MEDSTAFF NEWSLETTER

UPSTATE UNIVERSITY HOSPITAL

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

The December Medical Executive Committee (MEC) meeting was consumed with discussions about policies. The MEC has two roles when it comes to policies; approving them and enforcing them. The MEC is charged with monitoring the quality of medical care delivered at the hospital. Policies are a critical part of that quality process. Writing policies is a time consuming and sometimes frustrating process involving many different members of the medical community, often with very different areas of interest and expertise. Often physicians, because of lack of time or interest, are not involved in these discussions which may impact their practice. Often when physicians are involved, the policies may not adequately reflect the impact it would have on other physicians. Since there are over a thousand policies, this presents quite a workload. In the past this has been handled in one of two ways; a cursory review of all the policies or a review of very few.

We are currently working towards a more organized process that will enable us to do what we need to do within the time constraints that we all have.

The second part of policies is following through to make sure they are followed. Medical records completion can be done from your home, no longer requiring trips to the hospital. It is important that these records be completed in a timely manner so that they can be sent to the patients' physicians upon discharge from either the ER or inpatient status. Therefore, the rules that we have are being tightened up to adapt to the times, and are being enforced by the MEC when the clinical chief of service is unable or unwilling to make their department members adhere to the policies.

We are also combining some committees that were previously separated on their respective campuses, as well as adding new ones. We have started a Lab Formulary Committee of the medical staff. Infection control, pharmacy and therapeutics, and our peer review quality committees are in the process of being combined to provide cross-campus review of issues that arise. I am hopeful that with a free exchange of big ideas we will all be able to learn from each other, and improve the quality of care at Upstate.

DOCUMENT CONTROL

ANTHONY P. WEISS, MD, MBA

It has become *de rigueur* to complain about medical documentation, and the sagging quality of the medical record. Not a day goes by in which you won't hear a physician (typically of my generation or older), bemoaning the current state of our collective written record, typically slandering the Epic brand in the process. Perhaps no aspect of modern healthcare receives so much vitriol.

From where does this affect arise? I suspect it comes from a perception that our documentation is something other than our doctoring – that our note writing is some sort of obligatory exercise required by the government and other payers. Every moment spent documenting is a moment away from the "real" acts of being a physician – time spent with patients in the clinic, on the wards, or in the OR. So like any obligatory act, it serves as a target for our anger, and often receives short shrift.

I don't think this was always the case. But as the "required elements" have gotten longer and time-pressures on patient facetime have gotten shorter, the ratio of:

Physician Satisfaction: Joys of Doctoring and Teaching / Required Stuff

has gotten smaller and smaller. One wonders if this relates to the sense of burnout that is plaguing physicians nationwide.

Perhaps not surprisingly, the quality of our documentation actually appears to be worsening. Like anything viewed as a chore, our notes too often reflect a spirit of minimum necessary effort. This is equally concerning, as poor notes cannot be trusted by other physicians. As a neuropsychiatrist, I rely on the neurological and mental status exams to ascertain whether there has been a change in patient stratus. Can I be certain that "Cranial Nerves II-XII" were actually assessed and intact, and that this patient was truly "A&O x 3" at the time of admission? Other examples of documentation shortcuts present even bigger safety concerns. I suspect each of you can identify at least one case in which you saw something in the record that gave you pause.

The current state of affairs is unsustainable. As a nation we cannot have dissatisfied doctors, nor can we have an untrustworthy medical record. So, what can be done about it? I doubt the volume of required stuff will get any smaller. One option is to once again consider documentation as part and parcel of doctoring, and take pride in it. Interestingly both documentation and doctor come from the same Latin root – *docere* – which means to show or teach. Well written notes do exactly that, they show our thinking with regard to the diagnosis and course of treatment we are undertaking. And they can serve as education to other members of the treatment team – particularly in a subspecialized era in which our common body of medical knowledge is shrinking.

I know this may seem overly simplistic and naïve. But perhaps it's time for doctors to take control of our documentation and treat it like the important communication tool it was meant to be. When you write your next note, please keep this thought in mind – taking a few moments to show and teach can help restore trust in the written record, and may restore some satisfaction in your work as a doctor.

Hans Cassagnol, MD
Chief Quality Officer

Dear Colleagues,

I would like to take a moment to ensure that everyone is aware of Upstate's antibiogram. Within the antibiogram you will find organism/susceptibility data for both the outpatient and inpatient settings. This resource is found at the bottom of the clinical resource box at Epic login or can be directly accessed at the following URL http://www.upstate.edu/pathology/intra/pdf/Antibiotic_Susceptibility_Report.pdf

Recent case review highlights an opportunity to clarify that optimal antimicrobial selection varies between outpatient and inpatient populations. In the community, a patient presenting with an uncomplicated urinary tract infection may respond well to Trimeth/Sulfa, yet an inpatient would likely require a different antimicrobial selection for effective treatment. Kindly, take a moment to review our antibiogram and feel free to reach out to Infectious Disease staff for guidance in use.

Thank you. Dr. C

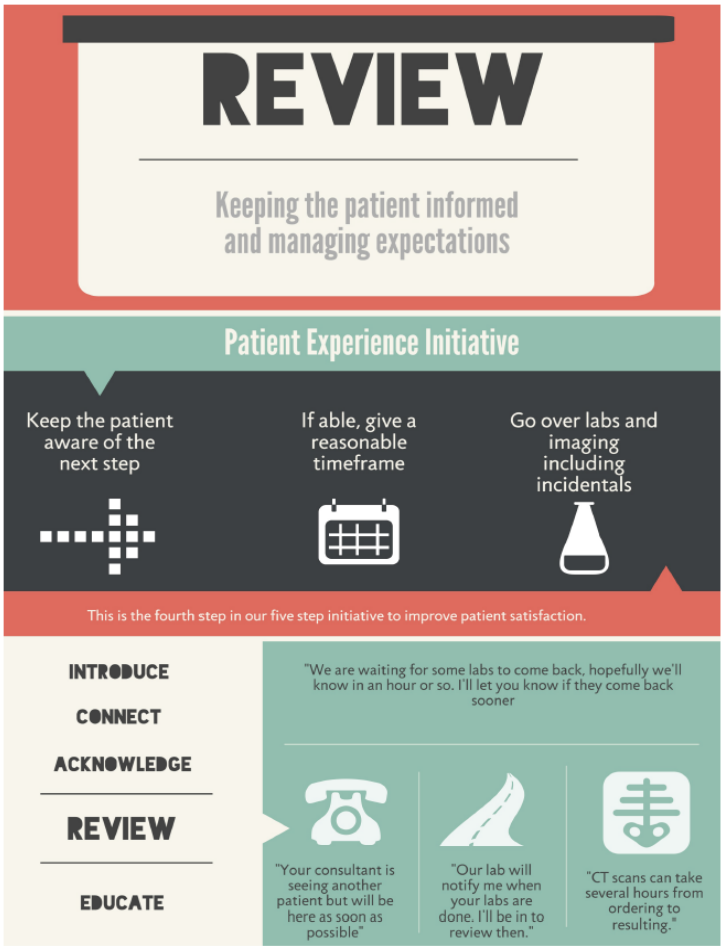
Patient Experience Corner: Continuing our focus on communication using the ICARE model.

	Essential Elements	Feelings associated with improved communication
I	Introduce/Inspire	Use "I" Statements, Interested
C	Connect/Contact	Care, Compassion, Customer Service, Courtesy
A	Acknowledge/Articulate	Amiable
R	Review/Remember	Respect, Reverence
E	Ensure/Educate/Express	Empathy

R=*Review, Remember, Respect, Reverence*

Review the plan of care, what tests and treatments are to be accomplished.

- Patients/families want to be a part of the care team; involve them when appropriate & necessary including the plan-of-care discussion.
- Explain what tests will be done & why.
- Allow the patient/family the opportunity to ask questions after any discussions.



Remember to say how long it is going to take.

- People want to know how long things will take; without being exact, give them an approximate time/length of procedure or test; always error on the side of caution and overestimate. You always want to **UNDERPROMISE AND OVERDELIVER**.
- If you tell someone you will be back in 30 minutes, make sure you are back in 30 minutes: giving them a realistic timeframe helps build trust and makes you good on your word.
- For the most part people are OK with delays; they just want to know they were not forgotten about; Check in on them & let them know you are aware they are waiting.

Respect/Reverence

- Treat people with respect & reverence; embrace diversity of background & what others can bring to the care team.
- Treat people how they want to be treated including making eye contact and greeting everyone you meet.
- Take the time to understand how your patient wants to be treated. Don't assume calling someone by their first name is appropriate unless they ask you to do so.
- Be respectful of the feelings, privacy, property, dignity and rights of all patients.

"One of the most sincere forms of respect is actually listening to what another has to say."
~Bryant H. McGill

WELCOME NEW MEDICAL STAFF & APP MEMBERS

Angela Mahajan, MD	Anesthesiology
Kelley Serens, NP	Emergency Medicine
Kevin Rosenberg, MD	Ophthalmology
Michael Sciarrino, NP	Radiology
Surya Kumar, MBBS	Surgery

Working with Medical Students

The College of Medicine (COM) is responsible for preparing everyone who works with and teaches medical students for their responsibilities. To assist with this, the Educational Program Objectives have been aligned with the ACGME objectives for residents, in order to better prepare medical students for their future role in residency. In addition, to be sure that the learning environment for medical students is conductive to the ongoing development of appropriate professional behaviors, faculty and staff treat all individuals with respect.

There are three policies you can review for additional information:

COM Graduation Competencies and Educational Program Objectives (EPOs): http://www.upstate.edu/com/document/objectives.pdf

Learning Environment and Mistreatment:
http://www.upstate.edu/com/document/mistreatment_policy.pdf

Professionalism:
http://www.upstate.edu/com/document/professionalism_policy.pdf

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)
Michael Iannuzzi,MD; (Medicine)
Po Lam, 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)
John McCabe, MD; Chief Executive Officer (Emergency Medicine)
Nancy Page, RN; Chief Nursing Officer
Anthony Weiss, MD; Chief Medical Officer and Medical Director (Psychiatry)