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Hospital and ER Overcrowding Leads to Increased Patient Risk

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The ER is a daunting place – and lately, the anxiety of an unexpected health problem has been compounded by the hazards associated with overcrowding. ER visits across the country reached a 10-year high in 2015, and in 2016, there were 145.6 million ER visits, with 12.6 million of them leading to hospital admission. These numbers have a significant impact on quality of care – and the resulting mistakes and lack of adequate attention are putting patients at risk.

There are numerous factors at play in ER overcrowding, but one persistent cause is the practice of boarding patients, or holding them in the ER while waiting for an inpatient bed. This means that the ER isn't just filled with patients who are experiencing an unexpected health crisis – there are also patients waiting for scheduled hospital procedures. In 2016, two-thirds of hospitals had admitted boarding patients in the ER or an observation unit for two hours or longer, compared with 57% in 2009.

Impact on quality of care

Boarding leads to overcrowding, which is a major problem. Overcrowding is linked to delays in administration of medications, longer hospital stays, greater likelihood of medical error, delayed treatment for cardiac events, and increased mortality. As the Institute of Medicine noted in a 2007 report, "The potential for errors, life-threatening delays in treatment, and diminished overall quality of care is enormous in these situations."

Boarding isn't only now being recognized as a problem. In the report mentioned, the Institute of Medicine recognized boarding as part of a "national crisis" affecting emergency care. But if boarding is such a problem, why has it continued for so long?

It comes down to money, as do many things in healthcare. The number of American hospitals has been on the decline since the 1970s. Reasons for the decline are various, but include increasing costs of technology, equipment, and staffing and an insurance system that has a stranglehold on reimbursements.

Under the weight of these constraints, many hospitals have merged or gone under. At the same time, more and more Americans use the ER to meet their primary care medical needs.

However, hospitals aren't operating at their full capacity. On average, hospitals are only at 65% of their total inpatient capacity at any point in time.

And why is that?

Medicare, which offers 60 million American's insurance, ultimately determines the level of payment and reimbursement for hospitals. These reimbursement rates favor invasive surgeries and/or elective procedures rather than medical condition management. As a result, hospitals are prioritizing the needs specialists who perform these procedures. This approach creates problems for scheduling and bed availability for ER patients, ultimately forcing hospital administrations to create an unsustainable balance between overcrowding and underutilization.

Is there a solution?

This inefficiency is the primary culprit for boarding, not lack of beds or doctors, although poor staffing and only assigning beds to certain specialties certainly has a negative impact as well.

Most hospitals acknowledge the problem. However, hospitals face the challenge of reducing boarding without impacting the positive cash flow that stems from elective surgery. Theoretically, addressing administrative procedures and inefficiencies is less costly than constructing a new hospital.

One specific approach to this is known as "smoothing." Smoothing adjusts surgical schedules and spreads surgical cases across the workweek to relieve the choke points in ER admissions. This has been performed successfully at a number of hospitals such as Cincinnati Children's hospital, which was able to increase its occupancy rate from 76% to 91% by reconfiguring their surgical schedule, as well as streamlining their discharge process.

However, while the cause of boarding stems from hospital- and even nation-wide problems, ERs themselves are able to mitigate some of the problems through departmental practices. As the Emergency Nursing Association points out, ERs have control over issues such as door-to-provider times and the total length of stay for discharged patients. While the general presence of boarded patients does decrease efficiencies in ERs, the article points out, many ERs aren't utilizing all the solutions at their disposal to correct the problem.

Despite the fact that the problem of boarding has been ongoing, and despite the serious implications it carries for patient outcomes, meaningful change has been slow to come. Among the most crowded hospitals in the US, a majority haven't adopted the most effective measures to fix the problem.

Legislative or legal action currently seems unlikely to help straighten out this tangled issue for the medical establishment. Medicare has started offering financial incentives to hospitals that address boarding and the Joint Commission, the accrediting board for US hospitals developed guidelines on improving boarding and overcrowding. However, any action is entirely optional for hospitals.

If you or someone who you love has been injured due to a hospital's negligence as a result of boarding, you have options for pursuing legal recourse. Under a legal theory known as "respondeat superior," if a hospital employee's actions cause patient harm, the hospital could be held liable.

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