Doing More With Less

❖ Edwin Leap, MD, FACEP
❖ Newberry County Memorial Hospital, Newberry, SC
❖ Near Columbia, SC, the hottest place in this part of the solar system.
Notice: I’m not going to tell you much that you don’t already know.

This is just about the small hospital perspective.

Lots of hospitals are doing more with less; and communities are doing less with less…

‘Since 2010, 82 rural hospitals have closed nationwide. As many as 700 more are at risk of closing within the next 10 years, according to Alan Morgan, the CEO of the National Rural Health Association, a nonprofit professional organization that lobbies on rural health issues.’

https://www.huffingtonpost.com/entry/rural-hospitals-closure-georgia_us_59c02bf4e4b087df15075e38
‘About 13 million children under 18 and 47 million adults live non-metropolitan areas. 65% of all counties in the country are rural.’

- Rural residents have less access to physicians.
- They tend to be ‘older, poorer, sicker and uninsured…’
- ‘They have higher injury, smoking, suicide and opioid misuse rates.’


This is not news.

- Rural hospitals are closing.
- Advanced care, specialists and procedures often aren’t available.
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- Furthermore, life in ‘the sticks’ is not without risk.
- For example, trauma mortality is higher. Longer transport times, fewer specialists, etc.

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- The money isn’t as good. (Sort of…)
- The culture is different from cities.
- The schools, the shopping, everything.
- Young doctors seek out cities.
If you really want to learn to ‘do more with less,’ find yourself a small community or critical access hospital and work there.

These are the perfect examples of limited resources in the face of crazy sick patients.

And crazy, sick patients too…

Large centers have lots of weird and complex cases…
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❖ Because they come from elsewhere…
❖ Where every day it’s MI, CVA, DKA, dissection, torsion, leukemia, open fracture, ruptured spleen…
❖ Ad infinitum…

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❖ What is a Critical Access Hospital?
❖ Defined in 1997 (Public Law 105-33) in response to closures of rural hospitals in 80s and 90s.
❖ Intended to reduce the financial vulnerability of rural hospitals.
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- 25 or fewer acute care/inpatient beds
- 35 miles or more from next nearest hospital
- (15 if in mountainous terrain or only secondary roads)
- Annual average length of stay of 96 hour or less for acute care patients
- Offer 24/7 emergency care services
Some hospitals I have loved…and feared.

Street Cred:

- The Memorial Hospital, Craig, CO.
- Kremmling Memorial Hospital, Kremmling, CO.
- Crawford Memorial, Robinson, IL.
- Community Hospital of Bremen, Bremen, IN.
- Decatur County Memorial, Greensburg, IN.
- St. Vincents/Randolph, Winchester, IN.
- Highlands-Cashiers Hospital, Highlands, NC.
- New Horizons Medical Center, Owenton, KY.
After 20 years in one busy semi-rural hospital, small hospital locums was a wonderful change.

And an education.

In order to do more with less, it helps to understand what you have less of...

If you work there, first talk to nurses, docs, CEO, etc.
Part of ‘doing more with less’ is not being surprised and blindsided.
Not having false expectations; for equipment and staff.
Understanding your assets and limitations.
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- Geography. What are the limitations? Is the hospital on the coast and affected by hurricanes?
- Is it on a mountain top and affected by snow, ice and fog?
- Personal note: helicopters don’t fly if there’s lots of smoke from a forest fire.

- All of these affect transport of your patients
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- I don’t really need to tell you about weather in Michigan...

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- Which reminds me: despite what accepting hospitals think, helicopters don’t solve everything.
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- Ground EMS transfer is also getting more and more difficult.

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- Many counties only have one or two trucks at any time.
- Crews are underfunded, understaffed and exhausted.
- Start arranging transport early. It may take hours.
Before working in a smaller facility, it’s wise to:
- Ask about the nearest referral centers.
- Ask if the hospital is part of a larger organization.
- This can make transfers much easier.
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❖ If you plan to work there a while, if your group is taking over, etc., go and meet the folks in the nearest referral center.
❖ Explain to them what you need and especially what you don’t have.
❖ New docs really don’t get it.
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❖ As soon as you can (even if it’s your first day), find out what you have in terms of staff.
❖ Is there a hospitalist? Sometimes there is.
❖ Will YOU be the hospitalist? (Ask this before you ever go.)
❖ Hospitals seem to assume a doctor is a doctor...

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❖ Being the hospitalist can be bearable when it’s slow.
❖ It can be agony during vacation seasons in some areas.
If you’ll be the hospitalist/ED physician, you’ll have to learn certain absolutely critical skills:

- Admission orders
- Discharge planning
- These make airways seem like simple affairs.
## Doing More With Less

- Let’s see, ED physicians. A,D,C,V,A,N,D,I,S,L…right?

### A 2nd commonly used Admit orders Mnemonic

<table>
<thead>
<tr>
<th>ABC order</th>
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<tbody>
<tr>
<td>A.</td>
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## Doing More With Less

- Deep breathing exercises may help…
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❖ You may simply have to round on patients on the weekend.

❖ Or you may be expected to admit, manage and discharge.

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❖ Personally I don’t enjoy this kind of work.

❖ Some EP’s enjoy the change of inpatient care.

❖ I’m interested in about two hours of anything.
Is there a surgeon? Is there an OB? A family doctor who acts as an OB?

Are there other resources in the community, like orthopedics? A plastic surgeon?

Are there agreements with other sites?

Sometimes you’ll have this surgeon in town. He landed at Normandy and hasn’t stopped operating since.

He’ll open skulls and chests, and used to put rods in femurs. He may be out hunting.
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- She delivered every child in a five county radius since just after the Civil War.
- She’s fearless and everyone owes her a favor.
- Including the Governor.

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- What about stroke?
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❖ Often no tele-neurology.
❖ The rules are changing in terms of time window, thanks to intervention. This is good.
❖ The weather is tricky, which is bad.
❖ Learn to describe the exam clearly.

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❖ You may use your cell-phone to send CT images.
❖ (If you say HIPAA three times and spit, it’s OK)
❖ You may have to give tPA.
❖ If possible, and stable, triage away when EMS calls.
❖ Many services already to this.
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- When the receiving hospital asks about your neurologist, don’t laugh too loudly.

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- Seriously, I thought they were mythical creatures
What about STEMI?

Many EMS services will go ahead and transport these patients to referral centers, knowing the delays in coming to the CAH first.

They still walk through the door.

You do what you can with what you have.

TPA still works…
Psychiatry is also a huge issue in rural America, where suicide and addiction rates are staggering.

Tele-psychiatry is helpful. Few can afford it.

If facility can contract with a larger system it can ease evaluation and transfer.

Most rural areas don’t have much. No easy answers.
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❖ This might help…

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❖ Maybe this is our future?
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❖ You always wanted to be a cardiologist? Neurologist? Neurosurgeon? Congratulations? On the mountain-top, in the hurricane, during the Sharknado, you are.
❖ You may keep an SAH overnight due to snow and ice.

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❖ Like stroke, or MI, you can manage head injury for a few hours if needed.
❖ Phone consult and do your best.
Communication is key. Use all resources available as you’ll most likely be...

Sometimes the hardest part is explaining to other people (often residents) that you don’t have the things the patient needs.
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❖ There are things you may not have. An ICU, a cath lab, an MRI.
❖ After hours ultrasound in days that end in Y.
❖ True story: a tech that can only scan men.
❖ People will think you’re kidding.

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❖ Be firm and be realistic. You can’t do a plastic closure for two hours while the ED piles up and there are sick people on the floor and taking up your five other beds.
‘Well I guess, but I’ve never had someone send me a laceration from an ER. Why can’t you close it?’
Maxillofacial fellow at referral center.

To whom I sent the photo.

‘We brought our own plastic surgeon, is that OK?’
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- Remember that EMTALA aside, sometimes you can only make a patient so stable.
- If the AAA is leaking and I have no surgeon, well a blood pressure of 60 may have to do…

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- Most sites use tele-radiology. Will you get real-time reads? Can you call for help if not?
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- When patients are seriously ill or injured, and you know they will need transport, call early and begin the process. Open fracture, sick infant, OB, stroke, etc.

- Get the ball rolling.

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- This is key, emergency medicine trained physicians:
- You don’t have to know it all, or do it all.
- Do what’s best for the patient.
- Resist the temptation to pride.
- The work up doesn’t always have to be complete.
If you have to send your patient with two large bore IV’s and an LMA, or bloody cric, well that’s what you have.

And they’re alive.

Two children ejected from buggy struck by F-250. Stable, no apparent injuries, normal VS. IV access. Awake and alert. C-collar, backboards.

Transported without labs or X-rays, within minutes of arrival and evaluation.
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- Seriously, what was I going to do with them in a Critical Access ED?

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- Other communications issues: will phones and Internet function?
- Not always.
- Connectivity may be poor due to weather or infrastructure.
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❖ First night as director in small rural hospital.
❖ 12 patients from bus crash.
❖ Internet and phone services down due to another crash.
❖ Nurse cell phones used to communicate with receiving hospitals and radiologists.
❖ Innovation is key when doing more with less.

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❖ Your skills are uniquely suited.
❖ Intubation is up to you.
❖ No anesthesia backup so consider adjuncts.
❖ There may or may not be video laryngoscopy.
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❖ Bougie, LMA, NP, OP airways.
❖ Cric kit.
❖ Warmed humidified nasal cannula oxygen may help avoid intubation in infants.

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❖ Many times, BiPap has saved the day.
Ultrasound? Can really help cut time to diagnosis.

If the hospital has one. This is not an absolute.

It’s heresy, I know. But sometimes, when you’re alone, CT is the better option. The accepting center will probably ask for it anyway.
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- IV access: Peripheral, EJ, central line.
- Femoral lines are fast. Dirty? Sure.
- But it does the job and gets you back to the patients.
- If you have time? Do what you like.

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- Don’t get hung up on central lines.
- Pressors through peripheral IV’s. More study needed, but looks good so far:
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- Most of the drugs we really need in a hurry can be given IO.
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4831096/

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- The IO is AWESOME.
- Don’t be proud, get access.
- Don’t apologize.
- ‘Say hello to my little friend!’
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❖ And there’s this: cool huh?

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❖ This was July 1st...
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❖ Brush up on your critical care skills.
❖ Review your infusions and vent management.
❖ You may find yourself running an ED ICU until transportation is available.
❖ Or Spring…

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❖ Don’t assume the pharmacy has what the big center has.
❖ Don’t assume you have much blood. You may only have two units.
❖ That’s right, 2 units.
❖ Don’t feel like you’re ‘dumping’ the patient if you can’t offer what they need.

❖ Don’t be afraid to call and ask questions, even if not for transportation.
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- Keep resources at hand. Hopefully the site has reference books.
- Don’t assume the Internet will work.
- Hopefully your smart-phone has some things you need.
Too many films and labs don’t change anything and delay care.

‘Hello, this is Dr. Leap at Highlands Cashiers Hospital. I have a five-year-old Hispanic male who has been run over by a car.’

Trauma surgeon: ‘Well he needs to be at the trauma center!’

‘Uh, yeah, that’s why I’m calling you…’
‘What if I can’t do anything to help?’

Simply by being there with your skills, you’re giving the sickest patients a fighting chance.

If you weren’t there they’d certainly die. If you are they might not.

Lesser issues: You’re no good if you’re starving.

Make sure they feed you or bring your own food. 24-36 hours is a long time to eat crackers.

Some hospitals may let you go 20-30 minutes away. They’ll just call you.
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❖ Some days you’ll do nothing.
❖ Some days you’ll wonder why you ever came to the middle of nowhere.
❖ Good time to read, do CME, write, or just put up your feet and watch the snow fall.

Community Hospital of Bremen, Bremen, IN, seriously has the greatest call room in the known universe.
❖ And a hitching post for horse and buggy.
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❖ These are not places for the faint of heart, who have little to no experience.
❖ If you feel ready, and comfortable, you give these communities a great gift.
❖ Your knowledge, experience and calm will change lives and save lives that might otherwise be lost.

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❖ And what a great place to go when you’re older, tired of the rat race and want to slow down but still be useful!
❖ You know, like security.
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- I tricked you. I’m here less to educate you than to recruit you.
- Rural America, small hospital America, is desperate for your skills and experience.
- The greatest resource they can have, the best chance the patients have, is you.

- So in summary: You have limited resources; use them well
- Communicate early
- Transfer early
- Don’t over-test or over-treat
- Know your limitations and that of the staff/hospital
- Stick to the essentials (airway, easy lines, necessary meds)
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❖ Check the weather
❖ Check the food situation
❖ Take a minute to talk to the patients (you’ll usually have time)
❖ Enjoy the peace and quiet
❖ Don’t feel guilty napping or watching Westerns
❖ Know that you’re valued

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❖ Rural hospitals are under enormous financial pressure.
❖ Rural communities often struggle without medical care.
❖ Please consider spending time at a small rural hospital or CAH.
❖ You won’t regret it.
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❖ After all, they’re part of Emergistan too!
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- Thank you!
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