ED to MEDICINE ADMISSION GUIDE

Patient warrants admission to a Medicine service*?

YES

High risk for clinical deterioration or unstable?

YES → MICU Consult or Admit Medicine Stepdown

NO

Assess for Saint Luke's Admission Pathway

YES → See guide for criteria/process (EPIC > Docs)

NO

Primary medical problem GI/Liver or Cardiology?

YES → Designated Pathways: *Cardiology* *GI (non-Liver)* *Liver*

NO

Admit to MSH Medicine

(1) Complete Provider Note text & key tests** before placing admit order
(2) In Updates, use .EDADMIT note for admissions triage summary
(3) Use 'ED Admit to IP - Medicine' order
(4) *Don't* call the MAPA. *Do* answer focused questions if MAPA calls you
(5) Give verbal hand-off to Medicine team (phone or in-person)***
(6) Document handoff in Progress Notes -> IP Handoff Documentation

* Is unfit for a RETU stay or admission to a surgical service.
** Labs/tests that could affect triage (ADS vs Teaching vs MPCU) must be resulted. The free text portion of the provider note must contain sufficient information for the MAPA to triage without a phone call. Include important updates (e.g. CTA negative for PE) and reason for admission
*** Sign out if not completed by end of your shift

ED Critical Care consult process

For ICU consults (patients requiring admission to an ICU) 24/7

COVID pending	COVID positive	COVID negative
-ED to call target unit SICU for a surgically ill pt MICU for medically ill NSICU for neuro CICU for cardiology pt -Target unit will do consult and triage patient -If ICU need identified, then target unit will employ bed management to locate a COVID negative bed in the appropriate ICU	**-ED to call target unit** SICU for a surgically ill pt MICU for medically ill NSICU for neuro CICU for cardiology pt -Target unit will do consult and triage patient -If ICU need identified, then target unit will employ bed management to locate a covid positive bed in the appropriate ICU	**-ED to call target unit** SICU for a surgically ill pt MICU for medically ill NSICU for neuro CICU for cardiology pt -Target unit will do consult and triage patient -If ICU need identified, then target unit will employ bed management to locate a covid negative bed in the appropriate ICU

For patients requiring non-ICU higher level of care

Admitted patients who have decompensated	Non-admitted patients requiring admission to stepdown level of care
- **Call RRT**	- **Admit to medicine team** for medical stepdown bed (Process is to call ED admitting team for admission, MAPA)

MICU consult phone: 646-784-5773
RRT consult pager: 1RRT
CVICU phone number: 49900

MICU phone number: 45721
Neurosciences ICU (KCC9): 45882
CTICU phone number: 47344

SICU phone number: 45111
TICU phone number: 47955
Annen 8 phone number: 42100

CICU (KCC6): 45882
MAPA phone : 78773
ED admitting team: see AMION

If any question, please reach out to Sanam Ahmed (sanam.ahmed2@mountsinai.org)

MICU vs Medical Stepdown Criteria
(If unsure - ask MICU Fellow)

System	9W (Medicine) Stepdown	Needs ICU
Monitoring or patient care	• Q2 hr vital signs • Q2 hr nursing interventions • Q2 hr nursing assessments • Q4 hr labs • New initiation of NIV • Won't benefit from ICU level of care	• Q1 hr vital signs • Q1 hr monitoring • Critical care medications
ID	• Sepsis including fluid-responsive hypotension, organ failure	• Septic shock
Cardiac	• Tachyarrhythmia with sustained heart rate >130 bpm • Recently weaned off vasopressors (>6h)	• Hemodynamic instability requiring vasopressors or hypertensive emergency requiring continuous intravenous medications
Pulmonary	• non-invasive positive pressure ventilation: BIPAP, CPAP, HFNC, FiO2<60%, RR<35 • *Sub-massive* pulmonary embolism (SBP>90, no vasopressor/inotropic support) with right heart strain on echocardiogram or elevated troponins/BNP	• high risk for intubation • Intubated • *Massive* PE and/or s/p catheter directed or systemic thrombolysis • non-invasive positive pressure ventilation: BIPAP, CPAP, HFNC with *altered mentation* • Increasing NIV requirements • NIV with FiO2>60% or RR>35 • Recent extubation with high-risk features requiring frequent monitoring or pulmonary physiotherapy
Neurology	• *Moderate* alcohol withdrawal • chronic neuromuscular disorders: protecting airway, no impending respiratory failure	• severe alcohol withdrawal • new onset stroke • opioid overdose with respiratory failure or requiring naloxone drip
GI	• GI bleed requiring q4h labs	• Hemodynamically unstable GI bleed
Endocrine	• Hypo- or hypernatremia requiring q4 laboratory monitoring	• Diabetic ketoacidosis or hyperosmolar state requiring insulin drip
Renal	• Hyponatremia with Na <125 • Hyponatremia requiring hypertonic saline (2%) if lab draws q4h or less frequent	• CVVH or aquaphoresis • Hyponatremia with Na < 120 • Hyponatremia requiring hypertonic saline (2% if lab draws more frequent than q4h or 3%)

Medical Stepdown Permitted Infusions

MEDICATION	DOSE
Amiodarone (Cordarone)	Initial bolus (stable tachyarrhythmia): 150 mg in D5W 100 ml IVPB over 10 min Maintenance dose: 1 mg/min x 6 hrs, then 0.5 mg/min x 18 hrs
Argatroban	Normal hepatic function: Start at 2 mcg/kg/minute Hepatic impairment/critically ill: Start at 0.2-0.5 mcg/kg/minute
Sodium bicarbonate gtt	6.25-50 mEq/hr
Digoxin iv	500 to 1000 mcg generally given over 2-4 doses every 4 – 6 hours as load
Hydromorphone (Dilaudid)	***For analgesia or for trach/vented patients*** Initial bolus: 0.2 – 0.4 mg over 2 min; Maintenance dose: start 0.2 mg/hour, MD will determine dose of medication
Morphine	***For analgesia or for trach/vented patients*** Bolus dose: 0.5-1mg IV push over 2 min; Maintenance dose: start at 1 mg/hr MD will determine dose of medication
Octreotide (Sandostatin)	25-50 mcg/hr
Pantoprazole	Loading dose: 80 mg IV Maintenance dose: 8 mg/hr x72 hours

ED to Cardiology Admission Guide

STEMI or possible CCU?

YES

STEMI Activation:
Weekday: x40935
Back-up page 917-827-9725.
Night/Weekend: Page 917-827-9725
CCU Consult:
x47222 or #0146.

NO

Patient requires admission to Cardiology?*

NO

Admit to Medicine +/- Telemetry

YES

Has a Sinai Subspecialist Cardiologist (page 2)?**

NO

MAPA Triage

(1) Open Admit to IP Medicine Order
(2) Admit to Cardiology Medicine
(3) Write .EDADMIT note
(4) MAPA Triages to Cardiology (ADS or Teaching)
(5) Give verbal handoff to inpt MD/PA/NP when called.

YES

EP***
Call Fellow (646 477 6969)

CHF/VAD/ Xplant***
Call Attend(347 758 2973)

IC***
Page IC fellow @ 0289.

Dr. Fuster
Call Fuster Fellow @ 646 438 3814

(1) Confirm Attending Name & Teaching vs ADS
(2) Open Admit to NON-IP Medicine Order
(3) Admit to Cardiology Medicine
(4) MAPA Triages ADS vs Teaching
(5) Give verbal haldoff to inpt MD/PA/NP when called

** Can admit to Medicine for non-cardiac volume overload, mild demand ischemia, AF w/ RVR concurrent with medical illness, SOB/dyspnea NOS, mild CHF unable to go to observation.*

*** Names a cardiologist on list or has an outpatient note from them. IP consults and cath interventions do not count.*

**** If admission dx unrelated to specialty area, follow MAPA Triage Admission instead.*

Please use the patient's Cardiology clinic notes in Epic to identify the patient's Cardiologist, then look them up in this list to call the correct number for admissions.

CARDIOLOGY SUBSPECIALISTS

To admit, page the appropriate service via AMION or page the cardiology attending via AMAC.

DO NOT call the General Cardiology Admission Fellow.

Chair/Director of Mt Sinai Heart:
Dr. Valentin Fuster
(calls should be directed to the Dr. Fuster fellow at 646-438 3814)

Heart Failure/LVAD/Transplant:
1. Dr. Maya Barghash
2. Dr. Johanna Contreras
3. Dr. Anu Lala
4. Dr. Donna Mancini
5. Dr. Sumeet Mitter
6. Dr. Noah Moss
7. Dr. Sean Pinney
8. Dr. Maria Giovanna Trivieri

Cardiac Cath Lab:
1. Dr. Usman Baber
2. Dr. Jeff Bander
3. Dr. Nitin Barman
4. Dr. George Dangas
5. Dr. Karthik Gujja
6. Dr. Vishal Kapur
7. Dr. Srinivas Kesanakurthy
8. Dr. Asaad Khan
9. Dr. Annapoorna Kini
10. Dr. Jason Kovacic
11. Dr. Prakash Krishnan
12. Dr. Atul Kukar
13. Dr. Pedro Moreno
14. Dr. Samin Sharma
15. Dr. Javed Suleman
16. Dr. Joe Sweeny
17. Dr. Matt Tomey
18. Sandeep Singla

Electrophysiology (EP):
1. Dr. Subbarao Choudry
2. Dr. Srinivas Dukkipati
3. Dr. Bill Frumkin
4. Dr. Tony Gomes
5. Dr. David Harnick
6. Dr. Jacob Koruth
7. Dr. Noelle Langan
8. Dr. Marc Miller
9. Dr. Vivek Reddy
10. Dr. Stuart Schecter
11. Dr. Aamir Sofi
12. Dr. William Whang

Draft: 10/29/18

ED to Medicine Oncology Admission Guide - Revised

Patient warrants admission to a Medical Oncology Service*+ ⇔ Oncology Fellows consulted for acute ED management questions only

⇩

ED Admits Patient to Oncology via Medicine Admission Pathway

- Complete Provider Note and Repeat VS (<2hrs) -

- Complete .EDADMIT note -

- Place order to admit to Oncology -

⇩

MAPA Triages patient to (1) Solid Onc, BMT, Leukemia, Lymphoma or Myeloma Services and (2) determines ADS or Teaching.** They notify team. ⇔ MAPA triage questions answered by Oncology sub-service POC***

⇩

Medicine resident or Oncology NP calls ED Provider for hand-off after reviewing chart.

* General criteria for medicine oncology admissions (vs Gen Med admission) to be provided by Oncology

+ Patients warranting stepdown or ICU level care will have an MPCU consult called and the respective Fellow notified if appropriate

** MAPA will possess criteria reviewed by Oncology specialties that guide which sub-specialty should be the primary team and ADS vs Teaching criteria (including malignancy-specific rules)

*** MAPA will have access to a point-of-contact for each oncology sub-specialty as a back-up for triage questions.

GI and Liver Admission Process (9/22/2017)

ED determines that pt has a primary GI or liver issue that warrants admission

***Known to Liver** = Scoped previously by Liver Medicine, seen in RMTI Transplant Institute, seen in Liver Disease Office, or recently admitted to Liver Medicine.

Pt is being admitted for **tense ascites (needs LVP)**

Call the Liver Consult Fellow (use AMAC)***

Pt is being admitted for **NEW abnormal LFTs**

Does the pt have **biliary obstruction** on imaging?

NO

Call the Liver Consult Fellow (use AMAC)***

YES

Call the GI Fellow #8730**

Pt is being admitted for **GI bleed**

IS THE PT KNOWN TO LIVER SERVICE?*

NO

Call the Liver Consult Fellow (use AMAC)***

YES

Does the pt have advanced HCC, follow primarily with Oncology, or was not recently admitted to Liver Medicine?

YES

Call the Liver Consult Fellow (use AMAC)***

NO

Call the Pre-Transplant Liver Fellow (use AMAC)

Pt is **post-transplant**

Call the Post-Transplant PA #5613

The PA will direct you to call either the **Post-Transplant Surgery or Liver Medicine fellow**

Pt is being admitted for **decompensated cirrhosis (encephalopathy, SBP)**

Call the Pre-Transplant Liver Fellow (use AMAC)

Once accepted by the fellow, place the admit order and call the MAR

Exam

ated

D or OCU as

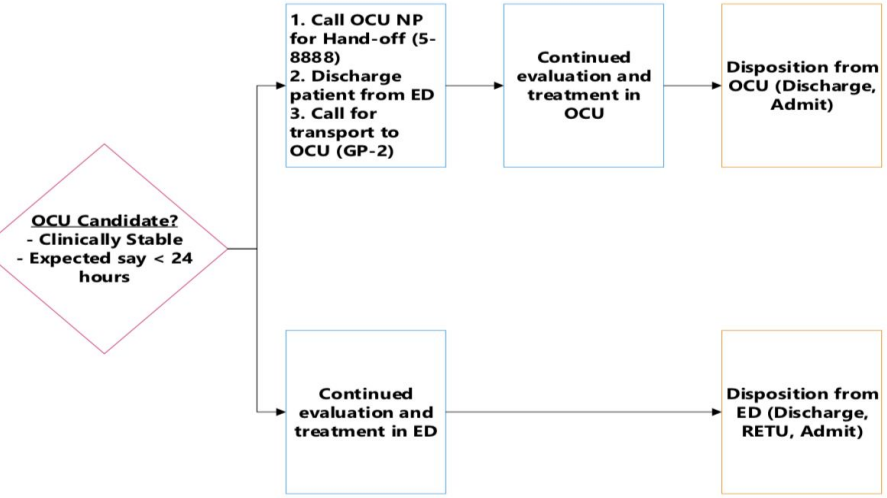
fluids

ED Evaluation

OCU Exclusions

- Unstable vital signs
- Expected length of stay > 24 hours
- Requiring additional work-up beyond the scope of OCU (e.g., thoracentesis)

OCU (GP-2) Clinical Pathway



Medical Alerts in OCU (GP-2)

Ambulatory Patients (ED Code Team)

Stabilize in OCU and bring to ED or admit from OCU

Admitted Patients (Hospital Code Team)

Stabilize in OCU and treat in place until inpatient bed available