By John Nelson, MD, FACP

Avoid Bottlenecks

Be diligent and efficient to manage ED and marginal admissions

I enjoy hearing about the value hospitalists provide our healthcare system. These stories come from peer-reviewed research, magazine articles, local newspapers, and even the occasional blog. When I talk to hospitalists from around the country, they are often eager to tell of their success and how they made it happen.

Not as often, I also hear about problems that may be a result of the hospitalist model. I think any successful practice, and our field as a whole, must remain open to the weaknesses in the hospitalist model and work continuously to address them. Issues like disruptions in care and poor communication between hospitalists and outpatient providers get a reasonable amount of attention and seem to be on most groups' radar screens. But there are some potential problems I don't hear discussed often, and I'm not aware of any significant research that has been published or presented to analyze them. I'll review two such potential problems here.

Large groups may decide to dedicate one hospitalist entirely to the emergency department from sometime in the morning until near midnight. This person is available to respond quickly to admissions and consult with emergency doctors regarding management and disposition of borderline cases.

ED Throughput

Are hospitalists sometimes the cause of a bottleneck in the emergency department (ED)? Hospitalist practice is nearly always credited with improving throughput at a hospital, including in the ED. But many hospitalist practices could impede throughput by delaying patients from leaving the ED when there are multiple simultaneous admissions. Consider the following scenarios:

The pre-hospitalist era: It is 7:30 p.m. and the ED has four patients ready for hand-off to an admitting doctor. There are several primary care groups at the hospital, and each has a doctor on call. Of the four patients needing admission, two go to Dr. Emerson from group A, one goes to Dr. Lake from group B, and one to Dr. Palmer from group C. Because the on-call doctor for these groups is home, he/she provides admitting orders by phone and may or may not see the patient that night. Of course, waiting until the next day to see the patient can be risky. In many cases the ED would have admitting orders on all four patients quickly, say within 30 minutes, and can send the patients up to the floor as soon as the bed is ready.

The hospitalist era: Things can happen differently when hospitalists are at this hospital. All daytime hospitalists are typically signed out to a single night hospitalist (nocturnist) at 7:30 p.m. when the ED has four patients to admit. This solo nocturnist might show up almost immediately after being notified about the admissions by the ED doctor and promptly start seeing the first of the four admissions. But it might take him/her three or four hours or more to finish admitting all four patients. By that time there are probably additional admissions waiting. The ED might end up keeping each patient much longer than in the first scenario.

The difference in these two scenarios is the availability of several doctors to admit patients simultaneously in the pre-hospitalist era. These doctors may be replaced by a single hospitalist who admits patients one at a time.

A clear benefit of the hospitalist system described in this example is that patients are seen in person by the hospitalist at the time of admission, rather than admitted over the phone by the primary care physician (PCP) and perhaps not seen in person by the PCP until the next day. Yet this may come at a cost of creating a bottleneck that didn't exist in the pre-hospitalist era.

Think about whether this is a common problem in your practice. Several strategies might help minimize this bottleneck. The most common approach in a practice of more than about 10 hospitalists is to ensure that there is more than one hospitalist available to admit patients until 10 or 11 p.m. when admission volume typically subsides. This has led some groups to develop an evening "swing shift" from late afternoon until about 10 or 11 p.m.

Large groups may decide to dedicate one hospitalist entirely to the ED from sometime in the morning (e.g., 11 a.m.) until near midnight. This person is available to respond quickly to ED admissions and consult with ED doctors regarding management and disposition of borderline cases. While ED staff are usually thrilled to have a hospitalist for the day, that hospitalist often will need to get help from other hospitalists when several patients must be admitted at the same time. And hospitalist-patient continuity suffers because the patient will nearly always need to be handed off to a different hospitalist for follow-up visits.

Marginal Admissions

Do hospitalists increase the number of marginal or potentially avoidable admissions?

The pre-hospitalist era: The ED physician sees a patient of Dr. Bernstein's at 1 a.m. and is having trouble deciding whether admission is the best approach. The ED doctor gets Dr. Bernstein or his on-call partner, Dr. Copeland, on the phone and learns this patient is well known to the practice and can be seen in the outpatient office early the next morning. Admission is unnecessary.

The hospitalist era: The ED physician sees the same patient at 1 a.m. Because there is a reasonable chance admission is the best approach, he decides to call the hospitalist first rather than the patient's PCP. Neither the ED doctor nor the hospitalist knows the patient well, and they are unaware outpatient follow-up with the PCP next morning is an option. After all, most PCPs are already "booked up" and probably unable to work someone in on such short notice. And, it's tough to be sure the PCP would have all the relevant records regarding the data gathered and decisions made during the ED visit. So the hospitalist and ED doctor agree the best approach is to admit this patient to observation status, when in the pre-hospitalist era the patient might have been safely discharged from the ED for outpatient follow-up.

I fear this is a reasonably common scenario for many hospitalist practices. And yet these marginal admissions are often discharged the next day, lowering the overall length of stay (LOS) for hospitalist patients. By admitting marginal patients, some of whom might have been safely discharged from the ED in the pre-hospitalist era, a hospitalist practice can improve its overall LOS. The hospitalists might be patting themselves on the back for such good performance on LOS by admitting patients who could be discharged.

These two problems are difficult to quantify. If you're confident these aren't an issue for your practice, you deserve lots of credit. But I think most practices should think carefully about both issues and work to minimize how often they occur. TH

Dr. Nelson has been a practicing hospitalist since 1988 and is co-founder and past president of SHM. He is a principal in Nelson/Flores Associates, a national hospitalist practice management consulting firm. He is also part of the faculty for SHM's "Best Practices in Managing a Hospital Medicine Program." This column represents his views and is not intended to reflect an official position of SHM.