HMC Consultation-Liaison Service (CLS) Orientation for Residents

Welcome to HMC Consults! This orientation guide was designed to quickly acquaint you with the standard procedures on our service and to serve as a resource for the unique aspects of our role at HMC. We look forward to working with you.

Getting Started

Arrival: Please arrive on-site between 7:45 – 8am. The following tasks should be completed every AM:

- Print out daily CORES census sheet with enough double sided copies for the entire team (10-12). Use "Psych Sign Out" report and sort patients by Gravity. (Medical Student can help with this.) *Please print to the printer in the mailroom (5EC01), instead of the printer in the CL room. All large printing jobs should be printed to 5EC01, due to a hospital-wide cost saving measure.*

- Update the CLS white board with your contact information and new patients from the night or weekend prior.

- Check the C/L office voicemail: The number is 744-9800. Mailbox number is 5927. Password is 333111.

AM Rounds: Start at 8:30am, with a goal of ending at 9:15am. For each patient you are following, give a brief summary; clarify if he/she will be seen that day, and with which attending. At AM Rounds, discuss any scheduling needs for the day (clinic, personal needs, etc).

PM Rounds: Start at 1pm (2pm on Thursdays) and end in about a half hour. Keep presentations brief and focused. Discuss any new developments, new patients, and challenges, but try not to repeat information that was already covered in AM Rounds.

Seeing Patients: After AM rounds, we break off to see the patients. The attending may or may not decide to see every patient with you, but you should plan to see all of your patients unless we decide otherwise. Enter a note into ORCA after every consultation encounter and send notes to the attending. New patients are divided up as they come in throughout the day. You should be prepared to see 1 new consult on your clinic day and 2-3 new consults on your non-clinic days (some days this may be more).

Initial Notes: For all CLS notes, use "**Consultation – Inpt**" as the folder header, NOT "Psychiatry – Inpt" or "Psychiatric Emergency Services."

- For billing, there now needs to be a separate ID and CC line. The ID line should include a brief statement about who consulted the Psychiatry CLS (team and attending name) and what the question is (for example, "suicide risk assessment"). ***This is very important for billing**!
- Comprehensive general medical ROS must be included for the note to be billable.
- All components of mental status exam need to be included for billing.

- Be sure your Assessment is not just a copy-paste job from a prior CL note or PES note but your own biopsychosocial formulation.
- Make your recommendations brief, clear and specific.
- Please send all notes to the designated attending for signature.

Progress Notes: Carry-over the original question from the ID/CC line of the Initial note to all Progress notes. Each progress note requires a 2-point ROS. Update the patient's formulation and plan as the case evolves. Please CC all progress notes to the attending with whom you are staffing the patient, so they can sign the note.

Documentation and Medical Students: We are lucky enough to have multiple medical students rotating on our service! Medical students can write their own notes but the only components of the medical student that count towards billing are review of systems, past medical history, past psychiatric history, social history and family history. Residents should make an addendum to the medical student note that includes HPI, MSE, assessment and plan, diagnosis and name of the attending.

CORES & Signout: CORES is our primary means of tracking vital patient information, so keep it updated as the cases evolve, and remove information that is no longer relevant. Be particularly attentive to issues of who has active ITA holds, who should be referred to the MHPs, what to do if a patient wants to leave overnight, and what to do about agitation. If you have a short day because of clinic, please be sure to sign-out to the other resident, and update CORES with a covering co-resident (or alternatively the fellow) so that they can update the team on afternoon rounds. When you attend didactics, please keep yourself signed in as the contact on CORES, so you can answer questions while at didactics.

- Between 4:45 and 5 PM, one resident should print the teams CORES and take it to sign out in the inpatient resident room. If you cannot find the PES resident, page them or take sign-out to the PES. Our service operates for new consults up until 5pm so be prepared to stay in-house until then.

Admission to Psychiatry from the CL Service: The CL and primary team's social workers will help facilitate/coordinate the pre-admission (with respect to locating an appropriate bed, navigating insurance, etc). Residents are responsible for the following: One a bed has been secured and the patient is cleared for discharge and re-admission (note, this is not a "transfer" but a full discharge from the med/surg service and readmission to psychiatry):

1) Contact primary team and request discharge medication reconciliation and a discharge summary be completed;
2) For patients being admitted to HMC/UWMC psychiatry, after a) the primary team completes the med reconciliation and an up-to-date treatment plan is available and b) a pre-admit encounter has been created, generate and sign (but do not initiate) admission orders in ORCA under the pre-admit encounter.
3) Verbally sign-out patient to the resident covering the inpatient team/service and establish responsibility for updating CORES once the admission is complete (as appropriate for inpatient sign-out, as opposed to CL signout.)

Teaching Rounds: 9:15 – 9:45am (Tuesdays and Fridays at least; if ambitious can do a "brown bag" 50 min Wednesday presentation).

- 15 – 20 minute presentations on core or interesting C/L topics.
- Everyone attending our rounds should participate (Attendings, Residents, Students, Pastoral Care, Rehab Psych). **RESIDENTS SHOULD SIGN UP TO GIVE ONE PRESENTATION**
- Presentation: You can fulfill your required presentation for the rotation on this service. It can be general psychiatry, but consultation oriented would be preferred. Ask an attending early in the rotation if you have an idea for a presentation.

Education Progress Plan: Residents should complete an education progress plan at the beginning and then the end of their rotation. This can be completed with an attending who is frequently on the service. It's a great way to organize your goals for the rotation and provides structure for feedback.

Consult Fellow: The CL Fellow is viewed as a junior attending on our service rather than a fifth-year full-time consult resident. Over the academic year, our fellows will be moving more into staffing roles. For this reason, unless our team census is extraordinarily high, we expect each patient followed by the CL fellow also to have a resident following.

Clinic/Vacation/Other Absences

**Please inform the chief resident of any times you will not be on-service, so this can be added to the team schedule.*

- **Clinic:** Residents are excused in the afternoons on their clinic day. In the morning, they are expected to see new and follow up patients, round with the team and write notes.
- **Vacation:** Before your rotation, vacation requests and other scheduling matters should be discussed with the C/L chief resident <u>at least 30 days in advance</u>. Y<u>ou must coordinate with your fellow residents</u> because they will be covering for you while you are away. In general, it is easier to leave the service when staffed by 3 residents (harder when only 2). Also, please do not leave all vacation time to the end of the year. Please reference the vacation policy or ask Liz Koontz for more information.
- **Sick:** If you are unexpectedly ill, call the team room, 744-5927, in the morning to inform the team of your absence and communicate any signout on your patients. If you are not able to reach someone at that number, please page one of the attendings. Please report your absence to the residency office for their records.
- **Supervision:** During the first week of your rotation, you will be assigned a primary supervising attending. Please coordinate with this attending to meet for 30 – 45 minutes during the first week to review the four areas of ownership skills and what your goals will be for the month. It is expected that you and the attending meet at least once weekly to review how things are going. That attending will be your primary evaluator with input from the other attendings and team members.
- **Off Ward Clinic Supervision:** Please make an effort to coordinate off ward supervision (generally psychotherapy supervision) with your resident colleagues such that there are as few gaps in coverage as possible. It is part of professional development and good practice to make sure that there are people available to cover when you are out. With that noted, off ward supervision is required so please let us know if there are conflicts you need help sorting out.

Off Ward Supervision Policy:

1) If you have supervision that starts at 3pm or later, we will not expect you to return to HMC, but please sign out to your co-residents before you leave, and *call to check in* with your co-residents after your supervision, to make sure there are no residual work that you could help with or questions that you may be able to answer.

2) If you have supervision that starts any time before 3pm, we will expect you to return to HMC to finish out the day on the service as usual. Even coming back for the final hour is very helpful for late consults and signout.

Miscellaneous Info

- Phone: Need to dial "9" then local number
- Fax Number: 206-744-3455. The fax machine is in the main CLS area.
- When a patient is in police custody, you cannot contact their outpatient providers, family members or significant others. This is a safety issue. If you have any questions about who you can and cannot talk to, ask your attending.

Other Members of Our Team

- **Carrol Alvarez, RN – pager 989-0738.** Carrol Alvarez is a clinical nurse specialist who provides staff and patient care, and interfaces this with education about a variety of issues including patient and staff management skills. She provides assistance in managing difficult staff and patient interactions, developing Care Plans, etc.
- **Cindy de la Maza, MSW, LICSW – 744-2170/pager 206-989-6937** Cindy provides social work coverage and support for our service. She offers help with psychiatric discharge planning, transfer to other psychiatric facilities when HMC is full or not a preferred provider, referral for ongoing outpatient psychiatric care, community resource information, consultation re CDMHP referrals and the ITA, and other specialized resources. Cindy also obtains authorization for voluntary patients who are transferring to inpatient psychiatry; however, if she is unavailable, then residents may be asked to assist with this to facilitate transfer. Cindy is the primary social worker for patients admitted to 5 Medical Maleng (5MM).
- **Chris Dunn, PhD/Barb McCann, PhD .** Drs. Dunn and McCann are Professors in the department with expertise in motivational interviewing, CBT, and other evidence based psychological interventions. They provide weekly supervision to the psychology resident. Dr. Dunn is the primary clinician on the Addiction Intervention Service, a program designed to support the American College of Surgeon mandate (based on research from HMC) that every trauma patient be screened for substance abuse and provided a brief, evidence-based intervention.
- **Melissa Hanbey.** Melissa is the administrative support for the service. She also serves a large role in the administrative feat that is managing the King County ITA process for HMC. She keeps a log of all consults for quality improvement purposes. We will update you with changes to this work through the month.
- **Psychology Resident -- pager 994-0498.** Psychology residents do four month rotations on the CLS. They attend rounds, follow patients, write notes, keep CORES updated and generally function like psychiatry residents with some notable differences. At times, a psychiatry resident

may need to help the psychology intern clarify if a patient truly is "medically clear" with the primary team or write orders if the patient is transferring to inpatient psychiatry.

- **Chemical Dependency Professionals (CDPs):** There are CDP's who are part of the HMC Addiction Service and see patients on the medical/surgical units either at our request (because they have been at rounds) or from direct referrals from the floors (the CDPs have their own pager). While also providing brief interventions, they also support referral and placement in formal CD treatment environments.

CLS Service Standards

- Be courteous and professional with everyone even when they are not being nice to you – it is about the patients, first and foremost!

- Be flexible and friendly with everyone on our team.

- Follow the UW Medicine **AIDET** Patients First Standards
  - **A**cknowledge
  - **I**ntroduce
  - **D**uration
  - **E**xplanation
  - **T**hanks and be appreciative; even if you have to abruptly end an encounter because of the patient's behavior

- **We do not turn down consults**. The patients eventually end up on our list. If there is a significant problem, let one of the attendings address it:
  - That said, triaging consults on a busy day is good clinical practice and teams are understanding as long as they know they have been heard.

- Dress and keep your work space as if expecting executive leadership to drop in.
  - Ties and white coats are not required but you need to dress professionally.
  - Some providers prefer a white coat because it is an important symbol, and helps patients and other teams to know your role.

GOALS AND OBJECTIVES FOR CONSULTATION-LIAISON PSYCHIATRY ROTATIONS

(http://psychres.washington.edu/policiesandprocedures/policymanual/policymanual.asp)

Goal: The goal of consultation-liaison psychiatry rotations is to provide organized instruction and supervised clinical experience in the evaluation of psychiatric and/or behavioral problems in patients on medical and surgical services, and in effectively consulting with their health care providers regarding their clinical management.

Supervision: Each resident must receive a minimum of two hours of direct supervision per week, at least one of which is individual, and must have direct access (in person or by telephone) to a supervising attending at all times.

Objectives: Residents completing consultation-liaison psychiatry rotations are expected to:

1. Patient Care

- Perform comprehensive, pertinent diagnostic interviews; collect data from important collateral sources; develop thorough, accurate differential diagnoses; formulate and carry out appropriate treatment plans
- Effectively assess behavioral conditions commonly seen on medical/surgical services (e.g. suicidal/homicidal statements or behavior, grief, depression, anxiety, personality problems, chronic pain)
- Perform complete and accurate assessments of patients' potential to harm self or others and of the level of psychiatric care needed after discharge
- Display the ability to adapt psychopharmacologic and psychotherapeutic treatments for medically ill patients

2. Knowledge

- Recognize and know the differential diagnosis of the psychiatric conditions most commonly seen in medical/surgical settings (e.g. delirium, depression, somatoform and factitious disorders, substance abuse and withdrawal)

3. Practice-Based Learning and Improvement

- Locate and critically appraise scientific literature relevant to patient care teach the rest of the team about literature findings, and use this information to improve patient care
- Regularly use information technology in the service of patient care
- Participate in practice-based improvement activities (CQI; e.g. case conferences, case reviews, quality improvement projects)

4. Interpersonal and Communication Skills

- Create and sustain effective therapeutic relationships with patients and families
- Display empathic listening skills and the ability to use both verbal and non-verbal communication
- Clarify the consultation request, identify important issues, clearly communicate findings and recommendations
- Display skills in liaison with medical/surgical services; help non-psychiatric providers to understand and manage psychiatric or behavioral problems in their patients

- Provide informative sign out to other providers caring for the patients he/she is responsible for (e.g. other consultation-liaison psychiatry team members, short call residents, night and weekend providers)

5. Professionalism

- Demonstrate respect for others, compassion
- Demonstrate reliable attendance and appropriate professional attire
- Demonstrate integrity, accountability, responsible and ethical behavior
- Demonstrate "ownership", i.e. taking responsibility to ensure that each patient receives excellent clinical care
- Demonstrate understanding of patients and their illnesses in a sociocultural context, including displaying sensitivity to the patient's culture, ethnicity, age, gender, socioeconomic status, sexual minority status, and/or disabilities
- Demonstrate concise and pertinent record keeping, and prompt completion of consult notes

6. Systems-Based Practice

- Display an understanding of legal issues involved in consultation-liaison psychiatry, including use of restraints, involuntary commitment, and competency/decisional capacity

7. Leadership

- Display effective team leadership skills, including the ability to triage, prioritize tasks, and delegate work as appropriate
- Display skills in teaching and supervising medical students

8. Educational Attitudes

- Display openness to supervision; accept constructive criticism
- Seek direction when appropriate; display eagerness to learn
- Display flexibility, self-awareness, and the ability to continuously improve one's clinical skills and practice based on feedback

Questions you should be able to answer about your patients at rounds

For Established patients (ones we have been following):

1. Who is the primary team?
2. What do the nursing notes say from overnight?
3. What does the primary team think the diagnosis is, especially for the issues we are consulted about (e.g. 'neurology believes the altered mental status is due to medication effects')
4. What is the medical status of the patient, particularly in terms of readiness for discharge vs. transfer?
5. What is the ITA or legal status of the patient, if relevant?
6. Are the vital signs stable? If not, what are they?
7. Are there new relevant labs or studies?
8. What are the results of other evaluations, such as PT/OT/Speech?
9. Is the patient taking his/her meds?
10. What are the prns given & how much?
11. How are any psychiatric symptoms or the symptoms/signs we are targeting with our management suggestions?
12. What are the recommendations of other consultants seeing the patient?

For New patients within first 1-2 days:

1. Who is the primary team?
2. What does the primary team think the diagnosis is, especially for the issues we are consulted about (e.g. 'orthopedics believes the lack of cooperation is due to depression')
3. What do the ambulance and/or police report say, if available?
4. What were the ED and/or PES course like? What meds given?
5. Did the patient have a urine toxicology on admission?
6. Does the patient have an outpatient psychiatry team/tier?
7. What do we know about their baseline mental status?

Please note that although you do not need to present all of this information during rounds, you should be ready to answer these questions if asked.

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HIPAA Privacy Rule Disclosures to a Patient's Family, Friends, or Others Involved in the Patient's Care or Payment for Care

	Family Member or Friend	Other Persons
Patient is present and has the capacity to make health care decisions	Provider may disclose relevant information if the provider does one of the following: (1) obtains the patient's agreement (2) gives the patient an opportunity to object and the patient does not object (3) decides from the circumstances, based on professional judgment, that the patient does not object Disclosure may be made in person, over the phone, or in writing.	Provider may disclose relevant information if the provider does one of the following: (1) obtains the patient's agreement (2) gives the patient the opportunity to object and the patient does not object (3) decides from the circumstances, based on professional judgment, that the patient does not object Disclosure may be made in person, over the phone, or in writing.
Patient is not present or is incapacitated	Provider may disclose relevant information if, based on professional judgment, the disclosure is in the patient's best interest. Disclosure may be made in person, over the phone, or in writing. Provider may use professional judgment and experience to decide if it is in the patient's best interest to allow someone to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information for the patient.	Provider may disclose relevant information if the provider is reasonably sure that the patient has involved the person in the patient's care and in his or her professional judgment, the provider believes the disclosure to be in the patient's best interest. Disclosure may be made in person, over the phone, or in writing. Provider may use professional judgment and experience to decide if it is in the patient's best interest to allow someone to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information for the patient.