



Administration: Key Concepts of Observation Medicine, and Developing and Maintaining an Observation Unit

Part I

Administration

Chapter

1

Observation Medicine – Key Concepts:
*How to Start (and Maintain) an Observation
Unit: What You Need to Know*

Clinical Issues

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Overview and Introduction

This chapter is an introductory chapter or primer on observation medicine that answers commonly asked questions, both clinical and administrative, about observation. It gives an overview and covers the key items that are essential in setting up (and maintaining) a successful observation unit (OU). Critical items involved in creating an OU are discussed with additional information covered in later chapters.

What is Observation?

The Centers for Medicare and Medicaid Services (CMS) definition of observation status is outpatient care ordered by a physician and provided in a hospital bed to determine the need for admission:

a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge. . . . (and) in the majority of cases, the decision . . . can be made in less than 48 hours, usually in less than 24 hours. In

only rare and exceptional cases do . . . outpatient observation services span more than 48 hours.¹

As noted in the CMS definition, since observation status is outpatient care, patients are not “admitted” to an OU so the terms “OU admission” or “admitted to OU” should not be used. Rather, patients are “placed in the OU” or “referred to the OU” The CMS definition also emphasizes the time-limited nature of typical observation, specifically < 24 hours in most cases.

Types of Observation Unit: Protocol Driven and Designated Unit

The types of OUs are based on whether or not they have protocols or are “protocol driven” and on whether they have a dedicated unit or dedicated space. The optimal unit is type I with both protocols and a dedicated unit. Type II is discretionary care provided in an OU. Type III, termed “a virtual OU,” is protocol driven with no discrete OU, thus, the OU bed is in any location with OU beds scattered throughout the hospital. Types II and III are intermediate. The least desirable is type IV with no set protocols and no dedicated space (Table 1.1). A Type I OU is most likely to succeed and Type IV is most likely to fail. Efficiency can only be achieved with a protocol-driven OU with

Table 1.1 Types of Observation Units

Type	Protocol Driven	Dedicated Unit	Comments
Type I	Yes	Yes	Optimal, most likely to succeed
Type II	No	Yes	“Discretionary care”
Type III	Yes	No	“Virtual OU”
Type IV	No	No	Least desirable, most likely to fail

dedicated space.² “The strongest evidence supporting the benefits of observation care is specific to care delivered in dedicated observation units, where evidence-based evaluation and standardized protocols are used to avert inpatient admissions.”³

This has been attributed to the fact that “ED (emergency department)-based OUs, which often provide operationally and physically distinct care to observation patients, have been touted as cost-effective alternatives to inpatient care, resulting in fewer admissions and reductions in length of stay (LOS) without a resultant increase in return ED-visits or readmissions.”⁴

This was confirmed by a recent study comparing type I OUs (e.g., OUs in a dedicated space with defined protocols) versus patients receiving observation services elsewhere in the hospital. This study found type I units (versus patients receiving observation services elsewhere in the hospital) had a 23–38% shorter LOS, a 17–44% decreased probability of subsequent inpatient admission and \$950 million in potential national cost savings each year. They further estimated that 11.7% of short-stay inpatients nationwide could be treated in a type I unit, with potential savings of \$5.5–\$8.5 billion annually.² As another study points out, “the operationally and physically distinct features of a designated OU may be required to realize the benefits of observation attributed to individual patients.”⁴

Open and Closed Units

There are also “open” and “closed” OUs. In a closed unit, only certain designated physicians can admit to the OU. This is similar to the concept that only intensivists can admit to an intensive care unit or neurologists/neurosurgeons can admit to a neurology intensive care unit. With a closed unit, the physicians who know the OU and the operations of the unit (including the specific protocols, orders sets, and care pathways), work there on a regular basis, and, most importantly, who are held to the administrative and clinical standards for that unit are the only physicians who can treat patients in the OU. Only physicians who know the guiding principle of observation medicine – which is the rapid, efficient diagnostic evaluation and/or therapy of selected patients in less than 24 hours – and are held accountable to

these standards can refer or place patients in the OU. Historically, this has been the province of the emergency physician⁴ with a majority of the OUs under ED administration.^{5, 6} Observation medicine is considered to be an integral part of emergency medicine and part of the curriculum for emergency medicine residencies.⁷ Recently, hospitalists have been involved with observation medicine and units.⁸ (See Chapter 13 Observation Medicine and the Hospitalist.)

An administrative policy that specifically states which physicians can place patients in your OU will be useful in achieving this goal. (See Chapter 88 Administrative Policies/Guidelines.) For the rapid turnover of OU patients to occur, there must be on-site coverage, which implies coverage by ED physicians or hospitalists. Thus, a closed unit with in-house staffing 24/7, 365 days a year is ideal and helps ensure the success of the OU.

With a closed unit only one specialty can place patients in the OU, while an open unit allows any physician on the medical staff appropriately credentialed to admit patients to the hospital to place patients in the OU.⁶ It is difficult, if not impossible, to make sure that the entire medical staff of the hospital knows, buys into the premise of observation, and consistently follows the administrative and clinical mandate of the OU. Moreover, the lack of availability at all times (including during office or clinic hours, during procedures or while in the operating room, and even at nights, e.g. 24/7) increases the inefficiency of the open unit and predisposes it to failure.

Hybrid Units

The term “hybrid unit” has been used to describe several variations in the OU. One definition of a hybrid unit (or combined unit) is an OU that accepts both adult and pediatric patients,⁹ while another definition refers to an OU that primarily has patients placed in the OU from the ED who need further evaluation and/or treatment, but also accepts post procedure or “recovery room” type patients¹⁰ with the premise that taking scheduled elective procedure patients may allow for “a more uniform patient census throughout the day,” thereby, “improving staff utilization.”¹¹ This is generally during the afternoon after the OU patients placed in the OU overnight from the ED have been discharged or admitted in the

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morning and before the busiest time of the ED, the evening shift, when most patients are placed in the OU from the ED.

Length of Stay

As per CMS guidelines, care in the OU is expected to be completed within 24 hours.¹ This has been the case as noted in multiple national surveys with a mean LOS of 15.3 hours,⁵ and a median LOS of 19.5 hours in another study.⁶

Location of the Observation Unit

Cohorting observation patients in one area in a dedicated space has many advantages.² Diffusing observation patients in “scatter beds” throughout the hospital makes it difficult, if not impossible, for everyone throughout the hospital to identify and prioritize the observation patient.

Observation is “a process and a mindset” and not a specific location. Location may have additional logistical advantages when the OU is physically near the ED when under ED management. However, space is a major issue in hospitals, and observation care has been successfully provided in locations that are not adjacent to the ED.⁵ If the OU is managed by the ED, a location adjacent to, in, or near the ED is preferable for many reasons. There is the ability for a more immediate response from ED staff if an untoward event, which although very rare, does occur;¹² if personnel have any “downtime,” they may help out in the ED, but are next to the OU, which is their first and primary responsibility. This brings up the next topic of “flexible” staffing.

Staffing the Observation Unit

Flexible Staffing

In order for the OU to run at maximal efficiency, there must be the ability for an immediate response at all times: from taking the patient from the ED and placing in the OU, to responding to changes in the patient’s condition, to dealing with test results and consults, and to discharging or admitting the patient. This is why there are dangers present in “flexible” or “flex” staffing. Ideally, staff covering the OU, especially nursing staffing, should be assigned only to the OU.⁵ If this is not possible, then the primary responsibility of staffing should be to the OU, with other

non-OU assignments or responsibilities being secondary, and with the ability to transition quickly, easily and seamlessly, back to the OU when the OU becomes “busy” with patients being placed in the OU, being discharged, or admitted to the inpatient unit from the OU and/or with the managing of patients in the OU.

Nursing Staffing Ratios in the Observation Unit

The ebb and flow of patients in the OU mirrors that of the ED with most patients placed in the OU during the afternoon and evening hours, which is when the ED is busiest. Most patients complete their diagnostic testing and therapy by the next morning, which is the busiest time for disposition (usually discharge) of the patient. So, in reality, nursing is usually quite busy during the day shift with disposition of patients and evening shift accepting new patients in the OU. Generally, there are fewer diagnostic tests – such as stress tests, GI tests: colonoscopy or esophagoduodenoscopy, or EEG – during the night shift. Thus, for nursing staffing, the usual ratio of nurses to patients is 1:4 on days and evening shifts, and 1:5 on nights.

It is probably not a good idea to significantly increase the nurse to patient ratio at night since there is often some time lag from when the patient is seen in the ED and then placed into the OU so the early night-time hours can be busy with new patients arriving in the OU. Also, patients generally need to be transported during the night shift to stress testing and other procedures or diagnostic testing before the day shift so they can start the procedures promptly at 7 a.m. In addition, morning blood draws and other tests are usually done around 6 a.m. so they can have the results back by the time the OU day-shift physician arrives at 7 a.m. If there is any “down time” then the night shift may accomplish other tasks, such as ordering supplies or stocking for the next day. The 1 nurse to 4 OU patients (days/evenings) and 1:5 (nights) is the recommended ratio. This is confirmed by a national survey that found the mean number of OU patients per nurse is 4.2 with 96% of nurses taking care of ≤ 4 patients,⁵ (See Chapter 7 Nursing)

However, it is realized that if the OU is very “under census,” nursing staffing may be temporarily assigned to another area with the provision

that their first and foremost priority is the OU. If the OU is near the ED and the OU is very under census, it would be best to assign the OU nurse to ED patients that are not critically ill, since it is probably easier to pull the nurse back from the “less acute” area, such as fast track or split flow, than if he or she is caring for an intubated ICU patient with multiple intravenous (IV) medications. The premise is that it is easier to finish taking care of a low acuity patient with a sprained ankle than an acute myocardial infarction (MI) or an intubated respiratory failure patient or septic patient on multiple IV drips and return to the OU for new patients placed in the OU. Again, pulling nurses from the OU to work in other units should be avoided if possible and only done if the OU is very under census and the nurses can return to the OU as soon as they are needed.

Cross Coverage in the
Observation Unit

When the OU is under the auspices of the ED, some have suggested there be “cross coverage” such that nurses work in both the ED as an ED nurse and in the OU as an OU nurse. This theory is that the nurse knows how the systems in the ED and the OU work and there is an understanding of what their colleagues do and this fosters collegiality. Conversely, it may be generally assumed that when a nurse chooses to work in a given hospital unit, they like that type of nursing care and forcing them to work elsewhere may hurt morale. One solution would be to orient the OU nurse to the ED (and OU, of course) during their orientation period so they are familiar with the processes in both the ED and the OU, but that once their orientation is over, they are scheduled primarily in the OU, but can function as an ED nurse if needed.

Nursing Staffing: Longevity and
Patient Satisfaction

It is our experience that the OU nursing staff enjoys their job, are empowered in that they are expected to check all tests including laboratory and radiology reports and consult notes etc. and notify the physician of significant results, and are able to do much patient and family education. Our OU nursing staff has some of the greatest number of years of experience and most stable

staffing of any unit in the hospital. The average OU nursing experience in our unit is around 15 years, of which most of the time has been in the OU. Our OU at the Cleveland Clinic, to our knowledge, may be the “oldest” continuously operating OU under the same management (e.g., since 1994 with the same OU medical director for 22 years) in the United States. Compared with the ED and other units in the hospital, the OU has one of the highest patient satisfaction scores and fewest patient complaints of any nursing unit in the hospital.¹³

Staffing the Unit: Physician

As with nursing and the advanced practice provider staffing of the OU, physician staffing is also dependent on the size of the OU. There are some parameters. The emergency physician workload time study found that the physician service time for an observation medicine patient was 55.6 minutes per patient.¹⁴ Similarly, at a meeting of the Society of Hospital Medicine it was noted “that conventional wisdom holds that 15 patients is the optimal daily census.”¹⁵ Generally, for the physician in the OU, the busiest time is the morning shift when patient dispositions are occurring with patients being discharged or admitted. Staffing, of course, is dependent on many variables: institutional support (e.g., advanced practice providers, residents, fellows), time needed for documentation (such as scribes or dictation versus electronic medical record keeping), patient complexity, and responsibilities (e.g., is medicine reconciliation part of the physician’s task or are there pharmacists who do this job).

There should always be a physician readily available on site in the area on hospital premises, even at night, who can immediately respond to the OU patients. This is a major advantage with a closed unit and points out the problem with an open unit where any physician may place patients in the OU, but they are not in house and, thereby, are unable to immediately respond, which prolongs the OU LOS and may lead to less than optimal patient care and outcomes.

Staffing the Unit: Advanced Practice
Providers

The use of nurse practitioners and physician assistants in the OU has increased over the years.

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There are several terms applied to these valuable and essential health care providers including Advanced Practice Providers (APP), Advanced Practice Clinicians (APC), midlevel providers and physician extenders. We have used physician assistants and more recently, advanced practice nurses, in our OU and ED to work alongside our physicians since the OU has been open over the last 23 years. We are currently evaluating and recruiting additional APPs in order to expand our OU coverage and further decrease our OU LOS.

The APP can identify patients in triage or in the ED who are likely OU candidates and evaluate them to determine whether or not they can be placed in the OU. If a patient is appropriate for the OU, they can start the history, physical evaluation, and OU orders; if not, they can begin ED diagnostic studies and treatment. This process allows patients to be quickly transitioned to the OU; if not suitable for the OU, an evaluation has already begun, which helps decrease the ED turn-around time (TAT) and ED LOS. Thus, by initially evaluating patients in triage or the ED and placing orders, the APP decreases the time to a “licensed provider,” which is an important metric that EDs are evaluated on.

There are many other duties that can be assigned to the APPs that can justify the need for additional APPs in the OU. (Table 1.2) Some of the additional responsibilities that can be delegated to the APP in the OU include reviewing all reports and ancillary studies including laboratory and radiology studies that are resulted after the patient has left the ED or OU, especially “culture reports,” and calling the patient and their pharmacist if any prescriptions including antibiotics are needed. When patients call in to the ED with questions or problems regarding their care in the ED or OU after they are discharged, the unit secretary pulls their ED or OU chart and gives it to the APP who can determine if the patient needs to return to the ED to be seen or needs other follow-up care. Routine “call back” programs on ED and/or OU patients have been recommended to increase patient satisfaction and Press-Ganey scores, and have identified problems with care that can be addressed, which benefits patient safety. With the emphasis on transitions of care, follow-up care, revisits to the ED and hospital readmissions; this may become more important in the future.

Table 1.2 Responsibilities of Advanced Practice Providers

- Documentation: initial history/physical examination, diagnostic studies, and treatment to occur in the OU; progress notes, discharge history, physical examination, OU course, discharge plan for continuing care
- Writes initial orders for patients placed in the OU
- Manages patients in the OU
- Discharge Planning: helps schedule follow-up testing and appointments
- Assists in seeing patients in ED who are likely candidates for the OU: does the initial history /physical examination, writes OU orders (with the caveat that OU patients are their primary responsibility)
- Reviews any follow-up ancillary ED and OU reports (laboratory, radiology, cardiac, or other studies)
- For example, reviews ED culture reports daily and if needed, writes or phones in antibiotic prescriptions
- Makes patient “call backs”
- Answers phone calls from patients discharged from the ED or OU

With the additional job responsibilities, especially in the larger OUs, there is justification for the staffing of an APP for the OU at least on the day and evening shifts. Of course, there should be onsite (in-house) physician availability 24 hours a day, 7 days a week, 365 days a year for the APP. Currently, the Medicare (and select other carriers) reimbursement for the APPs is 85% of that of the physician.

Staffing the Unit: Additional Personnel

In addition to physicians, APPs, and nursing staff, there should be consideration of additional staffing needs, again, depending on the size of the unit. Should there be unit secretaries, respiratory therapists to administer aerosols, pharmacists who perform medicine reconciliation, and technicians who assist in nursing procedures such as obtaining EKGs, drawing blood, starting IVs, etc.? What about housekeeping? Being a self-contained unit may increase efficiency and decrease LOS, particularly in larger units, so the OU does not have to rely on other hospital departments such as phlebotomy, ECG technicians, or respiratory therapy to provide services to OU patients. This eliminates the need to wait

for other departments to come to the OU and perform needed services, which could increase LOS.

Administrative Staffing of the Observation Unit

There must be a physician medical director and a nursing director for the OU. It is critical to have strong leadership for the OU. The physician medical director provides both administrative and clinical leadership. The physician medical director is responsible for patient care issues such as review of patient care and appropriateness of patients placed in the OU, and OU patient quality and safety. The physician medical director in concert with the nursing director of the OU is responsible for operational issues in the OU in order to ensure the OU provides optimal patient care in an efficient and cost-effective manner. The OU medical director works with other physicians, hospital departments and personnel to set up processes for the day-to-day functioning of the OU to improve the availability and timeliness of diagnostic testing and treatment for OU patients. The physician medical director is a resource and provides oversight for the APPs. The physician medical director works with the hospital to ensure reimbursement for services provided to patients in the OU. In order to adequately provide clinical and administrative oversight for the OU, there must be some designated nonclinical administrative time for the OU physician medical director.¹⁰

Similarly, there must be a nursing director for the OU, who provides direction and leadership for the nursing staff in the OU. The nursing director deals with nursing and ancillary staffing of the OU, personnel issues, operations, and sets the standards for the nursing care provided in the OU. Ideally, especially with larger OUs, the physician and nursing medical directors of the OU should be separate from the ED physician and nursing directors. When there is one physician and, similarly, one nurse director for both the ED and the OU, since time is limited, the focus tends to be on the ED and not the OU. This is a mistake and sends the wrong impression that the OU is not valued enough to have its own administration. This does not imply that the OU physician and nursing directors do not provide direct patient care in addition to their administrative duties, especially in smaller OUs. Providing direct

patient care, as well as administrative direction, is desirable since it allows for the direct understanding of the processes involved and how to continually improve them and promotes credibility and respect among the OU staff.

The job descriptions in the administrative policies Chapter 88 further delineates the job responsibilities of the OU staff.

Design, Equipment, and Supplies for the Observation Unit

The design of the unit, at least partly, depends on the type of patients placed in the unit. Since the majority of patients in the OU are cardiac – especially chest pain, heart failure, or syncope – then having telemetry capability for all patients or all beds having rhythm strip and vital sign monitoring is indicated. Respiratory equipment and supplies – oxygen, aerosols, CPAP for patients with sleep apnea, etc. – should be in the design of the OU since respiratory patients also comprise a large group of OU patients. If any patients with contagious infections, such as acute gastroenteritis or pneumonia, will be placed in the OU, then the OU should not be an open ward setting or design and should have some individual cubicles that can be “enclosed” or with doors in order to meet infectious disease precautions/guidelines. Considerations for parents/families as well as other items (equipment, bed sizes/cribs, medications, etc.) need to be taken into account if pediatric patients are included in a “hybrid” unit.⁷ (See Chapter 5 on Design.)

Size of the Observational Unit

How many beds should your OU have? This depends on many factors: the ED census or volume, hospital size (number of beds), the type of hospital (tertiary care or community, urban/suburban/rural), population density, financial considerations (number of 1-day stays, PEPPER report, etc.), and ED factors (LOS, TAT, % admissions). However, a rule of thumb has been that 10% of ED patients are potential OU candidates, so if your ED sees 50,000 patients a year, then about 5,000 ED patients could be placed in an OU. This applies to adult ED patients.

The percentage is lower for pediatric patients, where 5% may be a reasonable estimate. Thus, if there is an annual pediatric ED volume of 50,000

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patients then about 2,500 could be placed in an OU. The percentage may differ based on whether it is a tertiary care pediatric ED or a community hospital ED that sees pediatric patients with a lower percentage of potential pediatric OU candidates in the community hospital ED, which might reflect a greater incidence of transfers/referrals to the tertiary care hospital and varying patient acuity.^{7, 11}

Alternative methods for calculating the percentage of patients that could be placed in a type I OU, based on the number of short-stay inpatients, are 11.7% in one study.² This is similar to observation status patients comprising 10.4% of all hospital stays (of 43,853 stays in one large hospital system, inpatient was 89.6% and observation was 10.4%).¹⁶

Metrics, Benchmarks, Performance Improvement, and Patient Safety, Quality and Experience

Key metrics that must be reported for the OU are volume or census of OU patients, LOS for OU patients, disposition: admissions to inpatient services and discharges, and sentinel events. The benchmarks for the OU include: average LOS of 15–16 hours and about 80% of patients are discharged from the OU and conversely, only about a 15–20% are admitted to inpatient floors from the OU. Quality indicators include admissions to any of the following: intensive care unit, cardiac catheterization unit, or operating room. Sentinel events include resuscitations or codes, intubations or acute need for BiPaP, and use of vasopressors or ACLS drugs. (See Chapter 9 on Metrics and Performance Improvement, Patient Quality, Safety and Experience.)

Benefits of an Observation Unit: Clinical and Financial

The benefits of an OU are outlined in Table 1.3.

Business Plan

What are the problems facing the hospital and the ED? How can an OU help solve these issues? Is there overcrowding in the ED and a shortage of inpatient hospital beds? The opening of an OU is one of the easiest ways to add more beds to the hospital so patients are not waiting on a stretcher

Table 1.3 Benefits of an Observation Unit: Clinical and Financial*

Clinical Benefits of an Observation Unit (OU)
- Improved patient care - Fewer missed diagnoses - Decreased risk/malpractice liability - Third option for emergency physician/hospital staff: admit to inpatient, discharge, or observation - Shorter length of stay (LOS) - Increased patient and family satisfaction - Improved patient safety - Improves emergency department (ED) throughput (decreased LOS, faster turn-around times) - Expands the capacity of the ED - Maximizes ED efficiency and profitability - Increased sensitivity and specificity of ED diagnosis and management - Patients who do need care as an inpatient (from the OU) have a more specific and accurate diagnosis and are more likely to be admitted to the correct inpatient service - Decreased exposure to the dangers of inpatient hospitalization including medication errors, falls, exposure to multi-drug resistant bacteria and other pathogens, physical deconditioning, intensive care unit/hospital psychosis (observation for 15 hours versus a typical short-stay admission of 2 or more days limits the risk) - Increased, more appropriate referrals (more specific and accurate diagnosis) with easier evaluation since preliminary studies already done - Organizational structure and format allows for easier adoption of clinical pathways, algorithms, etc. for the standardization of care and best practices - Better patient outcomes
Financial Benefits of Observation Medicine
- Cost savings resulting from shorter hospital stay and efficient use of resources - Allows an inpatient bed to be filled by a patient with a more profitable diagnosis related group (DRG) payment

Table 1.3 (cont.)

- When the hospital is at capacity and at or near full census, use of OU may alleviate or help avoid cancelling elective surgeries, denying elective admissions, and refusing transfers
- Adding an OU is the easiest, fastest, and less expensive way to increase hospital capacity and add more beds
- Avoids inpatient admission that may have otherwise resulted in a loss for the hospital (several common diagnoses such as heart failure are recognized to not fully cover average inpatient hospital costs)
- Cost to manage a patient in the OU is less than in the inpatient floor (inpatient care has higher fixed costs and a longer LOS in addition to bundled payments, which generally leads to a loss for the hospital, whereas placement of the same patient in the OU would lead to a profit)
- Increased revenue if appropriate patients are placed in OU (bill for observation codes and fee-for-service basis as per ambulatory payment system) (use of current procedural terminology (CPT) billing codes after 8 hours have passed in OU) (hospital and physician billing)
- OU is currently not under the DRG system for completely bundled payments as with inpatient care but is now part of the list of Comprehensive APCs which bundle most labs and ancillary studies for the facility. The physician component is still billed separately to Medicare
- Risk of denial is lower than for inpatient unit (patients with short inpatient stays, especially 1–2 days, are targeted by payers as likely inappropriate)
- Risk of audits is lower than for inpatient unit (patients with short inpatient stays especially 1–2 days, are targeted by payers as likely inappropriate)
- Increased revenue since revenue created by the OU may be separate from or overlap with revenues resulting from patients who would have previously been sent home from the ED

* This not an all-inclusive list but gives some of the many benefits of a Type I observation unit.

in the ED for an inpatient hospital bed. Does the ED have a problem with a long LOS and slow turnaround times? An OU will increase ED efficiency, decrease ED wait times and turnaround times, and shorten the ED LOS.

Does your ED have poor patient satisfaction and low Press-Ganey scores? A less crowded, more organized ED that can off load ED patients to a more pleasant, quieter, and less chaotic location – specifically an OU – should improve patient satisfaction, Press-Ganey scores, etc.

What is highlighted in the Program for Evaluating Payment Patterns Electronic Report (PEPPER) report for your hospital? Has there been an excessive number of denials for 1-day inpatient admissions? Has your hospital been fined and had overpayments recouped? Placing patients in an OU instead of them being categorized as an inpatient admission for ≤ 24 hours should help ameliorate this problem.

There are likely other issues facing your institution and emergency department. The implementation of a well-organized and well-maintained OU should have a positive impact on the myriad of throughput challenges facing the hospital and ED.

Before opening an OU, talk with the payers in your region, discuss the advantages of observation with them, and give them time to set up their processes and information technology so they can pay you appropriately for services. Prior to opening your OU, have the systems in place, so you can identify OU patients and appropriately bill for your services with the recognition that you can bill for both physician services and hospital services. You must also be in compliance with all the local, state, and federal regulations, so meeting with your reimbursement specialists, coders, and compliance team is essential.

Hospital administration must be involved and supportive of the OU. Nursing and ancillary personnel in the OU and ED are key to the success of the OU as well as other departments in the hospital, such as stress testing, other cardiac testing (e.g., echocardiology, holter monitoring), radiology (for CT scans, MRIs, V/Q scans, etc.), gastroenterology procedure lab (if esophagogastroduodenoscopy or colonoscopies are to be done while patients are in the OU), and interventional radiology procedures. The physicians and advanced practice practitioners who will be

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staffing the unit must have “buy-in” for the OU to succeed. The medical staff should be apprised of the OU and how it fits into the patient care process. Presentations to the medical staff are invaluable in answering their questions or concerns and by explaining how the OU will benefit their practices. Face-to-face meetings will help attain their support and be instrumental in setting up referrals for the OU patients.

Meetings not only with internal hospital personnel/departments and physicians, but also key external “players” (such as payers), are important not only when setting up or starting an OU, but also in sustaining the efficient day-to-day operations of the OU. This organizational framework and preparation and ongoing maintenance is essential to the successful initiation and continuation of the OU.

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