The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BUDGET SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS
Senator Negron, Chair
Senator Rich, Vice Chair

MEETING DATE: Wednesday, September 21, 2011
TIME: 1:30 —3:30 p.m.
PLACE: *Toni Jennings Committee Room,* 110 Senate Office Building

MEMBERS: Senator Negron, Chair; Senator Rich, Vice Chair; Senators Gaetz, Garcia, Oelrich, Richter, and Sobel

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1		Return on Investment (ROI) Studies within Health and Human Services	
2		Update from the Agency for Health Care Administration on Florida Medicaid Waiver Requests Justin Senior, General Counsel and Acting Medicaid Director, AHCA	
3		Electronic Clinical Surveillance Systems in Florida Hospitals, by Hospira, Inc.	
4		Reimbursement for Patient Visits at Federally Qualified Health Centers Mark Dickinson, CEO/CFO Community Health Centers, Inc.	

No material available

2010 SB 1484: Extension of the 1115 Reform Demonstration Waiver

Overview:

The 2005 Florida Legislature directed the Agency for Health Care Administration (Agency), through Section 409.91211, Florida Statutes, to implement a Medicaid Managed Care Pilot Program. This statute directs the Agency to implement the pilot program in five Florida counties: Baker, Broward, Clay, Duval, and Nassau.

Pursuant to this statute, the Agency requested an 1115 Demonstration Waiver to implement the program. The federal government approved the request for a five year period from July 1, 2006 through June 30, 2011. Under an 1115 waiver, states have the option to request a 3 year extension after the initial 5 year approval period.

On April 30, 2010 the Florida Legislature passed Senate Bill 1484. Within this bill, the Florida Legislature directed the Agency to seek approval of a 3 year waiver extension to continue operation of the pilot program in Baker, Broward, Clay, Duval and Nassau Counties. The Legislature directed the Agency to submit the extension request by no later than July 1, 2010.

Request for Extension:

The Agency submitted a request to extend the pilot program to the federal Centers for Medicare and Medicaid Services (CMS) on June 30, 2010, as well as several follow up extension requests. The Agency currently has authority to continue the pilot program through September 30, 2011.

On August 17, 2010, CMS advised the Agency that they would review and process the State's request to renew the Reform Demonstration under section 1115(a) authority, rather than under section 1115(e) authority as originally requested by the State. By this decision, CMS notified the state that they will request changes/ amendments to the terms and conditions of the waiver. In addition, while there are timelines for CMS to respond to a state waiver requested under the 1115(e) authority, no timelines exist for CMS to respond under section 1115(a). Since that time, the Agency has been involved in ongoing discussion, provision of information and negotiation with CMS with regard to the waiver extension.

Key outstanding issues include:

- Whether or not CMS will require a medical loss ratio for participating managed care plans; and
- Changes to the requirements of the State's Low Income Pool (LIP) program.

Of particular concern is that CMS indicated that the federal Office of Management and Budget is evaluating an early sunset date for Florida's Low Income Pool program. CMS noted that they and OMB are considering a sunset date of December 31, 2013. The changes in the effective date would provide a partial year funding for LIP of $500 million during the last year of the renewal period instead of the $1 billion annual allotment currently authorized.

Additional details regarding the waiver extension and the Agency's interaction with CMS are available on the Agency's website: http://ahca.myflorida.com/Medicaid/index.shtml#reform

2011 House Bill 7107: Florida Statewide Medicaid Managed Care Program Status Update

Overview:

On May 6, 2011, the Florida Legislature passed House Bill (HB) 7107, relating to Medicaid Managed Care. The bill outlines a comprehensive expansion of managed care for most Medicaid recipients throughout Florida. This program is known as the Statewide Medicaid Managed Care (SMMC) program.

The SMMC program had two main components: (1) the Long-Term Care Managed Care program and (2) the Managed Medical Assistance program. HB 7107 directed the Agency for Health Care Administration (Agency) to apply for state plan amendments and federal waivers necessary to implement the program.

The Legislation contained timelines for implementation of the SMMC, including deadlines for public meetings, for submission of requests for federal authority, for release of invitations to negotiate to secure health plans, and for actual program implementation.

Deadlines:

Statutorily Mandated SMMC Deadlines		
	LTC Component	**MMA Component**
Public Meetings	Allow for 30 day comment period after meeting/ before submission of requests for federal authority	Allow for 30 day comment period after meeting/ before submission of requests for federal authority
Submission of Requests for Federal Authority	August 1, 2011	August 1, 2011
Release of Invitations to Negotiate	July 1, 2012	January 1, 2013
Program Implementation	July 1, 2012 - October 1, 2013	January 1, 2013 - October 1, 2014

Public Meetings:

The Agency held a public meeting in each of the 11 regions created by the legislation between June 10 and June 17, 2011.

The opportunity for public comment will continue throughout the implementation process. The Florida Medicaid program is open to feedback from any stakeholder, including recipients, providers, advocates and researchers. Based on feedback, Florida Medicaid has taken advantage of opportunities to adapt and improve and will continue to do so.

2011 House Bill 7107: Florida Statewide Medicaid Managed Care Program Status Update

Submission of Requests for Federal Authority

On August 1, 2011, the Agency submitted the required documents requesting various authorities to implement the program. An overview of those authorities follows:

Managed Medical Assistance Program	
Amendment Vehicle	**Subject**
1115 Medicaid Reform Demonstration Waiver	• Request for authority to mandatorily enroll the vast majority of individuals in managed care plans statewide. This includes children with chronic conditions, children in foster care and children who receive an adoptive subsidy, as well as Medicare/Medicaid dual eligible recipients. • Request for authority to allow health plans to develop customized benefit packages targeted to specific populations. • Request for authority to implement an Employer Sponsored Insurance program in which maximum payment will be the Medicaid authorized premium.
1115 Medicaid Reform Demonstration Waiver	Requests the authority to impose a $10 monthly premium on recipients enrolling in the SMMC program.
1115 Medicaid Reform Demonstration Waiver	Requests the authority to require a $100 copayment for non-emergency ER visits.
1115 MEDS AD Demonstration Waiver	• Premium option for Medically Needy population • Seeking 1115 authority to require a premium not to exceed share of cost after the first month of qualifying as a medically needy recipient and enrolling in a plan. The recipient would pay a portion of the monthly premium equal to the enrollee's share of the cost. • Continuous Enrollment –seeking 1115 authority to provide Medically Needy recipients with continuous enrollment for up to six months.
	• Seeking state plan authority relating to cost effective methods for employer-based group health plans • The Health Insurance Premium Payment Program (HIPP) program will enable Medicaid recipients to participate in employer-sponsored insurance. • The Medicaid MCO capitation payment that would have been paid for a Medicaid recipient will be used to pay the recipient's share of their employer-sponsored health insurance. • Medical services that are not covered by the recipient's employer-sponsored health insurance will be submitted to Medicaid by the Medicaid provider. Medicaid will pay the provider up to its allowable amounts. This is known as wrap-around services.

Long Term Managed Care Program	
Amendment Vehicle	**Subject**
New Waiver (1915 b/c combo)	The Agency is seeking a 1915(c) waiver from federal CMS for the authority to identify and allow qualified individuals to receive home and community based care services in lieu of nursing home care services. AHCA will also be seeking a 1915(b) wavier for the authority to enroll individuals in managed care plans statewide, and to allow for selective contracting of those plans.

2011 House Bill 7107: Florida Statewide Medicaid Managed Care Program Status Update

Timeline for Requests for Federal Authority to Implement the SMMC program

1915(b)/(c) and state plan amendment have three 90 day periods:

- The Agency submitted its 1915(b)/(c) waiver application and state plan amendment on August 1, 2011. Starting on that date, CMS has 90 days to review these materials and approve, deny or request clarification
- Upon receiving CMS' response, the Agency has 90 days to respond.
- Once CMS receives the Agency's completed responses, they have 90 days to make a final decision.
- CMS must approve sate plan amendments that comply with federal Medicaid law.

1115 waivers have no time periods to which either CMS or the Agency must comply.

September 21, 2011

The support for electronic clinical surveillance systems in hospitals

Presentation to the Florida Senate
Budget Subcommittee on Health and Human Services Appropriations

Stanley L. Pestotnik, MS, RPh
General Manager, TheraDoc

Juliana Reed
Vice President, Government Affairs, Hospira, Inc.

TheraDoc Clinical Surveillance System

- Incorporated June 28, 1999
- Acquired by Hospira December 2009
- Clinical IT Group – Salt Lake City-based
- Enterprise Clinical Surveillance Systems that include clinical decision support
- 283 Hospitals in 33 states

- Our presence in Florida:

All Children's Hospital
Community Living Center
Baptist Hospital of Miami
Baptist Medical Center Beaches
Baptist Medical Center Downtown
Baptist Medical Center South
Baptist Outpatient Service
Doctors Hospital
Homestead Hospital
Mariners Hospital
South Miami Hospital
Wolfson Children's Hospital
West Kendall Baptist Hospital
James Haley Veterans Hospital
Joe DiMaggio Children's Hospital
Mayo Clinic Jacksonville
Mease Countryside Hospital
Mease Dunedin Hospital
Memorial Hospital Miramar
Memorial Hospital Pembroke
Memorial Hospital West
Memorial Regional Hospital
Memorial Regional Hospital South
Morton Plant Hospital
Morton Plant North Bay Hospital
South Florida Baptist Hospital
St. Anthony's Hospital
St. Joseph's Children's Hospital of Tampa
St. Joseph's Hospital
St. Joseph's North
St. Joseph's Women's Hospital Tampa
Tampa General Hospital
Tampa General Hospital Children's Medical
Venice Regional Medical Center
Winter Haven Hospital

Heritage

Two decades experience in clinical informatics directed at patient safety.

Infection Control

COMPUTERIZED IDENTIFICATION OF PATIENTS AT HIGH RISK FOR HOSPITAL-ACQUIRED INFECTION

R. SCOTT EVANS, PhD,
JOHN P. BURKE, MD,
DAVID C. CLASSEN, MD,
REED M. GARDNER, PhD,
RONALD L. MENLOVE, PhD,
KATHY M. GOODRICH, RN, BS,
LANE E. STEVENS, BS,
STANLEY L. PESTOTNIK, RPh,
Salt Lake City, Utah

From the Departments of Medical Informatics, Infectious Diseases, and Pharmacy, LDS Hospital and University of Utah School of Medicine, Salt Lake City, Utah.

Reprinted from
AMERICAN JOURNAL OF INFECTION CONTROL,
St. Louis

Vol. 20, No. 1, pp. 4-10, February, 1992

Antibiotic Stewardship

Reprinted from ANNALS OF INTERNAL MEDICINE Vol. 124; No. 10, 15 May 1996
Printed in U.S.A.

Implementing Antibiotic Practice Guidelines through Computer-Assisted Decision Support: Clinical and Financial Outcomes

Stanley L. Pestotnik, MS, RPh; David C. Classen, MD, MS; R. Scott Evans, PhD; and John P. Burke, MD

Objective: To determine the clinical and financial outcomes of antibiotic practice guidelines implemented through computer-assisted decision support.

Design: Descriptive epidemiologic study and financial analysis.

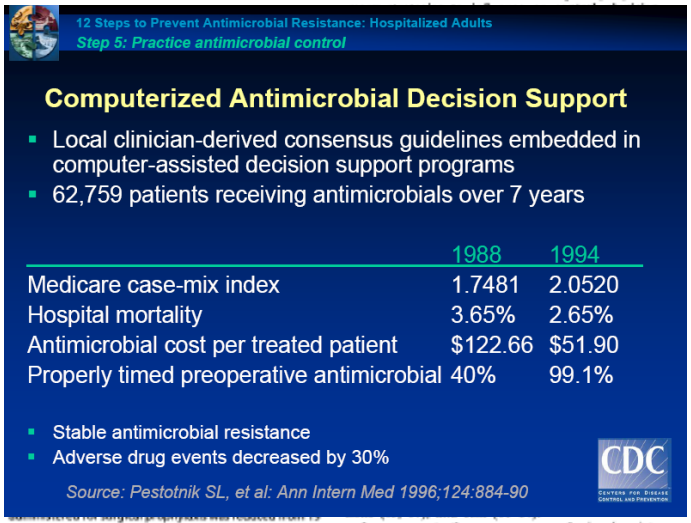
Setting: 520-bed community teaching hospital in Salt Lake City, Utah.

Patients: All 162 196 patients discharged from LDS Hospital between 1 January 1988 and 31 December 1994.

Ann Intern Med. 1996;124:884-890.

From LDS Hospital, Salt Lake City, Utah. For current author addresses, see end of text.

Physicians' decisions control between 70% and 80% of all health care dollars spent (1–3), and



doses in the base year to 5.3 doses in 1994. Antibiotic-associated adverse drug events decreased by 30%. During the study, antimicrobial resistance patterns were stable, and length of stay remained the same. Mortality rates decreased from 3.65% in 1988 to 2.65% in 1994 ($P < 0.001$).

Conclusions: Computer-assisted decision support programs that use local clinician-derived practice guidelines

In response to these pressures, professional societies and individual investigators have outlined methods with which to improve antibiotic use (20–29). Most of these methods (for example, drug formularies) use some form of a control mechanism, and, to date, experience with them has been mixed (11, 16, 25, 27, 28).

ADE – Drug Safety

Computerized Surveillance of Adverse Drug Events in Hospital Patients

David C. Classen, MD; Stanley L. Pestotnik, RPh; R. Scott Evans, PhD; John P. Burke, MD

Objective.—To develop a new method to improve the detection and characterization of adverse drug events (ADEs) in hospital patients.

Design.—Prospective study of all patients admitted to our hospital over an 18-month period.

Setting.—LDS Hospital, Salt Lake City, Utah, a 520-bed tertiary care center affiliated with the University of Utah School of Medicine, Salt Lake City.

Patients.—We developed a computerized ADE monitor, and computer programs were written using an integrated hospital information system to allow for multiple source detection of potential ADEs occurring in hospital patients. Signals of potential ADEs, both voluntary and automated, included sudden medication stop orders, antidote ordering, and certain abnormal laboratory values. Each day, a list of all potential ADEs from these sources was generated, and a pharmacist reviewed the medical records of all patients with possible ADEs for accuracy and causality. Verified ADEs were characterized as mild, moderate, or severe and as type A (dose-dependent or predictable) or type B (idiosyncratic or allergic) reactions, and causality was further measured using a standardized scoring method.

Outcome Measure.—The number and characterization of ADEs detected.

Results.—Over 18 months, we monitored 36 653 hospitalized patients. There were 731 verified ADEs identified in 648 patients, 701 ADEs were characterized as moderate or severe, and 664 were classified as type A reactions. During this same period, only nine ADEs were identified using traditional detection methods. Physicians, pharmacists, and nurses voluntarily reported 92 of the 731 ADEs detected using this automated system. The other 631 ADEs were detected from automated signals, the most common of which were diphenhydramine hydrochloride and naloxone hydrochloride use, high serum drug levels, leukopenia, and the use of phytonadione and antidiarrheals. The most common symptoms and signs were pruritus, nausea and/or vomiting, rash, and confusion-lethargy. The most common drug classes involved were analgesics, anti-infectives, and cardiovascular agents.

Conclusion.—We believe that screening for ADEs with a computerized hospital information system offers a potential method for improving the detection and characterization of these events in hospital patients.

(JAMA 1991;266:2847-2851)

From the Department of Clinical Epidemiology, LDS Hospital, Salt Lake City, Utah, and the Division of Infectious Diseases, Medicine, University of Utah School of Medicine, Salt Lake City.

AS MANY as 38% of hospitalized patients may experience an adverse drug event (ADE) during their hospital stay, according to current estimates.[1,2] Moreover, fatal ADEs are expected in approximately 0.31% of hospitalized pa-

tients (69 000 to 140 000 patients annually) in the United States.[1,2] Adverse drug events lead to 2% to 5% of all hospital admissions each year,[3,4] and one recent report found that complications from drug therapy were the most common adverse events in hospitalized patients.[5]

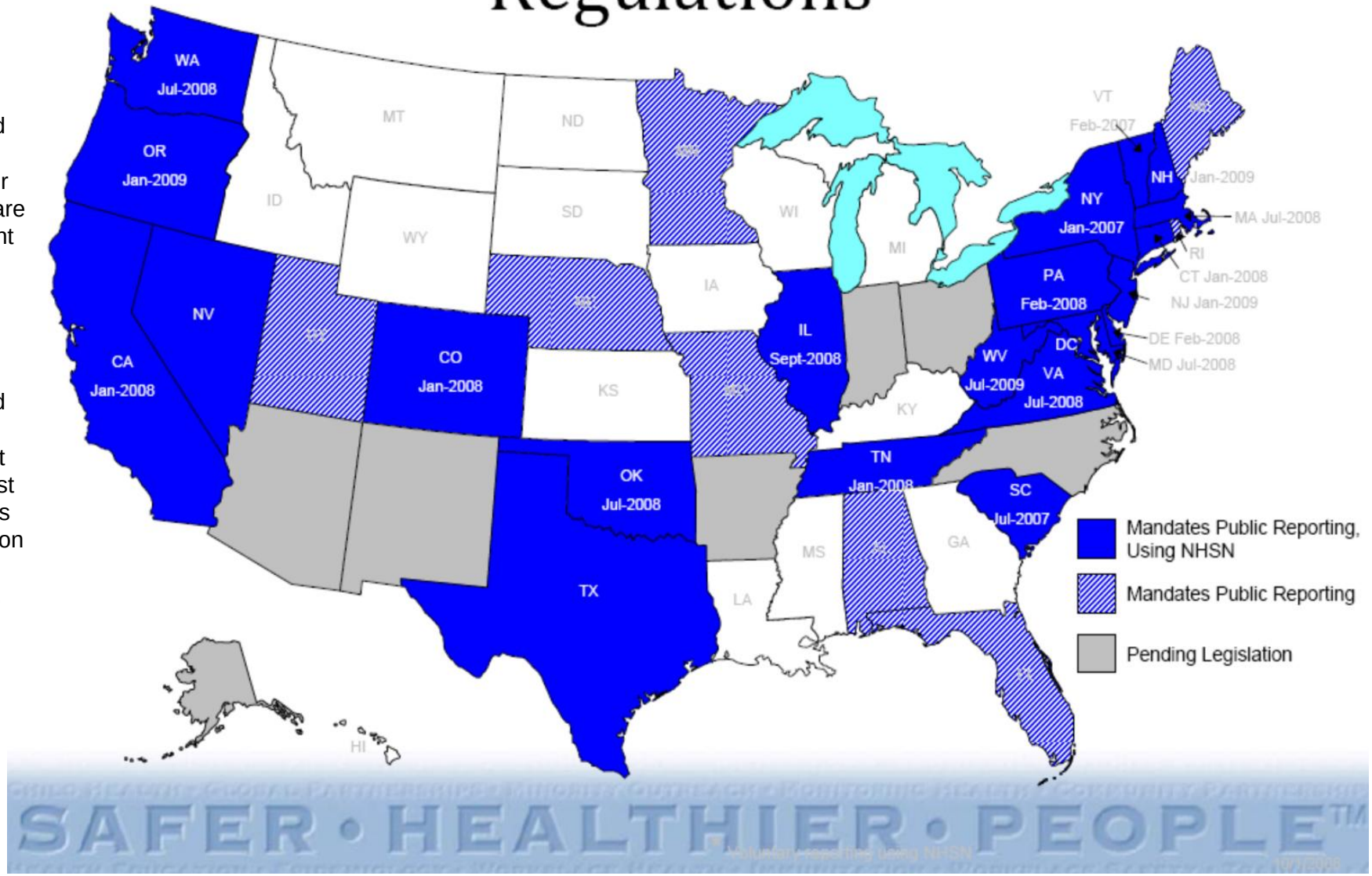
For editorial comment see p 2878.

The exact costs attributed to ADEs are unknown, but it has been suggested that ADEs can prolong hospital stays and add to health care expenditures.[3,6] Studies have indicated that hospitalized patients who are exposed to more than 16 different drugs during their hospitalization have a 60% probability of experiencing an ADE.[7] Patients who have experienced a true ADE are two to three times more likely to experience another subsequent event than patients who have not had an ADE.[8] In addition, hospitalized patients are often elderly and have underlying comorbidities that impair their ability to distribute, metabolize, and excrete drugs, and these elderly patients are more likely to experience toxic reactions. Clearly, hospitalized patients have multiple risk factors predisposing them to ADEs.

For these and other reasons, ADE detection and reporting systems have been advocated. The need for hospitals to assume a more active role in ADE surveillance has been addressed both nationally and internationally. The World Health Organization,[9] the US Food and Drug Administration (FDA),[10] and the Joint Commission on Accreditation of Healthcare Organizations[11] have all addressed this need. The

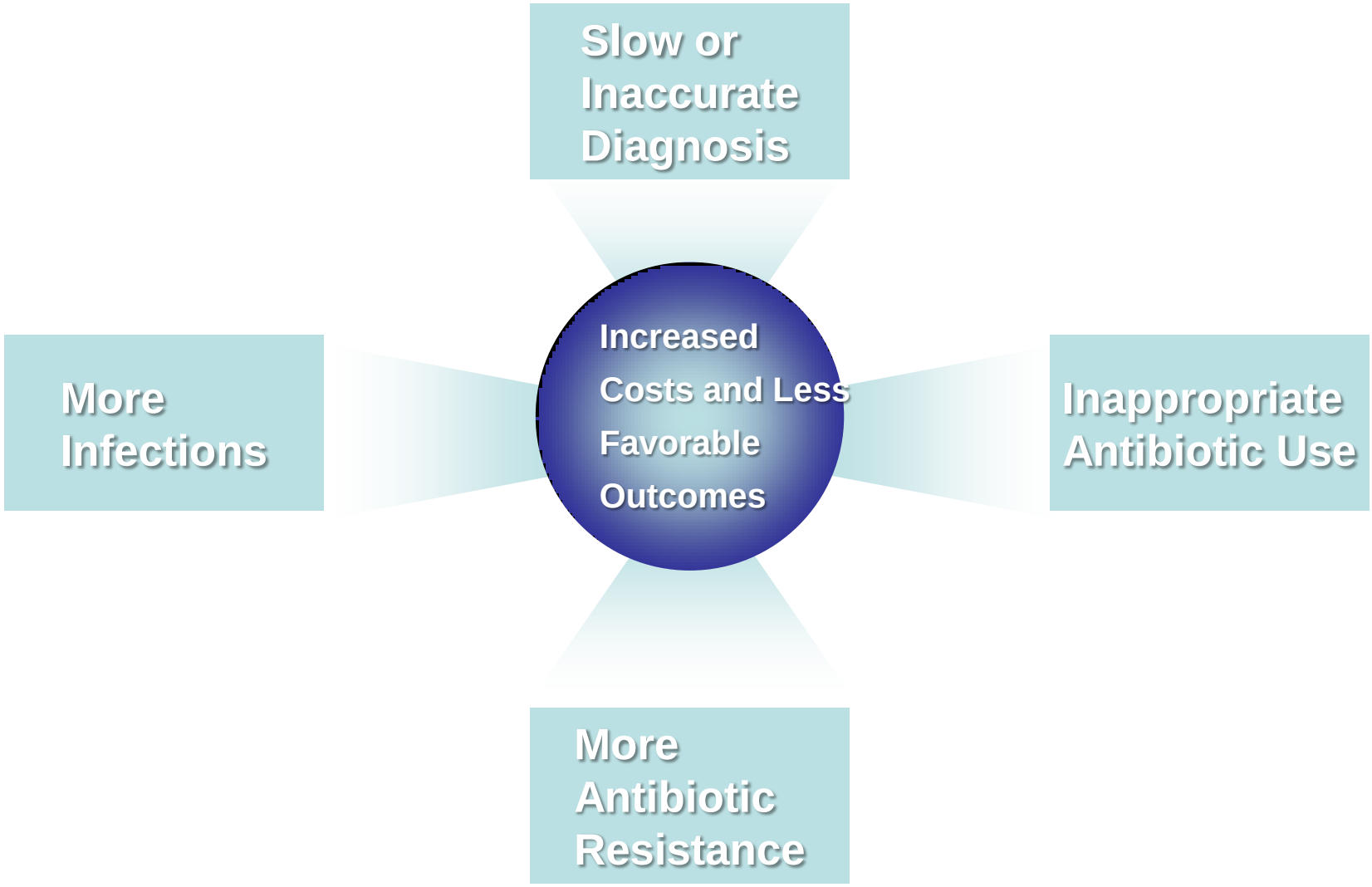
HAI Reporting Laws and Regulations

Hospital acquired infections (HAI) represent a major threat to healthcare quality and patient safety and outcomes, contributing to nearly 100,000 deaths annually. Hospital acquired infections also have a significant impact on the cost of care, adding as much as $33 billion in annual healthcare costs.
(source: CDC.gov)



There Exists a Significant Unmet Need to help reduce HAIs

Current methods for tracking, addressing and reporting hospital-acquired infections and resistant pathogens are typically labor intensive, leading to slow and sometimes inaccurate identification, diagnosis and/or treatment. These increase costs and negative outcomes.



P11-3179B

Electronic HAI surveillance reduced clinician time spent on surveillance activities by 80%, HAI confirmation time by 50%, while achieving 98% accuracy in identification of HAIs.

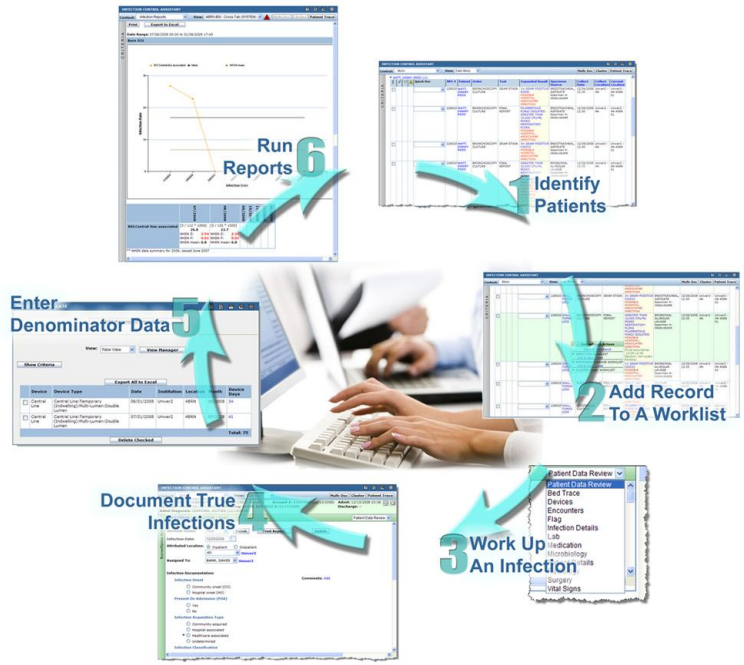
(John Hopkins Hospital, X Song, SHEA 2006, Abstract 229)

Traditional Infection Control

Manual, labor-intensive, time-consuming

Electronic clinical surveillance systems / Infection Control

Automated, standardized, real-time



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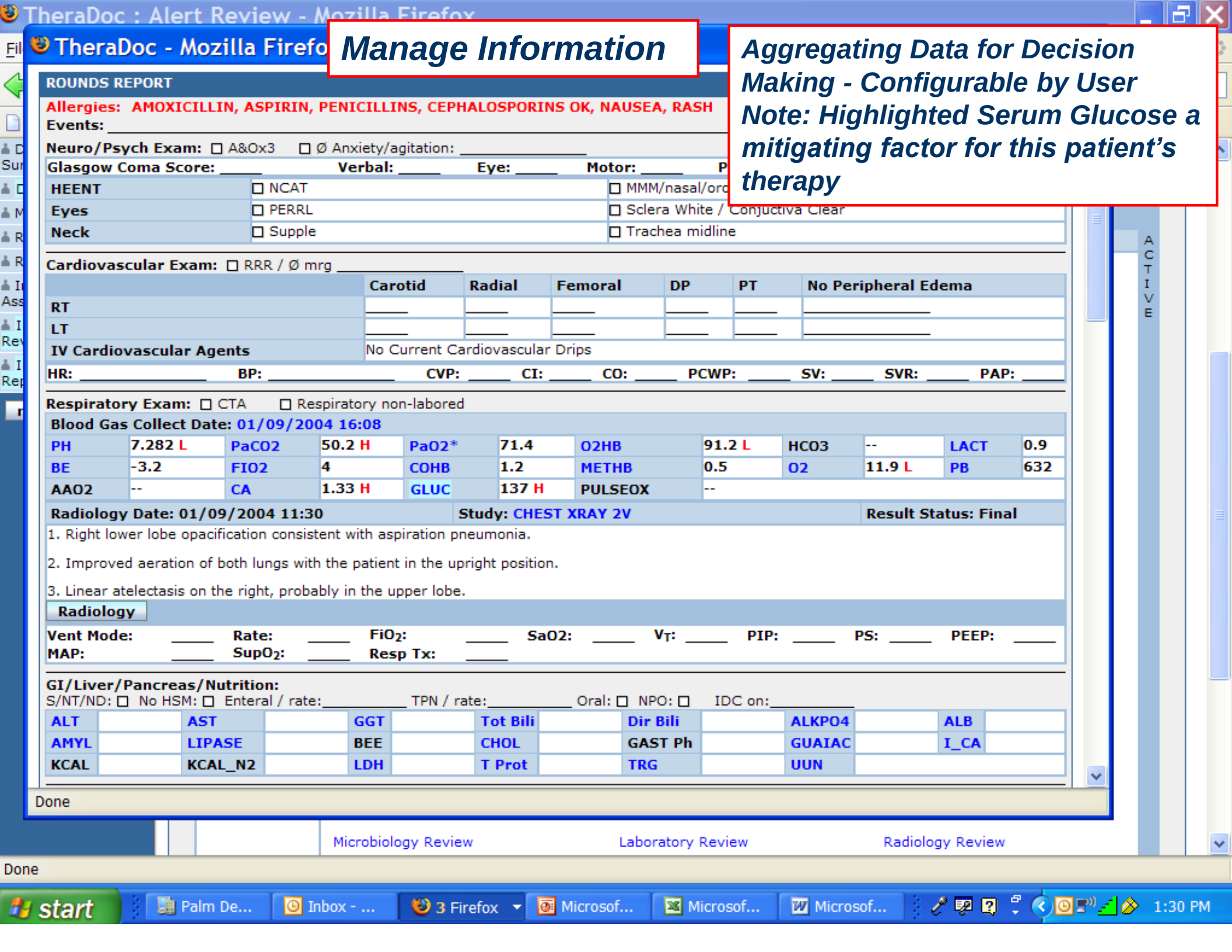
TheraDoc : Alert Review - Mozilla Firefox
TheraDoc - Mozilla Firefo
Manage Information
Aggregating Data for Decision Making - Configurable by User
Note: Highlighted Serum Glucose a mitigating factor for this patient's therapy
ROUNDS REPORT
Allergies: AMOXICILLIN, ASPIRIN, PENICILLINS, CEPHALOSPORINS OK, NAUSEA, RASH
Events:
Neuro/Psych Exam: ☐ A&Ox3 ☐ Ø Anxiety/agitation:
Glasgow Coma Score: Verbal: Eye: Motor:
HEENT ☐ NCAT ☐ MMM/nasal/orc
Eyes ☐ PERRL ☐ Sclera White / Conjuctiva Clear
Neck ☐ Supple ☐ Trachea midline
Cardiovascular Exam: ☐ RRR / Ø mrg
Carotid Radial Femoral DP PT No Peripheral Edema
RT
LT
IV Cardiovascular Agents No Current Cardiovascular Drips
HR: BP: CVP: CI: CO: PCWP: SV: SVR: PAP:
Respiratory Exam: ☐ CTA ☐ Respiratory non-labored
Blood Gas Collect Date: 01/09/2004 16:08
PH 7.282 L PaCO2 50.2 H PaO2* 71.4 O2HB 91.2 L HCO3 -- LACT 0.9
BE -3.2 FIO2 4 COHB 1.2 METHB 0.5 O2 11.9 L PB 632
AAO2 -- CA 1.33 H GLUC 137 H PULSEOX --
Radiology Date: 01/09/2004 11:30 Study: CHEST XRAY 2V Result Status: Final
1. Right lower lobe opacification consistent with aspiration pneumonia.
2. Improved aeration of both lungs with the patient in the upright position.
3. Linear atelectasis on the right, probably in the upper lobe.
Radiology
Vent Mode: Rate: FiO2: SaO2: VT: PIP: PS: PEEP:
MAP: SupO2: Resp Tx:
GI/Liver/Pancreas/Nutrition:
S/NT/ND: ☐ No HSM: ☐ Enteral / rate: TPN / rate: Oral: ☐ NPO: ☐ IDC on:
ALT AST GGT Tot Bili Dir Bili ALKPO4 ALB
AMYL LIPASE BEE CHOL GAST Ph GUAIAC I_CA
KCAL KCAL_N2 LDH T Prot TRG UUN
Done
ACTIVE
Microbiology Review
Laboratory Review
Radiology Review
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start
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Manage Information

TheraDoc - Microsoft Internet Explorer

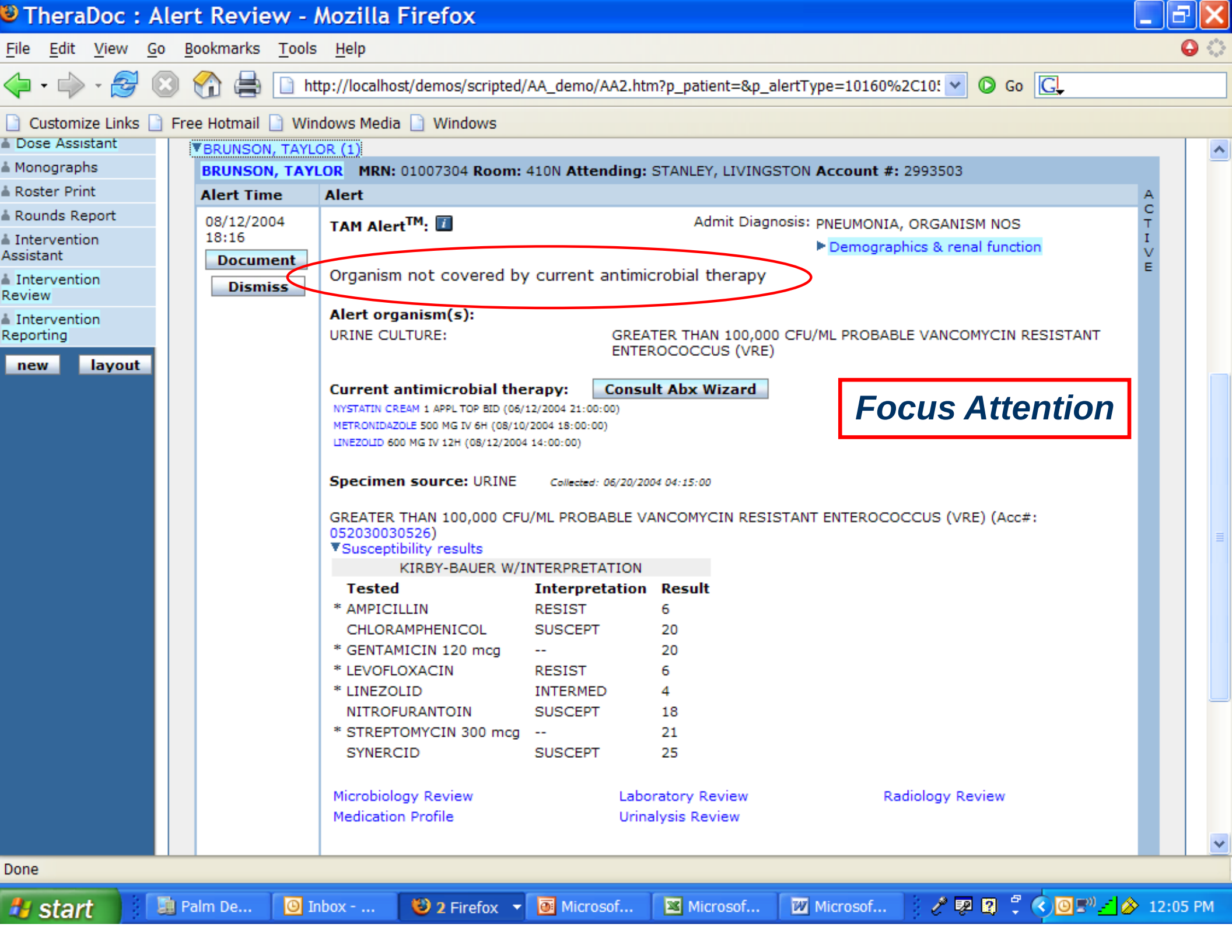
ID SUMMARY TM

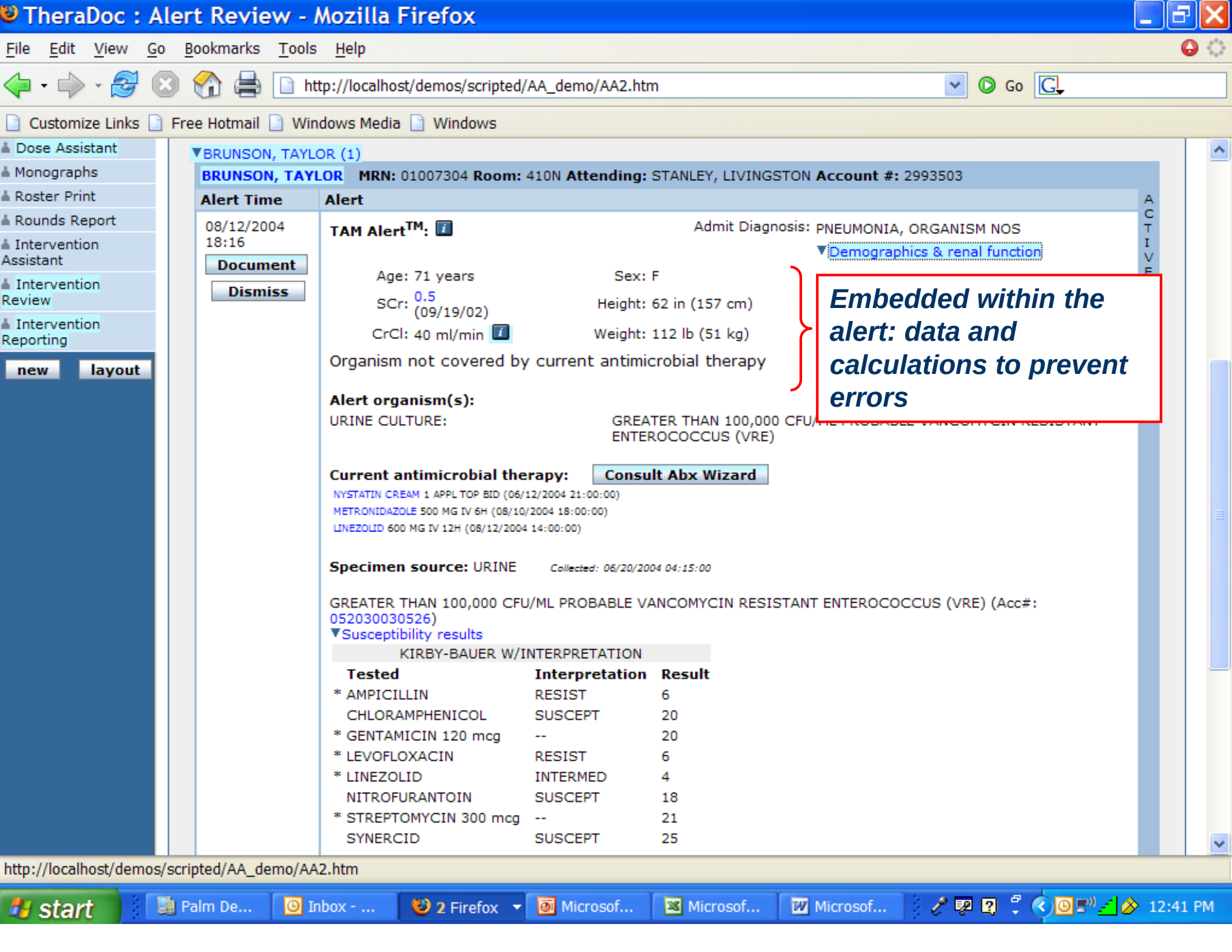
Show All | 10/25/2004 - Present | 10/25/2004 | Go | > | >>

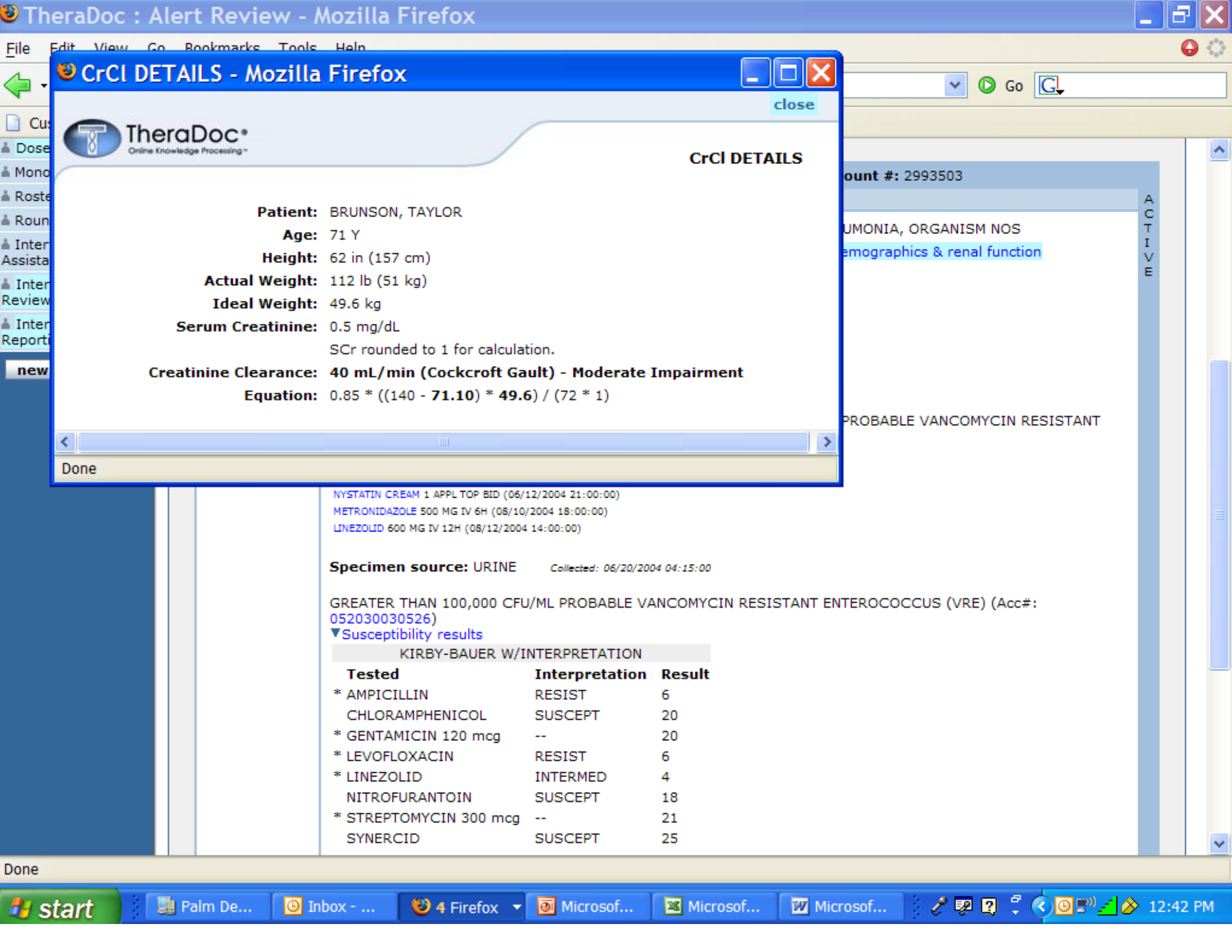
15 DAYS SINCE ADMISSION (10/25/2004 02:20) [1 prior day]	Day 15 11/08/2004 MON [Present]	Day 14 11/07/2004 SUN	Day 13 11/06/2004 SAT	Day 12 11/05/2004 FRI	Day 11 11/04/2004 THU	Day 10 11/03/2004 WED	Day 9 11/02/2004 TUE
LOCATION							
Room-Bed	410N	410N	410N	410N	4N 408N	4N 408N	4N 408N
MEDICATIONS (show history)							
Antibiotics	•LINEZOLID(600 MG IV 12H) •METRONIDAZOLE (500 MG IV 6H)*	•LINEZOLID(600 MG IV 12H) •METRONIDAZOLE (500 MG IV 6H)*	•LINEZOLID(600 MG IV 12H) •METRONIDAZOLE (500 MG IV 6H)*	•LINEZOLID(600 MG IV 12H) •METRONIDAZOLE (500 MG IV 6H)*	•LINEZOLID(600 MG IV 12H) •METRONIDAZOLE (500 MG IV 6H)*	•LINEZOLID(600 MG IV 12H) •METRONIDAZOLE (500 MG IV 6H)*	•LINEZOLID(600 MG IV 12H) •METRONIDAZOLE (500 MG IV 6H)*
Antivirals	--	--	--	--	--	--	--
Antifungals	--	--	--	--	--	--	--
Antiparasitics	•METRONIDAZOLE (500 MG IV 6H)*	•METRONIDAZOLE (500 MG IV 6H)*	•METRONIDAZOLE (500 MG IV 6H)*	•METRONIDAZOLE (500 MG IV 6H)*	•METRONIDAZOLE (500 MG IV 6H)*	•METRONIDAZOLE (500 MG IV 6H)*	•METRONIDAZOLE (500 MG IV 6H)*
Antipyretics	•ACETAMINOPHEN (650 MG DHT Q4PRN)	•ACETAMINOPHEN (650 MG DHT Q4PRN)	•ACETAMINOPHEN (650 MG DHT Q4PRN)	•ACETAMINOPHEN (650 MG DHT Q4PRN)	•ACETAMINOPHEN (650 MG DHT Q4PRN)	•ACETAMINOPHEN (650 MG DHT Q4PRN)	•ACETAMINOPHEN (650 MG DHT Q4PRN)
Immunosuppressants	--				--	--	--
POSITIVE MICRO	--				--	•URINE (F - 11/07/2004): GREATER THAN 100,000 CFU/ML PROBABLE VANCOMYCIN RESISTANT ENTEROCOCCUS (VRE)	--
NEGATIVE MICRO	--				•ASPIRATE, RIGHT HIP (3)	--	--
OTHER MICRO	--				--	--	--
PATHOLOGY	--				--	--	--
RADIOLOGY	--				•HIP ARTHROGRAM	--	--
URINALYSIS	--				--	•RESULTS	--
LAB							
WBC (K/uL)	--	11.59 H	13.42 H	9.57	8.74	9.74	10.38
Bands (%)	--	--	--	--	--	--	--
PLT (K/uL)	--	665 H	748 H	662 H	666 H	653 H	676 H
Bilirubin (mg/dL)	--	--	--	--	--	--	--
SCr (mg/dL)	--	--	0.5 L	--	0.5 L	0.5 L	0.5 L

Smart (Thought Flow) View of patient data. Summarizes and organizes key data in a manner intuitive to the management of an infectious disease (ID). For example, medications are a chronological display of those drugs pertinent to infectious diseases. Also displaying both positive and negative micro – important to ID but not to other diseases.

start | Microsoft PowerP... | TheraDoc - Onlin... | TheraChart : Infe... | TheraDoc - Micro... | 7:30 PM


TheraDoc : Alert Review - Mozilla Firefox
File Edit View Go Bookmarks Tools Help
http://localhost/demos/scripted/AA_demo/AA2.htm?p_patient=&p_alertType=10160%2C10
Go
Customize Links Free Hotmail Windows Media Windows
Dose Assistant
Monographs
Roster Print
Rounds Report
Intervention Assistant
Intervention Review
Intervention Reporting
new
layout
BRUNSON, TAYLOR (1)
BRUNSON, TAYLOR MRN: 01007304 Room: 410N Attending: STANLEY, LIVINGSTON Account #: 2993503
Alert Time
Alert
08/12/2004 18:16
Document
Dismiss
TAM Alert™:
Admit Diagnosis: PNEUMONIA, ORGANISM NOS
Demographics & renal function
Organism not covered by current antimicrobial therapy
Alert organism(s):
URINE CULTURE:
GREATER THAN 100,000 CFU/ML PROBABLE VANCOMYCIN RESISTANT ENTEROCOCCUS (VRE)
Current antimicrobial therapy:
Consult Abx Wizard
NYSTATIN CREAM 1 APPL TOP BID (06/12/2004 21:00:00)
METRONIDAZOLE 500 MG IV 6H (08/10/2004 18:00:00)
LINEZOLID 600 MG IV 12H (08/12/2004 14:00:00)
Focus Attention
Specimen source: URINE
Collected: 06/20/2004 04:15:00
GREATER THAN 100,000 CFU/ML PROBABLE VANCOMYCIN RESISTANT ENTEROCOCCUS (VRE) (Acc#: 052030030526)
Susceptibility results
KIRBY-BAUER W/INTERPRETATION
Tested Interpretation Result
* AMPICILLIN RESIST 6
CHLORAMPHENICOL SUSCEPT 20
* GENTAMICIN 120 mcg -- 20
* LEVOFLOXACIN RESIST 6
* LINEZOLID INTERMED 4
NITROFURANTOIN SUSCEPT 18
* STREPTOMYCIN 300 mcg -- 21
SYNERCID SUSCEPT 25
Microbiology Review
Laboratory Review
Radiology Review
Medication Profile
Urinalysis Review
ACTIVE
Done
start
Palm De...
Inbox - ...
2 Firefox
Microsof...
Microsof...
Microsof...
12:05 PM


TheraDoc : Alert Review - Mozilla Firefox
File Edit View Go Bookmarks Tools Help
http://localhost/demos/scripted/AA_demo/AA2.htm
Go
Customize Links Free Hotmail Windows Media Windows
Dose Assistant
Monographs
Roster Print
Rounds Report
Intervention Assistant
Intervention Review
Intervention Reporting
new layout
BRUNSON, TAYLOR (1)
BRUNSON, TAYLOR MRN: 01007304 Room: 410N Attending: STANLEY, LIVINGSTON Account #: 2993503
Alert Time
Alert
08/12/2004 18:16
Document
Dismiss
TAM Alert™:
Admit Diagnosis: PNEUMONIA, ORGANISM NOS
Demographics & renal function
Age: 71 years
Sex: F
SCr: 0.5 (09/19/02)
Height: 62 in (157 cm)
CrCl: 40 ml/min
Weight: 112 lb (51 kg)
Organism not covered by current antimicrobial therapy
Embedded within the alert: data and calculations to prevent errors
Alert organism(s):
URINE CULTURE:
GREATER THAN 100,000 CFU/ML PROBABLE VANCOMYCIN RESISTANT ENTEROCOCCUS (VRE)
Current antimicrobial therapy:
Consult Abx Wizard
NYSTATIN CREAM 1 APPL TOP BID (06/12/2004 21:00:00)
METRONIDAZOLE 500 MG IV 6H (08/10/2004 18:00:00)
LINEZOLID 600 MG IV 12H (08/12/2004 14:00:00)
Specimen source: URINE
Collected: 06/20/2004 04:15:00
GREATER THAN 100,000 CFU/ML PROBABLE VANCOMYCIN RESISTANT ENTEROCOCCUS (VRE) (Acc#: 052030030526)
Susceptibility results
KIRBY-BAUER W/INTERPRETATION
Tested Interpretation Result
* AMPICILLIN RESIST 6
CHLORAMPHENICOL SUSCEPT 20
* GENTAMICIN 120 mcg -- 20
* LEVOFLOXACIN RESIST 6
* LINEZOLID INTERMED 4
NITROFURANTOIN SUSCEPT 18
* STREPTOMYCIN 300 mcg -- 21
SYNERCID SUSCEPT 25
http://localhost/demos/scripted/AA_demo/AA2.htm
start
Palm De...
Inbox - ...
2 Firefox
Microsof...
Microsof...
Microsof...
12:41 PM


TheraDoc : Alert Review - Mozilla Firefox
File Edit View Go Bookmarks Tools Help
CrCl DETAILS - Mozilla Firefox
close
TheraDoc
Online Knowledge Processing
CrCl DETAILS
Patient: BRUNSON, TAYLOR
Age: 71 Y
Height: 62 in (157 cm)
Actual Weight: 112 lb (51 kg)
Ideal Weight: 49.6 kg
Serum Creatinine: 0.5 mg/dL
SCr rounded to 1 for calculation.
Creatinine Clearance: 40 mL/min (Cockcroft Gault) - Moderate Impairment
Equation: 0.85 * ((140 - 71.10) * 49.6) / (72 * 1)
Done
ount #: 2993503
ACTIVE
UMONIA, ORGANISM NOS
emographics & renal function
PROBABLE VANCOMYCIN RESISTANT
NYSTATIN CREAM 1 APPL TOP BID (06/12/2004 21:00:00)
METRONIDAZOLE 500 MG IV 6H (08/10/2004 18:00:00)
LINEZOLID 600 MG IV 12H (08/12/2004 14:00:00)
Specimen source: URINE Collected: 06/20/2004 04:15:00
GREATER THAN 100,000 CFU/ML PROBABLE VANCOMYCIN RESISTANT ENTEROCOCCUS (VRE) (Acc#: 052030030526)
Susceptibility results
KIRBY-BAUER W/INTERPRETATION
Tested Interpretation Result
* AMPICILLIN RESIST 6
CHLORAMPHENICOL SUSCEPT 20
* GENTAMICIN 120 mcg -- 20
* LEVOFLOXACIN RESIST 6
* LINEZOLID INTERMED 4
NITROFURANTOIN SUSCEPT 18
* STREPTOMYCIN 300 mcg -- 21
SYNERCID SUSCEPT 25
Done
start
Palm De...
Inbox - ...
4 Firefox
Microsof...
Microsof...
Microsof...
12:42 PM

TheraDoc : Alert Review - Mozilla Firefox

TheraDoc - Mozilla Firefox

TheraDoc - Mozilla Firefox

TheraDoc - Mozilla Firefox

TheraDoc®
Online Knowledge Processing™

#01007304
BRUNSON, TAYLOR (71 y F)

Admit Diagnosis: PNEUMONIA,UTI
SCr: 0.5 mg/dL (7/19/2004) **Height:** 62 in (157 cm) **Weight:** 112 lb (51 kg)
CrCl: 40 mL/min **BSA:** 1.49 m^2 **IBW:** 109 lb (50 kg)
Admit Date: **Attending:** STANLEY, LIVINGSTON **Room:** 410N
Allergies: AMOXICILLIN, ASPIRIN, PENICILLINS, CEPHALOSPORINS OK, NAUSEA, RASH

BLOOD GAS

Manage Information

Done

Done

Done

start | Palm De... | Inbox - ... | 5 Firefox | Microsof... | Microsof... | Microsof... | 1:04 PM

file:// - TheraDoc - Mozilla Firefox

print | close

TheraDoc® Online Knowledge Processing™

#01007304
BRUNSON, TAYLOR (71 y F)

Admit Diagnosis: PNEUMONIA,UTI
SCr: 0.5 mg/dL (07/19/2006) **Height:** 62 in (157 cm) **Weight:** 112 lb (51 kg)
CrCl: 40 mL/min **BSA:** 1.49 m^2 **IBW:** 109 lb (50 kg)
Admit Date: **Attending:** STANLEY, LIVINGSTON **Room:** 410N
Allergies: AMOXICILLIN, ASPIRIN, PENICILLINS, CEPHALOSPORINS OK, NAUSEA, RASH

ID MEDICATION SUMMARY

Manage Information

Show All | 07/06/2006 - Present

15 DAYS SINCE ADMISSION (07/06/2006)	7/20	7/19	7/18	7/17	7/16	7/15	7/14	7/13	7/12	7/11	7/10	7/09	7/08	7/07	7/06
ANTIBIOTICS															
* metronidazole (9 days)	▬	▬	▬	▬	▬	▬	▬	▬	▬						
vancomycin (6 days)									▬	▬	▬	▬	▬	▬	▬
gatifloxacin (6 days)										▬	▬	▬	▬	▬	▬
linezolid (7 days)	▬	▬	▬	▬	▬	▬	▬								
cefuroxime (2 days)									▬	▬					
cefazolin (1 day)										▬					
ANTIPARASITICS															
* metronidazole (9 days)	▬	▬	▬	▬	▬	▬	▬	▬	▬						
ANTIPYRETIC															
acetaminophen (15 days)	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬	▬
15 DAYS SINCE ADMISSION (07/06/2006)	23	22	21	20	19	18	17	16	15	14	13	12	11	10	09
	January														

* Medication belongs to multiple categories

Smart (Thought Flow) View of ID medications. A graphical review that quickly allows clinician to see continuity and breaks in therapy. Also automatically calculates days of therapy an important metric in ID and oncology.

Done

start | Inbox - Microsoft ... | 5 Firefox | Screen Shots_Phy... | 12:14 PM

Faster Treatment of Infection + Reduced Incidence of Resistant Infections = Cost Savings to the US Healthcare System

By diagnosing infections and providing appropriate treatment earlier, an average 200 bed hospital could save close to $185,000 per year

Reducing the prevalence of resistant infections by ~25% could yield cost savings of $275,000 per year to a 200 bed hospital.

Source: Lodise, Clinical Infectious Diseases, 2003; AHA.

Source: Styers, Annals of Clinical Microbiology and Antimicrobials, 2006; Thursky, International Journal for Quality in Health Care, 2006; AHA.

No material available