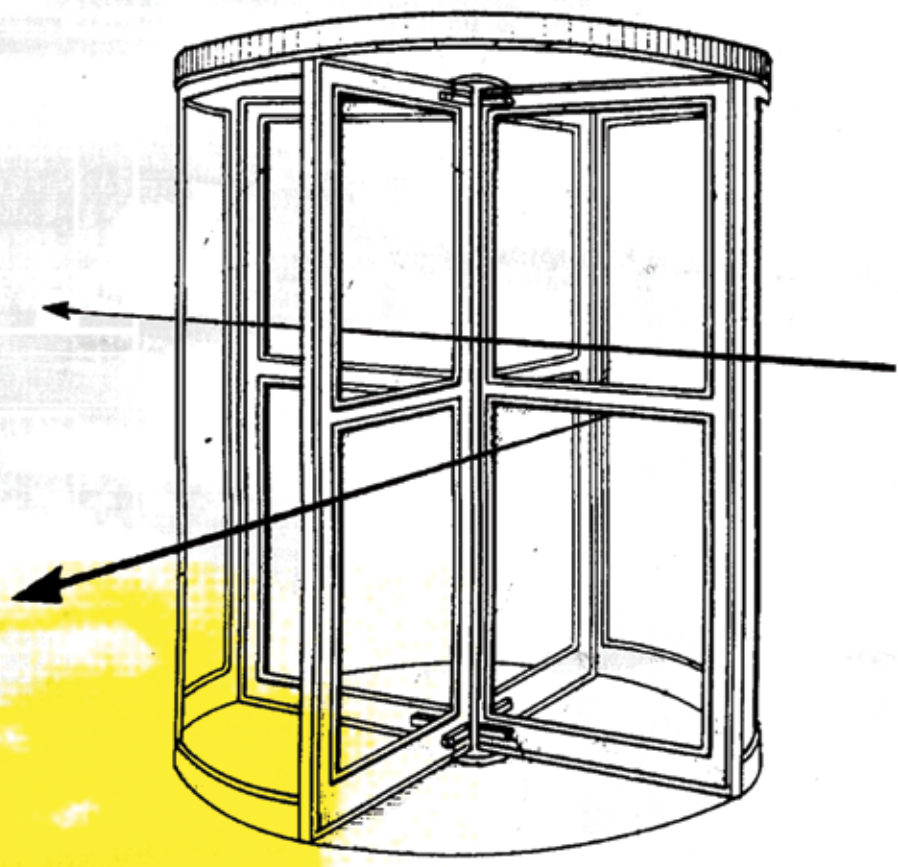# VALUE

OVER VOLUME

New Readmission Laws: Catholic Providers Are Positioned to Lead

BY HOWARD GLECKMAN

An 82-year-old woman who suffers from congestive heart failure and dementia was discharged a week ago from a local hospital to a nursing facility. But in the middle of the night, she spikes a fever and seems increasingly agitated. The nurse on duty suspects a urinary-tract infection, but when she calls the resident's primary care physician, he replies, "Just call 911. I'll see her in the hospital in the morning."

That story is, sadly, all too common. Almost 1 of every 4 Medicare beneficiaries who has transferred from a hospital to a nursing home is rehospitalized within 30 days, and as many as 60 percent of those readmissions are preventable. These events increase both risks to patients and costs to payers such as Medicare, Medicaid and managed care plans. As a result, nursing facilities are coming under pressure to reduce these events.

At the same time, however, hospitals and senior service providers may have access to new financial incentives and regulatory flexibility that make it possible to change the way they deliver care for vulnerable seniors and others with chronic disease. These opportunities may help reduce hospital admissions by improving care for at-risk patients, retraining staff, enhancing care transitions and developing new relationships with hospitals and other providers.

Meeting these challenges will be difficult, especially in what is already a demanding financial environment. However, the imperative for change will grow. For mission-based systems, the goal of reducing readmissions goes beyond payment rules or government regulations. It is not only good business practice; it is the right thing to do. As a result, mission-oriented Catholic systems are well positioned to take an industry lead in reducing readmissions.

In this environment, some facilities have developed models aimed at reducing hospitalizations, improving patient outcomes and both reducing

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costs and creating new business opportunities. In part, these changes stem from a growing recognition that hospitals are often not an optimal care environment for elderly patients who suffer from multiple chronic diseases. Risks of falls, infections and delirium are high. Multiple transfers from one care setting to another also increase the risks of medication errors and unnecessary or redundant diagnostic tests. In addition, hospitals are typically a higher-cost setting than are skilled nursing facilities

At the same time, nursing facilities with adequate, well-trained staff are fully capable of treating in-house many causes of routine hospitalizations — such as poorly managed congestive heart failure, pneumonia, urinary-tract infections and dehydration — with outcomes that are comparable to high-quality hospital stays.

THE READMISSION CHALLENGE

The numbers tell part of the story. In 2006, more than 419,000 Medicare beneficiaries discharged from a hospital to a skilled nursing facility were readmitted to the hospital within 30 days. The cost to Medicare of these readmissions exceeded $4.3 billion. The 2006 read-

mission rate of 23.5 percent represented a nearly 30 percent increase from 2000.[1] A substantial number of these hospitalizations are potentially avoidable, with estimates ranging from about 24 percent to as many as 60 percent.[2] For Medicare patients, the best-performing 25 percent of skilled nursing facilities have an average rehospitalization rate of less than 10 percent, while the worst average nearly 25 percent. Further, more than 900 facilities remained in the bottom 25 percent for three years in a row, while 326 were in the top 10 percent for three years running.[3]

Many studies also show wide state and regional variation. For instance, in 2006, 28.2 percent of skilled nursing facility patients were rehospitalized in Louisiana compared to just 15.1 percent in Utah and 15.7 percent in Vermont.[4] One-third of

dual eligibles — persons eligible for both Medicare and Medicaid — were hospitalized in 2005, whether they were living in nursing homes or receiving in-home care through community-based waver programs. More than 40 percent of these episodes — 380,000 — were deemed avoidable. Nearly 80 percent of the patients were hospitalized for one of five conditions: pneumonia, congestive heart failure, urinary-tract infection, dehydration and chronic obstructive pulmonary disease/asthma.[5] Nearly three-quarters of these hospitalizations involved patients from nursing homes.

New research suggests that patients with both chronic conditions and functional limitations are significantly more likely to receive hospital care than those with chronic disease only. While 20

CASE STUDY: WHEATON FRANCISCAN HEALTHCARE

Wheaton Franciscan Healthcare is an integrated health care system based in Milwaukee that comprises six acute-care hospitals, two specialty hospitals and three facilities that provide both post-acute skilled nursing and long-stay nursing care in southeast Wisconsin. In two cases, the hospital and skilled nursing facilities are on the same campus. Franciscan Woods is a 120-bed facility located at Wheaton Franciscan — Elmbrook Memorial Campus in Brookfield, where it is co-located with a hospital. In Milwaukee, the Terrace at St. Francis is an 81-bed facility located on the campus of Wheaton Franciscan Healthcare — St. Francis Hospital.

The hospital readmission rates from the Terrace and Franciscan Woods are already very low — averaging 9 percent in 2011. The system has set a goal of reducing those rates by an additional 10 percent in 2012.

Like most systems that have succeeded in curbing rehospitalizations, Wheaton has found no single magic bullet. Rather it relies on multiple tools, mostly aimed at improving communication — among nursing facility staff, between nursing home and hospital, between facility and patients (and their families) and between nursing home and

physicians.

Because Wheaton Franciscan Healthcare is an integrated system, it has been able to address the readmissions issue from both the hospital and nursing facility perspective.

In one key initiative, hospital and nursing facility senior staff meet regularly to share ideas and address concerns. These meetings are an opportunity for staffs to share best practices as well as to get to know one another in a noncrisis environment. Participants include medical directors as well as on-the-ground clinical staff such as emergency room and medical-surgical unit nurses and supervisors, hospital-based geriatric nurse specialists and directors of nursing and administrators from the nursing facilities.

Wheaton has found no single magic bullet. Rather it relies on multiple tools, mostly aimed at improving communication.

In an effort to create a smooth post-acute hospital discharge to skilled nursing, the system's skilled nursing facilities have embedded an admissions coordina-

tor at hospitals with which they share a campus. The coordinator works with the nursing and medical staff to learn about potential admissions in advance of discharge, and she often participates in developing a discharge plan.

At the same time, she provides key information about the patient's health status and care needs to the nursing facility's director of nursing so the facility can be better prepared for the admission. Finally, she shares information through an INTERACT (Interventions to Reduce Acute Care Transfers) communication tool with the discharging unit at the hospital.

Nearly a decade ago, the system adopted the Hospital End-of-Life Program (HELP), a package of low-tech interventions aimed at enhancing safety for older adults. Many of these efforts improve mobility, reduce the use of catheters and decrease medications that may cause delirium. These techniques have since been adopted in the nursing facilities as well.

In addition, the nursing facilities have initiated training through the NICHE program (Nurses Improving Care of Healthsystem Elders). Until recently, NICHE targeted this training to hospital-based nurses but it is now being implemented by nursing facilities as well.

percent of Medicare enrollees with three or more chronic conditions were hospitalized in 2006, more than one-third of those with both chronic disease and functional limitations were admitted for inpatient hospital care.[6]

Hospitalizations are a particular concern for nursing home patients and residents with dementia. A recent study of nearly 500,000 patients found that 19 percent of this population faced at least one burdensome transition in their last three months of life. Of these, 9 percent had multiple hospitalizations. Twelve percent were moved from one care setting to another in the last three days of life. Further, although 96 percent of family members reported that comfort was their primary goal of care for relatives with advanced dementia, only 73 percent of these patients had do-not-resuscitate orders, and fewer than 7 percent had do-not-hospitalize orders.[7]

As the elderly population grows older and sicker, home health care agencies and assisted living facilities are facing excessive hospitalization challenges as well. For example, 1 in 3 residents of assisted living facilities will visit the emergency department during the course of a year, and 1 in 4 will be admitted to the hospital.[8]

THE POLICY ENVIRONMENT

Policymakers have taken note of these high rates of readmissions both from facilities and from the community. As a result, an unprecedented series of regulatory and legislative initiatives adopted over the past few years is explicitly aimed at reducing preventable admissions. While much of

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The aim here is simple: If a patient is healthier and less debilitated when she is discharged from the hospital to the nursing facility, she is less likely to be readmitted. If she is mobile and active in the nursing facility, she is similarly less likely to be readmitted.

The system also is improving communication among nursing facility staff. Like many facilities, the system uses INTERACT tools to enhance these efforts. One recent initiative trained nurse's aides in recognizing symptoms and warning signs in congestive heart failure patients and taught them to quickly update RNs if they see a change in condition. At the same time, the initiative provided a refresher course to nurses on congestive heart failure care.

The nursing facilities also use the SBAR (Situation-Background-Assessment-Recommendation) tool, developed by the Arizona Hospital and Healthcare Association (www.azhha.org/patient_safety/sbar.aspx), to standardize information and communication among medical staff.

In the Wheaton system, if a patient has a significant change of condition, a nursing supervisor assists with direct care until the patient has been stabilized. Then the supervisor works directly with

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the attending physician to determine whether the patient can continue to be cared for in the facility or if she should be hospitalized.

The Wheaton Franciscan facilities, like many others, remain challenged on weekends, when readmission levels increase. In response, the system has increased training for weekend staff.

Another communications challenge focuses on outside physicians — often primary care doctors. As noted, clear communication between nursing staff and physicians as well as processes that increase physician confidence in the information they receive from nursing staff increase the likelihood that a change in medical condition is handled in the nursing facility.

Physician communication remains a challenge for the system. Because two nursing facilities share campuses with

hospitals, it is relatively easy for primary care doctors to visit their patients while they are being cared for in a rehab or post-acute unit. Still, many community doctors are not fully in sync with the facilities when it comes to patient care, readmissions and, especially, end-of-life care. Communication has been on a largely ad hoc, one-on-one basis.

Finally, the system is working to improve communication with patients and their families. Staff report that this is often their greatest challenge, especially with adult children whose parents are nearing the end of life. Many hospitalizations are initiated at the request of family members. The solution: Taking the time to build trust among facility staff, patients and their families. The system has found this easier to accomplish with long-stay residents but more difficult for post-acute patients, whose stays are shorter and who often have a limited relationship with facility staff.

In the Wheaton Franciscan system, reducing readmissions is a priority, and hospitalizations are monitored monthly. With 2012 readmission rates at 9 percent at Franciscan Woods and the Terrace, the system is making strong progress.

the attention has been focused on hospitals themselves, payment reforms are placing both direct and indirect burdens on nursing facilities as well. Some are coming in the form of growing market pressures, while others may be driven by regulation and payment rules.

While reducing preventable hospitalizations is important — and certainly will affect reimbursements — hospitalization rates are not a perfect predictor of patient outcomes.

In preparing for Medicare's financial penalties on excessive readmissions, hospitals are beginning to track admissions from specific nursing facilities. Their aim: Increasing discharges to facilities with relatively low rates of "round-trips," while cutting or even eliminating discharges to those with higher readmission rates. At the same time, the 2010 Affordable Care Act (ACA) and related regulatory initiatives are creating a wide range of new financial incentives aimed at rewarding nursing facilities for reducing rehospitalization of residents within 30 days.

Many of these incentives are linked to the ACA's focus on better integration of care among providers, including hospitals, home care agencies and nursing facilities. These integration models, including Accountable Care Organizations (ACOs), bundled payments, medical homes and other less formal relationships will be built upon the ability of each partner to provide optimal care at the lowest cost. One goal of all these arrangements is for nursing facilities to deliver high quality post-acute, rehabilitation and long-stay care in-house without the need to readmit to the discharging facility should a patient's health status deteriorate despite good care.

One government program allots a total $128 million to facilities that partner with hospitals, physicians' groups and others in evidence-based experimental programs aimed at reducing 30-day readmissions. The Centers for Medicare and Medicaid Services (CMS) reports that 1,800 operators have expressed interest in participating.[9]

Nursing facilities are likely to face growing direct regulatory pressures as well. Both President Barack Obama and the Medicare Payment Advisory Commission (MedPAC), an independent panel that advises Congress on Medicare issues, proposed penalties on skilled nursing facilities that would mimic the already-enacted hospital penalties. The MedPAC proposal was very specific and anticipated an eventual continuum of risk: Assuming that a readmission could be caused by a poorly coordinated hospital discharge, hospitals would continue to be responsible for readmissions within 30 days. Nursing facilities would be penalized for rehospitalizations after 30 days and for 30 days after discharge to the community from the skilled nursing facility. Putting providers at risk throughout the continuum, MedPAC argued, would encourage all providers to improve the quality of transitions.

The Obama proposal and MedPAC recommendations apply to Medicare admissions only. Thus, penalties would be imposed only on skilled nursing facilities where post-acute or rehab services are reimbursed by Medicare. They would not apply to residents of long-stay nursing homes, where payment is usually provided by Medicaid or private sources. However, it is quite likely that Medicaid would eventually adopt a similar requirement for long-stay facilities.

While reducing preventable hospitalizations is important — and certainly will affect reimbursements — hospitalization rates are not a perfect predictor of patient outcomes. In some cases, patients will receive more appropriate care in the hospital. Even some backers of current initiatives to reduce hospitalizations worry they will create perverse incentives for facilities and their staffs to keep a patient, even if such a choice may be detrimental to her health. Thus, avoiding problems in the first place is a critical goal. For example, while treating infections in-house at a skilled nursing facility may be important, preventing the infection is far more so. Thus, a key aim for nursing facilities is to reduce the acute episodes themselves.

CAUSES AND SOLUTIONS
What causes nursing facilities to send patients back to the hospital? There are many reasons, including: a lack of nursing facility resources, low levels of confidence in the quality of nursing facilities and their staffs by attending physicians and families, family dynamics, liability concerns, perverse financial and regulatory incentives, poor communication between nursing facility staff and

physicians and a lack of advance care planning and awareness of the patient's desires.[10]

Lack of resources: This may include insufficient or poorly trained staff; an absence of medical personnel, especially on nights and weekends; and delays in test results, either from in-house or outside labs. Facilities may also be limited in the care they are allowed to provide by the terms of their license.

In recent years, hospitals have been under tremendous financial pressure from Medicare and private payers to discharge patients sooner. As a result, skilled nursing facilities are caring for higher-acuity and more medically complex patients. While the new model presents financial opportunities for skilled nursing facilities, which can get significantly higher Medicare payments to care for these complicated cases, it is imperative that nurses and aides receive the additional training necessary to provide this care. Aides should be better trained to recognize changes in health status and communicate those changes. Improving this internal communication may also require significant change in institutional culture so that aides feel responsible for a patient, empowered to raise these issues and not fear they will be blamed if a patient deteriorates.

At the very least, coverage by RNs should be sufficient to manage the care of higher acuity patients. Several studies find that an RN staffing level of 30 minutes per patient, per day improves clinical outcomes and reduces hospitalizations.[11] It may be especially important to improve staff quality on nights and weekends, when physicians are frequently unavailable and staffing is often provided by part-timers and floaters who may not know the facility protocols or, more importantly, the patients themselves.

Nursing facilities may also reduce hospitalizations by increasing patient access to primary care doctors, physician assistants or nurse practitioners. In one study, for example, facilities with high rates of hospitalizations reported 30 percent lower patient involvement by physician assistants and nurse practitioners than facilities with low rates. Half of the facilities with low rates of hospitalizations reported a daily presence of a primary care physician, physician assistant or nurse practitioner, while none of those reporting the highest hospitalization rates relied on these health professionals on a daily basis.[12]

ArchCare, the New York Archdiocese's continuing care organization, has implemented such measures for some of its facilities, and Evercare, operated by United Health (and recently renamed UnitedHealthCare Nursing Home Plan), assigns a nurse practitioner to frail nursing home residents in an effort to reduce hospitalizations. One study finds the United Health initiative has resulted in a net savings of $103,000 per nurse practitioner.[13] However, it should be noted that these results are now nearly a decade old.

Negative perceptions: Regardless of the reality, physicians often perceive that nursing facilities are incapable of providing their patients with proper care, especially in a crisis. As a result, they routinely order the facility to send a patient to the emergency department in response to changes in health status. Similarly, family members may insist that a facility call 911 in the event of a fall or change of health status, even if a transfer is unnecessary.

In one recent study, one third of residents of skilled nursing facilities with heart failure were

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readmitted to the hospital within 30 days after discharge, and more than 79 percent were transferred within one hour after a change in health status. This suggests that either the facility's staff did not feel equipped to manage the patient's care — or the attending physician was unwilling to let them try.[14] These perceptions can be changed by a combination of high-quality care and better communications. Physicians will recognize enhanced resources and improved staff skills and are more likely to trust nurses with whom they have high-quality interactions.

However, nursing facilities may also need to undertake more aggressive marketing, such as meeting with local physician groups, inviting physicians to tour their facilities and engaging in cooperative training and resource-sharing sessions with local hospitals.

Liability concerns: Physicians may request that a patient be transferred from a nursing facil-

CASE STUDY: HEBREW SENIOR LIFE

Hebrew Senior Life is a large, integrated senior services provider in the Boston area. The provider has developed a multipronged initiative aimed at reducing hospitalizations. From 2008-2010, Hebrew Senior Life reduced acute-care admissions from its skilled nursing unit by about 20 percent. A second initiative, focused on avoiding rehospitalizations of discharged patients, appears to be successful as well, although data are limited. Hebrew Senior Life has now begun to expand its rehospitalization reduction program to its long-term care facilities.

Hebrew Senior Life offers a range of services, including rehabilitation and post-acute centers, long-term-care hospital facilities, a long-term-care nursing home, assisted and independent living, a continuing-care retirement community and subsidized housing with services. It is also a teaching affiliate with the Harvard Medical School, some of whose students, residents and fellows do geriatric rotations at Hebrew Senior Life.

The provider's Roslindale, Mass., campus includes 50 short-term, skilled nursing beds on the recuperative services unit, 46 post-acute beds on the medical acute-care unit (licensed as a long-term acute-care hospital) and 405 long-term care beds. A second campus in Dedham, Mass., includes an additional 48 short-term skilled-nursing beds, 176 long-term-care beds and 44 beds for residents with moderate to severe dementia.

Hebrew Senior Life's inpatient program has focused on the Roslindale 50-bed recuperative services unit, and it includes three important innovations:

■ A standardized admissions template for the admitting doctor

■ A palliative care consult at admission for any patient with more than three hospitalizations over the past six months

■ A 30-minute multidisciplinary staff conference to examine root causes of all rehospitalizations

The aim of this process is to better target care to the needs and desires of patients. In this way, Hebrew Senior Life believes it can not only improve the quality of a patient's stay but reduce hospitalizations and cut other costs.

The inpatient process at the recuperative services unit begins at admission. An admission template includes a goals-of-care discussion with the patient and her family, information on code status, medications and the number of hospital admissions within the past six months. A key question: Does the patient want to be hospitalized again?

If a patient has been hospitalized more than three times in six months, she automatically receives a consultation by a palliative care team that includes a physician, social worker and chaplain. On a typical day, 14 of 47 patients were receiving palliative care, significantly more than were on this service prior to the rehospitalization project.

The staff meetings, called Team Improvement for the Patient and Safety (TIPS) conferences, have been expanded to include other safety and quality issues as well. The goals of these sessions are similar to traditional root cause analysis meetings. However, the culture of the conferences is far more collaborative.

If a patient has been hospitalized more than three times in six months, she automatically receives a consultation by a palliative care team that includes a physician, social worker and chaplain.

At a typical 30-minute meeting, more than two dozen staffers, including physicians, pharmacists, nurses, aides and administrators, met to discuss a patient who had suffered severe and uncontrolled nosebleeds. The group first heard a brief presentation from the patient's daughter, then from the patient's nurse.

The meeting was facilitated by Randi Berkowitz, MD, the medical director of the rehabilitation services unit who designed the TIPS program. Staff at this meeting spoke candidly, without a sense of either hierarchy or defensiveness. The meeting was extremely goal-oriented: Where did the system fail and what specifically should be done to prevent a future occurrence? At the conclusion, the group agreed on a timetable for implementing changes.

While Hebrew Senior Life's research study did not attempt to unpack the individual effects of each of the three elements of the rehospitalization project, Berkowitz feels the palliative care program may have the biggest impact.

The provider has now extended its initiative into two other populations — long-stay residents and discharged patients. In the first quarter of 2012, Hebrew Senior Life took the first steps to expand this initiative to its nursing home population, including developing staffing and adjusting protocols.

In an effort to reduce rehospitalizations among discharged patients, Hebrew Senior Life has recently implemented the Re-Engineered Discharge program (RED) developed by a research team at Boston University Medical Center. The discharge program educates patients about their diagnosis, makes appointments for post-discharge follow-up, prepares a written discharge plan for the patient and transmits the discharge summary to the patient's clinicians. In addition, skilled nursing facility staff contact the patient after discharge to help with any problems or compliance issues.

While RED was initially created for hospital discharges, Hebrew Senior Services has adopted it for its nursing facilities as part of a demonstration project. After 30 days of discharge to home, hospitalizations for the first 50 patients declined from 17.4 percent to 13 percent. The percentage of discharged patients who visited their primary care doctor as prescribed rose from 46 percent to 73 percent.

ity to an emergency department in response to their fear of liability, and facilities may comply as a result of their own legal concerns — even if both believe such a decision is not necessarily in the best interest of the patient. Better and measurable quality of care at the nursing facility and communication will improve physicians' perception of quality. Combined with better documentation of patient wishes, these steps could reduce, though not eliminate, liability issues. Some tort reform aimed at limiting doctors' malpractice liability is possible in the coming years as well.

Perverse financial and regulatory incentives: Despite the new readmission penalties, the health care payment system remains filled with incentives that encourage hospitalizations. For instance, Medicare often pays physicians more money when a patient is in the hospital. Physicians can bill for short visits (which may also be more convenient if a physician has multiple patients in the same hospital) and they can perform more billable procedures. A nursing facility, for its part, may benefit financially by hospitalizing a Medicaid long-stay resident and recoding her after a three-day admission as a Medicare rehabilitation or post-acute patient, for whom reimbursements are far higher. In a practice known as the churn, some facilities do this repeatedly, generating significant concern from Medicare.

A facility may also send out medically complex patients on Friday afternoons if it believes it will be short-staffed on weekends. These choices may be encouraged by Medicaid bed-hold rules that allow the program to pay nursing facilities to keep a bed open for a hospitalized resident. Many of these regulations are inconsistent with the government's stated goal of reducing hospitalizations, and these rules are likely to be adjusted in coming years. Already, for instance, Medicare is aggressively reducing hospital admissions by redefining many of these stays as "observation status." Observation stays do not qualify a patient for Medicare skilled nursing benefits.

Poor communication among health professionals: This issue is often cited by physicians when describing phone calls from nursing facilities. If a nurse is unable to describe a change in a patient's health status in a clear, concise way, physicians say they are far more likely to order a 911 call. Conversely, when the nurse is able to articulate changes clearly and professionally, the

physician is more likely to order treatment in the nursing facility. There are a number of tools now available to improve this communication. One of these, known as INTERACT II (Interventions to Reduce Acute Care Transfers), has been adopted by many Catholic health systems. This package of

The INTERACT II package of tools is specifically designed to reduce the number of transfers from nursing facilities to acute-care hospitals.

tools is specifically designed to reduce the number of transfers from nursing facilities to acute care hospitals. It helps staff recognize and evaluate changes in a patient's condition, communicate those changes to appropriate medical personnel and guide treatment. In addition, it includes tools aimed at improving transfers that do occur and providing for later review of those transfers. (For more information, see www.interact2.net).

Although nursing facilities have been generally positive about the benefits of INTERACT II, some administrators have noted some flaws. For example, Anthony Lechich, MD, the medical director at ArchCare's Terence Cardinal Cooke Health Care Center, which was an early adopter of INTERACT, notes that the system requires constant training and an in-house champion to assure that staff adheres to its protocols.[15]

Electronic medical records and electronic ordering also have the potential to improve communication. However, due to persistent interoperability problems, digital systems frequently are unable to communicate with one another. As a result, even when providers are all using electronic medical records, transitions may still result in critical information being lost or delayed. For instance, systems still struggle to track prescriptions from community physician to hospital to nursing facility and back to hospital.

Finally, standardized discharge and admission documentation across settings provides another opportunity to avoid transition errors. For example, the CARE item set, being developed under the guidance of CMS, is a collaborative attempt to standardize measurement and rating scales so assessments can be common for all care settings.

Lack of awareness of the patient's desires: Patients may often be hospitalized even though they do not want to be, due to a lack of advance

care planning. Early palliative care consults; ongoing conversations among staff, patients and their families; and improved education may all improve communication regarding this critical issue.

Hebrew Senior Life in Boston has taken a lead role in using these techniques as part of an aggressive initiative to reduce hospitalizations. Its strategy includes a palliative care consult at admission for patients with a history of multiple hospitalizations as well as regular consultations with patients and their families throughout the course of their stay.

Patient wishes may also be clarified by the growing use of Physician Order for Life-Sustaining Treatment (POLST) forms. These documents are now available or in development in 34 states and provide a standard method for patients with chronic or terminal disease to make their care wishes known. Unlike other advance directives, POLST forms are signed by health professionals after consultation with patients and their surrogates. In some states, nursing facilities are now required to prepare a POLST form for all patients or residents (some jurisdictions refer to these as MOLST — Medical Orders for Life-Sustaining Treatment).

OBSERVATION STATUS? IMPLICATIONS ARE BIG

When is a hospital stay not exactly a hospital stay? When someone receives hospital services under observation status rather than as an admitted patient.

It is a complicated concept for patients, and even some physicians, to understand. A patient lies in a bed in a hospital. She receives care from hospital staff, visits from her attending physician along with tests, medications and food from the hospital. Yet she has not been admitted and is considered an outpatient. It is even more confusing when someone is changed from admitted to observation status during her stay.

A typical case might involve an elderly patient with chest pain. A decade ago, after coming into the emergency room, she might routinely have been admitted until she was ready to go home. Now if she stays at the hospital, it is increasingly likely she will do so under observation status.

According to a 2012 study, the ratio of observation stays to inpatient admissions grew by more than one-third from 2007 to 2009, from about 87 observation stays per 1,000 admissions to nearly 117. In 2009, about 1 million patients were kept under observation, and they remained for an average of 28 hours.[1]

The growth in observation status is being driven largely by Medicare payment rules, many of which have now also been adopted by managed care companies. Observation dramatically reduces Medicare costs in two ways: First, its reimbursement for the hospital stay itself may be significantly lower (20 percent lower in many cases, though this varies widely depending on the patient's diagnosis). Second, it allows Medicare to avoid paying for post-acute care or rehabilitation services in a skilled nursing facility, which are reimbursable only if a patient has first been admitted to a hospital for at least three days. Because observation status is not an admission, Medicare is not obligated to pay for these additional post-discharge services.

Medicare rules provide only very general guidance for when to admit and when to keep a patient under observation. While Medicare says it relies on a physician's clinical judgment, hospitals complain the audit process too often controls whether a patient should be admitted or not.

Both providers and some patient advocacy groups strongly oppose the rules, arguing that they compromise care. Consumers sued to challenge the impact of observation status on the three-day Medicare rule, but the practice was upheld by a federal appeals court in 2008.[2] A second case, Bagnall v. Sebelius, was recently brought by the Center for Medicare Advocacy and is now pending in district court in Connecticut.[3]

In addition, bills to require Medicare to count all time in a hospital towards meeting the three-day rule are pending in Congress but have not been acted upon.[4]

Despite the opposition, the growth of observation status has dramatically changed the old practice of patient admissions. Medicare rules generally allow a hospital to keep a patient under observation status for up to 48 hours, although stays may be as long as long as 72 hours. Managed care companies generally permit up to 24 hours of observation before a hospital must decide whether to discharge or admit.

It is important to note that a patient kept under observation status is not considered an admission for the purposes of Medicare's new penalties for excessive rehospitalizations.

— **Howard Gleckman**

NOTES
1. Zhanlian Feng, Brad Wright and Vincent Mor, "Sharp Rise in Medicare Enrollees being Held in Hospitals for Observation Raises Concerns About Causes and Consequences," *Health Affairs* 31, no. 6 (2012): 1251-59.
2. *Landers v. Leavitt* 545 F.3d 98 (2nd Cir. 2008).
3. www.medicareadvocacy.org/medicare-info/observation-status/ending-hospital-observation-status/.
4. *Improving Access to Medicare Coverage Act of 2011*, H.R. 1543, 112th Cong., 1st sess. (April 14, 2011) http://thomas.loc.gov/cgi-bin/bdquery/z?d112:h.r.01543:.

Evidence suggests that POLST and MOLST may be valuable tools to help drive conversations about aggressive treatment options and clarify a patient's wishes. It may also help protect facilities from legal liability in the event a family member litigates following the death of a patient or resident.[16] However, the documents have generated some controversy among Catholic ethicists.[17]

Poor Discharges from the Hospital. Nursing facilities cannot solve the problem of unnecessary rehospitalizations alone. Hospitals themselves will play a critical role, in large part by improving their own discharge planning. Some acute-care hospitals are beginning the discharge process at admission, giving staff more time to identify the most appropriate setting for discharge. Discharge planners are being given more resources and training, more time to learn about community facilities and new tools to both smooth discharges and track post-discharge compliance.

Tools include BOOST (Better Outcomes for Older Adults through Safe Transitions) and Project RED (Re-Engineered Discharge). BOOST relies on checklists, screening tools and enhanced documentation to reduce readmissions.[18] RED relies heavily on patient education and personal assistance with post-discharge compliance.[19] The Wheaton Franciscan Healthcare system in Milwaukee uses a modified version of BOOST to help coordinate discharges from its hospitals to its nursing facilities. Hebrew Senior Life is beginning to use RED for its own nursing facility discharges to the community.

Systems that include acute care, post-acute care and senior services have good potential for building collaborative programs aimed at improving care across the continuum, including transitions. The Wheaton Franciscan system, for instance, is taking steps to improve access to medical records for patients who move between settings, with a particular focus on medication reconciliation. This system has also begun a series of hospital and nursing facility staff meetings aimed at breaking down care silos. Covenant Health Systems in Tewksbury, Mass., is striving to improve communication among its facilities. For instance, at the request of hospital staff, its skilled nursing facilities have revised protocols for doing urinalysis to assure faster and more accurate test results.

These efforts also make it possible to improve communication among unrelated facilities. ArchCare's Terence Cardinal Cooke Health Center,

a continuing care facility in New York City, has developed a high-level collaboration with Mt. Sinai Hospital, a large neighboring, but unaffiliated, hospital in Harlem. This partnership is aimed at improving transfers between the two facilities and includes regular meetings of a joint management committee that consists of clinicians and senior staff from both organizations. In addition, the Cardinal Cooke Center has assigned a liaison nurse who is physically located at Mt. Sinai to help manage transitions from the hospital to the nursing facility.

While the ACA is encouraging broader, more far-reaching relationships, such as in ACOs, Catholic systems that offer a continuum of care are well positioned to build collaborations within their organizations without making major changes in payment structures. However, in some cases, this may require significant accounting adjustments that recognize who gets 'credit' for the financial benefits of these initiatives.

Within the current payment structure, providers are adopting delivery systems that make fully integrated care feasible. For instance, ArchCare operates as an Institutional Special Needs Plan (I-SNP) for more than 1,000 long-stay nursing homes residents who choose to participate in this managed care option. Through the managed care structure (called ArchCare Advantage), the system is able to assign nurse practitioners and physician assistants to these long-stay residents. The nurse practitioners and physician assistants work closely with residents, families, nurses, aides and primary care physicians to assure that the care plan is properly followed and to monitor changes in a patient's health status.

> **Catholic systems that offer a continuum of care are well positioned to build collaborations within their organizations without making major changes in payment structures.**

ArchCare reports that the combination of INTERACT II and the managed care program has sharply reduced hospitalizations. Eighty-six percent of the program's participants were never hospitalized in 2010, compared to about 47 percent of nursing home residents in fee-for-service Medicare.[20]

Overall, ArchCare reports that its hospitalization rate fell from 3.3 percent in 2010 to 2.7 per-

cent in 2011, as measured in hospitalizations per patient days.

CONCLUSION

Whatever the organizational structure of a health system, many of these reforms will cost money. More staff, better training and use of new technologies all require up-front investments. In addition, because the current payment system continues to reward facilities for certain rehospitalizations despite the regulatory push to discourage them, some nursing facilities will lose short-term revenue.

While both up-front and opportunity costs are real, systemwide cost savings remain largely hypothetical. Some studies do show savings, but evidence remains limited to small demonstrations. However, the cost equation may change as both Medicare and Medicaid shift to managed-care designs or even to fully capitated systems.

The ACA includes several initiatives, including the Medicare Shared Savings, value-based purchasing and bundled payments that are all also aimed, in part, at reducing rehospitalizations. More formal ACOs will also change payment mechanisms in ways that may create new financial incentives for nursing facilities to provide quality care in-house rather than sending patients back to the hospital.

Reducing readmissions is not simple. There is no single, silver-bullet solution. But better training and improved communication are keys to achieving both fewer transitions back to the hospital and, most importantly, better patient outcomes.

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NOTES

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