AMENDED

March 10, 2025

STANDARDS FOR OBSERVATION IN VA MEDICAL FACILITIES

1. SUMMARY OF MAJOR CHANGES:

a. Amendment dated March 10, 2025, removed language about multi-use bathrooms (which are no longer in place and not a part of hospital construction). The sentence that was deleted had the words “gender-specific” which has been removed to comply with EO 14168.

b. As published December 18, 2024, this directive:

c. Designated the Department of Veterans Affairs (VA) medical facility treating health care provider, rather than the VA medical facility Utilization Management (UM) Reviewer, as ultimately responsible for determining whether to convert the patient’s stay from inpatient admission to Observation (see paragraph 2.j.(1)).

d. Removed the VA medical facility UM Reviewer’s responsibility to conduct an analysis of the rate of conversion from Observation status to inpatient admission.

e. Added roles and responsibilities for the Chief Officer, Specialty Care Program Office (SCPO) and the National UM Program Executive Director (see paragraph 2).

f. Specified the metrics VA medical facility UM Reviewers are required to monitor (see paragraph 5.b.).

g. Added permission to correct an Observation stay to an inpatient admission following hospital discharge if proper criteria are met (see Appendix A).

h. Specified documentation requirements upon conversion from Observation to inpatient status (e.g., a separate Observation Transition note is not required) (see Appendix B).

i. Clarified that automatic conversion from Observation to acute admission at 48 hours is no longer required (paragraph 4).

2. RELATED ISSUES: VHA Directive 1002, Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities, dated November 28, 2017; VHA Directive 1101.14, Emergency Medicine, dated March 20, 2023; VHA Directive 1117, Utilization Management Program, dated October 8, 2020; VHA Directive 1351, and Staffing Methodology for VHA Nursing Personnel, dated January 18, 2023.

3. POLICY OWNER: The National Hospital Medicine Program (11SPEC11) is responsible for the contents of this directive. Questions may be referred to the National Hospital Medicine Program at VHA11SPEC11HospitalMedicine@va.gov.

4. LOCAL DOCUMENTS REQUIREMENTS: There are no local document requirements in the directive.

5. RESCISSIONS: VHA Directive 1036, Standards for Observation in VA Medical Facilities, dated January 13, 2020, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of December 2029. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

7. IMPLEMENTATION SCHEDULE: This directive is effective upon publication.

BY DIRECTION OF THE OFFICE OF THE UNDER SECRETARY FOR HEALTH:

/s/ Erica M. Scavella, M.D., FACP, FACHE
Assistant Under Secretary for Health
for Clinical Services and Chief Medical
Officer

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter*.

DISTRIBUTION: Emailed to the VHA Publications Distribution List on December 18, 2024.

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STANDARDS FOR OBSERVATION IN VA MEDICAL FACILITIES

1. POLICY

It is Veterans Health Administration (VHA) policy that all Department of Veterans Affairs (VA) medical facilities with Emergency Departments (ED), Urgent Care Clinics (UCC), or acute care inpatient beds must provide medically necessary care for Observation patients and ensure that these patients are placed in the most appropriate clinical setting. It is also VHA policy that all patients placed in Observation must be assigned an Observation treating specialty or accommodation through a patient status order entered by the authorized VA medical facility treating VA health care provider. **AUTHORITY:** 38 U.S.C. § 7301(b).

2. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer.** The Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer is responsible for:

(1) Supporting the Chief Officer, Specialty Care Program Office (SCPO), with implementation and oversight of this directive.

(2) Supporting the development of mitigation or corrective actions to address noncompliance with this directive.

c. **Chief Operating Officer.** The Chief Operating Officer (COO) is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Service Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Overseeing VISNs to assure compliance with and the effectiveness of this directive.

d. **Chief Officer, Specialty Care Program Office.** The Chief Officer, SCPO, is responsible for supporting the National Program Executive Director (NPED) for Hospital Medicine in executing their responsibilities as outlined in this directive.

e. **National Program Executive Director for Hospital Medicine.** The NPED for Hospital Medicine is responsible for:

(1) Overseeing the implementation of the standards specified by this directive.

(2) Supporting VISN Directors and VA medical facility Directors with the implementation of this directive.

(3) Providing national guidance to ensure a standardized approach for the evaluation of Observation patients.

f. **National Utilization Management Program Executive Director.** The National UM Program Executive Director is responsible for:

(1) Providing utilization management (UM) expertise to VISN Directors in the implementation of their responsibilities as outlined in this directive and in accordance with VHA Directive 1117, Utilization Management Program, dated October 8, 2020.

(2) Providing national UM guidance to ensure a standardized approach to the UM review of Observation patients in accordance with VHA Directive 1117.

g. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Ensuring that all VA medical facilities within the VISN comply with this directive and informing the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer and the COO when barriers to compliance are identified.

(2) Overseeing corrective actions to address noncompliance at the VISN and VA medical facilities within the VISN.

h. **VA Medical Facility Director.** The VA medical facility Director is responsible for ensuring the implementation of this directive and providing guidance for the management of Observation patients, to include:

(1) Ensuring overall VA medical facility compliance with this directive and appropriate corrective action is taken if non-compliance is identified.

(2) Defining treating VA health care provider responsibilities throughout the course of Observation treatment and the appropriate handoff of care to subsequent treating VA health care providers.

(3) Defining the process at the VA medical facility to be used by the VA medical facility Utilization Management (UM) Reviewer to monitor and report appropriate utilization of the Observation status program. ***NOTE:*** *The VA medical facility Director may delegate this responsibility to another position (e.g., Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Chief of Staff) at the VA medical facility.*

(4) Establishing the assessment, monitoring, and documentation requirements pertaining to Observation status at the VA medical facility (see Appendix B).

(5) Ensuring that appropriate equipment and supplies are available to provide care for the types of patients expected to be placed in Observation.

(6) Ensuring appropriate clinical staffing to provide effective Observation care.

i. **VA Medical Facility Chief of Staff.** The VA medical facility Chief of Staff is responsible for:

(1) Ensuring that appropriate clinical conditions are placed on Observation status (see paragraph 3). ***NOTE:*** *VA medical facility UM Reviewers provide input on clinical conditions appropriate for Observation at VA medical facilities.*

(2) Ensuring that all patients placed in Observation are assigned a VA health care provider, and that the treating VA health care provider designates the treating specialty as Observation. ***NOTE:*** *The treating VA health care provider is not a health care provider in the ED or UCC unless the patient is in ED or UCC Observation status.*

j. **VA Medical Facility Treating Health Care Providers.** The treating VA health care provider, who accepts and provides initial or continued Observation care to patients admitted to acute hospital Observation beds, is responsible for:

(1) Determining and placing corresponding order for appropriate admission and discharge from Observation status, including selecting the correct Observation treating specialty.

(2) Determining the appropriate designation of either inpatient admission or Observation status for the patient with guidance from the VA medical facility UM Reviewer. This may result in a need to correct inpatient admission orders to reflect Observation status when clinical expectations of patient needs are uncertain. ***NOTE:*** *UM Reviews are considered Quality Management activities that can generate confidential records and documents and are protected as provided under 38 U.S.C. § 5705. For further information, see VHA Directive 1117.*

(3) Correcting patients from inpatient to Observation status in accordance with the policies and procedures of Observation status.

(4) Generating all necessary documentation pertaining to the Observation status (see Appendix B), and ensuring that it is accurate and complete, including:

(a) An order for Observation status. If correcting a previously ordered inpatient admission(s) to Observation status, the order must be completed before the correction can occur, and prior to discharge of the patient (see Appendix A).

(b) A detailed note indicating the reasons for Observation.

(c) A working diagnosis.

(d) A treatment plan.

(e) A summary note documenting patient disposition with a clear discharge plan.

(f) A clear definition of the endpoint for patient disposition. ***NOTE:*** *Appendix B outlines the minimum requirements for patient record documentation of Observation patients. In the case of ED or UCC Observation, the ED or UCC note can serve as the admission note.*

(5) Examining the patient at regular intervals as directed by clinical need and writing notes documenting the patient's course while in Observation.

(6) Communicating directly with cross-covering health care providers, including discussion about the clinical course and treatment plan.

(7) Adhering to Observation length of stay standards (see paragraph 4).

k. **<u>VA Medical Facility Utilization Management Reviewer.</u>** The VA medical facility UM reviewer is responsible for:

(1) Determining whether a patient's documentation supports the level of care criteria for Observation status or inpatient admission and communicating this determination to the treating VA health care provider. This includes, when the documentation does not support the level of care criteria for an inpatient admission, providing guidance to the treating VA health care provider to correct the patient status order to reflect the change of stay from inpatient status to Observation status. Alternatively, when the documentation does support the level of care criteria for an inpatient admission, providing guidance to the treating VA health care provider to change the stay from Observation status to inpatient admission ***NOTE:*** *VHA follows guidance from Centers for Medicare & Medicaid Services (CMS) that outlines the procedures for converting a patient placed in inpatient status to Observation status after the patient is admitted (see Appendix A).*

(2) Monitoring and reporting utilization of the Observation status program at the VA medical facility to the VA medical facility Director or designee (e.g., Chief of Staff, Associate Chief of Staff). Monitoring includes an evaluation of Observation stays (see paragraph 5.b.) using the VHA licensed, standardized, evidence-based UM review criteria and documenting in the National Utilization Management Integration (NUMI) application or other Electronic Health Record (EHR) UM documentation tool.

3. OBSERVATION STATUS

a. **<u>Conditions Appropriate for Observation.</u>** Conditions appropriate for Observation must be consistent with the conditions in which CMS permits the use of Observation status. This promotes uniformity between the Observation care designations used in VA care and community care paid for by VA. Observation care assumes the patient is hemodynamically stable with a condition that can usually be resolved within 48 hours. Examples include:

(1) Continued diagnostic evaluations to determine if inpatient care is appropriate.

(2) Short-term therapies.

(3) Psychosocial needs.

b. **Conditions Not Appropriate for Observation.** These include:

(1) Elective or prescheduled health care services.

(2) Therapeutic procedures alone, such as blood transfusions or chemotherapy. ***NOTE:*** *If it is determined during an evaluation by the treating VA health care provider that the only therapeutic intervention necessary to obviate admission is blood transfusion, then this would be clinically appropriate for Observation status.*

(3) Services that are not reasonable or necessary for the diagnosis or treatment of the patient.

(4) Services that are provided for the convenience of the patient, the patient's family, or a VA health care provider.

(5) Services that are medically appropriate for inpatient admission, or services that are part of another outpatient service, such as postoperative monitoring during a standard recovery period, (e.g., 4-6 hours), which should be captured as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the recording and reporting of those diagnostic services.

(6) Standing orders for Observation following outpatient surgery.

4. OBSERVATION LENGTH OF STAY STANDARDS

a. **All Observation Within the Hospital.** In most cases, the treating VA health care provider's decision about whether to discharge a patient from the hospital following resolution of the reasons for the Observation care, or to convert to inpatient status, are made in less than 48 hours, often in less than 24 hours. Only in rare cases does reasonable and necessary Observation care span more than 48 hours. As such, conversion from Observation to Inpatient status at 48 hours is not required. Routine recovery from ambulatory procedures is not considered Observation, and Observation must not be utilized for this purpose. However, patients who develop a complication, require overnight post-procedure monitoring, or present another clinical reason that requires greater than 6 hours recovery from an elective ambulatory procedure for postoperative procedural management, or required monitoring of co-morbid conditions, may recover, and receive care and treatment, in Observation units or wards. The start time, and reason for Observation following an ambulatory surgery procedure, must be clearly documented in the EHR progress note and the order for admission to Observation by the treating VA health care provider.

b. **Observation Specifically Within Emergency Departments or Urgent Care Clinics.** Patients assigned to Observation status in an Observation location within the ED or UCC by treating VA health care providers, or as ED Observation, must be limited

to a stay of 23 hours and 59 minutes in the ED or UCC itself. Patients who cannot be discharged in this timeframe must be admitted, or placed in Observation status, on an inpatient unit at a location outside of the ED or UCC. The patient must be assigned under a clinical service that cares for admitted patients. Observation status beds are not to be used as holding beds for the ED or UCC. ***NOTE:*** *This does not extend the total duration of Observation care. The initial 23 hours and 59 minutes defines the limits of use of EDs and UCCs for Observation purposes.*

5. OVERSIGHT AND ACCOUNTABILITY

a. **Internal Controls.** The internal controls in this directive are:

(1) Leadership oversight by the Chief Officer, SCPO; NPED for Hospital Medicine; VISN Director; VA medical facility Director; and VA medical facility Chief of Staff as outlined in paragraph 2 of this directive.

(2) The VA medical facility Director ensures that VA medical facility treating health care providers convert patients from inpatient to Observation status following the policies and procedures for Observation status, and that there are appropriate equipment, supplies, and clinical staffing to provide effective Observation care.

(3) VA medical facility Chief of Staff ensures that there are sufficient support services available and appropriate clinical conditions for Observation patients, and that all patients placed in Observation care are assigned a VA medical facility primary treating health care provider, and an Observation treating specialty.

(4) VA medical facility UM Reviewers provide guidance to VA medical facility treating health care providers on when to convert the stay from inpatient to Observation status, and monitoring and reporting utilization of the Observation Status program at the facility level (see paragraph 2.k.).

(5) VA medical facility UM Reviewers ensure that patients who are admitted to an acute care inpatient setting, after a period of Observation, have their medical records reviewed by UM staff to assess the appropriateness of the initial Observation status, and the appropriateness of the conversion to inpatient status made by the treating VA health care provider.

b. **Metrics.** The metrics in this directive that assess the directive or program effectiveness are:

(1) Rates of Observation care within the ED or UCC exceeding 24 hours.

(2) Rates of non-ED or UCC Observation care exceeding 48 hours.

(3) Percent of Observation patients meeting Observation level of care criteria.

(4) For patients changed from Observation to inpatient status, percent meeting the updated level of care criteria (usually acute). ***NOTE:*** *Patients changed from inpatient to*

Observation status must not be included as acute care inpatients. They must be considered ambulatory for procedures performed while a patient is assigned to Observation status for performance measurement purposes (see Appendix A, paragraph 5.b.).Observation patients must be included as acute care inpatients in the bed days of care (BDOC) count for the reporting of health-care-associated infections related to performance measures (see Appendix A, paragraph 5.c.).Treating VA health care providers must generate the Observation Patient Record and ensure it is accurate and complete (see paragraph 2.j.(4) and Appendix B).

6. TRAINING

There are no formal training requirements associated with this directive.

7. BACKGROUND

a. VA recognizes the importance of placing patients in the most appropriate clinical setting. In many instances this requires observing a patient for an extended period as an outpatient before admitting them as an inpatient. The goal of Observation is to provide an opportunity for a response to initial therapy or to clarify a patient's diagnosis.

b. Observation status provides medical benefits by allowing for continued evaluation and better definition of the patient's problem. Additional advantages of using Observation include making efficient use of inpatient beds by reducing unnecessary hospitalizations, expediting hospital flow, reducing patient revisits by ensuring adequate time to make appropriate diagnosis, and facilitating difficult discharges from EDs and UCCs. The ultimate goals are to improve the quality of care provided to patients and optimize resource utilization.

8. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management can be addressed to the appropriate Records Officer.

9. DEFINITIONS

a. **Observation Unit or Ward.** An Observation unit, ward, or accommodation is a physical or virtual location that allows bed assignments as an inpatient admission to facilitate electronic order entry (e.g., for nursing care, medications). It does not count as an admission in the VA medical facility statistics. Observation status is classified by CMS as outpatient services provided in a bed.

b. **Observation Patient.** An Observation patient is one with a medical, surgical, or mental health condition showing a degree of instability, or disability that needs to be monitored. The patient is provided with short-term treatment and re-assessed before a

decision is made, i.e., whether the patient either requires further treatment in an acute care inpatient setting or can be discharged or assigned to care in another setting.

c. **Observation Status Bed.** An Observation status bed is a bed in the VA medical facility either in an outpatient location such as the ED or UCC, or in an inpatient location designated as an Observation treating specialty, where patients with medical, surgical, or mental health conditions can be kept for monitoring, evaluation, and treatment. Any acute bed, including Intensive Care unit beds, can be used for Observation status (see paragraph 4.b. for time limits on the use of ED or UCC beds by patients assigned to Observation status in the ED or UCC).

d. **Observation Treating Specialty.** Observation treating specialties, as outlined in Appendix C, are separate, orderable, treating specialties necessary for EHR placement of patients in Observation status. treating health care providers order an Observation Treating Specialty appropriate for the clinically indicated services, which is then recorded in the Patient Treatment File.

e. **Utilization Management.** For purposes of this directive, UM is a proactive program used by trained, licensed health care professionals, including nurses, physicians, and case managers as a key component of VHA's quality management system, providing vital tools for managing quality and resource utilization. It strives to ensure patients receive the right care, in the right setting, at the right time, and for the right reasons, utilizing evidence-based practices along with continuous measurement and improvement.

10. REFERENCES

a. 38 U.S.C. § 5705.

b. 38 U.S.C. § 7301(b).

c. VHA Directive 1117, Utilization Management, dated October 8, 2020.

d. Medicare Benefit Policy Manual, Chapter 1, 10 - Covered Inpatient Hospital Services Covered Under Part A: http://www.cms.hhs.gov/manuals/Downloads/bp102c01.pdf.

OBSERVATION STATUS GUIDELINES AND CORRECTIONS

1. Correcting From Acute Inpatient to Observation Status

a. The guidance to correct acute inpatient admission to Observation can be made by a VA medical facility Utilization Management (UM) reviewer when the patient's documentation does not support the level of care criteria for an inpatient admission. The order for the level of care change must be entered by a treating VA health care provider responsible for the patient care. The order, and documentation for Observation level of care, must be completed before this correction can occur and must occur prior to discharge.

b. The treating VA health care provider is ultimately responsible for determining whether to correct the order and change the stay from inpatient admission to Observation and must document this request for Observation in the patient's electronic health record (EHR) before the correction can be completed.

c. The correction of patient status from acute inpatient to Observation (which is an outpatient status) must occur prior to patient discharge or release with the exceptions of clerical error or unavailability of concurrent UM review. The following conditions must be met for retroactive correction of the Patient Treatment File (PTF):

(1) VA medical facility treating health care provider ordered correction for Observation status.

(2) The PTF has not yet been completed and transmitted (i.e., remains in open status).

(3) Less than 72 hours has elapsed between the time of discharge and time of PTF correction.

2. Correcting from Observation Status to Acute Inpatient

a. The guidance to correct Observation status to acute inpatient admission can be made by a VA medical facility UM reviewer when the patient's documentation supports the level of care criteria for an inpatient admission. The order for the level of care change must be entered by a treating VA health care provider responsible for the patient's care. The order, and documentation for inpatient level of care, must be completed before this correction can occur and must occur prior to discharge.

b. The treating VA health care provider is ultimately responsible for determining whether to correct the order and change the stay from Observation to inpatient admission and must document this request for inpatient admission in the patient's EHR before the correction can be completed.

c. Correction of an admission transaction from Observation to inpatient involves updating the corresponding PTF, which may only occur retroactively following hospital discharge, if the following conditions are met:

(1) The order(s) from the responsible treating VA health care provider have been placed in the patient's health record. ***NOTE:*** *This may only occur when the initial UM review is performed after hospital discharge if UM guidance and input was not available during the hospital stay or due to clerical error.*

(2) The PTF has not yet been completed and transmitted.

(3) Less than 72 hours has elapsed between the time of discharge and time of PTF correction.

3. Patients placed in Observation status are assigned to one of the Observation treating specialties listed in Appendix C, enabling the VA medical facility to track the patients on the Gains and Losses (G&L) sheet. In VA medical facilities using VistA/CPRS, an Observation patient requiring subsequent admission is released from Observation status by discharging the patient from Observation, and then admitting the patient to an acute care treating specialty. ***NOTE:*** *Observation care is classified as outpatient care involving a hospital bed status by CMS. The term and process "admitted to Observation" is used to support the activities related to bed management for admission, discharge, and transfer to account for bed availability, virtual beds, or in physical ward beds. This also addresses the Veterans Health Information Systems and Technology Architecture/ Computerized Patient Record System (VistA/CPRS) EHR limitation which prevents the electronic entry of orders for nursing care, pharmaceuticals, food, etc., when in an outpatient status.*

4. To facilitate treatment during the pre-operative, peri-operative, and post-operative phases of a planned outpatient ambulatory same-day procedure, patients without a planned immediate admission to Observation, or an acute admission, that sustain a complication that requires an extended stay, should be "discharged" from the post-procedure recovery area. An order must be written to add the admission to Observation for the complication.

5. Patients with a planned procedure and transition to inpatient post-operative care management, requiring inpatient admission post-operatively, must have a patient status order for admission in advance of the planned surgery. This requires having detailed instruction for admission post-operatively. The patient status order for admission must contain the planned admission date. The action in bed management may not be taken until after surgery and patient is in post-operative period. This is necessary to clearly document the clinical intent for admission. ***NOTE:*** *The order can be placed on hold, if necessary*. These patients must be "discharged" from ambulatory surgery outpatient status and "admitted to Observation" and must be assigned an Observation treating specialty. If further hospitalization is required following the Observation period (i.e., there is a complication or the patient requires additional monitoring) the patient must be "discharged from Observation" and "re-admitted" to acute inpatient status. ***NOTE:***

Utilizing this data report methodology enables data users to separate the activity of these patients for their purposes.

6. For performance measurement purposes, patients converted from inpatient to Observation status must not be included as acute care inpatients. Procedures performed while a patient is assigned to Observation status must be considered ambulatory for performance measure purposes.

7. However, for reporting of health-care-associated infections (HAIs) related to performance measures, Observation patients must be included as acute care inpatients in the bed days of care (BDOC) count. This includes but is not limited to methicillin-resistant Staphylococcus aureus (MRSA), Clostridioides difficile infection (CDI), catheter associated urinary tract infections (CAUTI), surgical site infections, central line-associated bloodstream infections (CLABSI), and ventilator-associated event (VAE).

OBSERVATION PATIENT RECORD

DOCUMENTATION REQUIREMENTS (DOCUMENT OR ITEM)	COMPLETION TIME	COMPONENTS OF DOCUMENT REQUIRED
Admission Order	On admission	A timed and dated order for "admission" of the patient to Observation.
Initial Assessment and History and Physical (H&P)	Within 24 hours of initiation of Observation or before discharge if the Length of Stay (LOS) is less than 24 hours	1. An Initial Assessment and History and Physical (H&P) screening of physical, psychological (mental), and social status to determine the reason why the patient is being placed in Observation, type of care or treatment to be provided, and need for further assessment, ***or:*** 2. An extensive Emergency Department (ED) note or Progress Note, or Community Living Center (CLC) Progress Note documented by the admitting VA health care provider, encompassing the normal criteria for an H&P is sufficient as an initial assessment, and H&P for the Observation patient. ***Note:*** *If Observation care leads to inpatient admission, a second H&P is not required. However, if an extensive ED or CLC note (as in item 2. above) is used for the initial Observation care, an H&P is required.*

DOCUMENTATION REQUIREMENTS (DOCUMENT OR ITEM)	COMPLETION TIME	COMPONENTS OF DOCUMENT REQUIRED
Progress Notes	Within the Observation period or as clinically indicated	1. Progress Notes must reflect the status of the patient's condition, course of treatment, patient's response to treatment, and any other significant findings apparent at the time the progress note is documented. 2. Reassessments must include a plan for: a. discharge or transfer b. admission or readmission to inpatient status c. continued Observation with evaluation and rationale
Discharge Order	On Discharge or On conversion from Observation to Inpatient status	A timed and dated order for discharge from the Observation status or for conversion from Observation to inpatient status.
Discharge Diagnoses	On Discharge	A complete listing of all final diagnoses including complications and comorbidities
Discharge Note	On Discharge ***NOTE:*** *On conversion from Observation to inpatient status, a separate discharge or conversion note is not required.*	A summary of the reason for the Observation admission, the outcome, follow-up plans and patient disposition, and discharge instructions (such as diet, activity, medications, special instructions). ***NOTE:*** *This summary may be documented in the Progress Notes or dictated according to local policy.*

PATIENT TREATMENT FILE

The following Patient Treatment File (PTF) treating specialties and revised Monthly Program Cost Report (MPCR) account numbers are utilized for recording Observation patient activity. Only the treating specialties outlined in this directive are used for setting up Observation units. The service for the Observation status bed must be a non-count service and must include the Gains and Losses (G&L) location.

Treating Specialty	PTF Number	MPCR Number
Medical Observation	24	1150.00
Surgical Observation	65	1250.00
Psychiatric Observation	94	1350.00
Neurology Observation	18	1151.00
Rehabilitation Medicine Observation	41	1153.00
Emergency Department (ED) or Urgent Care Clinic (UCC) Observation	1J	1150.00

NOTE: *PTF Treating Specialty 1J is used for ED or UCC health care providers admitting patients to the ED or UCC for Observation. For other Observation admissions, the appropriate PTF treating specialty number must be used based on the type of clinical Observation versus where the patient is physically being observed (i.e., a health care provider may admit a patient to Medical Observation in the ED or UCC using PTF Treating Specialty 24).*