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A NEWSLETTER ESTABLISHED AND COMPLETED BY THE THE MEDICAL & DENTAL STAFF OF ROCHESTER GENERAL HOSPITAL.
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24/7 PHYSICIAN HOTLINE NUMBER

922-4414

DIRECT ADMISSION NUMBER:

922-7333

CALL THE HOSPITALIST
FOR YOUR PATIENT

922-7444

2010-2011 Quarterly Staff Meetings

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

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

50% attendance recommended
for all attending Physicians

Our Commission

The Joint Commission recently completed an unannounced survey marking their three year visitation cycle. For several weeks prior to their visit a sense of measured frenzy was palpable throughout the hospital, medical groups, Behavioral Health Network and Independent Living for Senior's. The process of completing performance improvement projects, gathering data, organizing evidence binders, updating policies, etc. was much like cramming for final exams. (In fact, the accuracy of this comparison was well substantiated by the number of sweaty palms, nervous stomachs and assorted vagal responses.) Senior leaders rounded daily and team members engaged fully as everyone owned readiness.

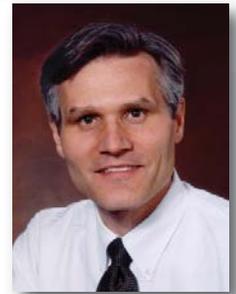
The effort was tremendous and well rewarded by very favorable survey results.

The success of the survey, however, was not solely the result of those anticipatory weeks. Months and years of consistent attention to regulatory detail, prioritization of safety culture, and a commitment to quality all contributed. Additionally, the exemplary work of nurses, physicians, midlevels and all team members alike was not only vital but wonderfully obvious.

During the survey I came to realize that the goals and mission of the Joint Commission broadly overlap our mission and vision. We share with them a common determination to advance healthcare is its most effective and refined state. Their mission statement reads, "To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value." Understanding this important principle caused me to rethink the meaning of the "Joint" commission and instead think of it as our joint commitment to the same noble end. Rather than outside strong arms, poised to deal us blows, I can see the Joint Commission as partners pushing us along the demanding quest for healthcare excellence. The possibility of a joint partnership was reinforced when the Joint Commission recognized and borrowed best practices from us.

Additionally, I speculate that The Joint Commission's message of joint partnership is an attempt to return to its roots. In 1918 the American College of Surgeons developed a strategy to improve the quality of health care provided in American Hospitals. The document they drafted was entitled, "Minimum Standards for Hospitals." Under the college's supervision, annual surveys of hospitals began. Then in 1951 the American College of Physicians, the American Medical Association, the American Hospital Association and the Canadian Medical Association joined this effort and formed the Joint Commission. Jointly, these influential societies collaborated to transform healthcare. Of the 29 member Board of Commissioners, 60% are physicians--signaling the incomparable role of physicians in the Joint Commission and in health care quality.

Now that the survey is over, the "real" Joint Commission has not departed. We, members of the AMA, ACP, ACS, AHA and MDS constitute the impetus and force driving our quality. As we move forward standards of practice, national patient safety goals, and all other quality and safety initiatives necessary to our work I won't think of "them" as the Joint Commission any longer but as Our Commission and hope that you will as well.



Dr. Robert Mayo,
President RGH MDS

Thomson Reuters 2010 Listing of Top 50 Cardiac Hospitals

By Mark C. Clement, President & CEO



Our unwavering commitment to continuous improvement at Rochester General Health System has given us a lot to be proud of in recent years. As we work tirelessly to become the community's health care provider of choice, we have established a hard-earned reputation, both locally and nationally, as an industry leader in setting the standard for quality,

efficiency, team member engagement, patient care and clinical outcomes. Our dramatic progress has been affirmed time and again by prestigious industry surveys, rankings and reports that consistently list RGHS among the top health care performers in the nation.

One such study that has provided a consistent endorsement of our clinical excellence is the Thomson Reuters annual survey of the 100 Top Cardiovascular Hospitals in the U.S. – which analyzes clinical outcomes for patients diagnosed with heart failure and heart attacks and for those who received coronary bypass surgery and angioplasties. The Rochester Heart Institute (RHI) at RGH has been recognized on this list nine times. Only eight other hospitals in the country – and only one other in the entire Northeast – have achieved this honor as many times as our team at RGH!

In 2010, Thomson Reuters made some significant modifications to this study, most notably, the listing of winners was reduced from the Top 100 to the Top 50. Rochester General Hospital did not make the Top 50 List for 2010. While certainly disappointing, it's important to put this news in perspective. Fifty hospitals did not make the list this year simply because the list was reduced by 50% – not because of any reduction in quality or performance. In fact, only 25 hospitals that were on the list in 2009 were listed in 2010. And only three hospitals that had previously made the list eight times or more were included on the 2010 list.

It is also important to note that the Heart Institute at RGH continues to be recognized for achieving superior outcomes for its patients as measured by publicly available outcome data. Some 2010 achievements include:

- The Society for Thoracic Surgeons, a national database of Cardiothoracic program outcomes, found RGH to have the highest level of quality – receiving a top 3-star rating. Only 12% of the almost 1,000 cardiac surgical programs in the national database have achieved this elite level of quality and outcomes.
- The most recent Healthgrades report (October, 2010), which compared all hospitals across the country based on 2007 – 2009 Medicare Data, recognized RGH with the Cardiac Care Excellence Award™, the Cardiac Surgery Excellence Award™ and the Coronary Intervention Excellence Award™. Additionally, RGH received top 5-star ratings for the vast majority of its coronary procedures/conditions including angioplasty/stent, heart attack, heart bypass surgery, heart failure, valve replacement surgery.
- Rochester General was identified as one of the Top 25 best cardiovascular programs in the country by Becker's Hospital Review in the company of many of the countries most well recognized hospitals including Cleveland Clinic, Brigham and Women's, John's Hopkins and Duke.
- In October, the Archives of Internal Medicine published an article on RGH's infection prevention successes in cardiac surgery recognizing our excellence in clinical care.

These are just a few examples that reinforce RHI's status as a growing model of excellence among the nation's cardiovascular programs. While we did not make the Thomson Reuters 2010 listing of 50 Top Cardiovascular Hospitals, it does not diminish, in any way, the outstanding reputation and unparalleled level of clinical outcomes achieved for our patients each day at RHI. We will use this experience as a learning opportunity to discover new and better ways to take our improvement efforts even further as we continue to build One Great Health System. And we will look forward to being recognized on the Top 50 List in the near future.

The Joint Commission Outcome

Over the past month, The Joint Commission (TJC) completed rigorous, unannounced surveys at RGH (including BHN, RGMG and our ambulatory sites) and NWCH, to evaluate our performance against national quality and patient safety standards. I am extremely pleased to report that the results were extraordinary and each facility was fully re-accredited! This means that both RGH and NWCH have not only met, but in many cases far exceeded the stringent patient care standards and CMS requirements for our industry. Congratulations!!!

The RGH survey took place last week with eight surveyors on-site over the course of two days, and five on-site for the full five days. Only five direct impact findings, 13 indirect impact findings for RGH, and only one indirect finding for BHN were cited – far fewer than other organizations of our size. In fact, the lead RGH surveyor commented that given the length and intensity of the survey, and the size and complexity of RGH, it was a “miracle” to receive so few recommendations. Obviously, it had little to do with miracles, and everything to do with the commitment to excellence of our team members, physicians and volunteers!!! Further, there were no Medicare Condition level findings for RGH. Surveyors also commented that RGH and our system are among the best and most cooperative organizations they’ve surveyed nationwide.

The NWCH survey, conducted by three surveyors across three full days in mid-October, was equally successful with only five direct impact recommendations, eight indirect, and only one Medicare Condition level finding, which was promptly corrected.

The Joint Commission was so impressed with many of the initiatives and processes in place throughout our system that they’ve asked us to submit them as industry best practices. These include: our Team Member Ideation Program and other activ-

ities around team member engagement at RGH; the development of our sepsis screening tool to assist with infection prevention at both sites; and the foley catheter evaluation and the risk screening tool completed by nursing on admission at NWCH.

Beyond our well maintained facilities and equipment, and our effective clinical processes, what most impressed the surveyors were our people and our culture. They commented often on the passion, pride, commitment to learning, and sense of purpose consistently displayed by each and every one of our team members, physicians and volunteers. You could not ask for a more glowing endorsement of the work that has been underway these past four years to build a patient centered and team member engaged culture. You – our 9000 team members, physicians, and volunteers – have embraced our vision of building One Great Health System and you are helping us to improve for our patients and community every day! Because of your dedication and contributions, we are leading

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the way and setting the bar for patient care excellence – and the industry, our community, and our peers are taking notice! Given where we were just a few short years ago – as one of the surveyors noted – this is nothing short of miraculous!

Congratulations on these remarkable achievements and thank you for your continued pursuit of excellence in everything we do to improve clinical quality and the patient experience for every patient, every encounter, every time! The growing strength and evolution of our culture and our people position us well as we continue our work to deliver unparalleled service and to build One Great Health System – adaptive, innovative, and ready for health care reform and the many challenges and opportunities ahead.



Rochester General Hospital Oncology Nurse Navigator Program



Over the past year, three oncology nurse navigators have started working at RGH to support oncology patients through their multidisciplinary evaluations and treatments.

Nurse navigators help to remove barriers to treatment; facilitate appointments; and recruit additional support services such as hospice, palliative care and home care for their patients. Additionally, nurse navigators offer emotional support, education and patient advocacy. Their roles also extend to physician offices where they assist with communication, referrals, medical literacy and other needed interventions. The patients and medical and dental staff of RGH are very fortunate to have three nurse navigators at RGH. Their names, areas of expertise and contact numbers are listed below. Please invite them to consult on your patients.

Meredeth Paddock RN, BSN, OCN
Lung Cancer Nurse Navigator
922-4024

Catherine Reda-Cheplowitz RN, BSN, OCN
Colo-Rectal Cancer Nurse Navigator
922-2064

Andrea LaRosa RN, BSN
Breast Cancer Nurse Navigator
922-4995

RGH MDS BYLAWS CHANGE History and Physical

*Samantha Vitagliano, DMD
RGH MDS Bylaws Committee Chair*

In response to standards of The Joint Commission (formerly JCAHO) and CMS, the RGH MDS Bylaws Committee developed a proposed amendment to the MDS Bylaws, Rules & Regulations relative to Histories & Physicals. This change has been approved through the RGH MDS Committee structure and was given final approval by the Hospital Board of Directors during their October Meeting.

Delete F. as noted below in the MDS Rules & Regulations as follows:

F. History and Physical Examination: A complete history and physical examination and basic laboratory work shall, in all cases, be recorded within twenty-four hours after admission. The history and physical examination and necessary laboratory work shall be recorded before any surgical operation is undertaken, unless the surgeon certifies in writing that any delay incurred for this purpose would constitute a hazard for the patient.

Modify Section 7 of the RGH MDS Bylaws

Section 7 History and Physical Examination

A medical history and physical examination are completed and documented by a physician, an oral and maxillo-facial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. Every patient shall have a complete history and physical examination documented within thirty 30 days before or 24 hours after admission. Within 24 hours prior to surgery or procedures requiring anesthesia services, the history and physical examination must be completed or reviewed and updated. The history and physical examination and necessary laboratory work shall be recorded before any surgical operation is undertaken, unless the surgeon certifies in writing that any delay incurred for this purpose would constitute a hazard for the patient.

Utilization Management Update

Continuous management of resource utilization is a challenge we all face in today's dynamic healthcare environment. This is being compounded by the increased pressures by the government and payors on extended lengths of stay, payment denials for avoidable days, appropriate admission status and compliance with Conditions of Participation. The only way to combat these issues is through a comprehensive approach that focuses on improving medical management, coordination of care, correct patient status from point of entry and communication among all members of the care delivery team.

Case/Utilization Management is the first line of defense, but their efforts need to be supported by experienced physicians who can both facilitate solutions for physicians and deal with the payors on justifying appropriate payments for services rendered to our patients. We will be implementing such a program in collaboration with Executive Health Resources (EHR), a physician-operated organization which provides outsourced physician advisor support to acute care hospitals. Their program is currently in place in over 1,000 hospitals covering 48 states. Their organization is extremely successful in assisting facilities with correct patient billing status, overturning denials, and facilitating efficient medical management.

A primary objective of the program is to ensure the appropriate utilization of resources and that they are rendered at the appropriate level of care. The program places a strong emphasis on interaction with attending physicians in a positive and collaborative manner as your intimate clinical knowledge of the patient provides critical information to the EHR Physician Advocates.

Case Management will begin working with the EHR physicians during the week of November 16th, 2010. The following week you may begin to receive calls from EHR to discuss cases selected for review. I ask for your support and your willingness to review cases, when necessary, with the EHR Physician Advisors.



Rochester General Hospital
Medical and Dental Staff

Dinner Dance

January 22, 2011
Rochester Convention Center

6 p.m.

Enjoy the Cocktail Hour with
Fortune Tellers and Music

7:30 p.m.

Dinner

9 p.m.

Dance the night away with
The Skycoasters

RSVP by January 14, 2011

Semi-Formal Dress

Please call the Medical and Dental Staff
Office with any questions (585) 922-4259.

Testing for Celiac Disease

By William Fricke, MD

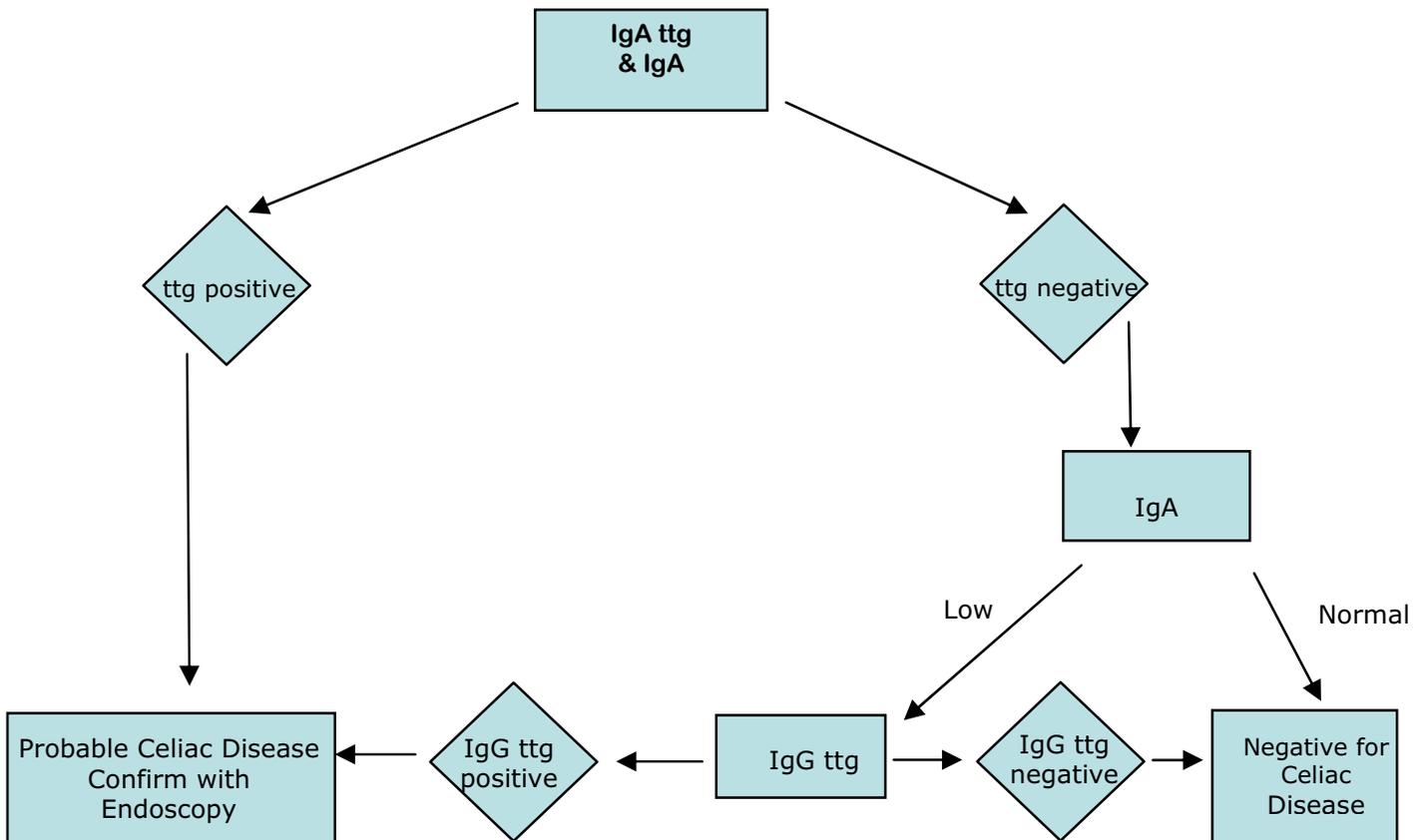
Testing patients for celiac disease can be confusing and frustrating because of the number of tests that are available and their varying sensitivity and specificity. The following algorithm, which has been reviewed and approved by several local gastroenterologists, is intended to simplify this process.

1. Order IgA tissue transglutaminase (ttg) antibodies and serum IgA levels.
2. If IgA ttg is positive, proceed to endoscopy for confirmation.
3. If IgA ttg is negative and patient has normal serum IgA, the patient is unlikely to have celiac disease. Additional testing is indicated only if the clinical likelihood of celiac disease is high.
4. If IgA ttg is negative and patient is IgA deficient, proceed to IgG ttg antibodies.
5. If IgG ttg is positive, proceed to endoscopy.
6. If IgG ttg is negative, the patient is unlikely to have celiac disease. If clinical suspicion is high, testing for IgA anti-deamidated gliadin peptide antibodies is appropriate. Patients who are IgA deficient should be tested for IgG anti-deamidated gliadin peptide antibodies.

Testing for anti-endomysial antibodies has been replaced by testing for anti-ttg antibodies. HLA typing may be appropriate in rare cases but has little diagnostic value. Testing for anti-gliadin and anti-reticulon antibodies is not indicated.

Please direct any questions to Dr. Fricke at 922-4576 or email: William.fricke@rochestergeneral.org.

Order IgA ttg & serum IgA



Pharmacy Corner – Can you read this?

This is part of an order that was received by a pharmacist last week for a prandial insulin dose. The patient was on 3 UNITS WITH MEALS prior to this new order.

AU TID Ac

The abbreviation “U” is on our Rochester General Hospital list of “Do Not Use” abbreviations. There is a potential problem with the letter “U” looking like a zero. Writing out “UNITS” is a best practice and recommended by The Joint Commission to improve patient safety.

ANSWER: This order is for 4 UNITS TID AC



Operation Facelift

Jim Harrison, Director Construction

Please read this important update regarding the Operation Facelift project. This project will modernize the 5th floor of the Liebert Pavilion, also known as E-Building. The project scope is identical to the ground floor project that was completed 2007-08. To summarize: flooring, ceilings, lighting, wall finishes and signage will all be replaced.

Floor replacement will be the single greatest challenge. This work will start Sunday, 11/21 and will be completed Thursday, 1/13. Sections of corridor will be closed in order to accomplish this work. Separate communication will go out as we complete each section and transition into the next. All work will occur during the overnight period from 9:00PM (2100) to 5:00AM (0500). Corridors will remain open each day.

Alternate routes to patient units have been established and we will provide staffing to assist with wayfinding and escort. Signs will be posted in key locations each night. A plan view of the 1st work zone is attached to this plan. Please print this and post it in your department.

All of the key leaders whose departments are directly affected have worked as a team to develop a plan that will safely re-direct traffic around the work zone and assure access to hospital services at all times.

You will receive additional updates as work progresses.

We need your help - Please consider how this project may impact your area of responsibilities and cascade this information to your team.

As always, Construction Services will direct all work, continually monitor activity around the work zone and make adjustments as needed. Please contact either Bob Grubb; 355-9109 or me if you have any questions or concerns.



Congratulations to Dr. Alok Gandhi

Dr. Gandhi was recently elected by his bariatric surgeon peers to the Board of Trustees of the New York chapter of the American Society for Metabolic and Bariatric Surgeons (ASMBS).

NEW FEATURE!!

GRIPA Patient Outreach Reports

As part of our continual effort to bring value to GRIPA Connect physicians' participation in Clinical Integration, a Patient Outreach Report can be run by any designated staff member. This report will provide you with a list of patients who have certain conditions, such as Diabetes or Hypertension, that are overdue for guideline-recommended office visits or lab tests.

This real time report, combining lab results and physician billing data, enables you to get a detailed view of the preventive services your patients need. So far, users of this report, like Kathy Rappenecker, practice manager for Medical Associates of the Genesee, have commented that "Running reports through the GRIPA portal to locate patients who need a reminder that their preventive care appointment is due or a follow up on CAD, BP or diabetes is very easy and beneficial to both the office and the

patient. With families that have very busy schedules, sometimes it is hard to remember to schedule these follow-up and preventive visits in a timely manner. With the collaboration of GRIPA and the physician offices, it is now possible to track these missing visits and get the patients into their doctor's offices for their required visits. It's almost like a safety net to make sure

that nobody falls through the cracks."

This report is available on the GRIPA Connect Portal through a link located on the left hand navigation bar under "My Reports". **GIVE IT A TRY TODAY!!**

If you do not see this link or have any other questions, please call GRIPA Provider Relations at 585-922-1525.

GRIPA Connect Clinical Integration Patient Outreach

The criteria listed below serve as the filters for identifying your patient population for this report. A patient is included in the report if he or she has any specified Condition(s) along with any specified Non-compliant Service(s). The "Managed Condition(s)" information provides all known conditions associated with a patient. The "Total Count of Non-compliant Services" reflects all services (not just the filtered service) for which a patient is non-compliant.

Filter Criteria for Patient Identification

Group/Practice: [Redacted]
 Providers: [Redacted]
 Condition(s): Diabetes
 Non-compliant Service(s): Physician Visit in last 6 months
 Contract Members Filter: All patients, including GRIPA CI Contract Members

Sort Order: Sort patients by the Total Count of Non-compliant Services

Patient Name	DOB	Age	Managed Condition(s)	Total Count of Non-compliant Services	Service Needed	Last Known Test or Visit relevant to the Service Needed Date Details (Results displayed where available)
[Redacted]	[Redacted]	45	CAD, DM, HTN, Hyperlipidemia	4	Physician Visit in last 6 months • Most recent A1c result in last 12 months < 7% • A1C in 3 months • >=1 A1cs in last 6 months	3/25/2010 3/20/2010 A1c: 9.3 3/28/2010 A1c: 8.3 3/20/2010 A1c: 9.3
[Redacted]	[Redacted]	64	DM, HTN, Hyperlipidemia, Hypothyroidism	3	Physician Visit in last 6 months • Most recent A1c result in last 12 months < 7% • >=1 A1cs in last 6 months	3/18/2010 3/14/2010 A1c: 7.3 3/14/2010 A1c: 7.3

GRIPA Announces a New Chief Medical Officer



Eric Nielsen, M.D.



T. Jeffery Dmochowski, M.D.

Eric Nielsen, M.D., resigned as CMO of GRIPA on 9/30/2010 to assist physician groups interested in the Clinical Integration model of medical management on a national level. Eric joined GRIPA in 2004, after 29 years in the private practice

of Internal Medicine. During his tenure, he championed GRIPA's efforts toward achieving clinical integration as evidenced by GRIPA's favorable advisory opinion from the FTC in September 2007. Under his leadership, GRIPA has developed guidelines by and for its member physicians, an IT infrastructure for sharing of clinical information among its members, and systems for monitoring the performance of members and the network. We offer him our heartfelt gratitude for his insightful leadership and limitless devotion in helping guide the development of GRIPA Connect. Eric has joined the Camden Group,

a national consulting organization headquartered in California. We sincerely wish him well in his efforts to "spread the word".

Dr. Dmochowski joined GRIPA as the associate medical director in February of 2009 and will now be filling the role previously held by Eric Nielsen, as acting chief medical officer.

