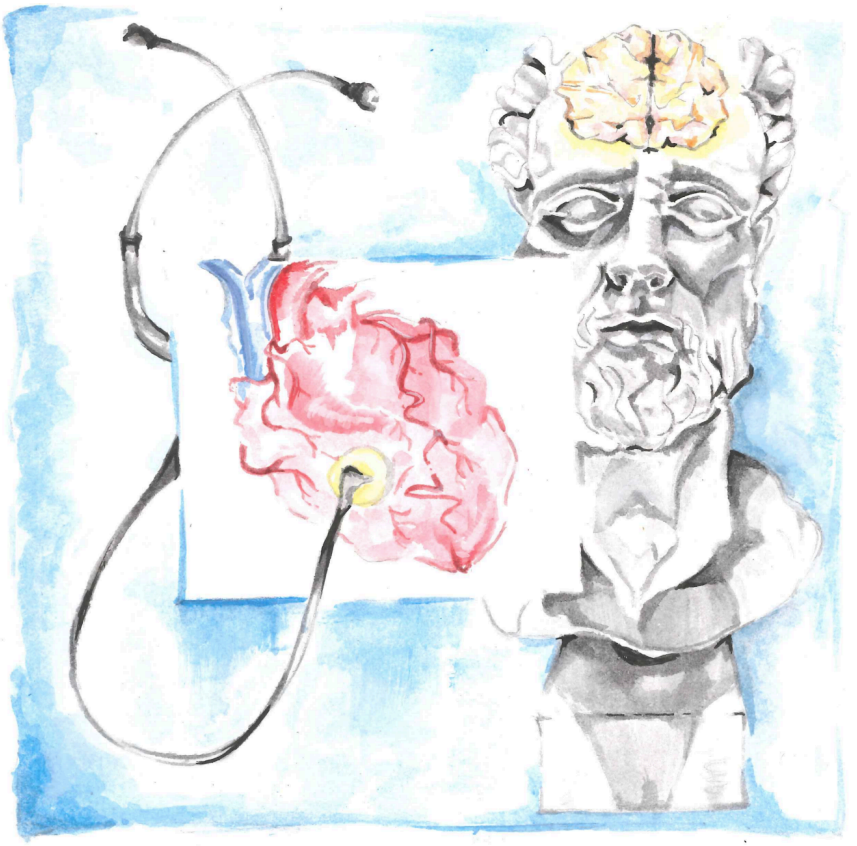
Elmhurst Residency Handbook
2025-2026



2025-2026 Block Schedule

BLOCK	START DATE	END DATE
1A	7/1	7/13
1B	7/14	7/27
2A	7/28	8/10
2B	8/11	8/24
3A	8/25	9/7
3B	9/8	9/21
4A	9/22	10/5
4B	10/6	10/19
5A	10/20	11/2
5B	11/3	11/16
6A	11/17	11/30
6B	12/1	12/14
7A	12/15	12/28
7B	12/39	1/11
8A	1/12	1/25
8B	1/26	2/8
9A	2/9	2/22
9B	2/23	3/8
10A	3/9	3/22
10B	3/23	4/5
11A	4/6	4/19
11B	4/20	5/3
12A	5/4	5/17
12B	5/18	5/31
13A	6/1	6/14
13B	6/15	6/30

Table of Contents

Introduction

A message from Dr. K –

Welcome to some of the most important years of your life! You will work harder than you've ever worked, learn more than you've ever learned; you'll laugh and cry with your colleagues like you've never done before. You will learn from your patients and your peers, from your attendings and your medical students, from your mistakes and your triumphs. We are here to help you on this journey. Every step of the way. This handbook contains just a portion of the gazillion things you will need to know to succeed in residency. It is by no means comprehensive, but you have to start somewhere. If it feels daunting, just keep these ten things by Richard Feynman in mind:

1. See failure as a beginning.
2. Never stop learning.
3. Assume nothing, question everything.
4. Teach others what you know.
5. Analyze objectively.
6. Practice humility.
7. Respect constructive feedback.
8. Take initiative.
9. Give credit where it's due.
10. Love what you do.

Residency Calendar

July

- Welcome to residency!
- Fellowship applications due
- Intern curriculum in noon conference
- Year-end semi-annuals for new PGY2s

August

- Intern curriculum in noon conference
- In-training Exam (ITE) for PGY2s and PGY3s
- ABIM exam
- Mock interviews for fellowships

September

- ITE for PGY2s and PGY3s
- Fellowship interviews (early September - early November)
- Grand Rounds start
- PGY3s start applying for jobs

October

- Residency recruitment season starts
- Pulse survey

November

- Fellowship Match Day
- Mid-year semi-annuals start
- Deadlines for many national Internal Medicine meetings
- Vote for Chief Residents

December

- Winter Solstice - days are getting longer from here!
- Register for ABIM exam in PGY3 year
- Board prep meeting

January

- Happy New Year!
- Residency interview season finishes
- Mid-year semi-annuals finish

February

- Deadline to take Step 3 or COMLEX 3 in PGY2 year
- Fellowship application prep meeting

March

- Residency Match Day
- ACGME Survey
- Fellowship personal statement workshop

April

- ACP/SHM/APDIM/SGIM meetings
- Work on personal statement and ERAS app for fellowships
- Individual fellowship prep meetings start

May

- Year-end semi-annuals start
- Request LORs for fellowships
- Next year's schedule comes out - plan electives for next year
- Vote for Graduation awards
- Fill out Year-end Survey
- Intern Retreat
- PGY2 Retreat
- Research & QI Symposium

June

- Graduation
- ERAS fellowship applications open
- New Intern Orientation

Hospital Geography

8	C8-15	Resident Lounge
7	A7 E7	CCU MICU
6	B6 C6-11 C6-10 D6-16 D6-04 D6-18A	Inpatient Wards Conference Room (Morning Report/Noon Conference) Medicine Office Wellness Center Chiefs' Office Jennifer Guevara's & Jessica Bodeta's Office Dr. Kanevsky's Office
5	B5	Inpatient Wards
4	 A4 B4 D4	Inpatient Pharmacy Stepdown Unit Inpatient Wards Sim Lab, Wellness Center
3	A3 D3	Inpatient Wards Chemistry/Hematology Labs Cardiology/Echo lab Pathology Lab Library
1	A1-22 E1-24 E1-37 B1	Auditorium (Grand Rounds, Wellness Meetings) US MRI ED
B	Au Bon Pain (ABP)	
Hope Pavilion – 77-11 Broadway (separate building to left of parking garage)		

- **Walk rounds every morning with your resident**, during which you will present your patients, review your findings, and develop the plan for the day. Bedside teaching on the art and science of medicine.
- **High-quality, face-to-face handoffs at 7 PM without distractions.** Oral (**IPASS**) and **up-to-date** written handoffs focused on clinical status and clear anticipatory guidance ("if/then") and To Do items.
- **Resident supervision of night residents.** Your supervising resident will work with you closely during the night to help you in your work (not just "call me if you need me".) You have the right (and the responsibility!) to close supervision as you assess acute medical problems.
- **Your resident will be working side by side with you during the day.** They will be present for questions and available for teaching.
- **Opportunities to present to your attendings and fellow residents. Ask questions and learn!**
- **Feedback from your residents and attendings.** Ask for it if you don't think you're getting it.
- **Respect and support.** You will treat colleagues and staff with respect and courtesy, and you will be treated this way in return. Your resident, your attending, the residency program and the department will have your back.

Intern Responsibilities

- **See your patients repeatedly during the day**. **Do not forsake your live patients for your iPatients**! The latter are much less rewarding and much less important. Most importantly, they are not why you went into Medicine!
    - Pre-round in the morning on all of your patients after receiving handoff from the night team.
    - Work rounds at the bedside.
    - Afternoon rounds to check in on your patients and update them on any new developments.
- **Take notes, make boxes and check them off** (get things done!)**. Never report as fact something which is a guess** ("I don't know" is *much* the preferred usage.). **Sweat the details**. Remember that little things can matter a lot, and each of them is connected to a patient.
- **Prioritize.** See sick patients first. Place orders and call consults before writing notes.
- **Don't copy-paste notes, and don't insert massive data dumps (e.g. verbatim radiology reports) into your notes**. Notes are crucial for communication and for thinking. If you are copy-pasting your notes, or your notes are dumping grounds for large clumps of undigested "data", then you are not communicating anything (other than that you cut corners) and you are not thinking!
- **Ask questions, listen closely, then look it up.** Know why you are doing things. Think critically, probe for evidence, don't (simply) trust anybody. To survive intern year you have to become efficient and organized and good at getting things done. Important skills, but not your ultimate goal.

    - Keep a notebook, pick a few things each day that you learned and write it down!
    - Reinforce what you learned (#5goodminutes et al; Podcasts (Curbsiders, CoreIM CPS); teach!)
- **Aim for excellence**. We are what we repeatedly do. Excellence is not an act but a habit. It is doing ordinary things very well, day in and day out.
- **Empathize**. With patients especially, but with staff and colleagues too. And sympathize with yourself.
- **Don't forget these are some of the best years of your life**. It's a crazy ride, but you're going to a really great place. When your day is a total dumpster fire, think "this is what getting better feels like".

Elmhurst Wards

Elmhurst Hospital has 4 Inpatient General Medicine units: A3, B4, B5, and B6. The patients on the Inpatient Medicine service are cared for by 12 teams, each composed of one or two interns, a senior resident, and an attending. Teams “B,” “C,” and “D” will include 1 intern and 1 senior resident; Team “C” will have a cap of 10 patients and Teams “B” and “D” will have caps of 14 patients. Team “A” will include two interns and 1 senior resident and will have a cap of 18 patients. **Per ACGME guidelines, each intern can take care of up to 10 patients on a given day.** If your team has 14 patients, the intern is responsible for up to 10 patients, and the senior is the first call for the remaining patients. The teams are named as follows:

A3-A	B4-B	B4-C	A3-D
B5-A	B5-B	B5-C	B5-D
B6-A	B6-B	B6-C	B6-D

During a 2-week block, you will be expected to work during the week and for one full weekend, and you will have one full weekend off. During the week, you will alternate with your senior resident between a Long day and a Short day. When you are working over the weekend, you are always Long.

Schedule #1 [5+7 schedule] (A/B Interns; C/D Residents)

	M	**T**	**W**	**TH**	**F**	**SA**	**SU**
Week 1	Short	Long	Short	Long	Short	*off*	*off*
Week 2	Long	Short	Long	Short	Long	Long	Long

Schedule #2 [12+0 schedule] (C/D Interns; A/B Residents)

	M	**T**	**W**	**TH**	**F**	**SA**	**SU**
Week 1	Long	Short	Long	Short	Long	Long	Long
Week 2	Short	Long	Short	Long	Short	*off*	*off*

Short Day:
Interns: 7 AM to 4:30 PM Residents: 7:30 AM to 4:30 PM
Long Day:
Interns: 7 AM to 7:30 PM Residents: 7:30 PM to 7:30 PM
Night Team:
Interns: 7 PM to 7:30 AM Residents: 7 PM to 8 AM

Ward Day Structure (weekdays)

7:00-7:30 AM: Night interns hand off old patients to Day interns. Day interns should ask for any overnight events as well as the outcome of Action plans that they handed off the night before.

- Residents and interns must sign in to their team(s) on Epic when they arrive and sign off when they leave hospital

7:30-8:00 AM: Night residents hand off new admissions to day residents.

7:30-8:30 AM: Intern Bedside Rounds. Start with sick patients, eyeball new patients.

- Print a team list with a blank column for notes - this will be your lifeline throughout the day.
- After bedside rounding, chart round to note significant results and make a note of any labs that haven't been drawn yet
- Start your notes (if you have time)
- if you need help or are concerned about a patient, contact the resident

8:00-8:30 AM: Residents attend Morning Report (all weekdays except first and last day of block)

8:30-9:00 AM: Resident and Intern meet to discuss urgent issues before rounds

9:00-11:30 AM: Resident Bedside Rounds (resident leads bedside rounds for their team on all patients)

- Attending accompanies the team. Intern/students present to resident, who leads rounds
- Residents manage time to keep on schedule. Intern and Student are expected to present efficiently using standard format and summarizing available data (eg vitals, imaging, imaging) as appropriate
- Chart round via Haiku during walk rounds.
- Make plans before moving on to the next patient; enter urgent orders and consults during rounds.
- Attendings who supervise 2 teams will alternate bedside rounds starting with the Early Resident team and finishing rounds with them by 10:45, then table rounding with their second team while the first team resident continues to lead rounds on any remaining patients.

9:45-10:45 AM: IDT rounds (time depends on team/floor, 15 min per team)

- Interns should enter orders and call consults during this time
- Attending should be present if they only have one team

10:45AM-12/12:30PM: Tasks and Consults

- Call Consults and perform tasks that were unable to be completed during rounds

12:30-1:30 PM M-W, 12-1 PM Th, 12-1:30 PM F: Noon Didactics

- **M/W/Th: Noon Conference** mandatory for all residents and interns
- **Tue: Intern Report/Resident Report**
- **F: 12:00-1:30 PM: Clinical Reasoning Seminar (CRS)/Chopped/MMI** mandatory attendance for everyone

3:30-4:30 PM: Afternoon Teaching/Wrap-up Rounds:

- Teams meet to do chalk talks, review outstanding To Do items, status of their plans.
- Early Resident hands off to sister team Resident.

- **F: Feedback Friday** as appropriate on first Friday, mandatory on second Friday

4:30-7:30 PM

- Early residents/interns can leave after Afternoon Rounds
- Late intern is supervised by the late resident of their sister team. This includes questions/problems that come up as well as late admissions (3:00-5:30 PM).

Admission Cut-Offs

- Day Teams
  - **3 PM** for **Early** Resident, **5:30 PM** for **Late** Resident
  - 5:30 PM – 7 PM: Floor senior or sister senior will triage, speak with ED staff, and enter orders as needed. Full admission completed by the Night team.
- Night Teams
  - **5:30 AM** - Last full Admission
  - 5:30 AM – 7:30 AM: Night Teams will triage, speak with ED staff, and enter orders as needed.

7:00-7:30 PM: Handoffs to Night Teams

- Handoff document is updated daily by resident (see Handoffs)
- Verbal handoff must be supervised by the Resident of their sister team, who then hands off their team.
- Sick patients should be added to Overnight Hotspot List to facilitate closer monitoring at night

A4/Stepdown

The A4 Stepdown unit has a greater nurse-to-patient ratio than the General Medicine floors but less than the MICU. In other words, the level of care is a “step down” from the ICU. These patients are typically more complicated and sicker, and some of them are intubated.

The schedule and workflow while working on A4 is identical to that of the General Wards. The biggest difference is the complexity of the patients and a lower cap.

There are regular in-service learning sessions on trachs and speaking valves presented by the SLP department. This is mandatory for all A4 housestaff.

CCU

The CCU is a 9-bed closed ICU and 12 bed CCU stepdown. The team consists of PGY2 IM residents and EM residents, one cardiology fellow, and a cardiology attending. You’ll learn how to manage and diagnose patients with STEMI, NSTEMI, ventricular tachycardia, decompensated heart failure and arrhythmias.

Short Resident: Primarily responsible for 2-3 CCU and stepdown patients respectively. Assist with early discharges and any procedures in the unit.

Long Resident: Responsible for taking care of 2-3 CCU patients and work closely with a cardiology fellow to admit new patients to the unit. Receive sign out for all CCU and CCU stepdown patients after 5pm.

Overnight: Work directly with the cardiology fellow on call for new admissions/consults. Respond to CPORT/STEMI alerts to obtain information, bring consent forms, and communicate with the CPORT fellow until they arrive at the hospital. Residents on the 27-hour call are also responsible for presenting new admissions during their shift, the following day during morning rounds.

Weekend: Responsible for patient care in all CCU as well as CCU step down. You will be rounding with the attending and cardiology fellow on call.

Schedule:

- Short Dayl: 9:00 AM to 5:00 PM
- Short Day: 9:00 AM to 5:00 PM
- Long Day: 9:00 AM to 7:30PM
- Overnight: 7:00PM to 9:30AM

Medical Intensive Care Unit (MICU)

The MICU is an 8-bed closed ICU. The team usually consists of two PGY2 IM residents, 1 PGY1 IM resident, 2 EM residents, one pulmonary/critical care fellow, and an intensivist. You'll learn about vent management, various procedures, and how to take care of critically ill patients. Seniors will also be responsible for seeing MICU consults with the fellow and discussing them with the attending.

Short Day: 7 AM to 5 PM
Long Day: 7 AM to 8:30 PM
Overnight: 8 PM to 7:30AM

Schedule:

- 7:00 – all residents/interns should arrive by 7 AM to receive sign out and pre-round. The overnight team leaves after signing out all of the patients.
- 8:30 – Attending rounds start
    - Be familiar with 24h events, all consult recs, and all new labs or imaging results
    - Presentations are done with the plan in order by organ system to ensure that nothing gets missed
- Following rounds, similar workflow to floors – ensure consults are called in a timely fashion, labs ordered, and patients get reassessed throughout the day.
- Afternoon/Evening rounds – before the day is over, the attending, fellow, and residents will do focused rounds for updates and overnight plans for any anticipated emergencies. Timing is at the attending's discretion.

LiveOnNY (LONY) is a nonprofit that facilitates organ donation. You are expected to notify them within one hour for all potential organ and tissue donors by calling at 1-800-443-8469.

Who is a potential organ and tissue donor? Anyone with the following:

- Loss of 2 or more brainstem reflexes
- GCS < 5
- Anyone with ongoing palliative discussions
- All deaths are potential tissue donors

Do I need to tell the family/patient? No, you should call LONY first to assess if the patient is appropriate. If the patient is a possible donor, then they will handle all discussions. <u>You are not qualified to have discussions with the patient or family regarding organ donation.</u>

Night Medicine

Each general medicine unit will have overnight coverage consisting of one senior and two interns. The shift is from 7 PM (evening handoff) until morning handoff at 8 AM. Residents are expected to work in the team room for their floor with their interns, so that they are available to review admissions, help with questions, and assess patients.

Interns will cover sister teams (AC/BD on gen med floors and AD/BC on A4). One night a week, each intern will cover all 4 teams to allow the other intern to get a night off. On nights where an intern is off, the resident will be responsible for admitting patients to the off intern's teams.

Every night (usually around 10:30 PM) you will have **Hotspot Rounds** with the Nocturnist. Hotspot patients are the sicker ones on your list – think about anyone with complicated withdrawal, patients with new chest tubes, physical exam findings that the primary team is asking you to follow, anyone the day team was worried about, etc. When receiving handoffs on these patients, you should make sure that they have the "EL Overnight Hotspot Team" listed under their care team. You should also save this list to your defaults for when you're on nights – it will help you keep track of your sickest patients. Following hotspot rounds, you are expected to write a brief "Significant Event" note that you will cosign to the nocturnist who saw the patient with you. These are not full progress notes – think of it as a brief update to the day teams about the patient's most pressing issues (the reason why they're a hotspot in the first place). Use the **.IMHOTSPOT** dotphrase for this.

You are expected to attend all RRTs on patients that you cover. All overnight interns and residents respond to codes. Both RRTs and codes are announced overhead.

Intern off nights:

- A4 (A&D) intern Friday
- A4 (B&C) intern Saturday
- A3A & B4C intern Friday (1st week), Thursday & Friday (2nd week)
- A3D & B4B intern Saturday (1st week), Saturday & Sunday (2nd week)
- B5 (A&C) intern Wednesday (1st week), Tuesday & Wednesday (2nd week)
- B5 (B&D) intern Thursday (1st week), Thursday & Friday (2nd week)
- B6 (A&C) intern Tuesday (1st week), Monday & Tuesday (2nd week)
- B6 (B&D) intern Wednesday (1st week), Wednesday & Thursday (2nd week)

Night Senior Resident off nights (will be covered by another senior):

- A4 resident: Friday & Saturday
- A3/B4 resident: Wednesday & Thursday
- B5 Resident: Monday & Tuesday
- B6 resident: Sunday and Monday

Finding the Overnight Hotspot List

- On the left hand sidebar there is a series of folders titled **Available Lists**
- Under the **Elmhurst** folder, scroll to **Elmhurst Teams - Ancillary Consult**
- Drag **EL Overnight Hotspot Team** list to your **My Patients** list for easy access

Adding Patients to the Hotspot List

- Right click on the patient who you want to add to the list
- Select **Assign Teams**
- Search Overnight Hotspot, then click Accept. The patient should be added to the list now.

Midnight Report

Midnight Report is from 12:00-12:30 on Monday through Saturday nights. Each intern will have an opportunity to present a case in a morning report style. Your senior will help you pick a case, ideally from the night's admissions (or from the previous night). You should let the hospitalist know which case you want to present by the time Hotspot rounds start so they can review it. This is a great opportunity to review the guidelines and management of classic medical conditions like COPD, cirrhosis, heart failure, etc.

Night	Intern
Monday	A3A / B4C Intern
Tuesday	B4B / A3D Intern
Wednesday	B6A / B6C Intern
Thursday	B6 B / B6D Intern
Friday	B5A / B5C Intern
Saturday	B5B / B5D Intern

Teaching Resident

The Teaching Resident (TR) is a PGY3 who serves in a number of critical roles within the hospital. There is always a TR in house and they are a great resource for you or your senior if you need help or are unsure about something. They are often available to help assist or supervise any procedures on medicine floors as long as they are signed off. Their other roles are as follows:

Consults: Think of this as the general medicine equivalent of when we call surgery, ID, or cardiology for a consult. Consults can range from assistance with management of common medical problems (e.g., diabetes or hypertension) to preoperative medical assessment (POMA) to requests for internal or external hospital transfers to the medicine service. All consults and transfers will be discussed with the consult attending, bell attending, or the nocturnist depending on the time of day.

Code Leader: The TR is also responsible for responding to any codes (except for on the first floor of the hospital) and leading them.

Overnight, the TR role will be divided among senior residents. All senior residents will be available to help with procedures as long as they are signed off and nocturnist/overnight intensivist will be available to supervise. The TR role will be divided as follows:

- Consults: PGY3 residents will be the consult resident as described above.
- Code Leader: PGY2 or PGY3 will be the code leader as described above.

Day Medicine Resuscitation/Rapid Response Protocol

- Day TR attends all events on floors 2-11 (medicine, surgery, psych, and OB).
- For all resuscitation events (not rapid response team):
    - Gen med A/C late interns/residents respond the 1st week of the block.
    - Gen med B/D late interns/residents respond the 2nd week of the block.
    - A4 (stepdown) teams only respond to A4 codes.
    - All late interns/residents respond to A4 codes.
- For rapid response events: primary team responds at all times.

Mount Sinai Hospital Wards

Mount Sinai Hospital has more than twenty inpatient teams. However, Elmhurst interns are only assigned to a handful of the color teams. You will have a senior resident, with whom you will alternate early and late days and weekends, and a sister team intern and resident.

Typically, Elmhurst interns will rotate on days for the first two weeks of their rotation and on nights for the second two weeks. The inpatient Ward workday and schedule is relatively similar to that of Elmhurst Hospital. On the first day of each A block, an "intro to the block" presentation is given during noon conference — this is meant to be an orientation for incoming interns and to provide any updates to floors workflow.

Travel

- Mount Sinai Hospital is located at **1468 Madison Avenue**.
- The easiest way to reach the hospital is via **subway** (directions below) or the Sinai shuttle (see tracker and schedule).
- From Manhattan, take the **uptown 6** to **96th Street**. Walk west on 96th street to Madison Avenue and then North on Madison Avenue to the Hospital.
- From Queens take:
    - The F to **Lexington Ave/63 Street** and walk to the 6 at **Lexington Ave/59th Street**
    - The N/R/W train to **Lexington Ave/59th Street** and switch to the 6
    - The E or M to **Lexington Ave/53rd Street** and switch to the 6
    - The 7 to **Grand Central-42nd Street** and switch to the 6

Pre-Rotation Action Items

- Please reach out to M**iguel Escalera (Miguel.Escalera@mssm.edu)** regarding obtaining an MSH ID and the sign in form that must be completed during your rotation here at MSH.
- Email the MSH Chiefs prior to your rotation and let them know if you prefer to be contacted using the pager that was given to you by your department OR get pages forwarded as text messages to your personal phone. If you want messages sent to your personal phone, please include your phone number and cell phone carrier.
- When you leave the hospital, please be sure to forward your epic messages to whoever will be the front line provider for your patients; please keep the front line provider line up-to-date so that nursing knows whom to contact
- Set up access to the Mount Sinai Haiku before your rotation at Mount Sinai Hospital (Go to Settings on your iphone→Apps→Haiku→Configuration
  Enter as below:
  Server: epicsoapproxyprd.mountsinai.org
  Path: interconnect-haiku-prd
- Verify Epic access

    - Call the IT help desk at 212-241-4357 to ensure the account is active and to get login information. They can also help troubleshoot access.
- Download the Inpatient CareTeam App
    - The CareTeam App is a directory that contains info for those rotating on Sinai Gen Med floors, including pager numbers, unit numbers, etc. Also contains useful guides, including the Intern Survival Guide
    - CareTeam App: https://inpatient.careteamapp.com/index
    - Instructions for installation: Type in url on safari (on phone) □ click “add to home screen” on bottom
- Other helpful links to add to home screen:
    - Chief website: https://sinaimedchief.wordpress.com/
        - pw: msmed
    - Liver guide: https://docs.google.com/document/d/13TUf-APuK2ByxRiM55-qOeT0v84hXCpfVZdZL_V61l4/edit

Schedule

- 6:30 AM – interns arrive for sign-out from night intern
- 7:30 AM – interns and residents run the list prior to attending rounds
- 8:00 AM-10:00 AM – attending rounds with both hemi-teams
- 10:00 AM -11:00 AM – residents attend morning report and interns call consults, start tasks
- 12:10 PM-1:00 PM – noon conference
- Short call signs out at 3 PM and long call signs out at 8 PM
- Tuesday 8:30 AM-9:30 AM – Grand Rounds. New patients from overnight are presented at bedside and the team breaks for Grand Rounds before regrouping at 9:30 to finish rounding on old patients

Escalation/Sick Call

An MSH chief is on call 24/7. They are listed on amion under Internal Medicine. The following are their emails, but please check who is the On Call Chief as it rotates. Do not email or text for any urgent issues – please call instead.

- Thomas Chen
- Emily Gore
- Rita Malley
- Natalie Plick
- Matthew Siano
- Nicholas Safian
- Shaleen Thakur

We cover our own sick call for interns at MSH, so if you need to call out, please contact the Elmhurst Chief on Call.

Neurology

The Neurology services are staffed by two Neurology residents (PGY-3) and one medicine/psychiatry intern during the day, and one Neurology resident (PGY-3) and one medicine/psychiatry intern overnight. Before your rotation, be sure to review the complete neuro exam.

Location

- Team room: B4-28.
- Neurology patients are mainly located on B4 and A4.

Workflow

- 8:00 AM – Receive sign out from overnight team
- 8:00-10:00 AM – Pre-round on all your patients
    - Identify and focus on changes in patient's neuro exam from baseline
    - After pre-rounding, review patient charts and discuss your plan with the resident.
- 10/10:30 AM – Attending rounds
- You will also attend Interdisciplinary team rounds on A4 and B4.
- You attend all stroke codes and help with new admissions
- You attend Medicine noon conferences unless asked to attend the Neuro noon conference for a particular topic

Shift Times

- Days (floor): 8 AM to 8 PM; 6 days/week with either Saturday or Sunday off
- Nights: 8 PM to 8 AM for 6 nights/week with Saturday night off

Stroke Codes

You respond to all stroke codes with the Stroke resident. The resident will go over expectations at the beginning of the rotation, but you can expect to participate in examining a patient with a suspected stroke, collecting collateral information, contacting families, and coordinating with the ED and Imaging departments.

Ambulatory Care Overview

Welcome to Medical Primary Care! In your continuity clinic you will build up a panel of patients to follow during your residency. Here are some tips to help you get started.

Before your rotation, make sure to check AMION for your MPC clinic schedule and specialty assignments – in addition to continuity clinic you may be assigned to other activities (Pap clinic, Breast clinic, Renal clinic, Clinical Pharmacist, MPC Social Worker, GI Clinic, Voces Latinas).

- Wednesday mornings are academic half days with didactics in the A1-16 conference room.
- Admin time is dedicated time to review and clear clinic in basket results and messages, and to work on modules.

Check out the **MPC Provider Guide** in the **AmbCare Shared Drive** for details on criteria and correct orders to use to refer to different services within the clinic (social work, dietitian, clinical pharmacist, collaborative care, etc.)

Desktop → Enterprise Department Shares → **ELM-AmbCareShare**

MPC Location: D1-55 on the ground floor of Elmhurst Hospital

- Enter via side door D1-23 (follow main hallway past elevators, past gym, door is on right)
- Stop by the nurse station in the back to get any needed PPE and to check your room assignments
- Check in with the preceptors in room D1-64 (in the back of the clinic)

Schedule

- Clinics occur during Elmhurst Ambulatory Care (EAC) blocks and weekly evening clinics during EL (EAC).
- Check AMION for your clinic schedule assignments
- Morning clinic starts at 9 AM, Afternoon Clinic starts at 1 PM, and Evening clinic starts at 5 PM
- Log onto Epic in the EL PRIMARY CARE context to see your patient schedule

Workflow

- Pre-chart to prepare before calling in your patient.
    - Read the last clinic note to follow the plan, check for any recent inpatient admissions or ED visits
    - Check labs and imaging for any new results to review
    - Review Health Maintenance and Immunizations tabs
    - Synopsis tabs for VS and weight trends, and diabetes screening reminders
- Patient is ready for you to call when schedule status is Arrived AND a green dot indicates vitals are done
- Always ask patient their name and date of birth to verify identity

- Interpretations Services - if needed, call x 4-1500 on speaker phone in clinic room and follow prompts
- After you see the patient, present to your preceptor. They will help you establish plan and place orders
- Return to the room to counsel the patient and review the plan with them. Once you're done, print the AVS and bring it to the team nurse or PCA in your hallway for exit.
    - Nurses provide same day education, vaccinations
    - Patient Care Associates (PCA) do scheduling, same day labs, retina photos
- Complete your documentation and billing; send encounter to your preceptor to co-sign
    - Enter the preceptor attending name under epic wrap up. Type of visit is "Direct Supervision"

Before leaving clinic, make sure to check with your preceptor to review your work. You are also responsible for the results of any tests you ordered and can use this time to discuss the results/next steps with your preceptor before writing result notes or calling patients with their results.

Admin Time
The 2 priorities for your admin time are:

1. Inter-visit patient care (closing encounters, review results, calling patients, in-basket messages, refills, forms) for yourself and the pod
2. Completing assigned reading/modules, preparing workshops

Working from home is a privilege**.** Admin time is still considered "on the clock" hours. You will need to have your pager with you and be ready to answer secure chat or pages if we reach out to you

If you are not completing work as expected during your admin time, you will receive two warnings. After your second warning, you will be required to come on site for your admin time during the next two EAC blocks to sign in and complete your work in the library.

Attendance Policy
You must inform Dr. Gordon in advance if you will miss any EAC workshops and provide a valid reason, or absence is considered unexcused.

Clinic Pods

- As an intern, you will only be reviewing your own in-basket.
- PGY-2s and PGY-3s have their in-baskets reviewed by a member of their pod. Each senior resident is put into a pod (names after one of the colors of the rainbow). The pod member who is currently completing a clinic block reviews the in-baskets of everyone in their pod.

Documentation:
Use the following MPC smart phrases for your clinic notes:

.AMBFollowUpVisitFemale
.AMBFollowUpVisitMale
.AMBInitialVisitFemale
.AMBInitialVisitMale

Useful EPIC Smartphrases:

.ASCVD (to calculate ASCVD risk score)
.lasta1c (most recent a1c)
.lastbp3 (last 3 BP readings)
.monofilmpc (diabetic foot exam)

PEAC Module Access: Hopkins Ambulatory Care modules will be assigned to you during EAC

- Visit **www.peaconline.org**
- Select “Create Account”
- User group: Mount Sinai Elmhurst Hospital Center
- Passcode: v5l (for learner account)
- Enter your email address

Care Teams/Supervising Attendings

- In MPC you are assigned to one of 4 Care Teams
- You have one team supervising attending who can help cover your in basket during difficult or away rotations (Night Float, Vacation, Sinai Wards, MICU)

In Baskets

- Close clinic encounters within 24 hours
- Discuss questions about patients results, forms, and refills with your preceptor
- Review result folder daily during clinic block
- Address and clear any clinic messages in Refill Requests, Contact Center, Staff, and MyChart messages

Specialty Clinics

During your clinic block, you will have mornings or afternoons in which you are working in a specialty clinic. The locations of these clinics differ from where you will have MPC.

Service	Time	Location	Supervisor
Breast	Mon 9 AM - 12 PM	Hope Pavilion 4th Floor	Dr. Pocock
Renal	Thur 12:30 - 5:30 PM Fri 8:30 AM - 1:30 PM	H2 Clinic Rooms 21-25	Renal Service
PAP	Thur 9 AM - 12 PM	H1-34, Room 12	Dr. Ast
Cardiology	Thurs 1 PM - 5 PM	H3	Cardiology Service
General GI	Mon 1 PM - 5 PM	H2	Dr. Aron
Liver	Thur 1 PM- 5 PM	H2	Dr. Aron
Rheum	TBD	Hope Pavilion 5th Floor	Dr. Dhamrah Dr. Chan
ID	Mon 9:00 AM - 12 PM	J-1 Immunology	Dr. Salama
Heme	Mon 1 PM - 5 PM Tue 9 AM - 12 PM	Hope Pavilion 4th floor	Dr. Guevara
Root Cause Analysis (RCA)	Mon + Wed 3:15 PM (in person and by webex)	Will receive email if scheduled	
Rehab Clinic	Fri 9 AM - 12 PM	D2	Dr. Nori
Endocrine DM	Mon 9 AM - 12 PM Tue 9 AM - 12 PM	H3	Dr. Feffer Dr. Siddiqui
Endocrine Thyroid	Fri 9 AM - 12 PM	H3	Dr. Feffer Dr. Siddiqui
PCC	Fri 1:15 PM - 5 PM	Hope Pavilion 3rd floor	Dr. Huang
Senior Care Clinic	Tues 9 AM – 12 PM Thurs 1 PM – 5 PM	H1-34	Dr. Ankur in H1-49
Pulmonary	Wed 1 PM - 5 PM	Hope Pavilion 3rd floor	Pulmonary Service
MPC Social Worker	Tues 9:20 AM	H1-34	Rhonda Bryant
Voces Latinas	During one EAC block you be scheduled to work with a community based organization		
Clinical Pharmacist	Tues or Thurs morning - see separate schedule H1-54 (inside H1-34)		

Electives

You will have opportunities to explore interests during your 2-week elective blocks by coordinating a clinical experience with a specialty or department of your choosing. Some divisions only allow one resident per block, so plan ahead! You can also plan an away elective, most commonly at Mount Sinai affiliates or other H+H hospitals. Consider doing an “audition” elective at a “reach” program in the specialty you are considering for fellowship late in PGY2 or early in PGY3 year.

Elective requests for the first 6 months of the year should be submitted to Jennifer Guevara by July 1 and for the second 6 months, no later than November 1. Proposals for **reading and research electives** are due 6 weeks prior to the elective start date (except block 1). The Elective Request Forms are available on the website under “Consents/Forms”. All reading and research elective requests require PD approval and are limited to one 2-week block per year for each.

Selected electives (S-electives/selectives) are specialty electives that are predetermined by the residency curriculum. Each class will have designated elective blocks when you work with a specific department. These selectives are designed to enhance your education and broaden your exposure to the amazing clinical pathology at Elmhurst.

- Categorical PGY-1: Infectious Diseases, jeopardy or non-jeopardy elective block denoted as EL (ID) or JEL (ID)
    - Monday to Thursday
- PGY-2: Cardiology/CCU, jeopardy block denoted as JEL (CCU)
- PGY-3: Hematology, jeopardy block denoted as JEL (HEME)

Away electives require significantly more lead time and often fill up months ahead. If the requested elective is outside the Mt. Sinai Health System, there are extra administrative tasks that both institutions have to perform. Please request away electives as early as possible (ideally, 6 months ahead), and we will make every effort to secure a spot for you.

All initial elective requests should go to Jessica Bodeta for Elmhurst electives and Jennifer Guevara for away electives. If you would like to discuss advantages and disadvantages of particular electives or to brainstorm ideal timing for an away elective, reach out to the Chiefs or Dr. K.

Jeopardy

Jeopardy covers personal days that were scheduled in advance. For job/fellowship applications, you need to find your own coverage (you **cannot** ask the people already listed for jeopardy).

During jeopardy electives you will be on backup call for that block. For those blocks, you should avoid selecting your most desired electives, like away electives and electives in the specialty to which you are planning to apply. For example, if you think you would like to do an Endocrinology fellowship, do not do an Endo elective on a Jeopardy block so that you don't end up missing several days of an elective that's key for you.

If you are on jeopardy call, you must be within an hour of the hospital at all times. Your phone cannot be put on silent, since you can potentially be called in at any time. If the Chief on Call contacts you for coverage during this time, you must answer the call within five minutes. If you do not call back within 15 minutes, another resident who is on an elective will have to be contacted for coverage instead of you. **If you are not available or do not respond in a timely fashion while you are on jeopardy, you will owe 3 additional shifts for coverage any time in the year as arranged by the chiefs.**

Whenever jeopardy coverage is needed, the chiefs will keep a tally to do their best to provide equity among residents. That said, there is no perfect coverage system. Some interns/residents will be called in to cover several days while others will be called in for very few days. Nevertheless, being called in for jeopardy is never negotiable.

If Jeopardy is exhausted and a non-Jeopardy resident needs to be called in, we will call in those on research/reading electives, followed by in-house electives, away electives, and lastly EAC.

If you are sick while on Jeopardy you must notify the chiefs immediately. If you report illness only after being called in, the same consequences apply as with not answering within 15 minutes.

Emergency Medicine

General Information

- EM orientation will be on the first day of the block.
- Generally, you will work nine 12-hour shifts on the A or B side with a mix of days and nights
- Dress: any color scrubs except teal/green (surgical/OR scrubs)
- Review the Elmhurst ED Resident Schedule before the start of your block to figure out what shift you are working on your first day. You can also access it at ehced.org and go to “Schedule: Residents - Elmhurst ED” at the bottom of the page.
- You may make schedule requests during your EM block. Please reach out to the Elmhurst EM chiefs, Malisha Shah (malisha.shah@mountsinai.org) and Neha Sikka (neha.sikka@mountsinai.org) with any requests WELL IN ADVANCE of your rotation.

Expectations

- Keep calm. You’re a brand-new resident and everyone knows you need to get your bearings. It will be understandable if you don’t know certain protocols or have never performed certain procedures before. In fact, you should take full advantage of this to ask as many questions as possible and learn as much as you can. Ask about anything and everything.
- Focus on mastering individual patients first; worry about patient volume later.
- Learn to navigate the ED (location of equipment, staff, the difference between areas, workflow, etc).
- Understand what goes on before the “admit button” is hit.
- Bring a stethoscope, a pen, and ideally a penlight.
- Try to work up to seeing about 8-10 patients on your 12 hour shift, depending on the time of year and how busy it is, other staffing, etc.
- Never pick up a new patient if you feel overwhelmed or won't be able to see them soon.
- After seeing a patient, you should present immediately to the senior or attending to come up with the plan
- Never discharge a patient without checking with the senior or attending first.
- Contact the on-call Internal Medicine Chief for call-outs
- DO NOT BE LATE. EM people are punctual people

Presenting ED Patients

Example Schedule/Workflow

- **6:50 AM** - Arrive at least 10 min prior to the start of shift. Identify your team and introduce yourself to everyone. Sign-In in EPIC (different from logging in), enter your zone phone (place a # before the 5 digits) and select your shift length.
- **7:00 AM - Handoff** (10-30 min). Handoff begins promptly at the scheduled start time of your shift. Have paper and pen ready, or (ideally) grab a computer. Be prepared to receive additional handoffs throughout your shift (especially on night shifts).
- **7:15 AM - See Handoffs** (30-60 min). Before picking up new patients, review your handoffs and briefly see them. Write a brief update note in the ED provider note with the handoff plan and time-stamp it with **.menow**. You may use the dot phrase **.ressignout** for your handoff note. Refer to this policy as a guide.
- **8:00 AM - New Patients**. Start by picking up 1 new patient. Briefly review their chart and then see them. You may need to present them before placing orders. If you are ready to present, do so before writing your Provider Note. Write frequent brief notes with the ".menow" timestamp in "Updates".
- **12:00 PM - Meal Break** (20-25 min). Sometime during your shift, take a break. Tell your attending or senior beforehand so they can cover your patients. Keep your phone on you at all times unless your senior offers to take it.
- **12:30 PM - Keep seeing new patients!** (and don't forget to pee.)
- **6:00 PM - Stop seeing new patients.** 1 hour before your shift ends, stop picking up new patients and start "cleaning up" your existing ones. This means completing all their procedures, calling all new consults, doing pelvic and rectal exams, arranging transportation, and trying to disposition them (admit, discharge, or obs) to the best of your ability. Run your list with your attending or senior at least 1 hour before end-of-shift. Your goal is to create tight handoffs with clear plans, and have as few patients as possible.
- **7:00 PM - Handoff** (10-30 min). Find your attending or senior promptly when your shift ends. Do not be away in Radiology or at bedside (unless it's a true emergency). It is normal to handoff 2-4 patients. If you have no handoffs, your notes are written and there is a long list of unseen patients, consider seeing more patients next shift. It's a learning process. Sign-Out in EPIC.
- **7:15 PM - "Clean Up."** Best practice is to finish all your Provider Notes, Procedure Notes, and other charting before leaving the hospital.

Tech Setup Tips

Remote Access

Epic remote access is great for research, getting handoff on a new block/coverage, or just using your laptop when there are no computers available. To set it up, you'll need to call IT and get your two-factor authentication set up, then head to https://epicremotedesktop.nychhc.org/ and log in.

Virtual Desktop

Elmhurst uses a virtual desktop system. The easiest way to think about this is like Epic and VMWare being a separate app that preserves all your information from computer to computer. This means you can write a note on the 8th floor, log in to another computer on the 4th floor, and pick up where you left off. Everything saved/downloaded erases in both the physical and virtual desktop after 24 hours. You cannot transfer things from the physical desktop to the virtual one and vice versa. The work around for that is email stuff to yourself.

HHC Email: webmail.nychhc.org

All non-@nychhc.org email services (e.g. gmail, hotmail, etc.) are blocked on institutional devices. You can still access them on personal devices using hospital Wi-Fi. You will need to activate 2-factor identification to access your HHC outside of the hospital network. Email is the primary mode of communication between you and the program leadership/hospital administration. **It is expected that you check your email regularly and at least daily.**

All interns and residents should have access to their NYCHHC email from a personal or work mobile phone. Follow the directions on your mobile phone to add an email account. It may take a few days for IT to approve your device, but you will ultimately see your NYCHHC emails be automatically uploaded to your email app

In order to keep your email uncluttered, it may be helpful to employ mailbox rules that filter hospital-wide or system-wide mass email. To create a mailbox rule:

- Log into your @nychhc.org email on webmail.nychhc.org.
- Click the gear icon in the top right corner of the page and select "Options."
- On the left side of the page click "Organize Email."
- Click on the "+" sign to create a new rule.
- Select "create a new rule for arriving messages…" or "move messages from someone to a folder…"
- Enter the email address or addresses to filter messages from and select an action (e.g. "move the message to folder…" or "redirect message to…"
- Save the rule

While we recognize that emails from institutional and systemic accounts contain important information, we make an effort to communicate any important information contained to you so that you can keep your inboxes clear. You can create email rules to filter out emails from the following accounts:

- NEWS@nychhc.org
- NYCHHCBoardAffairs@nychhc.org
- noreply@employeenews.nyc.gov
- HRRetirementServices@nychhc.org
- cs@perksatwork.com
- EnterpriseServiceDesk@nychhc.org
- Insider@nychhc.org
- EITSCommunications@nychhc.org
- Pointofentry@nychhc.org

Epic/Haiku

All Interns and Residents are expected to have Haiku access on either a personal or hospital-issued phone.To get Epic (Haiku/Limerick) on your phone: Download MobileIron (AKA mobile@work) → sign in with your Epic info (server name is mobile.nychhc.org) → accept and allow any prompts → go to settings and set up profile → download haiku and set up with your login info. This grants IT the ability to access your phone's data and location at all times. You can also find instructions to upload Haiku on your phone here.

New Innovations

This is where most of the "paperwork" required by the program is located. This includes onboarding materials, duty hour reporting, and many other useful documents. This is also where you fill out evaluations and where you can see attending evaluations of you. Let Jennifer know if you have any issues with NI.

Translation Services

Download the **LanguageLineInSight** app.
Authentication code: D3T7VPQFFP
This is only for audio interpretation only.

(OR)

Call Pacific Interpreters on 1800 264 1552 (Code for Elmhurst is 836136)

AMION

All of your schedules will be available on AMION including any schedule swaps, vacation days, or jeopardy coverage. Password: **ehc** (all lowercase).

Pagers/Telecommunications

If you are ever having pager issues, please contact Karina Pinillos as soon as possible. This is particularly important in order for consultants and nurses to be able to contact you in a timely fashion.

Email: PINILLOK@nychhc.org
Tel: 718-334-5182

Outside of business hours, you can dial "0" for the operator and ask for telecommunications for more assistance.

You can also reach out to Chief on Call to temporarily add your phone number in place of the pager number until the pager issue is resolved.

UpToDate

You will have access to UpToDate while on hospital computers. If you would like it on your phone, you should set up an academic account while you are on the hospital wifi.

Practical Advice for the Busy Life of an Intern

Things to bring with you on DAY ONE:

- Supplies: Pens (Try multi-color ones - easy for rounding/making to-do lists), stethoscope, pulse oximeter, penlight, scut sheets or templates if you want (see link to "medfools" resource below), and ACLS cards
- Your phone - fully equipped with medical apps (details below)
- Pocket medicine and know how to access UpToDate
- This guide!

Phone apps (All available for iPhone, hopefully for Android as well!)

***You may not find them all useful, but check them out so you know what will be helpful for YOU*

- MDCalc app: set your favorites for certain scores and ones you use frequently (ASCVD Risk, MELD, Cha2ds2Vasc, Wells, TIMI etc.), and check the Evidence section
- **UpToDate – one of most popular apps for quick reference with links to further reading**
    - *Make sure to first create an account when connected to the hospital wifi - it's free for you!*
- **Dynamedex:** great alternative to UpToDate
    - *Make sure to first create an account when connected to the hospital wifi - it's free for you!*
- Doximity: Useful for sending faxes, calling patients/families from your personal phone but making it look like the hospital's phone number
- Lexicomp / Micromedex for medication reference-- dosing, adverse effects, drug interactions, etc.
- Epocrates: medication dosing, adverse effects, interaction check, pill ID
- Sanford Antibiotic Guide. Download by going to https://www.sanfordguide.com/support/enterprise-login/ from a hospital computer
- GoodRx: help your patients find affordable prescriptions and print coupons
- AHRQ ePSS: FREE, Input pt info, get all screening recommendations
- Journal Club: $5 for a concise list/description of many landmark studies and trials (or use the website for free: wikijournalclub.org)
- CPSolvers: $15 app companion to ClinicalProblemSolvers website, podcasts; illness scripts, schemas, links to podcasts, videos, and twitter threads and tweetorials
- Pacemaker ID: Use this app to identify defibrillator and pacemakers in an x-ray image using your camera

Other useful resources:

- ACR "Appropriateness Criteria"; start with concern (Jaundice, Chronic Hip Pain) get best study (U/S, Xray, CT, MRI w? w/o?) https://acsearch.acr.org/list
- Fast Facts and Concepts (Fast Facts): Everything you need to know about palliative care
- Center to Advance Palliative Care (CAPC): modules on palliative care

https://www.capc.org/ (use your NYHHC email for login to get free access)

- Agency for Healthcare Research and Quality: good mix of evidence, infographics https://www.ahrq.gov/
- TRIP Database: Faster, easier to sort than PubMed https://www.tripdatabase.com/
- Scut sheets for H&Ps, daily rounding, etc. http://www.medfools.com/downloads.php
- Pocket medicine, of course! (Pocket Medicine)
- Physical exam https://meded.ucsd.edu/clinicalmed/ and https://stanfordmedicine25.stanford.edu/
- Collection of sites about EKGs: **http://www.clinicalskills.pitt.edu/electrocardiogram-interpretation/index.php**
- Critical care/procedure reviews: https://emcrit.org/ibcc/toc/

General tips for success:

1. **Update your nurses!** They are a great resource on the wards– they spend more time with your patients and their families and are experienced with how the hospital functions. In general, they can be very helpful for you if you are kind and keep them in the loop. Patient care is only effective with the help of the nursing and ancillary staff. If they're on the same page as your team, then you're on your way to provide high-quality patient care.
2. **Keep families in the loop.** Most family members are not present on rounds, so they always appreciate an update. It's also important to keep them updated, so your night team doesn't get calls at 8 PM that a family is here and hasn't been updated in a week! Always try to make a daily call to family members, especially for non-responsive/non-verbal patients, as they wont be able to talk to the patient to see what's going on with them. Let family members know that you will update one representative from the family and that the rest of the family members can receive updates from that representative, so you are not making multiple calls to the same family.
3. **Look at your own imaging!** Especially CXRs. If you cannot interpret the radiology images, that is ok, but you should get used to looking at imaging on your own – it shows that you are curious about the findings, saves time for urgent imaging, and this is the only way you will build your radiology skills.
4. **Don't be afraid to ask for help!** Don't be shy – you learn by asking. No one expects you to be perfect, and there is always room for improvement. Ultimately, patient safety is paramount, so when you don't know something, be sure to ask. When in doubt, ask for help! Your seniors and attendings will be happy to help you if you are ever feeling overwhelmed.
5. **Update hospital courses frequently.** This will make discharge summaries easier and also provides an updated hospital course for the intern you are signing out to at the end of a block or if urgent transfer notes are needed, etc. This can be found in the "discharge" tab on Epic. Avoid adding long descriptions - synthesize and summarize.

6. **Keep notes on things you learn** – Some people use OneNote/Evernote/the regular notes app on your phone…find a method that works for you. Keep track of facts that you learn, management strategies, etc. so you can reference them the next time you see a similar patient. You should also create your own list of interesting patients/cases to look back at and follow them through their treatment even if you are off-service.
7. **HAVE FUN!** Hours will be long, but you get used to it. Find a good work-life balance. Sounds very clichéd, but it is SUPER important to your success as an intern. Don't stop doing things you enjoy – exercise, cooking, sleeping, visiting family/friends... whatever keeps you sane :)

Bedside Manner/Communicating with Patients

You need to convey to your patient (verbally and nonverbally) that you respect them and that their well-being is important to you. If you do not develop this kind of relationship with your patient, it will be difficult to take care of them, and your treatment plan is liable to fail. Goals are to establish trust, build a therapeutic rapport, and educate your patient.

DO's:

- ✔ **"Knock Knock", "Good morning!"** Implicitly asks permission to come into their room and speak with them.
- ✔ **Wash your hands/Purell before and after seeing the patient** (do this in front of the patient)
- ✔ **Always introduce yourself (show your name tag) and your role on the team**.
- ✔ **Identify the patient by name and birthdate or MRN** (use their ID bracelets)
- ✔ **If you and the patient are not fluent in a common language, always get a translator (4-1500 or your cell phone)**
- ✔ **Try to put yourself at eye level with your patient** (pull up a chair, or ask if you can sit on their bed (use your judgment, eg leg wounds/fractures, contact isolation patient, etc). This communicates respect as well as "I have time to talk to you". *Sitting down multiplies by four the amount of time they think you've spent with them!*
- ✔ Take cues from the patient about a non-medical thing to talk about (eg "how old are your kids?", "who brought those beautiful flowers?" etc). Build a relationship, find out what matters to them!
- ✔ **Respect the patient's privacy.** Families may be vital sources of collateral information, but the patient has the right to be interviewed in private. If family is present, you should always ask the patient if it's ok with them if the family leaves the room for the interview and exam. If you find that the pt is unable to give important information (e.g. dementia or altered mental status), then you can ask if you can bring the family back in to fill in some of the missing information.
- ✔ **Examine the patient with tact.** Pull the curtain ("let's have some privacy"). Do not expose the entire body at once – instead, cover the parts you are not examining with the sheet. If either you, the patient, or the family seems uncomfortable because you and the patient are not of the same gender, ask for a nurse to be present. Make sure that for the admission exam you remove all of the patient's clothes, including socks and underwear. Crucial findings are often overlooked for days when this step is skipped. You might want to talk through the exam as you perform it, so that the patient understands what you are doing, and doesn't find your silence ominous.
- ✔ **Always make sure that you leave the patient with your (team's) impression and plan (including the schedule for the day).** If you don't know the plan, then tell the patient that you want to discuss with the team and that you will be

back. Patients are understandably anxious about what's going on, and you need to keep them informed or they will suffer and likely come not to trust or cooperate with you! If you do tell the patient that you're coming back, make sure you come back!

- ✔ **Take every opportunity to educate your patients about their diseases.**

What to do about conflict, dissatisfied patients, etc

- ✔ Apologize for miscues/delays/problems, and let the patient know that you're advocating for them.
- ✔ Ask about pain and other symptoms (typically the first thing you talk about after greeting the patient), and make a serious effort to treat them adequately.
- ✔ Set limits with difficult patients or families and stay calm. If the patient does not have capacity and no clear HCP, ask the family to designate one spokesperson to relay all information.

NEVERS

- **Never mislead your patient**. Trust is very important and once lost, you'll never get it back.
- **Never leave your patient in the dark** about changes in plan or results of tests.
- **Never limit your interaction with patients to morning pre-rounds**. Touch base multiple times a day (eg: Pre-Rounds, Morning Walk Rounds with your team, Afternoon Rounds).
- **Never let your frustration affect your interactions** with patients.
- **Never speak badly of another physician/service.** (Increases anxiety, leads to distrust of all of us)
- **Never be afraid to admit that you don't know something.** (So much better than guessing!)

Workflow 101: When to Get Things Done

AM Tasks

C - consults
O - orders
L - labs
D - discharges

PM Tasks

S - signouts
A - admissions
N - notes
D - diet/DVT ppx

AM Tasks:

1) Consults – call your consults early (preferably before noon) to make sure you give your consultants enough time to review charts, see patients, and provide recommendations.
2) Orders – place orders as soon as you're able to (even on rounds via Haiku) to try and expedite patient care. Placing orders immediately after rounds will make sure important orders are not forgotten.
    a) This is also a great time to review any current orders, renew any expiring meds/foleys
3) Labs – order any labs that need to be done in the afternoon or the next morning
4) Discharges - discharge anyone for whom everything has been done and the attending has signed off on the discharge

PM Tasks:

1) Signouts/Handoffs - Create/update the handoff for your patients as things happen throughout the day so that you'll be able to safely hand them off to your night team. This includes anything that needs to be followed up on, or things to watch out for
2) Admissions - Touch base with your senior about the new admissions, anything that needs to be done to tuck them in so that you can hit the ground running for the next day
3) Notes - Daily progress notes should be finished before you leave to ensure adequate communication between all providers
4) Diet/DVT ppx - Ensure that anyone with a procedure the next day is NPO and that all patients have appropriate DVT prophylaxis on (or off, if appropriate!)

Talk to your senior to help divide up the tasks or if you are getting overwhelmed. They can also help you with some techniques or organization tips to become more efficient.

Escalation Pathways

When should I medically escalate things?

- Any event in which patient safety is compromised
- Any time in which the resident feels uncomfortable or has a concern
- Violation of mutual respect or disagreement with plan of care (patient, family or consultants)
- Significant new vital sign abnormalities (systolic blood pressure <80 mmHg, heart rate >130 or <45 with concern for arrhythmia, new oxygen requirement of 4L or tachypnea)
- Significant new laboratory abnormalities (K >6 mEq/L, Na <120 mEq/L, Hemoglobin drop requiring transfusion, lactate >4 mmol/L)
- Change in mental status/new neurologic deficit or seizure/delirium tremens
- Positive cardiac enzymes or significant EKG changes
- Fall with injury
- Suicide attempt/disruptive behavior
- Procedures requiring consent (e.g. blood transfusion, paracentesis, central line)
- Transfer to higher level of care (Step-down or ICU)
- Unexpected death
- Against medical advice discharges or elopement

What if I have a problem that no one has a solution for?

The **AOD**, or **administrator on duty**, is a clinical manager of the hospital (typically an RN/NP, but very occasionally a non-clinical person) who can help with essentially anything, including issues with getting imaging completed, bed assignments, facility transfers, clinical questions that RN staff or your colleagues don't have an answer to. They are also present at all RRTs and all codes as they are instrumental in expediting transfer/upgrade, accessing/replenishing needed supplies and equipment, helping lead the many teams involved in critical scenarios.

They can be especially helpful at night. If you need urgent imaging or an MRI, they have the power to resolve these matters. They are also very knowledgeable about policies and protocols - and if they don't have the answer, they'll know where to find it. To reach them, dial x44357 (also listed on your green card!).

Notes: H&P and Progress Notes

In the era of duty hours, almost every hospital has a night/day medicine system. The night team does not know your patients as well as you do. Think about your notes as updates to the other members of the team and to consultants about what happened to your patients during the day and what you are actively doing. Please use the following dot phrases – they'll have everything you need to tell your colleagues what's going on with your patients.

'Stealing' other people's dot phrases:

You can access any Epic users' dot phrase and give yourself the ability to use it. If you see someone using a dot phrase you like, go ahead and share it with yourself.

1. Click the **Epic** button on the top left -> Tools -> My Smartphrases
2. On the left sidebar, select **Manage Phrases**.
3. Type in the person's name whose phrases you want to look at (ex: Mozell, Daniel) and hit enter
4. You will now see all of the dot phrases that that user has access to.
5. Find the dot phrase you want and click it.
6. Hit **Add to my SmartPhrases** on the toolbar below the person's name
7. Congratulations! You can now use these dot phrases for all of the notes you need.

Dot Phrases You Absolutely Need

.IMAdmit → Admission H&P

- History & Physical with all fields (including medical, family, social histories – please make sure they're filled out!)

.IMProg → Daily Progress Note

- APSO format – puts the Assessment & Plan at the top to streamline communication

.IMDCSum → Discharge summary

- Write the discharge summary you would want to read as a primary care provider taking care of this patient post-hospitalization!
- Hospital course will auto populate from the "Hospital Course" section of the Discharge tab, so keep these updated! Also copy the Hospital Course into Patient Instructions part of the DC summary to ensure the patient will get a copy.

.**IMTransfer** → focused Transfer note to a different service

- Again, the hospital course will auto populate from the "Hospital Course" section of the Discharge tab, so if this is updated you'll save yourself work in the event a patient needs to get emergently upgraded

.IMHotspot → Focused progress note for overnight hotspot patients

.**IMOffService** → Combo progress + handoff note done on the last day of rotation. This does not replace a verbal or written signout.

.IMDeathNote → Note for pronouncement of death

.IMDeceased → discharge as deceased summary

Handoffs

Verbal Handoff

- Systematic, organized, presented at an appropriate pace
- Serves to orient the receiver to patient acuity, provide a summary, issues to follow up for, and ask for feedback/check understanding
- I-PASS → framework for verbal handoff. Follow this for all handoffs and you'll never miss anything!
- Senior residents will supervise verbal handoff for the first few months of the year
- As the listener: you are an active part of the handoff process – don't be afraid to ask questions if you have them! We are all here to provide the best care possible for patients and you are a part of the team doing that.

Written Signout

- Make sure to update **daily** – this should be the most current and accurate information on your patient. Make it succinct – not a blow-by-blow description.
    - Imagine you are in the middle of a rapid for this patient – what would you want to know?
- Should be reviewed by senior resident before they leave for the day
- Night resident should update with any major events (eg, rapids, stroke codes) or changes

End Of Rotation Handoff

Use the **.IMOffService** template to write an Off-Service note on the last day of block to facilitate hand-off to the next team. This replaces that day's progress note. Residents, interns, and attendings must hand-off to their colleagues on the last day of block over H+H email. Include incoming and outgoing attendings on these signouts.

The I-PASS Mnemonic

I	Illness Severity	• Stable, "watcher," unstable
P	Patient Summary	• Summary statement • Events leading up to admission • Hospital course • Ongoing assessment • Plan
A	Action List	• To do list • Timeline and ownership
S	Situation Awareness and Contingency Planning	• Know what's going on • Plan for what might happen
S	Synthesis by Receiver	• Receiver summarizes what was heard • Asks questions • Restates key action/to do items

Illness Severity (and a little extra)

Illness Severity - how sick is the patient?

- ALC: Should be discharged but something is holding them up, like SAR placement or DME delivery
- Stable: Stable, progressing/improving. No major events over the day, nothing crazy anticipated overnight.
- Watcher: Sick, not completely stable
- Hotspot: Sick, not stable – someone you want the overnight intern and the nocturnist to see in person overnight. Examples include patients with complicated withdrawal, new chest tubes/lines, new O2 requirements/increased work of breathing.

Code Status -

- Full Code/DNR/DNR+DNI/Comfort Care

DVT ppx or therapeutic anticoagulation -

- If therapeutic AC, include reason (eg: VTE, AF, mechanical valve).
- If heparin drip, include reason (ACS vs VTE)

Antibiotics

- Antibiotic + reason (and end date if known)

Patient Summary

One-liner. This should be updated every day!

Action Items

Night:

[ ] tasks for night interns go here. In general if a lab/imaging result/consultant rec won't be acted on, don't include it.

- The night intern should write any overnight events here

Day team:

[ ] anticipated to-do items to get your day moving

Discharge:

- any anticipated d/c appointments if made or need to be requested

Situational & Contingency Plan

This is where you plan for all of the most likely scenarios and the worst-case scenarios. Remember that as the day team YOU are the patient's primary doctor and you have the most in-depth knowledge of their clinical course and medical problems.

- "IF [situation], THEN [response]"
- Include baseline abnormalities as applicable (eg, neuro deficits, orientation for demented/delirious patients, etc)

Contact: if patient is particularly sick or if there's a primary person in their life, include contact info – this will save the night resident time if anything happens to the patient

Presenting on Rounds

Your presentations on rounds are the way to get everyone on the same page and to convey any new information since rounds yesterday. While every attending will likely have their own preferences, by making sure that you consistently have the same information you'll know that you're hitting all the relevant points.

INTERVAL EVENTS:

- E.g. procedures, consult recommendations, new medications started since last discussed
- Overnight events

SUBJECTIVE: Patient's self-reported complaints or symptoms. You are just reporting here, avoid interpretation

OBJECTIVE:

- **Vitals** - list 24 hour ranges and most recent set if significantly different - try to avoid using the word "stable"
- **Physical Exam** - list pertinent positives and negatives. Avoid using the word "normal"
- **Labs** - report pertinent labs with trends (e.g. if trending sodium or WBC count, report the trend over the past few days). No other commentary – you are reporting objective data here, not interpreting.
- **New imaging**
- **New micro data or path**

ASSESSMENT: Who is this, what do they have, and what are we doing for them?

Components:

- One-liner
- Age/gender
- Relevant PMH
- Presenting symptoms + timeframe and relevant context
- Objective findings identified during hospitalization
- Diagnosis or differential diagnosis
- Current treatment
- Clinical status: patient is improving/worsening/unchanged

Age/gender with **relevant PMH** who presents with **presenting symptoms + timeframe and relevant context**, found to have **objective findings identified during hospitalization**, concerning for **diagnosis**. Currently treating with **treatment**. Patient is **improving/worsening/unchanged.**

PLAN: done by problem, in order from most pressing/urgent/active to least, unless in ICU where you go by organ system.

CC: in the patient's own words (usually no more than two or three), why the patient is seeking medical attention

HPI

First Paragraph

- The first line typically states the "one-liner" identifying statement (eg "54-year-old woman with a history of x, y, and z") and presenting complaint (eg "presents with three days of fever, cough, and shortness of breath").
- The rest of this paragraph tells the story of the present illness. Start at the beginning ("Pt was in her usual state of health until...").

Second Paragraph

- The first line often will contain more detail on the pertinent diagnosis from the PMH, if there is one. For example, if the presentation is shortness of breath, you might say, "Pt has moderate persistent asthma, poorly controlled with frequent admissions to hospital, triggered by dust and cold weather, last steroids received 12/07, never intubated", or "Pt has HFrEF class III, echo 10/16 EF 30%, last admission for CHF 12/16".
- The rest of the second paragraph will contain pertinent positives and negatives from the ROS relevant for the patient's complaint. Remember that the complaint implies a differential diagnosis, and the pertinent questions from the ROS are those which are needed to consider those possible diagnoses (as more or less likely, not "rule them out or in").
- A good HPI, and particularly a good second paragraph, will suggest the correct diagnosis, and will leave your audience speechless, as there simply won't be anything else to ask. If the audience has a lot of questions, either they weren't listening or their differential diagnosis includes diagnoses you haven't thought of.

PMH/SH

- In order of most relevant to the presenting complaint to least relevant
- Include relevant details parenthetically

Medications

- Include doses and frequencies when known, note any recent changes or compliance issues
- Note any discrepancies between different sources

Allergies

- Generic names of medicines, along with the specific reaction, if known

Family History

- For older patients (e.g. over 70 y.o.), can put noncontributory (because it's not); otherwise, group by disease

Social History

- Tobacco, alcohol, and illicit drug use (how much, how long, if actively using).
- Occupation and home environment are often relevant and should be detailed as appropriate.

ROS

- This represents the complete review of systems. It should *not* include the systems that are pertinent to the current illness (since those systems should be reviewed in paragraph 2 of the HPI). Rather, this is for "by the way" items, often things that may need to be attended to by the PCP. You need to obtain and write a complete review of systems, but you should be clear about those things which are relevant to understanding the current complaint (and should be in the HPI) and those that aren't.
- In the oral presentation, just mention the "positive" items from the ROS. As you ask the standard ROS questions, you should ask yourself what the questions you are asking are "getting at" (e.g. if a patient answers that yes, she does have night sweats, what illness or illnesses does that suggest?)

ED course

- Triage vitals, interventions (meds, BIPAP, etc) and response, consults called

Exam

Should be complete, including all parameters for all systems. For the oral presentation, you can limit yourself to the pertinent positives and negatives, but **at a minimum** you should always include the following systems.

- VS including the O2 sat (and inhaled oxygen %, if not room air) **when you are seeing the patient.**
- General – in terms a theater director could use, including habitus, level of distress, level of alertness
- HEENT
- Cardiac (including JVD)
- Lungs
- Abdomen
- Extremities
- Internist's Neuro exam

Labs/Imaging

Include baseline and trends for all abnormals. Include radiology and EKG here. Note if read is yours, prelim, or final. Look at prior imaging even if current is normal.

Summary/Assessment/Plan

First sentence should briefly restate the identifying statement and the salient points from the HPI, exam, and labs, imaging. This is the **summary**.

Assessment and plan should be problem-based – not system-based. For your **assessment**, state what you think the diagnosis is. You should follow this with the evidence that supports your diagnosis. You should then state the leading contenders for the correct diagnosis, and for each describe the evidence for and against. If you marshal the evidence well, you will have made a persuasive case, and at the same time will highlight the other diagnoses that the team is keeping under consideration. The **plan** follows naturally: for each problem, describe the diagnostic procedures you are planning to do, then the therapeutic intervention. Do not forget about symptom control (e.g. pain, nausea, cough), F/E/N, DVT prophylaxis, goals of care, dc planning.

Consults

Communicating effectively with your consultants not only helps make your day smoother but also makes sure that your patients get the subspecialty expertise that they need. Before picking up the phone/sending a page on AMION, take a moment to make sure you have a clear idea of why you're calling – you should have a clear question for your consultant to answer after their evaluation of your patient. If you're not clear or can't remember from rounds, check with your senior! When calling a consult, make sure to place the order in Epic – "**IP Consult to [service name]**" – so that they are able to see your patient on their list prior to calling/paging from AMION.

FRONT

C **ontact the Consultant Courteously**
Caller's name, training level, team, "I am requesting a CONSULT please."

O **rient**
Patient name, medical record number (MRN), floor, and bed

N **arrow Question**
Ask a focused question regarding diagnosis (workup, procedures) and/or management (treatments, pre-op)

S **tory**
Patient age, sex, *pertinent* history (HPI), hospital course, relevant labs, radiology, anticipated plan

U **rgency**
When should the patient be evaluated? 30 minutes to 1 hour (emergent), 2 to 3 hours (very urgent), 8 hours (urgent), 24 hours (routine)

L **ater**
Make a follow-up plan with the consultant (how and by when?) and give your pager/cell number

T **hank you**!

BACK

Other Tips for Calling a Consult:

Orient the listener to each component of the call.
Be courteous and polite (even if they are not).
Avoid calling a consult just to be "on board" with no particular question for that service to address.
For diagnostic questions, have a differential in mind.
For diagnostic questions, begin and anticipate the workup.
For therapeutic questions, have an anticipated management plan in mind.
Have pertinent information available (either written) or open on EPIC.
Follow up with the consultant after the initial recommendations to: ask questions and discuss the outcomes of the case (it's your time to learn!).

AMION Tip Sheet

From Epic Hyperspace, you can access Amion by clicking the link in the toolbar at the top of your screen. You can also access in your browser Amion - Home (doximity.com) using the access code **ehc** followed by your NYCHHC login.

You can view all medicine schedules including General Medicine, Step Down, MICU, CCU under the "Medicine" tab. The "Medicine Subspecialty" section includes Director of Medicine, Infectious Diseases, HIV Team, Rheumatology. You can also page anyone by clicking on the pager number to the left of the person listed on call.

Who/What to Page

- New ID consults (under Medicine Subspecialty) → ID fellow (except on Thursday)
- Dermatology -> Derm consult resident (only available Tuesday/Wednesday)
- Antiretroviral medication approval → HIV NP (ID Fellow on weekends)
- Pulmonology/Critical Care
    - ICU consult, ongoing vent/trach management → Crit Care fellow
    - Chest tube, general pulm consult → Pulm fellow
- Cardiology
    - General Cardiology Consult → cardiology consult fellow.
    - Cards critical care, possible upgrade to CCU (e.g. unstable AF, cardiogenic shock) → CCU fellow
    - STEMI → CPORT fellow
- GI consult → "Just Say Yes" fellow
- Renal
    - Chronic HD patient gets admitted → HD fellow
    - New consult → consult fellow
- Neurology
    - Stroke (ischemic/hemorrhagic) → stroke resident
    - All other consults → general neuro resident
    - NB: There may be a stroke or other neuro fellow listed on Amion, but always page the resident first
- Surgery → call the number listed as "All Peds, Gen. Surg. & Vascular ER CONSULTS" &
- Endocrinology → an attending-only service, can be paged via Amion. Weekends/nights they are not in house but typically take home calls.
- PM&R consult → Rehab
- Respiratory therapists are listed by floor
- Social workers are listed by floor but also generally responsive over Epic chat

Discharge Planning/IDT Rounds

Discharge planning begins the moment a patient is admitted – while you're managing their medical issues, you should also be thinking about everything they will need upon homegoing (HHA, VNS, PT, follow up appointments) so that you're not stuck waiting after someone's inpatient issues have all resolved.

Interdisciplinary Team (IDT) rounds happen every day on all of our inpatient medicine floors. See the schedule for your floor. If you have a patient on more than one floor, you only go to your floor's IDT rounds and touch base with the SW on the other floor afterwards.

B5, B6 ● 9:45 - Team A ● 10:00 -Team B ● 10:15 - Team C ● 10:30 - Team D	**A3** ● 10:00 - Team A ● 10:15 - Team D **B4** ● 10:00 - Team B ● 10:15 - Team C	**A4** ● 9:45 - Team A ● 9:50 -Team B ● 9:55 - Team C ● 10:00 - Team D

Who's Who on IDT Rounds:

- **Nurse Manager or Charge Nurse**: representative for nursing concerns. In addition to making sure you touch base with the patient's nurse, you can also discuss any concerns or nursing needs with the nurse manager to get everyone on the same page about the patient's care.
- **Social Worker:** each unit has their own social worker; patients are followed by their unit SW with a few exceptions:
    - Bridge team (patients with uncontrolled DM, COPD, HF)
    - CATCH – if a patient is interested in rehab after discharge, then the CATCH SW will help set this up
- **Physical Therapist:** each unit has an assigned physical therapist who will be on IDT rounds if possible. Their notes are generally pretty good, but you can always ask them in person for clarification or an idea of how many more sessions a patient will need before going home.
- **Case Manager:** nurses who act as liaisons between the hospital/healthcare system, insurance, nursing homes – they'll fill out PRIs (like a dc summary for a new NH or SAR placement), talk to your attending if an admission is being denied, etc.

Presenting on IDT Rounds:

Start by introducing yourself and which team you're on before moving on to the patients. For each patient, follow a set order and stay consistent.

- Room number/bed (orient everyone - lists are often organized by room # since they have the entire unit)
- Patient name

- **BRIEF** one-liner → you don't need the entire medical history, just maybe 1-3 most pertinent things (e.g. things they will need a HHA or visiting nurse for). Include your working diagnosis and what you are doing for treatment.
- Projected time until discharge → how long you think the patient will need before they are medically ready for discharge – can they leave today? Maybe a few days or longer? This helps SW/CM/PT so they can plan what order they see people in and so they can prioritize people who are more likely to get discharged soon.
- Where are they going? → Home vs SAR vs acute rehab? Or somewhere else?
- Any services? → If a patient is going home, do they need a HHA (or to have their HHA reinstated) or VNS/any other services? SW will help you coordinate/refer for this.
    - You do not need an inpatient PT/OT evaluation to refer patients for home PT/OT!
- Transportation → if a patient is leaving, will they need transportation? What time should it get set up for?

Example: "In room 502-02 we have Mr. Jones, a 67 year old man with COPD, diabetes, and HFrEF who came in for shortness of breath from heart failure exacerbation – he's very overloaded so we are diuresing with IV lasix, and he will likely need several days of diuresis before going home. He may need some home PT because he's debilitated, and would benefit from a visiting nurse for med management."

- After you've finished presenting, the SW will update the rest of the team on the appropriate referrals or any placement acceptances. The nurse manager can discuss any nursing updates or concerns.

Where do Patients Go?

	Who	How Long	Where
Acute Rehab	Patient with rapid major decline in functional level, can tolerate 3h of intensive therapy per day, needs 2 different therapy modalities (e.g. OT, PT, SLP), and expected to return home	1-2 wks Longer for TBI or SCI	Usually either separate floor in hospital or free-standing facility
Subacute Rehab (SAR)	Patient with moderate decline in functional level from baseline (eg PNA with deconditioning), unable to return home now but eventual plan for home or transition to SNF. Should be able to participate in therapy (ie follow directions) for 1h/day.	1 wk to 100 days	Nursing home, usually separate from long term care patients
Nursing Home (SNF)	Patient unable to be taken care of at home, no rehab potential	Up to forever	Nursing home
Home with services	Patient able to return home but has a skilled need (e.g. wound care, IV meds, home PT, new meds) and is homebound. Homecare nurse evaluated them at home 1-2d post discharge, can arrange for PT, regular nurse visits, HHA	Depends on medical need and insurance	Home
Home with hospice	Patient has <6 mo prognosis, can function at home with minimal help (no more than 4h/d from VNS), symptoms manageable at home	6 mo, can be renewed up to twice	Home
Inpatient hospice	Patient has <6 mo prognosis, cannot function at home or has symptoms requiring IV medications	Up to 6 mo, but generally much less	Hospice bed in a hospital, hospice facility, or SNF

How to Admit a Patient

All admissions should be completed through the **Admission Navigator** on Epic. By doing everything through here, you can easily keep track of all the orders and also help out your future self once it's time for the patient to go home.

1. Click the **Admission** tab while in your patient's chart to enter the **Admission Navigator.**
2. On the left sidebar, select **Med Rec-Sign Hold** to open all admission orders
3. You are now in the admission orders section, which opens by default on the **Review Current Orders** subsection where you can continue/discontinue any orders currently active for the patient. Once you are done click **Next** to save your work and move on to the next step.
4. In the **Review Home Medications** tab you can review all of the patient's medications – what medications they're taking and the date it was last taken.
    a. Add new medications by clicking "Add" next to the text box
    b. Make sure to click **Mark as Reviewed** in the bottom left hand corner to save your work before clicking **Next**.
5. In the **Reconcile Home Medications** tab, choose which of your patient's home medications you would like to re-order for the admission.
6. In the **Order Sets** tab, you can finally enter any other orders you need
    a. For all basic admission orders, type "**Gen admit"** which will take you to the general adult admission order set. This has everything you'll need to admit someone – VS frequency, code status, diet, PT/OT, etc
    b. This is also a good time to order any morning labs so you can hit the ground running!
7. Click **Sign** and all of your orders will be there.

Transfers/Upgrades/Downgrades

Transitions of care are the most vulnerable times for patients. Like with our handoff process between shifts, any time a patient changes hands, there should be an accompanying written and verbal handoff.

The **transfer note** includes the patient's HPI, hospital course to date, and reason for transfer. The **.IMTransfer** dot phrase will have everything you need in it and the hospital course should auto-populate, so be sure that you or your senior is keeping this updated – you'll save yourself time if your patient suddenly has to leave your service.

Escalation of Care (Upgrades)

If a patient decompensates, call your senior and the appropriate attending. **Do not leave the bedside of an unstable patient!** If someone is unstable and you need more hands, ask the nurse to call a rapid response (RRT). Once your seniors are there, they will help stabilize and triage the patient to the most appropriate location (A4, MICU/CCU) and work with TR and bedboard to expedite the transfer. Just remember that as long as the patient remains on the floor, they are still your patient! They don't change teams until they move to the appropriate floor.

Transfers between services

If a patient is being transferred to another service, you will need to write a transfer note. In the event that a patient goes to the OR, your team should reach an agreement with the operating team prior to surgery whether the patient will return to your service or if they will go to the operating service afterwards. This should be clearly documented in your notes so there is no post-op confusion.

Inter-Hospital Transfers

If a patient requires a service or a procedure that our hospital does not offer, they should be transferred to a facility that is able to provide that service or procedure. Once they have undergone an intervention, they can return to us to complete the remainder of their care.

- NYC Health and Hospitals Transfer center (844) 442-2337
- Mount Sinai Transfer Center (212) 540-4528
- NYU Transfer Center (212) 263- 8500

Downgrades

Patients who no longer require ICU or stepdown level of care can be downgraded to the general medicine floors. This should be decided on rounds with your attending; however, the patient may not get a bed until later in that day or overnight. Whenever a patient gets a bed, the senior on the current team should re-assess them to ensure they are still appropriate for downgrade before transferring the patient out of the unit.

How to Discharge a Patient

Discharge planning happens continuously throughout a patient's hospitalization, not just the moment they're medically ready to leave. You can help ensure your patients have timely post-hospitalization follow up (and that you aren't scrambling to get things done for them the day they leave!) by staying organized and starting to work on some of these things early. There are a few key components that go into every discharge, which you can keep track of with the mnemonic **MISO**.

M – Medications
I – Instructions
S – Summary
O – Order

Medications

All discharges should be completed through the **Discharge Navigator** on Epic.

1. Click the **Discharge** tab in a patient's chart to enter the **Discharge Navigator.**
2. On the left sidebar, select **Order Reconciliation** to open the discharge med rec.
3. You are now in the discharge orders section, which opens by default on the **Reconcile Problem List for Discharge** subsection. Since we aren't using the active problem list that auto populates through Epic for notes, you can move past this to click on the next section, **Review Orders for Discharge.**
4. **Review Orders for Discharge** is essentially the discharge med rec. You will be able to see all of their home medications as well as anything you've started during this hospitalization.
    a. In order to e-prescribe medications, you will need to link the patient's pharmacy to their orders. In the lower right hand corner above the "Sign" button, it will either have the name of their pharmacy or "no pharmacy." Click on this and it will take you to a screen where you can put in the patient's pharmacy.
    b. Each home medication has three icons next to the name.
        i. The **green arrow** will tell your patient to continue the medication as they were taking it.
        ii. The **yellow pencil** will open up the order for the medication so you're able to edit how they are taking it (frequency, dose)
        iii. The **red X** will tell them to discontinue the medication.
    c. Each inpatient medication has two icons next to the name
        i. The **green plus sign** will add it to your patient's medication list and allow you to prescribe it
        ii. The **red "no" symbol** will discontinue the medication upon discharge.
    d. You must take an action on each home or inpatient medication to complete this section.
    e. To refer your patients for follow up appointments, type **"Amb Ref [specialty]"** in the orders on this page. This will allow the clerk to

schedule them for follow up. You should be putting these orders in a day or two before discharge to ensure timely follow up.

f. A “Discharge patient” order will automatically populate on this tab. Make sure to close it if you’re just reviewing the medications and are not ready to discharge your patient yet!

5. Click **Sign** to finalize all your orders and send prescriptions to the patient’s pharmacy.

Instructions

Anything you put in the Discharge instructions will be given directly to the patient. This is where you can remind them what they were treated for, any changes in their medications, any important follow up, and give them return precautions. Copy and paste the top of the dc summary and the hospital course here, so patients can bring it to their PCP (unless there is a good reason you don’t want the patient to have it).

Summary

The discharge summary contains a succinct HPI as well as a narrative of what happened to them while inpatient. By keeping running hospital courses on your patients, you can save time on the day of discharge since this will autopopulate into the **.IMDCSumm** dotphrase. Your senior should be doing this for you during the first part of the year, but as the year goes on and you gain experience, you’ll be able to start doing this as well.

The hospital course is located in the **Discharge Navigator**.

1. Click the **Discharge** tab while in the patient’s chart.
2. On the left sidebar, select **Hospital Course**.
3. This will open a box where you can free text the patient’s hospital course to date. This should highlight any changes in clinical status, treatment decisions, and new diagnoses – it should not be a daily log of patient subjectives. Pretend that you’re seeing the patient in clinic a week after their discharge… what would you want to read?

If you do a discharge summary on the day of discharge, you do not have to write a daily progress note as long as your exam and subjective are included in the summary.

Order

You made it! Once you have everything confirmed with the patient, SW (for transportation/services if needed), and your senior, you can put in the “discharge patient” order. This will let the nurses print out the discharge paperwork and AVS so they can work on the discharge from their end.

Against Medical Advice (AMA) Discharges

If a patient decides to leave AMA, a physician is required to evaluate a patient at bedside to assess the patient's capacity to make informed medical decisions.

Anytime a patient decides that they wish to leave AMA an attending must be notified – this is either the primary team attending or the Bell/Nocturnist depending on the time of day.

The following points need to be addressed for a complete AMA discharge:

1. Complete bedside examination/assessment of patient's medical decision-making capacity
2. AMA discharge note- should be signed to the attending that you notified
3. Discharge order should reflect: Against Medical Advice (AMA)
4. Complete medication reconciliation, follow-up appointment, hospital course as you would do for regular discharge
5. Include the smart phrase, ". IMAMA" in your discharge summary
6. Complete the physical AMA form that needs to be signed by patient and witnessed by the patient's nurse (you will find this documentation at the nursing station or under the "consents" tab on ehcim.com)
7. You cannot provide social work services to patient leaving AMA: e.g placements, transport

AMA vs. Elopement

Leaving against medical advice is not the same as elopement! Elopement is when the patient walks out of the hospital prior to being assessed by a physician. Ideally, a patient leaving AMA should sign the AMA paperwork, but if they don't, you should document this in your discharge summary. If a patient leaves with an IV/medlock in place, NYPD needs to be notified by either the nursing staff or the primary medical team. You will then complete the same points as above with the exception of having the patient sign the AMA paperwork.

Harm Reduction Discharge:

We can't always keep our patients here when we want them to stay, but we can try and reduce the possibility of harm by their leaving. You still have to set them up for the appropriate follow up, send their meds to the pharmacy, and make sure that you give them return precautions.

Alfandre DJ. "I'm going home": discharges against medical advice. Mayo Clin Proc. 2009;84(3):255-260. doi:10.1016/S0025-6196(11)61143-9

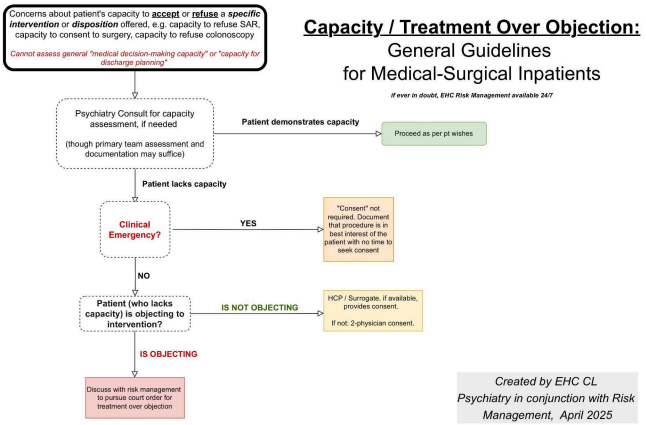
Capacity Evaluations

Decision making capacity is a functional assessment and clinical determination about a specific decision that can be made by any clinician familiar with a patient's case. Someone may have the capacity to make one decision (i.e., choosing a health care proxy) but not another (i.e., if they want dialysis). This is not to be confused with **competency**, which is a global assessment and legal determination made by a judge in court.

The three key components to address in a capacity evaluation include:

1) **Understanding**: can the patient understand and appreciate the diagnosis, prognosis, likelihood of risks & benefits, and the treatment alternatives? Does the patient have a related mood or other distortion of judgment (depression, fear, anxiety)? (Note, these do not necessarily mean that a patient lacks capacity to make a specific decision).
2) **Communicating a choice**: can the patient make and communicate a choice? Can the patient articulate a reason for refusal that is consistent with the patient's values?
3) **Rationalization/reasoning**: elicit the patient's reason for refusal: "help me understand why you decided to refuse xxx." "Tell me what makes xxx seem worse than the alternatives." "What do you believe will happen if you don't have xxx?"
4) **Consistency** over time: patients can be delirious sometimes and not recall what they've said previously. It's ok for them to change their minds, as long as the decision-making process is clear.

Appelbaum, PS. Assessment of Patients' Competence to Consent to Treatment. N Engl J Med 2007; 357:1834-1840. DOI: 10.1056/NEJMcp074045



Surrogate Decision Makers

Patients with full decision-making capacity have the full right to make decisions regarding their care, including decisions that may result in poor outcomes/death whether or not others may agree.

When a patient lacks decisional capacity, a surrogate (i.e. appointed health care proxy or guardian or next of kin) may make decisions on behalf of the patient.

The NYS surrogate list (highest priority is on top):

1) The spouse, if not legally separated from the patient, or domestic partner
2) A son or daughter 18 or older
3) A parent
4) A brother or sister 18 or older
5) A close friend

You need to assess the surrogate's:

1) Decisional capacity and appropriate concern for the patient's wellbeing
2) Decisions to assure that they are not unreasonable

Treatments that are likely to avert serious harm cannot be refused by a surrogate without clear evidence of the patient's wishes. If there are further questions or confusion, bioethics service consultation is available.

Advance Care Planning

When a very sick or elderly patient is nearing the end of life, there are a number of common questions that tend to arise from family members. The University of Wisconsin Fast Facts are an incredibly helpful resource that can give you some tools to address family questions and better take care of your patients at the end of their life. For a more in-depth dive, we have access to CAPC which contains modules that you can go through on your own time.

Palliative Care Fast Facts – https://www.mypcnow.org/fast-facts/

CAPC (will need to use NYCHHC email) – https://www.capc.org/

Any time you speak to the patient or their surrogate decision makers regarding changes in the overall goals of care (GOC) be sure to write an **Advance Care Planning (ACP)** note. This note should include who was present, a concise but thorough summary of the discussion, and any major decisions or changes in the plan of care. When transitioning away from aggressive medical measures to comfort care, we usually discuss the following measures:

- Stopping all non-essential medications (this will vary from patient to patient)
- Stopping all lab draws
- Stopping vitals checks/turning off monitors
- No IV fluids
- Allowing people with aspiration risk to eat whatever they want (pleasure feeds)

Whatever you discuss with the patient/their surrogate, make sure to document it in your ACP note and in the handoff so that everyone taking care of the patient is on the same page regarding the plan of care.

Declaring Death

Any time a patient expires in the hospital there are several steps that need to happen before they are moved to the morgue. If you have any difficulty completing these steps or if any questions arise, don't hesitate to reach out to your senior resident or the TR for more help.

1. Take a moment to yourself.

Losing a patient is always difficult, no matter the circumstance. Take a moment to yourself to process and grieve for the life that was lost. When you are ready, enter the patient's room for the death exam.

2. Pronouncing a patient

The death exam includes 4 parts. If it is your first time completing a death exam, ask someone to help guide you through the process:

1. Lack of pupillary response to light (use penlight to evaluate for pupillary constriction)
2. Absence of pulse and heart sounds (palpate for femoral/carotid pulse)
3. Lack of spontaneous respiratory effort (observe patient to see if any attempts at breathing)
4. Lack of response to tactile stimuli (use gauze to touch patient's eye or apply nail bed pressure)

If a patient meets all 4 criteria, find the current time and state "Time of death XX:XX". You will need to remember the time for later steps and it should be consistent across all documentation. Inform the nurses of the official time.

3. Notifying NOK/attending

A member of the team should notify the patient's next of kin (NOK). You can find this information in the chart under **Emergency contact** (see first box of handoff or end of notes).

- *Guide on how to inform patient's families coming soon*
- You should note down the name of the NOK informed for the death note
- You must ask the NOK if they would like an autopsy to be performed. If they do, there will be a delay before the body is released to the family. Ask the clerk for autopsy forms.

You should also notify your supervising attending.

4. Death note

EPIC dot phrase **.IMDeathNote** for Death Exam Note

5. Complete eVitals (Death Certificate)

6. Discharge orders and summary

Use the Epic dot phrase **.IMDeceased** for Discharge as Deceased Note. After this is completed, you will need to place a **Discharge Patient** order so that the patient can be moved to the morgue.

Reportable Death Criteria

OCME has jurisdiction over deaths occurring under the following circumstances:

- All forms of criminal violence or from an unlawful act or criminal neglect
- All accidents (motor vehicle, industrial, home, public place, etc.)
- All suicides
- All deaths that are caused or contributed to by drug and/or chemical overdose or poisoning
- Sudden death of a person in apparent good health
- Deaths of all persons in legal detention, jails or police custody
    - This category also includes any prisoner who is a patient in a hospital, regardless of the duration of hospital confinement
- Deaths which occur during diagnostic or therapeutic procedures or from complications of such procedures
- Deaths that occur during pregnancy, during childbirth, or within twelve months from the end of pregnancy.
- Deaths that occur during or within 24 hours after surgical or medical termination of pregnancy, stillbirth delivery, or fertility treatments.
- When a fetus is born dead in the absence of a physician or midwife
    - Stillbirths in the hospital need not be reported to OCME unless there is a history of maternal trauma or drug abuse, or the case has some other unusual or suspicious circumstance
    - Neonatal deaths from prematurity and its complications must be reported if the premature delivery was caused by maternal trauma or drug abuse
- Deaths due to disease, injury, or toxic agent resulting from employment
- When there is an intent to cremate or dispose of a body in any fashion other than interment in a cemetery
- Dead bodies brought into the City without proper medical certification
- Deaths which occur in any suspicious or unusual manner

Elmhurst Chief on Call

Current Chief Residents:

- Daniel Mozell
- Dorde Jevtic
- Chief email: ElmhurstMedChiefs@nychhc.org

How to Contact Us:

1. Sign onto amion.com (password: **ehc**). Select **Medicine** from the dropdown menu titled “Who’s On” and scroll to the bottom of the page to find the designated chief on call. This is your first point of contact for any issues.
2. For Urgent issues: **call** the Chief on Call via the phone number listed on Amion.
3. On weekends, one of the third-year junior chiefs may be the on-call chief. They will be the point of contact if something urgent arises.
4. All non-urgent issues that can be addressed in a matter of days to weeks: email us!
5. Please CC chiefs on all emails to ensure that your request is answered in a timely fashion. Two sets of eyes are better than one!
6. Scheduling requests: please read the block scheduling request emails when they are sent and reply directly to that email.
7. Any personal/professional issues? Feel free to walk in the Chief's office. Ideally, give us a heads up before you come to make sure we’re not in a meeting, but we are always here for you.
8. Jeopardy will be notified via text/page if you are being called in. We will call if you do not confirm within 5 minutes.
9. If you are sick or have an emergency, please **call** the Chief on Call so we are able to arrange appropriate coverage for you.

Other Scheduling Chiefs

- Mount Sinai
  - MedChiefs@mssm.edu
- Emergency Medicine
  - Diana Gregoriou - Diana.gregoriou@mountsinai.org
- Psychiatry
  - PsychChiefResidents@nychhc.org

Wellness

Residency is a physically and emotionally intense experience, and everyone processes things in different ways. We are here for you no matter what. Here are a few additional resources if you'd like to talk to someone outside of our program. All counseling services are 100% confidential. Currently located on C6-12.

- Helping Healers Heal (H3) is a peer-led program through H+H that will match you with someone else at Elmhurst for 1:1 or group debriefing and support
    - Contact: H3TeamElmhurst@nychhc.org
- WellConnect is a multidisciplinary platform with mental health, financial planning, and fitness resources available to you or anyone in your family to help with balancing all parts of your life. Includes a 24/7 support and **crisis hotline**.
    - https://wellconnect.personaladvantage.com/
    - School code: ICAHN
    - Contact: 212-241-2400 or 1-866-640-4777
- Mount Sinai Student and Trainee Mental Health:
    - 212-659-8805
    - stmh@mssm.edu
- Your health insurance covers mental health services if you would like to see someone outside of the MSH/H+H organizations.
- If you are feeling overwhelmed – or if you're worried about one of your colleagues – please let the Chiefs and Dr. K know.

Holidays/Schedule Requests

Block scheduling request emails will be sent throughout the year. If you have personal day requests, please complete the request form on EHCIM.com, so it's easy to keep track of which blocks you are requesting days off.

H+H recognizes a number of holidays throughout the year. We will tell you in advance if the program will be adhering to holiday/weekend scheduling during those holidays, or if short day residents will be allowed to sign out early.

Common Medical Conditions & Pertinent Information

This is by no means comprehensive, but should give you a good idea of what to include when reviewing patients' medical conditions and presenting them/writing notes. You should always question any unusual diagnoses and look for prior clinic notes to confirm and to prevent inaccurate information from being carried over.

Neuro:

- Dementia: specify type (e.g. vascular, Alzheimer's), baseline mental status (AOx1-3), physical dependency status (e.g. wheelchair-bound, bedbound)
- CVA: #, date of most recent, residual deficits. Eg. CVA x 2 (last 2019 with residual left-sided weakness)
- Epilepsy or seizures: on/off AEDs

Cardiology

- Afib: on/off AC, any ablations
- CAD: specify if prior PCI and date of most recent PCI; cardiologists will want to hear about specific anatomy
- HFrEF: specify EF on last TTE, etiology, and list device if present - e.g. ischemic vs. NICM. E.g. Rather than HFrEF (EF 15%) → nonischemic cardiomyopathy (EF 15% 7/2020, s/p CRT-D 8/2021)

Pulm

- COPD: specify if on home O2 and how much; most recent exacerbation and if ever intubated for prior exacerbations
- OSA: on/off CPAP

GI

- Cirrhosis: compensated/decompensated; if decompensated, specify if history of prior ascites, esophageal varices, hepatic encephalopathy or SBP. E.g. instead of "cirrhosis" → "decompensated cirrhosis (+ascites, + EV s/p banding 2029, +HE)

Renal

- ESRD: specify anuric/oliguric, what days patient receives HD, and via what access. E.g. Rather than "ESRD on HD" → "oliguric ESRD on HD MWF via LUE fistula"
    - If fistula, then location + thrill/no thrill on exam
- CKD: specify baseline creatinine

ID

- HIV: specify whether on HAART viral load and CD4 count. E.g. HIV (non-compliant with HAART, CD4 50, VL 16,000,000)
    - Any AIDS-defining illnesses and when (PJP pneumonia 2/2018)
- TB: treated/untreated + when/where treatment was

Heme/onc

- VTE: #, provoked/unprovoked, date of most recent, on/off anticoagulation, whether failed prior treatments. Rather than "recurrent DVT/PE" → "recurrent, unprovoked DVT/PE x 3 (last 2020, prior GI bleeding on xarelto, currently on coumadin)"
- Dig into onc history - diagnosis date, location of mets, prior treatments, any surgeries

Endo

- Diabetes: type 1 or 2, A1c, on/off insulin, and complications (nephropathy, retinopathy and neuropathy). E.g. rather than “DM2” → “uncontrolled DM2 (a1c 13.2%, non-adherent to insulin) c/b retinopathy, neuropathy and nephropathy”

Rheum

- Indicate if patient is on chronic steroids and specify how much. E..g. “SLE (on prednisone 20mg daily)”. Do this for anyone on steroids!

Psych

- Alcohol abuse → specify if history of complicated withdrawal. If has history of withdrawals, specify whether history of intubation, seizures or delirium tremens. E.g. “alcohol abuse c/b complicated withdrawals (+seizures, +intubations, + DTs)”

Other

- For transgender patients, the terms male-to-female (MTF) and female-to-male (FTM) are falling out of use; the preferred terms are assigned male at birth (AMAB) or assigned female at birth (AFAB). You can also update your patient’s gender identity and preferred pronouns on Epic under the Demographics tab.

Medical Education Resources

Google Drive

You can find helpful documents in our website: ehcim.com

Elmhurst Health Sciences Library

An underrated resource is our health sciences library which can be found online at: https://www.elmhursteducation.org/ The site includes information about accessing Uworld, MKSAP, as well as the major journals. The library itself is located on the 3rd floor and has physical copies of Harrison's, MedStudy, First Aid, as well as various nonmedical works for your vacation blocks! The library is led by Sheryl Ramer (Ramers@nychhc.org) who is an incredibly valuable resource.

Levy Library

As Elmhurst residents, you have access to the Mount Sinai library, the Levy Library. You can use your Mount Sinai login to access all major journals, as well as some rare historical documents. Online access is very extensive and includes full online versions of most medical textbooks with all current and prior versions (you can read the first edition of Harrison's from 1950!). You also have access to many library services, including their writing support service, where they can help with manuscript writing and even personal statements. To access Levy Library follow the instructions at elmhursteducation.org (under "library" tab).

Research Resources

Check out the Research Tab on EHCIM.com for many resources, including the Mount Sinai Research Toolkit, the guide to Levy Library, IRB navigation tips, case report consent forms, slides and recording of case report workshop, list of faculty mentors for case reports, intro to doing meta-analyses, and more!

Elmhurst Research Consortium

ERC is a consortium of specialty-specific working groups with shared interests aimed at collaborating, building connections, and conducting research, ultimately enhancing subspecialty opportunities and increasing scholarly output. You can sign up using this form.

BMJ Case Reports

Elmhurst's institutional fellowship with BMJ Case Reports allows house staff and faculty to submit case reports without paying article processing charges. They require a separate patient consent form. BMJ consent form

P-values (Pubs, Posters, Presentations) is a spreadsheet of scholarly activity accomplished during residency. Please add all your conference presentations and publications there!

Abstracts/Presentations:
https://docs.google.com/forms/d/e/1FAIpQLScI6sN9P7tFvs4Nu0Z6OHgKoKQ6Uw4x1jmIl3m_62SUC44BOg/viewform?vc=0&c=0&w=1&flr=0

Manuscripts:
https://docs.google.com/forms/d/e/1FAIpQLScnTfizeboH04R5jwWJmOV9x7A6-mSFkDM41MWYS7pF_0IhzQ/viewform?vc=0&c=0&w=1&flr=0

Online Medical Education Resources (June 2025)

Core Medical journals: use **app (Browzine** or **QX Read)** to browse core journals (eg NEJM, JAMA, Mayo, Lancet)

particularly look at review articles; otherwise, Journal Watch is a great way to get a curated sense of the literature

Clinical reasoning, Diagnostic Schema, illness scripts

Clinical Problem Solvers links to Morning Report, Diagnostic frameworks, Illness scripts, Podcasts

("In teaching diagnostic reasoning, there's no more valuable tool", Bob Wachter, UCSF Chair Medicine)

CPS Bluesky

CPS Resources page great source of links to other MedEd sites (Strong Medicine, etc), Podcasts, books

Schemas/Illness Scripts

Diagnostic shema (PDF's, images, and video explanations of the schemas)

Illness scripts

Tweetorials (threads on particular topics) (on CPS website -you don't have to go twitter!)

Virtual Morning Report

Virtual Morning Report (zoom Resident Reports)

Podcasts (highly recommended you **sign up for the mailing list** so that you get show notes mailed weekly)

Clinical reasoning sessions

Clinical content (as well as reasoning, tips for being a resident, etc)

EHC Residency curriculum **highly recommended**

orientation documents and noon conferences and links to good stuff from all over.

Sinai IM (click on annotated **Guide to Sinai IM** to see what's there)

drive with lectures and conferences developed for Mount Sinai IM residents

Clinical Correlations (NYU online Journal of Medicine)

CORE IM (website, podcast, show notes) (**probably best IM resource**; links to **podcasts**, **show notes**)

highly recommend that you **sign up for the mailing list** so you get show-notes in your email weekly

podcasts are grouped into **Series** (*5 Pearls*, Grey Matters, *At the Bedside*, *Mind the Gap*, *Hoofbeats*)

and **Topics** (Card, Pulm, GI, Nephro, ID, Rheum, HemOnc, Endo, MedEd, ClinReasoning, etc)

besides the podcasts, look under the ***Bytes*** menu for sections on EKG's, Radiology, and more

they're all really good, but for some examples check out the following episodes

Card

Troponins -5 Pearls
Mind the Gap on ACS and TIMI score
5 Pearls on Stress Testing
HFpEF -5 Pearls
HFrEF GDMT, HFrEF -5 Pearls on GDMT (part 1), HFrEF -5 Pearls on GDMT (part 1),
Afib Rhythm Control -5 Pearls, Afib Grey Matters
PAD -5 Pearls

Renal

Hyponatremia -5 Pearls (the best thing on Hyponatremia I've ever seen/heard)
Nephrotic Syndrome -5 Pearls
HF Inpatient -5 Pearls

Residency

Hoofbeats: Struggles with Clinical Reasoning
SNF, SAR, NH, ALF, and Other Dispo Options
Physical Therapists

Curbsiders (website, podcast, show notes, transcripts) (also great podcast resource)

highly recommended you **sign up for the mailing list** so you get the show notes in your email weekly

some particularly recommended podcast episodes (not exclusive!)

Clinical Reasoning

Train Your Brain: Clinical Reasoning (legendary Gurpreet Dhaliwal)
Clinical Reasoning: Become an expert diagnostician (Gurpreet Dhaliwal)
Kashlak Morning Report with Human Dx (Human Dx is a great clinical reasoning project)

Esp recommended podcast episodes (not exclusive!)

Card

HFpEF Update (Clyde Yancy)
Acute HF (Kittleson)
Heart Disease in Women (Bairey Merz)
HTN Are you Treating Adequately (SPRINT)
HTN Severe HTN and HTN Urgency
HTN Secondary HTN (HyperAldo, Cushing's, Pheo)
Valvular Heart Disease, AC, TAVR

Renal

Hyponatremia (Joel Topf)
Hypernatremia (Joel Topf)

Hyperkalemia (Joel Topf)
Acid base (Joel Topf)
RTA (Joel Topf)
Diuretics, Leg cramps, and resistant hypertension
Nephrotic syndrome vs Glomerulonephritis (Topf)
Dialysis for the Internist (Topf)

ID

ID Pearls (Paul Sax)
Rash An approach

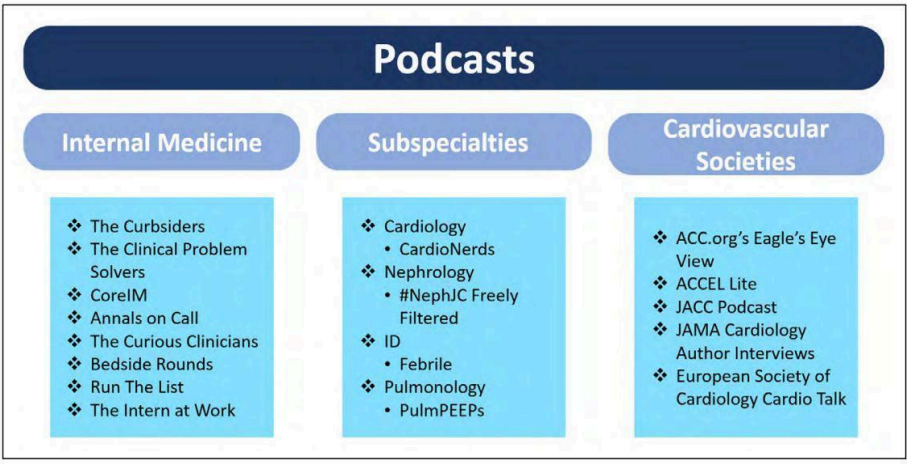
Residency

Surviving Intern Year (becoming a PGY1)
Becoming a PGY3: Not Just a Repeat of PGY2
PGY3 and Beyond with Alia Chisty MD
Reading Medical Literature like a Journal editor

Medical twitter was a fantastic resource, RIP. Bluesky is the place to go now.
Notable people to follow (excellent tweetorials and interesting discussions of the literature among smart people)

Hospitalist/General Medicine Tony Breu source of amazing "tweetorials" (threads on a topic asking "why?")
Hospitalist Andrew Sanchez
Hepatology Elliot Tapper
Nephrology Joel Topf also has a good blog site Precious Bodily Fluids, podcasts including Freely FIltered
Pulmonary/CritCare Josh Farkas (**also well-known for the outstanding IBCC** (Internet Book of Crit Care)
Pulmonary/Crit Care Nick Mark

#ICUOnePagers



Calculators
MDCalc, **Afib Stroke Risk,** **Medications/Interactions Tool**

Card
ECGpedia
ECGpedia Reference Card
ECG Maven (ECG reference, self-assessment guide, Harvard BID)

General Medicine
MGH Quickstart Guide
(34 pages) that MGH prepared for non-IM rotators on Medicine during COVID; worth a look for IM rotators too!
MGH White Book (253 pages; the full-on MGH IM handbook)
Vanderbilt Medicine online handbook **(use the menu in the right upper corner)**

Pall Care
Pall Care Fast Facts (Pall Care Network of Wisconsin) **indispensable quick reference for Pall Care**
how to's for Sx control and for communication skills (breaking bad news, advanced directives, etc),

Pulm/Crit Care
EM-Crit Project well-referenced, readable set of blogs on Critical Care
includes the excellent **PulmCrit** and **outstanding** **IBCC** (Internet Book of Critical Care) (IBCC Podcast if you prefer)
Sinai MICU links from Sinai IM (MICU guide, articles, tools)

Liver
LiverTox (NIH database) definitive database on dx, cause, frequency, pattern of injury, and management of drug-induced liver injury (**DILI**)

Renal
Neph JC is a great meet-up for **podcasts**, journal installments, etc
American Journal Kidney Disease blog which includes the amazing **NephMadness** annual med-ed projects
Joel Topf is the go-to place for Nephrology and the web

- **His website (Precious Bodily Fluids) which I'm sure is an amazing resource (lectures, slide shows, handouts for his students/fellows) but links are inaccessible at the hospital!**
- **Channel your Enthusiasm, the Bud Rose Book Club and Cocktail Hour, (a Renal Physiology Podcast) (recaps Burton Rose's master work on Renal Physiology one chapter at a time)**
- **Here's a list**
- Links to useful podcasts for residents and students rotating on nephrology

Curbsiders podcasts links on various topics (many of them Renal with Topf)

#2: Are You Treating Hypertension Adequately? Discussing the Implications of SPRINT.
#20: Hypertensive urgency and severe hypertension
#31: Diuretics, leg cramps, and resistant hypertension with The Salt Whisperer
or: Diuretics, leg cramps, and resistant hypertension (Reboot)
#39: Secondary hypertension, hyperaldosteronism, Cushing's, and pheochromocytoma
#48: Hyponatremia Deconstructed
Or: REBOOT #48 Hyponatremia Deconstructed
#61: Vasculitis and Giant-Cell Arteritis: 'Rheum' for improvement
#65: Scott Weingart of EMCrit on Emergency versus Internal Medicine: The Devil of the Gaps
#67: Chronic Kidney Disease Pearls with @kidney_boy, Joel Topf
#69: CKD Prescribing Do's and Don'ts with @kidney_boy, Joel Topf
#77: Hypertension Guidelines Showdown
#87: Toxicology 101: Talking Tox with The Dantastic Mr. Tox & Howard
#88: Acid base, boy bands, and grandfather clocks with Joel Topf MD
#104: Renal tubular acidosis with Kidney Boy, Joel Topf MD
#108: Point-of-care Ultrasound for the Internist
or: Reboot #108 POCUS: Point-of-care Ultrasound for the Internist
#137 Hyperkalemia Master Class with Joel Topf MD
or: REBOOT: Hyperkalemia Master Class with Joel Topf MD – #137
#143 NephMadness: Fluid Wars
#144 NephMadness: Inpatient Hypertension
#145 NephMadness: Hepatorenal Syndrome vs AKI
#146 NephMadness: Pain Meds in Chronic Kidney Disease
#150 HFpEF Update with Dr Clyde Yancy MD
#170 Hypernatremia is Easy with Joel Topf MD
#192 Dialysis for the Internist with Joel Topf MD
#199 NephMadness: Hyperkalemia, Diet, K+ Binders, Exercise
#204 NephMadness 2020: SGLT2 Inhibitors
#210 Kidney Transplant for the Internist
#226 Kidney Boy on Acute Kidney Injury: Myths & Musings
#230 Kittleson Rules Acute Heart Failure
#250 Nephritic/Nephrotic

Other podcast episodes which you may enjoy while on your nephrology rotation:

Hyponatremia w/ Kidney Boy:
Right heart failure w/ Sara Crager:
Central Line pro tips:

EPIC Tip Sheet

While on inpatient rotations, make sure you're logged in under the **EL V-General Medicine** context to ensure that your screen layout matches up with these directions.

Patient Lists

Finding your team list:

- Select the **Elmhurst** folder from the lower left hand corner section titled **Available Lists**
- Scroll to select the bottom folder, **Elmhurst Teams – Primary**
- Click and drag your team to the upper half of the sidebar under **My Patients**

Overnight Hotspot List:

- Select the **Elmhurst** folder from **Available Lists**
- Select **Elmhurst Teams – Ancillary Consults**
- Click and drag the **EL Overnight Hotspot Team** list to your patient lists.

Printing Lists

- You can adjust column sizes to preference so that the print layout matches what you find visually easy to keep track of
- To print lists, select the arrow next to **Print** in the upper right hand corner **Current List** to print your list of patients
    - **Handoff** will include all parts of your written handoff – helpful if your night team wants a hard copy of the handoff to reference
- Select **Add a blank column for note taking** so you have a place to keep track of your tasks for the day
- Select **Custom** so you can unselect whatever columns you don't need to print so that you can maximize space on the hard copy of the list – you should definitely keep patient Name, Room/Bed, and MRN at the very least.

You should also create a list of patients you'd like to keep track of. These can be patients whose results you want to follow, interesting labs/imaging findings, or whatever sparks your fancy! Think of it as longitudinal learning from your patients. This is also a great way to keep track of possible case reports or case series to publish or present at conferences.

Navigating Patient Charts – Useful Tabs & Tricks

Summary

- A window with a row of report tabs along the top. You can customize these by clicking on the wrench icon on the right top of the screen.
- Useful tabs:
    - FS: comprehensive flowsheet with VS, I/O, all drips/rates
    - Event Log: timeline of events so you can see in chronological order everything that's happened for the patient
    - Glucose: patient's glucose trend as well as the amount of insulin given. Also includes PO diabetes meds.

    - COVID: Like the FS tab, but includes labs/inflammatory markers
    - Med Hx: what time meds were given and if patients refused meds
- Everyone has different tabs they like best – you'll find out what works best for you with time.

Chart Review

- A comprehensive review of the entire patient chart. Unlike the Notes tab, which selects a sampling of notes from this hospitalization, this tab has it all.
- Encounters: any previous hospitalizations or upcoming appointments
- Media: any pictures of wounds, ambulance runsheets will be here
- Labs: all labs – lets you see if they're in process, cancelled, or if they still need to be drawn
- Cardiology: all EKG and echo reports here
- Imaging: all imaging, past and any pending imaging that's been ordered but hasn't been done yet
- Microbiology: all micro results.

Results Review

- Allows you to view all lab results over time, spreadsheet style
- Can also graph results for selected labs (e.g., Cr for someone with CKD)

Notes

- Review some of the notes from this current admission and write new notes! You'll be in this tab a lot.
- You can also see incomplete notes, so if you're stalking consultant recs, it's possible to see their pended notes here.

Manage Orders

- You'll also be in this tab a lot – it's where you can review all active orders and enter new ones.

Useful Dot Phrases

- You should already have all of the note templates saved from the "Notes" section of this guide. If not, go do that now!
- **.ASCVD** – calculates ASCVD risk score
- **.MELDpeId** – calculates MELD score
- **.LastA1c** – pulls up the most recent A1c
- **.VSRange** – 24h ranges for vitals
- **.LabTrend** – usual daily labs
- **.LabCard** – troponins and proBNP
- **.afut** – pulls up all future appointments – very helpful for discharges

Explore a bit! Starting with **.Last** or **.LL** can lead to a lot of the prior lab results and perhaps save you some time in your chart review

List of Common Abbreviations

This list includes both standard and non-standard abbreviations that you will see in charts. It is by no means comprehensive.

2/2: Secondary to
A&Ox3: alert and oriented to self, time, place
AAO: alert and oriented
ABG: arterial blood gas
AC: before meals
AKA: above knee amputation
AMA: against medical advice
AS: aortic stenosis
AUD: alcohol use disorder
B/L: bilateral
BG: blood glucose
BIBA: brought in by ambulance
BIBEMS: Brought in by Emergency Medical Service
BID: twice a day
BKA: below knee amputation
BS: breath sounds
Bx: biopsy
c/f: concerning for
C/O : complains of
c/w: consistent with
CAD: coronary artery disease
CC: chief complaint
CHF: Congestive Heart Failure
CLD: clear liquid diet
CPAP: continuous positive airway pressure
CTAB: clear to auscultation bilaterally
D/C: discontinue or discharge
d/t: due to
DOE: dyspnea on exertion
Dx: diagnosis
ED: Emergency Department
EHC: Elmhurst Hospital Center
ER: Emergency Room
F/U: Follow up
Fx: fracture
GIB: GI bleeding
gtt: drip/continuous medication (think heparin drip)
H/o: history of
HC: homecare
HHA: home health aide
Hx: history
I&O: intake and output
LLE: left lower extremity
LOC: loss of consciousness
LUE: left upper extremity
MDI: multi-dose inhaler (i.e., an inhaler like Albuterol)
MN: midnight
MSBI: Mount Sinai Beth Israel
MSH: Mount Sinai Hospital
MSMW: Mount Sinai Morningside West
MVA: motor vehicle accident
NAD: no acute distress
NKDA: no known drug allergies
NOK: Next of Kin
NPO: nothing by mouth
NSR: normal sinus rhythm
NTD: Nothing to Do
NWB: non-weight bearing
OD: right eye
OOB (TC): out of bed (to chair)
OS: left eye
OSH: Outside Hospital (try to name the hospital if you know which one – it makes getting medical records easier)
OTC: over the counter
OU: both eyes
PM&R: physical medicine and rehabilitation
PMHx: past medical history
PNA: Pneumonia
POCUS: point of care ultrasound
POMA: preoperative medical assessment
ppx: prophylaxis
PRN: as needed
PT: Physical Therapy
Q6H: every 6 hours

QACC: Queens Adult Care Center
QHC: Queens Hospital Center (a sister HHC hospital)
QHS: at bedtime
QID: four times a day
RLE: right lower extremity
ROM: range of motion
RRT: Rapid response team
RT: respiratory therapy
RUE: right upper extremity
RW: Rolling walker
Rx: prescription
s/p: status post
s/sx: signs and symptoms
SAR: subacute rehab
SCD: sequential compression device (also sudden cardiac death)
SLP: speech and language pathology
SNF: skilled nursing facility
SOB: shortness of breath
SW: social worker
Sz: seizure
TBI: traumatic brain injury
TID AC: before breakfast, lunch, dinner
TID: three times a day
TTP: tender to palpation
Tx: therapy or transfer
VA: Veterans' Administration
w/u: work up
WC: wheelchair
WNL: within normal limits

Cover artwork by Dorde Jevtic, Class of 2025

Thank you to everyone who helped make this handbook possible! If you have edits, comments, suggestions, or anything you'd like to see in the next edition, please email us at ehcimr@gmail.com with the subject "Residency Handbook."

To access an online version of this guide, scan the QR code below: