

CMC FAMILY MEDICINE SERVICE EXPECTATIONS/HANDBOOK

Version 6/25/2014

Admitted Patients:

1. For adult admissions (CMC, Mercy FAM MED):
 - a. We admit all patients from Elizabeth Family Practice and Biddle Point.
 - i. Patients must have been seen within the past 3 years to still be considered a patient of the practice. Please inform the ED physician if patient has not been seen in 3 years and the patient will need to be admitted by CHG instead.
 - ii. Besides reviewing recent office notes, the best way to confirm the patient is ours is by checking the visit history or encounters page.
 - b. We admit all of Dr. Menscer's patients from Sardis Oaks and White Oaks.
 - c. We admit all of Dr. Caprio's patients from Sardis Oaks and Sharon Towers
 - i. Be sure to confirm Menscer or Caprio as the patient's PCP, as there are other providers that care for patients at these facilities.
 - ii. If patients are at Sardis for Rehab and followed by Dr. Menscer or Dr. Caprio they will come to our service. Once discharged from rehab, they resume care under their PCP.
2. Adult admissions as transfers from CMC Main (see attached protocol):
 - a. Same criteria as above for admission to the family medicine service.
 - b. All transfer calls must have the attending physician on the line. If you are paged, please inform the PCL to page #8431 for a three-way conference call.
 - c. The Family Medicine Service accepts transfers from CMC Main ED Monday through Friday 7 am – 7 pm.
3. Pediatric admissions (CMC, FAM MED) :
 - a. We admit all pediatric patients from Elizabeth Family Practice, Biddle Point, and Northpark.
4. Newborn admissions:
 - a. We take care of newborns for EFP and BP only (no Northpark patients).
 - b. This includes newborns of mothers who have gotten prenatal care at EFP and BP, but plan to follow-up for newborn care elsewhere (unless the providers at the planned follow-up clinic see newborns in the hospital...list located in newborn nursery).
5. OB admissions:
 - a. All uncomplicated laboring patients will be admitted to CMC Family Medicine Maternal Child service. OB patients admitted for antepartum issues go to the OB service, with FM as a consult.
 - b. All OB patients (including triage patients) are staffed with an OB PGY3, PGY4, or attending.
 - c. When doing checks on laboring patients, every other check is required to be performed with an OB resident. However, the OB residents are available to

assist with all checks and things such as AROM, placement of IUPC and fetal scalp electrodes, etc.

- d. All CMC Family Medicine postpartum patients are staffed with the FM attending. All complicated patients (i.e. PreE) or C-section patients are transferred to the OB service.
 - e. When Dr. McWilliams is on Mom-Baby service, all post-partum patients are staffed with the upper level on OB. Notes should be forwarded to the OB resident, but only need to be forwarded to the OB attending if there is a complex patient. This is a process change. You no longer need to transfer the patients to the OB list.
6. While on the inpatient service, it is your responsibility to find out who the patient's PCP is and inform that PCP of the admission. This is best done by copying the PCP on the admission H&P or by sending a Cerner message.
 7. A complete adult admission includes:
 - a. Powernote H&P
 - b. Med reconciliation
 - c. DVT prophylaxis
 - d. Insulin order set for the non-pregnant adult (if pt is a diabetic)
 - e. Admission power orders completed
 - f. Alerting the PCP of admission
 8. If admitting a patient from clinic, the clinic MD is to notify the inpatient resident at #1915 and the admitting resident will evaluate the patient, perform the H&P, and write the orders. The clinic MD will arrange for the bed (call PCL). Please refer to admission algorithm in the Blue Book at each clinic station.
 9. General expectation for all residents: If you are notified that one of your patients is admitted, you are expected to go see your patient in the hospital and provide any additional insight you may have to the team.

On Call/Night Float Schedule:

1. The Nightfloat resident starts at 6pm on Weekdays and 7pm on Sunday and ends at 7am.
2. The On-Call resident shift begins at 7am. Day call goes until 6pm on week days and 7pm on Sunday. 24 hour call starts at 7am and goes until 7am the following day.
3. It is the responsibility of the Nightfloat resident starting their shift and taking the call pager to call for signout at or before 5pm on mom baby and 6 pm on adult. The day team will call for signout at 7am. It will also be the Nightfloat person's responsibility to give sign out in the morning at 7am.
4. There will be occasions while on call for the MCH service that your call will begin at 12:30. Please be cognizant of these times as it allows the resident on call in the morning to attend clinic in the afternoon.

Interns:

1. Interns on inpatient work Mon-Fri from 7am-6pm and also every Saturday. Saturday begins at 7am and may go as late as 5pm. However, it may be at the discretion of the

upper level resident to release the intern earlier in the afternoon on Saturday if all work is complete and there are no admissions. Interns have Sunday off.

2. When an intern is on the inpatient service, their Mom-Babies week must be with a 3rd year resident.
 - a. When an intern is on Moms/Babies and the list is small (<2 patients) and there is no laboring OB, the intern needs to return to Mercy to help the adult inpatient team until either:
 - i. A pediatric admission comes in.
 - ii. An OB patient presents to triage or is admitted.
 - iii. The third year will be responsible for informing both the intern and adult service of the above.

PAGER NUMBERS:

- a. Adult attending: #8431
- b. Mom-baby attending: #8432
- c. Adult resident: #1915
- d. Mom-baby resident: #4530

MERCY CALL ROOM CODES:

#6108: 3-2-5

#6109: 5-2-4

REQUIRED TO STAY IN HOUSE WHEN:

1. Patient (pediatric or adult) is on continuous nebulizer.
2. An OB patient is laboring (until PCP is able to come to hospital to relieve you). You should alert the PCP when their patient is admitted and they are expected to come in when the patient is 5 cm or as soon as possibly if they are otherwise occupied with clinical duties.
3. An adult patient is admitted to the ICU and the family medicine team is primary.
4. Any unstable patient, no matter their location.

FOLLOW-UP APPOINTMENTS:

1. Contact the discharge planner/clinical case manager as soon as you know a patient has needs at discharge (i.e. home O2, PT/OT, home IV antibiotics, Lovenox)
2. You are responsible for arranging f/u appointments for all patients discharged home. Patient's going to a SNF do not need a f/u appointment with their PCP.
 - a. Biddle Point Triage:
 - i. Before 5 pm: 704-446-9987 then press 9 to reach the scheduler.
 - ii. After 5 pm or on the weekend: 704-350-1095 and leave a message for Gina OR send a Cerner message to BP, Triage.
 - b. Elizabeth Family Medicine:
 - i. 704-304-7000
 - ii. Karen: 704-304-7012

- iii. Phyllis: 704-304-7013
- iv. Nights and weekends, send a message to EFP, Triage.

ON-CALL PHONE CALLS:

1. Document all on-call phone notes/conversations on Cerner. (Medical-legal issue)
 - a. Use ad-hoc at the top of the cerner homepage to open a telehealth phone message or plain phone message. Be sure to copy the patient's PCP on the message.
2. If you have told a patient to call in the morning for an appointment, send a Cerner message to EFP, Triage with the patient's name, MRN and reason for the appointment. Please specify if the patient needs to be seen that day.
3. We typically do not call in meds while on-call, especially pain meds or other controlled substances. Tell patients to call the office in the morning for refills.
4. We also take on-call phone calls for Dr. Menscer and Dr. Caprio's patients at White Oak, Sardis Oaks, and Sharon Towers. These calls range from simple medical questions, patients in need of transfer to the hospital for evaluation (AMS, hypotension), lab results, requests for meds, review of admit orders and notification of a patient death for release to the morgue. Document a note in Cerner but ALSO leave a message with Sindy McCrystle at (704) 304-7139.
 - a. These calls often can be difficult since we have no information on these patients. Very frequently you will have to ask the nurse for more information on the patient. The nurse should have the patient's most recent note and vital signs as well as their medication list at their IMMEDIATE disposal before calling you. If they do not, give them a number where they can call you back with that information.
 - b. You are also able to order the some labs, x rays, cultures, and start IV fluids and/or antibiotics as you would in the hospital. This can prevent a hospital admission, and Dr. Menscer or Sindy will see the patient the next day.
 - c. Also, always ask about code status and if there are situations in which the patient and/or family have decided they would prefer not to go to the hospital. Sometimes it is helpful to call the patients healthcare power of attorney/next of kin for guidance regarding their desires for aggressive care for patients who have advanced dementia or who are unable to express their desires.
5. The bottom line for anything is if you have any questions, please call the Attending on-call.

UPPER LEVEL RESPONSIBILITIES:

Goal: The inpatient experience will be an environment for upper levels to develop leadership and teaching skills.

1. The team presents to the 3rd year on rounds. The 3rd year takes an active and proactive role in eliciting additional information, developing plan, providing feedback on presentations, and education.

2. When there is only a 2nd and 3rd year on the service (no intern): The 2nd year resident will see all patients up to 5. This means the 2nd year will pre-round, write all notes and submit urgent orders. The 3rd year will know all of the patients but the day to day care of the patient will be the responsibility of the 2nd year. If there is an AI in this situation, the AI's patients will be seen by whichever resident is already covering that patient. (i.e. if there are 6 patients and the AI is seeing patient #6 then the 3rd year will be responsible for seeing that patient and writing a note, if the AI's other patients are #1-3 the 2nd year should see those patients as if the AI is not there since the note from the AI is not a legal document).
3. If there is an intern as well as a 2nd year resident: they will see ALL of the patients and divide them equally. The 3rd year resident will take on a complete supervisory role, knowing all of the patients. If there is an AI in this situation, then the 2nd year and intern will see all of the AI's patients.
4. If there are 2 residents of the same level on the service, they will divide the service equally.

Documentation:

1. History and Physicals:

- Use the following power note templates: CHS General Admission H&P (Adult), CHS Pediatric Admission H&P (Pediatric), and CHS Newborn Admission H&P (Newborn).
- When appropriate document at least a 10 point review of systems (should be performed on all adult admissions and most pediatric admissions).
- Copy PCP, daytime attending, AND (if staffing at night and a different attending) the night attending.

2. Progress Notes

- Do not have to be done by rounds, but they should be completed no later than 3 pm. Prioritize first completing orders/consults (before noon).
- Use the following power note templates: CHS General Progress Note (Adult), CHS Pediatric Progress Note (Pediatric) and CHS Newborn Progress Note (Newborn).

3. Discharge Summaries:

- All discharge summaries should be performed as power notes.
- Use the following power note templates: CHS Discharge Summary (Adult), CHS Pediatric Discharge Summary (Pediatric) and CHS Newborn Discharge Summary (Newborn).
- Discharge summaries are to be completed ON day of discharge. All patients being transferred to a SNF require a stat discharge summary prior to leaving the hospital.
- Include the completed discharge medication reconciliation in the discharge summary. Important for all patients, but especially patients being transferred to SNFs. This is where most d/c errors occur...triple check against home and inpatient meds.

Rounding:

1. Prioritize early d/c's:
 - Attending and resident touch-base before rounds to identify “early d/c patients” and attending sees prior to rounds or prioritize seeing “early d/c patients right after we see ICU patients on walk rounds
 - Goal for d/c order to **be written by 10 am on 35% of our patients**
 - Mention early/expected d/c's to nursing and case management the day before.
2. Round time:
 - Goal always to start rounds no later than 9 am, including on weekends.
3. Round # of patients: On weekends when there is 1 resident and > 10 patients...
 - A. Maternal/peds resident sees remaining patients IF ≤ 6 mat/peds pts, no one sick enough to require in-house (e.g. Continuous nebs), and no laboring patients
 - B. If Mat/Peds resident cannot see patients, attending sees and writes orders/notes on all patients over 10.
4. Involve nurses on rounds for **every** patient (standard part of prerounds to write down nurse ASCOM #'s).
5. Walk rounds:
 - Always some component of walk rounds and bedside teaching (ICU pt's, 'learning' patients, d/c's)
 - Call nurses on way to room to involve on rounds.
 - Touch base with Case Manager before leaving floor
6. Multidisciplinary Rounds:
 - A member of the team should be present for ICU multidisciplinary rounds on EFM patients at **11 am each weekday**. You may discuss with ICU having them start rounds on our patients.

ICU:

1. Start walk rounds (9 am) with ICU patients
2. Include ICU nurses in rounds
3. Consistent message to ICU and eICU – no orders on our non-level 3 patients, unless bipap/vent orders. **Resident to be called with all recommendations.**
4. Team to see all Level 3's daily. Residents leave basic note. Attending bills low level (1 or 2 as appropriate) daily.
5. FM Residents admit all ICU patients (even level 3). **Always use ICU order set.** If ICU is completely managing, the ICU should be made immediately aware with a clear conversation that: “the ICU is entirely managing this patient, we will follow-along”. In these cases the attending should still bill an appropriate h and p charge.

6. Every admit or transfer to the ICU at night requires a “check-in” call to the eICU. **704-512-6640**. Remember to say that: “This a Family Medicine resident patient, I am in house and can be reached at this #. Please contact me with ALL recommendations”. The eICU will do a patient evaluation on **every newly arrived patient**.
7. Code Sepsis – For patients (new admits or floor patients) with severe sepsis or septic shock. Follow the attached algorithm.

Teaching:

- **Afternoon** didactics daily (led by all members of team)
- Upper level in charge of creating weekly learning plan
- Expectation for attendings to block schedule in am, and to be widely available in afternoons.
- Working towards a shared repository for didactics on medhub
- R3 to take on a strong teaching role
- Reach out to specialist to teach in afternoons (cardiology, ICU, etc)

Sign-Out:

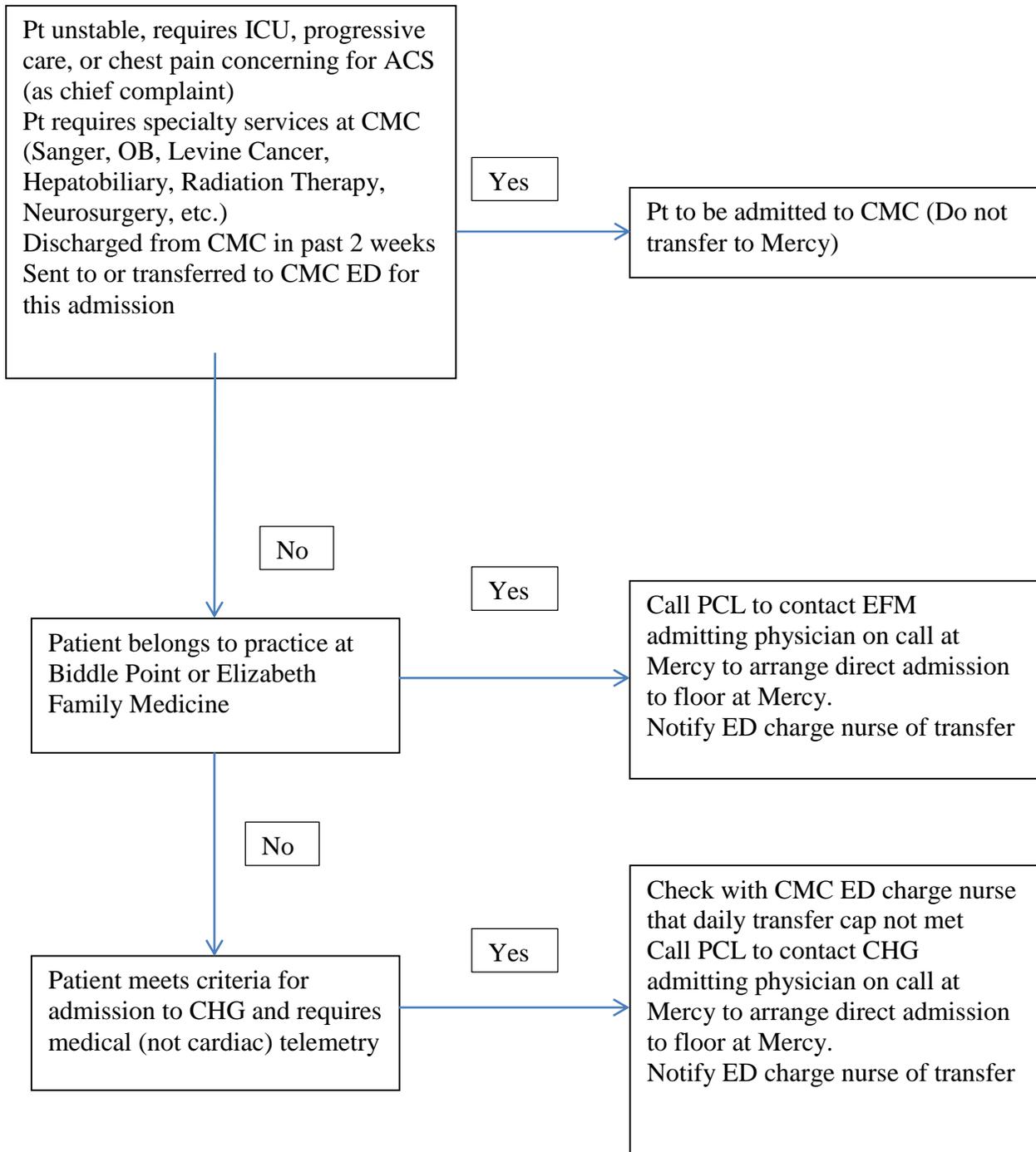
- Both services use a standardized Cerner based sign-out tool (residents and faculty to reevaluate sign-out tool biannually, but it will not change monthly)
- Include only pertinent pt information
- Time all items that need specific follow-up
- Sign-out should be updated by day team prior to sign-out and by night resident for new admissions
- Attendings will evaluate sign-out tool daily with in person evaluation of sign-out one night during the week (required milestone).
- EVERY night (including weekends) the night resident is to call the eICU between 6 pm and 8 pm to “check-in” on the EFM patients. **704-512-6640**. There are 2 points for this call: (i) a one liner of info to the eICU attending so they know about our patient and (ii) an explicit reminder that: **“This a Family Medicine resident patient, I am in house and can be reached at this #. Please contact me with ALL recommendations on these patients”**.

Attending Night, Weekend Coverage and Sign-out:

- ****Change in time.** For our new 2014 academic year, sign out will be Fridays at 5pm
- The attending receiving sign-out Friday afternoon, transfers both pagers to him/herself.
- Otherwise, Monday through Friday the attending not on call at night is in charge of signing the pager over to the night call attending AND then signing the pager back over in the morning.
- The night attending should contact the am attending to alert him/her of significant overnight events.
- Currently, we do not bill for overnight admissions. The day attending staffs and bills the following day. ****Needs to be consistent so we are not double billing.**

- Night attending should sign overnight h and p's as "discussed with resident..." and **ensure daytime attending is copied** for full addendum that supports billing.

Adult Patient Transfers to Mercy Hospital for CHG and Biddle Point/Elizabeth Family Medicine (EFM)



Emergency physicians are encouraged to exercise clinical judgment regarding advisability of transfer based on individual patient circumstances. Medical issues and patient satisfaction concerns may mandate keeping some candidates for transfer at CMC.

Mercy Inpatient Service CAP Policy and Procedure

Purpose:

The policy on inpatient census caps is to ensure patient safety by adequately matching house staff to patient ratios. The cap is of particular importance over the weekends when we have reduced staffing.

The Family Medicine Adult Inpatient service cap will temporarily halt all outside hospital and Emergency Department transfers. The service cap does **NOT apply to patients who present for admission to the Mercy ED, patients who are direct admissions from the Elizabeth Family Medicine or Biddle Point clinics, or ICU transfers.**

Responsibility:

The decision to cap the team rests solely with the attending physician, as does the responsibility to initiate and stop the process.

When to Cap:

The cap should be employed when the inpatient service has **greater than or equal to 15 actively managed patients**. This number does not include level 3 ICU patients.

The cap decision should be re-evaluated daily and stopped if the team census goes below 15 patients.

How to Initiate Cap:

1. Page the on call CHG Hospitalist at Mercy 9741. Let CHG know that we are going to be capped. This can simply be an fyi text page.

2. Call the Physician Connection Line (PCL). Tell them the Family Medicine Service at Mercy is capped to outside ED and hospital transfers.

How to Turn Off Cap:

1. Page the on call CHG Hospitalist at Mercy 9741. Let CHG know that we are no longer capped. This can simply be an fyi text page.

2. Call PCL. Tell them the Family Medicine Service at Mercy is no longer capped to outside ED and hospital transfers.

****If a patient is admitted to CHG at Mercy during a time the service is capped, the patient will remain with CHG until discharge.**

Code Sepsis Algorithm

Code Sepsis Checklist

- Baseline Labs POC
- Code Sepsis Activated
- Central line placed
- Time out
- Cultures obtained
- 1st lactate
- 1st antibiotic started
- temp sensing Foley placed
- patient transported
- 2 hour lactate
- 4 hour lactate

Patient arrives in the Emergency room or

ED
MD/Hospitalist/EFM
Screen for SIRS Criteria

- If meets 2 or more
- Temp >100.4F or <96.8F
 - HR >90
 - RR >20 or PaCO₂ <32
 - WBC > 12 or <4cells.mm³ or >10% bands

Enter Code Sepsis
Power Plan

Establish 2 large bore #18 gauge IV's for fluid resuscitation or CVC placement, if no CVC after one attempt; page ICU on call

Temp sensing Foley Placed

Notify PCL

Nursing Supervisor facilitate bed availability

ED Charge assists with involvement of resources

Respiratory

Lab

Critical Care RN

Pharmacy

Provide support to Code Sepsis Team, assist with intubation if

Provide support to Code Sepsis Team; assist with collecting blood cx/labs if needed

Charge RN to Call ED, if needed; go to ED to help facilitate care according to Code Sepsis Protocol; assist with transport to ICU

Assist with medication needs & facilitate delivery of meds

Move patient to ICU continue 6 hours sepsis resuscitation; if necessary consult Critical Care Team per Code Sepsis Power Plan Order set