Stony Brook Hospital Medicine Orientation Guide

Welcome to Stony Brook Hospital Medicine Section

Mission Statement

To Provide High Quality, Safe, Equitable and Efficient Inpatient Medical Care in a Patient-Centered and Team-Based approach

Hospitalist Program Physician Leadership

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Hospitalist Service schedule:

Service week starts on a Saturday and ends on a Friday
Day shift timings: 7 am-7pm
Night shift timings: 7pm-7am

General Structure

1. **4 General Medicine Hospitalist Teaching teams**
    - These teams include 15 Blue, 15 Red, 15 Green and 15 White. Floors: 15 North & 15 South
    - Each team is staffed by 1 attending, 1 senior resident and 2 interns
    - Average Census is 15 patients

2. **11 General Medicine Attending Directed Hospitalist teams (rounding only)**
    - 12 Green & 12 White. Floor: 12 South
    - 13 Red. Floor: 13 North (also known as MRN floor). This is primarily Neurology floor but half of the patients on the floor belong to Hospitalist service.
    - 16 Blue & 16 Red. Floor: 16 North.
    - 16 Green. Floor: 16 S. 16 S is primarily Cardiology floor, however, on high capacity days Hospitalist service Medicine floor level and Medicine Intermediate Care (MIC) level patients can be assigned to 16 S as overflow. MIC patients on 16 S are assigned to 16 Green. Floor level patients on 16 S are assigned to 16 Blue or 16 Red.
    - 9 Green & 9 White. Floor: 9 S. Both are Medicine Intermediate Care teams. New Pulmonary Consultants provide co- management in MIC unit.
    - 18 Blue (Hospital Observation team) & 18 White. Floor: 18 North.

Note: At present 18 North is converted to a COVID unit. Both 18 Blue & 18 White are COVID teams. Hospital Observation patients are assigned to all Medicine floors. Operation to be resumed as soon as COVID patient's volume decreases.

- 19 Red. Floor: 19 North. This is primarily Oncology floor but half of the patients on the floor belong to Hospitalist service. Hospitalist service takes care of oncology patients that belong to a private Oncology group, New York Cancer and Blood services (NYCBS). If their patients get admitted to 19 North, they are assigned to 19 Red. 19 Red accommodates all oncological and non-oncological Hospitalist service patients on 19 N. Stony Brook Oncology service admits their own patients and they are the other half of 19 North.
- Overflow teams. Depending on staffing, overflow assignments are scheduled to assist with volume and census.

3. General Medical Consult service

A team that consists of a hospitalist and rotating internal medicine residents and geriatric medicine fellows provides care for patients admitted to other specialties (Orthopedics, surgery, Neurology, Obstetrics and Psychiatry) who have underlying chronic medical illness or who develop acute medical problems while hospitalized. Team also provides pre-operative clearance. Schedule is Monday to Friday, 8am -4pm. Consult hospitalist also evaluates outside hospital transfer requests for appropriateness.

4. Admitting Service

- 1 Hospitalist (MAH) is assigned in ED, 24/7, to triage and distribute admissions assigned to Hospitalist service. Triage responsibilities include assessing necessity for admission, level of care (admission versus observation), severity and appropriate service. MAH coordinates with centralized throughput office for bed assignments as well. MAH also assists with admissions when volume of admissions is high.
- 1 Hospitalist is assigned daily from 7am-7pm for ED Admissions to attending directed teams. Teaching teams take their own admissions.
- 1 Hospitalist is assigned to do admissions from 3pm-2am. This is a scheduled shift covered by dedicated staff.
- 1 Hospitalist is assigned to do admissions from 5pm-1am. This is an optional moonlighting shift.

Admission Process

ED physician comes to MAH with an admission. MAH triages the admission and sends a text page to the ED admitting hospitalist with the admission name, MRN and name of the team assigned. ED staff calls admitting physician for sign out. ED admitting hospitalist completes the admission.

5. Nocturnist service (7pm-7am)

Nocturnist service includes Hospitalists and advanced practitioners.

- 1 advanced practitioner covers up to 4 attending directed floor level of care teams. 2-3 advanced practitioners are scheduled every night. 2 hospitalists precept advanced practitioners and complete admissions assigned to hospitalist service.
- 1 Hospitalist covers Medicine Intermediate Unit
- 1 Hospitalist covers Leukemia and Lymphoma transplant unit (LLT) and precepts teaching teams.
- Teaching teams are covered by interns and residents overnight. LLT Hospitalist precepts them.
- 1 Hospitalist serves as MAH

7am- 7pm Workflow for attending directed teams

Goal: To assign fair case load to all providers to ensure delivery of high quality care to our patients, enhance provider efficiency and to avoid provider burn out.

Admitting Hospitalist:

Expectations:

7-8 admits for 7am-7pm admitting shift

6-7 admits for 3pm-2am admitting shift

Above numbers will vary based on assignment time and acuity. MAH to evaluate and decide.

Cut off for accepting last admission:

5:30 pm for 7am -7pm admitting shift

12:30 am for 3pm-2am admitting shift

If there are multiple pending admits at 7 am (more than 4), MAH to assist with up to 2 low acuity admits. This should cover up to 9 admits from 7am-7pm.

Admissions back up policy:

If admitting hospitalist and MAH have reached their limit before 3 pm and there are more admissions to assign, admission assistance will be provided by a backup hospitalist. This back up hospitalist will be identified in the morning email and will preferably be an overflow attending. Follow up case load for this overflow attending will be determined based on expected admit volume. For example, on busy days and based on 7am admit volume, if assistance with up to 4 admissions is expected, follow up case load will be adjusted up to 5 patients. Admits can be floor or ICR level based on service need for the day. If admission assistance is not needed, this overflow physician can also be used for upgrades from floors to ICR or MICU downgrades to ICR. To summarize, if back hospitalist starts their day with 5 patients, they will be expected to assist with 4 more encounters which can regular floor admits, ICR admits, ICR upgrades from floors and MICU downgrades to ICR. This overflow physician will be working independently without NP assistance. MAH to notify Dr. Abbasi, Allen or Robin if admitting hospitalist, MAH and back up hospitalist have reached their expected census before 3 PM and more volume is expected.

Inpatient teams:

Expectations:

15 patients with 1 NP/PA. We try our best to control new patient load based on discharge data from day before.

8 patients without NP/PA but this is dependent on service census and throughput of overflow physician

Hospital Observation team:

Expectations for 1 attending and 1 NP/PA:

15 Patients. HOB NP/PA is expected to take care of up to 10 HOB patients for the shift. Attending will independently take care of the rest. For example if 7 am HOB census is 12, HOB NP/PA will take care of 10 patients. Attending will independently take care of 2 patients and take up to 3 admits to reach total 15 encounters expected of this team. Assistance with HOB admits will be provided beyond 15 encounters.

Expectations for 1 attending and 2 NP/PAs:

22 patients. Each HOB NP/PA will take care of 10 patients and attending will take care of 2 patients independently (follow ups or admits) Assistance will be provided beyond 22 HOB encounters to ensure efficiency.
Also, when HOB census exceeds 15, we might provide assistance from overflow physician instead of assigning 2 NP/PAs. This decision will be made after careful review of HOB census, total service census and NP/PA staffing for the day. Goal is best utilization of resources.

ICR teams:
Expectations:
10 encounters per ICR team. Downgrades and discharges will be counted towards encounters for the day. Number is set to facilitate throughput and quality of care in the step down unit. Assistance beyond 10 encounters will be provided for ICR admits, upgrades to ICR and Downgrades from MICU. Physician assisting will be identified in the morning email. For days when back support is not possible due to staffing and or census, ICR teams will be notified in the morning via email.
16 Green will be overflow ICR team if 7 am census exceeds 20 patients. NP/PA will be assigned to 16 Green. Depending on team census, 16 Green will assist with patient volume on other teams as able.
Proposed day Structure
Attending Directed teams:

- At 7 am, review all your patient charts. Review IPASS for overnight events. Covering night team will do a face to face sign out for critical events overnight but all routine matters are populated in IPASS. After reviewing the charts, meet with your advanced practitioner and go over the patient list. If no critically sick patients, prioritize rounding on dischargeable patients with your advanced practitioner. Advanced practitioner will prepare all the discharges.
- Participate in multi-disciplinary team meetings along with advanced practitioners between 8 am- 9:30 am. Timings are fixed but different for each floor. Advanced practitioner will help navigate. These rounds take 15 minutes on an average and should focus on discharge planning and needs. **Multidisciplinary team meeting discussion content should be driven by hospitalist team and should include items below**
  -Clinical Provider provides brief Impression and Plan
  -Anticipated Date of Discharge
  -Special attention to those patients planned for discharge same day or next day
  -What is the attributed LOS? Care Management/Social Work should be able to provide you this information. If approaching or crossing the attributed LOS, clinical provider should document any mitigating factors or active issues still being worked up or treated
  -What is the Readmission Risk Score for the patient? In order to access this information go to Inpatient Viewpoint → Manage → Risk Scores
  -What services need early activation for the patient, particularly if they are high-risk for readmission?
    - Social Work/Care Management
    - Opportunity for Pharmacy review and input?
    - Physical Therapy
    - Palliative Care – Do Not Hospitalize order?
    - Communication with outpatient PMD/Specialists

- After multidisciplinary rounds, continue and complete your patient rounding. While rounding, please update following items on the white boards in patient's rooms on daily basis.
  -plan of care in lay man language
  -anticipated discharge date. Range should be ok if definitive date cannot be anticipated
  - Date and time family was last updated
  Also, please make sure covering physician name is populated correctly by nursing, if not, please make appropriate corrections. Deliver your business cards to your patients while rounding.
- After completing patient rounding, start your documentation and address issues as they arise
- Dedicate a time in your day to update patient's families
- Advanced practitioners are first on call and answer all the pages. They call consults per attending's request. Prioritize consult requests in the morning so they can be completed in a timely manner. Discuss the labs needed for next day with your advanced practitioner so they don't order labs on all the patients without medical necessity.
- In case of rapid response or code, there is dedicated rapid response/code team but it is expected that primary team be present by bedside
- Hospitalist do not typically do procedures. Procedures can be requested from
  -Interventional Radiology
  -Pulmonary procedure group
  Please make sure not to involve both parties on one case at the same time
  -There is a dedicated bedside PICC and Mid line service from Monday to Friday.

Teaching teams

- At 7 am, review all your patient charts. After reviewing the charts, meet with your resident team and go over the patient list. If no critically sick patients, prioritize rounding on dischargeable patients.
- Attend multidisciplinary rounds at scheduled time for your team. Attending must be present in these rounds and should supervise residents to include discussion items mentioned earlier.
- Continue your patient rounding after multidisciplinary rounds. Patient rounding should be completed before 1 PM since that's the time for interns' and residents' academic noon conference. Please refer to required white board update mentioned earlier.
- After patient rounding, complete your documentation, address issues as they arise, supervise residents and interns as needed and update patient's families.
- Teaching teams complete their own admissions. Dedicated resident is assigned to do up to 4 admissions for teaching teams from 7am- 12pm. MAH precepts these admissions. After 12 PM team senior resident is responsible for admissions and team attending precepts. Morning assistance is provided to ensure timely completion of rounding and discharges.

Transfers/Downgrades

Downgrades from MICU, medical ICR, cardiac ICU, and cardiac step down (CACU) may occur during the day. Advanced practitioner on the team accepts the transfer, discusses with the attending and writes a brief acceptance note. Residents/Interns accept the transfers on teaching teams, discuss with their supervising attending and write acceptance note.

"End of shift" and "end of service" week sign out

IPASS is used for sign out. Critical issues are signed out in person.

Billing

Billing is completed in the power chart on daily basis.