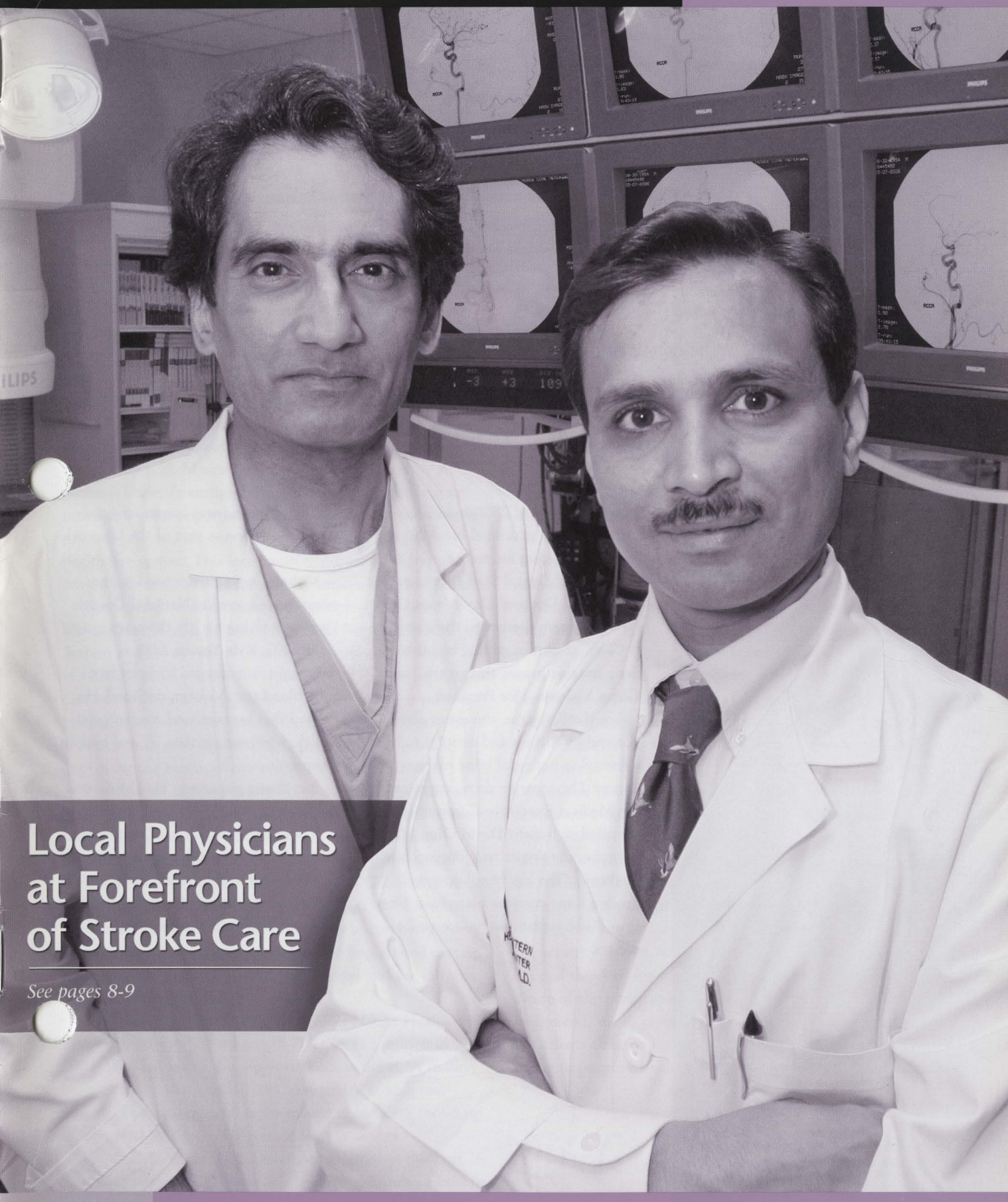
MOSES CONE HEALTH SYSTEM

VOLUME 4 | NUMBER 2 | JUNE 2006

MD journal

THE MOSES H. CONE MEMORIAL HOSPITAL
WESLEY LONG COMMUNITY HOSPITAL
THE WOMEN'S HOSPITAL OF GREENSBORO
ANNIE PENN HOSPITAL
MOSES CONE HEALTH SYSTEM BEHAVIORAL HEALTH CENTER
LEBAUER HEALTHCARE



Local Physicians at Forefront of Stroke Care

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MOSES CONE HEALTH SYSTEM

MDjournal

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ON THE COVER

Tony Deveshwar, *MD, (left) an interventional neuroradiologist, and* **Jay Ganji**, *MD, an interventional cardiologist, presented new techniques for treating stroke patients during a recent stroke conference at The Moses H. Cone Memorial Hospital.*

Billie Jo Boone, *Phlebotomist, Moses Cone Hospital*, takes blood from **Pramod Sethi**, *MD*, during a breakfast for National Doctors' Day.

Lab Work Proves a Big Draw on Doctors' Day

This year, a record 280 physicians turned out for an annual breakfast and free blood testing for members of the Medical and Dental Staff in recognition of National Doctors' Day. Moses Cone Health System sponsored the event.

"The interest in getting blood work done has just grown and grown," says **Glenn Visbeen**, *Vice President*.

For the first time, the event also allowed physicians and dentists to be screened as potential bone marrow donors. The separate drive, organized by the Medical Executive Committee, was intended to benefit **David Olin**, *MD*, a retired nephrologist and former chief of medicine. Olin has lymphoma and needs a bone-marrow transplant. More than 50 physicians were screened as donors.

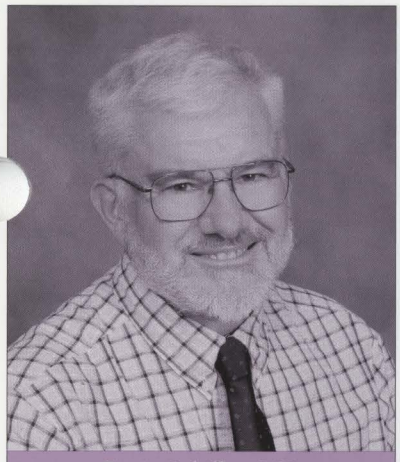
The screening was convenient since it could be done as part of the lab work process.

Visbeen, who participated in the event as well, credits National Doctors' Day with saving his life three years ago.

In 2003, **Kyle Young**, *MD*, a radiologist, encouraged Visbeen to sit for a blood test. Visbeen declined. He figured that he exercised, was in good health, was younger than 50 and had no symptoms.

But Young persisted. "He clearly was my guardian angel," Visbeen says now.

Visbeen's results showed an elevated PSA, which is the screening test for prostate cancer. Two weeks later, he was in surgery to remove the cancer. He has been cancer-free for three years.



Ernie Schiller, *MD*

Indigent Care: We All Have a Stake

by **Ernie Schiller**, *MD*
Chief, Pediatrics Service

As much as we doctors would like to practice in a bubble, two recent activities highlighted the importance of our being involved in the community and the importance of involving citizens in matters that affect not only their own health but also the health of our community.

One event was the 12th annual Mini-Internship Program sponsored by the Greater Greensboro Society of Medicine in partnership with Moses Cone Health System. Having a business leader from the community shadow you for a day provides a great opportunity to discuss not only the everyday practice of medicine, but also the problems facing our healthcare system. This internship opportunity happens only once a year and involves a relatively small number of people.

The second event touched more people. On April 20, Moses Cone Health System, High Point Regional Health System and the Guilford County Department of Public Health co-sponsored the first meeting and lecture on indigent care at the Greensboro Coliseum. This event was a wake-up call for us to invest our time and effort now in order to be able to continue to practice high-quality medicine while improving the health of our community in the future.

We all know uncompensated care is a growing problem. Meanwhile, managed care has placed more demands on our time and decreased our ability to recover compensation elsewhere in our practices. The indigent care conference highlighted many things I did not know. In Guilford County alone, there are 11,000 children and 52,000 adults with no insurance. I hope we all realize no care is uncompensated. All care creates overhead and expenses. Uncompensated care costs everyone – the providers, the hospital and the citizens of our community.

Costs for uncompensated care at Moses Cone Health System rose from $58 million in 2004 to $75 million in 2005. You may recall the politician's admonition: "A million here, a million there and pretty soon you're talking real money." The "real money" we're talking about here shows up as increased premiums for people with insurance.

The N.C. Institute of Medicine has found that this cost shift amounts to $400 per year of increased insurance cost for an individual and $1,100 in increased premiums for family coverage. We in Guilford County are among the most fortunate with HealthServe Community Health Clinic, Guilford Child Health and Moses Cone Health System and their commitment to the community. Ponder 1.5 million citizens statewide without insurance and another 1.2 million on Medicaid.

The Institute of Medicine has released a major position paper on the scope of the indigent care problem statewide. It offers suggestions for actions to begin to deal with North Carolina's uninsured crisis *(www.nciom.org)*.

Nearly 150 attended this breakfast meeting. Hospital administration was well represented. $75 million in costs and an almost 30 percent increase in lost revenue in one year got their attention.

The Guilford County legislative delegation was well represented as well as the health board and county commissioners. More than 63,000 uninsured individuals in Guilford County have gotten the attention of the legislators.

A handful of doctors attended. It is much more difficult for us to put a cumulative price tag on what uncompensated care means to us and our patients. The dollar costs to our offices are tough enough to track and tabulate. The lost revenue is even harder to calculate. Uncompensated care is often unscheduled and often begins at the Emergency Department. Unscheduled, insufficient care delivery is expensive and prevents our seeing other patients.

The Institute of Medicine is going to provide an opportunity to take action. Moses Cone Health System has opened the door for us. The politicians at the meeting were aware of the problem and that the uninsured can no longer be ignored. We as providers need to be ready to help shape the efforts directed toward the uninsured problem while trying to improve healthcare for everyone.

Ernie Schiller M.D.

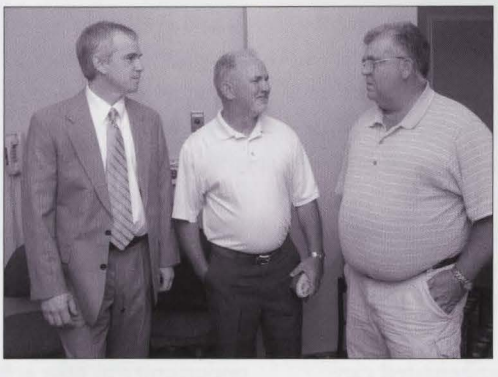
Joseph Stern, *MD, discussed a surgical procedure to treat Parkinson's disease recently at the N.C. Association of Operating Room Nurses meeting at Wesley Long Community Hospital.*

New Treatment for Parkinson's Disease Helps Control Tremors

A surgical procedure that treats the symptoms of Parkinson's disease by placing an electrode deep in the brain shows promise in helping patients have a better quality of life. This procedure is now available at Moses Cone Health System.

The N.C. Association of Operating Room Nurses recently saw a presentation by Greensboro neurosurgeon **Joseph Stern**, *MD*, and one of his patients, Larry Perry, at Wesley Long Community Hospital.

As onlookers watched, the Activa unit, which is implanted into the chest and delivers electrical impulses to the brain to stop tremors, was switched off. Tremors went through Perry's hands and arms. His speech slurred, and he had problems walking. The unit was turned back on and, just as quickly, the tremors disappeared.



Stern (left) talks with Larry Perry (center) and Glen Baldwin, two patients who received the implant to control their Parkinson's disease.

Perry said that the Parkinson's disease forced his early retirement from Lowes Foods, where he had been a project manager. He said the treatment enabled him to go back to work full time, to go hunting again and to trade in his wheelchair for a Harley-Davidson.

The procedure, which is an adjunct to drug therapy for Parkinson's, is particularly effective in a community hospital setting, Stern says. He pointed out that hospitals close to patients have the advantage because patients have to return frequently to have the equipment monitored and adjusted – and because a close relationship develops between the patient and the provider.

"For me, it is very gratifying, and I enjoy the work I am able to do," Stern says.

The particular technology has been around for years. More recently, the American Academy of Neurology has recommended that the procedure be done earlier as part of the overall treatment of Parkinson's disease.

Patients undergoing the procedure have MRI and CT scans to pinpoint the precise spot where the electrodes will go. A hole is bored into the skull, and the electrodes are inserted into the brain. The patient, who is awake during the procedure, is asked to do simple tasks, like pick up a coffee cup, to measure how effective the adjustments have been.

It has been effective for Perry, whose sense of humor remains. He says he's discovered that just because he can do things doesn't necessarily mean he should.

Take the Harley. Please.

"I laid it down and broke my leg in two places," he said. "I got rid of that thing."

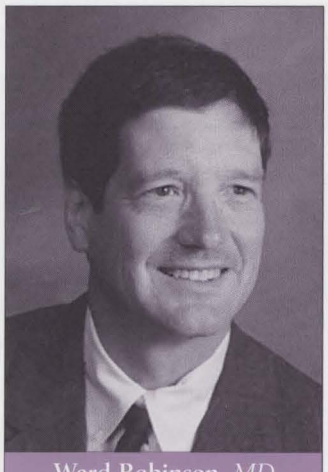
Want to Save Lives? Practice Hand Hygiene

by Ward Robinson, *MD*
Medical Director, Infection Control

The major source of transmitting bacterial pathogens from patient to patient is the hands of healthcare workers.

The earliest and most damning evidence of that came from the Vienna Birthing Center a century and a half ago. In 1833, a midwife team and a teaching program of physicians alternated caring for patients. Within months, the mortality of the teaching program was 10 times that of the midwives.

Ignaz Semmelweis, the Hungarian-born physician in charge of the teaching service, realized that the teaching staff performed autopsies and the midwives did not. He suspected that the doctors contaminated their hands with "cadaveric particles" and carried this contagion back to the birthing rooms. Semmelweiss introduced the first hand hygiene measure, requiring physicians to wash with a solution of chlorinated lime (think Clorox). Immediately, the mortality on the teaching service plummeted to that of the midwives.



Ward Robinson, *MD*

Semmelweiss' reward for saving lives? He was fired. Then, he developed rapidly advancing dementia and psychosis, was institutionalized in a mental hospital and was beaten to death by an "orderly" – such is the price we in Infection Control must pay for our devotion to the cause.

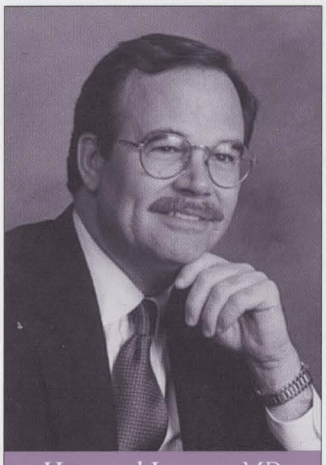
Several observations arise from this historic vignette:

1. The consequence of improper hand hygiene is the transmission of significant pathogens and antimicrobial-resistant organisms from patient to patient. We are now inundated with Vancomycin-resistant enterococcus, methicillin-resistant Staphylococci and Clostridium difficile.
2. Death can occur as a result of inattention to hand hygiene practices. Because the transmission occurs invisibly, no individual can be blamed for an epidemic. But the ongoing epidemic of bacterial pathogens in our hospitals is a direct effect of inadequate participation with infection control policies.
3. Hand hygiene is about the use of ***medicated*** soap or alcohol hand gels. Soap and water are used to remove visible debris or soil and to remove Clostridium difficile spores that may be resistant to medicated soap and alcohols.
4. Repeated use of any hand hygiene product, at the frequency our jobs demand, can and will lead to hand irritation/ dermatitis. But hand irritation is never an excuse for not performing hand hygiene. It's a small sacrifice to pay for keeping your patients alive and safe. The Infection Control department and Employee Health will work with you to find solutions – there are multiple formulations of alcohol solutions and gels that we can substitute if you can't tolerate Endure.
5. Hand hygiene is not optional. Every nosocomial outbreak investigation of the last century has linked hospital epidemics to the inadequacy of hand hygiene practices. Every intervention to stop the epidemic includes intensified hand hygiene. Since we are in the midst of many epidemics (VRE, MRSA, CDAD), we can conclude that our hand hygiene practices are substandard.

So go forth and rub your hands. I will write more about infection control practices in future issues of **MD***journal*.

EFFECTIVE HAND HYGIENE

1. **On entering a patient's room**, squirt alcohol gel into your palm. While you walk to the bedside and introduce yourself to the patient and family, rub the alcohol gel over the entire surface of both hands. If you need to touch the patient before the alcohol has dried, you can touch dry skin. Alcohol in the eye or in a wound would not be pleasant for the patient or healthcare provider.
2. **On exiting a patient's room**, squirt alcohol gel into your palm and rub it in while you contemplate your next task. Proper hand hygiene entails using the alcohol gel BEFORE and AFTER examining the patient.
3. **If the patient is on contact isolation**, rub your hands with alcohol gel, don a gown and then put on gloves. Once the exam is finished, remove the gloves and gowns in the room. Then use the alcohol hand rub or, if the patient has C. difficile disease, wash your hands with soap and water (plain soap is sufficient in this case).



Haywood Ingram, *MD*

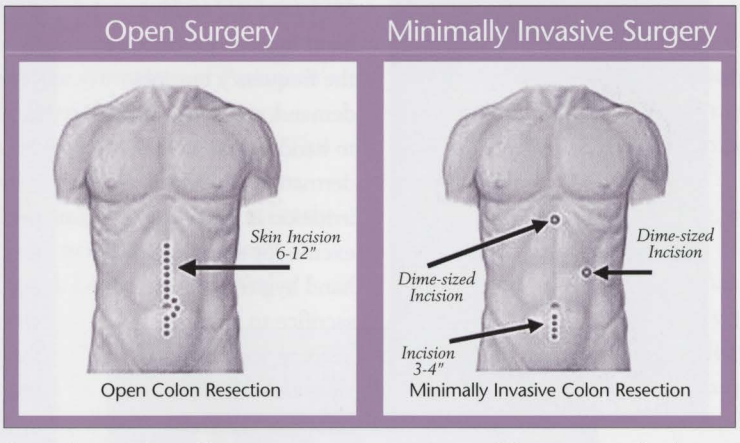
Laparoscopic Colon Surgery Decreases Pain, Recovery Time

Laparoscopic colon surgery to treat a variety of diseases offers patients many advantages, including reduced post-operative pain, a shorter hospital stay, an earlier return to a normal diet, a lower risk of complications and less scarring.

"It is now becoming the preferred approach in many, if not most, cases," says **Haywood Ingram**, *MD*, a general surgeon and president of Central Carolina Surgery. "All patients are potential candidates for this approach."

Surgery can be done laparoscopically for colon diseases, including cancer, Crohn's disease, ulcerative colitis, premalignant polyps, diverticulitis and colostomy procedures. "We are doing in Greensboro what all university hospitals are doing," Ingram says.

Rather than using a 30- to 40-centimeter incision for the standard open surgery, the laparoscopic procedure is done through a tiny hole (about 3 to 12 millimeters) in the patient's abdomen. The patient's abdomen is filled with carbon dioxide, and a video camera is inserted to display the surgical site on monitors in the operating room. "With the video monitors, everyone who's participating in the surgery has the same excellent view," Ingram says. Surgeons operate using instruments inserted laparoscopically, through trocars.



While many patients are candidates for laparoscopic colon surgery, the surgeon selects the best approach in each case. The removal of large colon tumors, for instance, may not be done completely laparoscopically. Many times, it requires an open surgery or, at least, an additional small incision of 5 to 8 centimeters to remove the tumor.

Research has shown that the laparoscopic technique has no negative effect on cancer recurrence rates, Ingram says.

Most patients see a 20 percent to 30 percent reduction in their hospital stay with laparoscopic colon surgery and go home after about three to four days. Patients can often resume work or normal activity after about two to three weeks, versus four to six weeks for open surgery.

In addition to colon surgeries, general surgeons in Greensboro use laparoscopic techniques for a variety of procedures, including hernia operations, splenectomies, adrenalectomies and bariatric surgeries.

"All patients are potential candidates for this approach."

Medical Staff Leaders Develop Quality/Safety Initiatives

Work Begins on an Electronic Medical Record


Melissa Taylor, *MD*

As chairwoman of the Medical Information Systems Committee, **Melissa Taylor**, *MD*, is preparing for a paperless medical record also known as an Electronic Medical Record or EMR.

President George W. Bush established the goal of a totally paperless system by 2012. Several Quality Improvement institutions have included an EMR with Computer Physician Order Entry (CPOE) in their list of top quality goals for medical institutions nationwide.

"To meet these standards and goals set forth by standard quality improvement overseers, we must start now to prepare the people, projects and products for the future," Taylor says. "Our vision is to develop a multidisciplinary CPOE committee that will complete multiple short-term and long-term projects that will prepare the Health System to go paperless."

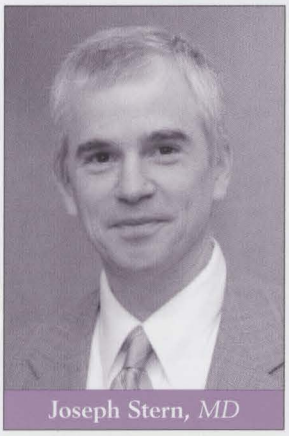
Plans are under way to interact more formally with the Medical Staff. "Time will tell how effective our efforts will be," Taylor says. "Helping to change the culture of a group of individuals is often challenging. But these changes will provide safe, effective patient care and ultimately result in an environment where physicians can thrive and function."

In her committee role, Taylor facilitates communication between the Medical Staff, the information technology staff and hospital administration. She encourages Medical Staff involvement in current and future information technology projects and educates committee members and the medical staff about current technology at Moses Cone Health System and future needs related to compliance and regulations.

FOR ADDITIONAL INFORMATION, VISIT

www.leapfroggroup.org/news/leapfrog_news/97902 or
www.qualityforum.org/txsafeexecsumm+order6-8-03PUBLIC.pdf.

Medical Director Works with Rehabilitation on Quality Initiative


Joseph Stern, *MD*

Joseph Stern, *MD*, Medical Director of the Neuroscience and Neuro Intensive Care departments, is working with **Karen Black**, *Director, 3000, Neuroscience*, and **Susan Davis**, *Director, Acute Rehabilitation Services*, to improve the timeliness of physical therapy treatments for patients.

"This effort of coordination between the nurses, physical therapy staff and physicians will provide better care to the patients and improve the Health System's length of stay," Stern says.

Stern's current initiative involves measuring how quickly patients receive an assessment for rehabilitation services and how soon those services are performed. The team is continuing to gather data and has not given a formal report.

"The goal is not to create new clinical pathways but to improve on already existing ones," Stern says. "The quicker a patient is up and ambulated, the better they are." Stern says quality improvement is not about creating more work. It is about physicians, administrators and other clinicians being proactive and anticipating patients' needs.

As medical director of these departments, Stern collaborates with hospital administration to resolve problems, foster professional relationships and improve the quality of care for patients. His role helps physicians, administrators, nurses and other clinical staff work together to deliver patient care more effectively.

Interventional Cardiology Procedure Could Lessen Risk for Stroke

Physicians have long known that a certain procedure that helps the heart also can help the brain – and for the first time, patients in Guilford and surrounding counties will be able to have the procedure done close to home at Moses Cone Health System.

Jay Ganji, *MD*, an interventional cardiologist, will begin offering the patent foramen ovale (PFO) closure procedure, according to an announcement in late March at the Health System's Acute Stroke Treatment Update: 2006 meeting.

The PFO is an opening in the fetal heart, between the left and right atrium. The opening allows blood to bypass the lungs before birth, because fetuses get their oxygen supply from the mother.

"When the baby takes his first breath, the pressure goes up on the left side and closes it," Ganji says. "Once it closes, it is supposed to stay closed, but between 15 percent and 25 percent of the population may have a small hole that is not clinically significant."

Ganji says that medical research shows that people younger than 55 who have had a stroke – and who do not have risk factors including smoking, a family history of stroke, diabetes, hypertension and illicit drug abuse – often also have a PFO that did not close at birth.

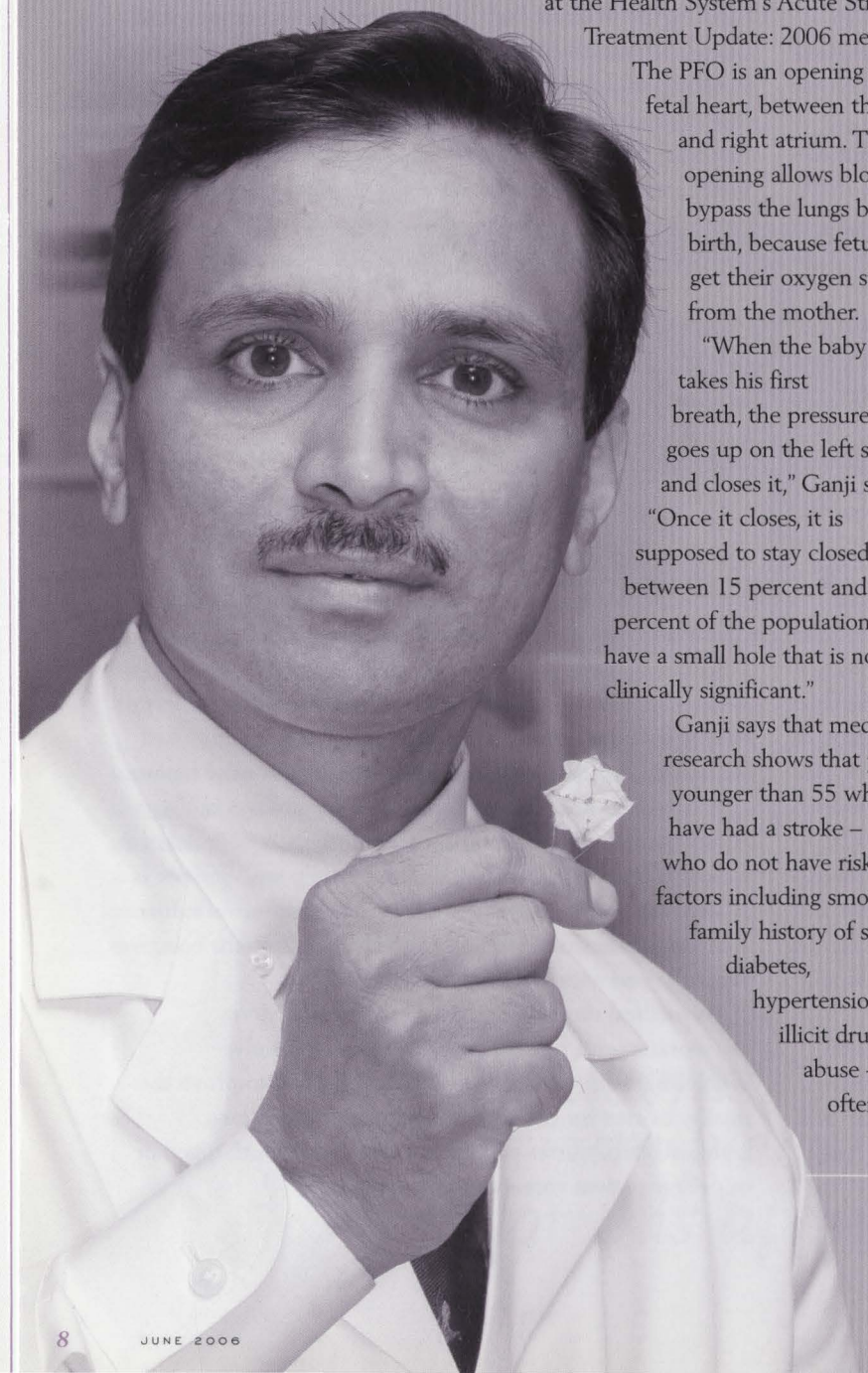
The patient could be facing a 10 percent to 15 percent chance of having another stroke. Closing the PFO reduces the chances to less than 2 percent, Ganji says.

Patients are identified through transesophageal echocardiograms and consultation with neurologists. Then, Ganji uses cardiac catheterization to thread a tiny device, which is similar to two unopened umbrellas, into the heart. At the opening, the two umbrellas are opened, with one on one side of the opening and the other on the other side, then tightened together and left in place.

Ganji added that some patients older than 55 also benefit from the procedure in an appropriate clinical setting.

Pramod Sethi, *MD, Medical Director, Moses Cone Health System Stroke Center*, said the best treatment option for stroke is still a subject of ongoing research.

"The best treatment for PFO and stroke patients is yet undecided, and ongoing trials will determine whether PFO closure is better than maximal medical therapy," Sethi says. "The Food and Drug Administration has given only a limited human device exemption approval to two PFO closure devices, hence this should be done in only carefully selected patients who will be closely monitored as part of an institution-approved protocol."

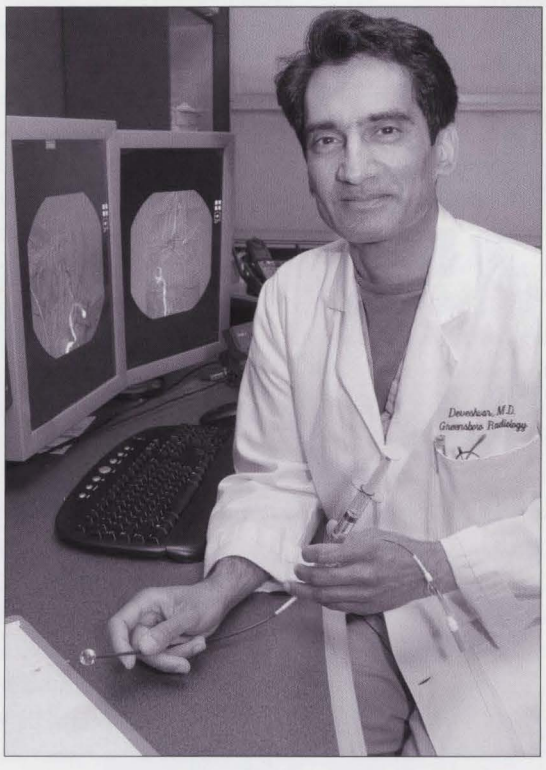


Jay Ganji, *MD, holds a device used to close PFOs in patients' hearts, which could decrease their risk for strokes.*

Merci Device Limits, Reverses Stroke Damage

Physicians who treat stroke patients at Moses Cone Health System have one more weapon in their arsenal with the Merci device, which ensnares and removes blood clots in the brain.

Sanjeev "Tony" Deveshwar, *MD*, gave a presentation about the device to the Health System's Acute Stroke Treatment Update: 2006 meeting in late March.



Deveshwar says that the idea is to use a mechanical means to establish blood flow to save brain tissue – and therefore reduce brain damage – either without using a clot-busting drug or by using it in the smallest dose possible. The drug – tissue plasminogen activator or tPA – is a thrombolytic agent that dissolves blood clots, but it carries a risk of causing bleeding in the brain.

"It allows us to increase the window of opportunity for removal of these clots," says Deveshwar, an interventional neuroradiologist.

To remove the clot, an angiogram is done to precisely determine its location. The Merci Balloon Guide Catheter is inserted through a small incision in the femoral artery in the groin – then guided by X-ray up to the carotid artery in the neck, according to Concentric Medical, which makes the device. A guide wire and the Merci Microcatheter are pushed through the catheter to a location just beyond the clot.

Deveshwar says that a balloon is then inflated in the artery to temporarily stop blood flow, while the retriever device, which looks similar to a corkscrew, snares the clot. The clot is then suctioned out of the body, and the balloon is deflated to restore blood flow. Dye is injected, and an X-ray is taken to determine if the artery has successfully been reopened.

The idea is to reverse as much of the brain damage as possible. A blood clot will starve some brain cells of oxygen and nutrients but leave other nearby cells potentially salvageable if blood flow is restored quickly, Deveshwar says.

Given the incidence of stroke in the Southeast, the Merci device – and its use at Moses Cone Health System – is an important step to improve stroke care in this region, Deveshwar says.

"We get patients from as far away as southern Virginia to Asheboro," he said. "With the success of this treatment, we can offer it to a larger population with improved neurological outcomes."

Pramod Sethi, *MD, Medical Director, Moses Cone Health System Stroke Center*, agreed.

"Early revascularization of blocked arteries is important for better clinical outcomes," he says. "The Merci device is an important advance in this direction and, in fact, is the first device to get limited FDA approval with human device exemption to remove blood clots from the brain. It should be used in certain carefully selected patients only at stroke centers with trained neurointerventionalists. It is being studied in new trials both with and without thrombolytic drugs to achieve better recanalization rates."

Bariatric Surgery Trial Combines Two Procedures

Kristen Hardcastle, *MD*

Surgeons at Moses Cone Health System are taking part in a pilot study that combines two surgical procedures to fight obesity, according to **Kristen Hardcastle**, *MD, Medical Director, Bariatric Surgery Program.*

The procedures are laparoscopic adjustable gastric banding – in which an adjustable band is surgically placed to reduce the size of the stomach – and truncal vagotomy, in which the vagus nerve is severed as it enters the abdomen.

The banding has the advantage of making the patient feel full after a small meal. The vagotomy makes the stomach feel full longer and gives the stomach an intolerance for meals high in carbohydrates.

That means that patients who eat what they shouldn't will have nausea, cramping, vomiting, sweating and diarrhea, which researchers believe will help ensure compliance to a diet.

Appropriate candidates for the procedures are those with a body mass index (BMI) of 40 to 50. Candidates with a BMI of 35 to 40, with at least two co-morbidities, such as diabetes, hypertension or obstructive sleep apnea, also qualify.

Hardcastle said that one advantage to the study is that it gives patients in the area an opportunity to be treated and have their cases followed close to home.

"Until now, patients had to go to Charlotte, to Duke or to UNC to be enrolled in a bariatric clinical trial," Hardcastle says. "Patients in this study won't have to leave the Triad."

Letter to the Editor

One afternoon in March, **Michael Mattingly**, *MD*, was inside his car, waiting for the light to change on Wendover Avenue. The driver of the car next to him began motioning for him to lower his window. Reluctantly, he did so. The driver asked him what his license plate meant.

Dr. Mattingly said, "KIDNEY, I'm a kidney doctor."

The man started talking about his mother's situation. Dr. Mattingly told him to call his cell phone and gave him the number. When the call came in, the man began expressing concerns about his mother, who is a dialysis patient and had been at a medical facility in Raleigh. But she had been transferred to a nursing facility in Illinois – 800 miles away. The man explained how this was causing much emotional distress for his mother and their family members. Dr. Mattingly assured the man that he would check into the situation and get back to him.

After researching what had transpired and contacting the medical facilities and care providers, Dr. Mattingly facilitated the patient's transfer back to North Carolina. She is now a resident at an Asheboro nursing home and is receiving dialysis treatments at one of the Carolina Kidney Centers there.

The patient said that just before he saw Dr. Mattingly's license plate, he was "banging his head on the steering wheel, asking God to give him a sign about what to do next."

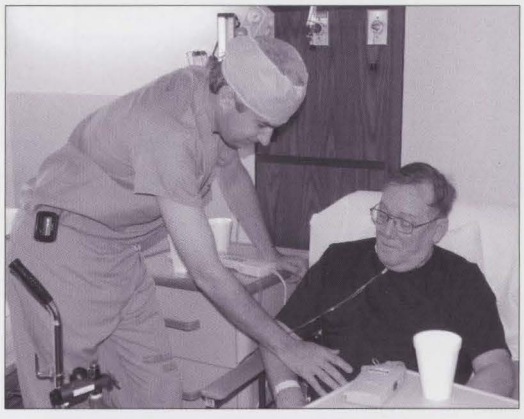
This is just another miracle that has involved a member of Moses Cone Health System. We never know when or where it can happen.

The staff of 5500, Medical/Renal Department, at The Moses H. Cone Memorial Hospital is proud of Dr. Mattingly for going beyond the extra mile.

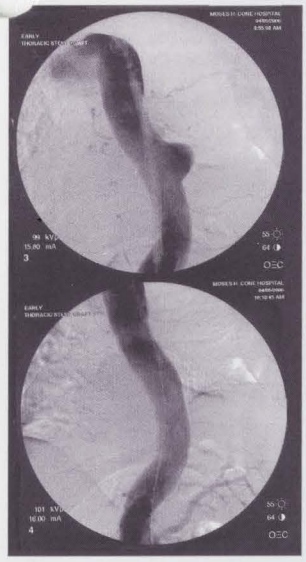
Susan Brady, RN

ON THE
cutting edge

Thoracic Aneurysm Now Corrected in Less Invasive Surgery



Todd Early, *MD, checks on Bob Carter the morning after his surgery.*



These images show Bob Carter's thoracic aneurysm before and after it was corrected with a thoracic stent graft.

Given the choice between open-chest surgery and being the first patient in Greensboro to undergo a new procedure, Bob Carter's decision was an easy one. He opted for a new thoracic stent graft to correct his aortic aneurysm.

"I've never had the other (open-chest surgery), but I imagine it would be a whole lot more difficult than this," Carter said the day after his procedure. "I'm glad this was available to me."

Todd Early, *MD*, and **Edward Gerhardt**, *MD*, performed the procedure in April using a device that was FDA-approved in the fall of 2005. The self-expanding stent is attached to a fabric graft. It is positioned in the thoracic aorta via a catheter introduced from the patient's groin. Once the stent reaches the proper place, it is deployed. The stent graft attaches to the artery and seals the aneurysm.

Similar technology was approved to correct abdominal aortic aneurysms in 2000.

The new method offers patients the advantage of not having to endure an open-chest procedure, in which surgeons stitched the graft into the aorta.

"A certain number of patients couldn't tolerate the standard open operation," Early notes. "Typically, with this new procedure, there is a lower risk of perioperative complications, a lower risk of paralysis. Patients typically go home in several days rather than spending a week in the hospital."

In clinical trials, endovascular thoracic aortic aneurysm repairs had about one-fifth the rate of paraplegia/paraparesis of an open surgery (3 percent versus 14 percent), Early says. The new procedure has about a 1 percent mortality rate, compared to a 6 percent mortality rate for an open procedure.

The success of the procedure hinges on the preoperative planning, Early says. "We use CT scans and arteriography to determine whether a patient is a candidate," he says. "Once we determine the patient can have the procedure, we're confident we'll be able to seal it with this new technology."

As for Bob Carter, Early saw him in a follow-up visit in May. He's doing fine.

Know a physician who has been published, received an award, is pioneering a new technique or is otherwise "on the cutting edge"?
Contact MD*journal at 832-6516 or e-mail newsletter@mosescone.com.*

CONSTRUCTION UPDATE

The following projects are continuing throughout Moses Cone Health System, according to **Ron Galloway**, *Director, Construction Management, who was interviewed in May:*

At **The Moses H. Cone Memorial Hospital**, construction on the new Moses Cone Health System Heart and Vascular Center is continuing and should be complete by the end of the summer. After the new Heart and Vascular Center is occupied, the vacated space on the second floor of Moses Cone Hospital will be renovated.

CT Room 1 in the Radiology Department also is being renovated. Once complete, the room will accommodate a new 64-slice CT scanner for cardiac studies.

Development of the Moses Cone Hospital master facility plan is under way. This six-month process should be complete by early fall.

At **Wesley Long Community Hospital**, work on the East Tower renovation is complete. Occupation of the East Tower began in mid-May and will continue through mid-June. All nursing units, except the Intensive Care Unit, will be located in the East Tower. Phase 2 construction to the West Tower will start in late summer.

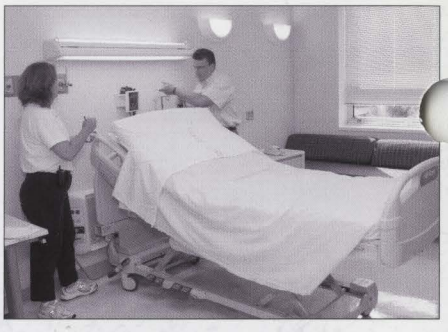
In February, construction began on an enclosed patient elevator to improve accessibility to the lithotripsy pad. The project should be complete by the end of June.

Design options are being considered for the expansion of the **Regional Cancer Center**. The designs will combine renovation to existing space and new construction. A design plan should be ready by the end of the summer. Work on this project could begin in FY 2007. Construction to reconfigure the Post Anesthesia Care Unit at The Women's Hospital of Greensboro has been put on hold. Work to address window leaks and to renovate rooms on the third floor is complete.

At **Annie Penn Hospital**, work is complete on a new exterior stucco finish on the surgical tower, which will eliminate future problems with water infiltration.

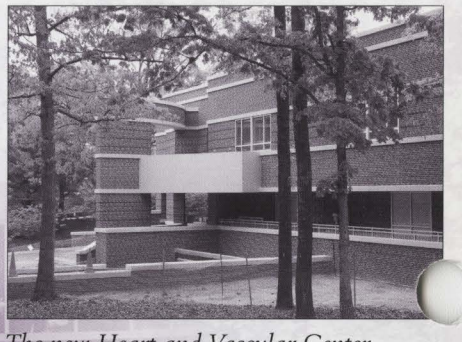
A certificate of need application has been submitted to the state to expand and renovate the Emergency Department. The renovation will occur, pending approval from the state. Work continues to expand and reconfigure existing parking areas to maximize parking for staff and visitors. Parking lot construction will begin this summer.

Renovations at **LeBauer HealthCare at Elam** are nearly complete. Clinical areas should be fully occupied by June.



Dianne Quillen, *Patient Care Support Manager, and* **Mike Cooke**, *Plant Manager, help move a bed into a patient room on the renovated sixth floor of Wesley Long Community Hospital.*

(At lower right), **Mark Johnson**, *PC Systems Specialist, MIS, installs a computer in the newly renovated East Wing of the hospital.*



The new Heart and Vascular Center (shown above and below) is expected to be completed by late summer.

Six Sigma Project to Improve Reimbursement for Patients Under Observation

The latest Six Sigma project at Moses Cone Health System kicked off in February with an aim to improve the tracking and management of patients under observation status.

If hospital staff is not careful and precise in its management of patients under observation, the result can be a denial of reimbursement from Medicaid, Medicare and private insurance companies.

Observation status is an outpatient category used when a patient needs short-term treatment or evaluation for inpatient admission. Observation status generally does not exceed 24 hours. It should not be used for the convenience of the patient, family or provider. Patients should not be put on observation status for routine recovery following outpatient surgery, cardiac catheterization or other types of outpatient procedures.

Six Sigma methods will be used to look specifically at the observation process at Wesley Long Community Hospital, where 1,800 to 1,900 observation patients are managed annually.

Angie Orth, *Vice President/Administrator*, is the Project Champion for the team, and **Susan Thompson**, *Director, Admissions Services*, will be the Process Owner. She will coordinate and manage the team's activities under the guidance of **Susan Ellzey**, *Black Belt, Quality*. The team includes representatives from a variety of departments and disciplines as well as **George Osei-Bonsu**, *MD*, with Eagle Hospitalists.

"Although the project focus is at Wesley Long Community Hospital, we hope that process changes will eventually be rolled out Systemwide," Ellzey says.

COMMON USES FOR OBSERVATION STATUS:

- *Chest pain requiring ongoing testing to rule out a myocardial infarction or unstable angina.*
- *An unanticipated complication following outpatient surgery requiring further testing and/or observation to determine stability or need for admission.*
- *Acute exacerbation of asthma.*
- *Mild exacerbation of congestive heart failure.*
- *Acute abdominal pain.*

CRITERIA FOR OBSERVATION STATUS:

- *Patient is medically unstable for immediate discharge to home, and the physician needs additional time to evaluate the patient to determine his/her need for inpatient admission.*
- *Patient requires aggressive, rapid intervention, and/or access to diagnostic testing.*
- *Patient can likely be stabilized within 15 to 23 hours and transitioned to an alternate level of care/home.*
- *Patient's insurance plan covers observation care.*

Patient Satisfaction Data Now Available

After collecting several months of data from the new telephone surveys of patients, Moses Cone Health System has established goals for patient satisfaction among inpatients, outpatients and Emergency Department patients.

The new survey offers more detail into the patient's experience, faster response time and allows staff to tie patients' clinical outcomes to their patients' satisfaction.

Three-month trend charts have been compiled reflecting how patients rate the quality of care and service they received while in the hospital. Additional charts reflect the degree to which patients would recommend the hospital to others.

The new company, called Premier, replaces Press Ganey, which surveyed patients in the past.

For copies of the trend charts, contact **George Karl**, *Director, Service Excellence*, at 832-7090.

Ken Roberts, *MD, accepts his award from Diane Kittredge, MD, Immediate Past President, Ambulatory Pediatrics Association.*

Roberts Delivers Major Pediatrics Speech

Ken Roberts, *MD, Director, Moses Cone Health System Pediatric Teaching Service*, recently delivered the George Armstrong Lecture at the annual meeting of the Ambulatory Pediatric Association (APA).

Roberts joins four U.S. surgeon generals, former FDA Commissioner David Kessler and other major figures in medicine, including Benjamin Spock, MD, in delivering the address.

"I am well aware of who the past Armstrong Lecturers have been, and I am both proud and humbled by the knowledge that my name will appear on a list with theirs," Roberts says.

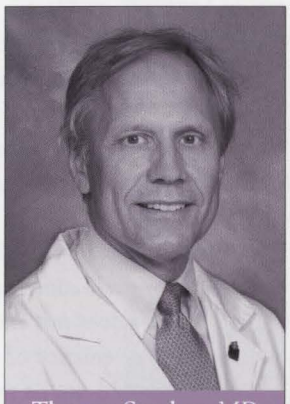
According to the APA, Roberts was honored "for his exceptional skills as a clinician and teacher and for his wide-ranging contributions to the field of pediatric education."

Roberts received a standing ovation for the April 30 speech at the annual APA meeting in San Francisco. He spoke about child health services in communities that don't have university or children's hospitals.

"I chose this topic in part because of my own experiences in such communities but also because the members of the pediatric academic societies work in university or children's hospitals and generally have a limited view of child health nationally," Roberts says. "The question I want to invite people to think about is who is worrying about all the children in a region and what are they doing about it?"

He specifically addressed emergency and critical care services for children, primary care for poor children, and the role the new breed of hospitalists and community hospitals can play.

Roberts is also a professor in the Area Health Education Center program in the Department of Pediatrics at the University of North Carolina at Chapel Hill School of Medicine. He has been part of Moses Cone Health System since 1997.



Thomas Stuckey, *MD*

Cardiac Researcher Presents Findings in Paris

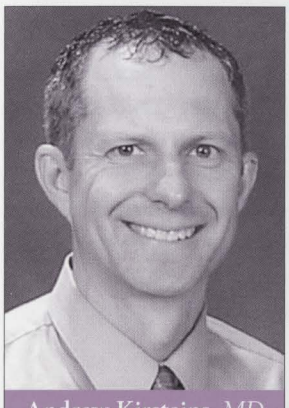
Thomas Stuckey, *MD*, presented research findings involving care given to diabetics at a major European cardiology conference in Paris. Stuckey attended the Paris Course on Revascularization (EuroPCR) in May. He is an interventional cardiologist with LeBauer HeartCare and part of the LeBauer Cardiovascular Research Foundation.

"Greensboro is fortunate to have Dr. Stuckey and his team of research scientists bringing clinical trials to Moses Cone Hospital," says **Charles Wilson**, *MD, Medical Director, Moses Cone Heart and Vascular Center*. "By having these trials performed locally, our community becomes exposed to the newest methods and tools as soon as they become available."

Stuckey presented the results of an 11-hospital trial that looked at two different drug-eluting stents placed in diabetics to treat heart disease. The study followed the patients for nine months and found no difference in their outcomes.

EuroPCR is a top conference in Europe for cardiac and vascular researchers.

Kirsteins Honored for Shoulder Pain Study in Stroke Patients



Andrew Kirsteins, *MD*

Andrew Kirsteins, *MD, Medical Director, Center for Pain and Rehabilitative Medicine*, has received the American Congress of Rehabilitation Medicine's 2005 Sidney and Elizabeth Licht Award for Excellence in Scientific Writing for a paper he co-authored.

The paper, "Intramuscular Neuromuscular Electrical Stimulation for Poststroke Shoulder Pain: A Multicenter Randomized Trial," focused on a study out of Case Western Reserve University School of Medicine. Kirsteins completed his part of that study while he was practicing at the Charlotte Institute of Rehabilitation.

Stroke patients with hemiplegia and shoulder subluxation have a 50-50 chance of developing shoulder pain that can become severe, Kirsteins says. The study looked at patients who had chronic shoulder pain on the same side as their hemiplegia for longer than six months. It divided the patients randomly into a group that used an arm sling (current treatment) and a group that had electrodes implanted into muscle around the shoulder girdle. The electrodes were connected to a pager-sized stimulator.

The implanted muscle electrodes were used six hours per day for six weeks. Thirty-four percent of the treatment group achieved pain-free status that persisted until the six-month follow-up visit. Less than 10 percent of the control group had a pain-free status.

Also, about 60 percent of patients in the treatment group had a significant pain score reduction versus 20 percent in the control group, with effects persisting at least until the six-month follow-up visit.

"The mechanism of action appears to be a neuromodulation effect rather than a muscle strengthening effect," Kirsteins says. "The device is currently being evaluated for FDA approval."

Steve Reece, *MD, now practices with Advanced Orthopaedic Centers in Richmond.*

Former Sports Medicine Fellow Honored in Richmond

Steve Reece, MD, who was a fellow in primary care and sports medicine in the Moses Cone Health System Family Medicine Residency Program in 1997-98, was named one of three top sports medicine physicians in Richmond, according to a poll by Richmond Magazine.

Reece graduated from the Medical College of Virginia in Richmond and is now an assistant clinical professor of family medicine at Virginia Commonwealth University. He practices at Advanced Orthopaedic Centers in Richmond.

New Interns Start in Family Medicine, Internal Medicine

The Family Medicine and Internal Medicine residency programs have recruited new first-year residents, who will be trained in June and start work on July 1. Leaders of both programs say they are pleased with this year's match.

"We have more Alpha Omega Alpha (medical school honor society) folks then we have ever had in one group, and the clinical letters and test scores for our new interns are most outstanding," says **Sam Cykert**, *MD, Director, Internal Medicine Residency Program*. "Hopefully, clinical performance will match the excellence that we have on paper."

Bert Fields, *MD, Director, Family Medicine Residency Program*, expressed similar satisfaction with the class of new residents this year.

"We were delighted to attract as talented a group of interns as we have recruited since my arrival in 1984," Fields says. "Five of these interns had done rotations at Moses Cone Health System and performed exceptionally well. The remaining three interns visited here two to three times and had a great opportunity to see the high-quality teaching that our residents receive. We look forward to all of them becoming great additions to our medical community."

The Internal Medicine residents and their medical schools are:

Elizabeth "Liz" Agnew, *DO*
Philadelphia College of Osteopathic Medicine
Yogesh Bhusal, *MD*
Tribhuvan University (Nepal)
Will Corcoran, *MD*
Wake Forest University School of Medicine
Donna Culton, *MD*
University of North Carolina at Chapel Hill School of Medicine
Veronique Duguay, *MD*
Universite de Sherbrooke (Canada)
Todd Eckelberg, *MD*
New York Medical College
Lauren Golding, *MD*
Duke University School of Medicine
Estela Hernandez, *MD*
Universidad Nacional P. Henriquez Urena (DR)
Isabel Newton, *MD*
Wake Forest University School of Medicine
Sangeeta Sastry, *MD*
Kempegowda Institute (India)
Fabian Rodriguez, *MD*
East Tennessee State University

The Family Medical residents and their medical schools are:

Melissa Bagwell, *MD*
University of Mississippi
Katherine Fuchs, *MD*
Temple University
Heidi Grandis, *MD*
UNC-CH School of Medicine
Aaron Leininger, *MD*
UNC-CH School of Medicine
Joe Pye, *MD*
St. George's University (Grenada)
Makeecha Reed, *MD*
Wake Forest University School of Medicine
Mark Rowand, *MD*
Penn State College of Medicine
Kristen Samuhel, *MD*
UNC-CH School of Medicine

The Sports Medicine fellows and their medical schools are:

Adam Kendall, *MD*
UNC-CH School of Medicine
Ryan Modlinski, *MD*
Medical College of Virginia

The Obstetrics fellows and their medical schools are:

Tracey Williams, *MD*
University of Kansas School of Medicine
Angie Brown, *MD*
The University of Tennessee Health Science Center

New Program to Improve Documentation and Reimbursement

The Care Management and Medical Records departments of Moses Cone Health System have launched a documentation improvement program at The Moses H. Cone Memorial Hospital to more accurately reflect patients' severity of illness and their risk of mortality as well as to increase rates of reimbursement.

Four experienced nurses will concurrently review the charts of Medicare patients at Moses Cone Hospital looking for ways to improve clinical documentation. These nurses will communicate with physicians and other healthcare team members, either in person or in writing, to ensure that the Health System is appropriately capturing inpatients' acuity and severity of illness.

If there is a question, the practitioner will see a query sheet (bordered in bright blue and located in front of the most recent progress note) asking for clarification of the patient's clinical status or treatment plan. If the provider agrees, he should clarify the diagnosis or plan in the progress note. If he disagrees with the query, just noting "no" on the query sheet is all that is required.

Upon discharge, the coders will be able to capture this data, which will more accurately reflect how ill patients are and support the treatment rendered.

The program was developed after consultants with 3M HealthGrades reviewed a random sample of 150 Medicare inpatient records to assess DRG assignment and profiling opportunities in October 2005. Successful implementation of the Quality Excellence Program (QEP) will improve the validity of the Health System's mortality index report, increase Case Mix Index (CMI) from 1.4923 to 1.5722, and result in an estimated Medicare savings opportunity of $1.8 million for fiscal year 2006.

Grant Helps Improve Diabetes Care

The Outpatient Clinic at Moses Cone Health System is taking steps to improve its diabetes care, thanks to a grant from the Moses Cone-Wesley Long Community Health Foundation.

Rita Layson, *MD, Medical Director, Outpatient Clinic, The Moses H. Cone Memorial Hospital*; **David Talbot**, *MD*, the former medical director of the Outpatient Clinic and now a physician at HealthServe Community Health Clinic, and other clinical staff applied for the grant in 2004 after a medical resident presented a case study outlining opportunities for improvement in diabetes care. The physicians found that often diabetes care was not coordinated, and patients lacked the resources and education needed to help themselves.

After receiving the grant, the Health System hired **Donna Riley**, *Diabetes Program Coordinator, Outpatient Clinic*. Riley began working on implementing the new program based on the six components of the Chronic Care Model:

Self-Management Support Educating patients to take a central role in managing their disease.

Decision Support Adopting standards of care based on good evidence for improving health and creating protocols to guide care according to these standards.

Patient Registry Using a database that tracks diabetes care, reminds patients and clinical staff when care is needed and measures quality of care. (The Outpatient Clinic Diabetes program is using Diatrends, a diabetes database developed by **Charles Gegick**, *MD*, and **Michael Altheimer**, *MD*.)

Delivery Design Changing how care is delivered to improve coordination, efficiency and effectiveness.

Community Resources and Policies Working with community organizations to develop programs and policies that support chronic disease care.

Health Care Organization Promoting chronic disease care as an integral part of the organization's annual plan.

Health System Opens Fund Development Office


Bill Porter

For the first time, Moses Cone Health System will formally solicit money from outside sources. While Health System finances remain strong, the new Fund Development office will help offset the growing costs of caring for the uninsured, as well as provide a way for those already giving to healthcare organizations to keep their donations within the community. **Bill Porter** is the new *Vice President, Fund Development*.

The Fund Development office will focus on applying for healthcare grants and will provide an easy way for people in the area, who currently give money to healthcare providers outside the community, to support local healthcare. The program will not initially involve any community-wide fundraising and will be carefully overseen by the Board of Trustees.

Porter recently ran William A. Porter Consulting in Winston-Salem. The consulting business helped non-profit groups with annual and capital fundraising. Before that he worked at the North Carolina School of the Arts as Vice Chancellor, Development and Public Relations.

"I am delighted to become part of the Moses Cone Health System community and look forward to helping build a new program that will engage others in the Health System's tradition of excellence," Porter says.

Porter is a graduate of Duke University and earned his master's degree in business administration from The University of North Carolina at Chapel Hill.

System Saves Cost with Star Close Devices

The Cath Lab at The Moses H. Cone Memorial Hospital and various Radiology sites have tested and will use new devices to close the site where a patient's artery is punctured for interventional procedures. The change will provide a financial savings for the Health System without compromising quality.

The Cath Lab has used Angio-seal, a gel-type substance that hardens into a seal and Interventional Radiology used the Perclose device. As part of the Systemwide savings projects, clinical and medical staff in both Radiology and the Cath Lab evaluated the use of Abbott's Star Close physical closure device.

The physicians found this device equally effective. Changing brands will save the Health System $20 per procedure. Since the Cath Lab uses 1,100 per year and Radiology uses about 200, this ultimately will save $26,000 per year on an ongoing basis while meeting the needs of patients and physicians.

Trauma Conference Draws 160 Attendees

More than 160 clinicians attended the fifth annual Key Issues in Trauma Management Conference at the downtown Greensboro Marriott. The conference was sponsored by Moses Cone Health System, Greensboro AHEC and the School of Pharmacy of The University of North Carolina at Chapel Hill.

Jay Wyatt, *MD, Medical Director, Trauma, Moses Cone Health System*, led a discussion of interactive case studies using an audience response system.

Other speakers included **J. Wayne Meredith**, *MD*, a surgeon from Wake Forest University School of Medicine and the chairman of the American College of Surgeons committee on trauma. He gave an overview of trauma changes in the past 20 years as well as a session on pancreatic trauma.

Robbi Hartsock, *RN*, the trauma designation and improvement manager for the R. Adams Cowley Shock Trauma Center in Baltimore and the president of the American Trauma Society MD Division, led a session on reducing intentional injury and violence.

Some Tips for Meeting with Plaintiff's Attorneys

You get a call from a plaintiff's attorney requesting to meet with you as the treating physician in a case under litigation. Should you wait for a subpoena? What do you do?

According to the defense counsel for Moses Cone Health System, it is legal for a patient's attorney to contact a treating physician with the consent of the patient. However, physicians should take care discussing a case with a plaintiff's attorney, especially if the statute of limitations has not expired.

If the statute of limitations has expired, the physician can meet with the plaintiff's attorney "off the record" to discuss the care, but the physician should realize that the plaintiff's attorney will go "on the record" to get the formal testimony if it will be helpful to the case. Any opinions criticizing the care of others would be something that the plaintiff attorney would want in an affidavit or deposition.

The physician should be willing to discuss and explain his or her care, but be careful about expressing opinions about causation or prognosis.

Insulin Pump Standing Orders Now Available

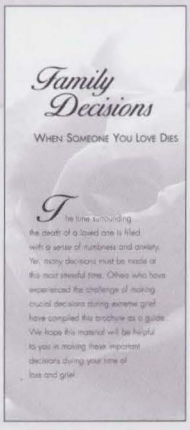
When diabetic patients are admitted to the hospital for surgery, labor and delivery or other medical conditions, many of them want to continue to manage their glucose levels by using their insulin pump. A new insulin pump policy has been developed to guide the nurse in assessing whether it is appropriate for the patient to manage the insulin pump without clinical help.

The Insulin Pump Standing Orders have been developed to provide continuity of care throughout the Health System, reduce errors, reduce calls to physicians and improve patient satisfaction. Orders are available upon admission at The Moses H. Cone Memorial Hospital, Wesley Long Community Hospital, The Women's Hospital of Greensboro and the Behavioral Health Center. Pharmacies at Moses Cone Hospital, Wesley Long Community Hospital and The Women's Hospital also have order sets available.

Refer to the poster in the Physician Lounge at these hospitals for additional information and a copy of the orders. The Insulin Pump Policy can be found on the e-mail system under Public Folders/Diabetes Resources/Insulin Pump Policy.

For additional information or a copy of the orders or policy, contact **Elaine Button**, *Director, Inpatient Diabetes Services, Diabetes Treatment Program*, at 230-2107 or *elaine.button@mosescone.com*.

New Brochures Help Grieving Families Make Decisions



What do individuals experience when their family member dies? We know it is grief, but we may not be fully aware of how disoriented they can feel when the doctor tells them, "I'm sorry but your (relative) has died."

Family members may not know what to expect or what decisions have to be made.

Working with the Organ Donation Collaborative Team, **Marion Martin**, *Director, Emergency Department, The Moses H. Cone Memorial Hospital*, and **Bob Hamilton**, *Director, Pastoral Care Services*, have developed a brochure to guide family members through the experience and help with decisions they may have to make.

This brochure, called "Family Decisions When Someone You Love Dies," addresses those difficult questions and provides information on grief support and funeral information. It can be provided to families as needed.

Copies of this brochure are available in the Emergency Department and through the Pastoral Care Office at 832-7950.

New Scrub Vending Machines Cut Losses

Several hospitals now have a new vending system for scrubs, called scrubEx, that cuts loss. The system is available at The Moses H. Cone Memorial Hospital, including its Cath Lab and Interventional Radiology departments, Wesley Long Community Hospital and The Women's Hospital of Greensboro.

Employees can check out two scrubs at a time by sliding their name badges through a card reader. At that point they have to return a set to get a set.

No longer are carts empty. Laundry staff monitor the machines and reload sizes that are running low.

The Regional Cancer Center at Stoney Creek opened in May.

Regional Cancer Center at Stoney Creek Opens

Kalsoom Khan, *MD*

The Moses Cone Health System Regional Cancer Center opened its fourth treatment facility in May in the Stoney Creek community.

The Stoney Creek facility will provide additional medical oncology/hematology services for the Health System's existing cancer program. **Kalsoom Khan**, *MD*, is the hematologist/oncologist on staff.

The decision to build and staff an additional treatment center was made with the patients' interests in mind, says **Jim Whiting**, *Vice President, Oncology*. "We serve a significant number of patients from the eastern Guilford County and western Alamance County area. This is a growing population that can be best served with a local oncology practice."

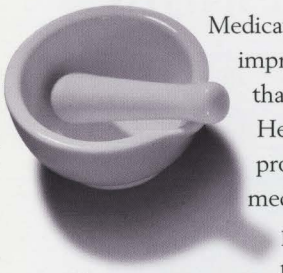
The new 4,500-square-foot Stoney Creek facility includes patient examination rooms and offices, a laboratory, pharmacy and six-bed chemotherapy area. It is located at 945 Golf House Road West, just off U.S. 70, about 15 minutes east of The Moses H. Cone Memorial Hospital.

"We are providing the same type of high-quality care that our patients expect from us, but in a smaller, more personalized setting," Khan adds.

In addition to the Regional Cancer Center located at Wesley Long Community Hospital in Greensboro, other medical oncology treatment centers are located at Annie Penn Hospital in Reidsville and Randolph Cancer Center in Asheboro.

The Moses Cone Regional Cancer Center is designated a Community Hospital Comprehensive Cancer Center by the American College of Surgeons Commission on Cancer.

Medication Reconciliation to Start



Medication reconciliation is a quality improvement and patient safety initiative that will be rolled out across Moses Cone Health System in June. This is a formal process to ensure that an accurate home medication list is collected from each patient and to match current medication orders with patients' medication regimens at their previous level of care.

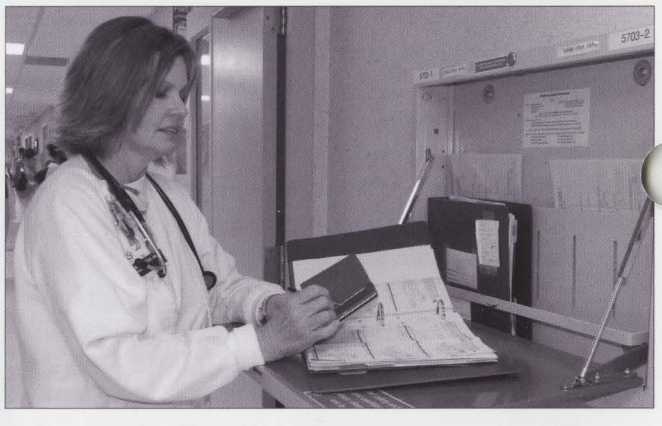
Other health systems that have implemented similar programs have reduced errors in drug dosing, drug interaction and drug omission by 40 percent, on average. They have reduced adverse drug events involving harm to patients by 15 percent.

A process improvement team led by **Tim Lane**, *MD*, has developed, tested and refined a reconciliation process during the past six months. Its key steps are as follows:

1. Nurses or pharmacists collect a home medication list on each new admission. They may contact community pharmacies or other sources to verify the accuracy of the list.
2. Nurses or pharmacists complete the Home Medication Reconciliation Orders form, which can be found in the orders section of the chart. For each medication, they will check a box indicating whether it was ordered as previously taken at home.
3. For those medications that do not match, the attending physician is asked to check the appropriate box: "Order as taken at home," "Do not change current order" or "Change to ____." When signed by the physician, the form becomes an order sheet.
4. At discharge, the nurse will review the discharge medications against the hospital regimen and home medication list and contact the physician if clarification is needed.

"The team believes this process will result in more accurate home medication lists," says **John Long**, *Black Belt, Quality Improvement*. "It also will provide the attending physician with a simple tool to minimize medication discrepancies as patients move among various levels of care and providers."

Med-Surg Impact Project Strives to Improve Bedside Care



Karen Bates, *RN, 5700, The Moses H. Cone Memorial Hospital, is among several nurses who carry a handheld computer that alarms at various points in a shift. When an alarm sounds on the computer, the nurses document exactly what they were doing.*

Moses Cone Health System is working with a national quality organization on a nursing project to test new ways to improve patient care by streamlining nursing processes and improving work environments so nurses can focus more on patient-centered tasks.

Nurses in Department 5700 at The Moses H. Cone Memorial Hospital are testing the project, nationally called "Transforming Care at the Bedside." The Health System calls the project "Med-Surg Impact."

The first goal is to ensure that nurses spend quality, or "value-added," time with their patients rather than being occupied with other activities such as hunting for supplies. Nurses carry handheld computers that alarm at various points during a shift. At this point, the nurses document exactly what they were doing.

The project also measures patient satisfaction using surveys distributed at discharge.

The project is being done through a partnership with the Institute for Healthcare Improvement (IHI), a non-profit group that works with health systems to improve quality and safety.

'Silencing the Call Light' Program Trains Staff

Wesley Long Community Hospital is piloting a training program called "Silencing the Call Light," which is designed to improve patient satisfaction by helping staff better meet patient needs.

More than 40 classes have been conducted, and 650 employees have been trained.

About 25 employees from different departments worked together to study patient care and determine how to improve staff's ability to meet the needs of patients. The trainers relied on this information to develop the course.

Administrative News

Becky Clark is the new *Director, Outpatient Rehabilitation*. She was director for Children's Services at Hitchcock Healthcare in Aiken, SC. She also has worked for Walton Rehabilitation Hospital in Augusta, GA, in a variety of leadership positions.

Hope Rife is the new *Director, Social Work*. The department is a new one at the Health System. Previously, she was Manager, Clinical Social Work, Care Management.

Heart and Vascular Center Has New Vice President

Vicki Block is the new *Vice President, Moses Cone Health System Heart and Vascular Center*. Block comes to the role from the University of North Carolina Hospitals in Chapel Hill, where she was the director of cardiac services. She also has served as director of the Heart Center at Carolinas Medical Center – Mercy in Charlotte and as a manager in the Office of Clinical Effectiveness at The Cleveland Clinic Foundation in Cleveland.

"Vicki has the right mix of experience, enthusiasm and ambition to be a tremendous success in this role," says **Tom Gettinger**, *Executive Vice President, Moses Cone Hospital*. "We are so pleased to have someone with her background on board as we open the new Heart and Vascular Center. It's an exciting time for cardiovascular services at Moses Cone Health System."

Block says she is "thrilled and honored to be joining Moses Cone Health System and one of the pre-eminent heart and vascular centers in North Carolina. I consider it a privilege to be part of such an exceptional team and am looking forward to furthering the mission and success of the Moses Cone Heart and Vascular Center."

Block has a bachelor's degree from the University of Akron in Akron, OH, and a master's degree in hospital and health administration from Xavier University in Cincinnati, OH.

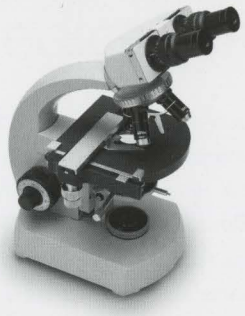
System Receives VHA Leadership Award

Moses Cone Health System has received the 2006 VHA Leadership Award for Operational Excellence.

VHA, a national healthcare alliance based in Irving, TX, recognized the System because all five of its hospitals gained Magnet status. The award was presented to representatives of the hospital on May 21 during VHA's Leadership Conference in St. Louis, MO.

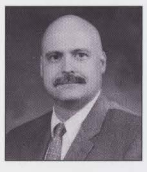
"In 2005, only 13 VHA-member hospitals nationwide were designated as Magnet organizations by the American Nurses Credentialing Center," says **Joan Wessman**, *Chief Nursing Officer, Moses Cone Health System*. "Recruiting and retaining top quality nursing staff is critical to our ability to fulfill our mission to the communities we serve. We are extremely proud to be among the leading healthcare organizations in the country that have received this designation."

The VHA 2006 Leadership Award for Operational Excellence is given to member organizations that go the extra mile to pursue excellence. The Magnet Recognition Program was developed to recognize healthcare organizations that provide the very best in nursing care. Magnet is the gold standard in patient care.



New Physicians Join Staff

Moses Cone Health System
Medical and Dental Staff



C. Wesley "CW" Bean, *MD*, (Provisional Active status) completed his residency and fellowship in surgery and plastic surgery at William Beaumont Army Medical Center. He is board certified in surgery and plastic surgery and practices with Patseavouras Center for Plastic and Laser Surgery.

Nancy M. Bednarz, *MD*, (Provisional Active status) completed her residency in radiation oncology at Yale New Haven Hospital. She is board certified in radiation oncology and practices with Piedmont Radiation Oncology at Wesley Long Community Hospital.

Joseph H. Boyle, *MD*, (Provisional Consulting status) completed his residency in psychiatry at East Carolina University/Brody School of Medicine and his fellowship in forensic psychiatry at Duke University. He is board certified in psychiatry and practices with ACT Medical Group in Wilmington.

Elman G. Frantz, *MD*, (Provisional Consulting status) completed his residency in pediatrics at the University of North Carolina Hospitals and fellowships in pediatric cardiology at UNC Hospitals and the University of California at San Francisco. He is board certified in pediatrics and pediatric cardiology and practices with Moses Cone Health System Pediatric Sub-Specialists of Greensboro.

Paola A. Gehrig, *MD*, (Provisional Active status) completed her residency in obstetrics and gynecology at the University of Virginia Health System and her fellowship in gynecologic oncology at the University of North Carolina at Chapel Hill School of Medicine. She is board certified in obstetrics/gynecology and gynecologic oncology. She practices with the Gynecologic Oncology Department at Moses Cone Health System Regional Cancer Center.

Novlet C. Jarrett, *MD*, (Provisional Active status) completed her residency in internal medicine at The Moses H. Cone Memorial Hospital. She is board certified in internal medicine and practices with Eagle Internal Medicine at Tannenbaum.

Andrew L. Katz, *MD*, (Provisional Active status) completed his residency in pediatrics at the University of North Carolina Hospitals. He is board certified in pediatrics and pediatric critical care medicine. He practices with the Moses Cone Health System Pediatric Intensive Care Unit (PICU) at The Moses H. Cone Memorial Hospital.

Michelle A. Matthews, *MD*, (Provisional Active status) completed her residency in internal medical/pediatrics at Detroit Medical Center. She is board certified in internal medicine and eligible for certification in pediatrics. She practices with Piedmont Senior Care.

Nikki Tucker, *DDS*, (Provisional Active status) completed her residency in pediatric dentistry at Bronx Lebanon Hospital Center. She practices with Perry L. Jeffries, DDS, and Associates.

Annie Penn Hospital
Medical and Dental Staff

Paul V. Kowalski, *MD*, (Provisional Active status) completed his residency in ophthalmology at the University of Louisville. He is board certified in ophthalmology and has his own medical practice.

ORGANIZATIONAL ACTIVITY

	April 2006	March 2006	February 2006	January 2006	December 2005	November 2005
MOSES CONE HOSPITAL						
Beds in Service	506	506	506	506	506	506
Occupancy (percentage)	77.18	80.30	80.66	77.56	73.71	74.09
Average Daily Census	390.53	406.32	408.14	399	379.97	374.90
Average Length of Stay (days)	5.95	5.56	5.75	5.72	5.59	5.53
Surgical Procedures	1,028	1,277	1,150	1,141	1,075	1,195
Emergency Dept. Total Patients	5,671	5,868	5,407	5,595	5,605	5,221
WESLEY LONG COMMUNITY HOSPITAL						
Beds in Service	119	119	119	119	119	119
Occupancy (percentage)	89.66	91.92	90.12	88.12	84.08	86.83
Average Daily Census	106.70	109.39	107.25	104.87	100.06	103.33
Average Length of Stay (days)	5.7779	5.408	5.150	5.269	5.052	5.39
Surgical Procedures	428	494	422	484	500	514
Emergency Dept. Total Patients	3,713	3,905	3,589	3,697	3,616	3,617
THE WOMEN'S HOSPITAL						
Beds in Service	134	134	134	134	134	134
Occupancy (percentage)	63.25	62.15	63.91	66.77	61.98	61.09
Average Daily Census	84.76	82.29	85.64	89.48	83.06	81.86
Average Length of Stay (days)	4.01	4.31	3.867	4.5	3.88	4.37
Births	455	460	441	456	484	460
Surgical Procedures	398	456	421	471	472	425
ANNIE PENN HOSPITAL						
Beds in Service	87	87	87	87	87	87
Occupancy (percentage)	58.66	62.96	64.03	51.46	57.50	56.43
Average Daily Census	51.03	54.77	55.71	53.81	50.03	49.10
Average Length of Stay (days)	4.67	4.10	4.44	5.01	4.43	4.52
Surgical Procedures	183	235	171	190	184	209
Emergency Dept. Total Patients	1,888	2,079	1,812	1,996	1,851	1,785
BEHAVIORAL HEALTH CENTER						
Beds in Service	80	80	80	80	80	80
Occupancy (percentage)	62.75	62.13	66.78	64.51	48.98	52.57
Average Daily Census	50.2	49.71	53.43	51.61	39.19	42.06
EXTENDED CARE CENTER						
Beds in Service	144	144	144	144	144	144
Occupancy (percentage)	91	91	92	92	90	87
Average Daily Census	132.06	131.77	133.07	133.1	129.74	125.87
WESLEY LONG NURSING CENTER						
Beds in Service	140	140	140	140	140	140
Occupancy (percentage)	94	94	92	87	84	87
Average Daily Census	132.16	132	128.89	122.32	117.45	121.63
MOSES CONE SURGERY CENTER						
Total Patients	492	603	584	590	614	586
WESLEY LONG SURGERY CENTER						
Total Patients	211	252	214	228	243	195
CARELINK						
Number of Transports	639	695	654	727	664	667
Resource Line Physician Consults	158	200	156	172	144	155
Resource Line Patient Referrals	94	130	94	139	104	111

MD*journal*

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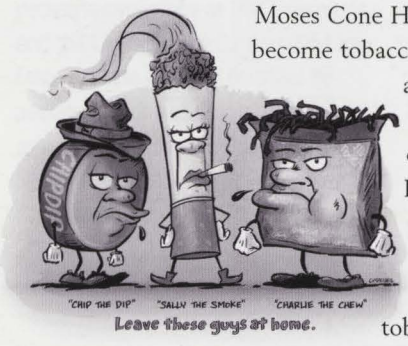
Health System to Go Tobacco-Free July 1



Moses Cone Health System will become tobacco-free at all its campuses and facilities on July 1. This means that employees, Medical and Dental Staff, volunteers, patients and visitors will not be permitted to smoke or use any tobacco products while on Health System property. This includes buildings, parking lots and vehicles in parking lots, garages, grounds and most off-site locations.

In the past, people could smoke and use tobacco outside.

The change also means that physicians will no longer be able to write an order in the chart allowing patients to go outside to smoke. A protocol is being developed to offer patients options for nicotine replacement. This ranges from gum and lozenges to a nicotine patch and pharmaceuticals such as Zyban. The protocol is being reviewed by the Pharmacy and Therapeutics Committees in Greensboro and Reidsville and by the Medical Executive Committee. Additional support will be provided to Emergency Departments.

Employees are being educated with Computer Based Learning programs about the policy and how to handle patients and visitors who want to smoke.

"We encourage physicians to help us in supporting this policy, which will help fulfill our mission to prevent illness and restore health," says **Cindy Farrand**, *Vice President/ Administrator, The Women's Hospital of Greensboro*, and the co-chairwoman of the Health System's Tobacco-Free Task Force.