LEHIGH VALLEY HOSPITAL AND HEALTH NETWORK

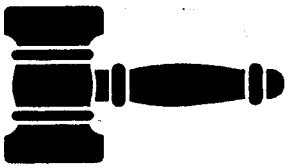
PROGRESS NOTES

Medical Staff

Lehigh Valley Hospital ❁ Muhlenberg Hospital Center

June, 1999 ❁ Volume 11, Number 6

In This Issue . . .



From the President

"It is better to light one small candle than to curse the darkness." -- Confucius

Colleagues:

Another month has passed and spring, with its delightful weather, has arrived. Congratulations to Dr. & Mrs. Robert Murphy, who recently married and are currently enjoying a long-awaited "vacation."

One of Troika's major responsibilities is to represent the interests of the medical staff in our discussions with the hospital's administrative leadership. We want to assure you that this responsibility is taken very seriously, and we spend many hours expostulating important medical staff issues with our hospital's leaders. After talking to medical staff leaders from other institutions, I believe it is fair to say that our hospital administration devotes an extensive and unusual amount of time to discussion with your elected Medical Staff leaders.

Weekly, Troika meets with Drs. Sussman and Laskowski, and Mr. Liebhaber. This is an extremely useful meeting at which time we can address difficult issues openly and can frankly discuss the concerns of the medical staff. In addition, each week we meet with the hospital's Senior Management Council, which is comprised of all the clinical chairs and our hospital's senior management. Bob, Ed, and I meet monthly at the Chairs/Troika meeting. We attend the regularly scheduled Lehigh Valley Health Network Board meetings, as well as the meetings of the Lehigh Valley Hospital and Muhlenberg Hospital Center Boards as full voting members. I have the opportunity to make a

(Continued on Page 2)

(Continued from Page 1)

report to our Network Board at each of these meetings. Bob, Ed, and I also are members of several Board committees including Finance, Community Relations, Executive, and Clinical Case Review. As most of you know, Drs. Sussman and Laskowski and Mrs. Taylor (Chair of the Board of Trustees) are ex-officio members of the Medical Executive Committee. Mr. Liebhaber and Mrs. Kinneman attend this meeting as invited guests. What is important for you to understand is that at all of these meetings the views of the medical staff are sought, heard, and fully discussed.

I feel that we have many and ample opportunities to deliver our message to the hospital administration which listens attentively. It is our job, as your medical staff leadership, to try to build a collaborative relationship with the hospital's administrative leaders. This will allow us to move ahead in a positive way for the betterment of our hospital, its medical staff, our community, and most importantly, the patients we serve.

We, as physicians, have a responsibility to comport ourselves in the hospital in a professional and respectful manner toward our physician colleagues, the nursing and ancillary staff, residents and medical students. We are seen as role models for many groups throughout the hospital. Disrespectful, arrogant or impolitic behavior on our part is a detriment to our professional position and has a tendency to filter down to other members of the organization and become an accepted pattern of behavior. If we want to build an organization that provides the highest quality of care for our patients, we need to depend on the staff to assist us in providing that care. How can we expect staff to help us if we treat them in a disrespectful manner? Would we want our patients to be treated in the same way? Would we want to be treated in such a manner if roles were reversed?

This medical staff has had significant success in shortening hospital length of stay over the past few years. This success is a tribute to the efforts of all of the members of the staff. As all of you know, the incentives for each of us to take these actions are not always aligned with those of the hospital. Shortening length of stay results in lower reimbursement for many of us and more work for other physicians. The hospital administration appreciates our efforts in making this reduction in length of stay possible. Unfortunately, we seem to have learned how to do the same number of laboratory tests, x-ray procedures, scans, etc., into this shortened length of stay. Each time we order a test or procedure, someone has to do this job. Every person who is required to take a patient off the floor is one less person who can provide care for other patients on the floor. Our nursing colleagues tell us that they are often stressed to their limit. Such continued stress results in burnout and a decrease in the quality and compassion of patient care. As I've suggested before in this report, we need to think about ways that we as the "orderers" can reduce the work that the nursing and ancillary staff have to perform for our patients. Are all of the things we do necessary? Is the result of the test or procedure I'm ordering now going to change the way I manage my patient? If not, does it really need to be done? Could what I'm doing for my patient today be done just as well but at a lower cost somewhere else? If so, should the patient still be here in the hospital? We need to all cooperate in learning how we and the administration can collaborate to "take work out of the system." The LVPHO is working to develop a "gainsharing" plan with members of the GLVIPA so that incentives between the hospital and physicians can be better aligned.

For those of you who don't use e-mail regularly at the hospital, I'd suggest again that you **appoint someone from your staff to serve as your "surrogate"** to both read and print out e-mail messages addressed to you.

Remember, the majority of hospitalized patients appreciate when you sit at their bedside, ask them if they have any questions, answer their questions, and make some type of physical contact when you visit them on your daily hospital rounds.

Next month, look for a discussion in this report about the possibility of members of the active and retired medical staff volunteering to provide care for some of the 40,000 working but uninsured in our community.

I hope you all have a great month. By the time you read my next report, it will be summer! To paraphrase Confucius, let's try to look for the light in our lives instead of complaining about the trial and tribulations which we face each day.

David M. Caccese, MD
Medical Staff President

A meeting of the General Medical Staff will be held on Monday, June 14, beginning at 6 p.m., in the Auditorium at Lehigh Valley Hospital, Cedar Crest & I-78. Please plan to attend.

Robert Kricun, MD, Named Chairperson of Radiology

Robert Kricun, MD, was recently appointed as Chairperson of the Department of Radiology/Diagnostic Medical Imaging. Dr. Kricun has been serving as Acting Chairperson of the department since 1997. Prior to that, he was the Vice Chairperson of the Department of Radiology/Diagnostic Medical Imaging, a position he held from 1993 to 1997.

Dr. Kricun received his medical degree from Temple University School of Medicine, and completed a residency in Diagnostic Radiology at Hahnemann Hospital. A member of the medical staff since 1976, Dr. Kricun organized a fellowship program in Radiology in 1979, and served as program director of the fellowship program from 1979 to 1997.

Dr. Kricun is an Associate Professor of Clinical Radiology at Penn State University's College of Medicine and has been actively involved in medical student education. He has authored numerous articles as well as two books, the most recent, "MRI and CT of the Spine: Case Study Approach."

Dr. Kricun is a member of the American College of Radiology, the Pennsylvania Radiology Society, and the Radiological Society of North America, as well as the Lehigh County Medical Society and the Pennsylvania Medical Society.

Good Shepherd Rehabilitation Hospital to Expand Services by Mary Alice Czerwonka

Leaders from Good Shepherd Rehabilitation Hospital (GSRH) and Lehigh Valley Hospital and Health Network (LVHHN) announced May 6 they have signed a letter of intent that will ultimately enable GSRH to expand the scope of rehabilitation services available throughout the region.

The agreement has two parts. First, GSRH will purchase Muhlenberg Rehabilitation Center (MRC) in Bethlehem from LVHHN. Second, GSRH will lease space from Lehigh Valley Hospital (LVH) to establish, own and operate a long-term acute care hospital unit at LVH, Cedar Crest & I-78

According to Elliot J. Sussman, MD, LVHHN President and CEO, "LVHHN and GSRH, organizations with long-standing roots in the Lehigh Valley, share key values of service and high-quality care, and a great deal of mutual respect. We have been working together since last spring to create expanded post-acute health care services that improve the quality of life for the people of our community."

In acquiring MRC, GSRH will now have additional licensed levels of care and the ability to extend its services as a highly regarded, specialized long-term care provider to the Bethlehem area. The acquisition also allows GSRH to offer sub-acute rehabilitation services to the broader Lehigh Valley community -- services that bridge the gap between more intensive acute hospital care and longer-term nursing facility care. MRC will continue to be available as home to its current long-term residents.

"GSRH was already committed to replacing 36 long-term care beds in antiquated space in Allentown, and we had begun exploring options, including new construction, " said Larry Deal, senior vice president of finance at GSRH. "The planned acquisition and renovations of MRC will enable Good Shepherd to replace those beds, add new long-term care beds and add sub-acute beds, all at a cost less than that of new construction only to replace the 36 long-term care beds."

Ronald Macaulay, LVHHN's senior vice president for business development, emphasized that care for MRC's long-term residents will continue uninterrupted throughout the transition to new owners. "Also, we anticipate that MRC employees will continue in their current or substantially similar positions with substantially similar benefits," he said.

The long-term acute care hospital unit that GSRH will own and operate at LVH is the first in the region and is often referred to as a "hospital within a hospital." Typically, patients have just undergone major complicated surgery or are recovering from a very serious illness or injury, and require rehabilitation services and/or continued extensive nursing care. The average time a patient spends in a long-term acute care hospital unit is 25 days. The plan is for the 28-bed service to be located on a vacant unit at LVH, Cedar Crest & I-78, and to welcome admissions from all area and regional hospitals.

"The long-term acute care hospital unit is a highly appropriate level of care for many of our patients who have passed the crisis stage in their recovery," said Mary Kinneman, senior vice president, patient care services. "The availability of that unit will help relieve some of the capacity issues we experience while still maintaining the patient in an appropriate level of care." She emphasized there will be no reductions in staff at LVH as a direct result of the development of the long-term acute care hospital unit by GSRH, since it will be created on a vacant unit.

Muhlenberg Rehabilitation Center became part of Lehigh Valley Hospital and Health Network following the merger of Lehigh Valley Hospital and Muhlenberg Hospital Center in November 1998. GSRH will purchase the rehabilitation center for $6.45 million, when the agreement is finalized no later than September 30, 1999. There is no merger between GSRH and LVHHN as part of this agreement; each organization remains independent of the other.

Cardiologists Take New Approach to Catheterization by Rob Stevens

Cardiologists at Lehigh Valley Hospital recently added a new approach to heart catheterization. Bryan Kluck, DO, Division of Cardiology, has begun placing a cardiac catheter into some patients' hearts through the wrist, or radial artery, making it more comfortable for them and, in some cases, decreasing how long they stay in the hospital. The traditional insertion site for this procedure has been the groin, or femoral artery.

Catheterization and angioplasty patients, who have back problems, obstructive lung conditions or groin arteries that are diseased or scarred from previous procedures, will benefit the most from the "transradial" cardiac procedures, according to Dr. Kluck.

"Instead of having to lie on their backs for up to eight hours after the procedure, which can be uncomfortable or painful for these patients, they sit comfortably during the recovery period, which is also much shorter," Dr. Kluck explained.

Patients who undergo the conventional catheterization or angioplasty must lie still to prevent bleeding at the insertion site. Transradial catheterization and angioplasty patients only require a pressure dressing on the wrist for 30-60 minutes following their procedure.

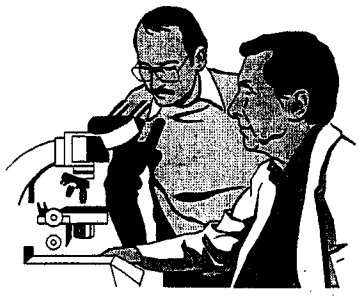
"Men seem to be the best candidates for the new approach, because their radial arteries are larger than women's," Dr. Kluck said. "And, while the patient still must lie still during the procedure, that's the only time he's flat on his back in the catheterization lab."

"This new approach can be more convenient and comfortable for patients, and may also reduce costs to the hospital, particularly if the angioplasty patient can go home the same day as the procedure," Dr. Kluck added. "Furthermore," he continued, "In all likelihood, we'll soon be able to offer the transradial option to many of the patients we treat in the cath lab."

Dr. Kluck learned the transradial technique in April from Gerard Barbeau, MD, chief of cardiology at Laval Hospital in Quebec, Canada. Dr. Barbeau claims 98 percent of all catheterizations and angioplasties performed in Quebec are transradial procedures.

"This technique has helped Laval Hospital significantly lower their expenses for cardiac care," Dr. Kluck reported.

Colorectal Cancer Screening Initiative



Over the past few months, several members of the Medical Staff have been involved with the development of a valley-wide colorectal screening initiative. Medical Staff members include: **Charles M. Brooks, MD**, Division of Gastroenterology; **David M. Caccese, MD**, Medical Staff President; **Carl F. D'Angelo, MD**, Chief, Division of Gastroenterology; **Gregory R. Harper, MD, PhD**, Director, John and Dorothy Morgan Cancer Center; **William L. Miller, MD**, Chairperson, Department of Family Practice; **John D. Nuschke, MD**, Division of General Internal Medicine/Geriatrics; **Lester Rosen, MD**, Associate Chief, Division of Colon/Rectal Surgery; and **Michael H. Ufberg, MD**, Division of Gastroenterology. This initiative was started by the Allentown Health Bureau, and in addition to our Lehigh Valley Hospital colleagues, involves input from physicians on staff at all the Lehigh Valley hospitals and representatives from their respective organizations. The goal of this collaborative effort is to develop a mechanism to increase awareness and appropriate utilization of current colorectal screening procedures. Recent studies have suggested that increased utilization of these screening procedures will lead to a better outcome for patients who are diagnosed with early colorectal cancers.

In an attempt to promote patient awareness regarding the importance of appropriate colorectal screening procedures, the Allentown Health Bureau, in conjunction with local media and hospitals, will coordinate a media campaign later this summer. The purpose of this article is to inform physicians of the upcoming media campaign and to make them aware of the possible impact on their practices. It is hoped that the educational process will stimulate patients to seek appropriate hemoccult testing, sigmoidoscopic evaluations, and/or colonoscopic evaluations.

Without a doubt, this cooperative effort between the major institutions in the Lehigh Valley and the physicians involved with colorectal cancer screening and detection will lead to an overall improvement of health in our community.

For more information regarding this issue, contact MaryEllen Shiels, Manager, Cancer Prevention Program, Allentown Health Bureau, (610) 437-7513 or (610) 437-7660.

Violence: A Public Health Issue

y Sarah L. Stevens, MD, MPH, Adolescent Medicine Physician, Division of General Internal Medicine

The recent shootings in Littleton, Colo., and Conyers, Ga., have been grim and tragic reminders about the issue of violence in our society. Violence is a major public health issue that should concern us all, not only as parents, but also as members of our community. Although this may at first seem to be an overwhelming problem, we must become knowledgeable about the issues and be prepared to address them with our patients.

In the United States, adolescents are the most likely age group to be victims of violence as well as having the highest arrest record as perpetrators of violent crimes. Intentional and unintentional injuries (motor vehicle crashes, homicide and suicide) account for 73% of all adolescent deaths in the U.S. Violence is not just an inner-city gang problem. Most violent injuries and deaths occur at the hands of a friend or family member. Among female adolescent homicide victims, the perpetrator is most often a boyfriend.

Violent behavior among adolescents is a multifactorial problem. The most significant factor that puts teens at risk for violence is poverty. Other factors include: dropping out of school, poor schools, absence of a strong, consistent emotional tie with a caring adult (such as a parent), isolation from peers, association with violent peers or gangs, drug and alcohol use, low self-esteem and depression, authoritarian, abusive parents, and exposure to violence in early childhood. Exposure to media violence has been demonstrated in over 1,000 studies to be related to violent and aggressive behavior in children. There are approximately 5-12 violent acts per hour of prime-time television, and by age 18, the average U.S. child is exposed to 200,000 acts of television violence. Television, movies and video games portray graphic violent acts, particularly violent acts against women. The media portrays violence as being an acceptable, effective solution to conflicts and problems, without a need for negotiation or compromise. Perpetrators are portrayed as being powerful, exciting, charismatic and desirable and rarely are the negative physical and psychological consequences of violence portrayed. Cartoons show violent acts more frequently than other programs, in a humorous context and with the fewest consequences. Who can forget the Road Runner, who was run over and blown up so many times, only to come back to life, as good as new, for another round?

Firearms, particularly handguns, are involved in over 80% of teen homicides and over 50% of teen suicides. It is estimated that 43% of U.S. homes have one or more handguns, and 30% of gun owners with children keep a loaded gun in the home, giving 9 million teens access to handguns in the home. Between 11% and 48% of teens *own their own guns*. Although many gun owners report "self defense at home" as the primary reason for owning a gun, those who attempt to use a gun in self-defense are actually seven times more likely to be shot at than victims who did not use a gun. Suicide is the most common firearm-related death in the home, and unloading and locking firearms does not prevent teen deaths.

Data from the 1997 Youth Risk Behavior Surveillance System survey, a national, school based survey of 9th - 12th graders, included:

- 18% had carried a weapon (gun, knife or club) to school in the preceding 30 days
- 37% had been in a physical fight at least once in the preceding 12 months
- 4% had been treated by a doctor or nurse for injuries sustained in a physical fight in the preceding 12 months
- 7% had been threatened or injured with a weapon on school property at least once during the preceding 12 months
- 21% had seriously considered attempting suicide during the preceding 12 months
- 8% had attempted suicide at least once during the preceding 12 months

Developmentally, adolescents are at particular risk to be perpetrators and victims of violence. Adolescence is a time of transition. Emancipation from the family unit and establishment of an individual identity is an important process, which involves testing limits, questioning authority, experimenting and taking some risks. Early adolescents begin to identify more with their peer group than with their families. A sense of invincibility alternates with feelings of insecurity. Magical thinking results in the perception of being unique, special and able to escape the harm that others experience. Early adolescents are concrete thinkers with limited capacity for abstract reasoning, which, when better developed, helps them to imagine the possible consequences of an action or behavior that they haven't experienced yet. Adolescents tend to exhibit some narcissistic and paranoid thinking and tend to be impulsive and have trouble with delayed gratification. Contrary to popular belief, adolescence is not an inherently tumultuous period of life and most adolescents (80%) make it through this transition without significant problems.

What is our role as health care providers in violence prevention? First, we must understand that whenever we see an adolescent in our office, in the hospital or in the emergency department, we should seize the opportunity to assess that individual's risk for violence. Second, we should remember that troubled teens may present with seemingly unrelated problems when they are, in fact, looking for help with a

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(Continued from Page 5)

psychological or social problem. In one study, 50% of adolescents who committed suicide had seen a health care provider for an unrelated problem in the month prior to the suicide.

The most important part of most adolescent encounters is the psychosocial assessment. This includes asking about current living situation and family relationships, school performance, school attendance or other school problems, peer relationships and connectedness, substance use by peers, family and self, feelings of sadness or hopelessness, and a history of partner violence (both sexes). In particular, we can ask specifically about weapon-carrying, violence that has been witnessed by the teen, what makes the teen mad enough to fight, and whether the teen feels safe at home, at school and in the neighborhood.

When time is limited, as is all too frequent these days, we should consider the following screening questions that will help identify at-risk teens:

- *"How is school going?"* - poor school performance, dropping out or expulsion are red flags for low self-esteem, depression, substance use and other violence-related activities
- *"What do you want to do when you grow up?"* - teens who feel hopeless and who are not expecting to live long enough to make a plan for the future may be at particular risk for violence
- *"What do people in your family do when they're angry?"* and *"Have you seen much violence at home, in school, or in the neighborhood?"*

What can we do when we identify youth at risk for violence?

- Provide appropriate referrals for the underlying problems (poor school performance, depression, etc.)
- Help adolescents think through the consequences of their actions (i.e., gun-carrying, fighting, drinking and driving, etc.)
- Help adolescents come up with alternatives (i.e., walk away from a conflict)
- Help adolescents identify and negotiate for support from a parent or other trusted adult

School's Out
Watch that Child!

Expanding the Post-Acute Continuum of Care

In response to the need to discharge patients sooner from the acute, general hospital setting, it is critical that they receive post-acute services that are best suited to their continuing treatment needs. At the request of the Department of Medicine, Division Chiefs, and discharge planners, an easy-to-read grid was created to help you determine which setting is most appropriate for your patients. This grid, which is located on Page 17, was jointly developed by physicians and administrators from Lehigh Valley Hospital (LVH) and Good Shepherd Rehabilitation Hospital (GSRH).

While most of you are familiar with the TSU and GSRH, many are not familiar with Muhlenberg Rehabilitation Center (MRC). MRC is essentially a skilled nursing facility (SNF) currently providing skilled nursing and rehabilitation services for our patients, some of whom reside in Bethlehem. The major difference between GSRH and MRC is intensity of rehabilitation services and physician services. **Physician CPT billing codes at GSRH are the same as in acute care, while those at MRC are the same as in the TSU, Nursing Facility CPT billing codes.** Although MRC is currently owned and operated by LVH, a letter of intent was recently signed which will transfer ownership to GSRH sometime in the near future once the details of the transfer have been agreed upon.

The LTACH is a totally new level of care to the Lehigh Valley and was created to serve the needs of complicated patients who no longer require extensive work-ups, but do require intensive nursing support (e.g., ventilator patients, prolonged recovery from complicated surgeries, CNS patients with prolonged recovery, etc.). The average length of stay for these patients is 25 days. Because reimbursement for this service is capped, close daily management is essential. **Physician billing CPT codes are the same ones you use in acute care.** By law, the LTACH cannot be owned and operated by Lehigh Valley Hospital. It, too, will be owned and operated by GSRH. It will have 28 beds and is currently scheduled to open in January 2000.

Both LVH and GSRH embrace the vision of care management extending into the post acute continuum of care. By working together, it will be possible to provide the flexibility needed to manage our patients in the appropriate setting. Not only will patient outcomes be optimal, efficiencies will be realized as well.

At the June 14 General Medical Staff meeting, Jane Dorval, MD, Chief, Division of Physical Medicine/Rehabilitation, will make a presentation regarding this important development in the continuum of care for our patients. If you have any questions or concerns regarding this issue prior to the meeting, please contact Dr. Dorval at (610) 776-3340 or by e-mail at jdorval@gsrh.org.

Care Management Council to Coordinate Work of LVPHO and LVH by Mary DeHaven

A Care Management Council has been established at Lehigh Valley Hospital, combining the efforts of the hospital's care management systems and patient care departments with the Lehigh Valley Physician Hospital Organization (LVPHO), the regional health care management and delivery organization formed five years ago by Lehigh Valley Hospital and the Greater Lehigh Valley Independent Practice Association (GLVIPA). The care management process collects and analyzes data about patient care, creates clinical pathways, protocols and guidelines, and then communicates that data to physicians and LVH staff to ensure that patients receive quality care at a reasonable cost.

"It takes both doctors and hospitals to make care management work," said Gregory Kile, LVPHO executive director. "Unless we all work together, our future will be threatened because payers -- from managed care companies to Medicare -- are tightening their purse strings."

"Eighty percent of medical costs are determined by the stroke of doctors' pens," said John Jaffe, MD, executive medical director, LVPHO. "When it came to care management, the LVPHO had physician support, the energy and the ideas, but not the resources. The hospital had the resources but not the complete buy-in of the providers of the care. This structure will ensure physician involvement."

Traditionally, doctors have not been particularly concerned about costs," Dr. Jaffe said. "Their focus has been solely on the patient. Despite this, however, most physicians have supported the hospital's efforts in clinical operations improvement."

"It's amazing what doctors have already done to reduce health care costs, such as reducing length of stay," Dr. Jaffe said. "This often has resulted in a loss of income to them because of the way the reimbursement system compensates physicians."

With the increase of managed care, however, incentives are changing as controlling costs become a higher priority for insurers.

Representing its physician members, LVPHO will play a leadership role in the Care Management Council, serving as the center for all the care management responsibilities. This structure will give physicians a stronger voice in the care management decision-making process. A new LVPHO Care Management Committee will assist the council through educational measures, such as clinical pathways and protocols, as well as provide feedback to the council. Its members will represent the GLVIPA.

PennCARE℠ Names New Executive Medical Director

Kenneth D. Coburn, MD, MPH, of Elkins Park, Pa., recently joined PennCARE as its senior vice president/executive medical director/chief quality officer of the PennCARE health care system. He replaces Louis I. Hochheiser, MD, who left the organization in February.

Dr. Coburn most recently was associate medical director with the office of disease management at the University of Pennsylvania Health System. Prior to that, he was medical director of quality improvement at Health Partners in Philadelphia, and director of the AIDS Center at Montefiore Medical Center in the Bronx.

As PennCARE's senior physician executive, Dr. Coburn has responsibility for the design, development and integration of high-quality, cost-effective clinical programs throughout the network, with a particular focus on clinical quality improvement, outcomes management, care management and evaluation.

PennCARE, established in 1995, is an integrated health care delivery system comprising 11 hospitals and their medical staffs: Abington Memorial Hospital, Doylestown Hospital, Easton Hospital, Gnaden Huetten Memorial Hospital, Grand View Hospital, Hazleton General Hospital, Hazleton-St. Joseph Medical Center, Lehigh Valley Hospital, Muhlenberg Hospital Center, North Penn Hospital and Pocono Medical Center. The network was formed to negotiate managed care arrangements and facilitate the provision of medical services to patients by its health care provider members.

"This is a very committed group of people, moving their organizations to achieve the goal of improving the community's health," Dr. Coburn said.

Dr. Coburn received his doctor of medicine and a master's in public health from Columbia University, and completed his residency at Columbia-Presbyterian Medical Center, and a fellowship in infectious diseases at Montefiore Medical Center, both in New York.

Last Call to All Hospital Staff

The Department of Health Studies is finalizing the 1997-1998 LVH Staff Publications Yearbook. If you had any peer-reviewed publications (journal articles, editorials, case studies, book chapters, letters) published in 1998 (1997 is already compiled), please provide either a reprint (preferred) or a clean, clear copy of the publication and mail it **no later than June 15** to: Bernadette Glenn, Editor, Health Studies, Moyer House, 17th & Chew. Please make sure the name of the journal and date of publication are visible on the copy if you don't have reprints available. If you have any questions, please contact Bernadette Glenn through e-mail or by telephone at (610) 402-2529.

Transfusion Medicine

The FDA has recently alerted the medical community to the possibility that patients who receive blood transfusions through a bedside leukocyte reduction filter may experience a precipitous drop in blood pressure.

This reaction has a rapid onset (within one hour of transfusion). Some patients may also experience respiratory distress, facial flushing, abdominal pain, and shock with loss of consciousness. In most situations, the reactions resolve when the transfusion is discontinued and when appropriate medical intervention is performed, i.e., follow the protocol Transfusion Reaction Form #Lab-22.

A summary of the FDA's letter is as follows:

- Since 1994, 80 reports of patients developing a significant hypotensive episode have been received. These are more common with platelet transfusions. These 80 are from a total of 20 million transfusions using bedside leukocyte reduction filters. The two hypotheses of the cause are as follows:
  1. Concomitant ACE inhibitor therapy retards the degradation of brandykinin (a potent vasodilator), yet the reactions are also experienced by patients who are not receiving ACE inhibitor.
  2. Negatively charged membranes used in filters activate factor XII (Hageman Factor) which triggers a production of brandykinin. However, there have also been adverse events reported with the use of positively charged filters.

If you have any questions regarding this issue, please contact Bala B. Carver, MD, Medical Director of Transfusion Medicine, at (610) 402-8142 or pager 3433.

LOVAR Study Update

Those of you who attended the March 9 Medical Grand Rounds will recall that stroke and MI are the leading causes of death and disability in the U.S. and their economic impact is estimated at $300 billion annually. In the Lehigh Valley, these illnesses are the primary reason for inpatient admissions. Lehigh Valley Hospital ranks among the top 10 hospitals for stroke admissions nationally and among the top five hospitals in Pennsylvania for open heart surgery admissions. Many of the risk factors are highly prevalent in the Lehigh Valley and are above state and national averages.

The LOVAR *(Lowering of Vascular Atherosclerotic Risk)* Study is a grassroots initiative to help physicians help their patients make important life-saving lifestyle changes. **John E. Castaldo, MD**, Director, Neurosciences Research at Lehigh Valley Hospital, and Associate Professor of Clinical Medicine at Penn State University, is the Principal Investigator for LOVAR. Jane Nester, MPH, MEd, Director of the Center for Health Promotion & Disease Prevention, is the Co-Principal investigator. LOVAR is funded primarily by a grant from the Dorothy Rider Pool Health Care Trust. Through this collaboration of medicine and public health, LOVAR will contribute toward improving the health status of our community.

To accomplish this, the support of LVH physicians is needed in the form of patient referrals to the study. Patients who meet the criteria, which can be found on Page 9, are eligible for LOVAR. Please review this criteria and call (610) 402-4088 to refer patients to LOVAR. The referral process is simple and brief: all that is needed is the name and medical record number (or social security number and birthdate) of the patient.

LOVAR physicians and nurses work closely with the patient's primary care and referring physician's office in the management of cardio-cerebro-peripheral vascular disease (CCPVD) patients to complement the physician's care, not replace it. Primary care and referring physicians will be informed of the patient's progress throughout the study. Patients are encouraged to maintain regular appointments and follow-up with their usual physicians.

Detailed brochures about the LOVAR study, complete with inclusion/exclusion criteria pocket reference cards, are available by calling the LOVAR office. Call (610) 402-4088 with questions, to refer patients and for brochure copies.

News from MHC Nuclear Medicine

The Nuclear Medicine Department of Muhlenberg Hospital Center is pleased to announce the institution of the dual isotope method for myocardial perfusion imaging. This method uses Thallium-201 *and* Technetium-99m Sestamibi for rest and stress imaging, respectively. It offers significant advantages over other methods and is widely accepted at many respected centers nationwide as the "standard of care."

Advantages include a greatly shortened exam time (one and one-half hours vs. up to five hours or more for other methods), increased patient and physician satisfaction, greater ease in scheduling, increased number of exams per day (reduces delays), and allows for GATED SPECT imaging for assessment of left ventricular function.

If you have any questions, please contact Gregg D. Schubach, MD, Associate Chief, Division of Nuclear Medicine (MHC), at (610) 861-2232.

Inclusion/Exclusion Criteria for Enrollment in the LOVAR Study

Inclusion Criteria

The answers for these items must be YES to qualify for the study.

YES	NO	
		1. Age 39-79 years, inclusive
		2. Symptoms of atherosclerotic vascular occlusive disease of cardiac, cerebral or peripheral circulatory beds. Entry must be within 6 months of symptoms or event.
		3. Vascular symptoms qualifying for entry cannot be attributable to anything other than atherosclerotic disease.
		4. Patient must have at least two (2) identifiable treatable risk factors for atherosclerotic disease.
		5a Patients selected to participate in the control group of the study must be willing to sign informed consent and participate in a series of visits for collection of information about their health status.
		5b Patients selected to participate in the intervention group of the study must be willing to sign informed consent, agree to participate in aggressive monitoring and treatment of atherosclerotic risk and participate in a series of visits for collection of information about their health status.

Exclusion Criteria

The answers for these items must be NO to qualify for the study.

YES	NO	
		1. Medical condition which prevents aggressive treatment of underlying atherosclerotic disease, including engaging in active exercise program.
		2. History of schizoaffective disorder or mental illness which would interfere with compliance in the study.
		3. History of poorly controlled seizure disorder defined as experiencing generalized tonic clonic seizures on the average of > 4 per year
		4. History of condition which might interfere with the identification of neurologic or cardiac vascular endpoints such as multiple sclerosis, encephalopathy, migraine with neurologic accompaniments, fibromyalgia, costochondritis or somatoform disorder.
		5. History of documented or suspected systemic or CNS vasculitis.
		6. Any condition which makes five-year longevity unlikely including systemic metastatic cancer refractory to treatment, end stage liver, heart, lung or renal disease.
		7. Patient involved with experimental protocol that may interfere with the integrity of outcome research in vascular disease.
		8. Living in an area too distant to comply with frequent follow-up needed for the study.
		9. CE for stenosis that is felt to be the cause of TIA/stroke as qualifying event.
		10. Iatrogenic stroke from procedure such as arteriography, cardiac cath, CE or OHS.
		11. Chronic atrial fibrillation.
		12. Use of illicit drugs such as cocaine or amphetamines.
		13. Use of prescription drugs in the class of monoamine oxidase (MAO) inhibitors.
		14. Use of planned Coumadin therapy for > 6 months.
		15. Alcohol abuse or alcoholism.

Lanier Access for Dictated Radiology Reports

The instructions to access the Lanier system for dictated Radiology reports at Lehigh Valley Hospital were recently revised as follows:

- Dial one of the following numbers – (610) 402-5631 or (610) 402-5632
- Press "#" and "1"
- Enter your four-digit physician number preceded by a "50" if you are a staff physician, or "48" if you are a resident
- Enter the transcription destination code:
  - "1" for Radiology transcription
  - "2" for LVDI transcription
  - "3" for LMIC transcription
- To review the dictated report using the medical record number, press "3" followed by:
  - For six digit medical record numbers – press six zeroes and the six digit medical record number
  - For seven digit medical record numbers – press five zeroes and the seven digit medical record number
  - For eight digit medical record numbers – press four zeroes and the eight digit medical record number
- The system will start with the most recent dictation. Press "5" to go to the next dictation on the same patient.

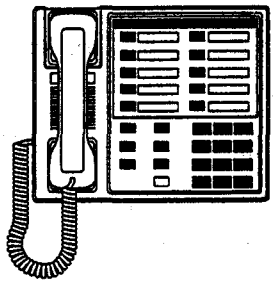
PLEASE NOTE: Due to space constraints, voice reports are only held on the Lanier system for approximately five days.

If you have any questions regarding this issue, please contact Valerie Hunsicker, Operations Coordinator, Radiology Department, at (610) 402-0393.

Nutrition Subcommittee Update

The revised Doctor's Order Sheet for Enteral Nutrition Orders is now available (see attached form # DO-120-1 found on Page 18). This form was revised to be utilized on all units. Previously this form was only used in the critical care units. All initial enteral nutrition orders should be written on this form. The form can be used for either intermittent or continuous feedings, and includes standard monitoring orders and an order for a dietitian assessment. The physician checks the box for the amount of residual that would require holding the tube feeding. Orders for standard lab values were not included on the form to encourage cost effective use of lab monitoring. These forms should be available on all nursing units and can be ordered from Consolidated Graphics.

The new Enteral Nutrition Formulary cards are now available and include all the approved enteral nutrition products for Lehigh Valley Hospital and Muhlenberg Hospital Center. Nutritional information is provided for all products and includes a key that designates those products that are more cost effective. Actual pricing could not be printed due to contract obligations. Indications for Use of Specialized Immune-Enhancing Enteral Nutrition Products are included on the card. A listing of the Registered Dietitians who work at Lehigh Valley Hospital and Muhlenberg Hospital Center, along with their floor responsibilities and pager numbers, is also included. Cards will be distributed to all the resident mailboxes. Physicians who wish to receive an updated card should contact the Clinical Nutrition office at (610) 402-8313.



Mandatory 10-Digit Dialing Begins June 5

In December of 1998, Bell Atlantic activated two new area codes in the 610/215 area – 267 and 484. The 267 area code will share the same boundaries as the 215 area code; the 484 area code will share the same boundaries as the 610 area code. In preparation for the introduction of the overlay area codes and mandatory 10 digit dialing within the 215 and 610 area codes, a six-month permissive dialing period began on December 5, 1998. **Beginning June 5, 1999, it will become mandatory to use the 10-digit dialing plan.**

On February 8, the hospital's telephone system dialing plan at Lehigh Valley Hospital (LVH) and Muhlenberg Hospital Center (MHC) changed over to the 10 digit dialing plan. Since that time, individuals have been able to dial using both the 7 digit and the 10 digit dialing plans.

Sometime between now and June 5, you will need to re-program all local numbers that are programmed in speed call lists, fax machines, dial up modems, call forwarding, auto dial keys, and any other devices that dial out to a local number. **Please remember, after June 5, you will not be able to place a call using the 7-digit dialing plan.**

Following is the 10-digit dialing plan for the hospital network:

- To place a local call, dial 99 + Area Code + 7 digit number.
- To place a long distance call, dial 99 + 1 + Area Code + 7 digit number.
- To place a call within the hospital's network (from LVH to MHC or from MHC to LVH), dial 98 + 3 digit exchange + 4 digit extension. (Examples: 98 + 861 + 2200 or 98 + 402 + 8001)

If you have any questions regarding this issue, please contact Ann Schneck, Telecommunications Manager, at (610) 402-1802.

"Express Select" Coming to Cedar Crest & I-78

Beginning in August, patients at Cedar Crest & I-78 will be treated to "Express Select," a restaurant-style service, right in their own rooms. A host or hostess will read the menu to the patient, answer questions about the food, work with the patient on diet restrictions, as well as serve the meals and pick up the tray. Through "Express Select," the host or hostess gets to know the patient's likes and dislikes, and it builds a bridge to communication between health care professionals and food and nutrition services so they can meet all the patient's needs.

With this new service, patients no longer have to order meals days in advance or strain their eyes to read the fine print on the menus.

"We have gotten rave reviews at 17th & Chew since we started the program in October of 1998," said Paul Fite, General Manager of Food and Nutrition Services. "We have seen significant improvement in patient satisfaction. Implementing the program at Cedar Crest & I-78 is the next logical step in our continuing efforts to improve satisfaction."

If you have any questions regarding "Express Select," please call Paul Fite in Food and Nutrition Services at (610) 402-8314.

Congratulations!

John P. Fitzgibbons, MD, Chairperson, Department of Medicine, has been elected as a Councillor of the Association of Program Directors in Internal Medicine. He was also appointed Chair of the Public Policy Committee of the same organization.

Michael S. Weinstock, MD, Chairperson, Department of Emergency Medicine, has been appointed to a three-year term on the Board of Trustees of the Emergency Medicine Foundation (EMF). The EMF is a national organization that works closely with the American College of Emergency Physicians that directly supports grants for education and research in the field of emergency medicine.

Papers, Publications and Presentations

Bala B. Carver, MD, Medical Director, Transfusion Medicine & HLA Lab, organized, hosted, and served as a moderator at the American Society for Histocompatibility – Eastern Regional meeting which was held at the Allentown Hilton from May 5 to 7. The meeting, which included topics such as HLA – Past, Present and Future; Bone Marrow and Cell Transplantation; and Pre Transplant Antibody Screening – Science or Art, was attended by almost 100 participants from as far as San Francisco, Calif., and Puerto Rico.

Mark A. Gittleman, MD, Division of General Surgery, was an invited speaker at the spring meeting of the American College of Surgeons, held April 26 to 28, in New York City. At this meeting, Dr. Gittleman gave a lecture on Breast Ultrasound at the post-graduate course for "General Ultrasound for Surgeons." In addition, Dr. Gittleman served on the faculty for the hands-on training in Breast Ultrasound and Stereotactic Breast Biopsy in the post-graduate image-guided biopsy course.

In addition, Dr. Gittleman presented a seminar on "Stereotactic Breast Biopsy" on April 10, at the Chadwick Medical Center in Worcester, Mass.

Peter A. Keblish, MD, Chief, Division of Orthopedic Surgery, was the invited guest speaker at the SICOT (Societe Internationale de Chirugie Orthopedique et de Traumatologie) in Sydney, Australia. Dr. Keblish spoke on "Simplified Approach to Revision Total Knee Arthroplasty." He also served as moderator for sessions on various aspects of total and partial knee replacement arthroplasty. Additionally, he moderated a Learning Center on Mobile Bearing Total Knee at the University of Western Austrailia in Perth, Australia. The sessions included cadaver dissections for demonstrating surgical approaches to the knee and hip related to total joint replacement.

Dr. Keblish was also the Grand Round speaker at Emory University and the Atlanta Orthopaedic Society. His topics were "Mobile Bearing Knee Arthroplasty, The Newest Innovation in Knee Replacements." He also assisted in surgical cases of mobile bearing knee surgery at DeKalb Medical Center, a major teaching center of Emory.

Glen L. Oliver, MD, Chief, Division of Ophthalmology, presented a case report of idiopathic sclerochoroidal calcification at the recent ophthalmology-oncology meeting at Wills Eye Hospital, Philadelphia, on May 6. The presentation included a review of the literature on idiopathic sclerochoroidal calcification and emphasized the importance of recognizing this syndrome and differentiating it from other intraocular tumors.

(Continued on Page 12)

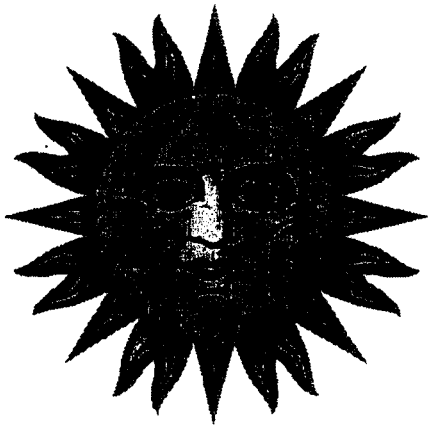
(Continued from Page 11)

In addition, Dr. Oliver and **Masayuki Kazahaya, MD**, Division of Ophthalmology, presented a poster at the annual International Ophthalmologic Oncology meeting at Wills Eye Hospital titled "IRVAN (Idiopathic Retinal Vasculitis with Aneurysms and Neuroretinitis) Syndrome." The poster presented the clinical features of IRVAN syndrome and emphasized its differentiation from intraocular leukemia, lymphoma and other causes of intraocular inflammation and hemorrhage.

Francis A. Salerno, MD, Chief, Division of Geriatrics, was a moderator and guest speaker on the topic, "The 20 Minute Office Visit – What's Working and Why," for the American Geriatric Society that was held at the Marriott Conference Center in Philadelphia from May 19 to 23.

Howard S. Selden, DDS, Division of Endodontics, authored a paper, "Endo-Antral Syndrome and Various Complications," which was published in the May issue of the ***Journal of Endodontics***.

Peggy E. Showalter, MD, Department of Psychiatry, authored "Divalproex for Agitated and Aggressive Brain Injury Symptoms," which she presented as a poster presentation at the annual meeting of the American Psychiatric Association, held in May in Washington, DC.



Have a Safe and Happy Summer!

Upcoming Seminars, Conferences and Meetings

Medical Grand Rounds

Medical Grand Rounds are held every Tuesday beginning at Noon in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78.

Topics to be discussed in June include:

- June 1 – Managing the Alzheimer's Patient – Beginning to End Including Caregivers
- June 8 – Chloride Channel Disorders from Bench to Bedside

There will be no Grand Rounds during the summer; however, Medical Grand Rounds will resume on Tuesday, September 7. Have a wonderful summer!

For more information, please contact Evalene Patten in the Department of Medicine at (610) 402-1649.

Department of Pediatrics

Department of Pediatrics conferences are held on Fridays beginning at Noon in the Auditorium of Lehigh Valley Hospital, 17th & Chew.

Topics to be discussed in June include:

- June 11 – Case Presentation of Young Lady with Abnormal Genitalia
- June 25 – Hypertension in Children: Recognition, Evaluation and Principles of Management

Noon conferences will resume in September.

For more information, please contact Kelli Ripperger in the Department of Pediatrics at (610) 402-2540.

Who's New

Medical Staff Appointments

Orest Balytsky, DMD
Easton Endodontic Associates
1714 Washington Blvd.
Easton, PA 18042
(610) 258-4379
Fax: (610) 258-3145
Department of Dentistry

Division of Endodontics
Provisional Active
Site of Privileges: MHC

Christine E. Hinke, MD
Coordinated Health Systems
2775 Schoenersville Road
Bethlehem, PA 18017-7326
(610) 861-8080
Fax: (610) 861-2989
Department of Medicine

Division of Physical Medicine/Rehabilitation
Provisional Active
Site of Privileges: MHC

Appointment to Medical Staff Leadership Position

Jane Dorval, MD
Chief, Division of Physical Medicine/Rehabilitation including MHC

Change of Practice Name

Robert A. Barnes, DO
East Penn Medical Practice, Inc.
1040 Chestnut Street
Emmaus, PA 18049-1998
(610) 967-4830
Fax: (610) 965-7737
(No longer associated with Health Care Associates, PC)

Status Change

Linda P. Augelli-Hodor, DO
Bethlehem Steel Family Health Center
Department of Medicine
Division of General Internal Medicine
Site of Privileges: LVH & MHC
From: Active To: Affiliate

Francis J. Cinelli, DO
Bangor Medical Center
partment of Family Practice
ite of Privileges: LVH & MHC
From: Affiliate To: Emeritus Affiliate

Frank DeFrank, MD
Bethlehem Steel Family Health Center
Department of Family Practice
Site of Privileges: LVH & MHC
From: Provisional Active To: Provisional Affiliate

John P. Galgon, MD
Pulmonary Associates
Department of Medicine
Division of Pulmonary
Site of Privileges: LVH & MHC
From: Active To: Emeritus Active

Joseph W. Gastinger, MD
Lehigh Valley Internists
Department of Medicine
Division of General Internal Medicine
From: Active To: Honorary

Lauro S. Geronimo, MD
Willow Park Medical Group
Department of Family Practice
Site of Privileges: LVH & MHC
From: Active To: Emeritus Active

David J. Hacket, DO
Department of Family Practice
Site of Privileges: LVH & MHC
From: Affiliate To: Emeritus Affiliate

Carol A. Hunter, MD
Bethlehem Steel Family Health Center
Department of Family Practice
Site of Privileges: LVH & MHC
From: Active To: Affiliate

John E. Kenvin, MD
Department of Pediatrics
Division of General Pediatrics
From: Emeritus Associate To: Honorary

Theodore J. Kowalyshyn, MD
Bethlehem Steel Family Health Center
Department of Medicine
Division of General Internal Medicine
Site of Privileges: LVH & MHC
From: Active To: Affiliate

Francis A. Lovecchio, MD
Pocono Orthopaedic Consultants
Department of Surgery
Division of Orthopedic Surgery
Site of Privileges: MHC
From: Associate To: Emeritus Associate

John C. Lychak, MD
Department of Psychiatry
Site of Privileges: MHC
From: Associate To: Emeritus Associate

James R. Regan, MD
Department of Medicine
Division of General Internal Medicine
Site of Privileges: LVH & MHC
From: Active To: Emeritus Active

William O. Sloyer, DMD
Department of Dentistry
Division of General Dentistry
Site of Privileges: LVH & MHC
From: Associate To: Emeritus Associate

Christopher M. Snyder, DO
Bethlehem Steel Family Health Center
Department of Medicine
Division of General Internal Medicine
Site of Privileges: LVH & MHC
From: Associate To: Affiliate

Robert Sutton, DDS
Department of Dentistry
Division of General Dentistry
Site of Privileges: LVH & MHC
From: Associate To: Emeritus Associate

James Turner, DDS
Department of Dentistry
Division of General Dentistry
Site of Privileges: LVH & MHC
From: Provisional Associate To: Provisional Emeritus Associate

Donald E. Willard, MD
Department of Surgery
Division of Ophthalmology
Site of Privileges: MHC
From: Active To: Emeritus Active

Stewart G. Wolf, MD
Department of Medicine
Division of General Internal Medicine
Site of Privileges: LVH & MHC
From: Associate To: Emeritus Associate

Richard C. Zahm, DDS
Department of Surgery
Division of Oral & Maxillofacial Surgery
Site of Privileges: MHC
From: Associate To: Emeritus Associate

Leave of Absence

Christopher Dankmyer, MD
Department of Medicine
Division of Physical Medicine/Rehabilitation
Site of Privileges: MHC
From: Provisional Active
To: Provisional Active/LOA
One-year Leave of Absence

Paul Guillard, MD
Department of Medicine
Division of General Internal Medicine
Site of Privileges: LVH & MHC
Additional One-year Leave of Absence

Resignations

Ramon T. Arreola, DMD
Department of Dentistry
Division of General Dentistry
Associate

Janice H. Axelrod, MD
Department of Obstetrics and Gynecology
Division of Gynecology
Section of Gynecologic Oncology
Provisional Affiliate

Joseph E. Bartos, MD
Linden Street Medical Practice
Department of Family Practice
Active

J. Brent Bond, MD
Lehigh Valley Ophthalmic Associates
Department of Surgery
Division of Ophthalmology
Active

Edmond Chow, DMD
Department of Dentistry
Division of Endodontics
Associate

Randolph J. Cordle, MD
LVPG-Emergency Medicine
Department of Emergency Medicine
Division of Emergency Medicine
Active
Effective 6/30/99

Frank J. Dracos, MD
Pocono Orthopaedic Consultants
Department of Surgery
Division of Orthopedic Surgery
Associate

Robert C. Emery, MD
Warren Cardiovascular Associates
Department of Medicine
Division of Cardiology
Affiliate

James Farr, MD
Department of Obstetrics and Gynecology
Division of Primary Obstetrics and Gynecology
Active

Joseph A. Gaspari, DMD
Department of Dentistry
Division of Periodontics
Associate

Ann L. Hunsicker-Morrissey, DMD
Department of Dentistry
Division of General Dentistry
Associate

Nercy Jafari, MD
Department of Surgery
Division of Cardio-Thoracic Surgery
Active/LOA

Eugene D. Kim, MD
Coordinated Health Systems
Department of Surgery
Division of Orthopedic Surgery
Provisional Active

Jeffrey R. Kralstein, MD
Valley Gastroenterologists
Department of Medicine
Division of Gastroenterology
Active

Giselle Lafond-Kim, MD
Progressive Physician Associates Inc.
Department of Radiology/Diagnostic Medical Imaging
Division of Diagnostic Radiology
Provisional Active

Cynthia H. Olenwine, DMD
Greenstreet Dental Associates
Department of Dentistry
Division of General Dentistry
Associate

Robert B. Ruyak, DMD
Department of Dentistry
Division of General Dentistry
Associate

Joseph M. Viechnicki, DDS
Department of Surgery
Division of Oral and Maxillofacial Surgery
Associate

Kerry L. Wentling, DMD
Department of Dentistry
Division of General Dentistry
Associate

Allied Health Professionals

Appointments

Robin M. Dunstan, PA
Physician Extender
Physician Assistant – PA
Site of Privileges: LVH & MHC
(Coordinated Health Systems – Brett P. Godbout, MD)

Dana R. Ide, PA-C
Physician Extender
Physician Assistant – PA-C
Site of Privileges: LVH & MHC
(Lehigh Valley Orthopedics – Barry A. Ruht, MD)

Changes of Supervising Physician

Michael F. Altrichter
Physician Extender
Technical – Surgical Technician
From: Panebianco-Yip Heart Surgeons – Geary L. Yeisley, MD
To: Panebianco-Yip Heart Surgeons – Antonio C. Panebianco, MD

Cheryl A. Fedak, RN
Physician Extender
Professional – RN
From: The Heart Care Group, PC – Bruce J. Silverberg, MD
To: The Heart Care Group, PC – Steven L. Zelenkofske, DO

Ruth A. Gerchufsky, RN
Physician Extender
Professional – RN
From: The Heart Care Group, PC – Bruce J. Silverberg, MD
To: The Heart Care Group, PC – Paul Gulotta, MD

Elizabeth Hyde, CRNP
Physician Extender
Professional – CRNP
From: Lehigh Valley Family Health Center – Headley S. White, MD
To: Lehigh Valley Family Health Center – William L. Miller, MD

James J. Perez, RN
Physician Extender
Professional – RN
From: Lehigh Valley Orthopedic Group, PC – Peter M. Anson, MD
To: Lehigh Valley Orthopedic Group, PC – Leo J. Scarpino, MD

Kelly C. Pompa, RN
Physician Extender
Professional – RN
From: Lehigh Valley Cardiology Associates – Ian Chan, MD
To: Lehigh Valley Cardiology Associates – John P. Kristofich, MD

David R. Renner, PA-C
Physician Extender
Physician Assistant – PA-C
From: Lehigh Valley Orthopedic Group, PC – Peter M. Anson, MD
To: Lehigh Valley Orthopedic Group, PC – Leo J. Scarpino, MD

Kathleen A. Rosati
Physician Extender
Technical – Surgical Technician
From: Lehigh Valley Ophthalmic Associates – Thomas O. Burkholder, MD
To: Children's Eye Care of the Lehigh Valley – Mark Trachtman, MD

Robert E. Rush, RN
Physician Extender
Professional – RN
From: Lehigh Valley Orthopedic Group, PC – Peter M. Anson, MD
To: Lehigh Valley Orthopedic Group, PC – Leo J. Scarpino, MD

Beth A. Schoch, LPN
Physician Extender
Professional – LPN
From: Lehigh OB-GYN, PC – Carl A. Lam, MD
To: Lehigh OB-GYN, PC – Joseph N. Greybush, MD

Pamela R. Stocker, RN
Physician Extender
Professional – RN
From: The Heart Care Group, PC – Michael A. Rossi, MD
To: The Heart Care Group, PC – Steven L. Zelenkofske, DO

Marjorie A. Trinkle, LPN
Physician Extender
Professional – LPN
From: Lehigh OB-GYN, PC – Carl A. Lam, MD
To: Lehigh OB-GYN, PC – Joseph N. Greybush, MD

Resignations

Edward F. Bangor, PA-C
Physician Extender
Physician Assistant – PA-C
(Lehigh Valley Orthopedic Group, PC)

Krista F. Carson, PA-C
Physician Extender
Physician Assistant – PA-C
(LVPG-Emergency Medicine)

Susan M. Durkin, CRNP
Physician Extender
Professional – CRNP
(LVPG-Emergency Medicine)

Ronald J. Esteve, PhD
Associate Scientific
Psychologist

Cynthia F. Kelly, RN
Physician Extender
Professional – RN
(Oncology Specialists of Lehigh Valley)

Nancy K. McFadden, CRNP
Physician Extender
Professional – CRNP
(John J. Cassel, MD, PC)

Cassandra J. Snyder, RN
Physician Extender
Professional – RN
(John & Dorothy Morgan Cancer Center)

POST ACUTE CARE OPTIONS

COMPARISON CRITERIA	LTACH (Long Term Acute Care Hospital) I-78 & Cedar Crest Blvd. , Allentown	TSU (Transitional Skilled Unit) 17th and Chew, Allentown	MRC (Muhlenberg Rehab Center) 2855 Schoenersville Road, Bethlehem	GSRH (Good Shepherd Rehab Hospital) 501 St. John Street, Allentown
Top 3 Admission Criteria	1. Patients who need continued acute care 2. High medical complexity or instability 3. Require an average of greater than 25 days of continued acute level of nursing and respiratory therapy	1. Qualifying skill needed 2. Viable discharge plan 3. Appropriate financial coverage	1. Prior functional status 2. Rehab potential and motivation to achieve goals 3. Discharge plan with family support	1. Interdisciplinary team with two or more therapies 2. Potential for functional improvement 3. Close medical supervision by rehab physician and 24 hour/day rehab nursing
Nursing Support	6.5 to 9.0 direct care hours per patient day 60:40 licensed; unlicensed	5.5 direct care hours per patient day 60:40 licensed: unlicensed	4. 5 direct care hours per patient day 50:50 licensed:unlicensed	5.5 to 9.0 direct care hours per patient day 60:40 licensed:unlicensed
Rehab Services Available	PT, OT, speech, respiratory, psychology, cognitive, recreational therapy, Care Management	PT, OT, speech, rec therapy, discharge planning, respiratory therapy	PT, OT, speech, neuropsychology, social services, rec therapy	PT, OT, speech, neuropsychology, rec therapy, warm water pool, Care Management
Rehab Services Intensity	PT and OT provided 6 days/ week, for 1-3 hours per day	PT available 7 days/week OT available 6 days/week Speech available 5 days/week Intensity 1-3 hours per day	PT and OT provided 7 days/week, other therapies 5 days/week Intensity 1-4 hours per day	PT and OT provided 7 days/week, other therapies 6 days/week Intensity 3+ hours per day
Inpatient Rehab Specialty Programs	Complex medical, ventilator mgmt, pulmonary, CHF, brain injury, multi-trauma, coma stimulation, stroke, spinal cord, complex wound care, oncology	Balance, wound care, amputee training, stroke rehab, multi-trauma, complex medical, total joint rehab	Balance/Vestibular program, neuro team, ortho team, general medical/surgical team, prosthetic/orthotic clinic, wound care program	Traumatic brain injury, spinal cord injury, CVA, amputee, vent care/weaning, complex trauma, orthopedics, burns
Medical Staff	LTACH Medical Staff-Board Certified -Pulmonology -Internal medicine -Cardiology -Physiatry	LVH medical staff - 254 primary care - 10 physiatrists -1046 specialists	MRC medical staff - 54 primary care - 6 physiatrists -108 specialists	Good Shepherd medical staff - 20 primary care - 8 physiatrists - 85 specialists
Freq of Physician Visits	7 days/week minimum	2-3 times per week	By patient care need	5 days/week minimum
Physician Coverage	Attending physician on-call 24 hours/day	Attending physician on-call 24 hrs/day, residents on-call off-hours	Attending physician on-call 24 hrs/day	Attending physician on-call 24 hrs/day
Top 5 Diagnostic Groups	1. Post cardiac surgery 2. General medicine 3. Ventilator care 4. Circulatory disorders 5. Brain injury/coma management	1. Hip fxs 2. Pneumonia 3. CVA 4. AMI 5. CHF	1. TKR 2. THR other fxs, 3. CVA, 4. Medical/surgical post acute care 5. Amputees	1. CVA 2. Brain injury 3. Spinal cord 4. Amputees 5. THR, TKR, other fractures
Ancillary Support Services	In-house pharmacy, lab, radiology, dietary, Vent care/weaning, CAPD and dialysis arrangements, central line, TPN, lymphedema management, chemo/radiation arrangements, Care Management for lifelong disability	Parenteral nutrition, antibiotic treatment, all of diagnostic and treatment services available at 17th and Chew; clinical nutrition in-patient hospice, pain management, infectious disease management, enterostomal, dialysis, PICC team, CAPD, chemo, geriatric assessment team, cancer support team	Enterostomal care, EKG, radiology and lab services, dialysis agreements, central line IV services, CAPD, radiation arrangements, pharmacy services through MHC	Vent care/weaning, CAPD, dialysis arrangements, central line, TPN, lymphedema management, urodynamics, chemo/radiation arrangements, spasticity management, electrodiagnosis, Care Management for lifelong disability management, in-house pharmacy
Follow Up Services	Outpatient therapy and all LVHN and Good Shepherd services as noted in the following sections. (TSU, MRC, and GSRH)	All LVHN services including home health and 17th & Chew speciality clinics, cancer support. All support groups affiliated with LVH.	Amputee clinic Outpatient services	Specialty clinics - MD/ALS, CVA, brain injury, spinal cord injury, amputee, post polio, MS, adult spina bifida, chronic pain Outpatient satellites in Kutztown, Laurys Station, Palmerton, Affinity. Vocational assessment and counseling, job placement and tutoring, vocational support services and life skills training
Licensed Level of Care	Hospital	Skilled	Skilled	Hospital
Accreditation	JCAHO	JCAHO	CARF Level II	JCAHO and CARF Level I
Licensed Beds	28 Medicare certified, LTACH hospital	52 subacute Medicare certified	74 rehab specialized care 46 long term care	75 Medicare certified, acute rehabilitation

LEHIGH VALLEY HOSPITAL

DOCTOR'S ORDER SHEET

DRUG INTOLERANCES: REACTIONS:

DRUG ALLERGIES: REACTIONS:

☐ NONE KNOWN

DATE & TIME ORDER WRITTEN	UNIT CLERK INITIALS & TIME	NURSE SIGNATURE AND TIME	HT / WT	DOCTOR'S ORDERS — WRITE WITH BLACK BALL POINT PEN ONLY
				ENTERAL NUTRITION ORDERS Page 1 of 1
				FORMULA: _____
				ROUTE: (check one) ☐Nasogastric ☐PEG/Gastrostomy ☐PEJ/Jejunostomy ☐Other _____
				FORMULA ADMINISTRATION: (check one) ☐ **Intermittent** ☐ **Continuous**
				INTERMITTENT FEEDING: Goal: ____ cc ____ times per day. FREE WATER: ____ cc ____ times per day.
				ADMINISTRATION SCHEDULE: (check one)
				☐ A. Day 1, 120cc; Day 2, 240cc; Day 3, 360cc full strength TF infused 5 times/day.
				☐ B. Other: _____
				MONITORING ORDERS:
				1. Elevate HOB 30-45° during and one hour after feeding.
				2. Flush tube with 50cc H_2O before and after feedings.
				3. Administer feeding over 20-30 minutes.
				4. Check gastric residual before feeding. Hold TF if residual ≥ ☐ 200cc ☐ 100cc ☐ Other _____. Recheck in 1 hour. If residual still ≥ amount indicated, hold TF and notify M.D. If < amount indicated, administer feeding.
				5. Flush tube with 30cc H_2O before and after medication administration.
				6. Hold TF if nausea, vomiting, cramping, abdominal pain/distention.
				CONTINUOUS FEEDINGS: Goal Rate ____ cc/hr over ____ hrs/day. FREE WATER: ____ cc ____ times per day.
				ADMINISTRATION SCHEDULE: (check one)
				☐ A. Start TF at full strength 25cc/hr X 8 hours. Increase TF by 25cc/hr q 8 hrs as tolerated to goal rate.
				☐ B. Other: _____
				MONITORING ORDERS:
				1. Elevate HOB 30-45°.
				2. Hang no more than 4 hr of TF at one time.
				3. Flush tube with 30cc H_2O before and after medication administration.
				4. Check gastric residual before feeding. Hold TF if residual ≥ ☐ 200cc ☐ 100cc ☐ Other _____. Recheck in 1 hour. If residual still ≥ amount indicated, hold TF and notify M.D. If < amount indicated, administer feeding.
				5. Hold TF if nausea, vomiting, cramping, abdominal pain/distention.
				ENTERAL ORDERS:
				1. Consult Dietitian for Nutritional Assessment.
				2. ☐ Consult Clinical Resource Management for home feeding patients.
				3. ☐ Consult Pharmacist for DNI (Drug Nutrient Interaction).
				M.D./D.O.

"Authorization is hereby given to dispense the generic or chemical equivalent unless specified as brand necessary by the physician."

THERAPEUTICS AT A GLANCE

The following actions were taken at the March/April 1999 Therapeutics Committee Meeting -Clinical Pharmacy Services - Joseph Ottinger, R.Ph., MS, MBA, Christopher Moore, R.Ph., James Sianis, Pharm.D.

Newest SSRI Approved

Citalopram (Celexa) is indicated for the treatment of depression. The FDA-approved indications for the selective serotonin reuptake inhibitors (SSRIs) are summarized in Table 1.

Table 1: FDA-Approved Indications:

Indication	Citalopram	Fluoxetine	Fluvoxamine	Paroxetine	Sertraline
Bulimia Nervosa		X			
Depression	X	X		X	X
Obsessive-Compulsive Disorder		X	X	X	X
Panic Disorder				X	X

Citalopram is an SSRI. It is a racemic phthalane derivative, structurally unrelated to other available SSRIs or other available antidepressants. Citalopram is more selective for serotonin activity than fluoxetine, paroxetine, sertraline and fluvoxamine. Citalopram has minimal effects on norepinephrine and dopamine reuptake. Like the other SSRIs, citalopram has a no or very low affinity for serotonergic, dopamine, adrenergic, muscarinic, cholinergic, histamine, benzodiazepine, GABA and opioid receptors.

The most common adverse reactions reported during citalopram therapy have included dry mouth, nausea, somnolence, insomnia, increased sweating, tremor, diarrhea and sexual dysfunction. The incidence of fatigue, impotence, insomnia, increased sweating, somnolence and yawning increased with increasing doses over the range of 10 to 60 mg. In general, the side effects are similar to those occurring with the other SSRIs. Compared to tricyclic antidepressants, citalopram is associated with a higher incidence of nausea and sexual dysfunction.

Citalopram does not inhibit CYP3A4, but it is a weak inhibitor of CYP1A2, CYP2D6 and CYP2C19. These effects are not clinically significant, but sufficient data to assess the impact are not presently available.

Inhibitors of CYP3A4 (e.g., ketoconazole, itraconazole, fluconazole, erythromycin, clarithromycin) and CYP2C19 (e.g., omeprazole) may reduce the clearance of citalopram. Drugs that inhibit CYP2D6 do not affect citalopram levels.

Administration with cimetidine resulted in increased citalopram levels. Dosage adjustments are not necessary when these agents are administered concomitantly.

Citalopram is a weak inhibitor of CYPD6, and as such may alter concentrations of tricyclic antidepressants. Citalopram has been used concomitantly with amitriptyline without increasing amitriptyline or nortriptyline concentrations; however, citalopram has resulted in an approximately 50% increase in single-dose AUC of desipramine after coadministration of citalopram and imipramine. Administration with metoprolol resulted in a two-fold increase in metoprolol levels.

Coadministration of citalopram and lithium

resulted in no changes in the pharmacokinetics of either medication. Monitoring of lithium levels is recommended, however. Also, because lithium may enhance the serotonergic effects of citalopram, these agents should be used concomitantly with caution. Lithium augmentation of citalopram therapy has been used in the treatment of therapy-resistant depression. Fluvoxamine increases citalopram levels, particularly levels of the more active S-citalopram, via inhibition of CYP2C19, CYP2D6 and CYP3A4. This has been used therapeutically to augment citalopram therapy in nonresponders, but it also results in increased side effects.

Pharmacokinetic interactions with digoxin and warfarin have not been observed.

Citalopram therapy should be initiated with a dose of 20 mg once daily. Most patients will require an increase to a dose of 40 mg once daily. Dose increases should occur in increments of 20 mg at intervals of no less than 1 week. The dose may be increased up to 60 mg/day; however, no advantage of this dose over the 40 mg dose has been observed. Citalopram should be administered once daily, in the morning or evening, with or without food.

For most elderly patients and patients with hepatic impairment, the 20 mg dose is recommended, with titration to 40 mg/day only in those patients not responding to 20 mg.

Citalopram is an effective antidepressant, with efficacy and tolerability comparable to the other SSRIs. There is little in the way of comparative literature to support the selection of any agent(s) as the primary Formulary product. Currently, the Drug Formulary consists of all marketed antidepressant products irrespective of their pharmacologic action. The marketing strategies of the newer agents are predicated on promoting "cost neutrality"- daily therapy costs of comparably dosed products are essentially identical. Therefore, there is little economic motivation to select an agent based solely on cost. "Responder" variations appear to justify carrying multiple pharmacologic agents at this time. It is expected that the use of citalopram will offer another therapeutic alternative in the treatment of depression.

Binding Agreement

Sevelamer (Renagel) is indicated for the reduction of serum phosphorus in patients with end-stage renal disease (ESRD). In patients on hemodialysis, sevelamer reduces the incidence of hypercalcemic episodes compared to therapy with calcium acetate while producing similar reduction in serum phosphorous levels. Sevelamer has not been evaluated in patients not receiving hemodialysis. Sevelamer is a nonabsorbed cationic polymer that binds phosphate ions through ion exchange and hydrogen binding.

Patients with ESRD retain phosphorus and can develop hyperphosphatemia. Historically, aluminum hydroxide was commonly used. However, the use of aluminum binding agents can result in accumulation of aluminum and resulting toxicities (osteomalacia, anemia myopathy, dementia). Calcium carbonate and calcium acetate are now more widely used. Calcium carbonate is less expensive, but often associated with an incidence of adverse effects; calcium acetate binds more phosphorus. The use of calcium salts at the doses required to reduce phosphorus levels can cause hypercalcemia.

Sevelamer can reduce the serum phosphorus levels to a same degree as therapy with calcium acetate while offering several potential advantages over calcium and aluminum containing phosphate binding agents. It has a lower risk of hypercalcemia compared to use of calcium containing binding agents and is less likely to cause constipation. It also avoids exposing the patient to aluminum, which can accumulate in patients with ESRD causing toxicity.

This agent can also reduce total serum cholesterol and LDL cholesterol by way of its effects on bile acid; binding and increasing the fecal excretion of the bile acid.

Sevelamer is not absorbed. Calcium acetate is 30% to 40% absorbed systemically. Each 667 mg calcium acetate tablet (*PhosLo*) contains 169 mg of elemental calcium.

Renagel is contraindicated in patients with hypophosphatemia or bowel obstruction, and in patients with known hypersensitivity to sevelamer or any of the product ingredients. Sevelamer capsules expand in water; therefore, they should not be taken apart prior to administration and should not be chewed. Sevelamer should be used with caution in patients with gastrointestinal disorders including dysphagia, swallowing disorders, severe motility disorders or major gastrointestinal tract surgery, as safety and efficacy have not been demonstrated in patients with these disorders.

Adverse effects reported during therapy with sevelamer have included diarrhea, dyspepsia, nausea, vomiting and flatulence. Adverse effects reported in the cross-over study comparing sevelamer and calcium acetate in 82 ESRD patients on hemodialysis are summarized in Table 2.

Table 2: Calcium Acetate and Sevelamer Adverse Effects:

	Calcium Acetate	Sevelamer
Any adverse event	79%	78%
Body as a whole	46%	44%
Headache	11%	10%
Infection	11%	15%
Pain	16%	13%
Cardiovascular	35%	29%
Hypertension	10%	9%
Hypotension	12%	11%
Thrombosis	6%	10%
Digestive	28%	34%
Diarrhea	10%	16%
Dyspepsia	4%	11%
Vomiting	5%	12%
Respiratory	22%	10%
Cough increased	11%	4%

Drug interaction studies have not been performed with sevelamer; however, there is the possibility that sevelamer may bind other medications and reduce their absorption. Oral medications should generally be administered at least 1 hour before or 3 hours after patients taking antiarrhythmic and antiseizure medications were excluded from clinical trials. Caution is advised when using sevelamer in patients taking these medications or any others where consistent absorption is critical.

The recommended starting dose is two to four capsules with each meal depending on the severity of hyperphosphatemia. Table 3 lists recommended starting doses based on serum phosphorus levels. The dosage should be adjusted gradually based on serum phosphorous levels to achieve a serum phosphorus level of 6 mg/dL or less. The dose may be increased or decreased by one capsule per meal as needed. The

average dose in clinical trials was three to four capsules per meal. The maximum daily dose studied was 30 capsules.

- Calcium acetate is initiated with a dose of two tablets with each meal, with the dose titrated to reduce the serum phosphorus level below 6 mg/dL, as long as hypercalcemia does not occur. Most patients require three to four tablets with each meal.

Table 3: Starting Sevelamer Dose:

Serum Phosphorus	Sevelamer Starting Dose
>6 and <67.5 mg/dL	2 capsules three times a day with meals
≥7.5 and <9 mg/dL	3 capsules three times a day with meals
>9 mg/dL	4 capsules three times a day with meals

Sevelamer ($0.46/cap) is as effective as calcium acetate and has a similar side effect profile, although with a lower incidence of hypercalcemia. It offers an alternative to calcium phosphate binding agents, particularly in patients who have developed hypercalcemia or are unable to tolerate the calcium salts. Calcium carbonate is the cheapest ($0.03/tablet); however, calcium acetate ($0.08/tablet) is better tolerated. Pricing, tolerability and efficacy in a given patient are likely to determine the selection of agents in this class.

The daily cost of one day's therapy at LVH for Sevelamer would be $4.15 vs Calcium Acetate daily costs of $0.72 (predicated on identical regimens of 3 caps/tabs with meals). Effects on cholesterol and LDL cholesterol are beneficial since many medications used in are poorly tolerated by patients with ESRD. The ability to bind additional meds may necessitate altering the administration schedule of other agents. In addition, little is known about sevelamer's effects on the absorption of antiarrhythmic and antiseizure meds.

Fast Track Additions

To expedite action on Formulary requests, the P&T Committee Chairperson will be permitted to approve selected agents to the Drug Formulary where "significant" issues are not anticipated. These decisions will be announced at the next scheduled committee meeting.

Three agents were subsequently approved via this mechanism. The soft-gel formulation (better bioequivalence) of saquinavir (Fortovase) will be added and the hard-gel formulation (Invirase) will be deleted. However, patients previously stabilized on Invirase will be maintained on this product, if therapy is ordered during their hospital stay.

Imdur (isosorbide mononitrate) was added in anticipation of deleting the currently used mononitrate product Ismo. Once a day dosing (compliance), cost, and physician preference all favored the selection of his branded mononitrate product.

Finally, an 81 mg enteric coated ASA product was added to facilitate administration of this smaller dose of aspirin. The soluble baby ASA will also be stocked.

THE CENTER FOR EDUCATIONAL DEVELOPMENT AND SUPPORT

June, 1999

Mark your Calendar:

On Friday, June 11, 1999, Resident Graduation will be held at the Holiday Inn in Fogelsville beginning at 6:30 pm. Invitations have been mailed.

Continuing Education:

Joseph A. Miller, MD Resident Research Day will be held on Friday, June 4, 1999 7:30 am – 2:15 pm in the Lehigh Valley Hospital Auditorium 17th & Chew Streets.

For more information or to register, contact Bonnie Schoeneberger at 402-1210.

See the following calendar for grand rounds and tumor boards.

News from the Library

OVID/PubMed TRAINING.

To schedule one-on-one OVID (MEDLINE) training session, call Barbara Iobst in the Health Sciences Library at 402-8408. Barbara can also instruct you in the use of PubMed, a free, Web-based MEDLINE service offered by the National Library of Medicine (NLM). MEDLINE can be searched directly using PubMed.

COPYRIGHT UPDATE:

The latest attempt to revise the copyright law resulted in the Digital Millennium Copyright Act. While this act includes some changes which deal with new formats of information, there were no modifications made to the Copyright Act of 1976 regarding library copying and educational "fair use" copying.

While the library staff alerts you to currently published information, it may not be possible under the copyright law to furnish you with copies of everything you request, especially if they are from the same journal issue. This also applies when articles are requested from other libraries. The "fair use" provision allows for photocopying only under certain circumstances.

A common misconception is that copyright of an article belongs to the author. In most cases it belongs to the publisher. This is one reason publishers charge libraries an institutional rate that is significantly higher than what an individual pays, i.e. **Journal of Surgical Oncology**—individual rate is $190, library rate is $1,750.

The library staff is required to stamp the copyright warning on articles they copy and also display the warning prominently near the library photocopiers. It is the law.

CEDS page on the hospital's Intranet provides links to information regarding the Copyright Act and the new Digital Millennium Copyright Act .

News from the Office of Educational Technology

Computer-Based Training (CBT):

CBT has replaced instructor-led classes previously held at LVH. A proctor will be in the room with the learner while s/he takes the CBT, but the learner will control the pace and objectives of the learning.

Topics covered by CBT include:
Access 2.0 & 97
Windows NT 4
Word 97
Excel 97
PowerPoint 97
PHAMIS Lastword Inquiry only commands
E-mail GUI

CBT takes place in JDMCC, Suite 401. From April through December 1999, there will be two CBT sessions every Tuesday. The morning session is 8:00 am to noon. The afternoon session is 12:30 to 4:30 pm.

Twelve slots are available for each session

To register, please contact Bonnie Schoeneberger via email or at 402-1210. If you have questions regarding CBT, please contact Craig Koller via email or at 402-1427.

PC Basics, Windows NT/95 & Email:
The following classes will be held at Muhlenberg Hospital Center in the I/S Training Room off the lobby of the main building. Please call 317-4771 to register. Registration is required.

PC Basics
June 4 - 9-11am
June 18 - 9-11am

Windows NT/95
June 4 - 1-3pm
June 18 - 1-3pm

Email Intro.
June 11 - 9-11am
July 2 - 9-11am

Any questions, concerns or comments on articles from CEDS, please contact Sallie Urffer 402-1403

Medical Staff F s Notes
Grand Round and
Tumor Board Schedule

1999 June 1999

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
		1 7 am Surgical Grand Rounds - CC-Aud - 8am Pediatric Grand Rounds - 17-Aud 12 Noon Medical Grand Rounds CC-Aud	2	3 9 am Emergency Medicine Grand Rounds- 1251SCC, Suite 308C 12 Noon Combined Tumor Board - JDMCC - CR1 A/B	4 730 am OBGYN Resident Research Day- 17 Aud 12 Noon Breast Tumor Board - JDMCC- CR1 A/B	5
6	7 12 Noon C/R Tumor Board - JDMCC - CR1 A/B	8 7am Ambulatory Clin Guideline Dev - SON 7 am Surgical Grand Rounds - CC-Aud 8am Pediatric Grand Rounds - 17-Aud 12 Noon Medical Grand Rounds CC-Aud	9 12 Noon Pulmonary Tumor Board - JDMCC - CR1 A/B	10 12 Noon Cancer Committee - JDMCC - CR1 A/B	11 7am OBGYN Grand Rounds -17 Aud 12 Noon Pediatric Noon Conf - 17 Aud 12 Noon Breast Tumor Board - JDMCC- CR1 A/B	12
13	14	15 7 am Surgical Grand Rounds - CC-Aud - 8am Pediatric Grand Rounds - 17-Aud 12 Noon Medical Grand Rounds CC-Aud	16	17 12 Noon GI Tumor Board - JDMCC - CR1 A/B	18 7 am GYN Tumor Board/OBGYN Grand Rounds - 17 Aud 12 Noon Breast Tumor Board - JDMCC- CR1 A/B	19
20	21 12 Noon C/R Tumor Board - JDMCC - CR1 A/B	22 7 am Surgical Grand Rounds - CC-Aud - 8am Pediatric Grand Rounds - 17-Aud 12 Noon Medical Grand Rounds CC-Aud 12 Noon Urology Tumor Board - JDMCC - CR1 A/B	23	24 12 Noon Combined Tumor Board - JDMCC - CR1 A/B 12 Noon Psychiatric Grand Rounds-17-Aud	25 7am OBGYN Grand Rounds -17 Aud 12 Noon Pediatric Noon Conf - 17 Aud 12 Noon Breast Tumor Board - JDMCC- CR1 A/B	26
27	28	29 7 am Surgical Grand Rounds - CC-Aud - 8am Pediatric Grand Rounds - 17-Aud 12 Noon Medical Grand Rounds CC-Aud	30			

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Medical Staff Progress Notes **is published monthly to inform the Medical Staff of Lehigh Valley Hospital and employees of important issues concerning the Medical Staffs.**

Articles should be submitted to Janet M. Seifert, Physician Relations, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box 689, Allentown, PA 18105-1556, by the 15th of each month. If you have any questions about the newsletter, please call Mrs. Seifert at (610) 402-8590.