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PODCAST CAPSULE SUMMARY

The Practice of Emergency Medicine

Emergency department boarding: The canary in the coal mine

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Emergency department (ED) boarding, defined by the American College of Emergency Physicians as anyone who "remains in the ED after the patient has been admitted or placed into observation status," is a growing problem and frequent reality for physicians across a wide variety of settings in the United States.[1] In this month's *JACEP Open* podcast, we discuss the recent article by Smalley et al[2] and explore the potential dangers of ED boarding from the top of the health system down to the patient left sitting in the waiting room.

1 | THE MISSING METRIC?

Walking into a crowded waiting room last night I heard a staff member tell a patient, "I'm sorry for the wait; the whole hospital is full and everyone is really busy." On the surface this statement makes sense, yet Smalley et al found an inverse relationship between overall occupancy and emergency department (ED) wait times. These findings suggest that prolonged wait times in the ED may in fact be a reliable and reproducible marker of inefficiency within the health system rather than being a byproduct of a system running at full speed. As increasing scrutiny is placed on metrics such as percentage of patients who leave without being seen and time from arrival to ED discharge, ED boarding should be an increasingly helpful statistic.[3]

2 | BIG BROTHER IS WATCHING

From an administrative standpoint, prolonged ED wait times related to ED boarding come with a significant host of potential problems, including allegations of violating the Emergency Medical Treatment and Labor Act (EMTALA). Under EMTALA, departments "may not delay access to screening, stabilizing treatment."[4] In a busy waiting room, any delay between patient arrival and this mandated screening could open up a hospital to allegations of an EMTALA violation.

3 | STUCK IN THE MIDDLE

From a patient care standpoint, ED boarding appears to have the greatest impact on potentially high-risk patients. Nationwide, various staffing models and flow modifications have been developed to quickly take care of the sickest patients (triage Emergency Severity Index (ESI) scores 1, 2) and those with less acute complaints (ESI 4, 5). Although these efforts may improve current metrics such as time from arrival to being seen by a clinician, they may have the unintended consequence of filling ED beds, consuming clinician resources, and contributing to ED boarding. Consequently, patients with mid-range triage scores (ESI 3), who make up more than one third of ED patients nationwide, may be stuck in the waiting room as the sickest and least sick patients are seen first.[5] Smalley et al[2] found that patients with an ESI score of 3 had the longest wait times despite having an overall admission rate of ≈27%. As rates of ED boarding increase, this large cohort of patients with moderate ESI scores is left stuck in the waiting room waiting.

Smalley et al[2] make a compelling argument that increased rates of ED boarding can affect us all. For hospitals and departments, ED boarding likely reflects overall efficiency. For individual patients, focusing on ED boarding may allow us to provide expedited care for a subset of patients who are often overlooked in the mad dash for efficiency.

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