

Development and Maintenance of Key Partnerships in an ED Observation Unit

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The key to the successful operation of an ED observation unit is through the careful cultivation of strong relationships with multiple diverse services. It is imperative to identify the services impacting each institution's specific needs and goals. These stakeholders should be independently targeted with the aim of cultivating a mutually beneficial, respectful and collaborative relationship.

Each institution will have its own specific set of stakeholders. This toolbox is meant to cover the likely players and to outline the opportunities each one could provide. The spreadsheet is an attempt to outline a comprehensive list of possible partners.

The annotated list below is to spotlight some of the key players and discuss specific issues to consider.

Cardiology Services

This is most likely the most important partner in an ED observation unit (OU). It is advisable to establish clear pathways for chest pain (ACS) work-ups with consideration of preferred testing resources or follow-up. It would be helpful to ask for prioritization of OU patients for stress testing.

Every institution will have different preferences and availability of provocative testing. Generally the choices will include:

- Standard Bruce protocol treadmill (not used commonly, but in theory could be performed entirely by OU staff). Problem is higher rate of false positives than most other modalities.
- Exercise Stress echocardiogram (minimal risk to patient, dynamic information quickly obtained)
- Dobutamine Stress echocardiogram (for patients unable to perform on treadmill)
- Nuclear Stress (exercise or pharmacologic) – may be required for certain patients
- CT coronary angiography (some institutions rely on this heavily). Problem with increased radiation exposure and false positives when compared to stress echo. (Ref 1)

There needs to be consideration of how to triage patients arriving on weekends. Many of these patients can be discharged home without provocative testing if appropriate follow-up is arranged.

There should be specific discussion regarding OU referral criteria and management regarding:

- Syncope (what type of ambulatory rhythm monitoring is available?)
- Atrial fibrillation (new onset in particular)
- Cath lab referrals (process in particular)
- CHF (acceptance criteria in particular)
 - CHF sidebar: Institutions are now mandated to limit 30-day re-admits. The OU needs to specifically consider how involved to be in managing these patients, who can require a lot of resources. The hospital may attempt to limit counting a re-admit by attempting CHF OU management as an observation service. However, Medicare patients with CHF who pass a second midnight generally must be converted to inpatient status. Then, a 30-day re-admit after a stay in the OU, will be attributed to the OU.

Tip: Establish a “hotline” for communication in either direction to request consults, receive test results or consult opinion.

Pitfall: Avoid specific consultation for every chest pain or syncope patient once a routine is established.

Utilization Management (UM)

Develop a mutually respectful, working relationship with utilization management. Most institutions require a utilization review of all observation service patients and will advise whether inpatient criteria are met. Risk of conflict may occur when UM recommends inpatient upgrade and the patient is improving with discharge imminent. The flip side is when a patient appears to require more time and care than the OU can provide and UM will not support inpatient conversion. If the organization is using a third party medical advisor service, such as EHR (Executive Health Resources), there will need to be discussion regarding how referrals to the advisor service may impact flow to the OU.

Neurology

There should be a discussion whether the OU would accommodate patients with suspected TIA. These patients should be ideal for OU management, though many institutions have a specific stroke center/unit. Certain patients with headache can be successfully managed in the OU. It would be helpful to discuss a possible protocol for these patients.

Gastroenterology

The focus on patients requiring gastroenterology services will generally concern procedures (EGD or colonoscopy) and proper preparation. Most patients who leave the unit for endoscopy can return and be further triaged later.

Tip: Establish a routine of maintaining NPO for patients with GI complaints and consider initiating bowel prep for patients anticipating a need for colonoscopy. Many diverticulitis patients are ideal OU candidates and generally would not require GI consult in-house.

Pitfall: Specialist practitioners have different thresholds for procedures. Discuss dietary advice with specialist before reviewing with patients (ie, fiber/nut debate in patients with diverticulitis).

Surgery

Each institution will likely have sets of surgical service patients who would be suitable for management in the OU. Patients with SBO, undifferentiated abdominal pain, bariatric patients with non-specific symptoms and certain types of trauma patients would be best managed after specific discussion with representatives from each service.

Urology

Nephrolithiasis is an ideal condition for the OU. Many of these patients can return to the OU after brief urologic procedures in the OR. Discussing triage and “flow” of these patients with urology providers is key.

Infectious Disease/Dermatology

The most common infectious disease managed in the OU is cellulitis or other skin and soft tissue infections. Although consultation is probably not necessary for most of these cases, it would be worthwhile to have a discussion regarding the general approach to these patients.

- Cellulitis sidebar: Research indicates that about 30% of patients hospitalized for cellulitis have another diagnosis (usually stasis dermatitis) that could be managed at home. A discussion between dermatology and ED providers can help to correctly identify appropriate patients for treatment in the hospital. The OU could be used as a clearinghouse for these patients and reduce costs significantly.(Ref 2)

Tip: Patients with cellulitis (and generally, other infections) do not need to transition to an oral antibiotic to assess for response before discharge home.

Endocrinology/Diabetes Educator

Either new onset or out of control diabetes (without DKA) can be effectively managed in the OU. Patients who present to the ED with a new diagnosis are high maintenance in terms of initiating therapy and organizing appropriate follow-up. The endocrinology unit will likely have a diabetes educator who can work with the OU to streamline management of these patients, including arranging follow-up.

Tip: health insurance often will only cover certain test strips/devices, so avoid providing patients with a “free” glucose monitor that requires strips not covered by their plan.

Pitfall: once the ED realizes the OU is organizing care for newly diagnosed diabetes, there is the risk of all patients with hyperglycemia being referred. Many of these patients can be discharged from the ED if they have a competent primary care provider.

Physical Therapy

Physical therapy (PT) is a key service to assist in safe and efficient disposition of many OU patients. It is possible they will identify “red flag” patients who are receiving observation services, but require rehabilitative services before discharge home. These patients in particular will require a multi-disciplinary approach with social work and utilization management.

Tip: Avoid consulting PT for every frail patient for a “road test”. Many patients can be assessed by nursing or medical staff as an initial screen. If PT evaluations are reserved for the most important cases, then they are more likely to be completed in a timely fashion.

Social Work

The OU functions optimally with a motivated, accessible social worker to assist with patient needs regarding home situation, medication dispensing, transportation and follow-up.

1-Foy AJ, Liu G, Davidson WR, et al. Comparative effectiveness of diagnostic testing strategies in emergency department patients with chest pain. *JAMA Intern Med* 2015;175(3):428-436.

2-David CV, Chira S, Eells SJ, et al. Diagnostic accuracy in patients admitted to hospitals with cellulitis. *Dermatol Online J.* 2011;17(3):1.