LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

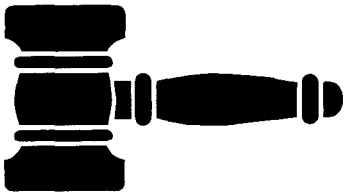
PROGRESS NOTES

Medical Staff

November, 2000 Volume 12, Number 11

In This Issue . . .

Happy Thanksgiving!



From the President

Colleagues,

Dr. Donald Levick has accepted the position as Director of the coordinating group that will be responsible for tailoring and implementing the computerized Physician Order Entry (P.O.E.) system that will be a part of the PHAMIS 4N upgrade of the Patient Management System. Don will be leading several groups, which will help to tailor the system, so that it will help us to be efficient while improving the quality of the care we deliver to our patients.

One of the main drivers for the implementation of this new system is to help reduce the number of errors that occur in the hospital. The recent Institute of Medicine report, ***To Err is Human***, pointed out the frequency and severity of these errors. Although the accuracy and magnitude of the data on which this report is based has been debated, the fact that errors do occur is unquestioned.

We on the Medical Staff can be proud of our outstanding accomplishments of quality. When we compare ourselves to other similar medical staffs and organizations, we generally are superior on most measures of quality. Despite this excellent record of achievement, many opportunities for improvement remain. This is particularly true in the area of the accuracy of physician orders.

Dr. Zubina Mawji collected the following information for the LVPHO Care Management Council:

> The process of medication delivery in the inpatient setting can be separated into four distinct functions, which include: order writing, transcription of orders, dispensation, and administration. These activities occur in succession, with each activity's accuracy often dependent upon the previous step. A review of our hospital data indicates that over the last six months, of the documentation deficiencies reported, 57% were due to order writing, 18% due to transcription, 10% due to dispensing, and 13% due to administration.

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By eliminating most inaccuracies of order writing and transcribing, physician order entry has the potential to eliminate **75%** of potential medication errors at LVH. Furthermore, since medication delivery relies on four functions that occur in succession, any errors that occur early in the process, due to incorrect orders or transcription, can be carried through to incorrect dispensing and administration. Therefore, physician order entry has the potential to impact all ***four*** areas of medication delivery.

Finally, physician order entry will benefit patients, but it may also reduce the overall cost of care. Data indicates that medication errors occur in 5.3 percent of hospitalized patients and cost health care organizations from $2,500 to $4,500 per episode.[1]

A recent article in the ***Archives of Internal Medicine***[2] addressed the potential benefits of a computerized physician order entry system.

"The implementation of computerized order entry systems, supplemented by clinical decision support, can be effective in improving physicians' prescribing practices. Previous research has shown that computerized order entry could reduce costs, improve care and prevent medical errors by providing information such as drug prices and laboratory results. To further gauge the impact of computerized prescribing practices, researchers from **Harvard Medical School** evaluated ordering patterns at Boston's **Brigham and Women's Hospital**, where an average of 14,000 computer orders are placed daily. After an educational program proved unsuccessful in changing ordering behavior, the researchers established a computer intervention, in which a clinical support program presented guidelines on the screen for which drugs to prescribe within a class of medications and suggested dosages. The study's authors note that implementing a computerized physician order entry system can be "difficult and expensive"; however, they point out that the return on such an investment is "substantial," as one of the studied interventions saved about $250,000 in the first year. Further, overall savings from reduction of drug costs, appropriate use of lab tests and diagnostic studies and ADE prevention are estimated to be between $5 million and $10 million annually."

I have been collecting a series of written orders from LVH patient charts, which are truly remarkable due to the difficulty in reading and interpretation. These confusing and illegible orders increase the work of the nursing and administrative staffs who have to decipher them. They also increase the number of calls to physicians who have to interpret the orders. This takes up our valuable time and interrupts our day. They also can potentially result in errors that may adversely affect our patients.

We believe that a computerized Physician Order Entry system is in the best interests of our patients. It will increase the quality of care we deliver to our patients. It will reduce errors. It should eventually make us more efficient in our daily patient care activities. We recognize that any new complex system will require a period of learning and familiarization until it becomes acceptable and "second nature." We have learned how to use the present PHAMIS LastWord system and now are comfortable using it and have actually become dependent upon the information it provides for us in caring for our patients. (Remember September 14 when the system was unavailable for several hours and how much we complained about how our day was made much more difficult!) Remember the initial concerns about the IMNET system. Most of us have now found that this system makes it much easier to sign and complete our charts than the old way. Most of us would not want to go back to the "old way" and have to go the Medical Record Department each week.

I believe that this new system will have the same affect on our daily activities in the hospital. There will be a learning curve. Initially, we will all have to struggle until we become comfortable with the new system. Once we learn how to use the system, we will begin to depend on it. After a time, we will wonder how we ever got along without it!

Don Levick has pledged to help make the system as "physician friendly" as possible. A committee of physicians is being organized to help to design and tailor the Physician Order Entry system so that it meets our needs. Members of this committee will also be involved in demonstrating the system to their colleagues. They will, in effect, become ambassadors or envoys to help their Medical Staff colleagues learn to use the system. They will also receive suggestions from their colleagues as to how the system can be made more effective and easier for their personal use. Individual members of the Medical Staff will be able to tailor the computer screens for their personal use. Information Services has pledged that doctors on the staff will be able to develop their own order sets for use with their patients. Current preprinted order sets will also be available for use.

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[1] VHA email 9/28/2000

[2] Teich et al, Arch Intern Med. 2000; 160:2741-2747

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Extensive physician and staff training will be available prior to the activation of the new system. Those of us who have been involved with this concept from the beginning understand that the introduction of this new way of caring for our patients will represent a big change. We recognize that if the new system is to be successful, we will need "buy-in" from the Medical Staff. Without this "buy-in," the system is bound to fail.

The hospital administration, the I/S Department staff, and the physicians involved in this project have pledged to wait to activate the new system until we feel comfortable with **P.O.E.** and the medical and nursing staffs are trained. There will need to be adequate support from physicians and other members of the hospital family before the Physician Order Entry part of the new Patient Management System is activated. **"It won't happen until we are ready."**

Don will be providing us with regular updates in ***Medical Staff Progress Notes*** on the efforts of his committee as the Physician Order Entry project moves forward.

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.

As most of you already know, LVH has announced that without significant changes in the hospital's current Aetna/U.S. Healthcare contract, the hospital will not renew that contract when it expires on March 1, 2001. I am including in this article information to help bring all of you up-to-date regarding the hospital's position and where the discussions with Aetna/U.S. Healthcare stand.

Despite reassurances you might have heard to the contrary from Aetna, LVH's attempts to negotiate a fair arrangement with Aetna have been disappointing, and it is unlikely that the contract will be renewed when it expires on March 1, 2001.

To date, LVH has received two proposals from Aetna's negotiating team, and both were extremely inadequate. Aetna's latest offer would actually pay 12.5 percent less for Medicare patients ($7,700 per person) than regular Medicare reimbursement ($8,800), when, in fact, Aetna's Medicare enrollees are sicker than our average Medicare patients and require more resources for their care.

The hospital seeks payments from AUSHC that produce a positive margin, which LVH needs to maintain staffing levels and compensation, fund investments in new medical technology and patient care initiatives that benefit the Lehigh Valley. We simply cannot accept a financial arrangement that forces Lehigh Valley Hospital into a negative margin situation, nor should our community accept the premise of a lower level of care for Aetna enrollees that is implied in Aetna's proposed contract terms. The contract produces a net loss of 35 percent of revenues annually for Lehigh Valley Hospital. Last year alone, AUSHC paid Lehigh Valley Hospital $10 million less than was required for health care services provided to its enrollees.

As you know, the care of our patients is our first priority. It is simply not in the best interests of the people of the Lehigh Valley, Lehigh Valley Hospital or the LVHHN medical staff, to sacrifice the quality of care we provide **to subsidize a for-profit insurance company** by accepting a financially devastating contract.

Our communication effort extends to caregivers, patients, community leaders, CEOs and benefits managers of area businesses and specially trained telephone operators at 402-CARE who have spent a great deal of time with patients who call or visit, helping to explain options for insurance coverage so individuals can make informed decisions. This week, for the second time, we are sending letters to businesses updating them on our negotiations with Aetna.

Like our colleagues in the business community, we too are very concerned with costs. Through our operations improvement initiative, we have reduced our operating costs by $106.3 million over the last eight years and reinvested those savings in needed programs and services to enhance the scope and quality of care Lehigh Valley Hospital provides to our community.

LVH's workforce - the bulk of its costs - was reduced by 21.5 percent, or the equivalent of 850 full-time positions over the eight-year period. In terms of cost per case, a standard measure of efficiency in the health care industry, over the last eight years LVH has had an average increase of 1% per year, at a time when inflation was double or triple that amount. Despite the many challenges posed by an aging population, technological innovations and a biological revolution, we are committed to maintaining our efforts at cost control in the future.

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> I find the situation with Aetna regrettable. LVH's requirements of Aetna are not unreasonable. We ask no more from Aetna than we receive from the many other insurers with whom we have negotiated fair and mutually acceptable arrangements in a reasonable and collegial manner. Unfortunately, Aetna doesn't seem to share this same outlook regarding the current contract negotiations.[3]

PAGING

When paging your physician colleagues, remember to use the blue "***Medical Staff Handbook***" to find the direct pager numbers. You can speed the response time by direct paging. This will reduce the burden on the page operators and, as a result, will decrease the time you have to wait "on hold" to place your page.

Several years ago, I suggested some **"Guidelines for Consultation"** in ***Medical Staff Progress Notes.***[4] I am not going to reprint these here at this time, but it has been pointed out to me on several occasions that some of the suggestions regarding our professional interactions are frequently being ignored. I suspect that many of these failures are a result of our busy schedules. As I said in 1997, *"Physicians are professionals, and as professionals, we expect and deserve a certain amount of respect from our physician colleagues."* Is it fair or appropriate for a physician to receive a call at 10:30 p.m., from his/her answering service requesting him to perform an "urgent" consultation on a hospitalized patient without the courtesy of a call from the requesting physician? Not only would such a call be the professional thing to do, but the requesting physician could provide important information as to the reason for the consultation and any historical information which would be helpful to the consultant. Many of us have concluded that if the physician requesting an urgent consultation at night does not have the respect for his/her colleague to make a personal call requesting and explaining the reason for the consultation, then perhaps the consultation is not important enough to leave home and come back to the hospital to do. The consultant should also call the requesting physician to describe his findings and recommendations after the consultation is completed, unless asked not to call back at the time of the request.

Don't forget to get your influenza vaccinations this fall. By many of us getting our influenza vaccinations this year, we can help to develop "herd immunity." If a large enough group of physicians and hospital staff are immunized, there will not be enough unimmunized individuals to allow an influenza epidemic to spread. It is now time to begin to think about getting your influenza vaccination for the 2000-2001 influenza season.

E-MAIL

One more time, I'd like to encourage all members of the Medical Staff to read their email regularly or to designate a staff member to be your appointed "surrogate" who can read and print out your email messages for you on a daily basis. If you or your staff need help in assigning a "surrogate," please call Information Services at (610) 402-8303.

Remember the Medical Executive Committee resolution regarding printing your name after your written orders and progress notes. This is now part of the Rules and Regulations of the Medical Staff of Lehigh Valley Hospital. If it becomes too much of a burden to print your name, please call Medical Staff Services at (610) 402-8590 to request a pocket stamp with your name, pager number, and office phone number. It will be provided free of charge by the hospital.

Recently, the Atlantic City Medical Center recruited "handwriting experts" to curb prescription errors. The hospital said its handwriting course is the first of its kind on the East Coast and it is the third hospital in the U.S. to hold such an event.[5] Do any of us really think this is the solution to our legibility problems?

Finally, there is a new addition to the e-mail bulletin boards -- the Medical Staff Directory. It is now available under **Directories** in e-mail by clicking on **Bulletin Boards**. This provides a way to look up any physician on our Medical Staff, their group name and members, their phone numbers and pager numbers. This is another example of the benefits of the computer and our e-mail system to provide up-to-date information to members of our Medical Staff and hospital family.

Stay tuned for more about the cost of prescription drugs, the pharmaceutical industry, and what we can do to deal with pharmaceutical company marketing in my next month's (and last) ***Medical Staff Progress Notes*** article. When you're offered a free Thanksgiving turkey or ham, courtesy of your friendly pharmaceutical representative, just think about where the money for this gift comes from!

Remember to vote in the November general election. Have a Happy Thanksgiving!

David M. Caccese, MD
Medical Staff President

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[3] Email from Dr. Elliot J. Sussman 10/13/2000 (with my edits).

[4] Guidelines for Consultation, ***Medical Staff Progress Notes***, July 1997.

[5] ***The Philadelphia Inquirer*** 10/4/2000.

News from the Health Information Management Department

LVH HIM Departments

Change in Office Hours at Cedar Crest & I-78 - Due to decreased physician activity, the new office hours at Cedar Crest & I-78 are 7 a.m. - 8:30 p.m. (Monday - Friday) and 7 a.m. - 5 p.m. (Saturday - Sunday).

When there is no staffing available at either the Cedar Crest & I-78 or 17th & Chew sites, physicians and residents may access the department with their photo ID badge to utilize the PC's to review or complete medical records. If you have difficulty accessing the HIM Department at either the Cedar Crest & I-78 or 17th & Chew sites, please call Susan Cassium at (610) 402-8330.

Short Procedure Unit (SPU) Cases

A *history and physical* is required for any invasive procedure that places the patient at significant risk, regardless of whether the procedures is done (ambulatory surgery, SPU, GI Lab, Invasive Radiology, etc.) Form (MRD-60), specifically designed for use in these areas, can be ordered from the LVH Print Shop utilizing e-mail bulletin board, forms_/LVH. This form allows you to document a short history and physical, procedure and discharge summary, all on the same form.

Procedure Request/Consent Form

The *Procedure Request/Consent Form* (MRD-04), which is required to be filled out completely, *dated and timed*, was revised in January 2000 as a consolidated form for LVH and LVH-M. Forms can be ordered through the hospital via Pic 'n Pac.

Document Imaging

Universal Chart Order - The HIM Department has received many concerns from clinicians that viewing historical records is difficult from the document imaging system because documents are not in chronological date order. HIM staff are working with the patient care units to assure that the charts remain in chronological order when patients are on the unit and after discharge.

If you need to review a discharged patient's record that has been removed from the binder, please remember to keep the chart in order.

The HIM staff will also review charts after discharge to assure that there are no large missing portions in addition to assuring that the progress notes and orders are in chronological date order.

Editing Transcribed Reports - If you encounter a report that needs corrections, you may print the report from Phamis/IDX, make the corrections, and send to the HIM Department at Cedar Crest & I-78. Be sure to update your deficiency in the imaging system to indicate that the report is being corrected.

Hardware System Upgrade - Due to the rapid growth and wide acceptance of the document imaging system (electronic signature, chart completion, and chart review), the Information Services Department will be upgrading the hardware and clinical work stations to provide increased speed and capacity. This upgrade will quadruple the optical disk capacity, while providing additional servers.

Software Upgrade - A software upgrade is scheduled within the next four months that will provide additional features for the clinicians and Health Information Management Department. Some of the new features that will impact clinicians include:

- Physician Groups - Allows definition of physician groups with ability to complete deficiencies for group members.
- AutoSign - Allows physician to define a time delay for automatic presentation of documents for electronic signature, with ability to sign entire batch at one time.
- Encounter Screen - Allows more reviewing functionality from the encounter screen to move from patient to patient.
- User Defined Record View - Allows users to set up and change his/her own record view (documents to be viewed).
- Missing Text - Gives clinician the ability to add missing text to imaged documents (transcription, written documents, etc.).

Verbal Orders

According to Department of Health regulations, *verbal orders must be signed/dated/timed within 24 hours following the order.* Clinicians who take verbal orders are tagging the orders with a yellow "sign here" label to alert physicians of orders that need signatures. Since attending physicians are responsible for their patients, the attending physicians are being asked to check the charts on daily rounds for verbal orders that may have been given by the residents or consultants on their patients.

The majority of upcoming JCAHO record reviews for compliance will be done by surveyors on the patient care units. Verbal orders tagged and not signed by the physician during the hospital stay are not included as a deficiency after discharge since they must be signed/dated/timed within 24 hours following the order.

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Pennsylvania State Law - "Oral orders for medication or treatment shall be accepted only under urgent circumstances when it is impractical for the orders to be given in a written manner by the responsible practitioner. The order shall include the date, time, and full signature of the person taking the order and shall be countersigned by a practitioner within 24 hours. If the practitioner is not the attending physician, he must be authorized by the attending physician and must be knowledgeable about the patient's condition."

Bylaws of the Common Medical Staff - "A physician may not give a verbal order except in an emergency situation. When a verbal order is taken in an emergency, it must be counter-signed by a practitioner within twenty-four (24) hours. If the practitioner is not the attending physician, he or she must be authorized by the attending physician and must be knowledgeable about the patient's condition."

Documentation Requirements

The following list summarizes required documentation in the medical record. In addition, the requirements have been placed at dictate stations and in the HIM Departments at LVH (Cedar Crest & I-78) and LVH-M for your assistance.

History and Physical

H&P in the Inpatient Setting - Documentation should include the following:

- Patient Complaint
- History of Present Illness
- Previous Medical History
- Family and Social History, where pertinent
- Review of Symptoms
- Vital Signs
- Physical Examination

H&P in the Outpatient Setting

--All *ambulatory procedures in the operative suite* require a complete H&P prior to the procedure and should include the following:

- Indications/symptoms for surgical procedure
- Previous medical history
- Current medications/dosages
- Known allergies/reactions
- Past medical/surgical history (including co-morbid conditions)
- Vital signs
- Physical examination

--All *ambulatory procedures not performed in the operative suite* that place the patient at significant risk require a brief H&P consisting of the following:

- Reason for procedure
- Significant past medical history
- Current medications
- Allergies
- Plan for anesthesia
- Post-operative plan and, at a minimum, a record of vital signs
- Examination of heart, lungs, and part to be invaded

Discharge Summary/Note

Discharge Summary in the Inpatient Setting - The clinical resume (Discharge Summary) should recapitulate, concisely:

- Diagnoses/procedures
- Reason for hospitalization
- Significant findings
- Procedures performed and treatment rendered
- Condition of the patient on discharge; and
- Any specific instructions given to the patient and/or family, as pertinent

Discharge Note in the Ambulatory/Outpatient Setting or patients hospitalized less than 48 hours

- Final diagnosis
- Condition on discharge
- Discharge instructions to patient/family (meds, diet, activity, etc.)
- Follow-up care

Consideration should be given to instructions relating to physical activity, medication, diet and follow-up care. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague or relative terminology, such as "improved."

Discharge summaries are to be dictated by the attending physician or designee at the time of discharge.

If you have any questions regarding any of these issues, please contact Zelda Greene, Director, Health Information Management, at (610) 402-8330.

Effective November 1, the Wound Care Center®, located at Lehigh Valley Hospital-Muhlenberg, will be closed.

Illegible Handwriting

Due to the ongoing problem of illegible handwriting by numerous members of the Medical Staff, the Medical Executive Committee directed the Bylaws Committee to consider inclusion in the Bylaws a requirement that wherever a signature appears in a patient chart, it must be followed by a printed name. Upon review of the Bylaws and the Medical Staff Rules and Regulations pertaining to legible handwriting, the Bylaws Committee recommended a revision to the current language in the Rules and Regulations as follows:

Medical Staff Rules and Regulations – E. RECORDS, #11: All orders and progress notes written on the chart shall be dated. Timed documentation is encouraged. All orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. ~~Any practitioner with non-legible handwriting~~ Each practitioner will be required to print or stamp his or her full name under his or her signature.

At its October meeting, the Medical Executive Committee approved this revision to the Bylaws. Therefore, **all members of the Medical Staff are reminded to print or stamp his or her full name under his or her signature wherever it appears in a patient's chart.** A signature stamp will be provided by the hospital to physicians who feel that printing their name is too burdensome. To order a stamp, please contact Janet M. Seifert in Physician Relations at (610) 402-8590.

Important Notice

Due to a lack of authorization for outpatient services, each Lehigh Valley Hospital site has been loosing revenue from managed care plans. This lost revenue is currently being tracked and reported, and has been found to be significant.

Authorizations for outpatient services are required from most, if not all, managed care plans for CT scans, Ultrasound, and Nuclear Medicine studies, as well as Interventional Radiology procedures. These authorizations cannot be obtained by the hospital. The managed care plans require the ordering, referring, or, in certain circumstances, the primary care physician to obtain them.

In order to curtail the loss of revenue, staff members have been assigned to follow up with the ordering/referring or primary care physician's office to insure that every managed care patient requiring prior authorization has the proper authorization for procedures and document it in Phamis Lastword. These confirmation calls will be done between the time the procedure is scheduled and 24 hours from the time of the procedure. If the proper authorization is not obtained, the procedure will not be completed at that time and will need to be rescheduled.

If you have any questions regarding this issue, please contact Lisa Coleman, Director, Admitting/Registration/Pre-admission Testing/Scheduling, at (610) 402-8066, or Mark Holtz, Vice President of Operations, at (484) 884-4710.

Radiology News

In order to expedite the care of patients and to make sure that the correct studies are performed, guidelines have been developed for ordering imaging studies.

The following are guidelines for ordering radionuclide bone scans:

- If the clinical indication is to rule out osteomyelitis, the order should read three-phase bone scan since the vascular phase is very important for this entity.
- If there is any history of cancer, the order should be written as a whole body bone scan in order to have a comprehensive examination for any occult sites of metastatic disease.
- If the patient is 50 years of age or less and has low back pain, the order should read - multi bone scan series with spine, pelvis, hips, femurs and SPECT imaging of the lumbar spine.

The following indications should have an order for three-phase bone scan:

- Osteomyelitis, septic arthritis, reflex sympathetic dystrophy and loosening vs. infection of a prosthesis.
- Three phase bone scans are not necessary for avascular necrosis.

The following is a guide for ordering gallium scans for the clinical concern of lymphoma:

- If the clinical concern is staging Hodgkins or non-Hodgkins lymphoma, the order should read - whole body gallium scan with SPECT of the chest, abdomen and pelvis.

If you have a question, please contact Robert J. Rienzo, MD, in Nuclear Medicine, at (610) 402-8387.

LVDI - State-of-the-Art Ultrasound

Lehigh Valley Diagnostic Imaging (LVDI) has taken another step towards ensuring its patients of diagnostic exams that are accurate, safe and comfortable, by acquiring a state-of-the-art ultrasound system.

The LOGIQ 700 PRO system's advanced coded technology has put LVDI at the forefront of diagnostic technology. It has a combination of superb image quality and deep penetration, which means that ultrasound can now be used to examine anatomy that could once be evaluated only with more invasive tests.

Ultrasound creates images from high-frequency sound waves, avoiding exposure to ionizing radiation. The technology in this system provides substantially improved imaging of the vascular system and deep-seated abdominal structures. It provides excellent diagnostic confidence, often without the need for additional tests.

The acquisition of LOGIC 700 PRO, developed by GE Medical Systems, underscores LVDI's commitment to physicians and patients. Providing advanced technology to diagnose disease earlier and more accurately can help translate into successful treatment for the patient. If you have any questions regarding this issue, please contact Alan H. Wolson, MD, Chief, Division of Diagnostic Radiology, at (610) 435-1600.

News from Infection Control

C. difficile has become a major problem as a nosocomial pathogen for hospitals across the country. Prevention and control of this organism has proven to be an ongoing challenge.

Although the most common clinical manifestation of C. difficile infection is diarrhea, the disease spectrum ranges from asymptomatic colonization or fecal excretion to pseudomembranous colitis (PMC) to Toxic Megacolon, which may present with signs of an acute abdomen but without diarrhea.

Symptoms of C. difficile may consist of only a few loose stools per day or multiple, large volume, watery stools and signs of dehydration. Stools may have mucus or evidence of occult blood. In addition, a distinct fecal odor is often recognized. Other symptoms may include abdominal pain, ileus, fever, and leukocytosis.

Although poor handwashing is known to play a key role in the spread of infection, there is evidence that compliance with handwashing protocol is low in many hospitals.

It is IMPERATIVE that everyone adhere to the following Infection Control practices designed to prevent transmission of nosocomial C. difficile.

- **Barrier Precautions**
  - **Glove use for all patient contacts**
  - **Adherence to strict handwashing between all patients**
  - **Contact precautions or cohorting**
- **Clean the Environment Meticulously**
- **Judicious Utilization of Antibiotics**

No single infection control practice alone can effectively prevent or control nosocomial C. difficile infections. However, a combination of all the practices together can make a difference. It requires the active participation of all healthcare providers in all disciplines to make it work.

If you have any questions, please contact Terry Burger, Manager, Infection Control at (610) 402-0680.

Get Your Flu Vaccine!

Protect yourself, protect your family, and protect your patients! This year, the hospital is striving to achieve an 80% vaccination rate for flu among doctors, residents, and healthcare workers. In anticipation of a pandemic this year, vaccination is extremely important. Members of the Medical Staff can be vaccinated in the hospital Employee Health Office at both Cedar Crest & I-78 and LVH-M as a courtesy if they cannot get the vaccine in their own offices.

Employee Health Walk-In Hours include:

Cedar Crest & I-78
Monday, Wednesday, Friday - 7 to 8:30 a.m.
Monday & Thursday - 1:30 to 4 p.m.
Tuesday - 1 to 3 p.m.

LVH-Muhlenberg
Tuesday - 9 to 11 a.m.
Wednesday - 2 to 4 p.m.
Thursday & Friday - 8 to 10 a.m.

Healthcare workers, including members of the Medical Staff, are **NOT** permitted to bring food or drink on the patient care units. This is a JCAHO requirement.

Stress Ulcer Prophylaxis

At its October meeting, the Medical Executive Committee approved Stress Ulcer Prophylaxis Protocol which was spearheaded by Stanley J. Kurek, Jr., DO, Division of Trauma-Surgical Critical Care/General Surgery, Section of Burn/Pediatric Trauma, in conjunction with the Trauma-Surgical Critical Care Clinical Management Protocol Committee. A copy of the protocol is attached on Pages 25-27.

Coding Tip of the Month

Dehydration - When documenting dehydration, it is important that the word "dehydration" be documented in a patient's record. Indicators such as rehydrate, give IV fluids, dry skin/mucous membranes, poor skin turgor, profuse vomiting/diarrhea, will hydrate, etc., may suggest that a patient is dehydrated, but may not be used to interpret the diagnosis of dehydration. When a patient is dehydrated, it is essential for a physician to clearly state in the patient's record that the patient is "dehydrated." This can affect the DRG assignment and hospital reimbursement as well.

Congratulations!

Raymond L. Singer, MD, Chief, Section of Thoracic Surgery, was elected to the Executive Council of the Pennsylvania Association for Thoracic Surgery for the next two years.

Jay S. Talsania, MD, Division of Orthopedic Surgery/Hand Surgery, Section of Ortho Trauma, was recently notified by the American Board of Orthopaedic Surgery that he passed the 2000 Certificate of Add Qualifications in Surgery of the Hand Examination.

Michael S. Weinstock, MD, Chairperson, Department of Emergency Medicine, was recently honored by the American College of Emergency Physicians as he was awarded the James D. Mills Outstanding Contributions to Emergency Medicine on October 25 in Philadelphia, Pa.

Papers, Publications and Presentations

Joseph D. DeFulvio, DO, Division of Primary Obstetrics and Gynecology, presented a paper titled "Evaluation of Subclinical Inflammatory Processes in Patients with Asymptomatic Sonographic Cervical Changes During the Second Trimester" at the American College of Obstetricians and Gynecologists 2000 District III Annual Meeting in Philadelphia, Pa., which was held October 11-14, 2000. The paper was co-authored by **Orion A. Rust, MD**, Division of Obstetrics, Section of Maternal-Fetal Medicine/Clinical Inpatient Obstetrics, and **Robert O. Atlas, MD**, Division of Obstetrics, Section of Maternal-Fetal Medicine.

Kevin B. Freedman, MD, Division of Orthopedic Surgery, published the lead article in the August issue of the ***Journal of Bone and Joint Surgery***. The article -- "Treatment of Osteoporosis: are Physicians Missing an Opportunity?" -- reached national attention being reviewed in multi-media including USA Today, the New York Times, the LA Times, CBS Healthwatch, HealthCentral.com, and CNN.

Mark A. Gittleman, MD, Division of General Surgery, was an invited speaker for the Pennsylvania Association of Cancer Registrars, "Breast Cancer Detection," in Hershey, Pa., on September 6. Dr. Gittleman was also an invited speaker for Methodist Healthcare, Memphis Hospital, "Stereotactic and Breast Ultrasound Workshop," held September 23 in Memphis, Tenn.

Peter A. Keblish, Jr., MD, Division of Orthopedic Surgery, Section of Ortho Trauma, presented exhibits and scientific papers at three European meetings in September.

Poster exhibits at the European Society for Sports Knee Arthroplasty included:

- Tibial Axis Method of Determining Femoral Component Positioning in Total Knee Arthroplasty
- Patella Non-Resurfacing in Low-Contact-Stress Mobile-Bearing Total Knee Arthroplasty
- Analysis of Radiolucent Lines in Uncemented Porous-Coated Low-Contact-Stress Total Knee Arthroplasty

These posters were co-authored by Dr. Jens Boldt and T. Kashiwagi, research fellows with Dr. Keblish in 1999, and illustrated by Carol Varma of the Biomedical Photography Department.

Dr. Keblish also presented a scientific paper, "Rotational Alignment in Rotation Based on Tibial Axis," at the International Society for Arthroplasty. At the Journees Genou -

(Continued on Page 10)

(Continued from Page 9)

"Experiences in Knee Arthroplasty" meeting in Paris, Dr. Keblish presented papers titled "Radiolucent Lines in the LCS Knee: Evolution Indication for Revision" and "Are There Limits for Using an LCS Mobile Bearing Knee?" He also was the moderator of a symposium titled "Severe Genu Valgum" (Severe Valgus Knee).

Indru T. Khubchandani, MD, Division of Colon and Rectal Surgery, was an invited speaker at the First International Course of Advanced Techniques in colo-rectal surgery in conjunction with VIII Congresso Nazionale Societa Italiana di colon-proctologia and VII Annual Meeting Associatzione delle unita di colonproctologia at Verona, Italy, from September 19-23. Dr. Khubchandani chaired a symposium on surgery for Rectocele and moderated a panel on Endocrine Tumors of the Colon and Rectum. He also mediated the Confederation of the two Italian Societies into one organization.

Zubina M. Mawji, MD, MPH, Division of General Internal Medicine and Clinical Director of Special Projects in Care and Resource Management, presented the Primum Non Nocere Needlestick Reduction project at the Quality Interagency Coordination (QUIC) Task Force's Best Practices Conference in Pittsburgh, Pa., on October 18. The QUIC Task Force is comprised of several government agencies working to improve quality care. The abstract, titled "It's Time to Move Forward," was co-authored by Paula Stillman, MD, Senior Medical Director, Care Management; Terry Capuano, Senior Vice President, Clinical Services; and Terry Burger, Manager, Infection Control.

Howard S. Selden, DDS, Division of Endodontics, authored two papers -- "Diagnostic Thermal Pulp Testing: A Technique," which was published in the October issue of the ***Journal of Endodontics***, and "Endodontic Radiographs: Realities and Illusions," which was published in the September-October issue of the ***Journal of General Dentistry***.

Raymond L. Singer, MD, Chief, Section of Thoracic Surgery, co-authored a paper -- "Routine Right Axillary Artery Cannulation for Repair of Type A Aortic Dissection: Case Report and Illustration of Technique" -- which he presented at the annual meeting of the Pennsylvania Association for Thoracic Surgery in Bermuda.

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, and via videoconference in the First Floor Conference Room at Lehigh Valley Hospital-Muhlenberg, and in the Video Teleconference Room (formerly the Medical Staff Lounge) at 17th & Chew.

Topics to be discussed in November will include:

- November 7 - "New Therapeutic Approaches to the Treatment of Inflammatory Bowel Disease"
- November 14 - "Recent Advances in the Treatment of Osteoporosis in Women and Men"
- November 21 - "Percutaneous Therapy for Renal Artery Stenosis in Patients with Ischemic Nephropathy: Does it Work?"
- November 28 - "Bone Marrow Transplantation"

For more information, contact Diane Biernacki in the Department of Medicine at (610) 402-5200.

Joint Commission Survey December 4-8 and 11-13

The Joint Commission on Accreditation of Healthcare Organizations will conduct an accreditation survey December 4-8 at Lehigh Valley Hospital, Behavioral Health Program, Health Spectrum, Lehigh Valley Home Care and Lehigh Valley Hospice; and December 11-13 at Lehigh Valley Hospital-Muhlenberg.

The purpose of this survey will be to evaluate the organization's compliance with nationally established Joint Commission standards. The survey results will be used to determine whether, and the conditions under which, accreditation should be awarded to the organization.

Who's New

The Who's New section of ***Medical Staff Progress Notes*** contains an update of new appointments, address changes, resignations, etc. Please remember to update your directory and rolodexes with this information. In addition, the Medical Staff Directory is now available on the e-mail Bulletin Board -- **Directories**. Updates will be made to the Medical Staff Directory at the beginning of each month.

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Section of Cytopathology
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Department of Medicine
Division of Neurology
Position: Co-Director, Vascular Lab (LVH)

William B. Dupree, MD
Department of Pathology
Division of Gynecologic Pathology
Position: Chairperson, Department of Pathology

James Goodreau, MD
Department of Surgery
Division of Vascular Surgery
Position: Co-Director, Vascular Lab (LVH-M)

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Department of Surgery
Division of General Surgery
Section of Surgical Oncology
Position: Chief, Section of Surgical Oncology

James Jaffe, MD
Department of Radiology-Diagnostic Medical Imaging
Position: Co-Director, Vascular Lab (LVH)

James Newcomb, MD
Department of Radiology-Diagnostic Medical Imaging
Position: Co-Director, Vascular Lab (LVH-M)

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Division of Vascular Surgery
Position: Co-Director, Vascular Lab (LVH)

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Section of Surgical Oncology
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Division of Colon and Rectal Surgery
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Michael Scarlato, MD
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Division of Anatomic Pathology
Position: Vice Chairperson, Department of Pathology

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One-Year Leave of Absence

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Richard H. Snyder, MD
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Additional One-Year Leaves of Absence

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Resignations

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**RECOMMENDATIONS TO THE BOARDS OF TRUSTEES
OF LEHIGH VALLEY HOSPITAL AND
LEHIGH VALLEY HOSPITAL-MUHLENBERG**

**FROM GENERAL MEDICAL STAFF
MEETING OF SEPTEMBER 11, 2000**

REPORT FROM THE BYLAWS COMMITTEE

**Revision to Part II - Rules & Regulations
Section E - Records**

"1. History and Physical Examination and Discharge Summaries must be signed by an attending physician.~~or his or her physician designee.~~"

'Community-acquired pneumonia' is not a helpful term for billing, or for anything else

By Robert Gold, MD
Vice President
Healthcare Management Advisors
Alpharetta, GA

Over the past several years, the issue of documentation, coding, and billing Medicare for hospital pneumonia admissions has come under considerable scrutiny. The Office of Inspector General of the Department of Health and Human Services has been vigilant in investigating hospital billings and pursuing possible "fraud."

Many physicians are unaware of the pneumonia issue right now, but not knowing about or not understanding the ins and outs could eventually affect your pocketbooks and your reputation.

For Medicare billing of elderly patients (for this purpose, anyone over the age of 17), there are two major diagnosis-related group (DRG) categories of pneumonia:

- Simple pneumonia and pleurisy—designated as DRG 89 (90)
- Respiratory infections and inflammations—designated as DRG 79 (80)

The difference between 89 and 90, and 79 and 80 is the presence or absence of a comorbid condition—another diagnosis that exists in the patient, such as stable congestive heart failure or atrial fibrillation, and other problems, such as urinary tract infection or IV line phlebitis.

Simple pneumonia (DRG 89) results in a reimbursement of approximately $4,450 per case. Respiratory infections and inflammations (DRG 79) permits payment to the hospital of about $6,740 per case—a difference of $2,300 on a national average.

What's the trouble?

In the past, some hospitals have submitted claims for the higher reimbursing pneumonia without adequate proof that the DRG assignment was valid. Hospitals under investigation have had to pay back millions of dollars in overpayments and fines to the Medicare program for such incidents.

"So how does this affect me?" you might ask. The relative weights assigned to the two categories of pneumonia are based on hospital charges—and hospital charges start with physician treatment.

The more resources utilized for a patient—and the more expensive those resources—the higher the cost per patient. If the costs go up, and the reimbursement goes down, the physician is indicated nationally as an overutilizer.

Insurance companies base their selection or deselection of preferred providers partially on these utilization profiles.

Web sites note the complication and death rates of physicians and their hospitals based on DRG assignments. These are purely based on expected morbidity and mortality per dollar charged.

Severity of illness parallels dollars charged. Severity of illness parallels length of stay allowed. When a physician costs more than the severity reflected in the DRG assignment, he or she is an overutilizer. When a patient cohort dies with a lower severity designation, the physician is suspect.

And it all comes from physician documentation.

What are the documentation issues?

The "simple pneumonia" category includes epidemic pleurodynia, viral pneumonia, pneumococ-

cal pneumonia, pleurisy, and pneumonia due to haemophilus influenzae. Most importantly, it is also used when physicians don't want to take the time to explain the type of pneumonia and just want to get through the paperwork.

The "respiratory infections and inflammations" category includes lung abscesses, empyemas, and tuberculosis as well as staph pneumonia, pseudomonas and klebsiella. It includes all gram negative organisms, and mycobacterium avium, toxoplasmosis, post-measles, and post-varicella pneumonias. More importantly, it includes aspiration pneumonia.

From an epidemiological perspective, the "community-acquired pneumonia" v. the "hospital-acquired pneumonia" designation takes into account all patients, regardless of age, residence, and other disease processes. It includes patients with tracheostomies, patients who are malnourished, and patients on chemotherapy. It includes elderly patients as well as young, working folks. It includes patients dying of cancer, and other immunocompromised patients.

Recent trends have been to utilize shotgun therapy for patients with pneumonia that was not hospital-acquired, and to use specific groups of antibiotics with broad spectrum coverage. From a diagnostic and therapeutic perspective, this designation is useless. Physicians need to use their observation and examination skills to come up with the likely pathogenesis of disease processes. That kind of assessment is what will succeed in DRGs.

Different patients, different diagnoses, different treatments

Scenario #1: An elderly patient presents, and says the rest of the family has "the flu." The patient has had upper respiratory symptoms for a week and developed fever and chills like the rest of the family. The x-ray shows "bronchopneumonia" pattern, and the white count is 5,500 with 45% lymphocytes. It's likely a viral pneumonia. The patient should be treated appropriately and, if you want to use prophylactic coverage because the patient is otherwise at risk, some second generation cephalosporin would probably be quite effective.

Scenario #2: A nursing home patient has the sudden onset of chills and a temperature of 104 degrees. Her x-ray shows lobar distribution, and there are some gram negatives all over the sputum smear. It's likely klebsiella and the patient should be treated for that (once you're sure it's not pneumococcus).

The most common bacterial organism group causing pneumonias in the elderly nursing home population is aerobic gram negative rods. Most of the medical textbooks recommend treating these with the specific primary bacteriocidal agents that you are using now, but they state, in this group, that they are chosen for their coverage of aerobic gram negative rods.

Scenario #3: An elderly patient has debilitating gastroesophageal reflux or has had a stroke and has pharyngeal dysfunction. The patient wakes up at night with bronchospastic events, or has sleep apnea and bibasilar atelectasis under normal conditions, and is gurgling after meals. Aspiration is a likely culprit, and specific coverage should be chosen for that.

For Medicare, institutionalized, alcoholic, and diabetic patients who don't make fibronectin anymore, calling a pneumonia "community-acquired" is counterproductive.

Try to name the organism or group, and tailor your treatment toward the suspected organism. You'll be able to validate your treatment better. You'll use more evaluation and management skills. And you'll have a much better reputation and utilization profile in the long run.

The Center for Educational Development and Support

October, 2000

News from the Library

OVID Training.

The Library has completely converted to OVID's on-line MEDLINE system. This Web-based system is updated daily by Ovid. Call Barbara Iobst in the Health Sciences Library at 610-402-8408 to schedule a one-on-one training session.

Newly Added Titles to MD Consult.

A reference library of major textbooks is available at your desktop through MD Consult. The following titles have been recently added or updated:

The 25th edition of the American Academy of Pediatrics *"Report of the Committee on Infectious Diseases"* (AAP 2000 Redbook) is now on-line via MD Consult.

Other recent additions to MD Consult include: *"Ophthalmology"* (Yanoff – 1999) This text "presents ophthalmology as practiced, rather than as a collection of separate aspects."

***"Clinical Oncology,"* 2nd edition (Abeloff – 2000).**

If you need assistance in accessing MD Consult, see any member of the Library staff.

Computer-Based Training (CBT):

Computer Based Training (CBT) programs are available for LVHHN staff. Topics covered by the CBT programs include:

Access 2.0	Power-Point 4.0
Windows NT 4	Word 97
Excel 97	Access 97
PowerPoint 97	Lotus 1-2-3 Millennium
WordPerfect 8	E-mail GUI

PHAMIS LastWord Inquiry Only commands

CBT programs replace the instructor-led classes previously held at Lehigh Valley Hospital. A proctor will be in the room with the learner while he/she takes the CBT, but the learner will control the pace and objectives of the learning.

Computer Based Training takes place in **Suite 401** of the **John & Dorothy Morgan Cancer Center** (the computer training room) and in the **Muhlenberg Hospital Center computer training room** (off the front lobby). The schedule of upcoming dates is as follows:

CBT sessions for JDMCC, suite 401 are as follows:

November 7 - 8am - Noon
December 5 - 8am - Noon

Sessions at MHC, I.S. Training room are as follows:

November 21 - Noon - 4pm
December 19 - Noon - 4pm

Twelve slots are available for each session.

To register, please contact Suzanne Rice via e-mail or at 484-884-2560 with the following:

date of session
second date choice
department
phone number

You will receive an e-mail confirming your choice within two business days. If you have any questions, please contact Craig Koller at 610-402-1427 or through e-mail.

Any questions, concerns or comments on articles from CEDS, please contact Bonnie Schoeneberger 610-402-1210

2000 November 2000

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
			1	2 12 Noon Combined TB - JDMCC - CR1 A/B	3 7am OBGYN Grand Rounds -CC-CL1 12 Noon Breast TB - JDMCC- CR1 A/B	4
5	6 12 Noon Colon/Rectal TB JDMCC-CR1A/B	7 7 am Surgical GR-CC-Aud 8am Pediatric GR - CC-Aud 12 Noon Medical GR CC-Aud	8 12 Noon Pulmonary TB - JDMCC - CR1 A/B	9 12 Noon Combined TB JDMCC - CR1 A/B	10 7 am GYN TB/OBGYN GR - 17 Aud 12 Noon Breast TB- JDMCC -CR1 A/B	11
12	13	14 7 am Surgical GR-CC-Aud 8am Pediatric GR - CC-Aud 12 Noon Medical GR CC-Aud	15	16 12 Noon Combined TB - JDMCC - CR1 A/B	17 7am OBGYN Grand Rounds -CC-CL1 12 Noon Breast TB - JDMCC- CR1 A/B	18
19	20 12 Noon C/R TB -JDMCC - CR1 A/B	21 7 am Surgical GR-CC-Aud 8am Pediatric GR - CC-Aud 12 Noon Medical GR CC-Aud	22	23 	24 7am OBGYN Grand Rounds -CC-CL1 12 Noon Breast TB - JDMCC- CR1 A/B	25
26	27	28 7 am Surgical GR-CC-Aud 8am Pediatric GR - CC-Aud 12 Noon Medical GR CC-Aud 12 Noon Urology TB JDMCC CR1A/B	29	30 12 Noon Combined TB- JDMCC - CR1 A/B		

THERAPEUTICS AT A GLANCE

The following action was taken at the September 20, 2000 Therapeutics Transfusion Subcommittee Meeting

TO: Physicians

FROM: Bala Carver, MD
Medical Transfusion Medicine

DATE: October 16, 2000

SUBJECT: Blood Component Transfusion Order Form

The Medical Executive Committee has approved a Blood Component Transfusion Order Form (See reverse side for a copy of the new form.) This form will be implemented with transfusions ordered after October 31, 2000.

The cost of blood related products at LVHHN is approaching $3 million annually. Over the next few years it is anticipated that the cost will increase another 30% because of new testing, such as FDA approval for Polymerase Chain Reaction (PCR) based tests and procedures to modify blood components, e.g., frozen plasma and universal leukoreduction.

JCAHO requires hospitals to monitor blood usage to ensure appropriate utilization.

The concept of using a Transfusion Blood Order Form is not new and many hospitals use similar forms. Rather than being intrusive on physician practice, the intent of this form is to improve patient care by reducing the chance of handwritten order errors.

LEHIGH VALLEY HOSPITAL
ALLENTOWN, PA

LEHIGH VALLEY HOSPITAL - MUHLENBERG
BETHLEHEM, PA

BLOOD COMPONENT TRANSFUSION ORDER

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
				Diagnosis: **Page 1 of 1**
				Blood Consent Form Signed ☐ **Yes**
				Tests: ☐ Type and Crossmatch _____(#)units ☐ Stat ☐ Routine
				☐ On hold at all times _____ (#) units.
				☐ Type and Screen ☐ Type for platelets, FFP and/or cryoprecipitate
				☐ Autologous red cells ☐ Directed red cells ☐ Other (specify) _____
				☐ **Irradiated (indication_____)** ☐ **Leukoreduction filter (indication_____)**
				Pre-medications: ☐ yes ☐ no, see separate Doctor's Orders
				Red Blood Cells: ☐ Active bleeding, systolic BP<90.
				☐ Anemia (Hgb/hct < 7/21)
				☐ Hgb/hct<9/27 before surgery, myocardial ischemia,chemotherapy and/or radiation.
				☐ Other (reason)_____.
				Transfuse _____ **unit(s), each over** _____ **hour(s)**
				Platelets: ☐ Pool of random concentrates (5 units per pool) ☐ (Single Donor) Platelets
				☐ Prophylaxis: Platelet count< 10,000 (due to bone marrow failure, no other risk factor).
				☐ Invasive procedure or bleeding and platelet count<50,000.
				☐ Massive blood volume replacement with diffuse microvascular bleeding.
				☐ Platelet>50,000 with documented platelet function disorder (other than vWF deficiency) or
				anti-platelet agent with bleeding or preoperative. Specify disorder _____.
				☐ Other (reason)_____.
				Transfuse _____ **unit(s), over** _____ **hour(s)**
				Fresh Frozen Plasma:
				☐ PTT >50, PT>20.2 or INR>1.5 with bleeding or preoperative with coagulation factor deficiency
				(other than Factor VIII, vWF or fibrinogen), liver disease or drug-induced coagulopathy.
				☐ Other (e.g. TTP, Microvascular Bleeding)(reason) _____.
				Transfuse _____ **unit(s), each over** _____ **hour(s)**
				Cryoprecipitate: ☐ Bleeding or preoperative with fibrinogen<100mg or documented dysfibrinogenemia.
				☐ Uremia, bleeding or preoperative with documented vWF or Factor VIII deficiency
				untreatable with DDAVP.
				☐ Other (reason)_____.
				Transfuse _____ **unit(s), pooled over** _____ **hour(s).**
				M.D./D.O.

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

DO-xx6-1 Rev 10/00

STRESS ULCER PROPHYLAXIS

Gastric stress lesions manifest as multiple punctate erosions in the proximal stomach after a stressful insult. Time to development of these erosions is variable and they may bleed mildly or profusely depending on their depth and location. The pathophysiology involved in the development of such lesions is complex. The main risk factor for development of stress erosions appears to be impaired supply of oxygenated blood to the mucosa. Gastric acid secretion tends to be reduced in many ICU patients; however, notable exceptions include sepsis, cerebral trauma, and increased intracranial pressure where gastric hypersecretion has been documented and may contribute to the development of the erosions. Inadequate mucosal oxygenation results in low tissue pH and ATP, increased lactate production, release of oxygen radicals, and impaired synthesis of protective prostaglandins causing reduced production of bicarbonate and mucous. The frequency of relevant bleeding has been estimated to range between 1 and 20% in intensive care patients.

The most effective stress ulcer prophylaxis is achieved by general intensive care measures. It is preferred to restrict specific pharmacologic prophylaxis to patients running a high risk of developing stress bleeding. In a recent perspective multicenter trial looking at gastrointestinal bleeding in ICU patients, it was found that only 1.5% of patients had clinically important bleeds. Two strong independent risk factors for bleeding were identified: respiratory failure and coagulopathy. The group conducting this study concluded that stress ulcer prophylaxis could be safely withheld from critically ill patients unless they had coagulopathy or required mechanical ventilation. Other factors including sepsis, hypotension, renal failure, hepatic failure, Glasgow Coma Score <7, severe burns >30%, tetraplegia and multiple organ failure have conflicting data as to whether or not they are risk factors. Therefore, patients with these factors should be given consideration for stress ulcer prophylaxis.

When pharmacologic therapy is necessary, the best agent for stress ulcer prophylaxis would ideally be inexpensive, effective, easily administered, and without significant side effects. Based on current literature review, this protocol prophylaxes patients at high risk for stress ulcer development. The agent of choice in these patients is famotidine.

STRESS ULCER PROPHYLAXIS PROTOCOL

(1) In a study by Cook et al, patients who did not undergo mechanical ventilation for >48 hours and who had no coagulopathy were at extremely low risk of clinically important bleeding.

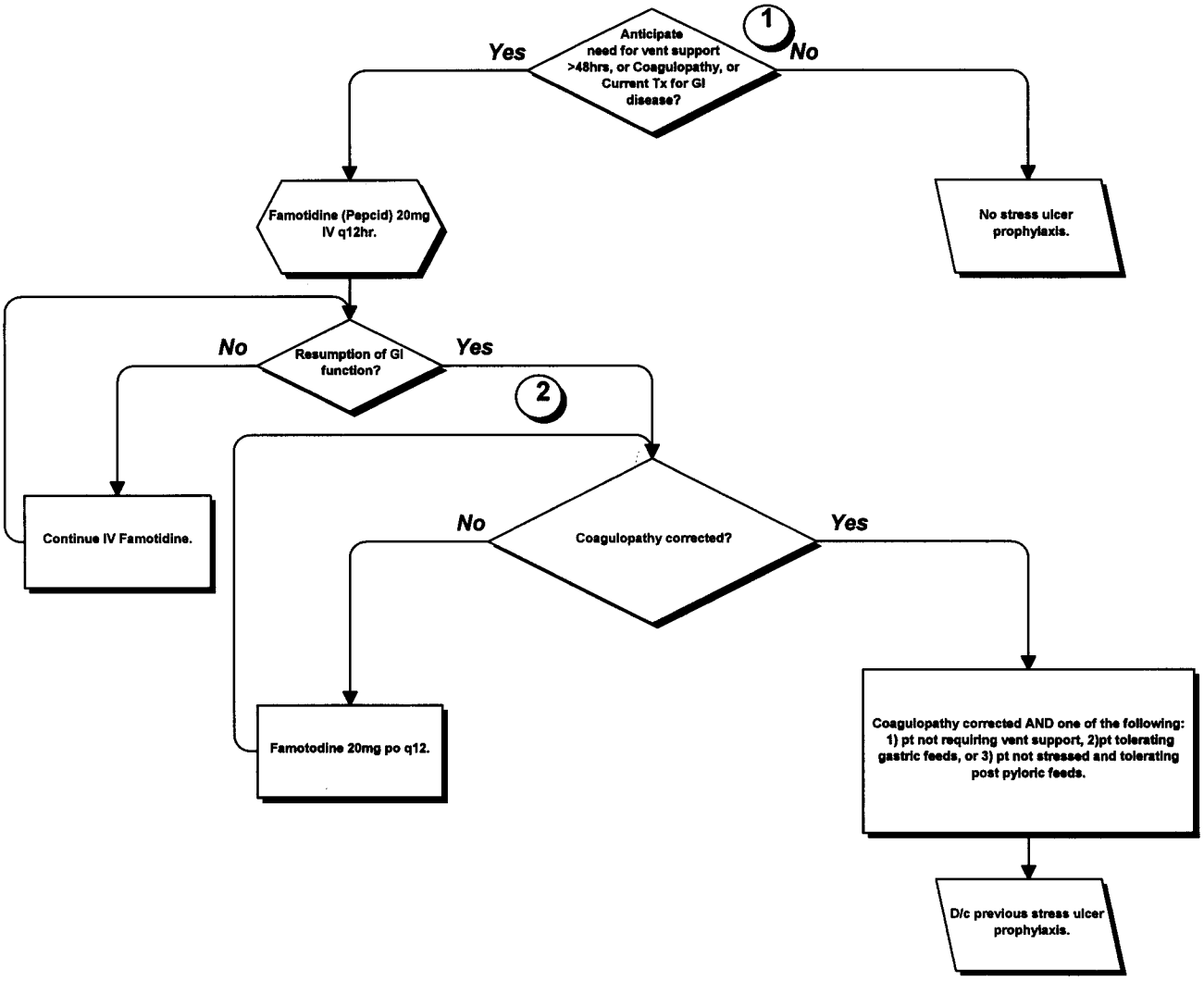
Coagulopathy is defined as any of the following:

- INR > 1.5
- Platelet count <50,000
- PT >1.5 x control
- Activated PTT >2 x control
- Fibrinogen <100mg/dl
- D-dimer - abnormal
- Fibrin degradation product (FDP) - increased

*One exception to this node is the patient who is coagulopathic because of heparin or coumadin therapy, but is non-stressed, and tolerating gastric feedings. This patient population should not require stress ulcer prophylaxis.

(2) Famotidine (Pepcid^{R}) competitively inhibits the action of histamine on the H2 receptors of parietal cells, reducing gastric acid secretion and concentration. It is excreted primarily in the urine and is not removed by hemodialysis. Famotidine rarely causes thrombocytopenia, so other causes of decreased platelet count should be ruled out prior to initiating alternate therapy.

STRESS ULCER PROPHYLAXIS



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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 Staff.**

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.