MEDSTAFF NEWSLETTER

UPSTATE UNIVERSITY HOSPITAL

APRIL 2014

IN THIS ISSUE:

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MESSAGE FROM THE MEDICAL STAFF PRESIDENT

BETTINA SMALLMAN, MD

The following is an anecdote that was recently shared when a group of professionals gathered. It is freely translated and somewhat modified.

"In one of the remotest corners of the Adirondack Park a rumor had been started and spread like wild fire: the local black bear had created a "wanted list" of several local forest animals that he was going to kill. Needless to say the news was met with curiosity and disbelief. Finally, the white tail deer approached the black bear and asked: am I on your wanted list? Yes, said the bear. Two days later the white tail dear was found dead. Great fear developed and the local wild hog could not help but ask the bear: am I on your wanted list? Yes, said the bear. Two days later the wild hog was found dead and true panic broke loose. It took all its courage for the rabbit to track down the bear and ask the question: am I on your wanted list? Yes, said the bear. The rabbit reflected for a moment and than asked: can you take me off your wanted list? The bear replied: certainly, no problem!"

Lesson learned from this anecdote: the rabbit survived. Communication is essential.

In a study by Hayes in 2009 up to 80% of patient errors in health care and social services resulted from negative conflict and poor communication.

Effective and professional communication does not just happen but needs to be acquired and practiced. It is key for the thoughtful delivery of bad news to a patient or sharing of important information among caregivers during daily clinical practice.

Bettina Smallman, MD

‘Hunker Down’
Anthony P. Weiss, MD, MBA

What is the best way to handle the winds of change? For some people, change is an opportunity, a chance to do something not possible during calmer weather. In Boston we’d get nasty Nor’easters, and the TV weather watcher would be filmed somewhere on Cape Cod, drenched in rain, fighting to stay upright with the hood of their coat whipping around. And inevitably, just behind them amidst the waves of the usually dull Atlantic, there would be surfers. Through the sounds of wind crackling in the television microphone, one could hear the shouts of bold exuberance from people riding the waves. A bit too adventurous, perhaps, but an example of surviving (and even thriving) in spite of adversity.

For others, the reaction to the threat of change can be a feeling of powerlessness and fear. In the face of uncertainty their tendency is to become as small as possible, to *hunker down*.

Hunker down. A funny phrase, one I’ve heard a lot recently. One that seems to reflect the response of many from within healthcare these days. The etymology is somewhat uncertain, but it appears to reflect the physical act of squatting to avoid a storm. For me, the connotation of hunker down relates to hiding, to isolation, to avoidance. It is a passive and defensive position.

I guess the thought is, “let’s keep our heads down and wait till the storm blows over.” So people focus on the task in front of them, limiting their exposure to additional risks. People move to protective mode, securing what they have for fear that the gusts will take it away.

This hunker down mentality, when sustained, is detrimental to the health of a community, an organization and a hospital. It limits collaboration, promoting silos and turf wars. It precludes the future-oriented planning that allows us to excel in the days to come. And it squelches the curiosity and risk-taking that are necessary for improvement and progress.

The weather here in Syracuse can be pretty nasty. I’m not suggesting we grab our boards and head to the lake. But I do hope we can come out of our storm shelters and develop enough courage to work together. In so doing, we can regain the sense of collaboration, preparation and innovation that will not only keep us safe, but will allow us to make the care we provide even better than what we were doing before the storm.

CORE MESASURE CORNER:

VTE Core Measures

- All hospital patient should be considered at risk for VTE
- Contraindications to VTE prophylaxis must be clearly documented
- If pharmaceutical prophylaxis is contraindicated, **please order SCDS** or other mechanical prophylaxis
- Patients with VTE being prescribed warfarin should have 5 days of overlap therapy with heparin, Lovenox or other parenteral anticoagulant therapy; or a reason for not providing overlap therapy must be documented

UPSTATE QUALITY GOALS

Louise A. Prince, MD, FACEP
Chief Quality Officer, University Hospital

Each year we set goals for quality improvement both to improve the quality of care rendered to our patients as well as to comply with requirements set forth by DNV, our accreditation agency. For 2014, we have chosen a number of high level goals that will assist with care improvement as well as many of our quality markers that are publically reported and used to compare our hospital to others. Because we use University Health Systems Consortium (UHC) as our benchmarking agency, for many of the goals we have chosen to strive for improvement to the UHC median as a minimum goal standard. **For many of the goals, we are below the UHC median currently.** UHC compares us with other academic hospital facilities in the United States. In 2014, the Quality Governance Sub Council has chosen:

1.) Reduction of Risk Adjusted Mortality in our overall patient population (see Chart 1)
2.) Reduction of Risk Adjusted Mortality for sepsis patients
3.) Reduction of 30 day all cause Readmissions
4.) Improvement of Patient Satisfaction (see Chart 2)
5.) Reduction of Central Line Associated Blood Stream Infections
6.) Reduction of Catheter Associated UTI's
7.) Improvement of our composite of SCIP (Surgical Care Improvement Project) score (see Chart 3)
8.) The Development of regular scorecards/dashboards for overall quality

It is important for all of our staff to be aware of these overarching goals. As providers, we can help by:

1.) Increasing our attention to documentation. Focusing on the admission history and physical of all patients. Pay special attention to the problem lists and ensure that diagnoses present and active on admission are marked as such as well as discussed in the initial assessment and plan.
2.) Answer all queries from the coding and clinical documentation staff.
3.) Participate in departmental quality and morbidity/mortality meetings where applicable.
4.) Identify potentially septic patients early and use the current treatment bundle. Ensure that they receive prompt antibiotics, fluid resuscitation, and that a lactate level is drawn.
5.) Participate actively in discharge planning.
6.) Be attentive to communication with patients. Discuss their diagnoses, plans, and results of tests in language that they can understand. Explain any new medications you are adding. Keep them as informed about their treatment and involved in their care as possible.
7.) Follow sterile technique for insertion of central lines. Document daily their necessity (PICC lines are considered central lines). Remove them promptly when no longer needed.
8.) Only order Foley catheter insertion when absolutely needed. Document daily the necessity of ongoing use. Remove them promptly when the patient no longer requires them (within 2 days for the majority of surgical patients).
9.) Be attentive to pre operative antibiotic choices as well as antibiotic choices for patients who present with pneumonia.
10.) As Core Measure education is offered to your department, be attentive to the requirements that are set forth by CMS. If you have questions, the Core Measure abstractors and Clinical Educator assigned to develop education on these measures can assist with answering and giving presentations to your department.

All that you do for our patients is highly appreciated as is the increased attention to quality improvement initiatives. It is very clear that quality improvement will be an ever increasing focus area for our patients and our institution especially in light of required measurements both statewide and nationally. As providers, we want to render the best patient care possible. Even though measurement of quality of care is controversial, we want to show the great care rendered here at Upstate when we are publically reported. Your active participation in quality within the institution is needed greatly. Please consider how you can help in this mission.

See the 3 charts on the following page.

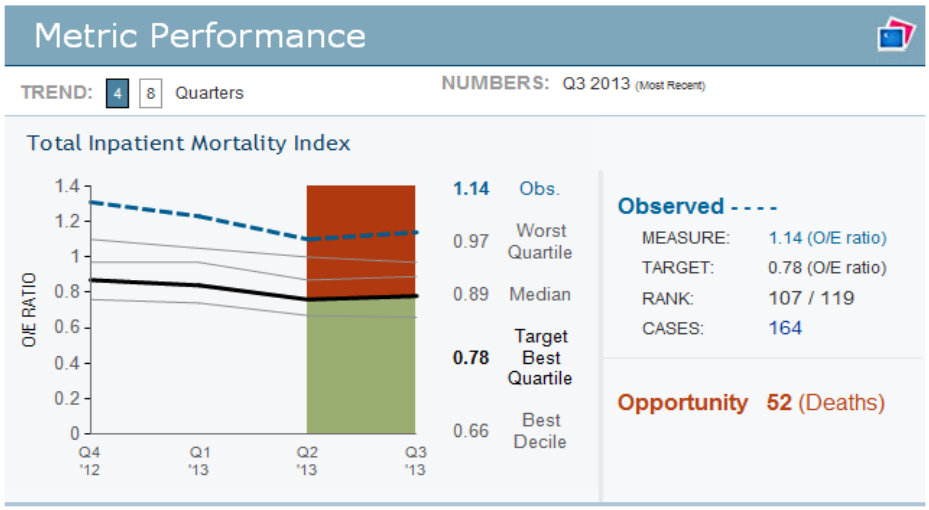

Chart 1

- Reduction of Risk Adjusted Mortality in accordance with the observed to Expected (O\E) aggregate
- Minimum Goal = UHC Median, Highest Goal is the best quartile

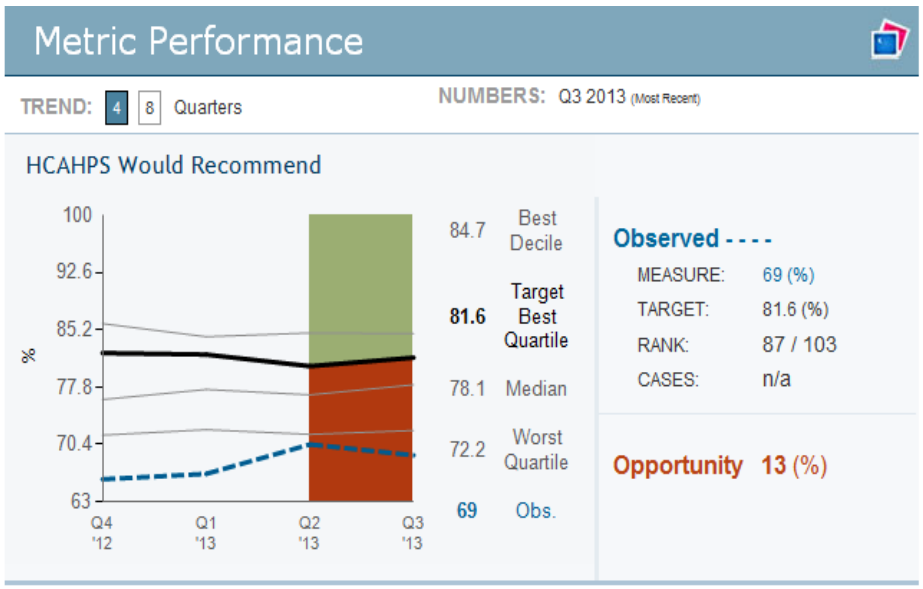

Chart 2

- Improve Patient Satisfaction – HCAHPS Would Recommend
- Minimum Goal = UHC Median, Highest Goal is the best decile

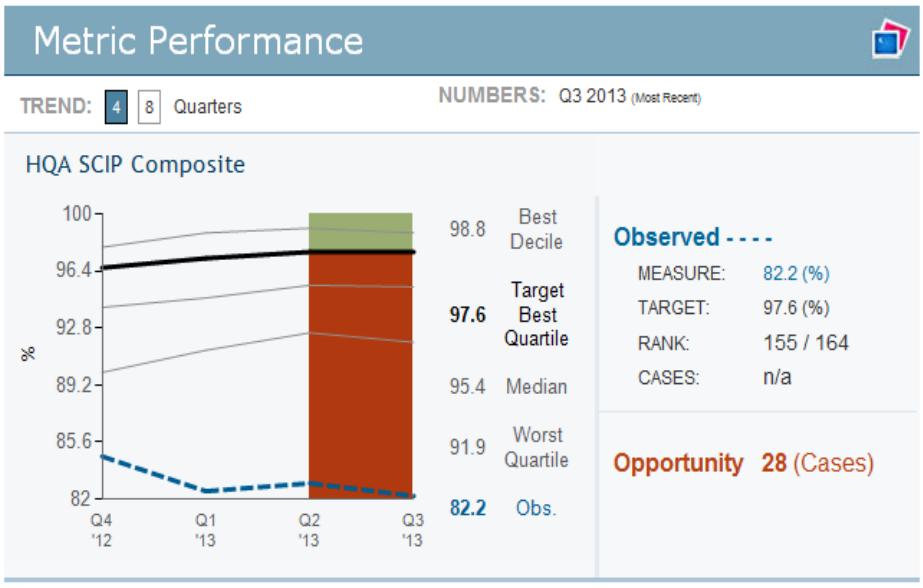

Chart 3

- Improve SCIP composite score for inpatients to 97% Compliance –Excellus set goal

WELCOME NEW MEDICAL STAFF & APC MEMBERS

Hak Chin, CRNA	Anesthesiology
Linda Lebedovych, CRNA	Anesthesiology
Samuel Alpert, MD	Ophthalmology

MEC MEMBERS

Bettina Smallman, MD; Medical Staff President, Chair, Medical Executive Committee (Pediatric Anesthesiology)
Mitchell Brodey, MD; Medical Staff Vice-President (Medicine)
Robert Kellman, MD; Medical Staff Vice-President (Otolaryngology)
Satish Krishnamurthy, MD; Medical Staff Treasurer (Neurosurgery)
Colleen E. O'Leary, MD; Medical Staff Past President (Anesthesiology)

MEMBERS AT LARGE

Tamer Ahmed, MD; (Pediatric Surgery)
Sharon Brangman, MD; (Medicine)
Derek Cooney, MD; (Emergency Medicine)
Timothy Creamer, MD; (Medicine)
David Halleran, MD; (Colo-rectal Surgery)
Leslie Kohman, MD; (Thoracic Surgery)
Kara Kort, MD; (Surgery)
Zulma Tovar-Spinoza, MD; (Neurosurgery)
Howard Weinstein, MD; (OB/GYN)

APC ELECTED MEMBER

Lisa Cico, NP; (Surgery)

EX-OFFICO, NON VOTING MEMBERS

Nancy Daoust, MS, FACHE; Chief Administrative Officer, Upstate University Hospital at Community General
Gregory Eastwood, MD; Interim President, SUNY Upstate Medical University
Beth Erwin, CPCS, CPMSM; Director, Medical Staff Services
Sarah Fries, NP; Associate Director of Nursing for Advanced Practice Services
William Grant, EDD; Interim Associate Dean for Graduate Medical Education
Bonnie Grossman, MD; Associate Medical Director (Emergency Medicine)
John McCabe, MD; Chief Executive Officer (Emergency Medicine)
Nancy Page, MS, RN; Interim Chief Nursing Officer
Paul Seale, FACHE; Chief Operating Officer

AD HOC, NON VOTING MEMBERS

Robert Carhart, MD; Chair, Credentials Committee (Medicine)
David Duggan, MD; Dean, College of Medicine, SUNY Upstate Medical University; (Medicine)
Louise Prince, MD; Chair, CQI Committee & Chief Quality Officer (Emergency Medicine)
Anthony Weiss, MD; Chief Medical Officer and Medical Director (Psychiatry)