UW Family Medicine Service Orientation Manual

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D4/619 & D4/621
600 Highland Ave.
Madison, WI 53792

(608)262-2122 (operator)
(608)262-0230 (work room)
(608)262-8674 (fax)

Why we have a service at UWH.

… **Because our patients get admitted to this hospital**. Our primary motivation for maintaining an inpatient service at UWH is because we believe that our involvement with patient care here is better for our patients than if we were absent. We believe we add value for our patients by:

- Providing excellent acute hospital care
- Providing robust coordination of care between the outpatient and inpatient world because we work in both worlds, often actually know the patients, know our colleagues who are the patients' PCPs, and know how to "work the system" to assure care and follow-up in clinic.
- Preventing unnecessary hospitalization by actively involving ourselves in the disposition plans for our patients in the ER who otherwise might be admitted unnecessarily.
- Understanding that while the hospital is a great place for a patient if specific hospital services are needed… it is NOT a good place to be if care can be managed safely outpatient. If not needed, any hospital becomes an "expensive dangerous hotel" that
    - Debilitates patients physically (promotes lounging around in bed)
    - Socially isolates them from their milieu
    - Promotes institutional dependence
    - Exposes them to resistant infections and potential injury
    - Sleep deprives them with constant interruptions
    - And costs a lot of money.

  Hospitalization IS a great tool but needs to be applied judiciously with an eye always to facilitating safe discharge to home or other community settings.

We provide value for our residents by

- Maintaining a busy "aerobic" educational environment where residents truly practice core clinical decision making skills
- Allowing our residents to participate in the educational offerings provided at UWH
- Facilitating interactions between our residents and the residents and fellows of other departments. They are all the true future of the medical care system.
- Role modeling the competence of Family Physicians as managers of patient care in the hospital.

We provide value for UW Health by

- Maintaining a several decades long "lowest severity of illness adjusted length-of-stay" for patients in the hospital. This is a clear persistent advantage of our service.
- Participating in efforts to improve our UW Health system of care as it provides care across the spectrum from intensive hospital care to care in the community.

1. Getting Around

Navigating the adult services

Here is a picture of the hospital floor plan. Note that:

- The hospital is divided into lettered modules, ranging from A through K.
- The west wing of each module is numbered '4.' The east wing is '6'. D6 means the east side of module D, *NOT* the sixth floor.
- The floor is listed after the module number. B6/4 is on the fourth floor.
- **Family Medicine is headquartered on D4/6.** Our workroom is D4/621. To get there, take the E elevators to the 6th floor and take a left. . The code to the door is 1234*.
- The E elevator lobby is your friend! E elevator 2nd floor gets to the ER. E elevator 3rd floor gets you to Peds, the TLC, dialysis and EVP coffee at the VA! E elevator 1st floor gets you to the cafeteria. E elevator 2nd floor gets you out of the hospital and back to your family!
- The ED is accessed via the 2nd floor. From the E elevators, take a left at the entrance to the PT services floor (left at the "hand" sign), and follow the hall. This 'back way' requires ID access for the double doors.

Finding your pediatric patients

American Family Children's Hospital (AFCH) is reachable by taking the E elevators to the **third floor**. Follow the symbol of three children, stenciled above the doorframes. You need your ID card to take the staff elevators in AFCH.

2. Daily Workflow

Key People

- General administrative and logistical issues: Contact **Katy Bixby**, Medical Program Assistant: 263-9980, Kathryn.bixby@fammed.wisc.edu. She is the go-to person for:
    - Parking (Our UWHC liaison is Angela Johnson in Administration, ajohnson4@uwhealth.org or 890-5465.)
    - Office supplies (If printer cartridges are needed, you should contact Jackie Steiger 263-8205)
    - Meal card issues (Our UWHC liaison is Linda Donoghue in Administration, ldonoghue@uwhealth.org or 890-8836)

- Service Director: For any concerns, questions, problems, or conflicts related to the service call **Nicole Bonk**, MD, Medical Director. Cell phone is (630) 865-3054 or email nicole.bonk@uwmf.wisc.edu. Nicole likes to know when there are problems and when wonderful things happen. Feel free to call during normal waking hours.

- Discharge planning:
    - Social work: **Teresa Foster** and **Paige Sutton** are the primary social workers for all Family Medicine patients. They can assist with patients' discharge planning, psychosocial concerns, healthcare power of attorney/guardianship issues, financial problems, and other non-medical concerns. They can assist in finding community resources to help serve patients. Teresa's pager is 9177 (best), her phone is 263-9178. Paige's pager is 9475 (best), her phone is 262-0857. Please try to give them as much advanced notice as possible regarding patients' discharge needs.

- Nurse Practitioner: **Amanda Goplen**, APNP, is the nurse practitioner on the UW inpatient family medicine service. She provides continuity to the service and is present in the hospital M-F from 7:00am until approximately 3:30pm. Her exact role is dependent on patient census. She is assigned a variable number of patients to round on each day. Generally, these patients are of low "teaching value" but may be socially complex or in need of complex discharge planning. She completes discharge summaries on patients whose care she has been following. When census is low, she is assigned few or no patients in order to provide opportunity for R1s to gain adequate experience. Her focus during low census times is on transition of care to the outpatient world, prevention of re-admission, service quality improvement, and enhancement of team functioning. Her cell phone is 608-535-2871. Feel free to call during normal waking hours.

- Nursing concerns: Each floor has a nurse manager whom you can contact for concerns. **Terry Gion**, RN, supervises D4/6. Terry is dedicated to improving care and communication on our unit. She can help with moving people to D4/6 when they are roomed on other floors. Her office is directly across the hall from the workroom in D4/620. Her pager number is 9345 and phone number is 262-8408.

- Pharmacy questions: The pharmacist for D4/6 has an office just around the corner from the nurse's station. He or she can be reached at 263-0579 or paged at 3078.

Key Phone Numbers

- Note: At UW all internal numbers can be dialed using the last five digits. You will receive pages with 5 digit call back numbers often. In order to dial these numbers from cell phones, add '89' to any five digit numbers beginning in 0 and '26' to any other five digit numbers. For example, the Family Medicine workroom number is 262-0230 or in shorthand 2-0230, paging is 262-2122 or 22122.
- Paging: You can send text pages directly from HealthLink EPIC. Go to the EPIC button > Comm > Paging. You can directly text a specific person or whoever is on call for a specialty consult using the 'On Call Now' section. You can phone 262-2122 to page via phone or to contact any department or clinic in the UW system. 262-2122 is a very helpful number.
- Service conference room phone number: 262-0230
- Service fax number: 262-0714
- Service cell phone number: 235-0447
- Nurses' stations: D4/6 is 263-9322. For all others, hover the mouse over a patient's room number when in a HealthLink chart and the nurses' station phone number will pop up.
- See also the extensive list of numbers on the dry erase board in the resident office.
- Here is a list of important contacts for all of the clinics that admit to UW Family Medicine service including main phone numbers, fax numbers, direct/back office numbers, and clinic pool names for urgent response:

16 Clinics that admit to UWH Family Medicine Service

Clinic	Front Desk #	Fax #	Back Office #	Pool Abbrev for rapid next morning response
Access Community Health: Evjue Clinic	443-5480	443-5534	443-5260	P ACHC WTE TRIAGE; P ACHC WTE CLINICAL ALL
Access Community Health: Erdmann Clinic	443-5480	443-5554	443-5562	P ACHC ERD TRIAGE; P ACHC ERD CLINICAL ALL
Arboretum Family Medicine	287-5899	251-2332	287-5861, 287-5814	P ESP IFM RN TEAM
Belleville Clinic	424-3384	424-3256, 424-6353	424-9102, 424-3857, 424-9001	P DBVBW FM RN TEAM
Cottage Grove Clinic	839-3104	839-3404	839-9923	P CTG MAIN FM RN TEAM
Cross Plains Clinic	798-3344	798-1369	798-6420	P CRO FM RN TEAM
DeForest-Windsor Clinic	846-3741	846-7898	846-9981	P WIN FM RN TEAM A; P WIN RECEPTION
Fitchburg Clinic	274-5300	274-4224	277-4712	P FIT FM CLINICAL AUTO; P FIT FM RN TEAM
Mt. Horeb Clinic	437-3064	437-4542; 437-4543	437-0270	P MTH FM CLINICAL AUTO; P MTH FM RN TEAM
Northeast Clinic	241-9020	240-4237	240-4220, 243-7678	P DNE FM RN TEAM
Odana Atrium Clinic	274-1100	274-0310	278-4738, 278-4739, 277-4802	P OA FM CLINICAL AUTO ALL; P INTUW Odana Atrium Family Medicine
Oregon Clinic	835-5588	835-8026	835-6393	P ORE FM CLINICAL AUTO; P ORE FM RN TEAM
Sun Prairie Clinic	837-2206	837-9752	825-4316, 825-4317	P SNP FM RN TEAM
Verona Clinic	845-9531	845-8684	845-1941	P DVN FM RN TEAM
Wingra Clinic	263-3111	263-6663	287-5812	P ESP WFM RN TEAM
Yahara Clinic	222-8779	222-8944	226-5012	P YAH FM RN TEAM

Mark all pool notes with HIGH priority

"Back office" means phone rings in clinic (nurses area) even after clinic closes and front desk phone calls go to answering service

The P INTUW pools are limited in that a telephone encounter can't be routed there, just RE:Patient messages.

If you know another pool at a clinic that DOES take telephone encounters for rapid response then let Lou Sanner know.

Typical Daily Schedule

- The full day team is composed of two interns (one family medicine and one psych), an R2, an R3, a nurse practitioner, and a Family Medicine faculty attending physician. Night coverage is provided by a senior family medicine resident (7pm-7am).

- Attending seminars is important and may result in adjustment of the typical daily schedule outlined below.

- **7:00 am - Sign-out from overnight resident**. The night senior will give a BRIEF a.m. sign-out. The goal is to sign out is 10-15 minutes, more if numerous admits but never >30 minutes total. There is no need to repeat info about previously admitted patients as the daytime senior can do this after the tired, weary night senior has left. Sample scripting for this brief sign-out:
    - "Mr. Smith – No events overnight"
    - "Ms. Jones – Weaned from O2"
    - "Mr. Anderson – New admit, so let me tell you the details about this patient…"

- **7:30 am – Assign patients.** Assignment of patients is an art that needs to consider:
    - Continuing and prior relationship with the patient.
    - Giving each intern 3-5 patients.
    - Considering which residents will be in the hospital all day vs gone in the afternoon. Patients clearly being discharged in the morning can go to Amanda or a resident who is gone in the afternoon. Complex patients with lots of anticipated action should go to a full day resident.
    - Teaching value of the patient. Low teaching value patients awaiting placement can be assigned to Amanda.
    - "Frequent flyers" – patients who need more active coordination of care and problem solving to prevent readmissions. Amanda can help with these patients by either managing them or helping investigate long-term solutions even when a resident manages care.

- **7:30 - 8:00 am - Review new data, Pre-round**. Interns should begin progress notes on their patients during this time while their co-intern is discussing other patients. New data may be reviewed independently or as a group during this time depending on team preference. Group review is done on the big screen with the intern responsible for the patient guiding the investigation, interpretation of data, and development of a preliminary plan for the day/stay. Independent review is done by the intern separate from the senior at their individual computers.
    - New data includes:
        - Afternoon/evening updates from the previous day's senior/intern
        - Review of vitals, I&Os, weights, labs, imaging, consult notes, nursing notes, etc.
    - Development of a preliminary plan for the day and stay involves initial interpretation of data prior to actually laying eyes on the patient for the day and anticipating their care needs for that day as well as the remainder of their stay.
- The nurse practitioner will round independently and will be present for the team discussion of all our patients. **Morning admissions** that would otherwise interfere with resident rounding tasks or conferences will be managed by Amanda.
- Pediatric morning report occurs on Tuesdays and Wednesdays at 8am in the City Council Room of AFCH. The Pediatric seminars can be difficult to participate in when our service is busy but

should be attempted with skillful time management of the tasks that need to be accomplished between 7am sign-out and 12pm Care Team Visits.

- **8:00 - 10:45 am – Round on patients.** Priority should be to round on the sickest patients first, then D4/6 patients (prior to Interdisciplinary Table Rounds), then the rest.
    - Actively seeking the nurse's involvement in rounds is expected! Nurses are on the front line and know the most up to date and pertinent bedside data about the patient's condition, concerns, and questions. Involve the nurse in rounding by telling the unit coordinator at the nurses' station where you will be rounding so the nurse may join you or by putting the nurse call light on when entering the patient's room.

- **10:45 – Conference.** The Internal Medicine morning report tends to not interfere with morning work. Often the whole team can attend after rounds. This conference is held Monday, Tuesday, Wednesday, and Friday in E5/492. Other IM conferences can be found on the IM department calendar.
    - Senior residents will adjust the morning rounding schedule as necessary to allow for conference learning.
    - If attending a formal conference is not possible, the TEACH cards can help provide a framework for informal evidence based learning. Residents or attendings may also guide teaching talks that pertain to patients seen on the service or that are otherwise interesting.

- **Post-conference, Pre-Interdisciplinary Table Rounds – Run the list, LUNCH.** The team runs the to-do list together, receives sign out from half day residents, and updates the team sign-out tab. After running the list, EAT!

- **12:00 - 12:45 pm – Interdisciplinary Table Rounds**. The full-day senior, attending and Amanda will conduct interdisciplinary table rounds with nursing, pharmacy, social work on D4/6. The purpose of these rounds is to gather as a care team to discuss discharge, care coordination, nursing, and pharmacy needs. These rounds are integral for information gathering and planning for these supporting disciplines – Please ensure that you are allowing time for RN/SW/RPh to ask questions and that you are answering them. Be prepared to discuss intended discharge dispositions, discharge timeframes, and discharge needs for every patient on the service.

- **12:45 pm to Evening – Manage the service, admit patients, and prepare for everyone's eventual discharge** by updating dc summaries and completing dc orders the night before if appropriate. In order to meet a goal of discharge by 12:00 noon, some of the discharge work must be done before morning. This can be integrated into the evening work flow if admissions and the service are manageable.
  The service attending physician supervises all admissions called in from the Emergency Department or direct admits from clinics before 5 pm.

- **7:00 pm** - **Evening sign-out**. The afternoon residents must take care of all admissions until 7 pm. After the afternoon resident's sign out they are no longer involved in direct patient care or admissions but before leaving are expected to complete all H&P notes, admission orders and initial consults/tasks for patients admitted before sign-out. The intern is scheduled to be in the hospital until 9:00pm to complete tasks but can be let go sooner at the discretion of the night senior.

- **Weekends.** On the weekends the service is run by one intern, one senior resident, and one attending. Resident sign-out times do not change: 7 am for morning sign-out and 7 pm for evening. The plan for rounding and note writing varies depending on how big the service is and work is generally divided between the intern and senior resident. The team will typically round as a trio after morning sign-out.

Pager / Cell phone:

- The UWFMS pager extension is **0400**. The pager is generally carried each morning by the half-day senior. The pager is carried each afternoon by the intern that will be present for the full day. It is the pager carrier's responsibility to receive/triage pages and promptly respond. Typical pages include patient care requests from nursing/staff and consult follow-ups. Initially interns may need to discuss pager items frequently with the senior resident but as they progress through the rotation the interns are encouraged to address items on their own as they feel comfortable.
- Always call back pages as quickly as possible.
- Always let the senior resident know ASAP if you have a page from the ED or a transfer from IMC or the TLC. See "When the ER calls" section.
- The service has a cell phone (**608-235-0447**) that is intended to be carried by the full day senior and used for calling back consults and for direct senior to senior communication with the half-day senior in the work room.

Other Logistical Issues

- Pelvic exams E5/666 is a pelvic exam room. A key is available from the D4/6 unit coordinator.
- Scrubs Click here to get access to scrub dispensing equipment by submitting a scrub request form: You will need your UW Hospital ID Badge number to sign up, and be sure to select "**GME – Graduate Medical Education**" under Work Area. Scrub vending machines are located in the OR locker rooms on the 3rd floor.
- Patient Day Passes These are a thing of the past and you should not incorporate this concept into your practice. If a patient requests to leave the hospital midway through an inpatient stay for any period of time, this must first be approved by the patient's insurance company. Generally, insurance companies refuse to pay for any remainder of a patient's stay after the patient has left the hospital on a pass because if the patient is stable and well enough to travel elsewhere one could argue that that they no longer require inpatient care. If a patient requests a day pass, the patient must call their insurance company directly to gain approval (contact number can be found in 'Demographics').

3. Parking

Resident Parking

Family Medicine resident parking is in Lot 76. On the UW Parking Map, Lot 76 is a ramp on University Bay Drive, is colored in blue, and is located northeast of the hospital.

Lot 76 window tags must be hung from the rearview mirror upon entering the lot. If the ramp sign says "Lot Full" this means that all the *visitor* spots are full, not the staff parking. Alternatively, if 76 really is full, Lot 60 located across University Bay Drive just east of the ramp may be used for overflow. On Football Saturdays, if parking in the ramp is being enforced, tell the security officer that you are a resident working in the hospital and that you need to park there.

Residents are responsible for passing their parking pass to the next resident coming on the service from their class. If lost, the resident is responsible for paying for a replacement ($65.00).

Attending Parking

Lot 75 window parking tags are issued to Department of Family Medicine Faculty who attend at the UW Family Medicine Service. These cards are for the main hospital visitor's ramp and should be displayed hanging from the front rearview mirror.

- How it works:
  1. When you pull up to the ticket dispensers, a sensor in front of and above the driver's side of your car will be activated by the presence of the window tag. After a pause, the barrier will come up. Do not take a ticket.
  2. Repeat the same when you leave. You can use any lane when exiting.
- What to do if:
  1. *It doesn't work*. If the card does not work, take a ticket to get in, and use the ticket to get out, paying for parking or begging for mercy from the parking gate attendant. Call or email Kathryn Bixby in the Madison Residency Program at 263-9980 or kathryn.bixby@fammed.wisc.edu to report the problem and develop a backup plan as needed.
  2. *It is lost.* If the card is lost, you will need to pay for a replacement card ($65.00) and pay for parking until a replacement can be made. To get a replacement, call the Madison Residency Staff Pager at 608-376-9124. Getting a replacement card may take 4-6 weeks.

4. Resident Responsibilities

Sign-out

An organized sign-out must always take place before a resident leaves for the day. Residents ***must*** update the patient to-do list before sign-out and highlight outstanding items for the new resident coming on shift. A number of patient complications and delayed responses to test findings have arisen because of poor sign-out.

When to Call the Attending

When in doubt, call! If a patient needs more intensive care or is deteriorating in any way, or if a concerning test result is received, contact the attending who actually saw the patient that day. The service attending is responsible for issues related to any patients he or she has already met. The on-call attending covers patients they have admitted up to the time that the service attending sees them.

R1 Family Med and R1 Psych (Interns)

Patient Care

1. Participate in AM sign-out
2. Participate in daily rounds with prepared SOAP presentations for new patients and problem-oriented presentations for established patients.
3. Complete daily progress notes, consult requests, and orders for assigned patients.
   The R1's are the "detail people" – they should be intimately aware of their patients' vitals, I/O's, lab results, plans for the day, and other specifics.
   The R1s should also be the "relationship people" who maintain contact with the patient and family.
4. Manage patient care for the WHOLE service with the aid of senior resident each afternoon at the hospital. The senior and intern will together triage the workload when patient care and admissions accumulate.
5. Regularly update discharge summaries and prepare discharge orders for their patients.
6. Update patient sign-out list in HealthLink.
7. Participate in PM sign-out.

Learning

1. Attend Peds, Internal Medicine lectures when guided to do so by the senior resident.
2. Attend weekly afternoon department lectures as scheduled.
3. Prepare 5-minute teaching point each week to present to the team related to one of their patients.
4. Check in with R3 on Fridays for feedback on their performance (and respectively provide feedback to the senior resident)
5. Meet with the attending going off service to get feedback on Thursday.

Carrying the pager

1. The full day R1 should carry the 0400 pager in the afternoon.
2. If an R1 is doing an admission, he or she may hand off the pager to the other R1.
3. Calls from the ER should be efficiently directed to the senior resident.

Admissions

1. Afternoon admissions should be done by the full-day R1 with the senior resident and attending.
2. Morning admissions will be triaged by the senior resident and may be done by Amanda or the R1 (senior resident and attending to supervise).
3. For all new R1 admissions, the intern will evaluate the patient, discuss his/her plan with the senior resident and attending, place admission orders, call necessary consults and complete an H&P note. If the service is busy, the senior resident may help complete these tasks as well.
4. Interns will take all admissions up until sign out (6:59 PM). Admissions arriving after 7:00 PM will go to the night senior. The scheduled time after 7 PM is to be used to catch up on documentation and patient care before going home.

Other

1. See patients at clinic as scheduled on designated afternoons during the week.

R2 and R3 (Seniors)

- Responsibilities of the R2/3 may vary depending on the needs of the team.
- The R2 oversees all patient care on the UW Family Medicine Service. The focus for R2s should be transitioning into a leadership role of a multidisciplinary team.
- The R3 oversees all patient care on the UW Family Medicine Service. The focus for R3s should be preparation to move fully into an inpatient attending role.

Patient Care

1. Lead the AM sign-out, assign patients for rounding.
2. Participate in daily rounds. See Typical Daily Schedule for details.
3. Lead Interdisciplinary Table Rounds on designated days.
4. Complete daily progress notes, consult requests and orders on any assigned patients if workload is high for R1s. Assist with calling consults, placing orders, etc. if the service is very busy.
5. Perform senior resident role for all patient care for the service with the aid of the intern each afternoon when at UW for a full day. The senior and intern will together triage and divide the workload when patient care and admissions accumulate.
6. Update patient sign-out list on Health Link. This is a necessity that must happen regularly.
7. Participate in PM sign-out.
8. When time permits:
    a. Ensure all primary care providers are aware of admissions of their patients to the Family Medicine Service either via InBasket, Call, or Text.
    b. Follow up daily on TLC or IMC patients who are likely to be transferred from the unit to the Family Medicine Service.
    c. Prepare teaching topics based on interesting cases or on the learning needs of the team.

Learning and Teaching

1. Teach EMR nuances to interns: Organizing Health Link view, Ordering, Admissions, note templates, Transfers, discharges.
2. Assist interns with basic day-to-day clinical and patient care skills, such as calling consults.
3. Sit-down teaching at least weekly during the weeks not taking Thursday night call.
4. Attend Peds, Internal Medicine lectures. Ensure that interns get to seminars on time.
5. Consider trying to arrange for guest lecturers (subspecialists, fellows, etc).
6. Lead "Feedback Fridays (or Thursdays)" by spending several minutes with each co-resident to give (and accept) feedback on individual performance and team dynamics.

Discharge planning

1. Predict discharge date/time and discharge patients before 12pm when possible.
   a. Enter anticipated discharge date on admission by double clicking on this cell on the shared list.
   b. Enter a confirmed discharge date and time as soon as this is known by the same process.
2. Prepare for everyone's eventual discharge in advance by regularly updating discharge summaries (hospital course) and by preparing discharge orders the night before their departure (either by actually signing the orders or saving your work).
3. Assist with completing discharge summaries. The senior residents and Amanda are together responsible for completing discharge summaries in a timely fashion. Note the NP generally will complete discharge summaries for patients she has seen on their day of discharge.
4. Assist with continuity, including following up with any test results that are received after a patient's discharge and verifying that patients have outpatient follow up.

Admissions

1. All phone calls from the ER for admissions will go to the full day senior (R2/R3). See "When the ER calls" section below. The senior will determine if the patient may be transferred to the floor or if the Family Medicine team prefers to evaluate the patient in the ER first. Responsibility for writing the H&P goes to the intern.
2. Act as senior resident by supervising and assisting with R1 admissions in the afternoon. Contact the attending to notify them about the admission.
3. May help put in orders, write H&P, etc. as needed but this role is primarily for the intern when time permits.

Weekends

1. Round with attending and R1. Share responsibility of managing the entire service with the R1 by writing progress notes, entering orders, etc. for half of the service's patients.

Health Line Phone calls

1. On weekends, take daytime Nurse Triage and Nursing Home (NH) calls from 12pm – 7pm.
2. During the week, the full-day senior will take Nurse Triage and NH calls from 5 pm – 7 pm.
3. **The UW operators will page residents' personal pagers for these phone calls.**

Other

1. Be a role model for junior residents!
2. See patients at clinic as scheduled in the afternoon.

Night Senior (R2 or R3)

Patient Care

1. Receive PM sign-out
2. Admit patients. See "Admissions" and "When the ER Calls".
3. Take ownership of currently admitted patients and assume an active role in the continuation of patient care overnight. Perform tasks off the patient to-do list. Follow up on labs, final radiology reads, and consultant recommendations. Ensure appropriate morning labs/studies are ordered.
4. Do "walking rounds" on the patients. This means see them, assess them, address any lingering concerns or questions that were unanswered earlier in the day, collaborate with their nurses to ensure understanding of the plan for the night. If time is short, at least lay eyes on the sickest or more complicated patients.
5. Write interim progress notes for any patient when significant results return, if their status changes, or if there are behavioral events.
6. Cover the 0400 pager overnight and take overnight Health Line calls from Nurse Triage and NH.
7. Update the to-do list before the day team arrives.
8. Give BRIEF a.m. sign-out at 7 AM. Goal is to sign-out in 15 minutes, more if numerous admits (never >30 min). There is no need to repeat info about previously admitted patients, the daytime senior can do this after nighttime sign-out is done as part of pre-rounding.
    a. Use the following scripting:
    "Mr Smith – No events overnight."
    "Ms. Jones – CXR resulted and clear."
    "Mr Anderson – New admit, so let me tell you the details of this patient's case…"

Discharge Planning

1. Prepare for everyone's eventual discharge in advance by readying discharge summaries and by preparing discharge orders the night before their departure (either by actually signing the orders or saving your work).

Admissions

1. Perform all admissions occurring after 7 PM with overnight attending.
2. Complete H&Ps and orders for any new admissions.
3. Complete transfer note and transfer order reconciliation for those transferred to the service. See "Transfers"
4. Once a senior resident has been "approved" to complete admissions alone, admissions performed after midnight do not require the attending physician to come in to see the patient. The night senior is still expected to evaluate the patient and discuss a plan of care with the attending over the phone. This means that the attending should at least be called for ALL admissions. If the patient is

at all unstable or if the resident is uncomfortable, the resident may request the physical presence of an attending at any time.

A Note on Evening Sign-outs:

1. The full-day R1 and senior will sign out the service at 7 pm every night to the oncoming senior.
2. The full-day R1 is scheduled to stay until 9 pm and this extra time after sign out is meant to allow the intern time to wrap up work from the afternoon. The intern should take all admissions up until 6:59 PM, but should not take any admissions after 7 PM. The intern may be sent home before 9 PM if work is finished.
3. The full-day senior resident must stay until the night senior comes on at 7 pm. They are not obligated to stay for the full sign-out but they may do so. They should stay when there is an inexperienced or new intern giving sign-out or an inexperienced or new resident coming on shift.
4. If the afternoon is very slow, the senior resident may send the full-day R1 home earlier in the afternoon, but they must understand that they are then responsible for signing out to the night senior resident at 7 pm.
1. The exception to this is Friday night, when the daytime senior **must** stay for sign out from 7-8 pm because there is a new night senior on service on Friday nights.

5. Attending Responsibilities

General Duties

Patient Care

1. Round on all service patients each day.
2. Stay on-site until Noon on weekdays, and preferably until 5 pm.
3. Take **legal responsibility** for all patients on the service.
4. Contact consultant attendings if problems arise with consultations or obtaining diagnostic testing. Speak directly with other attendings as needed to facilitate patient management.
5. Complete daily notes. Review all resident notes. Attendings should preferentially choose to ADDEND resident notes, as opposed to cosigning them. Use the Epic dot phrase ".attendingcosign" or develop your own scripting for this. If you happen to addend a resident's note after the day of service then you must document when you actually saw the patient on the day of service – e.g. "On March 8, 2016 at approximately 9:00am I examined…"
6. See patients the NP is admitting or discharging and addend these notes. The attending can also see NP patients who are not being admitted or discharged and should see those that are medically active.

Teaching

1. Prepare *at least* one formal teaching session per week.
2. Role model attending skills to R2 and R3.
3. Attend Peds and Internal Medicine lectures.
4. Encourage literature searches and provide resources to direct resident learning. This should be a priority, even if the Service is busy. The "Teach" cards are a great resource for guiding the team to dive into the literature to answer core clinical questions.
5. Encourage independence in management of the service by the residents as much as is appropriate.
6. Keeping rounds moving efficiently while allowing the senior residents to run them.

Admissions

1. Be knowledgeable of the cap rules (14 patients from 7a-6p, 16 otherwise unless "Surging") and "Is this our patient?" rules.
2. Participate in all day-time weekday admissions called in by the ED before 5 pm on weekdays. Review the patient's H&P and addend that note. Use the Epic dot phrase ".attendingcosign" or develop your own scripting for this.
3. Staff any admissions that occurred after midnight and were not physically examined by the overnight attending. Review the patient's H&P and addend that note.
4. Review/accept any direct admissions or transfers to the UW Family Medicine Service.
5. Cosign admission orders specifying inpatient vs observation status.

Transfers from other services

Family Medicine patients who are coming out of the TLC or IMC will be transferred to us for the remainder of their hospitalization. On the day of transfer our residents will see the patient and discuss the patient's care plan with you. You don't actually have to see the patient on the day of transfer since the patient has already been seen and managed that day by another service attending (who has billed that service). You certainly can see the patient that day if it helps the team plan for care. You do have to see the patient on the day of transfer if the plan is to discharge the patient from the hospital the same day. Yes, this happens.

Weekends and Holidays

Once all patients have been seen and plans for the day are made the attending can go home. You can then addend notes from home via Citrix login to EPIC. All new admissions on the weekend are supervised by the faculty physician on med-peds call. However if you happen to be still present at UWH in the morning when there is a new admission in the ER you can elect to see that patient as a courtesy to your on-call colleague.

Discharges

You must always see a patient on the day of discharge. When the discharge summary is finalized, it will be forwarded to your EPIC In-Basket and should be reviewed and addended quickly. A helpful Epic dot phrase for this is ".attendingcosigndischarge".

Resident Evaluation

1. Give residents oral feedback at least once a week during the attending experience.
2. Touch base with the R3 and Amanda at least once per week to review how the team is performing and discuss any changes.
3. Complete resident evaluations on New Innovations in a timely manner.

Other

1. Be available to residents anytime. Attendings cover all service patient issues 24/7 during the time they attend. (The on-call attending covers issues related to patients whom the service attending has not yet met.)
2. Contact the Service Director, Nicole Bonk, in the event of any problems.
3. **Billing**: Our department biller-coders search through every UWH encounter (H&P, progress note, discharge summary, consult note, procedure note) to pull anything done in your name (last addended by you). They then code the service and bill it. So the attending only needs make sure that each note is addended and that the documentation allows for the appropriate billing level. If the residents provide unclear or inadequate documentation then our biller-coders will contact you and the resident.
4. **Quality/Safety Issues:** If any potentially preventable complications arise for patients or if it seems a member of the team has made an error, please file a "Patient Safety Net (PSN)" and contact Nicole Bonk to discuss. We WELCOME opportunities to review cases in efforts to improve care provided by our service. Our service QI committee meets monthly.

5. Provide a clean **transfer of the service** to the next attending. Contact them directly with a verbal sign-out of the service and patients. Attendings are responsible for a service until the subsequent attending has begun rounding on the service.

Faculty Call Rooms

A call room can be reserved by calling Bed Control at 263-8775 the same day you are on-call. The UWHC call rooms each have a touch pad security system and the codes will be given to the physicians when reserving the room. They will ask you for your name, department, and pager. The call rooms available to us are B6/366, B6/368, E5/574 (closest to our service), and F8/175.

Backup Attending

Purpose

1. Have a proactively-designated individual who is available to take over attending responsibilities in the event of:
   a. Attending illness
   b. Attending family emergency
   c. Other emergent issues requiring the designated attending to not be able to perform their duties

   Note: The back-up is **NOT** intended for work-related "urgencies" such as "I accidentally scheduled myself in clinic", or "I forgot I'm also teaching a course that day", or "I have to coach my kid's soccer game on Saturday morning" sort of scheduling conflicts.
2. Have a designated attending available to assist with extreme work load, very high number of admissions during the morning, or Amanda's absence.

Scheduling expectations for the backup attending

1. Be available to round independently (if needed) from **7am-9am** on either our UWH or St Mary's service, usually seeing 2-4 patients who are less likely to require team attention later in the day (e.g. discharges or more straightforward cases).
2. **Pager on 24/7** during that week.
3. Available 7am-1pm to help each day including weekends if needed.
4. Be willing to perform morning admissions to allow the inpatient team an opportunity to care for the patients already admitted.
5. Be willing to CANCEL, last minute, any other responsibilities you might have in order to assist on either inpatient service from 7am-1pm.
6. Have an attitude when called for help by either a UW or St. Mary's Attending of "How may I help you?"
7. **No OB call** while on back-up
8. Limited clinic duties the mornings of back-up attending. Have a contingency plan for cancelling morning activities last-minute.

Backup risk is different on days/weeks when Amanda is not available

1. We attempt to schedule co-attending weeks when we know Amanda will be gone. Sometimes that is not possible.
2. When Amanda is absent, the backup attending should be aware that the risk of being called in to provide help weekday mornings or on the weekend is higher. For week-long planned Amanda absences the back-up attending (if no co-attending) will be informed many months in advance and can plan that week accordingly. We suggest NO clinic or staffing in the mornings on these weeks.
3. The risk of being called in when Amanda IS available is quite low but not zero.

Backup co-attending job when an Internal Medicine hospitalist is attending

1. We have an arrangement with our brothers and sisters in Internal Medicine where they do some attending weeks on our service each year. We do this primarily because they do a good job! …and it facilitates our collaborative work with the hospitalist group all year. Our residents get a "different perspective" from the hospitalists who are generally very savvy in the inner working of UWH. Additionally, the hospitalists get a better understanding of the aerobic nature of our service and of Family Medicine culture and care. It is generally a mutually beneficial learning opportunity
2. When the IM hospitalists attend they do not manage pediatric patients on our service. However we continue, as a service, to admit and manage children. Our "backup co-attending" then has primary responsibility for children admitted to our service.
3. When you have this job you should plan as follows:
    a. You CAN schedule clinical activities in the afternoon and academic work in the AM. OB call is generally fine since you can generally fit rounding on 1-2 kids at some point into that schedule. Rarely will you need to cancel anything in the afternoon. You might need to go in after clinic to see a child who was admitted in the afternoon but you can ask the med-peds call person to assist with this after 5pm. Remember that unstable pediatric admissions go to the PICU and we aren't involved with those admissions.
    b. You will only need to round in the AM if there is a child to round upon. Stay in touch with the senior resident (and night senior) to be informed about new pediatric admissions.
    c. On the 2nd weekend that an IM hospitalist attends you WILL be asked to round on the WHOLE SERVICE either Saturday or Sunday so that the IM hospitalist can have a break from the relentless 6am alarm clock that otherwise goes for 14 days. It sometimes helps to go in Friday sometime (either for 7-10am rounds or later in the day) to familiarize yourself with the patients if you are rounding Saturday.

6. Admissions

When the ER calls a senior resident should respond. There are several possible outcomes:

1. We determine this is not our patient (see below). Goodbye.
2. We are capped and patient is neither pediatric, a bounce back, nor a patient very well known to the service (See Cap Rules). Ask the ED to call the Triage Hospitalist. Good bye.
3. We talk them out of the admission on the phone without ever seeing patient. This is often because we find chart data that the ER didn't notice or we suggest some other test be done which then shows a reassuring result.
4. We can agree to take the admission on the phone. Done. Now we just need to do the work. Sometimes we later discover that we regret this (didn't really need admission or actually not our patient...). We generally then do admit them anyway because we said we would...
5. We can ask the ER physician not to put a bed request in because we want to see them first in the ER. Often the ER says they are going to put in a bed request anyway (or already did). So the clock is ticking to get down there and see patient in the ER. Once our resident sees the patient, then:
   a. Our resident agrees that admission is needed. So, we do the work. If before midnight then our attending always sees the patient that same day. After midnight the overnight attending puts in a very short note from home. Inpatient attending sees patient in AM and addends H&P.
   b. Our resident may determine (with on-site or supportive phone call from our attending) that patient doesn't need to be admitted. Resident (and/or attending on site or on the phone) talks with ER attending. Two possible outcomes:
      i. ER attending agrees to cancel bed request and send patient home without a formal consult. Done. We often arrange some outpatient follow-up via an EPIC message to PCP clinic (list of clinic InBasket pools). Our resident note does need to be signed by the attending. If attending did not see the patient (e.g. on-call) be clear that you didn't see the patient. This is then not a billed service. If our attending saw the patient in the ER then have the ER order a FM consult and addend the resident's consult note so this service can be billed.
      ii. ER attending insists that our overnight attending come in and see the patient. We then ask the ER attending to order a formal FM consult and our attending comes in. Usually then the ER ends up discharging the patient after we see the patient. Sometimes there is further "conversation" about this.

When The American Center (TAC) ED Calls.

What is TAC?

- The American Center (TAC) is a smaller UW hospital on the east side of Madison that opened in 2015.
- TAC has an ED, outpatient clinics, inpatient general medical/surgical beds, and IMC level beds. They also have limited ICU services by tele-ICU.
- Medical admissions admitted to TAC are managed by a hospitalist service.

- There are limited specialty consulting services available at TAC and many procedures aren't currently done there (e.g. endoscopy, cardiac caths). So, some patients in TAC ED require admission at University Hospital for subspecialty involvement or procedures.
- The services offered at TAC is evolving and growing, Nicole knows well what is/is not offered there because she is a TAC Hospitalist. The on-call and pageable TAC Hospitalist is also a good resource.

What to do when TAC ED calls?

- If TAC ED calls, there are several questions to be asked:
  - Is the patient a FM patient (consider just like UWH ER calls)? If not, then you are done.
  - Has the TAC Hospitalist first evaluated the patient? If so may be best to talk directly to that TAC hospitalist who has thought through the issues below.
    - If it is very straightforward then the TAC hospitalist doesn't need to be involved.
    - If the TAC ED is hesitant to discuss with Hospitalist, you may page TAC Hospitalist to request their evaluation by paging "Hospitalist TAC Medicine" during the day or "Hospitalist TAC night" during the night.
  - Does the patient need to be admitted? This is MUCH harder to "challenge" since we can't see the patient before admission. Still a quick chart review sometimes generates important information the TAC ER may have missed or we can help them consider "alternatives to admission" like an expedited next day clinic visit.
  - Can the patient be admitted to TAC? Just because the patient is a DFMCH patient does NOT mean they need to transfer to UWH. The TAC hospitalists can and should care for DFMCH patients at TAC if there is no medical reason to transfer.
    - Main transfer reasons are that the patient needs CCU/TLC care, a procedure not done at TAC or a consult not available at TAC. There are video consults available at TAC and some procedures can actually be done on TAC patients by transferring to UWH just for that procedure and then the patient returns to TAC. This is an evolving situation and the TAC hospitalist has the most up-to-date info.
  - Is this a potential IMC or even TLC patient? It is *very* bad to transfer a patient from the TAC ER to UWH general care (e.g. D4/6) just to find the patient actually needs a higher level of care. D4/6 and other general care units are not staffed by nurses to allow them to do intensive stabilization and monitoring while re-transfer to IMC or TLC is arranged. If this is a potential issue then the TAC hospitalist really must evaluate the patient at TAC or at least provide phone guidance to you.
- If you and/or the TAC Hospitalist agree with the TAC ED that a patient needs to transfer to the main UWHC hospital in a general care status, then accept the patient and await the call from the unit at UWH that the patient has arrived, and go see the patient and admit them!

<u>Our relationship with the UW ER</u>

The ER is our friend. We have a lot in common with our colleagues in the ER. We both spend most of our clinical time (clinic and ER) evaluating patients for acute complaints that carry no diagnosis yet and could end up being low risk self-limiting conditions or life-threatening problems. We both try to avoid

unnecessary hospitalization and to provide definitive care during our visit. The ERs send the vast majority of the patients they see home. The ER care and follow-up planning provided can be quite complex and many chronically ill and medically fragile patients go home without the ER ever contacting us. Walk a mile in their shoes. The ER is the "miner's canary" of the local health care system. If the health care system isn't working (not enough PCPs, poor access to primary or specialty care, poor PCP/specialty management plans for chronic problems, poor access to mental health services, lack of adequate insurance, poor patient education, etc.) then the ER gets overwhelmed with patients that should have been evaluated elsewhere or should have had more definitive care provided prior to the ER visit.

When the ER calls us about a patient they don't "win" if we immediately agree to take the patient and we don't "win" if we end up not admitting the patient. The patient wins if we work together efficiently to manage the patient's problems and determine the best next step (home or hospitalization) for the patient. We often agree on what is needed. When we don't we should approach the conversation with less ego ("My expert opinion is inherently better than yours…") and more collegial discussion. Our attending can always assume direct responsibility for the patient and discharge the patient if the disagreement can't be otherwise resolved. It is best to avoid confrontational management. Focus on what is best for the patient. Build positive relationships with the ER. Just like us, the UWH ER is a training ground for the future of our specialties. Help build a positive collegial future.

Our service director and the ER service director want to know if there are problems – and if things are going well! We both appreciate forwarded comments about encounters that went particularly well (resident names attached). This helps in evaluating residents and attendings from each of our programs. Problems can also be addressed quickly when we stay in touch.

How do we determine that a patient is "ours" for the purpose of admitting to our FM service at UWH? It depends on the answer to two questions:

1) **Who is your PCP?** Or… Where do you usually go for primary care?
   - Answer may be straight-forward that he is our patient: "Dr. Sanner is my doctor for the last 10 years" or "I go to the Verona Clinic but I haven't seen the same doctor there much. "
   - Answer may be straight forward that he is NOT our patient: "I used to go to Wingra but I have been going to Dean/Meriter/GHC for the last 2 years."
   - We maintain a list of UW FM CLINICS we admit for which is more useful than an every changing list of PCPs at those clinics. We don't cover all UW FM clinics. See details below.
2) **Where were you last seen for primary care?**
   - A patient has to actually be seen for a visit (not a no-show, future appt, or a telephone call) to be considered under the care of that clinic for the purpose of determining which service should admit patient at UWH.
   - Intent to be seen does not count. For example, "I plan to make at appointment at ACHC in the future" or "I plan to switch care to a UW Internal Medicine doctor."

The answer to these two questions then drives the decision to admit to us vs Medicine (or Peds):
If the patient identifies one of our clinics as his/her PCMH and was last seen there for primary care appointment (with no subsequent PCP visit anywhere else) then this is our patient regardless of how long ago that visit was. Sometimes patients go >3 years between visits but if the patient hasn't established elsewhere and still considers him/herself our patient then s/he is our patient.
If patient says "I don't have a PCP or regular primary care clinic" and their last visit with us was >3 years ago then this is NOT our patient.

If patient plans to establish with us but hasn't yet been seen then this is *not* our patient for admission purposes. We have this rule because patients often plan to do a lot of things… and then don't follow through. Similarly if last appointment with any PCP was with us and that appointment was <3 years ago then this is still our patient even though they plan to go elsewhere in the future.

If patient has a PCP in some other system (e.g. Dean, GHC, Meriter, Chicago…) and has seen that PCP more recently than one of us then this is not our patient. The patient would have to "re-establish" a PCP here and being admitted to the hospital does not do this.

Some patients don't "get it" about Primary Care or are demented or otherwise non-communicative. So use the family/POA to determine "Who is your doctor?" or just review the chart (and sometimes look at Dean/Meriter/GHC CareEverywhere) to make a determination.

Sometimes patients are angry and want to change clinics or are otherwise "at loose" in multiple care systems. Generally these are not our patients unless the last PCP appointment anywhere was with us and that was in the last 3 years. Example: A patient leaves Meriter AMA and comes to the UW ER because they are mad at their Meriter physician and now want to come back to a UW FM physician they saw years ago. This is not our patient until seen again in one of our clinics to establish care.

Be aware that we have trained lots of the family physicians in the region. A patient may identify a physician on our list (if not updated) who was a resident but is now working elsewhere. If the patient is being seen at this outside clinic then the patient is not ours.

The Provider List: Whose Patients Are Admitted?
The Family Medicine Service admits for the following clinics in the UW Health system:

- Access Community Health Centers *(Family Medicine patients only)*
  - William T. Evjue Clinic
  - South Side Clinic
- Arboretum Clinic
- Belleville Family Medical Center
- Cottage Grove Clinic
- Cross Plains Clinic
- DeForest Windsor Clinic
- Fitchburg Clinic *(Family Medicine patients only)*
- Mt. Horeb Clinic
- Northeast Family Medical Center
- Odana Atrium Clinic
- Oregon Clinic
- Sun Prairie Clinic
- Verona Family Medical Clinic
- Wingra Family Medical Clinic
- Yahara Clinic

We currently admit for approximately over 150 providers from 16 different clinics. The clinic list is more reliable than the list of admitting providers. The best way to see if this patient comes from one of our clinics is to look in Chart Review > Encounters > Filter > Encounter Type > office visits.

Transfers from Other Hospitals Any transfers from outside hospitals generally go to the Medicine or Pediatric services, as most of these are for patients from clinics we do not admit for. The one exception to this would be if we agree to a transfer from a UW Family Medicine colleague at St. Clare Hospital, Meriter or St. Mary's if the PCP is on our provider/clinic list. The Family Medicine attending (daytime attending or attending on call) should be contacted directly to discuss this. Oftentimes hospital transfers occur due to clinical deterioration, so consider whether a patient is appropriate for general care versus IMC/TLC when in this situation.

IMC Admissions The Family Medicine Service currently does not admit to intermediate care (IMC) status at UWH. The hospitalists are responsible for IMC patients. We do accept our patients back onto our service once they are ready to leave the IMC and return to general level of care.

Trauma/Life Support Center (TLC) Admissions The TLC is the equivalent of the ICU in most hospitals. Family Medicine does not follow patients in the UW TLC but will resume care when they are transferred out of that unit to general level of care.

Documentation The resident on-call will typically do admissions. This includes seeing the patient, discussing him/her with the attending, entering orders, and formulating a differential diagnosis and treatment plan under the attending's guidance. If our admitting attending saw the patient before midnight but the documentation occurred after midnight, this should be clarified in the attending addendum, e.g. "On 2/14/2014 at approximately 11:30pm I examined…". The physician admission bill will be based on the date our attending (on call or on service) first saw the patient.

Attending Presence at the Hospital On-Call Typically, attendings see new admissions ASAP. When the night senior resident is on duty and it is after midnight, if patients are stable and the resident feels comfortable managing a new patient after discussion with the attending by phone, the service attending can see the patient the following morning. The on-call attending then should leave a short note in the chart documenting that you were called, why you think this patient should be admitted and be clear that you didn't see the patient. This can be done as a "Miscellaneous Note" in EPIC or as a telephone encounter.

Pediatrics Admissions Family Medicine admits children of any age. We do not follow patients in the Pediatric ICU. Pediatric patients are admitted to the American Family Children's Hospital. The same rules apply for admitting children before and after midnight but attendings tend to come in after midnight for many Pediatric admissions.

- **Pediatrics Senior** There is a Pediatric senior on night float that is available to assist residents with any patient issues that may arise with children on the service. Page "Peds Red Sr Resident"

- **Pediatric Hospitalists** The pediatric hospitalists are very willing to cover, curbside, or accept transfers. They do request **direct attending-to-attending contact** for this to occur. If our service is very busy and a child is on the edge of needing PICU admission (e.g. unstable croup, bad asthma exacerbation) and requires frequent bedside reassessment, then that patient is best admitted by Peds where the residents are constantly physically present at AFCH. It is very stressful for the AFCH nurses and our resident to have a constant need for reevaluation when our resident is tied up in the ER and adult units at UWH. Page "Peds Red Hospitalist".
- **Transfers from outside ED's** The transferring attending should specify whether or not they want a child to go to the Family Medicine Service or to the Pediatric Hospitalist Service. It is not uncommon for the Meriter ED to transfer Family Medicine children to the AFCH due to limited inpatient pediatric bed availability at Meriter.

Unassigned Admissions Family Medicine **does NOT** take unassigned patients at UWH.

Observation Status vs Inpatient status Patients are admitted as either "inpatient" or "observation" status.

- Inpatient status is appropriate if you are providing the patient with higher acuity hospital-level services (IV antibiotics, transfusion, IV PCA, surgery/procedures, etc) and/or the anticipated length of stay is more than two midnights (which includes any midnights spent in the ED).
- Observation status is given when the anticipated length of stay is one midnight or less.
- Please ensure that the admission status order matches documentation in the bottom "Dispo" section of the H&P.
    - For example, an inpatient's dispo statement would read: "Patient admitted to **inpatient** status for management of ___ and is risk for ___. Expected duration of admission is **>2 midnights**."
    - An observation patient's dispo statement would read: "Patient admitted to **observation** status for management of ___ and is at risk for ___. Expected duration of admission is **<2 midnights**."
- Know that any midnights spent in observation status do not count towards Medicare's required 3 inpatient midnights to qualify for SNF stay coverage.
- If in doubt, **use your best medical judgement** and consider the anticipated length of stay, acuity, and expected discharge disposition (SNF?). Document your thinking.

Direct Admissions Direct admissions from clinic should be discussed by the clinic physician with our senior resident or attending. There are several points of discussion that need to be clarified:

1. Is this admission needed? If not clear then patient should be sent to ER for evaluation.
2. If admission needed, is it clear what level of care is needed (general care vs IMC vs Cardiology ICU vs TLC)? If it is NOT clear then the patient should be sent to the ER for evaluation. Based on prior experience we try NOT to direct admit potentially unstable patients (e.g. chest pain with no troponins) to the floor when they may actually require ICU admission once various ER level tests are completed. Turning the floor nurse into an ER nurse is to be avoided. It is potentially dangerous for the patient and delays proper care.

3. How will patient come to hospital? Private vehicle vs ambulance? Is the patient stable and ambulatory such that can go to admissions desk?
4. When might they likely to arrive at the hospital? Sometimes many hours have passed between phone call and patient arrival.
5. Please keep patient in clinic (if stable) until Access center identifies a bed.
6. Who is going to call Access Center (if not already on phone)?
7. Ask the clinic provider to write a helpful note (not an H&P) and clean up the chart (med list, problem list, PMH, Social History, etc.) for ease of admission.

The resident who first sees the patient at the hospital will write the H&P and orders in inpatient EPIC. The first attending physician who sees the patient in the hospital (generally same day as admission for direct admits) will then addend the resident's H&P and bill for the H&P at that time. If the patient is stable and the patient actually arrives quite late in the evening then the on-call attending can choose not to come in since the clinic provider has seen the patient that day. The service attending then will see the patient the following morning. In this situation a clinic charge will be billed for the clinic visit and the H&P will be billed the next day.

Call the Access Center at 263-3260 to check for bed availability when doing a direct admission BEFORE sending the patient out of clinic.

7. Transfers

To Family Medicine (From IMC/TLC)

For all transfers, the accepting team must complete transfer order reconciliation using the 'Transfer Navigator'. This reconciliation includes eliminating things like q1h vitals and supplemental electrolyte protocols among other things that are inappropriate for general level of nursing care.

Transfer notes are summary notes that should be written promptly and should succinctly summarize the patient's hospital course prior to care being assumed by the Family Medicine team. Typically transfer notes are written on a day when a patient has already been seen by an attending on another service therefore these notes do not need to be addended by the Family Medicine attending.

NOTE: Medicare patients transferred from the FMS to inpatient psych or rehab must have a discharge summary done prior to the transfer. All other transfers within the hospital (including psychiatry transfers for patients with Medicaid or commercial insurance) will have their discharge summary done by the service the patient is on when they leave the hospital. If they come to us from the TLC, we do the discharge summary.

To TLC/IMC (From Family Medicine)

Transferring a deteriorating patient to a higher level of care within the hospital should be smooth in order to prevent delays in providing critical care to our patients.

The **TLC** (Trauma Life Support Center) provides critical care: pressure support, ventilator support, 1:1 nursing, etc. and is managed by the TLC/Critical Care Team.
The **IMC** (Intermediate Care) is managed primarily by Hospitalists and allows for more intense nursing care, some cardiac drips, continuous CPAP/BiPAP, etc.

Use the following workflow plan to help guide the logistics of transferring a deteriorating patient:

1. Recognize the patient is deteriorating (by discussion with RN, examination, or chart review)
2. Assess the patient
3. If appropriate at any time, Resident or RN may **call a Rapid Response on Code by dialing 2-0000**. A Rapid Response brings additional critical care nursing staff, an RT, and a lab tech.
4. Order appropriate interventions and **page the "Hospitalist Triage" (daytime) or "Hospitalist Night Cross Cover" (nighttime) pager for patients needing IMC level of care or the "TLC Fellow" for ICU level of care**.
5. Assess response to interventions
6. If continued deterioration or lack of stabilization, page the Hospitalist or TLC for urgent assessment/transfer

7. If the patient codes, he/she must be admitted to TLC or CCU. Page the TLC fellow or the Cards Fellow.
8. Keep the nurse informed of the status of the consultation/transfer while he/she cares for the deteriorating patient.
9. Manage the patient until transferred, re-page Hospitalist/TLC as needed, call Rapid Response if unable to otherwise arrange for higher level of care when clinically indicated.

Key points:

- Communicate with Hospitalist/TLC services early.
- Hospitalists have admitting privileges in the IMC (intermediate level of care).
    - Daytime: Page "Hospitalist Triage".
    - Nighttime: Page "Hospitalist Night Cross Cover" or "Hospitalist Triage".
- TLC fellows admit to critical care services.
- Communicate with nurses often.
- If not receiving desired response, know that Rapid Response is always an option.
- If a patient codes, they must be transferred to a critical care service – TLC (TLC Fellow).
- In order to best facilitate these transfers during code situations, it is usually best to have the TLC fellow run the code while the Fam Med physician coordinates the transfer (by calling the Cardiology service or by jumping through whatever other hoops you are presented with).

8. FM Service Consults

Q: Do we do consults?

A: Yes… and no. We definitely do consults in the ER as detailed under "When the ER Calls" section. We also rarely follow patients as a "consulting" team who are already on our service and get transferred to another specialty surgical service – e.g. managing medical issues for a patient who gets transferred for a cholecystectomy or a skin graft. However we generally do NOT do consults and follow patients who start out admitted to another service – e.g. patients admitted to Orthopedics for elective hip surgery or a patient on the Psychiatry service with an abnormal thyroid test result. These patients should be evaluated and followed by the consult hospitalist. We also don't do consults on pediatric inpatients at AFCH. So the general rule is "We don't do consults on patients we didn't admit."

Q: Are there exceptions to this rule?

A: Yes. If a patient *very* familiar to our current team (e.g. senior resident is PCP and patient can be difficult to manage) is admitted to a surgical service it may be better for patient care to have our team follow as a consult service. This is up to our attending's discretion.

Q: If we are following a patient as the consult team does that patient count towards our cap?

A: Usually not. So if the service is particularly busy it is often best to transfer medical consulting services to the Internal medicine consult hospitalist. They actually prefer this since it functionally opens up space on our service to take more admissions. If for some reason the hospitalist consultant declines to take on the patient then I would consider the patient countable towards our cap if we are continuing to actively manage daily.

9. Discharges

Timing: Early discharges clear beds for incoming patients and allow for more free transfer to/from higher levels of care. They save money and can improve patient satisfaction. Work to meet patients' expectations of discharge times by completing discharge orders in as timely a fashion as possible. Always enter a confirmed discharge date/time in Epic as soon as this is known so that the Fam Med service and all of the other care disciplines know the discharge deadline.

Attending Role When attendings complete signing off on a discharge summary, they should put a brief addendum designating the amount of time they spent with the patient for discharge (more or less than 30 minutes).

Discharge Summaries The senior residents and Amanda are responsible for ensuring that discharge summaries are completed in a timely fashion. Incomplete records data are monitored closely. Attendings and Department Chairs receive regular updates regarding which notes are incomplete. The best process is to start a discharge summary very early in the hospitalization, share it with the team, and update it throughout the stay. Doing this makes completing the discharge summary much easier on the day of discharge.

Following Up Results The UW Team should assure there will be follow up on all pending test results at a patient's discharge. There is a section of the discharge summary which facilitates transferring responsibility for pending test results to the PCP. If new labs are indicated at discharge, you may "recommend" these to the PCP in the discharge navigator so that they may be followed up by the PCP and not the inpatient team.

10. Capping the Service

Since August 1, 2014 we have had a cap of 16 patients. Starting August 2015 we modified this to cap at 14 during the day (7:00am-6:00pm) and 16 at night. Additional adult patients who normally would be admitted to our service will instead go to one of the Hospitalist services - or a General Medicine service as assigned by the triage hospitalist. When our census falls to below 14 (below 16 at night) we will again be admitting to our service. A new evolution of the cap is to add "Surge" status which extends the cap by 1 patient to help out occasionally overloaded Hospitalist services. There are some important details about how this cap will work. We anticipate these questions:

1) **How do we determine the current census of the FM service?**
    a. The official list is in HealthLink EPIC under "Patient Lists" > "All Services" > "Family Practice". When the number of patients on that list is 14 (16 at night) or greater, we are capped.
2) **How about patients accepted for admission who are not yet on that list?**
    a. Any patients we are currently seeing in the ER (likely admits) or who are direct admits from clinic should be added to the official list to determine if we are capped. E.g. if the list says 12 but we have accepted an additional patient as direct admit from clinic plus one likely admit we are seeing in the ER then our census is now 14 (unless ER patient not admitted) and we are capped until 6pm for any additional admissions.
3) **How about children?**
    a. At this point we are NOT capping for pediatric admissions to the service. Night (6pm-7am) example: We could be at 16 patients and admit 1-2 children (thus census now 18) and wouldn't "uncap" until the total census dropped to 15. We DO sometimes ask our Pediatric hospitalist colleagues to take a patient but that generally is not for high-census reasons. The determination of which service (FM vs Peds) takes an admission is an attending-attending conversation.
4) **What do I do when the ER calls but we are capped?**
    a. The ER may call us even if the EPIC census list is 14 (16 at night) because they don't understand the cap or do not know that we have already accepted admissions not yet on the list. If you think we are capped please tell the ER to call the triage hospitalist. If it is not obvious that we are capped (e.g. EPIC census <14) you should consider first paging the triage hospitalist and explaining why you think we are capped. The ER physician could also pass along this message.
5) **How about patients who have discharge orders but have not yet left the hospital?**
    a. The list is the list. Until a patient disappears from the HealthLink patient list they are considered on the service and count towards the cap.
6) **How about patients transferred from the TLC or IMC to our service?**
    a. If a patient was originally admitted to our service then, during that same hospitalization, was transferred to the TLC or IMC, and now is stable for transfer back to the general care floor, the patient can be transferred back to our service even if we are now capped.

b. If the patient was originally admitted to the TLC or IMC (not Family Medicine), then the patient will go to the hospitalist service if we are capped and that patient is stable for general care.

7) How about readmissions?

a. We have many patients who are chronically unstable and despite UW Health's best efforts are frequently admitted. In general these are treated like a regular admission and, if we are capped, the patient goes to the hospitalists.

b. The exception is when this is a clear "bounceback" – e.g. the patient is discharged in the morning and returns to the ER that same evening for the same problem. If a patient is being readmitted while the **same attending** is still on service, then we will readmit that patient despite the cap. This is the same rule that the hospitalists follow.

8) Are there other exceptions to the cap?

a. We are trying to make this simple and avoid arguments at 3 in the morning… However exceptions are possible at the discretion of the attending on the service or our on call attending. These exceptions are:

i. Children - as discussed above. Generally no cap.

ii. IMC/TLC transfers back - as discussed above. Clear guidelines.

iii. "Bounceback" admissions to same attending as described above.

iv. Specific patients well known to the service and/or one of the team who may be admitted entirely at the discretion of the current service attending. Example: A patient well known to the service is in clinic and the PCP calls the service attending and presents a case for why this particular patient would benefit from admission specifically to the FM service even if the service is capped. Another example: A patient whose PCP is one of the current FM service team who is very well known to that physician and the PCP advocates for admission to the FM service above the cap. We expect that these sorts of requests will be uncommon.

v. If the triage hospitalist wants us to take a 15th or 16th admission before 6pm we are willing to consider this and it should be discussed with the FM attending. Actually taking an admission over 14 during the day is often easier for us since we also have more resident and onsite attending coverage then.

9) Should we communicate regularly with the triage hospitalist?

a. Establishing a clear daytime cap of 14 should eliminate a need to constantly be in contact with the triage hospitalists when we are near cap. However, communication is never a bad thing. The triage hospitalist can be contacted through paging at all times: "Hospitalist triage & Access 24/7," or by calling the page operator at 262-2122 and asking to page the triage hospitalist.

10) What is "surge" status?

a. Sometimes when the Hospitalist services are very full, the Hospitalists will declare "Surge" status. Surge status applies when the combined census of the 5 hospitalist services exceeds 80 patients, or if their census exceeds 70 patients and there are <3 Hospitalist NP/PAs working that day. When the hospital is in surge status, our cap will be extended by one patient, so daytime cap will be 15 (instead of 14) and evening cap will be 17 (instead of 16). The hospitalists will call/page in the morning if we are in surge status. If you wonder whether we are surging, then page the Triage Hospitalist.

11) What if there are problems or disagreements about how this cap works?

a. The process we have set up is nearly identical to the process used in capping the General Medicine services, so we hope that there will be few misunderstandings about how this works. If unforeseen issues arise, please feel free to call Nicole Bonk, FM Service Director, during normal waking hours to discuss. In general, please try to work out disputes directly keeping the goals of good patient care, collegiality, patient satisfaction and fairness in mind.

11. HealthLink (Epic) and other Computer/IT Resources

IT Help Desks

For all IT issues, you may electronically file a ticket for service by going to UConnect > Quick Link > Service Now > Something Broken. Patient critical issues are handled quickly this way.
If you prefer to call: For UW Intranet issues call 265-7777
For HealthLink/Epic related concerns, call 829-5474.

Order Sets There many very helpful order sets for common diagnoses. Residents should use the General Care or Pediatric Admission ones for every admission. **NOTE: Use the CHF and Pneumonia order sets whenever possible.** These are written to ensure that various quality indicators are accounted for during an admission; these indicators are used to rate performance for the hospital overall. An example would be that all pneumonia patients should have blood cultures and verification of Pneumovax status.

- **General Care – Medical Admission – Adult**
- **Pediatric – General Care – Admission**
- Alcohol Withdrawal
- Asthma Exacerbation
- Blood Transfusion
- Bowel Management
- COPD Exacerbation
- Cirrhosis - Admission
- Diabetic Ketoacidosis
- Diabetes Management without pump (Sliding scale insulin orders)
- GI Bleed
- Heart Failure
- Pneumonia – CAP or HCAP
- Tobacco Abstinence
- IV Patient Controlled Analgesia (PCA)
- Venous Access Team – PICC Placement

Useful discharge order sets are:

- IP – General Adult
- IP – Skilled Nursing Facility (SNF) Adult
- IP – General Pediatric

12. Quality Issues

Patient Relations Patient Relations **(263-8009)** can be called whenever a challenge arises with a patient's care. Examples:

- Patients expressing high dissatisfaction with their care
- Family/friends of patients in conflict with the healthcare team
- NOTE: The ethics committee and Spiritual Care Services are also worth considering in extreme situations.

Legal Services If a legal issue could potentially arise, attendings can contact Legal Services at 261-0025 to discuss the case with the on-call hospital lawyer.

Patient Satisfaction Patients are sent satisfaction surveys 2 weeks after their hospital stay. Patient satisfaction is a priority to the UW Family Medicine Inpatient Team. This data is regularly released to Department Chairs, Service Directors, and hospital administrators.

Peer Review Each month, quality analysts provide the service director with a list of patients who died, were transferred to the TLC, or who returned to the hospital within 30 days of discharge. Information on complaints to Patient Relations is also provided. ***Please contact the Service Director, Nicole Bonk, ASAP if you have a patient with an unexpected outcome or complication.***

Patient Safety Net (PSN) If you note a patient safety issue, you can bring attention to it by filing a PSN. To do so, Search UConnect for "PSN", click the link, and enter details of the event/issue. Review of a PSN allows for nursing, hospital administration, and the Family Medicine service director to address the issue and work to prevent its recurrence.