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## Emergency Department Boarding of Behavioral Health Patients

This In Focus outlines emergency department (ED) boarding of behavioral health (BH) patients. Behavioral health refers to patients with psychiatric and/or substance use disorders. Boarding refers to the holding of inpatients in an ED after an admission or transfer decision has been made. ED boarding, as it contributes to ED crowding, has been a long-standing area of concern for Congress, payors, and health care providers (see CRS Report R43812, *Hospital-Based Emergency Departments: Background and Policy Considerations*). This In Focus highlights areas for research and discusses policy options Congress may consider to reduce BH patient boarding.

In general, patient boarding can last from hours to multiple days. Data show that BH patient boarding times are longer than non-BH patient boarding times. For example, research examining one U.S. hospital and published in the journal *Emergency Medicine International* found that the average length of ED stay was more than three times longer for BH patients compared with other patient types (Nicks and Manthey 2012). BH boarding typically occurs because there are too few BH providers available to diagnose and treat a patient or because, after an assessment has been made, an inpatient psychiatric/substance abuse disorder treatment bed is not available. As a result, BH patients are boarded in the ED, which contributes to a backlog in the treatment of other ED patients. In the same *Emergency Medicine International* study, the researchers found that each boarded BH patient prevented an additional two patients from being seen.

### Defining the Problem

One barrier to developing and implementing effective strategies to reduce BH boarding is the lack of an accepted definition of boarding, for either BH or non-BH patients. Moreover, comprehensive data on how often boarding occurs are lacking. Some states have attempted to reduce boarding (e.g., in response to the Washington State Supreme Court case *In re the Detention of D.W. et al.*, 2014), but they have found little success without the necessary baseline data to evaluate change and enforce oversight and accountability.

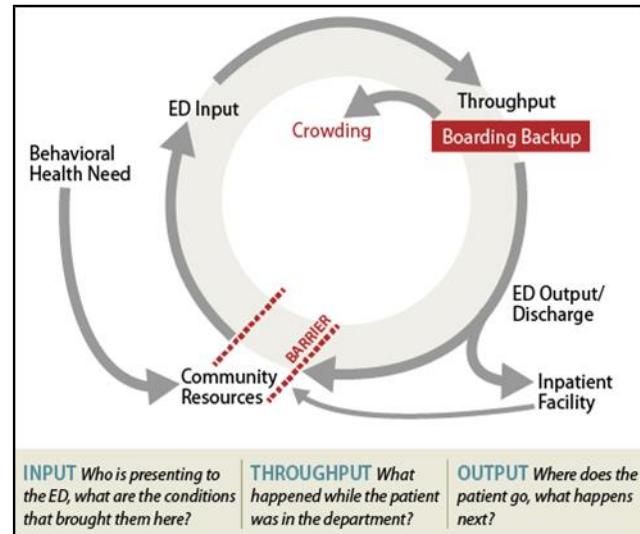
Expert groups use different definitions of boarding. For example, The Joint Commission—the organization that accredits hospitals—developed new standards to address “Patient Flow in the Emergency Department.” During the development of those standards, The Joint Commission found that two federal agencies (the Centers for Medicare & Medicaid Services and the Government Accountability Office) and the major professional organization for emergency physicians all defined boarding differently (The Joint Commission 2011). For example, one definition of

boarding was a length of stay of four hours after an admission decision, while another definition of boarding was “for a minimum time” after an admission decision was made. Researchers also use different definitions of boarding in peer-reviewed research, which limits study comparability and the ability to assess the extent of the issue.

### BH Boarding and ED Crowding

ED crowding, of which boarding is one cause, reflects systemic dysfunction between emergency services, inpatient services, and community health resources. One cause of crowding is that EDs, unlike other health care providers, must treat all patients regardless of their ability to pay, in accordance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA). As such, EDs are safety net providers and may be the only source of care for uninsured or underinsured patients. These patients along with other patients—including BH patients—who seek care in the ED for emergent conditions may cause ED crowding.

**Figure 1. Behavioral Health Boarding and Emergency Department (ED) Flow**



**Source:** Congressional Research Service.

The problem of ED crowding can be divided into three intricately related components: input, throughput, and output (see **Figure 1**). BH boarding, a throughput component, results from inefficiencies in each of these three components. The model presented in **Figure 1** begins with an unmet BH need in the community, which prevents appropriate treatment in an outpatient setting. If there is a barrier to care in the community, the need may become an ED input.

Boarding may occur because a patient cannot be discharged from the ED if there is no available and appropriate inpatient bed. Boarding BH patients is resource-intensive, because some BH patients require constant staff monitoring and some may receive specialized psychiatric care. The staff monitoring, in particular, diverts ED resources away from other patients and delays the flow of care in the throughput component, preventing other patients from receiving appropriate and timely care.

In cases where patients are discharged, the patient returns to the community for outpatient follow-up. If the community lacks BH treatment options to appropriately manage the patient's condition, the patient may need to return to the ED, which can contribute to crowding again. ED use for BH patients can be cyclical. However, one way to break the cycle is to provide access to appropriate outpatient follow up and treatment in the community (which may prevent future BH boarding), or providing treatment in inpatient settings to shift inappropriate behavioral health treatment from EDs to more appropriate settings.

### **Consequences of BH Boarding**

BH patients may become more agitated or aggressive in overcrowded, noisy, and bustling EDs as compared with designated psychiatric or substance use treatment areas. This behavior may be risky for both patients and staff. A literature review by the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) found that boarding for psychiatric patients was associated with worse outcomes for the boarded patients and increased hospital costs (ASPE 2008). A more recent study in the journal Academic Emergency Medicine found that the length of ED boarding was associated with both increased hospital mortality and increased length of stay for both physical and BH patients (Singer et al., 2011). However, as mentioned above, existing studies lack a standard definition of boarding, which makes it difficult to definitively quantify the effects of BH boarding on patient outcomes or financial costs.

### **Policy Options**

**Table 1** lists some policy options that Congress may consider to reduce boarding of BH patients, in terms of the three components presented in **Figure 1**: input, throughput, and output. BH boarding can be improved by reducing input, making throughput more efficient, and increasing output. Input and output are related to larger aspects of the health care financing and delivery system, which may make them more amenable to federal and/or state policy interventions. In contrast, much of throughput is determined by hospital policy and procedures. Still, the federal government, primarily in its role as a payor for hospital health services, may be able to motivate hospitals to adopt policies to reduce BH boarding by addressing input, output, or possibly throughput.

**Table 1. Policy Options to Reduce Behavioral Health (BH) Boarding in Emergency Departments (ED)**

#### **Reduce ED Input**

- Increase efforts to manage mental health conditions and substance abuse disorders (e.g., reduce access to illicit drugs).
- Increase access to BH treatment in outpatient settings (e.g., community health centers).
- Incentivize or fund programs that reduce the likelihood that first responders will bring BH patients to the ED (e.g., crisis intervention teams that can clear patients medically outside of the ED or de-escalation training for medical and law enforcement personnel).
- Permit reimbursement for ambulances that transport non-emergency BH patients to alternate destinations (e.g., BH provider offices).

#### **Improve Throughput Efficiency**

- Incentivize hospitals to have specific staff, triage, and locations in the hospital for BH ED patients.
- Incentivize resource-sharing between local hospitals (e.g., use telehealth for small facilities to share BH providers).
- Develop and require hospitals to report standardized data on BH patient boarding.

#### **Increase and Maintain Output**

- Increase access to inpatient BH treatment options (e.g., number of inpatient psychiatric beds) or reimbursement options available for BH treatment in Medicaid (see CRS In Focus IF10222, *Medicaid's Institutions for Mental Disease (IMD) Exclusion* and CRS In Focus IF10870, *Psychiatric Institutionalization and Deinstitutionalization*).
- Incentivize timely and effective hospital bed monitoring system and room turnover in ED and inpatient wards.
- Incentivize hospitals to develop and implement discharge processes and outpatient management to encourage hospitals to better connect BH patients with outpatient resources.

#### **Challenges and Barriers**

Some of the policy options in Table 1 are being pursued as part of recent efforts to address the opioid epidemic (e.g., prevention of substance use disorders). However, other options may be more challenging to implement. For example, some policy options (e.g., permitting reimbursements for ambulances to transport patients to alternative destinations) would require new or additional funding streams, which can be costly. Others—such as reporting data—involve more indirect mechanisms to achieve outcomes, and may not be a sufficiently direct policy lever to effect change. In addition, some options may be more appropriately addressed by state and local governments (e.g., states may operate psychiatric hospitals).

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