



AUGUST 2011

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

RGH MDS ELECTED REPRESENTATIVES

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24/7 PHYSICIAN HOTLINE NUMBER

922-4414

DIRECT ADMISSION NUMBER: 922-7333

CALL THE HOSPITALIST FOR YOUR PATIENT

922-7444

2011 Quarterly Staff Meetings

9/16, 12/16 7:30 - 9:00 a.m. Twig Auditorium

50% attendance recommended for all attending Physicians

Message from the MDS President

Bloody Hands

he twenty seven bones of the human hand provide Homo sapiens with fantastic dexterity unique in the animal kingdom. The evolution of this hand with its opposable thumb is thought to have begun around 2.5-1.4 million years ago. At that time, the ancient hominid nearest to our chimpanzee ancestor was named Homo habilis — meaning skillful man. The descriptor



Dr. Robert Mayo, President RGH MDS

"skillful" seems like a gross overstatement compared to modern man but in his epoch Homo habilis was skillful indeed. It is theorized that he excelled at behavior that developed his preeminence among animals and propelled him through the evolutionary millennia toward *Homo sapiens*.

The behavior most fundamental for *Homo habilis'* ascribed success and skillfulness was throwing and clubbing. Richard Young, Professor emeritus from UCLA Medical School described this theory, "It has been proposed that the hominid lineage began when a group of chimpanzee-like apes began to throw rocks and swing clubs at adversaries, and that this behavior yielded reproductive advantages for millions of years, driving natural selection for improved throwing and clubbing prowess." (J Anat 2003) It had not previously occurred to me that throwing and clubbing would be any measure of success or achievement not to mention evolutionary prominence. However, upon reexamining this idea it is suddenly very clear to me that the histories of both ancient and modern man are overly abundant with horrific tales of bloodshed and conquest. Perhaps the human proclivity for violence has its roots in evolutionary behavioral genetics. Shakespeare even captured the dread of life and death with Macbeth's grief stricken words after murdering King Duncan, "Will all great Neptune's ocean wash this blood clean from my hand? No, this my hand will rather the multitudinous seas incarnadine, making the green one red." None of this would be possible without the tiny, three-boned structure called the opposable thumb.

The fear of abusive hands is the source of the legendary origin of our common handshake. Though not known, it is suggested that the handshake was initially an attempt at grabbing the right hand before a weapon could

Hands, continued

be raised. Additionally, the shaking of the hand was designed to jostle free any sleeve hidden daggers. Over time, the domestication and civilization of humankind no longer required the defensive handshake and it evolved into the pleasant greeting we know today.

Thankfully, most survival pressures known to our ancient predecessors no longer impinge on our day-to-day and our wonderfully developed hands are now expressive tools of the creative mind. Hands are the means of Rococo carvings, masterpiece paintings, calligraphied poetry, haute cuisine, and the limitless expressions of human creativity. Hands now symbolize help, work, creation, and comfort among other things. Living without hands would be an extreme challenge because much of what we accomplish is dependent on them.

Despite the marvelous and enriching handiwork advances of the last century, we are now facing another sinister evolutionary threat. Our hands may once again be becoming the instruments of death. The CDC reported in 2002 there were 1.7 million healthcare associated infections in US hospitals. Among these infections 98,987 deaths occurred. In 2009 the CDC published estimated infection-related costs

of \$35.7 to 45 billion nationally. The impact of sepsis is vast. Its incidence doubled from 2002 to 2008 and inpatient mortality related to sepsis was 17%. Survivors of sepsis have a 3.3 times higher rate of having lasting moderate to severe cognitive impairment. Consequently, the WHO and the CDC have launched extensive infection prevention programs including hand hygiene imperatives; we also measure and report hand hygiene compliance. Hand hygiene compliance reported nationally and within RGHS averages from 35-45%. The landmark work of Ignaz Philipp Semmelweis is well known to most of us and has profoundly impacted the value of hand hygiene. In 1847 he recognized the same autopsy findings of puerperal fever in the corpse of his close friend who died from a scratch incurred during a cadaver dissection as those seen among post-partum women. He concluded that something in the cadavers was responsible for the mortalities and he named it "cadaverous particles." Determined to eliminate these particles he began to wash his hands in chlorinated

lime and the mortality rate among the maternity patients dropped from 18.3% to 1.2 % in just three months. His miraculous discovery still inspires hand hygiene efforts today.

Several papers have been published that have



studied the attitude and understanding of physicians about hand hygiene. One from the Annals of Internal Medicine (2004;141-8) reported 57% compliance with hand hygiene among 163 physicians across many specialties. Only 65% of the physicians knew when to wash their hands and 28% recognized the importance of hand hygiene after degloving. Fifty-six percent felt that they should be role models of good hand hygiene practices. It is my hope that all physicians and providers at RGHS would be role models of hand hygiene. I have included the WHO Five Moments of Hand Hygiene and the Indications for hand Hygiene During Patient Care in this edition of the Forum for your review.

As health care providers it is imperative that we do all that we can to reduce the risk of healthcare-associated infections. Let us not digress to the destructive hands of *Homo habilis* but nurture the healing potential of our clean hands.

Indications for Hand **Hygiene During Patient** Care

Wash hands with soap and water when hands are visibly dirty or contaminated with proteinaceous material, blood, or other body fluids (IA) and if exposure to Bacillus anthracis is suspected or proven (II) In all other clinical situations described below when hands are not visibly soiled, an alcohol-based hand rub should be used routinely for decontaminating hands (IA).

- Before having direct contact with patients
- Before donning sterile gloves when inserting a central intravascular catheter (IB)
- Before inserting indwelling uringry catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure (IB)
- After contact with a patient's intact skin (eg, when taking a pulse or blood pressure or lifting a patient) (IB)
- After contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled (IA)
- If moving from a contaminated body site to a clean body site during patient care (II)
- After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient (II)
- After removing gloves (IB)

*Classified according to the level of scientific evidence and based on Centers for Disease Control and Prevention hand-hygiene guidelines.⁷

CATEGORY IA = strongly recommended for implementation and strongly supported by welldesigned experimental, clinical, or epidemiological studies; CATEGORY IB = strongly recommended for implementation and supported by certain experimental, clinical, or epidemiological studies and a strong theoretical rationale; CATEGORY IC = required for implementation, as mandated by federal or state regulation or standard; CATEGORY II = suggested for implementation and supported by suggestive clinical or epidemiological studies or a theoretical rationale.

Trampuz A, Widmer A, Hand Hygiene: A Frequently Missed Lifesaving Opportunity During Patient Care. Mayo Clin Proc. 2004;79:109-116

Appointment - Chief of Surgery for RGHS

Mark C. Clement, President and CEO, RGHS and Richard Gangemi, MD, Chief Medical Officer, RGHS

e are very pleased to announce the appointment of Dr. Ralph Pennino as the new Chief of Surgery for Rochester General Health System. Dr. Pennino has held the role of Interim Chief of Surgery since January of this year when Dr. Ralph Doerr retired from his administrative

responsibilities as Chief of Surgery.



Ralph Pennino, MD

As Chief of Surgery of our System, Dr. Pennino will lead the work currently underway to make RGHS the highest quality and safest surgical program anywhere in the

country. He will also collaborate with Dr Gangemi and others to lead continued clinical integration of surgical services across the system and advancement of clinical partnerships with independent affiliated

hospitals and physicians in the secondary service area.

Dr. Pennino's appointment follows an extensive national search in which we had the opportunity to interview and consider a number of highly qualified and interested candidates. Dr. Pennino quickly emerged as the consensus choice. Dr. Pennino is well-known to and highly respected by Rochester General Health System family and the larger Rochester community. As a Plastic, Reconstructive and Hand Surgeon in private practice with the Plastic Surgery Group of Rochester and Chief of Plastic Surgery for Rochester General Health System, he joined the staff of RGH in July 1987 and has served as Associate Chief of Surgery for Rochester General Health System since May 1, 2001.

Dr. Pennino earned his undergraduate degree from the University of Notre Dame, and received his medical degree from Georgetown University Medical School. He completed a plastic surgical residency and hand fellowship at the University of New Mexico, general surgical residency at the University of Rochester Medical Center, and an aesthetic fellowship at Manhattan Eye, Ear, Nose, and Throat Hospital in New York. Dr. Pennino is board certified in hand surgery, plastic surgery, and laser surgery. He is also a Clinical Associate Professor of Surgery at the University of Rochester Medical Center and an Adjunct Professor at Rochester Institute of Technology.

In addition to his surgical and administrative responsibilities, Dr. Pennino is widely respected and recognized for co-founding InterVol. the non-profit international humanitarian organization that provides critical medical supplies, equipment, and services to people in need around the globe.

We would also like to express our thanks and appreciation to the Search Committee, chaired by Dr. Richard Speisman along with Kathy Peishel and the Physician Services Department, for their efforts in conducting such a thorough and thoughtful search and selection process.

Please join us in congratulating Dr. Pennino as he assumes his new role as Chief of Surgery for RGHS.

Rochester General Hospital Welcomes the Daisy Award

Patricia L Koops RN BSN CCRN CSC

This July RGH will announce three nurses who will receive a Daisy Award and begin our partnership with the Daisy Foundation. The Daisy Award is given to nurses who are deemed extraordinary by their peers, patients, patients' families, physicians and anyone who can attest to their extraordinary care.

This award was started by the family of Patrick Barnes who watched their loved one being cared for by nurses everyday during his eight week hospitalization.

After his death at age 33 from complications of ITP his family wanted to thank the nurses and formed the Daisy Foundation. Daisy is an Acronym for Diseases Attacking the Immune System. The foundation was formed in 1999 and they set a goal to recognize nurses everywhere who make an enormous difference in the lives of so many



people with the work they do every day.

As of February, 785 healthcare facilities have committed to honoring their

nurses with the Daisy Award. Nursing literature demonstrates that recognition is a Key element in nurse retention, commitment and a healthy work environment. It celebrates why nurses became nurse for the first part, Compassionate care. Nurses may think their work is routine, but the Daisy Award will reinforce the impact they have on so many people, patients and everyone in their lives.

All nurses nominated will receive a Daisy nomination pin. The nurses chosen for the award will receive a Daisy Pin, Healing Hands statue (hand made in Zimbabwe, Africa) and a certificate all within a signature green Daisy Bag.

Nomination forms will be available on each unit, in the hospital common areas such as the cafeteria, main entrances and waiting rooms.

It is also available on the portal within the nursing page and the RGHS website, just look for the daisy at the bottom of the page with all our other partners' logos.



care connect Computer Proficiency Classes

After an overwhelming response to the Care Connect Computer Skills Assessment Survey that was conducted over the past month, the Care Connect Team will be holding a number of Computer Proficiency Classes tailored specifically to the needs of our RGHS Team. Our Computer Skills Training is an optional training that will be one hour in length and cover the necessary computer skills to get our team members ready for our November 5th Go-Live.

As we try to help better prepare all of our team members for increased usage of a computer, it is important to note that the class itself is not a typing class. The class will help drive home important skills necessary to successfully navigate a computer, specifically Care Connect. Supplemental materials will be offered to assist.

Below, please find our July/August 2011 schedule.

All classes will be located in the RGH Medical Library Computer Lab. Additional classes will be added based on Team Member response. To register



for one of our courses, please call 922-LINK.

Date	Time
Tuesday, August 2	8 -9 am
Wednesday, August 3	
Thursday, August 4	12 - 1pm

Thank you again for your commitment to making our transition to Care Connect as seamless as possible.



Doctors Across New York (DANY) Programs Offers Up to \$150,000 in Awards to Qualifying Physicians!

by Sara Kreher, Physician Recruitment and Retention Liaison

Rochester General Health System would like to inform you that the State funded Doctors Across New York (DANY) Physician Practice Support and Physician Loan Repayment Programs have been reopened with new sets of quidelines and additional funding. The DANY program was enacted to help train and place physicians in underserved communities in a variety of settings and specialties to care for New York's diverse population.

One of your current Physicians or a new recruit to your practice may meet the basic qualifications to participate in the Doctor's Across New York's Physician Practice Support or Physician Loan Repayment Programs.

THE PHYSICIAN PRACTICE SUPPORT PROGRAM

The Physician Practice Support Program provides up to \$100,000 in practice support funding or repayment of qualified educational debt over two years for providing medical services in an underserved area of New York. This award may potentially be used for a variety of expenses depending on your practice's situation including:

- Land/building acquisition (for individual physician applicants starting a practice)
- Renovation/construction (for individual physician applicants starting a practice)
- Equipment/furniture (for individual physician applicants starting a practice)
- Staff salaries (for individual physician applicants starting a practice)
- Qualified educational loan repayment (for individual physician applicants only)
- Income guarantees
- Investment in partnerships
- Recruitment/productivity bonus
- Relocation reimbursement
- Professional membership fees
- Continuing medical education costs
- Other direct compensation payments to physician Applications for this program will be accepted

continuously from June 14, 2011 through March 30, **2012** or until the \$7.2 million in funds are exhausted. This program's application process is on a "first come, first serve" basis.

THE PHYSICIAN LOAN REPAYMENT **PROGRAM**

The Physician Loan Repayment Program provides up to \$150,000 in loan repayment funds to Physicians in return for 5 years of service in an underserved area of New York.

Applications for this program will be accepted continuously from June 27, 2011 through March 30, **2012** or until the \$3.4 million in funds are exhausted. This program's application process is on a "first come, first serve" basis.

Some of the key requirements for a Physician to be eligible for these programs are listed below. Please refer to the Physician Practice Support and Physician Loan Repayment Program links for the complete list of qualifications as well as instructions on how to apply.

- U.S. citizen or permanent resident; and
- Licensed to practice in New York State; and
- Not fulfilling an obligation under any state or federal loan repayment program where the obligation periods of the state or federal loan repayment program would overlap or coincide with the DANY obligation period, including other DANY programs;
- Not currently working in, or serving, an underserved area, where the current service to the underserved began prior to July 1, 2010; and
- In good standing with the NYSDOH Office of Professional Medical Conduct.

Please note that a physician meeting these requirements MUST now be identified and have an executed employment contract with the applicant institution prior to application submission by an institution or an individual physician. In addition to the Physician's qualifications, your practice location must also be considered an underserved area as defined in each of the program's RFAs.

Questions, contact: Sara Kreher, sara.kreher@rochestergeneral.org, 585-754-4355) or Kathy Peishel, kathy.peishel@rochestergeneral.org, 585-922-9348

GRIPA Providing Direction

In last month's Forum, Rob Mayo authored an excellent article relating responsibility to privileges. In his summation, he advocates adopting familiarity with and implementation of clinical guidelines into our practice of medicine.



Second only to the National
Debt crisis, the continually rising
GRIPA, Chief Medical Officer

cost of health care looms in the consciousness of our populace. We accuse our politicians of not taking action on the top issue. Who bears responsibility for the second? As with the National Debt, we all bear a measure but, physicians, by virtue of the privilege deriving from our position, bear greater. We conscientiously strive to provide the best care to our patients but, amidst the daily, ever-pressing, distractions

of phone calls, emergencies, meetings, and missing

delivering the highest quality, most efficient, care.

Where are our leaders to provide direction?

As Rob alluded, they are throughout the MDS: those leading and serving on committees....seeking solutions.

information, we not infrequently fall short of consistently

GRIPA, your association, through your Clinical Integration Committee, your Specialty Associated Group

Committees, and, your Quality Assurance Council, all composed of fellow physicians, has, over the past 5 years, developed 45 clinical guidelines and over 160 associated clinical measures specifically adapted to the Rochester physician practice culture. This effort consumed hundreds of hours of their time. Their invaluable contribution to your association's efforts to structure a systemized, clinically integrated solution to delivering consistently efficient and high quality care only awaits your engagement and implementation to "answer the challenge".

GRIPA, your association, is presently completing rolling out the Accountable Care Medical Program to all our participating adult primary care practices (see article following). It is an "entry level" program into the Clinical Integration journey. We currently have 5 contracts around this model and several more in negotiation. Are we going to imitate "Washington" and kick the can to the next generation or are we going to act now? Are we deserving of our privilege?

Hope to see all of you on this journey; if not leading, at least supporting.

Comments Welcome:

Jeffrey.Dmochowski@rochestergeneral.org

NEWS FROM NORTHRIDGE MEDICAL GROUP

Patient Outreach Success

he GRIPA Accountable Care Program's level of success depends on physician support and office implementation of the Patient Outreach Reports (POR). One of the practices, which has successfully implemented the POR into their daily workflow, is Northridge Medical Group.

This particular office has designated the task of running the POR every 2 – 3 weeks to a clinical staff member. This person brings information on patients identified as "not at goal" to the physician's attention to determine if they should be seen and instructs the appropriate office staff to arrange office visits for those overdue for visits or not at goal.

Shawna Tyler, LPN at Northridge Medical Group said

"It does take some time but it's worth it. We've brought in lots of people who haven't been seen in a long time and we have caught some patients who were missing blood work. It is a very beneficial program for both our patients as well as the office."

The GRIPA Accountable Care Medical Program focuses on three areas, Chronic Disease Management, Diabetes Prevention and Cardiac Risk Management. Patient outreach reports easily identify what contracted members are overdue for visits, overdue for labs, or not at goal based on the GRIPA Clinical Care Guidelines created by GRIPA physicians.

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.

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CHANGE TO INACTIVE

James R. Boynton, MD William S. Burgin, MD Tulsi Dass, MD Bahram Dowlatshahi, MD Timothy Hutchings, DO Karl Illig, MD Harry McCrea, III, MD Lewis Mehl-Madrona, MD

Colleen Raymond, MD Gill Rubin, MD Shweta Singha, MD Elizabeth Sofia, RPA-C

Heidi Springer, NP Pamela Stone, MD David Tinkelman, MD Laura Woodson, RPA-C

Pharmacy & Update Therapeutics Update

FORMULARY CHANGES:

- BELIMUMAB (BENLYSTA): Restricted to the
 outpatient setting due to the high cost and non emergent indication. Benlysta was added to the
 formulary for the treatment of adult patients with
 active, autoantibody-positive, systemic lupus
 erythematosus (SLE) who are receiving standard
 therapy. It is the first new option for SLE therapy
 in decades and has shown to be moderately
 effective.
- ERIBULIN MESYLATE (HALAVEN): Restricted to Oncology. Eribulin mesylate, a non-taxane synthetic analog of halichondrin B and microtubule inhibitor, was added to the formulary for treatment of metastatic breast cancer patients that have previously received at least two chemotherapeutic regimens. Eribulin adds another treatment option for metastatic breast cancer patients with a unique mechanism of action and is recommended by the 2011 National Comprehensive Cancer Guidelines.
- IPILIMUMAB (YERVOY): Restricted to Oncology. Ipilimumab, a recombinant, human monoclonal antibody, was added to the formulary for the treatment of unresectable or metastatic melanoma. It has demonstrated an improvement in overall survival in patients who have become refractory to other economical medications. However, it is associated with severe and fatal immune-mediated reactions which may involve any organ system. As a result, a REMS program was designed to inform healthcare providers about the risks. Despite safety concerns, the advantages in overall survival and unique ability to boost immune response against melanoma providers another treatment option for unresectable or metastatic melanoma.
- DELETIONS: Imipenem/cilastatin IM formulation has been withdrawn from the market.



SHORTAGES RECENTLY AFFECTING RGH (AS OF 5/6/11):

- VALPROIC ACID 100MG/5ML INJECTION: no reason provided for the shortage; expected release date is mid-Summer 2011
- HYALURONIDASE 150 UNITS/ML (AMPHADASE): shortage is due to Baxter recall and Akron discontinuing production; we are researching an alternative strength of Hyaluronidase (Vitrase)
- RESOLVED SHORTAGES: glucagon injection