

The Consult

Winter 2010



Inside:

Reducing Emergency Room Wait Times
Home Health – Extending the Continuum of Care
Improving Heart Failure Management and Compliance
Innovative Cancer Vaccine Trial

ROPER
ST FRANCIS
HEALTHCARE

Contents

From RSFH Leadership.....	1
21st Century House Calls	2
Quality Improvement Initiatives: Reducing Emergency Room Wait Times.....	4
Heart & Vascular Consult	
New Approaches to Attacking Heart Failure.....	8
In Brief.....	10
Reducing Hospital Required DVT	11
Cancer Consult	
Innovative Immunotherapy Trial for Non-Small Cell Lung Cancer	12
In Brief.....	14
Research Corner	15
Medical Society of South Carolina	16
New Physicians.....	16

FROM RSFH

LEADERSHIP

Dear Colleagues,

In this issue of *The Consult*, we feature our Home Health agency. These services are becoming extremely important as there is a movement to have patients spend less time in the hospital setting and more at home. This trend is not just being driven by hospitals, but by patients and their families. Recent data shows that there are more than 1.3 million people receiving home care services in the United States, and in the South, where diabetes and heart disease is prevalent, the rate is particularly high (51 of every 10,000 people). This number is only expected to grow in the future with our aging population.



Home health, especially RSFH's Home Care telemetry capabilities, can also play a role in managing congestive heart failure, one of our Heart & Vascular Consult topics. Heart failure accounts for about 37% of all Medicare spending, and 50% of all hospital inpatient costs, according to 2005 data from the American Heart Association. Early intervention, sustained outpatient care and medication compliance is key to keeping heart failure patients out of hospitals and emergency rooms (also relevant to this issue's Quality Improvement article on Reducing ER Wait Times).

We hope you find this issue of *The Consult* to be timely and relevant to your practice. As always, if you have questions about the Roper St. Francis services mentioned, or suggestions about topics for future issues of *The Consult*, I welcome your feedback.

Steven D. Shapiro M.D.

Steven Shapiro, MD

VP of Medical Affairs

steven.shapiro@rsfh.com

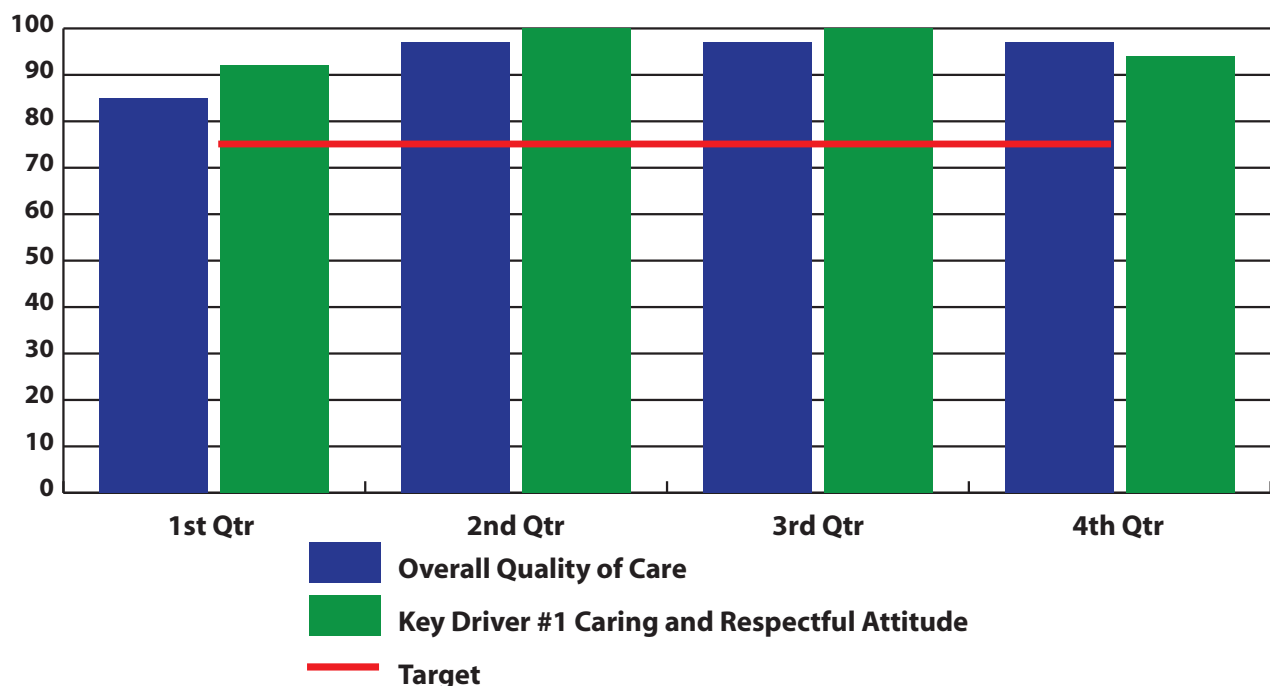
21st Century House Calls

Roper St. Francis' Comprehensive Home Health Program

Home health programs have experienced significant growth over the last two decades due to a number of concurrent economic and cultural factors. Changes in reimbursement and the fiscal push to reduce hospital stays and curtail healthcare costs are a main reason for the growth. Additionally, the fact that America is graying, families are more geographically disperse and more women (traditionally the caretakers of elderly or infirm family members) are in the workforce means more and more recovering, disabled or chronically ill patients now rely on the assistance of home health care providers. Technological advances that make sophisticated patient care more mobile have also contributed to the growth of the home health industry.

As the area's only hospital-owned home health agency, Roper St. Francis Home Care provides a comprehensive array of services designed to get patients back to the comforts of home more quickly and reduce hospital readmissions and/or the need for urgent care. Our multidisciplinary home health team includes licensed nurses, social workers, home health aides, and physical, occupational, and speech therapists. Over and above these services, Roper St. Francis Home Care offers more than the typical independent agency, with certified wound and ostomy care nurses, a certified IV specialist and a registered dietitian who is also a certified diabetes educator. We are also the region's only home health agency to use sophisticated 24-hour telemonitoring to manage patients with congestive heart failure and diabetes.

2008 RSFH Home Health Patient Satisfaction



Highlights of Roper St. Francis Home Care

“Our goal is to ease the transition from hospital to home, or vice versa,” says Bonnie Mello, RN, CHCE, director of Roper St. Francis Home Care. “As a hospital run agency, we can optimize continuum of care. Our patients know they can trust the Roper St. Francis name when they go home, and receive the same quality of care they received in the hospital.”

Roper St. Francis’s highly-skilled home health nurses and therapists are also able to monitor what’s going on in the home setting and identify and address problems before they become serious. Our nurses and therapists can be proactive to reduce the need for hospital readmission, and are communicating this to the attending doctor.”

About 7.6 million people receive care from 83,000 providers in the U.S., according to the National Association for Home Care and Hospice. In 2007, home health costs were projected to be \$57.6 billion, and accounted for 3.6 percent of total Medicare spending, and these numbers are on the rise. The cost effectiveness of home care is indisputable: for example, a COPD patient can receive one year of home oxygen therapy for the cost of one day in the hospital.

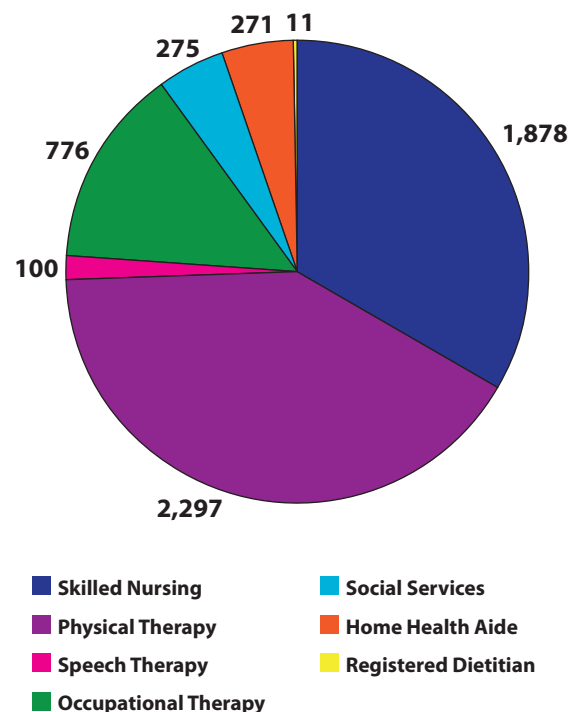
However cost-effectiveness is only one benefit of home care. Patients typically prefer to be home and home care helps empower and encourage them to take an active role in their recovery and wellness. Home care reinforces and supplements care provided by family and friends, enabling patients to better maintain dignity, comfort and independence, qualities that can be compromised even in the best hospitals.

The Roper St. Francis Home Care team is anchored by experienced nurses with med/surg experience. “Home care nurses have to be able to function autonomously, with good time management and assessment skills,” says Mello, who oversees a staff of 94, including two nursing teams and two rehabilitation teams covering different geographic zones throughout Charleston, Berkeley and Dorchester counties.

“Home health care is tremendously rewarding,” adds Mello. “We’re there with them, one on one in a very personal setting. We deal with the social situation as well as the medical; it’s holistic care. And our staff goes above and beyond. I’ve had staff pay out of their own pocket to turn a patient’s electricity back on.”

- Only accredited hospital-based home care agency in the area, established in 1989.
- Offers continuum of care between hospital and home for patients and doctors.
- RSFH Home Care is completely paperless; all orders and notes done in Electronic Medical Record. Physicians have easy, fast access to records.
- Only agency in region to offer telemonitoring at no additional charge, with 36 telemetry units and more to be added.
- 94 employees, average daily census of 350 patients, 24-hour coverage.
- Specialized staff, including:
 - Certified wound and ostomy care nurses
 - Certified IV specialist
 - Registered Dietitian and Diabetes Educator
- Home Infusion services with registered pharmacists
- PRC Patient Satisfaction 5-Star Award five years in a row
- High employee satisfaction; 23% turnover rate in home health nationally, compared to RSFH Home Care’s 8%

2008 RSFH Home Health Clients Served





Quality Improvement Initiatives

Reducing Emergency Room Wait Times

Emergency Departments (EDs) are a crucible of the healthcare system, where quality, accuracy and efficiency are tested to the extreme. The current economic climate, coupled with a cultural mentality of instant gratification, contributes to further strain on EDs. High rates of unemployment mean more people without insurance and with less access to routine preventive care from primary care doctors end up in EDs. And everyone expects immediate attention.

The parameters around ED wait times are getting increasingly narrow, according to Wanda Brockmeyer,

RN, a 45-year veteran of emergency medicine and director of Roper St. Francis Emergency Services. “Customers want healthcare when they want it, at their convenience. Every patient who comes in, whether for a hangnail or a heart attack, believes he or she has an emergency. And the real truth is, when they’re sick, it is their emergency,” says Brockmeyer, who adds that our RSF EDs never go on “Divert” status, meaning they never turn patients away, even if they are backlogged. “That’s why it’s important to create systems that allow us to triage patients very quickly.”

“But that wasn’t good enough for us,” Brockmeyer says. “If we can do it in four hours, then we can do it in two (after decision to admit). We raised the bar, and made our goal for ED Door to bed (total time) of four hours, which means two hours after decision to admit.”

The four Joint Commission-accredited 24-hour emergency departments that comprise Roper St. Francis Emergency Services have been working since 2003 to reduce cycle times for ED discharge patients and admit times for ED-to-hospital admissions. Brockmeyer and her team began reviewing data related to ED wait times, measured in the hours to discharge or admission after the decision to admit is made. The benchmark in 2003 was to have the patient to a hospital bed within four hours after decision to admit.

Brockmeyer created a Throughput Team to review data and processes coordinated between the ED, radiology, lab, admissions and environmental services departments. “We discovered and addressed several issues across the system where improvements could be made,” she notes, and those steps, such as better central census of all hospital discharges and potentially available beds, resulted in an 80 to 90% success rate in 2003 to 2004 in meeting the four hour ED decision-to-admit to hospital bed benchmark.

In 2004 – 2005, Roper St. Francis invested in a “TeleTracking” board that electronically monitors the status of every bed in the hospital from one centralized screen. This addition resulted in more efficient hospital discharge communication, which created greater inpatient bed capacity, thus ED patients to be admitted are moved out of the ED more efficiently, and ED beds are opened up more quickly for those waiting.

In 2009, Brockmeyer instituted another Throughput Team to again review and improve processes. “Our mantra is ‘The Right Patient in the Right Bed at the Right Time,’” she says, pointing to national data by the American College of Emergency Physicians indicating that hospital LOS is relative to the length of time an ED patient waits in an ED bed prior to admission. The “Gold Standard” that Brockmeyer’s team strives for is two hours from presentation to discharge for patients who are treated and released, and one hour to hospital bed after decision to admit for admitted patients. These

criteria do not apply to patients presenting with stroke, heart attack or surgical emergencies.

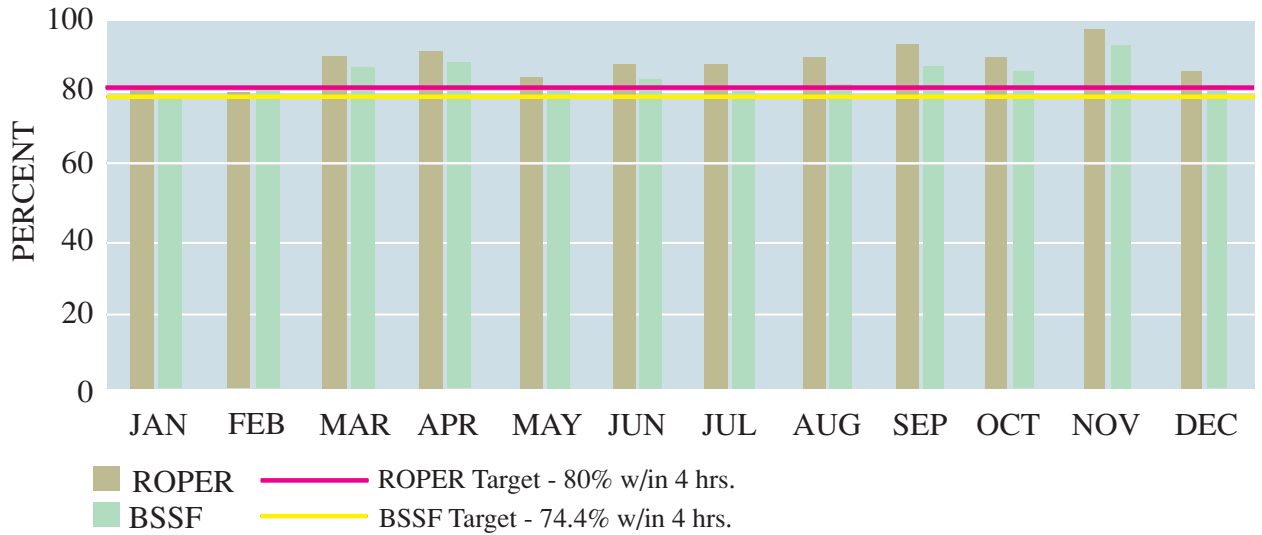
Wait times for the RSF EDs have consistently decreased over the last four years, despite increase in ED volume. St. Francis Hospital ED has seen the greatest increase in patient volume, while Roper Hospital ED tends to get patients with greater acuity. “‘No’ is not an operative term for us. When we get crazy busy, we compensate by coming together as a hospital system,” says Brockmeyer. Initiatives instituted to achieve reduced ED wait times include:

- TeleTracking system to monitor and juggle hospital beds
- Staggered staffing in EDs, according to peak volume times, adjusted daily
- Improved triage process
- Fast Track service at BSSF, open from 10 a.m. to 10 p., with extended hours Saturday – Monday, and in 2010 will be daily 8 a.m. to 3 a.m.
- A Rapid Admission unit at BSSF
- New telemetry beds at Roper Hospital and BSSF
- An “Empty Waiting Room” initiative adopted for 2010

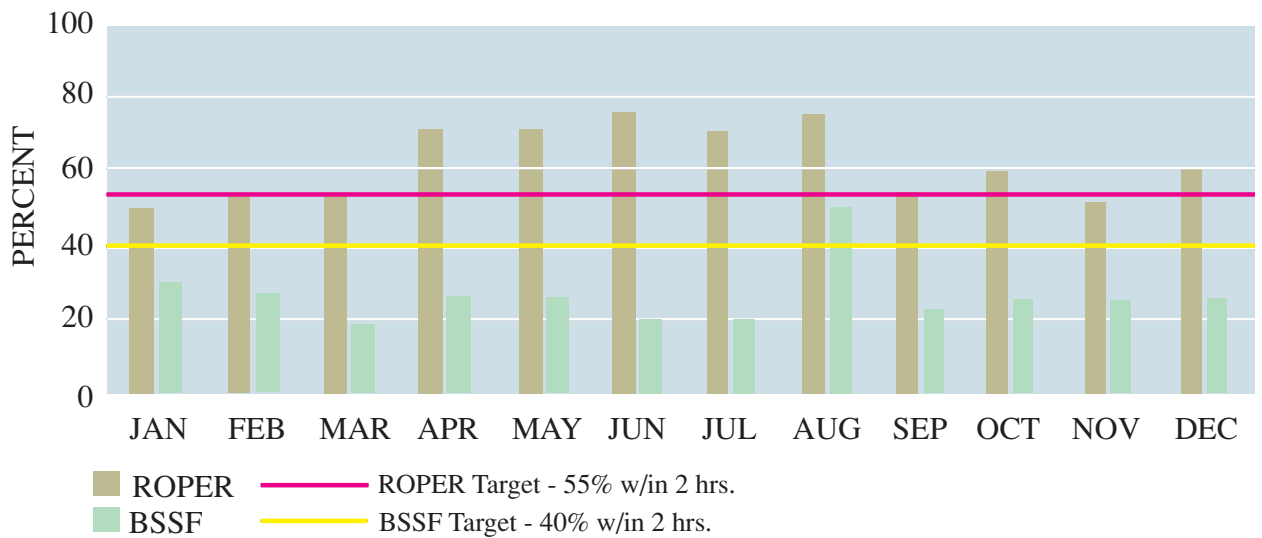
Other facts about RSF Emergency Services:

- 230 employees staffing four EDs, with minimal staff turnover
- 28 Emergency Physicians who are board certified
- Seven mid-level providers
- 112,000 patients seen in 2008
- 12,650 hospital admissions in 2008
- Five percent volume growth in 2009 overall; 12% increase in volumes through August and September

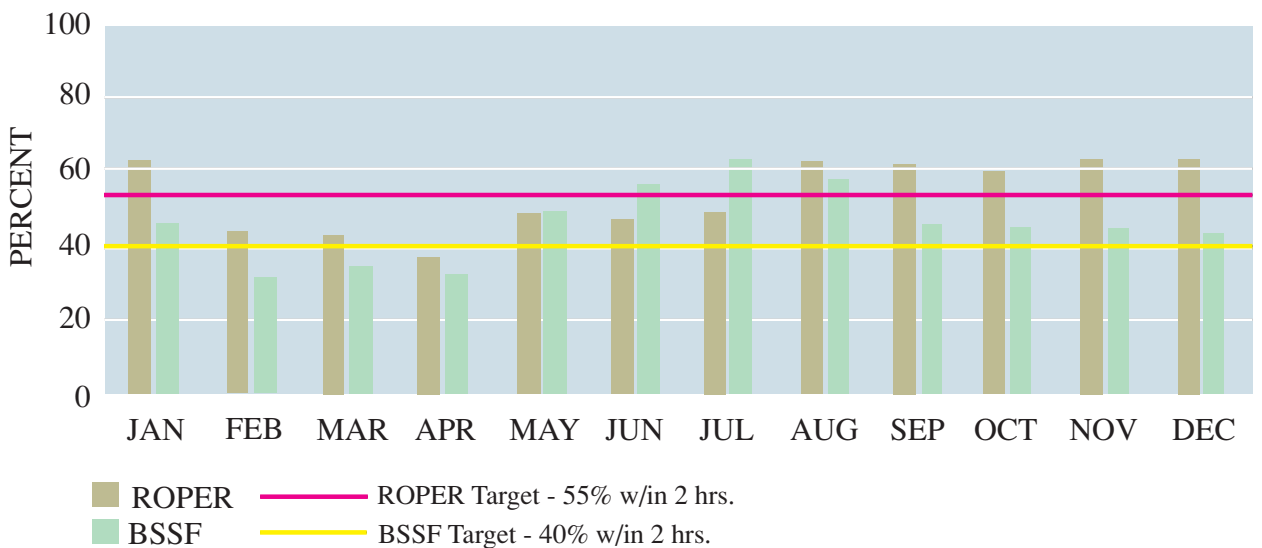
2003 Monthly Cycle Time of ER Patients from Decision to Admit to Bed in < 4 Hours



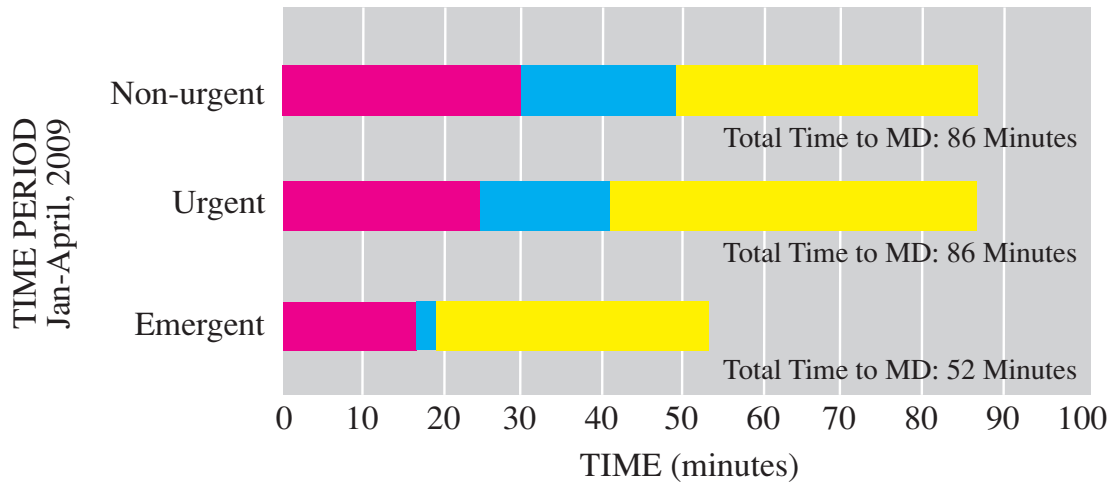
2004 Monthly Cycle Time = < 2 Hours from Decision to admit to Bed within Same Facility



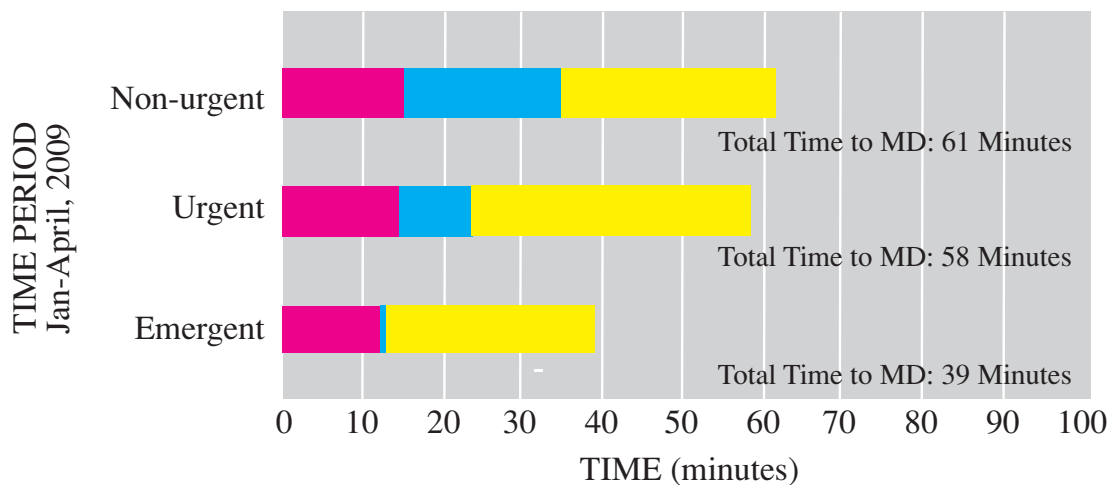
2007 Monthly Cycle Time = < 2 Hours from Decision to admit to Bed within Same Facility



**ED Time Metrics: Door to Triage, Triage to Exam Room, Exam Room to Physician Eval for All ED Patients
January - April, 2009
St. Francis Hospital Emergency Department**



**ED Time Metrics: Door to Triage, Triage to Exam Room, Exam Room to Physician Eval for All ED Patients
January - April, 2009
Roper Hospital Emergency Department**

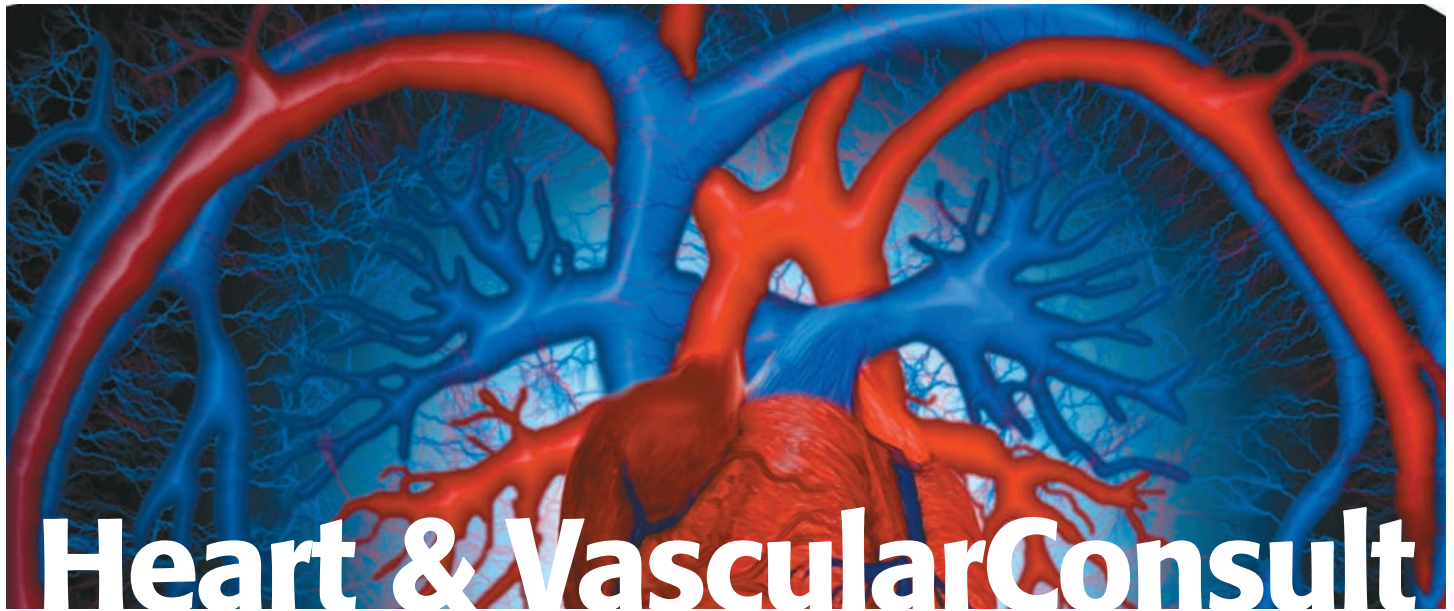


- Average of Arrival to Triage Valid
- Average of Triage to Bed Valid
- Average of Valid Bed to MD

National Benchmarks for Door to Depart

	Median	Quartile	Top Quartile
Non-urgent.....	117 min	100 min
Urgent	180 min	153 min
Emergent	307 min	258 min
overall	192 min	157 min

Data Source: Premier Benchmarking, ACEP Benchmarking



Heart & Vascular Consult

New Approaches to Treating Heart Failure

More than 22 million people worldwide suffer from congestive heart failure (CHF), nearly one quarter (5 million) of those are in the US, with the Southeast being ground zero. Heart disease is South Carolina's leading cause of death: in 2004, 12,597 of our state citizens died from cardiovascular disease – more than the total number of people who died from all cancers, pneumonia, influenza and car accidents combined. The financial burden for the 74,000 South Carolinians with cardiovascular disease who visited hospitals amounted to \$2.8 billion, or 55% of the state's total health budget (2004 SC DHEC data). A significant number of those have heart failure.

Nationally, hospitalizations for heart failure have increased dramatically, rising from 402,000 in 1979 to 1,101,000 in 2004 (National Hospital Discharge Survey). Recent findings from Centers for Medicaid/Medicare Services (CMS) suggests that 24.50% of CHF patients who are hospitalized will be readmitted within 30 days, and over one-half of those

will not have seen a physician within that 30-day window.

“The key to managing heart failure and avoiding hospitalization is early intervention and a sustained continuum of outpatient care,” says Jeb Hallett, MD, medical director of the RSF Heart & Vascular Center. Patient education is critical, both in the hospital and in the primary care setting, to ensure patients understand the importance of medication compliance and monitoring sodium intake and weight gain, notes Anne Spencer, PharmD, Roper St. Francis Cardiovascular Care Pharmacy Specialist. “We work to educate the patient and communicate clearly with the referring physician regarding the list of medications given at discharge for our CHF patients,” Spencer says. “We know that repetition of information is important to help patients learn, especially given the fact that 30 to 40% of CHF patients have some cognitive impairment. Primary care doctors or other referring physicians play an important role in reinforcing this information and compliance.”

Spencer's recommendations for optimal pharmacological management of CHF include:

(For systolic HF):

- Angiotensin-converting enzyme inhibitors (ACEI)
- Beta blockers
- Aldosterone antagonist therapy
- Diuretics

(While digoxin has historically been used, it has been relegated to a secondary role by these more effective agents.)

"The ultimate goal is to keep CHF patients out of the hospital," says Spencer. Nonetheless, despite excellent care, most heart failure patients will inevitably need hospital care. For those patients, the RSF Heart & Vascular Center has a dedicated HF unit in the Heart & Vascular tower, staffed by a multidisciplinary team specializing in treating heart failure. The unit has the ability to provide:

- Aggressive diuresis as a standard of care
- Individualized education concerning dietary sodium restriction, medications and physical activity
- For patients with severe hyponatremia, vasopressin antagonists to augment
- Inotropic support and renal ultrafiltration therapies when clinically indicated
- Cardiovascular pharmacy specialist to review all medications

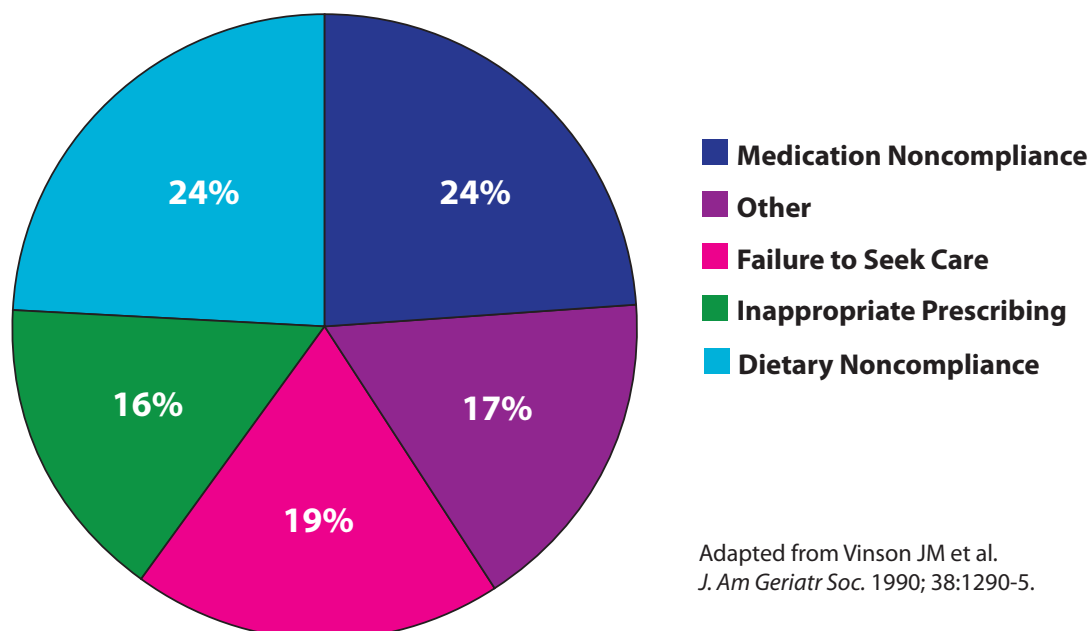
Role of ICDs in Treatment of Heart Failure

"One of the biggest concerns we have for patients with heart failure is the increased risk of cardiac arrest and sudden death," says Dr. Brett Baker, a board certified electrophysiologist affiliated with the RSF Heart & Vascular Center. Multiple studies show that selected heart failure patients live longer with an implantable cardiac defibrillator (ICD).

In addition, Cardiac Resynchronization Therapy (CRT), which involves simultaneous pacing of the left and right ventricle, has been shown to reduce hospitalization for heart failure patients and improve symptoms, such as shortness of breath, dyspnea on exertion and fatigue. CRT is currently indicated for CHF patients with left bundle branch block and symptoms refractory to medical therapy.

Dr. Baker cites recent encouraging results from the landmark MADIT-CRT Trial, demonstrating that early CRT intervention in minimally symptomatic patients with low ejection fraction and left bundle branch block can halt the progression of heart failure and improve survival. "This is the first ICD trial to show that we can inhibit the deterioration in left ventricular function that typically is associated with cardiomyopathy even in the absence of significant symptoms."

Common Causes of Congestive Heart Failure



In Brief

Continual Community Cardiovascular Screening

Screening programs are a significant part of the Heart & Vascular Center's commitment to community care. In recent years there has been an increased national focus directed toward screening for undiagnosed vascular disease. Typically, screening programs are periodic throughout the year and discover some disease in 5 to 10% of patients. Often these screenings are commercial or sometimes "free" and focus on discovering advanced disease that leads to profitable, downstream revenue for physicians and hospitals. They are not generally linked with primary care needs.

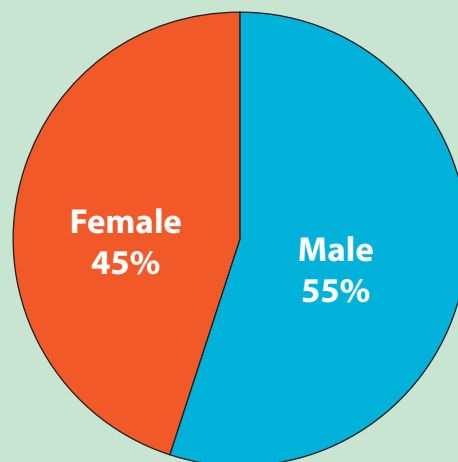
In May 2008, the Roper St. Francis Heart & Vascular Center initiated a novel approach to community screening. At the request of multiple primary care providers, the center began offering continual, five-day per week, "pay-out-of-pocket" screening for carotid disease, abdominal aortic aneurysm (AAA) and peripheral arterial disease (PAD) in patients with at least one cardiovascular risk factor.

The primary goal is to identify early atherosclerosis and use the information to guide and reinforce appropriate management of early occlusive and aneurysmal arterial disease. In our accredited vascular lab, Vascular Center staff perform carotid ultrasound with intimal thickening measurement (CIMT), aortic ultrasound, and ankle-brachial pressure indices (ABI) at a relatively low cost of \$125 for all three tests. We also offer cardiac calcium scoring for an additional \$125. A board certified vascular surgeon interprets all studies. Abnormality is defined as CIMT >1.5 mm, gray-scale evidence of atheroma, or carotid stenosis > 50%; aortic diameter > 3 cm; and ABI < 0.90. Critical thresholds are defined as carotid stenosis > 80%, AAA > 5 cm, and ABI < 0.40.

Results: To date, the Vascular Center has screened 293 patients with increasing demand with each month of the program.

No patient had a critical lesion in any vascular bed. Only one patient with a 50-79% carotid stenosis underwent endarterectomy. CIMT was performed in the second six months of the study and increased the detection of early carotid disease from 6 to 16%. Primary care providers reported that demonstrating early carotid atheroma was the most important influence on convincing patients to adhere to risk factor control.

Our conclusion is that a continual, five-day-a-week cardiovascular screening program at a low cost appears to be more useful than periodic screenings in assisting primary care providers in detecting early atherosclerosis and motivating patients to control their cardiovascular risk factors.



Age range of 36-91 years
Abnormalities were discovered in 13%
(Carotid-24, Aorta-7, and PAD-8)



Reducing Hospital-acquired Deep Vein Thrombosis

Pulmonary embolism resulting from deep vein thrombosis (DVT) is the most common preventable cause of hospital death. Fortunately, pharmacologic methods to prevent DVT are safe, effective, cost-effective, and advocated by authoritative guidelines; however, despite the reality that the risk for DVT is nearly universal among inpatients, large prospective studies continue to demonstrate that these preventive methods are significantly underutilized. Only one-third of at-risk hospitalized patients receive DVT prophylaxis.

A common definition for “hospital-acquired DVT” would be a clot first discovered during the course of hospitalization, or discovered within 30 days of a prior hospitalization. According to the Agency for Healthcare Research and Quality (AHRQ), a 300-bed hospital that lacks a systematic approach to DVT prevention can expect roughly 150 cases of hospital-acquired DVT over a one-year period. Approximately 50 to 75 of those cases will be potentially preventable because of missed opportunities to provide appropriate prophylaxis. Approximately five of those patients will die from potentially preventable PE.

While the number and type of DVT risk factors appear to influence a patient’s overall risk, there is no validated

method to predict accurately or efficiently an individual patient’s risk for DVT. Meanwhile, in the absence of prophylaxis, the risk of DVT across almost all populations of hospitalized patients is significant, as indicated below.

In 2007, the RSF Heart & Vascular Center spearheaded a DVT prevention program for every hospitalized patient. This initiative includes:

- Prevention protocol for venous thromboembolism
- Nurse daily risk assessment
- Increased leg compression availability by 150%

“With institution of the Roper St. Francis prevention program for DVT in hospitalized patients, we have reduced the risk of a DVT or PE to less than 1% in patients who receive preventive measures. We are ‘hardwiring’ our hospitals to strive toward eliminating fatal pulmonary embolism as a cause of death,” says John (Jeb) Hallett, MD, a board certified vascular surgeon and medical director of the RSF Heart & Vascular Center.

“Our current focus is on preventing community-acquired deep venous thrombosis and pulmonary embolism. Educational programs and easy access to early diagnostic tests are currently being rolled out into all practices in the Roper St. Francis Physician Partners Network.”

Inpatient Group	% DVT Incidence
Medical patients	10–26
Major gynecological, urological or general surgery	15–40
Neurosurgery	15–40
Stroke	11–75
Hip or knee surgery	40–60
Major trauma	40–80
Spinal cord injury	60–80
Critical care patients	15

(Source: Agency for Healthcare Research and Quality)



Innovative Immunotherapy Trial for Non-Small Cell Lung Cancer

According to the American Cancer Society, cancer immunotherapy is a promising field and most likely the area from which most future cancer fighting advances will come. To date, however, immunotherapy plays a fairly small role in treating most cancers. In most cases, immunotherapy, or educating the patient's own immune system to identify and attack tumor cells, is used mainly to improve efficacy of other forms of treatment, or to offer cancer patients a less-toxic option than traditional therapies.

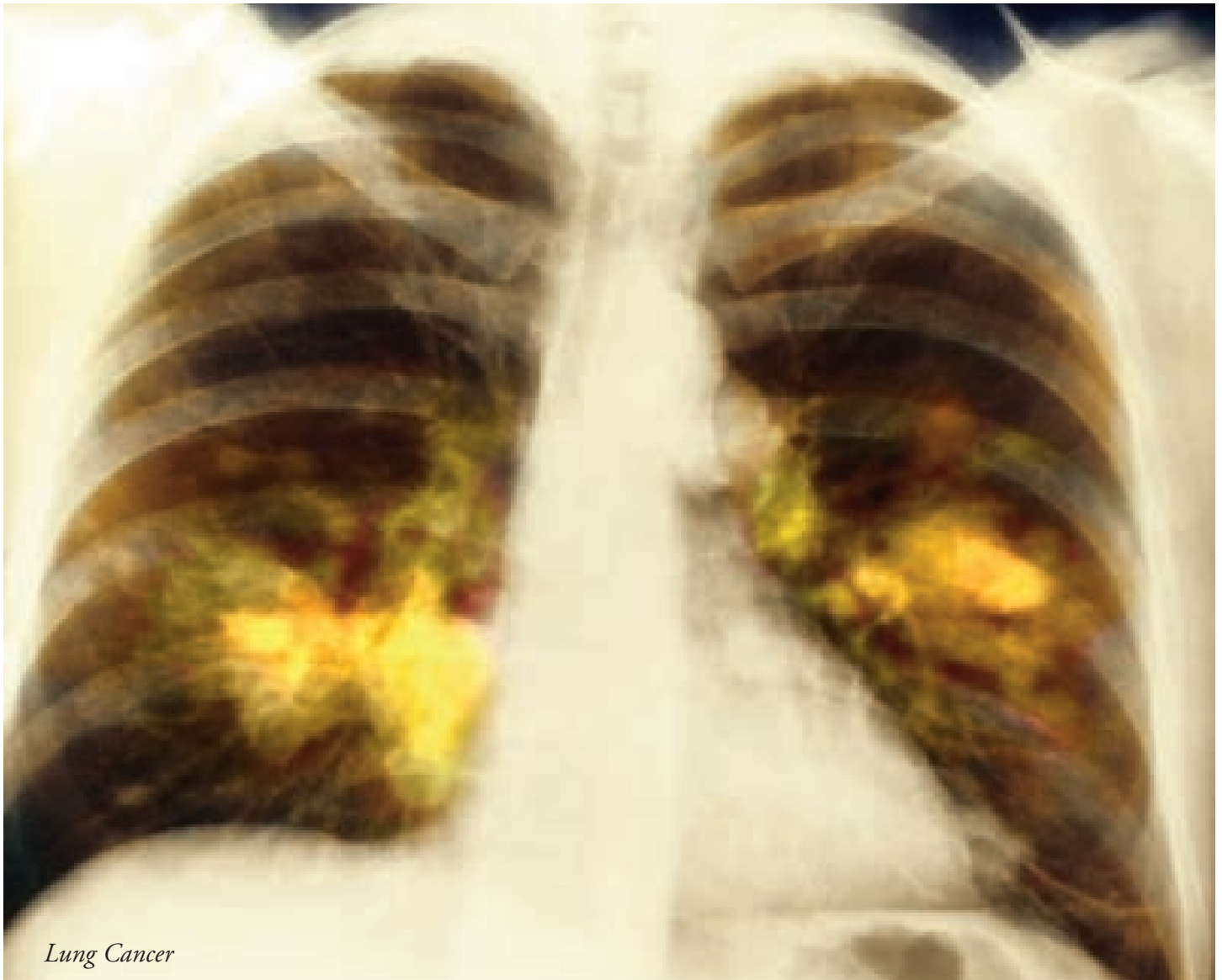
This may soon be changing. Dr. George Geils Jr, an oncologist affiliated with Roper St. Francis Cancer Center and director of the Roper St. Francis Blood and Marrow Transplant program, is spearheading recruitment of patients in the first major clinical trial harnessing the immune system to target a unique protein present on the cells of some lung cancer patients. The GlaxoSmithKline-sponsored trial evaluates the MAGE-A3 candidate Antigen-Specific Cancer Immunotherapeutic (ASCI) for the treatment of non-small cell lung cancer (NSCLC).

This Phase III trial follows promising results from the Phase II proof-of-concept study using this potential therapy in two cancer types, and is the largest trial of vaccine therapy for cancer ever designed. Investigators seek to enroll 2,270 patients internationally. This randomized, double-blind and placebo-controlled trial is for patients with MAGE-A3 who have undergone surgery and have no evidence of remaining cancer. The vaccine administration will be initiated in patients after surgery and standard chemotherapy, or patients who undergo surgery only. The trial's primary endpoint is disease-free survival.

“Unfortunately, despite the effectiveness of chemotherapy, radiation, and surgery, some patients will not be cured because we are unable to destroy every last cancer cell with available technologies,” says Dr. Geils Jr, who will enroll patients through Charleston Hematology Oncology Associates, the first study site in South Carolina, and the first to enroll a patient. “Our hope is that a cancer vaccine that stimulates an immune attack on the cancer will kill the last few cancer cells, thereby improving the chance of cure.”

“I believe that if this investigational therapy realizes its early potential, we could see a paradigm shift in the way cancer is treated,”

– Dr. Geils Jr.



Lung Cancer

Cancer vaccines are designed to train the immune system to recognize and eliminate cancer cells in a highly specific manner. These novel cancer immunotherapies combine tumor antigens, delivered as purified recombinant proteins, and GSK's proprietary Adjuvant Systems, which are specific combinations of immunostimulating compounds designed to increase the anti-tumor immune response. This vaccine is being evaluated for use to reduce the risk of tumor recurrence following surgery, or to impact tumor growth in an early metastatic setting. The tumor-specific antigen MAGE-A3 is present in approximately 35 to 50% of early non-small cell lung cancer.

“I believe that if this investigational therapy realizes its early potential, we could see a paradigm shift in the way cancer is treated,” says Dr. Geils Jr. “Although nothing is guaranteed, it is only through rigorously conducted clinical trials that we will improve the possibility of cure and ultimately win our war on cancer.”

For more information, contact Debbie McNeal, RN, OCN at Charleston Hematology Oncology Associates, PA, (843) 266-2540 or d.mcneal@choasc.com.

In Brief

Gene Expression Assays Guide Breast Cancer Therapy

Advances in genome profiling have expanded understanding of the genetic pathways associated with breast cancer development and progression. Tests for genetic prognostication have been demonstrated to better assess future risk of metastatic disease than conventional histological assessment of tumor aggressiveness by grade. Gene expression assays such as Oncotype DX™ and the newer MammaPrint can help guide therapy decisions in breast cancer patients. Paul Baron, MD, a surgeon affiliated with the Roper St. Francis Cancer Center, is pioneering this new technology in the Charleston area.

Oncotype Dx is a 21-gene multiplex real time polymerase chain reaction (RT-PCR) performed on paraffin-embedded breast cancer samples. The profile determines the 10-year risk of disease recurrence in estrogen receptor(ER)-positive, lymph-node negative tumors and classifies the tumor as either low, intermediate or high risk of recurrence. “Oncotype is very effective at predicting recurrence and helps identify which patients will really benefit from chemotherapy,” says Dr. Baron. “In the past, many patients received chemotherapy for node negative disease who may not have benefitted from it. This technology helps identify the 30% who are truly at high risk of cancer recurrence and will have an improved survival from systemic treatment.”

MammaPrint analyzes 70 genes in a woman’s tumor to predict the patient’s 10-year survival, and has a wider indication than Oncotype Dx by including both ER-positive and -negative patients. MammaPrint, however, is used only with fresh tissue (not paraffin-embedded) so the surgeon has to know prior to biopsy or surgical removal that he or she will send for MammaPrint profiling. Additionally, MammaPrint only evaluates low or high risk. “There’s no gray zone,” according to Dr. Baron.

Currently the MammaPrint assay is validated as a prognostic test only, while Oncotype Dx has been validated both as a stand-alone prognostic test and as a predictive test for response to tamoxifen and to the cytoxan, methotrexate and fluorouracil adjuvant chemotherapy regimen (concurrent with tamoxifen). The two assays each have advantages and disadvantages, notes Dr. Baron, with Oncotype Dx accepted as current standard of care.

“This is an exciting development, providing further stratification of risk which can be a valuable tool in guiding therapeutic decisions,” says Scott Broome, director of the Roper St. Francis Cancer Center.

Research Corner

Roper St. Francis Cancer Center's Oncology Research Department maintains an active clinical trials program, offering our patients access to cutting edge protocols. Listed below is a sampling of open trials. For more information on our full range of open trials, please contact the Elizabeth Strojny, RN, OCN, at (843) 720-8386, or visit www.rsfh.com.

NSABP B-46

A Phase III Clinical Trial comparing the combination of TC plus bevacizumab to TC alone and to TAC for women with node-positive or high-risk node-negative, HER2-negative breast cancer. The main purpose of this study is to learn if adding bevacizumab to standard treatment with chemotherapy (docetaxel, doxorubicin, and cyclophosphamide) for early stage HER2-negative breast cancer will prevent breast cancer from returning. A second purpose of this study is to learn if adding bevacizumab to treatment with chemotherapy will help women with HER2-negative breast cancer live longer. The researchers are also investigating potential side effects of this particular combination of drugs.



RSFH Website Offers CaringBridge, a Patient and Family Resource

CaringBridge® is a charitable nonprofit offering free personalized websites that allow patients and family members to stay in touch with loved ones during a health crisis, treatment and recovery. The service helps ease the burden of keeping friends and family updated, while also providing a way for them to send their love, support and encouragement.

With a few keystrokes, Roper St. Francis patients and family members can quickly and easily create private and personalized websites that display journal entries and photographs. Family and friends visit the site to read health updates and leave messages of support in the guestbook.



Visit www.rsfh.com

Medical Society of South Carolina

Founded in 1789, the Medical Society of South Carolina is the fourth oldest medical society in existence and has been influential in promoting healthcare excellence for almost 320 years. Its history is long and proud: in 1824, the Medical Society founded the Medical College of South Carolina (known today as the Medical University of South Carolina) for teaching and research, and in 1852, with a bequest from the will of Col. Thomas Roper, the Society established Roper Hospital "to treat all sick and injured people without regard to complexion, religion, or nation," and to serve as a teaching hospital for the Medical College. Today, members of the Medical Society of South Carolina remain dedicated to improving the health of our community through clinical excellence, support and participation in Roper St. Francis Healthcare and other endeavors.

The Medical Society of South Carolina is the majority owner and a founding member of the Roper St. Francis Healthcare System. The Society provides funding for state-of-the-art equipment and other capital needs. These important initiatives positively impact the quality of medical care that Roper St. Francis provides in the community.

Membership in the Society is considered an honor and is open to any physician on the active medical staff of a Roper St. Francis Healthcare facility. An application and two recommendations from Society members are required.

If you would like more information about joining the Medical Society, please call (843) 789-1789.

New Physicians

Roper St. Francis Healthcare welcomes the following board certified physicians to its active medical staff:

Daniel Carson, DMD
Oral Surgery/Dentistry

Tal Klatchko, DO
Internal Medicine

Gene Saylor, MD
*Internal Medicine/
Hematology/Oncology*

Francis "Arc" Clarkson, MD
Emergency Medicine

Heather McIntosh, MD
Orthopaedics

Robert Schoderbeck, MD
Orthopaedics

Thomas Davis, MD
Surgery

Ronald McVicar, MD
Otolaryngology

Kenneth Silvia, MD
Anesthesia

Jennifer Fisher, MD
OB/GYN

Brian Morris, MD
Gynecology

Aldona Spiegel, MD
Plastic Surgery

Mark Ghegan, MD
Otolaryngology

Gregory Nelcamp, MD
Anesthesia

Lee Yarborough, MD
Dermatology

Noelle Jennings, DO
Emergency Medicine

William Proctor, MD
Radiology

Andrew Roberts, MD
Pain Management



316 Calhoun Street
Charleston, SC 29401

www.rsfh.com