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Medical Staff PROGRESS NOTES

Inside This Issue:

LEHIGH VALLEY HOSPITAL AND HEALTH NETWORK

LVH Cardiologist First in Region to Use Newly FDA-Approved Drug-Coated Stent to Treat Patient with Narrowed Artery

Doctors at Lehigh Valley Hospital and Health Network are now treating heart patients with one of the most anticipated advancements in heart care.

Cardiologist **Eugene E. Ordway, MD**, became the first doctor in the region to treat a patient with a narrowed artery using the new CYPHER drug-coated stent.

The CYPHER stent, made by Johnson & Johnson's Cordis Corporation, was approved April 24 by the FDA for the treatment of previously untreated coronary artery blockages. The CYPHER stent was developed to address the problem of in-stent restenosis, or re-blockage, which occurs in as many as 15-30 percent of patients who receive a bare metal stent.

The stent is a wire mesh tube coated with a polymer containing sirolimus, a naturally occurring antibiotic found in Easter Island soil. It is slowly released into the vessel lining to prevent scar tissue growth through the openings of the stent mesh, which frequently causes the re-narrowing of the artery.

The 74-year old female patient rested comfortably at Lehigh Valley Hospital following the one-half hour procedure. Dr. Ordway inserted the CYPHER stent into the patient's right coronary artery, after using a balloon angioplasty to flatten the fatty blockage against the walls of the artery.

"The CYPHER stent provides new hope for patients with coronary artery narrowing," Dr. Ordway said. "We at Lehigh Valley Hospital are pleased to offer this advanced stent therapy to our community and be one of the first hospitals in the U.S. to provide this effective treatment."

Results of large studies involving nearly 1,400 patients worldwide show that the CYPHER stent reduces the incidence of restenosis by more than 75-90 percent over a bare metal stent.

Each year, Lehigh Valley Hospital cardiologists perform more than 1,700 non-surgical (angioplasties) procedures to open narrowed coronary arteries. The availability of this drug-eluting stent is expected to generate widespread interest among patients and physicians.

From the President

On the importance of beauty contests . . .

"Beauty is in the eye of the beholder"
-Proverb

"Winning a beauty contest is like dying; no one can do it for you, and you're out there all alone"
-Terry Meeuwsen, Miss America 1973

How the world sees you is not how you see yourself. You develop an image of yourself from long internal acquaintance. The image is framed to provide you maximal comfort. You tend to gloss over your bad points, making your moments of failure less a problem of character than a problem of circumstance. The world becomes interpreted through your eyes, and ceases to exist outside your door. You are convinced of your possibilities and capacities, many of which are unknown to others. You have inner thoughts that you share with no one, and can be confident that no one could possibly share. The world, to you, is a creature of your creation.

It's jarring, therefore, when you bump up against the image of you that the world has created. Often this comes about in a heated moment, when your spouse tells you of your problem with being self-centered, or your tendency to smell, or something else equally distressing, true, and previously unknown to you. These moments, few and far between, are startling enough to your self-confidence to cause a shift in your paradigm. When your partners tell you that you aren't cutting it, when your boss confides in you that you are abrupt with clients, you are forced to take a long, appraising look at yourself.

If you are wise, you use these moments to reflect and try to modify your behavior to have a more positive impact on the world around you. You try to smooth out the rough edges, so that any abrasive characteristics you might have are muted and restrained. You wait a second or two before letting your ready anger, your cutting tongue, your irritating wit, or your pungent sarcasm emerge. You try to listen to the world around you for traces of insight into how you are seen by others. With age, you find out that you aren't quite as perfect as you once imagined yourself to be. It's more realistic and more adult to see yourself this way.

Hence, the issue of beauty contests. These are painful affairs where all of your faults, all of your bulges, birth marks, and warts are exposed for a large crowd to see under a glaring, unflattering light. Strangers you don't know rank you on scales using their own irritatingly idiosyncratic view of the world. You troop across the stage, with other scantily clad contestants looking equally ill at ease, and know that only a few of you will be judged at the top of the beauty contest heap. Only one will emerge successful, crowned the Queen of the Harrison County Rhubarb Festival, or some such title.

In medicine, there are many beauty contests. They may be local, regional, or national. We have to dress up for the judges and show off our talents, hoping against hope that they will pick us over the other contestants. Judges come into our hospital and look us up and down, putting us under a microscope. We get ranked, rated, scaled and scored. At the end of the day, on a list, we end up with some ahead of us and some behind. And most of us, being mortals, find comfort in denigrating the contest. "They haven't seen us in action", "They didn't get our real scores". They "Should have seen us last year" or they "Didn't use this year's figures". "They are using the wrong scores to judge us", or "They don't know what they are saying". Anything to avoid the awful truth that maybe we aren't as perfect as our image of ourselves leads us to believe.

There are, at last count, 6,045 hospitals in the United States. Before 1993, there was no standard measure of the quality of care in these hospitals, no universally agreed upon yardstick for beauty. In that year, the National Opinion Research Center at the University of Chicago (NORC) developed a measure. Since that time, their 'report card' has been supported and published in ***U.S. News and World Report*** in an issue titled "America's Best Hospitals." This identifies centers of exceptional capacity in 17 medical specialties. This has become the ultimate 'beauty contest' for hospitals, as important to our institutions as the ranking of colleges is to those institutions.

In the 1980's, Donabedian identified three dimensions of health care each of which was necessary for excellent care. These dimensions were structure (i.e. the buildings, labs, equipment, available services, etc.); process (how care is delivered, the systems of care); and outcome (measures of efficacy and safety of care, such as morbidity, mortality, cost, length of stay). All three of these dimensions are necessary but not sufficient for quality care; all three are necessary for a comprehensive measure of care. To this end, NORC developed the Index of Hospital Quality (IHQ). This was designed to be useful to the consumer and provider of care in comparing institutions. It combines 'robust and sensitive' measures to each of these dimensions from the group of tertiary-care hospitals across a wide range of medical and surgical specialties.

The sources of information for the IHQ are all secondary sources, primarily the American Hospital Association (AHA) annual survey of hospitals. NORC also continually tries to find better sources of information for their survey.

Major components of the IHQ are reputation, structure, and mortality. How are these derived? This is all precisely reviewed in NORCs 101 page summary of their methodology. The reputation score is based on cumulative information from annual NORC surveys of physicians using samples of physicians selected from the AMA physician master file of about 811,000 physicians. Within this sample, physicians are stratified by region and specialty, and a subgroup of physicians are surveyed. For 2002, 3,060 physicians were sampled, with 180 in each specialty in 17 specialty areas. These physicians received a questionnaire with hospital nominations. Each physician was asked to list the five hospitals providing care within a specialty area (e.g., cancer). These were rank ordered. From this, the reputation score was developed.

The structural score is based on data related to structural characteristics within each specialty in each hospital. The major elements include volume of work (number of cases of specific types), technology, and other characteristics of the hospital environment. Most of the data comes from the AHA survey. Volume data comes from the Centers for Medicare and Medicaid Service MEDPARS database, which has data on all Medicare discharges in each specialty.

The mortality outcome measures are based on CMS's MEDPARS database. Adjusted

Continued on next page

mortality rates for each hospital and specialty are computed based on predicted and actual mortality rates using the All Patient Refined Diagnosis Related Group (APR-DRG) method designed by 3M Health Information Systems. This method adjusts the expected deaths for severity of illness by means of principal diagnosis and categories of secondary diagnoses. This method is applied to a pooled three-year data set. In the case of 2002, the data came from 1998-2000.

Not every hospital even makes the rankings. This beauty contest has inclusion criteria. Ranked hospitals must be members of one of the following: Council of Teaching Hospitals (COTH); medical school affiliate; or a score of 9 or more on the hospital wide high-technology index. In 2002, using these criteria, 1,958 tertiary centers were eligible for ranking. Once the hospitals were found to be eligible, their data was drawn from the 2000 AHA annual survey database.

For each specialty, there are also threshold measures that hospitals must meet to enter the ranking 'universe'. For example, for neurology and neurosurgery, minimum discharges annually must exceed 500, and minimum surgeries must be greater than 95. In 2002, there were 1,137 eligible hospitals for this specialty category.

Structure:
For technology ranking, each specialty had certain types of technology that were either present or absent. The more technologies available at the institution specific for this specialty area, the higher the score. For urology, the technologies measured included CT scanner, Diagnostic Radioisotope facility, Extracorporeal Shock Wave Lithotripter, MRI, PET scanner, SPECT, Ultrasound, and Radiation Therapy.

Volume measures are DRG based, and depend on data that each institution submits. Again, a running average of three years is used, so data reflects activities up to five years prior to any years' published rankings.

Many other measurable components are taken into consideration during the survey process. RN to bed ratios, a trauma indicator, in-hospital discharge planning, service mix for alcohol/drug and rehab and other social services, geriatric services, gynecology services, med/surg ICU beds, National Cancer Institute indicator, hospice/palliative care indicator, and COTH membership are all in the score. These all come under the heading of 'structural components' of care.

Process:
The process dimension of quality is the net effect of physician decision making. Choices about tests, treatments, length of stay, and choice of units and admission all come into the process of care. There are no robust national measures of these choices available. NORC, therefore, relies on a proxy for such measures, based on the assumption that when a 'qualified expert' in a specialty area chooses a hospital as a 'best hospital', that is an endorsement of the process of care within that institution. Again, pooled nominations for a three-year period are used, and only five hospital nominations from each physician are obtained. The sample of physicians is widespread and covers all regions of the U.S., non-federal and federal aid based physicians, and both allopathic and osteopathic physicians. All 50 states and the District of Columbia are represented. Specialties ranked include cancer, digestive diseases, ear, nose, and throat, eyes, geriatrics, gynecology, heart and heart surgery, hormonal disorders, kidney diseases, neurology and neurosurgery, orthopedics, pediatrics, psychiatry, rehabilitation, respiratory disorders, rheumatology, and urology.

Outcome:
The major outcome measure comes from DRG diagnoses and mortality rates within specific DRGs. Many physicians have decried the use of these rates because of their inaccuracies. However, a variety of research methodologies have found a correlation between a better-than-average risk-adjusted mortality and overall quality of care. So, even though it's a harsh light, it's a reasonable light for comparison. For neurology and neurosurgery, some of diagnoses used include craniotomy for trauma age >17, spinal disorders and injuries, specific cerebrovascular disorders except TIA, and carpal tunnel release. Each institution's discharges, again for a three-year running average, are used and compared with an expected mortality.

The three major measures, structure, process, and outcome are weighted, and combined in a score, which is normalized to a scale of 100. And there you have it, the ***U.S. News and World Report*** ranking. For heart and heart surgery in 2002, the Cleveland Clinic ranked top, scoring 100. We were 32nd, an excellent result, scoring 29. What did this score consist of? For reputation, a whopping 0. Cleveland got a 62.8% score here. For mortality ratio, lower being better, we scored 0.84, not as good as Cleveland's 0.68. For volume, Cleveland got a whopping 14,311 discharges, to our still robust 10,021. For RNs to beds, Cleveland Clinic was 2.14, while ours was 1.23. For technology, Cleveland Clinic scored 9 out of 9. We got 8.5. So where did they beat us? Reputation counts one-third, and here we have it tough. But they still outnumbered us, had a better mortality, and a higher nursing ratio. In technology, we have little to go.

But here's the striking thing. If you look over the rankings for neurology and neurosurgery, where we didn't even rate, the difference in index between 12th place Henry Ford and Memorial Sloan-Kettering, is only a 3.8 point difference on the 100 point scale. Mayo Clinic got 100 points, Henry Ford 32.4, and Sloan-Kettering 28.6 points. Very small difference in mortality, RN ratios, and volume cause major differences in ranking. In all the specialty rankings, after the first 12 or so, there is a tight clustering of the overall index score. You and I see this, but I'm sure the rest of the world doesn't. To them, the difference between 45 and 50 is as big as between 1 and 6.

So why have I spent so much ink on this topic? It's only because until recently I, too, was a doubting Thomas, suspicious of the purpose, validity, and truth of this beauty contest. I wanted you to understand in some detail that there is nothing capricious, transient, or slip shod about this rating. It is carefully developed, with a sophisticated design and one that is constantly being upgraded. For this reason, I'd rather that we were on the list, up at 32nd like heart and heart surgery, rather than not on the list. The list is important in how the world sees us. When physicians look at us as a place to work, they look us up in USNWR. If we don't rank, we don't rate. Patients look us up, and proudly tell their friends if they see their urology groups in the ranking. Medical students, residents, nurses, and a host of prospective workers check out the ranking and thumb down to see if we made the list or not. Warts, blemishes, acne, and that old appendix scar are there for all to see.

We should look at how to be on the list in as many categories as possible. We should do this carefully, precisely, honestly, to the best of our advantage. And we should rejoice when our services, such as heart and heart surgery, make the list. It let's us know, precisely, how the world judges us. And we all want to look good when we're out there, alone, under the lights.

Alexander D. Rae-Grant, MD
Medical Staff President

Regional Heart Center Update

Our Regional Heart Center continues its vibrant growth and dynamic clinical innovations that increase its value as a resource for our patients and physician colleagues. To help you stay informed of the news of The Regional Heart Center, I will provide routine updates in this publication starting with this edition.

Michael A. Rossi, MD
Chief of Cardiology and Medical Director of the Regional Heart Center

Clinical Leadership Announcements

I am pleased to welcome the following physicians as clinical leaders in our Division of Cardiology:

- **J. Patrick Kleaveland, MD**, as medical director of the Cardiac Catheterization Lab at LVH-Cedar Crest & I-78
- **Robert F. Malacoff, MD**, as medical director of the Electrophysiology Lab at LVH-Muhlenberg

Drs. Kleaveland and Malacoff are in good company, joining the following leaders in the division:

- **Robert H. Biggs, DO**, associate chief of cardiology at LVH-Muhlenberg
- **Norman H. Marcus, MD**, medical director of the Electrophysiology Lab at LVH-Cedar Crest & I-78
- **Anthony M. Urbano, MD**, medical director of the Cardiac Catheterization Lab at LVH-Muhlenberg

In Other News . . .

Our interventional cardiologists were the first in the region to implant the new drug-eluting stents in patients the day after FDA approval in April. Research has found these devices to substantially reduce the incidence of in-stent restenosis in patients undergoing angioplasty and stent placement.

On June 5, the open heart surgery program at LVH-Muhlenberg, under the directorship of Fernando M. Garzia, MD, marked its one-year anniversary. Congratulations to Dr. Garzia and his team of physicians, nurses and support staff on their impressive volumes and excellent clinical outcomes.

Work is nearly complete on The Regional Heart Center on the third floor of the Pool Pavilion at LVH-Cedar Crest & I-78. I encourage you to visit this beautiful facility, which provides an enhanced experience for patients, families and caregivers alike.

We broke ground in May for the new seven-story building at LVH-Muhlenberg, which will house, in addition to other services, that site's Regional Heart Center's facilities, including cath/EP labs and rooms for cardiology and cardiac surgery patients. Completion is expected in 2005.

Current Regional Heart Center Efforts

Vincent Tallarico, Vice President of The Regional Heart Center, and I are working on several new initiatives. The Regional Heart Center has begun planning a women's heart initiative, which will focus on educating and treating the population that has the nation's highest mortality from cardiovascular disease. We will seek advice, support and involvement from our physician colleagues as this initiative moves towards implementation later this year.

This fall, LVHHN will begin offering to cardiac patients Lifestyle Advantage, the Dr. Dean Ornish program for secondary prevention and treatment of coronary heart disease. LVHHN will be the exclusive provider of Lifestyle Advantage in our region. Gerald E. Pytlewski, DO, will provide medical leadership for the program, with support from Deborah Swavely, Administrator for Vascular Medicine and Surgery, and Barbara Carlson, Director of the Helwig Health and Diabetes Center.

I welcome your comments, observations and questions about activities of The Regional Heart Center. To contact me, please call (610) 402-7150 or send me an email at michael.rossi@lvh.com.

Patient Safety Video

"Patient Safety at LVHHN," an 11-minute patient safety video, is now available for all physician practices. The video, which was produced to educate physicians, staff and patients regarding Pennsylvania Act 13, Medical Care Availability and Reduction of Errors (MCARE), covers the following patient safety goals: individual treatment plan, medication administration, surgical site identification, fall prevention, hand washing and discharge planning.

To receive your copy, please call Kelly Beauchamps, Patient Safety Analyst, at (610) 402-2787. Physicians are encouraged to offer the video during office visits for patient education to assist in promoting a patient safe environment.

If you have any questions regarding the Patient Safety Video, please contact Fran Miranda, Risk Manager/Patient Safety Officer, at (610) 402-2803.

News from CAPOE Central

Now that many of you are using CAPOE for most of your orders, we are beginning to see some recurrent patterns of order entry. I would like to highlight several of these to help everyone become more efficient CAPOE users.

- Please check the Order Profile Screen for existing orders before entering new orders. This will avoid duplicate orders being placed. Some orders will trigger duplicate order alerts, but many do not. Thus, it is important to view all the orders to avoid duplicating orders. Remember, you can sort the orders by name, category, order number, start date, etc., just by clicking on the column header.
- When in the ED - admission orders for adult patients going to non-critical care units should be placed online. Please write on the paper chart "Admission orders are online." Admissions to critical care units or specialty units (i.e. Pediatrics) should be handwritten. Orders that should be done specifically while the patient is in the ED should also be handwritten. Handwriting these types of orders will not adversely affect your utilization percentages.
- Radiology orders to be done while the patient is still in the ED should be handwritten. For radiology orders to be done later or the next day, please remember to adjust the start date and time. Many of the order sets have the time offsets already built in.
- Please remember to use the stickers, "Orders are Online," for post-op orders and Admission orders from the ED. These stickers alert nursing to look online for orders. The stickers are located in each OR and in the ED.
- Please be sure you have the correct patient activated when looking up information or entering orders. We can add a popup alert verifying each patient, but we believe this may be too much of an annoyance to the users. Instead, please check the top of the screen and be sure you have the correct patient activated.
- For patients who need coumadin doses ordered on a day by day basis, please remember to use the "Coumadin Initiation Set with PT and RN Note." This order will generate a daily order for PT and will place the reminder "Coumadin - call physician for dose," on the Order and Medication profiles.
- Orders to transfer patients INTO critical care units should be handwritten. The critical care units are not set up to chart electronically. Handwriting these orders will not affect your utilization statistics.
- Please use the ASAP checkbox if first doses are to be given right away. Do NOT type "first dose now" in the comment screen, as this may be missed and will not generate the correct timing of doses.
- Please do not use the medication comment fields to change IV rates, D/C meds, or change routes of administration. These should be separate orders. Also, do not use the "Communication to Nurse" order to order medications. The system cannot do allergy and interaction checking on those orders.
- If a medication is to be given a limited number of doses (Ancef 1gm IV x 3 doses), please do not type this into the comments. The best way is to use the "Max Doses" field near the bottom of the screen.
- Please choose the medication with the correct route of administration from the initial medication list. There have been numerous instances of PO orders being entered and the route being changed to IV.
- When discontinuing medications - use "Discontinue" if the medication is already active and has been given; and use "Retract/Error" for medications that have not yet been given (such as when you change your mind about an order). This will ensure that the proper action is taken on the medication by both pharmacy and nursing.

These tips will help make your CAPOE experience more efficient and accurate.

I appreciate the feedback and support from the physicians over the past several months. We are making tremendous progress and will continue to move forward.

Don Levick, MD, MBA
Physician Liaison, Information Services
Phone: (610) 402-1426
Pager: (610) 402-5100 7481

CME Tracker

At the end of March, the Center for Educational Development and Support (CEDS) sent letters to members of the Medical Staff who accumulated CME category 1 credits at Lehigh Valley Hospital during 2002. In the letter, it was noted that CEDS has purchased a new system for tracking physician CME category 1 credits. This new system, **CME Tracker**, provides an efficient and accurate method of tracking CME credits. CEDS automatically enters credits into the system from sign-in sheets provided from hospital affiliated CME activities. In addition, any member of the Medical Staff who participates in a CME activity outside of the hospital can send or fax a copy of any category 1 credits received to CEDS for entry into the CME Tracker system. These credits will appear on the same annual report as hospital affiliated credits.

If you wish to have your category 1 credits (those received from outside the Lehigh Valley Hospital system) tracked for you, please send or fax them to CEDS, Attention: Sandi Yaich, 17th & Chew, Suite 601, Fax (610) 402-2203.

If you have any questions regarding CME credits or the new CME Tracker, please call Sandi Yaich in the Center for Educational Development and Support at (610) 402-2552.

Palliative Care Initiative

Palliative Care initiatives are continuing to develop around the Lehigh Valley Hospital and Health Network. To better coordinate the resources of LVHHN, a Palliative Care Advisory Board has been established. Although it has found a home in Care Management, the board members include representatives from multiple disciplines and levels of administration. It is also seeking members from the non-medical community such as former patients and clergy. More information on the Advisory Board, its mission and membership will be highlighted in future editions.

This month's ***Medical Staff Progress Notes*** showcases a program developed through the Lehigh Valley Home Care and Hospice.

HomMed™ Health Monitoring System

Through the use of the HomMed™ Health Monitoring System, sophisticated monitoring equipment available at Lehigh Valley Home Care and Hospice, a lifeline between health care professionals and their patients in the community can be established. It is hoped by enhancing communication between patients and their health care providers, the use of this home-monitoring system will improve a patient's quality of life and provide improved outcomes in disease management. By measuring health indicators such as vital signs, oxygen saturation, and blood sugar levels, patients can be closely monitored between scheduled home visits. In addition, patients can answer up to 10 YES/NO pre-programmed questions on a daily basis.

Lehigh Valley Home Care and Hospice has exclusive rights to the HomMed™ Health Monitoring System in Lehigh, Carbon, and Northampton counties. If you have any questions or wish to preview the home monitoring machines, please contact Lehigh Valley Home Care and Hospice at (610) 402-7300.

Fast Facts of the Month

Communication is the key to holistic care of the patient and family. This month's Fast Facts are related to communication with patients and families. They are meant to serve as guides to offer information on effectively communicating bad news to patients and families.

Title: Fast Fact and Concept #06 and #11 **-- Delivering Bad News Part I and Delivering Bad News Part II -- Talking to Patients**

Author(s): Ambuel, B.; Weissman, D.

Fast Fact #06

Question: What steps do you take to prepare to give bad news before talking with the patient?

Case Scenario: You are caring for a previously healthy 52 y/o man with one-month of abdominal pain and weight loss. On exam he had a 2 cm hard left supraclavicular lymph node. A CAT scan showed a focal mass with ulceration in the body of the stomach and numerous densities in the liver compatible with liver metastases. The radiologist feels that the findings are consistent with metastatic stomach cancer. How do you discuss these test results with the patient?

Main Teaching Points:

1. Create an appropriate physical setting: A quiet, comfortable room, turn off beeper, check personal appearance, have participants, including yourself, sitting down.
2. Determine who should be present? Ask the patient whom they want to participate--clarify relationships to patient. Decide if you want others present (e.g. nurse, consultant, chaplain, social worker) and obtain patient/family permission.
3. Think through your goals for the meeting as well as possible goals of the patient.
4. Make sure you know basic information about the patient's disease, prognosis, treatment options.
5. Special circumstances: Patient not competent (developmentally delayed, dementia, etc.) Make sure legal decision-maker is present.
6. Special circumstances: Patient doesn't speak English. Obtain a skilled medical interpreter if the patient or family do not speak English. Use ATT translation service or other phone service is necessary.

Fast Fact #11

Main Teaching Points:

1. Determine what the patient & family knows; make no assumptions. Examples: "What is your understanding of your present condition?" "What have the doctors told you?"
2. Before presenting bad news, consider providing a brief overview of the patient's course so that every one has a common source of information.
3. Speak slowly, deliberately and clearly. Provide information in small chunks. Check reception frequently.
4. Give fair warning --"I am afraid I have some bad news" then pause for a moment.
5. Present bad news in a succinct and direct manner. Be prepared to repeat information and present additional information in response to patient and family needs.
6. Sit quietly. Allow the news to sink in. Wait for the patient to respond.
7. Listen carefully and acknowledge patient's and family's emotions, for example by reflecting both the meaning and emotion of their response.
8. Normalize and validate emotional responses: feeling numb, angry, sad, and fearful.
9. Give an early opportunity for questions, comments.
10. Present information at the patient's or family's pace; do not overwhelm with detail. The discussion is like

Continued on next page

pealing an onion. Provide an initial overview. Assess understanding. Answer questions. Provide the next level of detail or repeat more general information depending upon the patient's and family's needs.

11. Assess thoughts of self-harm.
12. Agree on a specific follow-up plan ("I will return later today, write down any questions"). Make sure this plan meets the patient's needs. Involve other team members in follow-up.

Fast Facts and Concepts are developed and distributed as part of the National Internal Medicine Residency End-of-Life Education project, funded by the Robert Wood Johnson Foundation.

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Disclaimer: *Fast Facts* provide educational information, this information is not medical advice. Health care providers should exercise their own independent clinical judgment. Some *Fast Fact* information cites the use of a product in dosage, for an indication, or in a manner other than that recommended in the product labeling. Accordingly, the official prescribing information should be consulted before any such product is used.

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4. Ptacek, JT, Eberhardt, TL. Breaking bad news: A review of the literature. JAMA, 157:323, 1996.
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If you have any questions regarding palliative care, please contact Daniel E. Ray, MD, Division of Pulmonary/Critical Care Medicine, at (610) 439-8856 or page him at (610) 776-5554.

Express Admissions Unit

The Express Admissions Unit (EAU) opened last October to help facilitate the admission of direct patients at Cedar Crest & I-78. To date, almost 1,400 patients have been admitted through the EAU, and both physician and patient response to the unit has been very positive. However, to help the unit run at peak efficiency and ensure its long-term success, there are some key points to remember:

- Patients should come to the EAU with orders. There are several options for doing this:
  - A physician can enter the orders into CAPOE from any computer. If the patient is going to a CAPOE floor, the orders will remain electronic. If the patient is going to one of the few remaining non-CAPOE floors, the orders will be printed for the chart.
  - A Streamline Admission order set is being implemented for the EAU that will be similar to those used in the Emergency Department. This allows the physician to give the five or six essential orders to get a patient to a bed. The remainder of the orders can then be completed on the floor.
- It is important to remember that not all orders and tests are going to be carried out in the EAU. The EAU is really a portal to the hospital. A 120-minute target length-of-stay has been established for the EAU to ensure that patient flow through the EAU remains strong. To achieve this length of stay, patients will move up to the floor when the bed is ready. Patients should not be kept in the EAU for evaluation, consultation, or diagnostic testing (e.g., procedures like paracentesis, line placement, etc.).
- Physicians must notify the EAU nursing staff of a change in bed status.
- Prolonged discussions (e.g., teaching sessions) should be held in the EAU conference room to ensure patient confidentiality and keep the EAU operating at peak level.
- The EAU hours are 9 a.m. to 9 p.m. This is important to remember, as there have been instances where patients have been sent to the EAU before 9 a.m.

The EAU has been successful to this point, however, there is still room for improvement. Your continued support and cooperation are very much appreciated. If you have any questions, comments, or concerns, please contact Tami Lee, RN, BSN, Director of EAU, at (610) 402-8777 or Michael J. Pistoria, DO, Medical Director of EAU, at (610) 402-1150.

Moderate Sedation/Analgesia

On April 1, 2003, the Medical Executive Committee approved **Medical Staff and Allied Health Professional Staff Credentialing Criteria for Administration of Moderate Sedation**. This criteria works hand in hand with the Moderate Sedation/Analgesia Policy which is intended to facilitate a safe and comparable level of pre-procedure, intra-procedure, and post-procedure care to patients receiving moderate sedation. Moderate sedation is utilized by the practitioner for patients undergoing diagnostic, therapeutic, or surgical procedures. This policy does not apply to those situations in which medications are used solely for pain control or anxiety relief. (To review the policy in its entirety, go to the hospital's homepage on the Intranet, click "Resources," "Applications," Administrative Manual," "M," and "Moderate Sedation/Analgesia.")

In order to administer moderate sedation, all physicians on the Medical Staff will be required to complete certification in NRP, NALS, ACLS, PALS, APLS, or ATLS by December 31, 2003 as appropriate for patient practice population.

Various divisions of the Medical Staff who may administer moderate sedation are currently being identified. Some of these divisions include Cardiology, Gastroenterology, Pulmonary, Pediatric Critical Care Medicine, Cardio-Thoracic Surgery, General Surgery, Oral and Maxillofacial Surgery, etc. Letters will be sent to members of these and other identified divisions with supporting documentation regarding the credentialing criteria. However, in order to avoid missing anyone, please contact Brenda E. Lehr, Director of Medical Staff Services, at (610) 402-8975 or via email if you are currently administering moderate sedation.

If you have questions or for more information regarding this issue, please contact Brenda E. Lehr in Medical Staff Services at (610) 402-8975.

Institutional Review Board

- A retrospective chart review of patients with myocardial infarction and hypertension
- Using a drug for purposes other than its FDA-approved use
- Examining the medical information of patients who died over the last six weeks

Would you classify these items as research? According to Federal law, all of these things would constitute research, in one form or another. Research can be defined as “a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.” In addition, research activities can include some demonstration and service programs.

So how are you to know whether an activity or project is considered research? And if a project is research, what are the proper channels that must be gone through to carry out the research project. At Lehigh Valley Hospital and Health Network (LVHHN), the Institutional Review Board must approve all research projects for valid study design and methodology, and to ensure the rights and welfare of human subjects, and that studies are conducted appropriately and ethically.

The Institutional Review Board (IRB) is an independent committee within the hospital that serves to protect patients and to assure that research, in its many forms, is carried out ethically and within the guidelines of the FDA. The IRB meets monthly to approve or disapprove proposed research protocols within LVHHN. The IRB staff consists of Thomas Wasser, PhD, IRB Administrator, Bernadette Glenn, Senior IRB Coordinator, and Heidi Derr, Junior IRB Coordinator.

The purpose of the IRB is, above all else, to protect patients from unfair or unethical research practice and to assure that research is done with the patient’s best interest in mind. In addition to processing research proposals for full Board review, the IRB office staff also offers services such as consent form editing (for both readability and clarity), exempt protocol review, processing of HIPAA-related research waiver forms, and compassionate/expedited review of protocols.

If you feel that your research idea may fall under the federal definition of research or if you are unsure whether the project constitutes research or not, contact the IRB Office. The staff can provide you with general information, investigator’s training web sites, the criteria for protocol submission, HIPAA waiver forms, and they will be happy to answer any research-related questions.

Generally, new protocols that need full Board review are required to be submitted by a deadline. The calendar for protocol submission is available by email, posted monthly on the LVHHN and LVH_List Bulletin Boards, and can be obtained from either of the IRB coordinators. Requests for exemption or approval of HIPAA waivers are processed on a rolling review. Turnaround is about two weeks. True emergency protocols (compassionate use studies and the like) can be approved as needed. Both emergency protocols and regular full Board protocols review require the Principal Investigator to present the project at the monthly IRB meeting. Meetings are always held on the second Tuesday of the month at 4 p.m. in the fourth floor Conference Room 6 of the John and Dorothy Morgan Cancer Center. Materials must be submitted to the IRB office as a hard copy and must include the required elements, which are outlined in the LVH IRB-approved “Submission Guidelines” and “Consent Form Template.”

If you have any questions regarding the IRB, contact Heidi Derr, Junior IRB Coordinator, at (610) 402-2242.

Osteoporosis: Could Your Patients Be At Risk?

To better serve the Lehigh Valley community, a new outpatient Metabolic Bone Program was developed that is committed to your patients' bone health. The multidisciplinary team of healthcare providers who make up the Metabolic Bone Team (MBT) have special training in osteoporosis and have experience in metabolic bone disease evaluation and consultation. Team members include **Donald E. Barilla, MD**, and **Robert B. Doll, Jr., MD**, from the Division of Endocrinology; **Albert J. Peters, DO**, Division of Reproductive Endocrinology & Infertility/Gynecology; and **Steven A. Scott, MD**, Division of General Internal Medicine/Geriatrics. Consultations are available by appointment on the first Thursday of every month in the Center for Healthy Aging, 17th & Chew. If the Metabolic Bone Program can be of assistance in the management and treatment of your patients' bone health needs, please call (610) 402-2700 to schedule a metabolic evaluation and consultation with one of the physician specialists.

This program is important since a recent demographic analysis of Lehigh County and eight surrounding counties found that at least one-third of all women and men aged 45-75+ had osteoporosis, or low bone mass, which puts them at risk for osteoporosis. As a silent risk factor for fracture, osteoporosis represents a major cause of morbidity, hospitalization, and mortality. One of every two white women will experience an osteoporotic fracture sometime in her lifetime.

Osteoporosis is a multifactor condition with well-recognized risk factors. These include: age, gender, genetics, body size, lifestyle, other illnesses, and certain drug treatments. Bone density declines after age 30, especially in post-menopausal women. While the lighter and smaller skeleton of women makes them more likely to develop osteoporosis, 20% of all people with osteoporosis are men. Caucasians and Asians have a higher prevalence of osteoporosis. Excessive alcohol consumption, tobacco use, sedentary lifestyle, and a diet low in calcium increase the risk for osteoporosis. Illnesses that speed bone loss (e.g., hyperthyroidism, hyperparathyroidism) or cause immobility increase risk. Medications that affect bone metabolism include: Glucocorticoids, Adrenocorticotropin, Lithium, Aluminum, Cyclosporin A, Gonadotrophin-releasing agonists, cytotoxic drugs (Methotrexate), anticonvulsants, long term Heparin use, and excessive use of Thyroxine.

Osteoporosis is not an inevitable aspect of aging, but preventative efforts need to be lifelong. Early identification of individuals at risk and implementation of preventative measures, where possible, can result in minimization of bone loss, better skeletal preservation, and reduction in fracture risk. Regardless of age, it is never too soon or too late to think about bone health. Universal recommendations to maximize and preserve bone mass include: adequate intake of calcium and vitamin D, regular weight bearing and muscle strengthening exercises, and avoidance of both tobacco use and excessive alcohol.

Adults with vertebral, rib, hip, or distal forearm fractures should be evaluated for osteoporosis via bone mineral density (BMD) testing. The National Osteoporosis Foundation (NOF) recommends BMD testing for:

- post-menopausal women under age 65 who have one or more additional risk factors for osteoporosis (besides being post-menopausal and female)
- women age 65 and older regardless of additional risk factors
- post-menopausal women who present with fractures
- women who are considering therapy for osteoporosis if BMD testing would facilitate the decision
- women who have been on hormone replacement therapy for prolonged periods

The DEXA scan is a central scan enabling the BMD of the spine, hip, or other part of the body to be measured. DEXA scan services are offered at the Health Center at Bath and Lehigh Valley Diagnostic Imaging (LVDI). Patients can schedule DEXA scans at either location by calling (610) 402-TEST (8378).

If you have any questions concerning the Metabolic Bone Program or if you need assistance in the management and treatment of your patients' bone health needs, please call Kathy Kakareka, Administrative Coordinator, Center for Healthy Aging, at (610) 402-2700.

Are you missing a coat?

If you seem to have misplaced your coat, you may want to check the Medical Staff Lounge at Cedar Crest & I-78. Several winter coats have been hanging in the coatroom for quite some time.

Release of Information to Law Enforcement

With the implementation of the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA), there have been inquiries related to release of information to law enforcement. Below are general guidelines:

1. A health care provider is required to report certain patient information to a law enforcement official without patient authorization as mandated by Pennsylvania law. The following are reportable cases:
    a. Any *injury inflicted by a deadly weapon*, or any wound or other injury inflicted by means of a person's own act or by the act of another which caused death or serious bodily injury
    b. *Suicides* or attempted suicides with a deadly weapon
    c. Suspected *child abuse or neglect* is to be reported to Childline (1-800-932-0313) and to the Office of Children and Youth in the county where the alleged abuse occurred. The police must be notified of the following: all cases where death is the result of injuries sustained, all cases of suspected sexual abuse, all cases where the child's injuries result in serious bodily injury, any case where the alleged perpetrator is not related to the victim by blood or marriage, any case where the school employee allegedly sexually molests a student or inflicts serious bodily injury to a student.
    d. The *Coroner* needs to be informed of cases under his jurisdiction (sudden deaths not caused by readily recognizable disease; deaths occurring under suspicious circumstances; deaths occurring as a result of violence or trauma; any death in which trauma, chemical injury, drug overdose or reaction to drugs or medication or medical treatment was a primary or secondary cause; operative or peri-operative deaths in which the death is not readily explainable; deaths wherein the body is unidentified or unclaimed; deaths due to contagious disease and constituting a public hazard; deaths occurring in prison or a penal institution; deaths of persons whose bodies are to be cremated or otherwise disposed of so as to be unavailable for examination; sudden infant death syndrome; and stillbirths).
    e. Requests of lab results of *blood alcohol/ controlled substances* if requested to be completed by police
    f. Employers of home health and skilled nursing facilities who have reasonable cause to suspect a patient is a victim of *elder abuse* are mandated to report the case to the Area on Aging. An older adult is a person who is 60 years of age or older.

HIPAA does not preempt Pennsylvania law in these cases, and a provider should continue to report such information.

2. A health care provider should respond to a court order, court-ordered warrant, or a subpoena or summons issued by a judicial officer or a grand jury subpoena. It is advisable to have these requests reviewed by legal counsel.

3. In the event that law enforcement is requesting assistance for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, a provider may release the following information pursuant to HIPAA regulations:

    a. Name and address of patient
    b. Date and place of birth
    c. Social security number
    d. ABO blood type and rh factor
    e. Type of injury
    f. Date and time of treatment
    g. Date and time of death, if applicable
    h. Description of distinguishing physical characteristics, including weight, height, gender, race, hair, and eye color, presence or absence of facial hair (beard or moustache), scars and tattoos

    These particular disclosures occur when law enforcement needs limited but focused information. For example, a witness to a shooting may know the time of the incident and the fact that the perpetrator was shot in the arm, but not the identity of the perpetrator. Law enforcement would then have a legitimate need to ask local emergency rooms whether anyone had presented with a bullet wound to the left arm near the time of incident. In such situations, the above listed identifying information may be released. A provider is not permitted to release any protected health information related to the individual's DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue. The rule also notes that a request by a law enforcement official or agency is not limited to direct requests, but also includes oral or written requests by individuals acting on behalf of a law enforcement agency, such as a media organization broadcasting a request for the public's assistance in identifying a suspect on the evening news. It includes "wanted" posters, public announcements, and similar requests to the general public for assistance in locating suspects or fugitives.

Continued on next page

4. If the disclosure is not required by law, a health care provider may provide law enforcement with requested information about an individual who is or is **suspected to be a victim of a crime** under the following circumstances: if the individual agrees to the disclosure, *or* in the event that the patient is unable to agree due to incapacity (1) law enforcement represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim and (2) the law official must represent that immediate law enforcement activity would be materially and adversely affected by waiting until the individual is able to agree to the disclosure. The requirement of obtaining patient consent allows victims control over decision making about their health information where their safety could be at issue, i.e., domestic violence, but also allows the provider to exercise professional judgment to release information in the event the patient is incapacitated.

5. A health care provider may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the provider, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

If you have any questions regarding this issue, please contact Mary Ann La Rock, Compliance Officer, at (610) 402-9100.

Auto-Stop/ Stop-Order Policy

At the February 2003 Therapeutics Committee meeting, the following changes were approved to the Auto-Stop/ Stop Order Policy:

Anticoagulants – IV, from 24 hours to 48 hours
– oral/subcutaneous, from 5 days to 7 days

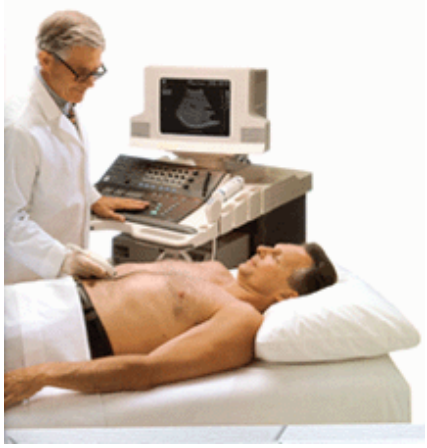
Steroids – Injectable from 14 days to 7 days

Clozapine – from 7 days to 14 days

According to the policy, there is a physician notification process and yellow stop order renewal notices are generated 48 hours before a medication stops. These renewal notices should be found in the progress note section of the patient chart.

In CAPOE, medications that require renewal appear at the top of the Order Profile Screen. To renew an order, click the renew/restart button.

If you have any questions, please contact Fred Pane, RPh, Administrator, Pharmacy Services, at (610) 402-8881.



As of May 1, **Lehigh Valley Diagnostic Imaging**, located at 1230 S. Cedar Crest Blvd., Suite 104, now has Ultrasound appointments available on Wednesday and Thursday evenings until 8 p.m. Also, since the addition of the second light speed CT scanner, many more CT scan appointments are available Monday through Thursday, 7 a.m. to 8 p.m., Friday, 7 a.m. to 5:30 p.m., and Saturday, 8 a.m. to noon. To schedule an appointment, please call (610) 435-1600, Option 1.

News from the Health Information Management Department

Illegible Handwriting

Illegible handwriting continues to be a challenge within the medical record documentation. Physicians and clinicians can help by documenting legibly and clearly. Some of the outcomes of illegible handwriting include:

- Increased physician/clinician phone calls to clarify documentation
- Delays in patient care
- Medication errors
- Delays in patient transfers
- Inability to capture billing/severity of illness documentation
- Reimbursement denials; 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

CAPOE is an excellent solution to illegible handwriting in reducing medication errors. However, 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 patient encounter.

Everyone should take a role in assuring that medical record documentation is legible. Next time you document in the medical record and sign your name, ask yourself, "if I were a new caregiver on the unit, would I be able to read this?" If you have already been identified with illegible handwriting, please (1) use your signature stamp every time you sign your name or (2) print your name and telephone number after your signature.

HINT: Do not use "felt tip" or liquid ink pens. The ink tends to blend together making decreasing legibility by smearing and soaking through the pages.

Use Your Credentials . . .

Help others distinguish your documentation from other caregivers. When signing your name, please place your credentials after your name —

John M. Smith, M D

Thank you for helping Health Information Management in its efforts to improve the quality of patient care documentation.

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

Congratulations!

◈ Congratulations are extended to **Elizabeth A. Dellers, MD**, **Michael Ehrig, MD**, **Larry R. Glazerman, MD**, **Laurence P. Karper, MD**, **Michael J. Pasquale, MD**, and **Patrice M. Weiss, MD**, who were recently elected to serve three-year terms as members-at-large of the Medical Executive Committee, beginning July 1, 2003.

A special "Thank You" to **Karen A. Bretz, MD**, **Richard L. London, MD, John A. Mannisi, MD, Stephen C. Matchett, MD, Alexander M. Rosenau, DO**, and **Hugo Twaddle, MD**, for their dedication and service to the Medical Staff as members of the Medical Executive Committee for the past three years.

◈ **Eamon C. Armstrong, MD**, Department of Family Practice, was selected to receive the 2003 Dean's Special Award for Excellence in Clinical Teaching at Lehigh Valley Hospital by the fourth year medical students at Drexel University College of Medicine.

◈ **Wayne E. Dubov, MD**, Division of Physical Medicine-Rehabilitation, was the recipient of the **Physician Friends of Nursing Award** at the recent Friends of Nursing Celebration held on May 1. The purpose of the award is to recognize a physician who demonstrates collaborative practice with nurses to promote the best practices and associated optimal patient outcomes.

In addition, Dr. Dubov was recently informed that he passed the Maintenance of Certification examination and has become recertified by the American Board of Physical Medicine and Rehabilitation.

◈ The three winners of the "Win a Check for Free Dues" drawing following the June General Medical Staff meeting are:
Richard D. Baylor, MD, Department of Family Practice
David P. Steed, DPM, Division of Podiatric Surgery
Fernando M. Garzia, MD, Section of Cardiac Surgery/Thoracic Surgery

◈ At this year's Graduate Medical Education Celebration held on Friday, June 13, the following members of the Medical Staff received Teacher of the Year Awards:

Clinical Teacher of the Year in Colon and Rectal Surgery - **Indru T. Khubchandani, MD**
Clinical Teacher of the Year in Dental Medicine (LVH-M) - **Deanna S. Dudenbostel, DMD**
Clinical Teacher of the Year in Dental Medicine (LVH) - **Ann K. Astolfi, DMD**
Clinical Teacher of the Year in Dermatology - **Stephen M. Purcell, DO**
Clinical Teacher of the Year in General Surgery - **Scott W. Beman, MD**
Clinical Teacher of the Year in Obstetrics and Gynecology - **Gregory J. Radio, MD**
Headley White, MD Award for Outstanding Teaching in Family Practice - **MaryAnne K. Peifer, MD**
Dean Dimick Teacher of the Year in Internal Medicine - **James M. Ross, MD**
LVH-M Clinical Teacher of the Year - **Iqbal Sorathia, MD**

In addition, the following members of the Medical Staff received a Penn State College of Medicine Medical Student Teacher of the Year Award as selected by the Third Year PSU Medical Students who complete a rotation at LVH:

Family Practice - **Eamon C. Armstrong, MD**
Internal Medicine - **Michael J. Pistoria, DO**
Obstetrics and Gynecology - **Patrice M. Weiss, MD**
Pediatrics - **Scott M. Brenner, MD**
Psychiatry - **Laurence P. Karper, MD**
Surgery - **Scott W. Beman, MD**

News from the Libraries

Ovid Training

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

Useful Evidence-Based Medicine Databases

The Cochrane Database of Systematic Reviews is available through OBID. UpToDate is available on the Intranet.

Online Card Catalog

LVHHN Cybertools for Libraries Catalog is available on the Intranet.

To access Library services from the hospital's Intranet, go to the hospital's Intranet Homepage, select Departments -- Clinical -- Clinical Services -- then make your selection from the list.

Recently Acquired Publications

Library at 17th & Chew

- Berek. Novak's Gynecology. 2003
- DeCherney. Current Obstetric & Gynecologic Diagnosis & Treatment. 2003

Library at Cedar Crest & I-78

- Scott-Connor. Chassin's Operative Strategy in General Surgery. 2002
- Volpe. Neurology of the Newborn. 2001

Library at LVH-Muhlenberg

- Kaplan. Kaplan's Clinical Hypertension. 2002
- Markovchick. Emergency Medicine Secrets. 2003

If you have any suggestions for new books, please send them to Barbara Iobst in the Library at Cedar Crest & I-78.

Papers, Publications and Presentations

◈ In May, **Geoffrey G. Hallock, MD**, Division of Plastic Surgery/ Hand Surgery, Section of Burn, presented a paper titled "Lower Extremity Perforator Flaps for Lower Extremity Reconstruction" at the 82nd Annual Meeting of the American Association of Plastic Surgeons in Baltimore, Md. The presentation was intended to show that soft tissue coverage using flaps of skin without muscle can be taken from donor sites restricted to the lower extremity to reconstruct lower extremities so as to minimize patient morbidity to the injured limb only.

◈ On May 19, **Indru T. Khubchandani, MD**, Division of Colon and Rectal Surgery, was a member of the faculty of "Advances in Colorectal Surgery," sponsored by Ethicon Endo-Surgery, in Cincinnati, Ohio. Dr. Khubchandani moderated a live stapled hemorrhoidectomy telecast from Miami, Fla., which was simultaneously telecast to the audience in Cincinnati and Cleveland, Ohio; Fargo, ND; and Birmingham, Ala.

◈ **Christopher J. Morabito, MD**, Chief, Division of Neonatology, presented a lecture titled "Treatment Modalities for Hypoxemic Respiratory Failure" at the annual Oklahoma Society for Respiratory Care meeting held on June 6 in Tulsa, Okla.

◈ **Michael J. Pistoria, DO**, Division of General Internal Medicine, was a panel member at the 2003 Society of Hospital Medicine's annual meeting held in San Diego, Calif., in April. The topic discussed was "Teaching Hospital Medicine: How to Structure Residencies and Fellowships." Other panel members were from the University of California at San Francisco, the Mayo Clinic, and the Beth Israel Deaconess Medical Center. The annual meeting was attended by over 900 people, making it the most successful SHM meeting yet. SHM is the fastest growing medical society and now has over 4,000 members.

Dr. Pistoria chairs the SHM Core Curriculum Task Force, which is developing an outline of the essential curricular needs of hospitalists, both in clinical and systems issues. Dr. Pistoria also sits on the SHM Education Committee and is a member of SHM's Northeast Regional Council.

◈ On May 31, **Lester Rosen, MD**, Division of Colon and Rectal Surgery, was a speaker at the New England Society of Colon and Rectal Surgeons in Kennebunk, Maine. He presented a paper titled "Analysis of Trends in Colon and Rectal Surgery Using the Pennsylvania State Legislated Database," written with Tom Wasser, PhD, Director of Health Studies. The paper dealt with 159,003 consecutive severity adjusted cases that underwent colon and rectal surgery from 1992 to 2001 in the Commonwealth of Pennsylvania. The annual length of stay decreased from 13.8 days in 1992 to 9.4 days in 2001. During this period, the annual mortality rate was unchanged. In a subset of 47,701 cases operated on for colon cancer in patients of age 65 or older, there was a decrease in mortality from 4.5% to 3.1%, which was statistically significant. Of the 221 hospitals within the Pennsylvania database, Lehigh Valley Hospital was in the top 1% for the lowest adjusted annual mortality over the 10-year period.

◈ **Peter F. Rovito, MD**, Division of General Surgery, and **Keith Kreitz, MD**, Chief Surgical Resident, were co-authors of the article, "Laparoscopic Roux-En-Y Gastric Bypass in the Mega Obese," which was accepted for publication in the July issue of ***Archives of Surgery***. The article describes performing Laparoscopic Roux-En-Y Gastric Bypass in extremely obese patients (body mass index of greater than 70) which previously has not been reported. Also, the term "mega obese" was coined to refer to patients with body mass index of greater than 70.

◈ **Prodromos A. Ververeli, MD**, Chief, Division of Orthopedic Surgery, presented lectures on Knee Revision and Blood Management for Joint Replacement Surgery at a regional symposium on The Leading Edge of Technology on May 30 and 31. He also moderated a session on New Advances in Joint Replacement during the symposium, which was attended by 120 orthopedic surgeons.

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 takes place 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 1245SCC (Educational Room):
(All sessions will be held from 8 a.m. to noon)

August 26 September 23 October 28

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

July 17 August 21 September 18

Twelve slots are available for 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.

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 July will include:

- July 1 - Pediatric Jeopardy
- July 8 - Child Maltreatment Series: Part 4 - "Community Resources for Victims of Child Maltreatment" **(Location Change -- Auditorium, Cedar Crest & I-78)**
- July 15 - Pediatric Journal Club (Topic to be announced)
- July 22 - "Catheter Treatment of Congenital Cardiac Defects in Children"
- July 29 - "Immunization Education Program"

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

Who's New

This section contains an update of new appointments, address changes, status changes, resignations, etc. Please remember to update your directory and rolodexes with this information.

Medical Staff

New Appointments

Joshua A. Bemporad, MD
Medical Imaging of LV, PC
Lehigh Valley Hospital
Cedar Crest & I-78, PO Box 689
Allentown, PA 18105-1556
(610) 402-8088
Fax: (610) 402-1023
Department of Radiology-Diagnostic Medical Imaging
Division of Diagnostic Radiology
Section of Neuroradiology
Provisional Active

Holly L. Binnig, MD
Healthspring
1730 Chew Street
Allentown, PA 18104-5595
(610) 402-3500
Fax: (610) 402-3509
Department of Family Practice
Provisional Active

Peter J. Feczko, MD
Medical Imaging of LV, PC
Lehigh Valley Hospital
Cedar Crest & I-78, PO 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

Steven M. Kaplan, MD
Medical Imaging of LV, PC
Lehigh Valley Hospital
Cedar Crest & I-78, PO 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

Eric B. Lebby, MD
Valley Sports & Arthritis Surgeons
798 Hausman Road
Suite 100
Allentown, PA 18104-9116
(610) 395-5300
Fax: (610) 395-5551
Department of Surgery
Division of Orthopedic Surgery, Section of Ortho Trauma
Provisional Active

Yuebing Li, MD, PhD
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

Matthew M. McCambridge, MD
Pulmonary Associates
1210 S. Cedar Crest Blvd.
Suite 2300
Allentown, PA 18103-6286
(610) 439-8856
Fax: (610) 439-1314
Department of Medicine
Division of Critical Care Medicine/Pulmonary
Provisional Active

Michael A. Moclock, MD
Bethlehem Medical Center
2092 Stefko Blvd.
Bethlehem, PA 18017-5445
(610) 694-1000
Fax: (610) 867-7180
Department of Family Practice
Provisional Active

Mary E. Pipan, MD
CHOP-Pediatric Development & Rehabilitation
Children's Hospital of Philadelphia
Division of Child Development & Rehabilitation
324 S. 34th Street
Philadelphia, PA 19104-4399
(215) 590-7994
Fax: (215) 590-6804
Department of Pediatrics
Division of Pediatrics Subspecialties
Section of Developmental-Rehabilitation
Provisional Associate

Jennifer J. Zambo, DO
LVPG-Emergency Medicine
Lehigh Valley Hospital
Cedar Crest & I-78, PO Box 689
Allentown, PA 18105-1556
(610) 402-8111
Fax: (610) 402-4546
Department of Emergency Medicine
Division of Emergency Medicine
Provisional Active

Two-Year Leave of Absence

Naseer A. Humayun, MD
Department of Medicine
Division of Pulmonary

Status Change

Robert J. Laskowski, MD, MBA
Department of Medicine
Division of General Internal Medicine/ Geriatrics
From: Active To: Honorary

Address Change

Geary L. Yeisley, MD
1210 S. Cedar Crest Blvd., Suite 3000
Allentown, PA 18103-6245
(610) 432-4377 ❖ Fax: (610) 432-3249

Practice Changes

Linda P. Augelli-Hodor, DO
Gnanaprakash Gopal, MD
Theodore Kowalyshyn, MD
(No longer with Bethlehem Steel Family Health Center)
Muhlenberg Primary Care, PC
2597 Schoenersville Road, Suite 308
Bethlehem, PA 18017-7331
(610) 868-6833 ❖ Fax: (610) 868-6210

Jennifer A. Derr, DO
(No longer with Creekside Family Health)
Ellsweig & Liu MD's, LLC
1251 S. Cedar Crest Blvd., Suite 102A
Allentown, PA 18103-6212
(610) 776-0377 ❖ Fax: (610) 776-0382

James K. Hoffman, MD
(No longer with Valley Sports & Arthritis Surgeons)
Coordinated Health Systems
2775 Schoenersville Road
Bethlehem, PA 18017-7326
(610) 861-8080 ❖ Fax: (610) 861-2989

Carol A. Hunter, MD
(No longer with Bethlehem Steel Family Health Center)
5992 Beverly Hills Road
Coopersburg, PA 18036-1857
(610) 282-2402

Paul J. Lynott, MD
(No longer with Trexlertown Medical Center)
Riverside Family Practice
Riverside Professional Center
5649 Wynnewood Drive, Suite 203
Laurys Stations, PA 18059-1124
(610) 261-1123 ❖ Fax: (610) 262-1739

Resignations

D. Lynn Morris, MD
Department of Medicine
Division of Cardiology

Carson Wong, MD
Department of Surgery
Division of Urology

Death

Henry H. Fetterman, MD
Department of Obstetrics and Gynecology
Division of Gynecology

Allied Health Staff

New Appointments

Cynthia L. Amundsen
Anesthesia Technical Assistant
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)

Cherie W. Barreca, RN
Registered Nurse
(The Heart Care Group, PC - David B. Goldner, MD)

Rachelle M. Gyuricsek, LPN
Anesthesia Technical Assistant
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)

Jeffrey S. Lohmann
Intraoperative Neurophysiological Monitoring Specialist
(Surgical Monitoring Associates, Inc.)
(Supervising Physician: Mark C. Lester, MD)

Marvin A. Moquin, Jr., PA-C
Physician Assistant-Certified
(The Heart Care Group, PC - Gary Szydlowski, MD)

Chad A. Roarabaugh, PA-C
Physician Assistant-Certified
(Surgical Specialists of the Lehigh Valley - Sigrid A. Blome-Eberwein, MD)

Mary P. Spengler, CRNP
Certified Registered Nurse Practitioner
(Pain Specialists of Greater Lehigh Valley, PC - Robert E. Wertz, MD)

Change of Supervising Physician

John C. Klaman, PA-C
Physician Assistant-Certified
From: Orthopaedic Associates of Bethlehem, Inc. - John M. Williams, MD
To: Valley Sports & Arthritis Surgeons - Lawrence E. Weiss, MD

Lynn A. Seagreaves, PA-C
Physician Assistant-Certified
(Valley Sports & Arthritis Surgeons)
From: James K. Hoffman, MD
To: Prodromos A. Ververeli, MD

Resignations

Suzanne L. Lindenmuth, CRNA
Certified Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC)

Donna A. Stevens, RN
Registered Nurse
(Lehigh Valley Cardiology Assoc)

LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

Cedar Crest & I-78
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Fax: 610-402-8938
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Medical Staff Progress Notes

Medical Executive Committee

We're on the Web!

If you have access to the Lehigh Valley Hospital intranet, you can find us on the LVH homepage under What's New — Medical Staff Services

Medical Staff Progress Notes *is published monthly to inform the Medical Staff and employees of Lehigh Valley Hospital of important issues concerning the Medical Staff.*

Articles should be submitted by e-mail to janet.seifert@lvh.com or sent 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 contact Mrs. Seifert by e-mail or phone at (610) 402-8590.