Advance Care Planning Updates & Refresher

Sarah Peterson

Director, Supportive & Palliative Care

Durable Power of Attorney for Health Care

- This document reflects who patients would want to make medical decisions on their behalf in the event they are too ill to make decisions for themselves.
- Also referred to as Health Care Agent and Health Care Proxy
- A health care agent should:
  - agree to the role
  - Know about a patient's goals, values and preferences
  - follow a patient's decisions (even if they don't agree)
  - make decisions in difficult moment.
- Recommended for anyone over the age of 18.

Washington State
Surrogate Decision-Making Hierarchy

1. A guardian with health care decision-making authority, if one has been appointed
2. The person named in the durable power of attorney with health care decision-making authority
3. Spouse or state-registered domestic partner
4. Adult children (over 18)
5. Parents
6. Adult brothers and sisters
7. Adult grandchildren
8. Adult nieces/nephews
9. Adult aunt/uncles
10. Close adult friend (with requirements and limitations)

Advance Directive: Durable Power of Attorney for Health Care

This advance directive, a durable power of attorney for health care, allows you to name and prepare your health care agent. This form meets the requirements of Washington state law.

My information:

FULL NAME: PRONOUNS (optional): *(i.e., he/she/they)*

ADDRESS, CITY, STATE, ZIP:

DATE OF BIRTH: / / *(mm/dd/yyyy)*

NAMING A HEALTH CARE AGENT

The person I designate as my health care agent is:

FULL NAME: PRONOUNS (optional):

RELATIONSHIP: BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP:

The people I designate as my alternate agents are:

If the person listed above is unable or unwilling to make my health care decisions, then I designate the people listed below as my first and second alternate health care agents.

First alternate

FULL NAME: PRONOUNS (optional):

RELATIONSHIP: BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP:

Second alternate

FULL NAME: PRONOUNS (optional):

RELATIONSHIP: BEST PHONE: ( ) ALTERNATE PHONE: ( )

ADDRESS, CITY, STATE, ZIP:

WSMA Washington State Medical Association
Physician Driven, Patient Focused

PRINTED NAME:

DATE OF BIRTH: / / *(mm/dd/yyyy)*

REV 05/2024

Guidance for my health care agent:

Write information you want your health care agent to know about your health care wishes.

AUTHORIZING A HEALTH CARE AGENT

Authority I give my agent: I grant my agent complete authority to make all decisions about my health care. This includes, but is not limited to (a) consenting, refusing consent, and withdrawing consent for medical treatment recommended by my physicians, including life-sustaining treatments; (b) requesting particular medical treatments; (c) employing and dismissing members of the health care team; (d) changing my health care insurers; (e) signing a Portable Orders for Life-Sustaining Treatment (POLST) form; (f) transferring me to or placing me in another facility, private home, or other places; and (g) accessing my medical records and information.

I attest to the following: I understand the importance and meaning of this durable power of attorney for health care (DPOA-HC). This form reflects my health care agent choices and my goals, values, and preferences. I have filled out this form willingly. I am thinking clearly. I understand that I can change my mind at any time. I understand I can revoke and replace this form at any time. I revoke any prior durable power of attorney for health care. I want this DPOA-HC to become effective if a physician or licensed psychologist determines I do not have the capacity to make my own health care decisions. This directive will continue as long as my incapacity lasts.

MY SIGNATURE: DATE:

Witnesses or notary requirement

You must have your signature either witnessed by two people or acknowledged by a notary public.

Rules for witnesses:

- Must be at least 18 years of age and competent.
- Cannot be related to you or your health care agent by blood, marriage, or state-registered domestic partnership.
- Cannot be your home care provider or a care provider at an adult family home or long-term care facility where you live.
- Cannot be your designated health care agent.

OPTION 1 – TWO WITNESSES

Witness attestation: I declare I meet the rules for being a witness.

WITNESS #1 SIGNATURE: DATE:

NAME PRINTED:

WITNESS #2 SIGNATURE: DATE:

NAME PRINTED:

OPTION 2 – NOTARY

STATE OF WASHINGTON)
)
COUNTY OF)

This record was acknowledged before me on this day of ,

by (name of individual):

Signature: Title: Exp:

WSMA Washington State Medical Association
Physician Driven, Patient Focused

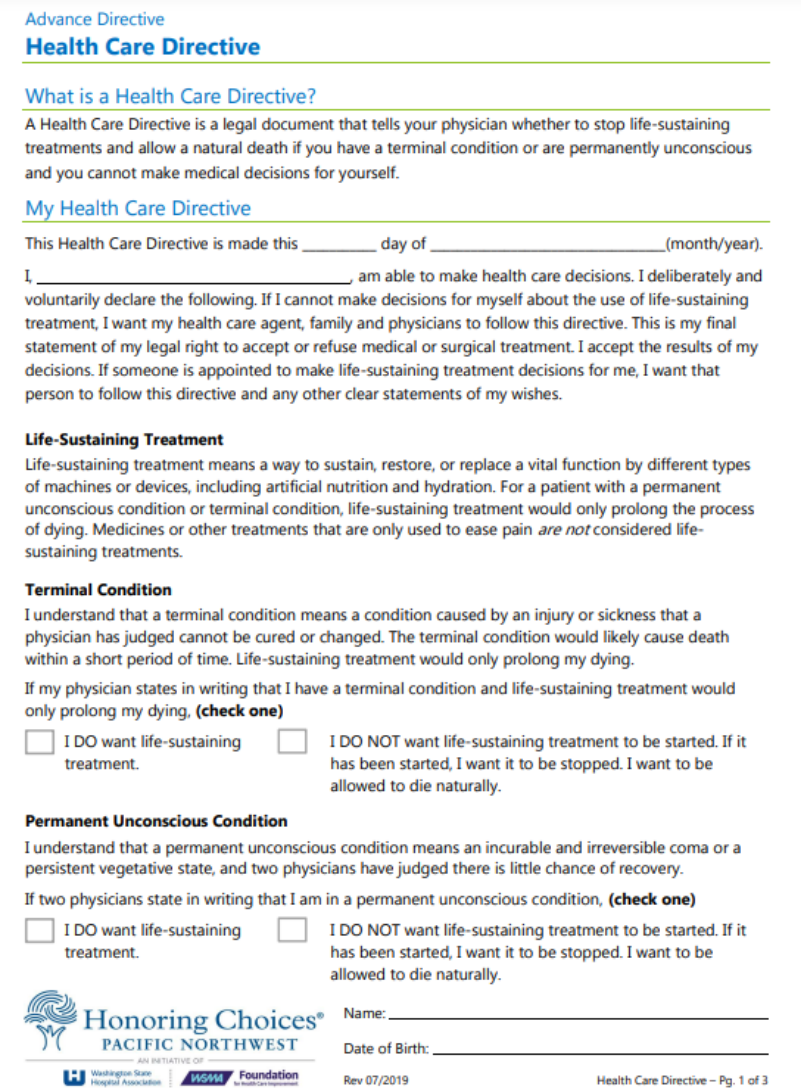
PRINTED NAME:

DATE OF BIRTH: / / *(mm/dd/yyyy)*

REV 05/2024

Health Care Directive

- Outlines a patients wishes and preferences for medical care in the event of a terminal illness or permanent state of unconsciousness
- Serves as a guide for health care providers and surrogate decision-makers when patients are unable to make decisions for themselves
- Recommended for anyone over the age of 18



Advance Directive

Health Care Directive

What is a Health Care Directive?

A Health Care Directive is a legal document that tells your physician whether to stop life-sustaining treatments and allow a natural death if you have a terminal condition or are permanently unconscious and you cannot make medical decisions for yourself.

My Health Care Directive

This Health Care Directive is made this _____ day of _____(month/year).

I, _____, am able to make health care decisions. I deliberately and voluntarily declare the following. If I cannot make decisions for myself about the use of life-sustaining treatment, I want my health care agent, family and physicians to follow this directive. This is my final statement of my legal right to accept or refuse medical or surgical treatment. I accept the results of my decisions. If someone is appointed to make life-sustaining treatment decisions for me, I want that person to follow this directive and any other clear statements of my wishes.

Life-Sustaining Treatment

Life-sustaining treatment means a way to sustain, restore, or replace a vital function by different types of machines or devices, including artificial nutrition and hydration. For a patient with a permanent unconscious condition or terminal condition, life-sustaining treatment would only prolong the process of dying. Medicines or other treatments that are only used to ease pain *are not* considered life-sustaining treatments.

Terminal Condition

I understand that a terminal condition means a condition caused by an injury or sickness that a physician has judged cannot be cured or changed. The terminal condition would likely cause death within a short period of time. Life-sustaining treatment would only prolong my dying.

If my physician states in writing that I have a terminal condition and life-sustaining treatment would only prolong my dying, **(check one)**

☐ I DO want life-sustaining treatment.

☐ I DO NOT want life-sustaining treatment to be started. If it has been started, I want it to be stopped. I want to be allowed to die naturally.

Permanent Unconscious Condition

I understand that a permanent unconscious condition means an incurable and irreversible coma or a persistent vegetative state, and two physicians have judged there is little chance of recovery.

If two physicians state in writing that I am in a permanent unconscious condition, **(check one)**

☐ I DO want life-sustaining treatment.

☐ I DO NOT want life-sustaining treatment to be started. If it has been started, I want it to be stopped. I want to be allowed to die naturally.

Honoring Choices® PACIFIC NORTHWEST

AN INITIATIVE OF Washington State Hospital Association | WSHA Foundation for Health Care Improvement

Name: _____

Date of Birth: _____

Rev 07/2019

Health Care Directive – Pg. 1 of 3

Portable Orders for Life Sustaining Treatment

Code Status

Defines a type of resuscitation procedures and medical treatment a patient would benefit from or desire

POLST

A portable order that defines a type of resuscitation procedures and medical treatment a patient would benefit from or desire. Intended for use in ambulatory settings and at at home

Typical Patient Criteria

Any one of the following:

- Last 1-2 years of life
- Medically frail
- Significant change in health status
- 1+ intervention doesn't align with goals
- Patient engaged in Goals of Care conversation

https://tip.valleymed.net/epic-acp-advance-care-planning-for-outpatient-providers/

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Washington POLST
Portable Orders for Life-Sustaining Treatment
A Participating Program of National POLST

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL		
DATE OF BIRTH / /	GENDER (optional)	PRONOUNS (optional)

This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.
IMPORTANT: See page 2 for complete instructions.

MEDICAL CONDITIONS/INDIVIDUAL GOALS:	AGENCY INFO / PHONE (if applicable)

A — Use of Cardiopulmonary Resuscitation (CPR): When the individual has NO pulse and is not breathing.

CHECK ONE

☐ **YES – Attempt Resuscitation / CPR** *(choose FULL TREATMENT in Section B)*
☐ **NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death**

When not in cardiopulmonary arrest, go to Section B.

B — Level of Medical Interventions: When the individual has a pulse and/or is breathing.

CHECK ONE

Any of these treatment levels may be paired with DNAR / Allow Natural Death above.

☐ **FULL TREATMENT – Primary goal is prolonging life by all medically effective means.** Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below.
Transfer to hospital if indicated. Includes intensive care.

☐ **SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible.** Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. ***Do not intubate.*** May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below.
Transfer to hospital if indicated. Avoid intensive care if possible.

☐ **COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort.** Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction, and manual treatment of airway obstruction as needed for comfort.
Individual prefers no transfer to hospital. EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional orders (e.g., blood products, dialysis): _____

C — Signatures:

CHECK ONE

A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with: ☐ Individual ☐ Parent(s) of minor ☐ Guardian with health care authority ☐ Legal health care agent(s) by DPOA-HC ☐ Other medical decision maker by 7.70.065 RCW	X **SIGNATURE** – MD/DO/ARNP/PA-C **(mandatory)**	DATE **(mandatory)**
	PRINT – NAME OF MD/DO/ARNP/PA-C **(mandatory)**	PHONE

X **SIGNATURE(S)** – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**	RELATIONSHIP	DATE **(mandatory)**
PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**		PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)
Encourage all advance care planning documents to accompany POLST.

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

WSMA Washington State Medical Association — Physician Driven, Patient Focused
Washington State Department of Health

All copies, digital images, faxes of signed POLST forms are valid.
See page 2 for preferences regarding medically assisted nutrition.
For more information on POLST, visit **www.wsma.org/POLST**.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL	DATE OF BIRTH / /

Additional Contact Information (if any)

LEGAL MEDICAL DECISION MAKER(S) (by DPOA-HC or 7.70.065 RCW)	RELATIONSHIP	PHONE
OTHER CONTACT PERSON	RELATIONSHIP	PHONE
HEALTH CARE PROFESSIONAL COMPLETING FORM	ROLE / CREDENTIALS	PHONE

Preference: Medically Assisted Nutrition (i.e., Artificial Nutrition)

☐ **Check here if not discussed**

This section is NOT required. This section, whether completed or not, does not affect orders on page 1 of form.
Preferences for medically assisted nutrition, and other health care decisions, can also be indicated in advance directives which are advised for all adults. The POLST does not replace an advance directive. When an individual is no longer able to make their own decisions, consult with the legal medical decision maker(s) regarding their plan of care, including medically assisted nutrition. Base decisions on prior known wishes, best interests of the individual, preferences noted here or elsewhere, and current medical condition. Document specific decisions and/or orders in the medical record.

Food and liquids to be offered by mouth if feasible and consistent with the individual's known preferences.

☐ Preference is to avoid medically assisted nutrition.
☐ Preference is to discuss medically assisted nutrition options, as indicated.*
Discuss short- versus long-term medically assisted nutrition (long-term requires surgical placement of tube).

* Medically assisted nutrition is proven to have no effect on length of life in moderate- to late-stage dementia, and it is associated with complications. People may have documents or known wishes to not have oral feeding continued; the directions for oral feeding may be subject to these known wishes.

Discussed with: _____ Individual _____ Health Care Professional _____ Legal Medical Decision Maker

Directions for Health Care Professionals

NOTE: An individual with capacity may always consent to or refuse medical care or interventions, regardless of information represented on any document, including this one.

Any incomplete section of POLST implies full treatment for that section. This POLST is valid in all care settings. It is primarily intended for out of hospital care, but valid within health care facilities per specific policy. The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

Completing POLST

- Completing POLST is voluntary for the individual; it should be offered as appropriate but not required.
- Treatment choices documented on this form should be the result of shared decision making by an individual or their health care agent and health care professional based on the individual's preferences and medical condition.
- POLST must be signed by an MD/DO/ARNP/PA-C and the individual or their legal medical decision maker as determined by guardianship, DPOA-HC, or other relationship per 7.70.065 RCW, to be valid. Multiple decision maker signatures are allowed, but not required.
- Virtual, remote, and verbal orders and consents are acceptable in accordance with the policies of the health care facility. For examples, see FAQ at www.wsma.org/POLST.
- POLST may be used to indicate orders regarding medical care for children under the age of 18 with serious illness. Guardian(s)/parent(s) sign the form along with the health care professionals. See FAQ at www.wsma.org/POLST.

NOTE: This form is not adequate to designate someone as a health care agent. A separate DPOA-HC is required to designate a health care agent.

Honoring POLST

Everyone shall be treated with dignity and respect.

SECTIONS A AND B:

- No defibrillator should be used on an individual who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the individual should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). This may include medication by IV route for comfort.
- Treatment of dehydration is a measure which may prolong life. An individual who desires IV fluids should indicate "Selective" or "Full Treatment."

Reviewing POLST

This POLST should be reviewed whenever:

- The individual is transferred from one care setting or care level to another.
- There is a substantial change in the individual's health status.
- The individual's treatment preferences change.

To void this form, draw a line across the page and write "VOID" in large letters. Notify all care facilities, clinical settings, and anyone who has a copy of the current POLST. Any changes require a new POLST.

Review of this POLST form: Use this section to update and confirm order and preferences.

This meets the requirement of establishing code status and basic medical guidance for admission to nursing and other facilities.

REVIEW DATE	REVIEWER	LOCATION OF REVIEW	REVIEW OUTCOME ☐ No Change ☐ Form Voided ☐ New Form Completed

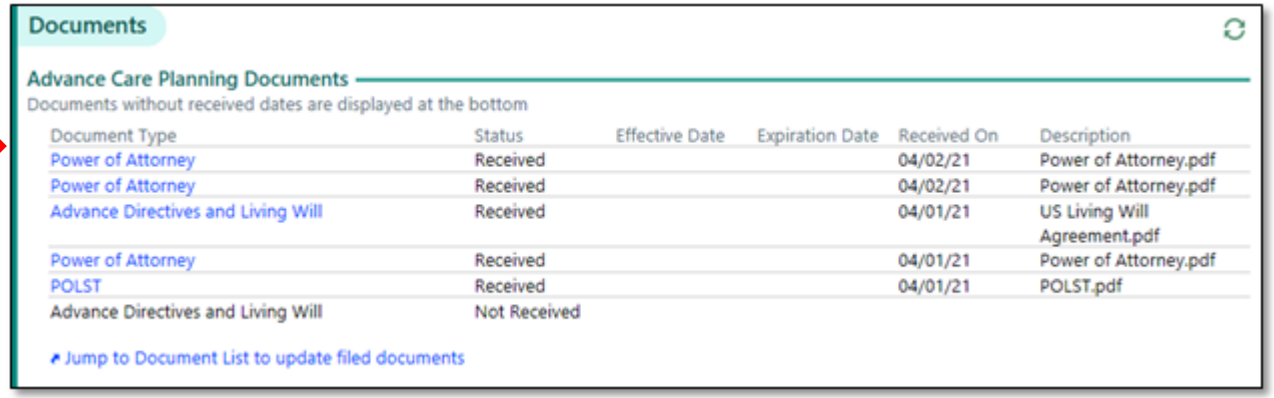
SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

Copies, digital images, and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST, visit **www.wsma.org/POLST**.

Epic Tools: Documents

To get to ACP Navigator, click on Code Status

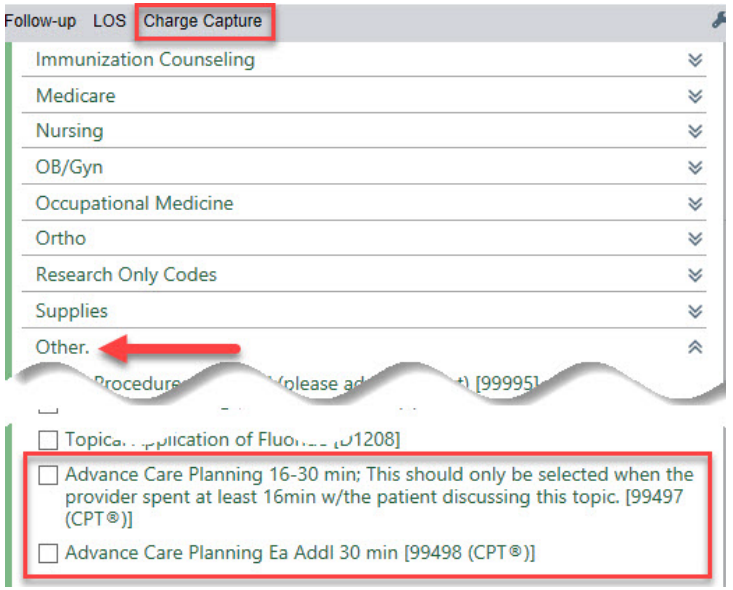
To see documents on file, scroll down



Epic Tools: Documentation

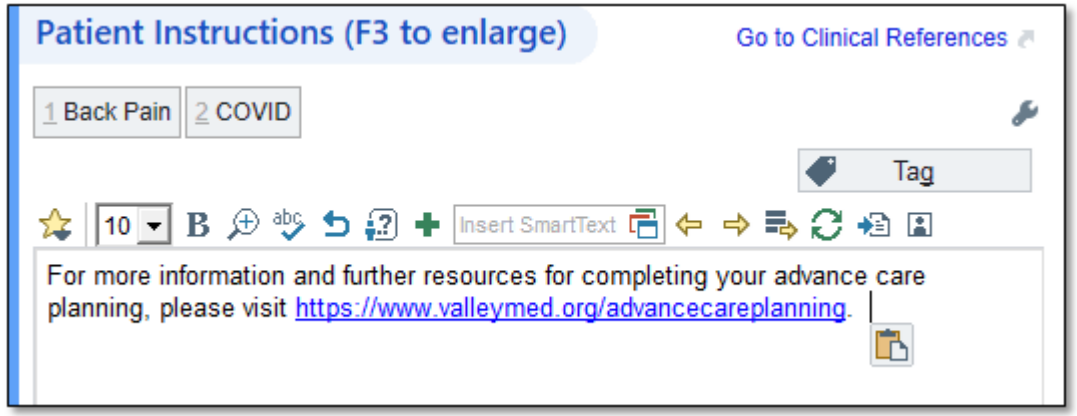
.ACPMDNOTE: for more extensive ACP conversations

- Use this if you are billing an ACP code



.ACPBRIEFSTMT: for brief conversations about ACP

.ACPWebsite: For patient instructions, includes a link to Valley Medical Center's Advance Care Planning website



RN Care Managers

Trainings in 2023-2024

- Basic advance care planning (DPOA-HC, Healthcare Directive)
- Serious Illness Conversation Guide

Care Plan Population

- Diagnosis of CHF and/or COPD
- 2+ admissions or 3+ ED visits in last 6 months OR
- VMC Risk Score 40+

Highlights

81 y.o. male, CHF, COPD on oxygen 2L NC, chronic pain, recent COPD exacerbation with hospital admission. RN Care Manager had serious illness conversation 1 week before PCP follow up. Discovered that the patient was having difficulty having conversation with spouse (LNOK) but trusted sister as DPOA (completed in 2022 and scanned into EMR). Found that independence, consciousness, and interacting with others are most important to the patient. At follow up with PCP, had conversation about goals and completed DNR Intermediate POLST.

CARING FOR OUR COMMUNITY LIKE FAMILY

Time out optimization

David Kim
Ambulatory Quality Manager
December 2024

Kathy McKee
Regulatory & Accreditation and Compliance Manager

Agenda

- Timeline/Background
- TJC Standards
- Time out steps
- EPIC tools
- Questions

Timeline/Background

March 2023

- Clinical Data Analysis identified a discrepancy in the Time Out Report of possible procedures that were not included in the current report (100+ codes).

June-July 2023

- Ambulatory Quality/Safety team conducted a review of 113 CPT codes with clinical teams

- Set criteria for what is considered surgical and nonsurgical invasive procedures

- A total of 100 CPT codes were added for tracking (started 1 Aug 23)

- Developed a new tool for monthly time out audit -part of monthly TJC tracer activity.

August 2023

- VMC Clinic Network is compliant with the Joint Commission (TJC)'s Universal Protocol Standards

- Monthly time out audit documentation migrated from SharePoint tracker to **TJC tracer portal** & reduced **manual processes**.

- Saves about **50 hours of admin time/month** at the CN

June 2024

- The Patient Safety team conducted a RCA regarding a clinic fire safety event

- Discovered that the Clinic Network **does not have formal policy or protocol regarding fire risk assessment and mitigation** when using cautery, laser, light source, or any instrument capable of causing heat for patient care.

January 2025

- Updated **Time Out EPIC tools** (Flowsheet & SmartPhrase) will "go-live"

- **New Percipio module** will be assigned to all clinical staff members (Physicians, APPs, nurses, medical assistants, etc).

TJC standards

- A part of VMC Clinic Network's (CN) journey to full compliance w/ Joint Commission's
  UP.01.01.01, UP.01.01.02, UP.01.01.03, & EC.02.03.01 ;

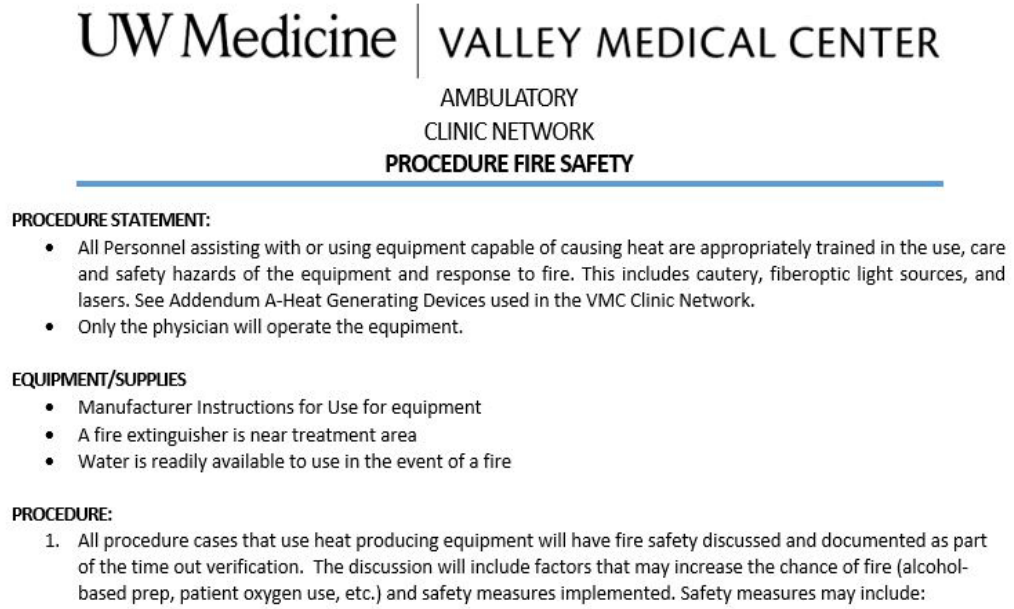
- Periodically **evaluate potential fire hazards** that could be encountered during operative or invasive procedures.
- Establish **written fire prevention and response procedures**, including safety precautions related to the use of flammable germicides or antiseptics.

Time Out

In addition to verifying the ☑ Correct patient ☑ Correct procedure and ☑ Correct site,

All procedures that use heat producing equipment will have fire safety discussed and documented as part of the time out.

This includes cautery, fiberoptic light sources and lasers.



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AMBULATORY
CLINIC NETWORK

PROCEDURE FIRE SAFETY

PROCEDURE STATEMENT:

- All Personnel assisting with or using equipment capable of causing heat are appropriately trained in the use, care and safety hazards of the equipment and response to fire. This includes cautery, fiberoptic light sources, and lasers. See Addendum A-Heat Generating Devices used in the VMC Clinic Network.
- Only the physician will operate the equpiment.

EQUIPMENT/SUPPLIES

- Manufacturer Instructions for Use for equipment
- A fire extinguisher is near treatment area
- Water is readily available to use in the event of a fire

PROCEDURE:

1. All procedure cases that use heat producing equipment will have fire safety discussed and documented as part of the time out verification. The discussion will include factors that may increase the chance of fire (alcohol-based prep, patient oxygen use, etc.) and safety measures implemented. Safety measures may include:

- See *Procedure Fire Safety* Policy for details
- Updated Percipio time out module will go live in January 2025

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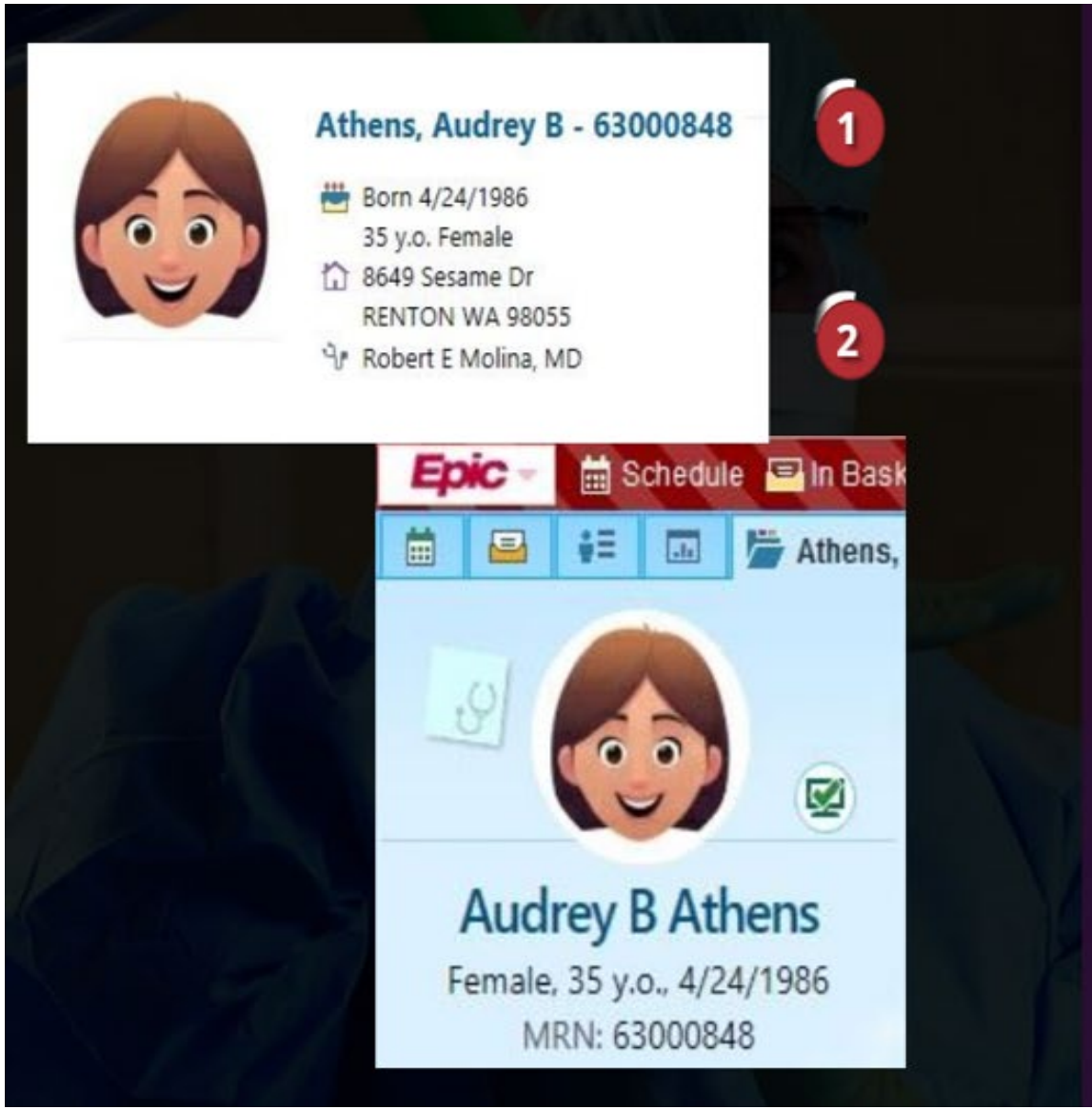
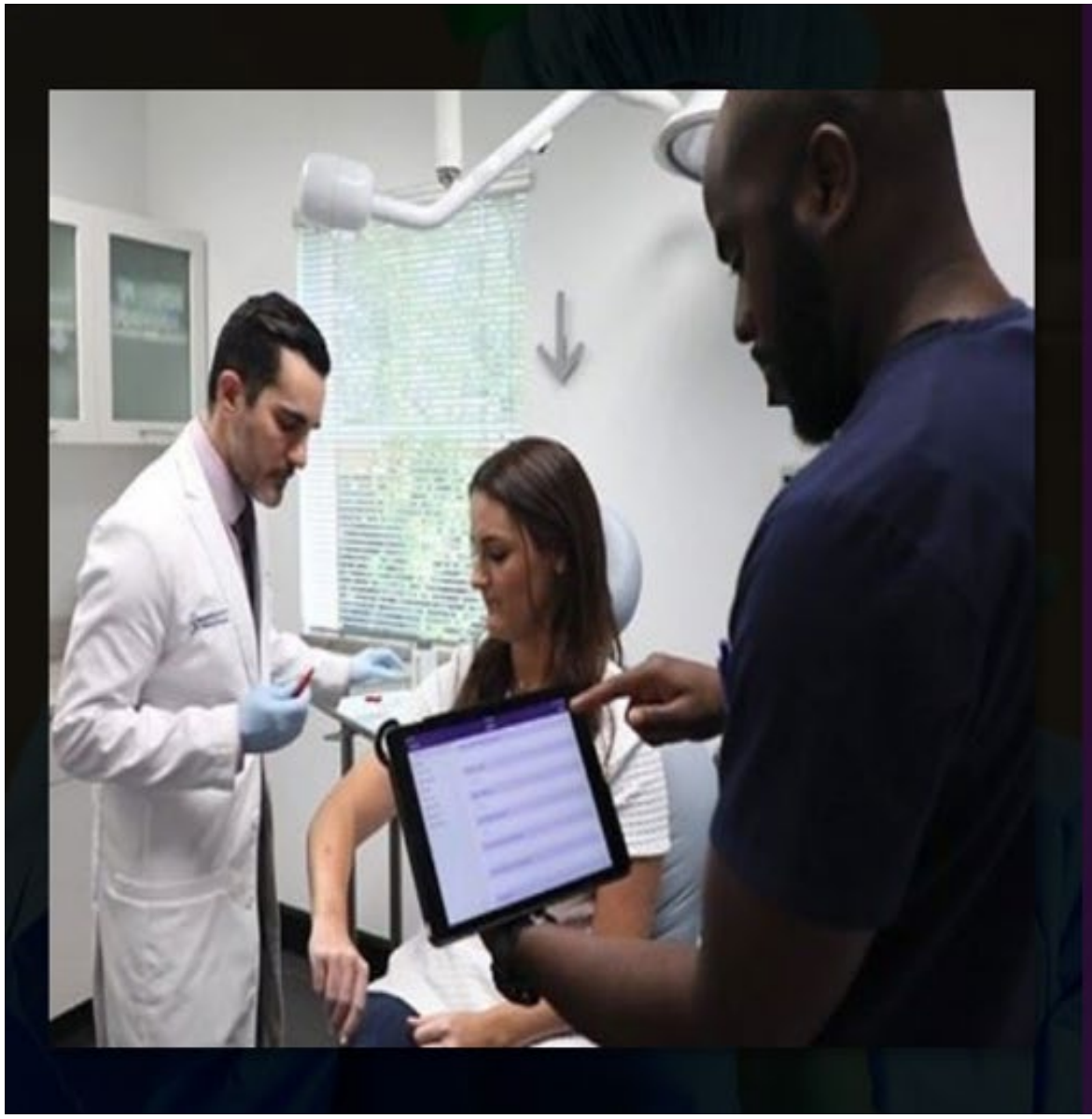
Step 1: Verify Correct Patient



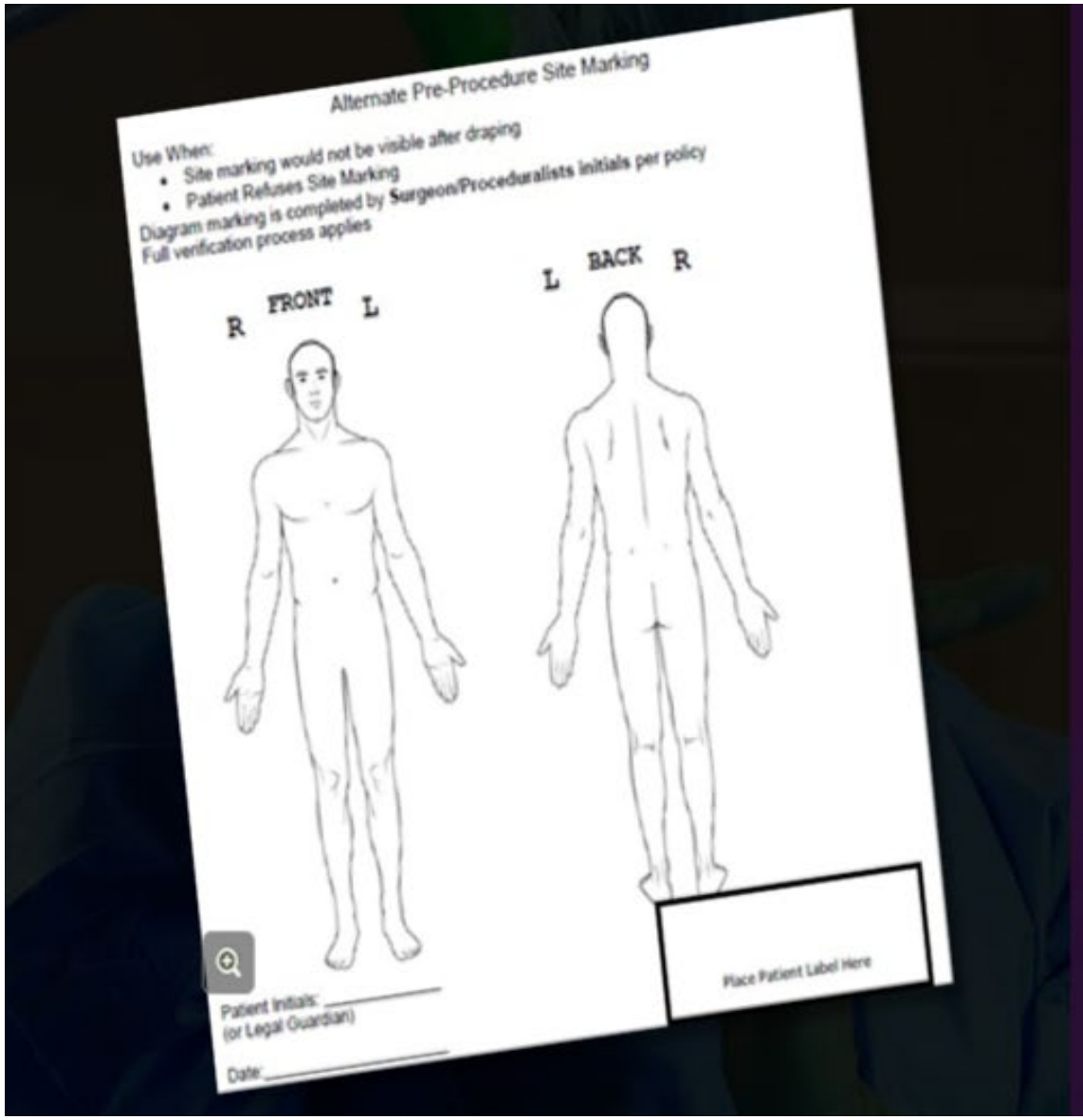
The correct patient is verbally verified using two patient identifiers (**name** and **date of birth**). The patient's name and date of birth are compared to the medical record.

Step 2: Verify correct procedure



The correct procedure is verbally verified and compared with the consent, order, or referral as appropriate.

Step 3: Site Marking (*if applicable)



For cases with more than one possible location the correct site/ side/level is verified using the consent, order, or referral and visualizing Provider's initials on the exposed/prepped procedure site or on the paper diagram.

Step 4: Ensure everyone agrees

All present, including the proceduralist and the patient (if able) verbally agree that the patient, procedure, and site are correct and resolve any disagreement before proceeding.

Step 5 Discuss Fire Safety

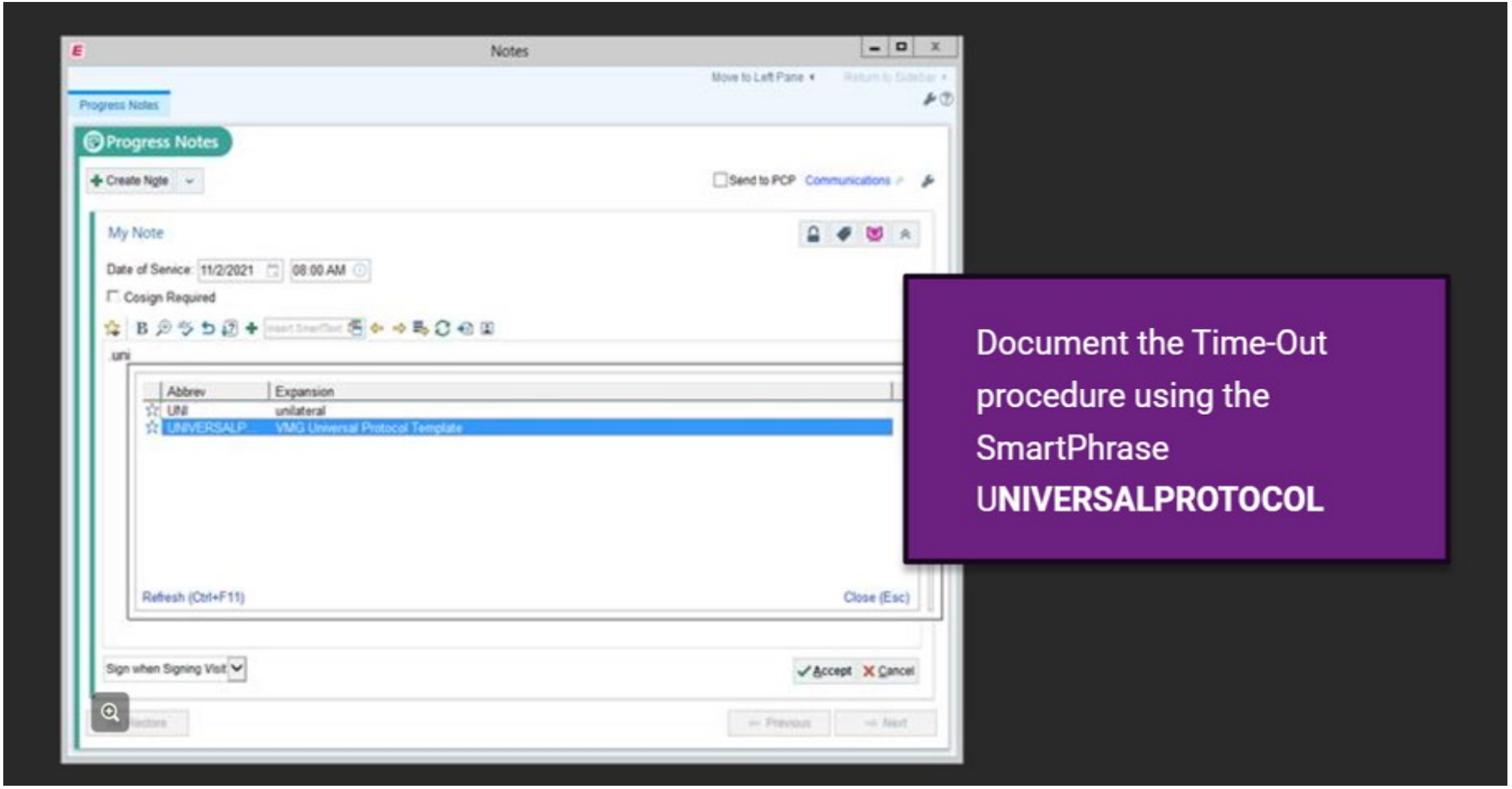
All procedure team members will participate in the review of fire safety when performed. The discussion will include factors that may increase the chance of fire (alcohol-based prep, patient oxygen use, etc.) and safety measures implemented. Safety measures may include:

- Allow sufficient prep dry time
- Do not drape until prep area is fully dry
- Water available for suppression purposes
- Minimize Electrical Surgical Unit (ESU) settings
- Use wet sponges, as appropriate

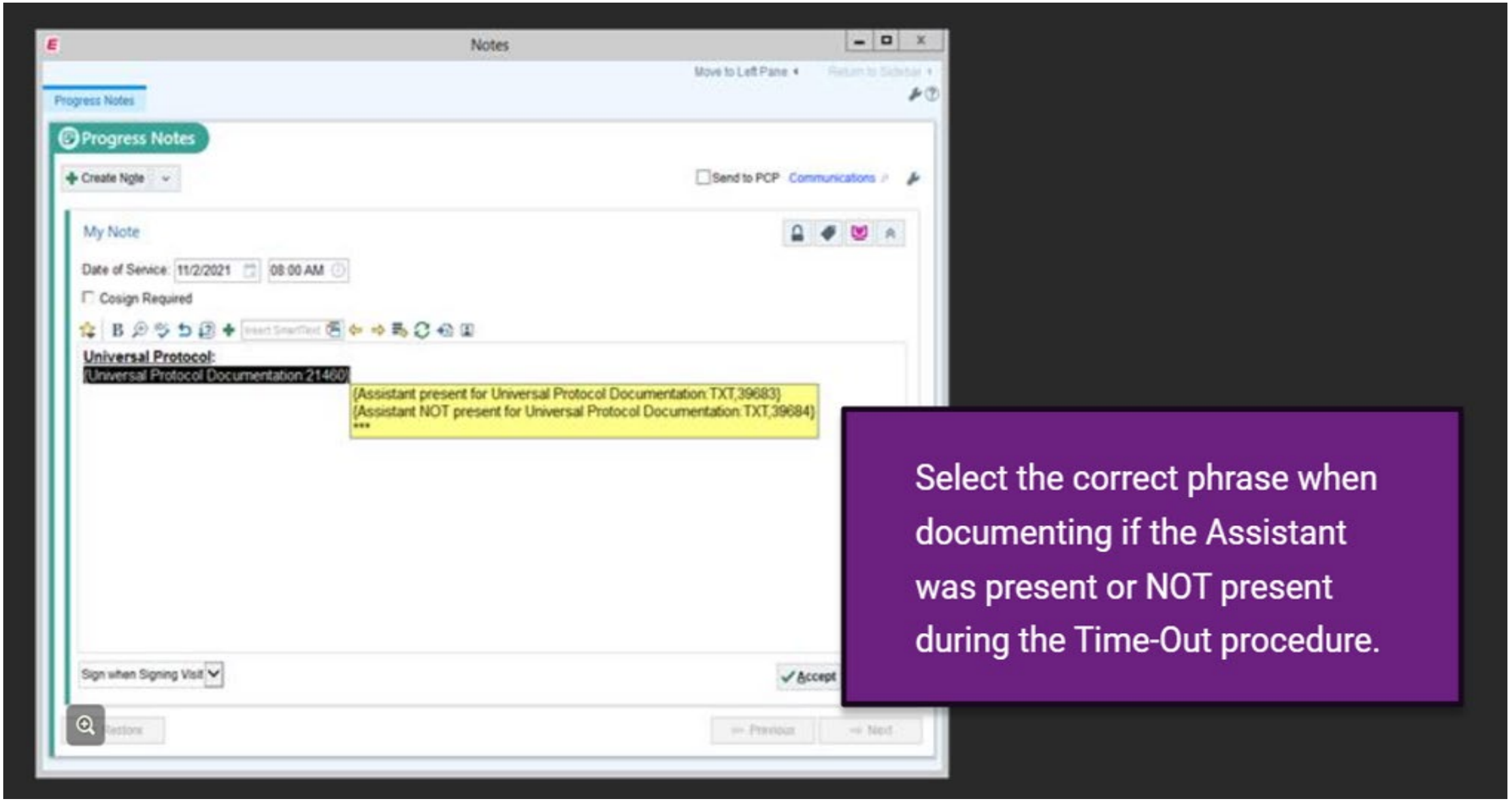
Additional Safety Tips

- Review the location of the fire extinguisher closest to the procedure room
- Know & follow the manufacturer instructions for use for the heat producing equipment that is being used

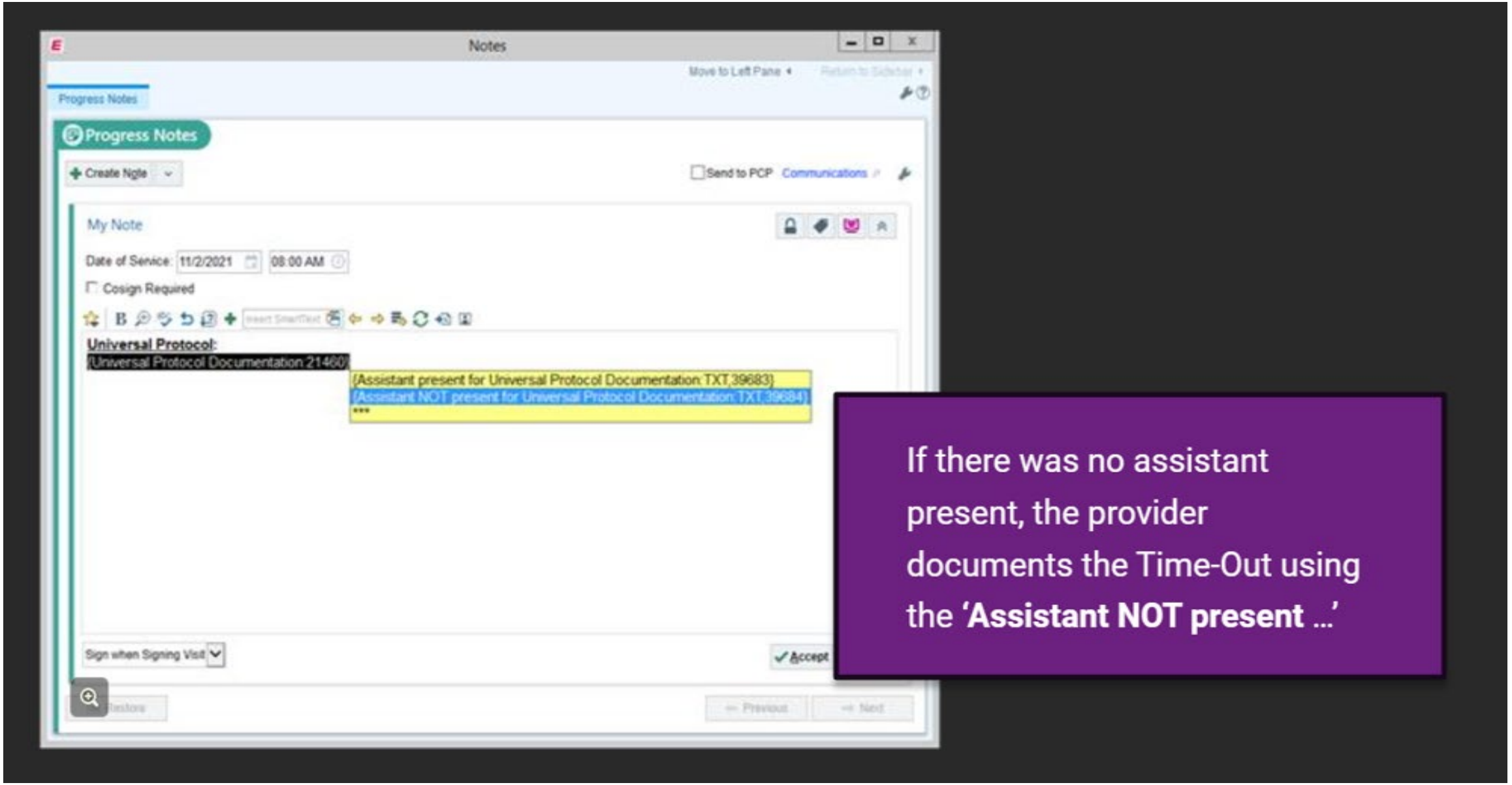
SmartPhrase - step 1 of 4:



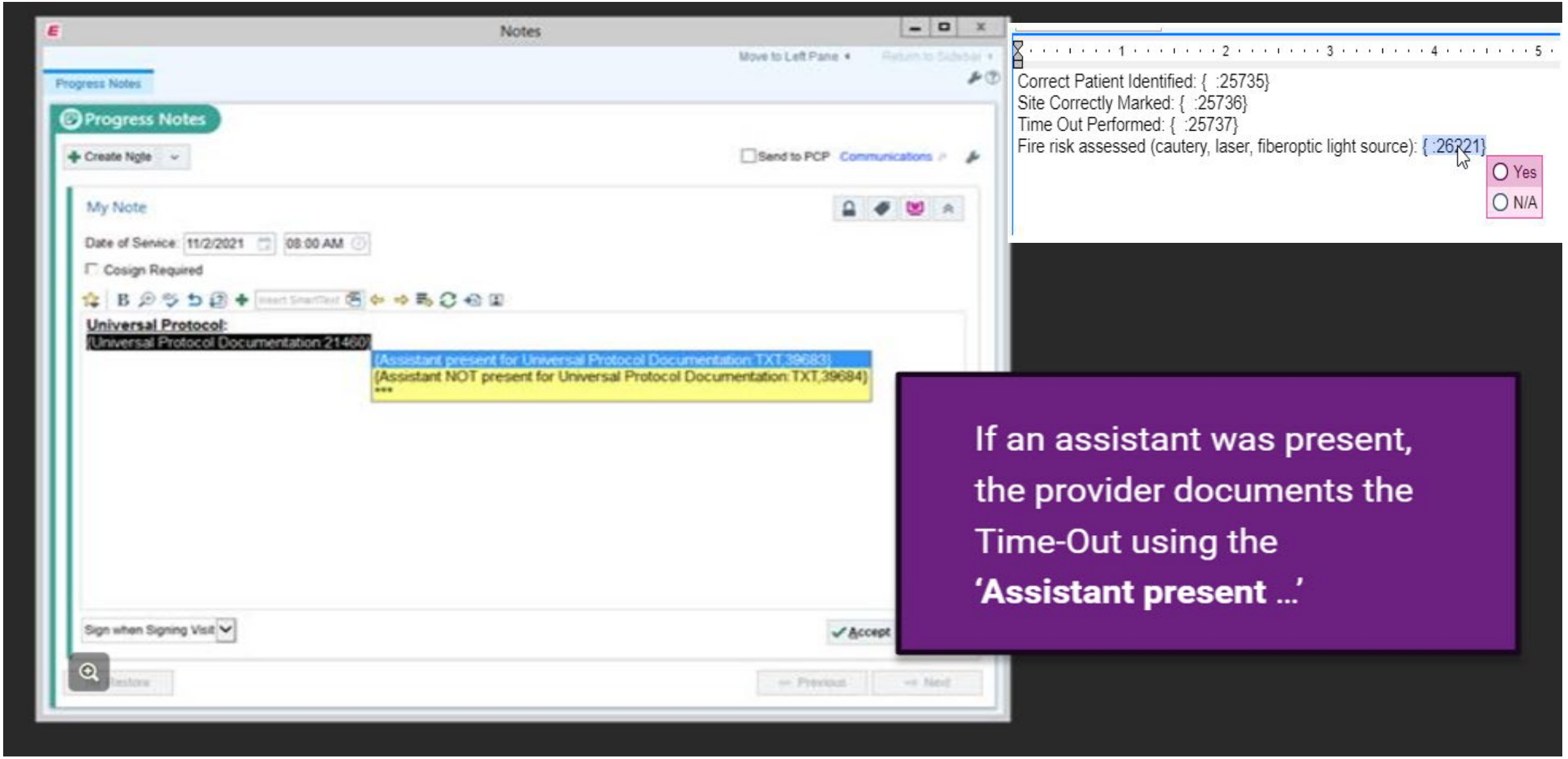
SmartPhrase - step 2 of 4:



SmartPhrase - step 3 of 4:



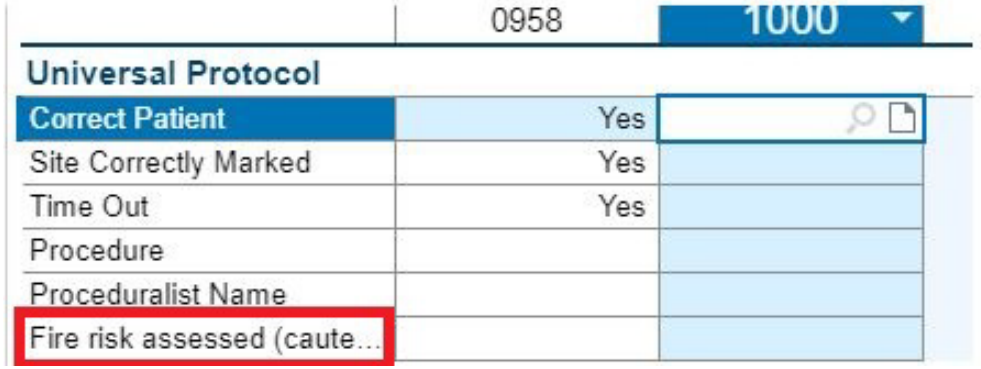
SmartPhrase - step 4 of 4:

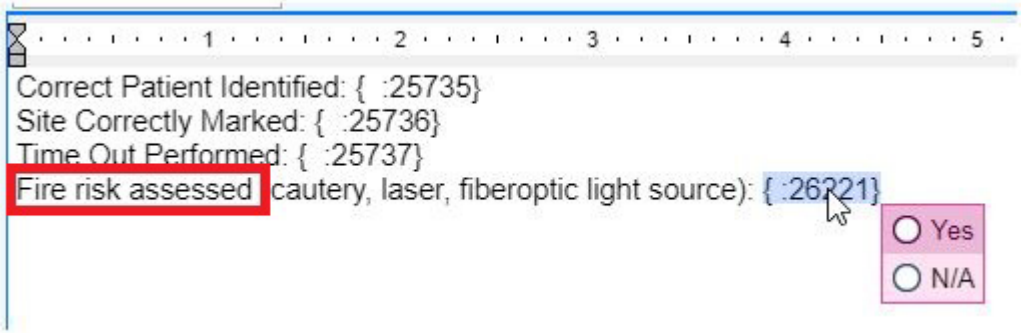


Fire Risk Assessment Documentation

- **Addition of the “Fire risk assessed” line is the only change made to the time out Flowsheet and SmartPhrase**

- **N/A is an option for procedures that do not require heat causing device**





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What to do

Prior to 1 Jan 25	On/After 1 Jan 25
- Continue to conduct and document time out per our current process.	- Fire Risk Assessment needs to be conducted prior to procedures. - Fire Risk Assessment needs to be documented on EPIC through Flowsheet or SmartPhrase.

Communication Plan

When	Who	How	What
Nov-Dec 2024	Sue Christian, Education and Training Coordinator Christine Wade, Education and Training Coordinator David Kim, Ambulatory Quality Manager Kathy Mckee, Regulatory and Accreditation Compliance Manager Yen Nguyen, Dir. of Ambulatory Ops and Educators	Present at various committee meetings (BOAT, Clinic Ops, Provider meetings, etc)	Fire risk assessment/mitigation and associate EPIC tools
Jan 2025	Denise Simao, LMS Manager	Sent out notification via Percipio	Introduction of updated Time out Percipio module

Reza Masoomi, MD

Interventional Cardiology

Cardiovascular Conditions

- Peri-operative Risk Stratification
- Hypertension
- Dyslipidemia
- Congestive Heart Failure
- Valvular Heart Disease
- Atherosclerosis
- Coronary Artery Disease
- Peripheral Artery Disease

Non-Invasive Evaluations/Studies

- EKG (including wearable cardiac monitors)
- Trans-Thoracic Echocardiogram
- Cardiac Stress Tests
  - Exercise treadmill test (ETT)
  - Exercise echocardiogram
  - Exercise treadmill test with nuclear perfusion (ETT-MIBI)
  - Pharmacologic stress with nuclear perfusion (MIBI)
- Holter/Loop Recorder/Pacemaker/ICD interrogation

Diagnostic Procedures/Interventions

- Trans-Esophageal Echocardiogram
- Cardioversion
- Coronary Angiography
- Right Heart Catheterization
- Percutaneous Coronary Intervention
- Mechanical Circulatory Support (IABP, Impella)
- Temporary Pacemaker
- Peripheral Vascular Intervention
- High risk, and complex coronary intervention
- Chronic total occlusion PCI (CTO)

Referrals and Consults

Cardiology Clinic: Please submit outpatient referrals via EPIC or by fax

Talbot Professional Center Suite 500
Phone: 425-690-3482
Fax: 425-690-9082

Reza Masoomi, MD
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WE ARE Valley

Joonseok (“Joon”) Kim, MD MSPH

Cardiac Electrophysiology

Cardiovascular Conditions

Atrial Fibrillation (AF) Atrial Flutter Premature Atrial Complexes (PACs) Supraventricular Tachycardia (SVT) Wolff-Parkinson-White (WPW) Syndrome Atrial Tachycardia (AT)	Premature Ventricular Complexes (PVCs) Ventricular Tachycardia (VT) Ventricular Fibrillation (VF)
Genetics and Cardiac Channelopathies Long QT Syndrome Brugada Syndrome Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT) Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)	Sudden Cardiac Arrest/Death Risk Evaluation Risk Stratification for Cardiac Arrhythmia Post-Ablation Arrhythmia Recurrence Management Antiarrhythmic Drugs Monitoring and Management
Bradyarrhythmias (e.g., Sinus Node Dysfunction, AV Block)	Device-Related Arrhythmias (Pacemaker, ICD, CRT dysfunction) Device Programming and Optimization

Non-Invasive Evaluations/Studies

- EKG (including wearable cardiac monitors)
- Cardiac Stress Tests focused on arrhythmia risk stratification
- Holter/Loop Recorder/Pacemaker/ICD interrogation
- Cardioversion

Ablation Procedures/Interventions

- Electrophysiology Study (EPS)
- Zero or minimal fluoroscopy catheter ablation
- Atrial Fibrillation Ablation (Radiofrequency Ablation and Pulsed-field ablation)
- Atrial Flutter Ablation
- Supraventricular Tachycardia (SVT) Ablation
  - Atrial Flutter Ablation
  - Ablation for AV nodal reentrant tachycardia (AVNRT)
  - Ablation of accessory pathways in Wolff-Parkinson-White (WPW) syndrome
  - Atrial Tachycardia (AT) and Premature Atrial Contractions (PACs) Ablation
- Premature Ventricular Contractions (PVCs) Ablation
- Ventricular Tachycardia (VT) Ablation

Device Procedures/Interventions

- Implantable Loop Recorder
- Transvenous Pacemaker (including left bundle are pacing, CRT-P and CRT-D)
- Leadless Pacemaker
- Transvenous ICD
- Subcutaneous ICD
- Device Generator Replacement

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December 17:

VMG All Provider Meeting

January 8:

Primary Care Meeting