Inpatient Care Model

Patient distribution algorithms

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General Concepts

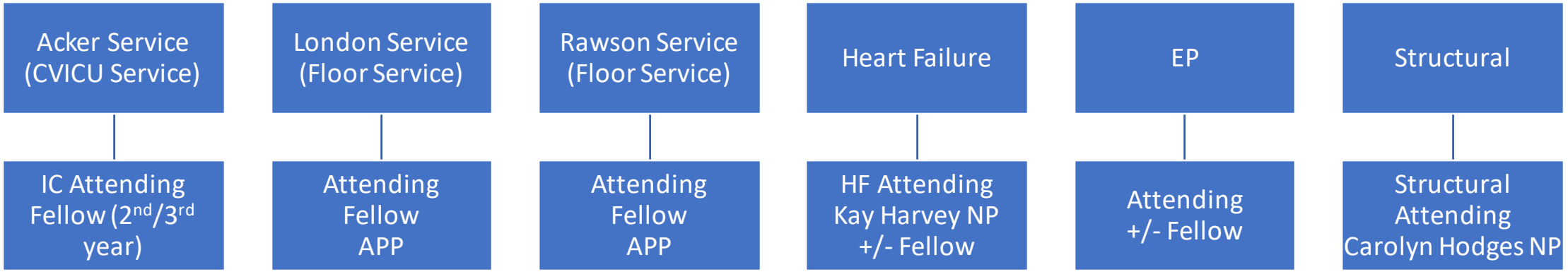
- Patient allocation and list updating will have both a clerical and clinical piece.
  - Clerical staff will primarily update list and send consults based on specified criteria
  - If there are clinical decisions to be made these are made by the physicians/APPs on service who may then need to change team assignments

- For service structure
  - “Primary” outpatient cardiologist is defined as the cardiologist who sees the patient in the office and has seen the patient in the office in the last 3 years.

- Patient Census
  - This is the number of active patients on your list at the moment it is being evaluated. If you start the day with 10 patients but as of noon you have signed off on 5 of them then your census is 5.

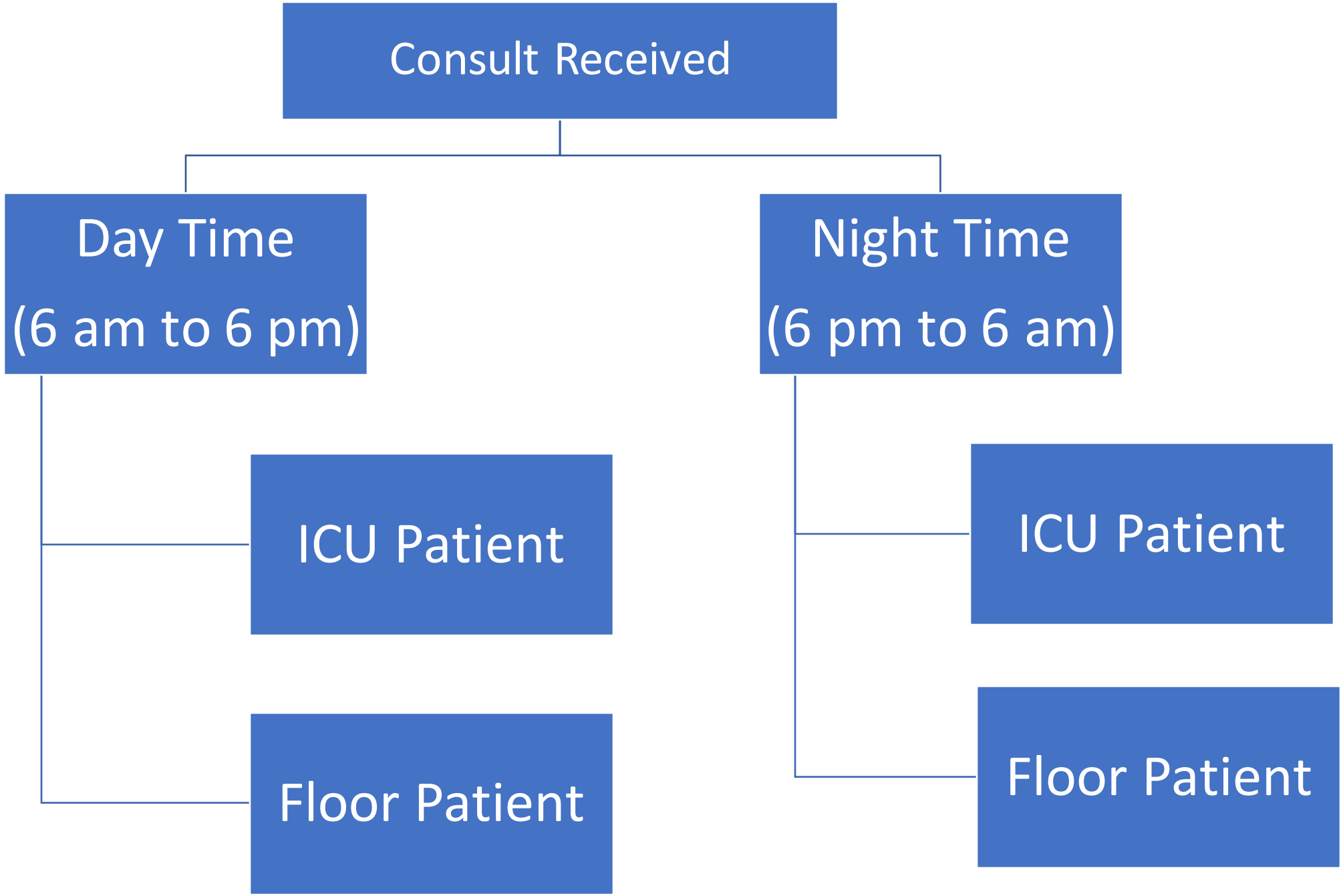
- Outpatient procedure patients
  - It is proceduralists job to discharge the patient the next day if patient stays overnight.
  - If patient requires inpatient admission after their procedure then the MA phone is contacted so that the appropriate team can be assigned.

Inpatient Services



Core CVICU Diagnoses

1. STEMI
2. High risk NSTEMI
3. Mechanical complications of MI
4. Heart failure requiring ICU level care
5. Unstable arrhythmias requiring ICU level care
6. Patients requiring mechanical support devices – IABP, Impella, or ECMO
7. Structural Heart Interventions requiring post procedure ICU monitoring – TAVR, Mitraclip.
8. Pericardial tamponade
9. Cardiogenic Shock
10. Cardiac arrest patients due to a primary cardiac etiology


Consult Received
Day Time
(6 am to 6 pm)
Night Time
(6 pm to 6 am)
ICU Patient
Floor Patient
ICU Patient
Floor Patient

Day Time Consults (6 am to 6 pm)

ICU Patient
(Currently or going there)

<u>Consult Arrives on MA perfect serve</u>

1. Consult Sent to Acker Service Attending/Fellow.

2. Patient added to Acker Service Cores List and billing list. Patient status listed as “new”.

3. Attending assigned and fellow added as contact person

4. Look patient up in Centricity. If already assigned update CORES with primary cardiologist. If new, create chart

<u>Acker Service Receives Consult</u>

1. If primary outpatient cardiologist is on either the London or Rawson service and patient not being seen for a core CVICU diagnosis then Acker service contacts primary cardiologist to see patient.

2. If Acker Service census ≤ 12 then patient assigned to Acker Service.

3. If Acker Service census > 12 patients and patient being seen for non core CVICU diagnosis then attending has pass/play option.

4. If Acker Service has >12 patients and consult is for a core CVICU patient assigned to Acker Service.

5. If Acker service gets >15 patients the attending on service as the option to transfer a floor patient or non core CVICU patient to the floor services.

6. If a patient is transferred to a different service the MA phone should be texted so that the patient can be reassigned to the service who is up for the next patient.

Day Time Consults (6 am to 6 pm)

Floor Patient
(Currently or going there)

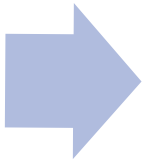
Consult Arrives on MA perfect serve

1. MA follows floor service patient allocation algorithm and assigns patient to correct service.

2. Consult sent to floor service attending/fellow.

3. Patient added to CORES list. Attending updated. Fellow assigned as contact person. Patient status listed as “new”.

4. Patient looked up in Centricity. Primary cardiologist updated on CORES list. If patient is new then a chart is created.



Floor Service Receives Consult:

1. If on chart review patient meets criteria for EP or HF service then the EP/HF attending is contacted directly. Clear communication is made about which service patient will be assigned to and if co-management is required. Patient added to EP/HF CORES team.

Night Time Consults (6 am to 6 pm)

ICU Patient
(Currently or going there)

Consult Received by Fellow (6 pm to 8 pm) or NP (8 pm to 6 am).

1. Patient seen and consult note written.

2. Routine consults are then added to the list for the Acker service to see in the AM. Patient status is selected as either “See in AM” or “Staff in AM”. If Acker service has >15 patients and the patient has a non core CVICU diagnosis then patient added to floor service.

3. Urgent Consults

- If patient requires urgent cath lab procedure then on call IC called.
- If patient doesn’t require urgent procedure then night call general cardiologist called.
- The contacted cardiologist chooses the most appropriate service. If it is the floor service then patient is assigned to the night call cardiologist’s team.

<u>Sign Out</u>

1. Overnight NP meets the CVICU fellow at 6 am in the CVICU.
2. New overnight consults discussed.
3. Overnight updates on CIVCU patients discussed.

Night Time Consults (6 am to 6 pm)

Floor Patient
(Currently or going there)

Consult Received by Fellow (6 pm to 8 pm) or NP (8 pm to 6 am).

1. Patient seen and consult note written.

2. Routine consults are then added to the appropriate floor service based on algorithm. Patient status is selected as either “See in AM” or “Staff in AM”.

3. Urgent Consults

- If patient requires urgent cath lab procedure then on call IC called.
- If patient doesn’t require urgent procedure then night call general cardiologist called.
- The contacted cardiologist chooses the most appropriate service. If it is the floor service then patient is assigned to the night call cardiologist’s team.

Sign Out:

1. Floor sign out is as needed (CVICU sign out is scheduled/expected)

2. NP calls appropriate service fellow with any required updates or new patient issues between 6-6:30 am.

Floor Services Patient Allocation Algorithm

Overnight Consults

1. If the overnight attending is contacted about a patient then the patient is assigned to that attending's service.
2. If the patient's primary outpatient cardiologist is on a floor service that patient is assigned to their service.
3. Reconsults are assigned to the prior team taking care of them. If the attending/fellow have rotated off service then reconsults just go to next up service.
4. All overnight consults are split equally between the two teams. If there is an odd number of consults the team with the lowest census gets the extra consult.

Floor Services Patient Allocation Algorithm

Day Consults

1. All new consults are given to each team in an alternating fashion.

2. If the patient's primary general cardiologist is on service the patient is assigned to that service.

3. Reconsults go to the previous team taking care of the patient (unless they have rotated off service).

4. Census should be updated real time. If a patient is discharged they should be deleted from the list. If you sign off on a patient the "pass" box needs to be clicked on CORES.

5. The Short call team will stop taking new consults at 4 pm. The long call team will take consults until 6 pm.

List Equalization:

1. If one team's census is >5 more than the other team then the team with the lower census will receive 2 new consults in a row.
2. If one team's census is >8 more than the other team then the team with the lower census will receive 3 consults in a row.

On Call Cardiologist

Day (6 am to 6 pm)

1. Acker Service fellow/attending take calls from the ED/outside transfers for patients requiring ICU admission or STEMIs.
2. Long Call floor service attending takes all other call. If long call floor service is called directly about a patient then that teams sees the consult (even if not next up)

Night (6 pm to 6 am)

1. Interventional cardiologist on call takes calls regarding STEMIs or any patient requiring urgent cath lab procedure.
2. Night call generalist takes all other calls including cross coverage of Acker service patients

Day STEMI (6 am to 6 pm)

STEMI Activation

1. Acker Service Fellow/Attending Evaluate patient.

2. If true STEMI the cath/PCI is done by the back up IC and then patient assigned to Acker service. Acker service does the H&P. MCC consulted and MCC takes over as primary service

3. If not a real STEMI

- Patient needs cardiology and is going to an ICU (Acker Service)
- Patient needs cardiology but is going to the floor (consult floor service algorithm followed)
- Patient does not require cardiology (no service assigned)

Night STEMI (6 am to 6 pm)

STEMI Activation

1. Fellow (6 pm to 8 pm) or NP (8 pm to 6 am) evaluate patient and communicate with on call IC.

2. If true STEMI the cath/PCI is done by the on call IC and then patient assigned to Acker service. On call IC assumes care for that patient for the remainder of the evening. MCC consulted and requested to take over as primary. Fellow/NP adds patient to CORES list and makes their “status” new.

3. If not a real STEMI

- Patient needs cardiology and is going to an ICU. NP/Fellow do a consult. (Acker Service Assigned)
- Patient needs cardiology but is going to the floor NP/Fellow do a consult (Floor service assigned)
- Patient does not require cardiology (no service assigned, no consult performed)

Patient Ownership after Discharge

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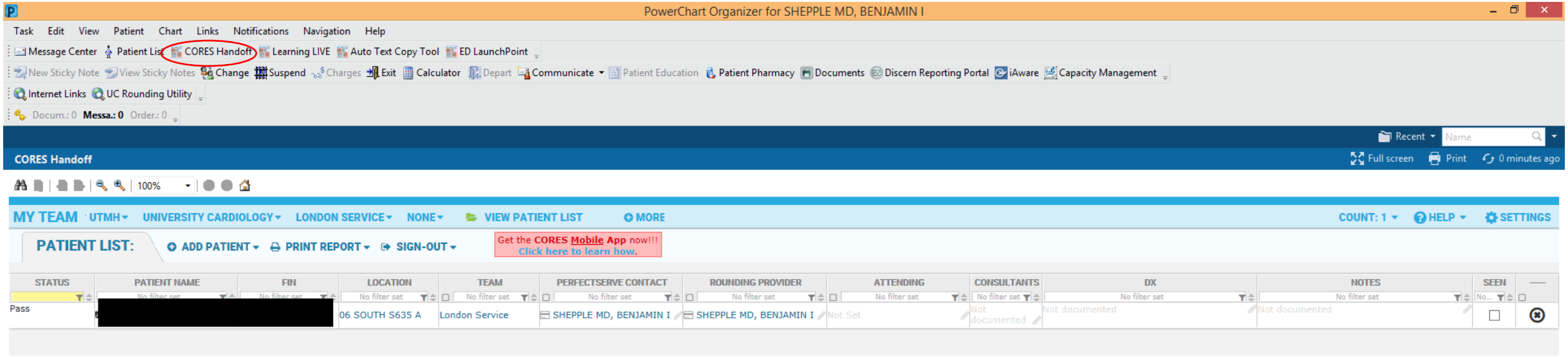
1. If the patient already had an assigned cardiologist prior to their admission they will follow up with that assigned cardiologist after discharge.
    a. If there is a reasonable clinical reason for the follow up to go to the physician on service, the physician will request a transfer to them.
        i. Ex: Dr. Shepple saw a patient for HTN 5 years ago and they didn't follow up. The patient was then admitted with Dr. Overly for a STEMI and needs a staged PCI as an outpatient.
2. If the patient is unassigned they will be assigned to the physician that admission who was most involved in their care.
    a. The discharging physician will decide who the patient will be assigned to after discharge.
    b. If the discharging physician is assigning the patient to someone other than themselves they need to notify the other physician by email/flag.

CORES


PowerChart Organizer for SHEPPLE MD, BENJAMIN I
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