



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**

ROBERT MAYO, MD
President

MAURICE VAUGHAN, MD
President-Elect

EDUARDO A. ARAZOZA, MD
Secretary

RONALD SHAM, MD
Treasurer

RICHARD CONSTANTINO, MD
Past President

Elected Representatives:

HOLLY GARBER, MD

ROLA RASHID, MD

DAWN RIEDY, MD

CHRISTOPHER RICHARDSON, DO

ERIC SPITZER, MD

DEREK TENHOOPEN, MD

Editorial Staff:

JEANNE GROVE, DO, EDITOR

24/7 PHYSICIAN HOTLINE NUMBER

922-4414

DIRECT ADMISSION NUMBER:

922-7333

CALL THE HOSPITALIST
FOR YOUR PATIENT

922-7444

**2011 Quarterly
Staff Meeting**

12/16

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

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

Message from the MDS President

Non-Contributory

Nothing is more uninformative than the chart entry, "non-contributory." What does this really mean? What information was elicited and deemed non-contributory? Who decided the information was non-contributory and on what grounds? For example, can it be assumed that a non-contributory GI Review of Systems has fully explored the breadth and depth of all possible GI diseases? Furthermore, can you be sure that the history taker actually knows all of the possible associated GI diseases relative to the chief complaint?

Sometimes I wonder if non-contributory is euphemistic for "don't care," "didn't ask," "don't know," or "too rushed." Is non-contributory universally applicable? Is hypertriglyceridemia non-contributory in a urology History and Physical but worthy of Problem List status in the endocrinology record? Just because one practitioner has decided some bit of information is non-contributory does not mean it is non-contributory to everyone else. Using non-contributory documentation places us at risk of missing relevant

information about the health and lives of our patients.

**I have discovered
a wealth of
information that
has broadened my
understanding of
others, enriched my
physician-patient
relationships and
assisted my clinical
decision making.**

Another failing of the label non-contributory is its gross one-sidedness. It reflects only the practitioner's generally limited perspective. This is most obvious in the Family and Social History sections of the medical record. A patient I saw many years ago with a "non-contributory" family history demonstrated how crucial information is lost by the designation "non-contributory." He was about 75 years old and was referred for hypertension and proteinuria. During the Family History section of the interview



Dr. Robert Mayo,
President RGH MDS

Non-Contributory, continued

I learned he was a widower. His wife had died over 40 years earlier. Buffered by a long stretch of time I mistakenly presumed it was safe to ask how she died. He hesitated, glanced away, than looked back at me. I realized by his body language that I was in sensitive territory and began to wish I had not questioned him. He sighed deeply and answered curtly, "She was shot—shot dead." "Oh no," I replied. "I am so sorry." We both paused; breathed, looked at one another—unmistakable eye contact. It was a strange moment; a little awkward, a time for grief, a moment of reflection; together—complete strangers. I wanted to move on with the interview away from the Family History but he began to tell me more. His son, age 7 had found his loaded gun. It was an accident—a tragedy at its most extreme. While playing with it, the gun discharged. A seven year old boy made motherless by a tender, misplaced hand. I could barely believe my ears. How had this man endured such pain? I reached toward him. After a moment of comfort I asked, "What about your son?" He answered, "I sent him away." Away! Where? I could no longer ask questions. My heart reeled back shocked by the expanding enormity of this man's tragic life. I do not recall how I recovered the interview but the impact of his story has remained with me.

After he departed I completed my documentation and replaced "non-contributory" with a lengthy Family History. I wondered how he would have felt if he had known his Family History had previously stated, "non-contributory?" Additionally, how much less would I have understood my patient if I had accepted the non-contributory documentation? In a recent editorial in the New England Journal of Medicine (365(7), 18 August 2011, p.587-589) R. Srivastava wrote about the Social History, "We need to listen to our

patients with the recognition that the most important information they can give us about their illness often lies in the folds of their social [and family] circumstances. And it's our obligation to tailor our prescriptions to an illness in its full context."

Since meeting my patient several years ago, I have taken a greater interest in Family and Social Histories. I have discovered a wealth of information that has broadened my understanding of others, enriched my physician-patient relationships and assisted my clinical decision making. It is my hope that we will all reach beyond the non-contributory and discover new opportunities for contributions.

THURSDAY  OCTOBER 6 2011

MUSIC +
WELLNESS

THE MEDICINE OF MUSIC

PRESENTED BY PITTSBURGH SYMPHONY ORCHESTRA'S

PENNY BRILL

LECTURE, MUSIC AND REFRESHMENTS

3:30 TO 4:30 TWIG AUDITORIUM

SPONSORED BY THE ROCHESTER GENERAL BREAST CENTER



Appointment of NWCH President

Mark C. Clement, President and CEO

I am excited to announce the appointment of **Mark F. Klyczek** to the position of President of Newark Wayne Community Hospital (NWCH), effective September 12, 2011.

Since he joined the NWCH team as Administrator of the DeMay Living Center in June 2010, Mark's achievements have included launching a new short-term orthopaedic rehabilitation center that increased the overall number of rehab beds and broadened our ability to serve the community. Additionally, satisfaction rates at DeMay are now well over 90 percent among both team members and residents.

These successes at NWCH are just the latest examples of Mark's extensive record of health services leadership that make him an ideal choice for his new position. Between 2002 and 2010, he served in Buffalo's Catholic Health System, including five years as Administrator of the St. Catherine Labouré skilled nursing facility within the Sisters of Charity Hospital organization. In that role, he led efforts that resulted in increased resident satisfaction and recognition as the most improved Catholic Health facility in his region. Mark has also held a progressive series of financial positions in the Catholic Health System and the State University of New York at Buffalo's Department of Orthopaedic Surgery.

Mark earned a Master of Science Degree in Health Services Administration from D'Youville College, where he has served as a member of the adjunct faculty; and he holds a Bachelor's degree in Psychology (certificate in Gerontology) from Canisius College.

Please join me in congratulating Mark Klyczek on his new role with the Rochester General Health System team, and in thanking Kathy McGuire for the exceptional leadership she has provided as Interim President since January 1.



Mark F. Klyczek

ROCHESTER GENERAL NAMED AN EXEMPLAR HOSPITAL

Agrees to Share Infection Prevention Expertise

Rochester General Hospital has been named an exemplar hospital by the Institute for Healthcare Improvement (www.ihl.org) for its work in infection prevention. Rochester General is participating in IHI's *Project JOINTS* (Joining Organizations in Tackling Surgical Site Infection) initiative.

In a letter to Rochester General, the IHI wrote "We commend your practices, specifically in alcohol skin prep. We also thank



you for your willingness to help your fellow Project JOINTS participants. Your organization's willingness to share your invaluable hands-on-experience with others will help make hip and knee surgery safer for patients across the country"

Rochester General Hospital has been recognized for developing a comprehensive surgical site infection prevention plan in orthopedic surgery. This plan utilizes the best available evidence and translates that evidence into checklists and protocols which can easily be implemented on all patients. This has resulted in an over 50% reduction in orthopedic surgical site infections.

"We are honored to be asked to collaborate with other healthcare providers to help reduce hospital infection rates," said Edward Tanner MD, Chief of Orthopedics at Rochester General Hospital. "This effort is all about providing the best patient care possible." The IHI Project JOINTS initiative includes 57 hospitals in New York State, and dozens across the country.

CHANGES TO YOUR RULES AND REGULATIONS

During the September meeting of the RGH MDS Medical Board and after development by the RGH MDS Bylaws Committee the following changes/additions have been made to the RGH MDS Rules & Regulations. If you have any questions, please contact the RGH Medical Staff Office at 585-922-4259.

Medical Record Suspension - change all available to specified

Q4. Two days prior to suspension, the Chief of the Member's Department will contact the Member by telephone as a reminder of impending suspension. If after that time the record is not completed, the practitioner's certified letters of suspension will be issued and privileges shall be suspended within seven days.

The suspension will remain in place until ~~all available~~ **the specified** medical records are complete.

Addition to the Rules and Regulations regarding Care Connect Training

T. Electronic Medical Record Training

Every member of the Medical and Dental Staff with clinical privileges must complete training and testing in the use of the Hospital's electronic medical record, at a level determined by the Department Chief. Failure to demonstrate satisfactory proficiency through testing shall result in suspension of clinical privileges. Such suspension shall be lifted upon the practitioner's successful completion of training and proficiency testing.

August 2011 Updates

Pharmacy & Therapeutics

FORMULARY CHANGES:

- **Fosaprepitant (Emend IV):** Not added to the formulary due to the high cost of the medication. Fosaprepitant is indicated for the prevention of nausea and vomiting associated with moderately or highly emetogenic cancer chemotherapy. It is also available in an oral formulation that patients can get filled at an outpatient pharmacy prior to their chemotherapy session.
- **Intravenous Acetaminophen (Ofirmev):** Not added to the formulary. Acetaminophen IV is approved for the management of mild to moderate pain, moderate to severe pain with adjunctive opioid analgesics, and fever reduction. Although clinical trials have demonstrated effective reduction in pain and fever compared to placebo, there have been no trials done with the US formulation comparing safety and efficacy with other routes of acetaminophen or other active agents. Common adverse events reported include nausea, vomiting, pyrexia, headache and insomnia. Hypotension-related reactions may occur and vital signs should be monitored with each dose. Due to its significant cost and lack of strong clinical data, it was recommended that it not be added to the formulary.
- **Intravenous Ibuprofen (Caldolor):** Not added to the formulary. Ibuprofen IV is indicated for the management of mild to moderate pain, moderate to severe pain as

an adjunct to opioid analgesics, and fever reduction. Similar to IV acetaminophen, its main advantage is its novel route of administration without much efficacy or safety data compared to other active agents. It is significantly more expensive than our current formulary agent, IV ketorolac, and therefore, was not recommended for addition to the formulary.

- **Additions:** Rifaximin 550 mg tablet for new FDA approved indication of hepatic encephalopathy

SHORTAGES RECENTLY AFFECTING RGH (AS OF 9/1/11):

- **Aminocaproic Acid inj:** national shortage due to manufacturing delays; alternatives being use by OR (tranexamic acid inj) and Urology (carboprost inj)
- **Potassium Phosphate IV:** shortage due to American Regent plant shut down causing delays in manufacturing and shipments; expected availability is 9/12/2011; changes made to TPN to account for the shortage
- **Ongoing shortages:** acetylcysteine inhalation and calcium gluconate
- **Resolved shortages:** Amino Acid products, Azithromycin 500 mg inj, Lipids 30%, loperamide cups, Potassium Chloride Inj, Propofol, and Sodium thiosulfate

a Sincere
THANK

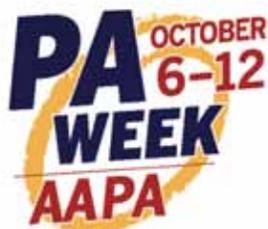
YOU

**NATIONAL PHYSICIAN
 ASSISTANT WEEK
 OCT 6 - 12, 2011**

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 152 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
 OCT 3 - 9, 2011**

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 3-9).

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.



Flu Vaccines

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



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

James Azurin, MD, Dept of Neurology/Refer & Follow 2101
Lac de Ville Blvd., Rochester, NY 14618, 585-546-3265

Dayana Cannan, RPA-C, Dept of Surgery/Gen. Surgery
1425 Portland Ave #173, Rochester, NY 14621, 585-922-3458

Sheema Chawla, MD, Dept of Radiation Oncology
1425 Portland Ave, Box 223, Rochester, NY 14621, 585-922-4031

Mary Andrea Dela Torre, MD, Dept of OB/GYN
43 Willow Pond Way #200, Penfield, NY 14626 585-377-5420

Daniella DeRosa, DO, Dept of Pediatrics
485 Titua Ave, Rochester NY 14621, 585-266-0310

Hazel Ann Doronila, RPA-C, Dept of Surgery/Gen Surgery
1425 Portland Ave Box 362, Rochester NY 14621, 585-922-3458

Michael Dunn, MD, Dept of Neurology/Refer & Follow
2301 Lac de Ville, Rochester NY 14618, 585-546-3265

Peter Fenton, DO, Dept of Emergency Medicine
NWCH ED Department, Box 111, Newark, NY 14513
315-359-2847

Lisa Fronczak, RPA-C, Dept of Surgery/General Surgery
1425 Portland Ave, Box 362, Rochester, NY 14621, 585-922-3458

Anurett Gill, MD, Dept. of FP R&F/ Peds & Int. Med.
2350 Ridgeway, Ste A, Rochester NY 14626, 585-922-2420

Amanda Gorman, MD, Department of OB/GYN
1682 Empire Blvd, Webster NY 14580, 585-671-6790

Sharon Greszler, RPA-C, Dept of Orthopaedic Surgery
1425 Portland Ave #143, Rochester NY 14621, 585-922-3963

Aubree Guiffre, PhD, Dept of Psychiatry & Pediatrics
1445 Portland Ave #204, Rochester NY 14621, 922-4698

Tracey Henderson, MD, Dept of Pediatrics
601 Elmwood Ave, Box 777, Rochester, NY 14642, 585-275-6918

R. Scott Hicks, MD, Dept of Radiology – Effective 11/1/2011
1425 Portland Ave #226, Rochester, NY 14621 585-922-3220

Rashmi Khadikar, MD, Dept of Medicine/Allergy & Immunology 2300 W. Rldge Rd 5th Flr, Rochester, NY 14626
585-922-2454

Karen Kolstee, NP, Dept of Emergency Medicine/Observation Unit 1425 Portland Ave Observation Unit, Rochester, NY 14621
585-922-9080

Panupong Larppanichpoonphol, MD, Dept of Medicine/ Infectious Disease 601 Elmwood Ave Box 689, Rochester, NY 14642, 585-273-5317

Amanda Lewis, NP, Dept of Psychiatry
490 E Ridge Road, Rochester NY 14621, 585-922-2500

Anthony Lister, DDS, Dept of Dentistry
1425 Portland Ave #166, Rochester, NY 14621, 585-922-5731

Lesley Loss, MD, Dept of Medicine/Dermatology
100 White Spruce Blvd, Rochester, NY 14623, 585-272-0700

Joseph Mann, MD, Dept of Neurology/Refer & Follow
2101 Lac de Ville, Rochester, NY 14618, 585-546-3265

Regina McNamara, RPA-C, Dept of Radiology
1415 Portland Ave #190, Rochester, NY 14621, 585-336-5000

Ana Molovic-Kokovic, MD, Dept of Medicine/Int. Med. Ambulatory, 222 Alexander St #5000, Rochester, NY 14607
585-922-8003

Jaime Navarrete Faubla, MD, Dept of Medicine/Hospitalist,
1425 Portland Ave #287, Rochester NY 14621 585-922-4368

Richard Paulis, MD, Dept of Emergency Medicine
1425 Portland Ave #304, Rochester, NY 14621 585-922-3846

Allen Pettee, MD, Dept of Neurology/Refer & Follow
2101 Lac de Ville Blvd, Rochester NY 14618, 585-546-3265

Traci Salter, NP, Dept of Physical Medicine & Rehab
1415 Portland Ave #445, Rochester, NY 14621, 585-922-5162

Neil Seligman, MD, Dept of OB/GYN
601 Elmwood Ave Box 668, Rochester, NY 14621, 585-487-3350

Abhay Shelke, MD, Dept of Medicine/Hospitalist
1425 Portland Ave Box 287, Rochester, NY 14621, 585-922-5067

Lindsay Short, NP, Dept of Surgery/Urological Surgery
995 Sentator Keating Blvd #330, Rochester, NY 14618
585-232-2980

Laurie Steiner, MD, Dept of Pediatrics
601 Elmwood Ave Box 777, Rochester, NY 14642, 585-275-2984

Lee Williams, DO, Dept of Pediatrics
1425 Portland Ave #228, Rochester, NY 14621, 585-922-2575

Directory Changes: CHANGE TO INACTIVE

Victoria Bida, RPA-C
Louis Cerami, RPA-C
Chrysa Charno, RPA-C
William Curtin, MD Carol
Fague-RPA-C

David Gentile, MD
Dragan Golijanin, MD
J. Peter Harris, MD
Arshad Masood, MD
Timothy Nolan, MD

Kevin O'Connor, RPA-C
Hani Rashid, MD
Silke Schweidt, MD
Annette Sessions, MD
Celia Stearns, CNM

Laura Szydowski, NP
Christina Wiedl, DO
James Wu, MD

THE NYS PALLIATIVE CARE INFORMATION ACT LAW

Article #2 – Compliance

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

On February 9th, 2011 Chapter 331 of the NYS Laws of 2010, commonly known as the Palliative care Information Act (PCIA) was enacted. This places new requirements for providers when caring for patients with advanced or terminal illness.

Last month we discuss the background and language of the PCIA law. This month we will take a moment to discuss compliance with the PCIA law.

Subsequent articles will discuss:

1. FAQ's about the PCIA law;
2. How to engage patients in advanced illness discussions;
3. Tools to help identify advanced/terminal illness; and
4. When specialty palliative care consultation might be considered for hospitalized patients.

HOW TO BE COMPLIANT WITH PCIA:

Compliance requires the offer of information and counseling. If the patient declines the offer – there is no requirement to deliver information over patient's objections – such a declination should be documented. If the patient accepts the offer – you must provide information and counseling directly (orally or written) or arrange for another MD, NP or a professionally-qualified individual to provide the information and counseling; or 3) if unwilling to provide information and counseling, must refer to another MD or NP. ("Arrange" – attending healthcare provider must remain engaged, must communicate and issue orders.)

SAMPLE DOCUMENTATION:

"We discussed the advanced nature of their condition(s). I provided information (verbally/in writing) to (patient/appropriate surrogate) and reviewed prognosis, care options appropriate for them and their associated risks and benefits, as well as their right to comprehensive pain and symptom management at end-of-life. The care plan, as noted in my assessment and plan, has been initiated."

"We reviewed, in general terms, the advanced nature of their condition(s). I offered to provide further information regarding prognosis and the range of options appropriate for their care. (patient/appropriate surrogate) declined this offer for information and counseling."

The consequences of non-compliance with PCIA are significant. The law permits fines up to \$2,000; \$5,000 for repeat violations within 12 months and imprisonment of up to 1 year and/or a fine of up to \$10,000 for willful violation of PHL. Furthermore, willful or grossly negligent failure to comply with substantial provisions of state law governing the practice of medicine, or repeated occasions or negligence, can trigger a medical misconduct action.

RGHS AND THE PCIA LAW:

Rochester General Health System is working diligently with the Care Connect implementation team to facilitate documentation requirements for the PCIA law. Until Care Connect is live at your facility/practice providers will need to incorporate appropriate documentation. As more information and training becomes available we will share this with you.

In the next article of this series we will discuss Frequently Asked Questions (FAQs) and the PCIA Law.

References and resources:

http://www.health.state.ny.us/professionals/patients/patient_rights/palliative_care/
<http://www.nationalconsensusproject.org/>
<http://www.getpalliativecare.org/>
<http://www.palliativedoctors.org/>

NOW! IS THE TIME

Care Connect Demonstrations for Community Physicians

For these past two years this column has described the changing landscape of third party physician payment: migrating from “fee for service” (F4S) to “pay for performance” (P4P). We explained how our national health care “system” increases in complexity; almost month to month; not only for providers but patients, and the threatened fragmentation of care resulting therefrom.

Previous articles have related how GRIPA, your organization, has developed a nationally recognized Clinical Integration program to provide a framework of: Care Management, information technology, data analysis around disease populations and physician reporting based on clinical measures derived from evidence-based guidelines composed by your fellow GRIPA physicians. This positions us, and our patients, to survive and potentially thrive in this new environment.

GRIPA, led by physician members, recently developed the ACMP (Accountable Care Medical Program) to aid physicians in transitioning from F4S to P4P by providing the Patient Outreach Report to identify those of our patients in need of care as indicated by the clinical guidelines. This approach facilitates filling open scheduling slots while simultaneously generating data, documenting desired performance, which can then be presented in P4P contract negotiations to produce improved reimbursement rates to physicians.

GRIPA, in conjunction with physicians and RGHS leadership, is assembling work teams to improve the quality of care provided as well as address cost: value. These teams will focus on using currently available technology to share relevant and actionable data, implement care management to support patients and physicians, and initiate discussions resulting in plans directed toward value enhancement.

None of this is going to happen without a crucial element...us and our active engagement in utilizing these tools. The pace and complexity of health care requires it.

GRIPA, your organization, is on the verge of completing contract negotiations for a significant patient population that will provide the funding to award physicians for quality and efficient care. This contract involves clinical measures closely aligned to the ACMP. It will also reward us for addressing: admission rates, unnecessary re-admissions, pharmacy costs, and network access.

Success with this agreement will require us to: focus on performance (individually and as a participating member of the larger network), effectively and efficiently communicate (Care Connect/EMR), adopt and adapt to information technology and the requisite work flow changes, and contribute feedback on what is working and how to improve what is not.

GRIPA will be scheduling “town meetings”, in the coming months, to provide more details around this contract.

RGHS has partnered with the Greater Rochester Independent Practice Association (GRIPA) to offer a private-practice version of Care Connect to our community practice partners. Community-based practices that choose Care Connect will experience an EMR and Practice Management system that is fully integrated and compatible with RGHS’ system – enabling seamless management of patient records, lab results, billing and scheduling across both the hospital and private practice settings. Additionally, community physicians will benefit from:

- A limited-time RGHS subsidy to offset some of the EMR costs
- Immediate, automatic availability of patient information
- Full implementation support and training
- Simpler, faster and more accurate documentation
- Future upgrades at no additional cost, including ICD-10
- Increased patient satisfaction
- Ability to share patient data with ease
- Certification and support to achieve Meaningful Use
- More efficient practice management processes
- Simplified, less costly hardware management
- Automatic E-prescribing functionality

If you have any questions about our Care Connect Community Physician Program offering, or know a practice you would like to recommend as an ideal candidate for the Care Connect system, please call Kelly Taddeo, Vice President of GRIPA Provider Relations to at 585-922-1543.

Come! Be informed! Get involved!
Our future depends on it.


gripa
health care
could look like this™