



NotaBene

TAKE NOTE OF THIS

A PUBLICATION FOR THE MEDICAL STAFF OF KENNEDY HEALTH SYSTEM

Appreciation

Over the last three years, I have filled this page with issues related to clinical outcomes, performance management, revenue challenges, and other healthcare management “fast talk.” My intent is to avoid couching issues in a context other than the one you experience, drawing a brief focus to a changing issue in healthcare. I hope that a little more understanding of changes will ease the burdens you face.

Still, it is difficult to escape the conclusion that, with each year, it becomes harder to be a physician. Our job is not well done until it is well documented, sometimes twice and more. Beyond doing a good job providing clinical services, we must also be good customer service agents, sociologists, and marketing agents, too. Revenues are down and our working hours are up -- sometimes way up.

The nursing and ancillary staffs experience the same trials. The call for greater efficiency is never silenced, just mollified by larger efforts or longer hours. The information age has promised greater efficiencies, but in reality, the systems that enable our work completion ironically measure our human failures with equal facility. I understand the despair that leads one to question if staying in healthcare is important.

In the middle of this equation is the patient – the salvation for our professions. The patient is the glue that really keeps our system together; a shared purpose that keeps efforts on track. Each patient is the reason for extra-mile efforts. Patients help us laugh, make us weep, share their joys, and carry us in their tragedy. It is their appreciation that keeps our systems going.

So as we start the New Year together, I must echo the words of many patients and say, “thank you.” Your efforts over the years past are the best evidence that the years before us will be better!

-DLH

New Appointments

Department of

Emergency Medicine

Amy C. Grogan, NP

Jarrid Bernhardt, DO

Department of

Family Practice

Geronima G. Alday, MD

Geriatrics

Department of

Medical Imaging

Mark H. Lee, MD

Department of Medicine

Ramya B. Arerangaiah, MD

Internal Medicine

Anshu Bhalla, MD

Geriatrics

Brian J. Corbett, DO

Internal Medicine

Rose M. Cummings, DO

Cardiology

Mark Friedman, DO

Neurology

Meshell Mansor, NP

Internal Medicine

Priya C. Singh, MD

Hematology/Oncology

Brahmesh Sivaprakasapilla, MD

Internal Medicine

Department of Pediatrics

Gerda Augustin, MD

Department of Surgery

Dorothy Albano, CRNA

Anesthesiology

Densie D. Collins, CRNA

Anesthesiology

Lisa Filbey, CRNA

Anesthesiology

Susan Sarkos, RNFA

Orthopedic Surgery

Physicians in the News

Melanie Angelo, DO, received the APPLE Award from the New Jersey Institute for Nursing at a Gala on October 30, 2008. Dr. Angelo was one of 10 doctors statewide to receive this award, which recognizes physicians who are supportive of nurses and the patient advocacy that is the foundation of nursing. She is the medical director of the Kennedy-Cherry Hill Emergency Department.



Joseph N. Bottalico, DO, FACOOG, worked with a clinical group from around the country to publish an article titled "The Clinical Content of Preconception Care: Women with Chronic Medical Conditions." It appeared in a special supplement of the AJOG.

Richard T. Jermyn, DO, FAAPM&R, received the Purdue Partners Against Pain Award for his work as director of the University Pain Care Center. The philosophy of the UPCC is multimodal, emphasizing the progression to wellness.

Joanne Kaiser-Smith, DO, FACOI, FACP, was selected as an AOA Mentor of the Year Finalist. Dr. Kaiser-Smith, Chief of Internal Medicine for UMDNJ-SOM, was selected as one of five finalists from more than 200 osteopathic physicians nominated nationally.



System-Wide Department Meetings for 2009

Medicine and Family Practice

7:30 a.m. in the Stratford 3rd-floor Large Conference Room – March 9 and October 19

Surgery

7 a.m. in the Stratford 3rd-floor Large Conference Room – February 23, May 18, September 21 and December 7

OB/GYN

7:30 a.m. in the Washington Township 3rd-floor Classroom – January 30, March 20, June 19 and October 2

Pediatrics

7:30 a.m. in the Washington Township 3rd-floor Classroom – March 10 and October 6

**Please Mark Your Calendars –
Annual Medical Staff Meeting Slated for March 25
6 p.m. at The Mansion in Voorhees**

Beacon Awards Shine Spotlight on Two Kennedy Physicians

The 3rd Annual Beacon Awards will be held at the Annual Kennedy Gala. This year, two of the four winners are physicians. The former Chief of Radiology at



Kennedy-Cherry Hill – **Dr. Sherman Bannett** – will be honored for his long service to Kennedy and many leadership roles, including Board Member, Chief of Staff and Medical Director at Kennedy-Cherry Hill. Even

after retiring, Dr. Bannett has always been available to assist Kennedy in meeting its objectives.

Dr. Joseph Pitone has been selected as a Beacon Award winner for his commitment to his patients and the field

of Nephrology, as well as his 30 years of service to Kennedy. Dr. Pitone was instrumental in opening Kennedy's first dialysis center in the mid-1990s. Kennedy is a leader in this service with more than 50 outpatient treatment stations.



Dan Ragone, CPA, a longtime Board member, and **Alice Farrell, RN, BSN, CEN**, will also receive Beacon Awards for their significant contributions to Kennedy and the community.

Restricted Resident Work Hours: Has It Worked?

Since its inception in 2003, the policy to reduce Medical Residents' work hours to a maximum of 80 hours – in an attempt to reduce fatigue-related medical errors -- has had mixed results at best, and overall improvement in patient safety and resident safety has not been realized.

Recent Studies

Several large studies have looked at the impact of restricted hours, including researchers at Boston's Brigham & Women's Hospital. While the mean length of call decreased by 2.7% to 28.5 hours and the rates of Resident burnout decreased greatly from 74.5% to 57%, researchers found that 24-30 hour shifts remained common, call frequency did not change; Residents' sleep hours also did not change. There was no change in overall medication errors, and a slight increase in Resident physician ordering errors, from 1.06 to 1.38 per 100 patient days. Other literature suggests that as long as 24-hour shifts remain the norm, the incidence of

fatigue-related errors in academic medical centers will remain high.

Good News from UCLA

Perhaps some recent good news: researchers from Harbor-UCLA Medical Center looked at Resident-assisted laparoscopic gall bladder surgery before and after the work-restricted hours and found fewer bile duct injuries and post-op complications after the work restrictions took effect.

The Institute of Medicine is expected to release new recommendations later this year regarding Resident hours and patient safety. Further restrictions are being recommended by some and may become reality, but unless CMS starts to expand cap numbers, covering all hospital services 24/7 will become impossible.

-CJB

Infection Control: Hand Hygiene and Physician Practices

By Todd Levin, DO – Infectious Diseases

In 1847 at the Vienna General Hospital, the father of hand hygiene, Ignaz Philipp Semmelweis, hypothesized that healthcare workers contributed to increased mortality from puerperal sepsis in the obstetrics clinic by not properly disinfecting their hands. Doctors and medical students delivered babies immediately after performing autopsies. Semmelweis noticed that an adjacent clinic tended by midwives had a lower mortality. After instituting effective hand hygiene with a chlorinated lime solution, the mortality rate decreased to less than 2%, comparable to the mortality in the midwives' clinic.

Poor Hand Hygiene Among Physicians

Despite understanding the benefits of proper hand hygiene, doctors are notoriously poor at adherence. A recent study showed that physician hand hygiene compliance was 72.4% compared to 91.3% for nurses ($p < .001$).¹ Another study stated that average physician adherence to hand hygiene was 57%.² This varied according to professional status (49.3% for attending, 56.9% for fellows or residents, 78.9% for medical students, and medical specialty (87.3% for internists, 82.6% for pediatricians, 50% for ED physicians, 36.4% for surgeons, and 23.3% for anesthesiologists). Even at a meeting of the Infectious Disease Society of America, adherence to hand hygiene in a public restroom was only 67.7% (86.6% for women and 56.4% for men).³

CMS Gets Stricter

On October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) stopped paying hospitals for certain "hospital-acquired conditions" such as catheter-associated urinary tract infections, catheter-related bloodstream infections, and various surgical site infections.⁴ In the future, the list may be expanded to include *Clostridium difficile* colitis, ventilator-associated pneumonia, *Staphylococcus aureus* septicemia, and surgical infections after elective procedures.⁵ Improved hand hygiene can help prevent all of these infections.

Standard Precautions Must Be Followed

Various forms of isolation are used to decrease the spread of nosocomial infections and to provide personal protection. Standard precautions must be followed for all patients. This includes hand hygiene before and after patient contact, the use of gloves, gowns, and eye protection when exposure to body secretions or blood is possible, and hand hygiene after gloves are removed. In addition, contact isolation is needed when patients are infected or colonized with multi-drug resistant organisms, such as MRSA, VRE, and some Gram negative rods. The outside of their rooms are marked with a yellow Contact Precautions sign. Contact isolation is also needed for patients with *Clostridium difficile* colitis. Their rooms are marked with a new green Contact Precautions CD sign. This green sign indicates that hand hygiene, specifically with soap and water, is necessary to kill or remove the spores from our hands.

How Can We Improve Hand Hygiene Adherence?

Pittet, et al.² noted that adherence was associated with the belief of being a role model for other colleagues, and the awareness of being observed. As physicians, we are all role models for fellows, residents, students, nurses, nursing aides, pharmacists, physical therapists, dieticians and transportation staff. **We must lead by example.** We are always being observed. Finally, we must help each other achieve higher adherence levels. Every hospital employee and even patient should be empowered to ensure that hand hygiene is being followed. If you witness a missed opportunity for hand hygiene or notice that isolation procedures are not being followed, it is a professional responsibility to ensure that it does not happen again. We will all benefit in the end.

1. Duggan, et al. *Infection Control and Hospital Epidemiology* 2008;29(6):534

2. Pittet, et al. *Annals of Internal Medicine* 2004; 141:1.

3. Plotkin, et al. *ICAAC abstract F156, 1994.*

4. www.cms.hhs.gov

5. Amin. *Infectious Diseases Special Edition* 2008;1:71.

Kennedy's Behavioral Health Services Observe World AIDS Day

On December 1, 2008, World AIDS Day was observed around the globe. Unfortunately, the connection between mental health disorders, substance abuse, and HIV/AIDS remains alarming. In the United States alone, among those with mental health and substance abuse issues, the prevalence of HIV is estimated at 3.1%¹ compared to the estimate for the general population of 0.03%. The Substance Abuse and Mental Health Services Administration (SAMSHA) reports:

- **AIDS is now the 5th leading cause of death in the U.S.** among people between the ages of 25 and 44.
- **One half of all new HIV infections in the U.S. are diagnosed in those under age 25.**
- **More than 60% of new AIDS cases in the U.S. occur among minorities.** Forty-five percent are among Blacks and 21% are among Hispanics.
- Among persons with HIV infection, **adjustment disorder and depression are the most common mental disorders.**²

Substance Abuse and Mental Health

In addition, among those with mental health disorders, patients who engage in substance abuse have been shown to be 4-5 times more likely to have increased risk of exposure to HIV than patients who are not abusing substances.

Initially, when patients are diagnosed with HIV/AIDS, they may feel overwhelmed, frustrated, or become depressed, angry, sad or hopeless. These and other feelings can potentially lead to negative and self-destructive behaviors which can further result in decreased compliance with HIV/AIDS medication regimens.

Risk Factors

Risk factors, such as "depression, mania, impulsivity, substance abuse, intoxication, cognitive impairment, and personality vulnerabilities," are all associated with HIV infection. Pinpointing exact cause and effect is difficult but one thing is certain; patients involved with treatment have better outcomes for their HIV/AIDS, mental health and/or substance abuse issues than those who are not engaged in treatment.

Mental health and substance abuse treatment offered by Kennedy's Behavioral Health services can offer hope to each of these groups. Treatment can help a patient gain better footing and begin the journey of recovery, assist a patient to develop self preservation or safer sex practices, or allow a patient with HIV/AIDS to take hold of their lives by grabbing onto hope and understanding. It can also complement the efforts and objectives of the medical practitioner.

To learn more about Kennedy's Behavioral Health Services and how to access our services, please call the ACCESS Center at **1-800/528-3425**.

*-John Pellicane
Behavioral Health Case Management Specialist*

1. "Prevalence of HIV Infection in a General Psychiatric Outpatient Population", John L. Beyer, M.D. et al. Dept. of Psychiatry, Duke University Medical Center, Durham, NC. *Psychosomatics* 48:31-37, February 2007

2. <http://mentalhealth.samhsa.gov/publications/allpubs/fastfact4/default.asp>

AND What's Next...

The hospitals' efforts to prevent sudden death have undergone a number of rewrites over the years. A review of the changes leads to some interesting perspectives on resuscitation. In its early form, physicians spoke of having nothing left to offer a patient. At the time, a patient's expectations at the end of life were not very high, and hospitals remained a place to go to die until the late 19th century. And many ill people never went to the hospital. This practice lasted well into the 20th century.

Early cardiac defibrillation later showed value in preventing sudden cardiac death. This technology really saved lives and, not unlike the revolution which antibiotics brought to medicine, defibrillation made doctors modern-day heroes. The hospital had come full circle: not only was it not a place to die, but a place where death could be prevented – at least, that was the implied promise.

Resuscitation Terminology

Changes in the terminology of resuscitation followed. When defibrillation was considered ill-suited to the patient, physicians ordered “No Heroic Measures.” At other times, we would be heroes. Television helped the public believe that cardiopulmonary resuscitation was entirely possible. TV's Dr. Marcus Welby was a multi-talented physician, but M*A*S*H's Hawkeye could restart your heart and put you back together in a forward battle zone. Obviously, your local hospital would have unlimited successes.

Of course, outcomes research on hospital resuscitation remained fairly sobering over the years. Critical care units were not preventing death as much as they were prolonging survival. Over time the “Hero” label was removed and *No Code Blue* was adopted, only to be economized to *No Code*.

The American Heart Association prompted growth in the science of resuscitation and decentralization of the response plan. Everyone can provide basic CPR and it is certainly beneficial when initiated in the community.

Public knowledge CPR, defibrillation, intubation and central-line placement grew quickly. The dominant model is that everyone is resuscitated, but in response, there was a backlash as not everyone wants death to end with the “violence” of CPR. Health rights advocates argued for greater patient control through *Do Not Resuscitate (DNR)* orders, a decision individual patients should make with their doctor. In later years, *Do Not Intubate (DNI)* was added to DNR. The reason for this addition is not entirely logical from a medical perspective, but when used appropriately, it is reassuring to patients with chronic respiratory concerns.

More recently, the language is changing again. The term *Allow Natural Death (AND)*, which has been around for some years, has been gaining acceptance. It is an appropriate language change that reopens the door to death being a natural process, not merely an end event to be thwarted by resuscitation. Dying is a process that concludes with death. Using AND signals the arrival of public consensus that discussion about resuscitation (DNR, no DNR) often fail to meet the breadth of the patients' personal needs during the dying process, and it yields greater control to the patient.

Coming Full Circle

We have come full circle from *No Heroic Measures* to *Allow Natural Death* to occur. One focuses on **what not to do** and leaves little clarity; the other changes the conversation to focus on **what to do**. Using AND helps us to be better communicators. *Allow Natural Death* are words that provide comfort to patients and families in difficult circumstances. And these words suggest a death unobstructed by technology, and instead supported by care that meets the patient's goals, including relief of pain and suffering.

At this time, Kennedy will have to consider the formal use of the term AND, but these words will surely find their place in our conversations with patients and families.

-DLH

Robotically-Assisted Surgery Debuts at Kennedy-Washington Township

In November 2008, Kennedy became the first hospital in the Gloucester County region to perform surgery using Intuitive Surgical's *da Vinci*® S HD™ System, commonly referred to as "robotically-assisted surgery."

Dr. Gordon Brown – a Fellowship-trained urologic oncologist who specializes in the surgical management of cancers of the kidney, bladder and prostate – performed a prostatectomy November 18th using the new *da Vinci S HD* Surgical System, which integrates 3D HD endoscopy and state-of-the-art technology to virtually extend the surgeon's eyes and hands into the surgical field. Dr. Brown underwent specialized training and has extensive experience in robotically-assisted surgery, having completed a urologic oncology Fellowship at M.D. Anderson Cancer Center in Houston, TX.



In mid-December, Board-certified obstetrician/gynecologist **Dr. Eric Grossman** performed a robotically-assisted *da Vinci Hysterectomy* using the new *da Vinci S HD* Surgical System. Board certified in Obstetrics and Gynecology, Dr. Grossman has additional training in Essure® Hysteroscopic Tubal Sterilization

and *da Vinci*® robotically-assisted surgery. He received the AMA Physician Recognition Award for 2007-2009 and was named a "Top Doc" by *SJ Magazine* in 2008.

Using the *da Vinci Surgical System*, the surgeon operates while seated comfortably at a console viewing a 3D image of the surgical field. The surgeon's fingers grasp the master controls below the display, with hands and wrists naturally positioned relative to his or her eyes. The system seamlessly translates the surgeon's hand, wrist and finger movements into precise, real-time movements of surgical instruments inside the patient.

Many surgical procedures performed today using standard laparoscopic technique may be performed more quickly and easily using the *da Vinci Surgical System*. This is because the *da Vinci Surgical System* delivers increased clinical capability while maintaining the same "look and feel" of open surgery.

For more information about the *da Vinci* robot, call Executive Business Director of Perioperative Services **Christine Therrien** at **856/582-5253**.



Administrators and Nursing AVPs at the Hospital Campuses

Below are the names and photos of the six key managers at the hospital campuses that physicians should go to with any problems or concerns. For nursing-specific issues, see the AVP of Patient Care Services. Operational issues should be addressed by the administrator at that campus.

Kennedy-Cherry Hill



Frank Hendricks
*AVP of Hospital
Operations*



Cheryl Rosselli,
RN, MSN
*AVP of Patient
Care Services*

Kennedy-Stratford



Kathy Emrich
*AVP of Hospital
Operations*



Helene Burns,
RN, MSN
*AVP of Patient
Care Services*

Kennedy-Washington Township



Joe Devine
*Sr. VP of Physician
Relations/Interim
VP of Hospital
Operations*



Karen Sobczak,
RN, MSN
*AVP of Patient
Care Services*



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