



Forum

A NEWSLETTER 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

**2012 Quarterly
Staff Meeting**

3/16, 6/15, 9/21, 12/21
7:30 - 9:00 a.m. Twig Auditorium

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

MESSAGE FROM THE MDS PRESIDENT

Cookbook

I have read more cookbooks that I should admit publicly. It started when I was first married over 25 years ago. At the time we were poor and cookbooks were cheap. We were both simultaneously in graduate school and free time was rare. Cookbooks seemed to offer a much needed creative outlet after long hours in lecture halls and science labs. Sometimes the books reminded us of home and comfort foods. It was something my wife and I could do together.

We both had mothers who loved to cook and entertain. For each of them, cooking was not only fun--it was a calling. Feeding family and friends was connected to who they were. They were healers and nurturers. There was nothing like a delicious tureen of homemade soup to cure the blues or RSV for that matter. Every visit home was punctuated by food and every trip back to school found our car laden with fresh and frozen specialties.

In time, reading the cookbooks transitioned into (surprise!) cooking. Survival after all, is predicated more on eating than reading. My cooking, similar to many cooks, has been characterized by nearly as many failures as successes. After a while I could determine if a recipe was well designed by simply reading it before I tried it. While cooking together my wife and I frequently consult other experts. A well used copy of Julia Child's two volume set, Mastering the Art of French Cooking sits on our counter top along with many other writers.



Dr. Robert Mayo,
President RGH MDS

One of the anticipated benefits of electronic medical records is the further standardization of clinical interventions and treatment pathways. With greater integration of clinical processes and electronic records we will be able to better refine the medical care we deliver and achieve the lofty clinical outcomes we desire.

Cookbooks, continued

Frequently we will discuss a certain technique or recipe and say to each other, "What does Julia say?" or "How does Martha do that?" These conversations come so naturally that a friend once said, "You talk about these cook books like you know the authors." Some recipes can be surprisingly complex and challenging. Even the finest cooks can not complete every recipe in exactly the same way every time. It is fascinating how differently a loaf of bread can bake, taste and feel depending on factors such as the oven's functionality, the ambient room humidity, and the gluten content of the flour.

With all of the variety, complexity, intellect, science and art behind cooking why do we as physicians and providers sometimes label clinical protocols with the disdainful expression, "cookbook medicine." The expression "cookbook medicine" implies some sort of clinician dumbing down. I find this curious since we, by nature of our training so strongly value research that is based on controls and strictly maintained protocols or in other words "cookbooks."

While a renal fellow, I worked in a research laboratory studying the effect of cyclosporine on renal interstitial fibrosis using immunohistochemistry. I was given a cookbook to perform the experiments. Nothing was working. I returned frequently to my lab supervisor and primary investigator to report the problems. I was convinced either the recipe was

wrong or the ingredients were inactive. Each time I reported a failed experiment and suggested possible explanations, I was told it was my technique and I had not yet learned the nuances of the laboratory. Finally after three weeks of wasted time, I convinced the supervisor to change the costly murine anti-body and we discovered that it had been the problem I previously suspected. For me, this experience highlights the value of following the cookbook since the failed antibody would have remained undiscovered without isolating it from the other necessary steps.

Progress, even as small as my lab experiment, is born of innovation made possible with standardization. One of the anticipated benefits of electronic medical records is the further standardization of clinical interventions and treatment pathways. With greater integration of clinical processes and electronic records we will be able to better refine the medical care we deliver and achieve the lofty clinical outcomes we desire. Though we are still in the stabilization period of our CareConnect implementation I am heartened by the large number of physicians, nurses, clinicians and team members who are working to refine it. Your recommendations for improvement are valued by the CareConnect team and I encourage you to stay engaged. Once CareConnect is fully functional, it will be a valued tool designed with laboratory proven "cookbook" concepts capable of further advancing the high quality care we demand of ourselves. Bon Appetit!

RGH MDS Lookin' for a Few Good People

Richard Constantino, MD RGH MDS Past President

This year we will be voting for a New President Elect, Secretary and Treasurer as well as three new Elected Representatives.

If you are interested, please contact me and we can discuss the responsibilities and role of these positions. This is an exciting time for the RGH MDS and we look forward to having representatives who serve all 1385 of us well.

Organizational Announcement

Mark C. Clement, President, CEO and Richard J. Gangemi, MD, Sr. Vice President, Chief Medical Officer

We are pleased to announce that Dr. Dawn Riedy, Director of the Department of Pathology, has been named Chief of Pathology and Laboratory Medicine for Rochester General Health System, effective Friday, January 27, 2012.



Dr. Dawn Riedy

Anyone who has worked with Dr. Riedy can attest to the combination of skill, dedication and enthusiasm that makes her a natural choice for this new role. Prior to joining the staff of The Genesee Hospital in 1991, she served for two years as the Director of Pathology at Penn State University Hershey Medical Center. Dr. Riedy was appointed the Director of Cytology of Rochester General Hospital in 2003 and Director of Pathology in 2009. She attended medical school and completed her residency at the University of Rochester School of Medicine and Dentistry, and completed a fellowship in surgical pathology and cytopathology at the University of Virginia. She currently serves as an elected member of the RGH Medical Board, member of the Executive Committee

of the Breast Center of Excellence and Co-Chair of a community-wide advisory group developing guidelines for appropriate laboratory testing utilization. Dr. Riedy has a strong interest in patient advocacy and is a champion of the interdisciplinary approach to patient care at RGH.

In her new position, Dr. Riedy succeeds Dr. Theodor Mayer, who has served as Chief of Pathology and Laboratory Medicine since 1999, following distinguished laboratory medicine leadership roles at United Health Services Hospitals in Binghamton and The Genesee Hospital in Rochester. In his role as Chief of Pathology, Dr. Mayer's accomplishments have included managing the successful merger of Genesee Hospital and Rochester General Hospital Pathology and Laboratory Medicine, and expertly overseeing RGH's laboratory medicine efforts during a time of significant growth in the last decade. Dr. Mayer will be leaving the system at the end of the month. The Pathology and Laboratory Department is highly regarded and we are grateful for Dr. Mayer's efforts on behalf of his team and the greater RGHS community.

Please join us in thanking Dr. Mayer for his dedication and leadership, and in congratulating Dr. Riedy on her new position and responsibilities!

New Director of Women's Health

Brian D. Jepson, President of Rochester General Hospital

I am pleased to announce the appointment of Jeremiah Kirkland to the position of Director of Women's Health for Rochester General Health System effective January 16, 2012. In this new role, Jeremiah will be responsible for directing and coordinating the administrative functions of the Women's Health service line.



Jeremiah Kirkland

Jeremiah has held progressive roles within our system for over 10 years, most recently providing exceptional leadership to our School-to-Work Program. Under his direction, the School-to-Work Program has grown significantly and has been

recognized as a national benchmark for success. Jeremiah will continue to provide oversight for this program in his new role as Director of Women's Health.

In addition to leading the School-to-Work Program, Jeremiah completed an Administrative Fellowship in 2011. As a Fellow, he worked closely with Mark Clement and the senior leadership team on special projects and co-led the Care Connect Communications Team.

Jeremiah earned a Master's Degree in Health Services Administration from Roberts Wesleyan College and a Bachelor's Degree in Health Sciences from the State University College at Brockport.

Please join me in congratulating Jeremiah on his appointment to Director of Women's Health for RGHS!



Care Connect Update - Stabilization Process

Mark C. Clement, President and CEO

January 5th marked the two-month milestone since Care Connect was launched at RGH and in our pilot Ambulatory sites. In just eight short weeks, our Care Connect team, department leaders, and end users have done an incredible job of transitioning to our new EMR and the many new processes and procedures that go with it.



Mark Clement, President & CEO
Rochester General Health System

Of course, this has not been without its expected challenges and related frustrations as our teams have been working tirelessly to address and manage process and system issues that have come up, all while continuing to provide outstanding care to each and every patient. This post-go live effort is called the Stabilization period and while not easy, it is a necessary part of the process required to fully operationalize our new EMR. While I recognize that any issue – especially those which impact the quality and flow of patient care – can be stressful and may even make you question the value of our new EMR, I want to assure you that what we have experienced so far has been typical for a transformation of our size and scope. And most importantly, we are confident that the global issues that have been identified can and will be effectively resolved in as timely a manner as possible.

ABOUT STABILIZATION

The Stabilization period began the day of go-live and will continue until all major issues are satisfactorily addressed. Stabilization is a planned part of the EMR implementation process and its purpose is to identify, troubleshoot, and resolve critical system issues that are being experienced by end users. The goal is to ensure that the highest levels of patient safety standards and procedures are maintained with our new EMR, and to support greater end user proficiency and confidence with the system. We have put in place a formal infrastructure made up of the following teams to collaboratively prioritize and resolve critical issues that have been identified through end user input and HelpStar tickets:

- **CARE CONNECT STEERING TEAM**

This multi-disciplinary team consists of RGHS senior operational and clinical leaders. Its purpose is to evaluate and prioritize key Care Connect issues occurring throughout RGH and pilot practices and to review and approve proposed solutions before they are implemented.

- **CARE CONNECT INFORMATICS**

DEPARTMENT This newly-formed group will become a permanent and ongoing function at RGHS and will consist of a Medical Division (staffed with Inpatient/Ambulatory providers) and a Patient Care Services Division (consisting of Nursing/Ancillary staff members). The Informatics Department, along with Care Connect technical teams, will work together to develop long-term strategies and solutions to both resolve Care Connect issues and put in place enhancements in order to continuously improve the overall effectiveness of our EMR.

- **CARE CONNECT TRAINING ADVISORY**

GROUP As proposed issue resolutions are tested, reviewed and approved, the Training Advisory Group will design and put in place the necessary education resources to support end user development and proficiency, and to standardize practices across RGHS.

Once all initial global Care Connect issues have been resolved, we will move from the Stabilization phase of our EMR adoption to the ongoing Optimization phase. Optimization is a period of continuous improvement where we refine and enhance the EMR technology and applications, and develop standardized user best practices to maximize the performance of the system. And, of course, we will also continue to address and resolve the less critical issues identified through HelpStar on an ongoing basis.

KEEPING YOU INFORMED

In addition to our efforts to resolve issues, we are also developing regular communication tools to keep you up-to-date and fully informed about the progress being made – and to also share the many Care Connect success stories that are emerging every day. This month, we will launch a simpler,

Nursing Changes

Cheryl Sheridan BS, RN, MPA, NE BC
Senior Vice President and Chief Nursing Officer

I am pleased to announce the following changes in Leadership which were effective January 3, 2012.

Theresa Glessner, DNP, RN, ACNP, BC, NEA, BC, CCRN is the Interim Director of Clinical Education and Research. In this role, Terri will be working with clinical educators across our system to develop and implement strategies toward the continued growth and development of our team supporting our goals focused on patient safety, exceptional service and breakthrough performance. Prior to this role, Terri was the nurse manager of CTICU/4400 and the perfusion team for the past 5 years. She completed her Doctor of Nursing Practice at the University of Rochester in 2010. Terri brings her experience as both a CNS and Acute Care Nurse Practitioner in Cardiac and Vascular Surgery with her to this new role.

Marcia Ragan RN is the Interim Nurse Manager for CTICU and 4400. Marcia has been a staff nurse at RGHS for 20 years. She has been with the cardiothoracic service for 15 years, most recently in the CTICU. Marcia was previously the manager of 5100 for 2 years. Marcia is working toward completion of her BSN in 2012 at St. John Fisher.

Sylvia Schenck MS, RN is the Patient Advocacy Coordinator RN. Prior to assuming her new role, Sylvia served as the Director of Clinical Education for the past 3 years and was a Clinical Educator for 7 years prior. In her new role, she will be a liaison working with our patients, families and health care service providers. Sylvia's wealth of experience, caring and compassionate manner and professionalism will serve her well in this new role.

Please join me in congratulating Terri, Marcia and Sylvia on their new roles.

more user-friendly Care Connect portal site to give you timely updates on the status of outstanding issues, the latest education and training schedules, team member recognition, user reference guides, and much more. Later this month, we will also be re-introducing our monthly NewsLink newsletter to provide you with a summary of Care Connect progress and people stories – and to share more details about what's involved in the Stabilization and Optimization phases. Finally, we will be equipping our front-line department leaders with up-to-the-minute reports on Stabilization progress and next steps to share at huddles and other team meetings.

NEWARK-WAYNE COMMUNITY HOSPITAL (NWCH) GO-LIVE UPDATE

In order to ensure that our full resources are devoted to successfully completing stabilization at RGH and in our pilot practices, we have decided to delay the go-live at NWCH from March 10 to May 1, 2012. This will enable NWCH and its staff and patients to fully benefit from the key learnings and hundreds of process and system fixes that are occurring, and will continue to occur over the next few weeks.

I want to thank you for your continued patience, active involvement, and perseverance as we work together to make Care Connect the high-performing EMR system it is meant to be. Because of your proactive efforts in identifying and troubleshooting issues, we have already made remarkable progress – and are well on our way to fully stabilizing the system. And every day, we hear more and more compelling stories from team members and providers at the “bedside” about patients being safer and care being delivered with greater ease and efficiency because of Care Connect. You can learn more about these great success stories (and the people who made them possible) in the upcoming issues of NewsLink and on the Care Connect website.



Need Help with Care Connect?

Call 922-1234 for dedicated assistance.



Proposed RGH MDS Bylaws Changes

THIS WILL REQUIRE YOUR VOTE DURING THE MARCH QUARTERLY STAFF MEETING

This past year, the RGH MDS Bylaws Committee has seen changes come forward from RGH legal counsel on the wording of the Bylaws as well as recommendations for change from your RGH MDS Officers relatives to Committees and their structures etc. As required, these changes were reviewed by your RGH MDS Bylaws Committee, modified in some cases and then presented to your Medical Board for their recommendation. During the past couple months the following changes have been reviewed and are now recommended for your approval. As required you are being provided with the changes that will be voted upon during the March Quarterly Staff Meeting, thereby allowing you at least 30 days review. If you have any questions about these changes, please contact Samantha Vitagliano, DMD, RGH MDS Bylaws Committee Chair or Mary Lou McKeown at 922-4259.

Article XI, Section 5 – Executive Committee of the Medical Board:

- a. The Executive Committee of the Medical Board shall be comprised of the following:
1. the President, who shall chair the committee;
 2. the President-Elect;
 3. the Past President;
 4. the Secretary;
 5. the Treasurer;
 6. two Department Chiefs at-large; and
 7. the six elected members of the Medical Board at-large.
- b) The following individuals shall be invited to attend all meetings of the Executive Committee, without vote:
1. the Chief Executive Officer;
 2. the Hospital's Senior Vice President of Academic and Medical Affairs;
 3. the Hospital's Chief Patient Care Executive;
 4. the Medical Director; and
 5. the Chair of the Hospital's Board of Directors
 6. the President of RGH
- c) Others may be invited to attend at the discretion of the President of the Medical and Dental Staff without vote.

f) The Executive Committee of the Medical Board shall meet on a monthly basis during any month when the Medical Board does not convene, and otherwise shall meet as frequently as needed. Meetings may be called by the President of the Medical and Dental Staff or by a majority of the elected membership of the Medical Board. The Executive Committee shall maintain a permanent record of its proceedings and actions. A report of the meeting of the Executive Committee shall be presented to the Medical Board at its next regular meeting.

Article XI, Section 6: Functions of other Standing Committees, subsection "m" [previously section "n"].

m)

The Quality Improvement Council shall be comprised of the Chiefs of each Clinical Department or their designees, and other representatives appointed from the Clinical Departments of the Hospital, Pharmacy, Nursing and Hospital administration. Because of the multidisciplinary nature of this committee, the voting membership will include individuals who may not be members of the Medical and Dental Staff. Such additional voting members shall include the Chief Nursing Officer, Directors of Nursing, the Director of Infection Prevention, the Director of Performance Improvement and Clinical Excellence, the Director of Pharmacy, the Senior Leaders for the Institute for Patient Safety and Clinical Excellence, the President of the Hospital, the Medical Director of the Hospital, the Medical Director of Rochester General Medical Groups, and the Chief Medical Officer of the Rochester General Health System. The Quality Improvement Council shall be responsible for the coordination and implementation of the Hospital's Quality Improvement Plan and shall assist in the development of that Plan. The Council shall oversee and coordinate the quality improvement process of all Hospital departments, in collaboration with the Medical Director. The Quality Improvement Council shall have the authority to recommend courses of action and to identify and correct problems. It shall evaluate the quality of patient care with the goal of furthering the provision of consistently optimal patient care and to insure an accountability mechanism that will contribute to the improvement of patient care...

ROCHESTER GENERAL HOSPITAL RANKED NATIONALLY FOR CLINICAL EXCELLENCE

Rochester Heart Institute Again Ranked #1 in New York State for Major Cardiac Surgery

Rochester General Hospital, the flagship affiliate of Rochester General Health System, has once again received some of the highest state and national rankings for cardiac care as well as overall hospital and surgical care – including being named the leader in New York State for *Major Cardiac Surgery* and *Cardiac Care* – according to the latest report from CareChex®, a division of The Delta Group.

The CareChex® 2012 study provides hospital rankings in the categories of Medical Care and Patient Safety, with awards based on an institution's cumulative performance across the most recent three (3) years of public data. In compiling its rankings, CareChex® incorporates six evidence-based peer-reviewed methodologies which address key components of inpatient care quality. These methods encompass quality measures including mortality rates, complication rates, patient satisfaction measures, inpatient quality indicators including core measures, and patient safety indicators.

In the study, Rochester General Hospital received among the highest rankings in categories including *Major Cardiac Surgery* (#1 in New York State, #3 in the United States), *Cardiac Care* (#1 in New York State), *Overall Surgical Care* (#3 in New York State) and *Overall Hospital Care* (#3 in New York State). RGH led the greater Rochester region in all of these categories.

A complete analysis of hospital performance data is available at www.carechex.com.

"The CareChex methodology of assessing medical excellence and patient safety provides an



ideal objective standard for comparing the quality of any hospital's care," said Mark C. Clement, President and Chief Executive Officer of Rochester General Health System. "These high rankings are the result of the unsurpassed dedication and skill brought by our team of nearly 10,000 physicians, care providers and volunteers to our shared mission to become the trusted provider of choice to the Rochester area and beyond."

In addition to CareChex, national organizations recognizing Rochester General Health System's commitment to healthcare excellence include SDI, which has named RGHS as among the Top 100 Integrated Health Networks in the United States; and the American Nurses Credentialing Center, which has twice consecutively designated Rochester General Hospital as a Nurse Magnet Hospital for high achievement in quality patient care, nursing excellence and innovations in professional nursing practice.





Top Global Care Connect Issues

RESOLUTION PROGRESS REPORT

As part of the Stabilization phase of our Care Connect implementation, we are working behind the scenes to address the technical and process issues affecting most Care Connect users. This report provides you with a monthly progress update on the status of these top global issues with projected completion dates (in parentheses). Please use this report to: LEARN about the latest status of top issues and solutions & SHARE the relevant information with your teams.

- 1. PATIENT CLASS ASSIGNMENTS** – Patient Class is currently not being assigned or modified appropriately.

SHORT-TERM SOLUTION: Care managers will review each admission and work with provider to ensure Patient Class is identified correctly.

FINAL SOLUTION: Admission orders will be redesigned, patient class options will be clearly defined, and providers will be trained about the solution. (1/31/12)

- 2. MULTIPLE CONTACT SERIAL NUMBERS (CSNs)**
– Prior to Care Connect, the visit # remained the same throughout a patient's hospital visit. Using the new system, the patient receives additional temporary CSNs when transferred to departments that require scheduling (such as the Cath Lab or Operating Room). When the wristband is scanned for patient identification, these temporary CSNs are causing confusion.

CURRENT SOLUTION: Use multiple identifiers, including name and date of birth, to ensure the correct patient is being treated.

FINAL SOLUTION: A solution will be finalized that enables a consistent CSN to be used throughout a patient's visit. (1/31/12)

- 3. THREE MEDICAL RECORD NUMBERS (MRNs)**
– Due to the fact that RGHS, RGH and NWH currently have separate MRNs, when searching for

a patient using the MRN, the system often reports multiple patients for the same number.

CURRENT SOLUTION: Use multiple identifiers, including name and date of birth, to ensure the correct patient is being treated.

SHORT-TERM SOLUTION: Care Connect will be modified to view search results similar to CCS. (3/1/12)

FINAL SOLUTION: All computer systems will be aligned across the organization to utilize a single RGHS MRN. (12/31/12)

- 4. BLOOD ADMINISTRATION PROCESS CHALLENGES** – Documentation of blood ordering and administration in Care Connect is inconsistent.

- **Education for end users regarding documentation of blood administration is inadequate.**

SHORT-TERM SOLUTION: Effective 1/9/12, a detailed instruction sheet is now attached to every blood bag.

FINAL SOLUTION: During the month of February, all end users requiring knowledge on this topic will receive mandatory education.

- **Need to improve the usability of blood ordering for providers.**

SHORT-TERM SOLUTION: We are working on an enhancement to alert the user if blood is ordered and no current type and screen is entered within 72 hours. In this case, a pop-up message will appear and the system will automatically add this information to the order. (1/23/12)

FINAL SOLUTION: A solution for usability will be implemented with education provided to end users about how to use the improved process. (2/29/12)

- 5. COMPUTER PROVIDED ORDER MANAGEMENT (CPOM) ERRORS** – Providers are unsure when to do order reconciliation resulting in duplicate orders and duplicated definitions of the phases of care.

FINAL SOLUTION: The Joint Commission policy on reconciliation will be reinforced and learning labs will be offered to providers. (2/15/12)

- 6. CHART REVIEW & NAVIGATION DIFFICULTIES** – The format of tabs is not user-friendly, there is confusing information in various tabs, and items are either generically dated and timed, or the incorrect date and time are being displayed.

SHORT- & LONG-TERM SOLUTION: The tabs will be “cleaned up” for a more accurate and standardized display of the information. Weekly updates will be made until the tabs more closely resemble the sections that were seen in CCS. All Date and Time issues will be resolved by 1/31/12.

- 7. CORE MEASURES & REPORTING** – Not all reports are pulling the desired data.

FINAL SOLUTION: All critical reports will be reviewed and validated to ensure their accuracy. (3/31/12)

- 8. SCANNING** – Users are unable to scan to future appointments and unit scanners are unable to scan large volumes.

SHORT-TERM SOLUTION: The ability to scan to future appointments is currently being tested.

FINAL SOLUTION: All departments will have the ability to scan to future appointment and be educated for use in production by 2/15/12. Each department will develop a list of documents to be scanned in depart

InterVol Receives \$5,000 Grant from UPS Foundation

DOLLARS WILL HELP IMPROVE STORAGE AND PRODUCTIVITY

InterVol, a Rochester community-based non-profit organization affiliated with Rochester General Health System, has received a \$5,000 grant the The UPS Foundation, the charitable arm of the United Parcel Service.

InterVol’s mission is to create community partnerships that generate opportunities to protect the environment by reducing the amount medical waste while benefiting patients around the world.

Since 1992, InterVol has collected tons of medical equipment and supplies that would otherwise (by regulation) be destined for disposal. Hundred of InterVol volunteers sort the collected supplies, the bulk of which are shipped to third-world countries in desperate need of these materials. However, some supplies stay here at home and benefit local organizations such as the Humane Society and the Seneca Park Zoo.

“We are very appreciative for this generous grant from The UPS Foundation,” said Ralph Pennino MD, president/founder of InterVol and Chief of Surgery at Rochester General Hospital. “This grant will allow us to build new shelving in our warehouse, helping improve storage and productivity.”

Established in 1951 and based in Atlanta, Ga., The UPS Foundation identifies specific areas where its backing clearly impacts social issues.



Article #5 Recognizing Terminal Illness

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

This is the Fifth installment of a six-article series. Please see the prior columns to review definitions, compliance, FAQ's, and engaging patients in advanced illness discussions.

INTRODUCTION:

The PCIA law requires practitioners to offer information and counseling to patients with a terminal condition to address appropriate treatment options and alternatives, prognosis, and the patient's right to comprehensive pain and symptom management. This begs a much more challenging evaluation and analysis of the medical circumstances.

What is a terminal condition? How sure do I have to be that the condition is terminal?

As defined by the PCIA law, a terminal condition is one where expected prognosis is less than six months, with or without disease-directed treatments. The law does not provide guidance on this determination. Medical education has excelled at teaching evaluation, diagnosis, and treatment; however, it did not train us nor does it effectively train residents today about prognosis.

Some guidance on terminal diagnoses follow below. First, we should address how confident we should be when giving a prognosis. There is no crystal ball, yet if asked, patients want to know. When I consider how confident we need to be, I think of the court of law: the criminal system requires unanimity and evidence 'beyond a reasonable doubt' - 95 percent sure; the civil system requires a majority concurring and 'more likely than not' - 51 percent sure. We provide prognosis not because we wish to dwell on the prediction, but rather, to allow patient and caregivers the opportunity to plan and prepare. The civil system - 'more likely than not' - is the level of certainty we should use when prognosticating. Consider this, what would a group of peers believe the prognosis is? I doubt all would agree on the exact time, but they may agree on what is 'more likely than not'. This is the standard the law holds us to. If we withhold communication until it is beyond a reasonable doubt we would not have prognosis discussions with our patients and would deny them the opportunity to plan and decide how they want to live. This is the very crux of the PCIA law. I routinely tell my patients what I expect the prognosis is

(remember to use a of time) with the understanding that I may be wrong. This provides opportunity and hope.

The NYS Department of Health directs us to the Local Coverage Determination guidance on determining terminal status (L25678). This is a place to start, but, as with any guidance, we must use clinical judgment to make a determination on prognosis. Generally, a terminal diagnosis involves a significant, documented deterioration in physical status such as weight loss or function and/or an end-stage disease. If a patient declines treatments, medications or hospitalization, this may contribute to determining a terminal prognosis. A patient may have a terminal diagnosis even without a specific diagnosis (see *Decline in Clinical Status* below).

All patients who meet *disease specific* guidelines should have decreasing functional status as demonstrated by Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) at least less than 70% - essentially requiring some assistance with self-care and unable to do normal work. Moreover, the patient should require assistance in two or more activities of daily living (ambulation, continence, transferring, dressing, feeding, and bathing). Additional co-morbidities may be supportive for a terminal diagnosis.

DISEASE SPECIFIC CRITERIA:

- 1. CANCER:** a **OR** b (other factors may be supportive)
 - a. distant metastases at diagnosis **OR**
 - b. progression to metastatic disease with either failure of treatment **OR** refusal of further treatment
- 2. DEMENTIA OF ALZHEIMERS TYPE:** a **AND** b (other factors may be supportive)
 - a. STAGE 7c on FAST SCALE à requires assistance for ambulation, dressing and bathing, incontinent of urine and stool, and no consistently meaningful verbal communication (stereotypic phrases only or six or less intelligible words a day) **AND**
 - b. In the last 12 months: a severe infection (e.g.

aspiration PNA, sepsis) **OR** multiple stage 3/4 decubitus ulcers **OR** poor intake with weight loss >10% in 6 months or albumin < 2.5

3. **HEART DISEASE:** a **AND** b (other factors may be supportive)
 - a. optimal treatment and either not a candidate for /or refuse surgery **AND**
 - b. NYHA class IV (discomfort with any physical activity; symptoms of CHF angina at rest). (EF =/< 20% if available)
4. **LUNG DISEASE:** a **AND** b; (other factors may be supportive)
 - a. Dyspnea at rest and minimal exercise tolerance, progression of disease with increased ER visits, hospitalizations or MD home visits **AND**
 - b. pO₂ <55 mmHg on room air **OR** O₂ SAT < 88 on O₂ **OR** pCO₂ >50 mm Hg
5. **KIDNEY DISEASE:** a **AND** either b **OR** c; (other factors may be supportive)
 - a. not seeking dialysis or transplant or stopping dialysis **AND**
 - b. creatinine clearance < 10 cc/min, <15 for diabetics (in CHF <15 and <20 cc/min) **OR**
 - c. creatinine > 8 mg/dl (> 6 for diabetics)
6. **STROKE:** a **AND** b; (other factors may be supportive)
 - a. KPS/PPS < 40% à unable to care for self, bed bound **AND**
 - b. inadequate nutrition with **one** of the following: weight loss > 10% in 6 months or 7.5% in 3 months; **OR** albumin < 2.5; **OR** aspiration pneumonia not responsive to speech therapy intervention; **OR** inadequate caloric intake counts; **OR** severe dysphagia and **NO** artificial feeding

DECLINE IN CLINICAL STATUS (formerly failure to thrive):

This category is for documented, irreversible decline over time from a known baseline and should

be based on several variables; however, there is no prerequisite number of variables required.

1. Progression of disease as seen by clinical status, symptoms, and signs. Labs can be supportive but are not required.
 - a. Clinical decline as seen by: 1) recurrent infections; 2) weight loss; 3) falling albumin or cholesterol; 4) dysphagia with aspiration and/or poor intake
 - b. Symptom progression such as: dyspnea with tachypnea; intractable cough, nausea/vomiting, or diarrhea; increasing pain on strong opioid treatments
 - c. Signs such as: low BP; ascites; vascular or lymphatic obstruction; edema; effusions; weakness; change in LOC
2. KPS or PPS < 70% à requiring some assistance with self-care and unable to do normal work
3. Additional supportive information: increasing visits to ER or to MD or hospitalizations; progression of advanced dementia; progression to dependence on ADLs, progressive decubitus ulcers 3/4 in spite of treatment.

The above is a partial list and does not cover all diagnoses. Additional guidance is available for patients with HIV, Liver disease, ALS, and Coma. Studies that assess these guidelines and the accuracy of prognosis are lack luster; however they do provide a starting point. I want to stress this is not a one-size fits all. I am sure many can think of exceptions, cases or anecdotes that defy the guidelines from CMS above. Again, the goal is to identify what is most likely to happen not what is guaranteed.

The last article in the series will discuss appropriate timing for palliative care consultation in the hospitalized patient.

REFERENCES AND RESOURCES:

- <https://www.cms.gov/medicare-coverage-database/license/cpt-license.aspx> (search for L25678)
- <http://aspe.hhs.gov/daltcp/reports/impquesa.htm>



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.

RGH MDS Welcomes the Following New Members

Bailee Dunshie, RPA-C, Surgery/General Surgery

1425 Portland Ave #362, Rochester, NY 14621
585-922-2906

Peter Frederick, MD, Obstetrics/Gynecology

Elm & Carlton St., Buffalo, NY 14263 716-845-3497

Sarah Gamel, RPA-C, Emergency Medicine/Observation Unit

1425 Portland Ave, Observation Unit Rochester, NY 14621
585-922-9080

Susan Jackson, RPA-C, Medicine/Internal Medicine

12 Leach Rd., Lyons, NY 14489, 315-946-6075

John King, MD, Ophthalmology

10 Hagen Dr. #220, Rochester, NY 14625
585-586-2020

Karen Mazza, NP, Medicine/Internal Medicine

1055 Weiland Rd, Rochester, NY 14621

Adekunie Odunsi, MD, Obstetrics/Gynecology

Elm & Carlton St., Buffalo, NY 14263, 716-845-3497

Christopher Popielarz, RPA-C, Medicine/Internal Medicine

48 Dalston Rd, Rochester, NY 14616

Julie Pum, NP, Cardiac Services/Cardio-Thoracic Surgery

1425 Portland Ave #127, Rochester, NY 14621
(585) 922-4188

Julie Riccio, MD, Pediatrics

601 Elmwood Ave Box 651, Rochester, NY 14642
585) 275-2972

Rohit Sahai, MD, Surgery/General Surgery

1415 Portland Ave #245, Rochester, NY 14621
(585) 922-4518

Rishin Shah, MD, Medicine/Hospitalist

1425 Portland Ave #287, Rochester, NY 14621
585-922-5067

Laurence Torpey, MD, Family Practice Refer & Follow/Peds & Internal Medicine

2550 Barid Rd, Penfield, NY 14526 585- 385-0590

Directory Changes: CHANGE TO INACTIVE

Marth Bottoni, NP
Kevin Briceland, RPA-C
Gerald Grumet, MD
Sean Halligan, MD
John Hausle, MD

Valerie Huck, NP
Effat Jehan, MD
Mark S. Johnson, MD
Jason Kump, RPA-C
Lester Katzel, MD

Elizabeth Murray, DO
Jessica O'Neill, PA
Christopher Rutledge, CRNA
Nancy Shedd, MD
Mary Wadsworth, RPA-C

Policy for Sponsored Research Conducted at RGHS

Effective January 1, 2012, all new sponsored research proposals including clinical trials are to undergo review and sign-off by the RGHS Office of Sponsored Research. This includes any kind of sponsored research proposal (human subjects or animals or basic research) that is to be solely or partially conducted at any RGHS affiliate's facility and funded by an outside sponsor (e.g. federal, state or local agency; pharmaceutical company; institution of higher education or other non-profit institution/organization).

Any sponsored research that involves human subjects must be reviewed and approved by the

RGHS Clinical Investigation Committee (CIC). This is a requirement for any protocol, informed consent, or contract/agreement that names any RGHS affiliate.

A RGHS Sponsored Research Guide with accompanying policies & procedures will be available on the RGHS portal. Questions regarding the guide and policies & procedures should be directed to Gayle Elledge (phone: 922-0627, e-mail: gayle.elledge@rochestergeneral.org), Director, RGHS Office of Sponsored Research.

RGH Transitioning To Disposable Isolation Gowns

Starting January 16th, 2012, inpatient services at RGH will be transitioning to disposable isolation gowns. Isolation supplies, including disposable gowns, will now be stored in a door caddy hung on the outside of each isolation room. Stepwise transition to disposable gowns and door caddies, with removal of isolation carts will be undertaken as follows:



January 16th - MICU, 5500, 6800, 7800, MAT, 4800
January 23rd - 3000, 3800, CTICU, 4400, SICU, 4200
January 30th - ASC, CDU, MOU, G1, 5100, 5200

Please contact Hospital Epidemiology (alexandra.yamshchikov@rochestergeneral.org), Infection Prevention (casey.calabria@rochestergeneral.org), or Purchasing/Value Analysis (Linda.moore@rochestergeneral.org) for questions or concerns. Additional information as per below.

GOWN CHOICE

- The blue plastic disposable isolation gown is recommended to be worn by staff when giving a patient a bed bath or if a task is going to be performed where heavy soiling is expected. Otherwise the yellow gown is recommended to be used by visitors and staff. The gowns are disposable and single use only, meaning they should be discarded when exiting the patient room.

DISPOSAL OF USED DISPOSABLE GOWNS

- Disposable gowns are to be disposed of ONLY in regular trash unless visibly stained by blood, in which case red disposal bins are to be used. Gowns stained by fecal material can be disposed of in regular trash
- In order to avoid garbage overflow, roll the isolation gowns in a ball (only touching the clean side of the gown to avoid contamination)
 - EVS has double lined the garbage pails, unit staff is responsible in assisting when they notice the garbage is overflowing by removing the bag and placing it in the dirty utility room.

STORAGE AND STOCKING OF THE ISOLATION GOWNS & CADDIES

- Unit night staff will be responsible for checking and restocking door caddies at the end of their shift between 4-5 am
 - Each caddy is stocked with 3 boxes of gloves (S, M, L), 2 pre-opened bags of disposable yellow gowns, 1 package of blue plastic gowns, a container of Dispatch wipes (optional), a container of surgical masks (when patients are on Droplet precautions), and a pink isolation sign displayed in front pocket
- Central Stores/Linen will check remaining stock of disposable gowns during their unit rounds at 715am and restock daily as needed
- On a day to day basis, the unit secretary will be responsible for calling Central Stores if par needs are exceeded and unit runs low on stored supply of disposable gowns to ensure timely delivery of extra gowns
- The responsibility for supervising the restocking by the night staff and communicating with unit secretary regarding low gown supplies throughout the day will be added to the charge board for each shift

Rivaroxaban (Xarelto®)

In December 2011, rivaroxaban, the first oral factor Xa inhibitor, was recommended for addition to the RGHS formulary by the Pharmacy and Therapeutics Committee. 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

Rivaroxaban is approved for the prophylaxis of deep vein thrombosis in patients undergoing knee or hip replacement surgery and reduction of risk of stroke and systemic embolism in non-valvular atrial fibrillation. **It is not yet approved for other diagnoses** such as DVT, PE, or prosthetic heart valves (mechanical or tissue).

Off-label use should only be considered if there is a strong compelling reason to consider rivaroxaban as an option. Hematology consultation is required for off-label use in VTE (new inpatient starts only).

RECOMMENDED DOSE

- Thromboprophylaxis in patients undergoing knee or hip replacement surgery
 - ♦ Rivaroxaban 10 mg orally daily starting at least 6 to 10 hours after surgery once hemostasis has been established
 - For those undergoing hip replacement surgery, the recommended treatment duration is 35 days
 - For those undergoing knee replacement surgery, the recommended treatment duration is 12 days
 - Not recommended for CrCl <30 mL/min or dialysis patients
- Stroke prevention for non-valvular atrial fibrillation
 - ♦ Rivaroxaban 20 mg orally daily with evening meal (CrCl > 50 mL/min)
 - ♦ Rivaroxaban 15 mg orally daily with evening meal (CrCl 15-50 mL/min)
 - Not recommended for CrCl <15 mL/min or dialysis patients
 - The 15 mg and 20 mg dose should be administered with food due to reduced bioavailability seen with higher doses

PHARMACOKINETICS

Rivaroxaban has a rapid onset of action within 2-4 hours after administration. It is primarily eliminated through the kidneys. The half-life is approximately 5-9 hours in healthy subjects, and increases to 11-13 hours in the elderly mainly due to reduced total body and renal clearance. It is a substrate of CYP3A4 and P-glycoprotein.

ADMINISTRATION

Absorption of rivaroxaban is highly dependent on the site of the drug release in the GI tract (gastric versus small intestine). A reduction in exposure can be seen when rivaroxaban is released into the small intestine versus the stomach. As a preventive measure, rivaroxaban will not be administered down any type of feeding tube.

CONVERSION FROM ANTICOAGULANTS OTHER THAN WARFARIN TO RIVAROXABAN

Unfractionated Heparin

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

Low-molecular weight heparins (e.g., enoxaparin) or dabigatran

Administer the first dose of rivaroxaban 0 to 2 hours before the next dose of the anticoagulant is due.

CONVERSION FROM RIVAROXABAN TO ANTICOAGULANTS OTHER THAN WARFARIN

Discontinue rivaroxaban and initiate the other anticoagulant when the next dose of rivaroxaban would have been due.

CONVERSION FROM WARFARIN TO RIVAROXABAN

Stop warfarin and begin rivaroxaban when the INR is below 3 to avoid periods of inadequate anticoagulation.

CONVERSION FROM RIVAROXABAN TO WARFARIN

Discontinue rivaroxaban and start both a parenteral anticoagulant and warfarin when the next dose of rivaroxaban would have been due.

RIVAROXABAN DISCONTINUATION PERIOD PRIOR TO PROCEDURE

Rivaroxaban should be discontinued at least 24 hours before the procedure. However, longer times may be considered in the elderly or those with known impaired renal function. Consider checking a PT and APTT prior to surgery to ensure it is within normal limits if elderly or renally impaired. Once further experience is gained with rivaroxaban, guidelines will be more defined.

ADVERSE REACTIONS

Rivaroxaban increases the risk of bleeding and may cause significant, and sometimes fatal bleeding. Overall, major bleeding rates were similar for rivaroxaban when compared to warfarin and enoxaparin for either indication. If severe bleeding occurs, discontinue rivaroxaban and obtain a hematology consult. There is no specific reversal agent available, although there is limited experience with prothrombin complex concentrate.

EFFECT ON LABORATORY PARAMETERS

No routine laboratory monitoring is necessary. The aPTT, PT, and Anti-Xa are increased but there is no established therapeutic range.

DRUG INTERACTIONS

Combined P-glycoprotein and strong CYP3A4 inhibitors or inducers should **not** be given concomitantly with rivaroxaban.

INSURANCE COVERAGE

Rivaroxaban is a Tier 2 medication for Excellus, and Tier 3 or non-formulary for other insurance plans at this time (e.g. MVP requires prior authorization, Tier 3). Please make sure that rivaroxaban is covered by your patient's insurance plan and that they are able to afford the co-pay before discharging them home.

KEY POINTS

- Although rivaroxaban is administered once a day, it has a relatively short-half life. As a result, a non-compliant patient is at an increased risk of thromboembolism if doses are missed.
- Rivaroxaban elimination is highly dependent on renal function. Specific recommendations are provided for patients with mild renal insufficiency. Rivaroxaban should be avoided in patients with severe renal insufficiency or dialysis.
- 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 rivaroxaban which may pose problems in those presenting with severe bleeds or need for urgent surgery. However, prothrombin complex concentrate may be an option in severe, life-threatening bleeds.

Drug	Effect on rivaroxaban	PI recommendations
Ketoconazole, itraconazole, ritonavir, conivaptan (combined P-gp and strong CYP3A4 <u>inhibitors</u>)	Significant increases in AUC and C _{max}	Avoid concomitant use of rivaroxaban with combined P-gp and strong CYP3A4 inhibitors
Carbamazepine, phenytoin, rifampin, St. John's wort (Combined P-gp and strong CYP3A4 <u>inducers</u>)	Decreases in AUC, C _{max} , and pharmacodynamics effects	Avoid concomitant use of rivaroxaban with combined P-gp and strong CYP3A4 inducers



Rochester General Hospital Edition

January 2012



PSYCHOLOGICAL STRESS AND THE HEART

Several decades of research indicate that chronic mental stress contributes toward developing cardiovascular disease (CVD). Various stress related hormones have been identified as playing a significant role in its development. The impact of anxiety and depression in the development of CVD is well known and documented.

In addition, acute psychological stress causes a number of physiologic responses that can trigger acute coronary syndromes.

If you would like copies of any of these articles, or if you would like further information on this or any topic, please contact any Library team member.

Chandola T. et al., "Work stress and coronary heart disease: what are the mechanisms?" *European Heart Journal*, 29(5):640-8, 2008 Mar.

Chumaeva N. et al., "Early atherosclerosis and cardiac autonomic responses to mental stress: a population-based study of the moderating influence of impaired endothelial function." *BMC Cardiovascular Disorders*, 10:16, 2010.

Fineschi V. et al., "Insight into stress-induced cardiomyopathy and sudden cardiac death due to stress. A forensic cardio-pathologist point of view." *Forensic Science International*, 194(1-3):1-8, 2010 Jan 30.

Ho RC. et al., "Research on psychoneuroimmunology: does stress influence immunity and cause coronary artery disease?" *Annals of the Academy of Medicine, Singapore*, 39(3):191-6, 2010 Mar.

Kubzansky LD. et al., "A prospective study of posttraumatic stress disorder symptoms and coronary heart disease in women." *Health Psychology*, 28(1):125-30, 2009 Jan.

Proietti R. et al., "Mental stress and ischemic heart disease: evolving awareness of a complex association." *Future Cardiology*, 7(3):425-37, 2011 May.

Soufer R. Jain H. Yoon AJ., "Heart-brain interactions in mental stress-induced myocardial ischemia." *Current Cardiology Reports*, 11(2):133-40, 2009 Mar.

Steptoe A. Brydon L., "Emotional triggering of cardiac events." *Neuroscience & Biobehavioral Reviews*, 33(2):63-70, 2009 Feb.

Vlastelica M., "Emotional stress as a trigger in sudden cardiac death." *Psychiatria Danubina*, 20(3):411-4, 2008 Sep.

Xu W. et al., "Job stress and coronary heart disease: a case-control study using a Chinese population." *Journal of Occupational Health*, 51(2):107-13, 2009.

Ziegelstein RC., "Acute emotional stress and cardiac arrhythmias." *JAMA*, 298(3):324-9, 2007 Jul 18.

Zupancic ML., "Acute psychological stress as a precipitant of acute coronary syndromes with undiagnosed ischemic heart disease: a case report and literature review." *Primary Companion to the Journal of Clinical Psychiatry*, 11(1):21-4, 2009.

Bibliography compiled by Lana Rudy, M.A., M.L.S.

WERNER HEALTH SCIENCES LIBRARY

585-922-4743 Voice
585-544-1504 Fax

<http://intranet/depts/medicalLibrary/medlib.asp>

Stabins Wellness Information Center

Patient Education Information

922-WELL (922-9355)

<http://www.rochestergeneral.org/library/wellnessinfocenter>

LIBRARY HOURS

Mon - Fri 8 AM – 9 PM
Sat 8:30 AM – 5 PM
Sun 12 NOON – 5 PM



www.shutterstock.com - 42840430

CYBERTOOLS

Library's Online Catalog

<http://maple.cybertoolsforlibraries.com/cgi-bin/CyberHTML?RGHRNYHO>



Patricia Lewis Adjunct Staff 2012 Award of Clinical Excellence

WHAT THE AWARD SIGNIFIES:

The Rochester General Hospital Medical and Dental Staff created this award of clinical excellence to be presented to one adjunct staff member annually. This individual will be recognized by The Medical and Dental Staff as excellent in patient and family care, collaborative with the healthcare team, and serve as a role model to other health care professionals. The award is named to memorialize Patricia Lewis who provided exemplary high level, competent, compassionate care and was a leader whose efforts yielded much recognition for Rochester General Hospital.

ELIGIBILITY:

All adjunct staff members at Rochester General Hospital are eligible.

EXCELLENCE QUALITIES/CHARACTERISTICS:

- o An asset to physicians in caring for patients
- o Patient-focused
- o An advocate for patients
- o Collaborative with interdisciplinary healthcare team members
- o Respectful of interdisciplinary contributions to patient care
- o Compassionate to others
- o Passionate about his/her profession
- o Involved in patient care planning and education
- o A teacher and/or mentor
- o Giving, thoughtful, polite, respectful
- o A role model for other healthcare professionals
- o Committed to the mission, vision, ethics and principles of practicing medicine

WHO MAY NOMINATE?

Any member of the Rochester General Hospital Medical and Dental Staff, past and present, or any Rochester General Health System employee or volunteer may nominate a candidate meeting the eligibility criteria.

NOMINATING PROCEDURE:

1. Write the name of the candidate ONLY ON THE COVER SHEET.
2. Three (3) nominators must collaborate on the nomination.
3. Complete all portions of the nomination packet.
4. You may attach letters and other supportive documents, if applicable.
5. Place the completed nomination packet in the ballot box in the Medical and Dental Staff Office by 4:00pm on Friday, February 3, 2012.

JUDGING PANEL/SELECTION OF WINNER:

1. Each submitted nomination packet will be assigned a number so the identity of the nominee is anonymous for judging purposes.
2. The judging panel consisting of the Medical and Dental Staff Elected Representatives, the last three Father George Norton Physician of Excellence Award winners and the last Pat Lewis Award winner will review each submitted packet.

ANNOUNCEMENT OF THE RECIPIENT:

The judging panel leader will notify the President of the Rochester General Hospital Medical and Dental Staff, Rochester General Hospital Medical Director, Vice President and Chief Nursing Officer, Senior Vice President of Academic and Medical Affairs, and the winning adjunct staff member's Chief of Service immediately following the judging. The Judging Panel Leader in consultation with the above mentioned individuals will determine the plan for notifying the winning adjunct staff member.

PRESENTATION OF THE AWARD:

1. The award will be presented at the March Quarterly Staff Meeting.
2. The award will be presented by the President of the Medical and Dental Staff or designee.

Nominator form on page 14.



RGH Patricia Lewis Adjunct Staff Award of Clinical Excellence

2012 Nomination Form

Adjunct Staff Member's Full Name:

Department (Specialty):

NOMINATOR #1

Name: Print _____

Signature: _____

Title: _____

Unit or Department: _____

NOMINATOR #2

Name: Print _____

Signature: _____

Title: _____

Unit or Department: _____

NOMINATOR #3

Name: Print _____

Signature: _____

Title: _____

Unit or Department: _____

**Submit the nomination to the Medical and Dental Staff Office by
4 pm, Friday, February 3, 2012 by faxing 922-4778.**

Your one Nomination Letter should include some of the Excellence Qualities/ Characteristics from the list on page 1 and describe in detail the manner in which this adjunct staff member portrays these individual qualities at Rochester General Hospital as well as identifying how the Adjunct Staff Member contributes to clinical excellence and makes them indispensable in caring for patients (give several examples). *Please maintain patient confidentiality if referencing individual patient situations (Mr. J.D., Mrs. J.D., etc.).*

Thank you for your time completing this nomination packet.

Rochester General Breast Center

The discovery of hereditary cancer genes demonstrated that susceptibility to cancer can be inherited as an autosomal dominant single-gene disorder. Research suggests that up to 10% of breast cancers are due to specific genes that are passed down in a family. Cancer risk assessment is an expectation across many healthcare disciplines as it is currently possible to identify individuals who have inherited mutations in critical genes that substantially increase the likelihood of certain cancers.

Increased availability of genetic testing is changing the primary and women's health care role in cancer genetics. Considerable research and societal guidelines outline the role of all providers in identifying and referring patients at elevated risk for cancer. Medical interventions are currently available that address increased cancer risk and offer life expectancy gains- including increased surveillance, surgical strategies and chemoprevention. Genetic counseling and testing for breast cancer susceptibility is an important component of the multidisciplinary breast cancer program at the Rochester General Hospital Breast Center.



individuals about hereditary cancer risk and the various medical management options. Implications of a positive and negative test result are addressed, as well as, technical accuracy, cost, potential psychological implications and strategies for surveillance or prevention.

Insurance coverage for the cost of genetic testing is widely available depending on established eligibility guidelines. DNA (either via blood or buccal swab) is submitted to a certified laboratory and result turn around time is often less than 2 weeks. Comprehensive pre and post-test counseling is provided to help individuals correctly interpret results and obtain the proper medical management. At-risk individuals have the opportunity to develop personalized cancer prevention programs with their physicians that can include timely screening, prophylactic and early-intervention strategies.

Breast cancer susceptibility testing provides useful information to members of high-risk families and allows for individualized medical management and accurate risk stratification. For more information please contact Kim Provenzano or Elizabeth Elmore, Nurse Practitioners in the Lipson Cancer Center at 922-4020.

Evaluation of family history is the single most useful tool in identifying individuals appropriate for genetic analysis. "Red Flags" for hereditary susceptibility to breast cancer include:

- Ovarian cancer
- Early-age-onset breast cancer (diagnosed < 50)
- 2 primary breast cancers in a single individual or on the same side of the family
- Male breast cancer
- Triple negative breast cancer (ER-, PR-, HER2-)
- Pancreatic cancer with a family history of breast, ovarian, or pancreatic cancers
- Ashkenazi ancestry with any history of breast, ovarian or pancreatic cancers
- A previously identified BRCA mutation in the family

The genetic testing process involves discussion with a trained clinician targeted at educating



From the GRIPA Medical Director

GRIPA Clinical Integration Committee

The GRIPA Clinical Integration Committee was inaugurated in 2005 for the purpose of guiding development of GRIPA's CI program and representing the concerns and interests of physicians participating in this venture; currently 661 (322 employed / 339 private) and growing.

At inception, there were many unknowns and tasks to be accomplished in prioritizing objectives, developing and implementing clinical guidelines and measures, as well as supporting the Clinical Integration concept in general. Term of service is 3 years, meeting monthly. From the first meeting to the present, there has only been one cancelled date; a tribute to the dedication and commitment of the members. 12 physicians, representing a cross section of primary care and specialty disciplines, dutifully accepted the initial invitation to serve and, at the end of their first terms, committed to another 3 years in the interest of maintaining direction and momentum.

In January of this year, six years into the project, 3 of those original 12 physicians have stepped down to offer the opportunity for other interested physicians to participate in sustaining the objectives thus far achieved and deepen their involvement in further improving and expanding the Clinical Integration Program. Each of these 3 physicians: Dr. William Rolls, Dr. Marvin Grieff, and Dr. Gary Wahl, has contributed immensely to guiding the development of GRIPA's Clinical Integration delivery model and, thereby, well-positioning us, GRIPA's physician and RGHS owners, to successfully participate in the rapidly changing national health care arena.

Please join me in thanking them for their service to us all...and consider following their example.

**Participate,
get involved,
it's worth it.**

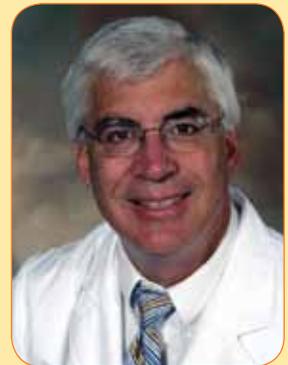
Jeff Dmochowski, CMO, GRIPA
Jeffrey.Dmochowski@rochestergeneral.org
585-233-2654 (phone)



Dr. William Rolls



Dr. Marvin Grieff



Dr. Gary Wahl

GRIPA has **moved** to the Riedman Campus!

As of January 23rd GRIPA is now located at
100 Kings Highway South, Suite 2500
Rochester, NY 14617.

