

Obs Unit Implementation: Denial, Anger, Bargaining, Acceptance...Trailblazing

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Disclosures

- I have no conflicts of interest or disclosures.

“Hey, when you have a minute, can you stop by my office? There’s something I want to tell you...”



THE BOSS

**“Congratulations,
you’re going to
have an Obs Unit”**



BOSS

Lessons learned along the way...

- There have been many, but leading transition to a new obs unit is one that I'm often asked about...

Change



'the tire is flat, again'

Adaptive Change



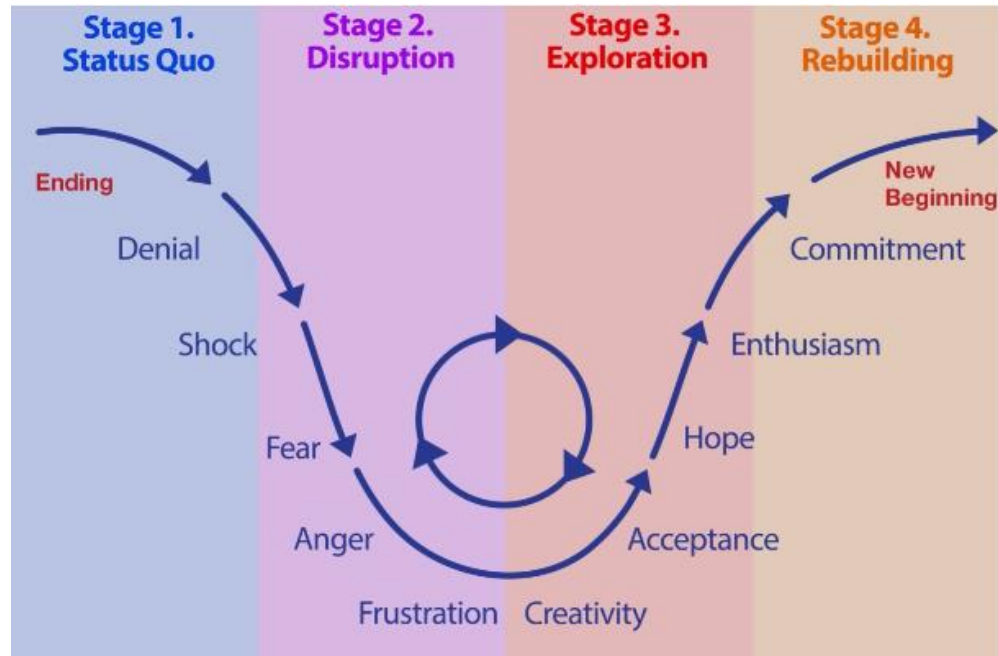
'repair the tire, again'

Transformational Change



'install a new tire'

Kubler-Ross Change Curve



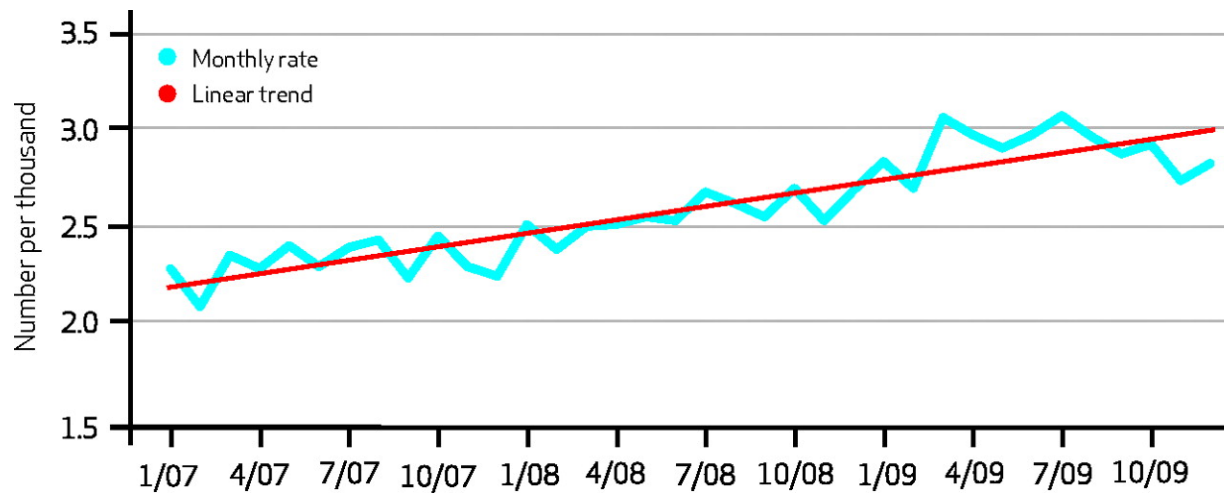
- Key to leadership is understanding those you lead
- Fundamentally change the way healthcare is delivered
- Individual/team/organization will progress through these phases
 - Not all will experience every phase
 - Some will get stuck, some will revert, some will move very quickly, etc...

Denial



Prevalence Of Hospital Observation Services

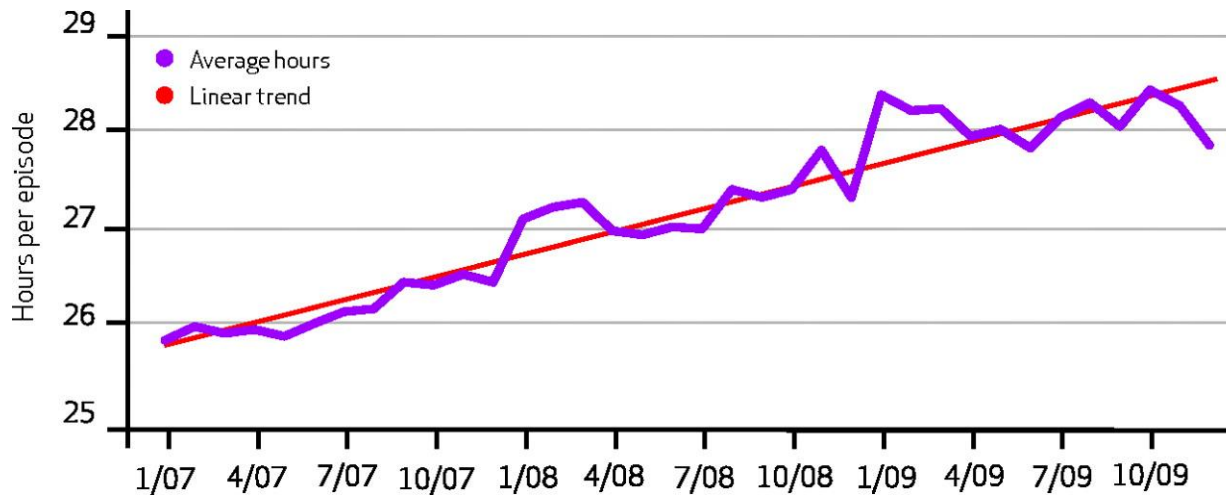
(Number Of Medicare Beneficiaries With An Observation Stay Per 1,000 Beneficiaries Per Month, 2007–09)



25% increase in observation stays over a 2 year span.

Duration Of Hospital Observation Stays

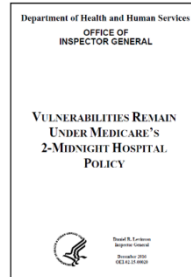
(Average Number Of Hours Per Observation Episode Per Month, 2007–09)



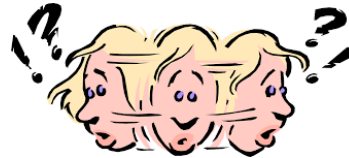
7% increase in average length of stay in observation over a 2 year span (26.2 hrs to 28.2 hrs).

Growth of Observation Services

- Recovery Audit Contractors (RAC)
- Expanded reimbursement for observation services
- Best practice standards recognizing use of observation units
- Readmission penalties
- 2 midnight rule
- ED overcrowding trends
- Institute of Medicine recommendation that OUs be part of solution to healthcare crisis
- Expanding literature base supporting use of OUs (Type 1)



Pros and Cons of Delivery Models



Emergency department observation units offer efficiencies that cut costs, improve care

By Dr. Anthony Napoli | November 1, 2014

By Christopher W. Baugh, Arjun K. Venkatesh, Joshua A. Hilton, Peter A. Samuel, Jeremiah D. Schuur, and J. Stephen Bohan

Making Greater Use Of Dedicated Hospital Observation Units For Many Short-Stay Patients Could Save \$3.1 Billion A Year

By Michael A. Ross, Jason M. Hockenberry, Ryan Mutter, Marguerite Barrett, Matthew Wheatley, and Stephen R. Pitts

Protocol-Driven Emergency Department Observation Units Offer Savings, Shorter Stays, And Reduced Admissions

Under 'Observation,' Some Hospital Patients Face Big Bills

MONEY | Thu Jan 23, 2014 | 12:52pm EST

Hospitalized but 'under observation'? Seniors, beware



By Mark Miller | CHICAGO

Two Kinds of Hospital Patients: Admitted, and Not

By PAULA SPAN | OCTOBER 29, 2013 12:01 PM | 66

Judith Stein got a call from her mother recently, reporting that a friend was in the hospital. "Be sure she's admitted," Ms. Stein said.



Why we are making this change now:

- Failure to realize favorable clinical outcomes
- Performance advantages and disadvantages
- Failure to recognize savings
- Potential for cost-shifting
- Need for value-based, reliable care

Observation Units as Substitutes for Hospitalization or Home Discharge

Saul Blecker, MD, MHS[†]; Nicholas P. Gavin, MD; Hannah Park, MS; Joseph A. Ladapo, MD, PhD; Stuart D. Katz, MD, MS

Observation Care — High-Value Care or a Cost-Shifting Loophole?

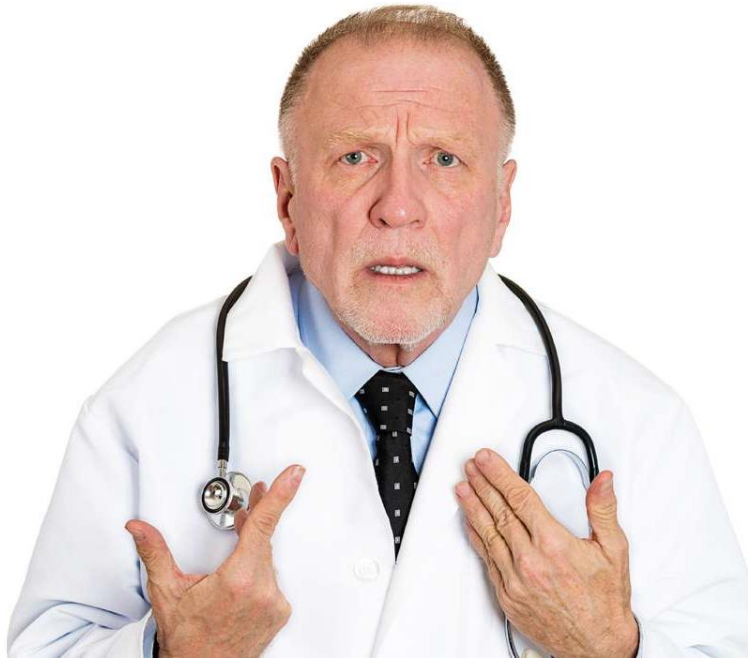
Christopher W. Baugh, M.D., M.B.A., and Jeremiah D. Schuur, M.D., M.H.S.



State of the Art: Emergency Department Observation Units

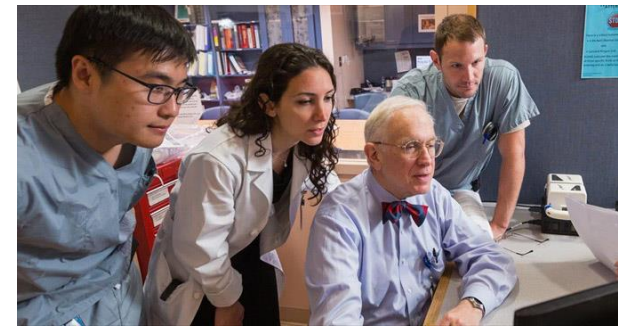
Michael A. Ross, MD,* Taruna Aurora, MD,† Louis Graff, MD,‡ Pawan Suri, MD,†
Rachel O'Malley, MD,§ Aderonke Ojo, MD,¶ Steve Bohan, MDI, and Carol Clark, MD**

Anger

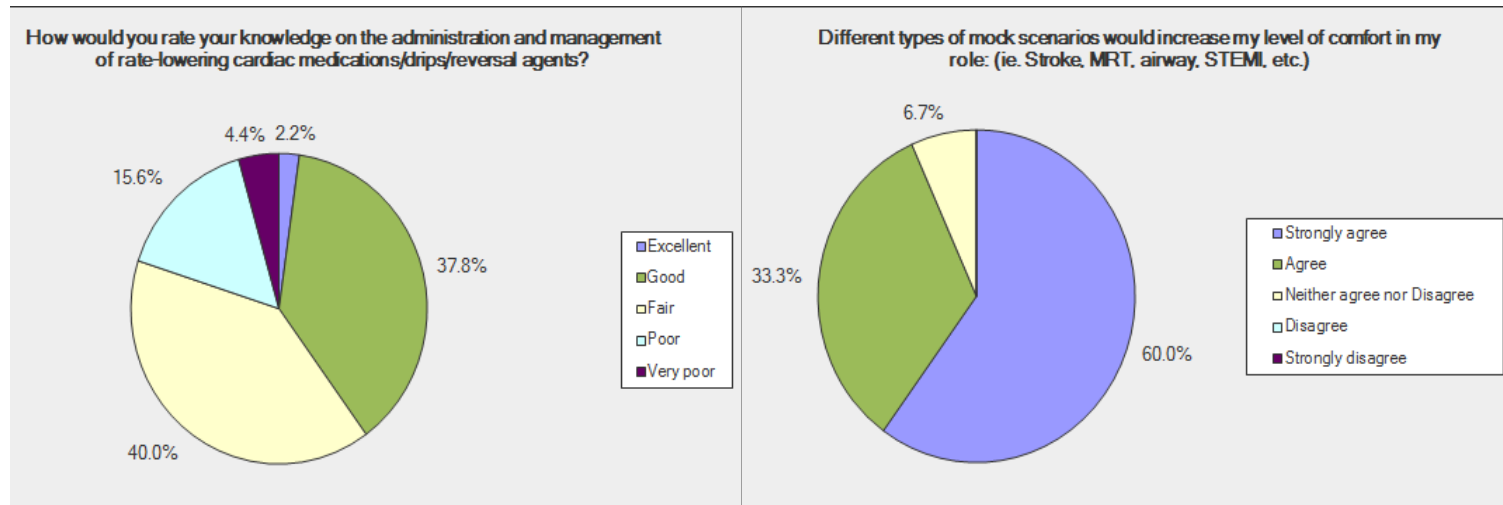


Education in Observation Medicine

- Majority (85%) of program directors felt observation medicine important part of training
 - but---
- Few programs have dedicated curriculum or required training
- Only recently (2016) a model observation medicine curriculum was presented
- In the interim:
 - Focused didactics
 - Interdisciplinary (physician, APP, RN)
 - Utilize 'in-house' experts
 - Intra- or Interdepartmental joint conferences (ie. EM-IM, EM-Cardiology, etc)
 - Local observation medicine experts
 - Targeted protocol-based reading
 - CME conferences



Developing a New Culture: Unit-Based Education Collaboration



- **Challenge:** New team members were asked to integrate themselves into a new unit delivering a novel form of healthcare and develop critical skills in a short timeframe
- **Strategy:** Leadership conducted a needs assessment for staff to self-identify learning opportunities
- **Lessons Learned:** Staff-level sharing of knowledge is an invaluable approach to team building and an effective tool for culture change

Bargaining



Hospital Support

- This is a strategic initiative for the hospital (not the department)
 - Messaging to medical community should emphasize this
 - Impacts everyone's patient care
- Goal alignment is important
 - What are they hoping for?
 - Improved efficiency?
 - Clinical outcomes?
 - Loss avoidance?
- Equip your team to succeed
 - If they say “if only we had”, then think “how can I get that”

Clinical Resources

- **Nursing**
 - 4:1 patient to nurse ratio
 - Dedicated to OU care
- **APP (NP/PA)**
 - Provide OU care under physician supervision
 - 24/7 coverage dedicated to OU
- **Attending**
 - Reassesses all patients in the OU daily
 - Dedicated OU time will depend on several factors
 - Available 24/7
 - Degree of dedication based on clinical need
- **Dedicated Leadership**
 - Develop and monitor protocols
 - Update competencies
 - Support flow from ED
 - Monitor utilization and quality

Collaborating services

- **Cardiology**
 - Chest Pain
 - Atrial tachycardia
 - CHF
- **Neurology**
 - TIA
 - Vertigo
 - Headache
- **Surgery**
 - Abdominal pain
- **Gastroenterology**
 - GI Bleed
 - Bowel prep, endoscopy procedures, NPO status
- **Diagnostic Services**
 - Priority testing and resulting
 - Streamlined workflows
 - Non-invasive cardiology
 - Radiology
 - IR
- **Care management, PT, SW**
 - Impact on ability to discharge
 - Ancillary service availability
 - Care management and social worker
 - Effective disposition planning

Prioritization

- Streamlined workflows
 - Consultants
 - Procedures
- Prioritized diagnostics, labs
 - Performance and interpretations
- Linens, food, garbage emptying, bed cleaning, etc...



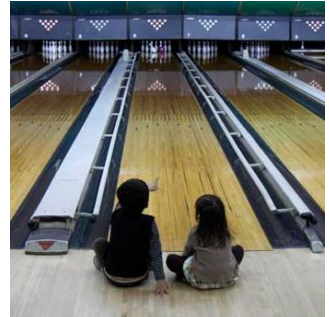
Beds

- Size matters
- Clinical breadth
- Simple vs Complex observation
- How beds will be used in the late afternoon



Clinical Protocols

- Streamline care
 - Scheduled investigations, therapies, reassessments
- Standardized management
 - Less variability
- Discharge and admission criteria
 - Reduced 30-day readmissions relative to routine care
- Inclusion/Exclusion criteria
 - Tailor to the unit, based on resources



Data/Analytics

- Measurement
 - Automatic
- Surveillance
 - Early recognition
- Key to quality improvement
 - PDSA
- Upward and outward management
 - Tell your story

ED Obs Protocol Name	Volume	ED Obs to I P Conversion..	Avg. ED Obs Length of Stay
General Protocol.	3,664	21.6%	20.97hr
Chest Pain Protocol.	3,363	6.0%	18.86hr
Cellulitis Protocol.	1,357	17.3%	25.39hr
Abdominal Pain Protocol.	1,356	15.9%	21.23hr
Syncope Protocol.	900	8.9%	19.38hr
Null	727	10.5%	17.65hr
Back Pain Protocol.	458	25.8%	26.33hr
Flank Pain/ Kidney Ston..	385	13.8%	21.99hr
Dehydration Protocol.	341	21.1%	21.13hr
TIA Protocol.	420	13.3%	18.58hr
Pneumonia Protocol.	349	30.7%	22.46hr
Asthma Protocol.	294	25.2%	22.73hr
Atrial Arrhythmia Proto..	321	10.0%	19.59hr
Transfusion Protocol.	254	7.9%	18.68hr
Geriatric/ Social Work P..	228	19.3%	26.52hr
GI Bleed Protocol.	196	14.3%	20.94hr
Headache Protocol.	164	14.6%	19.83hr
CHF Protocol	150	35.3%	25.04hr
DVT/PE Protocol.	130	13.1%	19.67hr
Metabolic Derangement..	114	14.9%	21.32hr
Abdominal Pain/ Colitis ..	114	14.9%	26.82hr
Allergy Protocol.	70	4.3%	16.84hr
Chest Pain/ Cath Lab Pr..	67	7.5%	24.59hr
Vertigo Protocol	47	0.0%	21.40hr



Acceptance

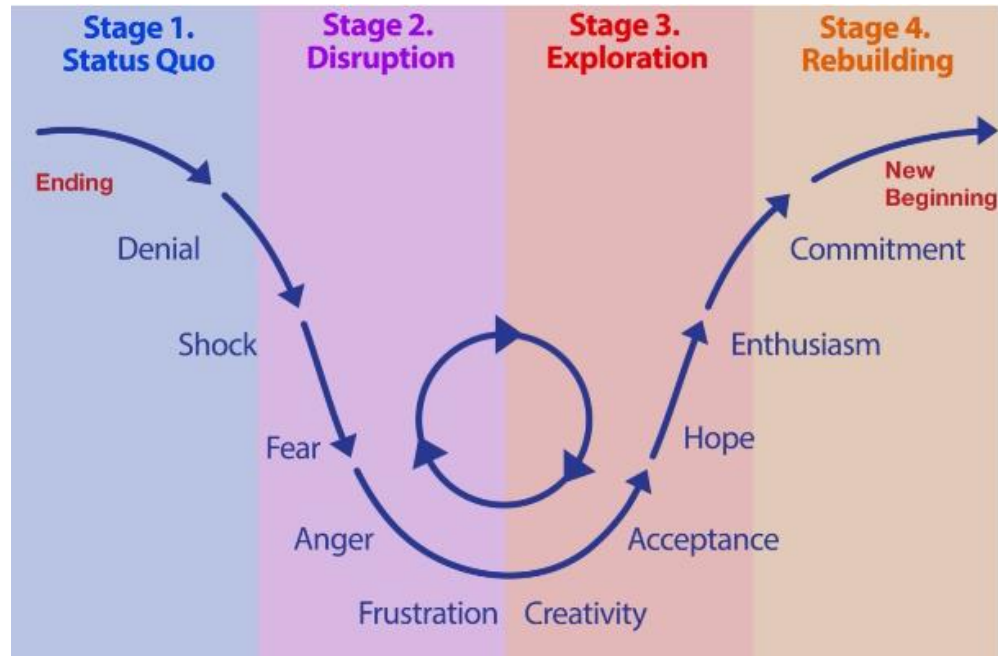
The stress test is negative!



You don't need to be admitted!



Acceptance and Beyond



- Institutionalize the change
 - Acknowledge connections between new state and successes
 - I.e. observation unit to deliver observation services and the new outcomes

Trailblazing

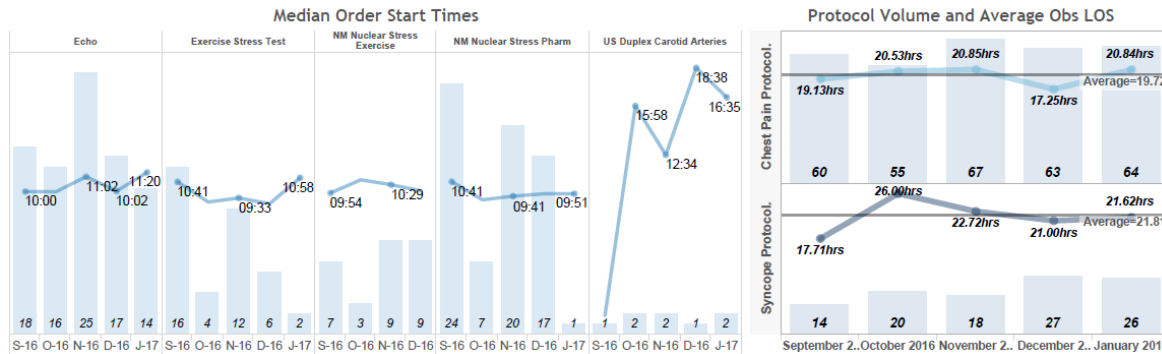


TRAILBLAZERS
Bad idea. Bears will eat you

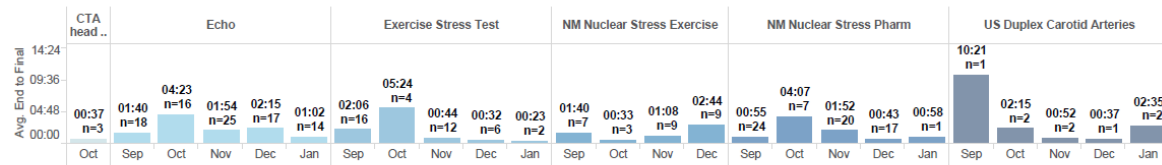
- Continuous quality improvement
- Expand dashboards
- Grow the program

Expanded Dashboards: Resource Utilization – The right care at the right time

Chest Pain & Syncope Analysis
September 1-January 31, 2016



Observation Test Turnaround Times

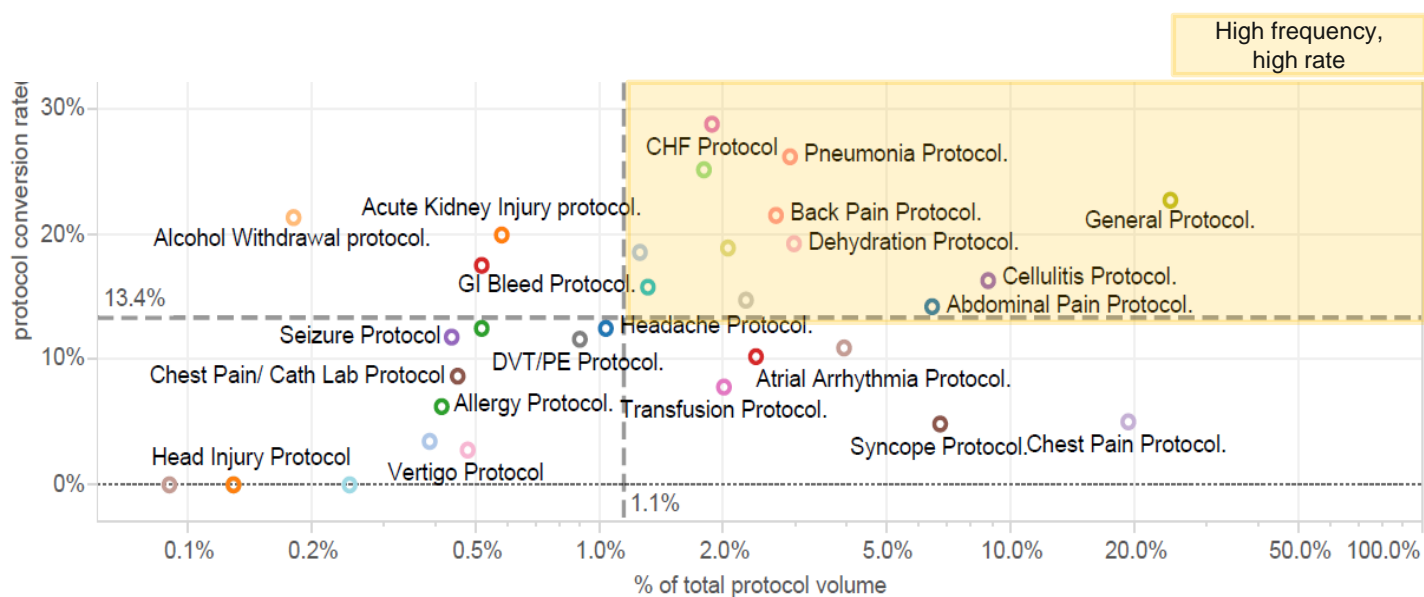


Disposition and Utilization

		Chest pain				Syncope				CTA head neck											
		Echo	Exercise Stress Test	NM Nuclear Stress Exercise	NM Nuclear Stress Pharm	US Duplex Carotid Arteries	Echo	Exercise Stress Test	NM Nuclear Stress Pharm	US Duplex Carotid Arteries	Volume	%									
		Volume	%	Volume	%	Volume	%	Volume	%	Volume	%	Volume	%								
Abnormal	Converted to IP	1	3%	1	3%	5	18%	13	20%	0	0	0	0								
	Discharge	10	26%	2	5%	3	11%	7	11%	0	12	23%	0	1	33%						
Normal	Converted to IP	5	13%	0	0	0	3	5%	0	0	4	8%	0	1	14%						
	Discharge	22	58%	36	92%	20	71%	42	65%	1	100%	36	69%	1	100%	6	86%	2	67%		
Grand Total		38	100%	39	100%	28	100%	65	100%	1	100%	52	100%	1	100%	4	100%	7	100%	3	100%

- Take advantage of analytics to optimize resource utilization with clinical outcomes

Expanded Dashboards: Dynamic Protocol Performance

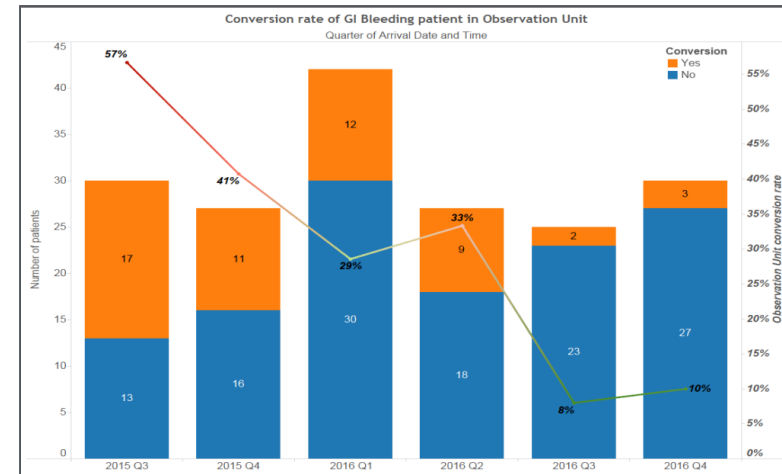
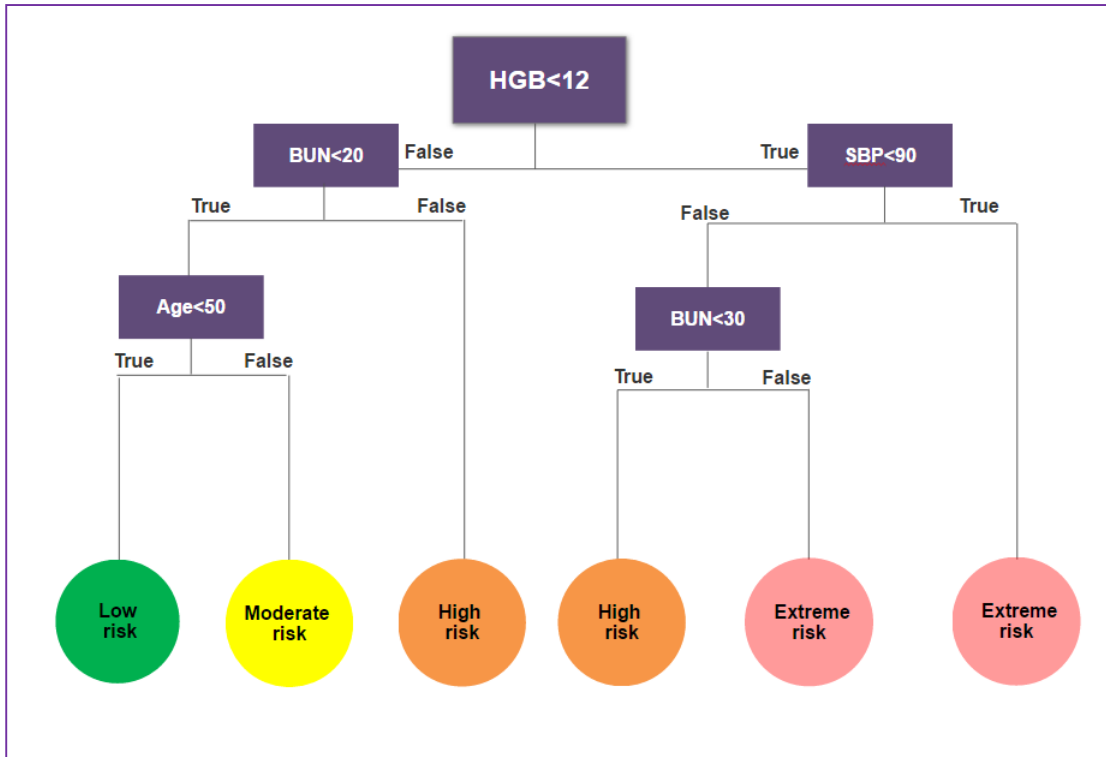


Conversion Rate Ranking

Asthma Protocol.	27%
General Protocol.	23%
Back Pain Protoc..	21%
Alcohol Withdraw..	20%
Acute Kidney Inju..	19%
Geriatric/ Social ..	20%
Abdominal Pain/ ..	18%
Dehydration Prot..	18%
Pancreatitis Prot..	17%
Metabolic Derang..	19%
Cellulitis Protocol.	17%
GI Bleed Protocol.	15%
Flank Pain/ Kidne..	14%
Abdominal Pain P..	13%
Headache Protoc..	12%
DVT/PE Protocol.	12%
TIA Protocol.	11%
Atrial Arrhythm ia ..	10%
Seizure Protocol.	12%

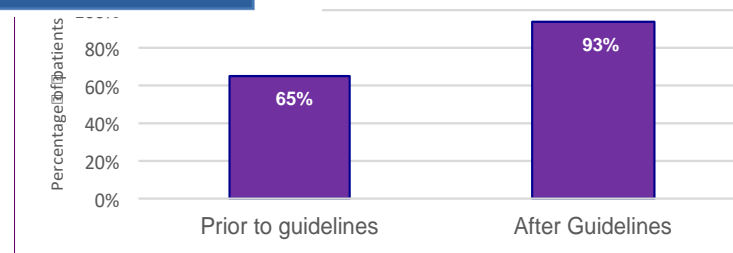
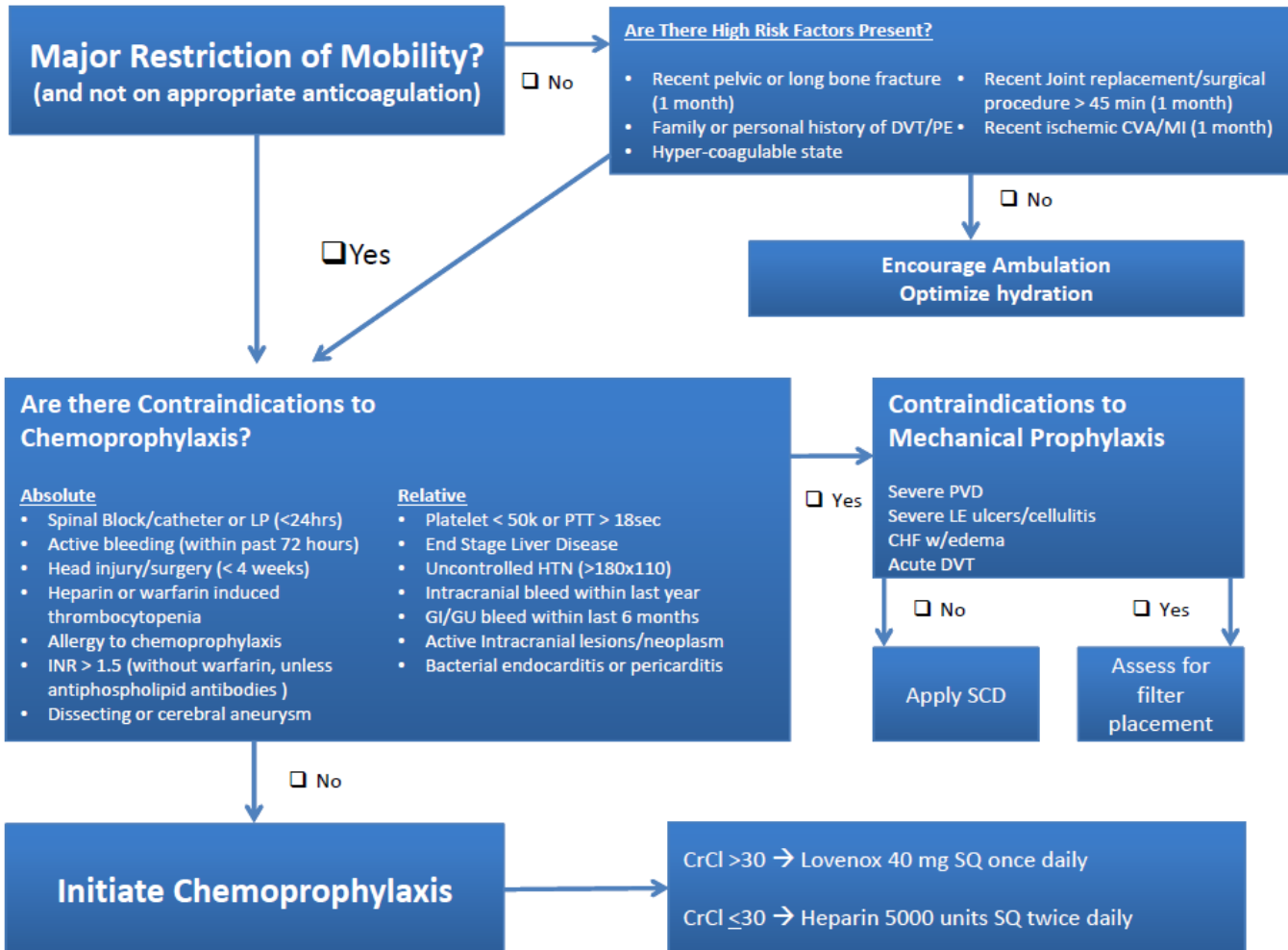
Protocol performance is continuously monitored to ensure desired outcomes and to identify opportunities for improvement.

Continuous Quality Improvement: Gastrointestinal Bleed Protocol

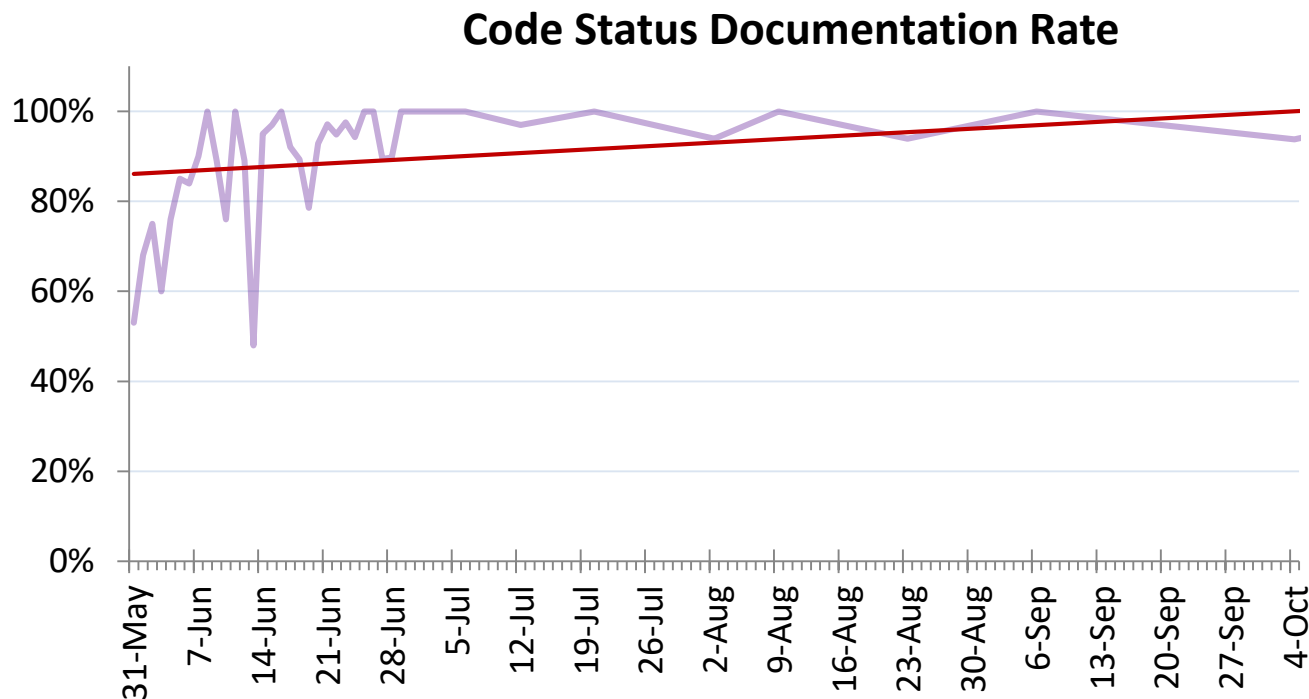


- **GI Bleed Protocol Exclusion Criteria:** use of anticoagulant or antiplatelet agent, history of varices, positive orthostatics, acute anemia, etc.

Venous Thromboembolism Prophylaxis Guidelines

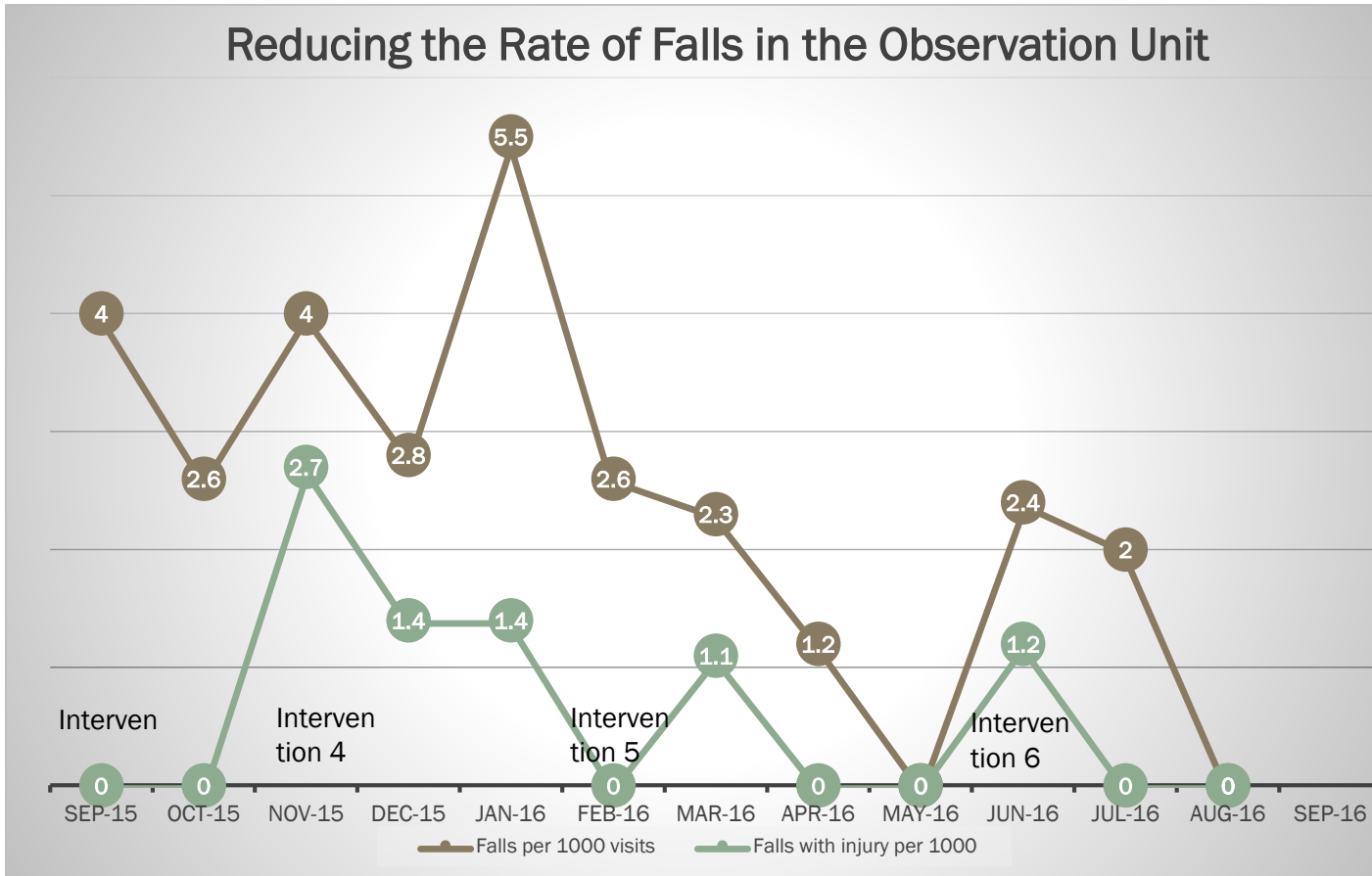


Meaningful Discussions About Code Status



- Lessons learned
 - Collaboration with nursing, Palliative care, social work is key
 - Education to providers regarding focused goals of care conversations
 - Downstream impact on procedure turn around time and community transitions post-discharge

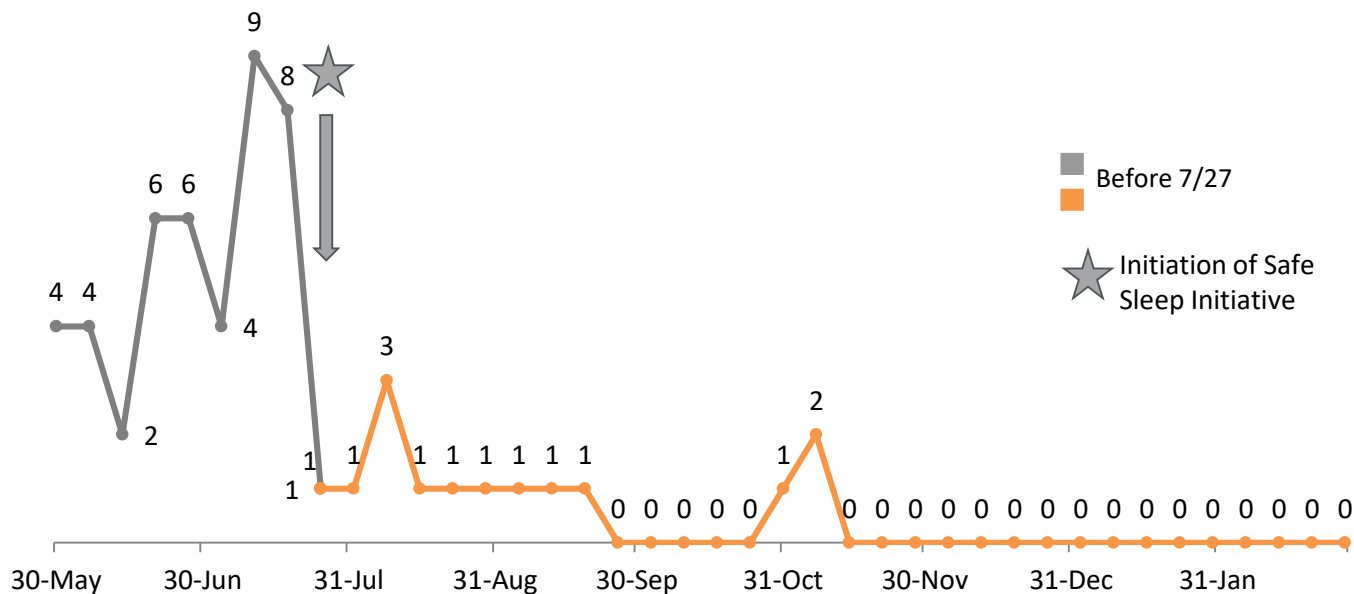
Reducing the Rate of Falls in the Observation Unit



- Keys to success:
 - Multidisciplinary collaboration between nursing, providers, pharmacist, PT, SW, care management
 - PDSA approach to quality and safety interventions is effective in fall reduction
- Next steps: language barriers and the peri-discharge period

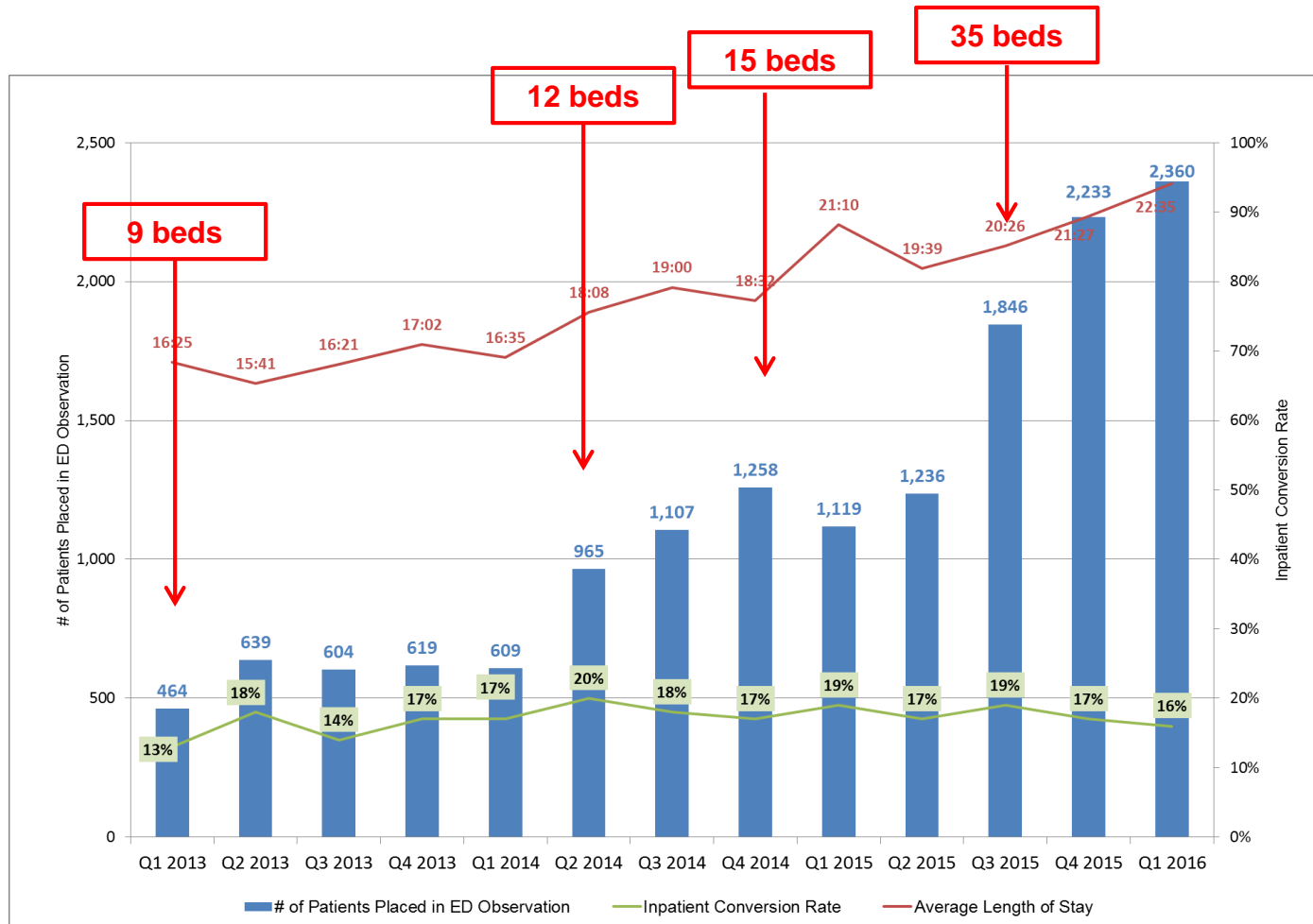
Safe Sleep Initiative

Frequency of Ordering of Pharmacologic Sleep Agents



- Lessons learned:
 - Multidisciplinary collaboration between nursing and providers is effective
 - Successful elimination in ordering/adverse events related to pharmacologic sleep agents
 - No patient complaints (patient's desire to be safe outweighs desire to sleep)
 - All patients eventually fell asleep

Depending on your Strategy, Opportunities for Growth will Present Themselves



- Consistent EDOU growth, innovation, clinical excellence
- Blaze this trail.

**“Let’s start an
Obs Unit!!!!”**





THANK YOU

I hope to hear from you!

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