



Observation Units As A Release Valve



To Our Healthcare Clients and Friends:

Over the past few years, an unprecedented increase in patient visits has challenged hospital emergency departments (EDs) to respond creatively. Patients seeking access to healthcare turn increasingly to their local EDs for primary care treatment. As hospitals across the country examine their operations and processes to improve ED patient throughput, many have implemented observation units. Those hospitals without such units are considering implementing them. An observation unit can provide a clinical and operational alternative for treating patients near, but not in, the ED proper. With careful planning and understanding of the concept, an observation unit can provide a release valve to the ED for those patients who may or may not need inpatient hospital admission. Rather than remain in the ED for many extended hours pending disposition decisions, these patients can be observed and treated in the observation unit. Unfortunately, operating an ill-conceived or ill-planned observation unit can present the hospital with a host of additional unwanted problems.



BACKGROUND



The clinical observation unit has evolved over the years from the clinical decision unit, designed primarily to observe and diagnose patients presenting to the ED with the chief complaint of chest pain, to a more complex unit for evaluating a variety of clinical conditions.

The Centers for Medicare and Medicaid Services (CMS) has established reimbursement for outpatient status for a minimum of eight hours to a maximum of 24 hours. Although hospitals can maintain a patient's observation status for up to 48 hours, the reimbursement will only be for a maximum 24 hours of care, with few exceptions.

The types of conditions now routinely seen and treated in an observation unit include chest pain, congestive heart failure, asthma, syncope, dehydration, a variety of abdominal and gastrointestinal conditions, head injuries, headaches and migraines, and seizures.

When well executed, an observation unit can help improve ED throughput, avoid unnecessary and costly inpatient admissions, or inpatient denials, and ultimately help to increase the hospital's case mix multiplier by avoiding unnecessary admission of patients who can be treated appropriately in an observation unit and be safely and promptly discharged.

The CMS guidelines for observation services billing provide challenges to hospitals who seek to bill appropriately for the level of service that is medically necessary. Previous IMA Insights articles (see March and December, 2008) noted that Recovery Audit Contractors (RAC) focus their attention on observation services and appropriate billing processes. In an effort to follow CMS guidelines for reimbursement, hospitals must prevent inappropriate utilization, but not err on the side of caution when a patient is clinically eligible for an inpatient admission.

CHALLENGES

Implementing and maintaining an efficient, effective observation unit requires vigilance to monitor for clinical appropriateness, operational effectiveness, and compliance with the required documentation to support billing and reimbursement. An ill-conceived, poorly executed observation unit can create more problems than it solves for the hospital.

Recent experience has shown a trend toward increasing numbers of observation patients. An analysis in one setting revealed the total number of patients seen by the hospital remained the same while the proportion of those patients seen in observation status increased by 75 percent. Another analysis showed that 75 of 100 observation patients studied could have been more appropriately treated in another setting. These challenges have significant clinical, operational, and financial implications for hospitals.



INSIGHTS

Since several models of observation units exist, it is important that a hospital implement the most effective model, depending on its available resources and physical plant constraints. Hospitals can locate observation units within the ED, with designated beds reserved for observation care; adjacent to the ED; in a dedicated unit away from the ED, in “virtual units”, where observation patients are cared for in any available hospital bed, with inpatient unit nurses providing the care. An observation unit best practice demonstrates that the most effective location for an observation unit is within or immediately adjacent to the ED.

Other best practices that help to promote observation unit measurable successes include the following additional elements.

- Clearly designated physician responsibility and accountability for clinical management and operational oversight of the observation unit increases its effectiveness. Frequently, the ED physician group holds responsibility for managing the observation unit. Doing so requires supplementing existing ED physician coverage. Some hospitals have turned to hospitalists to manage the unit and its patients. The least effective approach is an open unit that allows any physician to admit patients to the observation unit. This latter approach decreases physician conformity, resulting in incomplete documentation and unfamiliarity with unit clinical protocols, which increases unit length of stay.
- The unit must develop and utilize evidence-based treatment protocols for all the medically designated conditions assessed and treated in the unit. All physicians responsible for treating patients in the unit must agree on the protocols and adhere to them.
- The observations unit should have dedicated nursing and other support staff. Rotated ED staff, float pool nurses, and inpatient unit nurses pulled into service cannot provide a consistent level of timely care gained from intimate familiarity with the evidence-based protocols. Such staff lacks familiarity with the required cycle times for the frequency of reviews necessary to make the unit function effectively.
- Reimbursement for observation services depends upon thorough documentation. Educational programs reviewing required documentation elements of the patient’s observation status should be routinely updated and repeated to the physician and nursing staff. This includes mandatory medical documentation training at more frequent intervals than the traditional yearly refresher.
- ED physicians must avoid batching patient disposition, a common practice in which the ED physician reviews a group of patients who have been seen in the ED for disposition (discharge, observation, or admit) all at the same time. Batching decisions serve to distort the real time required for the ED episode of care, and can serve to erode the 24-hour care window of the observation status patient.





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- Medical records coders will also need routine supplemental education to sharpen their outpatient coding skills in order to consistently code and capture allowable reimbursement for observation services.

SUMMARY

With proper planning and ongoing attention to daily operations, a well run observation unit can promote patient throughput in the ED by providing an alternate area to observe any patient who may or may not require admission. Complete and accurate documentation of the patient's condition while on observation status will assure outpatient reimbursement according to the CMS Outpatient Prospective Payment System (PPS), and avoidance of potential overturned reimbursement decisions resulting from a RAC audit. A successful observation unit operates best with dedicated physicians, nursing, and support staff who are enabled to conduct frequent patient assessments, real time documentation, and timely final patient disposition decisions. In response to the observation unit's investment in dedicated operational resources, the hospital can expect improved ED patient satisfaction, additional reimbursement, a better case mix index, and facilitated patient throughput.

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We are pleased to have the opportunity to present this information to you. If you have any questions or need assistance, please contact me at 484-840-1984.

Truly yours,

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