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Hospitals may buckle under 'tsunami' of patients

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Health systems are treating sicker patients, straining already full emergency departments and inpatient units.

Many health systems are struggling to keep up with the increasingly complex healthcare needs of an aging population, leading to overcrowded emergency rooms and delays in care. Providers are ramping up strategies to treat patients more efficiently and keep those who aren't as sick out of emergency departments. These strategies are critical as capacity wanes and providers face a potential decline in federal healthcare funding, executives said.

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Health systems are revamping patient admission and discharge processes; bolstering virtual, home and urgent care offerings; expanding clinician recruitment efforts and adding observation beds. But providers are concerned they won't be able to act quickly enough to meet the growing demand for care.

“We are overrun,” Anthony Stahl, president of Silver Spring, Maryland-based White Oak Medical Center, said. “It’s like a tsunami hitting our front door.”

Executives at Fairview Health Services, Scripps Health, Vanderbilt Health, UVA Health, Northwell Health, Advocate Health, Adventist HealthCare, Cleveland Clinic and Endeavor Health said their inpatient facilities were at, near or over capacity. The patients they treat are increasingly sicker, and many are using the emergency room to access care, they said.

There are days where White Oak Medical Center has around 40 patients admitted to its emergency department but no available inpatient beds, Stahl said. The hospital has been at 102% capacity and emergency department visits have increased 25% since it opened in 2019. The facility is on diversion — meaning the emergency department must turn away ambulances — about 70% of the time, he said.

Systems expect the pressure on emergency departments and inpatient capacity to increase.

Executives are concerned Medicaid cuts Republicans are considering could increase the number of uninsured patients. People with limited insurance coverage or none at all tend to go to the emergency department more than those with more substantial coverage, potentially leading to unnecessary and costly procedures.

Decreases in insurance coverage may also lead to more complicated and advanced illnesses as patients forgo earlier care.

“If you are uninsured, you’ll likely go through the emergency department, which is not designed for that,” Dr. Ghazala Sharieff, chief medical and operations officer of Scripps Health, said. “But patients don’t have a choice because they can’t go to the primary care physician, and the federally qualified health centers are packed, too. These people who are really sick come to the [emergency department], and we have to find a way to admit them and get them the services they need.”

Emergency department volumes are rising as the population grows in metro areas and patients resume care after delaying treatment during the COVID-19 pandemic. For instance, San Diego-based Scripps saw emergency department volumes increase 6.1% over the past year, Sharieff said.

Similarly, Northwell Health experienced a 3% increase in emergency department visits over the past year, Dr. John D'Angelo, chief of integrated operations for the New Hyde Park, New York-based health system, said.

Health systems want to change that trajectory by keeping healthier patients out of the emergency room.

Scripps consolidated one of its obstetric units and leased beds at a skilled nursing facility to use to accommodate additional patients, Sharieff said. The health system is also expanding its HealthExpress network of urgent care clinics to try to keep those whose conditions aren't as severe out of the emergency department, she said.

Adventist HealthCare, the Gaithersburg, Maryland-based system that operates White Oak Medical Center, has what it calls the U-Turn program. The program aims to connect nurses, social workers and community health workers to emergency department patients that have non-urgent ailments and help them access home care and community resources.

Health systems are also expanding inpatient, ambulatory and observation care units to try to keep pace with rising patient volumes.

In November, Vanderbilt University Hospital opened a 38-bed inpatient unit and it was immediately full. The hospital will open addition 30-bed inpatient units later this year, said Lee Ann Liska, chief operating officer and president of the Nashville, Tennessee, hospital, said.

“We might see some relief when more units open, but I predict they will be full,” she said.

UVA Health is also adding more inpatient beds. The Charlottesville, Virginia-based academic system is finalizing architectural plans for a three-floor expansion of its bed tower, UVA Health CEO Dr. Craig Kent said. Two floors will have close to 60 inpatient beds, including one focused on cancer care. The third floor will be a roughly 50-bed neonatal intensive care unit.

UVA Health is also considering converting a long-term care facility that closed during the COVID pandemic to a 50-bed inpatient unit that will take care of lower acuity patients, he said.

“Despite our growth, we are still falling behind,” Kent said.

Health systems are also looking outside of the hospital to ease capacity constraints, as well.

Charlotte, North Carolina-based Advocate, Cleveland Clinic and Minneapolis, Minnesota-based Fairview are expanding their **hospital-at-home programs**, which aim to provide hospital-level care where patients live. Roughly 150 health systems have secured a Medicare Acute Hospital Care At Home waiver, which **providers hope Congress will extend** beyond the March 31 expiration date.

A dozen hospitals across Advocate’s North Carolina division have **hospital-at-home services**, treating about 90 patients per day. Early results show home hospital care has led to fewer readmissions and higher patient satisfaction than treatment in inpatient settings, Dr. Daniel Davis, senior medical director at Advocate, said. The health system plans to expand the program to its Midwest service area, he said.

“Hospital at home is a key component of our capacity decompression strategy,” Davis said. “We certainly have to increase our bed capacity in all our markets as time goes on given the aging population and increasing demand for hospital beds.”

Cleveland Clinic is screening patients in the emergency department with issues such as chronic obstructive pulmonary disease and diabetes to see if they'd be good candidates for its hospital-at-home program. The health system, which has implemented the program in five of its Florida hospitals, looks to expand hospital-at-home services to northeast Ohio by the year's end, Dr. Raed Dweik, chief of Cleveland Clinic's Integrated Hospital Care Institute, said.

Fairview, which has a home infusion program for patients with autoimmune diseases, will also focus on growing its hospital-at-home program this year, Jeoff Will, the system's chief operating officer, said.

In addition, Fairview is one of many systems changing its emergency department intake process to try to free up capacity by sending some patients home without being admitted to the inpatient unit. Emergency department clinicians are triaging patients in the lobby, where they can order labs, imaging and diagnostics, so low-acuity patients can either be sent home with a prescription or admitted as short-stay observation patients, Will said.

“Emergency department utilization is higher than I have ever seen it,” he said. Will likened day-to-day operations to air traffic control, trying to direct a constant stream of emergency department patients and inpatient transfers.

Hospitals cannot solve capacity issues on their own, executives said.

Northwell is working more closely with federally qualified health centers, skilled nursing facilities and post-acute providers to try to streamline the discharge process. The health system also set up a command center that has expedited the discharge process by better coordinating environmental services workers and other staff, D'Angelo said.

In addition, Northwell set up a centralized team to manage insurance authorization, and is working with an artificial intelligence-backed company to automate some of that work, he said.

“We’re now putting resources at the point of the acute care discharge process to do a warm handoff,” D'Angelo said. Many health systems emphasized the importance of transitions from inpatient facilities to post-acute providers.

Organizations that own post-acute facilities or have strong relationships with post-acute providers tend to have lower lengths of stay and better operating margins than their peers without those assets or partnerships, Erik Swanson, senior vice president of data and analytics at consulting firm Kaufman Hall, said.

“The ability to do early and active discharge planning and placement of patients in the appropriate sites of care is critical, especially as the acuity of patients is going to rise,” he said.

Health systems — including Adventist HealthCare — need to ramp up these efforts to boost emergency department and inpatient capacity before the potential drop in federal Medicaid funding, Katie Eckert, senior vice president of strategic operations at Adventist HealthCare, said.

“It’s already a fragile system, so that would be very concerning as we look at the healthcare landscape," she said.