The ambulance diversion crisis appears to be easing. Part of the reason may be a
downtick in inpatient utilization. But hospitals’ efforts to improve patient flow
apparently also have made a difference, a new report finds.

One strategy hospitals have shied away from is smoothing the elective surgical schedule. Most have elected not to tackle the schedule even though research shows when surgery is done can make a big difference in the availability of beds.

Hospitals hesitate because they worry about reducing surgeons’ productivity, which might prompt them to take their business elsewhere, notes the Center for Studying Health System Change, a nonprofit organization.

In fact, hospitals are pursuing more elective surgery, especially high-margin procedures like heart surgery, to boost revenues and keep physicians from shifting this profitable business to ambulatory surgery centers and specialty hospitals, the center found. That is true even though heart surgery affects availability of critical care beds for emergencies.

The report is based on visits to 12 cities across the country where researchers conducted interviews and did other analysis.

Emergency department (ED) diversions stem primarily from a lack of intensive care and other beds, creating bottlenecks and forcing hospitals to delay emergency admissions and send ambulances to other hospitals.

Better management

Though many hospitals are expanding their EDs, better management of inpatient capacity seems to have been a critical factor in easing diversions, the report finds.

Strategies that have made a difference:

• Hospitals have redoubled their efforts to fill nursing vacancies, enabling them to keep more beds open. They are offering financial incentives and more flexible work schedules. They also have recruited foreign nurses and used agency personnel.

• To improve physician coverage in the ED, hospitals in 6 of the 12 communities have started paying certain medical specialties for on-call coverage and, in some cases, are paying physicians for care of uninsured patients.

• Many hospitals have appointed “bed czars” to expedite patient flow. Some have appointed senior physicians and nurses to lead efforts to speed patient discharges. They also have increased the number of observation beds, worked to make housekeeping more efficient, and added space for discharged patients to wait for rides home.

• Communities have improved communication among hospitals. Most of the communities had guidelines for how long ambulance diversions can last, the types of patients or conditions that are off limits to diversions, and the type of capacity limits that warrant diversions.

Impact of elective OR schedule

The impact of the elective surgical schedule on ambulance diversions has been documented by Eugene Litvak, PhD, and his colleagues at Boston University. They found the elective schedule puts more strain on the system than the random cases that arrive through the ED.

During a hospital’s busiest times, they found nearly 70% of diversions from the ICU were associated with variability in the scheduled surgical caseload—when elective surgery peaked, so did the diversions.

The study also found smoothing out the schedule actually enables surgeons to
get more work done and increase their revenue (Anesthesiology. June 2003;98:1491-1496; also November 2003 OR Manager).

But hospitals apparently are not eager to embrace this strategy, according to the center’s site visits.

**New JCAHO standard**

Meanwhile, the Joint Commission on Accreditation of Healthcare Organizations issued a new leadership standard (LD.3.11) for managing patient flow, which takes effect January 1, 2005. Though the standard originally was supposed to focus on ED overcrowding, hospitals protested they didn’t have control over all the factors that contribute to overcrowding.

The standard directs leaders to assess flow issues and plan to mitigate their impact. Among these issues are planning for care of patients who must be held in temporary locations such as the postanesthesia care unit or emergency department, as well as in overflow locations such as hallways.

Specific indicators to measure the patient flow process are to include:

- available bed space
- efficiency of patient care and treatment areas
- safety of patient care and treatment areas
- support-service processes that affect patient flow.

The indicators are to be available to the personnel accountable for patient flow. Perioperative services is not specifically mentioned, though leaders would likely be included in addressing patient flow issues.

*The report, entitled Emergency department diversions: Hospital and community strategies alleviate the crisis, is available at www.hschange.org*