

**LBVA Internal Medicine  
General Orientation 2017 - 2018  
Updated 05/20/2018**

- **Conference Attendance**
  - SHOW UP & ON TIME! Conferences will start ON TIME and end ON TIME.
  - You will be held accountable by us and at semi-annuals for being on time and not missing conferences.
  - 60% mandatory conference attendance
  - **100% mandatory** conference attendance for senior residents on wards at **Chief Rounds**.  
**UNLESS YOU MUST, DO NOT TAKE THIS DAY OFF.**
  - **You will be contacted if you do not attend.**
  - Grabbing lunch & leaving does not equal attending conference, so please do not sign in, but you are always welcome to get food at those times.
  - For conference presenters, **10 minutes before presentation is on time**. Anything after that is late.
  
- **Evaluations**
  - Intern/Resident/Attending Evals: Submitted under new innovations
  
- **Call Rooms**
  - MICU Intern: 3<sup>rd</sup> floor room 352
  - 10<sup>th</sup> floor, rooms 1019 & 1052. Contact Chief Resident for door code.
  
- **Resident Lounges**
  - 8<sup>th</sup> floor, used to be team 4 room. Code is 1-2-3-4-5-6 (try to remember that)
    - There is a coffee pot, if you use it make sure that you prepare it for the following morning
    - If you see other people in there please let us know
    - Please aim to keep it clean
  
- **Days Off**
  - 3 days off per 3 week block/21 day period for every team member
  - Senior residents cannot take the first or last day off
  - Interns cannot take off on No Call Days in which the senior plans to take off
  - Seniors on wards should let Chief Resident know if they are going to be off on a day with Chief Rounds. They should avoid this if possible.
  
- **Hours**
  - ICU Team: 7am-7pm.
    - Morning and evening sign out both take place in the MICU team room.
  - Ward Teams: 6:30am-5pm on non-admitting days, 6:30am-6pm (for admitting team that is non long/middle team), 6:30am-7pm on admitting days (for middle & long call team)
    - All teams pick up at sign out at 6:30 AM in the Resident Lounge.
    - No Call & one of the admitting teams ("left most on call schedule) signs out to middle call team at 5PM/6PM, respectively. Cross cover pager is picked up in the morning by the middle call team and rapid/code pager is picked up by long call team.
    - Evening sign out for 2 of the admitting teams (middle/long call) is at 7PM in the Hospitalists work room (4<sup>th</sup> floor):
      - There will be 2 separate wards nocturnists who will cross cover and admit.
  - Weekdays
    - Pick up Sign Out in Resident Lounge at 6:30AM
    - No call 5pm → Sign out to middle call team
    - Short call stops admitting at 6pm, 1 team (left) signs out at 6PM to middle call, Middle/Long call sign out (all of the teams) to Nocturnist at 7pm
    - Long call stops admitting at 7pm, sign out to Nocturnist at 7pm (max 2 after 6)
      - If you reach that cap tell the ED that they will have to hold admission till the nocturnists come at 7
    - Regular (Middle) will carry the cross cover pager
    - Nocturnist shifts 7p-7am
    - Admissions will be allotted by the ED clerks 24/7 and will be on the Admission Board spreadsheet which each resident will have access to

- Weekends/Holidays
  - **After 12pm**
    - Two teams will sign out (both diamond and no call team) to the middle call team. The long call team will hold the rapid/code pager
    - First team on call (“diamond” team) takes a max of four overnight patients and does not admit for the rest of the day and may sign out to the Middle Call Team whenever their work is complete (after 12pm). The only exception to this rule is when Team 4 is the “diamond” team, they will only take Cardiology admissions overnight.
    - There is no late call on weekends. Sign out it still at 7PM for both remaining teams.
    - Teams will stop admitting at 6pm, any admissions after that the ED will have to page the nocturnists at 7pm for sign out
    - Admissions will be allotted by the ED clerks 24/7 and will be on the Admission Board spreadsheet which each resident will have access to
- **ED Admission Board-** All admissions will be allotted by the ED Clerks 24/7. There is NO LONGER an admission book.
  - If you receive any ICU/CCU Transfers or Direct admissions, please notify the ED Clerks about these admissions in order to receive credit, as well as so that it can be tracked on the admission board.
  - There is NO LONGER an admission book. Your chief residents will ensure that you have access to the admission board. If you do not have access, please request from your chief residents and an invite will be sent to your VA outlook.
- **Capping**
  - Team Cap: Teaching- 16 (Hard cap is 18), Non-Teaching- 11 (Hard cap is 13)
  - Must notify Attending when the team is capped and Attending must notify Dr. Rucker/Dr. Tanavoli.
  - Maximum number of overnight admissions is 5. If all teams are capped and only one is open for admissions, then that team will admit a maximum of 5 (or until it reaches soft cap). Following this, all teaching and non-teaching teams will admit in the drip till hard cap.
  - Patients that have a discharge order place and are awaiting a ride DO NOT COUNT towards the cap

#### Team 4 Cardiology Team Rules & Criteria

##### General Rules:

- Team comprised of: Attending, Fellow, Senior, 2 interns
- Admitting 6 days a week: No new ER admissions on No Call days.
  - OK to admit post-procedure patients on No Call days.
- Team cap 16 (Hard cap 18)
- Max overnight admissions: 5
- Intern Cap is 8 patients. Senior or Fellow to manage patients when interns reach cap.
- Admissions per Cardiology Admission Criteria. If unclear, needs to be discussed with cardiology fellow or chief resident.

##### Admissions:

- **In drip system with Teams 1-4 on admitting days, with preference to Cardiology admissions\***
  - **Cardiology admissions:**
    - All ER admissions meeting Cardiology admissions criteria should be admitted to team 4 on admitting days (not No Call)
    - ER admitting physician should notify the ER clerk of a cardiology admission. ER clerk should record the admission in the next team 4 slot on the admissions sheet and they will receive credit.
  - **Non Cardiology admissions:**
    - Team 4 will be “passed” on the first cycle of general medicine admissions daily but will enter the drip system thereafter.
    - After the first cycle of admissions, and if there are no pending Cardiology patients in the ER, Team 4 can take a general medicine admission if they are the next available team on the drip.
  - If resident receiving signout from ED believes patient has been mis-triaged, that resident should:
    - (a) Inform the ED to expect a call back within 20 minutes from the accepting physician
    - (b) Discuss disposition with senior resident and/or Cardiology fellow
    - (c) If it is unclear based on the admissions criteria, page the Chief Resident on call (p6666) for further clarification.
    - (d) The accepting team should then contact ED for full signout and assume patient care.

- (e) Let the clerk know of the final team assignment to receive credit.
- If a patient is admitted to Teams 1-3 & 5-6, but after further evaluation is felt to be best suited on the Cardiology service, *you must discuss this with the Cardiology fellow who will approve or deny inter-team transfer.*
  - There is no transfer of medicine patients out of Team 4 to the other teams or “trades”.
- **Overnight:** Team 4 gets Cardiology patients only. After morning signout at 6:30 am, there will be no reassignments.

### Weekdays

- No Call Day
  - Can take overnight cardiology admissions
  - No new day time admissions, unless post-procedure
  - Senior can be off
  - Interns cannot take off if senior off
- Short Call Days – Admit until 6pm
- Long Call Day – Admit until 7pm
  - 2 admits between 6-7pm can include NON cardiology patients

### Weekends

- No/Short Call Days
  - Can take overnight cardiology admissions only
  - No new day time admissions
  - If short take the first 4 admissions, regardless
  - Senior can be off
  - Interns cannot take off
- Regular/Long Call Days
  - Admit until 6pm, according to modified drip.
  - Preference is given to cardiology patients; however, will need to admit a non-cardiology patient for every patient admitted by the other medicine team.

### CCU

- CCU patients in the ICU: Cardiology team is primary. A MICU intern will round on the patients with the cardiology attending and fellow in the afternoon.
  - This MICU intern will also round with the MICU team in the morning.

## Admission Criteria to Cardiology Team

### Heart Failure

- A. **All New** onset heart failure should be admitted to Cardiology team **except:**
  - a. Initial ED workup reveals other causes of central volume overload or peripheral edema (such as acute kidney injury, cirrhosis, lymphedema, pulmonary embolism/DVT, etc)
- B. **Acute decompensated** chronic heart failure:
  - a. NYHA III-IV
  - b. BNP > 400 without other cause (such as CKD, sepsis, COPD, pulmonary embolism)
  - c. Dialysis patients are excluded
  - d. Initial ED workup excluded other causes of central volume overload or peripheral edema (such as acute kidney injury, cirrhosis, lymphedema, pulmonary embolism/DVT, etc)
- C. **Heart failure NP team** should be contacted for chronic stable heart failure or ADHF patients who overflow to other services

### Chest Pain

- A. High-intermediate to high cardiac risk
  - a. HEART score > 3\*
- B. Typical cardiac chest discomfort
- C. Patients with prior myocardial infarction
- D. Patients with prior coronary artery bypass graft (CABG) or percutaneous intervention (PCI)

### Acute Coronary Syndrome

- A. All ACS patients should be admitted to Cardiology team (tele/DOU/CCU level of care to be determined by cardiology fellow and attending)

**Arrhythmia**

- A. All ventricular tachycardia or fibrillation, or unknown tachycardias  
 B. Any atrial fibrillation with rapid ventricular rate and atrial flutter, unless known acute medical or surgical triggers (infection, COPD, substance induced, active GI bleed)  
 C. Significant abnormal cardiac device interrogation in ED

**\*HEART Score**

|                      | Criteria  | Score |
|----------------------|---|-------|
| <b>H</b> istory      | Highly suspicious                               | 2     |
|                      | Moderately suspicious                           | 1     |
|                      | Slightly suspicious                             | 0     |
| <b>E</b> CG          | Significant ST depression                       | 2     |
|                      | Nonspecific repolarization disturbance          | 1     |
|                      | Normal  | 0     |
| <b>A</b> ge          | ≥ 65  | 2     |
|                      | 45 – 65   | 1     |
|                      | < 45  | 0     |
| <b>R</b> isk factors | ≥ 3 risk factors or h/o atherosclerotic disease | 2     |
|                      | 1 or 2 risk factors                             | 1     |
|                      | No known risk factors                           | 0     |
| <b>T</b> roponin     | > 2x normal limit                               | 2     |
|                      | 1-2x normal limit                               | 1     |
|                      | ≤ normal limit                                  | 0     |

For patients NOT on Team 4 that require a Cardiology Consult:

Chest Pain/ ACS

- Please do not write “ r/o ACS” in your assessment/plan. Instead, if you think the patient may be having acute coronary syndrome, write “chest pain” or “probable CAD” or “symptomatic CAD” for example.
- All troponin results >0.04 have to be commented on by the cardiology fellow or attending.
  - HIGH SUSPICION FOR ACS: (e.g. typical,CP, dynamic /or new ,EKG changes etc)should be admitted to cardiology.
    - ASA must be given immediately
    - Beta blocker must be given within 24 hours, (indicated in Ant, anterolateral MI, in the absence of hypotension
    - If there is any contraindication to either of the above medications it should be stated in your progress note or in a separate noted titled “Medicine Contraindication.”
    - Consider heparin (either UFH or LMWH) in appropriate doses
    - Follow the protocol of ACS in CPRS.
  - Intermediate Suspiciion for ACS: typical chest pain with risk factors, or hx of heart disease, no EKG changes , or cardiac marker, place a consult in CPRS for Cardiology AND call the fellow personally to tell them about the patient.
  - LOW SUSPICION FOR ACS: (e.g. no symptoms or EKG changes BUT minimal troponin elevation (0.041-0.5 for example , “Trop Note”
    - DURING THE DAY: call the cardiology fellow to notify them of the elevated troponin
    - AT NIGHT: signout to the primary team that they must call the cardiology fellow early in the morning to notify him/her

CHF Patients: Heart failure NP team should be contacted for chronic stable heart failure or ADHF patients who overflow to other services

How do I get my ECHO done?  
(From the echo techs' perspective)

Do not d/c echo consults. If this is done and they have performed the echo it stops it from transferring and we have to do it over. You should just add a comment to the consult to discontinue. Echo techs leave a comment on the echo consult for all in patients stating echo has been done.

STAT is ONLY if you have talked to cards and it is a life threatening situation. There is only one on weekends and can only be called in by cards.

All requests for left ventricular function on inpts must have an ekg, chest xray, bnp and troponin as required by cards. If these are not done the consult will automatically be cancelled.

All requests for r/o endocarditis must have persistently positive blood cultures, fevers/chills, and murmur.

It is not necessary to call ECHO about pts. They receive the consult and triage. They almost always do the echo on the same day unless it is on hold for approval. Please read the comments on the consult. This will let you know if it is on hold for approval or if the echo has been done.

- **Computer access troubleshooting**
  - **Must have PIV ID (the VA badge with the security chip)**
  - If you can order labs but you are unable to order pharmacy (meds/IV), this is a problem with outpatient pharmacy (missing forms, NPI number, etc). Call outpatient pharmacy; the temporary contact at the pharmacy now is Ivy at VA extension x3073
- **Consents for procedures and transfusions**
  - Must be completed in CPRS in iMed Consent (instructions below)
  - Do NOT use paper consents
  - MUST HAVE NURSE DO TIME OUT BEFORE PROCEDURE
- **Code Blue Pager**
  - Carried by ICU team
  - Carried by long call team senior until 7PM, at which point the wards nocturnist will take the pager.
  - Do not leave hospital if you carry code blue pager, until you verify the ICU fellow will remain in hospital with the clone pager
  - Every response requires a rapid response/Code Blue note
- **Bed management**
  - Case managers and charge nurses manage this, you only intervene if you choose to or if emergent
  - Bed Coordinator x2577, cell 562-522-3320, pager 562-683-1580. Operates 24/7 to assign beds (ALL admits and any bed location change in the hospital). (Refer to Clinic Admission Flowsheet on page 12.)
    - If patient requires ICU level of care and there is no ICU bed, patient needs to be transferred to MICU team and boarded in the ED under MICU care (however ED physician will not see patient).
    - If needs emergent care that is best handled by ED physician (ie acute STEMI, acute CVA), then take patient to ED to be evaluated by ED physician (not boarded)
    - View ED patient board on EDIS: click VALBHS Resources on desktop, login with CPRS password to VA Long Beach
- **DMS Rounds (Daily Management Rounds)**
  - Begin promptly at 8:20AM and ALL senior residents are expected to attend DMS rounds (unless your attending has specifically stated that they will attend the rounds and represent the team)
  - Please come prepared to discuss if any issues are occurring with utilization management, consultative services, patient care, mobility, or throughput in the hospital. This is your opportunity to deliver feedback and be involved directly with quality/process improvement.
- **Observation Status:**
  - Observation status is good for a 47 hour admission.
  - On admission if you disagree with the admission order, then delete the admission order that states observation status and create new admit orders as inpatient.

- If a patient is admitted under observation status and will stay longer than 47 hours, you must enter a discharge order, and then enter new delayed admission orders “Admit to Medicine” and tell the floor secretary to activate the new delayed orders
- If definitely discharged in 47 hours, you can write an observation admission NOTE and discharge NOTE. However, if stays past 47 hours you must write a discharge SUMMARY. When in doubt, always just do a full H&P and DC Summary
- **MICU/CCU Transfers:**
  - Admissions to medicine ward team occur at the time of receiving the verbal sign-out AND when the patient physically transfers to the medicine floor. The process for transferring the patient from ICU/CCU is detailed below.
  - If the patient is physically in the ICU, they will always be under the care of the ICU (even if a team assignment has been given and a verbal signout between the teams has occurred).
  - If a patient does not leave the MICU by 5:00 PM, the MICU team will care for the patient regardless of their location (MICU, DOU, or ward floors)
  - For the MICU intern responsible for transferring the patient to the ward service, please follow the steps below in order to ensure a safe transition:
    - Inform charge nurse that patient is to be transferred to telemetry or med-surg level of care
    - Once bed is available, charge nurse will notify the MICU team
    - MICU team will call the emergency department for a team assignment (prior to 5:00pm) and sign out the patient to the ward team verbally as well as place a transfer note.
    - Once patient is physically on the wards (prior to 5pm), then the medicine team will assume care for the patient. If the physical transfer occurs after 5:00pm, then the MICU team will assume responsibility of the patient for the night. However, the medicine ward team will be responsible for providing a FYI to the nocturnist about the patient (but not an official sign-out as the patient will be under the care of MICU overnight)
    - The following day once the patient has physically transferred out of the ICU, the ward teams will be responsible for the patient starting 6:30am.
- **Medical Records**
  - Write “I am providing care under supervision of attending Dr. \_\_\_\_\_ who agrees with assessment and plan” on all notes.
  - EVERY patient needs a LST order entered along with note (if they are anything but FULL CODE). Please see below for details in regards to placement of these orders/notes
  - **Must use CPRS templates for all H&Ps and Discharge summaries**
  - R1– Writes H&P note for all admissions, cosigned by attending. Writes daily progress notes for all patients. Write DC summary and DC instructions on day of discharge. Must cosign MS3 notes on a daily basis.
    - **MS3 note DOES NOT replace the R1 progress note.** A new note must be created by the PGY1
  - Sub –I (MICU students are not sub-I’s)
    - Cannot write official H&P but can write daily progress notes. H&P must be written by senior, cosigned by attending. Daily **progress notes written by Sub-I, cosigned by senior resident.** DC summaries written by senior.
  - MS 3– use “Medical Student” note ONLY.
  - Rapid response – For any rapid response the senior resident is required to write a note entitled : “RAPID <RAPID RESPONSE TEAM NOTE/MULTIUSE>”
  - Code Blue – Senior residents are required to write an interim progress note outlining the events during and leading up to the code. At the top of this note, please write CODE BLUE NOTE.
    - Also, the senior is required to fill out the hand-written ACLS log that will be provided by the nurse.
- **Discharges**
  - **Discharge by noon is an important goal for all patients**

This is facilitated by 4AM lab draw so you have results by rounds. In CPRS on left column select "Labs Other Groups" then click on "Discharge labs Immediate Collect 4AM"
  - **Do your med rec early so that it can be verified and placed on the instructions.** The VA team pharmacist is responsible for medication reconciliation for all patients at the time of discharge. When decision is made in regards to a patient being discharged, please move medications under the “Outpatient Medication” list that you would like to add/continue. Once the outpatient medication list is finalized, let your pharmacist know that they can provide their medication reconciliation list. Once they completely their list, this can be copied over to the discharge instructions which will be provided by the housestaff.
  - **Structured Interdisciplinary Rounds**

**What you should know about SIDR (Structured Interdisciplinary Rounds)**

-Utilization Mgmt is leading the process to organize these rounds. They wrote the action plan that got you large new whiteboards and social rounds in your team room first thing in the day(2014)

**-Advantage to residents is you guys identify what the SW, UM, RN, dietician, pharmacist, etc can do to HELP YOU senior will lead the discussion efficiently (< 15 minutes) and should act professional, be enthusiastic, and be engaged.**

(follow the grids on the whiteboard! It took 3 months for the SIDR team to agree on the grid)

-state patient's name (so everyone knows who you're talking about)

-state patient's location (DOU, S8) and state if they still require DOU services

-state medical diagnosis in 1-2 **words**. CHF. COPD. SOB requiring O2. Cellulitis.

-state expected discharge date, disposition to home/SNF, and transportation needs

-state what you need from the team to facilitate the discharge that may pose a delay

-prosthetics, home O2, MRI, specialty consultation, nursing/pharmacy/dietician education.

-then assign a non resident team member to take care of this (UM – get MRI tech in, SW-call family to see if they will pick up, Nurse-educate on wound care/wound vac

**-DO NOT SKIP Patients. You MUST use the Grids for Discharge Planning.**

- **You have case management/ Utilization management just for your team, use them to help you with non-medical issues** (follow-up appointments, coordination of care, transfers to other hospitals). It is the responsibility of the senior to **specifically delegate tasks to help for discharging**. Their role is to make hospitalizaion more efficient whereas the social worker is there to help find resources in the community or organize social resources for patients in need.
- DC summaries and Discharge instructions must be done on day of discharge
  - If Admit order states observation status AND discharged in 48 hours then can write a Discharge NOTE instead of SUMMARY.
  - Every patient must have a **Post Hospital Follow-Up**. See attached policy on PHFU.
  - Acute OR Chronic CHF needs to be addressed on dc instructions. Click "CHF is one of the patient's Discharge diagnosis" box in the discharge instructions & fill out all required info. Also, address CHF treatment in DC summary.
  - For new diagnoses, please enter them into CPRS under the Problem List tab.
  - After you finish the DC summary, Health Information has to verify the DC summary. After that, you will see a notification in your CPRS notification box that it is verified. You can call Freddie x5086 or Nelson x2312 M-F to expedite verification. After verification you need to edit the DC summary and SIGN IT.
- **Deaths:** Please notify VA Chiefs so you can fill out a M&M conference form. Better to fill it now than when you are not at the VA

## H&P and DISCHARGE SUMMARIES

**Your default for every admission can always be a full H&P and full Discharge Summary. These are ALWAYS the correct option.**

However, there are some shortcuts ONLY if the patient is authentically an observation patient AND discharged within 47 hours. **But if they are admitted as observation and then overstay the 47 hours, then you'll have some extra work to do.**

### ED admits as FULL Admit:

1. Admission Order: S10 – GENERAL MEDICINE
2. On admission you need the regular H&P Note
3. On discharge you need the full Discharge SUMMARY

### ED admits as Observation AND patient is discharged within 47 hours:

1. Admission order: S10 OBSV – MEDICAL OBSERVATION).
2. On admission you can use the regular H&P Note
3. On discharge you can use the \*Observation Discharge Note OR full Discharge SUMMARY

### **ALTERNATIVE OPTION**

1. Admission order: S10 OBSV – MEDICAL OBSERVATION).
2. On admission you can write the regular H&P note OR the Observation Admission Note (these two notes are not much different, just different titles. Just write the regular H&P so it's easier to search for in the future)
3. On discharge you can write an \*Observation Discharge Note instead of a Discharge Summary.

\*The advantage is that it is an Observation Discharge NOTE, therefore it does not need verification. Also it shows up in the NOTES section instead of Discharge Summaries section.

However, if you follow the alternative option, patient must have the correct admission order and discharged in 47 hours

**ED admits as Observation AND patient is discharged MORE than 47 hours later:**

1. Admission order: S10 OBSV – MEDICAL OBSERVATION).
2. On admission you can write the regular H&P note OR the Observation Admission Note (these two notes are not much different, just different titles. Just write the regular H&P so it's easier to search for in the future)
3. Patient stays longer than 47 hours, then you have to put in a delayed DISCHARGE ORDER and then a delayed ADMISSION ORDER: S10 – GENERAL MEDICINE
4. On discharge you MUST write a full Discharge Summary that is verified by Rachel Sanchez.

**Team 5/6 rules:**

This is in the process of change, so if a question arises, please ask for clarification.

- A. Team 5/6 are in the Admission drip system like the other Teams
- B. Team Cap: 11 active (not discharged) patients on service (does not matter how many “encounters” they had)
- C. Admitting till 5:00PM on weekdays, and 3:00PM on weekends/holidays. So, between those hours and 7pm only the teaching service admits patients.
- D. Hours in Hospital: 7AM – 7PM on weekdays, and 7AM – 5PM on Weekends
- E. Admissions/day cap:
  - a. Team 5 and 6 will admit to ward teams if all 3 admitting teams are capped at 16 patients
- F. Sign out:
  - a. Attendings will sign out to the nocturnist at 7PM.
  - b. If still in-house before 7PM, they must be available to field any questions from the nocturnists
- G. Bounce-back policy
  - a. If the patient was seen by the same attending in the previous 7 days, they should be admitted back to the same attending.
  - b. If the bouncebackTeam 5/6 is capped, the patient is staffed by the teaching service, and once the patient has been staffed by the taching attending, the patient must stay on the teaching service
  - c. Bounceback admissions through the ER can occur on any given day.
- H. Chief resident responsibility
  - a. Any concerns or uncertainty should be addressed with the chief residents.
  - b. The VA chiefs available from **8am-5pm** on weekdays. Please call the on-call chief at 714-506-6666 at all other times, including weekends and holidays.

**VA Internal Medicine Policy on Bounceback Admissions**

A “bounceback” is a patient who returns to the hospital or comes back to a lower level of care (MICU) during the **same time period that the senior resident who took care of him/her** is still on a ward service at the same site. This includes the situation in which the resident is at the same site for two consecutive months, even if the resident switches teams.

- If the senior resident of the primary team is present when a bounceback returns, **the patient must be admitted by the primary team until 4pm on weekdays and until 12pm on weekends. If it is after those hours, the patient can go to the bounceback team in the morning.**(This can happen even if it a non-admitting day)
- If the senior of the primary team is off for the day, or if it past the deadline, the on-call team must admit the patient & count it toward their cap. The following day, before rounds, the patient shall be transferred to the primary team only if the senior resident is present. The bounceback to to the receiving team does NOT count as an admission on the drip.
- If a bounceback patient is admitted by the backup or nightfloat senior, care of this patient must be assumed by the primary team the following day only if the senior resident is present.
- Bouncebacks can only be transferred to the primary team when the senior resident of that team is present. This includes admitting days, an nonadmitting days

If a patient is seen or accepted by a ward team on-call, that patient is immediately and irreversibly assigned to that ward team. If the patient becomes unstable and is transferred to the MICU/CCU prior to being staffed by the ward attending, the patient will return to the ward team that originally admitted him/her when s/he is ready to leave the MICU/CCU team.

Any concerns regarding this policy should be directed to the on-call chief resident at the site. The chief resident has the authority to make exceptions to this policy as s/he sees fit according to the circumstances.



## CODE STATUS - VA Life Sustaining Treatment (LST) CPRS Note

**Purpose:** To have a durable note and order and proactively discuss goals of care, particularly with high risk patients.

1. The LST orders and notes will replace the previous code orders and DNR notes.
2. LST orders will follow the patient regardless of inpatient/outpatient status unless changed by patient and physician.
3. **Full code patients will no longer have a full code order, but this should be noted in the H&P and progress note.**
4. Patients who want anything other than full code should have a LST note and order written within 24hrs of admission.

### WHEN TO DISCUSS GOALS AND LST DECISIONS AND COMPLETE CPRS LST PROGRESS NOTES/ORDERS

- Outpatient providers with high risk patients
- For patients admitted to the VA hospital who want to limit their goals of care or are “high risk”.

### How to Write LST Note and Orders

- Open new note from note tab.
- Type LIFE to get <LIFE-STATING TREATMENT>
  - Will open note and template which should be followed to complete note and orders
- Must determine if patient/surrogate has capacity #1
- Must state patient’s goals #5
- Must determine patient’s scope of treatment other than during cardiopulmonary arrest and during cardiopulmonary arrest
  - i.e. full code, DNR, or DNR with exception such as during a procedure or surgery
    - **These will write automatic orders that will appear in the orders tab.**
    - **You cannot write these orders in another way.**
    - **Full code will not show up as an order**
- Must identify who has given consent for this plan (i.e. patient/surrogate)

### WHO SHOULD HAVE LST NOTES/ORDERS

- **NOT MEANT FOR ALL PATIENTS**
- **FOR patients that wish to limit life-sustaining treatment** – CPR, mechanical ventilation, feeding tubes, ICU care, hospitalization, dialysis, etc.
- **FOR high risk patients** - you would not be surprised if the patient experienced a life-threatening event within the next 1-2 years.
- **NOT FOR** low risk patients who do not wish to limit life-sustaining treatment. **Document these discussion and full code status in an H&P or progress note.**

### LOOK FOR EXISTING LST NOTES AND ORDERS ON EACH HOSPITAL ADMISSION

- CPRS LST Notes and Orders are **DURABLE** (they do not discontinue or expire).
- CPRS LST Notes and Order **DO NOT need to be rewritten or reordered** after being completed once unless the patient changes their mind (see 3 below).
- Check for CPRS LST Notes in **POSTINGS** and CPRS LST Orders in the **ORDERS TAB**.
- Scroll all the way down to the end of the LST Note – changes to the plan may be documented in an addendum.

### VERBALLY REVIEW GOALS AND CPRS LST ORDERS WITH THE PATIENT ON ADMISSION OR UPON SIGNIFICANT CHANGE IN CLINICAL STATUS

- If the patient confirms accuracy of the CPRS LST Orders, document it in the H&P or progress note and **leave the CPRS LST Note/Orders unchanged.**
- If the patient's goals or LST decisions have changed, then rewrite or addend the existing CPRS LST Note and change the CPRS LST Orders.
  - Is there anything more you can share to help us respect her decisions?

#### **DNI ORDERS HAVE BEEN REPLACED WITH "NO MECHANICAL VENTILATION" ORDERS**

- Intubation is a vague term; it means different things to different people, and differs from mechanical ventilation.
- Airway management is included in the procedure of CPR but mechanical ventilation is not. Patients are not given the option of declining airway management during CPR because partial CPR has not proven to be effective.
- Patients may choose to limit non-invasive mechanical ventilation (e.g., CPAP or BIPAP) or invasive mechanical ventilation (e.g., via endotracheal or tracheostomy tube).
- Some patients may be willing to accept a time-limited trial, but not want mechanical ventilation long term. That can be specified in LST orders.

#### **Neurosurgery Consults** (Revised 6/1/17)

#### **NEUROSURGERY**

**Option 1: Consultation:** THE VA IS CURRENTLY WORKING ON HAVING NEUROSURGERY CONSULTS ON SITE – STAY TUNED  
During weekday hours, contact Dr. Dennis Malkasian, Neurosurgery attending. He does not do surgery anymore but he DOES do consults in person at LBVA and can give management advice and determine whether patient needs emergent transfer to West LA VA neurosurgical service

Contact info: pager 562 683-1384, phone x4419, [dennis.malkasian@va.gov](mailto:dennis.malkasian@va.gov)

#### **Option 2: Need Emergent Neurosurgical intervention or phone consultation for management**

To contact the Neurosurgeon on call at West LA:

Ask the AOD for contact information (they usually have the UCLA 5 digit pager number.)

**OR**

Go here: <http://vawww.portal.gla.med.va.gov/sites/OCC/default.aspx>

Go to Neurosurgery and find junior or senior neurosurgeon on call and their pager number.

**THEN**

Go to UCLA paging system: <http://www.mednet.ucla.edu/>

Click on "paging" and type in pager number, then fill in information.

IF you see a 4 digit, West LA VA pager number, then dial: 310-268-3461, pager: xxxx

Of note, there is outpatient NSG services available at the VA. Dr. Golshani and Dr. Hsu are seeing only non-urgent patients

#### **01Transferring from LBVA inpatient to WLAVA or another hospital** (Revised 11/22/13)

#### **First , try to transfer to West LA VA**

1. Call AOD to find an accepting physician at the West LA VA. For example, if you need to transfer to neurosurgery they will give you the pager for WLAVA Neurosurgery. You can find an accepting physician in any specialty, including emergency room physicians
2. Talk to the accepting physician
3. Once accepted, talk to the AOD about entering travel consult in CPRS and arranging for a BLS or ACLS ambulance to transfer from inpatient floor to inpatient floor. This is the AOD's job, they cannot refuse.
4. If neurosurgery turns down a case, and an attending physician here feels that the patient should go to GLA, please call the admitting hospitalist at Greater LA VA at 310-403-0739. Dr. Dean Norman the Chief of Staff at GLA VA has notified them of his philosophy that high risk patients are best monitored at a place where neurosurgery is readily available in case the patient deteriorates.
5. If West LA refuses, then you have to get approval from the chief medical officer on call to transfer to a private hospital (LBMH, UCI, etc)

- a. Ask AOD to page the chief medical officer on call. If you are not comfortable talking to him, ask the attending physician or noctensivist to make that phone call
- b. Once you have approval from the chief medical officer and this is communicated to the AOD, then ask AOD for the phone number of the accepting physician.
  - i. Accepting physicians can be any relevant specialty, even an emergency department physician
  - ii. If AOD does not know number, you can google the phone numbers and find an appropriate one yourself
6. Once you have an accepting physician then, talk to the AOD about entering travel consult and arranging for a BLS or ACLS ambulance to transfer from inpatient floor to inpatient floor
  - a. This is the AOD's job, if they refuse then document this with their name.
7. Only in absolutely critical and emergent situations when the patient's condition is rapidly and emergently deteriorating to the point where you need EMS paramedics and get an ICU level of care, can you discuss with the ED physician sending patient to ED to call 911. If you are in this situation, you should involve the ward attending, noctensivist, and the chief medical officer.
8. Throughout this process, please keep the inpatient attending on service notified of the events

### **PALLIATIVE CARE CONSULTATION (revised 1/15/18)**

Here are [the official consult request](#) for hospice care and palliative care and only use these consult request, please!

#### **All these consult are under Geriatric consult section.**

For Hospice Care

Hospice in-patient consult (use when the patient is admitted at this facility)

Hospice out-patient consult (use when the patient needs assessment for hospice appropriateness or wants to know what hospice care is and be seen in out-pt clinic in OP 132)

Hospice E-consult (only for provider to provider discussion)

For Palliative care

Palliative in-patient consult (use for symptoms management, goals of care discussion, etc. , while patient is admitted to this facility)

Palliative out-patient consult (for symptoms management , goals of care discussion, etc., and will be seen in the clinic in OP 132)

Palliative E-consult (only for provider to provider discussion)

**\*\*\*Please do not place "Hospice/Palliative Consult" (the old version). This is not the official consult and there will be no view alert for the hospice and palliative clinician so it will not be seen in a timely manner if you place the consult under this request.\*\*\***

#### **HOW TO ADD-ON LABS**

**Option 1:** Enter order on CPRS. Call lab with the order number (located to the right of the lab order on CPRS)

#### **Option 2:**

1) Click on the VALBHS VISTA (looks like a computer screen with a red book) icon on the desktop

2) Under "Select Physicians master menu Option:"

--> Enter 2 for "Laboratory Look-up for Physicians..."

(this option has ordering add-on labs to samples already in the lab)

3) Under "Select Laboratory Look-up for Physicians Option:"

--> Enter "ADD1" for "Add-On Lab Test (sample already in lab)

4) Under "Select Patient Name:"

--> Enter first letter of pt's last name followed by the last four

5) Under "Patient Location:"

--> enter

#### **HOW TO RETRACT A NOTE:**

1) Click VALBHS VISTA icon (the computer with a red book on the VA desktop)

2) Login if you haven't already

3) Type "mail" and press "enter"

3) Type "SML" to send message

4) Enter in the Subject, "retract note"

5) In the body of the requesting message, type:

"Note Title: \_\_\_ write exact name of the note you would like to retract \_\_\_

Pt Name: \_\_\_\_\_

When signed (date/time): \_\_\_\_\_

Reason for error: \_\_\_\_\_ "

- 6) After you complete entering the above info, press and hold "Num Lock" first and then quickly press the key "E" together at the same time to send the message
- 7) Type in "g.retract" to select the recipients that will retract your note
- 8) Press "Enter"  
--> the screen would show "send mail: your name//g.retract"
- 9) There would be 4 names shown (as below). Type in one of the last names and press "Enter".  
--> Di Somma, James A  
--> Ottem, Melissa  
--> Sanchez, Rachel  
--> Grace, Brian N.
- 10) The message should be sent when screen says "Message sent"... :D
- 11) Don't forget to type in an Addendum to the note that you would like to retract, so the computer people don't retract the wrong note or don't retract any note at all! Type in something like "Please retract this note."  
--> the Addendum confirms your requesting message sent through VISTA.

### HOW TO UN-SIGN/COSIGN A NOTE (So you can continue working on the note)

Hopefully, this won't happen often... But, if it's one of those H&P notes that need to correspond to the time of admission, call Freddie at extension x5086 (weekdays, 7AM to 4PM-ish).

#### How to Synchronize the SIGN-OUT NOTES:

- 1) Go to CPRS and sign-in
- 2) Click "Tools" (as you would when going to "Handoff Notes")
- 3) Yeah, click "Handoff Notes"
- 4) Click "File" (before you open any of your patients' Handoff Notes info!)
- 5) Click "Change Preference" and a small box with "Preferences" on the top row should pop up
- 6) Double click "MEDICAL HCG" (HCG means Health Care Group, which was originally set up for Internal Medicine residents about 1.5 yrs ago, per IT)
- 7) Click "Yes" to save this as your Default Preference.
- 8) You're all set and we should all have the **synchronized version of Handoff Notes** (2 separate columns for "Night Float To-Do" and "Team To-Do")

## VA WARDS – DISCHARGE PROCESS

### 1. FREQUENTLY NEEDED SERVICES

- a. **Durable Medical Equipment:** Consult inpatient Prosthetics for BP cuff, compression stockings, nebulizer machine
- b. **Wound Care, IV antibiotics, TPN, Hospice, SNF, and HBPC (HOME BASED PRIMARY CARE for discounted caretaker at home).** Discuss at Case Manager Rounds necessity and forms needed.
- c. **Consult Telehealth.** Nurse monitors home vitals/symptoms for CHF, HTN, DM, PTSD, COPD via telephone.

### 2. TRANSFER ALL MEDICATIONS TO OUTPATIENT

- a. Highlight Inpatient Medication(s) -> "Action" -> "Transfer to Outpatient." Give 30 day supply of medications, unless a pain med/antibiotic, etc.
- b. Delete any outpatient medication prescriptions that you want to discontinue.

\*\*All narcotics other than vicodin require a paper prescription provided by inpatient pharmacy.

\*\*Window = available in 30 minutes at outpatient pharmacy. Mail = arrives at home in 1 week.

### 3. DISCHARGE SUMMARY (Under DISCHARGE SUMMARIES TAB). This is for medical charting.

- a. You do NOT need to write a separate daily "INTERIM" note if you include the Vitals, Exam, Labs from the day of discharge on the bottom of the discharge summary note.
- b. List all applicable problems addressed while inpatient under "Diagnosis". (Acute medical issues, then list the chronic problems addressed).
- c. List all surgeries/operations/procedures (paracentesis, central lines, PICC lines, Blood transfusions, CT/MRI, Echo, Cardiac cath, etc.) with the date of procedure. (if applicable).
- d. Copy and abbreviate the HPI from your H&P onto the discharge summary .
- e. Write "Brief Hospital Course" – address by problems if possible (especially if the patient has had a complicated or prolonged inpatient stay). If it is a brief hospitalization, a short paragraph or two is acceptable.
- f. Make sure a correct "Active Outpatient Medications" list is inserted at end of discharge summary (can insert list from Shared Template ->Medications->Active Outpatient Medications and Supplies)

- g. Discharge Summaries are viewable only by author until verified (phone x5086). If others need access to it before then, then copy the discharge summary and paste it to bottom of Discharge Instructions (Refer to item #3 below)
- 4. DISCHARGE INSTRUCTIONS (Under NOTES TAB). This is for the patient to take home.**
- a. Specifically write out all medication changes. **Make sure to click CHF box for acute or chronic CHF.**
  - b. Make sure the list of medications is correct (Re-insert updated lists from the Shared Templates explained above).
  - c. **Go over the instructions with the patient IN PERSON.** The nurses/staff WILL NOT explain them to the patient.
  - d. List all contact info for family/friends under emergency contacts (if applicable) and also list the LBVA main number (562) 826-8000.
  - e. Give specific red flag symptoms to seek medical assistance: Writing “Chest pain” is not as useful as stating “Severe chest pain unrelieved by rest or nitroglycerin.”
- 5. SCHEDULE POST-HOSPITAL FOLLOW UP (PHFU) & SUBSPECIALTY CLINIC**
- a. There is no longer any indication to email any providers in order to make post hospital discharge follow-ups
  - b. Please enter in “**RTC Clinic**” orders on the left side of CPRS. Following this, a pop-up will appear which will require time-frame and which specific clinic that patient will follow-up with. If it is unclear which sub-specialty clinic, patient will f/u with, then the subspecialist can be contacted (ie. arrhythmia clinic). Please also include the reason for the clinic (ie. CKD for Renal f/u) as well as time frame.
  - c. Once all of the orders have been placed, please talk to the floor clerks in order to obtain a date/time for primary care follow-ups. Sub-specialty clinics typically cannot be made by the floor clerks, as their scheduling process is different.
  - d. When providing discharge instructions to patients, remind the patient that his first primary care visit will be a check-in with the PACT nurse (not a physician). The patient will be contacted by the PACT nurse before his or her visit. Subsequently, they will have appointment with clinician.
- 6. ORDER OUTPATIENT LABS / TESTS** (if needed) for the day before the next appointment. Select “Send Patient to Lab” which is on 2<sup>nd</sup> floor. **\*\*Order labs all together and sign only once for your orders, otherwise they will have different order numbers and may not all be collected by the lab technician. \*\***
- DISCHARGE ORDER:** Enter by 11:59AM if patient is legitimately ready to be discharged before noon

#### VA Policy on Post-Hospital Follow Up

1. All Patients should be scheduled for post hospital follow up using **secure email**  
**Send secure email:** VA Outlook email, click on New email -> Options ->Encrypt (If you don't have the encrypt icon, then click on Permissions icon ->Encrypt)  
**Receive secure email:** call IT x3606 to remote access your desktop to set this up. You need to use PIV card to read these emails.
2. Most patients are in a PACT teams. PACT teams have mail groups, when emailed, will go to all team members: provider, care manager, LVN, pharmacist, clerk, social worker. (Per Dr. Anthony Vo 7/1/13)  
 Email group addresses are by provider's name: **vhalonpact** and then **providers name@va.gov**.  
  - i. Option 1: For ex. [vhalon.pact.sandor@va.gov](mailto:vhalon.pact.sandor@va.gov) (Dr Sandor) ; [vhalon.pact.vo@va.gov](mailto:vhalon.pact.vo@va.gov) (Dr Vo)
  - ii. **Option 2:**  
 When you are on logged into a VA computer open Microsoft Outlook which is configured to your personal VA email address (keep clicking Next until it configures).  
 Click “To” and search “vhalon pact” until you find [Vhalon](#) Pact Sandor.
3. For all **unassigned** patients: please Place a consult in newly enrolled, unassigned in CPRs. This is only to be used for patients who are new to the VA and do not have a primary care. If the patient wants to change his provider please still email the PACT system and mention that patient will also like a new provider. Do not use the consult for provider change. If there is a very urgent need of PCP for unassigned patient and appointment is needed within the next 2-3 weeks then please also put attention to Dr. Anthony Vo to help assign the patient faster.
4. **If patient is followed by Mental Health.** If patient is followed by mental health : Please email VHALON MH PACT PC Team
5. Important rules to protect patients health information that you must follow:
  - i. Last four numbers of Social Security Number and first initial are okay alone but when you add other individually identifiable information or health information you cannot send the email without encryption

- ii. The best way to comply with rules is to send a very brief message without compromising patients health information. Please schedule PHF for A1234. Page me 714-506-XXXX for more info.

6. Please try to call Primary physician as a way of more thorough communication

**Here is a list of the pact team email addresses:**

- VHALON PACT Bastanmehr
- VHALON PACT Vu
- VHALON PACT Camia
- VHALON PACT Cordell
- VHALON PACT Smith
- VHALON PACT Gilman
- VHALON PACT Guru
- VHALON PACT Hopp
- VHALON PACT First
- VHALON PACT Iyer
- VHALON PACT Craig
- VHALON PACT J Lee (Dr. Jenny Lee)
- VHALON PACT Jenkins
- VHALON PACT Holman
- VHALON PACT Lamers-Bagabo
- VHALON PACT Aubry
- VHALON PACT Gunawardena
- VHALON PACT Loos-Hannifan
- VHALON PACT Merchant
- VHALON PACT Griffin
- VHALON PACT Myint
- VHALON PACT Ngo
- VHALON PACT Petrarca
- VHALON PACT Rick
- VHALON PACT S Lee (Dr. Se-Young Lee)
- VHALON PACT Said
- VHALON PACT Sandor
- VHALON PACT Salty
- VHALON PACT Desser
- VHALON PACT Tan
- VHALON PACT Kim
- VHALON PACT V Lee (Vanessa Lee, NP)
- VHALON PACT Varughese
- VHALON PACT Vo
- VHALON PACT Wen
- VHALON PACT Wishnow
- VHALON PACT Patel
- VHALON PACT Wallace
- VHALON PACT Pedregon

**VA Proper Documentation Codes/Billing**

Adequate documentation & coding define reimbursement and length of stay. The severity of illness for an individual patient is guided by 3 factors. The primary discharge diagnosis consists of and should include all 3 factors.

1. The primary diagnosis
2. Complications
3. Active co-morbid conditions

| <b>If the primary diagnosis is</b>                         | <b>Include</b>   |
|--|--|
| <b>Chest Pain<br/>ACS</b>                                  | DO NOT USE ACS<br>Use <ul style="list-style-type: none"> <li>• STEMI</li> <li>• Non-STEMI</li> <li>• Unstable Angina</li> <li>• Stable Angina</li> <li>• Non-cardiac with specifics if possible</li> </ul>   |
| <b>Altered Mental Status</b>                               | DO NOT USE ALTERED MENTAL STATUS<br>Document Acute Encephalopathy<br>Include the cause, if known   |
| <b>Anemia</b>  | Specify whether acute or chronic<br>Include the etiology and whether it is symptomatic<br>Include factors which exacerbate the symptoms such as CHF or COPD  |
| <b>Asthma<br/>COPD<br/>Dyspnea<br/>Respiratory Failure</b> | Include Acute or Chronic or both<br>Respiratory Failure: <ul style="list-style-type: none"> <li>• Hypoxic: pO2 &lt; 60 or Pulse O<sub>x</sub> &lt; 91</li> <li>• Hypercapnic: pCO<sub>2</sub> &gt; 50 or 10 above baseline or pH &lt; 7.35</li> </ul> Chronic Respiratory Failure on continuous O <sub>2</sub> |
| <b>Cancer</b>  | “Chemotherapy” provides the lowest level of reimbursement.<br>Include the specific type, complications and stage of cancer.<br>Include the reason for admission and any complications during treatment.<br>Include complications from treatment or disease such as sepsis or tumor lysis                       |

|  |  |
|--|--|
| <b>Chronic Kidney Disease CKD<br/>Renal Failure or Insufficiency</b> | <p>Acute Kidney Injury &amp; Cause: ATN, Hepatorenal, Prerenal, Obstruction, Medication.<br/>If Chronic, include the stage</p> <ul style="list-style-type: none"> <li>• 3 GFR 30 – 59</li> <li>• 4 GFR 15-29</li> <li>• 5 GFR&lt;15</li> <li>• End Stage - Dialysis</li> </ul>   |
| <b>Congestive Heart Failure</b>                                      | <p>Acute, Chronic or Acute on Chronic<br/>Systolic with Decrease EF or Diastolic with Preserved EF or Both<br/>Include EF and BNP</p>  |
| <b>Electrolyte or Acid Base<br/>Abnormality</b>                      | <p>Include exact type of abnormality, etiology and actual numbers for electrolytes, pH, and anion gap</p>  |
| <b>Malnutrition</b>  | <p>Include cause, severity (auto-populates), BMI, lymphocyte count, albumin</p>  |
| <b>Pneumonia</b>   | <p>Include respiratory failure if present<br/>Include cause: bacterial, viral fungal, aspiration with or without bacterial</p>   |
| <b>Pulmonary Embolism or DVT</b>                                     | <p>Document type positive test<br/>Include acute heart failure, hypotension, hypoxia, shock if present</p>   |
| <b>Sepsis</b>  | <p>Never use "Urosepsis" – Use Sepsis from the Urinary Track<br/>SIRS Criteria: HR &gt; 90, WBC &lt;4 or &gt;12, T &lt;36.1 or &gt; 38.3 RR &gt; 20, CO2 &lt;32<br/>Severe: Organ Failure, Acute Respiratory Failure, Delirium, Hypotension, Shock, Lactic Acid &gt;2.1<br/>Document organism and include co-morbidities</p> |

## Top Ten Diagnostic Tips to Capture Complexity/Severity of Illness

- ✚ Only physician, nurse practitioner, and physician assistant notes may be used for coding.
- ✚ Document as “probable” or “suspected” if diagnosis is uncertain.
- ✚ Document diagnoses or suspected diagnoses in the discharge summary if present at any point during hospitalization, even if resolved.

| Instead of Writing ...   | Document as ...  |       |          |     |          |          |       |          |        |       |          |           |     |             |          |  |
|--|--|-------|----------|-----|----------|----------|-------|----------|--------|-------|----------|-----------|-----|-------------|----------|--|
| <b>Pneumonia (by itself)</b>   | <ul style="list-style-type: none"> <li>✚ Also document whether <b>Acute Respiratory Failure</b> and or <b>Sepsis</b> is present.</li> <li>✚ Always identify cause: bacterial, viral, aspiration.</li> </ul>  |       |          |     |          |          |       |          |        |       |          |           |     |             |          |  |
| <b>CKD<br/>Renal Insufficiency<br/>Renal Failure<br/>(without specifying<br/>Acute or Chronic)</b> | <ul style="list-style-type: none"> <li>✚ <b>Acute Renal Failure</b> or <b>Acute Kidney Injury</b></li> <li>✚ Document the cause:               <ul style="list-style-type: none"> <li>○ <b>Acute Tubular Necrosis (ATN)</b></li> <li>○ <b>Hepatorenal Syndrome</b></li> <li>○ <b>Hypovolemia or dehydration</b></li> <li>○ <b>Medication/toxin induced</b></li> </ul> </li> <li>✚ If Chronic, indicate the stage of CKD:               <table border="1" style="margin: 10px auto;"> <thead> <tr> <th>Stage</th> <th>Severity</th> <th>GFR</th> </tr> </thead> <tbody> <tr> <td><b>3</b></td> <td>Moderate</td> <td>30-59</td> </tr> <tr> <td><b>4</b></td> <td>Severe</td> <td>15-29</td> </tr> <tr> <td><b>5</b></td> <td>End-stage</td> <td>&lt;15</td> </tr> <tr> <td><b>ESRD</b></td> <td>Dialysis</td> <td></td> </tr> </tbody> </table> </li> </ul>         | Stage | Severity | GFR | <b>3</b> | Moderate | 30-59 | <b>4</b> | Severe | 15-29 | <b>5</b> | End-stage | <15 | <b>ESRD</b> | Dialysis |  |
| Stage  | Severity   | GFR   |          |     |          |          |       |          |        |       |          |           |     |             |          |  |
| <b>3</b>   | Moderate   | 30-59 |          |     |          |          |       |          |        |       |          |           |     |             |          |  |
| <b>4</b>   | Severe   | 15-29 |          |     |          |          |       |          |        |       |          |           |     |             |          |  |
| <b>5</b>   | End-stage  | <15   |          |     |          |          |       |          |        |       |          |           |     |             |          |  |
| <b>ESRD</b>  | Dialysis   |       |          |     |          |          |       |          |        |       |          |           |     |             |          |  |
| <b>Bacteremia<br/>Urosepsis</b>  | <ul style="list-style-type: none"> <li>✚ <b>Sepsis or Suspected Sepsis if two or more are present:</b> <ul style="list-style-type: none"> <li>○ HR &gt;90</li> <li>○ WBC &lt;4 or &gt;12 or 10%bands</li> <li>○ T &lt;36.1 or &gt; 38.3</li> <li>○ RR &gt; 20 or PCO2 &lt;32mmhg</li> </ul> </li> <li>✚ <b>Severe Sepsis</b> if any of the following are present:               <ul style="list-style-type: none"> <li>○ Organ dysfunction (renal or liver injury)</li> <li>○ Acute respiratory failure</li> <li>○ Encephalopathy/delirium</li> <li>○ Hypotension</li> <li>○ Lactic acid &gt;2.1</li> </ul> </li> </ul> <p><b>All above organ dysfunctions should also be documented as separate problems.</b></p> <p><b>Remember to identify Acute or Acute on Chronic for organ dysfunctions.</b></p> <p><b>Always document organism cultured, if known.</b></p> |       |          |     |          |          |       |          |        |       |          |           |     |             |          |  |

- **Comorbid Condition (CC)** that can increase complexity.
- **Major Comorbid Condition (MCC)** that can significantly increase complexity.



| Instead of Writing ...   | Document as ...   |
|--|---|
| <b>Altered Mental Status</b><br><b>Delirium</b>  | <ul style="list-style-type: none"> <li>📌 <b>Acute Encephalopathy</b></li> <li>📌 Include cause (if known): hepatic, metabolic, hypertensive, septic, toxic, postoperative, sundowning (environmental)</li> </ul>   |
| <b>Chest Pain</b>  | <ul style="list-style-type: none"> <li>📌 <b>STEMI</b> <math>\searrow</math></li> <li>📌 <b>NSTEMI</b> <math>\swarrow</math> <b>If readmitted, document again if onset &lt; 4 weeks</b></li> <li>📌 Unstable angina</li> <li>📌 Or non-cardiac chest pain (include cause if known)</li> </ul> <p>Avoid "Acute Coronary Syndrome" as a <u>final</u> diagnosis.</p>   |
| <b>COPD</b><br><b>Asthma</b><br><b>Shortness of breath</b><br><b>Respiratory Failure</b><br><b>(without specifying Acute or Chronic)</b> | <p><b>COPD or asthma are acceptable, but also document as applicable:</b></p> <ul style="list-style-type: none"> <li>📌 <b>Acute or Acute on Chronic Respiratory Failure:</b> <ul style="list-style-type: none"> <li>• <b>Hypoxic</b> - pO<sub>2</sub> &lt; 60mmHg or pulse ox &lt; 91% or pO<sub>2</sub> &lt; 10mmHg from baseline</li> <li>• <b>Hypercapnic</b> - pCO<sub>2</sub> &gt; 50mmHg and pH &lt; 7.35 or pCO<sub>2</sub> &gt; 10mmHg above baseline</li> </ul> </li> <li>📌 <b>Chronic Respiratory Failure</b> on all oxygen-dependent patients</li> </ul> |
| <b>Electrolyte Abnormality</b><br><b>Acid/Base Imbalance</b>   | <p><b>Use specific abnormality:</b></p> <ul style="list-style-type: none"> <li>📌 <b>Hyponatremia, hypernatremia, etc.</b></li> <li>📌 <b>Acidosis</b> - lactic, metabolic, or respiratory</li> <li>📌 <b>Alkalosis</b> - metabolic or respiratory</li> <li>📌 <b>Mixed acidosis and alkalosis</b></li> </ul>   |
| <b>Heart Failure (HF)</b><br><b>CHF</b>  | <ul style="list-style-type: none"> <li>📌 <b>Acute, Chronic, or Acute on Chronic (same as <i>decompensated</i>) heart failure</b></li> <li>📌 <b>Must include diastolic, systolic, or combined</b> for complexity</li> </ul>  |
| <b>Malnutrition</b>  | <p><b>Document severity (nutrition assessment will auto-populate into D/C summary):</b></p> <ul style="list-style-type: none"> <li>📌 <b>Moderate</b> (second degree)</li> <li>📌 <b>Severe</b> (third degree)</li> </ul>   |

Direct Admissions from VA Attendings

**A. Referring physician is an Internal Medicine physician/specialist (Oncology, GI etc)**

1. Referring physician decides patient needs to be directly admitted (bypassing the ED)
2. Referring physician or their delegate needs to notify hospital a bed is needed for this admission.
  - Call Bedflow coordinator x2577, x5639, cell: 562-522-3322.
  - During non-business hours the NOD serves as the bedfloor coordinator x5639.

**If admission is for future date, the following steps 3-5 are done when patient physically in hospital to be admitted**

3. Referring physician or their delegate needs a Medicine team assignment
  - Patients get assigned a team when patient is in the hospital. If patient is at home, they will go on a pending admit list and only when they physically arrive in hospital will they be assigned a medicine team.
  - During business hours call the ED back desk clerk x3558 for team assignment
  - If between 5PM-7AM then page Medicine admit pager 683-1658 for team assignment
4. Once referring physician receives a team assignment from step 3, then they need to sign patient out to the the receiving physician. (Step 3 will provide contact information for team)
5. Patient needs a ID wrist band -tell patient to go to the ED front desk clerk to get ID wrist tag banding

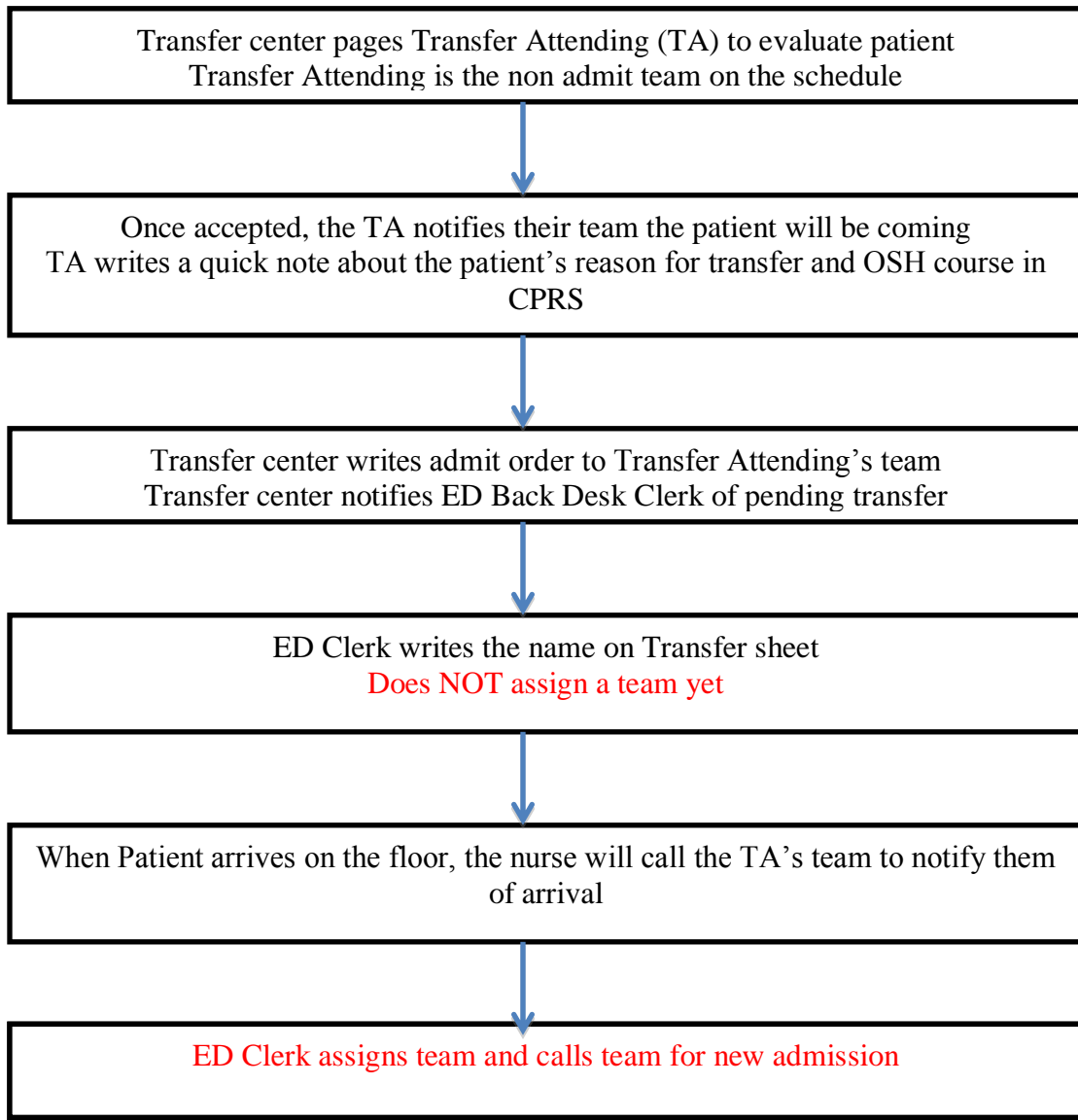
**B. Referring physician is not an Internal Medicine physician/specialist (Radiation Oncology, Surgery, etc)**

1. Referring physician decides patient needs to be directly admitted (bypassing the ED)
2. Referring physician needs Internal Medicine attending to agree Internal Medicine admission is needed  
-Call AOD to find out which Internal Medicine attending is accepting transfers
3. Once Step 2 is complete, referring physician or their delegate needs to notify hospital a bed is needed for this admission.  
-Call Bedfloor coordinator x2577, x5639, cell: 562-522-3322, pager 562-683-1580.  
-During non-business hours the NOD serves as the bedflow coordinator x5639.

**If admission is for future date, the following steps 4-6 are done when patient physically in hospital to be admitted**

4. Referring physician or their delegate needs a Medicine team assignment  
-Patients get assigned a team when patient is in the hospital. If patient is at home, they will go on a pending admit list and only when they physically arrive in hospital will they be assigned a medicine team.  
-During business hours call the ED back desk clerk x3558 for team assignment  
-If between 5PM-7AM then page Medicine admit pager 683-1658 for team assignment
5. Once referring physician receives a team assignment from step 4, then they need to sign patient out to the the receiving physician. (Step 3 will provide contact information for team)
6. Patient needs a ID wrist band -tell patient to go to the ED front desk clerk to get ID wrist tag banding

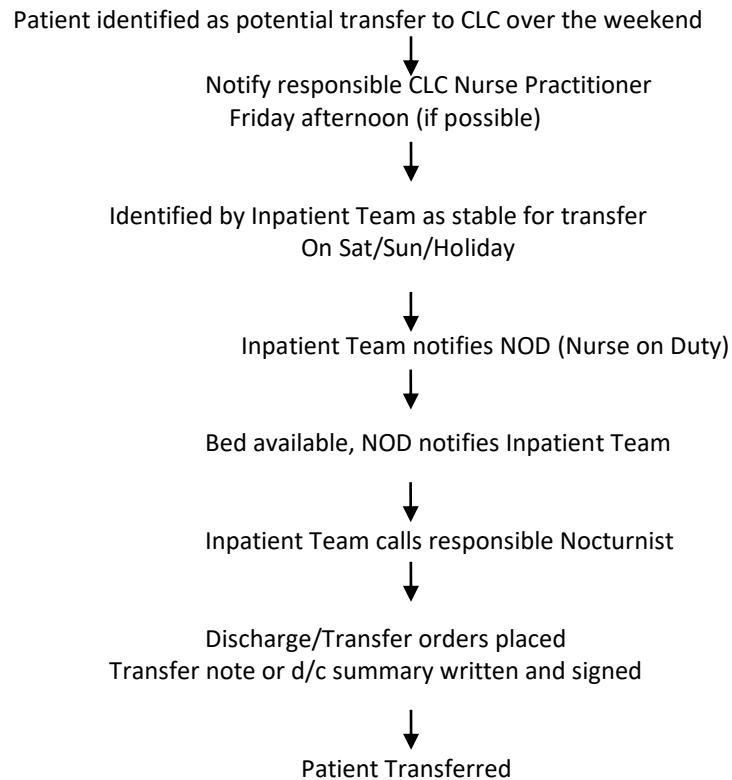
**Receiving Outside Hospital Transfers**



## Patient Transfers from Inpatient Medicine to CLC: Process for Weekends/Holidays

Applies only to those patients categorized as:

1. Absent/Sick (previously in CLC)



GEC Medical Supplement for requests for admission to the LBVAHS CLC Short Stay – 90 days or less

### Primary indication:

Rehabilitation

- Prior level of function
- Cause of loss of function
- Goals of therapy
  - Estimated length of time to reach goals
  - Response to therapy to date.

Medically Complex requiring skilled nursing care

Wound care

- Locations
- Stage/description
- Treatment
- Response to treatment to date

Infection requiring IV antibiotics

- Site
- Organism(s)
- Duration of IV treatment/start date/stop date
- Monitoring parameters

Radiation Therapy/Chemo/HBO

- Provider of service documentation of plan and duration
- Purpose
  - Cure
  - Palliative
- Patient's awareness of purpose
- Other

- Restorative Care
  - Functions lost
  - Why
  - Goals
  - Interventions to attain goals
  - Response to date
  - Estimated length of time to reach goals

Other

### **Additional indications/needs**

- Current problem list, (acute and chronic)
- Medications with indications
- Planned discharge location
- Diet
  - Regular
  - Modified - specify
- Life expectancy likely to be less than 6 months \_Yes \_No
- Activity
  - Unlimited
  - Limited – specify

Special equipment needs – specify (e.g. bariatric bed)

### **CPRS TIPS AND TRICKS FROM AN EX-INTERN:**

**Alerts/Notificatiois:** You can select the exact notifications you want to pop-up when you enter CPRS (e.g. abnormal labs). Open Any patient. Tools → options → Notifications tab → select and unselect the notifications.

**Admitting:** write delayed orders (top left hand side under “orders” tab) → “admit to medicine” , expected location : either S8 or S10, specify attending

**AM labs:** Labs other groups → 2 lab collect morning draw

**Blood transfusion:** reports tab → blood bank report to find blood type, then go to orders tab → blood bank request (obtaining consent instructions below)

**Consults:** call the consultant and place the request under consults → new consult (most consults you’ll place are under either #30 medicine or #49 surgery)

**Discharging:** 1.) Inform the patient and their nurse that you are discharging the patient 2.) Go to Orders tab → “Write delayed orders” → type in Discharge → sign the order 3.) make sure to reconcile all meds 4.) write a “discharge instructions” note for the patient. This is what you will hand them to take home with them 5.) go to notes tab and select new note → type in discharge note. This is the discharge note that will be immediately available for others to see 6.) go to D/C Summ tab → select “new summary” → copy/paste the discharge note you wrote into this template → sign your summary → it will disappear for the time being until the attending co-signs it.

**EKG order:** order tab → new procedure

**EKG results:** go to tools → vista imaging display → click red QRS complex box at the top

**Electrolyte replacement:** inpatient ward order sets → medicine admit → 57 IV drips/electrolyte replacement

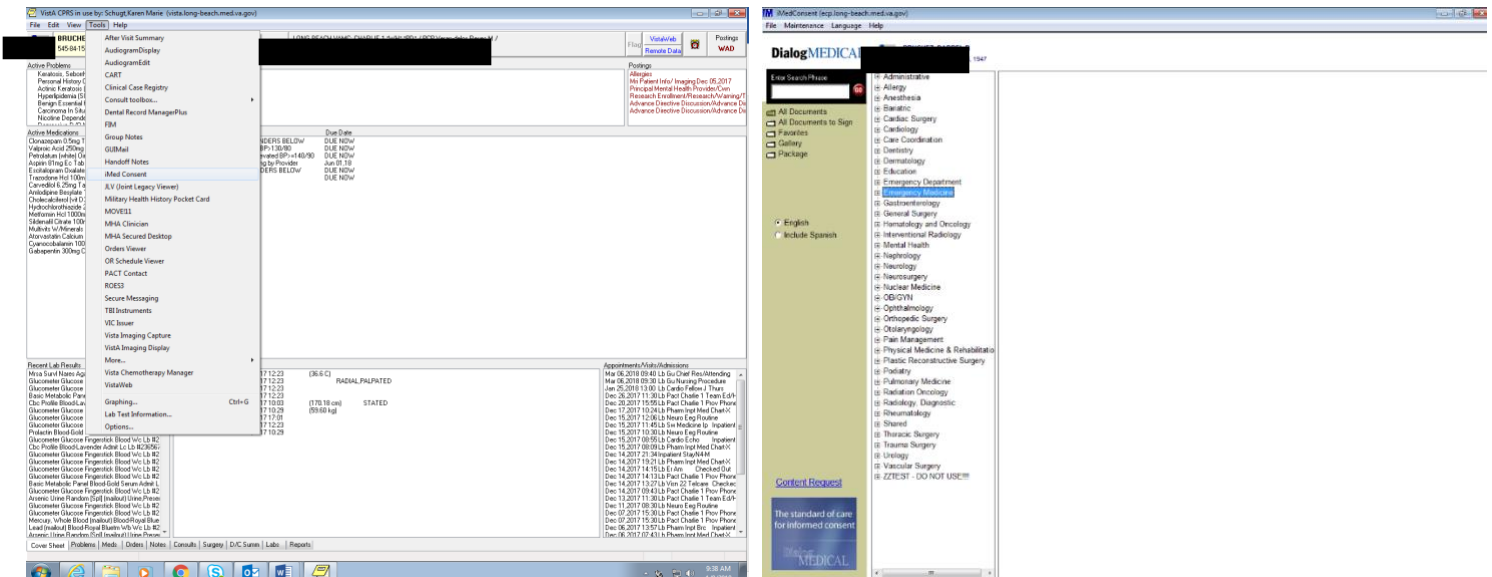
**Handoff:** tools → handoff

**iMedConsent** (found under “tools”. Use this tool to consent patients for blood transfusions and any procedures such as lumbar punctures, paracentesis, thoracentesis, etc.)

## iMED Consent Process

All consents must be done on a computer with signature pad

- 1) Open CPRS
- 2) Click on **“Tools”** then **“iMed Consent”**
- 3) There are multiple ways to search for the consent
  - a. Click **“All Documents”**
    - i. Select based on specialty
      1. Ex. **“Emergency Medicine”** -> **“Consents Basic”** (\* most procedure consults can be found this way)
        - a. Blood transfusions
        - b. Arterial line
        - c. Paracentesis
        - d. Lumbar puncture, etc.
      2. Ex. **“Emergency Medicine”** -> **“Administrative”** (AMA)
        - ii. Select based on Search (a little more difficult – require correct name of consent)
          1. Ex. Type AMA into search and hit enter
            - a. All AMA consents will come up, note consents are often located in multiple specialties (Ex AMA is in Emergency Med, Education, and Shared)
  - 4) Once the consent is found, double click till it opens
  - 5) Fill out each field questions as asked and click **“Next”**
  - 6) It will ask for the provider’s signature, then the patient.
  - 7) Once complete hit finish and the consent will be saved to the chart.



**Norco:** ED order sets → “discharge meds” (VA pharmacy) → “analgesics” (norco)

**Reconciling meds:** Medications tab → click on outpatient medications you want → action → transfer to inpatient

**GEC form (for all patients going to CLC, ie have some continued need such as IV antibiotics or physical therapy but don’t need to be hospitalized)** → select “new note” under notes tab → type GEC → select the first highlighted one “GEC <adult day health care consult>”

**Warfarin:** inpatient ward order sets → medicine admit → 54 medication quick orders

### Miscellaneous tips:

**Selecting specific lab results:** labs tab → worksheet → enter specific labs you want and click “add”

**organizing notes:** click on "all signed notes" → a dialog box will appear on the right hand side, you can organize notes according to author, title, etc.

- Alternatively, you can right click over notes → custom view → select check boxes title or subject contains (lower left hand side) → type in what you are looking for (for example, "ambulatory" – all notes with that title will appear in bold)

## **FREQUENTLY ASKED QUESTIONS (FAQ) :**

### **A. Is this patient a bounceback to Team 5/6?**

Same attending in the past 7 days counts.

View Hospitalists/noctensivist schedules:

<http://vavww.longbeach.portal.va.gov/Clinical/SitePages/Home.aspx>

### **B. How many admits am I getting today?**

Check EDIS (the ED electronic patient tracking board)

On your computer desktop ->click VALBHS Resources (looks like 2 screens)

Login with your CPRS password, select VA Long Beach

Any questions about the ED or floor patient tracking devices, contact Ely Roman Ingleton x4512

### **C. What is happening with VA Night Float?**

\*As mentioned above, an intern will cross cover Teams 1-4 until August 28<sup>th</sup>. After August 28<sup>th</sup>, there will be a cross cover nocturnist. Their hours are 7p-7a.

\*An admitting nocturnist will take all admission between 7PM-6AM. Sign out is at 6:30AM.

\*The admitting attending will assign admissions based on the updated sheet given by the Late Call senior.

### **D. How do I not get a phone call from the Chiefs/Dr. Swaroop?**

\*We are trying to decrease duty hour violations and have asked the ED to admit ASAP so you will likely get admissions that have not been fully worked up and are without labs. **DO NOT BLOCK THESE ADMISSIONS.** If they would be more appropriately served on another service, you must help mediate that.

\***MUST USE the H&P and Discharge Summary CPRS templates.** (Every patient must be screened for depression/suicidality, etc)

\*EVERY Admission needs a **CODE STATUS** order, even if it is full code

\*EVERY H&P written by an intern **REQUIRES** an MRAN note from the senior resident.

\*Any change in patient status needs to be communicated to **ward attending 24/7**

\*Remember that if you want to transfer a patient to the ICU from the ward floors and there is no ICU bed, you can **send them to the ED for the "ICU" bed** and patient will be followed by ICU team in the ED (the ED physicians will not be involved in care for the already admitted patient)

\*Log in duty hours DAILY

\***CODE BLUE NOTES** must be written for every code blue page you respond to, even if it wasn't a true code blue

### **E: What do I do with the med students?**

-They are expected at **8AM conference and Noon conference on time.** They are here to learn and the first 10 minutes is always the fundamentals so please round on their patients first and send them to conference first.

-they should not take **Tues, Wed, Thurs** off. (Vignettes, physical exam rounds, PRIME etc) occur during this time

-their **last day** is Thursday before their shelf at 5PM. This is to be fair to all medical students

-they should leave by 7PM on weeknights so they can go home to study

-they do not get to eat the resident call room food/chips/drinks

-the only note they open on CPRS is titled Medical Student Note. **You must EDIT** any information written by a med student if you want to use it in your note. Otherwise you take **FULL LEGAL RESPONSIBILITY** for anything inaccurate they write that you incorporate into your note.

### **F. How do I get into the call rooms?**

\* S10 ward call room (1052, 1019) codes will be given verbally at orientation

\* CCU/ICU call room and the S8 resident lounge is 24-3

**It is IMPORTANT that you do not share this code.** We have had incidents where non-resident staff have been using our rooms, and utilizing the computers to watch obscene materials. We want to ensure the safety of our residents and we will take any actions seriously if non-resident physicians are found in the room. If you do find someone, please notify the police immediately to file a report.

### **G. What do I do if I go to a Code Blue?**

Write a code blue note and explain what the situation was and what the plan is

#### **H. What do I do if I'm hungry after hours?**

If you are the night team or the long call team, you are welcome to eat the sandwiches/chips provided in the call room. Do not share with medical students. Do not let your night colleagues go hungry by eating this food. If you need a snack, stop by the chiefs office.

#### **I. TIPS (handed during orientation) :**

**LBVA Cheat sheet** - full of phone numbers and tricks like how to order VPAP (VA's version of bipap that can be used on the medical floor instead of sending them to ICU)

**VA Nights Reminders** (full of good information to make it easier for you)

-how to transfer to West LA VA and other hospitals (ooh la la, you know it happens when you least want it to)

-how to reach Neurosurgery here and at West LA VA

-how to reach Neurology (there are only attendings staffing now, no residents at all)

-how to find a clinic admission a bed (to help expedite if their is a delay)

-how to bounce patients back to Team 5/6

-what to do with ICU pt transfers out in the middle of the night (noctensivist covers them on the floor until AM)

#### **J. CHEMO oncology admissions**

Oncology patient who are here to only get chemo now go to the hospitalist service. when the patient gets here Dr. Tanovoli will assign them to the hospitalist service. If they come after 3:30 pm the patient goes in the drip and any team from 1-4 pm can be assigned. Overnight chemo admissions after 6:00 pm will be assigned by night float to the hospitalist team. If you are paged to admit a patient before 3:30 tell the clerk to call Dr. Tanovoli and let the chief at VA know so we could help the clerks figure it out. If the oncology patient is assigned to you page the onc fellow on consult to put in a note and chemo orders and also put in and oncology consult in CPRS.

#### **L. New ultrasound machines**

We have new ultrasound machines on every floor S10, S8, N4. They are in Med room and should be returned to the med room after use. Please remember to lock them back up. Also please be very careful with not dropping the probes. I suggest you put these codes in your phone.

S10 combination is : 17 27 33

S8 combination is: 15 33 27

N4 Combination is: 11 33 39

#### **M. NEW SECOND LAB DRAW TIME ADDED at 11 am:**

In CPRS now you have a new lab draw at 11am. This is only for weekdays. On weekends and holidays is not included. PLEASE MAKE SURE YOU PICK THE CORRECT TIME AND DO NOT DO DOUBLE ORDERS FOR 6 am and 11 am.