Decreasing the percentage of inpatients designated as "observational" contributed $900,000 to revenue in one year.

Improving The Bottom Line with Collaborative Change

THE CASE

This case study highlights a cross functional healthcare team that undertook a collaborative problem solving effort to standardize work around Pediatric hospital admissions. Optimal care of patients and care of the organization's bottom line mandates that the specialized knowledge and skills of nurses, physicians, administrators and multiple other professionals be integrated. This integration and powerful bottom line results were accomplished through a thoughtful, respectful and repeatable process.

OUTCOME SUMMARY

Within just months the solutions this team suggested and implemented led to an immediate 30% reduction in the percentage of patients incorrectly designated as "observational." Ultimately their focus on standardization brought clarity to the hospital and recouped $900,000 of lost revenue annually.

A true collaborative culture, supported by formal processes and structures emerged between administrators, physicians and other caregivers. This culture remains evident through the continued improvement in the incorrect

use of "observational" status, which continues to be driven down from 47% to 20%, on par with the National average.

Observational Status

The Medicare Benefit Policy Manual is surprisingly clear as to what constitutes "observational" status. Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients should be admitted to the hospital (inpatient) or discharged. In the majority of cases, this decision can be made in less than 48 hours, and often in less than 24 hours. Only in rare cases does outpatient observation services span more than 48 hours.

The difference between observation status and inpatient status in terms of billing can be substantial.

For the hospital to be reimbursed, observation services must be ordered by a physician or another individual authorized to admit patients to the hospital or order outpatient tests.

The difference in potential revenue for the hospital between "observational" status and "inpatient" can be substantial. If a patient is admitted but left under "observational" status many, if not all, services rendered during the patient's stay can be "left on the table" (i.e. written off as a loss), making this error very expensive.

Case Background

For our client, the number of pediatric patients designated as being in "observational" status was rising. Some 47% of all pediatric admissions were designated as being in "observational" status, compared to a national average of 20%. There was something of a benefit to this high rate, in that third-party payers were less likely to question billing codes resulting in a lower denial of payment rate. Denial of payment rates is an important metric for evaluating hospital administration. The low denial rates being established in pediatrics suggested not only that things were going well, but also that they were getting better. They were not; they were expensively worse.

The Team

Our consultants partnered to assemble a client team to analyze the problem, ensure that patient admissions were being accurately coded, and bring the hospital's observation/inpatient ratio closer to the national average. The team tasked with meeting this challenge consisted of the following:

- Two pediatric physicians (Sponsor)
- An administration representative (Sponsor)
- A hospitalist
- Nurses
- Unit secretaries
- Coding specialists
- A case management specialist
- A patient access services specialist

TEAM IMPACT

"This [deciding between Observations vs. Admission] needed to have that kind of multi-disciplinary team. We didn't realize that just getting the right status involved a lot of different people." ... MD

"I must admit that as a physician [I was] going happily through my life, not feeling any of the problems, but actually once we understood the impact on revenue, the correction of the revenue also meant correcting the processes. " ….MD

"I think the thing that got me was getting the front line people [involved]. There were some "aha" moments by physicians on the team. They didn't realize up until then, all of the work that was being done by these folks. And the front line folks didn't even realize they [the physicians] didn't understand their work." …RN

"At one point [the physician] was listening and she said, "Wow, I am the problem." And that was a powerful moment… This was happening because we don't communicate." …Hospitalist

Extensive evidence shows the negative impact of poor collaboration on various measurable indicators.

THE CHALLENGE

The Pediatric Hospital Medicine staff sought to diagnose the causes of the large difference between the hospital's observation rates and the national average. The sponsor and team chose to undertake an ambitious project to decrease the percentage of inpatients designated as observation status from the high of 47% to closer to the national average of 20%. The team was scoped to focus its study on the five most common diagnoses in pediatric patients: bronchiolitis, asthma, pneumonia, dehydration, and cellulitis.

The benefits the team anticipated included increased revenue through accurate billing; a boost in productivity due to decreased rework; increased patient and patient parent satisfaction, and decreased confusion for parents, patients, and the hospital staff and employees.

Extensive evidence shows the negative impact of poor collaboration on various measurable indicators including patient and family satisfaction, patient safety and outcomes, professional staff satisfaction, nurse retention and cost.[1]

SOLUTIONS

Following a thorough study of the issues, the team devised more than a dozen solutions. The three having the greatest impact were the following:

Solution 1

Criteria were established for assigning observation and inpatient status. These formal standards were derived from a set of evidence-based criteria for admitting and discharging patients devised by InterQual, a private-sector,

[1] Page A, ed. *Keeping Patients Safe: Transforming the Work Environment of Nurses.* Washington DC: Institute of Medicine Committee on the Work Environment for Nurses and Patient and Safety; 2003.

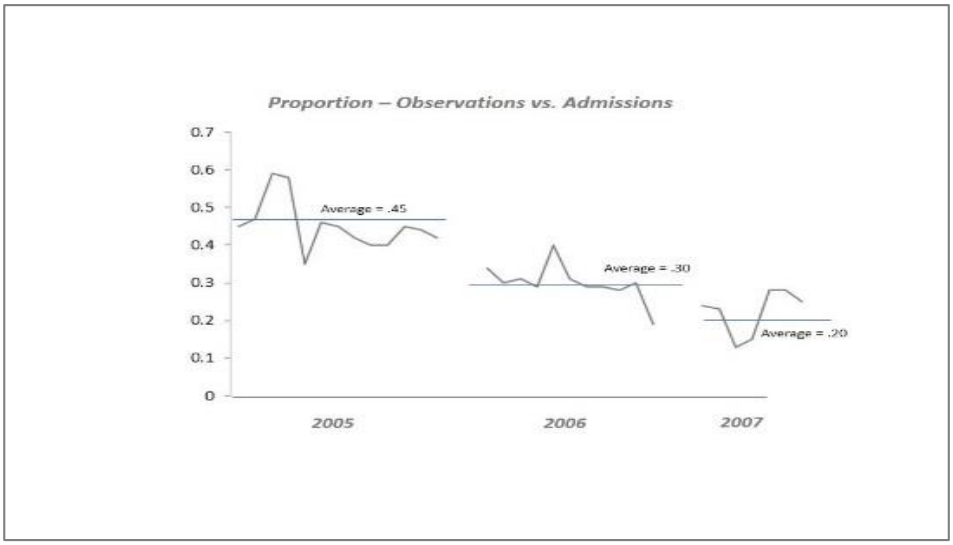
independent company. The criteria are now widely accepted by healthcare institutions.

Solution 2

The team devised reference cards that held diagnostic findings in sufficient detail to determine whether an individual should be assigned observational or inpatient status.

to incorporate other diagnoses for pediatric patients. The solutions led to an immediate 30% reduction in the percentage of patients designated as "observational."

Additional criteria were added when the program was shown to be effective and reduced the percentage of patients designated as observational to 23%.



Solution 3

A series of training programs to familiarize hospitalists and critical specialists with the nature and functions of the admissions criterion was developed.

RESULTS

The revenue obtained from this more accurate approach to status designation topped $900,000 annually. The success of this endeavor led to the establishment of a continuing training and education program and the regular assessment of patient assignment status. The program is being expanded

This constituted a 49% reduction from the initial rate of designation.

The reductions by disease category were as follows:

- Bronchitis, 28% to 16%
- Asthma, 30% to 23%
- Pneumonia, 26% to 14%
- Dehydration, 26% to 17%
- Cellulitis was an outlier with observational status increasing from 18% to 27%

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