

# MEDSTAFF NEWSLETTER

UPSTATE UNIVERSITY HOSPITAL

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2015

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

At this month's MEC, we endorsed a proposal by the bylaws committee to reflect Upstate University Hospital's more open medical staff model.

Historically Upstate, like many (but not all), had been a closed medical staff. In order to practice at the downtown campus, one had to have a faculty appointment. With the acquisition of Community General Hospital in 2011, an open staff model was created at the Upstate Community campus, while the Downtown campus remained closed to faculty only.

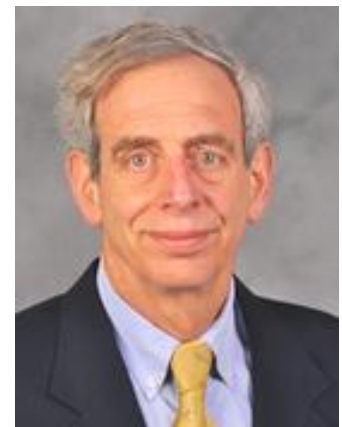
As we continue to work toward the concept of "one hospital, one medical staff, two campuses", it is difficult to justify the restriction of anyone with privileges to practice on only one of the campuses.

While in the end a faculty appointment may not be necessary, all physicians are encouraged to apply for faculty appointments to participate fully in the academic mission of the hospital.

Academic Chairs are free to appoint only the faculty they need, and medical staff physicians are under no obligation to apply. However, a faculty appointment is necessary to work with residents and students.

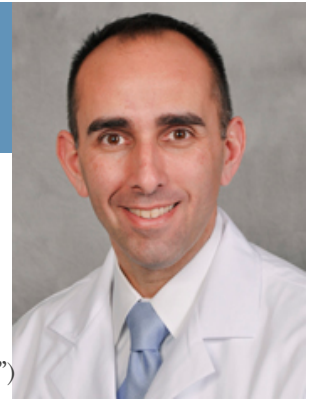
You will see, or have seen, these changes come out to you for discussion and comment; ultimately, the plan is for these changes to be taken to the entire medical staff for a vote. My expectation (hope) is that you will take some time to try to understand the issues. While this is a big change, and may appear threatening to some at first, in the long run we feel it will be better for the institution as a whole, and the patients we serve.

If you have questions or concerns please email me.



# THE VALUE EQUATION

## ANTHONY P. WEISS, MD, MBA



Last week I was in San Francisco for the Annual American Hospital Association Leadership Summit. Excellent meeting and I learned a ton. Several superb authors spoke about their work and its application to healthcare, including Dr. Atul Gawande (“Being Mortal”, “Checklist Manifesto”), Dr. Siddhartha Mukherjee (“Emperor of All Maladies”), Michael Lewis (“Moneyball”, “The Blind Side”) and Doris Kearns Goodwin (“Team of Rivals”). But perhaps the most compelling lecture was from a Harvard Economist named Michael Porter, whose 2006 book, “Redefining Healthcare”, has shaped the changing landscape of how hospitals and doctors get paid in the United States. I spent four hours listening to him discuss his perspective.

Porter is brilliant, having already made a name for himself in MBA circles with his work on competitive strategy (Google “Porter’s Five Forces” for a sense of this work). I can sum up his most recent work, saving you from reading the 506 pages, in a simple equation:

$$V = Q/C$$

The value (V) of healthcare is equal to the quality (Q) of that care divided by the cost (C) required to provide that care. Seems simple enough, and would seem like something we’d all want to know – what is the value of the care we are providing? But Porter argues that in fact none of us knows. None of us can actually provide these numbers, because we don’t measure them properly. He suggests that quality should be defined, not by process measures (e.g., antibiotics administered within a time window) but by outcomes defined by the patient (e.g., ease of ambulation, overall function). And costs are all too often equated to charges, rather than the actual cost incurred in providing care. He is not surprised that healthcare is struggling to succeed, as we are working in a “data free zone”.

Over the coming months we will attempt to emerge from this zone and begin an analysis of the patient-defined quality and activity-based costs of care for specific procedures or conditions here at Upstate. This is a critical step, for both the hospital and physicians, as increasingly payment is moving to “bundles” where our reimbursement will need to cover all care provided (in relation to a total knee replacement, for example). While on one hand, this is a daunting and dramatic change from the fee-for-service world we are used to. But on the other hand, I am excited, as with the right data we can dramatically improve the quality and efficiency of the care we are providing, and maintain a leadership role as the only academic medical center in Central New York. More to come...

## MEDICAL EXECUTIVE COMMITTEE SEEKS THREE CANDIDATES



### WELCOME NEW MEDICAL STAFF & APP MEMBERS

John Hergert, CRNA	Anesthesiology
Sigrud Marfo, CRNA	Anesthesiology
Parikshith Sumathi, MD	Anesthesiology
Jan Wong, MD	Anesthesiology
Leah Bennett, MD	Emergency Medicine
Rebecca Blue, MD	Emergency Medicine
William Dukes, MD	Emergency Medicine
Kevin Gaskin, MD	Emergency Medicine
Mark Suchowiecki, PA	Emergency Medicine
Muhammad Arif, MD	Medicine
Nabamita Bisen, MD	Medicine
Vikram Bisen, MD	Medicine
Angela Taylor, NP	Medicine
Avneet Singh, MD	Medicine
Abirami Sivapiragasam, MD	Medicine
Zachary Williamson, MD	Medicine
Zevidah Vickery, MD	OB/GYN
Naven Duggal, MD	Orthopedics
Brett Greenky, MD	Orthopedics
Lawson Smart, MD	Orthopedics
Jesse Ryan, MD	Otolaryngology
Wei Song, MD	Pathology
Robert Newmyer, MD	Pediatrics
Brian Tran, DO	Pediatrics
Molly Fischer, NP	Psychiatry
Lubov Leontieva, MD	Psychiatry
Rajiv Mangla, MD	Radiology
Aspan Ohson, MD	Radiology
Rebecca Swan, MD	Radiology
Yingzi Wang, NP	Surgery

Now is the chance for you and the members of your department to be part of the changing face of the medical staff at Upstate! The Medical Executive Committee (MEC) is seeking nominations for **3 Members-at-Large** to serve 3 year terms (January 1, 2016 to December 31, 2018). Members of the medical staff will vote for Members-at-Large based on their primary campus affiliation.

Positions being filled this year:

- **Downtown campus**
  - 2 Members-at-Large (3 year term 01/01/2016-12/31/2018)
- **Community campus**
  - 1 Member-at-Large (3 year term 01/01/2016-12/31/2018)

Incumbents are encouraged to run for re-election!

#### HOW TO NOMINATE A COLLEAGUE FOR A MEMBER-AT-LARGE POSITION:

Write a statement supporting your colleague, including what expertise or experience that physician would bring to the position. Send your statement to Beth Erwin, Director of Medical Staff Services, or a member of the nominations committee.

Ms. Erwin will follow up with the nominated individual to be sure that they are interested and willing to serve in this role, and will format your statements similarly to others, include the candidate's name and specialty, and provide the statement to the committee for their review.

#### HOW TO NOMINATE YOURSELF FOR AN MEMBER-AT-LARGE POSITION:

Write a personal statement that indicates why you are interested and what experience or special interest in medical staff governance you bring to the position. Send your statement to Beth Erwin, Director of Medical Staff Services, or a member of the nominations committee. Ms. Erwin formats the statements similarly, includes the candidate's name and specialty, and collects them for the committee for their review.

#### QUALIFICATIONS:

Members-at-Large must be a member of the Active category medical staff, may not be in provisional status, and must maintain status of good standing on the Medical Staff during their elected terms. Members-at-Large serve three year terms, starting January 1<sup>st</sup>, and ending December 31<sup>st</sup>.

#### DUTIES OF A MEMBER-AT-LARGE:

Members-at-Large shall represent and act on behalf of the Medical Staff by serving as voting members on the Medical Executive Committee. Bylaws Article 9, Section 4 has a full description. ([http://www.upstate.edu/policies/documents/intra/MSB\\_A-09.pdf](http://www.upstate.edu/policies/documents/intra/MSB_A-09.pdf), page 3)

Bettina Smallman, MD  
Past President, MEC  
Nominations Committee Chair

Timothy Creamer, MD  
Member, MEC  
Member, Nominations Committee

Tamer Ahmed, MD  
Member, MEC  
Member, Nominations Committee

Leslie Kohman, MD  
Vice President, MEC  
Member, Nominations Committee

# ICD -10 PROVIDER TIPS



## Provider Tip Sheet for ICD-10

### ICD-10 Compliance Date is October 1<sup>st</sup> 2015

Providers will be required to select ICD-10 diagnosis codes starting October 1<sup>st</sup> 2015. Providers can start to become familiar with ICD-10 codes using the EPIC diagnosis calculator (ambulatory) and EPIC problem list calculator (inpatient) beginning in August. Don't worry you won't need to know the ICD-10 alpha numeric code, you can enter descriptive language for the condition and EPIC will provide a list of possible codes for your selection.

### ICD-10 introduces new concepts in diagnosis coding

Manifestation codes: Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. Both codes should be used with ICD-10, the underlying condition code first followed by the manifestation code.

Combination codes: A single code used to classify two diagnoses.

Sequela (late effect): The residual effect after the acute phase of an illness or injury has terminated.

Laterality: Specifies whether the condition occurs on the left, right or is bilateral.

### Reminders for assignment of a diagnosis code

- Signs and symptoms should not be coded when a definitive diagnosis is known.
- Do not code probably, suspected, questionable, rule out or working diagnosis in outpatient settings. Use signs and symptoms.
- List first the diagnosis chiefly responsible for the services provided.
- Do not code conditions resolved that no longer require treatment.

### There are a number of identified benefits of ICD-10 transition

- ICD-10 better reflects current medical practice.
- ICD-9 is 30 years old, has outdated terms, and is inconsistent with current medical practice. ICD-9 was implemented in 1979!
- ICD-10 provides more specific data from clinical documentation than ICD-9.
- ICD-10 will provide better data for Physician quality profiles - mortality and morbidity and Physician utilization profiles - efficiency of treating patients.
- ICD-10 will improve public health reporting and tracking.
- ICD-10 structure will accommodate new codes. ICD-9 is running out of capacity and cannot accommodate addition of codes to reflect new diagnosis and procedures.

### How to get ready for ICD-10

- Consider your medical record documentation; will it include enough information to support ICD-10 coding?

Clinical documentation of key medical concepts is essential to assist coding staff in selecting specific ICD-10 codes and to support diagnosis assigned by a provider. Documentation should describe the patient's condition using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. As part of patient care, clinicians already document most concepts needed for ICD-10 coding. ICD-10 documentation should include where applicable the following items; condition, onset, etiology, location, laterality, severity, environmental factors, timing parameters, co-morbidities and complications, manifestations, healing level, findings and symptoms, external causes and the type of encounter.

- Providers are encouraged to identify top ICD-9 diagnosis codes used today and seek a mapping of those codes to ICD-10 to become familiar with new ICD-10 codes. Practice management and coding staff can assist providers in this effort.
- Become familiar with selecting ICD-10 codes in EPIC and consider the extra time that may be necessary.

*More resources can be found on the ICD-10 slide deck prepared for providers and on [www.upstate.edu/icd-10/](http://www.upstate.edu/icd-10/)*

## WHAT DO YOU THINK? GREGORY L. EASTWOOD, MD



### **Dying Isn't What It Used To Be**

And when Jacob had made an end of commanding (instructing) his sons, he gathered up his feet into the bed, and yielded up the ghost, and was gathered unto his people. - Genesis 49:33

We live longer than our grandparents did, we die for different reasons, we are less likely to die at home, and our dying costs more. Moreover, many of us will die after having received treatments that were unusual or unheard of two generations ago, such as potent drugs to sustain blood pressure, a tube in our trachea connected to a ventilator, and kidney dialysis. The description of Jacob's death - live a full life, make sure your children know your wishes, take to bed and, without lingering, depart this life - approximates a mode of death that was experienced as recently as one or two generations ago, but clearly does not describe the manner in which most people die in contemporary America.

Life expectancy at birth, which is the median number of years one is expected to live, has increased in the U.S. from 49 years for someone born in 1900, to 68 years in 1950, to 79 years in 2010 (1, 2). Women on average live a little longer than men and the averages are negatively affected by minority and low socioeconomic status. During the first part of the 20<sup>th</sup> century, gains in longevity were due mostly to eradication and control of infectious diseases, especially among children; improved water and sewage; and the advent of antibiotics, in particular, sulfa drugs in the 1930s and penicillin in the 1940s. Since then, prevention and control of adult diseases, especially heart disease and cerebrovascular disease, have accounted for further gains in life expectancy.

Although we live longer than our grandparents, our mode of dying is quite different and some experience a "social death" months to years before physiologic death occurs (3). Antibiotics, mechanical ventilation, artificial feeding, drugs to maintain blood pressure and cardiac function, and other means of sustaining or prolonging life have become routine. Further, whereas most people died in their own homes generations ago, now less than a quarter die at home; about half die in a hospital and another quarter die in nursing homes (4). Whereas dying at home used to be attended with little fuss and expense, now end-of-life care accounts for 10-12% of all health care spending (5) and about a quarter of the Medicare budget is spent on beneficiaries in their last year of life (6).

These changes in when, how, or even whether we die raise questions that are common now, but might have seemed strange and confusing to our grandparents. Should my life be extended at all costs, both financial and emotional? What is quality of life and how much does it matter to me? Who can make decisions about my health care when I am unable to make decisions? Can I control aspects of my dying, such as whether I am resuscitated if my heart stops (Do Not Resuscitate orders), whether I have a breathing tube or mechanical respiration (Do Not Intubate orders), or even whether I may die at home? Can I choose to kill myself under certain circumstances, such as is legally permissible in the states of Oregon, Washington, Vermont, and Montana? Should the costs at the end of life be controlled so that resources may be applied to other needs? Pervading these questions are the fundamental ethical principles of autonomy (self-determination), beneficence (doing good), non-maleficence (avoiding harm), and justice for individuals, for families, and for society.

Another set of important questions concerns the future. Humans always have yearned to recapture their youth (e.g., the Faust legend) and our society that celebrates the young does much to combat wrinkles, appear younger, and retard aging. But aging is inexorable. It is built into our genes and cells and organs. We may increase the likelihood that we will live a longer portion of our potential life span by being immunized, drinking clean water, avoiding smoking, practicing healthy habits, and maintaining appropriate weight. But, until recently, there was not much that we could do about extending the potential limit of human life, which seems to be about 120 years. However, our new knowledge of genetics, cloning, how cells reproduce, the role of telomeres - those little pieces of DNA at the tips of chromosomes that shorten with each cell division and when they become too short seem to stop cell reproduction - raises the possibility that people someday may be able to live for 200 years or longer. Is that what we want?

My grandma died at home,  
the place where she birthed my dad in the kitchen  
and raised a family and chickens and roses.  
No fuss and no expense,  
except for the undertaker, who laid her out in the parlor,  
where I, age three, gazed at her.

I probably will die in a hospital -  
that's where most people die -  
perhaps connected to a ventilator  
and with the correct level of blood pressure sustainer.  
And, oh yes, a six-figure bill for the insurance company  
and my heirs to figure out.

Grandma did not know about health care proxies.  
What was there to proxy about?  
She also was ignorant of DNR, DNI, and our existential  
questions -  
What does quality of life mean?  
Can I control my dying?  
Should the money be spent on someone who is not dying?

We live longer now,  
thanks to clean water, vaccines, pharmaceuticals  
...and ventilators and blood pressure sustainers.  
But living longer does not mean forever.  
It simply is a larger portion of what might have been.  
100 years, give or take, seems the limit.

Wouldn't it be great to live 200 years?  
Healthy, of course, and witty and unfoolish.  
But aging is inexorable.  
I don't have to tell you that.  
We are programmed to die.  
Death is built into our genes and cells and organs.

Can genetics, cloning, stem cells, long telomeres  
reprogram our genes and cells and organs?  
Recapture our youth?  
Extend our living?  
Render us immortal?  
...Or simply mortal for a while longer?

## References

1. Congressional Research Service, Library of Congress – August 16, 2006.
2. National Vital Statistics Reports, Vol. 60, No. 4, Jan 11, 2012.
3. Norwood F. The Maintenance of Life: Preventing Social Death through Euthanasia Talk and End-of-Life Care – Lessons from The Netherlands. Carolina Academic Press, Durham, 2009.
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5. Emanuel E. Cost savings at the end of life: what do the data show? *JAMA* 1996;275:1907-14.
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# ADMITTING AND DISCHARGE ORDERS



We have been experiencing difficulty in some instances obtaining the attending physician co-signature on admit orders recorded by Nurse Practitioners or Physician Assistants. The discharge process can not take place until there is a completed admission order in place and signed which includes a physicians co-signature if admit order was recorded by a mid level.

Once an NP or PA records an admit order, they indicate in EPIC a co-sign is required which creates a notification in the designated physician in-basket for incomplete records. It is very important that you sign these ASAP to avoid an unnecessary delay in the discharge of your patient.

Thank you for your prompt attention to this important matter.

## 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)

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**Sharon Brangman, MD;** (Medicine)

**Lynn Cleary, MD;** (Medicine)

**Timothy Creamer, MD;** (Medicine)

**Tanya George, MD;** (Medicine)

**Rolf Grage, MD;** (Radiology)

**David Halleran, MD;** (Colo-rectal Surgery)

**Po Lam, MD;** (Urology)

**Zulma Tovar-Spinoza, MD;** (Neurosurgery)

### APP Elected Representative

**Thomas Antonini, PA;** (Surgery)

### EX-OFFICIO, 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 at Community General

**David Duggan, MD;** Dean, College of Medicine, SUNY  
Upstate Medical University; (Medicine)

**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;** Associate Dean for Graduate Medical  
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**Bonnie Grossman, MD;** Associate Chief Medical Officer  
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**John McCabe, MD;** Chief Executive Officer (Emergency  
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**Nancy Page, RN;** Chief Nursing Officer

**Anthony Weiss, MD;** Chief Medical Officer and Medical  
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