OBSERVATION STATUS

When the decision to place a patient in Observation status is made, it is important to communicate the reasons behind that decision with the patient and family. Remember, Observation and Inpatient status are based on rules set forth by Medicare and other insurers. Your participation in those Plans requires you to comply with those rules, and it’s OK to communicate that to patients. Other key points about Observation to remember include:

Observation patients are not “Less Sick”:
- Observation patients are not necessarily “less sick” than inpatients. Their undiagnosed symptoms could represent anything from a minor illness to a life-threatening condition.
- Observation means the patient needs extra attention for a short time period to gain a clearer picture of the condition.
- Either we know we can “fix” the problem in less than 24-48 hours, or we don’t know exactly what their problem is, yet.

DISADVANTAGE to placement in Observation:
- For Traditional FFS Medicare, any time a patient spends in Observation does not count toward the 3 Day qualifying stay needed for Skilled Nursing placement after the hospital stay. The clock on those three days does not start until an inpatient order is written.

Continued...
Time:
- Time is measured in minutes/hours, not days – Time is of the Essence.
- Sense of URGENCY to decipher the nature and trajectory of the patient’s condition.

Patient Expense:
- Out-of-pocket costs for patients with similar conditions are significantly LESS when treated in Obs compared to inpatient.
- 93% of Medicare patients accessing Lee Health System have Medicare supplements that cover all out-of-pocket expenses.

Potential to Change Status:
- Change from Obs to Inpt is easy (when appropriate).
- Change from Inpt to Obs is possible, but it requires the OK from the System UM committee and some administrative work prior to discharge.

Location in Hospital:
- Observation patients don’t have to be in an “Observation Unit.” Level of care based on severity of condition, foreseeable risks and intensity of services provided, not based on physical location of the bed, dictates placement status.

Change the Culture of Language: (Medicare considers “Admission” to mean Inpatient)
- Verbiage/Vocabulary – Better to use term “Place” in lieu of “Admit” and “Placement” for “Admission.”

***Should you have questions about Observation/Inpatient Status or any other questions pertaining to Payer coverage or Utilization issues, feel free to contact one of the System’s Physician Advisors:

Jon Hart, MD – Cape Coral cell 812-345-0718  Bob Brown, MD – HealthPark cell 239-770-6702
Alex Paya, DO – Gulf Coast cell 786-223-3714  Anita Shinde – Lee Memorial cell 609-350-3666

Continued...
Medicare Observation or Inpatient? Placement Decision Test

Does condition require hospital treatment?*

Yes

Can condition be evaluated/treated/improved within 48 hours?

Yes

Observation is appropriate.

No

Alternate level of care is appropriate

No

Unsure

Additional time is needed to determine if inpatient placement is medically necessary. Observation is appropriate.

* "The decision to admit a patient as an inpatient requires complex medical judgment, including consideration of the patient’s medical history and current medical needs, the medical predictability of something adverse happening to the patient, and the availability of diagnostic services/procedures when and where the patient presents."
Good news for Athens users:

**Natural Medicines**, the evidence-based database of alternative therapies, herbs, vitamins, supplements, and their interactions with prescribed medicines is now available through Athens. If you don’t have Athens account yet, contact the medical library to access online resources from your home computer: medlibrary@leehealth.org. There is no charge for this service – just another benefit from Lee Health.
CORRECTION TO Revised Policy- M0303578- Methotrexate Administration for Treatment of Confirmed Ectopic Pregnancy- From February 2017 P & T Meeting

- ED Physicians do not want ordering privileges for methotrexate for ectopic pregnancy – this has been removed from the policy

Formulary Deletions:
Alum bladder irrigation is no longer manufactured. In place of alum, a therapeutic interchange will automatically occur to aminocaproic acid 0.2% for bladder irrigation in patients with hemorrhagic cystitis.

Therapeutic Interchanges:
Promethazine (Phenergan®) 25 mg/mL injection national shortage: therapeutic interchange to ondansetron

If the supply of promethazine injection 25 mg/mL is exhausted at any LMHS hospital an automatic therapeutic substitution will be allowed for the use of ondansetron at a dose of 4 mg IV Q8H prn unless the patient has already failed treatment with ondansetron.

Additional Drug Information:
ACETYLCYSTEINE (MUCOMYST 20%) oral treatment of acetaminophen overdose:
An order set for acetylcysteine oral treatment of acetaminophen overdose was developed in collaboration with ED and pediatric physicians.

Enoxaparin once daily EPIC default dose time change:
The enoxaparin once daily for VTE EPIC default dose time has changed from 09:00 to 18:00. This timing change will allow providers to evaluate patients and order procedures in the morning without enoxaparin as a confounding factor.

Current Drug Shortages:
Calcium Chloride Injection 1 g/10 mL vials/syringes – critical shortage, not being supplied
Diazepam Injection 10 mg/2 mL – critical shortage, not being supplied
Lidocaine 0.5%, 1%, 2% with Epinephrine, all sizes - critical shortage, not being supplied
Sodium Bicarbonate 8.4% 50 mL syringes/vials - critical shortage, not being supplied
Promethazine 25 mg/ml injection – sporadic availability
FORMULARY ADDITIONS:
Ferric Carboxymaltose - Injectafer® RESTRICTED TO OUTPATIENT USE - Adults

Therapeutic Interchanges:
Following up from March P&T safety hydromorphone initiative: A proposal allowing the following pharmacist therapeutic interchange is approved:

Initial Hydromorphone (Dilaudid) Injectable Dosing
In Opioid Naïve adult patients a maximum dose allowed is 1.5 mg unless the patient has demonstrated lack of pain relief with a previous therapy using a maximum 1.5 mg cap on the current admission. The pharmacist has the therapeutic interchange authority to automatically change orders to reflect this intention. For example: A range order of 1-2 mg iv q 3hrs prn pain in an opioid naïve patient will be interchanged by the pharmacist to 1-1.5 mg IV q 3 hrs prn pain.

Current Drug Shortages:
Calcium Chloride Injection 1 g/10 mL vials/syringes – critical shortage, not being supplied
Lidocaine 0.5%, 1%, 2% with Epinephrine, all sizes - critical shortage, not being supplied
Methylene Blue Injection 1 mL & 10 mL
Sodium Bicarbonate 8.4% 50 mL syringes/vials - critical shortage, not being supplied (Code blue carts will contain only 2 syringes and 1 vial of sodium bicarbonate)
NEW
3404-A PEDIATRIC ACETYLCYSTEINE (ACETADOTE) IV ORDERS FOR ACETAMINOPHEN OVERDOSE

REVISED
3018 NICU ADMISSION ORDERS
3019 NEONATAL CONTINUING CARE ORDERS
3202 ELECTROPHYSIOLOGY/TILT TABLE STUDY/IMPLANT LAB POST-PROCEDURE ORDERS
3256 NEUROSURGICAL POST-PROCEDURE SPINE ORDERS
3268 AMIODARONE (CORDARONE) INFUSION ORDERS
3283 CHOLECYSTECTOMY POST-PROCEDURE ORDERS
3356 NEONATAL PAIN MANAGEMENT ORDERS
3404 ADULT ACETYLCYSTEINE (ACETADOTE) IV ORDERS FOR ACETAMINOPHEN OVERDOSE
3456 PODIATRY PRE-PROCEDURE ORDERS
3456 PREP FOR PODIATRY PRE-PROCEDURE ORDERS (Epic 1367)
3488 ACUTE ISCHEMIC STROKE/TIA ADMISSION ORDERS
3574 ICU INTENSIVIST ADMISSION ORDERS
3578 COLORECTAL SURGERY ERAS POST-PROCEDURE ORDERS
3637 COMFORT CARE ORDERS
3655 INTRACEREBRAL HEMORRHAGE ADMISSION ORDERS
3663 COMPLEX WOUND MANAGEMENT ORDERS
3684 COLORECTAL SURGERY POST-PROCEDURE ORDERS
3703 SUBARACHNOID HEMORRHAGE ICU ADMISSION ORDERS
3723 STAGE 1 AND STAGE 2 PRESSURE INJURY ORDERS
3724 STAGE 3, STAGE 4 OR UNSTAGEABLE PRESSURE INJURY AND DEEP TISSUE INJURY ORDERS
3785 SPINAL CORD INJURY ORDERS FOR TRAUMA PATIENTS
3845 TOCILIZUMAB (ACTEMRA) FOR RHEUMATOID ARTHRITIS INFUSION ORDERS

Continued...
New & Revised Physician Order Sets - May 2017 (Cont’d)

3859  NEURO INTERVENTIONAL RADIOLOGY ADMISSION ORDERS
3860  NEURO INTERVENTIONAL RADIOLOGY POST-PROCEDURE ORDERS
3861  NEURO INTERVENTIONAL RADIOLOGY ARTERIOGRAM PRE PROCEDURE ORDERS
      PREP FOR NEURO INTERVENTIONAL RADIOLOGY ARTERIOGRAM PRE PROCEDURE ORDERS  (Epic 1254)
3862  NEURO INTERVENTIONAL RADIOLOGY ARTERIOGRAM POST PROCEDURE ORDERS

Multiple order sets, including most post-op sets, also have a revision to the wording for bladder scan/discontinue urinary catheter procedures.
Patient Safety Indicators

According to the AHRQ, Patient Safety Indicators (PSIs) are a set of measures that screen for adverse events that patients experience as a result of exposure to the health care system. These events are likely amenable to prevention by changes at the system or provider level.

PSIs are monitored from a Lee Health System perspective and are dependent upon accurate and complete documentation.

CDI’s role in regards to the documentation of PSIs is to ensure that the condition and all circumstances around the condition are documented with accuracy in regards to present on admission status, consideration of inclusion/exclusion criteria, as well as ensuring documentation of any associated/related medical conditions. All inpatient records that include the coding of a PSI within the PSI 90 bundle are sent through a second level review process to ensure accurate documentation/coding and/or to assess whether a query is needed for further clarification.

Ex: PSI 03 Pressure Ulcers – If pt develops a PU stg 3 or 4 that is not present on admission, this will count as a PSI. If the patient has hemiplegia/paraplegia/quadriplegia and is documented, this will negate or exclude the patient from this PSI.

Ex: PSI 07 Central venous catheter bloodstream infection – If patient develops a CVCBSI which is not present on admission, this will count as a PSI. If the patient is documented as having an immunocompromised state, this will negate or exclude the patient from this PSI.

Severe Sepsis

Outside entities, such as Healthgrades, Leapfrog, Truven, and CMS, grade our facilities on observed to expected outcomes and cost efficiency in the treatment of Sepsis and Severe Sepsis. To ensure integrity and clinical validity, consider a diagnosis of Severe Sepsis when evidence of new organ dysfunction manifests. Criteria include:

- Hypotension SBP <90, MAP<65, or 40mmHg drop in SBP from baseline
- Lactate >=2
- CR >2 or an increase of 0.5 from baseline/Acute Renal Failure

Continued...
- Urine output <0.5ml/kg/hr over 2 hours
- Hyperbilirubinemia: total bili >=2
- Coagulopathy: Plts <100,000, INR >1.5 or PTT>60sec/ DIC
- Altered mental status/Encephalopathy
- Acute/New Respiratory Failure
- Bilateral pulmonary infiltrates & increased 02 requirements to maintain sp02 >90%

**CMS-Hierarchical Condition Category (HCC)**

- Risk adjusted capitation payments for Medicare Advantage (Medicare Part C)
- Clean slate every year on January 1 (And yes, that means if it’s not documented yearly, it doesn’t exist (i.e. the knee amputation apparently grows back))
- More than 1 HCC can be assigned per encounter BUT Not all diagnoses map to HCC
- **Most importantly- document to the highest level of specificity!**
- Examples of HCC’s
  - Protein Calorie Malnutrition
  - Specified Bacterial Pneumonia and Aspiration- unspecified pneumonia is not an HCC
  - Diabetes w/complications
  - Drug/ Alcohol dependence
  - CHF
Medical Staff Matters

Continuing Medical Education
June 2017

Pediatric Grand Rounds: Is it an ALTE or a BRUE?
Rolando Chuquimia, MD
Pediatric Hospitalist
Golisano Children’s Hospital of Southwest Florida
6:30 – 7:30 PM on Thursday, June 15, 2017
HPMC Captiva Room

Target Audience: Pediatricians, Family Practice Physicians & Nurses
Learning Objectives: Participants will be able to identify an ALTE, identify a BRUE, and discuss the differences between an ALTE and a BRUE.
RSVP for CME and dinner by Thurs. 6/15 – (239) 424-2680 or email:
Maegan.Trice@LeeHealth.Org
For WebEx information for remote participation, please contact
Maegan.Trice@LeeHealth.Org

SAVE THE DATE
6:00 – 7:00 PM on Monday, June 19, 2017
LMH MOC 8th Floor Classroom

Pediatric ED Grand Rounds:
Reporting Child Maltreatment in the Florida Context
Walter Lambert, MD
Medical Director, Child Protection Team of Southwest Florida
Associate Professor of Clinical Pediatrics at University of Miami Miller School of Medicine
7:30 – 9:30 AM on Wednesday, June 21, 2017
HPMC Sanibel/Captiva Room

Target Audience: Physicians, nurses and allied health
Learning Objectives: Participants will be able to discuss FL Statues of reporting and identify injuries of children.
RSVP for CME and breakfast by Wed. 6/21 – (239) 424-2680 or email:
Maegan.Trice@LeeHealth.Org
Lee Health is accredited by the Florida Medical Association to provide continuing medical education for physicians. Lee Health designates this live activity for a maximum of 1 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Lee Health is an approved provider of continuing Nursing Education (FBN2151). Lee Health has applied for 1 contact hour for this lecture. Faculty and Lee Health will disclose any real or apparent conflict of interest related to the content of the presentation. Faculty will also identify any off label or investigational uses discussed as such.

Nicole Steinkohl, BS, CMA, CME Coordinator – Nicole.Steinkohl@LeeHealth.org
Maegan Trice, CME Secretary – 424-2397, Maegan.Trice@LeeHealth.org
Emergency Dial Codes changed to 444

Lee Health is dedicated to safe, quality health care. When an emergency occurs, clear communication is important for quick response to protect patients and staff. One way to ensure the quickest response in an emergency is to standardize emergency dial codes. Effective May 1, 2016, the emergency dial code in all Lee Health hospitals has changed to: 444.

The emergency code system notifies staff about an event that requires immediate action. The intent is to relay urgent information in a timely, understandable manner and elicit a prompt and proper response. Standardizing the dial code across the system provides clarity since employees often work in more than one facility, sometimes within the same day.

All gold card emergency information listings will be updated to reflect the new 444 dial code, and you may notice reminders posted near employee time clocks and volunteer check-in stations. Team meetings and huddles are great opportunities to remind staff of this important change, and to review all emergency codes.

For more information, or if you have any questions, please see your immediate supervisor.
The Staff and Administration of Lee Health are pleased to announce Juanda Vinodhkumar, M.D. as Physician of the Month.

We saluted Dr. Vinodhkumar for exemplifying the qualities of an excellent physician and we are pleased to have had Dr. Vinodhkumar as a respected member of our medical staff since August, 2012.

“Dr. Vinny is an excellent physician.”
“Works well with all her colleagues.”
“Her passion for all her patients is superior and exemplary.”
“A provider always with a smile and positive attitude.”
“She is the punctilious physician.”

Way To Go!

Congratulations Dr. Vinodhkumar!
PHYSICIAN OF THE MONTH NOMINATION FORM

PHYSICIAN OF THE MONTH NOMINATION

Please take a moment to nominate the physician that Wows you!

Nominations should be based on criteria such as consistent quality, attitude, professionalism, compassion, and going “above and beyond” what is reasonably expected. Lee Health wants to recognize physicians who exemplify these qualities of excellence.

Physician’s Name: ______________________________________________________________

Specialty: _____________________________________________________________________

Reason for Nomination: _____________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Name (optional):________________________________________________________________

*Dept/Area:_______________________________________________________________

*Your Facility/Location:________________________________________________________

*Award presentations are customarily scheduled in the unit where the most nominations are received.

Please fax nomination to 239-343-0487, e-mail to POM@leehealth.org or interoffice mail to Medical Staff Services @GCMC.
Has your email address changed for your home or office?

Please email Kim Coombs at Kim.Coombs@leehealth.org or call her at 239-343-2142 with your new email address

Please submit any future Medical Staff Matters Newsletter Articles to:
Yolene Derissaint, CPCS via e-mail at Yolene.Derissaint@LeeHealth.org