

STANDARDS FOR OBSERVATION IN VA MEDICAL FACILITIES

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive updates the policy for the observation of patients requiring continued evaluation and treatment who may not need admission to a VA medical facility. In addition, this directive outlines the definition and recording of observation status.

2. SUMMARY OF MAJOR CHANGES: Major changes include:

- a. Allowing for the conversion from inpatient to Observation status if, upon review, the initial designation as an inpatient admission was incorrect.
- b. Outlining the definition and recording of initial and final Observation status.
- c. Removing the previous requirement for local Observation policies.
- d. Clarifying the permitted duration of Observation status by adopting Centers for Medicare & Medicaid Services (CMS) language.

3. RELATED ISSUES: VHA Directive 1101.05(2), Emergency Medicine, dated September 2, 2016; VHA Directive 1117(1), Utilization Management Program, dated July 9, 2014; VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated December 20, 2017; VHA Directive 1002, Bed Management, dated November 28, 2017; and VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, dated December 22, 2010.

4. RESPONSIBLE OFFICE: The Office of Specialty Care Services (10P11) is responsible for the contents of this directive. Questions may be referred to Specialty Care Services (10P11) at 202-461-7120.

5. RESCISSIONS: VHA Directive 1036, Standards for Observation in VA Medical Facilities, dated February 6, 2014, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled to be recertified on or before the last working day of January 2025. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

January 13, 2020

VHA DIRECTIVE 1036

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

/s/ Lucille B. Beck, PhD.
Deputy Under Secretary for
Health for Policy and Services

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

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STANDARDS FOR OBSERVATION IN VA MEDICAL FACILITIES

1. PURPOSE

This Veterans Health Administration (VHA) directive updates the policy for the observation of patients requiring continued evaluation and treatment but may not need admission to the Department of Veterans Affairs (VA) medical facility. In addition, this directive updates policy for the definition and recording of Observation status.

AUTHORITY: Title 38 United States Code (U.S.C.) 7301(b).

2. 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 additional 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 Emergency Rooms. The ultimate goals are to improve the quality of care provided to patients and optimize resource utilization.

3. DEFINITIONS

a. **Gains and Losses Sheet.** The Gains and Loss (G&L) Sheet is a document that provides information concerning patient movement into, out of, or within a VA medical facility for a given date. It shows all gains (admissions, transfers in from other VA medical facilities, returns from authorized and unauthorized absence) and losses (discharges, transfers out, and deaths) of patients. Inter-ward transfers are counted as both a gain and a loss for that VA medical facility. The G&L Sheet also displays lodger check-ins and check-outs. Admission types (e.g., direct, ambulatory care) and discharge types (e.g., regular, service connected, non-service connected) are specified for each patient on the G&L Sheet. Applicable patient names and ward locations are listed under the appropriate sections.

b. **Non-Count Ward.** A non-count ward is one that allows bed assignments as an inpatient in order to facilitate electronic order entry (e.g., for nursing care, meds) but does not count as an admission in the VA medical facility statistics. Observation status is considered non-count as the services provided are considered outpatient services and not related to an inpatient admission.

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

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

d. **Observation Status Bed.** An Observation status bed is a bed in the VA medical facility either in an outpatient location such as the Emergency Department (ED) or Urgent Care Clinic (UCC), or in an inpatient location designated as a non-count ward, where patients with medical, surgical, or mental health conditions can be kept for extended monitoring, evaluation, and treatment. Any acute bed, including Intensive Care unit beds, can be used for Observation status.

e. **Observation Unit.** An Observation unit is a designated area that can be either a virtual unit or bed located anywhere in the VA medical facility where patients with medical, surgical, or mental health conditions can be kept for extended monitoring, evaluation, and treatment.

f. **Utilization Management.** Utilization management is a proactive program used by trained, licensed health care professionals, including nurses, physicians, and case managers, for managing quality and resource utilization. It strives to ensure patients receive the right care, in the right setting, at the right time, for the right reason.

4. POLICY

It is VHA policy that all VA medical facilities with EDs, UCCs, or acute care inpatient beds must provide care for Observation patients and ensure that these patients are placed in the most appropriate clinical setting. All patients placed in Observation must be assigned an Observation treating specialty and provider, an Observation code, as applicable, and all services and costs associated with the Observation treating specialty must be captured and assigned to inpatient services.

5. RESPONSIBILITIES

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

b. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for:

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

(2) Ensuring that each VISN Director has the sufficient resources to fulfill the terms of this directive in all of the VA medical facilities within that VISN.

(3) Providing oversight to VISNs to assure compliance with this directive, relevant standards, and applicable regulations.

c. **Deputy Under Secretary for Health for Policy and Services.** The Deputy Under Secretary for Health for Policy and Services is responsible for supporting the implementation and oversight of this directive across VHA.

d. **National Director for Medicine.** The National Director for Medicine is responsible for:

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

(2) Implementing policy and direction for Observation patients requiring continued evaluation or treatment, but not necessarily requiring admission to the hospital.

e. **Veterans Integrated Service Network Director.** The VISN Director is responsible for ensuring overall compliance with this directive for all VISN VA medical facilities with EDs, UCCs, or acute care inpatient beds.

f. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring the implementation of this directive and providing guidance for the management of Observation patients, to include:

(a) Ensuring appropriate patient care decisions are made for admission or discharge from an Observation bed.

(b) Establishing a clear delineation of the service and provider responsible for the patient.

(c) Defining provider and nursing responsibilities throughout the course of treatment and providing a description of appropriate handoff of care to subsequent providers.

(d) Describing the process to be used to monitor and report appropriate utilization.

(e) Establishing assessment, monitoring, and documentation requirements (see Appendix B).

(f) Ensuring all providers placing patients in Observation status follow the policies and procedures of Observation status, including the medical record documentation requirements and time limits.

(g) Ensuring appropriate equipment and supplies are available to provide care for the types of patients expected to be placed in Observation. This includes availability of gender-specific supplies and designated female bathrooms with locks to meet the personal care and privacy needs of female patients.

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

f. **VA Medical Facility Leadership (Chiefs of Staff, Associate Directors for Patient Care Services, and Department Directors or Managers)**. The VA medical facility leadership, as designated by each VA medical facility Director, is responsible for:

(1) Ensuring sufficient support services are available to ensure that necessary and appropriate care is consistently delivered to Observation patients.

(2) Ensuring appropriate clinical conditions are placed on Observation status (see paragraph 6). Clinical conditions appropriate for Observation within VA must be consistent with the conditions in which Centers for Medicare & Medicaid Services (CMS) permits the use of Observation status.

(3) Ensuring all patients placed in Observation care are assigned a primary treating provider and an Observation treating specialty code. **NOTE:** *The primary treating provider is not a provider in the ED or UCC unless the patient is in ED or UCC Observation bed status.*

g. **VA Treating Providers**. The VA treating provider is responsible for:

(1) Generating all necessary documentation, including a provider's order for Observation status, a detailed note indicating the reasons for Observation, a working diagnosis, a treatment plan, and a clear definition of the endpoint for patient disposition and ensuring documentation is accurate and complete. 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.

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

(3) At the end of their shift, transferring the patient's care to incoming staff, which must include a discussion about the clinical course and treatment plan.

(4) Documenting disposition in a summary note with a clear discharge plan.

(5) Adhering to length of stay duration standards (see paragraph 7).

(6) When concurring with the Utilization Management (UM) reviewer's recommendation to convert the stay from inpatient admission to Observation, documenting this concurrence, including justifying the Observation level of care and completing this documentation before this conversion occurs (see Appendix A).

i. **Utilization Management Reviewer**. The UM reviewer is responsible for:

(1) Determining, after review, when a patient placed in inpatient status should have been in Observation status. **NOTE:** *VHA follows guidance from CMS which outlines how a patient placed in inpatient status can be converted to Observation status after the patient is admitted (see Appendix A).*

(2) Monitoring utilization of the Observation status program. Monitoring includes an evaluation of Observation stays using the VHA licensed, standardized, evidence-based UM review criteria and documenting in the National Utilization Management Integration (NUMI) application or embedded in the electronic health record (EHR). Additional data collection should include patient volume, length of stay (LOS), number of patients subsequently converted to admission, types of patient in Observation status, and the percentage of total ED or UCC patient visits that are placed in Observation.

(3) Ensuring that patients who are admitted to an acute care inpatient setting after a period of Observation status have their medical records reviewed by UM staff to assess appropriateness of initial Observation status.

(4) Conducting an analysis of the rate of inpatient admission from Observation status. If admission rates are high (greater than 25 percent), the department must re-examine the unit's criteria for Observation, as well as proper utilization by the medical staff.

6. OBSERVATION STATUS

a. **Conditions Appropriate for Observation.** 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 that the only therapeutic intervention necessary to obviate admission is blood transfusion, then this would be clinically appropriate for Observation status.*

- (3) Convenience of the patient, the patient's family, the VA medical facility, or the attending physician.

7. OBSERVATION LENGTH OF STAY STANDARDS

a. **All Observation Within the Hospital.** In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reasons for

the observation care or to admit the patient as an inpatient can be made in less than 48 hours, often in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. 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 six 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 non-count Observation units or wards. The start time and reason for Observation following an ambulatory surgery procedure must be clearly documented in the EHR.

b. **Observation specifically within Emergency Departments or Urgent Care Clinics.** Patients assigned to Observation status within the ED or UCC by specialty services, 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 time frame 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 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 ED/UCC space for observation purposes.*

8. TRAINING

There are no formal training requirements associated with this directive.

9. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created in this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Manager or Records Liaison.

10. REFERENCES

- a. VHA Directive 1117(1) Utilization Management Program, dated January 18, 2018.
- b. VHA Handbook 1000.01 Inpatient Bed Change Program and Procedures, dated December 22, 2010.
- c. American College of Emergency Physicians (ACEP) Clinical & Practice Management Committee, Emergency Department Observation Services Policy statement. Revised and approved ACEP Board of Directors January 2008 (reaffirmed October 2015). <https://www.acep.org/patient-care/policy-statements/emergency-department-observation-services/#sm.00000174c16iiqecqy7wujlp4y9>.

d. American College of Emergency Physicians (ACEP) Policy Resource and Education Paper, State of the Art: Observation Units in the Emergency Department, May 2011.

e. The Joint Commission Standards. **NOTE:** *Current standards are available through Quality, Safety, and Value (QSV), Division of External Accreditation Services & Programs. These may be accessed through the facility Quality Management offices intranet site located at:*

<http://vawww.oqsv.med.va.gov/functions/integrity/accred/jointcommission.aspx>. **NOTE:** *This is an internal VA Web site that is not available to the public. The public may contact The Joint Commission at <http://www.jointcommission.org/> to learn more about accreditation of VA medical facilities.*

f. Medicare Claims Processing Manual, Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS (Rev. 4255, 03-15-19), attention to Section 290.1 – Observation Services Overview.

CONVERTING FROM INPATIENT TO OBSERVATION STATUS

1. The recommendation to convert from inpatient admission to Observation can be made by a Utilization Management (UM) reviewer when the patient does not meet the level of care criteria for an inpatient admission or may be initiated by a care provider with concurrence from the UM reviewer.
2. A physician must concur with the UM reviewer's recommendation to convert the stay from inpatient admission to Observation. The physician's concurrence and justification for Observation level of care must be documented in the patient's health record before this conversion can be completed.
3. The correction of patient status from inpatient to Observation (which is an outpatient status) must occur prior to patient discharge or release, except in the event of clerical error. The following conditions must be met for retroactive correction of the Patient Treatment File (PTF):
 - a. Treating physician ordered observation status before discharge.
 - b. The PTF has not yet been completed and transmitted, i.e. remains in open status.
 - c. Less than 72 hours has elapsed between the time of discharge and time of PTF correction.
4. Patients placed in Observation status are assigned to one of the treating specialties listed in Appendix C, enabling the Department of Veterans Affairs (VA) medical facility to track the patients on the Gains and Losses (G&L). An Observation patient requiring subsequent admission would be 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 considered outpatient care. However, the term and process "Admitted to Observation" is used to create virtual non-count beds or status that address the (Veterans Information Systems and Technology Architecture) VistA limitation which prevents the electronic entry of orders for nursing care, pharmaceuticals, food, etc., when in an outpatient status).*
5. Patients "admitted" to outpatient same-day procedure units to facilitate treatment during the preoperative, perioperative, and postoperative phases of ambulatory surgery may be discharged and then "admitted" to Observation if they sustain a complication that requires an extended stay.
 - a. These patients must be "discharged and re-admitted" to Observation status and must be assigned an Observation treating specialty. If further hospitalization is required following the Observation period, the patient must be "discharged from Observation and re-admitted" to inpatient status. **NOTE:** *Utilizing this data report methodology enables data users to separate the activity of these patients for their purposes.*
 - b. For performance measurement purposes, patients converted from inpatient to Observation status will 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.

c. For reporting of health-care-associated infections (HAIs) related to performance measures, Observation patients will 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), *Clostridium 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.	<p>a. An Initial Assessment and 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.</p> <p>b. An extensive Emergency Department (ED) note or Progress Note, or Community Living Center (CLC) progress note documented by the admitting physician, encompassing the normal criteria for an H&P is sufficient as an initial assessment, and H&P for the Observation patient.</p> <p>c. 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 b. above is used for the initial observation care, an H&P is required.</p>

DOCUMENTATION REQUIREMENTS (DOCUMENT OR ITEM)	COMPLETION TIME	COMPONENTS OF DOCUMENT REQUIRED
Progress Notes	Within the Observation period or as clinically indicated.	<p>a. 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.</p> <p>b. Reassessments must include a plan for:</p> <ul style="list-style-type: none"> (1) discharge or transfer; (2) admission or readmission to inpatient status; or (3) continued Observation with evaluation and rationale.
Discharge Order	On Discharge	A timed and dated order for discharge from the Observation status.
Discharge Diagnoses	On Discharge	A complete listing of all final diagnoses including complications and comorbidities.
Discharge Note	On Discharge	<p>A summarization 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).</p> <p>NOTE: <i>This summary may be documented in the Progress Notes or dictated according to local policy.</i></p>

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 unit 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) Observation	1J	1150.00

NOTE: PTF Treating Specialty 1J is used for ED or Urgent Care Clinic (UCC) 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 medical provider may admit a patient to Medical Observation in the ED or UCC using treating specialty 24).