The Inpatient Medicine in Psychiatry (IMIP) Rotation

KEY RESOURCES AND INFORMATION
2020-2021 academic year

Information for Interns
and students (sub-internship)

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What and Why of the IMIP Rotation for Psychiatry Interns

What Medicine do Psychiatrists really need to know and why?

1. Patients with psychiatric disease face significant health disparities. They are less likely to access preventive health, received fewer interventions, and die at younger ages.

2. As a psychiatrist, you will be an important advocate for your patients. Understanding the risk for chronic and acute medical conditions, recognizing signs of urgent medical concerns, and knowing the common complication and interactions of psychotropic medications will need to be part of your repertoire.

3. At one point, the vast majority of mental health professionals practiced almost exclusively in behavioral settings separated from medical settings. This is rapidly changing with the advent of ***collaborative and integrated*** health where mental health providers are imbedded in primary care settings or vice versa. It is important for future psychiatrists to learn about the changing mental health system and the opportunities for future collaboration with primary care.

Why a medicine in psychiatry rotation in addition to the internal medicine rotation?

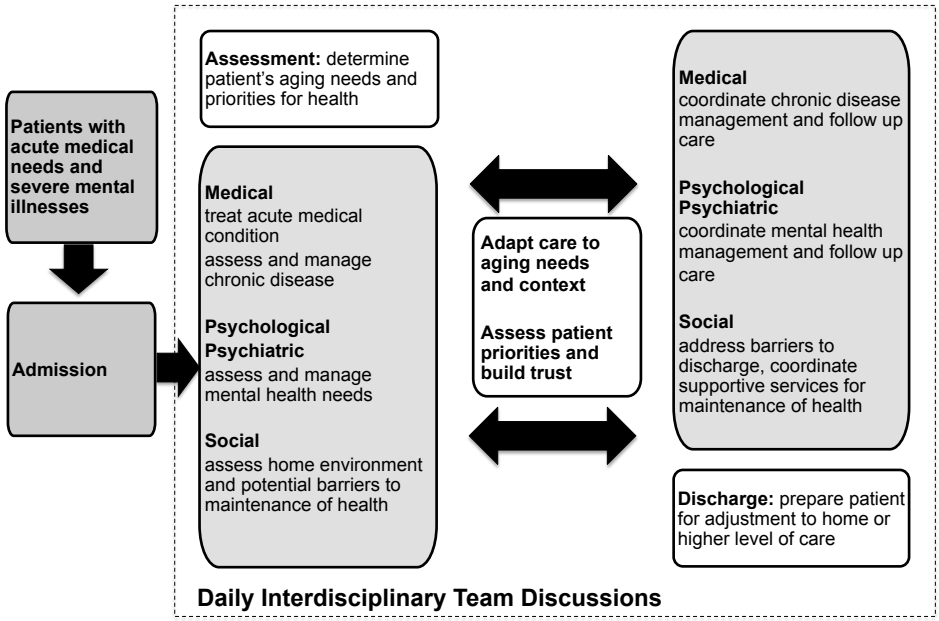
1. **MIPS takes care of the patients the Psychiatry department serves**
   Many of the patients you see on the unit are cared for in other venues served by the department of Psychiatry. Seeing these patients when they have acute medical needs will help you understand the entirety of their health needs and how the medical and psychiatric issues interact.

2. **MIPS takes an explicit team-based care approach**
   • As opposed to the internal medicine rotation, the Medicine in Psychiatry rotation takes an explicit team-based approach to care for patients with complex needs
   • **MIPS teaches residents to collaborate with nursing, social work, psychiatry, psychologists, care managers and consulting teams**

2. **MIPS makes a concerted effort to coordinate inpatient and outpatient care**, ambulatory behavioral health, strong ties and Strong recovery/chemical dependency programs to wrap services around patients

CONCEPTUAL MODEL, INPATIENT MEDICINE IN PSYCHIATRY UNIT

Figure 1: Inpatient Medicine in Psychiatry (IMIP) Unit
Person Centered Team-Based Integrated Care Model



Medicine is changing and new models of care are needed

•patients are living longer and more patients now suffer from 2 or more chronic medical conditions in addition to mental health conditions
•health cannot be isolated from context; patients who have poor access to housing, healthy foods and education are at heightened risk for morbidity and mortality
•the Medicine in Psychiatry Care Model builds on emerging advances in team-based, interdisciplinary care to provide humanistic and comprehensive care to patients with complex needs

Overview of the Medicine in Psychiatry Rotation for Psychiatry Interns (PGY-1)

What:
•an introduction to medical care of patients with underlying psychiatric needs and an introduction to integrated med-psych inpatient care

Duration:
•10 weeks total for interns (divided up differently depending on individual schedule)
•6 Saturday mornings

•2-4 weeks for subintern medical students

Setting:
•Monday-Friday on unit 19200 in Strong Behavioral Health
•**Tuesday afternoons:** residency didactics (as usual)

Overview of unit 19200:
•located on 1-9200 of the R-wing (psychiatry department) at Strong Memorial Hospital.
•created to improve comprehensive care for patients with acute medical and surgical conditions who have co-occurring psychiatric or behavioral issues.
•20 beds on the unit;
•rapid turn over for about ¼ to ½ of the patients
•other patients may stay for up to a few weeks.

Staff:
•staffed with medical/surgical trained nurses, nurse practitioners (NPs), physician assistants (PA's) and nurse technicians
•2 full time social workers.
•NPs and PAs on the unit also provide medical consultation to the inpatient psychiatry units (292, 392, 3900)

Interdisciplinary rounds:

An important and unique feature of the unit is that we take a distinctly interdisciplinary approach to patient care. We aim to consider the patient's acute medical needs ***in the context of*** their individual behavioral, psychiatric, social and functional needs. In order to systematically consider all of these aspects of patient care, we hold daily interdisciplinary rounds to coordinate patient care.

These rounds are attended by: the attending physicians and medical NPs/PAs, the unit charge nurse, unit social workers, an inpatient care coordinator and an outpatient care coordinator, occasional PharmD students, psychology interns (PhD candidates) and medical students. At times there will also be a representative from the Psychiatry Consult Liaison Service. Occasionally other providers from the following services are in attendance as well: palliative care, chaplaincy, occupational and physical therapy.

In addition we collaborate closely with the Medicine in Psychiatry Clinic which is located at:

- **Location: 2613 W. Henrietta Road (in Strong Ties Complex)**
- **Purpose:** Primary medical care services provided to adults ages 18 and up who may also be receiving mental health and/or substance abuse services within our health care system
- **Team based care**

Staff:

- Staffed with nurse practitioners (NPs), nurses (RN/LPN) and MDs
- Imbedded therapist

FACULTY AND STAFF ON IMIP

Attending Physicians/Faculty in the Medicine in Psychiatry Division: In addition to their roles as attendings on the unit, each of the faculty members are involved in other clinical, research and teaching activities in the department of Psychiatry and elsewhere. Click on the hyperlink to learn more about their work.

Dr. Telva Olivares serves as the Chief of the Medicine in Psychiatry Services in the department of Psychiatry and is double boarded in Internal Medicine and Psychiatry. MIPS includes the inpatient unit and the outpatient primary care clinic that is adjacent to Strong Ties.

Dr. Marsha Wittink is a Family Medicine physician and the medical director of the unit. She oversees the overall mission of the unit, research and quality improvement projects. She is also the chair of the National MedPsych Unit consortium.

Dr. Stella King is a Family Medicine physician with expertise in Addiction Medicine who divides her time between unit 192 and the Emergency Room (Observation Unit). Dr. King is involved in medical student community outreach programing.

Dr. Erik Bobeda is an Internal Medicine physician who works primarily on unit 192 and is interested in Quality Improvement initiatives aimed at improving our clinical services. He also enjoys teaching Psychiatry and IM residents and med students.

Dr. Conrad Gleber is an Internal Medicine physician who divides his time between the Hospital Medicine Division and unit 192. Dr. Gleber has a strong interest in Quality Improvement and practice metrics. 2020-21 is his first year with our team.

Dr. Diane Morse is an Internal Medicine physician who primarily sees patients in the Medicine in Psychiatry primary care clinic where she runs the Women's Initiative Supporting Health Transitions Clinic (WISH-TC). She also works part time on unit 192.

Dr. Kevin Brazill is double boarded in Family Medicine and Psychiatry and spends most of his time at the Medicine in Psychiatry primary care clinic but also covers weekends on unit 192. Dr. Brazill runs the post hospital discharge clinic and teaches internal medicine residents.

Nurse Practitioners/Physician Assistants:

Our Nurse Practitioners and Physician Assistants are an amazing asset to our team. They have been working with this patient population for a long time and are often very familiar with many of the patients and the common types of conditions we manage. The APPs have several additional roles: they run the MIPS consult service to the rest of the psychiatry wing, are involved in nursing education for the department and they provide overnight coverage and admissions.

They have a lot of expertise with acute management, discharge planning and orders; it will be helpful to get to know them early on in your rotation.

Our lead NP is **Lorraine Schild, NP.**
Lorraine is very involved in unit Quality Improvement Projects, APP education and department wide APP initiatives.

Other APPs include:
Cyrus Salehi, PA
Robert Newcomb, NP
Timothy Sampsom, PA
Jennifer Hawes, PA
Leslie Kaiser, NP
Scott Hall NP (mostly works afternoons)
Bill Willet PA (nocturnist)
Amy Garrison NP (nocturnist)

Social Workers

We are fortunate to have 2 excellent social workers who are a very important part of the team. **Brooklynn Ruggieri and Kathryn Strine** each have an incredible knowledge about community resources and significant expertise in figuring out placement issues. A good tip is to talk with the social workers about what is needed for any patients (e.g. medications called in to the pharmacy, scripts etc) the DAY BEFORE the patient will be discharged. In fact, this is an important part of our quality improvement initiatives to increase the number of discharges that happen before noon.

Nursing Staff and Nursing Leadership

All nurses on the unit are trained as medical nurses but also have additional expertise in behavioral aspects of patient care, many have spent time as psychiatric nurses as well.

Because of the important role nurses play on our unit, we have a dedicated nurse-resident liaison who will help with any nursing communication concerns and will reach out to you on your first days on the uit.

Each day there is an assigned “charge nurse” who oversees the other nursing staff, runs the nursing morning report at 7am and the 10:00am interdisciplinary rounds.

In addition, several nurses have other leadership duties such as overseeing particular quality improvement and regulatory projects.

We strongly encourage you to know the nurses while you are on the unit. They will have some of the most important insight into how patients are doing.

Our current Nurse Manager is **Heather Jackson, RN**. **MS**

Heather has an important role in the department's nursing care, she has a strong interest in Quality Improvement and is also the Nurse Manager for unit 292

Our Senior Assistant Nurse Manager is **Robert Balme, RN**
Assistant Nurse Managers are **Jillian Barry, RN and Nicole Fulle, RN**

Psychology Interns

We have 2-3 psychology interns (PhD candidates in their last year of their PhD completing clinical internship) rotate on the unit every year. This year we have **Caitlin Titus and Sonia Altavilla.**

Psychology interns are overseen by **Dr. Marc Swogger** who serves as their supervisor and is also available to the team on Wednesday mornings. Our Psychology team is helpful for psychological, suicide and cognitive assessments, brief counseling interventions (e.g. motivational interviewing) and they are instrumental in developing wellness (behavioral) and safety plans, talking with families about behavioral dynamics and helping clinicians with coping with a range of challenging behavioral situations.

Psychiatric liaison
We are fortunate to have a unique relationship with the Psychiatry consult team in the form of dedicated time from psychiatrist, **Dr. Aspen Ainsworth.** Dr. Ainsworth is truly part of our team, often joining us for "co-rounding" on new patient admissions, attending interdisciplinary rounds and checking in frequently with the team to determine the need for formal consults vs. supportive services. Dr. Ainsworth also oversees residents and fellows in her role on the consult liaison team.

Pharmacist
We are very fortunate to have a dedicated unit pharmacist, Dr. Liz Wojakowski. Dr. Wojakowski has a doctorate in pharmacy and brings expertise and pragmatic support for managing polypharmacy and drug-drug interactions. She is involved in several quality improvement projects for the unit and will often join one of the medical teams on rounds.

Intern Rotation Responsibilities

The Sunday before you start:

Please check your email.

You will receive an email with info about your rotation and your patient assignment for the first day.

First Day:

The first day will include a general orientation to the unit.
Interns and sub-Interns new to the service will be assigned just one patient on this first day **(see details in the daily timeline page 10)**

Daily responsibilities
Interns and Sub-Interns are expected to care for and follow up to 5 patients.

The total number of patients assigned over the ensuing week will be determined by the teaching attending; the expectation, however, would be to assume care of a total of 5 patients by the end of the week.

After the first week there is no cap for the number of new admissions/day except on Tuesdays (see below).

Weekly responsibilities

Medicine grand rounds
Interns and sub-Is are encouraged to attend grand rounds which are held on Tuesdays at noon.

Medicine noon lectures
Interns and sub-Is are encouraged to attend daily Medicine noon hour lectures held in the 3rd floor Medicine dept. **There is free lunch ** and the topics are very relevant to basic management/work up of common medical issues.

Tuesday Psychiatry didactics

Psychiatry **interns** (*does not apply to sub-interns) are expected to attend their usual didactics but only after seeing their patients and signing out to the attending.

Wednesday afternoons at 1pm in the Rivas Room. Please check the calendar on the back of the door in the APP room.

INTERN PRESENTATIONS
After the first week on service, interns and sub-Is are expected to present a case or summary of the literature on a relevant clinical or diagnostic topic. See also suggested readings page 19. There is also a form that needs to be filled out for evaluations. Attending will help with this. **Interns are expected to present a case or topic twice during their rotation.** The topic will be decided together with the attending and any other students/residents/psychology interns etc.; should ideally be related to one of the unit patients

Interns are expected to come back to the unit after didactics to check up on their patients before leaving for the day.

Progress Notes/H+Ps
Residents are expected to have their notes finished by 4:00 PM.

Weekends
Interns and Sub-Is are expected to round on their patients with an attending or fellow (we have cardiology fellows who round on our patients on some of the weekends)
-All interns are expected to come in for a **total of 6 Saturdays** across the 10-week rotation.
-When you are not coming in on a Saturday after you have been on during the week, this must be communicated to both the teaching attending and Dr. Wittink via email.
-As always, if you are not rounding on your patients on a Saturday, you need to sign out to the NP's and document thoroughly in the handoff and problem list.

DAILY TIMELINE: WHERE TO BE AND WHEN

FIRST DAY ONLY

6:45 AM: arrive on unit and go to the provider office to get sign out from the NP/PA who was on overnight.

First day you will pick up just one patient, review chart and pre-round on the patient before the attending comes in

7:45/8:00 AM: present patient to attending and examine together

8:15-10 AM: -further chart review, write note, order labs as discussed with attending

10-10:30 AM-sit down rounds as a team

after rounds (these times are somewhat flexible)

11AM- NOON: meet with RN, get tour of the unit, learn about nursing day-to-day, communication mechanisms and UPP QI projects.

Noon-2 PM:
meet with Social Workers and/or Melissa Huntzinger, RN, case manager
meet with APP to review hand offs, problem lists and discharge summaries

2PM-5 PM: meet with teaching attending:
-review rotation expectations,
-processes for feedback throughout the rotation
-presentation and documentation format and etiquette
-inpatient didactics
-logistics such as writing orders, accessing up to date, clinical practice guidelines, web paging, consults, and other sundries
-discuss which patients you will pick up the next day (2-3 patients)

AFTER THE FIRST DAY

6:45 AM:
Sign-out:
Get information about any active issues with your patients overnight (this includes checking in with the unit nurses if no notes the nursing handoff section)

pick up new patients if you have less than 5 after the 1st week.

Before the first day of the rotation you will receive your list of patients via email the night before. Thereafter, is up to you to work with the team to get assignment of any new patients to maintain the census of 5 patients.

- There is a cap of only 1 new patient on Tuesdays due to didactics

7:00 - 8:30 AM:
Pre-rounds:
Interns are expected to pre-round on all their patients, review labs, consults, and any new events overnight.

8:30-10:00 AM:
-Interns and sub-Is will round with the teaching attending and give a brief presentation about their patient, discuss events overnight, lab results and their exam findings/initial plan for the day

-Make phone calls to consulting teams, family members, primary care physicians, implement any plans discussed with attending as time allows. Follow up on labs and imaging results.

10:00 AM - 11:00 PM:
Sit-down interdisciplinary rounds
Interns and sub-Is are expected to present their patients and discuss issues particularly relevant to:

- nursing staff (e.g. does the patient need to begin sitting up and getting out of bed more?),
- psychiatry consult team (e.g. is there a question regarding medications or diagnoses, capacity or suicidal ideation?) and
- social workers (e.g. living circumstances or other disposition planning).

11:00 AM – 5:00 PM
-carry out care of patients,
-make phone calls to consulting services, family and outpatient providers
-meet with teaching attending to go over differential diagnosis and workup of new or ongoing concerns and treatment decision-making.
write notes.
-read up on conditions or do other reading that attending assigns
-pick up new admissions if not done in the morning

4:00-5:00PM:
Call teaching attending to discuss interim changes, develop a sign out plan for the evening and plan for the next day

5PM: Sign-out
Find NP who is on afternoon/evening shift
Sign out should include pending procedures (like imaging), follow up labs and what to do if they are abnormal, consult note review and order updates and any potential issues (medical or behavioral) to anticipate overnight including prns to use.

Provider Daily Checklist (copies in resident room)

Patient Name_____

- Problem list updated/marked reviewed [ ]
- Medication reconciliation completed AND marked up to date [ ]
- Labs ordered [ ] next day, [ ] weekend
- Consults called [ ]_____[ ]_____
- Differential diagnosis in chart, d/w attending [ ]
- Handoff updated daily [ ]
- Sign out on Tuesday, Thursday and Friday afternoon to covering APP [ ] MD [ ]
- Calls: PCP [ ] psych [ ] family [ ]
- D/C instructions started [ ]
- D/C summary started [ ]
- Scripts sent to pharmacy for discharge [ ] _____
- OP follow up appointments to: _____
- H& P for R-wing if applicable [ ]
- Above Reviewed w/ Dr._____

Important 19200 numbers

Floor Secretary 276-3700

Nurse Manager	
Heather Jackson	276-3705
Assistant Nurse Managers	
Jillian Barry	276-3706
Robert Balme	276-3706
Social Workers	
Brooklynn Ruggieri MSW	276-3708
Kathryn Strine MSW	276-3707
Care Coordinator	
Melissa Huntzinger	276-7761
MIPS primary care	
Clinic Care Coordinator	
Jalisa McCullough	279-4995, cell 623-9169
Nurse Practioners	
NP Back room	273-2549 273-2551 276-6658 276-5463
Resident Room	273-3643 273-3642
Dr. Wittink's office	273-3243
Dr. Wittink's cell	215-353-1735
ISD computer help desk	275-3200

LEARNING OBJECTIVES FOR THE ROTATION:

Medical Knowledge
A fundamental knowledge base regarding the diagnosis and treatment of common medical conditions encountered in psychiatric populations.

Sound fundamental skills in history taking, physical and medical examinations, basic ECG interpretation, and laboratory and study interpretation as evidenced by abilities to distinguish abnormal findings and plan appropriate next steps in evaluation and treatment algorithms.

The capacity to manage the care of a caseload of medical inpatients with supervision from attending physicians.

The capacity to recognize and integrate the patient's psychiatric/psychological, social and medical context into care planning; i particular, discharge and follow up planning.

The capacity to independently arrive at a working diagnosis, differential diagnosis and articulate a plan for evaluation and treatment for both medi and, if relevant, psychiatric conditions.

The capacity to independently initiate urgent and emergent medical evaluations, and make proper triage decisions about when attending or specialty consultation assistance is needed.

The capacity to formulate the questions for a consultation in a way that will help the primary team work with the patient and family (when appropr make shared decisions about treatment.

The capacity to initiate and monitor basic care for primary medical conditi with recommendations of consultants and/or supervisors.

Develop procedural skills such a blood draws, suture removal, NG tube insertion and ECG monitoring.

Patient Care

Interpret ECG, radiology, laboratory and study findings, and incorporate th findings into an overall treatment plan.

Utilize history, physical examination findings, and pertinent collateral data to formulate a working diagnosis and effective treatment plan.

Present a comprehensive oral presentation of clinical history, physical examination findings, assessment, and initial treatment plan.

Initiate care of medical conditions with supervision of faculty supervisors.

IMIP SURVIVAL GUIDE
developed by and for interns

This "survival guide" was written by previous interns to help you get the most out of your time here. Feel free to update as you see fit and pass along to the next intern.

Unit 19200 is a place to hone your independent learning skills, to apply your developing medical knowledge and to see first hand how medical, social, behavioral and psychiatric aspects of health are interconnected in ways that affect patients' quality of life.

The patients who come to this unit often have complex needs and can at times challenge you in ways you least expect. *It can be an exhausting and all encompassing rotation but it can also be extremely rewarding!! We are lucky to have a unit like this as part of our training. Most residencies don't have this.*

SURVIVAL KIT:
Stethoscope
A penlight
Reflex hammer
Pen/ paper pad, clipboard or moleskin type notebook or iPad
Your provider check list
Your brain
Food and water ☺

PAGERS:
Always have your pager on you.
Answer your page as soon as you can
If you don't have your pager on you for some reason, tell each nurse that you work with, tell your attending and the NPs.
Tip* keep door to your room open so nurses can come find you instead of paging

MEDICINE FLOOR WORK:

Sign-out (6:45-7:00AM in the NP work room)

*HELPFUL HINT **about signout** You will pick up your sign out from the nocturnist NP intern. Keep in mind the nocturnist is tired, wants to go home and may not have much to say about your patients so **always** ask if there were any issues that came up!*

On the Sunday evening before the first day of your rotation you will receive your list of patients to pick up from the teaching attending.

After the first day, it is your responsibility to talk with the teaching attending about which patients to pick up when your census goes below 5. You can pick up new admissions in the afternoon, on Saturdays or the next morning if discharges happen late in the day.

*HELPFUL HINT **about starting rotation**: call the intern on the 19200 rotation right before you and set up a time to "pick their brain" about what you need to know, also you will pick up any of their remaining patients so you should get an intern-to-intern sign out before you start.*

Pre-rounds (7:00 AM to 8:00 AM)
- The following need to be done before attending rounds at 8 am:
A. Trend all patient's vitals on the computer (keep a note of ALL abnormal vitals)

B. Check new consultant notes or event notes and labs):

C. Note ALL abnormal labs

D. Renew all orders for medications and restraints (marked in red). Make sure you understand what and why we are giving medications to each patient. ASK IF YOU DON'T KNOW!!

Be aware to stop or start medications in AM if needed (Ex: pt now hypotensive so stop the nifedipine)

E. See and perform PERTINENT *brief* physical exam on every patient.

F. Identify and prioritize any unstable/sick looking patients and notify attending immediately.

G. Always ask patients about PO intake, constipation/diarrhea, pain, SOB, cough, walking ability, or other complaints. Patient complaints are important.

H. Assess readiness to discharge (d/c) every morning, ask pt what prescription refills they may need other than the ones you want to give them if plan to d/c. This is also a good time to get consents for tests planned in the day (more on consents to follow).

*HELPFUL HINT **about notes**- If you have time before attending rounds, open your daily progress notes on patients after you see them (save as incompleted)This will help going home on time and help you remember anything that came up on your pre-rounds.*

*HELPFUL HINT **about the NP/PAs**: The NP/PAs have a great wealth of knowledge and are available to help with your questions but also be respectful of their space and time. Your relationship with them can make or break the rotation so get to know them and respect their expertise.*

*HELPFUL HINT **about resident room** needed break from the business of the unit, a place to make phone calls and eat lunch. It's also where the nurses can find you when they need you. But don't hide back there all day- so much to learn from hanging out with the patients and nurses!*

HOW TO PRESENT YOUR PATIENTS ON ROUNDS

Attending rounds (8:00 AM- 10:00 AM)
Interns, Sub-Is, Med-students meet with the attending to do walk rounds – check with the attending on that week how and when they like to round since they are also seeing other patients.

Dr. Steffers will go over this in your first week

Remember to always start with history and HPI, paying attention to medical, social and psych context, then move to overview of hospital course and pertinent issues of the day before discussing plan.

Example:

Mrs. Smith is a 56 year old woman with a PMH significant for HTN, CAD and DM in the context of schizophrenia and delusional disorders who was recently hospitalized for psychiatric decompensation and is now homeless. She presented to the ED 2 days ago with Chest Pain associated with Shortness of Breath that has now resolved but has a new complaint of HA. Her pressures remain poorly controlled ranging 160-190's systolic despite being on 3 antihypertensives. Her vitals otherwise are wnl: state BP 120/80, HR 60 afebrile On my exam this morning she continued to complain of a headache, I noted a 2/6 SEM, otherwise exam was wnl, state… note any changes to meds.

HOW TO PRESENT

Multidisciplinary Rounds (10-10:30ish)
Meeting in Bartlett room with the charge nurse, social workers, NPs, Psych C/L triage NP, and others to briefly discuss any pertinent daily activity for each patient (Ex: patient being discharged today, patient going for CT with PO contrast, monitor urine output, encourage walking etc).

These presentations should be much more succinct.

Give a *brief* "2 - liner" description of the patient and any pertinent update.

Example:

Mr. Jones is a 70 year old woman presenting with hypertensive emergency. Blood pressure ranging ___, symptoms ____, and end –organ damage ____, improving/not improving with medication. Will continue/change following meds. Possible d/c tomorrow pending improvement. Needs more ambulation and assistance with meals. Barriers to discharge include lack of family community support and housing issues.

emphasis is on addressing:
daily nursing issues
discharge preparation
social work concerns

***A note about record keeping**:*
It is important to develop a system for keeping track of all your hospitalized patients. Whichever mechanism you choose should allow you to:

> *-Have instant access to each patient's relevant past history, medications and baseline labs.*
>
> *-Be aware of in-house medications and daily lab results.*
>
> *-Maintain a list of things that need to be done for each patient.*

Why is this necessary?

You will frequently be required to recount specific information (when talking with consultants, arranging for studies, reviewing lab tests, etc.) at times when you don't have access to the patient's paper chart. It is therefore critical that you maintain a portable record keeping system. Furthermore, caring for patients can get quite complicated, particularly early in your careers when everything seems confusing. This tends to get worse with time as your responsibilities (and fatigue) grow. It's quite easy to either mistake one patient for another or simply forget to follow through on a previously determined plan.

As a wise chief resident once said: "There are two types interns; those who write things down and those who forget!".

OTHER HELPFUL TIPS:

Medfools.com has intern “scutsheets” templates prepared with problems and lab templates to keep track of daily info (e.g. see below).

Some people like to keep 5x8 index cards for each patient:

Tips for generating a good Differential Diagnosis for attending rounds and progress notes/H+Ps:

To come up with a complete differential (or truthfully to do anything else complicated) I usually need a memory aid of some kind. Here are three useful approaches:

Pathology: VINDICATE

Vasculitis
Infections
Degenerative (Aging)
Iatrogenic (Procedures/Drugs)
Congenital
Allergic/Autoimmune
Trauma
Environmental (Poisons/Chemicals)

Suggested and Useful Readings:

These articles are great to use for your Wednesday presentations

Integrated care and Medicine-Psychiatry Units

Hussain, M., Seitz, D. Integrated models of care for medical inpatients with psychiatric disorders: systematic review. Psychosomatics. 2014 55(4): 315-325
http://www.sciencedirect.com/science/article/pii/S0033318213001461

Leue, C. et al. Managing Complex Patients on a Medical Psychiatry Unit. Journal of Psychosomatic Research. 2010; 68:3.
http://www.sciencedirect.com/science/article/pii/S0022399909001767

Health Disparities Facing Patients with Serious Mental Illness

Rossenbaum. L. Closing the Mortality Gap- Mental Illness and Medical Care.NEJM 2016; 375:1585-1589
https://www.nejm.org/doi/full/10.1056/NEJMms1610125

The Best Medical Care in the World
Brendan Reilly
NEJM, 2018
https://www.nejm.org/doi/full/10.1056/NEJMms1802026

The Largest Health Disparity We Don't Talk About
Dhruv Khullar
NYTimes 2018
https://www.nytimes.com/2018/05/30/upshot/mental-illness-health-disparity-longevity.html

Common presentations or conditions treated on 19200:

Reston JT, Schoelles KM. In-facility delirium prevention programs as a patient safety strategy: a systematic review. Ann Intern Med 2013; 158:375.

http://www.uptodate.com/contents/delirium-and-acute-confusional-states-prevention-treatment-and-prognosis/abstract/2

Clegg A, Young JB. Which medications to avoid in people at risk of delirium: a systematic review. Age Ageing 2011; 40:23.

http://www.uptodate.com/contents/delirium-and-acute-confusional-states-prevention-treatment-and-prognosis/abstract/3

Cyrus S. H. Ho, Melvyn W. B. Zhang. Metabolic syndrome in psychiatry: advances in understanding and management Advances in Psychiatric Treatment Mar 2014, 20 (2) 101-112

Moss AJ. Long QT Syndrome. JAMA 2003; 289:2041.

http://www.uptodate.com/contents/acquired-long-qt-syndrome/abstract/1

Barr J, Fraser GL, Puntillo K, et al. Clinical practice guidelines for the management of pain, agitation, and delirium in adult patients in the intensive care unit. Crit Care Med 2013; 41:263.

http://www.uptodate.com/contents/sedative-analgesic-medications-in-critically-ill-adults-properties-dosage-regimens-and-adverse-effects/abstract/7

Kosten TR, O'Connor PG. Management of drug and alcohol withdrawal. N Engl J Med 2003; 348:1786.

http://www.uptodate.com/contents/management-of-moderate-and-severe-alcohol-withdrawal-syndromes/abstract/1

Johnson W, Nguyen ML, Patel R. Hypertension crisis in the emergency department. Cardiol Clin 2012; 30:533.

http://www.uptodate.com/contents/evaluation-and-treatment-of-hypertensive-emergencies-in-adults/abstract/4

M.P. Frost: The Medical Care of Psychiatric Inpatients: Suggestions for Improvement. The Internet Journal of Healthcare Administration. 2007 Volume 4 Number 2.

Benjamin G. Druss, Integrated Medical Care for Patients With Serious Psychiatric Illness. A Randomized Trial Arch Gen Psychiatry. 2001;58(9):861-868

Gitlin LN, Kales HC, Lyketsos CG. Nonpharmacologic management of behavioral symptoms in dementia. JAMA 2012; 308:2020.

Rochon PA, Normand SL, Gomes T, et al. Antipsychotic therapy and short-term serious events in older adults with dementia. Arch Intern Med 2008; 168:1090.

Tardiff K. The current state of psychiatry in the treatment of violent patients. Arch Gen Psychiatry 1992; 49:493.

Practice guidelines:

http://www.aasld.org/practiceguidelines/Documents/ascitesupdate2013.pdf

http://www.guideline.gov/content.aspx?id=47570&search=chf