

# BOARD OF DIRECTORS

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Kevin Prantikoff, M.D.  
Joseph A. Zizzi, Sr., M.D.

~ Regular Meeting ~



## ERIE COUNTY MEDICAL CENTER CORPORATION

**Tuesday, August 28, 2012**

**4:00 P.M.**  
**Staff Dining Room, 2nd Floor - ECMCC**

Copies to: Anthony J. Colucci, III. Esq.  
Corporate Counsel



# Mission

To provide every patient the highest quality of care delivered with compassion.

# Vision

## **ECMC WILL BE A LEADER IN AND RECOGNIZED FOR:**

- High quality family centered care resulting in exceptional patient experiences.
- Superior clinical outcomes.
- The hospital of choice for physicians, nurses, and staff.
- Strong collaboration with community partners to improve access to healthcare and the quality of life and vitality of the region.
- Academic affiliations that provide the best education for physicians, dentists, nurses, and other clinical staff.

The difference between  
healthcare and true care™





# Core Values

## **ACCESS**

All patients get equal care regardless of their ability to pay or source of payment. We address the healthcare needs of each patient that we can appropriately serve, without bias or pre-judgment.

## **EXCELLENCE**

Excellence is a standard that will never be lowered; there is an expectation of excellence in all areas.

## **DIVERSITY**

We recognize the importance and value of diversity and the enrichment that diversity can bring to ECMCC.

## **FULFILLING POTENTIAL**

We respect the value and potential of each individual as offering a significant contribution to the good of the whole organization. Personal growth and development is important for organizational success.

## **DIGNITY**

Each individual, no matter his or her limitations, background or situation, has intrinsic dignity and unique capabilities.

## **PRIVACY**

We honor each person's right to privacy and confidentiality.

## **FAIRNESS and INTEGRITY**

Equity and fairness are guidelines for all decision-making. We demand personal and institutional integrity.

## **COMMUNITY**

In accomplishing our mission we remain mindful of the public's trust and are always responsive to the immediate surrounding community and our natural environment. This commitment represents both our organization and us as individuals. A successful future for ECMCC depends on a vibrant community and a healthy environment.

## **COLLABORATION**

Collaboration with other organizations is beneficial within the context of our mission and is fundamental to achieving our goals.

## **COMPASSION**

All involved with ECMCC's service delivery demonstrate caring, compassion, and understanding for patients, employees, volunteers, and families.

## **STEWARDSHIP**

We can only be successful in carrying out our mission through solid financial performance and by assuring that resources provided to us are used effectively, in the way they were intended, and for the benefit of our patients and community.

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AGENDA FOR THE  
REGULAR MEETING OF THE BOARD OF DIRECTORS  
ERIE COUNTY MEDICAL CENTER CORPORATION

TUESDAY, AUGUST 28, 2012

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I.	CALL TO ORDER: KEVIN M. HOGAN, ESQ., CHAIR	
II.	APPROVAL OF MINUTES OF JULY 31, 2012 REGULAR MEETING OF THE BOARD OF DIRECTORS	5-39
III.	RESOLUTIONS MAY BE DISTRIBUTED TO THE BOARD OF DIRECTORS DURING THE MEETING ON AUGUST 28, 2012.	
IV.	REPORTS FROM STANDING COMMITTEES OF THE BOARD:	
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# Minutes from the



## Previous Meeting

MINUTES OF THE REGULAR MEETING  
OF THE BOARD OF DIRECTORS  
TUESDAY, JULY 31, 2012  
ECMCC STAFF DINING ROOM

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Voting Board Members Present or Attending by Conference Telephone:	Kevin M. Hogan, Esq., Chair Bishop Michael A. Badger Douglas H. Baker Richard F. Brox Ronald A. Chapin K. Kent Chevli, M.D.	Kevin E. Cichocki, D.C. Sharon L. Hanson Anthony M. Iacono Dietrich Jehle, M.D. Frank B. Messiah Michael A. Seaman
Voting Board Member Excused:	Thomas P. Malecki, C.P.A. Joseph A. Zizzi, Sr., M.D.	
Non-Voting Board Representatives Present:	Jody L. Lomeo Michael Hoffert	Kevin Pranikoff, M.D.
Also Present:	Mark C. Barabas Richard Cleland Anthony Colucci, III, Esq. Peggy Cramer Janique Curry Leslie Feidt Susan Gonzalez	John Fudyma, MD Susan Ksiazek Charlene Ludlow Kathleen O'Hara Thomas Quatroche, Ph.D. Michael Sammarco Janet Bulger, CSEA

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**I. CALL TO ORDER**

Chair Kevin M. Hogan, Esq. called the meeting to order at 4:37 P.M.

“How to Ensure Quality Care” and “Value Based Purchasing – National Programs” were distributed to board members during meeting. Copy of articles are attached to the minutes as requested by the Chair..

**II. APPROVAL OF MINUTES OF THE JULY 31, 2012 REGULAR MEETING OF THE BOARD OF DIRECTORS.**

Moved by Frank Messiah and seconded Michael A. Seaman to approve the minutes of the July 31, 2012 regular meeting of the Board of Directors as presented.

**Motion approved unanimously.**

### III. ACTION ITEMS

A. A Resolution Authorizing Filing a Certificate of Need Application and Application for Prior Approval Review Pertaining to Behavioral Health Center of Excellence

Moved by Bishop Michael A. Badger and seconded by Frank Mesiah

**Motion Approved Unanimously.** Copy of resolution is attached

B. A Resolution Authorizing Filing a Certificate of Need Application for Certain Clinical Space in ECMCC Medical Office Building

Moved by Michael A. Seaman and seconded by Anthony Iacono.

**Motion Approved Unanimously.** Copy of resolution is attached

C. A Resolution Authorizing the Purchase of 2282 Elmwood, Buffalo, NY

Moved by Frank Mesiah and seconded by Anthony Iacono.

**Motion Approved Unanimously.** Copy of resolution is attached

D. A Resolution Authorizing Contract With Minority or Women-Owned Business Enterprise.

Moved by Richard Brox and seconded by Frank Mesiah

**Motion approved unanimously.** Copy of resolution attached.

E. Approval of Medical/Dental Staff Credentials, Resignations, Appointments and Re-appointments of July 3, 2012

Moved by Sharon L. Hanson, and seconded by Douglas H. Baker.

**Motion approved unanimously.** Copy of resolution is attached

### IV. BOARD COMMITTEE REPORTS

Moved by Anthony Iacono and seconded by Douglas H. Baker to receive and file the reports as presented by the Corporation's Board committees. All reports, except that of the Performance Improvement Committee, shall be attached to these minutes.

**Motion approved unanimously.**

### V. PRESENTATIONS

LESLIE FEIDT, CHIEF INFORMATION OFFICER

Ms. Feidt provided an overview of the corporation's meaningful use initiatives, including moving to an electronic health record and the incentives associated with those efforts.

DR. BRIAN MURRAY, CHIEF MEDICAL OFFICER

Dr. Murray announced that ECMC has earned a Gold Award from the American Heart Association and will be listed as a golden recipient in the US News and World Report. He informed the board that Dr. Mark LiVecchi, Clinical Chief of Service for Rehabilitation Medicine, recently began his work on behalf of ECMC and Dr.

Mohammadreza Azadfarad was appointed Associate Chief of Family Medicine for Chemical Dependency.

Dr. Murray briefly presented data from the last QI meeting regarding Anesthesia, General Surgery, Neurosurgery, Patient Experience, Immunodeficiency, Rehabilitation, and Plastics and Reconstructive Surgery.

## **VI. REPORTS OF CORPORATION'S MANAGEMENT**

- A. Chief Executive Officer:
- B. President & Chief Operating Officer:
- C. Chief Financial Officer:
- D. Sr. Vice President of Operations:
- E. Sr. Vice President of Operations:
- F. Chief Medical Officer Report:
- G. Associate Medical Director Report:
- H. Senior Vice President of Nursing:
- I. Vice President of Human Resources:
- J. Chief Information Officer:
- K. Sr. Vice President of Marketing & Planning:
- L. Executive Director, ECMC Lifeline Foundation:

### **PRESENTATION BY CHIEF EXECUTIVE OFFICER: JODY L. LOME0**

- Mr. Lomeo committed to County Executive Polancarz that ECMC will have little or no negative impact on the Erie County budget for 2012-13.
- ECMC, County of Erie and CSEA have come to a tentative agreement. CSEA members will vote on August 23.
- ECMC and Kaleida continue to work together to consolidate cardiac services and behavioral health.
- The Fitness Center will open Monday, August 6 with more than 700 employees signed up to use the new center.
- A press conference was held for the unveiling of the mammography bus at the First Niagara Center. More than 300 women are scheduled for screening.
- A committee will be appointed to "name" the new long term care facility.
- ECMC has rented "people movers" (golf carts) to help move patients and visitors while ECMCC's parking facilities are under construction.
- A Strategic Retreat for board members will be scheduled to discuss ways to continue to collaborate with our partners.



PRESENTATION BY CHIEF FINANCIAL OFFICER: MICHAEL SAMMARCO

A summary of the financial results through June 30, 2012 and a Quarterly Financial Statement and projected statement of Yearly Cash Flows are attached in the Board Book for review.

Moved by Frank Mesiah and seconded by Michael Seaman to receive and file the June 30, 2012 reports as presented by the Corporation's Management.

**The motion was approved unanimously.**

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

Moved by Douglas H. Baker and seconded by Dietrich Jehle, MD to enter into Executive Session at 6:30 P.M. to consider matters made confidential by law, including certain compliance-related matters, strategic investments and business plans.

**Motion approved unanimously.**

**VIII. RECONVENE IN OPEN SESSION**

Moved by Douglas H. Baker and seconded by Anthony Iacono to reconvene in Open Session at 6:45 P.M.

**Motion approved unanimously.**

**IX. ADJOURNMENT**

Moved by Richard Brox and seconded by Anthony Iacono to adjourn the Board of Directors meeting at 6:45 P.M.

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Bishop Michael A. Badger  
Corporation Secretary

**A Resolution Approving Filings  
Related to a Behavioral Health Center of Excellence**

Approved July 31, 2012

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WHEREAS, the Corporation was created, among other things, to provide management with the flexibility to enter into business alliances and to collaborate with other health systems when such collaboration is in each system's common interest; and

WHEREAS, in furtherance of this purpose, the Corporation has approved a Restated Binding Agreement with Kaleida Health that commits both health systems to explore collaborative opportunities that would create value for both systems while adhering to certain principles as described in the Restated Binding Agreement; and

WHEREAS, the Corporation and Kaleida Health have determined that the consolidation of their respective behavioral health programs would benefit both health systems for a variety of reasons; and

WHEREAS, the Corporation and Kaleida Health jointly applied for and have been awarded a HEAL 21 grant of \$15 million by the New York State Department of Health to assist in paying for the costs associated with rebuilding existing facilities on the Grider Street Health Campus to accommodate the consolidation of behavioral programs currently operated by the Corporation and Kaleida Health; and

WHEREAS, among other things, the HEAL 21 grant and New York Public Health Law require that the Corporation file a Certificate of Need Application with the New York State Department of Health and an Application for Prior Approval Review with the New York State Office of Mental Health;

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

1. The filing by the Corporation of a Certificate of Need Application with the New York State Department of Health and an Application for Prior Approval Review with the New York State Office of Mental Health for the purpose of consolidating the behavioral health programs of the Corporation and Kaleida Health are approved.
2. The Corporation is authorized to expend such funds as may be necessary up to a maximum amount of approximately \$26 million (which amount includes the \$15 million HEAL 21 grant as well as any contribution by Kaleida Health) in order to rebuild existing facilities on the Grider Street Health Campus of the Corporation for this purpose.
3. The Corporation is provided with all necessary authority to carry out any other actions that may be incidental to the foregoing, but is required to return to the Board in the event that additional funding is required for this project.
4. This resolution shall take effect immediately.

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Bishop Michael A. Badger  
Corporation Secretary

**A Resolution Approving the Filing of a Certificate of Need  
And Certain Related Renovations to Medical Office Building**

Approved July 31, 2012

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WHEREAS, the Corporation constructed a four-story Medical Office Building in 2011 to house The Renal Center of Excellence and additional space for office and, possibly, clinical services adjacent to the D.K. Miller Building on the Grider Street Health Campus of the Corporation; and

WHEREAS, the cost of the Medical Office Building was paid for, in part, by a HEAL 17 grant intended to assist with the cost of combining the renal dialysis programs of the Corporation and Kaleida Health to form The Renal Center of Excellence with the remaining cost being paid for by the Corporation from cash reserves; and

WHEREAS, the Corporation now intends to complete the build out of two of the floors of the Medical Office Building at a total basic cost of approximately \$6.5 million; and

WHEREAS, once completed, the newly-built space will be occupied by the Corporation's Department of Head, Neck and Reconstructive Surgery, a Medical Oncology Clinic operated by a subsidiary of the Corporation, Primary Care offices operated by a subsidiary of the Corporation, Academic Medical Services, Inc. (internal medicine, nephrology, and endocrinology), a private cardiology group, cardiothoracic surgery, and University Urology Practice, Inc.; and

WHEREAS, certain of the uses of the space being constructed would require the Corporation to apply to the New York State Department of Health for a Certificate of Need;

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

1. The Corporation is authorized to complete the build out of two floors of the Medical Office Building to accommodate the foregoing offices and the services contemplated at a total basic cost to the Corporation in an amount not to exceed \$6.5 million.
2. The filing of a Certificate of Need application, to the extent required by the Public Health Law of New York State, is approved.
3. The Corporation is authorized to take all action necessary and incidental to the foregoing.
4. This resolution shall take effect immediately.

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Bishop Michael A. Badger  
Corporation Secretary

**A Resolution Approving the Purchase of  
2282 Elmwood Avenue, Buffalo, New York**

Approved July 31, 2012

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WHEREAS, the Corporation operates various outpatient clinics in Western New York, including a chemical dependency clinic known as the Northeast Buffalo Clinic located at 2282 Elmwood Avenue in the city of Buffalo, New York; and

WHEREAS, the property located at 2282 Elmwood Avenue, Buffalo, New York is currently leased by the Corporation, but the property has become available for purchase by the Corporation; and

WHEREAS, the administration of the Corporation has determined that the purchase of 2282 Elmwood Avenue, Buffalo, New York will be in the best interest of the Corporation; and

WHEREAS, the property has been appraised by the Corporation and also has been inspected by the Corporation and the Corporation has begun negotiating with the current owner of the property in an attempt to reach a fair market price for the purchase of a fee interest in the property;

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

1. The Corporation is authorized to conclude negotiations with the current owner of the real property and improvements located at 2282 Elmwood Avenue, Buffalo, New York at a purchase price at or less than the value discussed in Executive Session on July 31, 2012.
2. The Corporation is authorized to execute a Contract of Sale for the property after approval of the contract form by General Counsel.
3. This resolution shall take effect immediately.

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Bishop Michael A. Badger  
Corporation Secretary

**A Resolution of the Board of Directors Authorizing Discretionary Purchase  
from Minority or Women-Owned Business Enterprise**

Approved July 31, 2012

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WHEREAS, Erie County Medical Center Corporation [the “Corporation”] is a public benefit corporation subject to Article 15A of the Executive Law [“Participation by Minority Group Members and Women with Respect to State Contracts”] and Section 2879 of the Public Authorities Law [“PAL”]; and

WHEREAS, pursuant to PAL Section 2879(3)(b), where commodities or services are available from New York State certified minority and women-owned business enterprises [“MWBEs”], upon the approval of the Board of Directors, a purchase not exceeding the discretionary procurement threshold of two hundred thousand dollars (\$200,000) may be made from an MWBE without a formal competitive bidding process; and

WHEREAS, the Corporation intends to award a contract for window treatments for the new long term care facility, the value of which is not expected to exceed the discretionary purchase threshold; and

WHEREAS, the Corporation has received a quote for the window treatments from Chadwick House, a qualified MWBE vendor, which quote is reasonable and is below the discretionary purchase threshold; and

WHEREAS, the Board of Directors wishes to authorize the award of the contract for window treatments to Chadwick House without a formal competitive bidding process.

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

1. The Corporation hereby authorizes the award of the contract for window treatments for the new long term care facility to Chadwick House, a certified MWBE vendor, without formal competitive bidding..
2. This Resolution shall take effect immediately.

\_\_\_\_\_  
Bishop Michael A. Badger  
Corporation Secretary

# CREDENTIALS COMMITTEE MEETING

## July 5, 2011

### Committee Members Present:

Robert J. Schuder, MD, Chairman	David G. Ellis, MD (ex officio)
Brian M. Murray, MD (ex officio)	Timothy G. DeZastro, MD
Richard E. Hall, DDS PhD MD FACS	

### Medical-Dental Staff Office and Administrative Members Present:

Jeanne Downey	Emilie Kreppel
Susan Ksiazek, R.Ph.	Elizabeth O'Connor

### Members Not Present (Excused \*):

Yogesh D. Bakhai, MD (ex officio) *	Gregg I. Feld, MD *
Joseph M. Kowalski, MD (ex officio) *	Dietrich V. Jehle, MD (ex officio) *
Philip D. Williams, DDS *	
	Andrew J. Stansberry, RPA-C *

## CALL TO ORDER

The meeting was called to order at 3 PM by Dr. Robert J. Schuder. The proceedings from the previous meeting of June 7, 2011 were reviewed and accepted.

## RESIGNATIONS

The Credentials Committee was made aware of recent resignations, application withdrawals, leave requests or conclusions and presents the following names to the Executive Committee for information / overall action.

A. Deceased

Dr. Josephina Tienzo	Internal Medicine	3/20/1955 - 6/26/11
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B. Application Withdrawn

C. Resignations

Theresa A. Weremblewski, FNP	Family Medicine	As of February 7, 2011
Melanie A. Comstock, FNP	Internal Medicine	As of February 25, 2011
Jamil Sarfraz, MD	Radiology - <i>Teleradiology</i>	As of March 24, 2011
Beth L. Vaccarelli, ANP	Family Medicine	As of May 10, 2011
Brandon M. Coburn, ANP	Internal Medicine	As of June 3, 2011
Levi O. Sokol, MD	Radiology - <i>Teleradiology</i>	As of June 6, 2011
Tara L. Edmiston, RPA-C	Internal Medicine	As of June 11, 2011
Dana L. Drummond, MD	Family Medicine	As of June 16, 2011
Subhajit Datta, MD	Cardiothoracic Surgery	As of June 17, 2011
Andrea L. de Rosas, MD	Internal Medicine	As of June 20, 2011
Zohair Abbas, MD	Internal Medicine	As of June 20, 2011
William A. Holley, DPM	Orthopaedics - <i>Podiatry</i>	As of June 22, 2011
Vilasini M. Shanbhag, MD	Internal Medicine	As of June 28, 2011
Roland A. Honeine, MD	Internal Medicine	As of July 1, 2011
Anumeha Singh, MD	Emergency Medicine	As of July 17, 2011

D. Membership Conclusion

See Automatic Conclusion section below.

## CHANGE IN STAFF CATEGORY

### Dentistry

Margaret E. O'Keefe, DDS

**From:**

Courtesy, Refer & Follow Staff

**Orthopaedic Surgery**  
Robert M. Lifeso, MD

**To:** Associate Staff

**From:** Associate Staff

**To:** Courtesy, Refer & Follow Staff

*Committee discussion followed regarding the bylaws requirement for Associate Staff to not exceed 20 patient contacts per year and the anticipated volume levels. When contacts exceed the 20 level, Active Staff will be recommended.*

### **CHANGE IN DEPARTMENT**

Carol A. Miller, ANP

**Collaborating MD: Dr. Dominic R. Lipome**

**From:** Family Medicine

**To:** Internal Medicine

### **CHANGE IN COLLABORATING / SUPERVISING PHYSICIAN**

#### **Internal Medicine**

Sherria M. Lewis, RPA-C

Allied Health Professional

**Supervising MD: Dr. Mark Fisher**

Sara Hines Nash, RPA-C

Allied Health Professional

**Supervising MD: Dr. Nancy Ebling**

Jennifer Wollaber Rankie, RPA-C

Allied Health Professional

**Supervising MD: Dr. Yahya Hashmi**

Jessica L. Schmidt, RPA-C

Allied Health Professional

**Supervising MD: Dr. Mark Fisher**

Mark D. Wronecki, RPA-C

Allied Health Professional

**Supervising MD: Dr. Dan Brockman**

Kimberly A. Pierce, ANP

Allied Health Professional

**Collaborating MD: Dr. Jenia Sherif**

Joseph M. Rasnick, ANP

Allied Health Professional

**Collaborating MD: Dr. Muhammad Achakzai**

### **PRIVILEGE ADDITION/REVISION**

#### **Internal Medicine**

Brian M. Hill, RPA-C

Allied Health Professional

**Supervising MD: Dr. Jenia Sherif**

- Privileges requested for the Cardiac Care Unit (CCU)\*

Christopher P. John, RPA-C

Allied Health Professional

**Supervising MD: Dr. Nancy Ebling**

- Privileges requested for the Cardiac Care Unit (CCU)\*

*\* The above listed privilege requests were made pursuant to the transition of cardiac care services. The committee awaits final definition of the scope and location of these services, at which time the IM privilege form will be revised accordingly. Both practitioners currently possess medical intensive care privileges. The completion of FPPE will be determined based on the above.*

**OVERALL ACTION REQUIRED**

### **PRIVILEGE WITHDRAWAL**

#### **Emergency Medicine**

William H. Dice, MD

Active Staff

- Skin Grafting

- Skull Trephination-Perimortem

**Internal Medicine**

Kenneth L. Gayles, MD  
- Nuclear Cardiology

Active Staff

**OVERALL ACTION REQUIRED**

**APPOINTMENTS AND REAPPOINTMENTS**

- A. Initial Appointment Review (3)
- B. Reappointment Review (31+1)

Three initial appointments and thirty-two (31 single, 1 dual department) reappointment requests were presented to the Credentials Committee for review. The dossiers were found to be in order and are endorsed to the Medical Executive Committee for its approval with comments (if any) as indicated.

**APPOINTMENT APPLICATIONS, RECOMMENDED**

The following applicants are endorsed by the Credentials Committee for initial provisional appointment to the Medical-Dental Staff:

- A. **Initial Appointment Review (3)**

**Internal Medicine**

Sandeep Dhindsa, MD	Active Staff
Harry E. McCrea, III, MD	Active Staff

**Plastic & Reconstructive Surgery\***

Carly Ann Gerretsen, FNP	Allied Health Professional (Nurse Practitioner)
	<u><b>Collaborating MD: Dr. Thom Loree</b></u>

*\* The Nurse Practitioner privilege form for the Department of Plastic and Reconstructive Surgery is currently in development. Privileges under the Department of Surgery are endorsed until such time as the NP form for Plastics is approved and implemented.*

**OVERALL ACTION REQUIRED**

**REAPPOINTMENT APPLICATIONS**

- B. **Reappointment Review (31)**

**Anesthesiology**

Carole D. Brock, CRNA	Allied Health Professional (Nurse Practitioner)
Howard I. Davis, MD	Active Staff

**Dentistry**

Steven T. Braunstein, DDS	Courtesy, Refer & Follow
Mary Elizabeth Dunn, DDS	Courtesy, Refer & Follow
Margaret E. O'Keefe, DDS	Associate Staff

**Emergency Medicine**

Prashant Joshi, MD	Associate Staff
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**Internal Medicine**

Karuna Ahuja, MD	Active Staff
Nancy C. Ebling, DO	Active Staff

Daniel J. Ford, RPA-C	Allied Health Professional (Physician Assistant)
	<u><b>Supervising MD: Dr. Jenia Sherif</b></u>

Kenneth L. Gayles, MD	Active Staff
Nasir Mahmood Khan, MD	Active Staff
Karen S. Konikoff, NP	Allied Health Professional (Nurse Practitioner)

	<u><b>Collaborating MD: John Fudyma, MD</b></u>
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Shahid Mehboob, MD	Active Staff
Larisa Meras, MD	Active Staff



Bonnie A. McMichael, MD	Associate Staff
Archana Mishra, MD	Active Staff
Dhiren K. Shah, MD	Active Staff
Edward A. Stehlik, MD	Courtesy, <i>Refer &amp; Follow</i>
Adel S. Sulaiman, MD	Active Staff
Rocco C. Venuto, MD	Active Staff
Jai G. Wadhvani, MD	Active Staff
Kenneth S. Zimmerman, MD	Courtesy, <i>Refer &amp; Follow</i>
<b>Gynecology / Obstetrics</b>	
Armando Arroyo, MD	Active Staff
<b>Oral Maxillofacial Surgery</b>	
William S. Boyczuk, DDS, MD	Active Staff
Fred J. Rodems, DDS	Active Staff
<b>Orthopaedic Surgery</b>	
Robert K. Brown, MD	Associate Staff
Allison M. Fout, RPA-C	Allied Health Professional (Physician Assistant)
	<b><u>Supervising MD: Dr. William Wind</u></b>
James J. Kelly, DO	Active Staff
Robert M. Lifeso, MD	Courtesy, <i>Refer &amp; Follow</i>
Christopher A. Ritter, MD	Active Staff
<b>Radiology - Teleradiology</b>	
Christopher J. Connors, MD	Active Staff

**Dual Reappointments (1)**

**Internal Medicine and Rehabilitation Medicine**

Jennifer Anzalone-Kieta, RPA-C

Allied Health Professional (Physician Assistant)

***Internal Medicine Supervising MD: Dr. Nancy Ebling***

***Rehabilitation Medicine Supervising MD: Dr. Mary Welch***

**OVERALL ACTION REQUIRED**

***PROVISIONAL APPOINTMENT REVIEW, RECOMMENDED***

As required by the bylaws, the Credentials Committee and the respective Chiefs of Service are reviewing Provisional Staff members for movement to the PERMANENT STAFF. Candidates shall be presented to the Medical Executive Committee. Approval of this action will allow initiation of the regular reappointment review to be conducted every two years.

Any individual not recommended to PERMANENT appointment by the Chief of Service shall require specific written documentation of deficiencies with a recommendation to the Executive Committee for the revocation and termination of clinical privileges based on standards imposed by Part Three of the Credentialing Procedure Manual. Members not recommended, if any, are presented to the Executive Committee sessions for discussion and action.

The following members of the Provisional Staff from the 2010 period are presented for movement to the Permanent Staff in 2011 on the date indicated. Notification is sent to the Chief of Service at least 60 days prior to expiration of the provisional period.

**July 2011 Provisional to Permanent Staff**

<b>Internal Medicine</b>		<b>Provisional Period</b>
<b>Expires</b>		
Carol A. Miller, ANP	Allied Health Professional (Nurse Practitioner)	07/27/2011
	<b><u>Collaborating MD: Dr. Dominic Lipome</u></b>	
<b>Orthopaedic Surgery</b>		
Jacqueline A. Lex, RPA-C	Allied Health Professional (Physician Assistant)	07/27/2011

Supervising MD: Dr. Paul Paterson

**Orthopaedic Surgery - Podiatry**

Joseph M. Anain Jr., DPM

Active Staff

07/27/2011

**Radiology – Teleradiology**

Carl W. Hardin, MD

Active Staff

07/27/2011

**OVERALL ACTION REQUIRED**

***AUTOMATIC MEMBERSHIP CONCLUSION, RECOMMENDED***

**MEMBERSHIP REAPPOINTMENT NON-RECOMMENDATION**

The dossiers of the following member(s) remain incomplete as of 7/5/2011 to three or more requests for reappointment applications, information, privilege requests and/or credentials, or Chief of Service review are slated for membership conclusion and will automatically not be reappointed at the end of their current appointment period. Insufficient time remains for administrative processing.

**The motion will be presented to the next Medical Executive Committee on 7/25/2011 for subsequent notification / action by the Board of Directors at its next meeting in August 2, 2011.**

The Medical and Chiefs of Service have already been previously informed of this pending action before the Medical Executive Committee meeting and have been asked to encourage a response.

Clinical and admitting privileges and membership shall conclude at the end of the current appointment period. This action is considered a voluntary resignation will not be reportable to the National Practitioner Data Bank. A new application will be required for new Medical Staff membership.

<b>Department</b>	<b>Staff Category</b>	<b>Reappt. Expiration Date</b>
<b>Internal Medicine</b>		
Sherria M. Lewis, RPA-C <i>Leaving ECMC August 12<sup>th</sup></i>	Allied Health Professional (Physician Assistant) <b><u>Collaborating MD: Dr. Mark Fisher</u></b>	09/01/2011
<b>Neurosurgery</b>		
Kenneth S. Smerka, RPA-C	Allied Health Professional (Physician Assistant) <b><u>Collaborating MD: Dr. Lee Guterman</u></b>	09/01/2011
<b>Orthopaedic Surgery</b>		
Matthew J. Phillips, MD	Associate Staff	09/01/2011
<b>Radiology</b>		
Robert R. Conti, MD	Courtesy, Refer & Follow	09/01/2011

***Planned Credentials Committee Meeting: July 5, 2011***

***Planned MEC Action date: July 25, 2011***

***Last possible Board confirmation by: August 2, 2011***

***Next Board Meeting: September 6, 2011 too late***

**OVERALL ACTION REQUIRED**

***FUTURE MEMBERSHIP CONCLUSION, PLANNED***

The following members may have not responded as of 7/5/2011 to requests for reappointment applications, information, privilege requests and/or credentials, are slated for future membership conclusion and will automatically not be reappointed at the end of their current appointment period.

Requests for reappointment applications are distributed to applicants six months before the end of their current appointment period to allow time for return of the application and processing. After three requests for return and no response, little time is left for processing, submission to the Chiefs of Service, submission to the Credentials Committee, submission to the Medical Executive Committee and then Board of Directors, each of which takes a month. **The members below must be ready at the latest for the August 2011 Credentials Committee meeting to allow time for approval by the Board before reappointment expiration.**

The Medical and Chiefs of Service will be informed of this pending action before the Medical Executive Committee meeting and have been asked to encourage a response.

The planned membership conclusion letters will be sent from the Medical Director and Officers to the member with copies to the respective Chiefs of Service regretting the need for conclusion and with thanks for service to ECMCC.

<b>Department</b>	<b>Staff Category</b>	<b>Reappt. Expiration Date</b>
<b>Anesthesiology</b>		
Pedro A. Perez-Cartagena, MD	Active Staff	10/01/2011
<b>Cardiothoracic Surgery</b>		
Zachary A. Swanson, RPA-C	Allied Health Professional (Physician Assistant)	10/01/2011
	<b><u>Cardiothoracic Surgery Supervising MD: Dr. Stephen Downing</u></b>	
	<b><u>Emergency Medicine Supervising MD: Dr. David Hughes</u></b>	
<b>Family Medicine</b>		
Lorne R. Campbell, MD	Active Staff	10/01/2011
Attaullah A. Syed, MD	Active Staff	10/01/2011
<b>Internal Medicine</b>		
Helen B. Doemland, RPA-C	Allied Health Professional (Physician Assistant)	10/01/2011
	<b><u>Supervising MD: Dr. Nancy Ebling</u></b>	
Lynn M. Fries, RPA-C	Allied Health Professional (Physician Assistant)	10/01/2011
	<b><u>Internal Medicine Supervising MD: Dr. Yahya Hashmi</u></b>	
	<b><u>Rehabilitation Medicine Supervising MD: Dr. Mary Welch</u></b>	
Lynn M. Gruzca, MS, ANP	Allied Health Professional (Nurse Practitioner)	10/01/2011
	<b><u>Supervising MD: Dr. Adel Sulaiman</u></b>	
Sandra Sauvageau, FNP	Allied Health Professional (Nurse Practitioner)	10/01/2011
	<b><u>Supervising MD: Dr. Yahya Hashmi</u></b>	
Linda S. Weisenborn, RPA-C	Allied Health Professional (Physician Assistant)	10/01/2011
	<b><u>Supervising MD: Dr. Pamela Reed</u></b>	
Stephanie H. Weldy, ANP	Allied Health Professional (Nurse Practitioner)	10/01/2011
	<b><u>Supervising MD: Dr. Nancy Ebling</u></b>	
<b>Neurology</b>		
Robert N. Sawyer Jr., MD	Active Staff	10/01/2011

***Planned Credentials Committee Meeting: August 2, 2011***  
***Planned MEC Action date: August 22, 2011***  
***Last possible Board confirmation by: September 6, 2011***  
***Next Board Meeting: October 4, 2011 too late***

**PRESENTED FOR INFORMATION ONLY**

## **OLD BUSINESS**

### **New Plastic and Reconstructive Surgery Department**

Assembled with input of the Credentials Committee, the respective Chiefs of Service and Chief Medical Officer, minor formatting changes were made subsequent to last month's meeting. The final draft of the privilege delineation form for the new "Plastic and Reconstructive Surgery" department was presented and approved at the June 27, 2011 Medical Executive Committee meeting, with final approval of the Board of Directors slated for its July 12<sup>th</sup> meeting.

### **Joint Credentialing Software Platform under Great Lakes Health**

The committee was updated on the timeline for training and software implementation. All indications from testing performed to date suggest that the software conversion will be completed in August.

### **Physician On-boarding Update**

A new administrative mechanism has been implemented to encourage the recruitment and integration of new and potential physician staff members for ECMCC. Communication and teamwork are essential for smooth on-boarding. IT is developing an electronic tracking system to facilitate smooth movement of MD and Practice Plan applicants from recruitment to final

appointment. are thus informed regarding the specific needs in the affected department. In this spirit of coordination, the Medical-Dental Staff Office has stepped forward to facilitate the initiation of the IT access, badges, parking processes.

#### **Podiatry Member Status**

A letter of voluntary resignation has been received from a Podiatry division member.

#### **Leave of Absence Follow Up**

A Leave of Absence letter template has been composed and has been sent to a staff member requesting medical leave.

#### **Open Issues Tracking Form**

The committee still awaits a response from certain applicants for a request for the documentation of completion of credential requirements. The tracking form will be reviewed by the Credentials Committee on a monthly basis, and recommend additional action when deemed warranted.

#### **NYS Mandated Child Abuse Identification Training**

S.Ksiazek reported to the committee the information gathered from the New York State Education Department regarding the law enacted in 1989 for the above listed requirement. Proof of a two hour course in Mandated Child Abuse Identification Training or an exemption request is required for **initial licensure**. If a licensee who previously completed an exemption subsequently becomes engaged in practice involving patients under the age of 18, the course is to be completed and submitted to NYS. The Credential Committee's determination is that the need for child abuse recognition training resides within a requirement for licensure. Therefore, the committee recommends that the ECMCC adopt the approach of our fellow Great Lakes Health Partner, Kaleida, and not track specific abuse training requirements for physicians caring for patients under the age of 18.

#### **Temporary Privilege Tracking Form**

A tracking system has been formalized to list Urgent and Temporary Privilege expiration periods and the status of application completion. The current tracking matrix was reviewed by the committee and is attached.

**INFORMATION ONLY**

### ***NEW BUSINESS***

#### **Noted with Sadness**

It is with sadness that the committee noted the death of Dr. Josefina Tienzo, Associate Professor of Medicine University at Buffalo Attending, Nephrology, Erie County Medical Center, on Sunday, June 26, 2011. A Memorial Service was held on Thursday, June 30th, 2011 in the Smith Auditorium, Erie County Medical Center, with family present.

#### **Endocrinology**

Temporary privileges for urgent patient care continue to be utilized to ensure adequate endocrinology coverage. Three practitioners have participated in a rotational coverage, with one of the practitioners endorsed at this meeting for membership appointment, and the other two anticipated to be presented to the Credentials Committee at its August meeting.

#### **Telemedicine Credentialing**

The recent revisions, effective this date, to the CMS guidelines for the credentialing of telemedicine practitioners were presented. The benefits of enlisting the distant site entity to perform the credentialing were discussed. Information was solicited from our current teleradiology vendor as to how this could be effectuated. Further research will be conducted, and a formal recommendation made to this committee at its next meeting. S.Ksiazek noted for the group that the current version of the Credentials Manual allows for this option to be exercised, so no revisions will be necessary if it is determined to move forward.

D. Ellis raised a potential analogous issue regarding telemedicine support from Children's Hospital for emergency deliveries and cardiac arrests. The option of abiding by the distant site (Kaleida) credentialing vs. the granting of temporary privileges for urgent patient care needs was discussed. No formal recommendation was made by the Credentials Committee pending the provision of additional volume information by Dr. Ellis.

#### **Medicine C Changes**

The recent changes in the coverage of cardiology patients were reviewed. The addition of new providers to the medical-dental staff and the revision of privileges for existing members are anticipated.

**Dr. Prashant Joshi - Emergency Medicine Privilege Form Changes**

Under the previous Bylaws, a physician in the "Consulting" category completed a generic one page "Consulting" privilege form. With the 2010 Bylaws revisions, the "Consulting" membership category was eliminated, hence making the one page generic form obsolete.

Dr. Joshi was previously in the "Consulting" category in the Department of Emergency Medicine, and based on the type and volume of service provided to the ED, accepted a category of "Associate" under the new bylaws. Now scheduled for re-appointment, the ED privilege form does not have a delineated privilege to cover the service provided. A revision to the form is warranted.

S.Ksiazek added that this issue could potentially be applicable across all clinical departments. It was therefore suggested that a line be delineated on each departmental form to allow for specialty consultations, or adopt the approval grid utilized by Kaleida for consultations. As both options possess merit, the matter will be further discussed at the August Credentials Committee meeting. In the interim, the following revision to the ED privilege form is endorsed by its Chief of Service:

**PHYSICIAN REQUEST FOR CLINICAL (PATIENT CARE) PRIVILEGES:**

Enter " Y, Yes, +, x, or ✓" in Physician Request Column

(Please avoid sweeping vertical lines)

**EMERGENCY MEDICINE, (cont'd.)**



Chief of Service action:

EMERGENCY MEDICINE PROCEDURES,(cont'd)	Init/Reap Volume	Physician Request	Recommend		If Yes, indicate any requirements; If No, provide details. See p.8
			YES	NO	
<b>Toxicology Consultations</b>					

**Surgery Privilege Form**

The following changes to the Department of Surgery privilege form have been requested by the Chief of Service, have been recommended by the Credentials Committee and are presented to the Medical Executive Committee.

**Changes include the elimination of ACLS for Chest Tube insertion-**

**2010-2011 Appointments/Reappointments**

**DEPARTMENT OF SURGERY**

for privileges expiring in 2012 or 2013

**VII. ADVANCED PROCEDURES**

\_\_\_\_\_

Chest Tube Placement (~~Submit current ACLS certification.~~)

**Addition of Placement of tissue expander and permanent implant. Per Dr. Flynn, this is not a new privilege and FPPE will be deferred.**

**R. Plastic and Reconstructive Surgery**

\_\_\_\_\_

Placement of tissue expander and permanent implant

**Addition of Laparoscopic Liver resection/ablation. Dr. Flynn stated that he did not want FPPE waived, that it was a new privilege.**

**VI. Laparoscopic Procedures (performed by ACTIVE STAFF only)**

Provide required documentation with initial request (See criteria page 14)

\_\_\_\_ Laparoscopic Liver resection / ablation

**Clarification of Critical Care Specialist credentialing criteria to interface with the Department of Plastic & Reconstructive Surgery requests:**

\_\_\_\_ SICU, TICU, BICU BEDS (Surgical, Trauma and Burn Care Units)  
Critical Care Intensivist Specialist privileges  
Approved residency AND Critical Care fellowship or equivalent training

**Cardiothoracic Surgery Privilege Form**

The following changes to the Department of Cardiothoracic Surgery privilege form have been requested by the Chief of Service, have been recommended by the Credentials Committee and are presented to the Medical Executive Committee.

**Changes include the elimination of ACLS for Chest Tube insertion-**

**2010-2011 Appointments/Reappointments**  
**DEPARTMENT OF CARDIOTHORACIC SURGERY**  
for privileges expiring in 2012 or 2013

**III. ADVANCED PROCEDURES**

\_\_\_\_ Chest Tube Placement (~~Submit current ACLS certification~~)

**Discussion of ACLS Requirements**

A committee discussion followed regarding ACLS requirements for Airway Maintenance and Endotracheal intubation for Surgery, Cardiothoracic Surgery and other surgical specialties. Given additional training requirements of select specialties, no consensus was reached. Additional information will be sought.

**Orthopaedic Surgery, Emergency Medicine and General Surgery**

The staff office has noted that many applicants neglect to complete the Fluoroscan portion of the privilege form. It is believed that this may be due to the Fluoroscan section's location on the form. In response, the following format change is recommended to emphasize the reappointment selection or rejection of Fluoroscan privilege requests:

**ADDITIONAL PROCEDURES**

\_\_\_\_ Fluoroscan **reappointment** request (for an Initial Request see next page)

Medical-Dental Staff Office use: Original date initial privilege granted/criteria satisfied: \_\_\_\_\_

**Department of Pathology**

The Pathology Chief of Service has participated in the review and revision of the departmental privilege form, agreeing to adopt the format utilized by Kaleida. The committee recommends the form move forward for presentation to the Medical Executive Committee. Refer to attached.

**Department Privilege Forms**

Revisions to the IM privilege form, also modeled after the Kaleida format, consisting of separate sub specialty sections is in progress. Templates have been submitted by the Chiefs of Service of Anesthesiology and the Emergency Department. These too, will be revised shortly, in line with the harmonization under Great Lakes Health.

**Department of Plastic and Reconstructive Surgery – Nurse Practitioner privilege form**

Development of a new privilege form for Nurse Practitioners in the Department of Plastic and Reconstructive Surgery is in progress. A draft will be forwarded to the Chief of Service and presented back to the Credentials Committee at its August meeting.

**OVERALL ACTION REQUIRED**

***OTHER BUSINESS***

**Open Issues (Correspondence) Tracking**

The committee is awaiting responses from two reappointment applicants and a Chief of Service.

**FPPE-OPPE Report**

FPPEs were successfully completed in the following departments:

- Anesthesiology (1 MD, 1 CRNA)
- Cardiothoracic Surgery (1 ACNP)
- Emergency Medicine (1 RPA-C)
- Family Medicine (1 FNP)
- Internal Medicine (2 MDs)
- Ophthalmology (1 MD)
- Orthopaedic Surgery (1 RPA-C)

OPPEs were successfully completed for the department of Laboratory Medicine (1 MD, and 1 PhD).

OPPE for the department of Orthopaedic Surgery is complete (1 DO, 6 DPMs, 30 MDs, and 12 RPA-Cs) with the exception of 3 providers who have not yet submitted their documents in their entirety. The Chief of Service has signed off on the completed OPPEs and will review and sign the final 3 when the paperwork is returned.

The department of Neurology OPPE is near completion, with 2 physicians outstanding.

The department of Pathology is awaiting a response from 1 physician. As soon as the final documents are returned, the Chief of Service will be contacted to sign off on all OPPEs.

With measures identified and a small mailing complete (awaiting responses); OPPE has been implemented for the department of Urology.

OPPE for the department of Psychiatry has begun.

OPPE for the Chemical Dependency department will begin after feedback regarding measures has been received of the Associate Chief of Service.

An email dialogue with the Chief of Service for the department of Anesthesiology, Dr. Howard Davis and Richard Skomra, CRNA has indicated the commencement of the second round of OPPE for the department.

**Reappointment Reassurance**

The Medical-Dental Staff Office remains vigilant to ensure that re-appointments are completed in accordance with regulatory and accrediting compliance. To minimize risk of human error, parallel checks are performed within the credentialing database, supplemented with an audit report designed by our IT liaison and a concurrent Q&A archive. Last month, the office staff conducted a manual review of all the active files. Based on the success of this exercise, it has been determined that this process will be performed minimally on an annual basis to supplement the automated reports generated from the credentialing system. It is hoped that this will raise reappointment accuracy to new heights.

**ECMC Medical Staff Training Situations by External Physicians**

The Medical-Dental Staff Office, Administration, and Risk Management received a request for temporary privileges of an out of state physician to proctor training of a member of the ECMCC medical-dental staff on a new procedure. As the training involved direct patient care, it was advised by our medical malpractice legal counsel as not appropriate to grant

temporary privileges to the training physician. Participation may be permitted at a level similar to that of a vendor for this endeavor, with backup with an appropriately credentialed physician. Patient consent should also be strongly encouraged.

A question had previously been raised as to whether a physician not licensed in New York State could be granted temporary privileges for the purposes of emergency care or training. The above listed scenario has been determined to answer that question, and will be the opinion of the Credentials Committee until further such information is made available.

**PRESENTED FOR INFORMATION ONLY**

***ADJOURNMENT***

With no other business, a motion to adjourn was received and carried. The meeting was adjourned at 4:20 PM.

Respectfully submitted,



Robert J. Schuder, MD,  
Chairman, Credentials Committee



## How to Ensure Quality Care

### MONITORING QUALITY OF HEALTHCARE

*Michael Pugh, president, Verisma Systems, Inc., Pueblo, Colorado*

#### Board Responsibility for Quality and Performance

“Isn’t that what the doctors and nurses are supposed to be doing?” is a common first thought when new hospital board members are told that patient safety and the quality of care are ultimately the board’s legal responsibility. While physicians and nurses are critical to the quality process, and having well-trained and appropriately credentialed professionals on the staff is important, considerably more is required for boards to carry out their legal and fiduciary responsibilities for quality. Boards must have a broad view and understanding of quality to ensure that patient care is safe, effective, and reliable.

For many years, graduate programs in healthcare administration taught a model of hospital organization using the metaphor of a three-legged stool, with the administration, the board, and the medical staff as the legs of the stool supporting a platform for patient care delivery. The board was responsible for fundraising and gathering community input, the administration for staffing and operating the hospital, and the medical staff for bringing patients to the hospital and providing care. Board members assumed the quality was high if the hospital had well-trained doctors, state-of-the art technology and facilities, low staff turnover, satisfied patients, and generally clean reports from auditors, regulators, and accreditation agencies. While these proxies for describing good quality are important and contribute to high-quality patient care and experiences, simply equating quality to facilities, doctors, or reputation does not fulfill the board’s responsibility for ensuring that patient

### Brief History of Quality in Hospitals

I am called eccentric for saying in public that hospitals, if they wish to be sure of improvement,

- Must find out what their results are.
- Must analyze their results to find their strong and weak points.
- Must compare their results with those of other hospitals.
- Must care for what cases they can care for well, and avoid attempting to care for cases which they are not qualified to care for well.
- Must welcome publicity not only for their successes, but for their errors, so that the public may give them their help when it is needed.
- Must promote members of the medical staff on the basis which gives due consideration to what they can and do accomplish for their patients.

Such opinions will not be eccentric a few years hence.

Source: Codman (1916).

care is safe and every patient gets exactly the right care, every time.

For more than 200 years, the “three-legged stool” description, sometimes called the Franklin Model (based on the hospital concept used by Benjamin Franklin when he founded The Pennsylvania Hospital in the late 1700s), paralleled the basic legal responsibilities of doctors and hospitals. But beginning in the 1960s a series of legal decisions, most notably *Darling v. Charleston Community Memorial Hospital* (211 N.E.2d 253, 1965), established the hospital board was ultimately responsible for the outcomes of patient care.

**Credentialing.** During the 1970s and 1980s, the primary tool for ensuring quality was the medical staff appointment and reappointment process. Sometimes referred to as credentialing, this process established the level of care and procedures that individual physicians were allowed to perform based on their training and experience. Physicians would

apply for membership to the medical staff, and the hospital board would rely on a recommendation from the existing medical staff to allow physicians to admit patients to the hospital. The underlying hospital quality theory in the 1970s and 1980s: Keep the “bad” physicians off the medical staff.

**Peer review.** As an extension of the credentialing process, hospitals and medical staffs established peer review and other mechanisms to investigate and monitor individual physician performance; these efforts focused on the mistakes or errors a physician might have made in the care of patients. Recommendations to the governing board for corrective action might range from no action to relatively

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benign corrective actions, such as a letter to reprimand a physician or requirements for additional training. In some cases, recommendations might involve limiting privileges to perform certain procedures, or in extreme cases, terminating all care privileges and expulsion from the medical staff. The more punitive the potential board action, the greater the risk the board, hospital, or physicians involved in the peer review might be sued for violating the due process standards in the medical staff bylaws, which are meant to ensure fairness and impartiality in the review process.

In most states, the deliberations and investigations surrounding peer review have some measure of confidentiality and protection from legal discovery. But that is cold comfort for most physicians asked to be involved in the process. While the intent of peer review is good, the process is sometimes difficult and potentially flawed. Fear of lawsuits, potential conflicts of interest, variations in the professional knowledge of the reviewers, social relationships, closed sessions without nurses or others with a perspective present, and an unspoken but inherent reluctance among physicians to criticize their colleagues tend to diminish the potential impact and benefit of peer review on overall quality. Occasionally, suggestions do come out of the peer review process that might improve the care for all patients, but such suggestions are a byproduct of the process and not the focus of the effort.

**Quality assurance.** In the 1970s and 1980s, a quality control process known as quality assurance (QA) also emerged. In the QA process, patient charts were pulled after the patient was discharged and reviewed for the appropriateness and quality of care. The charts selected for review might have been pulled because of a patient complaint or known problem with the care, were sometimes selected for a routine review of specific types of admissions or might have been a random selection of charts. In some hospitals, but not all, efforts were made to ensure that every physician on the active medical staff had at least a few charts reviewed each year. Generally, the criteria for chart selection was determined by a committee of the medical staff and the charts were prescreened by a registered nurse (RN) employed by the hospital looking for specific issues, usually related to compliance with Medicare and Medicaid regulations. If the nurse noted a problem or gap in care, the chart was referred to a physician reviewer. If the physician reviewer felt the physician care was inadequate, the chart might be referred to a peer review committee that would investigate further. If the care by the hospital staff was poor or something bad had happened such as a fall, but it was not a physician mistake, the chart might be sent to risk management or referred to someone in management. Because Medicare and Medicaid reimbursement was often at stake, efforts were usually focused on improving documentation and payment issues. While some useful information was occasionally gleaned, leading to overall improvements in

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care, for the most part QA used the same quality theory as peer review: Find and eliminate the bad apples.

However, removing the bad apple from the barrel does nothing to improve the quality of the rest of the apples in the barrel. Credentialing, peer review, and QA remain important and necessary, but these efforts generally do not result in quality improvement for all patients, and they are not processes that completely fulfill the board's ultimate responsibility for quality care.

## **A Different View of Hospital Quality**

In the late 1980s, the theories and methods to improve quality and reduce manufacturing defects began to be understood and adapted in healthcare. The key breakthrough in thinking about quality in healthcare was the realization that poor quality outcomes were most often the result of system or process failure rather than individual physician or staff failure or just bad luck. Quality became a process problem, not a people problem. Physicians are a critical part of the process, but not the entire care process—a lot of other people are involved.

As an example, surgeons are sometimes compared or judged by their surgical-site infection rate. However, the surgeon rarely cleans the equipment, cleans the operating room, maintains the ventilation system, shaves the patient, prepares the surgical site, starts the prescribed antibiotic in the effective window prior to surgery, or controls the glycogen levels of the patient during surgery. How well these tasks are carried out is known to decrease the probability of a surgical site infection by as much as 90 percent, but they are out of the effective control or direct influence of the surgeon. So while surgical technique and maintaining a sterile field during surgery are clearly important, are surgical site infections a doctor problem or a hospital system problem? The answer is likely some unknown and unknowable combination. However, across the country, the rigorous adherence to a set of simple basic operating room tasks—such as hand washing, proper preparation of the surgical site, and the timely administration of antibiotics—has been shown to dramatically reduce the overall incidence of surgical-site infections.

Dr. Paul Batalden, a cofounder and the first chair of the board of the Institute for Healthcare Improvement (IHI), said it best: “Every system is perfectly designed to produce the results it gets” (McInnis 2006). Batalden's observation is grounded in statistical process control theory, which postulates that any stable process produces variation in outputs—some will be good and some will be bad. The required management action is not to chase the bad results but to change the process so it consistently produces the desired results. While perfectly logical, the

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idea that processes, rather than doctors, are the root of many of the poor outcomes in healthcare has been slow to take root.

System and process thinking got a major boost in 2000 when the government-sponsored Institute of Medicine (IOM) published *To Err Is Human* and in 2002 followed up with a second report, *Crossing the Quality Chasm*. The first report highlighted how error and poor quality were rampant in healthcare and reported that between 98,000 and 140,000 patients died unnecessarily each year in US hospitals, making hospital deaths the eighth leading cause of death, ahead of motor vehicle fatalities. As expected, there were fierce attacks on the report and challenges to the estimated number of preventable deaths and the ideas presented. However, since the original publication, other studies and estimates suggest the IOM understated the enormity of the problem.

The second report advocated healthcare redesign along the principles of safe, effective, efficient, patient-centered, cost-efficient, and equitable care for all. While initially controversial, the IOM reports served as a wake-up call for hospitals to begin thinking about quality and patient outcomes much differently. In the decade since the IOM reports, awareness has developed that many of the things we used to consider complications in the treatment of patients are actually avoidable patient-harm events. Potentially fatal hospital-acquired conditions—such as ventilator-associated pneumonia, sepsis, infections associated with venous catheters, and medication errors—can effectively be eliminated by strict adherence to simple care and procedure protocols.

Dr. Donald Berwick (2003), the founder and former president of IHI and now administrator of the Centers for Medicare & Medicaid Services (CMS), has said when you strip everything else away, what patients are really saying is

1. Don't hurt me.
2. Help me.
3. Be nice to me.

These three patient-centered elements, in the order of priority listed, redefine how we think about quality in healthcare. “First, do no harm” is part of the Hippocratic Oath all physicians take upon graduation—an old idea. But for healthcare organizations, “Don't hurt me” is a relatively new foundation to organizational quality improvement efforts. Unfortunately, as reported by the IOM, patient harm is widespread and insidious. In 2006, IHI launched its 5 Million Lives Campaign, aimed at encouraging hospitals to take steps to significantly reduce harm to patients. As part of that campaign, IHI (2006) adopted and published a broad and inclusive definition of patient harm:

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Unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment) that requires additional monitoring, treatment or hospitalization, or that results in death. Such injury is considered harm whether or not it is considered preventable, resulted from a medical error, or occurred within a hospital.

Hospitals and other healthcare organizations typically keep track of the number of falls, infections, medication errors, wrong-site surgeries, delayed treatments, bed sores, procedural mishaps, and other potential patient-harm events. However, this information may be gathered by different people for disparate purposes and is rarely compiled on an organization-wide basis. Reports on falls are separate from reports on infections, which are separate from reports on medication errors and so on. To further muddy the waters, harm is often reported as a rate per 1,000 patient days or some other denominator that tends to diminish the impact of the data. Board members, management, and medical staff leadership are routinely shocked the first time the aggregate actual number of harm events is presented—almost always much higher than expected. Boards need to ask to see the actual number of harm events and then set aggressive targets for reduction.

The second plea, “Help me,” is typically why most individuals choose healthcare as a career—they want to help other people. “Help me” does not mean “cure me.” Most patients are realistic in their expectations of what medicine can and cannot do. What they really want is for the healthcare system to reliably deliver everything that is known to help. Hospitals face two problems in meeting this need. The first is defining what is known to help. Numerous studies over the past decade have shown tremendous geographic variation in the treatment for almost all medical conditions and wide disparities in healthcare costs (Dartmouth 2011). The second problem is, after defining what is known to help based on clinical evidence, building the processes and systems to ensure that the “right care” is always delivered.

The IOM has estimated 30 percent of what is spent on healthcare in the United States adds no clinical value. Other studies suggest only about 50 percent of all care delivered is actually evidence-based, meaning there is hard, replicable science linking the treatment and the outcome.

The practical application of evidence-based medicine had its roots in an obstetrics malpractice insurance crisis in the late 1970s and early 1980s. In response, the American College of Obstetrics and Gynecology began publishing guidelines to help practicing physicians who agreed to practice according to the guidelines to obtain or maintain malpractice insurance. Next, in 2004, Medicare began measuring the quality of care in hospitals with a set of core measures that tracked whether the common evidence-based clinical treatment elements were delivered for the conditions of heart attack, pneumonia, congestive heart failure, and stroke.

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Medicare's action helped hospitals and physicians begin to think differently about the use of protocols and standardized care plans and spurred the concept of the "right care"—delivering evidence-based care every time for every patient.

Many hospitals have fallen into the trap of looking at the percentage of time individual care elements were delivered rather than how often patients receive all of the required care elements. If a patient qualifies for six elements in an evidence-based care plan, but the hospital only delivers four, did the patient get the right care? Numerous studies have shown hospitals that can reliably deliver all of the care according to the evidence have lower mortality and complication rates (Mukherjee et al. 2004; Eagle et al. 2005).

The third patient desire—"Be nice to me"—is reflected in patient satisfaction data. During the 1990s, almost all hospitals began focusing on patient satisfaction, conducting surveys and adapting service techniques from other industries to improve the patient experience. In 2009, Medicare began publishing comparative patient satisfaction statistics for all hospitals, available on the CMS website. Service quality and amenities are important, but a smiling nurse and valet parking will not likely offset the experience from a hospital-acquired infection, a wrong-site surgery, or a medication error resulting in harm.

## **Board Strategies for Measuring and Improving Quality**

The board is ultimately responsible for everything happening in the hospital, including reducing harm and ensuring care is delivered appropriately and according to the evidence. There are four common challenges with which boards and new board members may struggle:

- 1. Getting comfortable with the board's responsibility for the care and safety of patients.** Getting comfortable requires boards to have good processes in place for credentialing, discussing difficult issues, and resolving conflicts. There is no ambiguity about a board's legal responsibility for care and outcomes. But it takes a strong management and medical staff team and good board relations to be transparent and openly discuss patient harm and poor quality outcomes—topics that in most hospital environments have not traditionally engendered trust between the board, management, and physician leadership. As the nursing staff plays such an important role in the delivery of quality patient care on a 24-hour-a-day, 7-day-a-week basis, the board must be willing to appropriately involve nursing leadership in these discussions as well. Most CEOs did not get to be the CEO by delivering bad news. Boards have a responsibility to create a board meeting environment in which difficult issues can be discussed without fear of punishment.

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The way to begin to build the right board environment is by asking inquiry questions, not attack questions. Board members should feel comfortable asking governance questions about quality, such as

- How many patients were harmed last month?
- How does that compare to the previous six months?
- Are we trending downward?
- What are the plans for the next wave of efforts to reduce patient falls, medication errors, hospital-acquired infections?
- What percentage of the care delivered in our cardiac program was “right care”?

These questions are no different from the types of questions the finance committee asks about financial issues: Where are we, are we getting better, what is your strategy for improvement?

2. **Setting the right expectations for the organization’s leadership and medical and nursing staffs.** Setting the right quality expectations and having a good process to monitor progress are the two most important things a board can do in exercising its responsibility for quality patient care and preventing harm. Recent studies have shown that better outcomes are associated with hospitals in which:

- The board spends more than 25 percent of its time on quality issues.
- The board receives a formal quality performance measurement report.
- There is a high level of interaction between the board and the medical staff on quality strategy.
- The senior executives’ compensation is based in part on quality improvement (QI) performance.
- The CEO is identified as the person with the greatest impact on QI, especially when so identified by the QI executive (usually a physician on the hospital payroll who has responsibility for implementing QI programs).

The key is setting the right governance aims. Hospital boards should set aggressive aims seeking to dramatically reduce levels of harm to patients. External comparative data are not necessary and, in fact, counterproductive when it comes to harm—there is no appropriate level of harm, especially if you are the patient. All that is required is a simple monthly or quarterly count of the number of patients who experienced harm. Some organizations have developed composite indicators that measure not only patient harm but also the number of serious safety events whether the patient was harmed or not,



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on the theory that the focus should be on preventing any event that could lead to harm.

The board must also set “what by when” targets (e.g., reduce all harm events by 50 percent by December 2013), which will create the expectation that significant process change is required to reach the targets, not an incremental or marginal approach to improvement.

3. **Getting useful information and monitoring performance.** The board should also focus on what is important—high-level outcomes rather than detail. For far too long, hospital boards have suffered from an excess of data and a dearth of information from quality reports. Instead, the board should focus its review and discussion on a few high-level outcome measures that can be presented in a fairly simple scorecard or report format. The scorecard should include measures and targets for the following:

- Hospital mortality tracked over time (run chart)
- Number of patient safety and harm events, tracked over time
- Unplanned hospital readmission rate
- Percentage of time care is provided according to the evidence (right care)
- Patient satisfaction

Measures on the board’s quality scorecard should be limited to the most important areas to provide governance and not management oversight. The organization’s quality and operating strategies should be linked and should drive the measures in the desired direction.

In some organizations, boards may need to add a few other measures specific to the mission of the organization or challenges faced by the organization. Those types of measures might include the following:

- A measure that represents access or waiting time in clinics or emergency facilities
- A measure representing culture or staff satisfaction
- A measure representing cost efficiency or value
- A measure representing equity in care across demographics

The most effective boards have active quality committees that begin their meetings with a brief story of a patient experience, effectively putting a face on the data. The committee typically reviews the board’s quality aims and targets and progress toward achieving those quality aims. It also reviews the execution and quality improvement plans the medical staff and management propose for

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the next month or quarter. Further, the committee should review sentinel events and reports of harm and review regulatory dashboards for compliance exceptions; it may also periodically receive reports from risk management. Finally, the committee should consider any policy change recommendations which may require full board approval. Some boards use the quality committee to review medical staff credentialing recommendations prior to a vote by the full board. The chair of the quality committee, not the management team, should make the committee report to the full board.

Dr. James Reinertsen (2011), a senior fellow at IHI, advocates including patients on the quality committee of the board. Board members may occasionally be patients, but their experiences, because of their access and status in the organization, often do not represent the experiences of other patients. More importantly, a board member's fiduciary duty is to the organization. Patients in the boardroom tend to reduce self-serving conversations and add a perspective no one else in the room is free to deliver.

4. **Creating accountability for quality results.** The final challenge is to create accountability for quality results. Many hospitals are beginning to tie CEO and senior leader compensation to the achievement of strategic and quality goals. When structured correctly, compensation can align management actions with the board's goals and expectations. Organization-wide accountability is also created through transparency of aims, targets, and progress. Boards that spend as much time discussing quality issues at their meetings as they do financial and operating issues send a clear message to the organization, which can drive cultural change and foster accountability.

## The Business Case for Quality

Whether or not there is a financial case supporting a specific improvement strategy, there is always a business case for improving quality in healthcare. Poor quality represents waste in the hospital and healthcare system. Across the country, hospitals are learning that when they eliminate or dramatically reduce ventilator-associated pneumonias, central line infections, medication errors, and patient falls, operating costs go down, not up. Quality in healthcare does cost less when waste in the form of patient harm is reduced.

In 2008, Medicare began eliminating payment when any "never events" occur and reducing payment for complications that occur in the hospital. Depending on state regulations the event may be reportable to a public agency or to The Joint Commission.

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#### **Never-Event CMS Regulatory Categories**

1. Air embolisms
2. Mediastinitis—surgical site infection after coronary artery bypass graft
3. Catheter-associated urinary tract infections
4. Vascular catheter-associated infections
5. Blood incompatibility
6. Objects left in the patient during surgery
7. Falls, trauma
8. Pressure ulcers
9. Poorly controlled blood sugar
10. Infections after elective orthopedic and bariatric surgery
11. Deep vein thrombosis or pulmonary embolisms following total hip and knee replacement

Other payers have followed with even more restrictive policies. Under the 2009 healthcare reform legislation, the pressures ratchet up on hospitals with increasing payment reductions if the hospital has a higher-than-expected rate of readmissions, and expands those quality penalties to the Medicaid program. Not many carrots, but lots of sticks. Healthcare reform also envisions value purchasing—forcing hospitals to reduce costs to show greater value. Improving quality and reducing harm may be the most powerful value strategy on the board's strategy scorecard.

#### **The Board and Healthcare Quality**

New board members generally face a steep learning curve for ensuring quality in healthcare. But that curve can be flattened if they keep a few things in mind and in perspective:

1. Ultimately the board is legally responsible for the quality of care and service provided.
2. Medical staff credentialing and peer review are important but alone are insufficient to ensure good quality. Having good doctors does not automatically equate to decreased harm and better outcomes.
3. Every system is perfectly designed to produce the results it gets. Poor quality and patient harm are generally the results of flawed systems and processes.
4. Patients have three requirements: Don't hurt me, help me, and be nice to me. Quality in healthcare is about delivering on all three.
5. The board should track a few key quality metrics and set aggressive targets to set expectations and create organizational and strategic focus.
6. The quality committee of the board is the primary mechanism for monitoring quality performance and improvement efforts.
7. There is a strong business case for improving quality and reducing harm.
8. Ask lots of questions. The only dumb question is the one not asked.



Thomas Hicks, Who Won the 1904 Marathon with Help from Strychnine and Brandy.

toward consequences of scientific progress" (1991b).

Performance-enhancing drugs have cast a long shadow on the

modern Olympics. Whether the agents are the strychnine, heroin, cocaine, and morphine that athletes used in Athens in 1896 or the amphetamines, steroids, and erythropoietin that some use today, the dilemma remains the same. As a sports medicine specialist noted in 2004, the "attraction of performance-enhancing drugs is simply that they permit the fulfillment of the mythical promise of boundless athletic performance — the hubristic 'faster, higher, stronger' motto of the Olympic Games" (2004). The ensuing systems of medical surveillance have led, inevitably, to "a new type of competition," in which some athletes try to stay one step ahead of the authorities (2001).

The arms race will continue

as medical science produces ever newer means of performance enhancement. Will future athletes try growth factors or gene therapy?<sup>3</sup> One thing is certain: the Olympics will remain an object of medical fascination.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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## Value-Based Purchasing — National Programs to Move from Volume to Value

Jordan M. VanLare, A.B., and Patrick H. Conway, M.D.

The National Quality Strategy of the U.S. Department of Health and Human Services broadly defines the outcomes that the Centers for Medicare and Medicaid Services (CMS) wants to achieve through the care it purchases for its beneficiaries. The strategy's three aims of better health, better care, and lower costs capture CMS's concept of value — improved outcomes for individuals and populations at lower costs. CMS has many tools to support the three aims, but we believe that value-based purchasing (VBP) is one of the most potentially transformational. VBP rewards providers who deliver better outcomes in health and health care for the beneficiaries and commu-

nities they serve at lower cost. Unlike voluntary programs, such as the Shared Savings Program, VBP applies to nearly all providers in a given setting. Two programs are under way, and a third will begin next year (see box).

VBP programs are being launched even as the quality of care is improving. For example, between 2006 and 2010, hospital performance improved on 91% of the measures included in CMS's inpatient pay-for-reporting program.<sup>1</sup> Furthermore, a new trend of slowing growth in health care costs has emerged.<sup>2</sup> The national scope of the new VBP programs will make it challenging to isolate their incremental effect on these trends. CMS and others

must continue to evaluate VBP's effects and the potential for unintended negative consequences. Early descriptive data, however, are encouraging: during the first year of the end-stage renal disease Quality Incentive Program, 55 to 96% of facilities showed significant improvement on the program's three clinical process measures relative to their own baseline 2 years earlier. We await final data to assess the incremental effect of including hospital quality measures in VBP versus pay-for-reporting programs alone; the first performance year recently ended, and the payment adjustments begin in October 2012.

Previous analyses reached mixed conclusions regarding the

## CMS's Value-Based Purchasing (VBP) Programs.

**Hospital VBP**

Almost all acute care hospitals are in the program  
 Affects 1% of payment in initial year for all admissions, increasing to 2% in October 2017  
 Current measures include process of care, patient experience, and outcomes  
 Rewards both achievement and improvement  
 First performance period ended March 31, 2012; will affect payment beginning October 1, 2012

**End-Stage Renal Disease Bundled-Payment and Quality Incentive Program (QIP)**

Bundled-payment and quality incentive program for dialysis facilities  
 QIP affects 2% of payment  
 Current measures include outcomes, process of care, safety measures, and a patient-experience reporting measure  
 Rewards both achievement and improvement  
 First performance period ended 2010; began affecting payment January 1, 2012

**Physician Value-Based Payment Modifier**

Physician payments adjusted up or down on the basis of performance on quality and cost metrics  
 First performance period in 2013; will begin affecting payment in 2015  
 Some physicians eligible initially; expanding to apply to all physicians by 2017  
 Additional program details being proposed this year

value of VBP with respect to both outcomes and the potential effect on disparities in health and health care.<sup>3,4</sup> We remain optimistic that VBP can improve quality and reduce costs, given that providers have enhanced their efforts to measure and improve performance since the current VBP programs were launched. Of course, VBP can improve quality only in areas that it measures and for which it provides incentives. The Premier Hospital Quality Incentive Demonstration Project, which informed the design of the Hospital VBP Program, resulted in significant improvements in processes of care. These results confirm that VBP can change practice patterns. Moreover, the improvements on process measures achieved by a British-based VBP program that linked up to 25% of a primary care physician's compensation to performance ultimately reduced mortality.<sup>5</sup> Although improvements in condition-specific, process-of-care measures did not

contribute to reducing 30-day mortality in the Premier demo, we take this finding as an opportunity to strengthen our portfolio of measures rather than as a fundamental problem with VBP as a tool. For example, Premier did not provide incentives to participating hospitals on the basis of 30-day mortality, hospital-acquired infections, cost, or patients' experience. Measures for these outcomes are part of CMS's newest proposal for hospital VBP. It remains to be seen, however, what effect such VBP will have on outcomes at a national level.

VBP allows CMS to specify measures that best advance the National Quality Strategy's objectives. Measurement to date has focused primarily on clinical care processes, safety, and patient experience. In keeping with CMS's three aims, the scope of measurement will be expanded to include the objectives of better health for communities, care coordination, and lower costs. Six

domains of measurement, corresponding to the National Quality Strategy's priorities, capture this expansion and are the basis for a proposed reorganization of VBP measures (see table). A more comprehensive set of measures that includes costs, population health, and care coordination will help providers focus on the care and support available outside their walls. Use of these six domains to align quality measurement across settings will allow CMS to create shared accountability for performance. It increases the likelihood that VBP will move the needle in areas that have not previously been measured, and for which incentives have not been provided, on a national scale.

Five principles are important in developing the VBP portfolio further. First, programs must define the end goal, not the process for achieving it. The best way to improve outcomes with VBP is to measure patient-centered outcomes and provide incentives for achieving them. VBP programs' measure sets must clearly and parsimoniously define the most critical outcomes in health, health care, and cost for each setting. Core measure sets must measure similar aspects of care and health — such as care coordination, patient experience, functional status, and costs — uniformly across episodes and settings of care. Emphasizing patient-centered outcomes in VBP programs will allow providers to focus on a concise core set of measures in which they have the greatest opportunities for improvement without being unduly burdened with reporting. More important, outcome measures allow providers the flexibility to identify the most critical process or system improve-

Six Domains of Quality Measurement.	
Domain	Sample Types of Measures
Safety	Patient safety, health care–acquired conditions
Patient- and caregiver-centered experience and outcomes	Patient experience, caregiver experience, patient-reported outcomes
Care coordination	Admission and readmission measures, care coordination measures, provider communication
Clinical care	Acute care, chronic care, prevention, clinical process measures, and outcomes
Population or community health	Health-related behaviors, access to care, determinants of health, disparities
Efficiency and cost reduction	Annual spending measures (e.g., per capita spending), episode cost measures, quality-to-cost ratios

ments needed to improve outcomes. CMS can catalyze system-level thinking and improvement, but providers' innovation and action must be local.

Second, all providers' incentives must be aligned. Reimbursement under a fee-for-service system is often siloed according to the type of provider and setting. VBP has the potential to harmonize types of measures and provider incentives across settings. For example, including incentives to reduce readmissions and spending per beneficiary for acute care hospitals, post-acute care facilities, and outpatient physicians establishes shared accountability and incentives to coordinate care. Alignment is also needed between government and private-sector VBP programs.

Third, the right measures must be developed and implemented in rapid cycle. VBP programs need to identify the set of measures that defines the kind of patient-centered care the health system should provide. In at least three of the National Quality Strategy's domains — care coordination, population health, and costs — there are gaps in currently available measures. Patient-reported functional outcomes, longitudinal measures, and measures that cut across the care continuum are lacking in multiple domains. Under the current model of mea-

sure development, endorsement, and implementation, it takes 4 or more years for a measure to be included in hospital VBP. We must collaborate to develop (or modify existing) measures to fill gaps and implement measures as quickly as possible while maintaining the review and public-commenting processes.

Fourth, CMS must actively support quality improvement. VBP programs should reward improvement as well as overall achievement whenever possible, but incentives alone cannot improve quality. Providers need the knowledge and skills to identify opportunities and implement quality improvements. Quality Improvement Organizations are CMS-funded organizations that provide on-the-ground technical assistance to providers who require support in improving quality. Other examples of frontline support include the Community-Based Care Transitions program and Partnership for Patients.

Finally, the clinical community and patients must be actively engaged in VBP. VBP will improve care only when clinicians, provider organizations, and patients understand its goals, are engaged in active improvement, and make decisions on the basis of value. Federal VBP programs must collaborate with and leverage regional, state, and private-sector

pay-for-performance programs that, in many cases, have already substantially improved quality.

Shifting to a culture of shared accountability for patient and community outcomes and costs will be a journey. VBP programs are a step in the transition from a fee-for-service health system to one that is fully accountable for these outcomes. Given the national scope of VBP programs, it is critical to monitor and evaluate their effects, make adjustments when needed, and provide support to providers and communities that are struggling with improvement. The United States needs a health system that achieves better health and better care at lower costs, and VBP is a potentially important tool for achieving those goals.

The views expressed in this article are those of the authors and do not necessarily represent official policy or opinions of the Department of Health and Human Services or the Centers for Medicare and Medicaid Services.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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## The Cost-Effectiveness of Environmental Approaches to Disease Prevention

Dave A. Chokshi, M.D., and Thomas A. Farley, M.D., M.P.H.

How can society prevent the most disease and deaths per dollar spent? This question arose throughout the debate on U.S. health care reform and will continue to drive decision making as health care funding becomes increasingly constrained. In an atmosphere of austerity, demonstrating the cost-effectiveness of preventive health interventions becomes particularly important.

Although preventive approaches to disease are intuitively appealing — and frequently presented as a way to reduce costs — analyses have suggested that, as a whole, they're no more cost-effective than therapeutic interventions.<sup>1</sup> But are some preventive approaches more cost-effective than others? The National Commission on Prevention Priorities attempted to address this question, ranking clinical preventive services in terms of cost-effectiveness and “clinically preventable burden” of disease.<sup>2</sup> Yet some preventive services, such as tobacco taxes or water fluoridation, are not delivered in health care settings. Understanding whether certain approaches are more cost-effective than others requires a framework for categorizing preventive interventions.

Medicine traditionally classifies

preventive interventions on the basis of disease course: primary prevention aims to prevent new cases of disease; secondary prevention and tertiary prevention mitigate the effects of existing disease. We propose two overlapping dimensions to further characterize primary preventive interventions: environmental versus person-directed, indicating whether the proximate target is an element of the environment or an individual, and clinical versus nonclinical, indicating where an intervention takes place. Separating person-directed from environmental interventions permits the comparison of prevention conducted individual by individual (e.g., cancer screening) with prevention that acts on persons indirectly by altering the physical or social environment (e.g., a ban on trans fats). Whether an intervention takes place within a health care setting or elsewhere has implications for resource allocation, since funding streams for clinical and nonclinical interventions tend to be distinct. Some nonclinical interventions, such as syringe-exchange programs, are person-directed, but all environmental interventions are nonclinical.

Because reaching individuals directly is generally more expensive than changing an environ-

mental element, we hypothesized that unless a person-directed intervention was very effective (like childhood immunization, for example), environmental interventions would generally be more cost-effective. We further hypothesized that it mattered where an intervention was delivered and that nonclinical, person-directed interventions would be more cost-effective than clinical interventions. To test these hypotheses, we conducted a comparative analysis of the cost-effectiveness of environmental, nonclinical but person-directed, and clinical preventive interventions.

We analyzed the contents of the Tufts Medical Center Cost-Effectiveness Analysis (CEA) Registry, which contains information on 2815 cost-effectiveness analyses published through December 2011. Costs per quality-adjusted life-year (QALY, a unit of measure for survival that accounts for the effects of suboptimal health status) are reported after conversion to 2011 U.S. dollars. Only cost-utility analyses — which permit comparison of programs addressing different health problems by converting health outcomes into a common metric — are included in the registry. We excluded studies that didn't report on an intervention meet-



# Executive Committee



# Minutes from the



## Buildings & Grounds Committee

ERIE COUNTY MEDICAL CENTER CORPORATION  
BOARD OF DIRECTORS  
MINUTES OF THE BUILDING & GROUNDS COMMITTEE MEETING  
AUGUST 14, 2012  
ECMCC STAFF DINING ROOM

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BOARD MEMBERS PRESENT OR ATTENDING BY CONFERENCE TELEPHONE:	RICHARD F. BROX, CHAIR MARK BARABAS	DIETRICH JEHLE, M.D. JODY L. LOMELO FRANK MESIAH
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EXCUSED:	RONALD CHAPIN MICHAEL HOFFERT	JOSEPH A. ZIZZI, SR., M.D.
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ALSO PRESENT:	DOUGLAS FLYNN
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**I. CALL TO ORDER**

Richard F. Brox called the meeting to order at 9:45A.M.

**II. RECEIVE AND FILE JUNE 12, 2012 MINUTES**

Moved by Richard Brox and seconded by Frank Mesiah to receive and file the Buildings and Grounds Committee minutes of June 12, 2012 as presented.

**III. UPDATE – PENDING CAPITAL INITIATIVES / PROJECTS**

**Access Road Water Main**

- Since our June meeting the NYSDOT has received and rejected all received proposals for their intended design-build bridge repair project as all exceeded their established budget. They do plan to bid out this same repair scope next spring under a traditional design-bid-build approach within which they intend to again include ECMCC's desired water main repair work. More details to follow in upcoming meetings.

**Radiology Redesign** – Conceptual Level Discussion

- This initiative involves several Radiology related relocation & reconfiguration concepts, which shall lead to a larger conceptual Master Plan. Involved services currently include multiple components of the current Radiology department (aka Phase 2), the 1st Floor MRI concept, and Nuclear Medicine & Urology Space Swap, along with potential others. This planning effort remains conceptual in nature.

**Behavioral Health COE Project (HEAL21)**

- With HEAL Grant funds confirmed for \$15 million, the expedited submission of applicable CON was completed last week.

## ERIE COUNTY MEDICAL CENTER CORPORATION

- Architectural contract for this project is in its final round of execution, initial draft of the Construction Management contract in progress as of late last week.
- In order to ensure ECMCC's opportunity to exhaust the available HEAL fund a very aggressive project schedule shall be required, which shall involve multiple bid packages, allowing for a quick start to new building foundations and structural steel before the onset of full winter conditions.

### **Immuno Clinic Relocation**

- Final schematic design meeting scheduled for this week. A viable plan has been established in the Grider Family Health Center which shall incorporate a small addition which shall provide a dedicated entry and waiting room. Multiple grant avenues are being explored.

### **Transitional Care Unit @ 6 Zone 2**

- With Architectural contract nearly complete the design effort can now move toward the development of a bid document set. This project is expected to bid in late September with renovation start by mid October.
- This bid set shall include two bid individual bid alternates, one for the construction of a Lab Department Break Room and the second the construction of an Emergency Department Break

### **Operating Room Expansion @ Renal Center MOB Space**

- CON application has been in for several months now, with two rounds of applicable Q&A completed in early spring. At this point ECMCC awaits further commentary from DOH. This project includes (2) complete operating rooms, (2) shelled operating rooms and an Ambulatory Surgery Suite @ the 1<sup>st</sup> floor level of the Renal Center MOB space.

### **Furniture, Fixtures, & Equipment @ Capital Projects**

- The Skilled Nursing Facility FF&E (Furniture, Fixture & Equipment) bid package is on the street, pre bid meeting held last Friday, with bids due August 24th.

### **MOB Fit-Out @ Renal Center Bldg / Floors 2 & 3**

- With Board approval received, Administration working on an applicable CON application whose submission is planned for later this month. The planned occupants include a) 2<sup>nd</sup> flr - Head & Neck (incl/Drs. Bellis & Linfield), Oncology, & Dr. Sperry; b) 3<sup>rd</sup> flr - Cardio-thoracic, Cardiology, Department of Medicine (AMS/GIM/Endoscopy), & Urology Private Practice. 2<sup>nd</sup> flr level being hospital functions and 3<sup>rd</sup> flr being tenant occupancies.

### **Financial Counseling / Gift Shop Project**

- This revisited initiative has grown and now incorporates potential renovations and relocations of Employee Health, Switchboard & Patient Advocate. In an effort to maintain momentum we are pursuing an architectural services agreement which shall at this stage be limited to the first two project phases, these being the Financial Counseling / Medicaid renovation (\$450K+/-) & Gift Shop (\$250K+/-) renovation.

## ERIE COUNTY MEDICAL CENTER CORPORATION

### **Signage & Wayfinding Project**

- We are working on a multi faceted interior signage package which shall include requirements for the Skilled Nursing Facility, 10th floor Transplantation, and unit pricing intended to lock-in quotes for extended time frames. We are working toward a mid – late September bid phase.
- The development of a new Site Signage requirements has begun, working toward an early fall bid package with intended installations prior to winter.

### **Security Camera & Access Control Systems**

- Based on Committee recommendations Administration has approved the purchase of a head-end Security Camera & Access Control System. This enhancement is the second of a multiple steps (PARCS being 1st) in this initiative toward improved security and related efficiencies. This head-end system is expected to be functional by mid October and shall service the new SNF, Fitness Center, 4 Zone 3, CPEP Fast Track, as well as all newly renovated or newly constructed areas in the future, and in time will also pull in the existing security and access control infrastructure.

### **Dental Residency Expansion / Oral Surgery Relocation**

- Dental Department seeking additional treatment rooms as their number of residents has jumped. Current plan is to pursue opportunities of renovating the former Eye Clinic space into a new (3) Operatory Oral Surgery Suite. This allows for relocation of Oral Surgery and Dental suite expansion in place. We are currently pursuing related Architectural services.

## IV. UPDATE – IN PROGRESS CAPITAL INTIATIVES / PROJECTS

### **Site & Parking Reconstruction Project**

- **Site Reconstruction** - Lot D complete and in use, Lot C completion expected by end of August. Full reconstruction of Hospital frontage to be complete by end of September. Lots B, A and balance of site reconstruction to be complete prior to end of year.
- **All-Pro Parking Management**
  - Shall continue to manage the paid parking lots (A & B) until the B Lot is fully reconstructed.
  - Currently providing Valet services, which is envisioned to continue until at least the end of September ie the reconstruction completion of the Hospital frontage
- **Parking Valet Services / Patient Transportation Vans** - Doctors Lot has been emptied to accommodate valet parking services and to provide an alternate Patient Transport Drop-Off and Pick-Up location.
- **Utilization Planning for reconstructed Parking Facilities** – with the incorporation of the Behavioral Health COE Project and the intended changes in the use of the parking ramp we will need to revisit the originally intended parking assignments across the board to ensure everyone is accounted. We will also need to work with the PARCS system vendor toward the development of an internal operational plan.

## ERIE COUNTY MEDICAL CENTER CORPORATION

### **CPEP Fast Track Initiative**

- Renovation in full swing and is fully staffed as our number one in-house priority, since the completion of the Employee Fitness Center. Forecasted completion remains early September.

### **CPEP EOB Unit @ 4 Zone 3**

- This single prime contractor project is nearing substantial completion, in house cleaning and furnishing to occur late this week leading to the joint DOH/OMH inspection confirmed for Monday 08/20/12.

### **Skilled Nursing Facility**

- All trades fully involved, from interior finishes to sitework & landscaping, progress maintaining pace with the overall schedule.

### **Chilled Water Plant Improvements**

- New chillers #3 & #4 and new cooling towers on line as our primary system which concludes phase 1 of the project, phase 2 to begin in early fall.

### **Building 7 / Vacancy**

- Since our June meeting Kaleida's Women's & Children's OBGYN has completed their occupancy of their rental space.

### **Employee Fitness Center Project**

- Renovation project completed 07/30/12, Center open to members as of August 6<sup>th</sup>.

The Fitness Center has had an overwhelming response from the employees and has received good press as well.

Mr. Lomeo recommended a defibrillator be installed in the Fitness Center.

## V. ADJOURNMENT

Moved by Frank Mesiah to adjourn the Board of Directors Building and Grounds Committee meeting at 10:30 a.m.

Next Building & Grounds meeting – October 9, 2012 at 10:00 a.m.  
Staff Dining Room.

# Minutes from the



## Finance Committee

ERIE COUNTY MEDICAL CENTER CORPORATION  
 BOARD OF DIRECTORS  
 MINUTES OF THE FINANCE COMMITTEE MEETING  
 JULY 24, 2012

ECMCC BOARD OF DIRECTORS CONFERENCE ROOM

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VOTING BOARD MEMBERS PRESENT OR ATTENDING BY CONFERENCE TELEPHONE:	MICHAEL A. SEAMAN RICHARD F. BROX DOUGLAS H. BAKER	DIETRICH JEHLER, MD
VOTING BOARD MEMBERS EXCUSED:	ANTHONY M. IACONO	THOMAS P. MALECKI, CPA
ALSO PRESENT:	MARK R. BARABAS MICHAEL SAMMARCO ANTHONY J. COLUCCI, III	RICHARD CLELAND JOHN EICHNER PAUL HUEFNER
NON-VOTING MEMBERS EXCUSED:	JODY L. LOMELO RONALD KRAWIEC	

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**I. CALL TO ORDER**

The meeting was called to order at 8:30 A.M., by Michael A. Seaman, Chair.

**II. RECEIVE AND FILE MINUTES**

Motion was made and accepted to approve the minutes of the Finance Committee meeting of June 19, 2012.

**III. JUNE, 2012 FINANCIAL STATEMENT REVIEW**

Michael Sammarco provided a summary of the financial results for June, 2012, which addressed volume, income statement activity and key financial indicators.

Total discharges were under budget by 87 for the month of June. Year-to-date discharges were over budget by 105, and 361 over the prior year. Acute discharges were under budget by 93 for the month, 14 year-to-date, and 212 over the prior year.

Observation cases were 149 for the month, and the average daily census was 327. Average length of stay was 6.0 for June compared to a budget of 6.0 and 6.2 year-to-date. Non-Medicare case mix was 2.02 for the month compared to a budget of 2.14, and Medicare case mix was 1.64 compared to a budget of 1.88 for the same period.

Inpatient surgical cases were under budget by 15 for the month, 56 over budget year-to-date, and 203 over the prior year. Outpatient surgical cases were under budget by 90 for the month, 310 under budget year-to-date, and 195 less than the prior year.

## ERIE COUNTY MEDICAL CENTER CORPORATION

Emergency Department visits were under budget for the month by 266, for the year by 736; but 1,777 visits, or 6.0%, over the prior year.

Hospital FTEs were 2,415 for the month, compared to a budget of 2,478. Home FTEs were 323 for the month, compared to a budget of 333.

Net patient service revenue for the Hospital was under budget by \$2.3 million or 7.3%, primarily driven by acute care volume and Medicare case mix.

The Hospital had an operating loss of \$539,000, compared to a budgeted surplus of \$851,000; and the Home had an operating loss of \$446,000.

The consolidated, year-to-date operating loss was \$5.4 million compared to a budgeted loss of \$2.6 million and a prior year loss of \$8.4 million.

Days in accounts receivable were 37.1 in May and 34.1 in June compared to a budget of 40.0.

#### IV. MANAGED CARE UPDATE:

Mr. Sammarco reported that:

- An initial proposal has been received from Univera;
- A meeting has been scheduled with Independent Health to receive their initial proposal;
- Waiting for an initial proposal from Health Now;
- The Department of Corrections contract was extended for 12 months and will expire on September 30, 2012.

#### V. OTHER BUSINESS:

- Internal meetings will begin during the first part of August to discuss upcoming NYSNA negotiations;
- An agreement with CSEA has been signed-off by the union and the County, and is scheduled to go to the membership for a vote in early August;

#### VI. ADJOURNMENT:

The meeting was adjourned at 9:10 a.m. by Michael Seaman, Chair.





# ECMCC Management Team



# Chief Executive Officer

ERIE COUNTY MEDICAL CENTER CORPORATION

REPORT TO THE BOARD OF DIRECTORS  
JODY L. LOMELO, CHIEF EXECUTIVE OFFICER  
AUGUST 28, 2012

Hope everyone is enjoying the great weather as the summer winds down and we approach the fall season. Initially, I want to express my appreciation for all of our staff who have worked tremendously hard as we have seen a surge in volumes. I especially thank all of our nurses and physicians who have gone beyond the call of duty to ensure that our patients receive the highest quality of care.

HOSPITAL OPERATIONS/ACTIVITY

I have met with our physicians and surgeons regarding operating room capacity and hours of operation. We are in the process of completing a survey to determine if we can improve capacity by extending our operating hours. We are extremely busy in our 12 operating suites and need to continually find ways to support our surgeons and the patients we serve. We are working with the State of New York to fast track our CON application for the new outpatient operating suites, but need to remodel the existing operating room plan.

As I have mentioned earlier, the hospital has been extremely busy over the past month and continues to be busy throughout August. We are currently running a census in the area of 92-96 percent. Our staff has done a wonderful job in moving patients throughout and providing appropriate care to all involved. Our Emergency Department has been working closely with our nursing department under the leadership of Karen Ziemianski, R.N. to do their level best in transitioning patients from the ED into the main hospital tower. As you can see in the financials, we did have an operating surplus in July and have seen better financial outcomes as we enter the fall season.

As I discussed last month, the Executive Management team met for a mid-year retreat to discuss “revenue enhancements and expense reductions.” We also discussed a more focused approach to the use of overtime throughout the hospital system. As volumes have increased we have had to staff accordingly and additional overtime has been needed. We will continue to monitor overtime usage and have asked all managers to join us in an appropriate reduction in overtime and especially in the non-clinical areas.

## ERIE COUNTY

We held a meeting with County Executive Polancarz and his team on August 22 to discuss a solution to the IGT overage that the County faces in 2012 and 2013 for the indigent care provided by ECMC. Both we and the County believe we have a conceptual agreement in place that will have little or no impact on the County budget in 2012 and 2013. As I have mentioned previously, I am confident that this agreement will further enhance and promote a stronger relationship with the County and keep the best interest of not only ECMC but the community as a whole.

CSEA rejected the tentative agreement that was put forward to its members. The final count was 2,144 NO votes and 706 YES votes. We will continue to work with the County as well as our partners in labor to attempt to craft an agreement that will hopefully satisfy all involved and reflect the economic realities of today and the future. We also are beginning discussions with NYSNA. I will continue to keep you informed concerning progress.

### **PHYSICIAN RECRUITMENT/PRIMARY CARE**

In our Board meeting tonight, you will see a presentation on the successes of the primary care strategy that we have put forward in our strategic plan. We are proud of the work that is being done not only here on campus but also in practices in Hamburg and Orchard Park. We will continue to recruit primary care physicians throughout the community as long as it brings value to ECMC and the Great Lakes Health System.

### **GREAT LAKES HEALTH**

ECMC and Kaleida teams continue to move very quickly and have been working extremely well to coordinate services for the Great Lakes Health System. We continue to work to coordinate Cardiovascular Services with the GVI for the ECMC campus and I am pleased with the progress that has been recently made with our surgeons and the surgeons from the Kaleida system. I appreciate their willingness to not only participate but their belief in a change that will ultimately be better for the patients that we serve. They are open to a new model that will not only take care of the patients on Grider Street, but also provide an increased quality of care under one program servicing two sites.

We also are moving very quickly with our partners at Kaleida in the formation of the consolidated Behavioral Health Center of Excellence on the ECMC campus. Our teams are meeting bi-weekly and have been working extremely well together in preparing for this new center. I would like to thank Rich Cleland and his team for all their efforts. We are currently in discussions with Kaleida to begin the coordination of management services for the Kaleida Behavioral Health patients.

#### **ECMC LIFELINE FOUNDATION (MAMMOGRAPHY BUS & FITNESS CENTER)**

The mammography bus has been an overwhelming success and has brought an unbelievable amount of positive press to ECMC, the Buffalo Sabres and the First Niagara Foundation. The bus was stationed at the Erie County Fair for 12 days and received a tremendous amount of positive attention. The volume on the bus has been encouraging, and we will be coming to the Board of Directors with some numbers in the very near future. For example, a week before the Erie County Fair, the bus screened 190 women who otherwise may not have been screened. I could not be more proud of the fact that we have all stepped up again to treat and serve those who have been historically underserved.

The ECMC Employee Fitness Center is now open and is a wonderful site to see. The employees are excited and could not be more appreciative of this phenomenal center. I encourage everyone to not only sign up for the Fitness Center, but to also visit it. Everything about the Fitness Center is top shelf and we are pleased that we can provide this for all of the ECMC family.

Again these are two prime examples of how the dollars we raise impact not only the people we serve but also the people we work with.

#### **LONG TERM CARE UPDATE**

The Long Term Care Center is moving quickly and is getting closer to completion each and every day. The facility is spectacular and I am hopeful that each of you has been able to tour the facility. The team has been doing great work and as you can see the campus has gone through a tremendous transformation. We are on time for an opening of February 2013 and looking forward to welcoming the residents of the Alden home to the ECMC health campus.

## **CAMPUS UPDATE/PARKING**

Each day, the health campus is changing before our eyes. The new buildings have not only brought a new look to the campus, but also a new energy. The campus has undergone a major facelift as we continue to evolve and improve our physical plant. The parking lots are progressing nicely. We are expecting that the bulk of the parking in the front of our buildings will be completed by the end of September. Like many other projects, there is no easy way of doing this without causing some inconvenience. My heartfelt thanks to all those who understand that at times we must take a step backward to take multiple steps forward.

As always, I appreciate all of your support and guidance as we continue to grow. Thank you.

Jody L. Lomeo



# President & Chief Operating Officer

ERIE COUNTY MEDICAL CENTER CORPORATION

REPORT TO THE BOARD OF DIRECTORS  
MARK C. BARABAS, PRESIDENT AND CHIEF OPERATING OFFICER  
AUGUST 28, 2012

ECMC FITNESS CENTER

I am pleased to announce that the ECMC Fitness Center was completed and opened last month.

HOSPICE OF BUFFALO PALLIATIVE OF CARE

Our contract was completed with Hospice of Buffalo and their Palliative Care division. Its effective date is September 1, 2012 whereby they will be providing physician and physician extenders support for our patients that qualify for palliative care services.

PARKING

We are on target for the following parking milestones;

- The week of September 5<sup>th</sup>
  - C Lot will open
  - B Lot will close
  - Drive 3 will close
  - MRI and Rehab entrances will reopen

The drive lanes are expected to reopen at the end of October. The projects are on target.



SNOW MELT SCHEDULE (40% PROP. GLYCOL)

HATCH PATTERN	AREA	MANIFOLD LOCATION	SIZE	THERMAL MASS	TOTAL FLOW RATE	FLOW RATE PER CIRCUIT	PRESSURE DROP	CIRCUIT TEMPERATURE	TUBE SPACING	MAX TUBING LENGTH	CIRCUITS	HEAT LOAD BTU/HR	DESIGN EQUIPMENT	REMARKS
[Hatch]	AREA A SIDEWALK	BELOW GRADE	4390 S.F.	CONC. W/ WIRE MESH	80 GPM	4 GPM	27 FTWG	120°F	8"	333'	20	790,200	3/4" REHAU PEX A TUBING	USE TWO MANIFOLDS
[Hatch]	AREA A DROP OFF LANE	BELOW GRADE	3475 S.F.	CONC. W/ REBAR	63 GPM	4.8 GPM	48 FTWG	120°F	8"	400'	13	625,500	3/4" REHAU PEX A TUBING	-
[Hatch]	AREA B SIDEWALK	BELOW GRADE	1315 S.F.	CONC. W/ WIRE MESH	18 GPM	3 GPM	16 FTWG	120°F	8"	333'	6	236,700	3/4" REHAU PEX A TUBING	-
[Hatch]	AREA B DROP OFF LANE	BELOW GRADE	1320 S.F.	CONC. W/ REBAR	18 GPM	3 GPM	16 FTWG	120°F	8"	333'	6	237,600	3/4" REHAU PEX A TUBING	-
[Hatch]	AREA C NORTH MAIN ENTRY	BELOW GRADE	2085 S.F.	CONC. W/ WIRE MESH	33 GPM	3 GPM	16 FTWG	120°F	8"	333'	11	375,300	3/4" REHAU PEX A TUBING	-
[Hatch]	AREA C WEST MAIN ENTRY	BASEMENT CEILING SPACE	930 S.F.	CONC. W/ WIRE MESH	15 GPM	3 GPM	16 FTWG	120°F	8"	333'	5	-	3/4" REHAU PEX A TUBING	-
[Hatch]	AREA C SOUTH MAIN ENTRY	BELOW GRADE	1505 S.F.	CONC. W/ WIRE MESH	24 GPM	3 GPM	16 FTWG	120°F	8"	333'	8	-	3/4" REHAU PEX A TUBING	-

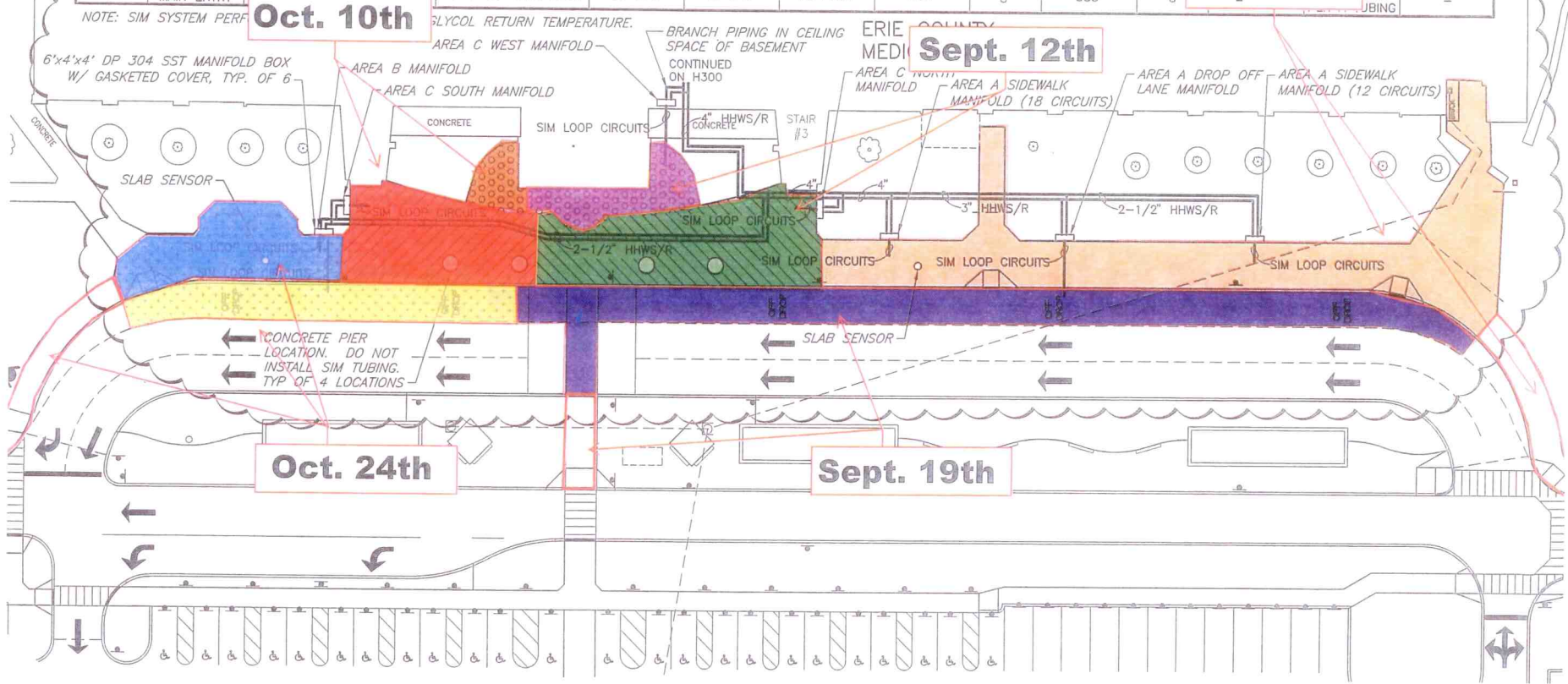
Sept. 5th

Oct. 10th

Sept. 12th

Oct. 24th

Sept. 19th



1 SNOW AND ICE MELT (SIM) SITE PLAN  
H301 SCALE: 1" = 30'

SNOW & ICE MELT NOTES:

- SUBSOIL REQUIREMENTS - INSTALLERS SHOULD INSPECT THE SUBSOIL UNDERNEATH THE SIM THERMAL MASS TO ENSURE THE FOLLOWING CONDITIONS: SUBSOIL IS CLEAN AND COMPACTED. SUBSOIL IS DRY AND WILL NOT ALLOW GROUND WATER TO PENETRATE THE PIPE. IF THE
- SLEEVE MATERIAL - PROTECTIVE SLEEVES SHOULD COVER ALL TUBING THAT EITHER PENETRATES THE THERMAL MASS, OR CROSSES A CONTROL OR EXPANSION JOINT. INSTALL AND SECURE THE PROTECTION SLEEVE TO ENSURE IT DOES NOT MOVE DURING THE THERMAL MASS INSTALLATION. PROTECTIVE SLEEVES ARE ALSO USED TO PROTECT THE TUBING FROM ULTRAVIOLET (UV) LIGHT.

**SNOW MELT SCHEDULE (40% PROP. GLYCOL)**

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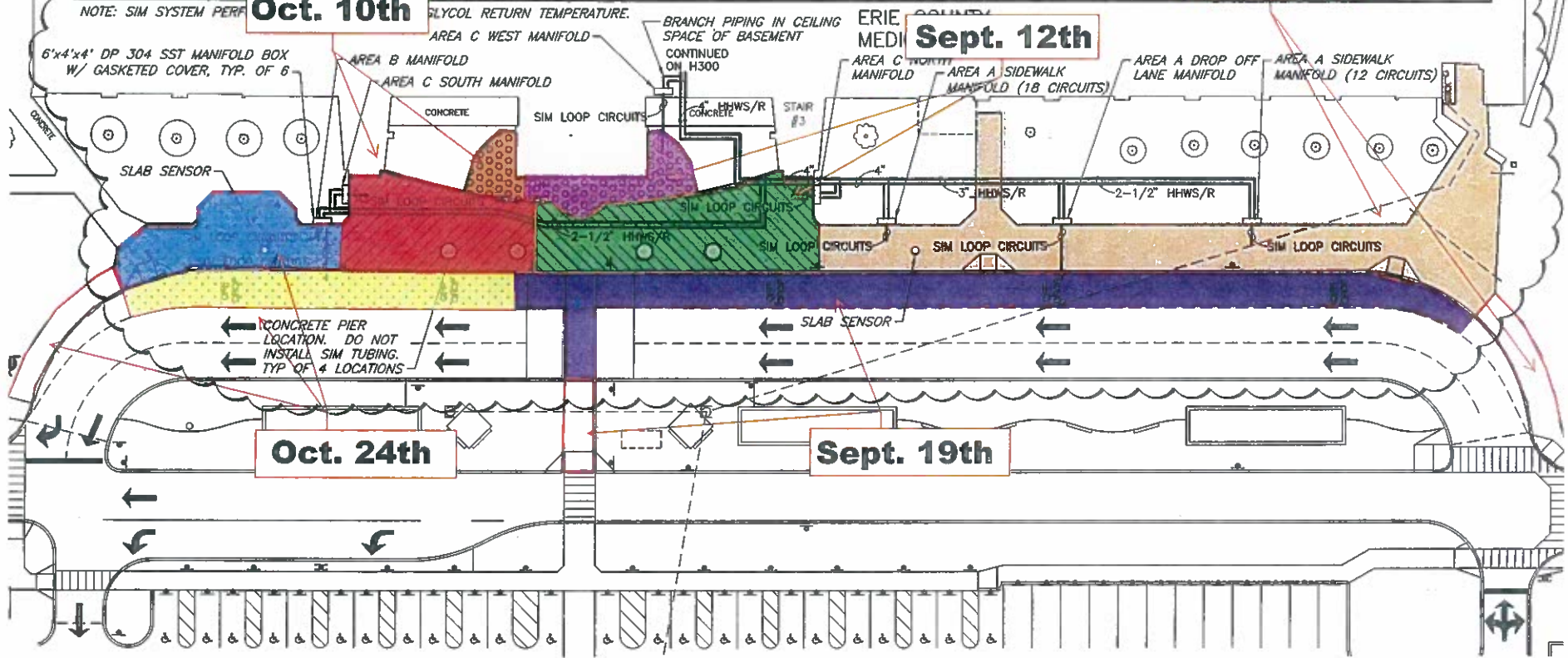
**Sept. 5th**

**Oct. 10th**

**Sept. 12th**

**Oct. 24th**

**Sept. 19th**



**1 SNOW AND ICE MELT (SIM) SITE PLAN**  
H301 SCALE: 1" = 30'

**SNOW & ICE MELT NOTES:**

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# Chief Financial Officer



The Culture of Care

**Internal Financial Reports**  
**For the month ended July 31, 2012**

Prepared by ECMCC Finance

## Erie County Medical Center Corporation

### Balance Sheet July 31, 2012 and December 31, 2011

(Dollars in Thousands)

	July 31, 2012	Audited December 31, 2011	Change from Prior Year End
<b>ASSETS</b>			
Current assets:			
Cash and cash equivalents	\$ 22,269	\$ 38,222	\$ (15,953)
Investments	12,932	46,306	(33,374)
Patient receivables, net	41,950	39,217	2,733
Prepaid expenses, inventories and other receivables	49,970	57,500	(7,530)
<b>Total Current Assets</b>	<b>127,121</b>	<b>181,245</b>	<b>(54,124)</b>
Assets Whose Use is Limited:			
Designated under self-insurance programs	87,680	79,426	8,254
Designated by Board	25,000	25,000	0
Restricted under debt agreements	53,827	93,412	(39,585)
Restricted	30,344	23,354	6,990
	196,851	221,192	(24,341)
Property and equipment, net	225,745	163,015	62,730
Deferred financing costs	3,157	3,233	(76)
Other assets	4,109	1,873	2,236
<b>Total Assets</b>	<b>\$ 556,983</b>	<b>\$ 570,558</b>	<b>\$ (13,575)</b>
<b>LIABILITIES AND NET ASSETS</b>			
Current Liabilities:			
Current portion of long-term debt	\$ 5,802	\$ 4,249	\$ 1,553
Accounts payable	39,265	39,138	127
Accrued salaries and benefits	13,919	17,908	(3,989)
Other accrued expenses	36,095	59,398	(23,303)
Estimated third party payer settlements	26,764	28,211	(1,447)
<b>Total Current Liabilities</b>	<b>121,845</b>	<b>148,904</b>	<b>(27,059)</b>
Long-term debt	184,657	187,290	(2,633)
Estimated self-insurance reserves	54,143	47,700	6,443
Other liabilities	96,511	88,566	7,945
<b>Total Liabilities</b>	<b>457,156</b>	<b>472,460</b>	<b>(15,304)</b>
<b>Net Assets</b>			
Unrestricted net assets	88,977	87,248	1,729
Restricted net assets	10,850	10,850	0
<b>Total Net Assets</b>	<b>99,827</b>	<b>98,098</b>	<b>1,729</b>
<b>Total Liabilities and Net Assets</b>	<b>\$ 556,983</b>	<b>\$ 570,558</b>	<b>\$ (13,575)</b>



## Erie County Medical Center Corporation

### Statement of Operations

For the month ended July 31, 2012

(Dollars in Thousands)

	Actual	Budget	Variance	Prior Year
<b>Operating Revenue:</b>				
Net Patient Revenue	\$ 35,283	\$ 31,987	\$ 3,296	\$ 30,721
Less: Provision for bad debts	(2,043)	(2,027)	(16)	(1,894)
Adjusted net patient revenue	33,240	29,960	3,280	28,827
Disproportionate Share/IGT Revenue	4,702	4,702	-	6,056
Other Revenue	1,910	2,701	(791)	1,998
<b>Total Operating Revenue</b>	<b>39,852</b>	<b>37,363</b>	<b>2,489</b>	<b>36,881</b>
<b>Operating Expenses:</b>				
Salaries / Wages / Contract Labor	13,505	13,257	(248)	12,951
Employee Benefits	9,022	8,702	(320)	8,601
Physician Fees	4,587	4,119	(468)	3,922
Purchased Services	2,923	2,640	(283)	2,459
Supplies	5,722	5,517	(205)	4,990
Other Expenses	654	691	37	683
Utilities	490	729	239	521
Insurance	589	537	(52)	599
Depreciation & Amortization	1,446	1,467	21	1,238
Interest	449	440	(9)	457
<b>Total Operating Expenses</b>	<b>39,387</b>	<b>38,099</b>	<b>(1,288)</b>	<b>36,421</b>
<b>Income (Loss) from Operations</b>	<b>465</b>	<b>(736)</b>	<b>1,201</b>	<b>460</b>
<b>Non-operating gains (losses):</b>				
Interest and Dividends	269	-	269	68
Unrealized Gains/(Losses) on Investments	1,322	172	1,150	39
Non-operating Gains(Losses), net	1,591	172	1,419	107
<b>Excess of (Deficiency) of Revenue Over Expenses</b>	<b>\$ 2,056</b>	<b>\$ (564)</b>	<b>\$ 2,620</b>	<b>\$ 567</b>



## Erie County Medical Center Corporation

### Statement of Operations

For the seven months ended July 31, 2012

(Dollars in Thousands)

	Actual	Budget	Variance	Prior Year
<b>Operating Revenue:</b>				
Net Patient Revenue	\$ 225,335	\$ 224,759	\$ 576	\$ 209,271
Less: Provision for bad debts	(13,257)	(14,184)	927	(12,878)
Adjusted net patient revenue	212,078	210,575	1,503	196,393
Disproportionate Share/IGT Revenue	32,913	32,913	-	29,857
Other Revenue	12,951	15,410	(2,459)	18,374
<b>Total Operating Revenue</b>	<b>257,942</b>	<b>258,898</b>	<b>(956)</b>	<b>244,624</b>
<b>Operating Expenses:</b>				
Salaries / Wages / Contract Labor	90,686	91,422	736	88,317
Employee Benefits	61,266	60,123	(1,143)	59,343
Physician Fees	29,585	28,792	(793)	27,582
Purchased Services	19,221	18,907	(314)	18,018
Supplies	37,474	36,411	(1,063)	33,925
Other Expenses	4,468	4,841	373	4,907
Utilities	3,262	4,595	1,333	4,523
Insurance	3,674	3,756	82	4,204
Depreciation & Amortization	10,134	10,272	138	8,669
Interest	3,074	3,077	3	3,118
<b>Total Operating Expenses</b>	<b>262,844</b>	<b>262,196</b>	<b>(648)</b>	<b>252,606</b>
<b>Income (Loss) from Operations</b>	<b>(4,902)</b>	<b>(3,298)</b>	<b>(1,604)</b>	<b>(7,982)</b>
<b>Non-operating Gains (Losses)</b>				
Interest and Dividends	2,375	-	2,375	2,140
Unrealized Gains/(Losses) on Investments	4,740	1,202	3,538	874
Non Operating Gains (Losses), net	7,115	1,202	5,913	3,014
<b>Excess of (Deficiency) of Revenue Over Expenses</b>	<b>\$ 2,213</b>	<b>\$ (2,096)</b>	<b>\$ 4,309</b>	<b>\$ (5,979)</b>



**Erie County Medical Center Corporation**

**Statement of Changes in Net Assets  
For the month and seven months ended July 31, 2012**

*(Dollars in Thousands)*

	<u>Month</u>	<u>Year-to-Date</u>
<b><u>UNRESTRICTED NET ASSETS</u></b>		
Excess (Deficiency) of Revenue Over Expenses	\$ 2,056	\$ 2,213
Other Transfers, Net	(79)	(484)
Contributions for Capital Acquisitions	-	-
Net Assets Released from Restrictions for Capital Acquisition	-	-
	<hr/>	<hr/>
Change in Unrestricted Net Assets	1,977	1,729
	<hr/>	<hr/>
<b><u>TEMPORARILY RESTRICTED NET ASSETS</u></b>		
Contributions, Bequests, and Grants	-	-
Net Assets Released from Restrictions for Operations	-	-
Net Assets Released from Restrictions for Capital Acquisition	-	-
	<hr/>	<hr/>
Change in Temporarily Restricted Net Assets	-	-
	<hr/>	<hr/>
Change in Total Net Assets	1,977	1,729
	<hr/>	<hr/>
Net Assets, Beginning of Period	97,850	98,098
	<hr/>	<hr/>
<b>NET ASSETS, End of Period</b>	<b>\$ 99,827</b>	<b>\$ 99,827</b>
	<hr/>	<hr/>



## Erie County Medical Center Corporation

### Statement of Cash Flows

For the month and seven months ended July 31, 2012

(Dollars in Thousands)

	Month	Year-to-Date
<b><u>CASH FLOWS FROM OPERATING ACTIVITIES</u></b>		
Change in net assets	\$ 1,977	\$ 1,729
Adjustments to Reconcile Changes in Net Assets to Net Cash Provided by (Used in) Operating Activities:		
Depreciation and amortization	1,446	10,134
Provision for bad debt expense	2,043	13,257
Net Change in unrealized (gains) losses on Investments	(1,322)	(4,740)
Transfer to component unit - Grider Initiative, Inc.	79	484
Capital contribution to/from Erie County	-	-
<u>Changes in Operating Assets and Liabilities:</u>		
Patient receivables	(8,360)	(15,990)
Prepaid expenses, inventories and other receivables	2	7,530
Accounts payable	2,904	127
Accrued salaries and benefits	(2,836)	(3,989)
Estimated third party payer settlements	120	(1,447)
Other accrued expenses	(376)	(23,303)
Self Insurance reserves	840	6,443
Other liabilities	1,135	7,945
Net Cash Provided by (Used in) Operating Activities	(2,348)	(1,820)
<b><u>CASH FLOWS FROM INVESTING ACTIVITIES</u></b>		
Additions to Property and Equipment, net		
Campus expansion	(8,648)	(65,984)
Routine capital	(2,002)	(6,804)
Decrease (increase) in assets whose use is limited	5,422	24,341
Purchases (sales) of investments, net	1,761	38,114
Investment in component unit - Grider Initiative, Inc.	(79)	(484)
Change in other assets	(48)	(2,236)
Net Cash Provided by (Used in) Investing Activities	(3,594)	(13,053)
<b><u>CASH FLOWS FROM FINANCING ACTIVITIES</u></b>		
Principal payments on long-term debt	(90)	(1,080)
Capital contribution to/from Erie County	-	-
Net Cash Provided by (Used in) Financing Activities	(90)	(1,080)
Increase (Decrease) in Cash and Cash Equivalents	(6,032)	(15,953)
Cash and Cash Equivalents, Beginning of Period	28,301	38,222
Cash and Cash Equivalents, End of Period	\$ 22,269	\$ 22,269

**Erie County Medical Center Corporation**

**Key Statistics**

**Period Ended July 31, 2012**

Current Period				Year to Date			
Actual	Budget	% to Budget	Prior Year	Actual	Budget	% to Budget	Prior Year
1,004	1,036	-3.1%	925	6,569	6,614	-0.7%	6,277
138	96	43.8%	94	895	745	20.1%	731
27	27	0.0%	25	185	214	-13.6%	222
209	152	37.5%	153	1,411	1,334	5.8%	1,341
31	41	-24.4%	27	260	250	4.0%	202
1,409	1,352	4.2%	1,224	9,320	9,157	1.8%	8,773
6,356	6,200	2.5%	6,457	40,680	39,565	2.8%	40,227
458	402	13.9%	346	2,872	3,122	-8.0%	2,520
464	501	-7.4%	567	3,554	4,007	-11.3%	4,408
2,538	2,072	22.5%	2,710	18,797	18,157	3.5%	18,158
839	1,032	-18.7%	771	5,613	6,307	-11.0%	5,053
10,655	10,207	4.4%	10,851	71,516	71,158	0.5%	70,366
205	200	2.5%	208	191	186	2.8%	190
15	13	13.9%	11	13	15	-8.0%	12
15	16	-7.4%	18	17	19	-11.3%	21
82	67	22.5%	87	88	85	3.5%	86
27	33	-18.7%	25	26	30	-11.0%	24
344	329	4.4%	350	336	334	0.5%	332
6.3	6.0	5.8%	7.0	6.2	6.0	3.5%	6.4
3.3	4.2	-20.7%	3.7	3.2	4.2	-23.4%	3.4
17.2	18.6	-7.4%	22.7	19.2	18.7	2.6%	19.9
12.1	13.6	-10.9%	17.7	13.3	13.6	-2.1%	13.5
27.1	25.2	7.5%	28.6	21.6	25.2	-14.4%	25.0
7.6	7.5	0.2%	8.9	7.7	7.8	-1.3%	8.0
4,158	3,597	15.6%	4,100	28,557	26,190	9.0%	27,891
134	120	11.9%	132	134	123	9.0%	132
62.5%	59.9%	4.4%	63.6%	62.7%	60.7%	3.1%	60.3%
78.1%	78.8%	-0.8%	81.2%	82.4%	79.9%	3.1%	77.0%
81.4%	78.8%	3.4%	84.8%	84.0%	79.9%	5.2%	80.4%
1.73	1.84	-6.0%	1.80	1.74	1.91	-8.8%	1.87
2.01	2.19	-7.9%	2.13	2.13	2.16	-1.7%	2.12
137	124	10.5%	106	934	1,015	-8.0%	861
471	523	-9.9%	464	2,947	2,943	0.1%	2,737
590	682	-13.5%	607	4,356	4,758	-8.4%	4,568
27,201	27,403	-0.7%	24,872	202,581	211,859	-4.4%	198,733
5,663	6,053	-6.4%	5,583	37,375	38,501	-2.9%	35,518
39.7	40.0	-0.7%	44.2	39.7	40.0	-0.7%	44.2
6.0%	6.5%	-8.5%	6.5%	6.1%	6.5%	-6.2%	6.5%
2,461	2,388	3.1%	2,395	2,395	2,401	-0.3%	2,393
3.12	3.23	-3.6%	3.15	3.10	3.17	-2.0%	3.17
\$ 13,389	\$ 12,400	8.0%	\$ 13,423	\$ 12,820	\$ 12,789	0.2%	\$ 12,287
\$ 15,256	\$ 15,247	0.1%	\$ 16,475	\$ 15,292	\$ 15,412	-0.8%	\$ 15,308
9,632	10,143	-5.0%	13,364	72,668	73,121	-0.6%	95,347
311	338	-8.1%	431	341	343	-0.6%	450
53.0%	57.7%	-8.1%	73.6%	58.2%	58.6%	-0.6%	76.7%
313	319	-1.7%	396	328	330	-0.5%	405





**Sr. Vice President of  
Operations  
- Richard Cleland -**

ERIE COUNTY MEDICAL CENTER CORPORATION

REPORT TO THE BOARD OF DIRECTORS  
RICHARD C. CLELAND, MPA, FACHE, NHA  
SENIOR VICE PRESIDENT OPERATIONS  
AUGUST 2012

LONG TERM CARE-ERIE COUNTY HOME/ECMC SNF:

Construction of the new nursing home is going very well. We are looking at an end of December 2012 completion with a “tentative” move in date by February 1, 2013.

The Long Term Care Steering Committee is overseeing, planning and carrying out:

- Remaining downsizing initiative(currently we are down to 304 beds at the Erie County Home and total bed census of 439);
- The new care delivery model(person-centered care);
- Operational components (labor, new positions, policy & procedures etc.);
- The move of 390 patients into the new facility;
- Impact negotiation session (AFSCME, CSEA, NYSNA)follow-up items;
- Appropriate exit(clear out and clean up)of the EC Home;
- Implementation of EMR and integration of the nursing home on ECMC Campus;
- FFE & technology initiatives

An LTC Facility Naming Committee is meeting and should have new nursing home name by early September (see attached brochure).

BEHAVIORAL HEALTH (PSYCHIATRY, CHEMICAL DEPENDENCY, CPEP,  
CD OUTPATIENT CLINIC):

The Behavioral Health Steering Committee has continued to meet monthly and bring about great improvement to the overall programs and services that we provide. We just completed our annual OMH CPEP survey in July. Based on the OMH exit we had our best survey in recent years;

Renovation to relocate the CPEP-EOB beds to the 4<sup>th</sup> floor started in April. The unit will be opened on August 27, 2012 pending joint OMH/DOH review;

The renovation of the CPEP Fast Track Triage started in April. This should be up and operational by early September;

The relocation of the EOB beds to the 4<sup>th</sup> floor and the Fast Track Triage will add about 4,500 square feet to CPEP (almost doubling the current size);

Great Lakes Health “Center of Excellence in Behavioral Health” HEAL-21 project’s Certificate of Need (CON), was submitted on August 3, 2012. Currently this CON is under review by both OMH and DOH. We are optimistic that both regulatory agencies will be able to approve by early October. Both clinical and operational teams from ECMCC and Kaleida continue to meet weekly and work through various planning and scheduling components to insure that we have a successful venture.

## ERIE COUNTY MEDICAL CENTER CORPORATION

The chemical dependency outpatient clinics are in process of implementing recommendations outlined in the Redesign Committee's report. This includes modifying all patient admission, registration and billing systems. This modification includes converting to an electronic system similar to the hospital. This will increase productivity and reduce inefficient processes. Volumes continue to incrementally increase and financial performance improve.

### REHABILITATION SERVICES:

Dr. Mark Livecchi has been appointed Clinical Director of Rehabilitation Services. Started date - July 1, 2012;

Outpatient clinic has expanded physician hours and schedules to meet patient demands and to insure continuum of care.

### HYPERBARIC/WOUND CENTER (HWC):

The center continues to slowly and incrementally grow volumes. We currently are running full day schedules Monday through Friday. A third HBO chamber is on the horizon;

Healogic (Management Company) are planning on holding a Hyperbaric/Wound Symposium in November. More details forthcoming;

Beth Engler has resigned as Director. Beth, recently a first time mom, decided to be a full-time mom and not return to ECMCC. Healogic is currently recruiting for a new Director of the Center.

### TRANSITIONAL CARE UNIT (TCU):

Jennifer Cronkhite, Director of Nursing SNF has been appointed TCU Project Champion;

Dr. Arthur Orlick has been named as Medical Director of the TCU;

Molly Shea, RN has been named as Director of Nursing (Unit Manager) for the TCU;

TCU Steering Committee developed and will be meeting twice monthly to insure TCU is up and operational by end of December;

Implex Partners consultants have been retained to help ECMCC put finishing touches on the TCU. ECMCC has an agreement which will require a 6-8 month engagement. This assistance will insure that the TCU is fully operational and ready to open in January 2013.

### FOOD AND NUTRITIONAL SERVICES:

Steve Foreman has been appointed Head Chef of the operations. Steve comes to us with a vast amount of restaurant experience and is the right person to make the needed changes in the customer menu areas;

ERIE COUNTY MEDICAL CENTER CORPORATION

Morrison has submitted proposal to extend current agreement (expires in 2014). This proposal will include up to \$2 million dollars of capital investment from Morrison into ECMC operations (cafeteria and food preparation areas). We are currently reviewing proposal and to insure that this will meet ECMC's needs. The proposal calls for a (5) year extension with a (3) year extension.

**Submission Deadline. August 24, 2012**  
**PLEASE MAKE THESE AVAILABLE TO STAFF:**



Help us name  
our new Long  
Term Care (LTC)  
Facility!

The "LTC Naming Committee," a team made up of facility residents, employees, board members, and physician leadership would like your suggestions as it looks to name our New Long Term Care Facility!

Please print and complete the form below/attached with your name suggestion and place it in the LTC Name Suggestion Box located at the Administrative Reception Desk on the 3rd Floor. This form may also be picked up at the 3rd Floor Reception Desk.

We appreciate your ideas for this very important initiative!

Thank you,  
The LTC Naming Committee

**Long Term Care Name Suggestion Submission Form**  
**(PLEASE PRINT IN THE SPACES BELOW)**

LTC FACILITY NAME SUGGESTION:

REASON FOR YOUR SUGGESTION:

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---

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YOUR NAME: \_\_\_\_\_

YOUR DEPARTMENT: \_\_\_\_\_ PHONE EXTENSION: \_\_\_\_\_

# Long Term Care Facility Tours

ECMC staff members are proud of our “State-of-the-Art” new Long Term Care (LTC) Facility and our residents are excited about their new home!

Come see what “Person-Centered Care” is all about.



**Tours of our Long Term Care Facility are offered weekly each Wednesday at 10:00 a.m.**

Our new state-of-the-art “Patient-Centered Care” LTC Facility will have many unique features that are new and exciting!

Over the past 18 months the “Driving Us Home Committee” has been leading the way in planning and developing new features which are unique and provide the “cutting edge” facility and culture that all our residents and staff require. The “Driving Us Home Committee” consists of residents, resident families, volunteers, and long term care staff representing both the Erie County Home and the Skilled Nursing Facility.

One of the great ideas that the committee came up with was to create a theme for the nursing home, to carry this theme to each floor, and to name each neighborhood (unit) with a name that reflects a specific area of Buffalo.

## New LTC Facility Theme: “**Everything Buffalo**”

### FLOOR THEMES:

### INDIVIDUAL NEIGHBORHOODS:

“The Parks”

Delaware, Cazenovia,  
Schiller, Front

“Harbor Side”

Naval Park, Lighthouse, Erie Basin  
Marina, Canal Side

“The Square”

Niagara, Roosevelt,  
Lafayette, Ellicott

“Architectural Landmarks”

Central Terminal, Botanical Gardens,  
Kleinhans, Albright

Come see our New Facility!

Please contact Michelle Kroupa at 716-898-5273 to schedule an LTC tour.

Tour guidelines and information will be provided prior to each tour.  
Please note that tour groups are limited to 10 people.



**Sr. Vice President of  
Operations  
- Ronald Krawiec -**

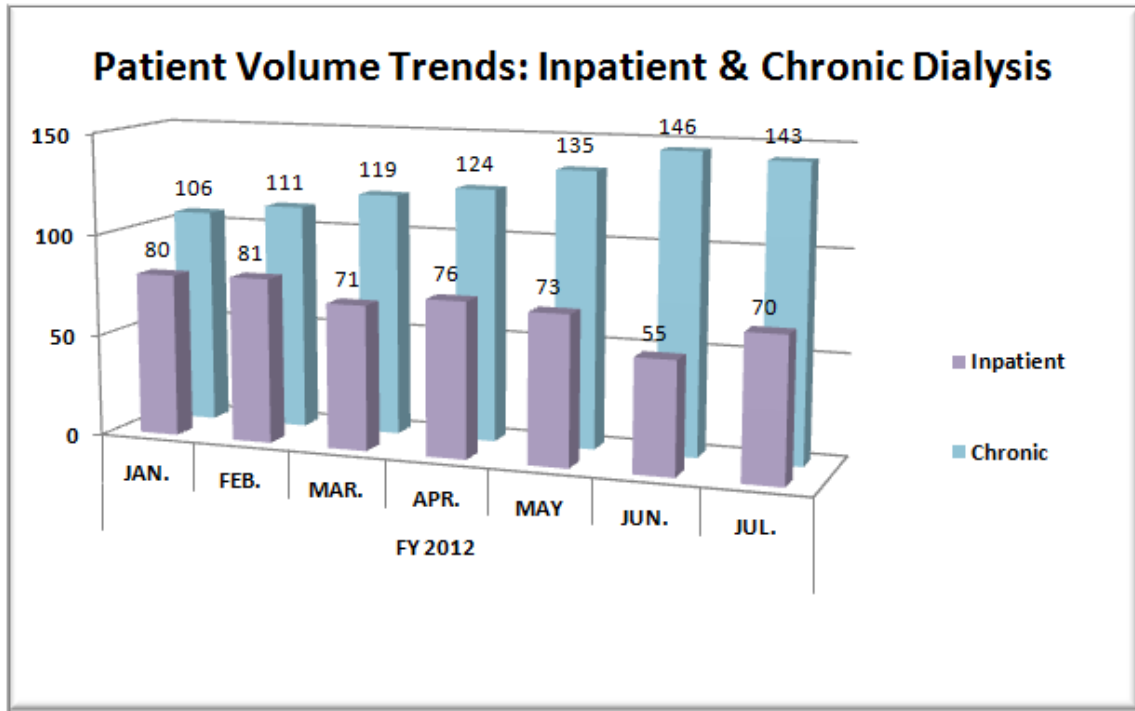


Erie County Medical Center Corporation  
Report to the Board of Directors  
Ronald J. Krawiec, Senior Vice President of Operations  
August 28, 2012

**TRANSPLANTATION & KIDNEY CARE CENTER – JOHN HENRY**

**DIALYSIS:**

Outpatient and inpatient dialysis volumes were relatively unchanged for July 2012 (see chart below). Current outpatient unit capacity is at 66% (143 patients). Total dialysis treatments are up (1,967) in July compared to June (1,912).



We have hired our first home hemodialysis nurse. She is currently orienting to meet our training requirements for the center-based outpatient dialysis. She brings a wealth of experience after operating a home hemodialysis program in Florida. We are planning an October kick-off for this new program.

**TRANSPLANTATION:**

Nine total transplants were completed in July, all with excellent outcomes (graft and patient). Three of these were part of our Living Donor Program. Of the 48 transplants (46 Kidney, 2 pancreas) completed in 2012, twelve have been from living donors. This equates to 26% of the transplants (kidney) completed this year have been from living donors. Our goal is to increase this percent to 30 – 35%. For comparison, last year ECMC completed 27 total transplants with 5 from living donors. Long term program viability requires a robust living donor program and we are on the right track to attaining that goal. We remain on track to complete approximately 85 transplants this year.

Of note, the ECMC Pancreas Program was put under probation by UNOS Membership and Professional Standards Committee in July 2011. At the time of the program merger last January, we completed the first pancreas transplant here at ECMC since September of 2010. We have since completed a second pancreas transplant in June. In July we received written notification that the program was fully recognized as a program in good standing.

## **AMBULATORY SERVICES – PAUL MUENZNER**

Grant Approval: Immunodeficiency (HIV) clinic has recently been awarded the full amount of their request for a Ryan White grant in the amount of \$1,243,548, or \$414,516 per year for 3 years effective 8-1-2012. This is a federal grant award through the US Dept of Health and Human Services - HRSA to enhance HIV medical treatment and case management supports to HIV+ women and HIV+ adolescents (18-24 yrs of age). The goal is to link HIV+ women who were lost to medical care back into care and stabilize their health along with implementing a plan of action to transition HIV+ adolescents into the adult medical care setting. The grant will provide funding for a Medical Social Worker, RN, Pharmacist, Medical Provider, and clerical supports. ECMC was one of only two upstate NY medical sites to be awarded this funding.

A Patient Appointment Reminder System has been implemented for patients at Cleve-Hill, IMC, HIV and GFH clinics. Its purpose is to reduce the patient no-show rate and increase the ability to fill cancelled appointments thereby increasing patients seen per clinic, associated revenue and efficiency of staff. Centralized Appointment Scheduling is being utilized in ENT, Podiatry, Pulmonology, Neurosurgery, and GFHC to gain efficiency and reduce the number of dropped calls. Cleve-Hill will be implemented during this quarter.

## **LABORATORY – JOSEPH KABACINSKI**

We met with representatives of the Hemophilia Center's Hemostasis Thrombosis Lab of Western New York. They are offering specialized Lab services, including Von Willebrand and factor assays, used by our Hematology/Oncology Clinic providers. We are investigating their services and possibilities of interfaced, electronic results reporting directly to ECMCC's electronic medical record. The relationship could improve quality and response time compared to our current vendor.

We will commence specimen collection services and lease space in ECMC to New York State for a study being conducted by the Great Lakes Biomonitoring Project slated to begin in late August or early September. The program will continue for 2 to 3 months. ECMC will receive additional revenues and assist in an important project. Other initiatives include performing Quantiferon TB-gold testing for a Kaleida Health study taking place in September and validating an in-house assay for *Everolimus*, a new

immunosuppressant drug prescribed for post-transplant patients. This assay is in demand by our Transplant physicians.

## **PHARMACEUTICAL SERVICES – RANDY GERWITZ**

ECMCC's Director of Pharmaceutical Services was appointed to a VHA Empire-Metro executive committee tasked with evaluating and negotiating the group's pharmaceutical wholesaler agreement. As a group this VHA region spends approximately \$22 million per month. We are pleased to report that the committee will be making a recommendation to the membership to sign an agreement that will save the member hospitals approximately \$10.4 million over the next three years. ECMC's projected savings is \$450,000 over that same time frame. This savings will effectively negate any inflation associated with medications for that period.

The DPS continues the transition of all drug preparation and distribution to Pharmacy. Time and effort will be expended in policy and procedure development, competency and educational efforts as well as refinements to the Meditech billing system. This represents a major change to our pharmacy operations and a substantial challenge for the department.



# Chief Medical Officer

**ERIE COUNTY MEDICAL CENTER CORPORATION**  
**REPORT TO MEDICAL EXECUTIVE COMMITTEE**  
**BRIAN M. MURRAY, MD, CHIEF MEDICAL OFFICER**  
**AUGUST 2012**

**UNIVERSITY AFFAIRS**

ECMC recently received the preliminary draft of the Annual Plan for residents for the academic year July 2013-June2014, which is attached. This is preliminary and not the final plan and in particular the distribution of residents into the common pool has not yet been determined so it is likely that the number of residents attributed to ECMC will increase by another 2-3. Currently 21% of all residents are assigned to ECMCC. There are no major changes and the majority of departments remain unchanged but the following do show some proposed changes:

Dermatology	+1.00
Internal Medicine	-2.50
Neurology	-1.00
Obstetrics & Gynecology	+1.00
Orthopedics	+1.00
Surgery	-1.67
ECMC Dental	+1.00

Clinical chiefs are encouraged to review the proposal as it pertains to their department and to let the CMO know if the plan represents any issues for their department.

**PROFESSIONAL STEERING COMMITTEE**

No meeting in July or August. Next meeting is in September.

**MEDICAL STAFF AFFAIRS**

See separate report by Sue Ksiazek for full details.

**CLINICAL ISSUES**

UTILIZATION REVIEW	May	June	July	vs. 2011 YTD
Discharges	1033	892	1006	up 4.7%
Observation	156	135	138	down 9.7%
LOS	5.8	6.0	6.2	down 3.3%

CMI	2.04	1.85	2.14	unchanged
Surgical Cases	873	793	849	up 1.1%
Readmissions (30d)	16.9%	12.2%		

## OTHER

### JOINT COMMISSION

Our accreditation, achieved in 2010, is valid through 2013 but we can expect a visit next summer. In preparation we recently had the VHA do a Mock Survey to identify our potential vulnerabilities. We are still awaiting their “findings” but they did share verbally areas that the JC is focusing on and some of the issues they identified during their 3 days here. Below I have outlined some of the issues that are most pertinent to the medical Staff.

Following areas require special attention:

1. Use of Unapproved Abbreviations.
  - a. This is not so much a problem that people are using dangerous abbreviations but that they are making up their own.
2. Telephone Orders not authenticated in the appropriate timeframe
3. Failure to sign, date and time signatures and co-signatures.
4. Preoperative History and Physical done within 30 days and appropriately updated.
  - a. VHA found instances where although the “Update” sticker was signed, dated and timed, the box attesting to the fact that there was no change in the patient’s condition since the office H & P was not ticked.
5. Restraints and Seclusion
  - a. Inadequate documentation and inappropriate use of prn orders
6. Moderate Sedation
  - a. No documentation of a pre-sedation assessment, airway assessment or discharge assessment.
7. Performance of Time Outs in accordance with policy (all practitioners must be present).
  - a. All time outs were appropriately documented but VHA o, during direct observations, noticed that not all those present stopped what they were doing to participate in the timeout.
8. Informed Consent.
  - a. VHA indicated that we need to be obtaining formal consent for administration of chemotherapy and other “high-risk” drugs such as new biologicals and immunomodulators.
  - b. Failure to document that patient has been informed of potential problems that may occur in the postoperative period. Either because this was not documented or patient could not relate this to the surveyors.
9. Attending Addendums.

- a. One chart had a note signed by 3 different individuals so that it was not clear who had actually written the note. We recommend that attendings write a brief statement as well as just co-signing.
  - i. If you are billing for the service the statement needs to reflect that you have confirmed the major aspects of the history and physical exam of the resident .
  - ii. If not billing but just documenting supervision then something like “Reviewed and Agree” would probably suffice.

10. OPPE/FPPE.

- a. Continues to represent a challenge. JC is not necessarily satisfied with the fact that there is evidence of data collection but asking what is being done with the data, and in particular how are outliers being addressed.

11. Performance Improvement

- a. JC again is looking to see that the Institution (and its individual departments) are not just collecting data but using that data to drive process improvement by setting specific goals to be obtained.

To: GMEC Membership

From: Carrie Eckart, MBA  
GME Director

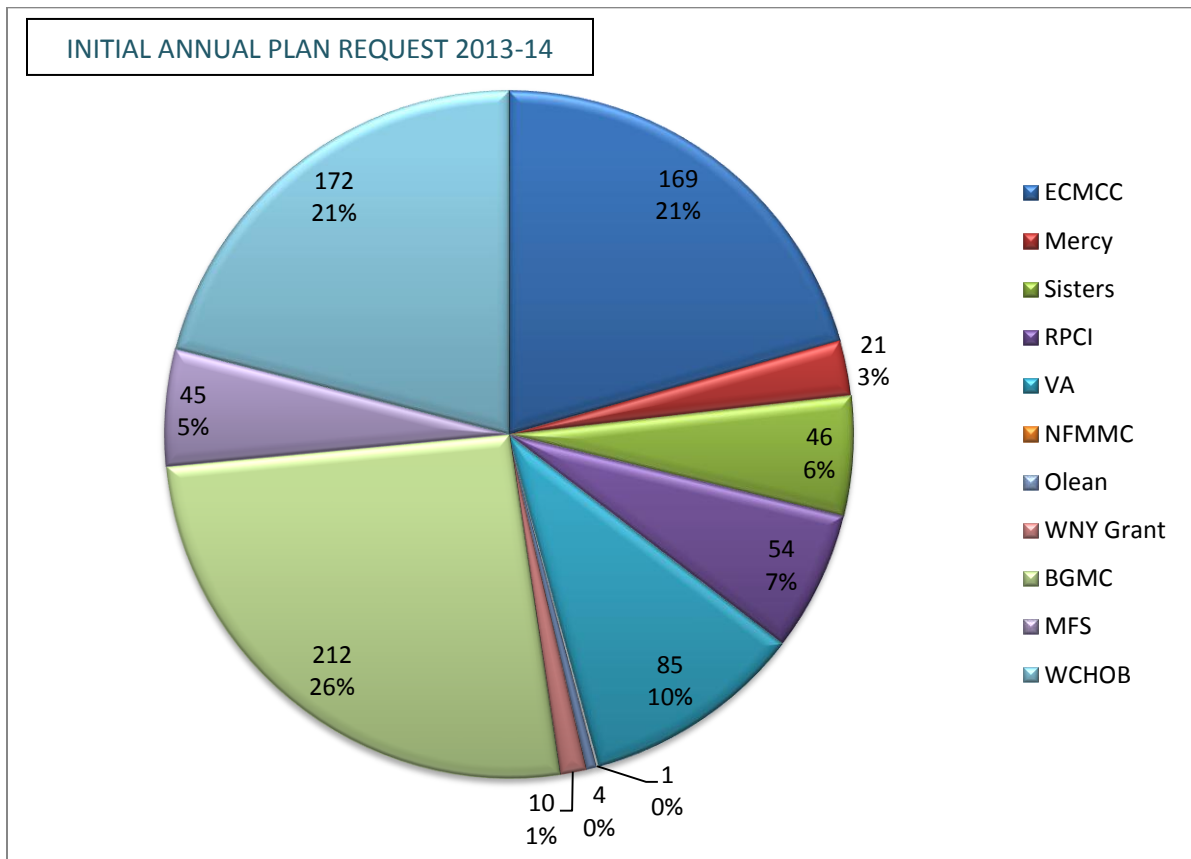
Re: Annual Plan Request/2013-14

Dear GMEC members,

I am attaching the Annual Plan Request for 2013-14. I wanted to make you aware of a few notes:

1. The 2012-13 Annual Plan, highlighted in green, is the current approved plan.
2. The 2013-14 Annual Plan, highlighted in peach, is submitted for your review.
3. In 2012-13, the Annual Plan included a distribution of 11.07 "pooled" positions to Kaleida Health, ECMCC and RPCI. This amount has not yet been determined for 2013-14. There have been no adjustments for the pool.
4. Five programs are representing increases that have not yet received ACGME approval, two of which are representing increases that have not yet received UB GMEC approval.
5. The below chart depicts the distribution of requested slots across our system.

We look forward to discussing this with you at the GMEC meeting on Tuesday August 21, 2012.







University at Buffalo  
Office of Graduate Medical Education  
Annual Plan for the Academic Year Ending June 30th, 2014

Residency or Fellowship	Department	PGY			Kaleida Health								ECMCC		Catholic Health						RPCI		VAWNHYS		NFMCC		OGH		WNY CPC / GRANT		POOL/GRANT				
			12 - 13 Approved	13-14 Request	Buffalo General		MF Suburban		WCHOB		Kaleida Total		12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request					
					12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request	12 - 13 Approved	13 - 14 Request			
Internal Medicine	Med CHS	1		15.00	16.00																														
		2	37.00	12.00	37.00	11.00									19.00	8.00	18.00	8.00	16.00																
		3		10.00		10.00										6.00	4.00	6.00	5.00	11.00															
Neurology	Neurology UB	2		5.00	5.00					4.80	4.80																								
		3	15.30	5.00	14.20	5.00	12.10	4.80			3.80	3.80		1.40													1.80	1.10							
		4		5.30		4.20					4.00	4.00																							
Neurophysiology		5	3.25	3.25	3.00	3.00					2.85	2.70	2.85	2.70												0.40	0.30								
Child Neurology		3		1.42		1.00																													
		4	3.13	1.00	3.00	2.00					2.49	2.00	2.49	2.00	0.32											0.32	0.15								
Vascular Neurology		5	2.25	2.25	2.00	2.00	2.25	2.00					2.25	2.00																					
Neurosurgery	Neurosurgery UB	1		2.00	2.00																														
		2		2.00		2.00																													
		3		2.00		2.00																													
		4	11.00	2.00	11.00	2.00	9.00	0.75			1.25	1.00	10.25	1.75	0.25							0.50						0.25	0.25						
		5		2.00		2.00																													
		6		1.00		1.00																													
Nuclear Medicine	NMed UB	2		1.00	1.00																														
		3	5.00	3.00	4.00	1.00	1.00																												
		4		1.00		2.00		1.00																											
Obstetrics & Gynecology	OB/GYN UB	1		9.00	9.00																														
		2		9.00		9.00																													
		3		9.00		9.00																													
		4	35.00	9.00	36.00	9.00	1.00		11.00			3.00	5.00	9.00	1.00																				
Obstetrics & Gynecology	OB/GYN CHS	1		3.00	4.00																														
		2	12.00	3.00	13.00	3.00																													
		3		3.00		3.00																													
		4		3.00		3.00																													
Ophthalmology	Ophth UB	2		3.00	3.00																														
		3	9.00	3.00	9.00	3.00																													
		4		3.00		3.00																													
		5		3.00		3.00																													
Orthopaedics	Orthopaedics UB	1		5.00	5.00																														
		2		5.00		5.00																													
		3	25.00	5.00	25.00	5.00	11.00																												
		4		5.00		5.00																													
		5		5.00		5.00																													
Hand Surgery		6	3.00	3.00	3.00	3.00																													
Adult Reconstructive		6	1.00	1.00	1.00	1.00	1.00	1.00																											
Sports Medicine		6	2.00	2.00	2.00	2.00	2.00	2.00																											
Otolaryngology	ENT UB	1		2.00	2.00																														
		2		2.00		2.00																													
		3	10.00	2.00	10.00	2.00																													
		4		2.00		2.00																													
		5		2.00		2.00																													
Pathology	Pathology UB	1		4.00	4.00																														
		2		3.00		4.00																													
		3	16.00	5.00	15.00	3.00	10.75	3.00																											
		4		4.00		4.00																													
Cytopathology		5	1.00	1.00	1.00	1.00																													
Selective Pathology		5	6.00	6.00	6.00	6.00																													
Pediatrics +	iatrics UB	1		15.00	19.00																														
		2		14.00		15.00																													
		3	49.00	18.00	49.00	13.00																													
		5		2.00		2.00																													
		1		4.00		4.00																													
IM / Ped Combined		2	16.00	4.00	16.00	3.00	5.00																												







# Senior Vice President of Nursing

## ERIE COUNTY MEDICAL CENTER CORPORATION

Report to the Board of Directors  
Karen Ziemianski, RN, MS  
Acting Director of Nursing  
Assistant Director of Nursing, Medical/Surgical

August, 2012

### Daemen College Appointment

Lynn Kordasiewicz, MSN, ANP, ECMC's Wound Care Nurse Practitioner, has accepted an invitation from Daemen College to become a member of their Wound Care Advisory Board. This is a great opportunity to learn valuable information that can be shared and incorporated here at ECMC.

### Cleve Hill Health Fair

A Health Fair is planned for Thursday, August 23<sup>rd</sup> at the Cleve Hill Clinic on Kensington Avenue. Paula Quesinberry, RN, ECMC's Stroke Coordinator and Andrew Grzeskowiak, RN, Diabetic Education, will be on-board from 4 pm to 7 pm to provide Glucose testing, as well as information on diabetes, blood pressure, stroke and BMI.

### Erie County Fair Booth

Peggy Cieri, RN, Unit Manager for 8 North, will be on-hand at the ECMC Booth at this year's Erie County Fair. Peggy joins a list of volunteers from various ECMC departments to provide visitors with breast health and wellness information.

### Trauma Conference

On August 17<sup>th</sup>, Peggy Cramer, RN, Vice President of Trauma and Emergency Services, will attend a conference on the topic of "enhancing trauma center systems of care and improving patient care". The conference is a collaboration of The American College of Surgeons Committee on Trauma (ACS COT) and the Society of Trauma Nurses (STN), with the goal of developing an "Optimal Trauma Center".

### AHA Get With the Guidelines "Gold"

ECMC was recently recognized by the American Healthcare Association's *Get With the Guidelines "GOLD"* distinction. This honor recognizes our facility for achieving "24 months of 85% or higher adherence on all achievable measures applicable to Heart Failure". The leadership of the following nurses was instrumental to our success:

- Beth Moses
- Sandra Beauchamp
- Nicole Cretacci
- Paula Quesinberry
- Karen Ziemianski
- Sonja Melvin
- JoAnn Wolf
- Judy Haynes
- Melinda Lawley



# Vice President of Human Resources

**ERIE COUNTY MEDICAL CENTER  
BOARD OF DIRECTORS  
HUMAN RESOURCES DEPARTMENT  
AUGUST 28, 2012**

**I. CSEA NEGOTIATIONS**

The CSEA is conducting a write-in ratification vote on the tentative settlement agreement. The results will be published August 23, 2012.

ECMCC and CSEA continue to conduct impact negotiations regarding the consolidation of the Home and the SNF.

**II. NYSNA NEGOTIATIONS**

NYSNA negotiations have not yet been scheduled. ECMCC and NYSNA have continued to conduct impact negotiations regarding the consolidation of the Home and the SNF.

**III. AFSCME**

ECMCC and AFSCME have been conducting impact negotiations regarding the consolidation of the Home and the SNF.

**IV. ERIE COUNTY HOME**

We are in the initial stages of staffing the new LTC facility. We recently posted over 400 positions for direct-care positions and RN supervisors. Other positions such as clericals, therapies, etc. will start to be filled in late September.

A change from the current staffing plan will be an increase in RPT positions in order to provide a more flexible workforce as well decrease OT costs.

Several new job descriptions have been written that reflect on the patient-centered care model and many others have undergone revisions. In addition, a 19-bed TCU will also open in the next few months which will add on additional new positions.

**V. BENEFITS UPDATE**

We are working on our automated Open Enrollment through IPA. Open Enrollment will take place from Monday 10/15 – Friday 11/16/2012. It will include passive enrolment for Medical and Dental related changes and Mandatory enrollment for Flexible Spending Accounts for Health Care & Dependent Care Spending, Parking Reimbursement and Premium Reimbursement Accounts. The effective dates for all changes and/or new enrollments will be January 1, 2013.



Information will be forthcoming via email, bulletin board announcements and at the Benefits Fairs to be held in early October.

**VI. NURSING TURNOVER RATES**

July Hires – 8 FTES, 1 FTE in Med/Surg, 4.5 FTES in Behavioral Health, 2.5 FTES in Critical Care & 1 FTE in Hemo.  
70 FTES & 2 Per Diems hired YTD.  
1 LPN FTE hired in Behavioral Health. 22 LPN FTES hired YTD.

July Losses – 7 FTES, 3 FTES in Med/Surg (1 resign in lieu of term, 1 terminated, 1 resign), 4 FTES in Critical Care (2 FTES retired, 1 FTE relocated, 1 FTE new job)

Turnover Rate .93% (.66% without retirees)  
Quit Rate .66% (.4% without retirees)  
Turnover Rate YTD 4.42% (2.78% without retirees) 4.72% 2011  
Quit Rate YTD 3.57% (2.17% without retirees) 3.71% 2011

August Hires – 9.5 FTES, 6 FTEs in Med/Surg, 2.5 FTES in Behavioral Health, 1 FTE in Critical Care.  
79.5 FTES & 2 Per Diem hired YTD.  
1 LPN FTE hired in Hemo. 23 LPN FTES hired YTD.

**VII. 2<sup>ND</sup> QUARTER EMPLOYEE WORKERS COMPENSATION**

Total Incidents Reported	RTW/Modified Duty	Days Away From Work/Month
209	32	382

**VIII. Fitness Center**

The Fitness Center is open. Over 800 individuals have registered for access.



# Chief Information Officer



## HEALTH INFORMATION SYSTEM/TECHNOLOGY

August 2012

The Health Information Systems/Technology department has completed or is currently working on the following projects.

### **Clinical Informatics**

**ARRA Meaningful Use - Inpatient and Outpatient Report Card.** Continue to monitor data collection and organizational adherence to workflow changes for inpatient MU Stage 1. In addition, the team is establishing a documented auditing process to validate our organization compliance to the new standards.

ECMC has secured Pricewaterhouse and Cooper (PWC) to conduct a HIPAA Security and Privacy audit. Team members PWC are currently on site conducting interviews and physical assessment. We anticipate receiving the final report within four to six weeks.

The ARRA Meaningful Use Stage 2 Requirements have been finalized as of August 23<sup>rd</sup>. A cross functional team will be developed to create ECMC's strategic plan. During this time a team charter will be presented to executive management to continue the Inpatient Computerized Physician Order Entry (CPOE) roll out throughout the organization. Pending approval, project will began immediately.

**Ambulatory Electronic Health Record.** IT continues to support the Clevehill Family Practice and Grider Health Family Practice with the transition from paper to electronic health record. In addition, we are activity supporting the analysis and project design for the Internal Medicine Clinic. This involves staff-reorganization and improvements with system support and integration.

**ECMC Security System.** ECMC has made the investment of an integrated Security Solution, Honeywell Pro Watch Access System, to manage the organizations parking, ECMC workforce badge process and physical campus security (i.e. cameras and door swipe access). This will allow the organization to gain efficiencies by streamlining processes and eliminate disparate systems. A team has been developed to implement this strategy. High level milestone dates will be presented to executive management at a later date.

**Centralized Inpatient Scheduling.** Working with Dr. Orlick, developed a prototype for the Radiology CT roll out of centralized scheduling. The template includes a centralized area to schedule inpatient procedures of all disciplines. The concept focuses on a process that is patient centric rather than department focused. Team plans to pilot process EEG, CT and Pulmonary followed by Radiology Department.

**IT Staffing Additions.** Approval for a Business System Analyst to support of the new Human Resource and Payroll System (HRIS) has been approved. In addition, approval for a Pharmacist Clinical Informatics has been obtained with the goal of supporting the Meaningful Use initiatives.

## At a glance: Stage 2 final rule

By *Healthcare IT News Staff*

Created 08/23/2012

WASHINGTON – The Centers for Medicare and Medicare Services (CMS) announced Thursday the final rule for Stage 2 meaningful use, with several adjustments being made to the initial proposals.

Below is a fact sheet from CMS detailing Stage 2 final rule:

### Rule Provisions

Through the Stage 2 requirements of the Medicare and Medicaid EHR Incentive Programs, CMS seeks to expand the meaningful use of certified EHR technology. Certified EHR technology used in a meaningful way is one piece of a broader health information technology infrastructure needed to reform the health care system and improve health care quality, efficiency, and patient safety. Highlights of the rule's provisions follow.

### Stage 2 Timing

In the Stage 1 meaningful use regulations, CMS established an original timeline that would have required Medicare providers who first demonstrated meaningful use in 2011 to meet the Stage 2 criteria in 2013. The Stage 2 rule gives providers more time to meet Stage 2 criteria. A provider that attested to Stage 1 of meaningful use in 2011 would attest to Stage 2 in 2014, instead of in 2013. Therefore, providers are not required to meet Stage 2 meaningful use before 2014. The table below illustrates the progression of meaningful use stages from the first year a Medicare provider begins participation in the program.

**For 2014** only, providers that are beyond the first year of demonstrating meaningful use will have a 3-month quarter reporting period to allow an additional up to 9 months to upgrade certified EHR technology to the 2014 edition.

### Meaningful Use (MU) Objectives

Nearly all of the Stage 1 core and menu objectives that were proposed are being finalized for Stage 2. The test of “exchange of key clinical information” core objective from Stage 1 is eliminated in favor of a more robust “transitions of care” core objective in Stage 2; and the “Provide patients with an electronic copy of their health information” objective is also eliminated because it was replaced by the “electronic/online access” core objective.

The final rule adds “outpatient lab reporting” to the menu for hospitals and “recording clinical notes” as a menu objective for both EPs and hospitals. There will be 20 measures for EPs (17 core and 3 of 6 menu) and 19 measures for eligible hospitals and CAHs (16 core and 3 of 6 menu).

The final rule reduces some thresholds for achieving certain measures and modifies criteria for exclusions to respond to difficulties commenters identified in implementing certain objectives in certain situations. For example, for some objectives CMS has added exclusions based on broadband availability that allow providers in rural or underserved areas to achieve meaningful use with fewer hurdles.

**New Core Objectives.** CMS finalized two new objectives in the core:

- New EP Stage 2 Core Objective: Use secure electronic messaging to communicate with patients on relevant health information. (See “Patient Engagement” section below for additional information.)
- New Eligible Hospital/CAH Stage 2 Core Objective: Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR).

**Group Reporting.** CMS finalized the ability to use a batch reporting process for meaningful use, which will allow groups to submit attestation information for all of their individual EPs in one file.

**Patient Engagement.** CMS proposed two new core objectives (providing patients online access to health information; secure messaging between patient and provider) with measures that require patients to take specific actions in order for a provider to achieve meaningful use and receive an EHR incentive payment. For both objectives, the threshold was set at 10 percent of patients. Many providers expressed concerns regarding this proposal. Accordingly, CMS is finalizing the proposed measures with reduced thresholds of 5 percent for both objectives. In addition, CMS is introducing exclusions based on availability of broadband in a provider’s practice area. CMS believes that the patient utilization thresholds are achievable and that the ability to access clinical information electronically promotes patient engagement.

**Electronic Exchange of Summary of Care Documents.** To spur provider commitment to electronic exchange, CMS had initially proposed two ambitious measures for this objective in Stage 2. The first measure required that a provider send a summary of care record for more than 65 percent of transitions of care and referrals. In the final rule CMS is reducing the first measure to a lower threshold of 50 percent. The second measure required that a provider electronically transmit a summary of care for more than 10 percent of transitions of care and referrals, and that the summary of care be electronically sent to a provider with no organizational or vendor affiliation. The intent of this second measure was to foster electronic exchange outside established vendor and organization networks. CMS is finalizing the 10 percent threshold for electronic transmittal, but eliminating the organizational and vendor limitations. Instead, CMS is requiring at least one instance of exchange with a provider using EHR technology designed by a different EHR vendor or with a CMS-designated test EHR.

[See also: [Final rules for Stage 2 meaningful use released.](#)]

**Outpatient Lab Reporting for Hospitals.** The rule includes lab reporting for hospitals as a menu objective, which gives hospitals the flexibility to select other objectives for meeting MU and receiving the incentive payment.

**Hospital-based EP Definition.** CMS has modified the regulations on “hospital based” so that EPs who can demonstrate that they fund the acquisitions, implementation, and maintenance of CEHRT, including supporting hardware and interfaces needed for meaningful use without reimbursement from an eligible hospital or CAH—and use such CEHRT at a hospital, in lieu of using the hospital’s CEHRT—can be determined non-hospital based and receive an incentive payment. Determination will be made through an application process.

### *Clinical Quality Measures (CQMs)*

#### *Measure Sets and Reporting*

The rule finalized that:

- EPs must report on 9 out of 64 total clinical quality measures (CQMs)
- Eligible hospitals and CAHs must report on 16 out of 29 total CQMs

In addition, all providers must select CQMs from at least 3 of the 6 key health care policy domains from the Department of Health and Human Services’ National Quality Strategy:

- Patient and Family Engagement

- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Processes/Effectiveness

### Data Submission

The rule finalizes that, beginning in 2014, all Medicare providers that are beyond the first year of demonstrating meaningful use must electronically report their CQM data to CMS. (Medicaid EPs and hospitals that are eligible only for the Medicaid EHR Incentive Program will report their CQM data to their state.)

EPs can electronically report CQMs either individually or as a group using the following methods:

- Physician Quality Reporting System (PQRS)—Electronic submission of samples of patient-level data. EPs can also report as group using the PQRS GPRO tool. EPs that are beyond the first year of demonstrating meaningful use who electronically report using this PQRS option will meet both their EHR Incentive Program and PQRS reporting requirements.
- CMS Portal—Electronic submission of aggregate-level data.

Eligible hospitals and CAHs will electronically report their CQMs through the EHR Reporting Pilot infrastructure for hospitals, which aligns with the Hospital Inpatient Quality Reporting program or through electronic submission of aggregate data through a CMS Portal.

### *Medicare Payment Adjustments*

Medicare payment adjustments are required by statute to take effect in 2015 (fiscal year for eligible hospitals/calendar year for EPs). The rule finalized a process in which payment adjustment will be determined by an EHR reporting period prior to the payment adjustment year 2015. Any Medicare EP or hospital that demonstrates meaningful use in 2013 will avoid payment adjustment in 2015. Also, a Medicare provider that first demonstrates meaningful use in 2014 will avoid the penalty if they successfully register and attest to meaningful use by July 1, 2014 (eligible hospitals) or October 1, 2014 (EPs). Meaningful use attestations to State Medicaid Agencies by EPs who are eligible for either Medicare or Medicaid but opted for Medicaid, will be accepted to avoid the Medicare penalty. However, Medicaid EHR incentive payments for adopt, implement, or upgrade will not be considered having met meaningful use for those same providers (there is no payment adjustment for Medicaid payments to eligible professionals or hospitals).

### Hardship Exceptions

CMS finalized four categories of exceptions for EPs: Infrastructure, New EPs, Unforeseen Circumstance, and By Specialist/Provider Type. These barriers are concentrated among three specialties: anesthesiology, radiology, and pathology. Infrastructure, Unforeseen Circumstances, and New CAHs/eligible hospitals are also exception categories for eligible hospitals and CAHs.

### Zero-Pay Claims

Patient volume requirements continue to be cited as a barrier to more providers participating in the Medicaid EHR Incentive Program. The rule expands the definition of what constitutes a Medicaid patient encounter, which is a required eligibility threshold.

### Children's Hospitals

Under Medicaid, approximately 12 additional children's hospitals have been made eligible to participate in the EHR Incentive Program. Previously, they were unable to participate, despite meeting all other eligibility criteria, because they do not have a CMS certification number since they do not bill Medicare.

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**Source URL:** <http://www.healthcareitnews.com/news/glance-stage-2-final-rule>

**Links:**

[1] <http://www.healthcareitnews.com/news/final-rules-stage-2-meaningful-use-released>





# **Sr. Vice President of Marketing & Planning**

**Marketing and Development Report**  
**Submitted by Thomas Quatroche, Jr., Ph.D.**  
**Sr. Vice President of Marketing, Planning and Business Development**  
**August 28, 2012**

**Marketing**

“True Care” and “Expansion” marketing campaign for 2012 in market  
Service line marketing underway in primary care and breast services

**Planning and Business Development**

Operation Room expansion CON filed and initial questions answered  
Coordinating Accelero Orthopedic and General Surgery margin initiative  
Coordinating planning for Great Lakes Health Strategic and Community Planning Committee meetings  
Working with Professional Steering Committee and assisting all subcommittees  
Managing CON processes  
Developing primary care and specialty strategy and have had multiple confidentiality agreements signed  
Dr. Howard Sperry’s practice has incrementally increased in patient numbers and ancillary business has had significant referrals  
Two large Southtown primary care practices underway and seeing approximately 300 patients per week  
In discussions with large specialty and primary care practices looking to affiliate with ECMC  
Two new orthopedic surgeons and one breast surgeon starting in the Fall

**Media Report**

- **The Buffalo News; MetroWNY.com: ECMC receives the Get With The Guidelines – Heart Failure Gold Quality Achievement Award from the American Heart Association.** ECMC has received the award for two consecutive years. Jody Lomeo is quoted.
- **Western New York Health Magazine: Specialized bus will offer breast-cancer screening.** In an effort to reach out to the medically underserved, Erie County Medical Center Lifeline Foundation, First Niagara Financial Group, Inc., and the Buffalo Sabres Alumni Association have banded together to deliver mammography to various Western New York Communities. Jody Lomeo is quoted.
- **WKBW-TV, Channel 7: Triple fatal raises concerns about older drivers.** A head-on collision caused by an elderly gentleman and resulting in three deaths brings questions about senior drivers and the risk they pose. ECMC offers evaluations to test the driver’s ability to operate a car.
- **WGRZ-TV, Channel 2: Hero Central: Best friend gives the gift of life.** After seeing the story of kidney donor and former ECMC employee Diane Bookhagen, Lisa Brennan chose to be tested as a potential donor for her best friend.
- **The Buffalo News: Being an organ donor is incredibly rewarding.** Former ECMC employee undergoes an elective nephrectomy to help a man in need.
- **WGRZ-TV, Channel 2: The family of ECMC employee talks about shooting.** ECMC is bringing Mary Murphy in to speak to employees to train them about ways to recognize and report incidents of domestic violence. Jody Lomeo is quoted

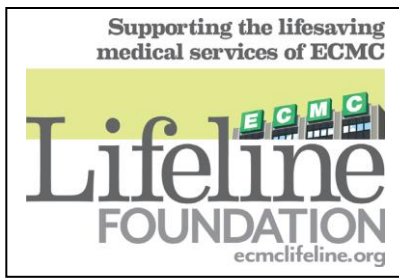
**Community and Government Relations**

Lifeline Foundation Mobile Mammography Unit screening patients and has 300 women being screened and scheduled to be screened  
Mammography Bus had over 8,600 people visit it during the Erie County Fair

Meetings held with various community groups regarding mammography bus and events scheduled  
Continuing to work with other PBC hospitals on legislation and advocacy efforts



# **Executive Director, ECMC Lifeline Foundation**



## ECMC Lifeline Foundation Report For ECMC Medical Executive Committee August 28, 2012

Submitted by  
**Susan M. Gonzalez, Executive Director**

### Grant Initiatives

- Lifeline Foundation continues to collaborate with various hospital departments to apply for grants to assist with securing goods and services not currently funded through the hospital budget. Applications completed/awarded since last meeting include:

**NYSDOT** - grant for wheelchair accessible van - pending  
**Patrick Lee Foundation** for Behavioral Health - \$3,000,000 letter of intent stage  
**Wound Care Symposium** sponsorships – several submitted - **\$11,000 to date**  
**Renaissance Foundation** – Mobile Mammography Bus - \$10,000 pending

### Event News

- **Shanor Memorial Golf Tournament/Transplant Fund**  
The Kaleida Foundation has now transferred all funds to Lifeline. The transplant fund balance is almost **\$75,000** from the Tournament and Kaleida transfer.
- **Tournament of Life Golf Classic**  
Just over **\$100,000** was raised from the Tournament due to our generous sponsors and golfers.
- **Mobile Mammography Unit/Erie County Fair**  
The new mobile mammography coach was on display at the Fair for 12 days providing the community with information on Breast Health. Almost 150 ECMC, First Niagara & AT&T volunteers staffed the unit and **\$8600** was raised at the Lifeline Prize Wheel Game.



**SAVE THE DATE!**  
**Heroes 5K Run & Healthwalk**  
**Saturday, September 29, 2012**  
**Delaware Park**

Honoring ECMC Professionals!  
Sponsorship opportunities are available.

**A Family, Fun event for all ages &  
Post Race/Walk Picnic with Live Music**

### Hospital Contributions

- The ECMC Lifeline Foundation approved the following Hospital grants:  
**\$10,000** for ECMC Nursing/Employee Accreditation Testing Scholarships  
**\$2,200** for a Smart board for the 8<sup>th</sup> Floor Acute Rehabilitation Unit.

# **NEW BUSINESS**

**OLD  
BUSINESS**



# Medical-Dental Executive Committee



**MEDICAL EXECUTIVE COMMITTEE MEETING  
MONDAY, JULY 23, 2012 AT 11:30 A.M.**

**Attendance (Voting Members):**

D. Amsterdam, PhD	W. Flynn, MD	J. Woytash, MD, DDS
Y. Bakhai, MD	C. Gogan, DDS	
W. Belles, MD	R. Hall, MD, PhD, DDS	
G. Bennett, MD	J. Izzo, MD	
S. Cloud, DO	J. Kowalski, MD	
N. Dashkoff, MD	M. LiVecchi, MD	
R. Desai, MD	K. Malik, MD	
T. DeZastro, MD	M. Manka, MD	
S. Downing, MD	K. Pranicoff, MD	
N. Ebling, DO	R. Schuder, MD	

**Attendance (Non-Voting Members):**

K. Ziemianski, RN	C. Ludlow, RN	
J. Fudyma, MD	M. Sammarco	
S. Ksiazek	R. Cleland	
M. Barabas		
L. Feidt		
R. Gerwitz		

**Excused:**

B. Murray, MD	J. Reidy, MD	
A. Arroyo, MD	R. Venuto, MD	
M. Azadfard, MD		
H. Davis, MD		
R. Ferguson, MD		
T. Loree, MD		

**Absent:**

A. Chauncey, PA.		
J. Lukan, MD		
P. Stegemann, MD		

**I. CALL TO ORDER**

- A. Dr. Timothy DeZastro, Secretary, called the meeting to order at 11:40 a.m. Dr. Kowalski joined the meeting at 11:50 am.

**II. MEDICAL STAFF PRESIDENT'S REPORT – J. Kowalski, MD**

- A. The Seriously Delinquent Records report was included as part of Dr. Kowalski's report. Numbers are very high. Please direct your staff to complete reports timely.

**III. UNIVERSITY REPORT – Dean Cain, MD**

- A. No report this month. See Chief Medical Officer for University updates.

#### **IV. CEO/COO/CFO BRIEFING**

- A. CEO REPORT - deferred in Mr. Lomeo's absence.**
  - a.
  
- B. PRESIDENT'S REPORT – Mark Barabas, President and COO**
  - a. **Welcome Dr. Mark LiVecchi**, Chief of Service, Rehabilitation.
  - b. **New Primary Care Office – Orchard Park** – New office is now open in Orchard Park expanding the ECMC primary health network.
  - c. **Behavioral Health Work Group** – Group is currently working on the new behavioral health center. The Heal Grant funds should be received soon. Mr. Cleland reports that the CON is expected be submitted by next week. Regulatory offices have been notified that the applications will need expeditious review. Construction should begin in the fall and will be located where the former Doctors' Parking Lot is on the west side of the campus. Discussion is underway regarding the reallocation of the current CPEP space.
  - d. **Lab and Cardiac Work Groups** – Currently active and meeting to consolidate services. Pertaining to the cardiac group, there is a meeting scheduled in August to meet with the surgeons from the GVI and ECMC team.
  - e. **Parking Update** – The Doctors Parking Lot closed officially today (July 23, 2012) for physician parking and is now the customer/valet drop off area. All physician parking is now located in the new parking ramp.
  - f. **Employee Fitness Center** – Some of the fitness equipment was installed and should be open for full use shortly. Employee pre-registration has already begun.
  
- C. FINANCIAL REPORT – Michael Sammarco, CFO**
  - a. **VOLUMES/FINANCIAL REPORT** – June admission and discharge volumes were down slightly. Inpatient and outpatient surgeries were also down. The hospital experienced an operating loss of just over \$500,000 blamed on the lower volume and poor case mix index. Erie County Home had a loss of about \$400,000. Year to date is showing a break even bottom line. It is expected to have improved volumes in the coming months.

#### **VI. CHIEF MEDICAL OFFICER REPORT – B. Murray, M.D.**

**Dr. Brian Murray provided the following report. The written report in its entirety was distributed and reviewed and is included as part of the record.**

## **A. UNIVERSITY AFFAIRS**

### **NEW CHIEF OF OBSTETRICS AND GYNECOLOGY**

The dean recently announced the appointment of Vanessa M. Barnabei, MD, PhD, as the new Chair of the Department of Gynecology and Obstetrics at the University at Buffalo School of Medicine and Biomedical Sciences. She will also serve as Medical Director of Women's Health Services at Kaleida Health. This appointment will be effective October 1, 2012.

A native of Vineland, New Jersey, Dr. Barnabei received her PhD in Biology and her MD from the University of Virginia. She completed her residency in obstetrics and gynecology (1985-89) at Northwestern University Medical Center in Chicago. She served as an assistant professor (1989-96) and associate professor (1998-2004) in the Department of Obstetrics and Gynecology at George Washington University in Washington, DC.

In 1998, Dr. Barnabei joined the faculty of The Medical College of Wisconsin in Milwaukee, Wisconsin. She currently is the Patrick and Margaret McMahon Endowed Professor of Obstetrics and Gynecology and Director of the Division of General Obstetrics and Gynecology.

Dr. Barnabei is an accomplished clinician, clinical investigator, and educator. She has expertise in the care of the midlife woman as well as vulvar disorders. Over the past 23 years, she has been an investigator in many pivotal trials on the effects of hormone therapy on the postmenopausal woman, including the Women's Health Initiative, the HERS trial and the PEPI trial.

### **NEW DIVISION CHAIR OF GASTROENTEROLOGY**

Dr. Andrew Talal has been appointed the new division chair of Gastroenterology. Dr. Talal is an expert in Hepatitis C and brings great leadership to the department.

### **NEW EXECUTIVE DIRECTOR OF THE INSTITUTE FOR HEALTHCARE INFORMATICS**

The dean also announced the appointment of Peter Winkelstein, MS, MD, MBA, as the new Executive Director of the School's Institute for Healthcare Informatics (IHI). His appointment will be effective July 16, 2012. Dr. Winkelstein possesses the administrative, leadership, financial, and visionary skills needed to fulfill the mission and specific goals of this unique Center.

IHI's mission is to generate new knowledge that improves the health of the Western New York community, New York State, and the nation through the application of advanced healthcare informatics. The IHI, located in the Roosevelt building on the Buffalo Niagara Medical Campus, is a HIPAA compliant computing center in which healthcare data are stored, aggregated, and analyzed using innovative tools.

Specific goals of the IHI are to:

1. House an electronic-based warehouse of clinical data that will serve as a resource for investigators in the Buffalo Translational Consortium to perform clinical research by analyzing large datasets.
2. Host electronic health records (EHR) and house large commercial, regional and statewide databases to create reports, perform comparative analytics and other services.
3. Develop and maintain public-private business partnerships with Dell, CTG, and others, to develop and contribute novel methods in biomedical informatics and healthcare data analytics.
4. Provide core biomedical informatics expertise, analytics, and support to investigators and clients who store data at the IHI in biomedical informatics, data management, research computing, and biostatistics.
5. Position the IHI as a resource for the Clinical and Translational Research Center through our NIH-submitted Clinical and Translational Science Award (CTSA) application, a resource for the national CTSA consortium, and a resource for faculty and students at UB, our hospital partners in our Academic Health Center, and our community.

Dr. Winkelstein is Professor of Pediatrics and currently serves as Chief of the Division of General Pediatrics. He also serves as Chief Medical Informatics Officer for UB/MD and was instrumental in the strategic and operational implementation of UB/MD's electronic medical record systems. Dr. Teresa Quattrin, Chair of the Department of Pediatrics, will make an announcement in the near future regarding governance of the Division of General Pediatrics.

## **B. CLINICAL ISSUES**

UTILIZATION REVIEW	April	May	June	vs. 2011 YTD
Discharges	885	1033	892	up 3.8%
Observation	124	156	135	up 10.4%
LOS	5.7	5.8	6.0	down 2.5%
CMI	1.87	2.04	1.85	down 0.7%
Surgical Cases	789	873	793	up 1.4%
Readmissions (30d)	16.9%	NA		

## **VII. DIRECTOR OF PHYSICIAN QUALITY AND ED. – S. Ksiazek**

- A. Written report received and filed. Motion from the Credentials Committee was presented and considered under "Consent Calendar/Approved Items."
- B. Nominating Committee Activated – Included in Ms. Ksiazek's written report is activation of the Nominating Committee to fill the upcoming vacancies on the Medical Executive Committee and the Professional Steering Committee. Once correction noted is that there are three (3) At-Large seats available rather than the two noted in the report.

**VIII. LIFELINE FOUNDATION – Susan Gonzalez**

- A. Written report received and filed. Golf tournament is Monday, August 13, 2012 and invitations were distributed.
- B. **Mammography Bus** – Has been out in the community and will be at the Erie County Fair.

<b>IX. CONSENT CALENDAR</b>		
	<b>MEETING MINUTES/MOTIONS</b>	<b>ACTION ITEMS</b>
<b>A.</b>	<b>MINUTES OF THE Previous MEC Meeting: June 25, 2012</b>	Received and Filed
<b>B.</b>	<b>CREDENTIALS COMMITTEE: Minutes of July 3, 2012</b>	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
	Family Medicine Privilege Form	Reviewed and Approved
<b>C.</b>	<b>HIM Committee Meeting: - Minutes of June 28, 2012</b>	Received and Filed
	1. MICU Progress Note- Paracentesis	Reviewed and Approved
	2. Procedural Progress Note for Paracentesis	Reviewed and Approved
	3. MICU Progress Note – Arterial Line	Reviewed and Approved
	4. Procedural Progress Note for Arterial Line	Reviewed and Approved
	5. MICU Progress Note – Central Venous Catheter Placement	Reviewed and Approved
	6. Procedural Progress Note for Central Venous Catheter Placement	Reviewed and Approved
	7. MICU Progress Note for Intubation	Reviewed and Approved
	8. Procedural Progress Note for Intubation	Reviewed and Approved
	9. Procedural Progress Note for Lumbar Puncture	Reviewed and Approved
	10. Procedural Progress Note for Lumbar Puncture	Reviewed and Approved
	11. Physician Discharge Order Form – Discharge Instructions for Patients with Tracheostomy	Reviewed and Approved
	12. Patient Controlled Analgesia	Reviewed and Approved
	13. Patient Controlled Analgesia Quick Reference Guide	Reviewed and Approved
	14. Contact List to Allow Communication with Family	Reviewed and Approved
<b>D.</b>	<b>Trauma Advisory Committee Minutes – July 16, 2012</b>	Received and Filed
	<b>NEW BUSINESS</b>	
<b>A.</b>	Utilization Review Plan (UR-015)	Received and Filed

**X. CONSENT CALENDAR, CONTINUED**

- A. MOTION:** Approve all items presented in the consent calendar for review and approval.

**MOTION UNANIMOUSLY APPROVED.**

- B. CREDENTIALS COMMITTEE RECOMMENDATION** – The following change was recommended to address the matter of board certification. Discussion will ensue at the Chief of Service meeting in July for more input. The matter will be brought back to the Credentials Committee for further recommendation.

*In the event that the appointee has failed to achieve board certification as outlined in Section 2.2.1.6 of the medical-dental staff bylaws or has failed to maintain such board certification, the appointee will be granted a one time 4 year grace period to remediate. The appointee will be notified of such in writing by the Chair of the Credentials Committee and the President of the Medical-Dental Staff. If the appointee fails to achieve board (re)certification during this time frame, he may apply to the Medical Executive Committee for a waiver as described in Section 2.2.1 of the medical-dental staff bylaws.*

**MOTION UNANIMOUSLY APPROVED.**

### **XIII. OLD BUSINESS**

#### **A. NONE**

### **IX. NEW BUSINESS**

- A. **Chief of Service Appointees** – Report was received and filed and will be submitted to the Board of Directors for approval.

### **XV. 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 12:10 p.m.

Respectfully submitted,



Timothy DeZastro, M.D., Secretary  
ECMCC, Medical/Dental Staff

# Reading Material



**From the  
Chief Executive Officer**

# BuffaloNews.com

## Achievement award given for heart failure treatment

Published: August 10, 2012, 12:11 AM

0 Comments

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Updated: August 10, 2012, 9:52 AM

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THE NEW YORK STATE  
FUNDRAISERS  
ASSOCIATION, INC.

The decision to  
prepare your  
funeral is a loving  
gesture for those  
you leave behind.



[www.nysfda.org](http://www.nysfda.org)

Erie County Medical Center has received an award for its success in treating patients with heart failure for the second straight year.

The Get With the Guidelines - Heart Failure Gold Quality Achievement Award recognizes ECMC for giving heart patients the follow-up measures to prevent future heart failure recommended by the American Heart Association and the American College of Cardiology.

Under the program, heart failure patients are started on cholesterol-lowering drugs, beta blockers, ACE inhibitors, aspirin, diuretics and anticoagulants while they're in the hospital. After discharge, they receive alcohol and drug counseling, thyroid management counseling and referrals for cardiac rehabilitation.

### Comments

There are no comments on this story.

Add your comment



WESTERN NEW YORK

## Health

AUGUST/  
SEPTEMBER  
2012

## IN THIS EDITION:

p.7 - Reader Survey | p.22 - Healthy Hookups | p.24 - Local Health Professionals

wnyhealthmag.com



## Mammography Bus unveiled

Erie County Medical Center Lifeline Foundation, First Niagara Financial Group and the Buffalo Sabres Alumni unveiled a bus that will convey two digital mammography machines to underserved and under-tested women in all areas of Western New York.

With a combined \$750,000 contribution from First Niagara Financial Corp., the Sabres Alumni Association, and Erie County Medical Center Lifeline Foundation, the clinical operations of the bus will be managed by Western New York Breast Health, the practice of Dr. Vivian Lindfield located in Amherst. Erie County Medical Center Lifeline Foundation, which is contributing to the purchase and operations of bus, will be the owner and maintain the bus.

Western New York had the highest rate of new breast cancer in Upstate New York, according to a 2010 report. In addition, Upstate New York had a higher breast cancer death rate per 100,000 women in 2011 at 24.5 per year, than nationally, 24, statewide, 23.7, or in New York City, 23.9, according to the Susan G. Komen Foundation of WNY.

All women will be welcome for mammographies on the bus. This includes those with insurance or those covered by Medicaid or Medicare, as well as the uninsured. Exams will require a prescription, but women without a primary-care physician can obtain a script at the bus. Appointments will be necessary and patients can call 1-855-go4pink (464-7465).



Erie County Medical Center Lifeline Foundation, First Niagara Financial Group and the Buffalo Sabres Alumni unveiled a bus that will convey two digital mammography machines.

## Bus...continued from front

"This is a great community program that will actually save lives and the ECMC Lifeline Foundation is thrilled to be a partner in," said Jody L. Lomeo, ECMC's CEO and Foundation Board Member. "We hardly finished our presentation when the Sabres alumni and First Niagara said 'yes' and stepped up to fund this. We all know someone touched by breast cancer and we all want to see earlier diagnosis and treatment."

The bus will tour inner-city as well as rural areas of the region. The 45-foot bus will be parked at festivals, health fairs, churches, and community centers to mention a few.

"Among our membership, we've had a number of player wives, daughters, sisters and mothers affected by breast cancer," said director of Alumni Relations for the Buffalo Sabres Larry Playfair. "This is such a useful and meaningful addition to the tools the region brings to bear to help thwart this disease. We are committed to this project, and will stay involved with its growth."

There are only a few dozen such buses in use in various regions of the country. There is one for the whole state of West Virginia and others in Alaska, southwest Florida, Arkansas, Michigan, southern Texas, coastal Connecticut and central Tennessee, and even one operating in Pakistan. One of the first started in 2004 in Western Washington. That program added another in 2008 to keep up with demand.

The program in West Virginia, which has the fifth-highest mortality rate from breast cancer nationally, reached 400 women in 2009 and 1,520 in 2011. The mammography bus is expected to test more than 1,500

in its first year and already has 300 patients scheduled over the first two months

"We say the bus is for the "underserved", it is really for the "never-served", said John Koelmel, president and CEO of First Niagara. "We all know that the key to surviving any cancer, but especially breast cancer, is early detection and treatment. What better way to provide this care than by saying, 'You can't get to us?' 'Then we'll come to you.'"

The bus also furthers ECMC's commitment to the inner-city neighborhoods around its Health Campus. Although the breast cancer incidence rate is 17 percent lower in African-American women than in white women, the mortality rate among black women is 32 percent higher. Moreover, the survival rate for breast cancer in African American women is 75 percent, compared with 89 percent among white women. Mammography screening reduces breast cancer mortality by 35 percent to 50 percent, according to the American Cancer Society.

Although 70 percent of white and African American women 40 years and older received mammograms in the last two years, only 54 percent of African American women nationwide reported having a mammogram within the past year in accordance with American Cancer Society guidelines.

"My philosophy has always been about prevention, access to care, and providing a full spectrum of care," said Dr. Lindfield. "Breast care in Western New York has been fragmented and incomplete for women in need. Today that changes."

Erie County Medical Center Corp.

2 On four side

Buffalo

# Hero Central: Best Friend Gives The Gift of Life

comments

Meissa Holmes

FILED UNDER

Hero Central

BUFFALO, NY- All of us have given a gift to a friend at least once in our lives, but one friend sacrificing so much to give the gift of life to another? That truly takes a special friendship and a hero.

It was once said, "A faithful friend is the medicine of life." That saying now defines the relationship of Ryan Miller and his best friend Lisa Brennan.

"She's been like a sister to me the past 10 years and will continue to be for the rest of my life," said Miller, 30, of Kenmore.

Ryan was born with Renal Tubular Acidosis, and combined with hypertension, it led to chronic kidney disease. Earlier this year doctors dealt the 30-year-old a devastating blow.

"I was told that I would need a kidney transplant or face dialysis," he said.

Ryan just married the love of his life, Nicole, last October, and the couple is expecting their first child this December. This family's bright future suddenly grew incredibly dark and Ryan feared he would lose everything.

"Watch my son grow up and be able to throw the

first baseball with him and play catch and his first day of school," he said.

Ryan wouldn't go down without a fight. He posted pleas for donors on Facebook and handed out donor bracelets with his name and phone number on them.

The response was overwhelming. Eight people came forward to get tested to see if they were a match, and unbeknownst to Ryan, one of them was his best friend, Lisa.

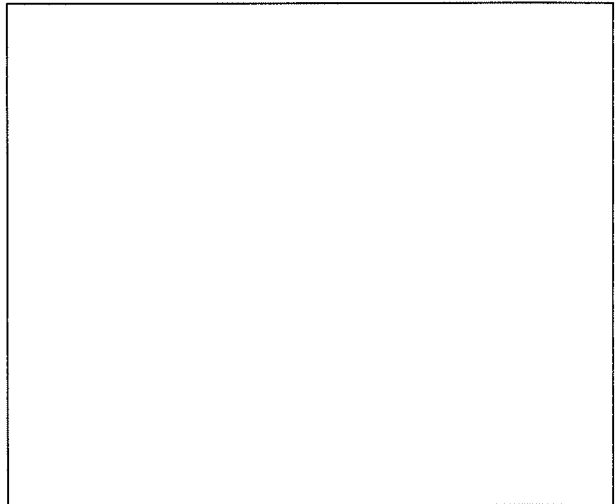
"I knew he would do it for me, in a heartbeat, I knew he would. And so I think that was the driving force," said Brennan, a special education teacher at the Stanley G. Falk School living in Williamsville.

The two met when Lisa was entering her freshman year at D'Youville College and Ryan was a Sophomore advisor helping her create her class schedule.

"We had been best friends ever since then," said Ryan.

"As busy as people's lives get we just always managed to check in with each other and I've been there with him through his engagement and his wedding and numerous birthdays. So we just have a very special relationship," Lisa added.

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## WNY Kidney Connection 2 On Four Side

Buffalo, N.Y.

As Lisa was waiting for the results of the test in May, and some were frankly trying to talk her out of it, she watched a story on Channel 2 News. It was about a man named Mitch Stone, who received a kidney from a complete stranger, Diane Bookhagan, thanks to the WNY Kidney Connection.

"I saw that story and I was so moved. And I was moved to the point where even if I wasn't a match for Ryan I was considering donating to a stranger just to be a living donor," Lisa said.

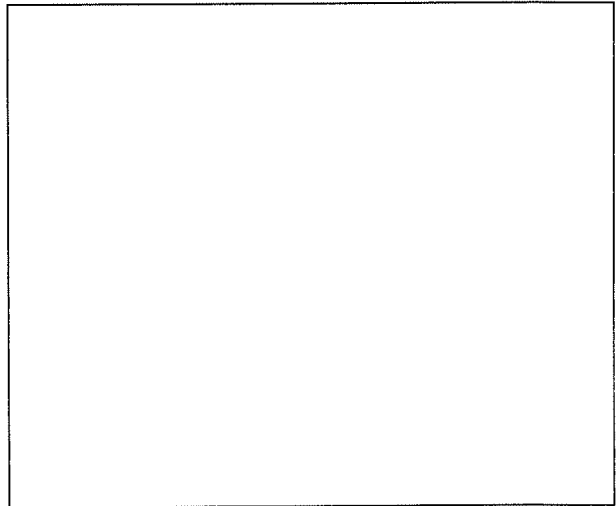
But that wasn't necessary because of all the people tested, Ryan and Lisa's kidney's were the most compatible. She didn't hesitate.

"I've just been so peaceful and calm about the whole thing, that's just how I know I'm doing the right thing," said Lisa. "It's not going to be easy, but it's going to be worth it."

"It takes a special type of person I think to give the gift of life like that and give me a second lease on my life," said Ryan.

Ryan and Lisa's surgeries are scheduled for August 20th at ECMC. On August 10th, the entire D'Youville campus community where Ryan works now as an advisor, and where Lisa's father also works, is coming together for a benefit to help with his medical costs not covered by insurance. They could be as high as \$30,000 in the first year. For ticket and donation information, go to <http://ryanfundraiser.org>.

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# BuffaloNews.com

## Being an organ donor is incredibly rewarding

By **Diane Bookhagen**

Published: July 24, 2012, 2:00 AM

0 Comments

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Updated: July 23, 2012, 5:10 PM

Three months ago, I was admitted to Erie County Medical Center for an elective nephrectomy. Today, with the exception of a small scar on my abdomen, I look and feel as well physically as I ever have. Although my outward appearance is the same, what has changed forever is my heart.

You see, my surgery involved removing my left kidney and transplanting it into a man I had met the week before. Mitch Stone had posted his profile on the Western New York Kidney Connection many months before. He was suffering from a hereditary kidney disease and was facing a future on dialysis. I am in excellent health, am retired and had considered donation for some time. We emailed each other, I was tested at ECMC and we discovered that we were a match. Little did I know that by giving Mitch something he needed, I, too, would receive some remarkable gifts.

When I made the decision to become an altruistic donor, I was aware of the physical risks of major surgery and ramifications of living with one kidney. As a registered nurse and former living donor advocate at ECMC, I could recite "patient education material" in my sleep. What I was totally unprepared for was how donation would impact my life in so many unexpected ways. Another altruistic donor once wrote that his experience was full of surprises. I was surprised when:

\* My loving but opinionated husband didn't put up much of a fight about my decision. He said he knows that when I make up my mind ...

\* Through the experience, my husband and I grew closer.

\* None of my friends thought I was crazy.

\* My Mom and Dad's faith, strength and support got even stronger.

\* I felt like I had known Mitch's wife, Cheryl, forever.

\* I found out how good a pre-op hug from Mitch felt.

\* My sons showed compassion and pride that overwhelmed me.

\* My sister's nurse/angel wings grew even bigger and brighter.

\* I found out how good a post-op shower and new white bathrobe could feel.

\* My friends at ECMC went above and beyond to care for me and protect my peace and privacy.

\* I found out how good a post-op hug from Mitch's family felt.

\* My brother-in-law said he was proud of me on Facebook.

\* My stoic teenage godson lent me the stuffed dog I got him when he broke his leg.

\* My husband continued to go above and beyond to take care of me and our home as I recovered.

\* I missed Mitch as soon as we left ECMC.

I don't know what Mitch experienced with his illness before accepting my gift to him. We haven't had the opportunity to talk much since the surgery. I know he is recovering well. I hope that his new kidney will help him have and share a better life with his family.

There is no way to measure what I have gained through all of this. I know my heart will continue to be open to whatever God's plan is for me from now on. For all of it, I am forever grateful to Mitch.

There are thousands of people like Mitch in Western New York in need of a kidney. We are fortunate to have a state-of-the-art facility right here in Buffalo that performs transplant surgeries. Living donation is a safe, highly successful and incredibly rewarding experience. I would encourage anyone interested in more information to visit [www.wnykidneyconnection.org](http://www.wnykidneyconnection.org).

# Wisniewski Family Speaks Out About Jackie's Murder

12:30 AM, Aug 8, 2012

Buffalo, N.Y. - On June 13th at 8:37 in the morning, Dr. Timothy Jorden, driving a black truck, pulled in to the driveway of his home in Lakeview. He had a .357 magnum with him.

2 On Your Side has obtained the video through a Freedom Of Information request from the Buffalo Police Department.

Four minutes later, at 8:41 that morning Jorden went out the back door of his home.

He walked a few hundred yards toward a wooded area, put the gun to his head and committed suicide.

When his body was found two days later by law enforcement, Jorden was identified in part by a tattoo on his arm.

2 On Your Side has obtained this picture of the tattoo which said "Forever Jackie."

Jackie was Jackie Wisniewski, Jorden's former girlfriend.

Dave Wisniewski is Jackie's older brother.

Dave Wisniewski: "My sister was just somebody who enjoyed life, who tried to smile everyday, she tried to find the positives throughout the day, she was deeply devoted to her family, she wanted nothing more than for people to come together, we called her the glue of the family.

"Jackie loved being a mother more than anything. Her son meant the world to her and she meant the world to him."

This is the first time that the Wisniewski family is speaking publicly about Jackie, and about how her relationship with Tim Jorden turned from a break up, to obsession, to murder.

It all started about a year ago. Jackie, who was a secretary at ECMC, and her young son were living with Jorden when she discovered that Jorden was cheating on her.

Dave Wisniewski: "My sister believed that when you're in a relationship with somebody you deserve a certain amount of respect and when she wasn't getting that respect she walked away. And I don't think there was anything he could have done to get her back."

But Tim Jorden didn't want to hear that, and he wouldn't accept it.

From the outside, Tim Jorden seemed to have it all. He was handsome, a successful trauma surgeon, he made hundreds of thousands of dollars a year and had that home on the lake.

But inside, Tim Jorden was hiding a dark secret.

He bullied and threatened and harassed women.

"One in four women will be touched by this in their lifetime," said Mary Murphy.

Murphy runs the Family Justice Center, a place where victims of domestic violence can turn to for help with everything from orders of protection, to medical treatment, to plans to safely leave an abusive relationship.

Mary Murphy: "Society needs to know that domestic violence does not stop at any zip code, municipal line or any level of education or affluence or any age or race or religion or culture- it's everywhere."

Scott Brown: "So in this case it's a doctor, he's making hundreds of thousands of dollars a year, didn't matter?"

Mary Murphy: "All about the power and control. All about the power and control."

2 On Your Side has learned that back in 2003, Jorden had lost that power and control when another local woman broke up with him.

A source in law enforcement tells us that on June 9th of that year, Jorden was a suspect after someone broke in to the ex-girlfriend's home and stole her computer.

The next day, our source tells us Jorden called his former girlfriend and threatened to kill her.

Jorden was convicted of aggravated harassment, but his record was later sealed after he left the woman alone.

Now nine years later, Jorden was repeating that same pattern of harassment with Jackie Wisniewski.

After Wisniewski broke up with Jorden he began:

- \* Constantly texting her.

- \* Leaving numerous messages on her home answering machine.

And then things escalated.

- \* Jorden started showing up wherever Jackie was.

- \* It turns out that Jorden had hidden a GPS tracking device on her car.

- \* Not only that, but our source tells us that Jorden rented a car in order to try and follow Jackie around without her recognizing him.

Mary Murphy: "When you hear about stalking, that's something that has the potential to turn deadly, very quickly."

Scott Brown: "Given what you know now, was there any question that she was in fear of her life of what he might do to her?"

Dave Wisniewski: "There was never a question, she was in fear of her life. All of her family and friends knew it."

Once Jackie discovered the GPS in March, She went for help to the police in West Seneca where she lived to tell them about the GPS and how Jorden refused to leave her alone.

At this point, Jackie Wisniewski would have just three months to live.

Dave Wisniewski: "When I think about the GPS incident, I think about how much strength it must have taken her to go to the police station."

When the police asked Jackie if she wanted press charges against Jorden she said no.

But that reaction is not unusual for victims of domestic violence.

Mary Murphy: "People who are trying to help victims need to understand that they could be suffering from Post Traumatic Stress Disorder which undermines their ability to think clearly and make good decisions and that they're probably scared to death and being threatened and blaming themselves."

Dave Wisniewski believes that the police should have at least contacted Jorden to let him know they were aware of the GPS device and his harassment of Jackie.

Dave Wisniewski: "We need to do a better job of protecting those who can't protect themselves."

2 On Your Side contacted the West Seneca police chief to ask him about his department's actions in this case, but he declined our request for an interview, telling us that anything he might say could cause the Wisniewski family more grief.

Whether intervention by the police would have stopped Jorden, as was the case with what happened back in 2003 it's impossible to know.

What is known is that Jackie Wisniewski continued to live with Tim Jorden's ominous shadow looming over her.

She tried to protect herself from him, having friends walk her to and from her car at ECMC where both she and Jorden worked, and at times she and her son would stay at her parents' home on weekends.

Dave Wisniewski: "She took the necessary steps that she was comfortable taking."

While researching this story, we wondered how no one who worked with Jorden during this time - his fellow doctors and nurses - could not have noticed some sort of change in him and reported it to someone.

Scott Brown: "Here was a man who was losing his mind, was he still able to operate and function where nobody here noticed anything?"

Jody Lomeo, Chief Executive Officer of ECMC: "Yeah he was. He was operating, he was doing a fine job clinically, he was doing wonderful work. We've searched high and low, we've searched for complaints, his superiors and others, nothing had happened prior."

Scott Brown: "Subsequently, when you heard that Jackie had people walking her to her car and that this harassment was going on, how did that make you feel?"

Jody Lomeo: "Quite honestly, a little disappointed. I'm disappointed that after the fact we heard about that, cause there is processes in place, formal where you can anonymously take advantage of and use that as an opportunity to help someone. In this instance for some reason, I do not know the reason, that didn't happen."

Scott Brown: "Is it fair to say there was a conspiracy of silence here?"

Jody Lomeo: "I will let others judge that to be honest with you, I don't want to, I don't want to make that decision."

Mary Murphy says domestic violence has become society's dirty little secret.

Mary Murphy: "People come up to me all the time and say I'm positive it's my son in law, or my neighbor, or I think it's my golfing buddy but I'm afraid to say anything. We have got to start speaking out and let them know that abusive behavior toward your loved one, toward anybody is completely and utterly unacceptable and you're not going to be golfing with us. Holding these people accountable and responsible I think is key to solving the problem. So that the onus isn't on the victim."

A year after Jackie Wisniewski broke up with him, Tim Jordan may have finally come to the realization that he would never again be able to control her.

Early on the morning of June 13, he left his home in Lakeview with the .357 magnum and drove to ECMC.

At 7:37 that morning Jordan called Jackie on her cell phone knowing she was in her car and on her way to work

The two had a 17 minute conversation that lasted until 7:54

During that conversation, Jordan lured Jackie into meeting him in a stairwell inside the Miller building on the hospital grounds.

At 7:55 Jordan was seen smoking a cigarette in the ECMC parking lot.

He then went into the Miller building and at 7:59, Tim Jordan shot Jackie Wisniewski five times at point blank range.

If Tim Jordan couldn't control Jackie - if he couldn't have her - then no one would.

Jordan then drove back out to his home and at 8:37 pulled into his driveway.

A short time later he turned same gun that he had used to murder Jackie Wisniewski on himself.

Scott Brown: "This has been such a difficult time for you and your family, why did you agree to sit down with us?"

Dave Wisniewski: "I go to bed every night hoping when I wake up the story will have a different



ending, but it never does. My family and I recognize there are a lot of stories out there where the ending hasn't yet been written and the hope is someone out there will hear our story and it won't end like this."

In the wake of Jackie's murder, ECMC is bringing Mary Murphy in to speak to employees to train them about ways to recognize and report incidents of domestic violence.

If you or someone you know is the victim of domestic abuse, here are two groups that can help:

**The Family Justice Center:** <http://www.fjesafe.org/>

**Haven House:** <http://www.cfsbny.org/programs/haven-house/>

A trust fund has been established for Jackie Wisniewski's son. Donations can be made to:

The Jacqueline Wisniewski Trust Fund

c/o M&T Bank, 490 Dorrance Avenue, Buffalo 14218