Starting and Expanding an OU - Pearls and Pitfalls: Lessons Learned

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Lessons learned

- Macro picture - acknowledging the game
  - C-suite buy-in
  - Right-sizing
  - Know the stakeholders
- Micro picture - assuring success and meeting the needs of your system and your community
  - Location, location, location
  - Mission, metrics
  - OM team
  - Prioritization
- Academic OM and Sustainability - next EM endeavor
  - Impact on UME, GME, APP learners

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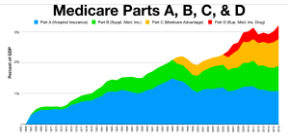
C suite - ROI - Revenue generation - Cost savings



Operational efficiency:

- ED timeliness of care - CMS stars
- IP LOS
- IP CMI
- Transfers, elective OR

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Growth of OBS Services

- ED overcrowding, resource overutilization, squeezed Medicare payments, avoidable admissions, payer audits and denials = HIGH COSTS, LOST REVENUE
- Hospital maximizes revenue by being able to accept more ED patients and by avoiding lost revenue from ambulance diversion and patients who leave without being seen
- As a result, observation units have grown in numbers

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Critical outcomes

- Reduce the number of unnecessary inpatient admissions
- Evolve to manage complex observation patients
- CREATE INPATIENT CAPACITY, OPTIMIZE ED THROUGHPUT

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Hospital Settings In Which Observation Services Are Provided

Setting	Description	Characteristics
Type 1	Protocol driven, observation unit	Highest level of evidence for favorable outcomes Care typically directed by ED
Type 2	Discretionary care, observation unit	Care directed by a variety of specialists Unit typically based in ED
Type 3	Protocol driven, bed in any location	Often called a "virtual observation unit"
Type 4	Discretionary care, bed in any location	Most common practice Unstructured care Poor alignment of resources with patients' needs

Ross et al. Health Aff 2013;32:2149-2156

Where Can Observation Services Be Provided

ACEP policy recognizes care in a dedicated ED observation area, rather than a general inpatient bed or an acute care ED bed, as a best practice

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CDU Background and Mission

The clinical decision unit [CDU] was created by the Department of Emergency Medicine to help decrease ED boarding, control resource over-utilization and create inpatient capacity

Mission to be a top-functioning observation unit that provides efficient, high-quality care that is Emergency Medicine driven, evidence-based, and patient-centered

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Observation Guidelines

- 80% probability of discharge within 24 hours - if managed actively
- Focused patient care goal
- Limited intensity of service and severity of illness
- Defined and supported endpoint

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Benchmarks

Type 1 OBS Units [protocol driven; highest evidence for favorable outcomes]:

- Target 5-15% of ED volume
- Turn 1-1.5 patients per room per day
- Mean LOS 15hrs **
- Inpatient conversion 20%

- RN staffing 1:4 to 1:5
- APP staffing 1:10 to 1:12
- MD staffing variable from 8-32hrs/day

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Observation Limitations

- Incomplete charting
- High severity or illness
- High intensity of service
- Inpatient level of service is required
- Age and gestational age limitations
- High risk of self-harm
- Anticipated LOS less 6hrs or greater 48hrs

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Pathways

- Generic:
- Abd pain
- Allergic reaction
- Asthma exacerbation
- Back pain
- SOB
- Cellulitis
- COPD exacerbation
- Dehydration
- DVT
- Headache
- Hyperglycemia
- Hypoglycemia
- Pneumonia
- Pyelonephritis
- Syncope
- Urolithiasis
- General

- Collaborative:
- EM Cardiology Chest pain
- EM Cardiology CHF
- EM Ortho Post op wound infection
- EM Ortho Post op pain
- EM Ortho Post op DVT
- EM Hepatology Refractory Ascites - Paracentesis
- EM Hematology Sickle cell vaso-occlusive crisis
- EM GI Chronic abd pain
- EM GI UGIB
- EM Neurology TIA
- EM Atrial fibrillation
- EM Low Risk PE
- EM Bariatric Post-op dehydration
- EM OB Hyperemesis gravidum
- EM Spine Back pain
- UCC to CDU

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Pathways 2.0

- EM Cardiology Intermediate risk Chest pain
- EM Ortho Post op infection
- EM Ortho Post op pain
- EM Ortho Post op DVT
- EM Hepatology Refractory Ascites - Paracentesis
- EM Hematology Sickle cell vaso-occlusive crisis
- EM GI Chronic abd pain
- EM GI Low risk GIB - AIMS 65 score 0-1
- EM Neurology TIA - ABCD2 score 0-3
- EM Neurology Headache
- EM Atrial fibrillation - CHA2DS2-VASC score 0-3
- EM Low Risk PE - sPESI score 0
- EM Bariatric Post-op dehydration
- EM Spine Back pain
- EM Opioid MAT
- EM Psychosis
- EM Trauma
- EM Low Risk PTX
- EM Low Risk TBI - BIG 1 Criteria

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Why Observation in Emergency Medicine

- The health system's tincture of time
- The ED's safety net
- The cutting edge of acute healthcare

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Why Observation in Emergency Medicine

- Improved patient satisfaction
- Lower health care costs
- Shorter LOS
- Improved use of hospital resources
- Less diagnostic uncertainty

*Financial Viability of Emergency Department Observation Unit Billing Models
Christopher W. Baugh MD, MBA Pawan Suri MD Christopher G. Caspers MD Michael A. Granovsky MD, CPC, CEDC Keith Neal MBA, MHL, CHFP Michael A. Ross MD

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Future of Observation

- It's not JUST about the $$$ and creating space
- Tincture of time
- Evidence-based medicine not metrics medicine
- Complex observation
- Hybrid provider model
- Novel pathways
- Education
- Research

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Lessons learned

- Institutional support
- Know observation best-practice
- Prioritization of all services
- Creating mission, guidelines, pathways and an established endpoint
- Trade clinical over-ulitization with evidence-based model
- Dedicated team – MD, APP, RN, CM, SW, PT, plus
  - Limit provider variation
  - ED culture
- Think ahead to sustain gains
  - Engage learners

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Thank you!

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