

PERIOPERATIVE BETA-BLOCKERS

By Mark A. Greenberg MD

Strong evidence exists for the use of perioperative beta-blockers to reduce cardiac events and mortality, especially in high-risk patients.

Excellent summaries of the literature are as follows:

1. AHRQ, Safety Processes, Chapter 25. *Beta-Blockers and Reduction of Perioperative Cardiac Events*.
2. NEJM, Vol. 345(23). Dec. 6, 2001. 1677-1682.
3. JAMA, Vol. 287(11). March 20, 2002. 1435-1444.

On the basis of the available evidence, the National Quality Forum elevated the use of perioperative beta-blockers to the level of a core safety process. It is almost certain that JCAHO will also adopt this practice as a core safety performance measure in the future. Given the minimal current use of perioperative beta-blockers by LMHS Medical Staff members, a multi-disciplinary group (member names available upon request) was convened to review the data and make recommendations regarding their use and implementation System wide.

The recommendation follows: Pending additional studies, the routine use of perioperative beta-blockers should be limited to patients at moderate and high risk of post-operative cardiac events who are undergoing high-risk surgical procedures.

High Risk Surgical Procedures:

- Vascular Surgery
- Intra-abdominal Surgery
- Thoracic Surgery

High Risk for Post Operative Cardiac Events:

- Ischemic Heart Disease: History of MI, history of angina and/or use of nitrates; history of positive exercise testing; Q waves on EKG; history of CABG and/or angioplasty with chest pain c/w angina.
- CHF
- Diabetes (IDDM)
- Chronic Renal Insufficiency: Serum creatinine ≥ 2.0 mg%, especially if secondary to HTN or diabetes.
- TIA's or history of CVA
- Peripheral Vascular Disease

Moderate Risk for Post-Operative Cardiac Events:

- Two or more: • Diabetes (NIDDM)
- HTN • Cholesterol ≥ 240 mg%
- Smoker • Age > 65 years

The Cardiology Section has approved these recommendations. Additional presentations are yet to be made to the General Surgery Council, Medicine Council, and Anesthesia Section. Additional details will be published once plans for implementation have been finalized.

In addition, LMHS has arranged a CME lecture on this topic by Andrew D. Auerbach, M.D., Assistant Professor of Medicine, University of California, San Francisco and primary author of the AHRQ Review on Perioperative Beta-Blockers. The dinner lecture will be presented on November 18 at the new Hilton Garden Inn. Additional details and reservation information will be forwarded to all Medical Staff members in the future.

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! ATTENTION! DELINQUENT MEDICAL RECORDS

CCH & LMHS Medical Staff Rules and Regulations require that:

- any physician placed on suspension four (4) times in one year must be reviewed by the Executive Committee.
- any physician on suspension for twelve (12) consecutive weeks will have his medical staff membership suspended and if ratified by the Medical Executive Committee, his membership will be terminated.

The latter is reportable to the Agency for Healthcare Administration and would require reapplication to the medical staff before engaging in any activity within the hospital.

Please keep your records up to date. Thanks.

G.P. Fitzgerald III, MD, Corporate Medical Director

MEDICARE PBS REIMBURSEMENT CHANGES FOR FY 2003

Major changes have been announced by CMS (Medicare) to the Prospective Payment System beginning October 2002. These proposed changes could have a significant financial impact on LMHS. Now more than ever, there is an increasing pressure on Health Information Management (HIM) to ensure that ICD-9-CM code assignments are accurately and legitimately supported by medical record documentation.

Physicians need to be as specific as possible about the documentation of disease, cause and /or potential causes of disease process. HIM Coding Staff is utilizing a physician query strategy and tool to help ensure medical record documentation is as precise as possible. Case Management will continue to use the Clinical Assessment Tool (blue forms also known as CAT) to assist physicians in determination/ documentation of proper specific classification of disease processes.

Below are some of the major DRG changes that lack of specific documentation could have significant financial impact on LMHS.

- Nonspecific CVA (ICD-9 Code 436) has been moved to lower paying DRG. CMS' data show that these cases consume fewer resources and usually shorter length of stay.

- Precerebral artery syndromes and unspecified transient cerebral ischemic (ICD-9's 435.0, 435.0 435.3, 435.8, 435.9) have been moved to a new DRG (524) /Transient ischemia. DRG 524 will have less reimbursement to LMHS than the previous year.
- Xigris (Drotrecogin Alfa Activated) has been approved as an add-on payment to hospital as a new technology. Medical Record documentation must indicate infusion of Drotrecogin Alfa (Activated) to allow HIM Coding Staff to assign the new ICD-9 procedure code 00.11 Infusion of Xigris.

Health Information Management and Care Management staff will continue to work as a Team to assist physicians in the proper documentation in the medical record to support the correct assignment of diagnoses, procedures and DRG's. Continued use and refinement of the current communication tools will be essential to maintain the financial stability of Lee Memorial Health System.

If you would like further clarification on the changes to Medicare's Prospective Payment System (PPS DRG) you may contact Stanley Padfield, System Director of Health Information Management at LMH campus.

PATIENT SAFETY CORNER

Mary Kirkwood, LMHS Director of Quality, Patient Safety and Standards

Health care organizations today, including Lee Memorial Health System, are taking a proactive approach to patient safety. The overall industry goal is to figure out what *could* go wrong and prevent errors before they happen.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which has made patient safety its top priority, has published six specific National Safety Goals for 2003. The Joint Commission has also set forth clear, evidence-based recommendations to help health care organizations reduce these six types of health care errors.

The Joint Commission's 2003 National Patient Safety Goals and Recommendations provide practical methods for preventing errors in the following areas:

1. Improving the accuracy of patient identification. Recommendations:

- Use at least two methods of patient identifiers (neither to be the patient's room number) whenever taking blood samples or administering medications or blood products.
- Prior to the start of any surgical or invasive procedure, conduct a final verification process, such as a "time out," to confirm the correct patient, procedure and site, using active, not passive communication techniques.

2. Improving the effectiveness of communication among caregivers. Recommendations:

- Implement a process for taking verbal or telephone orders that require a verification "read-back" of the complete order by the person receiving the order.

- Standardize the abbreviations, acronyms and symbols used throughout the organization, including those *not* to use.

3. Improving the safety of using high-alert medications. Recommendations:

- Remove concentrated electrolytes (including but not limited to potassium chloride, potassium phosphate, sodium chloride >9 percent) from patient care units.
- Standardize and limit the number of drug concentrations available in the organization.

4. Eliminating wrong-site, wrong-patient and wrong-procedure surgery. Recommendations:

- Create and use preoperative verification process, such as a checklist, to confirm that appropriate documents, (e.g., medical records, imaging studies) are available.
- Implement a process to mark the surgical site and involve the patient in the marking process.

5. Improving the safety of using infusion pumps. Recommendation:

- Ensure free-flow protection on all general-use and PCA intravenous infusion pumps used in the organization.

6. Improving the effectiveness of clinical alarm systems. Recommendations:

- Implement regular preventive maintenance and testing of alarm systems.
- Assure that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit.

INTRODUCING LIFETIME CLINICAL RECORD (LCR) – ENTERPRISE ACCESS TO PATIENT CLINICAL INFORMATION

LMHS is now offering a new computer database called the Lifetime Clinical Record that ties patient clinical information together across our healthcare system. One of the primary benefits of this system is that *clinical results from all acute care campuses and across all visits will be displayed once the patient is selected through Net Access. We also have an enhanced*

Microbiology display.

We have color printouts that depict the new Net Access functionality available in the Physician Lounges or, if you would like to see a Net Access demo, or receive training, please contact Karen Mueller at 335-7753, pager 930-6635 or e-mail karen.mueller@leememorial.org.

WHAT TO DO WHEN THE MEDICAL LIBRARY IS CLOSED?

By: Narges Ahmadi, Medical Librarian

The Medical Library at Lee Memorial Hospital, the main library of Lee Memorial Health System, is closed. Mold has been discovered growing on books, so the collection is being cleaned and treated. This library's collection will not be accessible until the library reopens around October 13th.

In the meantime, physicians and staff may use two branches of the library: in Cape Coral Hospital and in the Atrium of HealthPark Medical Center. Both are fully staffed. CCH library is open Monday to Friday 8 AM to 4:30 PM and on Saturday 9 AM to Noon. Barbara's Friends Medical Library at HealthPark is open Monday to Friday 8 AM to 5 PM.

Both libraries have collections of books and videoprograms as well as access to approximately 500 full-text journals and bibliographic databases.

Physicians who plan on using the library at HealthPark after hours may apply for "smart cards" at the security office at HealthPark. To access the library at CCH after hours, physicians need to call security at CCH.

To request copies of articles, users may fax their requests to 574-0205 (CCH) or to 432-4368 (HP), or call 574-0204 and 432-4367, respectively.

After hours, physicians may access the electronic library from their home computers. At <http://gateway.ovid.com> physicians may access MEDLINE, CANCELIT, HEALTHSTAR, Evidence Based Medicine databases, over 150 full-text medical journals and 37 full-text textbooks including Harrison's Principles of Internal Medicine. To search textbooks, physicians must select "Lippincott's Clinical Choice" from the OVID menu. Harrison's is temporarily placed under "Books at Ovid". To access these resources, users must know their users ID and passwords, which they may obtain from the Medical Library.

OVID is also now available in the physicians lounge room in all 3 hospitals. To access it from there, hold down the CTRL, Alt and END keys. This will bring you to the Connection Manager. Highlight Applications and click on Connect. Click Login on the next screen. Then, click on the OVID icon.

If Application is active (see status column, far right), you will hold down the Ctrl, Alt and the UP or DOWN arrow key. This action will take you to the first active application. If it is not OVID (Applications, CliniComp, Mainframe, etc.), hold down Ctrl, Alt, and the UP or DOWN arrow key again. You may need to repeat this action until you reach the

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application you desire.

ProQuest Company offers a free access to their collection of full-text nursing and medical journals until October 11th. Among medical journals, Lancet and British Medical Journals are available. To access them, go to: <http://trials.proquest.com/proquest/servlet/TrialsController?&userid=49191>

Call the medical library for a password.

Once in the database, chose method of searching by clicking appropriate option in the

box "search methods". To retrieve specific articles from a publication chose "publication" and type the journals name. Identify the issue, the article, and then click on a camera icon to retrieve full-text.

After October 11, Lee Memorial Health System will own a subscription to this service. It will be available in each library and will be also be accessible from personal computers. Users, who would like to access it that way, will need to obtain their passwords from the Medical Library at that time.

LEE CANCER CARE PRESENTS

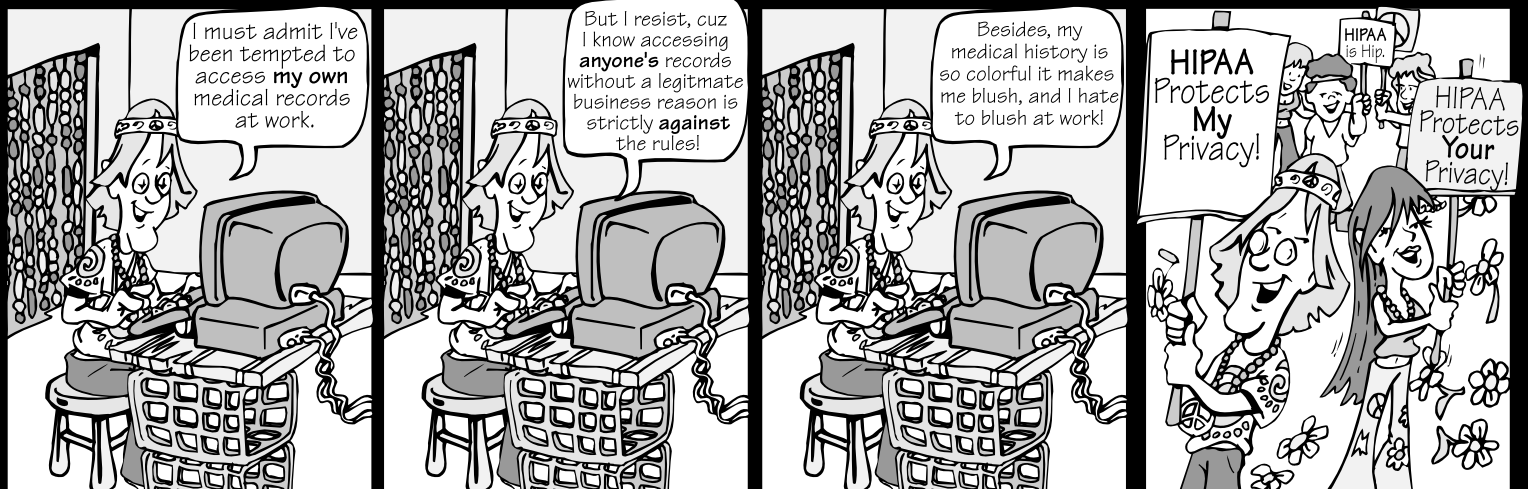
"Relative Quality and End-of-Life Communications in Palliative Care" Presented by Michael Weitzner, MD, Chief Palliative Care Service, H.Lee Moffitt Cancer Center and Research Institute

A CME Dinner lecture on November 6, 2002 for Physicians in Family Medicine,

Gastroenterology, General Medicine, Infectious Disease, Internal Medicine, Oncology/ Hematology, Pulmonary Medicine, Therapeutic Radiology, Surgery, Palliative Care, and Physician Assistants, Advanced Practice Nurses and Nurses in the field of palliative care.

RSVP by November 4, 2002 - 336-6137

HIPAA revolution: Your Privacy!



CONTINUING MEDICAL EDUCATION – CME OCTOBER 2002

“Travel Medicine”

Judith Hartner, MD, M.P.H.

Thursday, October 3, 2002

12:30 – 1:30 PM

Lee Memorial Hospital Auditorium

“New Trends in Sports Medicine”

John Mehalik, MD

Thursday, October 17, 2002

12:30 – 1:30 PM

Lee Memorial Hospital Auditorium

“A Potpourri of Risk Management”

Robert McCurdy, Esq.

Tuesday, October 22, 2002

12:30 – 1:30 PM

Lee Memorial Hospital Auditorium

“Coding: What Physicians Need to Know”

Jerry Williamson, MD

Monday, October 28, 2002

6:00 – 8:00 PM (2 CME credits)

Lee Memorial Hospital Auditorium

RSVP Dinner by 10/23/02 574-0374

Coordinated by:

Joanne Gorgone, RN - 574-0397

Cathy Hassen, CMSC - 574-0374

If you have questions or would like to submit an article to *Medical Staff News*, please contact

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