Community vs Academic vs Freestanding ED Obs Units

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Disclosures, COIs, Disclaimers, etc

• No conflicts of interest or disclosures

Objectives

• Learn strengths and weaknesses of each hospital type with respect to their obs unit
• Share strategies to mitigate specific inefficiencies within each setting
• Understand the opportunity for OUs and FSEDs (ie. the FSED OU)

Integrating Multiple Units into a Health System

Tisch – 38 bed unit
Brooklyn – 12 bed unit
Winthrop – 28 bed unit

How do we classify hospital settings?

• Community Hospital
• Academic/teaching Hospital

I am going to make some necessary generalizations
These will highlight key challenges by hospital setting
Then, we will discuss strategies to mitigate each challenge
Community Hospital
- Mostly clinical medicine (no research or teaching)
  - Amount of hospital patient care duties will vary within individual practice, departments, hospitals, and parts of the country
  - No teaching responsibilities
- Compensation usually based in RVUs, patient or procedure volume
- Prevalence of advanced practice providers (APPs = cost effective providers)
- Primary care physicians often admit
  - Very interested in continuity
- Specialty consults vary in availability
  - Not ‘in-house’ or immediately available
  - Often have choice
  - Some consultants may be more/less responsive

Academic Hospital
- Clinical medicine – and/or – research – and/or – teaching
  - Actual amount of patient care duties often reduced
- Various teaching responsibilities
  - bedside teaching rounds, didactic lectures, conferences
  - Require balance with clinical time
  - Physician compensation usually salaried
- APP staffing reduced/replaced by residents and fellows
- Faculty attendings on hospital staff often admit
- Specialty consults generally available
  - Fellows and residents often available 24/7
  - Often 1 resident and/or fellow will cover a service

How to Strategize for the Success of Your Obs Unit by Hospital Setting

Physician/Physician Groups

Academic Setting
- Challenge
  - Teaching/research responsibilities conflict with OU time requirement
  - EM vs IM
- Strategy
  - Staff w/dedicated provider
  - Staff with EM → IM can focus on complex, ‘interesting’ patients
  - Trainees lose educational experience for certain clinical conditions (i.e. chest pain, etc)
  - Create Obs curriculum, elective or rotation

Community Setting
- Challenge
  - PCP/private practice patient ownership (efficiency)
- Strategy
  - Dedicated OU staff, closed unit
  - Mitigate perception of poaching
  - Focus on collaboration w/PCP
  - PCP can visit patients in the OU, but keep unit ‘closed’
  - Refer all patients back to the PCP at D/C
  - Create f/u rotation for ‘unattached’ patients
  - Offer PCP shifts in OU to earn RVUs, build practice

Specialty Consults

Community Setting
- Challenge
  - Specialist availability
- Strategy
  - Create coverage schedule by:
    - Practice
    - Group
    - Specialty
  - Know who covers less available service (i.e. ortho covers podiatry on weekends, etc)
Specialty Consults

**Academic**

- **Challenge:**
  - Stepwise evaluation (intern → resident → fellow → attending)

- **Strategy:**
  - Request attending consult (or someone who can make decisions)
  - Share attending #s for escalation
  - Request OU is first consult of day
  - Build in required consults in certain protocols (with expected turn-around times)

**Diagnostic Services**

**Community**

- **Challenge:**
  - Limited availability (outside ‘9-5’)

- **Strategy:**
  - Leverage outpatient and ambulatory testing centers
  - Schedule elective/outpatient testing on weekends to justify resources on ‘off-hours’

**Diagnostic Services**

**Academic**

- **Challenge:**
  - Abundance of modalities, specialists recommending tests → inefficiency

- **Strategy:**
  - Educate all who interact with OU re: clinical protocols
  - Track appropriate testing
  - Reserve first-of-day time for OU patients competing w/other services

**Free-standing EDs**

**Freestanding Emergency Departments**:  
- Separated/distinct (from hospital ED) facility providing emergency care  
- Generally open 24/7 staffed with physician, RN, APP  
- Capable of:  
  - Labs (send-out and point of care)  
  - Basic and advanced imaging (Xray, CT, ultrasound)  
  - Can be in same physical plant as outpatient imaging centers (ie. MRI, etc)  
  - Specialty consultation (local specialist, telehealth)  

**Freestanding Emergency Departments**

- Currently hundreds of FSEDs  
- Recent growth driven by:  
  - Innovations in technology (EHR, POC testing, telehealth)  
  - Need for 24/7 care  
  - Extend emergency services in new markets  
  - Lower cost than building entire hospital
Freestanding EDs in Healthcare Systems

- FSED patients will need observation care
- FSED/Observation Unit
  - Equip the FSED to care for the patient
  - Keep patients local
  - Preserve beds at the 'main hospital campus'
  - Augment outpatient care/reduce unnecessary hospitalization
  - Triage patient requiring inpatient care to the right hospital at the right time
  - Multiple transfer agreements
  - Many states have examples of this model (ex. California, Colorado, Florida, Ohio, North Carolina)
- Direct placement from FSED to OU
  - Avoid sending patient to hospital ED

Top 10 Protocols Account for 80% Freestanding ED Observation

<table>
<thead>
<tr>
<th>Protocol</th>
<th>Protocol</th>
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<tbody>
<tr>
<td>Chest Pain</td>
<td>Cellulitis</td>
</tr>
<tr>
<td>General</td>
<td>Abdominal Pain</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>Abdominal Pain</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>Syncope</td>
</tr>
<tr>
<td>Syncope</td>
<td>TIA</td>
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<tr>
<td>TIA</td>
<td>Asthma</td>
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<tr>
<td>Asthma</td>
<td>Back Pain</td>
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<tr>
<td>Back Pain</td>
<td>Pneumonia</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Transfusion</td>
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</tbody>
</table>

Focusing on these 10 protocols allows care for the majority of observation patients.

Freestanding ED Obs Profile

<table>
<thead>
<tr>
<th></th>
<th>Volume</th>
<th>Conversion Rate</th>
<th>Length of Stay (hours)</th>
</tr>
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<tbody>
<tr>
<td>Grand Total</td>
<td>942</td>
<td>12%</td>
<td>21</td>
</tr>
</tbody>
</table>

Only 12% of patients receiving observation care subsequently required inpatient admission.

FSED OU: Diagnostic Protocols

- Chest Pain: exercise stress, coronary CTA, stress echo
- Abdominal Pain: CT, Ultrasound
- Syncope: echo, telemetry
- TIA: CT, carotid doppler, +/- MRI/MRA

FSED OU: Therapeutic Protocols

- Cellulitis: antibiotics
- Abdominal pain: analgesia, antiemetic, fluids, antacids
- Asthma: bronchodilators, steroids, peak flow, pulse ox, X-ray
- Back pain: analgesia
- Pneumonia: antibiotics, pulse ox
- Transfusion: blood products
THANK YOU

I hope to hear from you!
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