

Welcome (Back) to Inpatient Care Part 2: Updates, Recommendations, and Resources for Optimizing Inpatient Practice



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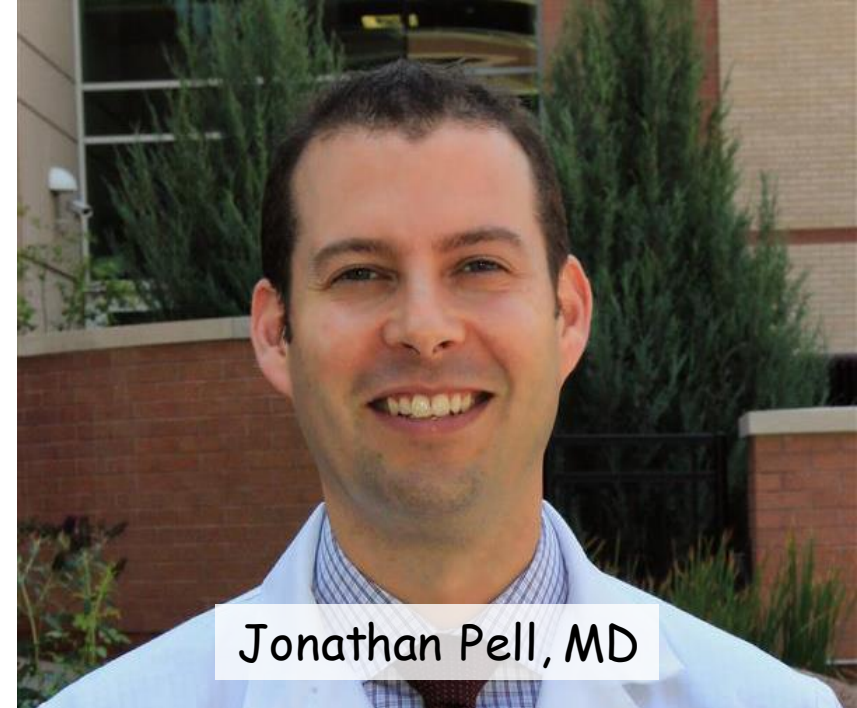




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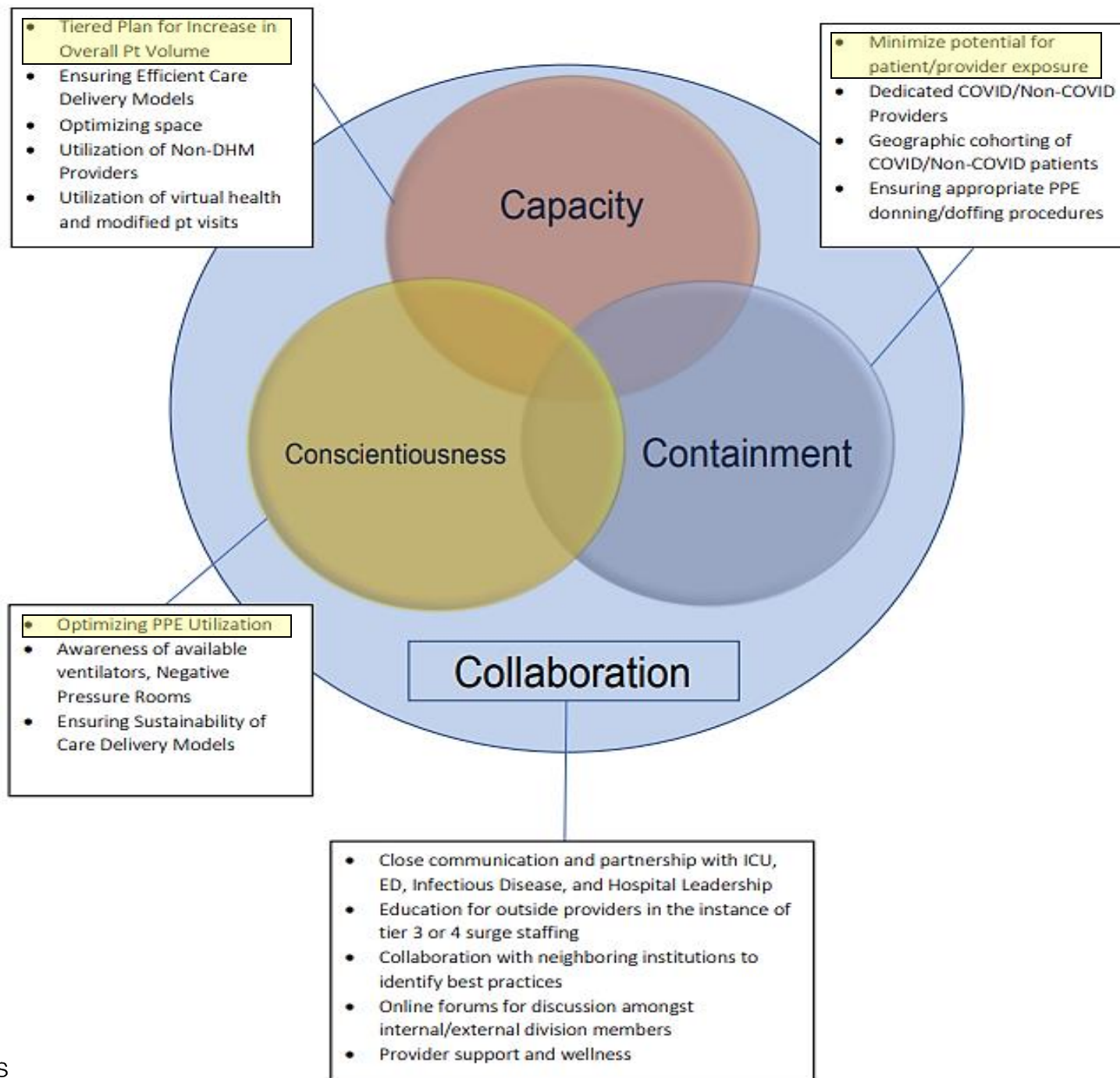
Brandon Combs, MD

Learning Objectives

- 1 Understand the **framework** for the DHM response to the current pandemic
- 2 List **resources** for successfully practicing inpatient medicine
- 3 Understand the **roles** of your inpatient team members
- 4 Recognize differences in working with **Residents and Advanced Practice Providers (APPs)** in the inpatient setting.

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Health

Ninety thousand medical workers volunteered to help New York battle coronavirus. Most are sitting idle.

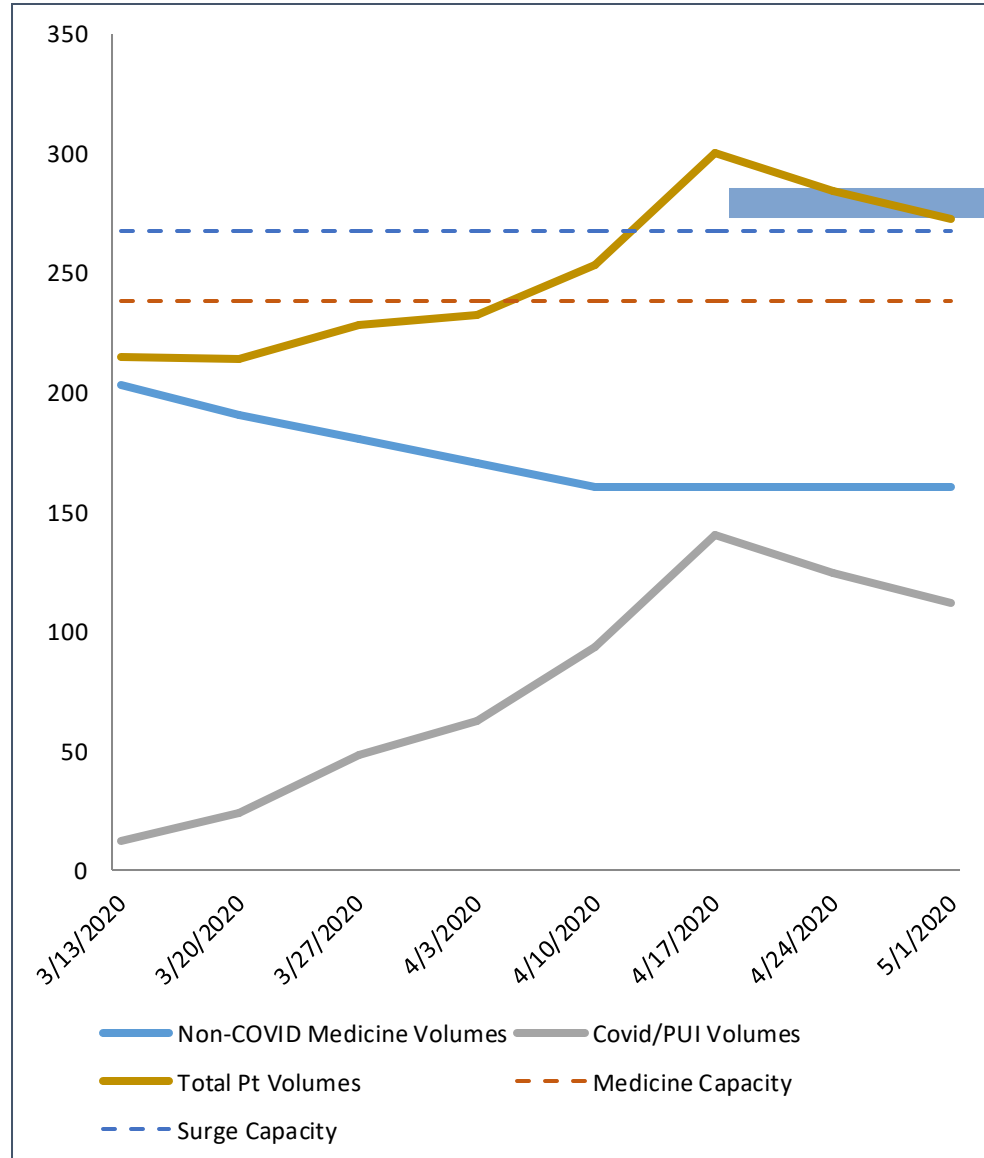


New York Gov. Andrew M. Cuomo , center, and other officials have called on volunteers to help the fight against the coronavirus in the state of New York. But few of them have been put to work since. (drew M. Cuomo D, center, and other officials have called on volunteers to help the fight against the coronavirus in the state of New York. But few of them have been put to work since.)

Non-DHM Provider Utilization

- **Physician:** Prioritize Non-COVID Rounding Teams
 - Minimize PPE
 - Minimize COVID Exposure
 - Added Clinical Support with Housestaff
 - Teaching Opportunities
- **APPs:** Swing/Cross Cover
 - Minimize PPE
 - Minimize COVID Exposure
 - Streamlined onboarding
 - Clinical Support with DHM Swing APP

What We Planned For:



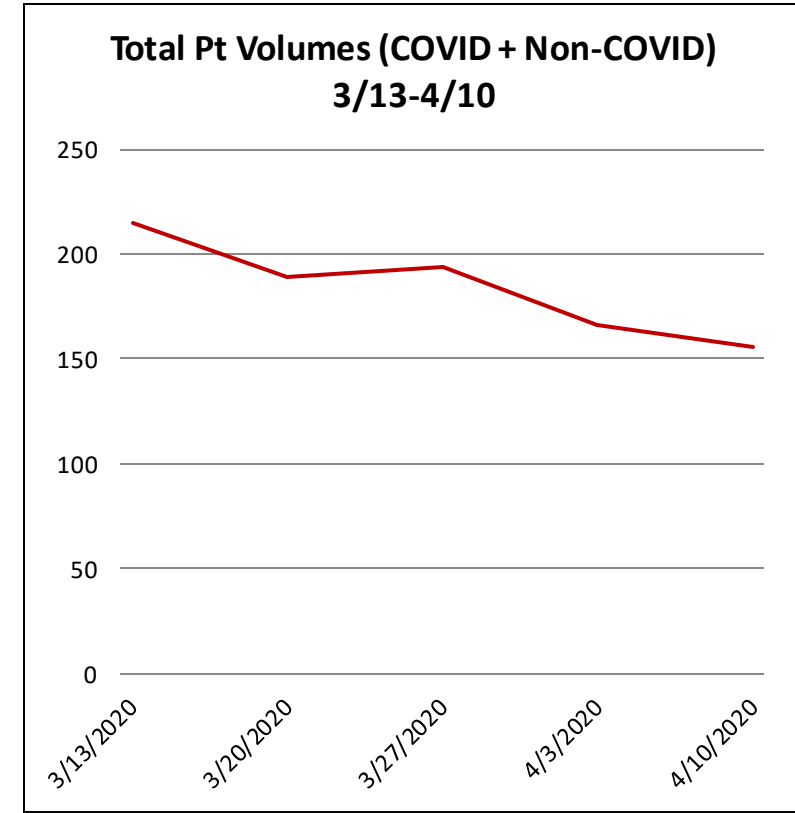
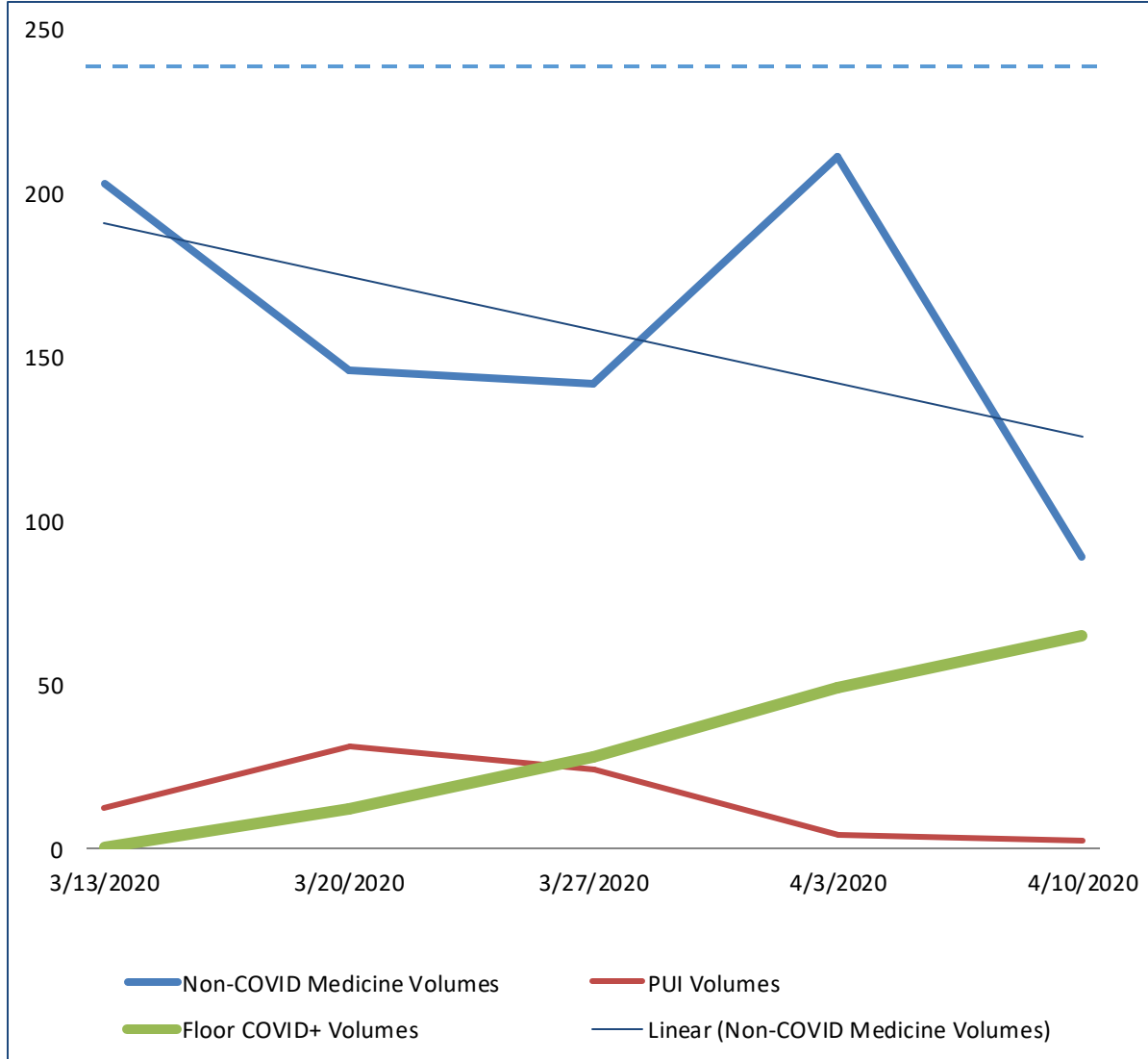
Provider Deficit

Unknown Variables:

- New Case Doubling Time
- Length of Stay
- Provider Illness

Our Experience

3/13-4/10:



Variables:

- New Case Doubling Time: **2-10 days**
- Provider Illness: **Minimal to date**
- **General Medicine: >50% Decrease in Pt Volumes**

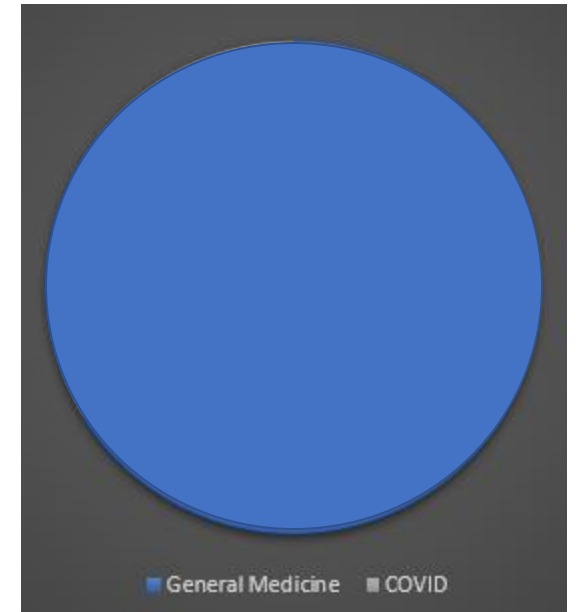
University of Colorado Division of Hospital Medicine Daytime Faculty Staffing:

21 Teams (Flex Teams Based on Pt Volumes)

21 Attendings

7 APPs

Total Patient Capacity: ~**238** Patients



6 Floor COVID Teams

- 4 Attending/APP Teams
- 1 Attending/Resident Team
- 1 Attending Only Team

COVID Capacity: ~**80 patients**

7 DHM COVID Providers on 4 ICU Teams

- 4 Daytime Attendings
- 2 Daytime APPs
- 1 Nighttime Attending

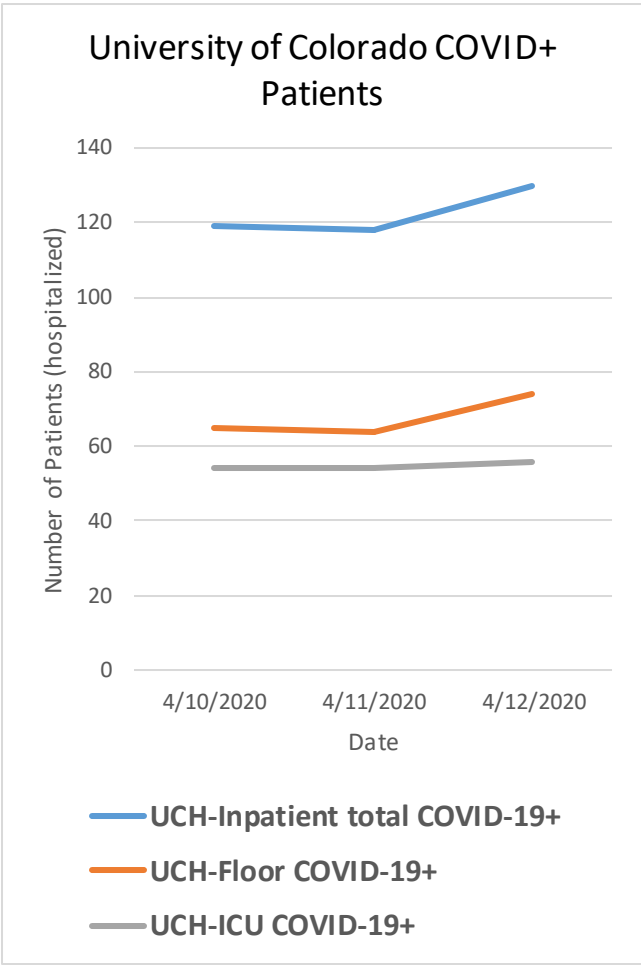
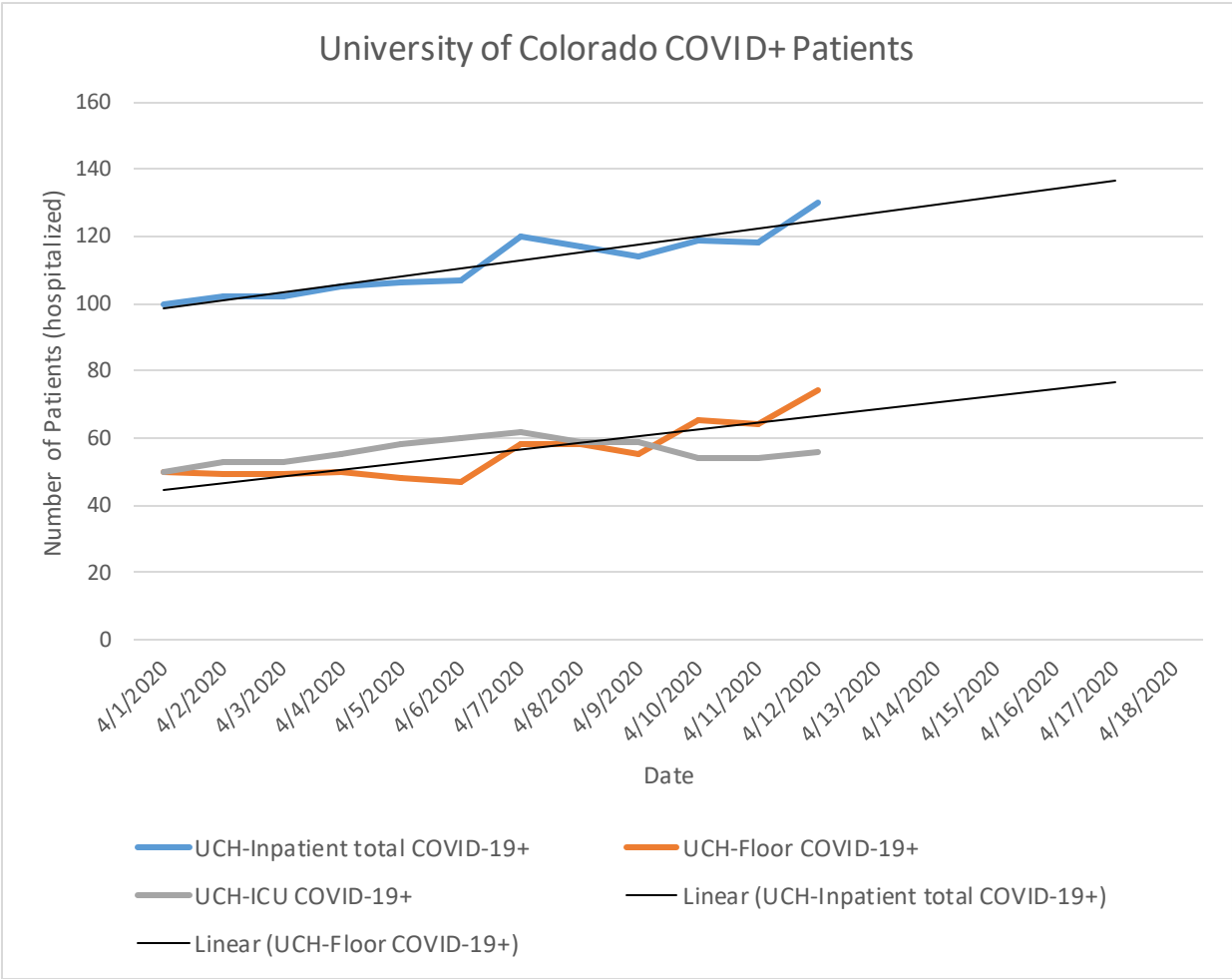
11 General Medicine Teams

- 7 Attending/Resident Team
- 1 Attending/APP Team
- 3 Attending Only Teams

General Medicine Capacity: ~**136-158 Patients**

Non-DHM Provider Need: Attending Coverage, 3 Day Teams

Another Perspective:



**New Surge vs
Bi-Modal
Surge? 4/17-
5/1?**

**+General Medicine
Surge?**

Length of Stay:

4/8: 3.9 ± 3.1

4/12: 4.5 ± 3.8

4/13: 5.3 ± 4.8

Majority of Increase
in Floor volumes r/t
New Cases, Not ICU
Transfers

DHM Operations Strategy 'Take-Home' Points

- Drastic decrease in medicine volumes have allowed DHM faculty to cover majority of COVID and Non-COVID Medicine Population with less initial outside coverage than expected
- COVID volumes continue to increase, Surge is still expected
- Expect 'surge' in general medical volumes as clinics re-open or more procedures performed
- Continued need for additional support in the coming months
- Thank you!!

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How to Page

- Call the number you want and wait for the beep.
- Put in the number at which you would like to be called back.
- Press the * button and put the last 4 digits of your pager in.
- Text pages can also be sent by clicking on a phone number on Amion.

This may seem like a silly reminder but knowing “paging etiquette”:

- ✓ **Allows individuals to triage their pages (decide how quickly they need to return it)**
- ✓ **Allows you to continue rounding while waiting for a call back from a consultant**



UCO

Login

Logins this hour: 7381 \$?

[Scheduling](#)[Messaging](#)[Help](#)[Order](#)

Amion Physician Scheduling

See why over 250,000 providers trust their schedules to Amion...

Groups Plan time off, create schedules, trade shifts, page staff, and manage [residents](#), [attending](#)s and other medical providers.

Enterprises Standardize an entire hospital into a single on-call list with minute updates & much more!

AMiON and COVID-19 AMiON is helping hospitals set up emergency coverage schedules. For hospitals with existing enterprise accounts, we're providing licenses, training and support free of charge...

10-Digit Callback

Priority ** required

Select a priority ...

Message RNs... Include **Service, Rm #, Message, Your name**

Send

Clear

Space remaining: 240

[Page someone else](#)

DocLine: Therapeutic GI: Pancreatitis, pancreatic pseudocyst, choledocholithiasis, cholecystitis, ERCP. After Therapeutic GI accepts, conference with Hospitalist for Therapeutic Transfers

General GI: Luminal GI, colitis, Chron's disease, inflammatory bowel, routine endoscopy. General GI cannot accept transfers. Use Outside Hospital Transfer Medicine Attending for acceptance.

Resident	303-266-3121
Resident	303-266-1224
Attending, Scott, Sullivan	
Fellow	303-266-1324
Attending	303-266-0004
Attending, Wani	
Nurse Practitioner	303-266-2533
Fellow	303-266-2512
Attending	303-548-8928 tel
Pager	303-266-4761

Who to Page For Procedures

- **Medicine 2 Team** – LP, Paracentesis, Thoracentesis
 - **Interventional Radiology (IR)** – LP, Paracentesis, Thoracentesis, Line Placements, PEG Tubes – computer order + page (if urgent)
 - **GI** – PEG Tubes
 - **GI Therapeutics** – ERCP, EUS
- ✓ Is your patient on anticoagulation? If so, when was their last dose? Does it need to be held?
 - ✓ What are your patient's platelets, PTT, PT, and INR?
 - ✓ Is your patient NPO (for procedures that will or may require sedation)?
 - ✓ For OSH transfers, have their images been uploaded to EPIC?

Consults

- Try to consult teams as early as possible (during pre-rounds and while rounding)
- Make sure any relevant outside hospital records are available for them to review (paper chart or uploaded – *see “media” tab*)
- Place consult order in the computer

Consultants are not required to see patients for the purpose of conserving PPE during the COVID Pandemic. They should still be writing notes with recommendations on patients they do not examine.

What if I get paged?

- “Priority Structured Paging” for pages from nurses
- Pages from other teams will have a similar structure to what was previously discussed (e.g. 84769*2106)

PRIORITY STRUCTURED PAGING HELP US ALIGN URGENCY and RESPONSE TIME <u>PRIORITY USE AT NURSING DISCRETION</u>
STAT (xxxxxx-911) *911 – We need immediate bedside evaluation
URGENT (xxxxxx-1) *1 - Response needed w/in 5 min. (does not require bedside evaluation) Unstable vitals, Clinical Change or Event, RN judgement
NON-URGENT (xxxxxx-2) *2 – Response needed w/in 15 min. (Non-urgent, but requiring prompt attention) Critical labs, Order Questions, VS parameter violations, Pain/Nausea requests
FYI / UPDATES (xxxxxx-3) *3 - Response needed w/in 30 min. (if text provider response may not be necessary) FYIs, UOP Updates, VS parameter violation w/ PRN available, updates
For comments and concerns, please contact psp@uchealth.org Brought to you by In-CITe (Interdisciplinary Comm. Improvement Taskforce)

MET
MEDICAL
EMERGENCY
TEAM

Example:
N Engl J Med 2011;
365:139-146

if you are worried about any patient
OR
if you notice any acute changes in

AIRWAY

- Obstructed airway
- Noisy breathing or stridor
- Problem with a tracheostomy tube

BREATHING

- Any difficulty breathing
- Breathing <8 breaths a minute
- Breathing >25 breaths a minute
- Oxygen saturation ≤90%, despite high-flow oxygen

IF PATIENT IS NOT BREATHING, CALL A CODE BLUE

CIRCULATION

- Pulse <40 beats a minute
- Pulse >120 beats a minute
- Low blood pressure (systolic <90 mm Hg)
- Urine output <50 ml over 4 hours

IF PATIENT HAS NO PULSE, CALL A CODE BLUE

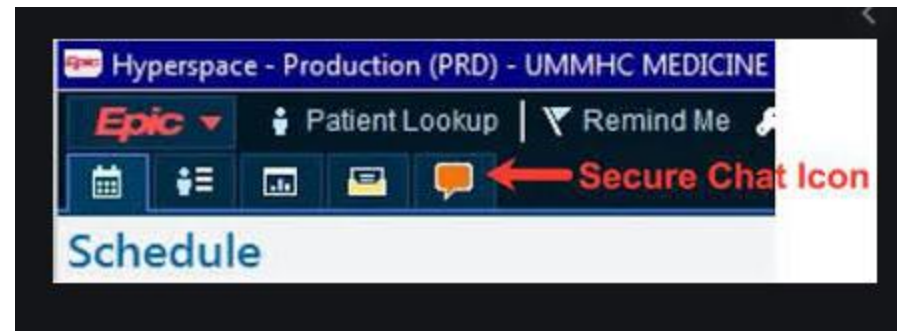
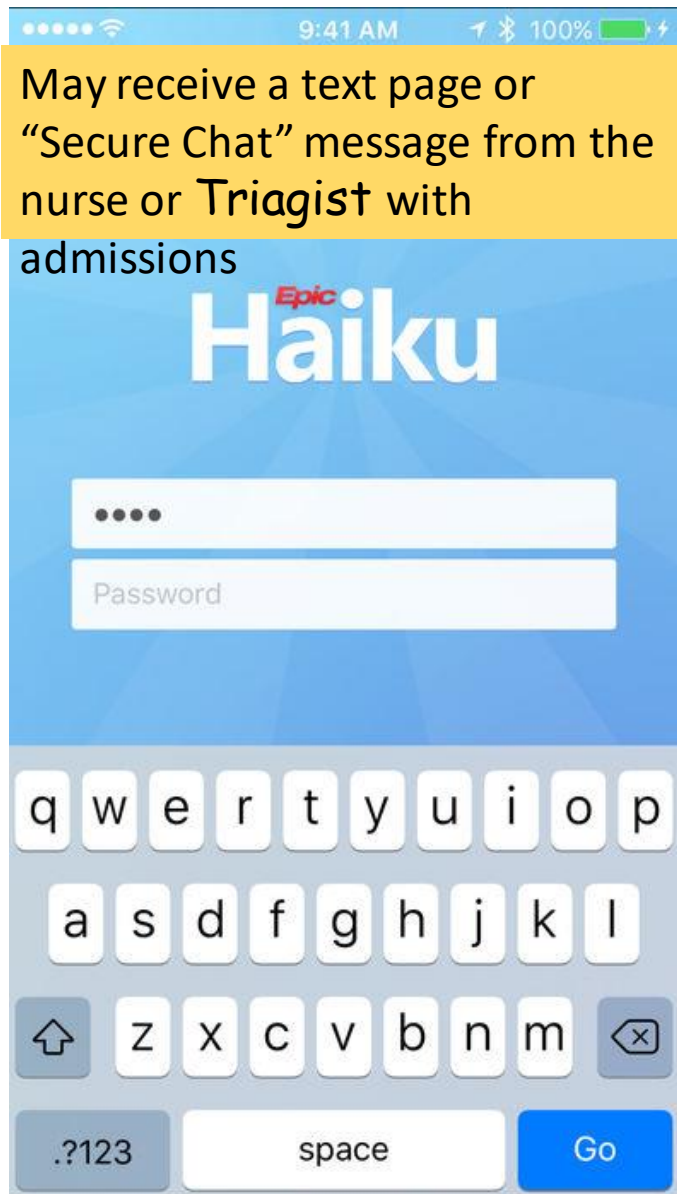
CONSCIOUS STATE

- Sudden change in conscious state
- Patient cannot be roused



Code Blue: Cardiac/Respiratory Arrest

- **Code Blue** is called whenever a patient is experiencing cardiac or respiratory arrest. For example, **Code Blue** is called when a patient has stopped breathing.



Who is the Triageist?

- Division of Hospital Medicine (DHM) Advanced Practice Provider (APP) who assigns ED admissions, outside hospital transfers, and direct admissions to the medicine teams
- They review the chart and determine if the admission seems appropriate and what team they should be assigned to (Oncology, ACE, HMS, general medicine wards)
- They will let you know the patient, MRN, and call back number to discuss the patient with the ED or Clinic Provider

UCH Level of Care Considerations



Contents (click to follow):

1. [Hemodynamic](#)
2. [Vital Signs Frequency](#)
3. [Neurologic](#)
4. [Oxygen and Ventilation](#)
5. [Cardiac](#)
6. [Metabolic](#)
7. [Dialysis Intervention](#)
8. [Procedures and Sedation](#)
9. [Vascular Access](#)
10. [Medication](#)

This content is intended to be used as a tool to assist when determining appropriate level of care (Medical-Surgical, Progressive Care or Intensive Care) unit placement upon admission or transfer.

It does not provide strict exclusion criteria and should not be used in isolation to decide care placement. These criteria should be used to trigger a collaborative discussion between sending and receiving charge nurses, hospital managers, and primary provider services in both the ED and Inpatient Services.

Level of Care:	Med-Surg / Floor 4+ patients: 1RN	Progressive Care Unit 3+ patients: 1RN	Intensive Care Unit 2 patients : 1 RN / 1 patient : 1 RN / 1 patient : 2 RNs
Hemodynamic "Adult Continuous IV Infusion Table" Policy and "Adult IV Push/Intermittent Infusion" Policy	<ul style="list-style-type: none"> Stable hemodynamics (within 20% of baseline) Elevated blood pressure without evidence of end organ damage and anticipation that BP will be controlled w/oral gents and no more than 3 doses of IV push meds Hemodynamically stable GI bleed or hemoptysis with no visible bleeding Brief ($\leq 2L$) fluid resuscitation for hemodynamic instability 	<ul style="list-style-type: none"> Minor hemodynamic instability Thrombolytic infusion in hemodynamically stable patient unlikely to decompensate (i.e., elective admissions). EKOS to be cared for in MICU Hemoptysis or GI bleed with minor instability Suspected heart failure Recent MI of 1 to 2 	<ul style="list-style-type: none"> Hemodynamic instability Require frequent titration of IV medications, fluids or blood products to maintain hemodynamic stability EKOS system to be cared for in ICU
Vital Signs Frequency Refer to MET Policy	<ul style="list-style-type: none"> VS Q4H; May be ordered more frequently for up to 6 hours (i.e. recovery from sedation). 	<ul style="list-style-type: none"> VS for up to 6 hours (i.e. recovery from sedation) 	

If you are concerned that the patient may not be floor appropriate, you can use this tool to help facilitate conversations with the ED and/or MICU Provider. This tool can be found on the "EPIC Dashboard."

Etc...

General Order Writing

- Include parameters for when medications should be held where appropriate (e.g. hold labetalol for SBP < 120 or HR < 60)
- Include end dates for antibiotics
- Be careful with writing too many PRN medications
- Utilize admission **order sets** if applicable
 - Geriatric
 - Pneumonia
 - CHF, etc...

* See "Intern Survival Guide" on Epic

Dashboard

* See "Order Sets" in Epic Order Entry

Electrolyte Repletion

Rough goals for lytes replacement (especially in cardiac patients or anyone with a history of arrhythmia) are K = 4.0, Mg = 2.0, Phos = 3.0.

Be very, very careful replacing lytes in a renal patient with poor ability to process them.

Potassium: Can be given PO (very effective, a little hard on the stomach at doses above 40 meq) or IV (should be given with lidocaine as it burns going in).

Expect a result as follows:

K = 3.5 – 4.0.....to raise the level by 0.1 will take 10 meq

K = 3.0 – 3.4.....to raise the level by 0.1 will take 20 meq

K = 2.5 – 3.0.....to raise the level by 0.1 will take 30 meq

K = 2.0 – 2.4.....to raise the level by 0.1 will take 40 meq

Never give more than 10 meq IV per hour as it can cause arrhythmias/death.

Give via PO route whenever possible, by both routes if the K is less than 2.5 and there is a high risk for the hypokalemia causing an arrhythmia or if multiple PVC's are noted on telemetry.

If hypomagnesemia is present as well, this must also be corrected. Low magnesium levels can cause patients to be refractory to potassium repletion.



© 2013 GS



Electrolyte Repletion

* See "Electrolyte Repletion Protocol" under order sets

* See "Intern Survival Guide" on Epic Dashboard

Magnesium: Can be given PO (also a little hard on the stomach, may cause diarrhea) 500-1000 mg per dose, up to TID or IV 1-4 g per dose. Expect approximately a 0.1 increase in Mg levels for every gram given IV. The max you can give in a single IV dose is 4g if the Mg is < 1.5.

Phosphorus: Can be given via PO or IV routes, equally effective. A great way to raise the phos in a patient who can eat is to add 1-2 containers of skim milk to each meal. PO dosing is 500 mg BID – TID, IV dose is 10 mmol IV x 1, repeat as needed.

Phosphorus IV comes in two flavors: NaPhos and KPhos. Both contain fairly negligible (7 meq) of their respective carriers but avoid KPhos if the K is high and NaPhos if the Na is high.

Never attempt to use KPhos to replete the K.

Calcium: Remember that calcium needs to be corrected for the patient's albumin based on the following formula prior to replacing it:

$$Ca = \text{serum } Ca + 0.8 \text{ mg/dL for every } 1 \text{ g/dL of albumin } < 4.0$$

If you are still unsure of the true Ca level or want to check more accurately, you can order an ionized calcium prior to replacement.

Things to consider when ordering electrolyte repletion:

- ✓ Can the patient tolerate PO?
- ✓ What is their renal function?
- ✓ How quickly do I need to replete their electrolytes?
- ✓ Do I need to get and EKG or place the patient on tele?

Epic Schedule Patient Lists In Basket Remind Me Patient Station UpToDate DynaMed Plus Chart Today's Pts DAR - Dept Appts Print Secure Log Out

TYLER A. Search

UCHS Provider Dashboard

My Reports

SlicerDicer

Analytics Report Library

SmartPhrase Manager

Dashboards

- Primary Care Quality Metrics
- Physician Practice Metrics
- My Panel Metrics
- Department Panel Metrics

Reports

- PB Provider Charges Filed

IT Training Resources

The Provider Portal houses IT resources and education. Use the Provider Portal to contact IT support, register for Epic training, schedule 1:1 Epic appointments, and more!

[Provider Portal](#)

UCHealth Epic Training Resources

Last Refresh: 10:02:50 PM

- New!
 - [Inpatient Guide for Outpatient Docs - AMC Version](#)
- Epic Provider Videos
 - IP Pre-flight Playlist
 - OP Pre-flight Playlist
 - ED Pre-flight Playlist
 - Core Competencies
 - Epic Provider Videos
- Provider Portal
 - [Inpatient, Outpatient, and ED/Urgent Care Providers](#)
 - [NEW JAN 2020: GoodRx coupon & Rx co-pay Tip Sheet](#)
- Dragon Videos
 - [Learn how to use](#)
- Epic Requests
 - [Help Desk, Optimi](#)
- Lab Test Catalog

The Intern Survival Guide has information on:

- ✓ Approach to Common Subspecialty Issues
- ✓ Approach to Common Cross Cover Issues
- ✓ Approach to Procedures
- ✓ And much, much more!

Antibiotics

* See "Antimicrobial Stewardship Guide" under DHM Pathways

* See "Discharge Order Sets" under Orders

uchealth Search...

DHM Pathways

Suggested

Bookmarks

All resources

UCH Emergency Medicine Pathways

Hospital Medicine Pathways

Clinical Calculators & Scoring Tools

Top suggestion

ACS Evaluation Pathway (Chest Pain)
UCH Emergency Medicine Pathways

See other suggestions related to "SHORTNESS OF BREATH"

All resources > Hospital Medicine Pathways

2018-2019 UCH Antimicrobial Guidebook

ACE Service Information UCH
UCH Inpatient Medicine. Updated 7/23/19, Juan Lessing, Anunta Virapongse

Candida infection/Invasive candidiasis
UCH inpatient medicine pathway. Antibiotic Stewardship Committee approved

Cellulitis and/or Soft Tissue Abscess Requiring Hospitalization Pathway
UCH Inpatient Medicine: Prepared 2017 by the AMS Team, approved by DHM pathways 6/2018, Updated 4/15/19

Clostridium Difficile Pathway
UCH Inpatient Medicine. Approved by AMS 4/2018, Approved by DHM pathways 6/2018, Updated 1/21/19

Decision making capacity vs Mental health hold
UCH inpatient medicine. Approved Feb 27 2018 by Jean Kutner, Sara Stowell, Jen Zwink, Frank Merrick

DHM Cardiology Consult expectations

Diabetic Foot Infection Management for Hospitalized Adults Pathway
UCH Inpatient Medicine: Approved by Antibiotic Stewardship 2018, updated 11/2018 by DHM

Direct Oral Anticoagulation
UCH Inpatient Medicine

GPC Bacteremia
UCH Inpatient Medicine

Powered by AgileMD

Allergies/Contraindications

BPA Review

Care Teams

CareNotes

Chart Central

Chart Completion

Clinical Archive

Consult

Document List

Education

Episodes of Care

Event Log

Flowsheets

FYI

Growth Chart

Health Maintenance

ICD-10 SmartPhrases

Images

Immunizations

Implants

Label Print

List Disclosures

Medications

OB Navigators

PACU Discharge

Patient List Membership

Post-op Admit

Pre-Admit Med Rec

Pre-op

Problem List

Procedures

Quick Disclosure

Release Orders

Request Outside Records

RL

Advisories

Graphs

Assign Bedside Questionnaires

Bedside Tablets

EMTALA Transfer

Intake/Output

Segd Message

Rarely Used

The Antimicrobial Stewardship Guide has information on:

- ✓ Resistance Patterns
- ✓ Antibiotic recommendations based on location of infection
- ✓ Recommended duration of antibiotics

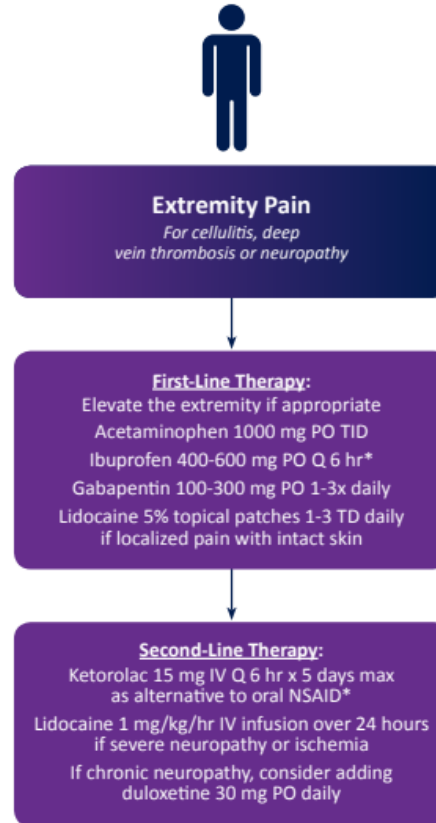
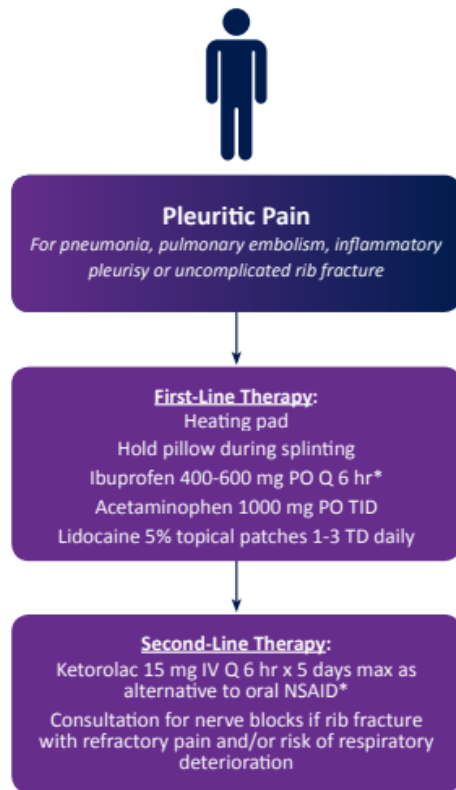
Antibiotics

The screenshot displays the uchealth DHM Pathways interface. The top navigation bar includes tabs for Summary, Chart Review, Care Everywhere, Results Review, Notes, Manage Orders, Charges, DHM Pathways, Admission, Discharge, and Intake/Output. The DHM Pathways tab is active, showing a search bar with 'uchealth' and a search icon. Below the search bar, there are sections for 'Suggested' and 'Bookmarks'. The 'Suggested' section shows a 'Top suggestion' for 'ACS Evaluation Pathway (Chest Pain)' and a link to 'See other suggestions related to "SHORTNESS OF BREATH"'. The 'Bookmarks' section lists 'All resources' and 'Hospital Medicine Pathways'. A blue star is placed next to the '2018-2019 UCH Antimicrobial Guidebook' entry. The right sidebar contains a list of 'Advisories' including Graphs, Assign Bedside Questionnaires, Bedside Tablets, EMTALA Transfer, Intake/Output, Segd Message, and Rarely Used. The bottom of the interface shows a 'Powered by AgileMD' logo and a 'GPC Bacteremia' entry.

When ordering antibiotics, consider:

- ✓ Coverage needed – Gram +, Gram -, Anaerobes
- ✓ Risk factors for resistance – Do you need MRSA or Pseudomonal Coverage?
- ✓ History of resistant organisms
- ✓ Oral antibiotic choices

Pain Management -iALTO



- ✓ All patients on opioids should be on a scheduled bowel regimen
- ✓ You can utilize the “Bowel Regimen Panel” (part of Admission Order Set) or type “docusate” in orders
- ✓ In general, Miralax and Senna tend to be a good combination

* See “DHM Pathways”



DHM Pathways

The screenshot displays the uchealth DHM Pathways interface. The top navigation bar features several tabs, with 'DHM Pathways' highlighted and circled in red. The main content area shows a list of pathways, including 'Cellulitis and/or Soft Tissue Abscess Requiring Hospitalization Pathway', 'Clostridium Difficile Pathway', 'Decision making capacity vs Mental health hold', 'DHM Cardiology Consult expectations', 'Diabetic Foot Infection Management for Hospitalized Adults Pathway', 'Direct Oral Anticoagulants (DOACs) in the Elderly', 'GPC Bacteremia', 'Hospital Medicine Service 1-7 Information UCH', 'Lumbar Puncture Pathway', and 'Medical Oncology Service Line Information UCH'. The left sidebar contains a 'Hospital Medicine Pathways' link, also circled in red. A yellow callout box in the bottom right corner states: '* Must sign in as "ZZ Hospitalist" to access.'

Pathway Example

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UCH Inpatient COVID-19 Testing and Management

References

- [UCHHealth COVID-19 Information on The Source](#)
- State Dept of Health: [Coronavirus Disease 2019 \(COVID-19\) in Colorado](#)
- Zhou et al. [Clinical course and risk factors for mortality in adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study](#). The Lancet. March 11, 2020.
- Guan WJ, Ni ZY, Hu Y, et al. [Clinical Characteristics of Coronavirus Disease 2019 in China](#). N Engl J Med. 2020.
- Wang D, Hu B, Hu C, et al. [Clinical Characteristics of 138 Hospitalized Patients With 2019 Novel Coronavirus-Infected Pneumonia in Wuhan, China](#). JAMA. 2020.
- [Expert reaction to reports that the French Health Minister recommended use of paracetamol for fever from COVID-19 rather than ibuprofen or cortisone](#). Science Media Center. March 16, 2020.
- Fang L, Karakiulakis G, Roth M. [Are patients with hypertension and diabetes mellitus at increased risk for COVID-19 infection?](#) Lancet Respir Med. 2020.
- [ACR Recommendations for the use of Chest Radiography and Computed Tomography \(CT\) for Suspected COVID-19 Infection](#). American College of Radiology. March 11, 2020.

Contributors

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Anything that is underlined in blue serves as a hyperlink to the literature or allows you to place orders per the recommendations.

Does your patient have:

1. Symptoms

- **Fever** A fever is defined as a temperature of 100.4°F or higher upon presentation, and 68-95% develop fever at some point during the course of their illness
- **New cough** is seen in 68-90% of patients
- **New shortness of breath** is seen in 19-31% of patients

-AND-

2. One or more of the following patient characteristics

- **Hospitalized** or being admitted
- [High risk patient or immunosuppressed](#)
- Outpatient **healthcare worker**
- Outpatient **part of public health investigation**

NO

As there is now evidence of community transmission in Colorado, we are recommending only testing high risk individuals, healthcare workers, and hospitalized patients. Those outpatients who are not tested should be advised to practice home isolation for at least 10 days after symptom onset and 72 hours from fever resolution

YES

Do you have a GOOD ALTERNATIVE EXPLANATION for the patient's findings?

- Patient has respiratory symptoms without fever and a good story for a non-infectious cause (e.g. CHF exacerbation, PE)
- Patient has a fever without respiratory symptoms with a convincing non-respiratory source for infection such as a urinary tract infection, cellulitis, intra-abdominal infection, etc.

YES

Do NOT test for COVID-19

- Treat the alternative etiology for their symptoms
- If unsure about whether or not to test, [Consult ID](#)

NO



DVT Prophylaxis

- Recommendations based off of Padua Score
- Built into Admission Order Set
- Allows you to order heparin Sub Q or LMWH for DVT Prophylaxis
- Not all patients need to be on chemical DVT Prophylaxis (low Padua Score, ambulatory, s admission)
- Consider any contraindications to chemical DVT Prophylaxis when ordering and document

Risk factor	Points
Active cancer ^c	3
Previous VTE (with the exclusion of superficial vein thrombosis)	3
Reduced mobility ^d	3
Already known thrombophilic condition ^e	3
Recent (≤ 1 mo) trauma and/or surgery	2
Elderly age (≥ 70 y)	1
Heart and/or respiratory failure	1
Acute myocardial infarction or ischemic stroke	1
Acute infection and/or rheumatologic disorder	1
Obesity (BMI ≥ 30)	1
Ongoing hormonal treatment	1

^aBMI = body mass index; VTE = venous thromboembolism.

^bIn the Padua Prediction Score risk assessment model, high risk of VTE is defined by a cumulative score of ≥ 4 points.

^cPatients with local or distant metastases and/or in whom chemotherapy or radiotherapy had been performed in the previous 6 mo.

^dAnticipated bed rest with bathroom privileges (either because of patient's limitations or on physician's order) for at least 3 d.

^eCarriage of defects of antithrombin, protein C, or S, factor V

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Care Coordination- Patient Resident Liaison (PRL)

- Can request records from outside facilities
- Help schedule follow-up appointments
- Help with Durable Medical Equipment (DME)

* See "Care
Management
Inpatient" on
Amion

Care Coordination – *Case Management and Social Work*

- Assist with discharge planning starting at time of admission
- Please make sure PT/OT have been consulted for patients who may need to discharge to a rehab facility or may need additional Home Health Services
- Make sure you fill out the appropriate discharge orders to resume Home Health Services

Diabetes Management and Educator

- Consult services available to help with titration of DM medications as an inpatient – **place consult order in computer**
- Can help give recommendations about DM medications on discharge
- Provide patient and caregiver education

Things to remember for inpatient management of DM:

- ✓ In general, we tend to hold oral DM meds given uncertainty about procedures and NPO status
- ✓ Most patients require some form of basal insulin to account for holding their oral medications
- ✓ Goal blood sugar is < 180



IV insulin on the floor: not so scary ...
todayshospitalist.com

Addiction Medicine Team

- Will meet with patients with substance use disorders – place consult order in computer
- Will give recommendations on inpatient and outpatient treatment options, including inpatient management of withdrawal symptoms
- Provide patients with outpatient resources

Pharmacists

- **Pharmacy Admission Specialist (PAS)** - can help complete medicine reconciliations on patients
- **Anticoagulation Pharmacist** – can consult if you need help managing a patient's anticoagulation, including med teaching with patients and caregivers
- **Unit Pharmacist** – available to give recommendations on medications, including dosing; will also review med lists in setting of inpatient falls
- **Transitions of Care (TOC) Pharmacist** – will review medications with patients and caregivers prior to discharge



Nurses

- Review nursing notes from overnight as they often contain information that was not reported to Cross Cover
- Please try to round with the nurses as they contribute significantly to the care plan for the day
- If a nurse is worried about a patient, you should be worried...go see the patient!

Learning Objectives

- 1 Understand the *framework* for the DHM response to the current pandemic
- 2 List *resources* for successfully practicing inpatient medicine
- 3 Understand the *roles* of your inpatient team members
- 4 Recognize differences in working with **Residents and Advanced Practice Providers (APPs)** in the inpatient setting.

Rounding with Residents

- Learners
- Quick teaching points best for efficiency
- Save “chalk talks” for the afternoon if there is time
- Run list after rounds and before sign out
- Review orders, including discharge orders and **After Visit Summary (AVS)**

Rounding with Residents during COVID

- Everyone is required to wear a surgical mask in patient care areas
- Round outside of rooms – the resident will not have seen the patient prior to rounds
- If additional PPE is needed (gown, gloves, etc.), only one person should go in and examine the patient (can be you or the resident)
- Should try to physically see newly admitted patients
- Utilize the appropriate .phrases for attestations to notes

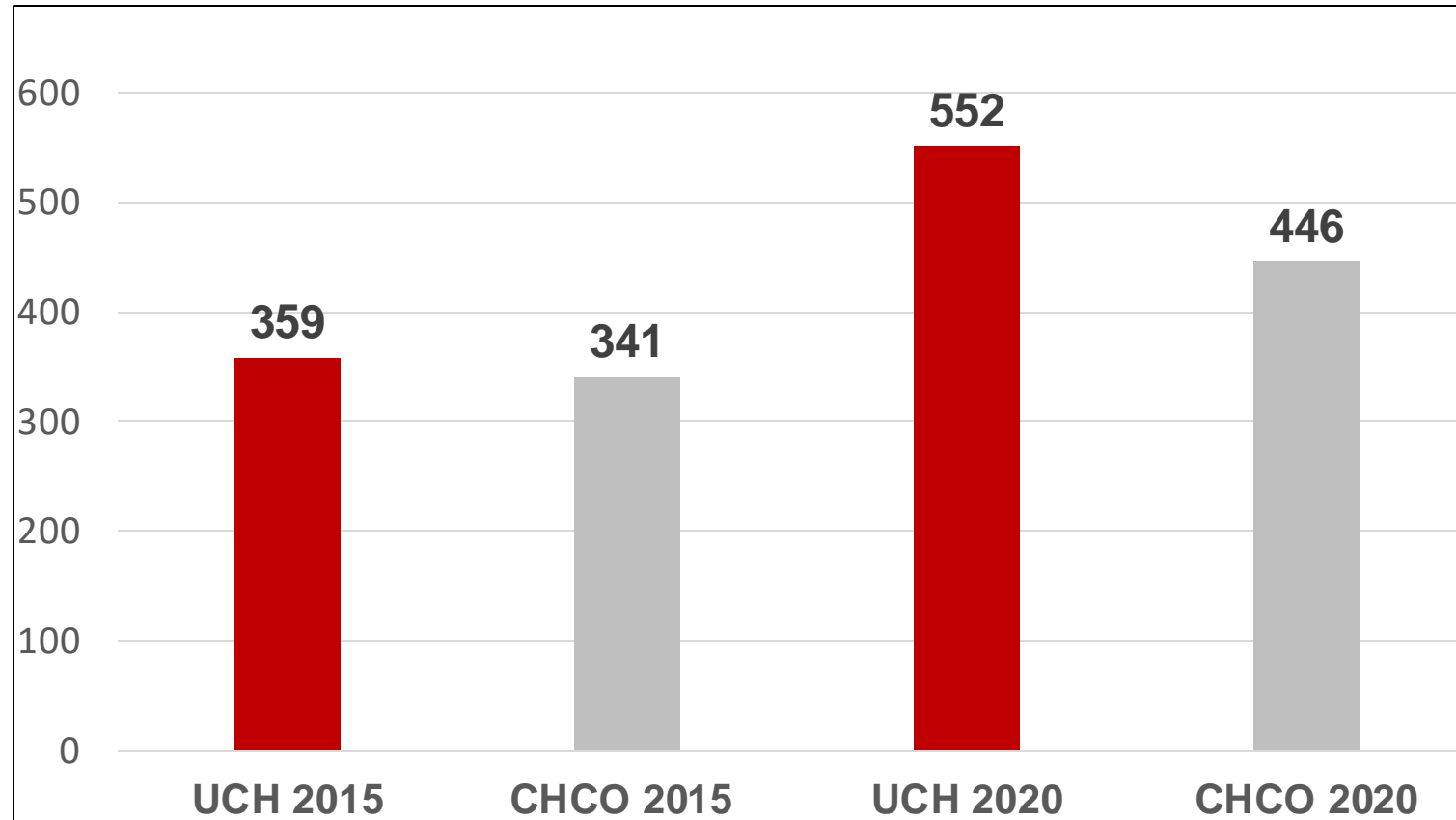
* See
 “.UPIEVAL”
 and
 “.UPIDISCH
 ARGE” for
 general tie-in
 statement used
 to cosign notes

	Documentation requirements	Codes Billed	Compliance/Epic Process
Telehealth A visit with a provider that uses telecommunication systems between a provider and a patient at a distant site. Example: Provider at home; patient in hospital	Document as normal if you can: CC, HPI, ROS, Exam (e.g. mention audible wheezing, rash or location of pain, data, A/P Include in documentation of where the provider and where the patient was for the visit	Bill as you would normally unless >50% of time is spent in counseling and coordination, then bill on time#. See codes (time in mins) below 99221: 30' 99231: 15' 99222: 50' 99232: 25' 99223: 70' 99233: 35'	<ul style="list-style-type: none"> If working with residents use .telesupervision Add smartphrase .IPTELEHEALTH (The patient was over live interactive videoconferencing. Location of patient: ***, Location of provider: ***) Select from the telehealth section on charge capture
Non-virtual visit Visit with provider in the same location as the patient with the provider not in the patient room Example: Provider in hospital, patient in hospital room	Include in documentation of where the provider and where the patient was for the visit	Bill as you would normally unless >50% of time is spent in counseling and coordination, then bill on time#. See codes (time in mins) below 99221: 30' 99231: 15' 99222: 50' 99232: 25' 99223: 70' 99233: 35'	<ul style="list-style-type: none"> If working with residents use .telesupervision Add smartphrase .IPNONVIRTUAL (During the COVID-19 public health emergency, the patient was seen via window or video and audio for this visits.) Select from the regular section on charge capture
Telephone Only Encounters	Document medical discussion, individual you spoke with and time spent on phone only	99441(5-10 mins) 99442(11-20 mins) 99443(21 – 30 mins)	
Post-op VIDEO or TELEPHONE visit	Brief documentation of patient status	99024 (from normal charge capture)	No consent required

#Time=time spent F2F/Floor time on audio and video with patient (does not count time spent in documenting outside of visit, does not count staff time or resident time, does not count time to address technology malfunction)

Working with Inpatient APPs

APP Growth



- Increased post-graduate specialty training
- Increased leadership roles/responsibilities
- Increased participation in quality improvement and research initiatives

What do we like to be called?

Preferred

- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Advance Practice Provider (APPs)

Less Desirable

- Mid-level
- Non-physician provider (NPP)
- Physician Extender
- Helper





Collaborative Approach to Patient Care

Goal:

Provide high-quality, high-value patient care in an efficient, cost-conscious, and rewarding manner.

Utilize All Members of the Team to:

- Increase time at bedside
- Improve discharge times
- Focus on Quality Metrics
- Provide Efficient Care Delivery
- Ensure Patient/Provider Satisfaction



* See
 “.UPIEVAL”
 and
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		s) ns) mins)	
		normal charge	No consent required

not count time spent in documenting outside of visit, does (technology malfunction)

Billing is done as shared service (can bill for your time + APP time). You can also use the same tie-in statements above for attesting APP notes. In addition, include:

- ✓ One-liner with subjective information
- ✓ One-liner with pertinent exam findings
- ✓ Plan for the day



THANK YOU



University of Colorado
Anschutz Medical Campus

uchealth