CASE STUDY -- Stein

<u>The Case of the Ill Long Term Care Medicare Patient</u>

44 year old female, resident of a long term facility, with a prolonged history of multiple sclerosis. She has a PEG feeding tube and is non ambulatory. She is alert but can not communicate in any meaningful way. She is sent to the ER with altered mental status, increased pulmonary congestion, and low grade temperatures. The ER physician's physical exam reveals rhonchi in both lung fields, chronic contractures, some stage I and II decubiti, and a patient who is alert but is non communicative. Evening temperature in the ER is 99.9 degrees. CXR shows chronic changes without focal infiltrate and a pulse ox of 91 % on room air. Respiratory rate is 24 per minute.

Admission? Observation? Or Discharge from the ED?

Probably not a clear answer. Almost always a patient with lots of comorbidities and the appearance of impending, acute illness is made acute. Difficult to argue this point. But observation could be appropriate as well, particularly if the attending is the one speaking to the ED physician.

The attending physician comes in the next day and states "this patient is ALWAYS like this." He discharges her back to her long term care facility.

Admission? Observation?

Change to observation code 44 prior to dc. Preferentially, do it so that the patient can be "observed" for 8 hours to capture the observation charges. This fosters the discussion of a difficult utilization case -- a patient who appears ill on presentation to physicians without knowledge of a patient's baseline but is abruptly discharged by a physician who knows the patient.