



Forum

A NEWSLETTER BY THE MEDICAL & DENTAL STAFF OF ROCHESTER GENERAL HOSPITAL
MORE OF YOUR MONTHLY UPDATES CAN BE FOUND AT <http://www.rochestergeneral.org/mds>

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CALL THE HOSPITALIST FOR YOUR PATIENT
922-7444

2013 Quarterly Staff Dates

- September 20
- December 20

Twig Conference Room

7:30 – 8:30 a.m. for all meetings
50% attendance recommended
for all attending Physicians

Message from RGH MDS Leadership

HEALTH INSURANCE EXCHANGES:

Profound Implications for the Health Care Provider



Derek tenHoop, MD
RGH MDS
President-Elect

The US Supreme Court's decision in June 2012 to uphold the majority of the Patient Protection and Affordable Care Act (PPACA or ObamaCare) assured the establishment of health care exchanges, or marketplaces, in all 50 states. This major provision of the ACA calls for the development of exchanges to provide a "competitive marketplace for individuals and small employers to directly compare available private health insurance options on the bases of price, quality and other factors". The idea is both to expand health insurance coverage and to foster competition among insurers, thereby promoting cost containment.

Exchanges are based on economist Alain Enthoven's concept of managed competition, which aims to establish regulated competitive markets in health insurance, health care purchasing, and health care provisions (NEJM, August 2012). Exchanges are regulated yet competitive health insurance markets, and they usually function in an environment where individuals are required to purchase health insurance. In the exchanges, insurers offer structured choices, compete on the price and quality of their service, and must accept all applicants.

As one can imagine, these exchanges will have a significant impact on the health care marketplace, with implications for the role of consumers in decision making, payer mix, prices, and margins. Their introduction will have profound effects on healthcare providers as well. These effects include, but may not be limited to, the following:

Continued on page 2.

HEALTH INSURANCE EXCHANGES, continued

1. Unprecedented transparency
2. The “Walmart Effect” with patient’s playing a greater role as healthcare consumers
3. A rise in narrow networks spurred by low prices and narrow geographies
4. The potential end of the cross subsidy of Medicare and Medicaid by commercial plans
5. The possible end of not-for-profit status for hospitals

(Healthcare Financial Management, November 2012)

To preserve our ability to practice and care for our patients, it is critical that physicians become engaged at every level of health insurance exchange development and governance.

Although many important questions about the detail of exchange implementation remain unanswered, the strategic implications for healthcare providers are monumental. For example, consumers will have much more data available about the health benefits that plans offer through the exchanges, and these data will include information about the quality of the providers. Furthermore, the “Walmart Effect” is very real. With the exchanges, although the insurers will remain, individual consumers will make the buying decision for themselves.

And when consumers do the buying, there is likely to be downward pressure on price. In addition, the exchanges will allow consumers to compare premiums on an “apples-to-apples” basis across similar benefits plans (e.g. bronze, silver, gold and platinum). To be competitive in such an environment, the plans will then need to apply downward pressure on unit payment rates to providers. They will continue to look to new payment methodologies--such as bundled payments, shared savings and capitation--that will bring down prices more rapidly. Obviously

these trends are what are encouraging payers and providers to work more closely to lower healthcare costs (thus the emergence of the Excellus/GRIPA partnership).

Starting on January 1, 2014, these health insurance exchanges will go live with coverage, with enrollment starting three months prior on October 1, 2013. Realistically, the exchanges will be a work in progress even after the start deadline. There are three major categories for state exchanges: the declared state-based exchange, the planning for federal partnership exchanges where the state has indicated it will partner with the federal government to operate an exchange, and the federal exchange. The majority of the states have opted for the federally facilitated exchange under which the US Department of HHS assumes the primary responsibility for operating the exchanges by default. Notably, New York State has opted for a state-run exchange. Nationally, the state exchanges are expected to extend health insurance coverage to 27 million uninsured Americans. Nearly 1.6 million of New York’s 2.7 million uninsured residents are projected to access coverage through the New York State exchange (Health Affairs, June 2012).

As the exchanges are developed, there will be challenges and opportunities. It is imperative for physicians and other healthcare providers to have a strong voice in the process. Currently, states are required to consult with a number of stakeholders. These include health care consumers enrolled in QHPs (qualified health plans), experts in QHP enrollment, representatives of small businesses, state Medicaid offices, and advocates for enrolling the hard-to-reach populations (PPACA, HR 3590). Of major concern is the fact physicians have been left out of this equation (although recently the US Dept of Health and Human Services has proposed regulations to add health care providers to the stakeholder list).

To preserve our ability to practice and care for our patients, it is critical that physicians become engaged at every level of health insurance exchange development and governance. The exchanges themselves will have substantial power over individual insurance companies, including determination of premiums (www.curtis.com). Success for all physicians will hinge on plans that provide strong provider networks and fair compensation. Obviously, any quality measures and physician rating scales need to reflect meaningful criteria rather than arbitrary cost-containing measures.



Partnership in Development

Mark Clement, President and CEO

We continue to make great progress on our merger development plans. We are actively finalizing the terms of the definitive legal agreement between RGHS and Unity, which outlines the agreed-upon governance, organizational structure and work process we will use to develop and execute our plans to bring our two systems together. We expect to have this agreement signed by early fall.

As shared last month, we have also enlisted Deloitte Consulting to help guide us through Phase 1 of our work to identify and objectively quantify the benefits to the community of the planned merger in order to make the case for regulatory approval. In mid-July, we conducted Phase 1 kick-off sessions with Deloitte and the senior leadership teams at both Unity and RGHS. Over the past few weeks, much of this Phase 1 work has been centered around an exhaustive data gathering process at each organization facilitated by Deloitte. This process has required our leaders and team members across the clinical, administrative and operational areas of Unity and RGHS to independently collect and submit hundreds of documents and other data to Deloitte during an intensive three week period. Deloitte is now evaluating this data to assess the individual strengths and opportunities of each organization, as well as identify the clinical, operational and cultural synergies that can be leveraged to build the proposed framework for the new consolidated system.

To further evaluate these synergies, Deloitte is now conducting a series of interviews with senior clinical and operational leaders at both RGHS and Unity. The information gathered from these interviews and the data review process will support the creation of the "blueprint" for the merger which will outline the proposed size, scope and scale of the consolidated system – along with the anticipated benefits to the community. This blueprint is the basis for our regulatory filing which we are on schedule to submit to

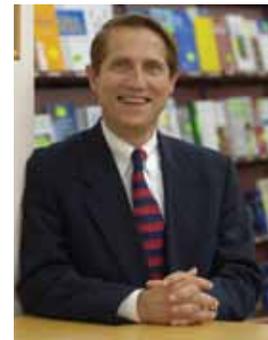
the Federal Trade Commission (FTC) this fall.

It's important to note that while we are building the directional framework of the new system right now in Phase 1, and will have the primary foundations identified and quantified for our FTC filing, many details of our clinical and operational integration plans will continue to develop during Phase 2. This Phase 2 work will involve input and leadership from a much wider group of clinical and operational staff.

Finally, we are continuing our very positive and productive discussions with the local business community, federal and state government officials and health insurance leaders to share our vision for this merger and set expectations about the planned benefits for the community. Attached for your reference is the handout we are using to tell our story.

Also attached is the August Leader Communication Guide that you can use to share this update with your departments. Please plan to convey this information to them within the next two weeks.

Thank you for helping to keep our employees informed about our partnership plans and progress. Please don't hesitate to contact me, if you have any questions or need additional support in your role as a communications leader in this process.



The Office of Physician Services invites you to join us for

The Annual Fall Physician Social

Thursday, October 3, 2013

5:30pm–8:00pm

Irondequoit Country Club

4045 East Avenue

Rochester, New York 14618

Get reacquainted with colleagues and meet the newest members of the Medical and Dental Staff. Enjoy delicious hors d'oeuvres, food stations & desserts.

Please respond to Stephanie Williams by September 25, 2013

(585) 922-2955 or email stephanie.williams@rochestergeneral.org

Credentialing and Privileging of Physicians for Fluoroscopy Use **NEW REQUIREMENTS** for RGH Medical & Dental Staff

Jonathan D. Broder, M.D., Chairman, Department of Diagnostic Imaging, and Debra Ann Koch, M.S., C.H.P., L.M.P., Department of Diagnostic Imaging

Due to the upward rise in the use of clinical fluoroscopy, our regulatory bodies are becoming stricter in their requirements for proof of competency, hence leading to the establishment of a credentialing and privileging program. Credentialing and Privileging are an essential part of healthcare administration. This process is required by the Joint Commission as well as other regulatory/ licensing entities such as the New York State Department of Health. It is also required by insurance companies for reimbursement. Credentialing records are oftentimes part of a clinical review during a regulatory inspection.

The use of fluoroscopy in all areas of medicine continues to increase. This has become largely possible due to equipment design improvements that make it easier for users to produce clinically useful images. Concurrent with this, fluoroscopy equipment including mobile units has increased in capacity and complexity.

Training for the safe use of fluoroscopy equipment has not kept pace with the expanding use and/or clinical applications. Credentialing and privileging programs are needed because of the increase in use of fluoroscopy by individuals whose medical education initially did not include formal training in fluoroscopy. Currently, physician specialists using fluoroscopy include: radiologists, cardiologists, gastroenterologists, orthopedic and vascular surgeons, and pain management specialists. Many of these special practice physicians have not been formerly trained in the principles of radiation protection, radiation biology, radiation or imaging physics, positioning or equipment operation safety. Training these physician groups will lead to improved patient care with a more judicious approach of fluoroscopy imaging.

Recently the Rochester General Medical & Dental Staff Credentials Committee as well as the RGH MDS Medical Board inclusive of all Chiefs, accepted a Fluoroscopy Credentialing program for physicians requesting privileges to use fluoroscopy under the RGH license. The Physician will be required to:

Initial Request

1. Review a Power Point presentation and complete an "open book" quiz thereafter.
2. The completed quiz will be sent to the Medical Staff Office along with their completed credentialing package. If two or more questions are incorrect, the physician will be required to take the quiz again and pass with an 80% or higher in order to be considered for fluoroscopy privileges.
3. In addition to passing the quiz, the physician will be required to take the Image Gently and Image Wisely pledge and provide a formal attestation to completing such.

Reappointment

1. The physician will be required to complete a "refresher" Power Point presentation and complete a shorter quiz.

All documentation will be provided by the Medical Staff Office upon Physician Request

Consideration for fluoroscopy privileges includes the physician showing that he/she has had adequate training or equivalent using fluoroscopy. Adequate training includes the expectation that the physician was trained by a physician that was experienced in the use of fluoroscopy. Following initial review of each application, Dr. Broder as Chief of Radiology will be decide if further documentation from a physician's preceptor is necessary.

The Joint commission requires an organization to review and revise clinical privileges and appointments at least biennially. Our credentialing program will suffice all aspects of this criterion.

It is agreed upon by all healthcare professionals that credentialing, privileging and re-privileging are complex, time consuming processes. The primary reasons for assuring that these processes are valid include:

Continued on page 5.



RGHS Signs Primary Partnership With Mayo Medical Laboratories

Rochester General Health System (RGHS) has entered into an expanded relationship with the Mayo Medical Laboratory (MML), a division of the widely respected Mayo Clinic. This new, primary partnership will give RGHS both access to the Mayo Clinic's extensive menu of reference laboratory tests and clinical expertise and access to innovative tools and resources. This new partnership will support initiatives being developed by the RGHS Department of Pathology & Laboratory Medicine and RGHS Ambulatory Care Laboratories Services to optimize lab test utilization for patients, physicians and other healthcare providers.

"Many healthcare decisions are influenced by lab test results, and laboratory testing costs patients and insurers billions of dollars each year", said Dawn Riedy MD, RGHS Chief of Pathology. "These tools and initiatives will help us guide ordering providers to choose the most appropriate tests for their patients. There are thousands of testing options, with new tests beginning developed every day, and it's difficult for healthcare providers to always know exactly which tests will give them the information they need to most effectively care for their patients. Our goal is the right test, for the right patient, at the right time. This is important to both proactively manage healthcare costs and ensure consistently highest quality care."

RGHS Laboratories perform millions of lab tests each year on-site at Rochester General and Newark Wayne hospitals. Like all local laboratories, RGHS collaborates with a reference laboratory for tests which are rarely ordered or highly specialized in nature. Mayo Medical Laboratories will now serve as the RGHS primary reference laboratory which also



means Mayo Clinic physicians and scientists in every specialty laboratory will be available for consultation regarding test selection, methodologies and result interpretation.

"RGHS Labs and our Ambulatory Service Centers already provide a comprehensive menu of high quality lab testing with excellent turnaround times and exceptional customer service, said Bridgette Wiefeling MD, Vice President of Clinical Innovation. " This new partnership with Mayo Clinic takes our lab capabilities to a new level and supports our broader system wide initiatives to provide the very best parent care to all patients across the care continuum. This is a win-win for our community."

While 99% of laboratory testing will continue to be performed onsite at Rochester General and Newark-Wayne Community Hospitals, this innovative partnership with MML will further enhance our testing capabilities, quality and access for both physicians and their patients.

Fluoroscopy, continued

- To ensure clinical and technical competence to correctly perform fluoroscopy procedures in a safe manner
- To assure and improve the quality of healthcare provided by Rochester General Hospital
- To improve and assure radiation safety for patients and hospital staff
- To assure and maintain a consistent standard of patient care.

This process will allow us to move forward in our continuum of patient safety and excellence in patient care. Understand that although you may have secured fluoroscopy procedure today, when it is time for your reappointment you will have to complete the steps of the Initial Request. From that point forward the refresher Powerpoint will suffice unless determined otherwise.

Should you have any questions, please give either of us a call at 585-922- 3220.

Leadership Announcements

Mark Clement, President and CEO

I am pleased to announce the following two leadership appointments effective immediately:

Bridgette Wiefling, MD, RGHS Vice President of Clinical Innovation and interim Executive Medical Director of Rochester General Medical Group (RGMG) is being promoted to the permanent role of Senior Vice President and Executive Medical



Director of RGMG effectively immediately. Dr. Wiefling will also continue in her role leading our system's clinical innovation team.

Since taking over as interim RGMG Executive Medical Director in March, Dr. Wiefling has quickly emerged as a visionary and highly effective leader for the organization as well as a strong advocate for, and collaborator with, our RGMG ambulatory physicians and team members. In addition to supporting the growth and leading the redesign of our RGMG practices, she has also worked closely with our inpatient physician and nursing leadership teams, as well as GRIPA and our community practices, to help us shape a truly integrated delivery network that standardizes quality of care and patient transitions across our inpatient, ambulatory and long-term care settings. These achievements, coupled with her proven track record in managing and growing a successful health care organization – and her experience as a practicing primary care physician – make her the ideal choice to lead RGMG and its future growth plans.

Dr. Wiefling joined RGHS in November 2012 from the Anthony Jordan Community Health Center, where she capably served since 2006 as the President and Chief Executive Officer. In that role, she successfully led the financial turnaround of the Center and its merger with the Westside Health Center.

Please join me in congratulating Dr. Wiefling on her well-deserved promotion, and wishing her all the best as she further expands her leadership contributions in support of RGHS' efforts to become the model health care delivery system of the future!

Barbara McManus, RGHS Senior Director of Marketing and Public Relations is being promoted to Vice President of Marketing and Public Relations. Barbara joined RGHS in early 2011 and soon after took over the added responsibilities of the



former Vice President of Marketing and Physician Services, enabling us to streamline the leadership roles in this area, while increasing our marketing and public relations efforts. Barbara has been instrumental in leading RGHS' brand strategy and integrated marketing plan, launching our highly successful "HEALTH + CARE" consumer campaign in 2012 and overseeing her team's efforts to dramatically strengthen and expand RGHS' social media presence and community outreach efforts. Barbara has also expertly guided the marketing strategy for our Ambulatory Care Division launch and expansion plans, as well as recent efforts underway to transform the Independent Living for Seniors (ILS) brand.

Prior to joining RGHS, Barbara worked at Bausch & Lomb as Director of Customer Marketing, responsible for brand program planning and execution for the U.S. contact lens business.

Please join me in congratulating Dr. Wiefling and Barbara McManus on these well-deserved promotions and wishing them all the best in their expanded leadership roles!



CARE CONNECT PROBLEM LIST USAGE GUIDELINES

Appropriate use of the Problem List in Care Connect helps us ensure accurate clinical documentation and care team procedures that result in the safest, most appropriate diagnoses, treatments and follow-up care for our patients. With the upcoming transition to ICD-10 in 2014, it's more important than ever that we are as knowledgeable and skilled as possible in performing complete, correct clinical documentation through the Care Connect Problem List. The following questions and answers provide you with guidelines for using the Problem List correctly. These guidelines were developed by Drs. Fedullo, Wiefling, W. Polashenski and Zsenits and were discussed and approved at the Medical Board.

If you have additional questions, please contact Anthony J. Fedullo, MD, RGH Medical Director & Director of Medical Education at Anthony.Fedullo@rochestergeneral.org.

1. Who can add a problem to the hospital section of the Problem List (PL) to identify problems being addressed during the patient's current hospital admission?

Any MDS provider, including midlevel practitioners and residents, can add a problem to the hospital section of the Problem List in the patient's EMR.

2. Who can change or delete a problem in the hospital section of the PL?

Providers who are directly responsible for addressing the patient's identified clinical problem can change or delete a problem in the hospital section of the PL. If others believe changes should be made (including deleting a problem from the PL), they should communicate their thoughts with the provider(s) directly responsible for addressing the problem (which may be the attending or relevant consultant) before any changes are made in the PL.

3. Who can resolve a problem in the hospital section of the PL?

Providers who are directly responsible for addressing the patient's identified clinical problem can resolve a problem in the hospital section of the PL. If others believe they can resolve a problem, they should communicate with those providers directly responsible for addressing the problem (which may be the attending or relevant consultant) before any changes are made in the PL.

4. Who can move/file a problem from the hospital section of the PL to "history"?

Providers who are directly responsible for addressing the patient's identified clinical problem can move/file a problem to "history." If others believe a problem should be moved/filed to history, they should communicate with those providers directly responsible for addressing the problem (which may be the attending or relevant consultant) before moving/filing the problem to "history."

5. Who can edit the "overview" of a problem?

Only the provider that placed the information in the overview, or the provider's service coverage, can edit the overview of a problem. Other providers may ADD information if they are directly responsible for addressing that clinical problem.

6. Who can edit (delete, resolve, change) chronic ("red pinned") non-hospital problems or outpatient problems?

Ideally, these should only be edited by the patient's primary care physician (PCP). Others may wish to communicate with the PCP about these types of problems, but it is advisable not to alter the problems in Care Connect prior to communicating with the PCP (whether or not the PCP has access to Care Connect). Similarly, if an outpatient consultation refines a problem, the consultant should communicate this to the PCP, rather than making a direct edit in the Care Connect PL.



Reduce Antibiotic Resistance by Clarifying the Penicillin Allergy

By Maryrose Laguio-Vila, MD

The β -lactam antibiotics are a large class of antimicrobials composed of not only the penicillins (PCN), but also the cephalosporins, carbapenems, and monobactams. They have in common the β -lactam ring, and differ in the number and character of side chains which dictate their pharmacokinetic properties, microbiologic activity, and potential to cross react with each other. Given their long history of safe use and range of antimicrobial spectra, β -lactams are first-line agents for a variety of infections. However, their use is often limited by patient-reported "PCN allergy". Studies have shown that 80-90% of patients reporting a history of a PCN allergy are not truly allergic when assessed by skin testing (JAMA 2001;285:2498-2505) and upon closer interview, patients often misconstrue PCN intolerances or adverse reactions as allergic reactions – conditions which may not necessarily preclude β -lactam prescription. The issue is further compounded by the custom of health care providers interpreting a reported "PCN allergy" as a contraindication to the other β -lactam antibiotics, which is not always the case. In fact, the risk of cross-reactivity between PCNs and 1st generation cephalosporins is between 4-15%, and even lower with higher generations such that 3rd and 4th generation cephalosporins carry a 1-3% risk (J Fam Practice 2006;55(2):106).

Despite this, the fear of PCN anaphylaxis prevails and medical providers often avoid nearly all β -lactam antibiotics when treating the infected "PCN-allergic" patient. This practice can potentially lead to therapy with a second-line, suboptimal,

or more toxic agent. Two studies describe the negative economic outcomes on healthcare costs due to these incorrect categorizations (J Allergy Clin Immunol. 1998; 102:281-285, Am J Med. 1999;107:166-168).

For the treatment of serious Gram-negative infections, aztreonam is the antimicrobial indicated for patients with an immediate/life-threatening PCN allergy due to its lack of cross-allergenicity to PCNs and cephalosporins (with the exception of ceftazidime). However, its other role is as a reserved agent for multi-drug resistant bacteria, such as *Pseudomonas aeruginosa*. It is considered a broad-spectrum antibiotic, and its cost per day is relatively greater than other antimicrobials with similar spectra (\$136/day aztreonam versus \$16/day cefepime, or \$1/day ceftriaxone). According to the RGHS pharmacy purchasing data, there has been a steady increase in the amount of aztreonam purchased (and thus prescribed) from 2008-2012 (see Figure 1). We may be seeing the consequences of such increased exposure in our population by examining the inversely declining susceptibility of our *P. aeruginosa* isolates for nearly the same time period, dropping from 83% to 71% susceptible.

The risk of losing aztreonam as an empiric anti-pseudomonal option due to the rising rates of resistance has motivated providers, including pharmacists, to reevaluate aztreonam use. An aztreonam utilization review for RGH in Jan–March 2013 revealed that of 92 patients prescribed aztreonam due to a PCN allergy, 41 (45%) had a documented tolerance to cephalosporins, either via patient report or historical administration records. Unfortunately, only 17 (18%) patients had therapy narrowed to an alternative β -lactam, 11 of which were recommended by the ASP or Infectious Diseases (ID) teams. Learning from this information, the ASP team in collaboration with Allergy

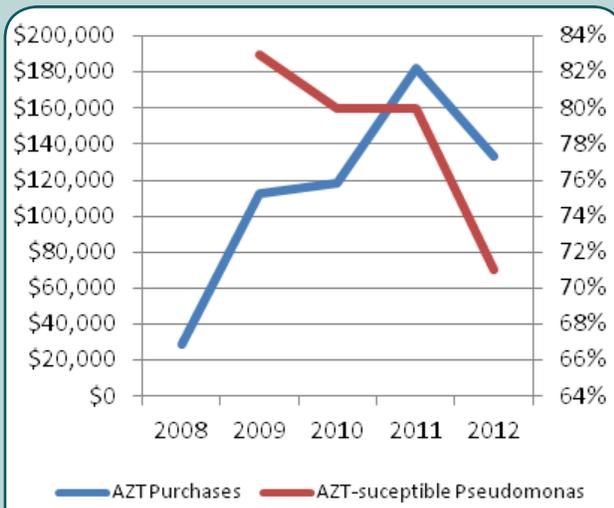


Figure 1: RGH aztreonam purchasing data and the percentage of aztreonam-susceptible *Pseudomonas aeruginosa* isolates, 2008-2012.

Continued on page 9.

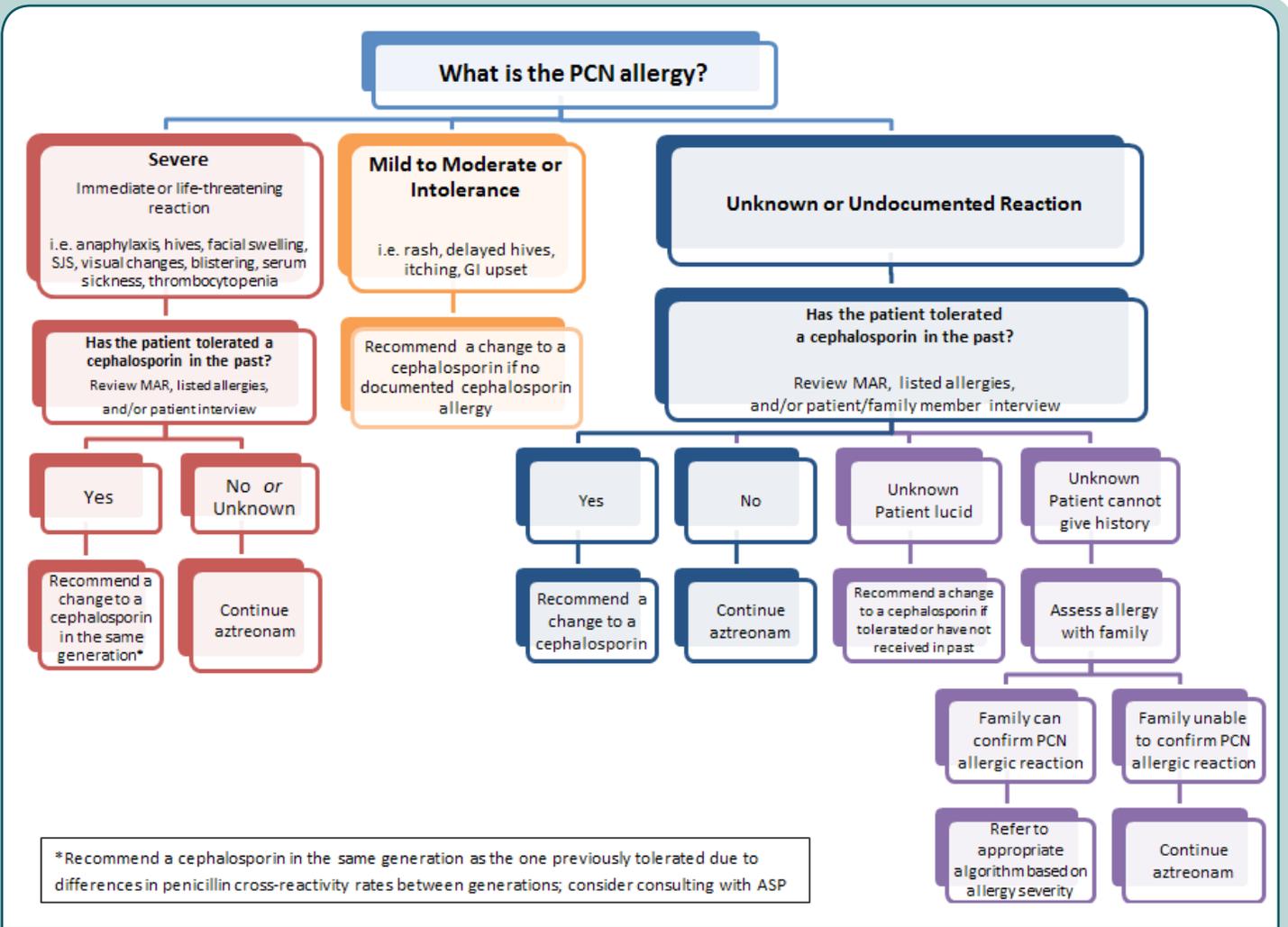


Figure 2: Aztreonam Screening Tool, based on the patient’s reported PCN reaction and prior exposure to a cephalosporin.

and Immunology has developed an Aztreonam Screening Tool (Figure 2) as a reference for providers. Two questions are the minimal requirement for the algorithm:

1. What is the penicillin allergy?
2. Has the patient tolerated a cephalosporin in the past?

The ASP team and ID would like to encourage providers to use this tool when considering antibiotic therapy for patients with a reported PCN allergy

and whether an alternative β -lactam such as a cephalosporin can be considered. An educational module on β -lactam cross-reactivity as well as the algorithm are available anytime on the Antimicrobial Stewardship Website, located on the RGHS Portal or via the RGHS links in CareConnect. Together, we can optimize antibiotic use at RGHS and hopefully reduce the prevalence of bacterial resistance. As always, please feel free to contact any of the members of the ASP team with any questions or comments!



Medical Informatics Committee

Robert Biernbaum, DO, CMIO

As you are aware, RGHS has been on Care Connect since November of 2011. We have recently combined the Ambulatory and Inpatient Informatics Committees into one group, called the Medical Informatics Committee.

This list represents all specialties across RGHS. Its members are noted below. Please feel free to use your department member as your resource and reference.

Committee Members:

- Robert Biernbaum, CMIO
- Robert Mayo, CMO
- Karan Alag, Internal Medicine/ Hospitalists
- Balazs Zsenits, Internal Medicine/ Hospitalist
- Robert Cafarell, Anesthesiology
- Dominick Cortese, Anesthesiology
- Kevin Casey, Gastroenterology
- Michael Chilungu, Neurology
- Melissa Collins, IS&T
- Lisa Comella, IS&T
- Jeff Decker, IS&T
- Kimberly Dickason, IS&T
- Michael Keyes, Emergency Medicine
- Keith Grams, Emergency Medicine
- Doug Hosie, Pharmacy
- Thuc Huynh, Family Medicine
- Paul Cabral, OB/GYN
- Saad Jamshed, Heme/Onc
- Cara Kaplan, Orthopedics
- Kevin McGrody, Cardiology
- Elizabeth Butterer, Cardiac Services
- Daniel Yawman, Pediatrics
- Suzanne Mullin, Pediatrics
- Laura Petrescu, Outpatient Internal Medicine
- Jane Salamone, Outpatient Internal Medicine
- Roberto Vargas, Lab and Pathology
- Elizabeth Varland, Surgery
- Alexandra Yamshchikov, Infectious Disease

Use UpToDate Remotely Or From Your Mobile Device

Elizabeth Mamo, MLS, Director, Werner Medical Library

Werner Medical Library at RGH has purchased a license for UpToDate Anywhere. Now you can access the UpToDate database when you are not on the RGHS network or when you are using your mobile device. You can also earn free CME credits each time you use UpToDate to research a clinical question.

For help creating your UpToDate account, downloading the app, and earning CME credit, stop in the library, call us at 922-4743, or email elizabeth_mamo@rochestergeneral.org.

You may also find instructions on the library's website at <http://intranet/depts/medicalLibrary/medlib.asp>

RGH Historical Trivia

1933

RGH opened the second Medical Records School in the country.

1943

Instituted by Dr. Gaspar, the Department of Medical Photography incorporated a school directed by John Beiter.

Feb. 1986

Labs began using the SMA-12-60 Auto Analyzer. The first such unit in Rochester, it was able to perform twelve different basic blood chemistry tests on a single specimen in one minute.

Sept. 1986

The Medevac Program trained and graduated its first group of flight nurses.

1990

RGH became the first hospital in New York State to offer the non-invasive Atherectomy procedure to remove plaque and cholesterol from arteries.

April 1991

Cardio-Thoracic Intensive Care Unit was split off from the Surgical ICU. The resulting twelve bed unit was the first such units in Rochester and one of the first in the state.

Sept. 16, 1994

RGH opened the first Cardiovascular Tech. School in New York State.

CDIP CORNER: The Power of the Pen

CDI Physician Queries

By Kim Miller, RHIT

A primary goal of the CDI program is to interact with the providers while the patient is in-house, with the purpose of education regarding requirements for the hospital's medical record, and obtaining clarification within a record when necessary. The practice guidelines for a compliant query process as set forth by AHIMA (American Health Information Management Association) indicate a query is required in instances where there is a discrepancy or conflicting documentation within the chart, or where further specificity is needed.

The RGHS CDI query process is being looked at to determine the best process. However, the current process is as follows: query notifications are sent to the provider's Care Connect In-Basket. The CDS (Clinical Documentation Specialist) generally will send an email notification that a query was generated. The query can also be viewed on the "Incomplete Notes" tab in Hospital chart. Though a query can only be sent to one provider, technically any provider treating the patient who reads the query on the notes tab may answer it. CDI queries are not a permanent part of the legal medical record; therefore the response must be documented within the body of the record either in a progress note or a note addendum. Once the query has been documented in the progress notes, the CDS will take care of marking the query as complete.

A CDS might also verbally query a provider. In that situation while a verbal response will most likely be given, it also must be documented within

the medical record.

One final piece is that the provider will also be asked to update the Active Problem List. This allows for easier access at a glance to see a more complete picture of the clinical course during the current admission, for use on future encounters, and to assist with continuity of documentation. For example, documenting chronic diastolic heart failure which was established on the current admission will save time on a future encounter in that a more extensive search will not be required to find the type of heart failure. For acute conditions, don't forget to mark as resolved when applicable, otherwise it could be misinterpreted as a current condition on a later admission.

At this time, the RGHS CDI team is only reviewing Medicare acute medical/surgical inpatient charts. However, if you are a provider working on a unit or service that does not fall into this category or with a service that primarily provides consulting services, but would like some CDI guidance, please contact us. We are happy to help all of our RGHS providers!

Please see a CDI team member or call the CDI office at 922-3721 for any questions or documentation needs.

Congratulations to **Chelsea Norcross, PA-C** of the vascular service who was chosen as the August Documenter of the Month by the CDI team!

RGH MDS QUARTERLY STAFF MEETING

September 20, 2013 @ 7:30 a.m.
in the Twig Auditorium



TRANSITIONS OF CARE PILOT

Dr. Bridgette Wiefeling, Senior Vice President and Executive Medical Director, of Rochester General Medical Group and Dr. Mark Belfer, Chief Medical officer at GRIPA, are pleased to share that on July 15, 2013, the **Transitions of Care Pilot** was launched within the 4500 and 4800 Units at Rochester General Hospital. This pilot is the beginning of a series of care delivery improvement initiatives that Rochester General Health System (RGHS) and the Greater Rochester Independent Practice Association (GRIPA) are undertaking to achieve: **better care for individuals, better health for populations and lower per capita costs.**

The Transitions of Care Pilot is the culmination of nearly six months of research, planning and staff development focused on further improving patient care quality, both during and after a hospital stay, and reducing the rate of readmissions. As part of this process, a series of 20 in-depth focus groups were conducted with physicians, clinical leaders and patients in care management programs and all agreed that, together, we can do better. As a result, we have developed:

- Standardized communication methods across the full continuum of care, including enhanced outreach to the patients' primary care physicians.
- Evidenced-based screening tools and standardized care management processes and practices to quickly identify patient health risks and ensure that the right follow-up care and handoffs are in place before the patient is discharged.

Here's What You Can Expect

If one of your patients is treated in the 4500 or 4800 Unit:

- He or she will receive a standardized health risk assessment screening upon admission.
- A Care Management Coordinator will be assigned to the patient and will be the single point of contact during the inpatient stay and through discharge.

- You (the PCP) will be contacted upon your patient's admission by the Care Management Coordinator who will review the health risk screening results with you and discuss appropriate care plans.
- Transition care plans, life planning and medication reconciliation will be documented and made available to you for review.
- Post-discharge PCP visits and post-acute care support will be arranged and followed up with by the Care Management Coordinator.

The following success measures will be used to evaluate the effectiveness of our standardized practices and procedures: **patient satisfaction, physician satisfaction, readmission rates, ED utilization, length of stay and expense per DRG.**

Once the processes have been worked out on the pilot floors this will be spread by floor to the remaining floors. The goal is to have both RGH and Newark Wayne Hospital utilizing the new transitions discharge process by mid-2014.

The Operational Leaders for this pilot are available to address any specific patient care issues or questions you may have:

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