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OBSERVATION METRICS

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In collaboration with the ACPA Observation Committee

1. INTRODUCTION

Observation services, often misunderstood as a status, hold a prominent role in hospital designations. The complexity of outpatient care with observation services has created some confusion in attempts to align observation services as a status by Electronic Medical Record (EMR) vendors to streamline designation and billing practices. The historical perception tends to label observation as unfavorable, contrasting with the perceived excellence of inpatient-level care, without due consideration for payer methodologies and performance drivers. This status determination for inpatient or outpatient with observation services has placed hospitals under stress even though the medical care provided to patients in either status is often indistinguishable.

This situation has led analysts, physician advisors, case management, and utilization management teams to grapple with the challenge of actively managing the observation-to-inpatient ratio, benchmarks, and conversions to ensure optimal hospital financial performance. While these metrics offer valuable insights that can impact performance and practice, they often face misalignment in benchmark comparisons and may fall short of accurately representing internal opportunities.

This white paper aims to revisit the original purpose behind the creation of observation services and establish standard definitions for commonly used observation and outpatient metrics, such as the observation-to-inpatient ratio. By doing so, it seeks to provide a comprehensive understanding of these metrics, shedding light on their significance and helping stakeholders navigate the complexities associated with hospital financial operations and operational workflows.

The value of accurate definitions and measurement of observation metrics helps align clinical and financial performance to accurately understand.

- Cost and Reimbursement
- Length of Stay and Resource Utilization
- Patient Care and Decision-making
- Regulatory Compliance
- Patient Outcomes and Quality of Care
- Capacity Management
- Provider Impact & Operational Workflow

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2. WHAT IS OBSERVATION?

There are likely many definitions for what observation is and is not, particularly when it comes to payer interpretive guidelines. However, CMS provides a clear definition of Outpatient Observation Services in the Medicare Benefit Policy Manual, Chapter 6- Hospital Services Covered Under Part B, 20.6 (2020). Observation is defined as a "set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment before a decision can be made regarding whether a patient will require further treatment as hospital inpatient or if they are able to be discharged from the hospital." The initiation of observation services occurs with a physician or authorized provider's order, per state licensure law and hospital staff bylaws. Services are continued until a decision is made to either admit, discharge, or end the observation period. According to CMS guidelines (2020), "the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours." In today's landscape with an increase in socially complex patients, there are instances where observation time ends prior to the patient being discharged. This would occur when all medically necessary services related to observation care are completed, however the patient may still physically be in the hospital due to avoidable delays, such as transportation or home care support arrangements.

The most common use for observation services is to evaluate patients who present to the hospital for the treatment of minor exacerbations related to chronic illnesses such as heart failure, asthma, or atrial fibrillation, however, require more time than an emergency room visit. Patients may also occasionally need observation services post-surgically due to complications requiring prolonged monitoring, such as: chest pain, syncopal episodes, new neurological findings, or uncontrolled pain (Ugarte Hopkins, 2023). MCG provides clarification around this time as "care that is provided beyond the emergency department (ED) care time frame (i.e., beyond 3 to 4 hours)" (MCG, 2023). Hospitals may choose to have designated units to provide observation services. However, patients can also receive observation services on other acute medical and surgical units located throughout the hospital, including in the emergency department.

Observation services are typically calculated by the hour to align with coding requirements HCPCS G0378 (hourly observation services) which is reported under the revenue code 0762. Pending the time, comprehensive observation services are reimbursed under C-APC 8011, averaging around $2,600 with price adjustments varying on hospital designations and location. Procedures with status T or J1 designation performed while the patient is under observation will be bundled and paid at the procedural rate, and sometimes lower than the amount provided under observation. The lower reimbursement of observation services compared to inpatients, with an average DRG reimbursement around $6,000 – $8,000, and the variability for potential patient responsibility, has exacerbated the growing concern around observation metrics.

Additionally, the use of observation services has increased significantly over the last decade while inpatient status has substantially declined. Outside of legitimate medical

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advancements in healthcare, payer practices and criteria guidelines have played a significant role in the decline of inpatient status determinations. In addition, in an attempt to standardize the use of observation services and decrease inappropriate utilization of inpatient status for short stays, Medicare released the Two-Midnight Rule in October 2013, resulting in an increase in short outpatient stays (Vulnerabilities Remain Under Medicare's 2 Midnight Hospital Policy (OEI-02-15-00020; 12/16) (hhs.gov)).

With the enrollee growth in Medicare Advantage (MA) plans, more patients are denied inpatient level of care until observation services are exhausted, leading to escalating concerns around often lower hospital reimbursement for observation services.

In April 2023, CMS stepped in to clarify Medicare Advantage plan behavior with the *2024 Medicare Advantage and Part D Final Rule* requiring MA plans to utilize and practice transparent and evidence-based clinical decisions that are consistent with traditional Medicare. This cultural shift, with legitimate concern, has raised concerns for observation metrics and how hospital financial performance is tracked.

3. OBSERVATION METRICS AND THE LACK OF STANDARDIZED DEFINITIONS

Origin & Definition

While there have been many attempts at defining the observation rate, the two most referenced are those by Dr. Steven Meyerson and Dr. Ronald Hirsch.

Dr. Meyerson (2013) proposes a method to calculate the observation rate by considering patients eligible for observation. The numerator includes patients with observation charges and emergency department (ED) charges, while the denominator comprises inpatient medical discharges with ED charges. Exclusions encompass inpatient surgical admissions, direct admissions to inpatient, and outpatient surgical cases admitted due to postoperative complications.

Conversely, Dr. Hirsch's proposed method (Hirsch, 2023), based on Medicare's claim data analysis from fiscal year 2021, yields a national average observation rate of 12.18%. In his method, the numerator comprises the number of C-APC 8011 claims, while the denominator encompasses the sum of C-APC 8011 claims and DRG payments. Exclusions consist of short observation stays, postprocedural (elective) observation stays, smaller hospitals with fewer than 50 beds, hospitals lacking C-APC 8011 claims, and non-Medicare claims.

Standardization Pitfalls

Common pitfalls to standardizing observation metrics include challenges related to population demographics, such as variations in patient demographics across regions or facilities. Payer mix and contractual agreements can also affect metric standardization, as different payer types may have varying reimbursement structures or requirements.

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Denials by non-Medicare plans when billed as observation, and state regulations, particularly those impacting Medicaid coverage, can introduce further complications. Additionally, the types of services available at a hospital, including those catering to obstetric, pediatric, psychiatric, or predominantly elective procedures, can influence metric standardization efforts. Outliers in observation stays, such as those lasting less than 8 hours or more than 30 days, pose challenges to accurate measurement. Finally, the availability of alternate levels of care, such as outpatient services provided in a hospital bed, can impact the standardization of observation metrics.

4. WHY THE EXISTING DEFINITIONS NEED STANDARDIZATION

Standardization is essential for several reasons:

Consistency: Standardization ensures that processes, procedures, and metrics are consistent. This consistency promotes reliability and comparability in outcomes and performance measurement.

Quality Improvement: Standardization enables healthcare providers to identify areas for improvement more effectively. By using standardized metrics and processes, they can track performance over time, benchmark against industry standards or best practices, and implement targeted interventions to enhance the quality of care.

Efficiency: Standardization can streamline operations by reducing redundancy, minimizing errors, and optimizing resource utilization. When everyone follows the same protocols and guidelines, there is less room for misunderstandings regarding key definitions.

Regulatory Compliance: Many regulatory bodies and accrediting agencies require healthcare organizations to adhere to certain standards and guidelines to ensure quality of care and patient safety. Standardization helps healthcare providers comply with these regulations more effectively and efficiently.

Metrics must be:

Measurable: Information collected should be pulled for relevant metrics

Accurate: Know your metric definitions

Current: Data should match the current healthcare landscape. Intervention factors should be incorporated into reporting.

Relevant: Reporting needs to tell a story

Actionable: Data should lead towards action

Shared: Information is meant to be shared for collective learning among stakeholders.

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5. PAST APPLICATIONS

The 2-Midnight Rule:

"The Centers for Medicare & Medicaid Services (CMS) implemented the "2-midnight" policy in October of 2013. The policy establishes that inpatient payment is generally appropriate if physicians expect beneficiaries' care to last at least 2 midnights; otherwise, outpatient payment would generally be appropriate." The implementation of CMS' 2-midnight policy is aimed to reduce short inpatient stays and long outpatient stays. A subsequent review by the Office of Inspector General (OIG) of claims from fiscal years 2013 to 2014 revealed notable shifts in stay durations. There was a decrease in inpatient stays alongside an increase in outpatient stays during this period. Specifically, short inpatient stays decreased by 10%, while short outpatient stays saw a corresponding 11% increase. However, the reduction in long outpatient stays was modest, only decreasing by 2.8%, indicating that many hospitals continued to bill for extended outpatient stays despite the policy change. (HHS OIG, 2016).

Cohort Study:

In a retrospective cohort study examining a 5% sample of Medicare patients nationally utilizing 2013 Medicare claims data, unsuccessful observation care stays were analyzed. These were defined by two main factors: Conversion to inpatient admission, accounting for 19.1% of cases, and observation length of stay (LOS) exceeding 48 hours, observed in 22.2% of cases. Several factors were identified as contributors to unsuccessful observation stays, including weekend admissions, specific disease diagnoses, and the need for post-acute services. These findings shed light on challenges within the observation care system and suggest areas for improvement in patient management and healthcare delivery strategies (Gabayan, et al, 2018).

6. TYPICAL OBSERVATION METRICS

- Observation/Outpatient Rate
  - Medical – Surgical
  - Diagnosis
  - Payer
- Length of Stay
  - Total hours
    - % of OBS patients discharged < 1 MN
    - % of OBS patients with stay > 2MN
  - Medical necessity vs throughput
- Status Conversions
- Observation Unit
- The proportion of OBS in the unit vs out
- LOS in OBS unit vs out
- The conversion rate in OBS vs out
- Transfers out of unit.

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7. A NEW CONSIDERATION FOR OUTPATIENT VS OBSERVATION RATE

With the advent of designations such as "outpatient in a bed," "extended outpatient," or "extended recovery," the need for a new metric has become evident. By solely calculating the observation rate, many hospitals overlook the true significance of what they are tracking. Instead, hospitals should focus on evaluating patients who are bedded, whether as outpatients or inpatients.

[This new approach does not come without its own advancements and limitations further explained below in the Table below.]

PROS	CONS
• Comprehensive evaluation of your total hospital occupancy by focusing on all bedded patients • Better assessment of resource utilization as "extended recovery" and "outpatient in a bed" patients also utilize system resources • Includes patients receiving observation services below the billing threshold • Translates simpler explanation for leadership who may be less familiar with billing policies	• Limitation of counter type based on health system electronic medical record • Makes comparison of "Observation Rate" across health systems more challenging • "Mixed" observation/outpatient rate • Excludes same-day surgery patients • May vary monthly (retrospectively) based on post-denial claim processing data resulting in encounter-type updates

8. NEW DEFINITIONS, PURPOSE, EXCLUSIONS, AND INCLUSIONS

Bedded Outpatient Ratio/Rate

DEFINITION	Number or percentage of bedded outpatients (OBS, extended recovery, custodial/social) patients compared to all bedded patients plus inpatients for total hospital census at time of discharge.
PURPOSE	Evaluating the percentage of patients being treated under outpatient status in the hospital versus the number of patients being treated inpatient. The ratio is not the anticipated daily rate, which does not factor in conversion numbers, but looks at the status the patient was in when they were discharged from the hospital.
INCLUSIONS	<u>Encounter level data</u> Bedded outpatients (OBS, extended recovery, and outpatient in a bed) ——————————— Numerator + Inpatient
EXCLUSIONS	Emergency services, outpatient same day procedures discharged from recovery, OB triage. If applicable inpatient psychiatric hospitalizations, inpatient rehabilitation facility, LTACH

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Length of Stay (LOS) – Medically necessary services

DEFINITION	LOS for observation hours is calculated from the time of the observation order to the completion of observation services based on medical necessity.
PURPOSE	The internal goal of LOS for observation patients is to examine the time it takes for the patient to receive observation services.
INCLUSIONS	Any patient receiving observation services in the hospital from a physician order (medical or surgical).
EXCLUSIONS	Active labor, hospice GIP/ respite care, and outpatient in a bed (social/custodial hospitalization).

Length of Stay (LOS) – Accessing Throughput

DEFINITION	LOS for observation hours calculated from the time of the observation order to patient departure.
PURPOSE	The internal goal of LOS for observation patients is to examine the time it takes for the patient to receive observation services AND utilize hospital resources.
INCLUSIONS	Any patient receiving observation services in the hospital from a physician order (medical or surgical).
EXCLUSIONS	Active labor, hospice GIP/ Respite care, and outpatient in a bed (social/custodial hospitalization).

Observation Unit – Fidelity Rate

DEFINITION	Number of patients that are outpatient w/ OBS services admit to discharge compared to total patients cared for in the unit at time of measurement.
PURPOSE	This metric evaluates the number of patients that align with unit designation to guarantee that only observation patients are treated in the observation unit.
INCLUSIONS	Level of care/status order Observation patients in OBS unit --- All patients cared for in OBS unit
EXCLUSIONS	Patients outside the observation unit.

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Observation Unit – Transfer Out

DEFINITION	The number of patients that start their hospital services in the observation unit and transfer out to another unit in this hospital.
PURPOSE	This metric evaluates the efficiency of observation unit criteria for placement and considers the resources that are involved in transferring a patient either laterally or to another level of care in the hospital. • This can be further subdivided into reasons for transfer (conversions, custodial, hospice).
INCLUSIONS	Level of Care/Status orders Patients with Initial OBS order placed in OBS unit that discharges from another unit --- All patients with an initial OBS order AND placed in OBS unit
EXCLUSIONS	Patients outside of the observation unit.

Observation Unit – Impact on total hospital throughput

DEFINITION	Number and % of patients that are managed in a given time for OBS services in the OBS unit compared to the rest of the hospital.
PURPOSE	This metric evaluates the number of patients that align with health system goals and unit designation to ensure the OBS unit is achieving its overall goal of alleviating throughput.
INCLUSIONS	Level of Care/Status Order OBS patients (discharged) from OBS unit --- OBS patients discharged from all units including OBS unit
EXCLUSIONS	Patients not discharged as OBS (Inpatient, extended recovery, outpatient in a bed, etc.).

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Conversions – Outpatient to Inpatient Conversion

DEFINITION	Number of patients that started as an outpatient (OBS, extended recovery, outpatient in a bed) order and changed to an Inpatient order at any point during the hospital stay.
PURPOSE	• Evaluate UM Initial review and secondary review processes, possible workflow opportunities. • Recommend analyzing by status AND hours. • Hours: If conversion occurs since initial order (< 8 hours, > 24 hours, >48 hours) which may highlight different opportunities of improvement. • Status: Elective procedure conversions could highlight scheduling and prior authorization opportunities.
INCLUSIONS	<u>Level of care/Status order</u> Patients with initial outpatient status (OBS, extended recovery, and outpatient in a bed) converted to inpatient in-house --- All patients with initial AND discharge outpatient status (OBS, extended recovery, and outpatient in a bed)
EXCLUSIONS	Patients who remain in the same status for the entire account.

Conversions – Inpatient to Outpatient Conversion Prior to Discharge

DEFINITION	Number of patients that started with an inpatient order and changed to an observation/outpatient order during the hospital stay prior to patient departure.
PURPOSE	• Evaluate UM Initial review and secondary review processes, possible workflow opportunities. • Recommend analyzing cases converted with and without UM committee input. • For elective surgery cases, could highlight scheduling and authorization opportunities.
INCLUSIONS	<u>Level of care/Status order</u> Initial inpatient status order patients converted to Outpatient in-house --- All patients with initial inpatient status order AND discharged with inpatient status
EXCLUSIONS	Missed Condition Code 44s if all criteria are not met at the time of discharge.

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9. CONCLUSION

To effectively manage healthcare operations, it is crucial to understand and actively apply key metrics that drive process improvement and demonstrate value for patients who are bedded, whether as outpatients or inpatients. We recommend taking the lead in collaborating with your analytics team to standardize measurement datasets, ensuring consistency and reliability across the organization. Clearly define your objectives and determine what needs to be measured, such as outpatient or observation rates, to ensure alignment with your hospital's goals.

Dr Meyerson (2016) proposes outpatient to inpatient conversion rates are a window of opportunity to learn about effectiveness of utilization management processes and physician performance. A high conversion rate could highlight inadequate utilization management reviews in the emergency room, or aggressive management of cases approaching second midnight or delays in care. Whereas a low conversion rate can also highlight inadequate utilization management processes or long observation length of stay. Instead of focusing on benchmarks, it is important to monitor the trends and identify the root causes behind the fluctuations.

Accurate reporting to the C-suite should be made a priority to facilitate proactive internal tracking and trend analysis. Teams can craft and deliver targeted messages that highlight areas for improvement and outline clear strategies for achieving them, thereby strengthening communication and alignment within the organization.

Understanding what to measure is fundamental, as it sets the direction for organizational progress. Knowing why these metrics matter to the organization's goals provides the motivation and clarity needed to align efforts with broader objectives. By focusing on the appropriateness of the status determinations, compliant revenue will follow.

Distinguishing between the relevant status designations with various transitions can improve the analysis to make standardized metrics more effective across hospital systems. Now is the time to drive these changes and lead your organization toward greater efficiency, enhanced patient care, and long-term sustainability.

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