LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

# PROGRESS NOTES

## Medical Staff

December, 2002 Volume 14, Number 12

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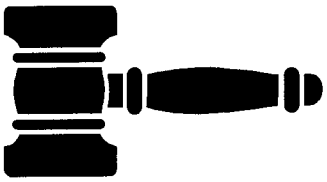
***Best Wishes for a Very Happy and Safe Holiday Season!***
***-- The Medical Staff Services Team***



## *From the President*

What lies behind us and what lies before us are tiny matters compared to what lies within us.
- Ralph Waldo Emerson

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**A Holiday Greeting**
On behalf of your Medical Staff Leadership -- Drs. Rae-Grant, Caccese, and myself -- I would like to extend our sincere wishes for a warm and meaningful Holiday Season. We hope that every member of the hospital family will embrace the richness of our heritage and enjoy the freedoms of our society. Understand the importance of our relationships with family and friends. Strengthen the bonds that make our society stable and strong. While we savor the holidays, we should not take this holiday season for granted. In a number of ways, we now recognize the values that our country holds in common. A sober look around the world will make us appreciate that we need to defend our freedoms and our way of life. Make this a very special Holiday season when we reinforce what is important to us all. Recognize and appreciate those who touch our lives and wish them well. We extend our greetings at this holiday time to all members of the LVHHN extended medical family. As always, we thank all of you for your contributions and look forward to working with you in the future.

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Great works are performed not by strength, but by perseverance.

-Samuel Johnson

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**Everyone take one step to the right** (or is it the left – I never got it straight)
As your leadership changes, I would like to first thank the Medical Staff for the opportunity to serve as President for the past two years. It has been a remarkable educational opportunity for me to participate in and understand the scope of the entire clinical enterprise. I offer sincere thanks to Dr. David Caccese who has served the Medical Staff with sincerity and consistency. I calmly pass the gavel of Presidency to Dr. Alex Rae-Grant knowing that your Medical Staff Leadership is in very good hands. And we all welcome Dr. Don Levick as President-Elect. Don understands the dynamics of the Medical Staff structure, has experience with information technologies, and has excellent clinical credentials.

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If marriage were outlawed, only outlaws would have in-laws.

It's frustrating when you know all the answers, but nobody bothers to ask you the questions.

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**A Critique – Medical Staff Leadership**

As I look back on the major themes during the past two years, I have focused on communication, teamwork, professionalism, a culture of respect, patient safety, valuing each member of the Medical Staff, and a call to political activism. I have emphasized these concepts in the monthly ***Medical Staff Progress Notes*** and ***Pro Tempore***, which were modified to be crisp, informative and timely. The intent was to "frame" our issues, put them in perspective, and see them on a local, regional and national level. At our weekly Troika sessions, we review all matters of concern to the Medical Staff on a timely basis and decide strategy. Troika has made a good faith effort to "do the right thing" and be fair to each member of our Medical Staff. Correspondence and communication with the Medical Staff was encouraged. In the words of Lyndon B. Johnson, we have tried to "reason together."

So did I make a difference? After speaking with members of the Medical Staff, it's hard to tell if they truly feel more informed, more part of a team, more valued, and more aware of professionalism in medical practice. I understand that this is often a slow, subtle, but important process and may be hard to measure. Certainly the effort was made, and I can point to themes and initiatives. I suspect that I was one of a number of different factors influencing our Medical Staff in the past two years. I believe that we have responded appropriately to the malpractice crisis, staying informed, supporting organized demonstrations, and now acting with LVH in our valley-wide petition. These are tumultuous times in healthcare and perhaps my best contribution is to keep reminding the Medical Staff about who we are and what we do.

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As one goes through life, one learns that if you don't paddle your own canoe, you don't move.

-Katherine Hepburn

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**CAPOE and Change**

The Veterans Administration physicians have used electronic order entry for several years. Jefferson Hospital in Philadelphia is using the same system that we now have at LVHHN. The St. Luke's Hospital system is initiating its own computer order entry system. Encouraged by coalitions for safety like the Leapfrog Group, leading hospitals around the country are moving to electronic order entry systems. CAPOE is not a pilot or a test. It's a quality and safety initiative. It's the present and the future. The day is coming when order sheets will permanently disappear from the chart. The residents will spend the rest of their careers using this or some equivalent electronic ordering system. We urge you to use the computerized order entry system for all orders on CAPOE floors. The CAPOE utilization data for each physician is now available and is being tracked. We will be recognizing those physicians who are CAPOE users. Be a leader, not a speed bump. CAPOE may take a bit longer at the start, but will become easier and faster with use. The CAPOE coordinators are doing everything possible to make the transition smooth and simple. Call them. Have them meet with you and review any problems or difficulties. Ultimately, the adjustment is to change. Please realize that healthcare is changing all around us and we need to keep pace. Change can take courage. We can do it!

**Computer prescribing reduces ED medical errors, new study finds** *11/15/2002*

Computer-assisted prescribing in a hospital ED can reduce the incidence of medical errors by eliminating problems caused by illegible handwriting, missing or incorrect information, and dosage and formulary mistakes, according to a recent study in *Academic Emergency Medicine.* Researchers from **Oregon Health & Science University** compared the incidence of medical errors in OHSU's ED that were made using handwritten prescriptions between May and June 1999 and a computer prescribing module between May and June 2000. The prescribing module was integrated into the hospital's existing computer system. The study found that computer-written prescriptions were three times less likely to include medical errors and five times less likely to require pharmacist clarification than hand-written prescriptions. The researchers conclude that computer-assisted prescribing decreased errors and improved formulary compliance, while also increasing efficiency for physicians and pharmacists and reducing wait-times for patients (Bizovi et al., November 2002).

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The race is not always to the swift, but to those who keep on running.

-Anonymous

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**Growing Organizational Capacity**

A major effort has begun to maximize the capacity and physical resources of our hospital system. This effort, which involves logistics, efficiency, and systems, has been called the Growing Organizational Capacity project. The sponsors are Lou Liebhaber, Dr. Jack Fitzgibbons and Dr. Alex Rae-Grant. The leaders and implementation team include Jim Burke, Terry Capuano, and Dr. Rick MacKenzie. There are 10 sub-project leaders in areas like bed management tracking, find-a-bed,

*Continued on next page*

expanded express admit unit, discharge process, and transport mechanics. The goal is smooth and efficient patient flow from admission to discharge, eliminating waiting times and improving patient experience. The project will require some changes in the standard processes. While the stimulus is the capacity crunch, the project is an idea whose time has come in terms of patient satisfaction.

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Don't ever take a fence down until you know the reason why it was put up.

-G.K Chesterton

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**Tort Reform Petition** – We need You!!
We have made our point about access to medical care to the community with a press conference which included all four major healthcare providers in the Lehigh Valley. We have contacted Senators Specter and Santorum, and explained our position to our State Senators and Representatives. We now need every member of the Medical Staff to gather signatures from their patients during December. After January 1, please send the petitions to the LVH Medical Staff Services office for tabulation with the other hospitals and forwarding to our legislators. The democratic process respects votes, numbers and involvement. Your political activism has been quite effective thus far. If you think this is important, you will do it.

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God put me on this earth to accomplish a certain number of things. Right now, I am so far behind, I will live forever.

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**Handwashing**
As a patient safety measure to decrease nosocomial infections, we are strongly encouraging all healthcare providers to wash their hands between all patient contacts. The two options are the standard soap and water method or the new waterless soap that is being touted by the CDC. The waterless soap dispensers are outside all patient rooms throughout the hospital. We are aware of the CDC focus on nosocomial infections and will proactively address this issue at LVH.

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Failures are divided into two classes – those who thought and never did, and those who did and never thought.

-John Charles Salak

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Doctors are not following guidelines recommending flu and pneumonia vaccinations for hospitalized adults, leaving millions of elderly patients vulnerable to potentially deadly ailments, according to a study published in Archives of Internal Medicine. (Associated Press, November 10, 2002)

Comment: We note that only 50% of adults >65 years old received the pneumococcal vaccine and only 65% get the annual flu shot. The guidelines now call for administration of these vaccines to adults during hospitalizations to boost vaccination rates. Please remember to ask about pneumonia and flu shots!

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The empires of the future are the empires of the mind.

-Winston Churchill

*Ed*

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

## *Spotlight on . . .*
## Joseph C. Guzzo, MD

Born in Newark, N.J., Dr. Guzzo completed his undergraduate education at the University of Notre Dame in South Bend, Ind., where he earned a Bachelor of Science degree. He received his medical degree from the St. Louis University School of Medicine in St. Louis, Mo. He completed his Internal Medicine residency at Temple University Hospital in Philadelphia, Pa., followed by a two-year Nephrology Fellowship at the University of Pennsylvania Hospital.

Dr. Guzzo is certified in both Internal Medicine and Nephrology by the American Board of Internal Medicine.

Dr. Guzzo joined the hospital's Medical Staff in 1979, and serves as the Chief of the Division of Nephrology. He is in practice with Eastern PA Nephrology Associates.

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

On a more personal note, Dr. Guzzo and his wife, Judy, have five children. In his spare time, Dr. Guzzo enjoys fishing.

In conclusion, Dr. Guzzo has the following "words of wisdom" to share with his colleagues on the Medical Staff: "Skepticism in the pursuit of good patient care is a virtue."

## *Pediatrician to Serve as President-Elect*

**Donald L. Levick, MD, MBA**, pediatrician, was recently nominated and elected to serve as Medical Staff President-elect for a two-year term beginning January 1, 2003.

Since joining the Medical Staff in 1985, Dr. Levick has served on a number of Medical Staff and Hospital committees including the Medical Executive Committee, Information Services Physician Committee, Managed Care Strategic Planning Committee, Pediatric Education Committee, Pediatric Executive Committee, and the Care Management Committee. Dr. Levick is also a member of the Boards of Directors of both the Lehigh Valley Physician-Hospital Organization and the Lehigh Valley Independent Practice Association. Dr. Levick has been serving as Physician Liaison with Information Services since 2000, and provides physician oversight to the hospital-wide initiative to implement the computer assisted physician order entry system (CAPOE). Previously, he served as the Chair of the Board of Governors of Lehigh Valley Physician Group, and also served as a member and Vice Chair of the Board. Dr. Levick was also the Director of the Operations Task Force of the Lehigh Valley Physician Group.

Dr. Levick graduated Magna Cum Laude from LaSalle College, where he received a Bachelor of Arts degree in Biology. He received his medical degree from the Medical College of Pennsylvania and completed his residency in Pediatrics at St. Christopher's Hospital for Children, both in Philadelphia. Dr. Levick is also a graduate of the University of Phoenix where he received a Masters in Business Administration.

Dr. Levick is a Diplomate of the American Board of Pediatrics, a Fellow of the American Academy of Pediatrics, and a Member with Advanced Standing of the American College of Physician Executives.

He is a member of ABC Family Pediatricians, a large physician practice with five office locations.

Dr. Levick and his wife, Mary Stahl Levick, MD (also a pediatrician), are the parents of three children -- Rachel, 14, Nathan, 13, and Aaron, 11.

## *News from CAPOE Central*

### Admission Orders for Patients in the Emergency Department

The expectation is that all CAPOE trained physicians will enter all admission orders for adult non-critical care patients into the CAPOE system. Until all the med-surg units at Cedar Crest & I-78 are live with CAPOE, potential exists for confusion if the ED nurses are not made aware that the orders are online. When a patient is admitted to a non-CAPOE unit, and has admission orders online, the ED is responsible for printing out the admission orders and sending them to the receiving unit with the patient. It is the responsibility of the admitting physician to make the ED aware that the orders are online. **Please either tell the ED Nurse or write on the ED chart "Admission Orders are Online."** Once all the med-surg units are live with CAPOE, this will no longer be an issue.

### Send me your top concerns via the CAPOE Feedback Button

We have received many valuable suggestions from the CAPOE feedback button. The button, located on the upper right side of the Lastword screen, opens a web form in which you can type your concerns, suggestions or complaints. The comments are directly emailed to me. This provides a great opportunity for users to provide their top concerns and issues. I read all the entries and the CAPOE team considers all the suggestions seriously. Also, if you would like a response, please include your name or user number. Otherwise, the form is completely anonymous. I look forward to your comments.

### More Published Evidence of the Benefits of POE Systems

An article in the September 2002 issue of the ***Journal of the American Medical Informatics Association*** documents the reduction of errors and improvement in patient care by use of a Computer Physician Order Entry system at Ohio State University Medical Center. The study documented that the physician order entry combined with online medication charting eliminated all physician and nursing transcription errors. The results also showed significant reductions in medication turnaround times (64% reduction, $p < .001$) and reduction in radiology procedure completion times (43%, $p<.05$).

Evidence continues to mount that physician order entry systems reduce errors and improve quality of care in hospitals with full implementation. As studies continue to be published, it is likely that physician order entry systems will become the standard of care. We have the opportunity to be on the cutting edge of this change.

If you have any questions or concerns, 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)

## *Patient Status Guidelines*

In order to be compliant with Medicare regulations, it is important for physicians to appropriately determine patient status and communicate that as part of the reservation process. Patient status should be written as part of the initial order set. Patient status may be ambulatory, observation, or inpatient. The following guidelines should be used to assist in this determination as part of the reservation process.

### Ambulatory Status

Patients who typically undergo a procedure in which they are expected to be discharged after a reasonable period of recovery --- **an overnight stay is not anticipated.**

*Ambulatory patients may be transferred to observation status if a change in condition (medical necessity) warrants further monitoring and/or treatment*.*

*Ambulatory patients may be transferred to inpatient status if a change in condition (medical necessity) warrants extensive work-up and/or treatment in which a stay of more than 24 hours is anticipated*.*

### Observation Status

If the anticipated stay of patient is less than 24 hours and the patient's condition warrants further monitoring and/or treatment. (In rare circumstances, 48 hours of observation may be allowed.)

*Observation patients may be transferred to inpatient status if a change in condition (medical necessity) warrants extensive work-up and/or treatment in which a stay of more than 24 hours is anticipated*.*

### Inpatient Status

If the patient's condition warrants extensive work-up and/or treatment in which a stay of more than 24 hours is anticipated**.

** A status change may not be made for the convenience of the patient, physician, or hospital.*

***The patient will remain inpatient if discharged before a 24 hour stay and the initial physician order was for inpatient status.*

If you have any questions regarding this issue, please contact Lisa Romano, Director of Bed Management, at (610) 402-5150.

## *Stolen/Forged Prescriptions – Reporting Process*

It is of paramount importance to make sure that all your prescription pads are located in a secure environment – either on your person at all times or in a secure/locked cabinet. Prescription pads should not be left in unsecured office patient treatment rooms. In addition, always keep them locked in a secure location when the office is closed.

DEA numbers and prescription pads can also be sold. A blank prescription can go for as much as $100 on the street.

If you ever suspect that someone has either stolen prescription blanks/pads or is forging prescriptions using your name and DEA number, please contact Pharmacy Administration at (610) 402-8881. Also, the Bureau of Narcotics Investigation and Drug Control should be contacted at (610) 791-6115. There is a retail pharmacy hotline, where the majority of retail stores are notified, based on the information reported. If necessary, the local police departments will be notified.

If you have any questions or concerns, please contact Fred Pane, RPh, Administrator of Pharmacy Services, at (610) 402-8882.

## Forgery Prevention Tip

In addition to the number, always "write out" the quantity you want dispensed for controlled substances.
e.g. Darvocet N-100 #15 (fifteen)

Recently, a patient changed the quantity of 15 to 45 on a prescription. Fortunately, the retail pharmacy picked up on the forgery. The "1" was changed to a "4."

### Safety Pearl of the Month

Recently, at another institution, a physician who intended to start his patient on Rheomacrodex (low molecular weight dextran) called the order in to the nurse as "Rheo" 10cc/hr. The nurse interpreted the order as Reopro (abciximab) 10cc/hr and transcribed it without reading it back to the physician for verification. The patient went on to receive a 24-hour infusion of Reopro.

Prevention strategy - Avoid stem words such as Rheo, Nitro, etc., and insist that verbal orders are read back to you by the nurse, pharmacist or other members of the health care team.

## *AJCC 6th Edition Cancer Staging Manual*

The American Joint Committee on Cancer (AJCC) has recently published the 6th edition of its cancer staging manual. Its TNM staging will be effective for cases of cancer diagnosed January 1, 2003. The 6th edition contains many changes, some of which are extensive revisions to common disease sites, particularly breast and melanoma.

Comparisons of the changes by site from the 5th to 6th edition can be accessed on the LVH intranet under the Department of Cancer Services. It is anticipated that this information will be posted there by the end of December, 2002. The new staging sheets for the 48 cancer sites will also be available at that time for viewing, downloading, or printing from the same site. A videotape of the AJCC 6th Edition TNM videoconference, which took place on November 21, will be available through the Tumor Registry and changes specific to the major disease sites will be discussed at their corresponding tumor boards during the beginning of 2003.

The manual is presently available and can be reviewed in the Tumor Registry. It is available as both a manual (8 1/2" x 11", softcover, $59.95) and handbook (8" x 4 1/2", softcover, $39.95). (The manual also contains a CD-ROM, which contains copies of the book's staging forms.) Copies can be ordered directly from the publisher, Springer-Verlag, in several ways:

- By calling 1-800-SPRINGER
- On the web at www.springer-ny.com
- Via e-mail: orders@springer-ny.com
- Write to: Springer-Verlag NewYork, Inc.
  Order Dept. B1024
  PO Box 2485
  Secaucus, NJ 07096-2485

Copies of the manual will be made available in the JDMCC and LVH-M cancer center libraries.

For additional information regarding the changes or to obtain the manual or videotape, please contact Mary Namiak at (610) 402-0521 or Vivian Person at (610) 402-0519 in the Tumor Registry.

## *Quality Insights of Pennsylvania*

On August 1, 2002, Quality Insights of Pennsylvania (QIP) became the new Medicare Quality Improvement Organization (QIO) for Pennsylvania. They hold the contract formerly held by KePRO. Quality Insights in now responsible for implementing the 7th Scope of Work developed by the Centers for Medicare and Medicaid Services (CMS). QIP will work with hospitals to improve care for hospitalized Medicare beneficiaries, measured by quality of care measures endorsed by CMS and others.

Quality of care measures have been identified for AMI, Heart Failure and Pneumonia patients. These measures are the same as the JCAHO Core Measures. Quality of care measures related to prevention of surgical infections have also been identified and will be monitored. Their intent is to publish these outcome measures.

In addition to their work with hospitals, they will also be facilitating improvements in physician offices, under-served and rural beneficiaries, Medicare + Choice organizations, nursing homes and home health agencies. There will be public reporting of quality indicators for nursing homes and home health agencies. Skilled Nursing Facilities (including TSU) have had their first data published in mid November. The report was based on MDS data from January through June 2002.

If you have any questions about this issue, please contact Susan Lawrence, Administrator, Care Management at (610) 402-1765 or Ruth Davis, Director, LVH-M Care Management, at (484) 884-2307.

### Mystery Medical Staff Member

? Born in New York City, NY
? Earned Bachelor of Arts degree from New York University
? Graduated from State University of New York at Buffalo School of Medicine
? Completed an internship at E.J. Meyer Memorial Hospital, Buffalo, NY
? Completed one year of residency at VA Hospital in Boston, Mass., followed by three years at Boston City Hospital, Boston
? Joined the Medical Staff in 1974
? He and his wife, Lota, have three children
? Enjoys skiing, golfing and photography in spare time

Give up? Turn to page 13 for the answer.

## *News from Rehabilitation Services*

**76 million Americans experience vestibular problems sometime in their lives.**

Do any of your patients have:

- Difficulty keeping their balance as they walk from one type of surface to another?
- A fear of falling or stumbling?
- A feeling of motion, spinning or falling when they move their heads quickly or change their position?
- A feeling that they are drifting or pulled to one side when walking?
- A sense of unsteadiness?

If so, Rehabilitation Services' Balance and Vestibular Rehabilitation Program may be able to help!

While some people's bodies can naturally compensate for vestibular and balance problems, others are left with chronic dizziness or imbalance. Vestibular rehabilitation exercises can offer an excellent and sometimes more effective treatment alternative than either medication or surgery.

In fact, once symptoms are properly diagnosed, a balance or vestibular disorder can be successfully treated with rehabilitation 90 percent of the time. These specially designed exercises help the CNS's ability to adapt, increasing a patient's postural stability and relieving the symptoms.

The Program's physical therapists are certified/specially trained in vestibular and balance rehabilitation. They evaluate a patient's current abilities and assess positions or movements that provoke their symptoms. Based on these findings, they design a customized therapy program to minimize those symptoms and improve balance.

To coordinate an appointment or to speak with a therapist with balance and vestibular training, contact Mary White, Rehabilitation Services secretary, at (484) 884-2251.

## *News from the Libraries*

In October, the Library at 17th & Chew moved to a new location and changed its name. The Health Library & Learning Center is now located on the first floor near the Center for Healthy Aging. In addition to the existing collection, it will provide some health-related consumer materials and will provide Internet access for people visiting the Center for Healthy Aging. The hours will be 8:30 a.m. to 5 p.m., Monday through Friday. The main library number will remain the same -- (610) 402-2263.

### OVID Instruction

To arrange for instruction in the use of OVID's MEDLINE and its other databases, please contact Barb Iobst at (610) 402-8408.

### Recently Acquired Publications

***Library at 17th & Chew***

- DiGeronimo, Theresa Foy. How to Talk to Your Senior Parent About Really Important Things. 2001
- Detwiler, Susan M. Detwiler's Directory of Health and Medical Resources 2001-2002. 2001

***Library at Cedar Crest & I-78***

- Lanken, Paul. Intensive Care Unit Manual. 2001
- Lerner, Alan. Little Black Book of Neurology. 2002

***Library at LVH-Muhlenberg***

- Barry, Patricia. Mental Health and Mental Illness. 2002
- Shives, Louise. Basic Concepts of Psychiatric-Mental Health Nursing. 2002

## *Practice Change*

Beginning in early December, the Huntleigh pneumatic compression device (PCD) calf sleeves and AV impulse boots will replace those previously used by the Kendall Company. This decision was made by Practice Council and a panel of experts, based on a randomized clinical trial completed recently at LVHHN on TTU and 5C. While both PCD's have been shown to be equally effective in preventing DVT's, no literature existed to evaluate compliance. With this in mind, the LVHHN trial looked at factors of satisfaction, comfort and compliance, and found that patients in the Huntleigh group reported better comfort and satisfaction scores with their PCD sleeves (less 'hot', $p = .014$, and less 'sweaty', $p = .029$) , and reported wearing their sleeves 87% of the time, compared to 81% in the Kendall group. (Just 'studying' this population increased compliance from a reported 73% of time with just the Kendall PCD sleeve during the pilot phase.) Further, nurses and clinical technicians reported significantly higher satisfaction ($p < .05$) with the Huntleigh over the Kendall in all areas, and felt it was more 'comfortable for patients' ($p < .0001$). Due to the study design, patients were comparing wearing the PCD sleeve to wearing no sleeve, while the nurses and clinical technicians were most likely comparing one product to the other.

If you have any questions or would like a copy of the complete trial report, please contact Joanna Bokovoy, Director of Health Care Research, at (610) 402-2636.

## Holiday Stress

Though the winter holidays are happy in nature and merry tunes may be playing everywhere, the holiday season may nonetheless bring on significant stress and distress. During the holiday and pre-holiday season there are many competing demands for your time. Shopping in crowded stores, cleaning and decorating your home, cooking special meals and snacks, planning a family vacation and attending holiday parties make for a very hectic, albeit exciting, schedule.

These tasks, when added to the usual demands of work and family, combine to place stress and strain not only on you, but on your pocketbook as well. No matter what your income level there never appears to be enough. Even with unlimited income one must balance generosity with the potential problems of spoiling and excess.

Unfortunately, these holiday stresses and demands come on top of the usual sources of stress such as job pressures (commuting, decision making, relationships with superiors, subordinates and co-workers), demands of children, parents and spouses, academic pressures, general financial stress and the overall problem of needing to do more things than you have time.

Yet, although stress has gotten a bad name, it is not necessarily bad. Stress is really just the body's response to change. Requiring our minds or bodies to accept challenges is not, in and of itself, negative.

It is distress that occurs when the needs for change and adaptation are required too frequently, and for long periods of time, that stress becomes a problem.

How do you know if you are under too much stress? Look for these symptoms:

- Emotional Symptoms: anxiety, depression, moodiness, phobias, major personality changes, trouble getting along with others
- Behavioral Symptoms: restlessness, withdrawal, lessened productivity, overeating, excessive alcohol consumption, problems on the job
- Cognitive Symptoms: increased distractibility, negativism, poor concentration, worrying, memory problems, obsessive thoughts, trouble sleeping
- Somatic Symptoms: high blood pressure, muscle tension, rapid heartbeat, headaches, gastrointestinal problems, decreased immunity

What should you do if you find you are frequently experiencing these symptoms? First, recognize it as a problem and be willing to change. Second, try some of these suggestions:

- Help your body cope with stress: Through relaxation, good health care, a nutritious diet and physical exercise, your body will become more adept at handling stress. Try walking more frequently. Develop an exercise program and stick to it. Take time to sit occasionally.
- Learn to set priorities: You can't possibly respond to all demands. Decide what is important to you and take care of that first. Choosing to let go of unnecessary obligations frees up your time and your mind.
- Learn to better manage your time: Establish long and short-term goals. Do the most difficult tasks when you feel most energetic. Make a schedule for yourself and stick to it.
- Set limits for yourself and others: Know when enough is enough. Don't overload yourself. Learn to say "No" when it is appropriate and to take time for yourself.
- Enlist the support of others: Don't isolate yourself when pressures begin to mount.

If you have many of the symptoms of stress listed above, try the suggestions given. But if they don't seem to work or if you have trouble implementing them, you should consider seeking professional help.

Professionals at the Preferred EAP, which manages the hospital's Employee and Physician Assistance Programs, have extensive experience helping individuals cope with the pressures of daily living.

With early intervention, you can prevent a problem from becoming a serious emotional, and possibly physical, crisis. This will mean many more happy and healthy holiday seasons for years to come.

For more information, contact Ollie Neith at the Preferred EAP at (610) 433-8550.

### Parking Issues at 17th & Chew

Lehigh Valley Hospital, 17th & Chew, has sufficient off-street parking capacity for every person that works at this site AND for anyone who needs to drop in for a meeting or other business.

Please be a "Good Neighbor" and use the appropriate physician parking lot, leaving the street parking on West Street and Chew Street for the neighbors who live there. The saving of a few extra steps isn't worth the un-neighborly reputation the hospital earns when its employees and physicians park in residential spaces.

Physician parking is located in Lot #1 in the Fairgrounds Parking Lot. If you have any questions regarding parking at 17th & Chew, please contact Jerry Kresge, Director of Security, at (610) 402-1077.

## *Congratulations!*

Three members of the Division of Orthopedic Surgery were recently installed as officers of the Lehigh Valley Orthopedic Society, which encompasses orthopedic surgeons in the Lehigh Valley from Easton to Allentown, along with members from Stroudsburg, Lehighton and Quakertown. **Walter J. Finnegan, MD**, was installed as the new president; **Mitchell E. Cooper, MD**, was named vice president; and **George A. Arangio, MD**, was named treasurer.

Over the next several months, the organization will focus on the current severe medical malpractice crisis. Dr. Finnegan, who is both a surgeon and a lawyer, is looking forward to spearheading malpractice reform efforts, especially those destined to benefit the citizens of the Lehigh Valley.

**Elliot J. Sussman, MD**, LVHHN President and CEO, was voted Chair-elect of the Council of Teaching Hospitals and Health Systems (COTH) on November 11, in Washington, D.C. He will serve as chair-elect until November 2003, when he will become Chair. COTH, of which LVHHN is a member, is a constituent component of the non-profit American Association of Medical Colleges (AAMC) and is composed of approximately 400 major teaching hospitals and health systems throughout the United States. COTH was established in 1965 to provide representation and services related to the special needs, concerns, and opportunities facing major teaching hospitals in the United States and Canada. It serves as the principal source of hospital and health system input into overall AAMC policy and direction. Dr. Sussman also serves on the AAMC's executive council.

## *Papers, Publications and Presentations*

**Jane Dorval, MD**, Chief, Division of Physical Medical-Rehabilitation, gave a presentation to the Children's Hospital of Pennsylvania on September 27, about adults with spina bifida. The presentation, titled "Outcomes: Medical, Developmental and Social" was given to ultrasonographers and obstetricians/gynecologists who handle high-risk children.

**Larry R. Glazerman, MD**, Division of Primary Obstetrics and Gynecology, was program director for an "Individualized Preceptorship in Advanced Hysteroscopic and Laparoscopic Surgery using Unembalmed Female Cadavers," held in San Francisco, Calif. The program was run by IMET -- Innovations in Medical Education and Training.

**Houshang G. Hamadani, MD**, Department of Psychiatry, presented two papers during the annual meeting of the Society for the Study of Psychiatry and Culture held in Charlottesville, Va., on October 18. The titles of the papers were "Culture, Religious Faith and Terrorism" and "Psychiatric Reaction to 9/11 Tragedy."

**Peter A. Keblish, Jr., MD**, Division of Orthopedic Surgery, Section of Ortho Trauma, served as a review editor for the first textbook devoted to mobile bearing total knee arthroplasty, a relatively new concept to the general orthopedic community. He also contributed four chapters as senior author on several aspects of total knee replacement and unicompartment knee replacement. The textbook was launched at the LCS 25th Anniversary Knee Meeting in Amsterdam. Dr. Keblish moderated two scientific sessions on total and unicompartmental arthroplasty and presented papers related to cementless prosthetic fixation, patella issues, and surgical approaches to the difficult primary total knee.

**Christopher J. Morabito, MD**, Chief, Division of Neonatology, was a visiting professor at Hershey Medical Center on October 25. He presented a talk on the "Foundations of Fetal Therapy" to the neonatology and perinatology groups, made rounds in the NICU, and participated in a clinical practice guidelines discussion.

Several members of the Division of Colon and Rectal Surgery -- **Mikhail I. Rakhmanine, MD, Lester Rosen, MD, Indru T. Khubchandani, MD, John J. Stasik, Jr., MD**, and **Robert D. Riether, MD** -- have published their experience of "Lateral Mucosal Advancement Anoplasty for Anal Stricture" in the November 2002 issue of the ***British Journal of Surgery***. They reported on 95 patients who underwent correction of anal stricture from 1981 to 1999. Eighty-two patients were followed up to 214 months for the development of re-stenosis that required re-operation. Ninety percent of the patients in the study did not develop re-stenosis during the follow-up period. This technique was originally developed and published by Dr. Khubchandani in 1985.

**Kathryn C. Worrilow, PhD**, Scientific Director, In Vitro Fertilization and Andrology Laboratories, presented the first 26 months of IVF data collected within LVHHN's Class 100 cleanroom IVF laboratory at the national meeting of the American Society for Reproductive Medicine, held in Seattle, Wash. The title of the presentation was "A Retrospective Analysis: Seasonal Decline in Implantation Rates (IR) and its Correlation with Increased Levels of Volatile Organic Compounds (VOCs)." Following the presentation, there was an overwhelming amount of questions and interest from IVF groups from all over the world. The data presented -- the significance of ambient air and subtle changes in air quality in human embryo implantation rates -- is completely new to the field of study and represents cutting edge technology.

# *Upcoming Seminars, Conferences and Meetings*

## General Medical Staff Meeting

The quarterly meeting of the General Medical Staff will be held on **Monday, December 9,** beginning at **6 p.m.**, in the hospital **Auditorium, Cedar Crest & I-78**, and via videoconference in the **First Floor Conference Room at LVH-Muhlenberg**. All members of the Medical Staff are encouraged to attend.

## GLVIPA Quarterly Membership Meeting

The next quarterly general membership meeting of the Greater Lehigh Valley Independent Practice Association will be held on **Monday, December 16**, beginning at **6 p.m.**, in the **Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78**. Pennsylvania State as well as Lehigh Valley Hospital representatives will form a panel to discuss insurance reform. Following the meeting, there will be an opportunity for additional discussion during the wine and cheese social.

**Reminder:** To receive credit for your attendance, please remember to sign in.

## 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 | Excel 97 |
| Word 97 | GUI Email | |
| PowerPoint 97 | PowerPoint 4.0 | |

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:

**2003 CBT Sessions for JDMCC, Suite 401**:
(All sessions will be held from 8 a.m. to noon)

| | | |
|---|---|---|
| January 28 | February 25 | March 25 |
| April 22 | May 27 | June 24 |

**2002 and 2003 CBT Sessions for LVH-Muhlenberg, I/S Training Room**:
(All sessions are held from noon to 4 p.m., unless otherwise noted)

December 19 - **8 a.m. to noon**

| | | |
|---|---|---|
| January 16 | February 20 | March 20 |
| April 17 | May 15 | June 19 |

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 December will include:

- December 3 - "Listeriosis: An Important Food-Borne Disease"
- December 10 - "Update on Immunotherapy for Allergy Patients"
- December 17 - "Update in Pulmonary Medicine"

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, unless otherwise noted. Topics to be discussed in December will include:

- December 3 - "Morbidity and Mortality Conference" - **LOCATION CHANGE - J&DMCC Conference Room 1A/B**
- December 10 - "Otology for the Primary Care Physician"
- December 17 - "Case Presentation"

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

*Continued on next page*

## 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 in December will include:

- December 3 - "Update on Hip and Knee Replacement"
- December 10 - "Low Molecular Weight Heparin: Therapeutic Advance or Not Quite Ready for Prime Time"
- December 17 - "Billroth and Brahms"

In addition, 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.

**Do you have an interest in participating on a Medical Staff Committee?**

In January, the Medical Staff leadership will change hands. With this change in leadership, it is an appropriate time to take a look at and make changes and additions to the membership of many of the Medical Staff committees.

If you have any interest or experience in serving on any of the following committees or would like more information, please contact Alexander D. Rae-Grant, MD, Medical Staff President-elect, or John W. Hart, Vice President, in the Medical Staff Services office at (610) 402-8980.

- Bylaws
- Cancer
- Code Blue
- Credentials
- Ethics
- Health (formerly Impaired Physician)
- Infection Control
- Institutional Review
- Medical Records
- Occurrence Analysis
- Technology Assessment
- Therapeutics (formerly Pharmacy & Therapeutics)

## *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***

**Christopher R. Ferrante, MD**
Orthopaedic Associates of the Greater Lehigh Valley
3735 Easton Nazareth Highway
Suite 1
Easton, PA 18045-8338
(610) 252-1600
Fax: (610) 250-9257
Department of Surgery
Division of Orthopedic Surgery
Provisional Active

**Eliot L. Friedman, MD**
Hematology-Oncology Associates, Inc.
1240 S. Cedar Crest Blvd.
Suite 103
Allentown, PA 18103-6218
(610) 402-7880
Fax: (610) 402-7881
Department of Medicine
Division of Hematology-Medical Oncology
Provisional Active

**Nick S. Garg, MD**
LVPG-Psychiatry
Lehigh Valley Hospital-Muhlenberg
2545 Schoenersville Road, 5th Floor
Bethlehem, PA 18017-7384
(484) 884-6503
Fax: (484) 884-6504
Department of Psychiatry
Section of Child-Adolescent Psychiatry
Provisional Active

**Jason A. Pellegrino, DMD**
Jason A. Pellegrino, DMD, PC
1617 W. Hamilton Street
Allentown, PA 18102-4213
(610) 432-4262
Fax: (610) 432-4793
Department of Dental Medicine
Division of General Dentistry
Provisional Active

*Continued on next page*

### *Change of Address*

**Samuel D. Land, MD**
**Saralee Funke, MD**
Forensic Pathology Associates Inc.
2020 Downyflake Lane, Suite 102
Allentown, PA 18103-4943
(610) 798-4460
Fax: (610) 798-4465

### *Practice Changes*

**Patricia A. deAngelis, DO**
(No longer with Bethlehem Medical Center)
Trexlertown Medical Center
6900 Hamilton Blvd.
P.O. Box 127
Trexlertown, PA 18087-0127
(610) 402-0101
Fax: (610) 402-0102

**Linda S. Loffredo, MD**
(No longer with Allentown Family Health Specialists)
Heritage Family Practice
2901 Hamilton Blvd., Suite 100
Allentown, PA 18103-2819
(610) 437-0739
Fax: (610) 437-3601

### *Status Changes*

**Robert A. Diamond, DPM**
Department of Surgery
Division of Podiatric Surgery
From: Affiliate
To: Active

**Jeffrey R. Faidley, MD**
Department of Medicine
Division of General Internal Medicine
From: Limited Duty
To: Active

**Lawrence P. Levitt, MD**
Department of Medicine
Division of Neurology
From: Active
To: Honorary

**Douglas D. Semian, MD**
Department of Medicine
Division of General Internal Medicine
From: Provisional Limited Duty
To: Provisional Active

**David B. Sussman, MD**
Department of Surgery
Division of Orthopedic Surgery
Section of Ortho Trauma
From: Active
To: Honorary

### *One-Year Leave of Absence*

**D'nese M. Sokolowski, MD**
Department of Obstetrics and Gynecology
Division of Primary Obstetrics and Gynecology
From: Active
To: Active/LOA

### *Resignations*

**Eric J. Bodish, MD**
Department of Medicine
Division of General Internal Medicine

**Michael J. McLaughlin, MD**
Department of Surgery
Division of Plastic Surgery

**Andrew T. Smith, MD**
Department of Surgery
Division of General Surgery

## Allied Health Professionals

### *Appointments*

**Louise M. Andrescavage, CRNP**
Certified Registered Nurse Practitioner
(Center for Women's Medicine - Ernest Y. Normington II, MD

**Vaishali Arjula, PA**
Physician Assistant
(Lehigh Neurology - John E. Castaldo, MD)

**David E. Bosket**
Anesthesia Technical Assistant
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)

**Kristen M. Buchman, PA**
Physician Assistant
(Colon-Rectal Surgery Associates, PC - Linda L. Lapos, MD)

**Holly Gaugler**
Anesthesia Technical Assistant
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)

*Continued on next page*

**Melissa C. Goertel, PA-C**
Physician Assistant-Certified
(Orthopaedic Associates of Allentown - Patrick B. Respet, MD)

**Kelly S. Hartshorne, RN**
Registered Nurse
(Valley Sports & Arthritis Surgeons - Barry I. Berger, MD)

**Brian K. Kephart, PA-C**
Physician Assistant-Certified
(Orthopaedic Associates of Allentown - Robert C. Palumbo, MD)

**Faithmaria M. Lauer, LPN**
Anesthesia Technical Assistant
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)

**Robert M. Mimari, CCP**
Perfusionist
(Perfusion Care Associates, Inc. - James K. Wu, MD)

**Tara L. Namey**
Genetic Counselor
(LVPG-Maternal Fetal Medicine - Robert O. Atlas, MD)

**Jason E. Peters, PA-C**
Physician Assistant-Certified
(Surgical Specialists of the Lehigh Valley - Ali Salim, MD)

**Judi A. Saxe**
Anesthesia Technical Assistant
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)

**John J. Swankoski, PA-C**
Physician Assistant-Certified
(Devendra K. Amin, MD, PC - Devendra K. Amin, MD)

**Karen E. Tiedeken, CRNP**
Certified Registered Nurse Practitioner
(LVPG-Maternal Fetal Medicine - Robert O. Atlas, MD)

**William J. Waldron, CRNA**
Certified Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)

**Jerrilyn E. Weitz, CRNP**
Certified Registered Nurse Practitioner
(LVPG-Maternal Fetal Medicine - Robert O. Atlas, MD)

**Catherine E. York, CRNP**
Certified Registered Nurse Practitioner
(The Heart Care Group, PC - James A. Sandberg, MD)

### *Change of Supervising Physician*

**Cheryl A. Tyler, RN**
Registered Nurse
From: The Heart Care Group, PC - David B. Goldner, MD
To: Valley Sports & Arthritis Surgeons - Prodromos A. Ververeli, MD

### *Status Change from RN to CRNP and Change of Supervising Physician*

**Mary A. Bealer, CRNP**
Certified Registered Nurse Practitioner
(OBGYN Associates of the Lehigh Valley)
From: Earl S. Jefferis, Jr., MD
To: Michael Sheinberg, MD

### *Resignations*

**Linda J. Barron, RN**
Registered Nurse
(Hematology-Oncology Associates Inc.)

**David W. Curran, PA-C**
Physician Assistant-Certified
(LVPG-Emergency Medicine)

**Anthony F. Friendy, PA-C**
Physician Assistant-Certified
(Bub and Young Family Medical Center)

**Kirandeep K. Gill, CRNP**
Certified Registered Nurse Practitioner
(CHOP-Pediatric Hematology/Oncology)

**David R. Hanssen**
Anesthesia Tech Assistant
(Lehigh Valley Anesthesia Services, PC)

**Matthew R. Hoppel**
Massage Therapist

**Susan A. Macomber, CRNA**
Certified Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC)

**Judith M. McDevitt, CRNP**
Certified Registered Nurse Practitioner
(The Heart Care Group, PC)

**Pamela R. Stocker, RN**
Registered Nurse
(The Heart Care Group, PC)

**Answer to Mystery Medical Staff Member**
**Robert M. Post, MD**

**REVISIONS TO THE MEDICAL STAFF BYLAWS**

**Approved by:**

**9/9/02 General Medical Staff**
**10/08/02 Lehigh Valley Hospital-Muhlenberg Board**
**11/06/02 Lehigh Valley Hospital Board**

Changes to Rules and Regulations – *E. Records*

E.RECORDS

*10.* ~~Whereas it is expected that a progress note appear daily on each patient's chart,~~ It is required that the attending physician or his/her medical staff member designee record a daily progress note on each patient's chart. ~~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.*

# THE OLD DAYS.

**It's July 1st, 1957, and it's hot ! Allentown Hospital has just issued us the high collar, starched white, " Dr. Kildare" uniforms, and Orlando Bowen is speaking to us from the podium in the auditorium - explaining our schedule of every second night on duty for the next year - with a salary of $ 200. per month.**

**Later that evening, up on the 6th floor interns quarters, the boys are playing poker in the TV room, while munching on snacks from the refrigerator - kept well stocked for us by staff secretary, Catherine Moncman. Down the hall in his room, John Clark, plastic surgery resident, is broadcasting from his ham radio set. " This is Dr. John Clark from high atop Allentown Hospital in Allentown, PA". Some guy in Alaska is receiving him. Billy Barr, Jr. is standing by the ping-pong table smoking a cigar, and telling us how tough this intern year is going to be. The switch-board operator is paging over the loudspeaker, "Dr. Kenneth R. Weston !". All the interns knew the secret code - that it was an urgent call if she used the doctor's first name and initial in the page.**

**We look out the window and see Forrest Moyer walking over from his home-office to make evening rounds on Pediatrics - like clockwork every night. Next week he is taking us up in his plane - from the Trexlertown airport. Do you know the rule on Peds ? The nurses over there say that the new intern on Peds has to help with the 6 PM infant feedings. That's right - you go over and scrub up, put on a white gown, sit down in a rocking chair, and they hand you a baby to bottle feed. ( But then, why are all the nurses looking in the window and laughing ? )**

**Anna Ziegler is in the delivery room saying, " Let the intern sleep, he needs his rest" - while two young OB residents, Stan Snyder and Joe Miller go down to the O.R. to scrub for her C-section.**

**Bob Turnbach is coming in to read late night EKG's, then make rounds up on section E - Men's Ward - where later this year several patients will succumb to the Asian Flu epidemic. There is a nurse I like up on section E.**

**Down in the lobby Morgan Person is flipping on his light switch on the doctors' board. Every winter, he and his wife have the single interns over for supper, then takes them sledding and tobogganing on the Cedar Crest College hill. Fred Helwig is coming in with him. "Fritz" takes the interns with him on house calls out in the farm country. He speaks with his patients in Pennsylvania German. Leaving the hospital is Jim Moatz, who has just set a child's fractured arm under fluoroscopy - and I thought, " Man, these docs can do everything !"**

**Tomorrow is the hospital clambake out in Hunsicker' Grove. Great swimming**

**there in the old quarry, where the water is crystal clear, cold and deep.**

**It's very late now, everyone has gone to bed - but in the distance we can hear the wail of a siren. It's our own ambulance bringing in a bad one from the New Smithville "S" curve, way out on 22 west. Soon Mrs. Creamer, RN, will be paging us to the ER - guess I'll mosey on down there now.**

**Suddenly, a loud POP from the crackling fireplace at home jars me awake. The nurse from section E is sitting beside me, and a small boy is playing beneath the Christmas tree, with his new Fisher-Price work bench from Santa.**

**He calls out, " Grand-Pop, come and play with me ! "**

**John Wheeler, MD**
**Pediatrics.**

# The Last Word...

**Tips and Techniques for the Lastword™ User, by Kim Szep, RN, BSN**

**December, 2002 – Volume 2, Issue 2**

## Easily Discharge a CAPOE Patient from the Hospital

To discharge a patient from the hospital to home or to another facility is a simple process in the CAPOE system. From the *CAPOE Order Pad*, click on the *Admitting* button. Double click on *May Discharge CAPOE Patient* from the choices presented. Then click *Process Orders*. The *Discharge CAPOE Patient Order* will present (see Figure 1). In the *TO* box, you may indicate if the patient is to be discharged to *Home* or to *Other*, but this is not a required field. In the *Comment* field you may indicate any additional information you may wish to provide, such as the name of the SNF or Rehabilitation Facility where the patient is being transferred. This field is also not required. When finished, click *Place This Order*.

If you wish to review the order you placed, access the *CAPOE Order Profile* by clicking on the *Orders* tab from the *Physician Base* screen. The order will be listed as *ADM-Discharge Patient, ONCE.*

## Start your Patient's Meds ASAP

When ordering medications in the CAPOE system, be alert for a small change. In the bottom left corner of the *Place a Medication* order screen, note *Start Now* has been changed to *Start ASAP* (see Figure 2). This is due to pharmacy turn-around time and MAR (medication administration record) charting by nurses on the CAPOE units. The expectation is the medication will be on the unit and administered in 30 minutes or less (instead of the next hospital scheduled dosing time) when this box is checked.

**Also recall,** if you are ordering most QD medications after 0900, they will default to the next 0900 on the nurses' MAR. (Coumadin and Digoxin are two exceptions, given at 1200 and 1800 respectively). Therefore, the patient may inadvertently miss a dose today. To avoid this, check the *Start ASAP* box. Fill in the exact *Start Date* and *Time* only if you want a medication to start at a particular time (i.e. noon tomorrow, etc.) To review the medication order you just placed, access the *CAPOE Order Profile*. The order will have a category of *MEDS*, followed by the ordered medication.

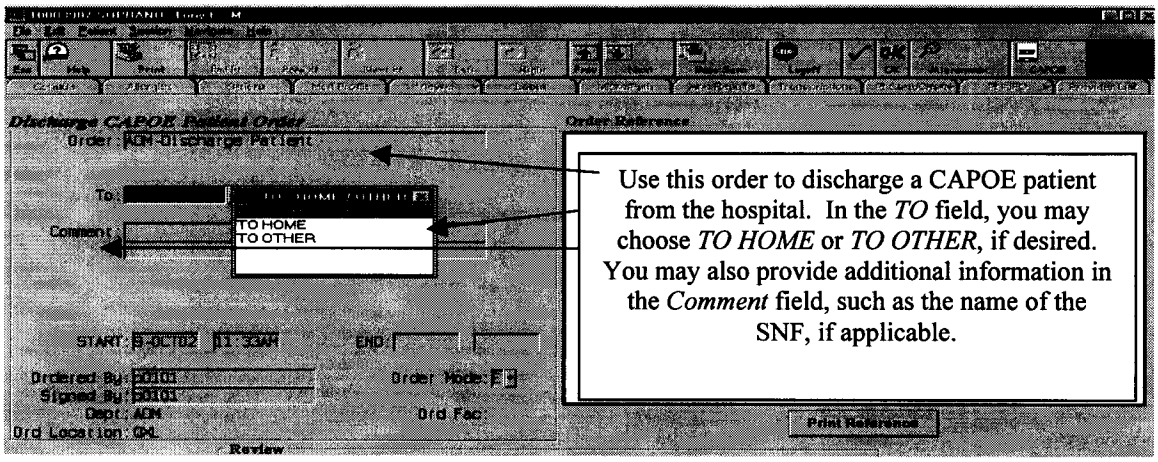


**Figure 1 - Discharging a CAPOE patient from the hospital**

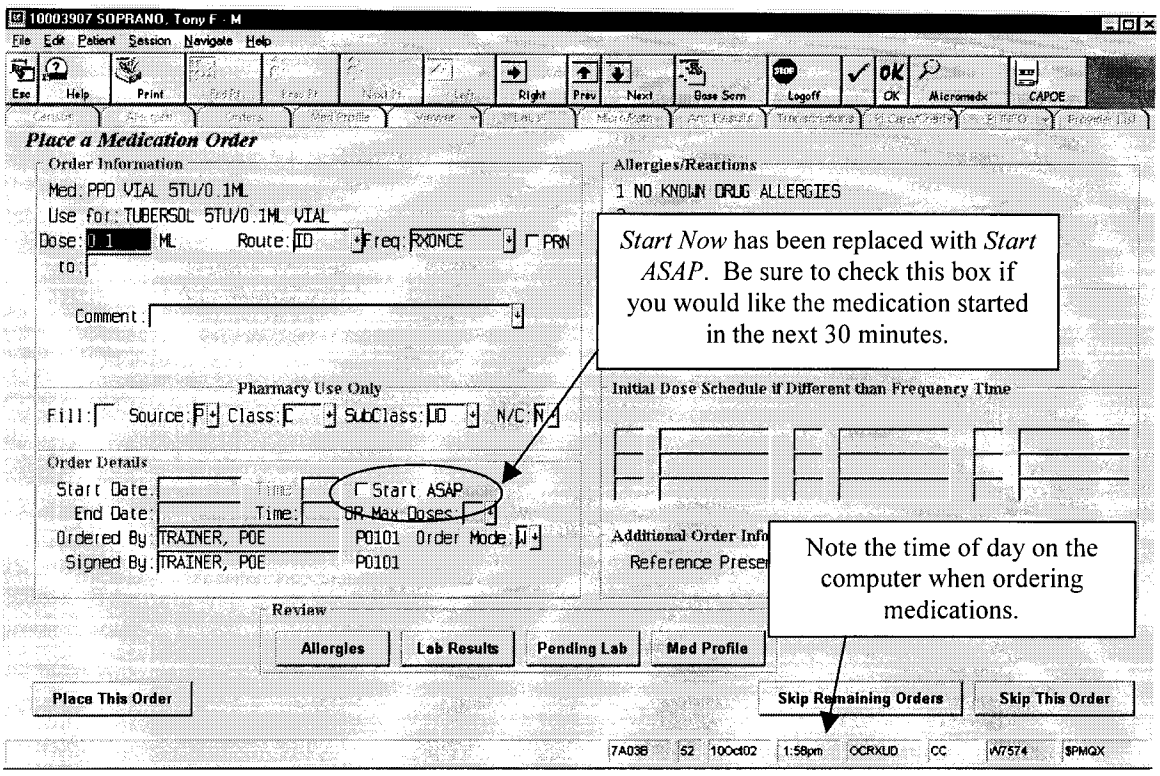


**Figure 2 - Starting medications *ASAP* instead of *Now***

## Ordering TB Testing

Physicians have asked members of the CAPOE team how to order TB tests and Anergy panels for their patients. Probably the easiest way to order TB testing is to use the provided *TB Order Set* located under the *M-Z* section of the *CAPOE Order Pad* (see Figure 3). Make sure both the *PPD* and *NURSH-Read Skin Test* orders remain checked (see Figure 4). This insures that the PPD will be administered and Nursing is reminded to read the results at the appropriate time. These orders are

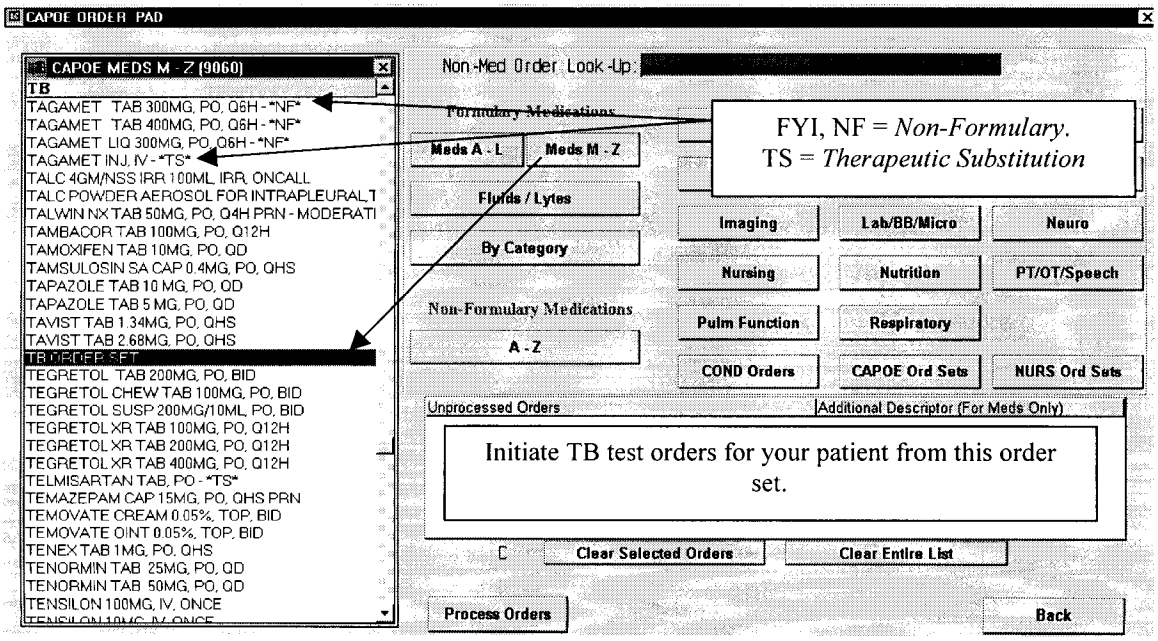


**Figure 3 - Ordering TB tests**

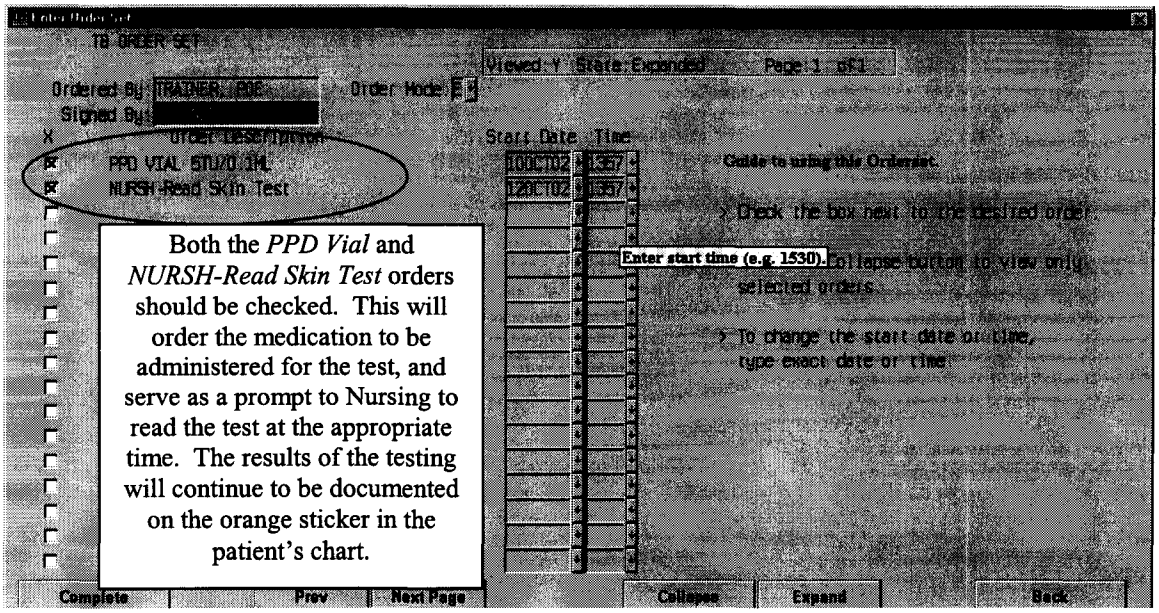


**Figure 4 – TB Order Set**

processed the same as other order sets in the CAPOE system. **Nursing will continue to document the results of all skin tests on the orange stickers found in the patient's chart in the progress notes section.**

*Anergy panels* **(including PPD testing)** are ordered under the *A-L* section of the *CAPOE* order pad. The ordering procedure is very similar to the TB test order set. Insure all the desired tests remain checked, as well as the notification to Nursing to read the skin tests at the appropriate times. The individual components of the panel may be ordered separately if desired.

Should you wish to review the orders you just placed, access the *CAPOE Order Profile*. The medications will have a category of *MEDS* and will be followed by the respective medication. The notification to Nursing to read the skin test has a category of *NURS*, followed by *READ SKIN TEST*.

## Ordering Blood Cultures

There are a few different ways to order blood cultures for your patient in the CAPOE system. From the *CAPOE Order Pad*, click on the *Lab/BB/Micro* button. The *Lab Orders* list will display. Blood cultures can be ordered from either the *Common Lab Orders* list, or may be accessed from the *Micro Orders [+]* list by double clicking to expand it. Here you will see the full range of all Micro tests that can be ordered for your patients.

Select the order desired. Order a single culture by choosing the order *Blood Culture*. Order multiple cultures by choosing *Blood Culture (Multiple) Order Set*. For the single culture (see Figure 5), be sure to specify the source of the blood draw from the choices in the drop down list. This is a required field. Change the time and date if you desire something other than the current time.

For multiple cultures, there are additional choices (see Figure 6). Specify if you would like antibiotics started after the culture is obtained, and how many cultures you would like by clicking next to each order. Process the orders as you would any order set.

To review your orders, access the CAPOE order profile. The orders will have a category of *MICR*, followed by *Blood Culture, ONCE*. The times may be different by 15 minutes for multiple cultures. This is due to the lab's interface with the hospital's computer system. Your original order will notify Nursing of exactly what you want. Remember, if you ordered *Blood Cultures x 2*, two orders should be on the *Order Profile*.

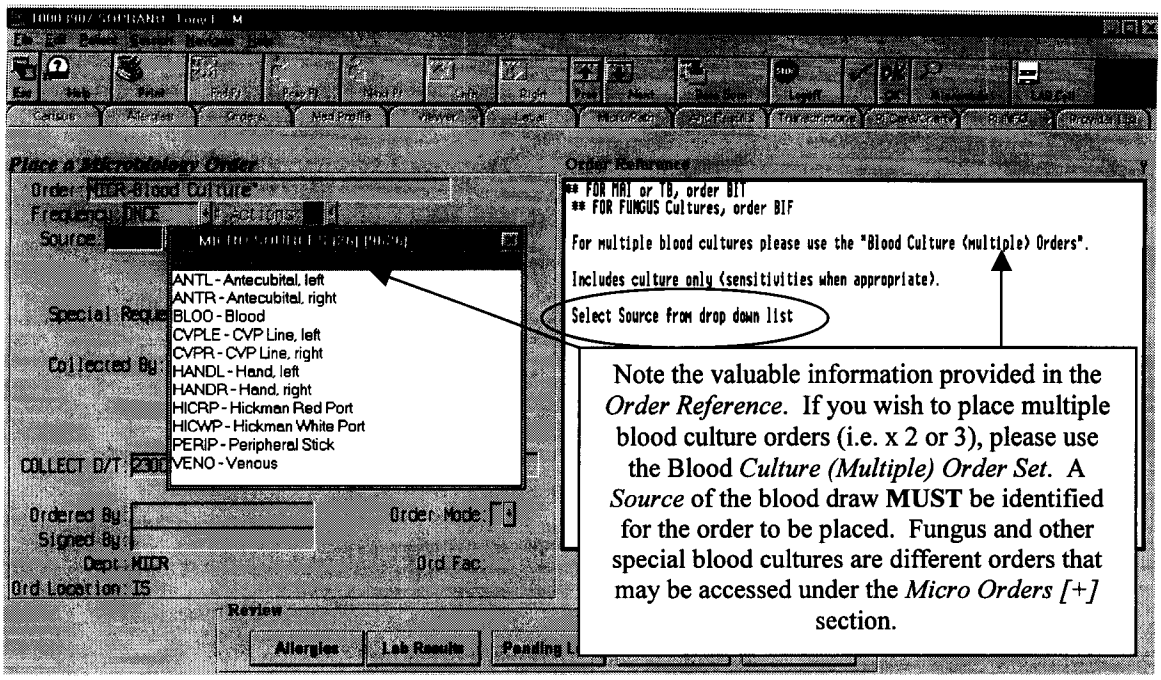


**Figure 5 - Placing a Blood Culture Order**

Should you encounter any difficulties or have questions while entering CAPOE orders, please call the **CAPOE Help Line at x 8303, option #9**. Enter your call back number and your call will be returned by the on-call CAPOE trainer/analyst. This service is available 24 hours a day, seven days a week. We will also be happy to assist with any Lastword (Phamis) questions or issues. If you have other hardware, software, or password issues, please choose **option #1** so we may provide you with optimal service.

**Physician Software Educators on staff are:**

**Lynn Corcoran-Stamm – x1425**
**Carolyn K. Suess, RN – x1416**
**Kim Szep, RN – x1431**

If you have training needs that pertain only to the Lastword (Phamis) system, please call **x1703.** Arrangements can be made for training at your convenience.

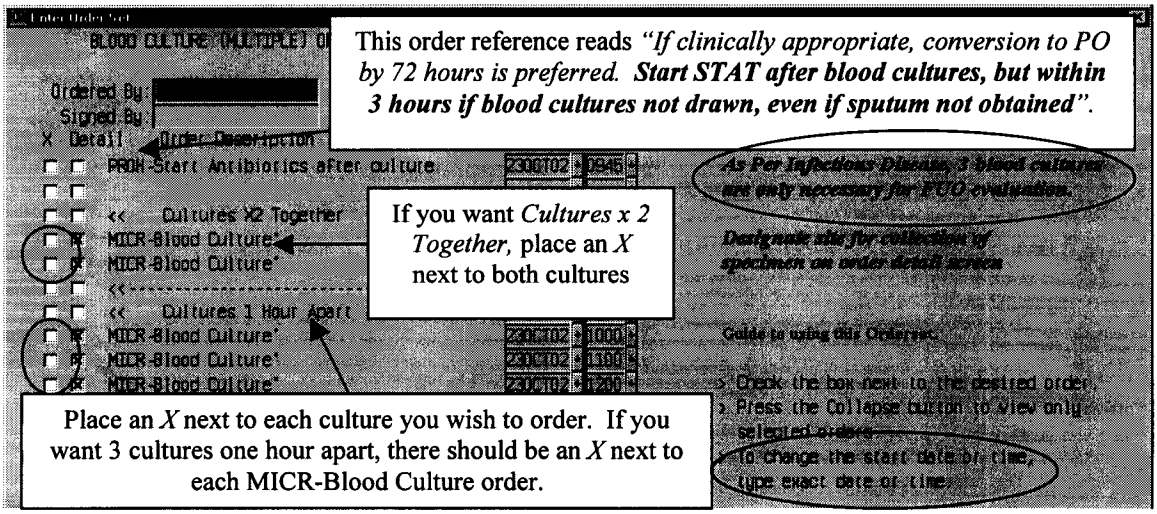


**Figure 6 – Ordering Blood Cultures**

# THERAPEUTICS AT A GLANCE

The following actions were taken at the October 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.

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## *HMG-CoA Reductase Inhibitor Addition*

Pravastatin has been added to the LVHN Drug Formulary based on primary and secondary prevention study data and its 'lack' of metabolic pathway-related drug interactions. Full autosubstitution policy will be delineated at a future meeting date. Presently, pravastatin will be autosubstituted for all fluvastatin and lovastatin orders on a mg for mg basis.

HMG-CoA reductase inhibitors are the most commonly prescribed agents for the treatment of hypercholesterolemia, due to their efficacy in lowering LDL and ability to reduce clinical outcomes in both primary and secondary prevention of coronary artery disease.[1] Currently available statins include atorvastatin, fluvastatin, lovastatin, pravastatin, and simvastatin.

**PRIMARY PREVENTION**

Two large trials have reported the effects of statins in the primary prevention of CHD. The first to be published was the WOSCOPS (West of Scotland Coronary Prevention Study),[2] a randomized, placebo-controlled trial of pravastatin 40 mg/d in 6595 men (aged 45–64) with hyper cholesterolemia but no evidence of prior MI or cardiac revascularization. The mean baseline LDL concentration for patients in this study was 192 mg/dL. Pravastatin was shown to reduce total cholesterol concentrations by 20%, LDL by 26%, and increase HDL by 5%.

After a follow-up period of 4.9 years, WOSCOPS demonstrated a reduction of 31% in nonfatal MI or CHD death (RR 0.69; 95% CI 0.57 to 0.83; $p < 0.001$). Nonfatal MIs (RR 0.69; 95% CI 0.55 to 0.85; $p < 0.001$) were also reduced significantly in the pravastatin group. A divergence between the pravastatin and placebo arms was seen six months after treatment initiation.[2]

The second primary prevention trial, the AFCAPS/TexCAPS (Air Force/Texas Coronary Atherosclerosis Prevention Study),[3] was a randomized, placebo-controlled study of lovastatin 20–40 mg/d in 6605 patients (5608 men) without coronary artery disease. It differed from WOSCOPS in two major ways: 997 postmenopausal women were included, and the mean baseline total cholesterol and LDL concentrations of the patients were near the average values in the general population (221 and 150 mg/dL, respectively). The mean baseline HDL concentration was 36 mg/dL. Lovastatin reduced LDL by 25% and increased HDL by 6%.

After an average follow-up of 5.2 years, lovastatin reduced the incidence of first acute, major coronary events by 37% (RR 0.63; 95% CI 0.50 to 0.79; $p < 0.001$), fatal and nonfatal MI by 40% (RR 0.60; 95% CI 0.43 to 0.83; $p = 0.002$), and coronary revascularization procedures by 33% (RR 0.67; 95% CI 0.52 to 0.85; $p = 0.001$). The differences in clinical outcomes appeared by one year of treatment. AFCAPS/TexCAPS was the first primary prevention trial to demonstrate efficacy in women as well as people with average cholesterol concentrations.

**SECONDARY PREVENTION**

To date, there have been three large, prospective studies with statins demonstrating reduced cardiovascular events when used in the secondary prevention of CHD. The first of these studies, the 4S (Scandinavian Simvastatin Survival Study),[4] evaluated 4444 patients (3617 men) with established CHD (angina or previous MI) treated with simvastatin 20–40 mg/d or placebo.[4] The average total cholesterol was 259 mg/dL. After a follow-up period of 5.4 years, simvastatin had reduced mean total cholesterol and LDL by 25% and 35%, respectively. Mean HDL was increased by 8%.

There was a clear reduction in total mortality (RR 0.70; 95% CI 0.58 to 0.85; $p = 0.0003$), major coronary events (RR 0.66; 95% CI 0.59 to 0.75; $p < 0.00001$), and CHD deaths (RR 0.58; 95% CI 0.46 to 0.73). There were no differences between the simvastatin and placebo groups in noncardiovascular deaths, cancers, suicides, or trauma deaths. Benefit of simvastatin became evident after approximately one year of treatment.

The CARE (Cholesterol and Recurrent Events) trial[5] involved 4159 patients (3583 men) with a history of MI in the two years prior to enrollment. Patients were randomized to receive either pravastatin 40 mg/d or placebo. The major differences between CARE and 4S were the mean cholesterol concentrations at enrollment. CARE evaluated patients with "average" mean cholesterol concentrations (total cholesterol 209 mg/dL, LDL 139 mg/dL, and HDL 39 mg/dL). Pravastatin therapy reduced mean LDL by 32%.

After a follow-up period of five years, pravastatin reduced death from CHD or nonfatal MI by 24% (RR 0.76; 95% CI 0.64 to 0.91; $p = 0.003$) and nonfatal MI by 23% (RR 0.77; 95% CI 0.61 to 0.96; $p = 0.02$). There were no significant differences in overall mortality or noncardiovascular mortality. The differences between the pravastatin and placebo arms began at two years.

The most recent and largest secondary prevention trial, the LIPID (Long-Term Intervention with Pravastatin in Ischemic Disease) trial[6] evaluated 9014 patients (7498 men) with a recent history of MI or unstable angina treated with pravastatin 40 mg/d. Mean baseline LDL was 150 mg/dL. After a follow-up period of 6.1 years, the study was stopped because pravastatin was associated with significant reductions in CHD deaths (RR 0.76; 95% CI 0.65 to 0.88; $p = 0.001$), overall mortality (RR 0.78; 95% CI 0.69 to 0.87; $p < 0.001$), MI (RR 0.71; 95% CI 0.62 to 0.82; $p < 0.001$), and coronary revascularization (RR 0.80; 95% CI 0.72 to 0.90; $p < 0.001$). The cardiovascular benefit with prava statin appeared after one year of treatment.

The above studies readily demonstrate the favorable effects of pravastatin in patients with both established CHD and patients no prior MI or cardiac revascularization events. It is the only HMG-CoA reductase inhibitor to clinically demonstrate a mortality benefit in published clinical trials for both primary and secondary prevention strategies. In addition, this agent is metabolized by sulfation and not via the cytochrome P450 isoenzyme system. This reduces dramatically the number of drug interactions that are sometimes problematic with the other statin products. It has also not been reported to cause rhabdomyolysis, when used concurrently with the fibrate, gemfibrozil. A recently published single center study (N=161) found that atorvastatin 80 mg/day

lowered low-density lipoprotein (LDL) cholesterol levels further than did pravastatin 40 mg/day, and it also reversed atherosclerosis as reflected by reduced carotid intima-media thickness (CIMT) (Sept. 23 in *Circulation).* It is the only head-to head study that has been published comparing these two agents. Of note, was the dosing strategy utilized for this study. Both pravastatin and atorvastatin have shown comparable LDL reductions at comparable doses. FDA approved dosing guidelines allow that each agent can be titrated to a dose of 80mg per day.

## *TSU Guidelines for Use of Antipsychotic Drugs*

Skilled Nursing Facilities must ensure, based on a comprehensive assessment of the resident, that:

1. When an antipsychotic drug has not been used in the past, it is not given unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record. Antipsychotic drugs should not be used unless the clinical record documents that the resident has one or more of the following specific conditions:

    - Schizophrenia
    - Schizo-affective disorder
    - Delusional disorder
    - Psychotic mood disorders (including mania and depression with psychotic features)
    - Acute psychotic episodes
    - Brief reactive psychosis
    - Schizophreniform disorder
    - Atypical psychosis
    - Tourette's disorder
    - Huntington's disease
    - Organic mental syndromes (now called delirium, dementia, and amnestic and other cognitive disorders by DSM-IV) with associated psychotic and/or agitated behaviors which:

        A. Have been quantitatively and objectively documented. This documentation is necessary to assist in:

            - Assessing whether the resident's behavioral symptom is in need of some form of intervention.

            - Determining whether the behavioral symptom is transitory or permanent.

            - Relating the behavioral symptom to other events in the resident's life in order to learn about potential causes (e.g. death in the family, not adhering to the resident's customary daily routine).

- Ruling out environmental causes (e.g. excessive heat, noise, overcrowding).

- Ruling out medical causes (e.g. pain, constipation, fever, infection).

B. Are persistent

C. Are not caused by preventable reasons; and

D. Cause the resident to:

- Present a danger to himself/herself or to others;

- Continuously scream, yell, or pace and results in an impairment of functional capacity; or

- Experience psychotic symptoms (e.g. hallucinations, paranoia, delusions) that are not exhibited as dangerous behaviors or as screaming, yelling, or pacing but result in distress or impairment of functional capacity.

- Short-term (7 day) symptomatic treatment of hiccups, nausea, vomiting, or pruritus. Residents with nausea and vomiting secondary to cancer or cancer chemotherapy can be treated for longer periods of time.

Antipsychotics should not be used if the only indication is one or more of the following:

- Wandering
- Poor self care
- Restlessness
- Impaired memory
- Anxiety
- Depression (without psychotic features)
- Insomnia
- Unsociability
- Indifference to surroundings
- Fidgeting
- Nervousness
- Uncooperativeness; or
- Agitated behaviors that do not represent danger to the resident or others

December 2002

*HIPAA UPDATE*

## *Topic: How has Research changed as a result of HIPAA?*

**Research** is defined as a systematic investigation designed to develop or contribute to generalizable knowledge. Due to recent changes in the HIPAA Privacy Rule, there is no longer the requirement of obtaining patient consent for the use of a patient's health information for treatment, payment or health care operations. This change was widely supported by the health care industry. However, it is important to note that research is not included in the definitions of treatment, payment or health care operations. The privacy rule specifically requires the researcher to obtain patient authorization to use a patient's health information (PHI) for research purposes, or if not feasible, to obtain a waiver of authorization from an Institutional Review Board (IRB) or a privacy board.

Some important points about the authorization:

- Patient authorization for the use and disclosure of health information for research purposes may be combined with the patient's consent to participate in the research.
- The authorization must describe the specific purpose of the disclosure; therefore, blanket authorizations are not acceptable.
- If the patient revokes authorization, the information obtained pursuant to a valid authorization may be used or disclosed to the extent necessary to preserve the integrity of the research study.

If it is not feasible to obtain patient authorization, the Privacy Rule allows for a waiver of authorization to be issued from an IRB or privacy board. The Rule specifies the criteria to be used in determining whether a waiver should be granted. A privacy board is similar in make up to an IRB, and is necessary for entities that do not have an IRB.

There are a few exceptions where neither patient authorization nor a waiver of authorization is required, as follows:

- **Reviews preparatory to research** provided that the researcher represents that the PHI is necessary to prepare a research protocol; no PHI is to be removed from the entity; and representation that PHI is necessary for research purposes.
- **Research on decedent's information** provided that the researcher represents in writing that the PHI sought is solely for research on decedents; documentation of the death of the individuals; and representation that PHI is necessary for research purposes.
- **Health information contained in a limited data set** may be used provided that the researcher enters into a data use agreement with the covered entity to properly safeguard the information. The limited data set may include admission, discharge, and service dates, date of death, date of birth, age, and five-digit zip code or any other geographic subdivision, except for street address.

The Office of the Institutional Review Board of Lehigh Valley Hospital is working to amend policies and create forms to comply with these HIPAA regulations.

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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.**