Observation units: A tightrope act

By Geri Aston

Only about a third of U.S. hospitals have them. But, they can aid throughput, cut readmissions and make patients happy. Just step carefully.

At a time of hospital and emergency department overcrowding, squeezed Medicare payments, and payer audits and denials, hospitals more than ever must make sure they’re utilizing each inpatient bed to the fullest extent. That means not admitting patients who could have been seen safely in a different setting. For a particular type of patient, that setting is an observation unit.

Only about one-third of emergency departments today have a dedicated observation unit. Many more hospitals could benefit from a unit but don’t have one for reasons that range from a lack of upfront resources, to a shortage of space, to a lack of understanding about the clinical and business cases supporting them.

Observation units are designed for a distinct group of patients with distinct service needs, says Michael Ross, M.D., medical director of observation medicine in the Emory University School of Medicine’s department of emergency medicine. These are ED patients who require further treatment, diagnostics or management of psychosocial needs before being safely discharged. Ross calls them six-to-24-hour patients. They need more than the average six or so hours that people spend in the ED but less than 24 hours or an admission. Patients should not be in observation more than 48 hours, he says.

The decision to create a dedicated observation unit often starts with ED overcrowding. Patients who otherwise would be waiting in the ED for test results can be cared for in a separate area with specially trained staff. This improves ED throughput and decreases the potential for ambulance diversion, notes Mary Ann Holt, R.N., partner at IMA Consulting in Chadds Ford, Pa. The hospital maximizes revenue by being able to accept more ED patients and by avoiding lost revenue from ambulance diversion and patients who leave without being seen. Moreover, by eliminating long waits or diversions, patient loyalty and good word-of-mouth about the hospital aren’t compromised.

Patients also benefit. The additional time for testing brings more accurate, and fewer missed, diagnoses. In patients with chest pain, emergency physicians are 10 times less likely to miss a heart attack, which presents atypically in one out of 20 patients, if the hospital has an observation unit, Ross says. In addition, patients are more comfortable in the observation unit because it’s less chaotic than and not as noisy as the ED, Holt says.

Another major rationale for dedicated observation units is that they provide an alternative to short-stay admissions. This has operational and financial benefits for the hospital and clinical benefits for patients.

Patients who are placed in ED observation and those who are admitted for short inpatient stays are remarkably similar in terms of demographics, ED presentation acuity, chief complaint, resource use and final diagnosis, according to a national study of ED observation services published in the September 2011 issue of Academic Emergency Medicine and co-authored by Ross. Several studies have shown that care for a variety of conditions is
equivalent or improved in observation units compared with the inpatient setting. Patient satisfaction often is higher in the observation unit than in an inpatient bed, the article notes.

Some of the most common complaints, including chest pain, asthma and transient ischemic attack, cost less to treat in an ED observation unit than in an inpatient setting, according to an article in the January/March 2011 issue of Health Care Management Review.

By providing an alternative to avoidable admissions, observation units allow hospitals to reserve inpatient beds for patients who truly need them, Holt says. This relieves hospital crowding, as well as ED crowding, because more inpatient beds are available.

The more serious conditions that clearly warrant an inpatient stay often are reimbursed better than the conditions that can be cared for in observation. "By managing patients who would have created a loss for the hospital as an inpatient, emergency observation units create value," notes the Health Care Management Review article.

Preventing avoidable short-stay admissions also reduces a hospital’s chances of Medicare recovery audit contractor reviews. "If a hospital is admitting people as inpatients who should be in observation, then they’re at risk of being audited and penalized by the RAC," Ross says.

RACs are targeting short-stay admissions on medical necessity grounds. Ninety-six percent of hospitals with RAC activity reported that auditors cited lack of medical necessity as a reason for complex denials, according to findings from a recent American Hospital Association RACTrac Web-based survey. Of those denials, 62 percent were for one-day stays that the RAC ruled to have been provided in the wrong setting, not because the care was medically unnecessary.

Different types of units, different issues

In considering an observation medicine strategy, it is important to look at the advantages and disadvantages of observation models. These range from a scattered unit, in which any inpatient bed can be used for observation, to a dedicated unit near or adjacent to the ED with specially trained staff and protocols for patient selection, testing and treatment. The decision about which type of model to use depends largely on resources and funding, space, ED volume and hospital size.

The scattered model is inexpensive, easy to implement, requires no additional staff and uses existing beds, notes the textbook Observation Medicine: The Healthcare System’s Tincture of Time. However, it can have major drawbacks including inconsistency of care and delays in care.

"When organizations put patients in any available bed, they unfortunately will lose insight into appropriately managing that patient within that 24-to-48-hour window of opportunity," Holt says. When observation patients are cared for by floor staff without specialized training, the requirements for checking test results and appropriate documentation can fall through the cracks.

Patients managed in a dedicated, protocol-driven observation unit are more likely to get necessary tests, to have shorter lengths of stay and lower overall care costs, and their satisfaction is higher, Ross says. American College of Emergency Physicians policy recognizes care in a dedicated ED observation area, rather than a general inpatient bed or an acute care ED bed, as a best practice.

The main disadvantages of the dedicated unit are the expense to create and staff it and the space and resource allocation necessary. However, many experts argue that the cost efficiencies generated by having a dedicated, protocol-driven unit make up for the investment.

The use of observation status has grown in recent years. The percentage of hospitals with a dedicated unit has grown from 18.8 percent in 2003, when Medicare first recognized it as a separate entity, to 32 percent in 2008.

Today, there is some pushback by Medicare patient advocacy groups against the use of observation status. In November 2011, the Center for Medicare Advocacy and the National Senior Citizens Law Center filed a class action against Health & Human Services claiming that Medicare patients who received inpatient services were classified by
hospitals as being under observation. Because observation is considered an outpatient visit, the plaintiffs were charged for certain items, such as prescription drugs, that would have been paid under Medicare Part A.

In addition, patients with long observation stays face huge out-of-pocket costs if they need skilled nursing care, because Medicare requires a minimum of three consecutive inpatient days for patients to qualify for SNF coverage, the two organizations argue. From 2003 to 2007, the percentage of Medicare patients whose observation stays exceeded 48 hours rose from 3 to 7 percent, according to ACEP.

One problem is limitations in the admission criteria on which hospitals rely to determine whether a patient should be admitted, Ross says. Some patients, particularly elderly patients with a painful condition, don't qualify to become inpatients under the admission criteria, but it isn't safe to send them home, he says. These often are the patients who are put in observation, but then still aren't ready to go home in 24 to 48 hours.

Between a rock and a hard place

The RAC audits of short stays put hospitals between a rock and a hard place when it comes to patients who don't fit easily into inpatient admission criteria, says Don May, AHA vice president for policy. Hospitals get hit by the RACs when these patients are admitted but only stay for a day or two, but they get complaints from consumers and others when these patients are placed in observation and the observation stay winds up being long.

One potential solution would be to change the admission criteria, especially for elderly patients with painful conditions, Ross says. Another possibility would be for Congress or Medicare to start the clock for SNF qualification on the second day of observation, he says.

It's unclear whether the federal government would be willing to pay for the increased cost that would result if observation days were to be included in SNF qualification, May says. Those costs, in turn, could create a new target for RAC audits.

One thing that is clear is hospitals must be vigilant about notifying patients when they are in observation and explain that observation is outpatient care, not an inpatient admission. This is especially important when observation patients are managed on inpatient floors, May notes. Having a protocol-based, dedicated unit helps avoid confusion because patients are more actively managed and not mixed in with the inpatient population, Ross says.

The Affordable Care Act is strengthening the rationale for dedicated observation units. The law's Medicare payment penalties for excess 30-day readmissions will place increased pressure on EDs to decrease inpatient readmissions with observation care because payers consider it an outpatient service, notes the Academic Emergency Medicine article.

Patients who have a high propensity to bounce back into the hospital but don't need a full admission can be taken care of safely in an observation unit and connected there with a medical home and disease management, says Pawan Suri, M.D., chair of the division of observation medicine, department of emergency medicine, at Virginia Commonwealth University Medical Center.

To really attack readmissions in this patient population, some hospitals may want to consider creating what Suri calls a resource-intensive observation unit, either within their existing unit or by developing a separate one. Resource-intensive units treat more complex patients who may have multiple problems.

Because complex patients fall outside the typical observation unit protocol, they require more clinical thinking and resources to treat and safely discharge them, Suri says. Advanced units need to provide more social work support, more advanced practice provider coverage, and dedicated physician staffing, ideally doctors with both internal medicine and emergency medicine training, he says.

This model makes sense for hospitals that want to create an accountable care organization because central ACO concepts are intended to reduce hospital readmissions and health care costs, Suri says. Although resource-intensive observation units require more investment, they pay for themselves in the long run, he adds. "The benefits of the observation unit are always realized at the back end."

Snapshot of ED observation units
Of the 124 million ED visits in 2008, about 2.3 million (1.9 percent) resulted in observation unit placement.

- The typical unit is four to 20 beds.
- The typical stay is 10-15 hours.
- 80 percent of patients are safely discharged home; 20 percent require inpatient admission.
- Observation patients should have at least a 70 percent probability of discharge and a relatively low severity of illness.
- Reimbursement varies by insurer. Payers, including Medicare, generally don’t pay clinical or facility fees for observation stays shorter than eight hours.
- If a patient is admitted, ED and observation are included in the inpatient payment code, such as Medicare’s DRG. If a patient is discharged, ED and observation are paid as an outpatient visit, in Medicare’s case using the ambulatory payment classification system.


Admission or observation? Ideas to aid decision-making and reduce denials

• Have someone from utilization management talk with the ED group about medical necessity admission criteria.

• If there is a problem with admission denials, place a case manager in the ED to implement an admissions review process.

• Make decision support software available to physicians to help them determine whether an observation or inpatient stay is more appropriate.

• Be aware that some patients don’t meet admission criteria, but might not be safe for discharge and shouldn't automatically be placed in observation. Physicians and case managers should look at the total picture to determine appropriate placement.

• Document the full clinical picture of a patient's severity of illness in the ED, including any social conditions, comorbidities and debilities that affect the decision to admit.

• Document why the patient is being admitted and why it is not safe to discharge the patient home; identify the risks.

• Be careful with physician order wording. "Admit to observation" can be confused with an inpatient admit. Instead, "place patient in outpatient observation" should be clearly written.

Source: American College of Physicians Utilization Review Issues FAQ

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Hospitals considering a dedicated, protocol-driven observation unit should take several factors into account:

ED volume
Does sufficient ED volume exist to justify the expense of an observation unit? About 5 to 10 percent of ED volume can be managed in an observation unit. The minimum unit size is five beds, and the nurse-to-patient ratio is typically 1:5. Some experts estimate that the minimum ED volume to justify an observation unit is 30,000 to 50,000 visits annually, but this figure can vary widely based on other factors, including average length of stay and bed turnover.

**Admission denials**

Hospitals should track inpatient admission denials. If a hospital has a large number of denials of short inpatient stays, an observation unit could help to solve the problem and lower the risk of a RAC audit. Many short-stay patients can be served better in an observation unit. Placing clinically appropriate patients in observation, rather than in inpatient bed, reserves beds for patients who truly need them.

**ED crowding**

Are ED wait times high? Does the ED go on diversion? What is the ED's left-without-being-seen rate? If a hospital's ED is crowded, an observation unit can decompress it by providing a setting for patients who need further diagnostics, treatment or psychosocial services.