Hospital Medicine

JEANETTE KELLEY, D.O., FACOI
INTERNAL MEDICINE

Disclosures

None that make any money!!

Trustee, Oklahoma Osteopathic Association

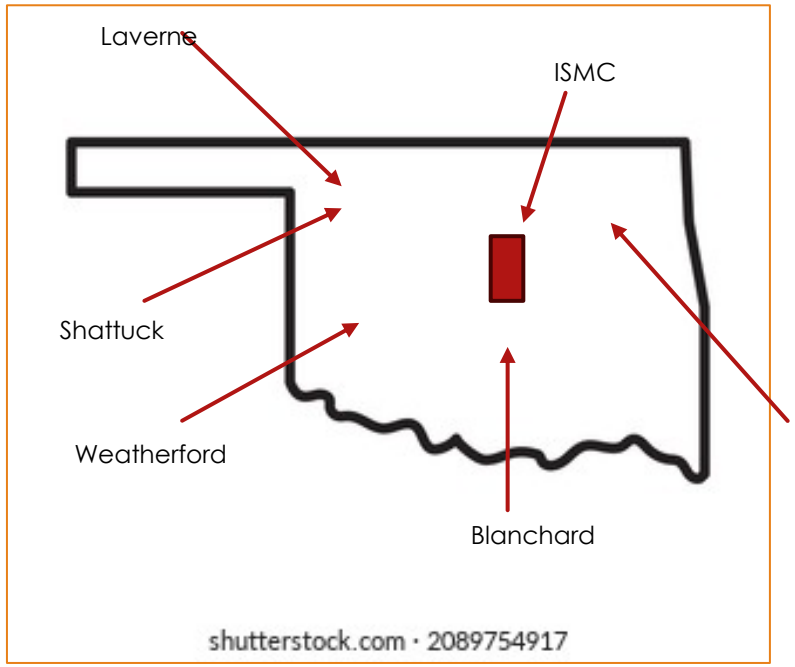
Trustee, Integris Southwest Medical Center

- Roll off my current 3-year term 6/30/2024

Chair, ACOI Government Affairs Committee

Who is this lady?

Born and raised in Western Oklahoma



Objectives:
The listener should gain information in the following

- Importance of owning your patient care and what this means.
- Including the patient in their care.
- Importance of detailed diagnoses.
- Problem based charting and why consider it.
- Sign out! Sign out! Sign out!!! (Did I mention sign out?)
- Inpatient versus outpatient status and why it matters
- Understanding RVU and DRG
- Understanding ICD-10
- Artificial Intelligence (A I) in your practice)

Importance of Owning your patient Care

- What does this mean?
  - Medicine is human care. Not shift work. We need to keep the mind set that this is our patient, not a check box.
  - **DO THIS**:
    - Take a deep breath before entering the patient's room. Knock on their door and ask if you may enter.
    - Sit down! Lean against a wall, do whatever you can to look unrushed.
    - If there are other individuals in the room, ask patient if you can speak freely in their presence.
    - Introduce yourself and ask their relation to the patient.
    - Ask the patient what matters most to them about their current admission

Importance of Owning your patient Care

- **NOT THAT!!!**
  - Come in the room, looking down at your phone, nursing is getting the patient on the bedside commode, you continue your exam while patient is having profuse watery diarrhea and cramps. Nurse tells you the patient's family JUST left to get something to drink. "They really wanted to talk to you, haven't left the room all night." You tell the nurse to report to the family your findings and move on, grabbing a small dab of hand sanitizer that dampens at least PART of your one hand not holding your phone, and mark your visit as complete.
  - Remember! This is not a check box to complete….this is a human being.

Including patient in their care

- HISTORY, HISTORY, HISTORY.
  - How many times have we heard this?
- Informed Consent
  - It is the law
- Inclusion of patient's opinion of their health and treatment plans can open to other very crucial and necessary conversations (they all deserve their own lecture)
  - Goals of care
  - Resuscitation status
  - Advance directives
  - Health care proxy
  - Safety concerns
  - Other social determinants of health.

Importance of Detailed Diagnoses

- Helps SUPPORT ACUITY OF ILLNESS and MEDICAL NECESSITY
  - Some diagnoses listed missing details could lack acuity of illness. Patient may not meet necessity to be admitted (insurance. We will get to that)
  - Without details, patient may be viewed as mildly ill
    - Even if the patient is in the ICU!
  - Without details, ICU patient may only be granted a 3 day stay instead of 10 day stay since insurers, billers and coders only see what the chart says.

Importance of Detailed Diagnoses

- QUERIES! Do you enjoy them?
  - Provide the details in your note and PREVENT THE QUERY
- **DO THIS**
  - Acute on chronic hypoxic and hypercarbic respiratory failure.
- **NOT THAT**
  - Respiratory distress (this is a symptom, by the way)
  - Respiratory failure

Importance of Detailed Diagnoses

- DO THIS
  - Acute on chronic HFrEF. Ejection fraction 15% based on cardiac catheterization from x date.
  - Acute HFpEF, Ejection Fraction 65%, newly diagnosed this admission based on echocardiogram.
- NOT THAT
  - Heart failure (barely even billable)

Problem Based Charting: Why should we consider it?

- Improves communication between specialties and hospitalists
- Makes it less likely to have dropped or missed labs/imaging
- Easier to put billing in at end of visit
  - Saves time in the long run
- Important to UPDATE the problem list as new diagnoses occur
  - Sepsis turns to septic shock when patient requires vasopressor support
  - Bacteremia update to bacteremia due to GNR
    - Update to bacteremia by Pseudomonas
      - Update to bacteremia by resistant Pseudomonas
      - LET'S DO AN EXAMPLE PROBLEM BASED NOTE

Problem based note

HISTORY OF PRESENT ILLNESS:

Patient is an 80-year-old female that presented from nursing home today by EMSA to the emergency department. She is normally able to communicate well, but is obtunded. She was last seen normal 12 hours ago when she went to bed. She had been complaining of increased cough and congestion. Her grandson had been to see her and had a cold, but no further details known. She had not suffered any falls, was found in bed. When paramedics arrived, she was hypoxic on room air with O2 saturation of 82%. Normally does not require O2 supplementation. She was placed on oxygen mask at 10 liters, given 50 mg IV solu-medrol and nebulized albuterol-atrovent solution. Her saturations increased to 89%. When she arrived to Emergency room, her mentation was slightly improved, opened eyes to name but not following commands.

Plain one view chest x-ray showed patchy infiltrates in bilateral lungs fields, no pneumothorax, no bony lesions. No pleural effusions.

Febrile at 103F BUN 50, Cr 1.4 Na 150, Hb 15, WBC 22 platelets 355.

Concern was for sepsis and shock due to bacterial pneumonia. Other possibilities were viral pneumonia with secondary bacterial component. She did not have a history of congestive heart failure and her skin appeared to be dry.

PMH: severe arthritis, kyphoscoliosis, protein calorie malnutrition, colon cancer, basal cell skin cancer, achalasia of esophagus, DVT's,

PSH: esophageal dilatation, TAH, BSO, IVC filter and removal, hemicolectomy, skin cancer removal.

MEDICATIONS: as yet unknown. List is being retrieved form the nursing home.

ALLERGIES: none

SH: never smoker, never drinker, never used drugs. Did dip snuff when she was younger, quit 60 years ago. Widowed. Traveled a lot with her grand kids until she got the DVT. Then decided she would live less dangerously. Retired school teacher.

Problem based note

Physical exam:

GENERAL: very frail elderly female, mild to moderate distress due to acute illness and hypoxia.
HEENT: dry mucous membranes. No exudates. No JVD, no lymphadenopathy
CV: tachycardia, regular, + SM loudest at aortic station. No edema.
Pulm: ronchi throughout lung fields. Tachypneic, poor effort
Abd: soft, NDNTTP no HSM
neuro/MSK: no focal deficits. Looks towards her name. Cannot answer questions.
Very thin extremities. Interosseous and temporal muscle wasting noted.
DERM: Venous stasis changes noted.

Labs, imaging, as stated in HPI

Problem based note

IMPRESSIONS AND PLANS (TRUNKATED VERSION…NOBODY LIKES WORDY SLIDES):

1. Acute Hypoxic Respiratory Failure:

She does not require baseline oxygen. Currently on oxygen mask and may require BIPAP.
DDX: bacterial pneumonia due to gram negative rod. Viral pneumonia with superimposed bacterial component. Less likely vasculitis. She has no prior history of vasculitis or family history. Pulmonary embolus based on history of DVT, although this was provoked and less likely.
Broad spectrum antibiotics will be needed. Blood cultures must be obtained.

Check VBG. If remains acidotic and hypoxic, place patient on BIPAP. Monitor for airway protection.

2. Sepsis with shock, likely due to gram negative pneumonia.

Sepsis protocol with fluid bolus 1 mL/Kg
Straight leg raise evaluation to assure no more fluid to be given.
Monitor sodium levels.
IV norepinephrine , wean as indicated. Maintain MAP of 65
Blood cultures
Broad spectrum antibiotics
Consider ID specialist consultation

Acute kidney failure

Differential due to septic shock and acute tubular necrosis vs pre-renal dehydration. More than likely, due to clinical picture is former rather than later.
Will need renal ultrasound, urinalysis with reflex to culture, urine sodium, creatinine, osmolality, serum osmolality, renal US to assure no renal etiology as a confounder of patient condition of septic shock.
Monitor output closely, if condition deteriorates may require renal replacement therapy and nephrologist to consult.
Repeat labs in 4 hours CMP, lactic acid, CBC

Sign out! Sign out! Sign out!

- Remember this is a patient safety issue first and foremost.
  - Forgetting to follow up on a lab, image, referral can be costly to the patient's overall wellness or cost them their life.
- This is showing respect to and keeping the trust of your colleagues
- Help the new guy or the locums rounders know how sign out works at your facility and expect follow through.
- Urban, rural, open vs closed ICU
  - the structure of how your group rounds will influence how your group handles the process.

Sign out! Sign out! Sign out!

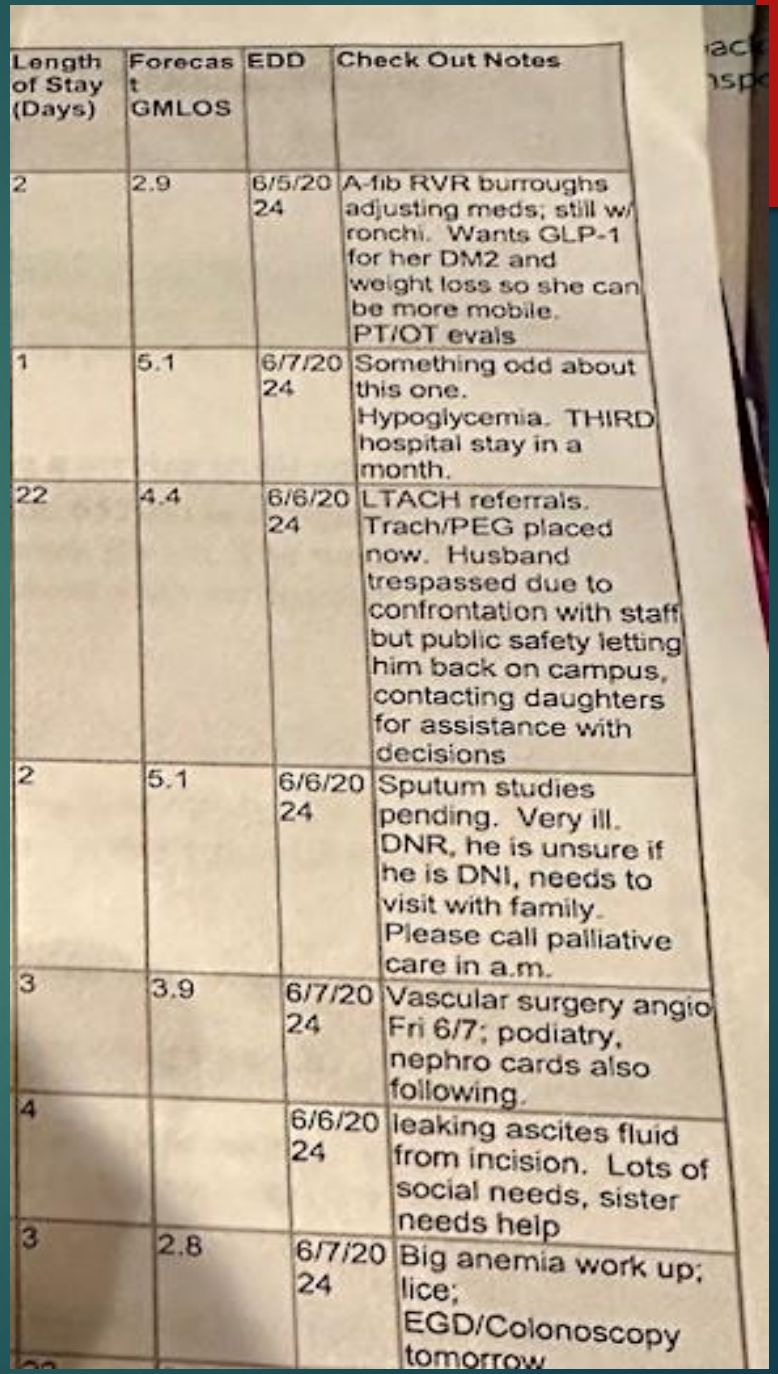
- Remember the golden and platinum rules for both your patients and your colleagues.
  - Treat others how you would have them treat you.
  - Treat others how they want to be treated.

  - Without appropriate sign out
    - Patient care is slowed
    - Physicians appear uninformed to the patient, and this causes a loss of trust
    - Missed diagnoses more likely
      - Increased possibility of bad outcome
      - Increased possibility of bad review
      - Increased possibility of litigation

SIGN OUT

ONE EXAMPLE OF CHECK OUT TO COLLEAGUE. IS ON THE MASTER HOSPITALIST LIST ELECTRONICALLY.

NO MATTER WHO PATIENTS ARE TRANSITIONED TO, CHECKOUT IS AVAILABLE.



Length of Stay (Days)	Forecast GMLOS	EDD	Check Out Notes
2	2.9	6/5/2024	A-fib RVR burroughs adjusting meds; still w/ ronchi. Wants GLP-1 for her DM2 and weight loss so she can be more mobile. PT/OT evals
1	5.1	6/7/2024	Something odd about this one. Hypoglycemia. THIRD hospital stay in a month.
22	4.4	6/6/2024	LTACH referrals. Trach/PEG placed now. Husband trespassed due to confrontation with staff but public safety letting him back on campus, contacting daughters for assistance with decisions
2	5.1	6/6/2024	Sputum studies pending. Very ill. DNR, he is unsure if he is DNI, needs to visit with family. Please call palliative care in a.m.
3	3.9	6/7/2024	Vascular surgery angio Fri 6/7; podiatry, nephro cards also following.
4		6/6/2024	leaking ascites fluid from incision. Lots of social needs, sister needs help
3	2.8	6/7/2024	Big anemia work up; lice; EGD/Colonoscopy tomorrow

Inpatient vs Outpatient Status. Why does it matter? They are both in the hospital!

- Inpatient- formally "admitted" to hospital
  - More serious or complex condition with higher level of acuity
  - Will require testing that can not be completed in 24 hours or less
  - Needs procedure/surgery and recovery will be extensive

- Observation- needs further evaluation and monitoring to decide if patient warrants admission as an inpatient.

Inpatient vs Outpatient Status. Why does it matter?

- Who decides inpatient or outpatient?
  - Good question!
  - The physician decides based on patient's clinical exam, etc. and level of acuity.
    - But….there are GUIDELINES set by payers.

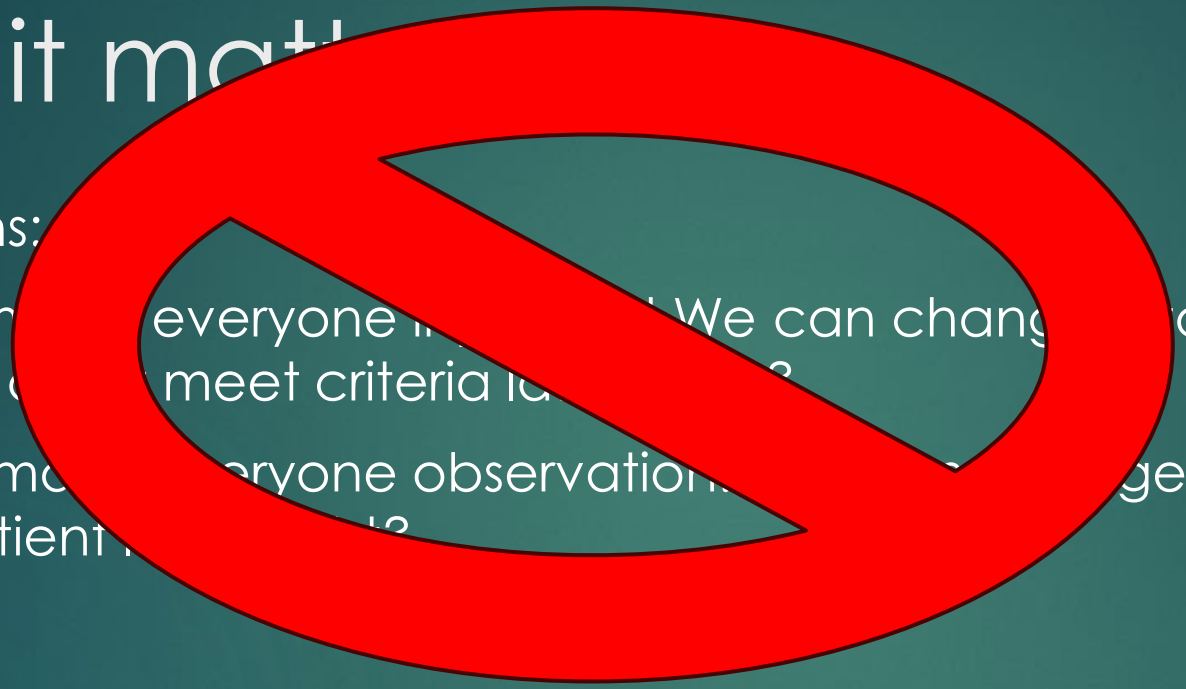
  - I will let the Utilization Management teams answer those details in separate lecture.
    - Multiple models, the hospital system chooses one to use to make decisions.
      - There are entire 4-year degrees for this.
    - Some insurers have their own guidelines (Medicare and Medicaid).

Inpatient vs Outpatient Status. Why does it matter?

Solutions:

- Just make everyone inpatient! We can change it to observation if they don't meet criteria later, right?
- Just make everyone observation. We can change them to inpatient later, right?

Inpatient vs Outpatient Status. Why does it matter?



Solutions:

- Just make everyone inpatient. We can change to observation if they don't meet criteria later?
- Just make everyone observation. Encourage them to inpatient later?
- ***Annnnd the Utilization Management team just fainted!***
  - ***Consequences for everyone***

Inpatient status: Medical Necessity

- Severity of illness
  - What brought the patient to the hospital?
    - Detail this in your history of present illness.
- Intensity of Services needed
  - What treatments and procedures have you ordered for the patient?
- Probability of adverse outcome if patient receives care somewhere other than acute care setting

Inpatient Status: Medical Necessity

Severity of Illness
- Vital signs
- Oxygen needs above baseline
- Lab data (BUN/Cr, H/H, Na, ABG, VBG, etc)
- Imaging
- Mentation below baseline

Intensity of Services
- Given solumedrol
- Given nebulizers
- Placed on BIPAP due to failure to improve on work of breathing and requiring 6 liters O2
- Failed BIPAP therapy, required rapid sequence intubation, placed on ventilator

Probability of Adverse Outcome if treated outside of acute care setting
- Note why patient cannot be discharged home & requires continued hospitalization
- Is patient back to baseline O2? Still tachycardic? Other factors such as age and comorbidities (mcc)?

Understanding ICD-10

- ICD
  - Used for categorizing the reports of Illness, Injury, Causes of Death and Incidences of Disease.
    - Also classifies surgeries, etc.
    - ICD on 10th version ICD-10
    - Started in 1890's with Bubonic plague
  - 1948 WHO (World Health Organization) took over stewardship
    - Worldwide common codes for physicians, researchers, etc.
  - 1979 USA decided good tool for Medicare and Medicaid medical billing
    - Only country to use the tool this way

Understanding ICD-10

- ICD-10 released 1992
  - USA did not adopt for years due to fear would cause financial fallout
    - Adopted in 2015

Understanding RVU and DRG

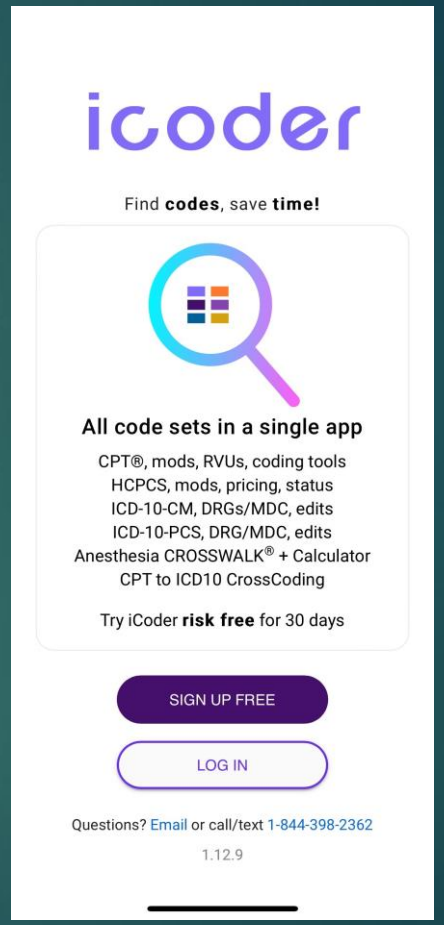
- RVU
  - RVU stands for relative value unit. It is a value assigned by CMS to certain CPT® and HCPCS Level II codes to represent the cost of providing a service. An RVU is made up of three components:
    - physician work,
    - practice expense,
    - and malpractice (insurance cost)
  - . Medicare payments are determined by RVUs multiplied by a monetary conversion factor and a geographic adjustment.

Understanding RVU and DRG

There is an app for that!

- Due to the complexity of coding language, you can find multiple apps.
  - This is one example; I am not advocating or advertising for this app.

- There is a transition occurring in the medicare and Medicaid world
  - Fee for service changing to quality of care payment



Understanding RVU and DRG

- DRG
  - Diagnosis Related Group.
  - Case-mix complexity system. Used to place patients with similar diagnoses to determine payment to hospital and physician
    - LUMP SUM
      - The longer the patient is in the hospital, the less is made.
  - https://www.definitivehc.com/resources/healthcare-insights/top-drg-codes-diagnosis-volume#:~:text=What%20are%20the%20most%20common,by%20respiratory%20infections%20and%20inflammations

Clear as mud. Importance of all of this…

- Medical documentation by physician is important to the patient's safety
- Medical documentation by physician is important to the physician and the staff that counts on the clinic and hospital staying open.

- https://www.aapc.com/resources/what-is-clinical-documentation

Understanding RVU and DRG

- Doesn't this just seem like we are making jobs for mathematicians and statisticians?

- Long story short, RVU and DRG are units used to assign a cost to provide care.
  - Without the details of your hard work, these codes can't be used.
  - Improper codes lead to audits.

Artificial Intelligence (A I) incorporation into your practice

- AI scribe
  - There are several options
  - Ask patient's permission to use
  - Scribe will catch items discussed you may forget you event brought up!
  - Can give detailed, personalized information to you patient to go home with
    - Hopefully, this can improve compliance with instruction
  - You can focus on your patient instead of taking notes. Your scribe is doing that for you!

- Insurers are utilizing A I to review and approve or deny claims looking for buzz words.

RECAP

- Don't forget that the reason you are coming to the hospital is for the care of the patient.
  - IT IS NOT A RACE.

    Slow down, let the patient talk. What is most important to them?
- Details are important!
  - Patient safety
  - Length of stay, quality of care
  - Improved patient satisfaction
  - Improved colleague satisfaction
  - Improvement in your quality of life

RECAP

- All of the details you add will pay off
  - Makes your patient status clear to billers and coders, insurers
    - Less queries in your in basket
      - don't shoot the messenger, just be complete up front with your diagnosis
  - Improves your RVUs , DRGs, and all the other alphabet soup that it is based on
  - Look for ways to make your life easier when rounding.
    - A I resources could speed your day along
    - Improve amount of the diagnoses you document
    - Take the focus back to the patient and off of the computer/phone/tablet
    - Improve billing
    - Increase speed your notes are completed, getting you back to your family and hobbies. Less time in front of the screen.

SOURCES

- https://www.cms.gov/medicare/physician-fee-schedule/search/overview
- https://www.aapc.com/tools/rvu-calculator.aspx
- "An American Sickness. How Health Care Became Big Business and How You Can Take It Back." Rosenthal, Elisabeth
- https://www.definitivehc.com/resources/healthcare-insights/top-drg-codes-diagnosis-volume#:~:text=What%20are%20the%20most%20common,by%20respiratory%20infections%20and%20inflammations

Sources

- https://www.aapc.com/resources/what-is-clinical-documentation
- https://www.hfma.org/finance-and-business-strategy/how-to-determine-appropriate-patient-status-and-navigate-observation-level-care/

QUESTIONS?

- Jeanette Kelley, D.O. FACOI
- jbartowkelley@gmail.com
- 405-626-8309