LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

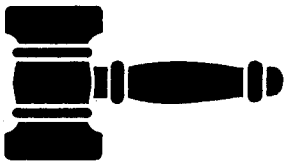
PROGRESS NOTES

Medical Staff

Lehigh Valley Hospital ❁ Muhlenberg Hospital Center

August, 1999 ❁ Volume 11, Number 8

In This Issue . . .



From the President

"Happiness is not a reward – it is a consequence. Suffering is not a punishment – it is a result."
– Robert Green Ingersoll

Dear Colleagues:

It's hard to believe that it is August. I hope all of you are having a great summer.

Since 1995, when I became chairman of the Care Management Committee of the LVPHO, I've been preaching, appealing, and begging all of my colleagues on the Lehigh Valley Hospital Medical Staff to consider how they can provide the most "clinically efficient" care for their patients. Now, as President of the LVH/MHC Medical Staff, I want to continue this. "Clinically efficient" care means the highest quality care delivered in the most appropriate setting at the lowest possible cost with the least duplication of effort for our patients. This type of care should be associated with the best outcomes and should be supported wherever possible by "evidence-based medicine."

Since most of the cost of the care which is delivered to our patients originates as a result of our orders as physicians, we share much of the responsibility for what is done to our patients and for the costs which ensue as a result of our orders. I'm sure that all of us want to do the best we can for our patients. We get up each morning thinking that we will do "good" not "bad." We don't try to order unnecessary tests, studies, and treatments for our patients. Sometimes we

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do order tests that may not really change the way we treat our patients. We often keep our patients in the hospital "one more day" because it is inconvenient to come back in the afternoon, check on outstanding test results, and discharge the patient. "What's one more day?"

A recent VHA study found that 70% of the hospitals in Pennsylvania and New Jersey are losing money. Fortunately, LVH/MHC is not one of the 70%. The University of Pennsylvania Health System lost $90 million last year and may lose $100 million this year! We have a positive bottom line - barely positive. Why is it important for the hospital to have a positive balance at the end of each fiscal year? We all want the best equipment and services for our patients. In order for the money to be available to purchase new equipment, to develop new programs, to make capital investments in the plant and facility, and to provide the highest quality services to our patients, the hospital needs to have a "positive bottom line." One of the main ways to insure that there is money at the end of the year for investment in the future is for us to decrease the amount of work that the hospital staff is required to do for our patients. This includes shortening hospital length-of-stay, reducing the number of tests and procedures which we order, and thinking about the costs of the drugs and treatments which we order for our patients. Do we really need to order expensive quinilone antibiotics for everyone with an uncomplicated urinary tract infection? Does every patient admitted need to be on an H_2 blocker for the duration of their hospital stay? Do we really need to order "cefexpensive" for everyone with pneumonia? In addition to being expensive, all medications are associated with potential adverse reactions, which may jeopardize our patients. We become so enthralled with the concept that "if it is new it must be better," that we often forget about the adverse effects and complications of expensive new medications, procedures, and treatments.

We need to learn how to live in a "new culture" different from the one in which we were trained -- a culture where we recognize that our nation's health care resources and our hospital's resources are finite and limited. We need to learn to be the stewards of these resources, while still being the advocates for each of our patients. If we squander these resources by ordering expensive drugs and treatments, and ordering unnecessary tests and procedures, there will not be money available to provide for new services and programs that our community needs for the future.

Every day we need to think about ways in which we can help to "take work out of the system." We need to ask ourselves not "why didn't I order _____," but "why did I order ____." As I've asked you before, every time we order a test or procedure, ask yourselves "how is the result of this test or procedure going to change the way I manage this patient?" "Could the things I'm doing for my patient in the hospital today be done in a more comfortable setting and at less expense in some other setting?

As teachers on this medical staff and in our respective departments, we need to take the responsibility to share with our resident physicians the importance of being cost conscious and to encourage them to learn how to provide "clinically efficient" care. For a dyspneic patient weighing 275 lbs. in medical clinic, is the first way to try to diagnose congestive heart failure to order an echocardiogram or to examine the patient and order a chest x-ray? At 2 a.m. in the Emergency Department, is the best way to diagnose a pulmonary embolus to order a "spiral CT scan" of the chest or to anticoagulate the patient and order a lung scan for the morning? I know that the Clinical Chairs are actively involved in discussions as to how to change their grand rounds formats so that "Care Management" issues become an important part of the curriculum. This is an important first step.

I'm sure by now, some of you are saying, "Wait a minute, David, what about that big new building which is almost finished next to the existing hospital? If the hospital is so short of money, how can they be building this expensive new addition?" Good question!

The Jaindl Family Pavilion is an investment in the future. The new wing will provide new, expanded and more functional space for all of our intensive care units. There will be a pediatric intensive care unit, so that critically ill children and their families will not need to travel to Philadelphia or Hershey for their care. The Obstetrics and Gynecology services, presently housed at 17th & Chew, will move to the new building so that those patients and their physicians can be closer to the other existing services which are often needed if their patients' care is anything but routine. There will be a new, efficient, well organized outpatient service area where patients can receive courteous care without the hassles which they are now forced to endure. The monies for this new addition were put aside in the past when the hospital was more profitable and reimbursements were different. This is a capital investment in the future. It is designed to help us provide the highest quality care for the patients of our community. Remember what happened to Bethlehem Steel by not investing in the future. Their plant was no longer able to be competitive with other steel mills which had modernized and is now a rust heap without any employees.

Congratulations to Ed Mullin, MD, Chief of the Division of Urology, and the members of the Department of Surgery, Division of Urology, and to Jay Kaufman, MD, Chief of the Division of Pulmonary, and the members of the Department of Medicine, Division of Pulmonary, for their success in being

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named in ***U.S. News & World Report's*** 10th annual guide to "America's Best Hospitals." This is a tribute to these physicians, the programs that they have developed for the care of our patients and our community, and to the Lehigh Valley Hospital, which has been supportive of their efforts.

E-Mail - As before, I'd like to encourage all members of the Medical Staff to read their e-mail regularly or to designate a staff member to be your appointed "surrogate" who can read and print out your e-mail messages for you on a daily basis.

Don't forget to complete and return the **Physician Satisfaction Survey** to Professional Development, J&DMCC. (A return envelope was included for your convenience.) Also, if you receive the survey about the organization of the LVH inpatient medical record, please fill it out and return it so that we can try to improve the efficiency of the charts which we all use on our daily rounds.

Sit, Answer and Touch! - Remember, when you are making hospital rounds to sit at your patient's bedside, ask for their questions, answer their questions, and make physical contact with the patient.

The 3rd (1999) edition of the **Medical Staff Handbook** has been published and is now available for members of the Medical Staff. This is a very useful little book that can be carried in your pocket. In addition to the phone numbers of the various floors, the nurses' cellular phone numbers, and other frequently called telephone numbers, the book contains information about the paging and dictating system. Most importantly, the handbook contains the names, office telephone numbers, and paging numbers of all physicians on the LVH/MHC medical staffs. You can page physicians directly without going through the page operators. This will reduce your time on hold, increase the speed of paging, and reduce the burden on the page operators, so that when their services are needed they won't be as overburdened.

Finally, I've been informed that the O.I.G. (Office of the Inspector General) will consider fraudulent, requests for payment from Medicare for consultations which have been performed if the consultation is addressed: *"Please see patient known to you."* When requesting a consultation, please be sure to make a specific request from your consultant as to why you are requesting help or an opinion. HCFA defines a consultation as a "request of another physician to obtain advice or opinion on patient care."

Stay safe, healthy, and happy.

"True happiness arises, in the first place, from the enjoyment of one's self, and in the next, from the friendship and conversation of a few select companions." - Joseph Addison

David M. Caccese, MD
Medical Staff President

LVH Ranks with Top Hospitals in U.S. News & World Report

Lehigh Valley Hospital is ranked as one of the top providers in the nation for urology and respiratory disorders in ***U.S. News & World Report's*** 10th annual guide to "America's Best Hospitals." Urology was ranked for the third year in a row. This was the first year LVH was recognized for respiratory disorders.

"This marks the fourth consecutive year that LVH has been ranked in this guide," said Robert J. Laskowski, MD, chief medical officer. "It's a tribute to the caliber of our physicians and patient care staff in these specialties and throughout our hospital."

According to ***U.S. News & World Report***, "America's Best Hospitals" assessed care in 16 specialties, and recognized 188 hospitals nationwide.

According to John Jaffe, MD, Division of Urology, and past president of the LVH Medical Staff, the Division of Urology has nine board-certified physicians who offer a comprehensive range of urologic services. These include urologic oncology treatments; impotence; urinary incontinence in men and women; urinary stone disease; malignant and benign urologic disease, and urologic services for women and children. The program is ranked 26th on the "America's Best Hospitals" list.

LVH ranked 46th nationally on the magazine's list for respiratory disorders. Jay H. Kaufman, MD, Chief, Division of Pulmonary Medicine, said the division's critical care program has received the Health Industry Research award from the National Society of Critical Care Medicine for achieving excellent outcomes and cost reductions. The division also participated in several multicenter studies and developed innovative community programs. Dr. Kaufman acknowledged the role of "excellent physicians, respiratory therapy department and nursing staff" in achieving the national ranking.

The divisions of geriatrics and cardiology/cardiac surgery at LVH have also been nationally recognized, ranking on "America's Best Hospitals" list in 1996 and 1997, and in 1998, respectively.

New Diagnostic Care Center Opens in Jaindl Family Pavilion

In mid-July, a number of hospital departments relocated to the Jaindl Family Pavilion as part of the new Diagnostic Care Center.

The relocated departments include:
- Health Network Laboratories
- Heart Station
- Neurophysiology Lab (EEG)
- Nuclear Medicine
- Pre-Admission Testing
- Pulmonary Lab
- Sleep Disorder Center

For future reference, telephone numbers and testing/treatment hours are provided below. Patients scheduled for testing in these departments should enter through the main entrance of the hospital and obtain directions to their testing/treatment area from the Information Desk in the main lobby. Assistance will be available for patients who have difficulty ambulating. In addition, free valet parking is available for your patients.

Health Network Laboratories – (610) 402-8838
Fax: (610) 402-8019
Monday through Friday – 7 a.m. to 5 p.m.
Saturday – 8 a.m. to Noon

Heart Station – (610) 402-8989
Fax: (610) 402-1692
Echo: Monday through Friday – 7 a.m. to 6 p.m.
Holter: Monday through Saturday – 8 a.m. to 4:30 p.m.
Stress: Monday through Friday – 7 a.m. to 5 p.m.
Saturday and Sunday – 8 a.m. to 4 p.m.
EKG: Monday through Sunday – 7 a.m. to 11 p.m.
(no appointment necessary)

Neurophysiology Lab (EEG) – (610) 402-8860
Monday through Friday – 7 a.m. to 5:30 p.m.

Nuclear Medicine – (610) 402-8383
Fax: (610) 402-5062
Monday through Friday – 8 a.m. to 5 p.m.

Please Note: Nuclear Medicine will be operating out of two locations for an interim period. Nuclear Medicine will perform all Thallium Stress Tests in the Diagnostic Care Center; however, please verify the correct area of testing (old or new) when scheduling outpatient tests. The Information Desk in the Main Lobby will have a camera schedule in order to direct patients to the proper testing area. Patients who have already been scheduled will check in at the Information Desk and be directed to the correct testing area in either the Diagnostic Care Center or old Nuclear Medicine Department.

Pre-Admission Testing – (610) 402-8877
Monday, Tuesday, Wednesday, Friday – 8 a.m. to 3 p.m.
Thursday – 8 a.m. to 6 p.m.

Pulmonary Lab – (610) 402-8530
Fax: (610) 402-4227
Monday through Friday – 8 a.m. to 4 p.m.

Sleep Disorder Center – (610) 402-8532
Fax: (610) 402-4227
Sunday through Thursday – 9 p.m. to 6:30 a.m.

An Important Reminder -- History and Physicals

According to Medical Staff Bylaws/Rules & Regulations Part II, Section E-Records, #2 – "A complete history and physical examination shall, in all cases, be documented in the medical record no later than twenty-four (24) hours after admission of the patient. History and physical examinations must be performed by a credentialed member of the Medical, Allied Health, or Residency Staff. When such history and physical examination is not recorded before the time of surgery, the surgery shall be canceled, unless the attending surgeon states in writing that such delay constitutes a hazard to the patient.

For elective or outpatient procedures, preadmission history and physical examinations must be performed by a credentialed member of the Medical, Allied Health, or Residency Staff within thirty (30) days prior to admission. Those noninpatient services requiring a history and physical examination to be performed by appropriately credentialed individuals shall include ambulatory surgery, procedures requiring anesthesia/sedation, and at the discretion of the treating physician, any other procedure which poses significant risk to the patient."

Coding Tip of the Month

When a physician documents an organ or site specific sepsis (i.e., urosepsis), further clarification is necessary to determine whether it is intended to mean:
a. Generalized sepsis (septicemia) or
b. Urine contaminated by bacteria or other toxic material, but without other findings.

Innovative Services Planned for 17th & Chew

For more than 100 years, Lehigh Valley Hospital and Health Network has been a vital community health care resource. The hospital that had its start in the heart of the Allentown community has now begun its evolution for the next 100 years, as a community-based facility focusing on outpatient, diagnostic and wellness services. And the transition promises to be as exciting as the end result.

The vision for a new kind of hospital at 17th & Chew is central to the network-wide facility plan that consolidates all acute inpatient at Cedar Crest & I-78, and expands subspecialty services at Muhlenberg Hospital Center in Bethlehem, according to James Burke, vice president, operations.

"The ultimate goal is to create healthier communities by providing the highest quality care in the most appropriate setting at the lowest possible cost," he said. Eliminating the duplication of services between the two LVH sites alone will reduce annual operating expenses by an estimated $4 million.

With the final approval of programming at 17th & Chew, a phased schedule of construction and renovations has been developed and some work has begun, Mr. Burke said.

Presently under construction is the School of Nursing lobby with plans to restore it to its original design from 1915. Additional renovations to the building will enhance Room 900, space occupied by the Communities in Schools program, Parlor A, the auditorium and the north wing. The lobby work is being funded by an $85,000 gift from the Allentown Auxiliary. A grand opening is tentatively planned for early September, when the recently completed renovations in the Emergency Department on the ground floor of the hospital will also be formally unveiled.

Now that the $2 million federal grant for geriatric and adolescent programs that was supported by Sen. Arlen Specter (R-PA) has received final approval, construction will begin on the Adolescent Education Department in the lower level of the School of Nursing building. Concerns that most frequently place adolescents at risk of health problems are use of alcohol, tobacco and other drugs, mental health issues, violence and irresponsible sexual behavior. These will be the focus of some initiatives addressed through this department.

As another part of the Specter grant, a design will be developed for the new Geriatrics Health Center, which will be located on the ground floor of the hospital. Services provided at the center will span two floors. The entry-level ground floor will house community-oriented education activities while the first floor will be the hub of clinical services. Also included will be a learning resource center, a multi-purpose room, and program offices for geriatric services and Vitality Plus staff members. The center is scheduled for completion by June 2000.

Renovations for the ground floor also include a new entrance on North 17th Street, which will be highly visible and accessible from both directions whether the approach is by foot, car or public transportation. An existing driveway will be lengthened and improved for patient drop-off and pick-up.

Reconfigured outpatient treatment areas; a small but comfortable lobby; and retail space – pharmacy, gift shop and food court – are all part of the plans for the ground floor.

Existing clinics on different floors are being renovated, relocated, and updated as part of developing the Model Practice program on the first floor. According to John F. Fitzgibbons, MD, chairperson, Department of Medicine, the Model Practice means a better experience for the adult ambulatory patients in the community. It will feature more privacy, better service, more consistency and more hours of operation. Rooms will be tailored for the groups of patients who come there for care. The geriatric clinic area, for example, will be furnished with adjustable exam tables, chairs with supportive arms, foot stools with handles, assistive hearing and visual devices, separate temperature controls, and sinks.

Secondarily, but importantly, a goal of the ambulatory center is to support LVH's educational mission, Dr. Fitzgibbons said. With the increasing emphasis on ambulatory education in internal medicine and other residencies, it is important that the residents have ambulatory experiences closely simulate the private practice environment, and that they be taught ambulatory care practices utilizing preventive services, patient education, evaluation of patient satisfaction, disease management, outcomes research, evidence-based medicine and cost-effective care. The grand opening of the Model Practice is expected in early fall.

Among other significant design changes at 17th & Chew will be the expansion of the Hospice unit and the creation of a Community Conference Center, a partnership with other health care programs and not-for-profit organizations who may be offered office space at marginal cost. The concept of a health care center where many different entities and organizations are involved will be unique to the Lehigh Valley health care arena.

These initial phases of reconstruction at 17th & Chew are being funded through a variety of sources: the $2 million Specter grant; a $1 million grant from the Trexler Trust; and $5.6 million in LVHHN approved capital expense.

Questions You May Have About LTACH, but are Afraid to Ask!

What is an LTACH?

An LTACH (long-term acute care hospital) is a hospital whose total length of stay is 25 days or greater. This is determined at the end of each cost report year by total number of patient days divided by discharges.

What is the level of care?

This is an acute care hospital. Patients must meet admission and continued stay criteria that indicates hospitalization is required.

How does the hospital function?

It has its own separate hospital license, separate CEO, Board of Trustees, medical staff, Director or Nursing, and nursing staff. Ancillary services can be contracted.

What types of patients are typically admitted?

Respiratory/ventilator supported patients and medically-complex patients with multi-system problems.

Stay tuned next month for more information . . .

If you have any questions regarding LTACH, please contact Jane Dorval, MD, at (610) 776-3340 or pager (610) 830-2793; Stephen C. Matchett, MD, at (610) 439-8856 or pager (610) 920-7225; or Linda Dean, LTACH Hospital Operations, at (610) 776-3395 or pager (610) 830-3110.

Gastinger Fund Established

A fund was recently established to benefit Joseph W. Gastinger, MD, and his family. If you wish to make a contribution, please make your check payable to: "The Joseph Gastinger Fund" and send it to Beth Martin, Medical Staff Services, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box 689, Allentown, PA 18105-1556. If you have any questions, please contact Ms. Martin at (610) 402-8980.

Spirit of Women

Do you know a special woman from Lehigh Valley Hospital and Health Network who has made a significant contribution to our community? She could be a nurse, a technician, a doctor - any provider who you feel has been an exceptional health advocate and has touched the lives of others. By the very nature of their work, health care providers have qualities that set them apart from most other people - but some shine brighter than others. She is an unsung heroine - she doesn't look for recognition although she certainly deserves it!

If so, nominate her for the 1999 Spirit of Women Health Care Provider award.

Two outstanding community award winners will be recognized in the following categories:

- **Spirit of Women Youth Category** - for living women age 14-21
- **Spirit of Women Community Category** - for living women age 22 and over

The Lehigh Valley Hospital Health Care Provider winner will be honored at the Spirit of Women 1999 Celebration on November 9 at the Holiday Inn in Fogelsville, along with the two community recipients. The event will include noted author and inspiring speaker - Judith Briles - who will challenge us with "embracing change in the new millennium".

The Health Care Provider winner will then enter the PennCARE Spirit of Women awards competition for a chance to be recognized at the national level in February, 2000 in Washington, DC, along with the winners in the other categories.

To nominate someone for any of the three categories, please call (610) 402-CARE for a nomination form. The form, along with two letters of recommendation, should be submitted by September 15.

If you have any questions regarding the Spirit of Women Awards, please contact Fran Derhammer at (610) 317-4973.

New Medical Staff Directories Now Available

The latest edition of the Lehigh Valley Hospital Medical Staff Directory (including Muhlenberg Hospital Center) is now available. If you have not yet received your copy, please contact Janet Seifert in Physician Relations at (610) 402-8590.

Blood Product Administration

The Hospital's policy for blood and blood products does state "the rate of infusion must be specified by the physician." Based on the policy, "ASAP" is not sufficient and unless a patient is being involved in a massive volume resuscitation, the order must specify rate of infusion.

Nutrition Subcommittee Update

The ordering of diabetic diets has been updated to reflect the current American Diabetes Association guidelines. As per the position statement of the American Diabetes Association Guidelines: "Meal plans such as no concentrated sweets, no sugar added, low sugar, and liberal diabetic diets are no longer appropriate. These diets do not reflect the diabetes nutrition recommendations and unnecessarily restrict sucrose. Such meal plans may perpetuate the false notion that simply restricting sucrose sweetened foods will improve blood sugar control." (Diabetes Care, 1997;20:106-108.)

With input from the Division of Endocrinology/Metabolism, diabetic diets have been adjusted from ordering by calorie level to ordering by consistent carbohydrate level. Previously, when diabetic diets were ordered by calorie level, the meal patterns were adjusted by calories, causing inconsistent carbohydrate levels to be provided at each meal. The No Concentrated Sweets diet restricted desserts and sucrose, but didn't limit the amount of carbohydrate provided at each meal, again causing inconsistent amounts of carbohydrates to be provided. As per the new policy, there will be four levels of consistent carbohydrate: Consistent Carbohydrate-Low (CCL), Consistent Carbohydrate-Moderate (CCM), Consistent Carbohydrate-High (CCH) and Consistent Carbohydrate-Very High (CCVH). The new policy will automatically substitute the new diets based on the following:

Patient Prescribed	Patient will receive
1000 ADA 1200 ADA 1300 ADA 1400 ADA 1500 ADA	Consistent Carbohydrate Low (CCL) 45-60gm carbohydrate per meal provided 15-30 gm carbohydrate provided at HS snack Fat restricted to 3 exchanges per day
1600ADA 1700 ADA 1800 ADA 1900 ADA 2000 ADA NCS	Consistent Carbohydrate Moderate (CCM) 60-75gm carbohydrate per meal provided 15-30gm carbohydrate provided at HS snack Fat restricted to a maximum of 4 exchanges per day
2100 ADA 2200 ADA 2300 ADA 2400 ADA 2500 ADA	Consistent Carbohydrate High (CCH) 75-90 gm carbohydrate per meal provided 30-45gm carbohydrate provided at HS snack Fat restricted to a maximum of 5 exchanges per day
2600 ADA 2700 ADA 2800 ADA 2900 ADA 3000 ADA	Consistent Carbohydrate Very High (CCVH) 90-105gm carbohydrate per meal provided 30-45gm carbohydrate provided at HS snack Fat restricted to a maximum of 6 exchanges per day

Gestational diabetic diet orders will continue to be ordered according to calorie level to allow for fetal growth. Pediatric carbohydrate counting diet orders will be provided based on the RDAs for age, providing consistent carbohydrate at each meal. The new policy was approved by the Division of Endocrinology/Metabolism on May 20, and by the Therapeutics Committee on June 16. Information Services has been contacted to adjust the ordering screens in PHAMIS to facilitate ordering. During the interim until these changes are made, Consistent Carbohydrate diets can be ordered in PHAMIS under misc diet. A self learning packet is being developed for nursing staff and home care staff. A site is being developed for the hospital intranet to provide education on the new consistent carbohydrate guidelines. If you have any questions concerning the new policy, please contact Dorothy McFadden, Assistant Director, Food Services, via email or at (610) 402-8609.

Congratulations!

K. Alexander Haraldsted, MD, Division of Pulmonary, has recently become certified by the American Board of Sleep Medicine.

Laurence P. Karper, MD, Division of Psychiatric Ambulatory Care/Adult Inpatient Psychiatry, recently passed his certification exam and is now certified in the medical specialty of Psychiatry by the American Board of Psychiatry and Neurology.

Thomas D. Meade, MD, Division of Orthopedic Surgery, Section of Ortho Trauma, has been appointed to the Medical Fitness Association National Board of Trustees as the only physician member. The Medical Fitness Association was created in 1991 and exists to promote and advance the medical fitness industry. There are over 400 facility members caring for 1.2 million fitness clients. The majority of facility members are hospitals that run health, fitness, and wellness centers.

Papers, Publications and Presentations

Joseph L. Antonowicz, MD, Chief, Division of Consultation/Liaison Psychiatry, presented a lecture titled "Assessing Capacity – Legal and Medical Perspectives" at the Second Annual Elder Law Institute sponsored by the Pennsylvania Bar Institute for Continuing Legal Education, held at the Pennsylvania Convention Center in Philadelphia on July 23.

Several members of the Medical Staff, representing the Breast Health Services Program, recently attended LaszloTabar's Interdisciplinary Breast Care Conference held in Montreal, Quebec, Canada. The international conference focuses on the interdisciplinary approach to screening, diagnosis and treatment of early stage breast cancer. Those attending the conference included: **Elizabeth A. Dellers, MD**, Division of Clinical & Anatomic Pathology; **Gregory R. Harper, MD, PhD**, Director, John and Dorothy Morgan Cancer Center; **Elisabeth Ladd, RN, MSN**, Program Director, Breast Health Services; **John G. Pearce, MD**, Chief, Section of Mammography; **Gerald P. Sherwin, MD**, Chief, Division of General Surgery; **Susan Steigerwalt, RT**, Coordinator, Breast Health Services; and **Douglas R. Trostle, MD**, Associate Chief, Division of General Surgery (LVH).

Keith R. Doram, MD, Chief, Division of General Internal Medicine, was one of the co-authors of an article, "The Medic Management of Geriatric Patients in Skilled Nursing Facilities, which was published in the May 31, 1999 issue of ***Primary Care Reports***.

Mark A. Gittleman, MD, Division of General Surgery, presented a training seminar for surgeons, radiologists, and mammographers on "Stereotactic Breast Biopsy" at Our Lady of Fatima Hospital, North Providence, RI, on June 26, and at the Northern Mississippi Hospital, Tupelo, Miss., on July 9.

Houshang G. Hamadani, MD, Department of Psychiatry, participated in a workshop -- Current Issues on Abuse and Misuse of Psychiatry -- which was held as part of the American Psychiatric Association Annual Meeting on May 19 in Washington, DC.

Peter A. Keblish, Jr., MD, Chief, Division of Orthopedic Surgery, was a member of the invited guest faculty at the Harvard Knee Course in Cambridge, Mass. Dr. Keblish delivered four papers on various aspects of total and partial knee replacement. He was also moderator and discussion leader in break-out sessions and case presentations. The Harvard Knee Course is held annually and covers all aspects of primary and revision total knee arthroplasty, with attendance of over 200 orthopedic surgeons.

Colin P. Kopes-Kerr, MD, Department of Family Practice, gave three presentations for the Osler Institute Family Practice Review Course that was held in Chicago, Ill., on June 23. His presentations included Preventive Health Care, Ethical and Legal Issues, and Low Back Pain.

Fred Laufer, MD, Department of Family Practice, was the invited speaker at a conference on "The Uses of Microdermabrasion," held in Annapolis, Md., on May 21. His topic was "Advanced Techniques of Microdermabrasion using the PowerPeel." In addition, he demonstrated various techniques on patients during a workshop held at the conference.

"Sensory Symptoms of Multiple Sclerosis: A Hidden Reservoir of Morbidity," an article authored by **Alexander D. Rae-Grant, MD**, Chief, Division of Neurology; **Nancy J. Eckert**, Research Specialist; **Sharon Bartz**, Administrative Secretary; and **James F. Reed III, PhD**, Evaluation Specialist, Community Health-MESH, was published in ***Multiple Sclerosis*** (1999) 5.

Who's New

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New Appointments

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Bethlehem, PA 18017-7384
(610) 861-4200
Fax: (610) 861-7052
Department of Radiology/Diagnostic Medical Imaging
Division of Diagnostic Radiology
Provisional Active
Site of Privileges: MHC

Change of Address

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1251 S. Cedar Crest Blvd.
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Allentown, PA 18101-1012

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Muhlenberg Behavioral Health
Joel Lerman, MD
Susan S. Matta, DO
David L. Schwendeman, MD
Banko Family Community Center
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Bethlehem, PA 18017-7384
(610) 866-9000
Fax: (610) 317-5757

Change of Practice

Larry R. Glazerman, MD
OB-GYN at Trexlertown, PC
Health Center at Trexlertown
6900 Hamilton Blvd.
P.O. Box 60
Trexlertown, PA 18087-0060
(610) 402-0161
Fax: (610) 402-0132

Garry C. Karounos, MD
M. Bruce Viechnicki, MD & Associates PC
1611 Pond Road
Suite 102
Allentown, PA 18104-2256
(610) 366-7000
Fax: (610) 366-0255

Resignations

Alfred P. Kennedy, Jr., MD
Department of Surgery
Division of General Surgery
Section of Pediatric Surgery
Active
Effective August 1, 1999

Allied Health Professionals

Appointment

Michael E. Krestynick, CRNA
Physician Extender
Professional – CRNA
(Allentown Anesthesia Associates Inc – Alphonse A. Maffeo, MD)
Site of Privileges: LVH & MHC

Change of Supervising Physician

Laurice L. Dunning, CNM
Physician Extender
Professional – CNM
(The Midwives & Associates, Inc.)
From: Center for Women's Medicine - James Balducci, MD
To: M. Bruce Viechnicki, MD & Associates PC - M. Bruce Viechnicki, MD
Site of Privileges: LVH & MHC

AMA E-mail News Briefs - Special Annual Meeting Edition - June 23, 1999

This edition of AMA E-mail News Briefs is being sent to you as a special service from the Chicago Hilton and Towers, site of the 200th meeting of the House of Delegates. This special edition of our e-mail newsletter is exclusively for AMA members.

Today's edition includes the full text of a historic announcement made this afternoon by the House regarding the formation of a national labor organization for physicians. It is followed by shorter items of interest from the meeting.

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AMA PHYSICIANS VOTE TO FORM NATIONAL LABOR ORGANIZATION

CHICAGO - Members of the American Medical Association (AMA) voted today to develop an affiliated national labor organization to represent employed physicians and where allowed by law, residents.

The move will enable eligible physicians to advocate more effectively on behalf of their patients, according to Randolph D. Smoak Jr., MD, Chair, AMA Board of Trustees.

"This is not for all physicians. This will not be a traditional labor union," Dr. Smoak said. "Doctors will not strike or endanger patient care. We will follow the principles of medical ethics every step of the way. No other organization can make that promise to the patients of America - and keep it.

"Our objective here is to give America's physicians the leverage they now lack to guarantee that patient care is not compromised or neglected for the sake of profits," Dr. Smoak said.

After extensive discussion this week at its annual meeting, a majority of the AMA's 494-member House of Delegates voted to support a series of recommendations aimed at increasing the advocacy tools physicians have available to improve patient care in today's increasingly competitive health care market place.

Highlights of the AMA House's actions include:

* A directive that all AMA activities regarding physician negotiation maintain the highest levels of professionalism and be consistent with the AMA's Principles of Medical Ethics and the Current Opinions of its Council on Ethical and Judicial Affairs.

* Approval for the immediate creation of a national labor organization, under the National Labor Relations Act, as an option for (a) employed physicians, and (b) residents and fellow physicians who are authorized under current law to collectively bargain.

* Continued support for the development of independent housestaff organizations for residents and fellow physicians. And the additional directive that the AMA be prepared to move ahead with a national labor organization in the event the National Labor Relations Board gives residents and fellows approval to collectively bargain under the National Labor Relations Act.

* Support and reinforcement of mechanisms for the Accreditation Council for Graduate Medical Education to address and resolve resident issues at the program and institutional levels.

* Continued vigorous support for antitrust relief for physicians and medical groups and the creation of a national organization to support development and operation of local negotiating units. These units would provide an option for self-employed physicians and medical groups consistent with the provisions of the Quality Health Care Coalition Act of 1999 (H.R. 1304) introduced by Tom Campbell (R-Calif.), or similar federal legislation, when enacted.

* A call for the AMA to work aggressively for antitrust relief with the U.S. Department of Justice and the Federal Trade Commission and for the AMA to help state medical associations achieve their own "state-action doctrine" legislation.

* Approved expansion of the AMA's private sector advocacy programs, including initiating litigation, stopping egregious health plan practices and helping physicians level the playing field with health care payors.

* Authorized programs to educate members and non-members of the possible limit on benefits and the risks to the formation of a national labor organization, concurrent to its creation.

"We will waste no time in turning the delegates' mandate into reality," Dr. Smoak said. "Our board will meet before the week is over to take the first steps. We'll report a full action plan within the next 30 days on how we will add this powerful new option to an already impressive array of tools that AMA physicians are using all across the country to fight for their patients' best interests.

"Throughout our 152-year history, AMA physicians have been able to make tremendous advancements in medical care and physician practice by joining together. We expect nothing less in this new endeavor," AMA President Nancy W. Dickey, MD, said. "The AMA Board looks forward to creating a labor organization for the profession that addresses the concerns of America's physicians and empowers them to act on behalf of our beleaguered patients and consequently, improves the health and well being of the citizens of America."

For more information, visit the AMA Annual Meeting Web site at http://www.ama-ssn.org/meetings/public/annual99/annual99.htm

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AMA FURTHERS ORGAN DONATION EDUCATION; GOVERNOR ADDRESSES HOUSE

In a high-profile visit to the AMA House of Delegates yesterday, Illinois Governor George H. Ryan urged physicians to take an active role in organ donation education. "It's a [medical issue] you can affect and have a big impact on," he said. Governor Ryan, who helped found Illinois' highly regarded organ donation education program, commended the AMA for its "Live and Then Give" campaign, which encourages physicians to become organ donors and to discuss the topic with their patients. Other organ donation efforts have taken place during the meeting, including a session sponsored by the Minority Affairs Consortium on organ donation in minority communities and a visit to Chicago's Navy Pier by members of the Medical Student Section to hand out organ donation cards.

For more information, contact: karen_goraleski@ama-assn.org

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AMA OUTLINES GUIDELINES FOR PHYSICIAN SALES OF HEALTH-RELATED PRODUCTS

The AMA adopted new ethical guidelines on Tuesday for physicians who sell health-related products from their offices. The new guidelines include three major points: Products should not be sold where benefits claims lack scientific validity; products should be distributed free or at cost; physicians should not engage in exclusive distributorships of health-related products.

* * * * * * * * * * * *

AMA ANTI-TOBACCO CAMPAIGN EXPANDED TO INCLUDE CIGARS

The AMA's considerable anti-tobacco policy was expanded yesterday to cover cigars. The literature on the specific health risks of cigars has been growing rapidly, with several studies appearing in the last few months.

* * * * * * * * * * * *

IOWA SIGNS ON TO AMAP CERTIFICATION PROGRAM

The AMA announced at the House of Delegates meeting yesterday that Iowa will join the District of Columbia and eight other states as a participant in the American Medical Accreditation Program (AMAP). The program is designed to streamline the fragmented and duplicative accreditation process that physicians currently face, offering a source for nationalized standardized information. The Iowa Medical Society, in partnership with AMAP, will offer physician quality assessment to more than 4,000 Iowa physicians.

* * * * * * * * * * * *

THANKS FOR READING!

This new AMA feature is designed to bring useful information to our physician members. We hope you found it helpful. Please feel free to forward this e-mail to other AMA members.

Health Network
LABORATORIES

TRANSFUSION MEDICINE

Irradiated Blood and Blood Components (Red Cells and Platelets)

Patients in the following categories are at high risk of developing TAGVHD (Transfusion Associated Graft vs Host Disease) and should, therefore, receive irradiated cellular blood and blood components (Red Cells and Platelets). **Irradiation should be included in each transfusion order.**

ADULTS

- Patients with hematological malignancies, i.e. acute and chronic leukemias
- Allogeneic and Autologous Bone marrow transplant patients/potential recipients
- Hodgkin's Disease / Non-Hodgkins Lymphoma and Mycosis Fungoides
- Patient receiving intense(very high dose alkylating agent) chemotherapy and/or radiation therapy
- Neuroblastoma, rhabdomyosarcoma, glioblastoma
- Directed (Designated) donor units
- Multiple Myeloma or Waldenstrom's Macroglobulinemia

PEDIATRICS

- Intrauterine transfusions and Exchange/replacement transfusion following intrauterine transfusions.
- Pediatric Hematology/Oncology patient and /or <1 year old with unknown diagnosis
- Congenital immune deficiency syndromes (SCID, ADA deficiency, Wiskott-Aldrich syndrome)
- Neuroblastoma, rhabdomyosarcoma, glioblastoma.
- Directed (Designated) donor units

For the following categories there is NO INDICATION for irradiation of celluar blood/components:

- Aplastic anemia (if not a Bone Marrow Transplant candidate)
- HIV infection/AIDS
- Solid tumors (except for those listed above)
- Term neonate

Leukocyte Reduced Cellular Blood and Blood Components (Red Cells and Platelets)

The leukocyte reduction filter will be used to provide Leukocyte Reduced Red Cells and Platelets. **The order should be written for a Leukocyte Reduction Filter for each transfusion order. Following are the current indications for Leukoreduction:**

- For patients who have experienced 2 or more febrile(recurrent) non-hemolytic transfusion reactions

- To prevent Human Leukocyte Antigen (HLA) alloimmunization due to presence of leukocytes.

  Hem/Onc

  - Patients with hematologic malignancies
  - Leukemia (Acute and Chronic)
  - Hodgkin's Disease/ Non-Hodgkin's Lymphoma
  - Allogenic and Autologous Bone Marrow Transplant patients/potential recipients.
  - Aplastic anemia

  Non Hem/Onc

  - Kidney and other solid organ transplant patients/potential recipients.

- To prevent CMV transmission:

  - Pregnant females (unless immediate delivery is imminent)
  - Patients with HIV

  If the patient is already CMV positive **leukoreducing filter is not needed.**
  If the patient is CMV negative or not tested for CMV then **use leukoreducing filter.**
  For pediatric HIV patients **use leukoreducing filter.**

  - Kidney and other solid organ transplant patients/potential recipients.
  - Allogeneic and Autologous Bone Marrow Transplant patients/potential recipients.

For the following categories there is NO INDICATION for Leukocyte Reduced blood/components:

- Solid tumors
- Term Neonates

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

a minute for the medical staff

A look at the new draft E&M guidelines for physician coding

by Tom Sills, MD
Clinical Financial Resource, Inc.
South Dartmouth, MA

There is good news about physician coding. The new guidelines for Evaluation and Management (E&M) coding, which are expected to go into effect sometime in the year 2000, should be simpler and easier to follow.

Currently, E&M coding is performed according to either the 1995 or 1997 guidelines. However, this is going to change. The American Medical Association (AMA) has drafted new guidelines to appease physicians who protested the 1995 and 1997 guidelines, saying they are too vague and complicated.

The AMA's CPT Editorial Panel has created a draft from which the Health Care Financing Administration is developing new E&M documentation guidelines. These new guidelines are now being piloted and will continue to be piloted through the rest of this year.

Shorter and simpler

Compared to the prior documentation rules, the AMA's draft revision is considerably shorter and simpler. The basic framework of selecting a code is the same. The level of service is still based on the key components of the history, examination, and medical decision-making.

However, the requirement for the level of these components is much easier to follow.

History: The new CPT draft describes the same four types of history: problem-focused, expanded problem-focused, detailed, and comprehensive. Each type of history is made up of four components: the chief complaint, history of present illness (HPI); review of systems (ROS); and past, family, and social history (PFSH). The grid below shows the progression for each type of history:

Type of history	HPI	ROS	PFSH
Problem-focused (brief)	One to three historical items of present illness or status of one to two chronic or inactive conditions.	N/A	N/A
Expanded problem-focused (brief)	One to three historical items of present illness or status of one to two chronic or inactive conditions.	Clinically pertinent, positive and negative responses for system related to problem(s)	N/A
Detailed (extended)	At least four historical items of present illness or status of at least three acute, chronic, or inactive conditions.	Two to four systems	At least one item from any history area
Comprehensive (extended)	At least four historical items of present illness or status of at least three acute, chronic, or inactive conditions.	Positive responses and clinically relevant negatives for at least five systems	At least one item from any two of three history areas.

These are significant changes from the old guidelines. The items in the HPI are not narrowly defined. They can include any historical item. For detailed and comprehensive histories, only two of the three categories (HPI, ROS, PFSH) need to be met.

Examination: The greatest outcry against the 1998 guidelines were the examination guidelines. The new draft has loosened these documentation requirements. CPT describes the same four types of examination but the required documentation for each type is different:

- Problem focused-examination: document one to five exam items
- Expanded problem-focused examination: document six to 11 items
- Detailed examination: document 12 to 17 exam items
- Comprehensive examination: document 18 or more items

The exam may be multi-system, single system, or any combination. The content of the exam is selected by the examining physician. The draft guidelines list approximately 150 exam items (such as auscultation of heart or palpitation of abdomen) that can be used as an exam item, the number of which determines the type of examination.

Medical decision-making: The draft guidelines also simplify the assignment of level for medical decision-making. There are three types: low, moderate, and high complexity. The straightforward level has been eliminated. The type is chosen by equating the patient's clinical situation with the descriptions in the grid below. The highest level in any one column will determine the type of medical decision-making.

It's important to keep in mind that this article refers to the draft guidelines, which will be modified and field-tested before being issued as new guidelines. Still, they give hope that the final form will be simpler and much more user-friendly than the 1997 and 1997 guidelines that are being used today.

Type of decision-making	Number of diagnoses and risk of complications	Procedure, test ordered, or amount of data	Management option
Low	One or two self-limited problem(s) One stable chronic illness Acute self-limited, uncomplicated problem Low risk of morbidity or mortality	Noninvasive or minimally invasive lab tests Noninvasive diagnostic procedures Noncardiac imaging studies Skin biopsy Superficial needle biopsy Arterial puncture	Rest Over-the-counter drugs Physical therapy/occupational therapy Management of one or two prescription drugs
Moderate	Three or more self-limited problems One chronic mild, or self-limited problem(s) Two or three stable chronic illnesses Undiagnosed new problem with uncertain prognosis Acute illness with systematic symptoms Moderate risk	Diagnostic endoscopy Stress tests Deep needle/incisional biopsy Cardiovascular imaging with contrast Obtaining fluid from body cavity Data to be obtained/reviewed requiring at least 10 minutes of physician time	Minor surgery Management of three or more prescription drugs or indication of new prescriptions Therapeutic nuclear medicine Hospitalization of patient
High	One of more chronic illnesses with severe exacerbations Four or more stable chronic illnesses Acute complicated injury Illnesses that pose a threat to life or function Abrupt change in bodily function	Intra-arterial cerebral angiography (excludes MRA) Data to be obtained/reviewed requiring at least 20 minutes of physician time	Major surgery Administration of controlled medications Therapeutic endoscopy in a patient with risk factors Parental drug therapy requiring intensive monitoring Total parental nutrition Decision for DNR

WOUND CARE CENTER®

AT

MUHLENBERG HOSPITAL CENTER

TEN MONTHS OLD AND GROWING..... HEALING WOUNDS

Current Staff:

Dr. Marc Granson, Medical Director
Dr. James Balshi, Vascular
Dr. Saeed Bazel, General Surgery
Dr. Neal Kramer, Podiatry
Dr. Edwin Hart, Podiatry
Dr. Mark Maehrer, Podiatry
Dr. Robert Murphy, Plastics
Dr. George Tyler, General Surgery

Peg Cowden, Program Director
Ginger Holko, Clinical Manager
Connie Hickernell, RN
Leah Bradshaw, RN (per diem)
Ina Levin, RN (per diem)
Monica Plata, Medical Assistant
Denise Cope, Office Manager

The Wound Care Center® at Muhlenberg Hospital Center is a comprehensive outpatient center designed to complement physicians' services and heal chronic nonhealing wounds.

Since we opened our center we have been pleased with the success of our program and the positive comments we have received from both physicians and patients.

We contribute our growth to market need, a specialized WCC staff, and to our success with healing wounds as a result of following our clinical pathway to wound management. We have outlined this pathway on the reverse side of this page for your reference.

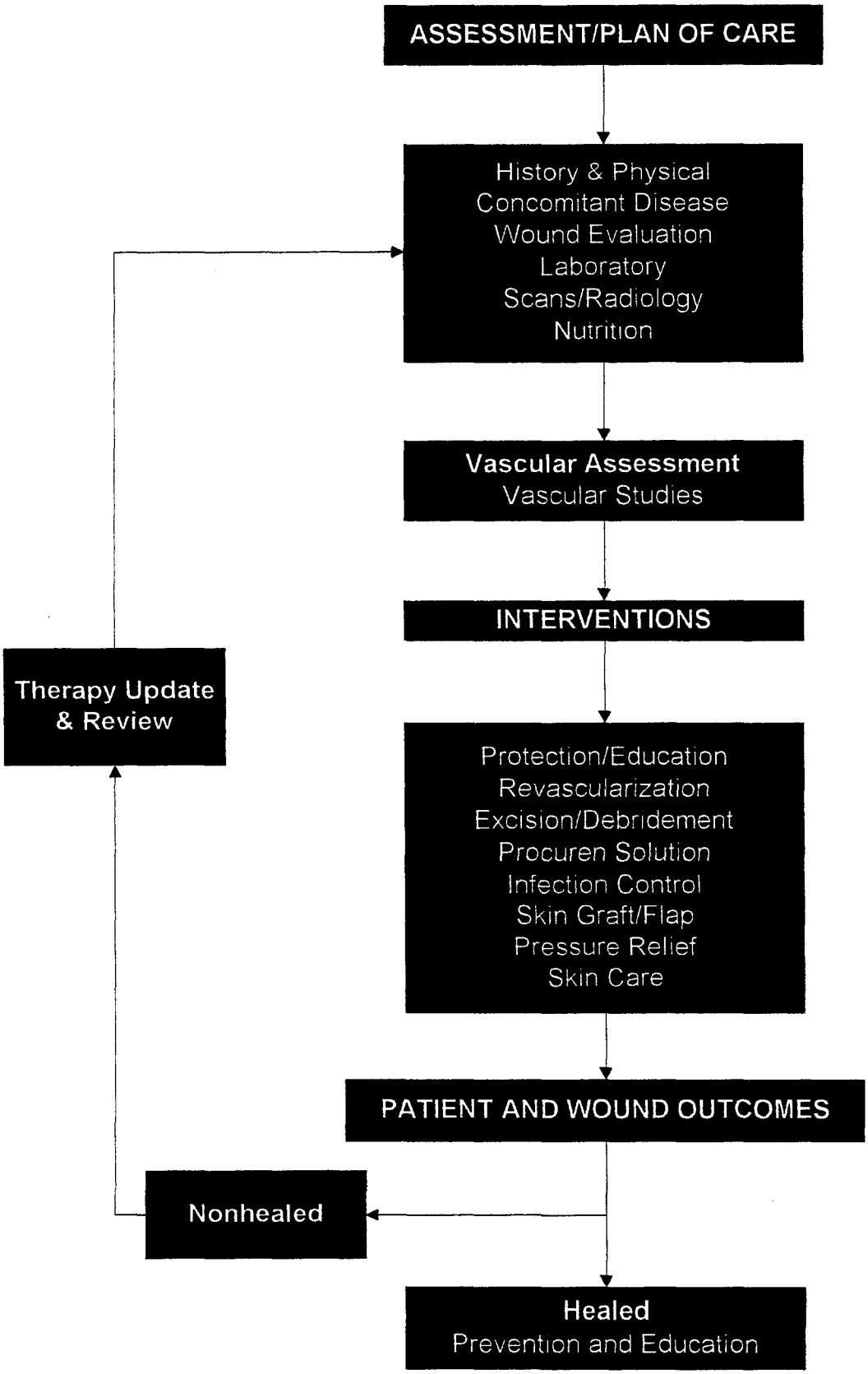
Growth Factor Therapies that we use, as appropriate include the following:

- **PROCUREN®** - autologous product, from the patient's own blood; multiple growth factors extracted from the platelets and placed in a clear liquid and applied once daily to the wound
- **Apligraf®** - bilayered living skin construct manufactured from human neonatal male foreskin tissue and with multiple growth factors; applied directly to the wound bed
- **Regranex®** - recombinant (not blood-derived) human platelet derived one growth factor indicated for diabetic neuropathic foot ulcers; applied once daily to the wound

Curative Wound Care Centers across the country have treated more nonhealing wounds than anyone, with an unmatched healing rate of over 80% (from outcome measurement data). As a Curative network member it is our goal to match and exceed those healing rates.

If we can assist you and your patients, please call your referrals to **(610)882-2989.**
We are open Monday through Friday 8 a.m. - 4:30 p.m. Voice mail messages after hours are welcomed. Also, visit our web sites: www.curative.com and www.lvhhn.org.

A Pathway to **Wound Management**



THERAPEUTICS AT A GLANCE

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

THROMBOLYTIC ALTERNATIVE

Reteplase is indicated for use in the management of acute myocardial infarction (AMI) in adults for the improvement of ventricular function following AMI, the reduction of the incidence of congestive heart failure and the reduction of mortality associated with AMI. Treatment should be initiated as soon as possible after the onset of AMI symptoms.

Compared to alteplase, reteplase has less affinity for fibrin, a longer half-life and greater thrombolytic potency. Also like alteplase, it activates plasminogen directly and does not require plasminogen complexing. Reteplase causes more fibrinogen depletion than alteplase, which could result in a higher frequency of bleeding complications. However, clinical trials have not demonstrated a difference.

Bleeding is the most common adverse effect associated with reteplase. Overall, bleeding rates have not differed in clinical trials comparing reteplase with alteplase or streptokinase. Rarely, allergic or anaphylactoid reactions have occurred during reteplase administration.

Reteplase is administered as two intravenous bolus 10 unit injections. Each bolus is administered intravenously over 2 minutes. The second bolus is administered 30 minutes after initiation of the first bolus injection. Each injection should be given via an intravenous line in which no other medication is being simultaneously injected. Alteplase (tPa) will also be available for use.

OXYBUTYNIN ALTERNATIVE

Tolterodine tartrate is approved for the treatment of patients with an overactive bladder with symptoms of urinary frequency, urgency or urge incontinence.

Tolterodine is extensively metabolized by the liver following oral dosing. In most patients ("extensive metabolizers") the primary metabolic route is the cytochrome P450 isozyme 2D6 (CYP 2D6), yielding the major pharmacologically active metabolite. A subset of the general population (about 7%) lacks CYP 2D6. In these patients ("poor metabolizers") the identified pathway of metabolism is the cytochrome P450 isoenzyme 3A4.

Tolterodine tartrate is contraindicated in patients with known hypersensitivity to the drug or the other product ingredients. It is also contraindicated in patients with urinary retention, gastric retention or uncontrolled narrow-angle glaucoma.

Tolterodine should be used with caution in patients with bladder outflow obstruction because of the risk of urinary retention and gastrointestinal obstructive disorders (eg, pyloric stenosis) to avoid gastric retention, patients being treated for narrow-angle glaucoma and patients with reduced hepatic or renal function.

Despite tolterodine's specificity for the bladder, it still has antimuscurinic effects on

the parotid gland and produces a dose-related dry mouth. The dry mouth can be mild to moderate, and the incidence increases with dose. Other reported adverse effects have included urinary retention, dyspepsia, headache, xerophthalmia, urinary tract infections, abnormal accommodation, constipation and headache. A complete list of the adverse effects reported with tolterodine therapy can be found in the product labeling.

Drugs that inhibit or induce the CYP 2D6 enzyme system may influence tolterodine's metabolism and the production and elimination of its active metabolite. Potent CYP 2D6 inhibitors in effect cause an extensive metabolizer to become a poor metabolizer.

No pharmacokinetic or pharmacodynamic drug interactions have been observed with warfarin, oral contraceptives (eg, ethinyl estradiol and levonorgestrel) and diuretics (eg, indapamide, hydrochlorothiazide, triamterene, furosemide).

The recommended initial dose is 2 mg orally twice daily with or without food. The 1 mg dose should be used in patients receiving CYP 3A4 inhibitors (eg, erythromycin, clarithromycin, ketoconazole, itraconazole, miconazole, mibefradil) or patients unable to tolerate the higher dose. Lower doses are not as effective as the 2 mg twice daily dose, and higher doses are associated with more side effects.

No adjustment in dose is necessary in elderly patients or patients with renal insufficiency. Patients with hepatic dysfunction should receive a lower dose of tolterodine, and the dose should not be higher than 1 mg twice daily. Safety and effectiveness of tolterodine have not been established in pediatric patients.

Tolterodine is available in 1 and 2 mg tablet strengths. Oxybutynin is available as a 5 mg tablet and a 5 mg/mL syrup. L.V.H. cost per day of therapy for tolterodine 1mg po bid is $1.88 and for 2mg po bid is $1.94. L.V.H. cost per day for oxybutynin 5mg po tid is $0.36.

Oxybutynin and tolterodine are equally effective in the treatment of patients with an overactive bladder with symptoms of urinary frequency, urgency or urge incontinence. Therapy with either agent is generally associated with adverse effects, but the tolterodine therapy may be better tolerated and requires less frequent dosing (two times daily versus three times daily). In addition, both agents need to be used with caution in patients already receiving medications that have anticholinergic side effects (eg, antihistamines, tricyclic antidepressants). Some prescribers and provider organizations may choose to use oxybutynin before tolterodine because of cost. However, a number of the patients will require discontinuation of the oxybutynin therapy because of side effects. In those cases, tolterodine is a reasonable alternative.

REPAGLINIDE (PRANDIN®): ADDED TO LVH FORMULARY

In May, the Lehigh Valley Hospital Therapeutics Committee unanimously approved the addition of repaglinide (Prandin®) to the Formulary. Repaglinide is short acting hypoglycemic agent used in the treatment of Type 2 Diabetes Mellitus.

Repaglinide is approved as monotherapy or in combination with metformin (Glucophage®) in patients with Type 2 Diabetes Mellitus. Repaglinide shares the same mechanism of action as the sulfonylureas. In contrast to the sulfonylureas, repaglinide as a shorter half life, which theoretically should decrease the

risk of hypoglycemia as well as decrease the incidence of down regulation of beta islet cells which promotes secondary drug failure.

Dosing in patients not previously treated or whose HbA1c is less than 8% should start at 0.5 mg before each meal. In patients who have been treated with other hypoglycemic agents or whose HbA1c is 8% or greater the dosing should begin at 1 or 2 mg before each meal. Doses should be changed according to patient response at weekly intervals until glycemic control is reached or until a maximum of 4 mg per dose or 16 mg per day. As with the sulfonylureas, patients should be monitored for hypoglycemia while taking repaglinide. Patients should be advised to take repaglinide right before a meal.

ADR REPORTING - FIRST QUARTER DATA

ADR reporting continued to be dominated by pharmacist and nursing personnel. Total suspected incidents were down for this period to sixty-two for the first quarter of 1999. One death was reported, but no cause-effect relationship was delineated. Below are the particulars for this quarter.

Table 1: **Adverse Reactions By Reporter**

Reporter	# Reports	% Reports
Pharmacist	41	66.1
Nurse	17	27.5
X-Ray Technician	2	3.2
Physician	2	3.2
TOTAL	62	100

Table 2: **Adverse Reactions By Drug Category**

Drug Category	# Reports	% Reports
Antibiotics	26	41.9
Contrast Dyes	5	8.1
Psych/Neurologic Agents	1	1.6
Narcotic Analgesics	3	4.8
Abciximab (ReoPro)/heparin/TPA	6	9.7
Dopamine	1	1.6
Cardiac	5	8.1
Other	15	24.2
TOTAL	62	100

Table 3: **Probability of Drug-Related Reactions**

Probability	# Reports	% Reports
Doubtful	0	0
Possible	23	37.1
Probable	39	62.9
Highly Probable	0	0
TOTAL	62	100

Table 4: **Adverse Reaction Severity**

Classification	# Reports	% Reports
Mild	16	25.8
Moderate	37	59.7
Severe	9	14.5
TOTAL	62	100

Medical Staff Progress Notes

THE CENTER FOR EDUCATIONAL DEVELOPMENT AND SUPPORT

August, 1999

Announcements:

Saving lives, supporting people's health, confronting extreme danger, and patching people back together, demands an enormous amount of physical and emotional energy. These are several factors that lead health care professionals to getting burned out and becoming dissatisfied and unhealthy. The many pressures and constant barrage of technology and media have caused many people to actively pursue balance.

To help people within LVHHN achieve balance, a Critical Incident Stress Management Team has been assembled to help prevent or mitigate the negative impact of acute stress. The program is coordinated by Betty Brennan, Director, Emergency Department--CC/17 and Barbara Rutt, Coordinator Pastoral Care-CC/17.

Critical Incident Stress Management (CISM) is a confidential group discussion about a traumatic event or series of events facilitated by a debriefing team. The debriefing team is made up of various volunteers including mental health professionals, nurses, pastoral care, and other professionals that provide peer support, who are certified in CISM. 17 employee volunteers are certified in CISM.

The CISM process is based in crisis intervention and educational intervention theories. It is designed to reduce the psychological impact of a traumatic event, prevent the subsequent development of a post-traumatic stress syndrome, accelerate recovery in normal people who are having normal reactions to abnormal events, and serve as an early identification mechanism for people who require professional mental health care following a traumatic event. The debriefing is not psychotherapy or a group therapy session. It is a structured group meeting or discussion where people have the opportunity to discuss their thoughts and emotions about a distressing event in a controlled, structured and rational manner. It is ***confidential***. We need to have a pact of trust between all who participate, and what is said in the room will stay in the room. No notes or recordings will be made.

Anyone can activate the CISM process by contacting Pastoral Care at 402-8465. Pastoral Care will notify the team and arrange for debriefing within 24-72 hours post event. Debriefing can last from 1 to 3 hours.

Some examples of times to activate the CISM process:

- An accident/severe injury involving a staff member at work or home
- Disaster event: explosion, school bus accident with injuries, tornado
- Sudden critical illness, death, suicide or murder of a staff member or physician
- Injury or death of a staff member's family
- Multiple patients/teenage death or injuries
- Multiple difficult cases/patients

The CISM team was formed for all LVHHN employees, therefore if you or your colleagues want help, please activate the CISM process. If you are interested in becoming a volunteer CISM team member or have questions regarding CISM, please contact Pastoral Care at 402-8465.

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.

New Publications-CedarCrest & I78

"Glenn's Urologic Surgery," 5th edition
Author: S.Graham Call # WJ168G559 1998

"Systematic Reviews: Synthesis of Best Evidence for Health Care Decisions"
Author: C. Mulrow, et al.
Call # W 20.5 S995 1998

New Publications - 17th And Chew

"The Psychiatric Clinics of North America"
Subject: "Addictive Disorders"
Guest Editor: Norman Miller, et al.
June 1999 - Vol. 22, No. 2

"Primary Preventive Dentistry"
Author: N. Harris, et al.
Call No. WU 113 P9522 1999

New Publications - MHC

"Clinical Electrocardiography: A Simplified Approach," 6th ed. Author: A. Goldberger
Call #WG 140 G616c 1999

"Surgical Clinics of North America"
Subject: "Endovascular and Minimally Invasive Vascular Surgery"
Guest Editor: W. Pearch, et al.
June 1999 - Vol. 79, No. 3.

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, & 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,contact Craig Koller via email or at 402-1427.

News from Youth Career Development:

With the 1999-2000 school year fast approaching we are looking for mentors willing to allow junior and seniors in high school shadow you for a day or to speak to high school students about what it is like being a healthcare professional. Please contact Sallie Urffer at 402-1403 or via email if you are willing to be a mentor.

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

Medical Staff Progress Notes
Grand Round and
Tumor Board Schedule

1999 August 1999

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
1	2 12 C/R Tumor Board - JDMCC - CR1 A/B	3 8am Pediatric Grand Rounds - 17-Aud	4	5 12 Noon GI Tumor Board - JDMCC - CR1 A/B	6 7am OBGYN Grand Rounds -17 Aud 12 Noon Breast Tumor Board - JDMCC- CR1 A/B	7
8	9	10 7am Ambulatory Clin Guideline Dev - SON 8am Pediatric Grand Rounds - 17-Aud	11 12 Noon Pulmonary Tumor Board - JDMCC - CR1 A/B	12 12 Noon Combined Tumor Board - JDMCC - CR1 A/B	13 7am OBGYN Grand Rounds -17 Aud 12 Noon Breast Tumor Board - JDMCC- CR1 A/B 12 Noon Pediatric Noon Conf - 17 Aud	14
15	16 12 C/R Tumor Board - JDMCC - CR1 A/B	17 8am Pediatric Grand Rounds - 17-Aud	18	19 12 Noon Combined Tumor Board - JDMCC - CR1 A/B	20 7am OBGYN Grand Rounds -17 Aud 12 Noon Breast Tumor Board - JDMCC- CR1 A/B	21
22	23	24 8am Pediatric Grand Rounds - 17-Aud 12 Noon Urology Tumor Board - JDMCC - CR1 A/B	25	26 12 Noon ENT Tumor Board - JDMCC - CR1 A/B	27 7am OBGYN Grand Rounds -17 Aud 12 Noon Breast Tumor Board - JDMCC- CR1 A/B 12 Noon Pediatric Noon Conf - 17 Aud	28
29	30	31 8am Pediatric Grand Rounds - 17-Aud				

LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

Cedar Crest & I-78
P.O. Box 689
Allentown, PA 18105-1556

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Medical Staff Progress Notes

Medical Executive Committee

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 20th of each month. If you have any questions about the newsletter, please call Mrs. Seifert at (610) 402-8590.