UCLA Ronald Reagan Medical Center

**MS 125**

# Co-Management of All ICU Patients by Intensivist-Led ICU Team

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| ***Manual*** | Medical Staff | ***Effective Date*** | 01/31/2012 |
| ***Policy #*** | MS 125 | ***Date Revised*** | |
| ***Responsible Person*** | Director, Medical Staff Administration | ***Next Scheduled Review*** | 12/31/2020 |

## PURPOSE

To assure uniform, high-level patient care and safety in the intensive care units.

## SCOPE

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| 4-ICU | 6-ICU | 7-ICU | 8-ICU | NICU |
| PICU | Pediatric CTICU | CCU | | |

## POLICY

1. All patients admitted to an intensive care unit will be managed by the intensivist-led team based in that unit.

   A. This requirement can be accomplished in either of two ways:
      (a) the complete transfer of the patient's care to the intensivist-led team; OR
      (b) co-management by the service of origin and the intensivist-led service.

   B. The NICU will be managed in all cases by option (a) above.

2. Each ICU (Medicine, Cardiac Intensive Care, Surgery, Neurosurgery, and Pediatrics) will have a physician medical director, appointed by the Service Chief corresponding to the specific ICU. The unit medical director will be an intensivist who is trained and subspecialty board certified in critical care medicine, or neurocritical care. Because of the specific focus of the Cardiac Intensive Care Unit (CCU), its unit director will be a board certified cardiologist or equivalent. Exceptions to the requirement for Board certification must be substantiated by appropriate medical education and training, and extraordinary experience, endorsed by the Service Chief and reviewed by the Medical Staff Executive Committee.

   <u>Responsibilities of the Physician ICU Medical Director</u>

   - staffing the unit with qualified intensivists during daylight hours (7 am – 5 pm; 7 days/week);
   - ensuring that during the evening hours (5 pm – 7 am) the attending intensivists who are on-call for the unit will answer stat pages within 5 minutes 95% of the time;
   - coordinating care between the intensivist-led team, which may include respiratory therapists, nurses, clinical pharmacists, social workers, and case managers, and the primary service;
   - developing privileges and competencies required for intensivists in each unit and across units for Medical Staff approval;
   - in collaboration with the nursing unit director and primary teams, developing and maintaining relevant clinical protocols (including triage), unit specific admission and discharge criteria, and overall quality of care in the unit; and

- in the circumstances of co-management with a primary team, organizing structured communications between the intensivist team and the primary team to assure coordination of the care plan on at least a daily basis and more often as necessary.

3. During periods (days or shifts) when a physician member of the intensivist team is on service as an intensivist, he/she will have no other clinical responsibilities except as noted in below (#4), unless an appropriate attending-level intensivist designee is appointed during those hours. Specifically, the intensivist will not see patients in an office or clinic setting, perform surgery in the operating room, or provide anesthesia for surgical cases in the operating room while on duty in the ICU.

4. It may be necessary for an attending intensivisit to consult at the bedside on the care of patients located outside an intensive care unit due to acute or potential cardiac, circulatory, neurologic, or respiratory instability because those patients may require transfer to an ICU.

5. An intensivist-led team will round on each ICU patient every day.

6. In the circumstances of co-management with a primary team:

   - The attending intensivist, as well as residents and fellows working under her/his direction, and the primary team also, can write orders on ICU patients; and

   - The attending intensivist will submit professional claims for critical care services according to established billing guidelines.

   - In the event of a dispute between the intensivist team and the primary service over clinical care, attending from the respective teams must communicate. In the event attending level interaction does not resolve the differences, the applicable Service Chiefs will adjudicate and make the decision. In the event Service Chief interaction does not resolve the differences, the Chief of Staff, or designee will adjudicate and make the decision.

7. When a new patient is admitted to an ICU, it is the responsibility of the primary service to ensure that the intensivist-led service is informed about the admission and provided with an adequate sign-out, regarding the patient's history and current condition and the plans for care going forward.

Approvals:

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| Medical Staff Executive Committee: | November 17, 2011/Reviewed w/no revisions 12/31/2017 |
| Governing Body: | January 31, 2012/Reviewed w/no revisions 12/31/2017 |