I. Call to Order

II. Guest Speakers – Dr. Cearlock (Cardiology Comfort Care & DNR Order Set) (pg. 2-5)  
Dr. Hilliard (EPIC Updates)

II. Approval of February 7, 2013 Minutes (pg. 6-9)

III. Committee Reports
   a. MEC Excerpts (March 2013) – Dr. Hodgman (pg. 10-14)  
   b. Administrative Report (March/April 2013) – Dr. Valliere (pg. 15)

IV. Quality Reports
   a. ACC-NCRD – Michelle Wehr

V. Old Business
   a. Credentialing Criteria Updates – Dr. Campbell
   b. Case Review Criteria Updates – Dr. Hodgman (pg. 16-18)  
   c. Pre-Operative Process Updates – Dr. Valliere (pg. 19)  
   d. Blood Transfusion Criteria – Dr. Hodgman (pg. 20-21)

VI. New Business
   a. Anticoagulation Center – Dr. Campbell (pg. 22-24)  
   b. Telemonitor Fact Sheet – Sue Dawson (pg. 25)  
   c. VTE Order Set – Dr. Campbell / Sue Dawson (pg. 26)  
   d. Renal Protection Protocol – Dr. Hodgman (pg. 27)

VII. Announcements
   a. VTE CME Presentation – Dr. Hodgman (pg. 28)  
   b. Blood Management CME Presentation (May 21st) – Dr. Hodgman

VIII. Next Meeting Thursday, June 6, 2013, 0700 in Mercy Katz Conference Room

IX. Adjournment
**Definition of Comfort Care:**

The goal of care is to provide comfort and alleviate suffering. The focus will be on pain and symptom management involving physical, spiritual & psychosocial needs. The palliative care team will complete a functional status assessment using the palliative performance scale.

**Cardiology Criteria for Comfort Care:**

1. Medical management only due to many co-morbidities (May include IV Heparin or Nitrates)
2. Anticipated end of life less than one year
3. Refusing invasive treatment
4. Refusing to take medications
5. Multiple readmissions within previous year (> 2)
6. Comorbidities are not conducive to MI treatment (Hx. of GI Bleed, HIT)
7. Age and comorbidities are not conducive to MI treatment (i.e. dementia)

**Cardiac Disease:**

- Valvular disease not appropriate for surgery (Severe aortic disease)
- High grade AV block, refusing pacemaker
- Severe pulmonary hypertension
- Severe Cardiomyopathy
- Severe CAD, not a candidate for revascularization
- Severe PVD, not a candidate for revascularization

**Documentation from Cardiology: (Palliative care referral needed)**

"From a cardiac perspective goal of care is for comfort measures only, may desire treatment interventions for other co-morbidities."

**Other Disease Criteria To Be Developed:**

1. Advanced Lung Disease (COPD & Pneumonia)
2. Stroke
3. Dialysis
Code Status orders in Epic

Full Code no questions associated with this order
DNR with Interventions – clarification questions attached which must be answered

For the responses at the entire answer cannot be read – you can hover over that response to see the whole response
DNR No Interventions

Process instructions appear on the DNR with Interventions and DNR No Interventions orders. This the information that currently appears on the back of the DNR order set.
**Discussion/Leader** | **Expected Result** | **Content/Agenda Item** | **Meeting Notes/Decisions/Actions or Assignments**
---|---|---|---
**CALL TO ORDER**
Dr. Hodgman | Action | Call to Order | Dr. Hodgman, called this regularly scheduled meeting of the Cardiovascular Medicine Department of Mercy Medical Center, a peer review committee, to order at 0700.

**APPROVAL OF MINUTES**
Dr. Hodgman | Action | Approval of October 4, 2012 minutes. | The minutes were reviewed and approved as distributed.

**QUALITY ASSESSMENT & IMPROVEMENT REPORTS**

**COMMITTEE REPORTS**

<table>
<thead>
<tr>
<th>Discussion/Leader</th>
<th>Expected Result</th>
<th>Content/Agenda Item</th>
<th>Meeting Notes/Decisions/Actions or Assignments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Hodgman</td>
<td>Information</td>
<td>Medical Executive Committee (December 2012 &amp; January 2013)</td>
<td>Included in packets.</td>
</tr>
<tr>
<td>Dr. Valliere</td>
<td>Information</td>
<td>Administrative Report (January/February 2013)</td>
<td>Dr. Valliere noted EPIC go live dates, training scheduling will begin in the next few weeks. Bylaws are being finalized and will be available for review. Also noted Joint Commission survey. Overall went very well, noted findings involving timing and dating of orders.</td>
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<tr>
<td>Michelle Wehr</td>
<td>Discussion/Action</td>
<td>ACC-NCDR</td>
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<tr>
<td>Ms. Wehr shared the Mercy specific Cath/PCI data compared to the nation from the ACC-NCDR database for the 2nd quarter 2012. It was noted the group is doing very well with &quot;Inappropriate Use of PCI&quot;. Mercy is using the radial approach 3 times more frequently than other hospitals across the nation. It was noted Mean Fluoro Time is currently above national average. <strong>Action:</strong> Dr. Hodgman advised group to work on decreasing Fluoro Time. Updates will be brought to future meetings. Group discussed sending data to members for review prior to meeting.</td>
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<table>
<thead>
<tr>
<th>Chad Ware</th>
<th>Discussion/Action</th>
<th>Heart Failure Data and Protocols in ED</th>
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<tbody>
<tr>
<td>Mr. Ware presented results from an ED Heart Failure Review. Objectives included: assess current practices provided to CHF population in the ED for gaps leading to unnecessary admissions or readmissions, opportunities to improve use of best practices, and the development of a CHF protocol for the ED. Mr. Ware noted education will be given in ED, CHF protocol will be introduced, and Cardiology consults will be increased.</td>
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<thead>
<tr>
<th>Sue Dawson</th>
<th>Discussion/Action</th>
<th>New Reportable VTE Measures</th>
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<tbody>
<tr>
<td>Ms. Dawson noted the new VTE measures reported to CMS, Joint Commission, and Meaningful Use beginning Jan. 1, 2013. An order set was created to address these measures and will print with admission packets. It was noted both Mechanical and Pharmacologic Prophylaxis must be completed and a reason documented if &quot;none&quot; ordered. Also noted must document a reason for choosing Xarelto.</td>
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<tr>
<td>Dr. Campbell</td>
<td>Discussion/Action</td>
<td>Credentialing Criteria Review</td>
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<tr>
<td>Dr. Hodgman</td>
<td>Discussion/Action</td>
<td>Vice Chair Needed</td>
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<tr>
<td>Dr. Hodgman</td>
<td>Discussion/Action</td>
<td>Meeting Frequency</td>
</tr>
</tbody>
</table>

**NEW BUSINESS**

| Dr. Hodgman | Discussion/Action | Policy Updates (Admitting, Attending, Consulting and Physician Notification, Escalation) | Included in packets for review. |
| Eric Voss | Discussion/Action | Rhonda Bridgewater Introduction | Ms. Bridgewater was introduced to group. She is the new Heart Failure ARNP. |
| Sue Dawson | Discussion/Action | Outpatient Telemonitor Data and Process | Ms. Dawson reviewed the outpatient telemonitor data and process with group. Outpatient telemonitoring showed a reduction in hospital re-admissions. Group encouraged to consider home telemonitoring. |
| Catherine Kane | Discussion/Action | Restraint Training | Included in packets. TJC requires physicians receive education on proper use of restraints. Information was shared on restraint types and conditions. |
| Dr. Hodgman | Discussion/Action | Case Review Criteria | Group reviewed current case review criteria. **Action:** Contact Dr. Hodgman with any criteria suggestions. |
| Sue Dawson | Discussion/Action | Diabetes Education ( Deb Kucera) | Ms. Kucera provided information on the Inpatient Diabetes Education Services. Anyone can refer and the service is not billed to patient. **Action:** Information on the referral program will be sent to all areas throughout the tower. Group would like this service built into ordersets. |
Date: February 7, 2013

Mercy Medical Center
Cedar Rapids, IA

Meeting Minutes for: Cardiovascular Medicine Department Meeting
Chair: Dr. Hodgman / Recorder: Heather Vasquez

ADJOURNMENT & NEXT MEETING:

| Dr. Hodgman | Information | The next meeting will be held on Thursday, April 4, 2013 @ 7am in Mercy Katz Conference Room. | With there being no further business, the meeting adjourned at 0800. |

Respectfully submitted by,
Nicholas Hodgman, MD
Review of Department Minutes
Dr. Wilbur reviewed the department meeting minutes for Anesthesia, Cardiovascular Medicine, Emergency Medicine, Family Medicine, Internal Medicine, OB/Gyn and Psychiatry. There were no action items for the Medical Executive Committee.

Flu Masking
Dr. Wilbur reported that the hospital mask mandate has been lifted. As a result, the mandatory masking policy for physicians without documentation of influenza immunization approved at the January 8, 2013 Medical Executive Committee meeting will no longer be in effect.

Administrator’s Report
Mike Trachta drew attention to the Administrative Report included in the agenda packet:
• EPIC Update – Mercy Care clinics went live with EPIC on March 1, 2013. Hospital go-live date remains June 1, 2013. Training sessions are being conducted. Prior to Go-Live, be thinking about your practice patterns and preferences. Your transition to EPIC will be easier if you have already thought through whether or not you will be using the Note Writer function, system smart tools and customized text. In the 2 weeks prior to Go-Live: All providers will have access to labs to complete desired customization.
• Joint Commission Update – Mr. Trachta thanked everyone for their participation and hard work that enabled the success of the recent accreditation survey.
• Thank you – Mr. Trachta thanked the physicians who participated in the MMC Capital planning scoring process. Projects are still in the approval stages. Further information will be coming soon.

Credentials Committee
The Credentials Committee meeting report of February 19, 2013 was given.

The following physicians were recommended for membership and privileges:
• Kirsten Redborg, MD – Anesthesia joining Linn County Anesthesiologist.
• Amy Andersen, MD – Family Medicine practicing at MercyCare North Liberty.
• Angela Godejohn, MD – Family Medicine joining Cedar Rapids Medical Education Foundation.

The committee reviewed the list of reappointments for the 1st quarter 2013.

Dr. Mouhamad Jamil did not apply for reappointment, thus will be considered to voluntary resign his Medical Staff membership and privileges.

The following physicians were recommended for Advancements:
Jenifer Schmidt, MD – Anesthesia – Active
David Glassman, MD – Cardiovascular Medicine – Active
Mitil Alam, MD – Internal Medicine – Active
Bradley Davis, MD – Internal Medicine – Courtesy
Hend Elsaghir, MD – Internal Medicine – Active
Athir Hajjar, MD – Internal Medicine – Active
William Thomas, MD – Internal Medicine – Active
Elizabeth Bussewitz, MD – OB/Gyn – Active
Erica LeClair, MD – Pediatrics – Active
Pankaj Nagaraj, MD – Pediatrics – Active
Patrick O’Grady, MD – Pediatrics – Active

The following physicians were recommended for continuation at Associate status:
John Byrn, MD – Surgery
Joseph Cullen, MD – Surgery
Hisakazu Hoshi, MD – Surgery
Isaac Samuel, MD – Surgery
Jessica Smith, MD – Surgery
Sonia Sugg, MD – Surgery

The committee accepted the resignations of the following physicians:
JoLynn Glanzer, MD – Family Medicine
David Basel, MD – Internal Medicine/Pediatrics
Pattaya Kullavan, MD – Pediatrics

Laura Hemann, MD and Brian Randall, MD were recommended for Nuclear cardiac examinations privileges.

Jonathan Rippentrop, MD was recommended for Renal cryoablation privileges.

A report of completed FPPE reviews and Department Chair recommendations was reviewed.

The Allied Health Practitioner Committee report of January 23, 2013 was given.

Applicants recommended for approval:
• Rhonda Bridgewater, ARNP – Cedar Rapids Heart Center (Dr. Campbell)
• Jessica Handke, PA – Cedar Rapids OB/Gyn Specialists (Dr. Rexroth)
• Sarah Kluesner, ARNP – PCI Orthopaedics (Dr. Pilcher)
• Anne Nugent, ARNP – Cedar Rapids Heart Center (Dr. Campbell)
• Patricia O’Donnell, ARNP – Internists Associates of Iowa (Dr. Yacoub)
• Allison Smith, CA – Biotronic for Intraoperative Monitoring Services (Dr. Maggio)
• Jamie Smith, ARNP – Mercy Psychiatry (Drs. Eyanson and Munagala)

Practitioners recommended for advancement:
• Austin Sibley, CA – Biotronic for Intraoperative Monitoring Services (Dr. Davis)
• Ellie Snavely, PhD – Mercy Psychiatry (Dr. Munagala)
Practitioners recommended for re-registration:
- Lori Bristow, DA – Cedar Rapids Oral Surgery (Dr. Van Heukelom)
- Stephen Gunn, PA – PCI Surgical Specialists (Dr. Levett)
- Joni Henderson, ARNP – Mercy Medical Center (Dr. Cearlock)

Practitioner resignations:
- Jamie Baier, CA – Biotronic for Intraoperative Monitoring Services (Dr. Maggio)
- Christopher Tello, CA – Biotronic for Intraoperative Monitoring Services (Dr. Davis)

NRP certification requirements were discussed.
Due to time constraints this item will be revisited at the next regularly scheduled meeting of the committee.

**Bylaws Committee**
Dr. Schweiger gave a presentation on the Medical Staff Bylaws revisions.

The committee recommended the bylaws revisions with clerical corrections and wording additions be forwarded to the Medical Staff membership for a vote.

**Joint P&T Committee**
The minute’s summary of the February 26, 2013 Joint P&T Committee was given.

Formulary additions:
- Exparel – Liposomal Bupivacaine (Exparel) was presented for reconsideration for addition to formulary. Dr. Rexroth requested the committee reconsider a previous decision on this medication. He feels the place in therapy is to improve postop pain and reduce the need for narcotic use. Dr. Nassif and Dr. K. Nowell are also interested in using this medication to improve postoperative pain. The medication was approved for addition to formulary with planned 6 month review to evaluate reduction in PCA and narcotic usage.
- Azelastine (Astelin) Nasal Spray – There is not currently a nasal antihistamine product on formulary. With frequent requests for non-formulary use the recommendation was made to add a product in this class to formulary. The two products on the market are very similar. The product with the available generic formulation, Azelastine, was approved for addition to formulary.

Formulary interchanges:
- Oloptadine (Patanase) nasal spray to Azelastine (Astelin) nasal spray at same dose and frequency
- Bimatoprost (Lumigan) 0.03% to Bimatoprost (Lumigan) 0.01% at same dose and frequency
- Zolmitriptan (Zomig) 2.5-5 mg PO at onset of headache, may repeat in 2 hours; NTE 10 mg/24 hours to Sumatriptan 50 mg PO at onset of headache, may repeat in 2 hours; NTE 200 mg/24 hours
• Fluticasone (Flovent Diskus) 110 mcg 1 puff BID to Mometasone (Asmanex) 220 mcg 1 puff daily
• Fluticasone (Flovent Diskus) 100 mcg 2 puffs BID to Mometasone (Asmanex) 220 mcg 2 puffs daily
• Fluticasone (Flovent Diskus) 250 mcg 1 puff BID to Mometasone (Asmanex) 220 mcg 2 puffs daily
• Fluticasone (Flovent Diskus) 250 mcg 1 puff daily to Mometasone (Asmanex) 220 mcg 1 puff daily
• Fluticasone (Flovent Diskus) 250 mcg 2 puffs BID to Mometasone (Asmanex) 220 mcg 2 puffs BID
• Fluticasone (Flovent Diskus) 50 mcg 1-2 puffs daily to Mometasone (Asmanex) 110 mcg 1 puff daily
• Acyclovir (Zovirax) topical to Docosanol (Abreva) topical 5 times daily
• Penciclovir (Denavir) topical to Docosanol (Abreva) topical 5 times daily

Formulary deletions:
• Bimatoprost (Lumigan) 0.03%) – Manufacturer Discontinued
• Edetate Calcium Disodium (Caldium Disodium Versenate) – Removed from Market
• Homatropine (Isopto Homatropine) 2% ophthalmic – Manufacturer Discontinued

Balanced Salt Solution for Irrigation with Additives:
The package insert for the BSS irrigation solution specifically states that nothing should be added to the irrigation solution. Mixing antibiotics and epinephrine into the eye irrigation solutions has been a historical practice at Mercy. Upon discovery of this information, Mercy pharmacy questioned the safety of continuing this practice. There is no information in the literature to support this practice. The current surgical infection prophylaxis guidelines do not have a standard recommendation for prevention of ophthalmic infection with surgical procedures. After discussion by the committee the recommendation was that the premixing of additives into the BSS irrigation solution should no longer be supported. The mixing of additives into the irrigation solution in the OR immediately prior to the procedure would be an acceptable practice.

A pharmacist initiated order set for conversion of Famotidine from IV to PO was presented and approved by the committee. The order set was included in the agenda packet.

Other Committees
Dr. Wilbur reviewed the committee meeting minutes for Cancer, IRB Cancer, IRB General and Medical Education. There were no action items for the Medical Executive Committee.

Critical Results of Tests Policy
The committee recommended the proposed revisions to the Critical Results of Tests policy.

Imaging Center Emergency Management Policy
The committee approved the Imaging Center Emergency Management policy as presented. This policy has been in effect since 2007. In response to a Joint Commission finding during the recent TJC survey, regarding contrast reaction coverage at the Imaging Center it was recommended to have this policy reviewed and approved by the Medical Staff.

**Contrast Ordering**
The committee approved the Contrast Ordering work flow as presented. This new ordering process was created to manage the workloads created by the upcoming Epic implementation. The work flow will assign orders for any contrast agents used to the practitioner who ordered the radiology exam with contrast as long as the order follows existing Radiology test designs. If the order or patient parameters do not fit the approved contrast administration test design and contrast order will be amended and signed off by the Radiologist who changed the order.

**Sample Medication Program Policy**
The committee recommended the Sample Medication Program policy as presented. This policy was created in response to concerns noted during the recent Joint Commission Survey.

**VTE Order Set Revisions**
The committee approved the proposed revisions to the VTE order set as presented.

**Blood Product Transfusion Criteria**
The committee approved the Blood Product Transfusion criteria as presented.

**Shared Medical Record Policy**
The committee recommended the Shared Medical Record policy as presented. Discussion included the situations where the record viewing would be prohibited, the physician’s ability to limit the viewing of records, and various situations involving minors and confidential information in the record.
EPIC Update: Mercy Care clinics are going live with EPIC on March 1, 2013. Special thanks to Dr. Don Hilliard and Dr. Bradley Beer for serving as physician champions for this massive undertaking.

Registration for providers who conduct inpatient work is open. Several physicians have expressed concern over the required training time. Please know that the Physician Advisory Councils established the parameters to ensure that all practitioners are receiving appropriate levels of training.

In order to gain access to EPIC, you will need to complete three things:

1. Review assigned eLearnings
2. Attend EPIC Classroom Trainings
3. Pass the assessment test

Prior to Go-Live, be thinking about your practice patterns and preferences. Your transition to EPIC will be easier if you have already thought through whether or not you will be using the Note Writer function, system smart tools and customized text.

In the 2 weeks prior to Go-Live: All providers will have access to labs to complete desired customization. Those times are being established and more information will be forthcoming.

Last but not least, EPIC will be available on your iPhones through a tool called Haiku. You will be able to view your schedules, review a patient chart and many other functions. Stay tuned for more information on mobile devices.

Bylaws: The Medical Staff Bylaws continue to be in legal review.

Joint Commission Update: TJC surveyed MMC January 7 – 11th. Overall the survey was very successful.

Surveyors gave the hospital 19 requirements for improvement (RFIs). Four items were fixed during the survey. Six items will be compliant by 3/8. Seven items will be compliant by 3/23. The last item will be compliant by the end of the summer.

If you would like further information on those specific projects, please feel free to reach out to Susan Wagner Hecht at 319.398.6138.

Thank you: To the over 30 physicians who participated in the MMC Capital planning scoring process. Your insight is helpful to our team to assist in the prioritization of capital spending.
POLICY/PURPOSE:
The Physician Case Review Policy describes the process which has been established to ensure quality of care through the evaluation and oversight of medical care provided by credentialed practitioners at Mercy Medical Center.

DEFINITIONS:
NONE

PROCEDURE:
1. The Clinical Improvement and Accreditation Department manages the Medical Staff Case Review process.
2. Cases are screened by a Quality Analyst in the Clinical Improvement & Accreditation department utilizing the following criteria:
   o All mortality cases are screened by the Analyst and reviewed with the Chief Medical Officer
   o Cases with codes indicating there was a coding match to select Patient Safety Indicators (PSI’s)
     ▪ 02 - Death in Low-Mortality DRGs
     ▪ 06 - Iatrogenic Pneumothorax
     ▪ 09 - Post-op Hemorrhage/Hematoma
     ▪ 11 - Post-op Respiratory Failure
     ▪ 12 - Post-op PE or DVT
     ▪ 13 - Post-op Sepsis
     ▪ 14 - Post-op Wound Dehiscence
     ▪ 15 - Accidental Puncture/Laceration
     ▪ 17 - Birth Trauma Injury to Neonate
     ▪ 18 - Obstetric Trauma, Vaginal Deliver w/Instrument
     ▪ 19 - Obstetric Trauma, Vaginal Deliver w/o Instrument
   o Cases with an unplanned returned to surgery
   o Cases which are statistically significant (at the 95th percentile) for Risk Adjusted Complications, Risk Adjusted Readmissions or Risk Adjusted Mortality
   o Cases involving a Serious Reportable/Sentinel Event
   o Cases identified with potential quality of care concern
   o Specialty departments may add specific criteria for case review as applicable
3. If issues needing additional review are identified by the Quality Analyst, the case is referred to the appropriate Subject Matter Expert (SME).
4. If no issues are identified following this review, the case is either closed or marked for trending.
5. If the SME identifies concerns needing further review, a case review form with pertinent clinical details is prepared for the appropriate Medical Staff Department Chair for review. If the SME is uncertain, they may discuss the case with the Chief Medical Officer to determine if the case needs physician review.
6. Upon completion of the case review, the Department Chair will rate the case 0 through 3 and indicate any areas of concern on the Physician Case Review Form.
   Rating 0 = Reviewer Uncertain
   Rating 1 = Care Appropriate
   Rating 2 = Care Could be Improved
   Rating 3 = Care Inappropriate

7. Upon rating of the case, the physician will identify any recommended action:
   Rating 0 or 1 = None
   Rating 2 = None or Education Letter to Physician
   Rating 3 = Refer to Peer Review Committee

8. Upon completion, the case review form is returned in a sealed envelope to the Quality Analyst in the Clinical Improvement & Accreditation department.

9. All cases which are reviewed, either at the Quality Analyst, SME or Department Chair level will be logged into the Quality Management software.

10. All findings of the Physician Case Review process will be privileged, confidential, and protected under the Medical Studies Act.

**RELATED DOCUMENTS:**
Physician Case Review Form
Specialty Department case review criteria list (DRAFT)

**REFERENCES:**
NONE
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<thead>
<tr>
<th>Medical Staff Section</th>
<th>Trigger #</th>
<th>Criteria/Trigger</th>
<th>Approval Date</th>
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<tbody>
<tr>
<td>ANESTHESIA</td>
<td>ANES - 1</td>
<td>Cardiac arrest within 48 hours of anesthesia</td>
<td>Aug-12</td>
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<td>ANES - 2</td>
<td>Dental Trauma</td>
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<td>ANES - 3</td>
<td>Infection following epidural or spinal anesthesia</td>
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<td>ANES - 4</td>
<td>Infection following peripheral nerve block</td>
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<td>Major systemic local anesthetic toxicity</td>
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<td>ANES - 6</td>
<td>Malignant Hyperthermia</td>
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<td>ANES - 7</td>
<td>Adverse Drug Reaction</td>
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<td>ANES - 8</td>
<td>Complication, Anesthesia Related</td>
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<td>ANES - 9</td>
<td>Death in OR</td>
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<td>ANES - 10</td>
<td>High spinal requiring airway management</td>
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<td>ANES - 11</td>
<td>Peri-op peripheral neurological complication</td>
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<td>ANES - 12</td>
<td>Resp. complications (i.e. re-intubation within 24 hrs.)</td>
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<td>ANES - 13</td>
<td>Sedation concerns</td>
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<td>ANES - 14</td>
<td>Sentinel Event</td>
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<td>ANES - 15</td>
<td>Stroke or MI within 48 hrs. of surgery</td>
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<td>ANES - 16</td>
<td>Unplanned transfer to ICC</td>
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<td>CARDIOLOGY</td>
<td>CARD - 1</td>
<td>Death in cath lab or within 48 hours post (note if case was emergent)</td>
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<td>CARD - 2</td>
<td>Death without appropriate documentation of comfort/hospice care</td>
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<tr>
<td>CARD - 3</td>
<td>Mortality</td>
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<td>CARD - 4</td>
<td>Inappropriate PCI</td>
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<td>CARD - 5</td>
<td>Inappropriate Stent Type</td>
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<td>Cath Lab Adverse Events</td>
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<td>CARD - 7</td>
<td>Unplanned return to procedure room</td>
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<td>Unplanned readmission &lt; 30 days</td>
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<td>CARD - 9</td>
<td>Standard of Care as defined per ACC/AHA Guidelines</td>
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<td>CARD - 10</td>
<td>Diagnosis Concern</td>
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<td>CARD - 11</td>
<td>Post-op MI (any time during stay) Appropriate perioperative evaluation per ACC/AHA Guidelines</td>
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<tr>
<td>DENTAL</td>
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<tr>
<td>OPHTHALMOLOGY</td>
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MEMO

TO: Mercy Medical Staff
FROM: Mark Valliere
SUBJECT: Pre-Operative Assessments
DATE: March 19, 2013

As you are aware, the Mercy Medical Staff and PASE Department have been working to improve our preoperative patient screening process. A great deal of work has gone into development of testing guidelines, information flow and the development of forms for this assessment. Thus far we are pleased with the improvements we have seen. But like all things, as we continue to evaluate our work, there are still some opportunities for improvement. These include:

- Please be careful of terminology such as “cleared for surgery” or “okay for surgery.” Consider assessing for Low/Medium/High risk based on your findings and the type of procedure being considered.
- Please include recommendations regarding medications. This is especially important for anti-platelet medications, beta-blockers, insulin, and anti-coagulants. Be specific where anticoagulant bridging is required.
- If the patient is medium-high risk, consider calling the surgeon to be sure he/she is aware of your assessment so they can properly document the risks and benefits to the patient.
- If postoperative medical management is anticipated and you no longer care for inpatients, consider contacting the Hospitalist Service or appropriate specialist in advance so perioperative care can be done in a seamless fashion.

We will continue to try and refine the process to be sure patients have the safest surgical experience we can provide.
ADULT TRANSFUSION GUIDELINES FOR RBCs, FFP, PLATELETS, AND CRYOPRECIPITATE

Red Blood Cells, Leukoreduced

- Hemoglobin ≤ 7 g/dL or Hematocrit ≤ 21%
- Postoperative surgical patients with Hemoglobin ≤ 8 g/dL or Hematocrit ≤ 24% with symptoms (chest pain, orthostatic hypotension or tachycardia unresponsive to fluid resuscitation, or congestive heart failure)
- Patients with preexisting cardiovascular disease with Hemoglobin ≤ 8 g/dL or Hematocrit ≤ 24% with symptoms (chest pain, orthostatic hypotension or tachycardia unresponsive to fluid resuscitation, or congestive heart failure)
- Large volume blood loss (>1500-2000 mL), ongoing blood loss, GI bleed, or non-responsive to appropriate volume resuscitation
- Tachycardia, hypotension not corrected by adequate volume replacement alone
- Sepsis with ScvO$_2$ or SvO$_2$ <70% and Hematocrit <30%
- Other: Please specify___________________________________________________

Fresh Frozen Plasma

- Emergent reversal of warfarin
- INR > 1.8 and significant hemorrhage
- INR > 2.0 and planned invasive procedure
- Large volume blood loss
- Treatment of factor deficiencies
- Plasma exchange

Plateletpheresis, Leukoreduced

- Platelet count ≤ 10,000/mm$^3$ prophylactically in a patient with failure of platelet production
- Platelet count ≤20,000/mm$^3$ and signs of hemorrhagic diathesis (petechiae, mucosal bleeding)
- Platelet count ≤50,000/mm$^3$ in a patient with active hemorrhage or in a patient with an invasive procedure (recent, in progress, or planned)
- Platelet dysfunction: Please specify___________________________________________________

Cryoprecipitate
□ Fibrinogen ≤ 100 mg/dL

□ Fibrinogen ≤ 150 mg/dL with active hemorrhage

**Indications for special product requirements:**

**IRRADIATED**

Absolute indications: congenital cellular immune deficiency, allogeneic hematopoietic stem cell recipients, autologous hematopoietic stem cell recipients, Hodgkin’s disease

Probable indications: patients with hematologic malignancies treated with cytotoxic agents, patients receiving high-dose chemotherapy, radiation therapy and/or aggressive immunotherapy, including all patients receiving fludarabine or other purine analogs

**WASHED**

Prevention of analphylaxis in IgA deficiency or other patients with antibodies to plasma proteins

**CMV NEGATIVE**

Allogeneic bone marrow, cord blood, or peripheral blood progenitor cell transplants where donor and recipient are CMV seronegative

**SICKLE CELL NEGATIVE**

Sickle cell disease
DATE: March 15, 2013

TO: Practitioners and Nurse Managers

FROM: Cam Campbell, M.D. Cardiology Medical Director

SUBJECT: Anticoagulation Center Opens at Mercy Medical Center

Practitioners and Nurse Managers,

Mercy Medical Center has now opened their own Anticoagulation Center (MAC), overseen by Rhonda Bridgewater ARNP and Dr. Campbell and is available to serve all of your patients.

Mercy’s Center will manage patients on all types of anticoagulants, including, but not limited to:

1. Coumadin (Warfarin)
2. Lovenox (Enoxaparin)
3. Xarelto (Rivaroxaban)
4. Pradaxa (Dabigatran)
5. Eliquis (Apixaban)

- This center will be located in the non-invasive cardiology department as well as the Heart Failure Center.

- When writing an order articulate: Mercy Anticoagulation Center (MAC) as the follow-up center.

- **Hours of operation:** Monday-Friday from 0800-1600.

- Any patients needing anticoagulation follow-up or management in the outpatient setting may call: **319-861-7778 to schedule an appointment with the ARNP & Fax the referral forms to 221-8563**. Please use attached referral form.

- For inpatient concerns or immediate needs, please contact **Rhonda Bridgewater ARNP at 319-440-7131.**
**Mercy Anticoagulation Center (MAC)**

**Referral Form**

701 10th Street SE – Cedar Rapids, IA 52403
Phone 319-221-8500 Fax 319-221-8563

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Address:</th>
<th>Patient Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referring Physician:</th>
<th>Office Phone:</th>
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<tbody>
<tr>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Nurse’s Name:</th>
<th>Office Fax:</th>
</tr>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Primary Physician:</th>
<th>Office Phone:</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Patient’s INR to be checked by Referring physician until seen at Mercy Anticoagulation Clinic</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary Indication for Warfarin</th>
<th>Goal INR</th>
<th>Treatment Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>427.31 Atrial Fibrillation</td>
<td>2.0 - 3.0</td>
<td>Lifetime user</td>
</tr>
<tr>
<td>451.83 Deep Vein Thrombosis, arm</td>
<td>2.5 – 3.5</td>
<td>To be determined</td>
</tr>
<tr>
<td>451.19 Deep Vein Thrombosis, DVT</td>
<td></td>
<td>Date to Stop:</td>
</tr>
<tr>
<td>434.91 Stroke, CVA w/infarct</td>
<td></td>
<td></td>
</tr>
<tr>
<td>435.9 Transient Ischemic Attack, TIA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Desired INR Goal</th>
<th>Treatment Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.0 - 3.0</td>
<td>Lifetime user</td>
</tr>
<tr>
<td>2.5 – 3.5</td>
<td>To be determined</td>
</tr>
<tr>
<td>Other ___________</td>
<td>Date to Stop:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications including OTC and Herbals (may attach a list of medications)</th>
<th>Coumadin/Warfarin Strength Dose (Please check one of below meds)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 mg</td>
</tr>
<tr>
<td></td>
<td>2 mg</td>
</tr>
<tr>
<td></td>
<td>2.5 mg</td>
</tr>
<tr>
<td></td>
<td>3 mg</td>
</tr>
<tr>
<td></td>
<td>4 mg</td>
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<td></td>
<td>5 mg</td>
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<tr>
<td></td>
<td>6 mg</td>
</tr>
<tr>
<td></td>
<td>7.5 mg</td>
</tr>
<tr>
<td></td>
<td>10 mg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coumadin (Warfarin)</th>
<th>Xarelto (Rivaroxaban)</th>
<th>Eliquis (Apixaban)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Lovenox (Enoxaparin)</th>
<th>Pradaxa (Dabigatran)</th>
<th>May Substitute</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription for Warfarin/Coumadin per prescription guideline</th>
<th>INRs and Warfarin dosing per MAC Clinic Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

____________________________________  _______ _______________________________
Physician Signature     Date

***Please fax completed/signed form, along with most recent history and physical, hospital course (if recently hospitalized), allergies, list of medications including Coumadin log (includes dose and INR results) to MAC Clinic 319-221-8563 ***

Please complete information on the reverse side of this form.
## Mercy Anticoagulation Center (MAC) Referral Form

Patient Name: _____________________________________________________________

Referring Office – complete as much as possible and fax with referral order ↓

### Bleeding Risk

<table>
<thead>
<tr>
<th>What risk factors are present?</th>
<th>(Check all that apply)</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>History of Stroke</td>
<td></td>
</tr>
<tr>
<td></td>
<td>History of GI Bleed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>History of MI, Hct. &lt;30, Creat. &gt; 1.5 or Diabetes Mellitus</td>
<td></td>
</tr>
</tbody>
</table>

### Classify your patient Sum of Risk Factors

<table>
<thead>
<tr>
<th>Risk classification</th>
<th>Low 0</th>
<th>Intermediate 1 - 2</th>
<th>High 3 - 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of major bleeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 3 months</td>
<td>2%</td>
<td>5%</td>
<td>23%</td>
</tr>
<tr>
<td>Within 12 months</td>
<td>3%</td>
<td>12%</td>
<td>48%</td>
</tr>
</tbody>
</table>

New Referral and Renewal Referral Checklist: ***Call 319-861-7778 to schedule an appointment***

- [ ] Completed and signed form
- [ ] List of medications
- [ ] Most recent office visit note
- [ ] Most recent H & P (new referral only)
- [ ] List of allergies (new referral only)
- [ ] Coumadin Log – doses and INR results (new referral only)
- [ ] Fax to the MAC 319-221-8563

Thank you for referring this patient to our clinic.
Home Telemonitor Fact Sheet

**Data:** Recognized by TJC and Highlighted in the TJC Leading Practice Website (Invitation Only)

**Reduction in Hospital Readmissions:**
- **Hospitalizations DURING the Home Telemonitor Episode:** 65% decrease (p<0.0001) when compared to hospitalizations prior to the monitor (within 100 days).
- **Hospitalizations AFTER the Home Telemonitor was Removed:** 50% decrease (p=0.0006) when compared to hospitalizations prior to the monitor (within 100 days).

**30-Day Readmission Rates:**
- **National Average (Heart Failure population):** 24.7%
- **Before the Home Telemonitor:** 17%
- **During the Home Telemonitor:** 10%
- **After the Home Telemonitor was Removed:** 9%

1. Physician order is required.
2. Telemonitor service provided through Mercy Home Care: **Call 319-398-6034.**
3. Patients can receive a monitor even if they cannot pay for this service and there is No Charge for the device.
5. A Fax will be sent to the physician’s office after an order is received to determine parameters for “alerts” stipulating when physician notification should be made and stipulating activation of specific standing orders. For example:

**STANDING ORDERS (CHOOSE ONE)**

- If weight is 3 pounds over the baseline weight, double the dose of the below meds for one day:
  - Bumetanide (*Bumex*)
  - Furosemide (*Lasix*)
  - Metolazone (*Zaroxolyn*)
  - Torsemide (*Demadex*)

6. Home Telemonitoring service includes daily monitoring of:
   - Vital signs;
   - Oxygen levels;
   - Weight (patient will be instructed on how to appropriately weigh themselves daily);
   - Blood sugars if appropriate.
7. The data is sent via phone line to a registered nurse at Mercy Home Care for review and prompt response if required.
8. All providers can receive read only electronic access to their patient’s information.
ORDER SET: VTE (DVT/PE) CONFIRMED, Anticoagulation Management

The following are initiated unless crossed through. Items with an open box (✓) prior to the order MUST be checked to be initiated.

Physicians: All

Allergies/Adverse Reactions: ______________

- No Known medication/Latex Allergies
- Obtain current actual weight prior to administration
- If Epidural in place, call anesthesia prior to administration
- Notify physician if IV Heparin is currently infusing – prior to administration

Enoxaparin (LOVENOX)

- 1.5 milligrams per kilogram Subcutaneously every 24 hours (for patients weighing 100 kg or less)
- 1 milligram per kilogram Subcutaneously every 12 hours (Renal dose: Creatinine Clearance less than 30 mL/min—first dose will be calculated by the pharmacy)

LABORATORY:
Creatinine, Hemogram (Hemoglobin, Hematocrit, Platelet Count) now AND every 3 days during administration

NURSING ASSESSMENT/ALERTS:
If used as a bridging medication with Warfarin (Coumadin) to achieve a therapeutic INR; Check the INR prior to administration.
Check baseline Creatinine and Hemogram results prior to administration

HEPARIN

- Standard Cardiac Nomogram Continuous IV (see Heparin Nomogram – Standard)
- Neuro Nomogram Continuous IV (See Heparin Nomogram – Neuro)

Warfarin (COUMADIN)

- Warfarin (Coumadin) ________ mg orally ________ Goal INR ________ to ________
- Pharmacy to dose to Goal INR ________ to ________

Overlap Therapy
Overlap/bridging therapy required times 5 days unless reason documented:

- Low risk for further complications
- Surgical Procedure
- Use of Rivaroxaban
- Patient/family refused
- HIT
- Platelet count low
- Bleeding
- Supratherapeutic INR
- Blood coagulation disorder
- Allergy
- Risk for bleeding

LABORATORY:
Daily INR

Rivaroxaban (XARELTO)

- Contraindicated in renal failure or severe renal impairment, defined as creatinine clearance less than 30 mL/min
- Rivaroxaban (Xarelto) 15 mg orally twice daily for 3 weeks; then 20 mg orally daily with evening meal

Guidelines for Rivaroxaban (Xarelto) Transitions

- Transition from Heparin to Rivaroxaban: Initiate Rivaroxaban at time of Heparin discontinuation
- Transition from Warfarin to Rivaroxaban: Do not start Rivaroxaban unless INR is less than 3.0. Discontinue Warfarin after the first dose of Rivaroxaban is given.
- Transition from Enoxaparin to Rivaroxaban: Initiate Rivaroxaban 2 hours before next Enoxaparin dose
- Transition from Rivaroxaban to Warfarin: Avoid abrupt discontinuation in A fib patients, consult pharmacy
- Transition from Rivaroxaban to Heparin/Enoxaparin, consult pharmacy
- Consult Pharmacy to assist with Rivaroxaban transition

Time: ______________ Date: ______________ Physician Signature: ____________________________
Pharm #4087
ORD–433–40001 03/13
**SBAR: Renal Protection Protocol in the Cath Lab**

**S:** Pursuing the potential for avoidable renal disease in a procedural setting.

**B:** Strong focus on Creatinine level in the pre-procedure setting with limited focus on the GFR level.

**A:** Inconsistent practice in the pre-procedure setting

**R:** **Hardwiring Best Practices:**
1. Hold diuretic morning of procedure- build into order sets in EPIC.
2. **GFR <60:** Notify Cardiologist- this is currently part of the pre-cath order sets for both inpatients and outpatients. Recovery Bay will notify the physician of a GFR of < 60. **It will be added as a documentation point in Sensis and cath lab staff will be instructed to include it in their pre-procedure Time Out.**
3. **During the procedure the physician will be notified if the contrast load has reached a level equal to or greater than 3 times the GFR.** Staff will document in the cath procedure record that the physician was informed.
Getting Smarter About Prevention & Treatment of VTE

Please plan to join Dr. Cam Campbell, Dr. Fadi Yacoub, and Lauren Cumings PharmD for review of practical strategies in the use of novel anticoagulants for prevention & treatment of venous thromboembolism (VTE) including DVT & PE. The attendee will:

- Understand new In-Patient Venous Thromboembolism National Hospital In-Patient Quality Measures from CMS, Joint Commission and Meaningful Use.
- Learn optimal management of antithrombotic therapy to maximize patient outcomes while adhering to current national guidelines.
- Understand pharmacologic overview of old and new anticoagulants.
- Learn current information on reversal of anticoagulants.
- Learn tips on how to transition from one anticoagulant to another.

Continuing Education Credit
Nursing: 1.2 contact hours will be awarded for attending the entire presentation. Mercy Medical Center is IBN Provider #57. NO partial credit will be awarded.

Other healthcare professionals: This offering may be eligible for 1.2 contact hours of continuing education credit. Consult your governing rules to determine if appropriate subject matter criteria will apply to credit hours.

ACCREDITATION
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Iowa Medical Society (IMS) through the joint sponsorship of The Cedar Rapids Medical Education Foundation, Mercy Medical Center and St. Luke’s Hospital. The Cedar Rapids Medical Education Foundation is accredited by the IMS to provide continuing medical education for Physicians. The Cedar Rapids Medical Education Foundation designates this educational activity for a maximum of 1 AMA PRA Category 1 Credit. Physicians should only claim credit commensurate with their participation in the activity.

CONFLICT OF INTEREST DISCLOSURE
As a sponsor accredited by the Iowa Medical Society, The Cedar Rapids Medical Education Program must assure balance, independence, objectivity and scientific rigor in all its individually sponsored or jointly sponsored educational activities. All faculty participating in a sponsored activity are required to disclose to the audience any significant financial interest or other relationship (1) with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in an educational presentation and (2) with any commercial supporters of the activity (significant financial interest or other relationship can include such things as grants, or research support, employees, consultant, major stock holder, member of speakers bureau, etc.). The intent of this disclosure is not to prevent a speaker with a significant financial or other relationship from making a presentation, but rather to provide listeners with information on which they can make their own judgments. It remains for the audience to determine whether the speaker’s interest or relationship may influence the presentation with regard to exposition or conclusion.

Disclosure forms for each presenter are on file in the CME office. DURING PRESENTATIONS THERE ARE OCCASIONALLY DISCUSSIONS OF UNAPPROVED USE OF FDA APPROVED DRUGS, DEVICES OR TREATMENTS. THIS MUST BE DISCLOSED TO THE AUDIENCE DURING THE LECTURE. DISCLOSURE: THE PHYSICIANS HAVE DISCLOSED THAT THEY DO NOT HAVE INTEREST IN COMMERCIAL SUPPORT.