

Main Line Health

# Physician

*Peter A. Villas, M.D. PhD  
Interventional Radiology*

Selective Internal Radiation Therapy:  
**Tough on liver cancer,  
not on patients**

**SUMMER 2012  
Inside:**

The importance of  
diagnostic coding

Preventing the  
preventable

Faster recovery for  
brain injury patients



**Main Line Health**  
Well ahead.®

## Lots of positives

BY RICHARD SCHMIDT, MD



Welcome to Andrew Norton, MD, Main Line Health's new Chief Medical Officer. He comes to us from Froedtert Memorial Lutheran Hospital, a 500-bed adult tertiary hospital affiliated with the Medical College of Wisconsin (MCW) in Milwaukee, where he most recently served as Senior Vice President, Medical Affairs, and Chief Medical Officer. Over the past 25 years, he has been a chief medical officer, academic and community hospital residency program director, clinician educator and small group practice partner. We look forward to working closely with him.

Dr. Norton's arrival is part of a wave of positive developments at MLH, including the rollout of an updated Strategic Plan (see article on page 8) and the integration of Riddle Hospital's active medical staff with MLH medical staff. As of July 1, MLH acute care hospitals now have one unified medical staff with more than 2,000 physicians, all with representation on the MLH Medical Executive Committee, and all now eligible to acquire privileges at any other MLH acute hospital, if they so choose.

Another positive: MLH has begun planning, with The Nemours/Alfred I. duPont Hospital for Children, a new pediatric ambulatory surgery center in the Bryn Mawr Hospital MOB. Nemours will also be opening a specialty clinic next to the ASC. All this progress is on the heels of the June opening of the BMH Neurovascular Center (see article on page 11).

Improving facilities, like improving care, takes long-term commitment by people who care. Across MLH, major projects are underway—like the expansion of Riddle's ED and Paoli's maternity unit and nursery, and Lankenau's massive master facility project—to provide the best "homes" for our efforts to treat patients.

These projects help cement the long-term future of these institutions. Making them happen requires philanthropic support from everyone. Potential donors in the community take note of the support coming from those associated with MLH, who know the level of our dedication, our success and our intentions.

I encourage you to support these hospital projects. If you're sending patients or treating patients here, it matters. If you care about training the next generation of physicians for the next generation of patients, it matters. Remember, the best charity is the one that begins at home. ■

*Richard Schmidt, MD, is president of the Main Line Health Medical Staff.*

## Accolades

*Recent recognition for MLH*

- Main Line Health was named to *Hospital and Health Network's* Most Wired list for 2012. This is the fourth time in the last five years that MLH has been recognized.
- Lankenau Medical Center, Bryn Mawr and Paoli Hospitals were named to the *100 Top U.S. Hospitals* in Thomson Reuters' annual study ranking overall organizational performance.
- *Becker's Hospital Review* has named Paoli Hospital among its list of "100 Great Hospitals" for the second consecutive year. The award recognizes U.S. hospitals that have contributed to the history of American healthcare, made newsworthy accomplishments in 2011, and will continue to make strides this year.
- Riddle Hospital has earned The Joint Commission's Gold Seal of Approval™ for hip and knee joint replacement surgery.
- Paoli Hospital has been voted "Best Hospital on the Main Line" and Bryn Mawr Rehab Hospital "Best Rehab Service" in the *2012 Best of Main Line Readers' Choice* awards by Main Line Media News.
- For the second year in a row, The Birthplace at Riddle has received the 5 STAR HealthGrades in Maternity Care Excellence Award,™ placing in the top 10% in the nation for maternity care.
- The Breast Centers at all four MLH acute care hospitals have been granted a three-year accreditation by the National Accreditation Program for Breast Centers (NAPBC), a program administered by the American College of Surgeons.
- Lankenau Medical Center's Intensive Care Unit (ICU) and Cardiothoracic Intensive Care Unit are recipients of the American Association of Critical-Care Nurses' (AACN) 2012 silver-level Beacon Award.
- All four MLH acute care hospitals have received above average scores in Leapfrog Group's Hospital Safety Score<sup>SM</sup>, based on publicly available data on patient injuries, medical and medication errors, and infections.
- Paoli Hospital is the only hospital in Pennsylvania to be named one of the Top 20 Most Beautiful Hospitals in America in Solient Health's public online voting contest.
- Riddle Hospital has received Chest Pain Center and PCI (Percutaneous Coronary Intervention) Accreditation from the Society of Chest Pain Centers (SCPC).
- Sixty outstanding Main Line Health physicians were selected by their physician peers throughout the region for recognition by *Philadelphia* magazine as 2012 "Top Doctors." ■



# Selective Internal Radiation Therapy (SIRT): tough on liver cancer, not on patients

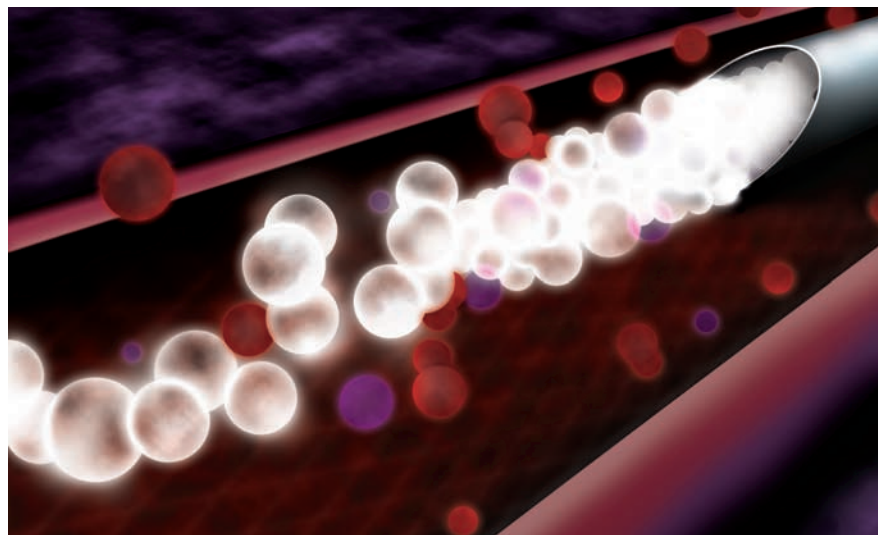
BY PETER VILLAS, MD, PhD

**I**nterventional Radiologists know there are two questions patients often ask when discussing treatment options for their cancer. One is, "How bad are the side effects?" The other is, "Will I need to be hospitalized for the procedure?"

For liver cancer, either unresectable primary liver cancer or metastatic cancer from a colorectal primary, most current therapies that reduce the symptoms of these diseases require hospitalization and usually cause side effects that reduce the quality of life for patients. For example, chemotherapy and chemoembolization often result in nausea, vomiting, hair loss and extreme fatigue. Therefore, there is a need for alternative cancer treatments that offer the convenience of outpatient therapy with fewer and less debilitating side effects. SIRT is a safe, innovative, and low toxicity radioembolic treatment.

There are two types of radioactive spheres, known as Sir-Spheres and TheraSpheres. Sir-Spheres consist of millions of resin microspheres, each 35 microns in mean diameter. TheraSpheres consist of millions of glass microspheres, each 20-30 microns mean diameter. Both have been infused/bonded with radioactive yttrium-90 (Y-90). The physician first makes a small incision in the patient's leg, then guides the catheter into the hepatic artery with the help of fluoroscopy. The spheres are injected into the hepatic artery through a catheter. The tiny radioactive beads flow directly into the tumor via the circulatory system and become permanently lodged in the capillary bed of the tumor. The Y-90 emits beta radiation directly to the tumor, attacking the tumor cells from within, with minimal impact to the surrounding healthy liver tissue.

Sir-Spheres and TheraSpheres are



*Tiny radioactive Sir-Spheres and TheraSpheres flow directly into the tumor via the circulatory system and become permanently lodged in the capillary bed of the tumor.*

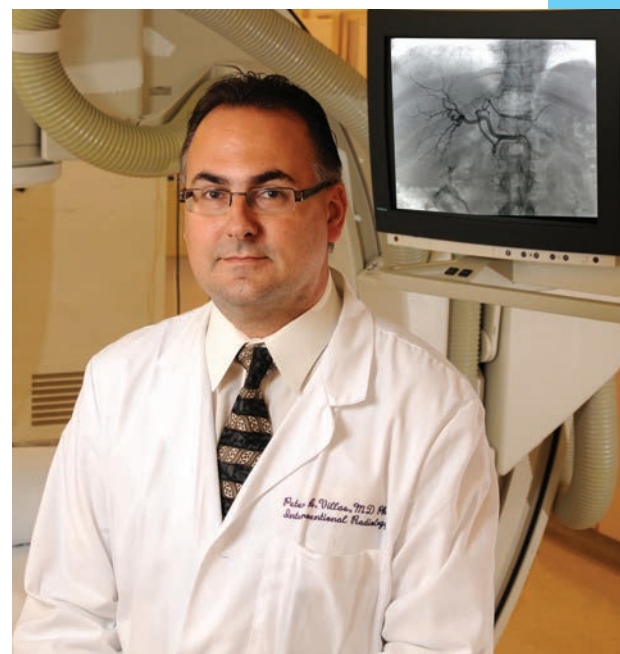
administered as outpatient procedures. The procedures are performed using conscious sedation and patients usually go home the same day. The radioactive microspheres continue to emit radiation over the course of several weeks after treatment, with radiation levels decreasing to insignificant levels. Typical reported side effects are mild to moderate. These include abdominal pain and fatigue similar to having the flu, and symptoms usually dissipate within 48 hours.

The FDA has approved TheraSphere as a Humanitarian Use Device for unresectable HCC. It usually represents the only treatment option for HCC patients who present with portal vein thrombosis (PVT). It can also be indicated for tumor downstaging prior to transplant. Therasphere has been used for patient treatment in the US since 2000. Sir-Spheres have been approved by the FDA since 2002 for the treatment of unresectable colorectal hepatic metastases. Treatment with Sir-Spheres has been shown to reduce tumor burden when combined

with chemotherapy more than chemotherapy alone.

The Lankenau Medical Center is proud to be the first hospital in Delaware and Chester Counties to offer these therapies. ■

*Peter Villas, MD, PhD, is an Interventional Radiologist at Lankenau Medical Center.*



# On the path to ICD-10 |

## The importance of diagnostic coding

BY ROBERT BENZ, MD

**D**iagnostic coding—few words in health care elicit more sighs of frustration. That's because physicians, coders and payors often speak different dialects when it comes to the documentation that is critical to proper coding.

Physicians speak in clinical terms; coders and payors speak in diagnostic terms. The result can sometimes leave all parties banging their heads against the wall.

But while documentation and coding can be frustrating at times, the system of assigning a consistent alphanumeric designation for every symptom, diagnosis and cause of death exists for a number of important reasons, including:

- **Patient safety**—Coding puts everyone on the same page. Inadequate or inaccurate documentation and coding can lead to miscommunication among healthcare providers and suboptimal patient care. For example, inaccurately describing a condition as acute rather than chronic can lead to unnecessary testing which is potentially dangerous to patients and a misuse of resources.
- **Admission status**—Failure to document key elements of a patient's condition or planned management can be the difference between a patient being admitted to the hospital or receiving outpatient care under observation status.
- **Accurate reimbursement**—Coding is the main source for accurate reimbursement of services. The narrative

text is matched to a code that, in turn, is used to calculate inpatient (DRG) or outpatient (APC) reimbursement. Lack of documentation or inadequate documentation can lead to underbilling by the hospital or physician.

Within Main Line Health, we estimate that the implementation of ICD-10 may present the opportunity for the system to collect up to \$15-\$20 million in additional revenue a year...

documentation present in the medical record, the government may consider that a "false claim." In addition to recouping the payment for the "false claim," the government can impose significant fines and penalties,

such as excluding the offending provider from participating in the Medicare program.

- **Denial appeals**—In some cases, payors will deny medical claims

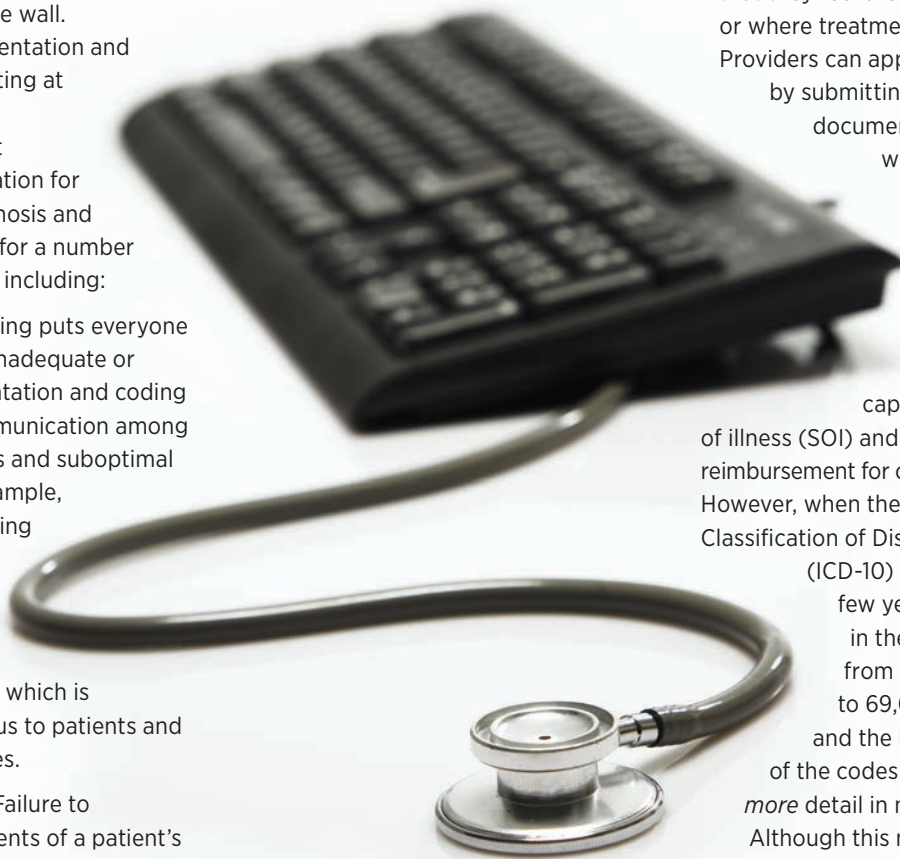
that they feel are incorrectly coded or where treatment was unnecessary. Providers can appeal those denials

by submitting supportive coding documentation that explains why specific codes were assigned for reimbursement.

Proper documentation has long been important for capturing the severity of illness (SOI) and receiving proper reimbursement for care provided. However, when the International Classification of Diseases-10th Revision (ICD-10) goes live in the next few years, the growth in the number of codes—from about 14,000 today to 69,000 under ICD-10—and the increased specificity of the codes are going to require *more* detail in medical records.

Although this may sound daunting, a few small changes today in the way care is documented can go a long way toward easing the pain, including:

- Be as specific as possible. Sometimes the answer is as simple as writing "due to" after a diagnosis (i.e. "pneumonia due to klebsiella" instead of simply "pneumonia"). The



- **Legal action**—Inappropriate or inadequate documentation can result in legal action by the federal government under the False Claims Act. For example, if a provider—physician or hospital—can't support services billed to Medicare with





Carol Jones, MLH Coding manager, clarifies information with Dr. Benz for an accurate diagnosis code to ensure proper reimbursement.

less specific the documentation, the greater the possibility that the SOI was not captured correctly and therefore the less reimbursement the payor is willing to provide.

- Use the “SI/IS” rule when thinking about inpatient admission. Is the *severity of illness* meeting the criteria for inpatient admission and is the *intensity of service* enough to justify inpatient services? Both “SI/IS” must be met.
- Don’t document as if you’re speaking to another physician. Document as if you are explaining the medical care to a patient or their family member. This often leads to a more detailed description of diagnostic terms for coders to use.

Can the coding system be an annoyance? At times, yes, but it’s the environment we live in, and it’s not going away.

Within Main Line Health, we estimate that the implementation of ICD-10 may present the opportunity for the system to collect up to \$15-\$20 million in additional revenue a year—money that would allow us to purchase new technology and improve facilities. ■

*Robert Benz, MD, is vice president, Medical Affairs, Lankenau Medical Center.*

## ICD-10 DEADLINE DELAYED ONE YEAR

Last April, the Department of Health and Human Services (HHS) proposed a one-year delay for the implementation of the new ICD-10 diagnosis coding system.

In announcing a new deadline of Oct. 1, 2014, HHS noted that “some provider groups have expressed serious concerns about their ability to meet the 2013 deadline.” HHS believes the new compliance date will give providers more time to prepare and fully test their systems to ensure a smooth and coordinated transition.

The deadline for ICD-10 may be delayed, but Main Line Health is progressing with its implementation plans, according to Suzanne Layne, system director for Health Information Management.

“The deadline extension should be seen as an extra year to shore up coding processes and communicate the changes to our physicians and staff,” she said. “The change is still coming, and we intend to be prepared.”

# Preventing the preventable

BY KAY KERR, MD

In 2010, 24.8% of hospitalizations for Congestive Heart Failure in Pennsylvania were considered preventable, according to a Pennsylvania Health Care Cost Containment Council report. That's 45,866 CHF patients who could have been spared a hospital stay, not counting those with the many other medical conditions with a significant number of preventable hospital admissions.

With our continuing focus on quality and safety, Main Line Health has identified reducing preventable readmissions as a priority. At each of the acute hospitals, pilot programs with elements of a national initiative called Project RED (Re-Engineered Discharges) have confirmed we share many of the national issues behind preventable readmissions, reflecting the importance of medication

management, communication between healthcare providers, individualized discharge instructions, a support system at home, and timely follow-up with the physician.

This spring, staff from across MLH—from physicians to Finance—formed three teams—Primary Care, Hospital Care, and Post-Acute Care—to address care transitions, patient access to care, and coordination of care. Improving these areas is the right thing to do for our patients.

**Now, significant reform within the healthcare payment system is going to add a financial incentive to delivering patient-centered care and reducing preventable hospital readmissions.**

On October 1, a new federal policy will reduce Medicare reimbursements to hospitals with readmissions above the national average for heart attack, heart

failure, or pneumonia. Private insurers are beginning to follow suit.

This marks a significant shift in the payment system to emphasize population management, coordination of care and ongoing treatment of chronic diseases, rather than procedures, volume and treatment of acute disease.

While all four acute MLH hospitals are already in line with the national averages, the policy adds new emphasis to the importance of developing effective programs to reduce preventable readmissions.

By working together, inpatient, ambulatory, and post-acute health care providers can develop personalized care plans that follow a patient across different settings of care, and provide appropriate resources for the individual patient. The elements of the Patient Centered Medical Home (PCMH) constitute a team approach to delivering coordinated, patient-centered care. Ideally, the PCMH provides the patient—and the physician—with a full range of support needed to address many of the patient needs in an outpatient setting.

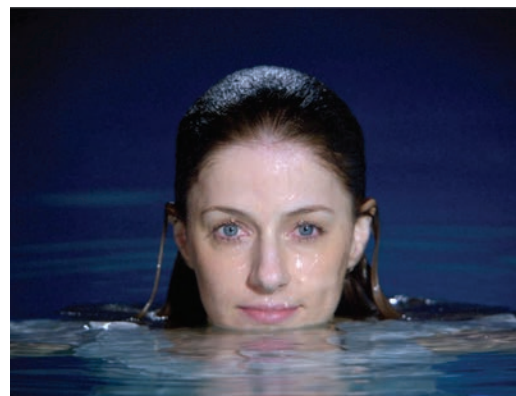
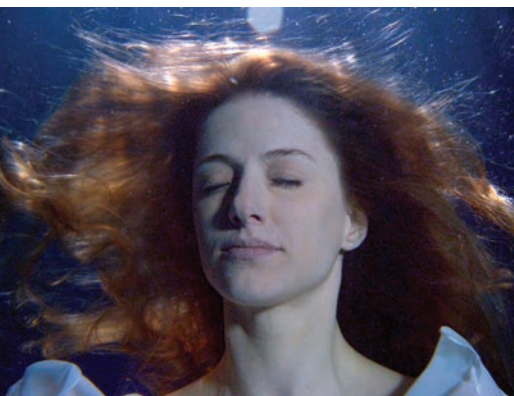
Changes in the payment system will help MLH primary care practices embrace this model, which is key to care coordination and chronic care management. MLH programs to support the adoption of EMRs, the creation of NOW clinics, and improved access and communication with specialists also support PCMH development and provide the right care, at the right time, in the right setting for the patient.

Reducing preventable admissions will need the support and effort of virtually everyone in the Main Line Health System. It's a commitment to quality and doing what is best for our patients that we, as a Medical Staff and healthcare system, embrace. ■

*Kay Kerr, MD, (shown left, visiting a patient) is chair of Family Medicine at Main Line Health.*







Above: still frames from the spring television commercial for Bryn Mawr Rehab Hospital. As the woman emerges from her coma and rises to the surface of the water, the music builds and the announcer reads, "How do you reawaken a brain that's been traumatized by injury or stroke? Coax it back from the deep? Every brain has a mind of its own. Every person's journey is different. So at Bryn Mawr Rehab Hospital, we adapt, innovate, push. Because we know what a brain can do, how far a person can come, if we never give up."

## Faster recovery for brain injury patients

BY DAVID LONG, MD

Perhaps you have seen the latest television commercial for Bryn Mawr Rehab Hospital: A woman in a trance-like state slowly surfaces from a deep pool of water and awakens. Patients with severe traumatic brain injury (TBI) often are initially comatose. Many awaken during the first hours or days after an injury, but some remain with disorders of consciousness for more prolonged periods of time. When these patients regain eye opening without other signs of conscious awareness, this has been termed a vegetative state. When some definite but limited or variable signs of consciousness re-emerge this has been termed a minimally conscious state.

While we have learned a lot about brain plasticity and recovery from injury in recent decades, recovery from these disorders of consciousness after severe TBI can still be frustratingly slow and challenging. Neuropharmacologic therapies are often used off label to enhance arousal and behavioral responsiveness, but no intervention has been shown to alter the pace

of recovery or improve functional outcome. Until now.

Bryn Mawr Rehab Hospital was one of 11 centers involved in a landmark study this year that investigated whether the drug amantadine could promote functional recovery in traumatic brain injury patients. Results of the study appeared in the *New England Journal of Medicine* in March 2012.<sup>1</sup>

Amantadine—originally meant to treat the flu and now prescribed for Parkinson's patients—was already often used to treat brain injured patients. However, no definitive study had ever been conducted to determine whether it was truly beneficial.

During this study, 184 patients who were in a vegetative or minimally conscious state four to sixteen weeks after injury were randomly assigned to receive amantadine or placebo for four weeks. They were also followed during the two-week period following removal of the drug.

The study found that during the four-week treatment period, the rate of recovery was significantly faster in the amantadine group, affecting

functionally meaningful behaviors such as consistent responses to commands, intelligible speech, reliable yes-or-no communication, and functional-object use. The rate of improvement in the amantadine patients slowed during the two weeks after they were taken off the drug but the patients did not lose ground in their recovery.

The mechanism of why amantadine works remains unclear, although the favorable effects of the drug may reflect enhanced neurotransmission in the dopamine-dependent neural circuits that are responsible for mediating arousal, drive and attentional functions.

There are many interventions that are employed in patients with traumatic brain injuries but the majority of them are not evidence based. This study is significant because it provides us with the first established treatment for potentially speeding recovery in this population. ■

*David Long, MD, is medical director, Brain Injury Program, for Bryn Mawr Rehab Hospital.*

1. Giacino JT, Whyte J, Bagiella E, Kalmar K, Childs N, Khademi A, Eifert B, Long D, Katz DI, Cho S, Yablon SA, Luther M, Hammond FM, Nordenbo A, Novak P, Mercer W, Maurer-Karattup P, Sherer M. Placebo-controlled trial of amantadine for severe traumatic brain injury. *N Engl J Med*. 2012 Mar 1;366(9):819-26.

# MLH Strategic Plan | Setting the course

**F**our years ago, Main Line Health implemented a long-range Strategic Plan that, among other initiatives, placed a high priority on patient safety. Within a short time, the accomplishments were accumulating. By 2011, MLH recorded a 50 percent reduction in its already low rates of healthcare associated infections, falls with harm and mislabeled specimens—examples of results directly traceable to the detailed strategies and action steps in the MLH Strategic Plan (see *accompanying article*).

This year, an updated Strategic Plan—benefiting from extensive input from MLH physicians—has begun to guide MLH decisions and actions for 2012-2016, again with a commitment to a superior patient experience, highly engaged people, market growth, research, clinical education and financial performance.

With the economy and health care in a state of flux, the key to the development of the 2012-2016 Plan was a thorough assessment of the national and regional environment, a candid analysis of MLH internal factors, and the participation of MLH executive and physician leadership. As a result, MLH has been able to better prepare

for the volume, reimbursement and technology changes associated with healthcare reform.



MLH planners studied national quality and safety trends, reimbursement prospects, the financial stability and competitiveness of other area hospitals (and even small niche players), plus demographic trends. They also examined MLH's progress toward quality and safety goals, financial strength, and the growth of both MLH market share and medical staff.

The conclusions drawn from the assembled research are setting MLH's course for the next five years. Among

the imperatives, MLH needs to

- Provide both world-class health care and a strong balance sheet
  - Gain more value from its strengths as a system and from standardizing its evidence-based care
  - Model economic and clinical alignment with the medical staff
  - Address looming physician shortages
  - Respond to the growing diversity and age of the community
- The resulting 2012-2016 Strategic Plan is consistent in many ways with the previous one, but expectations are higher for
- Eliminating preventable harm
  - Ensuring quality outcomes
  - Engaging staff
  - Lowering healthcare costs
  - Increasing patient satisfaction and community wellness

Physicians have a frequent and critical place in the MLH plan, as contributors to top decile quality performance, as engaged participants in research, education and communication, and as partners in the system-wide effort to determine and deliver a superior patient experience most efficiently. ■

*Town Meetings rolling out the 2012-2016 MLH Strategic Plan were held in June and July, including sessions for physicians at each MLH acute hospital. For a copy of the 2012-2016 MLH Strategic Plan, email [martinmi@mlhs.org](mailto:martinmi@mlhs.org).*

## IMPACT OF THE 2009-2012 PLAN

Impressive results attributed to the 2009-2012 Strategic Plan include:

- Expanded clinical collaboration and important improvement in patient safety indicators, stemming from overwhelming physician and employee participation in Culture of Safety training
- An emphasis on patient safety, clinical collaboration, electronic medical records, and evidence-based medicine
- Significant growth in MLH market share while other suburban community hospitals' share has declined
- High levels of physician engagement (at world-class levels in some locations)
- Improvements in the structure, scope and value of research activities
- Advancements in clinical education, such as the Simulation Center, creating a dynamic environment for personal growth
- A conscientious program of cost reduction, system thinking, and philanthropic initiatives, helping MLH achieve an enviable operating margin that is funding long-term strategic plans



In the field of Emergency Medicine, compassion and commitment are part of a physician's everyday life. At Paoli Hospital, Stuart Brilliant, MD, chief of Emergency Medicine, leads a dedicated team of nine board-certified, highly skilled physicians who exemplify this compassion and commitment every day in Paoli's Emergency Department.

## Philanthropy | "No better tribute to our medical care"

A CLOSER LOOK AT STUART BRILLIANT, MD

Dr. Brilliant grew up in Huntington, NY, and credits his older brother, who also practices Emergency Medicine, for leading him to such a rewarding career. With his brother's encouragement, Dr. Brilliant served as an Emergency Medical Technician in college and attended medical school at the State University of New York Health Science Center at Syracuse. After completing his residency in Emergency Medicine at the University of Connecticut Medical Center, he joined Paoli Hospital.

"In Emergency Medicine... you often see patients at their most vulnerable. But that's what I love about this profession—the ability to provide care to people at such a critical time in their lives."

Dr. Brilliant chose Emergency Medicine for the daily opportunity to dramatically improve individual lives in their time of need. For him and for his colleagues in the ED, their deeply-felt commitment extends into the area of charitable giving to the hospital. These physicians give because they realize that philanthropic support helps them to provide the best possible care for our community.

"I am proud to be a member of the hospital family. I give my time, and I think it is equally important to give financially," explained Dr. Brilliant, whose annual giving makes him a part of the *H. Phelps Potter Society*. "As a donor, you become part of a broader community committed to making a difference in health care."

Dr. Brilliant not only encourages charitable giving among his physician colleagues but has also inspired

patients to make charitable donations.

"In Emergency Medicine, you never know what you will see from one minute to the next, and you often see patients at their most vulnerable. But that's what I love about this profession—the ability to provide care to people at such a critical time in their lives. And when patients express their gratitude through a charitable gift, it is such an honor. There's no better tribute to our medical care." ■



Stuart Brilliant, MD

## Staff notes

**Edward Bedrossian, Jr., MD**, was recently promoted to Clinical Professor of Ophthalmology at Temple University School of Medicine.

**Sheetal Chandhok, MD**, was invited to the June international “Meet the Masters” EP fellows programs in Nice, France, to present “Transeptal puncture model/sheath management/ICE management.”

**Louis Ciliberti, DPM**, presented a poster abstract on synthetic grafts for Achilles tendon repairs at the World Congress on Bone, Muscle and Joint Disorders in Spain in January.

**Michele Columbo, MD**, co-authored and presented two clinical studies, “Asthma in the Elderly: The Role of Exhaled Nitric Oxide Measurements” and “The Effect of Allergen Immunotherapy on Exhaled Nitric Oxide in Adult Subjects with Allergic Rhinitis and Asthma,” at the 2012 meeting of the American Academy of Asthma, Allergy and Immunology in Orlando.

**Madeline Danny, DO**, was installed as the 165th President of the Montgomery County Medical Society.

**Alejandro Diez, MD**, was inducted as a Fellow of the American Society of Nephrology and was adjudicated a “Poster of Distinction” award after presenting two abstracts, “Correlation between Volumetric CT Measurements and Split-Renal Function and Its Utility in Donor Kidney Section” and “Donor Kidney Volume and Its Effect on Recipient Graft Function” at the American Transplant Congress in Boston.

**Matthew Dunn, MD, Mary Mallon, MD, Sarah Menashe, MD, Roman Politi, MD, and James Whitaker, MD**, successfully completed their oral board examination at the Bryn Mawr diagnostic radiology residency.

**Michael Ezekowitz, MD**, a cardiologist and researcher at the Lankenau Institute for Medical Research, has also joined the New York City-based Cardiovascular Research Foundation (CRF) to start a new center for atrial fibrillation research.

**Harold Farber, MD**, was a guest lecturer for the Medimetriks National Training Force at the Borgata Hotel in Atlantic City.

**John Feehery, MD**, recently lectured on “Dizziness Disorders in Women” at the Annual Women’s Health Issue Program at the Springfield Country Club.

**Francis D. Ferdinand, MD**, surgical director, Cardiovascular Quality and Strategy, at Lankenau Medical Center, has been named president-elect of the International Society for Minimally Invasive Cardiothoracic Surgery.

**Christian Fras, MD**, has two poster presentations accepted and will be doing a podium presentation on “Comparison of Lumbar Spine MRI Review: CD vs Film” at the North American Spine Society’s 27th Annual Meeting in October.

**Sunir Garg, MD**, received an achievement award from the American Academy of Ophthalmology. He has also published “Retained subretinal perfluorocarbon liquid in sutureless 23-gauge versus sutured 20-gauge vitrectomy for retinal detachment repair” and “Removal of Posterior Segment Retained Lens Material Using the OZil Phacoemulsification Handpiece Versus Fragmatome During Pars Plana Vitrectomy” in *Retina*, and “Comparative Analysis of the Retinal Microvasculature Visualized with Fluorescein Angiography and the Retinal Function Imager” in the *American Journal of Ophthalmology*.

**Reem Habboushe, MD**, has been chosen to be the editor of the newsletter for the Society of Hospital Medicine Philadelphia/Tri-State Chapter.

**Philip Kim, MD**, has been invited to the Polyalgic Consensus Panel on Treatment Guidelines for Intraspinal Infusion (2011). He is also the co-author of the “Diagnosis, Management and Treatment of Discogenic Pain” chapter in Volume 3 of *Provocative Discography*, and also served as the book’s editor.

**Peter Kowey, MD**, chaired the AF Spotlight event “Changing the Paradigm in Atrial Fibrillation Management: You be the Judge” in May.

**Helen Kuroki, MD**, presented “Building a Culture of Safety: Physicians and Nurses Moving from Collaboration to Interdependence” with Riddle Nursing VP Ann Marie Brooks, DNSc, at the National Patient Safety Forum in Gaithersburg, Maryland.

**Jeffrey Lehrman, MD**, along with his chief resident, **Mark Maurer, MD**, published the article “Significance of sesamoid ossification in peroneous longus tendon ruptures” in the May-June 2012 issue of *Journal of Foot and Ankle Surgery*.

**Jason Miller, DPM**, and **Louis Ciliberti, DPM**, presented “Ankle Sprain Induced Compartment Syndrome Secondary to Dysfibrinogenemia (Factor I Deficiency)” and “Talar Neck Fracture Treated with Percutaneous Pin Fixation and an External Fixator” at the annual American College of Foot & Ankle Surgeons Scientific Meeting in San Antonio, TX.

**William H. Pfeffer, MD, Michael J. Glassner, MD, and John J. Orris, DO**, have been awarded multiple grants/clinical research trials which help patients receive In Vitro Fertilization (IVF) procedures and medications at discounted prices. The trials include the effect of preimplantation genetic screening (PGS) of embryos on pregnancy rates and also the effect of egg freezing on embryo development.

**Melvin Roat, MD, FACS**, recently had two chapters, “Dry Eyes” and “Blepharitis,” published in the *5-Minute Ophthalmology Consult* series.

**Louis E. Samuels, MD**, was author of “Left ventricular apical papillary fibroelastoma,” published in *The Journal of Thoracic and Cardiovascular Surgery*.

**Stanley Schwartz, MD**, received an NIH R01 Grant on Studying Genes for LADA, published a book chapter on “Weight Reduction in Diabetes” and a paper on “Fibroblast Growth Factor in CKD,” and gave 12 CME lectures in the Jefferson/MLHS.

**William Surkis, MD**, director, Internal Medicine Residency Program, Lankenau Medical Center, was honored by the Class of 2012 at Jefferson Medical College with the Leon A. Peris Memorial Award, which recognizes a volunteer Jefferson faculty member for excellence in clinical teaching and superior patient care.

**Marc Togli, MD**, and his colleagues published “Single-Incision Mini-Sling Compared with Tension-free Vaginal Tape for the Treatment of Stress Urinary Incontinence—A Randomized Control Trial” in *Obstetric & Gynecology Journal*.



## New appointments

**FEBRUARY-JULY 2012**

### **ANESTHESIOLOGY**

Daniel Beneski, MD, PhD  
Lisa Luyun, MD  
Shalin Patel, MD

### **EMERGENCY MEDICINE**

Darcy Hayes, MD

### **FAMILY PRACTICE**

Lauren Baker, DO  
Tricia Beatty, DO  
Ellen Delea, MD  
Chris Duplass, DO  
Julia Elcock-Vengen, MD  
Harry Frankel, MD  
Winson George, DO  
Amy Luo, DO  
Kevin McCabe, DO  
Valentina Rutolo, MD

### **MEDICINE/ALLERGY & IMMUNOLOGY**

Neil Baman, MD

### **MEDICINE/CARDIOVASCULAR DISEASES**

Steven Domskey, MD  
Irving Herling, MD

### **MEDICINE/ENDOCRINOLOGY**

Rex Kessler, MD  
Margaret Ryan, MD

### **MEDICINE/HEMATOLOGY AND MEDICAL ONCOLOGY**

Rachna Anand, DO  
Nabila Chowdhury, MD

### **MEDICINE/INFECTIOUS DISEASES AND PREVENTIVE MEDICINE**

Amit Gangoli, MD  
Raida Rabah, MD

### **MEDICINE/INTERNAL MEDICINE**

Thomas Comerici, MD  
Alyson Dobracki, DO  
Amy Iwamaye, MD  
Dorothy Jenkins, MD  
Julie Katz, DO  
Antonio Luis, MD  
Nicole Nagy, DO  
AjayKumar Patel, MD  
Hammad Raza, MD  
Nicola Stepanian, DO

### **MEDICINE/RHEUMATOLOGY**

David Chen, MD  
Michael Jaworski, MD  
Michael Rosen, MD

### **OB/GYN**

Nancey Hahn, MD

## **MLH NEUROVASCULAR CENTER ELEVATES STROKE CARE**

"Main Line Health is a leader in stroke care, and now with the establishment of the Neurovascular Center at Bryn Mawr Hospital, we can offer patients a whole new level of care and hope for a full recovery," said Neurointerventional Neurosurgeon Grahame Gould, MD.

With the opening of the Center on July 2, Bryn Mawr Hospital is the only suburban hospital in the western suburbs with a university-affiliated neurosciences center for comprehensive stroke care. The affiliation with the Jefferson Neuroscience Network offers patients rapid access to advanced diagnostics and the latest treatments.

The multimillion-dollar Neurointerventional lab features the Siemens Artis zee Biplane system, providing a range of advanced 3-D applications that allow for greater speed and precision during angiography and fluoroscopy. For the treatment of embolic strokes and

non-ruptured aneurysms, patients have rapid access to innovative, nonsurgical procedures including aneurysm coiling, angioplasty and stenting of carotid and cerebral arteries, clot retrieval and glue placement in an aneurysm.

Following their procedures, patients receive care in Bryn Mawr Hospital's Neuro-cardiac ICU, the only unit of its kind in the southeastern Pennsylvania region. The NC-ICU is one of only three units in Pennsylvania to receive the American Association of Critical Care Nurses 2012 silver-level Beacon Award for Excellence. (Lankenau Medical Center's ICU and Cardiothoracic ICU are the other two.)

All of Main Line Health's four acute care hospitals have stroke center certification and see nearly 1,000 stroke patients annually. Patients requiring Neurointerventional care will be transferred to Bryn Mawr's facility.

### **PEDIATRICS**

Pallavi Arabolu, MD  
Cheryl Hausman, MD  
Michelle Karten, MD  
Rami Kharouf, MD  
Alexandra Solosko, DO

### **PSYCHIATRY**

Giampaolo Gallo, MD

### **RADIOLOGY/DIAGNOSTIC**

Diane Nathan, MD  
Hema Thaker, MD

### **SURGERY/CARDIAC SURGERY**

Michael Strong, MD (started Dec. 2011)

### **SURGERY/NEUROSURGERY**

David Andrews, MD  
James Evans, MD  
Yaron Moshel, MD  
Srinivas Prasad, MD

### **SURGERY/OPHTHALMOLOGY**

Michele Piccone, MD  
Michael Rabinowitz, MD

### **SURGERY/ORTHOPAEDIC SURGERY**

Louise Nichols, MD

### **SURGERY/PLASTIC & RECONSTRUCTIVE**

Raymond Jean, MD

### **SURGERY/PODIATRY**

Maggie Solimeo, DPM

### **SURGERY/VASCULAR SURGERY**

David Bigatel, MD  
Vincent DiGiovanni, DO



SUMMER 2012

## The HCAHPS challenge

BY JACK LYNCH

At a recent Schwartz Rounds I attended, a discussion emerged around the topic of patient satisfaction and the importance of the Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) survey. One physician shared his frustration that the effort to measure patient satisfaction focused on issues not directly related to clinical care. As the physician stated, “The reality is that ‘satisfying’ the patient isn’t always what’s best for the patient. Are we more concerned with making the patient happy or providing them with the most appropriate care?”

These comments have stuck with me, and I understand the physician’s concern. HCAHPS scores should never distract caregivers from providing clinically required care or acting in the patient’s best clinical interests. In fact, if the patient’s well-being remains our chief concern, I believe HCAHPS scores will follow suit.

In my view, HCAHPS allows patients to rate our hospitals in much

the same way they might rate a store or a restaurant. The food might be fresh, delicious and safely prepared, but if the waiter is slow and surly, it’s unlikely the diner will return. We have worked hard to make MLH hospitals among the best in the nation by virtually every quality and safety measure. Safety and quality must always come first. But all our hard work in these areas won’t be as effective as possible if a patient feels we don’t care about him or her as a whole person.

Measuring patient satisfaction is not new. What is new is the government’s plan to base Medicare and Medicaid reimbursement, in part, on HCAHPS scores. Among its questions, the survey asks patients to rate how well we listened to them, treated them with dignity and respect, kept the unit quiet, and explained things like medications or post-hospital care. These are “soft” data, based almost entirely on the patients’ perceptions and how well they remember their hospital stay when the survey shows up in the mail. We get credit only when a patient

answers “Always.”

I believe that HCAHPS is a positive development that can help take MLH to even greater heights of excellence. While the survey may not be perfect, it sets a standard of quality that our patients have come to expect and most certainly deserve. I count the MLH medical staff among the best—with your expertise, talent and compassion, we will meet the HCAHPS challenge. ■

*Jack Lynch is President and CEO of Main Line Health.*

**“We have worked hard to make MLH hospitals among the best in the nation by virtually every quality and safety measure ... But all our hard work in these areas won’t be as effective as possible if a patient feels we don’t care about him or her as a whole person.”**