Case Studies Working Lunch

6th National Boot camp

July 25-27, 2018

Goal of great working lunch

- Review 2 cases/present 1 and discuss the case and all the ‘other stuff’ that could be occurring that impacts the decision:
  - Identify the pt status and defend your decision.
  - What issues are pertinent to the P2P call- MA & commercial plans?
  - If inpt total knee – why? What is in the record or missing to support decision? 2 MN presumption or even 2 MN benchmark.
  - Share your strategy to ‘find the inpt’ and if not, why not.
  - HAVE FUN!

Faculty to host tables & Assigned Case Studies TKA, P2P, 2MN

Grab lunch and join your table

- Table 1: Phillip Baker 2 & 23
- Table 2: Jennifer Bartlett 1 & 24
- Table 3: Ernie delos Santos 11& 19
- Table 4: Ronald Hirsch 4 & 11
- Table 5: Maria Johar 3 & 8
- Table 6: Kalyana Kanaparthy 7 & 17

Enjoy learning with the case studies & other fun 'stuff"

- Table 7: Elizabeth Lamkin 13& 18
- Table 8: Donnah Mathews & Abby Pendleton 9 & 12
- Table 9: Ed Norwood 5 & 14
- Table 10: Ferdinand Richards 10&20
- Table 11: Michael Salvatore & Tamie Young 6 & 21
- Table 12: Sommer Slavin & Jessica Gustafson 15& 22

Case #1 – P2P call- Only approved OBS

- 79 YO female presents to cardiologist complaining of dyspnea at rest. Symptoms have progressed over the last 2 weeks and has gained weight but not sure how much.
- Patient with known complete heart block with permanent pacemaker, multi-vessel coronary artery disease considered not a surgical candidate, ejection fration of 20-25%, NY Heart Association Functional Class IV.
- Patient is being sent to the hospital directly from the cardiology office.

- What does the PA and UR team need to know to request an inpt from this MA plan?
- What strategies would you use in the P2P call to fight for an inpt? Or give up inpt and accept obs?
- MA plan. What do you need to know? Contracted? Non contracted? Strategy.

Case #2 – Total Knee – Inpt or outpt? Defend the status decision.

- 68 YO female with co-morbid conditions: irritable bowel (principal), osteoarthritis of rt knee, essential hypertension.
- Living situation: pt lives w/spouse in a 2 level house, but she will be staying on the first floor. Bathroom has a walk in shower and no grab bar. Toilet seat is tall with grab bar.
- Mental status; Indept with ADLs and IADL (No H&P on record at time of audit)
- Postoperative day one: she states her mouth is so dry that she if she puts something in her mouth to eat, it just sits there. Feeling woozy from pain meds. Getting Percocet 10 mg but still in pain.
- DC Summary: During surgery. We found that her medial tissues were severely attenuated. As a result, we had to reef them with stitches on two different locations, and that is the reason she was placed in the hinged knee brace. Her postoperative course was very significant for incredible sensitivity to pain meds. On the first night, she required the typical amts of pain meds and seemed to be doing well. Unfortunately, after that she become and more and more somnolent. By the evening, she was basically able to pronounce words. She was appropriate ; no signs of stroke or asymmetry but extremely sedated. Watched her thru the night. That night she eventually was able to void on her own.

Case #3 – P2P –Obs or Inpt? Defend status decision

- 64 YO male presented to the Emergency Department from an assisted living facility with complaints of back pain and weakness. History significant for bipolar disease and parkinsonism.
- The patient was ambulatory with a walker prior to becoming so weak he fell
- CT shows acute failure of T12.

- During the P2P call with the payer , what key issues would need to be addressed to get an inpt approved?

Case #4: Total Knee. Inpt or Outpt. Defend status decision

- 80 YO female admitted with co-morbid conditions: obesity, hyperlipidemia, hypertension, H/O ascending aortic replacement, CAD, COPD, fibromyalgia syndrome, hernia of anterior abdominal wall, primary osteoarthritis of rt knee.
- Mental status: Alert and oriented. Independent with ADLs.
- Living situation: Lives alone and state she has no family of friend that will be able to assist post op.
- At 1st point of contact: H&P – "We are going to take her to the operating room in a few minutes. Questions answered." Post op – "transferred to the recovery room in stable condition.
- Post-op Day #1: "I am going to discontinue her IV fluids and then get rid of the foley. I will defer to Dr Clair as to whether he wants to do anything about the hypokalemia. I think the white count we can just watch. I talked to her about the importance of being in a chair and about how to use a knee immobilizer and the Venapro compression devices when she leaves the hospital."

Case #5: P2P call. Defend pt status

- 59 YO male found unresponsive in very poor living conditions described by the EMS as multiple animals urinating and defecating in the home. Urine drug screen positive for benzodiazepines and was known to have a prescription for 90 Xanax filled 10 days prior to presentation.
- Treated with Romazicon 0.4 mg with minimal response in that his eyes would open but he was non-communicative. Labs normal CBC, CMET, lactic acid, ABG and LFT's except bilirubin of 2.0 and blood sugar of 174. Flu swab negative.
- Medical records show history of diabetes, lower extremely edema with venous stasis, A fib with pacemaker, restrictive lung disease, anxiety and hypoventilation. Next morning alert and oriented.

- During the P2P call, what key elements would be necessary to present to get an inpt?

Case #6- Total knee. Defend pt status decision.

- 71 YO with co-morbid conditions: hypertension, arthritis, hypercholesterolemia, idiopathic peripheral neuropathy with tingling that starts at about the midtarsals and burning as well that gets worse as it goes to the toes.
- Living situation: pt lives with her husband in a single level home with 2 steps to enter. The bathroom has a walk in shower with seat and toilet is tall.
- Mental Status: pt reports being indept with ADLs and does not use a device to ambulate.
- 1st point of contact: H&P – "Ms R is here for her left knee replacement. I refer the reader to the 12-18 note as well as the 1-12 note by Dr B done in preoperative clearance."
- Post op need: Day #1 – Ms R is doing well. They have got a pain regiment that is working well and she needs the Dilaudid it seems to help with the Percocet. She got a little behind on the meds and talked to nursing. Otherwise she has been very happy with her care."

Case #7: P2P call. Defend Patient Status Decision

- 76 YO female recently treated for bronchitis by her primary care physician with antibiotics and bronchodilators initiated by two days prior who was involved in motor vehicle accident with deployment of air bags and loss of consciousness at the scene.
- Initial saturations by EMS mid 80s. Emergency department evaluations demonstrated a minimally displaced fractured sternum with sats 96-98% on 2 liters 02. Also noted swelling in the sternocleidomastoid muscle felt to be related to the seat belt.
- Patient complaining of lot of chest pain and difficulty taking other than a very shallow breath. Also unable to raise arms above 30 degrees due to pain.

- During the P2P call, what key elements would be necessary /present to find the inpt?
- MA plan. Strategies to have. Contracted? Non –contracted?

Case #8: Total Knee. Defend patient status - inpt vs outpt

- 69 YO with co-morbid conditions: hypertension, hypercholesterolemia
- Living situation: Pt lives in single level home with his wife. There are 3 steps to enter. The bathroom has a walk in shower chair. He has ordered grab bars. He has a raised toilet set and fww.
- Mental status: Pt reports being indept with ADLs and IADL.
- At first point of contact: H&P – Mr S is here totday to have his rt knee replaced. I refer the reader to the very detailed discussion we had on 10-16-17. Questions answered.

NOTE) Office note indicates- "most people are ready to go home on post op day two."

- Post op day #1: We are going to try some Toradol on him and see if that gives him some pain relief without making him feel quite so groggy and combine it with the Percocet. I am also going to get his oxygen with the humidifier because he says he feels like he has a cotton mouth. I talked to him about the importance of being up in the chair. I will discontinue his IV fluids and get rid of the foley. I will check back later tonight."

Case #9: P2P call. Defend the patient status: Obs or inpt

- 73 YO female brought to the ED by family with increased weakness and confusion with history that she may have been running a fever.
- Work up demonstrated new onset atrial fibrillation with rapid ventricular response, troponin 0.47, WBC 16,400 creatinine 1.2, BUN 61, chest x-ray possible LLC infiltrate and new pericardial effusion.
- Initial impression was a concern for possible pericarditis and LLL pneumonia.
- Diltiazem bolus with conversion to sinus rhythm, blood cultures and IV fluids and antibiotics, trend troponins and consult cardiology.

- MA plan. Contracted? Non- contracted? Strategy. Questions to know.

Case #10: Total Knee. Defend patient status: inpt or outpt

- 65 YO female with hypertension, arthritis and migraines.
- Living situation: Pt lives at home with husband, approx 2 hrs from the rural hospital. Pt had left knee in Oct of last year and reports her home is already modified to meet her needs.
- Mental status: Independent
- At first point of contact: H&P- Julie is here to talk about her rt knee She is very happy with her left knee. Before I entered the room, she had just had a good long discussion with dietary to make sure they can meet her needs with eating postoperatively. Questions were answered.
- Post op day #1: Ms W is up in the chair and doing well. She is very excited that she was able to get up and walk in the hallway last night.

Case #11 – P2P call. Defend the patient status

- 55 YO male with Charcot Marie Tooth Muscular Dystrophy, ischemic cardiomyopathy, and Type 1 Diabetes complaining of worsening pain in his right foot.
- Recently admitted with diabetic foot infection and at the time of discharge, “I could have run a marathon.’
- Discharged on oral Keflex and foot has progressed in pain since discharge.
- Afebrile, WBC 10,400, glucose 214, CRP high sensitivity 28.50, MRI mild marrow edema surrounding the 1st interphalangeal joint of the great toe with edema in the plantar base of the great toe suspicious for osteomyelitis. Started on IV zoysyn.

Case #12- Total Knee. Defend pt status – inpt or outpt

- 66 YO who had his left knee replaced several months ago. He came for rt knee now.
- Co-morbid conditions: none found
- Living situation: Lives at home with wife. Home set up after other TKA
- Mental status: Alert and independent.
- 1st point of contact: H&P – not found in the record
- Post op: OP NOTE: had bradycardia down to the high 30s with what appeared to be a junctional rhythm. As far as we could tell, it was a response to probably getting a little extra neo-synephrine and having rebound, but his blood pressure were never low, hemodynamically otherwise he was doing well and by the time he came to the recovery room his pulse was back to the 90s.
- PO day 1#: Mr W is doing extremely well. He is up in his chair, controlling pain well with hydrocodone 10 mg tables. He is in very good spirits. He is already looking forward to going home. He says his stomach is rumbling and he is hopeful that means he is getting ready to have a bowel movement in the future."

#13 Case Study
Do we have a lost inpt below?

84 year old male presented to the MD office for increasing dyspnea and edema that did not respond to outpt. Diuretic therapy. Treatment included echo, IV diuretics, abx, bronchodilators for wheezing, routine labs, CXR, IV lasix x1

Co-morbid conditions: TIA, stroke, CAD, HTN, COPD, Chemo 9-1-15.

10-12 Direct admit to OBS status.

No obs order found.

Care Mgt documented beginning of care/obs – 4:00 pm

Dx in order: CHF

Course of tx: Tele documentation x10 times in the note with no tele order. Strips mounted x3 times with RN signature and note. Increasing dyspnea and SOB that did not respond to outpt therapy.

10-13

Inpt order written at 1003 am.

At the time of inpt conversion – nursing wrote: 10-13 0930 – "Previous documentation from obs admission – refer to ambulatory assessment."

No physician documentation at time of conversion.

Standing Heart Failure Core Measure Orders are signed illegibly without a date, time, or any boxes checked to the order.

10-14- Discharged 1855

- Any risk factors?
- Is this an inpt? Why or why not?

#14 Case Study
Hunting for a missed inpt!

78 year old man with a past and current medical history of chronic illnesses that are well controlled with medications.

Patient slips while shoveling and falls and sustains a closed wrist fracture.

- 11-9 Saturday

  11:00 p.m Pt presents to the ED following fall at home. Pt presents alone.

  11:30 pm Pt arm facture confirmed by MD. Pain medication provided.

- 11-10, Sunday

  3:30 am Pt pain is well controlled, stable for discharge, but continues to required custodial care. No family or friends are available and hospital social services are unavailable until Monday am.

  Pt is held in the hospital pending home care plan, no IV access, pain well controlled with oral medication.

- 11-11, Mon

  10:00 am Discharge to home with family members. No other complaints.

Is this patient an inpt? What is their status? Why would the weekend matter????

Clarify the options for status change, if any?

What to do to reduce risk?

#15 Case Study
How about this inpt?

73 year old male with an accidental environmental toxic exposure presents to the ED.

- 12-1
- 9:00 am Pt arrives by ambulance to the ED. Pt is awake and alert.

  9:03 am Poison control consulted which advises that pt requires telemetry monitoring; plan to intubate if necessary. Small hospital facility, tele monitoring is only available in the ICU.

  9:07 am Therapeutic and Dx modalities have all been ordered and initiated. Pt airway intact.

  10:00 am MD requests transfer to ICU for Tele. Unclear to the physician is this pt will need medically necessary hospital level care/services for 2 or more MN. Determination will be dependent on clinical presentation and results of diagnostic and therapeutic modalities.
- 12-2

  10:30 am Medical concerns/sequelae resolving; airway remained intact absent mechanical intervention.

  12:00 noon Physician writes orders to discharged

- Was there an opportunity to make this an inpt? How about rare and unsual?
- ICU = Inpt? Discuss

#16 Case study
Did we lose this inpt?

78 year m presented to Ed complaining of bleeding gums… condition is chronic for past 35 years. Platelet count critically low at 5,000. 9-20- 1100

Inpt order written by ED provider only/only bridge transitional orders. No authentication by attending. 9-20 1315

H&P plan: Patient is expected to need at least 2 MN for inpt care for the management of thrombocytopenia. Complicated by: Hypertension, irregular heart rate, hyperlipidemia, glaucoma. If not hospitalized, has a significant risk of bleeding to death.

Progress note: Thrombocytopenia resolved very nicely, patient is actually ready for discharge at this point. Will continue with oral prednisone. Follow up with Dr.__ Wean off steroids…other medical problems are stable.

Discharge summary: discussion with Dr ___ he was ready to be discharged .. Patient willing and ready to be discharged as well having no complaints. D/C 9-21

Is this inpt at risk? Why or why not?

What were the strengths in this short stay pt story?

(Can we clone this MD?) Happy face!

#17 Case Study
Do we have an inpt?

68 year old F presented to ED after having a syncopal episode at home. The pt was seen in the ED 3 days prior and was treated for UTI and sent home on antibiotics.

Because of the failed treatment and the syncopal episode, the ED physician and hospitalists felt she needed to stay overnight in OBS. She was treated with IV antibiotics and discharged the next day.

ED 1-22 0648

CPOE order set signed by PA/midlevel; not authenticated by MD directing care.

\ LOS: The PA wrote an admit order with LOS 2-3 days. The attending note prior to the 1st MN stated the LOS was 1 day.

Justification in the H&P by the PA: Failed outpt treatment for UTI

Discharged: 1-23 After care was included in the discharge note only

Is this an inpt? Why or why not?

What at risk issues are identified?

What internal processes should have occurred to prevent the at risk activity?

#18 Case Study
1 MN stay?

- 66 year old F w/history of Hepatitis B and alcohol use presented to ED s/p fall at home. Husband reports that pt has unsteady gait (rubber legs) slurred speech, and frequent falls. Reports her to be increasingly lethargic, sleeping 1-17 hrs day. CT of the head w/o acute findings. Blood alcohol level 0.228 , liver enzymes elevated ALT 114, AST 228.

- 10-26 Inpt ordered at 0930. "Estimated to stay over 2 MN." /from a template in CPOE
- H&P : CIWA precautions and seizure precautions maintained. CIWA score 15.
- The patient is admitted with IV fluids, pulse oz, IV and oral Thiamine, EKG, NSR, HR 60. On telemetry, monitor overnight , reassess in the am.

- D/C 10-27 Mildly tremulous on presentation, received 1 dose Ativan, but then displayed no other symptoms of withdrawal. On the following day, she was ambulating indpently and discharged from home on her usual meds with information on local rehab services.

Is this a presumption inpt? Why or why not?

What is missing to support inpt?

#19 Case Study
A goodie!

72 year old F presented to ED via EMS c/o worsening productive cough, wheezing, and shortness of breath. Received IV solumedrol during transport to ED. EKG without changes, normal sinus rhythm, 02 sat 95-96% RA.

Per ED report, acute exacerbation of COPD, IV antibiotics, and RT treatments administered.

WBC count monitored.

ED 9-30 0253

No inpt order found.

H&P plan: Will monitor WBC count, start her on broad spectrum IV antibiotics and IV steroids, and continue RT treatments.

Progress notes: Less dyspnea, occasional cough, no wheezing. Change to po Prednisone, possible discharge 10-2-15.

Discharge summary: Seems to be improving…insisted on going home due to family issues.

Actual D/C : 10-1

Is this an inpt? Why or why not?

How could this have supported an unplanned short stay inpt?

What risk factors are present?

#20 Case Study Obs to inpt?

94 year old F presented to the ED 4-8 @1450. She was seen in the ER 4 days ago after a fall but the work up showed no significant injuries.

OBS: 4-8 @1830

She was back to her baseline on 4-10 but the nursing home couldn't take care of her due to lack of supplies for her treatment and due to the fact she needed a higher level of care than what they NH could provide. Referred to external PA on 4-8. No documentation of referral/discussion internally.

At the time of 2nd MN, she is improved but continued to receive NS for low sodium level, had crackles in her lungs and blood pressure elevations. Her 02 was in the 90s on 2 L NC.

At the day of discharge, her BNP was slightly elevated and she possibly aspirated.

D/C from obs on 4-13

Is this a missed inpt? Why or why not?

What are some of the 'confusing' factors?

What enhanced issues could have occurred?

#21 Case Study
Same day discharge..

68 year old F presented to the ED c/o tight chest pain, radiating down left arm, also with SOB, diaphoresis and nausea. VSS, EKG concerning for unstable angina, troponin negative, nitroglycerin po, lovenox, cardiology consult. 11-11 0734

Inpt: 11-11 0848 With " Expected to cross 2 or more MN" checked.

H&P: Substernal chest pain/unstable angina. EKG with anterior wall ST depression, which resolved. Going through a lot of anxiety. Concern specific to acute coronary syndrome, questionable EKG changes, unstable angina.

Progress note: 11-11 There was initial concern for acute coronary syndrome because of apparent dynamic EKG changes noted by Cardiology. Cardiac catheterization revealed normal coronary arteries, ECHO with preserved LV function. She was felt to be inpt based on admitting dx of acute coronary syndrome/unstable angina. She improved earlier than anticipated and angiogram/evaluation was negative. She is thru being discharged home.

D/C 11-11 late in the evening

Was this a presumption inpt? Why or why not?

Documentation to support?

#22 Case Study
See a lost inpt?

72 yr old M to ED with 5 days of increasing cough, SOB, chills and fever. Can take 2-3 steps at a time and needs to rest. Pulse ox 86-87% RA.

Inpt order: 4-17 0143

Placed on 3 Liters of 02, lung bases diminished bilaterally. Duoneb treatments initiated. CXR to rule out pneumonia. Blood cultures, lovenox.

H&P: I anticipate the pt will be in the hospital 3 to 4 days ..will use steriods to control COPD. Acute exacerbation of COPD. We will get on IV antibiotics, IV steriods, mucolytics and pulmonary toilet in the form of Duoneb and albuterol.

Progress note 4-17: breathing better, afebrile, pulse ox 96-98%.

D/C 4-18 Got off 02 very quickly and responded to therapy extremely well. His lungs opened up nearly 100% with fairly preserved air exchange. He was discharged much quicker than anticipated. He was feeling well and wanted to go home.

Was this a presumption inpt? Why or why not?

What is at risk with this case?

#23 Case study
This is a good one!

72 year old F presented to the ED 4 days ago for a T7 compression fracture and presented this date for intractable pain and constipation. 10-25 1409

OBS: placed for intractable pain and constipation. Treated with IV meds, IVF, nausea medication. 10-25 1841

Inpt order: 10-27 1543 for continued IV pain and nausea medication.

Then placed back into obs: 10-30 1201 with no notation other than the order. She underwent a kyphoplasty 11-2 and was discharge 11-3 as obs.

No documentation for CC 44 if accurate.

Is this an inpt? Why or why not?

What confusing factors were present?

Sort this one out and advise on multiple status changes, if appropriate.

#24 Case Study
Looks good?

65 year old M brought to ED after being found at home unresponsive. Awake but weak and confused on arrival. Apparently had a fall at home and reported unable to get out of bed x 2-3 days. WBC 18,100

CRP 20, 02 sat 85% with wheezing and poor air movement, CK 2998. 6-19 1540

OBS: ER doctor placed in obs for syncope. 6-19 @1800

Inpt order: 6-20 1937 admitting documented sepsis with encephalopahty and rhabdomyolysis.

Treatment with IV meds, tele, 02 and nebs. Still confused, wheezy and requiring 02, WBC 15,200 and a new onset of Afib.

Expired 6-22 following a code.

Is this an 2 MN benchmark case? Why or why not?

What risk factors are prese