

# **Inpatient & Ambulatory Care**

**Combined Edition 2016**

***\*\*\* Edited for names/numbers for web***



Dearest class of 2019,

We are extremely excited to be your new classmates and are delighted to welcome you to the CCRMC family. All those things you've been told about the trials and growth you'll go through during residency—well, they're true. But we also believe that training here is a singular experience and adventure that you will look back on with fondness and wonderment.

What you hold in your hand is a tradition started by the residents of yore that we carry on today. It is not intended to be a repository of physicianship. You already have that in you. Consider this the CCRMC version of a Lonely Planet®, a guide meant to facilitate your desire to experience, grow, and learn.

This year, the inpatient and ambulatory care Scoops have been combined, with the idea that we as CCRMC residents operate in both the inpatient and outpatient world almost every single day.

Of course, don't forget that this guide is nothing compared to the resources that surround you: your fellow residents, attendings, nurses and other staff!

Happy Trails!

**THE 2016 SCOOP TEAM**

P.S. Please feel free to make your scoop your own – tear out needless pages, write things in the margins and extra pages, and think about all the changes you want to make when you design next year's Scoop!

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# Codes - redacted for web version

## Hospital Phone & Fax Numbers – amended for web version

Main hospital operator number: 925-370-5000

To call from outside: If extension starts with 5, then 925-370-####

If extension starts with 4, then 925-370-5200, extension ####

### Unplanned Absences – amended for web version

In ALL cases:

- Contact the Scheduler – Use cell phone first, especially on the weekends
- Contact the Residency Office -

Rotation Specific Instructions:

- **HospMed/GenSurg/ICU:** contact one of the 3rd years (i.e. on Medicine, contact the Med 3 resident) AND page your attending
- **OB:** call L&D and inform an OB attending
- **Nursery:** page and inform the pediatrician on-call
- **ER:** call the ER to inform the TEACHing attending listed on amion
- **CHO:**
  - Contact Eileen in the GME office
  - Contact your Senior Resident (if on inpatient) or the ED Attending (if on CHO UC or ED).

**All other rotations:** Contact your Attending or the Rotation Supervisor. If unknown e-mail residencysupport

Interpreter  
Language Codes  
00 – other  
01 – Spanish  
02 – American  
Sign  
03 – Cantonese  
04 – Mandarin  
05 --Vietnamese  
06 – Korean  
07 – Hmong  
08 – Cambodian  
09- Lao  
10 – Mien  
11 – Tagalog  
12- Tongan  
13 – Russian  
14 – Armenian  
15- Dari/Farsi  
16 – Hindi  
17 – Punjabi  
18 – Arabic  
19 – Mexteco  
20 - Thai  
etc (yes, there are more!)

# Residents – redacted for web version

## Staff – redacted for web version

### Resident Well-being

First off, we all know residency is exhausting and stressful. We want you to know, you have LOTS of support in place.

- If you are extremely exhausted and feel you need a break (whether this a 20 minute nap, an afternoon off, or day(s) off) please talk to a supervising resident or staff member.
- You can always get assistance from our behavioral medicine staff: Patty and Jessica .
- Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly encouraged. In general, the longer the nap the better, but even brief naps are beneficial. Naps can range from 10-120 mins. Preventative naps (in anticipation of sleepiness) can be used to bank sleep pre or post call. Replacement naps can be used in response to sleep loss.
- PLEASE remember that you may not ignore your clinical duties to take a nap.

### Educational Resources

- “Agile MD” app: Can be purchased for \$20 online: includes UCSF hospitalist app & ECG interpretation Cribssheets
- Pocket Medicine
- The Washington Manual
- The Harriet Lane Handbook
- Uptodate
- AAFP Summary articles
- National Comprehensive Cancer Network (great for percentages, survival odds, tx, etc)
- Reproductiveaccess.org

# Sign-Out

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## Every Patient Every day

Sign-out saves lives. It is a Joint Commission requirement that we verbally sign out each patient to the oncoming resident. It is also extremely helpful to the House Officer who takes care of your patients through the night. The expectation is that you signout ICU/IMCU patients to the ICU resident as close to 17:00 as possible. The sooner you signout your patients the sooner you don't need to respond to pages!!!!

### The ccLink process

1. Signoff notes should be updated by the primary team by 17:00 daily!
2. Find the Handoff tool within ccLink and type \*Hospitalist (or peds)
3. If the HO fails to receive a page or phone call from the departing resident, the HO should page the attending on the service to ask if there were any outstanding issues and to have the opportunity to ask questions about the service.

### Sign out tips

- **To-Dos:** If you ask the House Officer (HO) to follow-up on something (labs, imaging, exam findings), specify what you want done with that information. Examples:
  - "F/u on BMP, replete K as needed"
  - "F/u CXR, if concern for pneumonia start vanc & zosyn for HA-pna"
  - "Serial abdominal exams, if worsening pain, get CT scan and alert FMS registrar"
  - "Check net I/O at midnight. If not net -1.5 liters, give additional 40 mg IV Lasix"
- **If-Thens:** Leave specific "If...Then..." instructions based on your intimate knowledge of the patient. Assume the HO knows nothing about your patient (because they don't) and it will be much more difficult for the HO to assess a new finding on a patient or answer a nursing question/request. Think about what could happen overnight to your patients and what you would do about it if you were here. Then write that in your sign-out. If you are unsure, review with attending. Always helpful to remark on what to do if called about increasing pain, request for pain meds, and fever. Examples:
  - "If fever, check CXR. Consider aspiration pneumonia."
  - "If chest pain, take it seriously. Patient has known CAD, STAT EKG, ASA, Nitrate, cycle Tropics" or "If chest pain, patient has h/o chest pain with multiple negative work-ups. Likely doesn't need extensive work-up if exam is stable."
  - "If patient asked for pain med, NO IV opiates. H/o chronic opiate abuse. Try ibuprofen or Norco as last resort."
  - "If c/o anxiety, avoid benzos as patient is frail and prone to delirium"

# Admissions

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## GUIDELINES FOR ADMISSIONS

- Your pager rings '5973'. This means you got an admission!
- Call back as soon as possible to talk to the admitting ED Physician
- The ER trackboard will list the doctor 1st contact. **It is VITAL to place an admission order and also assign a doctor 1st contact** (daytime MOD places this, otherwise resident in swing/nights)
- Go assess the patient quickly (whether or not you start the admission). **Residents are expected to assess (not necessarily admit) the patient within 30 minutes.**
- Make your own evaluation of the patient's level of care — if you believe the patient may be at a higher level of acuity, do not hesitate to discuss this with an attending or senior resident.
- Use .medhp or .surghp for your med/surg H&Ps.

## ADMISSION STAFFING

- All admissions performed by an Intern after 5 & on weekends must be presented: preferably to a Senior Resident, though an attending is great too.
- **Med-Surg:** All patients should be presented to attending/registrar on duty in real time. With discussion, senior residents may present patients that were presented to them by interns IF they have physically seen and examined the patient.
- **Labor & Delivery:** All admissions to L&D are presented to the attending on call. All triages (even non-admitted) must also be presented.

## MEDICATION RECONCILIATION

This is an area of frequent errors that can jeopardize patient safety. The ED Nurse is supposed to put patient medications into the system (don't count on it), but you must also verify them yourself. DO THIS WELL.

## ADMISSION ORDERS

1. Click the "Admission" tab on the left
2. Click "med rec sign and hold" to complete admission orders
3. Go through process per your training
4. Use the premade order sets (ie. Medicine Admission, ICU Admission) and other order sets as applicable (Insulin sliding scale, high potency pain meds, sepsis, etc)
5. If you suspect that the patient is going to board in the ER, you can selective sign the more essential orders (e.g. meds, diet, IV orders) vs. the sign and hold order (e.g wound care, SW/PT/OT/DC planning)
6. Sign! Because you're a real doctor now.

# Procedure/Duty Hours Logging

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Remember to log things like CXR and EKG reading as well as 'procedures' like LPs and C/Sections. The list of required procedures is on the residency wiki. Logging hours is important and you **MUST** do it weekly.

## Instructions:

Go to: <https://www.new-innov.com/>

Institution: CCRMC

Click "Logger" in menu → "Procedures"

You'll need Pt ID, name, date of procedure, and supervisor.

# Discharges

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**ORDERS:** In discharge med-rec, type "discharge" into *order set*

**DISCHARGE SUMMARIES:** Complete AS SOON AS POSSIBLE (mandatory within 24 hours)  
Use the smartphrase **.surgdc** or **.meddc**

- The discharge summary should give an idea of why the patient was admitted, what happened during the hospitalization, the conclusions made, and ideas for follow up and future management. Be succinct.
- **Medications MUST be included in your discharge summary.** Think about what you would need to care for the patient in the clinic, or on a subsequent ER visit.
- Physical exam at time of DC is optional, but esp. important for abnl neuro exam, wounds, etc

## **FOLLOW-UP:**

- Interdisciplinary rounds coordinate the care your patients will need on discharge. Follow the schedule.
- If the patient is at high risk for readmission, consider scheduling a home visit. Page Dr. Stromberg to arrange home follow-up, especially for those with congestive heart failure (CHF), poor health literacy with complex medical problems, and the elderly.
- For CHF patients, be sure to include a discharge weight (or dry weight) in your d/c summary.

## **UNINSURED PATIENTS**

- Occasionally we will get uninsured patients who do not qualify for the County Health Plan or MediCal (especially undocumented patients), and therefore have no coverage for follow-up or medications.
- Please ensure to discharge these patients with medications that they can afford. This may mean choosing unusual medication regimens, or less than ideal choices that are better than no medications at all. The Walmart and Target \$4 lists can be accessed both from their pharmacy websites as well as the Epocrates drug formularies. Patients can also use Costco Pharmacy (whose prices are often less than Walgreens) even if they are not members.
- All pts (regardless of insurance status) are guaranteed one specialist visit after discharge.

**DICTATING** Make discharge summaries go faster!

- Type **.providerid** – this is your provider ID (obtain from Diane in HIM- she is only available M-F, 7:30-4 PM, no weekends).
- Open a note for your d/c summary & Import your template for d/c summary
- Wherever in your note you want to start dictating (i.e. under Hospital Course section), place your cursor and click the "microphone icon" located up near where smart text box is. Once you click the icon, it will import a Dictation # (this is if you want to do multiple dictations in a single note), the MRN, and the CSN
- Call the dictation line
- Prompts will ask you for
  - 1) Provider Number
  - 2) CSN (imported with microphone icon)
  - 3) Dictation # (usually "1" imported with microphone icon)
- State pt's MRN, name, date, then begin dictating!
- Press 5 to end and hang up
- The dictations will come to your inbasket to "sign" (so if you're nervous to start doing dictations, don't worry, you can edit them!!)

### Commands when recording:

1=pause  
2=resume  
3=rewinds a little bit  
5=end  
8=start next dictation  
\*= stat dictation



# Hospital Transfers \*we anticipate this becoming an electronic process in 2016-17

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## **YOUR ATTENDING SHOULD HELP YOU WITH THIS!**

1. Once you have decided that you need to transfer your patient to another hospital for services we do not provide, contact the discharge planner who can assist you with identifying possible accepting hospitals based on patient insurance, as well as assisting with contact information.
2. Call the Transfer Center and tell them you have a patient you would like to transfer. That person (typically a nurse) will walk you through the information they need. If (s)he decides they can accept, you will be asked for a contact number for their accepting clinician. Consider giving your cell since they might call back in 2 minutes or 2 hours.
3. When discussing, lead with the reason for your transfer and what service the patient needs (e.g., "I have a 65 year-old poorly controlled diabetic with uremia who I need to transfer for dialysis"). The accepting physician usually will ask for the info (s)he wants.
4. Once you get acceptance, notify the discharge planner, who will arrange for transport as well as a pile of paperwork for you to complete.
5. You will need to complete all patient paperwork including transfer summary and medication reconciliation. Social work usually will gather images, diagnostic reports for transport, but it may be good to verify this. Remember, you can get a CD of all pt images prior to transfer from the third floor radiology reception desk.

### **Transfer Centers**

CA Pacific Medical Center  
Diablo Nephrology

John Muir Medical Center - Concord  
(Ask for Nursing Supervisor)

Stanford University  
UCSF  
UC Davis  
CHO

## **How to do a Teleneurology Consult:**

**(Note: Teleneurology consults calls must be attending to attending)**

1. Page the UCSF group by calling and leaving full call back number including area code. Discuss the case, and give the UCSF MD a time frame for when the video cart will be set up and ready for them to log in.
2. Move the video cart to the patient's room and set up with the camera is facing the patient.
3. Wait for the UCSF doc to call the video cart. When they are online, you should be able to see them on the screen and they can see the patient and you.
4. Do physical exam on patient as directed by UCSF doc.
4. If there are body parts the neurologist can't see with the on-cart camera, there is a hand-held camera that can be used by the local MD.
5. **DON'T LOSE THE REMOTE CONTROL!!!** For reasons that are a little murky, the remote control is key to turning on the cart. UCSF swears they've never lost one, despite them not being tethered to the cart, so let's not be the ones to break their streak.
6. After the video consult is completed, the UCSF MD will write a teleconsult note that will file under the "Consult" tab. They will communicate **VERBALLY** to the local MD, who will be responsible for entering any orders they request.
7. Any follow-up questions should be addressed to them via phone call, not InBasket message.
8. Training video: <http://isite3/>

# Deaths

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Often the patient's nurse has already made the determination that the patient has died, but a physician must make the official pronouncement. California Health and Safety Code Sections 7180 and 7181 establish two methods of pronouncing death:

- Determine that there has been irreversible cessation of circulatory and respiratory functions. Generally this condition is satisfied when no heart beat or breath sounds are heard after approximately sixty (60) seconds of auscultation.
- Two physicians determine that brain death has occurred. In this case, the official time of death is the time that the second physician confirms brain death. This generally will not need to be done on the floor.

Once you have pronounced a pt:

- Note the **Time of Death**
- Write a **Death Note** (example below)
- Deceased pts also need **DC summaries** (can be done by primary team if you are HO)
- Sign the paperwork nursing will give you to complete
- Nursing will also take care of contacting other agencies
- **The coroner does NOT need to be contacted** in almost every case in the hospital. Reasons for contacting the coroner include undetermined cause of death; death that took place outside of medical care; suspected suicide; injury or accident; death caused by crime; anyone in jail custody.
- **If family is present** at an expected death, offer condolences and ask if they have any questions.
- If family is absent, discuss with the nursing supervisor or charge nurse how long the patient can be held in his or her bed until the family can arrive.
- **Notify the family if not present** (even if middle of night). Consider calling the primary doctor and asking if they want to make the pronouncement to the family.
  - Call the primary family member and inform of a "change in status." Ask if they can come to the hospital. You can say that the condition is "critical." This is done primarily for safety reasons with driving. If they ask if the patient has died, you can say yes.
  - If family sounds distraught on the telephone, consider asking if they can have a friend or neighbor drive
- If they have a funeral home chosen, they need to sign the official paperwork to give permission to release the body.
- In any **unexpected or not-straightforward death, offer an autopsy** to the family (e.g. in scenario of an unexpected code blue).
  - If autopsy requested, the next of kin must sign the official paperwork. All intubations and lines must be left in place for an autopsy and family should be forewarned of tubing, etc., before entering the room.
  - If they decline autopsy, have nursing staff prepare the patient for the family.
- You may ALWAYS ask for the assistance of other residents/attendings in speaking with family members if you would be more comfortable

## Death Note example:

Called to pronounce (name). On exam patient was unresponsive to verbal and physical stimuli. Pupils fixed and dilated, absent corneal reflex. Absent heart & breath sounds for more than 1 minute. Absent peripheral pulses. Patient pronounced dead at XX:XX. Next of kin/family notified (or at bedside). Autopsy offered & declined. Organ Donor Network will/will not be contacted in accordance with patient's wishes.

# On-Call Guidebook – Vital Sign Abnormalities

## GENERAL ADVICE

- When in doubt, ask the ICU resident. They are there to help, teach, and back you up when you need it. There is always a hospitalist attending in-house as well.
- Your job is not to solve all of the patient's problems overnight. Sometimes you have to gently set expectations of nurses, patients, and families regarding your role
- Don't be afraid to go to surgery overnight, or if the OB resident goes to c-section, cover the L&D floor.
- You have a ton of responsibilities when you are on call, do your best to triage – it will get easier over time. Here is your list of included expectations as house officer:
  - Crosscover nursery, all of the 4<sup>th</sup> and 5<sup>th</sup> floor (excluding OB/Post partum)
  - Neonatal resuscitation for OB response calls (stat C-sections)
  - Admissions
  - Assisting the surgeon for overnight cases
  - Procedures (per resident preference)

## FEVER (>100.4F, 38C)

Assess trend (low or high fever? New or old?)  
Get complete set of vitals; remember SIRS and see **sepsis algorithm and use order set!**

- Not worried: +/- lactate
- Worried (SIRS or new fever): lactate, blood culture, CBC, bolus
- Really worried (septic, pt looks bad): lactate, CBC, UA, urine culture, blood culture, CXR, **2 liters IVF, immediate antibiotics, transfer to IMCU +/- CMP, +/- ABG.**
- If known source and patient already being treated you usually don't have to obtain a full sepsis w/u, however consider re-culturing patient if > 24 hours since last blood culture.
- If septic, consider broadening antibiotics, if just fever generally no need to change abx

## HYPOTENSION

Check baseline, have RN recheck.  
Dehydration? Ask about urine output

- Assess for Sepsis (SIRS criteria + infection), if positive and lactate >4 or SBP<90 RRT will be called and they will order 2LNS, you order abx through sepsis order set.
- If not septic, try a little fluid bolus and see how the patient responds

- Med Check... on a bunch of BP meds?
- If very low, Trendelenberg, call ICU resident, likely transfer to ICU for pressors.

## HYPERTENSION

Check baseline, have RN recheck. Is the patient in pain? Anxious? -- most common, treat these first.

- Was the patient on meds as an outpatient that were not started/started at wrong dose.
- Use shorter acting medicines. All can be used PRN SBP>180
  - **NTG paste ½ inch** to chest q6 (can be applied and wiped off if BP falls too low)
  - **hydralazine 10mg PO Q6**
  - Renal function ok? Consider captopril 12.5 - 25 mg PO Q8

## TACHYCARDIA

- If unstable -> ACLS algorithms.
- Otherwise, review past HRs and other VS
- Does the patient have a reason for sinus tachycardia? pain? fever? sepsis? hypovolemia? If so and tachycardia is mild, can work-up, treat (give pain meds, bolus, give tylenol for fever) and recheck
- If considering sepsis, check for lactate >4 or SBP<90 = severe sepsis -> sepsis algorithm
- If significant tachycardia or dramatic change, definitely get STAT EKG to look for arrhythmia, always keeping PE in mind with new tachy and desaturation.

## BRADYCARDIA

You will often get called about patients who are on tele and are brady to 50s or even 40s.

- Find out if symptomatic (lightheaded, dizzy, chest pain, SOB).
- Check meds for beta blockers, calcium channel blockers, etc and consider holding them until primary team can re-evaluate.
- Look at telemetry for AV nodal block, pauses, other abnormalities, and consider ECG.
- If asymptomatic, not on meds, and nothing concerning on tele, can likely just observe, but give ICU resident a heads up and consider if patient needs pacer pads on or atropine 'at bedside'.

# On-Call Guidebook – Acute Issues

## CHEST PAIN

1. Go evaluate the patient
2. STAT EKG
3. Oxygen
4. Chew 325 mg ASA
5. Consider CXR
6. SL nitro 0.4 mg q 5 min x 3
7. 2 mg morphine for pain
8. If you suspect cardiac ischemia, call ICU resident to transfer patient to a monitored bed and order cardiac enzymes STAT.

Numbers 1-3 are usually done regardless of what your suspicion is for etiology of the chest pain. If it's a patient on 4A you may want to go ahead and order the NTG while on the phone... then go assess the patient.

Consider repeat EKG if suspicious of ischemic etiology, call ICU resident PRN. Remember to look at old EKGs for comparison. If STEMI activate inpatient STEMI protocol (order set)

## ARRHYTHMIA

Go look at the strip/note chronicity/note

Go see patient

Get EKG

Get Lytes/Mag

Refer ACLS algorithm

## RESPIRATORY DISTRESS

- Go assess the patient! Asthma? CHF? Pneumonia? PE? Oversedation?
- You can always call RT, they are great about giving good advice (Nebbs, BiPAP, etc.)
- If you're concerned about worsening CHF...consider CXR and LASIX
- If CO2 retainer... careful with giving O2
- If over-sedated...consider narcan
- If anxious...reassurance and POSSIBLY Ativan once evaluated
- ALWAYS CONSIDER GETTING AN ABG! IT OFTEN CLARIFIES THE PICTURE!
- **Low threshold for calling an RRT!**

## BLEEDING

- Assess patient... is it severe or just post-operative oozing? Stat CBC if anything more than a small ooze, consider checking coags.
- Check vitals and consider IVF... if hemodynamically unstable... LR wide-open and call ICU resident/registrar PRN.

- If severe or baseline Hgb is already on the low side <7-8, type and cross match several units of blood - call ICU resident/nocturnist PRN. Stop DVT prophylaxis!

## SEIZURES

- **Acute management:** IV access, start with 2mg Ativan IV and repeat every 5 minutes
- **Determine etiology (drugs)** (meth, cocaine, cipro, imipenem, lidocaine, PCN, TCAs, theophylline), **withdrawal** (barbiturates, benzos, etoh, opiates), **infection, ischemic injury, mass effect, metabolic** (hepatic/uremic encephalopathy, renal failure, hypoglycemia (excessive insulin, PO meds vs islet cell tumor), hyponatremia (<115-120), hypocalcemia, hypomagnesemia (<0.8 mEq/L)), **hyperthyroid**.
- **Labs/Images:** CMP, mag, CBC, tox screen, prolactin (drawn 10-20 min after event, compared to baseline 6 hrs later), CPK, LDH, CT, consider MRI, consider LP. Antiepileptic levels if pt has h/o epilepsy.

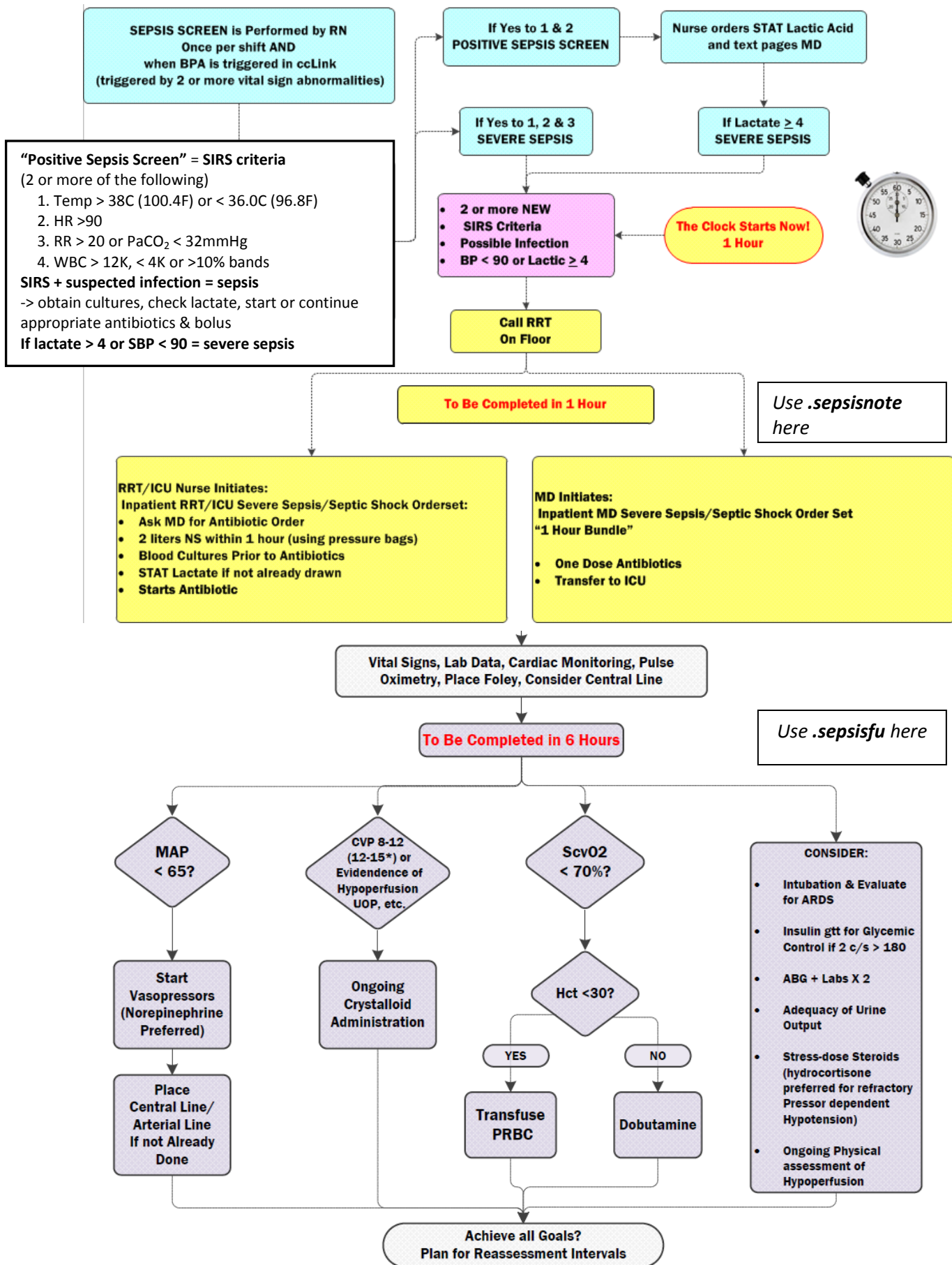
## AGITATION/ANXIETY

- Why is the patient agitated— sometimes it's a symptom: under-treated pain? Sundowning? Over medicated? Anxiety? **Withdrawing?** Air-hunger? Hypoxia? Urinary retention? Dementia?
- Go visit the patient to evaluate the situation if you have not seen the patient previously.
- First try talking to the patient, and encourage the nurses to try re-directing –it works!
- Sometimes **Benadryl** 25-50mg IV/PO may suffice for sedation, or **temazepam** (Restoril) 15mg (but don't mix benzos)
- **Ativan** 1-2 mg IV/PO q 2-6 hours PRN will do the trick (start with 0.5 mg in frail/elderly/benzo naive)
- However, benzos can actually worsen delirium in the elderly. Strongly consider haldol for these patients.
- **Haldol** 1-2.5 mg PO/IM (IV only in ICU/IMCU) q 4 PRN is a good start. If patient is still agitated you can increase dose and frequency. Measure and calculate QTc yourself – Bazzett formula.
- Also see **restraints** and **cocktails** on next pages



# On-Call Guidebook – Sepsis

USE .sepsisnote and .sepsisfu and sepsis order set!!! SO IMPORTANT.



# On-Call Guidebook – Sepsis

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Our hospital gets graded on whether or not we do certain things in a timely manner. The bottom line is we have 1 hour to give patients who meet criteria for severe sepsis (infection and lactate >4 or SBP<90) 2L IVFs, get blood cultures, and start antibiotics)

## Physician Checklist:

1. Confirm patient meets criteria
2. Complete the “Inpatient MD Severe Sepsis/Septic Shock Order Set”:
  - ☐ Order initial antibiotic dose
  - ☐ Place order to transfer patient, most likely to ICU
3. Work with RRT and bedside nurse to ensure the following (in RRT/ICU RN orderset):
  - ☐ 2 liters NS given within 1 hr (use 2 IVs and pressure bags) → **If not doing this, MUST discuss with attending and document well why not**
  - ☐ Blood cultures drawn prior to antibiotics
  - ☐ STAT lactate if not already drawn
4. Documentation and follow-up:
  - ☐ Use **.sepsisnote** to document initial resuscitation (This is a MEDICARE REQUIREMENT)
  - ☐ Order repeat lactate in 4hrs if initial lactate **was above 2**
  - ☐ Start peripheral norepinephrine through order set if SBP is still below 90 after 2L NS bolus while you are prepping for central line
  - ☐ Use **.sepsisfu** to document response to fluids including tissue perfusion within 6 hours
  - ☐ Add “sepsis” or “septic shock” to the problem list
  - ☐ Start antibiotic dose within 1 hour

**Remember:** Avoid overthinking. Sepsis has an international mortality of 20-50%. Because of this bundle sepsis mortality at CCRMC is now under 10%. If it MIGHT be sepsis then using this algorithm saves lives!

# On-Call Guidebook – Pain/other common calls

## RESTRAINTS

- Pt should be seen and orders for restraints written within 1 hour and renewed every 24 hours. Put a shorter duration of hours. Be skeptical of nursing and go see the patient. It is okay to say no.
- Try to document:
  - Alternative interventions attempted (verbal de-escalation, PRN meds, time out, bed guard/alarm, limiting noise, decreasing external stimulation, assessing underlying conditions, etc).
  - Behavior exhibited.
  - Type of restraint used (ask the nurse)
  - IT MAY DELAY DISCHARGE FOR YOUR FRIEND'S PATIENT.

## “THE FAMILY/PATIENT WANTS TO TALK TO A DOCTOR...”

Yes, that's you! Can be scary, but usually the family/patient appreciates seeing “a doctor” and you can tide them over until the morning.

- Read a little from the chart and learn from the nurse what exactly has happened before you were called and what the patient/family expects from you.
- Go talk with the family or patient.
- Emphasize that you want to help, remind them that you are not the primary doctor so you may not be able to answer all of their questions, but do your best to answer what you can.

## PT WANTS TO LEAVE AMA

- Read sign off note from primary team
- See the patient and explain why we recommend they stay in the hospital (based on sign-off/progress note from team)
- **Explain to them they may be billed for their entire hospital stay if they leave AMA**
- **MED REC if possible** most important abx and cards meds or anticoagulation
- Assess if pt has capacity, if so, have them sign AMA paperwork.
- **Assess capacity → medical hold → d/w attending.**

## PAIN MEDICATION

- Ask for the nurse's assessment of patient's pain.
- Strongly consider going to see the patient.
- Look at the MAR and see what the patient has been getting. Is this drug-seeking behavior? Is this new worrisome pain that needs a work up? Post op?
- Check sign off notes for suggestions from the primary team and to make sure you don't write for IV meds when they are trying to avoid them!
- Writing a one-time order and having the primary team reassess in the morning is usually ok – you don't know the patient like they do.
- Think about whether there is an anxiety component and consider benzos but be VERY wary about mixing benzos and opiates

### Mild pain:

- **Acetaminophen** 650mg PO/PR/IV q 6 hours (*max daily dose 3-4g or 2g in liver dysfunction*)
- **Ibuprofen** 600mg po q6-8 hours (avoid in pt with bleeding issues, stomach ulcers, liver/renal failure)

### Moderate pain:

- **Norco** or **Percocet** 1-2 tabs q4 hours (daily dose limited by acetaminophen, percocet is stronger)
- **Toradol** 30mg IV q6 hours (avoid in patients with bleeding risk, PUD, liver disease, renal disease, CAD – should have normal creatinine)

**Severe pain:** overall, should be managed by the primary team (avoid starting recurring doses)

- **Morphine** 1-2 mg IV is a good start
- **Dilaudid (7x stronger than morphine)** 0.5-1mg IV or 2-4 mg po
- If starting a PCA, use the preset “usual” doses and avoid using a basal rate!

### **Here is a brief conversion list:**

1 tab Percocet (5 mg oxycodone/325 mg Tylenol) =  
1.5 tab Norco (5mg hydrocodone/325mg tylenol)  
5 mg PO morphine = 1 tab Norco (5/325)  
3 mg PO morphine = 1 mg IV morphine  
4 mg PO Dilaudid = 1 mg IV Dilaudid  
1 mg IV morphine = 0.01 mg (10 mcg) IV Fentanyl  
7 mg IV morphine = 1 mg IV Dilaudid  
Can also check out

[www.globalrph.com/narcoticonv.htm](http://www.globalrph.com/narcoticonv.htm)

Methadone is VERY long acting and shouldn't be changed unless you know what you are doing - it is beyond the scope of The Scoop.

**Opiates are constipating!** – “the same hand that writes for opiates writes for DSS”

# On-Call Guidebook – Meds for common issues

## COCKTAILS

Everyone's favorite, especially on call

- **Haldol:** *Make sure you know why patient is agitated first – this is the same as physical restraints by the law.* Caution in the elderly or demented. **Haldol** 5 mg IM + **Ativan** 2 mg IV/IM + **Diphenhydramine** 25 mg IV/IM (or **Cogentin** 1 mg IV/IM).  
Diphenhydramine/Cogentin protect against the extrapyramidal effects of Haldol.
- **GI Cocktail:** (GI Lizard) Be sure the pain is GI and not cardiac! **Maalox** 30 mL + **Viscous lidocaine** 10 mL ± **Donnatal** 10 mL
- **Banana Bag:** Can be ordered directly in EPIC (type BANANA). Prevent Wernicke-Korsakoff: In 1 L NS, add **Thiamine** 100 mg + 1 mg **Folic acid**, **Multivitamin** 1 amp, **MgSO<sub>4</sub>** 3 grams.

## CONSTIPATION

From above:

- **Docusate** 250mg PO BID safe for everyone
- **Senna** 50mg (*contraindicated in bowel obstruction or undiagnosed abdominal pain*)
- **MOM** 15mL QID PRN
- **Miralax** 17gm daily
- **Lactulose** 15-30mL three times daily, titrate up from there

From below:

- **Bisacodyl** suppository
- **Tap water or soaps suds enema** – generally preferred over sodium phosphate enema
- **Sodium phosphate enema** - avoid in elderly and in renal failure

## INSOMNIA

IN ROUGH ORDER OF GENTLENESS, USE WITH CAUTION IN ELDERLY

- **Sleep hygiene, ear plugs, TV, lights, DC 4 AM vitals if stable**
- **Melatonin** 3 mg
- **Trazodone** 50-100 mg PO x 1 (most benign)
- **Benadryl** 25-50 mg PO/IV x 1
- **Temazepam** (Restoril) 15 mg PO x 1, may repeat in 45 minutes if insomnia persists
- **Zolpidem** (Ambien) 5-10 mg PO x1 (elderly or hepatic impairment may consider 5mg)

## ITCHING

**Benadryl** 25-50 mg PO/IV q6-8 PRN OR

**Atarax** 25-50 mg (max 100mg) PO q6-8 PRN

Have you tried lotion? Looking silky.

## NAUSEA

Can write PRN or standing and combine:

- **Zofran (Ondansetron)** 4-8mg IV/PO q6h (*prolongs QT*)
- **Phenergan (promethazine)** 12.5- 25mg topical q6h (*do NOT give IV- black box warning; prolongs QT*)
- **Reglan (metoclopramide)** 10mg PO or IV up to QID (*prolongs QT, prokinetic and antiemetic, associated with extrapyramidal side effects, give IV infusion over 15min not bolus*)
- **Compazine (prochlorperazine)** 5-10mg TID PRN (*hypotension & extrapyramidal side effects*)

## DVT PROPHYLAXIS

10-20% of hospitalized medical patients (↑in surg patients) get asymptomatic DVT if no prophylaxis.

**Who:** hospitalized patients if impaired mobility and acutely ill or any of the following risk factors: obesity, age>40, indwelling central venous catheter, CHF, COPD, IBD, sepsis, prior VTE, family history of VTE, malignancy, hypercoagulable state

**Contraindications to heparin prophylaxis:**

- **Relative:** mild/mod bleeding diathesis, active intracranial lesions, proliferative retinopathy, malignant hypertension
- **Absolute:** ongoing/uncontrolled hemorrhage, active intracranial bleed, major bleeding diathesis, platelet count <20,000, recent ocular surgery, neurosurgery, spinal cord injury, spinal instrumentation

**Regimens:**

- Heparin 5000u SQ q8-12h
- Enoxaparin 40mg SQ daily or 30mg BID (consider heparin instead if renal insufficiency (CrCl <30) or obesity (weight > 120kg))

**Monitor platelets:**

- if chronic thrombocytopenia, can give prophylaxis if platelets >50k
- if new thrombocytopenia, consider causes especially medications



# On-Call Guidebook – Fluids and electrolytes

## INTRAVENOUS FLUIDS

### Maintenance fluids

- **Average patient:** LR or NS at 125mL/h is always a safe bet
- **CHF/little old people:** go slower, eg 75mL/hr
- **Diabetics:** if NPO use D5LR or D5NS.
- **Be careful with LR in renal failure**

### Bolus/rehydrate: 500mL-1000 mL LR or NS

- **Young/healthy:** can handle 1-2 liters
- **CHF:** can give 250 or 500 cc boluses and then reassess and repeat

*If chloride high, consider LR instead of NS*

## HYPERGLYCEMIA

- Part of the sliding scale insulin order says “call HO if sugar is over...” Usually this is not a big deal, patients often run high while hospitalized, especially if on steroids.
- Ask what the highest step is on their sliding scale insulin and give that, or that + 2 units.
- Ask them to recheck in 2 hours and page you so you know that the glucose level is going down. Don't give extra insulin at the 2 hour re-check, because it takes 3 hours for the prior regular insulin dose to take full effect.
- If the glucose is sky-high (>500) and not responding you may consider checking a basic panel to evaluate bicarb/anion gap and r/o DKA. If they are in DKA they'll need to be transferred to the ICU/IMCU for an insulin drip. If the patient is consistently high you may need to bump them up to a higher level on the SSI order.
- Leave a note reminding primary team to consider a long acting insulin regimen

## HYPOGLYCEMIA

- Give an amp of IV dextrose and something oral (juice, crackers, meal)
- Evaluate why (prior insulin dose too high?) Consider sepsis!

## HYPOPHOSPHATEMIA

- IV for severe (<1) or symptomatic: 0.6 mg/kg/hr
- Phos 1-2: PO K phos (1200-1500 mg daily) (DC sucrafate and phosphate binders)

## HYPOKALEMIA

- Always check Magnesium and replete to 2
  - **IV Potassium Chloride** 20mEq in 100ml IVBP (burns if you don't run it with other IV fluids). Order 20mEq at a time and increase the number of **doses** to give more.
  - **Potassium Chloride Solution** 20 mEq /15ml, (up to 40 mEq at a time, tastes bad)
  - **Potassium Chloride Tablet** 8mEq per tablet (up to 40mEq at a time, causes upset stomach)

Serum K	mEq KCl to give IV or PO
3.7-3.8	20
3.5-3.6	40
3.3-3.4	60
3.1-3.2	80
≤3.0	100

Serum Mg	Grams MgSO <sub>4</sub> to give IV
1.8-1.9	1
1.6-1.7	2
1.4-1.5	3
1.2-1.3	4
<1.2	5

## HYPERKALEMIA

- **Order STAT repeat K** (may be hemolyzed)
- **Check STAT EKG**, look for:
  - Tall peaked T waves
  - PR prolongation
  - Loss of p waves, QRS widening, this progresses to “sine wave” and VF/asystole
- **If any EKG changes**, treat immediately with **Calcium gluconate** first (stabilizes cardiac membranes) then something to shift K into cells (insulin w/ glucose, albuterol, sodium bicarbonate) then something to remove K from body (lasix, kayexalate – modest short term efficacy and can rarely cause intestinal necrosis esp in setting of ileus)

## Dietary Supplemental Drinks

- Nectar consistency: dysphagia pts
- Breeze: pts on clears (not DM friendly)
- Juven: pt with wounds
- Peptamen: malabsorption
- Mighty shake (milk): high calories & proteins

# On-Call Guidebook – Surgical Issues

## POST-OP CHECK

One of the most common HO tasks. This is when early post-op complications are discovered. Needs to be done on ALL post-op patients 6 hours after the case ends. Usually will be signed out, but sometimes you're called and you'll notice they haven't been seen.

1. Read the op-note
2. Review orders, pay special attention to:
  - Antibiotics if patient needs them
  - IV fluids (especially if NPO)
  - Diet
  - Pain regimen
  - If diabetic, ensure patient has orders for glucose checks and ISS
  - Weight bearing status
3. Review home meds (surgeons may not do a thorough med-rec, may need to restart essential home meds-generally hold ASA/Plavix and dayteam can assess)
4. See the patient. Ask about pain, nausea, if voided, if using incentive spirometry
5. Examine patient
  - heart, lungs, abdomen, extremities, wound and drains
  - Generally do not remove dressing
  - Assess for bleeding, reinforce/apply pressure if saturated
  - If patient doesn't look stable, call senior/nocturnist
6. Modify orders as appropriate and write a note.

## SOAKED DRESSINGS

Post-op patients often have drainage from their wounds; the nurses will call you if they find a dressing is saturated.

- **Ask for vitals over the phone** -> if hypotensive or tachycardic, assess quickly
- **When assessing**, be concerned if:
  - Frank bleeding from a wound or coming out of a drain (JP or Blake drain)
  - Hemodynamic instability
  - Bleeding from an unidentifiable location, i.e. from inside the abdomen.
- **If unstable:** ABC's (CAB's): confirm IV access, fluids, order type and cross to transfuse blood, consider FFP, platelets etc,

transfer to ICU (consult with ICU resident or attending/surgeon on call)

- **If stable but concerning**, check serial CBC's to follow hgb, more frequent vitals, hold DVT prophylaxis
- **Consider pressure dressing**, cautery (in equipment cart on the floor)
- **If very slow oozing** (most common), just reinforce the dressing with more gauze

## POST-OP FEVER

General approach if unsure of etiology, get:

- **blood culture** peripheral and any lines
- **UA/Urine culture**
- **CXR**
- **STAT CBC w/diff**
- If clinically/hemodynamically concerning, discuss starting antibiotics with ICU resident / attending
- If well appearing and low grade fever, likely can order above studies, encourage incentive spirometry, and monitor

### Differential

- **Immediate** (within hours of surgery): meds or blood products given during procedure, trauma prior to/during surgery, infection present before surgery, malignant hyperthermia (rare), atelectasis (debated)
- **Acute** ( $\leq 1$  wk post-op): nosocomial infections
  - **Surgical site infection** (SSI), specific to abd surgeries: deep abd abscess
  - **Pneumonia**: risk factors include atelectasis, altered mental status or NG tube increasing risk for aspiration
  - **UTI** : risk factors include Foley catheters, urinary retention, GU procedures
- **Subacute** (1-4 weeks post-op): central line infections, C.diff, drug reactions (antibiotics), thrombophlebitis, DVT, PE.

## URINARY RETENTION

Post-op patients can have urinary retention related to anesthesia. Urine output can also be a marker of hydration status, renal function, and tissue perfusion. Options to consider:

- Assess for dehydration, give fluid bolus if signs of dehydration (ie: mucous membranes, vitals)
- Bladder scanner to assess bladder volume
- If bladder is full, ask nurse to insert foley, if nurse gets >300ml out, leave it in place.

# On-Call Guidebook – Surgical Issues

## NO BOWEL MOVEMENT

Post-op patients' pain meds can be constipating, but you need to consider more dangerous etiologies such as ileus or bowel obstruction, especially if they have abdominal pain or distention. Options:

- Reverse diet or make NPO
- Abdominal series, or KUB with upright and supine views: this will show bowel distension, air-fluid levels, etc. It can be hard to differentiate SBO and ileus with one film, but it can tell you GI function isn't normal.
- If you see distention on the abd series, or if the patient has a lot of pain, you can place an NG (nasogastric) tube to drain whatever is in the stomach. This can alleviate the distention, pressure, and pain.

## NGT/DOBHOF PLACEMENT

Nurses can place NG and Dobhoff tubes but MDs confirm position. You may be asked to confirm placement before they can be used to give meds, tube feeds, etc.

- **Dobhoff:** tip should be in duodenum, as it is often used for tube feeds. Confirm by making sure you see it cross the midline on X-ray
- **NG tube:** tip should be in stomach, confirm by making sure it goes below diaphragm. It may also curve around the stomach and can cross the midline a little.

## NGT CLAMP TRIALS/RESIDUALS

- Used to assess return of bowel function (gastric secretions move along instead of pool in stomach)
- Involves clamping the tube for 4-6 hours, then putting back on suction to see how much fluid is in the stomach (the "residual" fluid).
- Each surgeon has different passing criteria:
  - Weiss: 150ml after 3 hours
  - Gynn: 200ml after 4 hours
- If the residual fluid is less than the defined amount, you can remove the NG tube, and will likely see enough return of bowel function to avoid further need for an NG.

## TROUBLE-SHOOTING NG TUBES

- Make sure they are on Low Continuous Wall Suction (unless the air vent is known to be clogged/not working, NGs should be on continuous rather than intermittent)
  - Disconnect the NG tube and make sure you can see/hear suction from the wall
  - Work with the nurse to flush the NG – put 20-30cc of sterile saline in and try to draw it back out. May need to repeat.
  - Work with the nurse to flush the air vent (can use same flush syringe, flush air into the air vent and make sure it moves smoothly.
  - Take a look at x-ray position and consider advancing/withdrawing a few centimeters
  - If cannot unclog by above measures may need to place a new NG, preferably a larger French, confirm placement with an abdominal x-ray.
- Unclogging a G-tube: 2 tabs pancrelipase (Viokase) and 1 tab bicarb (650 mg), crushed in 5-15 mL of lukewarm water.

## DO I HOLD \_\_\_\_ FOR SURGERY?

- Only procedure you need to hold prophylactic heparin for is ERCP (not surgeries)
- "NPO" should almost always be "NPO except sips with meds" (exceptions: bowel obstruction, perf'd ulcer/viscus, fresh post-op from gastric sx) and many pre-op patients have essential meds they need to take
- **Anyone on a B-blocker MUST continue**, take with a sip of water on AM of surgery
- **Aspirin & Plavix** (more relevant for outpatient surgeries):
  - Continue aspirin up to and through surgery, hold Plavix 5-10d prior
  - In pt with bare metal stent within last 6w or drug-eluting stent within last 12mo, continue aspirin and Plavix, or if interrupted, bridge with heparin/LMWH
- **Warfarin:** stop 5 days pre-op. If high or moderate risk (CHADS2 score >3 or VTE in last 12 months), bridge with heparin/LMWH
- **Diabetes meds:** hold oral Diabetes meds morning of surgery, while NPO should be on ISS + 50% reduced dose long acting insulin
- **Statins:** continue if patient already on, and consider starting in anyone who should be on one.

# On-Call Guidebook – Wounds

## Pressure Injury (ulcer) Staging

It is important to document pressure injuries, both new and pre-existing, and the initial staging must be **done by MD within 24 hours of noting it** (especially on admission)  
-- can be left to primary team if time permits, but may be up to you while on call.

- **Stage 1:** Non-blanchable erythema of intact skin
- **Stage 2:** Partial-thickness skin loss with exposed dermis
- **Stage 3:** Full-thickness skin loss
- **Stage 4:** Full-thickness skin and tissue loss
- **Unstageable:** Obscured full-thickness skin and tissue loss
- **Deep tissue injury:** Persistent non-blanchable deep red, maroon or purple discoloration

**To officially stage the wound, you need to document in the 'flowsheet'**

1. Go look at the wound with the nurses. They will measure the wound and document other characteristics
2. **"Rounding"** TAB on the left hand column in a patient's chart
3. **"Wound Documentation"** under the "Documentation" grouping
4. Go nuts! Hopefully, you'll document it upon admission and then can stage it, describe the wound, intervention/care plan, etc. so that we don't get dinged in SERS or whatever other reporting modality

**There is an order set for patients with pressure injuries** (just type in "Ulcer") to get orders for mattress, turns, etc

**Table 2**

## Dressings for Pressure Ulcers

Type	Indication	MOA	Dosage	Commercially Available Product
Skin sealant, film	Stage I ulcers	Acts as a protective coating on the skin	Apply 1-4 times/day	Decubitone, Preppies, Pro-Q
Hydrocolloid	Stage II ulcers	Maintains a moist environment; naturally promotes autolytic debridement	Change every 3-7 days	Comfeel Plus, Curaderm, DuoDERM
Hydrogel	Ulcers with little to no exudate	Maintains a moist environment; naturally promotes autolytic debridement	1-4 times/day	AcryDerm, Aquaflo, Aquagauze, Aqua Skin, CarraDres, CarraGauze, CarraSmart Gel, Carrasyn, Carrasyn V, DermaGauze, DermaSyn, FlexiGel, SAF-Gel, SoloSite, Tegagel, TransiGel, Woun'Dres
Moist saline gauze	Stage II-IV ulcers	Maintains a moist environment; has antibacterial activity	3 times/day, as needed	Curasalt, Curity, Dermagran, Kerlix
Iodine-solution wet gauze	—	Has broad-spectrum antimicrobial activity	1-4 times/day	—
Alginate	Exudating stage II ulcers; stage III-IV ulcers that are deep	Serves as an absorbent by maintaining a moist environment	1 time/day, if needed	AlgiCell, AlgiSite M, CarboFlex, CarraGinate, DermaGinate, Kalginate, Kaltostat, Melgisorb, Restore CalciCare, Sorbsan
Foam	Exudating stage II ulcers; stage III-IV ulcers that are deep or have moderate drainage	Serves as a repellent for water, bacteria, other contaminants; maintains a moist environment; acts as insulation; reduces odor	1 time/day, if needed	Allevyn, Biatain, CarraSmart Foam, Curafoam, DermaLevin, Epigard, HydroCell, Lyofoam, Mepilex, Optifoam, Polyderm, PolyMem, Silon, SOF-Foam, Tielle, VigiFOAM

MOA: mechanism of action.

Source: References 9, 10, 15-17.



# On-Call Guidebook – Pediatrics

## RESPONSIBILITIES

**#1:** Page pediatrician to get sign-out as soon after 8pm as you can

**#2 Attend c-sections and OB responses.** If you get paged about a C-section or an OB response team is called, you're expected to go. *(Yes, the floor is busy and there are always ER admissions to do, but as long as the patient in the ER is stable, it's okay to go up to the nursery for a C-section and then come back and finish the admit)*

**#2: Cover Level 1 and Level 2 nursery**

- **Level 1** = baby at mom's bedside (most)
- **Level 2** = the nursery for any sick babies. Babies go to the nursery if there are any concerning issues, risk factors, etc. We do NOT have a level 3 nursery (NICU), so those babies are transferred to CHO

## ADVICE

Most of you will handle nursery calls before you do nursery.

- Unless you totally feel comfortable with the order you are giving, call the pediatrician (pager 733) to run the question by them.
- Avoid just telling the nurse to call the pediatrician. You'll learn more if you try to come up with a plan, assess the baby if needed, then call the pediatrician yourself.
- Even if you have done nursery and know what to do, page the Pediatrician (733) if you are transferring a baby from Level 1 to Level 2 so they are informed
- **It is often helpful to log in under "Pediatrics" in EPIC to get the right ordersets and defaults**

## NORMAL VITAL SIGNS FOR TERM NEWBORNS:

RR 30-60    HR 100-160    SBP 50-70

## TACHYPNEA (RR>60 OR E/O DISTRESS)

- Go see the patient
- Call the Peds attending.
- DDX = Retained Lung Fluid (Transient Tachypnea of the Newborn or TTN), RDS, Sepsis, Meconium Aspiration Syndrome, Hypovolemia, Acidosis, Pneumothorax, Congenital heart disease.

## JAUNDICE

### (BY FAR THE MOST COMMON CALL)

First ask the nurse:

- Is it a **manual / transcutaneous** bilirubin or a **serum** bilirubin measurement?
- How many hours old is the infant (The hours-age of the child determines the threshold for treatment (see [www.bilitool.org](http://www.bilitool.org))
- Is the gestational age of the infant  $\geq 38w0d$  ? (If 37w6d or less -> lower treatment level)

**Now you have the information you need.**

**Enter it into [www.bilitool.org](http://www.bilitool.org) to find treatment threshold and when to repeat bili**

- If they call you about a **manual bilirubin**:
  - Always send "**cord blood eval**" (type and coombs, doesn't poke the baby, if coombs+ this is a neurotoxic risk factor and treatment threshold is lower)
  - If <2 points from treatment or transcutaneous bilirubin >10, order a serum total and direct bilirubin
  - Generally wait for the serum bili to start phototherapy (manuals can be rather off)
- If you are looking at the **serum bilirubin**:
  - If above treatment threshold - start phototherapy (use orderset, transfer to level II nursery), call pediatrician so they are aware (or can help you if you haven't done nursery yet)
  - If very close to treatment threshold – discuss with pediatrician whether to start phototherapy vs follow serum bilirubin
  - If comfortably below serum threshold, bilitool tells you when a follow-up serum bilirubin should be ordered; often a serum draw at 6am is convenient for the team
- If **coombs +** -> order CBC and reticulocyte
- If **hyperbilirubinemia <24h of life**, alert the pediatrician

## HYPOTHERMIA

- Make sure that baby was re-checked after placing him/her skin-to-skin for 20 minutes
- If still hypothermic:
  - Transfer the baby to the nursery to be placed in the warmer
  - Call the peds attending to let them know
  - Consider sepsis workup (get risk factors and discuss with peds attending)

# On-Call Guidebook – Pediatrics

## FEVER

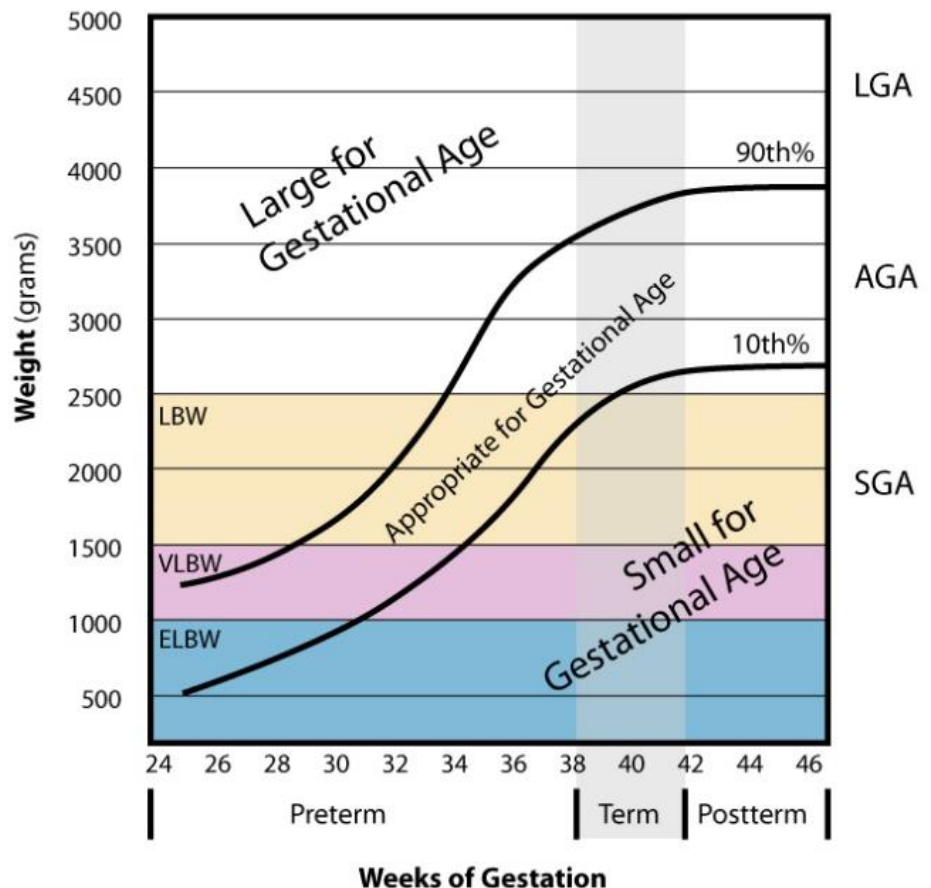
- EOS calculator – google Kaiser EOS – change to CDC incidence
- Make sure that baby was re-checked after taking off some of baby's clothes and placing him/her skin-to-skin for 20 minutes.
- Are there any risk factors for sepsis (Chorioamnionitis, pre-term, prolonged ROM)?
  - If so, go ahead and order the standard sepsis screen (CBC-D, Blood Cultures, possibly a CRP) and call the peds attending to discuss starting antibiotics.
  - If there aren't risk factors you can often get away with re-checking the temperature in 30 min. If you aren't sure, call the Pediatrician, that is what they are there for.
- Standard Antibiotics are Amp/Gent
  - **Ampicillin** 100mg/kg q12 hours
  - **Gentamicin** 4 mg IV q24 hours + Gent trough before 3<sup>rd</sup> dose

## NOTES ON BABY ADMIT ORDERS

- **GBS+ with inadequate treatment:** generally can do frequent vitals (needs to stay for 48h) or sepsis screen (CBC-D and blood cultures, baby gets stuck) per patient preference
- **Mom with chorioamnionitis:** discuss with pediatrician, generally get treated with 48h amp/gent, but can be exceptions
- **Infant of diabetic mother:** glucose checks per protocol
- **LGA/SGA:** glucose checks per protocol

## EMESIS/ DISTENSION

- Babies do spit up
- Bilious emesis (bright yellow or green) is always worrisome until proven otherwise. If an infant has true bilious emesis, they need urgent pediatric surgical evaluation. DO NOT WAIT.
- Worry about ischemic bowel (AKA necrotizing enterocolitis or NEC)
  - Risk factors for fetal hypoxia?
  - Is baby's belly getting distended per a nursery RN who has been checking serially?
  - Has baby gotten an abdominal x-ray yet?
- Ask yourself the simple questions like "does baby have an anus?"
- Consider when you want to call the peds attending, before you order studies or after. Just remember that the peds attending might want to add a study to your order set, and if that study is a lab you don't want to have to stick the baby twice.



# On-Call Guidebook – Pediatrics

## Algorithm: MANAGEMENT OF NEONATAL HYPOGLYCEMIA

Assess the neonate for presence of the following risk factors and symptoms.

### Risk factors:

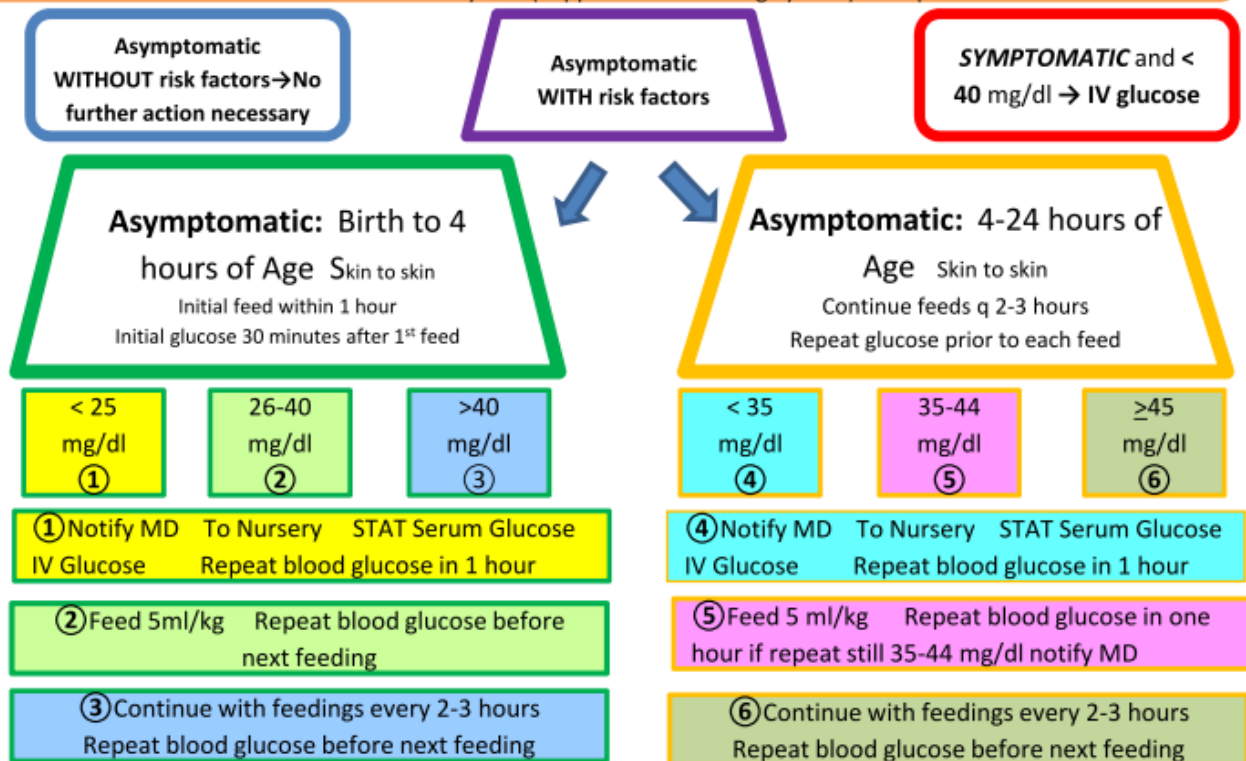
- A (NEEDS 24 HOURS OF SCREENING)**
1. Premature infants and late pre term infants (LPI) (< 37 weeks)
  2. Small for gestational age infants (SGA)
- B (NEEDS 12 HOURS OF SCREENING)**
3. Large for gestational age infants (LGA)
  4. Infants of diabetic mothers (IDM)
  5. Other risk categories: Example Infants with five minute Apgar < 7 and Mom's on beta blockers (labetalol)

**Major Hypoglycemic symptoms:** Jitteriness, Hypothermia, Seizures, Poor feeding, Lethargy, Irritability, Exaggerated Moro reflex, High pitched cry, Floppiness, Cyanosis

Check blood sugar immediately

Place neonates skin to skin and Initiate feeding as soon as infant is ready, preferably within 1 hour of birth.

Feed breast milk/colostrum or infant formula—NOT dextrose-water. Colostrum, if available, is preferred to formula. Feed formula by S&S (Supplemental Nursing System) or Cup



If due to maternal condition or situation (example an emergency cesarean section), when an attempt at breastfeeding cannot be done by one hour of life, and the baby remains asymptomatic, obtain a blood glucose at 1 hour of life. If the initial BG is >40, no treatment needs to be implemented but BGs should be rechecked hourly until an attempt at breastfeeding can be done. After breastfeeding, obtain blood glucose in 30 minutes. If at any check the BG is less than 40 mg/dl, follow the protocol for the 1<sup>st</sup> four hours of life.

**Discontinuation of Screening:** If the last 2 ac BGs have been ≥ 45 mg/dl may DC screening at 24 hours for risk category A and 12 hours for risk category B.

# On-Call Guidebook – OB-Gyn

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## **R/O Labor at Term**

- Reactive NST
- SVE, if <4cm, and not ruptured: Walk vs Home
- Check vertex with sono
- If 40+ weeks, check SDP
- Check active GBS (good for 5wk). If not, collect.

**R/O PTL** (Ask recent trauma, intercourse, hydration, recent illness, sick contacts)

- Send UA/UCx
- FFN if <34wks (**No gel & prior to SVE**)
- SSE: send GBS/GC/CT, do wet mount
- SVE (repeat in 2h, unnecessary if nl CL)
- If CTX on TOCO give IVF
- Cervical length (bedside sono)
- If <34wk GA, consider giving Beta (12mg IM q24hr x2)

## **Decreased Fetal Movement**

- Reactive NST (28 to 32wk: 10x10) (>32wk: 15x15)
- BPP (show mom baby moving, document mom now feels baby moving)
- DC home with kick counts (4 kick in 1hr, if not kick in 1st hour, lay on left side and drink juice, if not kick return to triage)

## **R/O ROM**

- **Do not perform VE if PPROM <34wks**
- SSE - check pooling/nitrazine/ferning
- Check SDP
- Wet mount, GC/CT
- If ROM and GBS+ or GBS unknown with + risk factor, then start PCN

**Vaginal Bleeding:** Previa vs Abruptio vs Other

- Check Vitals, IV access, O2 and IVF
- Check Fetal HR
- Ask about recent intercourse/infections
- Abdominal exam: uterine tenderness/tetany
- **Sono for placental location**
- SSE: if no evidence of previa then do cultures, wet mt, eval whole genital tract for VB source
- Labs to R/o Abruptio: CBC, T&S or T&C,

fibrinogen, coags, Kleihauer-Betke, +/- UTox

- Transfer to L&D for deliver if unstable
- RH-: Rhogam.
- If s/p Trauma and not in labor, admit for 23hr observation

## **Asthma**

- Check Peak Flow before/after nebs
- Neb x3 with albuterol and ipratropium q20min
- Solumedrol if not resolved with Albuterol
- +/- ABG

## **Hyperemesis/Gastroenteritis**

- D5 1/2 NS
- Reglan/phen/±compazine/±zofran combo, IV/PR
- (multiple medications is the key)
- Labs: CBC, UA, Amy/Lip, Chem 20, TFTs
- Inquire about weight loss, sick contacts, weird food
- PO challenge - if failed, admit
- Give Rx: Options include Zofran, Reglan (warn about torticollis) q 6 hrs around clock x 3 days then PRN, Vitamin B6 qD, Compazine PR q12

**DKA** (ie, there is an anion gap)

- FS: if >250, start NS + Insulin drip ~7u/hr
- When FS <250, switch to D5 1/2NS + consider K and slow insulin drip to 1-2u/hr
- Monitor FS q Hr.
- Labs: UA, CBC, Chem 20, Serum Ketones
- If No anion gap, just hydrate with NS.

**Elevated BPs:** ask about S/Sx pre-eclampsia (headache, vision changes, RUQ pain, edema)

- Serial BPs (Q15min), DTRs, lung exam
- Check BPs in PNC and intake BP
- PIH labs: CBC, BMP, LFTs, LDH, Uric acid (prior to delivery and only once), Urine Pr:Cr ratio
- If BP>160/105, repeat to verify then immediately give labetalol or hydralazine IV, start MAG



# On-Call Guidebook – OB-Gyn

## Antepartum testing Recommendations

DIAGNOSIS	MONITORING	RECOMMENDATIONS
<b>DECREASED FETAL MOVEMENT</b>	NST/AFI or biophysical profile same day	Consider kick count counseling for all patients in 3 <sup>rd</sup> trimester and especially if high risk
<b>POSTDATES</b> Low risk patient	Biweekly NST/Weekly SDP Begin 41-41 ½ weeks	Usually induce by 42 wks. Induce early after 41 wks for certain dates and favorable cervix. Delay induction if dates unclear, VTOL, or unripe cervix
<b>GDMA1</b> Adequate control on diet only	Biweekly NST/Wkly AFI. Begin by 41 <sup>st</sup> wk. May start 40-41wks.	Induce at 41 weeks
<b>GDMA2</b> Controlled on oral medications	Wkly NST/Wkly AFI start 32 wks. 36 weeks biweekly NST & wkly SDP.	Induction 39-40 weeks. Order 38 <sup>th</sup> week sono EFW if possible macrosomia. Offer cesarean EFW>4500g
<b>Pregestational DM or GDMA2 on insulin</b>	Biweekly NST/weekly SDP begin 32 weeks.	Induction as for GDMA2 or earlier if comorbidities such as hypertension. Sono EFW 38 <sup>th</sup> week.
<b>IUGR (&lt;10<sup>th</sup> percentile) or R/O IUGR (sono pending)</b>	Biweekly NST/Weekly SDP Begin at diagnosis or pending formal ultrasound for EFW Sono<10% qwk umb art doppler*	Continue monitoring if EFW < 15 <sup>th</sup> percentile by Hadlock chart. Stop if >15 <sup>th</sup> percentile Consult for delivery plan EFW < 10 <sup>th</sup> percentile
<b>CHRONIC HYPERTENSION</b> BP≥140/90 or on BP medication Start med if > 150/100	Biweekly NST/Weekly SDP. Begin 32 weeks. 36 weeks if mild/good control normal fetal growth	Deliver 38-39 weeks. Monitor closely for superimposed preeclampsia and fetal growth—consider growth ultrasound(s)
<b>GESTATIONAL HTN</b>	Begin at diagnosis biweekly Weekly urine dip/labs as indicated	Gestational HTN usually deliver 37wks EGA
<b>PREECLAMPSIA W/O SEVERE FEATURES</b>	Begin at diagnosis biweekly NST/weekly SDP; Weekly PIH lab, q3wk growth sono	Preeclampsia w/o severe features deliver 37w0d wks EGA. SBP 140-159 or DBP 90-105 and pro/creat ratio ≥ 0.3
<b>PREECLAMPSIA WITH SEVERE FEATURE(S)</b>	Consult immediately	To L and D for evaluation
<b>MATERNAL AGE≥40 years</b>	Biweekly NST/Weekly SDP. Begin at 37 weeks	Induction 39-40 weeks
<b>PREGESTATIONAL BMI≥40</b>	Biweekly NST/Weekly SDP. Begin at 37 weeks	Induce at 41 weeks EGA
<b>CHOLESTASIS OF PREGNANCY</b>	Biweekly NST/weekly SDP after 32 weeks. Begin if clinical suspicion pending bile acids.	Check LFTs and serum bile acids Treat with Actigall 300mg bid-tid Induce at 37 weeks; Consult if Bile acid > 40
<b>HISTORY OF PRIOR FETAL DEMISE or ABRUPTION</b>	Biweekly NST/weekly AFI Begin 2 weeks before prior demise after 28 weeks EGA or at 32 weeks	Consider induction at 39 weeks Consider growth sono 32 weeks Recommend high risk pregnancy consult
<b>TWIN GESTATION</b>	Biweekly NST/weekly SDPs. Begin 36 weeks for concordant dichorionic twins; 32 weeks for monochorionic or discordant	Deliver concordant didi at 38 weeks, monodi at 36-37 weeks. Consult with OB or Perinatology for all twins. Transfer monoamniotic to Perinatology. Serial growth sonos q4 wks didi, q2-3 wks monodi
<b>POLYHYDRAMNIOS</b> <b>AFI &gt; 24</b>	Biweekly NST Begin at 32 weeks or diagnosis	Consider level II ultrasound for anomaly Confirm no GDM
<b>OLIGOHYDRAMNIOS</b>	Consult immediately	To L and D for evaluation
<b>OTHER</b> Thrombophilia, Renal Disease, Lupus, Anemia Hb < 8 Hyperthyroidism, Seizure Dz.(uncontrolled), Active Substance Use, Abnormal markers state screen**, Maternal conditions e.g. cardiac, pulmonary, sickle cell, HIV, Two vessel umbilical cord IVF pregnancy	Biweekly NST/weekly SDP Usually begin at 32 weeks or when identified after 32 weeks  ** PAPP-A<0.29 MOM AFP> 2.5 MOM Bhcg> 4.0 MOM Inhibin >4.0 MOM Bhcg and Inhibin both >2.5 MOM	Consult if need to review prenatal care and delivery plan. May call OB on call, use inbasket, or refer to higher risk prenatal clinic or consult in High Risk Pregnancy Clinic (Perinatology). Specify if consult, co-management or transfer of care preferred.  *Umbilical artery dopplers performed in radiology and usually scheduled by antepartum testing staff

## Hypertensive disorders of Pregnancy (it is confusing but manageable!)

**Chronic Hypertension:** two readings sbp >140 or dbp >90 at <20 weeks GA  
Must treat if sbp >150 or dbp >100 to prevent end organ damage.

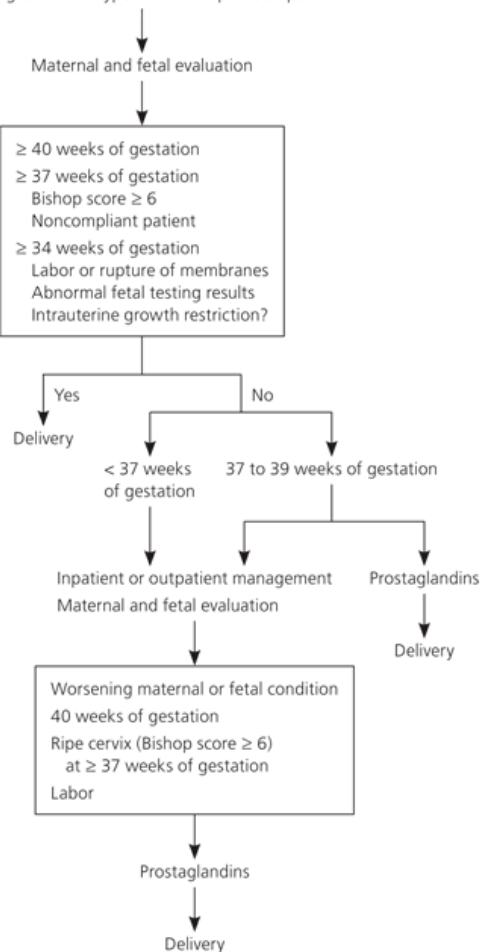
**Gestational HTN:** two readings sbp >140 or dbp >90 at >20 weeks GA that is nonproteinuric. Must treat if sbp >150 or dbp >100 to prevent end organ damage.

**Preeclampsia** is the development of new-onset hypertension with proteinuria after 20 weeks of gestation. Adverse pregnancy outcomes related to severe preeclampsia are caused primarily by the need for preterm delivery.

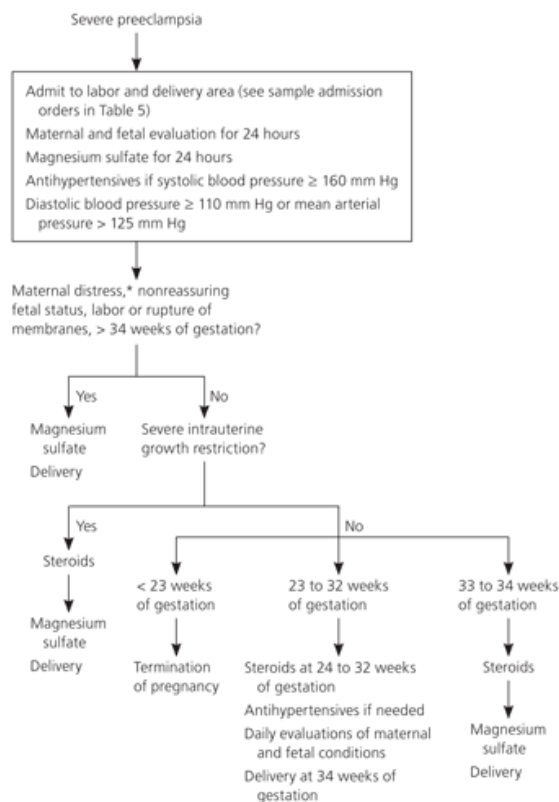
Risk factors: antiphospholipid ab, chronic HTN, chronic renal disease, elevated BMI, age >40, multiple gestation, nulliparity, prior Pre-E, GDM  
If with risk factors, tx with ASA and Calcium supplementation.

**Severe Pre-Eclampsia** BP >160 sbp or 110 dbp >6 hours apart on bed rest, symptoms, labs (lft, plt, etc), FGR, pulm edema, epigastric or RUQ pain. TX MAG! 6 gm bolus, then 2gm/hour. Also give antihypertensive.  
**HELLP** (20% of severe Pre-E): If platelets are <50000, check DIC labs.

Mild gestational hypertension or preeclampsia



## Management of Severe Preeclampsia



# Caring for Undocumented Patients

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## COUNTY CARE FOR UNDOCUMENTED PATIENTS

- Many patients listed as “self-pay” are undocumented (others simply do not have insurance)
- Inpatients with *diagnosed breast or cervical cancer* qualify for Medi-Cal for 18 months. Talk to **financial counseling**.
- Inpatients with *life-threatening conditions* may qualify for Medi-Cal via PRUCOL (Proof of Residence Under Color of Law). Ex: renal failure requiring dialysis, persistent vegetative state, diagnosed cancer. Patients must disclose immigration status. Talk to **financial counseling**.

## COMMUNITY HEALTH CENTERS

- Inpatients *without specialty clinic needs* should be referred to community health centers (e.g., Brookside, La Clinica de la Raza). Do not arrange follow-up for undocumented patients within our system as they will end up lost to care.
- Community Health Centers provide primary care ONLY. Labs/imaging are not covered.

## WOMEN’S HEALTH

- All pregnant women in California regardless of residency status are granted Restricted MediCal (Code TR). TR stays in effect until the second calendar month after giving birth. This means that women may have anywhere from 4 to 8 weeks of post-partum care (e.g., if the delivery happened at the beginning of June, the patient should be covered until the end of July (~ 8 weeks). However, if the delivery occurred at the end of June, the patient will also be covered until the end of July (~ 4 weeks).
- Post-partum patients who are losing insurance should be referred to a **FamilyPACT**. - County clinics in Concord, Richmond, Pittsburg, Martinez, La Clinica in Concord, Planned Parenthood are participating members. FamilyPACT provides free STD testing, Pap smears, contraception, and services that “Protect reproductive health by helping patients take care of themselves so that they can have a healthy baby when ready.”
- **Women must have reproductive potential to be eligible for FamilyPACT.** Post-menopausal women and women who have undergone a sterilization procedures (e.g., tubal ligation) are not eligible for FamilyPACT.

## NON-EMERGENCY SURGERY

- Inpatients who need non-emergency surgery should be referred to **Community Health Centers**, which can make a referral to **Operation Access**, a service that provides free non-emergency, outpatient surgeries (e.g. hernia repair, knee procedures, cataract, diagnostic colonoscopy) at John Muir and Kaiser.

## MEDICATIONS

- **Target and Walmart \$4 formularies** cover many common medications
- Please be sure to discharge undocumented patients with medications **THEY CAN AFFORD**, as they are otherwise uncovered.
- You can search their websites or download their formularies from Epocrates
- [www.GoodRx.com](http://www.GoodRx.com) allows you to search for prices of prescription medications at all local pharmacies to find the cheapest medication in the class and the cheapest pharmacy. Also has coupons.

# Notes

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# Ambulatory care: The Care Team

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*Family Medicine clinic is dependent on learning about your care team. On the first day of clinic, introduce yourself and get to know all the members of the team.*

Use the space below to fill in names and/or contact information for each role at your clinic site.

- **Care Coordinator:** \_\_\_\_\_  
They receive calls from patients and route messages to you (this is the easiest way for patients to reach you). Can track and assist with referrals initiated by HHPM (below). They are a clerical role so they cannot do any medical inquiries or assessments. It's helpful to make a dot phrase with CC contact info to include in your AVS (after visit summary) for clinic patients.
- **Health Home Panel Manager (LVN):** \_\_\_\_\_  
This is the person who can manage patients for you while they are outside the clinic walls. Follow-up on referrals, bring people back in for labs, follow-up on prescription errors and prior authorizations, update health care maintenance, manage narcotic Rx's
- **Advice Nurse:** 1 (877) 661-6230 or patient access line (800) 495-8885.  
Patients can call 24/7. If need be, there is an on-call doctor M-F 8a-12p and 4p-8p that can assist with prescriptions and follow up.
- **Registration Staff:** \_\_\_\_\_  
They check patient's insurance and contact info. They will inform you when patients show up late, how they behave in the waiting room, and clarify insurance issues.
- **Clinic Nurse:** \_\_\_\_\_  
This person may be an MA, LVN, or RN - learn the differences as they have different scopes of practice. They will room your patient and carry out any orders you need in clinic.
- **Resource Nurse (RN):** \_\_\_\_\_  
This is the person who has clinical assessment abilities. They can call a patient and ask them how they are feeling, assess their symptoms and follow standing orders to adjust blood pressure or DM meds, etc.
- **Treatment Nurse (RN):** \_\_\_\_\_  
This person can see a patient back in clinic, follow-up a weight or BP, or review medications. They can only follow standing orders and can't make an assessment without parameters.
- **Medical Records:** \_\_\_\_\_  
They are responsible for obtaining and scanning outside records, forms, and faxing information to outside agencies.

# Ambulatory care: Other Care Team Resources

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- **CASE MANAGEMENT:** Many patients have non-clinical needs. Consider referrals to Social Worker (in clinic), Public Health Nursing (for patients needing a comprehensive **home visit**), and CCHP Case Management. **Indications include but are not limited to:** medical non-adherence, high ED utilization, under/overutilization of med services available, frequent hospital admissions and readmissions, high-risk psychosocial risk factors, cognitive changes with significant functional fluctuations, need for coordinated care out of network, unstable medical conditions warranting closer monitoring, self care deficits, high risk seniors and persons with disability (SPD), Medicare-MediCal, disabled multiple chronic illnesses, end of life care. By RN certified case managers. To note, Mental Health also has their own case managers for some of their patients.
  - CCHP CM: For all CCHP members, refer to CCHP CM
  - For patients needing home visits and non-CCHP: refer to Public Health Nursing.
  - For resources that can be accessed during clinic visit, contact on-site Social Worker.
- **PUBLIC HEALTH NURSING:** PHN Intake Unit. The following are PHN Internal Referrals through ccLink:
  - PHN Adult INT: Homeless, case management support, home visits, substance abuse.
  - PHN Child INT: Developmental services, neglect, school advocacy, exposure to substance abuse, mental health, home eval.
  - PHN Communicable: HIV, TB, STD, Hansen's, other communicable diseases.
  - PHN Lactation: Home visit, newborn weight issues, lactation issues
  - PHN Perinatal: antenatal & postpartum patients; for depression, infant death, substance abuse, lactation and jaundice problems, substance abuse, socioeconomic and medically fragile, homeless, lack of support
  - PHN WIC: enrollment, specialty formula, nutrition counseling

# Ambulatory care: CCHP Resources/Referrals

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## CCHP RESOURCES:

- **AUTHORIZATION UNIT CCHP**
- **CCHP HEALTH PLAN:** <http://cchealth.org/healthplan/>
- **ccLINK and HELPLINE:**
- **FILING A GRIEVANCE:** 1 (877) 661-6230 (press 2) or <http://cchealth.org/healthplan/grievance/>
- **INTERPRETIVE LANGUAGE SERVICES:** Can use on speakerphone with patients in the room, or they can dial out to another number if you need to call a patient at home.

## CCHP REFERRALS:

- **ANTICOAG NURSE:** Used for monitoring PT/INR in patients on Coumadin. All referrals must be connected to a primary care doctor. If you are referring from the hospital, loop in the PCP. Best to also call the specific clinic when you're making this referral to make sure the patient is scheduled for visit soon after referral is made.
  - Anticoag clinic extensions: WCHC; MHC;; PHC:
- **COLON CA SCREENING:** check FIT first; use Flex Sig SmartSet (includes orders for bowel prep and patient education). If need for colonoscopy, order/refer to "GI procedures". GI scheduler will later order bowel prep and provide information on how to prep prior to procedure.
- **DIABETES:** order "Diabetes Care Management – Int Ref". Pharmacist-based DM management clinic open to referrals from all sites, initially limited to pts with HgbA1c > 9. Includes 1 face-to-face appt with pharmacist in MTZ then follow up by phone. Uses protocol-based algorithmic approach to medical management with pharmacists adjusting medications, ordering vaccinations, and referring to ophthalmology. Goal is to expand to face-to-face visit in East and West County.
- **INH:** for positive PPD, LTBI Rx for 9 mo. Tx and surveillance. Provide 1<sup>st</sup> 30-day Rx in clinic, then they follow. Search for "INH" in ccLink. See Wiki page.
- **NUTRITIONIST (Dietician):** Available for 1:1 and select groups through INT referral. Can assist with GDM, childhood obesity, heme/onc, home tube feeds, etc. MTZ: . PHC: . WCHC:
- **PHYSICAL THERAPY:** CCHP referral to PT/OT INT available at MHC, PHC, WCHC. MHC: . PHC: . WCHC.
- **REFERRAL COORDINATOR:** useful contact to field problems with CCHP internal referrals.
- **SPEECH THERAPY:** for CCHP patients, use internal ref at MTH, WCHC. External referrals need to be made for pts under 3 yo (to Regional Center of the East Bay); if over 3 yo to local school system. PH nurses are great resources for following up referrals and knowing up to date community resources.
- **STD CLINICS:** Evening free screening at Concord-Tues; Pittsburg-Wed; WCHC- Thurs. For appt: (800) 479-9664

- **TRAVEL IMMUNIZATIONS CLINIC:** MTZ **by appt only** Friday AM. Does **not** provide malaria prescriptions or other RX, only IZ. Free IZ to CCHP only; others charged:  
<http://cchealth.org/immunization/travel.php>

## **CCHP GROUP VISITS AND CLASSES:**

**\*PLEASE SEE CCRMW WIKI PAGE FOR ALL GROUP SCHEDULES → → →**

(<http://ccrmw.wikispaces.com/Groups+Schedules>)

- **ACTIVE AND HEALTHY FAMILIES:** learn how to help your kids eat healthy and be active. 6 sessions, no fee. MD's make referral to program. Offered at Brentwood, PHC, and WCHC. Spanish only. New one for African American patients in West County (English).
- **AFRICAN AMERICAN HEALTH CONDUCTOR GROUP – SOUL TO SOUL:** this group talks about health of body and spirit. Topics include mindful eating, tracking foods we eat, food cravings, diabetes, heart disease, food as medicine, the power of water, reading labels, shopping on a budget, sleep, and balancing your life. Offered at AHC in English.
- **DIABETES:** group visit with a doctor for people with type 2 diabetes. Topics include diabetes, daily self-care, blood sugar control, and wise food choices. 6 sessions. Offered at PHC, NRC, WCHC. English and Spanish.
- **DIETICIAN SERVICE:** private session with a dietitian. Single session. Offered at PHC, MHC, and WCHC. In any language via interpreter services.
- **DIETICIAN SERVICE – DIABETES CLASS:** a class on type 2 diabetes taught by a dietitian. Offered at PHC in English and Spanish, and at MHC in English only.
- **GESTATIONAL DIABETES CLASS:** offered through Healthy Start. Offered at WCHC in English and Spanish and at PHC in Spanish only.
- **PAIN AND WELLNESS GROUP:** covers topics such as nutrition, exercise, stress management, sleep problems, pain management, and positive thinking. 16 topics with weekly drop-in sessions. MD's refer patient to problem. Offered at PHC, MHC, WCHC. English.
- **PATIENT EDUCATION SERVICES:** private sessions with a nurse educator. Topics include diabetes; asthma; hypertension; how to use insulin, asthma inhalers, or a glucometer; smoking cessation. Single session. MD's make referral. Offered in any language via interpreter services.
- **PRENATAL ("CENTERING PREGNANCY"):** for moms-to-be whose due dates are close together. Topics include healthy pregnancy lifestyle, coping with stress, breastfeeding, nutrition. Patients ask to be in this group at Healthy Start visit. Offered at PHC and WCHC. English and Spanish. Offered at MHC and Brentwood in Spanish only.
- **SMOKING CESSATION CLASS:** single session. Offered at MHC and PHC in English.
- **WRIGHT INSTITUTE:** offers group visits for stress, grief/loss. Evenings in Martinez, and daytime in WCHC.



# Ambulatory care: Community Resources

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## BASIC NEEDS

- **211 Database:** [www.211database.org](http://www.211database.org), or call “211” -- West, Central, and East County resource guide, from alcohol to voter registration, as well as information on low cost medical resources in Contra Costa. In English and Spanish.
- **“FOOD STAMPS”,** formerly SNAP, now “CalFresh”: [www.calfresh.ca.gov](http://www.calfresh.ca.gov)
- **HEALTH CARE FOR THE HOMELESS:** (925) 313-6166
- **HOMELESS CONSULT AMION:** call for high intensity/healthcare for the homeless
- **HOMELESS SHELTER HOTLINE:** (800) 799-6599. Call 211 for English and Spanish assistance.
- **HOME HEALTH CARE Agencies:** can organize RNs, PT, OT, speech therapy, MSWs, and home health aids for **Medicare** and some Medical patients. Professional Healthcare At Home (excellent; John Muir Home health
- **HOSPICE:** Professional Healthcare At Home ; John Muir Home Health ; Sutter VNA and Hospice; Hospice of the East Bay
- **Senior food assistance, Soup Kitchens, Food Pantries:** Contact your local Medical Social Worker to assist, call **211**, or see 211 database, above

## LEGAL AID

- **Bay Area Legal Aid** Richmond Office on 1025 MacDonald Ave, Richmond, 94801; phone (510) 233-9954; fax (510) 236-6846.
- **Benefits Grid:** accessible at <http://ccrmc.wikispaces.com/West+County+Public+Benefits%2C+Resources%2C+and+Medical-Legal+Partnership>
- **Medical-Legal Partnership:**
- **Rubicon** Legal Services (formerly Hawkins Center):

## LGBT RESOURCES

- **CENTER FOR HUMAN DEVELOPMENT EMPOWERMENT PROGRAM FOR LGBTQ YOUTH:** Antioch and East County weekly support group and leadership development.. <http://www.chd-prevention.org/programs/empowerment.php>
- **LGBT COUNSELING AND SERVICE INTAKE:**
- **PFLAG:** Parents and Friends of Lesbians and Gays. Local support groups. [www.pflag.org](http://www.pflag.org)<http://www.pflag.org>
- **RAINBOW COMMUNITY CENTER:** Counseling, community resources info, and youth groups. Concord. [www.rainbowcc.org](http://www.rainbowcc.org).
- **RYSE CENTER:** Youth programs and LGBT support group. Richmond. [www.rysecenter.org](http://www.rysecenter.org).

# Ambulatory care: Financial and Insurance

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## **FINANCIAL AND INSURANCE** *(some of this may have changed with the ACA)*

- **CCHP PLANS:** A Covered California Affordable Care Act Plan. Also Employer Groups, IHSS workers, CCCounty employees, two Senior Health Medi-Cal plans, CCHP Medi-Cal Managed Care, AIM for Maternal–Child until 2 yo coverage if ineligible for no-cost Medi-Cal. Covers ambulatory care, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder treatment, rehab, labs, preventative and wellness services and chronic disease management, and pediatric WCC, dental & vision.
- **CCHP Medi-Cal:** Assigned to CCRMC and 8 clinics, Kaiser, and community network.
- **General Assistance (GA):** Low-income individuals who do not qualify for CalWorks or SSI can receive cash grants through GA. East Co (925) 706-4760; Central Co (925) 521-5001; West Co (510) 412-1920
- **(Straight) MEDI-CAL:** [Most will phase out after 2014 ACA implementation and become CCHP Medi-Cal managed plan.] Families of any size are eligible if eligibility guidelines met. Medi-Cal provides medical, vision and dental services for people with full-scope benefits. Contact your regional Contra Costa Medi-Cal office at: (800) 709-8348.
  - **Full Scope:** Eligible if U.S. citizen or a legal permanent resident alien **and:** Children birth to under 21 yo; Persons ≥ 65; Disabled and blind persons; Pregnant women; Families where at least one child < 21 yo and at least one parent is absent, disabled, unemployed or working (depending on hours worked and income earned); Former Healthy Families enrollees; Anyone who is eligible for CalWORKS, Supplemental Security Income and State Supplemental Program (SSI/SSP), or Entrant or Refugee Cash Assistance (ECA or RCA). Families with working parents may qualify if their employer does not provide health insurance; they pay a small share of their medical expenses; Persons in a skilled nursing or intermediate care home; Individuals who have been screened for breast and/or cervical cancer (Breast and Cervical Cancer Treatment Program). Services **not covered** by Medi-Cal for adults: Dental; Chiropractic; Acupuncture; Psychiatry Services; Eyeglasses (exam is covered); cosmetic surgery; infertility.
  - **Restricted Medi-Cal:** Emergency and pregnancy-related services for undocumented individuals. Pregnancy Restricted Medi-Cal is effective until end of 2<sup>nd</sup> calendar month after delivery.
  - **SOC:** Share of Cost. Based on a person's family size and income, a person may have to pay a share of cost (SOC) to the provider each month if Medi-Cal is used.
  - **PRUCOL Medi-Cal:** process for undocumented individuals who can prove residency in CA (paystubs, utility bills, rent, etc.) with severe medical needs to access Medi-Cal coverage (i.e. cancer, dialysis, etc). Need permission from Dr. Goldstein for temporary access to county services while pending PRUCOL application.
  - **CHDP Gateway:** 60 day CHDP presumptive eligibility for uninsured children awaiting approval by either Medi-Cal or CHDP
  - **CHDP:** Preventative and sports physicals for Medi-Cal enrolled children <21 yo or <19 yo in households at ≤ 200% FPL, Foster Care children. Health, Dental, Vision, Sports exams
- **MEDICARE:** A federal program. Also available CCHP Senior Health
  - **HealthCare Options:** Patient calls to change Medicare enrollment, such as from Blue Cross to CCHP. 1-800-430-4263
  - **Part A:** Covers hospitalization, SNF following hospitalization, DME, IHSS and home health care.
  - **Part B:** if low income or option as at an additional premium for higher income. Covers doctor bills, labs, diagnostic screenings, **and DME** prescribed by a doctor (up to 80%). Eye glasses covered q2yrs. Part D prescription drug discount cards with low cost monthly premium.
  - **Part D:** Restricted formulary drug program. A common Medicare Part D plan is Silverscripts. To see preferred Tier1 formulary: [www.silverscript.com](http://www.silverscript.com) . Ask which plan the patient has. To enroll or

switch plans, call HICAP (925) 335-8720 or (800) 510-2020. You can ask your coordinator to find the formulary of the Medicare part D plan that your patient has.

- **MEDI-MEDI:** If a patient is a Medi-Cal beneficiary with Medicare, s/he will get most of your prescription drugs from Medicare. Medi-Cal is secondary and picks up what Medicare doesn't. Covers prescriptions in their approved formulary; wheelchairs and repair; eyeglasses q2yr; PT; IHSS. May refer most to community specialists (e.g. colonoscopy, Ortho for joint replacement).
- **Unemployment Insurance** through **EDD:** Must be physically able to work, actively looking for and available to work, or laid off. Must have worked enough base wages prior to unemployment to make a claim. Totally or partially unemployed.
- **Presumptive Disability:** By CCC Employment & Human Services. Categories to receive Presumptive Disability include: **Terminally Ill with life expectancy <6mo**, total blindness, total deafness, bed confinement, **CVA >3mo ago** with loss of ambulation, speaking, or coordination UE, Down Syndrome, severe mental deficiency, Premie or Low Birth Weight until 1 yo, HIV, spinal cord injury with impaired ambulation, ESRD w/dialysis, ALS. File "Complete Disability Evaluation Process" attestation form and contact ----- for emergency filing.
- **SDI** (State Disability Insurance) through **EDD** (Employment Development Dept of CA): CA State "temporary" disability program. Only eligible if worked within the last 4 quarters AND have a job that paid into SDI or a private disability program. Includes disability caused by addiction and substance abuse.
- **SSDI** (Social Security Disability Insurance): Permanent disability through Federal Social Security. See link below for eligibility for physical or medical conditions. Commonly >1 but <2 years unless well documented eligibility: <http://www.ssa.gov/disability/professionals/bluebook/AdultListings.htm>. Require at least 3 months under your care; unable to do for "new patients"; clinical records needed to document severity and duration. If they do not meet clear criteria, need to hire a lawyer to prove to judge they can't work. See Legal Aide. Receive Medi-Cal initially when approved; if patient paid into Social Security will get Medicare after 2 years. It's helpful to send patients asking for SSDI to "amb ref functional capacity" for evaluation. Payments are about \$700/month (i.e., working can be more profitable).
- **Supplemental Security Income (SSI):** Low-income people who are blind, disabled, or elderly can receive supplemental grants through SSI. (800) 772-1213

## PREGNANCY RELATED DISABILITY

- **EDD SDI: State Disability Insurance** for employed or could be employed and pregnant. Claim may not be filed before time off and starts when patient stops working. Eligibility starts 4 weeks before EDD and extends for 6 weeks after for NSVD, 8 weeks for Cesarean. May start earlier or end later for complication—e.g. lumbar strain, preterm labor, etc. If eligible for SDI, patient also eligible for PFL.
- **PFL: Paid Family Leave** (Family Temporary Disability Insurance): Provides up to 6 weeks of partial (not full) wages for lost work while caring for family member or new child. Amount paid depends on prior base salary. Form AUTOMATICALLY sent by SDI if patient applied for disability insurance. Must be taken with FMLA if working for company subject to FMLA law (In other words, they are not additive; you can't take 12 + 6 weeks) and may be required to use up to 2 weeks of vacation (Paid Time Off) accruals before PFL kicks in. May be used for child bonding up to 6 weeks within 1<sup>st</sup> 12 months from birth.
- **FMLA:** Unpaid family leave. Federal Law that protects patient's job during absence. Often requires individual to use up accruals. Eligible if employed more than half time with company over 50 employees, ≥ 1 yr. Entitled to up to 12 weeks leave including before and after delivery. Must be provided usual insurance in absence and assured job upon return. Employer provides form upon patient request for FMLA. Provider fills out.

## Ambulatory care: Mental Health

## CCHP Mental Health

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- **Contra Costa CRISIS LINE: 24 Hour Mental Health Crisis Line:** 1 (800) 833-2900 or 1-888-678-7277 for crisis or referral information. **Grief Counseling** 1 (800) 837-1818
- **CCHP Mental Health Referrals:** MH referrals are now through cclink. Referral will be routed to local EPIC work queue for review and management who will assign a provider and make an appointment to their clinic. Use the same referral for both (1) mild to moderately mentally ill patients for psychotherapy, or (2) severely mentally-ill patients for psychotherapy and/or psychiatrist medication management. No longer need to give out MH Access Line number (it's still possible to provide this number, but this will not be tracked and will be less reliable than cclink referral).
  - When referring, document patient acuity/severity and failed trials of treatment. Ensure phone number in "snapshot" is correct and inform patient they will be contact and must return the call.
  - If patient gets therapy in external provider network, they will be given list of 3 providers to call and make appointment. If patient gets psychiatrist appointment, this will be through specialty MH clinic through the county.
  - If experiencing difficulty with this system, inbasket local MH program manager:
    - West Adult:-----; West Children: -----
    - Central Adult:-----; Central Children: -----
    - East Adult: -----; East Children: -----
  - If no response, inbakset -----
- **Contra Costa Mental Health Access Line:** (888) 678-7277; 1 (800) 846-1652 Alcohol & Other Drug Access
- **Miller Wellness Behavioral Health:** Acute psychologic crisis not currently connected to therapist or psychiatrist. pt can walk in m-f 12-9 pm or sat 8a-5p

## Uncategorized Mental Health

- **Community Counseling Resources:**  
<https://ccrmc.wikispaces.com/Counseling+Resources><https://ccrmc.wikispaces.com/Counseling+Resources>
- **Community Health for Asian Americans** (510) 233-7555
- **Familias Unidas Counseling:** (Spanish-speaking services) West County (510) 741-7286
- **Psychiatry "Doc of the Day"** phone consults: (925) 431-2600
- **Psych Curbside Consults in FPC:**
  - Look on amion M-F from 8:30 to 4:30
- **"Rapid Access" Program:** available at El Portal Clinic, San Pablo, PHC. Contact LCSW. Rapid Access Program allows for high-risk patients to drop-in for psych evaluation during certain hours of the week.
- **Stress Management CD's:** created by Kaiser. Available in most health centers. With guided meditations for stress management. In English and Spanish.
- **Wright Institute Health Coaches:**  
\*site specific: Ask your preceptor

## Children's Mental Health

- **CHILD MENTAL HEALTH:** Richmond -----; Antioch -----; Concord: -----
- **Early Childhood Mental Health:** ----- Will follow kids with mental illness or at risk due to mental illness in parent until age 5. Medi-Cal only

- **First Hope:** (925) 681-4450. County early intervention program for pre-psychosis. No electronic or paper referral required, just call. Especially helpful for adolescents with early odd/uncharacteristic behavior

## Older Adults Mental Health

- **IMPACT:** For patients with depression if  $\geq 60$  on Medi-Cal, Medi-Medi, or Basic Adult. **Straight Medicare ineligible** but will be given community resource recommendations. Up to 8 sessions CPT. Impact Depression Care Managers:
  - ----- (East County-PHC)
  - ----- (Central County)
  - ----- (West County)
- **Older Adults Mental Health** -----

## County Specific Resources

### **Crockett Counseling Center – Antioch (East County)**

3700 Delta Fair Blvd, #204  
Antioch, CA 94509  
925-370-6544

### **The Hume Center – Pittsburgh office (East County)**

555 School Street  
Pittsburgh, CA 94565  
925-432-4118

### **Family Unidas – Brentwood – SPANISH SPEAKING (East County)**

1191 Central Boulevard, Suite A  
Brentwood, CA 94513  
925-6334-4445

### **Bay Area Psychotherapy Training Institute (Central County)**

3468 Mt. Diablo Boulevard, Suite 201  
Lafayette, CA 94549  
925-284-2298

### **John F. Kennedy University Counseling Center (Central County)**

380 Civic Drive, Suite 200  
Pleasant Hill, CA 94523  
925-798-9240

### **The Hume Center (Central County)**

Concord Office  
1333 Willow Pass Road, Suite 102  
Concord, CA 94520  
925-825-1793

### **Touchstone Counseling Services (Central County)**

140 Mayhew Way, Suite 606  
Pleasant Hill, CA 94523  
925-932-0150

### **Crockett Counseling Center – Martinez Office (Central County)**

535 Main Street  
Martinez, CA  
925-370-6544

### **Asian Family Resource Center (West County)**

12240 San Pablo Avenue  
Richmond, CA 94806  
510-970-9750

**The Psychotherapy Institute (West County)**

2232 Carleton Street  
Berkeley, CA 94704  
510-548-2250

**Family Unidas Counseling and Information Center – SPANISH SPEAKING (West County)**

205 39<sup>th</sup> Street  
Richmond, CA 94805  
510-412-5930  
(Individual Therapy, Group Therapy, Case Management, Anger Management)

**Wright Institute Clinics:****Berkeley, CA****Addison Clinic (Long-term dynamic psychotherapy)**

510-548-9716

**Parker Clinic (Cognitive Behavioral Therapy)**

510-486-8998

**Chemical Dependency Programs****CONTRA COSTA COUNTY HEALTH SERVICES LINE**

1-800-846-1652

Drug and alcohol addiction, triage, and referral

**EAST COUNTY COMMUNITY DETOX CENTER**

925-427-1384

500 School Street, Pittsburgh, CA 94565

ETOH and Drug detox program funded by County & state. Serves all income levels. Detox service is non-medical, no methadone. Have 3 female beds, 7 male beds.

**FREDERICK OZANAM CENTER**

925-676-4840

2931 Prospect St., Concord, CA 94518

Recovery program for women 18+. Clients stay up to 6 months. Self paid or through county assistance.

**MERRIT PERALTA INSTITUTE**

510-652-7000

3012 Summit St., 5th Floor, C wing, Oakland, CA 94609

510-869-8850

Inpatient treatment, adults.

**PEUBLO DEL SOL**

925-676-2580

2090 Commerce Ave., Concord, CA 94520

Age 18+, 35 day inpatient, nonmedical detox center (social detox model), and referral service for men.  
Fee: \$7.00 / day or sliding scale.

**SUNRISE HOUSE**

925-825-7049

135 Mason Circle, #M, Concord, CA 94520

90-day, live-in social detox model drug/etoh therapy facility. 18+ year old men & women; accepts third party reimbursement; also has indigent services.

**WOLLUM HOUSE**

925-458-1978

Women's detox program; 90-day live-in program and 30-60 days reentry (sliding scale fee)

**John Muir Behavioral Health**

Chemical Dependency

Assessment, residential and day tx programs

2740 Grant St., Concord, CA 94520

Main Phone: (925) 674-4100 or (800) 680-65

# Ambulatory care: Topic-Specific Resources

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## CHRONIC PAIN

- **Chronic Pain:** See Wiki <http://ccrmc.wikispaces.com/Addiction+Medicine>
- **CHRONIC PAIN DOCUMENTATION:** standardized documentation for patients with chronic pain. Add “chronic pain” to the problem list. Try the chronic pain template in the Overview section of the problem list: .chronicpainoverviewlq (can get from ----- smartphrase manager if you don’t have it) – this allows for tracking last urine tox, red flags, current pain regimen, last CURES, etc. Use the Chronic Pain Smart Set for documentation – this provides a note template, common orders and referrals, and links to risk assessment tools, pain contracts, and misuse forms.
- **PAIN AND WELLNESS CLINICS:** support groups available at WCHC, MHC, PHC. They do not write any narcotics.
- **PAIN MANAGEMENT:** INT referral to Med Pain Clinic at MTZ, PHC, WCHC for PO analgesic consult. EXT referral to Pain Management specialists through EPIC for CCHP pts.
- **SPINE CLINIC:** Non-surgical management; review of MRI/CT and clinical presentation to advice regarding surgical management.
- **SPINAL EPIDURAL UNDER FLUROSCOPY:** must have recent MRI or CT. INT Referral. Also EXT referrals to Pain Management specialists.

## DURABLE MEDICAL EQUIPMENT

DME is medical equipment used repeatedly (over and over again) by a person who is ill or injured. Covered by CCHP - use INT REF. MediCare Part B pays 80%. Use ccLink DME referral and select “class: DME” to print out an order that can be faxed to the service provider. Give a copy to patient and route order to your LVN Panel manager to assist with referral. LVNPM should fax order, progress note, patient demographics and insurance benefits page to service provider.

### Suppliers:

- **WHEELCHAIRS:** Manual, Electric and Repair: Covered by Medi-Cal and Medicare part B when prescribed by physician. Must meet criteria. See sample note required by Medicare on Wiki. For those who require long-term wheelchair use for disabilities, needing modifications like seat pads and leg straps, they should first be referred to PT for wheelchair assessment. PT will complete and evaluation and make specific modifications/recommendations which MD can then cosign.
- **OSA AND RESPIRATORY SUPPLIES:** Nebulizers, Pulmo-Aides, Spacers, CPAP, BiPAP, O2.
  - **For CCHP OSA:** Requires sleep study within INT referral to order; if for **OSA**, must do prerequisite Ambulatory Sleep Study. Basic CPAP settings to start: 7.5 cm H2O. Request autotitration. Reorder supplies through LINCARE (CCHP contractor) at 1 (800) 284-2006
  - **For Non-CCHP/ Medicare OSA:** order Observed Sleep study at regional center. Internal referral will automatically complete CPAP referral.
  - **For COPD:** order CPAP or BiPAP if RR>25, pO2 < 94%, or use of accessory muscles to breathe. Refer as needed to CPAP Clinic for adjustments. Reorder supplies after approved sleep study; usually annually. CCHP authorized Respiratory Services provider: LINCARE (800)284-2006. Questions for cardiopulmonary can be referred to cardiopulm manager.
- **ORTHOTICS AND PROSTHETICS:** Braces, artificial limbs, crutches, canes, breast prosthetics and bras. Covered by CCHP - use INT REF. MediCare Part B pays 80%. Use referral and select “Class: DME” to print out an order to fax to Hanger Orthotics. Search for DME Order in ccLink. Fax to Hanger at ----
- **OSTOMY, WOUND, & MEDICAL SUPPLIES:** Covered by CCHP - use INT REF. MediCare Part B pays 80%. Use referral and select “Class: DME” to print out an order to fax to Shields Medical. Shields Medical phone: -----
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## INTEGRATIVE MEDICINE:

- **CCRMC wiki:** <https://ccrmc.wikispaces.com/Integrative+Medicine> - includes information on meditation, the doula program, local community referrals including options for acupuncture, and other helpful resources
- **Integrative Medicine for the Underserved:** IM4US.org
- **Acupuncture available in the community**
- **Santa Rosa Family Med Residency:** multiple patient ed handouts - <http://www.srfmr.org/integrative-medicine/im-handouts>
- **University of Wisconsin:** modules and handouts - <http://www.fammed.wisc.edu/integrative/modules>

## MATERNAL AND CHILD HEALTH

- **CCS** (CA Children's Services) for disabled children under 21 yo:  
<http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx>
- **CFS** (Children & Family Services – previously Child Protective Services):  
<http://www.childsworld.ca.gov/>
- **CHDP:** Child Health and Disability Prevention for WCC for infants through teens. For those under 21 on Medi-Cal; Non-MediCal under 19 yo if family incomes below 200% Federal Income Guidelines.
- **First Five:** Services for expectant parents (including teens) and children 0-5 yo, as well as expectant teens. Program provides home visits, parenting and child development classes, free parent-child playgroups, mental health evaluations and services for at risk children, family homeless shelters, and child literacy programs. Bilingual services available. Program available in Antioch, Bay Point; Concord; Brentwood; and West County. 211 phone referral or <http://www.firstfivecc.org>.
- **Healthy Start:** options counseling (if your patient is considering a termination), GDM classes and management, prenatal vitamins. PHC: -----. MTZ: -----. WCHC: ----
- **Lactation resources:**
  - Warmline: (866) 878-7767 – can refer to breastfeeding peer counselor
  - LaLeche league support groups: Pittsburg, Concord, and San Ramon
- **Regional Center of East Bay:** for developmental disabilities involving motor, speech or learning for children younger than 3 yo. (925) 691-2300. In Concord. You can call and leave a message for a referral; the parents MUST also call or the case will be dropped.
- **WIC** (Women, Infants and Children): nutritional support services (food packages). Also provides Lactation support services including consults, pumps. Eligible for expectant, post-partum, and lactating mothers; children <5 yo; Foster children on Medi-Cal. WIC: 1 (888) 414-4WIC.
  - 2311 Loveridge, Pittsburg (925) 431-2460 for clients; ----- – direct line for providers
  - 171 Sand Creek Rd, Brentwood -----
  - 2355 Stanwell Circle, Concord (925) 646-5370 for clients; ----- – providers
  - 39<sup>th</sup> Street and Bissell, Richmond (510) 231-8600 for clients; (----- – providers
- **Maternal-Child Health Phone numbers:**
  - Bay Area Crisis Nursery: (925) 676-2845
  - Black Infant Health: (510) 779-3194
  - Breastfeeding Advice: 1 (866) 878-7767; (925) 757-4053
  - Domestic Violence: 1 (888) 215-5555
  - Early Childhood Mental Health: (510) 412-9200
  - East Bay Perinatal Associates: (510) 444-0790; Provider Consultation Line: -----
  - Healthy Families: 1 (800) 503-9350
  - Familias Unidas (West County): (510) 412-5920
  - Healthy Start: WCHC -----; MHC -----; PHC ----
  - Homeless Line: (800) 799-6599
  - Labor & Delivery: CCRMC -----; Alta Bates Medical Center -----
  - Rape Crisis Center: (800) 670-7273

## OBESITY:

- **FOOD ADDICTS:** free support group. For various types of eating disorders, not just obesity. For a list of meetings, go to [www.foodaddicts.org](http://www.foodaddicts.org), or call (781) 932-6300.
- **GASTRIC SURGERY:** Consult Dr. Lo. CCHP will arrange for a preoperative mental health consultation to rule out severe mental disease and determine the ability of the member to comply with postoperative dietary restrictions AFTER meeting eligibility criteria. Information for steps required prior to mental health evaluation, and how to refer patients for evaluation prior to surgery, can be found on the **star icon** of CCHP desktop computers.
- **PEDIATRIC OBESITY:** refer to Active and Healthy Families (see section on CCHP Group Visits) of CCHP disease management program for pediatric obesity. The latter is a program for children ages 2-11 with BMI > or = 95%. Access referral form on [www.contracostahealthplan.org](http://www.contracostahealthplan.org) section under “Forms and Resources”. For more information: -----.
  - Other resources: (1) patient education referrals; (2) dietician/nutrition referrals; (3) pediatric obesity order set

## PEDIATRICS:

- **CIRCUMCISION RESOURCES:** ask your nurse or care coordinator for a list of physicians who perform newborn circumcisions in their office. Families call directly for appointments. CCRMC nursery also has this information. Can also find dot phrase (.circumcisionresources) with this information under (Laura) Emily Cotter’s smart phrase manager.
- **DENTAL:** ask your nurse or care coordinator for a list of dentists and clinics. This information is also available in a dot phrase (.dental) under Cotter’s smart phrase manager.
- **KIDS HEALTH:** patient info for parents, teens, kids, and educators. <http://kidshealth.org>
- **PEDS-ON-CALL:** check amion.com for pediatric MD on call. Great for same-day questions for patient in clinic.
- **SURVIVING PARENTHOOD:** resource directory for Contra Costa County. Information about requesting hard copies of document and PDF copies available at <http://www.capc-coco.org/surviving-parenthood.html>.
- **VACCINES:** patient information on the importance of childhood vaccines with resources to parents who wish to refuse childhood vaccines:
  - <http://www.cdc.gov/vaccines/hcp/patient-ed/conversations/conv-materials.html>
  - <http://www2.aap.org/immunization/>
  - <http://eziz.org/resources/parented/>

## PRE-OP RESOURCES

PreOp Smart Set: “PAT Pre-Op” will open perioperative order form/ DOT sheet to assist in knowing what preop orders are indicated. Don’t order more than indicated. This also links to Perioperative Guidelines for medication changes you will need to make preoperatively.

- **PONE nurses:** pre-op, patients are seen by the PONE prior to their Pre-op appt. Labs, EKG, CXR should have been ordered according to the Perioperative protocol and all the paperwork comes with the patient to the appt. In basket message to clinic specific Preop Nurse
- **ANESTHESIA CONSULT:** Look up in AMION or call -----
- **HIGH RISK PREOP CONSULT:** Order before pre-op H&P when METS < 4 (See also guidelines in standard pre op H&P)

## SENIOR SERVICES

- **Contra Costa Adult and Senior Services:** ----- (800) 510-2020 (Universal help line for all seniors and patient with disabilities, including financial services, social services, IHSS, elder abuse reporting, etc)
- **AGING AND ADULT SERVICES: NOT ONLY FOR SENIORS.** Excellent printable brochures of comprehensive County and Community resources:
  - West County English:
  - Spanish:
  - East County
  - Spanish:
  - Central County: <http://ca->
  - Spanish:
- **IHSS:** In-Home Support Services (for patients with high needs at home, family members can get paid for the time that they care for the sick). Eligible if on Medi-Cal and permanently disabled. Central County:-----; East County-----; West County-----. MSW, PHN, and CCHP case managers can assist patient to apply.
- **HOME HEALTH CARE AGENCIES:** Professional Healthcare At Home -----; John Muir Home Health -----; Sutter VNA and Hospice -----.

## SPECIALTY CONSULTS

- **CCHP CONSULTS:** check amion for schedule of who is on for various departments -----
- **HIV WARM LINE:** via UCSF Clinical Consultation Center. For a phone consultation, call (800) 933-3413. Monday – Friday, 9 a.m. – 8 p.m. EST. More information at <http://nccc.ucsf.edu/clinician-consultation/hiv-aids-management/>.
- **Poison Control:** Call anytime 24/7. Be prepared to give patient's name, DOB to discuss open case. (800) 222-1222

## SUBSTANCE ABUSE

- **Contra Costa Substance Abuse Access Line:** 1 (800) 846-1652
- **Wright Institute can help with resources**
- **Buprenorphine groups:** available in CHC, PHC, MHC through INT referral in ccLink
- **BAART:** Bay Area Addiction Rehab & Treatment: Specializing in detox programs and rehabilitation programs for prescription medication addiction including pills like oxycontin and vicodin, and opiate addiction. For patients >18 yo. Accepts Medi-Cal, CCHP, and Medicare.
  - BAART Richmond: 1313 Cutting Blvd, Richmond, CA 94804. Phone (510) 232-0874. Fax: (510) 232-0874
  - BAART Antioch: 707 Sunset Lane, Antioch, CA 94509. Phone (925) 522-0124. Fax: (925) 522-0133

## WOMEN'S HEALTH:

- **CONTRACEPTION SERVICES:** Family Planning Services Program. Non-CCHP through Family PACT (Planning, Access & Treatment). Available to all patients including undocumented and minors with sensitive services. Providers: Public Health Dept Women's Clinic at CHC, WCHC, PHC, MHC; Regional Planned Parenthood; La Clinica. Includes f/u for abnormal PAPs needing repeat or colpo, STDs. Post-menopausal and post-sterilization procedure patients not eligible for Family Pact services. Refer through ccLINK.
- **STAND! For Families Free of Violence:** <http://www.standagainstdv.org/>. 1 (800) 215-5555; Concord (925) 676-2845.

- **SCHOOL BASED TEEN CLINICS:** contraceptive services, sports physicals. PHN-run in West, East, and Central County High Schools.
- **UNDESIRED PREGNANCY:** refer patient to Planned Parenthood or to Linda Wise, social worker for MHC LAM clinic. Send inbasket message to Linda Wise, or phone (925) 370-5200 x4912. EPL Referral, then click “desired termination”

## WEB AND EVIDENCE-BASED RESOURCES:

All Login and Passwords for online resources available on iSite (type CCHS in any browser on a **county computer**) then follow link to “Degnan Library”.

- Dynamed:
- Alan’s myHQ web portal: Type **cchs.it** in browser window or <http://myhq.com/public/c/c/ccrmc/> - expansive guide to CCRMC links, clinical resources, etc.
- Audio-Digest [www.audio-digest.org](http://www.audio-digest.org)
- Noon Conference: Access -----.  
Powerpoint available:  
Recorded Conferences: Available afterwards on JUBILANT

## INBASKET MANAGEMENT:

- Expectation is all messages are dealt within 3 business days but best patient care is the same day.
- Order your inbasket with most pressing folders at the top (Settings → Display Order → Add folder you want to keep near the top)
- Ask for help. **Your superuser is a resource.** Schedule a training session, or ask a preceptor for help
- Check your inbasket at least daily. If you have a few minutes free try to get through a few items rather than letting things pile up.
- Do today’s work today. The seconds wasted by re-reading a message add up. Take care of things as you read them whenever possible. You can also write yourself a comment which is not part of the medical record.
- Whenever possible, try not to leave the inbasket to link to other parts of cclink (extra clicks waste time). The Rx request folder has windows for your last note, last labs, last vitals. The result folder also has several options including result note, encounter, etc.
- Use “patient lists” (used frequently in inpatient setting) to organize high need groups. Some proposed groups include chronic pain, OB patients (add column for their EDD), and high need / high risk patients. You can have as many lists as you want and share between providers. Go to “create a list”, name it, add list characteristics desired in header, and then add patients.
- Try to always stay in an encounter rather than creating multiple encounters for the same event. For example if you have an Rx Request and need to order labs click on Enc and order the labs while addressing the prescriptions. If something needs to be part of the medical record it must be in a encounter (ex. route notes to your care coordinator). Reply to sender is like a staff message and not part of the medical record (but could be discovered so be professional:)

# ALSO Algorithms

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## Shoulder dystocia

**H** = call for help  
**E** = evaluate for episiotomy  
**L** = legs : McRoberts Maneuver  
**P** = suprapubic pressure  
**E** = enter: rotational maneuvers:  
**R** = remove posterior arm  
**R** = roll patient to her hands/knees

### Rotational maneuvers:

**Rubin II** = push anterior shoulder anteriorly

**Rubin II + wood screw** = push anterior shoulder anteriorly and posterior shoulder posteriorly

**Reverse wood screw** = push posterior shoulder anteriorly

### Remove posterior arm:

1. Follow the posterior arm to elbow
2. Flex arm at elbow
3. Sweep forearm across the chest without pulling directly on hand, rotates baby

## Post Partum Hemorrhage

Four T's

### #1 Tone = uterine atony (70%)

- perform uterine massage
- perform bimanual compression
- Medications:
  - > **Pitocin** (Oxytocin) 10u IV/IM (10-40 u in 1L saline at 250 cc/hr)
  - > **Methergine** (Methylergonovine) 0.2mg IM (caution with HTN)
  - > **Hemabate** (Prostaglandin F2alpha) 0.25mg IM or intramyometrial, q15 min up to 8 doses, but consider surgery after 2 (contraindications: asthma; side-effects: n/v and diarrhea)
  - > **Misoprostol** 600-1000 buccal, vaginally, rectally, or SQ

### #2 Trauma = Cervix or vaginal lacerations (20%)

- Examine and repair

### #3 Tissue = retained placenta

## Vacuum application

Prevent with active 3rd stage management (10%)

- Manual removal
- Explore for fragments

### #4 Thrombin = coagulopathy (1%)

- Confirm with bedside clot test (2ml of blood, if does not clot after 7 min or only soft clot that breaks down easily, suggests coagulopathy)
- replace blood products (2u pRBCs then 1 FFP per unit pRBCs, 10u cryo)

## Massive PPH team

### #1. Uterus

- Massage uterus
- Coordinate: Helper 1 at head, helpers 2 and 3 at arms
- If bladder full or palpable, empty with a catheter
- If atony persists, bimanual compression
- Review other causes - 4 Ts (Tone, Trauma, Tissue, Thrombin)
- Move to surgery early if bleeding persists
- **Initiate massive transfusion protocol, verbal order**

### #2. Head

- Check airway
- Check breathing
- Administer oxygen
- Lie flat
- Note time of relevant events

### #3. Arms

- check pulse and BP
- Establish large bore IVx2
- Check blood counts, clotting, and crossmatch 4-6 units
- Start fluid resuscitation if required with 2 liters crystalloid
- Administer meds

**A** = address patient, ask for help, assess anesthesia

**B** = bladder empty

**C** = cervix must be completely dilated

**D** = determine position of head. think shoulder dystocia and review HELPPER

**E** = Equipment ready, extractor ready

**F** = place cup in proper relation to fontanelles (2/3 of distance from anterior to posterior fontanelle) on flexion point

**G** = gentle traction following the pelvic curve, rising as head crowns

**H** = halt traction between contractions, halt if cup disengages 3 times, halt if no progress in 3 pulls, halt procedure after 20 minutes of use  
--> be prepared to abandon the procedure and move to Cesarean

--> avoid prolonged use beyond the "halt" guidelines

--> avoid pivoting and rocking

**I** = Incision: evaluate for episiotomy when head is crowning

**J** = remove the vacuum cup when the jaw is reachable



# Rapid Sequence Intubation

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## Induction Drugs:

Drug	Dose	Pros/when to use	Cons
Etomidate	0.3mg/kg	hemodynamically neutral, good to use with head injury, stroke, heart disease, shock	?adrenal suppression
Midazolam	0.1-0.3mg/kg	status epilepticus	hypotension
Thiopental	3-5mg/kg	status epilepticus	hypotension, bronchospasm (dont use in sepsis)
Ketamine	1-2mg/kg	head injury, stroke, reactive airway ds, shock	
Propofol	1.5-3mg/kg	reactive airway disease	hypotension

## Paralytic:

Drug	Dose	Pros/when to use	Cons
Succinylcholine	1.5mg/kg	rapid onset/offset	hx malignant hyperthermia, risk for hyperK, stroke or burn >72yo, rhabdo, neuromuscular disease (not MG) muskulodystrophy
Rocuronium	1mg/kg (ideal body wt)		

# ACLS Algorithms

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In case you don't always have your code cards on you, here are the essential algorithms and references

## CPR QUALITY

- Push hard ( $\geq 2$  inches [5cm]) and fast ( $\geq 100$ /min) and allow complete chest recoil
- Minimize interruptions in compressions
- Avoid excessive ventilation
- Rotate compressor every 2 minutes
- If no advanced airway, 30:2 compression-ventilation ratio
- Quantitative waveform capnography
  - If  $PETCO_2 < 10$  mmHg attempt to improve CPR quality
- Intra-arterial pressure
  - If relaxation phase (diastolic) pressure  $< 20$  mm Hg, attempt to improve CPR quality

## RETURN OF SPONTANEOUS CIRCULATION (ROSC)

- Pulse and blood pressure
- Abrupt sustained increase in  $PETCO_2$  (typically  $\geq 40$  mmHg)
- Spontaneous arterial pressure waves with intra-arterial monitoring

## SHOCK ENERGY

- **Biphasic:** manufacturer recommendation (eg initial dose of 120-200 J); if unknown, use maximum available. Second and subsequent doses should be equivalent, and higher doses may be considered
- **Monophasic:** 360 J

## DRUG THERAPY

- **Epinephrine IV/IO dose:** 1mg every 3-5 min
- **Vasopressin IV/IO dose:** 40units can replace first or second dose of epinephrine
- **Amiodarone IV/IO dose:**
  - first dose 300mg bolus
  - Second dose: 150mg

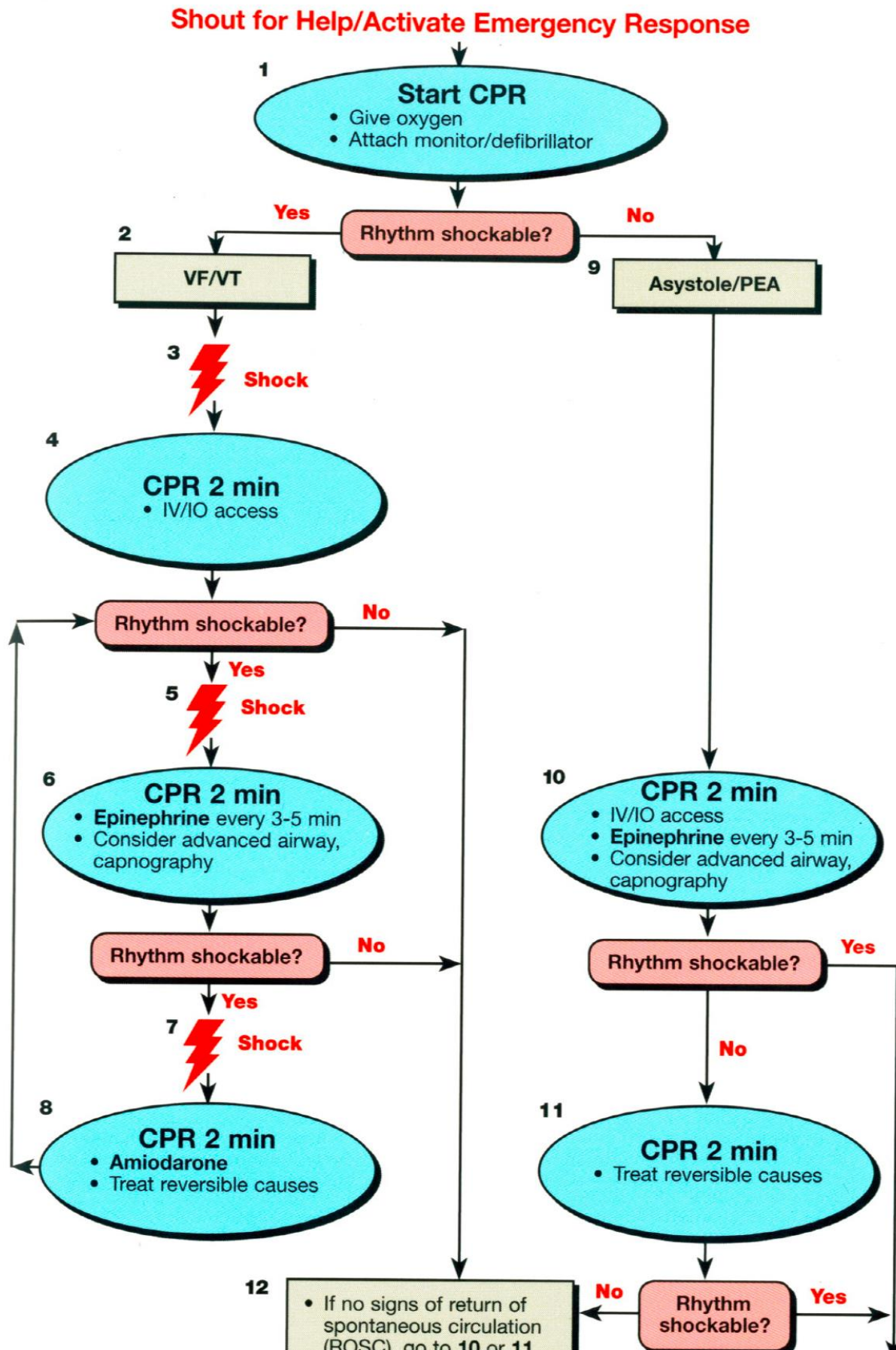
## ADVANCED AIRWAY

- Supraglottic advanced airway or endotracheal intubation
- Waveform capnography to confirm and monitor ET tube placement
- 8-10 breaths per minute with continuous chest compressions

## REVERSIBLE CAUSES

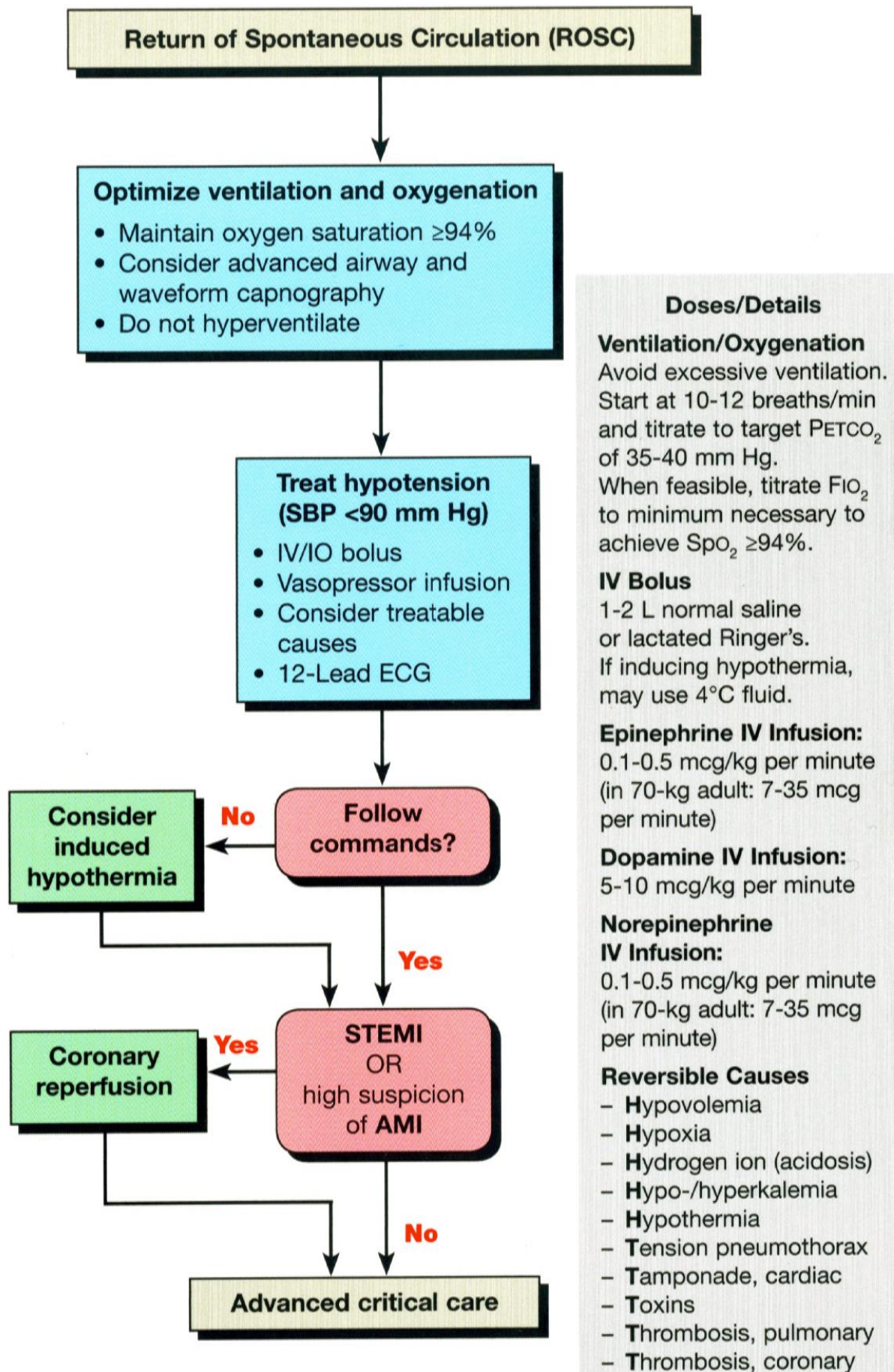
- Hypovolemia
- Hypoxia
- Hydrogen ion (acidosis)
- Hypo/hyperkalemia
- Hypothermia
- Tension pneumothorax
- Tamponade, cardiac
- Toxins
- Thrombosis, pulmonary
- Thrombosis, coronary

# Cardiac Arrest Algorithm



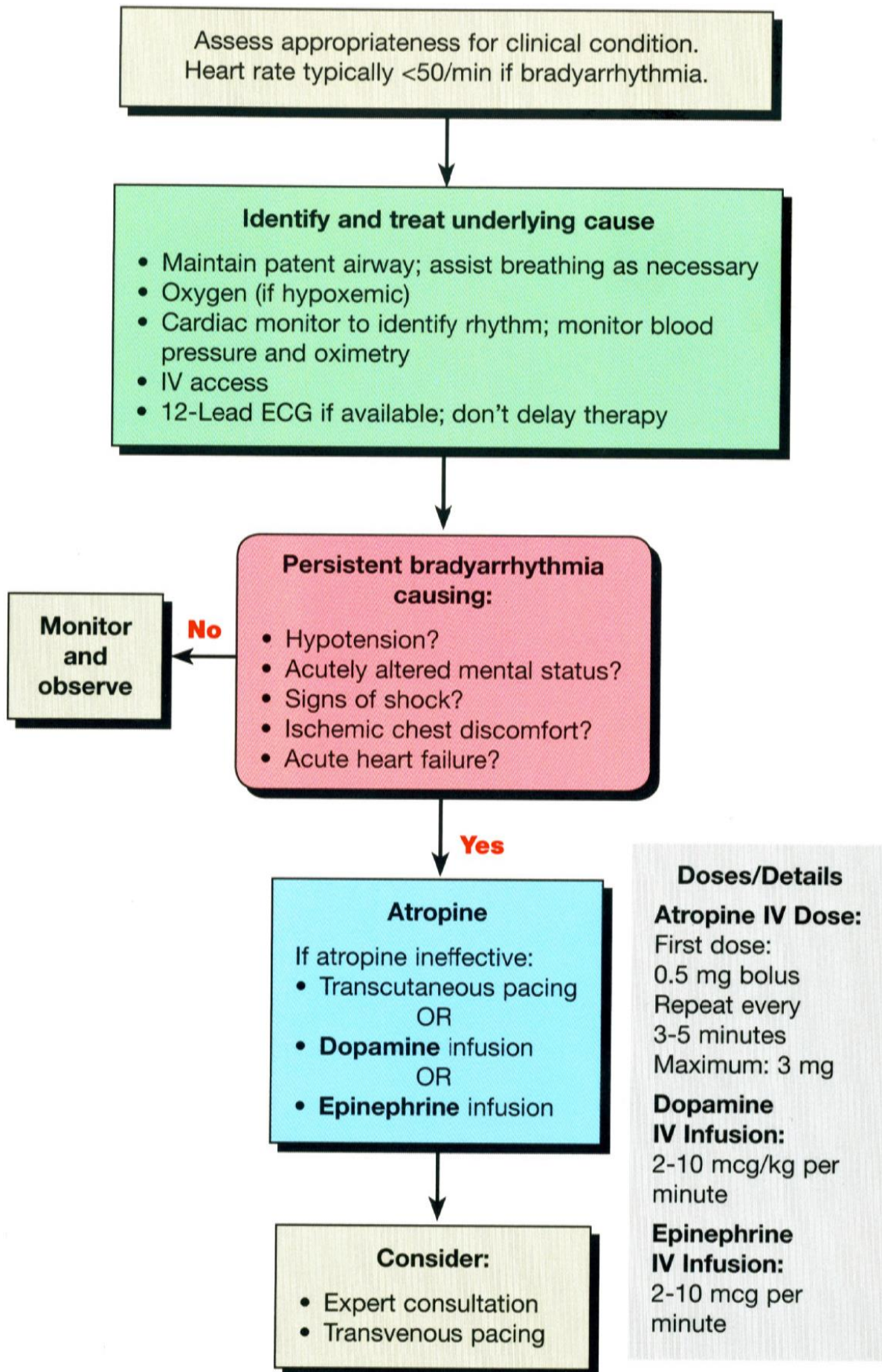


# Immediate Post-Cardiac Arrest Care Algorithm



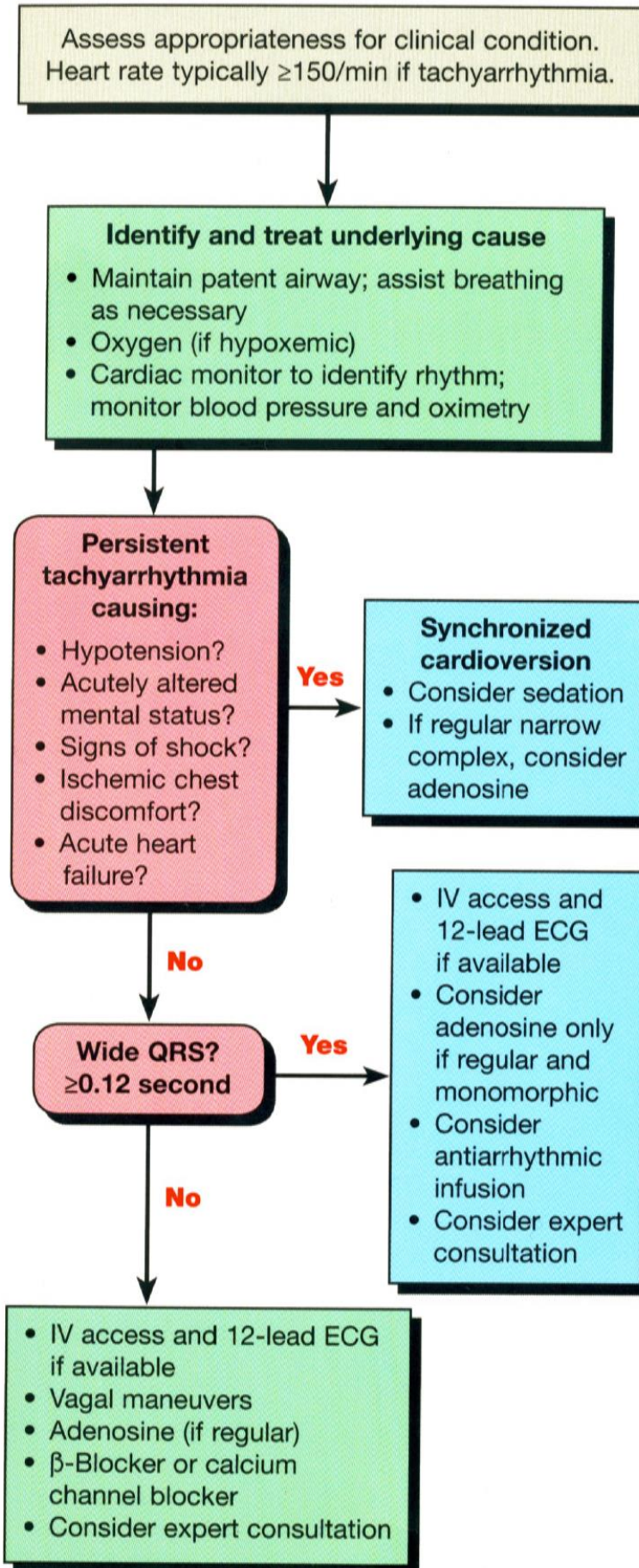


# Bradycardia With a Pulse Algorithm





# Tachycardia With a Pulse Algorithm



## Doses/Details

### Synchronized Cardioversion

Initial recommended doses:

- Narrow regular: 50-100 J
- Narrow irregular: 120-200 J biphasic or 200 J monophasic
- Wide regular: 100 J
- Wide irregular: defibrillation dose (NOT synchronized)

### Adenosine IV Dose:

First dose: 6 mg rapid IV push; follow with NS flush.  
Second dose: 12 mg if required.

### Antiarrhythmic Infusions for Stable Wide-QRS Tachycardia

#### Procainamide IV Dose:

20-50 mg/min until arrhythmia suppressed, hypotension ensues, QRS duration increases  $>50\%$ , or maximum dose 17 mg/kg given. Maintenance infusion: 1-4 mg/min. Avoid if prolonged QT or CHF.

#### Amiodarone IV Dose:

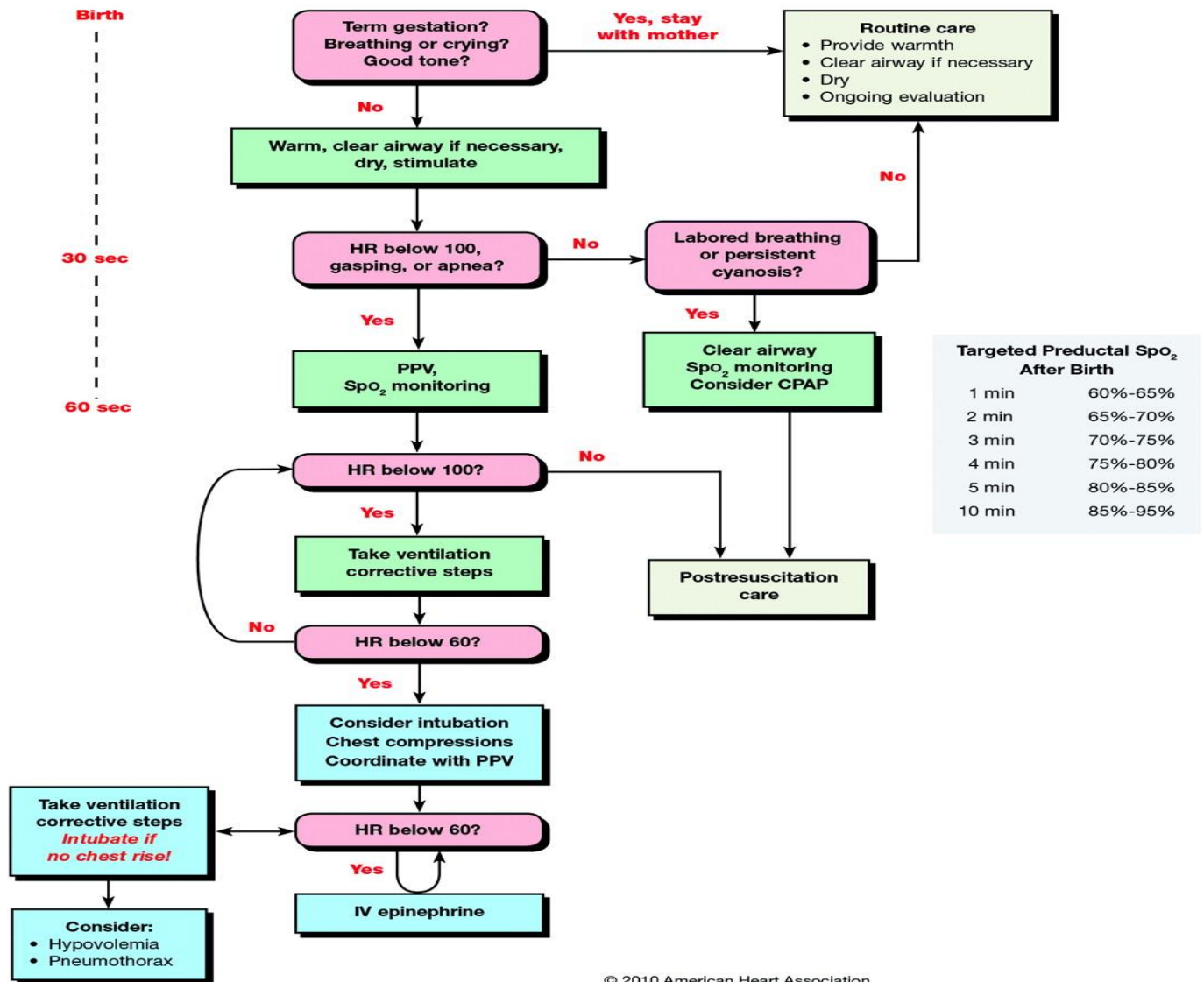
First dose: 150 mg over 10 minutes. Repeat as needed if VT recurs. Follow by maintenance infusion of 1 mg/min for first 6 hours.

#### Sotalol IV Dose:

100 mg (1.5 mg/kg) over 5 minutes. Avoid if prolonged QT.



## Newborn Resuscitation



- **Epinephrine:** Umbilical vein 0.1-0.3 ml/kg IV (1ml syringe) give rapidly followed by NS flush  
ET tube: 0.5-1ml/kg via ETT (5ml syringe) give rapidly followed by PPV
- **Bolus:** NS (recommended) or LR, O- pRBCs via umbilical vein  
10ml/kg over 5-10min
- **ETT size:** can use 3.5 for babies >2kg and above 34 weeks
- **ETT position:** vocal cord guide at level of vocal cord; tip to lip = weight in kg + 6
- **UVCs:** 5F, advance 2-4 cm beyond muco-cutaneous junction
- **UACs:** 5F for term infants; depth of insertion for low lying catheters approx. 60% of distance from shoulder to umbilicus

# Blood and Body Fluid Exposure

- Blood and Body Fluid exposure/needlestick policies can be found on iSite by searching "needlestick" ( [IC501 BloodBorne Pathogen Exposure Control Plan 2013-2014](#) and [PEP \(POST-EXPOSURE PROPHYLAXIS\) PACKETS \(4012\)](#) ). In a nutshell, wherever you are working there is someone who should know the "blood and body fluid exposure policy" for that area (including CHO and Planned Parenthood for their particular facilities).
- Everyone should wash the exposed area ASAP, notify the people you are working with (attending, etc) and then proceed to be evaluated by a physician. At MTZ, go to ED and they will take care of it. At any clinic site, usually the charge nurse can help direct you to an "urgent care" or "short notice" doc of the day to take care of the medical and paperwork things.
- Our facilities will have copies of the AK30 and DWC1 (or they are on iSite) for you to complete. These forms are for the County Risk Management - documentation in case anything should come of the exposure - and our Infection Control Coordinator so you get proper follow-up (patient and you both get tested, etc). You will also need to make decisions about PEP for yourself.
- If you are exposed offsite (non-Contra Costa), either download and complete the AK30 and DWC1 from iSite or get them from Tami in the Residency office and we will turn them in.
- Please notify Tami Sloan of exposure, especially "what" and "when"

## HIPAA

- Always use 2 patient identifiers on introduction or when discussing PHI.
- Do not carry PHI (notes/patient lists) outside of hospital/clinic. Always dispose of PHI in designated bins.
- Be aware of where you are when discussing PHI.
- Make sure to obtain patient permission and release of authorization prior to discussing patient's PHI with family members, friends, partners, etc. Document verbal consent in your note.

## SERS: The goal of reporting is to make our system better

- All unusual, unexpected, or untoward events/occurrences at Contra Costa Health Centers must be reported in SERS (Safety Event Reporting System).
- Procedure:
  - The employee who first becomes aware of the event incident should immediately complete the SERS and notify their supervisor (senior resident/attending/charge nurse).
  - For general health center events, the event should be reported to the preceptor/attending, and Clinical Services Manager (CSM) or Clinic Coordinator.
  - For events involving Ancillary Department staff or services, the event should be reported to the department manager.
  - The SERS report is an administrative record and should not be referred to in the patient ccLink record.
  - For serious events and events that have timed reporting requirements, the event should be reported to the Hospital Risk Management Office at -----.