Status **Active** PolicyStat ID **13843919**

Garfield County Hospital District
Caring for Generations

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| Origination | 10/2012 |
| Last Approved | 06/2023 |
| Effective | 06/2023 |
| Last Revised | 08/2022 |
| Next Review | 06/2024 |
| Owner | Jayd Keener: DNS |
| Department | Acute Care |

# Acute Admission Criteria



## Purpose:

To establish standards for admission and discharge that meet the requirements of Medicare and render appropriate care to the individual and completion of appropriate assessments and care plans.

## Policy:

Hospital staff will follow the established guidelines for admission and discharge of patients.

GCHD admiting Doctors and providers will utilize the program Interqual via our Third Party Application site with in our Electronic Health Care Record System- Athena to enter the patients specific information.

- Interqual will determine if the patient meets criteria for OBS or Acute
- The admiting Doctor/Provider will either copy this information into their admitting note or will print the page with the information to be scanned into the patients chart so billing will have access to it at a later date if needed.

## Procedure:

Admission criteria are used to verify the medical necessity of any hospitalization. Medical necessity as defined by CMS means **the patient has a condition requiring treatment that "can only be safely provided in a hospital setting**". The following information outlines specific criteria that the GCHD hospital will adhere to.

**HOSPITAL PATIENT STATUS REQUIREMENTS:** Providers will determine a patient's status, in conjunction with input from the Nurse Manager or hospital Discharge Planner. This decision is based on the level of care that the provider believes or expects the patient will require during the episode of care; this status is documented by the provider in an order.

To determine a patient's status the admitting provider must:

- Assess the severity of the presenting signs and symptoms of the patient on presentation
- Attempt to predict the clinical course for the patient
- Estimate whether or not the patient's condition will require hospitalization of more or less than 24 hours
- Anticipate the intensity of services to be provided to the patient during the episode of care
- On presentation, order inpatient admission when the expected hospital care is 48 hours or longer **and** there is no less intensive setting available that will not be a threat to the safety or harm of the patient. Treat all other patients as outpatients, including outpatient observation.
- Patient status can be changed from outpatient to inpatient status: providers will use clinical judgment to determine if an outpatient should be transitioned to an inpatient stay due to care needed. **This requires a provider order.**

**Documentation required for admissions:**
**Providers must document the reason for choosing a patient status. Medical records may be evaluated to determine the consistency between the provider order (intent of admission) the services actually provided (inpatient or outpatient) and the medical necessity of those services. The documentation will be different for each patient, however both types of status require:**



- Provider order stating the patient status
- Treatment plan
- Documentation of allergies
- Medication history, medication reconciliation, and medication sheet, with diagnosis for each medication ordered.
- Emergency room documentation (if applicable)
- Provider readmission (readmission vs. admission-evaluation and assessment for direct admissions to outpatient observation)
- Medical necessity support in progress notes and response to treatment
- Discharge note and discharge instructions
- Rationale for change of status (if applicable)

The medical records should substantiate the care setting required, support the medical necessity for services provided and state the rationale to support the level of care ordered.

**OUTPATIENT STATUS: can be either outpatient status or outpatient observation status**

**OUTPATIENT/MEDICATION ADMINISTRATION ETC:**

Outpatients have orders for diagnostic testing or treatment that can be performed on an outpatient basis with an appropriate diagnosis/symptom to establish the medical necessity.

- Outpatient status occurs when a patient with a **known diagnosis** enters the hospital for a **minor procedure or treatment** that is expected to require a stay **less than 24 hours** regardless if a patient uses a bed.

- **Required documentation includes:**
    1. Face sheet
    2. Provider H&P
    3. Providers Orders
    4. Provider progress notes
    5. Provider orders: medical necessity of services ordered documented, such as observation, radiology, heart monitor, lab procedures and medication orders
    6. MAR
    7. Nursing Assessment Note
    8. Nursing notes **(must stay for monitoring for 20 minutes after injection/infusion, etc.**)
    9. Vitals
    10. Diagnostic test results
    11. Discharge summary/instructions

**OUTPATIENT OBSERVATION:**

Observation patients though classified, as outpatients are more complex than a simple clinical outpatient who is presenting for a diagnostic test such as a CXR, lab panel or blood count. Observation patients generally:



- Present to the hospital on an unscheduled basis (no planned procedure)i.e. through the ED.
- Arrive **without** a providers order for tests or services
- Present to the hospital with a condition or symptom requiring immediate treatment and/or further evaluation to decide if the patient needs inpatient services (if the provider anticipates on presentation that the services will not require constant monitoring or the intensity of the services provided with inpatient services).
- Involve patient specific services; not services that are part of a protocol
- Observation status does not generally **exceed 24 hours** but can be allowable up to 48 hours
- Observation hours begin when the patient is placed in the observation bed
- Observation hours end when the provider writes the order for acute inpatient admission or discharge
- **Required documentation includes:**
    1. Patient Face sheet
    2. Provider H&P
    3. Provider Orders
    4. Provider progress notes for each day of stay.
    5. Provider orders: medical necessity of services ordered documented, such as observation, radiology, heart monitor, lab procedures and medication orders
    6. POLST

7. MAR
8. Nursing Assessment Note
9. Nursing Care Plan - initiated on admission and completed within 24 hours.
10. Any change in the patient's condition shall require an immediate reassessment in "Flow-sheet" / "Head to toe" with changes in the plan of care (care plan) reflecting the change in condition.
11. Nursing notes
12. Vitals
13. Diagnostic test results
14. Discharge summary/instructions
15. Preferred wording is "Outpatient Observation Status"
16. Medically necessary reason for observation status that is strictly unplanned outpatient service. Order must be dated and timed.

**Examples of acceptable use of observation:**

- Patient with serious condition that can probably be ruled out in less than 24 hours or an identified medical condition that is likely to abate in less than 24 hours
- Patient with an unconfirmed acute diagnosis that will require more intensive service if confirmed
- Patient with a condition that requires further monitoring and evaluation to determine the appropriate diagnosis and the need for admission
- If observation is associated with another outpatient services (ED evaluation) **there should be a clear event or decision point that triggers an order of physical transfer to mark the beginning of the observation period.**



**INPATIENT STATUS:**

A patient is admitted for inpatient services based on the provider order and the expectation that the patient needs inpatient care.

- Provider expectation is **based on information available at the time of admission regarding the severity of the illness and the intensity of the services needed.**
- Inpatient status involves a complex medical judgment that is made after considering a number of factors including but not limited to:
    1. patient's history
    2. current medical needs
    3. severity of the signs and symptoms
    4. medical predictability of something adverse happening
    5. need for diagnostic studies to assist in assessing whether the patient should be admitted
    6. availability of diagnostic procedures at the time and location of presentation

7. The provider intent at the time of admission is controlling. If in the judgment of the admitting provider, a patient has an acute condition that requires treatment in an inpatient setting at the time of admission, the provider should document this in the medical record. If the patient responds more rapidly to treatment than was anticipated, this should be documented. The medical record documentation will allow an outside reviewer to determine what the provider was thinking at the time of admission and understand that medical necessity for inpatient admission was present.
8. patient leaving AMA
9. patient transfer
10. patient recovery in a shorter period of time

- **Time consideration:** The general rule is that the provider should order an inpatient admission for patients who are expected to need hospital care for 72 hours or longer and meet inpatient severity of illness and intensity of service.

**Documentation for inpatient status: (in addition to standards previously identified)**

- Patient Face sheet
- Provider H & P
- Provider order( is required documenting medical necessity of inpatient stay)
- **Preferred wording "admit to inpatient status". ** Inpatient status is based on the information available at the time of admission.
- POLST
- Provider progress notes for each day of inpatient stay
- Nursing Admission Note
- Nursing Care Plan **-** initiated on admission and completed within 24 hours.
- Any change in the patient's condition shall require an immediate reassessment in "Flow-sheet" / "Head to toe" with changes in the plan of care (care plan) reflecting the change in condition.
- Vitals
- Nursing notes
- MAR
- Diagnostic test results
- Discharge summary/instructions
- Transfer form (if applicable)
- **NOTE: Outpatient observation converted to inpatient must have a physician order to inpatient admission and documentation in the chart supports the acute condition that requires treatment that can be safely provided only in the inpatient setting**

**Appropriate use of inpatient status:**

- Patient requires services that can only be provided in an acute care facility and the patient's clinical presentation (i.e. severity of illness) necessitates the need for high intensity of service

with provider involvement with daily visits and close medical monitoring by health care professionals.

- Though a stay is less than 24 hours, the admit can be appropriate if it is reasonable for the provider to expect the presenting problem required more than 24 hours to resolve when the patient was admitted.

**Swing bed admission status:**

- See policy #11775267

**EMERGENCY DEPARTMENT:**

- Patient face sheet
- ED Provider Assessment
- Provider orders (should reflect medical necessity of hospitalization)
- Provider progress note
- Nursing Initial Assessment
- Home medications
- Diagnostic test results
- Transfer form (if applicable)
- Discharge summary/instructions



## Approval Signatures

| Step Description | Approver | Date |
|---|---|---|
| Medical Director Approval | Andrew Park: Provider | 06/2023 |
| CEO Mat Approval | Mat Slaybaugh: PT Manager | 06/2023 |
| DNS Approval | Jayd Keener: DNS | 06/2023 |
| Department Manager Approval | Jayd Keener: DNS | 06/2023 |