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Central Scheduling at Lehigh Valley Hospital-Muhlenberg

On Monday, December 18, 2000, Central Scheduling at LVH-Muhlenberg will begin to schedule tests and procedures performed in Nuclear Medicine, the Neurodiagnostic Lab, and Non-Invasive Cardiology, in addition to those in Radiology (CT, Ultrasound, and Interventional) and Breast Health Services which are currently being scheduled by the department.

Physicians' offices that are scheduling patients for Stress Tests or Transesophageal Echocardiograms (TEE) should note that a performing cardiologist is required. It will consequently be necessary to have the time(s) when the cardiologist is available at the time the scheduling call is made in order to assure availability of all required resources. In addition, please note that routine echocardiograms require a reading physician.

Tests being done in the Neurodiagnostic Lab include EEGs, Evoked Potentials, and EMGs. EMGs are also scheduled based on performing physician availability.

Depending on the patient's insurance plan, most of the procedures performed in Nuclear Medicine, CT, Ultrasound, as well as Stress Tests in the Heart Station, require both a
referral and authorization number from managed
care companies. In addition, all tests are
required to have a written order (prescription)
for procedure. In order to facilitate the
patient's experience when he/she arrives at the
hospital, the scheduling clerk will remind the
office staff or the patient when the test or
procedure is scheduled that the above is
required. In order to streamline the process for
physicians' offices and decrease phone calls
back and forth, we are asking that the
prescription and the referral and/or
authorization numbers be telephoned or faxed
to Central Scheduling prior to the scheduled
test.

Patients who arrive without a referral,
authorization, and/or prescription will,
unfortunately, have to be rescheduled. In an
effort to avoid this from occurring, a scheduling
clerk will call the physician's office 48 hours in
advance to secure any necessary and still missing
information.

The number for Central Scheduling is (484) 884-
2279. The fax number is (610) 861-7310. For
physician office convenience, the department is
open Monday through Friday from 7 a.m. to 7
p.m.

If you have any questions, comments or concerns
please contact Lisa Coleman, Director of
Admissions, Registration, PAT and Scheduling, at
(610) 402-8066, pager (610) 830-6791, or Mark
Holtz, Vice President of Operations, at (484)
884-4710.

Consolidation of Admitting Functions
at LVH-Muhlenberg to Bed
Management

Effective January 8, 2001, LVH-Muhlenberg
Direct Admission services will be provided by
the Bed Management Department located at
Cedar Crest & I-78. Bed Management will also
assign beds for the Emergency Department,
inter-hospital transfers, and elective admissions.
The current Emergency Department admission
request will not change except for assignment of
the bed by Bed Management staff. This
assignment will be made based on unit specific
clinical criteria, physician preference, and other
patient specific needs.

Improved Process for Hospital Admissions
Directly from Physicians' Offices

Reservations for admissions directly from
physicians' offices will now be processed by the
Bed Management direct admission service. One
phone call to (610) 402-4508 will be all it takes
to admit a patient from the physician's office
directly to LVH-Muhlenberg, Cedar Crest & I-78,
or 17th & Chew. A specially-trained direct
admission clerk will take clinical, demographic,
and insurance information on the patient to be
directly admitted. (A copy of the Direct
Admission Reservation Form is attached on Page
8 to give you an idea of the information that will
be requested.) When possible, the bed
assignment will be given to the physician’s office
at the completion of the reservation call. If a
bed assignment cannot be made immediately, the
office from which the patient will be admitted
will be called with the bed assignment by the
Bed Management staff within five minutes.

In the event that the patient requires a critical
care bed, the direct admission clerk will

(Continued on Page 3)
begin use of the guidelines. The class of telemetry is required information, since it clearly defines the length of time the patient will be monitored. Telemetry is discontinued automatically by the RN as per the guidelines -- Class I (72 hours); Class II (48 hours); Class III (24 hours).

If the physician deems it necessary, telemetry may continue longer than defined in the guidelines. However, a physician’s order and documentation of the indication for continued telemetry monitoring is required in this instance.

The Guidelines for Telemetry Monitoring on Medical/Surgical Units are attached for your information. In addition, pocket cards that define the guidelines are available in the Medical Staff Lounge at Cedar Crest & I-78 or contact Mary Jean Potylycki, Director of 4A/4C, at (610) 402-8777.

If you have any questions regarding the guidelines for telemetry monitoring, please contact Bruce Feldman, DO, at (610) 770-2200.

For the Calendar!

The General Medical Staff meetings for the Year 2001 will be held in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78, beginning at 6 p.m., on the following dates:

- March 12
- June 11
- September 10
- December 10

All members of the Medical Staff are encouraged to attend.
News from the Health Information Management Department

LVH HIM Departments

Change in Office Hours at Cedar Crest & I-78 - Due to decreased physician activity, the new office hours at Cedar Crest & I-78 are 7 a.m. - 8:30 p.m. (Monday - Friday) and 7 a.m. - 5 p.m. (Saturday - Sunday).

When there is no staffing available at either the Cedar Crest & I-78 or 17th & Chew sites, physicians and residents may access the department with their photo ID badge to utilize the PC's to review or complete medical records. Physicians who experience difficulty accessing the HIM Department at either the Cedar Crest & I-78 or 17th & Chew sites should contact Susan Cassium at (610) 402-8330.

Short Procedure Unit (SPU) Cases

A history and physical is required for any invasive procedure that places the patient at significant risk, regardless of whether the procedure is done (ambulatory surgery, SPU, GI Lab, Invasive Radiology, etc.). Form (MRD-60), specifically designed for use in these areas, can be ordered from the LVH Print Shop utilizing e-mail bulletin board, forms_/LVH. If you do not have e-mail access, please call the Print Shop at (610) 402-8562. This form allows the physician to document a short history and physical, procedure and discharge summary, all on the same form.

Procedure Request/Consent Form

The Procedure Request/Consent Form (MRD-04), which is required to be filled out completely, dated and timed, was revised in January 2000 as a consolidated form for LVH and LVH-M. Forms can be ordered through the hospital via Pic 'n Pac.

Document Imaging

Universal Chart Order - The HIM Department has received many concerns from clinicians that viewing historical records is difficult from the document imaging system because documents are not in chronological date order. HIM staff are working with the patient care units to assure that the charts remain in chronological order when patients are on the unit and after discharge.

Please remind your physicians that if they need to review a discharged patient's record that has been removed from the binder, to keep the chart in order.

The HIM staff will also review charts after discharge to assure that there are no large missing portions in addition to assuring that the progress notes and orders are in chronological date order.

Editing Transcribed Reports - If a physician encounters a report that needs corrections, they may print the report from Phamis/IDX, make the corrections, and send to the HIM Department at Cedar Crest & I-78. Please remind them to update the deficiency in the imaging system to indicate that the report is being corrected.

Hardware System Upgrade - Due to the rapid growth and wide acceptance of the document imaging system (electronic signature, chart completion, and chart review), the Information Services Department will be upgrading the hardware and clinical work stations to provide increased speed and capacity. This upgrade will quadruple the optical disk capacity, while providing additional servers.

(Continued on Page 5)
Software Upgrade - A software upgrade is scheduled within the next few months that will provide additional features for the clinicians and Health Information Management Department. Some of the new features that will impact clinicians include:

- **Physician Groups** - Allows definition of physician groups with ability to complete deficiencies for group members.
- **AutoSign** - Allows physician to define a time delay for automatic presentation of documents for electronic signature, with ability to sign entire batch at one time.
- **Encounter Screen** - Allows more reviewing functionality from the encounter screen to move from patient to patient.
- **User Defined Record View** - Allows users to set up and change his/her own record view (documents to be viewed).
- **Missing Text** - Gives clinician the ability to add missing text to imaged documents (transcription, written documents, etc.).

**Verbal Orders**

According to Department of Health regulations, verbal orders must be signed/dated/timed within 24 hours following the order. Clinicians who take verbal orders are tagging the orders with a yellow “sign here” label to alert physicians of orders that need signatures. Since attending physicians are responsible for their patients, the attending physicians are being asked to check the charts on daily rounds for verbal orders that may have been given by the residents or consultants on their patients.

**Bylaws of the Common Medical Staff** - “A physician may not give a verbal order except in an emergency situation. When a verbal order is taken in an emergency, it must be counter-signed by a practitioner within twenty-four (24) hours. If the practitioner is not the attending physician, he or she must be authorized by the attending physician and must be knowledgeable about the patient’s condition.”

**Documentation Requirements**

The following list summarizes required documentation in the medical record. In addition, the requirements have been placed at dictation stations and in the HIM Departments at LVH (Cedar Crest & I-78) and LVH-M.

**History and Physical**

**H&P in the Inpatient Setting** - Documentation should include the following:
- Patient Complaint
- History of Present Illness
- Previous Medical History
- Family and Social History, where pertinent
- Review of Symptoms
- Vital Signs
- Physical Examination

**H&P in the Outpatient Setting**

--All ambulatory procedures in the operative suite require a complete H&P prior to the procedure and should include the following:
- Indications/symptoms for surgical procedure
- Previous medical history
- Current medications/dosages
- Known allergies/reactions
- Past medical/surgical history (including co-morbid conditions)
- Vital signs
- Physical examination

--All ambulatory procedures not performed in the operative suite that place the patient at significant risk require a brief H&P consisting of the following:
- Reason for procedure

(Continued on Page 6)
• Significant past medical history
• Current medications
• Allergies
• Plan for anesthesia
• Post-operative plan and, at a minimum, a record of vital signs
• Examination of heart, lungs, and part to be invaded

Discharge Summary/Note

**Discharge Summary in the Inpatient Setting**
The clinical resume (Discharge Summary) should recapitulate, concisely:
• Diagnoses/procedures
• Reason for hospitalization
• Significant findings
• Procedures performed and treatment rendered
• Condition of the patient on discharge; and
• Any specific instructions given to the patient and/or family, as pertinent

**Discharge Note in the Ambulatory/Outpatient Setting or patients hospitalized less than 48 hours**
• Final diagnosis
• Condition on discharge
• Discharge instructions to patient/family (meds, diet, activity, etc.)
• Follow-up care

Consideration should be given to instructions relating to physical activity, medication, diet and follow-up care. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague or relative terminology, such as "improved."

Discharge summaries are to be dictated by the attending physician or designee at the time of discharge.

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

**Get Your Flu Vaccine!**

Protect yourself, protect your family, and protect your patients! This year, the hospital is striving to achieve an 80% vaccination rate for flu among doctors, residents, and healthcare workers. In anticipation of a pandemic this year, vaccination is extremely important. Members of the Medical Staff can be vaccinated in the hospital Employee Health Office at both Cedar Crest & I-78 and LVH-M as a courtesy if they cannot get the vaccine in their own offices.

**Employee Health Walk-In Hours include:**

**Cedar Crest & I-78**
- Monday, Wednesday, Friday - 7 to 8:30 a.m.
- Monday & Thursday - 1:30 to 4 p.m.
- Tuesday - 1 to 3 p.m.

**LVH-Muhlenberg**
- Tuesday - 9 to 11 a.m.
- Wednesday - 2 to 4 p.m.
- Thursday & Friday - 8 to 10 a.m.

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**PHYSICIAN DOWNTIME PROCEDURES**

402-DOWN (3696)
During an extended network downtime (2 hours or more), please call 610-402-DOWN and press the appropriate number for the department you are trying to reach:
- # 1 - Admission/Bed Assignment
- # 2 - Pathology, Micro and Clinical Lab Reports
- # 3 - Pharmacy
- # 4 - Radiology
- # 5 - Operating Room Scheduling
Medical Staff Directory Now Accessible through E-mail

This year, in an effort to take advantage of today's technology, a new Bulletin Board -- Directories -- has been created in e-mail. Monthly updates of the Medical Staff Directory will be posted to the bulletin board. In addition, the Directories e-mail bulletin board will contain the following information:

- Medical Staff Division/Section Roster Listing
- Medical Staff Group Listing
- Department Chairs and Division and Section Chiefs Listing
- Unit Directors Listing
- Allied Health Staff Directory
- Medical Staff UPIN numbers

Anyone with hospital e-mail will be able to access any of this information. Therefore, by providing this information regularly, a limited number of directories have been distributed to departments and physicians' offices. This will provide a significant cost saving to the hospital and save many trees!

To access the above information, select Directories from e-mail Bulletin Boards and select the information you wish to view from the list provided.

Who's New

Linda Esterly, Office Manager
East Penn Rheumatology Associates
701 Ostrum Street, Suite 501
Bethlehem, PA 18015-1155
(610) 868-1336
Fax: (610) 882-1133

Beverly Haas, Office Manager
Gradwell & Astolfi, DMD, PC
1245 S. Cedar Crest Blvd., Suite 200
Allentown, PA 18103-6267
(610) 770-1050
Fax: (610) 770-6592

Charlene Keenan, Office Manager
Lehigh Valley Diagnostic Imaging
1230 S. Cedar Crest Blvd., Suite 104
Allentown, PA 18103
(610) 402-1015
Fax: (610) 435-8329

Brenda Raudenbush, Office Manager
Lehigh Neurology
1210 S. Cedar Crest Blvd., Suite 1800
Allentown, PA 18103-6208
(610) 402-8420
Fax: (610) 402-1689

Happy Holidays!
**LEHIGH VALLEY HOSPITAL – BED MANAGEMENT**

**DIRECT ADMISSION RESERVATION FORM**

Direct admission phone # (610) 402-4508  
Bed Management fax # (610) 402-1696

**Date:** ________  **Time:** ________  **Time Bed Confirmed:** ________  
**Time Patient Called at Home:** ________________________________________

**Name of Caller:** ____________________________  **Call-back #:** _____________

**Name of Patient:** _______________________________________________________

**Age/ DOB:** ____________________________  **Medical Record #:** ________________

**DX:** __________________________________________________________________

**Procedure/Date:** _______________________________________________________

**Inpatient:** ________  **Ambulatory:** ________  **Observation:** _____________

**Type of Bed Requested:**  
- M/S  
- M/S telemetry  
- Low-level monitor  
- High-level monitor  

(circle type of bed)

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**Drips:**  
- Nitroglycerine  
- Nipride  
- Dopamine  
- Dobutrex  
- Lidocaine  
- Pronestyl  
- Other: ________________________

**Referring MD:** ____________________________

**Admitting MD:** ____________________________

**Patient Demographic/Insurance information**

**SS#:** ______________________________________

**Address:** ______________________________________

**Phone #:** ______________________________________

**Primary Insurance:** ______________________________________

**Secondary Insurance:** ______________________________________
OVERVIEW

Patients are classified into three groups based upon their relative risk of a life threatening dysrhythmia.

CLASS I - The risk of VF, sustained VT, severe bradycardia (heart rate less than 40 BPM in association with altered consciousness) is significantly increased (>1/100 monitored patients). The likelihood of identifying a significant dysrhythmia that would result in a change in therapy is increased (> 5/100 monitored patients).

MONITORING MUST BE RENEWED EVERY 72 HOURS OR IT WILL BE AUTOMATICALLY DISCONTINUED.

CLASS II - The risk of VF, sustained VT, severe bradycardia, or the likelihood of identifying a dysrhythmia that would result in a change in therapy is low (approximately 5/1,000 monitored patients).

MONITORING WILL BE LIMITED TO 48 HOURS.

CLASS III - The risk of VF, sustained VT, or severe bradycardia, or the likelihood of identifying a significant dysrhythmia that would result in a change in therapy is very low (approximately 5/10,000 monitored patients).

MONITORING WILL BE LIMITED TO 24 HOURS.
CLASS I
MONITORING MUST BE RENEWED EVERY 72 HOURS
OR IT WILL BE AUTOMATICALLY DISCONTINUED

Patients with these clinical criteria should receive rhythm monitoring:

SYNCOPE in patients with: CHF - or respiratory failure; EF Less than 40%; nonsustained ventricular tachycardia; systolic BP less than 90 mmHg; second degree Type II or third degree heart block; bradycardia (heart rate < 45 BPM); tachycardia (heart rate >120 BPM); post VF/VT arrest and resuscitation.

SECOND DEGREE TYPE II OR THIRD DEGREE HEART BLOCK (ASYMPTOMATIC)

ATRIAL FIBRILLATION (NEW ONSET) in patients: receiving rate control treatment; undergoing pharmacologic cardioversion; D.C. electrical cardioversion.

POSTOPERATIVE (NONCARDIAC) SURGERY in Patients with: Angina; ST-T changes; myocardial ischemia on pre-op stress test; systolic BP < 90 mmHg; CHF with respiratory failure (O2 sat <90% on room air or respiratory acidosis); bradycardia (heart rate <45 BPM); tachycardia (heart rate >120 BPM).

POST CARDIAC SURGERY through Day 4.

DEVICE THERAPY: Post permanent pacemaker; Post temporary pacemaker; Post AICD.

POST RADIOFREQUENCY ABLATION

POST VF/VT ARREST RESUSCITATION

INITIATION OF TYPE I/III ANTIARRHYTHMIA AGENTS

DRUG TOXICITY WITH ARRHYTHMIA (e.g. - digitalis toxicity)

RESPIRATORY FAILURE as defined by: hypoxemia - PAO2 < 90% despite FIO2 ≥50%. Hypercapnea - uncompensated respiratory acidosis Ph <7.35 clinical evidence of severe respiratory distress - e.g. respiratory rate >35.

TRAUMA with significant blood loss, hypotension, respiratory failure.
The benefit of monitoring patients with these characteristics was considered controversial.

**CHEST PAIN WITH NORMAL EKG**

CHF in association with: EF greater than 40%; no respiratory failure; systolic BP >90 mmHg.

**SYNCOPE** in patients with no structural heart disease (as assessed by exam, ECG and echo).

**POSTOPERATIVE (NONCARDIAC) SURGERY** in patients with stable cardiac disease (status post CABG, status post PTCA, status post valve replacement with no clinical evidence of heart failure or ischemia).

**HYPOTENSION** (systolic BP <90mmHg) without associated cardiac disease.

**BRADYCARDIA** < 45 - (asymptomatic)

**TACHYCARDIA** > 120 - (asymptomatic)

**CARDIAC CONTUSION**

**RESPIRATORY FAILURE**

**MAJOR ISCHEMIC OR HEMORRHAGIC STROKES** with potential for arrhythmia.

**PATIENT WITH STATUS EPILEPTICUS** or seizure disorder at risk for sudden death.
CLASS III

The likelihood of identifying a significant dysrhythmia that would result in a change in therapy is very low.

*MONITORING WILL BE LIMITED TO 24 HOURS*

Patients with these characteristics are at a very low risk for life threatening cardiac dysrhythmias:

**TERMINAL ILLNESS**: End stage lung disease, heart failure, liver failure, malignancy or CNS disease.

**DNR STATUS** with specific identification that arrhythmia will not be treated.

**ASYMPTOMATIC PVCs**

**CHRONIC ATRIAL FIBRILLATION** with controlled rates.

**POSTOPERATIVE (NONCARDIAC) SURGERY** in patients with EF greater than 40%; no active ischemia; no signs of congestive heart failure.

**POST CORONARY ANGIOGRAPHY** in patients with: stable angina; no CHF.

**ACUTE MEDICAL ILLNESS** with: stable cardiac disease - no ischemia, no CHF.
FOCUS

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FOCUS is published quarterly for the office staffs of physicians on the Medical Staff of Lehigh Valley Hospital. Articles for the next issue should be submitted by March 9, 2001, to Janet M. Seifert, Medical Staff Services, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box 689, Allentown, PA 18105-1556.

For more information, please call Janet at (610) 402-8590.