

# 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>

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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 Meetings

3/18, 6/17, 9/16, 12/16

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

50% attendance recommended  
for all attending Physicians

## Physician Phuel

I knew about the tremendous dedication and long work hours of physicians when I was a boy. My father was an orthopedic surgeon and was an exemplary physician and community leader. He built his practice by working extra ED and trauma on-call. I watched him return home late many evenings after long grueling days. He worried about his patients and occasionally got pulled away from family gatherings. His career impacted his parenting in many ways. I was not allowed on skateboards because they were associated with so many elbow and wrist fractures. "They are the most dangerous of toys," he would say. Motorcycles and go-karts were absolutely forbidden. These restrictions did not only apply to the boys but my sisters were prohibited from ballet where intractable foot injuries would undoubtedly be the result. I will never forget one family vacation at a lakeside cabin where he performed picnic table surgery on injured family members twice within the first few days of our arrival. The extra suture, lidocaine, syringes and scalpels he had packed on a whim became crucial essentials for that ill-fated adventure.

There were other evidences of his surgical career in our house. My older brother loved reading the Ciba Geigy pamphlets filled with Ralph Netter anatomical illustrations my dad brought home from the office. In time there was a huge collection of them on the shelf. I also have vivid memories of sitting at the kitchen table and watching educational movies about total hip arthroplasties my dad used to teach the surgery residents. Admittedly, the movies were too much for me, but I replayed them several times in hopes of overcoming the nausea and diaphoresis that sickened me. Among these and other experiences, my father created in our home environment a fertile field for learning that motivated my brother and I toward medical professions.

Like my father's influence in my boyhood home, physicians have impacted the world in profound ways over the centuries. The common "home" we share here at Rochester General Hospital has similarly benefited from the vast contributions of Medical and Dental Staff members. Reviewing the monthly calendar of departmental meetings, grand rounds, teaching conferences, noon lectures, board reviews and journal clubs is powerful evidence of our commitment to teaching, learning and supporting one another. These educational offerings require untold hours of preparation after the clinical work is done. Many of the best lectures I have heard have been delivered here at RGH. The educational commitment so clearly demonstrated by the MDS extends to the clinical units where daily patient care rounds involve nurses, technicians, residents, students, attendings and other team members in a dynamic exchange of questions, knowledge and principles. Generally speaking, the nexus of these impromptu but vital interactions is the physician.

Among our many roles as educators, none is more important than teaching our patients, their caregivers and their families at the bedside. We educate about disease,



Dr. Robert Mayo,  
President RGH MDS

# Appointment of Interim Chief of Surgery for RGHS

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

We are very pleased to announce the appointment of Dr. Ralph Pennino as Interim Chief of Surgery for Rochester General Health System. Dr. Pennino assumes this role following the decision of Dr. Ralph Doerr to retire from his administrative responsibilities as Chief of Surgery at the end of December.

Dr. Pennino is a well-known and highly respected member of our Rochester General Health System family. 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 has also served as Associate Chief of Surgery for Rochester General Health System since May 1, 2001. He previously held the position of Interim Chief prior to Dr. Doerr's appointment ten years ago.

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.

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

A national search for a new Chief of Surgery is actively being conducted. Dr. Richard Speisman, Chief of Dentistry, is heading the search committee.

Once again we express our thanks and gratitude to Dr. Doerr for his service to Rochester General Health System over the past decade. His leadership and contributions have resulted in the growth and enhancement of surgical services that will long be remembered by our community and the thousands of patients who have benefitted.

Please join us in thanking Dr. Doerr and welcoming Dr. Pennino as he assumes this important clinical leadership position.

## New MOLST Chart Documentation Forms

By Chris Reynolds, MD, FACP

On June 1, 2010, the Family Health Care Decision Act (FHCDA) went into effect in New York State. This statute created a procedure to designate a surrogate decision maker for patients who lack a completed Health Care Proxy. As a result, the MOLST was revised. In the past, the MOLST form was occasionally paired with one of two supplemental forms: one supplemental form for adults without capacity and one for minors. Previously executed MOLST forms remain valid without revision, but now there is only one MOLST form and no supplemental forms. Under the new process, **the revised single MOLST form is used for all patients, and the information previously included on the alternate and supplemental forms is documented in a chart note.**

Six (6) template chart documentation forms ("notes") were created with input from the Department of Health and Dr. Pat Bomba for use state-wide, making compliance with the statute easy for providers in various situations. These "notes" are available in CCS Forms-on-Demand under both "MD/Physician forms" and under a separate heading, "MOLST Documentation." There is a separate "note" to use depending on who the decision maker is\*:

1. Patient with capacity (any setting).
2. Patient without capacity but with a Health Care Proxy (any setting).
3. Patient without capacity or HCP but with FHCDA Surrogate (for inpatients and SNFs).
4. Patient without capacity, HCP or a FHCDA Surrogate where the Physician or a Court of Competent Jurisdiction decides (for inpatients and SNFs).

5. Patient without capacity in the community (outpatients).
6. Minor patient (any setting).†

**If you use the template chart documentation forms as your note, no further documentation is necessary.** If you do not use the chart documentation forms, you must adhere to all legal requirements for completing the MOLST and must include documentation in the patient's chart regarding securing informed consent, clinical judgments necessary to support orders withholding or withdrawing life sustaining treatment and, where applicable, securing ethics committee approval and witnesses to the consent. I recommended using the forms.

The forms are cumbersome, but self-explanatory and track the statutory requirements needed to provide practitioners with available protections under the statute. Revisions to the forms are unfortunately not possible due to regulatory compliance issues. **Education on use of the forms will be provided by the Ethics Committee at Ethics Grand Rounds, noon on March 22nd in the Twig Auditorium.** Underlying all these efforts is the principle of patient autonomy: respect for our patients' rights to apply their own goals, preferences, values and beliefs to their health care choices. If you have any ethics concerns or would like to request a consultation, please call 922-7333: someone is on call 24/7.

\* If you are treating a person with mental illness or developmental disability who lacks decision-making capacity, there are separate requirements for completion of MOLST. OPWDD and OMH are currently developing checklists for use with these patient populations. In the meantime, please seek a consultation with the Ethics Committee to ensure compliance with legal requirements.

† This form not yet in CCS but will be in soon

## Physician Phuel cont. from pg. 1

diagnosis, prognosis, treatment, prescriptions, etc. Every detail of informed consent is about teaching. Our patients' thirst for knowledge is apparent in their google inquires and searching questions, but internet information pales in comparison to the directly applied knowledge of their physicians.

The impact of knowledge is amazing. It fuels (phuels) us and we fuel the vast healthcare effort of this venerable institution. The familiar ways of being educated and educating others will remain fundamental to our success as physicians, however, new opportunities for managing healthcare education are upon us. The advent of healthcare reform and electronic health records are setting in motion enormous changes and untold opportunities for us to shape and mold our future. Physicians are already contributing to this important work on the national stage and in the local arena. The national leadership of Dr. Joe Vasile with GRIPA and the local leadership of Drs. Rob Biernbaum and John Genier with CareConnect are examples of physicians fueling change. Their work is not performed in isolation, however, and many physicians and skilled professionals are contributing to these efforts. An expanding number of physicians are involved in all aspects of healthcare here at RGH. I feel heartened by the insight, knowledge and ingenuity the MDS brings to this enormously important work. A recent article in JAMA entitled, "Could Physicians Take the Lead in Health Reform?" underscores the tremendous importance of physicians fueling change (JAMA 304;24:2740-2741). Another article in the NEJM discussed how physicians and hospitals bring leadership and perspective to the accountable care organization debate (NEJM 363;27:2579-2582). It behooves us to be involved and remain engaged.

From the simple but important influences my physician father had on my life; to the tremendous impact the MDS has on RGH and the patients we care for; and to the developing contributions the MDS is having on shaping our national and local healthcare model; I am grateful for being a physician fueled by the legacy of the past, the responsibilities of the present and the opportunities of the future. Thank you for being involved and for being physician phuel in this dynamic and ever changing healthcare landscape.

## CDIP CORNER – THE POWER OF THE PEN The Patient Visit Summary (PVS) Read & Review before you sign

By Mary Darrow, CCDS

The Patient Visit Summary (PVS) is a summary of diagnoses and procedures that a patient was treated or monitored for during the specified admission. Each of these diagnoses and procedures has a "code" attached to it.



The data generated from these codes affects:

- Reimbursement
- Severity of Illness/Risk of Mortality Index
- Validation of Length of Stay
- Audits
- Case Mix Index (CMI)
- Physician and Hospital Profiling
- Case Management
- Risk Management
- Quality Management
- Utilization of Resources
- Medical Necessity

When notified via Physician Desktop on CCS that an Inpatient PVS signature is required:

- Verify the Principal Diagnosis (inpatient) (diagnosis **after study** that was the principal reason for the patient's admission)
- Verify all secondary diagnoses (pay particular attention to any diagnosis that indicates it was a complication of the stay; i.e., post-operative or iatrogenic conditions)
- Verify all procedures performed

**If you agree** with all diagnoses and procedures, click  (sign/complete.)

**If you disagree** with one or more of the diagnoses or procedures, click  (reject deficiency.) A dialog box will be displayed and you must type the reason for rejecting the PVS. This will remove the deficiency from your desktop and will be sent to the appropriate HIM IP Coder for review. A new PVS will be submitted by the coding staff based on the rejection notice or you will be notified for further clarification.

The minute or two it takes to review the PVS will be reflected in quality data and accurate statistics.

Please contact the CDI office @ 922-3721/3724 for questions related to this or any documentation issue.

*\*\* Congratulations to Dr. Gary Wahl for being selected the Documenter of the Month – Jan 2011 by the CDI Department. Dr. Wahl's legible and explicit documentation accurately portrays the patient's severity of illness and risk of mortality. Thank you Dr. Wahl!*

# Medical Staff Communication

## Dabigatran etexilate (Pradaxa®)

On October 19, 2010, the FDA approved dabigatran etexilate, the first oral direct thrombin inhibitor. This medication is a fixed-dose therapeutic anticoagulant that does not require routine laboratory monitoring. It is highly recommended that providers familiarize themselves with this agent.

### FDA APPROVED INDICATION

Dabigatran is approved to reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation. **It is not approved for other diagnoses** such as DVT, PE, prosthetic heart valves (mechanical or tissue), or orthopedic surgery prophylaxis.

**Hematology consultation** is required for any *off-label* new starts at RGH.

### RECOMMENDED DOSE

- Dabigatran 150 mg orally twice daily (CrCl > 30 mL/min)
- Dabigatran 75 mg orally twice daily (CrCl 15- 30 mL/min)
  - o There is NO clinical trial outcome data available for this dose
  - o Based on pharmacokinetic information only
  - o RGH does not recommend using this dose at this time
    - Hematology consult required for *new starts* with CrCl 15-30 mL/min- see recommendations for considering this dose under "Conversion to dabigatran from warfarin"
- **Not recommended for CrCl <15 mL/min or dialysis patients**

### METABOLISM / ELIMINATION

Dabigatran etexilate is excreted primarily through the kidneys. It is a pro-drug and a substrate of P-glycoprotein.

### ADMINISTRATION

**Dabigatran may only be administered as an intact capsule.** Only patients who are able to swallow can receive this medication. Opening or crushing the capsule may significantly increase the drug absorption resulting in excessive anticoagulation.

### CONVERSION TO DABIGATRAN FROM PARENTERAL ANTICOAGULATION

#### Unfractionated Heparin

Administer the first dose of dabigatran at the time of discontinuation of continuous intravenous unfractionated heparin.

#### Low-molecular weight heparins (enoxaparin)

Administer the first dose of dabigatran 0 to 2 hours before the next dose of enoxaparin is due.

### CONVERSION TO PARENTERAL ANTICOAGULATION FROM DABIGATRAN

The starting time is dependent on renal function:

CrCl ≥ 30 mL/min: Start 12 hours after the last dose of dabigatran

CrCl < 30 mL/min: Start 24 hours after the last dose of dabigatran

- Please note RGH does not recommend using dabigatran for those with CrCl < 30 mL/min

### CONVERSION TO DABIGATRAN FROM WARFARIN

Stop warfarin and begin dabigatran when the INR is below 2.

If considering a switch from those on chronic warfarin therapy, RGH advises restricting to patients with non-valvular atrial fibrillation and the following:

1. Caregivers should not make an across the board switch to dabigatran but rather restrict use to those patients:
  - a. With an average INR the past 6 months that has been >35% out of the time in therapeutic range (TTR)
  - b. Who require ≤ every 2 week INR monitoring to keep TTR > 65%
  - c. Who required an emergency room visit or hospitalization because of a supratherapeutic INR and/or sustained an intracranial hemorrhage
  - d. Have suffered a thromboembolic event in the setting of a subtherapeutic INR
  - e. Without accessible means for transportation for INR monitoring
  - f. Have an allergy to warfarin
  - g. Are aware of the increased cost compared to warfarin and are able to afford it
2. Dabigatran not to be used in patients with CrCl less than 15 mL/min

### CONVERSION TO WARFARIN FROM DABIGATRAN

The starting time is dependent on renal function:

CrCl (mL/min)	Timing of warfarin initiation
> 50	Start 3 days before stopping dabigatran
31 – 50	Start 2 days before stopping dabigatran
15 – 30	Start 1 day before stopping dabigatran

### DABIGATRAN DISCONTINUATION PERIOD PRIOR TO PROCEDURE

Minimum discontinuation time is dependent on renal function and surgical bleeding risk:

CrCl (mL/min)	Half-life (hrs)	Timing of dabigatran discontinuation prior to procedure	
		Standard bleeding risk	High bleeding risk
> 80	13	24 hours	2-4 days
51-80	15	24 hours	2-4 days
31-50	18	3 days	4 days
≤ 30	27	3-5 days	> 5 days

\*Once further experience is gained with dabigatran, guidelines will be more defined

## Medical Staff Communication Dabigatran etexilate (Pradaxa®), cont.

### ADVERSE REACTIONS

**Bleeding:** Dabigatran increases the risk of bleeding and may cause significant and, sometimes, fatal bleeding. If severe bleeding occurs, discontinue dabigatran and obtain a hematologist consult. There is no specific reversal agent available.

Bleeding Compared to Warfarin  
Per 100 patient years\*

Type	Dabigatran %	Warfarin %	OR
All	16.6*	18.4*	0.91
Life-threatening	1.5*	1.9*	0.8
Major	3.3*	3.6*	0.93
ICH	0.3*	0.8*	0.41
GI (major)#	1.6	1.1	1.5

**Gastrointestinal:** There is an increased incidence of GI adverse reactions with dabigatran (35% vs. 24% for warfarin). Symptoms include abdominal pain, dyspepsia, esophagitis, gastritis, GERD, hemorrhage and gastrointestinal ulcers. **Major GI bleeding also occurred more frequently in patients on dabigatran.** Adverse events lead to treatment discontinuation in 21% of patients taking dabigatran compared to 16% for warfarin.

### EFFECT ON LABORATORY PARAMETERS

No routine laboratory monitoring is necessary. The aPTT is prolonged but there is no established therapeutic range. Minimal effect is seen on the PT/INR.

### DRUG INTERACTIONS

Potent P-glycoprotein inducers **Rifampin and St. John's Wort will significantly decrease dabigatran exposure and should be AVOIDED.**

### INSURANCE COVERAGE

Dabigatran is a Tier 3 medication or non-formulary for many insurance plans at this time (e.g. MVP is non-formulary). Please make sure that dabigatran is covered by your patient's insurance plan and that they are able to afford the co-pay before discharging them home.

### KEY POINTS

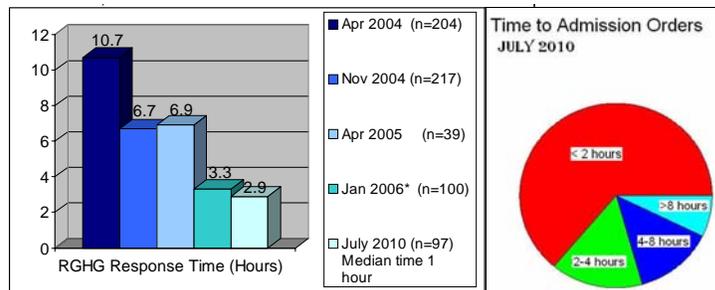
- Dabigatran is administered twice daily. With its short-half life, a non-compliant patient is at an increased risk of thromboembolism if doses are missed.
- Although no routine laboratory monitoring is required, patients will still need regular follow-up to monitor renal function, as well as, observe for signs/symptoms of bleeding or thromboembolism.
- There is no antidote available for dabigatran which may pose problems in those presenting with severe bleeds or need for urgent surgery
- Despite its wide therapeutic index, it is important to remember that any patient on this medication is fully anti-coagulated and should be monitored accordingly.
- This medication must be swallowed whole to avoid the risk of increasing drug absorption and overanticoagulation.

## Happy New Year from the Rochester General Hospitalist Group!

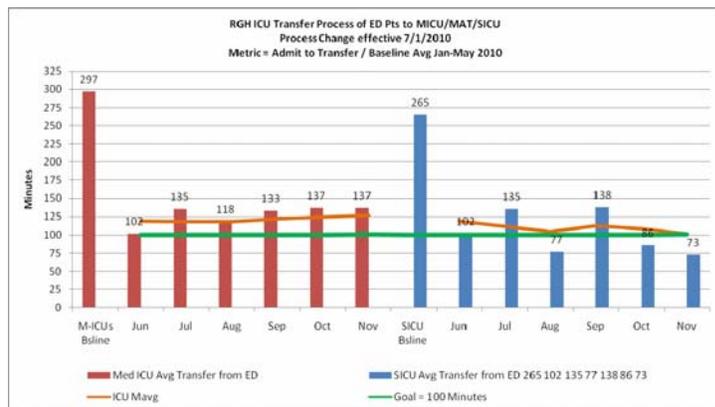
Chris Reynolds, MD, FACP

2010 saw great collaboration between RGHG and a large array of clinical and operational services leading to a variety of patient care and health system improvements, two of which I've outlined below.

First, we have worked hard to reduce the time from an ED request to admission order completion:



Second, along with Dr. Dick, bed coordination, IT and the ED, RGHG has helped to reduce the time to get critically ill patients (anywhere in RGH, on any service) into the MAT and ICUs:



Lastly, reductions in average length of stay (~0.63 days compared to internal benchmarks times ~6,000 quarterly discharges done by RGHG) open 15,000 available bed-days yearly to decompress the PACU and ED and provide rooms for additional patients to get the care they need.

As always, if you want to reach the hospitalist caring for your patient, please call 922-RGHG. If you've got ideas for how we can improve quality, efficiency, service or education, please contact me, Walter Polashenski or Balazs Zsenits.

## Pharmacy & Therapeutics December 2010 and January 2011 Updates

### FORMULARY AND POLICY CHANGES:

**Ferumoxytol (Feraheme):** An intravenous iron preparation that is currently only indicated for the treatment of iron deficiency anemia in adult patients with chronic kidney disease (CKD). The major advantage with ferumoxytol is the convenience of a more rapid infusion compared to other parenteral iron products. Due to its significantly higher cost, it was added to the formulary with restrictions to outpatients with prior approval from insurance company, such as CKD and other patients requiring IV iron such as hematology patients. Use in home dialysis is also approved, realizing it will increase costs but affects a very small number of patients. Ferumoxytol will not be used for inpatients or hemodialysis patients treated in the dialysis center.

**Nebivolol (Bystolic):** The newest 3rd generation  $\alpha$ -blocker indicated for the treatment of hypertension, but has been used in the treatment of chronic angina pectoris, CHF, and migraine prophylaxis without FDA approval. Due to significant cost and no significant benefit compared to other agents, nebivolol will not be added to the formulary. It has been added to the "Therapeutic Substitution List" to be replaced with metoprolol for the treatment of hypertension, and is as follows:

Nebivolol 1.25 mg po daily = Metoprolol 12.5 mg po Q12H  
Nebivolol 2.5 mg po daily = Metoprolol 25 mg po Q12H  
Nebivolol 5 mg po daily = Metoprolol 50 mg po Q12H  
Nebivolol 10 mg po daily = Metoprolol 100 mg po Q12H  
Nebivolol 20 mg po daily = Contact prescriber for further dosing

**Dabigatran (Pradaxa):** First oral direct thrombin inhibitor approved only for the prevention of stroke and systemic embolism in patients with non-valvular atrial fibrillation. This medication is a fixed dose therapeutic anticoagulant that does not require routine laboratory monitoring. This has been added to the formulary with some restrictions including limiting to patients with non-valvular atrial fibrillation and not initiating it in patients with CrCl of 15-30 mL/min until there is more experience with this drug. More information is available in the RGHS MDS Forum.

**Propoxyphene:** The FDA has removed brand-name propoxyphene products from the market due to the risk of cardiac toxicity at therapeutic doses. The committee voted to remove propoxyphene from the formulary.

### POLICIES AND GUIDELINES:

**Potassium Administration Guidelines for Adult Patients** – Revised to include a maximum hourly replacement of 40 mEq/hr for combined IV and immediate release oral preparations and a repeat potassium level to be drawn after 60-80 mEq of potassium (depending on patient weight). The policy also encourages the use of oral potassium preparations since the oral route is safer than IV and the immediate release oral form is absorbed quickly.

**Clinical Pharmacokinetic Guidelines** – Developed to guide providers through the process of aminoglycoside and vancomycin dosing including determining dose, interval and suggested peak and trough monitoring as appropriate for a given indication. These guidelines will soon be available on RGHSnet.

## Join us for a Fun and Exciting Day to Raise Money for Rochester General Hospital's Cardiac Unit

Rochester General Hospital is partnering with Fleet Feet Sports (2210 Monroe Avenue, Rochester, NY 14618) to host a 24-hour treadmill challenge to raise money for the hospital's Cardiac Unit. The event takes place Saturday, February 19th at 9am until Sunday, February 20th at 9am at Fleet Feet Sports.

The fundraising event has been nicknamed "kimstock" as Kim Rapp, Fleet Feet Staff member and ultra-marathoner, will run/walk on a treadmill inside the store for 24 straight hours. Anyone who makes a \$25 donation can run/walk on a treadmill next to Kim to support her efforts while raising money for this worthy cause. Our goal is to fill all 48 time slots, and donate 100% of the funds to RGH. The Rochester Heart Institute (RHI) at Rochester General Hospital is a nationally recognized, award-winning cardiac program that works with many of the best cardiologists, cardiac surgeons, doctors and nurses to provide comprehensive cardiology services focused on patient-wellness. Many people who are very special to us at Fleet Feet Sports have received amazing care at RHI. Fleet Feet Sports has chosen this foundation in order to raise awareness for heart health, and to thank RHI for taking wonderful care of our friends and family.

Fleet Feet Sports will donate 10% of all footwear sold during the 24 hour period to The Rochester Heart Institute. Use of the treadmills for the event is being provided by G & G Fitness.

A Midnight Moonlight Run, a Fleet Feet Dance Party and a Sunrise Snowshoe are a few of the heart-healthy events planned.

### How to participate:

- Pledge to run/walk with Kim in 30-minute intervals -- \$25 per 30 min. Sign up at Fleet Feet Sports.
- Pledge a dollar amount per mile that Kim covers in her 24-hour treadmill trek.
- Attend an event below, have fun, and donate any amount you can!

### Saturday 2/19 9am-Midnight:

Pledge to run/walk with Kim!

See staff for available timeslots and information.

8:00am	Distance Group Run
9:00am	Cheer Kim at the Start
6:00pm	Sunset Run/Walk
8pm – 11pm	FF Dance Party
Midnight	Midnight Moonlight Run/Walk

### Sunday 2/20 1am-9am:

Pledge to run/walk with Kim!

See staff for available timeslots.

1:00am	Movie Hour
6:00am	Sunrise Snowshoe
8:00am	Cheer Kim to the finish & Breakfast

For more information please contact  
**Fleet Feet Sports (585) 697-3338.**

## CHANGES TO YOUR RGH DIRECTORY

For those of you who have access to the ViaNet, 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](mailto:marylou.mckeown@rochestergeneral.org)

### NEW MEMBERS

#### **Sudipa Barr, MD**

Department of Pediatrics  
60 Barrett Dr.  
Webster, NY 14580  
585-872-3390

#### **Jennifer Burns, NP**

Department of OB/GYN  
1415 Portland Ave #400  
Rochester, NY 14621  
585-922-4200

#### **Lisa DeLucia, DDS**

Department of Dentistry  
527 Beahan Rd  
Rochester, NY 14624  
585-426-2550

#### **Cheryl Fontaine, NP**

Department of Medicine/Geriatrics  
6254 Lawville Rd  
Wolcott, NY 14590  
315-594-9444

#### **Steven Goldman, MD**

Department of Neurology  
601 Elmwood Ave Box 673  
Rochester, NY 14642  
585-275-2541

#### **Amit Habbu, MD**

Department of Medicine/Hospitalist  
1425 Portland Ave #287  
Rochester, NY 14621  
585-922-5067

#### **Jessica Kleinberg, MD**

Department of Pediatrics  
1800 English Rd #10  
Rochester, NY 14616  
585-225-2525

#### **Allison Mapes, NP**

Department of Emergency Medicine  
1425 Portland Ave - ED  
Rochester, NY 14621  
585-922-3469

#### **Temitope Oyegbile, MD**

Department of Psychiatry  
490 East Ridge Rd  
Rochester, NY 14621  
585-922-2500

#### **Christopher Rutledge, CRNA**

Department of Anesthesiology  
1425 Portland Ave Box 282  
Rochester, NY 14621  
585-922-4159

#### **Jarvis Sanchez-Rivera, MD**

Department of Medicine/Internal  
Medicine/Refer & Follow  
1500 Portland Ave  
Rochester, NY 14621  
585-367-6000

#### **Elizabeth Sanger, RPA-C**

Department of Emergency Medicine  
1425 Portland Ave Box 304  
Rochester, NY 14621  
585-922-3846

#### **Olga Selioutski, DO**

Department of Neurology  
1425 Portland Ave #220  
Rochester, NY 14621  
585-922-4371

#### **Anitha Shrikhande, MD**

Department of Medicine/Allergy &  
Immunology  
99 Canal Landing Blvd #7  
Rochester, NY 14626  
585-723-8710

### CHANGE TO INACTIVE

Maria Arambulo, MD  
William Cotanch, MD  
Shari Hogan, NP  
David Kotok, MD  
Meredith Kyle, RPA-C  
Linda Landstrom, NP  
Anne Marie Lynch, RPA-C  
Bridget McCarthy, RPA-C  
Robin Minielly, MD  
Michael Mitchko, MD  
Eric Nielsen, MD  
Geetanjali Rajda, MD  
Joseph Rube, MD  
Judith Stahl, NP  
Helen Strapko, MD  
John Waide, RPA-C  
Lynn Wengender, RPA-C

### NOW Available the New RGH MDS Member Directory

please call the Medical Staff Office at  
922-4259 or email  
[marylou.mckeown@rochestergeneral.org](mailto:marylou.mckeown@rochestergeneral.org)  
to obtain your copy

# GRIPA Accountable Care Medical Program

GRIPA is developing a medical program to distinguish our network from others and improve the quality of care offered to patients.

The program focuses on three categories:

- Chronic Condition Management
- Diabetes Prevention, and
- Cardiac Risk management

GRIPA will provide offices with Patient Outreach Reports on their contracted members who fall into any of these categories with a defined list of measures for which patients may be overdue or out of compliance.

The conditions and measures have all been reviewed by the Clinical Integration Committee which is made up of 12 GRIPA physicians representing multiple specialties.

We will be contacting your practices soon to schedule a meeting with you to provide details of the program and how your participation will provide greater opportunities for the GRIPA physicians in the future.

## Jeanette Altavela, Pharm.D., BCPS, Named President-Elect of NYS ACCP for 2011

The New York State Chapter of the American College of Clinical Pharmacy (NYS ACCP) elected Jeanette Altavela, Pharm.D., BCPS as the new president-elect for 2011.



Jeanette Altavela,  
Pharm.D., BCPS

The president elect will become familiar with chapter operations and prepare for the future presidential term in 2012 by serving as chair of the planning committee responsible for organizing the fall clinical meeting and other organizational committees, and then will have various roles as past president in 2013.

Jeanette joined the Greater Rochester Independent Practice Association (GRIPA) in 1999, bringing expertise in optimizing medication therapy in ambulatory patients. She became Manager of Pharmacy Services at GRIPA in 2005, Director of Care Management and Pharmacy Services in 2009 and VP of Care Management and Pharmacy Services in 2010. Currently, she is responsible for coordinating the implementation of medical management interventions which support strategic initiatives and key customer relationships in collaboration with the Chief Medical Officer and other company leaders, and to assist with business development efforts and outreach to current clients and partners.

**About the New York State Chapter of the American College of Clinical Pharmacy:** The NYS ACCP is a professional and scientific society dedicated to optimizing patient drug therapy outcomes by promoting excellence and innovation in clinical pharmacy practice, research, and education in New York State. For more information visit [www.nysaccp.org](http://www.nysaccp.org).

**About GRIPA:** GRIPA is a unique partnership of physicians and affiliate hospitals, Rochester General Hospital and Newark Wayne Community Hospital. GRIPA provides medical, business, and technology management services focused on making better health care easier to deliver, less costly for patients, and more rewarding for all involved. The GRIPA Connect Clinical Integration program creates a connected community of physicians, hospitals, labs, imaging facilities, and pharmacies, sharing patient information through a secure web portal and differentiating itself by delivering higher quality care at reduced cost. The program also includes robust care management and Clinical Guidelines ratified by physician members. For more information visit [www.gripa.org](http://www.gripa.org)

