



Empowering hospitalists.
Transforming patient care.

Overview of Inpatient Medicine

Tyler Anstett, DO, Assistant Professor, University of Colorado Anschutz Medical Campus
Megan Brooks, MD, MPH, Assistant Professor of Medicine, Duke University Health System



No Disclosures

Agenda

1

Cover a broad overview of inpatient medicine.

2

Apply the broad overview to admission, daily care, and discharge.

3

Case studies.

Learning Objectives

- 1 Describe the three primary objectives of inpatient medicine.
- 2 Apply the objectives of inpatient medicine to tasks of admission, rounding, and discharge.
- 3 Prevent harm.

“Since the inpatient setting involves the most intensive use of resources, it is the place where the ability to respond quickly to changes in a patient's condition AND to use resources judiciously will be most highly valued.”

Robert M. Wachter, M.D.
Lee Goldman, M.D.
NEJM, 1996

Objectives of Inpatient Medicine

- 1 **ACUTE condition diagnosis and management**
- 2 **Prevent harm during hospitalization**
- 3 **Progression to the next phase of care**

**ACUTE diagnosis
and management**

Triage

Stabilize

Treat

Prevent harm during hospitalization

The safest hospital bed is an empty one.

One in every ten patients are harmed while receiving hospital care.

Adverse events due to unsafe care in the Top 10 of leading causes of death and disability across the world.

**Progression to the
next phase of care**

**Discharge planning starts on
the day of admission.**

Apply the objectives of inpatient medicine to tasks of admission, rounding, and discharge.

ADMISSION

ACUTE diagnosis and management

Triage

Determine what level of care is appropriate.

Stabilize

Initiate therapies as soon as possible.

Make contingency plans.

Treat

Get collateral (PCP records, etc.)

Call consultants for definitive therapies.

ADMISSION

**Prevent harm
during
hospitalization.**

Medication reconciliation

Use the resources available to you.

Think about both upcoming procedures and potential for withdrawal.

Prophylaxis

Not just VTE -- also consider sleep hygiene, mobilization.

ADMISSION

Progression to the next phase of care.

Discharge planning starts on the day of admission.

Assess ability for self care

- mobility
- access to medications
- access to nutrition

Assess support system at home

Contact family

ROUNDING

**ACUTE diagnosis
and management**

(Re)Triage

Determine what level of care is appropriate.

DIRES, DISCHARGES, DECISIONS

Treat

Call consultants (early) for definitive therapies.

ROUNDING

**Prevent harm
during
hospitalization.**

Medication Review

Are they getting what you think?

Has anything been omitted or added?

Assess Function

Mobilization

Sleep hygiene

Diet

Bathroom

ROUNDING

Progression to the next phase of care.

Discharge Early

DIRES, DISCHARGES, DECISIONS

Multidisciplinary Team

Review therapy notes.

Keep team up to date on discharge readiness.

Discuss discharge plans DAILY.

Support System at Home

Call families to keep them informed.

DISCHARGE

ACUTE diagnosis and management

Discharge Criteria

Reliably administer self-care or with sufficient support to return home.

DO NOT have to be “cured” but rather on the road to recovery.

DISCHARGE

Prevent harm
AFTER
hospitalization.

Medication reconciliation

Verify the discharge instructions.

Outpatient Communication

Specific follow up items.

Medication changes with rationale.

If going to a facility -- ensure discharge summary is sent PROMPTLY.

DISCHARGE

Progression to the next phase of care.

Plan Early

DO NOT wait for the day of discharge to coordinate plans.

Be a bridge.

Ensure PCP follow-up.

Follow up on labs before sees PCP.

Call the patient after discharge.

Case Studies

Case # 1: Focus on Acute Care

53 yo amazon delivery driver presented to the ED with acute dyspnea and chest pain.

Found to have submassive bilateral PE with mild right heart strain and acute hypoxic respiratory failure. She was admitted to the ICU for close hemodynamic monitoring. She was started on anticoagulation and transferred to your service on the medical floor after 24 hours.

She has improved steadily but still requires 2 lpm oxygen with exertion to maintain o2 sats > 90%.

Case # 1: Focus on Acute Care

She has improved steadily but still requires 2 Lpm oxygen with exertion to maintain o2 sats > 90%.

What is your next step in management?

- A. Keep patient in the hospital for continued monitoring because he was only admitted just over 24 hours ago.
- B. Keep patient in the hospital until her oxygen requirement resolves as this is not likely to be a long-term need.
- C. Ensure patient has insurance coverage for oxygen, and if so, discharge home on oxygen with PCP to titrate off as an outpatient.
- D. Discharge patient without home oxygen as it is only with exertion, likely to be temporary, and an overutilization of resources.

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Case # 1: Focus on Acute Care

Take-Home Point

Discharge patients as soon as it is safe for them to leave the hospital.

Case #2: Avoid Inpatient Harm

75 yo man with systolic heart failure presented with dyspnea and 15 lbs weight gain after relying prepackaged foods since his daughter is unable to cook for him during social distancing orders.

On admission, a foley catheter was placed because he requires a walker for ambulation and he was getting substantial diuresis. He was also placed on telemetry out of concern that he may develop electrolyte abnormalities, though electrolytes were normal on admission.

Case #2: Avoid Inpatient Harm

Hospital Day #3

Doing well and lost 10 lbs with plan for possible discharge the following morning after transition to oral diuretics.

2000: became agitated and complained of inability to sleep. Covering provider ordered zolpidem for sleep.

Around 3 am, he was disoriented and stood to try to urinate and tripped over his catheter and struck his head.

Case #2: Avoid Inpatient Harm

Hospital Day #4

Patient continued to have waxing/waning mental status consistent with delirium. CT head negative for any hemorrhage. UA revealed UTI due to the catheter (CAUTI). He remained hospitalized for 5 more days due to treating UTI, worsening delirium and ultimately was discharged to nursing facility due to increased debility.

Case #2: Avoid Inpatient Harm

How might have this been prevented? (SELECT ALL THAT APPLY)

- A. It couldn't. Patients with many co-morbidities have worse outcomes.
- B. Do not insert urinary catheter for diuresis unless unable to get accurate I/Os or having skin breakdown.
- C. Do not order zolpidem or other sedative-hypnotics for elderly patients in the hospital.
- D. Do not continue telemetry unnecessarily in patients with stable electrolytes and no unstable arrhythmia.
- E. Discharge patient sooner – no need to wait for transition to oral diuretics.

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Case # 2: Avoid Inpatient Harm

Take-Home Point

The hospital poses many risks for harm, particularly for the elderly. Avoid unnecessary interventions.

Case # 3: Progress to next phase of care

A 65-year-old Veteran is transferred to your hospital for acute COPD exacerbation.

Patient did not practice social distancing and continued to attend regular meetings at his local VFW. On admission, he had an oxygen requirement up to 4L from his baseline of 2L, chest x-ray revealed hyperinflated lungs but no focal infiltrates. **COVID-19 testing was positive.**

Case # 3: Progress to next phase of care

Hospital Day #3

After treatment with metered-dose inhalers and oxygen therapy, patient is slowly improving but still with dyspnea on exertion and intermittent wheezing. Inflammatory markers are now downtrending.

You suspect the patient may be able to discharge home within one to two days.

Case # 3: Progress to next phase of care

Hospital Day #4

The COVID unit is across the hospital from your typical unit so you elect to see him last to save walk time. You enter his room at 11am. The patient feels ready to go home and is eager to leave. He is at his baseline oxygen requirement of 2L and he is no longer wheezing or coughing.

You take care to again review his home medications, you send an e-prescription albuterol as well as PRN cough medication for comfort to your in-house pharmacy.

You carefully write his discharge instructions including quarantine instructions and have arranged for follow up with his PCP. Feeling that this is a safe and well-planned discharge, you wish the patient well and leave the room.

Case # 3: Progress to next phase of care

Hospital Day #4

Two hours later you receive a call from the nurse that the patient is not able to get home as he cannot take a cab (due to COVID-19+), does not have portable oxygen tank, and prefers to get his medications filled at the VA.

You spend the next several hours faxing forms to the VA to cover his medications and get respiratory therapy to see the patient to provide a portable oxygen tank.

However, because the patient does not have a ride, the hospital must arrange for ambulance transportation but this cannot happen until the morning.

Case #3: Progress to next phase of care

How might have this delay been prevented? (SELECT ALL THAT APPLY)

- A. It couldn't. Discharges are complicated and dangerous -- care must be taken to prevent errors.
- B. Discuss discharge plans with Case Management daily.
- C. Asking the patient where they want their medications filled before the day of discharge.
- D. Rounding on the patient earlier in the day in the anticipation of discharging.
- E. Demanding the pharmacy provide a medication voucher.

Case #3: Progress to next phase of care

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Case # 3: Progress to next phase of care

Take-Home Point

Discharge planning starts on the day of admission.

In Summary:

Inpatient Medicine

Focus on the acute medical condition

Triage, Stabilize and Treat.

Prevent Harm

At admission, during hospitalization and at transitions in care

Progress to next phase of care

Plan early, coordinate with case management and actively bridge to outpatient care providers³⁸

For more training...

Utilization Management and Triage Decisions on Admission
[Hospital Triage and Systems-Based Practice e-Module](#)

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COVID-19 Resources

SHM is actively monitoring the evolving outbreak of COVID-19 and is dedicated to supporting hospitalists. We will be continually updating our [resource page](#) with information developed by hospitalists and by other organizations.

In the interest of providing valuable information to those who need it, SHM has also opened all member-only content to non-members during this time.

Welcome To The SHM Learning Portal

The best place for hospital medicine-specific CME and MOC, the Society of Hospital Medicine Learning Portal is the premier way for hospitalists to stay up-to-date on clinical content, continue their education, and enjoy the convenience of online learning modules.

<https://www.shmllearningportal.org/>



Thank you