HOSPITALIST CURBSIDE

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WHO AM I?

Hospitalist/Nocturnist for about 10 years

Previous Medical Director of small programs

MY ROLE

- NOT a Subspecialist
- NOT an authority on really anything

GOALS OF PRESENTATION

- Look at some of the Medical director things with a patient outlook
- Crafting useful notes (night time issues, utilization issues)
- Getting patients where they should be during high volume times: use of tele, seeing patients to be discharged first, moving people out before the end of your shift.
- How many patients should you be seeing
- Some practical and daily things that might not make us crazy when discussed outside of the Hospital.

ARE WE OVERWORKED?

- How many patients should a Hospitalist see?

CENSUS

CENSUS DURING FLU SEASON

UNTIL RECENTLY

- The ideal "patient load" per Hospitalist was a very subjective number. There were small studies that suggested that 18 to 20 patients encounters per day was ideal
- IPC, a large for profit Hospitalist company had also suggested that 18 patients visits per day was ideal.
- Also at 18 patient visits per day, Some of financial numbers looked better

THE STUDY

- In March 2014, JAMA Internal medicine published a study.
- *Effect of Hospitalist Workload and the Quality and Efficiency of Care.* By Elliot et al.
- The study was done in a single system (Christiana, in Delaware) over 1000 inpatient beds and 55,000 annual admissions.
- Data collected between Feb 1, 2008 and Jan 31, 2011
- Main Outcomes looked at: LOS, cost, RRT activation, mortality, patient satisfaction, 30 day readmissions

RESULTS

- Cost and LOS were the only factors affected
- LOS was found to be a j shaped curve as the Hospital census increased.
- The ideal census was found to be 15 visits per hospitalist per day (or 28.6 RVUs), with an exponential increase in LOS and cost after this number

WHAT SHOULD WE TAKE FROM THIS STUDY?

- There are many variables when it comes to studies like this
- Many factors can make a Hospitalist more or less efficient (EMR, supporting members of the team, case management, Hospitalist experience). Also this was a single system study, at 2 locations.
- This provides some rare data that might confirm that we are seeing too many patients to be efficient
- Interesting that quality measures, readmissions and mortality were not affected in this study

MOVING PATIENTS THROUGH THE HOSPITAL

- We all probably had super high volumes this Flu season.
- How can we help move patients through the Hospital. Is it our responsibility?
- Does it matter if a patient stays (boards) in the Emergency Department?
- What if a medical patient gets placed on a primarily surgical patient floor?

IT IS SAFER FOR PATIENTS TO BE IN THE RIGHT PLACE

- Mortality of hospitalized internal medicine patients bedspaced to non-internal medicine inpatient units: retrospective cohort study
- Bedspaced: British for admitted to off service wards
- Data collected from Jan 1st 2015 to Jan 1st 2016 in a single tertiary care center in Canada
- BMJ Quality Safety Published Nov 3rd 2017

RESULTS

- In this study about a third of patients ended up “bedspaced”
- There was a significant increase in mortality for the bedspaced patients in the study (8% vs 5%), which usually occurs in the first few days of admission.

WHAT CAN A HOSPITALIST DO ABOUT LACK OF APPROPRIATE BEDS OR HIGH CENSUS?

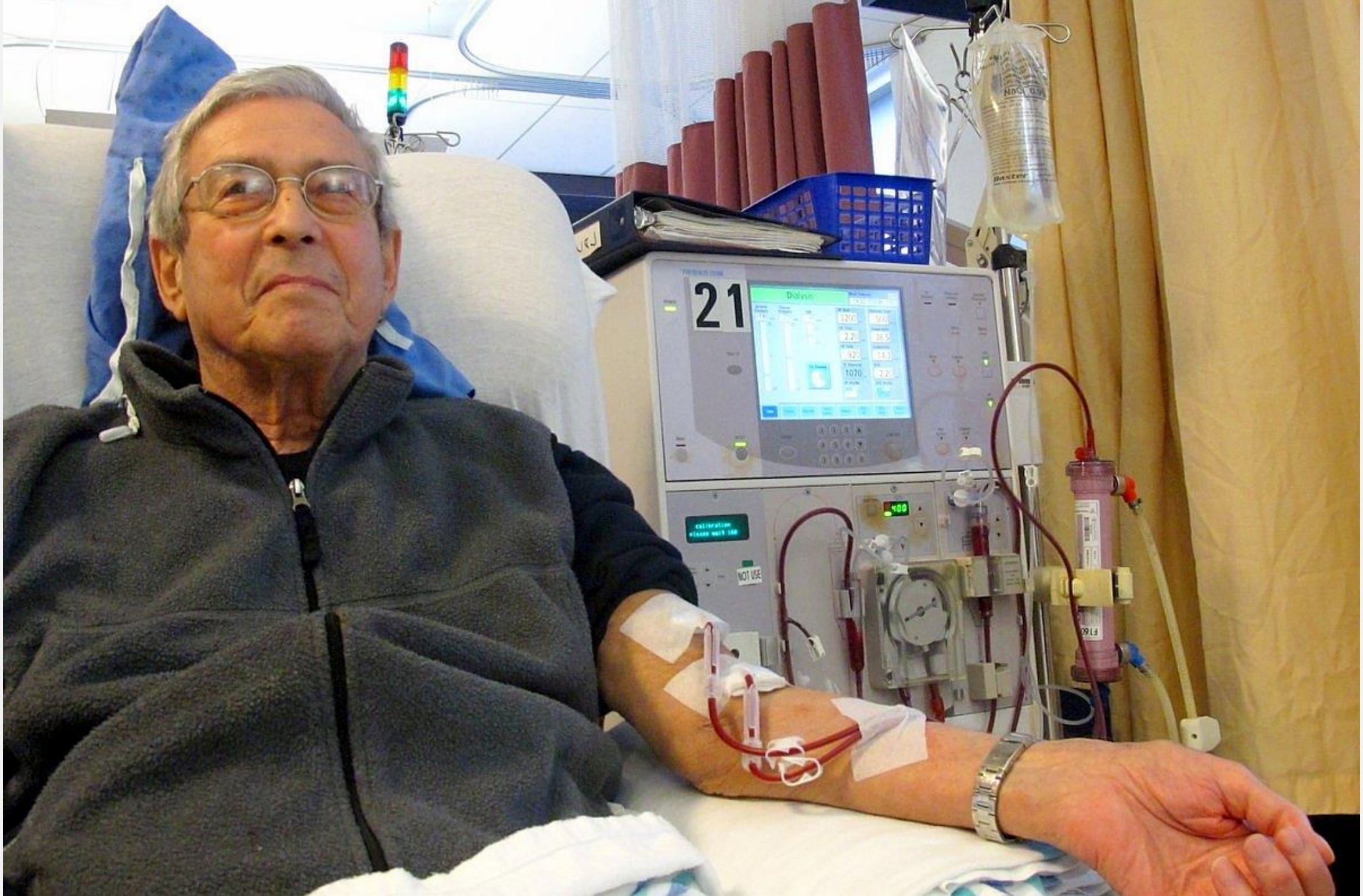
- If there are no new issues for the sickest patients, see them after the discharges. This will open up appropriate beds for new patients
- Take patients off telemetry. Open up these beds for patient who really need telemetry
- Move patients out of the advanced care areas before the end of your shift, if possible. These beds will likely be needed at night and having a nurse/Nocturist/Critical Care physician that does really note know the patient make a move at 2am is not ideal

THE HOSPITALIST'S NOTE

- In the era of the EMR, the quality note has become rare

WHAT DOES A HOSPITALIST DO?

CHEMOTHERAPY


21
NOT USE

Past medical history of heart stuff and blah, blah, blah. Plan OR tonight.

--An orthopedic surgeon's H&P

someecards
user card

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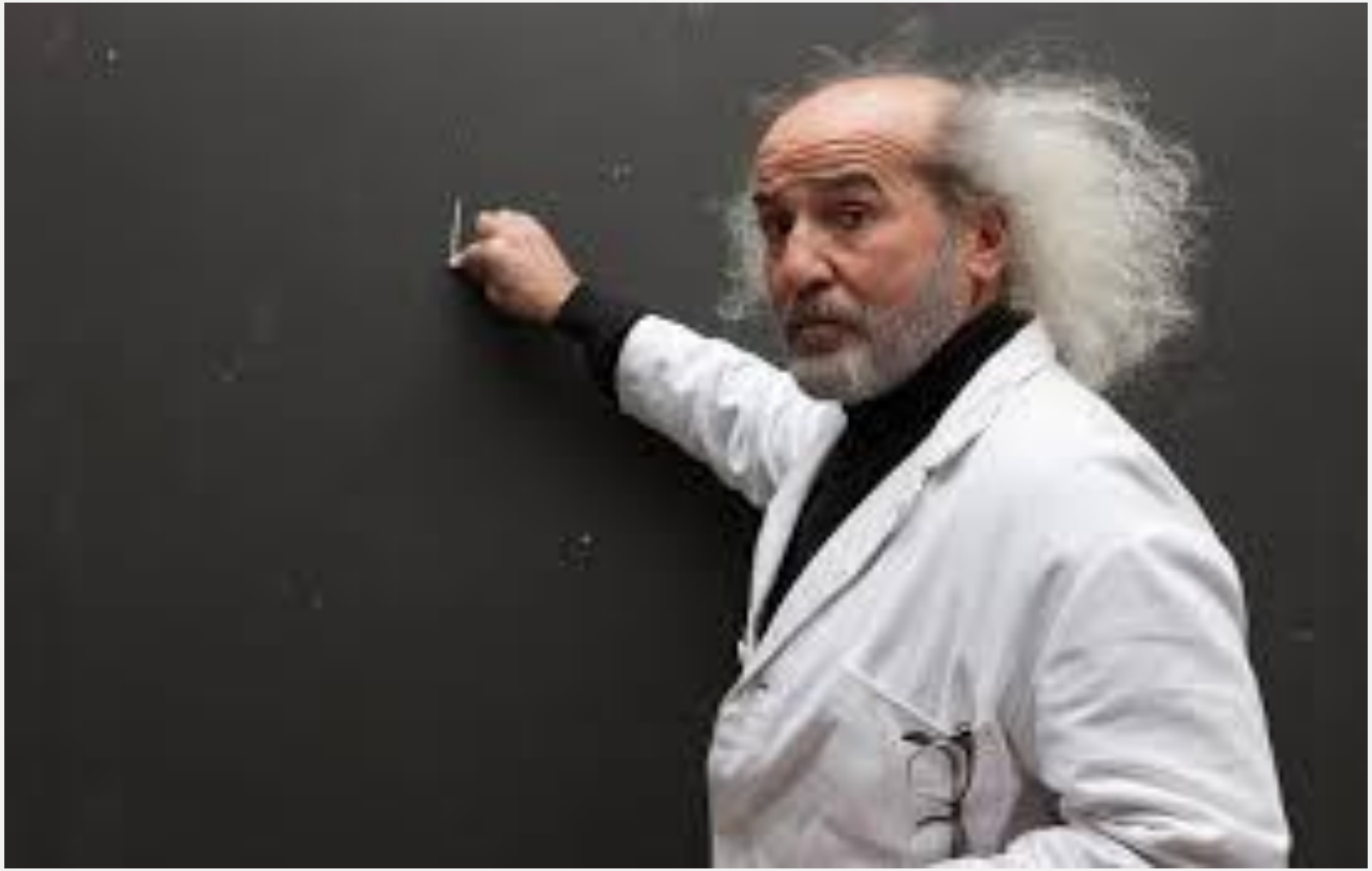


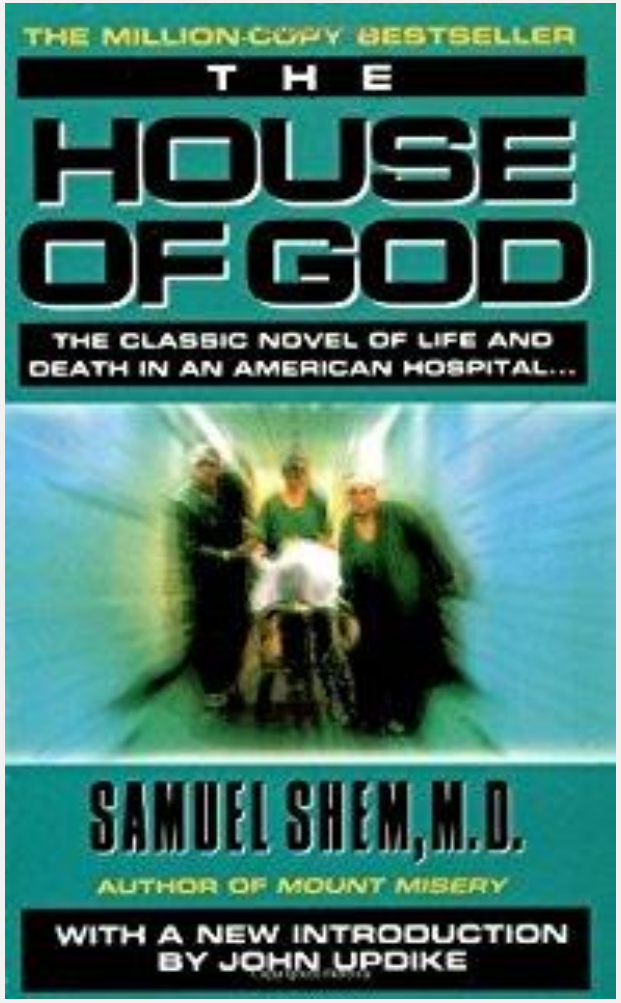
CASE PRESENTATION

- I currently work as a Nocturnist
- One night I admitted a 77 year old woman with a history of "Severe COPD" as per her last Pulmonologist visit, but who was not on Oxygen at baseline and had been well compensated for the years few years. No recent steroids, or hospitalizations.
- I admitted her for suspected Flu and COPD exacerbation. Some wheezing on exam, but comfortable (actually she was much more concerned about her sleeping pills and when she could eat)
- Placed on standard treatments and mostly forgotten about my myself (the life of a Nocturnist)

2 NIGHTS LATER

- I get called to a rapid response for a patient requiring an increased amount of Oxygen

- Allow me a quick digression…..


THE MILLION-COPY BESTSELLER
THE
HOUSE OF GOD
THE CLASSIC NOVEL OF LIFE AND DEATH IN AN AMERICAN HOSPITAL...
SAMUEL SHEM, M.D.
AUTHOR OF MOUNT MISERY
WITH A NEW INTRODUCTION BY JOHN UPDIKE

EMR REVIEWED AT BEDSIDE

- I see my H and P, look at it quickly to remind me of the patient's initial presentation.
- Look at the next two daily notes

EMR/PROGRESS NOTE. DAY #1

- PATIENT NEW TO ME TODAY

- Feeling better today

- Plan:
- Continue steroids, Mobilize and wean Oxygen

PROGRESS NOTE DAY #2

- PATIENT NEW TO ME TODAY

- Feeling better today

- Plan:
- Continue steroids, Mobilize and wean Oxygen

WELL.....
SH*T....

TAKE BACK THE NOTE

- https://www.todayshospitalist.com/drowning-in-note-bloat. This was published online In Today's Hospitalist in March 2014.
- There are many articles and words of wisdom to be found to help with note creation.

HOW TO MAKE A NOTE MORE USEFUL

- Some of the best suggestions:

- Up end the note. Instead of a SOAP note, use APSO. This makes the note easier to quickly read (no need to scroll to get to the useful information)
- Reduce Copy and Paste
- Use dates instead of words like today. This way if a copy and paste sneaks through, you are still being accurate (ie: blood transfused 3/14, instead of today being copied each day)
- Consider getting rid of lab and imaging data. It is in the EMR already, and unless you mention that you noticed the lab data you do not get "billing credit" for it being in your note.
- Consider getting rid of carried forwarded historical diagnoses that are not important to the hospitalization (every chart in my residency EMR contained 5 ophthalmologic diagnoses.

THE UTILIZATION DIRECTOR

- Interesting look into how Medicare and Medicaid interacts with the Hospital, our patients and our notes
- When a case is first denied, the Hospital sends a lengthy written appeal
- As the Director, a few times a month you get to discuss cases with the Insurance Physician representative from Medicare/Medicaid that were denied after this initial appeal

ONE OF MY TUESDAYS

- 3 Cases this day
- Picked by my hospital staff based on denials by Insurance. The charts were pulled for me to review before the conference call for the Medicare representative physician. The other physician had the chart to review as well

STORY OF THE PHONE CONVERSATION

- Let me tell you how these went down:

SOMETIMES THE CASES GO TO A SECOND APPEAL

- Usually after the first appeal, the case is settled one way or another.
- But on occasion, the Hospital or Director feels strongly about a case and an agreement cannot be found.
- Then the case goes onto a second appeal
- ALJ case (Administrative Law Judge)

UP TO THIS POINT…

NOW…..THE OTHER SIDE……

AND ME.....

THE TAKE HOME POINT ABOUT DOCUMENTATION

- It is not just about billing, ICD codes etc.
- Your documentation is going to be used/viewed by many types of people in the care of your patient. What you write matters