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Perspectives:

Measurement and Accountability: Medical Staff Is Key to Relieving Hospital Capacity Problems



With closures, mergers and downsizing, hospital care in this country is an ever-changing landscape. An aging population that requires increased medical care combined with fewer available hospitals is forcing facilities to care for more patients than they traditionally have treated. Today, hospitals may need to maintain occupancy rates above 90 percent to be financially viable, which creates patient flow imbalances and decreases overall efficiency of patient care. As hospital occupancies continue to increase, hospital senior leadership is faced with the challenge to run their systems more efficiently to balance new, incoming patient volume with outgoing discharged patients.

Virtually every successful industry today holds its staff accountable, and regularly implements measurement and evaluation tools. Historically, however, hospitals have not fostered such a culture for operational measurement and accountability. In fact, hospitals are probably one of the last remaining industries to implement flow measurement systems and formally assign accountability for operational goals. Medical staff and hospital leadership can play significant roles in addressing hospital capacity problems by establishing such evaluation, measurement and accountability techniques.

Creation of a patient discharge time goal is the first step in addressing this imbalance. More patients are being admitted to the hospital at the beginning of the day - usually between 8:00 a.m. and 2:00 p.m. Discharges don't typically start until noon, then they extend until about 7:00 p.m. To address this imbalance, hospitals need to discharge patients earlier in the day. This goal should be clearly communicated to patients, their families and medical staff. Working with medical staff leadership, the hospital then needs to calculate how much earlier it is necessary for physicians to write discharge orders or transfer orders for step-down patients so the hospital can meet its goals of patient discharge and then communicate that goal to the medical staff. Some successful examples of standard times include transfer orders by 8:00 a.m. and discharge orders by 9:00 a.m. Specialty and individual physician performance can then be measured with weekly reports on performance.

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Lack of critical care and telemetry beds is usually the biggest roadblock to admitting new patients. To help reduce the need for these beds, Case managers or charge nurses should proactively evaluate proposed admissions during high census times and review orders against formal admission criteria. Also, formalizing critical care physician review for certain patients based on either the acuity of the patient or the number of days in the critical care unit may also prevent crowded specialty beds. Hospitals should also formalize the triage process for moving patients out of specialized beds based on formal clinical criteria, rather than using incoming volume as the driver. If the patient does not meet criteria for admission or continued stay, a physician advisor needs to have the formal authority for conflict resolution.

Many nurses report that they have to negotiate individually with each physician involved in the patient's medical care when trying to discharge a patient. Formally assigning which physician is responsible for the coordination of the patient's medical care and discharge decreases the need for this type of negotiation. Explicitly assigning coordination of medical care responsibilities to the admitting physician and defining how the admitting physician formally transfers that responsibility to other physicians based on the clinical status of the patient will assign accountability for patient discharge to a specific physician who has the formal responsibility for the coordination of that care.

Throughout the process, communication is a key factor for successful implementation. Most informal approaches around medical staff behavior change initiatives fail because of informal communication of the proposed changes. Putting a formal communications system in place is essential to engaging physicians and garnering support. For example, pharmaceutical companies have successfully changed physician-prescribing behavior because they have "detail reps" that spend one-on-one time with physicians talking to them about the drug. Formally assigning a nurse manager or charge nurse to communicate the proposed change, seek input on those changes, and demonstrate current performance against those goals can increase the physician's participation and reduce reaction to those changes.

Typically, a hospital can expect formal changes such as these to take 12 to 18 months to be fully implemented. Once a facility decides to introduce a new policy or procedure, they need to get senior medical staff members to effectively implement the procedure. Typically, medical staff is usually willing to participate, as long as it improves patient care and flow.

When these approaches are used consistently, physician leadership can have a very significant and profound impact on overall hospital capacity and ultimately improve patient care quality and safety. By giving medical staff and leadership evaluation, measurement and accountability responsibilities, hospital capacity problems can be minimized and hospital efficiency can be maximized.

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