



Addressing the Emergency Department Boarding Crisis for Children & Adolescents: A Collaborative Approach

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Confidential and Proprietary Information

Objectives



Pilot Overview



Outcomes



Next Steps

The Question

Can having a dedicated behavioral health clinician in the emergency department, along with providing MORES resources for children and families, help reduce ED boarding times?



Pilot Development

- The ED boarding crisis led to many multidisciplinary discussions beginning in 2023 with provider workgroups facilitated by Carolina Complete Health Network (Emergency Medicine, Behavioral Health, Pediatrics, Primary Care, Women's Health)
 - Child/Adolescent behavioral health is not siloed to one practice area and requires a community response.
- CCHN discussed possible solutions to pilot, pulling from discussions with workgroups and NC DHHS

Crisis Intervention Therapy and Education (CITE)

A three-pronged approach to decreasing emergency department “boarding” while increasing community-based crisis response.

1

Emergency Department Behavioral Health Clinician

A behavioral health (BH) licensed clinician in the ED devoted to children/adolescents at-risk of boarding. The BH clinician is the point of contact for external providers and stakeholders and focuses on identifying appropriate community-based treatment options. The clinician is also the primary staff responsible for referring to MORES as appropriate

2

Community-Based Crisis Response (MORES Program)

The MORES provider responds to crises in the community and provides warm-handoff response for individuals that have presented to the ED but do not meet Inpatient admission criteria.

3

Education

Training will be provided by the MORES provider focusing on how to recognize crises, how to respond, and what resources are available in the community (i.e., Mobile Crisis Management, MORES, Facility-Based Crisis, Behavioral Health Urgent Care).

Pilot Development

- Potential pilot partners were identified, and discussions with those providers began surrounding possibility of implementing the idea.
- Biweekly meetings during development and implementation phase (and ongoing) to address any barriers & adjust as needed (i.e., MORES entrance criteria)
- Phase 1:
 - Begin with an ED that has high need for intervention for children/adolescents boarding and the benefit of referral sources to many community-based providers
 - Partner with a provider that already has an active MORES team

How it Works

Program Overview (BH Clinician)

- Onsite BH clinician in the ED:
 - Central clinical contact, helping families navigate complex systems of care
 - Enables clinical teams to focus on critical services and care for other patients
 - Streamlined care has ripple effect across ED

Program Overview (MORES Services)

- Collaboration between Novant Presby Pediatric ED and SPARC MORES Team
 - Warm-handoff and responsive, prompt care
- MORES 72-hour Components:
 - Face-to-face within 1 hour
 - Family defines the crisis
 - Crisis De-escalation
 - Assessment
 - + Up to 8 weeks of stabilization and treatment

Outcomes

Pilot Outcomes (January – December 2025)

Key Metrics (ED):

- **115 pediatric *unpreventable “social hold” patients** supported by designated clinician since January 2025
 - Therapist was added to the multidisciplinary morning rounds to expedite disposition from the ED, preventing social holds. Volume of pediatric BH patients through December 2025 was approximately ~1000 patients.
- **ED treatment rooms *unpreventable “social holds”** (i.e., ED “boarding”):
 - Pre pilot: 50–70% of rooms occupied by unpreventable social holds
 - Since pilot implementation **only <10%** of pediatric treatment rooms have unpreventable “social hold” patients.
- **Unpreventable social hold = Patient determined to not meet Inpatient admission, but guardian refuses to assume care of a discharged patient*

Pilot Outcomes (January – December 2025)

Key Metrics Continued (ED):

- **Average Length of Stay (ALOS) for unpreventable “social holds”:**
 - Pre-pilot: 4-6 weeks, with some boarding for up to 9 months
 - Since pilot implementation, ALOS of 3-4 days
 - ALOS for 115 pilot identified patients is **2.11 days (excluding 4 outliers)**
- ****NOTE: 115 patients at an average of 4 weeks stay is nearly a year of stay within the ED, occupying 9 beds available daily for an entire year***

Pilot Outcomes (January – December 2025)

Key Metrics Continued (ED):

- **Left Without Being Seen (LWBS) Rate:**
 - Pre-pilot: 2.16% (above national average of 2%)
 - Q1 Pilot: 1.2% (↓ 44%)

***LWBS Rate YTD: 1.01% (↓ 53%)**

Pilot Outcomes

- Unintended *positive* outcomes:
 - Reduced safety events for staff
 - Move bed capacity to care for other patients presenting to the ED
 - Increase in patients having a positive disposition and long-term plan
 - Overall improved staff satisfaction



Pilot Outcomes (October 2024 – December)

Key Metrics (MORES):

- 90 referrals since launch
 - MORES services initiated with 42 members, 33 from ED
 - Engagement barriers: Guardian contact issues, service refusal, existing services*

****Note: Members engaged directly in the community represent potential avoided ED visits.***

- Average interventions: 2.9/week per member
 - Peak activity: Weeks 2 & 3
- **Impact:** Warm handoffs from ED to MORES have improved timely disposition.

Education: Community-Based Crisis Services

- Education sessions completed:
 - 2 sessions onsite with Novant pediatric practices
 - 3 Webinars (66 participants)
- Community events attended:
 - Foster Care Conference
 - CCH Community Baby Shower



Lessons Learned

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- Opportunities:
 - Partnership between a Health Plan (payer), a Hospital System, and a Community-Based Provider can work together to address challenges in our system
- Barriers:
 - Need for night/weekend ED clinician coverage
 - Limited/no access to enhanced, community-based services for privately insured individuals.
 - MORES participants with private insurance face discharge challenges.



Lessons Learned

- Sustainability:
 - Maintaining licensed clinician in the ED is feasible, based on success of pilot and proven improved care and ROI
 - MORES funding was limited to certain payers or pilot programs and is not available in all areas (considerations for expansion). Funding has expanded since launch of this pilot.



Next Steps

Next Steps

- Novant Health, Presbyterian ED:
 - Maintain full-time, dedicated clinician
 - Hire another full-time (for evening/nights) and part-time (weekend) clinician specific to role of designated to children/adolescents at-risk of “social hold”
 - Implement telehealth to two satellite EDs
- SPARC, MORES Program:
 - Continue with this program, which they began in December 2022
 - Additional funding from Alliance Health for MORES
 - Potential expansion into additional



Next Steps

- Carolina Complete Health Network
 - Beginning process for implementing phase 2 of pilot, to another ED and community-based service provider.
 - Tentative start date of July 1, 2026
- Contact Dr. Michael Utecht or Katie McKay
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