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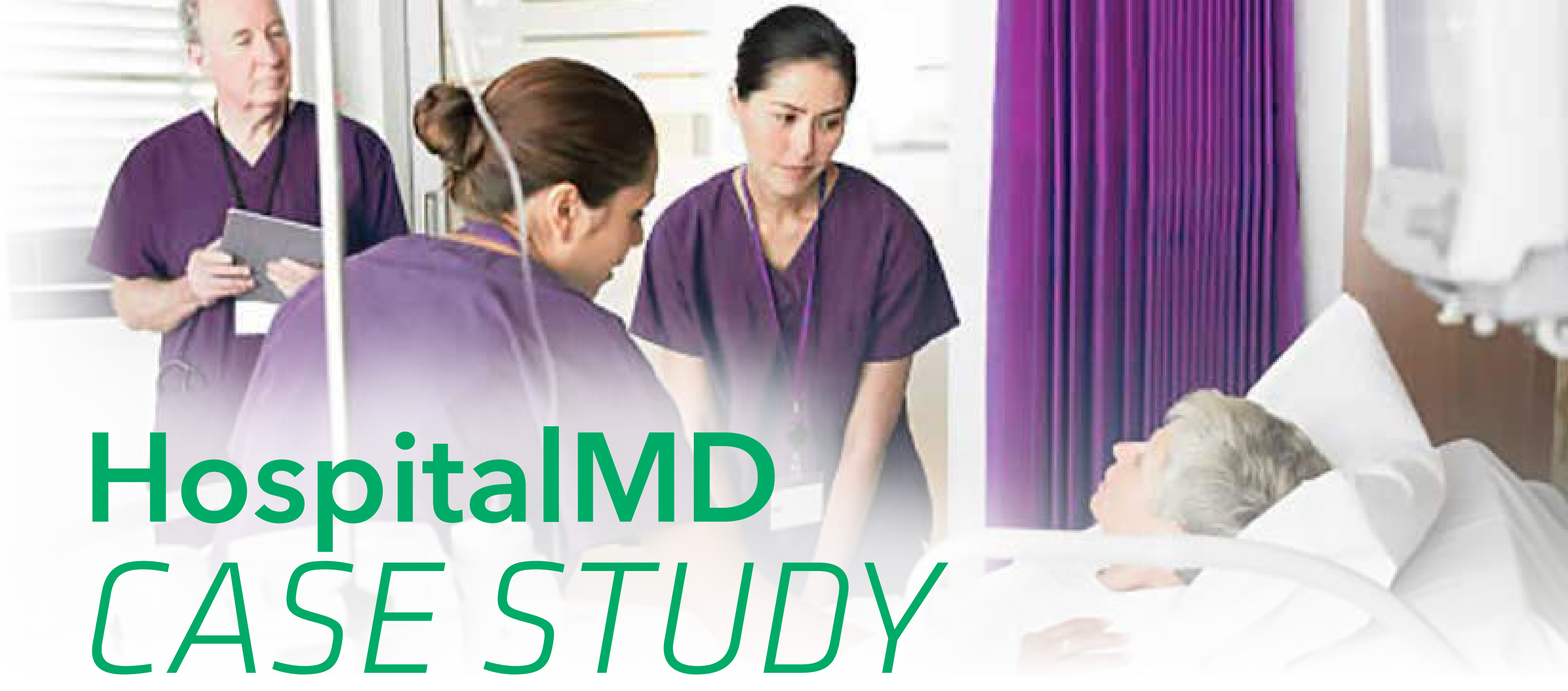
insight™

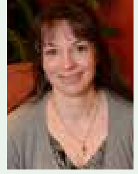
CLINICAL EDITION FOR SMALL COMMUNITY HOSPITALS



HospitalMD *CASE STUDY*

THE CASE: A 78-year-old female presents to the ED with fever, cough and anorexia x 3 days. The patient resides in a nursing home and the nursing home assistant with her states that there has been "a bug" going around the nursing home for a couple of weeks. She states that the patient has a slightly altered level of consciousness from her baseline, is refusing to eat and is only drinking minimally when prompted. She states that her temperature has been running around 101.5, with a tmax of 103, for 3 days and that Tylenol has been helping to reduce the fever. The assistant is concerned because the patient seems more listless than usual and does not seem to be getting any better. She states that the patient has not had a flu, pneumonia or shingles vaccine recently that she knows of.

Based on actual cases that HospitalMD providers have seen. However, details about the case, patient and outcomes have been modified in order to protect patient privacy.



From the Editor: Welcome to this installment of **HospitalMD insight™—Clinical Edition**! This publication is aimed to inspire and equip you to advance clinical excellence in your community hospital. I would love to hear your feedback, comments, suggestions and accolades. Please email me with any thoughts at: BNewberry@HospitalMD.com.

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Jim Burnette – CEO, Editor-in-Chief
Jim Blake MD, Jim DeSantis, MD – Consulting Editors

HISTORY: HTN, NIDDM, CAD, RLS

MEDS: Lisinopril 20mg PO daily, Metoprolol 25mg PO BID, Metformin 500mg PO BID, ASA 81mg PO daily, Requip 0.5mg PO TID.

VS: HR – 102, BP – 106/68, RR – 20, T – 101.8 °F, POx – 94% on RA

EXAM: HEENT: Normocephalic and atraumatic, no nasal discharge, oropharynx clear, uvula midline, TMs intact bilaterally, EOMs intact. Rales bilaterally, no wheezing. regular, tachycardic rhythm with no rubs, gallops or murmurs. Abdomen soft and non-tender. FROM all extremities. Patient is awake, alert at times and oriented to person only.

LABS: CBC, CMP, BNP, blood cultures, lactic acid, troponin, flu, ECG

IMAGING: CXR

TREATMENT: Oxygen to keep sats > 94%, NS 1000cc bolus then at 125/hr, Tamiflu 75mg PO

DIAGNOSIS: Influenza, dehydration, renal insufficiency, hyperglycemia

DISPOSITION: This patient was admitted with a diagnosis of influenza in order to treat inpatient with Tamiflu, rehydration fluids, blood sugar normalization, serial laboratory studies and monitoring.

THE OUTCOME: Patient was hospitalized for 3 nights and after improvements in respiratory status, fluid balance, blood sugar normalization and improved mental status was returned to the nursing home.

TAKEAWAYS:

- Have a higher index of suspicion for serious disease or more severe cases of common diseases in the elderly, patients with co-morbidities and patients in a communal living situation (such as a nursing home).
- Be sure to document a reason for the treatment of dehydration in your list of diagnoses (such as renal insufficiency).
- Check the CDC guidelines for which patients should be given anti-viral medications.

CUSTOMER SERVICE TIPS:

- Provide education to the family and nursing home staff about appropriate evaluation and treatment options.
- Educate the person bringing the patient back to the nursing home about any care for the patient and any isolation/ caution requirements with other residents.
- Always discuss vaccinations for preventable illnesses, especially in the high-risk population.

IT'S FLU SEASON!!!

Along with flu season comes the seasonal influx of patients to the ED for respiratory related complaints. We all know that a majority of flu patients should be treated symptomatically with fluids, rest and over-the-counter medications. But a huge number of patients come into the ED because they want some type of anti-viral medication. But are these medications appropriate for everyone? Below are the CDC guidelines for who should receive anti-viral medications. These guidelines may help you as you explain to the patient why they should or should not receive a prescription for an anti-viral medication.

- Children aged younger than 2 years
- Adults aged 65 years and older
- Persons with chronic pulmonary (including asthma), cardiovascular (except hypertension alone), renal, hepatic, hematological (including sickle cell disease), and metabolic disorders (including diabetes mellitus), or neurologic and neurodevelopment conditions (including disorders of the brain, spinal cord, peripheral nerve, and muscle, such as cerebral palsy, epilepsy [seizure disorders], stroke, intellectual disability, moderate to severe developmental delay, muscular dystrophy, or spinal cord injury)
- Persons with immunosuppression, including that caused by medications or by HIV infection
- Women who are pregnant or postpartum (within 2 weeks after delivery)
- Persons aged younger than 19 years who are receiving long-term aspirin therapy
- American Indians/Alaska Natives
- Persons who are extremely obese (i.e., body mass index is equal to or greater than 40)
- Residents of nursing homes and other chronic care facilities

Treatment should be started within 48 hours of symptom onset. Here are the CDC guidelines for the initiation of treatment with anti-viral medications for patients with flu.

SUMMARY OF INFLUENZA ANTIVIRAL TREATMENT RECOMMENDATIONS

- Clinical trials and observational data show that early antiviral treatment can shorten the duration of fever and illness symptoms, and may reduce the risk of complications

from influenza (e.g., otitis media in young children, pneumonia, and respiratory failure). See Complications.

  - Early treatment of hospitalized adult influenza patients has been reported to reduce death.
  - In hospitalized children, early antiviral treatment has been reported to shorten the duration of hospitalization.
  - Clinical benefit is greatest when antiviral treatment is administered early, especially within 48 hours of influenza illness onset.

- Antiviral treatment is recommended **as early as possible** for any patient with confirmed or suspected influenza who:
  - is hospitalized;
  - has severe, complicated, or progressive illness; or
  - is at higher risk for influenza complications.
- Antiviral treatment also can be considered for any previously healthy, symptomatic outpatient not at high risk with confirmed or suspected influenza on the basis of clinical judgment, if treatment can be initiated within 48 hours of illness onset.

To test or not to test? That is the question. Do you order a rapid flu test on any patient that you suspect of having the flu? It seems that we order this test more because the patients expect it rather than because it has value to us as ED providers. There are certainly instances where it is appropriate to know if a patient is flu positive. However, for the majority of patients, your clinical diagnosis is more than sufficient. This article goes into this very question in depth and offers helpful information.

Anti-viral medications are not without adverse effects, so the risk of adverse effects must always be weighed against any potential benefit. Many patients do not understand the adverse effects that can be associated with these medications can have so it is up to us to help educate them. This link on the CDC site has a nice grid showing the common adverse effects for different anti-viral medications.

REBEL EM has an article about this very issue as well that I think sums much of this up.

Important Update BLS/ACLS/PALS

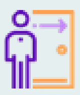
Please note that when you are renewing your BLS/ACLS/PALS HMD recommends that you use a renewal service that is AHA approved. Some sites will require this specifically and you can check with Pam or Brittany to see if you work at one of the sites that specifically requires this. There are lots of classes and services out there that are NOT authorized to state that they follow AHA guidelines. In order to cut down confusion, I would recommend that you use one of the two following options for EVERY renewal of your BLS/ACLS/PALS. If you don't, you will put yourself at risk for your certification not being accepted by the site and this will hold up your credentialing or scheduling ability.

LIVE CLASS

Find a live AHA class through your place of employment, local fire station or by using This link to find classes near you.

ONLINE VERSION

You may do the didactic portion of BLS, ACLS or PALS online through HealthStream at no charge. There MAY be a small fee for getting checked off depending on what instructor you choose to check you off. If you would like to use this option, please contact Brittany Newberry



ACLS CENTER

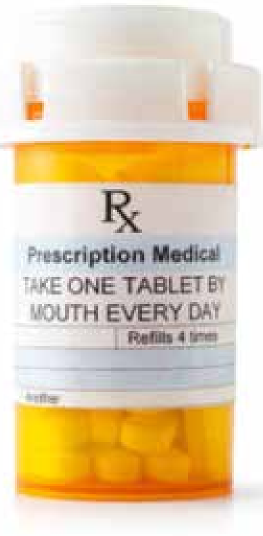
Alternatively, you may use the ACLS Training Center. You must pass the test, print the check-off sheet and be checked off by an AHA instructor (many of you may have an instructor at your facility). There is a fee for purchasing these courses.

Please remember that it is your responsibility to keep up with and renew these certifications as needed so that we are in compliance with the site requirements. Requirements may vary from site to site to please contact Brittany Newberry if you are unsure of your specific requirements.

Reminder:

Please keep up with and renew your certifications so we are always in compliance with site requirements.

DON'T FORGET!



Whenever writing a narcotic or benzodiazepine prescription for longer than 3 days of medication, please be sure to check your local drug database and DOCUMENT that you reviewed the patient's account prior to prescribing these drugs. For the MOST part, we should be writing very short courses (1-3 days) of these drugs, if we write for them at all. Patients should have these drugs prescribed and managed by their primary care provider in an effort to improve patient safety around these medications.

IMPROVE CRITICAL CARE DOCUMENTATION

ACEP Suggests that to meet Critical Care (CC) requirements, you must answer YES to all 3 questions:

1. Is at least one vital organ system acutely impaired?
2. Is there a high probability of imminent, life-threatening deterioration?
3. Did you intervene to prevent further deterioration of the patient's condition?

**In addition to YES, the physician request and time requirement greater than 30 minutes must be met

Still unsure? Ask yourself two questions:

1. Was patient admitted (based on medical necessity) to ICU or immediate disposition to OR?
   - ❒ If yes: strongly consider CC

❒ If no: is it really CC?
❒ If no (and you think it is CC): consider a Medical Necessity note

2. Will the patient die or deteriorate (soon) if you don't do something (quickly)?

❒ If yes: document CC time
❒ If no: is it really CC?
❒ If no (and you think it is CC): consider a Medical Necessity note

Medical Necessity"statement:

- "Organ system(s) at risk is…"
- Differential diagnosis
- "What and why" as far as diagnostic and/or therapeutic interventions undertaken by YOU
- Critical lab, imaging EKG findings documented and significance addressed
- ED course reflects frequent re-assessments and decision making
- Likelihood of life-threatening deterioration

Documentation that suggests your patient may not qualify for CC:

- NAD
- "Resting comfortably"
- Minimally documented and/or benign ED Course that does not support medical necessity
- Psych issues
- Maybe: High risk presentation with subsequent r/o of critical illness/injury
- Urgent call and arrival of specialist is not CC unless a substantial portion of workup and initiation of treatment by EP
- Abnormal lab values alone do not support CC unless MDM reflects high complexity MDM and initiation of life-saving assessment/treatment or prevention of serious deterioration

**Consider Medical Necessity statement if above scenarios justify CC

NEW EDUCATION REQUIREMENTS FOR 2020

Moving forward, all HospitalMD providers will be required to have **4 stroke** related CMEs per year AND **9 trauma** CMEs per year. This is to meet requirements for both stroke and trauma designation and just because it's good practice! Please send me these CMEs as you acquire them. If you take ATLS or TNCC in 2020, that will count for your trauma CME for the year. Below are some ways that you can obtain these CMEs. There are lots of ways to obtain these CMEs, below are just a few examples

STROKE

Requirement: 4 CMEs **annually**
EB Medicine "Emergency Stroke Care Series: Advances and Controversies"

- Cost: $179
- CME: 8 hours

American Heart Association "Acute Stroke Online Module"

- Cost: $27.50
- CME: 1.5 hours

National Stroke Association "Stroke Rapid Response Training"

- Cost: $20
- CME: 2 hours

NIH Stroke Scale Training

- Cost: Free
- CME: 3 hours
- Look for APEX NIH Stroke Scale Training in HealthStream on your To Do list

TRAUMA

Requirement: 9 CMEs **annually**

ATLS

- Cost: Varies but usually around $800-900
- CME: 17 (please note you can only count this to satisfy the requirement for one year even though your certification is for 4 – so this covers you in the calendar year that the course is taken)

Advanced Emergency Medicine Bootcamp

- Cost: $475
- CME: 2 Trauma CME (even though the entire course offers 23 CME in its entirety)

EM Crit – Trauma Compilation I

- Cost: $79.00 (includes 2 years' worth of access)
- CME: 16

EB Medicine

- Can mix and match topics that have trauma CME designated credits HERE and you can purchase each 4 hour course and CME test as a bundle for $49
- EB Medicine also has an 18 hour trauma course – Emergency Trauma Care: Current Topics and Controversies volume III – available for $249

DO YOU KNOW HOW TO ACCESS YOUR UPTODATE CME?

Did you know that UpToDate gives you CME credit for every subject that you review? It is easy to obtain a record of your completed CME with UpToDate!

- **Sign into your personal UpToDate account (this won't work with a generic "site" login).**
  In the upper right hand corner you will see a link for "CME".
- **Click on this link.**
- **Click "Redeem" to redeem your CME (credits are available for 2 years).**
  Click on "50 Credits".
  Place a checkbox next to the credits you would like to redeem and click "Continue" at the bottom.
- **Answer the appropriate questions.**
- **Click "Next".**
- **Answer the additional questions.**
  Click "Save".
- **Click "Download" next to your certificate to view and/or save.**

Documentation Reminders

- HPI – Strive to always include FOUR HPI elements in your charts.
- ROS – Document the necessary elements in the ROS and then write or check "ALL OTHER SYSTEMS REVIEWED AND ARE NEGATIVE". This statement must be present, and the wording MUST BE PRECISE in order to be considered acceptable by the billing company.
- Exam – You must have EIGHT exam elements present for a higher level chart
- ECG/Radiology interpretation – If you have ordered either of these, the statement "interpreted by me" must be present in the chart. **An ECG must have 3 elements and an interpretation documented and a radiology result must have an interpretation documented**.
- **Critical Care Time – If your patient qualifies for critical care, BE SURE to document this on the chart.**
- **Procedures – Be sure to include all pertinent details regarding procedures so that any more complex procedures (ie intermediate vs simple suture repair) can be billed at the rate that matches the true complexity of the procedure.**

If you have ANY questions about the documentation of any of these things, or any other types of documentation, please don't hesitate to contact your medical director or myself – bnewberry@hospitalmd.com.

Documentation Tips

HospitalMD facilities frequently have Swing Bed patients who are in the hospital for rehab and recovery from various illnesses or injuries. Just a few documentation reminder about these particular patients.

- ALL Swing Bed patients MUST have an admission note and H&P done.
- ALL Swing Bed patients MUST have a full progress note at least once a week. So please be cognizant of looking to see when the last full progress note was. If you are seeing the patient on day 7 after the last full progress note, please write a full progress note as you would for any other inpatient. On the other days it's fine to just have a short note that you have seen the patient and that they are progressing well or whatever is appropriate.
- A patient must also have a full progress note on any day that there are significant changes to the patient's condition or that you begin some type of new intervention based on their condition.

Resources

UPCOMING CONFERENCES

[ACEP Calendar of Emergency Medicine Conferences]

[Calendar of Hospital Medicine Conferences]

[AAENP Conference Events]

ONLINE EDUCATION

[Emergency Medicine Boot Camp]

[Hospital Medicine Boot Camp]

PROCEDURE TRAINING

[Global Training Institute]

[Emergency Procedures Course]

CERTIFICATION REVIEWS

[Fitzgerald ENP Certification Review]

[Rosh ENP Certification Review]

JOURNALS AND PROFESSIONAL ORGANIZATIONS

FREE! [Emergency Medicine News]

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FREE! ACEP Now

Emergency Medicine Practice

Advanced Emergency Nursing Journal

Annals of Emergency Medicine

Journal of Hospital Medicine

Society of Hospital Medicine

American College of Emergency Physicians

American Academy of Nurse Practitioners

American Academy of Emergency Nurse Practitioners

American Academy of Physician Assistants

Podcasts

EM: Rap

EMCRIT

FOAMCast

REBELEM

EMplify

Hospital and Internal Medicine Podcast

The Hospitalist Podcast

If you have a great resource you would like added to this list, let us know!

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