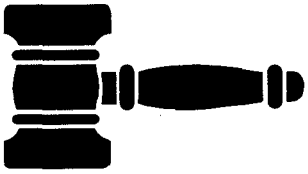
LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

PROGRESS NOTES
Medical Staff

February, 2003 Volume 15, Number 2

In This Issue . . .



From the President

The "Culture of Excellence"

"We are what we repeatedly do. Excellence, then, is not an act, but a habit." -Aristotle

Physicians exist in an environment where excellence is prized to the max. In fact, they are held to be infallible by an otherwise disenchanted and cynical public, one of the few remaining groups of professionals who are still held in high esteem. Such a status is a double-edged sword. While it encourages patients to listen when their doctor's talk and to take their advice, it also sets up the physician for unrealistic expectations. In perhaps no other line of work is the individual held to be capable of perfection. So far, no baseball player has a hit every time at bat, and no golfer cards a 59 every time out. Most football players do not score every time they carry the ball. It's a bit unrealistic to expect that in a field where nothing is certain, every patient is different, the hours are long and the demands are unrelenting, physicians will be perfect in their decisions and unerring in their instincts.

Most physicians would admit, behind closed doors, that they are not perfect. Let's face it; no human being is. Human error is an expected phenomenon, due to various perceptual, judgment, training, and emotional phenomena. Go on long enough, and we all make mistakes. So in our environment of excellence, we are set up to fail, and fail repeatedly. It is a disheartening lesson.

How can we organize to improve on nature? How can we establish an environment where we do better and better, where we approach an error free environment, knowing that human frailty lurks even under the veneer of the physicians' persona? The answer is multi-faceted, and starts with admitting that no matter how hard we try individually, we will never be perfect. Ted Williams, you can rest assured. It will always be difficult to bat .400!

The 'culture of excellence' describes an environment where excellence is prized and rewarded, supported and encouraged. It is a systematic, organizational, team approach, not an individual approach. It is the same approach used by the airline industry to continuously refine and overcome the fallibility of mortals. At LVH, we have been blessed with many of the components that are the cornerstone of excellence. We have an excellent nursing staff with high standards and

Continued on next page

national recognition. We have an excellent physical plant that promotes cleanliness and an atmosphere of professionalism. We have an extraordinary information system (There you go, Harry) which provides information on the patient, the medical literature, and communications in a heartbeat. We have support staff who make the elevators run, the floors shine, and the toilets flush. These support the culture of excellence and allow it to flourish.

So how can we, as a Medical Staff, promote excellence that is systematic and effective? Of course, it still depends on our individual effects, attention to detail, constant relearning from our prior mistakes, and underlying abilities. We need to keep bringing on board new, extraordinary partners to enrich and invigorate our institution, and instill in them the same pride in excellence that we maintain. An effective system is going to make us better; but it still does come down to each individual as the key foundation block of excellence. It has been a delight over the past two years to be able to meet bright, articulate, and optimistic young people coming to the Medical Staff to serve the community. The Medical Staff leadership interviews each and every new physician who joins the staff, about 100 per year, and have continued to be excited by the skills and talents they bring with them.

We need to continue developing systems that monitor, measure, and promote excellence, systems which allow us to be aware of systematic issues in care which hamper our move to a perfect batting average in medical care. Some systems are now in place, but more are needed. We now measure on a regular basis key statistics such as mortality for major procedures, mortality for key DRG diagnoses, falls, bedsores, DVT prophylaxis, and other measures of systematic excellence. A sad but true aspect of medical care is that boring, repetitive, brain-numbing routine may be more important than flashy, sophisticated procedures. We need to make sure that patients have DVT prophylaxis, that they get aspirin after MI, that they do not get decubitii, aspiration pneumonia, allergic reaction, the wrong medication, and any number of other irritating, predictable, and pointless problems. Systematic approaches to these key aspects of excellent care will yield more profound benefits to our patients than individual efforts can ever provide.

We need to join the airline industry in developing methods to critically and doggedly chase down sources of systematic error and find system solutions to these errors. The airline industry encourages pilots to report problems with their routines, possible sources of error, any indication at all of a breakdown in the meticulous care of their planes. The industry then utilizes this feedback to improve the system so that potential errors are eradicated at multiple levels. A failsafe system includes more than one place or step in the system where errors are perceived and prevented. For example, DVT prophylaxis is well established to save lives. There are guidelines as to who does or does not need DVT prophylaxis. There is a rich literature on how to utilize DVT prophylaxis and the relative merits of different methodologies to provide this. And despite these rich lessons, year after year we systematically fail in DVT prophylaxis. This is a no-brainer, but because it is such, it is the boring stepchild of clinical care. It is prone to be forgotten in the excitement of the diagnosis of nocardia septicemia, mitral stenosis, or a particularly juicy case of listeria rhomboencephalitis.

So in terms of this example, we are working on solutions that are systematic. The efforts by Dr. Pistoria and Dr. Pasquale and their teams to understand and improve DVT prophylaxis are important steps in the right direction. The blue bands that you should see on the arms of your patients on anti-coagulation are a step in safety for those on prophylaxis. The prompts in order sets are there to remind us to remember about DVT before we write the first order in the chart. The work on having systematic reminders in CAPOE is another level of systematic prevention of DVT and pulmonary emboli. These are only the first steps in a program that should bring us closer to perfection in this key step of care.

The Medical Staff leadership is committed to helping in the process of finding systematic and effective methods of improving care. We participate in the monthly PIC meetings where different projects of care improvement are reviewed and critiqued. We are involved in analyzing data on major indicators for care and working on making sure we are doing what we need to do in these areas. We are involved in discussing with the Chairs of the departments how to move the system forward another notch, constantly fine tuning how well we do what we already do very well.

Excellence is priceless; it is a key part of what makes Lehigh Valley Hospital a superior regional hospital. You are the core of its excellence in how you perform your duties day in and day out. You are supported by teams at multiple levels committed to helping in that endeavor. How else can you help? A key way is to bring to the attention of leadership at multiple levels any issues which may cause a lapse in excellence. If a patient doesn't get an antibiotic because of a quirk in CAPOE, help us all do better by making sure that this is recognized and the sources of error are improved, systematically (Thanks, Dr. Nuschke, for reporting this). Thanks, Dr. Rhodes, for your efforts on handwashing and helping get those dispensers for washless hand cleaners installed. Thanks, Dr. Laskowski, for your efforts in looking for systematic fixes for issues which come up at the Clinical Case Review Committee.

A culture committed to excellence must also be committed to learning where it is not excellent and fixing that. Systematically.

Alex

Alex Rae-Grant, MD
Medical Staff President

Spotlight on . . .

Luther V. (Pat) Rhodes, MD

Born in Lewistown, Pa., Dr. Rhodes was Valedictorian of his class at Lewistown High School. He took Pre-Med at the Pennsylvania State University in State College from 1963-1966. He received his medical degree from Loyola University, Stritch School of Medicine, Maywood, Ill., where he graduated Summa Cum Laude and Valedictorian. Dr. Rhodes did his medical internship and first year of medical residency at the University of Chicago Hospitals, Chicago, Ill. He served in the U.S. Navy on Guam at the Navy Hospital from 1971-1973 where he practiced largely OB-GYN. His ID Fellowship was with Dr. Maki at the University of Wisconsin, followed by a second year fellowship at Lehigh Valley Hospital with Dr. Gary Lattimer.

Dr. Rhodes is certified in both Internal Medicine and Infectious Diseases by the American Board of Internal Medicine.

Dr. Rhodes joined the hospital's Medical Staff in March, 1977, and has served as Chief of the Division of Infectious Diseases since 1979. He serves as Chairman of the Infection Control Committee, and medically oversees the hospital's Department of Infection Control. Dr. Rhodes has a special interest in bioterrorism preparedness, including the smallpox vaccination effort. He is the founding partner of the Allentown Infectious Diseases group. He serves as a Clinical Associate Professor of Medicine at Pennsylvania State University College of Medicine.

He is a Fellow of the American College of Physicians, and a Member of the Infectious Diseases Society of America.

In his spare time, Dr. Rhodes enjoys swimming and yard work.

Dr. Rhodes has the following comments to share with his colleagues on the Medical Staff: "I am blessed to be working with about the best group of physicians I could have ever hoped for. I learn from them each and every day."

"Keeping one's focus on the patient is about the single best piece of advice I would offer any physician."

News from CAPOE Central

Live in PACU - Urologists Get into the Flow

CAPOE went live in the PACU in early January, starting with the Urology Division. The Urologists have been quite cooperative, and most have entered their post-op orders on-line, directly from the PACU. Based on their feedback, changes have already been made to the post-op order sets, incorporating both individual and division-wide suggestions. Nursing and Pharmacy continue to adapt to the new procedures with incredible patience and ease. Plans are being made to bring the other Surgical Divisions live in the PACU over the next several months.

Communication

When entering admission orders on-line from the ED, or when placing post-op orders in the PACU, please remember to inform the nursing staff that your orders are on-line. This can be done verbally or by writing an order in the chart. To facilitate this communication, stickers have been developed that read, "Orders are On-line." These stickers can be found in the Emergency Department and in the PACU at Cedar Crest & I-78, and can be placed on the orders section of the chart. This will decrease any potential confusion about the orders while we are still living in the dual world of on-line and paper orders.

Order Sets 'R Us

As we work with the Medical Staff and Residents, I am increasingly convinced that order sets are critical to increasing efficiency with the CAPOE system. Order sets can be created for admitting diagnoses (pneumonia, trauma, stroke), for diagnostic evaluations (anemia evaluation, PE evaluation, fever evaluation), or for commonly grouped orders ("CBC, BMP, CXR in AM"). These mini-order sets can be created at the division, group or individual level. Please write them down and give them to anyone on the CAPOE team, send them inter-office to me, or email me with your requests. We will contact you with any questions or clarifications and work on them as quickly as we can.

Don Levick, MD, MBA
Physician Liaison, Information Services
1245 S. Cedar Crest Blvd.
Allentown, PA 18103
(610) 402-1426 (office)
(610) 402-5100 7481 (pager)

Important Message to Physicians

Retroactive to November 1, 2002, **Lehigh Valley Hospital-Muhlenberg** is contracted with Independence Blue Cross, which includes Personal Choice and Keystone Health Plan East. Both Lehigh Valley Hospital-CC and Lehigh Valley Hospital-Muhlenberg are Full Service in Network Facilities.

The Smallpox Initiative

Due to a heightened concern about the use of the smallpox virus as a terrorist weapon, the Pennsylvania Department of Health (DOH) recently released a Smallpox Vaccination Plan. The plan calls for hospitals to begin pre-event (before an actual case of smallpox is detected) planning. This is being accomplished regionally in partnership with local public health officials. The advantages of preparedness include: reducing the potential for paralysis of our health care delivery system, and devaluing the weapon potential of the smallpox virus. The Homeland Security Act of 2002, which becomes effective on January 24, 2003, is expected to result in a flurry of activity in the state and local public health departments as that will be the "kick-off" for implementation of the state plan. Since that also means the start point for smallpox immunizations in public health officials, it is also likely to draw more media attention to the smallpox initiative.

The DOH plan calls for smallpox to be given in three phases:

- First, volunteers from the public health arena and hospitals would be vaccinated to create a cadre of people to respond in the event of an outbreak
- The next group would be additional health care workers, emergency responders and law enforcement, and
- Finally, the DOH plan currently anticipates that vaccine would be available to the general public sometime in 2004.

As an organization, we continue planning and organizing activities for this initiative. At a minimum, LVH will be involved in the first stage of the DOH plan; additional scope beyond that will require further evaluation. There are two elements of this initiative that are absolutely essential: 1) vaccination is strictly voluntary, and 2) safety will be maximized by an unprecedented effort to screen all applicants. Because there are mild and serious vaccine complications, in addition to screening, education and post-vaccination monitoring will also be areas of emphasis. Contraindications for the vaccine, for either the health care worker or their family, include:

- Immunosuppression
- Pregnancy
- Dermatologic:
  absolute: eczema and/or atopic dermatitis
  relative: burns, acne, herpes, psoriasis, seborrhea, any skin disruption

On January 7, the Grand Rounds presentation by Dr. Luther Rhodes and Dr. Alan Schragger was "What You Need to Know as a Health Care Provider about Smallpox." It was a well-received presentation and, since then, many requests have been received for copies of the handouts.

If you have any questions regarding this issue, please contact Debra Geiger, newly appointed project manager, at (610) 402-4589.

Lehigh Valley Community Urges Medical Liability Reforms

At a press conference held on January 10, 2003, hospital executives and medical leaders in the Lehigh Valley announced that more than 23,000 signatures were collected during a petition campaign to urge federal and state government to enact additional medical liability reforms. The announcement was made jointly by representatives of Easton Hospital, Lehigh Valley Hospital and Health Network, Sacred Heart Hospital, and St. Luke's Hospital & Health Network. The petition drive began October 30 and concluded at the end of December, 2002.

"This shows how important it is to the community we serve that we continue to provide unimpeded access to high quality care," said Elliot J. Sussman, MD, president and CEO of Lehigh Valley Hospital and Health Network. "In 62 days, more than 23,000 signatures have been collected, which represents about one in every 21 adults in the Allentown, Bethlehem and Easton region who are served by our four hospitals."

The hospital representatives presented copies of the petitions to U.S. Rep. Pat Toomey, R-Pa., who was invited to attend the petition announcement to discuss his commitment to medical liability insurance reform at the federal level.

"This impressive grassroots effort demonstrates the widespread concern patients, doctors and hospitals have over the growing medical liability crisis," Rep. Toomey said. "What we're advocating today is real reform that is in the best interest of the health care providers and patients."

"Congressman Toomey has been an advocate for healthcare in the region, and we applaud his efforts," said Cornelio Catena, Easton Hospital's president and CEO. "It is our hope that this strong show of support on behalf of the area's hospitals and the community will send a strong message about the critical need for long-term, meaningful medical malpractice reform in Pennsylvania. For our doctors and our community, change cannot come too soon. Stories about physicians who are leaving the state, retiring early, or limiting their practice are becoming the common practice in Pennsylvania."

In addition to Rep. Toomey, state and federal elected officials representing the Lehigh Valley will receive copies of the petitions and a letter announcing the results.

The health care officials had urged the community to participate by filling out an electronic petition on the Internet, or by signing paper petitions in the hospitals' lobbies and at many physicians' offices throughout the Lehigh Valley. The electronic petition was available at www.keepdocsinthevalley.org. The four organizations provided links to the site – The Lehigh Valley Physician-Hospital Advocacy Network -- through their individual web home page.

News from Health Information Management

Delinquent/Incomplete Medical Records

The Medical Record Committee would like to take this opportunity to commend the medical staff on timely completion of medical records. The medical record delinquency rate remains well below the regulatory guidelines. It appears to have become common practice that the medical reports are being dictated prior to patient discharge resulting in better continuity of patient care.

Discharge Summary

A discharge summary insures continuity of high quality patient care. It provides a valuable tool for the physician on follow-up in the physician's office, patient readmission as well as providing a tool for accurate coding/DRG assignment for both the hospital and physician. For your assistance the following items should be included in the discharge summary narrative.

Diagnoses

Principal Diagnosis – According to the Uniform Hospital Discharge Data Set (UHDDS), it is "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
Secondary Diagnoses/Co Morbid Conditions – Any conditions that were treated while the patient is in the hospital or conditions that affect or complicate the hospital stay.

Procedures

All relevant diagnoses and operative procedures should be recorded using acceptable disease and operative terminology that includes topography and etiology as appropriate.

Reason for Hospitalization – Brief clinical statement of the chief complaint and history of present illness.

Significant Findings – Pertinent lab, x-ray and pathology findings. Negative results may be as pertinent as positive results.

Treatment Rendered – Include medical as well as surgical treatment noting the patient's response, complications and consultations.

Condition of Patient on Discharge – State in specific terms relative to condition on admission. Avoid use of vague terms such as improved. The presence and status of drains, wounds, and sutures should be noted.

Special Instructions to the Patient and/or Family – Include physical activity, medications, diet and follow-up care.

Illegible Handwriting

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

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

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

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

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

Coding Tip of the Month

With reference to updated inpatient coding guidelines effective August 1, 2002:
"For inpatient coding, if the attending physician does not confirm the pathological findings, query the attending physician regarding the clinical significance of the findings and request that appropriate documentation be provided." (Coding Clinic 2nd Quarter 2002, Article 22)

Regarding the above excerpt from coding guidelines, a coder cannot assign a code for findings on a pathology report *UNLESS* the findings have been documented by the attending physician. In cases where the attending physician does not document these findings, the coder may query the physician asking for these findings to be documented.

New ICD-9-CM Codes for 2003

Over 140 new ICD-9-CM codes for 2003 became effective on October 1, 2002. These codes were decided upon by The Centers for Medicare and Medicaid Services (CMS) in response to requests from medical specialty societies who want the codes to reflect the current state-of- the-art of medical science.

Thirty new V codes that describe follow-up care more specifically will provide more information about the underlying problems requiring aftercare. The V code expansion will enable hospitals to capture much greater detail. Four new V codes were also added to track events related to terrorism, as well as codes for diagnoses related to ectopic pregnancies.

Since Cardiovascular disease is a major disorder in this country, a significant number of code changes and additions were developed to allow greater specificity in reporting heart failure and specific vascular problems. CMS feels that the new heart failure codes represent the latest and greatest advances and understanding of heart failure. Their rationale behind the new codes for diastolic and systolic heart failure is that each condition is treated differently. Documentation of whether the patient has acute or chronic systolic or diastolic heart failure is key to assigning the correct code.

Four new codes to describe systemic inflammatory response syndrome (SIRS) by origin and organ involvement will specify whether it is a result of an infectious process or a non-infectious process.

The new codes for post-phlebetic syndrome require documentation by the physician if there is a link to past DVT with the current problem, i.e., ulcer and inflammation.

While the new codes will help hospitals gather more specific data, more specific physician documentation will be required in order to code to greater specificity.

If you have questions, please contact Arlene Lampart, HIM Operations Coordinator, at (610) 402-2871.

Attention Authors!

It is the intention of the Health Studies Unit at 17th & Chew to become a repository of published articles, book chapters, letters to the editors, etc., which members of the LVHHN staff produce. Therefore, all authors are requested to submit a copy of their work, shortly after publication, to William Cosgrove, Director of Administration, Health Studies, 17th & Chew Streets. Access to the collected works in this repository will be open to all LVHHN staff.

Radiology News

Lehigh Magnetic Imaging Center

During the first half of November, Lehigh Magnetic Imaging Center (LMIC) began scanning its first patients on its new General Electric OpenSpeed Open Magnet. The OpenSpeed represents the most advanced technology in open magnet design. At .0.7 Tesla, this high field open magnet is more than twice the field strength of most open magnets currently on the market and approaches traditional high field magnets in the quality of images it produces. Due to improved image quality, it is anticipated that many claustrophobic patients who previously had been scanned under anesthesia on a high field magnet will be good candidates for the OpenSpeed.

The OpenSpeed considerably increases LMIC's capabilities in performing studies not previously available on an open magnet. This currently involves MRA of the head and neck, and will shortly include MRA of the abdomen and diffusion weighted imaging of the brain to assess stroke.

For more information or if you have questions regarding this issue, please contact Elliot I. Shoemaker, MD, Vice Chairperson, Department of Radiology-Diagnostic Medical Imaging, at (610) 402-8088.

Nuclear Medicine

The mobile PET scanner is here every Wednesday and every other Tuesday. We are presently averaging about 15 patients per week. Medicare reimburses for the staging, restaging and monitoring therapy of the following: lung cancer, colon cancer, lymphoma, breast cancer, myeloma, esophageal cancer, head and neck cancer excluding thyroid and brain tumor. In the near future, many other indications will be reimbursed by Medicare including gynecologic cancer and multiple myeloma. Other indications may be covered by Medicare or other insurance companies if pre-approved as a necessary part of the patient's workup.

At Lehigh Valley Hospital, Cedar Crest & I-78, gated tomographic myocardial perfusion studies are currently being performed utilizing a dual isotope technique, which includes a resting thallium scan and a gated Myoview scan. This allows a more comprehensive nuclear cardiology examination that includes myocardial perfusion, and evaluation of left ventricular wall motion and left ventricular ejection fraction.

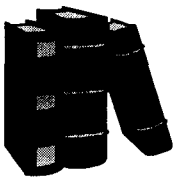
If you have any questions regarding this issue, please contact Robert J. Rienzo, MD, Chief, Section of Nuclear Medicine, at (610) 402-8373.

News from the Libraries

UpToDate Database
The UpToDate database is not new, however, new disciplines continue to be added to it. The following description was obtained directly from the UpToDate website. The content is "comprehensive and fully referenced and goes through an extensive peer review process to ensure that the information and recommendations you access from our service are accurate and reliable." The focus of the topics is primarily internal medicine and its subspecialties, obstetrics and gynecology and family practice. Pediatric topics are being added to the database in addition to expanding coverage in the areas of neurology and allergy and immunology.

The number of topics represented in UpToDate is not as exhaustive as those contained in a textbook, however, the advantage is that topics are reviewed and frequently edited to reflect the current literature.

Ovid Training
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

- Washington University. Washington Manual of Medical Therapeutics. 30 ed. 2001
- Katzung. Basic & Clinical Pharmacology. 8th ed. 2001

Library at Cedar Crest & I-78

- Berek. Novak's Gynecology. 13th ed. 2002
- Donegan. Cancer of the Breast. 2002

Library at LVH-Muhlenberg

- Kanner. Pain Management Secrets. 2003
- Sonis. Oral Medicine Secrets. 2003

Please forward new book suggestions to Barbara Iobst at the Cedar Crest & I-78 Library.

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 as of 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. The new staging sheets for the 48 cancer sites are also available 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 are also available in the JDMCC professional library, the LVH-M Cancer Center library, and the medical libraries at each campus.

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

Got Those Post-Holiday Blues?

The post-holiday blues -- those gloomy feelings that often come when the holidays are over and life returns to normal.

If you have them this year, there is no reason to face them alone. Just call the **Physician Assistance Program (PAP)**, which can offer you confidential, professional, short-term counseling to help you beat the post-holiday blues.

The Physician Assistance Program is a confidential (and if so desired, anonymous), professional counseling and referral service available to all members of the Medical Staff of Lehigh Valley Hospital and their dependents.

This service is provided through an agreement with Preferred EAP which operates the Lehigh Valley Hospital's Employee Assistance Program (EAP) and has been involved with over 4,000 employees and dependents since 1985.

The program is staffed by highly trained, experienced counselors. Their expertise in providing professional help in solving personal problems, plus the guarantee of confidentiality, makes the PAP an appealing benefit.

Preferred EAP is capable of handling a wide range of concerns. According to Oliver Neith, Program Director, "any problem that can turn a bad day into a bad week or a bad week into a bad month is appropriate for the EAP."

Please remember that the services of Preferred EAP are:

- CONFIDENTIAL: no one, not even family members, will know you have used the EAP unless you want them to. In addition, there are separate entrance and exit doors to further safeguard your privacy.
- COMPREHENSIVE: the EAP can assist you with any problem that turns normal stress into distress or a bad day into a bad week. There's no need to wait until the problem is overwhelming -- it's never too soon to call for help.
- AVAILABLE: you and your family members are eligible for between 1 and 5 counseling sessions per year at no cost to yourself.
- EASY TO USE: If you want to make an appointment or just get more information, call Preferred EAP offices at (610) 433-8550 or 610-770-7690.

Remember, you don't have to go it alone. If you have those "Post-Holiday Blues" and if you need to talk, Preferred EAP is there to listen!

Meal Bar Code System

Over the next several weeks, the Food Service Department will begin implementing a new food account scanning system at all locations. For physicians with existing food service accounts, the changeover should be fairly unnoticeable. The only changes will be new registers and the magnetic strip on the back of your photo ID will be read, rather than the barcode.

If you have any questions regarding this new system, please contact Paul Fite in the Food Service Department at (610) 402-8314.

Congratulations!

John P. Fitzgibbons, MD, Chairperson, Department of Medicine, has been elected as a Governor of the American College of Physicians representing Eastern Pennsylvania. The American College of Physicians is the nation's largest medical specialty society with about 115,000 members representing general internal medicine and all the medical subspecialties. The College is involved in Continuing Medical Education for physicians and also is a strong advocate on public policy issues facing medicine. The College has position statements on a variety of policy issues and College leaders often testify before congressional committees and serve on federal commissions and task forces. Dr. Fitzgibbons will assume his position as Governor at the ACP Annual Meeting in San Diego in April, 2003.

In addition, Dr. Fitzgibbons was informed that he will be the President-elect of the Association of Program Directors in Internal Medicine. This organization represents all of the internal medicine training programs in the United States and is responsible for all the subspecialty training fellowships. The Association is well known for its advocacy for quality in Graduate Medical Education. He will assume the Presidency in April, 2004.

Gregor M. Hawk, MD, Division of Orthopedic Surgery, Section of Ortho Trauma, will be inducted into the American Academy of Orthopaedic Surgeons on February 5. He is one of 603 new Fellows. The Academy is the largest medical association for musculoskeletal specialists.

Papers, Publications and Presentations

Geoffrey G. Hallock, MD, Division of Plastic Surgery/Hand Surgery, Section of Burn, was an invited speaker at the recent annual meeting of the American Society of Plastic Surgeons in San Antonio, Texas. The topic he was requested to discuss was on "Flap Priorities for Severe Lower Extremity Trauma." This consisted of a review of his past 20-year experience in taking care of difficult traumatic injuries at Lehigh Valley Hospital and unique ways for their management, including the transfer of free flaps and microsurgery as indicated.

Shannon Kearney, DO, third-year Internal Medicine resident, and **Marc Ellman, MD**, former transitional resident, recently served as medical editors for a new edition of "How to Live 365 Days a Year," a New York Times bestseller originally published in 1955. The book, which has sold more than one million copies, went out of print in the early '80s. Last year, Running Press of Philadelphia purchased the rights and published a revised edition. The book contains a mixture of health and self-help information and is believed to be the first book to explain the link between emotional stress and physical illness in layman's terms. Drs. Kearney and Ellman were recruited by Running Press to ensure the accuracy and update the medical content contained in the book, while maintaining the primary messages of the original author, John Schindler, MD.

Fred Laufer, MD, Department of Family Practice, presented a lecture on "The Treatment of Veins and Other Laser Procedures" along with patient demonstrations at the Clinical Education Conference of the Pennsylvania Academy of Family Physicians, held in Baltimore, Md., in November.

Zubina M. Mawji, MD, MPH, Division of General Internal Medicine, presented "From Baseball to Ice Hockey: The Physician's Role in Quality Healthcare" at Medical Grand Rounds at Easton Hospital on January 17.

Patrice M. Weiss, MD, Director of Medical Education for the Department of Obstetrics and Gynecology, authored, and **Craig Koller**, CEDS Liaison to the Department of Obstetrics and Gynecology, presented posters on the "Ability of Residents to Assess Medical Students' Fund of Knowledge as Measured by Performance on the NBME Shelf Exam in Obstetrics and Gynecology" at the 26th Innovations in Medical Education Exhibits, Annual Meeting of the Association of American Medical Colleges, in San Francisco, Calif., in November, 2002, as well as at the 10th Ottawa Conference of Medical Education in Ottawa, Canada, in July, 2002. The poster was also co-authored by **Craig J. Sobolewski, MD**, Chief, Division of Gynecology and Residency Program Director of OB/GYN; **Namita Singh, MD**, OB/GYN Chief Administrative Resident; Craig Koller, and **Teresa Benner**, Administrative Secretary, Department of Obstetrics and Gynecology.

Upcoming Seminars, Conferences and Meetings

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 will be held in **Information Services (Educational Room) at 1245 S. Cedar Crest Blvd., First Floor**, 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 Information Services Educational Room: (All sessions will be held from 8 a.m. to noon)

February 25	March 25	April 22
May 27	June 24	

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

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.

Continued on next page

Emergency Medicine Grand Rounds

Emergency Medicine Grand Rounds are held on Thursdays, beginning at 8 a.m., at various locations. Topics for February will include:

February 6 - LVH-Muhlenberg, Banko Building Rooms 1 & 2
- Pediatric Case Review
- "Asthma" and "Physician Wellness"
- Hypothermia

February 13 - St. Luke's Hospital, Laros Auditorium
- Base Station Command Course

February 20 - EMI - 2166 S. 12th Street
- Adrenal Disease
- Renal Patients
- Resident Case Presentation
- Tintinalli (pages 1565-1609)

February 27 - LVH-Muhlenberg, 4th Floor Conference Room
- Resident Case Presentation
- Recent Trauma Literature
- Tintinalli (pages 1609-1661)

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

Medical Grand Rounds

Medical Grand Rounds are held every Tuesday beginning at noon in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78, and via videoconference in the First Floor Conference Room at LVH-Muhlenberg. Topics to be discussed in February will include:

- February 4 - "Smoking Cessation"
- February 11 - "Life after Cancer -- What Happens to Cancer Survivors"
- February 18 - "An Integrated Approach to Insomnia"
- February 25 - "The Japanese Healthcare System -- Lessons for America"

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. Pediatric conferences are held in the **Education Conference Room 1** at Lehigh Valley Hospital, Cedar Crest & I-78, unless otherwise noted. Topics to be discussed in February will include:

- February 4 - "Morbidity and Mortality Conference"
- February 11 - "Early Head Start: Outcomes, Child Health and Initiatives"
- February 18 - "Catheter Treatment of Congenital Cardiac Defects in Children"
- February 25 - "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 in February will include:

- February 4 - "Renal Cell Carcinoma with Vena Cava Extension"
- February 11 - TBA
- February 18 - TBA
- February 25 - "Non-operative Management of Abdominal Gun Shot Wounds"

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.

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

New Appointments

Cindy M. Barter, MD
Lehigh Valley Family Health Center
1730 Chew Street
Allentown, PA 18104-5595
(610) 402-3500
Fax (610) 402-3509
Department of Family Practice
Provisional Active

Arnold H. Levine, 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

Brad H. Lilly, DPM
William T. DeFeo and Associate
Trexler Park Medical Arts Building
3131 College Heights Blvd., Suite 1500
Allentown, PA 18104-4890
(610) 821-0444
Fax: (610) 820-7006
Department of Surgery
Division of Podiatric Surgery
Provisional Active

Cathleen D. Roberts, DO
Good Shepherd Physician Group
501 St. John Street
Allentown, PA 18103-3296
(610) 776-3340
Fax: (610) 776-3168
Department of Pediatrics
Division of Pediatric Subspecialties
Section of Developmental-Rehabilitation
Provisional Associate

Y. Lynn Sun, MD
Lehigh Neurology
1210 S. Cedar Crest Blvd., Suite 1800
Allentown, PA 18103-6208
(610) 402-8420
Fax: (610) 402-1689
Department of Medicine
Division of Neurology
Provisional Active

Daniel Q. Yeager, MD
Good Shepherd Physician Group
501 St. John Street
Allentown, PA 18103-3296
(610) 776-3340
Fax: (610) 776-3168
Department of Medicine
Division of Physical Medicine-Rehabilitation
Provisional Active

Tim M. Zheng, MD, PhD
Health Network Laboratories
Lehigh Valley Hospital-Muhlenberg
2545 Schoenersville Road
Bethlehem, PA 18017-7384
(484) 884-4267
Fax: (610) 867-7318
Department of Pathology
Division of Anatomic Pathology
Provisional Active

Practice Change

Sangeeta Agrawala, MD
(No longer with ABC Family Pediatricians)
Zahra Pediatrics
11 Kevin Lane
Brodheadsville, PA 18322-9731
(570) 402-3175
Fax: (570) 402-3189

Michele D. Jones, DO
(No longer with Pottsville Hospital)
Easton Area Occupational Health Services
3601 Nazareth Road
Easton, PA 18045-8336
(610) 559-8520
Fax: (610) 559-8524

Continued on next page

Address Changes

Macungie Medical Group
- **Hal S. Bendit, DO**
- **Jill Bortz, DO**
- **William J. Liaw, DO**
- **Michael C. O'Connor, DO**

3760 Brookside Road, Box 487
Macungie, PA 18062-1741
(610) 966-4646
Fax: (610) 965-6201

Patrice M. Weiss, MD
OB-GYN Administration
Lehigh Valley Hospital
17th & Chew, P.O. Box 7017
Allentown, PA 18105-7017
(610) 402-9515
Fax: (610) 402-9688

Address/Phone/Fax Correction

Albert D. Abrams, MD
Orthopaedic Associates of Allentown
1243 S. Cedar Crest Blvd.
Suite 3500
Allentown, PA 18103-6268
(610) 437-9880
Fax: (610) 437-9884

Phone/Fax Correction

Kerry D. Miller, MD
(610) 776-5038
Fax: (610) 776-1967

Additional One-Year Leaves of Absence

Anjam N. Bhatti, MD
Department of Medicine
Division of General Internal Medicine

Joseph R. Drago, MD
Department of Surgery
Division of Urology

John M. Kauffman, Jr., DO
Department of Medicine
Division of General Internal Medicine

William J. Vostinak, MD
Department of Surgery
Division of Orthopedic Surgery

Resignations

Serena A. Jung, MD
Department of Anesthesiology

Kathleen L. McDonald, MD
Department of Radiology-Diagnostic Medical Imaging
Division of Diagnostic Radiology
Section of Nuclear Medicine

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

Steven T. Welch, MD
Department of Radiology-Diagnostic Medical Imaging
Division of Diagnostic Radiology
Section of Pediatrics

Deaths

Mark E. Rosenthal, MD
Department of Medicine
Division of Cardiology
Provisional Limited Duty

Charles E. Sieger, MD
Department of Radiology-Diagnostic Medical Imaging
Division of Diagnostic Radiology
Honorary

Allied Health Staff

Appointments

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

Jennifer E. Goetz, GRNA
Graduate Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)

Clare Laracy, PA-C
Physician Assistant-Certified
(Neurosurgical Associates of LVPG - Joseph P. Coladonato, MD)

Karen M. O'Leary, CRNP
Certified Registered Nurse Practitioner
(LVPG-Neonatology - Christopher J. Morabito, MD)

Lisa A. Reynolds, PA-C
Physician Assistant-Certified
(Orthopaedic Associates of Bethlehem, Inc. - Peter W. Kozicky, MD)

Resignations

Judi A. Saxe
Anesthesia Technical Assistant
(Lehigh Valley Anesthesia Services, PC)

THERAPEUTICS AT A GLANCE

The following actions were taken at the December 2002 Therapeutics Committee Meeting - Joseph Ottinger, R.Ph., MS, MBA, Janine Barnaby, R.Ph., Jenny Boucher, Pharm. D., Jason Laskosky, Pharm.D., V. Patel, Pharm.D., Heidi Mayville, Pharm.D., Fred Pane, R.Ph.

Autosubstitution Modifications:

1. The HMG CoA reductase inhibitor class was reviewed and the current policy was modified follows:

Autosubstitution (Based on the CURVES study data)

Drug Ordered	**For every 1mg of drug ordered convert to pravastatin dosing using the following multiplier**	**Maximum dose of Pravastatin (mg)**
Atorvastatin*	4	80 mg
Fluvastatin	1	80 mg
Lovastatin	1	80 mg
Simvastatin*	2	80 mg

*Patients requiring large reductions of LDL and utilizing doses of atorvastatin > 20mg daily or simvastatin >40mg will be continued on these regimens.

2. The review of low molecular weight heparins was presented. The assistance of Doctors' James Sandberg and Mark Cipolle in this process was invaluable. The Committee approved that patients treated with enoxaparin and aspirin for acute coronary syndromes will receive enoxaparin, if prescribed by the physician. Patients receiving enoxaparin for VTE prophylaxis post knee replacement will also not be addressed via an autosubstitution at this time. Utilization of the low molecular weight heparin, enoxaparin (Lovenox®) for other indications will be autosubstituted in the following manner with dalteparin (Fragmin®)

Dalteparin Conversion Chart	
Indication and *Enoxaparin dose*	**Dalteparin dose**
Prevention of DVT in hip surgery-*40mg daily or 30mg q12h*	5000 units daily
Prevention of DVT in abdominal surgery-*40mg daily*	5000 units daily
Treatment of VTE- *1mg/kg q12h OR 1.5mg/kg daily*	100 units/kg BID, maximum 18,000 units/day; may use 200 units/kg daily, if 'daily' dosing preferred
Severely Medically-ill (includes patients with cancer, CHF and COPD)-*40mg daily*	5000 units daily
Trauma-*30mg q12h*	5000 units daily
Anticoagulation 'Bridge' Therapy-*1mg/kg q12h*	100 units/kg BID; maximum 20,000 units/day

3. The new angiotensin blocker olmesartan will be converted to candesartan according to the following dosing schedule:
   Olmesartan 20mg daily to candesartan 8mg daily
   Olmesartan 40mg daily to candesartan 16 mg daily

4. The Committee modified the angiotensin converting enzyme autosubstitution policy to allow for use of ramipril (Altace) based primarily on the results of the HOPE trial data. The Formulary also contains captopril, enalapril, lisinopril and fosinopril.

Unfractionated heparin –New Therapeutic range:

The annual 'activated partial thromboplastin time' reagent lot number change necessitates re-titration of the institution specific 'heparin-curve' to determine both normal and therapeutic target ranges. Both ranges changed marginally. The new normal range is 23-36 seconds, while the new 'therapeutic range' is 68-106 seconds. The therapeutic range is based on a correlation with anti-factor Xa levels of 0.3-0.7 units/ml. The previously validated protocol adjustments for heparin titration were adjusted accordingly. This change occurred on December 17th.

Changes in psychiatric medications

The Therapeutics Committee has approved the following changes with the approval of the Department of Psychiatry.

1. Lexapro (escitalopram) will be substituted for Celexa (citalopram)

   Escitalopram is the therapeutically active isomer of citalopram, as demonstrated in in-vitro studies. Therefore, it possesses a more selective inhibition of serotonin reuptake than does citalopram. In one large meta-analysis, escitalopram produced statistically significant improvements in MADRS depression scores compared to placebo and to the citalopram group starting at week 1 of treatment. Also, using CGI-I scores, escitalopram showed statistically significant improvements compared to placebo at Week 1 onward. In both comparisons, the citalopram group did not show statistically significant differences compared to placebo until Week 4, which is typical of other SSRI antidepressants. Adverse effects that occurred in at least 10% of patients were nausea, diarrhea, insomnia, dry mouth, and ejaculatory disorder. Since doses of escitalopram at 20 mg/day did not show any statistically significant differences when compared to escitalopram 10 mg/day or citalopram 40 mg/day, escitalopram 10 mg/day will be substituted for all doses of citalopram up to 40 mg/day.

2. Formulary restriction and 6 month evaluation for Geodon (ziprasidone) IM

   Ziprasidone is the first injectable atypical antipsychotic medication used for the treatment of acute agitation in schizophrenic patients who need intramuscular medication for rapid control of agitation. It offers an alternative to haloperidol in patient populations where extrapyramidal reactions are a particular concern. Other atypical antipsychotics such as risperidone oral solution and olanzapine dissolving tablets have been introduced to be used for acute agitation, but they offer only oral alternatives. Since injectable ziprasidone is priced at over 10 times the price of injectable haloperidol, it will be evaluated for a six month period and restricted to psychiatry use only. It will not be a part of any floor stock. Other

restrictions include patients over the age of 65, creatinine clearance < 30 ml/min, concurrent oral ziprasidone, patients with hepatic dysfunction, and patients on medications that may prolong QT interval. These include Class IA and III antiarrythmics, mesoridazine, thioridazine, dolasetran, and droperidol. The recommended dosing is 10 to 20 mg every 4 hours as needed up to a maximum dose of 40 mg per day. Use of injectable ziprasidone for more than 3 days has not been studied.

3. Formulary addition and 6 month evaluation of Abilify (aripiprazole)

Aripiprazole is a novel atypical antipsychotic used for the treatment of schizophrenia. It offers a unique mechanism of action as a dopamine system stabilizer which decreases dopamine levels to exert antipsychotic effects and simultaneously prevent adverse motor effects. Since there are no peer-reviewed clinical trials published studying aripiprazole, it will undergo a six month evaluation. It is unsure whether there will be any clear clinical advantages over other atypical antipsychotics. Adverse events reported during aripiprazole therapy have included headache, postural hypotension, constipation, vomiting, akathisia, dry mouth, and extrapyramidal symptoms. Weight gain has also been reported to occur at an incidence similar to risperidone and greater than placebo. The recommended starting and target dose for aripiprazole is 10 or 15 mg/day once daily. Doses higher than 15 mg/day were not more effective than doses of 10 or 15 mg/day. The long-term efficacy of aripiprazole in the treatment of schizophrenia has not been established. The physician who elects to use it for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

Paxil (paroxetine) will be substituted for Paxil CR (paroxetine CR)

Recently, a controlled-release formulation of paroxetine has become available. Paroxetine is an oral antidepressant drug of the selective serotonin reuptake inhibitor (SSRI) type. It has no active metabolites and has the highest specificity for serotonin receptors of all the SSRIs. It is efficacious in depression resistant to other antidepressants, depression complicated by anxiety, and for all the major anxiety syndromes. Paroxetine potentiates serotonin (5-HT) in the CNS. This agent does not affect norepinephrine as do many tricyclic antidepressants. The precise action of SSRIs is not fully understood, but it is believed that paroxetine and related agents inhibit reuptake of serotonin at the neuronal membrane. SSRIs have less sedative, anticholinergic, and cardiovascular effects than the tricyclic antidepressant drugs due to dramatically decreased binding to histamine, acetylcholine, and norepinephrine receptors. Monoamine oxidase is not inhibited by any of the SSRIs. Anticholinergic activity is virtually absent. Because regular-release paroxetine has a mean terminal T1/2 of approximately 15-20 hours, a sustained-release product has minimal benefit over the traditional formulation. Therefore, orders for Paxil CR will be automatically substituted with regular-release paroxetine in the following way: paroxetine CR 12.5 mg will be substituted with paroxetine 20 mg, paroxetine CR 25 mg will be substituted with paroxetine 40 mg, and paroxetine CR 37.5 mg will be substituted with paroxetine 60 mg.

2003 National Patient Safety Goals

Through the combined efforts of the Medication Error Taskforce, Patient Safety Committee and Therapeutics Committee, patient safety is reviewed hospital-wide. For 2003, six(6) patient safety goals have been identified by the Joint Commission.

1. Improve the accuracy of patient identification.
2. Improve the effectiveness of communication among care givers.
3. Improve the safety of using high-procedure surgery
4. Eliminate wrong-site, wrong-patient, wrong-procedures surgery
5. Improve the safety of using infusion pumps.
6. Improve the effectiveness of clinical alarm system.

All of these issues have been addressed at Lehigh Valley Hospital over the years, but there is a new heightened awareness, because of the IOM report.

Also in January, a new patient education-safety video will be released for patients to view, addressing many of the aforementioned patient safety goals. The purpose, is to try and educate our patients and get them more involved as a patient.

The Last Word...

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

February, 2003 – Volume 2, Issue 4

View Medication Administration Directly from the Med Profile

You can now easily view medication administration **performed on CAPOE units** directly from the *Med Profile* screen. Previously, you would have needed to exit the *Med Profile* and access the *Viewer* to see this information. To use this new feature, click on the *Med Profile* chart tab from the *Physician Base* screen. Select a medication you would like to view with a single click. The medication will now be highlighted in blue. Once you have made the selection, click on *View Charted* (see Figure 1). A sub-table of the *Viewer* that shows only medication administration will be displayed (see Figure 2). To return to the *Med Profile*, close the *Viewer* by clicking on the *X* in the upper right corner.

You may access more than one medication administration record at a time. While holding the ***Control (Ctrl)*** key down (located on the bottom left corner of the keyboard), click with the mouse on each of the medications you would like to view. Each medication selected will be highlighted in blue. Click on *View Charted*. The sub-table will again display.

If you wish to see the **entire** administration record for the medications displayed on the screen, click on the first listing to highlight it. While holding down the ***Shift*** key with your finger, click on the last medication listed. The entire list should now be highlighted in blue. Click on *View Charted*. **Note**, if there is more than one page the process will need to be repeated on each screen.

Please note, all of the methods described above work on both the *Active* and *Inactive Med Profile* screens.

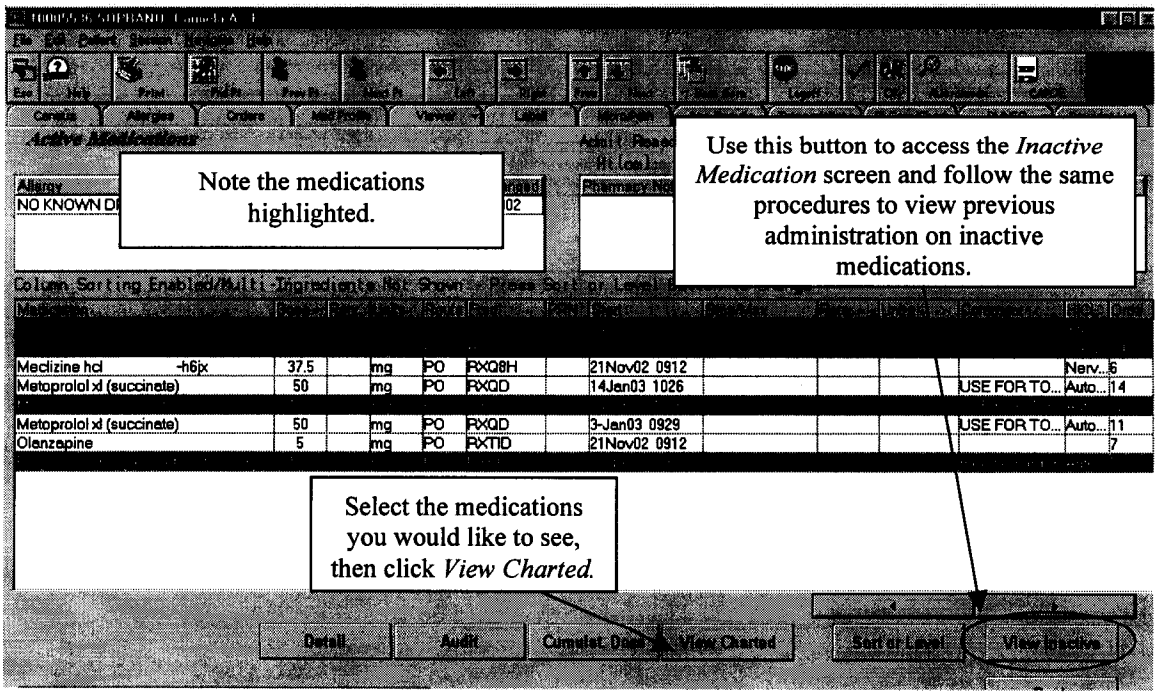


Figure 1 – Select which medications you would like to view to see if they were administered, then click on *View Charted*

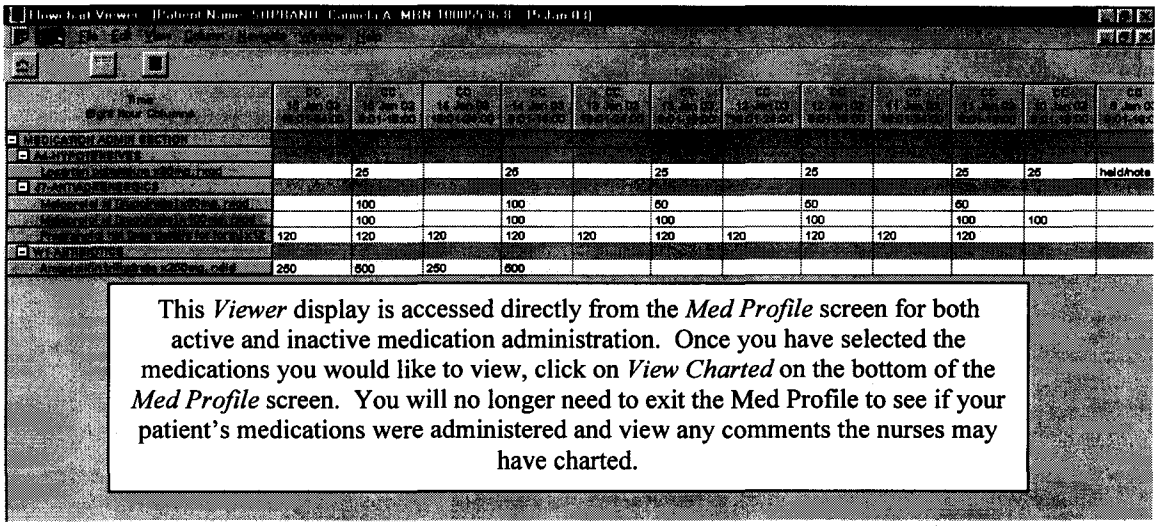


Figure 2 - A sub-table of the *Viewer* that shows medication administration directly from the *Med Profile*

CAPOE FAQs

Q How do I access the Internet/Intranet from the LifeBooks?

A Probably the easiest way to do this is to click on the Internet Explorer icon on the Neon tool bar with initial sign on. Another way to gain access is to click on the *Micromedx* button on the *Physician Base* screen while in LastWord (Phamis). This will connect you to the internet (*Micromedex* home page). From here, you can type any web address into the *Address* box at the top of the screen. To access the hospital home page, type ***www.lvh.com***. Another way to access the internet is to go to the *Start* button (recall, the tool bar on the bottom of the screen is on auto-hide, so you will need to tap with the stylus to make it appear) on the bottom left side of the screen. From here, click on *Search*. Next, click *On the Internet*. You will be connected to *Microsoft Internet Explorer*. Type the web address you wish to view into the *Address* box. **Please do not download anything (screen savers, wallpaper, games, documents, etc.) to your LifeBook, as this will cause connectivity problems and delays for you!**

Q How do I reboot the LifeBook?

A Turn the LifeBook around and look at the back of it. Locate the smallest hole (about the size of the tip of a pen) near the middle hinge. It will be between a long, thin opening and an opening for a phone line. Insert the provided stylus. After this, you will need to power your device back on by pushing the small silver button located on the bottom right side of the screen. Your LifeBook should reboot in about a minute. You will need to log on again. Rebooting the LifeBook is the first action you should take when encountering a problem. If this does not help, please call the Helpdesk at **x8303, option 1**.

Q How do I order lunch and dinner frequencies for my patient's medications?

A Order the medications the same way as any other medication. Once the order is processed, click on the *Freq* (Frequency) drop-down arrow. The *Common Freqs* table will display. The lunch and dinner frequencies are near the top of the list, each followed with *[+]*. Double click to expand the choices (everything from daily to specific days of the week). Choose the appropriate time and then click *Place This Order*.

Ordering and D/Cing a Foley

Ordering a Foley catheter for your patient can be simplified by using the new *Foley Order Set*. To access these new orders, click on the *Nursing* button on the *CAPOE Order Pad*. From the choices presented, double click on *Catheter [+]* to expand the list. Double click on *Foley Order Set* (see Figure 3). Process the order. You will be taken to the detail screen of the order set (see Figure 4). If you wish to add additional information to your order, place an *X* in the *Detail* box before you click *Complete*. Note the second order listed in the set, *NURSH – In AM chk can Foley be D/C*. This order will present on the nurses' MAR **in 72 hours** as an additional reminder to check with the physician if the catheter can be removed. This reminder to the nurses will continue to present every 72 hours until the catheter is removed.

To review the orders you have just placed, click on the *Orders* tab. Two orders should be present (see Figure 5). The actual Foley order will be listed as *NURS – CATH – Foley catheter to stra, NUR – qdn*. The reminder order to the nurses will be listed as *MISC – NURSH – Call phys in AM regar, Q72NOW*.

Should you wish to discontinue the Foley before questioned by the nurses, single click on the Foley catheter order on the *CAPOE Order Profile*. A red check should appear. Click on *Discontinue*. The *Change Linked Order Status* screen will be presented. Both the Foley order and the nursing reminder will be on the screen. These orders are *linked*, meaning they are related, came from the same order set, and are presented together for your convenience. If you are discontinuing the Foley, you should single click on each order. A black check mark will appear. Now click on *Discontinue*, and proceed to discontinue the order in the regular fashion. You will then be returned to the *Linked Order* screen. The bottom left side of the screen will have *Transaction Complete*. Click the *Exit Linked Order Status* button on the bottom right of the screen to be returned to the *CAPOE Order Profile*.

I Need Help...

Should you encounter any difficulties or have questions while entering CAPOE orders, please call the **CAPOE Help Line at x8303, 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.

A Physician Software Educator is available in the Medical Staff Lounge two mornings per month. The hours are posted in the Lounge. She can help you place orders on the practice workstation and answer any questions you may have. Feel free to practice placing orders on your own on the dedicated CAPOE practice workstation. Instructions are provided.

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.

If you have already been **CAPOE trained** but feel you may need a **refresher**, the Educators will be happy to accommodate you. **If you would like a manual** for using Lastword (Phamis), CAPOE, or the LifeBooks, please contact an Educator. We will be happy to provide any materials you may need.

Physician Software Educators on staff are:

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

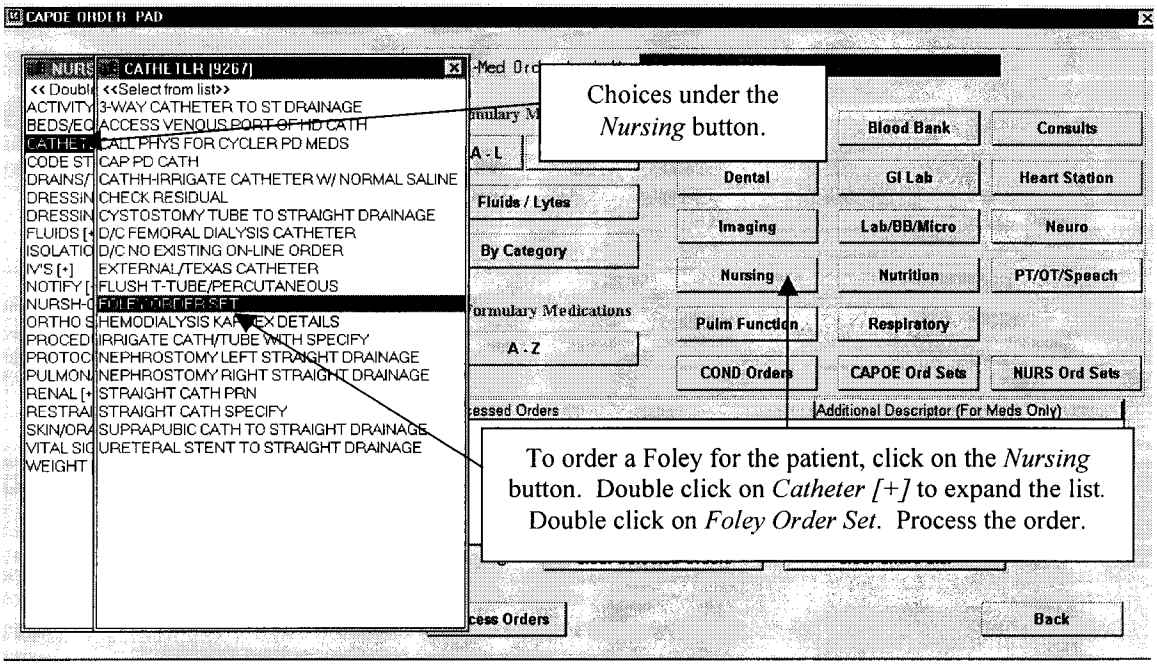


Figure 3 - Accessing the *Foley Order Set*

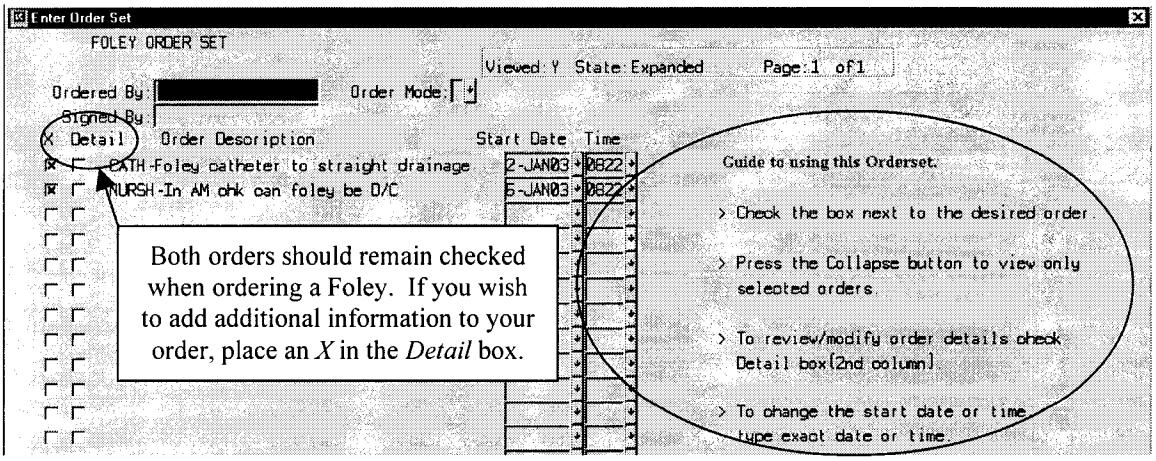


Figure 4 – The second step of the *Foley Order Set*

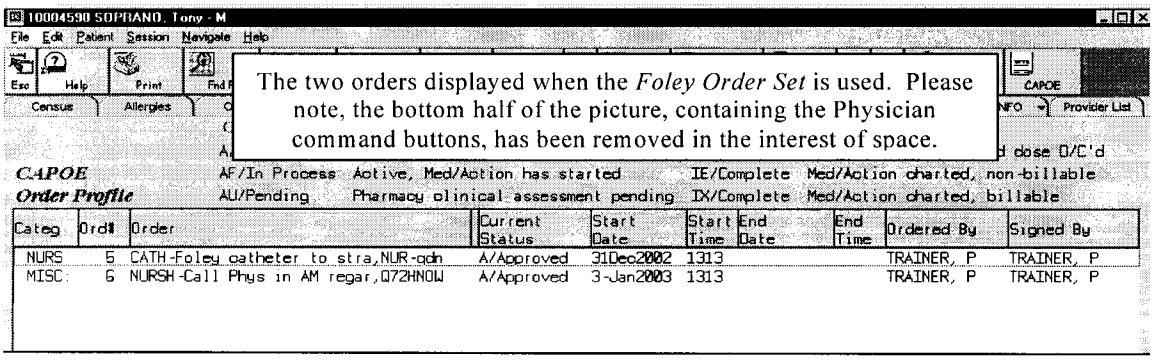


Figure 5 - The Foley orders on the *CAPOE Order Profile*

FOR REVISIONS TO THE MEDICAL STAFF BYLAWS

Approved by:

12/09/2002 General Medical Staff
12/10/2002 Lehigh Valley Hospital-Muhlenberg Board
01/08/2003 Lehigh Valley Hospital Board

ARTICLE XI - OFFICERS AND COMMITTEES- SECTION C - DESIGNATION OF COMMITTEES – e. -
In an effort to enhance the Committee's representation of allied health professional membership, the following changes are being proposed as well as some "housekeeping issues":

e. Credentials Committee:

(i) Purpose: Review and make recommendations concerning the credentials, membership and clinical privileges of all applicants and members of the Medical Staff and Allied Health Professional Staff.

(ii) Duties:

A. Investigate the qualifications of all applicants.

B. Assure that criteria for measuring qualifications of prospective or present Staff members are fair, objective, impartial and designed to promote quality care in the Institution.

C. Re-evaluate on a regular basis all Staff members as to their compliance with Medical Staff citizenship requirements, qualifications for continued performance of their clinical privileges and duties, and the expansion or reduction thereof.

D. Make timely recommendations on all evaluations and re-evaluations to the Medical Executive Committee.

(iii) Membership:

A. Membership of the Committee shall include: ~~Immediate Past President of the Medical Staff who shall serve as Chairperson,~~ Chairpersons of the Clinical Departments of Dental Medicine, Family Practice, Medicine, Obstetrics and Gynecology, Pediatrics, Psychiatry and Surgery, and at least six (6) at-large members as appointed by the Medical Staff President~~, including a minimum of two (2) members of the Medical Staff whose primary clinical activity takes place at the Lehigh Valley Hospital-Muhlenberg.~~ Additional membership may include allied health professionals as deemed appropriate by the President of the Medical Staff.

"Housekeeping Issues" under the Bylaws Fair Hearing and Appellate Review Process – The following "housekeeping issues" are being presented for consideration:

SECTION II. – HEARING PROCESS

B. REQUEST FOR HEARING.

1. REQUEST FOR HEARING.

A Practitioner has thirty (30) days after receiving notice under Section II.A.2. to file a written request for a hearing. The request must be delivered to the ~~CEO~~ Vice President, Medical Staff Services, c/o Medical Staff Services Office, either in person or by certified or registered mail. If the Practitioner intends to be represented by an attorney at the hearing, the request for a hearing must state that intent and the name of the Practitioner's attorney.

D. NOTICE OF HEARING.

1. NOTICE.

The ~~CEO~~ Vice President, Medical Staff Services, shall immediately deliver timely and proper hearing requests to the President of the Medical Staff or the Chairpersons of the Boards depending upon whose recommendation or action prompted the right to a hearing. Upon receipt of a request for a hearing, the President of the Staff or Chairpersons of the Boards, as appropriate, shall schedule and arrange for a hearing which shall be not later than sixty (60) days from the receipt of the request for the hearing. At least thirty (30) days prior to the hearing date, the ~~CEO~~ Vice President, Medical Staff Services, shall send the Practitioner special notice of the time, place and date of the hearing and of the composition of the hearing panel; provided, however, that a hearing for a Practitioner who is under suspension then in effect must be held as soon as the arrangements may be reasonably made, but not later than forty-five (45) days after the ~~CEO~~ Vice President, Medical Staff Services, received the hearing request. The notice of the hearing shall include a list of the witnesses (if any) expected to testify at the hearing on behalf of the body or bodies whose recommendation or action prompted the right to a hearing.

E. FAIR HEARING PROCEDURE.

11. HEARING COMMITTEE REPORT.

Within ten (10) days after final adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations and forwards the report along with the record and other documentation to the body (or bodies) whose adverse action prompted the right to a hearing to the Practitioner involved and to the ~~CEO~~ Vice President, Medical Staff Services, c/o Medical Staff Services Office. The Hearing Committee Report shall include a statement of the basis for the recommendations or action.

F. EFFECT OF HEARING COMMITTEE REPORT.

d. Notice.

The ~~CEO~~ Vice President, Medical Staff Services, shall provide the Practitioner and the President of the Staff with notice of the recommendation of the Joint Conference Committee and/or the action and/or final decision of the Boards.

SECTION III. - APPELLATE REVIEW PROCESS.

A. REQUEST FOR APPELLATE REVIEW.

1. REQUEST FOR APPELLATE REVIEW.

A Practitioner has thirty (30) days after receiving special notice under Section II.F.2.c. to file a written request for an appellate review. The request must be delivered to the ~~CEO~~ Vice President, Medical Staff Services, c/o Medical Staff Services Office, in person or by certified or registered mail and may include a request for a copy of the Hearing Committee Report and record and all other material, if not previously forwarded, that was considered by the Hearing Committee. If the Practitioner wishes to be represented by an attorney at any appellate review proceeding, the request for appellate review must state that desire and the name of the Practitioner's attorney.

B. NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW.

1. NOTICE.

The CEO shall immediately deliver timely and proper requests for appellate review to the Chairpersons of the Boards. Upon receipt of a request for appellate review, the Chairpersons shall schedule and arrange for an appellate review which shall not be later than sixty (60) days from the receipt of the request for appellate review. At least thirty (30) days prior to the appellate review, the ~~CEO~~ Vice President,Medical Staff Services, shall send the Practitioner special notice of the time, place, and date of the review and of the composition of the appellate review panel.

D. APPELLATE REVIEW ACTION.

2. NOTICE OF ACTION TAKEN.

The ~~CEO~~ Vice President, Medical Staff Services, shall provide the Practitioner, the President of the Medical Staff, the MEC, the Appellate Review Body and the Boards with notice of the recommendation and/or action taken by the Appellate Review Body, the Joint Conference Committee and the Boards.

ARTICLE VII – CLINICAL PRIVILEGES – Section B – Temporary Privileges – add:

#5. Emergency Temporary Privileges in the event of a Disaster: Practitioners who do not possess medical staff or allied health care staff privileges at Lehigh Valley Hospital and Lehigh Valley Hospital-Muhlenberg may practice at these hospitals during an "emergency" (defined as any officially declared emergency, whether it is local, state or national). All practitioners volunteering to provide services during a disaster are to report to the Medical Staff Services Office where they are to present any of the following information in order to be granted temporary emergency privileges:

1) Valid professional license to practice in Pennsylvania (Depending upon the extremity of the disaster, out of state medical licensure may be accepted if so declared by the State of Pennsylvania) and a valid picture ID issued by a state, federal or regulatory agency.
2) Current picture hospital ID card.
3) Presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity.
4) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).
5) Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity.

Medical Staff Services Department will issue temporary Identification Badges so hospital staff will be able to readily identify these individuals.

Verification of the above information as per Medical Staff Bylaws shall be done as soon as possible by personnel in the Medical Staff Services Office and will be retained there.

A practitioner's voluntary emergency privileges will be immediately terminated in the event that any information received through the verification process indicates any adverse information or suggests the person is not capable of rendering services in an emergency.

Privileges will be granted by the CEO, Medical Staff President or their designee(s). The hospital's Emergency Management Committee will accomplish the coordination and deployment of temporary emergency staff.

When the emergency situation no longer exists, the temporary, emergency privileges terminate.
*Rename current #5 to #6.

Health Insurance Portability and Accountability Act (HIPAA) – In order to be in compliance with HIPAA regarding the Joint Notice of Privacy Practices, our compliance officer and legal counsel have recommended the following Bylaws additions. Also identified in this Section was a "housekeeping item" in "N" to be corrected:

Add to **Definitions** - Page 2:

N. The term "~~Muhlenberg Medical Center~~Lehigh Valley Hospital-Muhlenberg" means the hospital located at 2545 Schoenersville Road, Bethlehem, PA 18017.

O. The term "Organized Health Care Arrangement" means a clinically integrated care setting in which individuals typically receive health care from more than one health care provider, i.e., a hospital and members of its medical staff. Participants in an organized health care arrangement may develop a joint privacy notice as mandated by the Health Insurance Portability and Accountability Act's Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164).

Add: **ARTICLE II, SECTION B – RESPONSIBILITIES**:

(f) Whenever engaged in an administrative, leadership, or consultative role regarding hospital and/or Medical Staff capital expenditure decisions, complete (and return to the Medical Staff President's Office within ten days of his or her appointment) the "Business Conduct Disclosure Statement for Medical Staff" to determine if potential conflicts of interest exist.

(g) Participate in an organized health care arrangement through the Medical Staff with Lehigh Valley Hospital and Lehigh Valley Hospital-Muhlenberg and adopt a single notice of privacy practices to cover the use and disclosure of protected health information while a patient is treated on the premises of the hospitals.

ARTICLE XII- DEPARTMENTS

SECTION B - ORGANIZATION OF DEPARTMENTS

1. Each Department shall have a chairperson whose general duties are outlined in Section B.3. Large Departments may have Divisions and Sections where appropriate and as listed in Section A. of this Article. Such Divisions and Sections shall have Division and Section Chiefs (and may have Hospital specific Associate Division and Section Chiefs as deemed appropriate by the Chairperson of the Department). Division or Section Chiefs (and Associate Division or Section Chiefs) are responsible for supervising and evaluating patient care and suggesting policy within their Division or Section. They are under the direction of and report to the Chairperson of their respective Departments.

2. Large Departments, at the discretion of the Chairperson of the Department, may have Executive Committees which are advisory to the Chairperson. Departments, at the discretion of the Chairperson of the Department, may also have a member(s) of that Department serve as the Vice-Chairperson(s). Any Vice-Chairperson shall be a member of the Department and shall assist the Chairperson in the performance of his or her duties. Vice-Chairpersons may have site specific responsibilities at that Hospital where the Vice-Chairperson performs his or her primary clinical activities. In the absence of the Chairperson, the Vice-Chairperson of the Department may act on behalf of the Chairperson on all Medical Staff Committees with vote.

Dues - The following Bylaws revision is being presented to eliminate redundancy and for clarification:

ARTICLE IV – CATEGORIES OF THE MEDICAL STAFF

SECTION A – THE MEDICAL STAFF:

3. DUES: To finance the activities of the Medical Staff, dues shall be assessed for ~~the~~ members of the Medical Staff as ~~defined~~ recommended by the Finance Committee and approved by the General Medical Staff at their annual meeting ~~in each category~~. Dues will not be assessed for members sixty-five (65) years and above nor Honorary Staff members. The dues shall be for a fiscal year and shall be billed on September 1 of each year. Only one (1) certified reminder letter will be sent to the staff member for return of dues ten (10) days prior to the October 15 deadline. Any member whose dues are not paid in full by October 15 shall be considered to have voluntarily resigned from the Medical Staff effective on that day not entitling the practitioner to the applicable provisions of the Fair Hearing and Appellate Review Process. ~~In order to regain his or her staff privileges, he or she must make a full payment of his or her dues, and then reapply for staff membership in the usual manner.~~ Re-application to the Medical Staff will be considered based on satisfaction of all Medical Staff Bylaw/Rules and Regulations, hospital Staff Development Plan criteria and any applicable fees. The Treasurer will append the copy of this paragraph to an affected practitioner's final billing. ~~Recommendation for the amount of dues shall be made to the Medical Executive Committee by the Finance Committee. This recommendation of the Medical Executive Committee shall then be presented to the Medical Staff at the annual meeting, which shall determine the amount of the dues by a majority vote of the Medical Staff.~~

SECTION B – THE ACTIVE MEDICAL STAFF

~~#2 (e) Pay all staff dues and assessments promptly.~~

SECTION C – THE ASSOCIATE STAFF

~~#2 (b) Pay all staff dues and assessments promptly.~~

SECTION E – THE LIMITED DUTY STAFF

2. Limited Duty Staff members (including those with Provisional status) may not vote at Medical Staff meetings, may not hold office on the Medical Staff, may not serve on any committees of the Medical Staff, and are exempt from the requirements of Article III, Section D., ~~but shall be required to pay all Staff dues and assessments promptly.~~

SECTION F – THE HONORARY STAFF – Last sentence

They are invited and encouraged to attend staff meetings. ~~and are excused from the payment of dues.~~

LEHIGH VALLEY
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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.