Lakewood Ranch Medical Center

PHYSICIAN NEWSLETTER

VOL. 9, ISSUE 3 MAY 2023

Let's Do Well Together

In this issue:

Physician Payments

A new mailbox has been set up for physician on-call and medical directorship payments. Please submit timesheets and questions associated with payments to physicianpayments@mmhhs.com.

If you have a current call agreement and your address changes, you must send a new W9 to Jacueline.Weller@lwrmc.com in order to get paid.

Electronic Order Entry

In order to promote patient safety, providers should routinely enter their orders in the electronic medical record. Lakewood Ranch Medical Rules and Regulations state:

Verbal orders may be used in an emergency situation only and must be authenticated, dated and timed.

P&T Committee Update

Formulary Deletions

- **Baricitinib Oral Tablets are no longer on the formulary.** Baricitinib was originally added to the LWRMC formulary in January 2021 as a 2nd line agent to Tocilizumab for COVID-19 due to national shortage of Tocilizumab. The supply of Baricitinib has recently expired and was discarded due to its very rare use. Currently there is a plentiful supply of Tocilizumab.

- **Belladonna/Opium (B&O) Suppositories will no longer be available** and have been removed from the formulary. LWRMC has not had Belladonna/Opium suppositories in stock for several months. The manufacturers were responsible for the delay of inventory. Recent news from the manufacturers is that they are no longer making this product, therefore this medication is not available for purchase.

Formulary Management

- **Antifungal Recommendations**: Pharmacy will be distributing “Lakewood Ranch Medical Center 2023 Antifungal Recommendation and Duration of Therapy”, a reference for providers and pharmacists for appropriate use of antifungals and to help improve overall antifungal utilization.
- **Long-acting Basal Insulin:** The formulary long-acting basal insulin at LWRMC is detemir (Levemir). Due to additions of newer, long-acting basal insulin formulations such as insulin glargine and degludec to the market, formulary evaluation and considerations of potential therapeutic interchanges were warranted.
  - ⇒ **Insulin Detemir** will continue to be the formulary option for long-acting insulin.
  - ⇒ Since there are no significant differences in safety and efficacy, any non-formulary long-acting insulin ordered will be automatically interchanged to insulin detemir.

Questions? Contact Jeff Cunningham, Pharm.D., CPh, Pharmacy Clinical Coordinator, at Jeff.Cunningham@lwrmc.com or 941-782-2329

Medical Staff Policy Updates

NEW

- LWRMC Quality Assurance and Performance Improvement Plan
- LWRMC Risk Management / Patient Safety Plan
- Point of Care Siemens epoc BUN and Creatine

REVISED

- Adverse Drug Events, Reactions, and Medication Errors (previously titled Medication Errors)
- Assessment & Care of Victims of Sexual Assault, Rape & Domestic Violence
- Authorized Users of Laboratory Services
- Disclosure of Unanticipated Outcomes
- Group B Strep Care of the Newborn
- MRI Cryogen Safety
- MRSA Screening and Surveillance Testing
- Patient Safety Event Reporting
- Visitors in the OR/LDRP Nursery
- X-Ray Equipment, Safe Usage in Surgery
- Admission Criteria for the ICU
- Bone Marrow Requests
- CJD Specimens
- Cytology Requests
- Phlebotomy Services
- Rapid Response Team
- Renal Dose Adjustment
- Restraint and Seclusion
- Telemetry Monitoring

ARCHIVED

- Adverse Drug Reaction
- Adverse Vaccine Reaction Reporting
- Blood Derivatives

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

CDI Tips

Documentation Time Saver!

If you know you are discharging your patient, instead of documenting a progress note day-of-discharge *and* a discharge summary, just complete a Discharge Summary. This will save you time and one less documentation requirement needed to complete the record. Give it a try and see how you like it!

Respiratory Failure Documentation Tips

- **Acute Respiratory Failure is defined as the following:**

  Any one of the following AND evidence of respiratory distress:

  - pO2 < 60 ***OR*** peripheral oxygen saturation of 88% or less, if no ABG available
  - pCO2 > 50 and pH < 7.35
  - P/F ratio (pO2/FiO2) < 300
  - pO2 decrease or pCO2 increase by 10 mmHg from baseline, if known
  - Supplemental O2 requirement of 40% or more

  Evidence of respiratory distress should include at least one of the following:

  - Tachypnea, SOB, severe dyspnea
  - Pallor or cyanosis
  - Anxiety or restlessness, confusion
  - Use of accessory muscles
  - Retractions (grunting in newborns)
  - Unable to speak in complete sentences

- **Acute on chronic respiratory failure**
  - Characterized by an abrupt increase in the degree of hypoxemia or hypercapnia in patients with preexisting chronic respiratory failure
  - Extent of deterioration best assessed by comparing the patient's present ABGs with previous ABGs
  - Any patient on supplemental oxygen with a P02< 70 or Sp02< 92% may have acute respiratory failure.
  - Any patient receiving supplemental oxygen with FI02 >32% may have acute respiratory failure if p02 is < 80 or Sp02< 95%
  - Any patient requiring FIO2 > 40% almost certainly has acute respiratory failure regardless of the p02 or Sp02.

- **Chronic Respiratory Failure: Continuous (24/7) home oxygen therapy**
  - No need to demonstrate hypoxemia, as oxygen therapy only covered by insurance for home use if specific hypoxemia requirements have previously been met.
  - May have hypoxemia or hypercapnia with a normal pH
  - Occurs over a period of months to years

- Can be identified by pH =7.4 and/or CO2 over 35 on Basic Metabolic Panel
- Home ventilator usage with tracheostomy
- Adds to severity of admission, morbidity and mortality

- **CDI Tips:**
  - Hypoxia without distress will be recorded as “Hypoxia, hypercapnia, and/or hyperbicarbonatemia only”
  - Ensure home oxygen therapy with baseline o2 flow rate is documented in the medical record
  - Be sure to update your physical exam template at the time of service to the patient. Patients cannot have Acute Respiratory Failure if their physical exam says they are “in NAD” with lungs that are “CTA without labored respirations” or they have “normal work of breathing’, etc.”
  - The cause(s) of the respiratory failure should be stated, such as:
    - COPD
    - Interstitial lung diseases
    - Obesity Hypoventilation Syndrome
    - Cystic Fibrosis
    - Muscular Dystrophies
    - Pulmonary Hypertension
    - Spinal cord injuries

Sources:

Respiratory Failure: Background, Pathophysiology, Etiology (medscape.com)
Chronic Respiratory Failure - Brundage Group
Acute Respiratory Failure - Brundage Group

Physician Recruitment

If you or a colleague is interested in a new opportunity in or around Lakewood Ranch, please contact Physician Recruitment at Karen.DeSimone@uhsinc.com or (941) 961-3107.

There is a need for physicians in many different specialties across the market. And there are currently multiple outpatient Internal Medicine and Family Medicine physician opportunities available.
