

The critical balance: How hospital medicine aligns patient acuity and system capacity to protect access to care



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Executive summary

American hospitals face an unprecedented convergence of crises that threatens the very foundation of patient access to care. Hospital occupancy rates have surged to 75%—a dramatic 11-percentage-point increase from pre-pandemic levels—and are projected to reach a critical 85% threshold by 2032 without intervention.^[1] At the same time, observation patient volumes continue to rise year over year while inpatient days decline, creating operational complexity without adequate infrastructure or standardized care pathways.^[2] The nursing workforce crisis has become so severe that, for the first time, The Joint Commission has introduced nurse staffing ratios as a National Patient Safety Goal beginning in 2026.^[3]

These challenges are not isolated problems—they are interconnected symptoms of a health care system struggling to balance two fundamental imperatives: acuity management and capacity management. Hospital medicine, born nearly three decades ago to address these pressures, now has the opportunity to reaffirm its founding purpose as the "quarterback of inpatient care" and lead health systems through this transformation.

The solution lies in hospital medicine's unique position to orchestrate the strategic balance between managing patient acuity and optimizing system capacity. Hospitalists can transform these converging crises into an opportunity by strategic and practical integration of three approaches:

1. Length-of-stay optimization that creates "virtual capacity"
2. Standardized observation medicine pathways that reduce care variation while improving patient throughput
3. Strategic workforce deployment that aligns patient needs with clinician skillsets and scopes of practice

This white paper examines how improved acuity management drives optimized capacity management, and vice versa, creating a virtuous cycle that improves patient access, enhances quality outcomes, and ensures financial sustainability. The window for strategic action is closing rapidly, and health systems that empower hospital medicine to lead this transformation today will be positioned to thrive in the face of such adversity.

1 | The perfect storm: Three converging crises

Hospital leaders today confront three interconnected pressures that collectively threaten sustainable care delivery. Each crisis amplifies the others, creating cascading effects throughout the health care continuum—from high volume and acuity that result in long waits in emergency departments and strain inpatient capacity, to overloaded ancillary services unable to provide timely diagnostics, to clinical teams stretched beyond sustainable levels. Understanding these pressures and their interconnections is the first step toward developing integrated solutions.



Crisis 1: The capacity crunch

U.S. hospitals currently operate, on average, at 75% capacity, up from 64% in the decade before the COVID-19 pandemic—an 11-percentage-point increase that represents not a temporary surge but a new baseline.^[4] This increased occupancy is driven primarily by the effective loss of 128,000 staffed hospital beds (equivalent to losing 160 average-sized hospitals) rather than by increased hospitalizations, which have remained relatively stable.^[5]

If hospitalization rates and staffed bed supply trajectories remain unchanged, average national hospital occupancy could reach 85% by 2032.^[6] And an aging U.S. population will require an estimated 4 million additional hospitalizations annually by 2035.^[7]

Dr. Richard Leuchter, assistant professor of medicine at UCLA and lead author of the capacity study, warns that "if the U.S. were to sustain a national hospital occupancy of 85% or greater, it is likely that we would see tens to hundreds of thousands of excess American deaths each year."^[8]

Crisis 2: The observation status surge

Observation patient census has been increasing year over year, fundamentally altering the composition of hospital populations. From 2019 to 2024, for example, Medicare Advantage average observation length of stay grew substantially while reimbursement for those patients fell 8.8%—meaning hospitals care for observation patients longer while receiving less payment. In fact, hospitals received only 49% reimbursement of actual costs for observation status patients in 2024.^[9]

Without clear criteria for observation versus inpatient determination, standardized care pathways specific to observation patients, and proper status attribution from admission, hospitals struggle to appropriately deploy resources, manage length of stay, and ensure quality outcomes.

Crisis 3: The workforce shortage

The Health Resources and Services Administration projects a shortage of 187,130 physicians across 31 of 35 specialties by 2037, while over 138,000 nurses have already exited the workforce since 2022—creating an unprecedented staffing crisis that threatens every dimension of hospital operations.^[10]

The physician and nursing workforce crisis extends beyond supply and demand. It's about strategic resource allocation, deployment effectiveness, and sustainable practice models, and intersects directly with capacity management. Understaffed units cannot safely care for additional patients, effectively reducing hospital capacity even when physical beds exist.

Moreover, the traditional approach of uniform staffing models fails to account for the heterogeneity of hospital patient populations. Without strategic deployment that matches workforce capabilities to patient needs, hospitals waste scarce resources while simultaneously delivering suboptimal care.

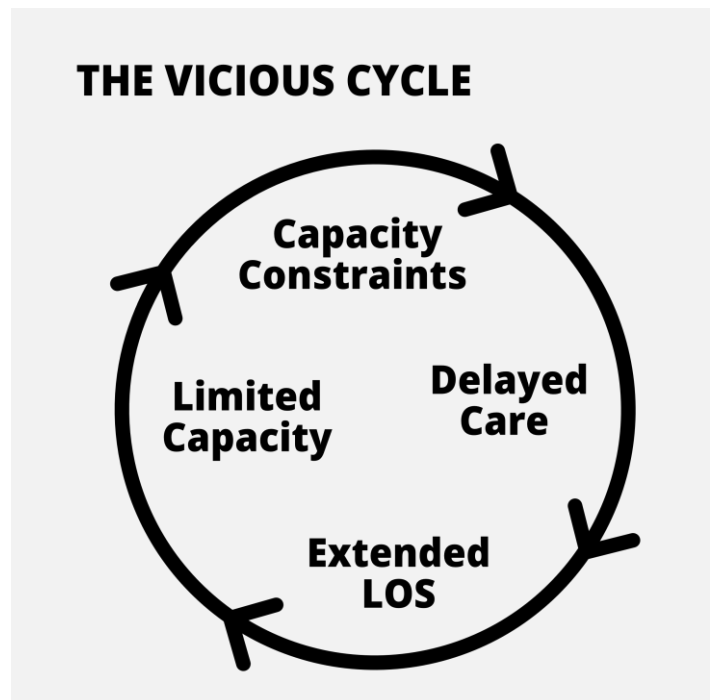
The interconnected nature of these crises

These three crises reinforce and amplify each other in a vicious cycle many hospitals currently experience: Capacity constraints force longer ED wait times, ED boarding, and patient holds. Long waits delay care. Delayed care leads to increased morbidity and mortality. Increased morbidity extends length of stay. Extended length of stay further constrains capacity. Limited capacity forces patient transfers and longer ED wait times.

The cycle continues and the human costs are profound. Patients experience delayed treatments, increased risk of hospital-acquired conditions, and separation from family support systems when transferred to distant facilities. Clinicians face frustration from being unable to provide the care they know patients need. Health systems absorb financial losses while struggling to maintain quality and safety standards.

This interconnected crisis demands a comprehensive solution—one that addresses capacity, observation medicine dynamics, and workforce challenges simultaneously rather than sequentially. Hospital medicine, uniquely positioned at the intersection of these pressures, can provide this integrated leadership.

Since its founding in 1996, hospital medicine has served as the “[quarterback of inpatient care](#).” Yet over nearly three decades, the specialty has gradually drifted from its mission, focusing on managing complex medical conditions while ceding coordination responsibilities. The current crisis presents both an opportunity and an imperative for hospitalists to reaffirm their role, leveraging their daily bedside presence, operational understanding, and clinical credibility to lead health systems through transformation.



2 | The strategic balance: Acuity management and capacity management

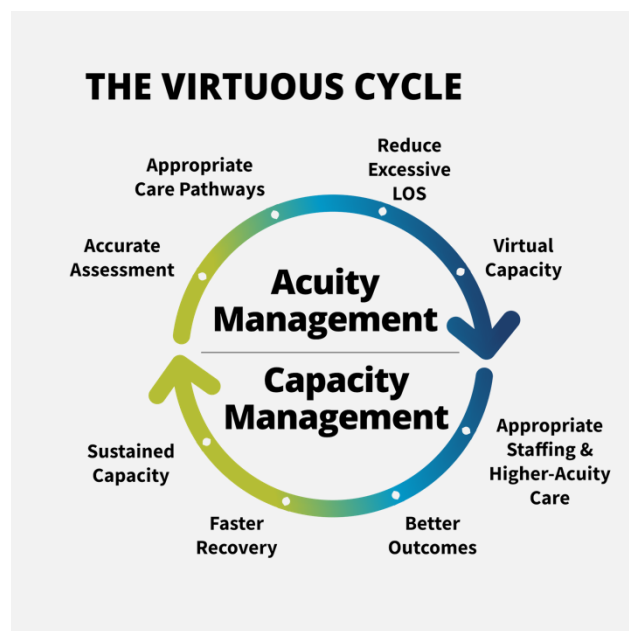
To address the converging crises, we must understand that hospital medicine operates at the intersection of two fundamental imperatives: acuity management and capacity management. These represent the strategic framework through which hospitalists can transform current challenges into sustainable solutions.

Acuity management involves matching clinical resources—including clinician expertise, time investment, and service intensity—to patient needs based on severity of illness and care complexity. It answers the question: *Who needs what level of care, and how do we ensure they receive it?*

Capacity management focuses on optimizing patient flow, throughput efficiency, and resource utilization to maximize the number of patients who can access needed care. It answers the question: *How do we create sustainable capacity while maintaining or improving quality outcomes?*

The critical insight is that these two imperatives are not competing priorities—they are mutually synergistic. **Better acuity management drives better capacity management, and vice versa, creating a virtuous cycle that improves access to care and benefits patients, clinicians, and health systems alike.**

Accurate acuity assessment leads to appropriate pathways. Appropriate clinical pathways reduce excessive length of stay. Reduced length of stay creates capacity. Available capacity allows hospitals to maintain appropriate staffing ratios and accept higher-acuity patients. Higher-acuity patients receive focused resources from appropriately skilled clinicians working under sustainable conditions. Better care leads to better outcomes and faster recovery. Faster recovery feeds back into reduced length of stay and continued capacity creation. A virtuous cycle.



Breaking the vicious cycle and establishing the virtuous one requires leadership—specifically, hospital medicine leadership that can orchestrate the balance between acuity and capacity across the three key domains where these pressures converge: length of stay optimization, observation medicine standardization, and strategic workforce deployment.

3 | Three strategic pillars for hospital medicine leadership

Hospital medicine can orchestrate the balance between acuity and capacity management through three integrated strategic approaches. Each pillar addresses one of the converging crises while reinforcing the others, creating a comprehensive solution to sustainable care delivery.

Pillar 1: Creating virtual capacity through length of stay optimization

Length of stay optimization represents the most direct pathway to virtual capacity creation. When hospitals reduce average length of stay while maintaining or improving quality outcomes, they effectively create "virtual beds"—additional capacity without construction costs, additional staffing requirements, or years of planning.

The mathematics are compelling. Consider for example a 500-bed hospital with 400 average daily census and an average length of stay of 5 days. The hospital admits approximately 29,200 patients annually. Reducing length of stay by half a day (10%) creates capacity for approximately 2,920 additional admissions per year—the equivalent of 40 virtual beds operating year-round.

Meanwhile, the evidence corroborates hospital medicine teams' ability to deliver these results.

Programs implementing hospitalist-led clinical models have achieved average length of stay reductions of 0.5 days within 6-12 months of implementation, with some programs showing even greater and faster improvements.^[12] Critically, these improvements have a positive impact on quality of care delivery. Readmission rates remain stable or improve, patient satisfaction increases, and other quality metrics trend positively.

Consider the patient impact: Every unnecessary day a patient spends in the hospital increases their risk of infection, delirium, deconditioning, and other adverse events. Shorter stays that maintain quality represent better care, not compromised care.

However, length of stay optimization requires sophisticated clinical leadership. Blind reduction targets risk compromising care quality, leading to premature discharges and increased readmissions. Hospital medicine's role is to identify truly avoidable days—delays caused by inefficient processes, poor coordination, or system failures—while maintaining appropriate length of stay for patients' acute clinical needs.

This requires hospitalists to lead the implementation of evidence-based practices including twice-daily interdisciplinary rounds with clear discharge planning, early discharge orders placed at bedside during morning rounds, proactive identification and escalation of discharge barriers, standardized care pathways that reduce practice variation, and robust post-discharge support to prevent avoidable readmissions.

The key metric is not length of stay alone, but length of stay paired with readmission rates and quality outcomes. When these three indicators move in the right direction simultaneously—reduced length of stay, stable or declining readmissions, improving quality—health systems know they are achieving true optimization rather than simply shifting the cost of care.

Pillar 2: Observation medicine standardization

With observation volumes growing year over year and Medicare Advantage plans historically using observation stays more frequently than Traditional Medicare, hospitals need standardized observation medicine models that provide clarity, efficiency, and quality.

The current state leaves much to be desired. Many hospitals lack clear admission criteria distinguishing observation from inpatient status. Observation patients may spend days in limbo without defined care pathways or discharge planning. The absence of standardization creates wide practice variation, with similar-acuity patients experiencing vastly different levels of care and lengths of hospital stay.

Standardized observation medicine clinical models require several key components.

1. **Clear admission criteria** help clinicians accurately determine at the point of admission whether a patient should follow an observation or inpatient pathway. The [Two-Midnight Rule](#) provides one framework: observation status is appropriate if discharge is expected before the second midnight of hospital stay, and the medical record supports this reasonable expectation at the time of admission.
2. **Condition-specific observation pathways** create efficiency. Common conditions like chest pain, syncope, mild heart failure or COPD exacerbation, pneumonia, and uncomplicated infections follow protocols that standardize diagnostic workup, treatment, and discharge criteria. These pathways reduce care variation, accelerate decision-making, and improve throughput.
3. **Dedicated observation units and clinicians** enhance care quality. These units provide workspace adjacent to patients, specialized training for all unit staff, and daily coordination between hospitalists, nursing, and case management. When dedicated units are not feasible, hospitals should implement at minimum a prioritization system that ensures observation patients receive early-morning rounds and focused discharge planning.
4. **Clear conversion criteria** guide decisions about when observation patients require inpatient admission. Clinical documentation must demonstrate medical necessity, explain why inpatient care is needed, detail why lower levels of care are insufficient, and address severity of illness, service intensity, and mortality risk. Common scenarios triggering conversion include increased oxygen requirements, hemodynamic instability, and acute clinical deterioration.

The goal is to ensure patients receive the appropriate level of care based on their clinical condition while facilitating efficient throughput. When done well, observation medicine creates capacity by moving lower-acuity patients through the care continuum efficiently, reserves inpatient resources for higher-acuity cases, and deploys the clinical workforce strategically based on patient needs.

Pillar 3: Matching skillsets to needs with strategic workforce deployment

As hospital patient populations become increasingly stratified by acuity, workforce models must evolve accordingly. Strategically aligning clinician skillsets and scopes of practice to patient needs addresses staffing shortages not by producing more clinicians but by using the existing workforce more effectively and efficiently.

The traditional model, where all hospitalists manage similar patient panels regardless of acuity mix, fails to optimize either clinical outcomes or workforce sustainability. This approach overburdens

physicians with high volumes of lower-acuity patients while underutilizing [nurse practitioner \(NP\)](#) and [physician assistant \(PA\)](#) capabilities.

Conversely, strategically deploying a balanced clinician mix in highly collaborative, physician-led care teams, and integrating virtual care creates several benefits:

- **Optimizing physician productivity** by focusing their expertise where it provides greatest value
- **Expanding patients' access to care** by utilizing NPs, PAs, and virtual care platforms
- **Improving job satisfaction** across clinicians and nurses
- **Creating workforce sustainability** by preventing clinician and nurse burnout

Success hinges on a clear infrastructure of detailed protocols, comprehensive onboarding programs, and effective communication systems.

Aligning workforce to patient acuity

Strategic workforce deployment begins with the observation medicine framework. As observation volumes grow and lower-acuity patients increasingly follow observation pathways, hospitals can deploy NPs and PAs as primary clinicians for this patient population, working in close collaboration with physician hospitalists who provide consultation, oversight, and support.

This approach allows physicians to dedicate more clinical time to higher-acuity inpatients whose complex conditions, multiple comorbidities, and higher risk of decompensation require more complex medical decision-making. Meanwhile, observation patients benefit from the excellent care that well-trained and well-supported NPs and PAs deliver.

The natural stratification creates an opportunity to deploy the entire inpatient care team more strategically. When observation pathways are standardized, and acuity levels are clearly defined, nursing staff can also more effectively allocate their time and expertise. Matching clinical and nursing intensity to patient needs reduces the burdens that contribute to burnout and turnover, while enabling appropriate staffing ratios, including those The Joint Commission now monitors as a patient safety measure.^[11]

To be effective, this model must allow clinicians – physicians, NPs, and PAs – to embrace their roles on highly collaborative, physician-led teams. It is also critical for clinician teams to seamlessly integrate with nursing teams through structured interdisciplinary rounds, clear communication protocols, and collaborative care planning.

Virtual care integration

Virtual care platforms—including [telemedicine](#) and [remote monitoring](#)—can also provide crucial support. Virtual hospitalists can provide nighttime coverage, surge support, and cross-coverage duties, reducing the burden on on-site care teams. Telemedicine extends care access to rural and underserved markets where recruiting clinicians to work on-site proves challenging. Remote monitoring enables earlier identification of clinical deterioration, potentially preventing ICU transfers and improving outcomes.

4 | The integrated approach: Greater than the sum of its parts

While each pillar delivers value independently, their true power emerges through integration. Length of stay optimization leverages observation medicine standardization by identifying which patients can be safely managed on expedited pathways. Observation medicine clinical models clarify and guide workforce deployment by distinguishing patient populations with different care needs. Strategic workforce deployment enables length of stay optimization by ensuring appropriate clinician involvement at appropriate times.

Consider how these pillars reinforce each other in practice:

A patient presents to the emergency department with chest pain. Using clear pathway criteria, the admitting hospitalist determines the patient is appropriate for observation status rather than inpatient admission. The patient enters a standardized chest pain observation pathway with protocol-driven care. A well-trained nurse practitioner serves as the primary clinician, following the pathway efficiently. Within 18 hours, the patient completes necessary diagnostics, receives appropriate treatment, and is safely discharged with primary care follow-up. A [follow-up program](#) sends automated text messages to check in with the patient post-discharge, ensuring they understand their care plan, have filled prescriptions, and have scheduled the recommended appointment—bridging the critical gap until primary care engagement is established.

The observation pathway reduced what might have been a 2-3 day stay to less than 24 hours. The patient received excellent care. One virtual bed was created. Access to care was secured.

Multiply this scenario across thousands of patients monthly, and the capacity implications become substantial. Multiply it across all three pillars—with length of stay optimization for inpatients, observation pathways for appropriate candidates, and strategic workforce deployment across both populations—and the transformation becomes system-wide.

Hospital medicine provides the essential leadership to orchestrate this integration. Hospitalists understand the clinical nuances that determine appropriate pathways. They have the operational knowledge to identify system barriers. They possess the peer credibility to drive practice changes. Most importantly, they have the daily presence and coordination capabilities to ensure these integrated approaches function smoothly in real-world practice.

5 | Evidence of success: Proof in performance

The strategies outlined in this white paper represent proven approaches already demonstrating results across multiple health systems. Hospital medicine programs implementing these integrated models consistently achieve:

- **Length of stay reductions averaging 1.1 days below national benchmarks** (3.6 days versus national average of 4.7 days).^[12]
- **All-cause readmission rates of 12.3%** compared to the national average of 14.6%, demonstrating that shorter stays improve rather than compromise quality.^[12]
- **Maintained or improved patient satisfaction scores**, with programs showing consistent increases in patient experience metrics as throughput improves.^[12]
- **Excellence in quality measures, with >98% MIPS performance** for both hospital medicine physicians and nurse practitioners/physician assistants.^[12]

These outcomes validate the central premise that better acuity management and more streamlined capacity management create a virtuous cycle that benefits all stakeholders. Patients receive high-quality care with shorter hospital stays and reduced complications. Clinicians work in more sustainable models with clearer role definitions. Health systems improve access while maintaining financial viability.

6 | Conclusion: The window for action is closing

American hospitals face a convergence of crises that will define health care delivery for the next decade. A dangerous hospital occupancy threshold of 85% is projected to be reached by 2032—less than seven years away. Observation volumes continue to increase without adequate infrastructure. The Joint Commission begins monitoring nurse staffing as a patient safety measure in 2026.^[13] These are not distant future concerns; they are present realities accelerating toward crisis.

If nothing changes, the consequences are clear and severe – for patients and health systems alike.

Patients will face:

- **Prolonged emergency department waits**, with some patients experiencing life-threatening delays
- Increased **adverse events** and **preventable mortality and morbidity** due to overcrowding
- **Transfers** away from local communities and family support systems
- **Reduced access** to specialty care when they need it most

Health systems will experience:

- **Cascading overcrowding** throughout the care continuum—from inpatient units to emergency departments to urgent care centers to primary care offices
- **Overloaded ancillary services** unable to provide timely imaging, laboratory, and pharmacy services
- **Clinical workforce stressed** beyond sustainable levels, accelerating turnover and shortages

Without hospital medicine leadership to balance acuity and capacity strategically, health care delivery approaches operational failure. These projections assume current trends continue—but as the right clinical intervention can change a patient's outcome, the right solution can change the trajectory.

The solution exists. Hospital medicine can and should orchestrate the integrated transformation health care systems need. The question is whether health care leaders will recognize this opportunity and provide hospital medicine with strategic support to lead this transformation.

Depending on their starting point, health systems can take the following actions:

Phase 1: Foundation building <i>(Immediate)</i>	• Elevate hospital medicine leadership: Empowers hospitalists to lead capacity planning and system transformation • Invest in standardized care pathways: Ensures consistent, evidence-based care delivery • Implement length of stay initiatives: Reduces avoidable delays while maintaining quality outcomes
Phase 2: Integration <i>(Short-term)</i>	• Deploy workforce strategically: Aligns clinician skillsets with patient acuity levels • Establish acuity-based nursing models: Matches nursing intensity to patient needs and reduce burnout • Enhance observation infrastructure: Streamlines patient flow and improve throughput efficiency
Phase 3: Sustained transformation <i>(Long-term)</i>	• Integrate virtual care platforms: Expands capacity and improves access through telemedicine • Align incentives with quality: Rewards operational excellence and quality outcomes • Nurture a culture of collaboration: Promotes interdisciplinary teamwork and shared goals

By following this phased roadmap, health systems can move beyond reactive crisis management to build a resilient, efficient, and patient-centered delivery system capable of meeting the challenges of tomorrow.

Hospital medicine stands ready, offering a brighter and more optimistic path. Through strategic balance of acuity management and capacity management, integrated across length-of-stay optimization, observation medicine standardization, and workforce deployment, health care can transform crisis into opportunity.

The time to act is now.

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