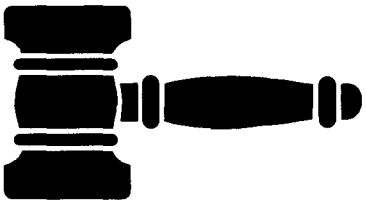
LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

PROGRESS NOTES

Medical Staff

January, 2002 Volume 14, Number 1

In This Issue . . .



From the President

Our Values at LVHHN

We dedicate ourselves to service.
We respect each individual's dignity and right to privacy.
We demonstrate ethical behavior in our attitudes, actions and words.
We commit ourselves to teamwork, collaboration and honest, open communication.
We value the contribution of physicians, nurses and staff in the pursuit of clinical excellence.
Empathy and compassion guide us in creating an environment of understanding and concern for all.

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Tolerance – One of the side effects of 9/11/01 is the potential that terrorism has for dividing our society and weakening us as a nation. America has worked hard to eradicate racial profiling as well as ethnic, religious and gender discrimination. We promote tolerance and welcome sensitivity toward diversity. In many ways, we have made real progress and have become stronger. We are the "melting pot."

At LVH, we have worked side by side for years and realize that we are members of the same team. We have come to value one another as skilled team members of our clinical enterprise. Lack of tolerance and insensitivity to diversity is not acceptable behavior for any member of the LVH medical staff. I ask for patience and understanding from all medical staff members. Mature judgment will prevail.

These events have made us ask who we are and what we value. At LVH, we welcome and value diversity. It is a strength we will use. It's a new year! Let us resolve to work together.

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If we do not hang together, we will, most assuredly, all hang separately.

- Benjamin Franklin

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New Board Members with the New Year

There are presently 21 members of the LVHHN Board of Trustees (of which five are physicians). Stepping down are: Kathryn A. Stephanoff, Charles D. Snelling and Frank J. Ryan. We wish them health and good cheer. They have served this institution well with their advice, counsel, leadership and humor over the years. The medical staff and the network all owe these community leaders a genuine debt of gratitude, and we will miss them.

New board members include: Arnold H. Kaplan, William H. Lehr and J.B. Reilly. We welcome these energetic and talented leaders and look forward to working together for the benefit of the community and the institution.

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Signs of growing older:

- You buy a compass for the dashboard of your car.
- You consider coffee as one of the most important things in your life.
- You constantly talk about the price of gasoline.
- You get cable to monitor the weather channel.

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About Us

LVHHN (with three locations in Allentown and Bethlehem and 700 acute care beds) is now the area's largest employer with 6,500 employees.

The medical staff totals over 1,250; 170 of these are members of LVPG. LVH started as The Allentown Hospital in 1899 – now one of 400 members of the prestigious Council of Teaching Hospitals.

LVHHN is currently training 131 residents in 11 residency programs.

The nursing staff consists of approximately 1,000 professional registered nurses. Patients rate nursing care at LVHHN in the 95th percentile among similar hospitals nationwide. LVHHN is applying for magnet hospital designation – the most prestigious recognition of nursing excellence in the nation. Magnet hospitals attract and retain the best nurses because of their reputation.

In the words of Bobby Gunther Walsh: "But wait! There's more."

More to come about us next month.

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You say you want more trivia? (Amaze your friends at holiday parties.)

Although a distinction in name only, there are four U.S. states that are actually commonwealths: Pennsylvania, Massachusetts, Kentucky, and Virginia.

Puerto Rico became a commonwealth in 1952 and its residents are U.S. citizens, have a non-voting representative in Congress, and pay no Federal taxes.

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Malpractice – the pot is bubbling

"The basic tenets of risk management are boring, but effective. Communicate with patients, document your efforts, make timely referrals." Sarah H. Langhorne, PMSLIC

A Medical Malpractice Insurance Relief Bill was introduced in the PA House.

Under a bill introduced by Rep. Ellen M. Bard (R-Montgomery) and endorsed by the Pennsylvania Orthopedic Society:

* Physicians and other health care providers would be required to obtain annual malpractice insurance coverage of $250,000 per occurrence and $750,000 per annual aggregate beginning in 2002, down from current requirements of $500,000 per occurrence and $1,500,000 per annual aggregate.
* The CAT Fund would be privatized beginning January 1, 2002.

Bard said that the bill was a stopgap measure intended to provide immediate medical liability insurance cost savings to allow physicians to continue to practice in Pennsylvania until tort reform is passed. Bard also noted that Harrisburg's largest orthopedic group, the 18-member Orthopedic Institute of Pennsylvania, reported that it has been unable to secure malpractice insurance after January 1, while an 11-member group from Willow Grove, Pa., the Orthopedic Specialty Center, is in the same predicament.
Representative Ellen Bard, December 10, 2001

Remember that Pennsylvania does not allow a professional medical license without malpractice insurance. While reducing the required malpractice coverage is a small step in the right direction, the real tort reform measures must follow, or our state will imitate West Virginia and require a state bailout plan as outlined below:

The West Virginia Legislature Passed a Sweeping Medical Malpractice Insurance Bill Establishing a State-Run Insurance Plan Under the Existing Board of Risk and Insurance Management.

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Doctors unable to get affordable malpractice insurance elsewhere can now turn to the state plan, which will offer insurance at rates comparable to those available on the private market, reported the Charleston Daily Mail. The bill also makes some changes to the state's civil justice system as it relates to medical malpractice suits. Charleston Daily Mail, December 3, 2001

Our TORT system is starting to crumble under its own weight and requires public sector bailout. It is expensive and has NOT reduced the malpractice problem, i.e. it is ineffective. When the public starts to pay the bills, legislators become engaged and this, hopefully, will lead to change.

Following is another indicator of instability in this area:

Largest malpractice insurer to exit business. The St. Paul Companies, the largest U.S. underwriter of medical liability coverage, today announced plans to exit the medical malpractice business as part of a series of actions intended to improve profitability. Chairman and CEO Jay Fishman said the company would exit the business globally through non-renewal of policies on expiration. The insurer, based in St. Paul, Minn., forecasts its medical malpractice business will generate an underwriting loss of about $940 million this year. The announcement is available at http://www.stpaul.com.
(I was surprised to find out that no one on the LVH medical staff now has St. Paul coverage.)

At the same time that Pa. physicians are looking at a 60% jump in malpractice premiums, **Congress is scrambling to avert the scheduled 5.4% Medicare cut which could cost physicians in this Commonwealth an average of $4,000 –** the fourth highest loss in the country, according to data from the AMA. Pa. has 17% of its residents eligible for Medicare and one of the highest percentages of elderly and disabled citizens in the country (right behind Florida). Paralleling this is the fact that 44% of Pa. family physicians are over 50 years of age. You do not have to be a brain surgeon to see a crisis brewing (or do you?). We are all feeling the squeeze – and I'm not talking about oranges.

Senator Arlen Specter and Senator Rick Santorum and Representative Pat Toomey need to hear from YOU.

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Quality Improvement White Paper (formerly known as Quality Assurance)
Included on pages 15-18 of this issue is a copy of the current quality improvement process at LVHHN. This is an attempt to put on paper our current system to assure a network wide uniformity and hopefully dispel some of the misconceptions. In our nation, hospital medical staffs were organized to provide credentialing and quality oversight. As the medical staff, WE are charged with this QI obligation and WE are the ones who design the plan and make it work. It is an evolving process and the "White Paper" is simply descriptive – after discussions with Sue Lawrence and Dr. Paula Stillman of Care Management. It was discussed at Chairs/Troika, endorsed by the Medical Executive Committee and by the LVH Board. It can be changed and improved with time – and I expect it will. Look it over and send me any comments via e-mail. The system is designed to protect our patients, the community and us.

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Let your soul stand cool and composed before a million universes.

- Walt Whitman

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There is a Shortage of Anesthesiologists in the U.S. that will continue for Years unless more People are attracted to the Field, according to a report published in Mayo Clinic Proceedings.
An analysis of data from federal agencies, the American Medical Association and the American Society of Anesthesiologists concluded that there is currently a shortage of anesthesiologists that ranges from 1,200 to 3,800, which could reach a shortage of as many as 4,500 anesthesiologists by 2005 if the current supply trend continues, Yahoo News reported. The study noted that the shortage may disappear or be reduced to a shortfall of 1,000 by 2010 if the number of anesthesiology residency positions increases by 15 percent per year until 2006, meaning that almost 60 percent more anesthesiologists will need to be trained by 2005 than were graduated in 2000, and almost 100 percent more will need to be trained by 2010, Yahoo News added. Mayo Clinic Proceedings, October, 2001

So...please politely thank your anesthesia provider at the end of the case...smile and mean it!

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Golfer: "Caddy, do you think my game is improving?"
Caddy: "Oh yes, sir. You miss the ball much closer than you used to."

Happy New Year!

Ed

Edward M. Mullin, Jr., MD
Medical Staff President

Spotlight on . . .

Jack A. Lenhart, MD

Born in Pottstown, Pa., Dr. Lenhart completed his undergraduate education at Depauw University in Greencastle, Ind., where he earned a Bachelor of Arts degree. He received his medical degree from the University of Michigan Medical School in Ann Arbor, Mich. He completed his Family Practice residency at Wilson Memorial Hospital in Johnson City, N.Y. Dr. Lenhart is certified and recertified by the American Board of Family Practice with Added Qualifications in Geriatrics.

Dr. Lenhart joined the hospital's Department of Family Practice in 1978, and is in practice with Parkland Family Health Center. He is an Assistant Clinical Professor of Family and Community Medicine at Pennsylvania State University College of Medicine. Dr. Lenhart was instrumental in the planning and development of the Lehigh Valley Physician Hospital Organization and currently serves as the Medical Director and a member of the Board of Trustees. He is also a member of the Board of Trustees of the Greater Lehigh Valley Independent Practice Association. For the last two years, he has worked with Dr. Paula Stillman in the Department of Care and Resource Management of Lehigh Valley Hospital.

On a more personal note, Dr. Lenhart and his wife, Carol, have three children. In his spare time, he enjoys hiking, canoeing and gardening.

In conclusion, Dr. Lenhart has the following comments to share with his colleagues on the Medical Staff: "Almost a decade ago, believing the Managed Care movement to be a significant threat to the doctor/patient relationship, I decided to get involved. The ensuing years have been exciting, challenging, at times frustrating, but mostly rewarding. The following are my thoughts as I reflect on that journey.

- It has been my experience that you are more effective as part of the process than merely opposing it from the outside.
- In this time of renewed healthcare cost inflation, real collaboration between hospital and physicians, payers and employers is needed for true solutions to be possible.
- We would do well to shift our focus from vanquishing disease to the reduction of human suffering and healing in the broadest sense.
- Keeping the well being of our patients as our true central focus, and not just as a rhetorical smoke screen for protecting our own self interests, will ultimately win the day."

News from CAPOE Central

We continue to make progress on all CAPOE fronts, including the wireless effort. We have gotten excellent and helpful feedback from the users that have carried around the PenCentra wireless handheld devices. There is no perfect solution that combines small size, large and bright screen, long battery life, and rugged durability. We will be testing new devices as they are released in the coming months. We hope to offer physicians and groups multiple wireless options in the hopes of finding the best option to meet their rounding patterns.

Many doctors have asked about putting Phamis on a small handheld device, such as a Palm or Compaq iPaq. We have been able to get Phamis to run on an iPaq Â– but the screen size is too small to read any of the text. Phamis is working on porting a new version of Phamis to an iPaq, but will need to re-design their screens to accommodate the small screen size. I expect it will be several years before we see this.

At the various meetings I have attended, I have heard doctors express concern about login time at the desktop workstations. Because of our complex environment, there are multiple layers of configuration to access applications at the desktop. LVH has implemented the Neon Secure product to help facilitate the access to all applications from one toolbar, eliminating the need to remember multiple passwords.

We have investigated biometric sign-on devices (retinal scan, fingerprint, etc.). It appeared that fingerprint technology might hold some promise, but it would still require the user to enter a user number before fingerprint recognition could occur (matching the user number to the correct fingerprint). Although this would eliminate dealing with passwords, it would not save significant time. There are several ways to address the log-in time issues. The use of the wireless handheld devices will allow the user to remain logged in during an entire rounding session. Access to Phamis and the other applications would be continuous. There are wireless devices located at the Physician Dictation Stations on 6B and the TTU. The user will have to carry the device around with him/her for this to be effective. Another option, which may save a bit of time, is to have the I/S Department set up the user to automatically launch Phamis upon sign-in. This would save the user from having to wait for the Neon button bar to launch and then clicking on the Phamis button. If you are interested in having your account set up to do this, please contact me by phone or email.

The CAPOE team continues to listen to user feedback, and make changes to the system to improve the overall user experience. I truly believe that the system will work and we will positively impact patient care with CAPOE.

Don Levick, M.D., MBA
(484) 884-4593 (office) or (610) 402-5100 7481 (pager)

News from the HIM Department

LVH

HIM Change of Hours

Due to continued utilization of the electronic medical record by physicians and clinical staff, the departmental staffing hours are being changed. Effective immediately, hours of operation for the department at both Cedar Crest & I-78 and 17th & Chew will be *Sunday to Saturday, 7 a.m. to midnight.* After hours, physicians may continue to access the Cedar Crest & I-78 HIM Department utilizing their ID badges to use computer terminals to review and/or complete medical record documentation.

LVH-Muhlenberg

HIM Card Access

Entry into the HIM Department at LVH-Muhlenberg is now available through card access. Physicians will be able to access the department with their photo ID badge during non-staffed hours to utilize the computer terminals to review and/or complete medical record documentation.

Physician Assistance

The physicians at the LVH-M site who need assistance with chart completion during hours, when the office is not staffed, have raised concern. As a result, effective February 1, 2002, the Nursing Supervisor at LVH-M will be available to assist physicians during off-hours with electronic medical record completion. You may page the Supervisor as you would for other issues in the facility.

Ambulatory/Outpatient Discharge Note

Medical record reviews indicate that many short stays do not contain the required information in the discharge note. The following documentation is required:

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

Therefore, effective February 1, 2002, discharge notes that do not contain required information will be returned to the physician for completion.

Master Patient Index

From January to May, 2001, the computerized master patient index (MPI) underwent an extensive cleanup process merging registrations to reduce the number of duplicate medical record numbers. This cleanup process allows IDX users to properly identify patients and retrieve information efficiently. At the end of the project, the HIM (Medical Record) Department assumed responsibility for maintaining the accuracy of the new medical record number assignments in the MPI.

Since completion of the cleanup project, as patients are registered or seen within the organization, each registration goes through a software package to determine if there is a potential duplicate registration. A work list is created, which HIM reviews to determine if enough information is available to verify that a potential duplicate registration belongs to the same person. Once verified, the duplicate registrations (old or newly created) will be merged. Registrations are merged to the oldest (lowest) medical record number. **Therefore, there is no need to notify HIM every time a potential duplicate registration is identified.**

- If the registration (medical record number) has been merged, it will be identified by an "*" in the MPI search screen between the medical record number and patient name, under the heading "merged."

- If the registration (medical record number) has been merged, and you choose the incorrect medical record number for the new registration, IDX will automatically take you to the correct patient under the surviving medical record number.

- Due to patient care issues, duplicate registrations **cannot** be merged while the patient is actively being treated (IP/AMB/ED) within the organization. The duplicate registration software will identify these cases at the time of registration and they will be reviewed and corrected following patient discharge, pending verification of information.

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

The HIM Department extends wishes for a happy, peaceful and prosperous New Year!

Coding Tip of the Month

The diagnoses or conditions that abnormal test results represent can only be coded if the physician specifically documents the diagnosis or condition in the patient's record.

Radiology News

Radiology and CAPOE

Radiology has been working with the CAPOE staff to deliver the radiology portion of computerized assisted physician order entry. The goal is to make the ordering process as easy as possible while providing relevant clinical information to better care for patients. The most common signs and symptoms for the various studies that might be ordered are being entered into the system. This should make it easier for the referring physician to select the appropriate reason for the study.

In order for the hospital to conform to the regulations of CMS (Center for Medicare and Medicaid Services--formerly HCFA), the proper "reason for study" needs to be used when ordering any imaging examination. The patient's signs or symptoms are always an appropriate selection. A known diagnosis can also be used, but a "rule out" diagnosis cannot be used. For example, if a patient has cough and fever, and there is clinical suspicion of pneumonia, the acceptable reason for the study could be "cough" or "fever" but not "rule out pneumonia." Once the diagnosis of pneumonia is firmly established and a follow-up x-ray is ordered, "pneumonia" can be used as a reason for doing the study.

Bioterrorism Response Resources

LVHHN has several available resources to assist the clinician with information to respond to a bioterrorism event. A **Bioterrorism Response Update** link can be found directly on the LVHHN Intranet's home page. Clicking on the link will connect the user with information about the LVHNN's response plan for bioterrorism, question and answer fact sheets, pictures of smallpox and anthrax cases, and **physician assessment tools.** There are also additional links to other important bioterrorism web sites such as the Centers for Disease Control and Prevention's, Johns Hopkins, and USAMRIID. The LVHHN Intranet is an excellent place to find up to date information on the developing events of bioterrorism.

Another resource available from the Medical Staff Services office is the **Physician Quick Reference Card**. The pocket size laminated card has information about the new Code Silver communication plan that was put into place to respond to a known or suspected bioterrorism event. Also found on the card are short descriptions of information that can be accessed on the LVHHN Intranet Bioterrorism Response Update site and addresses for other Internet web sites of interest.

For more information or questions, contact Deborah Fry in the Infection Control Department at (610) 402-0680.

Ethics Corner

Do Not Attempt Resuscitation

By Joseph E. Vincent, MD, Division of Pulmonary and Medical Director of the Palliative Care Service

"Code Blue, code blue" is a familiar announcement within the hospital setting. It mobilizes a team of persons with skills to attempt resuscitation in a person who has had a cardiac "arrest," a cardiac event that cannot sustain life.

Closed chest cardiac massage was first described in 1960 and was initially advocated to be used only on those patients who were "salvable." With the addition of cardiac defibrillation, intubation and mechanical ventilation, and, eventually, the complex pharmacology of ACLS, the process has become a highly skilled team approach to an emergency situation.

It is an automatic order unless nullified by an order commonly called DNR -- Do Not Resuscitate. Consequently, it gets applied to patients frequently who have little chance of benefiting from the procedures. Even the term "Do Not Resuscitate" makes it sound like an all or nothing result, when we know that the percentage of successful resuscitations are small when applied to all patients, and even smaller when applied to patients with certain categories of diseases, such as multisystem organ failure, advanced metastatic cancer, advanced CHF and COPD, and late Alzheimers disease patients.

Because we honor informed consent/refusal, an automatic order requires discussion with the patient or surrogate, giving them enough information to make an autonomous decision; a decision that is consistent with the person's wishes, values, beliefs, and life experiences. When these discussions do not occur, the code is called whether or not it seems consistent with the patient's condition and prognosis. Studies have shown that patients want their physicians to discuss this topic with them, but they believe it should be initiated by the physician. Many physicians feel uncomfortable talking about death and dying with patients and avoid the issue of cardiopulmonary resuscitation, often leaving it to a time when the patient cannot make his/her own decisions.

When it is addressed with the patient, the prognosis of the patient's underlying disease process as well as the likelihood of successful resuscitation and restoration to a quality of life acceptable to the patient are often overly optimistic and inflated. Additionally, it sometimes sounds like abandonment to the patient or family. At other times, the DNR request of a patient/family is ignored. This was shown to be prevalent in the comprehensive SUPPORT study, where a large group of patients with poor prognoses and an expected mortality of 50% within six months was studied.

(Continued on Page 7)

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Some physicians are reluctant to write a DNR order because they fear it will label the patient in a way that results in suboptimal care and attention to other medical problems. Too often, DNR is interpreted to mean no medical therapy rather than merely no cardiopulmonary resuscitation in the event of a cardiac arrest. Changes of conditions of patients are not reported and assumptions are made that certain aggressive medical therapy should not be pursued. Unless otherwise stated on the withholding/withdrawing sheet, DNR means no CPR only. All other medical therapies could be offered and delivered if they are consistent with the patient's disease, prognosis, and autonomous wishes.

Fear of legal liability for not doing CPR is now countered by the fact that suits have been filed and upheld where patients have been coded against there expressed wishes. It is important to know what the patient's wishes are and to follow these wishes, or to make it clear to the patient that these wishes cannot be followed by their physician and they should seek another caregiver who can comply with their wishes.

In a study by Bedell et. al. reported in the New England Journal in 1983, 14% of 294 consecutive patients who were resuscitated in a university teaching hospital, were discharged from the hospital alive. No patients with pneumonia who coded, survived and none of the 179 patients in whom resuscitation took longer than 30 minutes survived to be discharged. Patients with hypotension, renal failure, cancer, and a home-bound life style before hospitalization were significantly associated with in-hospital mortality.

The Ethics Committee struggles recurrently with how to formulate policies and order sheets that facilitate the care of patients. The Withholding/Withdrawing order sheet should be tailored to each patient's needs and wishes. It is meant to be a template upon which the patient's individual orders can be built.

All physicians are encouraged to talk with their patients about their advance planning and what their wishes would be in the event of a cardiac arrest. It should be made clear that a DNR order in itself does not preclude other vigorous or aggressive medical therapy. We all need to be aware of the statistics of code procedures and be forthright with our patients so they can better integrate this into their decisionmaking. All caregivers must understand that DNR does not mean avoiding the accepted medical care and attention that a patient without a DNR order would expect. The discussions need to occur while the person in able to make his/her own decisions, if possible. Hopefully these conversations could take place before the patient has serious or life-threatening disease and could be part of a bigger plan in the patient's advance planning.

The Ethics Committee is eager to have clinician feedback about the code blue and withholding/withdrawing policies for the hospital. If you have questions or comments, please contact Joseph E. Vincent, MD, at (610) 439-8856 or page (610) 920-7220.

Palliative Care

by Joseph E. Vincent, MD, Division of Pulmonary and Medical Director of the Palliative Care Service

Two years ago, the Dorothy Rider Pool Health Care Trust provided a grant to initiate a model for a palliative care program at Lehigh Valley Hospital. Part of this grant was to provide educational opportunities to the clinicians, and particularly the physicians, in palliative care and end-of-life care for our patients. The Education for Physicians on End-of-Life Care (EPEC) program was adopted as the main curriculum to provide much of this education.

EPEC was developed by the American Medical Association, recognizing a need in helping physicians hone basic knowledge and skills in caring for persons with palliative care needs and especially those who are dying. It identifies a body of knowledge and clinical skills that are available to physicians to meet these needs in their patients.

EPEC is a two-day conference consisting of four plenary sessions and 12 modules covering topics like "Pain Management," "Symptom Control," "Anxiety, Depression, and Delirium," "Communicating Bad News," "Withholding and Withdrawing Medical Therapies," and "Advance Care Planning." Each module and plenary session is introduced by a short video trigger tape, followed by multidisciplinary discussion and further presentation of materials concerning the subject of the module by a facilitator. Groups of 15-20 participants are formed for discussion groups.

For the last two years, there have been about 200-250 participants in the multiple EPEC programs that have been produced with the financial support of the Pool Trust. In addition to physicians, most of the medical residents and some of the surgical and family practice residents have attended the conferences. Many chaplains and members of the clergy have also participated. Although at national medical meetings, EPEC is frequently offered as a two-day pre-conference seminar for $350-450, our programs have been offered free of charge. In addition, physicians, nurses, and social workers receive continuing education credits.

Those who have taken the EPEC course, as well as the core group for palliative care, believe that EPEC should be an on-going program for our region, even after the grant has ended. Therefore, after the next EPEC program in March, a fee will be required in order to support the costs of presenting this two-day conference.

(Continued from Page 7)

The Palliative Care Team encourages more attending physicians to take the EPEC program so that the basic concepts and skills can be integrated into the daily practice of medicine in our hospital and community.

Anyone interested in learning more about the program or registering for the March 2002 EPEC conference should contact Joseph E. Vincent, MD at (610) 439-8856 or page (610) 920-7220.

? ? ? Mystery Medical Staff Member ? ? ?

? Born in East Stroudsburg, Pa.
? Received a Bachelor of Science degree from Ursinus College
? Received Medical degree from Jefferson Medical College of Thomas Jefferson University
? Completed internship and residency at York Hospital
? Joined the Medical Staff in 1978
? Very involved with the GLVIPA

Give up? Please see Page 14 for the answer.

Congratulations!

Jane Dorval, MD, Chief, Division of Physical Medicine-Rehabilitation, will become Chair of the Board of Trustees of CARF -- the Rehabilitation Accreditation Commission -- for the 2002 term. Dr. Dorval began her association with CARF in 1984 as a surveyor in the Medical Rehabilitation Division and has participated in many of the accrediting body's National Advisory Committees, which draft new and revised accreditation standards. She was seated on the CARF Board of Trustees in 1997 as a representative of the American Academy of Physical Medicine and Rehabilitation. She recently completed her one-year term as Chair-elect of the Board of Trustees.

Flagging Orders

It appears that after writing orders on the patient's chart, many of the residents and attending physicians are forgetting to pull up the flags on the wall charts. This is the signal to the patient care staff that new orders have been placed on the chart. This can result in delayed treatment, missed medications, etc. Please remember to flag the charts after writing new orders.

Papers, Publications and Presentations

Raymond A. Fritz, Jr., DPM, Section of Podiatry, authored the **Foot Section** for the ***Special Operations Medical Handbook***, a manual that will be used by all the United States Operations Forces.

On November 21, **Mark A. Gittleman, MD**, Division of General Surgery, was a Visiting Professor at Christiana Hospital in Newark, Del., where he presented Grand Rounds on "Image-Guided Breast Invervention."

Geoffrey G. Hallock, MD, Division of Plastic Surgery, was an invited speaker at the 28th Annual Meeting of the Japanese Society of Reconstructive Microsurgery held in Yamanashi, Japan. His topic was titled "A Schema for Priorities in Flap Selection after Trauma of the Upper Extremities." This explained the rationale for choosing soft tissue coverage for traumatic wounds based on the experience within our trauma center over the past two decades. Dr. Hallock, along with **David C. Rice**, Director of Advanced Clinical Technologies Department, then discussed "The Role of a Microsurgical Laboratory in a Community Hospital."

Peter A. Keblish, Jr., MD, Division of Orthopedic Surgery, was a guest lecturer at the Joint Perspective Meeting 2001, an orthopedic meeting held in Tokyo, Japan. Dr. Keblish presented five scientific presentations on total joint arthroplasty including: "The Management of Varus or Valgus Deformity," "Correlation Between Femoral Rotation and Arthrofibrosis," "The Benefits of Mobile Bearing Knee Designs," "Long Term Outcomes with Mobile Bearings," and "Revision Made Simple." In addiiton to his presentations, he was also asked to speak on "Critical Clinical Pathways in Total Joint Replacement." Dr. Keblish was instrumental in establishing the LVH Critical Pathway in Total Joints which has decreased length of stay to 3+ days. Dr. Keblish also participated in multiple learning centers and performed surgeries in China, specifically in the cities of Shanghai, Hangzhou and Nanjing.

On December 1 and 2, **Indru T. Khubchandani, MD**, Division of Colon and Rectal Surgery, visited Nuremberg, Germany, to observe and perform the new technique of stapled hemorrhoidectomy. He will become part of an international multi-institutional study to evaluate the outcome studies. Dr. Khubchandani also performed transrectal repair of rectocele, which was telecast to other Centers including Italiatian Society of Coloproctology in Naples, Italy. In addition, Dr. Khubchandani authored a book chapter -- "Closed Hemorrhoidectomy" -- which was published in ***Surgical Treatment of Haemorrhoids***.

(Continued on Page 9)

(Continued from Page 8)

Dominic P. Lu, DDS, Director of Medical and Dental Externship Education, and **Lawrence Kleinman, MD**, Chief of Health Studies, collaborated on an article -- "Acupuncture and Clinical Hypnosis for Facial and Head and Neck Pain: A Single Crossover Comparison" -- which was published in the November issue of the ***American Journal of Clinical Hypnosis***.

Neurology, part of the House Officer Series, by **Lawrence P. Levitt, MD**, and **Alexander D. Rae-Grant, MD**, Division of Neurology, and **Howard L. Weiner, MD**, Center for Neurological Diseases at Brigham and Women's Hospital, Boston, Mass., was recently published in Chinese for use in Mainland China.

Michael D. Pasquale, MD, Chief, Division of General Surgery and Division of Trauma-Surgical Critical Care, co-authored three articles that appeared in the September and November issues of the ***Journal of Trauma***. The articles are "Contribution of Age and Gender to Outcome of Blunt Splenic Injury in Adults: Multicenter Study of the Eastern Association for the Surgery of Trauma," "Practice Management Guidelines for the Management of Mild Traumatic Brain Injury: The EAST Practice Management Guidelines Work Group," and "The Injured Intoxicated Driver: Analysis of the Conviction Process."

General Medical Staff Meetings for 2002

Following are the dates for the General Medical Staff meetings for 2002. Please mark your calendar.

- March 11
- June 10
- September 9
- December 9

The meetings will begin at 6 p.m., and will be held in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78, and via teleconference in the First Floor Conference Room at Lehigh Valley Hospital-Muhlenberg.

All members of the Medical Staff are encouraged to attend.

Upcoming Seminars, Conferences and Meetings

Emergency Medicine Grand Rounds

Emergency Medicine Grand Rounds are held on Thursdays, beginning at 8 a.m. (unless otherwise noted), at alternate locations. Topics for January will include:

January 3 - Banko Building, Rooms 1 & 2 - 9 a.m.
- Pediatric Case Review - St. Luke's Emergency Medicine Residency
- Current Diagnosis & Management of Thromboembolytic Disease in the ED
- Gunshot Wound Ballistics

January 10 - Auditorium, Cedar Crest & I-78
- Seizures
- Dermatology of Systemic Illness
- Who Wants to be An ED Physician?
- Tintinalli (Pages 443-497)

January 17 - 4th Floor Conference Room, LVH-M
- M& M
- Case Study - The Use of Ultrasound

January 24 - 4th Floor Conference Room, LVH-M
- Environmental Potpourri
- Labor
- Medical Command Tapes
- Tintinalli (Pages 497-539)

January 31 - Orthopedic/Splinting Lab - EMI - 2166 S. 12th Street

For more information, please contact Dawn Yenser in the Department of Emergency Medicine at (484) 884-2888.

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 LVH-Muhlenberg. Topics to be discussed in January will include:

- January 8 - To Be Announced
- January 15 - "New Concepts and New Therapies in the Treatment of Acute Stroke"
- January 22 - "Clinical Usefulness of Positron Emission Tomography"
- January 29 - To Be Announced

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

(Continued from Page 9)

Department of Pediatrics

Pediatric conferences are held every Tuesday beginning at 8 a.m., in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78. Topics to be discussed in January include:

- January 8 - "Recent Developments in Newborn Screening"
- January 15 - "Pediatric Plastic Surgery"
- January 22 - "Mimics of Child Abuse"
- January 29 - Case Presentation

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

Surgical Grand Rounds

Surgical Grand Rounds are held every Tuesday at 7 a.m., in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78, and via videoconference in the First Floor Conference Room at LVH-Muhlenberg. Topics to be discussed are posted each week near the Auditorium door and on the LVH_LIST bulletin board in e-mail.

For more information, please contact Cathy Glenn in the Department of Surgery at (610) 402-8334.

Shared Kutztown Medical Office Space

Office suite available immediately with receptionist, x-ray, lab, ample parking, and a primary care referral group across the hall. Half or full day sessions for specialists. Capture larger patient area and referrals. For more information, contact John W. Hart at (610) 402-8980.

A Message from Information Services

Sharing your user ID is like sharing a piece of your identity. You wouldn't loan someone your VISA card or driver's license would you? User IDs are unique to each person and should NOT be shared with anyone. Not only are there security risks, but there are regulatory issues as well. Please keep your ID and password confidential.

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.

Medical Staff

Appointments

Ewa A. Susfal, MD
(Solo Practice)
2061 Fairview Avenue
Easton, PA 18042-3953
(610) 515-8030
Fax: (610) 515-8070
Department of Medicine
Division of General Internal Medicine
Site of Privileges - LVH & LVH-M
Provisional Active

Address Changes

Heritage Family Practice
- Richard D. Baylor, MD
- Wendy Rush-Spinosa, MD

2901 Hamilton Blvd.
Suite 100
Allentown, PA 18103-2819
(610) 437-0739
Fax: (610) 437-3601

Muhlenberg Obstetrics & Gynecology
- Joseph D. DeFulvio, DO
- Zirka M. Halibey, MD

2597 Schoenersville Road
Suite 302
Bethlehem, PA 18017-7384

Practice Changes

Ann K. Astolfi, DMD
(No longer in practice with Scott A. Gradwell, DMD)
35 E. Elizabeth Avenue
Suite 20
Bethlehem, PA 18018-6505
(610) 882-1501
Fax: (610) 882-1502

John P. Pettine, MD
(No longer in practice with Candio, Kovacs & Lakata, PC)
John P. Pettine, MD, PC
1259 S. Cedar Crest Blvd.
Suite 220
Allentown, PA 18103-6206
(610) 821-5700
Fax: (610) 821-5756

Status Changes

Matthew S. Bartelt, DO
Department of Medicine
Division of General Internal Medicine
From: Active
To: Affiliate

Barry E. Herman, MD
Department of Medicine
Division of Gastroenterology
From: Provisional Active
To: Affiliate

Shanker Mukherjee, MD
Department of Medicine
Division of Gastroenterology
From: Provisional Active
To: Affiliate

Maureen C. Persin, DO
Department of Medicine
Division of General Internal Medicine
From: Provisional Active
To: Affiliate

Paul H. Schenck, MD
Department of Surgery
Division of Ophthalmology
From: Active
To: Affiliate

One-Year Leaves of Absence

Jenni Levy, MD
Department of Medicine
Division of General Internal Medicine

Norman L. Maron, MD
Department of Surgery
Division of Orthopedic Surgery

(Continued on Page 12)

(Continued from Page 11)

Additional One-Year Leave of Absence

Michael A. Renaldo, DDS
Department of Surgery
Division of Oral and Maxillofacial Surgery

Resignations

Jeffrey B. Alpern, DO
Department of Surgery
Division of Cardio-Thoracic Surgery

Harry W. Buchanan IV, MD
Department of Surgery
Division of Ophthalmology

Luis I. Campos, MD
Department of Surgery
Division of General Surgery

William F. Dunleavy, DPM
Department of Surgery
Division of Orthopedic Surgery
Section of Podiatry

Jerald N. Friedman, MD
Department of Surgery
Division of General Surgery

Edward F. Guarino, MD
Department of Surgery
Division of Plastic Surgery

Richard M. Hughes, MD
Department of Surgery
Division of Urology

Jimmy W. Huh, MD
Department of Pediatrics
Division of Hospital Based Pediatrics
Section of Critical Care Medicine

William J. Kitei, MD
Department of Surgery
Division of Ophthalmology

John K. Mahon, MD
Department of Medicine
Division of Neurology

John L. Potter, DMD
Department of Dentistry
Division of Periodontics

Eugene M. Saravitz, MD
Department of Surgery
Division of Ophthalmology

Chetan K. Shah, DO
Department of Medicine
Division of Nephrology

Julio E. Torres, MD
Department of Medicine
Division of Hematology-Medical Oncology

Laura R. West, MD
Department of Psychiatry

Deaths

Raul M. Abad, MD
Department of Surgery
Division of Neurological Surgery

Robert A. Feeney, MD
Department of Family Practice

David J. Hacket, DO
Department of Family Practice

Charles W. Reninger, Jr., MD
Department of Obstetrics and Gynecology
Division of Primary Obstetrics and Gynecology

Allied Health Staff

Appointments

Brandon L. Bossard, PA-C
Physician Extender
Physician Assistant - PA-C
(LVPG-Emergency Medicine - Gavin C. Barr, Jr., MD)
Site of Privileges - LVH & LVH-M

Daniel Delaney, CRNA
Physician Extender
Professional - CRNA
(Anesticare Anesthesia Services Inc)
(Supervising Physician - Thomas M. McLoughlin, Jr., MD)
Site of Privileges - Lehigh Magnetic Imaging Center only

Kathy L. Gottschall, RN
Physician Extender
Professional - RN
(Lehigh Valley Cardiology Assoc - George A. Persin, DO)
Site of Privileges - LVH & LVH-M

(Continued on Page 13)

(Continued from Page 12)

Beth L. Lloyd, GRNA
Physician Extender
Professional - GRNA
(Allentown Anesthesia Associates Inc - Thomas M. McLoughlin, Jr., MD)
Site of Privileges - LVH & LVH-M

Heather L. Lloyd, GRNA
Physician Extender
Professional - GRNA
(Allentown Anesthesia Associates Inc - Thomas M. McLoughlin, Jr., MD)
Site of Privileges - LVH & LVH-M

Eric H. Lucas
Physician Extender
Technical - Pacemaker/ICD Technician
(St. Jude Medical)
(Supervising Physician - Norman H. Marcus, MD)
Site of Privileges - LVH & LVH-M

James S. Moser
Physician Extender
Technical - Vascular Support Technician
(Guidant Corp)
(Supervising Physician - Gary G. Nicholas, MD)
Site of Privileges - LVH & LVH-M

Joseph P. Schell II, GRNA
Physician Extender
Professional - GRNA
(Allentown Anesthesia Associates Inc - Thomas M. McLoughlin, Jr., MD)
Site of Privileges - LVH & LVH-M

Laura Slomiak, PA-C
Physician Extender
Physician Assistant - PA-C
(LVPG-Emergency Medicine - Michael S. Weinstock, MD)
Site of Privileges - LVH & LVH-M

MaryKay Wegman, CRNP
Physician Extender
Professional - CRNP
(Eastern PA Nephrology Assoc - Joseph C. Guzzo, MD)
Site of Privileges - LVH & LVH-M

Status Changes

David A. Cederberg, PA-C
Physician Extender
From: Technical - Surgical Technician
To: Physician Assistant - PA-C
(Yeisley Cardiothoracic Surgery LLC - Geary L. Yeisley, MD)
Site of Privileges - LVH & LVH-M

Eileen M. Klang, RN
Physician Extender
Professional
From: LPN
To: RN
(College Heights OBGYN Associates, PC - Thomas A. Hutchinson, MD)
Site of Privileges - LVH & LVH-M

Change of Supervising Physician

Cynthia L. Dinsmore, CNM
Physician Extender
Professional - CNM
From: Lehigh Valley Women's Health Care Alliance - Carolyn S. Scott, MD
To: Ernest Y. Normington II, MD
Site of Privileges - LVH

Kristin M. Flora, CPNP
Physician Extender
Professional - CPNP
From: Kimberly C. Brown, MD
To: Rosauro A. Dalope, MD
Site of Privileges - LVH & LVH-M

Nancy L. Minnich, PA-C
Physician Extender
Physician Assistant - PA-C
From: Coordinated Health Systems - Leigh S. Brezenoff, MD
To: Medical Imaging of LV, PC - James W. Jaffe, MD
Site of Privileges - LVH & LVH-M

Jennifer B. Wall, PA-C
Physician Extender
Physician Assistant - PA-C
From: Muhlenberg Primary Care, PC - Iqbal Sorathia, MD
To: Surgical Specialists of the Lehigh Valley - William R. Dougherty, MD
Site of Privileges - LVH & LVH-M

(Continued on Page 14)

(Continued from Page 13)

Change of Supervising Physician for the Perfusionists

From: Raymond L. Singer, MD
To: James K. Wu, MD

- Joseph M. Castagna, CCP
- Barbara Anne Elmore, CCP
- Patricia A. Gustafson, CCP
- Norman J. Manley, CCP
- Ralph M. Montesano, CCP
- David A. Palanzo, CCP
- Michael Quinn, CCP
- Debra L. Zarro, CCP

Answer to Mystery Medical Staff Member
Bruce A. Ellsweig, MD

Resignations

Christine Kazonich, PA-C
Physician Extender
Physician Assistant - PA-C

Faith M. Lauer, LPN
Physician Extender
Professional - LPN

Joan O'Donnell-Pirog, CRNP
Physician Extender
Professional - CRNP

Renee A. Weiss
Physician Extender
Technical - Surgical Technician

QUALITY IMPROVEMENT WHITEPAPER

Quality Improvement

After discussion, we have agreed that the name Quality Improvement is a more accurate and positive description of this continuing, open-ended process than Quality Assurance, and we will use QI in the future.

The Process

The QI process is a responsibility of the LVH Board of Trustees which is delegated to the LVH medical staff. This structured process is designed to educate and instruct the medical staff as it studies and improves the quality of care rendered at LVH. Quality Improvement is part of life-long learning for health care professionals. The continued analysis of incidents and systems of care is part of the Quality Improvement process.

The identification of a QI case may be from several different sources. Cases presented at divisional or departmental M&M may be made QI cases at the discretion of the moderator/division chief. Most M&M cases will be simply closed, but some may be "kept open" after discussion and referred to QI for further discussion. Some cases will surface from patient complaints, sentinel events, lawsuits or concerns of the department chairs. Other cases may be selected by administrative and statistical indicators (unexpected return to the OR, readmission, complication, mortality, etc.) but all are subject to physician review before becoming QI cases. There is a wide funnel for selection of possible cases, but final confirmation of a QI case is by physician, based on apparent/possible deviation from accepted standards of medical care.

Most cases discussed at monthly Divisional M&M involve one division or department and can be assigned to one of the following categories:

Patient disease
Error in judgment
Error in management
Error in technique
Delay in diagnosis

These may become QI cases or may be closed at the Divisional level.

Once a QI case has been logged with Care Management, the case is sent to the appropriate departmental QI committee chair and the involved physician is to be notified. He/she is given 30 days to respond and the case is then discussed at departmental QI committee within 60 days of being logged. This discussion is conducted "physician-blind". Within one week after discussion at departmental QI, a letter is sent by the QI staff to chief medical officer and to the physician with the decision and recommendations. The letter is marked "peer review" and is not to be included in the patient's file.

Multi-Disciplinary Council

Alternatively, a case may be selected for referral to MDC if it involves more than one department of the medical staff. The multidisciplinary council is an overarching committee that parallels the departmental QI process, but focuses on cases that involve more than one department and examines statistical trends and system issues. The MDC is composed of 14 official members who represent the QI process in each of the major clinical departments, in

addition to representatives from nursing, risk management and care management. Before the presence of MDC, these cases were referred back and forth between departments, often taking considerable time and often closed without clear resolution. These were often cases in which there was a problem with the "system of care", the focus of the IOM reports.

CCRC

In addition, after review by the chief medical officer, some cases may be selected for discussion at Board level (Clinical Case Review Committee) at which all cases are again discussed "physician-blind". The CCRC is composed of several Board members, the major clinical chairs, and troika.

This Board committee has used incident analysis (in all clinical departments of LVH) to focus on network systems and correction of "systems of care" on a strategic level.

After peer discussion and deliberation (either at departmental QI, MDC, or CCRC), the case may be closed and a letter sent to the physician. The physician may be cleared OR there may be a QI concern. Where there is a QI concern, the physician may be counseled and then the case can finally be closed. The intent is to educate the physician so that we can all learn from the process and improve our care in the future.

The File

Either way, a letter is generated and sent to the QI file of the physician, and the physician is notified, thus sharing a copy of the final case summary which is then placed in the physician's file. (This notification is not to be placed in the patients medical record.) Even when the case has been closed and the physician has been exonerated, a summary letter is placed in the file documenting that the hospital and the medical staff have taken the case seriously, discussed it in the QI process, performed due diligence and cleared the physician (QI case with no recommendations). This is not counted as "QI File Activity" which is included in the reappointment documents. When there has been a recommendation, this IS then counted in the QI File Activity. This documentation of the QI process activity is necessary as a protection for the medical staff and the hospital network.

Members of the medical staff can access their QI files, if they wish, by calling Care Management at 402-1770 and setting up an appointment. The QI files are confidential and available only to the individual physician, the Division Chief, and the Department Chair.

Has there been a shift in the QI process recently?

There has been a move to tighten up and unify the entire process of QI across the network, including LVH-M, to strive for consistent quality of care. There was also a pre-existing backlog in the process and the new focus has resulted in this apparent increase in the number of cases until the backlog is cleared.

Are there real differences in how each department handles QI cases?

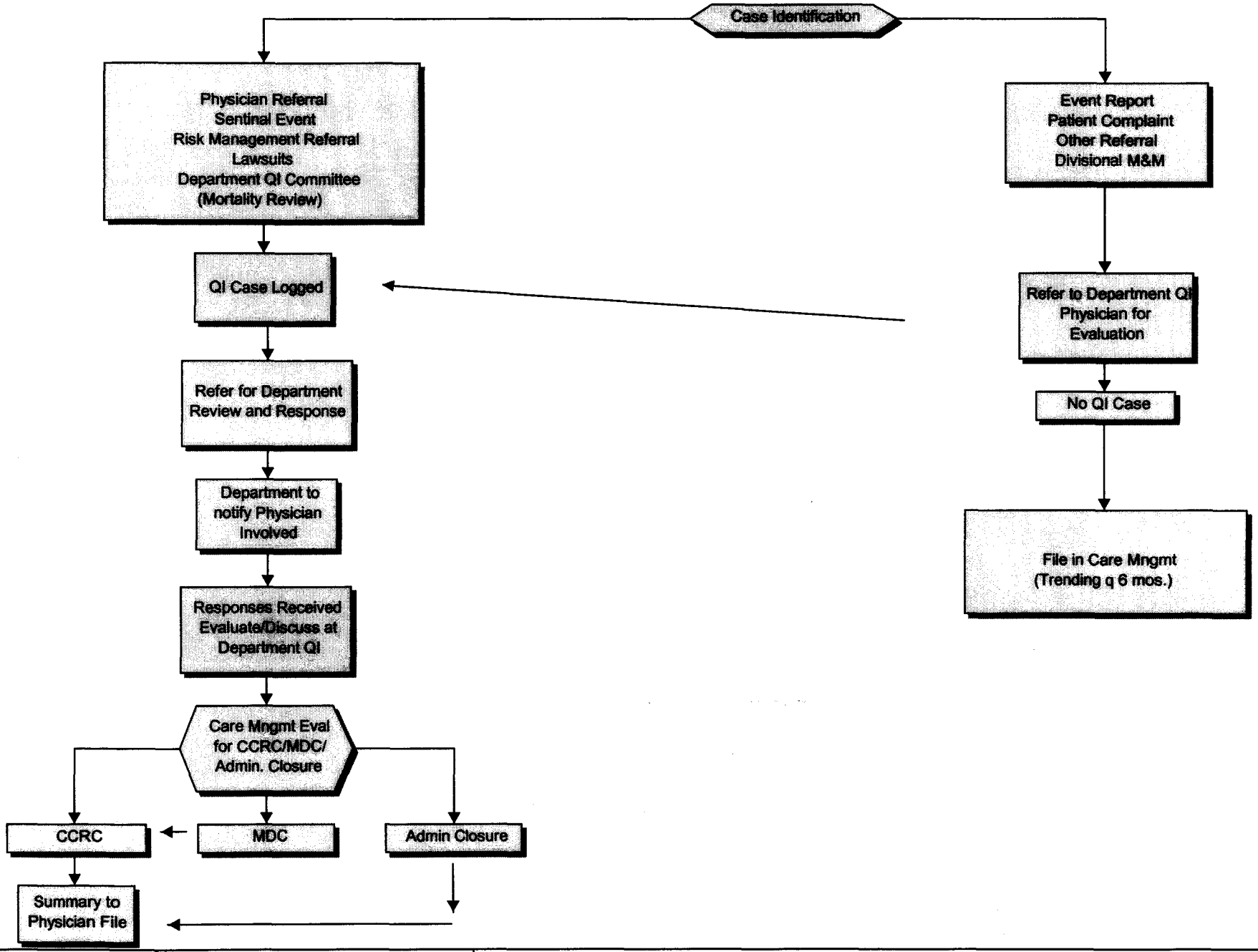
By virtue of the department (and the specialties within that department), there will be inevitable differences in the types of QI cases presented to the departmental QI committee. While there may be differences in how QI cases are managed, it is the hope that a more uniform standard will be applied across all departments with cases decided in good faith, with common sense, and with goals of educating the physician and improving quality patient care. Each division and department will document the QI process. Medical staff bylaws require all members of the LVH medical staff to participate.

Will health care practitioners be punished for too many QI cases?

This is an educational and informative process. There are no established quotas for QI cases. The process assumes that we are all still learning, sometimes from our mistakes. The QI mechanism is not intended to be punitive and is not intended to expose the healthcare practitioner to legal liability. The process is peer-review protected and this has been respected by the courts.

September 25, 2001
x:\pops\wordwin\emm\qiwhitepaper.doc

QI CASE LOGGING PROCESS



The Last Word...

Tips and Techniques for the Lastword™ User

January, 2002 – Volume 1, Issue 3

INBOX Alerts & Reminders – You Have Orders to Sign

by Carolyn K. Suess, R.N.

The *INBOX – Alerts & Reminders* portion of the *Physician Base* screen in Lastword serves as a reminder to sign orders (see Figure 1).

In an instance where a PA or medical student enters an order for a patient, or a physician calls in a telephone order, the CAPOE system requires the electronic signature of the ordering physician. The *You Have Orders to Sign* reminder appears in the *INBOX* window when these types of orders generate.

To access unsigned orders, click on this alert located in the *INBOX* window, then click on the **Select** button located at the bottom of the window. The *Sign Orders* window opens (see Figure 2). A list of outstanding orders is selected for you to sign.

Click on the **Review Selected Order Detail** button to review individual order details.

Click on the **Review Audit** button to review an *Order Audit Trail* (i.e., the date/time an order was entered into the system).

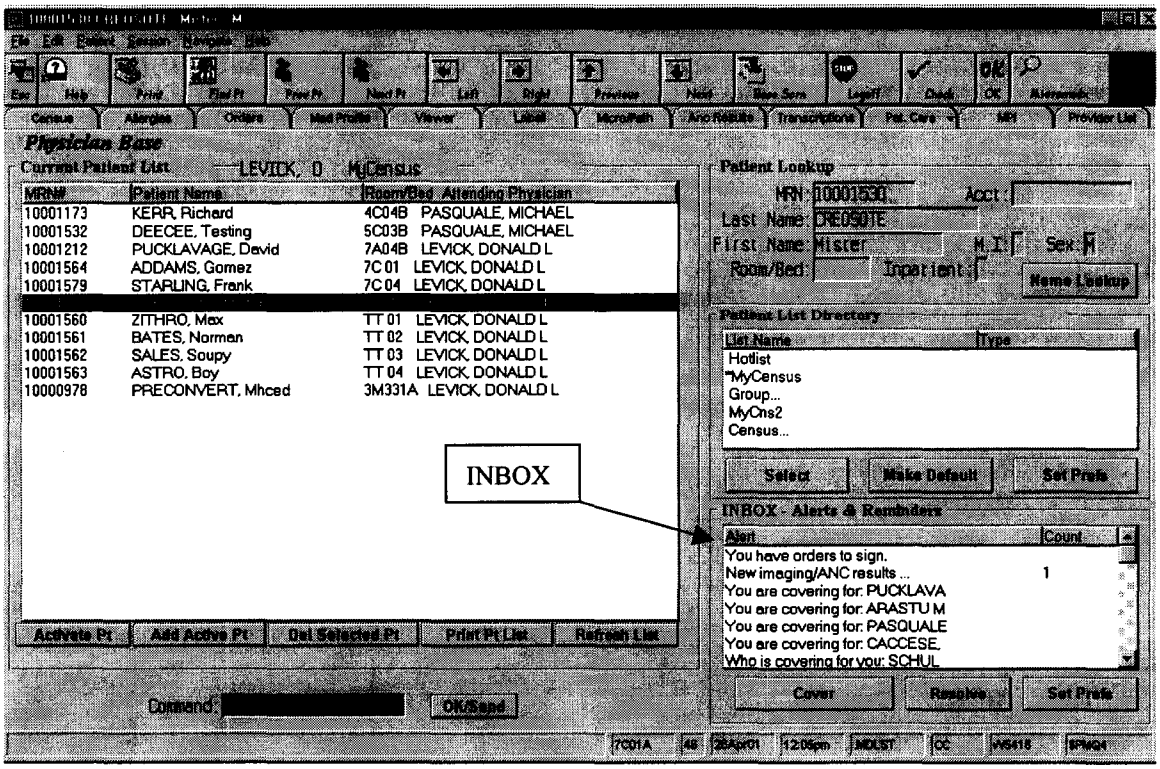


Figure 1 - Physician Base Screen showing INBOX location

All orders are selected by default, and can be unselected by clicking on the appropriate check boxes located to the left of each order. Click the **Sign Selected Orders** button to sign the orders you selected. The orders are now signed in the system just as you would have initialed written orders.

The *INBOX – Alerts & Reminders* feature also provides alerts for abnormal lab results, and new ancillary results that you order. If you are covering for another physician, click on the *You are Covering for:* INBOX reminder. A second INBOX opens and displays alerts for tests ordered by the physician for whom you are covering. Likewise, a physician covering for you has access to your INBOX alerts.

To learn more about INBOX and other Lastword features, please take a moment to review the on-line documentation for Lastword Version 4.1.7. Both the CAPOE and Non-CAPOE Physician User Guides can be found on the LVHNN Intranet under the *Resources* heading **Lastword for Physicians**.

If you wish to obtain a paper copy of either document, or are interested in a personal training session, please contact one of the Physician Software Educators on staff:

Lynn Corcoran-Stamm - ext.1425
Kimberlee Szep, R.N. - ext. 1431
Carolyn K. Suess, R.N. – ext.1416

Lynn, Kimberlee and Carolyn will be pleased to assist you.

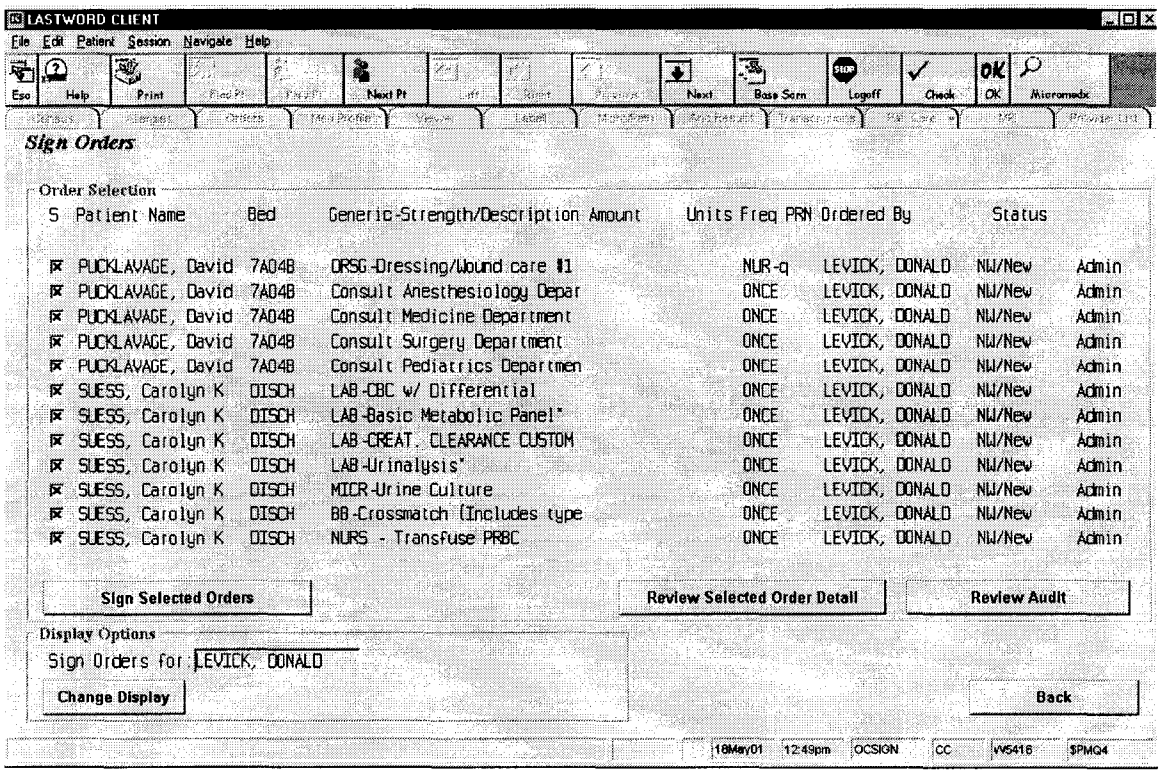


Figure 2 - Orders to Signs

Using 'Next Patient' to Expedite Patient Rounding

by Carolyn K. Suess, R.N.

Reviewing recent lab findings and vital signs is a routine part of conducting patient rounds. One way to streamline this process is using the **Next Pt** button.

After selecting a patient from your *Current Patient List* and clicking on any chart tab (except for *Census*, *Pt Care/Chart*, and *Provider List*), review your data, then click on the **Next Pt** button, located on the Tool Bar of the Lastword screen (see Figure 3). The chart tab displays results for the next patient on your *Current Patient List*.

The *Viewer* chart tab opens a second window which overlays the Lastword screen. Keep in mind, you may want to move the viewer window so as not to obscure the Tool Bar. This is accomplished by clicking on the extreme upper margin of the window and while holding the mouse button down, "drag" it to the location you desire. Once you have done so, you can use the **Next Pt** button without difficulty.

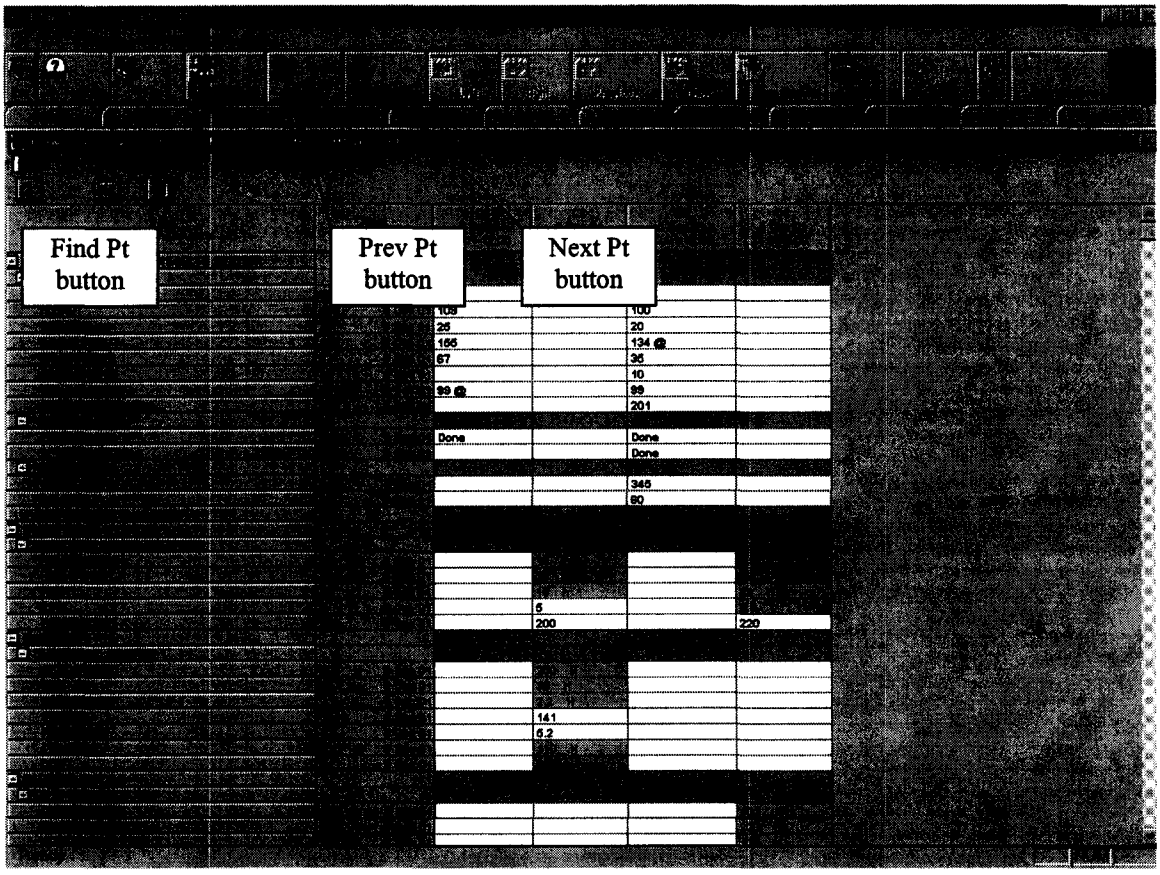


Figure 3 – Viewer screen overlaying Lastword screen. Note location of Next Pt, Prev Pt, and Find Pt buttons on the Lastword Tool Bar.

Located adjacent to the **Next Pt** button is the **Prev Pt** button. It serves a similar function by activating the patient listed prior the one currently active on your *Current Patient List*. Should you wish to select a specific patient from your list, click on the **Find Pt** button. It displays your *Current Active Patient List* (see Figure 4). Simply double-click on the patient you wish to activate and the result screen updates with that patient's results.

Using the **Next Pt**, **Prev Pt**, and **Find Pt** buttons saves mouse clicks and time reviewing patient data. This is especially true for those physicians utilizing wireless hand-held devices such as the PenCentra during patient rounds. Should you wish to try one if these devices while rounding on TTU or 6B, they are located at the physician dictation areas on both of these units.

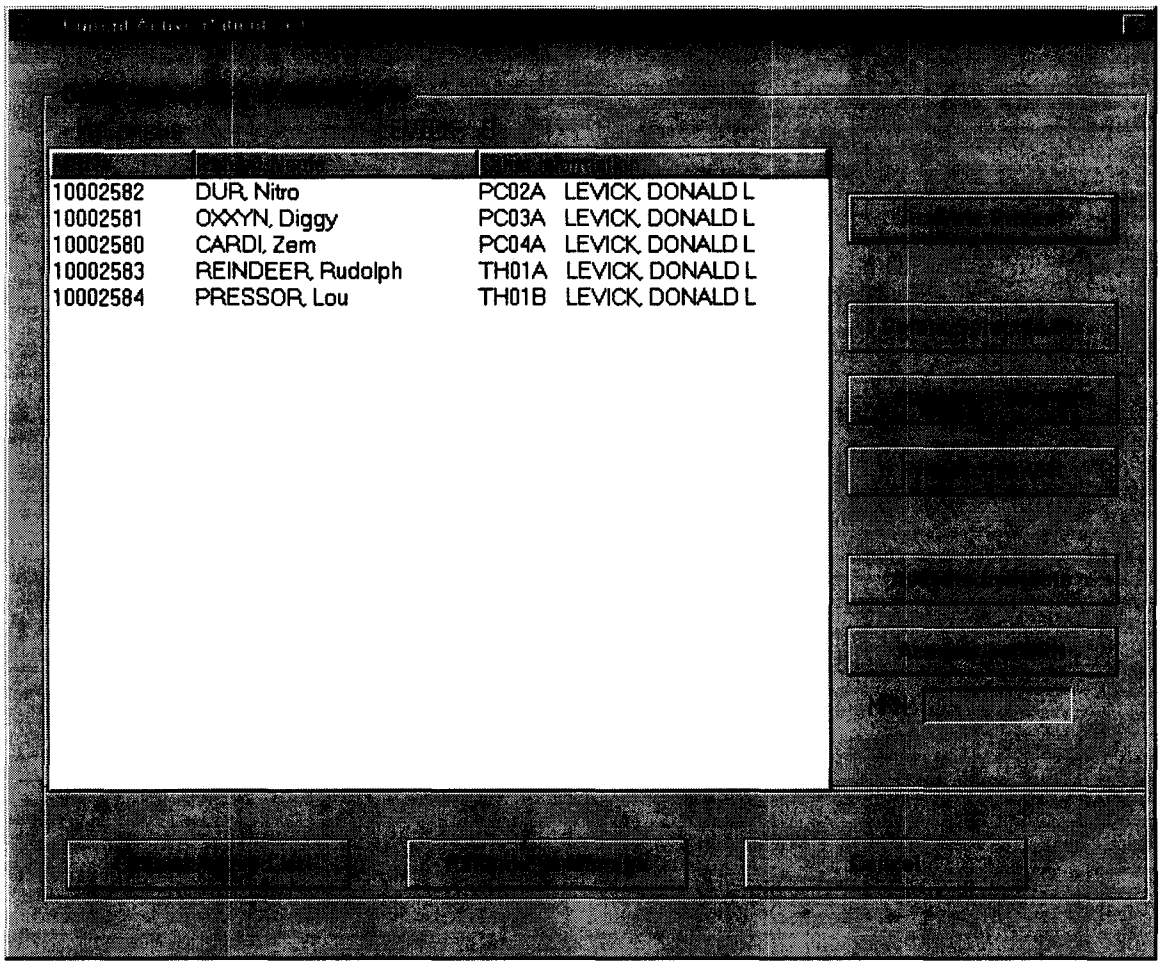


Figure 4 – Current Active Patient List window

THE CENTER FOR EDUCATIONAL DEVELOPMENT AND SUPPORT

January 2002

NEWS FROM THE LIBRARY.

OVID Instruction.
Contact Barb Iobst at 610-402-8408 to arrange for instruction in the use of OVID's MEDLINE and its other databases.

Library at 17th and Chew Streets

"The Psychiatric Clinics of North America" (Subject: *"Social Anxiety Disorder"*) December, 2001 – Volume 24, Number 4

Library at CC & I-78 Campus

"Handbook of Kidney Transplantation," 3rd edition. Editor: G. Danovitch

"Clinical Obstetrics and Gynecology" (Subjects: *"Alternative Medicine in Obstetrics"* and *"Alternative Medicine in Gynecology"*) December, 2001 – Volume 44, No. 4

"Principles and Practice of Geriatric Surgery." Editor: R. Rosenthal, et al.

"Massry & Glassock's Textbook of Nephrology," 4th edition. Editor: S. Massry, et al.

Library at LVH-Muhlenberg

"Child Abuse: Medical Diagnosis and Management," 2nd edition. Editor: R. Reece

"The Clinical Practice of Emergency Medicine," 3rd edition. Editor: A. Harwood-Nuss

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:

January 8, 8am – noon	February 12, noon - 4pm
March 26, 8am – noon	April 23, 8am - noon

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

March 5, noon – 4pm May 14, noon – 4pm

Twelve slots are available for each session.

To register, please contact Suzanne Rice via e-mail or at 610-402-2475 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 610-402-2413 or through e-mail.

The Graduate Medical Education Office of the Center for Educational Development and Support is pleased to announce that two of our residency programs have filled their positions for the 2002-2003 academic year.

Lehigh Valley Hospital-Muhlenberg's Osteopathic Emergency Medicine residency program has filled all eight of their positions. The new residents are:

Robert D. Cannon, DO, a graduate of Philadelphia College of Osteopathic Medicine
Adam M. Fox, DO, a graduate of University of Health Sciences-College of Osteopathic Medicine
Terrence E. Goyke, DO, a graduate of Chicago College of Osteopathic Medicine
Alex Morales, DO, a graduate of University of Medicine and Dentistry of New Jersey
Andrew V. Nicholes, DO, a graduate of University of Health Sciences- College of Osteopathic Medicine
Tariq S. Noohani, DO, a graduate of Nova Southeastern University- College of Osteopathic Medicine
William E. Sotack, Jr, DO, a graduate of Philadelphia College of Osteopathic Medicine
Kevin T. Washington, DO, a graduate of Philadelphia College of Osteopathic Medicine

The Colon/Rectal Surgery Program at the Cedar Crest site has filled both of its positions. Joining the program for the 2002-2003 academic year will be:

Steven A. Esser, MD, currently a Resident at St. Luke's Hospital
Boris Sachakov, MD, currently a Resident at New York Hospital

Congratulations to Alex Rosenau, Program Director, Emergency Medicine and to Robert Riether, MD, Program Director, Colon/ Rectal Surgery.

January

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1 Happy New Year!	**2**	**3** 8am Emergency Medicine GR Banko Rm 1&2 12 noon Combined TB JDMCC CR1	**4** 7am GYN GR CC CR1 11 am Neurology Conf CC Cr1 12 noon Breast TB JDMCC CR1	**5**
6	**7** 12 noon Colon/Rectal TB JDMCC CR1	**8** 7am Family Practice GR-JDMCC 1A/B 7am Surgical GR CC-Aud 8am Pediatric GR CC-Aud 12 noon Medical GR CC-Aud	**9** 12 noon Pulmonary TB JDMCC CR1 12 noon MHC TB OR Con Rm	**10** 8am Emergency Medicine GR LVH-CC-Aud 12 noon Combined TB JDMCC CR1	**11** 7am OBGYN GR CC CR1 11 am Neurology Conf CC Cr1 12 noon Breast TB JDMCC CR1	**12**
13	**14**	**15** 7am Surgical GR CC-Aud 8am Pediatric GR CC-Aud 12 noon Medical GR CC-Aud	**16** 12 noon MHC TB OR Conf RM	**17** 8am Emergency Medicine GR LVH-M-4th Fl. Conf Rm 12 noon Endocrin TB JDMCC CR1	**18** 7am OBGYN GR CC CR1 12 noon Breast TB JDMCC CR1	**19**
20	**21** 12 noon Colon/Rectal TB JDMCC CR1	**22** 7am Surgical GR CC-Aud 8am Pediatric GR CC-Aud 12 noon Medical GR CC-Aud 12 noon Urology TB JDMCC CR1	**23** 12 noon MHC TB OR Conf RM	**24** 8am Emergency Medicine GR LVH-M – 4th Fl. Conf. Rm	**25** 7am OBGYN GR CC CR1 12 noon Breast TB JDMCC CR1	**26**
27	**28**	**29** 7am Surgical GR CC-Aud 8am Pediatric GR CC-Aud 12 noon Medical GR CC-Aud	**30** 12 noon MHC TB OR Conf RM	**31** 8am Emergency Medicine GR EMI-2166S12th		

2002

A supplement to *medical records briefing*

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Diabetes cases require appropriate documentation

Remember what qualifies as 'unstable' and 'insulin-dependent'

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

As we know, the American Diabetes Association changed the classification of diabetes yet another time. They keep doing this for good reasons, but it gets tough to follow the endless changes. This time, the main issue revolves around the use of Arabic numerals rather than Roman numerals.

International Classification of Disease codes (ICD) were developed so that doctors in one country could talk about diseases with doctors in another country by the use of a common vocabulary of numbers rather than words. And the accuracy of data accumulation depends on the proper assignment of ICD codes.

Unfortunately, physicians have developed behavioral patterns that require modification for the sake of the accuracy of this data accumulated by the World Health Organization. Right now, regarding diabetes and its sequelae, we're way behind!

The bad habit we've gotten into is the indiscriminate use of the terms "IDDM" or "NIDDM." According to the new classification, insulin dependence is to be reserved for what we used to call juvenile diabetes, even when it occurs in the adult stages of life.

In order to properly code the patients we see, we must reserve the term "insulin dependence" for those people who do not make insulin at all. Patients who take insulin for convenience or for better control of an "adult onset" case of diabetes should be referred to as "insulin-*requiring*" diabetics or "insulin-*taking*" diabetics. Their disease process will not cause death from not taking insulin, as it will in the diabetic "formerly known as juvenile." They are the previously known "NIDDM" patients who happen to be taking insulin—either situationally or routinely—but they are *not* "insulin-dependent" diabetics.

This problem exists in both inpatient and outpatient arenas. Insulin-dependent diabetics are notoriously tougher to deal with. Certainly, adult onset diabetics can experience the same consequences of diabetes as the juveniles, such as nephrosclerosis, peripheral vascular disease, or blindness. But historically, the "insulin-dependent" diabetics get it earlier in life and live shorter lives.

Be aware that the current meaning of Type 1 (that's Arabic 1) diabetes covers only true *insulin dependent* diabetes. Don't call non-insulin dependent diabetics on insulin "IDDM." It will always result in bad data.

It's also important to let the coders—whether in the hospital or your office—know whether a diabetic patient is stable or unstable at the time of the visit.

When a diabetic becomes hypoglycemic because of overexercise or starvation and passes out with a blood sugar of 40, indicate whether you consider that unstable. When a patient is admitted with sepsis from a urinary tract infection and a blood sugar of 650, let them know whether you consider that unstable.

Certainly, after surgery a patient taking varying doses of insulin based on blood sugar determinations is not likely "unstable," but rather being controlled with sliding scale. If the control is out of hand and it takes extra work to maintain homeostasis, then call it "unstable."

Etiologic classification of diabetes

Harrison's Online McGraw-Hill

I. Type 1 diabetes – beta cell destruction, usually leading to absolute insulin deficiency

II. Type 2 diabetes – insulin resistance or deficiency plus resistance

III. Other specific types

- A. Genetic defects of beta cell function
- B. Genetic defects in insulin action
  1. Type A insulin resistance
  2. Leprechaunism
  3. Rabson Mendenhall syndrome
  4. Lipoatrophic diabetes
- C. Diseases of the exocrine pancreas
  1. Pancreatitis
  2. Trauma/pancreatectomy
  3. Neoplasia
  4. Cystic fibrosis
  5. Hemachromatosis
  6. Fibrocalculous pancreas
- D. Endocrinopathies
  1. Acromegaly
  2. Cushing's syndrome
  3. Glucagonoma
  4. Hyperthyroidism
  5. Somatostatinoma
  6. Aldosteronoma
- E. Drug or chemical induced
  1. Vacor
  2. Pentamidine
  3. Nicotinic acid
  4. Steroids (glucocorticoids)
  5. Thyroid hormone
  6. Beta agonists
  7. Thiazides
  8. Dilantin
  9. Alpha interferon
- F. Infections
  1. Congenital rubella
- G. Uncom. immune-mediated diabetes
  1. "Stiff man" syndrome
  2. Anti-insulin receptor antibodies
- H. Other genetic syndromes
  1. Down's syndrome
  2. Klinefelter's syndrome
  3. Turner's syndrome
  4. Wolfram's syndrome
  5. Friedrich's ataxia
  6. Huntington's chorea
  7. Porphyria
  8. Lawrence Moon Biedl syndrome
  9. Myotonic dystrophy
  10. Prader Willi syndrome

IV. Gestational diabetes (GDM)

* Patients with any form of diabetes may require insulin treatment at some stage of their disease. Such use of insulin does NOT, of itself, classify the patient.

Source: The Expert Committee on the Diagnosis and Classification of Diabetes Mellitus, 1997.

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