Operating an OBSERVATION UNIT

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Objectives

1. Provide a historical overview of observation medicine
2. Identify ten key steps to a successful observation unit
3. Analyze and apply the benefits of an observation unit
Historical Overview

1980’s

Medicare changed from cost based reimbursement to Diagnosis Related Groups (DRG) - Observational services came to light
Office of inspector general (OGI) study of observational services

1998

Outpatient Perspective Payment System (OPPS) begins

2000

New OBS APC (0339) created for 3 conditions
- Chest pain, asthma, CHF
- Multiple condition restrictions

2001

Coalition (SCPC, ACEP, ACC, AHA, etc.) meets CMS on this issue:
Six point proposal supported by AHCPR research

2002

2007

New composite APC (8003) for all conditions
What is Observation Services?

MEDICARE DEFINITION:

A well-defined set of specific, clinically appropriate services include:

– ongoing, short term, treatment, assessment, and reassessment before a decision will require further treatment as:
  - hospital inpatients
  - discharged from the hospital

Medicare policy manual rev. 137 12-30-10
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

Medicare from HIM-10 455 (Pub. 100-2, Medicare Benefits Policy Manual, Chapter 6, 70.4)
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
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

Observation services and units provide:

HIGH

VOLUME

IMPACT

BENEFIT
Advantages of Observation Services

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

OBSERVATION SERVICES AND UNITS

SOCIETY OF CARDIOVASCULAR PATIENT CARE
Advantages of Observation Services

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

2. Avoid EMS diversions

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

Avoid Diversions
Advantages of Observation Services

2. Avoid EMS diversions
   - EMS business partner, national average for EMS ED volume = 15%
   - Admission rate for patients via EMS = 34% nationally
   - 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

3. Decrease medical errors/liability
Advantages of Observation Services

3. Decrease medical errors/liability

4. Increase ED throughput and efficiencies
   - Less boarding
   - Decrease Left Without Being Seen (LWBS)
   - Decrease ED LOS

5. Decrease patient costs
   - Make sure the patient understand they are in an outpatient status

6. Decrease unnecessary admission
   - Observation admission gives time needed to make a decision
Advantages of Observation Services

7. Increase case mix index

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

7. Increase case mix index
8. Avoid 30 day readmit penalties
9. RAC avoidance
   • One day inpatient stays
10. Increase patient satisfaction
    • Return to work, instant gratification-reality- halo effect on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
Current Status

National Survey
- *Emergency Department Observation Units* (EDOU) in 19% of US hospitals
- 12% planning a unit.

2003
19%
EDOU USE

2006
The Institute of Medicine supported the use an EDOU to decrease ED boarding, ambulance diversion, and avoidable hospitalizations

2007
36%
INCREASE IN USE OF EDOU

National Hospital Ambulatory Medical Care Survey data:
- the percent with an EDOU had increased to 36%
- with more than half managed by ED

Ross et al. Critical Pathways, 2012  The State of the ART: Emergency Room Observation Units.
Team Members

**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 Director**
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??

SOCIETY OF CARDIOVASCULAR PATIENT CARE
<table>
<thead>
<tr>
<th>Team Members (cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
</tr>
<tr>
<td>Must have protocols regarding patient taking home meds within OBS setting</td>
</tr>
<tr>
<td>Case Management Utilization</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Additional education for nurses/physicians to understand observation status</td>
</tr>
<tr>
<td>HIM</td>
</tr>
<tr>
<td>Hospital Health Information Management</td>
</tr>
<tr>
<td>Laboratory</td>
</tr>
<tr>
<td>Turnaround time for labs will directly effect LOS</td>
</tr>
<tr>
<td>Stress Lab Director</td>
</tr>
<tr>
<td>Turnaround time for stress testing will effect LOS</td>
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</table>
PEPPER RESOURCE

Short-Term Acute Care
Program for Evaluating Payment Patterns Electronic Report

Website: PEPPERresources.org

- Report available to all types of hospitals (ie: short and long-term, critical access hospitals)
- Helps to identify trends and comparisons to other facilities
- Key for Observation Services

SOCIETY OF CARDIOVASCULAR PATIENT CARE
1) Detect and correct past improper payments in the Medicare fee-for-service program

2) Provide information to CMS and to the Medicare claims processing contractors that could help protect the Medicare trust funds by preventing future improper payments.

   • All one day inpatient stays
   • If an inpatient is not discharged and the billing has not occurred the facility can use code 44 to convert the patient from inpatient to outpatient status
More than 50% indicated they spent roughly $10,000 managing the Recovery Auditor (RAC) process during the second quarter - 9% say they spent more than $100,000.

84% of American Hospitals Association’s survey respondents indicated that medical necessity denials represented the most costly and complex form of denials.
Observation Research

<table>
<thead>
<tr>
<th>Average LOS</th>
<th>75% &lt; 18 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients placed in observation unit</td>
<td>91% &gt; 3100</td>
</tr>
<tr>
<td>Percent admitted to an inpatient status after an observation study</td>
<td>25-40%</td>
</tr>
<tr>
<td>Number of observation beds</td>
<td>91% had 16 beds or more</td>
</tr>
<tr>
<td>Number of observation units in operation</td>
<td>91%</td>
</tr>
<tr>
<td>Nurse to patient ratio</td>
<td>4:1</td>
</tr>
</tbody>
</table>
National level:

- Use of observation care after an ED visit increased from 0.6% in 2001 to 1.9% in 2008

Simulation model:

- $3.1$ billion in annual national cost savings from 2.4 million avoidable inpatient admissions.

The use of observation care in the setting of a dedicated unit should be included in health policy and delivery reform discussions and payment systems should be evaluated to encourage changes to support it.

_Baugh, c et al. Health Affairs, October 2012_
Characteristics of the 18 Participating Hospitals

- Total # ED visits - 1.28 million
- Total # Hospital Responders - 18
- Average # Hospital Beds - 602 (± 213)
- Hospital Inpatient Occupancy % - 82.3 % (± 8.5%)
- Average ED Visits in 2007
- 75,570 patients (± 24,895)
  - Average # ED Beds 59 (± 19)
<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average # Beds in the EDOU</td>
<td>13.3 ( 7.4)</td>
</tr>
<tr>
<td>Percent of ED census that is observed</td>
<td>7.2% (+ 6.7%)</td>
</tr>
<tr>
<td>Number of EDOU beds per ED beds</td>
<td>4.25 ED beds / 1 EDOU bed</td>
</tr>
<tr>
<td>Number of EDOU beds per ED visits</td>
<td>1 EDOU bed / 7,461 ED visits</td>
</tr>
<tr>
<td>Daily number of EDOU pts / EDOU bed</td>
<td>1.14 patient / bed / day</td>
</tr>
<tr>
<td>Metric</td>
<td>Value</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Average # ED Patients Observed</td>
<td>4,430 (3,478)</td>
</tr>
<tr>
<td>% of EDOUs Located Within/Adjacent to ED</td>
<td>82.3%</td>
</tr>
<tr>
<td>% of ‘CLOSED*’ Units (EM only)</td>
<td>93.8%</td>
</tr>
<tr>
<td>Average ED Length of Stay for EDOU Patients</td>
<td>4.2 hours (1.6 hrs)</td>
</tr>
<tr>
<td>Average EDOU Length of Stay</td>
<td>15.7 hours (3.8 hrs)</td>
</tr>
<tr>
<td>% Discharged From EDOU</td>
<td>82.4% (4.3%)</td>
</tr>
<tr>
<td></td>
<td>Value</td>
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<td>--------------------------------</td>
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</tr>
<tr>
<td>Number of Observation Beds</td>
<td>8</td>
</tr>
<tr>
<td>Ratio ED Beds/Observation Beds</td>
<td>3.8 :1</td>
</tr>
<tr>
<td>Number of Observation Patients per year</td>
<td>1550</td>
</tr>
<tr>
<td>Percent of patients discharged after treatment</td>
<td>89.1%</td>
</tr>
<tr>
<td>Length of stay</td>
<td>19.5 hours</td>
</tr>
</tbody>
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### Society of Cardiovascular Patient Care

**SURVEY QUESTION**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Median</th>
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<tbody>
<tr>
<td>Number of inpatients beds</td>
<td>250</td>
</tr>
<tr>
<td>Percent Inpatient Occupancy</td>
<td>70%</td>
</tr>
<tr>
<td>Number of Emergency Department Beds</td>
<td>27.5</td>
</tr>
<tr>
<td>Number of ED visits annually</td>
<td>41,660</td>
</tr>
<tr>
<td>ED length of stay prior to Observation (hrs)</td>
<td>3.18 hours</td>
</tr>
</tbody>
</table>
For every 1,000 Medicare admissions in 2009, there were another 116 observation care visits, 34 percent more than in 2007 - Brown University
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”
Out of Sight, Out of Mind?
The Challenge of Managing Virtual Patients

Clinical Advisory Board Members with Observation Units

- Have OU: 29%
- Don’t Have OU: 71%

Mixed Across Disparate Patient Locations

- Staff does not focus on discharging patients within 24 hours
- Staff often does not know that patients are under observation status

Observation patients treated the same as inpatients
Staffing

• A 2003 survey reported that units were staffed with an average 4.2 patients per nurse
  - Reality -5 patients per nurse

• 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

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)
Physician Documentation

- Document Emergency 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
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 Extended Care Facility (ECF) placement
- Routine prep
- Recovery from a diagnostic procedure
Suggested Metrics

Observation Metrics

- Length of Stay - by diagnosis
- Utilization
- Percent observation to inpatient conversion
- ICU admissions
- Work with finance to determine financial measurements
- No. patients/EDOU bed/day
- Cardiac Biomarker TAT
Emergency Metrics

- Decrease left without being seen
- Length of stay in ED
- Return visits with 7-14 days
- Decrease boarding hours
- Decrease ambulance diversion hours - translates to revenue
- Cardiac biomarker TAT
The key to wellness and its efficacy is in cost avoidance - it is not in cost prevention.

The objective is to decelerate the trend in rising health care costs.
Lab can help impact Outcomes!

- Leadership in guidelines applied to practice
- Drive quality at all Levels
- Be patient centered and outcome-oriented
- Communicate and collaborate with all disciplines
SCPC Resources:

www.scpcp.org

info@scpcp.org

SUBJECT LINE:

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