

# RGH MDS ANNUAL DINNER DANCE

Saturday, January 28, 2012 • Country Club of Rochester



DECEMBER 2011

# 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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JEANNE GROVE, DO, EDITOR

24/7 PHYSICIAN HOTLINE NUMBER

**922-4414**

DIRECT ADMISSION NUMBER:

**922-7333**

CALL THE HOSPITALIST  
FOR YOUR PATIENT

**922-7444**

## 2011 Quarterly Staff Meeting

12/16

7:30 - 9:00 a.m. Twig Auditorium

## 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

### Caroling

Sharing good news has been one of mankind's avocations for centuries. Vestiges of the Herculean effort expended to share, declare and broadcast good news dot the globe. Take for example the Bell and Drum Towers of China. Initially built in Beijing around 200 B.C. they later became standard installations throughout much of the country side. They first functioned primarily as musical instruments and later as time keepers. The massive bell in the Bell Tower is cast of bronze 10 inches thick. It is 7 meters high, weighs 63 tons, is rung with a huge 2 meter long log and can be heard over 20 kilometers. The drums too were amazing manufacturing accomplishments. Twenty-four of them were housed in the Drum Tower. They were 1.5 to 2 meters in diameter and would be rhythmically beaten 108 times every two hours throughout the night. These penetrating reverberations provided important information for the masses. As time pieces, they regulated commerce and the day-to-day activities of the entire city. Perhaps even most importantly, they communicated to the nation and to the world the accomplishments of the emperors who championed their development and use. To those who heard these awesome instruments, ancient Chinese pre-eminence could not be doubted.

The Europeans also built bell towers for much the same purpose but did not routinely deploy this technology until after the 5<sup>th</sup> Century. Predating bell towers, however, was the centuries long developmental



Dr. Robert Mayo,  
President RGH MDS

**The greater than 1,300 members of our staff provide exceptional care (crescendo). The outstanding work that is accomplished among us is in part recognized by regional, state and national organizations.**

Continued on page 2.

## MDS President, continued

evolution of carols. Ambrose (340-397), the Bishop of Milan is described as the first composer of carols and published at least three in the 4<sup>th</sup> Century. Unlike present-day carols, early carols were generally written with somber melodies. St. Francis of Assisi (1182-1226) was credited with writing more joyful lyrics, rhythms and harmonics into his carols. His directional change so greatly impacted carol writing that it is still felt today almost eight hundred years later. In fact, the word carol is a French and Anglo-Norman word meaning dance song or circle dance accompanied by singing. The basic concept behind carol writing is magnification of otherwise inadequate words. In this way, the full impact of the message was not lost on the words but synergized with the music. The addition of crescendo, fortissimo, staccato, diminuendo, etc, all change the words from a mere intellectual exchange to a penetrating message capable of impacting both mind and soul. Like the Bell and Drum Towers of ancient China, European carols were designed to communicate powerful messages.

Here at Rochester General Hospital the Medical and Dental Staff has a powerful message to share as well. Unfortunately, I am neither a drummer, nor a bell maker. I am not a lyricist or a composer. Notwithstanding these inabilities, I will attempt to describe our message in words—that is, the tremendous outcomes of our work. The greater than 1,300 members of our staff provide exceptional care (crescendo). The outstanding work that is accomplished among us is in part recognized by regional, state and national organizations. A sampling of 2011 accolades includes (forte): the only Quality Breast Center of Excellence by The National Consortium of Breast Centers in all of New

York State; A Bariatric Center of Excellence from the Surgical Review Committee and the American Society for Metabolic and Bariatric Surgery; and a Quality Breast Imaging Center of Excellence from the American College of Radiology. Additionally, infection prevention has been recognized by the Institute for Healthcare Improvement as an Exemplar Hospital in its Project JOINTS (Joining Organizations in tackling Surgical Site Infection) and by HHS for being 1 of 6 hospitals nation wide for achieving >25 months of sustained reduction in catheter associated blood stream infections (fortissimo!). These accomplishments are the aggregate result of incredibly dedicated physicians, midlevels, nurses, team members and leaders. No one can accomplish this alone. This is the harmonic fulfillment of immense collaboration and team work.

Carechex recognized Rochester Heart Institute as the #2 provider of cardiac care in the nation and #1 for New York State. Additionally, the Society of Thoracic Surgeons awarded our Cardiac Surgery Program with a "3 Star" rating placing it among the top 12% of all programs for quality, mortality and appropriate medication usage in the nation. Premier, the nation's largest healthcare data management corporation rated RGH in its Top Performance Threshold award winner hospitals. This is a robust award that takes into consideration mortality reduction, 23 process measures for evidence-based care and the overall cost of care. Only 118 of its >2,500 (4.7%) member hospitals achieved this distinction.

There is much more to say about the outstanding achievements of the RGH MDS but there is not enough time or space to review them completely in this brief article. Suffice it to say, give the drum role, strike the bells, sing the chorus—RGH has a great team!

Mark Your Calendars

Rochester General Hospital  
Medical & Dental Staff

**DINNER DANCE**

**Saturday, January 28, 2012**

Country Club of Rochester

Invitations Forthcoming



## Flu Vaccines

ALL RGH MDS Members are required to provide Accountability for Flu Vaccine. Forms were mailed to all Members September 15 and maybe found on the RGH MDS Website. Failure to provide Flu Vaccine documentation will result in a suspension of your privileges on December 15, 2011.

## RGHS Primary Care Council Reports to You...

On October 11, 2011, RGHS and the RGHS Primary Care Council sponsored its fourth community-wide dinner program for RGHS-employed and private/affiliated primary care physicians. The well-attended event was held at the Monroe Golf Club from 6-8PM. The dinner program is part of an ongoing effort by RGHS to maintain and strengthen existing relationships with area primary care physicians. Additionally, it is our sincere hope that we will be able to foster new relationships as well. In the age of "the hospitalist," RGHS recognizes that there may be fewer opportunities to directly interact with primary care physicians. The community-wide dinner programs, offered every 6 months, help to address that limited contact.

After welcoming remarks by Robert Cole, MD, (Chief of the RGHS Family Practice Department and Chair of the RGHS Primary Care Council) and Brian Jepson, President RGH, several new appointments were announced to the community. William Faber, MD, has recently been appointed Senior Vice President/Executive Medical Director for Rochester General Medical Group. Also, Mark Klyczek has been recently appointed President, Newark-Wayne Community Hospital. Both were welcomed warmly by the assembled primary care community.

While previous dinner meetings had focused partly on introducing/reintroducing a service line to the primary care community, this dinner meeting was focused entirely on drawing questions, concerns, comments from the physician participants. RGHS is committed to seeking regular feedback from our primary care community. The system wants to know when and where things are working and when/where they aren't. RGHS is also open to suggestions for change that will help to better support the practice of primary care in our community.

Rob Biernbaum, DO (RGHS Chief Medical Information Officer) provided updates on the Care Connect launch set for November 4<sup>th</sup> and 5<sup>th</sup>, 2011.

A written statement from Associate Emergency Dept Chief, Brian Gargano, MD, was read to the group. With the launch of Care Connect, the ED Dept expects both auto-faxes and ED discharge documents to be more accurate and meaningful to their primary care users.

Other topics discussed by the evening's participants included a concern that potential premature discharges might be resulting in early and more frequent readmissions. Additionally, several physicians expressed a desire to see more inclusion of primary care activities in RGHS marketing and advertising efforts. Finally, a brief discussion ensued regarding RGHS' support of those employed and private physicians still admitting and attending to their own hospitalized patients. A future dedicated floor for such admitters is being considered and additional NP/PA support has been committed to. All of these concerns will be addressed further by RGHS administration/clinical leadership in follow-up.

John Genier, MD, President RGPO, closed the meeting with a fabulous summary of the changes that are about to affect all of our practices. He encouraged robust participation and integration.

The RGHS Primary Care Council was established 2 years ago to promote, retain, and grow the RGHS-employed and private/affiliated primary care community. It is a great venue for sharing your thoughts/opinions regarding existing and desired RGHS programs. We are looking forward to hosting future community-wide dinner programs. If you or a colleague have an interest in joining the Primary Care Council, please feel free to contact Dr Cole at 771-0943 or at [Robert.Cole@rochestergeneral.org](mailto:Robert.Cole@rochestergeneral.org). We are currently a group of 15 primary care physicians, (IM, FP, and Peds) meeting approximately every 8 weeks (as a small group) and twice per year with the larger primary care community.

# International Pioneer in Sacral Nerve Stimulation for Fecal Incontinence visits RGHS



Dr. Klaus Matzel, professor of Surgery at the University of Erlangen in Germany, visited the Rochester General Health System in October. Dr. Matzel's visiting professorship was made possible by generous support through the Womens Association Teaching Fellowship.

Dr. Matzel, an internationally acclaimed surgeon, pioneered Sacral Nerve Stimulation (SNS) in the mid 1990s in Germany and Europe. SNS is a minimally invasive treatment to target fecal incontinence (the uncontrolled passage of stool or gas) and can eliminate fecal incontinence, allowing previously housebound women and men to resume their daily activities.

Dr. Matzel's contribution has eliminated the need for a colostomy (bag) in tens of thousands patients.

In advance of surgery, potential candidates for neurostimulation therapy undergo a trial assessment that lasts several days. This allows patients to 'test' the therapy before making a long-term commitment. If the preliminary outcome proves improvement, the surgeon implants a thin, flexible wire attached to a small stimulator device (similar to a pacemaker) which sends mild electrical pulses to the tailbone to keep bowel incontinence in check.

"SNS is a breakthrough option to treat fecal incontinence", said Dr. Claudia Hriesik, who learned the procedure from Dr. Matzel in Germany. Since June 2011 she and her partners at Rochester Colon and Rectal Surgeons offer SNS at RGH. "Most patients could not achieve normal bowel control before this unique approach" she explains. "The FDA approved SNS only this year for patients here in the US; my colleagues in Europe have been curing bowel incontinence with Dr Matzel's system for over a decade so we know the long term results are excellent".

During his visit Dr. Matzel gave several lectures featuring Sacral Nerve Stimulation to RGH's staff and physicians in the community. He also observed Dr. Hriesik performing the procedure sharing his expertise with the colorectal operating room team. Dr. Matzel noted "This has been a wonderful opportunity for international exchange and the transfer of advanced surgical therapy" and his hosts agree.

## RGH Makes the Switch to Electronic Medical Records (EMR)

On Saturday, November 5<sup>th</sup> Rochester General Hospital celebrated an historic, transformative change with the launch of Care Connect, the health system's name for its new Electronic Medical Records (EMR) system.

As expected, the launch of the EMR system at Rochester General went smoothly with hospital officials crediting the vast amount of time and team member efforts dedicated to planning, training and testing.

The transition to Electronic Medical Records at Rochester General is just the beginning. Over the next two years, the 65-million dollar project will convert the entire Rochester General Health System from a combination of independent paper-based and computer-based patient record systems to a *single, fully-integrated electronic system* that will significantly enhance quality and patient safety as well as the efficiency and effectiveness of care provided to all patients.

Protecting patient confidentiality is a major component of the Care Connect system. All of the data in the EMR is encrypted and password protected, so access to a patient's information is strictly limited only to those who are authorized.

In addition, Rochester General Health System is partnering with many community physicians to assure they have, with the patient's explicit permission, access to the patient's most up-to-date records to further improve clinical outcomes and quality of care. And because other hospitals in Rochester are also moving to electronic medical record technology, sharing of patient information between Systems will be greatly simplified. In fact, on Saturday – the first day of our implementation, physicians at RGH were able to access important patient information from URMHC.

The Care Connect system is also protected against the loss of patient information through a robust back-up system that is readily available, in the event of a computer malfunction.

## 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.

### NEW MEMBERS

#### **Anthony Colosimo, RPA-C, Dept of Ortho. Surgery**

1425 Portland Ave Box 143, Rochester, NY 14621  
(585) 922-3963

#### **Anne Hall, RPA-C, Dept of Surgery/Vascular Surgery**

1445 Portland Ave #108, Rochester, NY 14621  
(585) 922-5550

#### **Maria Kilari, MD, Dept of Medicine/Internal Medicine**

1338 Ridge Road East #101, Rochester, NY 14621  
(585) 922-7140

#### **Anne Marie Lynch, RPA-C, Dept of Medicine/Int Med**

2550 Baird Rd, Penfield, NY 14526, (585) 467-4143

#### **Stephanie Mann, MD, Dept of Obstetrics/Gynecology**

1425 Portland Ave Box 232, Rochester, NY 14621  
(585) 922-3785

#### **Aimee Maseduca, RPA-C, Dept of Emergency Med.**

1425 Portland Ave Box 304, Rochester, NY 14621  
(585)922-2000

#### **Mary Lou Robinson, NP, Dept of Cardiac Services/ Cardiology**

1425 Portland Ave Box 258 Rochester, NY 14621  
(585) 922-2300

#### **Jaе Hyun Shin, MD, Dept of Medicine/Int. Med. R&F/Ambulatory**

1425 Portland Ave #340, Rochester, NY 14621  
(585) 922-4101

#### **Bettina Trcinski, NP, Dept of Surgery/Urological Surg**

1425 Portland Ave #173, Rochester, NY 14621  
(585) 922-3458

#### **Laura Wells-Spicer, NP, Department of Emergency Medicine/Observation Unit**

1425 Portland Ave ED Obs Unit, Rochester, NY 14621  
(585) 922-9080

### Directory Changes: CHANGE TO INACTIVE

Kristen M. Christian, MD

Craig Durie, NP

Beth Freeling, DPM – effective 12/31/2011

Michael Graney, MD – effective 1/1/12

Brenda Iannucci, MD

Rebecca Ledwin, NP

Pamela Mapstone, NP

Theodore Oates, MD – effective 1/1/12

# Article #4 – Engaging patients and families in advanced illness discussions

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

This is the fourth installment of a six-article series on the PCIA Law. Please see the prior columns for more information. Subsequent articles will discuss: tools to help identify advanced/terminal illness, and; appropriate timing to consider palliative care consultation for hospitalized patients.

## INTRODUCTION

One of the most difficult discussions to have with a patient (and/or family) is sharing news that they are dying. The topic is often avoided and euphemisms are frequently used. Knowing there is now a legal duty to discuss prognosis with those who have end-stage or terminal illness (expectation of <6 months), it is helpful to have a systematic approach to inform patients of their condition and elicit their preferences for further care. Despite the frequency with which I engage in these conversations, they remain the hardest in my practice.

Outlined below is a stepwise approach that I have found helpful when sharing prognosis with patients and exploring preferences for future care. It is based on Buckman's SPIKES protocol.

## 1. RECOGNITION

A major obstacle is our failure to realize that our patients have a terminal illness. In a subsequent article I will address some prognostication tools and guidelines that can help us identify terminal illness. Studies have shown that 1) physicians with less experience, and 2) physicians who have a long term relationship with a particular patient, are more likely to overestimate prognosis, sometimes as much as by two-to fivefold. Moreover, as physicians, we are taught to heal and prolong life. When we have to share with a patient that they are dying, it strikes at the heart of our professional axiom – to save our patients. Speaking of death and dying with patients can feel like failure.

## 2. SET-UP

Allow enough time, turn off distractions such as pagers and phones, ensure the right people are present, be at eye-level with the patient, and have tissues available.

## 3. PERCEPTION

Start with what the patient and family understand. Most patients, if given the opportunity, can identify their own decline. We may think they don't want to discuss it, but invite them to do so. It may be the very reason they seeking an expert opinion.

*"I have been reviewing your medical history and there is a lot going on. How do you think your health is?"*

You may be surprised by the response. Many often say something like 'I don't think I have much time' or 'I'm dying' or 'I know I'm not doing well'. Offering this sentiment often means they have been thinking about this more, and they may have done a lot of work for you. Affirm what they have said:

*"You are right. The decline you describe is what I'm seeing clinically."*

If they do not offer insight, then express concern for their health and clearly express the advanced nature of their illness/condition.

*"While in the past we've been able to manage your condition, even with our best efforts we are now losing ground. Your illness is terminal/end-stage."*

## 4. 'WARNING SHOT'

Ask what they would like to know, normalize their interest, and provide a 'warning shot'.

*"Most patients and families want to know what this might mean and what to expect. Many want to know 'how much time' they have or what their prognosis is. Are you interested in hearing about this?"*

*"I have some bad news..."*

## 5. OFFER INFORMATION

If the patient (and/or family) accepts the invitation for more information/prognosis, provide a brief statement and allow silence.

*"Based on XYZ and your medical problems I expect prognosis is on the order of weeks-months." (Allow silence)*

Avoid hard numbers like “you have X months” as this permits patients to divert attention to specific numbers, to bargain, or deny. Ranges allow patients to think about the big picture. It allows for some ‘wiggle room’ where patients and family can retain hope, avoid fixating on the specifics of exactly how much time is left, but rather focus on how to spend that time. A small percentage of patients may decline the information. One strategy is to explore.

*“What do you think I’m going to say” and  
“what do you think it will mean”*

Often this will open doors to share this information. If they decline (a small minority may) ask if there is a family member or caregiver they would like to have informed.

## 6. CHECK FOR UNDERSTANDING

Silence is your friend. We all dislike and become uncomfortable with silence, yet it allows the patient to process and understand what you have told them. If we fill that void, we impair their ability to process the information.

*(Silence)*

*“What are you thinking?”*

## 7. RESPONDING TO EMOTION

Expect tears, expect anger, expect denial, expect just about anything. Reflect emotion. Avoid declarative statements like “I know this is difficult” or “It must be hard” as these can incite anger and a desire to “shoot the messenger”. Use inquisitive statements and silence to allow patients to define their emotions.

*(Silence)*

*“I can’t imagine what you’re feeling but you seem angry/overwhelmed/frustrated”*

## 8. REASSURANCE

Patients fear suffering both physical and emotional symptoms; they fear abandonment and isolation. Let them know you will continue to care for them. Remove the following phrase from your repertoire: “There is nothing more we can do” and “there are no treatments”. Instead replace them with:

*“While there are no cancer-/lung-/heart-directed therapies that can stop the progression of the disease, I will continue to work with you to aggressively treat symptoms to maximize quality of life as long as possible.”*

## 9. DEFINE GOALS OF CARE/VALUES

You have to ask what is important to the patient. A laundry list of life-sustaining treatments is NOT

what should be addressed here.

*“What makes life worth living?”*

*“Hypothetically, if you knew you had a month/week how would you spend that time? What would be the most important things to say or do?”*

*“What do you imagine would be a good death?”*

Provide your expert recommendations.

*“Based on your comments I will focus care that will accomplish your goals/values. I will maximize symptom treatments no matter what. I would/would not recommend XYZ life sustaining treatments, because they are not consistent with and/or will not accomplish your goals/values for quality of life.”*

## 10. SUMMARIZE

In short declarative sentences, summarize your discussion. Ask for confirmation with simple yes/no questions. If no decisions have been made, reassure them you will support them and help them as they face decisions in the near future. Remind them that we “Hope for the best, prepare for the rest.” Plan to follow up after a short interval.

Engaging patients and families about advanced illness is extremely challenging even for the most experienced practitioners. It is often helpful to have a framework to guide these discussions.

The recommendations presented are not ‘one-size fits all’; they are suggestions of some successful language to consider. While this may seem daunting and time consuming, it is not. Maintaining a consistent process will allow these discussions to stay on track. Resist the urge to skip steps, as the core of each step is two-way communication – allowing you to provide information and guidance, and allowing the patient and family to absorb, process, and respond. Permitting two-way communication opens the door for successful advanced-care planning and directives.

## ADDITIONAL REFERENCES AND RESOURCES:

Nicholas A Christakis, Elizabeth B Lamont, BMJ 2000; 320

Buckman, R., M.D., Breaking Bad News: A Six-Step Protocol. How to Break Bad News: A guide for Health Care Professionals. John Hopkins, 1992.

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

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

## Summary Information of Meaningful Use Bonus Incentives

# Earn up to \$44,000 or \$63,570 in Meaningful Use Money Over a 5-Year Period Beginning in 2011

Eligible health care professionals can qualify for incentives when they adopt certified EHR technology and use it to achieve specified objectives; either through Medicaid or Medicare.

Early adoption better ensures a physician will receive the maximum incentive!

### Medicare Summary - Earn up to \$44,000

The incentive is based on 75% of Medicare Part B, Fee for Service, allowable charges with a maximum incentive of \$18,000 in 2011 or 2012 (depending on when you file for the bonus).

*example:*

Allowable Charges	Incentive Percentage	Maximum Incentive	Your Bonus Incentive
\$50,000	75%	\$18,000	\$18,000
\$24,000	75%	\$18,000	\$18,000
\$20,000	75%	\$18,000	\$15,000

The maximum allowable incentive is reduced in subsequent years and the criteria become more difficult, so it is important to adopt an EHR and qualify for the incentive early.

### Medicaid Summary - Earn up to \$63,570

Providers who have at least 30% (20 % for pediatricians) Medicaid beneficiaries qualify for up to \$21,250 the first year and payment is not based on allowable charges.

### What is "Meaningful Use"?

The American Recovery and Reinvestment Act (ARRA) of 2009, specifies three components:

1. The use of certified EHR in a meaningful manner
2. The use of certified EHR technology for electronic exchange of health information
3. The use of certified EHR technology to submit clinical quality and other measures.

### What are the requirements for Eligible Providers for Stage 1 of Meaningful Use (2011 and 2012)?

You must meet 20 of the 25 meaningful use objectives and report on 6 clinical quality measures.

- There are 15 required core objectives.
- The remaining 5 objectives may be chosen from the list of 10 menu set objectives.
- Clinical quality measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures (selected from a set of 38 clinical quality measures).

Call GRIPA Provider Relations for more information at 585-922-1525 to learn more about how GRIPA can assist you in achieving meaningful use.

