Observation Medicine:
Past, Present, and Future

MCEP Observation Medicine: Science and Solutions 2017
Nashville, Tennessee
September 14, 2017

Michael A. Ross MD FACEP
Professor of Emergency Medicine
Emory University School of Medicine
Medical Director – Observation Medicine
Atlanta, Georgia

Disclosure of Commercial Relationships:

<table>
<thead>
<tr>
<th>Nature of Relationship</th>
<th>Name of Commercial Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advisory Board</td>
<td>None</td>
</tr>
<tr>
<td>Consultant</td>
<td>None</td>
</tr>
<tr>
<td>Employee</td>
<td>None</td>
</tr>
<tr>
<td>Board Member</td>
<td>None</td>
</tr>
<tr>
<td>Shareholder</td>
<td>None</td>
</tr>
<tr>
<td>Speaker’s Bureau</td>
<td>None</td>
</tr>
<tr>
<td>Patents</td>
<td>None</td>
</tr>
<tr>
<td>Other Relationships</td>
<td>ACC Accreditation Management Board</td>
</tr>
<tr>
<td></td>
<td>Co-chair, ACEP E-QUAL Chest Pain (CMS TCPI)</td>
</tr>
<tr>
<td></td>
<td>Past CMS APC Advisory Panelist</td>
</tr>
<tr>
<td></td>
<td>Chair – Visits and Observation Subcommittee</td>
</tr>
</tbody>
</table>
Topics

A. Past - leaders, definitions, science, and shifts

B. Present – leaders, trends, scope, benefits, and coming of age

C. Future – leaders, visions, policy, clinical practice, and big needs

A. The Past . . .

“Leave nothing to chance, overlook nothing: combine contradictory observations and allow enough time . . . A great part, I believe, of the art is to be able to observe”
“Leave nothing to chance, overlook nothing: combine contradictory observations and allow enough time . . . A great part, I believe, of the art is to be able to observe”

. . . Hippocrates 410 B.C.
What is Observation Medicine?

... The principle

1. **What defines Emergency Medicine?**
   - TIME (acuity)

2. **What defines Observation Medicine?**
   - TIME (acuity)

3. **What defines Observation Patients?**
   - TIME (acuity)
   - ED LOS for admitted patients = 5 hours
   - IP LOS for admitted patients = 5 days
   - Penalties for short IP LOS

4. What about patients needing **6-24 hours** of care???
What is Observation Medicine?

. . . the “Service”:

OUTPATIENT OBSERVATION SERVICES

- Observation services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission as an inpatient...

Medicare: Hospital Manual, 3663

To determine the need for inpatient admission. . .

What is an inpatient? - The “2-Midnight Rule” Definition

- A 2-midnight benchmark: FOR DOCTORS
  - An inpatient is expected to stay in the hospital at least two midnights:
    - 24 hours and 1 minute, or 47 hours and 59 minutes
    - Outpatient time (ED or observation) counts
    - Inpatient stays < 2-MN not paid as an inpatient
      - except death, transfer, AMA, etc

- A 2-midnight presumption: FOR REVIEWERS
  - If a patient met benchmark criteria, the admission will not be scrutinized by reviewers (RAC, MAC, etc)
What is Observation Medicine?

. . . The “Setting”:

- Management: *to determine the need for inpatient admission*
- Target – 70-90% discharge within 15-18 hours
- Setting – a protocol driven observation unit (type 1 setting)

<table>
<thead>
<tr>
<th>EXHIBIT 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Settings In Which Observation Services Are Provided</td>
</tr>
<tr>
<td>Setting</td>
</tr>
<tr>
<td>Type 1</td>
</tr>
<tr>
<td>Type 2</td>
</tr>
<tr>
<td>Type 3</td>
</tr>
<tr>
<td>Type 4</td>
</tr>
</tbody>
</table>

The Observation Unit: . . . a dynamic setting

*Driven by innovations in science, health care, and economic forces. Conditions will enter and leave the observation unit over time. . .*

Management of Observation Units

Case study: Chest Pain 1988
The Observation Unit: . . . a dynamic setting

• 1999 ACEP Policy – Chest Pain restriction removed
  • Care shifted from an inpatient to an outpatient setting

Decline in inpatient admissions for symptoms related to AMI attributed to ED chest pain protocols

• “We strongly advocate for randomized clinical studies that will provide definitive guidance for this prevalent, high-risk, and vexing clinical problem.”
What is Observation Medicine? . . . a dynamic “Setting”

- A “box” which conditions enter and leave over time...
- Driven by payer policy? An “insurance status”?
- Driven by malpractice risk?
- Driven by provider behavior?
- Driven by a random sequence of events?

<table>
<thead>
<tr>
<th>Year</th>
<th>Condition</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988</td>
<td>Chest Pain</td>
<td>Inpatient</td>
</tr>
<tr>
<td>1999</td>
<td>Chest Pain</td>
<td>Observation Unit</td>
</tr>
<tr>
<td>2005</td>
<td>Chest Pain</td>
<td>Outpatient</td>
</tr>
<tr>
<td>2017</td>
<td>Chest Pain</td>
<td></td>
</tr>
</tbody>
</table>
Observation Medicine Research: Drives changes in Observation Medicine

- 1960s – Growth of EDs. First Observation Units described
- 1980s – Initial Chest Pain background research.
  - Novel studies in pediatrics, geriatrics, trauma, asthma, abdominal pain.
- 1990s – Landmark RCTs (AHCPG) show efficacy of ADPs for Chest Pain and ATPs for Asthma.
  - 1998 - SCPC forms.
  - Novel studies in the elderly, as well as the impact of an EDOU on hospitals.
- 2010 – 2017 – Health Services Research focuses on the impact of obs units on hospitals, health systems, and policy.
  - Studies describing which chest pain patient do not need observation
- 2008 ACEP Policy on ED Observation Units . . . a new line in the sand

<table>
<thead>
<tr>
<th>Condition / Year / Author</th>
<th>N</th>
<th>Primary Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syncope / 14 / Sun *</td>
<td>124</td>
<td>↓ admissions and LOS</td>
</tr>
<tr>
<td>Chest Pain / 10 / Miller *</td>
<td>110</td>
<td>↓ Cost (stress MRI)</td>
</tr>
<tr>
<td>Atrial Fib / 08 / Decker</td>
<td>153</td>
<td>↑ conversion to sinus</td>
</tr>
<tr>
<td>TIA / 07 / Ross</td>
<td>149</td>
<td>↓ LOS and cost</td>
</tr>
<tr>
<td>Syncope / 04 / Shen</td>
<td>103</td>
<td>↑ established diagnosis, ↓ admissions</td>
</tr>
<tr>
<td>Asthma / 97 / McDermot</td>
<td>222</td>
<td>↓ admissions, no relapse ↑</td>
</tr>
<tr>
<td>Chest Pain / 98 / Farkouh</td>
<td>424</td>
<td>No difference cardiac events</td>
</tr>
<tr>
<td>Chest Pain / 97 / Roberts</td>
<td>165</td>
<td>↓ LOS and cost</td>
</tr>
<tr>
<td>Chest Pain / 96 / Gomez</td>
<td>100</td>
<td>↓ LOS and cost</td>
</tr>
</tbody>
</table>

*(Cot Pathways in Cardiol 2012;11: 128-138) *Added since published after this review
Is “Observation Medicine” simply describing an insurance status?

No!

It is based on a growing body of literature that conforms to contemporary scientific evidence and medical practice.

Policy Statements

Emergency department (ED) patients frequently require services beyond their initial ED care to determine the need for inpatient admission. These distinct and reimbursable services may include but are not limited to: further diagnostic evaluation, continued therapy or management of acute psycho-social issues.

To promote quality of care and patient safety for ED observation patients, the American College of Emergency Physicians (ACEP) supports the following principles:

- **Observation of appropriate ED patients in a dedicated ED observation area, instead of a general inpatient bed or an acute care ED bed, is a “best practice” that requires a commitment of staff and hospital resources.**

- An emergency physician and emergency nurse should direct ED observation areas with clearly defined administrative responsibilities for the unit.

- Written policies and procedures for the ED observation area should be approved by appropriate ED and hospital medical staff representatives.

- ED observation area policies and procedures should address the following:
  - Patient criteria for admission into the unit, discharge from the unit, and admission to an inpatient bed;
  - A clear statement of which physician bears clinical responsibility for each patient in the area;
  - A clear delineation of emergency physician and nursing staff roles and responsibilities throughout the day – including how care will be transferred between providers;
  - Circumstances that require notification of the physician who is responsible for the patient; Maximum allowable length of stay in the unit and means to address outliers; and
  - A description of how utilization and relevant quality measures will be monitored and reported.

- ED observation areas should have adequate space, staffing, equipment, and supplies appropriate for the conditions being managed.

- Mechanisms should be in place to expedite the discharge or the transfer of patients to an inpatient bed, when appropriate.
B. The Present

1. Leaders
2. Trends
3. Scope
4. Benefits
5. Coming of age
Background: U.S. Health System

THE NATION'S HEALTH DOLLAR ($3.2 TRILLION), CALENDAR YEAR 2015, WHERE IT WENT

Note to self: In 2014 it was 3.0 trillion
In 2015, that is 17.8% of the U.S. Gross Domestic Product

Annual Growth in Spending by Type of Good and Service, 2013-2015

Note: Some of pieces may not equal 100% due to rounding.

Hospitalization rates declining: CDC NCHS – 1975 - 2015

- Percent of U.S. population with a hospital overnight stay in 2015 = 7.6%

SOURCE: NCHS, Health, United States, 2016, Figure 18. Data from the National Health Interview Survey (NHIS).

Hospital beds and length of stays declining: CDC NCHS 1975 - 2014

SOURCE: NCHS, Health, United States, 2016, Figure 20. Data from the American Hospital Association (AHA).
Why the shift from inpatient to outpatient

- Innovations in medical science
- Innovations in clinical practice
- Payer policy driven to control health costs
- Patient driven desire to not be hospitalized
- Contracting hospital beds in the face of an expanding Medicare population

3. Scope of Observation Services in the U.S.

1. What percent of patients staying in the hospital following an ED visit are “observation” status?
2. What percent of U.S. Hospitals have an observation unit?
3. What percent of U.S. Emergency Medicine Residencies include training in Observation Medicine?
1. How many patients are observed following an ED visit?

**National Study of Emergency Department Observation Services**

Jennifer L. Wilke, MD, MBA, Michael A. Ross, MD, and Adit A. Glinsy, MD, MPH

**ACMEM 2011. 10.7 © 2013 by the Society for Academic Emergency Medicine**

**AHRQ HCUP claims data:**

- 4 states — Ga, Nb, SC, Tn
- 2009–2013
  - All ED, Obs, Inpatient claims
  - Rates per 100,000

**Focused on top ten conditions:**

- Heart failure, bacterial pneumonia, chronic obstructive pulmonary disease, asthma, dehydration, urinary tract infection, uncontrolled diabetes, diabetes with long-term complications, and hypertension
  - Represent >20% of general medicine admissions

**Trends:**

- Inpatient admissions declined
- ED discharges increased:
  - ED – home
  - ED – obs – home: did not fully account for decline in IP admits
  - Inpatient admissions preceded by an obs visit increased across all payers
Observation admissions
CDC NHAMCS survey data - 2013

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Number of visits in thousands</th>
<th>Percent of visits (standard error in percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admit to the hospital</td>
<td>12,116 (207)</td>
<td>9.3 (0.7)</td>
</tr>
<tr>
<td>Critical care unit</td>
<td>1,516 (173)</td>
<td>1.2 (0.1)</td>
</tr>
<tr>
<td>Stepdown or telemetry unit</td>
<td>487 (135)</td>
<td>0.4 (0.1)</td>
</tr>
<tr>
<td>Operation room</td>
<td>636 (199)</td>
<td>0.5 (0.1)</td>
</tr>
<tr>
<td>Mental health or detoxification unit</td>
<td>450 (88)</td>
<td>0.3 (0.1)</td>
</tr>
<tr>
<td>Cardiac catheterization lab</td>
<td>257 (89)</td>
<td>0.2 (0.1)</td>
</tr>
<tr>
<td>Other bed or unit</td>
<td>7,119 (658)</td>
<td>5.5 (0.5)</td>
</tr>
<tr>
<td>Discharged or transferred to another facility</td>
<td>1,176 (333)</td>
<td>1.3 (0.2)</td>
</tr>
</tbody>
</table>

Admit to observation unit

- Then hospitalized | 2,270 (286) | 1.7 (0.3) |
- Then discharged | 1,070 (207) | 1.3 (0.2) |

Return or refer to physician or clinic for follow-up | 90,005 (6,534) | 66.0 (1.9) |

No follow-up planned | 16,076 (2,265) | 12.3 (1.7) |

Other

- Left prior to completing visit | 1,176 (333) | 0.3 (0.1) |
- Left after transfer | 2,856 (596) | 2.3 (0.5) |

Source: Medicare and outpatient 2012 standard analytic file claims.
2. Percent of hospitals that have an obs unit
CDC NHAMCS survey data 2011

<table>
<thead>
<tr>
<th>Hospital and ED Characteristics</th>
<th>Total</th>
<th>Fewer than 150 beds</th>
<th>150-500 beds</th>
<th>500 or more beds</th>
<th>Metro/Nonmetro status</th>
<th>Total</th>
<th>Fewer than 150 beds</th>
<th>150-500 beds</th>
<th>500 or more beds</th>
<th>Metro/Nonmetro status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent distribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of hospitals in which observation units are available</td>
<td>13.0 (3.7)</td>
<td>39.4 (7.0)</td>
<td>9.3 (3.0)</td>
<td>15.4 (3.3)</td>
<td>9.6 (3.3)</td>
<td>123.1 (7.4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15.3 (3.6)</td>
<td>39.3 (7.0)</td>
<td>9.4 (3.4)</td>
<td>16.5 (3.5)</td>
<td>9.4 (3.4)</td>
<td>126.0 (7.0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>10.7 (3.0)</td>
<td>39.2 (7.0)</td>
<td>9.2 (3.0)</td>
<td>14.7 (3.3)</td>
<td>9.2 (3.0)</td>
<td>120.1 (6.6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unavailable or unknown</td>
<td>9.0 (2.5)</td>
<td>36.3 (6.0)</td>
<td>9.0 (3.0)</td>
<td>14.3 (2.7)</td>
<td>9.0 (3.0)</td>
<td>114.0 (5.6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How best coordinator?</td>
<td>Yes</td>
<td>90.7 (4.5)</td>
<td>42.0 (5.2)</td>
<td>59.6 (4.3)</td>
<td>80.7 (4.1)</td>
<td>77.8 (4.3)</td>
<td>444.0 (8.0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>9.3 (4.5)</td>
<td>58.0 (6.0)</td>
<td>40.4 (4.3)</td>
<td>19.3 (4.1)</td>
<td>22.2 (4.1)</td>
<td>36.0 (8.0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unavailable or unknown</td>
<td>7.3 (3.0)</td>
<td>49.0 (5.0)</td>
<td>31.0 (4.5)</td>
<td>32.0 (4.5)</td>
<td>32.0 (4.5)</td>
<td>211.0 (5.5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How their hospital best guesses are available (in parenthesis)</td>
<td>Yes, definitely</td>
<td>79.5 (5.0)</td>
<td>50.5 (5.0)</td>
<td>73.4 (4.0)</td>
<td>76.0 (4.0)</td>
<td>77.8 (4.2)</td>
<td>584.0 (5.0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No, not sure</td>
<td>14.4 (5.0)</td>
<td>9.1 (4.5)</td>
<td>9.5 (4.5)</td>
<td>9.5 (4.5)</td>
<td>9.5 (4.5)</td>
<td>81.0 (5.0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>6.1 (3.0)</td>
<td>5.0 (4.5)</td>
<td>5.0 (4.5)</td>
<td>5.0 (4.5)</td>
<td>5.0 (4.5)</td>
<td>18.0 (5.0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown or unavailable</td>
<td>7.5 (3.0)</td>
<td>5.0 (4.5)</td>
<td>5.0 (4.5)</td>
<td>5.0 (4.5)</td>
<td>5.0 (4.5)</td>
<td>26.0 (5.0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. How many E.M. residencies have training in Observation Medicine?

Survey of all E.M. residencies in 2000 to evaluate observation unit (OU) prevalence, emergency medicine (EM) resident exposure in observation medicine (OM), EM faculty/residency director (RD) OM training, and RD attitudes toward OM.

**RESULTS:**
- 36.1% have OUs
- 44.9% plan to have an OU
- Observation medicine resources included:
  - Textbooks 32.0%
  - Articles 45.9%
  - Lectures 36.9%
  - Fellowships 2.5%
  - Research 2.5%
- Observation medicine patient care occurs
  - 1) during residency: 25.4% of RDs, 11.3% of entire faculty
  - 2) as an attending: 45.1% of RDs

**CONCLUSIONS:** Nearly two-thirds of EM programs have or are planning an OU. Resources are lagging behind. This survey describes current OM education strategies to teach OM.

4. Major Benefits

1. **Local - What is the impact of type 1 EDOU on hospitals in terms of:**
   - Cost reduction
   - Revenue enhancement

2. **National - What is the potential impact of type 1 EDOUs on the U.S. health care system?**

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

OCTOBER 2012 . 31:30. HEALTH AFFAIRS

Estimates:
- Savings per hospital: $4.6 million
- Savings per patient: $1,572
Protocol-Driven Emergency Department Observation Units Offer Savings, Shorter Stays, And Reduced Admissions

<table>
<thead>
<tr>
<th></th>
<th>Emory/Grady (Type 1 units)</th>
<th>Georgia (HCUP 2010)</th>
<th>National (NHAMCS 2009-10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED volumes</td>
<td>165,901</td>
<td>4,194,602</td>
<td>133,160,000</td>
</tr>
<tr>
<td>OS Volumes</td>
<td>7,199</td>
<td>162,375</td>
<td>1,216,000</td>
</tr>
<tr>
<td>OS LOS &gt;8hr (avg)</td>
<td>17.2 hr</td>
<td>27.2 hr</td>
<td>22.3 hr</td>
</tr>
<tr>
<td>% OS LOS &gt;8hr</td>
<td>0.1%</td>
<td>20.8%</td>
<td>14.9%</td>
</tr>
<tr>
<td>% OS LOS &gt;36hr</td>
<td>0.1%</td>
<td>19.9%</td>
<td>14.9%</td>
</tr>
<tr>
<td>% OS LOS &gt;72hr</td>
<td>0.1%</td>
<td>15.5%</td>
<td>9.9%</td>
</tr>
<tr>
<td>OS-IP admit rate</td>
<td>13.1%</td>
<td>17.8%</td>
<td>22.5%</td>
</tr>
</tbody>
</table>

- **U.S. Savings Potential from Type 1 Units:**
  - Observation patients - $950 Million / year
    - 38% shorter stays
    - 44% lower admit rates
  - Short Inpatients - $8.5 Billion / year
    - 11.7% of all admissions
    - Savings potential – ED visits vs ED admissions:
      - Avoided ED visits = $2.3-3.4 Billion/yr
      - Avoided ED admits = $5.5-8.5 Billion/yr
      - Relative savings = (avoided: admitted vs ED visits) 2.4-2.5 times greater

---

**EXHIBIT 3**

Observation Visit Length-Of-Stay Across Three Study Groups

- Emory/Grady
- United States
- Georgia
Avoidable ED visits vs Avoidable ED admissions
Which saves more?

<table>
<thead>
<tr>
<th></th>
<th>Avoidable ED visits</th>
<th>Avoidable ED admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>69 hours with ED</td>
</tr>
<tr>
<td>Total ED visits, n</td>
<td>120,970.044</td>
<td>120,970.044</td>
</tr>
<tr>
<td>Eligible ED visits, n</td>
<td>7,000.000</td>
<td>7,000.000</td>
</tr>
<tr>
<td>Eligible ED visits eligibile, %</td>
<td>9.0</td>
<td>9.0</td>
</tr>
<tr>
<td>Low estimated reduction, millions US &amp; £</td>
<td>2.946</td>
<td>2.976</td>
</tr>
<tr>
<td>High estimated reduction, millions US &amp; £</td>
<td>3.111</td>
<td>3.123</td>
</tr>
<tr>
<td>Low ratio^2</td>
<td>N.A.</td>
<td>1.0</td>
</tr>
<tr>
<td>High ratio^2</td>
<td>N.A.</td>
<td>1.2</td>
</tr>
</tbody>
</table>

- Qualitative interviews—
  - 3 hospitals (1 U.S., 2 England)
  - 24 Emergency Physicians
  - Physician views of antecedents of observation care:
    - Economic, operational issues
  - Observation as a “safe space” for patients with unresolved medical, social, and legal issues.

- Physicians used observation status for the specific presentations for which it is well evidenced but acknowledged administrative and financial considerations in their decision making.
- They also highlighted an important role for observation not described in the literature: as a “safe space,” relatively immune from the administrative gaze, where diagnostic uncertainties, sociomedical problems, and medicolegal challenges could be contained.

Ann Emerg Med, March 2017
5. Observation Medicine has come of age . . .
What is Observation Medicine?

... is it a procedural or cognitive skill?

- **Procedural skill analogy: Ultrasound**
  - Like an ultrasound machine, users of an *observation unit* need to know its:
    - How to operate it
    - When it breaks how to fix it
    - Cost of purchasing and best models
    - Indications for use
    - Limitations
    - Proven benefits

- **Cognitive skill analogy: Toxicology**
  - Like toxicology, *observation medicine* is:
    - A cognitive (non-procedural) skill
    - All ED physicians must know
    - There are benefits to having local content experts (Obs Unit Directors) to run the program

- **PGY I** – Principles and observation patient selection
- **PGY II** – Managing patients in the observation unit
- **PGY III** – Managing the observation unit
- **Fellowship** – Learning the research, clinical science, administration, and policy of observation medicine
C. The Future . . .

1. Future leaders
2. A vision for Emergency Medicine
3. Home to home
4. Policy directions
5. Teaching Observation Medicine
6. Future roles - Short Stay Services
7. The big request. . .

1. Future leaders* ...

*? - YOU
2. A vision for Emergency Medicine: the “Central Hub” model

**Decentralized Model:**
- The emergency department is a necessity that must be “dealt with” that competes with elective cases for beds
- Emergency physicians run codes and triage patients
- Major services own and run their respective “pieces” of the ED
- Care is fragmented and more costly

**Central Hub Model:**
- Emergency department is the “front door” of the hospital
- Triage is the central focal point
  - Urgent care centers
  - Prehospital care
  - Resuscitation
  - Specialty zones (trauma, peds)
  - Observation unit
  - Care coordination
- Patient centered, less costly

3. Shift from “readmissions” to “home to home”

**Home-to-Home Time — Measuring What Matters to Patients and Payers**

Michael L. Barnett, M.D., David C. Grabowski, Ph.D., and Ateev Mehrotra, M.D., M.P.H.

- Post acute care (SNF) following admission has increased from 5% to 20% of Medicare discharges.
- Time away from home is what matters most to patients
- For selected patients, type 1 observation units can improve this metric
4. Policy directions.

- Current Medicare policy issues:
  - Count time in observation toward the 3 day SNF rule
  - Include Self Administered Meds in the Comprehensive APC

- Clarify and address physician payment issues and incentives

- Address the CPT conundrum:
  - Which Evaluation and Management Service does not have its own "site of service" code?  
    1. Emergency  
    2. Clinic  
    3. Critical Care  
    4. Inpatient  
    5. Observation

5. Teaching Emergency Medicine: Avoidable ED visit vs Avoidable ED admissions

- Avoidable ED visits
  - Under constant scrutiny by policy makers
  - Currently being provided by APPs in most EDs
  - Being shifted to Urgent Care Clinics

- Avoidable ED admissions
  - Maintains the "Central Hub" model of EM
  - An area where EM has clearly established expertise
  - Strong evidence of improved outcomes relative to traditional practices
  - Ability to rapidly adapt to innovations in health care and clinical science
6. Future Roles: Evolution of the Observation Unit Medical Director

- Observation Unit Director skill set:
  - Clinical skills
    - Emergency Medicine, Internal Medicine, Family Medicine, Pediatrics
    - Unique Knowledge – Observation Medicine
  - Administrative skill – designing and running a unit, leadership, team building
  - Health Policy expertise - required
    - Emergency, Observation, Inpatient policy issues
    - Medicare policies and updates
    - Full understanding of issues around “Obs, LOPS, and SIPS”
  - CPT coding and billing
  - Analytic skills – IT, data analytics; reporting for utilization, quality, and finance
  - Academic Medical Centers –
    - Service – above
    - Integration into training programs
    - Clinical and health services research

WHY STOP THERE???
EDOU Medical Director – growth to the next level

- ED OU director will likely have the most expertise in the management of observation patients, and short stay services.
  - Observation Patients (Obs)
  - Long OutPatient stays (LOPS, or elective outpatient procedures)
  - Short InPatient Stays (SIPS)

- Expand the footprint:
  - Address “disparities in care” of observation patients by settings
  - Observation patients –
    - ANYWHERE in a hospital
    - ANYWHERE in a system
  - Analyze by setting, service, disposition
  - Opportunity to
    - Improve quality of care
    - Decrease cost
    - Open inpatient bed (revenue enhancement)

Emory Healthcare: Short Stay Services Project
April 2015 – March 2016

- **Population**: Discharged observation status patients
- **Timeframe**: 12 consecutive months
- **Hospitals**: EUH, EUHM, ESJH, EJCH
- **Settings**: ED Obs Unit (CDU), HMS Obs Unit (HMS OU), Floor (Non-OU)
- **Outcome**: Census, LOS, Total Direct Cost, Savings (relative to floor).

<table>
<thead>
<tr>
<th>Setting</th>
<th># Units (#Beds)</th>
<th>Count of Cases</th>
<th>Percent total</th>
<th>Ave LOS (hrs)</th>
<th>Bed Days Saved (per year)</th>
<th>Ave Total Direct Costs</th>
<th>Cost savings (per year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDU</td>
<td>3 (29)</td>
<td>6,017</td>
<td>46%</td>
<td>17</td>
<td>4,065</td>
<td>$1,342</td>
<td>$3,824,115</td>
</tr>
<tr>
<td>HMS OU</td>
<td>2 (20)</td>
<td>2,040</td>
<td>16%</td>
<td>28</td>
<td>398</td>
<td>$1,874</td>
<td>$211,254</td>
</tr>
<tr>
<td>Non-OU</td>
<td>N.A.</td>
<td>4,916</td>
<td>38%</td>
<td>33</td>
<td>0</td>
<td>$1,978</td>
<td>0</td>
</tr>
<tr>
<td>Grand Total</td>
<td>5 (49)</td>
<td>12,973</td>
<td>100%</td>
<td>25</td>
<td>4,464</td>
<td>$1,667</td>
<td>$4,035,369</td>
</tr>
</tbody>
</table>
7. The big request . . .

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of All U.S. Registered Hospitals (2017 AHA stats)</td>
<td>5,564</td>
</tr>
<tr>
<td>Number of U.S. Community Hospitals</td>
<td>4,862</td>
</tr>
<tr>
<td>- Number of Nongovernment Not-for-Profit Community Hospitals</td>
<td>2,845</td>
</tr>
<tr>
<td>- Number of Investor-Owned (For-Profit) Community Hospitals</td>
<td>1,034</td>
</tr>
<tr>
<td>- Number of State and Local Government Community Hospitals</td>
<td>983</td>
</tr>
<tr>
<td>Number of Federal Government Hospitals</td>
<td>212</td>
</tr>
<tr>
<td>Number of Nonfederal Psychiatric Hospitals</td>
<td>401</td>
</tr>
<tr>
<td>Number of Nonfederal Long Term Care Hospitals</td>
<td>79</td>
</tr>
<tr>
<td>Number of Hospital Units of Institutions (Prison, College Infirmaries, Etc.)</td>
<td>10</td>
</tr>
</tbody>
</table>

Estimates:
- Hospitals WITH an Observation Unit = 1,391 (25%)
- Hospitals WITHOUT an Observation Unit = 4,173 (75%)

That leaves a LOT of room for growth!
- 10% = 417
- 20% = 834

8. THE BIG ASK...

¾ of U.S. Hospitals don't have an observation unit...

We NEED YOU.
Summary

Observation Medicine is based on a growing body of literature that conforms to contemporary scientific evidence and medical practice.

There is a need for well trained observation medicine leaders to help the U.S. Health Care System meet current and future needs for observation services.

There has never been a better time to become involved in Observation Medicine!