Observation Care and the Bottom Line

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Objectives

- Understand the difference between inpatient and observation services and how it impacts nursing practice.
- Describe the impact of length of stay, reimbursement, and how this effects financial performance for nursing units.
- Learn key takeaways from North Oaks journey towards aggressive observation management.

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There are just **two** levels of care: **Inpatient** and Outpatient

An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services

Generally, a patient is considered an inpatient if

- formally admitted as inpatient
- expectation that he or she will require hospital care that is expected to span at least two midnights after medical necessity has been determined
- occupy a bed

Medicare Benefit Policy Manual, Rev 10892 08-06-21

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There are just **two** levels of care: Inpatient and **Outpatient**.

Observation is not a status – it is a service provided to outpatients with a physician order.

- *"Observation is an active treatment to determine if a patient's condition is going to require that he or she be admitted as an inpatient or if it resolves itself so that the patient may be discharged."*

- Think of observation (OBS) services as an extension of the information gathering, decision-making process used in the ED to determine need for inpatient admission.
- The Federal Register, 11/30/01, pg 59881

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Observation is not Extended Recovery

Physician may not order OBS for care normally included in the payment for a provided service (e.g.: routine recovery following outpatient procedure as defined by physician.

- I & D may be 30 mins while a hernia may have 4-6 hours and a mastectomy or prostatectomy may include an overnight recovery period.

To bill for observation (Medicare Part B, Outpatient Hospital Services)

- Minimum 8 hours
- Between 24-32 hours
- Rare >48 hours

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Patient Scenario

Surgeon Jones decided that he is going to add on an additional surgery based off an urgent patient seen in clinic who is experiencing abdominal pain, nausea, vomiting, and unable to keep down solids and liquids. Patient has some abdominal tenderness and has slightly elevated BP and temp. Patient has been scheduled to come in for an urgent lap chole this evening at the hospital.

After successful completion of the lap chole, due to evening time and PACU wanting to close the patient is transferred to the hospital unit for overnight post- operative recovery.

The next day, patient is able to tolerate liquids and have a mild breakfast. Nursing informs that patient that he will be discharged today as orders were already placed post-operatively. Patient calls his family to pick him up. Patient's caregiver arrives around 10am and patient finally departs around 12:30pm.

What level of care was this patient?

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Observation metrics impact the nursing staff in many ways

- Organizational financial health

  Average Medicare Fee Schedule
  - C-APC 8011- Observation- $2,610.71 all inclusive (respectively)
  - DRG 293- HF no CC/MCC- $5,600+
  - Outpt Lap Chol'y- ~$4,000
  - Inpatient DRG Lap Chol'y- ~$12,000

- Extended Recovery is by the hour and to avoid a bed if possible: surgical payment only
- Observation Services is by the hour: generally reimbursed for 8 hours of service
- Inpatient paid per DRG: LOS monitoring by the day

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Impact of nursing and bed flow

- Bed Availability and capacity
  - Increase OBS LOS = decreased bed availability and capacity
  - Boarding in ED
  - Delays in PACU
  - Deferring admissions
- Patient Flow- Progression of Care
  - Focus tends to be on the complex placements and cases. This misses the opportunity.
- Nursing Process
  - Monitoring of patient response to treatment and interventions
  - Documentation Requirements

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The avoidable delays matter

- Waiting for a patient ride
- Staying for lunch
- Getting a lab test that will not impact discharge
- Ordering PT eval prior to discharge for a patient walking laps in the hall
- Organizing multiple consultants to sign off of care

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Observation Unit Characteristics

Size & Location
- Proximity to the ER
- # of Beds

Closed vs. Open Unit
- Transfer after conversions vs. keep

Coverage
- ED docs, Hospitalists, APPs
- Employed vs Non-employed
- Overnight coverage- 24/7 vs day coverage

Unit selection criteria
- Strict vs loose guidelines

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Ideal State

Low OBS hrs. w/ > volume than bed count

- The unit is consistently full
- Patients are rapidly moving through the observation unit to alleviate bed capacity in other areas.
- There are little conversions to inpatient in this unit
- The primary discharge destination for this unit is home rather than placement.

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Problem Unit

- The OBS LOS is not any better than OBS patients in the general population.
- The unit is filled with inpatients
- Patients are sitting on the unit waiting for post-acute placement
- There are open beds or patients that do not 'belong' on the observation unit because the bed was available.
- The criteria is so strict no one wants to use the unit and it sits under-utilized

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When the Observation Unit falls apart

There is a mismatch between observation patients and unit parameters

The placement in observation units and bed-flow are misaligned

The location is not ideal

The clinical staff is not aligned with incentives for quick turnover.

There are too many specialists involved in patient care.

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Getting the rest of the hospital to aggressively manage

Understand your metrics by unit, diagnosis clusters, and provider groups

Utilize your case managers to efficiently manage progression of care

Involve and potentially educate nursing staff on OBS, requirements, and the impact to the bottom line.

Involve UR & PAs to support aggressive OBS management throughout the house.

Review common OBS diagnosis and use of consultants- use evidence-based practice for when a consulting specialty is not needed.

Re-evaluate the number of unnecessary therapy consults that may increase delays

Utilize notices (i.e. ABN) when OBS services is no longer warranted

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Maximize your UR & PA Team

- Consider aligning UR by process (dedicated OBS reviewer/team)
- Create regular reviews for OBS
- Establish an escalation process for extended OBS patients.
- Aggressively manage and tracking delays
- Contact attending and CMs to check on any missed conversions and to educate on payer payment limitations
- Create calculated risk- your OBS rate may be self-inflicted!

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Observation Project

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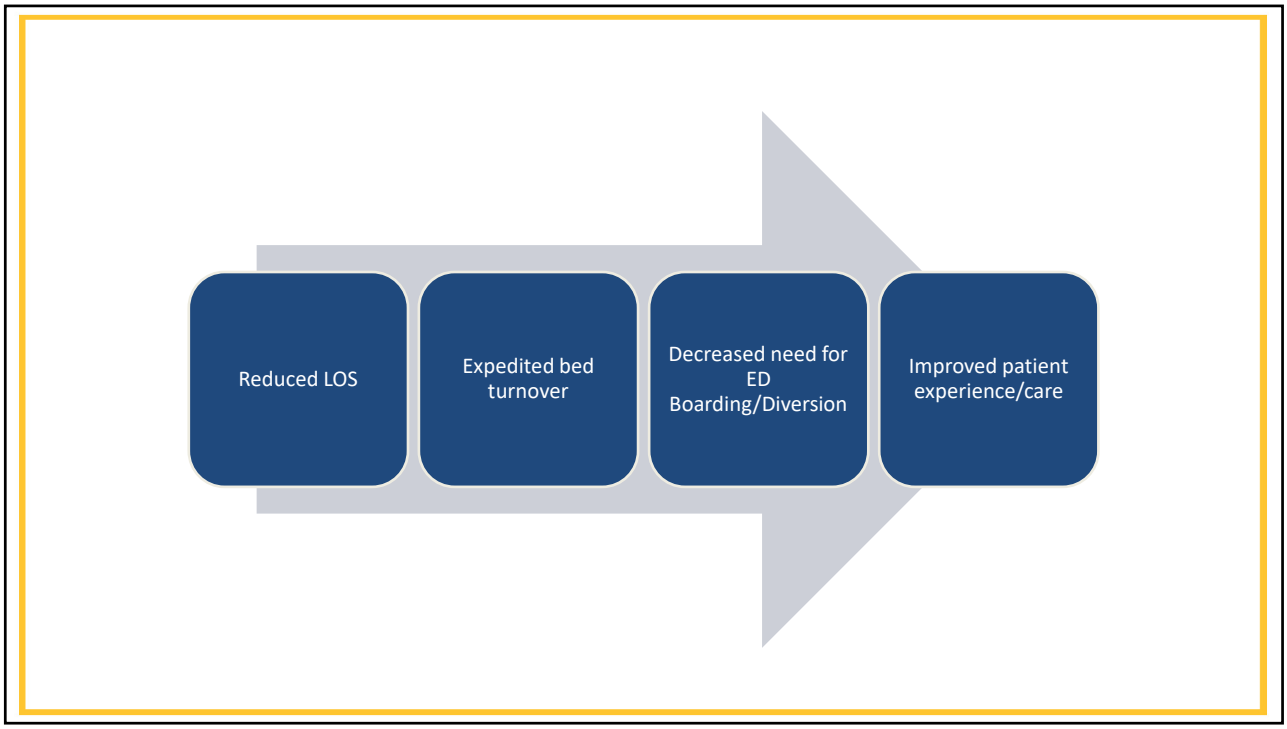
Reduced LOS
Expedited bed turnover
Decreased need for ED Boarding/Diversion
Improved patient experience/care

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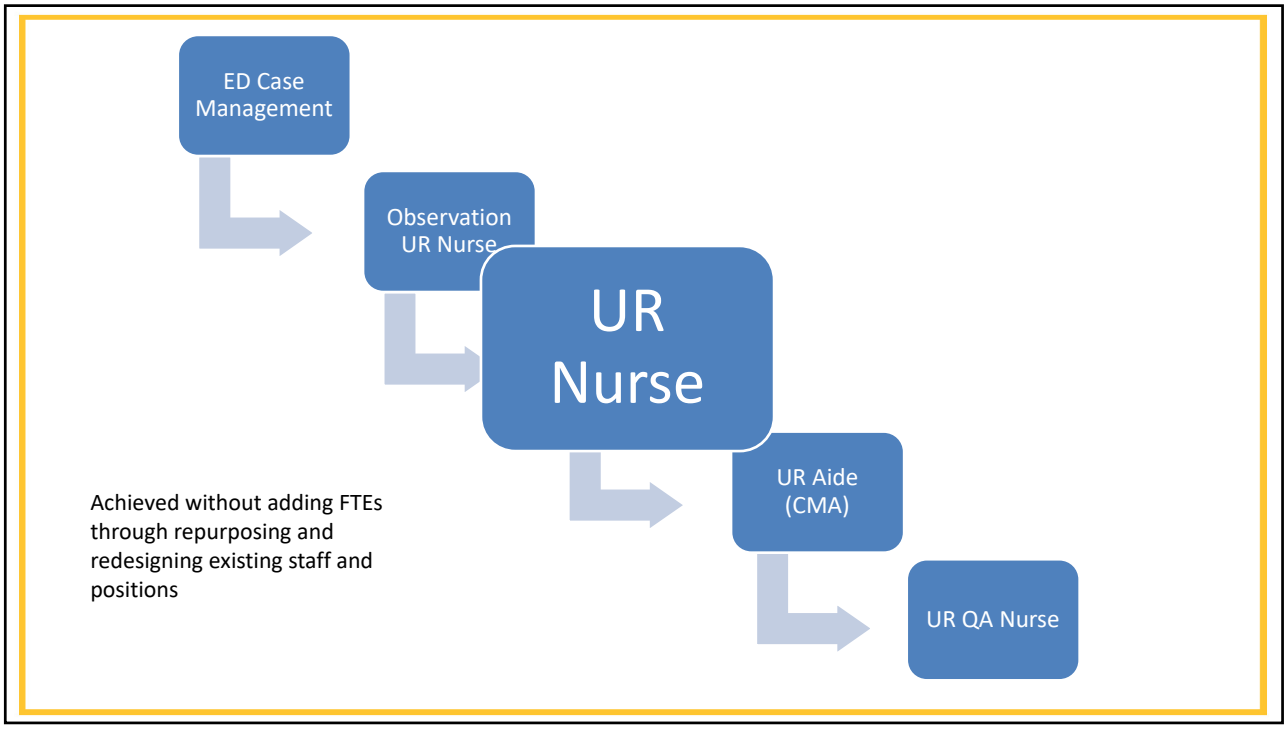
ED Case Management
Observation UR Nurse
UR Nurse
UR Aide (CMA)
UR QA Nurse
Achieved without adding FTEs through repurposing and redesigning existing staff and positions

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Improve patient throughput/progression of care through decrease of avoidable days

Baseline
- Task-driven, order-based workflows; waiting for instructions

Improve
- Proactive screening and assessment to identify needed interventions for progression of care and capture of avoidable days

Optimize
- Analysis of avoidable days with actions to improve; Develop case managers as drivers of care progression, not coordinators

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OBS Workgroup

Observation Unit Placement Criteria
- Reasonable expectation to discharge within 48 hours
- No suicidal/homicidal ideation
- Observation placement is not related to chronic pain control needs
- Discharge needs are expected to be minimal and non-complicated

Multiple huddles with specific purposes
- OBS Utilization Management Huddle
- OBS Planning/Expectation
- OBS follow up

Leadership Awareness
- Bi-weekly discussions regarding metrics and outliers
- Avoidable delay reviews

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OBS Workgroup - Initial focus areas for optimization

In Scope

1. Syncope
2. TIA
3. RDTU Protocol inclusion criteria
4. Acute on Chronic CHF requiring <5L oxygen via nasal cannula
5. Symptomatic anemia with ≤ 2 units of blood ordered
6. Post IR/Cath lab procedures
7. Non-surgical abdominal pain workups requiring ≤ every 4 hour pain medication
8. Emergent hemodialysis in known hemodialysis patients

Out of Scope

1. Psychiatric patients
2. Social/placement needs
3. Orthopedic patients
4. Oncology patients
5. General surgical patients
6. Recurrent COPD admissions (2 or more in last 6 months) or severe COPD at baseline
7. Pregnant patients > 20 weeks.

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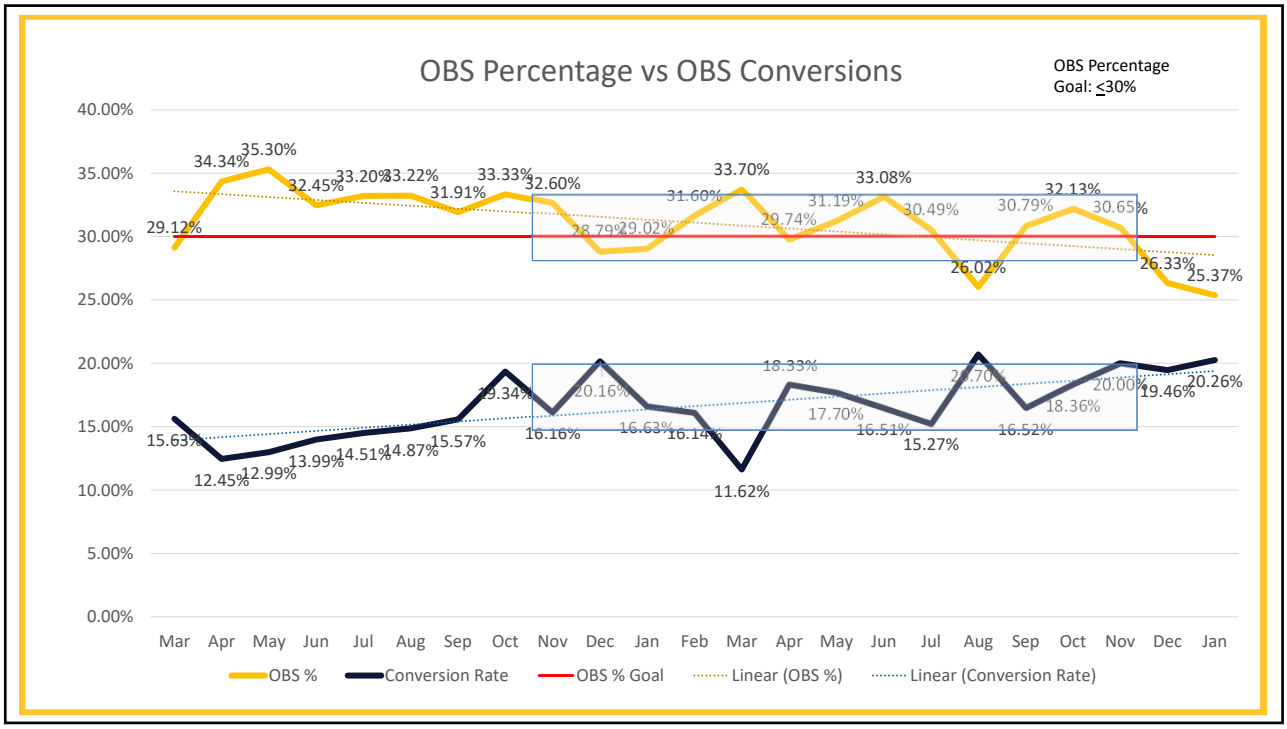

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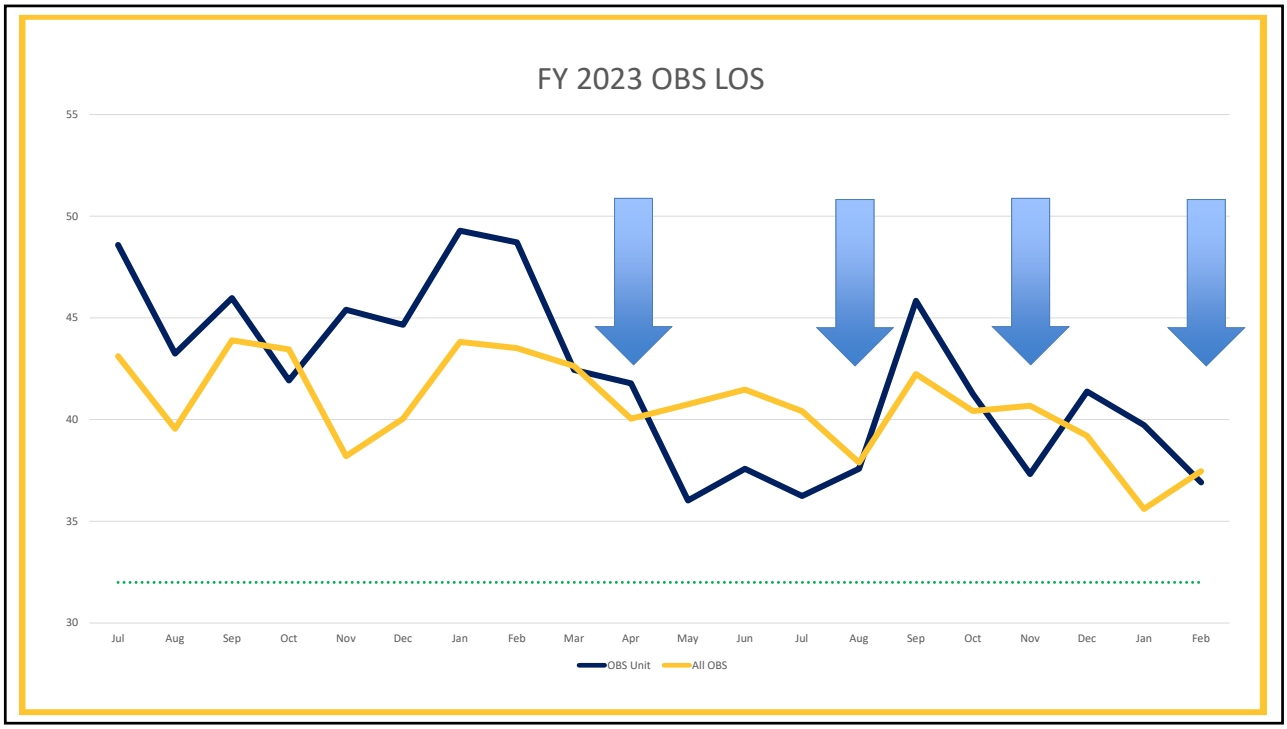
FY 2023 OBS LOS
55
50
45
40
35
30
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
OBS Unit
All OBS

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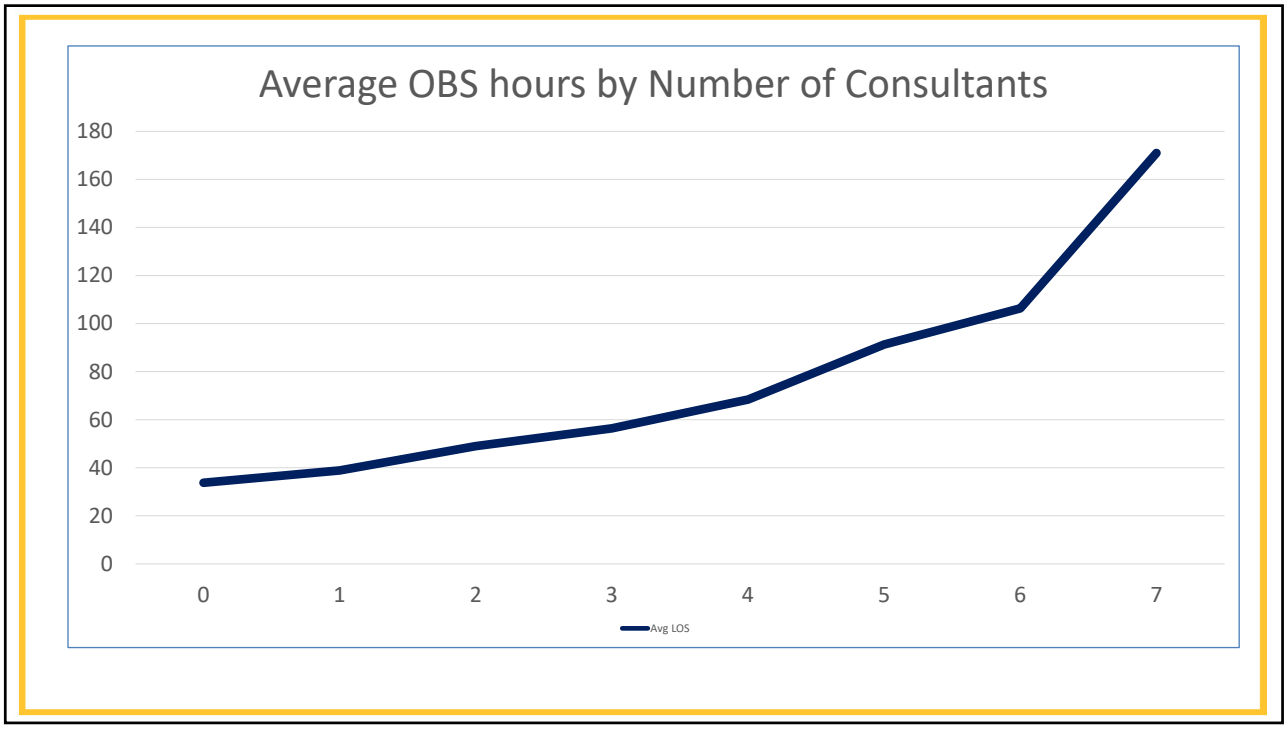
Average OBS hours by Number of Consultants
180
160
140
120
100
80
60
40
20
0
0
1
2
3
4
5
6
7
Avg LOS

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What can nursing do?

- Decrease the time from physician discharge to departure
- Reach out to Case Management if any delays are noticed
- Evaluate in huddle any outstanding testing delays- what can be done to improve patient progression.
- Help the attending, if the consultants have seen the patient- catch up the attending!
- Identify and remove barriers

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What should nurses know when caring for OBS patients?

Documentation requirements are different

- Focused Assessments
- Frequent Interventions/re-evaluations
- Changes in patient status
- Patient Education regarding need for OBS
- Interdisciplinary collaboration focused on rapid decision making
- IMM vs MOON

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Questions

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