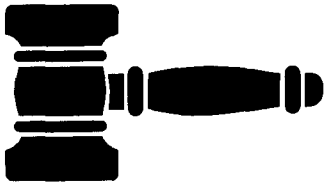
LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

PROGRESS NOTES

Medical Staff

August, 2000 ◆ Volume 12, Number 8

In This Issue . . .



From the President

"But know also, man has an inborn craving for medicine. Generations of heroic dosing have given his tissues such a thirst...for drugs. As I once before remarked, the desire to take medicine is one feature which distinguishes man, the animal, from his fellow creatures. It is really one of the most serious difficulties with which we have to contend. Even in minor ailments, which would yield to dieting or to simple home remedies, the doctor's visit is not thought to be complete without the prescription." [1]

Colleagues,

Last month, I discussed the problem of physician handwriting legibility. The Medical Executive Committee has reacted to this chronic problem by passing a resolution that applies to all the members of the Lehigh Valley Hospital Medical Staff. I insert this resolution here again so that we can all be aware of the policy that now applies to all of us.

The committee voted to **require that signatures must be followed by the physician's printed name whenever it appears in the chart**. A self-inking name stamp will be provided by the hospital to physicians who feel that printing their name is too burdensome. (For more information, contact Janet Seifert in Physician Relations at (610) 402-8590.)

I know that many of you are already printing your name after your signature. I would encourage you to continue this process and to follow your printed name with your pager number so that the staff can contact you easily if they have questions about your orders or notes. A number of the members of the Medical Staff have actually improved their handwriting to the point that their notes and orders have become more legible.

The ad hoc committee which has been organized jointly by the Medical Staff and the LVPHO to assist in the implementation of the "4N" version of the PHAMIS/IDX *"LastWord"* computer system has begun to meet. This new version of our current medical information system includes better "Patient Management" software including computerized physician order

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[1] Osler, William. Teaching and Thinking. 1895. [Reprinted in Aequanimitas with Other Addresses to Medical Students, Nurses, and Practitioners of Medicine, 3rd ed. Philadelphia: Blakiston's Son; 1932, p. 125.

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entry. It is expected that this system will be operational by late spring 2001. The members of the committee will be assisting the staff of the I/S department in an effort to make a smooth transition to the new system. Our goal is to make the introduction of the new system as physician-friendly as possible. All physicians will be adequately and intensively trained in the use of the new software. The primary driver for the new software is the hope that this change will result in improved quality of the care that we deliver to our patients. Hopefully, errors, due to transcription, will be reduced, and issues of illegible or confusing orders should disappear with the new system.

Although the introduction of this new system may result in a brief period of increased work by physicians on their daily rounds, it is hoped that within a brief period of time during which physicians become acclimated to the new processes, that our rounds will become more efficient. Many of us will also have the housestaff available (at least part time) to help us with order entry. The 4N version also contains "Channel Health," which will allow referring physicians to obtain information about their hospitalized patients over the web. We will also have the ability to enter orders on our patients from our offices or from home via computer links that already exist.

At our September General Medical Staff meeting, representatives from Information Services and IDX will make a presentation of this new system. After the meeting, workstations will be set up so that members of the staff can see the new system in operation and have some "hands on" experience with the new technology. I would encourage all of you to try to attend this important meeting.

I know that most of the active members of the staff, with privileges at Cedar Crest & I-78, have begun to use the IMNET electronic patient medical record system to complete their charts. Although there have been some of the expected early glitches with the system, I feel the introduction has been remarkably smooth. My conversations about the IMNET system with members of the staff have been overwhelmingly positive. One problem we do have is getting completed charts dictated from the computer terminals. This does take some practice. I would encourage all of my colleagues to try to dictate their discharge summaries on the day of patient discharge while the paper chart is still available on the floor. The Medical Record Department staff has informed me that chart signatures are up-to-date. Dictation of discharge summaries lags somewhat behind. I expect this will improve as we all become more familiar with the process of dictating from the computer screen.

For the past few months, I've been editorializing about large "for profit" managed care organizations. As we all know, Aetna/U.S. Healthcare is one of the largest of these organizations and provides health insurance coverage for more than 20 million Americans. They have recently announced that their quarterly returns will be below expectations and have attributed this to rising health care costs. They have also indicated that as a result in a decrease in their profits, they may be forced to increase premiums to their customers. In the northeastern U.S., PennCARE℠ has been the most clinically successful "integrated delivery system" with which Aetna/U.S. Healthcare has had a contractual agreement. In spite of this, PennCARE℠ has lost money in this relationship over the past four years. Our LCU (Lehigh Valley PHO) has been very successful from a standpoint of patient length of stay, and denied or downgraded hospital days. This is a tribute to the hard work of all of our physicians and the efforts of the Care Management Systems care managers who work with us on the floors.

You have all heard that after nine months of difficult negotiations, an agreement was finally reached between PennCARE℠ and Aetna/U.S. Healthcare. This agreement addressed the percentage of premium to PennCARE℠ from Aetna/U.S. Healthcare for both Medicare and commercial subscribers. It also dealt with outstanding reimbursement issues.

In spite of this new contractual arrangement with Aetna/U.S. Healthcare and our LCU's success in managing care for our hospitalized patients, the Lehigh Valley Hospital feels that it cannot profitably continue in the "risk" arrangement with PennCARE℠ and Aetna/U.S. Healthcare. Physicians in the LVPHO and the Muhlenberg PHO have been given the option to either continue to participate in or withdraw from the "risk" arrangement with Aetna/U.S. Healthcare. If none of the physicians in the GLVIPA decide to participate in "risk," LVH will then announce that it will withdraw from the "risk" arrangement which exists between PennCARE℠ and Aetna/U.S. Healthcare. Lehigh Valley Hospital-Muhlenberg will take the same action if its physicians elect not to participate in "risk."

This represents a major change in policy and approach to this MCO's by the Lehigh Valley Hospital. Further discussions with Aetna/U.S. Healthcare may take place regarding the "network services agreement." "Medicare Managed Care" is widely seen as being a failure for the insurers, physicians, and the patients who have enrolled after being lured by the offers of free medications, eyeglasses, and dental care. One of the causes for these failures has been the rising cost of pharmaceuticals nationwide.

Many hospitals in neighboring counties in Pennsylvania have felt so mistreated by Aetna/U.S. Healthcare that they have not

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renewed their contracts. They have risked the loss of patient volume rather than continue in contracts that resulted in financial losses for every patient for whom they provided care.

Perhaps stockholders in Aetna/U.S. Healthcare should feel more sanguine about the future of their investment since the company will no longer be paying Mr. Leonard Abramson $3 million annually to serve on their Board of Directors! In a number of states, the corporation has been forced to reevaluate some of their contracting practices and to agree to change many of their notorious reimbursement policies for physicians and hospitals.

"Aetna Inc. has agreed to sell its financial and international units, and will focus entirely on the business of health care. Aetna's financial and international units will be merged into one of the subsidiaries of Dutch insurer ING Group Inc., which will assume $2.7 billion of Aetna's debt and pay $5 billion in cash. Aetna CEO William H. Donaldson is still seeking a permanent head of health care operations, which posted net income of $437 million last year on revenue of $20.9 billion."[2] One wonders if they have chosen to focus on the correct area of business.

Most large "for profit" MCO's are experiencing hard financial times. As I've said in the past, I do believe that care needs to be "managed," however, I'm not sure that "for profit" MCO's provide the best vehicle for that care management. I continue to believe that a consortium of community leaders, corporate executives, physicians, and hospital administrators would be better able to design a health care delivery system which would best serve the population of our community. This concept is an expression of the concept that "all health care is local." There may be no national model for health care delivery that fits every community in the country. What may work well in Philadelphia may not satisfy the needs of our Lehigh Valley community. Physicians working with hospitals and the community should be able to develop a system which provides for the appropriate financial incentives to make care management work. This care management should be lead by physicians who have the best interests of their patients at heart. We need to remember that our primary responsibility as doctors is to provide the highest level of care for **each** of our patients. We also need to be aware that health care resources are limited and that we need to think about these limitations when we think about designing a delivery system. Rationing decisions need to be made by society through the political process.

[2] The Hartford Currant, July 20, 2000.

Sit, Answer and Touch!

Remember, when you are making hospital rounds to sit at your patient's bedside, ask for their questions, answer their questions, and make physical contact with the patient.

One of my "pet" concerns over the past several years has been the frequency with which we see routine pulse oximetries recorded as part of our patients' vital signs. This month's edition of ***Medical Staff Progress Notes*** contains a policy change relative to the performance of pulse oximetry. This change should reduce the work of the nurses, technical staff, and administrative partners. I hope that it will reduce the number of calls which physicians receive from the floors. It may also reduce the cost of patient care as it may eliminate some unnecessary testing which occurs as a result of low oxygen saturation levels detected in asymptomatic patients.

E-MAIL

One more time, I'd like to encourage all members of the Medical Staff to read their e-mail regularly or to designate a staff member to be your appointed "surrogate" who can read and print out your e-mail messages for you on a daily basis. If you or your staff need help in assigning a "surrogate," please call Information Services at (610) 402-8303.

I've recently been asked by one of our medical staff members, "What ever happened to your plan to reorganize the inpatient patient chart?" Dr. Linda Lapos, the chair of the Medical Records Committee, conducted a survey to determine what changes our Medical Staff felt should be made in the patient chart. Those who responded to the survey suggested that the chart order should remain the same. They did feel that the divider tabs should be the same color and in the same position in all of the charts. They also felt that there were some pages in the medical record that could be moved so that the chart would be easier for physicians to use. This is a "work in progress." I recently have had discussions with Terry Capuano, Senior Vice President, Clinical Services, about her plans to reduce the amount of documentation that our nurses perform in every chart. She feels, and I agree, that the admission evaluation could be streamlined so that patients are not asked the same questions over and over by multiple interviewers. One of the most frequent complaints we hear from patients is the frequency with which they are asked identical questions.

I have received a number of interesting comments regarding my discussion last month about drug costs and the pharmaceutical industry. I thank those of you who have offered your opinions and your attention to my remarks. I feel very strongly that Americans are being asked to spend too

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much for their medications. I believe that pharmaceutical industry profits are abnormally (some would say obscenely) high and that their marketing efforts and budgets are excessive. It appears that the federal and many state governments are taking note of the rapid rise in drug costs and will be addressing this important issue soon. What possible connection exists between the gift of an earphone and tiny microphone which attaches to my cellular phone and the Pepcid[tm] that I am being encouraged to prescribe for my patients?

I hope you're having a pleasant, interesting, and even restful summer. This is a great time for vacations. We all need to be able to take some personal time for our families and ourselves. This allows us to return to our daily work rested, relaxed, and recharged.

David M. Caccese, MD
Medical Staff President

Urology Ranked Again on U.S. News' "Best Hospitals" List

For the fifth consecutive year, Lehigh Valley Hospital (LVH) is ranked as one of the top health care providers in the nation in ***U.S. News & World Report's*** annual guide to "America's Best Hospitals." The hospital's urology program made the honor roll for the fourth year in a row.

"We enjoy the accolades we've received from being included among the best hospitals in the country the past five years– four in urology and other years in heart services, geriatrics and respiratory disorders," said Robert J. Laskowski, MD, LVHHN's chief medical officer.

The 2000 edition of "America's Best Hospitals" assessed care in 17 specialties, one more than in 1999. Kidney disease programs were not ranked in previous years. Rank for all specialties is based on a three-part score: reputation, mortality and a set of other data including technology and nursing care.

"This recognition for the fourth year is not coincidence, but reflects the high-quality urologic care provided by the professionals in the division," said Edward M. Mullin, Jr., MD, chief, Division of Urology. "I think our listing in ***U.S. News & World Report*** indicates that people do not have to leave the Lehigh Valley for the best urologic care available."

If anything, the division is even stronger this year because of the addition of Joseph G. Trapasso, MD, a board-certified urologic oncologist," Dr. Mullin added. "We are pleased and honored to be ranked among the best urology services in the country and happy to be part of Lehigh Valley Hospital, a high-quality institution," he said. The program is ranked 44th on the list of the top 50 urology programs on the "America's Best Hospitals" list.

LVH's urology division has 10 board-certified physicians who offer a comprehensive range of urologic services. These include urologic oncology treatments; impotence; urinary incontinence in men and women; urinary stone disease; malignant and benign urologic disease, and urologic services for women and children. Also, the urology service maintains an active residency program affiliated with the Penn State College of Medicine at Hershey. All 10 physician members of the division participate in the teaching program, which is run by Brian P. Murphy, MD.

While recognition for providing quality health care from national organizations like ***U.S. News*** and HCIA is important, Dr. Laskowski said, "What matters to us most is what our community thinks." HCIA, Inc., a leading provider of health care quality information, named LVH as one of the country's top providers of coronary angioplasty and open heart surgery in 1998.

"A recent independent study conducted by the National Research Corp. last year tells us what we most want to hear: LVH is named the first choice for heart care by 57 percent of Lehigh Valley residents who were surveyed. The next closest hospital was named by 20 percent," Dr. Laskowski added.

Fair Parking for Physicians/Housestaff at 17th & Chew

It's that time of the year again . . . time to begin preparation for the Great Allentown Fair. As in past years, parking changes will be made. From Tuesday, August 15, through Monday, September 11, physician and housestaff parking will be reassigned to Lot #4 - North West Street and Lot #5 - Gordon Street. Physician and housestaff photo IDs will be programmed to access these areas during this period.

If you have any questions regarding this issue, please contact Louis Geczi in Security at (610) 402-2986.

News from the HIM Department

Document Imaging

The Health Information Management Department would like to thank the Medical Staff for its cooperation in implementing the "paperless historical medical record." Through your cooperation and willingness to convert to a system that is both beneficial to the medical staff and the organization, dramatic improvements have been made in services offered by the Health Information Management Department.

Computer Access - The Document Imaging system can be accessed from any clinical workstations within the organization. In addition to utilizing the workstations in the Health Information Management Department, look for the PCs with the label "document imaging enabled" to sign/dictate medical record documentation.

Document Imaging Tips

- Remember to check the imaging system for incomplete charts a couple of times a week (between cases, waiting for assistance, etc.)
- When rejecting deficiencies, be sure to give the reason in order that your cases may be forwarded to the appropriate persons.
- Dictate HP/DS/OP/Consults while patient is still on the unit (charts remain on unit until noon the day following discharge).
- Your PIN (personal identification number) is your personal number and no one has access to this except you.
- When completing dictations identified in the imaging system, remember to hit the "complete" button after you have dictated.
- If you click on "process all" to complete your deficiencies, you will not have to enter your PIN after each report.
- You can complete your records from Clinical Workstations on the units labeled "document imaging enabled."
- Chart addendum forms are available in the HIM Department at the Cedar Crest & I-78 and LVH-M sites to add documentation to the medical record after the record has been imaged.

Dictations/Transcription

If transcriptions need to be amended or corrected, you can print the reports from Phamis, make the corrections, and have the units forward the report to the HIM Department. In the HIM Department, staff can assist you with corrections/addendums.

Pre-admission Medical Records - Effective August 1, the HIM Department will supply a medical record abstract for readmits for records that are included in the document imaging system. The abstract will be printed on "buff" colored paper, which indicates that this is an imaged record. If additional information is needed for patient care, clinical workstations are available in the patient care areas to view the records.

Paper/microfiche historical records will continue to be made available for records prior to implementation of the document imaging system.

If you have any questions regarding Document Imaging, please contact Sue Cassium, Operations Coordinator, at (610) 402-4451.

Health Information Management Department Access

Due to the success of document imaging, elimination of the need for the paper historical medical record and lack of activity in the HIM Department at the Cedar Crest & I-78 and 17th & Chew sites, office hours/staffing is being altered as noted below. The HIM Department at 2024 Lehigh Street will continue to be available 24 hours a day, seven days a week at (610) 402-8445.

17th & Chew - The HIM office will no longer be staffed. Physicians who need access to the department to utilize the PCs may use their ID badge for access. For assistance, a telephone is located at the entrance to the department for direct access to HIM staff or you may dial Ext. 8445.

Cedar Crest & I-78 - For security purposes, the Cedar Crest & I-78 HIM Department will be automatically locked from 6 p.m. each day until 7 a.m. the following morning. Physicians may use their ID badge to access the department to utilize the PCs. For staff assistance, please dial Ext. 8445.

Lehigh Valley Hospital-Muhlenberg

Multidisciplinary Progress Record - Effective with September 1 admissions, multidisciplinary progress note charting will be implemented at LVH-Muhlenberg to assist clinicians in documenting in the medical record for continuity of care. All disciplines will document on the white Progress Record (form # NSG-03). Chart tabs for miscellaneous departmental documentation of progress notes will be removed and the only remaining one will be Progress Record.

Forms Consolidation/Chart Order/Chart Binders - Several months ago, "walleroos" (chart binder holders outside the patient rooms) were installed. Effective with the September 1 admissions, LVH-Muhlenberg will convert to side hole binders and the binders will be stored outside the patient 's room.

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JCAHO Update

Briefly, JCAHO provides guidelines for hospitals on which surveys are based. If HCFA (Health Care Financing Administration) or State (Department of Health) guidelines are more stringent than JCAHO, the organization is reviewed based on the more stringent guidelines.

Signature Stamps - According to HCFA and the State (Department of Health), the use of signature stamps is an unacceptable form of physician authentication because use by only the physician cannot be verified. An exemption may be granted by HCFA for physicians who find handwriting a hardship due to legitimate disability. To obtain exemption, physicians should submit a letter to HCFA stating the nature of the disability to support the request. The Department of Health does not provide an avenue for requesting an exemption.

Medical record studies indicate that signature stamps are infrequently used while patients are in the hospital. However, it has been identified that many pre-admission documents (HP, orders, etc.) and discharge summaries from physician offices contain a rubber stamped signature. Your cooperation is requested in affixing an official signature to these chart documents.

Effective September 1, histories and physicals, consultations, and operative reports that are identified with a rubber stamp signature will be made a deficiency and returned to the physician for an electronic signature. Electronic signature is an approved mode of signature.

If you have any questions regarding the above issues, please contact Zelda Greene, Director, HIM Department, at (610) 402-8330.

Ambulatory Patient Classification Grouping

The new Hospital Outpatient Prospective Payment System (OPPS) uses the Ambulatory Payment Classification (APC) grouping to set payment rates. APCs group HCPCS codes that have similar clinical characteristics with similar costs or resources. Implementation is scheduled for August 1, 2000. Hospitals must ensure that all services provided directly or under an arrangement during an outpatient encounter are billed together—or the hospital may be subject to civil penalties.

Physician education and involvement are essential to the implementation process to assure hospitals do not lose reimbursement under APCs. Following are some areas identified to alert the medical staff to the changes:

Accurate Coding
Documentation drives coding and that coding will drive everything else under OPPS. "Physician documentation in the medical record serves as the backbone for correct coding of services."

Inpatient-only Procedures
Hospitals won't get paid if physicians perform one of the "inpatient-only" procedures on an outpatient basis. The Health Care Financing Administration (HCFA) has designated 1,803 HCPCS codes that represent procedures that require inpatient care and will not be paid under OPPS. Scheduling areas will assist you with these cases.

Discontinued Procedures
Hospitals will get different payments when procedures are discontinued. For example, modifer-73—used when a procedure is terminated after a patient has been prepared for surgery and taken to the operating room, but before induction of anesthesia—results in a 50% reduction in payment to the hospital. The hospital, however, will receive full payment for the procedure if it is started but discontinued after the induction of anesthesia—indicated by use of modifer-74.

Observation Status
Observation services will be packaged into the APC payment rate. Packaging of observation may give hospitals an incentive to admit certain patients, (i.e. chest pain), however, HCFA will be monitoring one-day stays.

Scheduling
Physicians need to provide precise and accurate information when scheduling surgeries. For example, if a doctor does not convey the correct procedure to the registration staff, then he or she may end up performing a procedure on the list of "inpatient-only" procedures. The result could be the wrong information on the claim and its subsequent denial by HCFA.

Timely Documentation
Completing and signing operative reports in a timely fashion is important. A hospital's cash flow will depend on getting these reports done quickly so that the claim can be submitted in a timely fashion to maintain a healthy cash flow.

Medical Visits
Hospitals should work closely with the emergency room physicians to develop a system to measure the intensity of hospital resources used for clinic visits. Physicians should be aware the HCFA does not expect a high degree of correlation between the physician's code for his services and the code reported by the facility for resources used.

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

An Update from Radiology

Voice Recognition

Radiology implemented a voice recognition system in late June. The radiologists correct their own reports. In the few short weeks the system has been in place, report turnaround has been reduced by half in most areas. In some areas, close to 100% of the reports are signed in less than 24 hours.

If you have any questions or concerns, please contact Valerie Hunsicker, Operations Coordinator, at (610) 402-0303, or Sheila Sferrella, Administrator, at (610) 402-4473.

Radiology Physician Order Form

Over the last two years, the Radiology Task Force has made several attempts to reduce the percentage of incorrect diagnostic, ultrasound, and CT scan orders relating to RN/administrative partners order entry and physician ordering by developing reference sheets, increasing awareness by communicating to nursing and the medical staff, and revising the Phamis screens to include reference information. Most recently, the Radiology Task Force created a Radiology Physician Order Form that provides specific ordering information for physicians and a simple check off for selection of studies. The form focuses on high volume/high frequency orders placed incorrectly.

The goal of the Radiology Physician Order Form is to decrease the percentage of incorrect errors, perform the correct study on the patient the first time, eliminate unnecessary calls to physicians for clarification, obtain faster results, and eliminate rework.

The form was approved by the Forms Committee in June, and by the Medical Executive Committee in July. The Radiology Task Force will now begin RN/administrative partner education through September, when the use of the form will be implemented. Continued measurement and evaluation will be performed from September through December.

If you have any questions or concerns regarding this issue, please contact Joy Schatz, Operations Coordinator, at (610) 402-0386, or Sheila Sferrella, Administrator, at (610) 402-4473.

Pulse Oximetry Policy Change

Effective June 26, a revised policy has been put into place, based upon the investigation of the workflow analysis team report. It was identified that pulse oximetry was being performed as a fifth vital sign. This task was performed frequently on patients who did not require this procedure.

Based upon this finding, a work group was brought together to assess, evaluate and implement a plan of action. The plan is as follows:

A. All patients who are ordered on O_2 will automatically be placed on the O_2 titration protocol. The physician has two obligations:
   1. He/she must write an O_2-saturation goal for the RN to maintain the O_2 titration.
   2. If he/she does not want the patient to be on the O_2-titration protocol, then he/she must write an order for that patient not to be on the O_2 titration protocol.

B. If the physician does not want the patient on the O_2-titration protocol and wants the patient on oxygen, he/she MUST write for pulse oximetry to be performed. The physician must write an order **every 24 hours** to maintain pulse oximetry.

The act of pulse oximetry will only be performed under the following circumstances:

- Upon arrival to the floor (transfer or admission)
- Post-op
- Initial placing of O_2
- While the patient is on the O_2 titration protocol
- With a physician order, renewed every 24 hours.

If you have any questions regarding this revised policy, please contact Elizabeth Seislove, Patient Care Specialist, Trauma Neuro Intensive Care, at pager 7655.

Golf Tournament to Benefit Lehigh Valley Hospice

The Potts' Memorial Golf Tournament, which will benefit Lehigh Valley Hospice, will be held on Friday, September 8, at the Wedgewood Golf Course in Coopersburg, Pa. Tournament format includes Blind Draw and Best Ball. Starting time is 1 p.m., with a Shotgun Start. Entry fee is $75 per player, which includes green fees, cart, lunch, steak dinner, and prizes. Sponsorship opportunities are also available. Registration deadline is September 1.

For more information, please contact Barb Clouden at (610) 402-7363 or Tracey Sechler at (610) 402-7033 at Lehigh Valley Home Health Services. All proceeds benefit Lehigh Valley Hospice.

Dysphagia Consult Revision

At its June 6 meeting, the Medical Executive Committee approved the following changes regarding dysphagia consults. These changes were recommended in order to address the nutritional needs of patients in a more efficient manner. The changes are effectively immediately.

When a physician orders a dysphagia evaluation, a Speech Language Pathologist (SLP) will receive the consult, initiate the evaluation, and complete documentation that includes the establishment of po management as follows:

- If the patient is NPO, it will be documented on the consult and in the progress note. The patient's RN will call the physician for further orders.
- If the patient is NPO and no previous diet level was ordered, the SLP will write recommendations for a diet level and defer to the attending physician for further dietary restrictions. The RN will contact the attending physician.
- If the patient does have previous diet orders, the SLP can upgrade and downgrade the diet without obtaining an additional physician's order.

If you have any questions regarding this revision, please contact Callie McClatchy, Director, Speech Pathology and Audiology, at (610) 402-2544.

Stroke Alert

Following a great collaborative effort between the Division of Neurology and the Department of Emergency Medicine, on June 20, Stroke Alert was implemented in the Emergency Department at Cedar Crest & I-78.

Stroke Alert is a procedure whereby when a patient arrives in the Emergency Department with stroke symptoms less than two hours from onset, the Emergency Department physician will activate the Rapid Response Team. Members of this team -- neurologist on call, neuro patient care specialist, neuro research coordinator, CT tech, triage bed nurse, MICU resident, and neuro resident -- respond to the Emergency Department to assist the patient. In addition, the neurologist covering the Emergency Department carries a dedicated cellular phone to assist in co-managing care for the acute stroke patient.

The goal of this initiative is to decrease the time for diagnosis and treatment in the hyperacute stroke patient and allow approved and experimental treatment that may benefit the patient to be offered. This model of care very much resembles the treatment afforded Trauma patients.

For more information regarding this initiative, please contact either Richard S. MacKenzie, MD, Vice Chairperson, Department of Emergency Medicine, at (610) 402-8130, or John E. Castaldo, MD, Division of Neurology, at (610) 402-8420.

Acceptable Reasons Required for Diagnostic Testing

Stress tests, echocardiograms, EKGs, and holter monitors are examples of diagnostic tests that require an acceptable reason when ordered by the physician, to enable the performance and reimbursement (hospital and physician) of the test. Tests ordered without a reason noted, or without an acceptable reason, have been identified as a problem. To address this problem, a list of acceptable reasons from the 1999/2000 Medicare Medical Policy Bulletin have been compiled for each of these tests.

Attached to this newsletter, on pages 25-32, are acceptable reasons listed for each of these tests. Please use these lists when ordering a test for your patient, both inpatient and outpatient. These lists are also published in PHAMIS as tables. Beginning August 22, the "reason" field of the test order will be a required or mandatory field in PHAMIS, and will only accept a reason from the published list. Therefore, to avoid annoying phone calls, as you write your patient orders, please also write an acceptable reason for the test.

If you have any questions or need clarification, please contact James A. Pantano, MD, Medical Director, Non-Invasive Cardiology, at (610) 770-2200, or Audrey Lichtenwalner, RN, Director, Clinical Services, at (610) 402-8924.

Chairs and Chief List

Attached for your convenience is the revised listing of Chairpersons of Departments and Chiefs of Divisions and Sections as approved at the July 8 meeting of the Medical Executive Committee. Congratulations are extended to those who have been appointed to new leadership positions.

Bylaws Changes

For your review and information, attached are revisions to the Medical Staff Bylaws as approved by the Boards of Trustees in June, 2000.

Primum Non Nocere Projects

As a response to the Institute of Medicine's report on medical errors, Lehigh Valley Hospital has implemented a series of efforts to improve quality of care. These are known as the Primum Non Nocere (PNN), "First Do No Harm," Projects. Each project has an Senior Management Council sponsor, at least one leader, and an interdisciplinary team with representation from the medical staff, nursing, Care Management, and other stakeholder departments.

Baseline data has been collected for each project in order to assess the incidence and potential impact of these efforts. Each team has developed a measurement and tracking system and set a goal for decreasing the incidence of each problem area. For some projects, the financial impact will be estimated. The steering committee consists of Paula L. Stillman, MD, Senior Medical Director, Care and Resource Management; Sue Lawrence, Administrator, Case Management; Vince Tallarico, Vice President, Planning and Development; Jack Lenhart, MD, Department of Family Practice; Deb Halkins, Senior Management Engineer; Chuck Nace, Director, Finance; and Zubina Mawji, MD, Division of General Internal Medicine.

Following is a list of the projects, along with the sponsor and leader(s):

PROJECT	SPONSOR	LEADER
1. Improvement in Management of Intra-op/Post-op Diabetes	Fitzgibbons	Merkle/Swavely
2. Reduction in the Development of In-house Delirium and Confusion	Kaufmann, M.	Antonowicz
3. Reduction of Stress Ulcer Development	Hoover	Kurek
4. Reduction of Complications from Anticoagulation	Hoover	Cipolle/Pistoria
5. Reduction of UTI's	Fitzgibbons	Kratzer/Mullin
6. Reduction of Deep Vein Thrombosis/Pulmonary Embolism	Hoover	Cipolle
7. Reduction of Medication Errors	Miller	Pane
8. Prevention/Management of Decubitus Ulcer	Capuano	Matula
9. Prevention of IV Infections/Infiltrations	Capuano	Outcomes/Research Committee
10. Prevention of Fluid Overload	Fitzgibbons	Mawji
11. Improve Management of Atrial Fib Post-CABG	Fitzgibbons	Morris
12. Reduction of Falls	Capuano	Lavin
13. Reduction of Unplanned Returns to OR	Hoover	Pasquale
14. Reduction of Needlesticks	Capuano	Capuano/Jagiela
15. Site Identification Team	Maffeo/Hoover	B. Leader/M. Lester

News from Infection Control

Contact Isolation for Major Wounds

Please use your professional judgment in determining whether or not a person with a major wound(s) needs Contact Isolation. The hospital's isolation precautions policy (Infection Control Policy #2300) requires patients with major wounds to be placed on Contact Isolation in a private room. A wound is considered "major" for isolation purposes when it is **not covered by a dressing** or the **dressing does not contain drainage adequately**. A written isolation order from the physician is necessary. DOCUMENTATION is critically important.

Multiple Antibiotic Resistant Organisms

There have been a recent number of cases of **multiple antibiotic resistant *E. coli* and *P. aeruginosa*** isolates in both inpatient and outpatient cultures. Patients with multi-resistant organisms are to be placed on Contact Isolation in a private room. Please be alert for these and other organisms demonstrating unusual resistance patterns and initiate contact precautions. The entire medical team should be informed of the presence of these organisms and strict contact isolation precautions followed to help reduce the nosocomial spread of multiple antibiotic resistant organisms.

For more information, please contact Terry Burger, Manager, Infection Control, at (610) 402-0680.

New Bulletin Board for Physician On-Call Schedules

A new e-mail bulletin board has been created titled MD_on-call list. Physician on-call schedules and changes no longer have to be mailed and/or faxed to multiple departments. This time-consuming process can be eliminated by simply completing the e-mail form titled Forms_ on_call or by sending an e-mail to the bulletin board with the on-call list attachment. Corel, Microsoft Word, and Excel all are accepted by the bulletin board. Any department can access the bulletin board, choose the list they are interested in viewing, and print a hard copy. Changes to the on-call schedule may be submitted to the bulletin board by e-mailing the change or updated list and sending to: MD_on-call list.

Please copy the change to Lisa Romano and the incorrect list will be promptly deleted. Each month, the previous month schedule will be deleted to eliminate confusion. If you have any comments or questions, please contact Lisa Romano, Manager, Bed Management, at (610) 401-5150. Thank you for your support of this new process.

Good Shepherd Specialty Hospital-Allentown: Focus on the Medical Staff

Despite the small size of the 32-bed Good Shepherd Specialty Hospital-Allentown, the medical staff leadership and membership has demonstrated impressive growth over the past six months. With the medical staff coordinators and credentialing staff working overtime, there are now 157 physicians on the GSSH-A medical staff, approximately 30 still in the application process, and several others who have expressed interest in joining the medical staff.

At the July 18 GSSH-A Board of Trustees meeting, the recently elected slate of medical staff officers was approved as follows: James T. McNelis, DO - President; Michael R. Goldner, DO - President-elect; and Wayne E. Dubov, MD - Secretary/Treasurer. Supporting the medical staff structure are the three medical directors -- Stephen C. Matchett, MD, Pulmonary Program; Drs. McNelis and Goldner, Medically Complex Program, and Dr. Dubov, medical director for the Transitional Rehabilitation Program. These medical directors and other committed physicians have provided care for the first 46 patients managed in the GSSH-A since it opened in mid-January. The care needs of these patients were varied and included continuous cardiac and respiratory monitoring with 10 patients presenting with tracheotomies, seven requiring ventilatory support and weaning, three requiring hemodialysis, and one requiring peritoneal dialysis. In addition, their complex nutritional and medication needs were met. Approximately 45% of the patients were discharged to home, 13% were transferred back to acute care, and the remaining 42% had various other discharge destinations (SNF, Acute Rehab, and Hospice).

With an average length of stay of 30 days, the medical staff has reported a high degree of satisfaction in caring for the patients in the GSSH-A. They have been impressed with the steady ramping up as the specialty hospital continues to accept both a higher volume as well as an increased complexity of patient problems. In addition, the patients have come to appreciate the comprehensive care delivered in a pleasant environment over an extended length of stay.

The challenges that are faced are constant. The strategies for managing them are continually being redefined in order to meet the needs of the patients, their families and you, the medical staff.

For questions, suggestions, or concerns, please contact one of the following individuals:

- Stephen C. Matchett, MD, Medical Director, (610) 439-8856 or pager (610) 920-7225
- Jane Dorval, MD, President, Medical Staff, (610) 776-3340 or pager (610) 830-2793
- Beverly Snyder, RN, Assistant Administrator/Director of Nursing, (610) 402-8599 or pager (610) 830-7665
- Joseph Pitingolo, Administrator, (610) 402-8559 or pager (610) 830-4023
- Linda Dean, Administrative Consultant, (610) 402-8963 or pager (610) 830-3110
- Nancy Hardick, Medical Staff Affairs, (610) 402-8962

Congratulations!

Raymond A. Fritz, Jr., DPM, Section of Foot and Ankle Surgery, was recently recertified by the American Board of Podiatric Surgery after passing the Voluntary Diplomate Recertification examination in Foot and Ankle Surgery.

Papers, Publications and Presentations

Joseph L. Antonowicz, MD, Chief, Division of Consultation/Liaison Psychiatry, presented a lecture titled "Mental Health Issues in the Elderly" at the Third Annual Elder Law Institute held on July 14 at the Hershey Hotel and Conference Center in Hershey, Pa.

The following members of the Medical Staff received awards at this year's Residents' Graduation ceremonies:

(Continued on Page 11)

(Continued from Page 10)

- **Robert O. Atlas, MD**, Interim Chief, Division of Obstetrics – Council on Resident Education in Obstetrics & Gynecology National Faculty Award for Excellence in Resident Education
- **Deanna S. Dudenbostel, DMD**, Division of Pediatric Dentistry – Clinical Teacher of the Year in Dentistry (LVH-Muhlenberg)
- **Kevin Farrell, MD**, former member of the Division of Trauma-Surgical Critical Care, Section of Burn – Clinical Teacher of the Year in General Surgery
- **Joseph J. Fassl, MD**, Division of Emergency Medicine – Teacher of the Year in Emergency Medicine
- **Thomas A. Hutchinson, MD**, Interim Chief, Section of Clinical Obstetrics – Association of Professors in Gynecology and Obstetrics Medical Student Teacher of the Year in OB/GYN
- **Dieter W. Leipert, DDS**, Division of Oral and Maxillofacial Surgery – Clinical Teacher of the Year in Dentistry (LVH)
- **Larry N. Merkle, MD**, Chief, Division of Endocrinology/Metabolism – The Dean Dimick, MD Teacher of the Year Award
- **Alexander D. Rae-Grant, MD**, Chief, Division of Neurology – Hahnemann University School of Medicine Dean's Special Award for Excellence in Clinical Teaching
- **Robert D. Riether, MD**, Director, Colon/Rectal Residency Program – Clinical Teacher of the Year in Colon & Rectal Surgery
- **Orion A. Rust, MD**, Division of Obstetrics, Section of Maternal-Fetal Medicine – Clinical Teacher of the Year in Obstetrics & Gynecology
- **Brian Stello, MD**, and **Mark A. Wendling, MD**, Department of Family Practice – Clinical Teacher of the Year in Family Practice

At the appreciation dinner for preceptors of the Allentown College PA program, **Gavin C. Barr, Jr., MD**, Division of Emergency Medicine, was selected as Teacher of the Year.

Richard C. Boorse, MD, Division of General Surgery, and **James C. Weis, MD**, Division of Orthopedic Surgery, Section of Ortho Trauma, were members of the guest faculty for a course titled "Minimally Invasive Spinal Surgery," which was presented at the University of Texas, Southwestern Medical Center at Dallas. In addition, Dr. Weis also presented a lecture titled "Interbody Fixation in the Degenerative Spine" to the Texas Spine Study Group.

Peter A. Keblish, MD, Division of Orthopedic Surgery, Section of Ortho Trauma, served as an examiner for Part II of the American Board of Orthopaedic Surgeons (ABOS) certification examination held in Chicago. The examinations represent the culmination of orthopedic surgeons' certification process for a period of 10 years, after which they must recertify. Part II examinations are given after the applicant has been in the practice of orthopedic surgery for two years and has passed Part I (knowledge based written part). Part II is an oral examination designed to test the application of knowledge based on case experience. Approximately 750 candidates were examined.

Dr. Keblish also served as a re-certification examiner during the first day of the examination period. The re-certification examination is required after an orthopedist has been in practice for 10 years. Orthopedic surgeons in practice prior to 1986 were grandfathered from the 10-year examination, but may take the examination on a voluntary basis. Dr. Keblish was certified by the ABOS in 1969 and voluntarily re-certified in 1995. He has served as an examiner for the past three years.

Terry Mangino, CURN, Allied Health Professional, successfully completed the Urologic Registered Nurse Certification Examination and has received certification as a Certified Urologic Registered Nurse by the Certification Board for Urologic Nurses and Associates.

William L. Miller, MD, Chairperson, Department of Family Practice, and **Joanne Cohen-Katz, PhD**, Family Systems Associate, Department of Family Practice, attended the Society of Teachers of Family Medicine Annual Spring Conference held in Orlando, Fla., where they co-presented on "The Pragmatics of Biopsychosocial Medicine: Routine, Ceremony, and Drama Meet Family Systems." **Tom Lynch, RPh**, Clinical Pharmacist, Department of Family Practice, presented on "The State of Clinical Pharmacy Practice on Family Medicine Residency Training Programs—Results of a Comprehensive Nationwide Survey."

John G. Pearce, MD, Chief, Section of Mammography, has been invited as a visiting professor to the Tripler Army Medical Center in Hawaii from August 14 to 18. Dr. Pearce will be teaching 10 hours of mammography education, workshop training, and quality assurance for MDs and Radiologic Technologists for the U.S. Army.

George M. Perovich, EdD, psychologist, gave a case presentation – "A Family Tragedy: Multi-generational and Multi-death Trauma" – at the Trauma Evening Seminar held on June 13 at Lehigh Valley Hospital. Additional members of the faculty were **Bruce D. Nicholson, MD**, Chief, Division of Pain Management, who presented "Pediatric Pain Management," and **Sarah L. Stevens, MD**, Division of General Internal Medicine, Section of Adolescent Medicine, who presented "Protecting Adolescents from Harm: A Public Health Perspective."

Howard S. Selden, DDS, Division of Endodontics, authored a paper, "A Successful Non-surgical Treatment of an Endodontic Failure," which was published in the July issue of the ***Journal of Endodontics***.

Who's New

Medical Staff

Address Changes

Harvey S. Cheng, MD
401 N. 17th Street
Suite 109
Allentown, PA 18104-5049
(610) 821-8806
Fax: (610) 821-8854

Elizabeth L. Stanton, MD
Fogelsville Family Medicine
7735 Main Street
Fogelsville, PA 18051-1617
(610) 336-4676
Fax: (610) 336-4677

Practice Name and Address Change

Heritage Family Practice
Richard D. Baylor, MD
Wendy J. Rush-Spinosa, MD
401 N. 17th Street
Suite 303
Allentown, PA 18104
(610) 437-0739
Fax: (610) 437-3601

Practice Name Change

Zirka M. Halibey, MD
Muhlenberg Obstetrics & Gynecology

Practice Change

David G. Clymer, MD
Is now associated with
Hamburg Family Practice Center
260 State Street
P.O. Box 488
Hamburg, PA 19526-1823
(610) 562-3066
Fax: (610) 562-3125

Garry C. Karounos, MD
Is no longer associated with M. Bruce Viechnicki, MD
New Solo Practice – Garry C. Karounos, MD
3131 College Heights Blvd.
Suite 2200
Allentown, PA 18104-4894
(610) 435-8130
Fax: (610) 435-4515

Marian P. McDonald, MD
Is no longer associated with General Surgical Associates
New Solo Practice – Marian P. McDonald, MD
701 Ostrum Street
Suite 602
Bethlehem, PA 18015-1155
(610) 776-5025

Robert J. Rienzo, MD
Has joined Medical Imaging of LV, PC, and will continue to provide nuclear medicine services for Lehigh Valley Hospital at both Cedar Crest & I-78 and LVH-Muhlenberg

Carol A. Slompak-Patton, MD
Has joined Peters, Caccese, Scott & DuGan
Allentown Medical Center
401 N. 17th Street
Suite 201
Allentown, PA 18104-5085
(610) 432-6862
Fax: (610) 432-9705

Sarah L. Stevens, MD
Has joined ABC Family Pediatricians
Paragon Building
1611 Pond Road
Suite 400
Allentown, PA 18104-2256
(610) 395-4300
Fax: (610) 530-9372

LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

Medical Staff
Chairpersons of Departments and Chiefs of Divisions and Sections
2000-2001

(Approved - Medical Executive Committee – July 8, 2000)

MEDICAL STAFF OFFICERS

President	David M. Caccese, MD	1/1/99 - 12/31/2000
President-elect	Edward M. Mullin, Jr., MD	1/1/99 - 12/31/2000
Past President	Robert X. Murphy, Jr., MD	1/1/99 - 12/31/2000
Secretary	John J. Shane, MD	7/1/2000 - 6/30/2001
Treasurer	John J. Shane, MD	7/1/2000 - 6/30/2001

CHIEF MEDICAL OFFICER Robert J. Laskowski, MD

Department of Anesthesiology

Alphonse A. Maffeo, MD, Chairperson
Domenico Falcone, MD, Vice Chairperson (LVH-M)
Karen A. Bretz, MD, Vice Chairperson for Quality Assurance
Thomas M. McLoughlin, Jr., MD, Vice Chairperson for Education and Research

Section of Cardiac Anesthesia	Thomas M. McLoughlin, Jr., MD, Chief
Section of Pediatric Anesthesia	(Open)
Section of Obstetrical Anesthesia	(Open)
Division of Pain Management	Bruce D. Nicholson, MD, Chief

Department of Dentistry

Eric J. Marsh, DMD, Chairperson
S. Clark Woodruff, DMD, Vice Chairperson (LVH-M)
Scott A. Gradwell, DMD, Vice Chairperson (LVH)
Charles J. Incalcaterra, DMD, Residency Program Director (LVH)
Russ S. Bergman, DMD, Residency Program Director (LVH-M)
Dominic P. Lu, DDS, Director of Medical and Dental Externship Education

Division of Endodontics	Mark R. Eisner, DMD, Chief
Division of General Dentistry	Charles A. Kosteva, DDS, Chief (LVH) Gary G. Peters, DDS, Chief (LVH-M)
Division of Orthodontics	Sara C. Karabasz, DMD, Chief
Division of Pediatric Dentistry	Marsha A. Gordon, DDS, Chief
Division of Periodontics	Scott A. Gradwell, DMD, Chief (LVH) Ann K. Astolfi, DMD, Chief (LVH-M)
Division of Prosthodontics	John D. Karabasz, DMD, Chief (LVH) Bernard D. Servagno, DMD, Chief (LVH-M)
Division of Special Care	Russel S. Bleiler, DDS, Chief

Department of Emergency Medicine

Michael S. Weinstock, MD, Chairperson
Richard S. MacKenzie, MD, Vice Chairperson
Brian A. Nester, DO, Associate Vice Chair (LVH-M)
Alexander M. Rosenau, DO, Associate Vice Chair/Practice Management
Charles C. Worrilow, MD, Director, Education
Michael B. Heller, MD, Residency Program Director

Section of Prehospital Emergency Medical Services	John F. McCarthy, DO, Chief
Division of Emergency Medicine	Michael S. Weinstock, MD, Chief

Department of Family Practice

William L. Miller, MD, Chairperson
Julie A. Dostal, MD, Vice Chairperson (LVH)
Dale M. Weisman, MD, Vice Chairperson (LVH-M)
Pamela F. LeDeaux, MD, Residency Program Director
Larry Fritchman, MD, Chief Resident

Division of Occupational Medicine	Carmine J. Pellosie, DO, Chief

Department of Medicine

John P. Fitzgibbons, MD, Chairperson
Michael Ehrig, MD, Vice Chairperson (LVH-M)
Richard H. Snyder, MD, Vice Chairperson (LVH)
Richard H. Snyder, MD, Residency Program Director
William F. Iobst, MD, Associate Program Director, Internal Medicine Residency Program
Joseph A. Candio, MD, Chief for Clinical Practice
Larry N. Merkle, MD, Student Mentor
James Freeman, DO, Chief Medical Resident

Division of Allergy	Howard A. Israel, MD, Chief
Division of Cardiology	D. Lynn Morris, MD, Chief
	(Open) Associate Chief (LVH)
	Robert H. Biggs, DO, Associate Chief (LVH-M)
Division of Dermatology	Arthur C. Sosis, MD, Chief
Division of Endocrinology/Metabolism	Larry N. Merkle, MD, Chief
	Mohammad I. Arastu, MD, Associate Chief (LVH-M)
Division of Gastroenterology	Carl F. D'Angelo, MD, Chief
	Lawrence W. Bardawil, MD, Associate Chief (LVH)
	Frederic A. Stelzer, MD, Associate Chief (LVH-M)
Division of General Internal Medicine	Keith R. Doram, MD, Chief
	Michael Ehrig, MD, Associate Chief (LVH-M)
Section of Adolescent Medicine	(Open)
Division of Geriatrics	Francis A. Salerno, MD, Chief
	David P. Carney, MD, Associate Chief
Division of Hematology/Medical Oncology	Gregory R. Harper, MD, PhD, Chief
	Victor M. Aviles, MD, Associate Chief

Department of Medicine (cont.)

Division of Infectious Diseases	Luther V. Rhodes III, MD, Chief Jeffrey A. Jahre, MD, Associate Chief (LVH-M)
Division of Nephrology	Joseph C. Guzzo, MD, Chief Nelson P. Kopyt, DO, Associate Chief
Division of Neurology	Alexander D. Rae-Grant, MD, Chief Pradip K. Toshniwal, MD, Associate Chief (LVH-M)
Division of Physical Medicine & Rehabilitation	Jane Dorval, MD, Chief
Division of Pulmonary	Jay H. Kaufman, MD, Chief Brian Burlew, MD, Associate Chief (LVH-M)
Division of Rheumatology	Albert D. Abrams, MD, Chief Ellen M. Field-Munves, MD, Associate Chief (LVH-M)

Department of Obstetrics and Gynecology

Vincent Lucente, MD, Acting Chairperson
Ernest Y. Normington, MD, Vice Chairperson
Albert J. Peters, MD Vice Chairperson
Albert J. Peters, MD, Residency Program Director
Craig J. Sobolewski, MD, Associate Residency Program Director
Patrice M. Weiss, MD, Director of Undergraduate Medical Education
Miles Murphy, MD, Administrative Chief Resident

Division of Obstetrics	Robert O. Atlas, MD, Interim Chief
Section of Maternal-Fetal Medicine	Robert O. Atlas, MD, Interim Chief
Section of Clinical Obstetrics	Thomas A. Hutchinson, MD, Interim Chief
Division of Gynecology	Vincent R. Lucente, MD, Chief
Section of Gynecologic Oncology	Weldon E. Chafe, MD, Chief
Section of Pelvic Reconstructive Surgery	Vincent R. Lucente, MD, Chief
Section of Reproductive Endocrinology & Infertility	Albert J. Peters, DO, Chief
Division of Primary OB/GYN	Gregory J. Radio, MD, Chief

Department of Pathology

John J. Shane, MD, Chairperson
William B. Dupree, MD, Vice Chairperson

Division of Clinical & Anatomic	John J. Shane, MD, Chief (LVH) Elizabeth A. Dellers, MD, Chief (LVH-M)
Section of Cytopathology	Eugene Alexandrin, MD, Chief
Section of Dermatopathology	(Open)
Section of Gastrointestinal Pathology	Michael Scarlato, MD, Chief
Section of Gynecologic Pathology	William B. Dupree, MD, Chief
Section of Hematopathology	Dennis B. Cornfield, MD, Chief
Section of Neurosciences	Daniel F. Brown, MD, Chief
Division of Forensic Pathology	Saralee Funke, MD, Chief

Department of Pediatrics

John D. VanBrakle, MD, Chairperson
Oscar A. Morffi, MD, Vice Chairperson

Division of General Pediatrics	Oscar A. Morffi, MD, Chief
Division of Inpatient Pediatrics	L. Kyle Walker, MD, Interim Chief
Section of Critical Care Medicine	(Open)
Division of Neonatology	Ian M. Gertner, MD, Chief
Division of Subspecialty Pediatrics	(Open)
Section of Allergy	(Open)
Section of Cardiology	(Open)
Section of Development & Rehabilitation	(Open)
Section of Endocrinology	(Open)
Section of Gastroenterology	(Open)
Section of Genetics	(Open)
Section of Hematology/Oncology	(Open)
Section of Neurology	(Open)
Section of Pulmonary Medicine	(Open)
Section of Rheumatology	(Open)

Department of Psychiatry

Michael W. Kaufmann, MD, Chairperson
Susan D. Wiley, MD, Vice Chairperson (LVH)
Laurence P. Karper, MD, Vice Chairperson (LVH-M)

Division of Adolescent Inpatient Psychiatry	John F. Campion, MD, Chief
Division of Adult Inpatient Psychiatry	Clifford H. Schilke, MD, Co-Chief Laurence P. Karper, MD, Co-Chief
Division of Consultation/Liaison Psychiatry	Joseph L. Antonowicz, MD, Chief
Division of Psychiatric Ambulatory Care	Susan D. Wiley, MD, Chief (LVH) Joel Lerman, MD, Chief (LVH-M)

Department of Radiation Oncology

Victor R. Risch, MD, PhD, Chairperson
Steven J. Perch, MD, Vice Chairperson

Department of Radiology/Diagnostic Medical Imaging

Robert Kricun, MD, Chairperson
Elliot I. Shoemaker, MD, Vice Chairperson
John F. Cox, MD, Residency/Fellowship Program Director

Division of Diagnostic Radiology	Alan H. Wolson, MD, Chief
Section of Cardiovascular/Interventional	James W. Jaffe, MD, Chief
Section of Chest	Alan H. Wolson, MD, Chief
Section of Gastrointestinal	Christopher L. Brown, MD, Chief
Section of Genitourinary	Christopher L. Brown, MD, Chief
Section of Mammography	John G. Pearce, MD, Chief
Section of Neuroradiology	Elliot I. Shoemaker, MD, Chief
Section of Nuclear Medicine	Robert J. Rienzo, MD, Chief
Section of Orthopedics	John F. Cox, MD, Chief
Section of Pediatrics	Howard D. Rosenberg, MD, Co-Chief Thomas R. Fitzsimmons, MD, Co-Chief
Section of Trauma/Emergency Medicine	James A. Newcomb, MD, Chief

Department of Surgery

Herbert C. Hoover, Jr., MD, Chairperson
Michael D. Pasquale, MD, Vice Chairperson for Clinical Affairs (LVH)
Gregory Brusko, DO, Vice Chairperson (LVH-M)
Mark C. Lester, MD, Vice Chairperson for Operations (Operating Room and OI)
Gary G. Nicholas, MD, Vice Chairperson of Educational Affairs
Walter J. Okunski, MD, Senior Advisor to the Chair
Gary G. Nicholas, MD, General Surgery Residency Program Director/Education Director
Robert D. Riether, MD, Colon/Rectal Residency Program Director
Walter J. Okunski, MD , Plastic Surgery Residency Program Director
Michael D. Pasquale, MD, Surgical Critical Care Residency Program Director
Mehrzad Bozorgnia, MD Chief Surgical Resident
William Bromberg, MD, Chief Surgical Resident
Kevin Hibbett, MD, Chief Surgical Resident

Division of Cardio-thoracic Surgery	Michael C. Sinclair, MD, Chief
Section of Thoracic Surgery	Raymond L. Singer, MD, Chief
Division of Colon/Rectal Surgery	John J. Stasik, MD, Chief Lester Rosen, MD, Associate Chief
Division of General Surgery	Michael D. Pasquale, MD, Chief Douglas R. Trostle, MD, Associate Chief (LVH) Gregory Brusko, DO, Associate Chief (LVH-M)
Section of Pediatric Surgery	Chris CN. Chang, MD, Chief
Section of Transplantation Surgery	Craig R. Reckard, MD, Chief
Division of Hand Surgery	Michael A. Chernofsky, MD, Chief
Division of Neurological Surgery	Mark C. Lester, MD, Chief Joseph P. Coladonato, MD, Associate Chief (LVH) Robert P. Marcincin, MD, Associate Chief (LVH-M)
Section of Neuro Trauma	(Vacant)

Department of Surgery (cont.)

Division of Ophthalmology	Glen L. Oliver, MD, Chief Alan B. Leahey, MD, Associate Chief (LVH) Steven J. Kanoff, MD, Associate Chief (LVH-M)
Division of Oral/Maxillofacial Surgery	Mark H. Grim, DMD, Chief Jonathan A. Tenzer, DMD, Associate Chief (LVH-M)
Division of Orthopedic Surgery	Prodromos A. Ververeli, MD, Chief James C. Weis, MD, Associate Chief (LVH) Ranjan Sachdev, MD, Associate Chief (LVH-M)
Section of Foot and Ankle Surgery	Prodromos A. Ververeli, MD, Acting Chief David P. Steed, DPM, Associate Chief
Section of Ortho Trauma	Patrick B. Respet, MD, Chief
Division of Otolaryngology	John D. Harwick, MD, Chief John S. Papola, MD, Associate Chief
Division of Plastic Surgery	Walter J. Okunski, MD, Chief Geoffrey G. Hallock, MD, Associate Chief (LVH) Manny Iyer, MD, Associate Chief (LVH-M)
Division of Trauma-Surgical Critical Care	Michael D. Pasquale, MD, Chief
Section of Burn	William R. Dougherty, MD, Chief Walter J. Okunski, MD, Associate Chief
Section of Pediatric Trauma	Stanley J. Kurek, Jr., DO, Chief
Section of Trauma Research	Mark D. Cipolle, MD, PhD, Chief
Division of Urology	Edward M. Mullin, Jr., MD, Chief Richard M. Lieberman, MD, Associate Chief
Division of Vascular Surgery	Gary G. Nicholas, MD, Chief James G. Goodreau, MD, Associate Chief (LVH) Marc A. Granson, MD, Associate Chief (LVH-M)

COMMON MEDICAL STAFF
LEHIGH VALLEY HOSPITAL AND LEHIGH VALLEY HOSPITAL-MUHLENBERG
REVISIONS TO THE MEDICAL STAFF BYLAWS

APPROVED BY BOARDS OF TRUSTEES – 6/7/2000 and 6/13/2000

Revision to Membership of Cancer Committee and Medical Advisory Committee

ARTICLE XI-OFFICERS AND COMMITTEES

SECTION C – DESIGNATION OF COMMITTEES

b. Cancer Committee:
(iii) Membership:

A. Commission on Cancer required membership shall include a representative from: Surgery, Medical Oncology, Radiation Oncology, Diagnostic Radiology, Pathology, Cancer (ACOS) Liaison, the program leadership of the Five major Sites of cancer seen in the previous year, Quality Improvement, Administration, Oncology Nursing, Psychosocial Services and Tumor Registry.

B. Additional members shall include a representative from Family Practice, General Internal Medicine, disease oriented Program Directors, Dentistry, and Physical Medicine/ Rehabilitation Services; the Director of the John and Dorothy Morgan Cancer Center shall be an ex-officio member.

~~Nominations for required and ex-officio members will be submitted to the President of the Medical Staff for annual appointment and/or renewal by a nominating committee chaired by the Vice Chair.~~ Committee shall recommend a Chair whose term would run concurrent with that of the President of the Medical Staff, subject to the approval of the Medical Staff President. The Medical Staff membership of the Committee shall also be appointed by the President of the Medical Staff.

D. ~~The Chair and Vice Chair shall represent different departments. Term of office shall consist of two years. The Vice Chair shall serve as Chair elect.~~ To maintain committee membership, ~~3~~ 4 of ~~5~~ 6 meetings per year must be attended.

~~E.~~

k. Medical Advisory Committee
(iii) Composition

A. The composition of this Committee shall include: The Vice President, Medical Director MHC; Senior Vice President for Clinical Services; Senior Vice President Operations MHC; Vice President Medical Staff Services; Director of Care Management Systems, MHC; Senior Medical Director, Care Management Systems; PHO Representative, MHC; the four (4) at large members of the Medical Executive Committee whose primary clinical activity takes place at the Muhlenberg Hospital Center, and representatives of each of the Departments shall be selected by the President of the Medical staff following consultation with the Vice-President, Medical Director and the Chairperson of the Department and shall be members of the Medical Staff whose primary clinical activity takes place at the ~~Muhlenberg Hospital Center~~ Lehigh Valley Hospital-Muhlenberg site.

****

Creation of New Sections (Following MEC's approval of guidelines for small divisions/sections)

ARTICLE XII – DEPARTMENTS

SECTION A - DEPARTMENTS, DIVISIONS AND SECTIONS

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

1. Department of Anesthesiology which shall include the Division of Pain Management and the sections of Cardiac Anesthesia, Pediatric Anesthesia and Obstetrical Anesthesia.

2. Department of Dentistry...

3. Department of Emergency Medicine shall include the Division of Emergency Medicine and Section of Pre-hospital Emergency Medical Services.

4. Department of Family Practice which shall include the Section of Home Care.

5. Department of Medicine which shall include the following Divisions: Allergy, Ambulatory Care, Cardiology, Dermatology, Endocrinology/Metabolism, Gastroenterology, General Internal Medicine, Geriatrics, Hematology/Medical Oncology, Infectious Diseases, Neurology, Nephrology, Pulmonary, Physical Medicine and Rehabilitation, and Rheumatology.

   a. The Division of General Internal Medicine shall include the section of Adolescent Medicine

6. Department of Obstetrics and Gynecology...

7. Department of Pathology which shall include the Divisions of Forensic Pathology, and Clinical and Anatomic Pathology.

   a. The Division of Clinical and Anatomic Pathology shall include the Sections of Dermatopathology, Hematopathology, and Neurosciences.

8. Department of Pediatrics which shall include the following Divisions: Allergy, ~~Behavioral Pediatrics~~, ~~Cardiology~~, ~~Development and Rehabilitation~~, Gastroenterology, General Pediatrics, Neonatology, Neurology, ~~Pulmonary.~~

   a. The Division of General Pediatrics shall include the Sections of Cardiology, Development & Rehabilitation, Hematology/Medical Oncology, Pulmonary.

9. Department of Psychiatry which shall include the following Divisions: ~~Adolescent Inpatient Psychiatry~~, Child/Adolescent Psychiatry, Adult Inpatient Psychiatry, Psychiatric Ambulatory Care, ~~Consultation/Liaison Psychiatry~~, and Psychiatric Home Care and the Section of Consultation/Liaison Psychiatry.

10. ...

****

Revisions for Compliance with Americans with Disabilities Act

The following revisions are proposed for compliance with the federal Americans with Disabilities Act (ADA) and JCAHO Standards. These statements are consistent with the ADA's emphasis upon a worker's ability to perform essential job functions and assuring compliance with JCAHO standards.

The current Bylaws allow for a Department Chairperson to establish the current health status of an individual. It was felt that this should be preserved, but would be more appropriately located in the article pertaining to the Medical Staff Rehabilitation Program. The following are the proposed revisions:

ARTICLE III – MEDICAL STAFF MEMBERSHIP

SECTION C- SPECIFIC QUALIFICATIONS FOR MEMBERSHIP

(4) Can demonstrate ~~document~~ that they do not have any ~~their~~ physical or ~~and~~ mental health impairments that adversely affect ~~is such as it will not impair~~ their ability to perform their clinical privileges and Medical Staff duties ~~render quality patient care,~~ at time of initial application, during the pendency of their appointment, and upon each reapplication for Medical staff membership and clinical privileges.

[Note: The remainder of the section is now moved to Article X and added as a new 5.]

ARTICLE VI – PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

SECTION B – APPLICATION FOR APPOINTMENT

(h) information pertaining to any physical or mental health impairment of the applicant which adversely affects or is reasonably likely to adversely affect the applicant's ability to perform the clinical privileges that he or she is requesting or his/her Medical Staff duties, and any reasonable accommodation that may be required to enable the applicant to perform such functions ~~the condition of the applicant's physical and mental health~~;

3. Processing the Application:
   (a) Applicant's Burden: The applicant shall have the burden and responsibility of producing accurate and adequate information for a proper evaluation of his or her experience, background, training, demonstrated ability, ~~physical and mental status~~, and all other qualifications specified in the Medical Staff Bylaws and Rules and Regulations and of his or her compliance with . . . . . .

SECTION C – REAPPOINTMENTS

2. Application for Reappointment:

   (c) At the time of application for reappointment to the Medical Staff, members shall demonstrate their compliance with ~~document their physical and mental health as such as it will not impair their ability to render quality patient care as outlined in~~ Article III, Section C, number 4.

ARTICLE VII – CLINICAL PRIVILEGES

SECTION A – DELINEATION OF CLINICAL PRIVILEGES

4. Periodic redetermination of clinical privileges and the expansion or reduction of such privileges shall be based upon a reappraisal that will include consideration of professional performance, judgment, skills and knowledge; the practitioner's current licensure; the practitioner's demonstrated ability to perform his or her clinical privileges and Medical Staff duties ~~physical and mental health status~~, status of continuing education; timely, complete, accurate . . .

ARTICLE X – MEDICAL STAFF REHABILITATION PROGRAM

SECTION B – POLICY

3. The Medical Staff Rehabilitation Program is not a prerequisite to corrective action under these Bylaws and an ~~physical, emotional or mental~~ impairment may be the basis of corrective action requested or taken under Article VIII of these Bylaws.

4. Both the Medical Staff and its individual members, collectively and individually, recognize the legal obligation of the Hospitals, peers and colleagues who have substantial evidence that a Staff member has an impairment ~~active, addictive disease for which the member is not receiving treatment, is diverting a controlled substance or is mentally or physically incompetent to carry out the duties of his or her license~~ to make or cause to be made a report to the appropriate State Board of Licensure.

5. When the Medical Staff or the Boards have reason to question whether a Medical Staff member is impaired, upon the request of the Department Chairperson, the Medical Staff member shall be required to submit to an evaluation of his or her ability to perform his or her clinical privileges and/or his or her Medical staff duties by a mutually acceptable physician as a prerequisite to further consideration of his or her application for appointment or reappointment, to the exercise of previously granted clinical privileges, or to the maintenance of his or her staff appointment. The resulting evaluation shall be forwarded directly to the Department Chairperson from the evaluating physician.

SECTION C – DEFINITION

IMPAIRED: The inability to practice the member's clinical privileges or to perform his or her Medical Staff duties ~~profession~~ with reasonable skill, care and diligence due to a physical or mental illness ~~disability~~ including, but not limited to, deterioration through the aging process, loss of motor or sensory skills or current abuse of drugs or alcohol.

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AHP Appeals Process (for compliance with JCAHO Standards)

ARTICLE V – ALLIED HEALTH PROFESSIONALS

SECTION B – STATUS OF ALLIED HEALTH PROFESSIONALS

1. Allied health professionals are not members of the Medical Staff and are not entitled to the procedural rights delineated in Article IX of these Bylaws unless the Governing Bodies determine otherwise for any specific category of allied health professional. Allied health professionals shall, however, be entitled to the procedural rights described in Section D below.

SECTION C – CLINICAL DUTIES AND FUNCTIONS

2. The procedure for monitoring the quality of care of all allied health professionals shall be similar to the procedure utilized for members of the Medical Staff. Each Chairperson of the Department to which an allied health professional is assigned shall be responsible for evaluating the allied health professional and making recommendations on the continuation, expansion, ~~or~~ reduction or termination of clinical duties and functions. Such recommendations shall be made to the Credentials Committee for review and recommendation to the Medical Executive Committee. Final approval rests with the Governing Bodies.

3. In making recommendations on the continuation, expansion, ~~or~~ reduction or termination of clinical duties and functions, each Chairperson of the Department to which the allied health professional is assigned shall take into account applicable state licensing statues and regulations; recognized education, training, certification and/or licensure; experience, demonstrated competence and judgment; available facilities and resources; and patient care needs of the community.

SECTION D – PROCEDURAL RIGHTS

1. Any affected allied health professional shall be provided with written notice of any recommendation of reduction or termination of clinical duties or functions by the Credentials Committee or the Medical Executive Committee, as applicable. The affected allied health professional shall have thirty (30) days from receipt of the notice to request a hearing by filing a written request for a hearing with the Chairperson of the Department to which the allied health professional is assigned. The Medical Executive Committee shall act as the hearing panel. The affected allied health professional shall have the opportunity to present written information to the panel. The hearing panel will issue a final report after review of the written information or appoint an ad hoc committee to further investigate the matter. The ad hoc committee (if any) will submit its written report to the hearing panel for action by the hearing panel. The affected allied health professional shall receive written notice of the determination of the hearing panel, and shall have the right within thirty (30) days of receipt of such notice to appeal the adverse determination to the Executive Committee of the Governing Bodies. The affected allied health professional shall have the same rights before the Executive Committee as before the hearing panel. The decision of the Executive Committee shall be final.

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Name Change of Bylaws

Consistent with the recent name change of the Muhlenberg Hospital Center to Lehigh Valley Hospital-Muhlenberg, the title of the Bylaws is being changed to ***Bylaws of the Common Medical Staff of Lehigh Valley Hospital and Lehigh Valley Hospital-Muhlenberg***.

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Dentists and Podiatrists Performing Portions of History and Physical Examinations **(for compliance with JCAHO Standards)**

Part II – Rules and Regulations

E. RECORDS

1. History and Physical Examination and Discharge Summaries must be signed by an attending physician or his or her physician designee.

2. A complete history and physical examination shall, in all cases, be documented in the medical record no later than twenty-four (24) hours after admission of the patient. History and physical examinations must be performed by a credentialed member of the Medical, Allied Health, or Residency Staff. ...

3. All patients admitted for dental surgery shall have a history and physical examination recorded on their charts. The completion of this history and physical examination may be the responsibility of: 1) an oral surgeon who is credentialed by the Medical Staff to perform history and physical examinations and who admits a patient without medical problems and who is in anesthesia class I category; or 2) an attending medical physician in collaboration with a dentist or oral surgeon who will be responsible for the part that relates to dentistry. Any patient so admitted who has medical problems must have the attending medical physician perform the admitting history and physical examination and supervise any required medical care. Criteria for granting history and physical examination privileges to oral surgeons are contained in the Facility's Directives Manual.

   All patients admitted for podiatric surgery shall have a history and physical examination recorded on their charts. The completion of this history and physical examination will be the responsibility of a medical physician in collaboration with a podiatrist who will be responsible for the part that relates to podiatry. Any patient admitted with medical problems must have the attending medical physician perform the admitting history and physical examination and supervise any required medical care.

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Update of Consent and Autopsy Language to Coincide with Current Practice and State Law

PART II – RULES AND REGULATIONS

B. CONSENT

1. Except in the case of emergency:

(a) A surgical operation shall be performed ~~only~~ after ~~written~~ consent has been obtained from the patient or his or her legal representative by the physician and/or the physician designee. It shall be required that the patient or his or her legal representative must sign the operative consent/request form attesting that informed consent has been obtained prior to the procedure being performed. A verbal/telephone consent is acceptable if the patient and/or his or her legal representative is unable to physically sign. The patient will not receive preoperative sedation, nor will he or she be transported to the procedure area until the above is completed.

(b) Anesthetic shall be administered ~~only~~ after ~~written~~ consent has been obtained from the patient or his legal representative.

(c) A pre-operative sedation shall be administered only after ~~written~~ consent has been obtained from the patient or his or her legal representative.

(d) Blood and blood products shall be administered ~~only~~ after ~~written~~ consent has been obtained from the patient or his or her legal representative.

(e) An ~~diagnostic or~~ interventional ~~angio~~ radiographic procedure shall be performed ~~only~~ after ~~written~~ consent has been obtained from the patient or his or her legal representative. A physician may, at his or her discretion, obtain written consent for other radiographic procedures. For radiologic procedures not requiring pre-operative sedation, the consent may be obtained in the procedure area.

~~(f) It shall be required that the patient or his or her legal representative must sign the hospital consent form attesting that informed consent has been obtained. This signature shall be required prior to the procedure being performed. The patient will not receive preoperative sedation, nor will he or she be transported to the procedure area until the above is completed. For radiologic procedures not requiring pre-operative sedation, the consent may be obtained in the procedure area~~

(f) HIV testing shall only be done after the proper consent has been obtained by the patient and/or his or her legal representative as permitted by Pennsylvania law.

(g) Chemotherapy shall be administered after consent has been obtained from the patient or his/her legal representative.

(h) It shall be required that the physician obtaining the informed consent will sign the same consent form. While the signature will not be required prior to the procedure, it shall be required for completion of the medical record. Failure to sign this form shall be deemed a medical record deficiency. Sanctions for prolonged or repeated violations are to be found in the Medical Staff Bylaws, Article VIII, Section D.

(~~h~~i) Any telephone/verbal consent must be obtained by the physician or his/her designee with ~~at least~~ one witness ~~present~~.

2. Autopsies:

(a) ...
...

(e) Coroner cases do not require family permission for autopsy. In cases other than Coroner cases~~, a permission~~ consent from the legal representative/next of kin must be procured. If the legal representative/next of kin refuses to have an autopsy performed, this fact must be documented in the medical record.

(f) If consent for autopsy is obtained via telephone, Pennsylvania State law requires two witnesses other than the physician.

STRESS TEST, Accepted Reasons For *

*According to covered ICD 9 codes, 1999 Medicare Medical Policy Bulletin

Short Name	Long Name
abdominal pain	abdominal pain
acute MI	acute myocardial infarction
angina/coronary insuff	angina/coronary insufficiency
aortic valve disorders	aortic valve disorders
atherosclerosis, coronary	atherosclerosis, coronary
atrial fib & flutter	atrial fibrillation & flutter
cardiac dysrhythmias	cardiac dysrhythmias
cardiovs. abnl. EKG	cardiovascular abnormal EKG
cardvs. abnl.function study unspecified	cardiovascular, abnl function study unspecif
cardiomyopathy	cardiomyopathy
chest pain	chest pain
CHF	congestive heart failure
comp, card device,implant,graft	complication, cardiac device, implant, graft
comp,transplant heart	complication of transplanted heart
conduction disorders	conduction disorders
congenital heart block	congenital heart block
coronary artery anom	coronary artery anomaly
heart transplant	heart transplant
heart valve transp	heart valve transplant
history of surgery to ht & gt vsls	history of surgery to heart & great vessels
ill-defined desc&comp of ht ds	ill-defined descriptions & complic of ht ds
ischemic ht ds, chronic	chronic ischemic heart disease
jaw pain	unspecified disease of jaws (jaw pain)
lung transplant	lung transplant
mitral valve ds	mitral valve disorders
MI, acute	myocardial infarction, acute
orthopnea	orthopnea
pain in limb	pain in limb
paroxysmal vent tachy	paroxysmal ventricular tachycardia
pre-cordial pain	pre-cordial pain
prim pulm. hypertn	primary pulmonary hypertension
pulmonary insuff	pulmonary insufficiency
shock w/o trauma	shock w/o trauma
status post-coronary artery proc	status post-coronary artery procedures
symptoms involv resp system	symptoms involving respiratory system
syncope & collapse	syncope & collapse
valve disease	valvular disease
v-fib	ventricular fibrillation

ECHO, Accepted Reasons For *

* According to covered ICD 9 codes, 1999 Medicare Medical Policy Bulletin

Short Name	Long Name
acute MI <8 wks	acute myocardial infarction<8 wks
adriamycin drug exposure	adriamycin/other neoplastic drug exposre
amyloidosis	amyloidosis
aneurysm - heart or aorta	aneurysm - heart or aorta
angina pectoris	angina pectoris
aortic regurg	aortic regurgitation
aortic stenosis	aortic stenosis
ARDS	ARDS
arrhythmia-any	arrhythmia - any
A fib	atrial fibrillation
A flutter	atrial flutter
atrial tachycardia	atrial tachycardia
atherosclerosis-coronary	atherosclerosis - coronary
atrial myxoma	atrial myxoma
CAD	coronary artery disease
CAD of bypass graft	coronary artery disease of bypass graft
cardiac arrest	cardiac arrest
cardiomyopathy	cardiomyopathy
card-toxic drug eval	cardio-toxic drug evaluation
CHF	congestive heart failure
chest pain-unspecified	chest pain - unspecified
chronic ischemic ht. ds.	chronic ischemic heart disease
congenital anomolies(specify)	congenital anomalies (specify under comments)
cor pulmonale-acute	cor pulmonale - acute
cor pulmonale-chronic	cor pulmonale - chronic
donor heart	donor heart
dyspnea	dyspnea
Ebstein's anomaly	Ebstein's anomaly
edema	edema
electrocution/lightening	electrocution/lightening
embolic source	embolic source
endocarditis-acute or subacute	endocarditis - acute or subacute
endocatditis - valvular	endocarditis - valvular
flail chest	flail chest
FUO	fever of unknown origin

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hemochromatosis	hemochromatosis
hypertension-benign	hypertension - benign
hypertension-w/ CHF	hypertension - with CHF
hypertnsn-malig/renovas	hypertension - malignant or renovascular
hypoxia/hypoxemia	hypoxia/hypoxemia
ICD complication	ICD complication
ischemic ht ds	ischemic heart disease
Kawasaki ds	Kawasaki's disease
L&D complication	labor & delivery complication
left heart failure	left heart failure
LVH or cardiomegaly	LVH or cardiomegaly
lupus	lupus erythematosis
lyme disease	lyme disease
Marfan's syndrome	Marfan's syndrome
MI-acute<8 wks	MI - acute <8 wks
MI-old>8 wks	MI - old >8wks
MI-other sequelae	MI - other sequelae
mitral regurg	mitral regurgitation
MR-ruptured cordae	mitral regurg - ruptured cordae
mitral stenosis	mitral stenosis
murmur	murmur
myocarditis	myocarditis
neoplasm of heart	neoplasm of heart
orthostatic hypotension	orthostatic hypotension
pacemaker complicat	pacemaker complication
pericardial ds - other	pericardial disease - other
pericarditis-acute	pericarditis - acute
pericardts-infect/viral	pericarditis - infectious/viral
periferal vasc. ds.	periferal vascular disease
poisoning-drug	poisoning - drug
poisoning-chemical	poisoning - chemical
post op infection	post operative infection
premature beats	premature beats
puerperium complic	puerperium complication
pulmonary edema	pulmonary edema
pulmonary embolism	pulmonary embolism
pulm hypertn-primary	pulmonary hypertension-primary
pulm hypertn-chronic	pulmonary hypertension-chronic
radiation to heart	radiation to heart
resp failure-post op	respiratory failure - post op
resp failure-S/P trauma	respiratory failure - post trauma

Page 3 - ECHO

resp failure-other	respiratory failure - other
rheumatic ht ds-acute	rheumatic heart disease-acute
rhmatic valve ds-pulm	rheumatic valve disease-pulmonary
sarcoidosis	sarcoidosis
septicemia	septicemia
shock-trauma	shock - trauma
shock-not trauma	shock - not trauma
shortness of breath	shortness of breath
source of embloism	
source emboli-stroke	source of embolis - stroke
source emobli-TIA	source of emoblis - TIA
stroke	stroke
syncope & collapse	syncope & collapse
Takayasu's disease	Takayasu's disease
TIA	TIA
trauma to heart	trauma to heart
trauma-great vessels	trauma - great vessels
valve ds-aortic	valve disease - aortic
valve ds-mitral	valve disease - mitral
valve ds-pulmonary	valve disease - pulmonary
valve ds-tricuspid	valve disease - tricuspid
valve prosth-complic	valve prosthesis-complication
valve prosth-mech	valve prosthesis-mechanical
valve prosthes-tissue	valve prosthesis-tissue
volume depletion	volume depletion
wheezing	wheezing

EKG, Accepted Reasons For *

* According to covered ICD 9 codes, 1999 Medicare Medical Policy Bulletin

Short Name	Long Name
abdominal pain/nausea	abdominal pain/nausea
abortion-complicated	abortion - complicated
acute cereb. disease	acute cerebrovascular disease
acute MI	acute MI
anaphylactic shock	Anaphylactic shock
aneurysm-aorta/disct	aneurysm, aortic & dissection
angina	angina
anomalies of heart	anomalies of heart other than ASD/VSD
aortic stenosis	aortic stenosis
ARDS	ARDS
arrhythmia	arrhythmia
ASD	aortic septal defect
asphyxiation	asphyxiation
AV disease	aortic valve disease
birth hypoxia	birth hypoxia
card comp from proc	cardiac complic from procedure/surgery
cardiomyopathy	cardiomyopathy
carditis-rheumatoid	carditis - rheumatoid
cardiac device compl	cardiac device complication
card graft/impl comp	cardiac graft/implant complication
cereb vasc ds - other	cerebrovascular disease - other
chest pain	chest pain
conduction disorders	conduction disorders
congenital anomalies	congenital anomalies
CHF	congestive heart failure
convulsions	convulsions
cor pulmonale-chronic	cor pulmonale- chronic
cyanosis	cyanosis
delirium-acute	delirium-acute
delirium-alcohl wthdl	delirium-alcohol withdrawal
delirium-drug inducd	delirium-drug induced
delirium-psychotic	delirium-psychotic
dizziness & giddiness	dizziness & giddiness
drowning	drowning
dysrhythmia	dysrhythmia
edema	edema

Page 2 - EKG

electrocution/lightening	electrocution or lightening
electrolyte imbal.	electrolyte imbalance
electroshock therapy	electroshock therapy
endocarditis	endocarditis
exercise intolerance	exercise intolerance
flail chest	flail chest
heat stroke	heat stroke
heart sounds- abnormal	heart sounds - abnormal
hypertension	hypertension
hypertn ds-heart/renal	hypertension disease - heart &/or renal
hypotension	hypotension
hypothermia	hypothermia
ICD implant	ICD implant
ICD reprogram	ICD reprogramming
ischemic heart ds	ischemic heart disease
injury - heart/lung	injury - heart/lung
L&D compl - anesthesia	L&D complication - Anesthesia
L&D compl - CV	L&D complication - Cardiovascular
L&D compl - shock	L&D complication - Shock
mental status chg.; CV	mental status change due to CV disease
mitral stenos/regurg	mitral stenosis/regurgitation
murmur	murmur
MI- acute	MI - acute
MI- old	MI - old
MV disease	mitral valve disease
myocarditis-acute	myocarditis - acute
myalgia & myositis	myalgia & myositis
neoplasm-mediastinum	neoplasm- mediastinum structure incl heart
open wound of chest	open wound of chest
pacemaker implant	pacemaker implant
pacemaker reprogram	pacemaker reprogramming
pallor	pallor
pain in limb	pain in limb
palpitations	palpitations
pericarditis-acute	pericarditis - acute
pericardium - other ds	pericardium - other diseases
poisoning-drug	poisoning - drug
poisoning- toxic chem	poisoning - toxic chemical
polymyositis	polymyositis
pre op CV exam	pre operative cardiovascular exam
pregnancy-mom CVds	pregnancy - mother complication; CV ds
pregnancy-ht compl	pregnancy - heart complication

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pulmonary edema-acute	pulmonary edema - acute
pulmonary embolism	pulmonary embolism
PEmb- obstetricial	pulmonary embolism, obstetricial
pulmonary insuf-chronic	pulmonary insufficiency-chronic
pulmonary insuf-other	pulmonary insufficiency-other
resp. distress synd.	respiratory distress syndrome
resp. failure/arrest	respiratory failure or arrest
rheumatic heart ds	rheumatic heart disease
septicemia	septicemia
shock	shock
shortness of breath	shortness of breath
stroke	stroke
syncope and collapse	syncope and collapse
tachycardia-unspecified	tachycardia - unspecified
throat pain	throat pain
TB-endo,myo,pericardium	tuberculosis specified organs-endo/myo/ pericardium
transaminase/LDH elev	transaminase/LDH elevation
trauma-abdomen	trauma-abdomen
trauma-chest	trauma - chest
trauma comp - embolism	trauma complication - embolism
trauma-heart/lung	trauma - heart &/or lung
valve ds- aortic/mitral	valve disease - aortic &/or mitral
valve replacement	valve replacement
valve replac-comp	valve replacement - complication
VSD	ventricular septal defect

HOLTER , Accepted Reasons For *

*According to covered ICD 9 codes, 1999 Medicare Medical Policy Bulletin

Short Name	Long Name
Atriovent Excitation	Anomalous Atrioventricular Excitation
Adverse drug effect	Adverse Drug Effect, Unspecified
A-Fib	Atrial Fibrillation
Cardiac Arrest	Cardiac Arrest
Cardiomyopathy	Cardiomyopathy, Alcholic
	Cardiomyopathy, Hypertrophic Obstructive
	Cardiomyopathies, Other Primary
Comp device,implant,graft	Complication of Cardiac Device, Implant or Graft
Dizziness & Giddiness	Dizziness & Giddiness
Endocard Fibroelast	Endocardial Fibroelastosis
Endomyocard fibro	Endomyocardial Fibrosis
Mech comp of device	Mechanical complication of cardiac device
Palpitations	Palpitations
PSVT	Paroxysmal Supraventricular Tachycardia
Paroxys Tachy	Paroxysmal Tachycardia, Unspecified
PVT	Paroxysmal Ventricular Tachycardia
Premature Beats	Premature Beats
Sinus Node Dysfunct	Sinus Node Dysfunction
Syncope	Syncope and collapse
Tachycardia	Tachycardia, Unspecified
V-Fib	Ventricular Fibrillatioin
V-Flutter	Ventricular Flutter
V-Tach	Ventricluar Tachycardia

The Center for Educational Development and Support

August, 2000

News from the Library

NEW TELEPHONE/FAX NUMBERS FOR LEHIGH VALLEY HOSPITAL-MUHLENBERG LIBRARY.

The Library staff continues its commitment to cost containment and customer service. **Effective immediately, please use the following telephone number when requesting information from the LVH-Muhlenberg Library: 610-402-8410.**

This is the number to use when faxing information requests to the Muhlenberg site Library: 610-402-8409.

Using these numbers will result in faster service for our customers.

OVID/PubMed Training.

To schedule a one-on-one OVID (MEDLINE) training session, call Barbara Iobst in the Health Sciences Library at 610-402-8408. She can also instruct you in the use of PubMed, a free, Web-based MEDLINE service offered by the National Library of Medicine.

New LVH-Muhlenberg Library Books:

"The ICU Book," 2nd edition.
Author: Paul Marino

"Manual of Emergency Care," 5th edition.
Author: Susan Budassi Sheehy, et al.

New CC Library Publications:

"Surgical Clinics of North America"
Topic: "Critical Care of the Trauma Patient"
Volume 80, Number 3, June 2000

"Burn Care"
Author: Steven Wolf, et al.

New 17 Street Library Books:

"Ambulatory Surgery"
Author: Bruce Schirmer, et al.

Computer-Based Training (CBT):

Computer Based Training (CBT) programs are available for LVHHN staff. Topics covered by the CBT programs include:

Access 2.0	Power-Point 4.0
Windows NT 4	Word 97
Excel 97	Access 97
PowerPoint 97	Lotus 1-2-3 Millennium
WordPerfect 8	E-mail GUI

PHAMIS LastWord Inquiry Only commands

CBT programs replace the instructor-led classes previously held at Lehigh Valley Hospital. 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.

Computer Based Training takes place in **Suite 401** of the **John & Dorothy Morgan Cancer Center** (the computer training room) and in the **Muhlenberg Hospital Center computer training room** (off the front lobby). The schedule of upcoming dates is as follows:

CBT sessions for JDMCC, suite 401 are as follows:

August 15, 8am - Noon
September 12, 8am - Noon

Sessions at MHC, I.S. Training room are as follows:

August 29, Noon - 4pm
September 26, 8am - Noon

Twelve slots are available for each session.

To register, please contact Suzanne Rice via e-mail or at 484-884-2560 with the following:

date of session
second date choice
department
phone number

You will receive an e-mail confirming your choice within two business days. If you have any questions, please contact Craig Koller at 610-402-1427 or through e-mail.

Any questions, concerns or comments on articles from CEDS, please contact Bonnie Schoeneberger 610-402-1210

August 2000

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1 8am Pediatric GR-CC-Aud	2	3 12noon GI TB-JDMCC-CR1	4 7am GYN Tumor Board-CC-CL1	5
6	7 12noon Colon/Rectal TB-JDMCC-CR1	8 8am Pediatric GR-CC-Aud	9 12noon Pulmo TB-JDMCC-CR1	10 12noon Combined TB-JDMCC-CR1	11 7am OBGYN GR-CC-CL1 12noon GI Breast TB-JDMCC-CR1	12
13	14	15 8am Pediatric GR-CC-Aud	16	17 12noon Combined TB-JDMCC-CR1	18 7am OBGYN GR-CC-CL1 12noon GI Breast TB-JDMCC-CR1	19
20	21 12noon Colon/Rectal TB-JDMCC-CR1	22 8am Pediatric GR-CC-Aud 12noon Urology TB-JDMCC-CR1	23	24 12noon ENT TB-JDMCC-CR1	25 7am OBGYN GR-CC-CL1 12noon GI Breast TB-JDMCC-CR1	26
27	28	29 8am Pediatric GR-CC-Aud	30	31 12noon Combined TB-JDMCC-CR1		

LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

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Medical Staff Progress Notes

Medical Executive Committee

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

Articles should be submitted to Janet M. Seifert, Physician Relations, Lehigh Valley Hospital, Cedar Crest & I-78, P.O. Box 689, Allentown, PA 18105-1556, by the 15th of each month. If you have any questions about the newsletter, please call Mrs. Seifert at (610) 402-8590.