Measure Observation Rate

If you aren’t measuring – you can’t improve! So – the first step in improvement is to gather data about your observation process.

To calculate your observation rate, divide the number of observation patients by the total number of observation patients (plus) inpatient admissions.

There is not an absolute benchmark for observation rate – but the range is between 8% and 12%:

- Ralph Wuebker, MD, MBA, Vice President of Audit, Compliance and Education for EHR, states that the national average observation rate is between 8% and 12%.¹
- Credit Suisse conducted an analysis of observation services as part of its review of the lawsuit between two for-profit hospital chains. Based on American Hospital Directory data and its own estimates, Credit Suisse reported an observation rate of 11.8 percent for acute care hospitals in 2009.²

Once you have determined an overall observation rate, it is important to drill down to identify opportunities for improvement as the grid (on page 2) illustrates.

If your rate of observation for commercial payors is high, you may discover that they are requiring any hospital stay shorter than 48 hours to be automatically classified as observations. Or, you may find that the majority are Medicare patients placed in observation after outpatient surgery.

Pay close attention to the time (hours) in observation — this is usually an opportunity for improvement.

¹Ralph Wuebker during the April 5 HCPro, Inc., audio conference, “Short Stays: A Data-Driven Approach to Medical Necessity.”
²Summary of allegations in the complaint filed by Tenet Healthcare Corporation against Community Health Systems, April 11, 2011.
1. Trend your rate of observation over time by payor, diagnosis and length of stay.
2. Compare Observation rates with 1-2 day inpatient admissions.
3. Report number of Medicare and Medicaid observation patients to senior leadership daily.
4. Report observation data to UR Committee at least quarterly — and — preferably monthly.

Using Screening Criteria

Understanding the role of screening criteria is extremely important. According to Deborah Hale, President of ACS Consulting, “Many hospitals have found that about 25% of their inpatient admissions that don’t appear to meet criteria can be approved by a physician advisor — the only thing a case manager can determine is if the case appears to meet criteria. It completely takes medical judgment out of the mix.” Hale suggests that case managers should always consult a physician advisor when patients don’t meet inpatient criteria.

Other authors agree including Ralph Wuebker, MD, MBA, Vice President of audit, compliance, and education for Executive Health Resources. “Admission decisions based solely on a physician order can frequently lead to an overuse of inpatient and observation services depending on the medical staff’s regulation knowledge and bias. Most facilities have a solid Medicare review process that involves some type of review of the physicians’ orders. In many hospitals, screening criteria are applied to each case by a utilization review (UR) nurse or case manager to see whether the physician made the correct decision. Process problems tend to come up following this point. If a case does not meet first-level screening criteria, a facility must refer the case to a second-level physician review.”

There are companies that provide second-level physician review if hospitals do not have sufficient internal resources. These companies have a physician review the medical record for medical necessity and documentation. According to one HealthTech facility who is using one of the companies, it has significantly reduced the number of patients they place in observation.
Develop Protocols

Hospitals have utilized protocols and care paths for inpatients for many years. Their use for observation patients appears to be much more limited. Protocols for observation patients can significantly improve the process of rapid treatment and decision making — and can also help meet Medicare requirements for documentation. Common protocols include: Chest pain, Asthma, Dehydration, Hyperemesis, Renal Colic, Pyelonephritis, Rule/Out Appendicitis, and Syncope.

It is important to note however, that these should not be the same types of protocols used for inpatient admissions. These should be evidence-based protocols specifically focused on rapid treatment and decision making.

Clinical Decision Unit (CDU)

Separating observation patients from inpatients may provide more rapid treatment and decision making — as well as reduce cost. Deborah Hale states, “Opening up a clinical decision unit is a big move. Hospitals that previously determined that the benefit didn’t measure up to the cost may revisit it because of the RAC audits and other CMS crackdowns.”

Many clinical decision units are located within or adjacent to the emergency department and are managed by emergency department providers who are accustomed to rapid treatment and decision making. Other facilities have developed clinical decision units staffed by Hospitalist.

A good example of a Clinical Decision Unit, including guidelines, opened by William Beaumont Hospital can be found on the Robert Wood Johnson web site, www.rwjf.org.6

Hospitals considering opening a Clinical Decision Unit may want to complete a cost-benefit analysis. The following questions may be helpful as you start the analysis.

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1. Use appropriate screening criteria that is nationally accepted.
2. Apply screening criteria to 100% of Medicare patients.
3. Refer cases that need second-level physician review to UR physician.
4. Have more than one physician on staff that can perform second-level reviews.
5. Ensure that Case Managers are educated and knowledgeable regarding rules for observation for all payors – not just Medicare.
6. Educate Case Managers regarding their role and the role of medical necessity criteria.
7. Make review of observation patients A PRIORITY for case managers. (Time is $.)

1. Identify most common observation diagnosis.
2. Work with medical staff to develop evidence based protocols for each diagnosis.
3. Review and update protocols at least annually.
4. Measure effectiveness of protocols and report to UR Committee or appropriate medical staff committee.
<table>
<thead>
<tr>
<th>Question</th>
<th>Consideration</th>
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<tr>
<td>What types of patients will be placed in the Clinical Decision Unit (CDU)?</td>
<td>You should determine if you will place ALL observation patients — or only a subset.</td>
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<tr>
<td>What is the average number of patients that will be placed in the unit per day?</td>
<td>If a small number of patients, it may not be possible to staff the unit efficiently. However, this may be mitigated by what is “costing” the hospital to not have a dedicated unit.</td>
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<td>What space will be utilized? Is it in proximity to the Emergency Department?</td>
<td>The location of the space will also determine who is most likely to staff the CDU — i.e., ED physicians, Hospitalist or others.</td>
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<td>Which providers will staff the unit?</td>
<td>Consider if the physicians will require additional reimbursement for managing the CDU.</td>
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<td>Will there be any concerns on the part of community physicians?</td>
<td>Make sure issues are identified up front and you have the concurrence and support of the medical staff.</td>
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<tr>
<td>What are the costs of a separate CDU compared to the cost of placing observation patients on the same unit(s) as inpatients?</td>
<td>Staffing and other costs may be “less” in a CDU because the length of stay should be “shorter.” This should also decrease Medicare patients’ out-of-pocket expenses.</td>
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<td>What is the value of the additional in-patient beds?</td>
<td>For Critical Access Hospitals who are close to the 25-bed limit, removing observation patients from inpatient beds can increase capacity.</td>
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1. Complete cost-benefit analysis of CDU.
2. Review cost-benefit analysis with hospital and medical staff leaders.
3. Develop comprehensive guidelines for how the unit will operate prior to opening.
4. Educate medical staff and case management regarding the CDU operating guidelines.
5. Develop metrics regarding clinical and financial effectiveness of the CDU and report to the UR Committee and Administration on a regular basis.

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