There May Be No Room in the Inn, but the Innkeepers Sure Are Happy

Handel and McConnell,[1] in comparing hospital profitability during times of high ambulance diversion versus none, demonstrate the unsurprising conclusion that a full hospital enjoys greater profit than one less full. Given the perpetual myth of the emergency department (ED) as money loser, it is heartening to read that ED admissions yielded a higher per-patient profit than elective admissions. For this finding alone, this article should be kept in the ''key findings'' file of any ED director.

They compare their results to those expected from a hotel with all rooms booked. The hospital is, indeed, a special kind of hotel.[2] Should you wish to spend the night, room availability does not matter. You may be placed on a couch in the lobby, possibly paying the same rates as if you were in the presidential suite. However, there will be no cable TV or wet bar for you or, for that matter, a hot meal or private bathroom. There is not even an obligation on the part of the hotel that an exhaustive search for a room should occur before you are placed in the lobby. In this sense, the authors are entirely correct that there is currently no financial disincentive to a hospital operating at greater than 100% capacity or, for that matter, stacking up admissions in the ED.

There is a popular view that hospital administration (i.e., ''them''), in a Machiavellian fit of greed and disregard for patient safety, has created a system intent on maximizing profits. Furthermore, ED admissions are often considered less financially desirable.[3,4] In this view, ''they'' are perfectly content to have an ED full of boarded admissions. Although such a result may well be financially beneficial to the hospital, to say it was ''designed'' as such is to give credit where none is due. What we see is the result of an unanticipated evolution of both our patients' needs and what we can do to help, without concomitant evolution of when we can provide it. It should surprise no one that a system that provides a full solution 5 days a week cannot match a problem that occurs 7 days a week.[5] Ambulance diversion is but one of several examples of attempts to fit the patient to the system, rather than vice versa. In this relatively inflexible system, the ED serves as the primary point of flexibility. In effect, the ED we see today is precisely the result of a failure to design a rational system overall.

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History and first-hand experience readily confirm this. EDs were not first designed and then created. They came into existence almost as an afterthought, at a time in history when hospitals primarily cared for patients admitted on an elective basis. As EDs have evolved, design has always chased after them. Wherever flexibility was needed in the health care system, the ED, because of its ill-defined and evolving role, became the answer. The volume and the acuity always kept a step ahead of needed resources, space, and staff. Crowding, boarding, and ambulance diversion also came upon us without ''design'' and with a cacophony of competing reasons for their causes and cures. Because each of the various areas of the hospital was its own little world, an institutional perspective on the problem would not arise until emergency medicine as a specialty pushed for it, redefining and replacing the term ''ED crowding'' with ''hospital crowding.''

Ambulance diversion is one such example of an illusory solution to the problem of ED (or institutional) crowding. Diversion does not prevent arrival of patients by other means, nor does it prevent arrival of the most critically ill, who cannot be diverted a greater distance. Diversion is not an option if the hospital is the only one in the region. Even in regions with multiple hospitals, the usual case is for all hospitals to be at full capacity if one is. The belief that diversion provides relief to either the patient or the hospital is hopeful at best.[6] The only sustained impact that ambulance diversion has ever had is to divert the discussion away from real solutions to capacity problems. Does anyone care that this is dangerous?[7] In this author's view, ambulance diversion should be abandoned, save for fire, flood, or plague in the ED.

Ultimately, the hospital cannot provide needed services to patients without an adequate flow of funds, and funds flow more when the capacity is filled. Running at high capacity necessarily means that there will frequently be no inpatient bed for an admission. This is why an institutional perspective, and action, on this problem is so critical.

Boarding in the ED is not the best way to maximize the flow of either patients or funds. The literature is replete with evidence of patient harm resulting from ED boarding and includes medication errors and even increased mortality.[8,9] Boarding increases length of stay by about 1 day, and moving the patient to an inpatient area to a hallway or solarium until a bed becomes

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available reduces length of stay by 1 day.[10,11] This action in effect creates capacity. It also can substantially improve nurse to patient ratios and places the right nurse and right doctor at the bedside.

There is also good evidence that the skewed flow of elective, not emergency, admissions creates capacity issues. Smoothing out elective admissions, including surgical cases, can smooth the flow of patients through the hospital and improve capacity.[12]

Where does all of this lead? Hospitals must maximize capacity to sustain their financial health. Maximizing capacity regularly leads to overcapacity without some flexibility in the system. Unless we continue to endanger our patients by stacking up admissions in the ED, it is time that hospitals fully embrace practices that will enhance patient safety. Minimizing the times the system is over capacity (through smoothing of elective admissions, moving health care to a 7-day-a-week system, and redistributing patients in inpatient areas during times of boarding) will improve care and reduce length of stay. These are effective solutions that are not costly. They marry the financial needs of the institution with the welfare and safety of the patient. They require no new building, new beds, or new staff. They require leadership to make them happen. It should be clear by now that this leadership, which will require changing not the ED but the hospital institution as a whole, must come from within emergency medicine.

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