Main Line Health

Physician

Building a real life tricorder

SPRING 2015

Inside:

- Ebola: The silver lining
- Cancer and the heart: The case for specialized care
- Modern help for the severely depressed

Main Line Health®

Well ahead.®

Physician involvement in EMR

BY ANGUS GILLIS, MD

In this edition of *Main Line Health Physician* magazine, you'll read about several areas in which physician involvement has made an impact recently: emergency planning and preparedness in the face of the Ebola virus threat, new therapeutic regimens in psychiatric treatment, and research cooperation between cardiology and oncology. MLH physicians are making a difference in some great programs.

There are other areas that also need physician involvement in order to be successful. One of the most critical of these is the need for physician input into the selection of a new Electronic Medical Record system. MLH is considering, with the assistance of consultants, the selection of a new EMR because of changes in the vendor and support of our current system. The input of physicians — the everyday users of the EMR — is essential for making the best choice.

Different physicians will have different requirements for the EMR's function and potential interface with other technologies. Surgeons and others doing procedures will have certain requirements based on their activity. Physicians who are doing clinical documentation on in-house patients will have other needs. Physicians who work in the out-patient setting but require two-way communication between the hospital's EMR and their office system will have yet another set of requirements. Finally, physicians who practice at a largely teaching hospital will interface with the system differently than physicians doing all their own clinical documentation. We must choose a system that meets the needs of all of our physicians no matter their specialty or location. Your input is invaluable in making this important decision.

The EMR is also used in a way that clinicians might not see on a daily basis. It helps facilitate quality and safety reviews. It is important for billing and for financial management. These functions are very important and must be considered in our choice. However, our ultimate goal should be a system that enables us to provide excellent patient care and is physician-friendly. The new system should minimize the amount of time physicians are spending on administrative tasks and "figuring out" how to work around cumbersome electronic processes. Your input is essential, so please make your voice heard!

On a related note, the Medical Staff leadership would like to thank all those physicians who participated in the Magnet accreditation visit and congratulate our nursing colleagues on achieving System Magnet® designation. We appreciate your continued support of hospital functions like this. The leadership would also like to thank the physicians who participated in our educational effort with the Horty Springer Conference in NYC and with the dinner and greeting with the new President and CEO of TJUH System, Dr. Steve Klasko.

Remember, our involvement in the process of the EMR structure, vendor, implementation, and facilitation of connectivity to outside offices is the only way that a well-functioning EMR will be adopted. We hope to hear your suggestions and will be providing more information in the coming months. ■

Angus Gillis, MD, is president of the Main Line Health Medical Staff.

You are the patient experience

BY BARBARA WADSWORTH, DNP, RN, FAAN, FACHE, NEA-BC

First, please accept my heartfelt thanks for taking the time to participate in the American Nurses Credentialing Center Magnet® Site Visit at Main Line Health in early February. As you may know, we have received System Magnet designation. MLH is one of only 22 systems in the country with this recognition. I am extremely grateful for the many physicians who attended sessions and spoke with the appraisers about physician/nurse collaboration and nursing excellence at MLH.

You may soon hear about "I am the patient experience" education, a program created by MLH for all staff. In two hours, we focus on creating a healing environment for patients, reinforcing best practices for customer service, and introducing a new service recovery model — REACT (Recognize, Empathize, Apologize, Correct, Thank). Throughout the program, we discuss patient safety, quality and measurement, because these form the foundation on which we do our work. Several physician colleagues are helping us create a modified patient experience course that would be intra-professional so you can participate with other clinicians from your work environment. Watch for more information.

I look forward to partnering with you on this important initiative that will enable us all to provide a superior patient experience in all settings across MLH. Please email me if I can help you in any way. ■

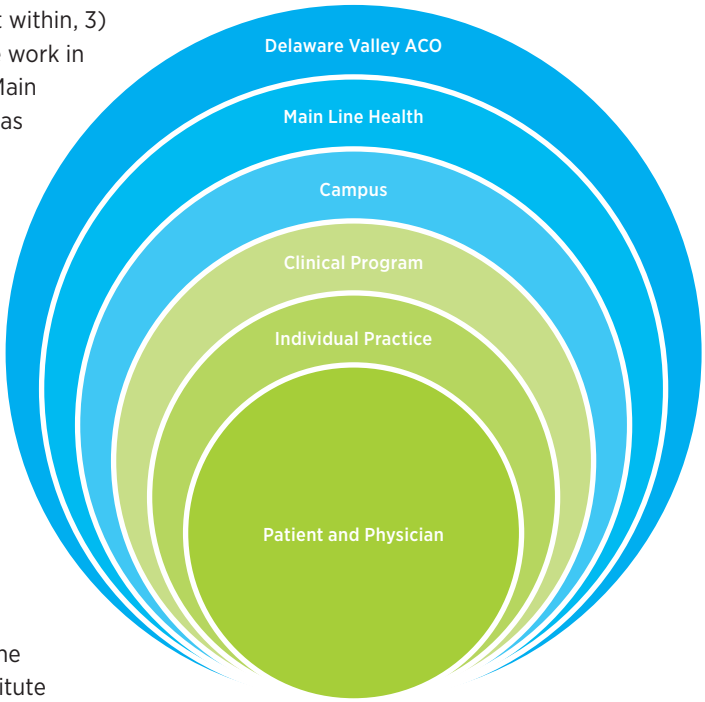
Barbara Wadsworth is chief nursing officer for Main Line Health.

Creating essentiality by managing the matrix

BY ANDY NORTON, MD

In the parlance of modern healthcare administration lingo, Main Line Health has ***essentiality*** in the Philadelphia health care market. That essentiality comes from our geography and market share, our patient-centered approach to health services delivery, the high quality in the outcomes we deliver, and the fact that we, as Main Line Health physicians and institutions, are sought out by patients throughout the region. In the years to come, we need to work together to retain our essentiality as we see market consolidation and, with it, increased competition. We are well positioned to rise to that challenge, but we will need to work together as a health system and its medical staff to retain our position in the market.

It's been almost three years since I had the privilege to join the leadership at Main Line Health. I have tried to understand our organization, the legacy of its fine individual institutions, the strengths of its medical staff, and the nature of our pluralistic physician model. What I have come to believe is that, as a System, we form a great organization with a great opportunity to care for and improve our community's health. To best take advantage of that opportunity, we need to learn to manage our unique ***matrix*** that involves the overlap that we have 1) as physicians and our own patients within our individual clinical practices, 2) the clinical programs those practices exist within, 3) the local campus we work in or near, and 4) the Main Line Health System, as a whole. Our unique matrix will also include regional collaborations such as through the Delaware Valley ACO.



As an example, a high priority for Main Line Health is to maintain our regional essentiality in cardiovascular services. That work will be directed by the Lankenau Heart Institute (LHI), which is not just the brand for our cardiovascular services, but an evolving collaboration between cardiovascular clinicians (both independent cardiovascular physicians as well as physicians employed by Main Line HealthCare) and the administrative leadership of Main Line Health. The System goals of the Lankenau Heart Institute are:

I. Grow the cardiovascular business for MLH and its physician partners
II. Provide a comprehensive range of services, from consultation and diagnostic assessment to therapeutic intervention at appropriate sites of service
III. Evaluate the distribution of services to ensure that patient care is provided in the most appropriate environment to ensure consistent clinical outcomes and overall patient safety
IV. Enhance overall satisfaction and accessibility with LHI program for patients, referring physicians, and participating providers
V. Provide care from a cost effective perspective to ensure continued fiscal viability

As a System, we form a great organization with a great opportunity to care for and improve our community's health.

To accomplish its work of setting the highest standards in cardiovascular care in the region and to retain its regional essentiality, LHI has to ***manage the matrix*** between individual clinicians, cardiovascular programs within LHI, and coordination between System objectives and local operations. LHI has organized itself within Centers of Distinction where clinical experts can design and develop clinical programs that meet the needs of our communities, support our clinical practices and assure our essentiality in cardiovascular services throughout the Philadelphia region. The LHI Centers of Distinction include: Structural Heart Disease, Heart Failure/Pulmonary Hypertension, Cardiac Rhythm

(continued on page 9)

Ebola: The silver lining

BY MARK INGERMAN, MD; CONNIE CUTLER, RN, MS, CIC, FSHEA; AND ROBERT FEINBERG, MS, EMT-P, PA-C

In March 2014, when the outbreak of Ebola in West Africa was first reported, US health care facilities were not concerned that the disease would make its way here. In June, as the pandemic grew and health care workers lost their lives treating Ebola patients, the US began to pay attention. By August, although the Centers for Disease Control and Prevention (CDC) had not yet issued any recommendations, Main Line Health was developing a comprehensive plan that would protect our employees, medical staff, patients and visitors should the Ebola virus surface here.

Ensuring our preparedness for a pandemic of this magnitude (more than 23,000 cases and over 9,000 deaths since 2014) posed unprecedented challenges — and, equally significant, resulted in System-wide readiness for future crises.

Our initial actions, at the time, were above and beyond anything that the CDC had asked for, and far ahead of the curve. Our first steps were to:

- Create a specific protocol, starting with an admissions questionnaire for every Emergency Room patient to complete upon arrival. The protocol, outlining the exact steps to take depending on the patient's answers, quickly expanded to every Main Line Health outpatient venue.
- Formulate an initial response for isolation and establish intake procedures at our hospitals.
- Designate Lankenau Medical Center as our System's Ebola Treatment Center, while training and equipping all MLH hospitals to keep an Ebola patient for 12–24 hours prior to transfer. (Once the CDC established regional Treatment Centers, including several in our area, our process changed to incorporate transfer to the designated Treatment Center).
- Develop a secure transportation plan with the Riddle EMS team in case we needed to move an Ebola patient from any of our facilities to a regional treatment center.

The arrival in the US of the first Ebola patient in September 2014 was a learning experience for US health care workers, significantly magnifying our understanding of what was needed for patient care and staff protection. Issues ranged from identifying the appropriate personnel and entities to be notified of a potential case, to

purchasing extensive (and expensive) protective and transport equipment, to training 1,200 health care team members across Main Line Health. It was an extraordinary undertaking.

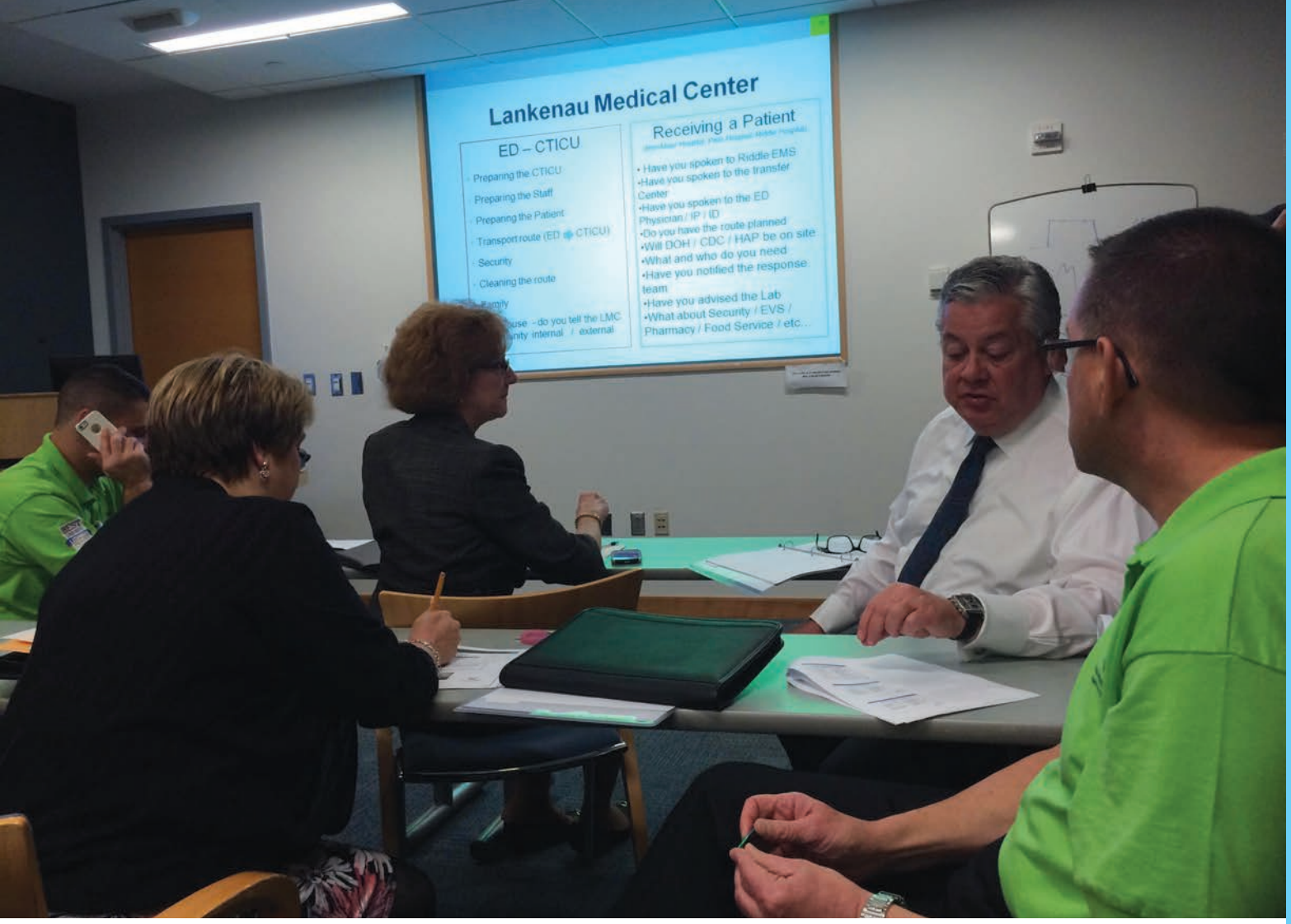
With previous threats, such as SARS or H1N1, a sound infection prevention plan could readily be put into place and executed accordingly. However, Ebola was unlike anything we had seen before — one of complete evolution. The information we were receiving changed daily, so we were making modifications to our plan every day.

To expand our knowledge, we attended lectures presented by the physicians who directly treated Ebola patients in the US.

Within Main Line Health, we

- Brought together emergency medicine personnel, hospitalists, and staff from infectious disease and infection prevention, obstetrics, laboratory, EVS, emergency management and senior leadership, as well as community partners and other specialists to coordinate every aspect of care that might be involved.
- Established Level One and Level Two alert protocols for patients suspected of having Ebola, and conducted intensive training sessions.
- Created two educational videos for staff — one regarding proper protective equipment for personnel and one for the laboratory processing of specimens.
- Held functional exercises at each of our Emergency Departments.

MLH senior leadership team, led by President and CEO Jack Lynch, provided critical support — ranging from substantial investments in equipment and training to night shift visits at each of our hospital Emergency Departments by Chief Nursing Officer Barbara Wadsworth and Chief Medical Officer Andy Norton, MD — to ensure we were ready to manage any challenge we might face. In fact,



Members of the Ebola response team at Lankenau Medical Center were led by LMC President Phil Robinson (in white shirt).

across Main Line Health, nurses, physicians, security, environmental services, finance, communications and more came together magnificently to quickly prepare our organization and our staff. We were especially proud of how many nurses and physicians stepped up and volunteered to care for any Ebola patients we might see.

There was ongoing dialogue with the medical personnel and staff who provide direct care for patients, as well as frequent System-wide communications to ensure that MLH's 10,000 employees were aware of the extensive steps being taken to ensure their safety.

The Ebola threat created an immense need for collaboration — both internally and externally — that led to powerful partnerships that will be valuable against any future threats of infectious disease.

The Ebola threat created an immense need for collaboration — both internally and externally — that led to powerful partnerships that will be valuable against any future threats of infectious disease.

Externally, a deep network of infectious disease physicians has been solidified across our region and throughout the US to collectively share information. Our relationships and channels of communication with the state and county health departments are significantly strengthened.

Internally, our rigorous groundwork surrounding Ebola has resulted in an extensive preparedness program that will serve us well into the future. We have a highly functioning framework connecting emergency medicine, specialty departments, our communications team, infection preventionists, Emergency Management and more.

This sound infrastructure, with protocols and procedures marshaled for Ebola, is now ready to help us manage any other infectious diseases or bioterrorism threats that we may face. ■

Mark Ingerman, MD, is system division chief, MLH Infectious Diseases & Preventive Medicine; Connie Cutler is director, MLH Infection Prevention and Control; and Robert Feinberg is director, MLH Emergency Management.

Building a real life tricorder

Lankenau ED physician leads team in global competition

What one portable device can monitor a patient's vital signs and diagnose up to 15 diseases?

Until now, that device has existed only in science fiction. However, an emergency medicine physician at Lankenau Medical Center, Basil Harris, MD, is leading a team that just might turn Star Trek's tricorder into science fact.

Dr. Harris is competing for the Qualcomm Tricorder XPRIZE, which offers $10 million in prize money to the top three teams that develop the best portable, consumer-focused device for monitoring vital signs and diagnosing 15 diseases ranging from anemia to tuberculosis. In short, a real-life tricorder.

"The competition goes way beyond what was envisioned on Star Trek," said Dr. Harris, leader of "Final Frontier Medical Devices" — a seven-person team that is a Top 10 finalist in the competition.

"On Star Trek, the tricorder was just a device that collected data that the doctor had to interpret. The devices in this competition are completely autonomous. They must collect the data, analyze it and provide a diagnosis without input from a medical professional," he said.

Later this year, the finalist teams must deliver 30 prototypes of their tricorders for final judging. Consumer volunteers will test the devices, and judging will be based on how easy they are to use, accuracy of diagnosis, ability to detect all of the diseases, and other technical criteria. Winners will be announced in January 2016.

Dr. Harris and his team members — three of whom are his siblings — took a slightly different approach than their competitors when creating their device. Instead of a sensor-heavy device or one that requires blood samples, they used just a few wireless monitors and a tablet that queries patients about their symptoms and then guides them toward a diagnosis. Call it the artificial intelligence approach.

"We did a validation study on our algorithms based on real medical data from actual patients to understand whether these algorithms were robust enough," says Dr. Harris.

"I think that a device like the ones in this competition will have a huge impact on the healthcare system. It won't replace doctors — the device can't take your appendix out — but it will provide a first step to figuring out what a patient's symptoms mean and where to go next."

According to Dr. Harris, who says he grew up watching Star Trek, this type of contest is boldly going where no one has gone before.

"This is very different than a traditional research project," he says. "It puts different competitive gears in motion and promotes finding the best of these devices. A lot of people are working toward this type of thing and it's a combination of these ideas that will lead to the development of a device for actual use. This is just the tip of the iceberg." ■

Dr. Harris' tricorder prototype was built, layer upon layer, by a 3D printer.

Cancer and the heart: The case for specialized care

BY IRVING HERLING, MD

Currently, two of every three people diagnosed with cancer in the United States survive at least five years[1], contributing to a rising cancer survivor population now more than 14 million strong[2]. With greater survivorship, however, comes a growing need to address potential cancer-related complications.

Cardiovascular disease is common in patients with cancer, either as a pre-existing condition or new problem brought on by effects of cancer or its treatment. In fact, as the population ages and cancer survival improves, it is increasingly likely a person will have both cancer and heart disease, with the latter potentially impacting choice of cancer treatment, quality of life, and survival.

Cardiovascular complications can occur with many anti-cancer medications and with radiation therapy to the chest, neck, or mediastinum. Cardiac dysfunction and heart failure are among the most serious side effects of chemotherapy. Conventional agents such as anthracyclines, antimetabolites, and cyclophosphamide may induce permanent myocardial injury, whereas signaling inhibitors may cause transient contractile dysfunction. In a study of 12,500 women with invasive breast cancer, heart failure risk was 4 times higher in women treated with trastuzumab and 7 times higher in those treated with an anthracycline plus trastuzumab, compared with women who did not receive chemotherapy.[3]

A new clinical discipline has emerged as a result of growing awareness of cancer-related cardiovascular complications. Termed cardio-oncology, this specialized field emphasizes an integrative approach to patients with cancer and heart disease or risk of cardiovascular injury from cancer treatment, with an important mission to ensure patients who survive cancer do not die of heart failure.

To address this need, Main Line Health has established a Cardio-Oncology Program offering collaborative evaluation and coordinated cardiovascular care of patients before, during, and after cancer treatment. The program is led by an integrated team of cardiovascular and oncology specialists working across the health system, with the goals of minimizing adverse heart and vascular effects of cancer treatment,

enabling completion of effective cancer therapy, and maximizing cardiovascular outcomes for cancer survivors.

The Program is committed to keeping pace with advances in cardio-oncology by integrating the latest cardiac screening and monitoring technologies and best practices for prevention and management of cardiovascular complications of cancer treatment. The cardio-oncology team has developed a core set of guidelines to maintain a superior standard of care, which will evolve as the field evolves.

The MLH Cardio-Oncology Program can be accessed from multiple Lankenau Heart Institute practices across Main Line Health System, and cardiologists welcome questions about patients who may benefit from referral. For locations and phone numbers, call 866.CALL.MLH. ■

Irving Herling, MD, is director of Clinical Cardiology for Lankenau Medical Center.

CARDIOVASCULAR COMPLICATIONS OF CANCER TREATMENT

Radiation therapy

- Acute or delayed pericardial disease
- Coronary artery disease
- Diastolic/systolic heart failure and cardiomyopathy
- Valvulopathy
- Conduction disease

Chemotherapy

- Acute or delayed myocardial injury/ventricular dysfunction
- Arrhythmia
- Coronary vasospasm and thrombosis
- Pericarditis
- Hypertension
- Hypercoagulability

WHO CAN BENEFIT FROM A CARDIO-ONCOLOGY REFERRAL?

- Patients with cardiovascular disease or risk factors who are starting potentially cardiotoxic cancer treatment and require monitoring of cardiovascular status during treatment
- Patients who are undergoing cancer treatment with known cardiotoxic therapies and develop evidence of cardiovascular injury
- Cancer survivors who have received potentially cardiotoxic cancer treatment and may develop cardiovascular problems months or years later

1 Howlader N, et al (eds). SEER Cancer Statistics Review, 1975-2011. National Cancer Institute. Available at: http://seer.cancer.gov/csr/1975_2011/.

2 American Cancer Society. Cancer Treatment and Survivorship Facts & Figures 2014-2015. American Cancer Society; 2014.

3 Bowles EJ et al. Risk of heart failure in breast cancer patients after anthracycline and trastuzumab treatment: a retrospective cohort study. J Natl Cancer Inst. 2012;104:1293–305.

Modern help for the severely depressed

BY MARC BUROCK, MD

For decades, a common treatment for patients with depression was electroconvulsive therapy (ECT). Then, in 1975, "One Flew Over the Cuckoo's Nest" hit the movie theaters. The film's frightening portrayal of ECT, combined with already existing questions about its safety and the wide introduction of antidepressant medications, led to a significant decline in its use.

Now, 40 years later, ECT is still considered one of the most effective treatments for severe depression and is recognized by the American Psychiatric Association and the National Institutes of Mental Health as an important therapy to treat mental illness. This resurgence within the psychiatric community is based on two developments: scientific proof that ECT is remarkably effective in severely depressed patients, and the introduction of safer, more refined delivery techniques.

For these reasons, Bryn Mawr Hospital began offering Inpatient and Outpatient ECT treatment of severe depression in the summer of 2014. Bryn Mawr Hospital is home to Main Line Health's only inpatient psychiatric unit.

The case for ECT is compelling.

- The remission rate for severely depressed patients who undergo this therapy is about 70 percent, compared to a 30 percent remission rate from antidepressants among this population.
- Older patients respond particularly well to ECT, although it can be used on adults of any age.
- ECT offers an effective alternative when medications are ineffective or trigger significant adverse effects.
- While the ideal candidate has severe depression, ECT may also be used in treatment of psychosis and mania.

Today's improved, painless version of ECT is thanks to a better understanding of how to stimulate the brain, tailor the dosing, and minimize side effects.

During the procedure, the patient is sedated using general anesthesia. An electrical stimulus, lasting from one to eight seconds, is then delivered to the scalp to cause a seizure lasting 30 seconds to two minutes. Although patients may experience some initial confusion upon waking, they are typically able to go home soon after the procedure.

Some patients see results in as little as only one treatment. Typically, though, patients undergo six to 12 sessions over a two- to four-week period.

It's not known why ECT works. One theory suggests that the seizure activity causes an alteration of the brain's neurotransmitters. Another theory proposes that ECT adjusts stress hormone regulation in the brain, which may affect energy, sleep, appetite and mood.

Bryn Mawr Hospital is one of only a handful of suburban Philadelphia hospitals to offer ECT, a procedure that is covered by most insurance plans. Its introduction means that the hospital, which houses an inpatient psychiatric unit, can offer a comprehensive psychiatric program ranging from activity therapy and creative/expressive therapy to medication management and aftercare planning. ■

To refer a patient for ECT evaluation or for more information about outpatient ECT services at Bryn Mawr Hospital, call 1.888.CARE.898. For more information on ECT, see http://www.mainlinehealth.org/behavioralhealth/electroconvulsive-therapy.

Marc Burock, MD, medical director of Inpatient Psychiatry, Bryn Mawr Hospital, displays ECT equipment while nurse Sherry Lyle completes preparations for treatment.

Accolades

- All four MLH acute hospitals received the 2014 Get With The Guidelines® Quality Achievement Award from the American Heart Association for ensuring that stroke patients receive treatment according to nationally accepted guidelines. Riddle Hospital received the Gold Plus/Target Stroke Award, Lankenau Medical Center and Bryn Mawr Hospital received the Gold Plus Award, and Paoli Hospital received the Silver Plus Award.
- For the sixth time in the last seven years, Main Line Health was named one of the nation's "Most Wired" health systems for its commitment to implementing innovative technology solutions, as reported by *Hospitals & Health Networks* magazine.
- The Health Care Improvement Foundation (HCIF) named MLH the first place winner of the 2014 Delaware Valley Quality and Patient Safety Award for its project submission *Improving Mortality through Strategies that Drive Change in Culture and Behavior*. Along with this honor, MLH is receiving a grant of $3,000 toward the advancement of quality and patient safety initiatives.
- For the eighth consecutive year, Lankenau Medical Center has been named one of the nation's 50 Top Cardiovascular Hospitals® by Truven Health Analytics in the "Teaching Hospitals with Cardiovascular Residency Programs" category.
- The Hospital & Healthsystem Association of Pennsylvania (HAP) has recognized Riddle Hospital with a 2014 Achievement Award in the category of Patient Care (medium-sized hospitals) for "Promoting Staff Engagement and Patient Safety Through Innovative Purposeful and Leader Rounding."
- Selected by their physician peers throughout the region, over 400 Main Line Health physicians have been recognized by *Main Line Today* magazine as 2014 "Top Doctors."
- For the second year in a row, The Advisory Board named MLH a 2014 winner of its annual Excellence in Engagement Award, recognizing employee engagement.
- *Philadelphia Business Journal* honored MLH as the Gold Winner in the Extra Large Company category of its 2014 Best Places to Work competition.
- Paoli Hospital has been named a 2014 Guardian of Excellence Award winner by Press Ganey for Patient Experience in Inpatient Care. The hospital received this distinction by reaching the 95th percentile for each reporting period for the award year in patient satisfaction.
- Bryn Mawr Rehab Hospital has received the Rehabilitation and Community Providers Association (RCPA) Innovation Award for its Project SEARCH program. Project SEARCH has achieved an 82% success rate in assisting adults with disabilities to gain competitive employment.
- Lankenau Medical Center, Paoli Hospital and Riddle Hospital have earned "Top Performer on Key Quality Measures" recognition from The Joint Commission (TJC). This is the fourth year in a row for Riddle and third time for LMC and the second time for Paoli to receive this designation.
- The Lankenau Medical Center's Transitional Care Center (TCC) was named a top performer by the American College of Health Care Administrators (ACHCA) and received *US News & World Report*'s five-star rating in the publication's 2015 report on the country's top long-term care facilities.
- The Pennsylvania Trauma Systems Foundation (PTSF) has once again awarded Paoli Hospital's Level II Regional Trauma Center a three-year re-accreditation. This is the second time the trauma center has been re-accredited since it opened in October 2010.

Creating essentiality

(continued from page 3)

Management, Coronary Artery Disease Management, Aortic and Peripheral Vascular Disease Management, Cardiovascular Prevention/Wellness, and Women and Heart Disease.

One example of managing the matrix in cardiovascular services is designing systems to optimize the care of our patients with Congestive Heart Failure (CHF). An LHI team led by Chris Droogan, DO, working with MLH administrative staff, is designing a coordinated system of care for our CHF patients that includes:

- standardized inpatient care bundles
- risk stratification for CHF patients to personalize outpatient management strategies
- outpatient management resources for managing CHF patients, including care navigation, outpatient treatment resources for weekends and after hours, and telehealth capabilities

Main Line Health is committed to developing organizational structures, such as the Lankenau Heart Institute, that allow collaboration with all of its clinical partners to develop systems of care to manage across the inpatient and outpatient environments. MLH needs to be deliberate in developing systems of care to optimize the outcomes of such patients through collaborations across the inpatient and outpatient environments and with partners such as skilled nursing facilities, insurers, home care agencies, etc.

Organizational collaborations like the Lankenau Heart Institute and innovative treatment strategies for complex patients will be essential building blocks in retaining our competitive position within the local health environment. We are actively building new service line structures, such as the MLH Cancer Program. Our partnership with the Delaware Valley ACO will offer new opportunities for collaboration and participation in Pay for Performance programs. We are exploring opportunities for collaborations within Main Line Health, such as a Clinically Integrated Network model. All of these are opportunities to work together to manage the unique matrix which is Main Line Health and its physician partnerships.

Maintaining essentiality of Main Line Health and its physician partners in the Philadelphia market is a priority. I hope you will work with Main Line Health and your medical staff colleagues in this collaborative work. ■

Andy Norton, MD, is chief medical officer for Main Line Health.

Staff notes

Raymond Baraldi, MD, was appointed vice president of Medical Affairs for Bryn Mawr Hospital. He joined Main Line Health from the Cooper Health System, where he served as acting chief medical officer for the System and chief of Radiology.

Ned Carp, MD, is the recipient of an outstanding achievement award by the Commission on Cancer (CoC) for his exemplary role as state chair for many years.

R. Brannon Claytor, MD, will teach the MOC (Maintenance of Certification) Advanced Course at the National Meeting for the American Society for Aesthetic Plastic Surgery (ASAPS). The course is titled "Scarpa Sparing Abdominoplasty with Concomitant Liposuction, No Drains Needed."

Michele Columbo, MD, and **Albert S. Rohr, MD**, are the main authors of the study "Asthma in the Elderly: A Study of the Role of Vitamin D" that has been accepted for publication in *Allergy, Asthma & Clinical Immunology*. This study was funded by the Sharpe-Strumia Research Foundation of the Bryn Mawr Hospital.

Michael Ezekowitz, MD, PhD, has been included in Thomson Reuters list of the Most Highly Influential Scientific Minds 2014.

Francis D. Ferdinand, MD, gave his presidential address "Quality Drives Innovation" at the International Society for Minimally Invasive Cardiothoracic Surgery Annual Meeting. "

Jonathan Fischer, MD, is the author of "The effect of supine versus upright patient positioning on inferior vena cava metrics," in the November 2014 issue of *The American Journal of Emergency Medicine*.

Atul Gupta, MD, has co-founded the GIRO (Global Interventional Radiology Outreach) medical mission initiative, bringing basic Interventional Radiology (IR) procedures and training to local radiologists in underserved countries. GIRO's first IR medical mission is targeted later this year and will take place in Managua, Nicaragua.

Reem Habboushe, MD, chief, Hospital Medicine, Paoli Hospital, has joined the Executive Committee for the Society of Hospital Medicine Philadelphia Tri-State Chapter.

Basil Harris, MD, will present at the national meeting of the Society for Academic Emergency Medicine (SAEM) May 12–15 in San Diego.

Philip Kim, MD, is among the 60 co-authors of one or more of the four articles due to appear in the August 12 issue of *Neuromodulation: Technology at the Neural Interface*.

Peter Kowey, MD, system chief of the Division of Cardiovascular Diseases, was named chair of an independent Scientific Review Board established by AstraZeneca to assess requests from external researchers that include patient level data...At the AF Symposium 2015, Dr. Kowey presented "Combined Anticoagulant and Antiplatelet Therapy in Patients with AF and CAD and Should We Be Dose Adjusting the NOACS?"... Dr. Kowey also received the Edward S. Cooper, MD, Award from the American Heart Association at its annual Heart Ball in February.

Jeffrey D. Lehrman, DPM, presented a talk and led a demonstration of total contact casting at the International meeting of the Academy of Physicians in Wound Healing...At the Symposium on Advanced Wound Care, Dr. Lehrman was awarded the American Podiatric Medical Association Wound Care Scholarship for "Excellence in Wound Healing."

Linna Li, MD, was elected to the National Cancer Institute Task Force for Rare Tumors Head and Neck Cancer.

Hans Liu, MD, FACP, chief of Infectious Diseases and director of Antibiotic Stewardship at Bryn Mawr Hospital, presented "Antibiotic Stewardship Programs: Overcoming Barriers to Successful Implementation," at the 16th International Congress on Infectious Diseases in Capetown, South Africa. Co-authors on the project were Bryn Mawr Hospital's **H.G. Williams, Jr., RPh**, director of Pharmacy, and **Lisa A. Cushinotto, PharmD**, Infectious Diseases pharmacist.

Lawrence L. Livornese, Jr., MD, **James Mullin, MD** and **Jonathan Raines, MD**, published an editorial, "Retrofitting the battlements: tight junction remodeling as a novel antimicrobial approach," in *Future Medicinal Chemistry* in January.

Demetri Menegos, DO, completed research with a professional baseball team for publication in the *Italian Journal of Sports Rehabilitation*. The research involved formulating an electrolyte sports beverage with an added FDA-approved compound to increase muscle strength in professional athletes. In addition, he was named International Associate Editor for the journal.

Konstadinos Plestis, MD, system chief, Cardiothoracic and Vascular Surgery, Lankenau Heart Institute, was guest of honor at an event sponsored by the *Hellenic News of America* attended by more than 100 physicians and community members.

Patrick Ross, MD, has been appointed system chair of the MLH Department of Surgery. Dr. Ross previously was professor of clinical surgery and chief of the Division of Thoracic Surgery at The Ohio State University Medical Center in Columbus. He also served as chief of staff of the James Cancer Hospital and Solove Research Institute.

David Thomas, DO, PhD, Riddle Hospital campus chief of Medicine, chief of Neurology and founder/president of The Center of Neuroscience, was honored by Upper Providence Township with a Recognition and Appreciation Award for providing the township police department with Advanced Stroke Awareness Training.

Michael Walker, MD, has been appointed medical director for the Main Line Health Cancer Program. His Main Line HealthCare clinical practice focuses on minimally invasive and robotic thoracic surgery.

New appointments

JUNE 2014–FEBRUARY 2015

ANESTHESIOLOGY
Ashley K. Caplan, DO
Rachel M. Dada, MD

EMERGENCY MEDICINE
Erin C. Kelly, DO
Dipak P. Sheth, MD

FAMILY PRACTICE
Benish Aqil, MD
Lindsey E. Cobbett, MD
Emily K. Fellin, MD
Susan Kirchdoerffer, DO
Gabriella E. Maris, MD
Jeffrey Mumie, DO
John E. Peacock, DO
Adam J. Tyson, MD
Michael A. Warner, MD
Damaris S. Wessel, DO

MEDICINE/ALLERGY & IMMUNOLOGY
Geeta A. Bhargave, MD

MEDICINE/ CARDIOVASCULAR DISEASES
Katie M. Hawthorne, MD
Muhammad Raza, MD
Brian R. Shaw, DO

MEDICINE/ GASTROENTEROLOGY
Maura M. Barr, DO

MEDICINE/HEMATOLOGY & MEDICAL ONCOLOGY
Aarti L. Shevade, MD

MEDICINE/INFECTIOUS DISEASES & PREVENTIVE MEDICINE
Kiran Paramatmuni, MD

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Documentation, quality and ICD-10

BY CHRISTINE STALLKAMP, MD, FAAFP

ICD-10 is now set for implementation on October 1, 2015.

Launch of this tenth global edition of the World Health Organization's International Classification of Diseases (ICD) will affect a wide variety of systems, from accounting, billing and financial systems to clinical protocols, disease management and birth defect registries.

ICD-10 diagnosis codes will be required for everyone covered by the Health Insurance Portability Accountability Act (but will not affect CPT coding for outpatient procedures and physician services).

With diagnosis codes increasing from about 14,000 to more than 69,000 and procedure codes going from about 4,000 to 72,000, accurate quality outcomes measurement and appropriate reimbursement will be both the goal and the challenge.

Of vital importance is physician awareness of the ICD-10 codes driving quality metrics (such as the Agency for Healthcare Research and Quality's Patient Safety Indicators), our understanding of the documentation and coding rules, and our engagement in ensuring their accuracy.

As if we needed one, the role ICD-10 codes will play in patient safety is a good reason to renew attention to correct documentation. The Patient Safety Indicators (PSIs) are critical in spotlighting potential in-hospital complications and adverse events after surgeries, procedures and childbirth. The public uses PSIs to assess hospital outcomes and select providers for elective surgeries. Medicare uses PSIs to influence hospital reimbursement and reputation, which will be of significance for physicians when CMS announces its plans for bundled payments.

Preparations for ICD-10 at MLH are well underway, with physician and staff training and awareness initiatives planned, and I will be working collaboratively with MLH's Health Information Management Coding and Clinical Documentation Improvement teams to facilitate the transition. Watch for timely updates on ICD-10 training and implementation in the weekly ***MLH Clinician*** enewsletter.

Christine Stallkamp, MD, FAAFP, is lead physician, Utilization Management, and medical director of Urgent Care.

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Philanthropy | A closer look at: Michael Shank, DO

Whether caring for patients in the office, the hospital, or local nursing facilities, Michael Shank, DO, founding partner of Rose Tree Medical Associates in Media and Campus Chief of Family Medicine for Riddle Hospital, sees continuity of care as the best way to help patients get well and stay well. He reinforces this approach by making house calls. Dr. Shank does about 20 visits per week and has made more than 16,000 in his career!

Ensuring continuity of high quality care is important to Dr. Shank when his patients need emergency care, too. He wants to be sure they have the best resources available to them.

"Our patients have come to rely on Riddle's Emergency Department, and our community deserves to have a high quality facility — one that matches the quality of the doctors and nurses who provide the care there," he said.

That's why, as primary care physicians, Dr. Shank and his partners at Rose Tree Medical Associates wanted to take a leadership role in funding Riddle's Emergency Department expansion, and contributed $50,000 to support the campaign.

"We wanted to demonstrate to the rest of the medical staff that we consider the ED an invaluable resource to our patients and their families," he said. "The better the ED, the better the medical care that is provided to the overall community."

Dr. Shank agrees there are many worthy causes in the region to choose to support, but recognizes that Riddle Hospital benefits all members of the community.

"Most of the physicians and staff at our practice live within Riddle's service area," he said. "So, deciding to make a contribution to the expansion of the ED is an investment. My children have been seen there and so have my parents. I have personally used the ED as well. We felt that at this particular time and place, Riddle's new ED was a priority interest for us as parents, as physicians, and, of course, as sons and daughters, and it deserved our attention."

The expansion of Riddle Hospital's Emergency Department was a $15 million project supported by a capital campaign that could not have been possible without the philanthropic spirit of the community, which raised half the total cost. The physicians at Riddle Hospital were also a big part of that success, keeping the needs of their patients first and supporting the campaign with their own generous philanthropy, contributing a combined total of more than $1 million to the project. ■

Michael Shank, DO

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.** **Editorial Board:** **Gary Daum, MD; Robert Day, MD; Steven Gamburg, MD; Ernest Gillan, MD; Scott Goldman, MD; Lawrence Livornese, MD; Jack Lynch; Stephen Mechanick, MD; Andy Norton, MD; Nancy Roberts, MD; Emma Simpson, MD; Robert Stavis, MD; Barbara Wadsworth, RN.**
Cover photograph: Basil Harris, MD, displays his team's entry in the Qualcomm Tricorder XPRIZE global competition.