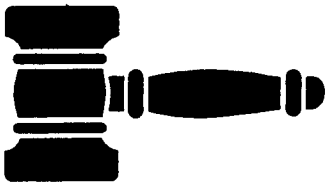
LEHIGH VALLEY HOSPITAL AND HEALTH NETWORK

PROGRESS NOTES

Medical Staff

July, 2002 Volume 14, Number 7

In This Issue . . .



From the President

Leadership is not always about blazing a new trail. Wisdom is not always about a groundbreaking thought. There are occasions when leadership and wisdom are best exemplified by a consistency of purpose in times of crisis.
- William F. Hecht, President & CEO, PPL

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Efficiency – LVH and hospitals around the country are facing capacity problems (med-surg beds, ICU's, and emergency department) – jeopardizing community access to regional healthcare. The demand for inpatient health services has taken a sharp increase, and demographics predict that this is not likely to change in the near future. Capacity issues in healthcare are going to be with us for a while, and we must seek efficiency in delivering healthcare services to the community we serve. This applies to both the inpatient and outpatient arenas.

When our ED goes on "divert" status, ambulances and patients bypass the hospital. When the PACU is full, the surgical patients stay in the OR rooms until a recovery room bed is available – delaying subsequent patients on the OR schedule. When inpatients are "awaiting placement," we are effectively converting an acute care bed to a custodial or residential bed. Call it "through-put" problems. While the concept may sound abstract, it has dramatic human impact, as was noted in the recent management retreat "Circling to Land."

Most physicians and healthcare providers are already well aware of the corresponding increase in demand for outpatient services in their offices. Many are struggling with a full office appointment schedule and patients complaining that they can't get an appointment on a timely basis. While we manage this issue in different ways, generally we seek ways to become more efficient in our offices. We need a parallel effort for our inpatients in the hospital.

Americans made 824 million trips to the doctor's office in 2000, representing a continuing increase over the past 10 years. According to a survey conducted by the U.S. Centers for Control and Prevention, the increase is largely due to population growth and to an aging population that needs to see their doctor more often, Yahoo News reported. (Yahoo News, June 7, 2002)

Continued on next page

The point is that demand for both inpatient and outpatient services is up. "Supply" of healthcare resources can expand in limited ways, so we must seek efficiency. How, you ask? This will be the more difficult, but rewarding part. Your Troika will be soliciting suggestions and observations from the medical staff on ways to improve efficiency. Please convey your ideas and observations on efficiency by e-mail, letter, phone or in person to any member of Troika or Beth Martin in Medical Staff Services. We need and appreciate your input. What would make your day more efficient? What would be your ideal system?

Send, phone or e-mail your comments to:

- Edward M. Mullin, Jr., MD, c/o Medical Staff Services, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box; 689, Allentown, PA 18105-1556, (610) 402-8980, edward.mullin@lvh.com
- Alexander D. Rae-Grant, MD, Lehigh Neurology, 1210 S. Cedar Crest Blvd., Suite 1800, Allentown, PA 18103-6208, (610) 402-8420, alexander.rae-grant@lvh.com
- David M. Caccese, MD, Peters, Caccese, Scott & DuGan, 401 N. 17th Street, Suite 201, Allentown, PA 18104-5085, (610) 432-6862, david.caccese@lvh.com
- John W. Hart, c/o Medical Staff Services, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box; 689, Allentown, PA 18105-1556, (610) 402-8980, john.hart@lvh.com
- Beth Martin, c/o Medical Staff Services, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box; 689, Allentown, PA 18105-1556, (610) 402-8980, beth.martin@lvh.com

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The greatest good you can do for another is not just to share your riches, but to reveal to him his own.

- Benjamin Disraeli

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Medical Staff Governance Renewal – Every year, the medical staff needs to look at our committee structure and determine whether each committee needs to continue its work. We need feedback from the committee members, the committee chair, and interested parties. In this way, we hope to avoid committees with marginal usefulness, refocus on the goal of every committee, and use the time of the medical staff efficiently.

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In his Odes, the Roman poet Horace speaks of the "middle way" and he was right (I think). Moderation is the key to a happy life, and it applies to many areas of human activity, from personal affairs, to finance, to exercise, to work. Moderation is not tepid, wimpy or cautious. It is prudent, sensible and rewarding.

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Recognition and Thanks – Physicians and healthcare providers often hear from one another only when there is a problem or a complaint. Often this is the result of the "assumed standard of excellence." When things run smoothly, even with considerable effort, we seem to hear nothing. But there's one little glitch... The human nature that we all share seems to require periodic positive feedback – even for repetitive routine tasks – ask any psychologist. Give each other a pat on the back when it's due and say those magic words "Nice Job!" Try it; it works.

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Life is motion, and motion means change.

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Unanswered Coding Queries to be treated as incomplete charts - Periodically, we have all had questions from the LVH coders on our clinical charts. The intent is not to make you (the provider) become a coder or take responsibility for assigning the correct code, but simply to supply the coding personnel with the appropriate clinical information (which we know) and allow them to assign the correct code – one which allows the institution to be appropriately reimbursed by third party payers for services rendered. While this sounds simple the medical staff response to these questions needs improving. After discussion, we will simply treat coding inquiries as part of the chart – thus, an incomplete coding question will become an incomplete chart. **As approved at the April 4, 2002 Medical Executive Committee, implementation of making non-response to a query a suspendable item will be effective beginning July 1, 2002.**

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Medical Education – Students Inadequately prepared to meet needs of the elderly.

Most U.S. medical students are poorly equipped to meet the unique health needs of elderly patients, leading to an inferior quality of care for a rapidly growing segment of the population, according to research presented at the recent annual meeting of the American Geriatrics Society (AGS) (Bryant, Reuters Health, 5/15). Currently, the 35 million U.S. patients over age 65 account for approximately one-third of the total demand for health care services. Yet evidence suggests that students' interest in geriatrics training or in the geriatrics specialty is waning (Kalson, *Pittsburgh Post-Gazette*, 5/21). Innovative programs designed to help students relate to seniors may help combat the impending geriatrician shortage by providing future physicians in all specialties with the knowledge and skills to better treat elderly patients. *06/06/2002*

Continued on next page

Malpractice Update -- May 2002 – Dr. Nancy Roberts, head of Ob/Gyn at Main Line Hospitals, stops delivering babies because it no longer makes economic sense. Obstetric training programs in and around Philadelphia are having trouble attracting residents who no longer even want to train in the area due to the malpractice situation. Six percent of all U.S. medical malpractice payouts now exceed $1 million. PA ranks second in medical malpractice awards. PA is responsible for 10% of all malpractice lawsuits, while accounting for 4% of the U.S. population. Increasing malpractice premiums are hitting medical schools as well – resulting in cutbacks in programs, positions, and salaries for the teaching staff.

Does This Sound Familiar? **New Jersey's Doctors are Organizing a Major Demonstration in Trenton on June 13 against high malpractice costs.** Many physicians are canceling patient visits and elective surgeries to rally in their white coats on the State House steps, fearing that rising malpractice insurance premiums may drive many of them -- especially obstetricians and gynecologists -- out of business or out of state, reported the Bergen Record. Chartered buses from more than 30 hospitals will carry patients, staff and families to the march. (Bergen Record, June 9, 2002)

Freedom of the press means no-iron clothes.
Age is important only if you're cheese.
You don't stop laughing because you grow old; you grow old because you stop laughing.

Ed

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

? ? ? Mystery Medical Staff Member ? ? ?

? Born in Philadelphia, Pa.
? Earned Bachelor of Arts degree from LaSalle College in Philadelphia
? Graduated from Temple University School of Medicine
? Completed an internship at Albert Einstein Medical Center
? Completed a three-year residency at the University of Colorado Hospital
? Joined the Medical Staff in 1989
? Wife's name is Audrey
? Father of three children
? Drives a Black Saab

Give up? Turn to page 12 for the answer.

Spotlight on . . .

Charles J. Scagliotti, MD

Born in Peckville, Pa., Dr. Scagliotti completed his undergraduate education at the University of Scranton in Scranton, Pa., where he earned a Bachelor of Science degree. He received his medical degree from Facolta di Medicina e Chirurgia dell'Universita di Padova in Italy. He completed a rotating internship, a General Surgery residency, and a Vascular Surgery fellowship at the Allentown Affiliated Hospitals.

Certified by the American Board of Surgery, Dr. Scagliotti joined the hospital's Division of General Surgery in 1976, and is in private practice. Dr. Scagliotti served as President of the Medical Staff from January, 1989 to December, 1990.

He is a Clinical Assistant Professor of Surgery at Pennsylvania State University College of Medicine.

Dr. Scagliotti is Past President of the Lehigh County Medical Society and the Eastern Pennsylvania Chapter of the American College of Surgeons.

On a more personal note, Dr. Scagliotti and his wife, Pat, have three children -- Katrina, Chris and Greg. In his spare time, he enjoys fishing, hunting and golfing.

In conclusion, Dr. Scagliotti has the following comments to share with his colleagues on the Medical Staff:

"As the business of health care grows, our demands to be better patient advocates will also grow. Our patients will need us even more than now."

"Get involved, join and be active in your medical society and specialty societies. We need every voice."

"Don't forget to sit down and talk to our patients -- hold their hands -- touch them. Remember, they are patients not diseases."

"No matter how busy we are, don't forget the people who are closest to us -- our families and friends. They need us also."

News from CAPOE Central

CAPOE is now live on four units, as 7A went live with CAPOE at the end of June. Overall, the project is going quite well, as more physicians are trained and are using the system. The CAPOE team continues to provide excellent support and response to physician input. The changes to Coumadin orders, as illustrated in this month's issue of ***The LastWord*** are an example of this.

In the quest for the perfect way to access and input information, we have begun to distribute Fujitsu LifeBooks to attendings and residents. These are really cool silver subnotebook computers that connect through the wireless network. The physicians who are using the LifeBooks are finding they are more efficient in their daily work. Once you get used to using CAPOE (which takes several weeks of practice), you will be able to integrate it into your work routine.

One of our physicians is now using the following routine: He takes the chart and the LifeBook into the patient's room. He reviews the medications, vital signs and labs with the patient. He then examines the patient, and as he discusses the plan with the patient, he enters his orders into the LifeBook. He has eliminated the need to find the med cardex, to login to a workstation, or to stand outside the patient's room.

As we continue to bring new units live with Medication/Vital Sign Charting and CAPOE, and train more physicians, the expectation continues that the Medical Staff will take the time to learn how to use CAPOE and make use of the system. The goal of CAPOE is to improve the quality and efficiency of patient care. I believe that the physicians using CAPOE are achieving these goals.

Please contact me with any questions or feedback.

Don Levick, MD, MBA
(610) 402-5100 7481 (pager)

Medical Executive Committee News

Congratulations are extended to Ravindra R. Kandula, MD, Glenn S. Kratzer, MD, Michael A. Rossi, MD, Raymond L. Singer, MD, and James C. Weis, MD, who were recently elected to serve three-year terms as members-at-large of the Medical Executive Committee.

A special "Thank You" to John D. Nuschke, MD, Michael Scarlato, MD, Elliot I. Shoemaker, MD, and Bruce J. Silverberg, MD, for their dedication and service to the Medical Staff as members of the Medical Executive Committee.

Controlled Access Divisions at LVH-M

The Lehigh Valley Hospital Board of Trustees, at its May 5, 2002 meeting, and the Lehigh Valley Hospital-Muhlenberg Board of Trustees, at its June 11, 2002 meeting, voted to move the residual of the specialty divisions at LVH-Muhlenberg to mirror the current status of controlled access at LVH in the Hospital Staff Development Plan. This will require the requesting of slots during the Spring (February 15 to March 14) and Fall (August 15 to September 14) Semi-Annual Needs Surveys. A blue memorandum (under John W. Hart's signature) regarding the Semi-Annual Needs Survey will be distributed prior to each survey. For your information and review, attached to this newsletter on pages 23-27 is a copy of the Staff Development Plan Status of Department, Division and Sections grid. If you have any questions regarding the grid or the Semi-Annual Needs Survey, please contact John W. Hart, Vice President, at (610) 402-8980.

News from the Health Information Management Department

Attending Physician

For purposes of coding case assignment, the attending physician is listed as the physician who saw the patient most during the hospital stay, except (1) if the patient went to a surgical suite, the surgeon becomes the attending and (2) if an order is written to change or designate the attending physician.

For accuracy in physician case assignment, it is recommended that the attending physician be identified in last progress note or in the discharge summary.

For purposes of chart deficiency assignment following patient discharge, physicians may set up individual or group guidelines for deficiency assignment. If there are no guidelines established, the coding/case assignment guidelines will be followed.

Corrections in the Medical Record

- Draw a single line through the documentation requiring the correction, making sure the original entry can still be read. *Do not use White Out or cross out documentation so that it is not legible.*
- Initial and date the correction, noting the reason for the correction.
- A late note or addendum should be written with the date of the entry and explanation for the late note/addendum.
- Major revisions/addendums may be dictated.

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Discharge Notes

Discharge notes in the ambulatory/outpatient setting must include the following:

1. Final Diagnosis
2. Condition on Discharge
3. Discharge Instructions to Patient/Family (meds, diet, activity, etc.)
4. Follow-up Care

Documentation in the Medical Record

When documenting in the medical record, be sure to utilize the appropriate forms. Do not write in the margins or on the back of one-sided forms. When these documents are canned into the imaging system, it does not scan information in the margins or on the back of one-sided forms.

GI Lab

Effective July 1, 2002, dictated procedures will be required on all GI procedures performed in the GI lab. If there is no dictated procedure on the chart following patient discharge, the HIM Department will assign a chart deficiency via the PIM electronic chart completion module.

Illegible Handwriting

Illegible handwriting continues to be a concern within the medical record documentation. Physicians are asked to clearly document within the medical record. Some of the outcomes of illegible handwriting include:

- Delays in patient care
- Medication errors
- Delays in patient transfers
- Inability to capture billing/severity of illness documentation
- Reimburse denials due to illegibility. Some third party payers follow the premise "if it isn't documented or cannot be read, it did not happen."
- Inadequate defense in malpractice cases

While CAPOE is an excellent solution to illegible handwriting in reducing medication errors, this is only a small part of the medical record documentation. The handwritten progress notes capture the ongoing progress of the patient and serves as a communication tool between caregivers, as well as documentation to support the encounter.

Everyone is requested to take a role in assuring that medical record documentation is legible. If you have been identified with illegible handwriting, please (1) use your stamp every time you sign your name or (2) print your name and telephone number after your signature.

LVHHN Health Information Management (Medical Records) Physician Guidelines

Upon appointment to the Medical Staff, each physician receives a copy of HIM Guidelines. The guidelines, formerly 8½ x 11, have been updated and revised into a pocketsize booklet. The booklet, revised annually, is divided into the following sections:

- Location, hours of operation
- Key personnel (with telephone numbers),
- General Guidelines
  - Operations
  - Coding**
  - TRX

***The coding section is new to the guidelines and contains documentation tips to assist in documentation required for coding and severity of illness assignment.*

Within the new few weeks, physicians with admitting privileges will receive copies of the guidelines. If you do not receive a copy and would like to have one, please contact Carolyn Buck, Staff Assistant, Health Information Management, at (610) 402-8330.

Physician Queries

On occasion, documentation in the medical record requires further clarification for coding and severity of illness ratings. These questions are assigned to the physicians in the PIM electronic chart completion module as deficiencies. Upon recommendation of the Medical Record Committee and approval by the Medical Executive Committee at its April 4, 2002 meeting, if these queries are not responded to within 15 days of assignment, they will become items for which physicians may have suspension of admitting and surgical privileges. This will become effective on July 1, 2002.

Signature/Authentication in the Medical Record

Medicare Conditions of Participation require that all entries be legible and complete and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.

Surgical History and Physicals

When dictating surgical histories and physicals, please use the work type 13. These cases receive top priority in transcription and assure that surgical history and physicals are available at the time of the procedure.

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

News from Coding

Principal Diagnosis

The principal diagnosis largely determines the DRG assignment. Physicians can do much to promote coding compliance and ensure that the hospital receives all legitimate reimbursement. By taking care of documentation up front, physicians promote accurate, efficient coding and reduce the number of times they need to respond to queries.

When documentation is in need of clarification, physician response to questions raised in the query process is essential to ensure the assignment of the most accurate DRG.

Consistency

- **Admission note** should describe presenting signs and symptoms. If possible, provide an admission/provisional diagnosis and treatment plan.
- **Progress note** should show the progression and treatment of the presenting problem.
- **Discharge summary** should provide a brief description of the hospital course. When diagnoses are noted solely in the discharge summary and not found in the body of the record, coders are obligated to query the physician. (Since coding takes place soon after discharge, the discharge summary is usually not available when coding. Therefore, it is important that all relevant diagnoses are documented as specifically as possible).

Specificity

- Specify acute or chronic (acute exacerbation of chronic CHF)
- Avoid confusing terms (e.g.,"urosepsis," instead state "sepsis" or UTI")
- State in the **progress notes** any etiologies clarified by diagnostic tests, consults, etc.
    - **Diabetes mellitis** – Specify type, identify complications of diabetes
    - **hypertension** – Specify type and cause, identify manifestations of hypertension
    - **respiratory failure** – Specify underlying cause (COPD, asthma, pneumonia, CHF, etc.)
    - **anemia** – Specify type (e.g., blood loss)
    - **pneumonia** – Document gram negative, gram positive, pneumococcal, viral, aspiration, etc.
    - **GI bleeding** – Document cause, if known
    - **Renal failure** – Document etiology

Completeness

- Identify co-existing conditions that are still under treatment.
- State a diagnosis for each prescribed medication (although Dilantin is ordered, seizure disorder cannot be coded unless documented by physician).
- Document all procedures performed.
- State any complications during the hospitalization and specify if post-operative events are normal occurrences or complications.

If you have any questions regarding this information, please contact Karen Caravetta, Coding Team Leader, at (610) 402-2874.

EXCLAIM Trial

Lehigh Valley Hospital is one of approximately 450 worldwide sites participating in the EXCLAIM trial. The trial is attempting to demonstrate the superiority of extended deep venous thrombosis prophylaxis with enoxaparin in the acutely ill medical patient. The trial dovetails nicely with efforts related to LVHHN's Primum Non Nocere project to heighten awareness of venous thromboembolism (VTE) and the need for appropriate prophylaxis.

The EXCLAIM trial is aimed specifically at medical inpatients. Many studies exist regarding VTE prophylaxis, but the majority look at surgical patients. The incidence of VTE in all medical patients is between 10-30%, depending upon risk factors. Certain subsets of medical patients are at clear risk - acute myocardial infarction (17-34%), ischemic stroke (23-75%), and admission to a medical intensive care unit (33%). There are multiple other risk factors for medical patients. Some are intrinsic factors (age, obesity, previous VTE, venous insufficiency, thrombophilia), while others are extrinsic (immobilization, malignancy, heart failure syndrome, pulmonary disease, inflammatory bowel disease). Many patients have multiple risk factors, and these risks are cumulative.

EXCLAIM will attempt to demonstrate the benefit of extended VTE prophylaxis in these patients. It is a Phase IV prospective, randomized, double-blind, placebo controlled study. The study aims to enroll approximately 5800 patients. The inclusion criteria are as follows:

- Male or female >= 40 years old
- Recent immobilization <= 3 days
- Anticipated immobilization of 6 +/- 2 days with either bedrest or bathroom privileges only at the time of enrollment, and likely to continue at this level of immobilization after the initial 6 +/- 2 days
- Presence of at least one of the following medical conditions:
    - Heart failure, NYHA class III or IV
    - Acute respiratory insufficiency without immediate need for ventilatory support
    - Other acute medical conditions, such as:
        - Status post acute ischemic stroke (within 72 hours after occurrence)
        - Acute infection without septic shock
        - Acute rheumatic disorder
        - Active episode of inflammatory bowel disease
        - Active cancer
- Anticipated survival time of >= 6 months
- Signed informed consent

Many patients are needed for this study. If you identify a patient who may be eligible for the EXCLAIM trial, please contact the Trauma Research Nurse on-call. The patient will be evaluated to determine if they meet enrollment criteria, and you will be contacted with the decision.

If you have any questions regarding the EXCLAIM trial, please contact Mike Pistoria, DO (primary investigator), at (610) 402-5200, Mark Cipolle, MD (sub-investigator), at (610) 402-1350, or Valerie Rupp, RN (study coordinator), at (610) 402-1036.

KePRO National Clinical Priority Projects

Atrial Fibrillation

Lehigh Valley Hospital and Lehigh Valley Hospital–Muhlenberg participated in the National Clinical Priority Project – Atrial Fibrillation. The project consisted of collection of baseline measurement data for the time period of April 1, 1998 to September 30, 1999. The organization was then required to submit an action plan for improvement for various quality indicators. Quality indicators include: proportion of eligible patients who were prescribed warfarin at discharge, proportion of eligible patients at increased risk of stroke who were prescribed warfarin at discharge, echocardiogram planned or obtained for new-onset atrial fibrillation, thyroid test obtained for new-onset atrial fibrillation, patient, family, or caregiver education regarding warfarin at discharge and planned or follow-up PT/INR. The re-measurement time period was April 1, 2000 to December 31, 2000.

Improvement efforts for this project focused on the open heart surgery patient who developed atrial fibrillation post operatively. Pre-printed order sheets were developed and education was completed in mid June. Documentation of education regarding warfarin at discharge was another improvement effort. This project will not be repeated in KePRO's Seventh Scope of Work, however, internally opportunities for improvement will be investigated in this patient population.

ATRIAL FIBRILLATION RESULTS

Quality Indicators	Lehigh Valley Hospital		Lehigh Valley Hospital – Muhlenberg		State	
	Pre	Post	Pre	Post	Pre	Post
Proportion of eligible patients who were prescribed warfarin at discharge	78.1	63.3	75.8	76.2	66.11	71.08
Proportion of eligible patients at increased risk of stroke who were prescribed warfarin at discharge	78.1	63.3	75.8	76.2	66.7	71.59
Echocardiogram planned or obtained for new-onset atrial fibrillation	85.7	64	63.2	60	69	66
Thyroid test obtained for new-onset atrial fibrillation	57.1	52	68.4	100	55.71	55.73
Patient, family, or caregiver education regarding warfarin at discharge	21.9	60	15	37.5	40.17	71.4
Planned or follow-up PT/INR	84.4	85.7	87.5	97.5	65.6	70

Pneumonia will be featured in the August issue of ***Medical Staff Progress Notes***.

Physician Reminder for Ordering a STAT Echo During Off Hour/On-Call Hours

If the attending physician for a STAT echo is **NOT** a Cardiologist, then he/she must contact a Cardiologist to enable the required STAT echo reading immediately following the echo performance. Since the Cardiologist is the person responsible for notifying the Echo Technician for the emergent study, the Echo Technician on-call will request to speak to the Cardiologist prior to coming into the hospital.

If you have any questions regarding this issue, please contact Audrey Lichtenwalner, Director, Heart Station, at (610) 402-8924.

Congratulations!

Robert X. Murphy, Jr., MD, Division of Plastic Surgery/Hand Surgery, Section of Burn, has recently accepted the position of Associate Medical Director at LVH-Muhlenberg. In this role, he will be responsible for care management, resource utilization, length of stay, and quality improvement. His activities will primarily be at the LVH-M campus.

Dr. Murphy will work closely with Dr. Gavin Barr and be supported by Maureen Sawyer, Director, Case Management, and Ruth Davis, Director, Care Management. He will make frequent rounds with the case managers in order to facilitate patient care and decrease length of stay and cost per case. He will work with the care management team at LVH-Cedar Crest to ensure a uniform standard of care across the network.

Joseph G. Trapasso, MD, Division of Urology, was elected as an active member to the Society of Urologic Oncology. This is a prestigious organization to which one has to submit credentials, publications, etc., and then be voted in, and limited to those with fellowship training in Surgical Oncology.

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At this year's Graduate Medical Education Celebration held on Friday, June 14, the following members of the Medical Staff received awards:

- **Eamon C. Armstrong, MD**, Department of Family Practice - *Headley White, MD Award for Outstanding Teaching in Family Practice* and *Penn State College of Medicine Medical Student Teacher of the Year Award in Family Practice*
- **Scott M. Brenner, MD**, Division of General Pediatrics - *Penn State College of Medicine Medical Student Teacher of the Year Award in Pediatrics*
- **Joseph D. DeFulvio, DO**, Division of Primary Obstetrics and Gynecology - *Clinical Teacher of the Year in Obstetrics and Gynecology*
- **Mark R. Eisner, DMD**, Chief, Division of Endodontics - *Clinical Teacher of the Year in Dentistry (LVH)*
- **Eric J. Gertner, MD**, Division of General Internal Medicine - *MCP Hahnemann University School of Medicine 2001 Dean's Special Award for Excellence in Clinical Teaching at Lehigh Valley Hospital*
- **Larry R. Glazerman, MD**, Division of Primary Obstetrics and Gynecology - *CREOG National Faculty Award for Excellence in Resident Education*
- **Laurence P. Karper, MD**, Division of Psychiatric Ambulatory Care/Adult Inpatient Psychiatry - *Penn State College of Medicine Medical Student Teacher of the Year Award in Psychiatry*
- **Indru T. Khubchandani, MD**, Division of Colon and Rectal Surgery - *Clinical Teacher of the Year in Colon and Rectal Surgery*
- **Ernest Y. Normington II, MD**, Division of Primary Obstetrics and Gynecology - *APGO Medical Student Teacher of the Year in Gynecology and Obstetrics*
- **Michael J. Pistoria, DO**, Division of General Internal Medic... - *Penn State College of Medicine Medical Student Teacher of the Year Award in Internal Medicine*
- **Ali Salim, MD**, Division of Trauma-Surgical Critical Care/General Surgery, Section of Burn - *Clinical Teacher of the Year in General Surgery*
- **Charles J. Scagliotti, MD**, Division of General Surgery - *Penn State College of Medicine Medical Student Teacher of the Year Award in Surgery*
- **Marc Shalaby, MD**, Division of General Internal Medicine - *Dean Dimick, MD Teacher of the Year in Internal Medicine*
- **Joseph A. Silvaggio, DMD**, Division of Endodontics - *Clinical Teacher of the Year in Dentistry (LVH-M)*
- **Patrice M. Weiss, MD**, Division of Primary Obstetrics and Gynecology - *Penn State College of Medicine Medical Student Teacher of the Year Award in Obstetrics*

Papers, Publications and Presentations

Gary S. Greenberg, DPM, Division of Podiatric Surgery, was chair of a national conference for podiatric educators. The "Second Annual COTH Conference" was held in Chicago and was attended by program directors and faculty from around the U.S. In additi moderating forums related to podiatric education, Dr. Greenberg presented several workshops on how to start a podiatric residency program. Dr. Greenberg is beginning his second year as Chair of the Council of Teaching Hospitals of the American Association of Colleges of Podiatric Medicine.

Larry N. Merkle, MD, Chief, Division of Endocrinology, along with **Glenn Stern** and **Thomas Wasser, PhD**, from Health Studies, authored two abstracts that were accepted for poster presentation at the Annual Scientific Meeting of the Endocrine Society held in June in San Francisco, Calif. The presentations were titled "Effectiveness of a Diabetes Health Educator in Increasing Physician Compliance with Type II Diabetes Case Management" and "A Cost and Clinically Effective Diabetes Disease Management Model in the Primary Care Setting."

Lester Rosen, MD, Division of Colon and Rectal Surgery, was elected Secretary of the Executive Council of the American Society of Colon and Rectal Surgeons at its Annual Meeting in June. At the meeting, Dr. Rosen participated in a panel, "Can We Reduce Postoperative Length of Stay and Still Provide Quality Patient Care?" His lecture was titled ""Reduced Length of Stay: Why Ileus is the Next Target." He related the experience of the

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Division of Colon and Rectal Surgery which, over a seven year period, had a significant reduction in the length of stay without an increase in existing low mortality or readmission rate. Further reduction in length of stay will likely take place in the postoperative period as elective surgical patients operated on the day of admission was 4% in 1991 and 57% in 2001. Currently, Lehigh Valley Hospital is one of several national sites testing a new drug to inhibit ileus postoperatively. **Mikhail I. Rakhmanine, MD**, Division of Colon and Rectal Surgery, is the principal investigator of this project.

Philip L. Tighe, DMD, Division of General Dentistry, presented a table clinic at the annual meeting of the American Association of Orthodontists held in Philadelphia in early May. The title of his presentation was "An efficient method of erupting impacted and semi-impacted molars."

Prodromos A. Ververeli, MD, Chief, Division of Orthopedic Surgery, lectured on current issues in primary hip replacement at the Leading Edge in Technology for Arthoplasty Symposium held May 31 and June 1. Dr. Ververeli also moderated the session on issues in primary knee replacement and participated as an instructor in technical sessions.

Upcoming Seminars, Conferences and Meetings

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 July will include:

- July 2 - Canceled
- July 9 - "Near Drowning"
- July 16 - "Use of Inhaled Steroids in Pediatric Allergy and Asthma"
- July 23 - "Use of Insulin Pump in Pediatric Diabetes"
- July 30 - "Morbidity and Mortality Conference"

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

Computer-Based Training (CBT)

The Information Services department has assumed responsibility for the computer-based training (CBT) programs available to Lehigh Valley Hospital (LVH) staff. CBT programs replace the instructor-led classes previously held at LVH. 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.

Topics covered by the CBT programs include:

Access 97	Windows NT 4
Word 97	GUI Email
PowerPoint 97	Excel 97

Computer-based training takes place in **Suite 401 of the John & Dorothy Morgan Cancer Center** (*the training room)* and in the **Lehigh Valley Hospital-Muhlenberg I/S training room** (*off the front lobby*). The 2002 schedule of classes is as follows:

2002 CBT sessions for JDMCC, Suite 401:
(All sessions are held from 8 a.m.to noon, unless otherwise noted.)

August 27	September 24
October 22	November 26
December 18 * *(noon to 4 p.m.)*	

2002 CBT sessions for LVH-Muhlenberg, I/S Training Room:
(All sessions are held from noon to 4 p.m., unless otherwise noted.)

July 18	August 15
September 19	October 17
November 21	December 19 * *(8 a.m. to noon)*

Twelve seats are available at each session. To register for a session in email, go to either the **Forms_/LVH** or **Forms_/MHC** bulletin board, (based on your choice of site and training room). The form has all the available information in an easy to choose format, detailing titles, dates, times, and locations. Simply do a "Use Form" (a right mouse option) on the **CBT Trng Request for CC Site or CBT Trng Request for MHC site** form. Complete the form indicating your desired session selection and mail the form. Shortly thereafter, you will receive a confirmation notice.

If you have any questions, please contact Information Services by calling the Help Desk at (610) 402-8303 and press option "1." Tell the representative that you need assistance with I/S education.

General Medical Staff Meeting

John Hayden Hollingsworth, MD, a retired cardiologist, a novelist, a poet, a theater reader, and a storyteller, will be the featured speaker at the next General Medical Staff meeting. Both an entertaining and motivational speaker, Dr. Hollingsworth will present "The Joys of a Life of Practicing Medicine." Members of the Medical Staff and their spouses or significant others are invited to attend. The next meeting of the General Medical Staff will be held on **Monday, September 9**, beginning at **6 p.m.**, in the **Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78**. Please mark your calendar now! More information to follow.

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

Lora Baker, DPM
Allentown Family Foot Care
1633 N. 26th Street
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Division of Podiatric Surgery
Provisional Active
Site of Privileges - LVH & LVH-M

Sigrid A. Blome-Eberwein, MD
Surgical Specialists of the Lehigh Valley
1240 S. Cedar Crest Blvd., Suite 308
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(610) 402-1350
Fax: (610) 402-1356
Department of Surgery
Division of Trauma-Surgical Critical Care/Plastic Surgery
Section of Burn
Provisional Active
Site of Privileges - LVH & LVH-M

Michael T. Chung, DPM
Orthopaedic Associates of Bethlehem, Inc.
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Department of Surgery
Division of Podiatric Surgery
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Site of Privileges - LVH-M

Sarah K. Finnerty, MD
LVPG-Emergency Medicine
Lehigh Valley Hospital
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Fax: (610) 402-4546
Department of Emergency Medicine
Division of Emergency Medicine
Provisional Active
Site of Privileges - LVH & LVH-M

Bryan G. Kane, MD
LVPG-Emergency Medicine
Lehigh Valley Hospital
Cedar Crest & I-78
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Department of Emergency Medicine
Division of Emergency Medicine
Provisional Active
Site of Privileges - LVH & LVH-M

Ami S. Kulkarni, DO
LVH Department of Medicine
Lehigh Valley Hospital
Cedar Crest & I-78
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Allentown, PA 18105-1556
(610) 402-5200
Fax: (610) 402-1675
Department of Medicine
Division of General Internal Medicine
Provisional Limited Duty
Site of Privileges - LVH & LVH-M

Vadim A. Lavin, MD
The Heart Care Group, PC
Jaindl Pavilion, Suite 500
1202 S. Cedar Crest Blvd.
P.O. Box 3880
Allentown, PA 18106-0880
(610) 770-2200
Fax: (610) 776-6645
Department of Medicine
Division of Cardiology
Provisional Active
Site of Privileges - LVH & LVH-M

Bonnie E.B. Osterwald, MD
(Solo Practice)
1251 S. Cedar Crest Blvd.
Suite 108
Allentown, PA 18103-6214
(610) 820-5800
Fax: (610) 820-5754
Department of Obstetrics and Gynecology
Division of Primary Obstetrics and Gynecology
Provisional Active
Site of Privileges - LVH & LVH-M

Continued on next page

Address Changes

Henry H. Fetterman, MD
401 N. 17th Street
Suite 210
Allentown, PA 18104-5050

Fernando Garzia, MD
Opcor, P.C.
2545 Schoenersville Road
4th Floor
Bethlehem, PA 18017-7384
(484) 884-1011
Fax: (484) 884-1012

Peter J. Racciato, MD
1036 N. Ninth Street
Stroudsburg, PA 18360-1210
(570) 421-4222
Fax: (570) 476-0581

MacArthur Medical Center
- **Larry W. Todd, DO**
- **Gregory S. Tomcho, DO**

3691 Crescent Court East
Suite 201
Whitehall, PA 18052-3498
(610) 434-9561
Fax: (610) 434-5122

Surgical Specialists of the Lehigh Valley
- **Michael M. Badellino, MD**
- **Sigrid A. Blome-Eberwein, MD**
- **Mark D. Cipolle, MD**
- **William R. Dougherty, MD**
- **Stanley J. Kurek, DO**
- **Michael D. Pasquale, MD**
- **Ali Salim, MD**
- **Barry H. Slaven, MD**

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(610) 402-1350
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Whitehall Medical Center
- **Michael D. Gabriel, DO**
- **Thomas Renaldo, DO**

3691 Crescent Court East
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Whitehall, PA 18052-3498
(610) 434-4294
Fax: (610) 439-1224

Change of Status

John P. Hentosh, MD
Department of Pediatrics
Division of General Pediatrics
From: Active
To: Honorary

Reinstatement of Previous Privileges

Raymond A. Rachman, MD
Department of Pathology
Division of Anatomic Pathology
From: Honorary
To: Limited Duty

One-Year Leave of Absence

John S. Halcovage, DO
Department of Medicine
Division of General Internal Medicine
From: Active
To: Active/LOA

Additional One-Year Leave of Absence

Jay B. Lipschutz, DO
Department of Medicine
Division of Pulmonary
Associate/LOA

Resignations

Neil Dicker, DDS
Department of Dental Medicine
Division of General Dentistry

Kevin T. Fogarty, MD
Department of Radiology-Diagnostic Medical Imaging
Division of Diagnostic Radiology

Steven S. Friedenberg, MD
Department of Radiology-Diagnostic Medical Imaging
Division of Diagnostic Radiology

Amitabha Gupta, MD
Department of Surgery
Division of Ophthalmology

William P. Jordan, MD
Department of Surgery
Division of General Surgery

Continued on next page

Bruce M. Kaufmann, MD
Department of Obstetrics and Gynecology
Division of Primary Obstetrics and Gynecology

Kevin W. Kramer, DO
Department of Emergency Medicine
Division of Emergency Medicine

Laura S. Kramer, DO
Department of Medicine
Division of General Internal Medicine

Nancy A. Mao, MD
Department of Medicine
Division of General Internal Medicine

Ann M. Sledz, MD
Department of Radiology-Diagnostic Medical Imaging
Division of Diagnostic Radiology

G. Edward Streubert, MD
Department of Radiology-Diagnostic Medical Imaging
Division of Diagnostic Radiology

Death

Raymond M. Smith, MD
Department of Anesthesiology
Honorary

Allied Health Professionals

Appointments

Giacinta Aspite, CRNA
Physician Extender
Professional - CRNA
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)
Site of Privileges - LVH & LVH-M

John M. Cary, CRNA
Physician Extender
Professional - CRNA
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)
Site of Privileges - LVH & LVH-M

Paulette S. Dorney, RN
Physician Extender
Professional - RN
(Lehigh Valley Cardiology Assoc. - George A. Persin, DO)
Site of Privileges - LVH & LVH-M

Joanne M. Ehly, CRNP
Physician Extender
Professional - CRNP
(LOVAR Department - John E. Castaldo, MD)
Site of Privileges - LVH & LVH-M

Daniel F. Griffin, GRNA
Physician Extender
Professional - GRNA
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)
Site of Privileges - LVH & LVH-M

Marcel Knotek, PA-C
Physician Extender
Physician Assistant - PA-C
(Lehigh Valley Orthopedic Group, PC - Randy Jaeger, MD)
Site of Privileges - LVH & LVH-M

Sharon G. Smith, CRNP
Physician Extender
Professional - CRNP
(Allentown Family Health Specialists - Bruce A. Ellsweig, MD)
Site of Privileges - LVH & LVH-M

Additional Supervising Physician

Patricia A. Vaccaro, CRNP
Physician Extender
Professional - CRNP
(Surgical Specialists of the Lehigh Valley - William R. Dougherty, MD)
Additional Supervising Physician - Robert X. Murphy, Jr., MD
Site of Privileges - LVH & LVH-M

Food Service Accounts

Wood Dining Services is pleased to announce that the bar-coding system in the LVH-Muhlenberg cafeteria has been activated. All physicians with current food service accounts at Cedar Crest & I-78 and 17th & Chew may now use their barcoded photo ID badges to charge meals at all three cafeteria locations, as well as the John and Dorothy Morgan Cancer Center. If you do not have an existing food service account, applications are available at any cafeteria location. If you have any questions regarding this issue, please contact Trish Boyd in Food and Nutrition Services at (610) 402-8369.

Answer to Mystery Medical Staff Member
Steven J. Kanoff, MD

The Last Word...

Tips and Techniques for the Lastword™ User

July, 2002 – Volume 1, Issue 9

Changes to Coumadin Orders in CAPOE

by Carolyn K. Suess, R.N.

On May 29, 2002 improvements were made to Coumadin (warfarin) orders in CAPOE.

Prior to the changes, "Once" frequency doses for Coumadin did not appear under the active orders listing in the *Med Profile* and the *CAPOE Order Profile* screens. The one time dose orders would drop from both screens after nightly processing.

The *Coumadin – Call physician for dose* order now displays in both the *Med Profile* and *CAPOE Order Profile* screens (see Figure 1). It can be found on the *CAPOE Order Pad* under the **Meds A-L** listing as *Coumadin – Call physician for dose*, and also under the **Meds M-Z** listing as *Warfarin – Call physician for dose*. It is also part of the *Coumadin Initiation Set with PT and RN note* order set, which is listed under the **Meds A-L** button.

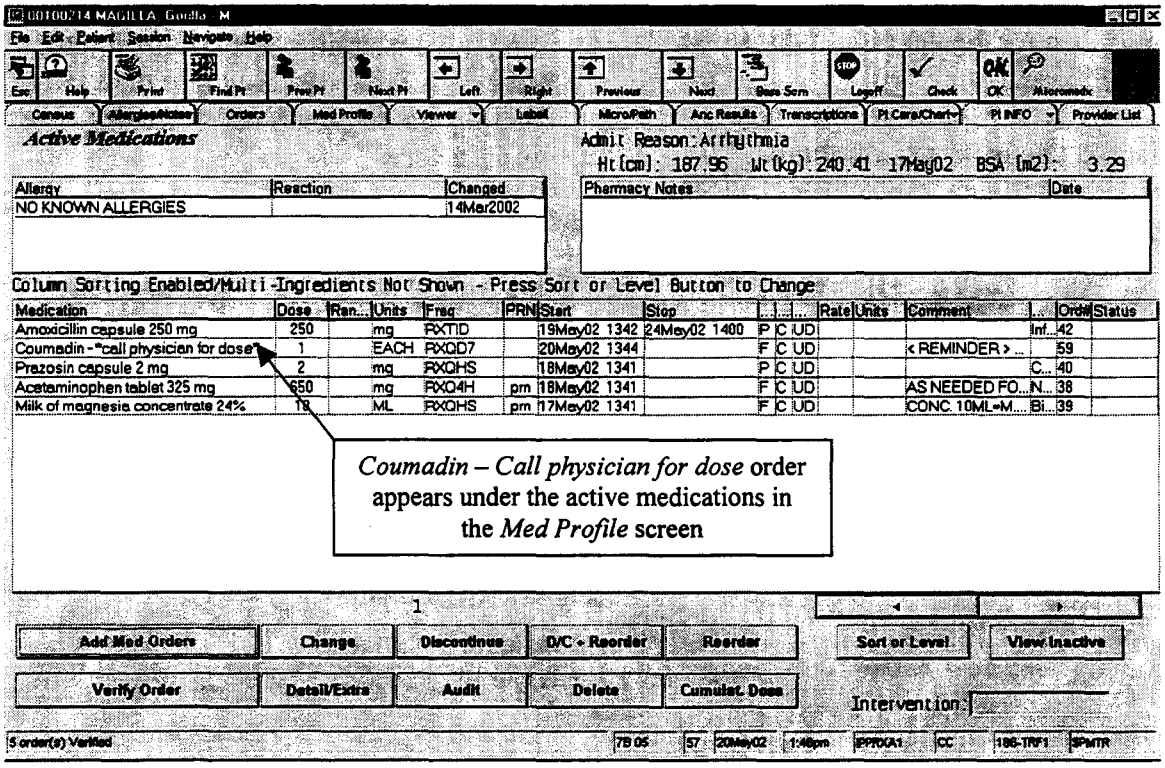

Figure 1 – Med Profile screen showing the *Coumadin – call physician for dose* order

Likewise, the nurse caring for the patient also sees the *Coumadin – Call physician for dose* order in his/her medication administration worklist. This prompts the nurse to call the physician for a Coumadin order.

It is important for the physician to select the *Coumadin – Call physician for dose* order either from the *Coumadin Initiation Set with PT and RN note*, or as a separate order. By doing so, he/she communicates to other physicians that the patient is receiving Coumadin therapy.

There are benefits to using the *Coumadin Initiation Set with PT and RN note*. The order set contains not only initial doses of Coumadin, but also a Laboratory order for a Prothrombin Time, and the Nursing order to call the physician for the next Coumadin dose (see Figure 2).

Should you have any questions pertaining to this recent change, please feel free to 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.

CAPOE Insulin Sliding Scale Modification Now Available

by Carolyn K. Suess, R.N.

Feedback from physician users brought about further changes to existing CAPOE orders on May 29, 2002.

The issue pertained to the Insulin Sliding Scale orders that reside in CAPOE. Due to space constraints, the insulin sliding scale was limited to only five lines of blood glucose ranges and corresponding insulin doses.

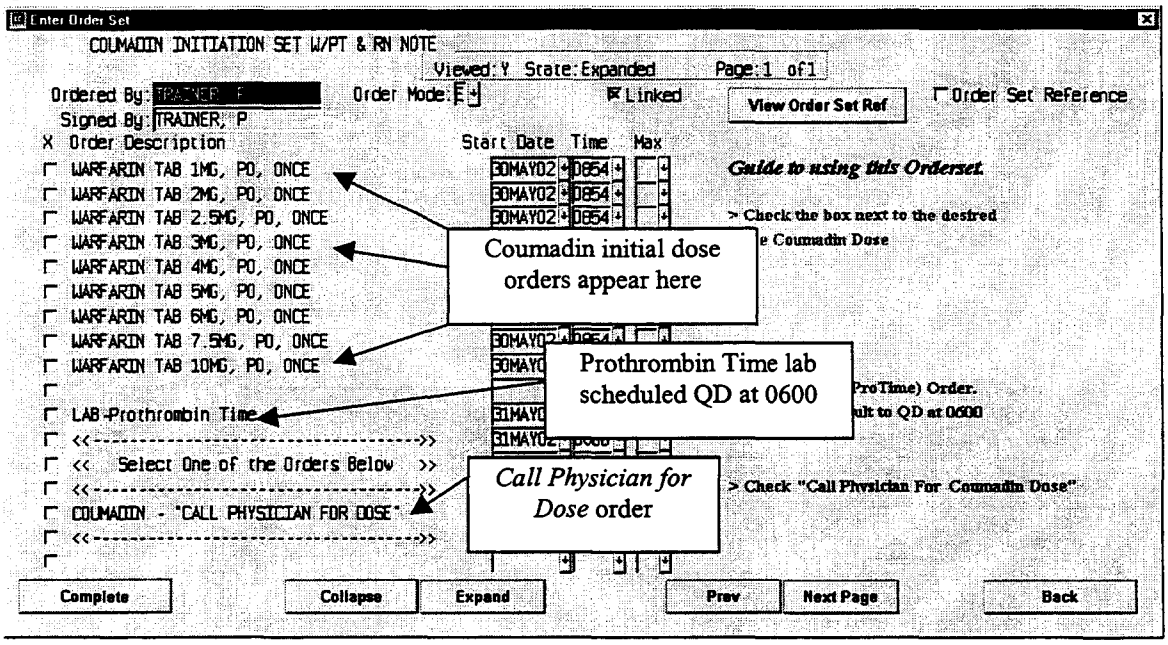

Figure 2 – Coumadin Intiation Set with PT and RN note

The solution was to add a new comment "Above, Call MD" permitting the use of an additional blood glucose range line (see Figure 3).

When using the Insulin Sliding Scale, if a sixth line is required, simply enter the blood glucose parameters in the boxes on the lowest line, then click on the down arrow adjacent to the comment section (see Figure 3). Double-click on the "Above, Call MD" comment to select it. By doing so, the nurse will contact the physician should the patient's blood glucose level fall above the higher value in the given range.

Should you have questions pertaining to the use of the new Insulin Sliding Scale comment, please contact on of the Physician Software Educators on staff.

Changing Medication Doses in CAPOE

by Carolyn K. Suess, R.N.

This procedure is useful for medication orders (not IV fuilds). It is *very important* that the Medication Order Conflict screen be read and understood prior to taking any action.

When changing a dose for a medication previously ordered, some users find themselves selecting the original order and discontinuing it first. Afterwards the new medication order is entered with the changed dosage. However, there is a less cumbersome way to accomplish this task.

Rather than first discontinuing the

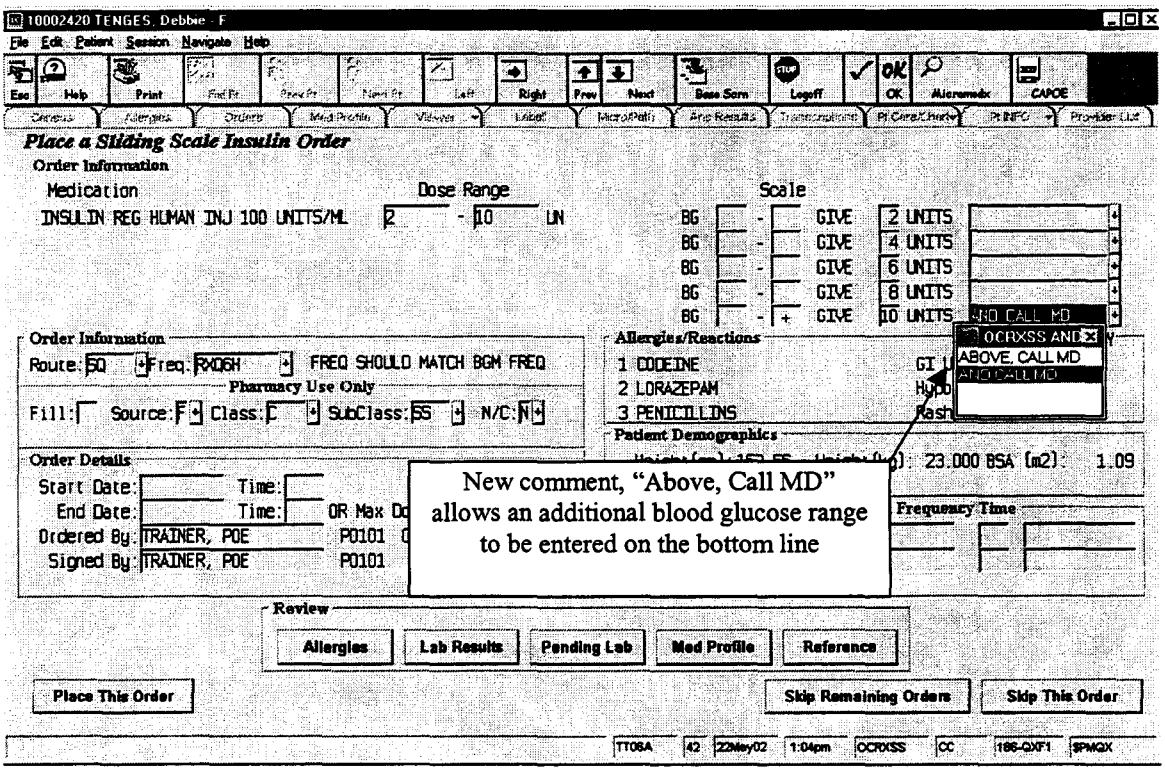

Figure 3 – Insulin Sliding Scale Order displaying added comment

original order, add the new medication order with the new dose. Upon processing the new order, a *Medication Order Conflict* screen appears (see Figure 4). The screen displays the existing medication order and the new one that is about to be placed. From this screen, click on the pull-down list adjacent to the original medication, and double-click on *Discontinue*. Click on the **Process Actions** button located at the bottom left side of the screen. The *Discontinue an Order* screen opens (see Figure 5).

Note the *Discontinue* option is already highlighted. If you wish to discontinue rather than retract the medication, press the **Enter** key on your keyboard. This action automatically selects *Discontinue*. Press the **Enter** key a second time to send your transaction.

The status of the existing medication order is now "D" for discontinued. Click on the **Place Order** button to continue processing the new medication order.

This same method can be used to change a medication frequency, too. If you have any questions regarding this procedure, please feel free to contact one of the Physician Software Educators on staff.

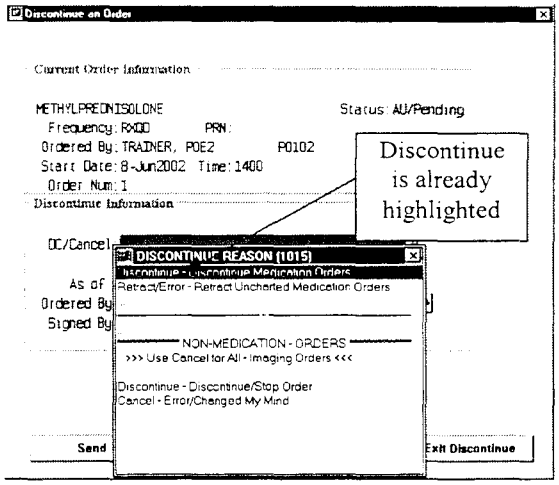

Figure 5 - Discontinue an Order screen

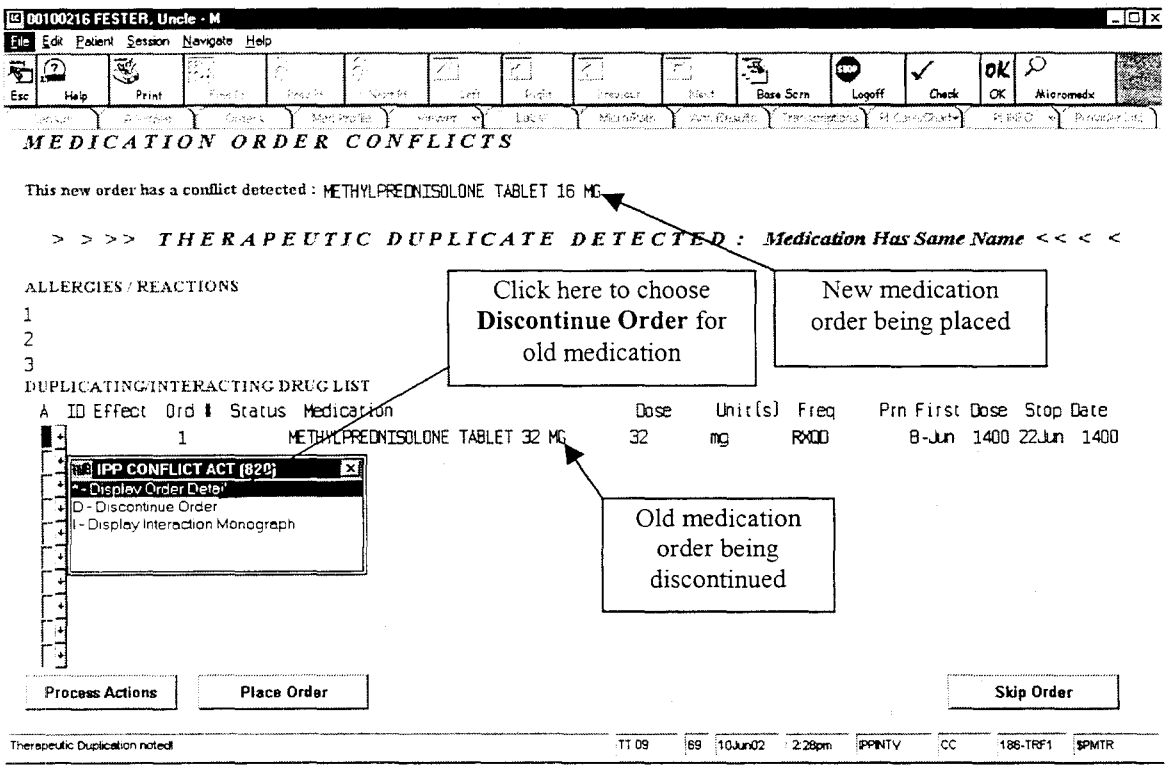

Figure 4 – Medication Order Conflict screen

a minute for the medical staff

Differentiate kidney diseases in your documentation

Most physicians must be aware of their patients' fluid and metabolic changes related to renal function.

Documentation has a considerable effect on the determination of illness severity and on the accuracy and specificity of the diseases you're treating. When physicians don't pay attention to the words they use, they can get into risky situations for themselves and their hospitals.

Failure or insufficiency?

Let's start with the difference between renal failure and renal insufficiency. Medical textbooks do not explain the difference between these two terms—if there is a difference.

Some textbooks name the chapter "Renal Failure" and discuss aspects of renal insufficiency throughout. Others name a paragraph "anemia of renal failure" and start by stating, "Anemia occurs in renal insufficiency . . . "

To define these terms and describe what's wrong with your patients so that the appropriate codes can be assigned, it helps to recognize how those who pay the bills and determine morbidity and mortality rates define these terms.

For the International Classification of Diseases and the version of Clinical Modifications used in the United States, **renal insufficiency** implies elevation of nitrogenous products in the bloodstream in which normal kidneys cannot deal with abnormal loads. Moderate dehydration, gastrointestinal bleed, and early outflow obstruction will result in elevations of blood urea nitrogen (BUN) and creatinine with no intrinsic renal damage.

Renal failure, on the other hand, implies that sick kidneys cannot deal with normal loads, according to the authorities.

Acute or chronic?

Once you realize this set of definitions is compatible with the textbooks and will reflect your risk and utilization profiles, it is important to consider whether a patient's encounter includes acute renal failure, chronic renal failure, or acute and chronic renal failure, in which a chronic renal failure patient has acute decompensation.

Be sure to define both the pathologic process for the chronic failure and the condition that resulted in the acute failure.

Next, let's discuss the various causes of chronic renal failure. Coding these patients' care can be tough enough, and when the physician does not define the pathology of the chronic renal disease, coders may go down the wrong trail.

Hypertensive disease can result in renal failure. However, not all renal failure patients are hypertensive, and not all hypertensive patients with renal failure have it because of the hypertension. Be sure to state whether a patient's chronic renal failure is due to hypertension.

Diabetics can also have renal failure. However, not all renal failure patients have diabetes and not all diabetics with renal failure have it because of the diabetes. Be sure to state whether a patient's chronic renal failure is due to his or her diabetes.

Patients can have renal failure due to toxicities, infectious processes, obstructive processes, congenital processes, vascular problems—any one of many reasons. But when you don't write down what you know to be the pathogenesis of a

patient's chronic renal failure, you don't evaluate or manage it adequately.

Acute renal failure can occur in patients for several reasons as well. When you don't draw the line in words between the offending pathologic process and the result of acute renal failure, you haven't evaluated or managed it adequately. If the acute renal failure is due to sepsis, state that relationship clearly.

If the acute renal failure is due to ingestion of nonsteroidal anti-inflammatory drugs, state that relationship clearly. Always draw the line from the offending process to the outcome.

Pinpointing the principal

Patients may be admitted to the hospital for problems related to chronic renal failure. When the problem is treated acutely, that becomes the principal diagnosis.

For example, if a patient on hemodialysis three times a week misses a treatment because he or she attended a wedding and comes in with arrhythmia due to hyperkalemia, hyperkalemia is the principal diagnosis, and the arrhythmia is a consequence of that imbalance.

The patient may be treated with dialysis, kayexelate, or insulin, but chronic renal failure isn't the reason for hospitalization.

Patients may be admitted with angina pectoris due to severe anemia of end-stage renal disease. Although the patient may be dialyzed while in the hospital, the anemia of end-stage renal disease that gets transfused to stop the angina is the principal diagnosis.

The terms azotemia or nephrotic syndrome and the like are appropriate for some admitted patients. These are manifestations, not the disease processes themselves.

Use these terms as manifestations, but document clearly the disease process that has led to the azotemia (dehydration? acute renal failure? congestive heart failure [CHF]? sepsis? Name it!)

Documenting dialysis issues

When a patient on dialysis has a complication either related to the dialysis tubing (vascular or peritoneal) or the dialysate or the dialysis procedure itself, draw the line clearly in documentation.

When a patient presents symptoms or signs not related to dialysis or the device, state that as well.

It is important to differentiate between sepsis related to central lines or an A-V shunt and sepsis unrelated to that device. Say, "line sepsis" or "sepsis unrelated to the dialysis vascular device" depending on your conclusion.

When a patient gets hypotension after dialysis and you relate fluid shifts to it, state clearly the relationship. Say, "hypotension probably due to fluid shifts of dialysis" to avoid inaccurate code assignment.

If the patient has a hypotensive episode unrelated to the dialysis, and perhaps due to bradycardia or a GI bleed, state the positive and negative relationships in your documentation to demonstrate a higher level of evaluation.

Chronic renal failure patients can develop fluid overload. In someone with marginal cardiac function, slight fluid overload can cause decompensation of CHF. Patients with stable cardiac function, however, can develop acute pulmonary edema with massive volume overload.

Again, it's important to differentiate clearly in your documentation whether the pulmonary edema is due to CHF (cardiac decompensation). Your treatment may include diuretics or dialysis—that's up to your evaluation of the patient's needs. But it must be clear if you believe that it's non-cardiac pulmonary edema.

REMINDERS FROM TRANSFUSION MEDICINE

1. The following guidelines for Leukocyte Reduction and Irradiation of cellular blood and blood components was adopted at the Jan. 31, 2002 Hem/Onc division meeting. The order for Leuocyte Reduction filter and/ or Irradiation need to be written for each transfusion order.
   A protocol specifically for the Pediatric Division is currently being developed.

LEUKOCYTE REDUCED CELLULAR BLOOD AND BLOOD COMPONENTS (RED CELLS AND PLATELETS)

The leukocyte reduction filter will be used to provide Leukocyte Reduced Red Cells and Platelets. **The request for the Leukoreduction Filter needs to be included when transfusion orders are written.** Following are the current indications for Leukoreduction, rationale for this is:

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

- To prevent Human Leukocyte Antigen (HLA) alloimmunization due to presence of leukocytes.
  (Transplant patients or chronically transfused patients who may need extensive platelet transfusion support in the future) Listed below:

Hem/Onc

- Patients with hematologic malignancies.
- Leukemia (Acute and Chronic)
- Hodgkin's Disease/ Non-Hodgkin's Lymphoma
- Allogenic and Autologous Bone Marrow Transplant patients/potential recipients
- Aplastic anemia
- Multiple Myeloma, Waldenstrom's Macroglobinemia, Monoclonal gammopathies
- Myelodysplastic Syndrome (MDS), Myelofibrosis or other Myeloproliferative diseases

Non Hem/Onc

- Kidney and other solid organ transplant patients/potential recipients

Per Transfusion Service or (Logistical Reasons)

- Patients with warm autoantibodies (current or previous)
- Patients with 3 or more specific alloantibodies or when antigen negative blood is provided.

To prevent CMV transmission Leukoreduced Blood (especially prestorage leukoreduced) is considered CMV Safe

- Pregnant females (unless immediate delivery is imminent)
- Patients with HIV
  If patient is already CMV positive a leukoreduction filter is not needed.
  If patient is CMV negative or not tested for CMV, then use leukoreduction filter.
- Kidey and other solid organ transplant patients/potential recipients
- Allogenic and Autologous Bone Marrow Transplant patients/potential recipients.

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

  - Solid tumors
  - Term neonates
  - Neutropenia

IRRADIATED BLOOD AND BLOOD COMPONENTS (RED CELLS AND PLATELETS)

Patients in the following categories are at high risk of developing TAGVHD (Transfusion Associated Graft vs Host Disease) and should receive irradiated cellular blood and blood components (Red Cells and Platelets) **Irradiated needs to be included when transfusion orders are written.**

ADULTS

- Hematologic malignancies, i.e. acute and chronic leukemias.
- Allogenic and Autologous Bone Marrow transplant patients/potential recipients
- Hodgkin's Disease/ Non-Hodgkin's Lymphoma and Mycosis Fungoides
- Patients receiving intense (very high dose alkylating agent) chemotherapy/ radiation therapy
- Neuroblastoma, rhabdomyosarcoma, glioblastoma
- Directed (designated) donor units from blood relatives
- Multiple Myeloma or Waldenstrom's Macroglobinemia, Monoclonal gammopathies
- Myelodysplastic Syndrome (MDS), Myefibrosis
- Aplastic anemia

For the following categories there is NO INDICATION for irradiation of cellular blood and blood components:

- HIV infection/ AIDS
- Solid Tumors (except for those listed above).
- Term neonate
- Neutropenia

MISCELLANEOUS REMINDERS

1. In order to encourage prudent use of a limited and precious resource, an **FYI letter** will be sent by the Transfusion Review Committee to the ordering physician if a blood or blood component is wasted due to cancelled orders. Nursing receives a similar notification when a blood/component is wasted due to improper ordering or storage.

2. **The BLOOD COMPONENT TRANSFUSION ORDER FORM** (DO-182-1) should be used for all transfusion orders in lieu of writing orders on the blue order sheet. For **CAPOE**, a drop down window with transfusion indications for each component is being developed.

3. **The Type and Screen** order should be utilized when the need for a blood transfusion is low and the **Type and Crossmatch** should be ordered when the probability of blood use is high. This results in a lower crossmatch to transfusion ratio (one of the performance indicators JCAHO and other accreditation agencies examine). This also results in overall cost savings.

4. **All cases of post transfusion related hepatitis** or other blood-borne diseases should be reported to the Medical Director (610-402-8142) and/or Technical Specialist (610-402-8180) of the Transfusion Service.

5. Last month during our on-site inspection by the American Association of Blood Banks it was brought to our attention that the **number of reported transfusion reactions** may be comparatively low. A quote from the AABB Weekly Report "Increased awareness of signs and symptoms of transfusion reaction, and of bacterial contamination as the possible cause of transfusion reaction, is obviously important for improved detection, and past studies have confirmed that increases awareness of the possibility of bacterial contamination by clinical personnel results in dramatic increases in the number of cases detected."

For the following categories there is NO INDICATION for transfusion of outdate blood and blood components:

- HIV Infection/ AIDS
- Solid Tumors (except for those listed above)
- Term neonate
- Neutropenia

STAFF DEVELOPMENT PLAN
STATUS OF DEPARTMENT, DIVISION, AND SECTIONS
RECOMMENDED APPROVAL BY CHAIRS/TROIKA CMTE – 04/30/2002

	LEHIGH VALLEY HOSPITAL Campus including CC & 17th St.			LEHIGH VALLEY HOSPITAL – MUHLENBERG Campus including Cancer Center & Behavioral Health Science Center		
	Open	Controlled Access (Requires Staff Development Slot)	Exclusive Contract	Open	Controlled Access (Requires Staff Development Slot)	Exclusive Contract
Anesthesiology			1			1
Cardiac Anesthesia			1			1
Pain Medicine			1			1
Dental Medicine						
Endodontics		1,2,3			1,2,3	
General Dentistry		1,2,3*			1,2,3*	
Orthodontics		1,2,3			1,2,3	
Pediatric Dentistry		1,2,3			1,2,3	
Periodontics		1,2,3			1,2,3	
Prosthodontics		1,2,3			1,2,3	
Special Care		1,2,3			1,2,3	
	* Minimum one clinic session per month with residents					
Emergency Medicine						
Pre-hospital Emergency Medical Services			1			1
Emergency Medicine			1			1
Family Practice	1,3			1,3		
Geriatrics	1	3		1	3	
Occupational Medicine	1	3		1	3	
Medicine						
Allergy		1,2,3			1,2,3	
Cardiology		1,3			1,3	
Critical Care Medicine		1,3			1,3	
Dermatology		1,2,3			1,2,3	
Endocrinology		1,3			1,3	
Gastroenterology		1,3			1,3	
General Internal Medicine	1,2,3			1,2,3		
Adolescent Medicine		1,2,3			1,2,3	
Geriatrics	1,2,3			1,2,3		
Hematology-Medical Oncology		1,3			1,3	
Infectious Diseases		1,3			1,3	
Neurology		1,3			1,3	
Nephrology		1,3			1,3	
Pulmonary		1,2,3			1,2,3	
Physical Medicine - Rehabilitation		1,2,3			1,2,3	
Rheumatology		1,3			1,3	

KEY:
1 = Active Staff
2 = Associate Staff
3 = Affiliate Staff

STAFF DEVELOPMENT PLAN STATUS OF DEPARTMENT, DIVISION, AND SECTIONS						
	LEHIGH VALLEY HOSPITAL Campus including CC & 17th St.			LEHIGH VALLEY HOSPITAL – MUHLENBERG Campus including Cancer Center & Behavioral Health Science Center		
	Open	Controlled Access (Requires Staff Development Slot)	Exclusive Contract	Open	Controlled Access (Requires Staff Development Slot)	Exclusive Contract
Obstetrics and Gynecology						
Gynecologic Oncology		1, 3			1,3	
Gynecology		1,3			1,3	
Pelvic Reconstructive Surgery		1,3			1,3	
Obstetrics		1,3			1, 3	
Maternal-Fetal Medicine			1			1
Primary Obstetrics and Gynecology	1,3 **			1,3 **		
Reproductive Endocrinology & Infertility		1,3			1,3	
	** Minimum average of 5 deliveries per month per individual or 10 deliveries per month per group at LVH					
Pathology						
Anatomic Pathology			1			1
Breast Pathology			1			1
Cytopathology			1			1
Dermatopathology			1			1
Forensic Pathology			1			1
Gastrointestinal Pathology			1			1
Genitourinary Pathology			1			1
Gynecologic Pathology			1			1
Hematopathology and Clinical Laboratory Medicine			1			1
Neuropathology			1			1
Transfusion Medicine And HLA			1			1
Pediatrics						
General Pediatrics	1,2,3			1, 2, 3		
Critical Care Medicine		1, 2,3			1,2,3	
Neonatology		3	1,2		3	1,2

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	LEHIGH VALLEY HOSPITAL Campus including CC & 17th St.			**LEHIGH VALLEY HOSPITAL – MUHLENBERG Campus including Cancer Center & Behavioral Health Science Center**		
	Open	**Controlled Access** (Requires Staff Development Slot)	**Exclusive Contract**	**Open**	**Controlled Access** (Requires Staff Development Slot)	**Exclusive Contract**
Pediatric Subspecialties		1,2,3			1,2,3	
Allergy		1,2,3			1,2,3	
Cardiology		1,2,3			1,2,3	
Developmental-Rehabilitation		1,2,3			1,2,3	
Endocrinology		1,2,3			1,2,3	
Gastroenterology		1,2,3			1,2,3	
Genetics		1,2,3			1,2,3	
Hematology-Medical Oncology		1,2,3			1,2,3	
Neurology		1,2,3			1,2,3	
Pulmonary		1,2,3			1,2,3	
Rheumatology		1,2,3			1,2,3	
Psychiatry						
Child-Adolescent Psychiatry		1,2,3			1,2,3	
Consultation-Liaison Psychiatry		1,2,3			1,2,3	
Adult Inpatient Psychiatry		1,2,3			1,2,3	
Psychiatric Ambulatory Care		1,2,3			1,2,3	
Psychiatric Home Care		1,2,3			1,2,3	
Radiation Oncology			1		1	
Radiology-Diagnostic Medical Imaging						
Diagnostic Radiology			1			1
Cardiovascular-Interventional			1			1
Chest			1			1
Gastrointestinal			1			1
Genitourinary			1			1
Mammography			1			1
Neuroradiology			1			1
Nuclear Medicine			1			1
Orthopedics			1			1
Pediatrics			1			1
Trauma-Emergency Medicine			1			1

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	LEHIGH VALLEY HOSPITAL Campus including CC & 17th St.			LEHIGH VALLEY HOSPITAL – MUHLENBERG Campus including Cancer Center & Behavioral Health Science Center		
	Open	Controlled Access (Requires Staff Development Slot)	Exclusive Contract	Open	Controlled Access (Requires Staff Development Slot)	Exclusive Contract
Surgery						
Cardio-thoracic Surgery		1,3			1,3	
Cardiac Surgery		1,3			1,3	
Thoracic Surgery		1,3			1,3	
Colon and Rectal Surgery		1,3			1,3	
General Surgery		1,3			1,3	
Pediatric Surgery		1,3			1,3	
Surgical Oncology		1,3			1,3	
Transplantation Surgery		1,3			1,3	
Hand Surgery		1,3			1,3	
Neurological Surgery		1,3			1,3	
Neuro Trauma		1,3			1,3	
Ophthalmology		1,3			1,3	
Oral and Maxillofacial Surgery		1,3			1,3	
Orthopedic Surgery		1,3			1,3	
Foot and Ankle Surgery		1,3			1,3	
Ortho Trauma		1,3			1,3	
Podiatry		1,3			1,3	
Otolaryngology - Head & Neck Surgery		1,3			1,3	
Plastic Surgery		1,3			1,3	
Burn		1,3			1,3	
Trauma-Surgical Critical Care		1,3			1,3	
Burn		1,3			1,3	
Pediatric Trauma		1,3			1,3	
Trauma Research		1,3			1,3	
Urology		1,3			1,3	
Vascular Surgery		1,3			1,3	

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STAFF DEVELOPMENT PLAN
STATUS OF ALLIED HEALTH STAFF
RECOMMENDED APPROVAL BY CHAIRS/TROIKA CMTE – 04/30/2002

	LEHIGH VALLEY HOSPITAL Campus including CC & 17th St.			LEHIGH VALLEY HOSPITAL – MUHLENBERG Campus including Cancer Center & Behavioral Health Science Center		
	Open	**Controlled Access** (Requires Staff Development Slot)	**Exclusive Contract**	**Open**	**Controlled Access** (Requires Staff Development Slot)	**Exclusive Contract**
Family Practice						
Massage Therapists	X[1]			X[1]		
	[1]Must maintain continued contract with LVHHN					
Obstetrics and Gynecology						
Nurse Midwives	X[2]			X[2]		
	[2] Must be employed by an Active Staff member of the Department of Obstetrics and Gynecology					
Psychiatry						
Psychology	X[3]			X[3]		
Independent Medical Social Workers	X[3]			X[3]		
	[3] Must maintain continued contract with LVHHN					
Surgery						
Chiropractors		X			X	

LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

Cedar Crest & I-78
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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, Medical Staff Services, 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.