


## CLINICAL CONCEPTS

## The Practice of Emergency Medicine

## Emergency department observation implementation guide

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**Abstract**

Emergency department (ED) crowding poses significant operational challenges to hospitals. One strategy to address these issues is the implementation of an ED observation (EDO) unit. EDO involves placing patients in observation status after their initial evaluation, allowing for continued assessment, treatment, and the determination of a safe disposition. This paper provides a comprehensive guide for ED leaders on the implementation of ED observation in their departments. It includes a checklist summarizing key implementation points, operational and financial considerations, staffing and location planning, patient selection, clinical care protocols, documentation and communication processes, securing buy-in from stakeholders, and outcome measurement. The guide also highlights the updated billing codes based on the 2023 updated Current Procedural Terminology (CPT) guidelines. Successful implementation of an EDO program has shown benefits such as improved patient flow, enhanced revenue generation, reduced costs, and comparable clinical outcomes. This guide aims to equip ED leaders with the necessary knowledge and tools to implement and manage an effective ED observation program in their departments, ultimately improving the overall efficiency of emergency care delivery.

**1 | INTRODUCTION**

Emergency department crowding continues to be a significant issue at many hospitals. The COVID-19 pandemic and increasing nurse and physician staffing shortages have contributed significantly to this problem. Although there are many factors leading to crowding, included are “ED output factors,” such as a lack of inpatient capacity, the inefficient transfer process from the ED to the inpatient unit, and the timing mismatch related to inpatient discharges and ED admissions.<sup>1</sup> One operational strategy that seeks to bypass these factors is the use of ED observation (EDO). In general, it is a strategy by which patients are placed in “observation status” after their initial workup, to continue evaluation, observation, treatment, and determine a safe patient disposition.

EDO can take many different forms depending on the specific circumstances of a given ED. A separate location is not required. By continuing the ED evaluation, one seeks to avoid hospital admissions or discharge selected patients more quickly than what could be done with a traditional, hospital admission. Developing a specific, formalized process for observation allows for additional revenue for the ED, can lead to process and quality improvement, and can improve patient flow. This guide seeks to provide ED leaders with a step-by-step guide on how to implement ED observation in their departments. It will refer primarily to a unit and set of processes operated by ED physicians, nurse practitioners, physician assistants, and nurses, rather than units staffed by others such as hospitalists. It will also include updated billing codes based on the 2023 updated Current Procedural Terminology (CPT) guidelines. A checklist with the summary points is in Table 1, and a detailed discussion follows.

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**TABLE 1** Observation unit implementation summary checklist.

- Understand the operational and financial effects
- Formulate a staffing and location plan
- Select appropriate patients
- Develop clinical care protocols
- Develop documentation and communication processes
- Secure buy-in from key stakeholders
- Implement and measure outcomes

## 1.1 | Understand the operational and financial effects

According to the National Hospital Ambulatory Medical Care Survey, in 2020, 69.9% of ED visits nationally are between one and six hours in length.<sup>2</sup> In 2019, the national, average, inpatient length of stay was 6.2 days according to the National Center for Health Statistics.<sup>3</sup> EDs using an observation unit strategy attempt to identify a subset of patients who cannot be safely discharged after the initial traditional ED evaluation but most likely could be discharged after 6–24 hours of additional observation, repeat assessment, treatment, and potentially additional testing. Studies have demonstrated that patients in an ED observation unit (EDOU) had a shorter length of stay, lower cost, and comparable clinical outcomes compared with patients admitted to inpatient wards.<sup>4–6</sup> Studies have shown decreased left-without-being-seen rates and the time that EDs spend in ambulance diversion.<sup>7</sup> The American College of Emergency Physicians (ACEP) Policy Resource and Education Paper by Ross et al reviews many additional studies of chief complaint-driven use of EDO on patient outcomes.<sup>8</sup>

Because EDs are staffed to function 24 hours per day, if a safe disposition arises off hours, the patient can be discharged immediately. Most inpatient services would wait until morning rounds. Also, by retaining control over which patients take the observation beds, the ED staff has more control over its own flow. As an example, when carefully selecting a chest pain patient in need of a stress test and placing them in ED observation, the emergency physician may be able to keep an inpatient bed open for a septic, elderly patient presenting later in the night. Literature directly comparing an observation unit run by emergency physicians to a dedicated observation unit run by hospitalists is limited. However, maintaining a unit within the ED has the theoretical benefit of fewer care team transitions that may provide additional efficiencies.

The effects of implementation of an EDOU on a group's finances can vary based upon volume, staffing, and payor mix. For patients with Medicare, groups can expect to see an average, additional relative value units (RVU) generation of 1 for same-day observation patients and 2.5 for multiday observation patients. The 2023 Physician Fee Schedule conversion factor is \$33.8872. Therefore, for Medicare patients, groups would expect to generate an additional \$33.89 for a same-day observation patient and \$88.72 for a multiday observation patient discharged on day 2.<sup>9–11</sup> Actual revenues will depend on the group's payor mix, collection rate, reimbursement contracts, physician documentation of medical decision-making (MDM) complexity, and individual patient characteristics. Medicaid rules may vary by state. It has been estimated that hospitals see an improved revenue of \$1506

**TABLE 2** Summary of billing for traditional ED patients versus observation patients.<sup>9–11</sup>

### Traditional emergency patient

- 99281–99285 based on MDM complexity

### Same-day observation patient

- 99234–99236 based on MDM complexity

### Multiday observation patient

- 99221–99223 on the initial day based on MDM complexity
- 99231–99233 on any subsequent day when the patient is not discharged
- 99238–99239 on the discharge day based on time spent by the physician (more or less than 30 minutes)

Abbreviations: ED, emergency department; MDM, medical decision-making.

per patient by keeping hospital beds open for higher-paying inpatients or surgical patients.<sup>12,13</sup>

Because most EDOUs are staffed by emergency physicians in the same group, the patient cannot be billed for both the Emergency Department Evaluation and Management (E&M) and the Observation History and Physical (H&P). This is in opposition to units staffed by hospitalists; in this case, the emergency physician can bill for E&M and the hospitalist would bill for their H&P.

For most payors, if the patient is placed and discharged on 2 different calendar days, billing can occur for multiday observation. For Medicare, patients should be in observation for at least 8 hours to bill same-day observation services. The authors' experience is that many private insurance carriers have negotiated payment for observation services greater than 4 hours. The billing for each patient type is summarized in Table 2. The RVUs for each code are summarized in Appendix 1.<sup>9–11</sup>

There are potential downsides to an EDO strategy. Additional physician and nurse staffing will need to be added to the ED or shifted from the normal ED or inpatient staff. The latter would obviously decrease the resources available to care for new patients. Patients in EDO may occupy additional care spaces in the ED that would have been otherwise empty. Also, physicians may find it easier to admit patients to observation rather than discharging or admitting them, in order to delay or avoid a disposition decision. This can be monitored via the final disposition rate. There can also be quality issues related to resource use (eg, over-ordering of stress testing) or handoffs.

## 1.2 | Select appropriate patients

The goal of an EDOU should be to target patients requiring additional time in the ED for reassessment, diagnostics, or treatments. There should be a specific goal to be accomplished by the observation stay. It is best practice to select patients that can be summarized with an algorithmic care plan (eg, "This patient is here for chest pain, if the stress test is negative, and they remain chest pain-free, they can be discharged. If it is positive, they will be admitted"). Patients with complex care needs, multiple problems, or lack of a clear disposition plan

are generally not appropriate and would be better served on a traditional, inpatient service. Common presentations that are appropriate for ED observation include behavioral health patients awaiting psychiatric evaluation and disposition, moderate-risk chest pain, elderly patients in need of facility placement or physical therapy and case management consults, cellulitis, urinary tract infection, syncope, and transient ischemic attack. Many units report discharge rates of 70%–80% for patients placed in observation.<sup>7,14</sup> It is the authors' experience that this is an achievable goal that maximizes the benefits of the unit.

Most groups initially use observation services for patients that they are already caring for, usually psychiatric patients awaiting placement. There has been a historical concern about billing for observation services for these patients. ACEP has worked with the American Medical Association CPT Editorial Panel and this practice has been deemed appropriate according to the July 2019 issue of *CPT Assistant*.<sup>15</sup>

### 1.3 | Formulate a staffing and location plan

Groups should start by considering their current staffing levels, whether they anticipate that the observation unit will be adding new patients or simply recharacterizing patients they are currently caring for. It has been estimated that an attending physician can round on 10 previously evaluated patients in observation in about an hour.<sup>16</sup> Further care would be spread throughout the rest of their shift as care needs are addressed or dispositions arise.<sup>16</sup> Many units will use resident physicians, nurse practitioners, or physician assistants to assist the attending or provide care in the EDO unit. Nurse staffing is generally consistent with inpatient standards of 5 to 6 patients per nurse.<sup>16</sup> Groups should also make a plan for appropriate technician, lab, transport, and other ancillary service staffing.

Many groups may be able to care for their ED observation patients within their current ED footprint. If expansion is needed, it is preferable to have the unit adjacent to the rest of the ED to improve communication and reduce travel time for staff. If the observation unit is a large distance away, groups should consider additional staffing. They should also consider a rapid response plan in case of a medical emergency in the observation unit. Patient satisfaction is generally improved if the location includes private rooms with bathrooms, hospital beds, and a television.

### 1.4 | Develop clinical care protocols

Observation works best if care algorithms are predefined as much as possible. Caring for observation patients is often beyond the traditional practice scope of many emergency physicians and nurses. Providing care algorithms before EDOU opening can expand this scope. The ACEP Observation Section maintains a repository of many care algorithms.<sup>17</sup> It is recommended to review any proposed algorithms with administration, lab services, pharmacy, nursing, and relevant specialists to determine if they fit local practice patterns and resource availability.

### 1.5 | Develop documentation and communication processes

Most of the required documentation is already carried out in the course of a regular ED visit. The original ED note serves as the H&P. However, the physician should indicate the medical necessity for observation in the MDM. The patient's discharge instructions qualify as the "Discharge Summary." A progress note should be written at least once per calendar day. There should be documentation of the disposition plan. This could be a new progress note or an addendum to the final progress note. It is best practice to also document any significant events or changes in the clinical course. The complexity level of the subsequent day progress notes is determined using similar rules to the E&M codes as determined by the 2023 CPT update.<sup>9–11</sup> The update has significantly reduced the required documentation elements. The overall effects on billing remain to be seen.

A process should be developed in the computerized provider order entry (CPOE) system or electronic medical record to allow the physician to input timed "place in observation" and "discontinue observation" orders or retrievable timestamps. The "place in observation" order is placed when the traditional ED evaluation is completed, and the physician determines that the patient requires additional observation. The "discontinue observation" time stamp can be tied to a separate order that is placed when the patient has a final disposition (whether discharged OR admitted to the hospital) or to the discharge or admit order. The times on these orders are used to determine the length of time for observation and if a visit qualifies for multiday observation (defined as a visit that crosses midnight for Medicare patients).

Patients should be informed about the reasons for and goals of their observation stay. The Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act) requires hospitals to provide oral notification and the standardized Medicare Outpatient Observation Notice within 36 hours of any outpatient observation stay lasting more than 24 hours.<sup>18</sup>

### 1.6 | Develop nursing/pharmacy processes

Physician and nursing leaders should partner to determine the nursing workflow for EDOU patients. Leaders should consider nursing assignments, handoffs, and shift schedules. They will also need to work with billing and compliance to determine what additional nursing documentation is required. The requirements should match what is done for patients admitted in observation status to the rest of the hospital (likely includes progress and disposition notes, height and weight, vaccination record, past medical history, fall risk, skin assessment, psychosocial/social history, and activities of daily living). Leaders should also anticipate that patients may need to receive scheduled medications such as antibiotics or home medications. They should work with pharmacy and nursing leadership to ensure that medication reconciliation and medication administration occur with high reliability and expeditiously. Physicians should pay particular attention to insulin, antiepileptics, anticoagulants, immunosuppressants, rate control (eg,

metoprolol) agents, and Parkinsonian medications. Missing these medications, even for a few hours, can lead to significant adverse events.

## 1.7 | Obtain buy-in from key stakeholders

Key stakeholders in an EDOU implementation include emergency physicians and nurses, inpatient physicians and nurses, specialists, hospital administration, and patients. Emergency physicians and nurses usually express concern about their clinical ability to care for observation patients that may fall outside of their usual practice patterns. This can be addressed by developing clear, algorithmic, clinical protocols with specialist input and offering reassurance that learning and support will continue to occur after implementation. Hospital administration, inpatient nurses, and inpatient physicians are usually very supportive of EDOU implementation due to the financial and operational benefits as noted previously. Patients often express concern about large copays. However, this is complex and can depend on insurance status or payor and individual case characteristics. In addition, most candidates for EDO would not meet inpatient level of care criteria if placed under the hospitalist service. One study found that in 2015, commercially insured patients' out-of-pocket costs were \$962 for EDO stays and \$1403 for an inpatient stay.<sup>19</sup> The Department of Health and Human Services reported that Medicare beneficiaries paid an average of \$359–\$572 more for short inpatient stays compared with observation stays.<sup>20</sup>

## 1.8 | Implement and measure outcomes

After the development of an EDOU plan, the team should plan for continuous process improvement as issues arise. Key process indicators that should be tracked to measure success include total length of stay, disposition percentages (admission, discharge home, skilled nursing facility, etc.) resource use (eg, stress testing), 72-return visits, adverse events, patient and staff satisfaction, RVU generation, and staffing costs.

## 2 | CONCLUSION

EDO is an operational strategy that can be used to improve ED and hospital flow and revenue. It can lead to significant cost savings for health systems and patients. Successful implementation has occurred at many hospitals, and observation care is within the skill set of emergency physicians. This article seeks to provide guidance and a checklist for ED leaders to implement an EDO program in their departments.

### AUTHOR CONTRIBUTIONS

Kyle W. Trecartin drafted the manuscript. Richard E. Wolfe contributed substantially to its conception.

### CONFLICT OF INTEREST STATEMENT

Kyle W. Trecartin serves on the Board of Directors for Massachusetts Chapter of the American College of Emergency Physicians. No conflict of interest is anticipated based upon this affiliation.

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## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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