LEHIGH VALLEY HOSPITAL

Medical Staff Progress Notes

January

1996
Volume 8, Number 1

From the President

The turn of a new year gives us an opportunity to start fresh, wipe the slates clean, and begin old processes with a new outlook. It should be a refreshing and reflective experience. At the December public meeting of the Board of Trustees and at the December General Medical Staff Meeting, I took the opportunity to reflect on our past year's activities. While I can't take the space here to outline all of that presentation, I can highlight a few major points.

The functional plan grew out of two years of physician and administrative strategic planning, which attempted to solve a number of problems in patient care. On our floors, the inefficiency of chart location, multiple form locations, the poor writing space, and the long delays in doctors order execution and time to test was fractionating patient care. With patient centered care (PCC), we proceeded to standardize charts at the patients door, along with vital signs and graphics. Writing space for the physicians was improved with chart carrels and better designed space for physicians and nurses to work on the med/surg floors. MD and RN interaction was improved and became more efficient. Communication with nurses became easier with wireless phones and nursing paging devices.

Patient satisfaction improved dramatically. The first results of the Press Ganey for last quarter showed that patient satisfaction rose from 70% to 90% on floors where the patient centered care architecture was being used. Along with this, we found physician orders being executed much more rapidly, the time to test occurring more rapidly, physical therapy being brought to the floors, assisting patients in a more efficient fashion, and we also saw an expected decrease in the overall cost of care.

Physician concern with the inefficiency of the emergency department led to the Board's funding of the emergency department redesign, which will be both a short-term and long-term project. Overall, the emergency department footprint will increase significantly and be coupled by radiologic support, including teleradiologic services. The space will be better designed since the Emergency Department Redesign Team, comprised of physicians from nearly every specialty, has had input into the process along the way. The emergency department is under new nursing leadership with Betty Brennan, and a search for a new Chairperson of the Emergency Department is progressing quite nicely. In addition to this space, plans to develop the emergency department

(Continued on Page 2)

In This Issue . . .

(Continued from Page 1)

observation area in another location and an Urgent Care ER for walk-ins was also developed in design to be executed in the upcoming year.

Improving outpatient services with better patient access and better parking availability took place with the design of the east wing, which also was part of our functional plan. Five physician dominated committees are now in the process to assess how this space can be best constructed to allow for ease of patient access, central scheduling, ambulatory surgery, outpatient radiology, cardiology, vascular testing, neuroservices, as well as an inpatient psychiatry and obstetric birthing unit and certain physician practices. In 1995, we proceeded to come closer to our goal of consolidating our inpatient services at one site. All med/surg beds were finally moved to Cedar Crest & I-78, including the pediatrics move to 4B. We opened a transitional skilled unit at 17th & Chew, which has helped shorten length of stay for hospitalized patients at Cedar Crest & I-78, and also afforded an opportunity for more efficient rehab services. We opened the Hospice unit at 17th & Chew, and at Cedar Crest & I-78, the nephrology unit was completed, as well as a new and better designed GI/Endoscopy unit.

In June of 1995, we had a physician retreat, which was the culmination of multiple interviews that I had with the Chairs and Chiefs of various departments, divisions, and sections at our hospital. The concepts of a) improving communication; b) improving trust and morale; c) empowering the PHO and IPA; d) developing physician leadership; and e) developing vibrant citizenship requirements evolved.

On the score of improving communication, I have continued to try to keep these ***Medical Staff Progress Notes*** as detailed and informative as possible, and you have let me know in our communication survey that over 90% of you find these to be very useful. We continue to have the monthly Medical Staff/Administration Exchange Sessions where we can enter in a frank and honest discussion of difficult topics which are best kept out of print. I have attempted to answer each of your concerns on electronic mail and through personal letters when you have written and contacted me. This system of personal communication will be improved with a new 402-DOCS hotline which will allow physicians to call in with questions and concerns, but also allow them to hear the latest updates on the functional plan, PennCARE and hospital news in 1996.

From a communications standpoint, PHAMIS has gotten better every month through the supervision and untiring efforts of the liS team directed by Harry Lukens. Transcription times have dropped dramatically, and we are all finding the benefit of being able to communicate with our reports in PHAMIS and reports delivered to the floor within 24 hours. Reports printing to the floor have also been accomplished, and this has assisted in the process. The ability to authenticate dictations on line has also saved physicians much time.

(Continued on Page 3)

(Continued from Page 2)

Information Services and the PHAMIS upgrade, which is now underway, will improve, yet again, PHAMIS to be quicker, more efficient, and easier to use for physicians. It will also include the ability to have order entry and authentication of H & P and discharge summaries from terminal rather than from paper in medical records.

The issues of improving trust and morale have been brought to the Senior Management Council (SMC), Med Exec, and multiple Board presentations culminating in an SMC Board retreat in October of 1995. We appreciate Dr. Robert Murphy, who headed up this project and developed a whitepaper on this, which was distributed at the December meeting of the General Medical Staff. (A copy of the whitepaper is attached to this newsletter for your information.) The principles of administration and physician relations have also grown from these discussions. The importance of guarding and protecting the pluralistic model of care, including private practice as well as physician practices associated with Lehigh Valley Hospital, evolved from this as well as the concept of using our PHO as our sole contracting agency.

The PHO and IPA continue to evolve organizationally, and we thank John Jaffe as CEO of the PHO and President of the IPA for his continuing efforts to date. Multiple physicians have engaged in the meetings of the IPA and PHO to direct it and its role in the Integrated Delivery System, and we are optimistic that the PHO and IPA is well positioned for managed care contracts in the very near future.

Vibrant citizenship has been the committee assignment headed by Alex Rae-Grant and has also resulted in redesigning physician categories with minimal standards. This has been presented at all department meetings and recently at the quarterly General Medical Staff meeting. It will be brought forward as an Action item at the next quarterly General Medical Staff meeting.

As we close out 1995, let us take a look at our medical staff goals for 1995-96 (listed below), and let's recall our goals as things that we should do and things that we should not do.

Medical Staff Goals 1995-96

Things Medical Staff Should Do

1. Work together as a team in a spirit of openness and cooperation toward shared goals.
2. Develop a sense of mutual respect, truthfulness, trust.
3. Empower the PHO to work on our behalf in the arenas of managed care, QA, and protocol development.
4. Develop vibrant citizenship requirements for hospital and physician which foster mutual growth, participation and interest.
5. Improve timely communication to the medical staff at all levels.
6. Enhance educational and leadership opportunities to assure the best possible patient care.
7. Recognize, respect and protect pluralistic models of health care in our hospital.

Things Medical Staff Should Not Do

1. Let the medical staff be governed by hallway rumor.
2. Stray from patient care as our central focus.
3. Polarize, splinter medical staff from each other and from the hospital.
4. Lose our identity as a medical staff.
5. Hesitate to speak the truth when necessary no matter how difficult.

(Continued on Page 4)

(Continued from Page 3)

I will continue to work at making progress in each of these areas, but particularly in developing a sense that we can work together as a team in a spirit of openness and cooperation, mutual respect and trust toward shared goals, the goals of taking the best care of our patients for the lowest cost. Throughout all of this, I will attempt to be a good communicator to all of you in 1996 through division and department meetings, through these ***Medical Staff Progress Notes,*** and through personal encounters in the work place.

Lastly, let me be so bold as to outline for us specific goals for the medical staff in 1996 which are more concrete in nature.

1. We must continue to dedicate ourselves toward physician input to the east wing design. This is a very important building for the care of outpatients, and it will be only as good as the energy that physicians dedicate to it.

2. We must continue to see the development and organization of PennCARE and the PHO in the way that protects and enhances the values and autonomy of the physician/patient relationship.

3. We must work toward true integration of services in our network of hospitals. We have all to learn from each other and will all improve in the process.

4. We must aggressively support clinical and hospital initiatives for operations improvement. This is a process where we attempt to cut the waste and inefficiency on the physician and hospital side to lower the cost of care of patients without lowering quality. This can only improve our position in the marketplace as a major tertiary center for businesses in the Lehigh Valley.

5. We must assist and be patient with the emergency department and radiology redesign process which will impact all of us who work at Lehigh Valley Hospital on a daily basis.

6. Lastly, we must monitor and improve the patient centered care concept in all of its facets from med/surg floors to emergency department to ambulatory care as it evolves functionally in 1996.

On behalf of Bob Murphy, Joe Candio, and myself, I would like to wish the medical staff and the Board of Trustees a happy, healthy and prosperous new year in 1996.

John E. Castaldo, MD
President, Medical Staff

For Your Calendar

General Medical Staff Meetings

Meetings of the General Medical Staff for 1996 will be held on Mondays, March 11, June 10, September 9, and December 9, in the Auditorium at Cedar Crest & I-78. Please note that these meetings will begin at **5:30 p.m.**

Medical Staff/Administrative Exchange Sessions

The Medical Staff/Administrative Exchange Sessions for 1996 will be held on the third Thursday of each month beginning at 5:30 p.m. Sessions will be held in **Classroom 1 at Cedar Crest & I-78,** unless otherwise noted.

Dates include: January 18, February 15, March 21 - Conference Room 1, Side B (Morgan Cancer Center), April 18 - Conference Room 1, Side B (Morgan Cancer Center), May 16, June 20, July 18, August 15, September 19, October 17, November 21, and December 19.

Intensive Care Unit Established on 3S/Perinatal Unit

Effective December 18, 1995, a four-bed intensive care unit has been established at 17th & Chew on the 3S/Perinatal Unit for antepartum and postpartum mothers requiring this level of care. The critical care response team has been previously determined and will remain in place. A nurse from the MICU/SICU at Cedar Crest & I-78 will respond to the unit within 20 minutes. The perinatal staff will manage the patient until the MICU/SICU staff arrives.

All other patients requiring critical care monitoring will be stabilized at 17th & Chew and transported via Cetronia Ambulance to Cedar Crest & I-78. This includes psychiatric patients, pre and post surgical patients from both 17th & Chew and the Fairgrounds Surgical Center.

If a post-operative patient requires observation for a short period of time (up to two hours), these patients may remain in the PACU at 17th & Chew until stable or until a decision is made for transfer.

If you have questions or concerns regarding this issue, please contact Robert J. Laskowski, MD, Senior Vice President, Clinical Services, at 402-7502 or via e-mail.

We are saddened by the recent passing of two members of the Medical Staff:

Betty B. Karron, MD
August 30, 1928 - November 22, 1995

Dr. Karron was a member of the Department of Psychiatry since 1977, specializing in adolescent and child psychiatry.

Memorial contributions may be made to: Lehigh Valley Hospital - Dr. Betty Karron, c/o Development Department, Lehigh Valley Hospital, 1243 S. Cedar Crest Blvd., Suite 3326, Allentown, PA 18103.

Forrest G. Moyer, MD
October 27, 1916 - December 2, 1995

Dr. Moyer was Chief of Pediatrics at Lehigh Valley Hospital for more than 20 years and was instrumental in the creation of the neonatal intensive care unit which was named for him in 1981. In honor of his dedication and loving service to the families and children of our region, the hospital's first fully endowed chair, The Forrest G. Moyer, MD Distinguished Chair in Pediatrics was recently established. Memorial contributions may be made to: Forrest G. Moyer, MD Distinguished Chair in Pediatrics, c/o Development Department, Lehigh Valley Hospital, 1243 S. Cedar Crest Blvd., Suite 3326, Allentown, PA 18103.

News from Medical Records

Attestation Statements

The attestation statement requirement was eliminated for CHAMPUS beneficiaries who are admitted to hospitals on or after October 1.

However, signatures are still required on attestation statements for Medicaid beneficiaries. The Hospital Association of Pennsylvania is currently working with the state to eliminate this requirement, but until then, physicians will be responsible for the attestation statements for all Medicaid patients.

The Medical Record Department will continue to deliver and/or mail attestations for Medicaid patients to your offices. We will also continue to ask for physician clarification on ICD-9 code assignment via the "Attestation Questionnaire" (pink form), by faxing or delivering questions to your offices with the attestations for your convenience.

All physicians are encouraged to review the Clinical Information Sheets (located behind the face sheet), on your records at the time of record completion. In addition, please review the code assignment and question anything with which you do not agree.

In order to continue to code with the highest quality, the staff of Medical Records requests your continued support to clarify documentation in the medical record.

If you have any questions or concerns regarding this regulatory change, please contact Michelle Meenan at 402-5035.

Discharge Summaries

Many nursing homes and skilled nursing facilities require that either a dictated or written discharge summary accompany the patients upon transfer to the designated facility.

Physicians are encouraged to dictate discharge summaries upon patient discharge. According to bylaws, "the clinical resume (Discharge Summary) should recapitulate, concisely, the reason for hospitalization; the significant findings, the procedures performed and treatment rendered; the condition of the patient on discharge; and any specific instructions given to the patient and/or family, as pertinent.

For those cases requiring discharge summaries for transfer, physicians may use the STAT dictation line.

Blood Consents

All patients who need a type and cross diagnostic test, also need to have a blood consent signed. This is especially crucial if the patient is going for elective surgery.

If the blood consent is not signed, the patient will not leave the unit for the operating room until the consent is signed by the patient. In order to prevent problems on the day of the procedure, it is suggested that the patient sign the consent in the physician's office during the office visit.

Site & Facilities Update

Emergency Department Redesign

The Emergency Department (ED) at Cedar Crest & I-78 has been redesigned as part of the functional plan. Built 21 years ago, it is currently undergoing renovations designed to better meet today's needs. Using feedback from patients, physicians, and staff, the department's new design will improve patient privacy, reduce noise, and make it easier and safer for physicians and staff to care for patients.

A new entrance for the Level I trauma unit on the side of the building will separate helicopter and ambulance traffic from walk-in patients who will continue to use the current entrance. Inside, a centrally located radiology department will be close to all patients, and separate areas will be designated exclusively to pediatric and psychiatric patients. Laptops and voice recognition systems are planned to allow physicians and staff to spend more time with each patient. After completion of construction, the ED will occupy 17,518 square feet -- which represents an approximate 70 percent increase in space.

Phase I of the redesign has eliminated a satellite pharmacy and relocated three trauma offices and the flight crew room to the third floor of the Morgan Cancer Center. Various other offices, including the ED supervisor and ED director, have moved to the first floor near Medical Records. This phase will be completed in early 1996.

Phase II, which involves the relocation of the Medical Staff Lounge and various storage areas to the first floor near Medical Records, is expected to be completed in March.

402-DOCS Makes Debut

Beginning January 1, 1996, **402-DOCS**, a telephone information hotline, will make its debut for members of the Medical Staff. This new hotline will provide timely information about numerous topics which may be of interest to physicians. Some of these topics will include information about the functional plan, PennCARE, the Greater Lehigh Valley IPA and Lehigh Valley PHO, facilities construction and renovations, and upcoming events. In addition, questions or comments may be recorded on the hotline which will be responded to by a member of the Medical Staff leadership.

So, if you want to hear the latest about what's happening, just dial 402-DOCS (3627).

New Medical Staff Directory

If you haven't received your new copy of the new Medical Staff Directory, please contact Physician Relations at 402-9853.

Valet Parking at Cedar Crest & I-78

In light of the overwhelming success of the valet parking program at 17th & Chew, a pilot valet parking program began at Cedar Crest & I-78 on December 11. As many as several hundred cars per day could utilize this exciting parking option. For the convenience of patients, there will be two drop-off sites: the main hospital entrance and the entrance to the John and Dorothy Morgan Cancer Center.

The cost of the program will be partially offset by a nominal $2.00 per car fee. The hours of operation are tentatively scheduled for Monday through Friday, 7 a.m. to 6:30 p.m., with no holiday coverage.

This service is for patients and visitors only. If you have any questions or concerns, please contact Gerald Kresge, Director of Security, at 402-8220.

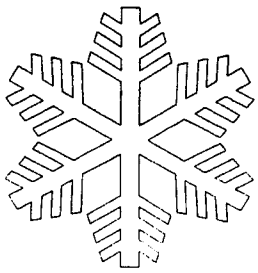
Congratulations!

Two members of the Medical Staff were recently honored by the American Lung Association of the Lehigh Valley for their contributions to the organization's efforts in preventing lung disease and promoting lung health. **Jerome Dunn, MD**, chief, Division of Pediatric Allergy, was the recipient of the Camp Wheeze-Away Service Award. This award is presented for service and commitment to Camp Wheeze-Away, an overnight camp for children with asthma. **Mark P. Shampain, MD**, allergist, received the Edward Livingston Trudeau Award, presented to an individual who represents Trudeau's pioneering spirit as a visionary of unique and vital programs for people with lung disease. Dr. Shampain spearheaded the association's pediatric asthma education programs.

Howard A. Silverman, MD, family practitioner, was recently recertified as a Diplomate of the American Board of Family Practice.

Papers, Publications and Presentations

"Differentiation of Alpha Coma from Awake Alpha by Nonlinear Dynamics of Electroencephalography," an article co-authored by **Alexander D. Rae-Grant, MD**, neurologist and Medical Director of the Neurodiagnostic Laboratory, has been accepted for publication in *EEG and Clinical Neurophysiology.*



Upcoming Seminars, Conferences and Meetings

Medical Staff/Administrative Exchange Session

The next Medical Staff/Administrative Exchange Session will be held on Thursday, January 18, 1996, beginning at 5:30 p.m., in **Classroom 1 (Cedar Crest & I-78)**.

These sessions are a perfect opportunity for physicians and members of senior management to exchange information.

Topics to be discussed will be announced prior to each session.

For more information, contact John E. Castaldo, MD, Medical Staff President, through Physician Relations at 402-9853.

Regional Symposium Series

Twelfth Annual Endocrinology Update: Insulin Resistance Obesity, An American Epidemic will be held on Saturday, January 13, 1996, from 8 a.m. to Noon, in the Auditorium at Cedar Crest & I-78.

Physicians, nurses, and other health professionals interested in an update in endocrinology will benefit from this program.

At the completion of the program, participants should be able to:

- describe the concept of insulin resistance and its importance in atherosclerosis
- identify the different modalities of therapy for the insulin resistant patient
- discuss the newer research in the area of obesity including as it relates to insulin resistance and its treatment.

Seventh Annual Symposium in Geriatrics will be held on Saturday, January 27, 1996, from 8 a.m. to 2:30 p.m., in the Auditorium at Cedar Crest & I-78.

Physicians, nurses, medical residents, pharmacists, social workers, and other health professionals interested in geriatrics will benefit from this program.

At the completion of the program, participants should be able to:

- identify attitudes towards aging that affect patient care
- describe recent therapeutic advances in the care of the elderly
- describe the differential diagnosis of Alzheimer's Disease and identify the role of drug therapy
- identify controversies in the treatment of hyperlipidemia in the elderly and describe therapeutic options.

For more information about these programs, contact the Center for Educational Development and Support at 402-1210.

(Continued on Page 10)

(Continued from Page 9)

Department of Pediatrics

Update on the Treatment of Nephrotic Syndrome in Children will be presented by Steven J. Wassner, MD, Chief, Division of Pediatric Nephrology and Diabetes, Hershey Medical Center, on Friday, January 12, at Noon.

Development of a Clinical Pathway for Attention Deficit Disorder will be presented by Martha Lusser, MD, pediatric neurologist, and George DuPaul, PhD, Associate Professor, School Psychology Program, Lehigh University, on Tuesday, January 16, at 8 a.m.

Anorexia Nervosa and Bulimia will be presented by Marlene Finkelstein, LSW, specialist in eating disorders, on Friday, January 26, at Noon.

The above programs will be held in the Auditorium at 17th & Chew. For more information, contact Cindy in the Department of Pediatrics at 402-2410.

Primary Care Seminars

Depression Update will be presented by Joseph L. Antonowicz, MD, chief, Division of Consultative/Liaison Psychiatry, on Wednesday, January 10.

Thyroid Update will be presented by Larry N. Merkle, MD, chief, Division of Endocrinology/Metabolism, on Wednesday, January 24.

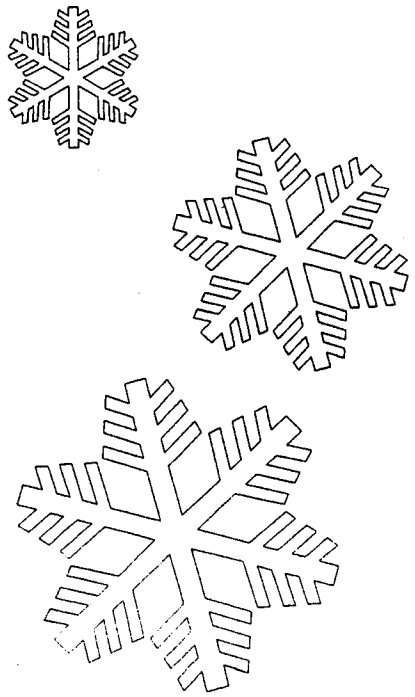
The Primary Care Seminars will be held from 7 to 8 a.m., in the Auditorium at Cedar Crest & I-78.

For more information, contact Karen Nodoline in the Department of Family Practice at 402-4950.

Department of Psychiatry

Resolution of Conflict in Couples will be presented by Gerald R. Weeks, PhD, Director of Training, Marriage Council of Philadelphia, and Clinical Associate Professor of Psychology, University of Pennsylvania School of Medicine, Philadelphia, Pa., on Thursday, January 18, beginning at Noon, in the Auditorium at 17th & Chew.

As lunch will be provided, pre-registration is requested. For more information or to register, contact Lisa Frick in the Department of Psychiatry at 402-9722.



Health Promotion and Disease Prevention News

Free Community Lectures

Prescription for a Healthy You!

Have you once again made a New Year's resolution to start exercising, lose weight, stop smoking, reduce your stress, or all around just get healthier? If so, than this interactive expo is just for you. A team of experts will help motivate you, get you going in the right direction, and share a multitude of ideas and program options that are sure to make 1996 your best year yet!

This program, which includes a brief lecture followed by a mini health expo, will be held on Tuesday, January 16, from 7 to 8:30 p.m., and on Sunday, January 21, from 1 to 2:30 p.m. Both programs will be held in the Auditorium at Cedar Crest & I-78.

Chef Mike Presents: Heart Warming Foods

Think about yummy foods that feel so good on a cold winter's night. While they may feel good going in, they may not be so good for you once they are in you. The mashed potatoes, gravy, meatloaf, and apple pie a la mode may be providing you with too much fat and calories. So don't hesitate to attend this lecture to learn how to "lighten up" many of your favorites. Pennsylvania Dutch cooking will be highlighted, and Chef Mike promises his best again!

This program will be presented on Wednesday, January 31, from 7 to 8:30 p.m., in the Auditorium at Cedar Crest & I-78.

In addition to these free public lectures, the Center for Health Promotion and Disease Prevention also offers numerous programs which may benefit your patients. Classes are offered in the following categories: Nutrition and Weight Control, Nicotine Dependence Services, Stress Management, and Fitness Programs.

For more information on these services or the above free public lectures, contact the Center for Health Promotion and Disease Prevention at 402-5960.

When you need to talk... help is just a phone call away.

PHYSICIAN ASSISTANCE PROGRAM

To arrange a confidential appointment or for more information, call (610) 433-8550 or 1-800-327-8878.

Who's New

The Who's New section of ***Medical Staff Progress Notes*** contains an update of new appointments, address changes, status changes, etc. Please remember that each department or unit is responsible for updating its directory and rolodexes.

Medical Staff

Address Change

Advanced Dermatology Associates, Ltd.
J. Greg Brady, DO
Marc W. Levin, MD
Stephen M. Purcell, DO
Alan H. Schragger, MD
Arthur C. Sosis, MD
Robert J. Thompson, MD
1259 S. Cedar Crest Blvd.
Suite 100
Allentown, PA 18103-6206
(610) 437-4134
FAX: (610) 437-2118

Telephone Number Change

E. Joel Carpenter IV, MD
(610) 439-0308
FAX: (610) 776-3116

Tamar D. Earnest, MD
(610) 402-1350

Clip and Save:

PCC Unit Telephone Directory

7A Director: Shelley Mesics x5192 - pager
Pharmacist: x0213
Physical Therapy: x0205

Room #	RN Cellular	"Server"/"Team"
1-4	x0201	x1901
11-15	x0203	x1903
16-19	x0204	x1904
Dialysis:		x1803
Fax:		x1857 (Dialysis)
General Info:		x1900
Admin. Partner		x0206
CNF: Sonja Mendez		x1914
Fax:		x1980

7B Director: Maryann Rosenthal x0835 - pager
Pharmacist: x0213
Physical Therapy: x0205

Room #	RN Cellular	"Server"/"Team"
1-5	x0208	x8761
6-10	x0209	x8792
11-14	x0210	x8793
15-18	x0211	x8794
General Info:		x8795
Admin. Partner		x0212
CNF: Debra Stroh		x5046
Fax:		x5235

7C Director: Shelley Mesics x5192 - pager
Pharmacist: x0213
Physical Therapy: x0205

Room #	RN Cellular	"Server"/"Team"
1-5	x0216	x1981
7-10	x0217	x1982
11-15	x0218	x1983
16-19	x0219	x1974
General Info:		x8755
Admin. Partner		x0223
CNF: Carolyn Kern		x1994
Fax:		x1938

6B Director: Carol Fox x0228
x2376 - pager
Pharmacist: x0229

Room #	RN Cellular	"Server"/"Team"
2-5	#0224	X5611
6-10	X0225	x5612
11-14	x0226	x5613
15-18	x0227	x5614
General Info:		X8785
Admin. Partner		X0231
CNF: Claranne Mathiesen		X0230
		x3467 - pager
Fax:		x1687

6C Director: Maryann Rosenthal x0835 - pager
Pharmacist: x0229

Room #	RN Cellular	"Server"/"Team"
1-5	x0232	x5481
7-10	x0233	x5482
12-15	x0234	x5483
16-19	x0235	x5484
General Info:		x8910
Admin. Partner		X0236
CNF: Mary Jo Bisty		X0238
Fax:		x5489

Peds Director: Cindy Max x0247
x6709 - pager
Inpatient Medical Director: x0242
Pediatric Resp. Therapist: x0244

Room#	RN Cellular	"Server"/"Team"
1-5	x0243	x6704
6-9	x0241	x6702
11-14	x0241	x6701
15-20	x0243	x6703
General Info:		x6700
Admin. Partner		x6700
Child Life Specialist:		x0245
Pediatric Clinical Specialist:		x6713
CNF: Shirley Wagner		x0246
Fax:		x6743
Fax:		x6744

P & T HIGHLIGHTS

The following action were taken at the November 17, 1995 Pharmacy and Therapeutics Committee Meeting - Maria Barr, Pharm.D., BCPS, Barbara Leri, Pharm.D.

VANCOMYCIN-HELP STOP THE RESISTANCE!

Appropriate and limited use of both IV and oral vancomycin is crucial during this time of increasing resistance of enterococcus. The CDC has published guidelines for the judicious use of vancomycin as recommended by the Hospital Infection Control Practices Advisory Committee (HICPAC). The following guidelines are recommended for prudent vancomycin use:

1. Treatment of documented or suspected serious infections due to a beta-lactam resistant gram-positive organism, i.e. MRSA. Vancomycin may be less rapidly bactericidal than are beta-lactam agents for beta-lactam susceptible staphylococci.
2. Treatment of infections due to gram-positive microorganisms in patients with SERIOUS ALLERGY to beta- lactam antibiotics.
3. Empiric treatment if a life-threatening strep. pneumoniae infection when high level resistance is suspected.
4. When antibiotic-associated colitis (AAC) fails to respond to metronidazole therapy or if AAC is severe and potentially life-threatening.
5. Prophylaxis, as recommended by the American Heart Association, for endocarditis following certain procedures in ampicillin/amoxicillin/penicillin allergic patients at high risk for endocarditis.
6. Single dose surgical prophylaxis for major surgical procedures involving implantation of prosthetic materials or devices at institutions with a high rate of infections caused by methicillin - resistant S. aureus or S. epidermidis.

Keep in mind, vancomycin should NOT be used as routine surgical prophylaxis; empiric therapy continued for greater than 3 days in patients with cultures negative for resistant gram-positive organisms; selective decontamination of the digestive tract; or first line therapy for AAC.

Reference: MMWR Vol. 44 Sept. 22, 1994.

OSTEOPOROSIS MEDICATION IS STRENGTHENING THE TREATMENT OPTIONS!

Alendronate (Foxamax^{R}, Merck) - Has been approved for the treatment of osteoporosis in post-menopausal women and for Paget's disease. This aminobiphosphonate selectively binds to active sites of bone resorption decreasing the amount of bone resorbed by inhibiting osteoclast activity. Bone formation exceeds bone resorption at these remodeling sites, leading to progressive gains in bone mass. This medication has been compared to other agents such as etidronate (Didronel^{R}) and pamidronate (Aredia^{R}) resulting in a much greater inhibition of bone resorption. Alendronate has been studied in long term trials (> 2 yrs) resulting in prolonged efficacy and lack of tachyphylaxis.

The Committee approved of this agent being added to the formulary with the removal of etidronate (Didronel®), one oral biphosphonate on formulary, due to the greater efficacious properties of alendronate.

Dose: Osteoporosis 10mg PO QD
Paget's 40mg PO QD x 6 months

The dose should be taken 30 minutes prior to first food beverage or medication with a full glass of water due to a reduced bioavailability when taken with the above items.

Special Population (Renal insufficiency): Alendronate is not recommended for patients with severe renal insufficiency (est. CrCl < 35ml/min) due to lack of clinical experience.

Drug Interactions: IV ranitidine has been shown to double the bioavailability of alendronate but the clinical significance is unknown at this time.

Calcium and multivalent cations will interfere with the absorption of alendronate and should be administered at least 1 hour after alendronate administration.

Adverse Reactions: The adverse effects associated with this drug are primarily gastrointestinal in nature, including abdominal pain, nausea, dyspepsia, diarrhea, flatulence, acid regurgitation and esophageal ulcer.

In an attempt to decrease the risk of the GI side effects, it is recommended that the patients avoid lying down for at least 30 minutes following AM administration of alendronate.

Cost:

$1.39/10mg tablet (inpatient)
~ $2.15/10mg tablet (outpatient)

The P & T Committee unanimously approved alendronate for our formulary as a welcome addition to the treatment options for both Paget's and osteoporosis. Etidronate will be removed as a result of this addition.

AUTOMATIC SUBSTITUTION LIST GROWS LARGER....

Three additional non-formulary medications will have automatic substitutions with formulary items. (See list below). Please note the substitutions for future prescribing.

DRUG DISPENSED	SUBSTITUTED FOR	COMMENT
oxycodone 5mg and aspirin 325mg	oxycodone HCl 4.5mg and oxycodone terephthalate .38mg and aspirin 325mg (Percodan®)	Order clarification will be received from pharmacy.
selenium sulfide 2.5% lotion/shampoo (Selsun®)	selnium sulfide 1% lotion/shampoo (Selsun Blue®)	Order clarification will be received from pharmacy.
phenylpropanolamine HCl 75mg and guaifenesin 400mg (Entex LA®) 1 tablet Q12H	pseudoephedrine HCl 120mg and guaifenesin 600mg (Entex PSE®) 1 tablet Q12H	Order clarification will be received from pharmacy.

TRUST

As one of my recent charges as President-elect of the Medical Staff, I have been asked by John E. Castaldo, MD, President of the Medical Staff, to investigate the concept of trust, or lack thereof, as it pertains to medical staff and hospital relationships. As a background for this treatise, I have used insights gained from discussions with other members of TROIKA, as well as hospital administration. Additionally, I have discussed this issue with Greg Shea, of Shea and Associates, and Larry Fox, of Lawrence S. Fox and Associates. My final source of insight into this issue was the Estes Park Institute Leadership conference, which dealt with medical staff and hospital issues as we enter the new era in healthcare:

I. Background:

The lack of trust between physicians and hospital administration is not unique to the Lehigh Valley. The basic difference between doctors and hospitals seems to have been further strained by the precipitous change in the way medicine is being practiced in the United States. This requires a basic change in the construct of our approach to medicine. Traditionally, physicians have been fiercely independent, tending to practice either in solo fashion or in small groups. Physicians were masters of their own universe and, assuming that quality of care was not an issue, were accountable to no one. The assumption was that, if you practice good medicine, patients would come to you based on reputation. What we are facing today is an environment in which physicians are being challenged at every turn and seem to have little control over their destiny. While the physician's reputation, at this point in time, still does provide a reasonable referral pattern, the move to managed care implies, in no uncertain term, patients will come to a physicians practice only if that physician is enrolled as a provider with that particular panel.

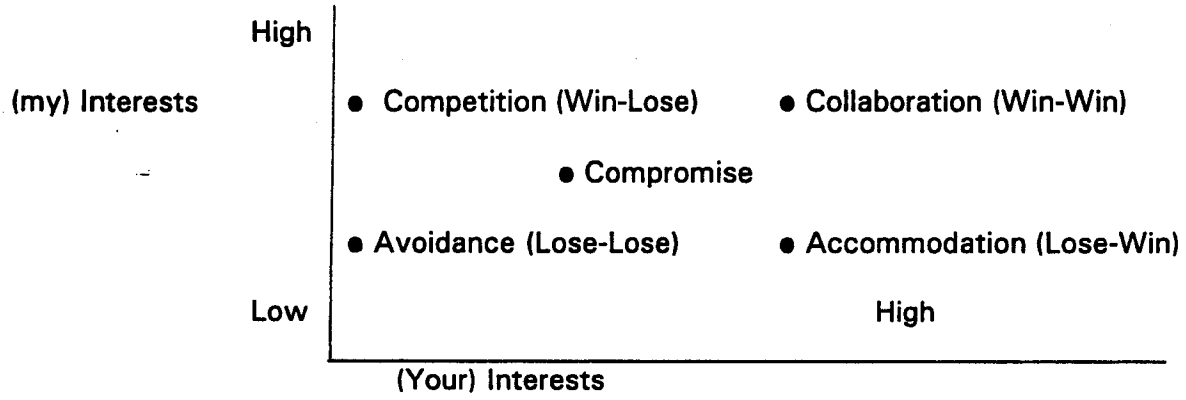
Another potential point of contention is that physicians who have chosen private practice feel that they are in competition with physicians who have "sold their souls" and their individual practices to either group providers or hospitals. Obviously, those in private practice feel very threatened by competing groups who have the backings of much larger institutions. This leads to an incredibly frustrating situation for physicians who are already being threatened as alluded to in the preceding paragraph. In our community here at Lehigh Valley Hospital, this uncertainty exacerbates the feeling that physicians have been previously victimized by past hospital administrations. Greg Shea has stated that "predictability is the currency of trust." While quite true, this presumes that one already has an established track record of consistency in action. As far as this generation of doctors on staff at Lehigh Valley Hospital is concerned, there has been no real pattern of consistent, cooperative action displayed between hospitals and physicians.

II. Gaining Trust:

In order to obtain this elusive entity of trust, there are several important principles to which the involved parties must adhere. To trust, it must be felt that all parties are remaining open minded and that no personal agendas are being advanced at the expense of the group. This assumes that there is some level of mutual respect, implying all participating parties are thought to be valuable partners who are able to contribute concepts, guidance, and action toward the obtaining a mutually desirable goal.

This concept of goal and goal definition is another important element of trust. Trust is not a static entity. There is no such thing as generic trust. It is a commodity which must be maintained from issue to issue, over the course of time. What does seem to be true, however, is that as more mutually satisfactory goals are achieved, a sense of mutual accomplishment, respect, and trust does evolve. This results in a more stable relationship with less suspicion. It is in this scenario that predictability is, indeed, the currency of trust. For this to happen, it is imperative that there be a recognition by all parties that the achievement of the final goal was a direct result of mutual cooperation reflected in information, task, and benefit sharing by all parties, i.e. a true partnership.

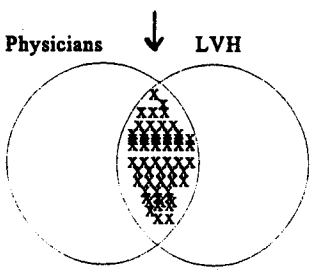
In these times of uncertainty, if we are to trust, both hospital and physician must realize that we must evolve new ways of thinking. In the world of medicine that is coming, I feel that the "old world" in which there was an omnipotent institution and a fiercely independent and well rewarded physician has passed and will never exist again. Accordingly, there are five approaches to conflict resolution and they are: 1) avoidance; 2) accommodation; 3) competition; 4) compromise; and 5) collaboration. Each of these have "characteristics of behavior" and "justification" schematically depicted in the graph below:



In order to attain a win-win situation, collaboration seems to be the tact of most mutual benefit. It should be pointed out that not all interests of physicians are aligned with that of the hospital or vice versa. However, to make strides in the future and to collaborate to achieve a win-win situation, the physicians and the hospital must identify portions of their agendas where there is mutual overlap, interests, and reward. This is represented, in simplistic fashion, by the graph below:

e.g decrease cost
or
increase market share

AGENDAS



This paradigm assumes that, while some battles may be lost, by advancing areas of mutual interest, the war may be won. It should be our responsibility, perhaps at the level of Senior Management Council, to identify these areas of overlap and aggressively advance them to a mutually agreeable conclusion. Once a track record of mutually beneficial outcomes is established, "trust" will become a fait accompli.

I must emphasize that advancing mutual agendas and "trust" does not require the complete alignment of agendas. Trust may still exist when there are differences of opinion, provided that there is mutual respect. One may trust either an ally or an opponent under these conditions. When one assumes that there are highly intelligent, well-trained individuals on both the medical staff and in hospital administration, this could represent the majority of all our experiences here at Lehigh Valley Hospital. We should not concern ourselves with dealing with those whom we do not trust or respect. This is represented in by the schematic below:

AGREEMENT ON GOALS

TRUST	Y	UNDECIDED	N
Y	ALLY		OPPONENT
N	BEDFELLOW		ADVERSARY

III. Conclusions:

My personal feeling is that the text of principles of the hospital and physician interaction which were mutually advanced by TROIKA and Elliot Sussman in the spring of this year was as basic a document to doctor/hospital relationship, as was the Bill of Rights was to our Constitution. This document details some principles which, if adhered to in both spirit and action, would lead to a behavior pattern which could provide an easily identifiable track record of consistency in action, thereby allowing for "predictability", and therefore, ultimately, to trust. This does serve as a double edge sword, however, because, for there to be trust, there must be congruence between words and actions! The principles of physician and hospital relationships are detailed below:

1. LVHN will support a diversity of practice models with multiple choices for physicians.

2. Clinical programs of a multidisciplinary nature (e.g. cardiac care, geriatric care, cancer care) will be highly attractive to patients; we must organize our diverse clinical resources to provide these programs efficiently to our patients.

3. Physicians more involved with LVHN will have more access to LVHN resources.

4. LVHN will seek the advise of its medical staff regarding ways to enhance physician practice and is committed to strengthen existing practices.

5. Faculty appointments are available for all members of LVH medical staff involved in teaching programs.

6. The IPA/PHO and PennCARE embody the principles of cooperation among physicians and hospitals. Unified approaches to managed care contracting afford the opportunity for both better coordination of patient care and better economic outcomes for the partners. Accordingly, the PHO and PennCARE will be the principal managed care contracting entities for the hospital and medical staff.

7. LVPG will not acquire additional practices in surgical or medical subspecialty areas unless:
   - the majority of members of a division seek LVPG association, or
   - community or hospital need not met (e.g. transplantation, genetics).

8. LVPG will not initiate discussions regarding the purchase of primary care practices. When approached by physicians in primary care who are interested in selling their practices, LVPG will evaluate these situations.

9. Physicians & LVH need to focus more on external "competition" and less on internal "competition".

10. Negotiations around issues between LVH and members of its medical staff will be based on constructive, honest exchange focusing on the greater good of our community and the alignment of our mutual interests to achieve this greater good.

During this past year, there have been several small advances in which it seems to indicate that a budding partnership between physician and hospital may be becoming a reality. The Cancer Center issues have been settled, although there is still a perception that physicians may have been "bullied" into this. Recent decisions by the Medical Executive Committee regarding the revocation of staff privileges were supported by the hospital administration and Board of Trustees. Although that these were very painful situations, it was recognized by both physicians and hospital, that these were necessary steps to ultimately serve the best interest of our patients and community. A collaborative effort by hospital administration and healthcare providers, including nursing, has led to the acceptance and advancement of patient centered care. All our early indicators show that this system of providing care has proven to be both efficient and very satisfactory to patient, nurse, and physician, alike.

My current greatest concern, however, revolves around the relationship between the IPA, the PHO, and the hospital. Physicians still feel uninvolved and unempowered in the development of PennCARE and the IDS. While 80% of physicians agree that they would benefit from an established Integrated Delivery System, very few, if any, truly understand how such a system would work. While they do understand that our Integrated Delivery System is bargaining for a larger percent of the premium dollar, there is no indication that the IPA has had an adequate hand in negotiating what proportion of that percentage would be guaranteed to the physician component. In the impending agreements with US Healthcare, Capital Blue and Cross Blue Shield, as well as numerous other managed care organizations which will soon be entering our valley, physicians must perceive that their financial situation will be equitably guaranteed; if not, physicians will see the hospital as leading them by the hand like a dutiful child instead of walking side by side as an equal partner. I feel this will be the most critical issue and the ultimate test of our ability to trust in the next several months.

While the IPA/PHO relationship is critical, there are some additional opportunities to establish a better working relationship between physicians and the hospital. The Functional Plan is the long range development plan of Lehigh Valley Hospital as it enters the new millennium.

Physicians are widely represented on the multiple committees which are designed to implement the various elements of our Functional Plan. TROIKA is currently chairing a number of committees which have been charged to develop the best patient care models for our hospital, our ambulatory care centers, our emergency rooms, and other such facilities. These committees, the membership of which consists of all facets of the providers at Lehigh Valley Hospital, but, in large part, are weighted towards physicians, can help direct the future of our institution towards a mutually common goal, i.e. excellent patient care which is physician friendly and hospital efficient. For it is only in this light, that we will be able to provide the highest quality of care to those which we serve in our community.

Robert X. Murphy, Jr.
President-Elect, Medical Staff

Rxm/bam
trust 3

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