



Forum

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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Editorial Staff:

JEANNE GROVE, DO, Editor

DIRECT ADMISSION NUMBER:

922-7333

CALL THE HOSPITALIST
FOR YOUR PATIENT

922-7444

2010 Quarterly Staff Meetings

9/17, 12/17

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

50% attendance recommended
for all attending Physicians

Redefining Reformation

It's no secret that we're all sinners. We unabashedly spend other people's billions without a single particle of remorse; we avoid accountability outcomes; we handoff and reconcile poorly; we write dreadfully; and discharge too slowly. It is no wonder that our sanctimonious leaders in the White Halls of Congress have called us to reformation. Reformation is a strong word—it usurps prejudice and creates legions of uncomfortable and unanswerable questions. Because of reformation's broad sweep, I turned to the dictionary for more clarity and containment. This is what I found, "to purge an organization of corruption and inefficiency," and "to rescue from error and return to a rightful course." No comfort in those words! They wreaked of individual condemnation. The nearest definition to reasonable was "intended to make a striking change for the better in social or political or religious affairs." At least this definition included the supposition that systems and society share some portion of responsibility. The burden of carrying the failings of the health care system was too great to shoulder alone. After a few disturbing mental gyrations I decided it was better to abandon my short lived exploration into the etiology, origin and semantics of health care reform. Instead, I now prefer the less threatening and proper name; The Patient Protection and Affordable Care Act, otherwise known as PPACA.



Dr. Robert Mayo,
President RGH MDS

Despite the abundant uncertainties of PPACA there are some areas that seem more comprehensible. These areas provide a measure of opportunity to prepare and to make a difference.

All kidding aside (but I am only kidding a little because this is serious) what does this mean? How did we get here? Did I really have a role? My response to these soul searching questions is to think, to reflect, and to wonder—where is the truth? How much money have I really spent? Could I have been more frugal with the health care dollars entrusted to me? Are my handoffs adequate and my medication reconciliations complete? I realize there is a degree of personal responsibility in all of this and that I have not always been my best. Truthfully, the PPACA really has caused me to think about reform—reform

Continued on page 2.

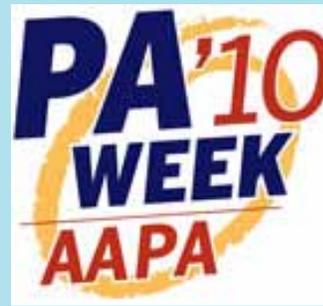
Redefining Reformation, cont.

in all of its denotations. But the past I can not change. So, I look to the future. What does it mean? Where will it take me and how will I master it?

Despite the abundant uncertainties of PPACA there are some areas that seem more comprehensible. These areas provide a measure of opportunity to prepare and to make a difference. Because of them, I look with a sense of anticipation to the future. One of these important areas is the concept of improved health care value. I feel motivated by the opportunity to provide safer care (less complications), better care (measurable, evidence-based outcomes) and more modern care (improved use of integrated IT systems and information sharing). Having meaningful metrics that are captured at the time of care and are linked to clinical decision support systems is really quite revolutionary. This means that components of evidence based medicine will be embedded into interactive protocols that help physicians and providers care for patients efficiently and thoroughly. For example, a physician caring for a patient newly started on warfarin can receive dosing guidelines based on today's INR. Because the computer links pharmacy orders with disease states it will alert prescribers of warfarin medication interactions before the orders are signed. Ideally, the clinical decision support system will then suggest an alternative medication. Other benefits will also be realized. Because of greater standardization in clinical care, innovation and clinical research will blossom. In essence, inpatient units will resemble clinical research laboratories because many variables in care will be easily standardized. With standardization, a tremendous increase in disease management strategies will be employed and comparative effectiveness research will direct how we care for patients. These and many other changes are expected to develop in a very short time. Tightly integrated collaborations between physicians, nurses, care managers, operational leaders and nearly every other hospital team member will be vital for efficiencies and quality. The role of physicians will actually increase as we participate in directing the development of processes, information technologies and other advances.

In preparation for these and other changes physicians will benefit from familiarizing themselves with current hospital order sets and protocols. Practicing using these aids will help acclimate and teach providers more about the processes of care and the complex interactions needed to deliver care. I have learned so much about nursing by taking an interest in their documentation and understanding their immense role in caring for my patients. I appreciate their involvement because it assists my patients more than I ever realized.

All of these changes and innumerable others will be part of our lives. It certainly won't be easy to change but I believe it will be interesting and meaningful. I hope that you will participate in this reformation and contribute to the "striking change for the better" that I hope will result.



A SINCERE THANK YOU

**National Physician Assistant Week
10/6/2010 – 10/12/2010**

To all of our Dedicated RGH Physician Assistants,
On October 6, 1967, the first Physician Assistants graduated from Duke University. Today, more than 50,000 PAs are providing essential medical and surgical services to people from all walks of life.

Rochester General Hospital has the honor of seeing 156 of you work with our patients on a daily basis. You have assisted each of us in assuring that patients receive the attention and care that we would all wish for our family members to receive.

The Medical & Dental Staff of RGH honor you on your nationally recognized day and thank you for your service and dedication. Please keep up the good work and continue to assist the hospital and its physicians with your invaluable care.



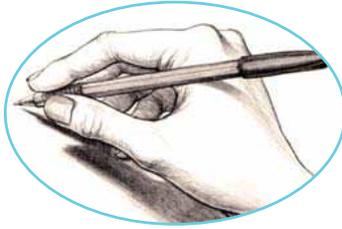
ALL OF OUR DEDICATED CERTIFIED NURSE MIDWIVES

In Honor of National Nurse-Midwifery Week the American College of Nurse-Midwives (ACNM) and certified nurse-midwives across the country will work to raise public awareness of domestic violence, as the theme of Nurse-Midwifery Week (October 3-19).

Rochester General Hospital has the honor of seeing you work with our patients on a daily basis. You have assisted many physicians, patients and their families by providing the attention and care that we would all wish for our family members to receive.

We honor you on your nationally recognized week and thank you for your service and dedication. Please keep up the good work and continue to assist the hospital and its physicians with your invaluable care.

CDIP CORNER – THE POWER OF THE PEN



Mortality Statistics and Documentation

By Mary Darrow, CCDS

Severity adjusted mortality statistics are dependent on physician documentation. If the documentation is complete, accurate and specific, the hospital's profile will likely be a true representation of the patient population. This is especially necessary when the patient enters the hospital and dies shortly thereafter. It is simply not enough to document the cause of death. Documentation must take into account every complication and co-morbidity that the patient presented with or developed during the dying process.

The Clinical Documentation Improvement Team reviews every inpatient death record to be certain that it meets an optimal level of risk of mortality. If the documentation calculates to a low risk of mortality, the attending physician is queried as to whether additional diagnoses might have been present based on lab values or non specific documentation. If the physician agrees that additional diagnoses were present, a Death Summary is dictated documenting these diagnoses. This ensures that the appropriate risk of mortality level will be calculated. Below is an example:

Initial Documentation: Patient enters ED s/p cardiac arrest and resuscitation. The patient dies shortly after transfer to the ICU. The documentation indicates Cardiac Arrest.

Initial Risk of Mortality – 2(moderate)

Post death review: The physician was queried and a Death Summary was dictated that further specified the cardiac arrest as being secondary to a Suspected AMI as well as complications of V-fib/tach and coma.

Post Review Risk of Mortality – 4(extreme)

It is essential to remember that on inpatient records, "rule out", "suspected" or "probable" diagnoses are allowed. This is important in the case of patients that die shortly after admission. If the patient was suspected of having an AMI,

but the lab results were incomplete, it is appropriate to document the AMI. (*Suspected diagnoses are not allowed on outpatient records.*)

Mortality statistics of the predictable dying patient with a short length of stay can damage the physician and hospital's profiles if the documentation does not support the severity of the patient's illness. Remember to document diagnoses such as acute respiratory failure, coma and hypotensive shock. In addition, document the patient's chronic conditions as specifically as possible; e.g., chronic diastolic heart failure and stage IV or V renal failure. By doing so, you will:

1. Appropriately capture the severity of illness
2. The mortality rate will be justified in the eyes of Medicare Provider Analysis and Review as well as other databases
3. Generate an appropriate predicted mortality rate
4. Ensure favorable profiles for both physician and hospital

Please contact the CDI staff for any documentation issues or concerns @ 922-3721. Or, visit the Clinical Documentation Improvement Portal site on the RGHSnet.

Congratulations Dr. Kevin Hix

Dr. Hix received the September *Documenter of the Month Award* from the CDI Team. Dr. Hix is being recognized for his commitment to a legible and complete progress note in the medical record utilizing both the Dragon system and typed notes.

RGHS Influenza Vaccination Campaign 2010-11 Update

With the influenza flu season fast approaching, the RGHS Infection Prevention Program is partnering with RGHS Employee Health Services and Pharmacy Services to commence our Staff Influenza Vaccination Campaign for the 2010-11 influenza season. Unfortunately, according to Centers for Disease Control (CDC) surveillance data, each year more than 200,000 people in the United States are hospitalized for influenza illness, with more than 36,000 deaths per year attributable to influenza. The influenza vaccine is highly effective at preventing influenza illness in healthy adults younger than 65 years of age (Nichol KL NEJM 1995; 333(14):889-893). Studies have demonstrated that vaccination in health care providers (HCPs) prevents morbidity and mortality from influenza among their patients, in addition to preventing illness among the HCPs themselves (Potter J, J Infect Dis 1997; 175(1):1-6), Salgado CD Infect Control Hosp Epidemiol 2004; 25(11):923-928)

In planning for this year's vaccination initiative, we hope to provide our staff and employees with maximal support and opportunity to demonstrate their commitment to patient safety by obtaining their influenza vaccination. While we do not anticipate that New York State Department of Health will implement a policy supporting mandatory influenza vaccination of all HCPs this year, CDC has issued recommendations for influenza vaccination during the 2010-2011 season which endorse a vaccination goal of 100% influenza coverage for HCPs (including physicians) who do not have medical contraindications to receiving influenza vaccination (Prevention & Control of Influenza with Vaccines - Recommendations of the Advisory Committee on Immunization Practices (ACIP)). MMWR 2010 Aug 6; 59(RR08):1-62). Retrospective analysis of our own data from the 2009-10 influenza season suggests that seasonal influenza vaccination

rates ranged from 29-72% among RGH and RGHS affiliate employees. Unfortunately, we are not able to stratify our data further on the basis of physician vs. non-physician employees, and employed vs. non-employed staff – issues we hope to resolve with this year's vaccination initiative.

This year, we are introducing several new strategies designed to optimize vaccine uptake among our staff, volunteers, and employees. An aggressive front-loaded vaccination campaign will start early in the season (October 11-29) with stationary large scale and medium scale clinics (Atrium, and Garage/Cafeteria locations, respectively) scheduled to provide near-daily opportunities for vaccination of all employees and affiliated staff, including those working night and weekend shifts, as well as staff working at affiliate sites. All physicians with RGHS privileges are welcome to

SEASONAL INFLUENZA VACCINE CONSENT/ WAIVER/ DECLINATION FORM This form MUST be completed for every employee and returned to Employee Health

INFLUENZA VACCINE IS STRONGLY RECOMMENDED FOR HEALTHCARE WORKERS, not only to protect themselves, but to reduce the risk of spreading influenza in the workplace and in the community. Approximately 36,000 persons die of influenza complications every year in the United States. Elderly, chronically ill, or hospitalized persons are at highest risk. **INFLUENZA VACCINATION IS HIGHLY EFFECTIVE IN PREVENTING INFECTION.** RGHS is committed to the health of employees and their families, considers influenza vaccination of all employees a high **PATIENT SAFETY PRIORITY**, and provides the influenza vaccine to all RGHS employees at no cost. Information regarding participation in the RGHS influenza program will be collected and made available to RGHS management. **PLEASE HELP PREVENT THE TRANSMISSION OF INFLUENZA BY RECEIVING ANNUAL INFLUENZA VACCINATION**

Section 1 - Please answer the following questions

1. Is this your first flu vaccine this season? yes no
2. Do you have a severe allergic reaction to chicken eggs? yes no
3. Have you ever had a severe reaction to a flu vaccine in the past? yes no
4. Do you have documentation of having received flu vaccine this season? yes no
5. Do you have a fever or feel ill today? yes no

Section 2 - Please complete one of the three sections below

I. Consent for Vaccination – Complete if requesting vaccination

- copy of 8/10/10 CDC Vaccine Information Statement (VIS) given
 verbal consent for influenza vaccination obtained

Manufacturer: **Sanofi-Pasteur**
 Deltoid IM **Right Left**
 Administered by _____

Lot Number _____
 Exp. Date _____
 Date Given _____

II. Waiver of Vaccine – complete if ineligible to receive vaccine for reasons 1-4 above (if #5, do not complete form – return in 1 week to receive flu vaccine. If illness unresolved, seek medical attention)

- I am not eligible to receive vaccine today for reason marked above

III. Declination of Vaccine – must be completed if refusing vaccine

I am eligible to receive vaccine today but do not want to take it. I understand that by refusing the vaccine I may be putting my friends, family, and patients at risk for getting influenza. I understand that I can transmit influenza even when not having symptoms myself. I am aware that hospitalized patients are at increased risk for serious complications of influenza infection. I am refusing the vaccine for the following reasons:

- afraid of needles never get the flu afraid of getting the flu from the vaccine
 afraid of side effects don't believe in vaccines don't have time
 other _____

Name (Please Print) _____ Date _____
 Signature _____ Employee or SS # _____

White copy – Employee Health Services at RGH
 Yellow copy – Employee Copy

Version --August, 2010

Influenza Vaccination, cont.

receive their vaccination at the EHS clinics - the finalized schedule of influenza clinics will be released September 27th, 2010. Phase II of the vaccination campaign will utilize mobile vaccination carts and will consist of targeted unit-specific, staff-specific interventions throughout the months of November and December, guided by close collaboration with our colleagues in Organizational Development to help identify areas with suboptimal vaccination rates. Initial focus will be on high priority areas with known high burden of influenza-related illness, such as Emergency, Intensive Care, Obstetrics, and Pediatrics. We will strive to stay abreast of the latest vaccination and clinical recommendations from the CDC

... we hope to provide our staff and employees with maximal support and opportunity to demonstrate their commitment to patient safety by obtaining their influenza vaccination.

as the influenza season progresses – links to the latest CDC guidance will be made available to RGHS staff via the intranet.

Enhancing our data capabilities using badge-swipe technology will allow us to measure vaccination rates more accurately and regularly throughout the influenza season, which in turn would allow better targeting of our vaccination efforts in the latter phases of the campaign. The creation of a new single mandatory form that can be used for consent, waiver, or declination of influenza vaccination by all employees and affiliated personnel will improve convenience of employee and staff participation, as well as data management. The form will be made available to RGHS physician staff through the Medical Staff Office, Employee Health Services, and the influenza vaccination clinics. Mobile vaccination carts will help improve access to influenza vaccination for staff working in high-volume, high-acuity areas of the hospital, and will be dispatched throughout the hospital starting October 25th, 2010. Overall, we at Infection Prevention and Employee Health Services are excited to implement these improvements in time for this year's campaign, and we hope to make vaccination an effective, easy, and accessible yearly practice for all staff and employees eligible to receive the influenza vaccine. Influenza vaccination of health care providers is a patient safety priority – please help prevent transmission of influenza this year by receiving your annual influenza vaccination!

EMERGENCY MANAGEMENT Universal Emergency Codes to Know

CODE BLUE

Cardiac and/or Respiratory Arrest

CODE RED

Fire or Smoke Emergency

CODE YELLOW

Disaster (Actual or Potential)

CODE ORANGE

Bomb Threat

CODE 77

Infant Abduction

CODE BROWN

Lock Down

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

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CHANGED TO INACTIVE

Changed to Inactive	Jamie Krautwurst,
M. Christine Arigo, MD	RPA-C
Thomas C. Burm, DMD	Lawrence LaRussa,
Dianne Marciano	RPA-C
Andrus, NP	Douglas J. Liano, MD
Andrew Bakken, MD	Jonah Marshall, MD
Stacie Berlowitz, MD	Kathleen M. Meeusen,
Robert J. Bingham, MD	NP
Chaya Diskind, RPA-C	Raymond Ochrym, MD
Gerald Druff, MD	Jeremy Smith, MD
Allison Cardin, MD	Carolyn Stern, MD
John W. Crofts, MD	Sanin Syed, MD
James Hadley, MD	Gina Teresi, DPM
Christa Heinsler, NP	

GRIPA welcomes Joseph S. Vasile, MD, MBA as our new President/CEO

Dr. Vasile is a practicing physician who is Board Certified in Psychiatry with a subspecialty in Geriatric Psychiatry. He has held several hospital and administrative appointments in Rochester, including Chief of the Behavioral Health Network for the Rochester General Health System, Director of Psychiatry and Mental Health Services at the Rochester Rehabilitation Center, Chief Psychiatrist for Geriatric Psychiatry, Intermediate Care and Neuropsychiatry Units at Rochester Psychiatric Center and Director of Acute Psychiatric Services at Strong Memorial Hospital.



Dr. Vasile has served on a number of hospital committees dedicated to quality, education, and organizational planning. He has been a member of GRIPA's Finance Committee since 2003. Dr. Vasile is active in several professional and scientific societies and has published articles in the Journal of Clinical Psychiatry and Schizophrenia Research. He is a member of the American College of Physician Executives and is a Distinguished Fellow of the American Psychiatric Association.

He completed his undergraduate studies at Yale University, received his Doctorate of Medicine degree from the State University of New York at Buffalo and a Masters Degree in Business Administration from the University of Pittsburgh. Following a residency in Psychiatry at the University Health Center of Pittsburgh, Dr. Vasile completed a Fellowship in Geriatric Psychiatry at Johns Hopkins Hospital.

Dr. Vasile is also a Clinical Assistant Professor of Psychiatry at the University of Rochester School of Medicine and Dentistry.

"I am very happy and excited to join the GRIPA team. In partnership with its owners, the physicians and healthcare system, GRIPA is in a unique position to address the health care reform challenges ahead." Joseph S. Vasile, MD, MBA.

Appropriate Screening Tests for Diabetic Nephropathy

Diabetic nephropathy occurs in 20-40% of patients with diabetes and is the leading cause of end-stage renal disease. Persistent albuminuria in the range of 30-299 mg/24 hour is the earliest stage of diabetic nephropathy in type 1 diabetes and a marker for the development of nephropathy in type 2 diabetes. Microalbuminuria is also a well established indicator of increased risk for cardiovascular and chronic kidney disease.

The American Diabetes Association (ADA), the National Kidney Disease Education Program (NKDEP), and the GRIPA Connect Clinical Care Guideline for Management of Adult Diabetes recommend an annual test to assess urine albumin excretion in patients with at least 5 years of type 1 diabetes and in all type 2 diabetic patients. Due to variability in urinary albumin excretion, 2 of 3 specimens within a 3 to 6 month period should fall within the microalbuminuric or macroalbuminuric range to confirm classification.

Definitions of abnormalities in albumin excretion

Category	Spot collection (ug/mg creatinine)
Normal	<30
Microalbuminuria	30-299
Macroalbuminuria	≥300

Optimal Labs to Order

The preferred method of screening for albuminuria is the measurement of the albumin-to-creatinine ratio in a random spot collection. This ratio corrects for variations in urinary concentration due to hydration and provides a more convenient method of assessing protein and albumin excretion. Twenty-four hour collection and timed specimens are not necessary.

Labs That Are Not Optimal

Measurement of a spot urine for albumin by immunoassay or dipstick test specific for microalbumin (i.e. spot protein) without simultaneously measuring urine creatinine is less expensive, but susceptible to both false negative and positive results due to variations in urine concentration. The ADA does not endorse screening for nephropathy using a urine dipstick test.

GRIPA's Clinical Integration Network Performance on obtaining an annual nephropathy screening in type 1 and 2 diabetics, as of 8/31/2010, is 55.2% (individual physician rates range from 2.7%-87.4%). Many of these low rates are due to non-optimal labs being performed. If you would like to see how your individual performance contributes to the performance of the network, you can access your Physician Achievement Report (PAR) on the GRIPA Connect Portal (under My Reports). This report can also provide you a list of patients that have not had an annual nephropathy screening that your practice can reach out to or proactively incorporate into their care plan.

If you would like access to the GRIPA Connect Portal please contact GRIPA Provider Relations at 585-922-1525.

References:

1. American Diabetes Association Standards of Medical Care in Diabetes. Diabetes Care, 33(1):S11-S61; January 2010.
2. National Kidney Foundation. K/DOQI Clinical Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification, and Stratification. National Kidney Foundation. 2002.





STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

August 30, 2010

Dear Colleague:

On July 30, 2010, Governor David A. Paterson signed Chapter 308 of the Laws of 2010 authorizing significant changes in HIV testing in New York State. This law was enacted to increase HIV testing in the State and promote HIV-positive persons entering into treatment. Implementing this legislation is critical, since approximately 20 percent of HIV-positive New Yorkers are unaware of their infection status and 33 percent of persons newly identified with HIV are diagnosed with AIDS within one year.

Key provisions of the legislation include:

- HIV testing must be offered to all persons between the ages of 13 and 64 receiving hospital or primary care services, with limited exceptions noted in the law. The offering must be made to inpatients; persons seeking services in emergency departments; persons receiving primary care as an outpatient at a clinic; or from a physician, physician assistant, nurse practitioner or midwife.
- Standardized model forms for obtaining informed consent and providing for disclosure will be developed by the New York State Department of Health (Department) and posted on the Department website (see below).
- Consent for HIV testing can be part of a general durable consent to medical care, though specific opt out language for HIV testing must be included.
- Consent for rapid HIV testing can be oral and noted in the medical record.
- Prior to being asked to consent to HIV testing, patients must be provided the seven points of information about HIV required by the Public Health Law.
- Health care and other HIV test providers authorizing HIV testing must arrange an appointment for medical care for persons confirmed positive.
- HIV test requisition forms submitted to laboratories will be simplified.
- Deceased, comatose or persons otherwise incapable of providing consent, and who are the source of an occupational exposure, may now be tested for HIV in certain circumstances without consent.
- Confidential HIV information may be released without a written statement prohibiting re-disclosure when routine disclosures are made to treating providers or to health insurers to obtain payment.

More information and forms will be available on or before September 1, 2010. Stakeholder feedback will inform further implementation, modifications and the development of regulations, as necessary. For additional information, please go to the Department's website www.nyhealth.gov. Questions not covered in the attached FAQ document may be sent to hivtestlaw@health.state.ny.us.

Sincerely,

Richard F. Daines, M.D.
Commissioner of Health

Enclosure

HIV Specific Model Consent Form

Chapter 308 of the Laws of 2010 instructs the New York State Department of Health (DOH) to create standard model forms for obtaining consent for HIV testing. The model below is for those providers who use the Department's current "Informed Consent to Perform HIV Testing" form, DOH-2556 Parts A and B. This form may be modified, or the provider may modify its own consent form, without Department approval but the form must contain information consistent with the model form and must be written in a clear and coherent manner using words with everyday common meanings. Note that Part A remains unchanged and is available on the Department's website in dozens of languages.

Informed Consent to Perform HIV Testing Part B DRAFT

My health care provider has answered any questions I have about HIV/AIDS. I have been provided information with the following details about HIV testing:

- HIV is the virus that causes AIDS and can be transmitted through unprotected sex (vaginal, anal, or oral sex) with someone who has HIV; contact with blood as in sharing needles (piercing, tattooing, drug equipment including needles), by HIV-infected pregnant women to their infants during pregnancy or delivery, or while breast feeding.
- There are treatments for HIV/AIDS that can help an individual stay healthy.
- Individuals with HIV/AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or being infected themselves with different strains of HIV.
- Testing is voluntary and can be done anonymously at a public testing center.
- The law protects the confidentiality of HIV test results and other related information.
- The law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences.

I agree to be tested for HIV infection. If the results show I have HIV, I agree to additional testing which may occur on the sample I provide today to determine the best treatment for me and to help guide HIV prevention programs. I also agree to future tests to guide my treatment. I understand that I can withdraw my consent for future tests at any time. If I test positive for HIV infection, I understand that my health care provider will talk with me about telling my sex or needle-sharing partners of possible exposure.

Consent for HIV-related testing remains in effect until I revoke it or until the following date _____. I may revoke my consent orally or in writing at any time. As long as this consent is in force, my provider may conduct additional tests without asking me to sign another consent form. In those cases, my provider will tell me if other HIV tests will be performed and will note this in my medical record.

Patient Name: _____

Date: _____

___ I do not want an HIV test

Signature: _____
(patient or person authorized to consent)

Medical Record #: _____

(8/25/10)



Model Form for Documenting Offer of HIV Testing

(Optional Form; Compliance with the required offer of an HIV test may be documented through proper annotation of the patient medical record)

Chapter 308 of the Laws of 2010 instructs the New York State Department of Health (DOH) to create standard model forms for obtaining consent for HIV testing. The model below is for documenting the offer of HIV testing. It may be modified without Department approval but must contain information consistent with the model form and must be written in a clear and coherent manner using words with everyday common meanings. Providers may also comply with the requirement for documenting the offer by proper notation in the patient's medical record.

Offer of HIV Testing

New York State Public Health Law requires that an offer of HIV related testing be made to all persons between the ages of 13 and 64 receiving hospital or primary care services except under specific circumstances. This includes inpatients, persons seeking services in emergency departments those receiving primary care on an outpatient basis at a clinic or from a physician, physician assistant, nurse practitioner or midwife.

HIV is the virus that causes AIDS and is passed from one person to another during unprotected sex (oral, anal or vaginal sex without a condom) with someone who has HIV. HIV is also passed through contact with blood as in sharing needles (piercing, tattooing or injecting drugs of any kind) or sharing "works" with a person who has HIV.

If your test result is negative, you can learn how to protect yourself from being infected in the future. If you are positive, you can take steps to prevent passing the virus to others, and you can receive treatment for HIV and learn about other ways to stay healthy.

_____ Yes, I would like to speak to someone about HIV testing.

_____ No, I do not wish to have an HIV test today.

Patient Name: _____

Date: _____

Signature: _____
(patient or person authorized to consent)

Medical Record #: _____

8/25/10