

Excess Hospitalization Days in an Academic Medical Center: Perceptions of Hospitalists and Discharge Planners

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Objective: To determine the frequency of and reasons for medically unnecessary hospital days.

Study Design: Prospective observational cohort study.

Methods: We developed an online survey to prospectively collect data on hospitalists' and discharge planners' perceived delays in treatment or discharge for patients on their general medicine services. Over a 2-month period, hospitalists and discharge planners completed a daily online survey.

Results: We collected data on 3574 patient-days from our hospitalists and data on 2502 patient-days from our discharge planners. Among the hospitalists' responses, 395 patient-days (11%) were thought to be unnecessary. Among the discharge planners' responses, only 186 patient-days (7%) were thought to be unnecessary. The hospitalists believed that the most common reason for discharge delay was lack of extended care facility availability (111 patient-days [28%]), followed by patient or family reasons (62 patient-days [15%]), procedure delays (62 patient-days [15%]), and test scheduling delays (52 patient-days [13%]). The discharge planners' data were similar.

Conclusions: More than 10% of hospital days were reported by our hospitalists to be unnecessary at this academic medical center. Major reasons were lack of extended care facility availability, patient or family reasons, procedure delays, and test scheduling delays. A simple survey instrument to assess perceived delays in the hospital may provide real-time information to initiate improvement changes to reduce excess hospitalization days.

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For author information and disclosures, see end of text.

Excess hospitalization days are of major concern to patients, payers, hospitals, and healthcare providers. Implications of excessive length of stay include the following: (1) greater costs, (2) potentially increased iatrogenic illness, and (3) high hospital occupancy with resultant loss of efficiency and access. To address these concerns, hospitals have developed support systems that include discharge planning services, home care services, and hospitalist services.

According to the Society of Hospital Medicine,¹ the hospitalist field has grown rapidly, with more than 30,000 hospitalists now in practice. At academic medical centers (AMCs) in particular, many programs have expanded to include the following 2 types of hospitalist services: (1) the traditional resident team (RT), where a hospitalist is the supervising attending physician, and (2) a non-house staff hospitalist team (HT), where the hospitalist works independently to provide direct patient care.² The growth of hospitalist programs in AMCs has been largely attributed to (1) offloading the volume of patients on RTs limited by work hour rules of the Accreditation Council on Graduate Medical Education and (2) filling an overall increasing demand for hospital care services.²⁻⁴

Previously, Selker et al⁵ published a study on the epidemiology of unnecessary hospital days in an AMC. Subsequent studies⁶⁻¹⁰ have measured and classified excess hospitalization days to assess the potential effect on healthcare systems. These studies found 10% to 20% of hospital days to be unnecessary. To determine the frequency of and most common reasons for delays on the general medicine services at our AMC, we asked our hospitalists and our discharge planners to complete a daily online survey. To our knowledge, this is the first study comparing the views of hospitalists (on RT and HT services) and of discharge planners on excess hospitalization days.

METHODS

Setting

Our hospital is a tertiary care AMC with more than 600 adult beds and 34,000 annual discharges. The 39 hospitalists in our group staff almost 10,000 total discharges.

Hospitalists serve as supervising attending physicians on RTs and see patients individually on HTs. Both teams provide hospital cov-

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verage 24 hours a day and 7 days a week. Each discharge planner works with 1 to 3 of these RT or HT services.

Survey

Using previously validated studies^{5,6} as guides, we developed a brief (<5 minute) on-line survey instrument that asked hospitalists and discharge planners whether any of their patients on the general medicine services experienced an excess hospitalization day. They could further categorize the delay as an intrahospital delay (related to an inhospital service not completed in a timely manner) or as a discharge day delay (prevented discharge of a patient who was otherwise medically ready for discharge). To facilitate completion of the voluntary surveys, we generalized the comprehensive categories of delay from previous studies to 4 intrahospital delay choices and 5 discharge day delay choices. The respondents were restricted to a single response choice and could type in more detailed information as free text, or they could select “other” and write in a response. We identified the hospitalists and their respective discharge planners working on the day shift for each day of the survey from a prearranged work schedule and sent daily e-mail messages asking them to independently complete the surveys from August 6 to October 1, 2008. The survey is given in the [Appendix](#).

Statistical Analysis

The survey responses were the only data source utilized in analyzing our results. Descriptive statistics were used to assess the frequencies and categories of excess hospitalization days. χ^2 Analyses were used to assess unadjusted bivariate comparisons between groups of interest with respect to reasons for the excess hospitalization days. Two-tailed α was set at .05. All analyses were performed using commercially available statistical software (STATA/IC 10.0; StataCorp LP, College Station, Texas).

RESULTS

Hospitalists completed 65% of the potential total number of surveys, yielding data on 3574 patient-days, and discharge planners completed 63% of the potential total number of surveys, yielding data on 2502 patient-days. The hospitalists' data included 1632 patient-days from the RT services and 1942 patient-days from the HT services. Among all hospitalist' responses, 395 patient-days (11%) were believed to be unnecessary. The RT patients experienced 171 delay days (11%), while the HT patients experienced 224 delay days (12%). Further comparison between weekdays vs weekend

Take-Away Points

More than 10% of hospital days were reported to be unnecessary at this academic medical center.

- This figure is in alignment with previously reported studies.
- Hospitalists working independently or with house officers reported similar rates of excess hospitalization days.
- Because hospitals are employing more hospitalists, the use of a simple real-time data collection tool to identify the frequency of and reasons for excess hospitalization days may focus improvement efforts in these highly occupied organizations.

days between the RT and HT services revealed no significant differences. Among all discharge planners' responses, 186 patient-days (7%) were believed to be unnecessary, a statistically significant difference compared with the hospitalists' responses ($P < .01$).

Hospitalists' Data

Of 395 excess hospitalization days reported by our hospitalists, 224 (57%) were due to discharge day delays, and 171 (43%) were due to intrahospital delays. The most common reasons for excess hospitalization days were lack of extended care facility availability, patient or family reasons, procedure delays, and test scheduling delays. [Table 1](#) lists the most commonly selected categories of delay as reported by our hospitalists and our discharge planners.

Discharge Planners' Data

Of 186 excess hospitalization days reported by our discharge planners, 145 (78%) were due to discharge day delays, and 41 (22%) were due to intrahospital delays. The discharge planners generally agreed with the hospitalists' categorization of the most common reasons for excess hospitalization days ([Table 1](#)).

Specific Categories of Intrahospital Delays

As part of a postsurvey analysis of intrahospital delays, 2 hospitalist reviewers (ALH and RFP) manually reviewed each free-text response provided and totaled the number of days attributed to each type of delay ([Table 2](#)). From the hospitalists' perspectives, procedure delays accounted for most of the intrahospital delays, followed by consult delays. Among the procedure delays, radiology-related services accounted for more than half of the delay days. The discharge planners provided fewer specific reasons for delays but generally agreed with the hospitalists' views on intrahospital delays.

DISCUSSION

Hospitalists at our AMC perceived 11% excess hospitalization days, with no significant difference between the RT and

■ **Table 1.** Hospitalists' and Discharge Planners' Perceptions of Excess Hospitalization Days Listed by Type of Delay^a

Variable		Hospitalists		Discharge Planners		
Discharge Day Delays						
Type of Delay	No.	Discharge Day Delays, % (n = 224)	Total Delays, % (n = 395)	No.	Discharge Day Delays, % (n = 145)	Total Delays, % (n = 186)
ECF	111	49.6	28.1	69	47.6	37.1
Patient or family	62	27.7	15.7	45	31.0	24.2
Other	22	9.8	5.6	20	13.8	10.8
Discharge planning	18	8.0	4.6	8	5.5	4.3
Physician or nurse	11	4.9	2.8	3	2.1	1.6
Total	224	100.0	56.8	145	100.0	78.0
Intrahospital Delays						
Type of Delay	No.	Intrahospital Delays, % (n = 171)	Total Delays, % (n = 395)	No.	Intrahospital Delays, % (n = 41)	Total Delays, % (n = 186)
Procedure	62	36.3	15.7	21	51.2	11.3
Test scheduling	52	30.4	13.2	5	12.2	2.7
Physician consult	21	12.3	5.3	13	31.7	7.0
Test result	20	11.7	5.1	1	2.4	0.5
Other consult	13	7.6	3.3	1	2.4	0.5
Other	3	1.8	0.8	0	0	0
Total	171	100.1	43.4	41	99.9	22.0
ECF indicates extended care facility.						
^a Hospitalists believed that 57% of excess hospitalization days were due to discharge day delays, while discharge planners attributed 78% to this cause. Hospitalists believed that 43% of excess hospitalization days were due to intrahospital delays, while discharge planners attributed 22% to this cause.						

HT services. Our discharge planners perceived 7% excess hospitalization days. Both hospitalists and discharge planners identified the following categories of discharge delay to be the most common: (1) lack of extended care facility availability, (2) patient or family reasons, (3) procedure delays, and (4) test scheduling delays.

We note similar rates of excess hospitalization days across study locations and periods relative to previously published studies. Carey et al⁶ reported a 14% rate of unnecessary hospital days in their general medicine services over 2762 days, while Selker et al⁵ reported a 17% rate of unnecessary hospital days among general medicine and gastrointestinal patients over 7795 days. More recently, a study⁷ of hospitalized general pediatric patients identified 9% excess hospitalization days over 911 days.

The hospitalist movement represents a dramatic evolution in healthcare, with 30,000 hospitalists now in practice.¹ At most AMCs, where the house staff census remains fixed and the demand for hospital care increases, medicine hospitalist groups have expanded their presence to provide direct patient care.² Resident teams have maintained the tradi-

tional structure of attending, resident, interns, and students. Attending-only hospitalist teams can theoretically run “leaner,” with improvements in efficiencies and work flow. However, our study shows no difference in the number of excess hospitalization days between these 2 types of general medicine services. When the categories of delays were classified as intrahospital delays vs discharge day delays, the rates were again similar between the 2 types of hospitalist services (38% on RTs and 47% on HTs for intrahospital delays vs 62% on RTs and 53% on HTs for discharge day delays). Despite speculation that direct attending-level care by hospitalist teams could run more efficiently and result in fewer excess hospitalization days, further studies are needed to determine how hospitalists' daily work flow compares with that of house staff-run teams and whether these differences lead to greater efficiencies in patient care services. It may be that the lack of differences observed between the 2 types of hospitalist services in our facility reflects external factors beyond the control of primary hospitalists. As hospitals have engaged discharge planners, home care services, and hospitalists, the next logical approach may be to identify and work with specific hospital

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services such as stress tests, radiology studies, and gastrointestinal procedures, as well as to employ skilled nursing facilities to establish partnerships to expedite the transition of patients from the acute care facility. Providing real-time feedback to hospital administration and providers regarding specific reasons for excess hospitalization days may drive health system efficiency efforts to these selected areas identified by the hospitalists.

Our analysis also revealed that among the top perceived reasons for excess hospitalization days was patient or family unreadiness. For many patients, the course of a hospital stay can be an intense experience and require ongoing care as they transition out of the acute care setting. Early discharge initiatives can prepare patients and families for the discharge process.¹¹ Patients and their family members need to be engaged and actively involved in the discharge process, identifying needs and facilities even as early as at the time of admission.

Excess hospitalization days raise concerns for patient safety, quality, and efficiency, but also herald significant financial costs to the healthcare system as a whole. Extrapolating our data over a year's time yields 5500 excess hospitalization days (11% of 10,000 discharges staffed, with a mean length of stay of 5 days). Patients and healthcare practitioners and administrators should certainly appreciate the resultant cost burden. These resources could be better used to provide care to a broader patient population within the community.

Our study also included the perspectives of discharge planners, who work closely with our hospitalists, and found that the discharge planners perceived a lower rate of excess hospitalization days. Closer evaluation of the survey responses revealed that our discharge planners perceived that a greater percentage of delays occurred after patients were believed to be medically ready for

■ **Table 2.** Specific Reasons for Intrahospital Delays

Variable	No.
Procedure Delays, Including Scheduling (n = 133)	
Radiology (n = 66)	
Magnetic resonance imaging	29
Interventional radiology	21
Nuclear medicine	10
Computed tomographic radiology	3
Ultrasonography	2
Unspecified	1
Internal medicine procedure related (n = 29)	
Echocardiography	12
Endoscopy	6
Other gastrointestinal	3
Electrophysiological cardiology	3
Interventional cardiology	3
Bronchoscopy	1
Allergy desensitization	1
Surgical procedure related (n = 28)	
Orthopedic surgery	18
General surgery	6
Urology	3
Cardiothoracic surgery	1
Pathology (n = 10)	
Pathology	10
Consult Delays (n = 27)^a	
Internal medicine (n = 4)	
Cardiology	2
Gastrointestinal	1
Rheumatology	1
Surgery (n = 9)	
General surgery	3
Orthopedic surgery	2
Plastic surgery	2
Neurosurgery	1
Vascular surgery	1
Other (n = 14)	
Physical therapy	9
Wound care	3
Speech pathology	1
Nursing education	1

^aConsults are defined as a service providing an evaluation and management decision and not a procedure that was the result of a consult.

■ TRENDS FROM THE FIELD ■

discharge than our hospitalists (and vice versa, where the discharge planners thought that fewer delays were attributable to intrahospital delays compared with our hospitalists). Although we can only speculate as to the reasons for these differences in perception, we believe that contributing factors to this observation may include the following: (1) discharge planners, whose specialty is to primarily focus on the needs of patients after (or near the point where) they have been deemed ready for discharge, may have been biased to find more delays in this category, and (2) discharge planners in general do not review all the consultant records, nor do they speak with the diagnostic or therapeutic procedural departments to order tests or obtain results. Therefore, they may not always have had the information to determine if there was an intrahospital delay and could have underestimated this category of delays.

Ongoing quality improvement initiatives to reduce the number of excess hospitalization days are proposed. A simple data collection tool can help identify the most common reasons for excess hospitalization days on a real-time basis, which in turn can be used to deploy countermeasures with appropriate hospital-based specialists and staff. In our organization, we expect to further explore the intrahospital delays as characterized in Table 2. By implicating procedural services with the largest proportion of excess hospitalization days, valuable feedback can be provided to these departments to improve patient flow. Furthermore, although our data did not directly evaluate whether weekend services led to greater rates of excess hospitalization days, the literature suggests that weekend service restrictions may contribute to inappropriate delays and that weekend availability of services should continue to be monitored for perceived delays.¹⁰ This type of real-time information regarding specific hospital services may be helpful to hospital administration focusing on efficiency of clinical operations.

There are inherent limitations to our quality improvement survey. First, our data were collected from a single AMC, and the results may not be generalizable. Furthermore, given that our study population included patients admitted to the general medicine services, the results may not be applicable to other clinical services such as pediatrics and surgery. Second, we had less than 100% compliance with completion of the survey. In particular, if there was some sort of systematic lack of response in which some hospitalists may have responded to the survey at a much lower rate than other hospitalists, there may be overrepresentation or underrepresentation biases introduced within the results. Because we collected data on more than 3500 patient-days from our hospitalists and more than 2500 patient-days from our discharge planners, we believe that the data are fairly representative of our AMC during the study period. Third, we identified a difference in

the perception of excess hospitalization days between the hospitalists vs the discharge planners. This could be attributed to our survey process in which discharge planners did not complete surveys on weekends, and review of the data showed that some discharge planners reported an unspecified number of multiple delay days. Given the lack of clarity, we input these data points as a single delay day, which may have underestimated some of the discharge planners' perceptions. Fourth, weekend days may be times of reduced efficiency, with at least 1 study¹⁰ noting resultant excess hospitalization days on weekends, and there are likely other forces (such as staffing and hours of operation) that can lead to excess hospitalization days for a hospital. Fifth, given that our survey allowed for respondents to select only a single response, it is unclear how respondents may have dealt with competing reasons for a discharge delay, which in turn may have affected some of our categorization of results. Furthermore, because the primary intent of our evaluation was to determine the frequency of delay, we did not ask our discharge planners or our hospitalists to include patient-specific information, and we were unable to perform any sort of interrater comparative statistical analysis.

In conclusion, more than 10% of hospital days on the general medicine services were found to be unnecessary at our AMC. A simple-to-use data collection survey can help staff recognize excessive hospitalization days in real time and quickly identify the reasons for delay. Hospitalists could work cooperatively with discharge planners to gather data prospectively and report their findings on causes of delay. This may be relevant to hospitalist groups, who care for an increasing proportion of inpatients. Moreover, such data should be of interest to hospital administrators, as well as to payers of this nation's increasingly costly inpatient care.

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■ **Appendix**

Survey content and screen shots of the excess hospitalization days survey that was used to ask hospitalists and discharge planners if their patients experienced a discharge day delay or an intrahospital delay. Page 1 contains introductory information and instructions for the survey. Page 2 asks for background information. Pages 3 and 4 ask about the categories of excess hospitalization days that the respondents believed their patients experienced.

PAGE 1 of Survey:

Introduction/Instruction:

Dear colleagues,

As you know, despite everyone's best efforts and intentions to help our patients receive appropriate and efficient care in the hospital to discharge, there are various reasons that lead to a delay in discharge, or a delay in their in-hospital stay. We would like to solicit your expert opinions on your patients.

The basic premise is as follows: There are essentially 2 main categories that can lead to a delay in discharge or a delay in their in-hospital stay which leads to an inability to get the patient ready for discharge.

- 1) The patient is medically stable for discharge, but there was a barrier to discharge.
- 2) The patient needs certain in-hospital interventions in order to get the patient ready for discharge, but these services for some reason were delayed.

Knowing what you know THIS MORNING, think about your patients on your service today from YESTERDAY'S view.

Do you believe that your patients experienced a delay in discharge (as they were medically stable yesterday); or that an in-hospital service was delayed beyond what you'd consider reasonable.

If so, please write down the reason from the choices given in the following pages 3 and 4.

Page 2 is demographic information about you, the date, and number of patients, and should be filled out every day.

As you are filling out the survey each day, please keep the following in mind to help guide you.

- We are asking for your independent assessment, and thus your answers should be determined before you round with your discharge planner/physician. Please place this answer in the survey. Naturally, you will likely discuss this in your discharge rounds, but please do not let this "change your mind" in filling out the survey.
- Remember, this is asking you for your expert opinions, and thus there is no right or wrong answer.
- If you are not sure if your patient experienced a delay (and the reason may fall in a "gray zone"), be conservative about your answer, and give "them" the benefit of doubt, and DO NOT count that as a delay.
- Although you will count "new" patients toward your entire patient census for today, you will not be able to comment on whether these new patients had a delay until they have had 1 full day of hospitalization.
- Thus, you will not be able to comment on whether patients should or should not have been admitted.
- But, if that patient stays beyond a day, then you should be able to start commenting on reasons for delay.
- As a suggestion, having a list of your patients in front of you to answer these questions will be very helpful.

Thank you very much for your help in collecting this important information for our patients, for our hospitalist group, and for our health system. We want to make this as easy on you as possible, so if you have any questions or suggestions, please feel free to email or page us at any time.

PAGE 2 of Survey:

Daily Background Information:

1. Please state your name.
2. What is today's date?
3. What is the day of the week today (the day for which you are completing the survey)?
4. What is the name of your service, and How many patients were on your service today?
5. Knowing what you know about your patients TODAY (this morning), and thinking about this from YESTERDAY'S PERSPECTIVE, how many of your patients experienced a delay to discharge or a delay of a day due to in-hospital services unable to be done in a "reasonable" time period?

PAGE 3 of Survey:

Discharge Delay--Hospitalists [Exit this survey](#)
3. Reasons for discharge delay--patient was medically ready yesterday:

The patient was medically stable for discharge, but there was a barrier to discharge yesterday. For EACH of your patients that you feel experienced this yesterday please check the most appropriate explanation, and briefly comment on the specifics.

1. For patient 1: check the most appropriate, and in comment box: write in patient's initials and brief explanation specifying reason for delay.

	Delays related to patient or family (e.g. patient is undecided about therapy or disposition location, or family is unavailable to meet for decision making)	Delays related to primary physician or nursing team (e.g. physicians rotating teams and feels differently about discharging, work overloaded, so unable to get to patient's case to discharge)	Delays related to discharge planning (discharge decision is made late in day and discharge preparations can not be made that day, or special home services could not be arranged)	Delays related to availability of outside care facilities (e.g. rehab bed, psych bed, other ECF bed)	Other reason not specified here
Patient 1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patient's Initial, and Brief explanation specifying delay					

PAGE 4 of Survey:

Discharge Delay--Hospitalists [Exit this survey](#)
4. A delay with in-hospital services beyond what's considered reasonable:

The patient needs certain in-hospital interventions in order to get the patient ready for discharge, but these services for some reason was delayed. Knowing what you know this morning, for EACH of your patients that you feel experienced a delay of this type YESTERDAY, please check the most appropriate explanation, and briefly comment on the specifics.

1. For patient 1: check the most appropriate, and in comment box: write in patient's initials and brief explanation specifying reason for delay.

	Delays related to test scheduling (e.g. inability to get on a busy schedule, or obtain a test due to unavailability in a weekend or no staff)	Delays related to obtaining test RESULTS (e.g. test result not available within a standard turnaround time, or are not received in a timely manner)	Delays related to procedures (e.g. surgery not done due to OR or surgeon availability, or procedure such as biopsy, GI study, IR, pulm study, cardiology study, etc...)	Delays related to medical consultation (consult not available on day, or not done within a standard time)	Delays related to other consult services not being available on day or not done within a standard time (e.g. PT, Speech path, OT, SW, etc...)	Other Reasons (not mentioned here)
Patient 1	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patient's Initial, and Brief explanation specifying delay						