Last updated 6/2020

# RESIDENT ORIENTATION TO VA PULMONARY OUTPATIENT CLINIC

**Changes due to coronavirus:**

In response to the COVID pandemic, the VA Pulmonary Outpatient clinic has pivoted to fewer face to face visits and more virtual clinic visits. 1/3 of your clinics will be face to face (F2F) and 2/3 will be virtual (video, phone). Most new patients will be seen face to face and most follow up patients will be seen virtually. For F2F visits, please wear PPE and scrubs to protect yourself from getting infected with SARS-CoV-2. Specific policies related to PPE and virtual visits are still being formulated but should be in place by July 2020 when you return to clinic.

**Schedule and staff:**

- Usually new patients at 1 PM and 2 PM with f/u patients scheduled at 3 PM and 3:30 PM.
- Resident clinic will be self-contained: In addition to seeing new consults, residents will see each other's f/u patients, providing continuity.
- The second attending in clinic (2nd staff) will supervise the continuity residents while the attending on VA Pulm service (1st staff) will supervise the Pulmonary consult resident, enabling staff to review resident patients in advance and giving residents someone to go to in advance with questions. In addition, there will sometimes be a third attending available to staff all trainees.

**Clinic workflow:**

- Review consult (under **Consults** tab) in advance, evaluate important data (eg, PFTs and imaging), and plan the clinic visit.
- See the patient, perform a focused H+P, staff the patient with 2nd attending.
- Order clinic f/u, medications, tests, and additional consults using "**Non-Surgery Clinic Check Out**" under **Orders** tab. Make f/u appointments before the patient leaves clinic (ask patients to check out with schedulers in front of clinic).
- Start your note (**Pulmonary Consult**, **Pulmonary Resident-New**, or **Pulmonary Resident-Followup**) and complete the **encounter form** (attending is the primary). Link the Pulmonary Consult note to an open consult to complete the consult. **Do not leave clinic without starting a note and completing an encounter form.**

**Expectations:**

- Review consults and f/u patients in advance and identify salient issues to look up before seeing the patient.
- **Start a note and complete the encounter form before leaving clinic.**
- Notes for Tuesday clinic should be completed and signed before Friday AM, preferably earlier.
- Add Mary Clites, RN and Juanita Alpuerto as additional signers for nursing and administrative issues. However, please do not flag Juanita or Mary for routine return visits. F/U appointments should be scheduled by clinic schedulers when the patient checks out of clinic.
- Check CPRS at least twice weekly when not at the VA. Respond to CPRS alerts,

email, pages, and phone calls in a timely fashion. When you go on vacation, forward your clinic alerts to the fellow on the consult service.

- Requests to cancel clinic must be received well in advance (the VA asks 90 days, we can be slightly more flexible). Requests made on short notice are <u>not</u> automatically approved. Please contact Juanita Alpuerto and Dr. Suil Kim or Dr. Thomas Prendergast directly.

**Clinic Follow-up Guidelines:**

Access for patients is a priority for the VA and for VAPORHCS Pulmonary clinic. In order to maintain timely access and to serve more patients, we need to consider criteria for returning patients to their referring providers. These guidelines will help assist in your decision making.

Patients who **<u>likely need</u>** ongoing/longitudinal follow-up in Pulmonary clinic:

1. Rare (relatively) pulmonary diseases.
    a. Diseases that require specialized pulmonary management such as interstitial lung disease, sarcoid, hypersensitivity pneumonitis, pulmonary vasculitis (e.g. eosinophilic granulomatosis with polyangiitis, granulomatosis with polyangiitis), bronchiectasis, rare lung diseases (e.g. LAM, alpha-1 antitrypsin deficiency).
2. Difficult asthma.
    a. (e.g., on systemic steroids, anti-IgE, anti-IL-5) who are *not yet* under good control on a stable regimen; ABPA
3. Difficult COPD
    a. Frequent exacerbations, close to considering transplant or have other special needs or concomitant health issues
    b. Note that we may work with the patient's primary IM/FM/NP/PA to tag team these patients.
4. Advancing neuromuscular disease requiring assisted ventilation.
5. No PCP.
    a. All efforts should be made to get the patient a PCP.
6. Patients considered for lung transplant who will f/u at OHSU for lung transplant care
    a. Those who have an established pulmonologist elsewhere should be referred back if they will be doing the post-transplant care.
7. Neuromuscular respiratory limitation (ALS, MS, etc).
    a. Most ALS patients will be seen in CDU or in ALS clinic with Respiratory Therapy.

Patients who **<u>likely do not</u>** need f/u clinic visits beyond first consultation:

1. COPD or asthma consults that are stable and have a directed plan.
    a. Patients who are sent back to their PCP will have a clearly outlined plan, and prn follow up if they develop new/worsening symptoms (specify).
2. Nodule on imaging; If F/U imaging is the only service needed, refer to URFs pathway.
3. Acute care follow up:

   a. Some ED and hospital F/Us for acute, one-time self-limiting problems (e.g., see once after pneumonia, follow up abnormal CT that is now resolved).
4. Smoking cessation:
   a. If appropriate, these patients should be referred to the complicated smoking cessation clinic.
5. "Longitudinal" patients who have been stable for >2 years since diagnosis.

Patients who **<u>may or may not</u>** need longitudinal pulmonary clinic:

2. Patients with COPD/asthma for whom we prescribe new medication and have specific parameters we need to follow rather than PCP.
3. Patients with pulmonary nodule with no PCP:
   a. Consider f/u via imaging with URFs pathway
4. Management sometimes better in other clinic
   a. NTM disease followed by ID/Chris Pfeiffer
   b. Patients with connective tissue disease or vasculitis (lung) who may be followed by Rheumatology
   c. Patients with lung issues and sleep disordered breathing may be followed sleep clinic if sleep is the principal issue. If sleep coincides with another pulmonary condition warranting clinic follow up, sleep issues can be co-managed through pulmonary clinic.
5. New referrals for evaluation of symptoms (e.g. cough or dyspnea) that require a sequential evaluation or medication trial. Likely a self-limited evaluation.
6. We should make special efforts for patients who live far away from Portland. This may mean active co-management with PCP or local Pulmonologist, telemedicine, or short-term active engagement with the clinic RN.

<u>Guidelines for Documentation when sending patients back to referring provider or to NP</u>

1. Write a well-outlined plan for continued management of the issue in question, anticipating common issues that may arise.
2. Write out specific parameters that would warrant returning to pulmonary clinic.
3. Educate patients on above recommendations. Thank referring provider for referral and assure that we are available to discuss the patient should their condition change.
4. Make sure to add PCP as co-signer.

**Education:**

1. Post-clinic conference (4:30-5 PM): Informal discussion of interesting cases/imaging from clinic or the consult service. Dr. John Gorman, Chest Radiology, provides expert radiographic consultation at the conference.
2. ILD workgroup/conference: Multidisciplinary (Pulmonary, Radiology, Pathology) conference held on Wednesday afternoons on an ad hoc basis (usually once/month) to discuss ILD patient issues (eg, approval of advanced therapy for UIP/IPF, referral for surgical lung biopsy, referral for lung transplantation). Please contact Dr. Katie Artis if you have an ILD patient whom you'd like to present to the group.

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