

Main Line Health

Physician

Christine Stalup M.D.
Lower Merion
Family Medicine

Special report:
**Getting EMR
via MLH**

**SUMMER 2011
Inside:**

Introducing
*Main Line Health
Physician*

Building a Reliable
Culture of Safety:
'Where Safety is
Our Main Line'

Malpractice
Responsibility—
Yours, Mine, Ours



Main Line Health
Well ahead.SM

Introducing *Main Line Health Physician*

Dear Colleagues,

It means something special to be a Main Line Health Physician. It means performing at the top levels of the medical profession and standing among peers who share a passion for delivering skilled, safe and compassionate care. It means working as part of a dynamic network of other caregivers, nurses, medical educators, researchers and practitioners and being part of a community of healers who are second to none.

To communicate the accomplishments, ideas and perspectives of the physicians of Main Line Health hospitals, health centers and affiliated practices, we are pleased to introduce this new publication, *Main Line Health Physician*. We think that the name says it all. This quarterly magazine will highlight exemplary doctors who are forging the effective medical treatments, groundbreaking research and best practices that are the hallmarks of the Main Line Health brand. The magazine will also report on administrative processes that are enhancing our healthcare operations and explore a variety of topical issues that are critical to the practice of medicine.

The overall content and themes of the magazine are guided by the Editorial Board, which is comprised of knowledgeable MLH physicians, and we want most of the articles to be presented by our doctors. Above all, we want the magazine to be informative and relevant. Let us know how we're doing and let us know your ideas for topics of interest.

We hope that you find this publication to be thought-provoking and useful, and that *Main Line Health Physician* becomes just one more reason to take pride in the excellent work that you do every day on behalf of our patients and the community.

Jack Lynch, FACHE

President and CEO of Main Line Health

Donald Arthur, MD

Senior Vice President and Chief Medical Officer of Main Line Health

Richard Schmidt, MD

Medical Staff President



Left to right: Jack Lynch and Don Arthur, MD.

Main Line Health is pleased to announce that Richard Schmidt, MD, has assumed the post of Medical Staff President.



MAIN LINE HEALTH PHYSICIANS HONORED AS "TOP DOCS"

Main Line Health salutes the 58 stellar physicians who were selected by their peers throughout the region to be honored among *Philadelphia* magazine's 2011 "Top Docs."

Allergy and Immunology—**Albert Rohr**, Bryn Mawr Hospital. Cardiology Electrophysiology—**Maribel Hernandez**, Lankenau Medical Center; **Glenn Harper**, Bryn Mawr Hospital. Cardiovascular Disease—**Peter Kowey**, Lankenau Medical Center; **Steven M. LaPorte**, Paoli Hospital. Colon and Rectal Surgery—**John Marks**, Lankenau Medical Center. Dermatology—**Harold F. Farber**, Lankenau Medical Center; **Stuart Lessin**, Bryn Mawr Hospital. Diagnostic Radiology—**Harry Zegel**, Lankenau Medical Center. Family Medicine—**William Carroll**, Paoli Hospital. Gastroenterology—**Keith Laskin**, Paoli Hospital. Geriatric Medicine—**David E. Galinsky**, Lankenau Medical Center. Gynecologic Oncology—**Charles Dunton**, Lankenau Medical Center. Hand Surgery—**Jack Abboudi**, Bryn Mawr Hospital; **Pedro Beredjiklian**, Riddle Hospital; **Marwan Wehbe**, Bryn Mawr Hospital. Infectious Disease—**Mark J. Ingerman**, Lankenau Medical Center; **Jerome Santoro**, Lankenau Medical Center. Internal Medicine—**Henry Ling**, Lankenau Medical Center; **Peter Spitzer**, Bryn Mawr Hospital; **William Greer**, Paoli Hospital; **Ann E. Reilly**, Paoli Hospital. Interventional Cardiology—**Frank C. McGeehin**, Lankenau Medical Center. Maternal and Fetal Medicine—**Nancy Roberts**, Lankenau Medical Center. Medical Oncology—**Paul Gilman**, Lankenau Medical Center; **Steven Cohen**, Bryn Mawr Hospital. Nephrology—**Robert Benz**, Lankenau Medical Center; **Keith Superdock**, Lankenau Medical Center. Neurological Surgery—**James Kenning**, Bryn Mawr Hospital. Neurology—**Thomas Graham**, Paoli Hospital; **Joyce D. Liporace**, Riddle Hospital. Obstetrics and Gynecology—**Mark Toglia**, Riddle Hospital; **Marlene Moster**, Lankenau Medical Center. Orthopaedic Surgery—**Richard Schmidt**, Lankenau Medical Center; **Robert Good**, Bryn Mawr Hospital; **Peter Sharkey**, Riddle Hospital. Pediatrics—**Rosemary Casey**, Lankenau Medical Center; **Harold M. Gordon**, Bryn Mawr Hospital; **Judith Turow**, Lankenau Medical Center. Physical Medicine and Rehabilitation—**Jay W. Siegfried**, Lankenau Medical Center. Plastic Surgery—**Ronald Lohner**, Bryn Mawr Hospital. Pulmonary Disease—**Andrew Pitman**, Bryn Mawr Hospital. Radiation Oncology—**Marisa C. Weiss**, Lankenau Medical Center. Reproductive Endocrinology—**Michael J. Glassner**, Bryn Mawr Hospital. Surgery—**Ned Z. Carp**, Lankenau Medical Center; **Thomas G. Frazier**, Bryn Mawr Hospital; **Jennifer Sabol**, Lankenau Medical Center; **David Rose**, Bryn Mawr Hospital. Thoracic Surgery—**Scott M. Goldman**, Lankenau Medical Center; **Louis Samuels**, Paoli Hospital; **Michael J. Walker**, Bryn Mawr Hospital. Urology—**Donald Andersen**, Paoli Hospital; **Robert Schnall**, Lankenau Medical Center; **David McGinnis**, Bryn Mawr Hospital; **Leigh Bergmann**, Bryn Mawr Hospital. Vascular and Interventional Radiology—**Joseph Bonn**, Lankenau Medical Center; **Eric Stein**, Bryn Mawr Hospital. Vascular Surgery—**Gerald M. Patton**, Bryn Mawr Hospital.

Cover photograph: Christine Stallkamp, MD, Lower Merion Family Medicine.



Preliminary results show reduction in radiation and contrast with 100% technical success

Paoli Hospital pioneers 3D image guided technique for uterine fibroid embolization

BY ATUL GUPTA, MD

Uterine fibroid embolization (UFE) has been shown to be a safe, minimally invasive treatment for symptomatic fibroids, and interventional radiology (IR) offers a nonsurgical treatment that is sparing women hysterectomy and requiring far less recovery time.

Paoli IR's preliminary results as the world's first and only site using a new 3D image guided technique for UFE have been positive. This novel technique is proving to make UFE safer for patients versus the traditional technique by reducing radiation and contrast the patient receives.

IR procedures are typically guided by contrast angiography, which expose the patient to significant ionizing radiation and iodinated contrast. UFE is a safe procedure, however, it has always been our goal to even further reduce radiation dose and contrast. Paoli IR has been working closely with scientists at Philips Healthcare as one of their primary global clinical research sites, and among the technologies we have been testing over the years has been 3D MRA roadmapping. We recently reported the world's first clinical experience using 3D MRA roadmapping for UFE.

This new technique is like a human GPS system. It allows real-time fusion of a patient's previously acquired CT or MRI with the live fluoroscopy stream, providing complete synchronization between the two during the procedure. It has been our belief that nearly all patients have pre-existing CT or MRI



Static image from a 3D MRA guided UFE, performed recently at Paoli Hospital, showing the MRA data in red superimposed upon the live fluoroscopy stream. Arrow points to a catheter in the right internal iliac artery.

data, so why not take advantage of that data to create a "human GPS" vascular roadmap? This new technology creates this roadmap and allows us to navigate our catheters to target arteries, with far less radiation, usually no contrast, and potentially reduced procedure time.

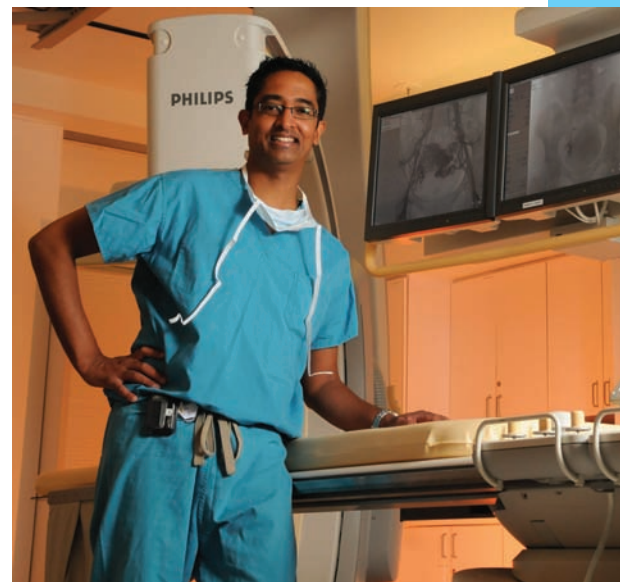
Following Main Line Health IRB approval, 10 consecutive women underwent UFE at Paoli IR using live 3D MRA roadmapping. The total radiation dose and contrast usage for the UFE was recorded and compared retrospectively to the dose and contrast usage in 16 patients who underwent conventional 2D UFE.

Technical success rate for UFE was 100% in both groups. In the 3D MRA roadmapped group, there was a 70% dose-reduction as compared to the conventional 2D UFE procedure. Contrast in the 3D MRA roadmapped group was 53% lower compared to conventional 2D UFE procedure. In fact, in 90% of the cases, no contrast

at all was needed to navigate the microcatheter into the uterine artery. Procedure time was also lower than most published series, averaging about 45 minutes.

Our study demonstrates the feasibility of using this novel technique for UFE, and preliminary data shows marked reduction in contrast and radiation. We will shortly embark on a randomized, multi-center study with colleagues at leading IR centers in Miami and Belgium who are very interested in Paoli's preliminary findings. It is my belief that this technique will have applications far beyond UFE, and physicians will one day be using 3D CT/MR roadmapping for safer interventions throughout the body.

To learn more about UFE at Paoli or schedule a consultation, patients or physicians can call 484.565.1255 or email guptaa@mlhs.org. ■



Atul Gupta, MD, provides medical leadership for the Interventional Radiology department at Paoli Hospital. He is board certified in diagnostic radiology, with added certification in interventional radiology. Gupta earned his medical degree from the Albany Medical College and completed his residency and fellowship at the University of Pennsylvania. He has lectured extensively in the United States and internationally on 3D guidance for IR procedures.



Physicians role play in an OR scenario for Culture of Safety training session.

Building a reliable culture of safety: “Where Safety is Our Main Line”

BY DENISE MURPHY, RN

At Main Line Health our core values promise that we will deliver high quality and compassionate care to all our patients. To deliver on this promise every day, to every patient, requires that we have a strong and *reliable* culture of safety. A culture with a set of beliefs, attitudes and values shared by all members of MLH, creating the “way we do things around here.”

At MLH, we do great things at every point of care and save hundreds of lives daily. But healthcare is a complex system. Risky tests, treatments and procedures occur frequently in a busy, stressful environment. Even the best and brightest people can make mistakes, resulting in patients being harmed. Poorly designed processes may result in errors or create gaps in handoffs of critical information. Often, teamwork and communication break down simply because we have different backgrounds, training and perspectives.

To better understand how errors happen across MLH, the safety teams conducted an intensive analysis of 100 patient safety events over the last several years.

- **The results:** Most errors came when communication breakdowns and process failures occurred across clinical teams and settings. According to

the Joint Commission, poor communication and teamwork are the most frequently reported causes for events that harm patients across the U.S.

- **The solution:** Build a culture of safety where common behaviors, practices and processes support an environment that is safe for patients, family and staff.
- **The goal:** Reduce patient-related preventable harm events by 50% in two years and, ultimately, reach zero events.

The strategy we have chosen involves building a *reliable* culture of safety that encompasses every person on every campus. Reliability will look something like this: Every member of our healthcare team will be expected to use the same language, behaviors and practices to keep every patient safe, especially in high risk situations. The physician teams are important leaders in this initiative and are crucial to supporting a reliable culture of safety.

To that end, 500 staff and physician leaders have been trained in leader methods for reliability and error prevention tools as of the end of April. In May, safety culture sessions began with the front line staff and physicians who care for patients in MLH hospitals, clinics, offices and even in their homes. Employees without patient contact will

GREAT CATCH & PSSST AWARDS:

A questioning attitude and attention to detail promotes safety

The tempo of a physician’s day is fast paced, filled with rapid decision-making, and involves a significant number of individual patient care situations. The very nature of the day to day environment requires vigilance for details, communication and collaboration.

Geraldine Dapul, MD, of the Department of Medicine at Lankenau, used her *questioning attitude and attention to detail* to avert potential harm due to mislabeling of patient chart paperwork. As a result of patient room transfers, paperwork for one patient ended up in the chart of the patient previously in the same room. Dr. Dapul’s attention to detail caught the incorrect paperwork filing and notified the nursing unit patient care manager and clinical team.

Speaking up for safety was the critical behavior used by **Walter Klein, MD**, pathologist at Bryn Mawr Hospital. Upon reviewing a skin specimen for a patient with suspected skin cancer, he noticed that the pathology of the specimen did not reflect any prior dermal scar or identifiable biopsy site, as would have been expected for this patient. By raising a question and asking for clarification around the patient situation, Dr. Klein was able to secure the second specimen for the biopsy site.

Drs. Dapul and Klein received Great Catch Awards for Safety. Their behavior sets a standard for safety and communicates the importance of physician leadership in creating a reliable culture of safety. If you observe a Great Catch for Safety among your peers, please submit the Patient Safety Success Story (Pssst) for consideration as a Great Catch winner on your campus! Go to the patient safety site on the Intranet for forms and more information.

receive training through department meetings and events. Everyone at MLH—including nonclinical personnel—will be trained by the end of 2011. MLH’s reliable culture of safety will grow exponentially as each individual is oriented to the new tools and methods. The result will be a dynamic shift in culture and common safety practices, enhanced communications, and behaviors making an already safe environment even safer. ■

Denise Murphy is vice president, Quality and Patient Safety, for Main Line Health.

Physician leadership: The key to cultural transformation

BY DAVID ROSE, MD



Our patients look to us for expert decisions. Our nursing and clinical support teams seek direction on the diagnostic approach and plan for our patients. Our students and residents request training and knowledge exchange. In all these examples, and innumerable other scenarios, each of us finds ourselves in a position as leader, mentor, influencer and decision maker.

As Main Line Health embarks on a heightened focus to create a reliable culture of safety, physician leadership will be a critical component to successfully launching a safety culture transformation. Physician engagement in this important initiative will have profound long-term impact on the quality of patient care delivered at MLH. As physicians, we influence the tone and morale of the care teams, set a standard for actions and behaviors,

and by means of the power gradient, we have the ability to promote (or inhibit) an open and respectful communication environment.

Each of us, as physicians at MLH, has the opportunity to embrace a position of leadership in a responsible and respectful manner. The reliable culture of safety setting is one in which barriers between positions are removed, communication is elevated, and common behaviors are utilized—all to improve the quality and safe practices deserved by our patients.

We have an outstanding and supportive organization at MLH that seeks to improve the patient quality care experience and to deliver care safely and compassionately. Your leadership and engagement in the culture of safety transformation is essential to meeting our safety goals of reducing patient adverse events across the health system. ■

David Rose, MD, is Physician Co-Chair, MLH Quality and Patient Safety Committee

BEHAVIOR EXPECTATIONS FOR SAFETY & ERROR PREVENTION

Safety Behavior Expectations	Error Prevention Tools
Attention to Detail	STAR (Stop, Think, Act, Review)
Communicate Clearly	3-Way Repeat Back and Read Back Phonetic & Numeric Clarifications Clarifying Questions
Handoff Effectively	SBAR (Situation, Background, Assessment, Recommendation)
Speak Up for Safety	Question and Confirm Crucial Conversations ARCC (Ask a question, Make a Request, Voice a Concern, Use Chain of Command) “Stop the Line I Need Clarity”
Got Your Back!	Peer Checking Peer Coaching

Enhancing the culture of patient safety

BY BARRY D. MANN, MD



The competency of Practice-Based Improvement, now a category for education and evaluation in residency and a

criterion for the re-credentialing of physicians, mandates that we must always learn to do things better—even as we practice.

In May of this year, the Medical Staff leadership in conjunction with the Quality and Safety leaders committed its support to enhancing the culture of safety throughout Main Line Health. An essential component of this effort

is a commitment to train all members of the medical staff in the language of “safety behaviors” and “error prevention tools.” In a one-hour session entitled Safety-Culture 101, physicians will review “safety behaviors,” including matters of paying attention to detail, communicating clearly, handing off effectively, maintaining a questioning attitude, and speaking up for patient safety. Physicians will then be instructed in the use of “error prevention tools” which were specifically selected last summer by representative physicians and hospital employees from MLH for use throughout the system. Error

prevention tools include mnemonics and other language devices for personal focusing, clarifying, organizing, and empowering all members of our healthcare teams to speak up for patient safety.

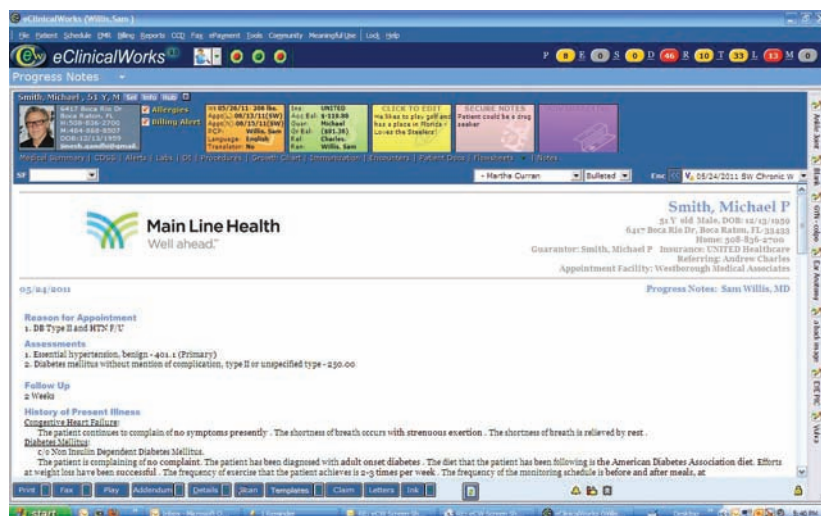
A major aspect of this training will be to recognize that the “Authority Gradient,” which exists in every culture, must be minimized among co-workers in order to ensure that every employee feels empowered to speak up for the safety and best care of our patients.

As physicians we have the clear responsibility to be the leaders of this culture enhancement at Main Line Health. This initiative is one additional element to ensure that all patients at Main Line Health enjoy a safe and superior patient experience. ■

Barry D. Mann, MD, is Chief Academic Officer for Main Line Health.

Getting EMR via MLH

BY HARM SCHERPBIER, MD



Done right, electronic medical records (EMR) can be a valuable tool. Done wrong, they can be a costly nightmare. Not done at all can be a real disadvantage.

To help physicians avoid the nightmare and the disadvantage, Main Line Health launched the Community Physician EMR Program in November 2010. This program offers both financial and technical assistance to physicians in Main Line Health's service area who want to implement a high-quality electronic medical record system. The program offers:

- significant discounts on software license fees
- assistance with training and building of the system
- connectivity to a health information exchange system.

Main Line Health uses the eClinicalWorks system, one of the most commonly used EMRs and one with high user-satisfaction ratings.

To date, more than 50 practices have expressed interest in the program and half have signed contracts. One practice that is already up and running is Lower Merion Family Medicine in Narberth.

"eClinicalWorks is a robust EMR that will add a lot of efficiency to our patient flow," said Christine Stallkamp, MD. "My office was already using an early type of EMR, but we are now

Top: Screenshot of eClinicalWorks sample page. Left: Dr. Stallkamp and assistant Tierra Hicks discuss options for entering data into EMR.

GIVING MEANING TO “MEANINGFUL USE”

You have may heard the term “meaningful use” but what does it mean? Simply put, “meaningful use” means that physicians can show that they are using certified EMR technology in ways that can be measured significantly in quality and in quantity.

To achieve meaningful use, a physician must meet 15 “core” objectives (think of these as your required courses in college). Providers must also meet 5 “menu” objectives of their choice, selected from a list of 10 (think of these as your electives).

Providers who go live with an EMR in 2011 or 2012 can simply attest that they have met these objectives. After 2012, they will have to electronically verify that they have met them.

For more detailed information about core and menu objectives, visit mainlinehealth.org/CommunityEMR.

transferring the data from that and our paper charts into eClinicalWorks, although we struggled some at first while we learned the system. The rapid exchange of information this system offers and the ability to update information in real time helps keep us efficient. The front desk can update a patient’s medication list, for example, and I have it on my laptop as I walk into the exam room.”

As part of the program, Main Line Health provides Bryn Mawr, Lankenau, Paoli and Riddle Hospitals’ medical staff members with financial assistance for the eClinicalWorks software license fee. Physicians pay for hardware, and implementation and training.

Implementing an EMR isn’t easy, and it forces physicians and office staff to work in different ways. But in the very near future there isn’t going to be a choice—everyone will need to have an EMR. After 2015, the Medicare

reimbursement rate will be reduced 1% every year for physicians without an EMR.

As Matthew Crawley, director of the MLH Community Physician EMR Program, noted, there are numerous benefits to an electronic medical record:

“By sharing information between practices and hospitals through an EMR, physicians can provide better service with decreased risk to patients. This program is a win-win for community physician practices and Main Line Health because we are creating a system with the goal of improving patient convenience, reducing medical errors, advancing patient safety, and improving people’s quality of life.”

For more detailed information about Main Line Health’s Community Physician EMR Program, visit mainlinehealth.org/CommunityEMR. ■

Harm Scherpbier, MD, is Chief Medical Information Officer for Main Line Health.

STIMULUS MONEY AVAILABLE

Need an incentive to take the EMR plunge? As part of the American Recovery and Reinvestment Act (ARRA), many healthcare providers can receive up to \$44,000 to implement EMRs.

To participate in 2011, physicians must have an EMR in place and will need to achieve “meaningful use” by Oct. 1, 2011. Physicians also can qualify in 2012 and may still receive the full \$44,000, but those who don’t qualify until 2013 or later will receive decreased funding. After 2014, funding will cease.

“I look at it very simply: Do it now voluntarily and get money from the government, or be required to do it later and get no money from the government,” said Matthew Crawley, director of Main Line Health’s Community Physician EMR Program.

For more information about ARRA funding, visit <http://healthit.hhs.gov> or contact Crawley at 484.596.2394 or crawleym@mlhs.org.



TERMS YOU NEED TO KNOW

ARRA—The American Recovery and Reinvestment Act. Part of this federal program provides money for eligible providers to implement an electronic medical record.

CCD—Continuity of Care Document. A concise, standard-format summary of a patient’s medical history, including medications, allergies, demographics, insurance information, treatment history (but not physician notes). The CCD is exchanged between EMRs to help information transfer when the patient transitions from one physician or facility to another. It’s the baton in the relay race.

CPOE—Computerized physician order entry. The process that involves the electronic entry of instructions for the treatment of patients. These orders are communicated over a computer network to the medical staff or to the departments responsible for fulfilling the order (i.e. pharmacy, laboratory, radiology, etc.)

EMR/EHR—Electronic medical record/electronic health record. These terms refer to the same thing and are often used interchangeably.

eRx—Short for e-prescribing. An electronic way of generating prescriptions through an automated data-entry process using software and a transmission network which links to pharmacies.

HIE—Health Information Exchange. A term used to describe both the sharing of health information electronically among two or more entities and also an organization which provides services that enable the electronic sharing of health information.

PP—Patient portal. A web-based communications tool that offers patients secure online access to portions of their medical records. Patients can also use the portal to request appointments, prescription refills, ask non-urgent questions and receive test results.

REC—Regional extension center. RECs are non-profit groups that receive funding from the federal government to help physicians in a specific geographic service area select, successfully implement and meaningfully use electronic medical records.

For years, the medical and legal professions have vehemently argued the issues of tort reform. The truth of the matter is—it's the patient who is on the losing side of the battle. It's time that we work together to affect meaningful change.

Perspective | Malpractice responsibility: Yours, mine, ours

BY PETER R. KOWEY, MD

In April 2011, more than 130 physicians, attorneys, and key stakeholders gathered in Philadelphia for a first-of-its-kind conference, where all sides could voice their frustrations, share perspectives, and, ultimately, join forces to tackle the numerous and complex obstacles standing in the way of tort reform. **"Malpractice Responsibility: Yours, Mine, Ours"** resulted in an eye-opening and surprisingly successful forum, and represented a significant first step toward achieving resolution.

Perhaps the most significant breakthrough at the conference was the stunning revelation that there is actually a great deal of common ground between the medical and legal professions...

Obviously, the threat of medical malpractice presents an enormous problem for physicians, from a standpoint both of cost and the potential destruction of one's reputation. But the most serious ramification of the current tort system is the corruption of everyday patient care. Physicians today are forced to practice "defensive medicine" to avoid the possibility of being charged as negligent. This comes in many forms—from ordering too many tests to performing unnecessary procedures on patients. The cost of practicing defensive medicine equates to billions of dollars in unnecessary spending. Economics aside, it is often the patient who suffers—undergoing potentially life-changing procedures that may not have been medically necessary.

In addition, the system devised to provide patients and families with

a method to address grievances is greatly in need of an overhaul. It's a selective and expensive process that does not allow fair representation for all cases; does not provide appropriate and timely compensation to patients and families who are deserving, and does not address the critical issue of physicians who are repeatedly sued for the right reasons and should no longer be permitted to practice medicine.

Perhaps the most significant breakthrough at the conference was the stunning revelation that there is actually a great deal of common ground between the medical and legal professions, and that resolution—albeit enormously complicated—can absolutely be achieved if we work together. The battle over tort reform is ultimately not about the money, the physicians, the lawyers, or the judges. It strikes at the very core of patient care.

Change will not come from physicians complaining or lawyers

resisting. Ultimately, change will come from public pressure. My hat goes off to the legislators who attended our conference—State Representative Kate Harper, State Senator Daylin Leach, and U.S. Congressman Patrick Meehan—for investing their valuable time to understand fully the issues at hand.

Each one of us needs to contact our own legislators to insist on the enactment of meaningful tort reform. And we need to endorse the legislators who do stand for the right things. It is our shared responsibility. ■



Dr. Kowey is System Division Chief, Cardiovascular Disease, Main Line Health, and author of Lethal Rhythm, a mystery novel to increase public awareness of the tort system's harm to medical care.



MAIN LINE HEALTH PHYSICIAN



Dr. Fried performing mock surgery demonstration for donors.

Giving back

A CLOSER LOOK AT ROBERT C. FRIED, MD

“**M**edicine is the greatest profession—I love what I do, each and every day, surrounded by dedicated caregivers,” said Bob Fried, MD, chief of surgery and vice president of Medical Affairs at Paoli Hospital. “When I go home I think about an operation I performed, a diagnosis I made, or how I helped a patient non-surgically—that’s a wonderful feeling.”

He is more than enthusiastic about his life’s work, but growing up in northern New Jersey, young Bob Fried entertained more than one option for his future.

“My father was a partner in a clothing business in Manhattan. I wanted to get into the business, but then decided to become an architect—I was always drawing and drafting when I was a teenager,” he said.

However, with a brother, six uncles and eight cousins who are all physicians, one might say Dr. Fried’s career choice was inevitable.

After earning his bachelor’s and medical degrees from the Washington University School of Medicine, he completed his residency and fellowship at the Hospital of the University of Pennsylvania. He joined Paoli’s medical staff in 1987 as a partner in a private practice, eventually forming Surgical Specialists, PC about 15 years ago with Scott Kripke, MD and Tim Fox, MD.

The decision to make charitable gifts and become involved in the work of fundraising is part of his upbringing. “I was raised in a family that was philanthropic—my father was, and my mother remains, a very kind, giving, and generous person. So giving back is a part of me and that is how I am raising my children too. Paoli Hospital is an important part of my life, and has

helped me get to where I am today.”

Dr. Fried has made charitable gifts to Paoli for over 20 years, supporting the Cancer Center, capital campaigns, the Holloway Breast Health Center, and the unrestricted fund. He has further supported the Paoli Hospital Foundation’s fundraising efforts by doing mock surgery presentations at donor events, and has gone the extra mile by establishing a bequest in his will.

“When I was thinking about my will and looking at the entire picture, I wanted to make sure that my family was taken care of should something happen. At the same time, it is important to remember the financial needs of organizations that provide services for our community.” ■

Thank you, Dr. Fried, for being a Development Champion on behalf of Paoli Hospital.

Staff notes

Edward Bedrossian Jr., MD, spoke to the Wills Eye Institute residents on “Eyelid Malpositions” and the Temple University Ophthalmology residents on “Upper Eyelid Blepharoplasty,” and spoke on “Browlift Techniques” at the Wills Eye Institute Cosmetic Surgery update course in May.

Joseph Bonn, MD, was appointed to a one-year term as President of the Board of the University of Virginia Medical Alumni Association in April.

Christine Stanko Burkholder, MD, was selected to serve on the Advisory Board for both Galderma Laboratories and Merz Aesthetics. Galderma Laboratories is a leader in dermatology research; Merz Aesthetics is a company focused on aesthetic dermatology innovation.

Anne Colton, MD, has been the team physician for the Philadelphia Women’s Professional Soccer team, the Independence, for two seasons.

Joseph Conroy, DO, completed certification in Clinical Lipidology and has been designated Diplomate, American Board of Clinical Lipidology.

Thomas S. Dardarian, DO, spoke to physicians in India and Hong Kong to build awareness of adhesions as a major source of morbidity in gynecologic procedures (including cesarean sections).

Albert DeNittis, MD, received a Sharp Strumia grant as co-investigator with George Prendergast in LIMR for “IDO2 Genetic Status Informs the Neoadjuvant Efficacy of Chloroquine in Brain Metastasis Radiotherapy.”

Charles Dunton, MD, immediate past president of the American Society for Colposcopy and Cervical Pathology, participated in the recent launch of Cervical Cancer-Free America, an initiative to prevent and eradicate cervical cancer nationwide.

Harold Farber, MD, was recently asked to speak on Fungal Infections at the Bronx Podiatric Monthly Meeting.

Francis D Ferdinand, MD, System surgical director of Clinical Effectiveness at Lankenau Medical Center, served as a Chairman for The Postgraduate Course—Atrial Fibrillation to the Annual Meeting of The International Society for Minimally Invasive Cardiothoracic Surgery (ISMICS) in June in Washington DC. He also was Presenting Author for two abstracts at Heart Rhythm 2011.

Joseph Ferroni, MD, was recently awarded Teacher of the Year honors at the St. Joseph’s University P.I.L.O.T. (Pharmaceutical Industry Leaders of Tomorrow) program.

Scott Goldman, MD, was a contributor to the paper, “Outcomes of the RESTOR-MV Trial,” in the *Journal of the American College of Cardiology*.

Dusan Kocovic, MD, was presenting author for two abstracts at the International Scientific Sessions of the Heart Rhythm Society.

Gerald J. Marks, MD, former president of the Pennsylvania Society of Colon & Rectal Surgeons, was honored by the Society with creation of an annual lecture in his name as an internationally recognized pioneer and thought leader.

Lee Mielcarek, MD, was recently nominated to the Board of Directors of the National Medical and Dental Association.

Marlene Moster, MD, presented a series of lectures on glaucoma in Tampa, Bala Cynwyd and Chicago, including “Pseudoexfoliation Revisited” at the University of Illinois Glaucoma Symposium.

Chinmay Patel, MD, was awarded first prize in the PA chapter ACC Meeting poster competition in 2010. The poster will be presented at National Meeting ACC at New Orleans this year as part of the national competition.

Melissa Neumann Schwartz, DO, recently became a Fellow of the American Academy of Otolaryngic Allergy. Dr. Schwartz has been on the editorial board of the *Montgomery County Women’s Journal*.

Emma Simpson, MD, chief of radiology at BMH, has been elected president of the Bryn Mawr Hospital Medical Staff, succeeding Anthony Zappacosta, MD.

David Singer, MD, started an organization called One Step at a Time, a non-profit focused on the education of breast cancer reconstruction.

Jeff Snider, DMD, was recognized among Top Dentists 2011 under the general dentist category in the June issue of *Main Line Today Magazine*.

Daniel Soffer, MD, was recently elected to the Northeast Lipid Association Board of Directors.

Ben Usatch, MD, the assistant chief at Lankenau’s ED, will be honored in November at the annual gala of the Delaware Valley Stroke Council as one of their “Stars for Stroke.”

Beverly Vaughn, MD, director of the Menopause and You Program for Main Line Health, was the guest lecturer at the Philadelphia Psychiatric Society in March 2011, presenting a lecture entitled “Sex and the Mature Woman.”

Laurence Wolf, MD, was awarded the Dean’s Award for Excellence in Education from Thomas Jefferson University in May.

Li Zhang, MD, was author of two abstracts accepted by the International Scientific Sessions of the Heart Rhythm Society for presentation and publications.



New appointments

JANUARY–MAY 2011

ANESTHESIA

Miriam L. Zentner, MD

DERMATOLOGY

Stuart R. Lessin, MD

FAMILY PRACTICE

Kristie B. Nichols, MD

GENERAL SURGERY

Manoucher K. Afshari, MD

Susan S. Chang, MD

Catherine M. Schermer, MD

HEMATOLOGY/ONCOLOGY

Jenia Jenab-Wolcott, MD

INTERNAL MEDICINE

Damian J. Cornacchia, DO

Renu Gupta, MD

Qaiss Mohammed, MD

Cathy S. Smith, MD

Thilagavathi Venkatachalam, MD

NEUROLOGY

Yun Lynn Sun, MD

OBSTETRICS/GYNECOLOGY

Wingkan W. Sbar, MD

OPHTHALMOLOGY

Anjana P. Jindal, MD

Michael A. Negrey, MD

ORTHOPAEDIC SURGERY

Michael A. Campbell, DO

Jonathan P. Garino, MD

Christopher M. Jones, MD

Charles F. Leinberry, MD

Eric A. Levicoff, MD

Steven J. Valentino, DO

PEDIATRIC EMERGENCY MEDICINE

Lauren Daly, MD

Christopher J. Russo, MD

PEDIATRICS

Sally J. Haas, MD

Jennifer Harris-Kaplan, MD

Michelle A. Hepburn, MD

PEDIATRIC UROLOGY

Jennifer A. Hagerty, DO

PLASTIC/RECONSTRUCTIVE SURGERY

Kevin J. Cross, MD

PODIATRY

Michael S. Downey, DPM

Andrew T. Teplica, DPM

REPRODUCTIVE ENDOCRINOLOGY

Rhonda Hearn-Stokes, MD

Jennifer L. Nichols, DO

RIDDLE PHYSICIAN'S JAUNDICE BLANKET INVENTION EARNS GATES FOUNDATION GRANT



electricity, that may not be an option. Without proper treatment, severe jaundice can lead to permanent disabilities or even death.

Enter Riddle Hospital neonatologist Harel Rosen, MD, and his father, Drexel University engineering professor Arye Rosen, who combined their expertise to

Switching on blue lights to help break down potentially toxic bilirubin is a normal procedure for treating infant jaundice. In areas

develop a solar-powered blanket.

"When you put an engineer and a physician in the same room, ideas go flying all over the place," Dr. Rosen said in an interview with the *Philadelphia Inquirer*.

"The blanket has dozens of blue LED lights, enabling the infant to be wrapped in the blanket and held, rather than lie alone under the lights," said Dr. Rosen, part of Onsite Neonatal Partners which provides neonatal care at Riddle. "That was my mother's original idea, recognizing that a jaundiced baby anywhere would benefit from being held while receiving phototherapy."

Incorporating flexible solar panels gives the blanket an advantage in less developed areas and helped the Rosens obtain a \$100,000 grant from the Bill and Melinda Gates Foundation, part of that foundation's commitment to global health projects.

BRYN MAWR REHAB HOSPITAL HOSTS BRAIN INJURY CONFERENCE

Over 100 physicians, nurses, case managers and therapists attended the Bryn Mawr Rehab Hospital brain injury medical education conference in March.

"Patients with Mild or Severe Traumatic Brain Injury: Emerging Treatments" included a faculty of specialists in the fields of traumatic brain injury and mild traumatic brain injury. The full-day educational conference focused on current treatment techniques, such as functional imaging, standardized assessment scales and computerized assessment tools, along with a report on a recent multicenter amantadine study. Much of the afternoon session focused on mild traumatic brain injury and post-concussion rehabilitation.

Guest speakers included:

- Michael W. Collins, PhD, assistant director of the University of Pittsburgh Medical Center, Sports Medicine Concussion Program
- Jonathan Fellus, MD, Medical Director of Rehabilitation, Meadowlands Rehabilitation Institute

- Joseph Giacino, PhD, Director of Rehabilitation Neuropsychology, Spaulding Rehabilitation Hospital and Visiting Associate Professor Harvard Medical School

- Michael Saulino, MD, PhD, Clinical Director of Intrathecal Services at Moss Rehabilitation

BMRH speakers included:

- Clint Beckley, OTR/L staff occupational therapist
- Barbara Hoffer, DO, staff physiatrist
- David Long, MD, medical director brain injury program
- Clare Small-McEvoy, PT, inpatient therapy manager
- Deborah Watson-Shaeffer, PT, staff physical therapist
- Lacey Ziman, CCC-SLP, staff speech pathologist

Main Line Health Physician magazine is published for MLH-affiliated physicians. For comments and contributions, contact Michael Martin, MLH Internal Communications manager, at martinmi@mlhs.org.

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The ABCs of ACOs

BY JOEL PORT

Right now, Accountable Care Organizations (ACOs) are untested concepts; only a few have been operating for more than several years. What you see today won't necessarily be what you see two or more years from now.

Much talked about but not always understood, Accountable Care Organizations are often defined as a set of healthcare providers that share responsibility for the quality, coordination and cost of care delivered to a defined population of patients.

The providers could include a hospital, a group of primary care providers, specialists and possibly other health professionals who together can provide and manage the continuum of care across different settings, including home, outpatient, inpatient and possibly post-acute care.

Created as part of the new healthcare reform legislation, ACOs are meant to control the growth of costs while maintaining or improving the quality of care patients receive. To qualify as an ACO, organizations must agree to be accountable for the

overall care of their beneficiaries, have adequate participation of primary care physicians and specialists, define processes to promote evidence-based medicine, report on quality and costs measures, and coordinate care.

The ACO model is one of the latest designs for managing healthcare costs and improving the health of our communities. It has drawn both support and opposition from lawmakers and healthcare professionals alike. But it's clear that we need to pilot new programs, when you look at demographic and financial data and the current and projected cost of health care in the US.

The growth of Medicare expenditures, which totaled \$225 billion in 1997, is expected to rise to \$857 billion by 2017. These exploding expenditures are being driven by an aging and increasingly sicker population. In 1997, 79 percent of Medicare patients had four or more chronic health conditions. In 2017, it's projected that number will be 96 percent.

The incentives of an ACO are different from the current fee-for-service reimbursement system. The

The focus of the ACO is to streamline its processes and care while exceeding the norm on quality and outcomes.

focus of the ACO is to streamline its processes and care while exceeding the norm on quality and outcomes. If the ACO spends less than projected, all members share in the bonus payments.

To enable primary care providers to manage the population health of their patients, investments in Electronic Medical Records are required. Also, to assist in managing chronic care patients, case managers are assigned to patients, not only in the hospital, but in their home environment, too. Both of these resources may be provided by the ACO.

Overall, ACOs provide one opportunity to slow down the rising cost of health care in this country, while offering patients more resources in the management of their care. Hopefully, ACOs will have a positive impact in many communities, not just the few where they are available today. The members of the Jefferson Health System (which includes Main Line Health) are evaluating options for developing an ACO for its members and affiliated physicians. ■

Joel Port is vice president, Planning and Business Development, for Main Line Health.