OBSERVATION CARE: NAVIGATING THE CHALLENGES OF OUTPATIENT HOSPITAL STAYS

ANTHONY ROSANIA | Healthcare Consultant; M.D.; M.H.A.
KATHLEEN SCHWARZ | Senior Healthcare Consultant; R.N.; M.P.A.

OBSERVATION CARE: NAVIGATING THE CHALLENGES OF OUTPATIENT HOSPITAL STAYS

ANTHONY ROSANIA | Healthcare Consultant; M.D.; M.H.A
KATHLEEN SCHWARZ | Senior Healthcare Consultant; R.N.; M.P.A.

OBSTACLES ASSOCIATED WITH OBSERVATION CARE

Observation care within U.S. hospitals has increased rapidly over the past two decades as the Center for Medicare & Medicaid Services (CMS) and private health insurers look to control the costs of short-term hospital stays. Today patients in observation care can represent up to 25 percent of hospitalized patients, up from an average of around 3 percent as recently as 2006. CMS defines observation as a "well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital." Originally this translated to the care of patients who required fewer than 24 hours in the hospital. Further cost-cutting pressures, such as the "two-midnight" rule, have resulted in observation care being expanded to include patients who require up to 48 hours of additional assessment prior to admission or discharge. The continued growth—and push—to place patients in observation care has created numerous challenges for hospitals, staff and patients, including:

Lower Payments; Similar Costs: As observation care is considered outpatient treatment, insurance reimbursement is significantly less (often less than one-fourth the amount) than for admitted patients. Yet the cost of care for observation patients is not automatically lower than the costs of patients who've been admitted to the hospital for inpatient care. Over-utilization of observation thus can lead to a large underpayment unless hospitals and health systems undertake efforts to reduce the overall cost of care. Likewise, hospitals must be careful not to utilize observation as a substitute for a good appeals process.

Medical Staff Stress: Twenty years ago, many of the patients who are today under observation care would simply have been admitted to the hospital. Now, as admission criteria become more stringent, the distinction between inpatient and observation care forces hospitals to "roll the dice" on short-stay patients. Should an admitted patient recover and be discharged prior to "two midnights," a hospital runs the risk that Medicare will deny the patient's claim, regardless of the resources utilized, forcing the hospital to eat the costs of treatment for that patient. On the flip side, a hospital can spend far more than what it is reimbursed for observation patients who require specialized care and/or remain hospitalized for longer than 24 hours.

Patient Misunderstanding: Many patients have the misconception that observation units provide a lower level of care—at a higher price—compared to inpatient care. While this may have previously been the case, it's not necessarily true today. Observation units typically have higher nursing ratios than inpatient units, and patients under observation care have been shown to have better health outcomes. The introduction of bundled payments for services (the CMS's comprehensive ambulatory payment classification, aka C-APC) has also significantly reduced patients' out-of-pocket expenses for observation care. Still the stigma exists that observation is "lesser" care.

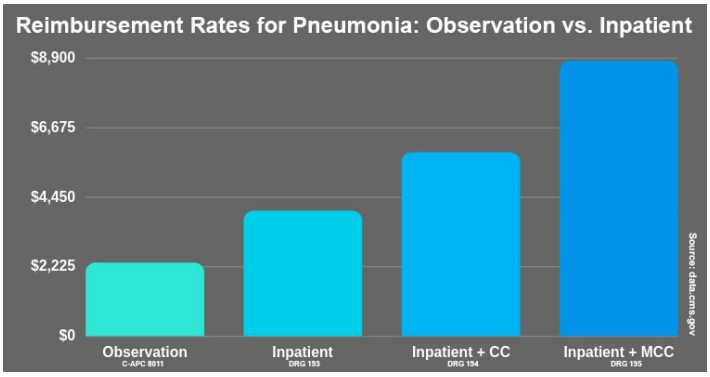
ANTHONY ROSANIA | Healthcare Consultant; M.D.; M.H.A
KATHLEEN SCHWARZ | Senior Healthcare Consultant; R.N.; M.P.A.

BEST (AND WORST) APPROACHES TO OBSERVATION CARE

Observation care varies across hospitals based on facility space, staff and financial resources. Yet research and practice has shown that not all observation is created equal. Certain types of observation perform better both in terms of quality and controlling costs.

Observation as a Money-Losing Default: The threat of reimbursement denials for inpatient stays can make observation care seem like the safe choice for hospital admitting staff. Though from a purely financial standpoint, hospitals may be incentivized to admit more patients and accept a larger denial rate. The reason for this is due to the much higher reimbursements for short-term inpatient stays. Hospitals can earn more by admitting borderline patients—and getting denied payment for some of them—than by placing those same patients in observation. (See chart below.)

Depending on a patient's pre-existing conditions—comorbidity (CC) or major comorbidity (MCC)—Medicare reimbursement for a pneumonia hospitalization can be nearly four times more for inpatient stays than observation care. Even without a comorbidity, reimbursement for inpatient treatment of pneumonia is nearly double the rate for observation care.



The 4 Types of Observation Units: Observation care typically conforms to one of the following four methods:

1. Protocol-driven care in a dedicated, closed observation unit (typically directed by an emergency department)
2. Discretionary care (directed by a variety of specialists) within a dedicated observation unit
3. Protocol-driven care with beds spread across the hospital (a.k.a. "virtual observation unit")
4. Discretionary care with beds spread across the hospital

The Best Type of Observation Care: Of the four types of observation care, only Type 1 in protocol-driven care within a dedicated obs unit has been proven to benefit both patient and hospitals. One of the most recognized studies, examining the health outcomes of TIA (mini-stroke) patients, found that patients treated in emergency department observation units with an accelerated diagnostic protocol had significantly shorter lengths of stay and lower costs compared with inpatient admission with comparable clinical outcomes.

ANTHONY ROSANIA | Healthcare Consultant; M.D.; M.H.A
KATHLEEN SCHWARZ | Senior Healthcare Consultant; R.N.; M.P.A.

FUTURE CONSIDERATIONS FOR IMPROVING SHORT-TERM MEDICAL STAYS

Good observation care requires a focus on improving quality and decreasing costs and variability. Going forward, hospital administrators and policy makers should consider how lessons from observation care can improve health outcomes for all patients (regardless of their classification) and how the current reimbursement system could be reformed to make innovative approaches to value-based observation care more attractive for hospitals.

Apply Protocol-Driven Care to More Patient Types and Conditions: Based on the proven health and cost benefits of protocol-driven observation care, hospitals should consider applying similar healthcare delivery for admitted patients, particularly cohort groups with specialized nursing needs. The Cleveland Clinic is one forward-thinking organization that is already implementing observation style protocols (what it terms "care paths") to provide a standardized approach to treatment and disease prevention. The hospital is currently developing care paths to address nearly 100 medical conditions with the goal of using these protocols to reduce unnecessary variability and expense and promote optimal, cost-effective patient care.

Address Medicare's Shortcomings: In creating the "two-midnight rule," CMS has failed to acknowledge the challenges hospitals face in determining which patients qualify for inpatient care. The rule arbitrarily places a cut off on who qualifies as an inpatient without taking into account the specific needs of the patient and may actually incentivize hospitals to prolong inpatient stays in order to meet the criteria. One alternative would be to introduce a tiered payment system for observation care similar to that used for the current inpatient DRG system. Under the current C-APC, all observation care is reimbursed similarly regardless of patient comorbidities or the resources utilized. Tiered payments could incentivize hospitals to care for sicker patients on their observation units, thereby taking advantage of the higher-quality protocolized care these units offer. Under current CMS rules, observation stays also do not qualify patients for subacute care at discharge. This policy places further stress on patients and encourages medical staff to admit patients who otherwise could be managed appropriately in an observation unit. Regulations that arbitrarily require three days of inpatient hospitalization to qualify for subacute care are antiquated and merely serve as a disincentive to high-quality observation services. Indeed, many of the same conditions that could lead a Medicare beneficiary to requiring rehabilitative services can be managed quite easily in observation units, resulting in lower cost of care and a shorter length of stay.

Use Protocols to Reduce Variability, Unnecessary Testing: Observation units lead to better patient care and reduced costs due to one factor: protocols. These checklists (or best practices) for specific patient types reduce inconsistent and ineffective care and help medical practitioners avoid needless and redundant tests and procedures. Hospitals that use these standardized, evidenced-based and quality-driven protocols will have the lowest cost and reap the most rewards.

SUMMARY

In many ways, the distinction between inpatient and observation care is arbitrary and irrelevant. Costs and quality of care are what matter. The introduction of observation care (coinciding with increasing denials for short-term inpatient stays) pushed hospitals toward protocol-driven care that reduces variability and operational deficiencies while also delivering high-quality care at lower cost.

Ironically, CMS regulations that were designed to spur the use of observation care may actually be discouraging its use as it can hamper a patient's access to additional care and place hospitals at an economic disadvantage. Hospital administrators considering whether to add or increase observation care units should evaluate these challenges before making a decision. Additionally, they should look at how the lessons of observation care protocols can translate to improved care and lower costs in other areas of health delivery.