UF UNIVERSITY of FLORIDA

Department of Medicine

A Culture of Caring, A Commitment to Investigation

MEMORANDUM OF UNDERSTANDING

SUBJECT:	Admission of Patients to Medicine Services	CREATED:	12/14/11
CATEGORY:	Administrative – Clinical	REVISED:	8/24/12
		EXECUTIVE COMMITTEE PRESENTATION:	N/A
		EFFECTIVE:	**9/3/12**

PURPOSE: Our common goal of safe and effective care makes the ED and DOM a continuum of service rather than separate aisles. The Hospitalist AOD now has a regular presence in the Emergency Department. The purpose of this document is to outline basic expectations and division of labor between the Emergency Medicine providers and the Hospitalist AOD. This document is to be reviewed annually or as needed.

GENERAL PRINCIPLES:

When presenting patients for possible admission, the ED practitioner shall:

- Provide patient sticker, age, room number, and PCP name.
- Give brief presentation to include chief complaint, clinical presentation, current VS, pertinent labs and data.
- Have BMP and CBC results available in order to expedite patient placement and management. The AOD will certainly agree to an exception when clinical case warrants.
- Stable IV access however this should not delay the admission process.
- Case already discussed with ED attending.
- Any consultations considered emergent, especially those impacting disposition [e.g. MICU] should be called by ED. Routine consults will be called by admitting team.
- Plan, disposition, and prelim radiology documented in ED note (at time of presentation or shortly after).
- Inform family that admitting doctor will need to talk with them and to leave contact info if they must leave the ED. Informing the patient or family about having medication lists available is especially important since triage medication lists may not be current or consistent with current medication regimen or may not have been reconciled at the time of admission.
- In the spirit of collegiality, the DOM does request the courtesy to be consulted for admissions rather than have other services "admit to Medicine". Likewise, differences in opinion between services about appropriate patient placement should be discussed and resolved directly between those services.

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AGREED GUIDELINES FOR INITIAL CARE OF ADMITTED PATIENT:

The following points are agreed upon by the Dept of EM and the Dept if IM with regard to patient care and management:

- It is agreed the following studies (see list below) should be ordered or performed on patients presenting with the identified diagnoses, consistent with usual care provided in the ED.
- Results of these studies should be *s available* prior to presentation to the AOD.,
- Given the unpredictable nature of patient volume and demand in the ED, it is understood that there will be exceptions in regards to availability of these results.
- A thorough history and physical examination should guide the medical management plan. Variations from the guidelines described herein may exist as dictated by clinical necessity, history and physical exam and laboratory and radiological data.
- In all exceptions, patient safety remains a priority and prompt bedside evaluations may become necessary in order to expedite care and to judge the appropriateness of any exceptions.

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Abdominal Pain – 3 way x-ray or CT, UA C&S, DRE/hemoccult. [ordered - LFTs, Lipase, Lactic acid]
Acute Renal Failure – UA C&S, [ordered – Renal u/s *when cause (e.g. dehydration) not readily apparent. Order bladder scan when u/s not available after midnight or on weekend]*

Altered Mental Status – Head CT, [ordered – UA], urine drug screen *when cause not apparent*.

Chest Pain – 12 lead EKG, Trop #1, CXR.

COPD Flair - CXR, EKG. [ordered – ABG]

DKA – ABG/VBG, running IVF with stable line, use of Adult ED Hyperglycemia Order Set.

GIB – INR, LFTs, hemoccult, T&S

HA & Fever with suspicion for meningitis – antibiotics and LP

Heart Failure – EKG, BNP, CXR
Hyperkalemia – EKG (if + findings, then order Nephro consult), emergent treatment rendered, repeat K+ ordered.
Liver Failure – CMP , ammonia, INR. If SBP is suspected then order appropriate antibiotics. The appropriateness of the performance of a paracentesis in the ED should be discussed with a primary focus on emergent therapeutic relief or urgent need for a diagnosis
PE – CT Angio chest or V/Q or LE Doppler, use of Heparin Order Set, full intensity DVT/PE Protocol.[for patients with contraindication to CT Angio who present on nights or weekends, access to V/Q and Doppler services are limited. This is a clinical operations issue that is currently being addressed and cannot be resolved by this MOU. Consequently, for the time being, each case will be managed based on the safest and most feasible approach for the given patient.]
Pneumonia – CXR, EKG, 2 sets blood cultures (may omit for non-SIRS CAP), appropriate antibiotics per Core Measure, viral NP swab as appropriate (if results come back after 48 hrs, then too late for Tamaflu).

Respiratory Failure – ABG, CXR, EKG, Trop, MICU consult

Sepsis/SIRS – CXR, UA, Lactate, ABG/VBG, 2 sets blood cultures; appropriate antibiotics ordered.
Syncope – EKG, on monitor, Head CT (if trauma), consider orthostatics *when cause not apparent and maneuver can be safely performed*.

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ROLE OF ADMITTING OFFICER OF THE DAY (AOD):

The Resident AOD and Hospitalist AOD will function as a team to accomplish the following tasks:

- Assist in the early identification DOM admissions and promptly facilitating the admitting process.
- Assist in the management of patients waiting for a medical bed.
- Identify medical admissions that could be discharged from ED and facilitate process.

Language of acceptance/non-acceptance for admission to communicate patient care status to the ED team:

"Aware" [aka NOT ready to assume care or admit yet]
"Accepted" [aka *YES*, we will *assume care* and *admit* the patient]
"Not accepted, please consider _____consult."

If a patient is not accepted for admission or the admitting team is not ready to assume care a clear reason must be articulated to the referring provider.
Any additional laboratory testing or diagnostic imaging studies ordered by the AOD that are deemed emergent or urgent in order to provide stabilizing care in the ED or soon after transition to an inpatient setting, should be performed in the ED. Any other selected non emergent or routine tests ordered by the AOD that are released in the ED must not delay transportation to an inpatient bed.
Active orders placed by AOD are to be released by ED nurses. AOD will directly communicate with nurses to facilitate orders.

COMMUNICATION GUIDELINES TO FACILITATE PATIENT CARE

If there are any differences in plans of care regarding patients to be admitted, the resident AOD or Hospitalist AOD will contact the ED Attending. Both departments work together as a team to facilitate safe and timely quality care for ED patients.

DISCHARGING IN THE EMERGENCY DEPARTMENT:

If after evaluation by AOD, recommendation is for discharge, then AOD will discuss with ED attending. If both are in agreement, then AOD will place consult with recommendations including secure outpatient follow-up. ED provider will discharge patient. If ED provider is not in agreement, then AOD will admit the patient and subsequently discharge.

ED TO ED TRANSFERS:

ED to ED transfers should have all basic labs repeated upon arrival. However, the results of these repeat labs should not delay the admission process

In general do not need to wait for those results to admit patient.

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MICU
See policy on **Non-invasive Mechanical Ventilation** and **ED to MICU Admissions**

Patients on Bipap/Cpap - require MICU consultation. Decision to admit to IMC is based on plan to wean off Bipap/Cpap within 8 hours and continued follow-up by MICU team.

Patients on 100% NRB - require either MICU consultation or be weaned to 50% VM before eligible for IMC admission, unless palliative care patient.

8-29-12

Robert Hromas MD, Chair — Date
Department of Medicine

8-24-12

Joseph A Tyndall, M.D., MPH Chair — Date
Department of Emergency Medicine

8/30/12

Robert Leverence M.D. — Date
Vice Chair for Clinical Affairs
Department of Medicine

8-24-12

Thomas Payton, MD., MBA — Date
Vice Chair of Clinical Operations
Department of Emergency Medicine