Managing ED Observation with Clinical Decision Areas

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Objectives

1. Define a Clinical Decision Area (CDA)
2. Review characteristics
3. Review cost savings
4. Review improved patient throughput
5. Review improved patient satisfaction
Saying *Adieu* from the CDA

https://vimeo.com/158772533
Scripps Memorial Hospital La Jolla
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)
• < 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
Exclusion Criteria

**Socio-economic:** Homeless, no support
Unable to self-care

**Psychosocial:** Cognitively/functionally impaired, Psychiatric

**Inpatient Staging:** Boarding waiting for an admission bed
Staffing

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
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
Assumptions

- NP rotates between the 8 bed CDA and ED from 11:00 am-11:00 pm where higher clinical skill level is required during ED peak hours
- Two ED nurses to staff 8 bed CDA 24 hours a day
- 12-hr NP shifts; 365 days/year; 2.1 FTEs
- NP compensation at $155,000/year (sal+fringe)
- RN compensation at $124,000/year/RN (sal+fringe)
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)
Cost Savings

Example

• If the average inpatient admission is 26 hrs and the CDA reduces this to 15 hrs, the floor nurse resource savings = 11 hrs per admission

• 11 hrs X the inpatient RN average sal+fringe cost of $57.50 ($46/hr+25% fringe) would save = $632.50 per admission

• 1,800 CDA admits = $1,138,500 savings potential

• 3,600 CDA admits = $2,277,000 savings potential
Example

1,800 pts/yr x $632.50/in-pt RN = $1,138,500
Less: Addt’l 2.1 FTE NP - 325,500
      Addt’l 3.9 FTE RN - 483,600
Net CDA cost savings $ 329,400

3,600 pts/yr x $632.50/in-pt RN = $2,277,000
Less: Addt’l 2.1 FTE NP - 325,500
      Addt’l 7.8 FTE RN - 967,200
Net CDA cost savings $ 984,300
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**.
“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.
Throughput

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
Conclusion

Benefits of a CDA

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

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.
### Current Data

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<th>2017</th>
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<td>Mar</td>
<td>Apr</td>
<td>May</td>
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<td>CDA Volume</td>
<td>75</td>
<td>96</td>
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<td>Convert CDA to Admit</td>
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<td>% of CDA Conversions to Admit</td>
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<td>Total CDA/Total ED Patient %</td>
<td>0.02%</td>
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<td>Number of CDA Clinic patients</td>
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*CDA Opened Jan 9, 2017*
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


Thank you

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