

MEDSTAFF NEWSLETTER

UPSTATE UNIVERSITY HOSPITAL

FEBRUARY 2014

IN THIS ISSUE:

- Letter from Dr. Weiss
- Core Measure Corner
- EPIC Training
- New Medical Staff and APC members
- SAW Fair
- Pharmacy news

<mailto:askmec@upstate.edu>

MESSAGE FROM THE MEDICAL STAFF PRESIDENT

BETTINA SMALLMAN, MD

Something of an epic nature is going to start at Upstate University Hospital on March 1st at the Downtown Campus and on May 1st at the Community Campus. It is therefore only natural that this edition of the Medical Staff Newsletter is mainly dedicated to the implementation of an electronic health record system, EPIC, in just a few weeks. The change from paper records to mainly electronic [yes, paper will not completely become a thing of the past] that started several years ago will enter its final stage March 1, 2014. All medical staff - physicians, nurses, therapists and others - will have spent significant time in training and preparation for this moment. Looking back, the impetus for the long and hard process is:

One record. EPIC dramatically improves how information is gathered and shared with respect to a patient's medical history, medications, insurance and billing. There will be one source for relevant clinical information, such as allergies, problem lists, medications, and past surgeries. This technology will reduce paperwork, streamline workflows, reduce the risk for errors and maintain patient confidentiality.

Improved access. EPIC is a powerful tool that will help a hospital to continue its mission of delivering care with increased levels of patient safety, clinical quality and personal service.

Coordinated care. EPIC software allows hospitals and physician's offices to run more smoothly and work more closely together, providing highly efficient patient care through enhanced communications. It will result in simplified scheduling, automated medication management, and medical decision -support software.

The overall expectation is that quality of care for our patients is ultimately improved, as well as research capabilities, overall operation performance, and educational endeavors.

Having stated all of the above, it is clear that this is the description from the top of the mountain looking back after a long climb. We still have the journey ahead of us. All the highly advertised system flexibility is a double-edged sword, and the process thus far has been overwhelming, perhaps even

prickly-to say the least. It is equally important to acknowledge that change, and what a change, is frightening. As the launch date is approaching, expectations need to be realistic: there will be growing pains; despite everyone's best effort, services will be slower and frustration levels will be elevated. By the same token, reassurance has been given that resources are in place to make the transition as smoothly as possible. Needless to say, both communication and good collaboration are key.

On a personal note, I am looking forward to being able to say I have documented my pre- and postoperative notes for my first patients using EPIC. Not Mount Everest, but certainly an important hurdle taken!



Bettina Smallman, MD

Institutional Trust

Anthony P. Weiss, MD, MBA



I've been thinking a lot about trust recently. This must happen to people when they move to a new city. Back in Boston I knew where I could go to get an order of pad thai (without getting sick), where I could take my dry cleaning (without losing any shirts), and where I could drop off my kids (without worry about their safety). These are trust-based decisions. Most of the important decisions in life are.

In broad strokes, there are two types of trust: *personal trust* and *institutional trust*. Personal trust is developed on the basis of first-hand experiences with other individuals, often over a period of time. By working with someone we begin to understand them, respect them, trust them. If we don't have a personal connection, we rely on institutional trust, a feeling that an organization can be counted on to provide good and safe service. This is why so many of us will go to McDonalds when visiting a foreign country – knowing neither the people nor the language, we can trust that we will get something we are least somewhat familiar with when we order from the menu there.

So what does this have to do with health care? Everything. Especially for someone being hospitalized. In the past, your trusted personal doctor would admit you to the hospital, they would round on you every morning, and they would know many of the staff and could assure you of their competence. Your feeling of security is based on personal trust. Today, the hospitalized patient will never see their personal doctor. In fact their personal doctor may not even know they are in the hospital. Every person with whom they come in contact with is a stranger. And they are trusting their lives to this group of strangers collectively known as Upstate University Hospital. Their feeling of security is based on institutional trust.

Everything that occurs to that patient is either working to build or destroy this institutional trust. Everything. A broken piece of machinery, a stain on the ceiling, a cold dinner, a rushed conversation with a nameless doctor, a delayed call-bell response, a cancelled radiology procedure, a crude joke in the hallway. Collectively these form the patient experience and collectively they can destroy the trust we need to earn and keep.

What can we as physicians do to build institutional trust? We can begin by making sure the patient knows our name, knows what role we play, and knows how we connect to other members of the team. Sadly, this is not always happening. We need to model this for our trainees and expect that they do the same. We can also demonstrate that we explicitly trust and respect the other people involved with that patient's care – in doing so we convey that it is safe to trust these colleagues and safe to receive care from them. And we can ask our patients whether everything is ok with their care.

These small gestures are just the beginning, but if done consistently, will help to further build the institutional trust associated with Upstate. And if there is one quality benchmark for our hospital that I would emphasize, it would be that each of us would trust our closest family member with care here, without reservation or concern. Please help me to be sure this goal is realized.

Anthony Weiss, MD, MBA

CORE MESAURE CORNER: SCIP



When the encounter of a planned 23 hour surgical patient needs to exceed the 23 hour time-limit for medical reasons, (stays more than one night) the patient's encounter must be converted to an inpatient and a complete discharge summary is required.

EPIC TRAINING

There are 2 main tracks for training

1. If you are ambulatory trained already, you will need to complete a 6 hour class.
2. If you do not have ambulatory training, you will need to complete a 12 hour course (spread over 3 classes).

*Within each track, there are 2 versions of the courses-
1 for non-surgeons / non-proceduralists and 1 for surgeons/proceduralists.*

Upstate and St. Joseph's have agreed to honor each other's training, and will require only an abbreviated course if you have successfully completed training at the other institution. Training at Upstate is 12 hours (unless you are ambulatory trained), but would only require 6 hours of training if you successfully complete the St. Joseph's training. St. Joseph's requires 16 hours of training. If you are already trained at Upstate, it requires about 5 hours to complete the St. Joseph's abbreviated course with the proficiency test.

To schedule, please go to the Epic website from any hospital computer
<http://epic.upstate.edu>

From there, either go to the provider or the training areas and look for inpatient provider training.

The direct link is
<http://epic.upstate.edu/intra/training/inpatient-training/uh-provider.php>.

Click on the appropriate course links to see the available dates and times. Click on the class you want to complete the sign up. Please note that there are e-learning pre-requisites for each course that you must complete. Trainers have been collecting questions from training, which are shown on the Epic website in the "Parking Lot" in the documents section. Dictation in Epic is available, but encouraged to be used sparingly. It is done with a microphone directly into Epic, then transcribed and placed in your inbox for review before insertion into the medical record.

Once your training is complete, you can attend a personalization lab to get direct help with creating smart phrases and personal preferences. You can also use your credentials from training to try out what you have learned in the 'playground'.

Training is occurring now.

If you write notes in charts, do procedures, operate, bill, or write orders you will need to be trained prior to being able to continue your clinical work at Upstate.

Dr. Seidberg can be reached at 315-464-7507.

EPIC HOTLINE 315-464-EPIC

WELCOME NEW MEDICAL STAFF & APC MEMBERS

Michael Loudner, CRNA	Anesthesiology
Lynn Hale, NP	Psychiatry
Lori Peppers, MD	Psychiatry
Palma Shaw, MD	Surgery

2014 SAW FAIRS (Safety at Work)

WideWaters

Wednesday, March 19, 2014
12:00-4:00 PM, Purchasing/AG
Conference Rm

University Hospital -- DOWNTOWN Campus

Wednesday, April 16, 2014,
8:00 AM-4:00 PM, Rm. 1328B
Wednesday, October 15, 2014,
8:00 AM-4:00 PM, Rm. 1328B

University Hospital -- COMMUNITY Campus

Wednesday, June 11, 2014,
7:00 AM-1:00 PM, Community Room
Thursday, June 12, 2014,
11:00 AM-4:00 PM, Community Room
Friday, June 13, 2014,
10:00 AM-4:00 PM, Community Room

SAW CAN ALSO BE COMPLETED VIA BLACKBOARD:

1. Login at <http://bb.upstate.edu>
2. In the Courses tab, search the word SAW
3. Click on the DOWN ARROWS next to UH110 and select ENROLL

Enoxaparin Designated as the Preferred Pharmacologic VTE Prophylaxis Modality: An Initiative to Improve Therapy Compliance and Reduce Patient Discomfort

Existing literature and internal data reveal that venous thromboembolism (VTE) prophylaxis administration rates with subcutaneous heparin are lower when compared to enoxaparin. These differences have largely been attributed to the difference in administration frequency between the agents (two or three times daily for heparin versus once daily for enoxaparin). In addition to adherence, added benefits to using enoxaparin are likely to include reduced patient discomfort, reduced nursing administration time, and reduced risk for heparin induced thrombocytopenia. The acquisition cost of enoxaparin has also come in parody with low dose heparin in recent months after the introduction of generically available enoxaparin. Due to these considerations, the Hospital's Pharmacy and Therapeutics Committee enacted a quality improvement initiative at the downtown campus in January 2014. This initiative designated enoxaparin as the preferred pharmacologic therapy modality for VTE prophylaxis. Prescribers are encouraged to prescribe enoxaparin for VTE prophylaxis in appropriate patients. To help with this initiative, a therapeutic substitution policy was approved that allows pharmacy to substitute orders for subcutaneous heparin with enoxaparin unless the patient has severe renal dysfunction (creatinine clearance <15mL/min) or the prescriber writes "Dispense as Written" on the order.

Since policy enactment, a random subset of patients prescribed VTE prophylaxis are being identified and evaluated to track the progress of this quality improvement initiative. To date, 93 medicine patients have been evaluated. Of these 93 patients, 81 (87.1%) received enoxaparin for VTE prophylaxis and 12 (12.9%) received heparin. Of the 81 patients receiving enoxaparin, 31(38%) originally had orders placed for low dose heparin which were substituted with enoxaparin by pharmacy. Therapeutic substitutions with enoxaparin among these 31 patients resulted in a combined total of 78 patient injections being avoided per day. The majority of patients who received low dose heparin were not candidates for enoxaparin due to severe renal dysfunction. Overall administration rates for enoxaparin were 90% as compared to 72% for low dose heparin. Furthermore, 70% of enoxaparin-treated patients received 100% of their scheduled doses as compared to 33% of heparin-treated patients. The most common reason for missed doses was patient refusal.

These initial data demonstrate success with this initiative at increasing enoxaparin use for VTE prophylaxis and reducing injection burden for patients. Pharmacy will continue to track the progress of this initiative and share with medical staff periodically. Specifically, a more robust comparison of VTE administration compliance before and after the initiative will be evaluated.

Any questions can be directed to: Christopher Miller, Pharm.D., BCPS Associate Director of Clinical Pharmacy Services
millechr@upstate.edu

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-OFFICIO, 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)
Regina McGraw, JD; Senior Managing Counsel
Katie Mooney, RN, MS, NEA-BC; 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)