Operating an
OBSERVATION UNIT

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Objectives

Define and describe observation services
How to start a observation service line
Review research to support observation services
Develop inclusion and exclusion criteria
Metrics to assure success
Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.
Observation services are those services:

a) Furnished on a hospital’s premises
b) Includes use of a bed/periodic monitoring by nursing or other staff
c) Reasonable and necessary
d) To evaluate an outpatient’s condition
e) Determine the need for possible admission as an inpatient
f) Ordered by physician
g) Usually do not exceed one day
h) May go for up to 48 hours
i) Under unusual circumstances may exceed 48 hours
j) Must be at least 8 hours

Medicare from HIM-10 455 (Pub. 100-2, Medicare Benefits Policy Manual, Chapter 6, 70.4)
Non-Qualifications for Observation Services

- Routine stays after surgery
- Diagnostic testing
- Outpatient therapy/procedures
- Normal post-op recovery time
- Convenience stays
- Stays prior to outpatient surgery
- Stays over 48 hours
- Stays while awaiting ECF placement
- Routine prep
- Recovery from a diagnostic procedure
Types of Observation Setting Models

TYPE 1
Protocol driven in an observation unit.

TYPE 2
Discretionary care in an observation unit

TYPE 3
Protocol driven in any bed in the hospital

TYPE 4
Discretionary care in any bed in the hospital
Types of Observation Units

CLOSED UNIT
- Limited admitting physicians
- In a designated area

OPEN UNIT
- All physicians can admit
- Patient can be placed in “virtual bed”
When Is Observation Appropriate?

Based on 3 concepts:

1. Probability of disease versus harm of the potential disease under consideration
2. Need for further testing to make a definitive diagnosis
3. The patient's condition warrants further observation and evaluation by the physician
Advantages of Observation Services

Observation services and units provide:

- HIGH QUALITY
- INCREASED THROUGHPUT
- COST AVOIDANCE
• Where did we go wrong with observation services?

• We did not change our processes...

• Observation was viewed as just a “financial status for reimbursement purposes”
Observation is not only a financial designation

Observation Medicine is a process

If you treat patient placed in observation services the same as inpatients you will get the same results
Benefits of Observation Two-Fold

Cost Avoidance

Increase Revenue
Advantages of Observation Services

- Increase patient satisfaction
- Meet Quality Indicators
- Avoid Diversions
- Decrease errors
- Increase ED throughput and efficiencies
- Avoid 30 day readmit penalties
- Decrease unnecessary admission
- Decrease patient costs
- Increase case mix index
- RAC Avoidance

Observation Services and Units
Advantages of Observation Services

1. Meet 2014 CMS quality indicators:
   - Increase ED throughput and efficiencies
   - Decrease patient costs
   - Decrease unnecessary admission
   - Increase case mix index
   - Avoid 30 day readmit penalties
   - Avoid Diversions
   - Decrease errors
   - Meet Quality Indicators
   - Increase patient satisfaction
1. Meet 2014 CMS quality indicators:

- Median time from admit decision time to time of departure from the emergency department (ED) for ED patients admitted to inpatient status.
- Median time ED arrival to time of departure from the emergency room for patients admitted to the facility from the ED.
- LWBS < 2%
ED Throughput

ED 2b

Median time Patient spent in the ED after the Doctor decide to admit them as an inpatient before leaving the ED for their inpatient room

National Average= 98 minutes

If observation patients are using inpatient beds it backlogs the ED
Advantages of Observation Services

2. Avoid EMS diversions

- Decrease errors
- Increase ED throughput and efficiencies
- Avoid patient readmits
- Avoid unnecessary admission
- Decrease patient costs
- Decrease unnecessary admission
- Increase case mix index
- Avoid 30-day readmit penalties
- Increase patient satisfaction
- Avoid Diversions
- RAC Avoidance

SOCIETY OF CARDIOVASCULAR PATIENT CARE
Advantages of Observation Services

2. Avoid EMS diversions
   - EMS is a business and healthcare partner
   - The national average for EMS ED volume = 15% - does any physician group bring this volume to your hospital?
   - Admission rate for patients via EMS = 34% nationally - typically higher acuity
   - Calculate for every hour the facility is on diversion lost revenue
   - Nine Boston area implemented a diversion ban in January 2009.
     - What Happened?
       - Hospitals volume rose 3.6 percent after the diversion ban BUT length of stay dropped 10.4 minutes for admitted patients, while ambulance turnaround time decreased 2.2 minutes, according to a study in the December Annals of Emergency Medicine
Advantages of Observation Services

1. Increase case mix index
2. Avoid 30 day readmit penalties
3. RAC Avoidance
4. Increase patient satisfaction
5. Decrease unnecessary admission
6. Decrease patient costs
7. Decrease errors
8. Increase ED throughput and efficiencies
3. Decrease medical errors/liability


4. Increase ED throughput and efficiencies

- Less boarding
- Decrease LWBS
- Decrease ED LOS

5. Decrease patient costs

On average Medicare paid nearly three times more for a short inpatient stay than an observation stay and beneficiaries paid almost 2x more.

*Memorandum Report: Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries, OEI-02-12-00040*

6. Observation services gives time needed to make a clinical decision
Patients generally fall into two categories—*diagnostic treatment* versus *short term therapy*.

**ADDITIONAL TESTING**
- Chest pain
  - serial biomarkers
- Syncope-resolve
- Abdominal pain
  - serial WBC

**SHORT TERM THERAPY**
- Acute exacerbation of CHF
  - lasix, nitrate
- Cellulitis - IV antibiotics
- A-fib - medications
- Asthma
  - nebulizers, steroids
Advantages of Observation Services

- Increase patient satisfaction
- RAC Avoidance
- Avoid 30 day readmit penalties
- Increase case mix index
Advantages of Observation Services

7. Increase case mix index
   low acuity patients will dilute the CMI

8. Avoid 30 day readmit penalties
   If a patient presents to the ED within 30 days of an inpatient admission and can be safely treated in an observation setting this always the facility to avoid the 30 day readmission penalty
786.59 OTHER CHEST PAIN

786.50 UNSPECIFIED CHEST PAIN

Low risk chest pain rarely will meet inpatient criteria per Milliman or Interqual criteria

The mean CMI for 786.59 = 0.62 and 786.50 = 0.63
9. RAC avoidance

The number one diagnosis for short one day inpatient stays is chest pain. All one day inpatient stays are vulnerable to RAC audits.

10. Increase patient satisfaction

Patients will not need to miss work for an additional follow day for stress testing, etc. Need to know age..... We want it now.

Not included in VBP but has halo effect.
Where do I Begin to Start an Observation Service Line?

1. Identify the current processes.................yes, flowcharts
2. Use quality tools
3. Establish metrics to validate successes
4. Create a team – who is on the team and why???
Assembly a Team
Team Members to Assure Observation Unit Success

**Finance**
Must be an expert in Observation billing
Must capture charges as well as time

**IT**
Can the facility's software accommodate observation documentation?
Do not use the inpatient model—overkill, will cost staffing time

**Administrative Champion**
Where does the buck stop?
- Observation Medical Director
- Observation Nursing Director

**Facility Director**
Addresses space issues
- Where is the unit located?
- Capital equipment expenses

**Staffing Model**
ED nurses rotate or dedicated staff??

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SOCIETY OF CARDIOVASCULAR PATIENT CARE
### Team Members (cont.)

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Case Management</th>
<th>Education</th>
<th>HIM</th>
<th>Laboratory</th>
<th>Stress Lab Director</th>
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<tbody>
<tr>
<td>Must have protocols regarding patient taking home meds within OBS setting.</td>
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<td>Additional education for nurses/physicians to understand observation status.</td>
<td>Hospital Health Information Management</td>
<td>Turnaround time for labs will directly effect LOS</td>
<td>Turnaround time for stress testing will effect LOS</td>
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In the Centers for Medicare and Medicaid Services (CMS) Change Request 5946 Transmittal 1445, under Reporting Hours of Observation, it states:

*Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy)*

*This means any testing where the patient is monitored by another professional*
There is not software product currently available to accommodate observation documentation requirements

BUT

There are software products to capture charges
Documentation Requirements/HIM

• Document Emergency H& P - if not admitted under Emergency medicine group need new H& P

• Separate Observation documentation
  - Order to place patient in observation status time and date
  - Note medical necessity and risks
  - Treatment plan
  - Progress notes regarding ongoing care
  - Discharge note should include:
    • Final exam
    • Course of treatment
    • Final diagnosis
    • Final disposition
Documentation Requirements – Nursing

- CMS does not specially address nursing documentation for observation services
- #1 Mistake - Facilities require nurses do a complete nursing assessment
Strong Medical and Nursing Director- gatekeepers

- Help develop and support inclusion and exclusion criteria
- Conversations with physicians to educate
- No boarders!!!
- Metric presentation to administration to support resources and cost savings of observation unit
- Educate staff
Where will you place the Observation unit? 
– *depends who is providing medical oversight*
Nursing Staffing Model

- Account for the frequent admissions and discharges
- One position must be accountable for charges
- Think about the right hire for this position? Medical-Surgical nurse versus ED nurse?
- Must have an orientation module for Observation Nurses
Staffing

- A 2003 survey reported that units were staffed with an average 4.2 patients per nurse.
  - Reality -5- 6 patients per nurse depends on types of patients admitted to the unit.

- 21.4% used associate providers (physician assistants or nurse practitioners).

- ACEP endorses Emergency Medicine oversight of observation unit.

- Many facilities use mid-level providers to cover the units as physician extenders.

Physician Staffing

In a physician work-time study by Graff:

- the typical ED patient required 22 minutes per case
- observation patients required a total of ...58 minutes per case

Although these patients are requiring less than one half of the amount of emergency physician service per hour (amount of work divided by length of stay), their total amount of emergency physician work required is more than double the overall average ED patient.

Graff estimated that for every 3000 patients observed, one physician full time equivalent (FTE)
Some drugs are not chargeable — pharmacy has this list

Example:

• Patient do not need prn nasal spray for < 24 stay
• OTC vitamin D, etc.

Have pharmacy take ownership over this process. Med reconciliation will usually not correspond with patient’s meds ordered while in observation.
Case Management

- UR person needs to be assigned unless the staff is educated enough to understand when to call UR for utilization questions.

- Social work must be accessible - if patient has SW needs question if they are appropriate for observation services - complexity of patient.

- Consults in observation should be rare. - the more consults the longer LOS.
Education

• All staff must be educated regarding observation services
• Scripting regarding observation - not “we are going to admit you”
• Must understand the goal of less than 15 hour LOS - it is all about throughput
• Educate physicians, stress lab and central laboratory
• Observation provides cost avoidance value as well as revenue
• Must change your processes
• Observation is a service line
• Presents metrics both current state to administration and potential opportunities for revenue
• Present a business plan
• Start slow with top 5 diagnosis - easy observation until you work out processes
• Need physician champion who “gets it”
Top Ten Opportunities With “Observation”
per the SCPC Accreditation Review Specialists

DARICE ALLARD RN, MSA, FABC, CPHQ
#1 Understand what “Observation” is and is not...

• These are outpatients.

• “a well defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they will be able to be discharged from the hospital”.
   -Centers for Medicare and Medicaid

• Time period to “rule-out”, “rule-in” or provide short term therapy
• Is a service- not a status
• Awareness of patient- may look identical but care is not
#2 Understand the appropriate patient populations...

- Inclusion/exclusion criteria

  **Cardiac**

  Low risk ACS population, A fib, Heart Failure

- Other most appropriate inclusions- COPD, Asthma, Syncope, TIA
Patient care needs to be managed differently for rapid, effective evaluation of these patients. Condition-specific protocols are crucial for improving patient care. These protocols include order sets, protocols, and processes. It is essential not to hold patients in an area waiting for a bed. Who is the gatekeeper in this process? All stakeholders, including the patient, need to understand the LOS expectation.
#4 Think in terms of hours...not days...

- All, including the patient, need to understand the LOS expectation
- Fast paced work
- Dedicated staff with critical thinking skills
- Rounding is core to staying on top of these patients.
# 5 Multi-disciplinary care effects plan of care...

- Physician Leadership
- Serial EKGs
- Central Lab
- Physician
- Stress Lab
- Lab TAT for serials draws
- Nursing Leadership
- Patient
- Pharmacy
- Counseling
- Case Management
- Nursing

Risk Stratification
#6 Difference in documentation and charging...

• CMS Physician documentation requirements clear

• CMS nursing documentation requirements - must have nursing documentation but why do a complete inpatient assessment?

• “Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy)”
  
  -CMS Change Request 5946 Transmittal 14445

• Outpatient is APC codes- not DRGs so not bundled. Are you capturing your charges?

• EDUCATE STAFF- include Finance!
#7 Importance of discharge education....

- Schedule follow-up appointments
- Teachable moment with the low risk patient r/t risk factors
- Close the loop- compliance achieved?
# 8 Location, location, location...

- Variety of settings
- Efficiencies for all to group patients in dedicated location
- Also a bed, is not a bed, is not a bed...

- Observation Unit?
- Clinical Decision Unit?
- Chest Pain Unit?
#9 Need metrics to track “runaway” hours....

- What process and quality indicators?
- Dashboard concept
- Whose responsibility?
- What committee?
#10 Effective solution to many facility issues...

- Increased Throughput/Patient Flow/LOS
- Decrease readmissions
- Increased patient satisfaction
- Cost avoidance/cost reduction model
Goal:

Most appropriate level of treatment, to the most appropriate patient, in the most appropriate location while controlling costs.
Thank you
From the Accreditation Review Team