



Progress notes

Summer/Fall 2005

A PUBLICATION OF ERIE COUNTY MEDICAL CENTER

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E C M C



OUR MISSION

The mission of the Erie County Medical Center Corporation is to be the hospital of choice by providing quality care.

OUR VISION

The vision of the Erie County Medical Center Corporation is to be a leader within Western New York in developing and supporting an integrated healthcare delivery system.

OUR VALUES

We value:

- Caring for the well-being of the community
- Communication among and between our patients, employees, medical staff, and community
- Excellence in service
- Quality
- Teamwork
- Customer Service

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FROM THE DESK OF THE CEO



Communication is a vital issue in any large academic hospital such as Erie County Medical Center (ECMC). *Progress Notes* is intended to be a regular and timely update to help increase communication among our medical/dental staff, and it is my hope that administrators, physicians, and other medical professionals will use this publication to communicate new clinical initiatives, research accomplishments, and other pertinent physician related information.

Since arriving at ECMC, one particular initiative I have been focusing on is the implementation of state-of-the-art technology for the medical staff. An ever-expanding array of technology is currently revolutionizing the practice of medicine and we want our medical staff to benefit from its advantages. Here are a few of the IT initiatives currently in place or about to be incorporated into our operations.

- **Electronic Signature.** New York State regulations permit the use of electronic signatures (or eSignature) "authenticated through the use of a computerized medical record when used in accordance with hospital policy." Drs. Gregory J. Bennett and Joseph Kowalski were the first to use this technology on a regular basis, outside of the radiologists who have been using this technology for the last few years.
- **Online Pathology Reports.** As part of our electronic medical records (EMR), pathology reports are online as of August 2005.
- **Document Imaging-** Bar codes on all patient prescriptions that enable the nursing staff and the pharmacy to scan scripts when they scan a physician's order. This allows for electronic access to information which previously had to be physically brought to the pharmacy. In addition, the emergency room medical records registration and patient accounting will move to a more comprehensive paperless environment.

- **Technology Updates.** We have replaced 110 Zenith PCs throughout the hospital with new computers.
- **New Echocardiogram System.** Thanks to the efforts of the cardiologists at ECMC, we have implemented a new echocardiogram system. The system enables the anesthesiologist to complete the echocardiogram in the operating room without calling in technicians who may be needed in the electrophysiology labs or elsewhere.
- **PAC System Being Evaluated.** The request for proposals for a picture archive and communication system (PACS) has been published and review of responses will begin shortly. This system will enable radiology images to be stored in an accessible database. It also allows for the quick and efficient transmission of images wherever they may be needed.

This newsletter is one example of our heightened effort to foster clear and timely communications with all of our medical/dental staff as well as other interested parties within and beyond the hospital. We look forward to covering many more topics of interest in subsequent issues to keep you abreast of all the exciting developments at ECMC.

Michael A. Young, MHA, FACHE
Chief Executive Officer
ECMC

A Model for Healthcare Quality

by John R. Fudyma, MD,
Medical Director



Each quarter, we submit data to Center for Medicare and Medicaid Services (CMS) regarding indicators for community-acquired pneumonia (CAP), congestive heart failure (CHF), and acute coronary syndrome (ACS). This data, and that of other hospitals, is used to develop national report cards for all hospitals so that we can compare ourselves to other peer hospitals both regionally and nationally. Hospitals in the top 10 percentile have consistently high scores for all of the CMS core measures.

One of the most important recent developments in the area of CMS indicators is the formation of our Interdepartmental Pneumonia Task Force (IPTF). Pneumonia is, of course, one of the CMS core measures and our IPTF was created specifically to more closely examine our performance for community-acquired pneumonia. Led by Dr. Tim McDaniel, the task force consists of members of nursing, pharmacy, and quality staff, case managers, and other physicians. The task force regularly reviews patient data and works to implement new programs addressing some of the deficiencies in pneumonia care. These include smoking cessation counseling and screening for pneumococcal and influenza vaccinations.

The group also includes pharmacist Sue Ksiazek; Holly Martin, Case Manager for Family Medicine; Dr. Joseph Mylotte, infectious disease physician and Director of Acute Geriatrics; Kitty Gazda; Dr. Ali El-Solh, Director of the MICU and a member of the Division of Pulmonary Medicine; and myself. The goal of the IPTF is to review ongoing performance, identify continuing issues, and to disseminate plans to address those issues. Also, the group has recently developed

a pilot order set that is available in the Emergency Department.

These are the basic CMS core measures for community-acquired pneumonia.

1. Draw blood cultures before dispensing antibiotics.
2. Give appropriate antibiotics within 4 hours (formerly 8 hours).
3. Assess the oxygen level of all patients.
4. If the patient smokes, provide counseling regarding smoking cessation.
5. Screen patients with pneumonia for the pneumococcal vaccination.
6. During flu season, screen for the flu vaccine.

Our goal is to develop similar interdepartmental groups for CHF and ACS. Our Cardiac Steering Committee currently reviews our performance for these diseases and examines a host of issues in terms of our cardiac care delivery. When formed, the CHF and ACS groups will make recommendations to the Cardiac Steering Committee, to executive management, and to the ECMC Quality Committee. This will facilitate continuing improvement in quality of care.

Other Issues:

Patient Flow Management Committee.

Currently the hospital has an interdepartmental committee comprised of nurses, cases managers, physicians, and administrators that addresses patient flow. The committee reviews ongoing issues that impact patient throughput. We have always focused on a patient's length of stay and recently minimized the amount of delay in the emergency department and improved the flow of patients through the tower. We're focusing on earlier discharges of patients, minimizing delays in transporting patients through the hospital, and improving bed

accessibility for peak times of Emergency Department (ED) utilization. Our goal is to minimize ED wait time and decrease delay in accessing care. We are continually studying ways to improve our patient throughput and enhance our strategies for disease management.

Education. ECMC is committed to improving the quality of education for residents, interns and medical students. We have started a process to review the performance of all of the ECMC affiliated residency programs. Our intent is to work collaboratively with the chairs and program directors to enhance the current experience. Meanwhile, we are all excited at the prospect of a new academic year and another class of new residents coming into the hospital. In closing, I want to highlight the fact that this group of incoming interns has written an inspiring code of professionalism and I would like to share it with you here.

2005 VISION FOR PROFESSIONALISM

To uphold the values we embrace, the incoming residents of 2005 aspire to be:

Compassionate advocates for all patients by being selfless, altruistic and diligent in their care

Attentive and empathetic to our patients by establishing good rapport through effective communication skills and treating them as we wish to be treated

Motivated to be a proactive educator through life long learning, not only for patients but also for colleagues

Humble enough to recognize our limitations and seek advice when needed

Balanced in our lives by remaining true to ourselves, committed to family, friends and to our own well-being

Enthusiastic about our profession and committed to its advancement
"We will persevere!"

Communication for Quality

by David G. Ellis, MD
 President, Medical/Dental Staff



I am very pleased to be able to introduce the first edition of *Progress Notes*, our new ECMC physicians' newsletter. Communication is a critically important component of successful healthcare organizations and this is one exciting new step in an ongoing process to reach out to our providers and the Western New York community to ensure the highest levels of communication in our organization. There is nothing quite as consistent as change and our success will depend on our ability to manage change effectively through communication.

One major recurring theme of this newsletter will reflect the current focus in the healthcare field on quality and patient safety. There is an ongoing effort to develop indicators, measurable facets of the care provided, and to monitor the performance of our hospitals and providers on those indicators. Every day we are seeing more and more outcome data made publicly available through direct mailings or through consumer oriented web sites. ECMC has the quality in its Medical/Dental Staff to excel at this process. We simply need to become focused on fine-tuning our systems to objectively show the high

quality of care we provide to our patients. The successful healthcare organization will be one that embraces this process and finds new and exciting ways to meet and exceed these benchmarks of quality and safety.

This newsletter will be one of many tools that we use to reach out to our Medical/Dental Staff and other healthcare providers and decision makers in our community and keep them informed along with telephone calls, emails, the web, and letters. We ask that you take a few moments out of your busy days as you sort through the deluge of information and include this newsletter in your regular readings. It will be full of important updates, news, advances, service changes, and upgrades that will enhance your understanding of the rich healthcare and educational environment that is the Erie County Medical Center. In return, we'll also be asking and looking for your input on news, events, happenings and developments within your own departments and groups. The future for ECMC is what we make it and I am proud to be a part of this dynamic force for healthcare in our community.



National Patient Safety Goals for Hospitals



The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is continuously working to update its policies and standards in order to improve the quality and safety of the care provided to the public. Here are the 2006 National Patient Safety Goals approved by JCAHO's Board of Commissioners at its May meeting. (*New goals and requirements are indicated in italics.*)

Improve the accuracy of patient identification.

Use at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products, taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures. Use the patient's name and medical record number – look at armband.

Improve the effectiveness of communication among caregivers.

1. A read-back of complete order or test result is required with all verbal or telephone orders, which also includes critical lab values.
2. Do not use dangerous abbreviations – *Zero tolerance.*
3. Report critical lab values to responsible licensed caregiver.
4. *Implement a standardized approach to "hand-off" communication, including an opportunity to ask and respond to questions. (effective 1/06)*

Improve the safety of using medications.

1. Standardize and limit the number of drug concentrations available in the organization.
2. Annually review a list of look-alike/sound-alike drugs and take action to prevent errors involving the interchange of those drugs.
3. *Label all medications, medication containers (e.g., syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings. (effective 1/06)*

Reduce the risk of healthcare-associated infections.

1. Comply with CDC hand hygiene guidelines.
2. Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a healthcare-associated infection.

Accurately and completely reconcile medications across the continuum of care.

1. Implement a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. The process includes a comparison of the medications the organization provides to those on the list.
2. A complete list of the patient's medications is communicated to the next provider of service when a patient is referred to another setting, service, practitioner or level of care within or outside the organization.

Reduce the risk of patient harm resulting from falls.

1. Implement a fall reduction program and evaluate the effectiveness of the program.

Physicians' Portals For Remote Records Access

by Brian M. Murray, MD, FACP
Associate Medical Director



Medical Informatics Report

Unlike the banker, the financial advisor, or the corporate executive, until quite recently the physician has had a difficult time accessing records. At the hospital, doctors move from unit to unit, from floor to floor. On each floor, if the physician wants to access an electronic medical record (EMR), he/she has to log onto a computer, perhaps see one patient, and leave. Going around the corner to see another patient means logging onto another computer to access the records for that patient. Back in the office, if a call comes in requesting information on that same patient, it may be necessary to call the floor nurse and ask her to log onto the computer to get the information again. Wouldn't it be nice to have all patient information at one's fingertips all the time? This is now possible with a physicians' portal system.

The Clinical Informatics Committee is currently exploring a number of physicians' portals for use by our medical/dental staff. This mobile software allows doctors to access hospital records at home and from other remote locations. Physicians' portals provide doctors with the freedom to no longer be tied to hospital computers. Different products on the market have various capabilities and we are now studying several products in the category. Many of these are software programs designed to extract information from EMRs that the physician is likely to need and provide it in a more effective and physician-friendly format. This capability is intended to combat inefficiency and reduce medical errors.

Physicians' portals can be web-based or VPM-based (Virtual Private Messenger), where they have a small server that enables you to reach the hospital EMR. You can also access

medical records from home or when out of town providing you have Internet connectivity. If you get a call regarding your patient while at home, you can look up their medical records. If you are covering for a colleague and are called on one of his/her patients, you can quickly log into the EMR and see the exact nature of the patient's medical problems. In addition to the convenience, this immediate accessibility to vital information allows you to practice a whole new kind of medicine. What's more, if you don't have time to catch up on your records at the office, these systems can ultimately allow you to do them from home by eSignature.

We're currently looking at three different systems:

1. **Patient Keeper**
(<http://www.patientkeeper.com/>)
2. **Valco**
(<http://www.valcodatasystems.com/ehealth.htm>)
3. **Meditech Physicians Care Manager**
(<http://www.meditech.com/products/briefs/pages/ProductBriefsCSPCM.htm>)

Feel free to examine the information on these systems at the websites listed above and share your opinions with me at bmurray@ecmc.edu. Some of the systems being considered offer an additional advantage: you don't have to be at a computer. All you need is a cell phone with Internet connectivity. This makes it possible to actually get all the information you need on a palm pilot. Regardless of which system we choose, our goal is to have this technology available for all physicians within the next few months. The system will be customized to our needs so all physician comments and contributions are most welcomed and encouraged.



WNY Leads Nation in Kidney Disease Screening With Glomerular Filtration Rate (GFR)

The Western New York Kidney Disease Project (WNYKDP), a unique collaboration of physicians, administrators, insurers and other organizations, was formed last year to improve the quality and cost effectiveness of kidney disease treatment. The project was based on the fact that, until recently, kidney disease was very difficult to diagnose early. The conventional test actually provided a false sense of security since it only detected kidney failure at a point when the organ is operating at about half of its capacity. Then, in February 2002, the National Kidney Foundation issued new guidelines for chronic kidney disease (CKD) evaluation based upon the Glomerular Filtration Rate (GFR). This new measurement factors serum creatinine, gender, race, age, and weight into blood test results and allows for detection of disease when a kidney has lost a fraction of its function.

Using these new criteria, it is estimated that about 20 million people in the US now have kidney disease and some 20,000 people in Western New York are likely to get it during the next decade. Nephrologists tend to see patients referred very late, when their kidneys are failing. We often have no other options but to put them on dialysis or do transplants. Nationally, 340,000 patients are currently on dialysis or have been transplanted, and 651,000 will need dialysis or transplant by 2010. Clearly, there is a growing need for effective disease management at a community-wide level.

Through the cooperation of the area's three major health insurers and the coordination of the Niagara Health Quality Coalition, the WNYKDP secured the agreement of all the major labs in Western New York to report estimated

GFRs. In a period of about 18 months, this non-competitive, community-wide project convinced every laboratory in WNY to report the GFR whenever physicians order a kidney test. The cooperation of Quest Diagnostics, the area's largest lab, was pivotal in the process. In fact, Quest not only agreed to participate, but also agreed to participate on a system-wide basis. As a result, Quest labs outside the area will also add GFR to their reports, extending the influence of our project nationwide. In addition, the WNYKDP has:



- Published articles and letters on CKD management for PCPs
 - Developed mandatory referral guidelines for PCPs in upstate New York
 - Developed patient and stage-specific guidelines for evaluation and management of individual patients
 - Secured the support of pharmaceutical representatives to pool their educational funds and donate them to the National Kidney Foundation of Western New York in order to conduct a series of educational symposia on CKD

We are currently studying the impact of these achievements on the delivery of health care to patients. There is no other community in the US with this level of

cooperation among insurers, physicians, and labs in the management of chronic kidney disease. Individual health plans like Kaiser Permanente and individual hospitals elsewhere are using the GFR test, but the Western New York Kidney Disease Project is unique in that nowhere else has there been a community-wide effort to make it the standard test for kidney health and function. Our ultimate goal is, of course, to develop a uniform, region-wide treatment model for current and at-risk kidney patients that will lead to measurable improvements in the quality and cost of kidney disease.

Brian M. Murray, MD, is Medical Director, Hemodialysis, Erie County Medical Center and Associate Professor of Medicine, University at Buffalo. His collaborators in the Western New York Kidney Disease Project include Bruce Boissenault and Joe Bielli, Niagara Health Quality Coalition; Vicki Keidel, National Kidney Foundation of Western New York; Chet Fox, MD; Bradley Truax, MD, Independent Health; Jay Pomerantz, MD, Univera; John Gillespie, MD, Blue Cross & Blue Shield of WNY; George Marinides, MD, Nephrology Associates of Buffalo; Romesh Kohli, MD, Buffalo Medical Group; and Rocco Venuto, MD, ECMC.

Policy Updates

by Brian M. Murray, MD, FACP
Associate Medical Director



Technology/Service Assessment Committee

A Technology Assessment Policy has been developed by the hospital and can be found on the ECMC Intranet. Its primary purpose is to serve as a recognized forum to assess the potential financial and functional impact on the hospital of implementing new technologies/services and to provide recommendations to the Medical Staff Executive and Executive Management on whether they should be adopted. The process will be analogous to that currently pursued by the Pharmacy and Therapeutics Committee before approving the introduction of new medications.

This process is not intended to replace the current budget and capital programs, but rather to complement them. Selected projects can be referred to the Technology/Service Assessment Committee for consideration by the CFO or Medical Director, either because the decision to adopt them is not clear-cut or because they have potential impacts outside their individual departments, e.g. on nursing, information technology, or pharmacy, that need to be taken into account.

The Committee will perform an in-depth review of the medical indications of the technology/service via an outcomes-based literature review as well as a financial assessment of the project's impact. The physician and managerial champions for each project will need to be available to answer questions. The Committee will then issue a recommendation to Executive Management concerning each project, which will be conveyed in writing to the physician champion. It is hoped that this will:

1. Establish a fair and open forum for consideration of new initiatives
2. Avoid the kind of mistakes that have occurred in the past, e.g. purchase of equipment that does not interface with our EMR, and failure to assess impact of new services on nursing resources
3. Allow the expeditious implementation of new technology/services that will enhance patient care
4. Enhance hospital programs by aligning new projects with the hospital's major overall master plan and goals

Details of the new policy can be found on the ECMC Intranet site under *Policies and Procedures* (<http://policy.ecmc.edu/scripts/policy.cgi?T-7>).

Other new policies and procedures adopted at the Medical Executive Committee meeting held July 25th 2005: New Postoperative Order Sets for the following Orthopedic Procedures:

- Total Hip Replacement
- Total Knee Replacement
- ACL Reconstruction
- Knee Arthroscopy
- Shoulder Arthroscopy

Physicians' Emergency Department Update

When sending a patient to the emergency department, call ahead!

Emergency Department backup is a major problem in all modern day hospitals, including our own. This is principally related to the volume of patients handled but also affected by the amount of time a patient spends in the Emergency Department. In an effort to expedite both the efficiency and quality of the care we deliver, we are asking for your help. Please call the Emergency Department at 898-4166 or 1-800-Say-Life anytime that you send a patient to the Emergency Department at ECMC. This allows the staff to know ahead of time what to expect and what tests or consultations the referring physician would like. Please include the following information whenever possible:

1. Nature of the complaint and probable diagnoses.
2. Significant co-existing morbidities.
3. Suggested diagnostic work-up.
4. Any specific consultation and which service or consulting physician you would like.
5. Whether you or a member of your group or service should be contacted after the initial evaluation and diagnostic testing.
6. If the patient requires admission, to which service you would prefer that they be admitted.

While we recognize that many of our physicians already follow these procedures, the quality of care to our patients would be greatly enhanced if it became the standard practice for all members of our staff. Thanks for your cooperation!

We wish our chief residents success in their leadership role.

Chief Residents

of the State University of New York at Buffalo, affiliated with ECMC

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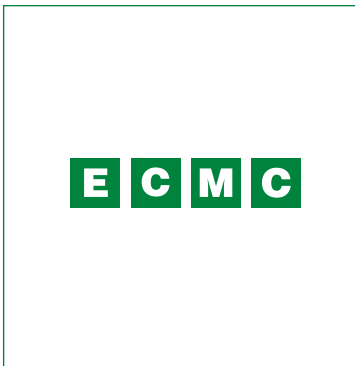
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The Erie County Medical Center Corporation (ECMCC) is the area's leading health care provider and one of the country's most modern, functional, and efficient health care delivery systems. The ECMCC encompasses on- and off-campus health centers, over 40 outpatient specialty care clinics, an advanced academic medical center (with 550 inpatient beds and 156 skilled nursing home beds), and the Erie County Home, a (586-bed) skilled nursing facility. The Medical Center, ranked among the nation's 100 top hospitals for cardiac and intensive care, serves as the regional center for trauma, burn, and rehabilitation, and a major teaching facility for the State University of New York at Buffalo. Most ECMCC physicians, dentists, and pharmacists are dedicated faculty members of the University. The ECMC Corporation is dedicated to being the medical center of choice through excellence in patient care and customer service.

ECMCC is situated on a 67-acre campus on the east side of Buffalo, NY. The Medical Center is easily accessible from all areas of Western New York, and is located right off Rt. 33 (Kensington Expressway) at the Grider Street interchange.



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