

INTERQUAL OVERVIEW

BY W. LEIGH DILLARD, MD

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DEFINITION: Sets of criteria used to determine suitability of patients for the level of care chosen by the physician and to assess the appropriateness of the service provided. McKesson Health Solutions, LLC, has developed these criteria and published them as screening guidelines. They are rapidly becoming accepted as "Standards of Care." The criteria are developed by McKesson's clinical research staff and refined as needed. These criteria are evidence-based standards and consensus opinions of current practices from many physicians, both specialists and primary care.

IMPACT: In my opinion, this extensive data set of criteria will become more and more binding on physicians. Knowledge is power, and, we, as physicians, should become familiar with InterQual. The double-edged sword here is, on the one hand, denial of payments or pre-certifications if the criteria are not met; while, on the other hand, measures of deviations from the standard of care having

legal ramifications of liability.

BUZZWORDS: Below is a short list of terms and abbreviations that will help you understand the language of Utilization Review and is by no means complete.

Severity of Illness (SI): Criteria that form objective, clinical indicators of illness, focusing on patient presentation rather than diagnosis. Components include: Time, Clinical Findings, Imaging Findings, ECG Findings, and Laboratory Findings.

Intensity of Service (IS): Monitoring and/or therapeutic service criteria that determine the appropriateness of the level of care selected. These criteria are also used to determine the appropriateness of the service provided according to the clinical indicators that were used for the SI.

Discharge Screens (DS): Criteria based on clinical indicators to determine if the patient has reached the level of stability that will allow safe discharge to the next level of care.

Review Types:

- Preadmission Review (SI)
- Admission Review (SI & IS)
- Continued Stay Review (IS)
- Discharge Review (IS)

Level of Care (Status):

- Observation Status
- Intermediate Care Status
- Acute Care Status
- Critical Care Status

TIPS: The more data you provide that influenced your decision to seek a certain level of care, the more likely the review will substantiate your decision. Do not seek a level of care based solely on the diagnosis (i.e. chest pain). Add to the diagnosis the clinical indicators that necessitate the chosen level of care. Observation status is your friend when you are unsure, or need more time or data to choose the appropriate level of care.

Reference: [InterQual Level of Care, Acute Adult Criteria](#); McKesson Corporation 2006

COMMENTS ON THE 2006 YEAR

BY PETER WAY, MD

Congratulations to all who survived this year! We had to cover a lot of new ERs and a lot of holidays for a long time, far from our families, and endure personal hardships. But, we come out wiser doc-

tors and better people. As we look forward to a brighter new year, there remain some details that we as a group can improve upon.

This year, we had an unexpectedly higher number of

pediatric and geriatric deaths. While this was a national trend, a number of these were due to an over-optimistic reliance on outpatient treatment after discharge.

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OH, THE QUESTIONS!

BY BRUCE HAMEL

A study published by Institute for Healthcare Improvement two years ago estimated that 60% of all unnecessary hospital deaths result from a lack of communication. Not surprising, as many other studies and organizations have come to similar conclusions. In response to these findings, the Joint Commission for the Accreditation of Healthcare Organizations (JACHO) has issued Patient Safety Goals, including Goal 2E, that addresses the hand-off of patients between peers. With JACHO accreditation on the line, many of our hospitals have launched campaigns to ensure they are in compliance.

Similarly, many professional physician societies and colleges have adopted new standards addressing handoffs between physicians. As an example, in February 2006, the Society of Hospital Medicine, the national organization for hospitalists, adopted Core Competency 47, which covers much of the same information as JACHO.

How does this affect an ED Physician? The answer is that we are being asked more questions when handing off a patient for admission. Questions include administrative details, clinical status, pending tasks and priorities, severity of illness assessment and others. Admitting physicians

are now being held much more accountable for the decisions they make at the time of admission. This includes documenting that proper handoff discussions were held with ED physicians.

A related change occurred on Oct. 1 of last year, when the CMS issued new guidelines for Diagnostic Related Groups (DRGs). These changes make it more difficult for hospitals to get paid for certain admissions. Admitting physicians are now also being held responsible for ensuring that the hospital has the capabilities to adequately treat admitted

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COMMENTS ON THE 2006 YEAR (CONT. FROM P. 1)

BY PETER WAY, MD

"Other than death due to missed diagnosis, incomplete charting is most likely going to get anyone removed from a schedule."

Whether this was due to increased pathogenic virulence, increased non-compliance, disregard for personal care, or a more susceptible population, the solution is more inpatient treatment either as observation or admission. This is especially true for the geriatric and pediatric population who are both more likely to get worse from all diseases and more likely to die from the same. The diagnoses I most frequently see in chart review and med staff meetings that lead to morbidity and mortality include: dehydration, sepsis, influenza, tracheobronchitis, bronchiectasis, exacerbation COPD, missed myocardial infarctions, in that order. Please also note that the medical staff is extremely critical when this happens to their patients.

We are doing much better following EMTALA regulations during transfers. If you are not completely familiar with

these laws, please get a copy of a review article on EMTALA from ESS. Please note that you may divert an incoming ambulance if you have no beds available in the ER or Hospital, or you feel another hospital equally close can provide care not available at your facility. Also, any non-emergent ambulance transfer from your ER will need an appropriate reason documented for transfer, such as bedridden state, needing oxygen or monitoring, requiring IV, etc.

Also, make sure to stabilize and diagnose as much as possible in the ER before admitting or transferring. If necessary, hold a patient in the ER until you determine if transfer is necessary, as EMTALA laws no longer apply once a patient is admitted, and this may make getting a transfer very difficult once admitted. Conferring with the on-call physician may be a wise choice in this process.

Unfinished charts generally irritate hospital administration and cause all kinds of trouble (no, you don't want to know). Please be certain to finish all documentation prior to your departure from an ER. If you are providing Hospitalist Care, this applies doubly for you. Other than death due to missed diagnosis, incomplete charting is most likely going to get anyone removed from a schedule.

For those of you who are newly graduated, or as we old timers say, "green," please have patience. It is very difficult to find a comfortable working environment at first, until after one or two years of experience to make everyone comfortable with your skills. We will do our best to work with you, but it is just "hard times" and all of us have lived through it.

So, as Forrest Gump said, "That's all I've got to say about that."

EVIDENCE-BASED MEDICINE IN YOUR FUTURE

BY W. LEIGH DILLARD, MD

As we accumulate data in the information age, certain patterns of diagnosis and treatment of disease are rapidly emerging. The result of this compilation and organization of data is called evidence-based medicine. In the very near future, this evidence will be used to evaluate the way we practice medicine. Insurance, government, and other payers are pushing for this data and will use it like a club to influence, if not direct, the pathways physicians follow in diagnosis and management of disease. Physicians are not at the forefront of this rapidly emerging database; but, beware, it is the next most ominous threat to physician autonomy on the horizon.

We, as physicians, should be open to evidence of better ways to fight disease. We, as physicians, have practiced some form of evidence-based medicine our entire professional lives. I know of no physician who desires to give a treatment that does not work or a diagnosis that is not correct. The key for physicians is not to let the peer review of evidence-based care be retrospective. The area where we always look bad is the interval

between the onset of symptoms and the arrival at an accurate diagnosis. The practice of medicine looks easy to researchers who have the benefit of a final diagnosis to start with. I wish patients I treated came with a specific diagnosis flashing on their forehead. A sick patient usually requires supportive treatment while a specific diagnosis is being sought. Often, the preliminary diagnosis does not turn out to be the final diagnosis. Evidence-based medicine, retrospectively, reviews from the specific, final diagnosis, and that is not fair to the treating physician.

Payers hope to use this retrospective review to deny payment for what they feel is redundant or unnecessary testing or treatment. I feel the payers see this only from the economic side and fail to recognize the complexity of the entire spectrum of care. Most of us have seen a CT scan, ECG, blood chemistry, etc. change dramatically in a short period of time. When there is no change, the test can be reviewed as redundant or unnecessary. Reviews fail to see the diagnostic value of a negative test. The simple

fact that the term "rule out" has become a billing curse word should attest to the ignorance of non-clinical reviewers.

I heard Paul Keckley, Ph.D. speak at a conference recently. I felt he was very physician unfriendly to those of us in attendance. I felt he thought he could do it better, as does everyone who is a Monday morning quarterback. He does have a large database available on his website under "Vanderbilt Center for Evidence-Based Medicine." There is also a tremendous amount of data available at this website: <http://www.guidelines.gov/> and all this data can be downloaded free.

Before I get on a rant here, suffice it to say to physicians and caregivers everywhere: **BEWARE OF HOW EVIDENCE-BASED MEDICINE IS THRUST UPON YOU.** Be informed and proactive as this concept evolves.

Until next time, Godspeed.

"The practice of medicine looks easy to researchers who have the benefit of a final diagnosis to start with."

OH, THE QUESTIONS! (CONT. FROM PAGE 2)

BY BRUCE HAMEL

patients, to include both specialty care and facility resources.

Again, this means more questions for you whenever you ask another physician to admit. While we are all convinced that good communication promotes quality care, answering questions takes additional time. As we are not used to having to answer these questions, it

would be easy to assume the attending physician is being stubborn or lazy. While some really are stubborn or lazy, we can't make that assumption just because they are asking questions associated with new standards of care.

As is the trend, physicians are being asked to put ten pounds of work into a five pound bag of time. This is

another one of these instances.

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“WHERE EVERYBODY KNOWS YOUR NAME”

BY W. LEIGH DILLARD, MD

Okay, so what is the great secret? What makes some doctors revered and others disliked? What is it that makes a patient feel comfortable with the care they have received and trusting enough to return to that doctor for any medical need? What is it? It is an attribute not commonly associated with the front line Medical Doctor. It is probably not even an attractive trait when viewed by a busy and pressured ER physician.

It is a compassionate and patient bedside manner. It is the ability of the physician to convince the patient that their case is important and that the physician truly cares. It has nothing to do with knowledge or medical ability. It has nothing to do with credentials or past performance. Medical knowledge and proper procedures can be judged later in court. Only the patient and family present can judge the feeling they get from the treating physician. If the patient or family feels the treating physician truly “gives a damn” about their welfare, no one will ever convince them differently. This ability to instill a sense of fraternity into the doctor/patient relationship even has positive medical treatment value.

So, how do you convey it? Here are some of the suggestions I feel are key points in developing this feeling in your patients:

1. Make eye contact with an interested look on your face.
2. Say something non-medical in greeting and shake their hand.
3. Ask about the illness, including how the patient feels.
4. Ask how the illness is affecting their lifestyle.
5. Use their name at least once in the medical interview.
6. Remember, laughter is the best medicine.
7. Touch the patient in a comforting way, and in the examination way.
8. If you don't know, tell the patient so, but express interest in finding out.
9. Make the advice you give sound personal, i.e. “I am writing a prescription for you,” not “I'll write a prescription.”
10. Be sure the patient and family feel comfortable in reporting back if the results of your treatment are not satisfactory. Many patients think they have to go to another doctor; they often think they will hurt your feelings if you find out your treatment did not work. You must address that at the initial encounter. Remember, the last doctor is always right.

There certainly must be other suggestions out there. Please send them to Donna at ESS (donna@emergencystaffingsolutions.com), and we will publish the best ones in the next newsletter. 'Till then, Godspeed.

ESS CORNER

Happy New Year to all! Out with the old and in with the new, as the saying goes. In that mode, ESS is busy reconstructing and improving our website. The new website will feature downloadable forms, a secure password system for administrators and physicians to access confidential information, as well as improved accessibility to pertinent information.

Back by popular demand—the ESS newsletter! Dr. Leigh Dillard and Dr. Peter Way have been the foundation for the success of this newsletter in the past. Future newsletters will also feature articles by EPBS, our billing company, Lockton, our malpractice insurance carrier, and our various medical directors. We encourage anyone who would like to share information to submit articles to Donna at donna@emergencystaffingsolutions.com for possible publication.

Also in the coming months, HCC will publish its own newsletter. Mr. Bruce Hamel, Vice President of HCC, contributed to the newsletter this month. Hopefully, you will find his article to be informative on both the ER and the Hospitalist side.