Geriatric Trauma Admission Pathway (12/05/17)

≥65 years old

- <5 medications
- Functional status independent
- No active medical issues

→ **Admit to TACS**
- TACS to manage

- ≥5 medications
- Partial/fully dependent fx status
- Admitted from nursing facility
- Multiple medical comorbidites
- ≥75 *without* aforementioned criteria

→ **Admit to TACS**
- **Medicine Consulted** for co-management

- Active medical issue resulted in minor traumatic injuries*

→ **Admit to Medicine or ACE**
- **TACS Consulted** for co-management

Transfer of Patients:
- Transfers from TACS to HMS may be appropriate if the patient's medical issue (either acute or chronic), not directly related to trauma, requires more frequent assessment or more intensive management than can be handled by the Medicine Consult Service.
- **Patients will be deemed appropriate for transfer to HMS based on collaborative evaluation by the Surgical and Medical Consult teams**

TACS Team Responsibilities
- H&P, Admission/discharge orders,
- Code status at time of admission
- Management of diet, bowel regimen, wound care, drain care, DVT prophylaxis, perioperative abx prophylaxis
- Discharge: transfer, discharge summary, coordination of discharge to home vs SNF

Shared Decision making:
- *Treatment of infections*
- *Pain management*
- *Transfusions*
- *Fluid management*
- *Anticoagulation*

HMS Team Responsibilities
- Management of chronic medical problems (Asthma, COPD, CHF, DM, Dementia, HTN etc), including adjustment of medications
- Identification of durable power of attorney/proxy decision maker
- Performance of frailty screening, cognitive impairment screening, elder/domestic abuse screening
- Management of acute medical issues as they arise
- Communication with PCP and other outpatient medical specialists on any changes in medical conditions
- Discharge: arrangement of primary care appointments

Examples:
- MI/Syncopal episode → fall → rib + ankle fx
- Wheelchair bound and frail → fall → multiple contusions + rib fx
- Fall on anticoagulation → no injuries identified on pan-scan, but cannot be discharged from ED due to need for medical optimization
- Fall → Small SDH, evaluated by NSG who feel no need to admit + ankle Fx to be repaired as outpatient → dementia with no home care, ankle pain for which cannot safely be discharged

effective 11/15/18

Geriatric Trauma Co-Management Guidelines

- The Medicine Consult Service will co-manage geriatric patients **(≥ 65 YO)** admitted to TACS. Patients should meet at least one of the following criteria:
    - ≥ 5 prescription medications
    - Functional status: partially or fully dependent
    - Admitted from nursing facility
    - Other active medical issues on admission for example: AKI, syncope, electrolyte derangement, active infection unrelated to surgical issue, etc.
      Or;
    - ≥ 75 years of age, even without the aforementioned criteria.
- TACS will be responsible for identifying patients that meet co-management criteria, placing the "IP Consult to Medicine" order in Epic, and calling the Medicine Consult Service (See AMiON: Hospitalist -> Medicine Consults section. Medicine Consult 2 APP listed as 1st call for TACS co-management Monday-Friday and Medicine Consult 2 Attending listed as 1st call Saturday-Sunday) with the consult.

Co-management Guidelines

Both teams of providers will be expected to write orders pertaining to their area of expertise and actively participate in the patient's inpatient care.

- **TACS TEAM WILL:**
    - Place admission and discharge orders, complete H&P, transfer/discharge summary, and will call consultants.
    - Make a good faith effort at medication reconciliation at the time of admission to ensure that patients do not miss critical medications. Hospitalists will also review home medications at the time of initial consult and reach out to family, primary care providers, or post-acute care facilities as necessary to ensure that the home medication list is accurate.
    - Enter code status upon admission, and share information with patients with regard to surgical options and prognosis
- **HOSPITALIST CO-MANAGEMENT TEAM WILL:**
    - Manage chronic medical co-morbidities (eg, hypertension, AFib, CHF, Diabetes
    - Review home medications upon admission and reach out to family, primary care providers, or post-acute care facilities as necessary to ensure that the home medication list is accurate.
    - Identify the medical durable power of attorney or proxy decision-maker
    - Facilitate goals of care discussions, including more in-depth conversations about code status, as applicable.
    - Perform fall assessment, frailty, cognitive impairment, and elder/domestic abuse screening as warranted.
    - Be proactive about preventing nosocomial complications (*e.g.*, delirium) and will manage acute medical issues as they arise.
    - Communicate with PCP and other outpatient medical specialists about any major changes in medical conditions.
    - Work with the care coordinator to arrange primary care appointment after discharge as warranted
- **HOSPITALISTS AND TACS WILL SHARE IN DECISION MAKING WITH REGARDS TO THE FOLLOWING:**: treatment of infections, pain management, transfusions (orders to be placed by TACS team), fluid management, and anticoagulation

- The primary point of contact for a given patient is the resident or APP who wrote the morning progress note. **They will be responsible for placing their contact information (pager or other phone number) in the daily progress note as part of their signature, in the form of a "dot phrase" or otherwise**.
- Hospitalists will write daily progress notes on co-managed patients.
- Patients will be admitted under the TACS attending's name.
- Any geriatric trauma patient admitted directly to the STICU will be managed by the Surgical Critical Care Team; TACS will call hospitalists for co-management once the patient becomes floor status.

- **Transfer of Patients:** Transfers from TACS to Medicine may be appropriate if the patient's medical issues begin to require more frequent reassessment and more intensive management than can be handled by the Medicine Consult Service. Criteria for transfer include:
    - Transfers must occur between 7AM-3PM, in order to avoid additional handoffs
    - Transfer patients should be anticipated to remain in the hospital for > 2 midnights
    - Transfer patients must be "floor" status, not "stepdown" status

Contact Information

Mary Anderson Wallace
Director, Medicine Consult Service
Pager: 303-266-3306
Email: Mary.Wallace@ucdenver.edu

Sarah Witowski
Assistant Director, Medicine Consult Service
Pager: 303-266-0609
Email: Sarah.Witowski@ucdenver.edu

Robert McIntyre
Director, TACS
Pager: 303-266-9887
Email: Robert.McIntyre@ucdenver.edu

Purpose

To outline the scope, duties, and logistics of the Trauma & Acute Care Surgery (TACS) co-management service.

Leadership

Marisha Burden, MD – Head, Division of Hospital Medicine
Robert McIntyre, MD – Director, Trauma & Acute Care Surgery Services
Eliza "Shevie" Moskowitz, MD – Resident, Department of Surgery
Mary Anderson Wallace, MD – Director, Medicine Consult Service
Sarah Witowski PA-C – Assistant Director, Medicine Consult Service
Brian Wolfe, MD – Director of Clinical Operations, Hospital Medicine Group

Trauma program certification requires that ≤ 10% of trauma patients be admitted to non-trauma services (*e.g.*, Medicine). On occasion, a patient has a traumatic injury that is minor enough to not warrant either 23-hour observation or inpatient admission but does have an acute medical issue that warrants observation or admission. In these circumstances, the patient is admitted to a medicine-based service through the usual ED process. The Medicine Consult Service, being separate from primary medicine teams, is not contacted in these instances.