



DOWNSTATE TIMES

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The Newsletter for SUNY Downstate
University Hospital of Brooklyn



New Leadership Appointments Dr. Moro Salifu appointed Chair of Medicine; Dr. Vinay Tak, Chief of Cardiothoracic Surgery

Two key positions at Downstate were recently announced:

Dr. Moro O. Salifu has been appointed chairman of the Department of Medicine, effective July 1, 2013. Dr. Salifu has served as interim chairman of the Department since January 2013.

Dr. Vinay Tak has been appointed chief of the Division of Cardiothoracic Surgery. He has held the position of interim chief since 2010.

Dr. Salifu is the first recipient of the Edwin C. and Anne K. Weiskopf Endowed Chair in Nephrology, founded in honor of Dr. Eli Friedman and his late wife, Mildred "Barry" Friedman. Dr. Salifu has served as fellowship program director since 2003, and as division chief of nephrology and director of the kidney transplant program since 2008. He is the current president of the New York Society of Nephrology, and contact-principal investigator on a \$5.5 million grant from the NIH to advance the work of the Brooklyn Health Disparities Center.

Dr. Tak attended medical school in India, completing his surgical and cardiothoracic training in England and Scotland. In the US, he worked at the Heart Institute at St. Vincent's Hospital in Portland, Oregon, with Dr. Albert Starr, co-inventor of the world's first artificial heart valve. He additionally trained at New York Hospital of Queens in NYC, and at St. Louis University in Missouri. Dr. Tak joined the Downstate faculty in 2007.

Dr. Tak is a highly skilled surgeon, with expertise in minimally invasive and video-assisted surgical techniques. He is well known for achieving excellent outcomes in difficult and high-risk cases.



Medicine Chair: Dr Moro Salifu



Cardiothoracic Chief: Dr Vinay Tak

Length of Stay Rounds: A Strategy for Success

One of the things that keep hospital administrators up at night is the throughput issue.

"Throughput" refers to the cycling of patients through a hospital's physical resources – beds, procedure rooms, imaging facilities, and so forth. Efficient management of throughput is an essential strategy for growth and for adding capacity to a hospital's ability to admit patients.

Inefficient throughput can negatively impact a hospital's bottom line. Most patient admissions have an estimated length of stay prescribed by third party payers for conditions or procedures. Additionally, if patients are not discharged on time, the emergency department gets backed up, with cascading results. Patients wait for too many hours in the ED, because ED beds are occupied by patients waiting for beds in the inpatient units.

continued on page 3



Moving Forward Under the Affordable Care Act



By *Grace Wong*
Vice President
Managed Care & Clinical
Business

The march towards full State-mandated Medicaid Managed Care enrollment continues. Hospital reimbursement systems are transitioning from being calculated on volume and fee-for-service to being calculated on “value-based care” that focuses on performance measures such as reduced inpatient readmissions and average length of stay.

to correctly identify insurance status, to contact payers with required patient information for approvals, to bill appropriately, and resolve denials quickly will only increase going forward. We need to work across internal silos to troubleshoot issues as they occur.

We also need to increase the use of observation status as a means of providing better, more efficient care to patients. Using observation status instead of direct admission for clinically marginal admissions should lead to a decrease in unnecessary admissions and subsequent

These efforts should improve Downstate’s quality indicator data. Quality metrics are quickly becoming a more integral part of managed care contracting. Improving Downstate’s quality scores will be critical to attaining the enhanced rates we have negotiated with several of our insurance partners, including Empire BlueCross Blue Shield, United Healthcare, and Healthfirst.

Our ultimate goal is to improve patient satisfaction, provide the best health care for our patients, and build a stronger hospital.

One-day stay admissions present red flags to managed care companies and these cases are at a higher risk of denial.

The result of this policy shift is shrinking fee-for-service admissions at all hospitals, including here at University Hospital of Brooklyn, and it has major implications for us.

To enhance revenue collection and ensure timely payment from insurers, it is critical that we focus on improving communication between Downstate’s clinical and operational sectors. The pressure

denials for payment by insurers. One-day stay admissions present red flags to managed care companies and these cases are at a higher risk of denial.

One of the ways we have addressed this is by adding an additional case manager in the Emergency Department during peak hours. This has doubled the number of cases admitted to observation status – a trend in the right direction.

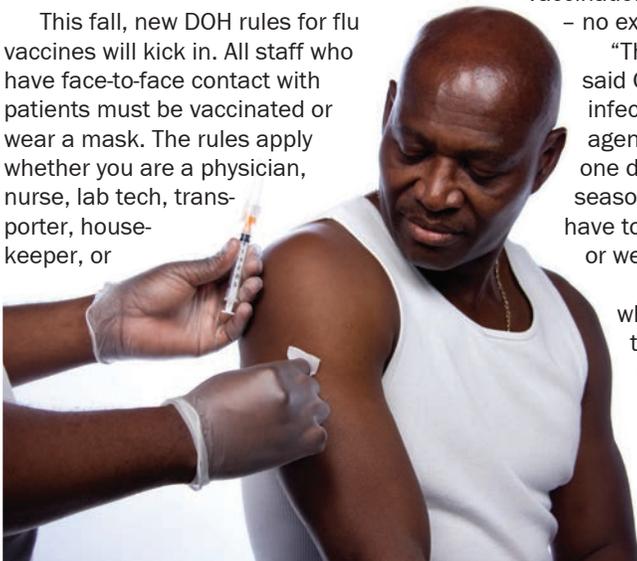
New “Two Midnight” Rule

On August 2, 2013, the Centers for Medicare and Medicaid Services issued a final rule for FY 2014 fiscal policies, clarifying inpatient hospital admissions guidelines for Part A payment. The “two midnight” rule presumes that inpatient admission is reasonable when a physician: (1) expects the patient-stay to cross two midnights, and (2) admits based on that expectation. Procedures must be on the “inpatient-only” list and clearly documented in the medical record.

Flu Shot or Mask? Hint: Go for the Shot

Under New DOH Vaccination Rules, Hospital Staff Who Aren’t Vaccinated Must Wear Masks to Protect Patients.

This fall, new DOH rules for flu vaccines will kick in. All staff who have face-to-face contact with patients must be vaccinated or wear a mask. The rules apply whether you are a physician, nurse, lab tech, transporter, house-keeper, or



food deliverer: If your job takes you into a patient room, or an area where there are patients, you will either need proof of vaccination or be prepared to mask up – no exceptions!

“The new rules are very strict,” said George Allen, director of infection control. “Even if an agency nurse were to work only one day during the current flu season at this facility, s/he would have to show proof of vaccination or wear a mask.”

The rule will kick in at whatever point in time the New York State Commissioner of Health determines that flu has become prevalent. In some

Robert Richards, UHB senior associate administrator, gets his flu shot.

UHB Vaccination Rates

2011-2012 **37%**

2012-2013 **57%**

UHB has substantially improved its vaccination rates. But the new regulations mean we need to do even better.

years, that could be as early as October, or as late as May.

“We’re not going to wait,” said Dr. Allen. “We’re going to be very aggressive with our vaccine fairs and with taking mobile vaccine carts to the floors, to make it easy for staff to get their shots.”

Watch for Upcoming Announcements of Flu Fairs and On-Unit Vaccination Schedules.

continued from page 1

On the inpatient units, length of stay rounds help to facilitate discharges. They also help to facilitate patient placement to rehab or nursing homes.

At Downstate, we initiated length of stay rounds in April 2013. They are conducted every Wednesday at 9 am, and start from the 8th floor down to the 3rd floor, except for the psychiatric unit.

At these rounds, all patients who have been in the hospital for 7 days and above are evaluated, with continuing stay justified by the nurse managers on the unit, social workers, case workers, and doctors/ providers caring for these patients.

This reflects the fact that optimizing throughput is a process that involves multiple connections and interdependencies. It requires communication between departments, and with support services, transport, timing of tests and physician discharge rounds – all elements that play a role in efficiently moving patients through the system.

Early results are encouraging: between March and July, UHB's average length of



(L to r): Rachael Saibu, case worker, Transplant; Diane Charet, director, Social Worker; Elizabeth Igboechi, Nursing; Carol Rowe-Johnson, supervisor, Case Management; Cheryl Rolston, Sr. TH. associate administrator, Nursing; Nelcia Trim, ADN NS82; and Joy Castro, interim director, Case Management, who leads the team. Not shown: Dr. Mafuzur Rahman, director, Hospitalists; Karen Lemer, Pitts Management.

stay dropped from 6.1 to 5.5 days.

It is evidence-based that discharges that occur on or before targeted length of stay help to decongest the ED. Improved hospital throughput also has another benefit: By helping to ensure that patients are seen timely in the ED and admitted

onto the units, patient satisfaction improves.

**By Elizabeth Igboechi, RNC-OB, MSN, FNP, NEA-BC
Director of Nursing, Women & Children/
Transplant/Dialysis**

Infant and Child Learning Center Celebrates Graduation

Every year in the spring at graduation ceremonies for its five colleges, SUNY Downstate Medical Center sends hundreds of dynamic new professionals into the fields of healthcare and science.

But each summer, SUNY Downstate also sends some of Brooklyn's most vulnerable children into the world newly equipped with important skills that they will need to grow into healthy and productive adults.

The occasion for the latter is the annual Graduation Celebration of Downstate's Infant and Child Learning Center (ICLC), which helps children with special needs overcome obstacles related to developmental delays.

ICLC offers programs for children from birth to five years old, both on site and in homes and daycare settings, and works in partnership with parents to achieve the best possible outcome for the child's

continuing development.

At the recent ceremony, hosted by ICLC Co-Executive Director Kathy McCormick, MS, LMHC, 55 children graduated from the Center's preschool program. In the fall many of them will enter kindergarten. In addition, approximately 200 younger children graduated from ICLC's early intervention program and most of them will go on to pre-kindergarten.



Pauline Foster, with daughter Kimora, who graduated from the preschool program.



Downstate's youngest graduates: over 250 children and their families celebrated a proud milestone at graduation exercises in August.

Alarm Fatigue and Patient Safety

By Dianne Forbes Woods, RN, MA, NE-BC
Deputy Nursing Director

Walking onto a patient care unit in a hospital today is anything but a quiet experience. Infusion pumps, ventilators, and ECG monitors are just a few of the types of medical devices attached to patients delivering therapies and providing clinical information.

These alarm-equipped devices are essential to providing safe care to patients; nurses and doctors depend on them for information needed to guide treatment decisions.

However, as The Joint Commission noted in its recent Sentinel Event Alert (Medical Device Alarm Safety, April 8, 2013) these devices present a multitude of challenges when their alarms create similar sounds; when their default settings are not changed; and when there is a failure to respond to their alarm signals.

The number of alarm signals per patient per day can reach several hundred depending on the unit, translating to thousands of alarm signals throughout the hospital every day.

The Joint Commission's national Sentinel Event database includes reports of 98 alarm-related events between January 2009 and June 2012, with 80 resulting in death, 13 in permanent loss of function, and five in unexpected additional care or extended stay.

Major contributing factors include:

- Absent or inadequate alarm system (30)
- Improper alarm settings (21)



Alarms can be critical to patient safety, but failed response to alarms can lead to patient harm and even death.

- Alarm signals not audible in all areas (25)
- Alarm signals turned off (36)

Another major contributing factor is "Alarm Fatigue." Alarm fatigue can develop when a person is exposed to an excessive number of alarms.

This situation can result in sensory overload, and can cause a practitioner to become desensitized to the alarms. Consequently, the response may be delayed, or alarms may be missed altogether.

Although studies show it is difficult for humans to differentiate among more than six different alarm sounds, the average number of alarms in an ICU has increased from 6 in 1983 to more than 40 different alarms in 2011.

As noted in a July 7, 2013 *Washington Post* article ("Too Much Noise from

Hospital Alarms Poses Risk for Patients") clinicians and patient-safety advocates have warned of alarm fatigue for years, but the issue is taking on greater urgency as hospitals invest in more complex, often noisy devices meant to save lives.

This "alarming" issue needs the full support of healthcare leadership, clinicians, researchers, and manufacturers to ensure patient safety.

Strategies to Combat Alarm Fatigue

In June, The Joint Commission, which accredits hospitals, directed facilities to make alarm safety a top priority. Starting in January 2014, hospitals must identify the alarms that pose the biggest safety risks by unnecessarily adding noise or being ignored.

Here are some action strategies suggested by the American Association of Critical Care Nurses and other organizations:

1. Provide proper skin preparation for ECG electrodes and change them daily (this reduces false alarms from poor connections).
2. Customize alarm parameters and levels on devices (Individualizing parameters reduces the number of alarms not requiring intervention.)
3. Provide ongoing education to all staff on alarm awareness and alarm fatigue.
4. All employees, from housekeepers to administrators, who pass by a patient's room should stop if they hear an alarm. They need to make sure the patient is breathing and call for help if necessary.

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Doris Youdelman, editor of Downstate Times, has retired from Downstate after 16 years of service. We wish her well and many thanks for shepherding the launch of Downstate Times.

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