Another STAT page! My already busy medical director’s day now looked even grimmer. Oddly, I recognized the source number on my cell phone as the admitting office. Perhaps the family of a new admission — or even a staff member working in the office — had suffered a medical emergency.

As I rushed to admitting, I spied the source of the call. An otherwise dignified-appearing 50ish couple were both shouting continuously at the panicked admission coordinator. After de-escalating the situation, I determined the cause of the confrontation. Upon arrival of their mother — I will call her Mrs. Brown — from the hospital, the couple had been asked to provide a $10,000 deposit for her skilled nursing facility (SNF) care. The family had expected the patient to be admitted under the Medicare benefit since, as the family stated, “The discharge planner said Medicare always pays for hospitalists from the Society of Hospital Medicine that revealed poor patient care after 3 days in the hospital. The family had expected the patient to even know whether they are on OBS or a true hospital admission. Bolstering this gray zone existence is a 2014 survey of nearly four in 10 of society members who receive an additional 2 days. Although the share of OBS stays remains a small share of overall hospital stays, hospitals have increased their use of outpatient observation status in recent years, both in number and length of stays. According to data noted in the June 2015 Medicare Payment Advisory Committee report, between 2006 and 2012 the number of outpatient observation stays increased by 88%, and the number of inpatient stays preceded by observation increased 96%. The growth in observation was most rapid between 2011 and 2012, when outpatient observation volume rose 14%.

More germane to our world, from 2009 to 2012, the number of hospital stays that were discharged to a SNF without SNF coverage increased more than 70%. As in the case of Mrs. Brown, my suspicion is this reflects many “Mrs. Browns” who receive a trifecta of hospital-based care (ED, OBS, or inpatient) that occurs over 3 days but does not include 3 inpatient days for SNF Medicare coverage.

Education for OBS patients and families has become mandatory through the recent NOTICE (Notice of Observation, Treatment and Implication for Care Eligibility) Act. As of Aug. 6, 2016 (recently moved back to an Oct. 1, 2016, implementation) a hospital must, within 36 hours of admission, notify a Medicare enrollee in writing that they are an outpatient under observation. Further, they are to be informed of why they are on that status and what the financial implications are. They must be informed that OBS does not count toward triggering the Medicare SNF eligibility benefit, and that payment will be under Medicare Part B, which requires a 20% copay for services provided rather than the single hospital deductible for Part A inpatient services

Additionally, the beneficiary may be responsible for hospital charges for self-administered prescription drugs used before the acute care stay and provided by the hospital. Hospitals will comply, but there are concerns about how that message will be conveyed (as part of multiple pages and forms the patient and family will receive during the stay) and how it will be understood, given the mental status of the patient and family receiving that information. Anxiety, medication effects, delirium, cognitive issues, and the overwhelming experience of being ill in the foreign environment of an ED or hospital can cloud comprehension. Despite the best efforts of the hospital, ED, nurses, discharge planners, and others, it is likely the potential residents for your facility will arrive onsite only to learn that the Medicare Skilled Nursing benefit has not been triggered despite their (presumed) hospital qualifying stay.

The family I encountered had been set up for failure by a common, although mistaken, mindset in America regarding nursing home care. Nearly four in 10 of American adults 40 years old and older mistakenly expect that Medicare will pay for their long-term care needs as they age, according to a 2016 poll by Associated Press-National Opinion Research Center for Public Affairs Research at the University of Chicago. This family fell into the 38% that assumed their mother’s SNF care was automatically paid for. They mistakenly assumed that even if the Medicare skilled nursing benefit was not available, Medicare would cover the costs for their mother’s nursing home stay. After a prolonged series of discussions over several days, which were confirmed by our own investigations, the family understood the situation. Our SNF could not extend the Medicare SNF benefit to their mother, it was too late to return her to the hospital for a critical third inpatient day, and Medicare would not be a payment source for what was now a custodial admission. Because the family had made no arrangements for care at home and skilled services were required, the only option was a self-paid—and expensive—nursing home stay.

In a time when patient and family satisfaction is a crucial ingredient for value-based payments, this encounter with the health care system will garner only negative evaluations. The family indicated to me they would have approached the ED visit very differently and made a totally different decision regarding discharge from the acute setting if they had known two things: first, that OBS stays do not count toward the necessary criteria for initiating the skilled nursing benefit coverage; and second, that Medicare does not, in fact, pay for custodial nursing home care. With that knowledge, an engaged discussion with the hospital care team likely would have established a better care path that served the clinical and financial needs of the patient and still met the current Medicare guidelines. Serving our patients traverses many avenues. Clinical quality is a given, but arming patients and their families with the administrative and payment data they need is now a necessity as well. Trust me when I tell you that a STAT page to the admitting department is a call you never want to receive.

A past Society president, Dr. Lett chaired the Society workgroup that created the clinical practice guideline “Care Transitions in the Long-Term Care Continuum” and currently is chair of the Society Transitions of Care Committee. This is his final column. Wayne Saltzman, MD, PhD, CMD, will be overseeing the editorial direction of this column in 2017.