

**NEW YORK PRESBYTERIAN HOSPITAL**

Columbia University Medical Center

Department of Medicine

**2011-2012 HOUSESTAFF MANUAL**

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## **Forward**

This manual has been written to aid you in the care of your patients while training at the New York Presbyterian-Columbia University Medical Center. Its primary intent is to conveniently and succinctly provide information which would not be readily accessible elsewhere. It is, however, not meant to serve as a primary medical reference, or to assist you in making complex medical decisions. For that, we recommend that you consult your peers, your texts, your revered pocket manuals, the burgeoning supply of computer resources (including our own house staff website at [www.columbiareidents.org](http://www.columbiareidents.org)) and always, your attending physicians. Credit for this manual is due to its many contributors, both current and past. However, the authors, publishers, Columbia University, NYPH and the Department of Medicine must disclaim any responsibility for errors contained within this book and for adverse outcomes from the use of this book.

## **Introduction**

You are part of a very select group of students chosen to be a resident at one of the great departments of internal medicine in the country. Residency is at once both one of the most demanding experience of one's life, and the most rewarding. An organized mind, intelligence, patience, humility and humanity are all necessary attributes of a successful resident, and for that matter of a successful physician. But more than anything, by always making the interests of your patients your overwhelming priority, you will, in the final analysis, do the right thing. Or, as the physician Rudolf Virchow phrased it, "Only those who regard healing as the ultimate goal of their efforts can, therefore, be designated as physicians."

## **Mission**

New York-Presbyterian Hospital is committed to providing:

- High quality and compassionate patient care
- Outstanding clinical education to physicians, biomedical scientists, and other health care personnel
- Innovative health care research and biomedical science
- Responsible and proactive community service
- Unmatched service to patients, families, and visitors

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## **ADMITTING GUIDELINES**

### **Readmissions**

A patient in need of readmission after recent discharge (within 24 hours) should be readmitted to the service from which they were discharged. Exception should be made if they present with a new medical problem requiring the expertise of a different service.

**The Surgery Service** will accept patients with the following presumptive diagnoses:

- 1) All bowel obstructions (including those felt to NOT require immediate surgical intervention)
- 2) Recurrent diverticulitis
- 3) Cholecystitis (including those NOT requiring immediate surgical intervention)
- 4) Gallstone pancreatitis
- 5) Appendicitis (including those NOT requiring immediate surgical intervention)
- 6) Diabetic ulcer: Vascular service
- 7) Lower extremity cellulitis with peripheral vascular disease: Vascular service
- 8) Most abscesses (see ortho exclusions) including abscess due to IVDU/bite wounds above wrist
- 9) Infection/cellulitis/clot involving AV fistulas/shunts: Vascular surgery

**The Orthopedic Surgery Service** will accept patients with the following presumptive diagnoses:

- 1) Pelvic fracture that cannot be discharged
- 2) All septic joints
- 3) Abscess or infection secondary to orthopedic procedure or implant
- 4) All abscesses in the wrist/hand and any infections (e.g.) cellulites of wrist/hand due to animal bite
- 5) Suspected bacterial tenosynovitis of hand
- 6) Deep abscesses (below forearm fascia) below the elbow

**The Neurology Service** will accept patients with the following presumptive diagnoses:

- 1) All TIAs
- 2) Meningitis (except in presence of HIV)—Odd unit numbers only
- 3) “Social Admissions” for whom the primary underlying medical condition is a neurologic process

**The Urology Service** will accept patients with the following presumptive diagnoses:

- 1) Urosepsis secondary to an infected ureteral stent
- 2) Urosepsis secondary to obstructive stone disease
- 3) Urosepsis secondary to obstructive prostate disease
- 4) Hematuria requiring hospitalization
- 5) Obstruction due to bladder or prostate cancer

**OB/GYN Service** will accept all pregnant patients regardless of stage of pregnancy, unless patient requires telemetry or ICU level of care

### Please note:

- 1) This list only includes diagnoses about which there may be ambiguity, and in no way excludes diagnoses that are currently routinely being accepted by the various services.
- 2) These guidelines refer to the primary or most serious diagnosis of the patient. Often patients are admitted to the hospital with two or more diagnoses, in which case the most serious,

immediate or life-threatening takes precedence with the understanding that full support from other services will be provided in consultation.

3) The ED Attending continues to reserve the right to admit patients to the service he or she believes to be most appropriate. Any difference in opinion between services should never delay care or admission and will be adjudicated post hoc by the relevant Service Chiefs or their designees.

## **MEDICINE SERVICE ADMITTING GUIDELINES, 2011-2012**

### **General Principles:**

- Private patients will preferentially be admitted to the PA service or made off-service. When private patients are too ill for these services or would provide a unique learning opportunity for the housestaff, they may be admitted to a housestaff service.
- Ideally, CCU and ICU transfers should not be assigned to night residents admitting without an intern. These patients should be cared for by the medicine consult until the day team arrives unless he or she is overburdened; this can be decided upon at the discretion of the medicine consult.
- There should be direct communication between a physician taking care of the patient and the accepting resident.
- Resident on call will begin hearing about new admissions at 7:30 AM from the ED, and may get signout on additional patients from the night resident upon arrival.
- Short call and pre-call ward teams are off on weekends and hospital holidays.
- Efforts should be made to inform the patient's PMD of an admission as soon as possible. If the patient's PMD is a resident or attending in AIM/ACN, please send a message through Eclipsys SHM which can be accessed in Eclipsys Acute Care or Ambulatory Care by "GoTo" Menu -> "Secure Health Messaging" option

### **General Medical Service - 1: Max 10 patients on an intern service.**

Patients: All general medicine patients.

Short Call Intern: Monday – Friday, up to 3 night resident "short" admissions. If there are less than 3 night resident admissions, one additional *new* admission may be assigned before 12:00 noon.

Long Call Intern:

- (1) Monday – Friday, the long call intern can accept one night resident short admission, followed by up to 3 new admissions. If there is more than one night resident short, only 2 new admissions can be accepted.
- (2) Saturday – Sunday, the intern can accept up to two night resident admissions, followed by 3 new admissions. If there are 3 or more night resident admissions, only 2 new admissions may be accepted.

There is a graduated cap for new admissions on both weekdays and weekends, with no more than 2 new admissions after 4pm, 1 new admission after 5 pm, and none after 6 pm.

Post Call Intern: On weekend days only (Saturday, Sunday, and Holidays), the post call intern may accept a single night resident short admission.

Night Resident: The night resident admits up to 3 patients until 5:00 am, one of which should be done with the night intern. The first admission should generally be done with the intern. After 3:00 am, the night resident may accept no more than 2 new patients, and after 4:00 am no more than 1 new patient. Night resident patients should be distributed to the short call teams in the morning; we should try to avoid overflow being distributed to the long call teams Mon-Fri. If teams are full, patients may at times be directed to short or long call senior medicine service or appropriate subspecialty services, as circumstances dictate.

Night Intern: Admits 1 general medicine patient overnight with the resident, and is responsible for cross-coverage of the day teams' patients.

### **General Medical Service - 2/Hepatology: Max 10 patients on an intern service**

Patients: Patients with liver and GI disease should preferentially be directed to this service, although GM2 can accept all general medicine patients.

Short Call Intern: Monday – Friday, up to 3 night resident "short" admissions. If there are less

than 3 night resident admissions, one additional *new* admission may be assigned before 12:00 noon.

Long Call Intern:

- (1) Monday – Friday, the long call intern can accept one night resident short admission, followed by up to 3 new admissions. If there is more than one night resident short, only 2 new admissions can be accepted.
- (2) Saturday – Sunday, the intern can accept up to two night resident admissions, followed by 3 new admissions. If there are 3 or more night resident admissions, only 2 new admissions may be accepted.

Graduated caps as per GM1 above.

Post Call Intern: On weekend days only (Saturday, Sunday, and Holidays), the post call intern may accept a single overnight short call admission.

Night Resident: The night resident admits up to 3 patients until 5:00 am, one of which should be done with the night intern. The first admission should generally be the one done with the intern. After 3:00 am, the night resident may accept no more than 2 new patients, and after 4:00 am no more than 1 new patient.

Night intern: Admits 1 general medicine patient overnight with the resident, and is responsible for cross-coverage of the day teams' patients.

**Cardiology: Max 10 patients on an intern service**

Patients: Patients whose primary reason for admission is cardiac should preferably be directed to this service.

Short Call Intern: Monday – Friday, up to 3 night resident “short” admissions. If there are less than 3 night resident admissions, one additional *new* admission may be assigned before 12:00 noon.

Long Call Intern:

- (1) Monday – Friday, the long call intern can accept one night resident short admission, followed by up to 3 new admissions. If there is more than one night resident short, only 2 new admissions can be accepted.
- (2) Saturday – Sunday, the intern can accept up to two night resident admissions, followed by 3 new admissions. If there are 3 or more night resident admissions, only 2 new admissions may be accepted.

Graduated caps as per GM1 above.

Post Call Intern: On weekend days only (Saturday, Sunday, and Holidays), the post call intern may accept a single overnight short call admission.

Night Resident: The night resident admits up to 3 patients until 5:00 am, one of which should be done with the night intern. The first admission should generally be the one done with the intern. After 3:00 am, the night resident may accept no more than 2 new patients, and after 4:00 am no more than 1 new patient.

Night intern: Admits 1 cardiology patient overnight with the resident, and is responsible for cross-coverage of the day teams' patients.

**ID: Max 10 patients on an intern service**

Patients: ID will preferentially admit HIV/AIDS and TB patients, but can now also admit any patients whose *primary* reason for admission is an infectious disease, whether HIV-related or non-HIV related. One spot a day will be reserved for a patient with a diagnosis of HIV or TB until 2pm. However, priority will be given to HIV/TB patients. General medicine patients without a primary infectious issue *cannot be accepted without approval of a chief*. If HIV/TB patients need to be admitted to the ID service the team coordinator may bump another case to the general medicine service or night float to facilitate the admission of appropriate patients to ID.

No more than 2 private patients may be admitted to the ID service; however, ID patients should receive preference for admission over private patients.

Long Call Intern:

- (1) Monday – Friday, the long call intern can accept one night resident short admission followed by up to 3 new admissions. If more than one night resident admission is received, only 2 new admissions may be accepted. One spot a day will be reserved for a patient with a diagnosis of HIV or TB until 2pm.
- (2) Saturday – Sunday, the intern can accept up to two night resident transfers, followed by 3 new admissions. If there are three or more night resident admissions, only two new admission may be accepted

Graduated caps as per GM1 above.

Post call intern: Will accept one short-call admission from the overnight team, up to a census of 10.

Night Resident: The ID/onc night resident admits up to 3 patients until 5:00 am, one of which should be done with the ID night intern (an infectious case) and one of which should be done with the Onc night intern (an oncologic case). Until 3 am, The NR may only admit a maximum of 2 ID or 2 oncology patients each night. At 3 am, a third oncology or ID patient may be accepted. Graduated caps as follows: After 3:00 am, the night resident may accept no more than 2 new patients, and after 4:00 am no more than 1 new patient. Up to 1 non-ID overflow patient may be admitted by the night team, though this patient should be worked up and presented by the resident and should not be one of the admissions for the interns.

Night Intern: Admits 1 ID patient overnight with the resident, and is responsible for cross-coverage of the day teams' patients.

**Oncology: Max 10 patients on a resident/PA service (to be increased to 12)**

Patients: Only patients with a hematologic or oncologic diagnosis related to their admitting diagnosis may be admitted to this service.

Short Call Resident: Monday – Friday, up to 3 night resident “short” admissions. If there are less than 3 night resident admissions, one additional *new* admission may be assigned before 12:00 noon.

Long Call Resident:

- (1) Monday – Friday, the long call resident can accept one night resident short admission followed by up to 3 new admissions. If more than one night resident admission is received, only 2 new admissions may be accepted.
- (2) Saturday – Sunday: The resident can accept up to two night resident transfers, followed by 3 new admissions. If there are three or more night resident admissions, only two new admission may be accepted.

Post Call Resident: On weekend days only (Saturday, Sunday, and Holidays), the post call resident may accept a single overnight short call admission.

Night Resident: See ID/onc night resident above

Night intern: Admits 1 oncology patient overnight with the resident, and is responsible for cross-coverage of the day teams' patients.

**Senior Medicine: Max 12 patients on a resident service**

Patients: Senior medicine admission should include all general medicine patients who are not acutely or severely ill. Some examples of inappropriate diagnoses would include ACS 2 with positive troponins, DKA, active upper GI bleed, severe sepsis, patients on vasoactive infusions, or a patient requiring an ICU triage consult. Clearly, there is a role for the discretion of the resident, and in difficult cases the chief-on-call should be contacted. The number of private patients

admitted to this service is minimized in an attempt that no resident should receive more than 1 private patient per short or long call.

Short Call Resident: Residents may receive up to 3 short call admissions Monday-Friday. If they receive less than 3 short call admissions, they may also admit one long admission before 1 pm Monday-Friday. Overnight patients should be taken from the house doctor and the Gen Med 1 & 2 night residents.

Long Call Resident: Resident may receive up to 4 patients until 6:30 pm with no more than 2 patients after 4:00 pm and no more than 1 patient after 5:00 pm. Long call resident may receive overnight overflow if the short call senior medicine is capped (but the admission counts as a long call admission towards the cap of 4).

**Allen Pavilion: Max 10 patients on an intern service**

Patients: Private patients should not be on the ward teams unless the patient's private admitting doctor is also the ward attending at the time.

Short Call Intern: Monday – Friday, up to 2 night resident “short” admissions can be accepted.

Long Call Intern: Can accept up to 3 new admissions from 7:30AM-6PM Monday-Friday. On weekends and holidays the long call intern also accept up to 2 short admissions, followed by three new admissions.

Post-call Intern: The postcall team can accept one night resident short call admission.

Night Resident: The night resident admits up to 3 patients until 5:00 am. After 3:00 am, the night resident may accept no more than 2 new patients, and after 4:00 am no more than 1 new patient. One admission, generally the first, should be done with the PA. If the PA is not present, the night resident will perform cross-coverage only, and do no admissions.

**Medical Intensive Care Unit – Milstein (MICU): Max 12 patients in the MICU**

Private and ward patients are cared for in a closed order-book fashion by the managing MICU service.

Short call resident: Up to 2 admissions (may be either primary work-ups or transfers from the inpatient medical services) from 6:00 am – 1:00 pm. The short call resident admits with the long call intern.

Long call resident/intern: The long call resident admits with either the Long call intern (7 am – 7:00 pm) or the night intern (9:30 pm – 6 am). These interns will assist in evaluation and management of patients which arrive during their shifts but are outside of these hours, e.g. between 7 pm – 9:30pm on long call. There is some flexibility with these hours for exceptionally busy or exceptionally light days. The long call resident starts admitting at 1:00 pm, unless the short call resident “caps” with 2 admissions before 1 pm, in which case further admissions go to the long call resident regardless of time. Caps are as follows. The long call resident may admit a total of 10 new patients during call. However, a maximum of 5 new patients may be admitted with each intern. The long call resident may admit an additional 2 patients with both the long call intern and the night intern to the Milstein MICU during this period if they are transfers of care for patients currently on a medical service. In circumstances where additional patients need to be admitted to the MICU, the long call overnight resident will triage/stabilize the patient, including initial admission orders, prior to the arrival of the short call resident who will complete the evaluation and management of that admission.

Night Intern: As above, the night intern admits with the long call resident from 9:30 pm – 6 am).

**Allen Pavilion Intensive Care Unit (AICU): Max 12 patients in the AICU**

Private and ward patients are cared for in a closed order-book fashion by the managing AICU service.

Long call intern: The long call intern admits a maximum of 5 new admissions under the supervision of the senior resident between the hours of 7 am – 7 pm. The long call AICU intern

may accept an additional two patients, but only if it is a transfer of care from a medical service. The night intern similarly may also admit a maximum of 5 new admissions under the supervision of the hospitalist from 8:30pm to 6am the following day.

Night intern: The night intern may admit a maximum of 5 new admissions under the supervision of the hospitalist from 8:30pm to 6am the following day. The night intern may accept an additional two patients, but only if it is a transfer of care from a medical service.

AICU Resident: There are two residents in the AICU rotating on shift schedule. One resident supervises the AICU from 7:45 am – 3:00 pm. The second resident arrives at 11:00 am for teaching and management rounds and remains in the unit until 9:30 pm. Alternatively, residents may elect to alternate individually covering the unit for the entire day.

### **Cardiology Care Unit (CCU): Max 14 patients in the CCU**

Short call resident: Up to 2 admissions (may be either primary work-ups or transfers from the inpatient medical services) from 6:00 am – 1:00 pm. The short call resident admits with the long call intern.

Long call resident/intern: The long call resident admits with either the Long call intern (7 am – 7:00 pm) or the night intern (9:30 pm – 6 am). These interns will assist in evaluation and management of patients which arrive during their shifts but are outside of these hours, e.g. between 7 pm – 9:30pm for the long call intern, or between 6 am – 7 am for the night intern. There is some flexibility with these hours for exceptionally busy or exceptionally light days. The long call resident starts admitting at 1:00 pm, unless the short call resident “caps” with 2 admissions before 1 pm, in which case further admissions go to the long call resident regardless of time. Caps are as follows. The long call resident may admit a total of 10 new patients during call. However, a maximum of 5 new patients may be admitted with each intern. The long call resident may admit an additional 2 patients with both the long call intern and the night intern to the Milstein CCU during this period if they are transfers of care for patients currently on a medical service. In circumstances where additional patients need to be admitted to the CCU, the long call overnight resident will triage/stabilize the patient, including initial admission orders, prior to the arrival of the short call resident who will complete the evaluation and management of that admission.

Night Intern: As above, the night intern admits with the long call resident from 9:30 pm – 6 am).



## ORDER ENTRY AND TEAM LISTS

At both the Milstein Hospital and the Allen Pavilion, orders are entered via our computer order entry system, Eclipsys.

To enter Eclipsys: go to the “Clinical Manager” icon in the Certified Applications folder (also under “Eclipsys XA” under Applications in the Certified Applications menu)

To log into Eclipsys enter the same username/password that you use for Webcis.

Each resident/intern team will constitute a distinct service. For example for each inpatient service there will be an A, B, C, and D team. All new admissions should be entered in Eclipsys as being on either the A, B, C, or D team for GM1, GM2, Cards, Onc, Senior Med, and the Allen. ID will have an A, B, and C team. Each team will have a distinct pager that will be signed out to the intern covering each team.

When admitting a patient please do the following:

- Enter an admit order with your own personal pager as the Resident/Intern pager.
- Then add the patient to you team list by entering “add to Intern Team x” for the patient. The team pager will automatically be linked to that order.
- Make sure the virtual team pager is always signed out to your personal pager or the pager of the intern covering your list.

Team List Pagers:

**Gen Med 1**

Team A	85298
Team B	85299
Team C	85300
Team D	85301

**Gen Med 2**

Team A	85303
Team B	85306
Team C	85307
Team D	85309

**Cardiology**

Team A	85310
Team B	85313
Team C	85314
Team D	85317

**Senior Medicine**

Team A	85341
Team B	85343
Team C	85344
Team D	85346

**Oncology**

Team A	85321
Team B	85323
Team C	85324
Team D	85347

**ID**

Team A	85325
Team B	85329
Team C	85335

**Allen Wards**

Team A	85337
Team B	85338
Team C	85339
Team D	85340

For help with Eclipsys call:

4-HELP (for problems with a computer)

917-241-7264 (Super User pager)

IT: 212-746-6700 (pager #30201)

COLE: 212-746-6700 (pager #13223)

## Quick Reference Guide Patient Lists and Order Entry

- Eclipsys Order Entry Beeper: (order entry assistance)  
212-746-6700 #30201
- Help Desk: 4-HELP (for technical issues & passwords)
- Email: [xs-support@nyg.org](mailto:xs-support@nyg.org) (suggestions/concerns)

### PATIENT LISTS

#### Creating a Personal Patient List (or: My Patient List)

Note: You must maintain lists you create. Patients will not automatically add or drop from personal lists as they are admitted or discharged.

1. Click the Patient List tab.
2. Select any criteria-based list from your Current List drop-down box (those without an asterisk).
3. Press and hold the Ctrl key.
4. Click the desired patients' names.
5. With the names highlighted, click the Save Selected Patients button.
6. Select Add or Replace patients to an existing list, or Create a new list name.
7. Click OK.

#### Creating a Criteria-Based List


1. Click Patient List tab.
2. Click File from the menu bar.
3. Select Maintain List.
4. Click New.
5. Click one or more tabs for criteria:

Tab	Steps
Role	<ol style="list-style-type: none"> <li>1. Check the box that indicates you want to create a list where you are a provider.</li> <li>2. Select appropriate radio</li> </ol>

	button and choose role(s).
Location	<ol style="list-style-type: none"> <li>1. Click the Show Patients Located at Selected Locations radio button.</li> <li>2. Select locations.</li> <li>3. Click Add.</li> </ol>
Providers	<ol style="list-style-type: none"> <li>1. Type partial name in the provider field.</li> <li>2. Select the provider name from the list.</li> <li>3. Select Role from the role drop-down list.</li> <li>4. Click Add.</li> </ol>
Service	Select the Service, if needed.
Visit Status	<ol style="list-style-type: none"> <li>1. Check List Currently Admitted/Registered or List Patients with Specified Event.</li> <li>2. Select a Status from the drop-down list and a date or date range.</li> </ol> <p>Note: For currently admitted patients, you do not need to select this tab.</p>

6. Click OK.
7. Type the name for your list in the List Name field.
8. Click OK.

#### Finding a Patient

1. Click the Patient List tab.
2. Click Find Patient icon (on the toolbar) 
3. Click the Name, Identification, Provider, or Other tab.
4. Enter the required information.
5. Click Search.
6. Select the patient from Search results.
7. Click Show Visits.
8. Select a visit.

### ORDER ENTRY

Note: You may only place orders on those patients who are on active order entry areas. Icons will not highlight on non-order entry patients.

#### Placing an Order

1. Click the Enter Order icon, or from the GoTo menu, select Order Entry Worksheet.
2. If you have the right to enter your own orders, Me is automatically selected next to Requested By. If you are entering the orders on behalf of someone else, select Other to open the Requested By dialog box.
3. In the Date field, enter the request date for the order. If you don't enter a date, the current date is displayed on the order entry form.
4. In the Time field, enter the request time for the order. The time you select is copied to the order form.
5. From the Session Type list, select a session type (Standard is defaulted).
6. If the Session Type is anything other than Standard, verify the defaulted value in the Reason field.
7. In the left pane of the Order Browse, select the order or order set you want.
8. In the right pane of the Order Browse, click Add or double-click the item name. If the order requires you to provide additional information the order form appears. If you provided a request date on the Order Entry Worksheet, it appears in the Request Date field. If the order is not a STAT order, you may also need to provide a time. The fields you must fill in display a Required Information icon (a red star). Provide the information and click OK. You return to the Order Entry Worksheet and the order is placed in the Order Summary window. If the order is pre-filled, meaning it requires no additional input from you, the order is placed directly in the Order Summary window.
9. You may now select another item or Submit the item.
10. To submit the order, click Submit.



## DISCHARGING PATIENTS

*Discharge planning should begin on admission.* SW involvement early in the process is helpful and will often facilitate a timely discharge. Interdisciplinary rounds are held daily and bring together many members of the treatment team: social work, utilization review, nursing, physical therapy and nutrition. A physician caring for the patient should be present daily. Daily discussion with your patient's nurses and social workers will help ensure timely and safe discharge for your patients.

Ask yourself the following questions before every discharge:

1. *Can my patient walk out of here?* Many patients become deconditioned in the hospital, and may be candidates for acute rehab or a subacute nursing facility. Please order physical therapy for your patients who you foresee needing rehab well before their discharge date.
2. *Does my patient need special medications or therapies?* Often patients begin injection therapy (insulin, enoxaparin) and will need teaching on self-administration. An order may be written for nursing to teach medication administration, and if the patient is unable, the nurse can teach the family. Patients starting home oxygen need special arrangements prior to discharge.
3. *With whom will my patient follow up as an outpatient?* Patients who have no insurance should be referred to the General Medicine Clinic at Harlem Hospital. The clinic is located on the 3<sup>rd</sup> Floor of the Ron Brown Pavilion on 136<sup>th</sup> Street between Lenox and 5<sup>th</sup> Aves. Call 212-939-8400 for an appointment. Please be sure to give copies of the discharge summary/clinic summary to the patient to take with him/her to the appointment. Alternatively, you can fax these documents to the clinic directly (fax #: 212-939-3892). If your patient has the appropriate insurance an appointment should be made preferably with the intern caring for the patient at the AIM clinic. Appointments at AIM can be made by calling 56354.
4. *Can my patient pay for his or her medications?* For our patients unable to afford their discharge medications, the social workers can often arrange for a short-term supply of medications at the time of discharge. Every effort should be made to find the most affordable regimen.
5. *Have I dictated or typed up the discharge summary?* The easiest time to do a discharge summary is on the day of the discharge when the patient is still fresh in your mind. If the patient needs to be re-hospitalized shortly after discharge, a discharge summary can be of great assistance in providing excellent continuity of care. A discharge summary can either be dictated or can be typed into Webcis directly through the Add DSUM function. Most interns prefer typing the discharge summary directly into Webcis or Eclipsys. If you prefer to dictate your discharge summaries, further assistance regarding dictation can be obtained from the Health Information Management department on the 1<sup>st</sup> Floor of Milstein.



## GUIDE TO DOCUMENTATION

The following guidelines have been adopted from those published by the Formula and Therapeutics Committee to minimize medication errors related to inappropriate prescribing. Although computerized order entry decreases the potential for confusion and medication error, it does not eliminate it. The following guidelines are also applicable when writing progress notes and prescriptions.

- *Use generic names of drugs*
- *Do not use abbreviated names*
  - “Levo” could be levophed, levaquin, levodopa, levothyroxine, etc.
- *A leading zero ALWAYS precedes a decimal point.* (e.g., levothyroxine 0.1mg)
- *A trailing zero NEVER follows a decimal point.* (e.g., diltiazem IV 10mg/hr)
- *Specify dosage strengths*
  - “One amp” or “one tablet” is insufficient data. Many drugs come in multiple strengths and volumes.
- *Write out instructions*
  - QD, QID, QOD can be easily confused. Write out “once daily” or “4 x per day.”
  - QH, QHS are also easily confused. Write “at bedtime” and “q hour.”
- *Write out words such as “units” and “micrograms.”*
  - “U” can be confused with a zero (e.g., 10U may look like 100)
  - Handwritten units of mcg and mg can be misread

<b>DO NOT USE THESE ABBREVIATIONS</b> in writing any orders and notes or in any part of the medical record.			
<b>Abbreviation / Dose Expression</b>	<b>Intended meaning</b>	<b>Misinterpretation</b>	<b>Term To Use</b>
<b>U</b>	Unit	Mistaken as zero, four or cc.	Write " <b>unit</b> "
<b>IU</b>	International unit	Mistaken as IV (intravenous) or 10 (ten).	Write " <b>international unit</b> "
<b>Q.D.</b>	Every day	Mistaken as Q.I.D. The period after the "Q" can be mistaken for an "I".	Write " <b>daily</b> "
<b>Q.O.D.</b>	Every other day	Mistaken as Q.I.D. The "O" can be mistaken for "I".	Write " <b>every other day</b> "
<b>No zero before decimal dose (.X mg)</b>	0.X mg	X mg	Always use a zero before a decimal when the dose is less than a whole unit. Write <b>0.X mg</b>
<b>Zero after decimal point (X.0 mg)</b>	X mg	X0 mg	Never write a zero by itself after a decimal point. Write <b>X mg</b>
<b>MS, MSO4</b>	Morphine sulfate	Confused for Magnesium Sulfate.	Write " <b>morphine sulfate</b> "

<b>MgSO4</b>	Magnesium sulfate	Confused for Morphine Sulfate.	Write " <b>magnesium sulfate</b> "
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## Guidelines for Progress Notes

### Basic rules of documentation:

- All notes must be entered in Eclipsys
- Date and time all notes
- Title all medical record entries; identify yourself and your role (eg. Intern Progress Note)
- Avoid abbreviations
- Except for Senior Medicine service, all admission notes can either be entered as free-text or structured notes
- For the Senior Medicine service admission notes must be entered as Milstein Hospitalist Resident/PA structured admission note
- Cutting and pasting from previous notes without editing and updating is not permitted; using another provider's observations or assessments is unethical, unprofessional, AND plagiarism.
- In addition to signing notes, print your name legibly and include your pager number.

### Progress notes:

- The purpose of a progress note is to provide a daily account of your patient, his/her illnesses, and of developments in their diagnosis and treatment, for all of those who share in their care.
- Progress notes can and should be relatively brief, focusing on developments since the previous note, and recapitulating only relevant, ongoing, active problems. A complete summary of the entire admission is not necessary, just an accounting of what has happened since the last note.
- A note must be written 7 days a week for each patient (on the day after admission only, the attending admitting note can count as the progress note). It is the resident's responsibilities to ensure that each patient has a note every day.
- All progress notes must be written in Eclipsys. For senior medicine the progress should be entered as Milstein Resident/PA progress note
- They should be written in the problem-oriented, SOAP format, as follows:
  - "Subjective" should include information from the patient about their symptoms and wishes, and from family and from other caregivers (eg. "nurse reports the patient had a sleepless night.")
  - "Objective" should only include new information. Information that is readily available to others can be briefly summarized, or include only abnormal or changing results. This section should include the following kinds of information:
    - vital signs and physical examination (ie. results of an appropriate, focused exam)
    - lab data
    - imaging data
  - "Assessment and Plans" should be summarized BY PROBLEM. Problems may be diagnosed diseases or syndromes, or symptoms, symptom complexes, or abnormalities from the exam, labs or imaging. Although sometimes a problem may be best expressed by reference to an organ system, eg. "pulmonary abnormalities," generally the problem list is not simply a list of organ systems (some diseases or problems involve several organ systems; some organ systems may have more than one discrete problem)
    - The assessment is the MOST important part. It can be brief, but should include the working differential diagnosis or established diagnosis, the severity or the prognosis when appropriate, and the "status" of the problem, i.e. whether the

patient is improved, has worsened, or has developed additional problems. It is where one interprets the changes in the patient's subjective status, the new diagnostic test results, summarizes input from consultants, and articulates an opinion re: the unfolding of the patient's diagnosis and treatment.

- The plan is what is next; it may be divided between diagnostic (or monitoring) plans and therapeutic plans.
- The required "last problem" (analogous to concluding ambulatory problem lists with "health maintenance") should be "disposition" or "discharge planning" and should always include discharge planning or needs.

### Sample Progress Note

2-14-08, 11:40 am

Intern Progress Note

S) Today she feels worse, failed a trial of p.o. nutrition and has been vomiting most of the night.

O) exam: appears comfortable.  
VS: P 110 110/70 T 98.2 RR16  
mucosa are dry  
abdomen is soft but mild mid-epigastric tenderness to palpation and bowel sounds are absent.

labs: amylase increased from 150 to 600  
Na 148 Cr 1.8

A/P)

1. Idiopathic pancreatitis, failed a trial of oral feeds yesterday, her 5<sup>th</sup> hospital day, persistent ileus by exam, clinically dehydrated  
Plan: increase IV fluid repletion, npo  
consider paraenteral nutrition – call GI  
repeat CT of her abdomen once renal function improves
2. Incr'd Na, creat, c/w dehydration, volume depletion
3. Discharge planning. Prolonged illness will likely require sub-acute rehab before return home.



## **BLOOD PRODUCTS**

In order to order blood products for patients, you will need an active “type and hold” (long light pink tube) in the blood bank. A “type and hold” specimen expires after three days. If drawing your own “type and hold”, remember to sign and date the label printed out by the Eclipsys label maker and attach it to the tube; also sign and date the requisition that prints out on the patient’s floor when you place the “type and hold” order in Eclipsys. The lab will under *no* circumstances accept a sample without the necessary paperwork/signatures (they will discard the specimen *and then* page you to notify you that the specimen was submitted incorrectly). Prior to giving blood products you must receive informed consent from the patient or a surrogate if the patient is unable (*except in an emergency*). In order to do this the patient/surrogate needs to be informed of the risks inherent in a blood transfusion.

### **Risk of Transmission**

<b>Etiology</b>	<b>Risk</b>
Hepatitis B	1:58,000-269,000
Hepatitis C	<1:1,900,000
HTLV	1:2,000,000
HIV	<1:2,100,000

Source: [www.uptodate.com](http://www.uptodate.com), Laboratory Testing of Donated Blood

### **Blood Products**

- *Packed Red Blood Cells (PRBCs)*
  - Most plasma removed, 1 unit should raise the Hgb by 1 g/dl (Hct by 3%)
  - Special types of PRBCs
    - Filtering (in the blood bank or during transfusion) removes some of the white blood cells from the unit of blood. White blood cells are thought to cause febrile non-hemolytic transfusion reactions (FNHTR), alloimmunization to HLA antigens, CMV and HTLV transmission, and immunomodulation. Consider ordering **filtered PRBCs** in patients with a history of FNHTR, those at risk of CMV infection, or those who might receive a stem cell transplant in the future.
    - Irradiation, by impairing T lymphocyte proliferation, prevents transfusion-associated graft-versus-host disease (GVHD). Consider **irradiated PRBCs** in patients with stem cell transplants, who are or will be immunosuppressed (e.g., by chemotherapy), or congenital immunodeficiencies.
- *Platelets (random donor)*
  - 1 unit of random donor platelets should raise the platelet count by 5,000-10,000
  - Typically, 6 units are transfused in order to raise the platelet count by 30-50,000
  - Indications for platelet transfusion include
    - Platelet count <10,000/microliter
    - Platelet count <50,000/microliter with bleeding or prior to a major procedure/surgery
    - Platelet count <100,000/microliter for neuro or eye surgery
    - Avoid platelet transfusion in TTP (can worsen thrombosis) and ITP (provides more antigenic stimulation)
- *Fresh Frozen Plasma (FFP)*
  - Contains stable coagulation factors
  - Can use in liver failure, elevated PT with bleeding (i.e., coumadin toxicity), DIC
  - Generally order 6 bags at a time
  - FFP will likely not bring a patient’s INR below 1.5

- *Cryoprecipitate*
  - Contains factor VIII, von Willebrand's factor, and fibrinogen
  - Used in fibrinogen deficiency, DIC, von Willebrand's disease, & hemophilia A
  - Generally order 10 a pack in Eclipsys



○ Adverse Reactions to Transfusion of Blood Products

Type	Pathophysiology	Incidence	Symptoms	Diagnosis	Outcomes	Treatment
Acute Hemolytic Transfusion Reaction	ABO Incompatibility (most commonly)	1:25,000	Fevers, chills, nausea, vomiting, flank pain, headache, dyspnea, hypotension that begins almost immediately after transfusion begins	1. + Coombs Test (direct)  2. Red plasma/red urine	Mortality 17-60%	1. STOP the transfusion 2. Notify the blood bank immediately if this is suspected (there will likely be another pt at risk) 3. Supportive care; consider ICU transfer
Delayed Hemolytic Transfusion Reaction	Alloantibody emerging because of an anamnestic response	1:7000	Often asymptomatic	1. Hallmark is unexplained drop in Hgb after transfusion  2. Increased bilirubin, LDH, reticulocyte count; decreased haptoglobin  3. New alloantibody on screen	Often asymptomatic	Provide compatible, antigen-units for future transfusions
Transfusion Related Lung Injury (TRALI)	Antileukocyte Ab of donor origin cause leukocyte aggregates to be deposited in the lung leading to alevolitis/ARDS	Rare	Acute hypoxic Respiratory distress during or soon after transfusion	Clinical		1. STOP the transfusion 2. Notify blood-bank (but unlikely to recur) 3. Supportive management (2-3 day course) 4. ?Avoid diuretics
Allergic Reactions	Donor plasma Ag causes acute IgE release/mast cell degranulation	1-3:100 More common with plasma/plt txf	Pruritic erythema, urticaria, wheezing, mucosal edema	Clinical	Usually self limited, but may progress to anaphylaxis	1. STOP the transfusion 2. Steroids and antihistamines 3. Observe for anaphylaxis
Anaphylaxis		1:20,000-50,000	Hypotension, respiratory distress, nausea, abdominal cramping, diarrhea	Clinical	Potentially fatal	1. STOP the transfusion 2. Steroids and epinephrine 3. Supportive management
Septic Reactions	Foreign materials that contaminate platelets  GMR and skin flora	For platelets 1:500-2000	Symptoms of sepsis beginning during or shortly after transfusion	Blood cultures (both the donor product and recipient's blood)	25% fatal	1. STOP the transfusion 2. Broad spectrum Abx, f/u cultures



## DIETS

For a swallow or dysphagia evaluation-- order in Eclipsys, can also call x57790 **for expedited consult**

- For *all* dysphagia diets (I, II, III):order crushed meds, *no* thin liquids, and “thick-it”
- *Dysphagia I*: moist cohesive bolus – pudding consistency
- *Dysphagia II*: cohesive bolus – e.g., banana, scrambled eggs
- *Dysphagia III*: soft chewable - e.g., meatloaf, baked potatoes
- *Puree*: pureed food. Liquids are allowed.
- *Mechanical Soft*: easily chewable solids. Liquids are allowed.



## ELECTROLYTE REPLETION

Edited in collaboration with Amy Dzierba, Pharm. D.

\*During 2011-2012 there will be ongoing national shortages of many intravenous electrolytes. Please refer to the Infonet for the most up-to-date information\*

*Electrolyte disorders can be life-threatening.* This section is an aid to writing orders for particular electrolytes after decisions on need for repletion, amount of repletion, and follow-up labs have been made with your resident.

As a general rule, STANDING IV electrolyte orders are not accepted by nursing/pharmacy (i.e. you **cannot** write KCl 10 mEq/100 mL D<sub>5</sub>W IV BID)

For complete electrolyte policies please see <http://www.crlonline.com/crlsql/servlet/crlonline>

Deviations from dosing parameters outlined in these policies **MUST** be approved by an ICU attending or fellow

### **Calcium:**

**Standard IV concentrations:** Calcium Gluconate 1 g/50 mL, 2 g/100 mL D<sub>5</sub>W

Condition	Recommended Dose
Ionized hypocalcemia secondary to massive blood transfusion via rapid infusion device (hemorrhagic shock)	<b>Calcium chloride:</b> 1 g IVP over 10 minutes via <b>central line</b> to correct ionized hypocalcemia
Cardiac arrest	<b>Calcium chloride:</b> 1 g IVP over 30 seconds via <b>central line</b> (dose per ACLS guidelines); if impossible to obtain central line and/or resuscitation is compromised in doing so, use peripheral line
Life-threatening hyperkalemia (rapid rise in serum K <sup>+</sup> >6 mEq/L, ECG changes, arrhythmias)	<b>Calcium chloride:</b> 1 g IV over 10 minutes via <b>central line</b> ; can repeat in 5 minutes OR <b>Calcium gluconate</b> 3 g IV over 10 minutes via <u>peripheral line</u> ; can repeat in 5 minutes  **Calcium should not be used for the treatment of hyperkalemia in digitalis toxicity
Symptomatic hypocalcemia	<b>Calcium gluconate:</b> 2 g IV over 10 minutes, followed by 1 g /hour over 4-6 hours or until symptoms resolve. Use 10 g/500 mL D <sub>5</sub> W standard concentration
Calcium channel blocker overdose	<b>Calcium gluconate:</b> 3 g IV over 10 minutes every 10-20 minutes as needed (Preferred if patient is severely acidotic)
Ionized hypocalcemia during CRRT with replacement fluid	Calcium gluconate: 10 g/500 mL D <sub>5</sub> W (see CRRT order form and consult Nephrology attending)

Asymptomatic hypocalcemia  (Hypomagnesemia, if present, must be treated to correct hypocalcemia)	<i>Patients able to take oral medications:</i> Calcium 260 mg (as carbonate) orally TID with meals (need acid secretion for absorption) If patient taking H <sub>2</sub> blockers or proton pump inhibitors, use calcium 200 mg (as citrate) orally TID, 2 hours after a meal <i>Patients unable to take oral medications:</i> Calcium gluconate: 1-2 g in 50-100 mL D <sub>5</sub> W over 30-60 mins IV daily PRN
Parathyroidectomy	Calcium gluconate: 1-2 g in 50-100 mL D <sub>5</sub> W over 30-60 min IV daily PRN

- All **IV** orders for calcium must be expressed as “grams” of a specific salt (gluconate or chloride)
- All **oral** orders for calcium must be expressed as “mg” of elemental calcium
- Calcium gluconate may be administered peripherally; calcium chloride should be administered through a central line. Calcium products should NOT be administered IM or SubQ.
- Adjusted serum Ca (mg/dL) = reported serum Ca (mg/dL) + 0.8 [4 – reported serum albumin (g/dL)] (As a rule of thumb, each decrease of 1 g/dL of albumin results in a decrease of 0.8 mg/dL of calcium)

## Magnesium:

Standard IV concentration: Magnesium sulfate 2 g (16 mEq/50 mL D<sub>5</sub>W)

Condition	Recommended Dose (consider decreasing by 50% in renal insufficiency)
Cardiac Arrest	Load with 2 g of magnesium sulfate diluted in 10 mL D <sub>5</sub> W or NS IV push over 1-3 minutes
Neurologically Injured Patients (for prevention of shivering) **Restricted to Neurology Critical Care Attending and Fellows in ICU (Note approval source in comment field of order)	Load 4 g magnesium sulfate over 2 hours, followed by 1-3 g/hour for goal magnesium level of 3-4 mg/dL. For patients with estimated CrCl < 50 mL/min, use goal magnesium level no greater than 3 mg/dL. Monitor magnesium levels every 6 hours initially, then every 12 hours
≤1.2 mg/dL With life threatening symptoms (seizures, arrhythmias)	Infuse 2 g magnesium sulfate diluted in 10 mL IV push over 2 minutes; Recheck level 1 hour after above; Follow with 4 g magnesium infused over the next 2-3 hrs  Recheck level 1 hour after infusion and repeat dose as needed per level or consider continuous infusion totaling 10 gms over 24 hours  NOTE: if seizures persist, the dose of 2-4 g over 5-10 minutes may be repeated up to a total of 10 gms over the next 6 hours
1.2 mg/dL Asymptomatic or when accompanied by other electrolyte abnormalities	Infuse 4 g magnesium sulfate IV over 2 hours; Follow with 4 g magnesium sulfate infused over the next 2-3 hours  If needed recheck level 1 hour after infusion and repeat as needed per level
1.3-1.8 mg/dL Symptomatic without life-threatening conditions or when oral replacement not possible	Infuse 4 g magnesium sulfate over 2-4 hours  If needed recheck level 1 hour after infusion and repeat as needed per level or consider 1-2 g/hr IV infusion over a 3-5 hour period
1.3 – 1.8 mg/dL Without symptoms	<b>Oral:</b> Magnesium Oxide 400 mg tablet: Give 1-2 tablets TID-QID (dose limiting side effect is diarrhea; consider starting at low doses and titrating gradually) <b>Intravenous:</b>

	<p><u>For Mg<sup>2+</sup> levels 1.3-1.6 mg/dL:</u> 2-4 g magnesium sulfate IVPB over 1-2 hours. If this dose fails to achieve/maintain the desired level, consider 1-2 g/hour IV infusion for a 3-5 hour period</p> <p><u>For Mg<sup>2+</sup> levels 1.7-1.8 mg/dL:</u> 1-2 g magnesium sulfate IVPB over 30 to 60 minutes. If this dose fails to achieve/maintain the desired level, administer an additional 2-4 g over 2-4 hours</p> <p>NOTE: At these levels, more aggressive doses (ie, 4 g) may be prescribed in the cardiac ICU setting to maintain serum magnesium &gt; 2 mg/dL.</p>
>1.8 mg/dL	<p><b>Oral:</b> Magnesium Oxide 400 mg tablet: Give 1 tablet BID-TID (dose limiting side effect is diarrhea; consider starting at low doses and titrating gradually)</p> <p><b>Intravenous (if patient cannot tolerate PO medications)</b> Infuse 1 g magnesium sulfate IVBP over 30-60 min</p>

- In patients with normal renal function, the kidneys excrete magnesium more rapidly when given as bolus as compared to continuous infusion or enteral administration. Therefore, continuous infusion or enteral routes are preferred to maintain elevated serum magnesium concentrations for some patients
- Magnesium may alter cardiac conduction leading to heart block; use with caution in patients on digoxin.
- Consider decreasing dose by 50% in renal insufficiency
- Monitor serum magnesium, calcium, potassium, blood pressure, ECG (for continuous infusions in the ICU), respiratory status, and neurologic status (mental alertness, deep tendon reflexes).
- Hypokalemia and hypocalcemia are frequently associated with hypomagnesemia. To effectively correct one deficiency, you should correct all deficiencies.
- Serum magnesium levels should be rechecked no sooner than 2 hours after an IV push or intermittent intravenous bolus dose
- Symptoms of Magnesium toxicity include:
  - Dramatic fall in blood pressure
  - Respiratory paralysis
  - ECG changes: ↑ PR interval, ↑ QRS, ↑ QT
  - Disappearance of the patellar reflex
  - Loss of deep tendon reflexes
  - Narcosis

### Phosphate:

**Standard Orders:** Oral route preferred (although diarrhea can result).

		Maximum Concentration	Maximum Infusion Rate	
			General Floor	ICU/ Stepdown Bed (with cardiac monitoring)
Sodium Phosphate	Peripheral	15 mmol/100 mL D <sub>5</sub> W	15 mmol over 2 hrs	15 mmol over 2 hrs
	Central	30 mmol/100 mL D <sub>5</sub> W	15 mmol over 1 hrs	15 mmol over 1 hrs
Potassium Phosphate	Peripheral	15 mmol/100 mL D <sub>5</sub> W	15 mmol over 4 hrs	15 mmol over 2 hrs
	Central	30 mmol/100 mL D <sub>5</sub> W	15 mmol over 2 hrs	15 mmol over 1 hrs

### Recommended Replacement Based Upon Serum Phosphate Levels:

Severity	Serum phosphate level	Dose* & rate of phosphorous repletion
Symptomatic / Life Threatening	< 1 mg/dL	30 mmol IV

Severe	1-1.8 mg/dL	15 mmol IV
Mild - Moderate	1.8-2.5 mg/dL	If asymptomatic, & taking POs consider Phos-Nak <sup>®</sup> PO 1-2 packets QID or Phospha 250 Neutral PO 1-2 tablets QID, otherwise, 15 mmol/100 mL D5W IV

<b>Oral Products</b>	Elemental phosphate (mg)	Phosphate (mmol)	Sodium (mEq)	Potassium (mEq)
Phos-Nak <sup>®</sup> (1.5 g packet)	250	8	6.9	7.1
Phospha 250 neutral	250	8	13	1.1

**Potassium:**

Standard Orders: Oral route preferred

KCL 40 mEq PO x 1 now and repeat x 1 after 4 hours

	Concentration		Maximum Rate
	Recommended	Maximum	
<b>Peripheral Line</b>			
Continuous (maintenance)	40 mEq/1000 mL	80 mEq/1000 mL	10 mEq/hour
Intermittent piggyback infusion (replacement)	10 mEq/50 mL 10 mEq/100 mL	10 mEq/50 mL	10 mEq/hour
<b>Central Line</b>			
Continuous (maintenance)		80 mEq/1000 mL*	20 mEq/hour*
Intermittent piggyback infusion (replacement)	20 mEq/100 mL	20 mEq/50 mL*	20 mEq/hour*

**\*For Central administration:** The concentration (20 mEq/50 mL intermittent, 80 mEq/L continuous) and rate (20 mEq/hour) may be exceeded in an adult ICU, ED, OR, PACU or designated patient care unit

- As a rule of thumb, 10 mEq of potassium administered will raise the serum potassium by 0.1 mEq/L.
- Any rate >20mEq/hour requires ICU setting or telemetry
- *Never* administer KCl as undiluted IV push or IM
- Replete through the PO route whenever possible (liquid preparations may be preferred for more rapid absorption; administer with meals to reduce stomach irritation)
- Patients on drugs sensitive to hypokalemia (e.g., digoxin) require serum potassium levels of 4mEq/l or more to avoid toxicity.

Serum K+	Total Replacement Dose (consider lower doses for renal insufficiency)
≤ 3 mEq/L	40-80 mEq
3.1-3.4 mEq/L	40-60 mEq
3.5-3.9 mEq/L	20-40 mEq
4-4.2 mEq/L cardiac patient	10 mEq



## ANTICOAGULATION

### **Unfractionated Heparin Algorithm**

For inpatients requiring heparin infusion, you should generally use the hospital's heparin algorithm, which provides a weight-based recommendation of heparin boluses, initial infusion rate, and adjustments based on follow-up aPTT. The algorithm can be found on [infonet.nyp.org](http://infonet.nyp.org) (type heparin in the search engine), and a link to the algorithm is provided by Eclipsys when you order the heparin drip.

Note that some patients should not be bolused when starting heparin infusions, and that the heparin algorithm is not applicable to every patient requiring anticoagulation (e.g. patients receiving IIb/IIIa antagonists, patients who have recently received thrombolytic therapy or who are receiving thrombolytics concurrently, patients who have undergone percutaneous coronary interventions, and patients with end stage renal disease). When in doubt, check with your resident.

### **Low-molecular weight Heparin: Enoxaparin (Lovenox) and Dalteparin (Fragmin)**

Enoxaparin and dalteparin can be used in place of unfractionated heparin for both prophylactic and therapeutic purposes. They both should be avoided in patients with renal failure, severely obese patients, and patients with suspected or documented HIT. Lastly, these agents are not recommended at our institution for patients with ACS who will likely undergo cardiac catheterization.

### **Bivalirudin in ACS Level 1 or 2 Algorithm**

In moderate and high risk patients (positive troponin, recurrent episodes of rest pain, known CAD and/or new ST-T wave changes) who are PCI candidates, Bivalirudin (Angiomax) is the preferred anti-thrombin strategy.

- Dose 0.10mg/kg bolus, then 0.25mg/kg/hr continuous infusion
- When Bivalirudin (Angiomax) is used do not use Heparin
- PTT does not need to be followed

### **Warfarin Order Writing and Monitoring**

- Prior to prescribing warfarin for an inpatient, the prescriber **must** have a current PT and INR level, drawn within 24 hours prior to initiation of therapy, that can be retrieved via a NYP lab system upon which to base the warfarin dose. This must be done even if the individual has been on a standing dose as an outpatient. (**Note: If the patient is warfarin-naïve or has not received a dose of warfarin for >5 days, then check a PT for baseline coagulation status.**)
- **ALL** warfarin orders **MUST** be written on a daily basis **for at least the first 7 days of in-house therapy**. From day 8 forward, orders may be written on a weekly basis providing the patient is within the therapeutic range for his/her diagnosis by day 8. This applies regardless of how long the patient has been receiving oral anticoagulant therapy as an outpatient prior to admission. This also applies to previously treated in-house patients whose therapy was held (as with surgical procedures) and then reinitiated.
- When warfarin therapy is initiated (or reinitiated), a PT and an INR must be checked daily for the first 7 days (or longer if the patient is not within the desired therapeutic range by day 7 or is otherwise medically unstable).

- After the first 7 days, if a patient's INR is within the desired therapeutic range, the INR should be checked **at least** weekly.
- Warfarin orders **may not** be prescribed on a “sliding scale” basis nor should the order be written in an “if, then” manner (eg, if INR is <2, then give warfarin 5 mg tonight **or** warfarin 5 mg orally tonight, but hold if INR is >3).
- Documentation in the progress note is required for clinical situations necessitating an INR outside the ranges stated above for adequate anticoagulation (ie, greater or less than the value for a given indication).
- Provide the indication for warfarin therapy on the initial order (for CPOE, select this from the drop-down list).
- More frequent monitoring of the INR should be reinstated if the patient becomes clinically unstable, if dietary patterns change significantly, or if the patient requires treatment with a medication that may enhance or inhibit the actions of warfarin.

**Direct Thrombin Inhibitors** (Argatroban and Lepirudin)  
Requires approval of Hematology Services (pager 82503)



## HYPERGLYCEMIA AND DIABETES MANAGEMENT

- Always distinguish between patients with Type 1 and Type 2 diabetes. Patients with Type 1 diabetes ALWAYS need some form of basal insulin (regular insulin drip, SQ glargine or SQ NPH). Holding insulin, turning off the insulin drip, or using “sliding scales,” predisposes the patient to develop DKA.
- Type of Hyperglycemic Management: Regular Sliding Scale Insulin regimens are discouraged for lack of effective glycemic control and greater incidence of hypoglycemia

General Care Floor	Medication Orders
NPO, not eating reliably, receiving TPN or receiving tube feedings	Insulin drip, Adult General Floors, Goal BG 120-180 mg/dl Must receive glucose containing fluid BG Monitoring q 3-6 hours
Eating reliably	<ul style="list-style-type: none"> <li>• SQ basal regimen: glargine or NPH alone <u>OR</u></li> <li>• SQ basal insulin (glargine or NPH) plus prandial insulin (short-acting insulin analogues, ie aspart flex pens) <u>OR</u></li> <li>• Oral regimens (if not contraindicated, see below)</li> </ul>
ICUs	
NPO, not eating reliably, receiving TPN or receiving tube feedings	Insulin drip, Adult ICU (NOT DKA) BG monitoring q 1-2 hours
Eating reliably	As above
DKA	
Acidotic, BG > 250 mg/dl	Insulin 0.15 unit/kg IVP, Normal saline +/- potassium, Insulin drip (Adult DKA, per MD order (0.1units/kg/hour)) BG monitoring q 1-2 hours
BG < 250 mg/dl Anion gap closed, serum acetone negative	NPO: Insulin drip/glucose infusion, either general care floor or ICU order set depending on patient location Eating reliably: SQ regimen as above

- Consider Endocrine Consult for difficult BG control. Medicine patients: Endocrine fellow #83637, Diabetes nurse educator: 5-7838
- Insulin drips can be used on the floor, the ICU, and on type 1 and 2 diabetics. On the floor, the insulin drip should be ordered as part of the Eclipsys order set labeled, “Insulin/Glucose Infuse Hyperglycemia Adult.” The order set asks you to identify the patient as a type 1 or type 2 diabetic. This insulin/glucose infusion protocol has a target blood glucose of 120 - 180 mg/dl. This protocol should be considered for patients who are hyperglycemic and are NPO, not eating reliably, receiving TPN or receiving tube feedings. This order set is NOT to be used for patients in diabetic ketoacidosis (DKA). For insulin drip protocols for patients in DKA please refer to <http://infonet.nyp.org/Pharmacy/Pharmacy-M/D---G/DKA-Hypergly.pdf>
- More intense glycemic control (Goal BG 80-120 mg/dl) should be considered in the ICU’s.



## PROTOCOLS

### Needlesticks and Other Exposures to Bloodborne Pathogens

An exposure is defined by a percutaneous injury (e.g., a needlestick or cut with a sharp object) or contact of mucous membrane or nonintact skin (e.g., exposed skin that is chapped, abraded, or afflicted with dermatitis) with blood, tissue, or other body fluids that are potentially infectious.

Occupational exposures should be considered urgent medical concerns to ensure timely postexposure management and prophylaxis against HIV and hepatitis B.

In the event of a needlestick or other exposure:

1. Wounds and skin sites should be washed with soap and water. Mucous membranes should be flushed with water.
  2. Notify your supervising resident and on-call chief resident, patient coverage will be provided.
  3. Go immediately to Occupational Health on Harkness 2 during business hours or to the ER during nights / weekends / or holidays.
- Appropriate baseline labs will be drawn and you will discuss with Health Services or the ER attending the need for prophylaxis depending on the exposure type. Follow-up tests will be scheduled through Occupational Health.
  - If the HBV, HCV, and/or HIV infection status of the source is unknown, the source person should be informed of the incident and tested for serologic evidence of bloodborne virus infection. Procedures should be followed for testing source persons, including obtaining informed consent.
  - The CDC has a detailed description of risks and procedures at its website: <http://www.cdc.gov/niosh/topics/bbp/emergnedl.html>
  - The National Clinicians' Post-Exposure Prophylaxis Hotline is a 24/7 resource that offers advice on treatment and follow-up options. You and/or your provider can consider using this resource: 1-888-448-4911 <http://www.ucsf.edu/hivcntr/Hotlines/PEpline.html>



## Declaring Death

- See the patient. Check the ID bracelet. Verify that the patient is unresponsive to verbal/painful stimuli, no respirations, no pulse, no auscultatable heart sounds, no corneal reflexes, no pupil reaction to light, no doll's eye pupils.
- If it is a private patient, notify the attending. It is his/her responsibility to notify the family and request an autopsy.
- If it is a ward patient, notify the attending. Call the family if they are not present. Ask the family if they wish to view the body before it is moved to the morgue, because once it has been moved, they will no longer be able to view it. If they wish to view the body, they must come into the hospital within a certain number of hours (discuss with charge nurse)
- Request an autopsy from the next of kin (see below).
- You must **always** contact NY Regional Transplant Inc. at 1-800-443-8469 within 1 hour of declaring death to determine if any organs (including corneas) are suitable for transplant.
- Call Census / ADB (5-2624) to notify them of the expiration. They will ask you information for the Death Certificate including: Name, MRN, age, date of admission, any surgeries or invasive procedures while in house, cause of death. For the cause of death, "cardiopulmonary arrest" is insufficient; they need the underlying diagnosis and the immediate cause (e.g. 'cardiopulmonary arrest secondary to *Strep. Pneumoniae* sepsis.')
- Census will also determine whether the case is 'reportable' to the NYC Medical Examiners Office. These cases involve accidents, crime, drug overdose, suicide, HIV, or an operation or major procedure in the past 24 hours. If the case is reportable, call the NYCME at (212) 447-2030 to receive a case number that you must record in the chart before it leaves the floor. Not all reportable cases will require an autopsy.
- Questions from the family regarding the body should be directed to the AOD / census and the funeral home of the family's choice. Generally, funeral homes handle the transfers.
- Fill out the small "Death Notice," which you may obtain from the unit clerk.
- Write a short Death Declaration Note in Eclipsys. Include the patient's name, age, admit date, diagnosis, date, time and cause of death, and any circumstances such as an unsuccessful code. Note the proper lack of pulse, respirations and brainstem reflexes. Document that the family, attending and census have been notified.
- Census/ADB will bring a Death Certificate form for you to fill out. After they enter the form into the computer, they will contact you for your electronic fingerprint signature.
- At the Allen Pavilion, page the Nursing Care Coordinator (NCC beeper 83906) who will bring you and assist you with the filling out of the Death Certificate form.
- The intern must complete the chart for all deaths in the form of a discharge summary.

## Autopsies

- Inform the legal next of kin that it is hospital policy to ask about autopsies on all deaths that occur in the hospital. Tell the family that they can consent to partial autopsies as well (e.g. everything except the head, these limitations must be written on the autopsy consent form). The legal next of kin are defined in the following decreasing order:
  - a. Spouse
  - b. Children over 21
  - c. Parents
  - d. Siblings 21 or older
  - e. Grandparents
  - f. Guardian at the time of death

Note: common law spouses or other health care proxies not listed above **cannot** grant consent.

- You must have a signed consent, (consent form is available on Webcis log in page under Hospital and Departmental Resources, Clinical Forms) – either an original or fax (telephone consent is not sufficient). Partial autopsy restrictions must be written on consent form.
- The requesting physician must countersign the form and place it in the chart.
- Notify Census (5-2624) that the family has consented to an autopsy and they will take care of the rest. Tell them of any time restrictions the family has placed on the autopsy.
- Notify autopsy/pathology service. (When you call, you can tell the service / resident that you want to be notified when the autopsy will occur so you can observe. They are good about accommodating this request.) Document in your Death Declaration Note that the family consented to an autopsy, and that you notified the pathology service.
  - a. Autopsy service (8am – 5pm weekdays): 5-6239
  - b. Autopsy Resident Beeper: bpr 87284 (8-PATH)
  - c. Autopsy Manager Beeper: bpr 86606
- Suggested Monologue-Requesting an Autopsy from Next of Kin. (Adapted from the Pocket Guide to Autopsy):

I am Dr \_\_\_\_\_, I am sorry to inform you that \_\_\_\_\_ just passed away. We believe the cause of death was \_\_\_\_\_. To help us better understand this disease, and to evaluate its effect on the body we seek your permission to perform an autopsy. The procedure may benefit other patients with this disease by helping us improve treatment. Sometimes diseases that run in families are found, and in those cases the family may benefit by early diagnosis. The autopsy will be performed in the hospital. Physicians trained in the procedure will perform the autopsy. The procedure usually takes about three hours. During an autopsy, surgical techniques are used and the procedure will not affect the viewing of the body at a funeral. The face is not altered, even when the brain is examined. There will be no charge to the family for the autopsy. You may get a copy of the report from Patient Relations (55904/44321) and someone will be able to discuss the autopsy findings with you in 2-3 months. If you have any religious concerns please feel free to discuss these with your religious or spiritual advisor. The hospital chaplain may also guide you. As next-of-kin will you grant permission for an autopsy by signing the autopsy consent form?



## **Isolation Protocols**

- **Respiratory / Airborne Isolation:** Requires Mask (N95), negative pressure room, hand-washing, patient wears mask for transportation.
  - *Examples:* Tuberculosis / Hemorrhagic fevers / Measles / SARS
  - Patients on respiratory isolation who require dialysis are to be dialyzed in Isolation / HD rooms.
- **Droplet Isolation:** Requires single room (not negative pressure room), surgical mask or fluid shield, hand-washing, patient wears mask for transportation.
  - *Examples:* Influenza, H. influenza, N. meningitides, Parvovirus, Rubella, Scarlet fever, Diphtheria.
- **Contact Isolation:** Requires single room (not negative pressure room), gowns, gloves, masks, hand-washing before and after being in patient room, discarding all protective suits before leaving patient room.
  - *Examples:* Contagious skin infection (HSV, impetigo, scabies, lice), infection or colonization with highly resistant bacteria (including MRSA, VREF, PCN-resistant pneumococcus), C. difficile diarrhea, RSV.
- **Varicella Isolation:** Isolation for varicella depends on the clinical scenario. Only personnel with known immunity should contact these patients. There should be a varicella exposure sign posted on door.

Clinical scenario	Isolation Protocol
1. Suspected or confirmed chicken pox 2. disseminated zoster 3. localized infection in an immunosuppressed host 4. exposed susceptible patient with the first signs of infection	1. respiratory isolation (negative pressure room, closed door) 2. wear gloves
1. localized in a normal patient	1. single room with closed door

\*\*\*\*\*If you are thinking of discontinuing isolation please contact hospital epidemiology at 5-7025 to verify that the proper steps have been followed.\*\*\*\*\*



## **Restraint Policy:**

Examples: mittens, two-point extremity restraints, four-point extremity restraints, vest restraints, full/four siderails, etc...

- Nurses follow a specific restraint protocol and keep a flowsheet. Restraint orders must be reordered in Eclipsys on a q24h basis indicating the behavior and reason they are being used as delineated by the Eclipsys drop-down list. An order for 4-point restraints is valid for only 4 hours whereas all other restraint orders are valid for 24 hours.
  - Restraint orders must include the following components:
    - the DATE the restraint is ordered
    - the TIME the restraint is ordered
    - the TYPE of restraint to be used
    - the AMOUNT OF TIME THE PATIENT IS TO BE RESTRAINED, not to exceed 4 hours for 4-point restraints, not to exceed 24 hours for all other restraints.
    - the patient's BEHAVIOR or CONDITION requiring the use of restraints
    - the specific REASON the restraint is being ordered for the patient
    - the physician/appropriately credentialed professional ordering the restraint
  - The required components of restraint orders have been incorporated into the computerized order entry program. For paper orders, a preprinted sticker that includes the required components is used for writing restraint orders. The sticker is affixed to the Doctor's Order Sheet and completed by the physician/appropriately-credentialed professional. Handwritten orders without the sticker cannot be implemented.
  - Alternatives to restraints:
    - Stop offending medications or bothersome treatments (e.g. oral vs. tube feeds, foley catheters)
    - Modify the environment, reduce noise and stimulation
    - Provide reality orientation and psychosocial interventions
    - Offer diversionary and physical activities (e.g. recreational therapy)
    - Consult additional disciplines (e.g. psychiatry consult liaison)
    - Provide 1:1 or 1:2 observation: this is an acceptable option-- although it may impose personnel difficulties on the floor, it is often the safest alternative to restraints (certain floors, such as 6GN and 9GS, also offer 1:4 observation in cluster rooms).



## Telemetry Criteria

For patients on Cardiology service (5GS and 5GN)- Many patients on this service will be on 24 hour telemetry monitoring. These are monitors that are attached to the patient and followed by technicians either on the floor as well as in a separate building on campus. When you are pre-rounding on your patients on floors with a telemetry technician present (5GS and 5GN), you should ask the floor-specific technician for a 24-hour report. If you have a patient on any other floor, you should call the Telemetry Office at 5-6018 for a full report. The nurses on the cardiac floors should have written down in the chart any telemetry events over their shift, and documented the overnight telemetry report in Eclipsys. You can print out any rhythm strips that you may need from the monitors in the nursing station. Ask your resident to show you how to use the telemetry monitors (see below for telemetry rules for non-cardiac floors)

Non-Cardiology patients- When you are pre-rounding, you should call the Telemetry Office at (x56018) for a 24 hour Telemetry Report on all patients that are not on 5GS or 5GN (see above). Any patient admitted to a non-cardiac floor may have telemetry ordered for the first 72 hours of admission via eclipsys. If extended telemetry monitoring is required, the primary team will need to obtain approval from the arrhythmia service at 83532. The service requires approval for additional use beyond 72 hours. In the absence of this approval, telemetry will be discontinued.

- There are 2 telemetry orders at Milstein. One labeled as “Milstein Telemetry-Cardiac Floors” and the other as “Milstein Telemetry-Non cardiac Floors.” It is MANDATORY that providers use the “non-cardiac floors” order for all patients on non-cardiac floors (all hospital floors except for 5GN, 5GS, 5HN, 7HN). This order will automatically expire after 72hrs with no notification being required. If approval is obtained for a further 72 hours, the “non cardiac floor” order will need to be re-ordered in Eclipsys. If extended approval is obtained for the duration of the hospital stay, the “cardiac floors” order must be reordered.
- The decision to place a patient on/off telemetry is determined by the intern, resident and attending. Telemetry boxes are available on all floors. **Please remember that telemetry boxes are somewhat limited, so review the need for telemetry boxes for your patients on a daily basis with your resident.**
- The telemetry screens are located in the service building and are continuously monitored by the technicians (5-6018). They may call you for rate change, but it is your responsibility to review telemetry activity for the past 24 hrs at least daily before work rounds by calling the telemetry center.
- If you are called for an arrhythmia, you should review the actual strips by printing them out from the monitors located in each nursing station.
- At the Allen Hospital, telemetry is monitored by technicians on 2RE. You can also view your patient’s telemetry on each floor by accessing the telemetry computers
- Some indications for telemetry monitoring include:
  - Known or life-threatening arrhythmias (e.g. VF or symptomatic sustained VT).
  - Arrhythmias during anti-arrhythmic medication adjustment.
  - Level II or Level III Chest Pain
  - Digoxin toxicity.
  - Other potentially pro-arrhythmic medications (e.g. TCA’s, phenothiazines, antiarrhythmics).
  - Syncope with high probability of arrhythmic cause (e.g. low EF, age > 65, structural heart disease, CAD, AS, IHSS, conduction disease, etc.)
  - New pacemaker or defibrillator insertion.
  - Post-op arrhythmias.
  - Post-infarct patients and recent CCU transfers.
  - CAD awaiting surgery.

- Electrolyte abnormalities.

## CROSS-COVERING PATIENTS

### **Receiving the sign out:**

- Make sure you know from whom the list is coming and to whom it goes in the AM

### **For lab checks:**

- Ask what time the test is supposed to be drawn (so you'll know when to look for the results).
- Get specific parameters for responses.
- Don't forget to order follow up labs if needed (next Troponin, PTT).

### **For radiology studies:**

- Ask what time the test is supposed to be performed (so you'll know when to look for the results).
- If it involves IV contrast, ask about the patients renal function, and if they have the proper type of IV.
- Make sure you know why the test was ordered (what is the team looking for?) and how to respond to it.

### **For attending notes:**

- Ask which attending/consult team notes need to be followed up.
- You should really only implement emergent recommendations, the rest should be left to the AM team.

### **For bed checks:**

- Ask specifics about what you are checking for and what they are concerned about. "Please check patient" is not enough.
- Ask what you should do with what you find. (eg. if you are supposed to check for orthostasis and the patient is orthostatic, what should you do?)
- Write a brief note about what you find and what you did.

### **For responding to a change in the patient's condition:**

- Whether it be chest pain, abdominal pain, fever, or dyspnea, *always* ascertain the patient's latest vital signs. You can ask the nurse or aid to obtain these while you are on your way to see the patient.

### **Responding to specific calls:**

- Chest pain
  - Before you go in the room:
    - get the EKG machine and sublingual nitro and take these into the room with you
    - check the sign-out so you know the patient's PMH and basic story
  - Once you are there:
    - do a directed history and physical
    - do an EKG and show it to your resident
    - discuss the plan with your resident
    - consider drawing basic labs (cbc, chem 7, troponin) and ordering a chest x-ray – discuss this with your resident
    - document what you are doing and the follow-up plan in the chart
- Shortness of Breath
  - Before you go into the room:
    - get the O2 sat monitor from the nurse on your way in
    - check the sign-out so you know the patient's PMH and basic story

Once you are there:

- put the O2 sat monitor on the patient while you take the history and physical
- place supplemental O2 on the patient, escalate quickly to maintain and O2 sat >90%
- do a directed history and physical
- remember the differential diagnosis of shortness of breath
- if the patient is in pulmonary edema, remember LMNOP: (lasix, morphine, nitrates, oxygen, position)
- give additional oxygen if appropriate
- consider performing an EKG and ordering a CXR or doing an ABG.
- as always, discuss the plan with your resident and write a note in the chart documenting what you did and the follow-up plan.



## CONSULTS

### **Tips on requesting consults:**

- Call early in the day (while pre-rounding)
- Provide your name/ pager; ask for consults name/pager.
- Explain reason for consult (ideally focused question)

What is the pager number for the \_\_\_\_\_ consult?

Look at the blue card, if not there/wrong number proceed to #2

See the On Call Consult section on the Webcis patient page (left column, near the bottom) to obtain the correct pager to call for the appropriate consult, if this fails proceed to #3 for consult services in Milstein Hospital.

Call the page operator x 5-2323

### **AIM General Medicine Clinic**

To schedule new patients or to schedule follow-up visits with an AIM resident/attending PMD: 55574

*For emergency scheduling issues, call Christina Collado at 5-6262*

### **Cardiology**

- General consult: pager 82737 (8-CRDS)
- Cards clinic: 851-5350
- Arrhythmia consult: pager 83532 (8-ELEC), Clinic 305-6345
- Heart failure clinic: 305-4600
- Lipid clinic: 305-7666

### **Dermatology**

- Consult (resident): pager 81799.
- On the weekends / nights / holidays if pager 81799 is signed out: pager 81704
- Clinic AP 12: 305-0505

### **Endocrine**

- Diabetes education for inpatients: 5-7838
- Endocrine consult (fellow): pager 83637 (8-ENDR)
- Diabetes consult (fellow/NP): 917-247-0936
- Clinic: 305-6354, 305-6355
- Diabetes clinic (Naomi Berrie Center): 851-5494

### **ENT**

- General consult: pager 83687 (8-ENTS)
- Trach consults - call page operator (changes q month)
- If consult is scrubbed in OR/unavailable, page Peds ENT consult or trach consult.
- Clinic: 305-9860

### **Ethics**

- Rose Ann Cannon: 305-5904 (Patient Relations)
- On weekends / nights / holiday, call the Administrator on Call (pager 82251)

### **Gastroenterology**

- General GI consult (fellow): pager 84427 (8-GIBS)
- GI Nutrition consult (fellow): pager 86887 (8-NUTR)
- Liver Transplant (fellow): pager 89666

- Liver clinic: 851-5350
- Liver transplant clinic: 305-0914

### **Genetics**

- Fellow's office: 2-1728
- Attending: Dr. Anyane-Yeboa: clinic # 5-6731

### **Hematology/Oncology**

- Heme consult (fellow): pager 82503
- Onc consult (fellow): 86628
- Clinic: 305-1983

### **Infectious Disease**

- ID consult fellow (for patients with an even medical record number): pager 83867 (8-EVNS)
- ID consult fellow (for patients with an odd medical record number): pager 86337 (8-ODDS)
- HIV Clinic (Harkness 6): 305-3174

### **Interventional Radiology**

- Call IR: 305-5123 to schedule a procedure (may require a paper requisition that they can fax you and then you can fax back), or visit the IR suite to fill out a paper requisition and/or speak with someone in person (MHB 4<sup>th</sup> floor)
- IR consult (fellow): pagers 82282 and/or 82283 (usually best to page both numbers at the same time)

### **Neurology**

- Neuro consult (resident): pager 86876 (8-NURO)
- Acute stroke (fellow): pager 89999 (for tPA or other intervention within 8 hours of acute deficit)
- Clinic (VC-10): 305-6500
- Memory clinic: 543-5853

### **Neurosurgery**

- Consult resident: pager 83425

### **Obstetrics & Gynecology**

- Consult resident: pager 86203
- Clinic (Audubon): 342-3220

### **Ophthalmology**

- Eye clinic: 305-6185
- Ophtho consult (resident): beeper 81681

### **Orthopedic Surgery**

- Milstein
  - Fracture resident: pager 86169
  - Non-fx (septic joints/onc/hand) resident: pager 86168
- Allen Pavilion: pager 81313 (all ortho issues)
- Clinic VC3: 305-5187

### **Pulmonary**

- Pulmonary consult (fellow): pager 87856 (8-PULM)
- Clinic (VC10): 5-6390
- Sleep clinic/lab: 305-1860

-Smoking cessation clinic (VC8): 305-9054

### **Psychiatry**

-Consult Liason: 305-9985

-On weekends/ nights / holidays, call psych ER resident on call: 305-8075

-Geriatric Psychiatry: 305-6354

### **Radiology**

-Call reading rooms during office hours

-On weekends / nights / holidays, call ER reading room 305-8418

-If no response in the ER reading room, call VC Xray for pager of resident on call: 305-6501

### **Radiation Oncology**

-Main number: 305-2991 (note: pagers do not work in sub-basement)

### **Rehab**

-Pulmonary Rehab: 305-0890

-Cardiac Physical Therapy: 305-6550

-Inpatient Rehab consult (resident): pager 82605

### **Renal**

-Renal consult (fellow): pager 87362 (8-RENA)

-For patients on the 5<sup>th</sup> Floor call Cards/Renal 82284 (8-CAVH)

### **Rheumatology**

-Rheum consult (fellow): pager 84686

-Clinic (VC 2-240): 305-5952

### **Surgery**

-Milstein

General consult (resident): pager 88882

-Allen Pavilion

General consult (resident): 88883

CT Surgery: please refer to On-Call site on Webcis as above

Allen clinic 3rd floor: 932-5200 (Meets Wed PM)

-Milstein Surgery clinic (includes general surgery, breast, and vascular surgery clinic): 305-6390

### **Urology**

-Consult resident: pager 84848 (8-GUGU)

-Clinic (at the Allen Pavilion): 932-5220

### **Wound Care Consults**

-The physician should call in the consult by calling 5-7190 and leaving a voice message.

Appropriate criteria for calling a wound care consult:

patients with stage III/IV decubitus ulcers

diabetic foot or arterial ulcers

patients with multiple level I,II decubiti

patients with a few level I,II decubiti do NOT need a formal evaluation

Note:

If vascular surgery is already seeing the patient, in general the wound care nurse consult isn't going to add much

## **APPLYING FOR NYS LICENSURE AND USMLE STEP III**

All housestaff must take the USMLE Step III prior to starting the PGY3 year. Housestaff are not required to, but are encouraged to apply for NY State medical licensure.

The overall process involves two applications:

- 1.) USMLE Step III application to the [Federation of State Medical Boards](http://www.fsmb.org) (<http://www.fsmb.org>)
  - USMLE Step 3 Application form (requires a passport-sized photo and notarization)
  - [Notarized](#) copy of your medical school diploma
  - \$635 application fee
  
- 2.) Licensure application to the [NYS Education Department](http://www.op.nysed.gov) (<http://www.op.nysed.gov>).
  - Form 1 - requires another passport-sized photo.
  - Form 2 - goes to your medical school and *they* send it to NYS.
  - Form 2PGT - hand in to Gladys Bueso
  - Completion of Child Abuse Reporting Course or Form 1CE – completed during orientation.
  - USMLE Scores (EBAHR form) – \$50 fee. Can download score request form at [http://www.fsmb.org/](http://www.fsmb.org) (click on Transcript Requests)
  - \$735 application fee (hospital will no longer be reimbursing license application fees)

**Notary Public Resources** - A Notary Public is needed for the USMLE application, diploma copy, and the EBAHR. This can be difficult to do given resident hours. Some options:

- Vilma Luciano, Chief Resident's Office MHB 6 Center Rm 12 (52913); \*only for residents
- Marina, Endocrine Department offices, PH-8W, Room 876 (5-6238)
- Alba Tapia, VC-12, Physician's Billing Office (5-9331)
- Most banks at which you have an account (including the Chase branch in Harkness Pavilion)

### **Moonlighting:**

-All residents who have passed the USMLE Step 3 exam, obtained a NYS medical license, and completed at least a rotation as a PGY2 in the MICU or CCU are allowed to apply to work as a moonlighting hospitalist

-In order to be eligible for moonlighting, residents must have completed all pending discharge summaries as well as be in compliance with mandated work hour regulations

-Residents can only moonlight while on vacation, elective, or outpatient, and their moonlighting hours will be counted towards their hours worked for work hours that week

-To apply for moonlighting contact Hector Torres at [hht2104@columbia.edu](mailto:hht2104@columbia.edu) and to find out more information please go to [http://www.hospitalist.cumc.columbia.edu/moonlighting\\_program.html](http://www.hospitalist.cumc.columbia.edu/moonlighting_program.html)



## **MEDICAL ETHICS CONSULT**

### Medical Ethics Consultation

This introduction to medical ethics was developed by Drs. Kenneth Prager and Gerald Neuberg. It includes provisions of NY's Family Health Care Decisions Act (FHCDA), in effect since 2010. For Milstein Ethics Consults, call Patient Services at x55904. At the Allen, call Patient Services at x44321 on weekdays (9-5); after hours call Milstein PSA.

### **When to call an Ethics Consult**

Common reasons for Ethics consultation include questions about end-of-life care, feeding tubes, patient capacity, substituted judgement, conflicts (family-physician, intra-family, etc.), futility, hospital policies and questions of law

Ethics consultation is required by hospital policy before:

- 1) Withdrawal of life-support
- 2) Withdrawal of nutrition and hydration
- 3) Extubation of a brain dead patient against objection of family

Ethics consultation is not routinely required for

- 1) DNR orders
- 2) Determination of capacity
- 3) Brain death determination

### **What to do before calling an Ethics Consult**

1. Collect accurate medical facts: what has occurred and what is the likely prognosis?
2. If the patient has capacity, determine his or her wishes concerning the issues at hand, and encourage designation of a Health Care Proxy.
3. Ask patient or relatives for any written advance directives - living will or health care proxy form – and place copies in the chart.
4. Contact the patient's primary care provider for information.
5. What are the ethical issues in the case? What questions are being asked of the consult? Review the Ethics ABCs below, if necessary.
6. Always inform the patient/surrogate that an ethics consult is being requested.
7. When appropriate, assess patient capacity as follows: Does the patient understand:
  - a) his or her illness,
  - b) the purposes, benefits, risks and alternatives of treatment, and
  - c) the consequences of declining treatment.

For questions of neuropsychiatric disease, request a neurology or psychiatry evaluation before calling an ethics consult.

8. If the patient lacks capacity, find out if his or her wishes ever were discussed with any family members or friends.

### **Patient's rights**

Competent patients have the right to be fully informed about their treatment and to refuse unwanted care. Patients may even forego lifesaving treatment for a variety of personal and cultural reasons. When the patient's reasons for refusing care seem irrational, consider assessment of decisional capacity and/or ethics consultation.

Patients without capacity can have most decisions made by their health care agent (proxy, if designated in writing by the patient) or a surrogate (if no proxy is available), in accordance with patients' stated wishes or best interests (if wishes are unknown). Before making substantive decisions about medical treatment without the patient's consent, it must be established that the patient lacks decision-making capacity. This must be documented in the chart by two Attendings. A psychiatrist need not be called unless there is an issue concerning psychiatric illness or developmental delay.

The priority order of who can be a surrogate (in absence of a proxy) is:

- a) A court-appointed guardian
- b) The spouse (if not legally separated) or domestic partner (latter added in FHCDA)
- c) A child at least 18 years of age
- d) A parent
- e) A sibling at least 18 years of age
- f) A close friend

For patients with no surrogates, two Attending physicians may approve procedures normally requiring written consent by documenting medical necessity in the chart. But patients without capacity still have rights, especially regarding acceptance or refusal of nonemergency treatment. Their preferences, comfort, privacy, dignity, and cultural background all must be considered in planning care. One should consider an ethics consult before carrying out diagnostic or therapeutic actions that the patient refuses, unless it is an emergency and delay will harm the patient.

### **Levels of care**

Levels of care can be divided into 4 general categories that provide a useful framework for staff and a valuable roadmap for patients and families.

**LEVEL 1 or FULL CARE:** This is the default category - all hospitalized patients are presumed to want full care unless otherwise specified. Discuss patient's wishes and proxy designation ASAP.

**LEVEL 2 or DNR/DNI:** Full treatment except for CPR and intubation. DNR can be considered when CPR is unlikely to succeed or, even if successful, will not restore the patient to a quality of life that would be acceptable. Before ordering DNI, verify that the patient *never* wants intubation, not even if temporary and life-saving. Some patients say no initially, meaning *not yet*, but later change their minds after their condition worsens. If the patient wants to separate these directives, the correct order is "DNR" (but not DNI) and the chart should clarify the reason for this distinction and address whether the patient would want to be kept on a ventilator indefinitely.

Importantly, DNR status only limits treatment in the event of cardiopulmonary arrest and does not affect on-going care. This definition must be strictly observed in order to maintain the trust of families who fear that, if they sign the DNR form, the patient's treatment may be compromised or limited.

**LEVEL 3 or ORDINARY CARE:** Noninvasive treatment will be given, but the patient is DNR and invasive or aggressive treatment - such as surgery, dialysis, and/or vasopressors - will be

withheld. If the patient already is on a ventilator or dialysis, the current level of life support will be continued, but none will be added.

**LEVEL 4 or COMFORT CARE:** Treatment should focus primarily on comfort rather than on further active treatment of irreversible illness, which will only prolong the dying process. Nonessential medications, needlesticks and tests are discontinued, and removal of life support may be considered.

The table outlines who may authorize decisions about levels of care, or about withdrawing and withholding life-support, or nutrition and hydration.

**LEVELS OF CARE and WHO CAN DECIDE (in NY STATE)**

Level of Care or Decision	Pt with capacity	Patient without capacity		
		Proxy	Surrogate	2 MDs
<b>1) Full care</b> (default level)				
<b>2) DNR/DNI</b> (Full treatment except CPR and intubation) <sup>a</sup>	Yes <i>Form 1</i>	Yes <i>Form 4</i>	Yes <i>Form 5</i>	Only with narrow criteria <sup>b</sup> <i>Form 6</i>
<b>3) Ordinary care</b> (withhold surgery, dialysis, pressors, etc)	Yes	Yes	Yes <sup>c</sup>	Yes <sup>d</sup>
<b>4) Comfort care</b>	Yes	Yes	Yes <sup>c</sup>	Yes <sup>d</sup>
Remove life-support <sup>e</sup>	Yes	Yes	Yes with criteria <sup>f</sup>	Only with narrow criteria <sup>f</sup>
Withhold or withdraw nutrition & hydration <sup>e</sup>	Yes	Yes <sup>g</sup>	Yes <sup>g</sup>	

a. A patient or representative may choose to be DNR but accept temporary intubation for reversible illness (DNR but not DNI; see text above).

b. For patients without capacity who have no available surrogate, two Attendings may authorize a DNR/DNI order under limited circumstances, which are now the same as for removal of life support. See text below for new criteria per FHCDA of 2010.

c. These decisions may apply near the end of life. However, when there is a reasonable chance of recovery, nonproxy surrogates have less authority than a proxy to refuse lifesaving procedures such as an appendectomy. Such requests must be interpreted in light of the medical situation and the patient’s previously expressed wishes, and ethics consultation may be appropriate.

d. When no surrogate is available, the Attending physician generally can decide on a medically appropriate level of care. For dying patients with no available surrogates or advance directives, physicians may even authorize comfort care on the basis of the patient’s best interests, though we are reluctant to unilaterally withhold all active care (e.g. antibiotics) unless death is imminent.

e. Patient Services must be consulted.

f. See text below for new criteria per FHCDA of 2010

g. Nutrition/hydration can only be withdrawn if it is being administered “medically” by artificial means. Oral nutrition (as tolerated) cannot be withheld by a proxy or surrogate. Criteria similar to removal of life support. See text below.

### Removal of Life Support

Patients who are dependent on some form of life-support (i.e. ventilator, dialysis, pressors, LVAD, pacemakers) may wish to have treatment withdrawn (or devices inactivated) if their condition and prognosis become very poor and if they fail to respond to treatment. However, removal of life-support requires special authorization.

In NY State, removal of life support requires the direct request of a patient with capacity or, for patients without capacity, requires one of the following:

- 1) A written living will which requests removal of life support in the current clinical circumstances,
- 2) Clear evidence of patient’s previously expressed verbal wishes to forego life-support in the current circumstances,
- 3) Request by a proxy,
- 4) Request by a nonproxy surrogate (without advance directives) if the Attending affirms that the patient is terminally ill or permanently unconscious and continued treatment carries an “extraordinary burden,” or patient has an irreversible condition and continued treatment would involve “excessive pain and suffering” under the circumstances (per FHCDA of 2010); or
- 5) If no surrogate is available, 2 Attendings must affirm that continued treatment provides “no medical benefit” because patient will die imminently and treatment would “violate accepted medical standards.” (also applies to 2-physician DNR, per FHCDA of 2010)

Prior to removal of life-support, Patient Services must be consulted. Attending and consult notes (i.e. neurology) must attest to an extremely poor prognosis, and DNR must be ordered. Additional preparations include:

- 1) Make sure the family is unanimous and emotionally ready,
- 2) Pastoral care,
- 3) Funeral arrangements,
- 4) Timing for family to be present if they wish,
- 5) Explain uncertain duration of survival,
- 6) Explain that distress and gasping are treatable with narcotic drip hanging, and
- 7) Notify NY Organ Donor Network (1-800-GIFT-4-NY). If the patient is expected to die within just one hour of extubation, consideration should be given to the Donation after Cardiac Death (DCD) protocol.

### Brain Death

Irreversible cessation of brain function is characterized by coma, absence of brainstem reflexes, and absence of breathing (apnea). Evaluation consists of two neurologic examinations at least 6 hours apart and a positive apnea test. At least one of the exams must be performed by a neurologist or neurosurgery attending. A confirmatory test such as an EEG, transcranial Doppler or cerebral SPECT scan is required only under certain circumstances.

After brain death determination, the family should be notified that the patient is legally dead and

therefore the ventilator will be shut off. A DNR order is not required. NY State requires “reasonable accommodation of an individual’s religious or moral objection to use of the brain death standard to determine death.” If the family objects to removal of the ventilator, it should be continued pending ethics consultation. The NY Organ Donor Network (1-800-GIFT-4-NY) must be notified as soon as there is a suspicion that a patient may be or soon will be brain dead – not after determination. Their representatives are specially trained to assess patients for possible organ donation and then to discuss it with the family. Treating physicians generally should not bring up donation with the family until after the Network representative has assessed the patient.



## **ANTIBIOTICS**

For information regarding antibiotic dosing, restrictions, and empiric treatment guidelines, go to the website of the Division of Infectious Diseases at <http://cumc.columbia.edu/dept/id/web/>

### **Restricted Antibiotics:**

- Antibiotic approval must be obtained during the day for starting many antibiotic and anti-viral medications (note IV vancomycin can be given for 72 hours prior to requiring ID approval). To obtain anti-biotic approval you must page 82298
- Overnight pharmacy will dispense all antibiotics without approval, but to continue an antibiotic that requires approval, you must call for approval in the morning

## ADMINISTRATIVE SUPPORT

The following is an attempt to describe a chain of command for the housestaff when there are “roadblocks” to obtaining medically necessary patient care or information, within the departments of **Medicine, Nursing, Laboratory, and Pharmacy**.

### **Physician Resources**

#### ICU Triage (b. 86332)

A senior resident carries this beeper 24 hours/day, 7days/week to perform medical consults and to assist in patient triage for the intensive care units. This resident can assist other residents with various patient care issues as needed.

Chief Resident On-Call – the page operator (5-2323) knows which chief resident is on call each night. The chief resident on call is also listed in amion.

#### Unit Directors

Call each unit's specific director:

MICU: Dave Chong, MD

CCU: Leroy Rabbani, MD

NICU: Stephan A. Mayer, MD

CTICU: Peter Salgo, MD

SICU: Robert N. Sladen, MD

### **Laboratory Resources**

#### Laboratory:

During weekday daytime hours, call the general lab numbers and ask to speak to the supervisor. After hours, page the lab supervisor at #86859

#### ECG Services:

##### Weekdays

8:00am – 4:00pm	5-9866
4:00pm –12:00am	5-7155 or page ECG techs directly: beeper 88009 for MHB 5GN, 5HN, 9th floor beeper 88461 for MHB 6th floor beeper 81018 for MHB 7th floor beeper 87657 for MHB 5GS and 8th floor
12:00am- 8:00am	beeper 85867 for MHB 5th and 6th floors beeper 85866 for MHB 7th, 8th, and 9th floors

##### Weekends and Sunday

12:01am –8:00am beeper 85866 or beeper 85867 (try both)

#### Phlebotomy Services:

Phlebotomy Director – June Mahoney 5-5602

##### Weekdays

8:30am – 4:00pm	5-7155
4:00pm –12:00am	5-7155 or page ECG techs directly: beeper 88009 for MHB 5GN, 5HN, 9th floor beeper 88461 for MHB 6th floor

	beeper 81018 for MHB 7th floor
	beeper 87657 for MHB 5GS and 8th floor
12:00am- 8:00am	beeper 85867 for MHB 5th floor and 6th floor beeper 85866 for MHB 7th, 8th, and 9th floors
Weekends and Sunday	
12:01am –8:00am	beeper 85866 or beeper 85867 (try both)

### **Nursing Resources**

House-wide coverage is provided by the Nursing Coordinators or Administrators in the nursing office located on the 6th floor from 4pm to 8am on weekdays and on weekends from 4pm Friday to 8am on Monday:

Office phone number: (212)305-5181 or (212)305-2877

Pagers: 85212 (Specialty units) and 85210 (General units)

Cell phone: (917)836-8763 (Specialty units) and (917)763-5987 (General units)

General units are: McKeen, 8GN rehab and med, 9GS, 8HN, 8HS, 7GN, 7GS, 6GN, 6GS, 6HN, 6HS and HP10. All of the ICU's, 8GN/S, 7HN/S, 9GN, 5GN/S are specialties.

### **Pharmacy Resources**

The NYPH Drug Formulary can be found at <http://www.crlonline.com/crlsql/servlet/crlonline> OR can be accessed from the NYP.

Infonet webpage below. This resource provides drug information as well as links to the policies associated with individual drugs (e.g. reconstitution information, dosage forms available, KCI policy, dofetilide prescribing policy, etc.).

Please see the NYP Infonet webpage (<http://infonet.nyp.org/>) for new policies and updates to pre-existing policies. In addition, the “Clinical Information and Drug Alerts” section on this page highlights recent drug warnings and shortages.

### Clinical Pharmacy Managers (Adult)

- Stacy Anamasis, Pharm.D., BCPS - Solid Organ Transplant, Liver (pager #86535)
- Lillian Chou, Pharm.D., BCOP - Oncology (pager #83646)
- Shalini Dosi, Pharm.D. - Emergency Medicine (pager #80554)
- Amy L. Dzierba, Pharm.D., BCPS - Critical Care, Medicine (pager # 88244)
- Jorie Frasiolas, Pharm.D. - Critical Care, CT/Surg (pager # 80161)
- Christine Kubin, Pharm.D., BCPS - Infectious Diseases (pager # 82356)
- Asma Lat, Pharm.D. - Infectious Diseases
- Christine Lesch, Pharm.D., BCPS - Critical Care, Neurosciences (pager # 83177)
- Karlene Ma, Pharm.D., BCPS - Critical Care, Cardiac (pager #84949)
- Spencer Martin, Pharm.D., BCPS - Solid Organ Transplant, Heart (pager #88727)
- Kelly Wright, Pharm.D., BCPS - Infectious Diseases (pager #80699)
- Mona Patel, Pharm.D. - Critical Care, Surgical (pager #85743)
- Martha Rumore, Pharm.D., JD - Drug Information (pager #85676)
- Jenna Scheffert, Pharm.D. - Solid Organ Transplant, Lung (pager #80097)
- Demetra Tsapepas, Pharm.D. - Solid Organ Transplant, Kidney (pager #81332)

## HEALTH CARE FOR THE HOUSESTAFF

**Roy Lackey, M.D.**  
**Medicine-General Medicine**  
161 Fort Washington Avenue, Suite 421  
New York, NY 10032  
Phone: (212) 305-2001  
Fax: (212) 305-0713

**Seth Feltheimer M.D.**  
**Medicine – Internal Medicine**  
161 Fort Washington, Rm 3-337  
212-305-8669

**Henry Lodge, M.D.**  
**Medicine-General Medicine**  
635 Madison Avenue, 8<sup>th</sup> floor  
New York, NY 10022  
Phone: (212) 857-4555  
Fax: (212) 752-3390

**Angela Dimango, M.D. (Offers Primary Care)**  
**Medicine-Pulmonary, Allergy & Critical Care Medicine**  
161 Fort Washington Avenue, Suite 312  
New York, NY 10032  
Phone: (212) 305-5730  
Fax: (212) 305-0242

**Douglass Marratta, M.D.**  
**Medicine-General Medicine**  
161 Fort Washington Avenue, Suite 218  
New York, NY 10032  
Phone: (212) 305-3477  
Fax: (212) 342-6054

**Aaron Manson, M.D.**  
**Medicine-General Medicine**  
161 Fort Washington Avenue, Suite 421  
New York, NY 10032  
Phone: (212) 305-3804  
Fax: (212) 305-0713

**Mindy Weiss, M.D.**  
**Medicine-Internal Medicine**  
110 East 59<sup>th</sup> Street, Suite 10A  
(212) 750-7404

**Christine Matera, M.D. (Only Oxford)**  
**Obstetrics & Gynecology**  
50 East 77<sup>th</sup> Street  
Phone: (212)639-9122

**Eileen DeMarco, MD**  
**Obstetrics & Gynecology-General**  
161 Fort Washington Avenue, Suite 435  
New York, NY 10032  
Phone: (212) 305-1517

**Elizabeth Visser, NP**  
**Obstetrics & Gynecology**  
161 Fort Washington Avenue, Suite 447  
Fax: (212) 305-6125

**Joshua Holden, M.D.**  
**Obstetrics & Gynecology-General**  
161 Fort Washington Avenue, Suite 4-437  
New York, NY 10032  
Phone: (212) 305-0311

**Katerina Eisinger, M.D.**  
**Joshua Holden, M.D.**  
**Obstetrics & Gynecology-General**  
161 Fort Washington Avenue, Suite 4-438  
16 East 60<sup>th</sup> street, Suite 480  
Phone: (212) 305-4029

**Thomas Shin, M.D.**  
**Obstetrics & Gynecology-General**  
161 Fort Washington Avenue, Suite 4-438  
New York, NY 10032  
Phone: (212) 305-5760  
Fax: (212) 305-1423

**Kate O'Connell, M.D.**  
**Paula Castano, M.D.**  
**Obstetrics & Gynecology**  
161 Fort Washington Avenue, Suite 423  
(212) 305-9368

**Laxmi Baxi, M.D.**  
**Obstetrics & Gynecology (Spec. MFM)**  
161 Ft Washington Ave, Suite 408  
Phone: (212) 305-5899

**Silvana Ribaldo, M.D. Mari Su, M.D.**  
**Jennifer Tam M.D.**  
**Obstetrics and Gynecology**  
161 Fort Washington, 6<sup>th</sup> Floor, Suite 622  
Phone (212)-305-3980

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## **HOUSE STAFF MENTAL HEALTH SERVICE**

The House Staff Mental Health Service (HSMHS) has been created to provide House Staff with immediate access to confidential, affordable psychiatric care with experienced clinicians.

**Program Overview:** The HSMHS provides a free consultation for House Staff upon request. After this initial consultation, where indicated, a referral is made for up to 10 sessions per year of treatment paid for directly by the Hospital. All services provided are entirely confidential.

**Eligible Employees:** Active full and part-time House Staff members of New York-Presbyterian Hospital on NYP payroll (the only exception are the Columbia Presbyterian House Staff members on the payroll of the Psychiatric Institute). Spouses/domestic partners and dependents are not covered under this program.

### **Site Coordinators:**

Cornell-

Scott Goldsmith, M.D. 212-439-6309

Minna Fyer, M.D. 212-861-2586

Columbia-

Laurel Mayer M.D. 212-543-5741, beeper 7125 or long range (917)899-3449

Brett Blatter, M.D. 212-769-4128

Maria Cleary-Guida, Administrator 212-305-2967

### **Process:**

House Staff members should contact a Site Coordinator on his or her campus with questions, and to determine if a consultation is appropriate. If so, the Site Coordinator will provide a consultation for the House Staff member and determine if the circumstances warrant additional treatment. If so, the house officer will be referred to an appropriate treating clinician, who will provide care for up to 10 sessions during a 12-month period at no cost to the patient.

House Staff who require additional treatment after these 10 sessions will need to assume the cost through his/her insurance plan and/or through personal resources. Please note that treating clinicians are not required to participate in the Hospital's in-network managed care plan, and therefore additional coverage for treatment may not be available. However, clinicians are encouraged to ensure that ongoing affordable treatment is accessible, as needed.

## **OCCUPATIONAL HEALTH SERVICE**

### **Expedited Care for House Staff**

Members of the housestaff who need non-emergent, non-routine health care, will be expedited through the Occupational Health Service in the following manner:

Call ahead (CPMC 305-7590; NY Weill 746-4370) to the front desk at OHS to schedule an immediate or same day appointment, or one for another time if you choose. The receptionist will ask for your social security number or medical record number to begin pre-registration and chart preparation.

**When you get to the clinic at the appointed time, alert the front desk of your arrival.**

The receptionist will notify the nursing staff of your arrival and arrange for you to be seen by the next available provider.

If you need on-going or complex care, OHS will help you arrange an appointment with your private physician or help you find a private physician if you do not already have one.

Medical care delivered in OHS that is not work-related will be communicated to your private doctor (with appropriate consent) for purposes of continuity of care.

Please call Bernadette Miles, RN (CPMC 305-7581) or Linda Fuentes, RN (NY Weill 746-4375) with any questions.

If you have problems with this system, please contact the GME office for assistance. (CPMC 305-6081; NY Weill 746-4055).