MISSOURI HOSPITALIST SOCIETY

Publisher:

Division of General IM

University of Missouri

Columbia, Missouri

Editor:

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MISSOURI HOSPITALIST

Issue 17 May 28, 2009

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Hospitalist Update

Novel Care Centers: Their Impact on Hospitalization and Hospitalists

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Timely, affordable primary care is increasingly inaccessible for many patients, especially for the growing population of those disenfranchised by the health care system; these individuals have increasingly relied on Emergency Departments for the acute management of their problems. At the same time, EDs, an expensive means of health care (especially for the uninsured) have become excessively crowded and inefficient, having to deal with the additional load of non-critical urgencies. Nationally, a commitment to Emergency Department services has declined while the demand for them has continued to rise.

Medical Boutiques, Retail Care Kiosks and Urgent Care Centers (collectively referred to as Novel Care Centers—NC—in this article) are springing up to fill the void, marketing themselves as convenient sites for episodic, cheaper and more efficient care. Within our fragmented health care system, they have positioned themselves to offer an alternative to traditional primary care while also siphoning low to mid acuity patients from the ED waiting rooms.

Staffed by PAs, NPs and Clinical Nurse Specialists, who are supervised by an off-site or on-site physician, they have attracted a growing number of patients who prefer episodic convenience to traditional continuity of care. As primary care clinics struggle with increasing overhead costs and decreasing reimbursement, the NCs have emerged as an attractive and competitive alternative for routine health care. These new service models offer expanded hours, one-stop shopping (including Xrays, labwork, minor trauma management, workmen's comp evaluations, drug testing etc.) and on-demand service. Since the shift to these health care facilities is a recent trend, much remains unknown regarding their long-term impact on traditional forms of health care.

In a recent study, both the payer mix and the provider salaries were comparable to a traditional family practice office. The same study emphasized the convenience of the NCs when it comes to evening, weekend and holiday service. (continued on page 2)

For the Hospitalist, these Novel Care Centers pose a number of potential problems:

1. Since these facilities concentrate on acute intervention, patients transferred for hospitalization may not have had adequate attention regarding preventive care and management of any chronic health problems that they might have. This may be an especially significant issue when dealing with elderly and complex patients.

2. Due to their independence from major hospitals, NCs may not have the capability to efficiently transfer medical records at the time of admission.

3. A lack of clear and consistent industry standards has resulted in a wide range of care quality in these facilities, potentially reflected in the patient's condition at the time of hospital admission. Unfortunately, most NCs are for-profit ventures, driven by market forces rather than by an operational mission. Currently, almost half of urgent care centers are owned by non-medical entrepreneurs.

4. The use of pre-packaged medications and a close relationship with pharmaceutical representatives and alternative health services may dictate the treatment patterns at some of these facilities.

5. Patients attracted to the NC model may have less interest in preventive health care and may present with advanced underlying disease which might significantly complicate their hospital course.

6. At the time of discharge, patients who routinely use NCs for their care may have no established relationship with a primary care provider, thereby complicating any follow up that may be indicated and essentially negating any continuity of care.

In conclusion, the increasing availability of Novel Care Centers may impact the Hospitalist's ability to provide quality care while also attempting to reign-in hospital costs and ensuring a smooth transition of care post discharge.

HOSPITALIST CONFERENCE

HOSPITAL ACQUIRED INFECTIONS

MISSOURI ACP MEETING

SATURDAY, SEPTEMBER 26, 12:15 PM

CASE OF THE MONTH

SYED AHSAN MD

A 46 year old female, with a past medical history of hypertension and hypothyroidism, presented to the Emergency Department with abdominal pain. The pain was described as epigastric, sharp, 7/10 and radiating around to the back, bilaterally. The symptoms started approximately 2 days prior to presentation and had been unrelenting in severity and quality. She noted that the pain increased with oral intake but denied any alleviating factors. She experienced nausea but no vomiting. The patient reported a similar episode about two weeks earlier, for which she was evaluated in the ED; at that time, she was discharged home with a diagnosis of probable gastritis after blood work and an ultrasound were found to be normal. There were no findings of gallstones, pericholestatic fluid or common bile duct dilatation on the abdominal ultrasound.

The patient's home medications included atenolol, hydrochlorothiazide, lisinopril, levothyroxine and Prilosec. She lives with her husband and daughter and works as a school bus driver. She is an active smoker with a history of 1 pack per day for 25 years. She reports rare alcohol intake and denies the use of illicit drugs. The patient also denied any recent travel or sick contacts.

Her physical exam was remarkable for normal, stable vital signs and a BMI >35. Her abdomen was obese and soft, with increased tenderness in the epigastric region. Bowel sounds were present with no guarding or Murphy's sign. The remainder of her physical exam was entirely normal.

Admission labs were remarkable for hyponatremia (131), hyperglycemia (315) and an elevated lipase (79). Her UA revealed 500mg/dL glucose and proteinuria of > 300 mg/dL. The remainder of her blood work, including CBC, LFTs and TSH, was normal. An abdominal CT with contrast revealed mild stranding around the pancreatic body and tail with evidence of moderate pancreatitis.

The patient was admitted to the Internal Medicine ward service with the diagnosis of pancreatitis. She was made NPO and treated with IV fluids and pain control. Further discussion with the patient revealed that her PCP informed her that she had diabetes mellitus but she did not return for follow up. A fasting lipid profile returned a serum triglyceride of 2386 mg/dL, total cholesterol of 409 mg/dl and a low HDL.

The patient responded well to conservative treatment and received education regarding her diabetes mellitus and hyperlipidemia. She was discharged on insulin, a fibrate and an oral hypoglycemic agent.

Discussion: Hypertriglyceridemia accounts for 1.3-3.8 percent of cases of acute pancreatitis. Serum triglyceride concentrations of > 1000 mg/dL can precipitate attacks of acute pancreatitis though the specific pathogenesis of inflammation is unclear; such attacks occur in less than 1 in 5000 individuals. The serum may appear opalescent due to an increase in very low density lipoprotein or milky due to hyperchylomicronemia. Most adults have a mild form of genetically inherited hyperlipoproteinemia, coexistent with conditions known to raise serum lipids; these cofactors include obesity, diabetes mellitus, hypothyroidism, alcohol abuse, pregnancy, HRT, glucocorticoid excess, nephrotic syndrome and beta blocker therapy.

The clinical presentation of these patients is very similar to other forms of acute pancreatitis but the serum amylase may not be elevated. Treatment is directed at active control of the hyperglycemia and hypertriglyceridemia with insulin and other agents. References are listed on the next page.

References:

Toskes, PP, Hyperlipidemic pancreatitis, Gastroenterol Clin N.A. 1990; 19:783

Fortson MR et al., Clinical assessment of hyperlipidemic pancreatitis, Am J Gastroenterol 1995; 90:2134

Krauss RM and AG Levy, Subclinical chronic pancreatitis in type 1 hyperlipoproteinemia, Am J Med 1977; 62:144

FROM THE JOURNALS — Kyle Moylan MD

Prevention of Postoperative Pulmonary Complications:

Zarbock, A. et al., *Prophylactic Nasal Continuous Positive Airway Pressure Following Cardiac Surgery Protects from Postoperative Pulmonary Complications: A Prospective, Randomized, Controlled Trial in 500 Patients*, Chest 2009; 135:1252-1259

Compared with intermittent nasal CPAP, six hours of prophylactic nasal CPAP reduced pulmonary complications and ICU readmissions after elective cardiac surgery.

Long term consequences of acute delirium:

Fong, TG et al., *Delirium accelerates cognitive decline in Alzheimer's Disease*, Neurology 2009; 72:1570-1575

Delirium is typically described as a reversible confusional state but this study demonstrated that delirium was associated with an accelerated course of cognitive decline in older adults with Alzheimer's Disease. Efforts to prevent delirium in hospitalized older adults may have long term benefits.

Transitions of Care: Room for improvement and a Consensus Policy Statement:

Jencks, SF et al., *Rehospitalizations among patients in the Medicare Fee-for-Service Program*, NEJM 2009; 360:1418

Rehospitalizations were prevalent in this study, up to 34% within 90 days. Up to half of those rehospitalized in the first month had no bills submitted for an outpatient visit. The estimated cost to Medicare for rehospitalizations in 2004 was $17.4 billion. Hosptialists can expect policy/reimbursement rules regarding this issue in the near future.

Snow, VS et al., Transitions of Care Consensus Policy statement by ACP, Society GIM, Society Hospital Medicine, Am Geriatrics Society, Am College Emergency Physicians, Society Academic Emergency Medicine:

http://www.springerlink.com/content/e30wn8313124138j/?p=e558167b5f9d411b9c7d39b26417f5e2&pi=2

ID CORNER — William Salzer MD

Swine Flu: the words on everyone's lips. It is now referred to as Novel H1N1 influenza out of respect for pigs. But the New England Journal has published a whole issue on this subject, available online only:

http://content.nejm.org/early_release/#groupH1N1

Also, the CDC has a website devoted to this infection, which covers epidemiology, management of patients and outbreaks, etc:

http://www.cdc.gov/h1n1flu/

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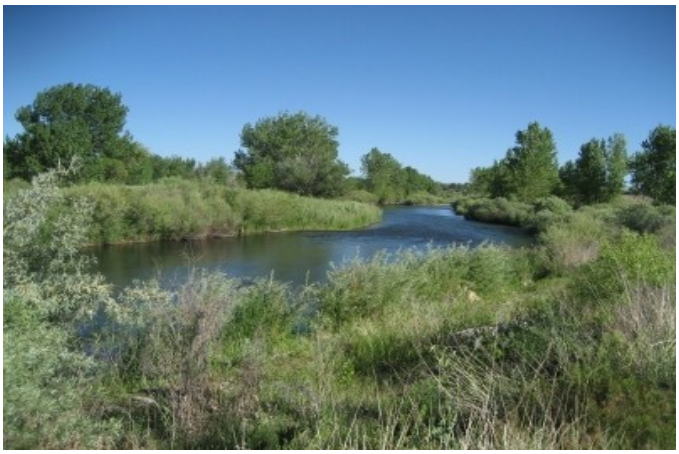
MISSOURI HOSPITALIST CALENDAR



19th Annual Conference, Caring for the Elderly, Missouri Association of Long-Term Care Physicians, August 21-22, Holiday Inn Select Executive Center, Columbia; call 573-882-0366 or visit the CME website at www.som.missouri.edu/CME; **LOCAL**

Missouri ACP Meeting, September 24-27, Lake of the Ozarks; Hospitalist Conference Luncheon on Saturday, September 26, 12:15 pm; topic: Hospital Acquired Infections; **LOCAL**

Hypertension & the Cardiometabolic Syndrome, October 15, 2009, Hampton Inn & Suites, Columbia, MO, University of Missouri Department of Medicine, call 573-882-0366 or visit www.som.missouri.edu/CME; **LOCAL**

The Academic Hospitalist Academy: Essential Skills for Education, Scholarship and Professional Success, Society of GIM, November 8-11, Atlanta, Peachtree Conference Center; for more info, contact Amy Woodward, woodwarda@sgim.org; **note that attendance will be capped at 100 participants (register early).**

Please direct all comments, ideas and newsletter contributions to the Editor:

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Please forward this newsletter to Missouri Hospitalists that you might know!