



UnityPoint Health
Meriter

System of Care Playbook

University Hospital,

UnityPoint Health - Meriter,

and UW Health at The American Center

Last Update 10/15/2019

Introduction

The UW Health and UPH-Meriter System of Care is centered on a simple idea: Ensure that our patients get the right care, at the right time, at the right place. While both UW Health and UPH-Meriter hospitals have the capability to treat a wide range of patients at various UW Health and UPH-Meriter locations, this System of Care Playbook was created to provide general guidance on the preferred placement of patients requiring inpatient care within the System of Care.

Any movement of a patient from one location to another will be made in compliance with UW Health and UPH-Meriter policies and applicable laws, including the Emergency Medical Treatment and Labor Act (“EMTALA”). Patients presenting to an Emergency Department with an unstable emergency medical condition will not be transferred out of the Emergency Department unless the patient’s emergency medical condition has been resolved or the transfer otherwise complies with hospital policy and applicable law. Deviations from this Playbook should be made if it is in the patient's best interest considering real-time variables and circumstances.

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I. TAC Medicine

Strong preference against admission to TAC:

- Pediatric Patients
- Dept of Corrections Patients
- Mendota Mental Health Forensic Patients
- Heart Failure Service Patients
- Advanced Pulmonary Patients
- STEMI Patients
- Patients needing Ophthalmology
- Patients needing a stress test on Sat or Sun
- Patients needing electrophysiology
- Patients requiring ICU level of care
- Patients with a trach or chronically ventilated patients
- Complex withdrawal patients
- Patients needing psychiatric admission
- Patients with transplant other than kidney or hematopoietic transplants
- Patients in active oncological treatment
- Patients requiring eating disorders consult (prefer UH F6/4 for Hospitalist/Gmed and D4/6 for Family Medicine)
- Patients requiring GI procedures
- Patients with neurology consult needs
- Patients needing inpatient rheumatology consultation
- Patients needing inpatient dermatology consultation

II. Meriter Medicine

Strong preference against admission to Meriter:

- Pediatric Patients (exceptions)
- Central Wisconsin Center (CWC) Patients
- Mendota Mental Health Forensic Patients
- Dept of Corrections Patients
- Transplant patients other than renal or renal less than 12 months post op
- Patients admitted for traumatic injuries
- Patients with STEMI
- Pt. requiring Neuro-Endovascular Care
- Patients needing Burn consultation
- Patients undergoing or likely to need liver transplant evaluation
- Patients that are being admitted for cystic fibrosis and patient needing advanced hepatology consultation (see section XI Consultation)
- Patients being admitted for pulmonary hypertension on prostaglandins
- Patients requiring eating disorders consult (prefer UH F6/4 for Hospitalist/Gmed and D4/6 for Family Medicine)
- Aneurysm Subarachnoid Hemorrhage
- Plasmapheresis that requires cell separation i.e. sickle cell and leukophoresis
- OB/GYN patients under the age of 18 who are not pregnant are strongly preferred for AFCH

Meriter Preferred Patients

- Patients with a GI problem followed by gastroenterology at Meriter not meeting GI procedure exclusion criteria
 - **Antonio Bosch**
 - **Siobahn Byrne**
 - **Bryan Magenheimer**
 - **Jay Stangl**
 - **John Williams**
- Patients being admitted with oncology related problem followed by oncology at 1 S Park
 - **Dr. Rob Hegeman**
 - **Dr. David Hei**
 - **Dr. Mike Huie**
 - **Dr. Saurabh Rajguru**
 - **Dr. Amy Stella**
- Meriter can provide IMC level of care. Meriter can provide most ICU level of care.

III. Advanced Pulmonary Service

- Strong preference against admission to TAC or Meriter Hospitalist services:
 - Patients who carry a diagnosis of Cystic Fibrosis
 - Patients with Pulmonary Hypertension on prostanoids
 - Patients post lung transplant
- Some patients with chest tubes can be managed at Meriter (see thoracic surgery)

- Patients under the age of 18 are strongly preferred for AFCH

IV. Bone Marrow Transplant

- Strong preference against for admission to TAC or Meriter
- Patients under the age of 18 are strongly preferred for AFCH
 - All autologous stem cell transplant patients who have myeloma (To BMT if < 100 days and to hematology if > 100 days)
 - All autologous stem cell transplant patients for lymphoma < 1 year from transplant (To BMT if < 100 days and to hematology if > 100 days)
 - All allogeneic stem cell transplant patients
 - All recipients of CAR T-cell therapy < 1 year (To BMT if < 8 weeks and to Hematology if > 8 weeks)

V. Burn Surgery

- All patients being admitted for burn care should preferentially be admitted to UH

VI. Cardiology

Patients with strong preference for admission to UH CVM Service:

- ST Segment Elevation Myocardial Infarction (STEMI).
- High Risk Non-ST Elevation Acute Coronary Syndromes (e.g. hemodynamic or electrical instability, ongoing chest pain despite initiation of medical therapy, decompensated HF).
- Post Cardiac Arrest from presumed cardiac etiology (e.g. VT/VF arrest with ROSC, concern for ischemia or primary arrhythmia as the cause of the arrest).
- Cardiogenic Shock
- VT Storm, Complex VT ablations
- Complex, residual adult congenital disease – single ventricle physiology: If these patients need inpatient care, they will be admitted to the CVM Service on F4/5 or F4/M5 regardless of reason for admission.
- PE patients with indication for treatment with catheter-based treatment/catheter-based lysis (based on assessment by UW PERT).
- CAD patients in need of PCI with known high-risk anatomy or in need of brachytherapy.
- CAD patients in need of medical optimization prior to surgical revascularization.
- Laser-assisted device and lead extractions.
- Device infections (unless it has already been determined to pursue more of a palliative approach - leave device in place and pursue medical therapy).

Strong preference for University Hospital on HF Service

- S/p Heart Transplant or LVAD or patients currently listed for heart transplant.

- Patients actively being evaluated for heart transplant or LVAD.
- HF patients (followed longitudinally in the HF clinic) that are critically ill and require admission to the cardiac ICU.
- The Cardiology Triage provider may ask the HF service to admit HFrEF patients on a case-by-case review based on the service census and acuity of the inpatient teams.

Strong preference for UH CVM Service or Meriter with cardiology consult

- Intermediate or Low Risk Non-ST Elevation Acute Coronary Syndromes.
- Acute decompensated heart failure with reduced ejection fraction (EF \leq 40%)
- Acute decompensated heart failure with preserved ejection fraction (EF > 40%) driven by valvular disease or a new and/or uncontrolled arrhythmia.
- Syncope thought to be related to an arrhythmia, ischemia, or structural heart disease.
- Pericardial tamponade.
- Supraventricular tachycardia requiring admission, other than atrial fibrillation, as a primary diagnosis, without significant acute co-morbid medical conditions. (Most SVT cases may safely be discharged from the ED with outpatient cardiovascular evaluation and follow up.)
- Patient post-cardiac procedure with vascular access issues/complications.
- Significant Brady-arrhythmia requiring temporary pacing (Mobitz type II, complete heart block, profound sinus bradycardia associated with hypotension). Patients that may need an urgent pacemaker can be considered for admission to UPM on limited basis, especially if presenting to the ED at Meriter. This will be determined by the Cardiology Triage Provider in collaboration with the Interventional Cardiology team.
- Endocarditis complicated by heart failure, prosthetic valve involvement, left sided vegetation >1cm, and/or abscess. For outside transfers, the UW Health Triage Cardiologists should be involved in each case of known endocarditis with these potential surgical indications to help decide on patient placement (UH vs Meriter). At UH, these patients will be admitted to CVM service for medical optimization prior to surgery. At Meriter, these patients will be managed by Hospital Medicine with a cardiology consult and the CVM consult team will directly communicate the specifics of the case to the CT surgical team to determine timing/location of CT surgical consult and to determine if transfer to UW is warranted.

Strong preference for TAC/Meriter/UH Hospitalist service with cardiology consult as needed

- Type 2 myocardial infarction patients.
- Atrial fibrillation without underlying structural heart disease
- Acute decompensated heart failure with preserved ejection fraction (EF > 40%) without valvular disease or a new and/or uncontrolled arrhythmia.
- Endocarditis with none of the following: heart failure, prosthetic valve involvement, left sided vegetation >1cm, or abscess.
- Syncope NOT thought to be related to an arrhythmia, ischemia, or structural heart disease.
- Patients under the age of 18 are strongly preferred for AFCH

VII. Cardiac Surgery

- Any patient requiring the services of cardiac surgery should with strong preference be admitted to UH.
- Patients under the age of 18 are strongly preferred for AFCH

VIII. Colo-Rectal Surgery¹

IX. Dermatology

Patients being admitted with the following dermatological conditions should be preferentially admitted to University hospital

- Drug Rash with Eosinophilia and Systemic Symptoms (DRESS)
- Steven Johnson Syndrome (SJS)
- Toxic Epidermal Necrolysis (TEN)
- Staphylococcal scalded skin syndrome
- Pemphigus
- Pemphigoid
- Pyoderma gangrenosum
- Other conditions such as vasculitis that would require intensive multi-specialty workup (discuss with dermatology on call prior to location assignment)
- Meriter may be preferred for other secondary skin conditions or admissions for wet wraps (erythrodermic eczema or psoriasis)
- Telederm is available at TAC but can be logistically difficult. If TAC placement is considered, please discuss with dermatology on call prior to placement.
- Patients under the age of 18 are strongly preferred for AFCH

¹ Criteria in Progress

X. Emergency General Surgery²

XI. Endocrine Surgery³

XII. Endocrinology⁴

XIII. ENT/Facial Trauma

Patients with preference for admission to UH

- Patients with head and neck injuries secondary to trauma requiring facial trauma evaluation and/or treatment.
- Patients with head and neck injuries requiring complex airway management
- Patients with primary or secondary head or neck conditions not typically amendable to outpatient or emergency department treatment and discharge. Examples include but are not limited to:
 - Ludwigs angina
 - Buccal space infection
 - Parapharyngeal space infections

Patients with preference for admission to Meriter

- Patients with a secondary head or neck conditions requiring evaluation or treatment by otolaryngology that would typically be managed in an outpatient or emergency department setting who are being admitted for an unrelated primary reason. Examples include but are not limited to”
 - Sinusitis
 - Epistaxis
 - Peritonsillar abscess

Patients with primary or secondary head and neck conditions requiring otolaryngology evaluation and treatment should not be preferentially admitted to The American Center.

XIX. Family Medicine

- Patients under the age of 18 are strongly preferred for AFCH

² Criteria In Progress

³ Criteria In Progress

⁴ Criteria in Progress

Regional and Clinic Calls to the Access Center

- Patients with a PCP in UW Family Medicine Residency Clinics([Link](#)) should be preferentially admitted to UH unless:
 - UW Family Medicine Service is capped
 - Patient list >13 from 7a-6p
 - Patient list >15 from 6p-7a
 - UW General Medical Census is Red
 - If any of the above criteria are met the patient may be better served by admission to TAC or Meriter hospitalist service if not meeting other non-preferred criteria for those sites
- Patients with a Family Medicine PCP not in a residency clinic in the above link needing general medicine admission should preferentially be admitted to a TAC or Meriter Hospitalist Service instead of UH FM unless the following in which case University Hospital Family Medicine may be preferred:
 - The UW general care census is green and
 - The UW family medicine service is open (not capped) and
 - The Family Medicine PCP has a specific reason for placement at UH and
 - The patient does not meet exclusion criteria for admission to TAC or Meriter

Patients in UH ED

- Patients with a PCP in UW Family Medicine Residency Clinics([Link](#)) should preferentially be admitted to UH unless:
 - UW Family Medicine Service is capped⁵
 - Patient list >13 from 7a-6p
 - Patient list >15 from 6p-7a
 - UW General Medical Census is Red

If any of the above criteria are met the patient may be better served by admission to TAC or Meriter hospitalist service if not meeting other not preferred criteria for those sites
- Patients with a Family Medicine PCP not in a residency clinic in the above link should preferentially be admitted to a TAC or Meriter Hospitalist Service instead of UH FM unless the following in which case admission to the University Hospital Family Medicine service may be preferred:
 - The UW general care census is green and
 - The UW family medicine service is open (not capped) and
 - The patient does not meet exclusion for admission to TAC or Meriter

⁵ Any “cap” referenced in this Playbook reflects a preference and there may be situations where the “cap” is exceeded. For example, patients presenting to the UH ED with unstable emergency medical conditions requiring admission will be admitted to UH despite a cap if UH has the capability and capacity to treat the patient.

Patients in Meriter ED

- Family Medicine patients seen in the Meriter ED who require general medical admission should preferentially be admitted to Meriter or TAC unless otherwise meeting Meriter general medicine or TAC non-preferred criteria
- If capacity constraints may delay admission at Meriter then preferentially follow the process for “Patients in UH ED”

Patients in the TAC ED

- Family Medicine patients seen in the TAC ED who require general medical admission should preferentially be admitted to TAC unless meeting TAC general medicine exclusion non-preferred criteria. Consider Meriter unless meeting Meriter general medicine exclusion criteria.
- If capacity constraints may delay admission at TAC, then preferentially follow the process for “Patients in UH ED”

XV. Gastroenterology Procedures

- Patients under the age of 18 are strongly preferred for AFCH
- No patients requiring GI intervention should preferentially be admitted to TAC
- Patients can be preferentially admitted to Meriter unless one of the non-preferred criteria are met:
 - Need for Endoscopic Ultrasound
 - Liver patient with active variceal bleed
 - Liver transplant patient with active GI bleed
 - Pt. who may need TIPS
 - Pt. with known or suspected variceal bleeding
 - Recurrent GI bleed patients who made need a double balloon procedure for obscure bleeding
 - Pt. with Tephritis
 - Pt. on research protocols/medications related to IBD treatment
- *The patients with the following should be discussed with the on-call GI attending provider before admission to a hospitalist service to determine best care.*
 - *Patients who will require an ERCP should be discussed with GI on call attending prior to determining preferred admission site.*
 - *Patients being transferred from outside hospitals, UW ER or TAC ER*
 - *Weekdays 8-5 AM contact assigned ERCP attending*
 - *Weekday nights contact on call attending*
 - *Weekend Fri 5 PM – Monday 8 AM contact ERCP on call*
 - *admitted thru Meriter ER*
 - *Contact Meriter attending*
 - *Weekday nights contact on call attending*

- Patients being admitted for IBD related concerns should be discussed with the GI attending on call prior to placement.
 - IBD patients requiring admission for IBD related issues should preferentially be admitted to the location that their IBD gastroenterologist practices at. This will preferentially be UH except for patients followed by Meriter based GI in which case Meriter is the preferred admission site for:
 - **Antonio Bosch**
 - **Siobahn Byrne**
 - **Bryan Magenheimer**
 - **Jay Stangl**
 - **John Williams**
 - IBD patients requiring surgery may be preferred for Meriter if Dr. King is available to perform the needed intervention. GI attending provider will discuss case with Dr. King. If not available IBD patients requiring surgery should preferentially be admitted to UH.
- Patients with IBD with abscess on imaging may be managed at Meriter if IR resources are available, otherwise will require admission at UH. Discuss case with GI attending on call provider
- In times when capacity constraints or other factors may affect placement of patients based on this guideline contact the GI attending provider, as they will help problem solve to meet the needs of our patients where we can provide the best most timely care.

XVI. Gynecologic Oncology

- Patients under the age of 18 are strongly preferred for AFCH
- All patients being admitted for care related to their known or suspected gynecological malignancy should preferentially be admitted at UH

XVII. Hematology

- Patients under the age of 18 are strongly preferred for AFCH
- Non-preferred criteria for admission to TAC and Meriter
 - Any patient receiving treatment for a heme malignancy with the previous year
 - Any patient with suspected recurrence of their malignancy
 - Any patient suspected of microangiopathic hemolytic anemia (TTP, HUS)
- Any patient with active autoimmune hemolytic anemia or thrombocytopenic purpura

XVIII. Hepatology

Patients under the age of 18 are strongly preferred for AFCH

University Hospital strongly preferred (Liver Transplant Service or General Medicine with Liver Consult):

- All Liver Transplant Recipients
 - EXCEPTION – Elective surgery (i.e. joint replacement) in an otherwise stable post-transplant patient may be preferred for Meriter or the American center
- Patient with known cirrhosis AND
 - Waitlisted for Liver Transplant (see episodes of care tab)
 - Undergoing evaluation for transplant (see episodes of care tab)
 - Has been referred for Liver Transplant evaluation (see episodes of care)
 - MELD-Sodium score 15 or higher
 - Primary reason for admission is related to hepatic decompensation, regardless of MELD
 - Difficult to control or worsening ascites
 - Hepatic encephalopathy
 - New AKI with Cr > 1.5 mg/dL
 - GI bleeding
 - Known history of varices OR clinically obvious liver decompensation AND hemodynamically significant upper gastrointestinal hemorrhage (SBP < 80, tachycardic, likely heading to ICU status or may need TIPS)
- Hepatic tumors
 - Any patient with a known or suspected primary hepatic tumor (HCC or cholangiocarcinoma)

Patients below will likely be strongly preferred for admission to UH, however if admission to Meriter or TAC is being considered for other reasons hepatology on call should be contacted to discuss the case prior to location assignment to ensure best care can be provided.

- A patient without known liver disease BUT high clinical suspicion for liver disease
 - MELD > 15 or overt jaundice
 - Obvious clinical decompensation
 - Ascites
 - Presumed hepatic encephalopathy
- Acute Liver Injury (new injury) not suspected secondary to viral hepatitis – Defined as ALT and/or AST > 500 without a previous history of liver problem and no evidence of biliary obstruction
 - Primary reason for admission is liver related
 - Jaundice
 - Acetaminophen ingestion (known or suspected)
- Patients not meeting the criteria above can be preferentially admitted to Meriter or TAC (i.e. cirrhotics with a MELD-sodium score of less than 15 AND controlled complications of cirrhosis AND are being admitted for a non-liver related indication)
- Patients should not preferentially be admitted to TAC if they have a known liver issue that will require Hepatology subspecialty consultation

XIX. Hospital Medicine/General Medicine

- Patients under the age of 18 are strongly preferred for AFCH
- Patients with need for acute admission due to a medical problem or a combination of active medical and surgical problems, AND
- Patients are not better served on a medical or surgical specialty service (see preferred /non-preferred criteria in this playbook)
- Patients recently admitted to a specific Hospital/General Medicine service should be readmitted if the same care team, attending physician, and location (i.e. should "bounce back") as long as a strong argument can be made that the patient's care will benefit from continuity. If the desired admitting location is currently in red status, the patient should preferentially be admitted to another UW Health location unless they are meeting non-preferred criteria.

XX. ICU-Meriter

- Strong non-preferred list for the ICU:
 - Patients needing:
 - Post cardiac arrest with underlying cardiac etiology
 - Transplant or have had a transplant within the last 90 days
 - Cardiac Surgery
 - ECMO/Ventricular assist device (essentially, any invasive cardiac support that is more than an intra-aortic balloon pump- IABP)
 - TIPS procedure
 - Care due to severe burns
 - Endovascular CNS intervention due to a subarachnoid hemorrhage or endovascular thrombectomy
 - Care for traumatic injuries or ongoing care related to mechanisms of injury except in the case of:
 - necessary stabilization of critically ill patients prior to transfer
 - isolated traumatic brain injuries with neurosurgical consultation
- Preferred criteria
 - Patients under the age of 18 who are pregnant and require ICU level of care are preferred for the Meriter ICU in most cases
 - In addition to caring for hemodynamically unstable patients, Meriter also takes patients who need:
 - IABP
 - Plasma exchange
 - Continuous renal replacement therapy
 - ICP monitoring/ventriculostomy drains
 - Targeted Temperature Management

- Proning therapy/Rotoprone

XXI. IMC-Meriter Preferred

- Not Intubated,
- staffed RN 3-1, drips
- minimal titration (this is dependent on the types of drips),
- BiPAP okay
- Hospitalist Managed

XXII. Medical Transplant Kidney

- Patients under the age of 18 are strongly preferred for AFCH
- Patients <12mo out from surgery should preferentially be admitted to UH
- Patients should preferentially be admitted to UH if:
 - They are experiencing fevers
 - Have acute renal insufficiency or are not at their baseline renal function
 - Have unexplained abdominal pain
 - Have been diagnosed with an opportunistic infection
 - Have been diagnosed with a post-transplant malignancy
- Patients who do not have any of the above exclusions may be considered for TAC or Meriter Hospitalist service if:
 - Patient is unlikely to require renal transplant service consultation.
 - The admitting diagnosis is unlikely to require modification of the patient's immunosuppression.
 - The admitting diagnosis is unlikely to decrease the patient's renal function.
- If considering admission to Meriter or TAC the case must first be discussed with medical transplant staff physician to determine best care for the patient, followed by the appropriate hospitalist for admission

XXIII. Medical Transplant Liver and/or Pancreas

- Patients under the age of 18 are strongly preferred for AFCH
- All liver and pancreas transplant patients should preferentially be admitted to UH
- Patient <3mo out from surgery

XXIV. Medical Transplant Lung

- Patients under the age of 18 are strongly preferred for AFCH
- All patients with planned or completed lung transplant requiring admission should preferentially be admitted to UH

XXV. Minimally Invasive Surgery⁶

XXVI. Neurology

- Patients under the age of 18 are strongly preferred for AFCH
- Any patient requiring admission for known or suspected ischemic stroke should be triaged by paging UH “Stroke Staff” prior to admission to UH or Meriter
- Patients with non-stroke complaints requiring admission for neurological issues can be preferentially admitted to Meriter except for:
 - Patients in refractory status epilepticus should preferentially be admitted to University hospital
 - Patients with complex neuromuscular disease should preferentially be admitted to University hospital
- Patients with neurological issues needing admission should not preferentially be admitted to TAC

XXVII. Neurosurgery

- Patients under the age of 18 are strongly preferred for AFCH
- Most neurosurgery patients will preferentially be admitted to UH, however patients already in the Meriter ED with the following are usually preferred for admission to UH but may be appropriate for Meriter:
 - aneurysmal subarachnoid hemorrhage
 - strokes with need for possible endovascular treatment
 - Neurosurgical issues with co-morbid conditions that exceed Meriter ICU capability
- Neurosurgery attending should be involved in all regional referrals to determine best location (Meriter or UH)
- Neurosurgery patients are not preferred for admission to TAC

XXVIII. Obstetrics and Gynecology

- Patients requiring admission for OB/GYN issues should preferentially be admitted to Meriter
- For any patient under the age of 18 and not pregnant that requires admission or a procedure for a Gynecological condition there is a strong preference for AFCH
- For gyn onc admission see separate playbook section

⁶ Criteria in Progress

XXIX. Oncology

Non-preferred for admission to TAC

- Patients with solid tumors and:
 - Neutropenic Fever
 - Complications from chemotherapy
 - Require inpatient chemotherapy
 - Require inpatient radiation therapy
 - May need an oncology consult

Preferred/non-preferred criteria for Meriter and University Hospital

- Patients should preferentially be admitted to UH oncology service for known or anticipated procedures related to their oncological disease
 - Colon CA with SBO, pleural catheter placement due to lung CA, GI stenting for GI CA, etc.), or require certain therapeutic procedures such as chemoembolization-except in cases which are to be preferentially admitted to the Hospitalist service
 - HCC or lung mass ablations pre for admission to hospital medicine at UH
 - Require inpatient radiation therapy

- Patients with solid tumors and:
 - Neutropenic Fever
 - Complications from chemotherapy
 - Require inpatient chemotherapy
 - Were referred to UH or Meriter by outside oncologist

Should be preferentially admitted to the hospital associated with their oncologist.

Patients should preferentially be admitted to UH oncology service unless followed by one of the following oncologists

- **Dr. Rob Hegeman**
- **Dr. David Hei**
- **Dr. Mike Huie**
- **Dr. Saurabh Rajguru**
- **Dr. Amy Stella**

These patients should preferentially be admitted to Meriter hospitalist service with oncology consult.

- Patients under the age of 18 are strongly preferred for AFCH

XXX. Ophthalmology

- Patients under the age of 18 are strongly preferred for AFCH

- Patients needing ophthalmology procedures or consultation are non-preferred for admission to TAC
- Patients needing ophthalmology procedures or consultation are non-preferred for admission to Meriter
- Most patients requiring admission for primary ophthalmology evaluation will be preferentially admitted to UH

XXXI. Orthopedics

- Patients under the age of 18 are strongly preferred for AFCH
- Preferred for Admission to TAC Ortho
 - Infected joint replacement
 - Isolated wrist, hand, foot, and ankle fractures (per on-call physician)
 - Non-fracture spine (per on-call physician)
- Preferred for admission to Meriter Ortho
 - Hip fractures (per call physician)
 - Isolated foot and ankle fractures (per on-call physician)
 - Isolated wrist/hand (per on-call physician)
 - Non-operative stable pelvic fractures
- Preferred for Admission to UH Ortho
 - Trauma (level 1 & 2)
 - Long bone fractures (femur, tibia, humerus)
 - Peri-prosthetic fractures
 - Open fractures
 - Spine fractures
 - Pediatric fractures
 - Pelvic fractures
 - Elbow fractures
 - Shoulder fractures
 - Hip fractures (per on-call physician)
- All admissions should be discussed with on call orthopedic resident/ faculty to determine best care for the patient

XXXII. Palliative Care

- Patients under the age of 18 are strongly preferred for AFCH
- Palliative Care can be provided preferentially by UH and Meriter. Patient preference should be used to determine placement

XXXIII. Pediatrics/NICU

- Most pediatric admission should be preferentially admitted to AFCH except:
 - Neonates with Hyperbilirubinemia requiring admission will most commonly be admitted to the general pediatric hospitalist team at AFCH. If the following are present discussion with the AFCH NICU attending should occur for triage prior to placement decision in general care vs NICU:
 - Referring provider anticipates exchange transfusion may be needed
 - Neonate demonstrates vital sign instability
 - Neonate demonstrates excessive irritability
 - Neonates requiring NICU level of care should be discussed with the AFCH NICU attending for triage prior to placement decision.
 - All neonates being discussed for admission who have been discharged from the Meriter or AFCH NICU within the preceding 7 days should be discussed with the AFCH NICU attending before placement.
 - Pediatric patients who are pregnant and in their 3rd trimester may be preferred for admission to Meriter. OB and Pediatrics staff should discuss these cases prior to placement.

XXXIV. Psychiatry

- Psychiatry non-preferred criteria for admissions to TAC
 - Patients requiring in person psychiatric consultation during admission. (Tele consults are available)
- Meriter and UH have similar psychiatric capabilities and preferred admissions decisions should be based on each site's real-time capability to care for the patient
- Patients under the age of 18 are strongly preferred for AFCH

XXXV. Rheumatology

Patients preferred for admission to University Hospital

Patients that carry a diagnosis of:

- SLE
- Polymyositis/dermatomyositis
- Scleroderma
- Relapsing polychondritis
- Raynaud's (requiring hospitalization for critical ischemia)
- Behcet's disease

- Vasculitis (except giant cell arteritis)
- Sarcoidosis (neuro/cardiac)
- Any rheumatic disorder with interstitial lung disease
- Antiphospholipid syndrome
- Autoinflammatory diseases (includes FMF, Still's disease, TRAPS, Muckle-Wells, NOMID/CINCA, DADA2)
- Macrophage activation syndrome (MAS)

Patients under the age of 18 are strongly preferred for admission to AFCH

Preferred for admission to TAC or Meriter

Patients that carry a diagnosis of:

- RA
- Psoriatic arthritis
- Ankylosing spondylitis
- Giant cell arteritis (preferred for Meriter not preferred for TAC)

Patients with the following condition may be preferred for TAC or Meriter after consultation with radiology to determine the availability of MSK ultrasound at the preferred site.

- Gout
- Pseudogout
- Septic arthritis
- Acute mono arthritis

XXXVI. Surgical Oncology⁷

XXXVII. Thoracic Surgery

- Patients with chest tubes not requiring surgical intervention can be preferentially admitted to Meriter hospital medicine service with consultation from pulmonary medicine
- No patient with or who is likely to require a chest tube should be preferentially admitted to TAC

⁷ Criteria in Progress

- Patients being admitted with chest tubes status post recent thoracic surgery or admitted as a complication of thoracic surgery should be preferentially admitted to UH
- Patients in need of possible thoracic surgery should be admitted with strong preference to UH
- Patients under the age of 18 are strongly preferred for AFCH

XXXVIII. Transplant Surgery Cardiac

- All patients with a heart transplant should be preferentially admitted to UH
- Patients under the age of 18 are strongly preferred for AFCH

XXXIX. Transplant Surgery Kidney or Pancreas

- Patients who are <3 months post op from transplant
 - All should be admitted with strong preference to UH
- Patients under the age of 18 are strongly preferred for AFCH

XL. Transplant Surgery Liver

- Patients who are <3 months post op from transplant.
 - All should be admitted with strong preference to UH

XLI. Trauma Surgery

- Patients seen and evaluated at UH for a traumatic injury being admitted for treatment of the traumatic injury should be admitted with strong preference to UH.
- Patients seen and evaluated at UH who are found to have a traumatic injury but will be admitted predominately for a medical issue should be admitted preferentially to UH and non-preferentially to Meriter or TAC.
- Patients evaluated at TAC who need admission for care of their traumatic injury should be admitted with strong preference to UH.
- Patients evaluated at TAC who are found to have a traumatic injury but require admission for a predominately medical issue can be preferentially admitted to TAC if no other TAC non-preferred criteria are met.
- Patients evaluated at Meriter or come to Meriter through the access center who are found to have a traumatic injury but are being admitted predominately for medical reasons can be preferentially admitted to Meriter or TAC if no other TAC or Meriter non-preferred criteria are met.

XLII. Urology

- No patient requiring urology consult or intervention should be preferentially admitted to TAC
- Urology admissions from the ED should be discussed with urology. Urology attending (Meriter and TAC ED) or Urology adult res ER/Consult (UH ED) to determine preferred admission location.
- In general, the following patients are preferred for Meriter.
 - They are being admitted from an ED for management of nephrolithiasis.
 - Patients that are recently post-op from a procedure performed at Meriter.
 - Patient is followed by Meriter urology attending (list below)
 - **Sarah McAchran**
 - **Brian Le**
 - **Tudor Borza**
 - **Chris Manakas**
 - **Craig Kozler**
 - **David Paolone**
- Most Regional Referrals should preferentially be admitted to UH, discuss with on-call urology attending.

XLIII. Vascular Surgery

- Non-preferred for admission to TAC and Meriter
 - Vascular patients should not preferentially be admitted to TAC
 - Patients with emergent vascular intervention or operation needs should be with strong preference admitted to UH
 - Patients with other non-emergent conditions still requiring admission to vascular surgery may be considered for preferential admission to Meriter
- All patients considered for admission to vascular should be discussed with on call vascular surgery attending to determine best care for the patient

XLIV. Wound Service

Rationale: “Complex wounds” are wounds that require a specialized wound nurse &/or provider to perform and oversee wound care, wound cares that use extra medications necessitating special monitoring, or if there is a need for a multidisciplinary approach to the treatment (i.e. ortho/plastics/vascular, etc).

Patients who need to stay at UW:

- Burns
- Frostbite
- Necrotizing fasciitis

- TENS
- Purpura fulminans
- Complex surgical wounds – requiring VACs, dressings that the bedside nurse is unable to complete
- Wounds with fistulas/ostomies involved in wound area
- Complex painful wounds requiring extensive wound care and pain control
- Complex pressure ulcers that require multidisciplinary approach (ortho/plastics interventions in the long run)
- LE edema that requires compression wraps (UW or Meriter – Not TAC)

Patients who could go to Meriter:

- Complex pressure ulcers that are currently managed by Meriter Plastic Surgeon Dr. Jeff Larson or Meriter Wound Physician Dr. Ifat Kamin
- LE edema that requires compression wraps (UW or Meriter – Not TAC)
- If unsure about triaging, please call the Burn Unit 263-1490 and ask to speak to the Care Team Leader. They will be able to help you with the decision. The use of ImageMover (or future image capture applications) to upload images into the EMR will facilitate the discussion if possible. If there are still questions, please admit the patient to UW and the Burn and Wound service will triage as soon as they are able to evaluate the patient and determine needs.
- No patients with complex wound needs should be triaged to TAC – this includes cellulitic swollen legs that require compression.

XLV. Escalation Procedure

- Providers and Access Center should follow the playbook unless the playbook creates a patient safety issue or does not account for a unique clinical situation or unstable emergency medical condition.
- If there is disagreement on service, location, or level of care the UWHealth (including Meriter) attendings involved should discuss and decide on best course of action for the patient.
- If in the rare event the attending provider discussion does not lead to resolution, then the issue should be escalated in the following manner:
 - Division Heads or equivalent for the involved services should be contacted to remedy the barrier.
 - Department Chairs for the involved services should be contacted to remedy the barrier.
 - Chief Inpatient Medical Officer/s for the involved hospital/s should be contacted to remedy the barrier.

- UWHealth Chief Clinical Officer should be contacted to remedy the barrier.

