COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

HARBOR-UCLA MEDICAL CENTER

SUBJECT: ADMISSION MEDICAL SERVICE AND TRANSFER GUIDELINES POLICY NO. 370

PURPOSE:
To define the guidelines by which patients are admitted to specific inpatient clinical services and, when needed, transferred between inpatient clinical services.

POLICY:
Harbor-UCLA medical staff will follow the guidelines below to determine to which inpatient clinical service a patient should be admitted, and how to transfer a patient between inpatient clinical services. The guidelines below apply to patients who are DHS-eligible (e.g., not-empaneled to non-DHS healthcare systems) or who are too unstable to transfer, cannot be transferred, or are approved for admission within DHS by the healthcare system to which they are empaneled. Decisions regarding DHS eligibility, and regarding the location of care for patients who may safely be cared for in the Observation Unit (OBS) or an Internal Medicine/Family Medicine inpatient, will be made by personnel from Utilization Review with consultation from the Medical Director of Utilization Review or Medical Administration as needed.

PROCEDURE:

A. Expectations for Inpatient Clinical Services

All clinical services that admit patients to Harbor-UCLA Medical Center and provide ongoing inpatient care will be expected to do the following:

I. Provide high quality of care
   a. Focus on the True North goal of "Patient First" and ensure patient safety.
   b. Provide high quality care based on established national/DHS guidelines for specific disease processes whenever possible.
   c. Work to prevent inpatient complications (e.g., VTE prophylaxis, adequate nutrition, prevention of CLABSIs, CAUTIs, surgical site infections, and perform hand hygiene).
   d. Coordinate multidisciplinary care with other services (e.g., Nursing, Social Work, Utilization Review, Physical Therapy, Nutrition) as needed.
   e. Address critical results (e.g., laboratory, radiology, EKG) in a timely manner.

EFFECTIVE DATE: 4/1984 **SUPERSEDES:**
REVISED: 9/89, 6/92, 10/95, 7/96, 5/98, 12/98, 12/02, 2/03, 1/05, 5/06, 12/08, 9/09, 2/12, 5/15, 4/18, 12/19, 2/20, 5/20
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REVIEWED COMMITTEE: Professional Staff Association Review Committee

APPROVED BY:

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Chief Executive Officer

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Chief Nursing Officer

f. Use the medical chain-of-command (e.g., more senior resident physician, attending physician, department chair, and Chief Medical Officer) as necessary to escalate significant issues affecting patient care in a timely manner, consistent with the urgency of the patient's condition.
g. Ensure communication and shared decision-making with patients and families.
h. Participate in peer-review and other quality improvement processes for patient care to improve subsequent care.

II. Provide attending-level accountability and supervision of housestaff
a. Confirm adherence to care quality standards described above (in A.I.) at all times.
b. Provide oversight of resident activities in managing patients on service in accordance with Policy 622A.
c. Ensure appropriate and timely documentation in the medical record (e.g., H&Ps, operative notes, medication reconciliation) in accordance with Policy 615.
d. Ensure compliance with other DHS/Harbor-UCLA Policies and Procedures (e.g., report critical events, conduct TJC universal protocol for procedural time-outs).
e. Create and adhere to mandatory "attending call lists" which establish the criteria for which the attending physician must be notified by housestaff.
f. Work to improve compliance with patient care metrics established by regulatory agencies (e.g., Joint Commission, CMS, PRIME, QIP).

III. Maintain availability (by the attending physician covering the service) to respond to patient care issues when needed.
a. Assist with patient flow (downgrades and discharges to be discussed daily prior to 10AM).
b. Address patient/family complaints.

B. Admission Service Guidelines

Patients who require inpatient admission will be admitted to services according to the general guidelines below:

I. Except as listed below and low risk OB patients presenting to OB triage, adult patients with primary medical diagnoses will be admitted to Internal Medicine, Family Medicine or Neurology. The Obstetrics and Gynecology service will be consulted for any pregnant patient who requires hospital admission and, unless the patient has a medical or surgical condition that requires or is likely to require active management beyond the scope of practice of the Obstetrics and Gynecology service, the patient will be admitted to the Obstetrics and Gynecology service. The decision regarding the admission of pregnant patients to services other than Obstetrics and Gynecology will be made collaboratively between the Emergency Department and Obstetrics and Gynecology attending physicians and, in cases of disagreement, the final decision made by the Obstetrics and Gynecology attending physician. For low risk OB patients that are managed by a Family Medicine attending with OB privileges, OB consult is not needed unless the patient falls outside the scope of practice of the FM attending, to be determined by FM attending in discussion with OB attending as needed.

II. Adult patients with primary surgical diagnoses will be admitted to one of the Surgical Specialties (Surgery or Orthopedic Surgery). The decision regarding whether a primary diagnosis requiring admission is medical or surgical will be made by the Emergency Department (ED) attending physician. Guidelines for select specific diagnoses include:

a. **Aortic Aneurysms and Dissections**
   i. Thoracic Aorta
      1. Patients with traumatic aortic injuries will be admitted to Trauma/Acute Care Surgery.
         a. Patients with non-traumatic thoracic acute aortic dissections (Type A or B) will be admitted to Trauma/Acute Care Surgery (with planned transfer to Cardiothoracic Surgery or Vascular Surgery). If Cardiothoracic Surgery is immediately available to evaluate and admit the patient, the patient may be directly admitted to that service (versus admission to Trauma/Acute Care Surgery with planned transfer to specialty surgical service).
   ii. Abdominal Aorta
      1. Aortic aneurysm
         a. Patients with expanding (defined as either presenting with symptoms consistent with expansion, or with documented expansion by imaging) or ruptured abdominal aortic aneurysms will be admitted to Trauma/Acute Care Surgery (with subsequent transfer to Vascular Surgery).
         b. If Vascular Surgery is immediately available to evaluate and admit the patient, the patient may be directly admitted to that service (versus admission to Trauma/Acute Care Surgery with planned transfer to specialty surgical service).
         c. Patients with stable aortic aneurysms requiring hospital admission for other reasons should be admitted to the service warranted based on reason for admission.
         d. Patients with Complicating Medical Conditions (see below) will be admitted to the surgical services as listed above; the presence of a Complicating Medical Condition does not alter the admitting service for a patient admitted for an aortic aneurysm.
      2. Aortic dissection:
         a. Patients with acute aortic dissections requiring admission will be admitted to Trauma/Acute Care Surgery (with subsequent transfer to Vascular Surgery).
         b. If Cardiothoracic or Vascular Surgery are immediately available to evaluate and admit the patient, the patient may be directly admitted to that service (versus admission to Trauma/Acute Care Surgery with planned transfer to specialty surgical service).
         c. Patients with stable (chronic) aortic dissections requiring hospital admission for other reasons should be admitted to the service warranted based on reason for admission.
         d. Patients with Complicating Medical Conditions (see below) will be admitted to the surgical services as listed above; the presence of a Complicating Medical Condition does not alter the admitting service for a patient admitted for an acute aortic dissection.

b. **Arteriovenous (AV) Dialysis Access Issues**
   i. Arteriovenous fistulas or grafts that warrant immediate intervention in the operating room (e.g., uncontrolled bleeding) should be admitted to Trauma/Acute Care Surgery (with planned transfer to Vascular Surgery).
   ii. AV Fistula/grafts that *do not* need immediate operative intervention but require additional inpatient evaluation beyond an Interventional Radiology (IR) procedure should be admitted to Internal Medicine/Family Medicine (with inpatient Vascular Surgery and Nephrology consultations).

iii. Patients requiring an Interventional Radiology (IR) procedure
   1. Sunday through Thursday: Will be placed in OBS.
   2. Friday & Saturday: Will be admitted to Internal Medicine/Family Medicine (as IR is not routinely available on the weekends).

iv. Patients within 30 days post-op for their AV access should always have a surgical consultation by the Trauma/Acute Care Surgery service in the ED.

c. Brain Death

i. Patients who have had brain death determined in the Emergency Department or who are expected to have brain death determined after admission should be admitted to the service that would normally have cared for their primary illness or injury (see below). Patients will not be held in the Emergency Department for determination of brain death.
   1. Trauma/Acute Care Surgery: Trauma or surgical patient.
   2. Neurosurgery: Patient with intracranial hemorrhage as the primary cause of brain death.
   3. Internal Medicine/Family Medicine: Patient with medical diagnoses as etiology of brain death, including cardiac illness.
   4. Pediatrics/Pediatric ICU: All pediatric patients.
   5. Neurology: Isolated ischemic stroke not related to a traumatic injury.

ii. In all instances, the admitting service should notify the appropriate organ procurement organization as outlined in hospital policy #316A.

d. Burns

i. Burns meeting American Burn Association burn center referral criteria will be transferred to a hospital with a burn unit. No patient should be transferred to a burn center without evaluation by the Trauma/Acute Care Surgery service. In the event the patient cannot be transferred (e.g., no capacity, too unstable), the patient will be admitted by the Trauma/Acute Care Surgery service.

ii. Trauma patients with multiple injuries including minor burns, who require hospitalization, will be admitted to Trauma/Acute Care Surgery.

iii. LAC-USC cannot refuse a transfer due to lack of bed availability.

e. Cellulitis, Soft Tissue Abscess, and Necrotizing Soft Tissue Infections (excluding infected decubitus ulcers and diabetic foot infections [see below])

i. General guidance:
   1. Patients with cellulitis or abscesses requiring admission (e.g., estimated to require greater than two midnights of hospital-based treatment) should be admitted to Internal Medicine/Family Medicine, except as detailed below.
   2. Patients with cellulitis or abscesses requiring hospital-based care but not admission (e.g., requiring intravenous antibiotics but not estimated to require greater than two midnights of treatment) should be placed on OBS except as detailed below.

ii. Maxillofacial cellulitis or abscesses:
   1. Ophthalmology for infections involving the orbit or periorbital space.
   2. OMFS for odontogenic infections or abscesses. All facial infections that are thought to be secondary to a dental etiology will be admitted to OMFS unless there is facial and/or neck extension or risk of rapid loss of the airway, in which case, the patient will be admitted to Head & Neck Surgery.

3. Head & Neck Surgery for sinus infections, dental infection with facial and/or neck extension or risk of rapid loss of airway, and deep-space neck infections,
4. Face call (ENT, OMFS, Plastic Surgery) for all other maxillofacial infections requiring acute hospitalization.

iii. Upper extremity cellulitis (from the hand to the antecubital fossa) or deep space hand infections (such as flexor tenosynovitis) should be admitted to Hand Call (Plastic Surgery or Orthopedic Surgery). If the cellulitis is primarily located in the area distal to the antecubital fossa, but extends proximally beyond the antecubital fossa, but is limited to the upper arm, this guideline still applies. For patients with upper extremity infections and other complicating medical conditions, please see the guidelines for Complicating Medical Conditions above.

iv. Patients with a soft-tissue abscess (not involving the face, mouth, neck, or distal arms) requiring surgical drainage should be admitted to Trauma/Acute Care Surgery. If a soft tissue abscess, not involving the face, mouth, neck or distal arms, is drained in the ED and requires admission for surrounding cellulitis, the patient will be admitted to Trauma/Acute Care Surgery.

v. Patients with spinal epidural abscesses will be admitted to the service on Spine Call (Orthopedic Surgery or Neurosurgery).

vi. Patients with suspected or confirmed necrotizing soft tissue infection (including fasciitis) will be admitted to Trauma/Acute Care Surgery.

f. Complicating Medical Conditions

i. Some patients who would normally be admitted to a non-Medicine service for their primary condition have Complicating Medical Conditions and are best admitted to and managed by Internal Medicine (or Family Medicine if they are empaneled to a Family Medicine provider) with consultation from the applicable non-Medicine/non-Family Medicine service. Unless specifically noted (e.g., admission guidelines for patients with acute aortic disease), patients with Complicating Medical Conditions who would normally be admitted to a non-Medicine/non-Family Medicine service will, instead, be admitted to Internal Medicine (or Family Medicine if they are empaneled to a Family Medicine provider).

ii. A Complicating Medical Condition is defined as one or more potentially active acute medical condition(s) that the non-Medicine/non-Family Medicine service does not usually manage, and that is likely to require ongoing management or active monitoring during the hospitalization. The decision regarding what constitutes a Complicating Medical Condition is to be made by the ED attending physician.

iii. If a patient requires intensive care for a medical condition that is related to a primary surgical diagnosis (e.g., septic shock, acute kidney injury), then the patient will be admitted to the Surgical ICU under a Surgical Specialty with consultation by the Trauma/Surgical Critical Care service. Once the acute surgical disease has been appropriately addressed, the patient may be transferred by the surgical service to the Medical ICU, Medicine, or Family Medicine services as appropriate.

iv. **Any discussion about the most appropriate service to which to admit a patient with a complicating medical condition will occur at the attending level (e.g., inpatient service attending with ED attending) and be focused on what is best for the patient. Any failure to reach agreement will be escalated to the respective department chairs or the Chief Medical Officer/Associate Chief Medical Officer. Chief residents cannot replace attending physicians in this role.**

v. **Residents may not overrule admission decisions made by the ED attending physician. Further, resident physicians may not send a patient home from the ED who has been admitted to their service, without explicit prior discussion and agreement from their attending physician. The attending physicians of admitting services can chose not to provide hospital-based care for a patient admitted to their service from the Emergency Department, including discharging the patient home from the ED. If the admitting service attending feels the patient would best be cared for on another inpatient service, the admitting attending should speak with the attending of that service. A final decision between the two inpatient service attendings about which admitting service is most appropriate should be accomplished within 30 minutes and reported back to the ED attending. Failure to reach an agreement within 30 minutes should be escalated to the Chief Medical Officer/Associate Chief Medical Officer by the two inpatient attending physicians; the Chief Medical Officer/Associate Chief Medical Officer will then decide the admitting inpatient service.**

g. Congestive Heart Failure (CHF)

i. Patients with acute heart failure who have an anticipated length of stay less than two midnights and do not require intensive care will be placed in CORE. Any patient with CHF anasarca including abdominal or scrotal edema should be admitted.

ii. Patients with acute heart failure who have an anticipated length of stay greater than two midnights, will be admitted to (telemetry) Internal Medicine or Family Medicine if ALL of the following conditions are met:

1. Low suspicion for acute coronary syndrome (as determined by ED attending)
2. Heart rate < 110 beats per minute
3. Systolic blood pressure > 110 mmHg
4. Serum creatinine < 2.0 (unless ESRD on HD)
5. BiPAP not required at any time in the ED

iii. Patients with acute congestive heart failure who have an anticipated length of stay greater than two midnights who do not meet all five of the criteria listed above in (ii) or requiring ICU level of care will be admitted to C-team Medicine.

iv. Patients with another diagnosis but who also have CHF as a COMPLICATING MEDICAL CONDITION will be admitted to C-team Medicine only if CHF is the primary reason for admission; otherwise C-team Medicine may be consulted to assist with management.

v. Patients with hypertension as a COMPLICATING MEDICAL CONDITION will be admitted to Internal Medicine/Family Medicine only if the hypertension is the primary reason for admission; otherwise, Nephrology may be consulted to assist with management.

h. Decubitus Ulcers

i. Patients who require hospitalization primarily for wound care of decubitus ulcers should be admitted to Trauma/Acute Care Surgery, regardless of the need for surgical intervention.

ii. If adequate wound care management can be achieved in less than two midnights and the patient does not need surgical debridement, the patient should be placed in OBS.

iii. If a patient requires hospitalization primarily for management of medical problems but also happens to have decubitus ulcers, they should be admitted to Internal Medicine/Family Medicine or Neurology if the primary medical problem is neurologic.

iv. Patients primarily needing placement with concomitant decubitus ulcers should be placed in OBS, unless otherwise instructed by Utilization Review.
v. If there is concern for a necrotizing infection, Trauma/Acute Care Surgery should be consulted. If they feel there is no NSTI, the patient should be admitted per the guidance above.

i. Deep Venous Thrombosis (DVT)/Pulmonary Embolism (PE)

i. Patients with DVTs who cannot be safely managed as outpatients should be managed as follows:
   1. For patients who are less than 30 days post-op from an operation performed by a General Surgery service (Trauma/ACS, CRS, Surg Onc/Breast, Vascular, CT Surgery, or General/MIS) at Harbor-UCLA, the patient will be admitted to the surgical service who performed the operation.
   2. If the DVT occurs in a woman who is pregnant, less than six weeks post-partum, or is due to a gynecological malignancy, the patient will be admitted to OB/Gyn.
   3. For all other patients with DVTs, they will be admitted to Internal Medicine/Family Medicine if the estimated length of stay exceeds two midnights. Otherwise they will be placed on OBS.

ii. Patients with phlegmasia or resultant extremity compartment syndrome will be admitted to Trauma/Acute Care Surgery (with planned transfer to Vascular Surgery), superseding the guidelines (i) above.

j. Delirium and Dementia

i. Patients suffering from acute delirium (toxic, metabolic, or infectious) should be managed as follows:
   1. Admitted to Internal Medicine/Family Medicine if the anticipated length of stay is greater than two midnights, or;
   2. Placed on OBS if the anticipated stay is less than two midnights, except where intensive care unit level care is required.

ii. Patients presenting with new onset or previously undiagnosed dementia, based on information available in the ED, who cannot be safely evaluated and managed as an outpatient should be admitted to Neurology.

iii. Patients with new onset or previously undiagnosed dementia, based on information available in the ED, who cannot be safely evaluated and managed as an outpatient, *and who have one or more Complicating Medical Conditions* should be admitted to Internal Medicine/Family Medicine.

iv. Patients with previously diagnosed dementia, confusional states, developmental disorders and behavioral symptoms resulting from irreversible brain injury who primarily require hospitalization for placement should be placed in OBS unless directed otherwise by Utilization Review. If they are to be admitted based on input from Utilization Review, then they should be admitted to Medicine/Family Medicine.

k. Diabetic Foot Infections

i. Patients with isolated diabetic foot infections should be evaluated by Trauma/Acute Care Surgery and, if requiring hospital-based treatment, admitted to that service with plans for consultation by, or transfer to Limb Salvage Surgery. Antibiotics should be initiated prior to the

Surgery team's evaluation of the patient only if the patient demonstrates severe sepsis or a rapidly progressing infection.

ii. If the patient requires admission primarily for another medical condition but also has a diabetic foot infection that does not require emergent surgical intervention, the patient should be admitted to the team managing the primary concern and Trauma/Acute Care Surgery (or Limb Salvage Surgery) should be consulted.

l. Disposition Problems

i. Patients must sometimes be hospitalized for problems that do not usually require admission, simply because they are unable to care for themselves safely in an outpatient setting. All patients simply requiring long-term placement (acute care rehabilitation, skilled nursing, extended care facility, etc.) should go to OBS to allow time for appropriate placement while avoiding hospitalization, unless directed otherwise by Utilization Review. The need for hospitalization is then determined by the Observation Service and if such patients cannot be safely placed in a timely manner, they are generally admitted to Internal Medicine/Family Medicine. However, there are *two exceptions*:

1. A patient who develops complications from a medical or surgical problem who is already being followed by a particular service in the outpatient setting should be admitted to that service if hospitalization becomes necessary.
2. If a patient's problem is solely surgical and the patient does not have a Complicating Medical Condition, as defined above, the patient should be admitted to the appropriate surgical service for care and disposition (e.g., a patient with a fracture who cannot care for him/herself at home because of the injury will be admitted to Orthopedic Surgery).

ii. If the patient requires a physical therapy assessment for placement, this can occur in OBS.

iii. The tuberculosis rapid rule-out (GenExpert PCR) takes about 12 hours and can occur in OBS.

m. Gastrointestinal Bleeding

i. Patients with gastrointestinal bleeding, including post-endoscopy, who require admission should be admitted to Internal Medicine. If hemodynamically unstable or requiring massive transfusion, Gastroenterology should evaluate the patient immediately and the patient should be admitted to the MICU with Trauma/ACS consultation.

n. Hand Injuries and Infections

i. Fractures of the hand and forearm (up to the antecubital crease), with the exception of distal phalanx fractures, that require hospital-based care will be admitted to Orthopedic Surgery. Patients who meet trauma activation criteria as a TTA 1 or 2 will be cleared by Trauma/Acute Care Surgery prior to admission.

ii. Isolated fractures of the distal phalanx will be cared for by Hand Call (Plastics or Orthopedic Surgery) and, if the patient requires hospital-based care, they will be admitted to the Hand Call service. Patients who meet trauma activation criteria as a TTA 1 or 2 will be cleared by Trauma/Acute Care Surgery prior to admission.

iii. Patients with soft tissue injuries or infections of the upper extremity without fracture, up to and including the antecubital fossa, who require hospital-based care will be admitted to Hand Call (Plastics or Orthopedic Surgery).

iv. For patients with sepsis or other acute medical conditions in addition to an upper extremity infection, see guidelines for Complicating Medical Conditions.

o. **Hip Fractures**
   i. The management of isolated hip fractures is detailed in a multidisciplinary Hip Fracture Pathway.
   ii. Hip fractures (e.g., isolated femoral neck or other proximal femur fractures) from a low energy mechanism (e.g., a ground level fall) will be managed as follows:
      1. Patients 65 years or older will be admitted to Internal Medicine/Family Medicine.
      2. Patients younger than 65 years of age without active medical issues will be admitted to Orthopedic Surgery.
      3. Patients younger than 65 years of age with active medical issues/Complicating Medical Conditions and an isolated hip fracture will, when Trauma Surgery is in agreement, be admitted to Internal Medicine/Family Medicine.
   iii. Hip fractures from high-energy mechanisms (e.g., anything not a ground level fall), more distal femur fractures, having other injuries, or otherwise not cleared by Trauma will be admitted to Trauma/Acute Care Surgery.

p. **Intracranial Mass Lesions**
   i. Patients with a new solitary non-hemorrhagic intracranial mass lesion will be admitted to Neurology with consultation by Neurosurgery.
   ii. Patients with known solitary non-hemorrhagic intracranial mass lesion will be admitted to the service that manages the lesion as an outpatient (e.g., glioma, admit to Internal Medicine with consultation by Oncology; tumefactive multiple sclerosis, admit to Neurology).
   iii. Patients with hemorrhagic intracranial mass lesions, or non-hemorrhagic intracranial lesion(s) who are at risk for herniation (e.g., midline shift >5 mm), will be admitted to Neurosurgery, regardless of the presence of a Complicating Medical Condition.
   iv. Patients with non-hemorrhagic intracranial mass lesions who have a Complicating Medical Condition or who likely have metastatic disease, will be admitted to Internal Medicine/Family Medicine with consultation by Neurosurgery.

q. **Low Back Pain**
   i. Patients with low back pain without acute neurological deficits who require extended care (e.g., for pain control) will be placed on OBS.
   ii. Patients with low back pain with acute weakness, bowel/bladder incontinence, or requiring surgical intervention on the spine will be admitted to Neurosurgery.
   iii. Patients with low back pain failing a period of observation in the OBS unit or otherwise requiring hospitalization for reasons other than those in (q)(ii) above will be admitted to Internal Medicine/Family Medicine with a consultation by Neurosurgery.

r. **Maxillofacial Trauma**
   i. Patients with maxillofacial trauma requiring admission to the hospital will be admitted to Trauma/Acute Care Surgery.
   ii. Patients with isolated non-traumatic maxillofacial diagnoses requiring surgical intervention will be admitted to Face Call (Head & Neck Surgery, Plastics, or OMFS).
   iii. Patients with isolated injury to the globe will be admitted to Ophthalmology (e.g., FB with globe rupture).

s. **Meningitis**
   i. Patients with meningitis will be admitted to Internal Medicine or Family Medicine.
   ii. Neurology consultation may be obtained as needed to inform diagnosis or management.

t. **Non-ST Elevation Myocardial Infarction**
   i. Patients with an elevated troponin (e.g., above the 99th percentile) that appears to be due to cardiovascular disease (e.g., acute coronary syndrome [NSTEMI] or acute decompensated heart failure, etc.) will be admitted to C-team. If the elevated troponin appears to be secondary to a non-cardiovascular cause (e.g., demand or type II NSTEMI from sepsis), the patient will be admitted to Internal Medicine/Family Medicine or other service responsible for care of the primary condition. For patients in the Emergency Department, the determination of the most likely cause of the NSTEMI will be made by the ED Attending Physician.
   ii. If the elevated troponin is secondary to a traumatic injury (e.g., cardiac contusion after a motor vehicle accident) and not felt to be the etiology of the trauma (e.g., cardiac syncope leading to a motor vehicle accident), the patient will be admitted to Trauma/Acute Care Surgery with Cardiology consultation as needed.

u. **Osteomyelitis**
   i. Patients with presumed or confirmed osteomyelitis, requiring hospitalization, should be admitted to Internal Medicine/Family Medicine with the following *exceptions:*
      1. Osteomyelitis in the extremities should be admitted to Orthopedics, with the exception of isolated hand/forearm infections, which will be admitted to Hand Call (Orthopedic Surgery or Plastic Surgery) as above.
      2. If the osteomyelitis is underlying a diabetic foot infection, the patient should be admitted to Trauma/Acute Care Surgery with subsequent transfer to Limb Salvage Service as detailed above.
      3. Osteomyelitis located in the spine with acute weakness, numbness, or bowel/bladder incontinence should be admitted to Spine Call (Orthopedics, Neurosurgery). Osteomyelitis of the spine without these symptoms will be admitted to Internal Medicine/Family Medicine with consultation by the Neurosurgery service.

v. **Painless Jaundice**
   i. Patients presenting with painless jaundice that require inpatient care will be admitted to Internal Medicine/Family Medicine with consultation as needed by Gastroenterology, Hematology/Oncology, and Trauma/Acute Care Surgery. Surgical Oncology may be consulted by the inpatient team.
   ii. Patients that are stable for outpatient workup may be referred to the Expedited Work-up Clinic or be referred to Hematology/Oncology and/or Surgical Oncology. This referral should occur by asking the patient's designated Primary Care Provider (PCP), or in the absence of a designated PCP, the Continuing Care Clinic (CCC), to submit an eConsult to Hematology/Oncology or Surgical Oncology.

w. **Pancreatitis**
   i. Patients who are found to have pancreatitis secondary to gallstones, who require inpatient admission, will be admitted to the Trauma/Acute Care Surgery service.
   ii. Patients who are found to have pancreatitis secondary to a cause other than gallstones, who require hospital-based care, will be placed on OBS or admitted to Internal Medicine/Family

Medicine, depending on the anticipated length of stay. If the length of stay is expected to be less than 2 midnights, the patient should be placed on OBS.

iii. Patients with pancreatitis who require admission to the hospital will generally undergo a right upper quadrant ultrasound to determine the presence of gallstones. The use of an ultrasound performed by an ED provider to make this determination requires that the study include four key components: gallbaldder wall thickness, presence/absence of pericholecystic fluid, presence/absence of gallstones, and diameter of the common bile duct or common hepatic duct. If the ED ultrasound is not able to assess all four components, or if the patient's clinical findings do not match the ED ultrasound result, then a formal Radiology ultrasound will be obtained.

x. **Pyelonephritis**

i. Men and non-pregnant women with pyelonephritis who require hospital-based care will be placed on OBS or admitted to Internal Medicine/Family Medicine, depending on the anticipated length of stay. If the expected length of stay is less than two midnights, the patient should be placed on OBS.

ii. Pyelonephritis associated with nephrolithiasis, urinary stents, obstructive uropathy, or nephrostomies will be admitted to Urology, unless they have a Complicating Medical Condition as defined above. If they have a Complicating Medical Condition, they will be admitted to Internal Medicine/Family Medicine with consultation by Urology.

iii. Pregnant women with pyelonephritis who require hospitalization will be admitted to OB/Gyn.

y. **Return of Spontaneous Circulation (ROSC) after Cardiac Arrest**

i. Patients whose cardiac arrest is believed to be of cardiac etiology, as determined by the ED attending physician, who sustain ROSC will be admitted to C-team. Patients whose cardiac arrest is thought to be of a non-cardiac etiology **OR** of unclear etiology, as determined by the ED attending physician, who sustain ROSC will be admitted to the Medical Intensive Care Unit (MICU) service.

z. **Septic Arthritis** (diagnosis should be confirmed by arthrocentesis in the ED whenever possible)

i. Patients with native septic arthritis requiring admission should go to Orthopedics.

ii. Patients with infections of total joint replacements who require admission to the hospital and have no other Complicating Medical Conditions will be admitted to Orthopedics.

iii. If the patient has systemic sepsis or other Complicating Medical Condition, as defined above, the patient should be admitted to Internal Medicine/Family Medicine with consultation by Orthopedics.

aa. Spinal Injuries

i. Patients with cervical, thoracic, or lumbar spine injuries with or without neurologic deficit will be admitted to Trauma/Acute Care Surgery

bb. Stroke

i. Patients with an acute ischemic or hemorrhagic stroke should be admitted to Neurology with the following *exceptions:*

1. Patients with traumatic intracranial hemorrhage from isolated head injury should be admitted to Neurosurgery if cleared by Trauma/Acute Care Surgery.
2. Patients with a diagnosis of aneurysmal subarachnoid or any massive hemorrhage (defined as > 5mm midline shift, intraventricular extension, or GCS ≤8) should be admitted to Neurosurgery, even if no immediate operative intervention is planned.

3. Patients with other non-aneurysmal subarachnoid or any other non-massive intracranial hemorrhage (including post-tPA hemorrhage) should be admitted to Neurology with Neurosurgery consult.
4. If the patient has a Complicating Medical Condition as defined above, the patient should be admitted to Internal Medicine/Family Medicine with consultation by Neurology.

cc. Trauma/Fractures

i. Patients with multi-system trauma including fractures will be admitted to Trauma/Acute Care Surgery.
ii. Patients with proximal femur fractures following ground level falls will be admitted according to Hip Fracture Guideline above (Section O).
iii. Patients with isolated traumatic fractures may be admitted to Orthopedic Surgery.
iv. Patients who meet trauma activation criteria as a TTA-1 or -2 will be cleared by Trauma/Acute Care Surgery prior to admission.

dd. Vaginal Bleeding

i. Non-pregnant patients with vaginal bleeding and symptomatic anemia requiring extended stay or transfusion of greater than two units of pRBC's will be admitted to the Gynecology Service.

II. Pediatric patients under the age of 18 requiring hospitalization will be admitted to Pediatrics. Patients age 18-20 may be admitted to Pediatrics at the discretion of the pediatric admitting team and the capacity of the Pediatric service.

C. Admissions from the Emergency Department

I. The ED Attending will determine the need for all admissions from the ED. This determination will be informed by applicable Interqual (IQ) criteria and, when appropriate, consultation by specialty services.

D. Admissions from the Psychiatric Emergency Department

I. The Psychiatric ED residents and psychiatry attending physicians overseeing care in the Psychiatric ED determine the need for all admissions to the inpatient psychiatry services.

E. Observation and CORE Status

I. Patients who have been evaluated in the Adult ED or Rapid Medical Evaluation (RME) area and meet criteria for observation (OBS) or CORE services will be transferred to the Observations and CORE services as appropriate. The Adult ED attending physician will determine when a patient qualifies for Observation or CORE status with, as appropriate, input from Utilization Review.

F. Transfer Guidelines

I. Care for each patient is provided under the direction of an Attending physician.
II. When a patient's condition(s) is/are found to be predominately those treated by another discipline (e.g., medical problems becoming surgical), care of the patient will be transferred to an appropriate receiving service with the knowledge and approval of the receiving service.
III. Any disagreements regarding which service is most appropriate as primary should be resolved at the attending physician level or escalated to service chiefs, department chairs, or the Associate Chief or Chief Medical Officer.

IV. Prior to the patient's transfer, the history and physical examination, diagnosis, and reason for transfer will be documented in a transfer note by the transferring service and reviewed by the receiving service.

V. A provider from the transferring service will enter an order into the medical record to transfer the patient to the receiving service and indicate the physician of record. The "Transfer Inpatient Service/Level of Care" order will be placed in the electronic health record at the time of transfer.

VI. The name of the transferring and receiving physicians of record will be noted in the medical record.

VII. The receiving physician will enter into the medical record the new orders for the patient prior to transferring the patient from one service to another.

VIII. The acceptance and plan of care by the new service will be documented by the receiving physician.

IX. For transfer of patients during the admitting process in the Emergency Department, please see Hospital Policy 312.

Revised and Approved by:
Medical Executive Committee - 5/2020

Janine R. E. Vintch, MD
President, Professional Staff Association