

Part III

Accessing the Hospital

Doorways into the Hospital

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KEY TERMS

Admitting privilege	Full capacity
Advance directives	Golden hour
Discharge plan	Hospital-based clinic
Diversion	Medical home
Emergency Medical Treatment and Active Labor Act (EMTALA)	Preadmission workup
Federally Qualified Health Center (FQHC)	Proprietary clinic
First responder	Sliding fee scale
	Trauma
	Triage

INTRODUCTION

Patients usually have two general avenues by which they enter the hospital. They can self-refer or be referred to the hospital by a provider, but once they enter the doors of the hospital, the initial reception is similar. For patients who are not self-referred, the initial point of medical contact that begins the process of entering the hospital can take many forms, including physicians' offices, clinics, **Federally Qualified Health Centers (FQHCs)**, incarceration facilities, public health departments, and **hospital-based**

clinics. Depending on this initial point of entry, patients may enter the hospital through the emergency department or by going through the usual admission process. This chapter describes the patient's admission to the hospital and discusses key points along the way.

OBJECTIVES

By the end of this chapter, students should be able to:

1. Discuss the major avenues by which patients are admitted to a hospital.
2. Contrast hospital admission through a referral mechanism with emergency department admission.
3. Describe the general steps involved in entering a hospital.
4. Explain the importance of triage in the emergency department from the patient's viewpoint.
5. Explain the importance of the "golden hour" for emergency department personnel and patients.
6. Compare and contrast emergency departments and trauma departments.
7. Discuss the levels of trauma departments.

ENTERING THE HOSPITAL— PLANNED OR UNPLANNED

A planned entry into the hospital occurs when a medical provider refers a person to the hospital. The process begins with the patient going to the provider's office. The patient may initiate the process because of symptoms (e.g., headache, fever, or pain), for routine screenings (e.g., an annual physical, during which an abnormality is discovered), or because of a desire to have an elective medical procedure. When it has been established that the patient should go to the hospital, the provider will make initial arrangements for the person to be admitted to the hospital. Physicians have **admitting privileges** at certain hospitals, so the patient will generally be directed to go to a specific hospital. Although necessary admittance and elective admittance require similar **preadmission workups**, there is some variation in timing between the two. In elective admittance, the patient may visit the hospital's admitting office to complete admission forms, sign

advance directives, and arrange to have appropriate lab work before the actual day of admittance to the hospital. The information sought for pre-registration falls into three main areas: patient profile, guarantor (or person responsible for bill), and insurance (including any preauthorization requirements). If the patient has an illness necessitating immediate hospital admittance, the physician's office personnel will contact the hospital and send the patient directly to the hospital. Hospitals also provide a number of Medical Directive forms during admission, including Durable Power of Attorney for Healthcare Decisions (the patient appoints someone to make decisions should the patient be unable to do so), Do Not Resuscitate (specifies the conditions under which the patient does not want medical services provided), and Living Will (specifies the patient's wishes when faced with life-threatening illness) forms. During preadmission, patients will also be given a copy of the hospital's Patient's Bill of Rights and the Patient's List of Responsibilities, which describes what patients can expect while in the facility.

For planned admittances, patients may see their physicians at a number of specific clinic sites. Although clinic physicians have the same responsibility to provide care and refer patients to hospitals, the demographics of patients and their ability to pay may differ among the various clinic types. Most physicians are office-based, and these offices may contain a solo practice (one or two physicians, usually of a similar specialty, working together) or a group practice (a corporation consisting of numerous physicians of the same specialty or different specialties). Some physicians practice in **proprietary clinics** (i.e., clinics that are established according to a business plan with the goal of making money). A new type of proprietary clinic in many cities is the urgent (or emergency) clinic. These clinics are designed for nonappointments and to address medical situations that warrant expedient care with no waiting. People often use these clinics for minor emergencies or to see a physician during hours that are convenient for the patient. Proprietary clinics usually accept third-party payments as well as self-payments. Because they operate under a business plan, proprietary clinics do not accept nonpaying patients. Some hospitals have created hospital-based primary care centers to facilitate medical care for people who do not have a **medical home** and who are likely to inappropriately use the emergency department for minor illnesses. From a marketing standpoint, these hospital-based primary care centers may also be a source of hospital admissions.

Some physicians practice at FQHCs. FQHCs are federally funded clinics that emphasize primary care. In similarity to general community clinics, FQHCs serve as a medical home for people, although FQHCs usually have a **sliding fee scale** based on the current federal poverty guidelines. This means that people pay for services based on their income; although people are encouraged to pay for their needed services, FQHC guidelines allow patients to receive care regardless of their ability to pay. The social work department of the FQHC works with patients to identify paying mechanisms, such as Medicare, Medicaid, and Children's Health Insurance Program (CHIP), and can help them enroll in the appropriate program. Although FQHCs were once considered the medical home for people without health insurance, as more employers are decreasing the health insurance benefits offered to their employees, more people with insurance are seeking medical service at the FQHCs. Small FQHCs may offer limited primary care, whereas large FQHCs may offer several medical departments, including internal medicine for adults, pediatrics for children, obstetrics for pregnant women, and dentistry. Large FQHCs may be freestanding, meaning that they have an on-site pharmacy, laboratory, and limited x-ray capability.

People who are incarcerated in local jail facilities represent a unique population that may be referred to hospitals. Local incarceration facilities usually have agreements with local hospitals that allow inmates to be transferred to the hospital for extensive care. Most large jails have a medical director who oversees inmate health. Jails typically have limited medical staff (usually a mid-level provider and some support staff) on a 24/7 basis; however, large jails or prisons may have on-site medical clinics or limited hospital facilities. Because of the confined living arrangements, incarcerated people are subject to contagious diseases as well as **trauma**. Payment for medical services provided to incarcerated people is usually obtained from indigent funds (maintained by the county), but may also be made by other third-party sources. Because of the status of the incarcerated, hospitals and jail facilities must have policies and procedures in place to address transportation and treatment issues. Referral to the hospital is made through the medical director's admitting privilege and not through self-referral by the incarcerated.

Unplanned admissions to the hospital are generally associated with emergencies, and patients entering the emergency department usually have not been seen by their personal medical providers. In many cases, an un-

planned admission begins when a **first responder** assesses a person's medical needs and provides a specific amount of medical care while transporting that person to an emergency department. In these situations, patients enter the hospital through the emergency department. Although similar forms and initial lab work are necessary in the emergency department, the timing/flow for capturing this information may vary depending on the level of the emergency. This is especially true when it comes to ascertaining ability to pay for services. Under the **Emergency Medical Treatment and Active Labor Act (EMTALA)**, patients who present at hospitals with emergency medical conditions must be seen regardless of their ability to pay (American College of Emergency Physicians, 2009). EMTALA was created to prevent hospitals or emergency departments from refusing to treat people who do not have the ability to pay for the services.

Although EMTALA was established to prevent “dumping” of patients, it also contributes to the crowded conditions at most emergency departments. People who do not have insurance or an established medical home often seek treatment for nonemergency conditions in the emergency department (Viccellio et al., 2009; Xu et al., 2009). In addition, there are no medical histories on file for people seeking treatment in the emergency department, so more tests must be performed to ensure an accurate diagnosis. These extra tests and procedures increase the cost of the visit. Thus, inappropriate use of the emergency department is a contributing factor to the crowded conditions, long wait times, and high cost of emergency medicine.

THE EMERGENCY DEPARTMENT

More people enter the hospital through the emergency department than by any other route. There are advantages and disadvantages of going to the emergency department. For people with life-threatening issues, the emergency department is the essential avenue. For people who do not have a medical home and who rely on the emergency department as a source of primary care, the emergency department can be a place of frustration and anger. Emergency departments treat ill and injured people; because there is a wide variation in degrees of sickness and injury, emergency departments rely on a triage mechanism to determine when patients are seen. People who have life-threatening illnesses are seen before other people. The **triage** protocol is an established policy based on scientific

evidence and not on a patient's pain level or perception of illness. Often times, this creates friction within the emergency department, as patients waiting to be seen do not fully realize why other people are being seen before them (Moskop et al., 2008).

When patients initially enter the emergency department, they usually register. They are then assessed by the triage personnel for initial symptoms. Patients with severe trauma or life-threatening illnesses are placed at the top of the list, followed by patients with non-life-threatening illnesses. Some people who do not have medical homes will use the emergency department as a source of routine medical care (the type of care that should occur at the physician's office). These people are placed in the lowest position of the triage and thus usually have to wait a long time before they are seen by the physician. Some large city hospitals have established urgent care facilities adjacent to the emergency department, and people with non-life-threatening illnesses are given the option of going to the "urgicenter," which offers shorter wait times and less cost.

After patients are triaged in the emergency department, they then meet with a nurse who performs a written physical assessment. Patients will be asked questions about their allergies, medications, chronic illnesses, and medical history. Patients with life-threatening illnesses may be asked these questions while being wheeled to an examination department, whereas patients without life-threatening illnesses may answer these questions in an office setting. Women of childbearing age will be asked about their pregnancy status (this is required in case x-rays are to be ordered). Patients will be asked to describe their presenting problem and the severity of any pain they are experiencing. The nurse may ask numerous questions that may seem irrelevant to the presenting problem, but answers to these questions will be helpful when diagnostic procedures are ordered. Depending on the level of triage and the policies of the facility, patients may be asked about the form of their payment.

Once the initial diagnosis has been recorded, a physical evaluation will occur. Patients with non-life-threatening issues will put on a hospital gown and begin the physical assessment. Usually, the first step of the exam is to collect blood and urine specimens. Depending on the initial triage diagnosis, other tests (e.g., sonogram or x-ray) may also be administered. Initial physical tests are usually noninvasive and do not require written permission from the patient, although many hospitals have patients sign

permission waivers during the written assessment. Invasive procedures, which require some type of equipment to be inserted into the body, require written permission and may also require hospital admission before they can be performed. Test determination is based on written and initial assessments, and the attending physician will determine specific tests as dictated by the patient's presenting signs.

After the initial tests are performed, the patient may be admitted to the hospital, may be treated and released, or may be transferred to a more appropriate hospital facility. A patient who is admitted to the hospital must wait in the emergency department until a bed becomes available in the hospital. Depending on many factors, the waiting time may be long (Vermeulen et al., 2009). This waiting period is often one of the main reasons for overcrowding in the emergency department. During this time, more information will be gathered from the patient, such as the name of the patient's primary physician and whether the patient has any advance directives.

Patients with minor illnesses may be treated and released. For such patients, the next step would be the development of a **discharge plan**. This would include instructions appropriate for the diagnosis, follow-up procedures, and prescriptions. The plan would also include what patients should do if their symptoms worsen after they return home. Upon completion of the discharge plan, patients would then meet with the discharge person, who is responsible for ascertaining financial arrangements for the visit.

Emergency departments must see patients, but the ability of an emergency department to provide the appropriate level of service varies among hospitals. For cases involving massive trauma or other life-threatening issues, a small hospital may not have either the equipment or the trained personnel to provide the necessary degree of care. In these situations, patients will be evaluated, stabilized, and then transferred to hospitals that are more sophisticated.

THE TRAUMA DEPARTMENT

According to the National Foundation for Trauma Care, all traumas are emergencies but not all emergencies are traumas: "Emergency departments and departments treat ill and injured people, while trauma centers handle the most severe, life-threatening blunt force and penetrating injuries" (<http://www.traumafoundation.org>). Trauma centers are classified by the

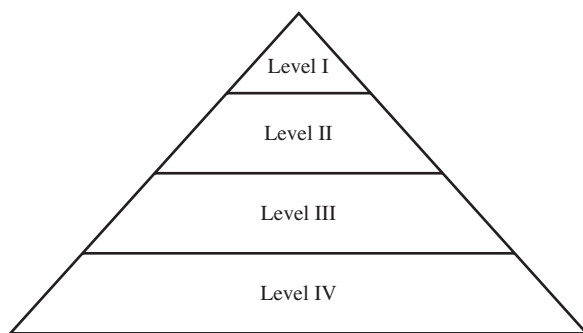


FIGURE 4-1. Trauma center model.

level of care provided (Centers for Disease Control and Prevention, 2009). As indicated in Figure 4-1, a Level IV trauma center provides initial evaluation and assessment, and 24-hour emergency coverage by a physician. Level IV trauma centers also have working relations with the nearest Level I, II, or III trauma centers so that patients with severe injuries can be readily transferred. Level III trauma centers offer continuous surgery coverage, have resuscitation and emergency surgery capabilities, and have standardized treatment protocols to address the care of patients who will be transferred to upper-tier trauma centers. Level II trauma centers provide comprehensive trauma care and are usually located in areas with no Level I trauma centers. Level I trauma centers are regional resource hospitals that are the core of the trauma care system. Level I trauma centers provide total care for every aspect of injury and usually serve as the point of care for the most severely injured patients. Level I trauma centers are usually associated with medical schools and teaching hospitals. These hospitals serve as referral sites for communities with less intensive trauma departments. Frequently, Level I trauma centers maintain air transport (either helicopters or jets) to fly patients from emergency departments or trauma sites to the Level I facility. Since Level I trauma centers usually are teaching facilities, they are staffed by both medical students and residents. Physicians in Level I trauma centers are board certified or may be pursuing a specialty that will allow them to become board certified in trauma surgery or a subspecialty.

The typical patient does not distinguish between emergency departments and trauma centers. However, emergency departments primarily treat ill and injured people, whereas trauma centers are charged with treating the

Table 4-1. Comparison of Emergency Department and Trauma Center by Type of Injury

Typical Patient Injuries Treated	
Emergency department	Trauma center
broken leg	multiple fractures
back sprain	paralysis
broken rib	punctured lung
laceration	stab wound
concussion	brain injury

Source: <http://www.traumafoundation.org>

most severe and most life-threatening cases. The National Trauma Foundation (<http://www.traumafoundation.org>) offers a comparison of emergency departments and trauma centers. As indicated in Table 4-1, emergency departments should be responsible for treating less complicated medical issues, and trauma centers should treat more complicated/complex issues.

Of course, if there is no trauma center in the vicinity, trauma patients usually are taken to the closest emergency department for stabilization. Sometimes, because of the severity of the trauma, victims are sent directly to a major trauma center. Frequently, transfer from the site of the traumatic occurrence to the higher-tier trauma center is coordinated through an air service (helicopters or planes that are designed and staffed to serve as mini emergency departments). These “life flight” services have contributed to saving many lives because they enable patients to receive the appropriate level of trauma care within the golden hour.

THE GOLDEN HOUR

The timing involved in the initial treatment of severely injured or ill patients is crucial. Emergency medicine/trauma departments refer to the first 60 minutes as the “**golden hour**.” Research has demonstrated that if appropriate care is provided during this hour, the patient has a much greater chance of survival. To address this timing issue, the concept of the

tiered trauma center model was created. According to this model, which was developed during the Vietnam War, trauma patients are initially seen by the closest facility and stabilized. If the diagnosis is beyond the capacity of the initial emergency department, the patient is transferred to the appropriate facility. About 10% of hospitals in the United States have some level of trauma capacity, and these 600 hospitals (<http://www.traumafoundation.org>) comprise the trauma center model.

COST OF RUNNING EMERGENCY DEPARTMENTS AND TRAUMA CENTERS

Today, not all hospitals have emergency departments, primarily because of the overhead costs associated with the emergency department. In the past, small hospitals were able to maintain an emergency department by having local doctors serve on a rotating basis. In 1979, emergency medicine became a recognized specialty for which physicians could seek board certification. Currently, emergency departments are staffed differently from most general hospital departments. Emergency physicians, nurses, and support staff must be in the emergency department throughout the day and night (24/7) regardless of the number of patients in the waiting room. Because personnel in the emergency department must be prepared to handle all medical conditions, they must be highly trained and have access to sophisticated medical equipment to facilitate diagnoses. Thus, the unit cost tends to be much greater for procedures done in the emergency department than elsewhere. The high costs of these procedures, along with the many people who do not pay for their emergency care, have contributed to most emergency departments being “in the red.”

Because of the financial drain, many hospitals have closed their emergency departments, and the remaining emergency departments have become even more crowded. There are times when the emergency department is so crowded that the triage system is overwhelmed and even priority patients cannot be seen in an expedient manner. When this occurs, the hospital may use an approach known as “**diversion**.” Hospital diversion requires intricate and real-time coordination between numerous emergency departments. Although diversion has a place in emergency care, it also leads to frustration and may lead to poorer patient outcomes (Olshaker, 2009).

SUMMARY

People enter the hospital through planned or unplanned routes. Planned entry usually is initiated at the medical provider's office, where the patient has been seen by the physician. If the diagnosis is serious, the physician may immediately refer the person to the hospital's admission office; for other procedures, a hospital admission may be scheduled. The first step in the hospital admission procedure is the preadmissions office, where the patient's information, including the payment mechanism, is gathered. The second step is the initial lab work. Unless the patient has been "handed off" to a hospitalist, the patient's primary care physician will be responsible for the medical care provided during the patient's hospital stay (see discussion of "Hospitalist" in Chapter 5).

The second avenue of entry into the hospital is through the emergency department. Sometimes a person may be too ill to wait for an appointment with his or her provider, and will go to the emergency department for more immediate treatment. People seeking treatment in the emergency department are assigned priority based on the severity of their initial assessment. Research in emergency medicine has shown that appropriate treatment within 60 minutes of an occurrence may greatly reduce the mortality rate for many diseases and traumas; for this reason, people with life-threatening issues are the first priority in the emergency department. For people who do not have life-threatening issues, the wait time in the emergency department may be long. Because many people who do not have medical homes or money for medical care use the emergency department as their primary source of care, emergency departments tend to be crowded.

Trauma centers and departments are geared more toward treating people who have been involved in accidents or traumatic situations. Just as not all hospitals have an emergency department, not all emergency departments have trauma departments. When severe trauma occurs, emergency department personnel may stabilize the patient and then transfer the patient to an appropriate trauma center for more elaborate care.

CHAPTER REVIEW

1. Discuss the difference between planned and unplanned entrance to the hospital.
2. What is triage? Why is it important in emergency departments?

3. What is the golden hour?
4. Discuss the meaning of the various levels of trauma centers.
5. How are trauma centers different from emergency departments?
6. How do the steps involved in hospital admission differ for emergency department (unplanned) and regular (planned) admittance?

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