

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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24/7 PHYSICIAN HOTLINE NUMBER

922-4414

DIRECT ADMISSION NUMBER:

922-7333

CALL THE HOSPITALIST
FOR YOUR PATIENT

922-7444

2012 Quarterly Staff Meeting

9/21, 12/21

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

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

June Quarterly Staff Meeting New Format, New Venue

June 14th from 5:00 pm to 7:00 pm
in the Riedman Campus Cafeteria
Light Dinner will be served.

The format and venue of the June Quarterly Staff meeting has been changed in response to MDS member feedback and Medical Board efforts to improve attendance and provide broad, meaningful information. Two thirty minute poster sessions will precede and follow the shorter meeting time and will be provided by clinical departments, the medical library, GRIPA, CareConnect and other departments.

Mark you calendars and join us for an informative and enjoyable evening.

AGENDA

5:00-5:30 pm
Poster Session

5:30-6:30 pm
Meeting

6:30-7:00 pm
Poster Session

Message from the MDS President

The Perception of Perspective

As a boy I collected a lot of stuff. I went nowhere without bringing home new found items. My book shelves, dresser tops and closet were overflowing with stuff. I filled boxes and stacked them in tall piles along the walls and in the corners. Thinking back on it, I am surprised my orderly mother tolerated it all. I remember spending hours gathering and sorting my things. I found them on beaches, road sides, in ditches, vacant lots, meadows, and forests. In fact, I was constantly



Dr. Robert Mayo,
President RGH MDS

Continued on page 2.

Leadership, continued

searching no matter where I was. I sat for hours admiring my prizes and contemplating their significance. The things I collected were not cast offs from the annual neighborhood garage sale or unwanted hand-me-downs. My stuff was the real McCoy—treasures by any measure.

My collection consisted of rocks, shells, twigs, bones, leaves, fossils and a myriad of natural specimens. I organized them by color, shape, and origin. My bedroom was like a mini natural science museum—it was my haven. One of my favorite specimens was a small feldspar stone about 3 cm long x 2 cm wide x 1 cm deep. It was shaped like a 3-D parallelogram. It was clear enough to read printed text through it. I used it like a lens, scanning books, surfaces and watching out the window. The optical distortions created by the stone are difficult to describe. Somewhat like a prism, light would be refracted into its component colors but the irregularities in the stone would interrupt the typical rainbow spectrum. Consequently unexpected colors and patterns would emerge. Words could be discontinuous or bisected creating new opportunities for discovery with each page turn. The predictable unpredictability of the stone captivated my attention and imagination for hours on end.

I no longer have the feldspar stone and most of my collections are long gone but the memory of the feldspar stands today as a fitting metaphor for the changing perceptions and unique complexities of the physician-patient relationship.

The physician-patient relationship has been considered vital and protected since the earliest days. Medical ethics is built upon the foundation of *Primum non nocere* and the primacy of the patient. Through the centuries, all physicians have been taught to nurture and protect this relationship. In our day, we too have been recipients of this teaching and protectors of its application. Despite our best efforts, perceptions of our patient relationships suggest increasing concern that our historical perspective is now wholly inadequate. Broadly speaking, the changing cultural philosophy and expectations of today's patients is not satisfied alone by the traditional physician-

patient relationship. There is increasing evidence to support this statement.

Press Ganey and HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) surveys regularly report low scores for physician and providers regarding communication. I doubt this is because physicians are not talking. Therefore, physicians must realize this performance gap is more about how they are talking and that talking is not necessarily communicating. Another evidence is the growing interest in patient-centered care. The name implies that patients are currently not considered the

... physicians who focus on patient-centered principles of care during the first visit in an episode of illness can within two months improve their patients' perceptions of wellness and reduce the utilization of diagnostic tests by four times.

M. Stewart et al. entitled "The Impact of Patient-Centered Care on Outcomes," (*J of Fam Pract* 2000;49(9):796-804)

center of care. If patients are not the center of care, who is? Or how did we unwittingly communicate to them that they aren't? Or worse yet, how did we take them out of the center and not recognize it? This disconnect challenges all providers with the opportunity to re-examine their perspective on this vital relationship.

Through the lens of the feldspar providers will discover previously unrecognized fragments and patterns that contribute to this circumstance. For example, a large body of published research demonstrates that physicians frequently exhibit racial bias in prescribing and treatment patterns (*Racial Injustice In Health Care NEJM* 2000;342(14):1045-1047). This indicting fact cuts sharply into our pride as providers no matter the

continued on next page.

Interim Nurse Manager Named

The Emergency Department Leadership Team is pleased to announce that Clare Pullano, MS, BSN, CCC/SLP, RN has accepted the position of Interim Nurse Manager for the **Medical Observation Unit and Clinical Decision Unit**. Clare is currently a Charge Nurse and Flow Coordinator in the Department and has been with Rochester General Hospital since 2009. Clare received her BSN from The University of Rochester. She has a Master of Science in speech Language Pathology and a Bachelor of Science in Education from the State University of New York College at Fredonia. Clare is a proven leader, and will be an asset to our leadership team.

We would like to take this opportunity to thank Michele Hobbs, MSL, BSN, RN, for her expertise and dedication in leading this team for the past three years. Michele has made the decision to transfer to 5800 as the Interim Nurse Manager and is very excited about this new opportunity.

These changes are effective April 8, 2012. Please join us in welcoming Clare and wishing Michele all the best in her new role.

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

Andrew Goodfriend, MD, Dept of Ophthalmology
919 Westfall Rd Bldg A, Rochester, NY 14618
(585)244-2580

Rajeev Ramchandran, MD, Dept of Ophthalmology
601 Elmwood Ave - Box 659, Rochester, NY 14542
(585)273-3937

Directory Changes: CHANGE TO INACTIVE

Kevin Jo, MD

origin of our patients. I remember vividly reading an article several years ago about racial bias in renal transplant referrals among nephrologists. This article struck me personally. I could not ever remember withholding transplant referrals on African-American or other minority patients but I became fearful that I might have unconsciously denied those who trusted me.

Closing the gap on patient perception and physician perspective is crucial for us today and tomorrow. The demographics of our MDS members suggests that few of us while in medical school have learned about the science, knowledge and skills necessary to consistently and effectively align our perspectives with our patients' perceptions. This area of behavioral science is very young, nevertheless, it has proven to positively impact patient outcomes. A compelling article by M. Stewart et al. entitled "The Impact of Patient-Centered Care on Outcomes," (J of Fam Pract 2000;49(9):796-804) is one of a growing number of studies in this area. The authors demonstrated that physicians who focus on patient-centered principles of care during the first visit in an episode of illness can within two months improve their patients' perceptions of wellness and reduce the utilization of diagnostic tests by four times. Generalized throughout medical practice, the impact of these concepts could be immeasurable.

How the gap between patient perception and physician perspective developed is not entirely clear but what is clear is the need to close the gap and that the responsibility lies primarily with the providers. The feldspar that entertained me as a youth teaches me now as an adult that my perspective is not always others' perceptions. Through self reflection, survey feedback, applied patient-centered care principles and other means we can build upon the traditional foundation of our patient-physician relationships and successfully exceed our patients expectations.



Important Message Regarding Health Information Privacy Rules

Cindy Bileschi, RGHS Privacy Officer and William Steinmetz, Chief Security Officer

It is imperative for Care Connect users to fully understand the legal requirement to abide by the HIPAA Privacy Rule.



RGHS is monitoring users' access in Care Connect and will take corrective actions for violations of the HIPAA Privacy Rule and RGHS policies as appropriate - up to and including termination of employment and/or access to the system.

HIPAA defines Protected Health Information (PHI) to include information related to the provision of health care to the individual and demographic and payment data related to the provision of health care to the individual.

In accordance with RGHS Policy R8 "Confidentiality of Patient Information and Breach Notification," access to Care Connect is for work-related purposes only.

As a Care Connect user, when you access patient information, always ask yourself whether you have a clinical or business "need to know." Test results, for example, may be accessed if a provider has a "need to know" to diagnose or treat the patient.

It is not permissible to access information in Care Connect on family, friends, neighbors, coworkers, etc, if it is not for work-related purposes.

Additionally, it is not permissible to access information on yourself in Care Connect.

- If you want to review your lab results, you will need to contact your provider to discuss your lab results.
- If you want to review information in your medical record, including lab results, please contact HIM directly at #25143 or (585) 922-5143 and complete the necessary request form. HIM will contact your provider and provide you with copies of the requested information.
- If your provider offers "MyCare," you can request access directly from his/her office to view your electronic medical records online. For a list of medical practices that offer MyCare to their patients, please visit: <http://www.rochestergeneral.org/care-connect/mycare/practices/>.

Please contact Cindy Bileschi, RGHS Privacy Officer, or your affiliate Privacy Liaison listed below if you have questions.

AFFILIATE	PRIVACY LIAISON
RGH.....	Melissa Collins
ILS.....	Jennifer Affronti
BHN.....	Lisa Wild
NWCH/DeMay	Kelly Shay
Hill Haven	Steve Ash

RGH Medical Library Database Password Changes

Passwords have changed for databases supplied through Ovid and EBSCOhost. Databases whose passwords have changed include Medline, the Cochrane databases, CINAHL, PsycInfo and Your Journals @ Ovid.

An updated document is attached that highlights the entire list of current databases accessible offsite. The document includes instructions on how to access the databases from your home or office computer, if your computer is not connected to the RGHS network. Print it, fold it in half and you will have a compact set of directions for future reference!

Other databases are available on the RGHS network only. Stop by the Medical Library or check out our RGHS Portal site next time you are at Rochester General Hospital.

No time to search on your own?

RGH Medical Librarians will search for you. Call the main RGH Medical Library extension at 922-4743 to request a literature search. Your search results will be sent to you by whatever method you specify – email, fax, US Postal mail or interdepartmental mail (if applicable).

Library From Home or Office

Database	Web Address	UserID	Pass Word
<i>Medline</i> (Medicine)	http://ovidsp.ovid.com	rghlibrary	rgh012
<i>MDConsult</i> * (Medicine)	http://www.mdconsult.com		
<i>Cochrane</i> (EBM)	http://ovidsp.ovid.com	rghlibrary	rgh012
<i>Lexicomp Online</i> (Drug info)	https://online.lexi.com	rochgenhosp	lexicomp
<i>Micromedex</i> (Drug info)	http://www.thomsonhc.com	Rochester	090903
<i>CareNotes</i> (Patient education)	http://www.thomsonhc.com	Rochester	090903
<i>Joanna Briggs Institute</i> (Nursing EBP)	http://connect.jbiconnectplus.org	viahealthy	jb13714
<i>CINAHL</i> (Nursing & allied health)	http://search.ebscohost.com Select using "Choose Databases"	rghlibrary	rgh012
<i>PsycINFO</i> (Psychology)	http://ovidsp.ovid.com	rghlibrary	rgh012
<i>Health Business Elite</i> (Management)	http://search.ebscohost.com Select using "Choose Databases"	rghlibrary	rgh012
<i>RefWorks</i> * (Manage reference lists)	www.refworks.com Group Code: RWRochesterGH		
<i>Your Journals @ Ovid</i> (Full text)	http://ovidsp.ovid.com	rghlibrary	rgh012

*** First establish your own user name & password using a computer at RGH**

Access provided for RGHS team members & medical staff only due to licensing agreements.

Please do not share your passwords.

Werner Health Sciences Library
Rochester General Hospital

1425 Portland Avenue
Rochester, New York 14621
(585) 922-4743
Wellness@rocheatergeneral.org



<http://www.rocheatergeneral.org/MedicalLibrary>

No Time to Search?



Here's how the Medical Library can help!

Answer Your Clinical and Job-Related Questions

We provide information for patient care as well as non-clinical information to all RGHS physicians and team members.

Urgent requests: Call the library!

Non-urgent requests: Email, call the library, or request forms are available on the library portal from RGHS networked computers.

Need Information for Your Patients?

The Stabins Wellness Information Center offers confidential answers to medical questions for patients and their families; RGHS physicians and team members; and the Rochester community free of charge.

We Can Get It!

Copies of articles are sent to your email, through interdepartmental mail, or you may pick them up.

Contact Us

Library Front Desk (585) 922-4743

Email: wellness@rocheatergeneral.org

Hours: M-F 8am – 9pm; Sat 8:30am – 5pm; Sun Noon to 5pm

Stabins Wellness Information Center (585) 922-WELL

Email: wellness@rocheatergeneral.org

Hours: M-F 8am – 4pm



Rochester General Hospital Inpatient Stroke Rapid Response Protocol

The **Inpatient stroke protocol** was developed by the Rochester General Hospital Stroke team to assure the rapid evaluation and treatment of hospitalized patients exhibiting new stroke symptoms.

The American Stroke Association states that all patients with suspected stroke should be triaged with the same priority as patients with acute MI or trauma. This is true for patients arriving in the emergency room with new stroke symptoms, and for patients already in the hospital who experience new stroke symptoms. As the busiest certified stroke center in the Rochester area, Rochester General is committed to meeting the acute clinical needs of stroke patients arriving in the Emergency Department with suspected stroke, and hospitalized patients experiencing new, acute stroke symptoms.

Stroke occurs every 45 seconds and is the third leading cause of death in the US with 7-15 % of all strokes occurring in patients that are already hospitalized. For patients experiencing an ischemic stroke, the timely restoration of blood flow to the brain, using intravenous thrombolytic therapy (rt-PA) is the only FDA approved treatment. Because the benefit of rt-PA decreases over time there is a narrow window (3-4.5 hours from symptom onset) during which treatment is effective.

The National Institute of Neurological Disorders (NINDS) tPA stroke study (1996) demonstrated favorable outcomes among 624 patients with ischemic stroke treated with rt-PA within 3 hours of symptom onset, when compared with placebo. Prior studies have also demonstrated that time to treatment is an important determinant of clinical outcome. The sooner the rt-PA is given, the greater the benefit.

The RGH stroke team developed the following protocol to assure the timely evaluation, and treatment of all stroke patients. Implementation of this protocol will ensure a rapid response, and timely evaluation for IV tPA administration, or endovascular therapy when appropriate. The key time intervals for intervention in the protocol were identified by NINDS, and are supported by the New York State Department of Health as a requirement for stroke center certification.

The time sequences are as follows:

- Symptom identification to provider evaluation10 minutes
- Stroke team notification.....15 minutes
- Completion of non-contrast brain CT25 minutes
- Interpretation of the CT45 minutes
- IV tPA infusion60 minutes

A "stroke alert" may be called for patients experiencing any of the following acute stroke symptoms of less than 6 hours duration:

- sudden numbness or weakness on one side of the body,
- sudden trouble seeing in one or both eyes,
- sudden confusion or trouble speaking or understanding,
- sudden trouble with walking, dizziness or loss of balance, or
- sudden severe headache with no known cause

The following actions will occur when a patient is identified with new stroke symptoms:

- The nurse will initiate stat notification to provider.
- The provider evaluates patient within 10 minutes, and initiates a "stroke alert" through the page operator using the (4444) phone number.
- The page operator alerts the stroke neurologist on call, and the SICU early nurse intervention team (ENIT).
- The ENIT nurse assists with coordination of neurologist notification, neurological evaluation within 15 minutes, brain CT within 25 minutes, lab results, administration of thrombolytics within 60 minutes and patient transfer to the SICU or acute stroke unit.

A copy of this protocol is located in each nursing station, and is available on the RGHS Neurology portal titled, Rochester General Hospital Inpatient Acute Stroke Protocol.

Please e-mail Cheryl Wood, ACNP, Stroke Center Coordinator, with questions or suggestions: (Cheryl.wood@rochestergeneral.org)



Effective 5/1/12
@ Midnight

Care Connect will Go-Live at NWHC and DeMay on Tuesday, May 1st at 6am. As we experienced at RGH, an interface downtime is required to prepare the system to bring them live on Care Connect. This is an interface downtime ONLY and Care Connect will be available for documentation. This downtime will begin at Midnight, going into May 1st. Outlined below is the summary of how this interface downtime will affect RGH as well as the estimated associated timeframes.

RGH Downtime for NWCH Go-Live

Documentation (No Downtime)

General documentation (i.e. notes, flowsheets, etc.) will not be affected by the downtime.

Device Interfaces & Surescripts (Midnight - 3am)

Device Interfaces are the monitors & machines that feed information (i.e. monitors, ventilators, anesthesia machines, etc.) into Care Connect. Surescripts (e-prescribing) will also be affected. Team members will need to enter the data into Care Connect directly. Prescriptions will need to be printed.

Lab (Midnight - 4am)

Orders will need to be placed on downtime requisitions. Lab results will be delivered directly to the floors. As usual, critical results will continue to be called to providers. When the interface comes back up, the results will automatically be released into Care Connect.

Scanning and Transcription (Midnight - 4am)

The scanning interface with Solcom will not be available. Scans should be held until the interface comes up. E-scription interface will be down. Providers can still dictate, but the transcribed document(s) will not be available until the interface comes back up.

Radiology (Midnight – 5:30am)

All Radiology orders need to be placed on downtime requisitions. As usual, critical results will continue to be called to providers. When the interface comes back up, the results will automatically be released into Care Connect.

MedSelect (On override Midnight – 6:30am)

All MedSelect machines will be on override. On May 1st, after we ensure the platform is stable, a decision will be made to take the machines off of override. This will be communicated at that time.

CDIP CORNER: The Power of the Pen

Make the Connection

By Kim Miller, RHIT

In general, the more detailed the documentation, the higher the Severity of Illness (SOI) and Risk or Mortality (ROM) scores. This correlates to individual diagnoses, and provides the link between related diagnoses, thus allowing for greater coding specificity.

Linking Relations Conditions:

For instance, Diabetes Mellitus, not otherwise specified, or history of a CVA, both are assigned unspecified codes that do not impact the DRG, reimbursement or SOI/ROM scores. However, when associated manifestations or residuals are documented, this can significantly impact the results.

For example, consider a past medical history which includes: Diabetes, Neuropathy, CVA, Hemiplegia. As each condition is listed separately they must be coded as unrelated, uncomplicated conditions.

Now compare a past medical history stating: Diabetic neuropathy; Hemiplegia due to prior CVA. As the links between the disease and the

manifestation are stated, the associated ICD-9 codes are considered complications, and result in an increased reimbursement and SOI/ROM.

Lab Cultures: Linking Cause and Effect:

Another area where associations must be specifically stated is with culture results. The sputum culture for a patient with pneumonia grows pseudomonas. The coder may not assign a code for any bacterial pneumonia based only on the presence of a positive culture; per Official AHA Coding Guidelines the coder may only assign a specific pneumonia code when the provider states "pneumonia due to pseudomonas" as in this example. The same applies for pneumonia due to aspiration.

Remember, your Clinical Documentation Improvement queries can be found in your Care Connect In-Basket, CDI Coding Query folder, and need to be answered while the patient is still in-house in order to assist us. Clarifying documentation concurrently may also reduce your number of retrospective deficiencies. As always, the CDI team thanks each of you for all of your hard work, and for your help with our queries!

And a special "Congratulations" to Dr. John Phelan for being chosen as the April Documenter of the Month!

GRIPA Clinical Integration Success

In past GRIPA articles, you've read about the benefits to you as physicians of clinically integrating as a network. We will now go into more detail about the benefits of a clinically integrated program to your patients as well as their employers.

GRIPA has been working with LiDestri Food & Beverage for over 2 years and has accomplished as near the perfect situation as possible with this organization. Specifically, through the GRIPA program all parties are actively engaged in improving the health care delivered to the membership while reducing the cost. GRIPA has aligned the interests and motivations of:

- **The employees and their dependents** – taking more responsibility for their health
- **The leadership of LiDestri** – active promotion of GRIPA services as a pathway to wellness
- **The payer (Excellus)** – providing timely and accurate claims data
- **The physicians and health care system** – opening their panels, creating access and providing nearly real time practice management information to the GRIPA data warehouse

GRIPA's work with LiDestri includes:

- Communicating gaps in patient/member care to physicians
- Targeted care management with an emphasis on those members who would benefit most from intervention
- Aggressive promotion of lower cost pharmacy alternatives
- And, general awareness and education of healthy lifestyles

GRIPA receives full support of the company's leadership and periodically attends benefit enrollment sessions as well as health fairs to ensure the employees know about GRIPA. As a result of this interaction, employees and their dependents are comfortable with GRIPA representatives. In addition to employees and dependents being more open to engaging with a GRIPA care manager, the employees also leverage GRIPA to find doctors and navigate through the complicated world of health care.

Once alignment is achieved and the membership (employees and dependents) trust and value GRIPA, it is time to measure results. And, the GRIPA representatives are thrilled to report the success of the program. GRIPA also meets regularly with the leadership at LiDestri to review this information, and it's no surprise both sides (GRIPA and LiDestri) eagerly look forward to these meetings!

As you are aware, GRIPA's program targets several chronic conditions, as well as members who will benefit from care management intervention. Below are some stats reflecting the success of the GRIPA Connect Clinical Integration Program with the LiDestri membership:

Diabetes Improvements:

- 22% more members have blood sugar level tested: Before working with GRIPA, 47% of LiDestri members with diabetes were getting their blood sugar (A1c) tested at least every 6 months (standard of care). Today, this value is at 69%.
- 17% more members have Cholesterol level tested: Before working with GRIPA, 69% of LiDestri members with diabetes were getting their Lipid Panel completed annually (standard of care). Today, it's at 86%.
- 11% more members with controlled blood sugar levels: Before working with GRIPA, 57% of LiDestri members with diabetes had controlled blood sugar levels (A1c < 7%). Today, 68% have controlled blood sugar levels.

Hypertension Improvements:

- 11% more members seeing their provider regularly: Before working with GRIPA, 64% of LiDestri members with hypertension were seeing their provider at least every 6 months (standard of care). Today, 75% are meeting the standard.

Prediabetes Improvements:

- 21% more members screened for diabetes: Before working with GRIPA, 67% of LiDestri members with prediabetes had a diabetes screening completed annually. Today, 88% are having the diabetes screening completed annually. While the number of members included in this statistic is small, we are very pleased with the result.

High Satisfaction from Members:

- 97% of LiDestri members indicated on a Satisfaction Survey that they were satisfied with their experience with GRIPA.
- 79% of LiDestri members indicated on a Satisfaction Survey that their physical or mental health had improved since working with GRIPA.

Medical Claims Cost – significantly lower than premiums paid!

These amazing statistics occurred after a little more than 2 years and demonstrate the significant opportunities possible when all parties work together.