LEHIGH VALLEY
HOSPITAL AND
HEALTH NETWORK

PROGRESS NOTES
Medical Staff

November, 2002 Volume 14, Number 11

In This Issue . . .

In Memoriam

William Gee, MD

November 4, 1931 – October 18, 2002

"An extremely dedicated, very hard working physician who went the extra mile for quality and service in the Vascular Lab."

From the President

"Learn from the mistakes of others. You do not have time to make them all yourself."
- Anonymous

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The Cycle of Leadership (or... Physicians are not Cats)
Two years ago, I began my term as your Medical Staff President with enthusiasm and a leadership agenda:

1. Value this singular opportunity to assist the welfare and potentiation of the medical staff -- "be all that you can be" – and appreciate that I have a brief two years at this.
2. Address collective challenges facing the medical staff and propose solutions, i.e. JCAHO inspections, computerized physician order entry, etc.
3. Represent the interests of the medical staff to the Board and the administration -- "see the big picture."
4. Recognize the limitations of the office -- "don't overstep your position."
5. Respect and value each member of the medical staff as a professional -- "everyone can make a contribution"-- and emphasize fairness, fairness, fairness.
6. Demonstrate authenticity of purpose, genuine concern for medical staff, and life perspective.
7. Develop leaders throughout the organization -- succession planning.
8. Give the medical staff what they need -- "it's not a popularity contest."
9. Effective leadership depends on relationships (medical staff, board, administration, nursing, community).
10. Don't take myself too seriously -- understand that it's the office and my constituency that's important.

As I look back, I didn't appreciate how big a challenge malpractice would become for us as providers in Pennsylvania. Of course, no one anticipated 9/11 or the threat of bioterrorism. We have had a tumultuous two years and healthcare continues to be unstable with unrelenting financial and liability pressures. On the positive side, I think the medical staff has stayed slowly forward. We are addressing the issues of medical staff morale, promoting political activism and embracing change and improvements in our profession.

In my final ***Medical Staff Progress Notes*** report next month, I will review the goals I projected for the medical staff and let you decide how I did.

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WIN-WIN means it's not important that you come out on top; what matters is that you come out alive.

- Bertholt Brecht

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Continuous Performance Improvement

Last month, we described renewal and growth, facing the future with openness and enthusiasm. A culture of continuous performance improvement assumes change. As good as any physician or department is today, we can always improve tomorrow, and performance data is one of the best ways to document this improvement. Measurement of complication rates and compliance with best practice protocols are tools that the medical staff understands and values. They are used by the Quality Improvement structure at LVHHN. These are the assurances of competence and safety that we are responsible for as a medical staff. We anticipate your input into the creation of physician performance parameters that you agree are relevant.

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The tongue in your mouth doesn't tell as much about what is real in your life as the tongue in your shoe.

- Msgr. John Murphy

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Malpractice - looking for the Jackpot Jury

Venue Bill Passes Senate -- Thank Your Senators and Representatives! Log on to www.pamedsoc.org and click on liability reform. Send your state senator and representative an e-mail thanking them for their support on this tort reform issue. We applaud the General Assembly for their remarkable speed on this matter.

In Congress, House passes a measure to limit awards for non-economic damages

The Associated Press --September 27, 2002 – by Janelle Carter

WASHINGTON -- Responding to physicians' complaints that insurance rates are driving them out of business, the House has passed a Republican-sponsored measure that would limit malpractice awards to patients injured by their doctors. The bill passed 217-203 on 9/26/02. It is unlikely the bill will be acted on by the Democratic-controlled Senate, which already has rejected a similar measure.

Interestingly, after pointing fingers, opponents of tort reform seem to offer no real solutions of their own. And now...closer to home...

Physicians at Community Medical Center's Emergency Room and Trauma Center in Scranton said they will leave at the end of the month unless the hospital or the State intervenes and eases malpractice insurance costs.

Annual malpractice insurance premiums for Emergency Services P.C., a group of about 10 physicians staffing the medical center's emergency room and trauma center, rose from $90,000 three years ago to $700,000 Tuesday when the group signed up for the JUA, reported the *Scranton Times Tribune*. (*Scranton Times Tribune*, October 2, 2002)

Isn't it ironic...don't you think? Alanis Morissette

Pa.'s Family Physician of the Year is considering leaving the State because of high malpractice costs. Wyoming County physician Dr. Edward Zurad, who was named by the Pennsylvania Academy of Family Physicians as Pennsylvania Family Physician of the Year, said he has been unable to find affordable medical liability insurance since learning that his insurer, Princeton Insurance Co. of New Jersey, is dropping medical liability coverage of all Pa. physicians this year, reported the *Times Leader*, October 10, 2002.

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Benefits of growing older:

- You enjoy hearing about other people's operations.
- Your investment in health insurance is finally beginning to pay off.
- Your back goes out more than you do.

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Medicare

Congress unlikely to increase Medicare payments to providers this year -10/9/2002

Despite support from both Republican and Democratic lawmakers, Congress is unlikely to pass a Medicare giveback bill that would increase payments for hospitals, physicians, and health plans this year, the Nashville *Tennessean* reports. Providers would receive $30 million from a bill passed in the House and $41 billion from the Senate's proposed giveback bill. However, with Congress expected to adjourn before the Nov. 5 elections so members can campaign (Snider, Bloomberg News/*Tennessean*, 10/9), one Senator "put the odds of getting a giveback bill [passed] at 50-50 (Rovner, *CongressDaily/AM*, 10/9).

More Skilled Nursing Facilities and Nursing Homes such as Harrisburg's Susquehanna Center are projected to close because of Federal budget cuts that went into effect Oct. 1. The Pennsylvania Department of Health received notification of the 180-bed Susquehanna Center's plans to close on Nov. 30. (*Central Penn Business Journal*, October 3, 2002)

Even venerable institutions like the Cleveland Clinic are struggling with financial pressures that have caused Moody's to downgrade their bond rating. Remember when we thought that the reduced Medicare payments to providers were some

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sort of legislative mistake? Not so! Congress is deliberately squeezing healthcare until they hear back from us and the public. We should not suffer in silence! Contact your legislators and let them know how you feel. They respond to "public pressure."

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If, at first, you don't succeed, skydiving is not for you.

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Hospitalists

The Nation's increasing number of hospitalist physicians represents one of the fastest growing trends in physician care. According to the National Association of Inpatient Physicians, there are 6,000 hospitalists now working around the country, up from 2,000 in 1998 and just a few hundred in the mid-1990s, while the group expects the number will swell to 20,000 by 2010, reported the *Associated Press*. (*Associated Press*, September 19, 2002)

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We are born naked, wet and hungry. Then things get worse.

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HIV

HIV will be added to the list of 52 diseases and conditions reportable to the Pa. Health Department. Effective October 18, laboratories, testing sites and doctors will be required to share HIV case data with state health officials, who will compile the information for tracking and prevention purposes, reported the *Times Leader*. (*Times Leader*, September 10, 2002)

Quietly, and without fanfare, HIV is reclassified from a disability to, what it really is, a chronic communicable lethal disease. Medical sense has prevailed...finally.

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Deep Thought:
In just two days, tomorrow will be yesterday.

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Gifts to Healthcare Providers

When Dr. David Caccese was medical staff president, he was appropriately critical of the pharmaceutical industry practice of giving gifts to physicians in an effort to induce the use of their products. Recent events essentially vindicate his efforts.

WASHINGTON, Sept. 30 - The government warned pharmaceutical companies today that they must not offer any financial incentives to doctors, pharmacists or other health care professionals to prescribe or recommend particular drugs, or to switch patients from one medicine to another. The new standards, the first of their kind, were issued by Janet Rehnquist, Inspector General of the Department of Health and Human Services, as guidance to the pharmaceutical industry where aggressive marketing is the norm. (Consumer Watch Group, Sept. 30, 2002)

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And finally, another interesting tidbit . . .

- If a statue in the park of a person on a horse has both front legs in the air, the person died in battle.
- If the horse has one front leg in the air, the person died as a result of wounds received in battle.
- If the horse has all four legs on the ground, the person died of natural causes.

Ed

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

Spotlight on . . .

Kamalesh T. Shah, MD

Born in Nadiad, India, Dr. Shah completed his undergraduate education at the University of Baroda in Baroda, India, where he earned a Bachelor of Science degree. He received his medical degree from the Government Medical College, Baroda University in Baroda, India. He completed his General Surgery residency at St. Agnes Hospital in Baltimore, Md., and a Trauma/Surgical Critical Care fellowship at Cook County Hospital in Chicago, Ill.

Dr. Shah is certified by the American Board of Surgery in both Surgery and Surgical Critical Care.

Dr. Shah joined the hospital's Medical Staff in 1989 and is a member of the Division of General Surgery/Trauma-Surgical Critical Care. He is in solo practice.

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

On a more personal note, Dr. Shah and his wife, Sunita, have three sons. In his spare time, he enjoys playing tennis and spending time with his family.

In conclusion, Dr. Shah has the following comment to share with his colleagues on the Medical Staff:

"Disasters, in the practice of medicine, generally do not happen. There are warning signals. We just have to look for them."

News from CAPOE Central

New ASAP Priority for Radiology Procedures

Beginning in October, a new priority for all Radiology procedures were added to the CAPOE system. In an effort to reduce the use of possibly unnecessary STAT priorities, the priority of ASAP has been added. The ASAP priority will be available in the Priority menu for all radiology procedures at all hospital sites. The reference text for several studies (the white box on the right side of the order screen) provides examples of clinical scenarios for each of the priorities. The Priority drop-down menu shows the expected timeframe for each priority:
Routine - within 8 hours
ASAP - within 2 hours
STAT - within 30 to 60 minutes

Please remember to use the priorities appropriately. This should improve the overall efficiency of the Radiology Department.

Reasons for Transfusion of Blood Products

The paper Transfusion Order Sheet has been converted to an on-line order. CAPOE users are probably familiar with the transfusion order sets, which allow the ordering physician to specify how many units to "set-up," and how many units to actually transfuse. A field has been added to the Blood Bank order, which requires the ordering physician to choose a reason for the transfusion. The reasons appear on a drop-down menu, and the physician has the option to choose one or type in a reason. This change should make it easier for CAPOE physicians to supply a reason, and will allow better tracking of the appropriate use of blood products.

Caring for your LifeBook

It seems as though you can't walk the halls of Cedar Crest & I-78 without seeing several silver LifeBooks being carried around. The demand for the wireless sub-notebook computers continues to grow, as many physicians have begun to see the advantages: continuous access to patient data and the ability to enter orders remotely.

It is helpful to remember a few points about taking proper care of the computer. This will ensure continued reliable functioning of the device and reduce the need for repairs.

- Do not stack anything on top of the LifeBook, even when it is closed and turned off. The computer screen can not tolerate more than 10 to 15 pounds of pressure.
- When using the touchscreen, use the stylus supplied or another stylus. Using your pen will leave pen marks and indentations on the screen that cannot be removed.
- Remember to keep the battery charged. Extra batteries are available in the Medical Staff Lounge, and will soon be available at the central reception areas (across from the main elevators) on floors four through seven. The batteries will be located next to the printers in each reception area.
- Clean the LifeBook with a damp, lint-free cloth. Do not use solvents. Clean the screen with a soft, lint-free cloth and never use glass cleaner.

If you have any questions or concerns, please contact me or one of the CAPOE Physician Educators -- Lynn Corcoran-Stamm, (610) 402-1425; Carolyn Suess, (610) 402-1416; or Kimberlee Szep, (610) 402-1431.

Don Levick, MD
(610) 402-1426 (office)
(610) 402-5100 7481 (pager)

Attention: Allopathic Physicians

If you are an allopathic physician, your Pennsylvania license will expire on December 31, 2002.

Renewal applications are usually mailed 60 to 90 days in advance of the expiration date to the last address of record provided by the licensee. If your address has changed since your last license renewal and you have not yet received your renewal application, you may want to notify the Pennsylvania Department of State of your new address. You can also renew your license on-line at https://www.mylicense.state.pa.us/Login.aspx

Don't take the chance of having your license expire!

In addition, since Medical Staff Services now verifies both licenses and DEA's on-line, there is no need to send a copy of either of these documents to Medical Staff Services when they are renewed.

Implementation of Streamline Admit

Emergency Department crowding is a well-documented regional and national problem that is being addressed on a number of fronts. There are many factors that affect the time patients spend in an Emergency Department including front end and backend issues. The Department of Emergency Medicine, working with a hospital wide management team, has successfully partnered with the Advisory Board of Washington, D.C., to identify and implement best practices in our three-site department.

The effort is ongoing and depends on the cooperation of many throughout our network. The Streamline Admit Committee was created to implement best practices that impact on the time interval from when an Emergency Department attending physician decides that a patient will need admission to when that patient actually reaches an inpatient bed. The three Emergency Departments are experiencing high acuity and volume pressures that tend to rapidly fill our Emergency Department beds. Essentially the peak inpatient discharge rate and the peak need for new inpatient beds do not match, resulting in a back up of patients waiting for a bed in our Emergency Departments.

Data was collected from the three campuses to look at the length of time from when the Emergency Department physician made the determination to admit a patient until the time when the admission orders were completed. At LVH-M, the average time was 57 minutes (n=90), at 17th & Chew -- 77 minutes (n=6), while at Cedar Crest & I-78, the average time was 104 minutes (n=51). These time spans cause delays in getting patients into the Emergency Department. This negatively impacts our patient satisfaction and revenue enhancement efforts in the Emergency Department and throughout the Network. Admitting physicians are also unhappy since there are delays in getting their patients into the Emergency Department.

The obvious question, then, is why are patients in the Emergency Department for so long? Several delays have been identified. Often, patients are held in the Emergency Department until the full history and physical as well as admission orders are completed. This occurs even when the patient's inpatient bed is available, thus delaying the patient from reaching his/her hospital bed. Diagnostic testing delays patients in the Emergency Department. Instead of a patient going to the floor and returning for a Ventilation/Perfusion scan, for example, the patient is held in the Emergency Department until the test is completed.

Another source of delays occurs when a physician refuses the bed assignment. This occurs when a physician places an order for a bed in a specific unit, such as MICU, but none are available. Bed Management, using established guidelines, will assign the patient an equivalent bed, such as ACU or OHU. However, the physician refuses the equivalent bed, demanding the patient be admitted to the MICU. Additional delays occur while waiting for the previous patient in MICU to be moved to another bed versus going to the ready bed in ACU or OHU. Other delays occur because the nursing staff on the units often want a full set of admission orders upon arrival to the floor.

In an effort to solve some of these problems, the Streamline Admit Committee has developed the following guidelines:

- Initial admission orders will be written or telephoned within 30 minutes of the notification of the need to admit a patient. Special order sheets have been developed which have the essential admission orders needed to appropriately move the patient to an inpatient bed. The Streamline Admit Committee will be aiming for 80% compliance with this guideline.
- Patients will be taken to their inpatient bed when it becomes available. Any workup or orders remaining can be completed on the floor. This will provide a quieter environment for the patient and admitting physician, and also open an Emergency Department bed for waiting patients.
- Bed management/triage has the authority to assign an equivalent bed if the requested bed is not available.

Implementation of this best practice guideline will help improve the flow of patients through the Emergency Department. This new process is not a stand-alone solution, however. Numerous other techniques already implemented will be augmented by further appropriate change including those suggested by the Growing Organizational Capacity Network Workgroup. Implementation of the Streamline Admit Best Practice was initiated on October 21, 2002.

A big "Thank You" to the nursing and physician staffs as well as the Admitting/Bed Management staff for their cooperation and involvement in this change.

If you have any questions or concerns, please email them to Richard S. MacKenzie, MD, Vice Chairperson, Department of Emergency Medicine.

Attention Authors!

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

Attention: Members of the Medical and Allied Health Staffs

At their respective meetings of September 4, 2002 and October 8, 2002, the Lehigh Valley Hospital Board of Trustees and Lehigh Valley Hospital-Muhlenberg Board of Trustees, approved one of the final steps in the merger of the Common Medical Staff. The action taken by both Boards, which is effective immediately, is that all members of the Medical and Allied Health Staffs who currently hold privileges at one of the hospital sites will now have full privileges at all sites. Sites of privileges include:

- Lehigh Valley Hospital – Cedar Crest & I-78
- Lehigh Valley Hospital – 17th & Chew
- Lehigh Valley Hospital – TSU at 17th & Chew
- Lehigh Valley Hospital-Muhlenberg – Schoenersville Road
- Behavioral Health Center at Schoenersville Road
- Cancer Center at Schoenersville Road

This action follows the actions by the Boards in late spring to have the Hospital Staff Development Plan (Manpower Plan) have the same access in all divisions across the Network. This means that staff development slots will need to be requested in those divisions currently approved for controlled access. Other divisions, such as Family Practice, General Internal Medicine, General Dentistry, General Pediatrics, and Primary OB-GYN are, at present, considered open and do not require Hospital Staff Development slot approvals.

If you need further clarification regarding the status of any division, please contact the Medical Staff Services office at (610) 402-8980. In addition, status updates of each division will be communicated in the semi-annual needs survey memo distributed in February and August of each year.

As a courtesy to staff, prior to exercising privileges at an unfamiliar site, please contact the Manager of the procedural area you plan to use in order that you may be oriented to the new site. The exercising of privileges at all sites does not include reading panels that are subject to contractual relationships with that particular hospital site. Your approved delineation of privilege sheet has been changed on the Intranet to reflect this action and will be individually changed at the time of the next reappointment cycle. Please note that Affiliate staff category members do not have clinical privileges within the hospital.

If you have any questions concerning this issue, please contact John W. Hart, Vice President, at (610) 402-8980.

Complimentary Sleep Studies Offered to Physicians

To promote the importance of sleep to a person's overall health and well-being, the Sleep Disorders Centers are offering a "Complimentary Sleep Study" to all physicians on the medical staff of Lehigh Valley Hospital. All amenities are included: free valet parking (at 17th & Chew), a free continental breakfast, evening snacks, private room with shower, television, room darkening shades, and an appointment with one of the sleep physicians to review the results of the study.

To schedule an appointment at 17th & Chew, please call Christine Ash at (610) 402-9777, Monday through Friday, from 7:30 a.m. to 4 p.m.

To schedule an appointment at LVH-Muhlenberg, please call Denise Schuler at (484) 884-8030, Monday through Friday, from 6:30 a.m. to 3 p.m.

If you have any questions, please contact Stephanie Betz, Administrative Director, Sleep Disorders Centers, at (610) 402-9767.

Relocation of Units

On October 11, the 7A and 6B units at Cedar Crest & I-78 moved. The renal patients, previously on 7A, moved to 6B. That unit will now be known as 6B, Renal Med/Surg. The purpose of the move was to have the renal population close to the Dialysis Unit on 6A and is part of the ongoing capacity work.

The neuroscience patients, previously on 6B, moved to 7A. That unit will now be known as the Neuroscience Unit.

Phone numbers and fax numbers are unchanged. Judy Bailey is the Director of the Neuroscience Unit -- pager (610) 402-5100 8459; Susann Groller is the Director of the 6B Renal Unit -- pager (610) 402-5100 5192.

News from the Health Information Management Department

November 3-9, 2002 -- National Health Information & Technology Week

Sponsored by the American Health Information Management Association (AHIMA), this weeklong event recognizes the unique contributions that health information management (HIM) professionals and health information technology (HIT) professionals make to the healthcare industry. This year's theme is ***"Unlocking the Power of Professionalism."***

According to AHIMA President Barbara Odom-Wesley, PhD, RHIA, National Health Information & Technology Week provides an opportunity to spotlight the major roles HIM and HIT professionals play in making our healthcare system work. As the experts in managing patient health information, administering computer information systems, and coding the diagnosis and procedures for healthcare services provided to patients—these individuals are responsible for maintaining, collecting and analyzing the data that doctors, nurses, and other healthcare providers rely on to deliver quality healthcare.

Please take a few minutes to remember the Health Information Management Departments at LVHHN who continually work behind the scenes to provide seamless access to medical record documentation throughout the network.

Physician Queries

The Coding Unit of the HIM Department has certain mandates from federal authorities and from the American Hospital Association. One area involves applying diagnostic and procedure codes properly, accurately and with the greatest specificity to your patient's hospital stays. The only place to get this information is through your documentation in the medical record. Charts lacking the appropriate documentation result in the "physician query" for documentation specificity.

Two things to include in chart documentation are: (1) assure that a diagnosis exists for all conditions for which the patient is treated, and (2) include the underlying cause of the disease process (suspected, questionable, and probable diagnoses can be coded in the inpatient setting). This will result in fewer questions following patient discharge.

The HIM Physician Pocket Guidelines contains a section on Documentation. These were mailed to the physicians about a month ago. They are also located in the Physician Lounges and HIM Departments at both the Cedar Crest & I-78 and LVH-Muhlenberg sites. If you have not received a copy, or would like additional copies, please contact the HIM Department at (610) 402-8330.

Legible Handwriting

There continues to be concern regarding illegible documentation in the medical records at health care facilities throughout the country. Like everyone else, we are struggling to make sure that the documentation in the medical can be easily read and interpreted to prevent interruptions in patient care. Caregivers depend on a legible signature as well as clearly written documentation contained on progress notes and consultations. Here are a few suggestions to make your documentation clear and avoid being called to interpret your notes:

- Use only black ink for chart documentation. Other colors become distorted upon scanning for the electronic record.
- Do not use "felt tip" or pens that make dark, bold lines. These pens tend to smear and cannot be clearly read in the electronic medical record.
- Do not use "very fine" writing pens which tend to skip at times. These notes do not scan well into the electronic medical record.
- Make sure that the final letters of words do not fade out.
- Avoid the use of abbreviations. Remember that abbreviations sometimes have more than one meaning.
- Include your phone number or pager number with your signature.
- Clearly write medications that can be confused with other medications.
- Do not rush when writing your documentation. Your written notes are used to treat the patient.
- If you have been designated as having illegible handwriting and are required to use a name stamper, please make sure that the pad is appropriately inked.

Documentation and Authentication in the Medical Record

The caregiver that assesses and/or treats a patient and/or client is responsible for documenting and authenticating his/her own care of the patient/client as soon as possible after the time of the encounter. Documentation and authentication should be legible and include the patient's name, date, caregiver's name and credentials.

Errors in documentation must never be obliterated. Corrections in the medical record documentation are as follows:

- Draw a single line in black ink through the incorrect entry
- Document "error in charting" at the top of the entry
- Enter legal signature or initials, date, time, title, reason for change and discipline of the person making the correction
- Late entries should be labeled with the date and time that the entry is being made

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Consultation Sheets

The consultation form is a one-sided document in PIM and the back of the page does not get scanned. If additional space is needed for documentation, please use an additional consult sheet.

Physician Chart Completion at 17th & Chew

Physicians who are at 17th & Chew may utilize the computers and dictation phones in the TSU (Transitional Skilled Unit) on the 5th Floor. A computer has also been designated for physicians to access PIM in the Center for Aging. Dictations may be done from any touch tone telephone by dialing 2515 or 8365 if you are within the 17th & Chew facility. For additional assistance, please call the Cedar Crest & I-78 Incomplete Chart area at (610) 402-8345.

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

Helwig Health and Diabetes Center

NEW Name, NEW Referral Form, and NEW Collaborative Services

The Helwig Diabetes Center will become the Helwig Health and Diabetes Center. In collaboration with Healthy You programs and the Metabolic Bone team, the referral form will now provide easy access to prevention services, as well as disease management. The new referral form will provide you and your office a "one stop" referral for a wide variety of services; just check off diagnosis and program, fill in the blanks for name, labs, and meds and fax the form. On the back page there is information describing the programs, the method of payment required (insurance coverage, self pay, or free), information about support groups, Camp Red Jacket for diabetic children, and DOME - the program for the uninsured and desolate who need diabetes care and education. The Helwig Health and Diabetes Center will assure the referral goes to the correct service, and your patient will be contacted for scheduling. The fax machine is located in a secure location that meets HIPAA regulations. The new form will be sent to all LVH site offices, as well as any other practices that refer patients to Helwig. Be one of the first offices to use the form, and you will be entered into a drawing for a seated chair massage session for your staff at your facility.

The services offered now include:

Diabetes Education - Type 1 and Type 2, Insulin initiation, Insulin pumps, Diabetic Meal Planning, Meter education, Complication prevention, and all the education required to help patients "self-manage" their day-to-day diabetes regimen.

Nutrition Education - Weight Management, GI, Cholesterol, Hypertension and most other nutritional diagnosis.

***NEW* - Diabetes Certified Nurse Practitioner** - Working with the Endocrinologists, the CRNP is available to assist with the management of complex patients and insulin pumps.

***NEW* - Diabetic Social Worker** - Financial counseling and "coping" education.

***NEW* - Exercise & Physical Activity** - A wide range of group exercise classes now available at the Healthy You Center, 3401 Fish Hatchery Road.

***NEW* - Heart Failure Education** - In collaboration with the Heart Care Group, PC, and Lehigh Valley Cardiology Associates for the CHF patient. This program includes nutrition, medication safety, and self care.

***NEW* - Massage Therapy and Mind and Body** - Individual massage treatments for relaxation and chronic conditions, as well as group yoga and tai-chi classes.

***NEW* - Metabolic Bone Program** - Consultation with an Endocrinologist.

***NEW* - Tobacco Treatment and Counseling** - In collaboration with Community Health and Health Studies, counselors will work with individuals to help them **QUIT** and the service is **FREE**.

Diabetes, nutrition education, and the Metabolic Bone programs are considered specialty services and may require an insurance referral prior to the patient's appointment.

Thank you for referring your patients to Helwig and Healthy You programs. If you have any questions or need additional information, please call the Helwig Health and Diabetes Center at (610) 402-5000.

Mystery Medical Staff Member

? Born in Kingston, Pa.
? Earned Bachelor of Science degree from King's College
? Graduated from Philadelphia College of Osteopathic Medicine
? Completed residency and fellowship at Allentown Affiliated Hospitals
? Joined the Medical Staff in 1978
? He and his wife, Janice, have two children
? Enjoys spending time with his wife

Give up? Turn to page 14 for the answer.

Physician Assistance Program

When Anger Gets the Best of You

Encountering difficult personalities and fast paces can build frustration. What can you do?

First, the alarm clock didn't ring. Then a driver cut you off on Route 22. So you're already stressed when you get to work – late, of course – and you find several tasks still undone. Three more "must-do" items cross your path. Your heart races.

Finally, a coworker tells you that a meeting – one that's crucial to the work at hand – is canceled. You can't help but take it personally. Your frustration turns to anger. You're ready to explode.

"Stop right there," says Gerald Rodriguez, Program Director at Muhlenberg Behavioral Health. "We're often frustrated by events we can't control. The key is to express that anger constructively."

The first step is realizing that your anger is building. "Often, your blood pressure soars, or you talk louder," says Linda Unser, **Preferred EAP** counselor.

From there, try using the **STOP and CALM technique.**

STOP

- **Slow down.** Stop your automatic response by taking a few deep breaths, a "timeout," or by thinking of a more pleasant situation. This will clear your mind so you can better process the frustration overload.
- **Think.** Examine why you're so angry. Determine if your anger might be from a miscommunication or negative feeling on your own part.
- **Options (consider them).** Acknowledge the other person's perspective (perhaps he had another meeting scheduled at the same time and is working hard to reschedule) and weigh the consequences of your response.
- **Proceed calmly.** Approach the individual you're angry with and use the following techniques:

CALM

- **Communicate clearly.** Explain your concerns by using "I" statements. It's better to say, "I'm uncomfortable with this situation," rather than "you're acting unfairly," because "you" statements immediately put a person on the defensive.
- **Ask questions.** "If you don't communicate with your coworkers, you might assume things are bad," says Unser. So express your feelings by asking questions that openly and gently address the problem.
- **Listen.** Hear what the other person is thinking and feeling, and find the truth in what they are saying. For example, your supervisor might be giving you more work because he knows you're a great worker, not because he doesn't like you.
- **Monitor your response.** Choose your words carefully and stay positive.

The Physician Assistance Program, which is provided through an agreement with Preferred EAP, can address workplace anger and help mediate conflicts. When you need to talk, there is someone to listen. For more information, call the Preferred EAP at (610) 433-8550, log onto www.preferredeap.org, or contact John W. Hart, Vice President, at (610) 402-8980.

Congratulations!

Theodore H. Gaylor, MD, Division of Otolaryngology-Head & Neck Surgery, was appointed to the International Otolaryngology Committee at the American Academy of Otolaryngology - Head and Neck Surgery Convention held in San Diego, Calif., in September. The Committee serves as advisors to the Academy Board on international affairs as well as the development of programs for international scholars.

W. Michael Morrissey, Jr., MD, Division of Plastic Surgery, was recently informed by the American Board of Plastic Surgery that he successfully completed the oral examination in Houston, Texas, and is now a Diplomate of the Board.

Papers, Publications and Presentations

George A. Arangio, MD, Division of Orthopedic Surgery, Section of Ortho Trauma/Foot and Ankle Surgery, was invited to speak at the International Foot and Ankle Society Meeting in San Francisco, Calif., on September 13. Dr. Arangio presented a biomechanical study of the effect of surgery on the adult flexible flatfoot. He also participated in a symposium discussion on flatfoot surgery and on the treatment of flatfoot.

Mark A. Gittleman, MD, Division of General Surgery, recently was an invited speaker at the Annual Clinical Congress of the American College of Surgeons held October 6 to 10, in San Francisco, Calif. His topics included "Image Guided Breast Biopsy" and "Interventional Breast Ultrasound."

Dr. Gittleman also co-authored the article, "A Prospective, randomized, multicenter clinical trial to evaluate the safety and effectiveness of a new lesion localization device," which was published in the October, 2002 issue of the ***American Journal of Surgery***.

Continued on next page

Margaret Hoffman-Terry, MD, Division of Infectious Diseases, presented "Influence of Past Hepatitis B Upon Risk of Highly Active Antiretroviral Therapy Induced Hepatotoxicity" at the XIV International AIDS Conference which was held July 7-12, in Barcelona, Spain. Allen Smith, RN, ACRN, from the AIDS Activities Office was a co-presenter. Erin O'Donnell, RN, from the Department of Medicine Research, and Thomas Wasser, PhD, from Heath Studies, were co-authors.

In addition, Dr. Hoffman-Terry gave an oral presentation at the 42nd Interscience Conference on Antimicrobials and Chemotherapeutic Agents, which was held September 27-30 in San Diego, Calif. The presentation, "Surrogate Markers Can Be Used to Predict Extent of Biopsy Proven Liver Damage in HIV/HCV Co-infected Patients," was co-authored by Drs. Sharon Kimmel and Lawrence Kleinman from Health Studies, and Erin O'Donnell, RN, Department of Medicine Research.

Dr. Hoffman-Terry was also senior author and presenter for a paper titled "Safety and Efficacy of 40 Kda Peginterferon Alfa-2a (Pegasys) in the Treatment of Patients Co-infected with HIV and HCV: Preliminary Results from a Randomized, Multicenter Trial" at the same conference.

Indru T. Khubchandani, MD, Division of Colon and Rectal Surgery, was invited to the faculty of the 7th Biennial Course at the International Meeting of Coloproctology at St. Vincent/ Torino, Italy, held September 30 to October 3. Dr. Khubchandani performed live surgery -- Endorectal Repair of Rectocele -- which was telecast to the meeting. He also moderated a panel on Newer Techniques in Hemorrhoidectomy, including the Stapled Hemorrhoidectomy, popular in Europe.

First published in 1974, ***Neurology for the House Officer***, now in its sixth and soon to be seventh edition in English, has recently been translated into Indonesian. The book, co-authored by **Lawrence P. Levitt, MD**, and **Alexander D. Rae-Grant, MD**, members of the Division of Neurology, and Howard Weiner of Harvard Medical School, with previous translations into Japanese, Chinese, Russian, Italian, French, Spanish, and Polish, has become the most widely read neurology book in the world.

Christopher J. Morabito, MD, Chief, Division of Neonatology, was recently invited to share his expertise with area pediatricians, OB/GYN physicians and the maternal/child services staff at Gnaden Huetten Memorial Hospital. Dr. Morabito presented a review of case studies and a discussion on neonatal seizures -- why they occur, initial treatment and subsequent management.

Gary G. Nicholas, MD, Program Director, General Surgery Residency and Chief, Division of Vascular Surgery; Daniel Morrison, MD, former general surgery resident; Thomas Wasser, PhD, Research Scientist, Community Health & Health Studies; and David Lawrence, MD, general surgery resident, co-authored the paper, "Evidence-based Cerebral Vascular Testing Criteria," which was presented at the 24th Annual Scientific Meeting of the Delaware Valley Vascular Society held in Philadelphia on September 19.

Michael D. Pasquale, MD, Chief, Division of Trauma-Surgical Critical Care; M. Todd Miller, MD, general surgery resident; William J. Bromberg, MD, former Trauma-Surgical Critical Care Fellow; and Thomas Wasser, PhD, Community Health & Health Studies, co-authored the paper, "Not So Fast," which was presented at the 61st Meeting of the American Association for the Surgery of Trauma (AAST) in Orlando, Florida on September 26-28.

Ali Salim, MD, Division of Trauma-Surgical Critical Care/General Surgery, Section of Burn; **Mark D. Cipolle, MD, PhD**, Chief, Section of Trauma Research; **Stanley J. Kurek, DO**, Chief, Section of Pediatric Trauma; **Michael M. Badellino, MD**, Associate Chief, Division of General Surgery; **William R. Dougherty, MD**, Chief, Section of Burn; **Michael D. Pasquale, MD**, Chief, Division of Trauma-Surgical Critical Care; William J. Bromberg, MD, former Trauma-Surgical Critical Care Fellow; Kenneth Miller, RRT, Respiratory Therapy; and Dale Dangleben, MD, general surgery resident, developed the poster, "High Frequency Percussive Ventilation: An Alternative Mode of Ventilation in Head-Injured Patients With ARDS," which was also presented at the AAST meeting in September.

Upcoming Seminars, Conferences and Meetings

OSHA Bloodborne Pathogens Standard

"Developing Your Office Specific Exposure Control Plan," a one-hour seminar intended for physicians, dentists, nurses, and/or office managers who are responsible for providing annual OSHA Bloodborne Pathogen Standard training to their staff, will be held as follows:

Mondays, November 4 and **November 11**
5:30 to 6:30 p.m. -- Third Floor Classroom
Lehigh Valley Hospital-Muhlenberg

Tuesdays, November 5 and **November 19**
5:30 to 6:30 p.m. -- Classroom 1, Anderson Wing
Lehigh Valley Hospital - Cedar Crest & I-78

At the conclusion of the program, attendees will be able to:

- Identify elements to be included in annual Bloodborne Pathogens Training
- Develop office specific Exposure Control Plan and training records
- Plan the evaluation and selection of safer medical devices as required by the Needlestick Safety and Prevention Act

Continued on next page

A fee of $35.00 per person will include printed materials and a certificate of attendance. A light snack and beverage will also be served. Advance registration is required.

For additional information, please call the Infection Control Office at (484) 884-2240. For registration information, please call the Center for Educational Development and Support at (610) 402-2277.

Computer-Based Training (CBT)

The Information Services department has computer-based training (CBT) programs available for Lehigh Valley Hospital (LVH) staff. CBT programs replace the instructor-led classes previously held at LVH. A proctor will be in the room with the learner while he/she takes the CBT, but the learner will control the pace and objectives of the learning.

Topics covered by the CBT programs include:

Access 97	Windows NT 4	Excel 97
Word 97	GUI Email	
PowerPoint 97	PowerPoint 4.0	

Computer-based training takes place in **Suite 401 of the John & Dorothy Morgan Cancer Center** (*the training room)* and in the **Lehigh Valley Hospital-Muhlenberg I/S training room** (*off the front lobby*). The schedule of upcoming classes is as follows:

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

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

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

November 21	December 19 - **8 a.m. to noon**	
January 16	February 20	March 20
April 17	May 15	June 19

Twelve seats are available at each session. To register for a session in email, go to either the **Forms_/LVH** or **Forms_/MHC** bulletin board, (based on your choice of site and training room). The form has all the available information in an easy to choose format, detailing titles, dates, times and locations. Simply do a "Use Form" (a right mouse option) on the **I/S Computer Educ Request** form. Complete the form indicating your desired session selection and mail the form. Shortly thereafter, you will receive a confirmation notice.

If you have any questions, please contact Information Services by calling the Help Desk at (610) 402-8303 and press option "1." Tell the representative that you need assistance with I/S education.

Medical Grand Rounds

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

- November 5 - "Treating Hyperlipidemia in the Older Patient"
- November 12 - "Medical Oncology in Community Based Private Practice; Exciting Developments in the Treatment of Lung Cancer"
- November 19 - "Novel Approaches to Progressive Kidney Disease"
- November 26 - "What's New in GI - An Update"

For more information, please contact Judy Welter in the Department of Medicine at (610) 402-5200.

Department of Pediatrics

Pediatric conferences are held every Tuesday beginning at 8 a.m., in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78. Topics to be discussed in November will include:

- November 5 - "Malpractice Misery in Pennsylvania"
- November 12 - "Shaken Baby Syndrome: Controversies and Prevention"
- November 19 - "Morbidity and Mortality Conference"
- November 26 - Case Presentation

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

Surgical Grand Rounds

Surgical Grand Rounds are held every Tuesday at 7 a.m., in the Auditorium of Lehigh Valley Hospital, Cedar Crest & I-78, and via videoconference in the First Floor Conference Room at LVH-Muhlenberg. Topics to be discussed in November will include:

- November 5 - "Current Issues in Liver Transplantation: Allocation in the 'Cyber' Era, Living Donor and Split Liver Transplantation"
- November 12 - "Breasts"
- November 19 - "Biliary Stricture"
- November 26 - To be announced

In addition, topics to be discussed are posted each week on the Auditorium and OR Lounge doors and in the LVH_LIST bulletin board in email.

For more information, please contact Catherine Glenn in the Department of Surgery at (610) 402-8334.

Who's New

The Who's New section of ***Medical Staff Progress Notes*** contains an update of new appointments, address changes, resignations, etc. Please remember to update your directory and rolodexes with this information.

Medical Staff

Appointments

Mark F. Indzonka, MD
Pocono Heart Center, Inc.
447 Office Plaza
100 Plaza Court, Suite D
East Stroudsburg, PA 18301-8258
(570) 424-8482
Fax: (570) 424-2899
Department of Medicine
Division of Cardiology
Provisional Active

Wei-Shen W. Lin, MD
Lehigh Valley Orthopedic Group, PC
ROMA Corporate Center
1605 N. Cedar Crest Blvd., Suite 111
Allentown, PA 18104-2304
(610) 821-4848
Fax: (610) 821-1129
Department of Surgery
Division of Orthopedic Surgery
Provisional Active

Dennis M. McGorry, Jr., MD
McGorry & McGorry
Allentown Medical Center
401 N. 17th Street, Suite 105
Allentown, PA 18104-5088
(610) 432-2013
Fax: (610) 432-6559
Department of Family Practice
Provisional Active

Marcos D. Sanchez, MD
Primary Care Associates in the LV, PC
1150 S. Cedar Crest Blvd., Suite 101
Allentown, PA 18103-7900
(610) 776-1603
Fax: (610) 776-6344
Department of Medicine
Division of General Internal Medicine
Provisional Active

Elisa K. Yoo, MD
Riverside Dermatology Associates
Riverside Professional Center
5649 Wynnewood Drive
Laurys Station, PA 18059-9998
(610) 261-1115
Fax: (610) 261-9601
Department of Medicine
Division of Dermatology
Provisional Affiliate
Site of Privileges - None

David P. Zambo, DO
(Solo Practice)
4263 Lonat Drive
Nazareth, PA 18064-8403
(610) 759-5501
Fax: (610) 759-2216
Department of Family Practice
Provisional Active

Last Name Change

From: Debra L. Kruse, MD
To: Debra L. Carter, MD

New LVPG Practice

Creekside Family Health
- **Lisa J. Caffrey, DO**
- **Jennifer A. Derr, DO**

1500 W. Uhler Road
Easton, PA 18040-6622
(610) 253-5150
Fax: (610) 253-3352

Address & Practice Name Change

C. William Riedel, DO
Hamilton Obstetrics & Gynecology, PC
Hamilton Medical Plaza
1941 W. Hamilton Street, Suite 100
Allentown, PA 18104-6413
(610) 432-4665
Fax: (610) 432-8512

Practice Name Change

Jeffrey A. Debuque, DO
William R. Swayser, DO
Former Practice Name: Lehigh Valley Medical Associates
New Practice Name: Coopersburg Medical Associates

Continued on next page

Practice Change

Kathleen O. Ververeli, MD
(No longer with Allentown Asthma and Allergy)
Allergy & Asthma Consultants of NJ/PA
555 Second Avenue, Suite C-750
Collegeville, PA 19426-3633
(610) 657-3561
Fax: (610) 409-9146

Status Changes

Abel A. Gonzalez, MD
Department of Psychiatry
From: Active
To: Associate

Jay E. Melman, DPM, MD
Department of Surgery
Division of Podiatric Surgery
From: Associate
To: Affiliate
Site of Privileges - None

Brendan J. O'Brien, DO
Department of Surgery
Division of Orthopedic Surgery
From: Associate
To: Active

Venugopal Thirumurti, MD
Department of Medicine
Division of Cardiology
From: Provisional Active
To: Affiliate
Site of Privileges - None

One-Year Leave of Absence

John B. Paulus, DO
Department of Medicine
Division of General Internal Medicine

Additional One-Year Leave of Absence

Stephen K. Klasko, MD
Department of Obstetrics and Gynecology
Division of Primary Obstetrics and Gynecology

Resignations

Norman L. Maron, MD
Department of Surgery
Division of Orthopedic Surgery

Robert P. Oristaglio, DO
Department of Medicine
Division of General Internal Medicine

Barry Pollack, MD
Department of Surgery
Division of Neurological Surgery

Vinh B. Tran, MD
Department of Surgery
Division of Orthopedic Surgery
Section of Foot and Ankle Surgery

Milicent E. Young, MD
Department of Medicine
Division of General Internal Medicine

Gerald M. Zupruk, MD
Department of Surgery
Division of Neurological Surgery

Allied Health Professionals

Appointments

Elizabeth J. Kochenash, RN
Registered Nurse
(Lehigh Valley Cardiology Associates - Robert H. Biggs, DO)

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

Kimberly A. Westra, CRNA
Certified Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD)

Change of Supervising Physician

Gretchen P. Fitzgerald, CRNP
Certified Registered Nurse Anesthetist
From: Palliative Care Program - Joseph E. Vincent, MD
To: Pain Specialists of Greater Lehigh Valley, PC - Bruce D. Nicholson, MD

Status Change

Carla M. Donkus, CRNP
From: Registered Nurse
To: Certified Registered Nurse Practitioner
(Gynecologic Oncology Specialists - Weldon E. Chafe, MD)

Continued on next page

Change of Group

Michelle R. Huber, CRNA
From: Lehigh Valley Anesthesia Services, PC - Thomas M. McLoughlin, Jr., MD
To: Lehigh Anesthesia Associates - Thomas M. McLoughlin, Jr., MD
(Coverage for OBGYN Privileges Only)

Resignations

Kathy L. Gottschall, RN
Registered Nurse
(Lehigh Valley Cardiology Associates)

Zanetta L. Keddie, PA-C
Physician Assistant - Certified
(Coordinated Health Systems)

Terrance McGinley, CRNA
Certified Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC)

Amy D. Scott, CRNP
Certified Registered Nurse Practitioner
(Center for Women's Medicine)

Mae L. Uttard, CRNA
Certified Registered Nurse Anesthetist
(Lehigh Valley Anesthesia Services, PC)

Mary A. Veitch
Massage Therapist
(Blue Swan Massage & Bodyworks)

Answer to Mystery Medical Staff Member
Stephen T. Olex, DO

The Last Word...

Tips and Techniques for the Lastword™ User

November, 2002 – Volume 2, Issue 1

View Brand Names next to Generics in the Med Profile

By Kim Szep, RN

Through valuable feedback from our users, there are questions regarding finding brand names of medications in the *Med Profile*. By system default, the generic name appears when the *Med Profile* is accessed from the *Physician Base* screen. To view the brand name, click on the right arrow on the bottom of the screen (see Figure 1). This will place the generic and brand names next to each other for easy viewing. You may also double-click on any medication in the *Med Profile* and you will be taken to a detail screen where the brand name is listed.

Should you need additional assistance with any aspect of the CAPOE module, a Physician Software Educator is available in the Medical Staff Lounge two mornings a month to help physicians use the CAPOE system and listen to any concerns. There is also a workstation in the lounge that is designated for CAPOE practice. Should you encounter any difficulties or have questions while entering CAPOE orders, please take advantage of the **CAPOE Help Line by dialing ext. 8303, and selecting option #9.** Enter your call back number and expect a return call from the on-call CAPOE trainer/analyst. This service is available 24 hours a day, seven days a week. We will also be happy to assist with any Lastword (Phamis) questions or issues. If you have other hardware/software/password issues, please choose **option #1** so we may provide you with optimal service.

Physician Software Educators on staff are:

Lynn Corcoran-Stamm – ext. 1425
Carolyn K. Suess, RN – ext. 1416
Kim Szep, RN – ext. 1431

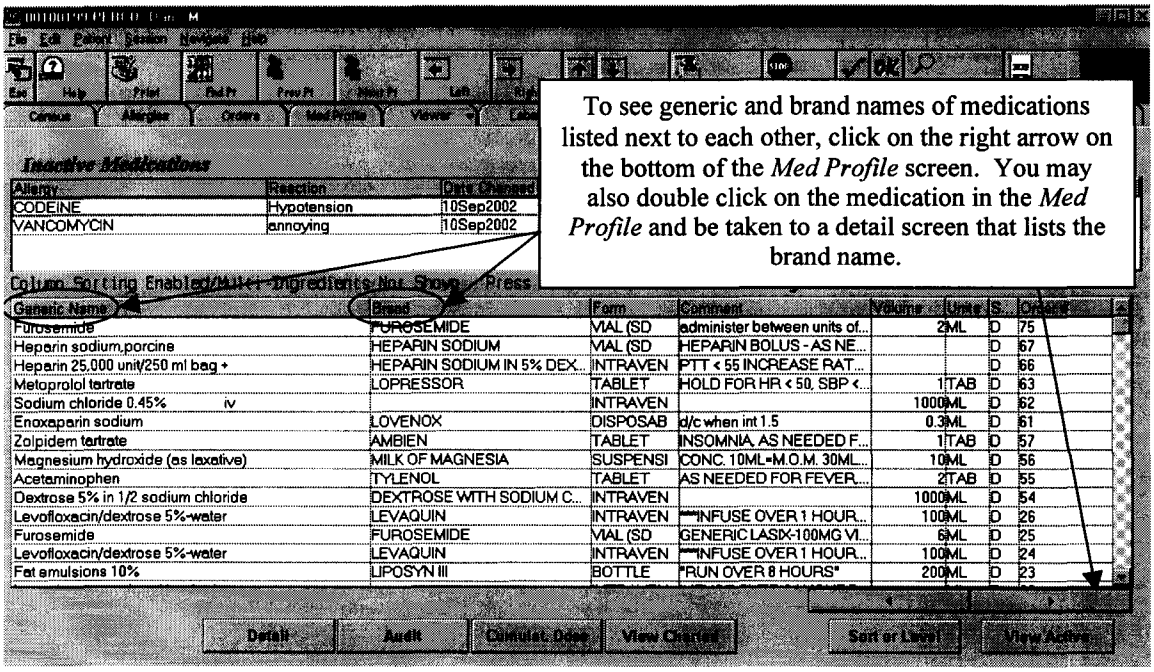

Figure 1 – Viewing brand and generic medications next to each other on the *Med Profile* screen

If you have training needs that pertain only to the Lastword (Phamis) system, please call ext. 1703. Arrangements can be made for training at your convenience.

Ordering Blood and Blood Products

By Kim Szep, RN

To order blood or blood products to be infused or put on hold for your patient and to order laboratory tests that are performed by Blood Bank (such as Type & Screen/Cross), click on the *Orders* tab on the *Physician Base* screen. Click on the *Add Orders* button on the bottom left of the *CAPOE Order Profile*. Now click on the *Blood Bank* button on the *CAPOE Order Pad* (you may also access the Blood Bank order section from the *Lab/BB/Micro* button). All of the Blood Bank orders will be displayed. There are many choices designed for ease of use, so be sure to review them before making your final

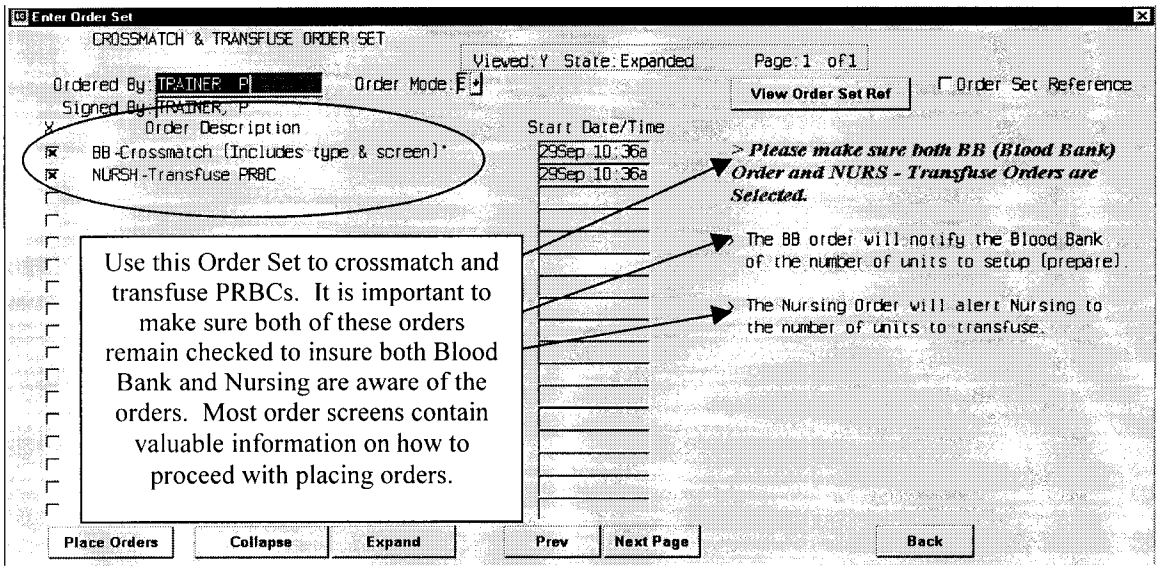

Figure 2 – The first screen of placing a Crossmatch and Transfuse order

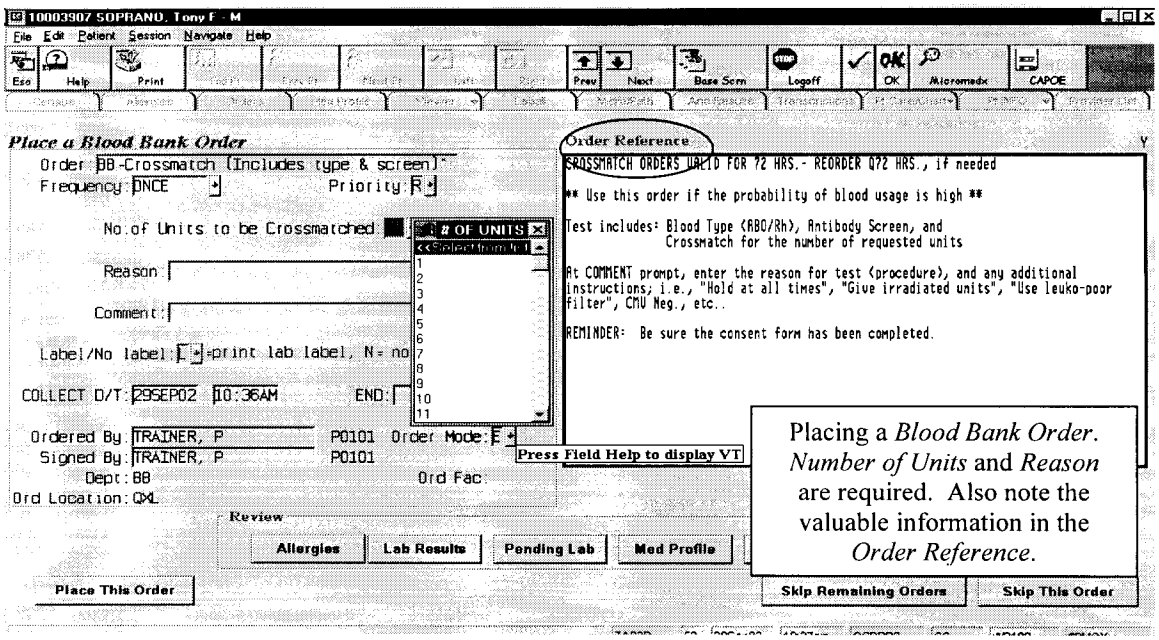

Figure 3 – Placing a Blood Bank order

selection. Included are order sets such as *Crossmatch & Transfuse* to simplify the process. This option will be reviewed here (see Figures 2 and 3), and most *Blood Bank* orders are placed in the same way. Double-click on the order selection. The order will be placed in the *Unprocessed Orders* box on the bottom right of the *CAPOE Order Profile*. When you have finished selecting orders, click on *Process Orders*. This will start processing the *Crossmatch & Transfuse Order Set*. Both the BB (Blood Bank) and NURSH (Nursing Transfuse PRBC) will be automatically checked (see Figure 2). This is to insure the order for the Crossmatch and the Transfusion is placed with Blood Bank, and Nursing is notified to draw the lab and infuse the PRBCs. Click on *Place Orders* on the bottom left of the screen. Next the *Place a Blood Bank Order* screen is presented (see Figure 3). The *Frequency* is automatically filled in, as is the *Priority* of routine. As with all orders, if they are desired stat, please inform the staff and change the *Priority* to *S. No. of Units to be Crossmatched* is a required field. Select the number of units to be crossmatched or "set-up" from the drop-down list. *Reason* is also a required field. You may select from the drop-down list or type your own reason. The *Comment* field is not required, but additional information may be entered here. Also note the valuable information provided in the *Order Reference* section. Once your choices have been made, click on *Place This Order* on the bottom left of the screen. The next step in this Order Set is the *Place a Nursing Care Order* screen. It is very similar to the Blood Bank screen. On this screen, Nursing will be informed of how many units to actually transfuse, if the units should be split, and the infusion rate (all required fields). *Transfuse In* is not required, but may be used to provide additional information (such as transfuse in hemodialysis). Now click *Place This Order*. If Lasix or other medications are desired with the blood or blood products, these may be ordered separately from the corresponding medication section on the *CAPOE Order Pad*.

Fluid Restrictions

By Kim Szep, RN

There are different ways in the CAPOE system to order patient fluid restrictions. If an admission order set is being used, the easiest way to order the restriction is to order a diet and use a modifier. Place an *X* next to the diet you wish to order, and place another *X* in the *Detail* box. Checking the *Detail* box of any order allows more information to be given about the particular

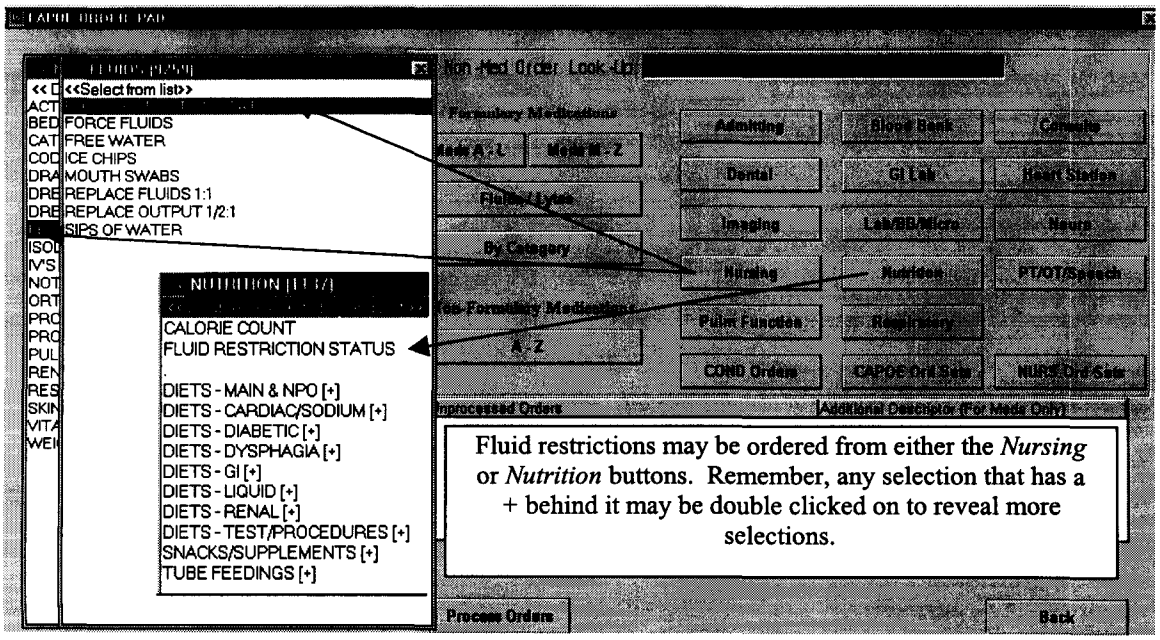

Figure 4 – Placing a fluid restriction from the *Nursing* or *Nutrition* buttons

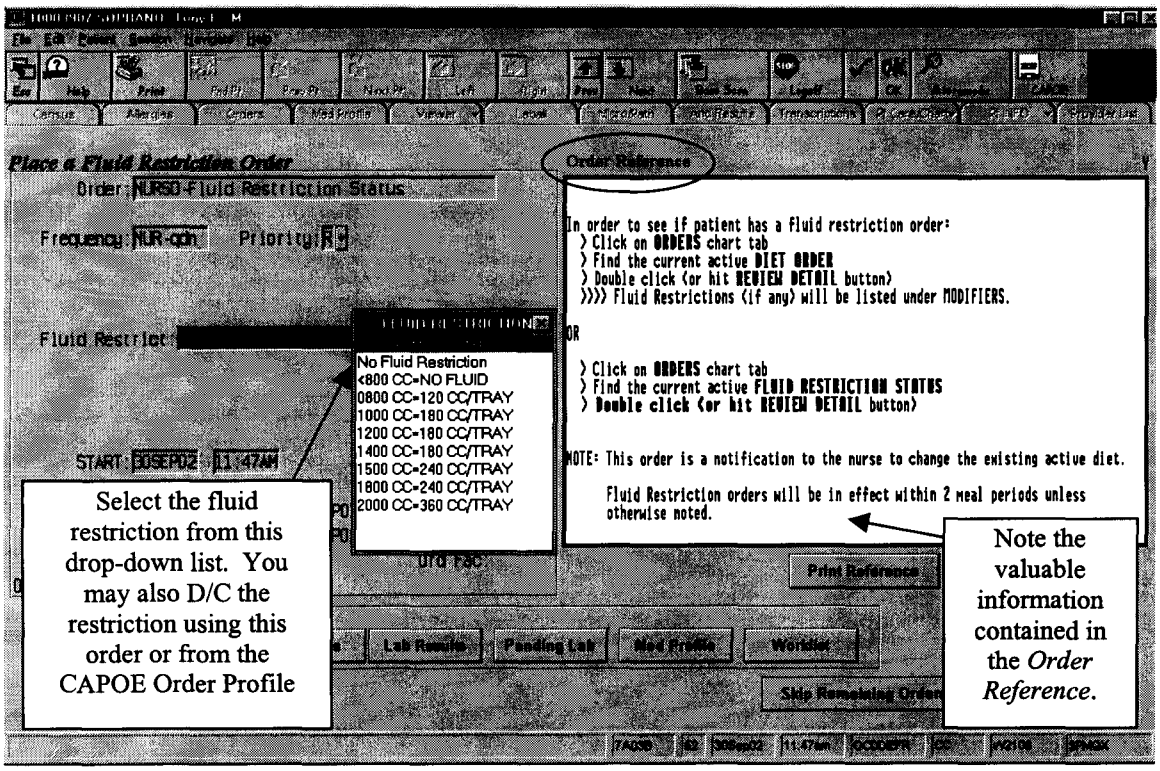

Figure 5 – Placing a Fluid Restriction Order

order after the *Complete* button is clicked. Next, click on the drop-down arrow next to *Modifiers* on the *Diet Order* screen. Another menu will appear, then double click on *Fluid Restrictions*. Choose the desired restriction from the list by double clicking. The total restriction is shown, as well as how many CCs per food tray will be delivered to the patient, if applicable. Click *Place This Order.*

If you wish to place a fluid restriction after the patient has been admitted, click on the *Orders* tab from the *Physician Base* screen. Click on the *Add Orders* button on the bottom of the *CAPOE Order Profile* screen. For ease of entry, the restriction may be obtained from either the *Nursing* or *Nutrition* buttons (see Figure 4). Under *Nursing*, double click on *Fluids* + to open another list then double-click on *Fluid Restriction Status.* Under *Nutrition*, simply double-click on *Fluid Restriction Status.* Click on *Process Orders*. Now choose the type of restriction desired from the drop-down menu (see Figure 5). Please note, you may also D/C a current fluid restriction from this order screen using the first choice listed on the drop-down menu: *No Fluid Restriction.* The order may also be discontinued from the *CAPOE Order Profile* by clicking on it once to select it, then clicking on the *Discontinue* button on the bottom of the screen. The order can be identified by the category ***Diet*** and the order description reads ***NURSD-Fluid Restriction Sta, NUR-qdn.*** Remember, when viewing the *Order Profile*, you may sort orders by their alphabetical category by clicking on the *CATEG* button on the top left of the screen. **When reviewing the patient's *CAPOE Order Profile* and you wish to see the CC restriction (even if you did not order it), highlight the fluid restriction order and then click on the *Review Detail* button on the bottom of the screen.** You will be taken to a screen very similar to Figure 5 where details of the order will be displayed.

A fluid restriction may be changed using the same ordering process detailed above. However, as a safety precaution, a conflict screen will present as a reminder that the patient already has a fluid restriction ordered. If you wish to override the current restriction, click on *Place Order* on the bottom left of the *Conflict* screen.

THERAPEUTICS AT A GLANCE

The following actions were taken at the August 2002 Therapeutics Committee Meeting - Joseph Ottinger, R.Ph., MS, MBA, Janine Barnaby, R.Ph., Jenny Boucher, Pharm. D., Jason Laskosky, Pharm.D.

Formulary Drug addition-Foltx tablets

Foltx (Folic acid 2.5mg, Cyanocobalamin 1mg, and Pyridoxine 25mg) tablets were approved to the Drug Formulary at the August meeting of the Therapeutics meeting. This unique combination product offers the convenience of supplying several individual agents found to decrease homocysteine levels. Thereby, reducing 'pill burden'. The cost of this product is $0.35 per tablet. The following information was prepared by PharmD candidate Andrew Gernerd.

Homocysteine's relationship with heart disease has been studied for many years, but its role as an independent risk factor that can predict the severity of the disease has only recently started to be uncovered. Drugs that are effective in decreasing homocysteine levels are also available, and are being studied to see not only if they are effective in decreasing homocysteine levels, but also if the decrease can help prevent heart disease.

Homocysteine (tHcy) is an amino acid. It is not used by the human body, but is an intermediate product in the metabolism of methionine to cysteine (5). Normal plasma tHcy levels can range anywhere between 5-15-μmol/L. Homocysteinemia is defined as elevated plasma levels of Homocysteine. These increased levels can have several different causes. First, a genetic deficiency of one of the enzymes necessary in the metabolism of homocysteine. These include cystathinine-B-synthase and methylenetetrahydrofolate reductase (3). Folic acid, B6, or B12 vitamin deficiencies are another cause of homocysteinemia. They are cofactors, or are needed to synthesize cofactors used in homocysteine metabolism. The deficiency can be caused by low levels consumed in the diet, or by alcoholism (5). Finally, impaired renal function can cause an increase in tHcy levels (3).

Studies have shown that homocysteine, in some cases in high doses, may have the following effects on blood vessels, "intimal thickening, elastic lamina disruption, smooth muscle hypertrophy" (5). Homocysteine has also been shown to cause platelet accumulation which can lead to the formation of thrombi and thus cause venous thromboembolism (5)." These effects, if they occur at tHcy levels corresponding to those found in homocysteinemic patients, would explain why homocysteine is being considered an independent risk factor for heart disease.

Homocysteinemia has been associated with atherosclerosis, coronary artery disease and, venous thromboembolism. Schnyder et al studied homocysteine levels in comparison to the number of coronary arteries blocked in patients with coronary artery disease. They

found, "a linear relationship" with average tHcy levels of 9.1 ± 3.2-μmol/L in patients with no blocked coronary arteries, 10.4 ± 3.9-μmol/L in patients with 1 artery blocked, 11.3 ± 4.7-μmol/L in patients with 2 blocked coronary arteries and, 12.4 ± 5.4-μmol/L in patients with 3 arteries blocked (4). Similarly Boushey et al, by meta-analysis, concluded that, "an increase of 5-μmol/L in tHcy is on the same order as lipid risk factors for coronary heart disease"(3). Thus "Total plasma homocysteine level is an important predictor of cardiovascular risk and correlates with the severity of coronary artery disease" (1).

Pullin et al recently published a study that showed that an increase in dietary folic acid, or treatment with low dose folic acid supplement was effective in decreasing homocysteine levels. But the lower levels did not correspond to or improve endothelial function assessed by measurement of flow mediated dilation. One possible reason for this is that the study was conducted using healthy volunteers without heart disease (2).

Another study conducted by Schnyder et al was designed to study patients with coronary artery disease that were to undergo angioplasty. One group received combination folic acid, B12, B6 therapy while the other group received placebo after angioplasty. After follow up they concluded that folic acid treatment decreased homocysteine levels and also significantly decreased the rate of restenosis after angioplasty (1).

At least partly because of the correlation between high Current treatment of homo-cysteinemia involves folic acid and vitamins B6 (pyridoxine) and B12 (cyanocobalmin). Although it has not been proven if decreasing homocysteine levels will in fact prevent heart disease, or just lower tHcy levels. These vitamins are used to decrease homocysteine levels with the hopes that the decrease will prevent or help reverse heart disease. Folic acid is the agent with the greatest ability to decrease tHcy levels, but using folic acid alone can mask the "hematologic manifestation of unrecognized pernicious anemia (cobalmin deficiency) while its neurologic manifestations, which may be severe and include spinal cord damage, may progress (3)." There is currently a combination product on the market that combines folic acid 2.5mg, cyanocobalmin 1mg, and pyridoxine 25mg in tablet form. There is some debate on dosage, both high dose and low dose folic acid treatment has been studied, but it seems that doses greater than 400μg per day do not cause any more lowering than lower doses (2). A 400μg per day dose can decrease levels anywhere between 10 and 50 percent depending on prior folate levels and homocysteine levels (5).

At least partly because of the correlation between high homocysteine levels and heart disease, but also for the prevention of neural tube defects, in 1998 the FDA began to require that, "all enriched grain products produced in the US to contain 140 micrograms of folic acid per 100g" (6). Future studies will help to uncover if the reduction of homocysteine levels can prevent heart disease. If it can indeed be proven then Boushey et al predict that treatment that results in a 5μmol/L decrease in tHcy levels in US men aged 45 and older could possibly prevent 35,000 deaths a year (3).

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Anticoagulation Reference

The Health Network has encouraged physicians to consider anticoagulating those patients at risk for the development of venous thromboembolism (VTE). Following are the current guidelines outlined in the Sixth American College of Chest Physicians (ACCP) Consensus Conference on Antithrombotic Therapy. Throughout the tables, there will be references to grades or levels of evidence to support recommendations An explanation of the grades of evidence can be found in Table 1.

These Guidelines have been reviewed and approved by the Therapeutics Committee, Multidisciplinary Council and the VTE Prevention Task Force. They are meant to provide general anticoagulation management directives based on current clinical evidence. As always, clinicians should always fully assess the individual patient's risk Vs. the benefit of any therapy.

Abbreviations:
ACCP= American College of Chest Physicians
ADH= Adjusted dose heparin (subcutaneous administration)
DVT= Deep Vein Thrombosis
ES= elastic stocking (graduated compression)
IPC= intermittent pneumatic compression
LDH= low dose heparin (subcutaneous administration)
LMWH= low molecular weight heparin
OAC= oral anticoagulant
PE= Pulmonary Embolism
RFs= risk factors
SC=subcutaneous injection
VTE= Venous thromboembolism

Table 1: ACCP Grades of Evidence

A	Methods strong, results consistent (randomized controlled trials, no heterogeneity
1	Methods strong, results consistent (randomized controlled trials, no heterogeneity)
2	Effect equivocal (uncertainty whether benefits outweigh risks)
B	Methods strong, results inconsistent (randomized controlled trials, heterogeneity present)
1	Methods strong, results consistent (randomized controlled trials, no heterogeneity
2	Effect equivocal (uncertainty whether benefits outweigh risks)
C	Methods weak (Observational studies)
1	Methods strong, results consistent (randomized controlled trials, no heterogeneity
2	Effect equivocal (uncertainty whether benefits outweigh risks)

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Table 2: Prospective Risk Factor Assessment Tool for Surgical and Medical Patients
Step 1-Clinical Setting

Score 1 factor	Score 2 factors	Score 3 factors	Score 5 factors
Minor surgery	Major Surgery (>45 minutes) Laproscopic surgery (>45 minutes) Patients confined to bed >72 hrs Immobilizing plaster cast Central Venous access	Major surgery with -Myocardial infarction - Congestive heart failure or -Severe sepsis/infection Medical patient with additional risk factors	Elective major lower extremity arthroplasty Hip, pelvis, or leg fracture Stroke Multiple trauma Acute spinal cord injury (paralysis)

Baseline 'Risk' Score based on clinical setting=_____

Step 2-Patient Specific

Clinical	**Hypercoagulable states**	
(1 factor unless noted) age 41 to 60 years old age > 60 years old (2 factors) history of DVT/PE (3 factors) history of prior major therapy pregnancy, or postpartum (<1 month) malignancy (2 factors) varicose veins inflammatory bowel disease obesity (>20% of ideal body weight) oral contraceptives or hormone replacement therapy	**Inherited (3 factors for each)** Factor V Leiden/activated protein C resistance Antithrombin III deficiency Protein C or S deficiency Dysfibrinogenemia Prothrombin 20210A Homocyteinemia	**Acquired (3 factors for each)** Lupus anticoagulant Antiphospholipid antibodies Myeloproliferative disorders Disorders of plasminogen & plasmin inhibitors Heparin-induced thrombocytopenia Hyperviscosity syndrome Homocyteinemia

Additional 'Risk' factor Score based on Patient Specific =_____+ Baseline Score_____(from above)
= Total Risk Assessment Score_____(see step 3 for treatment options)

Step 3-Recommended Prophylactic Regimen (See Specific ACCP Recommendations in Tables 3 and 5)

Low risk (1 factor)= No specific measures	**Moderate risk (2 factors)=** LDH or LMWH or IPC or ES	**High Risk (3-4 factors)=** ES* and (LDH or LMWH or IPC)	**Highest risk (≥5 factors)=** ES* and IPC@ PLUS (LDH or LMWH) or ADH alone or LMWH alone Oral anticoagulants.

* Combining ES with other prophylactic methods (LDH, LMWH or IPC) may give better protection than any modality alone
@ Data demonstrates benefit of Plantar Pneumatic Compression in total joint arthroplasty
Based on WH Geerts, et al: Prevention of Venous Thromboembolism. Chest 2001;119:132S-175S. International Consensus Statement: Prevention of Venous Thromboembolism, Guidelines According to Scientific Evidence; and Caprini JA, et al: Clinical Assessment of Venous Thromboembolism Risk in Surgical Patients. Semin Throm Hemost 1991; 17(suppl 3): 304-312.

Table 3: Prevention Strategies for VTE by Procedure

Procedure	PLACEBO VTE RATE (%)*	Sixth ACCP Consensus Recommendations
Total Hip Replacement	54.2 (50 to 58)	The guidelines recommend preoperative LMWH therapy started 12 hours prior to surgery OR 12-24 hours postoperatively OR 4-8 hours after surgery at half the usual dose and then continuing with the usual dose the following day (See Table 8 for specific dosing and agent). Adjusted-dose warfarin is an alternative agent. It should be initiated preoperatively or immediately after surgery (to a post-operative target INR of 2 to 3). Prophylaxis should be continued for at least 7 to 10 days, and longer prophylaxis may be considered in patients with continued risk, such as those with prolonged immobility, those who are elderly, and those who are obese.
Total Knee Replacement	**64.3 (57 to 71)**	For prophylaxis, postoperative LMWH (see Table 8 for specific dosing and agent), preoperative warfarin initiated to a post- operative target INR of 2 to 3, or IPC can be recommended (Grade 1B). The trials in support of IPC contained a small number of patients, and compliance may be an issue with the use of IPC. Prophylaxis should be continued for at least 7 to 10 days and may be considered for a longer period of time in patients at continued risk.
Hip Fracture	**48 (43 to 53)**	The guidelines recommend either LMWH or adjusted dose warfarin. (Grade 1B due to limited data)
Major Trauma	**46 (29-63)**	The recommended prophylaxis in patients sustaining major trauma at a high risk of bleeding is the use of calf-thigh IPC (Grade 1C). In individuals with a low risk of bleeding, enoxaparin, 30 mg twice-daily, is recommended.
Elective Neurosurgery	**N/A**	ACCP Consensus Conference guidelines have taken into account the differences in patients and provides recommendations that include both pharmacological and mechanical methods of prophylaxis. The guidelines recommend IPC, low-dose heparin, or LMWH, especially if the patient is at high risk of VTE and the bleeding risk is low.
General Surgery	**25 (24 to 27)**	See Table 4 to assess risk and Table 5 to define therapy options
Medically-ill	**30-75%**	Diverse patient population. Recommendations include use of LMWH or LDH. Patients with acute coronary syndromes should receive 'Therapeutic' ADH or LMWH during the acute phase of treatment.

*** Data from Chest 2001:119(1):132S-149S**

Table 4: ACCP Definitions of Risk for General Surgery

Low	Less than 40 yrs with no risk factors(RFs) with an uncomplicated minor surgery
Moderate	40 to 60 yrs with no RFs with major or minor surgery Less than 40 yrs with no RFs with major surgery Patients with RFs with minor surgery
Moderate-High	Greater than 60 yrs with no RFs with major surgery 40 to 60 yrs with RFs with major surgery Patients with RFs and myocardial infarction or medical condition
Highest	Greater than 40yrs with prior VTE, cancer, or hypercoaguable state with major surgery

Adapted from Chest 2001:119(1):134S

Table 5:ACCP Guidelines for General Surgery

	Low	Moderate	High	Highest
PE Risk	0.2 %	1 - 2 %	2 - 4 %	4 - 10%
Prox DVT Risk	0.4%	2 - 4%	4 – 8%	10 – 20%
Advice	Early ambulation	LDH (q12h), LMWH*, IPC	IPC, LDH (Q8h) or LMWH*	LDH (Q8h), LMWH, OAC. IPC/ES PLUS LDH/LMWH * or ADH

*** See table 8 for specific dosing and agent**
Adapted from Chest 2001:119(1):134S

Table 6: Treatment of Established Venous Thromboembolism

	Recommendations for Specific Agents
The Sixth ACCP consensus guidelines recommend that patients with DVT or PE be treated acutely with LMWH, unfractionated IV heparin, or adjusted-dose subcutaneous heparin.	Use of unfractionated IV heparin should utilize a weight based protocol (e.g., Raschke algorithm). The targeted PTT should correspond to a 'heparin level' (based on amidolytic anti Xa activity) of 0.3- 0.6 units/ ml. Enoxaparin dosed at 1mg/kg every 12 hours OR 1.5 mg/kg daily are FDA approved regimens Dalteparin 200 units/kg daily or 100 units/kg every 12 hours (maximum 18,000 units/day) is not FDA approved for this indication at present, but trial data have shown equivalence to unfractionated heparin regimens. Adjusted dose subcutaneous heparin is not recommended for inpatient care. All of above should be transitioned to warfarin at the earliest possible time. The target INR is 2.0-3.0. Concurrent 'Heparin' coverage should continue for 4-5 days or until the targeted INR is > 2.0 for two consecutive days. For massive iliofemoral thrombosis or PE, ten days of heparin may be beneficial (Grade 1C)
Duration of Therapy	If patient has symptomatic isolated calf vein thrombosis, anticoagulation should be continued for 6-12 weeks. If VTE risk factors reversible or time-limited, 3 months of therapy is recommended If first episode of idiopathic VTE, 6 months is recommended. If patient has recurrent idiopathic VTE or a continuing risk factor, treatment for 12 months or longer may be warranted (Grade 1C)

Adapted fromChest 2001:119(1):187S

Table7: "Bridge" Therapy

Patient Description	Recommendation
Patient with low risk thromboembolism – No VTE for > 3 months and/or has experienced atrial fibrillation, BUT DOES NOT have a history of stroke	Stop warfarin approximately 4 days before surgery, allow INR to return to near normal, briefly administer POST operative prophylaxis using UFH 5,000 units (SC) and simultaneously begin warfarin therapy
Patient with an intermediate risk of thromboembolism	Stop warfarin approximately 4 days before surgery, allow the INR to return to near normal. Cover the patient with UFH 5,000 units (SC route; frequency q12 hours) beginning 2 days BEFORE surgery. Continue UFH 5,000 units with warfarin after surgery.
Patient with a high risk of thromboembolism— Recent VTE <3 months, history of VTE, mechanical mitral valve (OR ball/cage valve)	Stop warfarin therapy approximately 4 days before surgery, allow INR to return to near normal, begin therapy with full-dose UFH (via IV drip) OR full dose LMWH as INR falls (approximately 2 days before surgery). Discontinue UFH 5 hours before surgery. LMWH heparin should be stopped 12-24 hours prior to surgery.

No "Bridge" Therapy option has ever been rigorously studied. ALL recommendations are rated as 2C by the Sixth ACCP Consensus Conference Adapted from Chest 2001:119(1):34S

Table 8. FDA-Approved Indications of LMWHs

Indications	Dalteparin	Enoxaparin	Tinzaparin
DVT-OPT		1 mg/kg q12 hours	
DVT/PE Treatment		1 mg/kg q12 hours OR 1.5 mg/kg daily	175 units/kg daily
Prophylaxis-general surgery	**Low risk=** 2,500 units 1-2 hours prior to surgery, then 2,500 units daily post-op. **High risk=** 5,000 units on evening prior to surgery, then 5,000 units daily post-op	40 mg daily, initiated 2 hours prior to surgery	
Prophylaxis Total hip	2,500 units 2 hours before surgery, then 2,500 units 4-8 hours post-op, then 5,000 units daily OR 5,000 units 10-14 hours before surgery, then 5,000 units 4-8 hours post-op, then 5,000 units daily OR 2,500 units 4-8 hours post-op, then 5,000 units daily	30 mg q12 hours given 12-24 hours OR 40 mg daily initiated 12 hours prior to surgery	
Prophylaxis Total knee		30mg q12 hours, given 12-24 hours post-op.	
UA	120 units/kg q12 hours (maximum dose 10,000 units q12 hours)	1 mg/kg q12 hours	

DVT-OPT=extended (outpatient) prophylaxis for DVT; DVT/PE= deep vein thrombosis/pulmonary embolus treatment; FDA=Food and Drug Administration; LMWH= low molecular weight heparin; UA-=unstable angina treatment

The use of ALL low molecular weight heparin is not well studied in patients with poor renal function (estimated creatinine clearance $\leq$ 30 ml/min. and/or obese patients.

Prepared by Joseph G. Ottinger, Clinical Pharmacist, Lehigh Valley Hospital Center September, 2002.

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