

# **Observation Medicine**

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## **Objectives**

- **Define what payers mean by observation and observation status.**
- **Discuss and understand the importance of appropriate patient level of care assignment.**
- **Discuss how observation care can be delivered and what conditions are amenable to observation.**
- **Discuss examples of observation cases.**

# **Definitions and Regulatory Considerations**

## **CMS Definition**

- **The Centers for Medicare and Medicaid Services (CMS) defines observation 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 being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.”**

## **CMS Definition**

- **Based on this definition, a few keep points should be noted:**
  - **The purpose of observation is to make a decision whether the patient should be admitted or discharged.**
  - **“Short term treatment, assessment and reassessment...”**
    - **Implies active management!**
  - **Observation level of care means something different than clinically “observing” a patient.**
    - **For insurance companies it is a billing status that is part of “outpatient.”**

## **CMS Definition Clarification**

- **"Inpatient care rather than observation is required only if the patient's medical condition, safety or health would be significantly and directly threatened if care was provided in a less intensive setting. A patient must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis."**

## Level of Care Assignment

- How are observation vs. inpatient cases assigned?
  - InterQual and Milliman Care Guidelines are clinical criteria utilized to help determine level of care assignment for patients
- InterQual Level of Care Criteria look at 3 specific indicators:
  - Severity of illness
  - Intensity of service
  - Discharge criteria
- None of these criteria is intended to supersede physician judgment.
- In general, physicians do not know these criteria exist and certainly do not know the criteria.

## Level of Care Assignment

Hospital Manual

Chapter II - Coverage of Hospital Services

210. COVERED INPATIENT HOSPITAL SERVICES

Page 21.3/Rev. 525, 01-89

- An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally a person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.

[ Note – The Hospital Manual definition is the ultimate CMS authority – it trumps InterQual]

## **Level of Care Assignment**

- **The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient.**
- **The physician should use a 24-hour period as a benchmark, i.e., he or she should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis.**
- **However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's bylaws and admissions policies, and the relative appropriateness of treatment in each setting.**

## **Level of Care Assignment**

- **Factors to be considered when making the decision to admit include such things as:**
  - **The severity of the signs and symptoms exhibited by the patient.**
  - **The medical predictability of something adverse happening to the patient.**
  - **The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted.**
  - **The availability of diagnostic procedures at the time when and at the location where the patient presents.**

## **Level of Care Assignment**

- **Significant challenges for us as physicians:**
  - This is not historically something we are taught as physicians in medical school or residency, yet level of care is determined by physician order.
  - We think of “observing” in the clinical context and not related to level of care or billing status.
  - Our documentation often doesn’t support what we are thinking about our patients.

## **Importance of Correct Status**

- **National emphasis on appropriate level of care and resource utilization being driven by payers**
- **Short-stay inpatient admissions are the number one target of federal auditors:**
  - CMS questions whether patients need inpatient status if they could be managed in the outpatient setting.
  - They also look closely at documentation to see if your care plan supports the level of service provided.
- **Financial burden to patients, payers, and society for picking the wrong status for patients.**

## Importance of Correct Status

- **“The Recovery Audit Contractor Program’s mission is to reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments.”**
  - **As of March 27, 2008, RACs succeeded in correcting more than \$1.03 billion in Medicare improper payments.**
  - **Approximately 96 percent (\$992.7 million) of the improper payments were overpayments collected from providers.**

## Importance of Correct Status

### Tip Sheet: Appropriate Level of Care Orders (ALOC)

Used by: Providers

ALOC orders will be required for all pre-operative and admission order sets. It will present for selection in post operative sets but is recommended for use ONLY if patient level of care changes.

The screenshot shows a list of radio button options for patient status:

- Ambulatory
- Observation
- Inpatient
- Outpatient

**Ambulatory Outpatient** – For Procedures/OR with a typical recovery.

**Ambulatory Outpatient (Extended Stay)** – select this status for patients who need to recover from a procedure for an extended period (beyond the normal recovery period generally of 4-8 hrs), but who are not experiencing complications that qualify for observation or inpatient care.

**Observation** – this status cannot be pre-selected prior to a procedure or surgery – Observation care is always unplanned. It is used when the physician needs a period of time to determine whether a patient can be discharged or will need to be admitted for inpatient acute care (ie, awaiting diagnostic test results; or for patient care issues that the physician believes can be resolved quickly (i.e. pain control, nausea and vomiting, etc that might likely resolve within 24 hours).

**Inpatient** – select “inpatient” when concerns about the patient will most likely not be resolved in 24 hours. You will need to document the patient’s severity/complexity and your treatment plan will need to be consistent with inpatient acute care needs.

A list of reasons that supports inpatient status is presented (examples: outpatient/observation treatment failure; presenting signs and symptoms are severe and complex). Please select the reason that applies to your patient’s condition, and provide documentation that explains the reasons for inpatient status in the H&P.

- **Most physicians do not understand the different levels of care for a patient’s billing status.**
- **Selecting the initial appropriate level of care is sometimes complicated and there are competing priorities.**

# Controversy

## PATIENTS SUE OVER HOSPITAL 'OBSERVATION STATUS' PLAINTIFFS FILE FIRST CLASS-ACTION LAWSUIT CHALLENGING THE MEDICARE POLICY

November 04, 2011

A group of patients on Thursday filed a lawsuit challenging a Medicare policy that allows hospitals to place patients under "observation status" for days without admitting them.

**Observation status rules**  
Medicare's observation status policy classifies certain hospital patients as outpatients although they may have stayed in the hospital for several days. Since patients never officially are admitted for inpatient care, they are responsible for a higher proportion of hospital and follow-up care costs.

According to Reuters, the policy is designed to protect hospitals from incurring penalties for admissions made in error. However, hospitals have increased their use of observation status in recent years, as claims rose from \$28,000 in 2006 to more than \$1.1 billion in 2009. CMS data indicate that claims for observation stays lasting more than 48 hours increased by nearly 300% from 26,176 to 43,183 across that period.

Some experts say certain federal health reform law provisions encourage hospitals to place patients under observation because penalties for 30-day readmissions will not apply to such patients. American Hospital Association EVP Rick Pirock last week wrote a letter to CMS warning that the agency's policies were driving hospitals to place patients under observation status instead of admitting them.

- Patient advocacy and senior's groups have challenged the legality of observation status.
  - Significant out of pocket costs (up to 20%) when beneficiaries are not admitted.
  - The concern is whether patients really understand if they are being observed or being admitted.

# Controversy

- Who cares? I'm a doctor not an insurance company auditor!
  - You may not care, but your patients may as placing them in observation status can mean more out of pocket costs for them.
  - Your hospital administrator cares as placing patients in observation status when they should be admitted is a significant source of lost revenue.



# Controversy

- **“I’m just going to admit everyone since that’s easier. Besides its only the hospital that’s liable and not me if I get this wrong.”**
  - RAC auditors are clearly going after physician group practices as well; especially when there is incongruence from hospital and E/M level of care documented.
  - Several institutions have tried this strategy and paid large fines for admitting everyone because it was perceived as easier and more lucrative.

# Delivering Care

## **What to do with a patient who needs 6-24 hours of care?**

- **Admit them?**
  - **Difficult sell, ties up inpatient beds, payers will not reimburse for, increased LOS.**
- **Discharge them?**
  - **Missed diagnoses, poor outcomes, lawsuits!**
- **Keep them in the ED for 6 – 24 hours?**
  - **ED crowding, ambulance diversion, angry patients and family members, burned out ED staff.**

Kellerman; Emory University; 2010

## **“Too sick to go home, but not sick enough to be interesting.”**

- **The patient that nobody wants!**
- **Payers will try to deny payment.**
- **Inpatient doctors do not want to admit them.**
- **You can't keep them in the ED, but they represent many of the most worrisome missed diagnoses in EM.**

Kellerman; Emory University; 2010

## **Allowable Conditions**

- **In the past, CMS only recognized a separate payment at the observation level for three medical conditions:**
  - Chest pain
  - Asthma
  - Congestive Heart Failure
- **As of January 2008, CMS recognizes that nearly any condition is eligible for observation, if:**
  - Clinical criteria are met from above.
  - The patient spends at least 8 hours in observation.
  - Documentation is sufficient observation.

## **Location**

- **While you do NOT have to have a specific unit to provide observation services, dedicated observation units have clearly demonstrated they can be used safely and efficiently**
  - This is particularly in the ED setting.
- **Numerous recommendations as a national best practice from ACEP, IOM, the Advisory Board, etc.**

## **Beds and Staffing**

- **Is an observation unit needed?**
  - Depends on ED metrics, inpatient capacity, ease of admission, and why the unit is being proposed.
- **ED based or not?**
  - Probably doesn't matter; staffing issues?
- **Closed or open unit?**
  - Open units don't work; lack of ownership.
- **How many beds and how is it staffed?**
  - Nurse staffing ratio needs to be appropriate for telemetry patients (4:1 or 5:1).
  - Provider staffing varies depending on unit size and complexity of patients.

## **The Different Flavors of Observation Units...**

- **The ED Throughput Tank:**
  - Initially stabilize patient in main ED bed, then move patient to "observation" bed until disposition.
  - Allows for more rapid turn over of main ED beds.
- **Pros:**
  - Good for efficiency, easy to staff.
- **Cons:**
  - Not true observation, no protocols, misses the low hanging fruit of observation medicine.

## The Different Flavors of Observation Units...

- **The Chest Pain Unit:**
  - Low risk chest pain patients are placed on observation protocols for serial marker rule out and/or provocative testing.
- **Pros:**
  - Clearly proven strategy; easy to staff; minimal complexity; benefit of protocol driven care.
- **Cons:**
  - Misses low hanging fruit of other disease entities that are amenable to observation protocols.

## The Different Flavors of Observation Units...

- **The Observation Unit (Simple - Protocols):**
  - Observation protocol care for narrowly defined inclusion/exclusion criteria.
  - Patients are usually cared for by mid level providers with a physician responsible for seeing and positioning patients.
  - Most common model is ED based.
- **Pros:**
  - Benefit of observation protocols for multiple conditions; manageable staffing costs.
- **Cons:**
  - Miss more complex observation patients.
  - Economics make staffing small units expensive

## The Different Flavors of Observation Units...

- **The Observation Unit (Complex – Any Patient):**
  - Comprehensive observation care for nearly any patient that meets observation status (not just for protocols).
  - Patients are cared for by separate team of mid level providers and observation physicians.
  - ED based models really only at large AMC's; community hospital based units tend to be Hospital Medicine based.
- **Pros:**
  - Can handle a lot of complexity; many protocols; lots of flexibility; specialization.
- **Cons:**
  - Expensive staffing model.
  - Who provides physician coverage?

## The Different Flavors of Observation Units...

- **The Short Stay Unit:**
  - Combines the benefits of comprehensive observation care with separate team with the ability to admit short stay patients to inpatient status.
  - Allows the unit to care for patients in observation up to 24 hours as well as admitted inpatients with expected LOS of less than 72 hours.
- **Pros:**
  - Financial holy grail; ultimate in flexibility.
- **Cons:**
  - Complicated to set up; institutional politics; compliance headaches; staffing costs.

## **Critical Success Factors**

- **Separate unit focused on observation patients?**
  - Allows for nursing and provider expertise.
  - If not, there must be high visibility for observation patients on inpatient floors.
- **Clinical protocols with clear endpoints that prompt patient re-evaluation and active management.**
- **Priority for diagnostic services and rapid turn around time for testing.**
- **Expertise and interest in this distinct patient population by the care providers.**

## **What Patients and Conditions Benefit from Observation?**

# National Survey Results

TARIF 4 Results: Most Common Conditions in Observation Unit\*

Chest pain/cardiac	80.6%
Gastrointestinal/abdominal	57.1%
Asthma/respiratory	58.1%
General ailments/medical	32.7%
Dehydration	32.7%
Psychiatric/social/services	14.3%
Syncopy/near/syncopy	11.2%
Congestive heart failure	11.2%
Head injuries	8.2%
Kidney problems	7.1%
Transient ischemic attacks/strokes	8.1%
Orthopedic injury (fractures)	4.1%
Back pain/back injury	3.1%
Trauma	2.0%
Blood transfusions	1.0%
Vertigo/ENT problems	1.0%
Deep vein thrombosis	1.0%

\*Each hospital listed their 5 most common conditions.

A National Survey of Observation Units in the United States

SHARON E. MAIZE, MD, FAAP, LOUIS GRAFF, MD,†  
MICHAEL BERNAL, MD,‡ AND MICHAEL ROSS, MD,§

The objective of this study was to survey the use of observation units (OUs) in the United States. An electronic survey was mailed to 1,000 hospitals in the United States. The survey included questions about the use of OUs, the number of OUs, the number of observation units per hospital, and the number of observation units per patient. The survey also included questions about the use of OUs for various conditions, the use of OUs for various services, and the use of OUs for various procedures. The survey was completed by 100 hospitals, representing 10% of the hospitals in the United States. The survey results are presented in this report.

**RESULTS**

There was a 10.1% response rate to the survey. Of 1,000 hospitals, 100 hospitals completed the survey. The average number of OUs per hospital was 1.0, with a range of 0 to 10. The average number of observation units per patient was 0.1, with a range of 0 to 1.0. The survey also included questions about the use of OUs for various conditions, the use of OUs for various services, and the use of OUs for various procedures. The survey results are presented in this report.

# OSU CDU Protocol Volumes

TOTAL NUMBER OF PROTOCOL PATIENTS (1/1/10 – 12/31/10) = 5,987	Cases
Chest Pain / Rule out Myocardial Infarction	1708
Abdominal Pain	678
Dehydration	534
Cellulitis	511
Back Pain	261
TIA	217
Syncope	215
Pyelonephritis	208
Trauma	184
Headache	183
Pseudotumor / Shunt	157
Hyperglycemia	146
Renal Colic	141
Asthma	140
General Observation Protocol	118
Vertigo	115



## OSU CDU Protocol Volumes

DVT	95
Pharyngitis	94
Allergic Reaction	91
Hypertensive Urgency	58
CHF	46
GI Bleed	44
Pneumonia	41
Palpitations/SVT	41
Shortness of Breath of Unclear Etiology	35
Hypoglycemia	28
Pancreatitis	22
Closed Head Injury	19
Epistaxis	14
Carbon Monoxide Exposure	8
Hematuria	6
Vaginal Bleed (non-pregnant)	4
AICD Device Malfunction	3

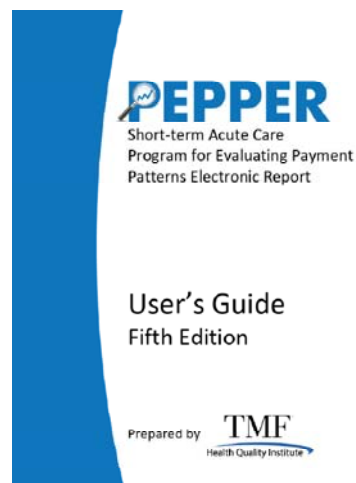
## Hospital Admission Data

- **Sources of data readily available to you at your hospital:**
  - Patients admitted from the ED and discharged within 24 hours.
  - Patients admitted from the ED that failed to meet InterQual.
    - Implies that you have robust case management!
  - Patients admitted from the ED who were made Condition Code 44.
  - Patients admitted from the ED whose claims were denied for not meeting inpatient necessity.

## Hospital Admission Data

- Are there any trends in terms of specific patient populations or diagnoses that show up frequently?
- Target observation protocols to address outliers consistent with your competencies and available resources.
- OSU Examples:
  - GI bleeding, gastritis, esophagitis
  - Abdominal pain
  - Syncope
  - Shunt patients

## Regulatory Reports



- PEPPER provides hospital-specific Medicare data statistics for discharges vulnerable to “improper” payments.
- PEPPER can support a hospital or facility’s compliance efforts by identifying where it is an outlier for these risk areas.
- This data can help identify both potential overpayments as well as potential underpayments.

## Regulatory Reports

- **PEPPER provides you with hospital specific data for DRG codes (targets) that compare your performance to local, state, and national performance:**
  - Provides number of discharges per target DRG, % for each target compared to other performers, sum of payments per target DRG, etc...
- **Complicated, but does include useful information about:**
  - Most common DRG's for one day stay patients.
  - Proportion of your hospital discharges with length of stay less than or equal to one calendar day.
  - Hospital re-admissions.

## Types of Observation Protocols

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• <b>Diagnostic Protocols:</b><ul style="list-style-type: none"><li>– Clinical uncertainty that requires a stable monitoring environment while additional diagnostic evaluation is completed.</li><li>– Ex: Chest Pain, Abdominal Pain, TIA, Syncope</li></ul></li></ul> | <ul style="list-style-type: none"><li>• <b>Therapeutic Protocols:</b><ul style="list-style-type: none"><li>– Diagnosis is relatively known and decision point is whether intensive therapy will allow timely disposition.</li><li>– Ex: Asthma, Cellulitis, Renal Colic, Pneumonia, Pyelonephritis</li></ul></li></ul> |
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## Complexity Considerations

- In my opinion, therapeutic protocols are relatively easier to implement:
  - Still need inclusion and exclusion criteria to select appropriate patients starting out.
  - Ex: Cellulitis.
- Diagnostic protocols are what clinicians really want and need:
  - More difficult clinical decisions with diagnostic uncertainty and the need to rule out life threats.
  - Tough to pick sick vs. not-sick upon initial evaluation.
  - Ex: Syncope.

## If I Was Starting from Scratch?

- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• Protocols I would start immediately (emphasis on therapeutic protocols):<ul style="list-style-type: none"><li>– Chest Pain</li><li>– Asthma</li><li>– CHF</li><li>– Cellulitis</li><li>– Dehydration</li><li>– Renal Colic</li><li>– Pyelonephritis</li><li>– Pharyngitis</li><li>– Allergic reaction</li><li>– Community acquired pneumonia</li></ul></li></ul> | <ul style="list-style-type: none"><li>• Protocols I would add after experience (adding more diagnostic protocols):<ul style="list-style-type: none"><li>– Abdominal pain</li><li>– Headache</li><li>– Back pain</li><li>– Trauma</li><li>– Hyperglycemia</li><li>– Hypoglycemia</li><li>– DVT</li><li>– Closed Head Injury</li><li>– ? Vertigo</li><li>– ? Syncope</li><li>– ? TIA</li><li>– ? GIB</li></ul></li></ul> |
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## Protocols vs. Provider Expertise

- **Protocols:**
  - Protocol driven care with clear inclusion and exclusion criteria are generally preferred and recommended.
  - Certainly a must when you are starting out to help with patient selection and to manage complexity.
  - Rigid adherence will significantly limit your volume.
    - Ex: “Cancer, transplant, immune compromise.”

## Protocols vs. Provider Expertise

- **Provider Expertise:**
  - Let your providers just select patients and be the gatekeeper for placement:
    - Perhaps more desirable for large, complex units with dedicated staffing and with more resources.
  - The concept of the InterQual unit that takes all observation status patients regardless of condition.
  - Downside is you may admit more patients because of inappropriate selection or complexity.
  - If you do this, you need a robust QA process to make certain patient selection is appropriate.

## **Protocols vs. Provider Expertise**

- **Protocols and provider expertise are both important and realistically you need both:**
  - **Patients may be very appropriate for observation, but don't fit a specific protocol.**
  - **Protocols can provide the framework, but provider expertise allows you to fit patients in that are appropriate for observation that are not black and white.**

## **Monitoring Your Progress**

- **Number of patients per protocol:**
  - **You do not want protocols that are seldom utilized.**
- **Percentage of patients per protocol that get admitted vs. discharged:**
  - **Goal is 20% admit and 80% discharge.**
  - **Willing to accept a higher failure rate for some patient populations (Ex: CHF).**

## Monitoring Your Progress

- **Overall length of stay for observation protocol patients:**
  - Will vary by protocol, but certainly needs to be considerably less on average than 24 hours.
  - OSU Ex: LOS is 16 hours on average for all protocols.
- **Percentage of patients with less than 8 hours in observation:**
  - Unclear what the benchmark is here?
  - OSU Ex: ~14% of patients less than 8 hours.
- **Patient satisfaction scores:**
  - OSU Ex: We set our CDU score benchmarks higher than the ED and we send out separate surveys.

# Cases

# **Observation Medicine**

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## **Cases - objectives**

- **Use cases to highlight important observation medicine concepts**
- **Focus process rather than clinical decisions**
- **Examples of common pitfalls in observation medicine**
- **Highlight how proper use of observation medicine can improve outcomes**



# Case #1

- **53 year-old male presents to the ED with chest pain. This has been intermittent for the past 48 hours.**
- **He has some associated shortness of breath and nausea. He has no arm or jaw pain.**
- **His symptoms are not worsened with exertion.**

# Case #1

- **ED work-up**
  - **ECG – no ischemic changes**
  - **Trop – negative**
  - **CXR – no acute disease**
  - **Chem 7, CBC – normal**
  - **What's next?**

## **Case #1**

- **Traditionally – call for admission to cardiology or internal medicine.**
  - Patient placed in an inpatient bed and managed by an inpatient team.
  - Inpatient order placed by admitting physician
  - Work-up and treatment takes 24-48 hours

## **Case #1**

- **Alternative option – observation status in an observation unit.**
  - Patient placed in observation unit and followed by observation team. Work-up completed in 12-24 hours.
  - Which do you choose?

## **Case #1**

- **Patient placed into observation status in an observation unit**
  - Serial cardiac enzymes are normal
  - Stress echocardiogram in negative
  - Symptoms improve with PPI
  - Discharged home after 12 hours
  - Improved patient satisfaction, improved quality of care, decreased LOS, decreased cost, reimbursed by insurance.

## **Case #2**

- **53 year-old male presents with chest pain. His troponin and ECG are unremarkable.**
- **Does this sound familiar?**
- **The patient is admitted to the hospitalist under inpatient status.**

## **Case #2**

- **Hospital work-up**
  - The patient has repeat cardiac enzymes which are normal.
  - Stress echocardiogram shows no ischemia.
  - The patient is diagnosed with GERD and discharged 24 hours later.
  - So, what is the problem?

## **Case #2**

- **What is the problem?**
  - Payment is denied to the hospital.
  - Patient spends an extra 12 hours in the hospital.
  - This inpatient bed could have been used by another more appropriate patient.

## **Case #3**

- **34 year-old female presents with dysuria and right flank tenderness for the past 3 days.**
- **She has extreme fatigue and decreased PO intake.**

## **Case #3**

- **ED work-up**
  - **WBC-14.5**
  - **Cr-1.25, BUN-26**
  - **UA- nitrite positive, >50 WBC, bacteria present**
  - **What's the diagnosis?**

## **Case #3**

- **Pyelonephritis (this is the easy part).**
  - What to do next?
  - Antibiotics, IV fluids, and pain medication.
  - Ok, but patient still hurts and has fever 2 hours later. Now what?

## **Case #3**

- **The patient is placed into observation status.**
  - Given IV antibiotics, IV fluids, and pain medications.
  - Patient has clinical improvement in 14 hours and is discharged home with oral antibiotics.
  - Some patients are “difficult sells” as admission, but require more time for symptom and evaluation.
  - Observation medicine prevents extended ED stays

## **Case #4**

- **45 year-old female with a history of migraine headaches presents with a severe headache.**
- **She also has subjective fevers and chills.**

## **Case #4**

- **ED work-up**
  - **Head CT – negative**
  - **Lumbar puncture – negative**
  - **WBC – 14.5**
  - **UA – small ketones**
  - **Patient placed in a hospital bed under observation status.**

## Case #4

- **Hospital work-up**
  - Headache does not improve with typical headache medications.
  - Neurology is consulted and recommends MRI and EEG, which are negative.
  - Flu swab ordered on hospital day 3 comes back positive.

## Case #4

- **Hospital work-up**
  - Symptoms improves on hospital day 4 and patient is discharged.
  - Patient was maintained in observation status throughout their stay.
  - What's the problem?



## **Case #4**

- **What is the problem?**
  - **Observation status should be limited to 24 hours in most cases.**
  - **It can be extended up to 48 hours in rare instances.**
  - **Patients that require treatment beyond 24 hours generally need to be made inpatient status.**
  - **This is better for the patient and the hospital.**

## **Case #5**

- **35 year-old homeless male with diabetes presents with swelling and pain in his right lower extremity.**
- **He reports having subjective fevers.**

## **Case #5**

- **ED work-up**
  - WBC –18.1
  - Cr – 1.1
  - X-ray – soft tissue swelling, no signs of osteomyelitis

## **Case #5**

- **Patient placed into the observation unit on the cellulitis protocol.**
  - Lower extremity doppler is negative for DVT.
  - Patient receives IV antibiotics.
  - Patient has improvement of his cellulitis in 18 hours.

## **Case #5**

- **Observation treatment**
  - Social work is able to help the patient with antibiotics and diabetic medications.
  - Case management is able to get patient into a follow-up clinic.
  - Dedicated support staff is important to the success of an observation unit.

## **Case #6**

- **43 year-old with a history of chronic pancreatitis presents with abdominal pain.**
- **The patient also reports having nausea, vomiting, and difficulty tolerating PO intake.**

## Case #6

- **ED work-up**
  - Urinalysis shows moderate ketones
  - Lipase - 50
  - Creatinine - 1.0
  - Given 2 doses of IV dilaudid in ED, but still having pain.

## Case #6

- **Placed in a hospital bed under the hospitalist service as observation status.**
  - Seen by hospitalist who places the following orders at 11AM:
    - 1 mg IV dilaudid q 3 hours
    - IV fluids at 100 cc/hr
    - NPO

# Case #6

- **Hospital day #2**
  - Rounded on by hospitalist attending at 11AM and patient is improved.
  - Plan: advance diet, trial oral medications.
- **Hospital day #3**
  - Seen by hospitalist at 10 AM.
  - Symptoms resolved, patient discharged at 11AM.

# Case #6

- **What is wrong with this case?**
  - 72 hour stay in observation status
  - Could be an admit? Maybe, although likely will not meet severity of illness or intensity of service.
  - Long observation stay is undesirable for patient and hospital.
- **What could be done differently?**
  - More frequent evaluations - q 6, q8, q 12 hour evaluations.
  - Advance diet after 8 hours, PO meds at 16 hours, discharge at 24 hours
  - If patient is truly not improved after 24 to 48 hours they should be converted to inpatient status.

## **Case #7**

- **89 year-old male presents with confusion.**
- **The patient has been confused for the past 24 hours and is oriented only to person.**
- **The patient also has difficulty with balance and is unable to ambulate on his own.**

## **Case #7**

- **ED work-up**
  - **Head CT – no acute findings**
  - **WBC – 9.5**
  - **Creatinine – 1.2**
  - **UA – normal**
  - **Ammonia – normal**
  - **Neurology consult recommends TIA work-up**

## **Case #7**

- **The patient is placed in the observation unit**
  - The patient has a negative brain MRI, normal transthoracic echocardiogram, and normal carotid duplex.
  - He continues to have difficulty with ambulation and is mildly confused.

## **Case #7**

- **Despite negative TIA work-up the patient requires admission to the hospital due to ambulatory dysfunction and continued confusion.**
  - Could this have been prevented?
  - Patient selection is critical for a successful observation unit.
  - You need either specific inclusion and exclusion criteria or experienced observation unit staff.
  - Patients need a clear, definable end-point which is achievable within 24 hours in the majority of case.

## **Case #8**

- **34 year-old female with a history of multiple abdominal surgeries presents to the ED with abdominal pain.**
- **She has had multiple admissions and several outpatient evaluations for her abdominal pain in the past.**

## **Case #8**

- **ED work-up**
  - **WBC – 8.1**
  - **UA – no ketones**
  - **Cr – 1.0**
  - **CT abdomen and pelvis – no acute abnormality**
  - **Patient given dilaudid 1mg IV with slight improvement in pain.**
  - **Patient noted by nurse to be eating a sandwich.**



## **Case #8**

- **The patient is placed into observation unit.**
  - Patient requires frequent pain medications with only minimal relief.
  - Patient eating food and walking through unit without difficulty.
  - Patient still has pain at 24 hours, now what?

## **Case #8**

- **Same question 24 hours later – admit vs discharge**
  - Again, observation medicine patients need a clear, definable end-point which is reachable in 24 hours.
  - Some patients may be better served by discharge or admission rather than observation.
  - Chronic pain is **NOT** usually solved within 24 hours.
    - What is being done that is new or different for the patient to justify observing them?