Prologue

Observation Medicine is Not the Same as Observation Status

Sharon E. Mace and Michael A. Granovsky

There has been a steady increase in the use of observation medicine in the emergency department (ED) in recent years. There has also been an unfortunate adoption of the use of "observation" to denote patients admitted to the hospital under observation status.[1–4] Observation medicine is not the same as observation status, and we need to be clear when we use the terms, as they have very different meanings.

Approximately 2.1% of all ED visits in the United States result in observation care.[5, 6] Observation medicine has shown tremendous benefits in terms of patient care and cost-effectiveness[7–9]; see Table 1.3 in Chapter 1. Observation medicine has been applied to a host of clinical conditions, including chest pain, heart failure, and respiratory ailments (see Section 4 for a more complete list). Considering the advantages of observation medicine, the question should be asked: If you are not doing observation medicine, what's stopping you?

On the other hand, the Centers for Medicare and Medicaid (CMS) has defined observation care as a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment that are furnished while a decision is made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department (ED) and who then require a significant period of treatment or monitoring in orders to make a decision concerning their admission or discharge. In only rare and exceptional cases, do reasonable and necessary outpatient services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.[10]

The caveat is that the benefits of observation medicine are best attained and may only be achievable in an observation unit (OU) that is "operationally and physically distinct" or a type I unit[8, 11]; see Table 1.1 in Chapter 1. Studies that fail to document the benefits of observation care generally are those in which patients in observation status differ markedly from the CMS definition of observation, and thus, are not treated in a type I unit[12]; see Chapter 1.

Why then the controversy surrounding observation medicine? The issue does not pertain to the clinical utility and the financial benefits of observation medicine practiced in a type I unit,[7–9] but instead is associated with the occasional case where there is an unanticipated and high out-of-pocket cost to the patient.[13–16]

According to the Office of the Inspector General's (OIG) report, of the 1.5 million observation stays in 2012, 78% began with the beneficiary being treated in the ED, 9% began with an operating room procedure, and 13% other.[17] The report observes "The most common operating room procedure was coronary stent insertion ... The remaining observation stays began in other ways, such as with scheduled clinic visits, minor procedures, or laboratory and imaging services."[17] Thus, we may be comparing apples and oranges. It seems obvious that ED patients are not the same as post-operating room patients or post-coronary stent patients.

Short inpatient stays are "inpatient stays that lasted less than 2 nights," per the CMS definition.[17] This time frame is similar to the CMS definition of observation.[10] The OIG report compared short inpatient stays with observation stays and found "on average, Medicare paid nearly three times more for a short inpatient stay than an observation stay and beneficiaries paid almost two times more."[17] Medicare paid an average of $5,142 per stay for short inpatient stays and only $1,741 for observation stays.[17] Thus, there is a concern by

CMS and others about beneficiaries spending long periods of time in observation status without being admitted as inpatients. [17]

When the patient is considered, "Beneficiaries also paid more for short inpatient stays than for observation stays."[17] Beneficiaries paid an average of $725 for a short inpatient stay, compared with only $401 on an average for the observation stay. "Beneficiaries typically paid more for short inpatient stays than for observation stays when they were treated for the same reason, although there were some exceptions."[17] The report continues: "For all but two of the most common reasons, beneficiaries paid more for short inpatient stays, with these stays costing an average of $359 to $572 more than observation stays. For the two exceptions – coronary stent insertions and circulatory disorders – beneficiaries paid more on average for observation stays than for short inpatient stays. For these stays, the difference in average payments was $817 and $167, respectively." In 94% of all the 1.5 million observation stays, beneficiaries did not pay more than the inpatient deductible, while in only 6% "of all observation stays, beneficiaries paid more than the inpatient deductible."[17]

This was confirmed by several studies.[18–20] According to the Hockenberry et al. study, which used the Healthcare Cost and Utilization Project data, the cost share for observation services stays under 24 hours is on average less than the Medicare Part A deductible amount, but stays longer than 24 hours may raise out-of-pocket costs.[18] The authors conclusion was: "Patient cost sharing for most OS [observation services] stays of less than 24 hours is lower than the Medicare inpatient deductible. However, prolonged OS stays potentially increase this cost sharing."[18]

The Adrion et al. study evaluated costs for those who had commercial insurance and found that: "Total and out-of-pocket spending were substantially lower for observation care" when compared to short-stay hospitalizations.[19] The report by Sabbatini et al. found that: "Compared to inpatients, out-of-pocket costs were substantially lower among patients with an observation stay for both the index hospitalization ($1403 versus $962 in 2015) and a 30-day episode of care ($1690 versus $1297 in 2015)." After matching, mean out-of-pocket costs for patients hospitalized as inpatients were 33% higher ($980 versus $739; difference $241, 95% confidence interval [CI] for a difference of $250–231) during the index hospitalization and 24% higher ($1,302 versus $1,049; difference $253, 95% CI $ for the 30-day episode of care–241) for the 30-day episode of care.[20] Thus, the lower costs seen with observation stays compared to short-stay hospitalization were true for patients with commercial insurance[19, 20] as well as for Medicare patients.[17, 18]

Two issues are at the core of the controversy. Patients in observation status lack coverage for their chronic routine medications and do not qualify under Medicare for skilled nursing facility (SNF) services.[13–16] Medicare coverage for SNF services requires a 3-day inpatient stay. According to the OIG report, "for 4% of these stays, beneficiaries received SNF services for which they did not qualify"[17] and, conversely, the other 96% of beneficiaries did qualify for SNF services. Please note that the OIG defined patients as not qualifying for SNF services based on their placement in observation status and not on the nature of their medical conditions or post-hospitalization needs. For example, a patient who has suffered a stroke and is placed in observation status would be defined by CMS as not qualifying for SNF services even if they required extensive rehabilitation following release from the hospital.

Why the problems or controversy with Medicare coverage? Inpatients are covered under Part A Medicare and outpatients are covered under Part B Medicare. Observation is considered outpatient care, and so an observation stay is covered by an outpatient insurance benefit. While patients are in observation status, any chronic routine medications that are administered during the observation stay are not covered.[16, 17] Beneficiaries who are not admitted as inpatients may not qualify for SNF services following discharge from the hospital and may end up paying out of pocket for their SNF services.[13, 14] Moreover, if a patient is admitted to the hospital, the time spent in the ED or OU is not counted toward the three-day SNF requirement.

The OIG has actually acknowledged these issues and made recommendations for addressing them, and "CMS concurred" with the OIG recommendations.[21] CMS has also provided guidance on the SNF 3-day rule waiver including how to apply for a waiver of the 3-day SNF rule.[22] During the coronavirus diseases 2019 (COVID-19) pandemic, a public health emergency (PHE), CMS issued a blanket waiver of the 3-day prior hospitalization requirement in order to qualify for SNF care under Medicare Part A. This waiver due

to the PHE took effect on March 1, 2020 and has been renewed multiple times by the Secretary of Health and Human Services. However, it is anticipated that this waiver will not be renewed at some time in the future.[22, 23]

What are the solutions? This loophole in coverage has been identified as a policy failure. There are ongoing efforts to try and fix this. The Improving Access to Medicare Coverage Act of 2021 would count the time a Medicare beneficiary spends in observation toward the 3-day stay requirement, so that Medicare patients who spend 3 days in a hospital, regardless of whether they are in an inpatient or observation status, would be able to have access to post-acute care in an SNF.[24] We still need to continue the advocacy for patients in order to address these issues. In 2023, CMS also issued new billing and coding guidelines. If and how this affects observation medicine remains to be seen.

The advent of observation began first with the straightforward or "simple" observation that focuses on one main complaint or problem using one protocol/order set, then was followed by complex or extended observation where the same time-limited focus now encompasses multiple problems or issues and several protocols/order sets concurrently, but still does so in an expedited or time-limited fashion. Observation medicine continues to hold promise for optimal patient outcomes and cost savings with benefits to everyone: the patients, their families, the health care providers, the hospital, and even the health care system. These benefits are best achieved, and indeed, may only be possible, through a type I OU. This is why we make the distinction throughout this textbook that the correct, appropriate use of observation is time limited and attainable via a type I unit. Thus, we agree with CMS that long, extended observation stays are inappropriate and should be discouraged.

Observation medicine holds great promise for your practice and your patients. By using the principles of observation medicine, the health care provider is able to contain costs, improve patient safety by reducing unnecessary hospital admissions and mitigating the risk of managing patients with potentially life-threatening complaints, and, most importantly, improve patient outcomes. This textbook provides information on how to start, manage, and expand an OU; ranging from the proper identification of patients, the appropriate protocols and order sets, how to make an impact on the social determinants of health for our patients, how to treat patients with a wide range of complaints and medical illnesses/injuries, and how to handle the administrative, business, and financial aspects of observation medicine. This is one-stop shopping for observation medicine. Everything you need to know about observation medicine is contained in this book. What are you waiting for?

References

1. American Medical Association. Inpatient versus observation. www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/issue-brief-inpatient-v-observation-care.pdf (accessed June 23, 2023)
2. Society of Hospital Medicine Public Policy Committee. The hospital observation care problem. September 2017. www.hospitalmedicine.org/globalassets/policy-and-advocacy/advocacy-pdf/shms-observation-white-paper-2017 (accessed June 23, 2023)
3 Lind KD, Noel-Miller CM, Sangaralingham LR, et al. Increasing trends in the use of hospital observation services for older Medicare advantage and privately insured patients. *Med Care Res Rev* 2019; **76**(2): 229–239.
4. Feng Z, Wright B, Mor V. Sharp rise in Medicare enrollees being held in hospitals for observation raises concerns about causes and consequences. *Health Aff (Millwood)* 2012; **31**(6): 1251–1259.
5. Cairns C, Kang K. National Hospital Ambulatory Medical Care Survey: 2020. emergency department summary tables. doi: https://dx.doi.org/10.15620/cdc:121911 (accessed June 23, 2023)
6. Wiler JL, Ross MA, Ginde AA. National study of emergency department observation services. *Acad Emerg Med* 2011; **18**(9): 959–965.
7. Baugh CW, Venkatesh AK, Bohan JS. Emergency department observation units: a clinical and financial benefit for hospitals. *Health Care Manage Rev* 2011; **36**(1): 28–37.
8. Ross MA, Hockenberry JM, Mutter R, Barrett M, Wheatley M, Pitts SR. Protocol-driven emergency department observation units offer savings, shorter stays, and reduced admissions. *Health Aff (Millwood)* 2013; **32**(12): 2149–2156.
9. Baugh CW, Venkatesh AK, Hilton JA, et al. Making greater use of dedicated hospital observation units for many short-stay patients could save $3.1 billion a year. *Health Aff (Millwood)* 2012; **31**(10): 2314–2323.

10. Department of Health and Human Services and CMS. CMS Manual System Pub 100-04 Medicare Claims Processing. Transmittal 11842. February 9, 2023. Change Request 13064. www.cms.gov/files/document/r11842cp.pdf (accessed June 23, 2023)
11. Macy ML, Hall M, Shah SS, et al. Differences in designation of observation care in US freestanding children's hospitals: are they virtual or are they real? *J Hosp Med* 2012; **7**(4): 287–293.
12. Sheehy AM, Graf B, Ganigreddy S, et al. Hospitalized but not admitted: characteristics of patients with "observation status:" at an academic medical center. *JAMA Intern Med* 2013; **173**(21): 1991–1998.
13. Lam C, Ditkowsky J, Sharma VK, et al. Financial impacts of ED observation units: literature and strategies review. Emergency Medicine Residents Association. February 3, 2021. www.emra.org/emresident/article/lit-review-observation-units (accessed June 23, 2023)
14. Center for Medicare Advocacy. Observation stays fact sheet. www.medicareadvocacy.org/wp-content/uploads/2017/09/Observation-Coalition-Fact-Sheet.pdf (accessed June 23, 2023)
15. Jaffee S. $18 for a baby aspirin? Hospitals hike costs for everyday drugs for some patients. *Kaiser Health News*, April 30, 2012. https://kffhealthnews.org/news/observational-care/ (accessed June 23, 2023)
16. Natsui S, Baugh C. What's your policy on home meds for observation patients? *ACEP News*, November 19, 2014. www.acepnow.com/article/acep-surveys-emergency-physicians/2/ (accessed June 23, 2023)
17. Wright S. Memorandum report: Hospitals' use of observation stays and short inpatient stays for Medicare Beneficiaries, OEI-02-12-00040. Department of Health and Human Services, Office of Inspector General, July 29, 2013. https://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf (accessed June 23, 2023)
18. Hockenberry JM, Mutter R, Barrett M, Parlato J, Ross MA. Factors associated with prolonged observation services stays and the impact of long stays on patient cost. *Health Serv Res* 2014; **49**(3): 893–909.
19. Adrion ER, Kocher KE, Nallamothu BK, et al. Rising use of observation care among the commercially insured may lead to total and out-of-pocket cost savings. *Health Aff (Millwood)* 2017; **36**(12): 2102–2109.
20. Sabbatini AK, Wright B, Kennedy Hall M, et al. The cost of observation care for commercially insured patients visiting the emergency department. *Am J Emerg Med* 2018; **36**(9): 1591–1596.
21. Medicare Shared Savings Program. Skilled nursing facility 3-day rule waiver guidance, May 2022. Version 10. www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/downloads/snf-waiver-guidance.pdf (accessed June 23, 2023)
22. Stulick A. CMS officials confirm end of PHE nursing home waivers, barring congressional action. *Skilled Nursing News*, February 22, 2023. https://skillednursingnews.com/2023/02/cms-officials-confirm-end-of-phe-nursing-home-waivers-barring-congressional-action (accessed June 23, 2023)
23. CMS. CMS waivers, flexibilities, and the transition forward from the COVID-19 public health emergency, February 27, 2023. www.cms.gov/newsroom/fact-sheets/cms-waivers-flexibilities-and-transition-forward-covid-19-public-health-emergency (accessed June 23, 2023)
24. Congress.gov. S.2048 – Improving Access to Medicare Coverage Act of 2021. (introduced in the 117th Congress 2021-2022). www.congress.gov/bill/117th-congress/senate-bill/2048/text (accessed June 23, 2023)

Section 1 Administration

Chapter 1

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

Clinical Issues

Sharon E. Mace

Overview and Introduction

This and the next Chapter are introductory Chapters, serving as a primer on observation medicine, to answer commonly asked questions, both clinical and administrative, about observation. They give an overview and cover 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 less than 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 dedicated space where OU patients are cohorted together in 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 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]

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

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, order 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 physician[4] 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 (see Chapter 15 on 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 106 on administrative policies). For the rapid turnover of OU patients to occur, there must be a mechanism for rapid response by physicians or advanced practice providers (APPs) to the OU patient's response to treatment and any change in their condition and/or to the results of diagnostic testing in order to expedite their care and disposition. This may be achieved by on-site coverage, which implies coverage by ED physicians or hospitalists. In some OUs, especially in larger OUs, there may be a closed unit with in-house staffing 24/7, 365 days a year. However, this is not always feasible, particularly in smaller or more rural units Thus, alternative processes using cross coverage from the ED or telemedicine or other mechanisms may be utilized to ensure the rapid response needed to achieve prompt decision making and rapid disposition of OU patients, to promote 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 night, 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,[8] 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 patients[9] with the premise that taking scheduled elective procedure patients may allow for "a more uniform patient census throughout the day," thereby, "improving staff utilization."[10] 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 morning, and before the busiest time of the ED, the evening shift, when most patients are placed in the OU from the ED. However, it should be remembered that these post-procedure or recovery room patients are *not* generally billable patients for the OU. This is done as a courtesy or service for the hospital and other departments. Postoperative and post-procedure recovery is generally part of the one charge for the procedure or operation so OU physician or hospital reimbursement in addition to the charge for the procedure or operation for these types of patients is untenable.

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[11]; if personnel have any "down-time," 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, 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 there, 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, gastrointestinal 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," the night shift may accomplish other tasks, such as ordering supplies or stocking for the next day. The 1:4 nurse to 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 up to four patients[5] (see Chapter 7 on 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/she is caring for an intubated intensive care 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), an intubated respiratory failure patient, or a 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. The 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 enjoy their jobs, 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 have some of the greatest number of years of experience and are the most stable staffing of any unit in the hospital. The average OU nursing experience in our unit is around 15–20 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/management for over a quarter of a century) in the United States and worldwide. 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.[12]

Staffing the Unit: Physicians

As with nursing and the APP 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.[13] 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."[14] 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. APPs, 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?).

Ideally, there should always be a physician or APP 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. In some OUs, an APP may provide on-site coverage with physician supervision/backup (see Chapters 16 and 25 on APPs and telemedicine, respectively). The ability to disposition patients 24/7 and to rapidly respond if an untoward event does occur is critical for optimal patient care and for achieving a short LOS.

Staffing the Unit: Advanced Practice Providers

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

There are several terms applied to these valuable and essential health care

providers including APPs, advanced practice clinicians (APCs), 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 opened for nearly three decades. We are currently evaluating and recruiting additional APPs in order to expand our OU coverage and further decrease our OU LOS (see Chapter 16 on APPs).

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 turnaround 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 these have identified problems with care that can be addressed, which benefits patient safety. There is an emphasis on transitions of care, follow-up care, revisits to the ED, and hospital readmissions, which may become more important in the future.

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 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

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
- Writing initial orders for patients placed in the OU
- Managing patients in the OU
- Discharge planning: helping to schedule follow-up testing and appointments
- Assisting in seeing patients in ED who are likely candidates for the OU: doing the initial history / physical examination, writing OU orders (with the caveat that OU patients are their primary responsibility)
- Reviewing any follow-up ancillary ED and OU reports (laboratory, radiology, cardiac, or other studies), for example, reviewing ED culture reports daily and, if needed, writing or phoning in antibiotic prescriptions
- Making patient "call-backs"
- Answering phone calls from patients discharged from the ED or OU

for the APPs is 85% of that of the physician (see Chapter 81 on observation unit physician documentation and coding).

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 ECGs, drawing blood, starting IVs, etc.? What about housekeeping? Being a self-contained unit may increase efficiency and decrease the 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 the 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. In some OUs, APPS may have an important administrative/clinical role and may fulfill some of the responsibilities of the OU medical director (see Chapter 16 on APPs). 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. He/she 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. He/she 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.[9] 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. The OU physician and nursing directors may provide direct patient care in addition to their administrative duties, especially in smaller OUs. Providing such 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 covered in Chapter 2 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 – having telemetry capability for all patients or all beds having rhythm strip and vital sign monitoring is indicated. Respiratory equipment and supplies – oxygen, aerosols, continuous positive airway pressure (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, it 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.

During the coronavirus disease 2019 (COVID-19) pandemic, many OUs cared for COVID-19