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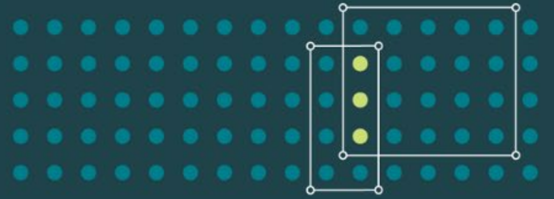
Illuminating Risks



Emergency Boarding Crisis Reflected in Medical Malpractice Data

A 32-year-old woman presented to the emergency department (ED) with abdominal pain and heavy bleeding eight days after delivering her second child via C-section. A CT scan revealed a small bowel obstruction. She was admitted for IV fluids and nasogastric (NG) tube decompression. Due to a lack of available beds, she remained in the ED for over 14 hours, initially sitting in a chair in the hallway. Her condition severely deteriorated during this time. Eventually, she was taken to surgery, which revealed that her small bowel had adhered to the C-section incision. Tragically, she died two days later. The case settled for more than $400,000 and incurred roughly $150,000 in expenses.

A 75-year-old man with a history of coronary artery and peripheral vascular disease presented to the ED with dyspnea, congestive heart failure, and acute/chronic respiratory failure. He was admitted to the intensive care unit (ICU) for hypercapnic respiratory failure, but because no ICU beds were available, he remained in the ED as a boarder patient. Several hours later, his respiratory distress worsened, and he was placed on BiPap and moved to a room closer to the nurses' station. No vital signs or other care were documented for more than seven hours. During this time, the patient became hypoxic, critically hypotensive, and hypoglycemic. He was intubated and resuscitated but suffered a severe anoxic brain injury and passed away a few months later. The case settled for over $500,000.

These devastating cases exemplify the ongoing crisis of emergency department (ED) boarding, where admitted patients are boarded and treated in the ED due to a shortage of inpatient beds. The lack of available beds was a prominent threat to patient safety long before the COVID-19 pandemic, but as The American College of Emergency Physicians remarked in 2023, *"Boarding has become its own public health emergency."*[1]

Overcrowded EDs emerged as a public health concern in the 1980s as deinstitutionalization policies pushed more psychiatric patients out of state-run hospitals into the ED. Deep-seated systemic issues, such as financial drivers associated with available inpatient beds, funding, resources, staffing shortages, and provider burnout, have also fueled the concern into the crisis it is today. The effects of the pandemic only exerted more stress on an already overburdened system and exacerbated the rising occurrence of ED boarding.[2]

The negative consequences of ED boarding are felt by both patients and clinicians. The necessity to board patients in the ED can contribute to delayed and missed care, medication errors, compromised patient privacy, higher morbidity and in-hospital mortality, longer length of hospital stays, and poor patient satisfaction. ED boarding also affects other patients, increasing the median length of stay for all ED patients by over 10 minutes for each boarded patient.[3] Moreover, ED boarding, wait time, and length of stay are all associated with increased odds of a patient safety event occurring.[4]

When considering providers, a study by The Joint Commission found emergency clinicians view boarding as a major contributor to burnout and perceive high rates of verbal and/or physical abuse from boarded patients.[5]

To shed a brighter light on the clinical severity, financial impacts, and key contributors associated with this health care crisis, this issue of Illuminating Risks takes a deeper look at Candello cases involving ED boarding spanning a 10-year period.

What Does the Data Show?

Looking at medical professional liability (MPL) cases asserted between 2014-2023 in the Candello database (n=112,402), **314 open and closed cases** involved ED boarding.

Figure 1: ED Boarding Cases by Loss Year

[a]Loss year (when incident occurred) of 314 asserted cases between 2014-2023

Figure 1 depicts ED boarding cases by loss year (when the event occurred). The number of annual events involving ED boarding remained steady between 2014 and 2018 and has shown a decline since 2019. However, case counts during the COVID years may continue to rise due to varying statutes of limitations for asserting a malpractice claim.

Figure 2: Financial Severity of ED Boarding Cases (2014-2023)

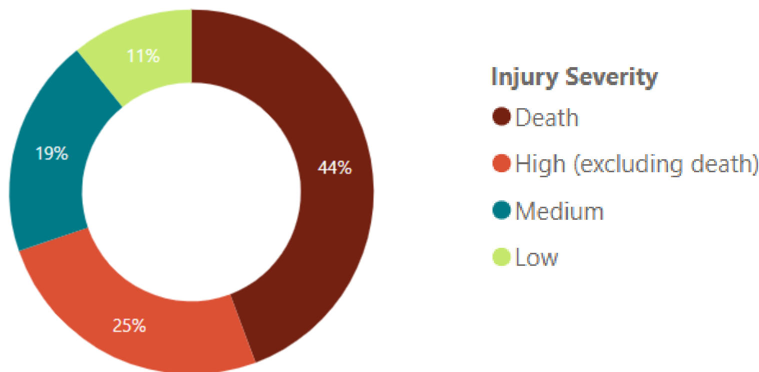
[a]Out of 112,402 cases asserted between 2014-2023 in the Candello database as of 6/30/2024

- The 314 open and closed cases included in this analysis have incurred roughly $119.9M in financial losses.
- The major allegations in claims were predominantly **diagnosis-related** (41%) or concerning **medical treatment** (35%).
- To be expected, emergency was the most commonly named primary responsible service (54%), followed by nursing (13%), hospitalists (5%), and various other disciplines.

Breaking down ED boarding cases by clinical severity iluustrated the immense risk ED boarding presents to patient safety and how the severity of an injury may influence gross total costs.

- Almost half of the ED boarding cases involved death and another quarter of cases presented high injury severity.
- The average total incurred for cases with high injury severity (excluding death) was **more than double** that of cases with fatalities.

Figure 3: Proportion of Cases by Injury Severity



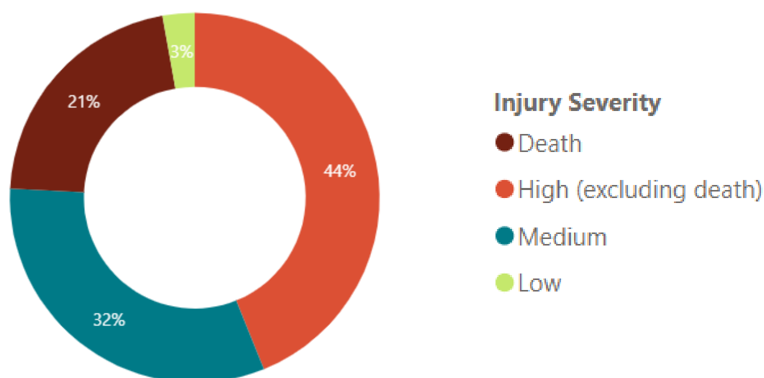
[a]n=314 cases asserted involving ED boarding between 2014-2023 (as of 6/30/24)

Table 1: Costs Associated with ED Boarding Cases by Injury Severity

Injury Severity	Case count	Avg. Indemnity Paid	Avg. Expenses Paid	Avg. Total Incurred
Death	139	$601.5K	$60.6K	$319.9K
High	80	$749.6K	$99.4K	$656.1K
Medium	61	$608.0K	$72.0K	$476.4K
Low	34	$37.0K	$24.2K	$41.9K

[a]n=314 cases asserted involving ED boarding between 2014-2023 (as of 6/30/24)

Figure 4: Gross Total Incurred by Injury Severity



[a]n=314 cases asserted involving ED boarding between 2014-2023 (as of 6/30/24)

Top 5 Co-occurring Contributing Factors

The majority of contributing factors that occurred across ED boarding cases involving death were related to clinical judgment.

	Contributing Factor	% cases	Odds of Payment*
1	Patient Assessment Issues	17.37%	79% increase
2	Selection & Management of Therapy	11.76%	29% decrease
3	Communication Among Providers	8.96%	206% increase
4	Patient Monitoring	7.28%	79% increase
5	Failure or Delay in Obtaining a Consult or Referral	5.60%	99% increase

[a]*Odds of payment compared to cases without ED boarding factor closed between 2014-2023*

When looking at the full cohort, cases involving ED boarding had 110% higher odds of closing with an indemnity payment compared to Candello cases without this factor. Although this cohort of cases is relatively small, the sheer clinical and financial severity associated with these cases compared to other cases in the database reinforces the public health emergency that ED boarding represents.

What is being done?

The root causes of ED boarding and overcrowding are complex and intertwined. The following components are some solution strategies proposed by clinical experts and health policy advocates.

Operational Improvements

To address ED boarding, operational improvements such as simplifying patient intake forms can expedite efficiency and improve patient flow, thereby reducing ED congestion. Implementing an ED fast-track processing area or a dedicated provider in triage could help expedite less critical patients. Some facilities have also adopted inpatient hallway boarding or an admission and/or discharge holding unit as an alternative, where patients can be safely held until admission or discharge.

System and Administrative Changes

Systemic and administrative changes are crucial, including integrating the ED into broader hospital capacity management decision-making and ensuring strong senior leadership to follow through on necessary changes.

In the inpatient unit, there is a delicate balance between expected admissions, such as scheduled surgical cases, unexpected admissions arriving from the ED, and delayed discharges. Efficient patient throughput is everybody's job. Involving case management can help ensure that expected daily discharges occur in a timely fashion to free up inpatient beds. Additionally, ongoing communication with the surgical suite and a process for managing fresh post-op patients in the PACU could help temporarily alleviate ED congestion.

Psychiatric Care

For behavioral health patients, expanding the use of telemedicine can reduce the time from patient arrival to treatment. Enhancing disposition planning, like transfers to community hospitals, can also help to alleviate ED pressures. Some organizations have taken a proactive approach to managing behavioral health patients by having a full-time psychiatric team in the ED and standardized therapeutic interventions to minimize behavioral health emergencies.[6] Managing these patients proactively can potentially result in discharge to the community rather than boarding for days or weeks awaiting placement at an inpatient facility.

Staff Well-being and Morale

Prioritizing staff well-being and morale is essential. This can be achieved through fostering a positive culture and providing teamwork training. Cross-training staff in the ED and inpatient units can also enhance teamwork and improve interpersonal collaboration so that each team member better understands the challenges in the other's work environment.

Policy-Level Initiatives and Advocacy

Policy-level initiatives and advocacy efforts play a crucial role in alleviating severe capacity challenges. The Massachusetts DPH urgent care initiative, which helps redirect patients who do not need emergency-level care to urgent care centers with the support of BCBS and Medicare, is one such effort.

The American College of Emergency Physicians consistently advocates for solutions to the crisis and held the first national summit on the boarding crisis in late 2023. The Joint Commission has identified boarding for more than four hours as a safety risk, and the Centers for Medicare and Medicaid Services (CMS) are developing new measures to track ED boarding, following the controversial elimination of a previous measure in 2021.

Conclusion

The crisis of ED boarding represents a significant threat to patient safety, contributing to delayed care, higher morbidity and mortality, and increased healthcare costs. The cases highlighted in this report emphasize the urgent need for systemic changes to address the root causes of this issue. Implementing operational improvements, systemic and administrative changes, and policy-level initiatives can help mitigate the risks associated with ED boarding. By prioritizing patient safety and clinician well-being, healthcare organizations can work towards alleviating this public health emergency and improving outcomes for all patients.

Contributors

Clinical Consultant: Christine Ringler, BSN, RN, CPPS
Clinical Taxonomy Advisor: Susan Jackson, RN
Data Analyst: Aaron Hunt
Editor: Hannah Tremont, MPH
Project Oversight: Michael Paskavitz

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