OBSERVATION STATUS, SHORT-STAY INPATIENT ADMISSIONS, AND THE ROLE OF SENIOR LIVING IN ACUTE CARE TRANSFERS

The following is a case study described in a recent publication of the Center for Medicare Advocacy.

> *Eighty-four-year-old Nancy Niemi of North Carolina was hospitalized for 39 days earlier this year after her doctor sent her to the emergency room. It took weeks to stabilize her blood pressure and she experienced serious complications. But unbelievably, Ms. Niemi was categorized as an outpatient on "observation status" for her entire hospitalization, and she therefore lacked the three-day inpatient stay Medicare requires for coverage of her subsequent, very expensive care at a nursing home. Ms. Niemi's son tried to help her challenge her lengthy placement on observation status, but Medicare does not allow beneficiaries to appeal this issue. She still owes thousands of dollars to the nursing facility. (www.medicareadvocacy.org)*

An ongoing challenge for the elderly is the handling of their visits to a hospital emergency room. Many seniors visit an emergency department (ED) and, despite hours or in some cases days of monitoring and treatments received in what appears to be an inpatient bed, they come to learn that they were never admitted inpatient, but rather, were placed on "observation status," pending a decision to admit, which never materialized. There are still questions and debates about whether this wide-spread utilization strategy is a legitimate and appropriate use of scarce resources, or if it is simply a fiscal strategy to protect hospitals from Medicare denials and penalties for readmissions and other quality measures. The answer of course depends on one's perspective in the health care quadrangle. For policy makers and insurers, keeping patients on observation status saves money. Hospitals would likely prefer to admit a patient in many cases, but are not sacrificing much in utilizing observational status as they are reimbursed for "outpatient" services provided under Medicare Part B and there is less risk to the hospital to bill outpatient and avoid potential audits which could result in a denial of the claim for inpatient services, and a claw-back of payments.

The Hospital Patient's Perspective

For elderly patients, languishing in an emergency room (ER) and not knowing whether the stay is observational status or inpatient, poses significant financial risk as well as uncertainty and confusion. Extended outpatient stays in a hospital ED can increase the patient's cost-sharing obligations which co-pays are assessed for each service performed with no upward dollar limit; there is no Part B coverage for pharmacy services: and the most significant negative consequence of observational status and even short-stay inpatient (under two midnights) to elderly patients, is in receiving no Medicare coverage for a skilled nursing facility-SNF rehab because Medicare requires three days of inpatient treatment before it covers a SNF stay.[1] Nevertheless, patients seen under observation status often receive identical care as if they were admitted to the hospital. In fact, some patients admitted to ICU are kept on observational status for days. Complicating the observational status issue is the fact that inpatient admissions often coincides with functional decline, as well as

[1] N ENGL J MED 369: NEJM.ORG, Jul. 25, 2013

increased illnesses, dependencies and increased morbidities like falls or confusion.[2] Thus, the choice on whether to admit a frail senior is not driven solely by the bottom-line, and in some cases, depending on the patient's status, an inpatient stay might be disfavored by the patient.

The Primary Issue

Although observation status has produced unintended overuse detrimental to the elderly, Centers for Medicare, and Medicaid Services, CMS, continues to embrace extended observation as an appropriate utilization of resources. The CMS Policy Manual defines observation care as a "well-defined set of specific, clinically appropriate services, which include treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital…" Despite its support for observational status, CMS did receive a chorus of criticisms from providers and patients over the last decade highlighted by numerous of stories of elderly patients incurring thousands of dollars in nursing home bills without notice that their nursing home stay which followed an observational stay in a hospital lacked Medicare coverage.

In response to the chorus of complaints, CMS implemented the so-called "two-midnight rule" in 2014, to streamline the determination of whether a patient should be admitted as an inpatient or remain on observational status. Recently, CMS has issued a clarification to the two-midnight admissions policy and its corresponding use of observational status, in Guidance Transmittal number 234, dated March 10, 2017: following a 2014 final rule as pertains to observation status, "an individual becomes an inpatient of a hospital…when formally admitted as such pursuant to an order for inpatient admission by a physician or other qualified practitioner…": this inpatient admission is appropriate when the physician expects the beneficiary to require care that crosses two-midnights, and admits the beneficiary based on that expectation."

This clarification to the 2014 two-midnight rule does little to square the inequities such as increased cost-sharing caused to the elderly patients and did little to boost the confidence level of admitting physicians on when to admit patients whose chronic illnesses have become unstable. In fact, the two-midnight rule has gaps in real time execution: when assessing this time based admission criteria-two-midnights, the attending physician is precluded from counting time waiting to be seen, and cannot count triage activities. What this means to seniors is that when sitting and waiting to be seen, even though a nurse may have received biographical data and took vital signs, if the clock strikes midnight before being seen by the treating practitioner who will be determining whether to admit inpatient, the first day is yet to count toward two-midnights. As unreasoned as it sounds, elderly patients who time their ER visits several hours prior to the first midnight would increase the chances of being admitted.

The two-midnight rule now frames the admission decision as follows:

- ORDER: The order to admit must come from a qualified or licensed practitioner who has admitting privileges at the hospital and is knowledgeable about the patient's hospital course, medical plans of care, and current condition;
- CERTIFICATION: Physician certification is necessary for ALL inpatient admissions, signed and documented in the medical record:

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[2] Wilber ST, Blanda M Gerson, et al, Short-Term Functional Decline and Service use in Older Emergency Department Patients: Acad. Emerg. Med. 2010; 17; 679-686

- EXPECTATION: The ordering provider must expect that the patient will require care that crosses the two-midnights and if there is not that expectation, then order outpatient services:
- DOCUMENTATION: The provider is admonished to say I believe this patient will need to stay inpatient for two-midnights because… (then provides documentation on reasons such as risk of adverse event, assessment of services the patient needs, or co-morbid conditions):
- TIME CONSIDERATION: In evaluating the time needed for servicing the patient, the physician can consider the time in the Ed and observation to make the decision on whether the patient is likely to need services for two-midnights, but, this time in observation will not ultimately count as the needed inpatient time for the three-day requirement for skilled nursing facility benefits to be satisfied.[3]

What do Doctors & Nurses Think?

Not surprisingly, hospital employed physicians (hospitalists) have been highly critical of the observation stay policy and the two-midnight rule fix. The Society of Hospital Medicine Public Policy Committee, SHM, published a white paper July 2014, titled Observation Status Problem.[4] In it, hospitalists were asked to weigh in on the observation status conundrum through a 28 question survey. 93 % of respondents rated observation status as a critical policy issue and three major areas of concern were identified: 1.) the two-midnight rule and its failure on admission decisions: 2.) impacts on patients, including coverage and financial barriers: and 3.) impacts on clinical care and practice. One survey respondent summed up the two-midnight rule conundrum in stark terms:

"I am part of the utilization committee and serve as a physician advisor to help determine inpatient vs. observation level of care. I have received special training and still don't feel I have a good grasp on how to assign level of care for all patients".

SHM argues for better educating admitting physicians and patients about the admission criteria, while reforming the SNF admission rules and particularly the RAC audit system. Currently, RAC Auditors are reimbursed only when they claim error and claw-back fees paid to a provider. As such there is significant financial risk of loss if a physician admits a patient, and certainly, according to the SHM article, this concern skews admission decision-making. Not only do RAC audits leave physicians weary of admitting a patient for a short-stay, but the hospital's own utilization review committee is known to change a short-stay patient back to observation status. Another policy weighing on admission decisions is the Affordable Care Act's provision which penalizes hospitals for certain readmissions which occur within 30 days of discharge. Physicians historically certified the admission of patients using criteria for admission tools such as Milliman or Interqual. But, according to the American Hospital Association[5], RAC audits at hospitals which use these standard screening tools, had resulted in large awards to the auditors for admission errors. Thus, most hospitals have adopted their own systems to determine whether to admit or not which creates added confusion to patients who may have visited more than one emergency department. Because the two-

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[3] Report on Medicare Compliance, Vol. 22, Number 31, pg. 6, September 9, 2013

[4] White Paper, Society of Hospital Medicine Public Policy Committee, "The Observation Status Problem" , July, 2014

[5] American Hospital Association, Exploring the Impact of the RAC program on hospitals nationwide, March 2013:

midnight rule has left unresolved the inequitable treatment seniors receive when visiting the emergency department, criticism for it and for extensive use of observational status continues.

Recently, CMS implemented Notice of Observation Treatment and Implication for Care Eligibility Act (Notice Act). The Notice Act requires that hospitals provide written and oral notice within 36 hours, to patients who are in observation status together with reasons for why a patient is in observation status and potential financial implications. (This is referred to as the Medicare Outpatient Observation Notice-MOON) However, CMS specifically denies appeal rights to beneficiaries who are noticed that they are being held in observation status, even though there are financial consequences to the decision. Contemporaneously, Medicare patient advocates have been launching attacks on observation status and recently, the US District Court of Connecticut certified a class action suit for beneficiaries dating back to 2009, on whether they should be granted appeal rights when denied an inpatient admission.[6] This case could lead to a shake-up of the current rule but in the meantime, the question remains on how to safeguard the elderly from the negative impacts of the strategic use of observation status by hospitals. Moreover, there is concern shared by advocates that a victory by the plaintiffs in the Alexander suit will likely not end the observation status practices, particularly its disuse of nursing home rehab following a short-stay admission.

Regardless of how observational status policy is applied in the future, hospital systems are increasingly recognizing the need to improve emergency department care of elderly patients, while policy makers recognize the need to improve acute care transitions of elderly patients in all areas from first visit to post-discharge.

The National Transitions of Care Coalition, NTCC, highlights in a White Paper the inadequacies of acute care transitions particularly in the elderly population and offers recommendations for improving acute care transfer protocols. [7] The Paper presents several anecdotal stories to illustrate the challenges confronting the typical ED in handling the complexities of geriatric medicine in emergency departments. (p.4-5) Examples include a vignette of an older man with A-fib who is taking warfarin for stroke prophylaxis is hospitalized for pneumonia. His dose is adjusted upwards of double during the hospital stay and is not reduced to his usual dose prior to discharge. He was returned to the hospital within 2 days with uncontrollable bleeding. Another story was told of an older woman with dementia. When hospitalized she is taken off medication for dementia in part because the medication is not a hospital formulary, and the staff viewed her dementia to be too advanced to get positive effect from the medication regimen. Neither the patient's primary care physician nor caregiver were consulted prior to discontinuing her medication. (p. 5)

The article echoes the concerns of many stakeholders in stating: "health care professionals and government leaders are increasingly aware that improving the coordination of care among various settings could improve patient safety, quality of care, and health outcomes… (and, that) making such improvements is a challenging task, however, and will require significant and meaningful collaboration… (and, that) patients and their families and caregivers will need to take a more active role in their health care and facilitate communication during transitions". (P.5) The white paper emphasizes the need for improvement in communication during transitions between providers, patients, and caregivers as a vital element to a successful transition, as well as improved clinician training on how to execute effective transfers of older patients. (p. 11) NTCC encourages

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[6] Alexander V Price, 3: 11-CV-1703; formerly Barrows V. Burwell

[7] National Transitions of Care Coalition, Improving Transitions of Care, May, 2008

use of a standardized tool to facilitate the transfer of necessary patient information during transitions of care. (p. 15)

What do front-line nurses say about the care of older adults in emergency departments? In a study "Care of the Older Adult in the Emergency Department: Nurses views of the Pressing Issues[8], several themes emerged in surveys of emergency room nurses: lack of ED environments suitable for older adults, inadequate application of correct and best procedures and treatments, staff time to conduct thorough geriatric assessments, quality transitions, and lack of a safe and enabling environment. Many nurses surveyed complained that respect for elders was lacking and that communication barriers were a root cause. (p. 447) Nurses expressed concern about the elderly patients' ability to hear and understand the care instructions they need to follow when released. A second category of concern to nurses surveyed in the study was the lack of adequate information about the medical conditions, and medical histories of the patients. (p. 448) A third category of concern of nurses surveyed was inadequate support of decision making for the older adult patient. The category on transitions revealed concerns about unsafe discharges and ineffective handoffs. (p. 450)

Hospital emergency departments are also aware of the need to better address the special needs of older adults who appear in emergency departments. In 2012, CMS innovations award program allowed a demonstration project, the GEDI-WISE Project, to test the value of a dedicated geriatric emergency department like pediatric emergency departments which are now common. The past several years has seen growth in geriatric-focused ED's across the country, although most adaptations have been environmental-bedding, flooring, and focused on staff training to better address geriatric patients as opposed to the launching of a full-service geriatric ED.[9]

As part of the trend toward geria-tizing the ED, a consortium including the American College of Emergency Physicians, The American Geriatrics Society, Emergency Nurses Association, and the Society of Academic Emergency Medicine jointly published "The Geriatric Emergency Department Guidelines to guide the innovation and evolution of emergent care departments focused on the special needs of the elderly to address deficiencies in current care protocols. [10] The goal of the geriatric ED according to the consortium is to better recognize those elderly patients who will benefit from inpatient care, and to effectively implement outpatient care to those who do not require inpatient resources. A summary of recommended changes includes staffing the ED and inpatient setting with geriatric-trained providers, including physicians, nurses, and case managers along with implementation of a "geriatric performance improvement program"; and developing an arrangement to transition the elderly ED visitor to and a safe and effective care transitions protocol which will communicate the following:

- Presenting complaints
- Test results and interpretations
- ED therapy and clinical response
- Consultation notes
- Working discharge diagnosis

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[8] Gerontologist 2013, June:53 (3): 441-453

[9] Innovation in Aging, Vol. 1; Issue Suppl.-1,1 July 2017, pg. 111

[10] The Geriatric Emergency Department Guidelines, Copyright 2013

- Ed physician notes and copy of dictation
- New prescriptions and alterations with long-term medications
- Follow-up plan (p. 7)

The guidelines also note the importance of facilitating timely outpatient follow-up care with the patient's PCP and placement of vulnerable older adults into community-supportive programs such as senior living; (p. 10) and the guidelines recommend that ED's adapt policies and procedures to suit the unique needs of the elderly such as implementing a "Identification of Seniors at Risk Tool", drug sedation, screening for drug sedation, delirium, fall risks, and medication reconciliation. (p.17) The Geriatric Emergency Department Guidelines are strictly advisory and are by no means standard procedure at area ED's which continue to serve a very diverse population.

The Role of Senior Living

Senior living communities can and should prepare to play an important role at improving the acute care transfer process. Senior communities regularly send and receive residents to and from the emergency departments of hospitals, but, historically, there has been no standard practice of communication or transfer protocols established by and between the AL community and hospital staffs. Ideally, senior living organizations which know the residents' health conditions well, would collaborate closely with the ED staff when transferring a resident to the hospital, presenting medical history, baseline functional status, and the real-time clinical facts on why there was an acute change of condition. Not surprisingly, a chief complaint of the ED personnel as summarized in this paper, is the lack of adequate information about the medical conditions, particularly a baseline status of the patient, information which the senior community likely possesses. Collaboration between staffs seems to be a natural fit yet, an elusive goal as well.

While many senior living organizations view increased collaboration with health systems through a marketing lens-staff referral, and this is no doubt a reason for increasing collaboration with health systems, we at Stonebrook and Colebrook look more to the impact of acute care transfers on our residents' overall rate of satisfaction with their stay with us, and of the business risks posed when residents experience poor quality hospitalizations. Our communities expend much effort and resources on enhancing the quality of life and level of satisfaction of our residents as a sound business practice and out of care for ensuring that residents truly enjoy their residency. However, we like all senior living operators are not immune from the negative impacts of a low-quality hospital experience on a resident which transfer started with a 911 call from the senior community.

As outlined in this article, emergent care is not well designed to address the special needs of the population who typically reside in senior living. There is real risk that without senior community involvement, a resident referred out to the ED may incur unexpected costs from being treated in a prolonged observation status, or if admitted, could acquire a hospital borne illness, suffer further functional loss, cognitive decline, and be returned with a non-optimal care regimen which increases the likelihood of repeating the same negative experience upon re-hospitalization. In our view, when a resident's overall quality of life suffers, it will reverberate to the community even if the cause of the discontent was not directly connected to the residency. For senior living organizations and residents, negative impacts from acute care transfers from the initial decision to call 911 to the post-discharge care plan, may lead to premature move-outs, increases in staff time dealing with re-hospitalizations and poor-quality discharges, and reduced satisfaction with the quality of their stay in

senior living. While acute care transfers are a fact of life in senior living, the quality of those transfers and subsequent hospital experience is an area in which senior living can be a positive influence whether their input is valued within the health system.

Our executive management decided to take proactive steps to improve the acute care transfer process for residents in as much as we can influence those outcomes. Some key elements of our new initiative are resident education about the regulatory maze including the financial impacts when held on observational status, improving communication protocols with the hospital staffs for residents referred by us to the emergency departments, whether welcomed or not, and being more involved with their discharge process. More specifically, our community staff will review with residents whether the transfer to the ED if it remains an outpatient visit, will trigger cost-sharing obligations, discuss resident preferences for being held in observation or admitted inpatient, request clarification on whether the resident is being admitted or not, and monitor whether coverage exists for a skilled nursing placement for rehab. We have also equipped our community with the capability to handle most levels post-discharge rehab on-site so that residents who never cross the three-day threshold for rehab coverage at a SNF, can receive rehab services on-site at the community.

To enhance the communication protocols with ED staff, our communities implemented the INTERACT tool specifically modified so that our staff can present concisely to hospital staff, all facts which are or may be pertinent to the assessment of the resident's conditions, and decision on whether to admit or not admit the resident on an inpatient basis, including resident preferences, provider and medication lists, medical history, diagnosis, baseline physical and cognitive function, and a clear clinical picture as to what caused the acute change in condition. Our staff is admonished to be proactive in the discharge process, by asserting as much influence as they reasonably can pursue such as collaborating on the post-discharge care planning process, pre-arranging follow-up appointments with the PCP, and resisting returns to the community, when medical orders do not appear appropriate for our setting.

Nevertheless, our communities have designs to devise new initiatives which enable our staff to avoid calling 911 in response to some acute changes of condition experienced by a resident; instead we would refer a resident in distress to care pathways which are not in the first instance, the ED. A promising pathway our communities will explore is in partnering with primary care physicians' which practice and bill for chronic care services and which has capability in triaging residents of our community 24 hours a day whether in-house or through another ambulatory care center with which the PCP works. Our goal is to be able to work cooperatively with physicians who can direct staff on how to respond meaningfully to residents' acute change of condition whether within our community or at alternative sites than the ED.

Chronic care reimbursement although limited, does broaden the scope of physician-directed care to include a variety of non-face-to-face encounters with patients and by extension their caregivers, like the staff at an AL community, who can act for them, while avoiding in some cases the need to make an office visit. Billing codes including CPT code 99490 provides a time-based reimbursement to physicians who expend at least 20 minutes or more of clinical staff time per month when the management services are directed to a patient who has two or more chronic conditions expected to last at least 12 months or until death, and the conditions pose a risk of death, acute exacerbation, decompensation, or functional decline.[11] For complex chronic care, CPT code 99487 provides additional time-based reimbursement when performing services for patients with complex chronic illness, with additional time to be billed using CPT code 99489.

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[11] CMS Medicare Learning Network, Chronic care management Fact Sheet

Chronic care coverage is an important and underutilized benefit available to residents of senior communities because many residents have either chronic or complex chronic illnesses. The idea of devising cooperative relationships between resident PCP staffs, and senior living staffs to medicalize the nursing functions being performed within the community which can be paid for in whole or in large part by insurance, creates a new paradigm which can lead to even better care pathways for older adults particularly those residing in a senior living community. We at Stonebrook and Colebrook Village are actively pursuing cooperative working relationships with area physicians to operationalize chronic care oversight of residents on a continuous basis which system will allow the community to in some cases avoid the call to 911, and a resident visit to the hospital. However, our executive management is also interested in standardizing its communications protocols with area hospitals, so we can help improve our residents' hospital experience when it is unavoidable.

This white paper was written collaboratively by the staff at Colebrook Village and Stonebrook Village, and the in house counsel of Optimus Senior Management. For more information, call 860-801-1114 or 860-690-7660 respectively.