Orientation to Inpatient COVID-19 Care

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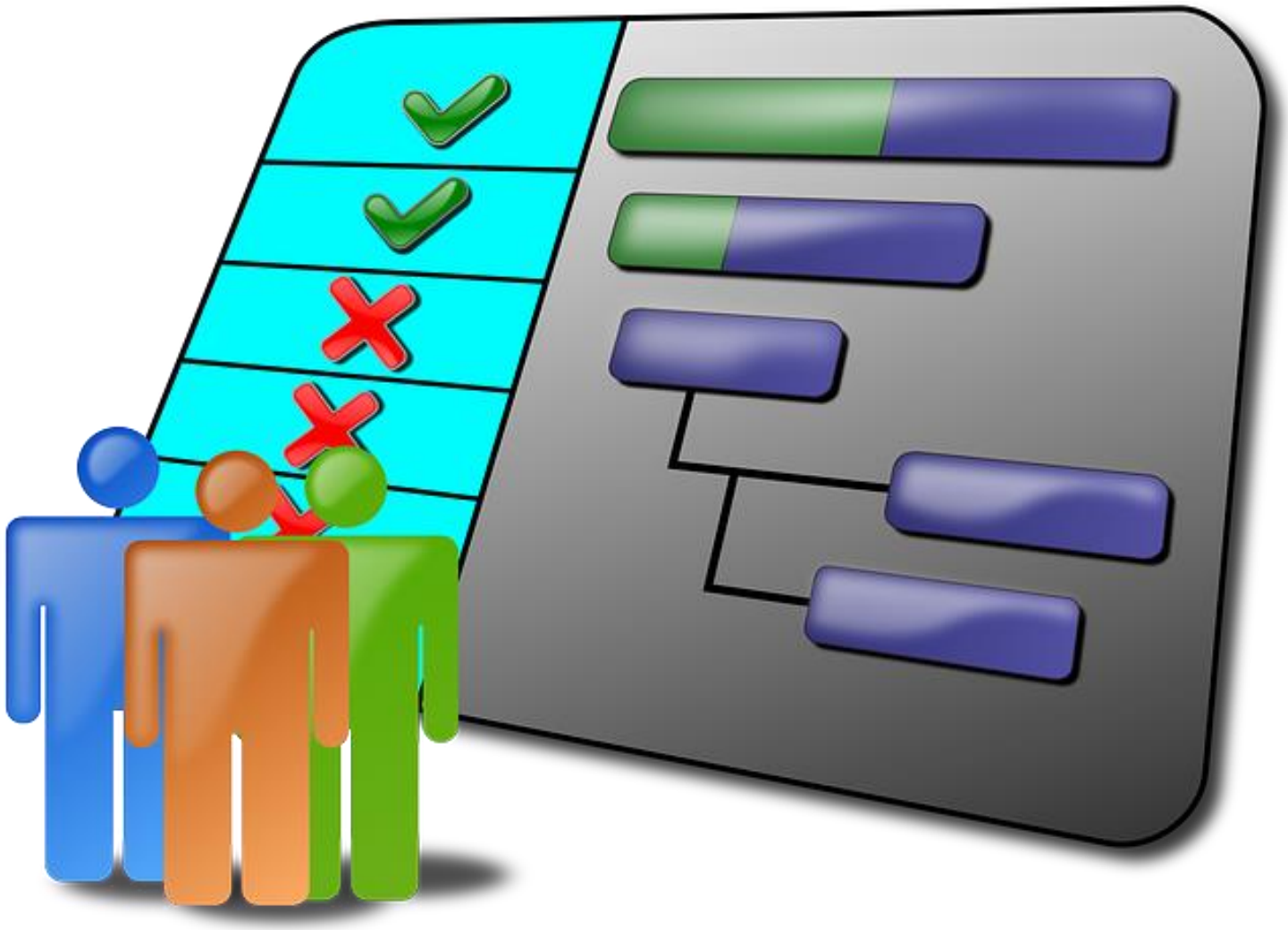


HOSPITALIST STRUCTURAL OVERVIEW & WORKFLOW

NITENDRA AGARWAL,
MD, MPH, FACP, FHM

Hospitalist Team Structure (Non-Surge)

TRIAGIST

Gatekeeper- Takes calls from ED, ICUs, Clinics, outpatient facilities

Helps with rapid assessments and assignment of patients to teams

DIRECT CARE TEAMS (A-G)

1 Hospitalist + 1 APP on each team

TEACHING TEAMS

Work with 1 Upper Level (PGY-2/PGY3) resident+ 2 Interns

TRANSPLANT TEAMS 1 & 2

1 hospitalist per team caring for half the transplant patients.

Night & Cross Cover Staffing and Roles

Night Attendings (2)

- Triage requests from the ED
- Help with admissions and cross cover
- Staff with residents and interns

Night Resident (1)

- Admissions
- Medicine Consults

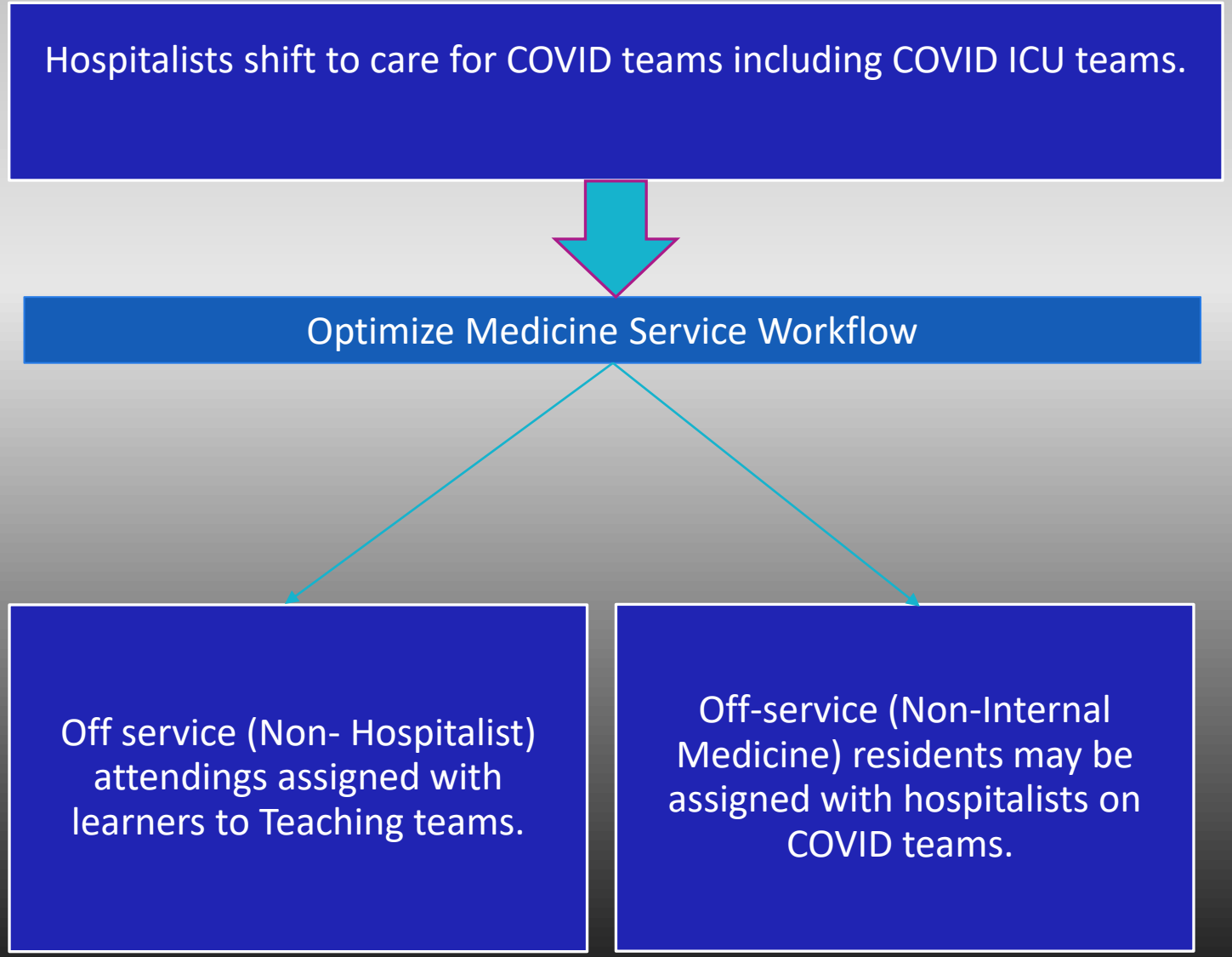
Night Interns (2)

- Admissions
- Cross Cover on Teaching Teams

Night APP (1)

- Cross Cover on Direct Care Teams

SURGE PLAN


Hospitalists shift to care for COVID teams including COVID ICU teams.
Optimize Medicine Service Workflow
Off service (Non- Hospitalist) attendings assigned with learners to Teaching teams.
Off-service (Non-Internal Medicine) residents may be assigned with hospitalists on COVID teams.

Typical Day On Teaching Service

DAY STARTS 7-8AM WITH REVIEW OF OVERNIGHT EVENTS AND ANY NEW ADMITS. FLASH ROUNDS BETWEEN 8:30-9:00A

TARGET IS FOR ROUNDS TO BE DONE BY 11AM

EACH TEAM HAS AN AFTERNOON FLASH ROUNDS TO PLAN DISPOSITION FOR THE NEXT DAY.

STAFF NEW ADMISSIONS WITH YOUR TEAM UNTIL THE END OF YOUR SHIFT

CALL SHIFT UNTIL 8PM (EVERY 6TH DAY)

STAFF NEW ADMITS ASSIGNED BY 6PM

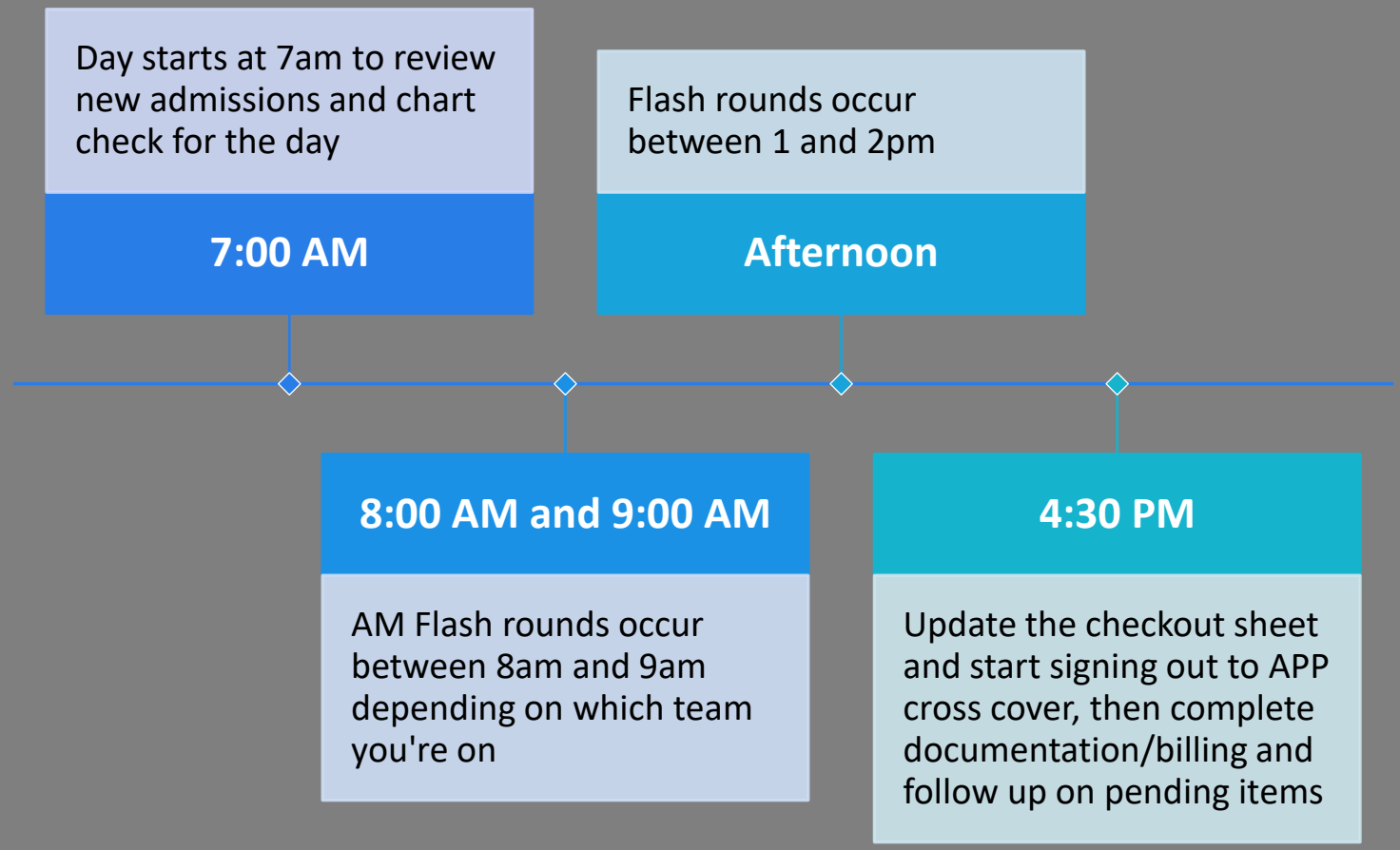
NON-CALL / REGULAR SHIFT: STAFF NEW ADMITS ASSIGNED TO YOUR TEAM BEFORE 4PM

Case management / Power Through Flash rounds

Goal: Help with workflow and facilitating discharge by coordinating transition of care to discharge facility, setting up discharge transportation, home health, etc.

- Morning: Discuss discharge status for each patient on the list. Anticipate and address any potential barriers to discharge. Prioritizing ancillary services such as PT/OT/ST to a patient if these services are rate limiting factors to discharge.
- Afternoon : Follow up on any issues and anticipate patient to discharge the next day

Typical day on Direct Care Team



Caring for COVID-19 at UHS

HOLLY DAY, MD

Common Presentations

Symptoms:

- Most common: Cough, fever, malaise/fatigue
- Additional symptoms: Myalgias, nausea or diarrhea, change in smell/taste
- Alarm Symptoms: Shortness of breath, chest pain

Exposure History:

- High-risk exposure history: Healthcare workers, recent travel to an area with high transmission, known exposure to a PUI or COVID+ patient.
- Community transmission is occurring in San Antonio

Differential Diagnosis

COVID-19

Pretend you were seeing the patient 4 months ago. What would you have suspected back then?

Differential diagnosis for FEVER and/or SHORTNESS OF BREATH

- Community acquired pneumonia – viral vs. bacterial
- COPD / Asthma Exacerbation
- Volume overload – acute heart failure, renal failure, cirrhosis
- Pulmonary Embolism
- Myocardial Infarction
- Malignancy
- And more…

Routine Studies

COVID-19 test

Respiratory Viral PCR

Sepsis work-up: blood cultures, urinalysis w/ culture, lactic acid

Pneumonia work-up: sputum culture, procalcitonin, legionella antigen

Inflammatory Markers: D-dimer, ESR/CRP, ferritin, LDH, CK

CMP, CBC with differential

Imaging: CXR or CT on admission

EKG on admission

Deciding Level of Care

Recommend Critical Care Consult if:

- High or rapidly-increasing oxygen needs (>4-6 liters O2)
- Respiratory rate >30 and/or respiratory distress
- pH <7.3 with or without hypercapnia
- Hypotension unresponsive to appropriate fluid bolus

Target floor patients to a negative-pressure room if:

- They have any of the above findings, or additional clinical information that makes them high risk for needing intubation
- They have conditions that make them likely to need aerosolizing procedures (OSA on CPAP/BIPAP, tracheostomy, etc.)

Management: Treatment and Supportive Care

Pretend you were seeing the patient 4 months ago. How would you have treated them then?

- Antibiotic coverage for CAP and/or sepsis: Start now, de-escalate later

COVID-19 Specific Care: Subject to Change

- Oxygen therapy: Via simple nasal cannula. Generally avoid high-flow nasal cannula, CPAP or BIPAP.
  - Consider self-proning for floor patients
- Hydroxychloroquine + Azithromycin can be considered for confirmed cases in immunocompromised patients and patients with high risk comorbidities
- Infectious Disease guides enrollment in Remdesivir trial, experimental use of Tocilizumab, Kaletra, or convalescent plasma
- Family communication

Discharge

Clinical stability:

- No need for supplemental O2, or return to baseline O2 usage*
- Fever controllable with Tylenol

Appropriate home conditions for safe isolation

- Separate room in the household for patient, ideally with separate bathroom
- Access to necessities (food, medicines, PPE for patient's caregiver, etc.)
- No household members with high-risk comorbidities (age >65, COPD, cardiac disease, immunosuppression)

Discontinuing Isolation

- 7 days since symptom onset
- PLUS 3 days of no fever (with no fever-reducing med use)
- PLUS significant improvement in symptoms

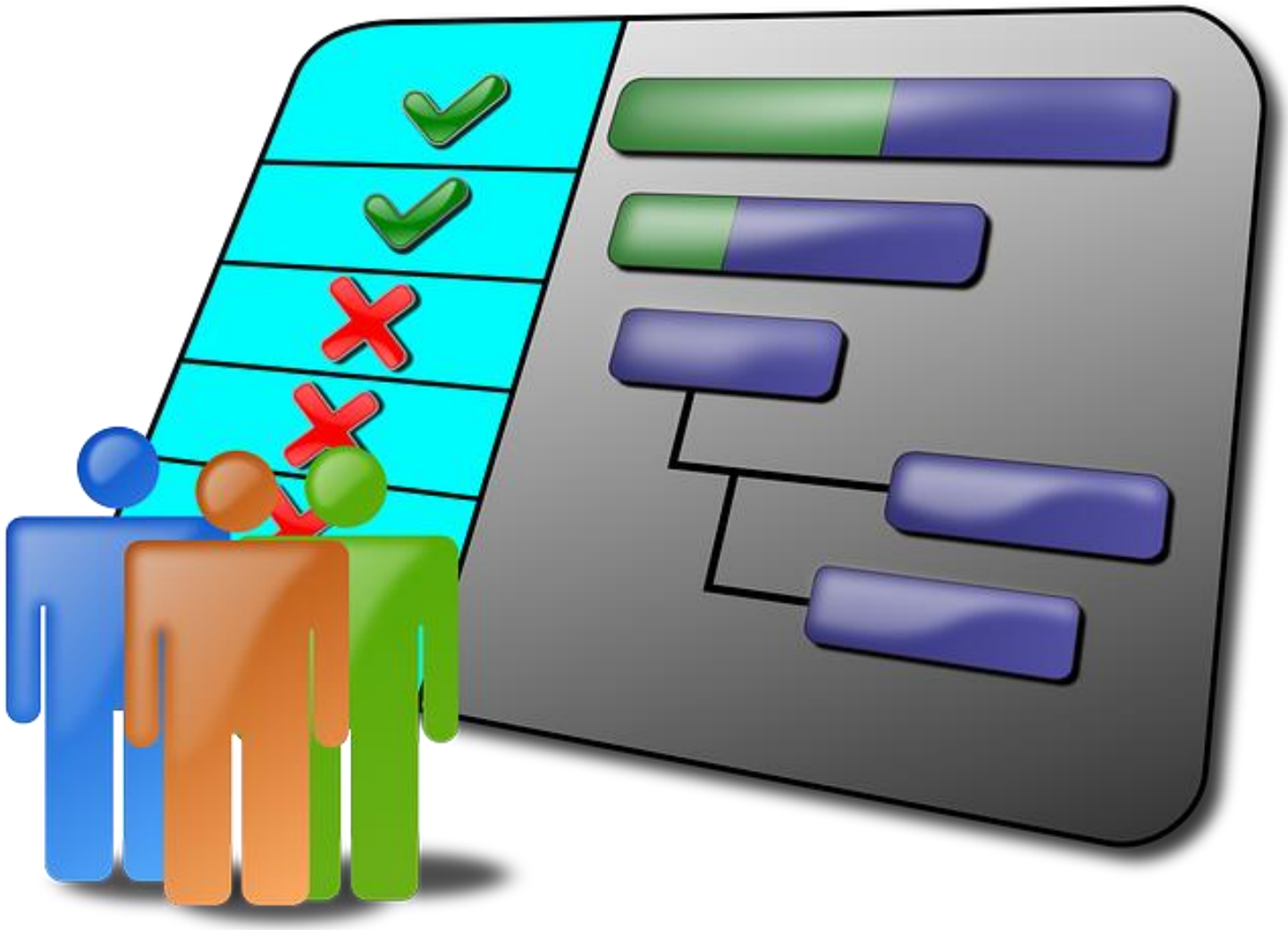
Facing Fear

Will I be expected to perform beyond my capabilities?

What risk does this exposure pose to me and my household?

Remember:

- You are **never** alone
- The vast majority of people who get this infection DO SURVIVE
- The patient is more afraid than you are
- Taking care of sick, scared people is what we trained for



VIDEO TUTORIAL: ADMISSION PROCESS

A Video Walkthrough: Admission & Daily Tasks

RAUDEL RODRIGUEZ, MD

Hospitalist-In-Time Orientation

Part I: Admission, Chart Check, and Daily Tasks

Questions?