



In rural communities, ER to hospital admission trends deserve special scrutiny.

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Many rural hospitals have experienced significant declines in inpatient admissions and census over the past decade. The Critical Access Hospital (CAH) Program, which provides cost based reimbursement, has permitted many of these hospitals to flourish despite fairly low admission and census levels. It is important, however, for CAHs to maintain a reasonable volume of inpatient census and admissions both as a hedge against possible future cutbacks in the Critical Access Hospital Program, and to ensure that the hospital is viewed by the community as the central hub of their local health delivery system.

Declines in inpatient admissions and census at Northern Cochise Community Hospital (NCCH), Willcox, AZ, a Critical Access Hospital, were the focus of much discussion at the Hospital's strategic planning retreat. In just three years, the hospital experienced a 38% decline in inpatient admissions. Between 1997 and 2003, although ER visits increased by 2400, actual hospital admissions from the ER declined by 57%, while the percentage of patients seen in the ER and subsequently admitted to the hospital declined from 8% to 2%. These statistics suggested that a considerable number of patients who could and should have been admitted locally, were being transferred to hospitals out of the area.

These facts prompted the hospital to request MJ Philps & Associates, LLC, a Nashville TN healthcare consulting firm, to conduct a study of Emergency Room to Hospital Admission Trends. The project was supported by a Small Hospital Improvement Program (SHIP) grant through the Arizona Rural Health Office.

The study approach included analyzing volumes of data (covering approximately a six-year period) describing all aspects of the ER process. It also involved interviewing all members of NCCH's medical staff, the hospital's management team,

Eye ON THE Emergency Room

ER personnel, and representatives of tertiary medical centers in Tucson.

Study findings confirmed that the Board and management had valid reasons for concern. A five-year projection of utilization trends indicated that unless NCCH addressed the problem, continuing declines in inpatient admissions and census could have very serious consequences for the hospital's long term viability.

The study also revealed that there was no single reason for these downward trends, and that no quick fix or "silver bullet" solution to the problem was possible. Many factors appeared to be influencing admission and referral decisions. These factors included:

- concerns about malpractice lawsuits and the related cost of malpractice insurance
- a much greater emphasis on "standards of practice" (frequently requiring a consult from a specialist in Tucson) and the growing tendency of physicians, particularly those trained in large urban academic medical centers, to seek the "definitive diagnosis"
- increasingly intense competition from modern, sophisticated,

urban medical centers with seemingly unlimited resources

- ongoing changes in physician practice patterns and the responses which physicians make to the sometimes conflicting requirements of caring for hospitalized patients, earning a reasonable income, maintaining a clinic based practice, and demands of family and community

An interesting conclusion reached in the course of the study was that the large urban medical centers in Tucson were not particularly interested in attracting the very patients which NCCH hoped to retain. Such referrals often "clog up" emergency rooms resulting in a frequent need to divert patients to other hospitals. Thus, these facilities appeared to share NCCH's interest in avoiding the unnecessary transfer of Willcox area residents to their facilities.

It seemed obvious that since hospitals do not admit patients... physicians do, no solution to the problem of declining inpatient admissions and census would succeed long term without the total "buy in" and support of the hospital's medical staff. The key to achieving this appears to have been physician involvement throughout the study

process. This included sharing preliminary data and later reviewing study findings in one-on-one meetings with physicians. It also included providing the opportunity for a spirited discussion of study recommendations in a meeting of medical staff, hospital board, and management.

Northern Cochise Community Hospital CEO, Chris Cronberg commented that, "What the study did was to remove all questions about the data and the physicians were able to feel like they were an important part of the process. It presented a clear picture of admission and census trends and their implications." Dr. Dawn Walker, NCCH Chief of Staff, remarked, "We had often been told that our declining census and admissions were a problem. It was nice to have this confirmed with data from an outside source. The Study described the problem objectively in a manner that offended no individual physician...and pointed to solutions that we could work on together as a team to implement."

Issues and Proposed Solutions

The key issues identified in the course of the Study, and the solutions developed to address these

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issues, focused on five areas likely to have the greatest impact on Northern Cochise Community Hospital's ability to retain a greater volume of appropriate inpatient admissions.

The ER process — The NCCH ER process seemed to almost guarantee that a number of patients who could appropriately be hospitalized locally would be transferred elsewhere. The ER physicians providing most of the ER coverage lacked admitting privileges and were required to obtain permission for an admission from the patient's primary care physician or the physician on call. These communications were nearly always by telephone. Reducing to a "sound bite", the myriad of information gathered in the process of examining the patient was a daunting task...further complicated if it occurred during the middle of the night or when the emergency room was very busy.

The absence of a green light to admit a patient generally resulted in a transfer to a Tucson hospital. To address this issue, it was recommended that ER physicians be granted admitting privileges.

Covering hospitalized patients —

Assuming the ER physicians have admitting privileges, it only makes sense to provide the patient's primary care physician with the option of either completing the admission process and following the patient in the hospital, or allowing these activities to be performed by a physician fulfilling a "hospitalist" function. Thus, it was recommended that the hospital add a hospitalist or assign an existing physician to serve in a hospitalist capacity.

Limited opportunity for exposure to less common medical conditions —

In today's very "litigious" environment, when NCCH physicians must deal with conditions that are confronted only rarely (even if they

could appropriately be hospitalized locally) there are understandable pressures on that physician to have the patient transferred to an urban medical center. To address this issue, it was suggested that the hospital's medical staff be provided opportunities for clinical rotations with hospitalists at the Tucson Medical Center. The reason the Tucson Medical Center was recommended over other urban medical centers was that TMC is NCCH's tertiary partner under the CAH network agreement.

Opportunities for enhancing nursing staff skill levels —

NCCH medical staff expressed a high level of confidence in the quality of hospital nursing staff and their skill levels. However, it was also clear that nursing staff were interested in and could benefit from additional training and education to enhance their comfort level in dealing with various clinical issues. It was recommended that NCCH collaborate with Tucson Medical Center for the provision of training and education sessions utilizing TMC clinical staff.

Clinical protocols as a means of retaining appropriate patients —

Establishing additional patient protocols (such as the NCCH chest

pain protocol) was identified as one means of ensuring the retention of patients who could be appropriately hospitalized at NCCH. It was recommended that resources be invested in the development of additional protocols drawing upon clinical resources of the Tucson Medical Center.

Optimizing improvements in technology and increasing communication with urban specialists —

NCCH's installation of digital radiology and the use of remote cardiac monitoring in other rural hospitals are examples of these improvements in technology. It was recommended that NCCH explore opportunities for maximizing such improvements, as well as identifying avenues for real time communication between NCCH medical staff and Tucson based specialists.

Conclusion

It should be noted that no two hospitals are likely to encounter the same set of problems or issues in their emergency departments. In each case, solutions developed to retain a greater volume of appropriate inpatient admissions, should reflect the hospital's own unique circumstances. Undertaking a study of emergency room to hospital

admission trends, similar to that carried out at Northern Cochise Community Hospital, is an appropriate means for hospitals to address the issue of declining admissions and census. According to Alison Hughes, Director of the Arizona Rural Health Office, "Michael's study turned out to be an excellent use of Small Hospital Improvement" (SHIP) dollars. I would encourage

other hospitals facing similar declines in inpatient admissions to take similar steps to objectively analyze trends as a means of reshaping the hospital's future."

NHC
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