# MEDSTAFF NEWSLETTER

## UPSTATE UNIVERSITY HOSPITAL

MAY
2016

*IN THIS ISSUE:*



mailto:askmec@upstate.edu

### MESSAGE FROM THE MEDICAL STAFF PRESIDENT MITCHELL V. BRODEY, MD

As mentioned previously, the hospital has engaged a consultant to examine our process of call and coverage. We have a steering committee organized and chaired by Dr. Weiss. The medical staff members of the steering committee, Drs. Chen, Albanese, Weinstein, and myself, met with members of the hospital administration a couple of months ago . The consultants then interviewed 35 leaders of the medical staff to get an understanding of how call works, and how docs feel about it.

Friday, May 27, they brought their findings and their recommendations back to the committee, which included the following:

- Every department handles call differently. For some it is paid directly to the doctor, for others it may go into the department pool.
- The hospital provides different levels of financial support for each department in different forms. A few examples would be paying for call and medical directorship's salary support for residents, physician assistants, and/or nurse practitioners.
- Some physicians take call at both campuses and are paid. Some take call at both campuses and do not get paid. Some call services are provided by physicians in the faculty practice plan. Some call is provided by non-faculty plan physicians, and for some services, it is both. Some departments refuse to come to the community campus, so patients are transferred to the downtown campus for consultations.

The hospital feels it is being extorted, the physicians who are not supported feel exploited, and patients and families are not happy with the experience.

Several solutions were offered, including:

1. Many academic medical centers have one compensation system for all the academic departments that includes payments for all the work expected of the physician. The hospital could then subcontract support to the non-faculty practice plan physicians for services needed .This has been under discussion for years; when and if it happens remains to be seen and is above this committee's pay grade.
2. The hospital can build on what we have now and try to make it fairer and more equitable. In our current system, call coverage support comes in the form of contracts based on a per diem rate. Another way of doing it, especially for services where the burden of call is not as great, is on an activation method. If you get called in, you get paid, plus something for the restrictions and responsibilities that being on call implies.

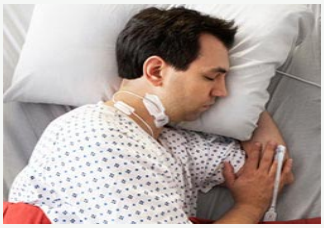
The consultants suggested a pilot program to look at hematology oncology, rheumatology, infectious disease, and endocrinology. We picked these because, currently, even though they are in one department, call is handled in all of the different ways previously described, making it a good study subject. They will bring this back to the committee in the next 4-6 weeks, and hopefully this plan can be implemented. If successful, it would be expanded to other departments. It may be just a Band-Aid for now, until a more comprehensive system is created, but right now we need the Band-Aid.

Hopefully this will result in a fair and transparent plan that will help provide the best patient-centered care for our patients.

## WELCOME NEW MEDICAL STAFF MEMBERS & APP MEMBERS

| | |
|---|---|
| Darielle Dartt, CRNA | Anesthesiology |
| Morgan King, CRNA | Anesthesiology |
| Fehid Mehic, NP | Anesthesiology |
| Erin Davies, DDS | Dental Surgery |
| Peter Moses, DD | Dental Surgery |
| Melissa Barton, PA | Medicine |
| Amit Bhardwaj, MD | Medicine |
| Sandra Gibson, PA | Neurology |
| Deborah Pflugh, NP | Orthopedics |
| Julie Middleton, NP | Psychiatry |
| Mihai Simionescu, MD | Psychiatry |
| Kyril Choumarov, MD | Surgery |
| Leah Marinelli, NP | Surgery |
| Sarah Leo, NP | Urology |

## MASIMO PATIENT SAFETY NET



The Masimo Patient Safety Net System is a bedside designed for use on the general medical/surgical units.
The system captures continuous pulse oximetry and has the capability for monitoring respiratory rate acoustically. The monitoring of the patients is wireless allowing the patients to be mobile. It provides nurse notification via vocera when any parameters are out of range. This system is designed to catch early desaturation and decreased respiratory rate in patients who are on narcotics, have OSA or bariatric patients.

It is currently installed on 6 and 4N at the Community Campus. The system will be coming to the Downtown Campus within the next few months, targeted for 5A, 5B and 7A.

**Downtown Campus is going live as follows:**

5A classes will be 6/6 and 6/7 on 5A with Go Live on 6/8/16

0500 – 0630
0730 - 0900
0930 – 1100
1130 – 1300
1330 – 1500
1600 – 1730
1800 – 1930

5B classes will be 6/20 and 6/21 on 5B class times should be the same as above with Go Live on 6/22/16

7A/B classes will be on 7/11 and 7/12 on 7A with Go Live on 7/13/16

**ALL ARE INVITED TO ATTEND THE CLASSES.**

## POLICY REVISION FOR KETAMINE INFUSION FOR THE MANAGEMENT OF PAIN POLICY # CM K-02 DOWNTOWN CAMPUS ONLY

http://www.upstate.edu/policies/documents/intra/CM_K-02.pdf *(New policy live on 5/ 1).*

Ketamine has been found to be particularly useful in patients with intractable pain and opiod tolerance resulting in a decrease in opiod use. Previously ketamine could only be administered in critical care, or palliative care areas. With this policy change, ketamine may be administered by nursing on a general medical-surgical floor **after** initiation and stabilization in the ICU or AP1. If a patient needs a ketamine bolus they will need to return to the ICU or AP1 for the bolus and stabilization prior to transferring back to the floor. Ketamine infusions are only ordered by Acute Pain Service/Anesthesia. Ketamine will be administered at a sub-anesthetic dose in the treatment of intractable pain in individuals > 40 kg and adults. *(This policy does not apply to the use of ketamine for anesthesia/sedation).* All other opiods or benzodiazepines for patients on ketamine are ordered by APS/anesthesia only.

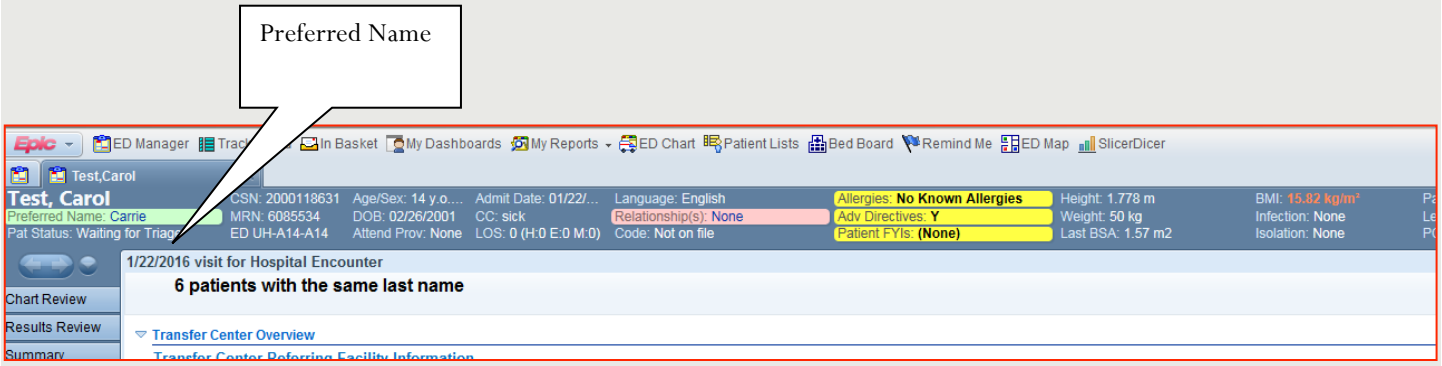
# Pharmaceutical Sample Policy

Change to Policy CM D-06 Pharmaceutical Sample Policy http://www.upstate.edu/policies/documents/intra/CM_D-06.pdf

Use of pharmaceutical samples are no longer prohibited. University Hospital will not charge for sample medications. Samples that are approved will only be for those patients meeting certain conditions as described in the policy (http://www.upstate.edu/policies/documents/intra/CM_D-06.pdf)

**Patient's Preferred Name**
**Starting June 1, 2016**

In addition to the legal name filed in EPIC there will also be listed a "preferred name" or "nickname" under the name field. The legal name remains the way we properly identify patients for all tests and treatments. The patient's preferred name is to help us "connect" to our patients.




# *Patient Experience Corner*:

We've started the conversation about communication & the essential elements of the communication model **ICARE** that we are adopting into practice. To refresh your memory, the acronym in its simplest form is: **I**-Introduce, **C**-Connect, **A**-Acknowledge, **R**-Review and **E**-Educate. The people we serve tell us that communication is important to them and that we can do better. Communication is a skill that needs to be developed and practiced.

In March 2016 I highlighted the first of five myths (*HCHAPS is only a hospital metric*) physicians believe about Patient Experience. These myths were shared in an article by The Advisory Board Company last year; we continue with the second myth mentioned in the article:

**Myth #2**: Patient experience is not a real clinical concern.

**Fact**: *Excellent patient experience-including **better** coordination and **clearer** communication drives clinical outcomes.*

"Eighty-nine percent (89%) of American adults are not proficient in health literacy; sixty percent (60%) of patients immediately forget the medical information explained to them. Yet studies show that patients listen closely when the physician is talking and care deeply about the physician's opinion. Excellent physician communication and strong care team coordination - both critical components of patient experience - are required to engage patients and achieve best outcomes."

Higher patient satisfaction is linked with lower thirty (30) day readmission rates (*American Journal of Managed Care*) and lower inpatient mortality rates through improved treatment plan adherence (*Circulation, Cardiovascular Quality and Outcomes*). There is also a correlation between patient-centered care and decreased use of care services and lower total charges (*Journal of the American Board of Family Medicine*).

Patient experience and clearer communication drive clinical outcomes; improving the patient experience is certainly something we all want for the health and well-being of our patients.

## FINAL SCHWARTZ ROUNDS OF 2016

SCHWARTZ ROUNDS
June 7, 2016
3:45 – 4:45
East Tower, 11405 A&B
All Staff Invited
Refreshments

**The Myth of Independence: The Challenge of Accepting Help**

We are used to giving help. After all we, no matter what our job title here, are in the helping professions. So how do we respond when we need help/support and even perhaps, need to ask for it?

What has been your experience of accepting help? Did you resist? Has it affected how you view a patient's experience of dependency?

Hearing each other's experiences and feelings on this issue is the purpose of this Schwartz Compassionate Care session.

Schwartz Rounds are NOT Root Cause nor problem solving forums. Rather they are the opportunity to talk and listen about things in our work life that bother us, cause us emotional upset or pleasure.

The Schwartz Rounds are open to all staff of University Hospital: Physicians, residents, faculty, nurses, students, therapists, social workers, spiritual care, housekeeping and other support staff. We speak from our own experience.

For more information, please contact: Rev. Virginia Lawson, PhD, Coordinator, Schwartz Center Rounds at Upstate. lawsonv@upstate.edu , 464-5596.

## MEC MEMBERS

**VOTING OFFICERS**
**Mitchell Brodey, MD**; Medical Staff President, Chair, Medical Executive Committee (Medicine, Infectious Disease)
**Leslie Kohman, MD**; Medical Staff Vice-President (Surgery, Thoracic)
**Howard Weinstein, MD**; Medical Staff Vice-President (OB/GYN)
**Satish Krishnamurthy, MD**; Medical Staff Treasurer (Neurosurgery)
**Bettina Smallman, MD**; Medical Staff Past President (Anesthesiology)

**MEMBERS-AT-LARGE**
**Lynn Cleary, MD**; (Medicine)
**Robert Corona, MD**; (Pathology)
**Timothy Creamer, MD**; (Medicine)
**Tanya George, MD**; (Medicine)
**Rolf Grage, MD**; (Radiology)
**David Halleran, MD**; (Colo-rectal Surgery)
**Po Lam, MD**; (Urology)
**Oleg Shapiro, MD**; (Urology)
**Zulma Tovar-Spinoza, MD**; (Neurosurgery)

**APP ELECTED REPRESENTATIVE**
**Thomas Antonini, PA**; (Surgery)

**EX-OFFICO, NON VOTING MEMBERS**
**Lisa Alexander, Esq**; Senior Managing Counsel
**Robert Carhart, MD**; Chair, Credentials Committee (Medicine)
**Hans Cassagnol, MD**; Chief Quality Officer (OB/GYN)
**Nancy Daoust, FACHE**; Chief Administrative Officer, Upstate University Hospital Community Campus
**David Duggan, MD**; Dean, College of Medicine, SUNY Upstate Medical University; (Medicine)
**Beth Erwin, CPCS, CPMSM**; Director, Medical Staff Services
**Sarah Fries, NP**; Associate Director of Nursing for Advanced Practice Services
**William Grant, EDD**; Associate Dean for Graduate Medical Education
**Bonnie Grossman, MD**; Associate Chief Medical Officer (Emergency Medicine)
**Danielle Laraque-Arena, MD**; President, SUNY Upstate Medical University (Pediatrics)
**Robert Marzella, MHA**; Chief Operating Officer
**John McCabe, MD**; Chief Executive Officer (Emergency Medicine)
**Nancy Page, RN;** Chief Nursing Officer
**Anthony Weiss, MD**; Chief Medical Officer and Medical Director (Psychiatry)