



Position Statement

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Protocol-Driven Emergency Department Observation Units

Description

Based on the most recent data provided by the National Hospital Ambulatory Medical Care Survey (NHAMCS), there were 130 million emergency department (ED) visits in 2018 in the U.S. (Centers for Disease Control and Prevention [CDC], 2021). Of that, 16.2 million resulted in hospital admission (CDC, 2021). Between 1995 and 2016, ED visits increased from 369 to 458 visits per 1,000 people, with emergency medical providers in U.S. emergency departments seeing nearly 411,000 patients daily and determining that around 74,000 attendees would benefit from hospital admission (Augustine, 2019a). This number represents about 70% of the 106,000 patients admitted to the U.S. hospitals each day (Augustine, 2019a). Though hospital admissions have increased, the number of ED admissions has declined. Meanwhile, an increasing number of new tests and treatments have been introduced, and boarding of patients has emerged (Augustine, 2019b). As the population increases and ages, the number of ED visits (Conley et al., 2017; Shankar, et al., 2016;) and demand for inpatient beds is expected to surge (Augustine, 2019a; Shankar et al., 2016). Many hospitals and health systems have chosen to approach these issues with the use of ED observation units, which are considered an outpatient service by payors (Conley et al., 2017; Capp et al., 2015). The 2015 American College of Emergency Physicians Board of Directors reaffirmed their policy statement that modern hospitals and EDs continue to face an array of challenges including overcrowding, inefficient use of resources, escalating health care costs, and concerns over avoidable admissions (Bellew et al., 2016). One solution to these challenges is the use of observation service units. Emergency department observation units (EDOUs) use protocolized care to extend an efficient alternative with shorter lengths of stay, lower costs, and greater patient satisfaction (Baugh et al., 2019; Zafar et al., 2020).

Beyond initial and stabilizing care, ED patients may require additional services to determine whether inpatient admission is warranted (Conley et al., 2017). Active management of patients following initial care to determine appropriate disposition is the defining feature of observation services. Length of stay in an observation unit is typically anywhere from 6–24 hours, falling outside the “ED visit with discharge” and/or “ED visit with full inpatient admission” categorizations (Augustine, 2019b; Emory University School of Medicine, 2016). The primary goal of observation service units is to create incentives for an efficient and effective healthcare alternative, thereby lowering healthcare costs (Favila & Rizk, 2017). EDOUs provide short-term care to reduce hospitalizations and cost (Zafar et al., 2020). In one study, strategies to improve outcomes in ED observation units aimed to reduce 30-day ED revisits for chronic obstructive pulmonary disease (COPD) exacerbations managed in EDOUs units with implementation of a COPD care bundle (Zafar et al., 2020). This approach was successful in reducing 30-day ED revisits (Zafar et al., 2020). In some EDOUs there are limitations on patient's age and some may exclude patients over 65 years old. In another study, an EDOU extended the limitations to accept patients up to 79 years old (Madsen et al., 2019). It was noted that EDOUs with extended age limitations have the potential to be utilized even more heavily, even for presenting complaints of chest pain (Madsen et al., 2019). EDOUs provide a setting and mechanism for further ED patient care and provide care to a wide variety of



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patients, who may require multiple consultation and care coordination. The EDOUs do this while maintaining an acceptable length of stay and admission rate (Southerland, et al., 2019).

EDOUs offer appropriate monitoring, diagnostic testing, therapy, and assessment of patient symptoms and response to therapy while determining disposition (Favila & Rizk, 2017; Southerland et al., 2019). The Centers for Medicare and Medicaid Services (CMS) defines observation care as “a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital” (p. 20, 2015a). Observation service units are assigned varying titles based on specific patient populations served and local preferences (Bellew et al., 2016). Regardless of the title, it is important to distinguish between patients designated as observation status; patients with a disposition already determined; and patients being held or boarded in the ED pending movement, admission, or transfer (Emory University School of Medicine, 2016). Overall, observation services are designed to provide diagnostic and treatment capabilities managed by appropriate provider and registered nurse staffing in an efficient, safe, and comfortable environment (Baugh et al., 2013; Favila & Rizk, 2017). Selected ED patients of all ages, presenting with a variety of medical issues, may be deemed “not well enough for immediate discharge, but not sick enough to warrant inpatient admission status,”² leading to treatment as outpatients, using observation services. Patients verified by physician order as eligible for admission to observation status have specified treatment goals to be met within a certain identified time limit (Favila & Rizk, 2017; Southerland et al., 2019).

Across the US, observation services are currently provided in one of four distinct hospital settings defined by the presence or absence of two features: dedicated units (Emory University School of Medicine, 2016) and condition-specific protocols, as described by Ross et al. (2013). Type 1 protocol-driven, ED-directed observation units have been the most studied and offer less diagnostic uncertainty, improved clinical outcomes, and higher patient satisfaction (Augustine, 2019b). Care provided in a dedicated observation unit generally driven by protocols and located in the emergency medicine environment, provides patients with continuous rounding and the ability to expedite discharge at any time of the day or night (Hess & Nestler, 2012).

According to Ross et al. (2013), when observation units are used, patients and hospitals benefit from shorter lengths of stay, lower costs, and improved use of hospital resources (Augustine, 2019b; Emory University School of Medicine, 2016). Relative to inpatient care, Type 1 observation units offer cost savings of 27–42% (Augustine, 2019b). Key elements required to manage a Type 1 model include a dedicated unit setting with operational guidelines, condition-specific protocols, administrative oversight, and appropriate staffing with qualified professionals (Augustine, 2019b). Operational guidelines set the standards for appropriate patient selection, the creation of order sets and protocols to ensure consistent condition management, and criteria for home discharge (Augustine, 2019b). Collaborative approaches to care using evidence-based protocols have the potential to achieve similar clinical outcomes at a lower cost than inpatient admission. EDOUs provide “the right care for the right patient at the right time” and are expected to continue to advance health care delivery in the future (Hess & Nestler, 2012).



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ENA Position

It is the position of the Emergency Nurses Association (ENA) that:

1. Protocol-driven EDOUs enhance the quality and safety of patient care.
2. EDOU services offer a safe, cost-effective alternative treatment and evaluation plan, preventing unnecessary hospital inpatient admissions and negative outcomes.
3. Observation status is regulated by medical needs and is not appropriate as an alternative holding area for patients awaiting disposition to inpatient care or transfer to another facility.
4. Emergency nurses, advanced practice providers, and physicians participate in the development of policies, diagnostic protocols, and standardized pathways that define criteria for patient selection, care, transfer, and discharge and the oversight of observation units.
5. Dedicated EDOUs are appropriately managed by emergency physicians and advanced practice providers and are staffed with emergency-trained professionals.
6. Emergency nurses deliver quality nursing care to observation patients, employing standardized pathways, evidence-based protocols, and practice according to regulatory and jurisdictional guidelines.
7. Emergency nurses support the rights of patients to be informed regarding services provided, financial implications, cost-sharing, and insurance limitations of observation care.
8. Observation units provide dedicated staffing, space, equipment, and supplies, and offer hospital resources and diagnostic services to meet patient needs.
9. Emergency nurses, advanced practice providers, and physicians, participate in collaborative research to refine and improve clinical and operational outcomes provided in EDOUs.

Background

EDOUs are safe and effective and considered best practice when managed appropriately. These units offer an important service line for hospitals to help avoid financial penalties associated with patient readmissions (Bellew et al., 2016). EDOUs provide access to quality care to selected patients at lower costs (Augustine, 2019a; Favila & Rizk, 2017). These distinct and reimbursable services may include further diagnostic evaluation, continued therapy, and management of acute psychosocial issues (Emory University School of Medicine, 2016). EDOU systems provide a benefit to health systems in diagnosing a variety of acute conditions including asthma, chest pain, heart failure, dysrhythmias, syncope, neurological conditions, abdominal pain, and more (Augustine, 2019a).



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The number of U.S. hospitals delivering observation services has steadily increased to 36%, typically in or adjacent to the ED and sometimes located on inpatient floors; only half of these hospitals use condition-specific protocols (Augustine, 2019b; Bellew et al., 2016; Hess & Nestler, 2012). In one study, the EDOU was used for the management of overdose patients who did not require airway management (Shastry et al., 2020). In the study, 946 patients were screened, 648 were included in the cohort, and of the 132 patients requiring additional medical management after the ED visit, 25 (18.9%) were managed in the EDOU. Eighty-eight percent of the EDOU patients were discharged home, only one patient experienced an adverse cardiovascular event requiring admission, and there were no deaths (Shastry et al., 2020). This example demonstrates the variety of patients that can be monitored safely in an EDOU. Clearly, further research in this type of outpatient setting will provide a better understanding of its benefits and improved use of resources as compared to patients admitted to the inpatient setting (Augustine, 2019a).

Leadership and appropriate staffing are essential for EDOUs to operate successfully. Quality observation care is provided by experienced emergency nursing professionals and monitored by emergency physicians and advance practice providers with the ability to manage complex patients (Peacock et al., 2014). A national survey by Mace et al. (2003) revealed observation units were staffed with an average of one nurse per 4.2 patients, and 21.4% of observation units employed advance practice providers to assist in patient care (Macy et al., 2010; Pecci, 2015).

Pediatric observation units have emerged as an alternative site of care for children with selected diagnoses (Peacock et al., 2014). Patients younger than 15 years account for close to 25 million ED visits per year, and those 15–24 years make more than 22 million visits (Kelley-Salvador et al., 2016). Previous data have shown that pediatric patients are often hospitalized for brief durations, with nearly one third admitted for one night or less, and for these reasons, pediatric observation units are an ideal setting for monitoring, serial physical examinations, awaiting consultations, and administering short courses of treatment (Peacock et al., 2014). The most frequent pediatric diagnoses associated with observation services include abdominal pain, allergic reactions, asthma, bronchiolitis, croup, dehydration, gastroenteritis, minor trauma such as head trauma, and toxic ingestions (Emory University School of Medicine, 2016; Kelley-Salvador et al., 2016). Limited data show there are pediatric observation units in

almost 39% of free-standing children's hospitals, 39% of hospitals with separate pediatric wards, and approximately 4% of hospitals without pediatric wards (Peacock et al., 2014). Macy et al. (2010) attempted to summarize the literature on standard outcome measures for pediatric observation units and found that the metrics, including length of stay, admission rates, return visit rates, and costs, were variable and not clearly defined.

Elderly patients are an increasingly large demographic seeking care in the ED (Conley et al., 2017), representing 43% of all admissions (Shankar et al., 2016). These patients are often quite complex, require longer ED visits compared with their younger counterparts, undergo far more testing, and pose unique treatment needs, given their comorbidities and social circumstances (Shankar et al., 2016). Often admitted when diagnosis is unclear, geriatric patients are more vulnerable to complications resulting from inpatient hospitalization, including nosocomial infections, skin breakdown, and functional decline (Kelley-Salvador et al., 2016). Observation units are a clear option for effectively monitoring and further



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evaluating the geriatric patient with an unclear presentation. Even in more complex patients who are considered high risk, such as patients with left ventricular assist devices (LVADs), the use of EDOUs by these patients have been shown to be successful (Tolia et al., 2020). With a strong relationship with the advanced heart failure team and ED staff comfortable with the care of the LVAD patient, one study showed a significant percentage of these patients can be safely observed in the ED and discharged home, avoiding a hospital admission and the risks associated with an inpatient stay (Tolia et al., 2020).

While there are many benefits to the use of EDOUs, there still remain difficulties with reimbursement. Under the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act of 2015, hospitals are required to notify Medicare beneficiaries of their outpatient observation status, including services provided and the cost-sharing implications (Center for Medicare Advocacy, 2013; CMS, 2015b; Kangovi et al., 2015; Pecci, 2015). Observation services are classified as outpatient and may not be covered by insurance, including the three-day stay required by Medicare to be eligible for long-term care and skilled nursing facilities (Center for Medicare Advocacy, 2013; CMS, 2015b; Kelley-Salvador et al., 2016; Pecci, 2015). CMS finalized changes to the two-midnight rule in 2015 (CMS, 2015b). Observation length of stay may not count toward the inpatient stay and is not covered by the two-midnight rule. For stays in which the patient will require hospital care spanning less than two midnights, inpatient admission may be allowed on a case-by-case basis with supporting documentation from the admitting physician or may be subject to review (Center for Medicare Advocacy, 2013; Peacock et al., 2014).

Despite the many reimbursement challenges, EDOUs have emerged as a diagnostic treatment option at the intersection of outpatient and inpatient care during a time of dramatic change in both emergency and hospital medicine (Macy, et al., 2010). Observation services offer safe, efficient, and quality care to ED patients with common complaints, decreasing unnecessary inpatient admissions and improving fiscal performance for hospitals (Augustine, 2019a). As more hospitals choose the benefits of observation services, education and research will further optimize the use of ED observation and clinical decision medicine for patients of all ages (Augustine, 2019a; Macy et al., 2010).

Resources

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