Med Team: New Admissions Expectations

- **Confirm home medications with every new patient & complete an admission med rec in the chart**
  - *The Med Rec is considered complete only when the EPIC med list under the "admission navigator" is edited*
    - Add new home meds to reflect the home med list you've obtained - *Do not assume the list in EPIC is accurate!*
    - Click the red 'X' to completely remove meds no longer taking
    - Note: You are able to modify this list at any time of the hospital stay without needing to redo the admission orders
  - Do this with new admissions & patients transferred out of ICU/CCU
  - Get patient's pharmacy information if concerned about accuracy of list or compliance & CALL their pharmacy
- **Review with patient and update EPIC history tabs regarding medical, surgical, family, & social histories**
- **Obtain collateral history if patient unable to provide by themself**
  - May need to contact family members, SNF Staff, pharmacy, etc.
- **Interns should put in majority of admission orders *on patients they see***
- **Seniors are expected to personally see all new admissions prior to staffing** - this ensures an independent assessment of the patient by an experienced supervising physician
- When medical students do the H&P, it should be **reviewed and edited by the intern or senior resident**
- **Practice with a questioning attitude**
  - If something doesn't look right, it probably isn't
  - Confirm diagnoses yourself (e.g. if CHF listed, are prior labs/imaging/ECHO consistent with diagnosis?)
  - Avoid carrying forward incorrect diagnoses in chart
  - Ask "why" for everything abnormal or for anything that doesn't fit what you expect
  - E.g. Why isn't the patient tachycardic when he's febrile? Why is the patient thrombocytopenic? Why is this non-menstruating patient iron deficient?
- **Know ALL details about your patient before staffing**
  - E.g. If admitted for COPD exacerbation, when were their last PFT's or if admitted for CP, what prior cardiac workup have they had?
- **Come prepared to discuss differential diagnoses & planned workup/treatment**
  - Construct a differential diagnosis list– it's okay to go back and clarify things with patient/ask additional questions after your initial eval
  - It's okay & expected to look things up before staffing (e.g. use up-to-date)
  - Commit to a plan before others fill it in for you; learn from your mistakes
- **Do not go over admission caps**
  - Interns can only participate in 5 new patient H&P's in 24 hours
    - *Even if interns just start or scribe an H&P, that counts as one of their 5*
  - Seniors can only do 10 new patient H&P's in 24 hours (this includes intern H&P's that they are supervising)
  - If working on >1 admission at a time, it is expected that the intern does one H&P (supervised by the senior) and the senior does the other independently
  - AR2/AI2/AI3 will take over admissions when caps are reached
- **Staffing overnight**
  - From 11pm - 6am residents are to staff with the SHMG hospitalist on call
  - If patient staffed with SHMG hospitalist overnight and discharged home from ED, please route that H&P to the hospitalist you staffed with
  - If patient staffed with SHMG hospitalist overnight and admitted to the hospital, please route note to the med team attending that will be seeing the patient in the morning

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Med Team: Daily Rounding Expectations

- **Seniors must see all patients daily** (if unable to see all before rounds, ensure they are all seen after rounds)
- **Seniors should lead education for the team** - e.g. lead short topic discussion vs assign short topics to team members
- **Interns should be familiar with plans on all patients, not just those they are writing notes on**
- **Med Teams should help each other out**
  - If your census is light or another team is busy post-admit–- **offer to take patients**
- **Review orders daily**
  - How many days have patients been on their antibiotics & how many prn meds they have required in last 24 hours?
  - If renal function abnormal or QTc prolonged, adjust medications as necessary
  - Know all things attached to your patient (lines, tubes, devices)
    - Discontinue foley or IVF if not needed
  - Consult PT/OT/SW early to avoid prolonging stay
  - Discontinue standing labs if no longer needed– goal is cost-conscious care!
  - Adjust medications to progress patient towards discharge
    - IV to PO and de-escalation of pain meds
  - Advance activity (avoid orders for BEDREST!)
- **Know patients' vascular access -** Peripheral IV, Central Line, PICC, Port, HD VasCath, Fistula
- **When medical students are on the team, the patients they follow should also be assigned to an intern**
  - Intern should be ready to present the patient as if they wrote the note
  - All medical students notes / exams should be reviewed and edited daily
- **Do NOT read your note verbatim when presenting on rounds**
- **Discuss with attending any new consult** (if consult not urgent, consider starting working up and treatment yourself)
- **MUST CALL all stat/urgent consults** (otherwise, consultants have up to 24 hours to see patient)
- **Sometimes, key updates/changes/events occur after rounds**
  - If you *needed* to see the patient or change management, You MUST DOCUMENT IN CHART (can be a short/ quick note)
    - ***If it's not documented, it didn't happen***
  - Be sure to notify/touch base with your attending
- **Don't leave early prior to 5 pm during the week, unless:**
  - All hand-off notes are updated
  - Epic inbox and IMC paper box are addressed/empty
  - Your fellow interns & residents don't need any assistance
  - You've read up on all your patients' conditions & are prepared to discuss interesting diagnoses/workups on rounds
  - Patients' family members/significant others updated on patients' condition (with permission of patient)
  - All d/c paperwork has been started on all patients & cases discussed with TCC/SW
  - You are up to date on MKSAP quizzes & Healthstreams
- **Be your patients' advocate & take ownership of their care** - You are their doctor!
  - Treat your patients as you would want a physician to treat you or your loved ones
  - Keep patients updated of any new results, changes in therapy, or labs/tests you are ordering on them
  - ***Discuss care with family, lead family meetings, guide treatment plans, troubleshoot concerns***
  - If something isn't right or you have a concern, speak up!
- **Follow-up on all of your patients after rounds/noon conference**
- **Seek out direct observations of you with patients and ask for feedback from your attendings –** we are here to make you the best you can be!

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Med Team: Discharge Expectations

- **Update history tabs in patient's chart with new diagnoses**
  - E.g. if patient admitted for new HFrEF, that diagnosis should be under the history tab in chart along with problem list
- **D/c process should be patient centered and AT THE BEDSIDE**
- ***Never* discharge a patient without discussing the following key items with the patient or caregiver:**
  - Hospital course/diagnoses
  - All new/changed/discontinued meds (including potential side effects/risks/benefits/indications for each new med)
  - Ask about refills needed on chronic meds excluding controlled substances from outside providers
  - Confirm patient's desired pharmacy - ***use 'Meds to Beds' if able***
  - *Involve patient in setting date/time for follow-up appointment in the IMC*
  - If patient is going home but doesn't follow at the IMC, *call their PCP's office to set up follow-up prior to d/c*
  - Discuss contingency planning
    - i.e. discuss when to call office/return to ED/adjust meds (e.g. weight based lasix dosing)
- **Check to confirm the patient is trained and prepared to provide self-care adequately**
  - e.g. wound care, new insulin administration, daily weights, disease specific diets (CHF vs DM vs Pancreatitis)
- **Be aware of patients' insurance status as this will affect disposition**
- **Before d/c order placed, seniors should review ALL d/c med recs done by interns**
- Create a telephone encounter to initiate the **Transitional Care Management** process if **all of the following** are true:
  - Patient was admitted (including "Obs" but not ED discharges)
  - Patient discharged to home (not SNF, LTAC, Hospice, etc)
  - Patient is going to follow up with IMC for hospital followup
- **Tips for a great discharge medication reconciliation:**
  - Form the discharge med rec from an *accurate home med list*
  - Include "through dates" for new short-term medications (e.g. antibiotics, steroids, etc)
  - Home meds may have been held on admission for a reason - *restart only if appropriate*
    - e.g. no NSAIDS if hospitalized for GI Bleed
  - Review/document notable med changes and reasoning on d/c
    - i.e. reasoning why a home med was stopped/adjusted or a new med was started
  - Review new meds started during hospitalization and whether appropriate to continue on d/c
  - Ensure accurate doses, instructions, quantity dispensed of Rx's
- **Tips for a great discharge summary:**
  - Appropriate principal diagnosis with etiology (e.g. "*New Onset HFrEF 2/2 NSTEMI s/p DES to LAD*" -vs- *just "Heart Failure"*)
  - Thorough list of secondary d/c diagnoses (curated from assessment list in progress note)
  - Avoid H&P copying (outpatient providers will read H&P if they want those details)
  - Concise & succinct
    - Avoid unnecessary details– such as typing out vitals/labs/specific doses of meds given in hospital
  - Overall length of summary should probably be ~1-2 paragraphs
    - Not too short that PCP needs to read chart for key details but not too long that PCP won't read it
  - Avoid redundancy
    - Put details of key labs in lab section, follow-up in follow-up section, & notable med changes in notable med change section