Real Solutions for Emergency Medicine and Hospitalist Conflict
WHAT DO THESE RISKS HAVE IN COMMON?

The common denominator is the physicians involved: ED docs, hospitalists, specialists, and primary care physicians. When these doctors are at odds about where and to whom a patient should go next, their conflict has a ripple effect, compromising throughput, patient flow, the patient experience, and even a patient’s well-being.

In this white paper, we’ll examine six common scenarios—and proposed solutions—to improve the interactions between emergency, hospitalist, and primary care physicians, ultimately creating a safer and more efficient care continuum.

Created by Dr. Kenneth R. Epstein, chief medical officer of Hospitalist Consultants; Dr. Kenneth J. Heinrich, medical director of the ECI Healthcare Partners Advisory Group; and Dr. John W. Duff, medical director of MidMichigan Medical Center-Midland’s emergency department, this white paper is designed to help you:

• Identify the challenges faced by emergency medicine, hospitalist, and primary care physicians
• Understand the different approaches of each discipline
• Develop a plan to apply the learned techniques with colleagues
• Find ways in which collaboration between physicians can lead to improved patient care

Each scenario’s proposed solutions are followed by an actionable checklist you can use to make implementation or communication with each scenario’s stakeholders easier.

EXECUTIVE SUMMARY

The risk of liability for sending a patient home from the ED and the risk of unnecessary admissions are often at odds.
THE SITUATION:
A community PCP calls the ED to send his patient to the hospital. The EM physician claims the ED is very busy and, based on reported patient symptoms, feels that the patient needs to be admitted. The EM physician asks the PCP to call the hospitalist for a direct admission. The hospitalist, after hearing the presentation by the PCP, suggests that the patient should be seen first in the ED to get stabilized. The PCP feels that he has been met with obstruction by both the ED and hospitalist physicians.

HM PERSPECTIVE:
When fielding a call from an outside PCP, a hospitalist often feels uncertain exactly how sick a patient truly is and what level of care he or she will require. As such, the hospitalist feels more comfortable admitting a patient after the patient is seen in the ED.

EM PERSPECTIVE:
When the EM physician hears about the patient from the outside physician and feels that the patient will definitely need to be admitted and has no emergent needs, the EM physician feels that an ED visit is unnecessary. The visit would tie up a room, physician time, and resources, and there is little value added. Additionally, time spent in the ED would only delay the time until the patient can be put into a hospital floor bed and begin treatment.

PCP PERSPECTIVE:
For good reason, the PCP feels caught in the middle. He’s certain he can’t effectively treat the patient as an outpatient, and he needs to feel confident that his patient will be getting the necessary care as quickly as possible. He also has space and resource issues with the patient staying in his office. Additionally, the longer the patient remains in the PCP’s office, the greater the risk that the patient’s condition will worsen. The PCP needs help from both the ED and hospitalist physicians to make patient transfers from his office easier.

“By making a transition unit available, patients can be examined by a physician or midlevel provider, and an informed decision can be made about the appropriate disposition...”

SUGGESTED SOLUTION:
Many hospitals are creating, near their ED, a transition unit where patients referred from outside physicians’ offices can be seen. By making a transition unit available, patients can be examined by a physician or midlevel provider, and an informed decision can be made about the appropriate disposition, whether it’s a discharge to home after some intravenous therapy, an admission to the hospital for inpatient treatment, or continued outpatient observation in an observation unit. We also recommend developing clear admission and transfer protocols so that all services are satisfied, and patients’ needs are addressed.
TAKE ACTION CHECKLIST:

Ideas for resolving conflict about whether to admit or send home a stable but potentially high-risk ED patient

☐ COMMUNICATE
   Listen to and acknowledge the unique perspectives of the ED, hospitalist, and primary care physicians.

☐ CONSIDER
   Is it feasible for your hospital to create a transition unit—near the ED and staffed by a physician or midlevel provider—where patients referred from outside physicians’ offices can be seen and routed appropriately?

☐ DEVELOP
   Discuss and determine clear admission and transfer protocols that satisfy all services while at the same time addressing patients’ needs.
SCENARIO No. 2

PCP vs. ED vs. Hospitalist: Admit or Send Home

THE SITUATION:
The EM physician wants to send a stable patient with chest pain up to hospitalist service for observation and evaluation. He feels the patient is too high risk to send home. The hospitalist wants the ED to perform a two-hour rule-out for a heart attack, and then send the patient home with instructions to follow up with a primary care physician. A complicating factor: The patient doesn’t have a PCP.

EM PERSPECTIVE:
Before an effective decision can be made on whether a patient should go home, that patient must be stabilized and his or her emergency medical condition identified—the latter is viewed as the hospitalist’s role if it cannot be completed in the ED in a timely fashion. The EM doc’s thinking: “If you haven’t ruled out a life-threatening condition, the patient could go home [from the ED] and potentially have a fatal outcome—a liability risk for the ED.”

HM PERSPECTIVE:
If a hospitalist admits, and the patient doesn’t meet inpatient or observation criteria, the hospitalist is at a different kind of risk—that of having to defend his decision to admit the patient during later case management or utilization review.

PCP PERSPECTIVE:
Whether the patient is discharged from the ED or the hospital, it is important that the patient knows and understands what was done while he or she was in the hospital (e.g., imaging studies) and understands the discharge physician’s follow-up plan. It is impossible for the PCP to know the EM or HM physicians’ mindsets and try to guess whether certain tests were ordered, what conclusions were reached, and why.

“The hospitalist needs to understand that the ED physician is assuming the risk of a bad outcome if he sends the patient home, and the ED physician needs to understand that the patient should only be brought in if he or she meets appropriate criteria.”

SUGGESTED SOLUTION:
Communication between the ED and hospitalist physician is crucial. Both physicians need to understand the other’s perspective. The hospitalist needs to understand that the ED physician is assuming the risk of a bad outcome if he sends the patient home, and the ED physician needs to understand that the patient should only be brought in if he or she meets appropriate criteria. By working collaboratively, both physicians can achieve agreement and consensus. Whether the patient does go home from the ED or from the hospital, the PCP needs accurate notes of what occurred, what tests were done, and details on the recommended follow-up.
TAKE ACTION CHECKLIST:

Ideas for resolving conflict about whether to admit or send home a stable but potentially high-risk ED patient

☐ COMMUNICATE
Share the unique perspectives on the particular situation the ED and hospitalist physicians are facing.

☐ EVALUATE
Determine the benefits and risks of the available care options. How might each affect the patient, the ED physician, and the hospital physician?

☐ COLLABORATE
Reach a consensus that offers the least risk to the patient and, if possible, enables both the ED and hospitalist physician to satisfy hospital requirements, goals, or other important criteria.

☐ REACH OUT
Whether the patient is discharged from the ED or from the hospital, commit to sending the patient’s existing PCP accurate notes of what occurred, what tests were done, and details on the recommended follow-up. If the patient doesn’t have a PCP, make efforts to recommend one.
SCENARIO No. 3

ED vs. Hospitalist: Admit to Surgeon or Hospitalist

THE SITUATION:
A patient is seen in the ED with a problem that could be appropriately managed by a surgeon or a hospitalist. The ED physician calls the surgeon, who tells the physician to admit to the hospitalist. The hospitalist’s opinion is that the patient should more appropriately be admitted to the surgeon, but he (the hospitalist) feels pressured to accept the patient.

EM PERSPECTIVE:
In this situation, an EM physician feels caught in the middle. Since the specialist—in this case the surgeon—has refused to accept the patient, he feels forced to plead with the hospitalist to accept the patient. He knows that the patient needs to be admitted and would prefer to leave the ED as soon as possible. He also wants to move the patient to the inpatient floor and free up an ED bed so as not to impact arrival-to-provider time, throughput, and left-without-being-seen numbers. The EM physician has no preference who accepts the patient, as long as someone does. He would rather have the hospitalist and specialist talk directly, but this is the situation he’s been handed.

HM PERSPECTIVE:
The hospitalist physician also feels caught in the middle. Because the surgeon is refusing the patient, he’s forced to accept a patient that he feels would be best served clinically by being managed by a specialist. Additionally, he feels disrespected. In the hospital hierarchy, the medical staff considers it acceptable for specialists to refuse to care for a patient, but hospitalists, like ED physicians, feel a professional responsibility to care for the patient.

SUGGESTED SOLUTION:
Don’t shoot the messenger. Understand that both the ED and hospitalist physicians are caught in the middle, and that the time to establish policy is not while a patient is in the ED and needs to be admitted. Rather, the three groups—specialists, hospitalists, and ED physicians—should meet at a non-urgent time in the future to discuss and reach a consensus on which clinical conditions would be most appropriately managed by which specialty. Together they can set standard protocols, so there’s no question about who is responsible for what when each situation arises.

POSSIBLE PROTOCOL:
If it’s likely that a patient will need to go to the operating room in the first 24 hours of admission, the trio might agree the patient should go to the surgery service, and the hospitalist will do a consult; if the patient isn’t likely to go the OR in the agreed-upon time, the trio might agree that the hospitalist will primarily admit the patient, and the specialist will serve as the consultant.

Consider, too, creating protocols specific to each specialty. For example, for patients with potential neurosurgical problems, the hospitalist, ED physician, and neurosurgeon should meet to agree on which diagnoses can be admitted to the hospitalist service versus neurosurgery, and whether the neurosurgery service will commit to consult within a specified time frame on any patient admitted to the hospitalist service.
TAKE ACTION CHECKLIST:

Ideas for resolving conflict about whether an ED patient would be more appropriately managed by a hospitalist or a specialist

- **REMEMBER**
  Don’t shoot the messenger.

- **UNDERSTAND**
  Both the ED and hospitalist physicians are caught in the middle.

- **SET STANDARD PROTOCOLS**
  At a non-urgent time in the future, specialists, hospitalists, and ED physicians should meet to discuss which clinical conditions would be most appropriately managed by which specialty.

- **AGREE**
  Determine who is responsible for what in a variety of common situations.

**DISCUSSION TIPS:**

- Begin with the most common conflict situations and plan to meet again as new situations arise or to revisit protocols that, once established and utilized, require further refining.

- **Consider creating protocols specific to each specialty.**
  Example: for patients with potential neurosurgical problems, the hospitalist, ED physician, and neurosurgeon should meet to agree on which diagnoses can be admitted to the hospitalist service versus neurosurgery, and whether the neurosurgery service will commit to consult within a specified time frame on any patient admitted to the hospitalist service.

- **Introduce “if/then” scenarios to allow for variables.**
  Example: If it’s likely that a patient will need to go to the operating room in the first 24 hours of admission, the trio might agree the patient should go to the surgery service, and the hospitalist will do a consult; if the patient isn’t likely to go the OR in the agreed-upon time, the trio might agree that the hospitalist will primarily admit the patient and the specialist will serve as the consultant.
THE SITUATION:
The EM physician wants to admit his patient to a hospitalist for further testing and treatment. The hospitalist resents receiving patients from the ED when no diagnosis has been made and feels that more diagnostic testing should be ordered by ED because the ED can get results faster.

HM PERSPECTIVE:
The hospitalist approach to medicine, as guided by training, is that treatment follows diagnosis. How can one decide admitting is needed without even knowing what’s wrong? Complicating matters further: Radiology and labs typically won’t respond to hospitalist requests as fast as they will those from the ED, which slows down the hospitalist’s ability to properly diagnose and treat the patient.

EM PERSPECTIVE:
The EM approach, also guided by that specialty’s training, is that the EM physician’s priority is to identify a patient’s life threats (i.e., emergency medical condition) first, then to stabilize those life-threatening conditions, then to identify the disposition: “Once the disposition is known, the important part is done.” For emergency physicians, training is not focused primarily on diagnosis, so they believe that additional testing and intervention is best done outside of the ED.

SUGGESTED SOLUTION:
Understand first that each physician’s training is different. Neither is wrong, but the difference between internal medicine training and emergency medicine training necessitates a significant change in communication. EM physicians need to understand that their hospitalist colleagues will be looking for a diagnosis, so EM physicians will want to explain at the outset that it will not be feasible to identify a specific diagnosis in the ED. Hospitalists need to understand that, in identifying the diagnosis and best treatment course, they are working with the emergency physicians as part of a team. In this particular case, the patient is better managed outside of the ED.

Equally important, the two groups need to work on a system-level approach to the “testing is faster in the ED” phenomenon. For best results, we recommend that representatives of both the ED and hospitalist programs team up to fight this battle. They should work together (at a non-urgent time) with administration and/or radiology and lab to explain their challenges and request a change to the protocol that can result in a win-win for both sides and the hospital’s metrics: If the treating hospitalist is able to request tests and labs as high priority and receive results faster, the ED is better able to quickly move the patient to the floor, and the hospitalist can quickly diagnose and treat the patient.

“...explain their challenges and request a change to the protocol that can result in a win-win for both sides...”

The two groups collaborating to change the system so that it works to achieve mutual goals ultimately benefits the ED, hospitalist program, and the patient in terms of care quality and efficiency.
TAKE ACTION CHECKLIST:

Ideas for resolving conflicts about who should order diagnostic tests

☐ COMMUNICATE
Understand how the differences in training can complicate the communication and expectations of internal medicine and emergency medicine physicians—especially regarding the where and when a diagnosis should be made.

☐ TEAM UP
Select representatives from the ED and the hospitalist program to work together—at a non-urgent time—with administration and/or radiology and lab to elevate the priority of test and lab requests from hospitalists.

☐ ESTABLISH PROTOCOL
Seek to find and implement a solution that results in a win-win for the ED, hospitalist program, and hospital metrics.

i.e., If the treating hospitalist is able to request tests and labs as high priority and receive results faster, the ED is better able to quickly move the patient to the floor, and the hospitalist can quickly diagnose and treat the patient.
SCENARIO No. 5

ED vs. Hospitalist: Importance of Throughput & Bed Space

THE SITUATION:
A patient is seen in the ED after having suffered a medication overdose. The ED physician has determined that the patient is clinically stable but is not yet medically cleared for either discharge or transfer to a mental health unit. The ED physician therefore wants to move the patient to the medical floor to be observed by the hospitalist service for several hours. The hospitalist feels that since the patient likely will be cleared for discharge or transfer in the next few hours, the patient should remain in the ED for observation.

HM PERSPECTIVE:
The hospitalist understands the need to move patients along but knows this patient will ultimately be cleared to go within four to six hours. If he accepts the patient, he’ll fill a floor bed, have to do a complete initial history and physical exam, and then discharge the patient. The floor nurse will have to perform a complete admission nursing evaluation and complete the nursing database. To do all this when the patient is going to be released in just four to six hours is seen as inefficient and a waste of manpower and space.

EM PERSPECTIVE:
Throughput is an important part of the EM physician’s job. ED doctors are under a lot of pressure to “move beds” quickly. Having a stable patient occupy an ED bed for four to six hours is wasteful. Additionally, the ED physician must always consider the patients in the waiting room who have not yet been seen. These patients are at higher risk for adverse outcomes if they experience a delay in evaluation and treatment, which happens when the ED beds remain full.

SUGGESTED SOLUTION:
It is important to first acknowledge that both the ED and hospitalist physicians are dealing with significant pressures to achieve certain metrics. Emergency medicine physicians are tracked on left-without-being-seen rates (LWBS or LWOT), arrival-to-provider time, overall length of stay, and other throughput measures. Hospitalist physicians are tracked on discharges before noon, length of stay, productivity values, and other throughput measures.

“...acknowledge that both the ED and hospitalist physicians are dealing with significant pressures to achieve certain metrics.”

There are several potential ways in which these two specialties can partner to resolve their areas of conflict. First, they both can assist in the development of a short-term observation unit or transition unit. These units, whether managed by the ED or hospitalist physicians, are an efficient means of managing patients who have an anticipated short stay while in observation status.

Second, this case illustrates the value of identifying ED performance metrics for the hospitalist physician as well as hospitalist performance metrics for the ED physician. Once identified, each of the physician’s metrics can be incorporated into shared performance tracking systems and incentive plans. By having shared metrics, these two groups of physicians can arrive at policies and patient care decisions that help both groups and, most importantly, all patients.
TAKE ACTION CHECKLIST:
Ideas for resolving conflict related to a patient’s location while in observation status

☐ UNDERSTAND
   ED and hospitalist physicians should discuss the metrics each is under pressure to achieve:
       • LWBS LWOT
       • Arrival-to-provider time
       • Overall length of stay
       • Discharges before noon
       • Length of stay
       • Productivity values
       • Other throughput measures

☐ EXAMINE
   After acknowledging individual challenges, seek to pinpoint and prioritize areas of conflict that can be resolved with actionable solutions.

☐ CONSIDER
   Would the development of a short-term observation unit or transition unit help manage patients in observation status who have an anticipated short stay? If so, partner up to decide who would/could manage it, determine steps necessary to implement this unit, and formulate an action plan.
THE SITUATION:
The ED wants to send a stable patient up to the hospitalist floor; the hospitalist would prefer to come down and evaluate the patient in the ED.

EM PERSPECTIVE:
The EM physician feels there is no advantage to having the hospitalist come down. Furthermore, when will the hospitalist actually arrive? (Hospitalist says soon but past experience shows it can be an hour or more—leaving a valuable ED bed unnecessarily full.) Furthermore, the EM physician resents that the hospitalist is questioning his judgment: “I’ve established what she needs. Why do you need to come down and evaluate after I’ve told you what’s going on? You’re just slowing down the ED.”

HM PERSPECTIVE:
The hospitalist physician wants to do a diagnostic workup to determine the best place for the patient—maybe telemetry, or floor bed, or maybe ICU bed. The hospitalist feels it’s more efficient to see the patient in the ED, make a decision, and get orders written. The hospitalist also recalls prior patients where he disagreed with the emergency physician’s assessment.

PCP PERSPECTIVE:
Regardless of where the patient actually ends up, the decision-making process behind it is often a mystery to the PCP. When the patient arrives at the PCP’s office following his or her hospital experience, often the discharge summary hasn’t yet arrived. And if it has, it is often maddeningly brief—perhaps with new prescriptions prescribed but no indication why. Insufficient hand-off communication is frustrating not only for the PCP but also for the patient. A patient who views his or her hospital experience unfavorably is typically less inclined to return to that ED or be admitted in the future.

SUGGESTED SOLUTION:
Break down silos and collaborate.

In the hospital: At a non-urgent time, the ED and hospitalist medical directors should sit down and work out some systems and criteria for handling such cases. The groups should work out guidelines for determining which patients can be admitted directly without a hospitalist evaluation in the ED and which will need evaluation prior to admission. All parties should, of course, keep exceptions in mind. The groups should also acknowledge each other’s goals and understand that sometimes the ED will need to help the hospitalist finish inpatient discharges, and the hospitalist will need to help the ED with throughput.

“...acknowledge each other’s goals and understand that sometimes the ED will need to help the hospitalist finish inpatient discharges, and the hospitalist will need to help the ED with throughput.”

This perfectly illustrates the value of shared ED/hospitalist performance metrics. If, for example, IP discharge-before-noon-%, a traditional hospitalist performance indicator, is added to
SCENARIO No. 6

CONTINUED

ED vs. Hospitalist vs. PCP:
Should the Hospitalist See the Patient in the ED
or Admit to Floor ... plus Primary Care Communication

an ED physician’s productivity-based incentive plan, the ED physician will be rewarded doubly for
assisting the hospitalist with morning workflow. Similarly, incorporating ED door-to-doc times into
the hospitalist’s incentive plan would motivate the hospitalist physician to get patients out of the ED
more quickly in the afternoon and evening, when rapid ED-bed turnover is crucial to reduce crowding.

For situations in which ED patients awaiting inpatient beds are being held in the ED—especially if
intentionally, as in the example above—protocols should delegate who is responsible for providing
the patient with a clear explanation and realistic estimate for the wait. The responsibility might be
delegated to the ED physician or nurse or to the hospitalist by way of a brief drop-down introduction.

Out of hospital: Understand that the drop-off from
inpatient to outpatient is a critical point in patient
safety. As such, make a full and complete discharge
summary a high priority. Put a plan in place to fax or
e-mail summaries to ensure they arrive at the PCP’s
office before discharged patients do. Better yet:
Take the time to place a phone call so that PCP also
has opportunity to ask questions and clarify any
information he or she needs: “Three minutes on the
phone can make a huge difference in patient safety
and patient satisfaction.” Finally, we recommend
utilizing technology to improve communication.

“Three minutes on the
phone can make a huge
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and patient satisfaction.”
TAKE ACTION CHECKLIST:

Ideas for resolving where and when a hospitalist evaluates an ED Patient, and how a PCP is informed following discharge

☐ COLLABORATE
At a non-urgent time, the ED and hospitalist medical directors should sit down and work out some guidelines for determining which patients can be admitted directly without a hospitalist evaluation in the ED and which will need evaluation prior to admission.

☐ REMEMBER
There are always exceptions; consider the guidelines a framework for more common situations.

☐ UNDERSTAND
Acknowledge each physician’s goals and understand that sometimes the ED will need to help the hospitalist finish inpatient discharges, and the hospitalist will need to help the ED with throughput.

☐ CONSIDER
Would shared ED/hospitalist performance metrics help the situation? By incorporating shared goals into each other’s productivity goals, both parties can be incentivized to help the other succeed.

☐ ESTABLISH A PATIENT COMMUNICATION PROTOCOL
Delegate responsibility for providing the patient with a clear explanation and realistic estimate about his or her wait for evaluation or admittance.

☐ ESTABLISH A PCP COMMUNICATION PROTOCOL
Make a full and complete discharge summary a high priority. Plan to fax or email summaries to ensure they arrive at the PCP’s office before discharged patients do. Better yet: Call the PCP so he or she has opportunity to ask questions and clarify any information needed.
This white paper, and the strategies and solutions contained herein, come courtesy of ECI Healthcare Partners, the fourth largest provider of physician staffing and management services to healthcare facilities in the United States. Physician-owned and managed, ECI Healthcare Partners offers integrated services to support emergency, urgent care, and hospitalist medicine. It is the parent company to staffing and management companies Emergency Consultants, Hospitalist Consultants, and ECI Healthcare Partners TeleHealth; coding and billing company SymMetric Revenue Solutions; and practice management software company Clinix.

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