LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

PROGRESS NOTES

Medical Staff

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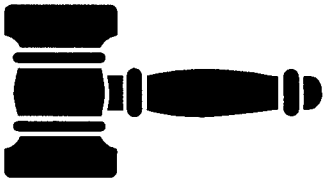
Please refer to pages 21 & 22 for the latest revisions to the Medical Staff Bylaws.



From the President

"Forgive your enemies, but never forget their names."
- John F. Kennedy

As Dickens wrote in the opening lines of ***A Tale of Two Cities***, "It was the best of times; it was the worst of times." There is a paradox in today's healthcare arena, one that providers will have to live with for now.

Renewal and Growth
Feel the excitement – obvious growth and change at LVH-M with expansion of clinical services in cardiology/cardiac surgery on that campus. With the creation of new facilities, there is the opportunity for further enhancement of the premier cardiac program in the Lehigh Valley – one that sets an even higher standard and leads the way.

This is also the time for renewal of focus and clinical excellence for us all. At Cedar Crest & I-78, and across the network, we possess intellectual capital and physical assets that are remarkable. We foster and encourage clinical innovation and education. We have impressive resources in both information technology and clinical programs. We have intangible assets as well: dedication, experience, energy and a drive toward excellence. We have achieved repeated national recognition by ***U.S. News & World Report*** and numerous other evaluation polls.

Our goals are:
1. improving the health of the Lehigh Valley community and beyond, and
2. reducing the burden of human disease for our fellow travelers on this ever-changing journey of life.

Our challenge, and the measure of our success, will be the degree to which we can bring these goals to life. Our future as an institution will be defined by the synergy of our medical staff, allied health professional staff, nursing staff, hospital administrative staff and all hospital employees.

We have administrative leadership that understands the balance needed in today's complex world of modern medicine, and utilizes revenues for capital investment which enriches our programs and technology. We have a board of trustees who

Continued on next page

understands and supports the exciting and innovative clinical vision, and who understands stewardship and takes it seriously. We have clinical leadership which has been fostered and developed. Your medical staff leadership has worked toward an expanding medical staff model in which the essential ingredients for new members of the medical staff are competency and safety, but the most desirable ingredient is talent.

We have community and civic leaders, public and private patrons who clearly understand the need for progressive high quality health care and support our goals, financially and otherwise. Many in the Lehigh Valley community also understand that our citizens deserve high quality healthcare and we will all benefit from their support.

At LVHHN, we recognize our problems with openness and face the future with enthusiasm. We are eager to move ahead to tomorrow's challenges. Today's challenges have already strengthened our resolve to be a special resource to the community and the region.

Network size is not an end in itself. In patient care, the ultimate emphasis is always on quality.

Whether you believe you can or whether you believe that you cannot, you are absolutely right. - Henry Ford

Lehigh Valley Hospital Officials Plan to Build a seven-floor addition that will nearly double the number of beds at the Lehigh Valley Hospital-Muhlenberg Campus in Bethlehem. Officials said the growing elderly population of the Lehigh Valley spurred the need for the $60 million building. The 205,000-square-foot building will accommodate 188 beds and house the hospital's proposed regional heart center, as well as an intensive care unit, diagnostic center and cafeteria, the Morning Call added. (***Morning Call***, September 6, 2002)

It's not the mountains we conquer, but ourselves.
- Sir Edmund Hillary

Reduced Medicare Reimbursements
In July, the AMA news headlined "Doctors closer to Medicare pay relief." Unfortunately, by late September, despite testimony before Congress, nothing has happened to change the annual 5.4% x 4 years cut in Medicare reimbursements. Congress was preoccupied with the Medicare prescription drug benefit package – which stalled. Once again, it seems as though it will take a crisis to get the attention of the public and Congress.

Almost one-quarter of U.S. physicians say they have limited or will restrict the number of Medicare patients they treat because of reduced reimbursement cuts, according to an American Medical Association survey. Medicare cut physician payments 5.4 percent this year, and the AMA said that physicians face an additional 12 percent cut over three years if Congress fails to overhaul Medicare's payment formula, Bloomberg News noted. Of 520 doctors surveyed, 42 percent said they wouldn't continue to participate in Medicare without assurance that payments won't be cut further, Bloomberg News added. (***Bloomberg News***, September 4, 2002)

Happiness is someone to love, something to hope for, and something to do. - Old Chinese Proverb

Office management techniques for medical staff members: One simple and very effective method of relating to your office employees (office manager, front desk receptionist, billing personnel, etc.) is to have periodic (usually quarterly) meetings in which you meet with them individually and ask if they have any suggestions for you. Ask if they have any input on the systems you are using in your office - and you listen . . . perhaps jot down a few notes.

HIPAA (Health Insurance Portability & Accountability Act)
On August 14, HHS published final modifications to the HIPAA privacy rule, incorporating the majority of changes suggested in the March 2002 proposed rule. The changes are intended to relieve "unintended administrative burdens created by the privacy rule."
Hotly debated consent provision deleted.

The most contentious portion of the HIPAA privacy rule — a clause that required providers to obtain written consent from patients prior to using personal health information for any purpose — has been modified in the final rule so that consent is no longer necessary for routine purposes such as treatment, payment, and health care operations (Hawryluk, *AMNews*, 8/26/02). Ultimately, common sense prevailed and the privacy of our patients was still protected.

When prosperity comes, do not use all of it. - Confucius

Continued on next page

Patient Safety Issues

More than 40 potentially harmful drug errors daily were found on average in hospitals, according to a study published in Archives of Internal Medicine. The study of 1999 data from 36 hospitals and nursing homes in Colorado and Georgia found that the most common errors were giving hospitalized patients medication at the wrong time or not at all, and that errors occurred in nearly one of five doses in a typical, 300-bed hospital, which translates to about two errors per patient daily, reported the Associated Press. Seven percent of the errors were considered potentially harmful. (***Associated Press***, September 8, 2002; ***Archives of Internal Medicine***, September 9, 2002)

Comment: We need continued focus

In the game of life, heredity deals the hand, and society makes the rules; but you can still play your own cards.

- Peter's Almanac

Malpractice – the crisis that won't quit

It is difficult to analyze issues of interest and concern to the medical staff without at least mentioning the BIG crisis that festers on. Physicians have looked to our legal representatives for help with this legal problem. The PA legislature has made some progress but it has not resulted in lower premiums yet. The U.S. House passed legislation limiting medical liability jury awards, but the U.S. Senate killed it 57-42. (Rick Santorum voted in favor of the amendment, but Arlen Specter voted to table it.) All reports agree that Pennsylvania is one of the hardest hit states. The nation's top 25 writers of medical liability insurance increased their premiums 22.4% last year and expect another 25% in the future. So how do insurers adjust premiums? According to an article in the Protector (GE Medical Protective, August 2002), "Insurers use a number of assessment tools to determine rate adjustments. One particularly valuable tool is the analysis of closed claims. Insurers review closed cases to identify: win/loss issues, amounts paid, allegations against professional specialties, number of suits filed by location, and losses related to procedures being performed." So is this a problem generated by the insurance industry, as our legal friends suggest? I think not! The insurance industry simply analyzes the claims experience according to set formulas and comes up with their premium rates. Nothing personal, doc!

When you hire people who are smarter than you are, you prove that you are smarter than they are. (Hmmm...) -R.H. Grant

Ed

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

LVHHN Announces Additions to LVH-Muhlenberg Expansion, Unveils Design of New Building

On September 5, Lehigh Valley Hospital and Health Network (LVHHN) officials unveiled the design of a new multi-story building to be constructed on the Lehigh Valley Hospital–Muhlenberg (LVH–Muhlenberg) campus in Bethlehem. Officials also said the revitalization and expansion project announced in January has been modified to include more beds and all private patient rooms. The upgraded project will increase the number of potential medical/surgical beds at LVH–Muhlenberg by 80 for a total of 188. (In addition to this number, there are also 65 behavioral health beds at LVH-Muhlenberg's Behavioral Health Science Center.)

Other features of the new seven-story, 205,000 square foot facility include the expansion of LVHHN's Regional Heart Center, new intensive care unit, Diagnostic Care Center, new hospital entrance and lobby, new cafeteria, retail space, and increased visitor and staff parking.

"This project will enable our physicians and nurses to continue to provide the highest level of hospital care services and address the increasing demand for Lehigh Valley Hospital's high quality services by our Northampton County community and surrounding communities," said Elliot J. Sussman, MD, LVHHN's president and CEO.

The additional beds and decision to construct all private rooms has added $21million to the original $39 million cost of the project, the total representing 12 percent of LVHHN's proposed total capital spending over the next five years. When the work is finished, all medical/surgical beds at LVH–Muhlenberg will be relocated to the new building.

The red brick and steel structure will be built on the north side of the hospital and face Route 22.

Nationally recognized healthcare architect FreemanWhite of Charlotte, N.C., will team up with internationally acclaimed Venturi, Scott Brown & Associates (VSBA) of Philadelphia to design the project.

"The red brick design is meant to look friendly and comfortable," said Robert Venturi, FAIA, HON. FRIBA, Principal, VSBA. "The exposed steel beams are an architectural element that telegraph the technological advancement of the institution."

Mr. Venturi said VSBA has also included an iconic element in the design – in this instance the blue letter "H" symbolizing hospital – to give the building added visibility and impact from a distance.

Groundbreaking is expected next spring with completion anticipated in the spring of 2005.

Growing Organizational Capacity

Meeting the Demand for Quality Care

You've felt the frustration. You've gone to your favorite restaurant only to be greeted by a crowded lobby and a lengthy wait. The same thing is happening at hospitals nationwide – and often the patient can't wait for care.

When every bed is full, a hospital's emergency department fills rapidly. Ambulances are diverted, patients from other hospitals can't be transferred here, and patients referred by their doctors face long waits.

Hospitals nationwide have wrestled with this situation, and now LVHHN is taking the lead. A groundbreaking project called **Growing Organizational Capacity** (GOC) focuses on increasing LVHHN's bed space and streamlining processes to eliminate frustrating delays and provide a higher level of service to all who seek our care.

"It's our mission and privilege to provide the community with direct access to the care it needs," says Alexander D. Rae-Grant, MD, president-elect of the LVHHN medical staff. "Growing our capacity allows us to better serve that mission."

Increasing capacity means more than adding beds and involves the whole network, not just the Emergency Department. Richard S. MacKenzie, MD, Vice Chairperson, Emergency Department, discovered that during Clockwork ED, a project launched to reduce ED waiting times. "We reduced that wait, and then delays happened in getting patients to floors," Dr. MacKenzie said.

What causes such a situation? "If a patient's diagnostic test runs late, radiology becomes backed up, or a patient's orders aren't written on time, it creates a bottleneck," said Deborah Halkins, Management Engineering Director.

The first step to alleviating bottlenecks came at a July mid-level leadership retreat that produced 1,016 fresh ideas. Now, the GOC team, which devotes full-time energy for the next 18 months, reviews those ideas and plans projects addressing bed turnaround time, discharge planning, standardization, collaboration, transport service and additional bed space.

While the team leads, everyone plays a vital role. "The people who provide the service are the best ones to identify improvements," said John P. Fitzgibbons, MD, Chairperson, Department of Medicine. "We have an extremely talented organization, and we use that talent to make this happen."

A Glance at the GOC Team

Chief Sponsor

Lou Liebhaber, *LVHHN Chief Operating Officer*
As COO, Mr. Liebhaber is supremely confident of our ability to grow capacity. "When we all push in the same direction, our energy is unstoppable," he said.

Co-sponsors

John Fitzgibbons, MD, *Chair, Department of Medicine*
Half of direct hospital admissions from doctor's offices come from internists, and Dr. Fitzgibbons has seen hospital demand soar nationwide.

Alexander Rae-Grant, M.D., *President-elect, LVH Medical Staff*
Dr, Rae-Grant brings insight and focus of the medical staff and ensures the hospital remains physician- and patient-friendly.

Co-leaders

James Burke, *Vice President, Operations, LVH—17th & Chew*
With an extensive management engineering and work processes background, Mr. Burke gets to the heart of the matter.

Terry Capuano, RN, *Senior Vice President, Clinical Services*
Mrs. Capuano focuses on maintaining quality patient care. Her vision ensures patients' and families' needs are constantly met.

Richard MacKenzie, MD, *Vice Chair, Emergency Department*
Dr. MacKenzie is on ED front lines: 48 percent of LVH—Cedar Crest & I-78 admissions and 77 percent of LVH—Muhlenberg admissions come there.

Support

Linda Durishin, RN, *Organizational Development Consultant*
Mrs. Durishin provides her hands-on expertise to major LVHHN projects like Clockwork ED and now works full-time on GOC.

Deborah Halkins, *Director, Management Engineering*
Ms. Halkins brings industrial engineering experience with capacity issues. "To find solutions, we look not only at health care but also other businesses," she said.

Susan Hoffman, *Director, Marketing Development*
Mrs. Hoffman helps communicate the impact of changes and successes to LVHHN colleagues and the community.

Kristi Pintar, *Director, Organizational Development*
Mrs. Pintar helps keep the project on the right track by assisting in prioritizing projects while attaining key team goals.

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Express and On Time

Teamwork and speed are the qualities of any winning relay team in sports. At LVHHN's Express Admit Unit (EAU), a three-bed pilot program for patients directly admitted with physician orders, those same qualities are winning high marks all around among patients, physicians and staff.

Just ask David Caccese, MD, general internist. "I had a patient with fever and pneumonia," he recalls. "We couldn't get him into the emergency department and there were no beds available, but I was able to get the patient into the EAU."

Within two hours, the patient's admission paperwork and diagnostic tests were completed, antibiotics administered and he was moved to a bed on an assigned unit. "The patients like it, the physicians love it and it improves the hospital's efficiency," Dr. Caccese said.

Located on the Special Care Unit at LVH - Cedar Crest & I-78, the EAU was launched to meet physician demand for direct admissions. That demand has grown from an average of 10 a day at Cedar Crest & I-78 to an average of 16 a day and a high of 40 a day in the winter.

By the end of September, plans call for expanding the EAU to six beds in the former temporary Acute Coronary Care Unit/Intensive Care Unit East at LVH - Cedar Crest & I-78. "Our goal is to serve between 18 and 24 patients a day," says Lisa Romano, Manager, Bed Management, who is overseeing the project with Molly Sebastian, Administrator, Medical/Surgical/Trauma.

"Target time for length of stay is 120 minutes, so it's a real team effort involving the clinical units, bedside nursing staff and ancillary staff," Mrs. Sebastian said.

Kerry Kennedy, RN, a 19-year nursing veteran and the first full time EAU staff member, is excited about the transformation of the EAU team. "We'll be able to help a lot more people and really take some of the burden off the floor nurses," Ms. Kennedy says. "I have high hopes the EAU will exceed expectations."

Looking for Beds in All the Right Places

The challenge: explore, find existing space and put it to work in a different way.

So blueprints in hand, that is just what Carol Bury, LVHHN Vice President of Facilities and Construction, and Brian Hardner, Director, Facilities and Construction, did. They went floor by floor at LVH – Cedar Crest & I-78, looking for space that could be revamped to accommodate patient beds.

Working closely with Terry Capuano, Senior Vice President, Clinical Services, and Molly Sebastian, Administrator, Medical/Surgical/Trauma, room will be made for 32 additional beds by remodeling office space, overnight family accommodations and equipment storage rooms without sacrificing staff, patient or family needs.

Construction on the semi-private rooms will begin mid-September on the Transitional Trauma Unit, 4C, 5B, 6B, 7A and 7B, with completion expected in mid-November. "This was truly a collaborative effort between nursing and facilities management that should help the flow of admissions overall and greatly benefit our patients," Mrs. Bury said.

2002 LVHHN United Way Campaign
"Up, Up and Away -- Lifting Spirits, Lifting Lives through your United Way"

Last year, the gifts of the LVHHN family totaled over $279,000! This was an amazing showing of generosity and support to those in our community who needed our help in so many ways. Even someone in your family may have benefited from a United Way agency or through a program sponsored by the United Way of the Greater Lehigh Valley. Through education to schoolchildren by the Burn Prevention Foundation, lives have been saved in home accidents and fires. Through the Girl Scouts and Boy Scouts, thousands of children have been taught to "be prepared" and have grown to be the leaders of our community. Our parents learn computer skills and participate in wellness activities at the Lehigh County Senior Citizens Centers, and children go to camp at the Jewish Community Center. These are all United Way agencies that need your support to survive. Our goal for this year's campaign is to raise over $284,000. We hope you will help us!

With the recent kick-off of this year's campaign, we hope you will watch for your pledge form and join your colleagues through the Lehigh Valley Hospital and Health Network as we celebrate our community.

When we reach out to others from the heart, we lift spirits higher and give them the power to soar to untold heights!

For more information on how you can participate, please contact Betty Anton at (610) 402-8897 or Don Hougendobler at (484) 884-2293, this year's LVHHN United Way Campaign Co-chairs.

News from CAPOE Central

Two More Units Join the CAPOE Club

On September 18, 5B and 5C went live with Medication and Vital Sign charting. The staffs on those units have done a wonderful job with adapting to the new processes and had some excellent suggestions for improvements. Early in October, these units will become CAPOE units. All physicians and residents who have been CAPOE trained will be expected to enter their orders on-line for the patients on those (and the other live units). The CAPOE team is finalizing the process for entering post-op orders, and we expect to begin using them later in October. To accommodate entering post-op orders on-line, we have placed four extra workstations in PACU and two more in the Surgical Lounge.

EAU Goes Live - and CAPOE is There

The Express Admit Unit (EAU) began operation in September. Admission orders for these patients should be entered into the CAPOE system (for those physicians who have been trained). When the office calls with the admission, the Admitting office will provide the physician office with an account number to be used to enter the orders. This account number should be chosen from the list that may be presented to the ordering physician. The combination of the convenience of the EAU and the benefits of CAPOE should help physicians admitting patients from their office and should streamline the movement of patients through the system.

Recent Enhancements to the System

We have made several significant enhancements to the system in response to requests by the physicians and other users. Telemetry orders are now distinct orders that can be entered as part of Admit Orders, and the Telemetry order now appears in the list of active orders. To discontinue Telemetry, you can now find the order in the orders list, and d/c it as with any other order. In response to requests from the surgical staff and nurses, we have added a new view in the Viewer. It is the "Vital Signs and INO Continuous View." This view will show all I&O entries by time of entry, which should help in the management of these patients.

Nursing Instructions Regarding Lab Results

It is not uncommon that a physician would like to be called from the nurses about specific lab results that may not be critical values (i.e. "call physician if Hb < 9.0"). There are two ways in CAPOE to handle this issue. The "Call Physician" and "Call Housestaff" orders have blank fields besides those for vital signs, etc. You can type your instructions in the blank fields, and the nurses will be notified. The "Call" orders can be found under the "Nursing" button in the "Notify" list; and the "Call" order is also in the main list of lab tests. The other option is to type the instructions into the comment field on the lab order. These orders will print out on the floor, and the nursing staff will be notified when the orders print out.

Feeling Lonely? Let Us Round With You

The Physician Educators and the CAPOE team have worked incredibly hard to support the physicians and other users. However, we realize that there is a learning curve with CAPOE. One of the services we offer is to have one of the Physician Educators round with you during morning or afternoon rounds. Having someone round with you will provide direct real-time help and feedback with the CAPOE system. If you are interested in this service, please contact me or one of the CAPOE Physician Educators -- Lynn Corcoran-Stamm, (610) 402-1425; Carolyn Suess, (610) 402-1416; or Kimberlee Szep, (610) 402-1431.

Don Levick, MD
(610) 402-1426 (office)
(610) 402-5100 7481 (pager)

Important Reminder Concerning Reappointment Applications

As stated in the Medical Staff Bylaws, when applying for reappointment to the Medical Staff, it is the responsibility of the applicant to document information pertaining to any professional liability claims, complaints or causes of action that have been lodged against them and the status or outcome of such matters. Due to the importance of this and all other information contained in the reappointment application, Medical Staff members should complete the application personally. Misstatements or inaccurate information may be grounds for corrective action including termination from the Medical Staff, as stated in the Medical Staff Bylaws.

In addition, throughout the year, members of the Medical Staff are responsible for notifying both Medical Staff Services and Legal Services of any new claims and changes or outcomes of any existing claims.

Pediatricians Should Ask About Snoring in Children

The American Academy of Pediatrics recently issued a new set of guidelines suggesting that routine medical checkups for children should include questions about snoring in order to identify possible cases of obstructive sleep apnea syndrome (OSAS). OSAS has been linked to learning problems, behavioral problems, slow growth, bed-wetting, and high blood pressure in youngsters.

Snoring is one of the most common symptoms of OSAS, a breathing disorder characterized by repeated obstructions of the upper airway occurring during sleep during which efforts to breathe continue. Studies suggest that about half a million children between the ages of two and eight might be affected by OSAS. Risk factors include enlarged tonsils and adenoids, allergies, and obesity. The sleep fragmentation associated with OSAS in addition to episodic hypoxemia may result in behavioral and cognitive problems, as well as physiological derangements including pulmonary hypertension and growth retardation. Sleep deprivation and/or the lack of quality sleep at night may be the most common sleep disorder that affects daytime function in children (Sleep Review, pg. 58). Studies show that 37% of children, kindergarten through fourth grade, suffer from at least one sleep-related problem

Daytime somnolence, declining school performance, personality changes, attention disorders, memory and learning disabilities, frequent enuresis, school failure, developmental delay, hyperactivity, aggressiveness, and withdrawn behavior are all possible signs that a child could have OSAS. Some studies suggest that these children may be misdiagnosed with attention deficit disorder. The first line of treatment for OSAS in children is usually adenotonsillectomy. Behavior and learning problems often improve after the operation, and children may experience a spurt of growth afterward as well.

Obtaining a complete sleep history is vital to diagnosing sleep disorders. However, history cannot reliably distinguish between primary snoring and OSAS. A nocturnal polysomnogram or sleep study is the most effective diagnostic tool to diagnose OSAS as well as many other sleep disorders that primarily affect young children.

The Sleep Disorder Center at Lehigh Valley Hospital provides services to children ages one and up. Four board certified sleep physicians, in addition to technologists with significant pediatric sleep experience, are on site to provide the highest level of care possible in an environment that is friendly to children as well as adults. Parents of young children are allowed to stay with their child during the study.

There are two locations for the Sleep Disorder Center -- 17th & Chew (610-402-9777) and Lehigh Valley Hospital-Muhlenberg (484-884-8030).

For more information regarding the above issue, please contact Stephanie Betz, Administrative Director, Sleep Disorder Center, at (610) 402-9767.

New Pilot Program on TSU

In an effort to best meet the needs of patients who have had a stroke or vascular surgery, a new pilot program is being trialed on TSU. The goal is to examine the efficiency and effectiveness of using a subacute level of care to provide "staged care" for select vascular patients and stroke patients. Five beds will be dedicated to meeting the rehabilitation needs of these patients on TSU. Patients will receive skilled nursing care, wound care and rehabilitation services, in a non-acute hospital setting.

For further information or to determine if your patient meets the admission criteria, contact Terry Hilliard, Skilled Care Coordinator for TSU, at (610) 402-0356.

Mystery Medical Staff Member

? Born in Allentown, Pa.
? Earned Bachelor of Science degree from Muhlenberg College
? Graduated from Hahnemann Medical College of Philadelphia
? Completed internship and residency at Allentown Hospital
? Joined the Medical Staff in 1974
? He and his wife, Carol, have three children and three grandchildren
? Enjoys sailing, traveling and model railroading

Give up? Turn to page 13 for the answer.

Radiology News

Nuclear Medicine

The Section of Nuclear Medicine at Cedar Crest & I-78 was recently accredited by the American College of Radiology. This is the only Nuclear Medicine site in the Lehigh Valley and only one of three in Pennsylvania to be accredited by the American College of Radiology.

Two new Skylight gamma cameras have been ordered -- one for LVH-Cedar Crest & I-78 and one for LVH-Muhlenberg. These new gamma cameras are state-of-the-art technology and will perform a variety of routine diagnostic nuclear medicine studies at each site. The new cameras are expected to be installed sometime in October.

After the new cameras are installed, it is anticipated that dual isotope myocardial perfusion scans will be initiated to replace routine thallium scans to diagnose ischemic heart disease. These studies will provide the ability to perform wall motion and to obtain a left ventricular ejection fraction as well as myocardial perfusion on appropriate patients. These studies are expected to begin in October.

Beginning October 1, Medicare will reimburse for the staging, restaging, and monitoring therapy of breast cancer patients for FDG PET Scans.

The Section of Nuclear Medicine at Cedar Crest & I-78 has started radioimmunotherapy utilizing Yttrium-90 Zevalin isotope for the treatment of non-Hodgkins lymphoma refractory to conventional therapy. Zevalin is the first isotope approved for radioimmunotherapy in the country.

Thanks to the hard work of the dedicated Nuclear Medicine staff, there has been a decrease in the backlog for performing outpatient studies at both LVH-Cedar Crest & I-78 and LVH-Muhlenberg. Greater efficiency is also expected when the new gamma cameras arrive.

Currently, there are six students in the LVHHN Nuclear Medicine Technology Program affiliated with Cedar Crest College. They will complete their clinical training this year and will graduate in the Spring of 2003.

Breast Imaging

New state-of-the-art ultrasound equipment has been ordered and is expected to arrive in the next few weeks. The technical capabilities of the new equipment allow Breast Health Services to remain on the cutting edge of Breast Ultrasound utilization with advanced high-resolution techniques and will play an important role in the continuous fight for early diagnosis.

A new mammography machine will be installed at LVH-Muhlenberg. This will allow easier access for the physically challenged and is similar to that in place at LVH-Cedar Crest & I-78 and LVH-17th & Chew. The existing mammography machine, which will be replaced by the new machine, will be reinstalled at the Bath site, replacing an older machine.

Through the efforts of John G. Pearce, MD, Chief, Section of Mammography, who is a registered mammography educator, Breast Health Services has again been accredited for their training programs for mammography technology (52 hours CME) and their Stereo Technology Program (7.5 CME) hours by the American Society of Radiological Technologists.

Congratulations!

W. Michael Morrissey, Jr., MD, Division of Plastic Surgery, was recently notified by the American Board of Plastic Surgery that he successfully completed the oral examination and is now a Diplomate of the Board.

Papers, Publications and Presentations

"A Complication You Should Know When Contemplating Coronary Artery Bypass Surgery," an article about brachial plexus injuries, written by **Joseph V. Episcopio, MD**, Division of General Internal Medicine, has been accepted for publication in an upcoming issue of ***Geriatric Times***.

Geoffrey G. Hallock, MD, Division of Plastic Surgery/Hand Surgery, Section of Burn, wrote an article -- "The Utility of Both Muscle and Fascia Flaps in Severe Upper Extremity Trauma" -- which was published in the July 2002 issue of the ***Journal of Trauma***. This reviewed the system of priorities for flap selection after serious upper extremity injuries from a two-decade experience. Flaps were used for both skin coverage and bony reconstruction with a hierarchy of priorities suggested based on the frequency used in these typically devastating injuries.

Houshang G. Hamadani, MD, Department of Psychiatry, presented a paper titled "Stimulant & Anti Psychotic for ADHD and Behavior Disorder" at the XII World Congress of Psychiatry held August 29 in Yokohama, Japan.

William F. Iobst, MD, Division of Rheumatology, and **Michael J. Pistoria, DO**, Division of General Internal Medicine, co-authored an article -- "The Hospitalist and Graduate Medical Education: Random Thoughts from an Internal Medicine Program" -- which was published in the July/August issue of ***The Hospitalist***. In addition, Dr. Pistoria's article, "Core Competencies Task Force Moves Toward Product Development: A Report," was also published in the July/August issue of ***The Hospitalist***.

Continued on next page

Peter A. Keblish, Jr., MD, Division of Orthopedic Surgery, Section of Ortho Trauma, and Director of the Orthopedic Learning Center at Lehigh Valley Hospital, hosted the annual Mobile Total Knee Bearing course held on August 16. More than 30 surgeons interested in total knee and unicompartment knee arthroplasty attended. Live surgery was performed by **Paul F. Pollice, MD**, Division of Orthopedic Surgery, Section of Ortho Trauma, and Dr. Keblish. The invited moderator was Dr. David Fisher of Indianapolis, Ind., a well-known hip and knee surgeon. Dr. Michael Harrer, fellowship-trained total joint surgeon from New Jersey was also part of the faculty. The Learning Center was supported by the Photographic and AV staff of Lehigh Valley Hospital.

"Establishing Priorities for Hospital Education," an article written by **Martyn O. Hotvedt, PhD**, Director, Center for Education, and **Robert J. Laskowski, MD, MBA**, Chief Medical Officer, was published in the Summer 2002 issue of ***The Journal of Continuing Education in Health Professions***.

John G. Pearce, MD, Chief, Section of Mammography, was a visiting professor at Palmerston North Hospital and Hawkes Bay Hospital in Hastings, New Zealand, from May 21 to 24. Dr. Pearce spoke and had training sessions for the Breast Screening Consortium Staff (technologists, nurses and physicians) for the Central District and the Hawkes Bay Regions of the New Zealand Breast Consortium. This is the breast screening arm of the national health programs in New Zealand for these areas. His topics included: "From Screening to Biopsy," "Breast Masses," "Diagnosis of Calcifications in the Breast," and "Practical Position Hints for Mammographers."

Upcoming Seminars, Conferences and Meetings

OSHA Bloodborne Pathogens Standard

"Developing Your Office Specific Exposure Control Plan," a one-hour seminar intended for physicians, dentists, nurses, and/or office managers who are responsible for providing annual OSHA Bloodborne Pathogen Standard training to their staff, will be held as follows:

Mondays, November 4 and **November 11**
5:30 to 6:30 p.m.
Third Floor Classroom
Lehigh Valley Hospital-Muhlenberg

Tuesdays, November 5 and **November 19**
5:30 to 6:30 p.m.
Classroom 1, Anderson Wing
Lehigh Valley Hospital - Cedar Crest & I-78

At the conclusion of the program, attendees will be able to:

- Identify elements to be included in annual Bloodborne Pathogens Training
- Develop office specific Exposure Control Plan and training records
- Plan the evaluation and selection of safer medical devices as required by the Needlestick Safety and Prevention Act

A fee of $35.00 per person will include printed materials and a certificate of attendance. A light snack and beverage will also be served. Advance registration is required.

For additional information, please call the Infection Control Office at (484) 884-2240.

For registration information, please call the Center for Educational Development and Support at (610) 402-2277.

Computer-Based Training (CBT)

The Information Services department has computer-based training (CBT) programs available for 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	PowerPoint 4.0
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 schedule of upcoming classes is as follows:

2002 and 2003 CBT sessions for JDMCC, Suite 401:

December 18 - noon to 4 p.m.
January 28 - 8 a.m. to noon
February 25 - 8 a.m. to noon

CBT sessions for LVH-Muhlenberg, I/S Training Room:

October 17 - noon to 4 p.m.
November 21 - noon to 4 p.m.
December 19 - 8 a.m. to noon

Continued on next page

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 **I/S Computer Educ Request** 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.

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 October will include:

- October 1 - "Diastolic Dysfunction"
- October 8 - "Prevention of Secondary Stroke/TIA"
- October 15 - "The Role of Erythropoietin Insufficiency in the Pathogenesis of Anemia in the Geriatric Population"
- October 22 - "Lung Cancer"
- October 29 - "An update on Stroke, Amputee and Spinal Cord Injuries"

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

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 October will include:

- October 1 - "Pertussis: Persisting Perplexing Problem: Are There Solutions?"
- October 8 - "Morbidity and Mortality Conference"
- October 15 - "Breaking Bad News to Parents"
- October 22 - "Food Allergies in Children"
- October 29 - "Case Presentation"

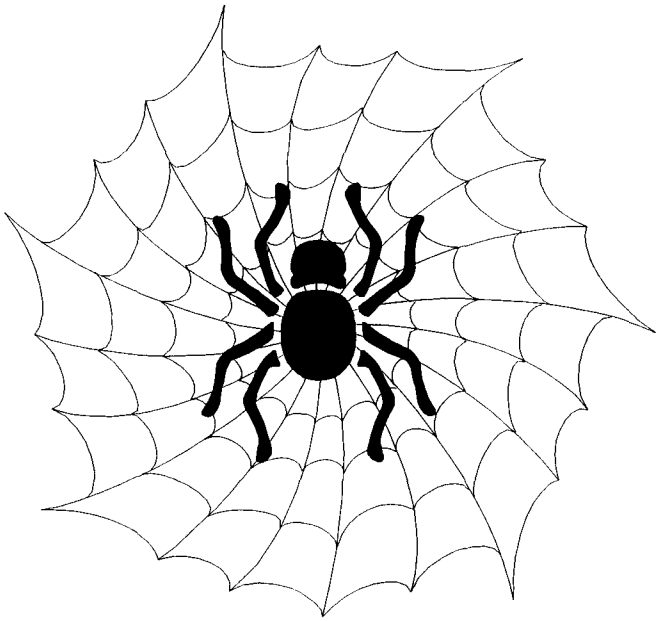
For more information, please contact Kelli Ripperger in the Department of Pediatrics at (610) 402-2540.

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 on the Auditorium and OR Lounge doors and in the LVH_LIST bulletin board in email.

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



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

Thomas M. Bailey, MD
Muhlenberg Primary Care, PC
2649 Schoenersville Road, Suite 201
Bethlehem, PA 18017-7326
(610) 868-6880 Fax: (610) 868-5333
Department of Pediatrics
Division of General Pediatrics
Provisional Active
Site of Privileges - LVH & LVH-M

Lisa J. Caffrey, DO
1755 Blossom Hill Road
Easton, PA 18040-8351
Department of Family Practice
Provisional Active
Site of Privileges - LVH & LVH-M

Christopher J. Conners, MD
Medical Imaging of LV, PC
Lehigh Valley Hospital
Cedar Crest & I-78, P.O. Box 689
Allentown, PA 18105-1556
(610) 402-8088 Fax: (610) 402-1023
Department of Radiology-Diagnostic Medical Imaging
Division of Diagnostic Radiology
Provisional Active
Site of Privileges - LVH & LVH-M

Jennifer A. Derr, DO
117 Main Street
Freemansburg, PA 18017-7231
Department of Family Practice
Provisional Active
Site of Privileges - LVH & LVH-M

Gerardo M. Garcia, MD
Toselli & Brusko Surgical Associates, LTD
2649 Schoenersville Road, Suite 202
Bethlehem, PA 18017-7317
(610) 691-8074 Fax: (610) 861-9449
Department of Surgery
Division of General Surgery
Provisional Active
Site of Privileges - LVH & LVH-M

Maria B. Gesualdo, DO
Bethlehem Pulmonary Associates, Inc.
5325 Northgate Drive, Suite 209
Bethlehem, PA 18017-9416
(610) 866-2048 Fax: (610) 866-5058
Department of Medicine
Division of Pulmonary
Provisional Active
Site of Privileges - LVH-M

Melanie S. Koscelnick, MD
LVH Department of Medicine
Lehigh Valley Hospital
Cedar Crest & I-78, P.O. Box 689
Allentown, PA 18105-1556
(610) 402-5200 Fax: (610) 402-1675
Department of Medicine
Division of General Internal Medicine
Provisional Limited Duty
Sites of Privileges - LVH & LVH-M

Address Changes

Gynecologic Oncology Specialists
- **Richard M. Boulay, MD**
- **Weldon E. Chafe, MD**

Fairgrounds Medical Center
400 N. 17th Street, Suite 201
Allentown, PA 18104-5000
(610) 402-3650 Fax: (610) 402-3673

Primary Care Associates in the Lehigh Valley, PC
- **Michael J. Nimeh, DO**
- **Anuja Singh, MD**
- **David M. Stein, DO**

1941 W. Hamilton Street, Suite 102
Allentown, PA 18104-6413
(610) 776-1603 Fax: (610) 776-6344

Michael D. Schwartz, MD
ABC Family Pediatricians
Health Center at Trexlertown
6900 Hamilton Blvd., P.O. Box 60
Trexlertown, PA 18087-0060
(610) 402-0460 Fax: (610) 402-0409

Practice Changes

Mary T. Greybush, DO
(No longer with Lansdale Medical Group)
Women's Health Care Group
1010 Horsham Road, Suite 214
North Wales, PA 19454-1505
(215) 853-3421 Fax: (215) 745-7578

Continued on next page

Aaron D. Katz, MD
(No longer with HealthWorks)
West End Medical Group
3710 Broadway
Allentown, PA 18104-5297
(610) 395-0307 Fax: (610) 395-0950

Louis M. Spikol, MD
(No longer with Southside Family Medicine)
Louis M. Spikol, MD Family Medicine
1111 Sixth Street
Whitehall, PA 18052-5212
(610) 403-3800 Fax: (610) 403-3805

Status Changes

James D. Balshi, MD
Department of Surgery
Division of Vascular Surgery
From: Active
To: Affiliate
Site of Privileges - None

William W. Frailey, Jr., MD
Department of Surgery
Division of General Surgery
From: Active/LOA
To: Honorary

Marc A. Granson, MD
Department of Surgery
Division of Vascular Surgery
From: Active
To: Affiliate
Site of Privileges - None

Bengt L. Ivarsson, MD
Department of Surgery
Division of Vascular Surgery
From: Provisional Active
To: Affiliate
Site of Privileges - None

Timothy C. Oskin, MD
Department of Surgery
Division of Vascular Surgery
From: Active
To: Affiliate
Site of Privileges - None

Joel C. Rosenfeld, MD
Department of Surgery
Division of Vascular Surgery
From: Active
To: Affiliate
Site of Privileges - None

Stanley Snyder, MD
Department of Obstetrics and Gynecology
Division of Primary Obstetrics and Gynecology
From: Affiliate
To: Honorary

One-Year Leave of Absence

Daniel T. Mulcahy, DO
Department of Medicine
Division of General Internal Medicine
From: Active
To: Active/LOA

Additional One-Year of Absence

Lawrence Klein, MD
Department of Surgery
Division of Vascular Surgery

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

Resignations

Luis Constantin, MD
Department of Medicine
Division of Cardiology

Kevin G. Hibbett, MD
Department of Surgery
Division of General Surgery

Harjeet P. Kohli, MD
Department of Surgery
Division of General Surgery

Allied Health Professionals

Appointments

David A. Angelitis, PA-C
Physician Extender
Physician Assistant - PA-C
(Orthopaedic Associates of Allentown - Christopher A. Hawkins, MD)
Site of Privileges - LVH & LVH-M

Christine J. Breithoff
Physician Extender
Technical
(John J. Cassel, MD, PC - John J. Cassel, MD)
Site of Privileges - LVH & LVH-M

Continued on next page

Peter Carpenter, Jr., CRNA
Physician Extender
Professional - CRNA
(Lehigh Anesthesia Associates - Thomas M. McLoughlin, Jr., MD)
Site of Privileges - LVH & LVH-M (Coverage for OBGYN Privileges Only)

Robert W. Ehle, CRNA
Physician Extender
Professional - CRNA
(Lehigh Anesthesia Associates - Thomas M. McLoughlin, Jr., MD)
Site of Privileges - LVH & LVH-M (Coverage for OBGYN Privileges Only)

Elizabeth A. Kamp, PA-C
Physician Extender
Physician Assistant - PA-C
(The Head & Neck Center, PC - Edward A. Tomkin, DO)
Site of Privileges - LVH & LVH-M

Alan B. Mason, PA-C
Physician Extender
Physician Assistant - PA-C
(Lehigh Valley Hospital-Muhlenberg)
(Supervising Physician - John A. Mannisi, MD; Substitute Supervising Physician - Fernando Garzia, MD)
Site of Privileges - LVH & LVH-M

Renee D. Mitterling, CRNP
Physician Extender
Professional - CRNP
(Anticoagulation Services - Mark D. Cipolle, MD, PhD)
Site of Privileges - LVH & LVH-M

Jill C. Palanzo, CRNA
Physician Extender
Professional - CRNA
(Lehigh Anesthesia Associates - Thomas M. McLoughlin, Jr., MD)
Site of Privileges - LVH & LVH-M (Coverage for OBGYN Privileges Only)

R. Gregory Scott, RN
Physician Extender
Technical - Pacemaker/ICD Technician
(Biotronik Inc - Norman H. Marcus, MD)
Site of Privileges - LVH & LVH-M

Concetta M. Vivian, CRNA
Physician Extender
Professional - CRNA
(Lehigh Anesthesia Associates - Thomas M. McLoughlin, Jr., MD)
Site of Privileges - LVH & LVH-M (Coverage for OBGYN Privileges Only)

Change of Supervising Physician

Karen M. Williams, CRNP
Physician Extender
Professional - CRNP
From: Good Shepherd Rehab Hospital - Jane Dorval, MD
To: Peters, Caccese & Scott - David M. Caccese, MD
Site of Privileges - LVH & LVH-M

Additional Supervising Physician

Beverley J. Genetti, RNFA
Physician Extender
Professional - RN First Assistant
Supervising Physicians - Charles J. Scagliotti, MD and Manny Iyer, MD
Additional Supervising Physician - David S. Warsaw, DO, Lehigh Plastic Surgery Center
Site of Privileges - LVH & LVH-M

Answer to Mystery Medical Staff Member
Ernest Y. Norrington II, MD

THERAPEUTICS AT A GLANCE

The following actions were taken at the July/August 2002 Therapeutics Committee Meeting - Joseph Ottinger, R.Ph., MS, MBA, Janine Barnaby, R.Ph., Jenny Boucher, Pharm. D., Jason Laskosky, Pharm.D., Fred Pane, R.Ph.

Therapeutic Substitution Policy

Therapeutic equivalent substitution is defined as a substitution of one product of similar composition or action for an ordered product. Therapeutic substitutions are designed, to maintain a workable "Hospital Formulary," decrease inventory needs, achieve contract compliance of market-share requirements to obtain best pricing, and control hospital expenses.

All drugs are reviewed for efficacy, safety and then cost. Clinical studies (both U.S. and abroad) are reviewed, just like with any drug discussed for formulary addition. Support of the Medical/Surgical divisions is obtained as necessary.

The Medical Executive Committee, through the Therapeutics Committee, grants the pharmacy department "therapeutic substitution" authorization for specific products. A pharmacist will write an order on the chart, indicating the Therapeutics Committee approved substitution.

Recently, the American Journal of Health System Pharmacists published the results of a survey conducted by SUNY, Syracuse in 1999. One hundred ninety-two (192) teaching hospitals responded to the survey, including Lehigh Valley Hospital. Depending on the class/type of drug, therapeutic substitutions were being done in up to 91% of the hospitals.

Ceftriaxone to Cefotaxime Auto-sub Revised

Currently the Therapeutics Committee policy permits the auto-substitution of ceftriaxone 1gm/d to cefotaxime 1gm IV q8h only (with provisions for renal dose adjustments for Est Crcl <30ml/min then 1gm q12h and < 10ml/min then 1gm/d). At the latest Therapeutics meeting the policy was expanded to include the following:

Ceftriaxone	Cefotaxime	Est CrCl (ml/min)
1gm/24h	1gm q8h	>30
	1gm q12h	10-29
	1gm q24h	<10 or HD
2gm/day OR 1gm q12h	2gm q8h	>30
	2gm q12h	10-29
	2gm/day	<10 or HD
2gm q12h	2gm q4h	>50
	2gm q6h	30-49
	DNS	<30

DNS for pediatrics will remain.
DNS for one-time ER doses will remain; if ER patients are then admitted, the above policy will then be instituted.

IV-PO linezolid (Zyvox®) Step-down

After oral dosing, linezolid is rapidly and extensively absorbed 100%. Additionally, linezolid may be administered with or without food. Similar to the previously successful floroquinolone IV to PO step down policy, linezolid will be automatically converted to the oral formulation upon meeting defined GI tolerance criteria (as previously established in the IV-PO levofloxacin policy). Patients will be converted to PO linezolid on a 1 to1, milligram to milligram basis.

e.g. linezolid 600mg IV q12h to 600mg PO q12h

Synercid® is Removed from the Formulary

Synercid® has been removed from the LVH formulary. This deletion is due to the poor susceptibilities of Synercid® relative to linezolid (Zyvox®) based on the 2001 LVH antibiogram. Linezolid possesses indications identical to and in addition to those of Synercid®.

AmBisome® to Abelcet® conversion in the Adult Population

While it is known that liposomal amphotericin products are significantly less nephrotoxic than conventional amphotericin B (Fungizone®), the differences among these agents are not as clear-cut. The two proposed major advantages of the liposomal agents above Fungizone® include decreased infusion related reactions and nephrotoxicity. Because ABCD (Amphotec®) has not shown a decrease in infusion related reactions, it typically is not considered a formulary option. The two agents left are ABLC (Abecet®) and L-AmB (AmBisome®). Both these agents have proven both a decrease in infusion-related reactions and a decrease in nephrotoxicity. However, neither agent has established itself as clearly superior. For this reason, the therapeutics committee has decided to allow economics to be the deciding factor. Given the lower acquisition cost for Abelcet®, orders for AmBisome® for adults will require a call by pharmacy to the physician offering AmBisome® as the alternative. There is no milligram to milligram substitution for these products. The typical recommended dose for Abelcet® is 5mg/kg/day. Since the Children's Hospital of Philadelphia currently prescribes AmBisome® for its population, AmBisome® will remain available to pediatric patients until CHOP changes its formulary to Abelcet®.

Voriconazole (Vfend®) Trial period

Voriconazole is a new second generation triazole antifungal with a spectrum of action similar to itraconazole. It is indicated for the primary treatment of invasive aspergillosis and is also indicated for the treatment of serious fungal infections caused by *Scedosporium apiospermum* and *Fusarium* spp. in patients intolerant of, or refractory to, other therapy. Voriconazole is available as 50 and 200 mg tablets and as in 200 mg single-use vials for intravenous administration.

The following dosage regimen is for treatment of adults. Initiate treatment with a loading dose of 6 mg/kg IV every 12 hours for two doses, followed by a maintenance dose of 4 mg/kg IV every 12 hours.

Due to high oral bioavailability of voriconazole, once the patient can tolerate oral medication, patients may be switched to the tablet form. Patients weighing more than 40 kg should receive an oral maintenance dose of 200 mg every 12 hours. Adult patients weighing less than 40 kg should receive an oral maintenance dose of 100 mg every 12 hours.

The most frequent adverse event associated with voriconazole is a reversible, dose-related, visual disturbance. This effect occurs in approximately 30% of patients.

Due to the current limited data for this agent and the presumed primary use by infectious disease physicians, voriconazole will be restricted to I.D. use for a 3-month trial period. This agent is not considered a primary treatment option in most fungal infections. The need for restriction beyond 3 months will be evaluated at that time.

IV cefotaxime to PO cefpodoxime step-down policy

Cefpodoxime (Vantin®) has been added to the LVH formulary as part of a new IV to PO step-down policy. Like cefotaxime, cepodoxime is a third generation cephalosporin with an almost identical spectrum of activity as compared to cefotaxime. Cefpodoxime posses excellent bioavailability with

absorption enhanced after the administration of food. Also like cefotaxime, cefpodoxime is renally cleared. Dosage adjustments are required in renal impairment.

Per the Therapeutics Committee, cefotaxime will be converted to cepodoxime following meeting preset inclusion and exclusion criteria. Inclusion for substitution requires a decreased WBC and/or decreased bands cited on one occasion on most recent CBC, an improvement of cough and dyspnea noted in the medical record (***for CAP only***), a temperature < 100 F on two different occasions < 8 hours apart, and GI tolerance. GI tolerance has previously been defined in the IV to PO levofloxacin policy. Excluded from this policy will be those with meningitis, endocarditis/ pericarditis, osteomyelitis, Lyme Disease, mediastinitis, pediatrics, or those with a medical record stating patient scheduled to receive home IV antibiotics.

Moxifloxacin (Avelox®) Automatic Substitution

Moxifloxacin is a fluoroquinolone antimicrobial with enhanced activity against gram-positive organisms and a broad spectrum of activity against gram-negative and anaerobic microorganisms. Moxifloxacin generally possesses *in vitro* activity against gram-negative organisms comparable to the other fluoroquinolones with exception to Pseudomonas for which it has decreased activity. Against gram-positive organisms, moxifloxacin is more active *in vitro* than ciprofloxacin, gatifloxacin, levofloxacin, ofloxacin, and sparfloxacin, and similar in activity to trovafloxacin which has been pulled from the market. While moxifloxacin offers enhanced gram-positive activity in vitro compared to levofloxacin, it is not yet clear whether this translates to a clinical advantage over levofloxacin. In fact, while LVH susceptibility data has not shown an increase in the cases of levofloxacin resistant S.pneumonia over the past year. A linear regression of S.pneumonia MICs compared to time shows a slight negative slope. This is representative of levofloxacin retaining its susceptibility against S.pneumonia at LVH.

Against anaerobic organisms moxifloxacin has demonstrated *in vitro* activity comparable to trovafloxacin, and greater than that of ciprofloxacin, levofloxacin, ofloxacin, and sparfloxacin. At this time, however, moxifloxacin is not indicated for use in anaerobic infections. Additional clinical studies are necessary to determine their role in such infections. Like levofloxacin, moxifloxacin is active against atypical pathogens including *Chlamydia* spp., *Mycoplasma pneumoniae*, and *Legionella eumophilia*..

Several studies have compared gatifloxacin or moxifloxacin with other quinolones, cephalosporins, and macrolides in various types of infections, and generally reported comparable efficacy. Most studies have focused on the use of these agents in respiratory infections (community-acquired pneumonia, sinusitis, and acute exacerbation of chronic bronchitis). These agents, like levofloxacin, are likely to be used first-line in the treatment of community acquired pneumonia.

Moxifloxacin has demonstrated effects on the QT interval and should be avoided in patients predisposed to QT internal changes. The risk of QT interval changes can be considered as having a known risk of an unknown degree.

Given the lack of clear benefit from utilizing moxifloxacin on the LVH formulary, the Therapeutics committee has approved the automatic substitution of moxifloxacin to levofloxacin.

Moxifloxacin	Levofloxacin	500mg/d	(est crcl>50ml/min)
	OR		
		500mg (Day 1)	(est crcl 20–49ml/min)
	then	250mg/d	
	OR	500mg (Day 1)	(est crcl < 20ml/min or HD)
	then	250mg q48hr	

The Last Word...

Tips and Techniques for the Lastword™ User

October, 2002 – Volume 1, Issue 12

Additional Views and Clinical Values Easily Displayed in the Viewer

by Kim Szep, RN

The *Viewer* now has additional ways for you to easily access patient information. In response to physician feedback, additional *Views* have been added. One of these is the *Coag View* (see Figures 1 and 2). This *View* is similar to the paper Anticoagulation Flowsheet. It lists relevant laboratory data (platelets, PT/INR, and PTT), VTE score, heparin drip rate (if applicable), and other anticoagulant medications. To access this new view, click on the *Viewer* chart tab from the *Physician Base* screen (see Figure1). Now click on *Coag View* from the drop-down list choices.

The *Viewall* function has been modified to improve this view for physicians. *Titratable* medications such as heparin and insulin have been added for easy access. *Phlebotomy* and *IV Site Care* have been removed from this view. Should you wish to see this information, click on the *Pt. Care/Chart* chart tab from the *Physician Base* screen. Click on *Viewnurse* and these parameters will display (see Figure 1).

The *Viewer* also has additional clinical values for easy display (see Figure 3). These include positive and negative results from *Heme* tests for NG drainage, stool, and a category for "other". Also included with this change are positive and negative charted values for *Urine Dip* including Leukocytes, RBCs, Protein, and Glucose. You can easily access this information by going to the *Viewer* tab on the *Physician Base* screen and choosing the *Viewall* option.

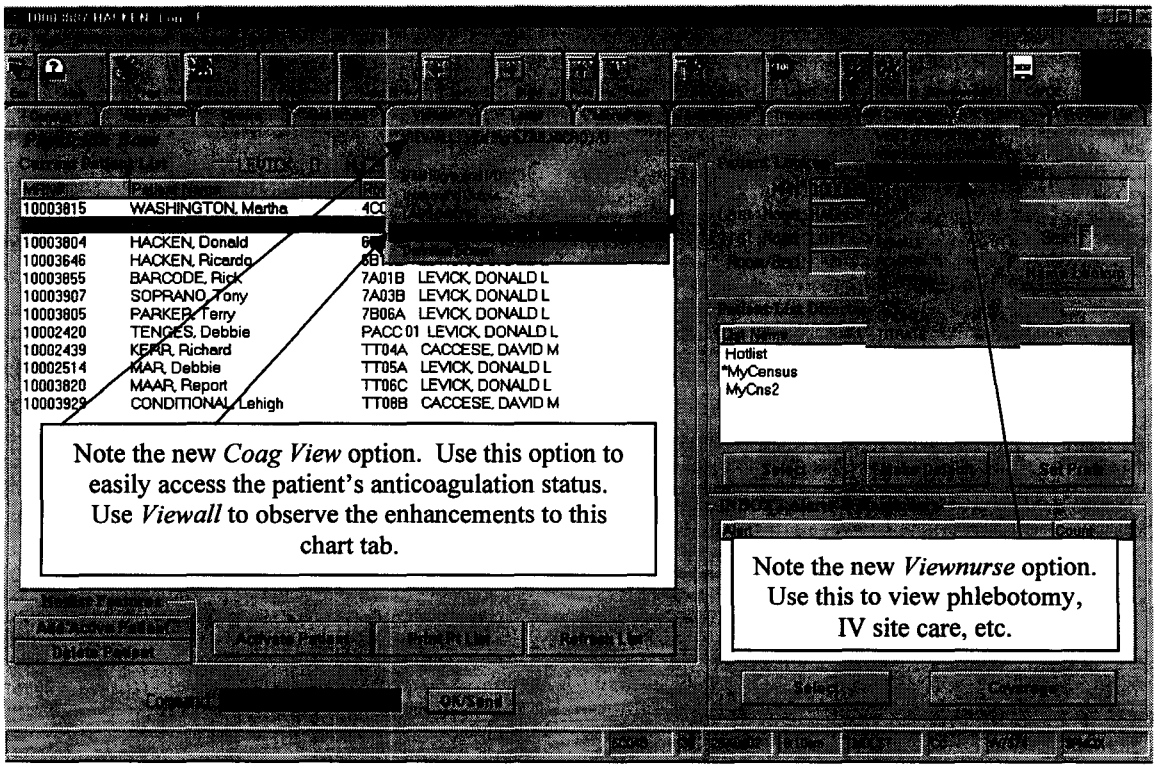


Figure 1 – Accessing the new *Coag View*, *Viewall* and *Viewnurse* displays

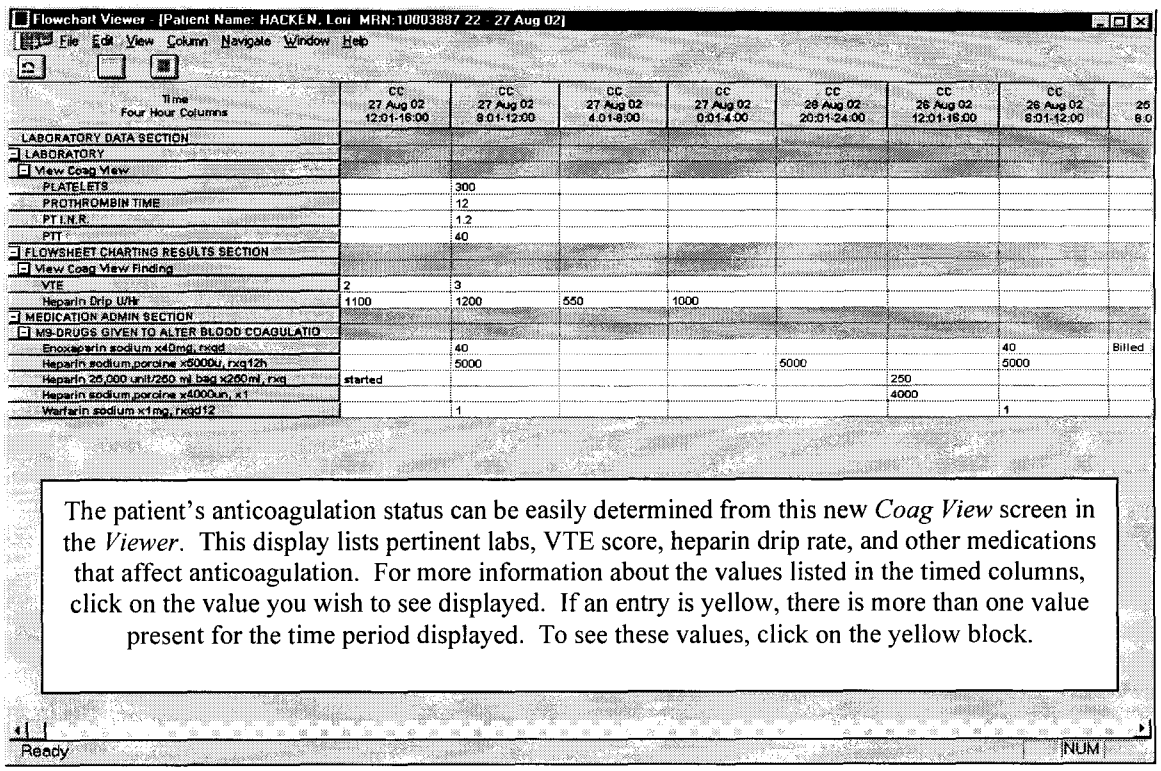


Figure 2 – New *Coag View*

For questions or comments regarding CAPOE, please contact one of the Physician Software Educators on staff:

Lynn Corcoran-Stamm – ext. 1425
Carolyn K. Suess, RN – ext. 1416
Kim Szep, RN – ext. 1431

You may also take advantage of the **CAPOE Help Line by dialing ext. 8303, and selecting option #9**. Enter your call back number and expect a return call from the on-call CAPOE trainer/analyst. This service is available 24 hours a day, seven days a week. If you have other hardware/software/password issues, please choose **option #1** so we may provide you with the best service. We will also be happy

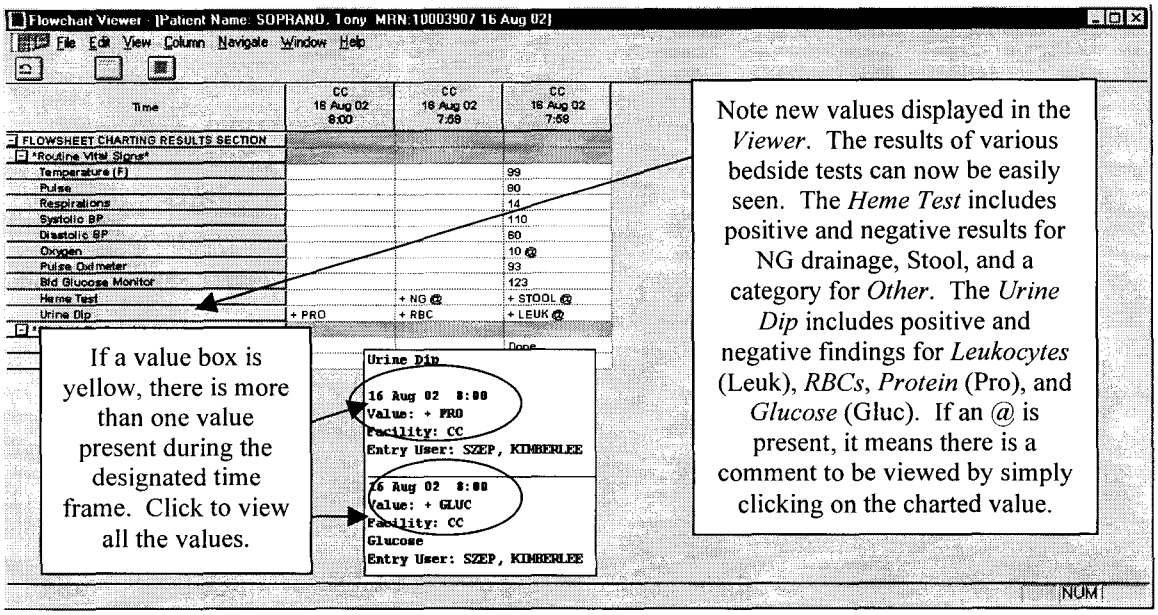


Figure 3 – Results of Heme Tests and Urine Dips displayed in the Viewer

to assist you with any general Lastword (Phamis) questions you may have. **If you have training needs that pertain only to the Lastword system, call ext. 1703 and** training can be scheduled at your convenience.

New Insulin Add-on/Instead of Order Set

by Carolyn K. Suess, RN

On September 12, 2002, a new insulin order was added to the *A-L* medication listing on the *CAPOE Order Pad*. The *Insulin Dose Add-on/Instead of Set* was designed to permit an ordering physician to modify a patient's current insulin order(s) without having to discontinue the order(s).

As mentioned, the order is found under the name *Insulin Dose Add-on/Instead of Set* in the *A-L* medication listing on the *CAPOE Order Pad*. Double-click on the order to select it. The order appears in the *Unprocessed Orders* window. Click on the **Process Orders** button to view the order set.

The order set opens (see Figure 4) to reveal Regular, NPH, and Novalog doses that may be ordered as a one time dose, given in addition to a next dose, given instead of a next dose, or given instead of an AM dose. For example, let's presume a patient has an order for Regular Insulin, 6 units, QD at 0700. The patient's physician determines that a one-time increased dose of 9 units of Regular Insulin is required the following morning.

Rather than discontinue the daily dose for 6 units of Regular Insulin, and re-enter a new dose of 9 units with a *Once* frequency, the physician selects the *Regular Insulin X 1 Instead of AM Dose* order. This order is listed beneath the *Give Instead of AM Dose* heading (see Figure 4) and is selected by clicking on the adjacent check box. After clicking the **Complete** button, the order detail screen appears (see Figure 5).

Under the *Dose* field, the physician enters a "9". Note the *Once* frequency and the comment, ****GIVE INSTEAD OF AM DOSE**** on the order detail screen. The physician clicks the **Place This Order** button, located in the bottom left side of the order detail screen to complete the order.

The following morning, the nurse caring for the patient sees the new insulin order with the comment, ****GIVE INSTEAD OF AM DOSE**** in her medication administration worklist. This comment alerts her to

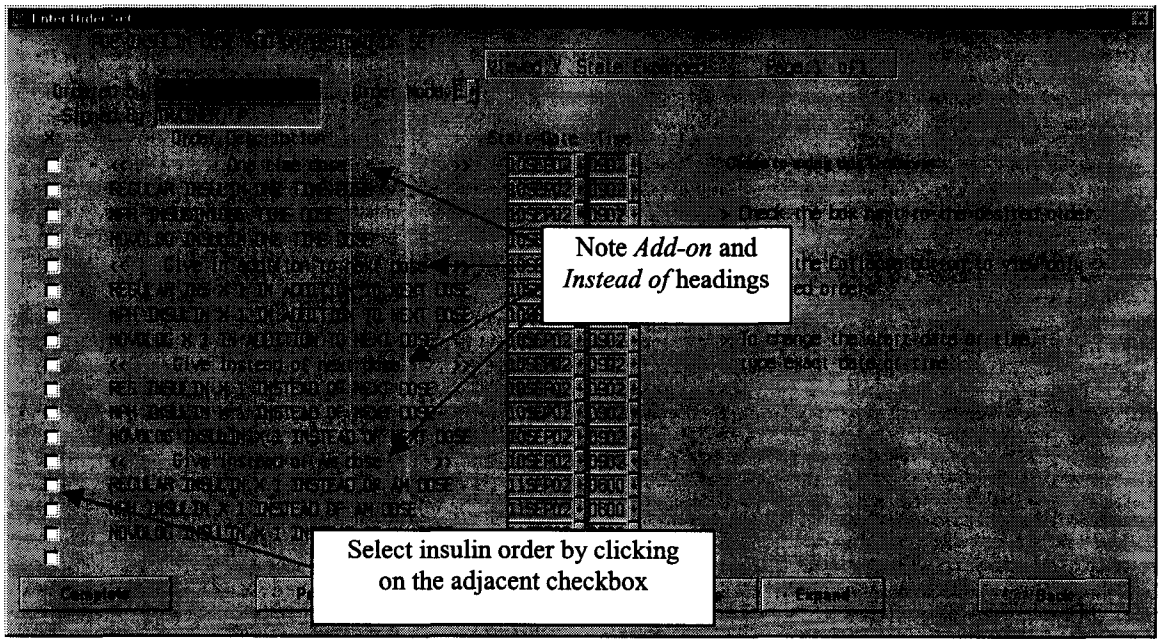


Figure 4 – *Insulin Dose Add-on/Instead of Set* showing the individual orders

administer 9 units rather than 6 units of Regular Insulin that morning. All future AM doses of Regular Insulin resume the 6 unit dosing per the original order.

If you have any questions pertaining to this new order set, please feel free to contact any of the Physician Software Educators on staff.

Patient Regulates Own Insulin Order Now Available in CAPOE

by Carolyn K. Suess, RN

A new order named *Insulin, Patient Regulates Own* is located under the *A-L* medication listing on the *CAPOE Order Pad*. This order allows the physician to have patients determine their own insulin dosing during their hospital stay.

This order instructs the nurse to obtain the daily dose(s) from the patient. Once obtained, the nurse enters the appropriate insulin order in CAPOE with the correct dose of insulin to be charted against.

New orders such as this are the direct result of physician user feedback to the CAPOE Team. If you would like to request additional enhancements to the CAPOE module in Lastword, please contact us via the **CAPOE** button located on your Lastword toolbar (see Figure 5). This button links you to an Intranet Web page where you can provide constructive comments or requests.

You will also see a button for **CAPOE Updates**. This links you to the Lastword for Physicians home page and other links to Lastword User Guides, Lastword FAQs, Physician Tips & Tricks, etc. Please take a moment and share your thoughts with us.

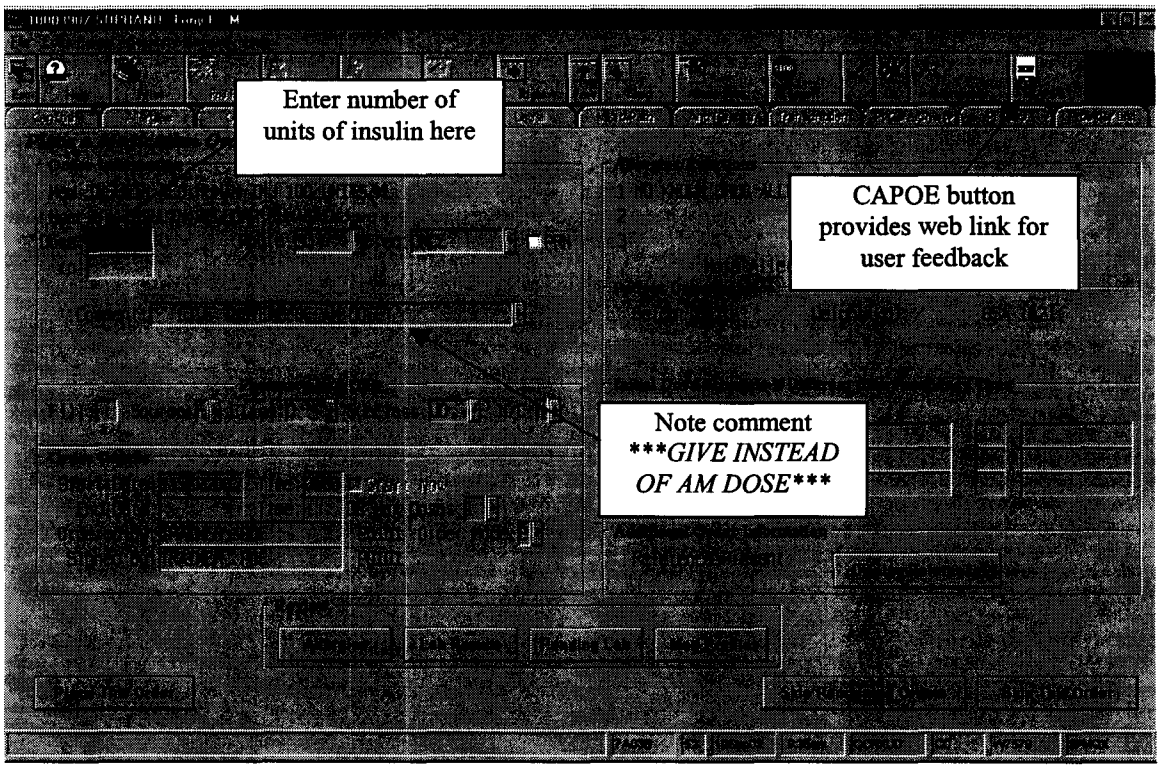


Figure 5 – *Give Instead of AM Dose* Insulin Order

RECOMMENDATIONS TO THE GENERAL MEDICAL STAFF FOR REVISIONS TO THE MEDICAL STAFF BYLAWS

FOR MEETING OF JUNE 10, 2002

The following proposed revisions, having received the recommendation of the Bylaws Committee and Medical Executive Committee, are being presented for action.

Proposed Changes to Rules and Regulations – *J. Transitional Skilled Unit*

The following changes were proposed by the TSU Medical Director and Administrator in consideration of Federal, State, and JCAHO regulations, and with the advice of legal counsel, in an effort to enhance the quality of care in the Transitional Skilled Unit.

E. RECORDS

12. Whereas it is expected that a progress note appear daily on each patient's chart, it is required that the attending physician record a note appropriate to his or her patient's progress at a minimum of every forty-eight (48) hours. This requirement is in addition to daily progress notes written by residents and/or physician extenders, when approved to do so. For Transitional Skilled Unit progress note requirements see Rules and Regulations for Transitional Skilled Unit.

J. TRANSITIONAL SKILLED UNIT

4. Records:

All requirements as designated in Section E. Records, will apply. In addition the following is also required:

1. The initial physician visit must occur within a time frame appropriate to the patient's condition, but not to exceed 48 hours after admission.

~~1~~ 2. Physician extenders' documentation on the patients' records must be counter-signed by the supervising physician within seven (7) days with an original signature and date by the licensed physician. This includes progress notes, physical examination reports, treatments, and any other notation made by the physician extenders, including verbal and telephone orders.

~~2~~ 3. A physician visit and progress note is required once every seven (7) days or more frequently whenever the patient's condition warrants (medical necessity)~~, or at least weekly~~.

~~3~~ 4. The discharge summary shall be completed on all patients in accordance with Medical Staff Rules & Regulations. In addition, the rehabilitation potential shall be included.

~~4. The Progress Notes must reflect that a Patient's Rights have been respected by documenting that the patient has agreed to the transfer of services.~~

5. The patient or his or her legal guardian may, upon oral or written request, have access to all records pertaining to the patient including current clinical records, within 24 hours (excluding weekends and holidays). Photocopies of the record or any portion thereof may be purchased upon request with two (2) working days notice to the TSU.

6. The physician is required to complete, sign and date the Medicare Certification and Recertification form on or before admission, on or before the 14th day, and every 30 days thereafter on all Medicare residents. This form must specify the skilled care qualifiers and verify medical necessity for a skilled nursing facility stay.

Revision of Section Name to Podiatric Surgery

The following revision was requested by Division Chief and Department Chairperson:

ARTICLE XII – DEPARTMENTS

SECTION A – DEPARTMENTS, DIVISIONS AND SECTIONS

The Departments of the Medical Staff shall be organized as follows:

12. Department of Surgery which shall include the following Divisions: Cardio-Thoracic Surgery, Colon and Rectal Surgery, General Surgery, Neurological Surgery, Ophthalmology, Oral and Maxillofacial Surgery, Orthopedic Surgery, Otolaryngology-Head & Neck Surgery, Plastic Surgery, ~~Podiatry~~ Podiatric Surgery, Trauma-Surgical Critical Care, Urology, Vascular Surgery, and Hand Surgery.

Approved:
June 10, 2002 - General Medical Staff Meeting
June 11, 2002 - Lehigh Valley Hospital-Muhlenberg Board of Trustees
September 4, 2002 - Lehigh Valley Hospital Board of Trustees

October 2002

HIPAA UPDATE

Topic: What Information should be included in a Privacy Notice?

Pursuant to HIPAA's Final Privacy Rule, Physicians, like other health care providers are required to provide patients with a **Privacy Notice** to identify privacy practices in their office setting. The regulations define the required elements for the Notice as follows:

- The notice must contain the following statement as a header: **" THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."**
- Description of the types of uses and disclosures of health information that a provider is permitted to make for treatment, payment and health care operations, and an example of each
- Description of other uses and disclosures of health information that a provider may make without patient authorization, i.e., reporting of communicable diseases
- Statement that other uses and disclosures will be made only with the individual's written authorization, and that the individual may revoke such authorization
- Statement that the provider may contact the individual to provide appointment reminders or information about treatment alternatives
- Statement of the individual rights created under HIPAA, and description of how the patient can exercise their rights
    - **Right to request restrictions on certain uses and disclosures**, which must be accompanied by a parallel statement that the provider is not required to agree to the restriction. (*an example of a restriction is when a patient requests information not be sent into their health plan*)
    - **Right to receive confidential communications** (*patients may request health information, such as a bill, be sent to an alternative address other than their home*)
    - **Right to inspect and copy** the individual's own information
    - **Right to amend** incorrect or incomplete information
    - **Right to receive an accounting of disclosures** (*accounting generally consists of disclosures mandated by law, such as to a public health agency*)
    - Right of the patient to obtain a paper copy of the notice
- Statement that the provider will maintain the privacy of personal health information, will give the notice of privacy practices, and will abide by such notice
- Statement that the provider reserves the right to change the terms of its notice
- Provide the name or title and telephone number of the person to contact for more information or to file an internal complaint with the provider or the Secretary of the Department of Health and Human Services
- Provide an effective date of the notice

Providers must make a good faith effort to obtain a patient's written acknowledgement of receipt of the Privacy Notice no later than the date of first service delivery. The Privacy Notice must also be posted in a prominent location where patients are able to read the notice. Compliance date for this regulation is April 14, 2003.

This update was written by Mary Ann La Rock, Corporate Compliance Officer for LVHHN.

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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.