Simple Vs. Complex Observation

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The presenter has no conflicts of interest, commercial or otherwise related to the contents of this talk.

The presenter affiliations with Janssen pharmaceutical company and has received honorarium for consulting in the past two years.
56 y/o F with a hx of DM2, HTN, dyslipidemia, obesity and 2V CAD s/p DES to LAD and RCA a year ago presents to the ED with 1 day hx of intermittent, dull L precordial chest pain. Pain radiates down the L arm, is worse with exertion, better with s/l nitro and rest. She cannot always afford her Plavix and “stretches it out”.

Her EKG shows Q waves in inferior and anteroseptal leads but no acute ST elevation or depression.

First set of cardiac enzymes is negative.
Socratic Method: Asking continual questions until a contradiction is exposed, thus proving the fallacy of the initial assumption.

Socrates
20 y/o F presents to the ED with a 3 day history of fever, body aches, nausea, vomiting, right flank pain and dysuria.

ED work up reveals a temp of 104 F, HR 126, white count of 14K and a dirty UA.

She is given 1 gm Ceftriaxone IV and 4 mg Zofran and fluid challenged but vomits after 30 mins.

She is admitted to the Observation Unit under “Acute Pyelonephritis” protocol.

“Simple”? 
20 y/o F presents to the ED with a 3 day history of fever, body aches, nausea, vomiting, right flank pain and dysuria.

ED work up reveals a temp of 104 F, HR 126, white count of 14K and a dirty UA.

She is given 1 gm Ceftriaxone IV and 4 mg Zofran and fluid challenged but vomits after 30 mins.

Oh BTW: She has a hx of Kidney/Pancreas transplant 3 years ago and her med list is 17 deep.

“Complex”? 
Simple Observation

- Single active problem
- Limited co-morbidities, medication needs
- Easily managed through standardized protocols
- Limited nursing needs
- Ideal for nurse or advance practice provider run Obs unit with some physician oversight
- Can be initiated in the ED (virtual obs)
Complex Observation

- More than one active problem
- Multiple co-morbidities, poly pharmacy
- Not easily protocolized
- Resource intensive, demanding care
- Need considerable physician oversight
- Increased LOS
The Hot Potato

- ED physician calls the hospitalist for a potential admission
- Hospitalist service either “full” or “patient does not meet inpatient criteria” – request admission to the Observation Unit
- Observation Unit provider says “patient is excluded from the protocol”, refer back to hospitalist
- Now ED physician is on his 4th phone call
Current Challenges Driving Obs. Units

- Health care costs out of control
- High readmission rates
- Recovery Audit Contractors
- Accountable Care Organizations
Principles of Obs. Medicine

- The 80/20 rule
- Share the same vision as the ED
- Protocol Driven
- Flexibility
- Very strong leadership (prevent dumping)
- Buy-in from all other departments
Growth in observation units

1999 – 2007: Observation Units

89% rise in observation units

Obs. units capture less than half of patients

Mace, Amer J of Em Med 2003 21:7
Wiler , Acad Emerg Med, 2011; 18:1-7
Natural History of OU’s

- Usually built with great fanfare
- Initial resistance – especially cardiology, hospitalists
- Inadequate resources: Physicians, PA’s and often nurses
- Inconsistent leadership
- Inability to keep the unit full
- Quickly morphs into a “holding unit”, “ED overflow”, “Post-procedure unit” or worse a “storage area”
“Making Greater Use Of Dedicated Hospital Observation Units For Many Short-Stay Patients Could Save $3.1 Billion A Year”

The average cost savings per patient would be $1,572, annual hospital savings would be $4.6 million, and national cost savings would be $3.1 billion.

By Christopher W. Baugh, Arjun K. Venkatesh, JoshuA. Hilton, Peter A. Samuel, Jeremiah D. Schuur, and J. Stephen Bohan
What type of Observation Unit do you have (or need)?
Get accurate numbers

• Emergency Department
  ED wait times
  Average length of stay (LOS)
  Left without being seen (LWBS)
  Boarding times for admitted patients

• Hospital
  Observation LOS
  Occupancy
  Denials
  Readmissions
Types of Observation Units

Emergency Department based
Hospital based
Chest pain centers
Clinical Decision Units
Simple vs. Complex Observation Unit
Open vs. Closed Observation Unit
Hybrid Observation Unit
The VCU Experience

10 bed unit - opened in Feb ’06; started with 14 protocols
Two joint directors (EM/IM boarded)

Staffing:
- 2 Nurses/10 beds
- One Patient care technician
- One desk clerk
- 24 hours of PA coverage
- 6 hours of onsite physician coverage

Initial census was only 5-6 patients/day
What were we missing?

• “Complex Observation” cases, not meeting protocol
• Extended ED patients – LOS>4 hrs.; 30% of these patients met Observation Criteria
• Patients outside our protocols: trauma, overdose etc.

So we expanded our scope to include all the above

Our census went up to 290 patients/mth by end 2006
In 2008 our average census was 370 patients/month.

Excluded post procedure and “hold” patients.

No pediatric patients
Direct Admissions/Transfers

- Additional source of patients for the unit
- Mandate direct communication with the physician requesting admission
- Set up an “accelerated triage” through the ED
- Try to provide feedback to the referring physician
Protocols: the double edged sword

- Standardize care but discourage creative thinking
  One size fits all philosophy

- Have to be resource sensitive and hospital specific
  UM model
  Inpatient Vs outpatient Observation

- Do not capture:
  “Outside the box” Obs. (20%)
  “Complex Observation Patient”: multiple chronic problems, yet not meeting acute inpatient criteria.
The Hybrid Unit
The Hybrid Unit

- Jack of all trades, master of none
- Moves the bottleneck up
- Possible uses:
  - Admit holds
  - Extended ED workups
  - Post-procedure unit
  - “Fast-track” ED patients

If used as an option, Must have strictly defined criteria
Who will run the Observation Unit?
Observation Unit Staffing

- Physician Staffing
  - Emergency Physicians
  - Hospitalists
  - How many hours of coverage?
- Advanced Practice Providers
- Nursing and ancillary staff
  - 1:5 nursing ratio
  - 1:10 patient care technician
ED run Model

- ED physician rounds for a brief period every morning prior to starting ED shift
- Nurses run the unit and track down ED physician for orders/disposition
- Variable mid-level coverage
- ED group not allowed to bill two separate visits (no financial incentive)
- ED physicians averse to sub acute and chronic care – do not relish CDU work
Hospitalist Run Model

- Unless incentivized, consider CDU as more work
- Not familiar/comfortable taking care of non-medical conditions
- Rounding culture, increased LOS
- Limited flexibility to deal with ED needs
- No vested interest in the ED
Use of Advanced Practice Providers

- Who will pay for APPs?
- Advantages
  - Flexibility in implementing protocols
  - Patient turnover
  - Complex observation patients
  - Can perform minor procedures
  - Help out in other areas
- Disadvantages
  - Expensive
Use of Advanced Practice Providers

- Must have
  - Clearly defined expectations
  - Strong and dedicated physician leadership
  - Training manual, continuing education
  - Rotate in other areas of the ED
  - Scheduled Unit meetings with physicians and nursing staff
  - Preferably have prior experience in the ED and/or inpatient setting
Who will pay for the unit?
(and more importantly)
How will the unit pay for itself?
Current Payment Models for Observation Services

Physician (CPT) Payment Models

Hospital (CMS) Payment Models
Professional fee reimbursement

- Observation Unit as a separate billing entity OR part of a multispecialty group
  - Hospitalist, Internist, FP
  - Dual boarded (EM/IM)
  - EM boarded
- The capture of professional fee revenue allows:
  - Enhanced physician coverage
  - Faster throughput
  - Improved quality
- Use EMR to maximize revenue capture
- Negotiate fair compensation with local commercial payers
## EMERGENCY & OBSERVATION CPT CODES

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<th>Service</th>
<th>CPT codes</th>
<th>Required Documentation **</th>
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1 vs. 2 day Explained

**ONE DAY SCENARIO**: 
- ED
- Obs
- D/C
- One day “combo” codes (initial E/M + d/c)
  - 99234, 35, 36

**TWO DAY SCENARIO**: 
- ED
- Obs
- D/C
- Initial E/M
  - 99218, 19, 20
- Obs discharge code - 99217
Evolution of Hospital Payment


2. **2000** (OPPS / APC) – **Nothing**. Observation “packaged” (not paid separately)- utilization dropped

3. **2002** – **APC 0339** Observation “unpackaged” for Chest Pain, Asthma, CHF. Multiple complicated criteria.

4. **2004** – **Code 44**. Allowed inpatient to outpatient “retro-conversion” (i.e.. to observation status).

5. **2005** – **APC 0339 “light”**. Multiple testing criteria lifted

6. **2007** – **APC 8003** “Condition” restriction lifted, a “composite” APC:
   - Combined ED (or clinic) visit + observation visit into one APC.
   - Utilization should have increased 100-150%. Only increased 67%.
Hospital Payment Models – APC 8003

Requirements:

- Level 4 or 5 ED visit (or clinic/critical care)
- Over 8 hours of observation care
- No associated “T-status” procedure
  - Major procedures: EGD, cardiac cath, etc

If requirements not met – pay ED visit only

“Composite” APC payment: ED+Obs visits into one payment

For 2013 = $813
Why Observation LOS is critical

- Direct costs (visible, easy to track and quantify)
  - Physician cost, diagnostic and therapeutic intervention
  - Rarely time-dependent

- Indirect costs
  - Overhead and nursing cost
  - More directly a function of LOS
Why Observation LOS is critical

- Observation units accomplish the same diagnostic and therapeutic interventions as a short-stay inpatient admission, in less time.

- **ED OU mean length-of-stay is fifteen hours**
  

- Lower indirect cost per square foot - cost savings come from a reduction of indirect costs
  
Additional indirect cost savings

- Avoidance of complications associated with inpatient hospitalization
- Decrease in interdepartmental hand-off errors
- Improvements in patient satisfaction and quality of life


- Creation of virtual inpatient capacity

Case in Point

• In 2012, a university hospital had a total of 5,390 ED observation patients.
  • Average charges: $3,003 ($16.18 million)
  • Average collection: $1,113 ($6 million)
  • Costs: $306/patient (1.65 million)
  • Contribution margin: $807/patient (4.35 million)

37% collection rate
What Politics will I encounter?
Politics

- Institutional
  - Leadership
  - Support
  - Space
  - Turf Wars
  - Expectations

- Regional
  - Contract negotiations for fair compensation

- National
  - Defining Acute vs. Observation admission
  - Pay for performance
Is there a secret sauce for a successful Observation Unit?
Ingredients for success

- Leadership – ability to say NO
- Adequate resources and hospital support
- Cost Effective - Generate revenue
- Using cross-trained ED nurses
- Mechanism for admitting patients who fail Obs.
- Monitor Outcomes
By E. Rattray

I like to confuse people!

I am a warrior.

A warrior? Eh? You must be an expert on bravery.

Sure.

This is Socrates.

This is Socrates.

Poor innocent victim.

This is Socrates.

So what is this "bravery"? Being... brave?

Being brave?

Are you sure?

No.

Ha!

I don't like you!

This is Socrates.

This is Socrates.

This is Socrates.

This is Socrates.

Pool of blood.