

Jaundiced Eye

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I READ AN ARTICLE ABOUT neurologists in developing countries. The points were that there weren't enough neurologists in the third world and that volunteers from wealthier countries were greatly needed. The author asked the rhetorical questions, "What can neurologists do in the third world?



They can't treat anything, so why bother?" The answer is quite clear, once one thinks about this, especially if one has some knowledge of the practice of medicine in the poorest parts of the world. Many medical problems cannot be successfully treated there, neurological or not, but understanding what the problem is, beginning by determining where it is, is crucial to our discipline. Neurology centers on localization. Our modus operandi is to first localize and then diagnose. Indeed, all of medicine starts with localization, beginning with identification of the affected organ systems. Teaching how to recognize neurological symptoms and signs, and then how to localize within the nervous system may not provide a treatment, but it might. It also might provide a prognosis as well as help to avoid useless or even counterproductive tests and treatments. It's like shining a flashlight in a dark place. You need to first decide where to look.

The above seems straightforward. But what got me thinking, and provided the

title for this commentary, was the apparent confidence the author had in the superiority of medicine in more wealthy countries. While this may be true, I am uncertain of the magnitude of the difference. We neurologists hear about the tremendous strides we've taken in our discipline over the

past few decades. We've had the decades of the brain and then the spinal cord and we'll soon probably have the decade of the synapse, but aside from some impressive gains in our understanding of the genetics of many diseases and the development of extremely helpful and expensive treatments for some uncommon or rare disorders, we've not made that much progress. To be sure, our treatments for migraines have advanced tremendously with the introduction of the triptans 20 years ago. The immune therapies for multiple sclerosis have altered the course of this disease considerably, but not stopped it and not prevented the enormous disabilities it causes. Non-relapsing-remitting multiple sclerosis (MS) is still not treatable, and most MS ultimately evolves into that category. Deep brain stimulation was introduced 20 years ago for Parkinson's disease (PD) and continues to provide great improvement for about 1% of PD patients. New medications for PD are modified old drugs. Our

stroke advances consist of prevention with anti-platelet drugs which reduce incidence by 20–30%, which is substantial, and incredibly sophisticated interventional radiology techniques which are available to a fraction of a percent of the affected population. An Alzheimer specialist recently stated that the major clinical advances in Alzheimer's disease (AD) research had been in showing that previous hypotheses were incorrect. Another, who has been a leader in the development of the drugs now used routinely to treat dementia in AD, praised the wonderfully effective treatments we had for PD, and when I told him they weren't so wonderful, he stated, "well, at least you have treatments." In the third world, diseases of the elderly, AD, PD and atherosclerotic stroke aren't such major concerns, as there aren't so many elderly. There have been no advances in treating neuromuscular diseases or epilepsy, other than the development of newer drugs with somewhat improved side effect profiles.

The major difference between neurology in developed and third world countries is the availability of diagnostic testing, which is now at such a level of sophistication that the ordering neurologist frequently doesn't know what test to order, when to order it, or exactly what the results mean. I see many patients with rare and undiagnosed disorders, occasionally with diagnoses not found at autopsy. Sophisticated tests often do not yield an answer, yet, I am more

confident in not knowing a diagnosis when I work in Rhode Island than I am in Rwanda or Zambia. My treatments, however, aren't much different.

The question, "What use is a neurologist?" in the third world may therefore also be asked in the wealthy world. As a biased observer, being an old neurologist, I do think we have value, and our referral networks and long queues suggest that patients and other doctors agree. But we should be careful

to understand what our limits are. We clearly should not think ourselves, as I heard one patient advocate declaim, "Medical Deities" (MD). We should not, "Diagnose and adios," as some old joke used to describe neurologists.

The practice of medicine has its limits everywhere. These limits are greater than many of us would like to think they are. Despite these limits, we do have value, whether or not we have an MRI or a PCR result. ❖

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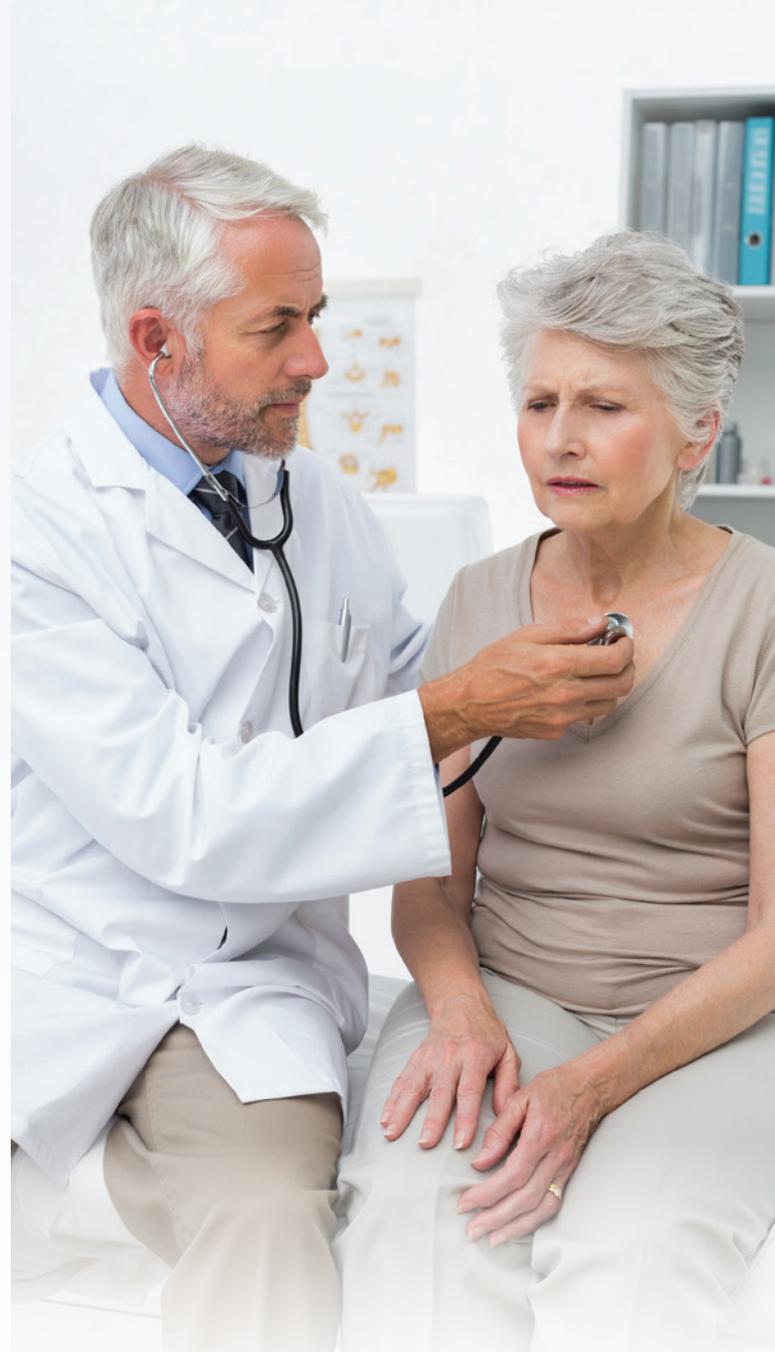
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The Affirming Ties That Bind Us

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THE PRIMARY PURPOSE OF medicine is to comfort and sometimes cure the ills of individual patients. The science of medicine also studies communities of humans, to clarify the causes – the etiologies – of prevailing diseases; and then to wonder why certain persons rather than others have fallen



victim to a particular malady. Why, in other words, does vulnerability to illness appear to be so non-randomly selective? Are there risk factors that impinge on some but not on others?

The pursuit of epidemiological understanding therefore begins with some very fundamental inquiries. Beyond the obvious search for biologic causes, might there be non-biological factors, social or environmental, which influence such important measures as susceptibility to disease and even relative survival?

Physicians, social workers and clergy have long recognized that the well-being of medically-threatened adults is dependent upon a complex tapestry of extrinsic and intrinsic factors, some of which are readily measurable such as nutrition and genomic heredity. Certainly the concept that interpersonal support may be medically beneficial, particularly in the elderly, is intuitively appealing. There is now more than sufficient evidence that loneliness, the absence of interpersonal support, has

a negative impact upon human longevity.

But beyond the obvious elements such as the quality of the diet and hygienic protections, there are the poorly measured attributes of life which are collectively subsumed by such imprecise phrases as social environment, degrees of acculturation and psychosocial resources.

One of the first formal studies to equate diminished survival with social isolation was undertaken by a group of social scientists, in 1965, studying patterns of mortality in the citizens of Alameda County, California. Does social support, they asked, allow people to live longer?

How did they measure the intensity of social support? Their initial “index” of intimate contacts consisted of whether the person was/wasn’t married; the number of friends/relatives living close by; and the extent of participation in church groups.

And their findings, using mortality as an outcome? In general, increased social contact was associated statistically with a reduced risk of mortality. But their careful analyses also disclosed that this beneficial effect of increased socialization was not uniformly experienced by the sexes or by all ethnic groups. The close interdependency between social contacts and increased survival was

evident particularly with white males, and only equivocally so with white females. This is consonant with the oft-made observation that male widowers survive fewer months after the death of their spouse than do female widows; and that males, in relative isolation, are significantly more vulnerable to the vicissitudes of life.

A group of epidemiologists and social workers undertook a similar but even more extensive study in 1980, using the citizenry of Evans County, Georgia, to explore whether social isolation/social ties are related to increased mortality risk. Their published findings reinforced the earlier observations in the Alameda County study and again demonstrated that male survival was more strongly linked to social networking. Indeed, the only very dramatic finding in this demographic study, was the inescapable conclusion that white male survival is dramatically more dependent on social interplay. This relationship is less evident with black males; and still less evident with females, either black or white. Furthermore the relationship between social isolation and diminished life expectancy was equivocal in populations of Asiatic ethnicity. In the words of one sociologist, “Social ties and relationships are not as important for nonwhites and women as they are for white men.”

An informal survey of Rhode Island elderly residing in assisted living facilities during 1975–1985 revealed a similar



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pattern of male vulnerability.

Some six decades ago, a military commission, with the author as a member, had studied the social ties of army personnel who had committed suicide. The commission concluded that no one could possibly know the inner thoughts and collective experiences of those who elected to terminate their lives; and accordingly, that judgment of these soldiers was at best inappropriate; yet it was inescapably evident that willful social isolation and a paucity of memberships in interactive groups – whether they be secular, athletic or religious – was a common thread in the lives of those distressed soldiers who chose suicide.

We humans are obligate social creatures and by nature part of a complex, interdependent organic society. The ties that bind us provide spiritual sustenance particularly when our inner faith falters; and when all else fails, a circle of friends can, at the least, provide a date for Saturday night. ❖

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Re-thinking the 'Two-Midnight' Rule: The Challenge of Regulating Hospital Admission

BENJAMIN C. SILVER, BA

ABSTRACT

Hospital observation services are meant to care for hospitalized patients with less severe conditions and the expectation of a short length of stay. In recent years, use of these services has increased and been highly variable; but it is often unclear whether they're appropriate for a particular patient. The Centers for Medicare & Medicaid Services' (CMS) most recent attempt to address this was a policy known as the "Two Midnight" Rule which states that observation care should be provided to patients expected to be in the hospital for fewer than two midnights. Nearly one year after its passage, the rule has yet to be implemented and criticism is abundant. As CMS begins to reform these policies, factors such as clinical needs, cost, and post-acute care needs should be considered to maximize the utility and quality of care while also minimizing the costs incurred by CMS, patients, and providers.

KEYWORDS: Two-Midnight Rule, CMS, Observation Care, Medicare, Elderly, Observation Status



In July, 2014 the Office of the Inspector General (OIG) at the US Department of Health and Human Services (HHS) testified before the Senate Special Committee on Aging, including committee member Sen. Sheldon Whitehouse of Rhode Island, about the issues of observation care, the "Two Midnight" rule, and future reforms. Three key takeaways were presented: "1) significant issues exist with observation and short inpatient stays, 2) policymakers must ensure that beneficiaries with similar post-hospital care needs have the same access to and cost-sharing for skilled nursing facility (SNF) services, and 3) careful evaluation of the two-midnight policy and possible alternatives is essential."²

Observation Care and the "Two Midnight" rule

Under the Medicare benefit, patients in observation care are considered outpatients. That is, their services are covered by Part B of the Medicare program and are subject to its reimbursement mechanisms and cost-sharing requirements (e.g., Part B deductible, 20% coinsurance, etc.).^{1,7} Hospitals on average receive lower reimbursement for an observation stay than a full inpatient admission; though it is important to note that part of the hospital outpatient billing mechanism is fee-for-service which can lead to higher charges for some patients.^{2,8} Yet use of observation care has increased in recent years. In 2009, there were approximately 1.02 million observation stays; up from 815,000 in 2007.⁹ By 2012, that number had risen to 1.5 million, and 37% of the cases were in the hospital for two or more nights.^{2,3} Simultaneously, Medicare was billed for 1.1 million short inpatient stays (lasting 1 night or less); which may have been more appropriately billed as observation.^{2,3} It is estimated that at the hospital level, the proportion of short-stay cases admitted as inpatients ranges from 10–70%.^{2,3} At the state level, utilization ranged from 0.76 to 5.87 observation stays per 1,000 beneficiaries, and Rhode Island ranked among the highest states (between 3.69-5.89 per 1,000).⁹

Some of the recent trends may be due to unclear regulations from CMS. Until recently, Medicare's official guidance described an observation stay as being resolvable "within 48 hours," and "typically within 24 hours."¹ A second possibility is that recent policies penalizing hospitals for readmissions are incentivizing use of observation care; since a

INTRODUCTION

Hospital observation services are meant to care for hospitalized patients with less severe conditions and the expectation of a short length-of-stay. Medicare covers these services as a less costly form of hospitalization for those who do not need the full array of hospital services.¹ Often observation stays last less than 48 hours before discharge; though observation may also be used temporarily while determining whether the patient's condition warrants an inpatient admission.¹ Over the past several years use of these services has increased and been highly variable across the country; but it is not always clear if they are being used appropriately.^{2,4} The Centers for Medicare & Medicaid Services' (CMS) most recent attempt to address this was a policy known as the "Two Midnight" Rule which states that observation care should be provided to patients expected to be in the hospital for fewer than two midnights.⁵ Nearly one year after its passage the policy has yet to be enforced (delayed until March, 2015)⁶; criticism is abundant, and CMS has begun to explore new alternatives.²

readmission is only recognized if both hospitalizations are inpatient.¹⁰ Some also argue that retrospective audits by CMS and review contractors have left hospitals wary of admitting when there is a borderline need.^{4,11} If a claim is denied, the hospital must begin an extensive appeals process and risks losing revenue for the stay.

CMS clarified its policy with the “Two Midnight” rule in 2013.⁵ The rule was intended to reduce the number of short inpatient stays and extended observation stays.² Yet several problems remain unaddressed. First, the rule conceptually bases the decision to admit on projected length-of-stay but time of day can have an impact on the likelihood of exceeding two midnights.¹² Second, the rule fails to address concerns that a retrospective review of billing claims could leave hospitals at risk in unclear cases. Third, the rule is not sensitive to potentially important clinical factors (e.g., diagnosis, comorbidities, etc.) that may indicate a need for intensive services even for a short period of time.¹²

The rule also fails to address the impact of observation care on access to Post-Acute Care (PAC) services. An inpatient must spend 3 or more nights in the hospital to qualify for rehabilitation in a Skilled Nursing Facility (SNF).¹³ Patients in observation stays are not entitled to these services, and if any are needed they must also be obtained on an outpatient basis. This is likely an infrequent occurrence if the admitting hospital is anticipating a need for PAC. A similar issue arises, however, if observation is used initially while the need for inpatient care is determined. In 2012, there were approximately 618,000 patients with hospital stays lasting 3 or more nights that, due to initial observation days, did not include 3 inpatient nights and were therefore not entitled to SNF services; 25,000 of these patients then went on to seek care from a SNF, and CMS actually inappropriately paid for most of those SNF stays.² It is unclear how many additional patients sought rehabilitation on an outpatient basis. Though this constitutes a small proportion of total Medicare hospitalizations, increased use of observation care may increase the frequency of these cases in future years.

Moving Forward

Successful reform is contingent on several factors, some of which are not yet well understood. First, Medicare must possess and employ a better understanding of the nature of patients with short hospital stays. Current policy bases the decision to admit to inpatient solely on the projected length-of-stay, with no consideration of other clinical factors. The OIG stated in its testimony that Medicare paid an average of \$5,142 per short inpatient stay, while only paying an average of \$1,714 per observation stay; and that when stratifying by “common reasons for admission,” short inpatient stays were consistently more expensive to Medicare than observation stays.^{2,3} Further, beneficiaries on average paid several hundred dollars less in cost-sharing under observation than

they “would have” in an inpatient stay.^{2,3} Yet it is unclear how exchangeable these two patient groups are. One study of a Midwestern hospital found significant differences in the diagnoses of inpatients and outpatients who were in the hospital fewer than two midnights.¹² Another study found that among hospitals that provide observation care, the amount of observation care provided depended largely on clinical factors such as primary diagnoses and the proportion of outpatient visits occurring in the emergency department.⁸ Policies guiding the use of observation care should attempt to be sensitive to these factors in addition to length-of-stay to ensure that patients are receiving necessary services.

The need for post-acute care should be considered in any reform. As noted by the OIG, an inpatient who spent the initial part of the hospital stay in observation status should not be penalized while attempting to seek post-acute care,² and in the event that a patient with PAC needs is only admitted to outpatient, these services should be available as well.

Hospitals should also feel comfortable exercising their judgment as it complies with the regulations without risk of unwarranted retrospective claim denial. That is not to say that billing should not be subject to scrutiny; but coupled with clear regulations, there should be a more efficient mechanism for justifying decisions so that the only incentive is clinical appropriateness.

Observation status is an important level on the continuum of care. Providing a specified subset of hospital services catered toward less severe or complex patients at a lower cost and intensity is an efficient concept and should be encouraged. But these services should also be delivered in a just and equitable manner, without ambiguity or misaligned incentives. As CMS begins to reform their policies regulating the use of observation stays, factors such as clinical needs, cost, and post-acute care needs should be considered to maximize the utility and quality of care while also minimizing the costs incurred by CMS, patients, and providers.

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