



Forum

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

RGH MDS ELECTED REPRESENTATIVES

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JEANNE GROVE, DO, EDITOR

24/7 PHYSICIAN HOTLINE NUMBER

922-4414

DIRECT ADMISSION NUMBER:

922-7333

CALL THE HOSPITALIST
FOR YOUR PATIENT

922-7444

**2012 Quarterly
Staff Meeting**

3/16, 6/15, 9/21, 12/21
7:30 - 9:00 a.m. Twig Auditorium

**50% attendance recommended
for all attending Physicians**

MESSAGE FROM THE MDS PRESIDENT

Preserving Prestige

As physicians, we have enjoyed unprecedented prestige over the past 150 years. In the early half of the 20th Century when we could offer few healing interventions, we were honored for our dedication to community and compassion for sufferers. As scientific advances accelerated and educational demands multiplied through the later half of the 20th Century, our recognition expanded to include reverence for our advanced and specialized knowledge.

Years of education and incomparably long hours of toil earned us heightened esteem and social status. Empowered by ever increasing knowledge and a vast armamentarium of medical procedures, pharmaceuticals and therapies our renown leapt forward. Stunning accomplishments like the eradication of small pox, open heart surgery with cardioplegia, transplant medicine, the development of insulin and many other bold, disease stopping treatments created an invincible physician aura. Society clearly communicated to us their appreciation not only through respect and distinction but also through handsome financial remuneration. The gift of prestige was granted to us by a grateful society.



Dr. Robert Mayo,
President RGH MDS

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Preserving, continued

Attendant to this prestige is physician privilege; the privilege to interview patients with probing personal questions intolerable in any other setting; the privilege to hear the private thoughts and concerns of patients withheld from their closest confidants; the privilege to prescribe forbidden drugs; the privilege to invade corpus and cavity.

The full scope of physician prestige and privilege is probably underestimated by most of us. A brief study of the etymology of the word prestige is instructive and helps bring to light its full meaning. In the early 1800's, the word prestige was applied to Napoleon Bonaparte and came to mean "dazzling influence." Prestige became a word for the extraordinary and rare. Fittingly applied to our work, I too am dazzled by the accomplishments and capacity of our Medical and Dental Staff.

Curiously, the definition of prestige was quite the opposite in the 1600's. Taken from the Latin, *præstigium*, meaning a deception or illusion—the word prestige in those days carried quite a negative denotation. Like a double edged sword, the two antonymic definitions of prestige alert us to the potential for its misuse. Occasionally Quantros entries describe situations wherein physician behavior is antithetical to physician prestige and privilege. The following direct quotes are unedited and only reflect one side of the situation, nevertheless they demonstrate the significant negative repercussions of physician misbehavior.

"I was verbally abused throughout all the cases. Patient safety was compromised when I asked for clarification of medications from the field and also when specifying his request for a specific needle type. When I would ask for verification he refused to answer on numerous attempts. He inappropriately yelled the answer. Everyone in the room was aware of the negative atmosphere and the other staff members kept apologizing for his behavior. I felt humiliated."

"Dr. came into my office while I was interviewing a patient. In a loud manner he wanted to know why it took me a half hour to register his patient. I explained that I had another patient ahead of her. Nothing could be said to calm him. After he left, the patient I had in my office said 'I can't believe how unprofessional he was. I hope he is not the doctor that is doing my procedure.' I apologized for the

interruption and assured her that another doctor was doing her procedure."

"Emergency case called so unable to start the scheduled outpatient. Dr. walked in and asked if we were here for his patient. I said we have an emergency to do first—suddenly he started acting very mad, swearing, kicking air—he walked through room mumbling to himself. I was scared."

"I had one out of two surgical instruments needed, so I asked if he wanted the one I had opened. He proceeded to say it was a stupid question, and that he couldn't believe I even asked such a dumb question. I felt singled out and I told him I was just explaining what was going on and that he didn't have to be rude. He told me that I was being hormonal and proceeded to go on about how stupid my question was. I felt belittled and embarrassed."

"Dr. was called about her patient who is s/p surgery—inquiry on when bandage coming off. Dr. states, 'Why does no one look in the chart? Did you look in the chart? That's orthopedics not me. They said to leave the bandage on. Did you not see that?' I explained, 'No, I'm sorry I did look but I did not see a consult.' The doctor stated, 'Ok...well I saw it! Call ortho with those types of questions!' hung up the phone."

These scenarios bring to mind the wise saying "an ounce of prevention is worth a pound of cure." In other words, it is far better for us to behave in concert with the prestige we enjoy than try to recapture it after we have carelessly thrown it away. It seems that no one is more efficient at undermining the prestige of physicians than physicians themselves. In an article by Allan Berger, M.D. entitled "Arrogance among Physicians" (*Acad. Med* 2002;77:145-147) he reminds us that arrogance, "detracts from the nobility of our profession, its dignity and the quality of medical care." Nothing could be truer.

I have challenged myself to more thoroughly and honestly reflect upon my actions and measure them against the prestige and privilege both granted me and expected of me. I extend the same challenge to each of you and hope that we may all find ourselves within the parameters of the current-day denotation of prestige and not the distant 1600's contrary one.

RGHS Team Member Recognition – Again!

As I've said many times before, the remarkable progress we have made – and continue to make – in achieving our vision of becoming the most trusted health care provider in the region is due entirely to you – our team members, physicians, and volunteers. And, that is why I am so excited to announce that we have received yet another significant third-party acknowledgement that the RGHS team is among the best in the health care industry based on the excellence you deliver – every day!!

The Rochester Business Journal will announce its selections for the 2012 RBJ Health Care

Achievement Awards, and the RGHS team has once again earned significant recognition in this highly competitive merit-based competition. In fact, Rochester General Health System physicians, team members, and volunteers have been recognized in five categories for 2012, and they are:



Mark Clement, President & CEO
Rochester General Health System



Beatrice Deshommès, MD, Associate Medical Director of the RGH Outpatient Department & Twig Clinic, earned the *Special Needs* award for her tireless efforts on behalf of the Rochester area's most vulnerable patient populations.



Grace Sanford, an inexhaustible and invaluable RGH volunteer since 1957, was a natural choice for the *Volunteer* category. Grace has contributed more than 18,400 hours of service – most notably in the RGH mailroom, where she embraces a wide variety of duties with dedication and attention to quality. And she's still going strong!



Linda R. Greene, RN, MPS, CIC, Director of Infection Prevention at RGHS, was recognized in the *Nurse* category for her leadership, her cooperative spirit, and most importantly, her relentless pursuit of continuous improvement in the eradication of hospital-acquired infections.



John Genier, MD, a physician at Cross Keys Internal Medicine and President of the Rochester General Physicians Organization, is an outstanding choice in the *Physician* category. John's passion for delivering superior patient care is matched by his expert advocacy on behalf of the RGHS physician community, especially with regard to growing payment and delivery system reform.



Kathy McGuire, BSN, MS, Senior Vice President of Long Term Care and Senior Services, was honored in the *Senior Care* category for her innovative leadership of Hill Haven, DeMay, and the Independent Living for Seniors program. As we continue to redefine senior care to accommodate the evolving needs of our community, Kathy's vision is a big part of our success.

I could not be more pleased that your hard work – and your commitment to providing excellent care for every patient, at every encounter, every time – is being noticed by our peers, our patients, and the community. Our 2012 award recipients will

be honored along with other regional health care awardees at a March 29 luncheon. Please join me in congratulating Bea, Grace, John, Kathy and Linda for their well-deserved recognition!!



Proposed RGH MDS Bylaws Changes

THIS WILL REQUIRE YOUR VOTE DURING THE MARCH QUARTERLY STAFF MEETING

This past year, the RGH MDS Bylaws Committee has seen changes come forward from RGH legal counsel on the wording of the Bylaws as well as recommendations for change from your RGH MDS Officers relatives to Committees and their structures etc. As required, these changes were reviewed by your RGH MDS Bylaws Committee, modified in some cases and then presented to your Medical Board for their recommendation. During the past couple months the following changes have been reviewed and are now recommended for your approval. As required you are being provided with the changes that will be voted upon during the March Quarterly Staff Meeting, thereby allowing you at least 30 days review. If you have any questions about these changes, please contact Samantha Vitagliano, DMD, RGH MDS Bylaws Committee Chair or Mary Lou McKeown at 922-4259.

Article XI, Section 5 – Executive Committee of the Medical Board:

- a. The Executive Committee of the Medical Board shall be comprised of the following:
 1. the President, who shall chair the committee;
 2. the President-Elect;
 3. the Past President;
 4. the Secretary;
 5. the Treasurer;
 6. two Department Chiefs at-large; and
 7. the six elected members of the Medical Board at-large.
- b) The following individuals shall be invited to attend all meetings of the Executive Committee, without vote:
 1. the Chief Executive Officer;
 2. the Hospital's Senior Vice President of Academic and Medical Affairs;
 3. the Hospital's Chief Patient Care Executive;
 4. the Medical Director; and
 5. the Chair of the Hospital's Board of Directors
 6. the President of RGH
- c) Others may be invited to attend at the discretion of the President of the Medical and Dental Staff without vote.
- f) The Executive Committee of the Medical Board

shall meet on a monthly basis during any month when the Medical Board does not convene, and otherwise shall meet as frequently as needed. Meetings may be called by the President of the Medical and Dental Staff or by a majority of the elected membership of the Medical Board. The Executive Committee shall maintain a permanent record of its proceedings and actions. A report of the meeting of the Executive Committee shall be presented to the Medical Board at its next regular meeting.

Article XI, Section 6: Functions of other Standing Committees, subsection "m" [previously section "n"].

m)

The Quality Improvement Council shall be comprised of the Chiefs of each Clinical Department or their designees, and other representatives appointed from the Clinical Departments of the Hospital, Pharmacy, Nursing and Hospital administration. Because of the multidisciplinary nature of this committee, the voting membership will include individuals who may not be members of the Medical and Dental Staff. Such additional voting members shall include the Chief Nursing Officer, Directors of Nursing, the Director of Infection Prevention, the Director of Performance Improvement and Clinical Excellence, the Director of Pharmacy, the Senior Leaders for the Institute for Patient Safety and Clinical Excellence, the President of the Hospital, the Medical Director of the Hospital, the Medical Director of Rochester General Medical Groups, and the Chief Medical Officer of the Rochester General Health System. The Quality Improvement Council shall be responsible for the coordination and implementation of the Hospital's Quality Improvement Plan and shall assist in the development of that Plan. The Council shall oversee and coordinate the quality improvement process of all Hospital departments, in collaboration with the Medical Director. The Quality Improvement Council shall have the authority to recommend courses of action and to identify and correct problems. It shall evaluate the quality of patient care with the goal of furthering the provision of consistently optimal patient care and to insure an accountability mechanism that will contribute to the improvement of patient care...



CDIP CORNER: THE POWER OF THE PEN

Care Connect and Clinical Documentation

Kim Miller, RHIT

2011 saw a lull in chart reviews, queries, and communication from the Clinical Documentation Improvement Specialists due to staffing and Care Connect preparation. Now with additional CDI staff hired and RGH in the Stabilization period, CDI reviews will be ramping up. Concurrent chart reviews will be performed across the board, with the exception of the OB/GYN, Newborn, Pediatric, and Rehab units.

With the implementation of the electronic medical record, gone are the highly visible, bright orange query sheets the CDI team used to insert in the progress notes. In their place, electronic queries for documentation clarification are sent to the provider's Care Connect In-Basket. There is no electronic notification to the individual provider that a query has been initiated. Therefore, this requires manual checking of your In-Baskets to look for CDI queries. As before, responses to queries should be documented in the progress notes.

Keep in mind these are concurrent queries and are effective only when answered prior to discharge. Completion of CDI queries may reduce post-discharge queries by HIM Inpatient Coders and your number of deficiencies. Documentation clarification not only impacts reimbursement and the hospital's overall case mix index, it also affects the SOI (Severity of Illness) and ROM (Risk of Mortality) scores, the hospital profile, and individual provider profiles – just to name a few of the areas impacted. Remember, good documentation in = good data out: data that supports the quality of care, and amount of work done by our providers, and also which will withstand the scrutiny of auditors and payers.

When documenting in the chart, be aware of outdated terminology and non-specific phrases

when utilizing Epic's core Smart Text, such as urosepsis for example. This has been a big documentation issue over the years as urosepsis codes to an uncomplicated UTI. If sepsis is present, UTI with sepsis must be documented to be coded as such.

A few other Smart Text terms to be on the look out for:

- **High and low:** with lab values = not code-able. Use hypo and hyper with the specific diagnosis (ie hypokalema; hypoxia in addition to listing O2 sat levels.)
- **Poorly controlled diabetes:** = uncomplicated diabetes. Clarify as Uncontrolled.
- **Thyroid disease:** Clarify hypo or hyperthyroidism, or other related diagnosis.
- **CHF:** scroll past the NYHA Classifications to find the terms Diastolic and Systolic. Specify acute, chronic, or acute on chronic. Coders are not allowed to assume that "mild CHF" correlates to CHF exacerbation.

Lastly, be conscientious of using the copy and paste function. Medicare Recovery Auditors have indicated they will be closing watching for this, and other auditors and payers are sure to follow suit. The HPI (History of Present Illness), Exam, Assessment and Plan must be updated each day to reflect that day's occurrences for ongoing and new issues. The active Problem List should also be updated to include what is currently being monitored or treated, and to note issues that have been resolved.

CDI staff may be reached at 922-3721 for questions. You may also visit the Clinical Documentation Improvement Portal on the RGHS net.



Article #6 Appropriate Timing for Palliative Care

Submitted By Adam Herman, MD, Director of Palliative Care, RGHS

This is the final installment of a six-article series. Please see the prior columns to review definitions, compliance, FAQ's, engaging patients in advanced illness discussions, and recognizing terminal illness.

INTRODUCTION

The PCIA law requires practitioners to offer information and counseling to patients with a terminal condition to address appropriate treatment options and alternatives, prognosis, and the patient's right to comprehensive pain and symptom management. Recently, in September of 2011, the NYS legislature passed the Palliative Care Access Act (PCAA) which broadens the scope, intent, and implications of PCIA.

Palliative Care Access Act (PCAA) builds upon PCIA in the following ways:

1. The law applies to health care facilities, home care agencies, and assisted living residences, as well as individual practitioners;
2. The law expands patients/residents population to include those with "**advanced life limiting conditions or illnesses who might benefit from palliative care**" and not just those who are terminally ill;
3. The law requires, not only an offer of information and counseling, but facilitation of access to appropriate palliative care and pain management consultations and services.

Like the PCIA, the PCAA is intended to ensure that patients are fully informed of the options available to them when they are faced with a serious illness or condition, so that they are empowered to make choices consistent with their goals for care, and wishes and beliefs, and to optimize their quality of life. Patients and providers should recognize that palliative care and disease-modifying therapies are *not* mutually exclusive. Patients may opt to pursue palliative care while also pursuing aggressive treatment.

An advanced life-limiting condition is generally understood to mean a serious illness that is likely to progress over time, and that may not be reversible with disease-directed or curative intent therapies. Serious illness often causes significant functional and quality of life impairments (physical and emotional),

and is likely to progress over time resulting in physiologic and functional decline, and shortened survival.

WHAT INPATIENT PALLIATIVE CARE CONSULTATION PROVIDES

Inpatient Palliative care team consultation provides substantial supporting services to referring physicians for complex pain and symptom management, assistance with complex decision making, family dynamics and care planning.

Inpatient palliative care consultation offer attending physicians and practitioners:

1. Time saving by handling repeated family meetings and patient/family counseling;
2. Support for resolving questions and conflicts between families/patients and physicians concerning goals of care, DNR orders and treatment requests;
3. Expertise in managing complex physical and emotional symptoms;
4. Coordination of care across settings.

Maximal benefit to physicians, patients and families occurs when palliative care services are provided *at the same time as curative and life-prolonging care*. Palliative care services are *not* linked to prognosis and should be integrated at *all points in the illness trajectory*.

APPROPRIATE REFERRALS FOR PALLIATIVE CARE CONSULTATION IN THE HOSPITALIZED PATIENT

Palliative care information, counseling, and services benefit hospitalized *patients with serious illness*. **Some general inpatient circumstances** that can benefit from palliative care include, but are not limited to:

1. Frequent hospital admissions for the same diagnosis (two or more within the last 6 months)
2. Presentation with declining ability to complete activities of daily living, and/or unintentional weight loss.
3. Prolonged length of stay (>5 days) with complications and/or no evidence of improvement in patients with serious illness.
4. Patient/family/team needing help with complex decision making and determination of goals of care.

Consultation in the Hospitalized Patient

5. Unacceptable level of pain or other symptom (e.g. SOB, Nausea) distress >48-72 hours in the setting of serious illness.
6. Uncontrolled psychosocial or spiritual issues, and/or limited social supports in the setting of serious illness.
7. Patient/family/team uncertainty regarding prognosis, appropriate treatment options, or requests for futile care
8. Patient/family distress or discord hindering decision-making regarding code status, or long-term artificial nutrition.
9. Assistance needed to determine hospice eligibility

- ◆ Parkinson's disease with poor functional status or dementia; Dementia with dependence in all ADLs
- ◆ Any recurrent brain neoplasm

TIMING OF REFERRALS IN THE INPATIENT SETTING

Palliative care is a collaborative process. Ideally, palliative care works across transitions in care and *augments* the medical and psychosocial support that is already in place for patients. Palliative care helps patients and families “hope for the best and prepare for the rest.” Early palliative consultation can streamline management of difficult to treat symptoms – right when they start – and assist in shared decision-making with the understanding that disease-modifying treatments may eventually fail. When palliative care referrals occur late, opportunities may be missed to optimize symptom management and the patient may experience increased distress related to serious illness, the perception of disjointed care, and delays in safe, durable care transitions. As with other medical consultations, when the clinical circumstances warrant, early palliative care consultation can successfully facilitate management of physical and emotional symptoms, and also expedite *coordinated* care planning and disposition. Early referral signals to patients and families that you are bringing to bear all possible resources that may help with the patient's quality of life.

Inpatient consultation at RGH is easy. In Care Connect under *order entry* type in “Palliative Care Consult” answer a few simple questions regarding the reason for consult, diagnosis, and how we can best help. Click ‘accept’ and then sign the order. The RGH operator always has a provider on-call from Palliative care to reach and a direct call will close the communication loop and expedite care.

References and resources:

<http://www.capc.org/>

http://www.health.ny.gov/professionals/patients/patient_rights/palliative_care/information_act.htm

http://www.health.ny.gov/professionals/patients/patient_rights/palliative_care/phl_2997_d_memo.htm

Additionally, there are some specific inpatient populations with serious illness that may benefit from palliative care consultation:

- **Cancer patients** (regardless of treatment status with cancer-directed therapies) with significant systemic markers of illness such as:
 - ◆ Metastatic or locally advanced cancer progressing despite systemic treatments
 - ◆ Poor functional status: Karnofsky < 50, or ECOG 3 or 4
 - ◆ Neurologic complications: brain metastases, spinal cord compression, or neoplastic meningitis
 - ◆ Malignant hypercalcemia; Progressive pleural/peritoneal or pericardial effusions
 - ◆ Poorly controlled symptoms related to the treatments of, or related to, the underlying malignancy.
- **ICU patients:**
 - ◆ Admission from SNF or two or more visits to the ICU during the same hospital stay
 - ◆ Multiorgan failure (MOF); Metastatic Cancer; Status post cardiac arrest, or anoxic encephalopathy
 - ◆ Prolonged or failed wean from ventilator or consideration of ventilator withdrawal with expected death
- **Patients with Neurologic conditions:**
 - ◆ ICH and poor prognosis; significant stroke in a medically frail patient at baseline; status epilepticus > 24 hrs
 - ◆ ALS or other neuromuscular disease considering mechanical ventilation



Changes to your RGH Directory

For those of you who have access to the RGHSNet, don't forget the on-line directory in Departments and Medical & Dental Staff. For those of you who do not have access to the ViaNet, there is a monthly excel directory available for you upon request.

Contact Mary Lou McKeown at 922-4259 or marylou.mckeown@rochestergeneral.org. And Finally, when you are in CCS you will find a full directory under VIEW and STAFF DIRECTORY for your use.

RGH MDS Welcomes the Following New Members

Craig Benson, MD, Dept of Emergency Medicine
Peds ED - Box 308, Rochester, NY 14621
(585) 922-4097

Nefertiti duPont, MD, Department of Ob/GYN
Elm & Carlton St, Buffalo, NY 14263
(716) 845-3497

Jeffrey Tatar, RPA-C, Dept of Med./Dermatology
20 Hagen Drive, Suite 220, Rochester, NY 14625
(585)922-9770

Barry Turek, DO, Dept of Emergency Medicine
Box 111 Driving Park Ave, Newark, NY 14513
(315) 332-2267

Directory Changes: CHANGE TO INACTIVE

Farideh Aziz, MD
Roderick Davis, MD
Ruvim David Falkovich, MD
Catherine Kleckner, NP
Paul Maurer, MD
Thomas Penn, MD
Philip Schirck, MD
Catherine Schroeder, NP
Pearce Sloan, DPM
Brigette Rose Smith, RPA-C
Matthew Tomaino, MD
Kimberly Tuttle, RPA-C

Patient Advocacy Program at RGH



Rochester General Hospital has added an exciting new program which reflects our Mission, Vision and Values. The Patient Advocacy Program will serve as a voice for patients and families, provide healthcare team support, act as a conduit for accurate information/communication, protect patients' rights, and identify and facilitate resolution of care and service concerns. Patients, families, providers, team members, volunteers and visitors may contact me through the following methods:

Contact Information

Sylvia Schenck, MS, RN
Patient Advocacy Coordinator
Office: (585) 922-4686 Cell: (585) 451-9961
sylvia.schenck@rochestergeneral.org

Office Location

Directly across from the Medical Library on the first floor

Infection Prevention Policies re: Influenza

With the official start of the influenza season in Rochester, we wanted to take a moment to remind our staff members of the influenza-specific policies and practices that we have in place here at RGHS. Although influenza activity is still very limited in our area, we hope that this will offer some helpful guidance as we move forward in anticipation of increased flu activity over the next few weeks. Full versions of the policies referenced can be found in the Infection Prevention Manual on the RGH Portal.

DIAGNOSIS AND ISOLATION OF INFLUENZA POSITIVE PATIENTS:

Patients who are positive for influenza A or B need to be placed in a private room with droplet precautions, and should not be cohorted. This year, the use of a PCR-based assay with a turnaround time of < 2 hours allows for rapid diagnosis and triage of influenza positive patients. The sensitivity of the assay is 98%, with a specificity of 95-97%, so no confirmatory testing is necessary. Patients who test negative by the PCR assay require no isolation for influenza, there is no need to wait for a culture result. Viral culture on respiratory specimens is done primarily to rule out other viral pathogens (i.e. RSV, etc). Standard Precautions should be exercised with patients with upper respiratory symptoms awaiting the results of a PCR test - i.e. place patient in private room if available, or utilize cubicle isolation if private room unavailable, or ask patient to wear a surgical mask if awaiting PCR results in a common area.

MASKING FOR INFLUENZA POSITIVE PATIENTS AND PROVIDERS:

Influenza positive patients must wear a surgical mask if being transported outside of their room. The transporting provider is not required to wear a mask. If patient unable to tolerate wearing surgical mask during transport, cough etiquette and respiratory hygiene must be reinforced with the patient to extent possible, and transporting provider may wear a surgical mask during transport. Surgical masks must be worn while performing routine patient care tasks for influenza positive patients, as per droplet isolation precautions. Patient care staff involved in performing aerosol generating procedures (i.e. bronchoscopy, sputum induction, intubation and extubation, autopsies, cardiopulmonary resuscitation, suctioning of non-intubated patients) on patients with confirmed influenza should wear a fitted N95 mask, as these procedures are considered higher risk for disease

transmission than routine coughing, sneezing, talking, or breathing. Droplet precautions for hospitalized influenza patients should be continued until the patient is afebrile AND seven days out from onset of symptoms, or until discharge.

INFLUENZA-LIKE ILLNESS IN HEALTHCARE WORKERS:

Providers who develop fever (>100.5 Fahrenheit) and upper respiratory symptoms should notify their supervisor, Team Member Health Services, and Infection Prevention, and should be dismissed from patient care activities until afebrile for >24 hours without antipyretics. If symptoms develop during routine working hours, the provider should report to Team Member Health Services prior to dismissal for influenza testing. Longer duration of reassignment/dismissal from patient care duties may be required for providers that work in high risk patient care environments. Providers who are afebrile but with upper respiratory symptoms should wear a surgical mask for all patient care duties and practice meticulous hand hygiene, respiratory hygiene, and cough etiquette while symptomatic.

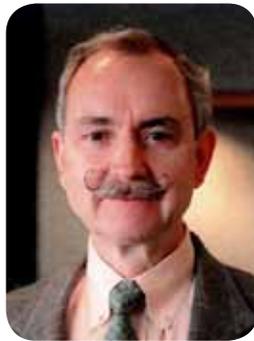
We hope that this clarification of influenza-specific policies at RGHS is helpful. More information about nationwide influenza trends, influenza symptoms, and influenza vaccination can be found at www.flu.gov, a website sponsored by U.S. Department of Health & Human Services and the Centers for Disease Control. Influenza vaccination is also recommended for all health care workers without contraindications to the vaccine, and it remains the best way to protect ourselves, our family members, and our patients from influenza. Vaccine may be received without charge at all Team Member Health Services locations, or by contacting your primary care physician. Thank you in advance for your partnership in helping us protect our hospital community against flu. As always we welcome your concerns and questions - please feel free to contact us at any point throughout the flu season (Linda.greene@rochestergeneral.org, ext 922-5607 and alexandra.yamshchikov@rochestergeneral.org, ext 922-4003, robin.marshall@rochestergeneral.org, ext 922-4026)

Alexandra V. Yamshchikov M.D., Hospital Epidemiologist, RGH
Linda Greene, R.N., CIC, Director, Infection Prevention Program, RGHS
Robin Marshall, R.N., Director, Team Member Health Services, RGHS

WHAT WILL IT TAKE ?



As a member of the search committee, I recently had the pleasure of participating in the interview process of a candidate for the position of CMO of GRIPA. He is from downstate, with an impressive resume` of work experience and successes; verging on being intimidating. When I asked why someone with his accomplishments would consider a position with GRIPA he replied that he has followed GRIPA's development for years and is convinced that the changing movement in health care delivery and payment for services is firmly in the direction GRIPA envisioned over 5 years ago and that GRIPA's development of our Clinical Integration Model positions us, far ahead of most other delivery systems, to thrive in this new environment. He wants to participate in fully implementing this model within the GRIPA network and bring it to national attention.



Jeff Dmochowski, M.D.
GRIPA Chief Medical Officer

Some early indicators of this potential can be identified in the outcomes associated with the current GRIPA employer contracts. With one employer in particular, more than half of the members have a primary care physician outside the GRIPA network. 3,086 members of this employer were identified as having gaps in care on the September 30, 2011 GRIPA Patient Outreach Report based on certain GRIPA clinical guidelines. 18% of members under the care of GRIPA physicians received the identified needed care in the 4th quarter of 2011; compared to only 8% of the patients under the care of non-GRIPA providers. This is clear evidence our program works and we have differentiated ourselves from the rest of the community! The GRIPA provider network and Care Management staff are proactively reaching out to these individuals to identify and address barriers to quality care.

The difference between these two results I attribute to the collaboration of some GRIPA physicians with our Care Management team as well as effective use of the GRIPA Patient Outreach Report to proactively identify these patients. It's a systematic approach that does not remove physicians from their essential role in ministering to the needs of the patient but enhances their capacity to achieve greater success. Our goal must be to move that 18% closer to 100%. More participating physicians are a big factor in this equation.

As experienced physicians we all recognize that acute illness and chronic disease do not exist apart from the patient; with all of his or her life circumstances impacting the final outcome. To achieve the optimal health goal in these instances requires a care team beyond the treating capability of the sole practitioner. The evolution of specialization within medicine over the last 4 score years is clear recognition of this reality. A single physician cannot manage the myriad needs of every patient. Physicians and patients; and physicians as patients, have benefitted from that evolution. The time to advance to the next stage of improvement for health care is NOW. We must embrace Clinical Integration to coordinate care of the whole patient. There is no better option.

GRIPA physicians are well positioned to succeed in a performance based contract around which GRIPA is currently negotiating to bring this opportunity to the network. The possibilities are incredible for us as physicians, for our patients and for our health care system. We will be requesting physicians most impacted by this contract to attend informational meetings to learn how to most effectively participate. We will continue to keep you apprised of our progress in this area and I welcome any questions or comments about GRIPA's initiatives.



*To Our Distinguished RGHS Physicians
Please Join Us For A Doctor's Day Breakfast
In Your Honor*

Thursday March 29th

7:00 a.m.-10:00 a.m.

Rochester General Hospital Atrium

Sponsored By

The Office of Physician Services

Door Prizes, Food, and Music

*Please RSVP no later than March 22, 2012 to Michelle Simmons at
585-922-2955 or michelle.simmons@rochestergeneral.org*

Nurse's Week: May 12, 2012

Surprise your favorite nurse with a ticket
for Nursing Fundraiser on
May 12, 2012, 11:30 a.m. 1:30 p.m.

- Enjoy Brunch and Fashion Show by Dress Barn
- Models from Isabelle Graham Hart Nursing School
- TO BENEFIT Nina Morris Education Fund at Rochester General Hospital.

For Tickets call 922-5074 or 922-5891