**MOD Memo**

***The MOD memo is saved here by date created:*** *\\WRNMDFPISISMBD1\DeptShares$\Dept3\InternalMedicine\2024 - 2025 IM Residents\.MOD Memo*

\*\*\*Note – The MOD memo is a living document and should be updated semi-annually to reflect the dynamic changes that will happen to the MOD role. Please reach out to your class IMREC reps or the IM Chiefs with any suggested updates, information that is outdated or inaccurate, or new items that should be added to the MOD memo\*\*\*

**MOD General Expectations**

Be ready to take a call on the MOD phone at any time. Sign into the MOD on AMS.

You will get unexpected phone calls. You represent the Department of Medicine, so be pleasant, professional, and helpful. You may not know the answer but you can help figure it out or least direct the caller to the right department.

If you have a question, feel free to ask another resident or chief. If you are uncomfortable or unsure of next steps, the attending is always available. We are a team and are always happy to help. No need to reinvent the wheel.

Track all admitting, inbound, and consult patients on the board.

When in doubt about a situation or if ambiguities arise, the foremost priority is the safety of the patient. All decisions should be made in the best interest of the patient, If you are ever concerned about a situation, you are ALWAYS encouraged to involve an attending.

Anyone acting as MOD should keep the Charlie list IPASS’s updated for all consults/inbound patients (transfers or MEDEVACs). When tracking a patient for transfer, PAD should be asked to make a “preadmit” chart (after the patient has been accepted) so that this patient can be added to the IPASS. For inbound patients, include appropriate information such as arrival date, accepted ward, transferring physician contact, and location of origin.

Print and sign out the Team Charlie list with each change of shift (if the MOD phone changes hands, the list should be signed out).

If the MOD is declining a transfer/admission for any reason, this needs to be discussed with an attending. This provides top cover. In general, residents are empowered to say "yes" by themselves but should include attendings when we say "no.”

**Schedule**

Hours are 0600 to 1730 M-F; off on weekends, minimal manning days and federal holidays.

Hand off the MOD phone to the call resident at 1500. MOD is expected to remain available for consults between 1500 and 1730. However if the call resident is comfortable with the workload for that afternoon they can release MOD for the day. MOD is still expected to be available to return to the hospital should the call team need assistance.

MOD goes to noon conferences and Tuesday academics; pass the phone off to the chiefs who will answer and triage calls during noon conference (MOD holds it during Tuesday Academics).

Weekends/federal holiday/minimal manning days MOD is the on-call resident each day.

**Admissions – General Notes**

The ACGME Cap for admissions for one resident in a shift is 10 total patients (this includes the NMOD + AMOD night shift); the cap for admissions in consecutive shifts is 16. If you are approaching this admissions cap, day or night, reach out to the IM Chiefs ASAP.

Patients requiring trauma evaluation should be seen by TACS (see separate guidance on what qualifies as a trauma). TACS has the right of first refusal for trauma admissions, and if they decline the admission then we can admit.

There is no gestational-age cutoff for when pregnant patients are allowed to have an internal medicine primary. If the attending is comfortable with it and the issue is better served on an internal medicine service we can be the primary team.

**Admissions from the WR Emergency Room**

You are only expected to see patients if you have time and they seem sick but the admitting team is rounding, at RRT, or otherwise occupied.

NOD/PAD should be on the call for admissions. Notify the admitting team to see the patient after the call. If no inpatient beds are available, refer to the separate ED boarding/transfer policy.

Keeps teams and NOD updated on changes to patient disposition (changing teams, pausing admissions for dispo, etc). Refer to Cardiology and Oncology service admission criteria in the MOD room if there is a question.

Ask MICU to see the patient if you are concerned or they seem unstable.

**Admissions from NCR Emergency Rooms (Ft. Belvoir, Malcolm Grow, etc)**

NOD and PAD should be on the line for any transfers from NCR/DoD emergency rooms.

These patients have received a full ED workup and the ED provider is calling for an admission; if the level of care is appropriate (doesn’t need MICU etc.) then you are authorized to accept the patient. Since they have been seen by an ED provider in the system these are not considered direct admissions.

If you are concerned about the level of care you should discuss it with the transferring provider and the accepting attending (who is ultimately accepting liability for the patient).

During the day, the attending of record is the attending most likely to receive the patient when they arrive (if expected before 1500, follow the trickle system; if expected after, give to the call team)

If there are no beds available, see guidance at the end of this document (Section on Requiring Department of Medicine Chief Approval).

**Admissions from Regional Civilian Hospitals**

If an outside hospital requests a transfer to Walter Reed for continuity or escalation of care, NOD and PAD should be on the line.

If the request is for an escalation of care then confirm the following: what the transfer is for, whether we have the requested capabilities, and if the service responsible can offer them. You are authorized to call back the transferring provider if you need to verify this first. This includes anything requiring the expertise and resources of another service such as dialysis, surgical interventions, or IR.

NOD and PAD will confirm that the patient is eligible for care at Walter Reed and beds are available.

If the patient is eligible and a bed is available, you are authorized to accept the transfer with the attending of record to be the one most likely to receive the patient when they arrive (if expected before 1500, follow the trickle system; if expected after, can give to call team).

If no bed is available, see guidance below (especially if the patient is active duty).

If a bed is available but Walter Reed does not have the capabilities requested (such as a request for a heart transplant), you are authorized to decline the transfer on those grounds. Again, you are encouraged to verify and call back the transferring provider if you are unsure about what services we can provide.

Transfers from the VA are generally always eligible for escalation of care (if the patient themselves are not eligible, the VA is still covering the cost of care). As long as a bed is available and we have the requested services it can be reasonable. You must notify Department of Medicine Chief before accepting any VA transfers (see guidance at the end of this document, Section on Requiring Department of Medicine Chief Approval).

**OCONUS Transfers**

OCONUS (Outside the CONtinental United States) transfers to our inpatient services at Walter Reed for definitive care are one of the unique duties of the MOD to handle.

All calls should have NOD and PAD on the line to verify patient’s eligibility for care and bed status.

OCONUS transfers should always be discussed with the Department of Medicine Chief. Take a detailed message (including transferring provider/point of contact/chain of command) and discuss with the Department of Medicine Chief before accepting.

OCONUS Transfers requesting outpatient to outpatient DO NOT go through MOD; those are arranged between the facility and the requested outpatient clinic.

*Current Department Medicine Chief: Dr. Holtzclaw: 843-834-3320*

*A note on contacting foreign bases:*

*Foreign bases will give you a DMS number or international number. If you are having difficulty calling this, you can call the pentagon switchboard at 703-545-6700 for assistance in making the call!*

**Direct Admissions**

Direct admissions from a Walter Reed outpatient clinic to an IM team are permissible. You can accept these and trickle to the appropriate inpatient team if:

1. It is from a Walter Reed outpatient clinic. Other outpatient clinics in the NCR should send direct admits to their respective inpatient services or to the ED as appropriate (you need to be able to see the patient if needed).

2. The request is before 1500 (requests after 1500 should be sent to the ED).

3. The request is for a stable patient that requires inpatient observation or management of an established condition; any direct admit request that requires labs, imaging, or other clinical assessments to determine disposition and plan of care should be sent to the ED.

- For example, if ID has a case of TB presenting from the barracks that is clinically stable but cannot be sent back to their shared living quarters, that can be a direct admit. Requests for undifferentiated or urgent concerns that require further workup and disposition (such as shortness of breath, altered mental status, chest pain, evaluation for stroke, etc.) should be sent to the ED.

Direct admit requests should go through NOD/PAD with MOD on the line just as with other admissions.

The referring provider is responsible for facilitating nursing report between their clinic and the accepting unit.

The referring provider should arrange transportation for the patient. Hospital transport services are authorized (if the direct admit is too unstable for hospital transport services and requires EMS to be safely moved from clinic to ward, use your clinical judgement and consider ED evaluation if needed).

As with all admissions, feel free to see the patient yourself before accepting or call the attending if you are concerned. We are here to help our outpatient colleagues and facilitate the best possible care for our patients. If questions arise regarding disposition, you are encouraged to involve your attending for guidance.

Direct admits should be stable as outlined above, but as with any other admission, a mistriage can happen and clinical statuses will change en route or on arrival. This is part of the job and why we are here to facilitate these transitions of care. The most important thing is that the patient is in the hospital and will get the care they need.

**Admissions or Transfers from Non-Medicine Services at Walter Reed**

Most of the non-medicine services at Walter Reed are primary admitting teams as well but may request a medicine admission if the patient is medically complex. If they request a medicine primary and the patient is stable for a med/surg bed, you are authorized to accept these patients.

If the patient is in the ED or at an outside hospital, follow the guidance above for these admissions.

If the patient is inpatient at Walter Reed and it is a lateral transfer between services, triage the admission to a medicine team (day MOD) or do the admission directly (night MOD).

These requests from the non-medicine services are their way of asking for our help. When situations arise overnight or the utility of a medicine primary is ambiguous, air on the side of accepting the patient. We should help our colleagues and operate in the best interest of the patient, and the appropriate primary team can be sorted out later if needed.

If you are concerned that the request from a non-medicine service is inappropriate, you are encouraged to discuss it with your attending. Again, help our colleagues, stay professional, and air on the side of accepting the patient.

**Trickle System and Bounceback Admissions**

Follow the trickle system during the day. The order is T1, T2, on-call, and then repeat. The post-call team (team that was on call yesterday) is “protected” from NEW admissions to include overnight admissions after completing call, but not from bouncebacks.

Bouncebacks are defined as:

1. Readmissions or transfers to the same intern or resident during their time on service OR

2. To the same attending within 30 days of discharge

Check for bounce backs being admitted or transferred from other services. Bouncebacks take priority over the trickle system (for example, if the first admit of the day is a bounceback to T2, it should go to them).

If it is after 3 pm, the bounceback generally goes to the call team, but this can be discussed with the bounceback team and they can accept the patient as well.

**Code Blue/RRT**

Respond to and be prepared to run ALL code blues regardless of location aside from the OR and pediatrics. This is an infrequent but key MOD role and we are expected to run these Code Blues, so be ready to take on this responsibility.

If the day MOD is available, then respond to ALL Internal Medicine RRTs to ensure there is a resident on scene; if the team resident or MICU resident is present and comfortable taking lead then you do not need to stay (this is to make sure medicine team interns are not left alone running an RRT).

If an Internal Medicine RRT occurs overnight, Nighthawk is considered the primary team (as they should have received sign-out on the patient) and should lead the RRT.

**Consults**

MOD is responsible for all IM consults; day MOD from 0600 to 1730 and night MOD from 1730 to 0600.

Staff with the consult attending listed on Amion; touch base with the consult attending to establish expectations on workflow and when/how they prefer to staff consults. If you are worried about a patient or the consult is urgent, you are always encouraged to contact the attending (even during rounds).

Add consults to the consult team list and update the iPASS for each accordingly.

See consults early and write a note (can save without signing). Write using ‘Impression and Recommendation’ first then S/O. Genesis has a medicine consult template and examples are also in the Share Drive.

Call or AMS the team with recs early if possible.

Sign out each day’s consults to the night team; write active consults on the board. ALWAYS thank the consulting team for ‘allowing us to participate in this patient’s care”

MOD as consult is not expected to put in orders (a rule in general for consult services). Other primary teams should not be asking the MOD act as consult and put in the orders. You are authorized to put in individual orders as a convenience or courtesy if the primary team requests, but are NOT expected to do so routinely and can decline.

Co-management (medicine and another service both follow the patient daily and enter orders with medicine addressing most inpatient needs) is not offered due to the risk of miscommunication.

If the primary team is concerned about their ability to order things appropriately or a complex patient is better served with a medicine primary, you authorized to offer this to the consulting team. As always, you can discuss this with your attending if questions arise.

On the weekends, the call resident sees new consults. The consult attending sees consults from the week.

NOTE - You may be called by EMS about a patient with a Walter Reed PCM who has passed away outside of the hospital (ie passed away at home). This is NOT the responsibility of the inpatient admitting service/MOD and EMS should be directed to the ED/coroner/their chain of command for this.

**ICU Boarding**

Medicine patients only – if being asked to board patients in the MICU for oncology, this must be cleared through the oncology fellow and staff.

ICU teams will transfer patients as "ICU boarders" when the ICU team census is >=5. If the ICU team has <5 census then they will continue care for the patient until a med-surg bed is secured.

If a patient must be transferred for the purpose of dispositioning there will be a team discussion to ensure that the benefit of handoff for dispositioning outweighs the risk (such as when a patient in the ICU must be transferred to a med-surg bed at WR to facilitate transfer to a med-surg bed at another hospital).

Given the distance from the med-surg units, the MICU will respond to RRTs/codes until the IM team arrives.

Both the ICU and IM team (and MOD if necessary) should work with the NOD to evaluate bed availability to transfer patients as expeditiously as possible.

**Accepting Critical Lab Values**

You may get called by the WRNMMC lab or another facility in the NCR/DoD to accept a critical value; you must accept the lab value if the provider a physician in the NCR, is not reachable (outside of regular business hours), and it is for an ADULT MEDICAL case (not surgery, ob/gyn, pediatrics etc; refer them to the appropriate call team as needed).

Of course, if the lab needs to be acted upon, please contact the patient and provide guidance. You are to create an “In-Between” encounter in GENESIS to document conversation.

**Transfers or Admissions from Outside Hospitals Requiring Department of Medicine Chief Approval**

Department of Medicine Chief (as of 2024)

MAJ Arthur Holtzclaw: 843-834-3320 or AMS Connect

Reach out to Dr. Holtzclaw 24/7 for any of the below concerns

Active duty transfers:

• If bed available: admit

• If no bed available: Call Department of Medicine Chief above or Chief on Call

Non-AD transfers:

• If bed available: admit

• If no bed available: Call Department of Medicine Chief above or Chief on Call if the patient or member of the care team is insistent that the patient be transferred to WRNMMC

VA transfers:

• Call Department of Medicine Chief or Chief on Call

Additional phone numbers if unable to reach Chief on Call or Department of Medicine Chief POC above:

• COL Jason Blaylock: 301-448-7240

Joseph M. Maciuba, MD, MHPE

MAJ, MC

Program Director, Internal Medicine