

Operations Management Committee

ED Crowding and Boarding: A Shift in Strategy

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While crowding and boarding inpatients in the emergency departments seem to be yearly hallmarks of flu season, throughout the year they remain enduring problems. Both reflect significant structural problems, such as a lack of inpatient bed capacity and delays in transporting admitted patients out of the ED, and are therefore difficult for emergency physicians to address directly.¹ However, short of taking a year to train in a waiting room medicine fellowship,² there are some direct, practical ways for us to help mitigate the effects of crowding and boarding.

For emergency departments that are part of larger hospital networks, sometimes rethinking inpatient capacity across hospitals can be equivalent to adding capacity. Admitting lower-acuity patients to crowded tertiary-care facilities may misalign resources. A relatively stable patient with a COPD exacerbation or pneumonia may be served as well by a community hospital as a tertiary-care center, but the inpatient bed that they occupy at the tertiary-care center might be the one that a patient with an NSTEMI or stroke needs. While many patients who arrive at a tertiary-care or academic center might bristle at the idea of being transferred to a lower-acuity facility, when given the option of an inpatient bed versus the prospect of a night boarding in the emergency department, their perspective may change rapidly.²

Placing a doctor at triage can lead to improvements in length of stay and department flow, but can also lead to significant increases in cost and the frequency of testing.³ Some larger emergency departments may have enough demand for a dedicated doctor in triage to make a substantial difference in throughput; however, for many departments, the same effect can be accomplished by allowing doctors to “flex” into triage at times of high crowding or boarding. This will help to expedite needed tests and reduce door-to-doctor times, and can be particularly useful if there’s no available beds in the emergency department to see new patients and the waiting room is filling up.

Rethinking your groups’ shift schedules or patient assignment strategies can also yield significant dividends. We tend to have a much greater capacity to see new patients early on in our shift – so even if your group tends to schedule more physicians to work at periods of higher demand, they might be less productive than a single doctor who is coming onto their shift fresh.⁴ Similarly, many of us have an unconscious tendency to slow down when working together with a colleague. Instituting a rotational strategy of alternating new patients between providers (or another strategy to balance the load) can help keep everyone at an even pace.⁵

Radiology and laboratory testing can represent significant bottlenecks for workups in the ED. Although adding an additional CT scanner or a lab in the ED might seem like appealing solutions to improve throughput, like adding inpatient capacity, these are major capital investments, and often involve the conflicting interests of many stakeholders (for whom improving crowding isn’t a priority). Often, streamlining protocols with other departments, such as radiology or pathology, can yield similar benefits. Allowing just a few critical tests to be point of care tests completed at bedside, such as creatinine for expediting CT scans, or troponin for chest pain, may have an outsized effect on throughput. Similarly, some routine practices in radiology, such as oral contrast for abdominal CT scans, can be safely eliminated for many patients, yielding a major improvement in throughput without affecting accuracy.⁶

Sometimes the most effective strategy is to keep low-acuity patients out of the emergency department altogether. Converting a single room within the emergency department to a low acuity zone with multiple chairs, or repurposing a portion of the waiting room as a “results pending” area for ambulatory patients with minor injuries can make a substantial difference in patient flow. While it often runs against our instincts and sense of duty as emergency physicians to prioritize patients who have minor complaints or quick dispositions, sometimes it really is necessary to get these patients out of the department quickly, if only to ensure that available beds in the emergency department are available to those who need them. ●



References

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