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SUCCESS STORY | SEPTEMBER 2021

The inpatient vs. observation dilemma

A bundle of interventions decreased use of observation status.

By Mollie Frost

Where: *Seven nonprofit hospitals in Georgia, Illinois, Indiana, Maryland, Nebraska, New York, and Ohio with a range of 94 to 631 beds.*

The issue: *Reversing hospital financial losses due to overuse of observation status.*

Background

Many hospitals and hospitalists struggle with which patients to admit and which to observe. Several hospitals with higher than average use of observation status sought assistance changing that from Hospital Physician Advisors, a North Carolina-based consulting firm.

After digging into the seven hospitals' data, the consultants saw a clear solution. “We were surprised that a sizable proportion of [observation patients] could have been inpatient status if the documentation describing the clinical scenario was more clearly detailed, especially to explain why it might take a certain amount of time for the patient to become discharge-ready,” said Scott Dillon, managing partner of Hospital Physician Advisors.

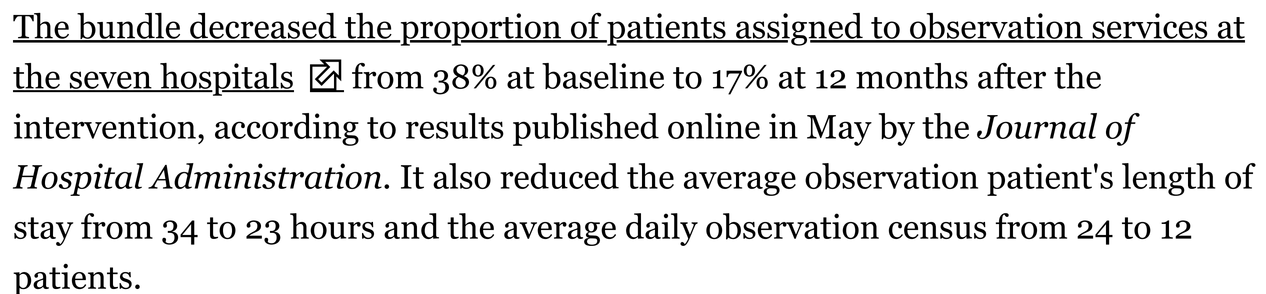
In response, the company in 2017 created a bundle of interventions that was implemented at each hospital. “The trends were fairly consistent across the hospitals and, within each hospital, persistent. It wasn't an erratic event that occurred for one year or one season,” said Amar V. Munsiff, MD, FACP, chief medical officer of the firm. “We eventually realized that it might be a similar problem at the hundreds of other hospitals.”

How it works

The most important component of the bundle is education, he said, as it establishes a common language among physicians, care managers, nurses, and utilization management staff regarding patient status, medical decision making, and the necessary documentation to justify the chosen patient status. At each hospital, the bundle included prompts to document patient status justification at the time of hospitalization, helping physicians to prepare responses to anticipated insurance denials.

"One of the things we do in our bundle is actually teach physicians how they *used* to do it. We all [provided more detail in documentation] in our training; it was required," said Dr. Munsiff, who is also a hospitalist practicing in New York. "That's how we learned to practice medicine and showed that we had learned, and we empower them to actually go back to doing it."

Results



The bundle decreased the proportion of patients assigned to observation services at the seven hospitals from 38% at baseline to 17% at 12 months after the intervention, according to results published online in May by the *Journal of Hospital Administration*. It also reduced the average observation patient's length of stay from 34 to 23 hours and the average daily observation census from 24 to 12 patients.

In addition, the accuracy of initial patient status assignment and medical necessity documentation increased while the proportion of hospitalized patients undergoing any status change during their stay decreased. The overall postintervention financial gain ranged from $2.5 million to $20.8 million per year.

The results were more impressive than expected, said Mr. Dillon. "We initially did not anticipate it would be as significant as it turned out to be," he said. "But in fairness, we also did not anticipate that the numbers of observation patients would be as high as we found in a number of hospitals."

Challenges

An initial challenge was physicians' lack of knowledge about the issue. "It is not too difficult because we are dealing with some of the most educated groups in the hospital that are used to continuing education," said Dr. Munsiff.

It does also take about five to 10 minutes to write the four to five sentences that serve as documentation to back up a decision, he said. “Administration in hospitals has to allow their medical staff to be staffed and have the time to do it,” Dr. Munsiff said.

Hospitals also needed help capturing relevant data from the electronic medical record (EMR). The consultants designed and built a dashboard on the EMR that provides real-time feedback on metrics of observation and patient status determination, such as length of stay, Mr. Dillon said. “It has the ability to drill all the way down to an individual physician.”

Words of wisdom

For hospitalists, the most important takeaway point is to make time to document their clinical thinking, including providing a reasonable estimate for how much time it will take to treat the patient to the point of discharge readiness, said Dr. Munsiff. Make the history of presenting illness (HPI) sufficiently detailed, as well as the assessment portion of the history and physical (H&P), he said. “With the advent of EMRs and emphasis on developing lists of billable diagnoses, we found relatively less documentation time available for the HPI and assessment parts of the H&P.”

Next steps

Moving forward, the consultants want to further quantify the relative impact of different aspects of the bundle on various performance metrics, such as accuracy of initial patient status choice, status conversion rates, and length of stay, Dr. Munsiff said. ◆

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