Managing ED Observation with Clinical Decision Areas

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Scripps Memorial Hospital
1. Define a Clinical Decision Area (CDA)
2. Review characteristics
3. Review cost savings
4. Review reduction in readmits
5. Review improved patient throughput
6. Review improved patient satisfaction
CDAs are:

- an extension of the Emergency Department (ED)
- in which patients are admitted as observation patients to the CDA who
- require additional testing to determine the need for admission to the hospital
Observation patients are those

✓ with > 6 hour but < 24* hour length of stay in the ED, and

✓ requiring additional testing to determine if hospital admission is needed, and

✓ with a 70% probability* of discharge with low co-morbidities

*(Ross, et al., 2012)
Characteristics

- < 24 hours
- Established clinical inclusion/exclusion criteria
- Established physician protocols
- Established nursing protocols
- Closed unit attached to ED vs. separate unit
- Staffed by ED physicians

Note: If ≥ 20% of patients convert to inpatient, the inclusion/exclusion criteria should be re-evaluated for appropriateness of admission

(Bohan, 2015)
Inclusion Criteria

Extended treatment: Asthma, low risk CHF Dehydration, UTI

Prolonged Evaluation: Chest Pain (R/O MI) Syncope, TIA

Additional typical observational diagnosis: CP, Gastroenteritis, Hyperglycemia, Cellulitis
Socio-economic: No support
Unable to self-care

Psychosocial: Cognitively/functionally impaired, Psychiatric

Inpatient Staging: Boarding waiting for an admission bed
Specialized team

Current

- Emergency Nurses (now also trained to focus on moving the patient to discharge)
- Rehab services – PT, OT, ST
- Lab and Radiology
- Emergency Department Physicians

Additional

- Nurse Practitioner or Physician Assistant
Cost Savings

Assumptions

✓ Preventing unnecessary floor admissions, reducing length of stay, and reducing overall inpatient care resources on patients admitted to the hospital floor unit vs. a CDA will yield cost savings
Cost Savings

Example

• Based on published studies, 5-10% of the ED census could be admitted as CDA observation patients (current yearly ED census of 36,000) would equal 1,800 to 3,600 patients.

• This would equate to five (1,800/365) to ten (3,600/365) patients per day.
“Most observation patients enter the hospital through the ED. Transferring to another floor and service adds unnecessary rework for a group of patients likely to leave in the next 15 hours”

(Ross et al., 2012, p. 129)
A CDA for ED observational patients has cost avoidance. **Why??**

With increasing CMS *denials* for patients admitted less than 24 hours, patients from the ED not mixed in with the regular hospital census will not impact expensive inpatient space and resources that will go *unreimbursed*.
Reduction in Readmissions

Patients returned to the Emergency Department after recently being discharged from the hospital due to:

- Additional resources needed at home
- Unable to care for self at home and require temporary or permanent placement
- Additional treatments that are short term and can be discharged from the CDA
“In its discussion of ‘improving the efficiency of hospital-based emergency care, the 2006 Institute of Medicine supports the use of EDOU [CDUs] as a means of decreasing ED boarding, ambulance diversion, and avoidable hospitalizations.”

(Ross, et al., 2012, p. 128)
When observation patients are admitted into inpatient beds, it occupies beds that otherwise can be used for those that truly need admission.
Keeping patients from being lost in the sea of daily admissions

Floors        CDU

Thanks!
✓ Admission to the hospital is a disruption to the patient’s everyday life and may lead to a decrease in income

✓ Expediting discharge can return the patient to their normal daily routines

✓ 1% of what Medicare withholds from hospitals is an incentive for hospitals to achieve their patient satisfaction goals

(Geiger, 2012)
“Studies have shown that when these patients are mixed with inpatients throughout a hospital, it results in LOS [length of stay] that are well beyond 24 hours, with associated decreases in patient satisfaction”

(Ross et al., 2012, p. 128)
SWOT Analysis

**Strengths:** Reduced length of stay, improved patient satisfaction and improved throughput from the ED, cost savings

**Weakness:** Metrics to identify weaknesses within the inclusion/exclusion criteria in the selection of patients admitted to the CDU

**Opportunities:** Protocols will be identified, used and improved through communication between the Medical Director of the CDU and the Supervisor Lead

**Threats:** Protocols are not followed, exclusion criteria in patient selection not enforced
Evaluation

Metrics to be tracked monthly by ED administration:

- # of patients admitted to CDA
- Length of stay of patients in the CDA
- Patient satisfaction scores
- # of CDA patients that require inpatient admission
- Diagnoses to expand inclusion criteria for patients that are able to be admitted to this unit
Benefits of a CDA

- Increased Patient Satisfaction
- Decrease in patients left without treatment
- Decreases unbillable observation hours
- Decreases observation LOS
- Decreases labor expense
Evidence Synthesis

Results, when protocol driven, show an improvement in patient satisfaction, a reduced length of stay, a decrease in the number of resources based on the decrease in the length of stay, and efficient utilization of inpatient beds to care for those who require additional resources and care.
Average ED Observation Times July 2015-February 2016

Cardiovascular: 26.94
Endocrine: 24.25
ENT: 27.22
Gastrointestinal: 27.71
General Surgery: 25.54
Integument: 28.64
Labs: 26.29
Misc.: 29.59
Neuro: 28.21
Ortho: 25.91
Psych: 27.81
Renal: 50.14
Reproductive: 22.35
Respiratory: 25.37
Trauma: 38.00
Urinary: 27.11
Total: 20.04
Data Collection

ED Observation Admits July 2015 to February 2016

- Cardiovascular: 1107
- Endocrine: 29
- ENT: 23
- Gastrointestinal: 72
- Integument: 62
- Labs: 315
- MISC: 162
- Neuro: 97
- Ortho: 3
- Psych: 20
- Renal: 86
- Reproductive: 5
- Respiratory: 60
- Trauma: 5
- Urinary: 60
<table>
<thead>
<tr>
<th></th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
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<tbody>
<tr>
<td><strong>CDA Volume</strong></td>
<td>128</td>
<td>160</td>
<td>177</td>
<td>164</td>
<td>186</td>
<td>176</td>
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<tr>
<td><strong>Convert CDA to Admit</strong></td>
<td>25</td>
<td>32</td>
<td>36</td>
<td>24</td>
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<td>26</td>
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<tr>
<td><strong>% of CDA Conversions to Admit</strong></td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>16%</td>
<td>23%</td>
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<tr>
<td><strong>Total CDA/Total ED Patient %</strong></td>
<td>4%</td>
<td>4%</td>
<td>5%</td>
<td>4%</td>
<td>5%</td>
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<td><strong>Total ED Volume</strong></td>
<td>103</td>
<td>128</td>
<td>141</td>
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<td><strong>Total ED Admissions</strong></td>
<td>3612</td>
<td>3582</td>
<td>3308</td>
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<td><strong>% ED Admits to Hospital</strong></td>
<td>762</td>
<td>733</td>
<td>757</td>
<td>824</td>
<td>851</td>
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<td><strong>% ED Admits plus CDA patients</strong></td>
<td>21%</td>
<td>21%</td>
<td>23%</td>
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<td><strong>Reduced % in Volume of Units</strong></td>
<td>25%</td>
<td>24%</td>
<td>27%</td>
<td>27%</td>
<td>25%</td>
<td>26%</td>
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<tr>
<td><strong>Average Length of Stay</strong></td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>5%</td>
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<td><strong># of preventable 30 day readmits</strong></td>
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<td><strong>Number of CDA Clinic patients</strong></td>
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<td><strong>% CDA Clinic patients</strong></td>
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<td>64</td>
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<td><strong>Number of Nursing Hours</strong></td>
<td>40%</td>
<td>41%</td>
<td>42%</td>
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<td><strong>Number of pts admitted as OBS to the Hospital 2017</strong></td>
<td>2088</td>
<td>2613</td>
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Lessons Learned

• Challenges with staffing Emergency Department Nurses
• Getting the ancillary staff onboard: Lab, Food and Nutrition, Imaging
• Everyone wants in: Sticking to the inclusion/exclusion criteria
Questions?
References


References


References


