MEDSTAFF NEWSLETTER

UPSTATE UNIVERSITY HOSPITAL

MARCH 2016

IN THIS ISSUE:

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

We had the first meeting of the executive committee to discuss call. As you may recall, at the request of medical staff leadership, the hospital has hired a consultant to help in the process of developing a fair and equitable system of compensation for call coverage. This is necessary because the current bylaws and current practice are incompatible.

The medical staff members of the committee are Drs. Chin, Albanese, Weinstein, and I, and we all had an opportunity to express our opinions on the subject. The next step will be for the consultant to reach out to other leaders of the medical staff. They will need to know what the actual burden of call is, or how much time is actually involved in patient care. They will also need to know how much support the hospital and / or medical school already supply to the physicians in terms of midlevel and resident support. This, of course, brings up the issue of teaching vs. labor for the latter group, and the contributions of the medical service groups financially as well. There is also the issue of citizenship. Opinions range from compensation for all income lost by having to take call instead of being in the office to taking call as a necessity for hospital privileges for nothing, as it was in the good old days. Clearly, we will wind up somewhere in the middle.

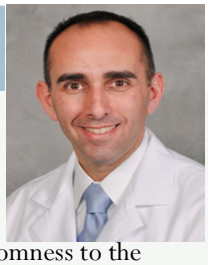
The medical staff is governed by a representative democracy. To make your thoughts and concerns heard, you need only make your opinions known to your clinical Chiefs of Service on your respective campuses so that they can be conveyed to the consultants, and then back to the executive committee.

We need a system that ensures that all patients in both campuses are taken care of in a patient-centered environment. There will be some costs involved on the part of the hospital and the various components of the medical staff. These kinds of discussions can bring out the best in people or the worst, and we will probably see both. There will need to be cooperation and compromise. Ultimately, the goal is to create a plan that is fair, and that even if everyone does not like, we will be able to live with. We can then finish the task of revising the bylaws accordingly.

And I will assume unless I hear otherwise that everyone is in agreement that infectious disease doctors will be receiving $10,000.00 a day for call, which we will take from anywhere in the world we want with Epic and a web cam.

FLIPPED CLASSROOM?

ANTHONY P. WEISS, MD, MBA



For those of you not directly involved with medical education nowadays, there is actually quite a bit of innovation occurring. In addition to revamping our pre-clinical curriculum, there has been an effort to bring the overall educational model in line with cultural changes, time pressures, and the needs of students. For example, most medical schools (including Upstate) are gradually implementing a concept known as the "flipped classroom" – an approach to education that is more learner-centric than teacher-centric. In the flipped classroom, students prepare for the class in advance, by reading or viewing videos on the subject matter in advance. The time spent with the teacher is then less didactic and more conversational, with an opportunity to explore issues raised by the readings.

While innovations like this are moving forward on the undergraduate and pre-clinical side, our educational model on the clinical side remains fairly staid. This is true nationally, not just at Upstate. The same model of pre-rounding, rounding, and scut lists largely look the same today as when I trained 20 years ago. While there is much value in this enduring approach (and I have personally witnessed some incredible hands-on teaching while shadowing some of our master clinicians), there is also ample opportunity for wasted time, and a randomness to the education that may not provide the breadth of experience our students and residents need.

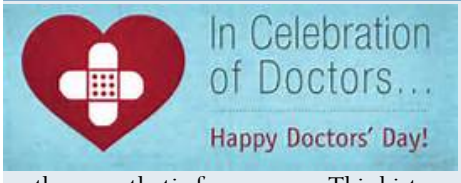
One area where the existing model comes in conflict with realities of modern healthcare is in the timeliness of discharge. While at the Community Campus two-thirds of patients are discharged before 2PM, the number Downtown is only 39% (and falling).

The implications of this are multiple:

- Patients get stuck in our ED waiting for beds, leading to overcrowding, poor patient experience, and delays in care
- Patients don't get home until late (nearly a fifth of patients downtown are discharged after 6PM!), meaning they cannot access services open normal business hours
- Back-ups in our ED and floors mean we need to decline transfers from outside hospitals and divert EMS traffic – patients who are critically ill who could benefit from our help

It's time to consider innovative models of inpatient care, models which do not distract from our educational mission as a teaching hospital. One approach, suggested by Dr. Tim Creamer, would be to implement *functional rounds* in the morning – working to discharge patients who can safely go home and see critically ill patients admitted overnight. *Didactic rounds* could then be conducted in late morning or early afternoon, where interesting or complex cases can receive attention and presentations on the latest literature can be considered. This timing would better allow discharges to take place and would permit teaching to occur at a time of day when time pressures are slightly less acute.

Perhaps this concept will not work here at Upstate. But we need to think together about ways in which we can innovate to provide education in the context of modern healthcare realities and pressures. "That's the way we've always done it" can no longer be the rationale – as we've seen with flipped classrooms, new approaches can work and must be considered. In part, this innovation is our duty as we prepare physicians to work in this reality in the years ahead. I hope we can begin the discussion and even lead the way forward in this area. I welcome your ideas.



Doctor's Day is March 30. We would like to wish all of our physicians a happy Doctor's Day and say thank you for all your hard work and efforts. We appreciate everything you do for our patients.

On March 30, 1842, Dr. Crawford W. Long of Jefferson, Georgia, administered the first ether anesthetic for surgery. This history making achievement and the continuous efforts by doctors to alleviate human suffering has become the basis for celebrating Doctor's Day. Doctors of all specialties are honored on Doctor's Day. In 1990, President George Bush signed into law a Joint Resolution of the U.S. Congress proclaiming March 30th of each year as National Doctor's Day.

Everyone understands that our physicians are important to our communities not only as caregivers, but as neighbors and civic leaders. Our doctors are part of our communities and are part of our families, so we want to be sure to publicly thank and acknowledge them for their vital role in caring for the sick, advancing medical knowledge, and promoting good health.

In celebration and recognition, a donation from the Upstate University Hospital Medical Staff has been made to the Salt City Hope Fund.

Patient Experience Corner:

We've spent the last 5 months talking about communication & the essential elements of Upstate's preferred communication model; ICARE. To refresh your memory, the acronym in its simplest form is:

I-Introduce, **C**-Connect, **A**-Acknowledge, **R**-Review and **E**-Educate.

Our patients tell us that communication is important to them and that we can do a better job with the information we are giving the people we serve. Communication is something that needs to be developed and practiced. Patients are telling us they do not understand the information we are giving them; assessing what your patient already knows may help guide the education you deliver and save you time.

Over the next five months I am going to share with you five myths about Patient Experience. You may have seen these myths were in an article by The Advisory Board Company last year.

Myth 1: **HCAHPS is only a hospital metric.**

Fact: ***Patient Experience has direct financial ramifications for physicians.***

Medical liability is greater if patients are dissatisfied. There is a direct correlation between low patient satisfaction scores and malpractice suits.

The Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CGCAHPS) survey is a standardized tool to measure patient perceptions of care delivered by a provider (e.g. physician, nurse practitioner, physician assistant, etc.) in an office setting; this public reporting is tied to future reimbursement.

Social media platforms are increasing consumer information, thus influencing market share for providers. Patient reviews revolve around how they perceive their patient experience. Patients can now choose their provider based on these Amazon-type, perception-based reviews.

Patient perceptions are their reality; we need to consider improvements in communication based on how our patients feel their care was delivered.

"*Excellent patient experience is a critical piece of modern medicine, reflected clearly in outcomes. More than amenities, clean rooms, or keeping quiet during the night, the factors that most reflect Patient Experience all relate to communication and coordination among the care team; factors that physicians are in a unique position to influence. Clinician-patient communication, leadership of the care team, and support and empathy for the patient across the unit are the most important factors for success, and they're all driven by the physician as the "Influencer-in-Chief."*
Advisory.com/pec/patientexperience, 2015

SCHWARTZ ROUNDS
April 5, 2016
3:45 – 4:45
East Tower, 11405

PANELISTS:
Colleen O'Leary, MD; Anesthesiology, Gene Latorre, MD; Neurology, Emily Watson, BSN Unit 6H

Just Because We Can Doesn't Mean We Should (Or Does it?)

There can be disagreements between clinical specialties and disciplines as to what is appropriate treatment for a critical patient especially when that patient has a poor prognosis and there are (opinion here) no curative treatments available. Hearing each others' views and philosophies on this issue is the purpose of this Schwartz Compassionate Care session.

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

WELCOME NEW MEDICAL STAFF & APP MEMBERS

Lynda Karpick, CRNA	Anesthesiology
Shikhar Soni, MD	Anesthesiology
Parvin Azizi, MBBS	Neurology
Janice Bach, MD	Pediatrics
Melanie Comito, MD	Pediatrics
Sherri McMullen, NP	Pediatrics
Lori Peppers, MD	Psychiatry
Donald Bitto, MD	Radiology
Kopresh Gudi, MBBS	Radiology
Stacey Patterson, MD	Radiology
Amir Paydar, MD	Radiology
Cynthia Wallentin, MD	Radiology

Appointment to the NY State Board of Midwifery

Kathleen Dermady, DNP, CNM, NP has been elected to serve as Chairperson of the New York State Board of Midwifery beginning April 2016. Ms. Dermady has served on the Board a representative for the 5th Judicial District since 2009. Members of the Board of Midwifery advise and assist the Board of Regents and the State Education Department on matters of professional regulation, professional preparation, and conduct.

Board members provide advice on licensing requirements, licensing examinations and practice issues, and provide community outreach, as well as participate in licensure discipline and/or restoration and moral character proceedings.

There are currently 1160 licensed midwives practicing in NY state. This is the first time a midwife from Upstate NY has served as chairperson since 1994. Congratulations to Ms. Dermady for this outstanding achievement!

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)