Intro to Observation Medicine
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Intro to Observation Medicine

- Unique Perspective
  - Will always be an ‘ER Doc’, but...
  - New insight into the world ‘upstairs’

- ED Observation Units (EDOU) increasing rapidly
  - >35% w/ dedicated EDOU, 66% of academic programs
  - >50% administered by E.D. & growing
  - 10% required rotation/25% electives
    - Quasi floor experience-leads to better knowledge and decisions

- Type 1 Units
  - 23% - 38% decreased LOS
  - 17% - 44% decreased admit rate
  - Lower rates of missed MI’s (4.5% vs 0.4%)
  - 5.5 – 8.5 billion savings/year (27-42%)
  - Better outcomes/satisfaction/resource utilization
  - Cost generally not greater to patient (denied admit expensive!)
    - Watch unnecessary meds
    - 30 day re-admits/ACO’s
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### Table 1

<table>
<thead>
<tr>
<th>Type</th>
<th>Settings for Observation Services*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td>Dedicated OU; protocol-driven care</td>
</tr>
<tr>
<td>Type 2</td>
<td>Dedicated OU; discretionary care</td>
</tr>
<tr>
<td>Type 3</td>
<td>Bed in any location; protocol-driven care</td>
</tr>
<tr>
<td>Type 4</td>
<td>Bed in any location; discretionary care</td>
</tr>
</tbody>
</table>

OU = observation unit.
*Source: Ross et al.\textsuperscript{13}
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- Goal: LOS >8 hrs but <24 (15?) (>8hrs in 1 calendar day)
- Open versus Closed (3T vs CDU)
- Provider Staffing
  - Physician/MLP
- Protocols
  - Order Sets
- Typical Workload
  - H&P (FH)
  - Progress Note
  - Discharge Summary
- Accurate Times
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- Nursing ‘buy in’ to rapid turn around
  - Nurses very happy to have physicians readily available
  - Nursing now integrated between 3T, CDU and the E.D.

- Resource Commitment from Hospital (gaming the system)
  - Transport
  - Radiology
  - Ancillary Tests
  - Expedited test results and consults
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ED Model: Original Harper CDU

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Everything Model: DRH 3T (and now CDU)

- Previous 32 diagnoses, plus *everything else* that doesn’t meet Interqual/Admit criteria & many potential 30 day readmits; plus social issues (DRH)
- (Thank God for internists in 3T)
- E.D. physicians bring trauma experience and ‘ER Mentality” to the table
- 2\textsuperscript{nd} & 3\textsuperscript{rd} year elective opportunity
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- **CDU-2016**
  - 3,211 Patients
  - 16 Beds/Staffing
  - Discharges: 18 hrs 28’
  - Upgrades: 16 hrs 47’
  - Upgrade Rate: 25.9%
  - LOS>24hrs 20%
  - LOS>48hrs 1%
  - % of all Observation Patients: 95%
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- 3T-2016
  - 4,997 Patients
  - 24++beds/Staffing
  - Discharges: 23 hrs 47’ *
  - Upgrades: 24hrs *
  - Upgrade Rate: 23.4%
  - LOS>24hrs 38.3%
  - LOS>48hrs 5.5%
  - * Despite huge ‘social admit’ issues
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- Consult the Wiki

IT'S NOT LUPUS
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- **ASTHMA**
  - *Condition-Specific Guidelines*

- **Transfer Criteria**
  - Intermediate response to therapy in ED
  - Acceptable VS
  - PEFR (peak flow) 40–70% predicted (or personal best) after nebulized treatments
  - Nebulized treatments plus steroids given in ED
  - Unremarkable chest x-ray
  - ED management for ≥ 2 hours
Exclusion Criteria

- Unstable VS (RR > 40)
- Poor response to initial ED therapy
  - Impending respiratory fatigue – persistent accessory muscle use, poor air exchange
  - Depressed mental status
  - O2 Sat < 92% on RA (unless chronic hypoxia)
  - PEFR < 40% predicted or personal best
  - Elevated pCO2 > 50, decreased pH < 7.30 (if ABG done)
- Suspicion of ACS or ECG changes (if done)
- Abnormal chest x-ray – pneumonia, new onset CHF
- Toxic theophylline level
- Bronchospasm due to epiglottitis, aspiration, or foreign body
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More and more like the floor

Things I’ve learned

- Timely ED Dictations
- Sign Out
- Critical Orders on Boarded Patients
  - Diabetic PEER Cases
- Everyone’s Busy!
  - (But not necessarily on time...)
- Medication Reconciliation/Medication Lists!!
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Things I’ve learned

- Careful what you tell patients
  - Leads to unrealistic expectations

- Social Work/Case Managers more blunt than us!
  - And many times do not have what the patient wants/demands

- Don’t be a Triage Doctor (my pet peeve)
  - Can’t always have diagnosis, but try not to be too robotic
And now...the bad news:

- Tenet/DMC new direction
- Mid November??
- Observation Admission Orders and Cancellations
  - Still important for the time being
- Or-check the wiki or call the observation physician
Tales from the Dark Side

CDU

Admit

Only patient seen in emergency room may be transferred to CDU

Resuscitation Status Orders.

Observation Placement

TN

Observation

Observation on CDU

06/21/2016 14:09 EDT

Nursing

- Adult System Assessment
  - TN, Routine, Q4H, 36 hr
  - Adult Admission Intake
    - TN, One Time Only
  - Adult System Assessment - Admission
    - TN, L200, One Time Only
  - Adult Admission Intake
    - TN, One Time Only
  - Adult System Assessment
    - TN, Routine, Q12H, 36 hr
  - Braden Assessment
    - TN, Q3H, 36 hr
  - Schmid's Fall Risk Assessment
    - TN, Q2H, 36 hr

Problems

Add

ICD-10

Annexed Data

No Results

Details for Observation on CDU

- Details
- Order Comments
- Diagnosis

- "Requested Start Date/Time: 06/21/2016 14:09 EDT"

- "Attending Physician's Name:"
  - Hospital Service
  - Transfer Location

- "ADT Instructions (Choose up to 5 Selections):"

Do Table  OK  Cancel
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**The Future**

Observation Units are a high growth area

Elective—still??

Follow Up emails/lectures from 3T—yes

ED “safety net” of Health Care
EDOU “safety net” of ED
Dissection...x 2