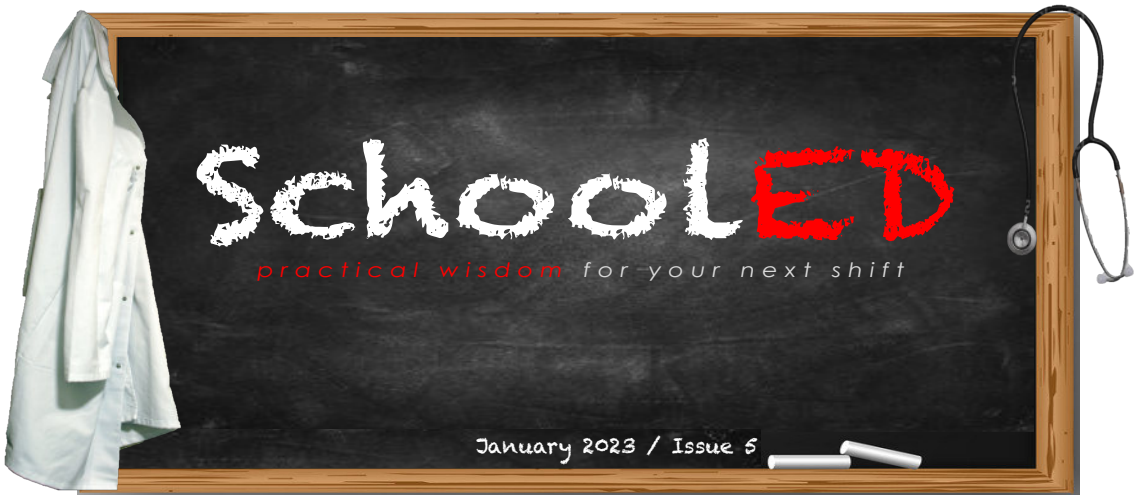

Let the CHART speak for itself

by Jason Adler, MD

We spend too much time in the EMR. Much of our education on documentation leaves us feeling like we need to write *more*, click *more* boxes, and add *more* information. However, more isn't always better especially if it fails to capture the "essence" of your direct patient care. Over the course of that care, the patient may be discharged or stay in the hospital but the chart lives forever. Many people, each with their unique lens, may read that chart later for different reasons. Clinicians may do a chart dive to understand what happened during a previous visit. Coders capture reimbursement while auditors verify coding is accurate. Quality and peer review committees review charts to ensure patient safety and mitigate risk. Attorneys access charts for medicolegal purposes and patients can now read their own charts after a visit. This provides an opportunity for targeted documentation, focused on creating a meaningful medical record without all the bloat. Instead of more documentation, we can focus on the information that matters the most. Efficiency is key.

Let's start with the **history of presenting illness (HPI)** and **Medical Decision Making (MDM)** which are ripe with opportunities for streamlined documentation.

HPI PEARLS

- **Document outside referrals**

  Note when a patient was referred to the ED from outside clinicians (ie - PCP, urgent care). This demonstrates the medical necessity of the emergency visit and validates the need for emergency services.

- **Include arrival by EMS**

  This also supports the medical necessity of the visit.

- **Capture history obtained by someone other than the patient**

  We often get history from EMS, patients' families/significant others, referring clinicians, the old medical records and CRISP. It's our job to organize and process this, clearly delineating what information came from where. For example, using key phrases like "per EMS" or "old records reviewed", can demonstrate your efforts and labor in developing a treatment plan for the patient.

  For example, a patient presents with an opioid overdose by EMS and is currently awake and alert with the only complaint being nausea. Without context, some would read that chart as saying the patient has only a simple uncomplicated complaint and doesn't need to be in the emergency department.

Cont'd on p.2

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Alternatively, if you document the patient came by EMS, you clearly state what information was obtained from whom, indicating that EMS shared that the patient was apneic, and was given naloxone and oxygen during transport, you have a completely different note that will be interpreted differently. You are demonstrating the patient needs to be in the hospital, while showing the complexity of your care, and creating a record that would provide context to the patient and other readers in a meaningful way.

- **Address the question "Why did the patient come in today?**
  This is a question we almost always ask at the bedside and is especially relevant in patients with chronic conditions. If a patient has months of chronic abdominal pain, and came in because it has either progressed, or is associated with a new symptom (i.e. vomiting) in the past 24 hours, we want to capture this in the record.

MDM PEARLS

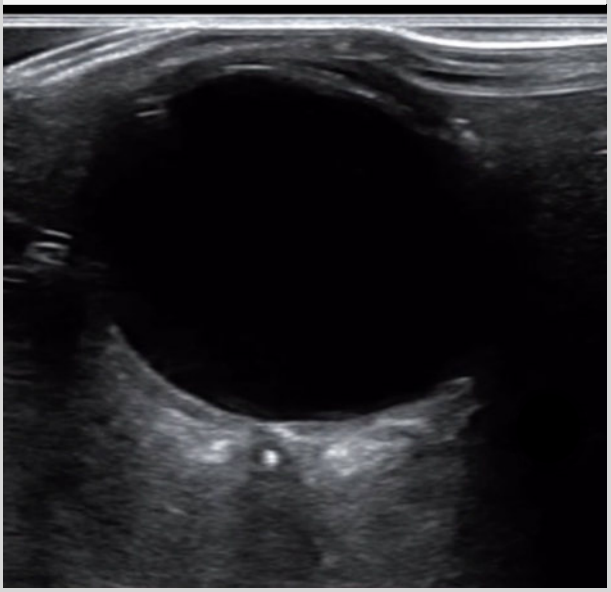
- **Documentation of differential diagnosis**
  There is a lot of debate about the best way to document your differential diagnosis. Templated statements are generally problematic. Rather, it is reasonable to state what you are considering in the context of your workup and how the diagnostics ordered support your work.
- **Discuss your rationale for ordering, or not ordering tests**
  If you order a head CT to evaluate for an ICH, you are sharing your concern for a potential life threatening condition which is also part of your differential diagnosis. Alternatively, if you use the PERC rule and have effectively ruled out a pulmonary embolism, you have done the same.
- **Document your discussions with consultants**
  Include who you spoke with, what was discussed and when this took place. This information will help delineate your clinical concerns and help reduce your medicolegal risk should something go wrong.
- **Reassess your patient and describe any response to treatment**
  We often reassess patients throughout their ED course. Documenting this will capture your engagement in patient care, support medical necessity, and create a record that is aligned with the work you are doing.
- **Provide rationale for hospitalization or discharge**
  If a patient needs to stay in the hospital because of failed outpatient management, or intractable vomiting/pain, documenting this clearly will support the hospital lens of medical necessity for the patient staying in the hospital.

Our charts have enough bloat in them already. Instead of making them longer or voluminous, focused and deliberate documentation lets the record speak for itself while allowing us to spend more time at the bedside.

VISUAL DIAGNOSIS: Ultrasound

By Tu Nguyen, MD

what do you see?



A patient presents with sudden onset of unilateral, painless vision loss and an ultrasound is performed, demonstrating the finding above.

What is this sign and what is the diagnosis?

See page 4 for answer.

DON'T RISK IT!

good advice for bad situations

by Rhamin Ligon, MD & Priya Kuppusamy, MD

So, you've done an amazing job (if you do say so) and fixed all the ailments in the chief complaint - the patient is now ready for discharge. This is generally a win-win, "everybody's happy" situation, but it can be a dangerous one as well. We have a few tips that will help ensure discharge is done safely and you avoid missed warning signs and risky mistakes:

1. **TALK TO ME!** - It's a good idea to check in with the treatment nurse to let them know you're planning to discharge the patient. Make sure they have no concerns about letting the patient go home.
2. **ONE FOR THE ROAD** - You'll never be wrong for getting that one last set of vitals (even if they've been normal) to make sure nothing is brewing prior to discharge. It's always good to have at *least* 2 sets on the chart, even for short or uncomplicated ED visits.
3. **TESTING, TESTING, 1,2,3** - Do one last review of the diagnostics ordered and done during the visit to ensure you haven't missed anything. Read the **body** (not just impression) of radiology reports for details including incidental findings requiring follow up. Also, it's not unusual to have "straggler" results come in after the main results have posted (i.e. differentials on a CBC) which could change everything.
4. **SO NICE, SO NICE, YOU ALWAYS DO IT TWICE!** - Repeat and document exams and subjective findings for patients with pain, AMS, or neuro complaints.
5. **WRAP IT UP!** - It's really, really, really, really important to always have a final conversation with the patient and/or family just before discharge. Give them an opportunity to ask questions or voice concerns and allow time for you to review key portions of the discharge instructions. So, always *personally* close the visit … Oh, and did we mention that it's really important?

See ya' next time! Rhamin & Priya

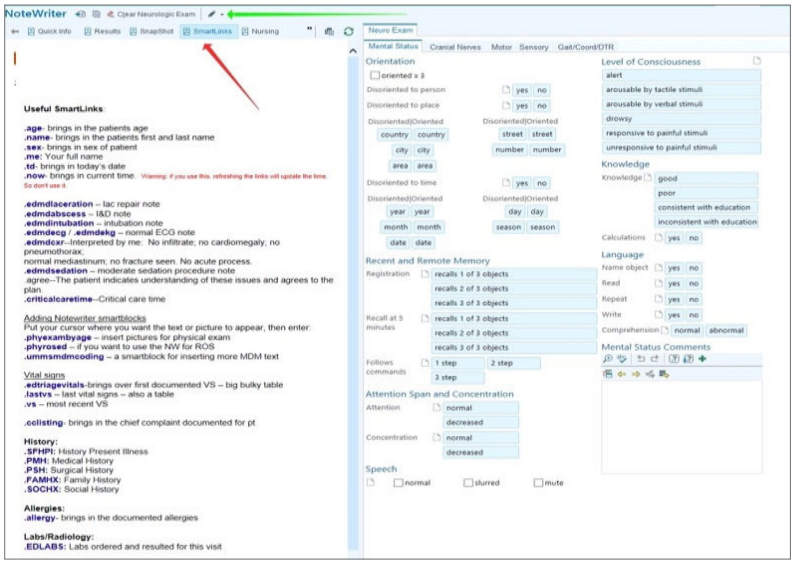
EPIC PEARLS

by Michael Bond,MD

The care that we provide patients who arrive in our Emergency Department is excellent. At times however, our documentation does not accurately reflect that. Most of us also think that the training we received to use Epic was sub-par or did not provide enough insight into the power of the system and what it can deliver. Here are some highlights that can help improve your documentation **AND** save you time.

NEURO EXAMS:

Our documentation of the Neuro exam is often limited and incomplete. This is likely due to the fact that the standard Physical Exam SmartBlock is also not very complete. For a more thorough Neuro SmartBlock, use the smartphrase ".**peneuro**". It will show up as below (enlarge image for better view):



You can click the pencil icon (see green arrow) and save a version of this smartblock so that in the future you can just push a button and your Macro will fill it in. The best way to use macros is to set it up for ONLY the physical exam elements that you ALWAYS do and record it as if everything is normal. When you have a real person in front of you, you would then click on all the abnormal findings, and then click on the macro. The macro will not change a positive finding into a normal finding. So, you are essentially documenting your exam by exception which is quicker. You can have multiple macros, so you may want to make one for your stroke patients, another one for back pain patients, etc.

Also pay attention to the red arrow in the picture. This area of the screen can provide a lot of useful information when you are writing your note. Here is a review of some helpful tabs: **Nursing** shows you their notes; **SmartLinks** has a list of DotPhrases you may find helpful; **Snapshot** reports allergies, chief complaint, problem list, and home medications; **Results** show your diagnostic tests; **QuickInfo** includes vital signs, meds, social and medical history.

Recording macros for your review of systems and physical exam is recommended, but remember to only record the things you ALWAYS ask or perform. You do not want to document something you did not ask or do.

Cont'd on p.4

You can't meditate your way into wellness anymore. Research shows that you can't yoga your way into wellness either–it is the system that is breaking and burning out emergency physicians. So, how do we start to fix the system?

Let's begin by talking about Herb Kelleher and Southwest Airlines. In 1981 Herb Kelleher became Southwest Airline's President and CEO. Southwest has become one of the most successful airlines because of Herb Kelleher's objectives. Herb insisted employees should come first and that the customer is NOT always right. Empowered by the knowledge that their boss had their back, employees treated customers well. Those satisfied customers, in turn, became repeat customers, which made the airline successful. Let's put that in "doctor" terms–Clinicians come first and if they are treated well by the organization, they will excel at providing exceptional care to patients. In turn, those patients will be satisfied and what results is a very successful practice with professionally fulfilled clinicians and happy patients.

Another organization we should talk about is Alcoa, the world's 6th largest producer of aluminum and one of the safest organizations in the world. Alcoa expects their workers to find joy and meaning in their daily work, so each person in the workforce must be able to **answer 3 questions affirmatively each day:**

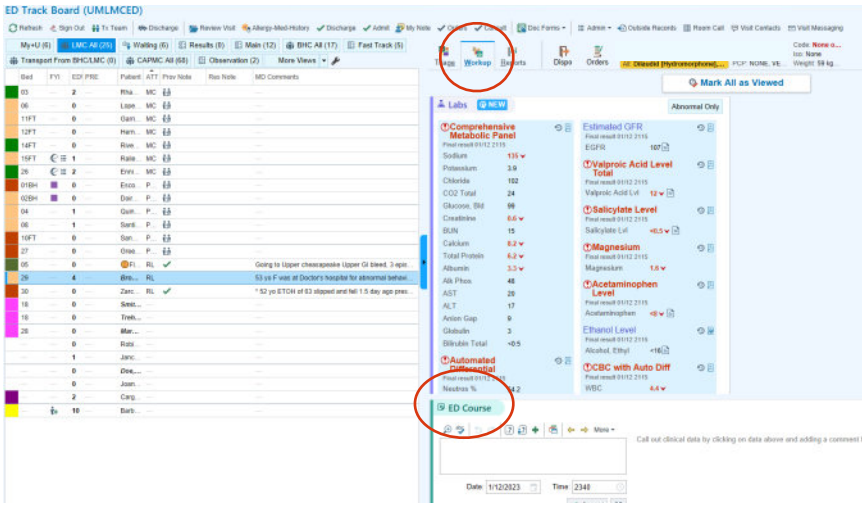
1. Am I treated with dignity and respect by everyone?
2. Do I have what I need so that I can make a contribution that gives meaning to my life?
3. Am I recognized and thanked for what I do?

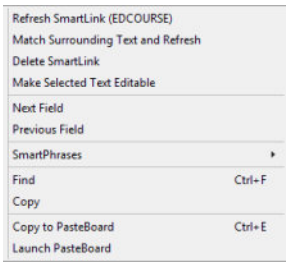
Cont'd on p.4

EPIC Pearls - cont'd from p.3

ED TRACKING BOARD:

On the ED Tracking board, you can see a lot of additional information by opening up information from the bottom of the right side. The right side is recommended, as it gives you access to the **Workup** Tab. This tab will display the results of labs, CTs, ECGs, and notes. At the bottom is **ED COURSE**, which allows you to quickly document assessments and updates to the patient's chart. It's much quicker than going back into the note, which requires numerous clicks to open the chart and then the note itself (a huge time sink). If you insist on doing things this way, please use the dot phrase "**.tsm**" which provides a timestamp with your name. This makes it clear as to who is entering the update as well as the date and time of completion. If you type the same information into ED Course within the Workup tab, this is done automatically for you. The ED Course is recorded in your notes and is automatically updated whenever you open the note, so all of your updates made in the Workup tab will show up in your note when you sign it.





IMPORTANT: If you sign your notes the next day or several days later, the ED Course might have information and updates from after your shift. You can Right Click on the ED Course and you will see the menu to the right. Click on **Make Selected Text Editable** and you can delete entries that occurred after you left. It can also be used to correct spelling or dictation errors.

VERY IMPORTANT: If you assume care of a patient, you **MUST** create your own note and sign it for the ED Course to be included in the final patient record. If you document in the ED Course and do not create a note, these entries never become a permanent part of the medical record. **Have questions, comments, or suggestions?**

Email the author at mbond@som.umaryland.edu

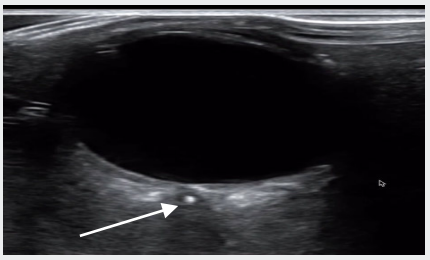
Basic Wellbeing May Not Start With You
cont'd from p.3

Wouldn't it be fabulous if your department chair or leader in your organization asked you these 3 questions? This would indicate that leadership is really paying attention to one of the pulse points of the organization that fosters professional fulfillment.

The opposite of professional fulfillment or engagement is burnout. Burnout and engagement exist on a spectrum and are driven by the same forces: workload and job demands, efficiency and resources, organizational culture and values, social support and community, control and flexibility, meaning and purpose, and work-life integration. Research from the Institute of Healthcare Improvement and the National Academy of Medicine reveals:

So, back to Alcoa's 3 daily questions. Rather than using the 3 questions above as a specific measurement tool, let's look more globally and ask, "What would it look like in our Emergency Department if we could answer "Yes" to each question?" It is essential that our system or department operates with an organizational understanding of wellbeing and resilience. We all need to promote interventions that address the underlying operational issues that lead to unwellness in the first place. We must find solutions that benefit everyone– health care providers and all the patients we serve. We need to change the health care system that we work in. Together, pandemic or not, we can make this happen.

ANSWER VISUAL DIAGNOSIS: what do you see?



Retrobulbar Spot Sign
Indicative of central retinal artery occlusion

HOLD THE HYDRALAZINE!

Severe Asymptomatic Hypertension…. AKA Hypertensive Urgency

By Michelle Adamczyk, PharmD

Severe asymptomatic hypertension, frequently still referred to as hypertensive urgency, is defined as a systolic BP greater than 180 mmHg or diastolic BP greater than 110 mmHg without any signs or symptoms of acute target organ injury (i.e. cardiac ischemia, encephalopathy, CVA, pulmonary edema, renal injury), or abnormal physical findings (i.e. papilledema, retinal hemorrhage, S3 heart sounds, rales, jugular venous distention, new sensory/motor deficits, or pulsating abdominal bruit). So in the absence of these, how do we treat the patient and not just the numbers?

The fear of asymptomatic patients having a major cardiovascular event if discharged without an acute blood pressure reduction continues to be dispelled by more evidence. In 146 patients discharged from the ED, ninety percent of these patients received prescriptions for antihypertensive agents and more than 35% still had BPs greater than 190/110 mmHg at the time of discharge. At the 10-day follow up visit, mean BPs had significantly improved and no serious adverse outcomes were noted.

Aggressive blood pressure lowering in patients with severe asymptomatic hypertension can lead to serious adverse events, such as syncope, MI or CVA. So before reaching for an IV agent, consider the following when deciding the best way to treat patients with severe asymptomatic hypertension:

Cont'd on p.5

If your patient is:	Management Considerations	Oral or IV Antihypertensive?
Asymptomatic **with** a history of hypertension	• Assess adherence to hypertensive medications and either adjust or resume treatment • Patient should follow up with PCP in 2-4 weeks	**AVOID IV Antihypertensives** - Consult ED Pharmacist** to check adherence history and potential modifications to home regimen **Remember - If there's not a pharmacist onsite, there's always one available to you at our affiliated hospitals.
Asymptomatic with **no history** of hypertension	• Assure that repeat blood pressures are still elevated and accurate • Consider initiating oral starting dose of an antihypertensive agent with PCP follow up in 2 weeks	**AVOID IV Antihypertensives** - Follow JNC 8 guidelines* for choice of agent and/or consult with ED Pharmacist
Presenting **with mild symptoms** (eg, headache, lightheadedness, dyspnea, anxiety, epistaxis, nausea, palpitations) and **NO signs of acute target organ injury**	• Consider either initiating a long-acting agent with close PCP follow up in 1-2 days or administer a short-acting antihypertensive agent in ED and observe patient prior to determining disposition • If symptoms and BP improve, discharge with longer-acting antihypertensive agent and follow up with PCP in 1 week	**AVOID IV Antihypertensives** – instead use short-acting ORAL agents: • Labetalol 100 mg • Captopril 25 mg • Hydralazine 10-25 mg • Clonidine 0.1- 0.2 mg Follow JNC 8 guidelines* for choice of long-acting agent and/or consult with ED Pharmacist
Presenting with signs or symptoms of acute target organ injury **or** Has abnormal physical exam findings	• Hospitalize for hypertensive emergency • If target organ injury confirmed, administer IV antihypertensive agent	**GIVE IV Antihypertensives** - Preference for clevidipine/nicardipine if rapid blood pressure reduction or tight control is needed (aortic dissection, stroke, etc). • Consider Labetalol 10-20 mg IV in all other cases • **Avoid** using Hydralazine, Enalaprilat due to slow onset and unpredictable duration

*** In general hydrochlorothiazide or amlodipine are preferred unless the patient has diabetes or CKD (Then preference to ACEI/ARB), or another compelling indication (i.e. CAD, CHF, etc.)**

cont'd on p. 6

Below are two additional tables reviewing short and long-acting antihypertensives for your reference. As always, reach out to the ED Pharmacist for help with selecting an agent!**

**Remember - if there's not a pharmacist onsite, there's always one available to you at our affiliated hospitals.

Selecting a short-acting antihypertensive agent

Short-Acting Antihypertensive Agents	
Captopril 25 mg	· **Drug class**: ACE inhibitor (unlike other ACEIs, works within 30 minutes and has peak response in 60-90 minutes) · **Possible ADRs**: rash, hyperkalemia
Labetalol 100 mg	· **Drug class**: Beta-blocker · **Possible ADRs**: nausea, dizziness, bradycardia (more common with IV, but consider other agent if patient's HR <60)
Diltiazem IR 30 mg	· **Drug class**: CCB · **Possible ADRs**: peripheral edema, headache, dizziness · Avoid in patients with HF with reduced EF
Hydralazine 10-25 mg	· **Drug class:** peripheral vasodilator · **Possible ADRs:** GI disturbances, edema, headache, hypotension · **Caution**: hydralazine has an unpredictable response and prolonged duration of action, making it an undesirable first-line agent
Clonidine 0.1-0.2 mg	· **Drug class**: Central alpha$_2$ adrenergic agonist · **Possible ADRs**: bradycardia, orthostatic hypotension, drowsiness, headache, fatigue · Withdrawal symptoms not usually of concern for one-time dose
Prazosin 1-2 mg	· **Drug class**: Alpha blocker · **Cautions**: Can cause syncope and orthostatic hypotension, as well as tachycardia prior to syncope - this is the least preferred option for this reason

Selecting a longer-acting antihypertensive agent

General Recommendations Per JNC 8 Guidelines	
Non-black patient without diabetes or CKD	Thiazide-type diuretic (i.e. hydrochlorothiazide) ACEI/ARB (i.e. lisinopril, losartan) Dihydropyridine CCB (i.e. amlodipine)
Black patient without diabetes or CKD	Thiazide-type diuretic Dihydropyridine CCB
Any patient with diabetes or CKD	ACEI/ARB
Compelling indications - no longer considered in JNC 8 other than DM or CKD; JNC 8 recommends against use of beta blockers 1st line, but can be considered 2nd line if indicated below	
Heart failure with reduced EF	ACEI/ARB, beta blocker, diuretic
Post-MI	ACEI/ARB, beta blocker
Atrial fibrillation/flutter	Beta blocker or non-dihydropyridine CCB like diltiazem