# Team 4 Cardiology Team Rules & Criteria

General Rules:

- Team comprised of: Attending, Fellow, Senior, 2 interns
- Team admits 6 days a week: No new ER admissions on No Call days.
  - OK to admit post-procedure patients on No Call days.
- Accepts overnight cardiology admissions per criteria only, on all nights. (No medicine admissions at night unless all teams are capped).
- Team cap 16 (Hard cap 18)
- Max overnight admissions: 5
- Intern Cap is 8 patients. Senior or Fellow to manage patients when interns reach cap.
- Admissions per Cardiology Admission Criteria. If unclear, needs to be discussed with cardiology fellow or chief resident.

Admissions:

- **In drip system with Teams 1-4 on admitting days, with preference to Cardiology admissions***
  - **Cardiology admissions:**
    - All ER admissions meeting Cardiology admissions criteria should be admitted to team 4 on admitting days (not No Call)
    - ER admitting physician should notify the ER clerk of a cardiology admission. ER clerk should record the admission in the next team 4 slot on the admissions sheet and they will receive credit.
  - **Non Cardiology admissions:**
    - Team 4 will be "passed" on the first cycle of general medicine admissions daily but will enter the drip system thereafter.
    - After the first cycle of admissions, and if there are no pending Cardiology patients in the ER, Team 4 can take a general medicine admission if they are the next available team on the drip.
  - If resident receiving signout from ED believes patient has been mis-triaged, that resident should:
    - (a) Inform the ED to expect a call back within 20 minutes from the accepting physician
    - (b) Discuss disposition with senior resident and/or Cardiology fellow
    - (c) If it is unclear based on the admissions criteria, page the Chief Resident on call (p6666) for further clarification.
    - (d) The accepting team should then contact ED for full signout and assume patient care.
    - (e)Let the clerk know of the final team assignment to receive credit.
  - If a patient is admitted to Teams 1-3 & 5-6, but after further evaluation is felt to be best suited on the Cardiology service, *you must discuss this with the Cardiology fellow who will approve or deny inter-team transfer.*
    - There is no transfer of medicine patients out of Team 4 to the other teams or "trades".
  - **Overnight admissions**: Team 4 gets Cardiology patients only, on all nights of the week. After morning signout at 6:30 am, there will be no reassignments.

Weekdays

- No Call Day
  - Can take overnight cardiology admissions
  - No new day time admissions, unless post-procedure
  - Senior can be off
  - Interns cannot take off if senior off
- Short Call Days – Admit until 6pm
- Long Call Day – Admit until 7pm
  - 2 admits between 6-7pm can include NON cardiology patients

Weekends

- No/Short Call Days
  - Can take overnight cardiology admissions
  - No new day time admissions
  - Senior can be off
  - Interns cannot take off
- Regular/Long Call Days
  - Admit until 6pm, according to modified drip.
  - Preference is given to cardiology patients; however, will need to admit a non-cardiology patient for every patient admitted by the other medicine team.

Sign Out

- Wards Nocturnist will take sign out at 7PM in the nocturnist workroom, 4th floor
- For overnight admissions: Call the Chief Resident on Call (p6666) if there is a question about the triaging/assigning of patients.

Ward Nocturnist Role

- Admit all patients (including Cardiology and Medicine) between 7pm to 7am the next morning

CCU

- CCU patients in the ICU: Cardiology team is primary. A MICU intern will round on the patients with the cardiology attending and fellow in the afternoon.
  - This MICU intern will also round with the MICU team in the morning.

## Admission Criteria to Cardiology Team

### Heart Failure

A. **All New** onset heart failure should be admitted to Cardiology team **except**:
   a. Initial ED workup reveals other causes of central volume overload or peripheral edema (such as acute kidney injury, cirrhosis, lymphedema, pulmonary embolism/DVT, etc)

B. **Acute decompensated** chronic heart failure:
   a. NYHA III-IV
   b. BNP > 400 without other cause (such as CKD, sepsis, COPD, pulmonary embolism)
   c. Dialysis patients are excluded
   d. Initial ED workup excluded other causes of central volume overload or peripheral edema (such as acute kidney injury, cirrhosis, lymphedema, pulmonary embolism/DVT, etc)

C. **Heart failure NP team** should be contacted for chronic stable heart failure or ADHF patients who overflow to other services

**Chest Pain**

A. High-intermediate to high cardiac risk
    a. HEART score > 3*
B. Typical cardiac chest discomfort
C. Patients with prior myocardial infarction
D. Patients with prior coronary artery bypass graft (CABG) or percutaneous intervention (PCI)

**Acute Coronary Syndrome**

A. All ACS patients should be admitted to Cardiology team (tele/DOU/CCU level of care to be determined by cardiology fellow and attending)

**Arrhythmia**

A. All ventricular tachycardia or fibrillation, or unknown tachycardias
B. Any atrial fibrillation with rapid ventricular rate and atrial flutter, unless known acute medical or surgical triggers (infection, COPD, substance induced, active GI bleed)
C. Significant abnormal cardiac device interrogation in ED

## *HEART Score

| | Criteria | Score |
|---|---|---|
| **H** istory | Highly suspicious<br>Moderately suspicious<br>Slightly suspicious | 2<br>1<br>0 |
| **E** CG | Significant ST depression<br>Nonspecific repolarization disturbance<br>Normal | 2<br>1<br>0 |
| **A** ge | ≥ 65<br>45 – 65<br>< 45 | 2<br>1<br>0 |
| **R** isk factors | ≥ 3 risk factors or h/o atherosclerotic disease<br>1 or 2 risk factors<br>No known risk factors | 2<br>1<br>0 |
| **T** roponin | > 2x normal limit<br>1-2x normal limit<br>≤ normal limit | 2<br>1<br>0 |