MEMORANDUM OF UNDERSTANDING

Boarding in the Emergency Department

The Oregon Nurses Association ("Association") and Oregon Health & Science University ("Employer") hereby agree to the following provisions regarding boarding in the Emergency Department.

The Parties acknowledge a significant issue with patient boarding in the Emergency Department (ED) at OHSU. ED boarding results in increased patient mortality and morbidity, incidence of delirium, increased length of stay, and increased costs to the hospital. Moreover, nurse burnout and moral distress/injury from treating boarded patients correlates with lower patient safety and quality of care. Therefore, the following provisions shall be in effect for the life of the parties' current Agreement:

A. ED Boarding Task Force: The parties will establish an ED Boarding Task Force (EBTF) to track data and develop solutions. The EBTF will:
    1. Be composed of at least 2 ED Charge RNs, 1 Charge RN from Acute Care, 1 Charge RN from Critical Care, 2 staff RNs, 1 Charge from South OR, 1 transfer center RN, 1 case management RN, 1 ED physician and an equal number of administrators or managers authorized to have decision-making authority on this Task Force. Nurses on this task force will be paid at their regular rate of pay, and shall be released from regular work duties. Meetings shall occur at a regular cadence as determined by the taskforce. Once meetings are scheduled, they shall occur, regardless of who is able to attend on the day of the meeting. Selection of AURN nurses will be made by appointment of the AURN Board of Directors.
    2. Monitor trends in the issues that impact ED boarding, including but not limited to: daily hospital bed census, open hospital beds, transfers, barriers to discharge, direct admits and the impact on boarding in the ED, divert status, Oregon Capacity System, the length of stay for patients boarding in the ED, time spent in each Tier [see Exhibit 1], delays to going to the inpatient location, logistics and equipment availability delays for patients moving out of the Emergency Department, staffing issues and barriers to staffing available beds, and any other issue that impacts the issue of boarding in the ED.
    3. Make recommendations for "surgical smoothing" strategies to distribute elective surgeries more evenly throughout the week, reducing peaks in bed demand.
    4. Develop a plan to limit boarding in the ED to a standard of time rooted in evidence-based practice that is appropriate for delivering safe and effective health care to every patient. Proposals will prioritize physical spaces and protocols so that the hospital will efficiently transfer patients to appropriate units, available beds, and spaces of care.
    5. Meet with regional stakeholders to analyze the Oregon Capacity System, assess the divert protocols across the region, and the boarding levels and lengths in the OHSU ED compared to other local EDs.
    6. Address barriers and delays to discharge, including but not limited to transfers to non-partner hospitals.
    7. Assess hospital units for what barriers exist to taking boarding patients, and how to

ensure the units will be appropriately resourced, including nursing and ancillary staff.
8. Make recommendations which shall be implemented by the Chief Nursing Executive.

B. Actionable interventions, determined by the EBTF, shall be implemented if either of the below metrics are reached:
    1. More than 20% of the ED bed capacity are boarders (ie. no more than 6 boarders in a 32 bed ED).
    2. Any of the current ED boarders have been in-patient status for 4 hours or longer.

C. The emergency department shall have 2 primary Charge nurses. Charges will be in communication with both Acute and Critical Care Clusters daily in staffing meetings regarding boarding patients.

D. Executive Leadership will round on the patients, on a daily basis, who have been in the ED and boarding for over 24 hours.

E. ED nurses shall receive a Safety Differential of nine dollars ($9) for all hours worked in any pay period where the majority of days (8 days or more days in a 14-day period) fall under Tiers 1-3 (as established 1/7/2025 [see Exhibit 1]).

F. Acute care spaces, including hallway beds and the 6A PCU, will be staffed with RNs for admissions and patient care 24/7.

G. OHSU Health Executive Leadership team shall spend a full clinical shift in the Emergency Department once per month, alongside the OHSU health care workers and patients experiencing the crisis firsthand. Direct engagement on the frontlines is essential to fully understand the daily operational constraints, ethical challenges, and patient safety risks created by prolonged boarding.

H. For the purpose of this MOU, all of the above is in reference to the ED, not the ED Observation Care Units.

Exhibit 1:

OHSU

ED Tiered Capacity Job Aid

Effective Date: 1/7/2025 Next Review Date: 1/7/27

Full Capacity Protocol – ED, Mission Control and Inpatient Operations

	NORMAL	TIER 1	TIER 2	TIER 3
THRESHOLD	• <12 ED boarders for AAC • No patients boarding for >12 hours • No ICU boarders in ED • <10 patients in waiting area	ED Full AND ≥12 ED boarders for AAC and any of the following: • Any patient boarding >12 hrs • 1-2 ICU boarders in ED • More than 1 level 1 ESI patient in ED with active resuscitation • >10 patients in waiting area	ED Full AND ≥15 ED boarders for AAC and any of the following: • Any patient boarding >24 hours • >2 ICU boarders in ED • >20 patients in waiting area	ED Full AND EITHER ≥20 boarders for AAC AND any of the following: • Any patient boarding >36 hrs • >2 ICU boarders in ED for longer than 4 hours • All inpatient beds filled • >25 patients in waiting area

ACTION	**ED:** Patient in need for admission get informed about health system approach & consented for possible transfer to Adventist, HMC (to next available bed). 5-7 RNs in triage.
	
	Mission Control:
	• TCRN & POD to triage all new admissions for H@H, HMC, and AHPL, placement
	• BFM prioritizes placement between all entry portals
	• AOD/BFM coordinate with EVS for prioritization
	• POD to prioritize boarders
	
	Inpatient:
	• Redistribute admitted patients boarding in the ED to the next most appropriate bed, regardless of upcoming shift changes, break periods, or hour of the day
		Everything in prior tiers AND:
		
		ED:
		
		Mission Control:
		• BFM make decision about transfer center waitlist status based on IP capacity
		• PPO pages ED patients for HW spaces
		• Use OMCC for ICU boarders unable to be placed within our system within 6-8hrs
		
		Inpatient:
		• Hallway beds and 10D Infusion room assessed and placed for IP boarders and discharging patients
		• Utilize 6APCU and 11COF (4 bed bay) to maximum capacity
		• Utilize 6A to OCU process for DPs
			Everything in prior tiers AND:
			
			ED:
			• ED to ED non-trauma transfer divert
			• Consider Communication tools
			  • Patient Handouts to manage patient expectations
			  • Public Facing Visitor Policy
			
			Mission Control:
			• Close entry portals as able to match new admissions to discharges
			• Activate young adults to DCH (if capacity)
			• MC Leader to alert health system leadership about ED status for increased load balancing?
			• POD screen direct admission today and tomorrow for delay options/risk of ED visit if delayed
			
			Inpatient:
			• Directors and CNO will round upon request
			
			Office of Visitors and Volunteers:
			• Request additional volunteer coverage for high priority programs or areas (e.g. Guides, ED)
				Everything in prior tiers AND:
				
				ED:
				• Review need for trauma divert
				• Directive messaging to patients about transferring to partners for non-CCI patients
				
				Mission Control:
				• All alternative care spaces to be filled by direction of BFM
				• Consider OMCC activations (AAC and ACC)
				
				Inpatient:
				• Move appropriate observation boarders to OCU (potential future state)
				•
				
				Care Management:
				
				Prioritize ED patients for placement

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