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With Chest Pain Protocol, Hospital Reduces Patients' Time in Observation

By Nina Youngstrom

The story is familiar: a 65-year-old man comes to the emergency room after five hours of chest pain and a history of smoking and hypertension. His chest pain subsides shortly after arriving at the ER, where he is given an electrocardiogram (ECG) and cardiac enzyme test. Although the tests are negative, the ER physician places him in observation, where he stays for 16 hours.

"Even though the doctor has seen this case 1,000 times and knows there's very little risk of a cardiac event, the doctor brings them into the hospital instead of sending them home and doing an outpatient stress test," says Paul Arias, assistant vice president of care coordination at Loma Linda University Health in California. "The ER doctors are risk averse, mostly because they fear malpractice lawsuits in the unlikely event something bad happens to the patients before they are seen by the cardiologist as an outpatient."

Reluctance to discharge low-risk patients, or keeping low- or moderate-risk patients too long in observation or improperly admitting them as inpatients, raises hospital costs and leads to claim denials. It's not great for patients either, between the risk of adverse events and higher copays, he says.

To change these dynamics, Loma Linda University Health in July 2018 implemented chest pain guidelines that help physicians determine where patients should go after they're evaluated in the emergency room—an inpatient bed, observation or the emergency room—or whether they should be discharged with close follow-up (see chart below). It has helped drive down the volume and length of observation stays, Arias says.