Observation Services: New Trend in Healthcare, New Focus for Nurses

State of the Art
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Objectives

- Define Observation Services and the patient population served
- Describe how having an Observation Unit benefits the patient and hospital
- Recognize that opportunities may exist to improve workflows, patient satisfaction and throughput based on a unit's unique needs
Background
Observation

What is it?

- An *Outpatient* service

- *Clinically appropriate services* that can include further diagnostic testing, ongoing short term treatment, assessment and reassessment

- The decision to discharge or admit the patient to inpatient can usually be made *in less than 24 hours*
Observation

When to consider

- Patient does not appear to require admission but is not yet appropriate for discharge from the ED

- More time is needed for evaluation related to a specific medical condition or diagnosis.
  - Additional testing
  - Short term therapy
Two Midnight Rule

- Inpatient admission is generally not appropriate for hospital stays not expected to span at least 2 midnights (Medicare Part A)

- Variation between insurance providers on when the clock starts

- Recommended best practice is to have one rule for all OBS patients and not consider payer

- To bill for observation (Medicare Part B, Outpatient Hospital Services)
  - Minimum 8 hours
  - Between 24-48 hours
  - Rare >48 hours
Patient Population

Inclusion/Exclusion Criteria

☑ Put in place to help identify patients who can be safely and effectively managed in observation
  - Patients with a single acute problem
  - Stable condition
  - Able to identify a discrete clinical endpoint
  - 80% chance of going home
  - Patients who will allow for expedited throughput
    - Excludes Patients dependent-for-cares, non-ambulatory, confused/intoxicated/altered mental status, extensive care coordination
Patient Population

Potential Diagnoses

- Abdominal Pain
- Allergic Reaction
- Asthma
- Atrial Fibrillation
- Blunt Abdominal Injury
- Cellulitis
- Chest Injury
- Chest Pain
- COPD Exacerbation
- Deep Vein Thrombosis
- Dehydration or Vomiting or Diarrhea
- Dilantin Toxicity
- Electrolyte Abnormality
- Head Injury
- Headache

Inclusion Criteria

- Serial exams needed to exclude rapidly progressive cellulitis
- Cellulitis which requires > 1 dose antibiotics
- Temp < 40.0°C, WBC < 16,000 and WBC > 4,000.
- Cellulitis with a drained abscess which requires a brief period of observation and wound care

Exclusion Criteria

- Septic or toxic patients – clinical appearance, evidence of severe sepsis (Temp > 40, SBP < 100, RR > 22, HR > 100, * acute organ dysfunction, lactate > 4mmol/L *)
- Immunocompromised patients – neutropenia, HIV, transplant patients, ESRD/hemodialysis patients, patients on immunosuppressants or chemotherapy, post-splenectomy patients.
- High risk infections – diabetic foot infections; infections proximate to a prosthesis, percutaneous catheter or “indwelling device; infections of the orbit or upper lip/nose, neck; infections of >9% TBSA; extensive tissue sloughing; suspicion of osteomyelitis or deep wound infection.

Potential Interventions

- Mark edges of cellulitis with indelible marker to monitor progression
- IV antibiotics - MRSA coverage as indicated (Vancomycin, Bactrim, Clinda, Doxycycline)
- Pertinent labs (CBC, glucose, blood or wound cultures PRN)

Discharge Criteria

Home

- Improvement or no progression of cellulitis
- Improved and good clinical condition (ie. No fever, good VS) for 8 hrs.
- Able to perform cellulitis care at home and take oral medications

Admit

- Increase in skin involvement
- Clinical condition worse or not better (i.e. rising temp, poor vitals)
- Unable to take oral medications
- Unable to care for wound at home, home care unavailable
Patient Population

Appropriate patients

General patient condition
- Must be alert & oriented
- Must be able to ambulate & complete ADLs independently or with minimal assistance
- Must be reasonably expected to discharge within 48 hours (patients who need inpatient admission & are waiting for a bed are NOT appropriate)
- Reason for observation must NOT be pain control related to a chronic condition (i.e. sickle cell, short gut syndrome, etc.)
- Weight must be >40kg
- Age must be >19 years, unless weight & diagnosis are appropriate
- Must be appropriate to utilize standard hospital bed (no specialty beds)
- If pregnant must be <20 weeks gestation
- Vital signs: SBP>90, HR<120, RR<26 or stable at patients baseline

Discharge disposition
- Patient must be expected to have discharge disposition of Home with no services OR Home with HHC
- Must not require extensive resource coordination (i.e. case management, social work) to address medical, psychosocial or financial needs.

Psychiatric
- No suicidal/homicidal patients
- Must not be clinically intoxicated from any substance or medication
- Must be able to participate in plan of care
- No disruptive behaviors that will negatively impact care of others on the unit

Direct admissions
- Must meet diagnosis specific criteria for admission
- Must be seen & evaluated by a physician or APP immediately prior to request for admission

Chest pain
- Must have initial negative troponin and normal EKG (or unchanged from pts baseline)
- No nitro drips for the purpose of managing chest pain
Preparing the Patient

- This is a *focused* observation period to determine whether the presenting condition requires further inpatient care or can be managed as an outpatient.

- Observation patients are required to be given a handout within 36 hours of admission if stay is 24 hours or longer:
  - Explains the reason that the patient is an outpatient
  - Describe the implications of that status both for cost-sharing in the hospital and for subsequent “eligibility for coverage” in a skilled nursing facility (SNF).

- Stays for convenience or services that are not medically necessary for the diagnosis or treatment of the patient condition will not be covered.
Benefits of Observation
Benefits of Observation

For the Patient:

- Increase patient satisfaction
  - Not included in HCAHPS, but it does have a halo effect

- Increased patient safety
  - Reduced LOS = reduced exposure to potential hazards

- Cost savings
  - Observation is covered under Medicare Part B (Outpatient Hospital Services)
Benefits of Observation

For the Hospital:

Cost avoidance

- Decrease medical errors/liability – i.e. missed MI's
- RAC (Recovery Audit Contractors) avoidance
  - CMS uses RAC to find and correct past improper payments & help avoid future improper payments.
  - All one day inpt stays are vulnerable to RAC audits.
- Avoid 30 day readmission penalty
Benefits of Observation

For the Hospital:

**Increased Revenue**
- Increase pts per bed per day = increased revenue
- Open ED beds sooner
- Decrease LWBS

### Observation vs. Inpatient example: Chest pain (DRG 313)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Observation</th>
<th>Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOS</td>
<td>15 (best practice)</td>
<td>43.2 hours</td>
</tr>
<tr>
<td>Patient per day per bed</td>
<td>1.3 (allow TAT)</td>
<td>0.5 (allow TAT)</td>
</tr>
<tr>
<td>Reimbursement per patient per day</td>
<td>$2111</td>
<td>DRG- $3300 (national mean)</td>
</tr>
<tr>
<td>Reimbursement per bed per day</td>
<td><strong>$2744.30</strong></td>
<td>$1650</td>
</tr>
</tbody>
</table>
Getting Started
Settings

- 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

- Location
  - ED based
  - Dedicated Unit (close proximity to ED is ideal)
  - Integrated Observation beds

- Care Management
  - ED Provider, Hospitalist, Combination
  - Closed Unit - limit admitting physicians
  - Open Unit - all physicians can admit
NM Observation Unit

Demographics
- Located on 2nd floor Clarkson Tower near ED and PACU
- 26 beds total, all telemetry capable
  - 4 beds (two rooms) designated for short stay (procedural) patients

Type 2 Hybrid Unit
- Observation or Ambulatory status patients
- Open for any team to admit
Building the team

Members Needed for Success:

- Nursing staff
  - Need to be educated/understand philosophy & goals of obs
  - Experienced, strong clinical ability, critical thinkers
  - Autonomous, problem solvers
  - Team oriented, able to multi task

- Leadership
  - Need good understanding of obs philosophy/goals who will be strong advocates

- Utilization/Case Management
  - UM should be assigned unless staff is educated enough to know when to call with utilization questions

- Pharmacy
- Lab/Ancillary
- Physicians
- Patient Placement Unit
Staff Accomplishments

- Learning and adopting Observation philosophy
- Adjusting to a faster paced care environment
- Learning two different charting systems
- Understanding Observation charges and learning how to document to support charges
- Learning how to monitor tele patients without HMU
- Adjusting to unique scheduling needs
Need for Change
The Early Days
Spring 2015

- Outpatient care area using Inpatient documentation requirements
- Staff overwhelmed with documentation needs in the setting of rapid patient turnover

- Modified Admission Profile

- Inpatient pharmacy process not working for our unit
  - Long wait times for meds
  - Returning large amounts of unused meds

- Worked with Pharmacy to modify processes
  - Frequently used meds were added to unit pyxis
  - Content of patient medication rings was reduced to 12 hours from 24 hours
## An Average Day on the Observation Unit....

<table>
<thead>
<tr>
<th>Admissions</th>
<th>Discharges</th>
<th>Transfer to Inpatient</th>
<th>Short Stay</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.5</td>
<td>12.3</td>
<td>1.5</td>
<td>2.9</td>
<td>29.7</td>
</tr>
</tbody>
</table>

22 Overnight Beds

4 Short Stay Beds
Record Days

1/12/16 - 16 discharges, 20 admissions, 1 inpt tx, 3 short stays
1/19/16- 8 discharges, 10 admissions, 1 inpt tx, 7 short stays
1/22/16- 22 discharges, 19 admissions, 2 short stays
2/11/16- 20 discharges, 15 admissions, 1 inpt tx, 2 short stays
6/17/16- 22 discharges, 14 admissions, 3 inpt tx, 4 short stays
7/18/16- 22 discharges, 5 admissions, 1 inpt tx, 2 short stays
Our “Lightbulb” Moment

Fall 2015

- Observation Workshop at the Society of Cardiovascular Patient care in Dublin, Ohio
- Recognized we had many opportunities to improve our unit!
- Presented learnings and ideas to Department Leadership
- Created a plan to educate unit nursing staff
- Reviewed current documentation and formulated a plan for change
- Asked for feedback from staff
The amount of charting we are required to do is appropriate for the level of care our patients require.

Answered: 17  Skipped: 0

Response

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.88%</td>
<td>23.53%</td>
<td>47.06%</td>
<td>17.65%</td>
<td>5.88%</td>
</tr>
</tbody>
</table>

How often do you feel documentation requirements impact the quality of care you are able to provide your patients?

Answered: 17  Skipped: 0

Response

<table>
<thead>
<tr>
<th>Always</th>
<th>Frequently</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>41.18%</td>
<td>41.18%</td>
<td>17.65%</td>
<td>5.88%</td>
<td>5.88%</td>
</tr>
</tbody>
</table>

“I feel our charting could be much simpler if we focused our charting on the patient's reason for admission... It would save time for initial assessments and help you focus more on patient care than documentation requirements.”
“Not always sure what needs to be charted for obs pts. Example Schmid scale..Had no idea”

“I find it frustrating to try and figure out the many places that I have to chart something. And it keeps changing!”
“Writing meds on the AVS can take forever and definitely delays discharge.”
Implementation

January 2016

Received Leadership approval to move forward with changes

• Nursing Professional Practice

Staff education on workshop content and new documentation requirements

• Began to develop a chart auditing process to ensure compliance

Implemented workflow changes!

• Modified admission profile and discharge process
• Observation tab
• Focused assessments
• Tracking discharge delays
Workflow changes

Admission

- Reduced Admission Profile
  - Started process in fall 2014 working with Nursing Professional Practice
  - Intake questions asked in ED or pre-op meet JC requirements for outpatients
  - Direct admits require a shortened admission profile

Obs vs. Inpt
Workflow Changes

Assessment

- Focused assessments rather than full head to toe
  - CMS doesn’t mandate full assessment
  - Charting should be concise and focused on signs and symptoms of the patients – needs to support the physicians plan of care.

- Cellulitis: integumentary, wounds, CMS, pain

- Chest pain: cardiac

- TIA: neurological, cardiac

- Allergic reaction: respiratory, integumentary, cardiac if indicated

Charting is my favorite part of my job.

Said no nurse ever!
We created an “Observation” Tab in Doc flowsheets

- Condensed from 5 tabs to 4; some existing tabs only 1 or 2 lines were being used.
- Previous process was challenging and time consuming for staff to make sure charting requirements were met.
- Staff were charting items that they shouldn’t because it was there (Schmid scale)
Workflow Changes

Discharge

- After Visit Summary (AVS)
  - Brought our practices in line with other outpatient areas (ED, PACU/short stay)

- Delay tracking
  - Staff are to document on ALL discharged patients
  - Delays occur only after all care is complete
Monitoring and Maintaining Success
Measuring Impact

Spring 2016 and ongoing

- Staff response to change
- Daily admissions and discharges
- Length of Stay
- Discharges before noon
- Conversion rate
- Discharge delay
- Stays < 8 hours
Workflow Changes

**NOV 2015**

How often do you feel documentation requirements impact the quality of care you are able to provide your patients?

- Always: 41.18%
- Frequently: 41.18%
- Occasionally: 17.65%

**MAY 2016**

How often do you feel documentation requirements impact the quality of care you are able to provide your patients?

- Always: 18.75%
- Frequently: 25.00%
- Occasionally: 50.00%
- Rarely: 6.25%

“I have missed some documentation in order to give hands on care”
Workflow Changes

**NOV 2015**

Our documentation system makes it easy to determine if all necessary items have been charted.

- **Answered:** 17
- **Skipped:** 0

- Strongly Agree: 35.29%
- Agree: 29.41%
- Neutral: 35.29%

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**MAY 2016**

Our documentation system makes it easy to determine if all necessary items have been charted.

- **Answered:** 16
- **Skipped:** 0

- Strongly Agree: 68.75%
- Agree: 18.75%
- Neutral: 6.25%

---

It is easy to find the correct place to chart items.

- **Answered:** 17
- **Skipped:** 0

- Strongly Agree: 52.04%
- Agree: 41.18%
- Neutral: 5.88%

---

It is easy to find the correct place to chart items.

- **Answered:** 16
- **Skipped:** 0

- Strongly Agree: 56.25%
- Agree: 31.25%
- Neutral: 6.25%
Workflow Changes

**NOV 2015**

How often do you need to stay after your scheduled shift to finish documentation requirements?

- Always: 47.06%
- Frequently: 35.29%
- Occasionally: 11.76%
- Rarely: 5.88%

- Never: 0%

**MAY 2016**

How often do you need to stay after your scheduled shift to finish documentation requirements?

- Always: 31.25%
- Frequently: 37.50%
- Occasionally: 31.25%
- Rarely: 0%

- Never: 0%
Workflow Changes

**NOV 2015**

How often do you feel documentation needs delay discharge of a patient? (any aspect of the discharge process including AVS work, patient education, removing from computer, etc)

Answered: 17   Skipped: 0

**MAY 2016**

How often do you feel documentation needs delay discharge of a patient? (any aspect of the discharge process including AVS work, patient education, removing from computer, etc)

Answered: 16   Skipped: 0
Basic Numbers

November ‘16 – February’17

- **Length of Stay**
  - 21 hours

- **Conversion to Inpatient**
  - 10%

- **Discharges before noon**
  - 33%

Health Care Mgmt Review 2011
## Discharge Delays

<table>
<thead>
<tr>
<th>Delay Reasons:</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>237</td>
<td>243</td>
<td>247</td>
<td>221</td>
</tr>
<tr>
<td>Social Work</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Ride</td>
<td>25</td>
<td>56</td>
<td>58</td>
<td>48</td>
</tr>
<tr>
<td>Signing Rx</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Consults</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>19</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>Documentation not done</td>
<td>37</td>
<td>47</td>
<td>21</td>
<td>20</td>
</tr>
</tbody>
</table>

**Total patients discharged:**

- November: 323
- December: 370
- January: 346
- February: 313
Keys to Success

- Selecting the appropriate patients
- Understanding length of stay goals
  - Patient safety & satisfaction are increased
  - Cost effective for patient and organization
  - Helps with hospital throughput
- Managing patient expectations
- Leadership support
- Invested nursing staff
- Processes that fit the environment and goals of patient care
- Collaboration between all key team members
Education and Collaboration

Ongoing

- Internal Medicine/Hospitalist
- Cardiology Fellows
- Patient Placement Unit
- Emergency Department
- Social Work and Case Management
- Pharmacy
- Family Medicine
- Ancillary Departments
Takeaways

- Observation is an outpatient service intended to be used when more time is needed to evaluate a patient’s condition and determine if they need to be hospitalized or can be treated as an outpatient.

- Observation has many benefits for the hospital and the patient.

- When your work environment or the goals of your work change, consider whether your methods may need to change as well:
  - “We’ve always done it this way” is not a reason to continue.
  - Involve your leadership when opportunities are identified.
  - Use your resources and be persistent!
Thank You For Your Attention Any Questions?
References


