Hospital Searches for Ways to Trump Full House

By Tyler Smith

For many employees on the front lines of patient care, a typical day at University of Colorado Hospital is a bit like a health care version of the old “Priceless” MasterCard campaign.

An ad would portray, say, a trip to Disneyland for parents and kids. After reeling off the price of admission, hotel and food, the narrator would add: “Memories of good times together: priceless.”

As a seemingly endless stream of patients continues to flow to UCH, the hospital’s bottom line continues to strengthen. But on any given day, it is medical/surgical and critical-care beds that have become . . . priceless.

For the capacity-challenged hospital, those beds are the ultimate prize for both staff and patients. Day after day, inpatients line the halls of the Emergency Department, waiting for a bed to open on an inpatient floor. Patients also fill the beds of the Post-Anesthesia Care Unit (PACU), the Critical Care Surge Unit that was carved from the PACU last summer, and the Express Admit Unit.

On one level, the challenge is as basic as it gets: the hospital’s patient volumes increase every year, but the total number of beds has long been fixed at 407. That fact creates mismatches — more patients admitted than patients scheduled for discharge — that occupy large portions of the day for many at the hospital who juggle capacity.

House cleaning. The challenge: find patients who can safely be discharged early to make room for the many others who need a bed on an inpatient unit.

“The issue is a lack of available bed space,” said Rob Leeret, the hospital’s director of emergency/trauma services and capacity management. “We have unprecedented volume.”

Much of Leeret’s day is taken up with figuring out how to manage safely the many inpatients — typically two or three dozen — boarding in the ED.

Those patients, some of whom must now wait in the ambulance vestibule and radiology hallway outside the ED, require thousands of hours of care each month and increase pressure on an ED staff that already has its hands full with its regular patient load — the number of ED visits in September was 4.5 percent higher than in September 2011.

With 35 exam rooms and 15 stretchers, the ED must in effect turn beds four times a day if it receives 200 patients, Leeret said.

The large number of boarders and visitors frequently speeds the clock beyond the point staff can keep up.

“As much as we concentrate efforts, as the number of boarders increases, we can’t keep up,” he said. Every four boarders, he added, subtracts one ED nurse from the pool caring

Continued
for emergency patients who come through the door. To help out, he said, Patient Services Director Deb DeVine, RN, MSN, sends inpatient nurses to the ED.

“That means we can avoid subtracting one of our nurses,” he said. “But we’re still functioning in chaos.” When DeVine sends nurses to the ED, he added, she has to turn to the Resource Office to fill those holes.

Search for space. To deal with the crunch, Leeret frequently requests from Ambulatory Services additional space in the Interventional Pain Management Practice on the first floor of the Anschutz Outpatient Pavilion. The hospital opened the space as an ED “surge” area earlier in the year to handle overflow during evening hours, but Leeret reluctantly asks for space for medium-acuity patients during regular business hours when he has no other choice.

“It’s reactive,” he said. “We’re putting ED patients alongside pain patients, but sometimes we have no other options.”

The pressure is often no less intense on the inpatient and critical-care units, both of which frequently run close to or at capacity.

The volume numbers tell the same stark story for Angela Hill, RN, nurse manager for the 9 East General Surgery and 6 West Transplant units. Inpatient surgery volume for the first quarter of fiscal year 2013 (July 1 through Sept. 30) is up 185 procedures compared to the same period last year, but the units have the same number of beds.

“It gets tougher and tougher with more patients,” Hill said.

Product of success. There is a bright side to the robust volume, of course. Many hospitals are struggling with flat or even declining volumes and razor-thin operating margins. At UCH, by contrast, patient revenue and earnings before interest, depreciation and amortization, a key measure of financial strength, are both greater than the budgeted figures through the first quarter of the fiscal year and up by double digits over last year’s figures.

Data also indicate that the hospital’s intense focus on discharging patients in a timely fashion has yielded results. For example, medical/surgical length of stay through September was down slightly compared to the year before, despite the heavier volume and a more acutely ill patient population.

The average percentage of beds taken from clean to occupied within 60 minutes, another key to moving patients expeditiously, was 58 percent as of early October – well above the 44 percent baseline for fiscal year 2012 and the hospital’s goal for this year of 50 percent. The median discharge time, meanwhile, has dipped slightly.

The regular morning capacity meetings, started in 2009, also continue to have a positive effect, said Cathy Ehrenfeucht, RN, director of critical care, dialysis and cardiology.

“We’ve gotten good at it,” said Ehrenfeucht of the 8 a.m. gatherings, where nurse managers, directors and other hospital leaders review the day’s anticipated volume and identify “red units” faced with more admissions than discharges.

“When we have a lot of patients boarding in the ED, the units upstairs have gotten good at turning over beds,” Ehrenfeucht said. When volume is especially heavy, the group meets again at 11 a.m. to reassess and strategize – “shaking the trees” to find beds, as she put it.

“If we didn’t have the meetings, the issues would be even greater,” Ehrenfeucht said. “The problem is people are still coming to the hospital even when we have 40 inpatients boarding in the ED.”

Ehrenfeucht said the hospital’s initiative to encourage each medical/surgical team to write one discharge order by 10 a.m. compared to the same period last year, but the units have the same number of beds.

“It gets tougher and tougher with more patients,” Hill said.

Product of success. There is a bright side to the robust volume, of course. Many hospitals are struggling with flat or even declining volumes and razor-thin operating margins. At UCH, by contrast, patient revenue and earnings before interest, depreciation and amortization, a key measure of financial strength, are both greater than the budgeted figures through the first quarter of the fiscal year and up by double digits over last year’s figures.

Data also indicate that the hospital’s intense focus on discharging patients in a timely fashion has yielded results. For example, medical/surgical length of stay through September was down slightly compared to the year before, despite the heavier volume and a more acutely ill patient population.

The average percentage of beds taken from clean to occupied within 60 minutes, another key to moving patients expeditiously, was 58 percent as of early October – well above the 44 percent baseline for fiscal year 2012 and the hospital’s goal for this year of 50 percent. The median discharge time, meanwhile, has dipped slightly.

The regular morning capacity meetings, started in 2009, also continue to have a positive effect, said Cathy Ehrenfeucht, RN, director of critical care, dialysis and cardiology.

“We’ve gotten good at it,” said Ehrenfeucht of the 8 a.m. gatherings, where nurse managers, directors and other hospital leaders review the day’s anticipated volume and identify “red units” faced with more admissions than discharges.

“When we have a lot of patients boarding in the ED, the units upstairs have gotten good at turning over beds,” Ehrenfeucht said. When volume is especially heavy, the group meets again at 11 a.m. to reassess and strategize – “shaking the trees” to find beds, as she put it.

“If we didn’t have the meetings, the issues would be even greater,” Ehrenfeucht said. “The problem is people are still coming to the hospital even when we have 40 inpatients boarding in the ED.”

Ehrenfeucht said the hospital’s initiative to encourage each medical/surgical team to write one discharge order by 10 a.m.

Continued
has had spotty results, but teams do respond when the capacity pressure is greatest.

**Sign of a squeeze.** The “visual cue” for the floors that capacity is tight, Ehrenfeucht said, are hallway beds, deployed only in capacity crisis situations. Providers don’t want to put patients in the hallways; privacy is an issue and oxygen tanks have to be monitored, for example.

So when those at the 8 a.m. meeting determine the admission-discharge mismatch is so great that it can’t be balanced, the hallway beds roll out. “Physicians don’t want to see their patients out there, so we say, ‘Work with us,’ ” Ehrenfeucht said. “That’s when we get discharge orders written by 10 a.m. and patients are out by noon.”

She stressed, however, that teams shouldn’t be judged purely on the basis of whether or not they meet the discharge-order goal.

“Just because a team doesn’t write an order by 10 a.m. doesn’t mean they’re not doing a good job,” Ehrenfeucht said. Pointing to the stable length of stay, she said some teams are writing orders for patients late in the afternoon or the evening prior to the day of discharge. Teams work to facilitate these discharges for patients who are clinically ready to leave the hospital.

“There is no one metric we can look at,” she said. “They are all pieces we fit to find what works.”

**Paying the price.** But the steady pressure also has had negative consequences. For example, through the end of October, the hospital averaged more than 18 hours a week on divert, meaning it was so full it had to close its doors to ambulances carrying all but critically ill or injured patients. That’s more than four times the organizational goal.

And the regular capacity alerts with the message that providers need to find patients to discharge have taken a toll on caregivers. Predictable days are a rarity.

“It used to be that we’d know that a patient assigned to a bed on our unit would come,” Hill said. “Now assignments change can change four or five times a day” as hospital managers and inpatient directors scramble to find beds, she added.

The lack of space frequently forces hospital managers to place patients in the first bed available, meaning that nurses and physicians on many floors care for patients outside their service.

Overflow medical and surgical patients, for example, often fill beds on the Transplant Unit, Hill said. That makes it more difficult for teams caring for those patients to coordinate the care needed for discharge: medications, education, durable medical equipment, follow-up appointments and so on.

Nowhere is that challenge greater than for providers caring for General Internal Medicine patients, who frequently are scattered throughout the hospital, from the ED to the 12th floor (Insider, Oct. 24). Kristin Furfari, MD, a hospitalist and the medical director for the 7 East Internal Medicine Unit, said the patient dispersals typically add an extra 30 minutes to an hour of rounding time for a team.

“We may not know the nurses on the floors, so we’ll get more pages instead of a nurse just finding us and asking a question,” Furfari said. That’s particularly true when patients wind up on a floor where the nurses aren’t used to caring for medicine patients, she added.

There are also odd but frustrating problems that face a team rounding from floor to floor, Furfari added. For example, the Epic electronic medical record is designed to print prescriptions on the floor where physicians order them. Logical enough, except that by the time a prescription prints out on one floor, the team might be on another. For Furfari and other General Internal Medicine attendings, that means trooping back to sign the prescription.

**Teaching toll.** The push to discharge can also run up against an academic medical center’s educational mission.

“I don’t feel like we can push farther,” Carrie Goodson, MD, a third-year medicine resident, said bluntly when asked about the pressure to discharge patients. “It doesn’t supersede patient care.”

Goodson acknowledged, for example, the hospital’s 10 a.m. discharge-order request, but questioned its viability.

“It’s not feasible,” she said. Medicine rounds typically begin at 8:30 a.m. and take two hours, if not longer, she noted.

“It would take a paradigm shift to write orders by 10 a.m.,” she noted. “From a medicine standpoint, we often can’t do that. We generally don’t make discharge decisions until we’ve done rounds.”

Furfari, however, said the capacity issues have heightened awareness of her team and her unit of the importance of timely
discharge, regardless of the time. She said she works closely with nurse practitioners, physician assistants and others to identify early-discharge candidates and then tries to see them at the beginning of rounds – a change in itself. The traditional clinical approach, understandably, is to tend to the sickest patients first. The 10 a.m. discharge-order goal at the very least modifies it.

“We’re not taught to think that way,” Furfari said of looking for early-discharge candidates. “We think in terms of the ‘sick/unsick’ rather than the ‘leave or stay,’” she said.

However, Furfari added, her residents have not been resistant to the discharge demands.

“They see now that having our patients all over the hospital has a negative impact on our day,” she said, “and that inpatients who have to stay in the ED don’t necessarily get the same kind of care that they would on the floors. A full hospital affects our ability to practice. The residents have shown an acceptance that something needs to change and our part is to help facilitate that.”

Discharge dilemmas. No matter how keenly aware providers and staff are of tightening capacity, however, discharging patients from the hospital will always be a complicated process, Hill said.

The number-one barrier to discharge, she said, is late and unexpected changes in patients’ conditions.

“We may have progressed the patient to discharge, but on the day he or she is to leave, there could be a change in lab values or vital signs, or there is chest pain or changes needed in the medications or oxygenation — something that tells you the patient is not ready,” Hill said. “When that happens, there is nothing you can do.”

On the other hand, she said, the hospital has a “huge opportunity” to improve communications between nurses and physicians. The hospital’s eight surgical teams, she said, normally round early in the morning, then head to the OR to scrub and begin their procedures for the day. If they haven’t written orders, it can be difficult to make contact with them, Hill said.

“If nurses and physicians can get together each morning to develop a plan of care, we’ll have a better idea through the day of what patients can expect,” she said. “We can make judgments on discharge with the input of physicians, because they are the ones who are doing the final discharge determinations.”

Leeret, who worked with Information Services to develop a “dashboard” to keep units apprised of the hospital’s capacity situation in real time (see accompanying story), said despite the daily stress, the hospital must continue to monitor closely all its performance and quality measures.

“There is real apprehension,” he said of the unrelenting volume. “We’ve had success in managing our length of stay, but we also have to look at our 30-day readmission rates to make sure we aren’t discharging patients too soon. That’s a concern.”

It’s an example of the old saying that no good deed goes unpunished, he concluded with a slight smile.

“The entire hospital has pulled together to streamline our processes to fit in more patients. The payoff has been we have more patients come in,” he said. “It’s still not enough.”