Overview of Community Sites:

- There is an on-site pediatric hospitalist and PICU attending available for admission/consultation of patients 24/7.
- The clinical team will determine if the special needs of the patient can be addressed at the community sites. Decisions are made based on the skills set of the clinical team*, availability of consultants, and specialty care.
- West Campus: Acute Care includes 42 beds (24- 3W + 18- 5W) + 4 overflow on 4W. PICU includes 22 beds.
- Woodlands Campus: Acute Care includes 46 beds (3rd, 5th Floors). PICU includes 14 beds (4th Floor). NICU includes 14 beds (4th Floor).

Included below are exclusions based on monitoring needs and also diagnosis specific exclusions. These are general recommendations and should not replace discussion amongst the teams.

Please pay particular attention to the far-right column which includes exclusions for all Community sites (West and The Woodlands Campuses).

Woodlands NICU: Please discuss with NICU attending for all patients <44 weeks post gestational age prior to decision to transfer.

* The Clinical Team is defined as:

- Physician responsible for care
- RN responsible for care
- Physician receiving the patient
- NAC equivalent

Problem/Diagnosis	Acute Care (AC) Accept	Decision by Clinical Team	AC Exclusion, PICU Accept	Community Exclusion
Physiologic Parameters/Monitoring Needs				
Telemetry			X	
Non-rebreather mask for respiratory distress			X	
Continuous beta agonist treatment		X		
CRS				
• Score 4-5		X		
• Score >/=6 (and not improving)			X	
HFNC (max flow for cannula size and not improving)			X	
Glasgow Coma (non-trauma)				
• Score <9			X	
• Score 10-14		X		
Hourly or q2 hr assessments/treatments without expected imminent improvement			X	
Aggressive fluid resuscitation (> 60 cc/kg)			X	
Continuous EEG monitoring			X	
Hypothermia (<97F), q1 temp checks, Bare hugger warmer			X	
Infants weighing <2.5 kg				X[ǂ]
Diagnosis Specific				
Specialty care not available at Community Site		X		
Cardiology[#]- See Appendix A (Cardiology SOP Document)				
Drug ingestion with physiologic instability			X	
Endocrine				
• Diabetes, new onset Type 1 or 2, not in DKA	X			
• Diabetes in DKA, mild ketosis, HCO3 >15	X			
• Diabetes in DKA, HCO3 <15 (requiring insulin drip)			X	
• Diabetes insipidus		X		
• Persistent hypoglycemia in pt <6 mos				X[ǂ]

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Problem/Diagnosis	Acute Care (AC) Accept	Decision by Clinical Team	AC Exclusion, PICU Accept	Community Exclusion
Gastrointestinal				
• Hyperbilirubinemia – TSB within 2 below exchange lvl				X‡
• Presence/concern for portal hypertension				X
• GI bleed with hemodynamic instability o Hgb drop =/> 3 g/dl or Hgb 8-10 g/dl if unknown baseline				X
• Gallstone pancreatitis/biliary obstruction suspected and need for ERCP				X
• Acute liver failure (INR>/=2 or >1.5 w/ mental status changes)				X
• Transplant patients				X
Genetics/Metabolic				
• Suspected metabolic disorder				X
• Known metabolic disorder with risk of neurologic compromise or specialized formulas		X		

Problem/Diagnosis	Acute Care (AC) Accept	Decision by Clinical Team	AC Exclusion, PICU Accept	Community Exclusion
Hematology/Oncology				
• Anemia not requiring plasmapheresis/exchange transfusion		X		
• Need for plasmapheresis				X
• Malignancy requiring ongoing monitoring/intervention		X		
• Anticoagulation requiring heparin drip			X	
• Other anticoagulation		X		
• Confirmed new diagnosis malignancy				X
o Leukemia patients in induction chemotherapy				X

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Problem/Diagnosis	Acute Care (AC) Accept	Decision by Clinical Team	AC Exclusion, PICU Accept	Community Exclusion
• Deep venous thrombosis (NOTE: if new onset, large DVT, consider tx to MC for other specialized care)		X		
○ DVT- need for heparin drip			X	
○ DVT- need for vascular surgery				X
• IR procedures requiring catheter directed thrombolysis				X
• Pulmonary embolism				X
• Bone marrow transplant patients				
○ Transplant pts still under care of BMT team				X
○ Allogenic or autologous transplant pts no longer under care of BMT team (Discuss w/ Onc)		X		
Infectious Disease				
• Suspected bacterial meningitis in infant (1st 24 hours of admission): <60 days: CSF +GS +/-pleocytosis; >60 days-12 mos: meningitis score >/=2; ill-appearance any age			X	
Neurologic				
• Evidence/suspicion for stroke				X
• Intracranial process (bleed, mass) or need for intracranial monitoring				X
• Presence of altered mental status (not improving)			X	
• Progressive neuromuscular dysfunction			X	
• Seizures requiring frequent interventions (hourly)			X	
• Status epilepticus requiring continuous EEG			X	
• Infantile spasms – suspected new diagnosis				X
• Seizure in neonate <30 days (needs continuous EEG)			X	
• Acute inflammatory process requiring plasmapheresis				X
• Vagal nerve stimulator or baclofen pump malfunction/infection				X
Pregnant or Complications of Pregnancy				X

Problem/Diagnosis	Acute Care (AC) Accept	Decision by Clinical Team	AC Exclusion, PICU Accept	Community Exclusion
Psychiatric Diagnoses		X**		
Aggressive Behavioral Health Patients Requiring Multiple Medication Interventions (**During weekends and/or holidays when no in-person or telehealth available, patients with acute psychosis requiring urgent psychiatry evaluation should be transferred/direct admitted to Main Campus for in-person psychiatry consult)		X**		
Ophthalmologic				
• Pre-septal cellulitis without concern for post-septal involvement (Note: if <2 yrs, strongly consider CT to exclude orbital involvement)	X			
• Post-septal involvement, abscess, rapid progression, or need for frequent eye exams/surgical intervention				X
• Atypical presentation (no source of infection, concern for malignancy, etc.)				X
• Immunocompromised patient				X
Renal				
• Hypertensive emergency (neuro changes)			X	
• Oliguric renal failure requiring close fluid management			X	
• Need for peritoneal or hemodialysis				X
• Electrolyte abnml needing q1-2 blood draws or meds			X	
• Renal transplant patients				X
Respiratory				
• Recurrent apnea, unstable airway			X	
• Tracheostomy present			X	

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Problem/Diagnosis	Acute Care (AC) Accept	Decision by Clinical Team	AC Exclusion, PICU Accept	Community Exclusion
• Ventilator/Bipap/CPAP required			X	
• Pulmonary hypertension (requiring sildenafil only)			X	
• Severe pulmonary hypertension (requiring 2+ meds)				X
• Cystic fibrosis patients w/ complications of CF				X
• Lung transplant patients				X
Rheumatologic				
• Kawasaki requiring IVIG	X			
• Kawasaki needing Rheum evaluation (Not responding to 1st line tx, age <12 mos, coronary artery dilatations- discuss with Rheum)				X
• New diagnosis or worsening underlying primary rheumatologic conditions				X
• Suspected/confirmed MIS-C:				
○ without evidence of shock		X		
○ with evidence of shock (tachycardia refractory to aggressive fluid resuscitation [>60 cc/kg], AMS, etc.)			X	
○ evidence of cardiac failure				X
Trauma§ or Neurosurgical patients				X
Burn patients (considered Trauma)				X
Interventional Radiology				
• Arterial studies (diagnostic or therapeutic)				X
• Venous studies:				
○ Lesions with airway, head, or neck involvement				X
○ IR procedures requiring TPA, thrombolysis				X
○ Other venous/lymphatic malformations		X		
○ Patients requiring vascular surgery				X

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Problem/Diagnosis	Acute Care (AC) Accept	Decision by Clinical Team	AC Exclusion, PICU Accept	Community Exclusion
Neonatology			**WL NICU Accept**	
• Neonates up to 44 weeks post-gestational age		X		
• Infants weighing <2.5 kg			X	
• Neonates requiring subspecialty consultation at birth			X	
• Prematurity			X	

ǂ: Neonatology acceptance at The Woodlands Campus if bed availability. Discussion with neonatology service prior to acceptance from outside hospital.

§: See the TCH Trauma Services SharePoint for full trauma exclusions and algorithms.
https://texaschildrens.sharepoint.com/sites/Depts1_TraumaServices
Certain trauma patients involving only one organ system (ex: fracture) or trauma with mild complications (ex: dog bite with infection), may be admitted to Acute Care at Community Sites to appropriate surgical service. All non-accidental trauma (NAT) patients, including those medically cleared and pending CPS disposition, as well as all head trauma with complications (including concussive symptoms) should be transferred to the appropriate surgical service at the Medical Center Campus.

Appendix A

Cardiology Scope of Practice (SOP)- Texas Children's Hospital- Community Sites (Woodlands and West Campus)

Guidelines to admit cardiac patients for in-patient monitoring

***** ALL patients should be discussed with the cardiologist-on-call *****

	TIER III	TIER II	TIER I
	Admit to Community Site	**All attempts should be made to admit to Community Site**	**Transfer to Main Campus Cardiology**
Congenital Heart Disease	-Status post cardiac repair (>6wks), unless not approved by CT surgery -Unrepaired and stable biventricular heart disease (except in neonatal period)	-Status post Glenn/Fontan palliation, admitted for non-cardiac etiology -Cardiac diagnosis with palliative/comfort care	-PGE dependent lesions -Status post cardiac repair (<6wks) -Single ventricle (during inter-stage) awaiting Glenn -Congenital heart disease in the neonatal period, regardless of severity. -Unstable congenital and acquired heart disease
Heart Failure Transplant	-Status post-transplant (with preserved systolic function) admitted for non-cardiac etiology, unless not approved by the HF/TX team	-Cardiomyopathy patients with compensated heart failure (EF > 45%) and not requiring IV inotropic support, unless not approved by the HF/TX team	-Decompensated heart failure -Patients listed for heart transplant -Mechanical assist device -Any patients not cleared by the HF/TX team.

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	TIER III	TIER II	TIER I
	Admit to Community Site	**All attempts should be made to admit to Community Site**	**Transfer to Main Campus Cardiology**
Acquired Heart Disease	-Kawasaki with no evidence of toxic shock syndrome -Stable endocarditis in non-cardiac patients (line-associated, etc.) once discussed with multi-specialists and treatment plan has been initiated and established. Cardiology responsible for notifying the appropriate service *cardiology as the primary provider- will contact the primary team i.e. heart failure team; CV surgery team	-Stable Kawasaki with mildly dilated coronaries, unless not cleared by the Kawasaki team -Stable previous diagnosis of myocarditis/myopericarditis, unless not cleared by the HF/TX team -Endocarditis in patients with known congenital heart disease and to complete treatment (after initiation of therapy and work up in the MC), unless not approved by primary cardiologist and/or CT surgery	-Kawasaki with evidence of toxic shock syndrome or moderate/severe coronary artery dilation -Evidence of myocardial ischemia (i.e. elevated ST segments on ECG) -Endocarditis in patients; not approved by CT surgery -New myocarditis/myopericarditis
Arrhythmia	- New diagnosis or history of SVT responsive to medical therapy and/or vagal maneuvers, cardiology will contact the primary team (EP team), unless not cleared by EP team -BRUE patients with non-cardiac history (Holter to be placed)	-History of pacemaker placement admitted for non-cardiac diagnosis, unless not cleared by EP team -Status post successful cardioversion – for monitoring, unless not cleared the EP team	-SVT/arrhythmia requiring escalation of care, which includes need for drips (inotropic, chronotropic, antiarrhythmic) -Complete heart block -Need for telemetry, pacing, cardioversion (multiple times)
Procedures	-Clear with CV anesthesia	-Clear with CV anesthesia	-Need for procedures requiring CV anesthesia