Lakewood Ranch Medical Center

PHYSICIAN NEWSLETTER

VOL. 8, ISSUE 3 MAY 2022

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In this issue:

Medical Staff Policy Updates

NEW

- Care of the Post-Cardiac Arrest Patient
- C. diff Screening Protocol

REVISED

- Admission Criteria for the ICU
- Critical Results Reporting
- Determination of Brain Death
- IV to PO Conversion
- Paramedics in the ER and ICU
- Patient and Family Education
- Standard Precautions for Infection Prevention
- LWRMC EOP Response Plan – Infant and/or Child Abduction
- LWRMC Risk Management / Patient Safety Plan 2022
- Mandatory COVID-19 Vaccination Requirements and COVID-19 Mitigation Precautions

For questions or a copy of any Medical Staff Policy, contact Carla.Anzalone@lwrmc.com or call (941) 782-2182.

CDI Tip: Uncertain Diagnoses & Appropriate Linking Terms

From CDI Strategies - Volume 16, Issue 13

Q: There are multiple resources available which define acceptable terminology for uncertain diagnoses, and the Official Guidelines for Coding and Reporting provide a list of those terms allowed. However, we have not been able to find the same type of resources for acceptable terms to establish a link between two conditions. It is widely accepted that “with; due to; related to; caused by” are acceptable linking terms. Providers often document “in the setting of,” for example “GI bleed in the setting of anticoagulants”. Currently we query the provider to establish if this indicates a link between the two conditions. This in turn leads to frustration by the providers who feel their documentation clearly establishes a link. This has led to three questions:

1. Is there a list or guidelines for what terminology is considered adequate to establish a link between two conditions, similar to the uncertain diagnosis list?

2. Would the example above of "GI bleed in the setting of anticoagulants" be sufficient to establish a link between conditions, or would ACDIS recommend a query in this situation?

3. Is this a scenario that should be submitted to Coding Clinic?

A: There is no list or set of guidelines for linking terminology that would be considered acceptable in the same way that we have for uncertain diagnoses. The documentation of "in the setting of" says that the two conditions exist at the same time, and that they could be linked to each other, but what it does not demonstrate is a cause-and-effect relationship.

There are times where physicians believe their documentation is sufficient (and others may agree with them based on the information provided in the medical record), but sometimes the CDI specialist knows the information isn't enough for accurate code assignment. Proper documentation should allow someone with no clinical background to agree with the story being told based on the verbiage being used. Would they agree that the anticoagulant was in fact the cause of the GI bleeding? Or would someone have questions about it based on the verbiage? If the answer is not everyone would come to the same conclusion, then clarification is needed. All documentation within a medical record has to support the patient's story, and stand on its own when it comes to supporting code assignment.

The second part of this question is asking if documentation of "GI bleed in the setting of anticoagulants" would be enough to establish a link between the two conditions. If you are looking for a *cause-and-effect* relationship between the condition and the treatment, then no, that documentation is not sufficient; this documentation does not say that the anticoagulant *caused* the GI bleed.

Although anticoagulants can put a patient at a higher risk of bleeding, including a GI bleed, this statement does not indicate that the anticoagulant is the culprit. It only states that the patient with the GI bleed is on some type of anticoagulant therapy at the time the GI bleed occurred. As previously stated, we do know that a patient on anticoagulants is at a higher risk for developing a GI bleed but, this association is based on a few variables such as what anticoagulant the patient is taking. Is it a direct oral anticoagulant or a non-vitamin K antagonist oral anticoagulant? What is the patient dosage? What type of GI bleed is the patient experiencing? Is it an upper or lower GI bleed? Are there other contributing factors also involved such as a Helicobactor pylori (H.pylori) infection? There is a little more to think about with this scenario, other than just that the patient is on an anticoagulant.

ACDIS reference: Q&A: Uncertain conditions, linking terms | ACDIS (urlisolation.com)

Discharge Medication Reconciliation & e-Prescribe

Per The Joint Commission, best practice regarding medication reconciliation at discharge is to tell the patient when their new medication is due based on what they received in the hospital (especially anticoagulants and narcotics). Chart audits for have revealed that if patients have been e-prescribed medications from the surgeon's office, these drugs are not being addressed on the discharge medication reconciliation. Please help us instruct our patients accurately on what medications to continue after discharge and then to take them. **If you are e-prescribing medications from the office, please mark to continue those medications on the hospital discharge medication reconciliation.**

National Backorder: Fibrin Degradation Products (FDP) Tests

Due to a national backorder, the FDP or Fibrin Degradation Products test is currently unavailable. This is a test that the laboratory sends to MMH; however, MMH is out of test kits. The kits are scheduled to be available sometime in May. This test is commonly ordered for patients in DIC. The lab will still offer all other coagulation tests, including D Dimer which is an applicable option in the absence of the FDP test.

There is an option to send FDP tests to LabCorp; however, the turnaround time is 2-3 days. Please contact the lab if you would like to send out an FDP to LabCorp.

P&T Committee Update

Formulary Management:

Dipeptidyl- Peptidase 4 (DPP-4) Inhibitors (Update)

- At LWRMC, we currently have linagliptin on the formulary.
- Alogliptin has the following benefits: no clinically significant drug interactions, average decrease in HgbA1c of 0.6-1%, and a more favorable cost profile than others in the same class.
- Because of the above benefits of alogliptin and guidelines not specifying the preference of one agent over the other, we have switched to alogliptin as the formulary DPP-4 inhibitor product.
- A therapeutic interchange will be automized for all other DPP-4 inhibitor products.

Sodium-Glucose Cotransporter-2 (SGLT2) Inhibitors (New):

- A drug class review of SGLT2 inhibitors for heart failure (HF) was requested with focus on empagliflozin to be added to the formulary.
- ACC HF Guidelines supports the use of empagliflozin and dapagliflozin as adjunctive agents of choice for heart failure with reduced ejection fraction (HFrEF).
- February 24,2022, the FDA expanded the approval of empagliflozin for HF **regardless of EF.**
- We have added empagliflozin to our formulary with the following considerations:
    - **Diabetes**: eGFR <30 mL/minute/1.73 m^2: manufacturer does not recommend.
    - **Heart Failure:** eGFR <20 mL/min/1.73m^2: not recommended, trials did not enroll patients with the above parameter.
    - Hold empagliflozin at least three days before scheduled surgery.
- A therapeutic interchange will be automized for all other SGLT2 inhibitor products.

Drug Shortages:

Dextrose 50% syringe continues to be on back order! Therefore, the Pharmacy Department at LWRMC is continuously monitoring the use of this agent and advises prescribers to be judicious in making sure other agents like juice and glucose tablets are utilized first.

Glucose gels are also on backorder and only to be utilized in nursery. In the meantime, dextrose 50% syringes are reserved for **crash cart use only**!

Antimicrobial Stewardship:

LWRMC 2022 Antibiogram and Spectrum of Activity

- 2022 Antibiogram now available at **LWRMC View->Medication Resources ->Antibiogram ->2022**
- When comparing 2021 vs 2022 Antibiogram, the following differences were observed/ made:
    - Medications that weren't on formulary were removed, for ESBL K. pneumoniae: consult ID for ertapenem utilization, and fluoroquinolones should be reserved as last line agent.
    - Citrobacter freundii had lower sensitivity to fluoroquinolones this year versus 2021

LWRMC Key Antibiotic Changes: First Quarter 2022

To provide adequate coverage for Pseudomonas, revisions were made to the dosing to aztreonam and cefepime. **All patients initiated on the above agents, the standard dosing, regardless of indication, will be the following: cefepime 2g q8hrs or aztreonam 2g q6hrs**. Pharmacy will renally adjust automatically when clinically necessary.

Lakewood Ranch Medical Center 2022 Antibiogram and Spectrum of Activity[1]

	Antibiotic Spectrum of Activity organism (# isolates)	Gram (+)				Gram (-)								
		MSSA (188)	MRSA (144)	Staph Species CoNS (100)	Enterococcus faecalis (215)	Citrobacter freundii complex (36)	Enterobacter cloacae complex (62)	E. Coli (Not ESBL) (828)	ESBL[8] E. Coli[5] (89)	Klebsiella oxytoca (36)	Klebsiella pneumonia[8] (240)	Proteus mirabilis[5] (128)	Pseudomonas aeruginosa (183)	Serratia mascescens (30)
β – LACTAM	Ampicillin	0			100			58	0			78		
	Pip/Tazo	100			100	97	85	99	93	100	96	99	91	80
	Amp/Sul	100			100			66	28	92	83	89		
	Amox/Clav	100			100			90	70	92	93	94		
	Meropenem					100	100	99	100	100	100	99	96	100
	Nafcillin[7]	100	0	52										
CEPHALOSPO	Cefazolin	100	0	52				90	0	39	86	79		
	Cefuroxime	100						92	0	92	84	84		
	Ceftriaxone	100						97	0	100	89	90		
	Ceftazidime							99	1	100	89	92	92	73
	Cefepime	100				94	98	99	7	100	91	95	90	97
OTHER AGENTS	Aztreonam					81	79	98	2	97	90	89	81	90
	Gentamicin					89	98	95	74	100	94	95	83	100
	Tobramycin					89	98	95	70	100	93	95	99	90
	TMP/SMX	98	72	93		92	90	80	47	94	87	91		93
	Vancomycin	100	100	100	98									
	Daptomycin	99	99	100	99									
	Linezolid	100	100	100	98									
	Nitrofurantoin[2]	100	100	100	99	78		98	79	94	44			
	Clindamycin[6]	78	74	59										
	Tetracycline[4]	89	81	78	22	78	85	81	39	92				7
	Minocycline[4]					81	93	92	81	94	83			90
FQ	Ciprofloxacin[3]	86	19	64		83	98	81	26	97	90	84	85	97
	Levofloxacin[3]	88	19	66		89	98	82	31	97	94	87	81	100

Recommended	Usually Susceptible	Variably Susceptible/Resistant	Not Recommended

1. Only organisms with an incidence of greater than 30 isolates are included in this antibiogram.
2. Nitrofurantoin is used for Urinary Tract Infections (UTI) only.
3. Quinolones should not be empirically prescribed for treatment of Urinary Tract Infections (UTIs) and are not preferred agents for treatment of MRSA and MSSA infections.
4. Organisms that are susceptible to tetracycline are also considered susceptible to doxycycline and minocycline. However, some organisms that are intermediate or resistant to tetracycline may be susceptible to doxycycline, minocycline, or both.
5. 10% of Escherichia coli isolates were Extended Spectrum Beta-lactamase (ESBL) producers. 10% of Klebsiella pneumoniae isolates were ESBL producers. 5% of Proteus mirabilis isolates were Extended Spectrum Beta-lactamase (ESBL) producers.
6. Clindamycin should not be empirically prescribed for Staphylococcus aureus (MRSA and MSSA) infections.
7. Penicillin/Oxacillin-susceptible staphylococci are susceptible to other β-lactam/cephalosporin agents with established clinical efficacy for staphylococci infections.
8. If ESBL organism obtained, consult ID for ertapenem utilization.

Modified March 2022 by:
M. Barber, Pharm.D., BCPS
G. Delgado, Pharm.D. Candidate 2022

References:
LWRMC Antibiogram 2022
The Sanford Guide to Antimicrobial Therapy 2021