DoIM Hospital Medicine and DFCM Inpatient Service Agreement

Note: This document supersedes the following:

- DoIM HM and DFCM IPS Collaboration for Census Overflow (Non-Covid Overflow Pathway threshold numbers effective 5/21/21)
- Family Medicine/Internal Medicine Service Transfer Agreement (2/16/2017)

PURPOSE

This document outlines collaboration regarding census management between the UNM Department of Internal Medicine Division of Hospital Medicine (HM) and Department of Family and Community Medicine Inpatient Service (IPS), and expectations and procedures regarding transfer of patients between the two services.

DEFINITIONS

A. "FM patient" means a patient who usually would be admitted to IPS based on their established relationship with a primary care provider in the Department of Family and Community Medicine (see FAMILY MEDICINE IPS ADMITTING/CONSULT CRITERIA).
B. "IM patient" means a patient who usually would be admitted to a Division of Hospital Medicine team.
C. "IPS census" means the total combined census of patients admitted to or followed as inpatient consults by FM Team A and FM Team B.
D. "HM census" means the total combined census of patients admitted to or followed as inpatient consults by resident "color" teams and direct care "metal" teams within the Division of Hospital Medicine.
E. "Overflow trigger" refers to IPS census and HM census conditions where an IM patient or FM patient may intentionally be admitted to IPS or HM, respectively.
F. "IPS soft cap" is the upper bound of the IPS target census, at which the IPS generally no longer will accept new admission, consultation, or transfer requests. Certain exceptions apply for pediatric patients and adult patients whose reason for hospitalization is a cardiac condition.
G. "HM leadership team" refers to the UNMH Hospital Medicine Section Chief, Section Vice Chief(s), UNM Hospital Medicine Division Chief, Division Vice Chief(s), or their designees.
H. "IPS leadership team" refers to the Director of the Department of Family Medicine Inpatient Service or their designee.
I. "Bounce back" means a patient recently discharged from the hospital who requires readmission.

POLICY

WHEREAS, the IPS has two resident teams with variable resident and APP staffing, no direct care teams, a lower total patient capacity that magnifies the effect of IPS census fluctuations on workload, and limited mechanisms to recruit or compensate extra help when the IPS census is high;

WHEREAS, HM has four resident teams with consistent staffing, multiple direct care teams, a higher total patient capacity that buffers the effect of HM census fluctuations on workload, and routine mechanisms to recruit or compensate extra help when the HM census is high;

WHEREAS, the IPS and HM strive to provide a clinical learning environment that balances education and service by maintaining resident team censuses within stable target ranges;

WHEREAS, to promote family medicine's core value of continuity of care over time, patients whose PCPs are residents, faculty, and APPs in the Department of Family Medicine are preferentially admitted to the IPS;

THEREFORE, the IPS and HM hereby enter into this agreement:

1. The target IPS census shall be twenty-four (24) to thirty (30) patients, based on the current IPS staffing model. The Director of the IPS reserves the right to modify the target IPS census based on projected temporary staffing changes and will immediately notify the HM leadership team of the modified target range and effective dates of the temporary modification. Such modification shall not affect other provisions of this agreement.

2. If at the start of the day or night shift, the IPS census is below the floor of the target, this shall constitute an overflow trigger. IPS shall accept the referral of up to two (2) admission, consultation, or transfer requests per shift that HM receives for IM patients. HM reserves the right to select which admission, consultation, or transfer requests to refer to IPS based on their own census conditions and workload.

3. If at any point the IPS census reaches the IPS soft cap, this shall constitute an overflow trigger. The IPS shall refer any additional requests for admission, consultation, or transfer they receive for FM patients to HM, until the IPS census falls below the soft cap. During the night shift, IPS residents shall remain available to participate in the admission, consultation, or transfer of such patients, under the supervision of HM faculty.

4. If within one (1) calendar day of admission, consultation, or transfer to HM of an FM patient, the IPS census is below the soft cap, HM may transfer the FM patient to IPS. Such transfers shall be effected only at the morning or evening shift change. This provision applies to FM patients admitted to HM either inadvertently, or intentionally as the result of an overflow trigger.

5. No bounce back rule shall apply. Requests for admission, consultation, or transfer shall be addressed by the respective service according to the other provisions of this agreement and without regard to prior inpatient encounters or care teams.

PROCEDURE

- At 7 a.m. and 7 p.m. the IPS admitting resident will calculate the IPS census and communicate it to the triage hospitalist by sending a TigerConnect message from role "FM Resident Admit" to role "IM Hospitalist Admit / Transfer Triage On Call." The message should indicate how many IM patient referrals can be accepted, or whether the IPS is capped.

- If the IPS census is below the overflow trigger from HM to IPS (generally 24 patients), the triage hospitalist may refer up to two admission or transfer requests to the IPS admitting resident. For example, if the morning or evening IPS census is 23, then the triage hospitalist may refer 1 request to the IPS admitting resident during their shift. If the morning or evening IPS census is 22 or fewer, then the triage hospitalist may refer 2 requests to the IPS admitting resident. The triage hospitalist should not refer an IM patient already admitted to Medicine Gray (e.g. a patient triaged during the previous shift or a PALS direct admission or transfer), or an admission that HM would perform for another service according to another service agreement (e.g. after hours oncology admissions).

- The triage hospitalist should notify the requesting service (e.g. the Emergency Department or Medicine Critical Care) that their request for admission or transfer is being referred to IPS for census reasons, and that the requesting service should place the appropriate consult order to Family Medicine in PowerChart. The triage hospitalist should also alert the IPS admitting resident and forward any communication they receive related to the request to the "FM Resident Admit" TigerConnect role. **The triage hospitalist should NOT enter a bed request, admit/observation, or transfer order because the patient is not being admitted to an HM team.** The IPS admitting resident shall triage the patient, enter an appropriate bed request, admit/observation, or transfer order, and assign an IPS team member to complete the admission. The IPS team member shall staff the admission with the IPS admitting attending physician, who shall attest and countersign their documentation. Any dispute regarding the disposition of the patient shall be resolved between the requesting service attending and the IPS admitting attending physician.

- If at any point, the IPS census reaches the soft cap (generally 30 patients), the IPS admitting resident shall immediately notify the triage hospitalist by sending a TigerConnect message from role "FM Resident Admit" to role "IM Hospitalist Admit / Transfer Triage On Call." The message should include a projection of whether the IPS census will fall below the cap by the end of the shift (due to expected discharges). The IPS admitting resident shall refer additional requests for admission, consultation, and transfer of adult FM patients to HM.

- The IPS admitting resident shall notify the requesting service (e.g. the Emergency Department or Medicine Critical Care) that their request for admission or transfer is being referred to HM for census reasons, and that the requesting service should place the appropriate consult order to Internal Medicine in PowerChart. The IPS admitting resident should also alert the triage hospitalist and forward any communication related to the request to the "IM Hospitalist Admit / Transfer Triage On Call" TigerConnect role. The IPS admitting resident should keep track of patients admitted or transferred to HM and identify them for potential transfer to IPS if the census falls.

- If the IPS census is at or above the soft cap during the day shift and adult FM patients are referred to HM to admit, consult, or transfer, then the triage hospitalist shall triage the request. If appropriate for admission or transfer, the triage hospitalist shall place the appropriate bed request, admit/observation, or transfer order to Medicine Gray. The triage hospitalist shall then assign a member of the HM admitting team to complete the admission, consultation, or transfer. The triage hospitalist should avoid assigning the request to the short- or long-call resident team, if possible.

- If the IPS census is at or above the soft cap during the night shift and adult FM patients are referred to HM to admit, consult, or transfer, then the triage hospitalist shall triage the request. If appropriate for admission or transfer, the triage hospitalist shall place the appropriate bed request and admit/observation order, preferentially to Medicine Gray or a metal team. The triage hospitalist shall then assign a member

of the IPS admitting team to complete the admission, consultation, or transfer. The IPS admitting team member shall staff the admission with the appropriate HM attending physician (generally either the swing shift admitter or nocturnist), who shall attest and countersign the resident note. The IPS admitting team member shall be responsible for the patient until the end of their shift and provide signout as directed by the nocturnist.

- If the IPS census has fallen below or is anticipated to fall below the soft cap by the end of the shift (e.g. due to pending discharges), the IPS admitting resident should notify the triage hospitalist and offer to accept FM patients admitted to HM in transfer to IPS. If during the day shift, such notification ideally should happen before 3 p.m. when the triage hospitalist distributes patients to HM teams. Any transfer shall take effect only at the change of shift, and the HM provider shall be responsible for the patient until then. The covering HM provider shall give a verbal signout to the IPS admitting resident. The IPS admitting resident shall update the cache in the Family and Community Medicine view, enter a transfer order to the appropriate IPS team, and pass the verbal signout to the oncoming cross-cover or rounding resident.

- For the purposes of this agreement, transfers of patients between HM and IPS are considered lateral transfers, with only one service required to enter a billable note on the day of transfer. For example, if an FM patient is admitted to HM in the morning and then transferred to IPS at 7 p.m., the HM provider shall write and bill the H&P. The receiving IPS team is not required to enter another note on that same calendar day. The following day, the IPS team provider rounding on the patient shall write and bill a regular progress note or discharge summary as appropriate.

Gabriel Palley (Jul 29, 2022 08:46 MDT)
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Last Revised: Jun 25, 2022

Appendix A: Transfer Scenarios

Scenario 1 (inadvertent FM patient admitted to HM, IPS not capped): An FM patient is inadvertently admitted to Medicine Gray during the day because their PCP name is not up to date in Cerner PowerChart, but it is discovered that they just established with a current FM resident at the UNMH North Valley Clinic while the IM Gray Resident is working on the H&P at 11 a.m. The IPS census is 28 (within the target).

- The IM Gray Resident completes the H&P and staffs with the HM attending.
- The triage hospitalist contacts the FM admitting resident and requests to transfer the patient to IPS.
- The FM admitting resident receives a verbal signout and enters a cache note in the Family & Community Medicine view. The patient is transferred to the appropriate IPS team effective at 7 p.m. Until then, the IM Gray team is responsible for all calls regarding that patient.

Scenario 2A (inadvertent FM patient admitted to HM, IPS capped): An FM patient is inadvertently admitted to Medicine Gray during the day because they presented from Odelia Healthcare, where they were receiving short-term rehab after a prolonged hospitalization at Lovelace. The IM Gray Resident discovers that the patient's last PCP visit was with an FM faculty at Atrisco Heritage UNM Clinic 1 year ago. The IPS census was 29 at 7 a.m., but is now capped at 30 patients at 2 p.m.

- The IM Gray Resident completes the H&P and staffs with the HM attending.
- The triage hospitalist informs the FM admitting resident that the patient is admitted to Medicine Gray and verifies that the IPS is anticipated still to be at or above the soft cap at the next change of shift.
- The triage hospitalist distributes the patient to an HM metal team.
- The FM admitting resident makes note that the patient is admitted to HM and keeps track of them (e.g., by adding them to the Family Medicine Consult Team list).

Scenario 2B (inadvertent FM patient admitted to HM while IPS capped, IPS census falls the following day):

- If, the following day, the FM IPS census falls below the soft cap, the FM admitting resident on duty reaches out to the metal team attending physician and offers to accept the patient as a transfer back to FM IPS effective at 7 p.m.
- The FM admitting resident receives a verbal signout, enters a cache note in the Family & Community Medicine view, and enters a transfer order to the appropriate IPS team effective at 7 p.m. The metal team provider is responsible for that day's progress note and all calls regarding that patient until 7 p.m.

Scenario 3A (inadvertent IM patient admitted to FM IPS while IPS census below target range): A patient whose PCP is listed in Cerner PowerChart as an FM faculty is referred to IPS for admission. It is subsequently discovered that the patient is a long-term care resident at Princeton Place and no longer sees the listed PCP. The IPS census at the start of the shift is 23 (one below the target range).

- The patient is admitted to IPS.
- The FM admitting resident notifies the triage hospitalist that they admitted the IM patient. This counts as an overflow from HM to FM IPS, and the FM IPS would not be expected to admit further IM patients during the shift.

Scenario 3B (inadvertent IM patient admitted to FM IPS while IPS census is within target range): A patient whose PCP is listed in Cerner PowerChart as an FM faculty is referred to IPS for admission. It is subsequently discovered after admission orders are placed that the patient recently has transferred her care to a PCP in the Lovelace system, and no longer sees the listed PCP. The IPS census at the start of the shift is 25 (within the target range).

- The patient remains on the FM IPS team until discharged or transferred to a higher level of care.

Scenario 4A (IPS census below target at start of shift; subsequent FM patient admission requests): At 7 a.m., the IPS census is 23, and neither HM nor IPS have any pending admission/consult/transfer requests. At 8 a.m., the FM admitting resident receives a request to admit an FM patient. At 9 a.m., the triage hospitalist receives 3 admission requests from the ED.

- Because the IPS census was below the target at the *start* of the shift, the triage hospitalist can refer one of their pending admission requests to IPS *without* triaging the request. The triage hospitalist informs the FM admitting resident of the referral.
- The triage hospitalist asks the ED provider to place an ED consult to Family Medicine order.
- The FM admitting resident triages the patient, decides the admission is appropriate, and admits the patient to IPS.

Scenario 4B (IPS census below target; referred IM patient consult request not admitted/transferred): At 7 a.m., the IPS census is 23. The triage hospitalist refers a transfer request from the ICU for an IM patient to IPS. While the FM admitting resident is evaluating the patient for transfer, the patient decompensates, and transfer out of the ICU is not deemed appropriate.

- This patient encounter (whether or not a complete consultation note is written or billable) counts as an "overflow" referral. The triage hospitalist does not refer subsequent admission/consultation/transfer requests for IM patients to IPS for the remainder of the shift.

Scenario 5A (no IM patient IPS bounce back when IPS census within target): An IM patient is admitted to FM Team A when the IPS census is below target. The patient subsequently decompensates and is transferred to the ICU. The next day, her condition has improved, and she is deemed stable for transfer to the floor. The IPS census at 7 a.m. is now 26 (within target).

- The triage hospitalist evaluates this IM patient for transfer to an HM team.

Scenario 5B (potential IM patient IPS bounce back when IPS census below target): An IM patient is admitted to FM Team B when the IPS census is below target. The patient subsequently decompensates and is transferred to the ICU. The next day, his condition improves, and he is deemed stable for transfer to the floor. The MICU team consults the triage hospitalist to transfer the patient. The IPS census at 7 a.m. is 22 (two below target). The triage hospitalist has not yet referred an admission/consult/transfer request to IPS.

- The triage hospitalist may elect to refer the request for transfer to the FM admitting resident. This would count as one of the two transfer referrals for the shift.

Scenario 6 (FM patient discharged from HM team while IPS capped, no HM bounce back): An FM patient is admitted by the HM swing admitter and distributed to a metal team when the IPS census is capped. The patient

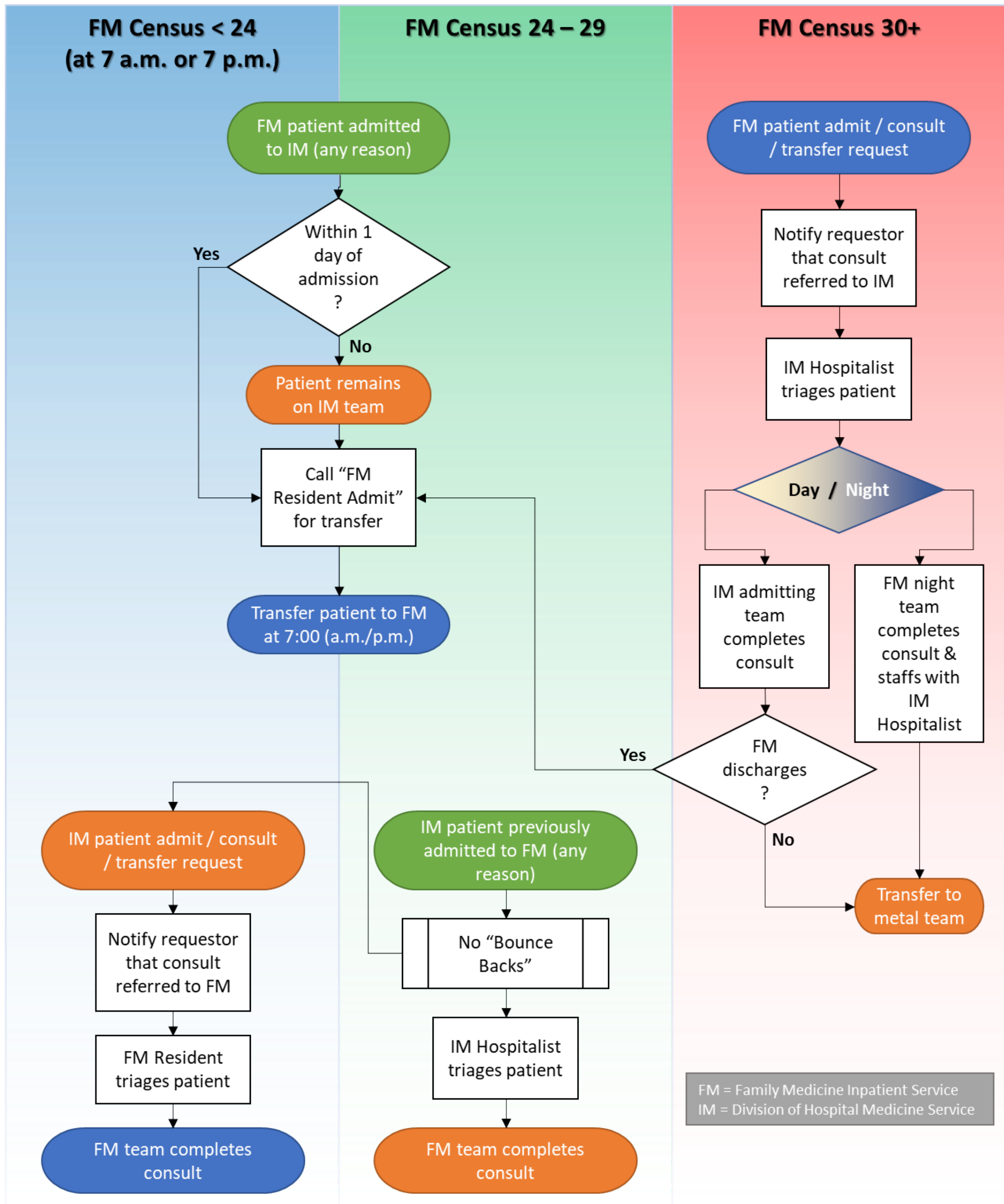
leaves against medical advice the next day after being seen by the metal team attending. The patient is back in the ED a few hours later. The ED provider consults the triage hospitalist to re-admit the patient. The IPS team census is 28 (within target).

- The triage hospitalist asks the ED provider to place an EM consult to Family Medicine order and forwards communication about the patient to the FM admitting resident.

Scenario 7 (FM patient admitted at night while IPS census capped, census falls below cap before end of shift): At 1 a.m., an FM patient is triaged by the nocturnist because the IPS census is capped at 30 patients and deemed appropriate for admission. The IPS resident writes the H&P and staffs with the nocturnist. At 5 a.m., another patient on an IPS team decompensates and is transferred to the ICU, dropping the IPS census to 29.

- The patient is distributed to an IPS team.

Hospital Medicine / Family Medicine Admitting Flow Diagram



2022 FM-HM Service Agreement

Final Audit Report 2022-07-29

Created:	2022-07-26
By:	David Goldstein (david.jonathan.goldstein@gmail.com)
Status:	Signed
Transaction ID:	CBJCHBCAABAAr4l1GygTLKWGUhzr8TowP-elMN6XYujQ

"2022 FM-HM Service Agreement" History

Document created by David Goldstein (david.jonathan.goldstein@gmail.com)

2022-07-26 - 7:25:21 PM GMT- IP address: 73.26.130.58

Document emailed to Gabriel Palley (gpalley@salud.unm.edu) for signature

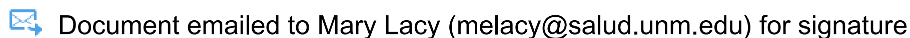
2022-07-26 - 7:26:22 PM GMT

Email viewed by Gabriel Palley (gpalley@salud.unm.edu)

2022-07-26 - 7:30:53 PM GMT- IP address: 206.192.168.19

Document e-signed by Gabriel Palley (gpalley@salud.unm.edu)

Signature Date: 2022-07-29 - 2:46:08 PM GMT - Time Source: server- IP address: 206.192.168.28



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2022-07-29 - 2:46:11 PM GMT

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