Crowded hospitals in Virginia have few open beds to offer the rush of patients

Sean Bennett started throwing up blood, so he went to the emergency room at LewisGale Hospital Montgomery near his home in Southwest Virginia. Bennett has dealt with prolonged liver disease for over a year, sending him to the hospital repeatedly.

A small community facility, LewisGale didn't have a gastrointestinal doctor available to treat his condition, an enlarging of the veins in his esophagus called esophageal varices. There wasn't a hospital with both a GI doctor and an available bed for 200 miles.

"They tried everywhere," said Bennett, 38.

So LewisGale staff put him in an ambulance and sent him 3½ hours east to Henrico Doctors' Hospital, which had a bed and a doctor.

But a few weeks later, in late summer, he was spitting up blood again, and he returned to LewisGale. This time, the closest available bed was 250 miles away at Reston Hospital Center. Doctors determined his condition was so urgent, they sent him there in a helicopter.

When he became ill for a third time, LewisGale put him back in a helicopter and flew him to Henrico Doctors', once again sending him across the state.

Six months after the nursing crisis began, omicron has brought the highest number of COVID-19 patients to Virginia hospitals, putting beds at a premium and patients with all types of ailments at risk.

Some patients, like Bennett, have been transferred hours away across the state. Others remain in hospitals ill-equipped to treat them. And others sit in emergency room beds — or chairs — waiting for an open bed upstairs.

Waiting diminishes the care the patients receive, and searching for open beds eats up the precious time of emergency room staff.

Last week, the state continued setting records for hospitalized COVID patients with more than 3,500 per day.

There were nearly 90,000 emergency room visits the first week of the year, 45% higher than before the pandemic began. The non-COVID patients are generally sicker than before.

Virginia Commonwealth University Health's downtown medical center "is seeing unprecedented demand for inpatient care," a spokesperson said.

As patients flood in, they are being treated by a smaller, weary medical workforce that lost 8,100 nurses nationwide in September alone.

This perfect storm represents a "failure of our bigger medical system as a whole," said Dr. David Fosnocht, head of Augusta Emergency Physicians in Augusta County.

Transferring patients

In the fall, a patient with a brain bleed arrived at an emergency room in eastern Virginia. Dr. Todd Parker, president-elect of the Virginia College of Emergency Physicians, determined the patient needed to be transferred to a larger hospital with an ICU.

Parker and his staff contacted 17 hospitals in five states but couldn't find an open bed. After 12 hours of searching, a bed became available in the same hospital system.

From his hospital in Hampton Roads, he has sent patients to University of Virginia Health, Duke Health and Inova Fairfax.

Before the pandemic, Fosnocht often transferred patients to Roanoke Carilion and UVA. Now, those hospitals are often full, sending him to look in all corners of the state. One night, he could find only one available intermediate-level bed — hospital beds are divided into categories based on severity of illness — in the entire state.

The longer a patient is in transit, the greater the risk, doctors say. Transferring critically ill patients to a new hospital often means taking them out of the hospital and putting them in an ambulance for an hourslong trip.

Transferring patients is labor intensive and takes a doctor's time away from other patients. Fosnocht carries a printed spreadsheet of 25 or so of the largest hospitals in the state. It's updated regularly to show which ones have the capacity for new patients. The open ones are highlighted.

To initiate a transfer, he calls the closest open hospital on the list. He usually starts with UVA — a 40-minute drive away — or Carilion Roanoke, which is 1½ hours away. When a hospital tells him it can't accept his patient, he moves down the list and expands his geographic circle.

If he can find a receiving hospital in 15 or 30 minutes, that's a success. The difficult transfers take hours.

For years, he never transferred patients to Inova Fairfax, which is more than two hours away. Now, he does so

routinely. Sometimes, he sends patients to Hampton Roads, some three hours away.

If no bed can be found, a patient might stay in a sub-optimal hospital. During one week in September, when the delta variant was at its worst, there were 27% fewer transfers than the same week in 2019.

If a patient can't be transferred, the hospital will hold them, hoping conditions don't worsen. If they don't worsen, sometimes the patient can be released. If they do worsen, the hospital will search for a transfer destination again, asking other facilities to make an exception for a serious condition.

Transferring a patient also raises the cost of the medical bill.

A 50-mile transport through the Richmond Ambulance Authority can cost $2,500.

And it occupies transport services. Augusta Health typically operates two ambulances of its own at a time, depending on staffing. If one ambulance is dispatched to Hampton Roads, half of the hospital's ambulance resources become tied up for more than six hours.

American Medical Response operates many of the inter-hospital transports in the area. A spokesperson for the company declined to comment.

'Boarding' in the ER

Sometimes a patient doesn't need to be transferred away, but the hospital doesn't have a bed to offer, either. So the hospital admits the patient but keeps them in the emergency room while waiting for a bed upstairs, a circumstance known as "boarding."

One day this winter, in a 50-bed emergency room in Hampton Roads, 36 beds held a patient boarding, Parker said. That creates a logjam, preventing the emergency room from seeing other sick people.

Recently, having 10 or 20 patients boarding in his ER is normal, Parker said. Long an issue in health care, boarding has been exacerbated by omicron and the nursing shortage.

Sometimes it takes two or three days for a bed to open up — maybe a patient's entire hospital stay.

"It's horrible," Fosnocht said. "It continues a downstream effect on quality and being able to take care of patients the way it really should be done."

While boarding, patients don't get the same level of care, the doctors said. The emergency room is chaotic, noisy and bright, and it's a hard place for patients to sleep. Instead of a dedicated nurse, staffers rotate in and out. The nurses are less familiar with the patient's medicine and treatment. The doctor in charge isn't down the hall — they are on another floor, maybe on another wing.

Those small details result in poorer care, Fosnocht said. Boarding is "a significant risk to morbidity and mortality every hour they're there."

When every room is full, patients may wait in chairs, be seen in the waiting room or get a bed in a hallway.

When an emergency room can accept no more patients, it gives itself a designation known as diversion, directing ambulances to go elsewhere. Diversion isn't unusual — one day last month, 12 hospitals in the region were simultaneously on some form of diversion, unable to accept certain patients based on their medical needs.

In less urban areas, hospitals can't go on diversion, because there are no other nearby facilities.

Lower staffing

Burnt out, nurses have left emergency rooms and intensive care units in droves. In Virginia, the workforce of about 100,000 nurses is probably 10% below what is needed, Kathy Baker, associate chief nurse for VCU Health, said in the summer.

The number of nurses employed can sometimes dictate the number of beds a hospital can keep open. At Augusta, fewer nurses have forced the hospital to operate about 25% fewer beds than ideal, Fosnocht said. The three major health systems in Richmond — VCU Health, Bon Secours and HCA — declined to say how many nurses they have lost this year and if they are staffing fewer beds.

The hospital's other option is to operate the same number of beds with fewer nurses, stretching their staff thinner, giving every nurse more patients to care for.

"There are just no options for nursing staffing right now," Fosnocht said. "It's a nationwide crisis, and it certainly is in Virginia and locally here as well."

Hospitals are left competing for scarce resources, squeezing their budgets to pay nurses more, even though they aren't receiving higher reimbursement from insurance companies.

In response to the surge and staffing shortage, then-Gov. Ralph Northam declared a limited state of emergency last week designed to allow hospitals to expand their staffing capacity.

Sometimes it’s easier to send a patient not to the hospital 30 minutes down the road but to the one three hours away. That’s what happened to Bennett.

A hospital will go to greater lengths to accept a patient already in the health system. Because large hospitals are already taking patients from smaller facilities in their own system, they often cannot accept patients from other systems.

When Bennett got sick and went to Montgomery LewisGale, he entered a facility owned by HCA Virginia Health System. Doctors sent him to two other HCA hospitals — Henrico Doctors’ and Reston Hospital Center. A spokesperson for HCA said doctors consider a patient’s needs, bed availability, the timeliness of the transfer and continuity of care to decide if the patient will stay in the system or leave it.

When Bennett arrived at Henrico, his gastrointestinal doctor recommended Bennett stop visiting LewisGale, because he’d keep getting transferred, Bennett said. The doctor recommended Carilion Roanoke Memorial Hospital, about a 40-minute drive from his home. It’s the largest hospital in the Carilion system, and it was unlikely Bennett would be transferred farther from home.

So Bennett started visiting Carilion, and he hasn’t been transferred since. But that doesn’t mean the care has been quick. Sometimes he has waited four or five hours before seeing a doctor.

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Virginia hospitals charge hundreds of dollars for this COVID drug, even though the government distributes it for free

In late 2021, the Food and Drug Administration approved a drug that protects immunocompromised patients from COVID-19 and succeeds where traditional vaccines had failed.

But there's a catch. Receiving the shot can cost more than $1,000, even though the federal government agreed to purchase more than a million shots and give them to hospitals for free.

Patients with immunocompromising conditions, such as organ transplants and cancer, often receive little or no boost from traditional vaccines. But a drug called Evusheld protects these patients from developing infection.

While healthy patients can receive COVID vaccines for free, Virginia Commonwealth University Health and University of Virginia Health charge more than $1,000 for the administration of Evusheld. What a patient actually pays out of pocket depends on insurance.

One organ transplant recipient who lives in Charlottesville got her shot at UVA. While her insurance covered most of the expense, she was left with a bill of $296.

These aren't one-time costs, either. The FDA recommends immunocompromised patients receive Evusheld every six months. The expense is likely a reason why so few immunocompromised people have taken the medicine, and that leaves them feeling neglected.

"It's been extremely frustrating," said a Southwest Virginia kidney transplant recipient. "Those who have chosen to fight for their survival have been forgotten and abandoned."

Hospitals aren't the only facility charging for it. The Virginia Cancer Institute in Mechanicsville charges an administrative

fee, but what a patient pays out of pocket depends on insurance, said Shonda Clements, a nurse there.

Stephanie DeNicola, 44, of Charlottesville is one of about 7 million Americans living with an immunocompromising condition.

She has rheumatoid arthritis, and her medication, methotrexate, acts like a chemotherapy, dampening her immune system. She's more susceptible to ordinary viruses and bacteria, such as E. coli, which she said almost killed her.

"Anything can kill me," DeNicola said. "COVID is just the latest thing that can kill me."

Vaccines have limited or no effect on her and, when she received her first COVID shot, her antibody level was one-one-thousandth that of a healthy recipient, she said. By the time she got her third shot, she had one-tenth as many antibodies as a healthy patient.

But Evusheld offered a glimmer of hope in a way vaccines had not. The AstraZeneca-made drug is a monoclonal antibody designed for people not infected with COVID who can't mount an adequate immune response. It received its emergency-use authorization in December and, in trials, it reduced the risk of COVID infection by 77%.

While health care facilities have plenty of shots, uptake has been low. Only 165,000 have been delivered as of last month, a Health and Human Services official said. Many people still don't know about the medicine.

Others are choosing to pay whatever it costs to gain protection. Leanne Cook, a resident of Orange County, Calif., said she paid $1,300 for Evusheld through her high-

deductible plan with Aetna. Her next dose is scheduled soon. Because she's already paid her out-of-pocket maximum, the next round should be free.

UVA Health doesn't charge for Evusheld itself, but it does charge to administer it, a process that includes monitoring the patient for an hour after injection. UVA charges insurance companies between $149 and $1,190.

Asked why UVA asks for so much, a spokesperson said the health system set the price based on administrative charges for similar medications. Administrative charges reflect substantial time for preparation, delivery and post-injection monitoring.

VCU's gross charge for Evusheld administration is $1,400, according to a spokesperson for the health system. A gross charge is the price before a hospital negotiates a lower rate with an insurer.

VCU Health aims to "lead the nation in quality, affordability and impact as a trusted and preferred academic health system," the spokesperson said. "As such, we are committed to empowering patients and their families to make informed decisions about their health care."

HCA Healthcare doesn't offer Evusheld, a spokesperson said. Bon Secours does not charge for it, a spokesperson for the health system said.

While the federal government decided health care facilities can't charge for COVID vaccine administration, it didn't make the same decree for Evusheld.

"It's outright discrimination that the immunocompromised are required to pay and those who are immunocompetent are not," said the Charlottesville woman who paid $296 for her

shot from UVA. The woman, who received a kidney transplant, requested anonymity because she fears speaking out could impact her ability to receive another kidney later in life.

The Southwest Virginia kidney recipient also opted to get Evusheld, even though he didn't know how much it would cost him until he got his bill. It felt like signing a blank check, he said. Ultimately, his insurance covered the entire cost. He also requested anonymity.

DeNicola didn't have to pay, either. Her Elevance Health (formerly Anthem) insurance plan covered the entire cost.

In Virginia, the state health department does not have the authority to set caps on administrative costs, a spokesperson for the department said. It doesn't monitor which facilities charge and which do not.

Immunocompromised people are essentially left to protect themselves, the Charlottesville woman said. At the very least, eliminating administrative fees for Evusheld would put "us on an even keel with everyone who's immunocompetent," she said.

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After 5 waves and a nursing shortage, VCU Health staffers brace for the pandemic's 3rd year

Dr. Renee Reid stepped into the Virginia Commonwealth University emergency room the day after Christmas, and the waiting room was packed. That week, the ER saw an average of 180 patients per day, almost double the volume a few weeks earlier.

Some had mild illness — runny nose and a headache. Others truly sick — coughing, short of breath and feeling feverish. But others weren't sick at all, in search of the rapid antigen tests that had sold out at drug stores.

The omicron variant had taken hold in Richmond, but this time working conditions had changed. Like hospital departments across the country, the emergency room nurses had lost full-time staff, with many tired and feeling undervalued during five waves of the pandemic. They were replaced by out-of-town nurses on short-term contracts.

The patients who came to the ER were sometimes unwilling to look beyond their own perspective. Some told Reid she "made up" their positive COVID-19 tests, despite obvious symptoms. Another sick patient said he didn't believe in vaccinations, so he requested monoclonal antibodies to cure him instead.

Now these health care staffers enter the pandemic's third year, and the nursing shortage persists. Cases in Virginia are low but have ticked upward in the past two weeks. One hundred fifty people were hospitalized for the virus this week. While the rest of the world seemingly moves on, Reid and other staffers worry another wave could arise.

"No one really cares" that doctors and nurses continue going to work, treating the ill, Reid said. "We don't really get to be normal."

Before the nursing shortage accelerated last summer, there were 81,000 full-time equivalent nurses in the state of Virginia, some full-time and some part-time. Not nearly enough, said Richard Ridge, a professor of nursing at the University of Virginia.

The state had just 72% of the nurses it needed and many worked overtime to make up the difference. Now, the state likely has a workforce staffed between 60% and 70% of capacity, Ridge said. The median salary for a nurse working 40 hours a week in Virginia was between $67,000 and $80,000 last year.

Critical care — like emergency rooms and intensive care units — has been hit the hardest. Some ICU's operated with half the nursing staff needed during the omicron surge. Because ICU's treat the sickest patients, one nurse typically cares for one or two patients.

When the pandemic began, 30,000 health care workers in Virginia lost their jobs, according to the Virginia Employment Commission, because hospital patient volumes had declined.

"They were kicked to the curb is how many felt," Ridge said.

Some nurses retired, others cut back their hours, and others took jobs treating less ill patients. Many took short-term, high-paying jobs with travel agencies in other parts of the state and country. Hospitals offered to pay anywhere from $50 and $250 an hour.

In October, VCU staffers discussed calling in sick together to protest their compensation. While VCU employees last year received appreciation payments of $400 and average annual merit raises of 2% — the figures were lower than a year before.

The pandemic caused revenue to decline in 2020, Dr. Art Kellermann, CEO of VCU Health, said in the fall. VCU can't pay its staff at the same level as the area's two other major health systems — Bon Secours and HCA — can. Bon Secours

is nonprofit, HCA is for-profit, and VCU is government affiliated.

"Given our role in the state, we can't go head-to-head with the other two systems that are national organizations with revenue in the billions of dollars," Kellermann said at the time.

The industry's staffing shortage is the most challenging employee situation he's seen in his lifetime, he said.

'We're like family'

There's a bulletin board on the wall inside the VCU emergency room showing the names and photos of the department's new nurses, paramedics and technicians. One day in the winter, there were eight new employees on the board. Beside each person's name is a small bio: work experience, family and pets.

Every two weeks a new batch of employees arrive and their names are posted to the bulletin board, too.

The adult ER is so large — with about 370 employees — there's always some turnover, said Amanda Stark, 33, a registered nurse and clinical coordinator. It was hard to notice when nurses started leaving faster than usual.

Since last May, the ER has hired 75 nurses from travel agencies, a spokesperson for the health system said. The typical assignment lasts 13 weeks.

Stark has worked in the VCU emergency department since she was a teenager in nursing school. She started as a care

partner, assisting nurses by checking vital signs and placing the electrodes for EKGs.

Though other nurses left for higher paying jobs, Stark never thought about following. That would feel like abandoning her team.

“Those of us who have been here a long time, we’re like family,” Stark said.

Working the ER was tough on staffers before COVID arrived. A Level-I trauma center, VCU treats every type of illness and injury — from car crash victims and gunshots to heart attacks and strokes.

Stark makes it a habit to check in on her coworkers with a call or text message a day. Privacy laws limit who staffers can talk to about specific cases, so she makes herself available to listen.

Then COVID arrived and everything changed. Doctors wrote up wills in case they died, and they lived in hotels to ensure they didn’t spread the virus to their families.

For the first four months, Reid swapped houses with her cousin. Reid lived alone, while her cousin cared for Reid’s parents and 12-year-old daughter. Reid dropped off the groceries at the door step and waved to them through the window.

At first, doctors and nurses were the heroes, she said. Now they’re too often seen as part of the problem. She thinks about the sacrifices she makes, and the sacrifices regular people have been asked to make — like getting a vaccine or wearing a mask at the grocery store.

She thought things would go back to normal once the vaccines arrived. Instead, more Americans died of COVID in the pandemic's second year than its first.

The toll on nurses

First, hospitals lost nurses who resigned. Then, in the height of omicron, they lost nurses to COVID.

Alyssa McKee, 29, a nurse coordinator in VCU's respiratory intensive care unit, tested positive in early January. Her throat became sore and her energy was sapped. It took five days to recover.

It was her second bout with COVID, and it wasn't as bad as the first time she got sick, on July 4, 2020.

"We had a lot of people test positive," McKee said of the omicron wave. "That's probably what hit us the hardest."

VCU used a group of nurses who float from unit to unit called supplemental staffing to help fill the void. Pediatric ICU nurses were trained to take care of adults. Other nurses picked up extra shifts. VCU requires nurses to rest at least 12 hours between shifts, and they can't work more than four consecutive days.

Of the 80 or so nurses in the unit, maybe 15 have left since last year, McKee estimated. The nurses who have two or three years' experience — the younger ones who earned less and don't have families — were the most likely to depart.

The shortage of nurses never affected the kind of care patients received, the three VCU staffers interviewed for this article said.

“The nurses pour their heart and soul into every patient,” McKee said.

The medical respiratory ICU — a 27-bed unit on the fourth floor of the critical care hospital — receives many of the sickest COVID patients. There are eight negative pressure rooms where COVID patients are isolated. When the door opens, air is sucked into the room, and the virus can’t escape. Before entering the room, the nurses donned their PPE — gowns, gloves, N95 masks and face shields or goggles.

During omicron, these rooms were full every day. By mid-January, nearly 200 beds in the VCU adult inpatient hospital were filled with a COVID patient, roughly 30%.

For the unconscious, intubated patients, nurses administered medication every two hours. They washed the patients’ hair, shaved their faces and turned them from their backs to their stomachs 12 times a day.

It was common for patients to die during the height of the delta and omicron waves. McKee worked two or three shifts a week, and it felt like someone would die every time she worked. Nearly one million Americans have perished from COVID.

When cases were high, VCU didn’t allow visitors, even if patients were at the end of their lives. Visitors are allowed now, but during the omicron surge, nurses gave patients iPads so they could video chat with their loved ones. The worst part was watching patients die alone.

“That’s the reason a lot of people have left,” McKee said. “It does take a toll.”

Some nurses started therapy, and McKee told other nurses to limit the overtime they pick up. To take care of herself, McKee goes to the beach with her husband and their Labrador retriever, Porter. They visit her mother-in-law's house in North Carolina where she kayaks and bikes.

Of the nurses who left, some had good experiences, while others were thrown into high-pressure situations, treating five or six patients at a time, far more than the one or two in VCU's medical respiratory ICU.

McKee never considered leaving for travel nursing, either. She's comfortable in a routine and parachuting into a new hospital for a few months never appealed to her.

But a change is on the horizon. Next month, she'll graduate with her master's degree as a nurse practitioner, a higher level of expertise.

She debated how to proceed with her career and even considered leaving the medical respiratory ICU, where she worked for six years.

Ultimately, McKee decided she hopes to stay. Despite two years of seeing the worst of what COVID has done to people, she still feels the want to take care of the patients who are most critically ill. And she looks forward to staying with her coworkers, who have grown close.

"We got through all of this because we had each other," she said.