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After Joint Replacement Surgery
As we reflect upon St. Joseph’s 140th anniversary of serving Central New York, I’d like to take this opportunity to mention another very notable anniversary in our community and life as a hospital. In 2010, the Sisters of St. Francis—St. Joseph’s founders and sponsors—will celebrate the 150th anniversary of their arrival in Syracuse. Beginning with just a handful of sisters who came to teach immigrant children, the sisters’ reach has extended far and wide and has greatly advanced the quality of life in Central New York. We owe them a great deal of gratitude. Their vision and courage to establish St. Joseph’s Hospital in 1869 to care for the sick and poor has continually inspired the St. Joseph’s community to live boldly and faithfully.

As St. Joseph’s looks ahead, we admit that the future is often uncertain. Health care reform, an aging population in need of advanced medical care, and a sluggish economy all loom. Yet, like the Sisters of St. Francis, we proceed bravely yet practically to plan for the health care needs of the 21st century.

Having recently completed Phase I of a facility master plan that included a new Medical Office Centre, sky bridge, parking garage, and main entrance and lobby, we are carrying that momentum into Phase II. At a total estimated cost of $220 million, the first part of Phase II will include a new emergency department, clinical observation unit with a focus on chest pain, psychiatric emergency unit, kitchen, green space and data center. The second part will include a patient tower with private rooms, operating room suite with hybrid technology, green space and a corridor to North Side businesses.

St. Joseph’s expansion is the largest green health care facility project in Upstate New York, and we will seek LEED silver certification. The project will include a green roof and data center, solar panels, day-lighting views, energy-conserving systems, greenway park, site drainage, as well as upgraded underground water and storm water infrastructure.

This transformative project will meet patient and community needs:

- accommodating an estimated 40 percent increase in emergency department visits by 2015
- increasing access to health care; 64 percent of St. Joseph’s patient visits are Medicare, Medicaid or self-pay
- creating approximately 600 construction and 200 permanent health care jobs
- generating an expected $1 million to $2 million in additional local revenues (e.g., meals, room and board, as well as ancillary expenditures)
- helping to revitalize the North Side in collaboration with other organizations, including the city of Syracuse, Onondaga County, New York state, New York State Energy Research and Development Authority, Metropolitan Development Association, Central New York Regional Planning Board, Home Headquarters, Housing Visions and North Side Collaboratory.

In order to fund this auspicious project, St. Joseph’s is conducting a fund-raising campaign, Generations of Compassion, Healing, Innovation, that will reach out to our employees, friends, physicians, community leaders and foundations as well as government funding sources.

We firmly believe in the viability of this initiative to expand and modernize our facility. Our patients and their loved ones depend on St. Joseph’s, and this investment in our community and its health care is never more needed.

In the spirit of our founders, the Sisters of St. Francis, who stepped out boldly to help those in need more than a century ago, we pledge to be good neighbors and good stewards as we embark on this initiative for our collective future. We are committed to you.

Sincerely,

Theodore M. Pasinski
President
Kathryn Ruscitto has been named executive vice president of St. Joseph’s Hospital Health Center. Under the leadership of Theodore M. Pasinski, president and chief executive officer, Ruscitto will guide the leadership structure and provide overall direction for the administrative team. Mary Brown will continue to serve as senior vice president and chief operating officer responsible for aligning the operations structure for St. Joseph’s network.

“Kathryn Ruscitto has been an enthusiastic and visionary leader for St. Joseph’s network,” says Pasinski. “In her new position, she will continue to lead us to achieve our vision to be world-renowned for passionate patient care and outstanding clinical outcomes.”

Ruscitto has served as St. Joseph’s senior vice president of strategy, development and government affairs since 2001. In addition to leading the organization in strategic planning, Ruscitto was responsible for overseeing mental health services, facility and support services, marketing, communications and development, mission services, and physician relations. She also has served as the hospital’s liaison to government and community organizations.

“During her tenure with St. Joseph’s, Ruscitto has led successful team efforts to build strategic alliances, streamline business operations, enhance internal efficiencies, and improve employee satisfaction. With a focus on “patient first” and “employee as family,” she has encouraged a cutting-edge health care environment that includes such innovations as Lean Six Sigma, a physician engagement team, green infrastructure, and hospital-led neighborhood revitalization, including a Prospect Hill master plan.

Ruscitto is active in many national and local organizations such as the United Way and the Catholic Health Care Association. She also serves on the boards of several foundations and not-for profits, including the Community Health Foundation of Western & Central New York and the Anna Mahan Foundation.

A resident of Syracuse, Ruscitto holds a master’s degree in public administration from the Maxwell School at Syracuse University and a bachelor’s degree from Le Moyne College.
St. Joseph’s Higher Level of Care Recognized

St. Joseph’s is the recipient of a number of awards and recognitions recently, including:

**Excellence Awards in cardiac care, cardiac surgery and coronary intervention** from HealthGrades®, the leading independent health care ratings organization. The recognition is based on HealthGrades’ 12th Annual Hospital Quality in America study, which analyzed patient outcomes at virtually all of the nation’s hospitals. This is the third year in a row that St. Joseph’s cardiac surgery program has ranked No.1 in the state.

In addition, St. Joseph’s orthopedic program was recognized with a 5-star rating for joint replacement and total knee replacement for the fourth year in a row.

For more information: www.healthgrades.com.

**Chest Pain Center Accreditation** from the Society of Chest Pain Centers. St. Joseph’s is the only hospital in Syracuse with this accreditation. As an Accredited Chest Pain Center, St. Joseph’s ensures patients who come to the hospital complaining of chest pain or discomfort are given the immediate treatment necessary to avoid as much heart damage as possible. Developed by leading cardiac care experts, protocol-based procedures to reduce time to treatment in the critical early stages of a heart attack are part of St. Joseph’s overall cardiac services.

For more information: www.scpcp.org.

**Redesignation as a Blue Distinction Center for Cardiac Care®** by Excellus BlueCross BlueShield. To be designated as a Blue Distinction Center for Cardiac Care, St. Joseph’s meets criteria that include:

- an established cardiac care program, performing required annual volumes for certain procedures (e.g., a minimum of 125 cardiac surgical procedures annually, including both coronary artery bypass graft and/or valve surgery)
- appropriate experience of its cardiac team, including sub-specialty board certification for interventional cardiologists and cardiac surgeons
- an established acute care inpatient facility, including intensive care, emergency and a full range of cardiac services
- low overall complication and mortality rates

For more information: www.BCBS.com.

**Beacon Award for Critical Care Excellence** from the American Association of Critical-Care Nurses, which places St. Joseph’s intensive care units among the top ICUs in New York state and the nation.

For more information: www.aacn.org.

St. Joseph’s Home Care cited as one of the top 500 home care providers in the United States, according to the 2009 HomeCare Elite Top 500 List from Outcome Concept Systems (OCS), the leading post-acute health care information company. St. Joseph’s Home Care was one of only 15 home care agencies in New York state—and the only one in Onondaga County—to receive this designation.

In addition, **Hospitals Home Health Care is one of the top 100 home care providers in the United States**, according to OCS, and the only home care agency in New York state to receive this designation. Hospitals Home Health Care is a partnership of Oswego Health and St. Joseph’s Hospital Health Center, focusing on serving patients in their homes in Oswego County.

For more information: www.ocshomecare.com.

St. Joseph’s also has been redesignated by the American Nurses Credentialing Center as a **Magnet Hospital for Nursing Excellence**. Magnet is widely accepted as the nation’s highest honor for nursing services, recognizing excellence and professionalism in nursing.

For more information: www.nursecredentialing.org.

**ACS Patient Navigator Program Now at St. Joseph’s**

The American Cancer Society and St. Joseph’s Hospital Health Center have formed a special collaboration as an extension of their ongoing commitment to provide guidance and support to cancer patients, survivors and caregivers through the American Cancer Society Patient Navigator Program.

Patient navigators are specially trained American Cancer Society staff and volunteers who are available to provide support and link cancer patients, survivors and caregivers to needed information and resources throughout the cancer journey, including ACS programs and services, as well as community resources to help with common concerns associated with cancer such as finances, housing, transportation and many other issues.

To contact a patient navigator, call 315-433-5658.
For additional information anytime, call toll-free 1-800-ACS-2345 or visit www.cancer.org.
St. Joseph’s Founders Celebrate 150 Years of Serving Syracuse

There is comfort in living with what we know, in keeping things the same as they always were. Yet we all realize that change is inevitable, and it offers great opportunity.

Just ask St. Joseph’s sponsors, the Sisters of St. Francis, who next year will celebrate the 150th anniversary of their arrival in Syracuse in November 1860 to teach immigrant children.

Within nine years of arriving in the city, five of the sisters, responding to a need to care for those suffering from the common malarial and typhoid fevers of the day, purchased an old dance hall and saloon in 1869 and transformed them into Syracuse’s first hospital—St. Joseph’s. Equipped with compassion to care for the sick poor, vision and tenacity, the sisters laid a foundation of care that has evolved and prospered over 140 years. The original 15-bed hospital staffed by the sisters (who were known to go house to house seeking alms and supplies to make ends meet) has grown into a 431-bed hospital and health care network serving 16 counties with an annual $435 million budget.

“Through the years, the sisters’ constant presence (see page 7) has anchored the hospital and has been described by one retired employee as “a peaceful port in the storm.”

As the number of sisters available to serve St. Joseph’s declines, the hospital will remain viable, assures Sister Grace Anne Dillenschneider, St. Joseph’s former vice president of mission and former general minister to the Sisters of St. Francis.

“The sisters hear frequently from employees and physicians how special it is to work in a faith-based organization. As the torch continues to pass from the sisters to others, it may be different, but that is OK. It will transform us.”

—SISTER ROSE ANN RENNA

“Instilling the importance of living St. Joseph’s mission begins before an employee is ever hired and is reinforced continually. During the interview process, prospective employees are shown a video that explains St. Joseph’s mission and values, so they can determine if they and St. Joseph’s would be a good fit. Sister Rose Ann Renna, vice president for St. Joseph’s mission services, is photographed leading a 2006 new employee orientation session during which St. Joseph’s history, mission and core values are reviewed.

““The sisters work together with laity to understand and practice the compassion, reverence and respect that have been a constant since the hospital’s founding,” says Sister Grace Anne. “There is honor and respect on both parts, and the sisters entrust the laity to carry on the Franciscan values as the sisters physical presence becomes less and less.”

“Our physicians, nurses, all of our support services, and every one of our employees share in a common bond to serve our patients and their families,” says Sister Mary Obrist, who recently retired as St. Joseph’s vice president for support services. “That is why we are all here. It is our common purpose and our way of life.”

There is no doubt “the sisters work in partnership,” explains Sister Rose Ann Renna, St. Joseph’s vice president for mission. “The sisters hear frequently from employees and physicians how special it is to work in a faith-based organization. As the torch continues to pass from the sisters to others, it may be different, but that is OK. It will transform us.”

The teaching and practicing of Franciscan values at St. Joseph’s is continual.
Identifying a need for medical care in Syracuse, five Franciscan sisters purchased two buildings (on the far left and far right) in 1869 for $12,000 and constructed a three-story structure in the center to join them. In doing so, they established St. Joseph’s, the city’s first hospital.

With the input of employees, physicians, board members and sponsors, St. Joseph’s recently adopted a clearer and more succinct mission statement and core values that give guidance in living that mission (see page 3). Other initiatives to teach Franciscan values include training sessions; a planned pilgrimage to Assisi, Italy, home of St. Francis of Assisi, the Franciscan sisters’ patron saint; as well as an emphasis for all to live the mission each and every day through their work.

“The sisters established their ministries because they saw a need,” says Sister Grace Anne Dillenschneider. “Our ministries have helped others, but have been a blessing to us as well. Our relationships with those at St. Joseph’s have been reciprocal. It is not only what the sisters have given through the years, but what we have received from those we have worked with, as well.”

Congratulations to the Sisters of St. Francis on the 150th anniversary of their arrival in Syracuse and the 140th anniversary of the founding of St. Joseph’s Hospital Health Center. Secure in the Franciscan tradition, we are prepared to provide a higher level of care well into the future.

Over the decades, St. Joseph’s continued to expand to meet growing patient needs. Sisters M. Wilhelmina Fitzgerald, Mother M. Carmela Prandoni and Sister M. Antonia Fleck (from left to right) were photographed with Arnold Kaufmann, MD, in 1950 when St. Joseph’s dedicated a new wing that added 170 beds, a new operating room, lab, X-ray, pediatrics and outpatient department.
In celebration of the 140th anniversary of St. Joseph's Hospital Center, which was founded by the Sisters of St. Francis in 1869, we reprint the names of all the sisters who have served the hospital during that time. Their vision and commitment to serve those in need—whether as administrators, medical care providers or volunteers—has prospered both St. Joseph's Hospital Center and the Greater New York community. We recognize and thank them.
Successful Knee Replacements Seem To Be Par for the Course

At 78, Harold Willard leads a physically active life that includes mowing other people’s lawns and climbing ladders to clean out friends’ gutters—the kinds of things that good neighbors do for each other even if it hurts a little.

The turning point for Willard, however, came when the pain in his right knee started affecting his golf game as well as his good deeds.

“The pain got so bad that he had to ride in a golf cart, and he hates that,” Willard’s wife, Barbara, says.

Willard sought out John F. Parker, MD, a St. Joseph’s orthopedic surgeon, to determine what was happening to what had always been a reliable joint, and whether anything could be done to stem the pain.

Like many other Central New Yorkers treated at St. Joseph’s Hospital Health Center each year, Willard’s knee had gradually succumbed to decades of stress created by years of work as a pipefitter/steamfitter, and years of play chasing a little white ball around the golf course. The cartilage that normally cushions the joint where the upper leg bone (the femur) meets one of two lower leg bones (the tibia) was gradually worn away, allowing bone to rub on bone. The resulting pain, he discovered, would continue to increase and hamper his mobility.

The alternative was a total knee joint replacement performed by Dr. Parker at St. Joseph’s, where thousands of others have had successful knee, hip and shoulder replacements. It’s an elective surgery, but not one to be taken lightly. While most of the focus is on the 45- to 90-minute surgery itself, there is far more to a successful outcome than what happens in the operating room. Practice makes perfect, and St. Joseph’s has developed, tested and standardized a start-to-finish hospital-wide process aimed at giving patients the best mobility.

When explained by John Parker, MD, the mechanics of an artificial knee are fascinating, but to Willard and his wife, Barbara, the most important aspect of the prosthesis is the immediate relief of pain—pain that otherwise would have grown worse with each passing year.

Perhaps the first step in the process for the patient is realizing that something can be done. Dr. Parker says. He vividly remembers watching joint problems slowlyconfine his paternal grandmother to painful disability. At the time, he said, there was little that could have been done to reverse or halt her decline. Not so today, he says.

“When a joint becomes painful with every step, when people can no longer get up out of a chair, when they can’t prepare food for themselves, or handle other daily tasks, they need to understand that the opportunity exists to return them to a higher level of function,” Dr. Parker says.

“The process can be challenging with a lot of work on the part of the patient, but if they want to be better, most of them can be. These procedures are safe for people even into their 80s.”

Once the decision had been made and the June 30 surgery date set for Harold Willard’s knee replacement, events happened quickly.

Back to school with “Joint Class”

JUNE 24—A week before surgery, Willard and other joint replacement patients meet at St. Joseph’s for what is commonly called the “Joint Class.” The hour-long session presented by nurses, physical therapists and discharge planners acquaints patients with what to do, what not to do, and what to expect before, during and after the surgery. Even before the Joint Class, the Willards received a 28-page booklet published by the hospital and aimed specifically at those scheduled for knee replacement surgery.

Terra Crannell, RN, who leads the Joint Class, puts a more human face on it with her comments:

• “You’ll receive a joint replacement card after the surgery that may help you explain why you’re setting off the metal detectors at the airport.”

• “From now on, you need to pre-medicate before dental appointments or procedures like colonoscopies to help prevent infection, so you don’t get yourself in a pickle!”

• “After the surgery, it’s really important to get up, get moving and work with the physical therapists! If you don’t get up and do the exercises you need to do, it’s not going to matter how good your surgeon is.”

That message, more than any other, is the most repeated.

Welcome. How are you feeling?

JUNE 24—Immediately after the Joint Class, Willard moves on to pre-admission testing (PAT) to confirm he is fit for surgery. Nurses in PAT review Willard’s health history and order any required blood or urine testing, electrocardiograms or other tests. They also carefully review any medications that Willard is taking to make sure there will be no interaction with drugs he may receive during his hospital stay or be required to take after his discharge.
time for a “gut check”

JUNE 29—Less than 24 hours before his surgery is scheduled to begin, the Willards meet with Dr. Parker one more time. It is kind of an “OK, are you sure you want to go through with this?” session.

Dr. Parker reiterates that he will be performing a total replacement of Willard’s right knee using the standard prostheses used on almost every patient, but he may have to make changes during the surgery depending on what he encounters. He then repeats a list of possible risks—some small, some devastating but highly unlikely.

“You may not like these risks, but do I still have your consent?” Dr. Parker asks.

“You do,” answers Willard. “I’m looking forward to it.”

Today’s the day!

JUNE 30—The alarm clock awakens the Willards at 3:30 a.m., so they’ll have plenty of time to get ready for the drive to Syracuse and their 6:30 a.m. appointment at St. Joseph’s. “We wouldn’t want to be late for anything, would we?” Willard asks with the puckish grin that would become his trademark after the surgery and during his rehabilitation.

Throughout his 78 years, Harold Willard has never been a patient in a hospital and never experienced surgery. Everything Willard is about to experience will be new to him, of course, but the fact is that many of the advanced techniques and procedures used by the St. Joseph’s orthopedic surgeons would be new to any orthopedic surgery patient in Central New York.

The hospital gowns haven’t changed much, but Willard’s introduction to his anesthesiologist, Mark Cady, MD, was indicative of what would follow. Instead of receiving his anesthesia in the operating room, Willard is anesthetized in what is now referred to at St. Joseph’s as the “line room” in a quiet alcove off the hallway leading to the hospital’s surgery suite.

“Good luck. I love you,” Willard’s wife says as her husband is rolled into the line room. “Do everything they say.”

The line room is dedicated solely to offering patients a quiet, calming space in which to begin their anesthesia, Dr. Cady says. The process can be stressful, but the intimate atmosphere, they’ve learned, reduces anxiety.

For what seems like the hundredth time, the anesthesia nurse gently quizzes Willard about his name, his birth date and what the surgeon will be doing to him today. She also looks at a distinct “JP”—the surgeon’s initials near Willard’s knee—as confirmation that it is the right knee joint that will be replaced.

Before administering a mild sedative, Dr. Cady tells Willard he will be somewhat awake during the surgery, but unable to feel any pain from his waist down thanks to a pair of peripheral nerve blocks that eliminate pain in the area of the knee and a shorter acting spinal block that will numb everything from his waist down.

“Whatever the peripheral blocks miss, the spinal block will get,” Dr. Cady explains. “The blocks may not work, in which case we’d have to use a general anesthetic, but almost every patient prefers to be mildly awake during the surgery. Their post-operative recovery is faster, we use very little narcotics that way, and the peripheral blocks may last for almost 24 hours making it easier for the patient to begin physical therapy after surgery.”

continued on next page
After allowing a few minutes for the blocks to take effect, Willard is rolled into one of 12 operating rooms, three of which are designed specially for orthopedic surgery. It looks as if it might have been lifted from the set of a science fiction movie. Virtually everything in the room is designed to lower the chance of infection for the patient.

The surgeon, surgical resident, physician assistants and nurses are draped in blue gowns from head to foot—more or less standard garb for any operating room—but the similarities with other operating rooms end there. Everyone in the room also is wearing a full helmet with a clear faceplate and an internal fan that keeps the wearer cool while further reducing the chance of airborne infection.

The full coverage, including gloves for everyone, allows the hospital to use another microbe-busting technology—ultraviolet lighting. The invisible UV radiation bathing everything in the room is a potent bacteria killer, but it would also burn any exposed skin in a matter of minutes were it not for the protective clothing. Needless to say, the patient also is well shielded from the UV light.

The surgery itself will only take between 45 and 90 minutes, but everything stops one last time before, as Dr. Parker says, a knife is lifted.

“What we call the ‘time out’ mandates that we check every detail one more time and that I am satisfied we’ve taken all the precautions we can to insure Mr. Willard a safe, successful surgery,” Dr. Parker says.

The circulating nurse, standing outside the “sterile field” reads from a two-page prepared script asking questions to which each person on the surgical team must respond.

“Our patient is Harold Willard,” she begins. “Mr. Willard will be having a right knee replacement. Is that your understanding?”

Each answers.

“Please visualize the surgical site. I can see that Dr. Parker’s initials are present and visible over the right knee within the prepped and draped area. I need each of you to confirm this for me, as well.”

The circulating nurse questions whether all the prostheses and equipment needed are available, whether blood products are at the ready, whether Mr. Willard has had antibiotics, whether the X-ray images on display represent the correct knee... everything, as Dr. Parker says, to make sure the “side, site and procedure” are confirmed.

“The time out has been completed. You may pass the instrumentation to begin the case,” the nurse states.

It’s 8:24 in the morning and tension in the room seems to palpably fade as Dr. Parker makes the first cut—a six- or seven-inch vertical, centerline incision starting just above the knee and ending just below it. It exposes one of the most complex joints in the human body, but makes clearer what has to happen to restore function and eliminate the pain in Harold Willard’s right knee. Essentially, the worn lower end of the femur and the worn upper end of the tibia must be replaced with smooth polyethylene prostheses. The under part of the patella, or kneecap, also will get a new polyethylene replacement. A polyethylene insert will be snapped in between the top of the new tibia and the bottom of the femur so both bones will have a solid, smooth surface on which to glide.

Easy to describe in a paragraph, it is much harder to accomplish.

The process begins as the kneecap that slides over the lower end of the femur as the knee flexes is carefully nudged to one side, but is still connected to thigh and lower leg muscles by tendons at each end. Dr. Parker continues from page 9

continued on page 12
The small amount of blood Harold Willard "lost" during and after his knee replacement surgery wasn’t really lost at all; it was filtered, washed and went right back into his body as part of St. Joseph’s blood conservation program.

Actually, because of other blood conservation techniques during his surgery, it amounted to only about two fluid ounces of concentrated red blood cells—about the same volume as a couple of tablespoons of water.

But when you add up the number of orthopedic and cardiac surgeries at St. Joseph’s each year, the amount of concentrated red blood cells used is huge. In 2008, the hospital transfused 13,750 units into patients. The good news is that by the end of 2009 St. Joseph’s blood conservation program will have reduced the amount of blood the hospital transfuses to about 11,500 units—a decrease of 2,250 units.

The goal is to reduce it even more, and for good medical reasons.

America’s blood resources seem to be in a constant state of low supply. In many cases, however, there are no other substitutes for whole blood, “packed” red blood cells, and other blood products. So preserving that blood for patients who really depend on it makes sense.

Says Barb Wagoner, CCRN, St. Joseph’s integrated blood conservation program associate: “When you’re bleeding heavily, there’s nothing else like it, but there are downsides to transfused blood, as well. There is an increased risk for infection, for example, that is caused by the body’s response to someone else’s blood. The risk for developing HIV and hepatitis C is very small, but few people are aware of the other risks. The evidence is there. The American College of Surgeons released a report in June with findings that a patient receiving two units of blood during treatment faces a 14 percent increased risk of possible infection, pneumonia or death. Clearly, it’s better for patients, where possible, to have their own blood conserved and returned to their body,” Wagoner says.

In 2007, St. Joseph’s Hospital Health Center was one of four hospitals in the country asked by the American Red Cross to take part in an investigation of various ways to decrease the use of transfused blood and blood products. St. Joseph’s is in the third year of the study now and reports that the hospital has recorded a 400 percent decline in the per-patient requirement for concentrated red blood cells from 1.6 units to 0.4 units in orthopedic surgery.

Barb Wagoner says the dramatic decrease has been accomplished in a variety of ways:

- Prior to surgery and childbirth, patients are screened for anemia or lack of red blood cells. They are taught about the advantage of iron-rich diets and vitamin therapy to raise their red cell count before they come to the hospital.
- If necessary, patients may come in for outpatient iron transfusions to raise their iron levels.
- When blood is drawn for testing, the amount drawn has been more than cut in half.
- During surgery, especially joint replacements and other orthopedic surgery like that undergone by Willard, techniques are used to prevent bleeding in the first place. During Willard’s surgery a tourniquet on blood vessels leading to the surgery site stopped the blood flow.
- When there is bleeding, as when the tourniquet is removed, the patient’s blood is suctioned away from the surgery site and processed through machines that separate and remove damaged blood cells, fat cells or other waste. The blood is then bathed in sterile salt water to remove any other contaminants, and then returned to the patient’s body. The procedure continues even after surgery with temporary drains.

“Clearly, it’s better for patients, where possible, to have their own blood conserved and returned to their body,” Wagoner says.

Harold Willard wasn’t expected to lose much blood during his surgery, but with St. Joseph’s Hospital Health Center’s blood conservation program any blood he loses will be filtered, cleansed and returned to his system instead of relying on a transfusion. Explaining the program to Willard is Barb Wagoner, CCRN.
carefully scoops a semi-spherical section of worn bone from the underside of the patella creating a depression that will later be filled by a smoothly cupped prosthesis.

Moving the kneecap and bending the knee exposes the bottom surface of the femur that is similar in shape to the toy rubber bones found in pet stores. Using a precision oscillating saw, Dr. Parker removes the rounded edges of the bone forming a cube-shaped structure to which the femoral component can be attached.

It’s more difficult than it sounds. Dr. Parker removes small amounts of bone in a series of steps. As he says, “It’s easy to take off bone, it’s impossible to put it back on. That’s why I take off as little bone as possible and measure each time until the prosthesis we’ve selected fits.”

Preparing the upper end of the tibia involves making a flat cut across the bone. Dr. Parker and his team must precisely measure both the length of bone to be left and its alignment with the shaft of the tibia. Once the cut is made, Dr. Parker uses a drill, a mallet and a “keel punch” to create a two-inch deep opening in the core of the bone into which the tibial component can be inserted and pounded home with a mallet using what Dr. Parker describes as “gentle, controlled force.”

After all three metal prostheses are attached with bone cement, Dr. Parker is ready to reassemble the joint and snap in the insert, the “articulating surface,” upon which the ends of the femur and tibia will ride. It’s 9:32 when Dr. Parker begins to close the incision.

His next task is letting the Willard family know that their husband and father has come through the surgery with flying colors. Dr. Parker, who has three more surgeries to perform that day, excuses himself and heads for the St. Joseph’s cafeteria for a quick cup of coffee, and a debriefing.

“We didn’t find anything with Mr. Willard that we didn’t expect,” Dr. Parker says. “We know almost everything when we go in from looking at X-rays and examining the patient physically—there are very few surprises if you do it right.”

Dr. Parker often talks in the plural when he discusses successful knee surgery. Success depends as much on his associates as it does on the surgeon.

“There are always a dozen things you need, and a good circulating nurse knows exactly where to find them. We keep them running, and anything we can do to prevent delays is good for the patient because he or she spends less time under anesthesia and there is less risk of infection.

“The same is true with a good scrub nurse. If there’s a shift in plans, if something out of the ordinary happens, he or she will have the right instrument ready for you almost before you think of it yourself. You reach your hand back and whatever you need is right there.”

But there are singular pleasures, too. For Dr. Parker, it’s seeing a patient a month or two after the surgery walking briskly without pain.

“I think of my grandmother every time I see a patient struggle into my office in pain,” he says. “I think of her, too, every time a see a patient leave my office with a smile.”
The road back
JUNE 30-JULY 2—When Andy Childs, PT, walks into his life a little more than five hours after his surgery, Harold Willard is ready for him. He’d heard about the pain he might expect as he was encouraged to stand up, get out of bed and walk mere hours after major surgery. “I don’t care how tough you are with me,” Willard says in mock ferocity. “I want to get it done, so let’s go!”

Along with Jill Townsley, a physical therapy student, Child’s goal is to get Willard out of bed for the first time and possibly get him to take three or four steps, turn around and walk back to bed. He’ll also give Willard some exercises to do in bed that will ready him for two far more strenuous hour-long therapy sessions on the day after his surgery. Childs has found a willing conscript in Willard.

After maneuvering himself to the edge of the bed, swinging his legs gingerly over the edge, and grasping a wheeled walker for support, Willard shoots erect as if he had been ordered to attention on the battleship Wisconsin during his first tour in the navy. When Childs and Townsley regain their composure, Willard slowly walks six feet to the wall, turns around and walks back to the bed. He completes that circuit two more times before Childs says he can get back in bed again.

“No pain,” Willard smiles. “You probably won’t feel so good tomorrow when the peripheral nerve blocks have worn off,” Childs warns. “But don’t hesitate to take your pain medications. It will allow you to do more in your therapy sessions and regain the strength and mobility you’re after.”

Once again Childs is surprised by Willard’s performance the next day in the hospital’s physical therapy center.

“Our goal here is to make sure that patients can get around safely when they’re discharged, but he’s exceptional,” Childs marvels. “Most knee patients are five to 10 percent shy of full extension of their leg. Mr. Willard is within one or two percent already and he’s not showing any apparent pain.”

Homeward bound
JULY 2—There are no fireworks for Harold Willard on his Independence Day, but he does meet a very good friend in Darrell O’Keefe, RN, MS, his case manager or, as he’s also known, discharge planner.

With orthopedic surgeries like Willard’s, care doesn’t end when patients leave the hospital. There are still weeks of physical therapy left and where patients go for post-surgical care depends on many variables. It’s O’Keefe’s job to sift through those variables, keep track of patients’ medical recovery, and chart the right course for his patients. It turns out to be relatively easy

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As novice ballet dancers use the bar or “barre” for extra support, likewise the bar becomes Willard’s silent partner as he learns to use his new knee under the guidance of Andy Childs, PT, a St. Joseph’s physical therapist.
As Linda Kelly, RN, prepares to painlessly remove the “staples” from Harold Willard’s incision, Willard is waiting for the words he has longed to hear for two weeks: “You are now free to take a shower!”

Inpatient physical therapy at a site near his Fulton home was the answer for Willard, but O’Keefe ran into some obstacles. The first center he tried did not accept Willard’s health insurance. A second center accepted his insurance, but was fully booked. The answer was the Oswego Hospital about nine miles away from Willard’s home.

Outpatient physical therapy at a site near his Fulton home was the answer for Willard, but O’Keefe ran into some obstacles. The first center he tried did not accept Willard’s health insurance. A second center accepted his insurance, but was fully booked. The answer was the Oswego Hospital about nine miles away from Willard’s home.

A wobbly balance board at Oswego Hospital—near Willard’s home—helped him to rebuild strength in his knee, but also helped him relearn the fine motor skills involved in maintaining his balance. Joel Julian, PT, helps Willard for five weeks of regular physical therapy sessions.

During a late afternoon break in his already busy day, O’Keefe says each patient is different, each family is different and each insurance company has different restrictions on patients’ post-discharge care.

“It requires adaptability and a broad knowledge, but that’s why I love my work,” O’Keefe says. “It’s also enjoyable to have such a close working relationship with nurses, doctors, physician assistants and families as we all work toward getting the best for patients like Mr. Willard after they leave St. Joseph’s.”

**Par for the course**

**JULY 8**—Harold Willard’s hospital experience has lasted three days, but he faces physical therapy three times a week for the next four to six weeks to “reeducate” the muscles in his right leg, says Joel Julian, PT, a physical therapist at Oswego Hospital.

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for Harold Willard, but not without some patience and persistence on O’Keefe’s part.

“I am essentially an advocate for each patient trying to get them good information and making sure they get the care they deserve after they leave the hospital,” O’Keefe says.

“Mr. Willard doesn’t need home care from a certified home care agency because he has great support from his wife and their home is on a single story with only three or four steps up to the front door. His progress during his hospital physical therapy was phenomenal, as well, so he doesn’t need skilled nursing care at a separate rehabilitation center.”

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Approaching Orthopedic Care as if It Were the Olympics

C

hat with Seth Greenky, MD, and Kim Murray, RN, MS, CNOR, about successful orthopedic surgery, especially total joint replacements, and it won’t be long until they mention the Olympics.

Neither is an Olympic-caliber athlete, nor have any of their patients been, but they are fond of comparing St. Joseph’s Hospital Health Center’s joint replacement program with the ultimate in individual and team competitions. The goal at St. Joseph’s, both say, is to inch ever closer to the Olympic ideal of perfection. St. Joseph’s success with and leading reputation for total joint replacements can be laid at the feet of the department’s and the hospital’s constant striving to, as an Olympic sprinter might say, “shave a fraction of a second off here and there.”

As Dr. Greenky explains: “Prolonged operative time increases the risk for infection. We don’t just focus on speed, but strive to complete the procedure in the most efficient way possible. We’re good at what we do, but we never stop trying to improve.”

These constant improvements, says Murray, St. Joseph’s director of surgical services, is the result of a closer collaboration between St. Joseph’s administrative staff and the orthopedic surgeons through the establishment of “co-management” of the hospital’s orthopedic surgery offerings.

“There is now a shared responsibility for the changes that make these procedures better for patients clinically and better for the hospital operationally and from a cost-containing standpoint,” Murray says. “With this close cooperation and shared service line responsibility between the hospital staff and surgical staff, we can now identify improvements, implement those improvements instantly and sustain the outcomes associated with those changes.”

A significant part of St. Joseph’s success can be attributed to the thousands of joint replacement surgeries that have been performed successfully. As word of those successful outcomes spreads, more and more

Seth Greenky, MD

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...seek them out—success breeds success. More than 1,000 joint replacement surgeries were performed at St. Joseph’s in 2008, and that number is expected to increase to nearly 1,100 this year.

“A multitude of studies over the years has shown that, regardless of what kind of surgery you’re talking about, if you go to a hospital that does a large volume of those surgeries, the outcomes are better,” Dr. Greenky says. “We do more than anyone, and our success is reflected in those numbers.”

But there’s more to it, he says, than large volumes.

Hip and knee replacement is not an individual “sport.” It is, Dr. Greenky stresses, a team effort in which the surgeon is only one part. Even with the best “athlete”—the best surgeon—the overall effort is compromised if other members of the team don’t perform up to standard.

“Our teams are composed of specialists,” Dr. Greenky continues. “Our nurses, many of them with advanced credentialing, do this every day, and, clearly, the more you do it, the better you are at it. It really is a team effort. They get to know the surgeons and anticipate our requests even before we ask for something. They magnify our strengths and that, ultimately, helps the patients.”

This specialization that differentiates St. Joseph’s joint replacement program from others, Dr. Greenky says, did not happen by itself. It was the result of this close collaboration, brainstorming and hours of discussions among hospital administrators, surgeons and nurses about how an already good program could be improved.

Good examples of this closer working relationship are changes to the operating rooms used for joint replacement surgery. Two years ago, St. Joseph surgeons, anesthesiologists, physician assistants and nurses within the “sterile field” were wearing traditional sterile gowns, head coverings and surgical masks to minimize the chance of infection—a serious concern in joint surgery because infection may necessitate removing the joint components, treating the area with antibiotics for weeks and then repeating the operation. St. Joseph’s infection rates remain lower than national averages, and the hospital is careful to carry out all known best practices to reduce this risk.

Why? In St. Joseph’s joint replacement operating rooms today, everyone in the room wears a full-body sterile suit including a helmet equipped with a battery-powered fan for air circulation. And, although it’s invisible, the room’s lighting system is augmented with ultraviolet (UV) lights that kill bacteria. UV lights have been shown

Kim Murray, RN, MS, CNOR

to reduce infection rates dramatically. As an aside, the suits also protect the surgical staff from serious sunburn caused by the UV lights. (Sterile drapes protect the patient.) Since anyone who enters the operating room without the suit would be at risk of sunburn, the traffic into and out of the operating rooms is reduced dramatically. That reduction in traffic as well as the number of individuals in the room, Murray says, eliminates another source of possible infection.

“Infection rates in Syracuse are very low,” Dr. Greenky says, “but if the patient does get an infection, the consequences are serious, so we work all the time to figure out ways to reduce those chances even more.”

The high joint replacement volumes at St. Joseph’s also have allowed the staff to develop standard procedures that apply from before a patient is admitted to well after the surgery is complete. St. Joseph’s Web site (www.sjhsyr.org) lets them know what to expect. Just before admission, as with Harold Willard, patients and family members enroll in “Joint Class” that teaches them some “dos” and “don’ts” to remember. On the admission day, everyone is admitted through the same location and undergoes the same experience-tested “routine.”

“Our processes are aimed at one thing,” Dr. Greenky says, “continually improving the outcomes for our patients.”

That, he says, is better than any gold medal.
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He starts out with heel stands, toe stands and weight resistance training as Julian has him walk 10 steps forward and 10 steps back. Sounds easy, but with each step Willard tugs against cables attached to 50-pound weights.

“It doesn’t hurt,” Willard says, “but I feel a little like a drunken sailor. I expect the Shore Patrol will be along any time now. I may joke about it, but everyone has said that keeping up with therapy is the most important part for the long term, and I intend to stick with it.”

Willard also undergoes some “passive” exercises in which he lies on his stomach as his therapist grasps his ankle and bends his lower leg as if he’s trying to touch Willard’s heel to the back of his thigh. For the first time since his surgery, Willard grimaces each time Julian brings the lower leg forward.

“Mr. Willard doesn’t want the surgery to slow him down, so I’m essentially telling his muscles this is what they’re supposed to do,” Julian says. “Actually, he’s phenomenal. There doesn’t seem to be anything he can’t do.”

Finally, a hot shower!

JULY 13—It has been two weeks since Willard’s surgery and today he hears the words he’s wanted to hear the most. As Linda Kelly, RN, painlessly removes the last of more than a dozen metal staples that have held his incision closed, she says: “You are now free to take a shower!”

“Ugh, finally. Thank you. Thank you,” Willard says dramatically.

“You’re welcome,” Kelly says. “You’ve been a very good patient. Now you’re supposed to say I’ve been a very good nurse.”

The staples may be out and everyone is smiling, but Dr. Parker will continue to follow Willard’s progress.

“The motion in your leg is terrific,” Dr. Parker tells Willard. “We checked during the surgery and your leg can be extended absolutely straight, although your tendons may argue with that, but there’s no need to aggressively pursue motion.

There is still quite a bit of bruising and a little swelling. We’ll continue to monitor that.”

Fore!

AUG. 6—After physical therapy three times a week for five weeks, Willard’s therapist “fired” his patient, a week early.

“I was scheduled for six weeks of therapy, but he told me I really didn’t have to come back again after five,” Willard remembers. “I could stretch my leg out straight and that’s really what they were after. There is no pain and you could hardly see the scar.”

The therapist wrote a letter to Dr. Parker to that effect and Willard’s surgeon gave him the OK to do anything he wanted, including, of course, golf!

A hole in one

LATE SEPTEMBER—“Dr. Parker told me I was the kind of patient that made surgeons look good,” Willard says. “I took it easy, at first, just nine holes the first week and nine holes the second. I was a little tired after the first nine, but I’m playing 18 holes now and looking forward to playing golf this winter down south.”

The replacement of Willard’s right knee has had other benefits. He now says he can put on a pair of long trousers without holding onto anything for support. He also says his left knee, on which he put extra pressure for years to compensate for the pain in his right knee, was feeling better, too.

“You know, I probably should have had this done years ago,” Willard says, “but I just wasn’t ready. Now I know better.”

Returning to the green—having more fun than playing competitively—Willard and his friend, Dennis Kenney, are back in the game.
Accreditation as Chest Pain Center Again Distinguishes St. Joseph’s Cardiac Care

When St. Joseph’s Hospital Health Center received national accreditation as a Chest Pain Center recently, the recognition confirmed what had already been informally understood for years—hearts are in the right place at St. Joseph’s. In fact, St. Joseph’s is the only hospital in Syracuse with the distinction.

The recognition from the Society of Chest Pain Centers, an international not-for-profit agency whose goal is to erase heart attacks as the No. 1 cause of death worldwide, came after St. Joseph doctors, nurses, administrators and any employee even tangentially involved with cardiac care examined themselves under a magnifying glass for nearly nine months. They documented the strengths and any weaknesses in the processes through which incoming patients suffering from chest pain, discomfort or any other possible heart attack symptom, receive treatment—especially in the critical early stages.

“The accreditation shows the public, and us, that we are using the very best evidence-based processes to treat incoming patients with chest pain,” says Therese Whitt, MD, chair of emergency services and co-chair of the Chest Pain Center.

The self-examination portion of the accreditation process uses techniques originally developed for businesses, but equally applicable to patient care, which is itself a collection of processes. Each individual process is “flow-charted” by the employees closest to it and any possible gaps in performance are identified and corrected.

It may begin with improving how the hospital works to educate the public about heart attack symptoms and the critical importance of calling 9-1-1 and getting aboard an ambulance as soon as possible.

“People tend to wait when they think they might be having a heart attack, and that’s a mistake,” says Ronald Caputo, MD, a cardiologist and co-chair of the Chest Pain Center. “The average patient arrives in the emergency department between two and three hours after the onset of symptoms. The sooner a heart attack is treated, the less damage to the heart and the better the outcome. We’re doing our best to get that information out to the public we serve.”

As one way to speed treatment, St. Joseph’s emergency department has already partnered with several local ambulance companies to install equipment that transmits information about the patient’s heart function from the ambulance to the emergency department. If the patient is having an active heart attack, the literature shows that 15 to 20 minutes can be saved by bypassing the emergency department and taking the patient directly to the hospital’s catheterization lab for further diagnosis and treatment. Even before the ambulance has reached the hospital, emergency medical technicians can be directed to insert two intravenous lines instead of one, saving another minute or two, in the person’s treatment.

Not all patients arrive by ambulance. Some walk through the front door, and there are processes in effect for that eventuality, too, says Virginia Jones, MS, RN, who is the chest pain coordinator and educator in the emergency department.

“Seconds count when someone is having a heart attack, so paying attention to and seeking treatment for symptoms is critical. The sooner an interventional cardiologist like Ronald Caputo, MD, (rear) assisted by Greg LaFrata, LPN, can diagnose a patient’s problem and begin treatment in St. Joseph’s cardiac catheterization lab, the better the outcome is likely to be.

“Process—and how to improve the process—is drilled into everyone involved in the treatment of patients who report chest pain or other heart attack symptoms. So is communication among departments and within departments. There are little things, like improving exterior signage directing people to the emergency department, and larger things like spending several thousand dollars on synchronized clocks throughout the emergency department and catheterization lab to make sure everyone is on the same page.”

Measurement is important, too. With heart attacks, the key measurement is time. How long did it take from...
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a patient’s arrival until an electrocardiogram (EKG) was finished? (The national recommendation is 10 minutes. St. Joseph’s average is six minutes, and its goal is five minutes.)

How long did it take from the patient’s arrival until the blocked artery was opened and blood flow was returned to the heart muscle? (The national recommendation is 90 minutes. St. Joseph’s average is 61 minutes, and the hospital’s fastest time was 11 minutes while treating a 29-year-old patient.)

All of this information accompanies the patient through discharge, says Sarah Tubbert, RN, MS, director of the emergency department.

“Each AMI call is looked at individually and feedback is given to everyone involved in the process, so that everyone knows how well they did,” says Tubbert. “We ask ourselves, ‘What could be done to shorten it up?’ There’s always room for improvement.”

Not everyone who complains of chest pain is having a heart attack, so there are other pathways to be followed. Those who do not need an immediate trip to the cath lab for angioplasty, or even emergency heart surgery, are sent to a telemetry area in which they can rest and be observed before being assigned a risk score, given medications, and discharged safely to their own internist or cardiologist.

There are many pathways—processes—that can be followed when a person arrives at St. Joseph’s complaining of chest pain or just an “odd feeling” that has made him or her anxious and fearful. St. Joseph’s goal is to make sure everyone is quickly diagnosed and treated depending on their individual set of symptoms.

Joel Rosenberg, MD, one of the cardiac surgeons who may be called upon to treat the very sickest arrivals, puts St. Joseph’s care of cardiac patients in perspective.

“Each patient is important,” Dr. Rosenberg says, “and more resources are used for cardiac patients than any other diagnosis in the hospital. A tremendous number of people are brought together to care for that one person.”

And, according to the Society of Chest Pain Centers, St. Joseph’s is making the most of those resources.

A Heart Attack? “No Way. Not Me!”

A s a nationally recognized Accredited Chest Pain Center, it’s obvious that St. Joseph’s Hospital Health Center adheres to a well choreographed process that provides rapid, intense care for those who arrive at the hospital with possible heart attacks.

Too often, however, patients ignore what turns out to be an active heart attack and postpone an ambulance ride to the hospital because they don’t understand the symptoms, don’t believe it can happen to them, or “don’t want to bother anyone.”

In his 30 years as an interventional cardiologist, Gary Walford, MD, has heard each of these explanations hundreds of times.

“People expect a heart attack to feel like an elephant is standing on their chest, or at the very least, they’ve been punched,” Dr. Walford, director of St. Joseph’s catheterization lab, says. “That does happen, but symptoms vary greatly and are often far more subtle, like breaking into a profuse cold sweat, or shortness of breath, or an odd pain into the shoulder, arm, back or abdomen.

“One person arrives at the hospital, we can diagnose a heart attack and begin restoring blood and the oxygen flow to a dying heart muscle in a matter of minutes, but they have to activate the system first. Right now, the average time it takes from the onset of symptoms to the recognition that something is really wrong is about three hours. That’s the problem we have to solve.”

Heart attack symptoms, as compiled by the American Heart Association, have been well publicized for years. St. Joseph’s and other hospitals try to raise public awareness of the symptoms, as well. Many lives could potentially be saved if everyone were to memorize the following, and then act immediately if they appear:

- Discomfort in the center of the chest that lasts more than a few minutes, or that goes away and comes back. That discomfort may feel like uncomfortable pressure, squeezing, fullness or pain.
- Discomfort in other areas of the upper body that may include pain or discomfort in one or both arms, the back, neck, jaw or stomach.
- Shortness of breath (with or without chest discomfort) while at rest or during minimal activity.
- Other signs may include breaking out in a cold sweat, nausea or lightheadedness.
- As with men, women’s most common heart attack symptom is chest pain or discomfort. But women are somewhat more likely than men to experience some of the other common symptoms, particularly shortness of breath, nausea or vomiting, and back or jaw pain.

Besides knowing the symptoms of a heart attack, it’s wise to recognize the risk factors, as well: smoking, high blood cholesterol,
Dear St. Joseph’s Hospital Health Center,

On May 14, 2009, I was admitted to St. Joseph’s for the removal of a myxoma tumor from the left atrium of my heart. You would think that open heart surgery at St. Joseph’s would become routine, with so many such procedures being completed each week. But, as you can imagine, it was anything but routine for my family and me. The staff at St. Joseph’s never made me feel that mine was just another surgery.

I am a very active outdoors kind of guy. I especially enjoy touring the country on my motorcycle (www.normsmotorcycletrips.blogspot.com) and spending family time with my wife, kids and grandkids at camp. Open heart surgery was not on my list of things to do this summer.

There are so many fine people to thank that there is no way I could name them all. I never even knew many of them by name—only as a friendly concerned face. Dr. Mehdi Marvasti is top notch! I know I had one of the best surgeons there is. Thank God for Kim Murray, RN, who took the time to be with my family and kept them advised of my progress during surgery. My anesthesiologist, Dr. Patrick Healey, spoke to me at length before surgery and put me at so much ease that I felt like I already knew him. As I was lying in that cold operating room—with the very warm blankets—Kim introduced me to the entire team. I thanked them then, but I would like to do it again.

According to my wife, Mari, and daughter, Elizabeth—both of whom are nurses themselves—I was quite a sight when they first saw me in the surgical intensive care unit (SICU) after surgery. Lucky for them—and me—Kathryn Mancarella, RN, was assigned as my nurse. She immediately explained everything in detail to my wife and daughter and put their concerns to rest.

Mari and Elizabeth later told me that Kathryn was one of the best nurses they had ever seen in their careers. She was professional, competent and, most of all, caring. So much so, that they requested Kathryn as my nurse for the following day.

I remember very little of my time in the SICU. Although they tell me I was talking to my family, I don’t recall any of it today. I do recall meeting Kathryn though. It’s probably the only thing I do remember of those two days. I don’t know what happened, but I recall being in a great amount of distress. I seemed to have trouble getting enough air to breathe. I tried to get someone’s attention but, before I could speak a word, Kathryn was right there. I remember looking up at her, and immediately knew I was in good hands. She realized I was in pain, and took care of me. I will never forget her.

As soon as I was moved out of SICU and to another unit, I started vomiting. This continued for a day and a half. With a busted-up chest, it certainly wasn’t the most fun I’ve ever had. Theresa Miller, LPN, was my first nurse on the floor. I remember her concern and attempt to make me as comfortable as possible. Each following day, I looked forward to seeing her again.

As of yesterday, Dr. Alan Simons released me, so I no longer have a cardiologist. This is a good thing.

On Sept. 20, I walked Elizabeth down the aisle during her wedding. You were all there, in spirit.

Thank you,

Norm Doyle
Liverpool, NY

Norm Doyle accompanies his daughter, Elizabeth, at her September 2009 wedding.
Franciscan Sister Alice Benzing made a little history in mid-September, but she slept through it.

When vascular surgeon Lawrence Semel, MD, told Sister Alice, who had come to be assessed for carotid artery disease, that she had a life-threatening abdominal aortic aneurysm (AAA) ticking away in her abdomen that might be repairable, the 88-year-old nun’s answer was quick and unequivocal: “I want to live to be at least 99!”

And so, on Sept. 14, Sister Alice became one of the oldest patients to undergo an endovascular abdominal aortic aneurysm repair in St. Joseph Hospital Health Center’s newest and most advanced operating room designed specially for vascular surgery—Room 10.

Room 10 is the only one of its kind in Central New York. St. Joseph’s vascular surgeons call it a “hybrid” room because it is equipped as a fully functioning operating room, but also fitted with the latest in digital X-ray equipment and high-definition video monitors. It is, says Dr. Semel, a combination of an operating room and an angiography suite—the rooms that are routinely used by interventional cardiologists to diagnose and treat blocked coronary arteries.

Sister Alice’s abdominal aortic aneurysm repair is a good example.

The aorta is the body’s largest artery. As it passes through the upper chest and then down through the abdomen, it carries blood from the heart to the other arteries in the body that supply organs and limbs. If the wall of the artery weakens, the aorta can balloon in size from its normal inch in diameter to two inches or more. These aneurysms, which generally occur in the abdomen, may burst, and the result is often fatal, even if good emergency care is nearby.

When the risk of rupture outweighs the risk from surgery, the AAA is repaired in one of two ways: either surgically—a major operation—or during a minimally invasive endovascular procedure in which surgeons insert a fabric and metal stent through a small nick in the groin and then feed it through the leg’s femoral artery into the aorta. After the stent is carefully positioned and expanded, it bridges the gap between healthy sections of the aorta. Both approaches are used successfully at St. Joseph’s, but the number of non-surgical endovascular aneurysm repairs has risen from 30 percent of the total five years ago to nearly 80 percent of the total today, according to Syed Zaman, MD, who is a vascular surgeon himself and St. Joseph’s chief of surgery.

The endovascular approach is less traumatic than open surgery and was often chosen with older, higher risk patients who were unlikely to tolerate the traditional surgery as well, but open surgery was still considered the “standard of care.” Today, with improvements in the grafts themselves and also advances in X-ray technology, Dr. Zaman says that the endovascular approach is on par with the open surgery, especially utilizing facilities like the hybrid room at St. Joseph’s.

“The fact is that we, as surgeons, can make better decisions with better information,” Dr. Zaman says, “and the imaging with the ceiling-mounted C-arm fluoroscopy unit gives us much better images than the portable unit we used to rely on—much better information on which to base our surgical decisions.”

There are at least three large, high-definition video monitors nearby, so that everyone around the operating table has a clear view of what’s going on inside the patient’s body during the brief periods the fluoroscope is “powered up.” The fine metal mesh that forms the skeleton of the stent is clearly visible on the monitors as it is maneuvered into place making sure that it is firmly positioned inside the aorta’s wall without being so high that it would block the opening of the two smaller arteries that deliver blood to the kidneys. (See photograph on this page.)

The arteries themselves are essentially invisible on the X-ray, but can be clearly seen when injecting small amounts of contrast medium (“dye”) into the area to check for any leaks after the stent has been expanded. The dye can be irritating and the precision of the fluo-
Vascular surgeons James Riley, MD, (right, pointing to the monitor) and Lawrence Semel, MD, (left) have a close-up, high-definition view of the swollen abdominal aorta of Sister Alice Benzing, thanks to St. Joseph’s new hybrid operating room. Vascular surgeons and their patients now benefit from a fully equipped operating room combined with superior imaging that was once only available in separate locations. Also photographed are David Abell, radiology technologist, (right, foreground) and Ramona Cartegena, surgical technologist (rear).

The endoscopic allows less concentrated dye to be used. Less radiation also is required, Dr. Semel says.

James Riley, MD, a second vascular surgeon who worked with Dr. Semel during Sister Alice’s aortic repair, visited other hospitals that had similar hybrid rooms gathering the best design concepts from each that were then incorporated into Room 10.

“A hybrid operating room provides the enhanced imaging and fluoroscopy of a minimally invasive procedure room with the technical capabilities of an operating room,” says Dr. Riley. “It allows us to perform vascular procedures less invasively because it gives us safer and easier access to vessels that previously required large incisions.”

There are other patient benefits, as well, including shorter hospital stays and quicker recovery. A surgical aneurysm repair used to require as much as a week in the hospital, with a lengthy convalescence. Some patients undergoing the same treatment in the hybrid operating room can be back home the same day and recover more quickly. Just ask Sister Alice.
Technology Helps Colorectal Surgeons Ease the Pain of What Used To Be Major Surgery

Mention colorectal surgery and most of us are likely to cringe. We’d just as soon pretend those aspects of our body didn’t exist, but they do, and when they give us trouble, St. Joseph’s Hospital Health Center’s colorectal surgeons have pioneered new ways to treat what can be serious health problems.

John Nicholson, MD, a colorectal surgeon who has been practicing at St. Joseph’s for 30 years, says St. Joseph’s use of the da Vinci® surgical robot and a technique called transanal endoscopic microsurgery (TEM) to treat some colorectal ailments has truly been “transforming” for patients.

The colon, or large intestine, is the last four or five feet of the digestive system. It processes waste products before they are expelled from the body through the rectum (the last few inches of the colon) and anus. The colon, however, can fall prey to a variety of problems. Non-malignant polyps can grow on the colon’s lining. If untreated, the polyps slowly grow larger and may become cancerous.

The growth of polyps and cancer are not the only problems. In some cases the rectum can turn itself inside out protruding from the anus—a condition called rectal prolapse. Rectal prolapse occurs primarily among older women who have delivered children, had a hysterectomy, or whose pelvic muscles have weakened over time.

Dr. Nicholson has successfully used St. Joseph’s da Vinci surgical robot to repair rectal prolapse. Likewise, colorectal surgeon David Nesbitt, MD, is using transanal endoscopic microsurgery techniques to treat a growing number of patients with benign or malignant growths in the colon.

In the past, says Dr. Nicholson, traditional surgery for rectal prolapse might have been too hard on elderly patients with other health problems, so some patients ended up having no surgery at all.

“In cases like this, we often did the best we could by treating patients medically by prescribing stool softeners and changes in their diet,” Dr. Nicholson says, “but even that is hard on some patients. The success of the da Vinci surgical robot, however, has been remarkable in these cases.”

There are several ways to correct a complete rectal prolapse, but a procedure called rectopexy is generally considered the best in terms of creating the longest-lasting solution. Traditionally, the surgeon opens a vertical incision in the abdomen, separates the colon from the tissue surrounding it, then pulls the rectum back inside the body and stitches it securely to the sacrum, a bony structure near the end of the spine. The operation also can be done laparoscopically with a few small incisions made in the abdomen instead of a single large one. A video camera and small surgical instruments are maneuvered through the incisions. With this minimally invasive approach, hospital stays, bleeding and pain are reduced. But, Dr. Nicholson says, sometimes even laparoscopic surgeries are too hard on some patients.

That’s not the case when he relies on the most precise tool in his kit, the da Vinci robot.

“The visualization with the da Vinci is superior,” Dr. Nicholson says. “Because we can see the site so well and because the robot makes our movements so precise, there is less bleeding and trauma.”

Dr. Nicholson has been able to send some of his da Vinci patients home from the hospital the next day. Within a week or two, they are back to their pre-surgery activities. Compare that, he says, with patients who may spend a week in the hospital and take four to six weeks to fully recover from open surgery.
“The da Vinci is no more than a tool adapted to the procedures we’ve been doing all along,” Dr. Nicholson continues. “But we’re now offering a better operation because of it.

“The best thing? Patients who could not undergo what has always been the best treatment, now can. And in doing so have fewer chances of recurrence along with shorter hospital stays and quicker convalescence.”

St. Joseph’s Hospital Health Center invested in the da Vinci surgical robot to serve the needs of patients with a wide range of maladies, but they invested in the transanal endoscopic microsurgery equipment to meet the very specialized needs of patients with benign or early stage cancerous growths in the colon, says Dr. Nesbitt.

Benign polyps and cancerous growths occur throughout the length of the colon, but until recently in the United States, only growths in the lowest part of the rectum could be treated without making an incision in the abdomen. That has changed with the introduction of TEM under the guidance of Dr. Nesbitt. St. Joseph’s is the only hospital in the Central New York area to offer TEM.

“TEM is valuable because it is a reliable method of removing polyps and early stage cancers without open or even laparoscopic surgery,” Dr. Nesbitt says. “It is a far less invasive approach, and I realized that anywhere from 15 percent to 20 percent of our patients with polyps or cancer in the rectum and lower colon could benefit from it. Numerically, that’s a relatively small number, but if we could offer a far less invasive approach to appropriate patients, why not?”

The TEM procedure calls for a great deal of dexterity and skill on the part of the surgeon, but is relatively simple for the patient because it doesn’t involve cutting through the abdominal wall or removing part of the rectum and the trauma such surgery creates. The operating proctoscope that Dr. Nesbitt uses is about 20 inches long and an inch and a half in diameter. Inserted through the anus, it not only allows him to see a highly magnified, detailed image of the first seven or eight inches of the inside of the rectum and lower colon, but also contains surgical instruments with which he can delicately remove cancerous growths or benign polyps with very little bleeding.

Most of Dr. Nesbitt’s TEM procedures are done at St. Joseph’s Northeast Surgery Center in Fayetteville with patients going home the same day. Occasionally, if the patient has had previous heart problems, the TEM is performed at the hospital.

“I can’t say enough about St. Joseph’s surgical techs, nurses and other staff,” Dr. Nesbitt says. “They take such good care of the patients and the equipment. Everything is ready when we arrive.”

The procedure is not for all patients. If a polyp has grown too large or if a cancer has progressed through the wall of the rectum or colon and spread to nearby lymph nodes then traditional surgery is called for, Dr. Nesbitt says, but in almost all cases that can be determined before the TEM is even scheduled.

“For those who qualify,” concludes Dr. Nesbitt, “TEM has dramatically improved the treatment we can offer patients. When what used to be considered major surgery can now be completed in half the time, with very little pain or bleeding and only a brief convalescence, it’s a real step forward.”
Dear friend of St. Joseph’s,

At St. Joseph’s Hospital Health Center, we are mission-driven. Every employee plays a vital part in that mission, which was rearticulated when we celebrated the hospital’s 140th anniversary in May:

We are passionate healers dedicated to honoring the Sacred in our sisters and brothers.

These are not only inspiring words, they are the very foundation for everything St. Joseph’s does. Our physicians, employees, volunteers, donors and patients share in our mission, enabling us to carry it out every single day, building on our 140-year tradition as we plan for and address the challenges of the 21st century.

Our mission has brought us to what we call Phase II of our facility master plan, on which we are about to embark. This facility innovation and expansion will be, quite simply, the largest project of our generation. None of us now associated with St. Joseph’s will ever be involved in a project of greater scope or impact!

St. Joseph’s investment in Phase II will exceed $220 million, and will provide new and expanded emergency department and emergency psychiatric program facilities, a new surgical suite with 14 operating rooms, a patient tower with private rooms, a new primary data center, a relocation of nutritional services—and more. Moreover, it will be the largest “green” health care construction project in Upstate New York.

Essential to completing the project will be the continued support of St. Joseph’s valued patrons, volunteers and employees. One important means of support is planned giving, and I’m pleased to announce the first planned gift in support of Phase II, made by Dr. and Mrs. John D’Addario for the naming of an operating room.

In addition, I’d like to recognize Dr. and Mrs. Edward Carsky, who through a planned gift are establishing a scholarship at our College of Nursing in memory of their late son, Dr. Robert Carsky. These represent the first two planned gifts and first members of the 1869 Society (see accompanying articles)—and show how planned giving can advance such diverse activities as capital projects and scholarship funds.

The remarkable commitments made by the D’Addarios and Carskys are inspiring to us, and important to St. Joseph’s future. Why do so many donors, former patients, volunteers and employees of St. Joseph’s give? It all goes back to the mission, which could not be advanced without them.

Thank you for your support at any level, through any means. It is vital to the mission we hold sacred.

Sincerely,

Margaret Martin

Vice President
The 1869 Society was founded to recognize individuals who demonstrate their deep commitment to St. Joseph’s Hospital Health Center and its mission of service by making a planned gift. The generous contributions from those members serve as the cornerstone of St. Joseph’s future by establishing a strong foundation from which many generations will benefit.

There are a number of options for planned gifts. Popular choices include:

**Bequests:** designate a specific dollar amount or percentage of your estate to St. Joseph’s.

**Charitable Trusts:** you and/or a beneficiary continue to receive a percentage of your assets annually, with the remainder going to St. Joseph’s.

**Charitable Gift Annuities:** earn a fixed amount annually and leave the remainder to St. Joseph’s.

**Retirement Plan Assets:** name St. Joseph’s as your beneficiary and reduce the tax burden on your heirs.

For more information about planned giving opportunities, contact Margaret Martin, vice president, at 315-703-2137, Margaret.Martin@sjhsyr.org or visit www.sjhsyr.org/plannedgiving.

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**Dr. and Mrs. Edward Carsky**

Soft-spoken and unassuming, Edward Carsky, MD, describes the reasons for his and his wife Pat’s planned gift to St. Joseph’s College of Nursing in plain language: “I have a strong affinity for St. Joseph’s,” he says. “It had a strong reputation when I joined the radiology department with three other radiologists in 1968, and it’s even better now.”

Dr. Carsky served as chair of the radiology department at St. Joseph’s for 20 years. He received his training at Upstate Medical Center and was previously chair of radiology at Syracuse’s Crouse-Irving Hospital before joining the institution to which he devoted most of his career.

During his tenure at St. Joseph’s, Dr. Carsky saw the construction of a new wing that expanded his department in 1975, and he sees himself as fortunate to have been part of the hospital’s successful growth. By the time he retired in 1995, he had served under four hospital presidents: Sister Patricia Ann Mulherin, James Abbott, William Watt and the current president, Theodore M. Pasinski.

Yet Dr. Carsky’s—and his family’s—support of St. Joseph’s has not abated. In 2006, Ed and Pat, as they are known to their friends, started contributing scholarships to the college of nursing. Recently, they decided to make a planned gift to the college to endow a scholarship in memory of their son, Dr. Robert Carsky, who lost his life in West Africa five years ago.

Dr. Carsky describes the gift in their son’s honor very simply: “We like to support places that do good for people, and St. Joseph’s does good for people and the community.”

The Carskys’ planned gift is an appreciated memorial that will do significant good as well.

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**Dr. and Mrs. John D’Addario**

John D’Addario, MD, and his wife, Phyllis, have established a milestone: the first planned gift to St. Joseph’s in support of Phase II of the hospital’s facility master plan. Their generous bequest will result in the naming of an operating room in the new surgical suite—a meaningful and important gift from a physician whose relationship with St. Joseph’s began nearly three and half decades ago.

Here Dr. D’Addario describes why he and Phyllis made their planned gift:

“When I began my career at St. Joseph’s as an intern in 1975 and as a first-year anesthesia resident in 1976, the cardiac surgery program was shrouded in dark clouds. By recruiting Donald B. Effler, MD, after mandatory retirement from the Cleveland Clinic, we quickly became the number one cardiac surgery program in New York state. Upon his retirement, this was repeated under the leadership of Fritz Parker, MD, and Mehdi Marvasti, MD.

After Dr. Parker left, we had an extended ranking as the top cardiac surgery program in the state under the leadership of Drs. Marvasti, Rosenberg and Nazem. Now with the recruitment of Drs. Zhou and Green, we have, in my opinion, five of the best cardiac surgeons in the world today. My hope is that this bequest will provide these surgeons with the newest and most technically advanced operating rooms so that we can continue as the finest cardiac surgery program in all of New York state.”

Thanks to the D’Addarios, St. Joseph’s tradition of excellence in cardiac surgery continues with strong momentum.
Recent Grant Awards
We thank the following foundations and agencies for their support of St. Joseph’s:

$6.6 Million Grant will Co-Locate Children’s Health Services
St. Joseph’s has been awarded a $6.6 million grant to co-locate and merge its Maternal Child Health Center Pediatric Office with its children’s mental health services into one facility on James Street in Syracuse.

The grant was one of five awarded to health care providers in the Central New York region as part of the HEAL NY (Health Care Efficiency and Affordability Law of New York State) Phase 11 grant program. The emphasis is on collaborations to promote quality and efficiency in the delivery of care appropriate to the needs of the community.

“The largest ever awarded to the hospital network, this grant will fund St. Joseph’s new project, The Open Door to Comprehensive Primary Health Care for Children and Youth,” says Theodore M. Pasinski, St. Joseph’s president.

“HEAL 11 grant will enable us boldly to change the way we provide outpatient primary pediatric and children’s mental health services,” says Deborah Welch, director of St. Joseph’s mental health services. “By bringing together two services that are now three quarters of a mile apart, we will be a ground-breaking model for providing high-quality, cost-effective outpatient services to children and their families.”

“This funding will enable a significant advancement in health care for Central New York, and we want to extend our thanks to Governor David Paterson, Mayor Matthew Driscoll and our state delegation for helping bring this grant to St. Joseph’s,” says Theodore M. Pasinski, St. Joseph’s president.

Tobacco Cessation Center Awarded $1.3 Million
St. Joseph’s is the recipient of a grant of more than $1.3 million to continue the work of its regional Tobacco Cessation Center. The funding from the New York State Department of Health ensures the hospital will continue its efforts for at least the next five years.

“Serving Cayuga, Onondaga and Oswego counties, the Tobacco Cessation Center provides support and assistance to area physicians in their efforts to help patients “kick the habit.” It offers educational sessions for physicians and staff, patient education materials, nicotine replacement therapies for distribution by physicians, and assistance to area health care organizations as they initiate and continue tobacco-free grounds policies.”

Pharmaceutical Safety Program Targets Anticoagulants
The New York State Department of Health has awarded St. Joseph’s nearly $190,000 to help fund the start-up of a new pharmaceutical safety project aimed at decreasing the risk of negative patient outcomes associated with the use of anticoagulants. Funding for this project is from the New York State Attorney General’s settlement with Cardinal Health Inc.

Anticoagulation agents are considered high-risk medications and include the drugs warfarin, heparin and enoxaparin. These medications are widely used for treatment of deep vein thrombosis, pulmo-

College Corner

Lighting the Night
For the past three years, St. Joseph’s College of Nursing has formed a team to participate in the Leukemia & Lymphoma Society’s Light the Night Walk in September to bring help and hope to people battling blood cancers. Each year, the team and funds raised get bigger and bigger.

St. Joseph’s College of Nursing’s team had approximately 100 walkers who raised more than $2,700. Students, faculty, staff, administration, family and friends carried illuminated balloons—white for survivors, red for supporters and gold in memory of loved ones lost to cancer. St. Joseph’s human resources department joined the college of nursing team and raised an additional $2,300.

Beginning a Bright Career
St. Joseph’s College of Nursing’s held its 109th commencement ceremony on May 21 at the John H. Mulroy Civic Center. Of the 116 graduates, 73 completed the Weekday Program (including the first pilot group of six Dual Degree Partnership in Nursing students) and 43 students completed the Weekend Program. Susan Lamanna ’69, nursing professor at Onondaga Community College, gave the commencement address.

Faculty Member Receives Certification
St. Joseph’s College of Nursing faculty member Winifred Olmstead, MSN, CNE, RN, recently received certification as a nurse educator (CNE). She joins six other faculty members who have achieved this distinction: Gayle Bero, MS, NP, CNE, RN; Susan Chappuis, MS, CNE, RN; Nancy Hartel, MS, CNE, RN; Rhonda Reader, MS, CNE, RN; Mary Ryan, MS, NP, CNE, RN; and Carol Sheldon, MS, CNE, RN. According to the National League for Nursing Web site, certification is a mark of professionalism: “For academic nurse educators, it establishes nursing education as a specialty area of practice and creates a means for faculty to demonstrate their expertise in this role.” Currently, there are only 81 certified nurse educators in New York state.

Mariya Zhoyklaya celebrates her graduation from St. Joseph’s College of Nursing in May.
nary embolism, stroke and heart attack. The medications require close monitoring and optimization to ensure a positive outcome for the patient.

St. Joseph’s will implement a computerized surveillance system and hire a specialized pharmacist to monitor patients on anticoagulants and adjust their medications as well as to manage the safe and effective use of anticoagulants throughout the hospital.

Komen CNY Affiliate Grant Benefits
Breast Cancer Patients

The Central New York Affiliate of Susan G. Komen for the Cure® awarded $20,000 to St. Joseph’s Hospital’s Outpatient Physical Therapy Lymphedema Program to provide education about and comprehensive treatment for lymphedema, a disease that often occurs as a result of breast cancer treatment, causing swelling, discomfort, and, in some cases, infection.

The grant will support St. Joseph’s LEAP From Stage 0 Program. LEAP (Lymphedema Education and Prevention) provides education to medical practitioners and the community and gives the uninsured and underinsured access to compression garments and bandaging supplies.

Dear Ms. Margaret Martin,

My family received a letter from you regarding a donation to St. Joseph’s Hospital Health Center. I have enclosed a check in honor of my dad, Albert Spagnoletti. I would like to take this opportunity to thank the staff at the hospital during my dad’s stay in December and twice in January before his passing there on Feb. 5, 2009.

My dad suffered from congenital heart failure, which eventually led to kidney failure. He was a wonderful father and husband, and loved all of his family dearly. My dad was a proud WWII veteran, and continuously displayed his love for his country.

Many times he wasn’t himself during his hospital stay and could be a “bit” difficult. However, the staff was professional and helpful to him and my family. The staff displayed the utmost respect 24/7. During all three hospital stays, Dr. Mark Emerick was assigned to my dad as his primary care physician. He was wonderful to my family during this difficult time. Dr. Emerick went out of his way to make sure my dad was comfortable his last days, and that all his needs were taken care of. His bedside manner was incredible the day he told us my dad would eventually be “going to sleep for good.” Dr. Emerick also took the time to comfort my dad and explain to him how his last days were going to progress. This day was one of the most memorable last days with my father.

I know this is a small donation, but it comes from the heart. I hope it can be put toward the training of more professionals like the ones my family encountered at St. Joseph’s Hospital. I also hope that you would let Dr. Emerick know how thankful we are to him for all he did for my dad and my family.

Sincerely,

Nancy Iadanza

Nancy Iadanza (Al’s daughter)
Farnington, NY
HEART ATTACK?
EVERY SECOND COUNTS.
CALL 9-1-1.

Chest pain isn’t the only sign of a heart attack. Shortness of breath; back, arm or jaw discomfort; severe nausea; or heavy sweating also may indicate a problem. Seeking medical help right away can help protect you from serious heart damage and create a more positive outcome from a potentially dangerous situation. So, don’t hesitate to call 9-1-1. Your heart—and your life—may depend on it.

St. Joseph’s Hospital Health Center 301 Prospect Ave. Syracuse, NY www.sjhsyr.org
St. Joseph’s is sponsored by the Sisters of St. Francis.

WHEN YOUR HEART IS ON THE LINE, GETTING HELP FAST CAN MAKE ALL THE DIFFERENCE.

Chest pain isn’t the only sign of a heart attack. Shortness of breath; back, arm or jaw discomfort; severe nausea; or heavy sweating also may indicate a problem. Seeking medical help right away can help protect you from serious heart damage and create a more positive outcome from a potentially dangerous situation. So, don’t hesitate to call 9-1-1. Your heart—and your life—may depend on it.

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