AGENDA

REGULAR MEETING OF THE BOARD OF DIRECTORS
ERIE COUNTY MEDICAL CENTER CORPORATION
TUESDAY, NOVEMBER 17, 2015

I. CALL TO ORDER: KEVIN M. HOGAN, ESQ., CHAIR

II. APPROVAL OF MINUTES OF OCTOBER 20, 2015 REGULAR MEETING OF THE BOARD OF DIRECTORS

III. RESOLUTIONS MAY BE DISTRIBUTED TO THE BOARD OF DIRECTORS DURING THE MEETING ON NOVEMBER 17, 2015.

IV. REPORTS: PRESIDENT &ACTING CEO REPORT – THOMAS J. QUATROCHE JR.,PH.D.
CHIEF FINANCIAL OFFICER REPORT – STEPHEN GARY

V. REPORTS FROM STANDING COMMITTEES OF THE BOARD:

EXECUTIVE COMMITTEE:	KEVIN M. HOGAN, ESQ.
FINANCE COMMITTEE:	MICHAEL A. SEAMAN
HUMAN RESOURCES COMMITTEE:	MICHAEL HOFFERT
QI PATIENT SAFETY COMMITTEE:	DOUGLAS BAKER

VI. EXECUTIVE LEADERSHIP REPORTS TO THE BOARD OF DIRECTORS:

VII. REPORT OF THE MEDICAL/DENTAL STAFF: OCTOBER 26 , 2015

VIII. EXECUTIVE SESSION

IX. RETURN TO OPEN SESSION

X. ADJOURN

MINUTES OF THE REGULAR MEETING
OF THE BOARD OF DIRECTORS
TUESDAY, OCTOBER 20, 2015
STAFF DINING ROOM

Voting Board Members Present:	Bishop Michael Badger Ronald Bennett K. Kent Chevli, M.D. Kevin E. Cichocki, D.C. Jonathan Dandes	Kathleen Grimm, M.D. Sharon L. Hanson Michael Hoffert Kevin M. Hogan, Esq Thomas P. Malecki, CPA Michael A. Seaman
Voting Board Member Excused:	Douglas H. Baker Ronald Chapin	Anthony Iacono Joseph Zizzi, Sr., M.D.
Non-Voting Board Representatives Present:	Richard C. Cleland James Lawicki	
Also Present:	Samuel Cloud, D.O. A.J. Colucci, III, Esq Jim Dolina Leslie Feidt Kelley Finucane Stephen Gary Susan Gonzalez Al Hammonds Mary Hoffman	Julia Culkin-Jacobia Chris Koenig Susan Ksiazek Charlene Ludlow Nadine Mund Brian Murray Thomas Quatroche Karen Ziemianski

I. CALL TO ORDER

Chair, Kevin M. Hogan called the meeting to order at 4:30 P.M.

Jon Dandes asked for 100% participation from the ECMCC and Lifeline Board of Directors for the annual fund campaign for ECMC. Please fill out pledge cards and return to Stacy Roeder or Sue Gonzalez. The hospital staff donations are close to $100,000.

II. APPROVAL OF MINUTES OF SEPTEMBER 29, 2015 REGULAR BOARD MEETING.

Moved by Bishop Michael Badger and seconded by Jonathan Dandes.
Motion approved unanimously.

III. ACTION ITEMS

A. Resolution Approving the Governance Committee Charter.
Moved by Jonathan Dandes and seconded by Kevin Cichocki, D.C.
Thomas Malecki abstained.
Motion Approved Unanimously.

B. Resolution Approving Revisions to the ECMCC Code of Ethics.
Moved by Michael Hoffert and seconded by Jonathan Dandes.
Motion Approved Unanimously

C. Resolution Approving Amendments to the ECMCC Bylaws.
Moved by Jonathan Dandes and seconded by Michael Hoffert.
Motion Approved Unanimously.

D. Resolution Approving Revisions to ECMCC Conflict of Interest Policy
Moved by Kathleen Grimm, M.D. and seconded by Michael Hoffert.
Motion Approved Unanimously

E. Resolution Approving the Mission of the Corporation.
Moved by Michael Hoffert and seconded by Jonathan Dandes
Motion Approved Unanimously

F. Approval of October 6, 2015 Medical/Dental Staff Appointments/Re-Appointments.
Moved by Michael Hoffert and seconded by Kathleen Grimm, M.D.
Motion Approved Unanimously.

IV. PRESENTATION – NADINE MUND, CORPORATE COMPLIANCE OFFICER

Nadine Mund provided an overview of duties and responsibilities of the ECMCC corporate compliance officer, including the compliance work plan, DSRIP compliance initiatives, interaction with JCOPE, and the duties of ECMCC board members.

PRESENTATION – ANTHONY COLUCCI, III, ECMC LEGAL COUNSEL

Mr. Colucci's presentation accompanied the board's consideration of the first five (5) resolutions noted above. He provided an overview and explanation of the regulatory basis for the board's actions and answered questions concerning board committee structure as well as other governance matters.

Mr. Colucci noted that there currently are several proposed changes that will be recommended for the board's consideration relating to procurement matters. These changes will be reviewed at a subsequent meeting of the board.

IV. BOARD COMMITTEE REPORTS

All reports except that of the Performance Improvement Committee are received and filed in the October 20, 2015 Board book.

V. REPORTS OF CORPORATION'S MANAGEMENT

A. Chief Executive Officer:

Chief Executive Officer: Richard C. Cleland

- Many staff members from the third floor relocated to various offices due to water damage to the third floor; approximately $300,000 in damage. The flood started from the fourth floor behavioral health adolescent gym.
- September's volumes have been strong.
- Approximately $287,000 operating profit in September 2015.
- Three construction projects are underway;
  - Radiology-CT Scan,
  - Cardiac Cath Lab - replacement table
  - Renovation to the Orthopaedic clinic.

Chief Financial Officer: Stephen Gary

A summary of the financial results through September 30, 2015 and a Quarterly Financial Statement and projected statement of Yearly Cash Flows are attached in the Board Book for review.

Steve is working on developing more specific benchmarks for financial ratios to compare with other public hospitals. He provided an overview of results with other hospitals.

VI. **RECESS TO EXECUTIVE SESSION – MATTERS MADE CONFIDENTIAL BY LAW**

Moved by Kathleen Grimm, M.D. and seconded by Michael Hoffert to enter into Executive Session at 5:30 pm to consider matters made confidential by law, including certain compliance-related matters, strategic investments, and business plans. **Motion approved unanimously.** During Executive Session, the board was given a verbal presentation concerning executive compensation process and historic earnings. No action was taken during executive session, however.

VII. RECONVENE IN OPEN SESSION

Moved by Michael Seaman and seconded by Bishop Michael Badger to reconvene in Open Session at 6:10 P.M.

Motion approved unanimously

VIII. ADJOURNMENT

Moved by Michael Hoffert and seconded by Bishop Michael Badger to adjourn the Board of Directors meeting at 6:10 P.M.

Sharon L. Hanson

Sharon L. Hanson
Corporation Secretary

Resolution Approving Governance Committee Charter
Approved October 20, 2015

WHEREAS, the Corporation is a body corporate and politic constituting a public authority and public benefit corporation; and

WHEREAS, the New York State Authorities Budget Office does, from time to time, issue guidance for public authorities pertaining to the manner in which public authorities may wish to conduct business and other affairs of the authority; and

WHEREAS, the New York State Authorities Budget Office has issued guidance pertaining to the need for and content of a charter for a board-level governance committee; and

WHEREAS, the Governance Committee of the Board of the Corporation reviewed the proposed charter language and, on October 5, 2015, voted to recommend its approval by the Board of the Corporation;

NOW, THEREFORE, the Board of Directors resolves as follows:

1. The Corporation approves the Governance Committee Charter in substantially the form as is presented.

2. This resolution shall take effect immediately.

Sharon L. Hanson

Sharon L. Hanson
Corporation Secretary

Resolution Approving Revisions to the ECMCC Code of Ethics
Approved October 20, 2015

WHEREAS, the Corporation is authorized by law to make, adopt, amend, enforce and repeal rules for its governance and internal management; and

WHEREAS, since 2004, the Board of the Corporation has adopted a Code of Ethics to govern the conduct of members of the Board and employees of the Corporation; and

WHEREAS, the New York State Authorities Budget Office has issued guidance pertaining to the need for and content of a code of ethics for a public authority such as the Corporation; and

WHEREAS, the Governance Committee of the Board of the Corporation reviewed the proposed revisions to the Code of Ethics language and, on October 5, 2015, voted to recommend its approval by the Board of the Corporation;

NOW, THEREFORE, the Board of Directors resolves as follows:

1. The Corporation approves the revisions to the language of the Code of Ethics in substantially the form as is presented.

2. This resolution shall take effect immediately.

_____ Sharon L. Hanson __
Sharon L. Hanson
Corporation Secretary

Resolution Approving Amendments to the ECMCC Bylaws
Approved October 20, 2015

WHEREAS, the Corporation is authorized by law to make and alter bylaws for its organization and management and to make and alter rules and regulations governing the exercise of its powers and the fulfillment of its purposes; and

WHEREAS, the Corporation has adopted bylaws governing its organization and management and, at this time, desires to alter those bylaws in several respects; and

WHEREAS, the Governance Committee of the Board of the Corporation reviewed the proposed revisions to the Bylaws of Erie County Medical Center Corporation and, on October 5, 2015, voted to recommend the approval of those revisions by the Board of the Corporation;

NOW, THEREFORE, the Board of Directors resolves as follows:

1. The Corporation hereby waives the thirty (30) day waiting period in accordance with the language of Article XII of the Bylaws of Erie County Medical Center Corporation.

2. The Corporation hereby approves the revisions to the language of the Bylaws of Erie County Medical Center Corporation in substantially the form as is presented.

2. This resolution shall take effect immediately.

Sharon L. Hanson

_____

Sharon L. Hanson
Corporation Secretary

Resolution Approving Revisions to ECMCC Conflict of Interest Policy
Approved October 20, 2015

WHEREAS, the Corporation is authorized by law to make, adopt, amend, enforce and repeal rules for its governance and internal management; and

WHEREAS, board members and employees of the Corporation owe a duty of loyalty and care to the Corporation and have a fiduciary responsibility to always serve the interests of the Corporation above their own personal interests when conducting public business; and

WHEREAS, board members and employees have the responsibility to disclose any conflict of interest, including any situation that may be perceived as a conflict of interest, to this Board and the public; and

WHEREAS, the New York State Authorities Budget Office has issued guidance pertaining to the need for and content of a conflict of interest policy for a public authority such as the Corporation; and

WHEREAS, the Governance Committee of the Board of the Corporation reviewed the proposed revisions to the Conflict of Interest Policy and, on October 5, 2015, voted to recommend the approval of those revisions by the Board of the Corporation;

NOW, THEREFORE, The Board of Directors resolves as follows:

1. The Corporation approves the revisions to the language of the Conflict of Interest Policy in substantially the form as is presented.

2. This resolution shall take effect immediately.

_____ Sharon L. Hanson ____

Sharon L. Hanson
Corporation Secretary

Resolution Approving the Mission of the Corporation
Approved October 20, 2015

WHEREAS, Chapter 506 of the Laws of 2009 ("The 2009 Public Authorities Reform Act") added a new Section 2824-a in Public Authorities Law requiring state and local public authorities to develop and adopt a mission statement; and

WHEREAS, every public authority is also expected to annually review its mission statement; and

WHEREAS, the Corporation previously adopted its mission statement, vision and core values and this board has reviewed these statements in accordance with guidance from the New York Authorities Budget Office;

NOW, THEREFORE, the Board of Directors resolves as follows:

1. The mission statement of the Corporation is hereby approved in substantially the form as presented to this Board and without change at this time from the existing language.

2. This resolution shall take effect immediately.

_____ Sharon L. Hanson _

Sharon L. Hanson
Corporation Secretary

CREDENTIALS COMMITTEE MEETING
October 6, 2015

Committee Members Present:
Robert J. Schuder, MD, Chairman
Yogesh D. Bakhai, MD
Richard E. Hall, DDS PhD MD
Mark LiVecchi, DMD MD MBA

Medical-Dental Staff Office and Administrative Members Present:
Tara Boone, Medical-Dental Staff Services Coordinator
Judith Fenski, Credentialing Specialist
Kerry Lock, Credentialing Specialist
Riley Reiford, Medical-Dental Staff Office Systems Coordinator

Members Not Present (Excused *):
Brian M. Murray, MD *
Mandip Panesar, MS MD *
Susan Ksiazek, RPh, Director of Medical Staff Quality and Education *

CALL TO ORDER

The meeting was called to order at 3 PM by Dr. Robert J. Schuder. The proceedings from the previous meeting of September 1, 2015 were reviewed and accepted with the following update: Dr. Misbah Ahmad rescinded his resignation prior to the September Medical Executive and Board meetings. His re-appointment is included for this meeting, and is within the 24 month interval defined by accrediting and regulatory bodies.

The Committee welcomed Riley Reiford to the Medical-Dental Staff Office as the Systems Coordinator. Riley brings the necessary expertise to the provider Dictionary initiative and to enhance department operations with optimization of the IntelliCred software.

ADMINISTRATIVE

The Credentials Committee was made aware of recent resignations, application withdrawals, leave requests or conclusions and presents the following names for information:

A. Deceased
B. Applications Withdrawn

Abbatessa, Laurie, ANP	Internal Medicine
Rein, Jason, ANP	Internal Medicine

C. Application Processing Cessation
D. Automatic Processing Conclusion – (inactive applications > 180 days from date of signature by next meeting)

Burdick, Abbey, PA-C	Internal Medicine
Sullivan, Erin, PA-C	Internal Medicine

E. Resignations

Donnelly, Megan, PA-C	Emergency Medicine	08/14/2015
Ahmad, Anees, MD	Family Medicine	10/01/2015
Schonour, Christine, ANP	Family Medicine	06/01/2015
Sweet, Ann, PA-C	Internal Medicine	09/09/2015
Whiteside, Alyssa, PA-C	Internal Medicine	08/31/2015
Hoeplinger, Mark, MD	Otolaryngology	11/30/2015

Rong, Rong, MD, PhD	Pathology	09/04/2015
Fallahian, Amir, MD	Radiology/Teleradiology	09/30/2015

FOR INFORMATION

CHANGE IN STAFF CATEGORY

Internal Medicine

Mahl, Thomas, MD — From Associate Staff to Active Staff

Psychiatry

Kashin, Jeffrey, MD — From Active Staff to Courtesy Staff, *Refer & Follow*

Mostert, Marcelle, MD — From Active Staff to Courtesy Staff, *Refer & Follow*

FOR OVERALL ACTION

DEPARTMENT CHANGE or ADDITION

Internal Medicine to **Family Medicine**

Schregel, Kristin, FNP

Collaborating Physician: Dr. Stephen Evans

FOR OVERALL ACTION

CHANGE OR ADDITION OF COLLABORATING/SUPERVISING PHYSICIAN

Family Medicine

Schregel, Kristin, FNP

Collaborating Physician: Dr. Stephen Evans

FOR INFORMATION

PRIVILEGE ADDITION/REVISION, recommended – comments as indicated

Surgery

Posner, Alan, MD

-Ureter – elective surgery other than transplantation

-Groin dissection

Committee discussion: No activity at ECMC. Conversion to Courtesy Refer and Follow was discussed with Chief of Service at review of re-appointment file. The above listed privileges active at primary affiliation; to defer FPPE until practitioner has clinical activity at this institution.

FOR OVERALL ACTION

PRIVILEGE WITHDRAWAL

Surgery

Posner, Alan, MD

-Pericardiocentesis

-Swan-Ganz catheter placement

-Vascular surgery as part of Trauma Surgery

-Excision of infected vein

-Urinary, bladder –cystotomy

-Ovaries & tubes – incision or excision

-Breast – simple incision & excision

-Mastectomy – radical

-Cervical trachea – plastic excision

-Esophagus – plastic repair, stricture, fistula, etc. -Esophagus – diverticulum (thoracic)
-Esophagus – tumor – excision
-Amputation
-Ligate artery or vein
-Rib biopsy
-Varicose vein ligation with or without stripping
-Bronchoscopy
-Cervical node biopsy
-Esophagoscopy -Esophageal dilation
-Skin lesion excision

FOR OVERALL ACTION

APPOINTMENT APPLICATIONS, recommended– comments as indicated

A. **Initial Appointment Review (14)**

Emergency Medicine
McNamara, John, DO — Active Staff

Family Medicine
Scarpelli, Francesco, ANP — Allied Health Professional
Collaborating Physician: Stephen Evans, MD
Verostko-Slazak, Sherry, ANP — Allied Health Professional
Collaborating Physician: Stephen Evans, MD

Internal Medicine
Kallash, Mahmoud, MD — Active Staff
Linder, Christine, NP — Allied Health Professional
Collaborating Physician: Christopher Jacobus, MD
Schap, Ruth, NP — Allied health Professional
Collaborating Physicians: Bruce Troen, MD
Wheat, Deidre, MD — Active Staff

Neurosurgery
Dimopoulos, Vassilios, MD — Active Staff

Ophthalmology
Rouhani, Behnaz, MD — Active Staff

Orthopaedic Surgery
Forestal, Lisa, PA- C — Allied Health Professional
Supervising Physician: Nicholas Violante, DO

Psychiatry
Pell, Brian, MD — Active Staff
Perry, Char'lese, NP — Allied Health Professional
Collaborating Physician: Michael Cummings, MD

Radiology/Imaging Services
Femia, Ronald, MD — Active Staff

Radiology/Imaging Services - *Teleradiology*
Esmaeli, Azadeh, MD — Active Staff

FOR OVERALL ACTION

REAPPOINTMENT APPLICATIONS, recommended – comments as indicated

B. **Reappointment Review (38)**

Dermatology	
Sinha, Animesh, MD	Active Staff
Emergency Medicine	
Krause, Richard, MD	Active Staff
Family Medicine	
Mure, Joseph, MD	Active Staff
Schregel, Kristin, FNP	Allied Health Professional
Collaborating Physician: Dr. Stephen Evans	
Toland, Suzanne, ANP	Allied Health Professional
Collaborating Physician: Dr. Stephen Evans	
Internal Medicine	
Ahmad, Misbah, MD	Active Staff
Carlson, Richard, MD	Associate Staff
Cunningham, Eugene, MD	Active Staff
Freer, Jack, MD	Active Staff
Khan, Saleem, MD	Associate Staff
Kielbasa, Jennifer, PA-C	Allied Health Professional
Supervising Physician: Dr. Justine Krawczyk	
Mahl, Thomas, MD	Active Staff
Malayala, Srikrishna, MD, MPH	Active Staff
Milling, David, MD	Active Staff
Ryan, Augustine John, MD	Active Staff
Schregel, Kristin, FNP	Allied Health Professional
Collaborating Physician: Dr. Stephen Evans	
Sridhar, Nagaraja, MD	Active Staff
Neurology	
Benedict, Ralph, PhD	Allied Health Professional
Oral & Maxillofacial Surgery	
Boyczuk, Edward, DMD	Active Staff
Boyczuk, Michael, DDS	Active Staff
Orthopaedic Surgery	
Wheeler, Dale, MD	Associate Staff
Pathology	
Krabill, Keith, MD	Active Staff
Marchetti, Elizabeth, MD	Active Staff
Sands, Amy, MD	Active Staff
Psychiatry	
Anker, Jeffrey, MD	Associate Staff
Coggins, Evelyn, MD	Active Staff
Kashin, Jeffrey, MD	Courtesy Staff, *Refer & Follow*
Mostert, Marcelle, MD	Courtesy Staff, *Refer& Follow*
Rehabilitation Medicine	
Baker, John, PhD	Allied Health Professional
Salcedo, Daniel, MD	Active Staff
Surgery	

Anain, Shirley, MD	Active Staff
Cherr, Gregory, MD	Active Staff
Hoerner, Audrey, ANP	Allied Health Professional
Collaborating Physician: Dr. William Flynn	
Hofert, Misty, PA-C	Allied Health Professional
Supervising Physician: Dr. Joseph Caruana	
Paolini, Karen, ANP	Allied Health Professional
Collaborating Physician: Dr. Sunil Patel	
Posner, Alan, MD	Active Staff
Rossney, Nicole, PA-C	Allied Health Professional
Supervising Physician: Dr. Joseph Caruana	
Urology	
Sufrin, Gerald, MD	Active Staff

Minimal to no activity at ECMC. The committee advises formal confirmation of a request from the applicant (or COS) to remain on Active Staff. Such has already been done as part of the MDSO due diligence preparing the re-appointment dossier. As per the Urology Chief of Service, Dr. Sufrin takes second call and so, Active Staff category with clinical privileges remains appropriate.

FOR OVERALL ACTION

PROVISIONAL APPOINTMENT REVIEW, recommended

The following members of the Provisional Staff from the previous year period are presented for movement to the Permanent Staff in 2015 on the date indicated.

October 2015 Provisional to Permanent Staff		**Permanent Period Begins**
Emergency Medicine		
Baumler, Nicole, Jean, MS PA-C	Allied Health Professional	10/1/2015
Supervising MD: David P. Hughes, MD		
McCormack, Robert, Foster, MD	Active Staff	10/1/2015
Obstetrics/Gynecology		
Swenson, Krista, Marie, MD	Active Staff	10/1/2015
Internal Medicine		
Beintrexler, Heidi, MD	Active Staff	10/1/2015
Claus, Jonathan, Ashley MD	Active Staff	10/1/2015
Pathology		
Liu, Weigno, MD PhD	Active Staff	10/1/2015
Psychiatry		
McCunn, Kara, Lynn, MD	Active Staff	10/1/2015
Surgery		
Dominguez, Ivan, MD	Active Staff	10/1/2015

The future December 2015 Provisional to Permanent Staff list has been compiled for Chief of Service review and endorsement.

FOR OVERALL ACTION

AUTOMATIC CONCLUSION, Reappointment Expiration, FIRST NOTICE

Internal Medicine		
Levine, Michael, MD	Active Staff	12/31/2015

AUTOMATIC CONCLUSION, Reappointment Expiration, SECOND NOTICE

Internal Medicine

Tirunagari, Deepthi, MD	Active Staff	11/30/2015

AUTOMATIC CONCLUSION- Reappointment Expiration, FINAL NOTICE

None

Reappointment Expiration Date: as indicated above
Planned Credentials Committee Meeting: October 6, 2015
Planned BOD Action Date: October 20, 2015
Planned MEC Action date: October 26, 2015
FOR OVERALL ACTION

OLD BUSINESS

Department Name Change

Last month, a department name change was completed for physician forms in the newly named Department of Thoracic/Cardiovascular Surgery. Privilege forms for NPs and PAs will also be updated accordingly. ~~**DEPARTMENT OF CARDIOTHORACIC SURGERY**~~

DEPARTMENT OF THORACIC/CARDIOVASCULAR SURGERY
Nurse Practitioner Privilege Delineation Form
Physician Assistant Privilege Delineation Form

Initial Appointment Flag at September Meeting

The committee was informed that the Practitioner Wellness Committee endorsed the applicant and the appointment was granted by the Board of Directors at its September meeting.

American College of Physicians Correspondence

The committee received and reviewed an update issued by the ACP regarding the ABIM board certification process. The goal is to recommend a Maintenance of Certification program that would be defensible, relevant, and both engaging and efficient for physicians. At the same time, it would provide the public with a useful, valid assessment of physician competence. The above was provided for information and discussion, no formal action required. The committee was reminded of the proposed change in the bylaws pending organized medical-dental staff vote on November 9th, which will allow for certification by other recognized as criteria for membership.

Provisional to Permanent List for November Action

Because initial appointments from the November 2014 meeting were combined with the December 2014 group by the Board of Directors, there will be no action list prepared for the November 2015 Credentials meeting. Both groups will be presented at the December 2015 Credentials meeting.

WellCare Delegated Credentialing Audit

Though the written report has not yet been received, the auditor informed us that we again scored 100%.
Congratulations and thank you to the Medical-Dental Staff Office team!

Temporary Privilege Tracker
Refer to the attached tracker of Urgent and Temporary Privilege issuance and expiration.

FOR OVERALL ACTION

NEW BUSINESS

Psychiatry Privilege Form
At the request of the Chief of Service, the designation for Admitting privileges will be moved from the form cover page to the Level I Core Privilege Section. The COS request was endorsed by the committee.

~~**ADMITTING PRIVILEGES: Active or Associate Staff Categories only**~~

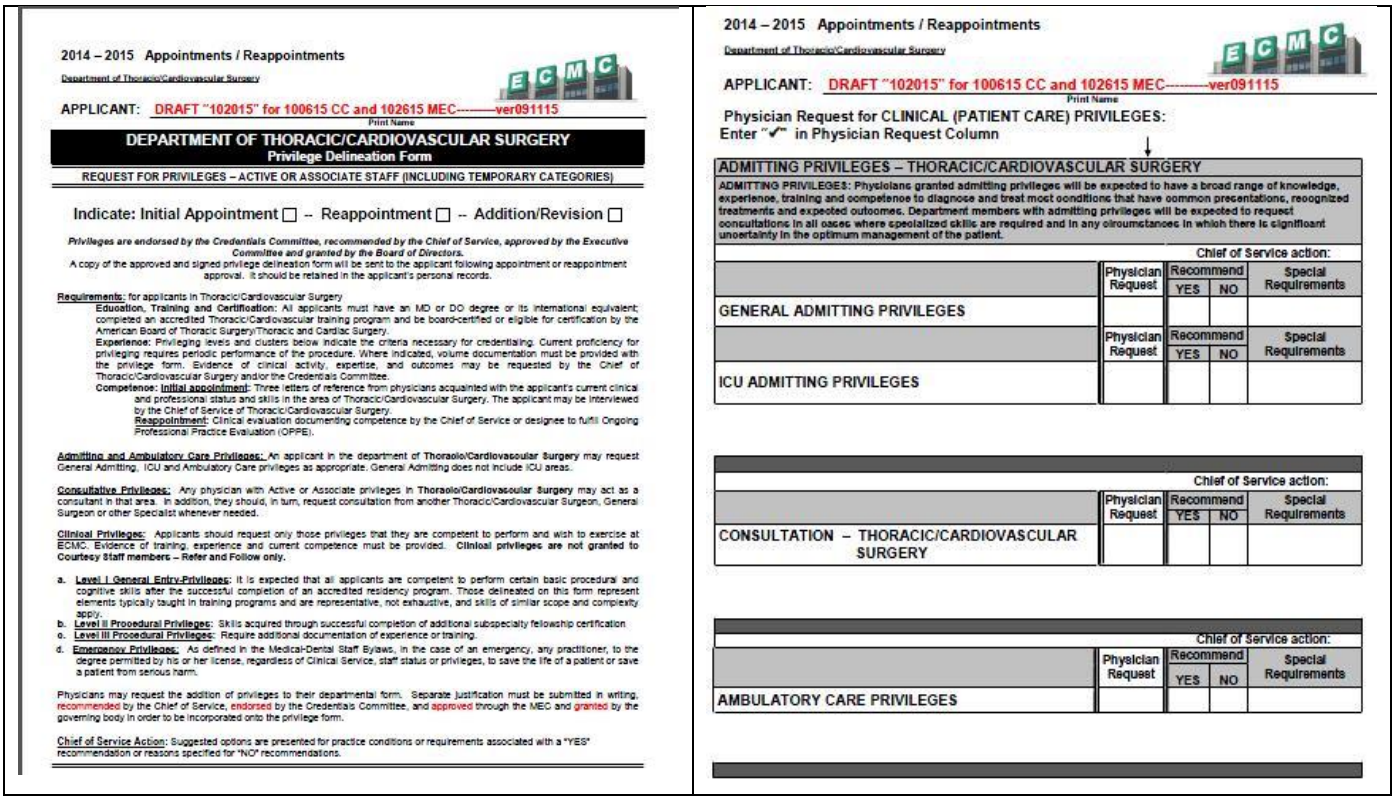
~~Enter "✓" for "**YES** OR "**NO**"~~

~~**Requested**~~	~~**Recommended**~~
~~by Applicant~~	~~by Chief of Service~~
~~Yes / No~~	~~Yes / No~~
~~└─┘└─┘ . . . . . ADMITTING PRIVILEGES . . . . . └─┘└─┘~~	

LEVEL I (CORE) PRIVILEGES

└──┘└──┘ └──┘└──┘ Admitting Privileges

New Thoracic/Cardiovascular Privilege Form
A draft of the new Thoracic/Cardiovascular privilege form was presented to the committee. Members suggested that the wording Thoracotomy added to the Level I General Entry privilege section as a core element. Others felt the wording is understood in the heading "Thoracic/Cardiovascular Surgery". The committee endorsed the form as submitted for action by the Medical Executive Committee and Board of Directors.



2014 – 2015 Appointments / Reappointments

Department of Thoracic/Cardiovascular Surgery

APPLICANT: DRAFT "102015" for 100615 CC and 102615 MEC--------ver091115
Print Name

DEPARTMENT OF THORACIC/CARDIOVASCULAR SURGERY
Privilege Delineation Form

REQUEST FOR PRIVILEGES – ACTIVE OR ASSOCIATE STAFF (INCLUDING TEMPORARY CATEGORIES)

Indicate: Initial Appointment ☐ -- Reappointment ☐ -- Addition/Revision ☐

Privileges are endorsed by the Credentials Committee, recommended by the Chief of Service, approved by the Executive Committee and granted by the Board of Directors.
A copy of the approved and signed privilege delineation form will be sent to the applicant following appointment or reappointment approval. It should be retained in the applicant's personal records.

Requirements: for applicants in Thoracic/Cardiovascular Surgery

Education, Training and Certification: All applicants must have an MD or DO degree or its international equivalent; completed an accredited Thoracic/Cardiovascular training program and be board-certified or eligible for certification by the American Board of Thoracic Surgery/Thoracic and Cardiac Surgery.

Experience: Privileging levels and clusters below indicate the criteria necessary for credentialing. Current proficiency for privileging requires periodic performance of the procedure. Where indicated, volume documentation must be provided with the privilege form. Evidence of clinical activity, expertise, and outcomes may be requested by the Chief of Thoracic/Cardiovascular Surgery and/or the Credentials Committee.

Competence: Initial appointment: Three letters of reference from physicians acquainted with the applicant's current clinical and professional status and skills in the area of Thoracic/Cardiovascular Surgery. The applicant may be interviewed by the Chief of Service of Thoracic/Cardiovascular Surgery.
Reappointment: Clinical evaluation documenting competence by the Chief of Service or designee to fulfill Ongoing Professional Practice Evaluation (OPPE).

Admitting and Ambulatory Care Privileges: An applicant in the department of **Thoracic/Cardiovascular Surgery** may request General Admitting, ICU and Ambulatory Care privileges as appropriate. General Admitting does not include ICU areas.

Consultative Privileges: Any physician with Active or Associate privileges in **Thoracic/Cardiovascular Surgery** may act as a consultant in that area. In addition, they should, in turn, request consultation from another Thoracic/Cardiovascular Surgeon, General Surgeon or other Specialist whenever needed.

Clinical Privileges: Applicants should request only those privileges that they are competent to perform and wish to exercise at ECMC. Evidence of training, experience and current competence must be provided. **Clinical privileges are not granted to Courtesy Staff members – Refer and Follow only.**

a. **Level I General Entry-Privileges:** It is expected that all applicants are competent to perform certain basic procedural and cognitive skills after the successful completion of an accredited residency program. Those delineated on this form represent elements typically taught in training programs and are representative, not exhaustive, and skills of similar scope and complexity apply.
b. **Level II Proceedural Privileges:** Skills acquired through successful completion of additional subspecialty fellowship certification
c. **Level III Proceedural Privileges:** Require additional documentation of experience or training.
d. **Emergency Privileges:** As defined in the Medical-Dental Staff Bylaws, in the case of an emergency, any practitioner, to the degree permitted by his or her license, regardless of Clinical Service, staff status or privileges, to save the life of a patient or save a patient from serious harm.

Physicians may request the addition of privileges to their departmental form. Separate justification must be submitted in writing, recommended by the Chief of Service, endorsed by the Credentials Committee, and approved through the MEC and granted by the governing body in order to be incorporated onto the privilege form.

Chief of Service Action: Suggested options are presented for practice conditions or requirements associated with a "YES" recommendation or reasons specified for "NO" recommendations.

2014 – 2015 Appointments / Reappointments

Department of Thoracic/Cardiovascular Surgery

APPLICANT: DRAFT "102015" for 100615 CC and 102615 MEC--------ver091115
Print Name

Physician Request for CLINICAL (PATIENT CARE) PRIVILEGES:
Enter "✓" in Physician Request Column

ADMITTING PRIVILEGES – THORACIC/CARDIOVASCULAR SURGERY

ADMITTING PRIVILEGES: Physicians granted admitting privileges will be expected to have a broad range of knowledge, experience, training and competence to diagnose and treat most conditions that have common presentations, recognized treatments and expected outcomes. Department members with admitting privileges will be expected to request consultations in all cases where specialized skills are required and in any circumstances in which there is significant uncertainty in the optimum management of the patient.

	Physician Request	Chief of Service action: Recommend YES	NO	Special Requirements
GENERAL ADMITTING PRIVILEGES				
	Physician Request	Recommend YES	NO	Special Requirements
ICU ADMITTING PRIVILEGES				

	Physician Request	Chief of Service action: Recommend YES	NO	Special Requirements
CONSULTATION – THORACIC/CARDIOVASCULAR SURGERY				

	Physician Request	Chief of Service action: Recommend YES	NO	Special Requirements
AMBULATORY CARE PRIVILEGES				

BOARD OF DIRECTORS
MINUTES OF THE FINANCE COMMITTEE MEETING
SEPTEMBER 18, 2015 – 8:00 AM
STAFF DINING ROOM

VOTING BOARD MEMBERS PRESENT OR ATTENDING BY CONFERENCE TELEPHONE:	MICHAEL SEAMAN BISHOP MICHAEL A. BADGER (VIA PHONE) RONALD BENNETT	THOMAS R. MALECKI, CPA
VOTING BOARD MEMBERS EXCUSED:	DOUGLAS H. BAKER JON DANDES ANTHONY M. IACONO	
ALSO PRESENT:	RICHARD CLELAND ANTHONY J. COLUCCI, III STEVE CHIZUK KELLY FINUCANE STEPHEN GARY VANESSA HINDERLITER	MARY HOFFMAN JARROD JOHNSON CHRISTOPHER KOENIG LESLIE LYMBURNER THOMAS QUATROCHE

I. CALL TO ORDER

The meeting was called to order at 8:12 AM by Chairman Michael Seaman.

II. REVIEW AND APPROVAL OF MINUTES

Motion was made by Ronald Bennett, seconded by Bishop Michael Badger and unanimously passed to approve the minutes of the Finance Committee meeting of August 24, 2015.

III. AUGUST 2015 FINANCIAL REPORT (AMOUNTS IN THOUSANDS)

ECMC had an operating income of $1,678,000 for the month of August compared to budgeted income of $122,000 and August, 2014 operating income of $41,000. Patient volume continues to be slightly higher (2.8% and 2.9% respectively) than budget and compared to last year. Case mix was again slightly better than budget for the month, but less than August of 2014.

IV. 2016 BUDGET REVIEW

Mr. Gary stated that the budget has been prepared to meet all regulatory reporting requirements and is required to be submitted by September 30, 2015. He reviewed key financial ratios, statements of revenues and expenses and cash flow and an operating

performance reconciliation from projected 2015 to budgeted 2016 operating income. He also discussed the principal assumptions made regarding volume, patient revenue and reimbursement; IGT/UPL payments, other revenues, expenses and cash flows. Mr. Gary explained how DSRIP revenue affects Millennium Collaborative Care and then ECMC. The committee had several questions regarding each component of the proposed budget that Mr. Gary answered. Mr. Gary noted that any information not specifically covered, or if committee members wanted additional information, he would make it available at any time.

Mr. Gary also reviewed mitigating factors, contingency plans, emerging issues and accounting pronouncements, a 2016 Capital Budget and 5 year financial projections.

Upon the conclusion of the presentation to the committee, Chairman Seaman called for a motion to recommend the budget to the full Board of Director's at their meeting on September 29, 2015. Upon motion made, a vote resulted with 3 votes for/1 vote against recommending the budget to the Board of Directors.

VI. ADJOURNMENT

There being no further business, the meeting was adjourned at 9:24 AM by the Chair.

ERIE COUNTY MEDICAL CENTER CORPORATION

BOARD OF DIRECTORS

MINUTES OF THE HUMAN RESOURCES COMMITTEE MEETING

FRIDAY, OCTOBER 2, 2015
RESCHEDULED FROM
TUESDAY, SEPTEMBER 8, 2015

ECMCC STAFF DINING ROOM

VOTING BOARD MEMBERS PRESENT OR ATTENDING BY CONFERENCE TELEPHONE:	MICHAEL HOFFERT, CHAIR BISHOP MICHAEL BADGER
BOARD MEMBERS EXCUSED:	

ALSO PRESENT:	RICHARD CANAZZI	CHRISTOPHERKOENIG
	JULIA CULKIN-JACOBIA	ANN MARIE KOPF
	MICHAEL CUMMINGS	BELLA MENDOLA
	ANTHONY DIPINTO	NORMAN MOORHOUSE
	CARLA DICANIO-CLARKE	KEVIN RANDLE
	MARY HOFFMAN	BILL WILKINSON

I. CALL TO ORDER

Chair Michael Hoffert called the meeting to order at 10:05am.

II. RECEIVE & FILE

Moved by Bishop Michael Badger to receive the Human Resources Committee minutes of the July 14, 2015 meeting and seconded by Michael Hoffert.

III. ENGAGEMENT REPORT

Julia Culkin-Jacobia reported that the talent acquisition department is reorganizing. The processes for new hire on-boarding and the new hire process are being revamped. Orientation will be undergoing changes by the end of the year. Open positions will be posted elsewhere (other than the ECMCC website) to add applicant diversity. A project for next year will be to reclassify the civil service job descriptions. Civil Service Updates will be added to the next agenda.

Human Resources is also working on a culture change. Employees will be seen as customers, HR teammates are rounding to different departments, and policies and being reviewed.

In the near future, ECMCC Leadership Academy will be taking place. This includes a small group of teammates going through the academy and training to move up their career path.

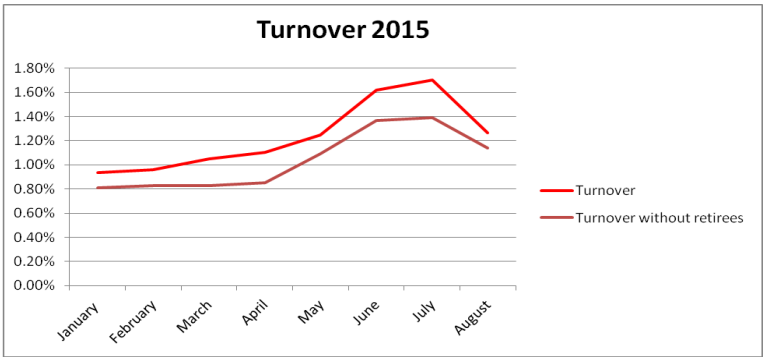
IV. LABOR RELATIONS

Carla DiCanio-Clarke reported that dates are set for AFSCME negotiations to begin. She is also working with CSEA to officially designate managerial confidential titles. The final draft of the NYSNA contract is being reviewed. NYSNA members should be in possession of a printed contract within 30-90 days.

V. WORKERS COMPENSATION AND EMPLOYEE OCCURRENCES

Dr. Michael Cummings gave a report regarding the behavioral health department. The focus is on CPEP and what factors lead to assaults. There was the highest volume ever in June and no assaults ensued. Dr. Cummings is meeting with multiple agencies to come up with a community plan. Various police agencies are beginning to be trained in crisis intervention. A behavioral health update will be added to the next agenda.

VI. EMPLOYEE TURNOVER RATE



VII. NURSING TURNOVER RATE

Turnover continues to be low. The summer surge attendance incentive for the nursing floors was successful. Winners were awarded $1000.

VIII. ADJOURNMENT

Moved by Michael Hoffert to adjourn the Human Resources Committee meeting at 11:00am.

CEO's INTRODUCTION

Over the past two weeks, our focus continues to be on the patient, our physicians, nurses, and staff. I, along with the executive team, started off with Town Hall meetings, and then continued with rounding throughout the hospital. We have rounded on the inpatient medical and behavioral health units on all shifts, the emergency department, CPEP, dialysis, Terrace View, some of the clinics and Grider Family Health. We also have met with environmental services, plant operations, Health Information, and other financial areas. The rounding will continue this week to ensure that we are getting to all areas of the hospital as soon as possible.

As we have rounded, we have learned that there are a few areas that need immediate attention. The first is our hospitalist service. This past year, we decided to change our hospitalist service from Team Health to Apogee. Many in the market decided to switch their hospitalist services at the same time, including Buffalo General Hospital and the Catholic Health System. I asked Apogee leadership to meet with Dr. Murray, Karen Ziemianski, and me to speak with them about the immediate need for more communication and support for nursing during this transition. They are beginning to respond and I have attached their communication to the hospital. They will also be rounding with our clinical leadership to ensure visibility with the nurses and physicians in the hospital.

Another area of focus will be the move of Cleve-Hill primary care to the Grider Family Health building. As you may recall, this was initiated due to severe water damage at Cleve-Hill. The physicians would like to stay on campus, but there is much needed work in order to make the space suitable. The Grider Family Health building also is home to Dr. Redhead's practice and we need to develop a long-term plan for both practices.

We also are in the process of reconfiguring our outpatient psychiatric and behavioral health clinics. This move is very time sensitive, and is an important effort that is in line with the goals of DSRIP. As this plan develops, we will be reporting back to the board.

Finally, we are working towards a decision regarding the emergency room renovation. We will be meeting with emergency department physician leadership and other surgical and medical leadership that will be directly impacted by renovations. I have asked for a meeting as soon as possible in order to develop a consensus on this project.

These are just a few of the areas that we are focusing our efforts on, and the executive team will keep the Board apprised of other initiatives as we move through this process. I would like to thank the executive team for stepping up during this transition. The Board should be encouraged by their professionalism and leadership.

I will not be presenting the entire report attached, but I will be focusing on four areas for future Board presentations: quality, patient experience, culture, and operations. I also would like to discuss one or two strategic initiatives every month that requires Board input. I also welcome Board input if there is an area or topic you think would be beneficial for the Board to learn more about.

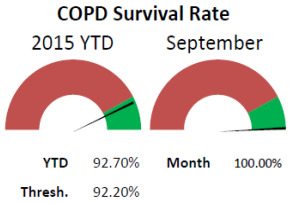
Thank you for the opportunity to serve in this new capacity, and for your faith in the executive team. Please find the report below that demonstrates the strength of our operations and focus on our number one priority---the patient.

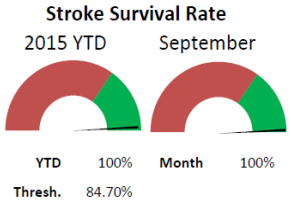
Sincerely,

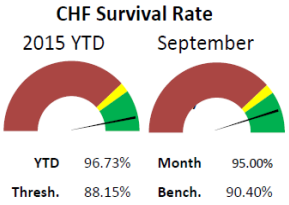
Tom

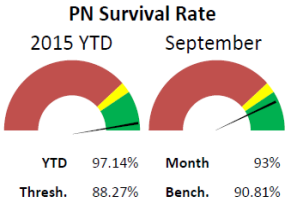
QUALITY

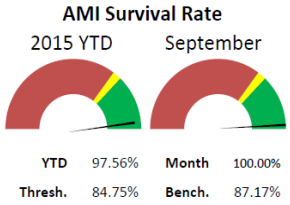
Executive Dashboard - November 2015

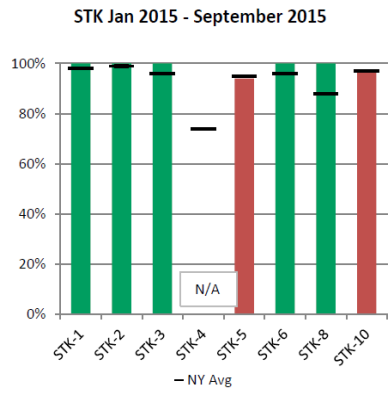


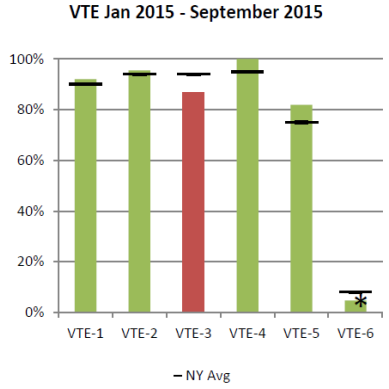




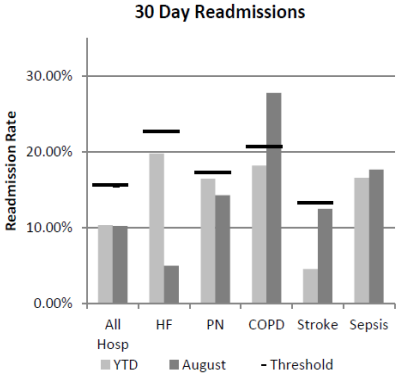


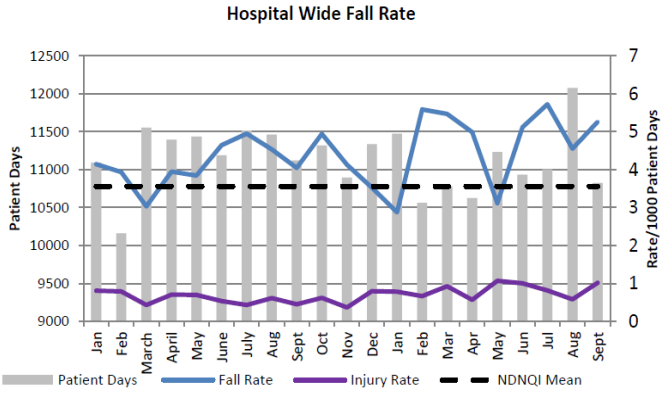






*VTE 6 - Lower is better.





To enable quick interpretation, please note the following:

- Black lines represent benchmarks
- Red represents worse than the benchmark
- Yellow represents equal to the benchmark
- Green represents better than the benchmark

TERRACE VIEW:

Quality Measures to date for Terrace View continue to show improvements:

- **QMs improved this month over last**
    - SR Mod/Severe Pain (S) 44.4% to 40.7%
    - New/Worse Pressure ulcer 2.3% to 2.2%
    - Behavior Sx affect others (L) 52.8% to 50.0%
    - Depression Sx (L) 5.1% to 3.8%
    - UTI (L) 5.2%to 4.4%

- **Number below state average**
    - We have 7 out of 17 QMs that are below NYS average

- **Any trends we are noting that cause a rise of fall - areas we are working on**
- **SR Mod/Severe pain**
    - A meeting was held with the medical staff regarding pain. It was decided that the pain interview will be completed with the facial scale instead of a numeric scale. The data repository for our pain assessment will change to sort by units instead of by residents. The TLs will be running these reports daily for the NP to address any pain issues. The MDS department will continue to alert the TLs of the pain interview outcome and then follow up with the TLs asking what interventions have been put into place. We have noticed a decrease with using the facial pain scale. We will be continuing education with the TLs regarding the indicators and what causes the triggers on the indicators.

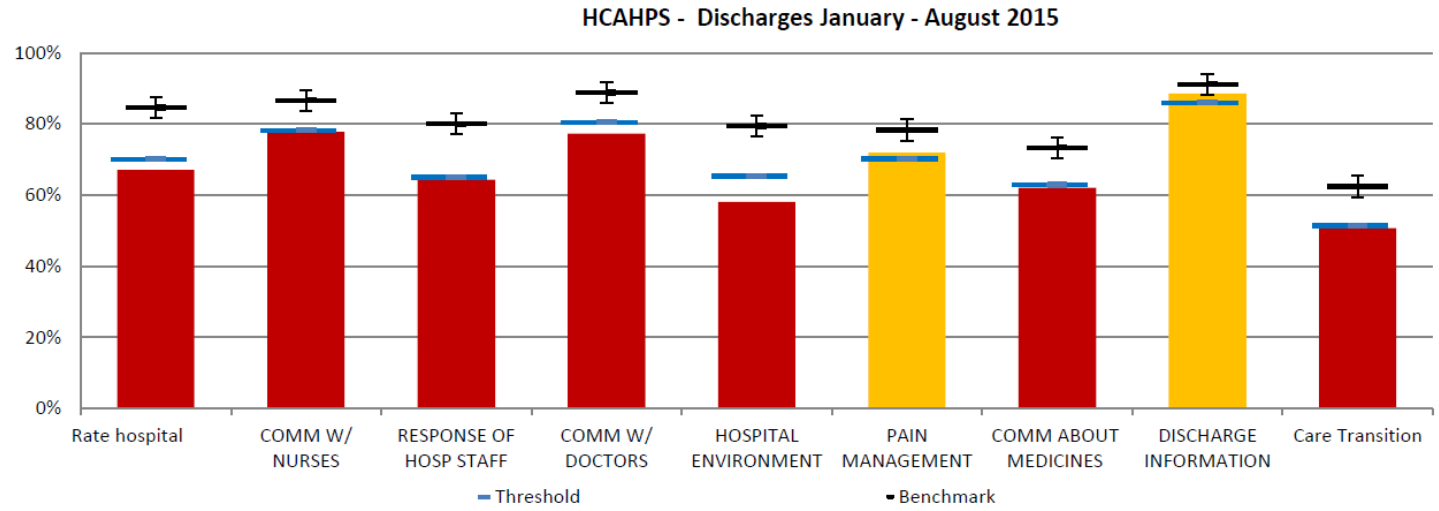
Transitional Care Unit (TCU, 6z2) Quality

- The TCU, under the direction of Dr. Orlick and Dr. Troen has seen great QM improvements recently:
    - 4.4% improvement in reports of pain
    - 2.6% improvement in pressure ulcers, now at 0%
    - Anti-anxiety medications now at 0%
    - TCU has had a period of 30 days with no falls, previously 3-4 per month. An interdisciplinary project with PT, “Call Don’t Fall” contributed greatly to this success.

PATIENT EXPERIENCE

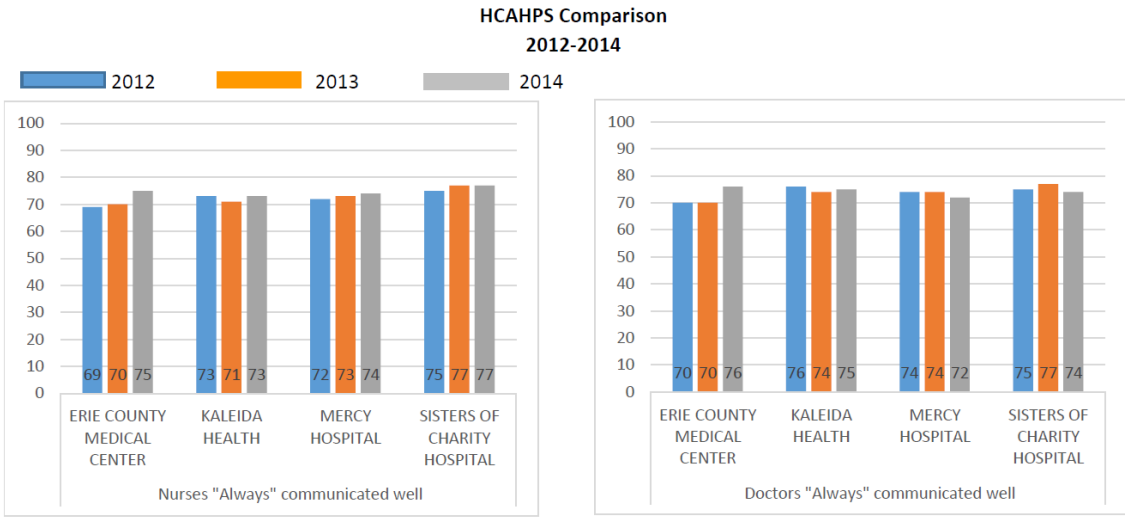
Press Ganey Survey Scores

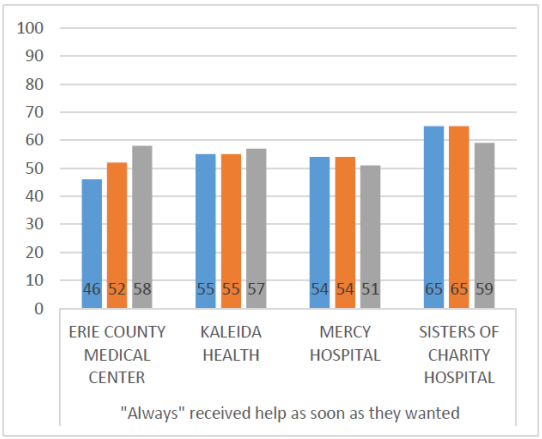
The Patient Satisfaction Survey asks patients questions about their experience from the following domains:

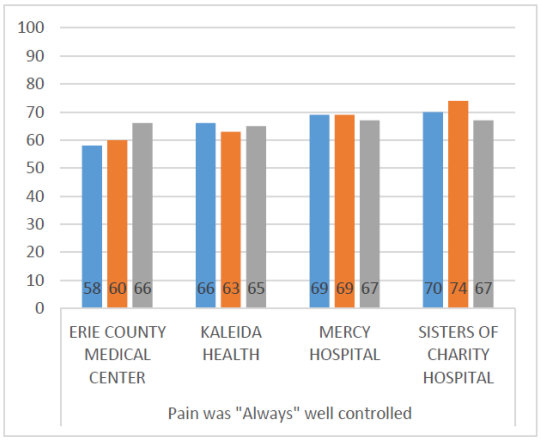


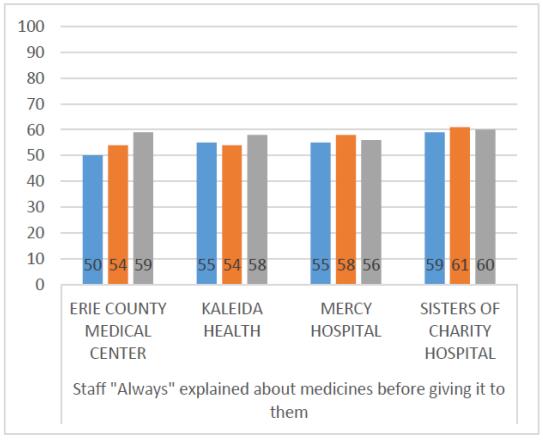
****The Threshold (blue line) represents the 50th percentile nationwide. The Benchmark (black line) represents the 90th percentile.**

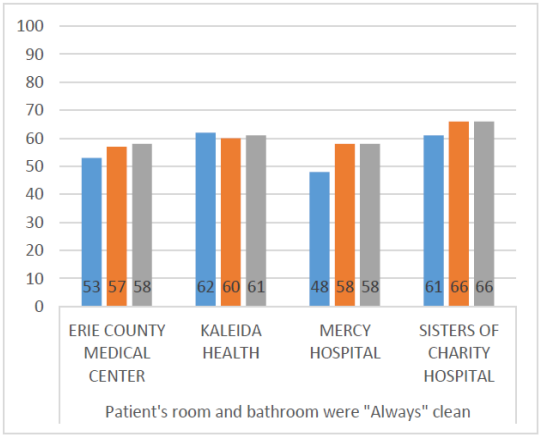
To reflect on the great improvement we have had over the last 2 years we did a comparison from 2012-2014:

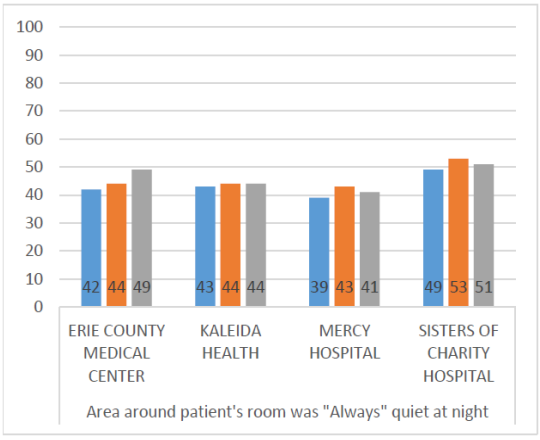


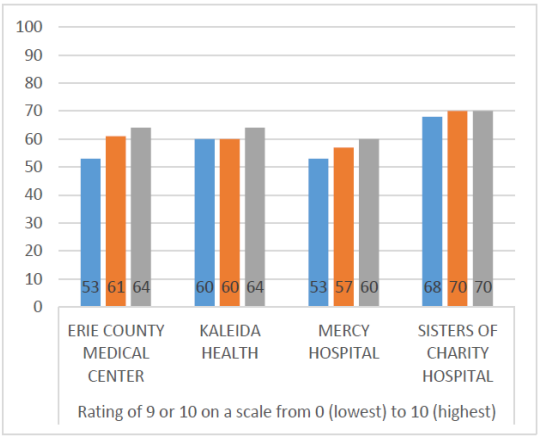

100
90
80
70
60
50
40
30
20
10
0
46 52 58
55 55 57
54 54 51
65 65 59
ERIE COUNTY MEDICAL CENTER
KALEIDA HEALTH
MERCY HOSPITAL
SISTERS OF CHARITY HOSPITAL
"Always" received help as soon as they wanted

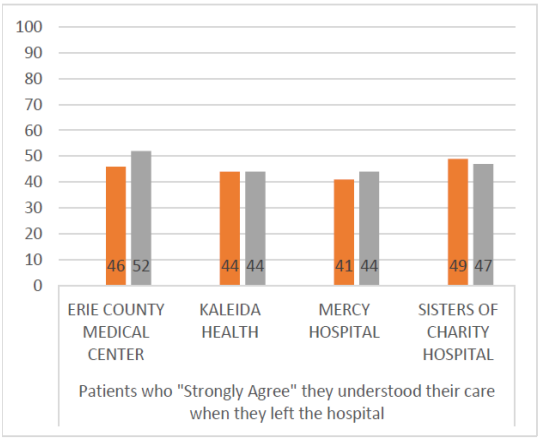

100
90
80
70
60
50
40
30
20
10
0
58 60 66
66 63 65
69 69 67
70 74 67
ERIE COUNTY MEDICAL CENTER
KALEIDA HEALTH
MERCY HOSPITAL
SISTERS OF CHARITY HOSPITAL
Pain was "Always" well controlled

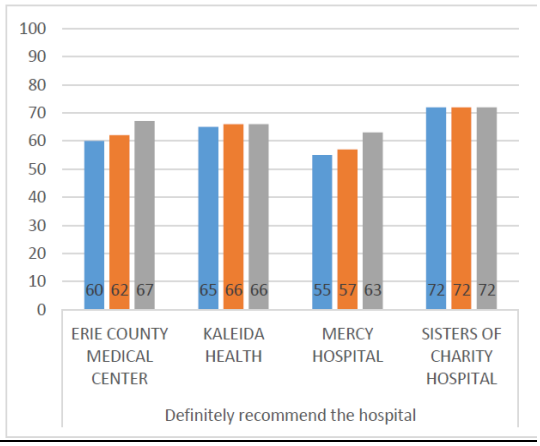

100
90
80
70
60
50
40
30
20
10
0
50 54 59
55 54 58
55 58 56
59 61 60
ERIE COUNTY MEDICAL CENTER
KALEIDA HEALTH
MERCY HOSPITAL
SISTERS OF CHARITY HOSPITAL
Staff "Always" explained about medicines before giving it to them

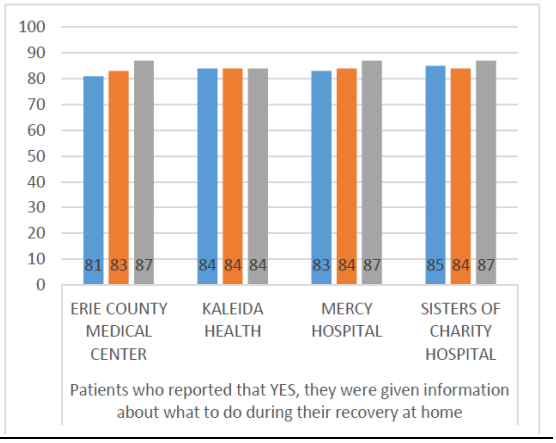

100
90
80
70
60
50
40
30
20
10
0
53 57 58
62 60 61
48 58 58
61 66 66
ERIE COUNTY MEDICAL CENTER
KALEIDA HEALTH
MERCY HOSPITAL
SISTERS OF CHARITY HOSPITAL
Patient's room and bathroom were "Always" clean


100
90
80
70
60
50
40
30
20
10
0
42 44 49
43 44 44
39 43 41
49 53 51
ERIE COUNTY MEDICAL CENTER
KALEIDA HEALTH
MERCY HOSPITAL
SISTERS OF CHARITY HOSPITAL
Area around patient's room was "Always" quiet at night


100
90
80
70
60
50
40
30
20
10
0
53 61 64
60 60 64
53 57 60
68 70 70
ERIE COUNTY MEDICAL CENTER
KALEIDA HEALTH
MERCY HOSPITAL
SISTERS OF CHARITY HOSPITAL
Rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)







Patient Experience Initiatives

- The Patient Experience and Excellence Contracts that the Executive Team signed at the beginning of the year has been expanded to include Senior Leadership/Management. The Nurse Executive Team recently signed the 'ECMC Departmental Leadership Contract for Patient Experience and Excellence'- committing to dedicated time for rounding with patients and teammates.

- This month we began piloting a drop off lunch service provided by Balkan Dining to have fresh foods available for the families of our same day surgery patients in the Ambulatory Center, as well as dialysis patients, guests and our own teammates.

- Friday November 6 Christina Dempsey, Chief Nursing Officer from Press Ganey was here for a presentation on the Patient Experience. The event inspired over 95 teammates through a talk about both the professional and personal viewpoints of patient experience.

PEOPLE

Teammate Engagement

- Breakfast Club held on October 16 for the Overnight shifts.
- Terrace View held a town hall meeting in October in which members 50 members of 1st and 2nd shift attended - Reviewed with staff the incorporation of employee committees with ECMC, toy drive, changes to employee recognition awards, as well as staffing redesign to improve nursing staffing through the facility.
- Administration continues to round with all staff and patients with positive response. Chris Koenig, VP of Post Acute Care, demonstrates another initiative by hosting 3-4 teammates in his office for a conversation over coffee.
- Ambulatory Services - Organized a T-shirt logo contest for all the staff. The staff participated in the design suggestions, the entries were voted on by the ambulatory staff with the winning design going to Tamara/Sonia from our IMC clinic. These shirts will be available for purchase by ambulatory staff to be worn on casual Friday's.
- Behavioral health celebrated 1 year of service for our most ill patients on the Transitions Unit (4z3) with a lunch for both staff and patients.
- Radiology - Weekly meetings with Radiologist and Sr. Techs have been beneficial in promoting consistency, increasing throughput, teamwork, quality, and communication.
- On Friday, November 6, 2015, nursing held their Preceptor dinner at Chef's Restaurant. The event honored preceptors throughout the organization – 85 plus attended this event.
- A lunch was held by 7z4 to celebrate the Time and Attendance Summer Surge Raffle success. Employees state they like to come to work and they feel happy to be recognized for their dedication.

Workforce Development

- AHRA (Radiology) Virtual Fall Conference was a success at ECMC. Many staff members from multiple departments were able to attend and learn about issues that related to their departments. Topics such as JC changes, ICD-10, Management styles, Effective leadership, XR-29, CDS, Population Health were discussed in detail. Very positive response from members of nursing, OR, coders, HR and Radiology staff members that were in attendance.
- Molly Shea, DON of TCU, was awarded a grant to send her to a conference for the National Association of Drug Diversion Investigators in response to her dedication to preventing drug diversion at ECMC.
- Palliative Medicine & Conversation project presentation to Family Medicine Residents on 10/1. Palliative Medicine & Conversation project presentation to Nephrology Medicine Residents on 10/2.
- End-of-life Nursing Education Consortium (ELNEC) training - 2nd training scheduled on Nov. 23, 2015.
- CPEP: Initiated weekly education sessions and staff newsletters to improve communication and coaching for clinical situations and in completing clinical ladder applications for all RN staff.
- OT and PT participated in the Forever Young Expo with good exposure and attendance by senior members of the community.
- On Wednesday, October 28, there was a Clinical Ladder celebration for all of the recipients from the Clinical Ladder. Congratulations to the 22 nursing members who took part.
- Julia Jacobia, Chief People Officer (CPO) working on 2016 Leadership Academy initiative. In addition, working on a Leadership development program, which would target all ECMC, middle Leadership (department managers, director's, coordinators, unit management, assistant vice presidents, and vice president levels).

HOSPITAL OPERATIONS

Several Key Statistics for the Month Include:

- Year to Date Operating Income of $1,067
  - YTD October, 2014 Operating Income of $78
  - Operating Performance Improvement of $989
  - October Operating loss of $287

- Discharges - 15,376
  - 361 (2.4%) Greater than October 2014
  - 162 (1.1%) Greater than Budget

- Case Mix Index - 1.74
  - 1.78 YTD October 2014
  - 1.77 Budget

- Overall Average Length of Stay – 8.0
  - 8.0 YTD October 2014
  - 7.8 Budget
- Emergency Visits and Admissions - 56,456
  - 55,785 YTD October 2014
  - 54,190 Budget

- Acute Length of Stay (LOS) for October 2015 was 5.9 with a financial LOS of 6.4. Continuing to work with the medical staff to improve throughput of our patients.
- ALC process: Our total ALC days for this month were 387. This is 15% improvement over last year. We have continued to focus on our internal screening process to expedite bed offers to the various rehab options available here at ECMC while continuing to ensure patient choice.
- Appeal and Denials: This area has shown growth concurrently with the Behavioral Health Team. The UR staff nurses are completing many denial appeals concurrently (while the patient is still in-house) with the assistance of our attending physicians. This change has led to a decrease in the denial received on the BH team from September to October by 29%. The Med/Surg denial process also continues to make positive gains with YTD recapture of $762,692.00.

Other Operational Notes

- Transplant - Primary response from UNOS was very positive regarding Living Donor, at the MPSC meeting October 29 - they indicated very impressed with progress made in program. They indicated we can "officially" request removal from probation on December 10, 2015 for a discussion at the March 2016 meeting and if granted final approval at the June 2016 UNOS executive board meeting.
- Rehab - "Call Don't Fall" project is underway and there have been no falls since its institution. It is a contract with our patients that they will continue to call for assistance even though they feel they may have learned enough in therapy to ambulate alone.
- Laboratory - Joint Commission Accreditation: The Department of Laboratory Medicine Accreditation was received on November 6, 2015.
- Ambulatory Services - The Center for Occupational and Environmental Medicine will enter into agreements to begin providing Occupational Health Services for the Laborers Local Union #4, HARMAC Medical Supplies, and the Painters DC #4.

- Capital Projects:
  - Emergency Department Modernization Initiative - Next conceptual presentation to be scheduled with the stakeholder group in the near future.
  - Main Entrance Enhancements - service orders placed; preliminary work began with existing raised letter signage removal and the installation of our temporary branding banner being placed.
  - Demolition of 409, 411 & 525 Grider Street Properties - All abatement and demolition complete, with final foundation removals @ 525 nearing completion.
  - Radiology Renovations: Phase 1 and 2 were completed on schedule by the end of October, with the first new bariatric grade CT and fluoroscopy units now in use; Phase 3 - renovation work for the second new CT unit is underway with completion targeted for the end of the year.
  - Cardiac Cath Lab #2 Renovations: work is progressing on schedule with completion targeted in February.
  - Orthopaedic Clinic Reconstruction: work is progressing on schedule with completion targeted in March.

Physician Affairs

- **UNIVERSITY AFFAIRS**
  We are pleased to report that the search for the next dean of the School of Dental Medicine is now underway. Dr. Jean Wactawski-Wende, dean of the School of Public Health and Health Professions, has accepted our invitation to serve as chair of the search committee. Under the leadership of Dean Wactawski-Wende, and with the support of the search committee, we have every confidence that our search for the next dean of the School of Dental Medicine will be a great success.
- **CLINICAL ISSUES**
  The Centers for Medicare and Medicaid Services (CMS) published the final payment rule for the Medicare Outpatient Prospective Payment System, which includes improvements related to the two-midnight policy. New outpatient payment rates and policies adopted through the rulemaking process will be effective for calendar year (CY) 2016—beginning January 1, 2016. Our team has worked on a solution to appropriately identify and follow the policy.
  The final rule also includes a discussion of changes to CMS' approach to educating hospitals and our enforcement of the Two Midnight rule. Specifically, CMS began using Beneficiary and Family Centered Care (BFCC) QIOs, rather than MACs or Recovery Auditors, to conduct the initial medical reviews of providers who submit claims for short stay inpatient admissions on October 1, 2015. Beginning in 2016, BFCC-QIOs will begin reviewing inpatient cases under the revised Two Midnight Rule.
- **APOGEE**
  See attached Memo at the end of the report.

TERRACE VIEW:

- Terrace View Census: Average of 97.9% occupancy in October. Multiple days near full occupancy.
- We have received acceptance of our offer out to the DON candidate of our choice, who will bring 20+ years experience in SNFs. She will begin in December. We have also received acceptance of our offer to the Director of Sub Acute Care, who will supervise both sub acute units and Team Leaders. She came to us with high recommendation of local Orthopedic Surgeons. We are very excited for these changes.

COMMUNITY ENGAGEMENT

- Behavioral Health completed educational sessions for staff and community agencies related to trauma informed care - 90 participants yielded $4,000+ for future sessions.
- Lisa Thorpe presented ECMC Driver Rehab program to local district NYS Occupational Therapy association- good exposure of program to referring sources.
- SPCA's PAWS for LOVE program began in November. SPCA volunteers will make their evaluated and approved pets available to families and friends in the critical care waiting areas on the 1st and 12th floors. The goal of the program is to provide a calm, therapeutic dimension to the time visitors spend at ECMC while their loved one recovers from critical illness and injury. As we strive to enhance the patient experience at ECMC, we are pleased and grateful to welcome these new members to our critical care team.
- November 2nd 'Let's Not Meet by Accident' was presented at ECMC for Pioneer HS EMT students. November 3rd and 4th it was presented to 112 students at Iroquois High School.
- MST Prep Partnership
    - Healthcare Professions Conference was held on October 27, 2015 for 5-8th grade students. It was an interactive hands-on workshop for the students to learn about different healthcare professions. The students went through rotations to learn about Nursing, Surgical Services, Pharmacy, HR, Respiratory Therapy, Rehab, Radiology, and Dentistry.
    - A Life Skills Workshop was held on Tuesday, November 10 with the 11th and 12th grade students.
- Comfort Home
    - Site visit to Isaiah House in Rochester completed.
    - Meeting with People Inc. on Nov 20, 2015. Community stakeholder meeting will be scheduled in December.
    - East Hill Foundation grant proposal denied. Roseanne did follow up and was told that family/board discretionary grant still a possibility and is available in 2016.
- The Conversation Project
    - Medical-legal partnership meeting with Helen Zafram, from ECDSS, and Danielle Pelfrey-Duryea, from UB Law school, to discuss collaborative opportunities to educate law students on Advance Care Planning/Directives was held on 10/6.
    - Conversation project presented at ECMCC Employee Benefits Fair on 10/14. 2nd presentation of Conversation project @ IHA on 10/19. Conversation project @ UB EOP Soiree on 10/22 - Invitation to present at State event in November. Conversation project to D'Youville Nursing students on 10/27. Conversation project @ ECDSS Public Hearing on 10/28. Follow up meeting with ECDSS for funding set.

MILLENNIUM COLLABORATIVE CARE/DSRIP

MCC Milestones and Activities

- **Governance**: By-laws have been completed and approved
- **Finance and Funds**: Funds flow model is still being finalized; Funds have been distributed to CBOs participating in project 2.d.i as well as two hospitals participating in the ED Triage Project, 2.b.iii
- **Workforce**: Collaborating with CPWNY on a Workforce survey
- **IT**: Completed assessment of RHIO; Coordinating with Great Lakes Health System to determine how PPS IT strategy fits; implemented Office 365 which includes Microsoft Azure which PPS is investigating for use in member roster receipt
- **Provider Engagement:** Hired a Provider Engagement Coordinator; meeting with safety net providers and Health Home representatives to improve engagement. Working collaboratively with CPWNY to engage behavioral health providers
- **Community Engagement:** Implemented radio spots and conducted and exposition in order to engage the community
- **Performance Management**: PMO established (contracted with Chartis to aid in development); contract signed with Performance Logic to track project progress

Project Milestones and Activities

Domain 2:

- Posted positions for Practice Care Coordinator & Practice Transformation Specialists. PCMH vendor search underway
- Project implemented at ECMC and CGMMC. Next target is Olean Memorial
- INTERACT training completed at 4 SNFs
- Rapid Response Team Coordinator hired at NFMMH
- Four RFPs awarded to CBOs with signed contracts

Domain 3:

- Workgroup meetings established with 50+ providers. Collaboration with CPWNY and FLPPS
- Tracked 2,288 patients with recorded self management goals (91.5% of goal for DY1 Q2)
- Initiated work with CBOs and began enrollment

Domain 4:

- Developed regional approach to MEB in collaboration with Catholic Medical Partners
- Established Maternal and Child Health Advisory Workgroup

Additional Highlights

- **Member Rosters**: Uncertainty regarding compliance with security standards needed to receive member roster; investigated the use of Microsoft Azure to accept PHI
- **PPS Participation:** MAX: Interested in participating in MAX series if location is moved closer to the PPS
- **PPS Collaboration:**
  - Collaborating with CPWNY on workforce
  - Working with CPWNY and FLPPS on Project 3
  - Discussing the use of Microsoft Azure to accept the member roster with FLPPS

MARKETING AND BUSINESS DEVELOPMENT

Corporate Initiatives

Strategic Planning

We have identified a speaker/facilitator to ensure that the strategic planning session for management considers the many changes in healthcare. We are hoping to conduct the session in the next couple of months and schedule a Board of Directors meeting in the first quarter to finalize goals and initiatives of the corporation in the Strategic Plan.

Rural Hospital Discussions and Vital Access Provider Assurance Program (VAPAP)

ECMC is continuing to assist and develop partnerships with some of the rural facilities in on-going efforts to redesign care to create sustainable organizations.

Strategic Alignments

ECMC has partnered with Greater New York Healthcare Association to begin a gain-sharing program and it has started in Orthopedics.

ECMC is continuing its partnership with Kaleida Health in Optimum Physician Alliance and has begun a focused effort to educate physicians on ECMC's involvement and inform them of the services provided.

MASH

ECMC continues to work with MASH through its joint venture to develop the following initiatives:

- A transportation network servicing the various hospital discharges and work to assist care coordination for population health initiatives
- A preferred diagnostic network to be the preferred provider for payer networks and self-insured organizations
- Continuing work with primary care for ED avoidance and specialist linkage

State Government and Department of Health

We are continuing our dialogue with the Governor's office to advocate the signing of the PBC Amendment. We have had numerous meetings with community leaders and Governor's staff and counsel office to discuss the bill. As soon as the bill is signed, we will be refocusing our efforts to developing a planning process in the coming months for collaboration.

Marketing and Business Development

ECMC is continuing its marketing efforts, and is in the midst of identifying service lines that need additional support.

ECMC will be launching its new website shortly. Various meetings have been held with stakeholders to get input before launch.

ECMC recent Medical Minutes featured Wound Care and Cancer of the Head and Neck and Specialized Wound Care.

ECMC is in the process of recruiting primary care physicians and physicians in various specialties. We are also activating our relationship with OPA providers by educating them on ECMC services.

ECMC FOUNDATION

- The ECMC Foundation has raised $112,000 so far in the Annual Campaign. The total for 2014 was $94,000.

- We are also in the process of hiring a major gifts/capital campaign director to raise money for the new Emergency Department. We have held interviews and are looking to hire a candidate in this fall.

Media Report

- **The Buffalo News: Courage Awards Presented.** Dr. Mark A. LeVecchi, chairman of Physical Medicine and Rehabilitation Department at Erie County Medical Center was honored with the Courage to Come Back Award for the Friendship Foundation.
- **Buffalo Business First; The Buffalo News: Historic collaboration planned for cardiac care facility.** Niagara Falls Memorial Health Center will house the cardiac catheterization lab in its Heart Center in a joint project with Mount St. Mary's Hospital and its parent, Catholic Health, along with Kaleida Health and Erie County Medical Center.
- **The Buffalo News; Hospitals work to shorten emergency room wait times but several exceed the state average.** In 2013, ECMC launched a project to improve efficiency, including the emergency department, and started a triage program in the spring to divert non-urgent cases from the emergency department.
- **Buffalo Healthy Living: Creating a living chain: be a part of ECMC's transplantation program.** Dr. Liise Kayler, ECMC's Director of Kidney and Pancreas Transplantation, describes the process for patients in need of a transplant.
- **The Buffalo News; Business First; WGRZ-TV, Channel 2; WIVB-TV, Channel 4; WKBW-TV, Channel 7; WBFO Radio, 88.7 FM: ECMC leader's termination unrelated to hospital performance. "**The hospital is on strong financial and operational footing and we reiterate that our physicians, nurses and staff will continue to provide great care today and tomorrow."

WE ARE LISTENING!

Apogee is now our Medicine H (Hospitalist) service at ECMC.

On November 11, 2015, Tom Quatroche, ECMC CEO, Dr. Brian Murray, Chief Medical Officer, Karen Ziemianski, Sr. Vice of Nursing & Dr. Michael Gregory, Apogee CEO with their Senior Leadership sat down to relay feedback that they have received from physicians and nurses and discuss how our new partnership will move forward, improve, and grow for the benefit of the patient.

As a united group, we have committed to:

- **Deliver open and clear communication:** We will continue to round with ECMC leadership to get your concerns and questions real time.
- **Leadership is Available. Please call us!** : 24/7 Apogee Senior Leadership at ECMC (Dr. Upegui Division 2 President, 917-327-1875 and Dr. Case 716-316-1581)
- **Hotline:** Apogee hotline to assist providers during their initial stage in the program. Expect this within in the next couple of weeks.
- **Suggestion Box:** Process improvement suggestion box on the floors. This will encourage communication and participation of nursing and support staff on ways to make our Hospitalist service the best it can be.
- **Staffing:** Under close mentoring by Apogee and ECMC leadership, our service will be fully covered. Our team of high quality, stable providers from Travel Team, Independent Contractors and Locums (Temporary) physicians will be here until our permanent team is established. **We will also be working to have these individuals be as consistent as possible.**
- **Our Team:** We are in the process of recruiting a strong, talented physician team. We anticipate that our full Apogee Team will be in place progressively from now to the summer of 2016.

ECMC and Apogee are focused on the patient, and we must work together to provide the very best care. We must help each other and help out those providers who are new to the community and to ECMC. Let's stand together to create a successful partnership for the good of our patients, our staff and our hospital!

The difference between healthcare and true care™

Internal Financial Reports

For the month ended October 31, 2015

Erie County Medical Center Corporation
Management Discussion and Analysis
For the month ended October 31, 2015
(Amounts in Thousands)

An operating loss of $287 was incurred for the month of October which is unfavorable to budget by $1,091 and unfavorable to the prior year by $1,345. Management notes that the October 2014 results included $1,800 for the cumulative effect of a change in accounting estimate, resulting in core operating results incurring a loss of $742. As a result, on a core operating basis, October 2015 represents a $455 improvement in operating results. On a year to date basis, ECMCC generated operating income of $1,067 which is unfavorable to budget by $8,161 and favorable to the prior year by $989. On a year to date basis, the favorable performance can be attributed to higher than budgeted volumes partially offset by lower than budgeted case mix and other factors noted below.

Discharges of 1,571 for October were 80 (4.8%) less than the prior year of 1,651 and 58 (3.6%) less than budget at 1,629. The unfavorable October discharge variance to budget is primarily due to 82 fewer behavioral health services and 8 fewer transitional care services which were offset by 21 more acute services and 7 more medical rehab services.

Average length of stay in October was 7.8 days which is unfavorable to budget of 7.6 days. The average daily census of 396 is unfavorable to budget of 400 but greater than prior year of 391.

The blended acute case mix for October was 1.74, which is 3.8% lower than budget of 1.81. The year to date blended acute case mix of 1.74 is 1.7% lower than budgeted case mix of 1.77. Management is currently in the process of measuring the impact of the change from ICD-9 to ICD-10 on the October case mix.

Outpatient visits at 26,463 were 11.9% less than budget due to decreased volumes across various services. Emergency volumes at 5,657 were 7.5% greater than budget and 0.1% greater than the prior year.

Other revenue for the month of October was greater than budget by $724 and on a year to date basis, was greater than budget by $4,610. Year to date favorable performance is substantially due to higher than expected rebate revenues coupled with recognition of DSRIP related grant revenue. This is offset by expenses incurred related to the DSRIP grant.

Salaries and wages were unfavorable to budget for October by $1,841 and year to date by $13,542. The variance in FTE's totaled 204 of which 62 are attributable to productivity gains assumed in the budget that are not realizable and 49 due to an assumed vacancy factor not being realized due to high volumes. This variance was driven by increased inpatient volumes, and not meeting the budgeted productivity and vacancy factors noted above. In addition, an increase in contract labor related to DSRIP offset by DSRIP grant revenue as referred to above.

Benefits were favorable to budget in October by $958 and $3,354 year to date primarily due to a decrease in annual pension expense. Benefits year to date are 50.0% of salaries compared to a budgeted rate of 57.4%.

Purchased services were unfavorable to budget for October by $463 and on a year to date basis by $4,988 primarily attributable to increased patient related dietary costs as a result of increases in volume and costs for reimbursable grant expenses including consulting related to DSRIP. This was offset by the recognition of DSRIP Grant revenue as noted above.

Depreciation expense was unfavorable to budget in October by $118 and on a year to date basis by $2,139 primarily due to the use of component depreciation method for Terrace View and the CPEP program after the budget was completed. This has been partially offset by the recording of the corresponding third party revenue for Terrace View and is expected to be offset by expected future reimbursement for CPEP that is currently in development.

Erie County Medical Center Corporation

Balance Sheet
October 31, 2015 and December 31, 2014

(Dollars in Thousands)

	October 31, 2015	Audited December 31, 2014	Change from December 31st
Assets			
Current Assets:			
Cash and cash equivalents	$ 14,962	$ 6,251	$ 8,711
Investments	19,414	3,270	16,144
Patient receivables, net	66,964	51,491	15,473
Prepaid expenses, inventories and other receivables	66,639	76,930	(10,291)
Total Current Assets	167,979	137,942	30,037
Assets Whose Use is Limited:			
Designated under self-Insurance programs	49,331	68,243	(18,912)
Restricted under third party agreements	60,148	28,617	31,531
Designated for long-term investments	23,639	21,837	1,802
Total Assets Whose Use is Limited	133,118	118,697	14,421
Property and equipment, net	278,197	288,997	(10,800)
Other assets	31,821	31,286	535
Total Assets	$ 611,115	$ 576,922	$ 34,193
Liabilities & Net Postion			
Current Liabilities:			
Current portion of long-term debt	$ 9,594	$ 8,137	$ 1,457
Accounts payable	34,134	34,076	58
Accrued salaries and benefits	40,530	22,274	18,256
Other accrued expenses	35,558	40,930	(5,372)
Estimated third party payer settlements	10,967	20,511	(9,544)
Total Current Liabilities	130,783	125,928	4,855
Long-term debt	170,562	166,579	3,983
Estimated self-insurance reserves	57,884	45,525	12,359
Other liabilities	128,599	119,859	8,740
Total Liabilities	487,828	457,891	29,937
Total Net Position	123,287	119,031	4,256
Total Liabilities and Net Position	$ 611,115	$ 576,922	$ 34,193

The difference between healthcare and true care™

Erie County Medical Center Corporation

Statement of Operations

For the month ended October 31, 2015

(Dollars in Thousands)

	Actual	Budget	Favorable/ (Unfavorable)	Prior Year
Operating Revenue:				
Net patient revenue	40,535	39,099	1,436	40,647
Less: Provision for uncollectable accounts	(1,576)	(1,376)	(200)	(2,125)
Adjusted Net Patient Revenue	38,959	37,723	1,236	38,522
Disproportionate share / IGT revenue	4,707	5,104	(397)	4,759
Other revenue	2,026	1,302	724	1,216
Total Operating Revenue	45,692	44,129	1,563	44,497
Operating Expenses:				
Salaries & wages / Contract labor	17,234	15,393	(1,841)	14,822
Employee benefits	7,618	8,576	958	8,563
Physician fees	5,218	5,269	51	5,037
Purchased services	3,635	3,172	(463)	3,534
Supplies	6,782	6,127	(655)	6,264
Other expenses	2,075	1,283	(792)	1,697
Utilities	514	747	233	643
Depreciation & amortization	2,218	2,100	(118)	2,173
Interest	685	658	(27)	706
Total Operating Expenses	45,979	43,325	(2,654)	43,439
Income/(Loss) from Operations	**(287)**	**804**	**(1,091)**	**1,058**
Non-operating Gain/(Loss):				
Interest and dividends	126	-	126	209
Unrealized gain/(loss) on investments	1,645	333	1,312	673
Non-operating Gain/(Loss)	1,771	333	1,438	882
Excess of Revenue/(Deficiency) Over Expenses	$ 1,484	$ 1,137	$ 347	$ 1,940
Retirement health insurance	1,534	1,421	(113)	1,375
New York State pension	463	1,807	1,344	1,827
Impact on Operations	$ 1,997	$ 3,228	$ 1,231	$ 3,202

The difference between healthcare and true care™

Erie County Medical Center Corporation

Statement of Operations

For the ten months ended October 31, 2015

(Dollars in Thousands)

	Actual	Budget	Favorable/ (Unfavorable)	Prior Year
Operating Revenue:				
Net patient revenue	390,309	382,676	7,633	376,148
Less: Provision for uncollectable accounts	(9,577)	(13,458)	3,881	(21,366)
Adjusted Net Patient Revenue	380,732	369,218	11,514	354,782
Disproportionate share / IGT revenue	50,576	51,043	(467)	60,185
Other revenue	21,041	16,431	4,610	11,754
Total Operating Revenue	452,349	436,692	15,657	426,721
Operating Expenses:				
Salaries & wages / Contract labor	165,022	151,480	(13,542)	150,363
Employee benefits	82,520	85,874	3,354	86,312
Physician fees	55,889	52,692	(3,197)	51,196
Purchased services	36,311	31,323	(4,988)	35,518
Supplies	60,142	58,414	(1,728)	58,362
Other expenses	16,241	12,778	(3,463)	10,976
Utilities	5,168	7,325	2,157	6,540
Depreciation & amortization	23,135	20,996	(2,139)	20,399
Interest	6,854	6,582	(272)	6,977
Total Operating Expenses	451,282	427,464	(23,818)	426,643
Income/(Loss) from Operations	**1,067**	**9,228**	**(8,161)**	**78**
Non-operating Gain/(Loss):				
Interest and dividends	1,520	-	1,520	2,374
Investment Income/(Loss)	2,571	3,333	(762)	1,527
Non-operating Gain/(Loss)	4,091	3,333	758	3,901
Excess of Revenue/(Deficiency) Over Expenses	$ 5,158	$ 12,561	$ (7,403)	$ 3,979
Retirement health insurance	15,216	14,209	(1,007)	13,750
New York State pension	12,913	18,155	5,242	19,908
Impact on Operations	$ 28,129	$ 32,364	$ 4,235	$ 33,658

The difference between healthcare and true care™

Erie County Medical Center Corporation

Statement of Changes in Net Position

For the month and ten months ended October 31, 2015

(Dollars in Thousands)

	Month	Year-to-Date
Unrestricted Net Assets:		
Excess/(Deficiency) of revenue over expenses	$ 1,484	$ 5,158
Other transfers, net	(90)	(902)
Contributions for capital acquisitions	-	-
Net assets released from restrictions for capital acquisition	-	-
Change in Unrestricted Net Assets	1,394	4,256
Temporarily Restricted Net Assets:		
Contributions, bequests, and grants	-	-
Other transfers, net	-	-
Net assets released from restrictions for operations	-	-
Net assets released from restrictions for capital acquisition	-	-
Change in Temporarily Restricted Net Assets	-	-
Change in Net Position	1,394	4,256
Net Position, beginning of period	121,893	119,031
Net Position, end of period	**$ 123,287**	**$ 123,287**

The difference between healthcare and true care™

Erie County Medical Center Corporation

Statistical and Ratio Summary

	October 31, 2015	December 31, 2014	ECMCC 3 Year Avg. 2012 - 2014
Liquidity Ratios:			
Current Ratio	1.3	1.2	1.1
Days Operating Cash, includes current Investments	21.4	12.7	13.6
Days in Designated Cash & Investments (Covenant 57 days)	66.9	92.3	110.6
Days in Patient Receivables	48.0	45.3	45.2
Days Expenses in Accounts Payable	21.3	25.2	27.3
Days Expenses in Current Liabilities	81.6	93.3	90.3
Cash to Debt	46.5%	58.6%	63.0%
Working Capital	$ 37,196	$ 19,574	$ 15,298
Capital Ratios:			
Long-Term Debt to Fixed Assets	61.3%	57.6%	63.5%
Assets Financed by Liabilities	79.8%	79.4%	79.5%
Debt Service Coverage (Covenant > 1.1)	1.3	2.3	1.8
Capital Expense	3.7%	3.2%	3.0%
Debt to Capitalization	61.6%	61.8%	63.5%
Average Age of Plant	11.4	11.3	13.8
Debt Service as % of NPSR	3.5%	4.0%	3.8%
Capital as a % of Depreciation	53.3%	99.2%	280.1%
Profitability Ratios:			
Operating Margin	0.2%	0.2%	0.2%
Net Profit Margin	1.3%	0.9%	2.1%
Return on Total Assets	1.0%	0.7%	1.5%
Return on Equity	5.0%	3.5%	7.5%
Productivity and Cost Ratios:			
Total Asset Turnover	0.9	0.9	0.9
Total Operating Revenue per FTE	$ 178,637	$ 186,752	$ 175,781
Personnel Costs as % of Total Revenue	53.6%	52.5%	54.6%

The difference between healthcare and true care™

Erie County Medical Center Corporation

Key Statistics

Period Ended October 31, 2015

Current Period					Year to Date			
Actual	**Budget**	**% to Budget**	**Prior Year**		**Actual**	**Budget**	**% to Budget**	**Prior Year**
				Discharges:				
1,011	990	2.1%	1,055	Med/Surg (M/S) - Acute	10,036	9,446	6.2%	9,639
321	403	-20.3%	363	Behavioral Health	2,987	3,558	-16.0%	3,160
139	136	2.2%	142	Chemical Dependency (CD) - Detox	1,413	1,310	7.9%	1,339
31	30	3.3%	28	CD - Rehab	293	265	10.6%	257
39	32	21.9%	26	Medical Rehab	347	308	12.7%	303
30	38	-21.1%	37	Transitional Care Unit (TCU)	300	327	-8.3%	317
1,571	1,629	-3.6%	1,651	Total Discharges	15,376	15,214	1.1%	15,015
				Patient Days:				
6,433	5,455	17.9%	6,169	M/S - Acute	65,410	55,859	17.1%	60,363
3,782	4,636	-18.4%	3,681	Behavioral Health	36,601	40,929	-10.6%	38,410
491	465	5.6%	471	CD - Detox	4,880	4,479	9.0%	4,624
470	552	-14.9%	482	CD - Rehab	4,929	4,873	1.1%	4,755
767	822	-6.7%	898	Medical Rehab	7,696	7,927	-2.9%	7,680
339	483	-29.8%	409	TCU	3,784	4,157	-9.0%	4,036
12,282	12,413	-1.1%	12,110	Total Patient Days	123,300	118,224	4.3%	119,868
				Average Daily Census (ADC):				
208	176	17.9%	199	M/S - Acute	215	184	17.1%	199
122	150	-18.4%	119	Behavioral Health	120	135	-10.6%	126
16	15	5.6%	15	CD - Detox	16	15	9.0%	15
15	18	-14.9%	16	CD - Rehab	16	16	1.1%	16
25	27	-6.7%	29	Medical Rehab	25	26	-2.9%	25
11	16	-29.8%	13	TCU	12	14	-9.0%	13
396	400	-1.1%	391	Total ADC	406	389	4.3%	394
				Average Length of Stay:				
6.4	5.5	15.5%	5.8	M/S - Acute	6.5	5.9	10.2%	6.3
11.8	11.5	2.4%	10.1	Behavioral Health	12.3	11.5	6.5%	12.2
3.5	3.4	3.3%	3.3	CD - Detox	3.5	3.4	1.0%	3.5
15.2	18.4	-17.6%	17.2	CD - Rehab	16.8	18.4	-8.5%	18.5
19.7	25.7	-23.4%	34.5	Medical Rehab	22.2	25.7	-13.8%	25.3
11.3	12.7	-11.1%	11.1	TCU	12.6	12.7	-0.8%	12.7
7.8	7.6	2.6%	7.3	Average Length of Stay	8.0	7.8	3.2%	8.0
				Occupancy:				
84.3%	83.8%	0.6%	83.1%	% of M/S Acute staffed beds	84.3%	83.8%	0.6%	83.1%
				Case Mix Index:				
1.74	1.81	-3.8%	1.82	Blended (Acute)	1.74	1.77	-1.7%	1.78
165	194	-14.9%	175	Observation Status	1,775	2,241	-20.8%	2,022
523	532	-1.7%	498	Inpatient Surgeries	5,002	4,887	2.4%	4,810
744	697	6.7%	714	Outpatient Surgeries	6,932	6,564	5.6%	6,488
26,463	30,022	-11.9%	29,431	Outpatient Visits	259,983	285,155	-8.8%	281,648
5,657	5,263	7.5%	5,649	Emergency Visits Including Admits	56,456	54,190	4.2%	55,785
48.0	44.2	-100.0%	44.6	Days in A/R	48.0	44.2	-100.0%	44.6
4.4%	3.9%	13.2%	6.0%	Bad Debt as a % of Net Revenue	2.5%	3.8%	-33.9%	6.5%
2,629	2,433	8.0%	2,431	FTE's	2,585	2,435	6.2%	2,440
3.84	3.43	11.7%	3.43	FTE's per Adjusted Occupied Bed	3.62	3.49	3.7%	3.45
$ 12,206	$ 11,207	8.9%	$ 11,165	Net Revenue per Adjusted Discharge	$ 12,067	$ 11,635	3.7%	$ 11,456
$ 15,162	$ 13,428	12.9%	$ 12,910	Cost per Adjusted Discharge	$ 14,955	$ 14,010	6.7%	$ 14,084
Terrace View Long Term Care:								
11,860	11,891	-0.3%	11,864	Patient Days	115,866	116,581	-0.6%	116,358
383	384	-0.3%	383	Average Daily Census	381	383	-0.6%	383
455	447	1.9%	446	FTE's	437	447	-2.3%	447
7.1	6.9	2.1%	6.9	Hours Paid per Patient Day	4.8	4.9	-1.7%	4.9

MEDICAL EXECUTIVE COMMITTEE MEETING
MONDAY, OCTOBER 26, 2015 AT 11:30 A.M.

Attendance (Voting Members):

S. Anillo, MD	A. Manyon, MD	
M. Azadfard, MD	M. Panesar, MD	
Y. Bakhar, MD	K. Pranikoff, MD	
V. Barnabei, MD	R. Schuder, MD	
W. Belles, MD	P. Stegemann, MD	
G. Bennett, MD		
S. Cloud, DO		
M. Cummings, MD		
W. Flynn, MD		
R. Ferguson, MD		
M. Brandwein-Gensler, MD		
J. Izzo, Jr., MD		
M. LiVecchi, MD		
M. Manka, MD		
J. Marshall, DO		

Attendance (Non-Voting Members & Guests):

D. Ford, PA	T. Quatroche	A. Billittier, MD
S. Gary	K. Ziemianski, RN	C. Cavaretta
M. Hoffman, RN	L. Feidt	
S. Ksaizek	R. Gerwitz	
B. Murray, MD	N. Mund, RN	
A. Orlick, MD	C. Davis	

Excused:

D. Amsterdam, PhD	E. Jensen, MD	
M. Anders, MD	T. Loree, MD	
K. Grimm, MD	J. Reidy, MD	
W. Guo, MD	M. Sullivan, DDS	
R. Hall, MD, DDS, PhD	R. Venuto, MD	
M. Jajkowski, MD		

Absent:

None		

I. CALL TO ORDER

A. Dr. Samuel Cloud, President, called the meeting to order at 11:40 a.m. Please review the seriously delinquent report and follow up with the significantly delinquent providers.

B. Methadone Prescribing – Randy Gerwitz provided an update on prescribing methadone pursuant to his memo of October 22, 2015. It is appropriate for a provider to write an order for Methadone maintenance based on current script until it can be verified. It not necessary for AIS to write the order in this case. It is recommended to obtain and confirm dosage as soon as possible with the

dosing pharmacy. Dr. Bakhai requested the requirements for psychiatry to become certified in Methadone detox so his staff may also prescribe therapy.

II. CEO/COO/CFO BRIEFING

A. CEO REPORT – Richard Cleland

1. No report

B. CFO REPORT – Steve Gary

1. September Operating Performance – A $280,000 operating surplus was realized and $1.3 million profit year to date which is ahead of last year.

C. PRESIDENT'S REPORT – Tom Quatroche

1. **Rural Hospitals** – Mr. Quatroche reports that his team has been working with rural hospitals pertaining to some additional funding opportunities. More information will follow as the relationships develop.
2. **New Quality and Efficiency Initiatives** – Are underway and a formal plan is being developed. A formal presentation will be forthcoming and changes are expected January 1.

D. COO's REPORT – Mary Hoffman, RN

1. **Volumes** – September continued to have increased volumes. LOS is 6.0 and operating expenses are on budget.
2. **Cleve-Hill Family Health** – Still operating out of the Grider Family Health space. Plans are underway to continue to renovate the space.
3. **CT Scans** – Two new CT scanner installs are on schedule and will replace the existing equipment.
4. **Orthopaedic Space**- On schedule and should open early next year.
5. **ED Renovations** – Hoping for a final decision on the renovation plans by the end of October. The Capital Campaign for funding will begin soon thereafter.
6. **Terrace View Update** – A new position for an Assistant Director of Nursing was approved and hiring will begin shortly.

E. DSRIP UPDATE – Dr. Anthony Billittier, Medical Director, Millennium Collaborative Initiative

1. **Health Homes**- Care management service model whereby all patient caregivers communicate with one another so that all patient needs are addressed in a timely manner. Patients that are eligible are Medicaid patients and have 2 chronic comorbities. The state identifies patients and provides a list of eligible patients to the PCPs or MCOs. Finding the patients is a bit of a challenge. The goal is to help patients with complex medical, behavioral and long term care navigate healthcare system more

effectively to improve their health and lessen costs. Reduce inpatient stays and reduce long term institutional care. Support is for the patients and families. Western New York Health Homes were listed. Dr. Billittier will provide the information for distribution.

F. CHIEF NURSE UPDATE – Karen Ziemianski, RN

1. **American Heart Association** – ECMC will be awarded the Gold Plus designation and involves a multidisciplinary team to achieve this designation.
2. **MST School Job Fair** – Nursing will be working with the Math Science Technology school introducing the students to opportunities available in healthcare.
3. **Recognition of Nurse Preceptors** – Recognition of those who mentor new orientees and students will take place on November 6th thanking them for their key role in our institutions.

V. CHIEF MEDICAL OFFICER REPORT – B. Murray, M.D.

A. UNIVERSITY AFFAIRS

Anu Mendu, MBBS joined UBMD Internal Medicine on 10/1. Welcome! Dr. Mendu will be working as a hospitalist at Erie County Medical Center. She completed her MBBS at NTR University of Health Sciences in India, her internship and residency in Internal Medicine at UB and her MPH, at the University of Illinois at Springfield. She is an assistant professor in UB's Department of Medicine.

B. PROFESSIONAL STEERING COMMITTEE

Next meeting planned for December.

C. UTILIZATION REVIEW

September Flash Report distributed for review.

D. CLINICAL ISSUES

!

Hospital Value-Based Purchasing Program Having Little Impact: GAO

Medicare's Hospital Value-Based Purchasing Program for hospitals, which provides bonuses and penalties based on performance, has not led to demonstrated improvements in its first three years, according to a GAO report released last week. Earlier this year Medicare gave bonuses to 1,700 hospitals and reduced payments to 1,360 hospitals based on their mortality rates, patient reviews, degree

of improvement and other measurements. The audit found the financial effect has been minimal. Most hospitals saw their Medicare payments increase or drop by less than half a percentage point. In the fiscal year that ended Sept. 30, 74 percent of hospitals fell within that range, with a median bonus of $39,000 and a median penalty of $56,000.

E. Most Hospitals In CMS' Mandatory Bundled Payment Program Are Hurt by Regional Pricing Averages

A new analysis of CMS' proposed Comprehensive Care for Joint Replacement (CCJR) bundled payment initiative finds that 65% of selected hospitals will be subject to target prices based on regional episode spending averages that are lower than hospital-specific spending averages. Specifically, the analysis finds that the average spending for an episode of care in hospitals selected for CCJR is $3,802 higher than the average of their respective census regions.

F. EEG Coverage

There was a gap in coverage recently and in order to address this, an agency was engaged to provide coverage and this is found to be a good opportunity to improve this going forward.

G. Delinquent Medical Records

Dr. Murray advised that 5 physicians will be receiving a letter advising them that they are in violation of the policy of the hospital. The names of the providers will be reported in Executive Session.

H. Signing Admit Attestation Orders

Due to a failure to comply by some providers, a significant amount of reimbursement was lost. A mechanism to address this is being developed and will be presented by Dr. Murray in Executive Session.

I. Great Lakes Health EMR Selection

Dr. Panesar, CMIO, reports that selection is still underway and will hopefully make a decision within the next month. Costs are of concern in selecting a vendor and strong consideration is part of the process.

VII. CONSENT CALENDAR

	MEETING MINUTES/MOTIONS	ACTION ITEMS
A.	**MINUTES OF THE Previous MEC Meeting: September 28, 2015**	Received and Filed
B.	**CREDENTIALS COMMITTEE: Minutes of October 6, 2015**	Received and Filed*
	- Resignations	Reviewed and Approved*
	- Appointments	Reviewed and Approved*
	- Reappointments	Reviewed and Approved*
	- Dual Reappointment Applications	Reviewed and Approved*
	- Provisional to Permanent Appointments	Reviewed and Approved*
C.	HIM Committee: No report	
D.	P & T Committee Meeting – Minutes of October 6, 2015	Received and Filed
	1. NUR-102 Guidelines for the Administration of IV Opioids and Benzodiazepines - approve monitoring concept	Reviewed and Approved
	2. Sitagliptin (Januvia®) 25 mg, 100 mg - add to formulary	Reviewed and Approved
	3. Aripiprazole Maintena lnj 300 mg – delete from formulary	Reviewed and Approved
	4. Erythromycin 500 mg tablets – delete from formulary	Reviewed and Approved
	5. FRM-011 Med Admin Times - approve review	Reviewed and Approved
	6. FRM-027 Pharmacy Dosing And Monitoring Antibiotics - approve revision	Reviewed and Approved

VII. CONSENT CALENDAR, CONTINUED

A. Credentials Committee Minutes and Recommendations – The ECMC Board of Directors met on October 20, 2015 and approved the appointments and reappointments. The October 6, 2015 Credentials Committee minutes and recommendations were approved unanimously by the Medical Executive Committee as presented in the Consent Calendar.

B. MOTION: Approve all items presented in the consent calendar.

MOTION UNANIMOUSLY APPROVED.

VI. OTHER NEW/OLD BUSINESS

NEW BUSINESS

A. ANNOUNCEMENT/REMINDER: MEDICAL DENTAL STAFF ANNUAL MEETING

Monday, November 9, 2015 – 5:30-6:30 pm

- VOTE: Bylaws Revisions (must have at least 50 VOTING members to ratify)

- Agenda also includes presentation of strategic plan for ECMC and Great Lakes Health.

B. **TEST MENU DELETIONS**

Per memo distributed from Dr. Daniel Amsterdam, Chief of Service, Laboratory Services, based on clinical utility and utilization to discontinue testing for creatine kinase (CKMB) enzyme as a reflexive assay from Troponin T or as a discrete orderable test as of December 1, 2015. If discontinued, requests received will be sent to our Reference Laboratory.

MOTION: Accept deletion of the Creatine Kinase (CKBM) Enzyme as a reflexive assay from Troponin T effective December 1, 2015. Requests received after that date will be sent to a Reference Laboratory.

MOTION UNANIMOUSLY APPROVED.

C. RADIOLOGY and NUCLEAR MEDICINE POSITIONS

MOTION: Approve the qualification, training and licensure requirements for the Radiology and Nuclear Medicine positions as submitted in attachment provided by Dr. Jonathan Marshall, p. 78-83.

- **Radiology Technologist**
- **Senior Radiologic Technologist**
- **CT Technologist**
- **Senior Special Procedures Technologist**
- **Magnetic Resonance Imaging (MRI) Technologist**
- **Senior Magnetic Resonance Imaging (MRI) Technologist**
- **Nuclear Medicine Technologist**
- **Senior Nuclear Medicine Technologist**
- **Senior Radiologic Technologist/Imaging Specialist**
- **Licensed Practical Nurse**
- **Radiology Nursing Team Leader**
- **Registered Nurse/Radiology**
- **Special Procedures technologist/Angiographer**
- **Radiology Physician Assistant (PA)**
- **Ultrasonographer**
- **Senior Ultrasonographer**
- **Assistant Director of Imaging**
- **Director of Imaging**

MOTION UNANIMOUSLY APPROVED.

D. HEALTH INFORMATION MANAGEMENT – Close on three holidays

Per interim director, Sandra Cutrona, the HIM department will close on Thanksgiving, Christmas and New Year's Day. They would service the hospital

as on a weekend day. Historically no one calls or comes by HIM on those holidays. There was no objection from the MEC regarding this request.

E. **STROKE CENTER DESIGNATION** – Due to the recent change in the hospitalist service, the providers are no longer meeting the criteria for certification. It was suggested that a small group, led by Dr. Cloud, meet to discuss the future of the stroke program at ECMC and meeting the necessary requirements.

VII. ADJOURNMENT

There being no further business, a motion was made to adjourn to Executive Session, seconded and unanimously approved to adjourn the regular session of the Medical Executive Committee meeting at 1:00 p.m.

Respectfully submitted,

Michael Cummings, MD, Secretary
ECMCC, Medical/Dental Staff

Monday, November 16, 2015

TheBuffaloNews.com

CITY & REGION

Courage Awards to be presented

on November 8, 2015 - 6:56 PM

Five community leaders will be honored with Courage to Come Back Awards when the Friendship Foundation Inc. hosts its fall banquet Friday evening in the Grapevine Banquet Facility, 333 Dick Road, Depew. A reception at 6 p.m. will be followed by dinner at 7.

The honorees are Michael J. Billoni, public and community relations director for the Food Bank of Western New York; Kenneth Houseknecht, executive director of the Mental Health Association of Erie County; Dr. Mark A. LeVecchi, chairman of the Physical Medicine and Rehabilitation Department at Erie County Medical Center; Karl Shallowhorn, director of community advocacy for the Mental Health Association of Erie County; and inspirational speaker and life coach mentor Sammy Violante.

Keynote speaker will be Raul Russi, chief executive officer for Acacia Network Inc. in New York City. Tickets are $50. The Friendship Foundation assists people through the Restoration Society Inc., which offers psychiatric rehabilitation services.

From the Buffalo Business First :http://www.bizjournals.com/buffalo/news/2015/10/23/historic-collaboration-planned-for-cardiac-care.html

Historic collaboration planned for cardiac care facility

Oct 23, 2015, 9:52pm EDT

Tracey Drury
Reporter- Buffalo Business First
Email | Twitter | LinkedIn | Google+

In a historic deal, the region's two largest health systems and two competing Niagara Falls hospitals have agreed to collaborate on a cardiac care facility.

Niagara Falls Memorial Health Center will house the cardiac catheterization lab in its Heart Center in a joint project with Mount St. Mary's Hospital and its parent, Catholic Health, along with Kaleida Health and Erie County Medical Center.

Joint applications were filed today with the State Department of Health for a $2.2 million project. They follow a series of past applications filed separately by Kaleida and ECMC with Niagara Falls Memorial, and others filed by Catholic Health to house a cardiac cath lab at Mount St. Mary's, both denied after state officials urged the competing health systems to find a way to work together.

Last year, Niagara Falls Memorial and ECMC filed a second application, citing a growing need for cardiac programs in the country, especially among African-American residents of Niagara Falls. The closest cardiac cath labs now exist in Erie County at ECMC, Buffalo General Medical Center's Gates Vascular Institute and at Mercy Hospital in South Buffalo, a Catholic Health site.

Currently, about 1,900 Niagara County residents undergo cardiac angiography and other cardiac catheterization procedures in Erie County each year, The Niagara cath lab is projected to serve 925 patients in its first year of operation. That number is expected to increase to 1,100 patients in the second and third years of operation.

The new application calls for ECMC to decertify one of its existing labs and transfer the license to the joint venture. It replaces an application filed last spring by Niagara Falls Memorial and ECMC to open a site.

"This plan effectively and collaboratively addresses the longstanding question of who should provide cardiac catheterization and interventional coronary care services to Niagara County

residents," said Joseph Ruffolo, Memorial's president and CEO. "It will also eliminate glaring local disparities in the heart care available to African-Americans, Native Americans, residents of low-income households, people challenged by mental health issues and those who are developmentally or intellectually disabled."In a statement released late Friday, the leaders of each organization put patient care ahead of competitive concerns.

"We essentially all wanted the same thing – to make cardiac catheterization services more convenient and accessible for the residents of Niagara County, and to do it in the most cost effective way possible," said Catholic Health President & CEO Joe McDonald. "We had some good discussions over the last few months between our organizations and the pieces began to fall into place."

Kaleida CEO Jody Lomeo agreed.

"This is a great opportunity for us to bring cardiac care directly to the community," he said. "There is a demonstrated need and, together, we can leverage our collective strengths and address the disparities that exist today in Niagara County."

Richard Cleland, CEO of ECMC, noted the cath lab also will fulfill a critical component of state Medicaid reform efforts by all four hospital systems to improve the region's cardiovascular health.

"ECMC is proud to be a collaborating partner in the Niagara Falls Cardiac Catheterization Lab," he said.

Cardiac catheterization is a procedure for diagnosing and treating cardiovascular conditions in which a long thin tube called a catheter is inserted in an artery or vein in a patient's groin, neck or arm and threaded through the blood vessels to the heart. The proposed Niagara County cath lab will host such procedures as cardiac angiography, stent placement and balloon angioplasty.

Tracey Drury covers health/medical, nonprofits and insurance

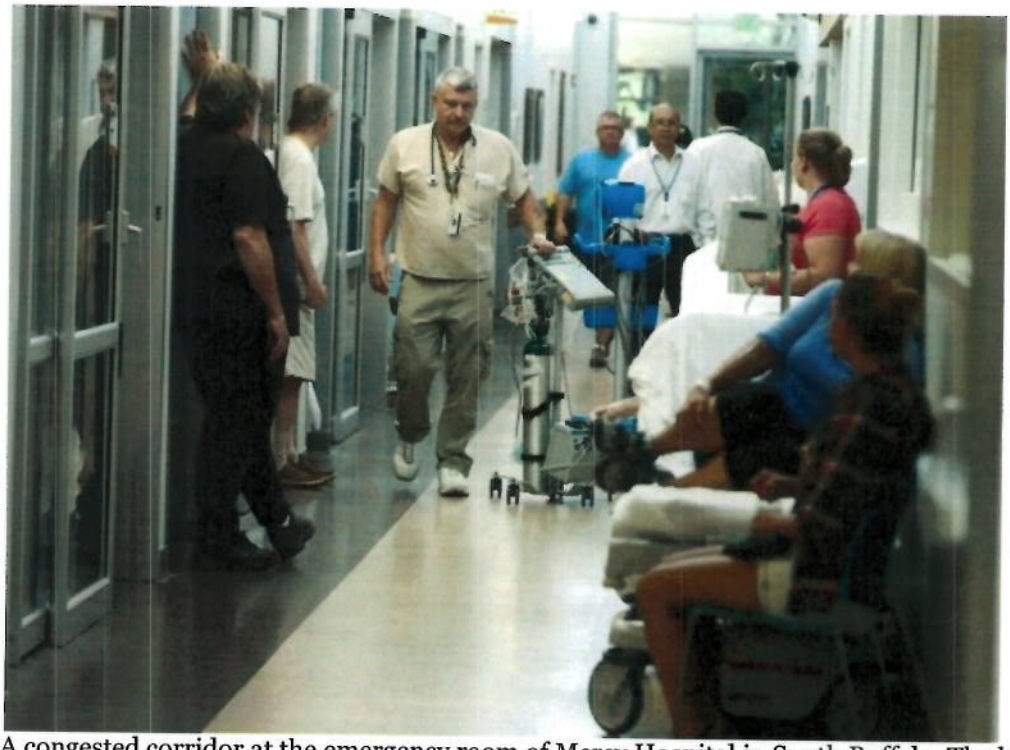
TheBuffaloNews.com

CITY & REGION

- *City & Region*

Hospitals work to shorten emergency room wait times but several exceed the state average

Emergency room waits always feel interminable, and a News analysis of WNY hospitals finds that feeling isn't just your imagination



A congested corridor at the emergency room of Mercy Hospital in South Buffalo. The busy hospital aims to keep patients moving through the system from the time they arrive, and it has instituted many small efficiencies to meet that goal. Robert Kirkham/Buffalo News

By Henry Davis | News Medical Reporter | Google+
on October 31, 2015 - 3:24 PM
, updated October 31, 2015 at 6:41 PM

It was Christmas Eve when Krista Thompson hurried her sick 2-year-old grandson to the emergency department at DeGraff Memorial Hospital.

And then, she waited.

As many families opened gifts and went to church, she waited an hour before someone took the screaming toddler to a triage area at the North Tonawanda hospital. Two-and-a-half hours passed before a doctor examined the child with a runny nose, ear infection and severe diaper rash.

"It was Christmas. Santa was coming," Thompson said. "The hospital was the last place we wanted to be."

The wait times at DeGraff's emergency department – whether to be seen by a health care professional or to be sent home or admitted to the hospital – exceed the state average for hospitals its size.

But it's not the only emergency room in the area where the waiting can stretch into hours, a Buffalo News analysis of federal data found.

The waiting starts when they arrive.

At Niagara Falls Memorial Medical Center, patients waited 64 minutes, on average, to be seen by a doctor, nurse or other health care professional – the longest time among Western New York's hospitals and double the state average for hospitals with similar patient volumes.

Then they wait to be sent home.

At Buffalo General Medical Center, patients spent about 4½ hours, on average, in the emergency department before being sent home. That's an hour and 22 minutes longer than the state average for the busiest hospitals.

At Millard Fillmore Suburban Hospital in Amherst, the average four-hour wait before being sent home was just five minutes shy of the longest average wait in the state, set by a Brooklyn hospital, among hospitals with similar patient volumes.

Or they wait to be admitted to the hospital.

Patients in Buffalo General's emergency department waited more than nine hours before being admitted to the hospital, an hour longer than the state average.

Wait times don't measure the effectiveness of care, and shorter wait times don't necessarily mean better quality.

But long delays in emergency rooms prompt some patients to leave without being treated. And, overcrowding in emergency departments increases the risk of poor outcomes.

Amid efforts to shorten wait times comes concern about quality, so hospitals struggle with the desire for speed and need for caution.

"You need a balance between providing quality care and assessing people properly, and keeping things convenient and moving the process along quickly," said Charlene Ludlow, chief safety officer at Erie County Medical Center.

The News' analysis of federal Centers for Medicare and Medicaid data also revealed where wait times were shorter than average and which hospitals showed improvement.

Women & Children's Hospital recorded the state's shortest average wait time before admitting emergency department patients. Its roughly four-and-a-half hour average wait was two hours shorter than the state average among busy hospitals.

ECMC, once the worst in the state for how long patients waited to be sent home, reduced its average wait by more than two hours – the best improvement of any local hospital.

The Catholic Health hospitals recorded below-average wait times. It took 23 minutes, on average, for emergency department patients to be seen by a health care professional at Sisters of Charity and Mercy hospitals in Buffalo – less than half the state average for the state's busiest hospitals.

The thinking is to get patients in front of a health professional as quickly as possible, even if it means on a bed in the hallway, said Dr. Richard Elman, chairman of the Catholic Health Department of Emergency Medicine.

"The idea is to keep patients moving through the process," added Mark Sullivan, a Catholic Health executive.

Mercy's moves

Mercy Hospital offers a peek at some steps being taken across the industry.

Catholic Health rebuilt the South Buffalo hospital's emergency room in 2010, creating a cavernous waiting area for patients that could pass for a stylish hotel lobby with its earth tones and stone work. Since it opened, the number of visits has increased 35 percent to about 55,000 a year.

"We thought the problem was with the waiting room, so we built a bigger waiting room," said Sullivan, executive vice president and chief operating officer of Catholic Health.

But their thinking changed. Now, the goal is to keep patients moving. On a recent afternoon, the waiting area looked empty even though the emergency room was busy.

"We could rent it out for bar mitzvahs or something," joked Mary Rose Graham, director of emergency services.

When patients arrive, they are placed in one of three categories. Acute patients get seen right away. Fast-track patients with routine issues go to another area. "Intake" patients who need lengthier evaluations get sent to an emergency department room or, if un available, placed on a bed in the hallway.

There is no magic solution at reducing wait times. But hospitals search for small efficiencies as they review their operations.

A pneumatic tube system at Mercy transmits patient specimens from the emergency department to the laboratory. Hospital officials counted 34 individual actions in the process. They found that something as mundane as a misaligned label caused delays that, in the past, were accepted.

Nurses used to replenish supplies from a central location. Today, the hospital uses 78 mobile supply carts throughout the emergency department stocked by someone hired just for that job.

Employees known as scribes, a new position, chart patient information wirelessly into an electronic medical record to save doctors time.

Another analysis identified 27 steps to communicate the need for an inpatient bed and transport a patient to it. So, the hospital found a way to cut out a few steps and has experimented with a "bed czar" to lower the time.

Hospitals, under pressure to avoid unnecessary admissions, have opened observation units to monitor patients when it's not clear whether to admit them. Mercy operates a "Comprehensive Admission Reception Expert Unit" that includes patients waiting for hospital beds and those being observed. An important feature is that inpatient hospital nurses provide the care.

"It allows ER nurses to take care of ER patients," Elman said.

Sicker in Niagara Falls

At Niagara Falls Memorial Medical Center – with the longest average wait time in the region to see a health professional – patients may wonder what takes so long.

Part of the answer can be found in who the hospital serves.

One of every four Niagara Falls residents lives below the poverty line. Niagara County also has high rates of heart disease and diabetes. But there are only 68 primary care doctors for every 100,000 population in the county, less than half the state average. The Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute ranks Niagara County 59th out of 62 counties in the state in overall health. Many patients, especially those on Medicaid or without insurance, have no ongoing relationship with a doctor.

"Probably one-third of emergency room visitors don't need to be there," said Joseph Ruffolo, chief executive officer of Niagara Falls Memorial.

The dilemma plays out in many cities.

Facilities now tend to many frail older patients with injuries and complicated chronic conditions that require lengthier evaluations. They also serve as the safety net for patients with mental illnesses or other problems like drug abuse.

"It takes longer to manage these patients," said Dr. James Augustine, vice president of the Emergency Department Benchmarking Alliance, a nonprofit group that tracks performance.

Hospitals have built bigger emergency rooms, but don't have enough workers or money to keep growing larger. The emergency department also is an expensive place to provide non-urgent care.

Officials at Niagara Falls Memorial say the solution lies in a long-term strategy to expand access to primary care in the community and improve coordination of services so that people who don't belong in the emergency department can get treated elsewhere.

"You can spend time trying to see more people in the emergency department or you can deal with the bigger issue, get ahead of the curve and avoid the unnecessary emergency visits," Ruffolo said. "We are taking the tougher road."

The hospital this year opened its sixth primary care office in Niagara County and last year completed a $1.9 million Niagara Wellness Connection Center that provides primary care,

behavioral health, addiction screening, wellness education, fitness activities and health insurance counseling.

Also, the hospital is constructing the $7 million Golisano Center for Community Health. It will offer services to adults with developmental and intellectual disabilities, as well as primary care, mental health treatment, housing assistance, and health insurance enrollment.

The center will also house a "hot spotting" project to identify clusters of individuals in the community suffering from chronic diseases, and a Medicaid initiative to provide intensive oversight of 6,000 patients with complex conditions.

Earlier this year, the hospital put in place emergency department triage to connect Medicaid patients to primary care. And in October, it created a rapid-response team to intercept patients with chronic conditions and link them with appropriate services.

So far this year, the hospital has seen a 6 percent decline in emergency room visits for medical care and a 12 percent decline for patients who need mental health treatment, said Sheila Kee, chief operating officer.

"These people are getting care elsewhere," Kee said. "That is the key way to get at emergency room wait times."

Kaleida's challenge

To frustrated patients, waiting feels like wasted time.

Three of Kaleida Health's hospitals – Buffalo General, Millard Fillmore Suburban and DeGraff – exceeded the state average for hospitals their size for how long it took patients to be seen by a health care professional. In Buffalo General's case, it exceeded the state average by only three minutes. Women & Children's, another Kaleida hospital, beat the state average by a couple of minutes.

Jeremy Rochevot of North Tonawanda recalls walking into DeGraff a few years ago with a bloody finger dangling from his hand. He nearly severed it on a table saw while doing trim work on a house.

An attendant told him to have a seat even though, to him, the emergency department didn't appear busy.

"I was sitting with people who were not bleeding or on stretchers," Rochevot said.

He made such a scene before he was treated that security was called.

"I was frantic, in a panic," he said.

The time it takes to see a health professional is what matters most to patients like Rochevot, although experts say it's the easier measure to fudge if emergency room staff do little more than introduce themselves.

Emergency departments serve as the hospital's front door, whether patients arrive with a life-threatening heart attack or a condition generally handled in a physician's office. Although patients with the most serious problems get seen right away, long waits have become common for many others.

The News analyzed wait-time data from April 2013 to March 2014 and found wide variations here and across the state.

Facilities with longer wait times tend to be large, urban or publicly owned hospitals, according to a study of nearly 3,700 hospitals published last year in JAMA Internal Medicine. In another related study, the researchers found that hospitals with shorter emergency department wait times tend to have higher admission rates. The takeaway: Too much pressure to shorten wait times may encourage admissions of patients who are better off going home.

An emergency department is a complicated place, with an intricate choreography behind the scenes that depends on other departments to work well. A bottleneck in one area – the laboratory, radiology, transport or discharge – can have a domino effect.

Emergency department patients who ultimately get admitted to a hospital wait the longest, and the busier the hospital, the longer the wait.

It took longer than nine hours, on average, to get admitted at Buffalo General, compared with slightly more than five hours at Sisters Hospital.

The waits are shorter at less-busy emergency departments. The eight area emergency departments considered to have medium patient volumes, from Niagara Falls Memorial to Olean General, reported waiting times for admission below the state average.

Hospitals can't ignore wait times. A portion of reimbursements from Medicare, the government health plan for people 65 and older and the disabled, is tied to patient satisfaction surveys. A similar survey of emergency department patients is on the horizon.

"The government has gotten it right. These are important metrics to follow," said Dr. Robert McCormack, chief of service of emergency medicine at Kaleida Health. "But it's a big challenge. The emergency department is the safety valve for the health care system."

Heightened scrutiny has pushed hospitals to study how best to speed up the flow of patients. Facilities are questioning old ways and embracing new ideas.

Buffalo General created a separate room for patients waiting for test results, such as blood work, to free up emergency department beds. Earlier this year, the hospital system partnered with MASH Urgent Care. One goal is to reduce non-urgent cases in its emergency departments.

"The biggest challenge is not the front door," McCormack said. "It's the back door – moving people who need hospitalization through the system. The hospital has problems placing a lot of people in the community, especially patients with both medical and social problems."

Shorter ECMC waits

ECMC in 2013 launched a project to improve efficiency, including in the emergency department, and started a triage program in the spring to divert non-urgent cases from the emergency department.

The effort resulted in a big improvement on one measure – how long patients waited in the emergency department before being sent home.

From July 2012 to June 2013, ECMC patients waited an average five hours and 15 minutes, the longest average wait among 153 hospitals in the state.

But from April 2013 to March 2014, the average wait time declined to three hours and four minutes, beating the state average by eight minutes.

ECMC also shortened by 40 minutes its average wait time before patients were admitted. Its nearly seven-hour average wait is 78 minutes below the average for the state's busiest hospitals.

The 41 minutes it took, on average, for a patient to be seen by a health care professional beat the state average by 13 minutes.

Ludlow, the chief safety officer at ECMC, contends the measures fail to reflect differences at hospitals. ECMC, for instance, operates the regional trauma center and is where many accident victims get care. It runs the region's 24-hour psychiatric emergency program.

"Not every facility is an apples-to-apples comparison," she said.

email: hdavis@buffnews.com

creating a living chain

be a part of ecmc's transplantation program

By Annette Pinder

ECMC is thrilled about the arrival of Dr. Liise Kayler, the hospital's new Director of Kidney and Pancreas Transplantation. The former director of Kidney and Pancreas Transplantation at Montefiore Medical Center in Bronx, New York, Kayler is working with other members of the ECMC transplant team to design a system and process for patients in need of transplantation.

Kayler says the system involves two phases. First is getting the patient referred and determining their eligibility through testing. Patients are then placed on a list while awaiting a donor. The second part is optimizing the hospital's ability to secure donors. Today, there are 800 people on a waiting list, and roughly 80 will be fortunate enough to get the help they need, with five years being the average wait time.

So who gets a kidney first? How is that determined? Kayler explains that a point system is in place, with priority given to pediatric patients and to patients that have developed antibodies that make it more difficult for them to obtain a match. Being an ideal match to a donor gets you more points, but most of the time it is based on how long you've been on dialysis.

To speed up the process and acquire more donors, living donation is becoming increasingly popular. Living donation involves working with people who are willing to donate an organ that they can live without to give someone else a second chance at life. Kayler works with ECMC staff to identify living donors and assure that they, too, receive exemplary and seamless care.

"ECMC has a kidney donor paired exchange in progress," says Kayler. This means that a person's brother might donate his kidney to someone in a different location that might be a perfect match. A person at that location might then donate to a person here in WNY that needs a kidney. Usually, these donors are altruistic. The longest chain Kayler is aware of involved 30 patients and 15 centers, which requires creating consents and documents to enter patients in a national swapping system.

While patients typically go to a medical center that does transplantation that is most convenient to where they live, patients are coming to ECMC from many other locations, including Olean, the southern tier, Rochester, Cleveland and Pittsburgh. What's exciting, too, is that the procedure is much less invasive than it was previously. Donors receive laparoscopic surgery, which is a small incision that is much more esthetically pleasing, with much shorter recuperation times. Patients can be out of the hospital within two days, and completely recovered in six weeks.

Kayler also performs pancreas transplants, although less frequently, and typically for Type 1 diabetic patients whose pancreas no longer functions. Her transplantation team consists of three surgeons, nephrologists, social workers, financial coordinators, pre- and post-transplant coordinators, a living donor coordinator, administrator, nutritionist, pharmacist and a person who performs quality assessments.

For information on becoming a member of the living kidney donor registry contact Nicole Haseley at 898-3318. You may just start a donor chain that saves many lives.