MOD-EMERGENCY DEPARTMENT Admission Guidelines

1. Urology patients will be admitted based on service attachment unless a Urology Attending specifically requests that a patient be admitted to Jag. Urology patients do not automatically go to JAG.
2. MCI patients will be admitted based on service attachment unless a MCI Attending specifically requests that a patient be admitted to JAG. MCI patients do not automatically go to JAG.
3. **OSH BRAIN MASS** transfers accepted by the NSICU who are determined to not require NSICU level of care are to be admitted to JAG. This only applies to OSH Transfers (FED is not an OSH). This is to expedite acceptance to a service for the transfer.
4. **OSH STROKE** transfers who are determined to not require NISCU level of care are to be admitted to JAG as first choice. If JAG is capped then they go to Medicine. If both teams are capped then, it goes as 1:1. This only applies to OSH Transfers (FED is not an OSH).
5. Patients seen by JAG Providers in the nursing home setting are Not Attached unless seen by a JAG Provider as their PCP.
6. Sickle Cell Patients, unless established with Family Practice, will be admitted to Academic Medicine in an effort to standardize care. Family Practice will continue to admit their Sickle Cell Patients.
7. There is a 72 hour bounceback rule on readmissions.
8. If a patient has not been seen outpatient by an 'Attached Service' in over 2 years, they are no longer considered 'Attached' to that service.
9. All admissions to the Department of Internal Medicine (JAG and Academics) should go through bed control when no MOD is present. Bed Control will determine which Service the patient should be admitted to.

Guidelines for when MOD is present:

1. Requests for admission to the Department of Internal Medicine (Jag ie Private Hospitalist group, Medicine ie Academic Hospitalist group) will go through the MOD when present.
2. Any service line requesting admission to Internal Medicine are to contact the MOD at that time to present their case. Exceptions to this rule will be made for established relationships.
3. Patients should not go to surgery without orders, and then after surgery be admitted to Medicine without discussing with the MOD. Once a patient is taken to the OR, they are considered as established with a surgical service until the MOD agrees to accept to Medicine.
4. Surgical patients will not be considered for admission to Internal Medicine for "optimization for surgery" or because there is "no surgical intervention planned at this time" unless there are significant medical comorbidities present ie;

    a. 3 or more chronic medical conditions requiring **active** inpatient management **beyond resumption of home medications or PRNs.**

    b. Any acute medical condition or chronic condition with acute exacerbation that would otherwise **warrant hospitalization and admission** to an Internal Medicine service.

NOTE: Ortho patients with osteomyelitis will be admitted to Internal Medicine as primary if Ortho requests such admission.

NOTE: CVT patients will be admitted to Internal Medicine if CVT requests such admission.

NOTE: Anyone presenting in the ED with a traumatic mechanism of injury (fall, MVC, GSW) is considered a trauma until the trauma team evaluates them. Even mechanical falls w/ fractures should be evaluated by Trauma Team as they may want to accept the patient. Even if Ortho has already evaluated, Trauma should be notified of the patient to evaluate. This is per Drs. Polite and Simmons. Trauma has the right of first refusal for these cases.

NOTE: These are Guidelines. Clinical Judgement should always come first. Certain disease processes are best taken care of by a Medical Team including decompensated cirrhosis and pulmonary arterial hypertension.

5. Any disagreement involving the MOD and any resident/fellow/midlevel requires discussion between the MOD and the Attending on the respective service.
6. Any disagreement between the MOD and another Attending will be escalated to Drs. Seaman/Polite for medical/surgical services or Dr. Travers for Utilization Review/CM.
7. FED transfers not felt to meet admission criteria will be transferred from ER to ER for evaluation by the MOD. This will not be considered as an Accept to Internal Medicine. If, after in person evaluation, the MOD feels that the patient could be safely transitioned to the outpatient setting, they will discuss the patient with the UH ED attending and write a note in the patient chart. Discharges will be handled by the ED.
8. FED transfers not felt to be candidates for the Medicine services will be transferred from ER to ER for surgical consultation consistent with current practice in the DEM between the USA FED and UH ED.
12. Attached patients to JAG, Academic Medicine, or Family Practice will go to their respective services.
14. If a safe disposition plan cannot be agreed upon by the MOD and ED Attending, the patient will be admitted to the hospital. In these instances, those involved are encouraged to complete an "Admission/Consult Concern Report" for quality review, tracking, and provider feedback.

MOD Guidelines for Neurology

1. All 'Low-Risk Stroke Protocol' patients should be discussed with the MOD when present.

After Hours Guidelines

1. When a Service recommends admission to the Department of Internal Medicine (DIM), they are to notify the ED of this recommendation. At that time, the ED will contact bed control who will determine who is up next for admission.
2. Any disagreement regarding appropriate disposition of a patient will be escalated to the appropriate attending on call for the particular Medicine Service in question (Jag or Academics), who will be acting as MOD for that Medicine Service. Any disagreement between the acting MOD and resident/fellow/midlevel of another service line will be escalated to a conversation between the acting MOD and Attending on call for the service in question.
3. All other guidelines apply as when the MOD is on duty.

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