Observation Level of Care
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How is OBS defined?

- What is observation level of care? Observation is a care status in an acute care hospital setting that is appropriate when a patient’s condition is rapidly changing and it is not clear if inpatient care is needed, but the physician is not confident that the patient can be treated at home. After several hours, and at 24 hours and 48 hours, an assessment can be made to determine if the patient requires inpatient admission, or may be discharged and receive follow-up in the outpatient setting.

- How long can a patient remain in observation? Ohio Medicaid will pay for up to 48 hours of observation care, and this is billed on a per hour basis. In addition to the observation charge, imaging studies, labs, and procedures are also reimbursed at the outpatient rate.

Source: molinacare.org

Other frequently-asked questions

- How does inpatient care differ from observation? The patient receives all necessary services as ordered by his or her physician in either setting. Observation, intermediate, and critical levels of care refer to facility payment only, not to care received.

- What happens if inpatient care is not approved? If inpatient care does not meet criteria for admission using InterQual or MCG acute care criteria, we will pay for up to 48 hours of observation care including all medically necessary services. Services provided after 48 hours will not be reimbursed.

- If a physician orders inpatient admission, and inpatient care is denied by the health plan, does this mean the provider and facility will not be paid for services? The participating physician bills for services and is paid per contract based on ODJFS fee schedule rates. Physicians receive payment for E&M services delivered to a patient whether in observation or admitted to the hospital, when appropriate CPT codes are used. The facility will not be paid a DRG payment, but will be paid for up to 48 hours for observation care, and per contract for testing, imaging, and other services in addition to the observation rate. Please note, Ohio hospital prior authorization guidelines will apply. Source: Molinacare.org
When a patient becomes acutely ill and presents to an Emergency Room, Urgent Care or Medical Office, the presenting symptoms, exam findings, lab results, imaging and other test results may indicate the need for immediate inpatient admission. In some cases while there is significant illness present, it may not yet be clear that inpatient admission is the appropriate level of care. However, the physician may not feel that the patient should be discharged, or may want to initiate treatment and observe the response to that treatment before deciding if admission is indicated. Observation allows the physician to keep the patient in a treatment environment where services are readily available if the condition changes. Often, observation for several hours or even up to two days will show improvement in the patient's general condition, lab values, or testing, and the patient may be discharged from this level of care without inpatient admission and treated at home or through the outpatient treatment setting. We frequently see patients admitted to an acute care hospital overnight and discharged in the morning. In these cases, the patient's condition was rapidly changing, whether from the natural course of the disease process, or from response to initial treatment. Acute hospital treatment is getting much better and more efficient. More significant disease can be treated in the emergency department or observation unit, and the patient improves in several hours and does not require inpatient admission. Early treatment of respiratory infections or skin infections often does not require admission. Even patients with diabetic ketoacidosis that is diagnosed early and treated with IV insulin can often be discharged in less than 24 hours and receive good care in the outpatient setting.

Case Example

A 45-year-old patient presenting with L precordial chest pain is a good example. Acute chest pain is related to acid reflux or similar non-cardiac complaints more frequently than to heart muscle damage from myocardial infarction (heart attack). However, the history and exam presentation could also be compatible with a heart attack or other more serious disease process. Such a patient would be admitted to observation in an acute care hospital, and a series of lab studies and EKGs would soon rule out heart muscle damage. The patient can be sent home to follow up with his or her physician as an outpatient. This patient does not require admission, but meets criteria for observation. InterQual lists observation status for acute coronary syndrome, where history and exam cause the clinician to suspect acute coronary syndrome, but initial cardiac biomarkers (troponins) are negative and EKG is either normal, or non-diagnostic. The patient can go home in the morning if biomarkers remain normal, and EKG remains unchanged. Positive biomarkers and acute changes on EKG would indicate acute MI or unstable angina, and acute inpatient admission is warranted and will be approved.

The American College of Emergency Physicians website has a FAQ section on observation status, stating: Because Observation services are by definition outpatient services, placement into observation ought to have been specifically ordered at a time when it was uncertain if an inpatient admission would be necessary (Chapter 1, Section 50.3.2 of the Medicare Claims Processing Manual (Pub. 100-04); FAQ 2723. Observation is a level of outpatient service that should be considered for any patient who requires continued care but does not meet inpatient admission criteria, or any patient that is expected to improve with treatment over the next 24 to 48 hours and for whom inpatient admission is not required. All covered hospital services are available to a patient in observation status. [Source: molinahealthcare.com]
Separate OBS Unit or Part of the ED?

[Source: Sarah Carignan, MBA; Administrative Director, Emergency Services; Boston Medical Center]

First things first... Look at existing data for observation status patients at your institution
- How many observation patients do you have in your hospital? And how many would qualify for your unit if included? How long do they stay on average? This will help determine the size of your unit, and the potential for backfill inpatient revenue. Be careful not to claim observation patients as new revenue to the institution.
- How many long LOS patients who are discharged from the ED could qualify for observation? This is potential new revenue.
- Get the average revenue for observation patients from Finance.

- Provide the right care to the right patient. Doing so has the potential to improve efficiency and free inpatient beds.
- If your institution is growing and could backfill revenue, these inpatient beds would be better utilized to free up ED and streamline higher revenue patients. And the opportunity to increase the revenue.
- If there is no backfill revenue anticipated your institution’s census is declining, there is still an opportunity to streamline documentation and systems, reduce cost, and provide the right care with fewer resources. In this case, add the cost savings of closing beds on inpatient units to your ROI.

Cost structure

Cost structure rationale
- In our FY, 12-bed had 20-30 patients in observation status each day, patient left in the ED 10-20 hours.
- Past experience and national benchmarks suggest we could reduce LOS to 16 hours with 15% rollover rate.
- We had a 12-bed unit designated for our use.
- Based on our institution's 85% productivity target – we calculated we could see up to 15 patients per day in our 12-bed unit designated for observation patients.
- Our new unit had reduced LOS, improved throughput, and significant cost savings.
- We continued to ramp up our census to free inpatient beds for observation, and improve the cost structure.
- We continue to ramp up our census to three observation beds for observation, and improve the cost structure.

KEY CONTRIBUTORS/Stakeholders
- Senior leadership
- Emergency medicine - physician, nursing, and administrative
- Case Management
- Department of Medicine
- Cardiology
- Neurology
- Stress lab
- Laboratory
- Radiology
- Housekeeping
- Transport
- Dietary
- Consult services
- Admitting
- IT (hardware, documentation, systems)
- Billing/Coding/Finance (Facility and Professional)
- If possible, has someone at your hospital opened a new unit recently? Use them as a consult.
3. Key Decision Points

- How many beds do you need? How many beds can you fit?
  - Data on current patients in initial and final observation status (volume, LOS, and rollover %)
  - What will your assumptions be about the new LOS?
  - How many patients are discharged from the ED that could have met observation status? (new revenue)


- How not to allow this to become a “boarder” or detox unit?

- Closed unit? – Only patients through the ED? Post op? Direct admissions?

- Space/design

- Staffing and Medical coverage decisions - Hospitalist vs Emergency Medicine

- IT requirements

- Professional and Facility billing experts should also weigh in

- You cannot achieve your target LOS only by cohorting observation patients.
  - What systems will you set up to improve throughput?

4. Support ongoing processes

- You cannot achieve your target LOS only by cohorting observation patients.
  - Medical coverage by Dept of EM with focus on throughput
  - Clinical protocols - with involvement of physicians, nursing, case management, and other services
  - Lab, Radiology, Pharmacy, and Consults - Make obs unit orders STAT
  - Stress Lab - Hold stress test appointments each morning for obs patients
  - Admitting - Determine priority bed assignment for obs patients who “roll over”
  - Dietary - Establish par levels of certain items that meet all dietary requirements. No ordering off the menu.
  - IT, Billing, Case Management - Reduce documentation from inpatient, but ensure it meets billing requirements.
  - Heavy Case Management involvement up front and whenever discharge issues are identified, daily rounds.
  - Can you justify adding key resources on the weekends? (e.g., stress test appointments)

- Identify any other items prevent timely discharge of these patients on inpatient units and re-engineer your processes

5. Timeframe

- “It depends.”

- Timeframes vary. Consider the time required at your institution to:
  - Get data, build your business proposal, and calculate your ROI.
  - Ensure leadership backing.
  - Establish your workgroup. Get the appropriate parties around the table (and really mean there) to educate the team on observation documentation, billing, and coding.
  - Get space/design approval from the Dept of Public Health
  - Recruit, hire, credential, and orient new staff who will work in the unit. Any union considerations before posting positions at your hospital?
  - Make changes to IT systems - adding a new location, downstream system effects, changing documentation
  - Make changes to current workflows and establish new (e.g., work with Lab and Radiology to make all orders STAT similar to the ED)
  - Identify admission guidelines (patient selection). Develop workflows with finance (re Otto for getting a patient to the unit, noting them to inpatient if necessary, etc.)
6a. Determine your key metrics up front, 2013

<table>
<thead>
<tr>
<th>Key Metrics</th>
<th>April</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admits to Obs Unit</td>
<td>177</td>
<td>196</td>
<td>184</td>
</tr>
<tr>
<td>Patients/Day</td>
<td>5.90</td>
<td>6.32</td>
<td>6.13</td>
</tr>
<tr>
<td>Average LOS (hrs)</td>
<td>19.1</td>
<td>22.5</td>
<td>18.1</td>
</tr>
<tr>
<td>Occupancy %</td>
<td>16%</td>
<td>42%</td>
<td>33%</td>
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<tr>
<td>Rollover %</td>
<td>15%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Obs Avg LOS off unit (hrs)</td>
<td>28.6</td>
<td>27.1</td>
<td>26.9</td>
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6b. Define your success, or opportunities for improvement

- **Improved LOS by 27%, improved throughput, continuing to monitor “leakage” to increase census and expand clinical protocols**
- **Patient Experience**
  - Patients love a short LOS and being out of the hectic ED environment.
  - It is advertised to patients as a continuation of their ED care.
- **Staff Engagement**
  - Staff are thrilled to be a part of something new.
  - Important that staff find change exciting rather than frustrating.
  - Some hesitation about lack of variety with protocol-based unit.
- **Some providers and other services were wary until they saw the success.**

7. Incidental Findings

- **Observation medicine can require a new way of thinking.** Don’t simply replicate current systems from the inpatient world. Adopt a hybrid of the inpatient and ED mindsets. Some would argue it’s closer to the ED.
- **Constantly revisit the data, opportunities, and metrics.** Our interdisciplinary workgroup continues to meet weekly after the opening of the unit and examines every LOS outlier and observation patient who was not placed in the observation unit.
- **A lot of places aren’t doing observation well.** Breaking open the process and workflow helped identify issues in current processes that were unrelated to this unit.
- **All of your “i”’s won’t be dotted, nor your “t”’s crossed when you open the unit.** The important piece is that the interdisciplinary relationships have been established, the commitment is there, and any issues can be continually improved upon.
- **This effort would not be possible without a team of dedicated colleagues who had no idea what they were getting into with the new kid.** A cast of many contributed time and effort to ensure the success of our observation unit.