

# URGENT Matters E-Newsletter

## Mission Critical Moving Outside the Walls of the ED

### **BEST PRACTICES: EMERGENCY DEPARTMENT FOLLOW-UP OFFICE**

The emergency department (ED) is most commonly associated with acute illness and traumatic injury — heart attacks, car accidents, gunshot wounds, even anaphylactic shock — but the reality is that many visits to the ED are triggered by symptoms that stem from grave but undetected conditions. That, and the transient nature of ED patients, creates special challenges for health care.

“Due to the nature of the ED, patients are most often unknown to staff, and yet the physician is expected to examine, diagnose and treat potentially serious conditions and injuries in a timely manner without the ability to determine if the treatment was effective or the diagnosis correct,” observes Judy Specht, R.N., of Stony Brook University Medical Center in New York. “Patient satisfaction with the ED is directly related to wait time and the speed and ease of discharge, but diagnostic testing performed in the ED often provides results hours or days after the patient has left the facility. So providing professional aftercare services is essential.”

The importance of carefully reviewing and documenting the diagnostics administered to ED patients is why

Stony Brook University Medical Center has a designated team whose sole job is to manage communications with patients and their providers after they have been discharged from the ED.

Housed in the Follow-Up Office, a highly specialized team of RNs and clerks inform patients about diagnostic tests completed after discharge, communicate with primary care and other community providers, and field calls from patients who have questions or concerns after leaving the hospital. Established in a trailer outside the hospital nearly 20 years ago, the office now occupies its own space and has expanded its caseload from roughly 90 to 300 patient chart reviews per day. Staffed by two full-time registered nurses, two part-time registered nurses, and three clerks, the Follow-Up Office is open seven days a week, 365 days per year, for 10 hours per day. Salaries are paid by the Department of Emergency Medicine, which also purchases all supplies and equipment.

### **Creating A Safety Net**

Specht, who runs the Follow-Up Office, characterizes the program as “a safety net that diverts all aftercare issues away from the ED staff.” The tasks of the Follow-Up Office staff fall into one of two categories: calling patients to alert them to medical conditions identified by tests and scans and handling in-coming patient inquiries covering a wide range of issues, from concerns about wound care to requests for proof of their ED visit to satisfy an employer.

Having a designated team to deal with these calls is beneficial for two reasons, Specht says. First, it relieves physicians and other ED clinicians of the burden of phone calls and paperwork. Second, it provides a back-up set of eyes to review the patients’ medical charts to make sure the ED staff did not fail to record any symptoms or diagnostic results during the visit. Often, she notes, a test ordered to address one symptom will flag another, sometimes more serious, condition. The Follow-Up Office staff cross-reference the diagnostic results with the patient chart to look for things that may have fallen through the cracks.

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"If something's not written in the chart," says Specht, "I'm going to assume no one discussed it with the patient."

For maximum efficiency, the RNs handle specific tasks and delegate others to the clerks. RNs review every lab result and radiology report to identify abnormal findings not documented on the chart, in which case the patient must be called at home and informed. Work sheets are created to follow every result to completion, and 50-60 patient follow-up calls are made daily. A progress note is created for the purposes of patient education and becomes part of the permanent medical record.

### **Communicating with Patients**

"There is an enormous amount of time spent on patient education when a patient must be informed of an incidental finding on a CAT scan or a positive culture," Specht notes, saying patients might be told, for example, they have a lung nodule, Lyme Disease, or they are infected with an organism resistant to the antibiotic they were given in the ED.

If the nurse is unable to contact the patient after two attempts and the finding requires non-urgent intervention, a letter is sent to the home. If the finding requires a treatment that should not be delayed, a letter is sent via UPS. Or, if it is urgent the patient return to the ED and the patient cannot be contacted by phone, the police are sent to the home.

In addition, every patient who walks out prior to discharge, leaves without being seen, or leaves against medical advice is contacted to determine why they left and to make sure that they have the resources that they need.

"We are often able to convince patients who remain symptomatic to return," Specht says. "If their needs are financial, we can provide contact with the financial aid department; if they're social, with our clinical social worker. If they have no primary medical doctor or dentist, we can share clinic numbers with them and may even negotiate an appointment. An effort is made in all cases to determine if safety is an issue. Victims service referrals can be initiated if there is an issue associated with domestic violence. Tracking the reason for a patient leaving without being seen and addressing those issues has decreased our walkout rate significantly. We now generally have only about a 1% rate."

The Follow-Up Office also handles daily and episodic reports to the Department of Health, which mandates the reporting of events such as animal bites, Lyme Disease, pesticide ingestion, certain burns, sexually transmitted diseases, possible rabies exposures, diagnostic clusters (i.e. food borne illnesses), and evidence of pandemic viruses.

"The DOH calls daily to log how many patients are encountered each day," a practice that started after 9/11, Specht says. "Requiring ED physicians to monitor and report these findings would prevent them from providing essential care to patients and thus all reporting has been assumed by our program."

Clerks conduct basic telephone screening, provide non-clinical information to patients, and maintain records of each chart processed through the office. The bulk of their workload entails faxing all ED reports to each patient's primary care physician. The Follow-Up Office has a

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computerized fax for ED forms and has installed the names and fax numbers of almost all the physicians in the county. Clerks often have to send information to other counties or states, which then requires a call to the physician's office to obtain fax numbers. In addition, the test results are manually faxed, and the office is currently working on a system to allow computerized faxing of labs as well.

Finally, if the office staff need advice or counsel from a physician to address a patient problem, the main ED attending or pediatric ED attending physicians are available for consultation.

According to Specht, the office has changed considerably over time. In addition to a far larger caseload — resulting from a stark uptick in ED volume — all ED charts are now scanned as the patient is discharged and all forms can be immediately accessed via ED Scanchart, eliminating the need for staff to search for a paper chart.

### **Improving the Quality of Care**

The Follow-Up Office is now seen as an important source of clinical expertise. All new RN staff members must spend a day in the office to learn about different types of concerns patients may encounter after discharge. In addition, all third-year ED residents spend 10 days in the Follow-Up Office. During this time, residents actually make some of the patient calls and spend time listening to concerns.

Specht, who has presented the Follow-Up Office on two occasions to the Emergency Nurses Association Scientific Assembly, has not identified a single comparable program in the country. According to Specht, similar offices do exist in other EDs, however their scope of work and resources is not as comprehensive as theirs.

Specht cautions hospitals to consider the costs and resources involved before launching a similar program, but she says the requirements are minimal. Staff are the greatest expense, and the requisite equipment is limited to phones, fax machines, computers and space. Specht also says, "it's critical to use only very experienced nurses with ED experience who are able to address a wide variety of patient concerns. Employees, both clerical and professional, need to possess knowledge and skills regarding patient education and must have a reassuring phone demeanor."

Specht says the Follow-Up Office has been well received by community physicians, who have been overwhelmingly positive in polls, as well as by patients, who express relief that the process for sharing information is simple and requires no cost or effort. Continuity of care is promoted. ED staff, she says, "has experienced relief from the numerous phone requests for guidance, information, clinical concerns, and requests to have information faxed to primary care physicians. In addition, ED staff have expressed relief that a second check may reduce the potential for liability."

Finally, notes Specht, "because we are the only department in the medical center that has the ability and charge to review every patient contact and all results, there have been many opportunities to initiate research and system change."

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Emergency Department Follow Up Program

Stony Brook University Medical Center

