patient privacy, increases in medical errors, detrimental delays in care, and increased mortality.<sup>4</sup> The Joint Commission identifies boarding as a patient safety risk that should not exceed 4 hours,<sup>5</sup> yet many of the responses to the ACEP’s call for stories cite boarding times much longer than that as an almost routine occurrence; 97 percent of stories with times provided cited boarding times of more than 24 hours, 33 percent over one week, and 28 percent over 2 weeks.

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<sup>3</sup> Kelen GD, Wolfe R, D’Onofrio G, et al. Emergency Department Crowding: The Canary in the Health Care System. [NEJM Catalyst](#). Epub 2021 Sep 28.

<sup>4</sup> Boudi Z, Lauque D, Alsabri M, et al. Association between boarding in the emergency department and in-hospital mortality: a systematic review. *PLoS One*. 2020;15(4):e0231253. doi:[10.1371/journal.pone.0231253](https://doi.org/10.1371/journal.pone.0231253)

<sup>5</sup> The Joint Commission. [R3 report: requirement, rationale, reference](#). Accessed March 13, 2022.

Descriptions of the negative impact on patient outcomes, including potentially avoidable deaths, follow:

*“We are a very rural hospital with only family practice and emergency physicians - there are no specialists within 90 miles...Recently I had a woman with abdominal pain in the ER. When she arrived she had normal vital signs and was not really very sick. Testing showed that she had an infected gallbladder - a simple problem for any surgeon to treat. We called 27 hospitals before one in a different state called us back when a bed finally opened up. She spent thirty six hours in our ER, and was in shock being treated with maximum doses of drugs to keep her alive when she was transferred. She didn't survive.”*

*“...The physician finally was able to see her in a side waiting room, he stepped out of the room for several minutes and on return she was face down and blue. They immediately began trying to resuscitate her, brought her back to our trauma bay in which they were unable to intubate her and then performed an emergent cricothyrotomy on her. She had anoxic brain injury and died. While this sounds like a random occurrence, I am frequently asked to come to the waiting rooms to help carry people out of their cars or off the floor because they have passed out or gone into cardiac arrest in the waiting rooms on multiple occasions. I have since reached out to nearly all my close friends and family and have begged them under no circumstances to go to the ED without reaching out to me first. I have begun doing house calls in my neighborhood as well as Zoom calls with family to keep them out of the ED's because they are so dangerous. In fact, I've gone as far as begun sending people home from the ED whom I would normally admit because the hospitals have become that dangerous. It's safer for many of these people to be discharged home and taken care of by family than run the risk of the multitude of mistakes that are taking place in the hospitals because there is no staff.”*

*“In the past six months, 3 people have died in our er waiting room. One only noticed when he had been sitting for > 6 hours and slumped to the floor. When he was found had been dead “awhile”. The patient had been triaged by a nurse, but in a very busy urban where the waiting room is always packed and people regularly wait > 8 hours to be seen regularly the er physicians were never aware of this patient. We can only see new patients all day rotating through 3- chairs as all other beds are full. We physicians want desperately to see patients but there is a huge stop gap as we cannot pull back patients efficiently because there are no nurses for new patients. All ER nurses are now functioning floor nurses for all the boarding patients.”*

## **Waiting Room Care**

Many emergency physicians who submitted stories reported daily numbers of boarders close to or even exceeding 100 percent of the total number of beds in their EDs, while the number of patients in the waiting room comprised up to 20 times the number of free treatment beds in which they could even be seen. In the past, that often left only hallway stretchers within the ED to care for incoming patients. But now, those too are increasingly over capacity, and so the emergency department waiting room has become the latest ad-hoc location for receiving patient care.

*“We’ve had lobby nurses responsible for 15-20 patients each. We’ve pushed diltiazem, hung amiodarone, cared for septic shock, and are now admitting patients regularly directly from the lobby. Care is being provided in chairs with little privacy and the hope of a portable monitor. Meanwhile 40 boarders are being cared for in an ED with overhead pages, lights on all the time and a total of 5 bathrooms and no showers. One night we had a septic patient waiting two hours for triage code and die in our triage room.”*

*“My shop is 34 bed rural tertiary care center that serves an area greater than 20,000 square miles. Month after month our boarding issues continue to exacerbate and have surpassed critical levels many months ago. We are frequently the largest in-patient ward in the hospital. Currently we average 28 boarding patients in our department and this has been as high as 41 boarded inpatients and 31 patients in the waiting room less than a week ago...Due to these challenges we have fully implemented “waiting room medicine”, closed down our Provider in Triage, instead all providers pickup patients in the waiting room. Nearly 50% of our patient encounters now result in discharge from the waiting room. Finally, it is not at all uncommon to have patients in*

*the waiting room with SarsCoV-2, pending orders for heparin, diltazem, or other vasoactive medications. In the past month we have had SAH [subarachnoid hemorrhage, or brain bleed], Fournier gangrene, hip fractures, Septic shock all being treated in the waiting room with no available beds to move them into.”*

*“...our 40 bed ED was boarding a large number of patients up to several days awaiting an inpatient hospital bed with a waiting room of >30 people. We had someone in the lobby who was not being appropriately monitored and began having large bloody vomiting. Vitals were only available from when he initially presented to triage almost 8 hrs ago. He lost pulses in the waiting room in front of others including children. As the resuscitation began in the lobby, this posed high risk for other patients in the lobby as we began CPR while blood ejected from his mouth with every compression. It wasn't until he was in a proper room that we were able to obtain IV access and suction the blood. This was not only scarring for the others and hospital workers, but may have been avoided if our emergency department was decompressed and an appropriate history/exam/workup had been done by me or another physician much earlier in order to initiate treatments that have been shown to improve outcomes related to his presenting complaint and known risk factors.”*

Patients don't just arrive in the ED through the waiting room—they are also brought in by EMS via ambulance. Many hospitals are unable to go on diversion status, even when the emergency department is completely backed up with patients, which means EMS crews must wait with the patient until they can be seen. This means the ambulances are stuck at hospitals and unable to respond to new emergencies:

*“We have 26 beds in the emergency department but often over 50 total patients. We are not allowed to go on divert as [County] does not allow us to. It is often very unsafe in the emergency department when there are too many patients without any physical space or enough nurses to care for them. It puts physicians in a bad place as we have to continue to accept ambulance traffic without being able to care for them or the 20+ patients in the lobby.”*

*“Our County's Emergency Medical Services reduced our ability to go on diversion down to 200 hours max for the month of October. Diversion is when paramedics bypass our hospital to take patients with heart attacks and strokes to other hospitals and is the only mechanism we have to offset ED overcrowding due to inpatient boarding. Removing this ability means patients will continue to arrive despite all beds being occupied with admitted patients thereby forcing us to care for these patients in areas such as ambulance ramps and public hallway spaces. Therefore we are essentially disrobing patients in public spaces in order to care for them. All this because of inpatients boarding in the ED. Basically the ED is the largest inpatient unit in the hospital. Patients are receiving bills for 2 or 3 days of inpatient care but never actually arrive upstairs to an inpatient space.”*

## **Pediatric Care**

Unfortunately, the pediatric population is not immune to the serious ED boarding issue we are facing—particularly those with mental health conditions. During the last decade, pediatric ED visits for mental health conditions have risen dramatically.<sup>6</sup> The COVID-19 pandemic led to a greater acceleration of these visits, causing several pediatric health organizations to issue a national emergency for children's mental health in 2021 and the U.S. Surgeon General to release an advisory on mental health among youth. According to the Centers for Disease Control and Prevention (CDC), during March–October 2020, among all ED visits, the proportion of mental health-related visits increased by 24 percent among U.S. children aged 5–11 years and 31 percent among adolescents aged 12–17 years, compared with 2019. Further, a metaanalysis conducted in 2020 illustrates the detrimental effects of boarding among the pediatric population. Multiple studies show that pediatric patients with mental health conditions who are boarded are more likely to leave without being treated, and less likely to receive counseling or psychiatric medications. Beyond mental health, children with other health care conditions are experiencing similar ED wait

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<sup>6</sup> Cutler GJ, Rodean J, Zima BT, et al. Trends in Pediatric Emergency Department visits for mental health conditions and disposition by presence of a psychiatric unit. *Acad Pediatr.* 2019;19:948–955.

times as adults; even children’s hospitals that only serve the pediatric population are already over capacity<sup>7</sup> as cold and flu season is only getting started. The stories below illustrate how boarding is particularly impacting those children in the greatest need of immediate medical attention:

*“We are a 28 bed pediatric ED, with a catchment area of 2.5 million children. I came onto shift yesterday morning. We had 15 children on psych holds, many of them waiting in the lobby for their 24-72 hours stays so we could use our beds to see medical patients. One of those patients had been in the ED for >150 hours, as their parents had relinquished their rights and DFS was refusing to take the patient back, even though our psychiatry team had cleared them as no longer a danger to self or others. We had 10 admissions boarding, 7 on high-flow oxygen, 4 of which were Peds ICU level. There are no open Peds ICU beds in our 4 closest counties, including our own. We had 35 patients in the waiting room in addition to the 20 medical patients being managed by the ED. We had 7 transfers pending from outside facilities to the ED, plus more awaiting direct admissions from an outside ED to an inpatient bed whenever a bed became available. One that left another hospital's ED against medical advice and came to our ED had been waiting 3 days for transfer. They had an AVM in their brain that needed urgent surgery.”*

*“We had a 12 month old patient who presented in respiratory distress and low oxygenation who was found to have pneumonia and required a high amount of oxygen (Opitflo) to maintain his oxygen saturations. After stabilizing him for the interim, we attempted to transfer to a Pediatric ICU (PICU). We were met with not a single open PICU bed in the state, as well as no hospitals with capability to accept transfer in every major city in the surrounding states. The critically ill child stayed in our emergency department for over 24 hours awaiting acceptance at one of our state's Children's Hospitals and still had an over 8 hour wait for EMS once a bed was available. Luckily, this child started to improve with antibiotics and treatment over those 24 hours though if they had progressed, we may have had to be boarding a child on life support (ventilator) without access to a Pediatric ICU.”*

*“My wife is a Pediatric Emergency Physician. She works at the [redacted] Children's Hospital in the world, with all available services at the hospital and patients from all over the world who come for care. She walked into her shift the other day with over 50 patients in the waiting room of a 60+ bed ER, with all hospital and ER beds already full with sick patients and others holding to be admitted. 27 ER beds were being held up with actively psychotic or suicidal children with nowhere else to go. A young child had to sit in the waiting room for 8+ hours with their lower lip lacerated and nearly completely hanging off of their face, because there weren't any beds available to properly evaluate and treat the patient.”*

## **Psychiatric**

Boarding of psychiatric patients in EDs is particularly prevalent, disproportionately affecting patients with behavioral health needs who wait on average three times longer than medical patients because of significant gaps in our health care system. While the ED is the critical frontline safety net, it is not ideal for long-term treatment of mental and behavioral health needs. Research has shown that 75 percent of psychiatric emergency patients, if promptly evaluated and treated in an appropriate location – away from the active and disruptive ED setting – have their symptoms resolve to the point they can be discharged in less than 24 hours. However, far too many Americans have limited options for accessing outpatient mental health care. This can exacerbate ED boarding from two directions: on one end, as patients who can’t access outpatient treatment may then enter into a crisis that requires an ED visit, and from the other end, a lack of available outpatient follow-up care prevents patients from being discharged from inpatient psychiatric care and freeing up a bed for the next admission waiting in the ED.

*“We have ~ 70 beds, this AM we had 42 admitted patients (admitted up to 38 hours earlier), 10 boarding Behavioral Health Patients, and 5 social boarders/group home patients. Our group home patients all have*

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<sup>7</sup> <https://www.cnn.com/2022/10/25/health/childrens-hospital-beds-delayed-care-long-waits/index.html>

*chronic, lifelong behavioral issues, and were inappropriately 'dumped' in ED by the group home and guardian (whether LME or DSS, after not following state guidelines related to appropriate group home discharge). Our group home patients have been here from 1200 - 3520 hours. Considering average ED visit being 3-4 hours, those 6 group home patients boarding hours = loss of ability to see upwards of 2500 other ED patients."*

*"Our system has failed our most vulnerable patients. We held a 14 yr old girl in a tiny ED room for 42 days (!!!) awaiting transfer/placement for inpatient psychiatric care. In our ED we routinely board patients due to the hospital at capacity, but it's particularly bad with mental health patients who need inpatient psychiatric treatment. Our hospital is not a licensed psychiatric facility, and by law we may only hold for 72 hours under a 5150 application. That said, just because there are no facilities able and/or willing to take the patients doesn't mean their psychiatric emergencies have resolved. Can you imagine being confined to a small room, without actually getting psychiatric care, for 42 days??? This could have been the subject of a Stephen King novel. Horrific."*

*"I'm working in a 9-bed ED with an additional 3-beds dedicated to psychiatric patients. We now have a patient who has been boarding with us for over 5 MONTHS with no end in sight. She is unfortunately a disruptive person as well, interrupting patient care elsewhere in the ED as she wanders the hallways (we do have to allow her out of her 10x10 room on occasion and tying up our security resources. She has injured herself on occasion, and has refused medications until she is so psychotic that she can't refuse them any longer."*

## **Burnout**

Overcrowding and boarding in the emergency department is a significant and ever-growing contributor to physician and nurse burnout, as they must watch patients unnecessarily decompensate or die despite their best efforts to keep up with the growing flood of sicker and sicker patients coming in. Health care professionals experiencing burnout have a much higher tendency to retire early or stop practicing all together. This increases the loss of skilled health care professionals in the workforce and adds more strain to those still practicing, which continues the cycle of burnout within the profession.

Though stress is a given in emergency medicine, the rate of burnout is of tremendous concern and causing additional strain to an already crippled healthcare system. Shift work, scheduling, risk of exposure to infectious disease, and violence in the emergency department can all affect the mental health and wellbeing of the physicians and nurses. Coupled with overcrowding and boarding in the ED, health care professionals are now facing stresses and moral injury that go well beyond everyday practice. The danger of the cycle of burnout is further demonstrated with the American Medical Association (AMA)'s recently released study that shows that **62.8 percent of physicians felt burned out in 2021**. Additionally, according to another recent study<sup>8</sup> in Mayo Clinic Proceedings, the burnout rate among physicians in the United States spiked dramatically during the first two years of the COVID-19 pandemic. As the winter's "triple threat" of flu, COVID-19 surges, and pediatric respiratory illnesses approaches, it is critical that we end the burnout cycle in EDs to ensure our nation's health care workforce can meet the needs of its patient population.

*"We are a large-volume ED, seeing 350-400 patients per day. When we have over 50% of our ED beds full of admitted patients (which happens frequently) we have a plan in place to move our physicians out to see patients in the waiting room. We also, at the same time, fill the hallways with stretchers, where patients are interviewed, examined and often given discharge instructions after their workup is complete. As you can imagine, this is not ideal as it is hard to ensure privacy, and patient comfort in either of these settings. Patient experience is impossible to improve for these patients (would you be happy if this was you or your family member???) Physicians are unhappy as it feels like we can't provide the care we want to, the care we went into medicine for..."*

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<sup>8</sup> Tait D. Shanafelt, Colin P. West, Lotte N. Dyrbye, Mickey Trockel, Michael Tutty, Hanhan Wang, Lindsey E. Carlasare, Christine Sinsky, Changes in Burnout and Satisfaction With Work-Life Integration in Physicians During the First 2 Years of the COVID-19 Pandemic, Mayo Clinic Proceedings, 2022, <https://doi.org/10.1016/j.mayocp.2022.09.002>.

*we are drowning, stressed and we need help - desperately.”*

*“Evening shift with 55 boarding admitted patients, waiting room backs up to 45-50 patients. A 70 year old woman presents with abdominal and back pain but relatively normal vital signs. She is in a chair in the waiting room. Due to the # of people in the waiting room her husband is sent up to another waiting area. She waits for over 3 hours. Her husband tries communicating with his wife via text messages, but no response. He comes down to ED to find his wife slumped over in the chair and yells to the triage nurses. The patient is in cardiac arrest. She is brought back to the resuscitation bay but is not able to be resuscitated and dies. The ED team, attending physicians, residents, nurses, techs, when finding out that she had been in the waiting room that long, are devastated, many in tears, highly frustrated by the failure of our institution and US healthcare in general to be able to provide adequate access for patients, adequate staffing for our hospitals and ED's, enough options for longer term care, and a safe environment for patients and providers. Our level of burnout in physicians and nurses is at an all time high. A tragic case like this, a consequence of boarding, is another wound in this long battle which shows no signs of letting up. It even seems to be worsening.”*

*“By the time I saw her she had been there for 6 hours, stuck on a stretcher inches from an intoxicated man who was vomiting on himself and another patient screaming obscenities. She had not gotten any pain medication and was having severe right hip pain. She also had to urinate badly but had been unable to get anyone to help her. There are 2 triage nurses who are there to watch the 15+people who were in ambulance triage that night while also receiving the new EMS patients. Orthopedic surgery saw my patient and admitted her from ambulance triage. For the rest of my 8 hour shift she remained in ambulance triage waiting for a bed upstairs or to go to the or, whichever happened first. She is only 1 of many patients with broken bones that I have seen wait for hours before being seen because of how boarded our ED is...It is demoralizing to start every patient encounter with profuse apologies for the wait and difficulty they have had to endure just being in our emergency department. It is heartbreaking to find someone who could be my grandmother languishing in pain for hours before we are finally able to see and evaluate her. We are in a crisis and although we do everything we can to MacGyver solutions to the problem while we are on shift, there is only so much we can do from the ground. We cannot fix this problem in the ED, we need help.”*

## **Staffing Shortages**

Nursing shortages have exacerbated the deficiency of the health care workforce and stretched care teams to take on extra hours, care for more patients, and shoulder additional clinical and nonclinical duties. Adding to this challenge is the fact that EDs are also not subject to the same staffing ratio requirements as other parts of the hospital often are, and as a result, the ED too often becomes the only place in which to keep many patients. Prior to the pandemic, the American Association of Colleges of Nursing already projected a nursing shortage. That trend has accelerated due to COVID-19, confirmed by a recent American Nurses Foundation survey<sup>9</sup> which found that 21 percent of nurses surveyed intended to leave their position, with another 29 percent considering leaving. Almost half of all respondents cited insufficient staffing as a factor in their resignation, and their departures will only increase the insufficiency, forcing their fellow nurses to an even more severe condition and impeding the ability to provide high-quality patient care.

*“I work in a 34 bed ED in [redacted]. At night we normally staff enough nurses a PA or NP and myself for 20 patients. We calculate one RN to 4 patients. Unfortunately over the past year or more we have nights we hold 20 or more patients in the ED waiting for beds. Some are ICU patients. In the unit they would have one nurse to 1-2 patients. Ours nurses will have one or more sick patient that takes lots of work and at least 3 other patients. Some nights 7 patients to one nurse. This is not safe. We cannot turn people away when over whelmed. That means many people sit in the waiting room uncared for 8-9 or up to 12 hours waiting to be seen.”*

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<sup>9</sup> [Mental Health and Wellness Survey Report](#). American Nurses Foundation 2021.

*“While previously we were able to adapt, utilizing float pool to care for these patients and creating “care spaces” in every nook and cranny, the current boarding and staffing crisis leaves us at the breaking point. ED nurses, with less than 50% staffing sometimes at night, are left to care for boarders in the ED as well as acute patients. Inpatient rooms are closed due to staffing with ratios upstairs barely budging from 1:4.”*

*“We are a 70 bed tertiary emergency department as part of a health system and we continually have holding of 10-30 patients in our emergency department for 7-72 hours. This holding may be a result due to volume, a lack of movement upstairs on the inpatient floors (having ‘clean’ beds available so the nurse doesn’t get another patient), holding ‘dead beds’ for theoretical postoperative patients and trauma victims, nursing ratios of how many patients an inpatient nurse can see (1:4,6 vs and emergency nurse 1:6,8,10,12,18). I’ve seen elderly patients that cannot fend for themselves in the hallway under cared for and dwindling for hours. I’ve seen pediatric psychiatric patients held with no free bed to transfer to for two to three days. I’ve seen adult psychiatric patients locked away on a constant observation order in a 4x6’ room for 48-80 hours with only the freedom to walk to the bathroom and back (no sunlight, no exercise).”*

## **Misaligned Incentives**

Despite years of advocacy and research to draw attention to the harmful impacts of boarding, it continues, largely due to misaligned incentives in how health care is financed. As hospitals continue to bring in and dedicate beds to elective admissions while boarding the backlog of non-elective patients in the ED, the financial benefits of ED boarding exceed the cost.<sup>10</sup> This was reflected in numerous anecdotes collected in the ACEP poll:

*“We are a top nationally ranked hospital that, due to budget issues, has now prioritized transfers and surgery admissions over ED admissions. We typically board 120-200 hrs/day and LBTC rates have climbed from 3-4% to 15-20%.”*

*“Since July boarding has become the new norm. In our 15 bed ER we are utilizing space in an adjacent unit to house holds. We have had a steady uptick from 5 in July to 5-10 in August, to now consistently 8-15 boarders/holds per day. Last week the AM doc came in to 15 holds and 2 spaces available to see patients. A nursing leader came down and he told them he was tired of this and admin answer was “we will get through it like we have the last few weeks”. We didn’t get through it, our patients suffered extensive delays and suboptimal care boarding. Admin doesn’t want to pay agency rates, so the ER is bearing the brunt of shortages...We are treating things like acute appendicitis out of the waiting room with IV fluids and antibiotics, fluids while awaiting OR. We have not cancelled any elective surgeries and until last week they were getting inpatient beds before people holding in ED >24 hours right after PACU.”*

*“We are a 38 bed ED, usually with 30-40 pts in the waiting room and many EMS patients waiting for rooms in the hallway. Patients come in agitated, acutely psychotic occasionally violent. We cannot provide these patients with high-quality medical care when they are waiting for a bed for hours/sometimes days. We also have critically ill patients requiring higher level of care who have to wait in hallways. It’s not unheard of for these patients to decompensate before we are able to get them into a ED room. This is not sustainable. Saving beds for elective surgical patients while truly ill, critically ill patients waiting hallways in the emergency department is disheartening. It’s unsustainable, morally, wrong, and dangerous for staff and for patients. How did we go from being healthcare heroes to an afterthought of the medical system?”*

All of these stories paint a stark picture of boarding’s impacts on every aspect of the health care system. Yet it is clear a disproportionate share of that burden is being carried by two key stakeholders – the emergency care team and their patients. At any time, any of our loved ones are just a moment away from becoming one of these

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<sup>10</sup>“Despite CMS Reporting Policies, Emergency Department Boarding Is Still A Big Problem—The Right Quality Measures Can Help Fix It”, Health Affairs Forefront, March 29, 2022. DOI: 10.1377/forefront.20220325.151088

patients, and their health and safety will depend on your immediate action to address a system that is heading towards collapse.

We greatly appreciate the commitment and attention your Administration has given to the health and safety of those in our nation over the last two years, and we implore you to now make the growing crisis of boarding a major priority. We stand ready to collaborate with you and other impacted stakeholders to identify near- and long-term solutions. If you have any questions, please contact Laura Wooster, MPH, ACEP's Senior Vice President of Advocacy & Practice Affairs, at [lwooster@acep.org](mailto:lwooster@acep.org).

Sincerely,

American College of Emergency Physicians  
Academy of General Dentistry  
Allergy & Asthma Network  
American Academy of Child and Adolescent Psychiatry  
American Academy of Emergency Medicine (AAEM)  
American Academy of Family Physicians  
American Academy of Physical Medicine and Rehabilitation  
American Academy of Physician Associates  
American Association of Oral and Maxillofacial Surgeons  
American College of Allergy, Asthma & Immunology (ACAAI)  
American College of Osteopathic Emergency Physicians (ACOEP)  
American College of Radiology  
American Foundation for Suicide Prevention  
American Medical Association  
American Nurses Association  
American Osteopathic Association  
American Psychiatric Association  
American Society of Anesthesiologists  
Association of Academic Chairs of Emergency Medicine  
Association of State and Territorial Health Officials (ASTHO)  
Brain Injury Association of America  
Council of Medical Specialty Societies  
Emergency Medicine Residents' Association  
Emergency Nurses Association  
Family Voices  
Infectious Diseases Society of America  
International Association of Fire Chiefs  
National Alliance on Mental Illness  
National Association of EMS Physicians  
National Health Care for the Homeless Council  
National Partnership for Women & Families  
Society for Academic Emergency Medicine  
Society of Emergency Medicine Physician Assistants (SEMPA)  
The National Alliance to Advance Adolescent Health

cc: The Honorable Xavier Becerra, Secretary, U.S. Department of Health and Human Services  
The Honorable Alejandro Mayorkas, Secretary, U.S. Department of Homeland Security